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HUMAN CAPITAL: ISSUES AND MONITORING CONCERNS
SOCIAL SCIENCE RESEARCH
ON REPRODUCTIVE HEALTH IN THE PHILIPPINES

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INTRODUCTION

The world has witnessed an unparalleled rise in human numbers during the past four decades. Most of this increment (2.8 billion between 1950 and 1990) took place in the Third World, where rapid declines in mortality accompanied the modest improvements in living standards during the 1950s and 1960s. In much of the developing world, the crude death rate was reduced by half, nearly equalling the levels of the more developed countries. Crude birth rates also fell, albeit more slowly, but in some cases remained at levels three or four times the developed country rates.

The populations of many developing countries continue to grow rapidly in the absence of prominent fertility declines and with greater survival of children. Consequently, the world is adding about 93 million persons to its population annually. If present trends are maintained, the yearly increment will be 94 million in 1995-2000. In the next century, growth is projected to continue at a slower rate before reaching equilibrium at an estimated 11 billion people. Most of this increase will occur among the world’s poor, 94 percent of it in the Third World.

The accelerated increase in world population has resulted in a vast rise in the number of people living in want, with women and children bearing the greatest burden. By the end of the century, almost one-half of the world’s inhabitants will be aged twenty-five years or less. The growing multitude of children will strain the capability of families and societies as a whole to supply the basic necessities of food, clothing and shelter, much less provide
education and health care. Entrants to the labor market will be hard put to find jobs. The next thirty to eighty years may witness serious difficulties in balancing population growth and available resources.

The last twenty years have seen an increase in women’s movements and a focus in society as a whole on reducing disparities and discrimination and on promoting the consideration of ethics and human rights. This concern for the quality of life has influenced the study of reproductive health and population by emphasizing the unfairness of centering on numbers of births and deaths without paying the same attention to people’s welfare. By the eighties, a deeper understanding of the complexities of reproductive decision making and its consequences for the whole family had altered the framework within which population policies were discussed.

Contraceptive research and family planning service delivery were also influenced so that now, increasing attention is being paid to such issues as how to provide medically and culturally appropriate contraceptive methods, along with adequate information to allow for a free and informed choice, as opposed to concentrating on numbers of new acceptors. New contraceptive methods are being developed that better meet women’s needs. The development of methods for males is also receiving added attention. There is a growing realization that research must be attuned not merely to the biomedical aspects but also to the social, cultural, economic and political factors influencing reproductive health.

This paper which is not comprehensive in scope begins with a definition of reproductive health, then goes on to summarize the findings of some local social science research works on reproductive health and their implications for policy formulation and program management.
REPRODUCTIVE HEALTH

Reproductive health, as defined by Fathalla (1988), means that —
1. people have the ability to reproduce as well as to regulate their fertility;
2. women are able to go through pregnancy and childbirth safely;
3. the outcome of pregnancy is successful in terms of maternal and infant survival and well-being; and
4. couples are able to have sexual relationships free of the fear of unwanted pregnancy and of contracting any disease.

Corollary to the above is that couples should have access to a wide choice of methods to regulate their fertility and to services that can provide contraception in culturally sensitive ways (WHO 1993).

Social science research on reproductive health as undertaken by the World Health Organization’s Special Programme of Research, Development and Research Training in Human Reproduction (HRP) is built on the goal of ensuring the individual’s ability to safeguard her or his health and to enhance people’s opportunities to exercise choice on all the events that surround or affect human reproduction, including service access and utilization.

Accordingly, social science research on reproductive health covers two main areas:

1. behavioral and social determinants of fertility regulation which include—
   • contraceptive choice and use;
   • gender roles and fertility regulation;
   • male contraception and fertility;
   • acceptability of new contraceptives; and
   • costs and benefits of contraception.
2. components of reproductive health such as-
   • causes of induced abortion;
   • sexual behavior and reproductive health;
   • social dimensions of maternal health; and
   • breast-feeding and birth spacing.

The sections that follow will describe selected social science research studies on reproductive health in this country following the above classification. The research had been based on national fertility and contraceptive prevalence surveys, operations research and special studies. For the sake of brevity, the findings and implications of only one or two examples for each subtopic are included.

SELECTED SOCIAL SCIENCE RESEARCH
ON REPRODUCTIVE HEALTH

Behavioral and Social Determinants of Fertility Regulation

Contraceptive choice and use. Included herein are studies dealing with the mechanisms of contraceptive adoption, continuation, use-effectiveness, discontinuation and/or switching of methods. The findings reported below are based on the various rounds of the quinquennial National Demographic Survey (NDS) starting from 1968 to 1993, the 1978 Republic of the Philippines Fertility Survey (RPFS), the 1972 and 1974 National Acceptor Surveys (NAS), Community Outreach Surveys (COS), the 1986 Contraceptive Prevalence Survey (CPS), a special study of NFP centers in Metro Manila, and an operations research study of clinic performance in four selected sites throughout the country.

While knowledge about the different methods of contraception is almost universal, the proportion of currently married women aged 15-44 years using a family planning method increased steadily from 15 percent in 1968 to 40 percent twenty-five years later (Cabigon 1985a; Perez and Cabigon 1985; Casterline 1991; NSO 1994).
The use of modern methods rose from some 3 percent in 1968 to 25 percent in 1993. Of these methods, the most popular in 1993 was female sterilization (12 percent), followed by the pill (9 percent). The observation of Casterline (1991) that the increased reliance on sterilization was perhaps the most significant change in method-mix during the period 1968-88 seems to have been upheld by the 1993 NDS. It is not known, however, to what degree disruptions in supplies of pills, IUDs and condoms contributed to this outcome.

Education proved to be the most important source of difference in contraceptive use. Differentials by residence, income, work status and occupational index were smaller but the differences portrayed the expected configuration (Cabigon 1985b; NSO 1994).

Contraceptive effectiveness is measured by a weighted average of method-specific use effectiveness scores which assume that sterilization provides 100 percent protection; IUD and injectables, 95 percent; the pill 90 percent; rhythm, 70 percent; condom, withdrawal and other methods, 60 percent. The resulting mean use-effectiveness indices rose from a level of 76 percent during the period 1973-77 to 79 percent ten years later. The use-effectiveness index for 1987 was 78 percent (Casterline 1991).

Based on the 1983 NDS round, Cabigon (1985c) calculated twelve-month continuation rates for pills to be 55 percent; for IUD, 85 percent; for condom, 37 percent; and for other methods, 59 percent. A special study of three natural family planning (NFP) centers in Metro Manila conducted in 1985 by de Guzman (1986) revealed the twelve-month continuation rates for calendar rhythm to be 63 percent and that for cervical mucus to be 46 percent. These NFP continuation rates were influenced by the women’s work status, education, previous family planning use, SES indexed by housing materials, and by their husbands’ involvement in sharing responsibilities for contraceptive practice (de Guzman 1986; Zablan 1986).

Choe and Zablan (1991), using data from the 1986 Contraceptive Prevalence Survey, found that the discontinuation rates for the pill, IUD and condom were highest among those switching to another method, followed by method failure. Substantial proportions of pill and condom users discontinued their practice because they wanted more children or because they...
perceived no need to resort to family planning. Dissatisfaction with the method and medical problems were pronounced reasons for discontinuing use of the IUD and condom. The most frequent reason for stopping cited by users of the withdrawal or rhythm method solely or in combination with other methods was unintentional pregnancy, followed by the switching to another method. Eight out of ten pill users were new acceptors of the method. Another reason given for dropping out is the pill’s side effects which, for the most part, were more imagined than real. Roberto’s (1991) study of acceptors of sample clinics in Metro Manila, Tarlac, Iloilo and Davao showed that switching took place from the pill to less effective methods such as condom and rhythm.

Implications of the findings:

1. Closing the gap between knowledge and practice requires a combination of well-trained motivational workers, efficient clinic workers and mobile clinics to cater to the underserved clientele in the hinterland.

2. Widespread fear by clients of the side effects of contraception can be allayed by an effective information, education and communication (IEC) program that also cites the advantages, disadvantages and contraindications of each method.

3. Continued contraceptive practice, particularly by the pill user, can be ensured by a thorough education and counselling of the client that includes “inoculation” against the fear of side effects, whether real or imagined.

4. Bringing a new acceptor into contraceptive practice via the pill is very risky in the light of the reasons given for dropping out of pill usage. From the point of early dropout incidence, the risk is greatly reduced if the entry is made either through use of the condom or through the practice of rhythm. Once into the contraceptive practice, the “trading up”, i.e., the persuasion and motiva-
tion to move up to the more modern pill or IUD, can start, with dropping out of either of these two methods becoming less likely.

5. An analysis of the reasons why some women continue using the same method, switch to other methods or stop using contraceptives altogether should provide a guide for program managers in reorienting the program towards increased participation of prospective users and drop-outs.

Gender roles and fertility regulation. Projects included under this topic are those investigating family planning-seeking behavior, gender differences in the awareness of reproductive health risks, and the role of Filipino males in fertility decision making. The findings and implications of a couple of the most recent studies are given below.

In an effort to understand the factors and the process of family planning decision making among married couples of reproductive age (MCRAs), Ventura et al. (1992) interviewed a sample of wives and husbands in one urban area and one rural area each in Bulacan, Davao and Iloilo from August to October 1991. To supplement data from these indepth interviews, focused group discussions (FGDs) were held. Service providers were also interviewed, and a profile of their clinics was drawn.

The study highlighted the following:

1. Married couples of reproductive age (MCRAs) go through a rational process of decision making about family planning. The process starts with some discussion about family planning, usually initiated by the wife. Most couples (both ever-users and never-users) acknowledged that their contraceptive practice was basically their own decision.

2. Major push factors to contraceptive practice derive from economic difficulties, concern for a better future and the wish to attain a desired family size. Decisions not to resort to contraception were based on the fear of side effects, rumors of problems associ-
ated with family planning practice and the lack of children or nonachievement of the desired family size.

3. Although husbands did not pose any problem in initiating contraceptive practice, they relegated the responsibility of family planning to the women.

4. In general, many couples knew of the presence of family planning clinics in their area. A significant number of current users seemed to depend on these clinics and their service providers for information and resupply. Many ever-users mentioned that they would prefer to consult service providers should they decide to resume their contraceptive practice in the future.

5. Service providers play a crucial role in providing factual information about the range of family planning methods, given the conflicting messages that MCRAs obtain from other sources such as relatives, friends and neighbors.

6. Service providers underscored the need to improve house-to-house visits, IEC materials, and logistics, and to give greater priority to family planning work as against administrative matters.

Implications of the findings:

1. Men must be encouraged to recognize their responsibilities toward the health of the family and to respect their partners' concerns, if they are to act as equal partners of women.

2. Motivational materials should tackle such issues as men's role in family planning, particularly the various ways in which they can be supportive of their wives or partners; the continuance of family planning practice; the side effects of contraceptives, and additional information support on the correct use of specific methods.
3. Basic as well as more specialized training on the various family planning methods should be offered for service providers. In addition, short refresher courses to update their knowledge should be planned on a regular basis.

4. Training for service providers must include motivation/persuasion techniques and pointers on how to deal with difficult clients and how to counter opposition.

5. Giving more emphasis to men implies the deployment of male service providers since the present work force consists mainly of women who are more likely to approach other women with whom they can empathize and feel comfortable.

A study of reproductive health risks and fertility decision making was undertaken by Casterline, Perez and associates involving 300 couples from five urban barangays of Metro Manila and 480 couples from eight rural barangays in Muñoz, Nueva Ecija. Currently married women aged 25-44 and their husbands whose ages ranged from less than 25 to over 44 were randomly selected in these 13 barangays. Information was obtained separately from both the husband and the wife on their perceptions of women’s reproductive health issues. Before the field work, focus group discussions (FGDs) took place. Content analysis of these discussions revealed the following:

1. Economic considerations were cited as the primary reason for a smaller family size, particularly since times were hard. The importance of education was also underscored as the only legacy which parents can leave their children. Although couples realized that children today cost more to raise than in the past, they nonetheless had higher aspirations for them.

2. The majority of FGD female participants from rural areas (unlike urban women) did not single out the expanding role of
women in society, in particular women’s entry into the labor market, as a major reason for the downward change in fertility.

3. The physical and emotional stress associated with childbearing and childrearing can be significant factors in spacing or limiting pregnancies as many participants cited the difficulty of looking after children and raising them nowadays.

4. Married participants were unanimous in stating that couples do discuss what method to use either to avoid or delay pregnancy. However, when disagreements arose the males believed that their view should prevail since they were the family heads. The females, on the other hand, believed that their decision should get the upper hand inasmuch as it is they who undergo the hardships of pregnancy, parturition and childrearing.

5. All FGD participants showed high levels of knowledge of contraceptive methods and of family planning service sources. But while most were aware of the effective methods, apprehension was expressed concerning their side effects. Hence, a significant number practised either rhythm or withdrawal.

6. Myths and misinformation regarding the side effects of modern contraceptive methods were widespread, particularly among the younger, unmarried Metro Manila participants, often hindering family planning acceptance and practice.

7. Participants believed that for health reasons, a woman should start having children in her early twenties and stop having them by age 35 or a few years beyond. However, a more important reason for stopping at 40 years and over was the social stigma encountered by women who bore children at such advanced ages.

8. Spacing of births was pinpointed by the FGD participants as a way of enabling mothers to regain their strength and energy and ensuring that children already born were well cared for. Although
the level of awareness of reproductive health risks was high, this seemed to exert little influence on fertility decisions.

9. The overall preference of these participants was for fewer children. When pressed for a definition, fewer children meant four to most of them.

Perez (1994) investigated the differences between women and men in their perceptions of selected age-related health risks of childbearing to women and the variations across subgroups of women and men differentiated by education and residence. The individual responses of 1,200 women and 780 men included in the above-cited Metro Manila and Nueva Ecija study to the questions listed below were analyzed.

“Considering the health risks of childbearing, at what age do you think a woman should start and stop childbearing?”

“Considering the health risks of childbearing, after how many months from the preceding childbirth should a woman get pregnant again?”

The differences and similarities in perception by age, education and residence of these women and men were as follows:

1. The majority of both women and men reported 15 to 19 years as the ideal age group to start childbearing. However, at comparable age groups, greater proportions of women than of men reported the age range 15-19 as ideal. For examples, at ages 35-39, more than half of the women respondents thought it safe to start bearing children at ages 15-19 but only 39 percent of the men were of a similar opinion.

2. The perceived ideal age to start childbearing varied directly with the educational attainment of women and men. But when it came to place of residence, whether city- or village-based, women thought bearing children in their late teens was not hazardous to their health. In contrast, more men in the towns and cities than in the villages stated that 20-24 was a better age range to start a family.
3. In general, men preferred a shorter birth interval than women (13-25 months as against 25-36 months) probably because the latter are the ones exposed to childbearing risks. The older the men, the greater was the proportion that thought that a shorter birth interval was ideal for women’s health. No pronounced age (or educational) differences were noted for women. Greater proportions of rural rather than urban women and men favored the modal birth intervals.

4. The modal age group to end childbearing according to both female and male respondents was 35-39 years. The proportions of women tended to drop with increasing age but the pattern was not as clear for their male counterparts. The fractions of both women and men preferring 35-39 years rose with education but declined with distance from urban centers. The data indicate that urban residents are generally more aware of the health risks associated with pregnancies and births during the later years of women’s reproductive lives.

5. Overall, the data on perceptions of age-graded health risks of childbearing suggest that both women and men appreciate the risks accompanying births that are either too early or too late. However, the distinctive gender difference that stands out is in the best birth interval length that promotes healthy childbearing.

Implications of the findings:

1. The provision of factual information regarding the proper use, advantages and disadvantages, and possible side effects of each family planning method is crucial to countering the myths, rumors and misinformation prevailing among married and unmarried persons of childbearing age.

2. IEC materials should capitalize on the importance given by couples to providing education to all their children as an important reason for a smaller family size.
3. Service providers, supported by the appropriate IEC materials, should spread the advantages of properly spacing births for the health not just of the mother but of her future children as well.

4. Innovative ways to alter the prevailing notion of *fewer children* from four to three or less have to be devised and propagated.

5. Maternal health services must be expanded to include education on safe motherhood, breastfeeding education and support services which can simultaneously contribute to birth spacing, better maternal and child health and higher child survival. Programs to engage men’s support for maternal health and safe motherhood should be developed.

6. The differences between the sexes in their perceptions of appropriate birth interval lengths imply that in cases of disagreement on the timing of first and subsequent pregnancies, the power relations between husbands and wives largely determine the desirability of births or the incidence of “mistimed” births.

**Components of Reproductive Health**

*Causes of induced abortion.* Studies on the determinants and consequences of induced abortion with emphasis on contexts where the practice is illegal are included under this topic.

An umbrella project on *Abortion and Reproductive Health Among Filipino Women* was undertaken starting in 1992 in four selected areas, namely, Metro Manila, Davao City, Cebu and Tuguegarao. In each area, an academic institution and a hospital collaborated in a study which sought to (1) improve the knowledge base on abortion among Filipino women particularly on the level of practice and the various abortion-level services available to women, the circumstances leading to abortion and the abortion sequelae; (2) improve data recording of abortion cases in participating hospitals; (3) improve legislation, policy and program formulation in the
areas of abortion, family planning, women and health through the provision of scientifically-based information on abortion; and (4) promote national and subnational awareness and expertise and foster local collaboration in both research and program areas on women and reproductive health.

Preliminary results based on the study of the prevalence of abortion among 1,169 women aged 25-44 interviewed in April-May 1994 in Metro Manila have been released by Cabigon (1994).

1. Two out of every five respondents said they were currently using contraceptives while four out of five stated that they had never used a contraceptive.

2. Among current users, nearly half (48 percent) were using modern methods while a third were practicing withdrawal. Only 3 percent were using natural family planning while 16 percent favored the rhythm method.

3. One in six women respondents (or 194 in all) reported having had an abortion. The reasons cited for resorting to abortion were economic difficulties, problems with the husband/partner, youngest child was still too young, too many children, not yet ready for the responsibility of bearing a child, and departing for abroad.

4. The majority, 77 percent, were Roman Catholics.

5. Some 4 percent of the women surveyed became pregnant with fetal losses (either induced or spontaneous) while practicing contraception.

6. Of the 1,169 women, some 8 percent used a family planning method after such fetal losses.

7. The 1993 Safe Motherhood Survey for the nation as a whole revealed an abortion prevalence rate of 7 percent compared with the 16.6 percent reported for this Metro Manila abortion study. Comparable data for previous periods are not available.
Implications of the findings:

1. To prevent the occurrence of a significant number of unsafe abortions and to forestall the loss of lives or permanent injury due to complications arising from such practices, particular efforts should be exerted to obtain objective and reliable information on the incidence and consequences of abortion.

2. To prevent unwanted pregnancies, national policies should be based on a better understanding of the need for responsible human sexuality and the realities of current sexual behavior. Support should be given to integral sexual education and services which should begin within the family, in the community and in the schools. Such educational efforts should reach adults, particularly men, through nonformal education and a variety of community-based efforts.

3. Reproductive health care should include family planning counselling, IEC and services as well as the prevention of abortion and the management of the consequences of abortion.

4. Greater community participation in reproductive health care should be promoted by decentralizing the management of public health programs and by forming partnerships in cooperation with all types of NGOs (local women’s groups, trade unions, cooperatives, youth programs and religious groups) and private health care providers.

_Social dimensions of maternal health._ Improving reproductive health requires the provision of quality services, particularly family planning services. Included under this topic are studies that look into the quality of care, the relations between clients and health-care providers, staff attitudes and the opportunities that women have to make an informed choice about the most suitable contraceptive.
An operations research approach was taken by Roberto (1991) in determining the correlates of high and low family planning clinic performance. The objectives of his study were to determine the (1) level of clinic performance by measuring it with four indicators: "goal effectiveness," "potency effectiveness," "realized efficiency," and "capacity efficiency"; (2) program managers' perception of the causes of high and low clinic performance; (3) indicators used by program managers and service providers for service quality; and (4) expectations, actual sources of satisfaction and quality perceptions of acceptors relating to service personnel, service outlet, and service performance at the clinic level.

The respondents consisted of clinic managers (doctors or nurses), clinic support staff (nurse, midwife and family planning volunteer worker) and the clinic's current and former family planning acceptors in 25 clinics per study site located in Metro Manila, Tarlac, Iloilo and Davao. The findings for the third and fourth objectives which are relevant to the social dimensions of maternal health are given below.

1. The clinic managers and support staff define quality family planning service as one that could keep continuing users returning for supplies and service, attract new acceptors, satisfy acceptors and ultimately impact on fertility rate reduction. These dimensions make up the "effect" aspects of quality service.

2. Quality service depends on supply availability and on the cordiality and approachability of clinic staff.

3. Quality service outlets and facilities are described in terms of the basic minimum requirements of a functioning service outlet.

4. Acceptors expected service providers to be accommodating and attentive to their problems, i.e., skillful in human relations.

Acceptors also expected the clinics to be clean and structurally sound and to be fully equipped with instruments and other necessities. For this last, acceptors wanted them to be "complete and
accurate." As for the clinic facilities, acceptors were satisfied with the basic minimum.

5. With regard to service processing, acceptors merely expected provision of service, not quality service at all.

Implications of the findings:

1. Clinic personnel must be trained in human relations skills to satisfy relationship-based acceptor expectations. The family planning training of clinic personnel must start including such skills as an integral part of the training program's skill-building objectives.

2. The pressure exerted by acceptors on the cleanliness of the clinic location, structure, appearance and interior suggests a great need to improve substandard clinic conditions and facilities.

3. The expectations of acceptors about service performance or processing for mere service provision implies that the present service has to be vastly improved before quality service can be attained.

4. Clinic location was identified as the strongest determinant of acceptor satisfaction. However, the three areas least satisfactory to acceptors and which required amelioration and upgrading proved to be (1) clinic equipment and instruments, (2) clinic interiors, and (3) outside structure and appearance.

Raymundo et al. (1991) looked into the interaction between grassroots family planning (FP) workers and clients in the Philippines focusing on its possible program impacts. This project formed part of a cross-country study under the sponsorship of the United Nations Economic and Social Commission for Asia and the Pacific (UN/ESCAP). The study had the following specific objectives: (1) to assess the quantity and quality of client-worker interaction; (2) to identify areas where client-worker interaction could be improved and remove barriers to effective interaction; and (3) to generate
Philippine-specific recommendations to improve the client-worker interaction process for enhanced program performance.

The study sampled three high performing regions in terms of FP service delivery and practice (Tarlac, Misamis Oriental and Davao del Norte) and two low performing regions (Iloilo and Metro Manila) covering a total of 18 municipalities. Each province was represented by one urban and three rural municipalities except for Metro Manila where all the municipalities were classified as urban.

For each municipality, a random sample was drawn consisting of 80 clients and 7 workers, composed of 4 motivational workers (MW), 2 clinic workers (CW) and 1 district hospital worker. To the extent possible, the clinics were divided equally between government and nongovernmental organizations. Immediately following the survey in May-July 1990, in-depth interviews of current users (CUs) were conducted and client-worker interactions were observed to provide a more thorough account of the interaction process.

The findings concerning the quality and quantity of interaction are highlighted below.

1. On average, CUs met their FP workers almost monthly. However, the number of interactions remained less than ideal with past users (PUs) and never users (NUs), who were at the tail end of the FP workers’ preference list.

2. There were imbalances in the client-worker ratio particularly among PUs and NUs who expressed the desire to practice FP in the future but who reported receiving only infrequent attention from their FP workers.

3. Clients rated their FP workers favorably for their friendliness and attentiveness to their needs (personal or otherwise), and for their ability to provide thorough and easy-to-comprehend FP information. On the other hand, FP workers described their clients as friendly, attentive to their questions, respectful, generous with their
time and able to express themselves in simple language. The favorable interaction process between clients and FP workers manifested an incremental effect on the client’s FP knowledge, attitude and practice, particularly among the CUs.

4. The low level of FP training of workers, poor logistical support and supply impinged on the interaction process.

5. Both MWs and CWs ranked motivation and counselling as very important among their activities. Yet, in terms of the time spent to inform and motivate clients, the CWs devoted more than half of their work hours to this activity as compared to just over a quarter for the MWs.

Implications of the findings:

1. The program’s budgetary requirements must be met adequately. Most of the problems identified in relation to the interaction process revolved around the issue of budgetary constraints.

2. Mobile FP clinics should be reactivated to service the “motivated underserved,” particularly in those regions which have established a clinic-based approach at the expense of motivated clients living in far-flung areas.

3. To enable each FP worker and outlet to deliver consistent, reliable and quality FP services, there should be greater focus on retooling both the motivational and clinic workers. Contraceptive drawbacks should be fully explained so that they can be better handled by both worker and acceptor.

4. Service delivery should be prioritized taking into account the health considerations and fertility preferences of the clients.
CONCLUSIONS

The findings from the selected social science research studies on reproductive health as described above merely echo and support previous research findings. Despite the almost universal knowledge of contraception and the favorable attitude towards it, contraceptive prevalence levels remain relatively modest. The implications of each of the studies included in this brief overview reinforce each other and point to the importance of a well-planned information, education, communication and motivation campaign geared toward allaying the fears of clients and correcting the myths and misinformation concerning modern family planning methods prevalent among the population. The human relations skills of workers in the family planning sector (both those assigned to clinics and those in the field) are prime requisites for enhanced client-worker interaction. The low expectations of clients for quality service imply that the substandard conditions and location of service outlets are accepted for what they are. If the family planning program is to achieve its goal of delivering consistent, reliable and quality family planning services, the training program for all levels of workers must be revitalized and the incentive system upgraded. Moreover, efficient program management and operations require the overcoming of the difficulties posed by the scarcity of human resources to meet the growing demand and by severe financial constraints. Unwanted pregnancies should be prevented through sexual health education and through expanded and improved family planning services, including proper counselling, to reduce the rate of abortion.

The above findings and their implications provide a firm basis for action. All that is lacking is the political will and the determination to moderate the still high rate of population growth.


I have been asked the impossible task to react to Dr. Concepcion’s paper. The task is impossible because the presenter of the paper is someone whom I regard as my mentor and professional mother. The task is made more difficult because this symposium is in honor of one of the more important social scientists in the Philippines.

Dr. Concepcion pointed to the centrality of reproductive health in women’s lives and in development issues in more ways than one. We can make several observations on the more recent studies she mentioned by looking at the centrality of women’s issues and reproductive health in what might be a quest for improving women’s lives and women’s contribution to development.

In the studies cited in Dr. Concepcion’s paper, we had an indication of the kind of social science research that has been relevant to reproductive health. Using the framework of the WHO-HRP, I would like to advance three additional conclusions to the ones that Dr. Concepcion made:

First, there had been an overemphasis on the contraceptive aspect of fertility regulation or of reproductive health. My view is that reproductive health is broader and fertility regulation is a subset. As a subset of fertility regulation, there is contraception or family planning.

Dr. Concepcion showed studies that are particularly high on the effectiveness of various methods. Also mentioned were pioneering or initial studies on decisionmaking and other gender considerations in contraceptive practice.
Second, the breadth of reproductive health has not yet been explored by social science in significant ways. There are still a lot of areas in reproductive health that should be examined, not for academic purposes but from the social science point of view. In finding ways to improve programs, they must be designed to help women.

Third, a woman-centered approach and a gender-fair approach in studying reproductive health is indicated if research studies are to be more policy-relevant and closer to pinpointing information gaps for the improvement of programs and policies.

I will attempt to answer the question: “Why/How could social science research be important to furthering reproductive health?”

Dr. Concepcion’s paper presented the WHO-HRP framework for reproductive health. There could be a supplement to that framework if we look at social science perspectives and other dimensions of reproductive health.

The definition of reproductive health — in addition to the one quoted by Dr. Concepcion as put together by Dr. Tapalia, basically derived from the point of view of WHO and was reiterated and amplified in the 1994 ICPD Cairo Conference — is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes. It therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide when and how often to do so.

Almost invariably, the concept of reproductive health acknowledges, as a basic tenet, the importance of reproductive choice as a universal human right. Thus, if reproductive health is to mean anything as a practice, these rights rest on the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, and to have the information and means to do so, and to have the right to attain the highest standard of sexual and reproductive health.

By definition alone, reproductive health cannot be treated as mere mechanics or as isolated biological events of conception and birth; rather,
it must be treated as a lifelong process that is inextricably linked to the status of women in their homes and societies, and properly contextualized in a world that is demographically complex and culturally diverse. I would argue therefore that a women-centered approach and reproductive rights highlight the need for social science research in tandem with medical advances in the promotion of reproductive well-being.

Three basic principles in women-centered approach and in reproductive health have been identified, each having implications on how social science can assist in making these approaches effective for reproductive health. First, a women’s approach to reproductive health is about trusting women and giving them autonomy to make decisions on reproduction and the ability to make those decisions based on access to complete information and services. Self-respect, dignity and control are important conditions of improved health.

Second, a women-centered approach means understanding and addressing reproductive health in a way that women experience it as an integral part of their everyday life. This includes not only service aspects but other quality of care issues that come from public health intervention programs, or even care from their own homes and communities. Relationships and how one feels about an event are part of the behavioral responses of people to stimuli. Reproductive health in this context involves stimuli and responses and, to a large extent, involves adaptation and socialization which are major factors in interaction. Women interact with many kinds of people: husbands, children, health providers, etc. The adaptation of women and socialization in these various interactions are important.

Third, the different levels in which policies and programs are developed and implemented — global, national and local — should be interconnected. At the national level, this is found in the dynamics of stakeholders from policy formulation to implementation. I emphasize that women should be regarded as the major stakeholders in this regard. Non-acceptance or non-compliance of target beneficiaries can sabotage what can be at the government and concerned elite groups, a logical and well-designed policy. Refusal of ordinary (often powerless) and poor people to surrender their
reproductive rights can render ineffective what can be a grand design of a reproductive health care program.

Thus, social science research and reproductive health can look at issues of women’s autonomy in making decisions in their day-to-day experiences related to reproductive health. It will involve life events during their entire life cycle where most events are related to reproductive well-being. This life-cycle view of clients or women should make it easier to view them and their changing needs over time (we should also consider that there could be overlapping needs over time). In developing countries where individual women are intended beneficiaries of public intervention programs, how adequately and appropriately addressed their reproductive aspirations and goals are will make much difference in the success of programs.

The Philippine maternal health program and the Philippine family planning program, unfortunately, are not yet anchored on a reproductive health framework and, thus, leave much to be desired. In the same manner, social science research in family planning and maternal and child health abound, but there is no significant and conscious effort to look at these from a comprehensive reproductive health perspective. Operations research, some mentioned in Dr. Concepcion’s paper, have concentrated on specific implementation details and have been designed to make the same program work better. As a result, the program indicators are quite narrow in scope, and most of the time are concentrated on cold statistics regarding program performance such as contraceptive prevalence rate, contraceptive prevalence rate by method, number of trained health personnel on IUD, and so on. Only lately were client-seeking behavior studies and joint husband/wife or male/female studies conducted. They deal with issues other than family planning and direct maternal issues such as pregnancy and child birth.

We need more studies on satisfaction over services and methods, and we need to broaden our program indicators or program statistics to look into qualitative measures of program performance and the satisfaction of women from these programs. Dr. Concepcion’s paper cited some studies on client-provider interaction, reasons for seeking a type of service, etc., all of which are, in a sense, pioneering studies on family planning. This undertaking
could be broadened to include reproductive health. While there is a slow broadening of issues toward reproductive health, more systematic studies on comprehensive reproductive health should be our direction. The framework on reproductive health and women's health, from the point of view of both programs and research, has not been adequately formulated.

The perspective of the Development Alternatives with Women for a New Era (DAWN) can be used as an initial framework for program formulation or for social science or biomedical study on reproductive health. The perspective is—

"Control over reproduction (reproductive rights) is a basic need and a basic right for all women. Linked as it is to women's health and social status, as well as the powerful social structures of religion, state control and administrative inertia and private profit, it is from the perspective of the poor women that this right can be understood and affirmed. Women know that childbearing is a social and not a personal phenomenon; nor do we deny that world population trends are likely to exert considerable pressure on resources and institutions by the end of this century. But women's bodies have become a pawn in the struggles among states, religions, male heads of households, and private corporations. Programs that do not take the interest of women into account are unlikely to succeed."

There is a large information gap, mostly social science in nature, on how reproductive health of women could be improved and how development could be pushed forward through the empowerment of women in reproductive health.
Early studies and demographic surveys in population were concerned mainly with measuring knowledge, attitude and practice toward family planning. The cold statistics of the past related to fertility because the goal then was to reduce birth and thus control population growth. The equation has since added the dimension of women’s health being the subject and object of many population programs.

Women’s welfare has taken centerstage in many population issues and debates. In recent times, women’s participation in decisionmaking processes is being sought for obvious reasons. The 1994 Cairo Conference in Population, for example, has shown commitment to women’s reproductive health. Given the broad scope of what reproductive health and sexuality embody, as spelled by both the Cairo Conference and the World Health Organization (WHO), it augurs well for future approaches to population to be much more pertinent to women’s perspectives and welfare.

One touchy issue discussed at the Cairo Conference is the access of women to abortion as a means of birth control. Many women perceive contraceptives as bad, partly because some groups, including the church, perpetuate the idea that contraception is bad and leads to abortion. Yet, contraception may represent the exact opposite of this notion. Contraception does not lead to abortion; rather, it diminishes abortion because it provides better options to birth control than the risky method of abortion. The problem is that information about contraception is inadequate and fragmented, and users are not warned on their side effects and contraindications.
In the Philippines, a study done in four major areas, namely, Metro Manila, Davao, Cebu and Tuguegarao, looked into the incidence of abortion from a combination of community and hospital units of observation. For Metro Manila, the incidence was 16.6 percent drawn from community data based on a random sample of single and married women. There are indications though that this rate, when compared to other metropolitan areas, especially Metro Davao, may still be lower. For instance, in one major hospital in Davao, data show that abortion has been one of the top three reasons for hospital admission in the past few years.

And while the figures for Metro Cebu and Tuguegarao have yet to be evaluated, it seems that abortion is prevalent in the Philippines. It is a reality to many women from all walks of life. It has therefore become a major public health concern.

The responsibility of both men and women are not only in marriage but also in family planning. Thus, couples should share the decision of whether or not to use contraceptives.