Executive Summary

1. **The Philippines’ population has grown 12-fold since the turn of the century, and will reach over 160 million in 2040 if the current trend (2.04% population growth and 3.03 average fertility rate) persists.**
   - This has led to the inability of governments to provide adequate social services, while poverty persists at 33%.
2. **Women are most affected by the inability to access effective reproductive health information and methods.**
   - Filipinos suffer from among the highest regional maternal health morbidity and over 500,000 induced abortions annually, and at least half of which can be prevented through a modern family planning program.
3. **Poor families are affected by the lack of access to family planning education and methods.**
   - The country’s persistent high fertility rate (3.03%) vs. more prosperous countries is due to inability of families, especially the marginalized ones, to meet their desired family size.
4. **Majority of Filipinos (9 of 10 surveyed) support family planning, particularly modern methods.**
   - Most Filipinos support the RH bill, politicians who advocate family planning, and the country is the only predominantly Catholic Country that does not have a policy supporting modern family planning methods.
5. **Global Sustainable Development Principles and the Philippine Constitution warrant family planning as a fundamental and constitutional right.**
   - With the country’s biocapacity (resources to sustainably support life) breached, and only 10% of its forest cover, coral reefs, and food self-sufficiency, the Philippines must exercise the globally accepted Precautionary Principle to preserve its remaining resources to ensure the survival and well-being of future generations.
6. **The Philippines can learn lessons from how progressive countries with different ideologies and faiths have adopted family planning policies that support their sustainable development.**
   - Catholic Countries such as Chile and Colombia; Islamic countries such as Iran and Indonesia; and Buddhist countries such as Thailand have shown success in terms of effectively lowering and sustaining fertility rates while improving their socio-economic indicators towards long-term sustainable development.
7. **Given these realities, a 5-point Demographic Governance Program must be implemented in the Philippines:**
   - **Funding for Family Planning***. Enabling adequate resources for both modern and natural family planning methods at the national and local level, with public, private, and international sources
   - **Public Private Partnerships for Family Planning Education***. Coordination of a nation-wide grassroots information and education program by national and local governments, NGOs, churches, and the media.
   - **Direct Poverty Interventions**. Synergistic, coordinated combination of Conditional Cash Transfers, Microfinance & Women’s livelihood, and Informal Settler Housing and Registration (I-SHARE) Program
   - **Demographic Institutional Alignment***. Consolidate all demographic programs under a Dept. of Population and Migration, or reform Population Commission to manage overall Family Planning Policy.
   - **Land use and Demographic Monitoring**. Finalize Land Use Policy (National and Local Level); Enforce the Urban Housing Development Act, Tax idle lands and use proceeds for I-SHARE Program, and map regional and nationwide demographic movements for better planning and responses.
8. **By balancing resources with sustainable demographic demand, this enables the ff. Key Result Areas (KRAs) in 10 years and allows the Philippines to meet its commitments to the U.N. Millennium Development Goals:**
   - Increase contraceptive prevalence rate from under 50% to above 70%,
   - Reduce unintended abortions to half (under 250,000/annually)
   - Lower total fertility rate from 3.03% to 2.1% (sustainable replacement rate)
   - Increase Health and Education budgetary spending by 30%
   - Improve GDP per capita and Human Development Indexes, and lower poverty rates 33% to 25%

*requires national legislation and complementary local regulations to ensure sustainability, optimal reach, and positive outcomes.
I. Philippines Overview
(c/o UN Development Programme, National Statistics Office, UP School of Economics)

- Philippine Population increased **12-fold from 7.6 million in 1903 to 94.6 million Filipinos (2010)**
  - expected at 160 million in 2038 (See Table 1)
    - conservatively assumes a 2.1 total fertility rate (TFR, average children/woman) by 2020
  - Philippines is **12th most populous nation** in the world, 72nd in land area
  - Fertility rate at 3.03%, 4 babies born every minute

Table 1: The year in which a country reaches replacement level fertility has a major impact on its ultimate population size.

- Despite economic growth, **53% of Filipinos rate themselves poor (SWS Survey 2007)**
  - Over 5 million households and **30 million Filipinos live under poverty line**.
  - Poverty incidence among population in the Philippines increased to 32.9% in 2006 from 30% in 2003.
    - Autonomous Region of Muslim Mindanao (ARMM) posting the highest incidence at 61.8%.
    - Poverty incidence among families also worsened from 24.4% in 2003 to 26.9% in 2006.
  - The Philippines is now **the 5th on the global hunger survey** (Gallup Voice of the People Survey)
    - 40% polled have experienced involuntary hunger, consistently since 2007.

- The Philippines has the **highest population growth rate in the ASEAN region** with 2.04%, higher than Cambodia (1.9%); Malaysia (1.6%); Indonesia and Vietnam (1.1% each); and Thailand with 0.4%.
  - The country also has the **highest fertility rate** with 3.3%, followed by Cambodia (3%), Malaysia (2.5%), Indonesia and Vietnam (2.1%), and Thailand (1.5%).
  - Because of growing young population, the country has the **highest unemployment incidence** with 8% followed by Indonesia (7.9%), Vietnam (4.6%), Malaysia (3.7%), Cambodia (3.5%) and Thailand (1.5%).

- On the Foreign Policy Annual Ranking of Failed States¹, the Philippines climbed up the ladder, thanks to high population pressures.
  - Philippines is in the same league as Equatorial Guinea, Egypt, Laos, Pakistan, and Bangladesh in terms of population pressures, (7.7/10); overall, ranked worse than West Bank, Papua New Guinea, and Angola.

- The country’s population has doubled since 1970, and is **expected to double in 30 years**.
  - If no family planning efforts are done, and replacement fertility is not reached until 2050, the population could grow to **160 over million, or almost twice as high as in 2007**.
    - For health, the growth scenarios above suggest that health expenditure will need to at least double, with an even higher burden for the high-growth scenario (Racelis, 2008).
    - Population pressures can also increase environmental degradation and may push more people into areas that are more prone to natural disasters.

¹ Foreign Policy Magazine’s Annual Ranking of Failed States. www.foreignpolicy.com; The Philippines climbed up the ranking and is now at 53 (2009) from 58 in 2007, driven by a key component: population pressures
- Philippines has less than 10% of its forest cover and coral reefs remaining.²
- Less than 50% of the country’s ground fresh water resources is potable.³
- Untreated domestic wastewater (90%) from congested communities threatens water bodies further.⁴
- Diseases from polluted water (31% of total illnesses in the country), in turn, costs Php 6.7 billion (US$134 million) annually.⁵
- Only 1,907 cubic meters of fresh water are available to each person each year, making the Philippines 2nd to the lowest among Southeast Asian countries with fresh water availability.⁶
- Only 39% of 525 water bodies are potential sources of drinking water.⁷
- 44% of the population earn less than $2/day, and of 2/3 of the population are engaged in unsustainable environmental and natural resource usage.⁸

- Population growth raises pressure to provide for a larger population, reducing the time to make necessary adjustments (technological & institutional) to accommodate a larger numbers at higher living standards.
  - Institutional and technological responses to population do not occur automatically, entail costs, and take time to provide desired results. Slow population growth allows for more space and time to create the necessary technological and institutional adjustments.⁹
  - “Slower population growth has in many countries bought more time to adjust to future population increases. This has increased those countries’ ability to attack poverty, protect and repair the environment, and build the base for future sustainable development. Even the difference of a single decade in the transition to stabilisation levels of fertility can have a considerable positive impact on quality of life.”¹⁰
  - Already, the Philippines shares the vicious cycle of high population growth, social conflict (insurgency, crime, rape); large migration; depleted ecosystems, food, water and energy insecurity/insufficiency/dependence; failing governance; failing health care and education systems as part of the same group of “political and environmental hotspots”¹¹:
  - Afghanistan, Bangladesh, Burundi, Haiti, Indonesia, Nepal, Madagascar, Mongolia, Pakistan, Philippines, and the Solomon Islands.

### Time is a scarce resource

<table>
<thead>
<tr>
<th>Rate of population growth in percent</th>
<th>Time in years for population to double in size</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>70</td>
</tr>
<tr>
<td>2</td>
<td>35</td>
</tr>
<tr>
<td>3</td>
<td>23</td>
</tr>
<tr>
<td>4</td>
<td>17</td>
</tr>
<tr>
<td>5</td>
<td>14</td>
</tr>
</tbody>
</table>

A slower population growth can provide more time to develop the economy and establish the necessary institutions to accommodate the doubling of the population at higher standards of living.

---

⁴ Ibid., p. 19
⁵ Ibid., p. 21
⁸ State of the Philippine Environment: A Progress Report, February 2006
¹⁰ ICPD Programme of Action para 3.14
II. Philippine Reproductive and Maternal Health Indicators

- Mean age at marriage for males is 20 & 19 for females. (YAFS3, 2002)
- Mean age at having 1st child is 19. (YAFS3, 2002)
- Adolescent pregnancy is 30% of all annual births. (DOH/WHO/UNFPA Training Manual)
- More than 60% of all pregnancies in the Philippines are high-risk. (NDHS, 2003)
- More than 10 Filipino women die daily due to pregnancy, and childbirth related complications and unsafe abortion (UNFPA, 2007) & over half (56%) of yearly maternal deaths are unreported.
- Mean age at first sex for males is 17 & 18 for females. (YAFS 3, 2002)
- 2.2. 16% of youth had first sex before age 15. (SPPR2, 2002)
- 2.3. 31.2% of males & 15.9% of females had premarital sex. (YAFS 3, 2002)
- 2.4. 27% of males & 14.5% of females used contraception during first premarital sex (YAFS 3, 2002)
- Almost 60% of women source their supply of FP services & supplies from the public sector.
  
- The government has been dependent on outside donors for its contraceptive commodities. USAID has completely phased out its donations this year.
- 61% of currently married women do not want additional children anymore. (NDHS, 2003)
- 50.6% of the youth wants to have only 2 children. (YAFS 3, 2002)
- Unmet need for contraceptives is 23.15% for poor vs. 13.6% for non-marginalized women. (NDHS, 2003)
- 97% of all Filipinos believe it is important to have the ability to control one’s fertility or to plan one’s family and 87% of total respondents are Roman Catholic. (Pulse Asia Survey, February 2004)
- The large majority of women having induced abortion are poor (68%), married (91%), with more than 3 children (57%), and Catholic (87%). (UPPU-AGI, 2006)
- Only half of married women practice family planning*
  
- Lack of information of and access to services
- Poor women have 3 times more children vs. non-marginalized/wealthier women*
  
- 5.9 vs. 2.0; spacing problems and earlier delivery
- Poor men father more children vs. non-marginalized/wealthier men*
  
- 5.0 to 3.0
- 1 in 4 pregnancies are mistimed; 1 in 5 are unwanted*
- 38% of deliveries attended to by skilled health care professionals*
- 26% of women aged 15-24 years have begun childbearing*
  
- 1 in 16 girls aged 15-19 already young mothers*
- 4.9 million young adults (15-27 years old) engage in pre-marital sex**
  
- 34% have multiple partners**
- 19% used any contraception**
- Gender disparity hinders proper family planning
  
- More married females vs. males believe that religion does not influence their use of contraception, and are more decisive in using contraception (modern and natural) 12
- Married males are more prone to believe in myths about medical side effects of contraception, which prevents wives/partners from exercising opinions and eventual use of contraception, leading to unwanted pregnancies and maternal health issues. 13
- International and local studies show natural methods not for everyone
  
- Limiting options to “Natural Family Planning (NFP) methods only” fails to address the private and social costs of mistimed and unwanted pregnancies.

---

12 Third Young Adult Fertility and Sexuality Study (YAFS3). Demographic Research and Development Foundation, UP Population Institute.

Family planning is not just about economic and income growth but in well-being, and meeting desired fertility and family sizes is vital to both. The large number of children, especially among the poorest families, is more a result of inability of couples to reach their desired (i.e., smaller) family sizes due to poor access to contraceptives.\textsuperscript{14}

- Current unmet need for contraceptives is 23.2\% for poor vs. 13.6\% for non-marginalized women*
- Desired fertility rate of Filipino women is 2.5 children/woman, but the total fertility rate is 3.5*
- 50.6\% of youth want to have only 2 children**
- 61\% of married women do not want additional children*
- 9 out of 10 Filipinos consider family planning important ****
- Filipinos prefer modern family planning methods, with the pill as the #1 consistent method of choice (\textit{National Statistics Office Surveys})

\textbf{The poor are less able to achieve their fertility goals than the rich}

\begin{table}[h]
\centering
\begin{tabular}{|l|c|c|c|c|c|c|}
\hline
\textbf{Indicator} & \textbf{Wealth status} & \textbf{Low} & \textbf{Second} & \textbf{Middle} & \textbf{Fourth} & \textbf{High} & \textbf{Total} \\
\hline
Total fertility rate & 5.9 & 4.6 & 3.5 & 2.8 & 2.0 & 3.5 \\
\hline
Wanted fertility rate & 3.8 & 3.1 & 2.6 & 2.2 & 1.7 & 2.5 \\
\hline
Difference (total less wanted) & 2.1 & 1.5 & 0.9 & 0.8 & 0.3 & 1.0 \\
\hline
\end{tabular}
\caption{The poor are less able to achieve their fertility goals than the rich.}
\end{table}

\footnotesize{Source: NSO and ORC Macro, \textit{2003 NDHS, 2003}}

• **Maternal Mortality at 162 per 100,000 live births***
  o Millennium Development Goal target: 52 by 2015 (unlikely to be met)
  o Lack of access to Family Planning leads to unwanted pregnancies → induced and illegal abortions, estimated at half a million annually since 2000 (Juarez, Cabigon et al. 2005).
  o **36% of abortion cases comprise women aged 15-24**
  o The Catholic Church’s position on family planning and contraception has little effect on individual’s decisions on family planning. *****
  o Contraception and choice of method are personal decisions and are made independent of religion.

* National Demographic Health Survey (NDHS, 2003)
** UP Population Institute (2002) Young Adult Fertility and Sexuality Study (YAFS)
*** 2006 Family Planning Survey
**** Ulat ng Bayan (2007)
***** Young Adult Fertility and Sexuality Study (YAFS3, 2002)

• Among poorest families, 22% of married women of reproductive age express desire to avoid pregnancies but do not use any family planning method (Family Planning Survey 2006)
  o **Among poorest 20%, over half do not use any method**
  o Among poorest women who want to avoid pregnancy, at least 41% do not use any contraceptive due to lack of information

• **Three in 10 Filipino women at risk for unintended pregnancy do not practice contraception.** These women account for nearly seven in 10 unintended pregnancies.15
  o Poor women are especially likely to need assistance in preventing unintended pregnancy.
  o The 35% of women aged 15–49 who are poor account for 53% of unmet need for contraception.

• **Maternal health care issues are the highest causes of morbidity** in the Philippines.
  o **400,000 morbidity cases** annually due to maternal-health related illnesses.
    ▪ Up to 200,000 cases could have been prevented through family planning. (See Table 1).
  o **10 women die daily** due to pregnancy and causes associated with childbirth and unsafe abortion.16
  o The Philippines has **among the highest maternal deaths in the region.** (See Table 2)

---

In 2008, more than two-thirds of unintended pregnancies (1.3 million) in the Philippines occurred among the 29% of women not using any contraceptive method (See Figure 3).

- Meanwhile, only about 8% of pregnancies occurred among the 49% of women practicing modern contraception, reflecting the relatively high effectiveness of these methods.
- Traditional method users (22% of all women at risk for unintended pregnancy) accounted for almost ¼ of unintended pregnancies.
  - This echoes similar recorded failure rates for traditional family planning methods = 24% failure rates (Ponzetti and Hoffler 1988); Withdrawal has a lower failure rate at 19%

Figure 3

The large majority of women having induced abortion are poor (68%), married (91%), with more than 3 children (57%), and Catholic (87%). (UPPU-AGI, 2006)

- 57.3% of families having many children are poor vs. only 15.7% having 2 children or less

---

A key factor is the inability of poor women to control their fertility through effective family planning methods. The poorer women are, the larger the unmet need for FP, and the greater the number of unplanned births. (See Figures 1 & 2)
Compared to maternal health costs associated with unwanted pregnancies, modern family planning methods are safe, effective, and inexpensive. (See Figure 3)

- At least 5.5 B (billion) pesos are spent each year in health care costs for managing unintended pregnancies and its complications.\(^\text{18}\)
  - in 2000, there were 78,901 hospitalizations for injuries due to safe abortions, induced abortions and 961,000 unintended pregnancies carried to term.
- Php 2.0 to 3.5 B pesos of public funds are needed in 2009 to finance a range of voluntary family planning services.
  - Such levels of public health spending will clearly be cost-effective, resulting in health care savings of several billions of pesos.

It is estimated that the use of modern contraceptives averts over 112 million abortions in the developing world each year. (Singh et al, 2009), and conforms to the majority of countries experiences where increased contraceptive use lowers induced abortions. (Marston and J. Cleland, 2003)

An alternative comparison shows a similar advantage of providing family planning choices, particularly using a combination of modern and natural family planning methods. (See Figure 4)

- Providing facility-based care for all pregnant women today would roughly double the annual costs of their medical care from the current minimum of P7.4 billion to P15.9 billion.
- Increasing the ability of women and their partners to use contraceptives, however, would reduce the costs of medical care for all pregnant women.19

**Figure 4**

**Costs of Contraceptive Use**

Investing in contraception could greatly reduce costs associated with unintended pregnancy.

Natural Family Planning has perfect-use failure rate of 2-9% but in practice, failure rate is 24% (Ponzetti & Hoefler (1988) – higher than abstinence or withdrawal, and despite decades of promotion by the Philippine Catholic Church and government, has only reached a 0.5% adoption and usage rate.

- Over 500,000 induced abortions occur annually (560,000 in 2008 vs. 473,000 in 2003).20

---

19 Meeting Women’s Contraceptive Needs in the Philippines. Guttmacher Institute. 2009 Series, No. 1
- One third of women who experience an unintended pregnancy end it in abortion.
- Women from all segments of society experience abortion. Women who have had an abortion resemble average Filipino woman: The majority are married, Catholic and poor. They have some high school education and have already had several children.
- When asked why they sought abortions, 72% of women cite the economic cost of raising a child; 54% say they have enough children; 57% report that the pregnancy occurred too soon after their last one.


- It is estimated that the use of modern contraceptives averts over 112 million abortions in the developing world each year. (Singh et al, 2009), and conforms to the majority of countries experiences where increased contraceptive use lowers induced abortions. (Marston and J. Cleland, 2003)

---

In the Philippines, however, the number of induced abortions is set to increase as the lack of access to safe and modern contraceptives compels women to engage in these dangerous, illegal practices.

- Majority of these women are mostly Catholic, poor, and users of natural/traditional family planning methods. (See Figure 3.1).

III. Poverty and Population

- Over 30 million people in poverty;
  - 20 years ago, 18 million
  - Overall poverty incidence increased from 30.0% ('03) to 32.9 percent in ('06).

![Population – Poverty Nexus](image)

<table>
<thead>
<tr>
<th>Year</th>
<th>Population (in millions)</th>
<th>Poor (in millions)</th>
<th>Percentage of Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000 (actual)</td>
<td>76.95</td>
<td>25.47</td>
<td>33.00</td>
</tr>
<tr>
<td>2003 (est)</td>
<td>81.83</td>
<td>24.55</td>
<td>30.00</td>
</tr>
<tr>
<td>2006 (est)</td>
<td>86.80</td>
<td>28.56</td>
<td>32.90</td>
</tr>
<tr>
<td>2009 (est)</td>
<td>92.23</td>
<td>30.44</td>
<td>33.00</td>
</tr>
</tbody>
</table>

Source: Mapa, Dennis, University of the Philippines School of Economics

- Population growing beyond its economic means
  - From 2001-2007, employment grew 13%, while working-age population grew 17.6%
  - Meanwhile, the average real wage declined by 5% between 2003-2006
- Poverty incidence <10% with one child
  - 57% for a family with 9 or more children National Demographic Health Survey, (NDHS) 2003
- Larger families make less investments per child in human capital (NDHS 2003)
  - Php 5,558 (1 child family) vs. Php 682 (9+ family)
  - Average health spending per capita drops from Php 1,700 to Php 150
- Continued high population growth rate is principally due to the continued high total fertility rate (TFR) over the last 20 years.
  - Critical difference is not that the Philippines’ TFR is relatively higher that other countries’, but that couples, particularly the poorest, are not able to achieve their fertility goals/desire family sizes.
  - Past failures to achieve lower fertility and rapid economic growth are reflected in poor outcomes in human development concerns:
    - High maternal mortality
    - High infant and child mortality
    - Poor educational performance
    - High unemployment and underemployment
- Poverty transmission
  - Large family size associated with negative determinants of school participation and poor health and survival rates among children

---

22 Ibid., p. ii
Organized family planning programs are a great contributor to increases in contraceptive prevalence (Allman, Vu, Nguyen, Pham, & Vu, 1991).

An analysis of 73 less developed countries for the period 1977–1983 showed that even though socio-economic changes were associated with the variance in contraceptive prevalence, provision of family planning programs significantly strengthened the association (Lapman & Mauldin, 1985).

Strong inverse relationship between the total fertility rate (TFR) and contraceptive prevalence (Fig. 5).

Thus, family planning contributes to fertility decline.

Because of poverty and large family sizes, Filipino children are undereducated and underperforming.²⁵

Ave. Grade 6 student score (2004-2008) in Math, 60%; in Science, 59%; in English, 59%.

Ave. High School student National Achievement Test (2004-2008); Math 45%; Science, 42%; English, 51%.

Only 6 out of 100 students academically prepared for high school (Kaakbay CDI 2005 Study)

The Philippines ranked 41 in Science and 42 in Mathematics in a study that involved 45 countries.

Fig. 5 Relationship between fertility and modern contraceptive use. Countries with at one (latest) DHS

Fig. 11 Maternal mortality and contraceptive prevalence for countries with a DHS in the last 5 years

Family size makes it difficult for families to emerge from poverty ('burden of dependency') as expenditures for education and health per family member decrease systematically as family size increases.\(^{26}\)

- **Average Educational expenditure**
  - 1-child families: Php 5,558
  - 9-children families: Php 682
- **Average Health expenditure**
  - 1-child families: Php 1,700
  - 9-children families: Php 150
- These handicaps are exacerbated by increased competition for low-wage and low-skilled jobs due to the increased population outstripping jobs available.

Human capital investment is lower among families with larger family sizes.

- Education resource shortage: Demand quantity outstrips Supply and Quality
  - Classroom: Student ratio at 1:100; 6,832 classroom shortage addressed by creating 2 shifts
  - Textbook shortage at 25 million; Teachers: 50,000 needed for public schools
  - Over 1 million children entering the school system annually, while 4 out of 10 reach 4th year high school, and only 14 graduate college (see table 1)

**Typical Progression of a Sample Cohort of Pupil**

Strong correlation between poverty incidence and family size.
- Poverty incidence rises from 9.8% for a 1-child family to 48.7%, 54.9%, and 57.3% for a family with a 7,8,9 child family.\(^{27}\)
- 10% of small families (1-2 children) experience hunger vs. 23.9% - 25.2% for large families (7-9 children), higher than the national average.\(^{28}\) (See Table E)

<table>
<thead>
<tr>
<th>Family members (number)</th>
<th>Total hungry (%)</th>
<th>Moderately hungry (%)</th>
<th>Severely hungry (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philippines</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-2</td>
<td>18.4</td>
<td>15.2</td>
<td>3.2</td>
</tr>
<tr>
<td>3-4</td>
<td>17.6</td>
<td>15.5</td>
<td>2.1</td>
</tr>
<tr>
<td>5-6</td>
<td>18.5</td>
<td>15.4</td>
<td>3.1</td>
</tr>
<tr>
<td>7-8</td>
<td>23.9</td>
<td>18.5</td>
<td>5.4</td>
</tr>
<tr>
<td>9+</td>
<td>25.2</td>
<td>17.9</td>
<td>7.3</td>
</tr>
</tbody>
</table>


- If the Philippines reduced its rate of population similar to Thailand’s (see Section II) between 1975-2000, per capita income grew only 1% vs. 5.4%, and would have at least been higher in 2000 by 22%.\(^{29}\) The estimated number of Filipinos living in poverty could have been reduced by 6 million from 1997-2000 alone.\(^{30}\)
  - Data shows that a reduction in birth rate can stimulate economic growth largely through a temporary impact on the age structure i.e., by increasing the proportion of the population in the working years and reducing the percentage of children supported.
  - Family planning has stagnated in the past decade, with persistent unmet needs for family planning and inadequate access to services for poor women. (Guttmacher Institute, 2009).
    - In 2003, only 24% of women in the poorest quintile were using any family planning compared with 58% in Vietnam and 49% in Indonesia.
    - While the national average is steady at 2.04%, poor provinces have higher growth rate:
      - Maguindanao’s population growth rate: 2000 - 4.6%; 2008 - 5.4%
    - Over half of pregnancies in the Philippines are unintended.
      - While poor women typically want more children vs. wealthier women, those in the poorest 40% of the population have between 1.5-2.1 more children than they desire
- Link between household size and poverty in the Philippines is strong due to its high population growth rate.
  - Despite a modest decline in fertility rates over the last few decades, the country’s population growth rate remains among the highest in the region
  - The annual population growth rate in the Philippines is 2.04 percent, compared to an average rate of 0.8% in East Asia and the Pacific and 1.2% for lower middle-income countries worldwide (NSO 2008 World Bank Development Data Platform).

\(^{27}\) Orbeta. Study on Hunger Incidence and Family Size using the 2000 Family Income and Expenditure Survey. 2004
\(^{30}\) Ibid., p. 186
Fertility rates have declined from 4.1 births per woman on average in 1991 to 3.3 births in 2006 (NSO and USAID, 2009), but this decline is among the slowest in Southeast Asia.

Over 30% of the population belong to households with 7 or more members.

At the household level, large family size is strongly correlated with higher poverty incidence, lower savings and asset accumulation, and reduced per capita household expenditures for education and health (Orbeta, 2002; Orbeta, 2005; Racelis 2008).

The country’s ‘youth bulge’ is a socio-economic and national security risk (See Population Momentum)

The growth of provincial per capita income is negatively correlated with the proportion of young dependents in the provinces (Mapa, Balisacan, and Briones, 2006).

Regions with the highest ‘youth bulges’ are prone to poverty-related conflicts. Between 1970-1999, 80% of civil conflicts occurred in countries where 60% of the population or more were under age 30.

Dependency ratio* is high given the country is still in early stages of demographic transition.

* ratio of children under 15 and adults over 65 divided by the total working-age population

The dependency ratio for the Philippines was calculated as 65% in 2005, exceeding the dependency ratios of Thailand (by 50%), Indonesia (by 27%), and Malaysia (by 16%).

Population momentum** is the largest source of future population growth in the Philippines. Analyses have pointed out that:

- between 1995-2020, the 37.1 million projected growth is broken down into:
  - 5.8 million from unwanted fertility
  - 6.7 million from high desired family size
  - 24.6 million from population momentum

- By 2040, the increase in population from 1995 level is 57.8 million, of which:
  - 9.3 million is due to unwanted fertility
  - 10.9 million from high desired family size
  - 37.6 million from population momentum

Population momentum is related to a high dependency ratio and youth bulge, which exacerbates pressures on social services and productivity.

The Philippines ranks 4th in the world in the number of child prostitutes, manifesting the lack of family planning and means to provide for a growing number of children and youth bulge.

---


33 http://newsinfo.inquirer.net/breakingnews/nation/view/20101119-304080/PH-ranks-4th-on-list-with-child-prostitutes
**defined as the tendency for population growth to continue beyond the time when replacement-level fertility has been achieved, because of a relatively-high proportion of the population in the childbearing ages, which in turn is due to past high fertility. In this situation, the number of births will exceed the number of deaths and the growth rate will remain positive for several decades before the age distribution fully adjusts to the changed fertility rates. Moreover, the early onset of childbearing shortens the length of a generation (i.e., the number of years after her own birth until a woman replaces herself with female children). The length of a generation affects the rate of growth of a population independently of the number of children born. This is so because the more rapidly a generation replaces itself, the more rapidly it will add new members to the population.

The Philippine population size is expected to continue growing despite the projected decline in population growth rate

### The Philippine population size is expected to continue growing despite the projected decline in population growth rate

**Sources of Population Growth in Y 2020**

<table>
<thead>
<tr>
<th>Source</th>
<th>Percent</th>
<th>In Million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Due to unwanted fertility</td>
<td>15.6</td>
<td>5.8</td>
</tr>
<tr>
<td>Due to high desired family size</td>
<td>18.1</td>
<td>6.7</td>
</tr>
<tr>
<td>Due to population momentum</td>
<td>66.3</td>
<td>24.6</td>
</tr>
<tr>
<td>Total increase from 1995 population</td>
<td>100</td>
<td>37.1</td>
</tr>
</tbody>
</table>

- Net effect of population management (simultaneous effect of higher per capita income and lower population) at the local level results in increased taxes and revenues and a lower expenditure on social services from a lower population base.  
  - If the proportion of youth (‘youth bulge’) were under 35.89% (dependency rate), average net monetary benefit per province would be at Php 331 million, and 11-19% higher per capita income average per province, realized from a higher taxed income and lower health and education expenditures from a lower dependent population.

---

For example, in Camarines Norte, where dependency rate is 47.03%, household poverty incidence is 46.10%, 21.7% higher than the national average.

The increase in per capital income translates to lower poverty incidence among households, equivalent to 156,000 Filipinos out of poverty every year and around 2.8 million between 1985 to 2003. • High population growth rate, among other factors plays a part in the Philippines’ poor economic performance vs. other countries (Hong Kong, Singapore, South Korea, Taiwan, Thailand, Malaysia, Indonesia, and China). • Population variables had a negative effect on economic growth rate by 0.8%

Other governance policy variables played a part as well:
- Government savings rate: -0.4%
- Openness of economy: -1.7%
- Quality of institutions: -1.2%

The increase in per capital income translates to low poverty incidence among households, equivalent to 156,000 Filipinos out of poverty every year and around 2.8 million between 1985 to 2003.

Population variables had a negative effect on economic growth rate by 0.8%
- Government variables had a negative effect on economic growth rate by 0.8%
- Other governance policy variables played a part as well:
  - Government savings rate: -0.4%
  - Openness of economy: -1.7%
  - Quality of institutions: -1.2%

The combination of these variables (family planning program and better governance) can help slow down the population growth and fertility rate to ensure sustainable human capital development.

Given the country’s persistent governance and socio-economic problems exacerbated by increasing population momentum, a family planning program can help slow the rate enough to allow the government to strengthen the economy and institutions to prepare for the time the population doubles.

At the current rate, population will double in 30 years and without proper mechanisms in place, the carrying (biocapacity) of the country will be overrun and the Philippines will experience conditions alongside other failed states.

According to the UP School of Economics, “Poverty is a complex phenomenon, and many factors are responsible for it. Rapid population growth alone cannot explain poverty. Bad governance, high wealth and income inequality and weak economic growth are the main causes. But rapid population growth and high fertility rates, especially among the poor, do exacerbate poverty and make it harder for the government to address it.”

Global Barriers to Family Planning

- Prices are too high.
- Outlets are unreachable.
- Medical rules make getting contraception difficult.
- Misinformation – the dangers of contraception.
- Community workers are not permitted to provide contraceptives.
- Method choices are limited.
- Gov’t services are poor.
- Pills are on prescription for reasons not evidence-based.
- Contraceptive supplies are not available in the community.
- Advertising about family planning isn’t allowed.
- Religions constrain providers.
- Mothers-in-law are in charge.
- Young brides lack power.
- Unmarried young females are excluded from services.

Source: Venture Strategies for Development

Because of decades of unmet need for family planning and growing population pressures on an already weakened state, the Philippines is now 5th in global hunger, 4th in the number of child prostitutes, among the top 10 in human trafficking, rising (#53) in the Failed States Index, among the top 10 environmental and political hotspots. The country has only 10% of forest cover and coral reefs (breaching its biocapacity since 1965), and the world’s largest food (rice) importer for its growing impoverished population with over 40% experiencing involuntary hunger consistently since 2007.

36 Ibid.
IV. Family Planning and Politics

- 2004 Pulse Asia Survey
  - 82% support candidates who advocate population measures
  - Only 8% believe that the candidates’ support of family planning will lead to electoral defeat
  - 8 out of 10 Filipinos (76%) believe in including family planning in candidates’ platform of action
  - 9 in 10 Filipinos believe in government budgetary support for modern methods of family planning including the pill, IUDs, condoms, ligation and vasectomy.
  - 1 out of 2 (50%) believe rapid population growth hinders the country’s development.
  - 44% vs. 33% of Filipinos believe the church should not participate in the issue of choice for family planning methods
  - Only 2.4% of married women cite religion in avoiding contraception (2003 NHDS)

- Social Weather Station (SWS) Survey (2008)
  - 84% support the Reproductive Health (RH) bill (those aware prior to the survey)
    - 59% support (only aware of the RH bill through the survey)
    - 68% back policy to distribute contraceptives
  - 71% of Catholics support the bill
  - Support for both family planning education (76%) and the RH bill (71%) is very high among both men and women, whether single or married, in all areas of the country (72% MM, 69% Luzon, 68% Visayas), and among all socio-economic classes (77% class ABC, 70% class CDE)

- 2010 Pulse Asia Survey
  - 69% of Filipinos surveyed support the passage of the RH Bill, while only 7% oppose the measure
    - Up 6% from previous survey; supported by 72% of Socio economic Class E to 93% of Class ABC.

- 2010 Elections
  - 68% favored giving couples access to all legal means of family planning; only 6% will vote for those who oppose the RH Bill (SWS January 2010 Survey)
  - 64% of voters favor candidates who support RH bill (2010 Pulse Asia Survey)
  - President
    - Despite endorsing Ang Kapatiran presidential candidate JC de Los Reyes, the latter only managed to garner .01% (or 44,244) of the votes cast and was last in the official tally
    - disqualified candidate Vetaliano Acosta: 181,985 votes
    - current President Benigno Aquino III: 15,208,678 votes
  - Congress

• Senate: 15 of 23 Senators have declared support for RH bill/family planning
• House: pre-election, of 286 seats in the House, about 65 congressmen and 17 party-list representatives support the RH bill.
• expected to increase with 84% of 125 first-term lawmakers
  o Pro-RH legislation candidates won elective seats vs. Anti-RH /Catholic Church ‘anointed’ candidates
• Medical science and global health standards have affirmed the safety and acceptability of modern contraceptive methods, while respecting individual countries’ policy independence (See Table 1):

<table>
<thead>
<tr>
<th>No.</th>
<th>Name</th>
<th>Formulation</th>
<th>Year Added</th>
</tr>
</thead>
<tbody>
<tr>
<td>18.3</td>
<td><strong>CONTRACEPTIVES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.3.1</td>
<td>Oral hormonal contraceptives</td>
<td>ethinylestradiol + levonogestrel: Tablet: 30 micrograms + 150 micrograms.</td>
<td>1979</td>
</tr>
<tr>
<td></td>
<td>ethinylestradiol + norethisterone: Tablet: 35 micrograms + 1.0 mg.</td>
<td>1977</td>
<td></td>
</tr>
<tr>
<td></td>
<td>levonorgestrel: Tablet: 30 micrograms; 750 micrograms (pack of two); 1.5 mg.</td>
<td>2000</td>
<td></td>
</tr>
<tr>
<td>18.3.2</td>
<td>Injectable hormonal contraceptives</td>
<td>medroxyprogesterone acetate: Depot injection: 150 mg/ml in 1-ml vial.</td>
<td>2005</td>
</tr>
<tr>
<td></td>
<td>medroxyprogesterone acetate + estradiol cypionate: Injection: 25 mg + 5 mg.</td>
<td>2007</td>
<td></td>
</tr>
<tr>
<td></td>
<td>norethisterone enantate: Oily solution: 200 mg/ml in 1-ml ampoule.</td>
<td>2005</td>
<td></td>
</tr>
<tr>
<td>18.3.3</td>
<td><em>Intrauterine devices</em></td>
<td>copper-containing device</td>
<td>1988</td>
</tr>
<tr>
<td>18.3.4</td>
<td><em>Barrier methods</em></td>
<td>condoms</td>
<td>1988</td>
</tr>
<tr>
<td></td>
<td>diaphragms</td>
<td></td>
<td>1988</td>
</tr>
<tr>
<td>18.3.5</td>
<td><em>Implantable contraceptives</em></td>
<td>levonorgestrel-releasing implant: Two-rod levonorgestrel-releasing implant, each rod containing 75 mg of levonorgestrel (150 mg total).</td>
<td>2007</td>
</tr>
</tbody>
</table>

Sources: WHO, 2007, p. 109 and Aziz J. et al for the “Year Added” column

Almost all modern contraceptives are in the World Health Organization’s (WHO) Model List of Essential Medicines. The latest list of the WHO (2007, p. 109) include the most common oral contraceptive pills and injectables, the copper-containing IUD, condoms, diaphragms and one type of implantable contraceptive. They are all classified by the WHO under the subgroup “Contraceptives”.

Contraceptives are systematically reviewed and chosen carefully by an Expert Committee of the WHO on the basis of priority health care needs, efficacy, safety and cost-effectiveness. The entire Contraceptives Subgroup was systematically reviewed from 2006-2007, triggered by the Expert Committee’s decision not to list several contraceptive medicines in 2005 (WHO, 2007, p. 48).

The review resulted in the retention of all previously listed contraceptives and the addition of two new products for the 2007 list (WHO Reviewer No. 1; WHO, 2007, pp. 50-52).

The WHO Expert Committee on the Selection and Use of Essential Medicines is independent of the WHO Department of Reproductive Health and Research (RHR).

---

40 Interview, Elizabeth Angsioco, Reproductive Health Advocacy Network. Quezon City. 6 November 2010.
Catholic countries like Panama, Guatemala, Brazil, Colombia, Dominican Republic, El Salvador, Honduras, Nicaragua, Venezuela, Paraguay and Ireland all prohibit abortion as a family planning method while vigorously promoting contraceptive use. Similar countries have family planning policies allowing contraceptives (IUDs, pills injectables), and have lowered their TFRs to sustainable levels, enabling families to plan their desired sizes. (See Tables 3 & 4)
• Furthermore, and despite various claims to the contrary, a 40-year study by the British Medical Journal has shown that oral contraceptives have proven health benefits, and lower women’s risk of various cancers and heart disease. (See Tables 2a and 2b)

Table 2a: Is the Pill safe? Two million women years of observation points to yes ….

- 46,112 women followed up to 39 years
- Women using oral contraceptives “had a significantly lower rate of death from any cause.”
- Relative risk of dying 0.88
  (confidence interval 0.82-0.93)


Table 2b. Relative risk of dying from various cancers

<table>
<thead>
<tr>
<th>Disease</th>
<th>Relative risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bowel &amp; rectum cancer</td>
<td>0.62</td>
</tr>
<tr>
<td>Melanoma</td>
<td>0.73</td>
</tr>
<tr>
<td>Breast cancer</td>
<td>0.9</td>
</tr>
<tr>
<td>Uterine cancer</td>
<td>0.43</td>
</tr>
<tr>
<td>Ovarian cancer</td>
<td>0.53</td>
</tr>
<tr>
<td>Cervical cancer</td>
<td>1.34</td>
</tr>
<tr>
<td>Ischaemic heart disease</td>
<td>0.75</td>
</tr>
</tbody>
</table>

Source: The Lancet, 2010

• Despite these realities, the Philippine Catholic Church hierarchy has focused most of its efforts on political means of preventing legislation on family planning policy at the expense of advocating an effective family planning program aligned with its teachings (i.e., Natural Family Planning-NFP).
  • The situation is exacerbated by conflicts within the Catholic Church about the legitimacy and effectiveness of various NFP methods.
    ▪ This ambiguity and lack of focus has led to NFP usage failure rates in marginalized communities such as Payatas, where a Catholic-church led program resulted in only 27 successful users (out of 390 documented women) after 4 years of effort.
    ▪ Overall, NFP programs are only used by 0.5% of married women in the Philippines, reflecting a need for the Church to focus on improving training and monitoring components (critical to success of usage rates in this area) as opposed to marshalling resources to combat national family planning programs that provide both modern methods and NFP.

64% of voters favor candidates who support RH bill
69% support the passage of the RH bill
(2010 Pulse Asia Survey)

9 in 10 Filipinos believe in government budgetary support for modern methods of family planning including the pill, IUDs, condoms, ligation and vasectomy.


• Catholic countries like Panama, Guatemala, Brazil, Colombia, Dominican Republic, El Salvador, Honduras, Nicaragua, Venezuela, Paraguay and Ireland all prohibit abortion as a family planning method even as they vigorously promote contraceptive use.
  
  o Similar countries have family planning policies allowing contraceptives (IUDs, pills, injectables), and have lowered their TFRs to sustainable levels, enabling families to plan their desired sizes (See Tables 3 and 4).

<table>
<thead>
<tr>
<th>Country</th>
<th>%Catholic</th>
<th>TFR before FP became available</th>
<th>TFR after FP became available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Italy</td>
<td>90</td>
<td>2.47</td>
<td>1.4</td>
</tr>
<tr>
<td>Spain</td>
<td>88</td>
<td>2.92</td>
<td>1.4</td>
</tr>
<tr>
<td>Portugal</td>
<td>90</td>
<td>6.5</td>
<td>2.2</td>
</tr>
<tr>
<td>Mexico</td>
<td>87</td>
<td>6.15</td>
<td>2.0</td>
</tr>
<tr>
<td>Brazil</td>
<td>79</td>
<td>4.1</td>
<td>1.4</td>
</tr>
</tbody>
</table>

Source: World Health Organization, UC Berkeley School of Public Health
• **The Chile Experience.**
  o Chile serves as a model of how a predominantly Catholic country can pioneer a family planning program with the **support of the Catholic Church, the academe, and the international community.**  
    - *Educational institutions* such as Universidad Católica and the Universidad de Chile and academics from FLACSO (Facultad Latinoamericana de Ciencias Sociales) served as centers of scholarly, scientific, and medical research and practice and provided the knowledge base to guide family planning policy.
    - The *Chilean medical, scientific, and political community* also advocated reducing the size of families and the judicious use of family planning.
    - Catholic Church hierarchy promoted such policies because they felt it would reduce the alarmingly high rates of induced abortions that were then prevalent in Chile.
    - Chilean medical and scholarly community shared a *unity of purpose* with U.S. foundations and agencies such as the Population Council and the Ford and Rockefeller foundations, U.S. government agencies such as AID or the Inter-American Development Bank; and transnational institutions, such as the **Pan American Health Organization (PAHO).**
    - The Frei government joined the Catholic Church in supporting birth control in order to decrease the high rate of abortions.
  o Today, Chile has a sustainable fertility rate, one of the largest GDP-per capita and Human Development Indices, and is an OECD country that has risen out of a military dictatorship and feudal agricultural system into a progressive nation.

• Theologians (e.g., J. Carroll, SJ) have called for a refocusing on the Catholic Church’s leadership toward  
  o A clear admission and recognition of the burden of large family sizes on the poor.
  o Dialogue* with government on providing a wholistic approach toward family planning, poverty alleviation, and equitable growth, and partnering with the government in carrying our family planning, even if its focuses on natural methods within its membership.
  o Forming consciences through value formation of its members in making rational decisions on adopting family planning programs within its teachings, amidst choices provided by the State (as supported by other beliefs and religions).

• *The conditions for such dialogue have been outlined by Bishop Pablo David*:  
  ```
  “[Dialogue] can only be possible, however, if we first suspend our pre-judgments and our tendencies to label anyone who doesn’t agree with us as anti-life, anti-God, or anti-family. It is counter-productive to simply take a sharp adversarial stance or a posture of militancy. We might end up alienating more people, or marginalizing ourselves.”
  ~ Bishop Pablo David
  ```

---

V. Family Planning and Religion

Roman Catholicism is the only religion that specifically and explicitly condemns contraception. First, let's look at other religions and then answer the question why contemporary Catholic teaching is so profoundly different from that of all other religions.

Hinduism values human sexuality. Hindu scriptures applaud small families and the Upanishads (texts delineating key Hindu concepts) describe birth control methods. At some phases of its history, it has decorated its temples with carvings illustrating the pleasures of sexual congress.

Buddhism, which grew out of Hinduism, has never condemned nor restricted access to family planning. One common Buddhist saying is that “Many children make you poor.”

Confucianism emphasizes the importance of balance and harmony in the individual, the family, and society. Since having too many children can upset this balance, family planning has been a valued part of human sexuality in both Taoism and Confucianism. In the Chinese religions, sex and sexual pleasure are esteemed and celebrated along with the need for moderation. Abortion is either allowed or is condemned as a crime within the family, not as a crime against the state.

Judaism has several manifestations, including Reform, Conservative and Orthodox, each of which places a different emphasis on the Biblical injunction to be “fruitful and multiply” and the drive to nurture and educate children. Orthodox Jewish woman have an interesting interpretation of oral contraception, encouraging its use before marriage in order to decrease the chances of menstrual bleeding on the wedding night, when the newlyweds are supposed to retire to a private room for time alone, known as Yichud. Yichud allows for the consummation of the marriage and is a requirement under Orthodox Jewish law but intercourse cannot take place during menstruation. A disproportionate number of scientists and physicians who have been leaders in family planning have also been Jews.

Christianity and Islam both recognize teachings found in the Old Testament. The Old Testament only mentions contraception once, in the story of Onan (Genesis 35) whom “God slew” because “he spilt his seed on the ground,” i.e. practicing withdrawal or coitus interruptus. Jewish theologians sometimes interpret Onan’s sin not as the use of contraception but as disobeying his father’s command to make his deceased brother’s wife pregnant. The only reference to abortion in the Bible is explicit that abortion is that it is not murder unless the woman dies as a result of the abortion (Exodus 21:23).

Islam allows a lot of latitude in its interpretation, which is reflected by the various differences in family planning policies by distinct Muslim groups and countries. The Qur’an calls on the faithful to “procreate and abound in number,” but there is not express prohibition of contraception and ‘azl’ or withdrawal is mentioned as acceptable in the Hadith, or sayings of the Holy Prophet.

The reason contemporary Catholic teaching is so profoundly different from that of all other religions goes back to Saint Augustine. No other religion asserts as Catholicism has done since Augustine that sexual intercourse is intrinsically sinful, that celibacy is preferable to marriage but that within marriage the sole justification for the pleasure of sex is that it must be open to procreation. The teaching of the Church was that new born babies would burn in Hell for all Eternity unless they received the sacrament of baptism. Augustine overcame this
intuitively cruel conclusion by arguing that Original Sin had been transmitted in the semen since Adam, like some latter day AIDS virus.

Augustine of Hippo (354-436) lived a time when even the role of the ovaries in reproduction was not understood and women were perceived fields in which men sowed their ‘seed.’— hence ‘wasting semen’ was perceived at wasting everything that was needed for conception.

Protestants as well as Catholics followed the Augustinian condemnation of contraception until relatively recently, when all denominations, except the Roman Church, have come to accept martial sexual relations as a blessing and therefore contraception as moral. The Anglican (Episcopal) communion did this at the Lambeth Conferences of 1920 and 1930. In 1954, The Evangelical Lutheran Church in America stated that “to enable them to more thankfully receive God’s blessing and reward, a married couple should plan and govern their sexual relations so that any child born to their union will be desired both for itself and in relation to the time of its birth.” The United Methodist’s Resolution on Responsible Parenthood encourages all possible efforts by parents and the community to ensure that every child enters is healthy body and wanted.

Why could Protestants escape a 1500 year old mistake but the Vatican could not? The answer is yet another twist in a tangled tragic tale of error and stubborn patriarchy. Cardinal Karol Wojtyla (later Pope John Paul) expressed the issue clearly in 1966,

“If it should be declared that contraception is not evil in itself, then we should have to concede frankly that the Holy Spirit had been on the side of the Protestant churches . . . It should likewise have to be admitted that for a half a century the Spirit failed to protect . . . a large part of the Catholic hierarchy from a very serious error.”

What Cardinal Wojtyla should have gone on to say is that the Vatican, unlike Protestant churches, was unable to admit ‘serious error’ because slightly over a century earlier, in 1870 Pope Pius IX had declared all popes as infallible in 1870. A less rigid man than Pope John Paul might have noticed that none of the comments of the Popes or the encyclical Humanae vitae which his predecessor Pope Paul was to issue in 1968, had been framed as infallible. Nevertheless, the fact that his Church, again in Wojtyla’s words, “had condemned thousands of innocent human acts, forbidding [artificial contraception], under pain of eternal damnation” was sufficient to prevent the hierarchy back tracking. Better to prolong a mistake from the fourth century, by a clever man bur one who new zero about the awesome wonders of human reproduction, than to relieve millions of women of earthly pain let alone ‘eternal damnation.’

VI. Family Planning and Sustainable Development

• United Nations International Conference on Population and Development (1994) has declared the right to reproductive health as a human right. 46
• Philippine Population Policy Statement of 1987: couples have the basic human right to decide freely and responsibly the number and spacing of their children.

**Philippine Constitution supports family planning**
- **Art. II. Sec. 12.** - ... The State shall equally protect the life of the mother & the life of the unborn from conception...
- **Art. II. Sec. 15.** – The State shall protect & promote the right to health of the people and instill health consciousness among them.
- **Art. XIII. Sec. 11.** – The State shall adopt an integrated & comprehensive approach to health development which shall endeavor to make essential goods, health & other social services available to all the people at affordable cost. There shall be priority for the needs of the underprivileged, sick, elderly, disabled, women & children. The State shall endeavor to provide free medical care to paupers.
- **Art. XV. Sec. 3. [1]** – The State shall defend the right of spouses to found a family in accordance with their religious convictions and the demands of responsible parenthood.

**Because of its growing population combined with inconsistent governance, the Philippines' demand on ecological resources increased from less than its own biocapacity* in 1961 to more than double its domestically available biocapacity in 2002, and is in excess of the global average47.**

- **Resource demand (Ecological Footprint) for the country as a whole is the product of population times per capita consumption. Resource supply (biocapacity) varies each year with ecosystem management, agricultural practices (such as fertilizer use and irrigation), ecosystem degradation, and weather.**

**Figure 1. Philippine Footprint vs. Biocapacity vs. the World's**

![Footprint and Biocapacity comparison graphs](image-url)

---

47 World and Country Trends. Global Footprint Network
Figure 2. Components of average per person Ecological Footprint in The Philippines.

- In the Philippines, the compound pressure of competing demands for cropland, pasture, and forest create a production Footprint in excess of available biocapacity.
  - This suggests that the forest stock is being depleted. The Philippines' forests shrunk at an average annual rate of 1.4% in the 1990s. (see Figure 4). per capita Biocapacity has been declining rapidly from 1.22 to 0.52 gha/cap, mainly due to growth in population and environmental degradation.
- A higher population exacerbates the effects of global warming identified by UN climate scientists:
  - Rising sea levels, floods and typhoons, dwindling drinking water supplies induced by drought, and shrinking food crops from parched agricultural lands increase human and ecological vulnerability.
- A 1-meter rise in sea level resulting from melting polar ice caps could put 64 of 81 provinces—a full 80%—in harm’s way (Source: Greenpeace).
  - This equals 700 million sq.m of coastal lands covering half of the country’s 1,610 municipalities, where half of the population depends on seafood as the main source of protein.

M. Wackernagel et al. / Land Use Policy 21 (2004) 261–269

- The Philippines can learn from countries such as Pakistan, which has a large population, fertility rate, and corresponding resource strains and conflicts.
  - Underlying these is its failing ecosystem and finite biocapacity, where forest cover has been depleted in favor of farmlands, which itself showing diminishing returns due to growing population and population density. (See Figure 5)

---

49 http://newsinfo.inquirer.net/inquirerheadlines/nation/view/20101130-306093/Studies-find-Philippines-a-disaster-waiting-to-happen
50 Ibid.
Because of the clear and present danger to current and future generations, citizens and policymakers can invoke the **Precautionary Principle** to enact legislation to proactively address and manage population growth and sustainable resource use. (See Section III)

- The 1992 *Rio Declaration on Environment and Development (Rio Declaration)* embodies this statement of precaution and takes the principle from Hippocrates’ oath and places it into the environmental arena:
  - “In order to protect the environment, the precautionary approach shall be widely applied by States according to their capabilities. Where there are threats of serious or irreversible damage, lack of full scientific certainty shall not be used as a reason for postponing cost-effective measures to prevent environmental degradation.”  

- In 2002, the International Law Association’s (ILA) *New Delhi Declaration of Principles of International Law Relating to Sustainable Development Law (New Delhi Principles)* provided a different formulation, broadening the scope of the principle, echoing recognition by the Vatican:
  - “A precautionary approach is central to sustainable development in that it commits States, international organisms and civil society, particularly the scientific and business communities, to avoid human activity which may cause significant harm to human health, natural resources or ecosystems, including in the face of scientific uncertainty.”

- These align fully with the universal concept of Sustainable Development:
  - “Development that meets the needs of the present without compromising the ability of future generations to meet their own needs”, balanced integration of social, economic and environmental aspects in development decision-making, socially and environmentally sound development...  

---


VII. Global Case Studies in RH Policy and Program Intervention

Source: UP School of Economics; UC Berkeley Bixby Center for Population, Health and Sustainability

Overview:

- Rapid population growth undermines economic progress and exacerbates unemployment.\(^{54}\)
- Lower birth rates and slower population rate over last 3 decades contributed to faster economic progress in developing countries (UN Population Fund 2002 Report)
  - Fertility declines accounted for 1/5\(^\text{th}\) of economic growth in Asia between 1960-1995.
  - Countries with investments in health (reproductive health and family planning and women’s education) register slower population growth and faster economic growth.

Battle of the Bulge

By 2050, the world’s population is expected to grow by an additional 2 billion people, mostly in the poorest countries and enclaves. Countries with young bulges are more prone to lengthy and frequent civil wars, and indeed, democratic success stories such as Brazil, Chile, Indonesia, and South Korea only came after population in those countries stabilized.

Country Case Studies:

- **Central Asia**
  - Abortion rate decreased 13% -20% for every 10% increase in contraceptive prevalence.

- **Mexico**
  - Pre-1975 Fertility Rate: 3.5%; Abortions: 37 of 1,000 women
  - Post-RH policy (2005) Fertility Rate: 1.8%; Abortions: 1 of 10,000 women

- **Thailand** (see pp. 31-32)
  - In 1970, RP’s population was 36.7M and Thailand’s about the same.
    - Population growth rate also about 3% p.a. for both
  - In 2007, RP’s growth rate reported as 2.04%; Thailand’s at 0.8%.
  - By 2008, Filipinos number about 90M, while Thais about 66.5 million
    - the difference nearly Malaysia’s population!
  - Ave. GDP Growth rate: Thailand at 6.1%; RP at 3.3%
  - If RP had sustained its population policy and FP programs with same vigor as Thailand, annual rice consumption only about 13M metric tons instead of 18M metric tons.
    - With 16M m.t. domestic production, RP would’ve been net exporter of 3M metric tons.
    - Conservative estimate because savings from lower spending on public services could have been used to boost productivity

---

Tale of two countries: What would have been the per capita income growth if the country’s population growth path was similar to that of Thailand?

FIGURE 1 Percent of women of reproductive age using contraception, Thailand 1988 and Philippines 1993, by residence and educational level

SOURCE: Based on Lee et al. (n.d.)

Population in millions

Population growth rate (%)

Total Fertility Rate (TFR)

Gross National Income (GNI) per capita
Total Fertility Rate (TFR)

Population in millions

Progress toward achieving the Millennium Development Goals (MDG’s)

Percentage of students enrolled in Tertiary education

Other Countries:

The Iranian Solution
Since 1950, countries as geographically and culturally diverse as Colombia, Iran, and South Korea have used smart policies to lower birth rates from more than five children per woman down to replacement level (2.1) as fast as and as permanently as China did through its draconian one-child policy. There’s hope for the Pakistanis of the world yet.

Contradictions of MDGs

Contraception and abortion remained illegal over the time that family size dropped (between 1942 and 1990), with limited legal access for the rich.

Contraception subsidized by the government until the 1980s, with a recent move toward private services. Abortion remains illegal.

Colombia 15 years
Thailand 8 years
China 7 years
Iran 6 years

• Indonesia
  o Contraceptive use contributed to 75% of the fertility decline (Gertler & Molineaux, 1994).
  o Changes in Indonesia’s education and economic development increased contraceptive use and subsequent fertility decline were only possible because an organized supply delivery system of contraceptives existed.

• Iran
  o Iran has achieved one of the most successful family planning programs in the world.
    ▪ Despite economic and political hardships, the newly established government recognized the risks of a ballooning population and prioritized the implementation of a national population policy.
    ▪ Full support of religious and community leaders, a well established primary health care infrastructure and intelligent resource allocation resulted in a rapid decline in fertility and population growth.
    ▪ This trend has had positive impacts on women’s health, education, and human development, and will help preserve natural resources for future generations.
  o The rapid drop in Iran’s fertility rate was also concurrent with remarkable decreases in infant, child and maternal mortality rates—a result of increased maternal and child care (See Figure 2)

![Figure 2](image)

**Fig. 2** Trends in maternal mortality per 100,000 (MMR), infant mortality per 1,000 (IMR), and total fertility rate (TFR) in Iran, 1960-2000 (Ministry of Health and Medical Education, UNFPA, 1998; Department of Public Health Bureau of Population and Family Planning, 2000)

![Figure 3](image)

**Fig. 3** Human development index trend. Source: Human Development Report, UNDP (2006)

The availability and use of family planning in Iran played an essential role in the achievement of developmental goals as reflected in the Human Development Index (HDI). The HDI value is calculated based on the combination of three measurable dimensions of human development: life expectancy, literacy, and income. As shown in Figure 3, the HDI in Iran has been increasing rapidly in the past two decades parallel to the rest of the world, reaching the level of developed countries (UNDP, 2006).
Slower population growth has in many countries bought more time to adjust to future population increases. This has increased those countries’ ability to attack poverty, protect and repair the environment, and build the base for future sustainable development. Even the difference of a single decade in the transition to stabilisation levels of fertility can have a considerable positive impact on quality of life.

Table 2. Bottom 20 Countries in the Use of Modern Contraceptives

<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
<th>Contraceptive Prevalence (% of married women of reproductive age)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somalia</td>
<td>1999</td>
<td>1.0</td>
</tr>
<tr>
<td>Chad</td>
<td>2004</td>
<td>1.7</td>
</tr>
<tr>
<td>Guinea-Bissau</td>
<td>2008</td>
<td>3.6</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>2005</td>
<td>4.3</td>
</tr>
<tr>
<td>Democratic Republic of the Congo</td>
<td>2001</td>
<td>4.4</td>
</tr>
<tr>
<td>Angola</td>
<td>2001</td>
<td>4.5</td>
</tr>
<tr>
<td>Niger</td>
<td>2006</td>
<td>5.0</td>
</tr>
<tr>
<td>Mauritania</td>
<td>2006/07</td>
<td>5.1</td>
</tr>
<tr>
<td>Eritrea</td>
<td>2002</td>
<td>5.1</td>
</tr>
<tr>
<td>Liberia</td>
<td>1996</td>
<td>5.5</td>
</tr>
<tr>
<td>Sudan</td>
<td>2006</td>
<td>5.7</td>
</tr>
<tr>
<td>Mali</td>
<td>2001</td>
<td>5.7</td>
</tr>
<tr>
<td>Guinea</td>
<td>2005</td>
<td>5.7</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>2008</td>
<td>6.9</td>
</tr>
<tr>
<td>Benin</td>
<td>2001</td>
<td>7.2</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>1998/99</td>
<td>7.3</td>
</tr>
<tr>
<td>Albania</td>
<td>2002</td>
<td>8.0</td>
</tr>
<tr>
<td>Nigeria</td>
<td>2003</td>
<td>8.2</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>2003</td>
<td>8.5</td>
</tr>
<tr>
<td>Burundi</td>
<td>2003</td>
<td>8.5</td>
</tr>
</tbody>
</table>

Source: UN Population Division, 2007 b

Fig. 3 Percent married women ages 15–49 using modern contraception according to wealth

Population growth has great momentum. Even though fertility has fallen in many developing countries, the last billion people were added to the planet in 12 years. India, now with 1 billion people, acquires a million more every 23 days. Delays and differences in access to family planning which emerged a quarter of a century ago will have their greatest influence in our new century. For example, in 1960 Thailand and the Philippines had the same number of people and the same TFR of 6.0. There is no evidence that the Filipinos wanted more children than the Thais, but the religious authorities blunted every family-planning effort and staunchly opposed safe abortion. Today, the TFR of the Philippines is 3.7 while that of Thailand is 2.0. Past mistakes will cast an ever darker shadow over the new millennium, and by the year 2025 there will be 73 million in Thailand but 112 million in the Philippines. In the Philippines, large differences in contraceptive use exist by a woman’s education. In Thailand, where family planning is easy to obtain, these differentials have evaporated. It is often assumed that uneducated people want large families, but the data suggest that they have more children because they are unable to surmount the hurdles society puts between them and the birth control methods they need.

Those countries that reach replacement-level fertility by about 2010 are likely to move forward economically and socially. Thailand and the other Asian ‘tigers’ with small families, despite some hiccups in their economies, are likely to prosper, while the Philippines could slide towards the African scenario of economic decline and social instability. The outlook for sub-Saharan Africa, northern India and Pakistan is bleak (Pakistan has only 16% more land area than Texas and in 2050 it will have an unsustainable population of almost 350 million). Growing unemployment, especially among young males, will provide tinder for ignition by political extremists and religious fanatics. The status of women in today’s high-fertility countries is almost always inferior to that in low-fertility countries, and if the population gap between the two is allowed to grow it will be women who suffer first. More and more countries with rapid population growth are likely to follow Rwanda into dependence on perpetual gifts of food from the West. Already the elites of Nairobi and Manila live in walled compounds, surrounded by growing slums. Wars are most likely when the population pyramid has a broad base and a high ratio of young males aged 15–29 to older males.
VIII. Recommendations for a Philippine Demographic Governance Program

Given the above-cited facts, particularly:

- **High Population growth rate plays a critical factor along with policy variables (economic openness, government institutions’ quality, and government savings’ rate)**
- **Majority of Filipinos believe in the State’s need to provide family planning information and method access.**
- **Religion (i.e., Catholic Church’s teaching on family planning and contraception) has little effect on individual’s decision to practice family planning, and that majority of other religions allow for modern contraceptives.**
- **The critical issue is providing access to education and modern contraceptive methods to meet the demand for family planning, especially to marginalized families who have limited access and means to use these methods.**
- **Philippine population growth program targets to reduce Population Growth Rate to 1.67% by 2015, and the Philippine government has committed to the Millennium Development Goals, particularly halving poverty incidence by 2015 (government target, from 32.9% to 20%).**

Based on international success stories on creating a sustainable demographic development, to overcome the persistent challenges of unmet fertility needs and a high population rate and its already significant effects on the Philippine ecology, socio-economic and political system, a Demographic Governance Program has to be proactive, swift, wholistic, unified, and voluntary, and has to have the following components:

- **Empowered Fertility Choices**
  - Focus on providing information, services, and methods to couples who want to reduce fertility safely and effectively as a priority, to complement national fertility and population growth rate targets.
  - Provision of quality services, including expanded choice and availability of contraceptive methods, information on effects and features, technical competence of providers.
  - Public funding by the State to ensure citizens, especially those from poor families, have access to information and methods to voluntarily achieve their desired family sizes.

- **Investment in Human Development**
  - These investments not only directly promote well-being, but also create necessary conditions for reducing the demand for more children
  - Investments include education, livelihood generation, and gender equity programs.
  - Key Result Areas include increased school participation by poor children and lower dropout/attrition rates, alleviating child malnutrition, and improving women’s empowerment to enable them to go beyond traditional roles and secure more livelihood and contributions to society.

- **Investments to reduce population momentum**
  - Involves raising the age of first births, increased birthspacing, and breastfeeding support more effective reduction in fertility rates and the resulting attainment of desired family sizes.\(^{55}\)
  - Increasing education and livelihood opportunities for women will result in the above.
  - By improving school participation rates and keeping the youth in school longer, and ensuring their optimal opportunities in the workforce, population momentum can be addressed.

To this end, a **5-point multi-sectoral program** is critical:

1. **Multilateral, national, and local government funding**\(^*\)
   - Legislation for automatic appropriations
   - Incentives at LGU level to promote family planning and responsible parenthood
   - Reverse LGU bans on contraceptives and promote regulatory standards nationwide.

---

Increasing contraceptive use will require increased investments in contraceptive supplies and services, both from international donors and from the Philippine government at all levels. For many years, funds for family planning services and commodities came mostly from households (45% in 2000) and from donors, technical assistance agencies and NGOs (24%).

- Local and national government covered smaller shares of the cost—22% and 8%, respectively. Until 2006, most contraceptive commodities were donated by the U.S. Agency for International Development (USAID).
- The end of USAID’s large-scale provision of contraceptives has presented a significant challenge for ensuring the availability of supplies.
- In 2004, the Philippines Department of Health (DOH) devised a plan for managing the remaining donated commodities. This “contraceptive self-reliance strategy” encourages local government units (LGUs) to give the poor priority access to the remaining donated contraceptives and to fund future supplies for poor clients. It also promotes shifting better-off users to commercial or partially subsidized sources of supplies, to be made available via LGU outlets.
- However, a recent survey of the 122 LGU chief executives (representing 76 provinces and 46 cities) found that in 2007, only 64 provinces and cities used funds from local budgets to purchase oral contraceptive pills. Another three LGUs procured pills with income from user or laboratory fees.
- The cost of contraceptive services in the Philippines is at least P1.9 billion, a rough estimate incorporating data on the lowest available prices for contraceptives, the costs of services for methods requiring supplies and the reimbursement rates for sterilization under the PhilHealth national insurance system.
- While modern NFP methods do not require supplies, the Philippines DOH Commission on Population budget for 2009 includes P164 million to reach 580,000 couples with Responsible Parenthood/Natural Family Planning classes.
- Based on these costs of P283 per couple, and assuming that all couples attending classes would subsequently use a modern NFP method, service costs to shift all 10.2 million women at risk for unintended pregnancy to modern NFP methods would be at least P2.9 billion.
- The cost of providing modern contraceptive supplies and services to all women who are currently at risk for unintended pregnancy would vary depending on the mix of methods used: P2.7 billion for full use of the current method mix to P4.0 billion for full use of modern methods.
- These costs, and the financial savings discussed below, underestimate the total financial impact of contraceptive services because they do not include the substantial portion of medical care paid for by Filipinos out-of-pocket (48% of health care-related spending in 2005).
- The supply of high-quality and medically safe contraceptives can be brought to the grassroots through a local manufacturing development program for low cost oral contraceptives, IUDs, implants, and condoms in partnership with other developing countries (Indonesia, India, China, Bangladesh, etc.).

### 2. Public Private Partnership for Family Planning Education*

- **Public Information and Education Campaign on:**
  - Value of smaller families (vs. gender preference/balance) and meeting desired family sizes
  - Benefits of birth-spacing and delaying first births for young couples.
  - Available means + medical, ethical information on modern and natural family planning methods
Family planning education for engaged and married couples to address sustainable family planning, and reduce the gap in gender disparity by strengthening males’ responsibility in family planning.

- Use of Church representatives (as done in Iran)
- Medical community (doctors, nurses, midwives)
- Political leaders (national and local government)
- Private sector (business, NGOs. media)
- Entertainment and Arts community (similar to other initiative e.g., Climate Change, such as using telenovelas in Brazil as an educational tool)

Instead of restricting State provision for family planning, the Catholic Church can focus its resources and efforts on institutionalizing within its members its preferred (NFP) methods, given:

- most NFP methods require close monitoring of fertility cycles, and monitoring, motivation, and guidance of couples to ensure success of NFP for Catholics who decide to use these methods
- NFP efforts in marginalized communities have produced limited results and poor usage rates.

Build on successful programs at Local Government Unit (LGU) level:

- Kapit-bisig Laban sa Kahirapan (KALAHI): livelihood development, social protection, human development, asset reforms, governance participation.
- Accelerated Hunger Mitigation Program (AHMP): food production, improved efficiency of logistics and food delivery, increased incomes, good nutrition.
- League of Municipalities of the Philippine (LMP’s) “Kung Malit ang Familia, Kayang Kaya”
- Population, Health, and Environment (PHE) Program of Concepcion, Iloilo
- RH Ordinance and Program of Quezon City
- Incorporate family planning programs into geo-morphologically relevant environments
  - Ex: Community-based Coastal Resources Management and Community-based Forest Resource Management.

3. **Direct Poverty Interventions : Conditional Cash Transfers, Microfinance, and Informal Settler Programs**

- **Strengthen Kalahi CIDSSS.** Leverage Millennium Challenge Account Grant and expand conditionalities for Conditional Cash Transfers (CCT) to enforce environmental preservation.

- **Microfinance and women’s education and livelihood programs.** Studies show that women’s loans double family income more than men’s loans, and increase child survival twentyfold.  
  
  - Microfinance makes a difference to poor participants by raising per capita income and consumption as well as household net worth, thereby increasing the probability that the program participants lift themselves out of poverty.
  - The welfare impact of micro-finance is also positive for participating and nonparticipating households, indicating that micro-finance programs help the poor beyond income redistribution and income growth.
  - By increasing access to education and livelihood for women, this empowerment results in delayed marriages, longer birthspacing, greater productivity and meeting desired family sizes.

- **Informal Settler Housing and Registration (I-SHARE) Program**
  - Balance Relocation or In-house-building with Land-Use Plans
  - Partnership with NGOs (Habitat for Humanity, Gawad Kalinga); ensure family planning provided
  - Register marginalized to enable access to credit and property (Source: Hernando de Soto)

---


4. **Demographic Institutional Alignment**
   - Create Dept. of Population and Migration (a’la Australia), or Reform Population Commission
   - Monitor and coordinate equitable growth across countryside and decongest urban centers by aligning decentralized growth strategy.
   - Formalization and accountability by local governments of migration and demographic changes

5. **Land use and Demographic Monitoring**
   - Enact Land Use Policy (NG and LGU) + LGU Compliance - Urban Development Housing Act (RA 7279):
     - Land inventory for socialized housing
     - Registration of beneficiaries
     - Identification of temporary relocation sites
     - Comprehensive Land use plans
     - Citizens’ registration to monitor migration, settlement, and productivity
   - Taxation of idle lands as provided by Sec. 236 of the Local Government Code
     - Use revenues to fund **Informal Settler Housing and Registration (I-SHARE)** program
   - Asia Society Young Leaders’ Program has initiated a Regional Demographic Mapping Programme
     - Available by January 2011; can be downscaled for country-level usage.

*requires national legislation and complementary local regulations to ensure sustainability, optimal reach, and positive outcomes

**IX. Key Result Areas**

By balancing resources with sustainable demand from manageable population pressures, and enabling poorer families to live within their desired sizes, this program enables the Key Result Areas (KRAs) in 10 years:

- Increase contraceptive prevalence rate from under 50% to above 70%
- Reduce unintended abortions to half (under 250,000/annually)
- Lower total fertility rate from 3.03% to 2.1% (sustainable replacement rate)
- Increase Health and Education budgetary spending by 30%
- Improve GDP per capita and Human Development Indexes, and lower poverty rates 33% to 25%

This supports the Philippines realistically attaining its commitment to the Millennium Development Goals, in which it is behind in 40% of the 21 indicators and will be unable to meet the 2015 target commitment, significantly due to the inability of resources to meet persistent demographic governance pressures.

**Quintin Pastrana** is a Masteral Candidate in International Relations and Development at the University of Cambridge, and was educated at Georgetown University graduating with an MBA in Global Management. He has worked in the Philippine government and is currently a private sector executive and convenor of the Movement for Good Governance.

**Lauren Harris** completed her Masters in Public Health at the University of California-Berkeley and is a research fellow at the University’s Bixby Center for Population, Health, and Sustainable Development. She has a Masters degree in Anthropology from the University of South Florida and has worked internationally on women’s health and development.

---

58 The MDGs are a set of **time-bound, concrete and specific goals** to reduce extreme poverty, illiteracy and disease that 189 leaders committed to achieve by 2015. These goals are: 1) end 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.