



ADOLESCENT AND YOUTH REPRODUCTIVE HEALTH IN

PHILIPPINES

Status, Issues, Policies,
and Programs



POLICY is funded by the U.S. Agency for International Development under Contract No. HRN-C-00-00-00006-00, beginning July 7, 2000. The project is implemented by Futures Group International in collaboration with Research Triangle Institute and the Centre for Development and Population Activities (CEDPA).



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January 2003

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ACKNOWLEDGMENTS

This report was prepared by the POLICY Project as part of a 13-country study of adolescent reproductive health issues, policies, and programs on behalf of the Asia/Near East Bureau of USAID. Dr. Karen Hardee, Director of Research for the POLICY Project oversaw the study.

The authors want to thank the POLICY/Philippines staff, led by long-term advisor Aurora Perez, for their valuable assistance in data collection and analysis for this report.

The authors would also like to thank the following people for their support of this study: Lily Kak, Gary Cook, and Elizabeth Schoenecker at USAID; and Ed Abel, Karen Hardee, Pam Pine, Lauren Taggart Wasson, Katie Abel, Nancy McGirr, and Koki Agarwal of the Futures Group. The views expressed in this report do not necessarily reflect those of USAID.

POLICY is funded by the U.S. Agency for International Development under Contract No. HRN-C-00-00-0006-00, beginning July 7, 2000. The project is implemented by the Futures Group International in collaboration with Research Triangle Institute (RTI) and the Center for Development and Population Activities (CEDPA).

ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
ARH	Adolescent reproductive health
ASFR	Age-specific fertility rate
AYH	Adolescent and Youth Health (Policy)
AYHDP	Adolescent and Youth Health and Development Program
CEDPA	Centre for Development and Population Activities
CHED	Commission on Higher Education
DECS	Department of Education, Culture, and Sport
DHS	Demographic and Health Survey
DOH	Department of Health
FAD	Foundation for Adolescent Development
FP	Family planning
FPOP	Family Planning Association of the Philippines
GDP	Gross domestic product
HIV	Human immuno-deficiency virus
IEC	Information, education, and communication
ILO	International Labor Organization
NGO	Nongovernmental organization
OTC	Over-the-counter
PASE	Population Awareness and Sex Education
POPCOM	Population Commission
POPED	National Population Education Program
RTI	Research Triangle Institute
SPPR	State of the Philippine Population Report
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TESDA	Technical Education and Skills Development Authority
TFR	Total fertility rate
UN	United Nations
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization
YAFS	Young Adults Fertility Study

1 INTRODUCTION

“There is no single concept of what a Filipino adolescent is...There is no such thing as a typical Filipino adolescent...”

This assessment of adolescent reproductive health (ARH) in the Philippines is part of a series of assessments in 13 countries in Asia and the Near East.¹ These assessments aim to highlight the reproductive health status of adolescents in each country within the context of the lives of adolescent boys and girls and outline policies and programs pertaining to reproductive health with emphasis on information and services relevant to ARH. The report starts with the social context and socioeconomic factors affecting the adolescent population of the Philippines. It then focuses on gender socialization that sets girls and boys on separate lifetime paths in terms of life expectations, educational attainment, labor force participation, reproduction, and duties in the household. Key ARH challenges and issues are then presented. In-depth discussions on ARH are based on insights from selected Filipino national and regional key informants interviewed in August 2001. The report then provides the policy context by outlining laws and policies affecting provision of information and services to adolescents. The report identifies operational policy barriers to ARH and ends with recommendations for action to improve ARH in the Philippines.

The Philippine population is one of the fastest growing in the world. Its youth population is also increasing quickly, from 4 million in 1950 to more than 15 million in 2000 with a projected population of 20 million by 2020 (Figure 1); its rapid growth is due to still high, though gradually declining, fertility rates coupled with improving life expectancy. One out of every five persons in the country is 15–24 years old. A profile of Filipino youth emphasizes that the Philippines is currently in the midst of a “youth bulge,” a transitory but important demographic expansion occurring in the latter part of the 20th century and the earlier segment of the 21st century.² It also points to the historical uniqueness of recent cohorts of Philippine youth: large numbers, rapid growth, and large proportion of the total population.

A larger segment of female adolescents reached higher levels of education compared with males, although the percentage of adolescent males with secondary education or higher rose slightly in contrast to notable declines among their female counterparts (Figure 2). Male adolescents in the labor force outnumber females (Figure 3), and the female unemployment rate (23%) was higher than that of males (19%). Both marriage and having children are socially important when couples marry. Young women ages 15–24 contributed 818,000 births in 2000; their contribution will likely exceed one million annually by 2020 (Figure 4). Estimates of induced abortions among adolescents reached 319,000 in 2000 and could approach 400,000 by 2015. Unmet need for family planning among adolescents, while lower in 1998 than in 1993, is still around 30 percent (Figure 5).

There are several governmental and nongovernmental initiatives that address the reproductive health needs of adolescents. The big challenge in the Philippines is addressing the lack of high-level political support for family planning in general, and even more so for family planning information and service delivery to adolescents. There is an urgent need to present and address family planning as a key element of ARH and for ARH to be part of a broader package aimed at development of youth and adolescents.

¹ The countries included in the analysis are Bangladesh, Cambodia, Egypt, India, Indonesia, Jordan, Morocco, Nepal, Philippines, Sri Lanka, Pakistan, Vietnam, and Yemen.

² Xenos and Raymundo, 1999.

Terminology and age categories

While “adolescent” and “youth” connote various age categories depending on context and audience, this paper focuses on individuals ages 15–24 years, and the terms “adolescent” and “youth” are used synonymously throughout this document. The overwhelming consensus among key informants was that, currently, the target age group for adolescent-focused programming and policy is ages 15–24. The apparent rationale for this is two-fold. First, such an age range is within the recommendations of the World Health Organization (WHO), which considers 15–24 year-olds “youth.” Second, it is widely assumed that within the Philippine context, individuals younger than 15 are not at risk for sexual and reproductive problems. Indeed, the results of the Young Adults Fertility Survey (YAFS) II showed the average age at sexual debut to be in the late teens.³

An added incentive to focus on older teens is the sensitive nature of ARH issues in general in the Philippines. However, despite resistance, there is clamor to focus attention on younger adolescents and to adopt the WHO definition of an adolescent, which includes 10–19 year-olds.

Data

Secondary data sources provide the demographic and socioeconomic profile of the adolescent population in the Philippines. Actual population data are from census and survey reports of the National Statistics Office. Population projections using POLICY’s SPECTRUM Models are used to highlight the current and prospective magnitude of the adolescent population and the importance of addressing adolescent-related problems now given their implications for the future. Other data sources included the National Statistical Coordinating Board and the YAFS II conducted in 1994.⁴ The sources of policy documents are the *Official Gazette* and government libraries, especially those of the Population Commission (POPCOM) and the Department of Health (DOH).

The POLICY Project also conducted in-depth interviews with selected individuals involved in a wide range of adolescent-focused work on multiple levels including research, policymaking, programming, and clinical and medical services. The nearly 20 respondents included representatives of the government, the nongovernmental sector, academic institutions, and international donor agencies (see Appendix 1). Interviews conducted in the cities of Cebu and Davao provided some regional perspectives that emphasize the importance of understanding more completely the needs of adolescents in varied areas of the country. Thus, the interviews present the views and opinions of people working on various levels in the field of adolescent sexual and reproductive health (SRH).

Despite in-depth interviews with individuals who represented a broad cross-section of ARH work in the Philippines, certain gaps remain. It was not possible to interview representatives of the DOH or the Catholic Church. Only one international donor agency, UNFPA, was available during the interviewing period. Further, despite trips to regional centers in the south (Cebu and Davao), a more balanced perspective with regard to rural and out-of-school youth is lacking. Finally, the interviews do not fully capture the youth perspective since most of the information came from those who work with adolescents instead of adolescents themselves.

³ Raymundo et al., 1999.

⁴ Raymundo et al., 1999.

ARH indicators in the Philippines

Figure 1. Total Adolescent Population (Ages 15-24)

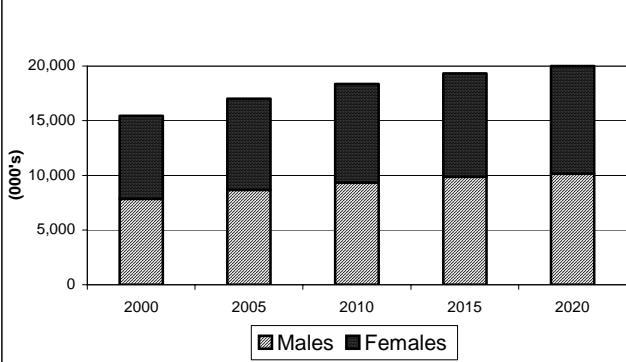


Figure 2. Years of Education Completed (Ages 15-24)

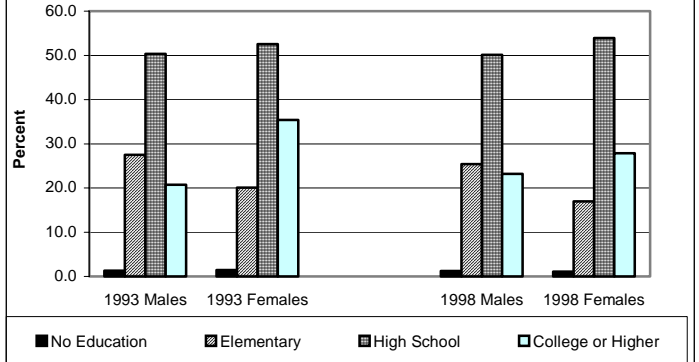


Figure 3. Employment by Sex (Ages 15-24)

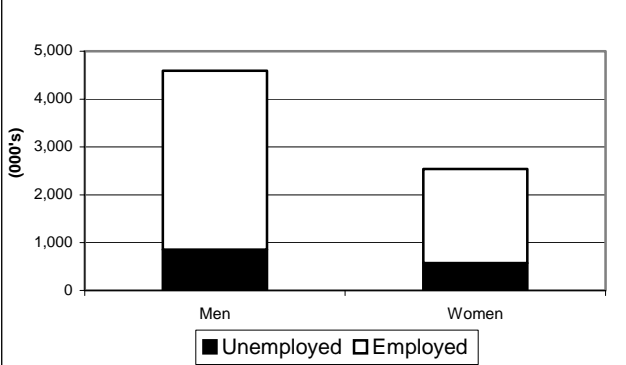


Figure 4. Annual Pregnancies and Outcomes (Ages 15-24)

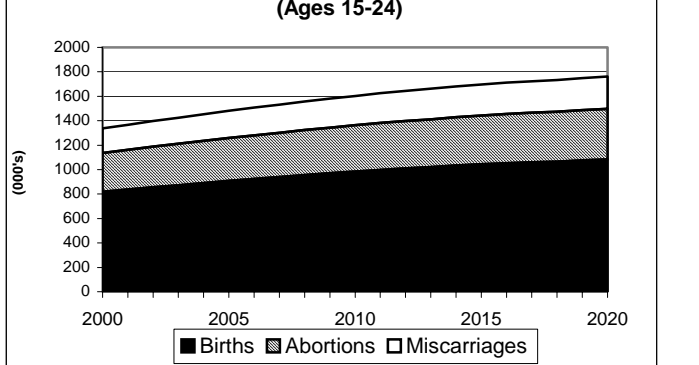
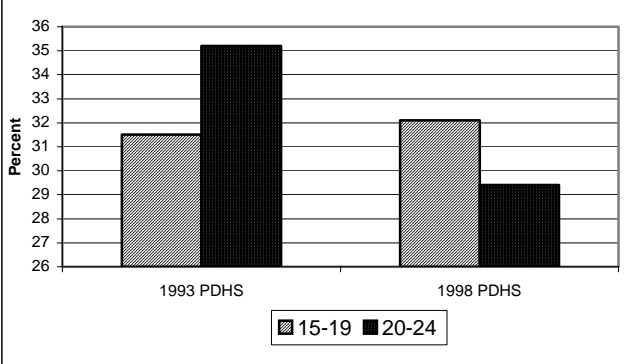


Figure 5. Total Unmet Need for FP (Ages 15-24)



Note: See Appendix 2 for the data for Figures 1 through 5

2 SOCIAL CONTEXT OF ARH

The quote at the beginning of the paper—“There is no single concept of what a Filipino adolescent is...There is no such thing as a typical Filipino adolescent”—was stated many times by those interviewed for this study. This is not surprising. The Philippine archipelago is vast and varied, with over 7,100 islands and more than 80 ethnic groups. While certain influences—mass media, modern technology, and historically dominant multicultural backgrounds that include Asian, Spanish, and American influences—are common to most young people in the country, the variation among socioeconomic groups and geographic regions and between urban centers and rural areas is such that characterizing a “typical” Filipino adolescent is difficult, if not impossible. Presented below are demographic, economic, and socio-cultural aspects of the broader social environment that must be considered in assessing ARH in the Philippines.

Economic context

Education, unemployment, and the economy: Data on educational attainment for 1993 and 1998 showed that over time, more female adolescents reported higher levels of education compared with males (Figure 2). However, the percentage of adolescent males with secondary education or higher improved slightly compared with a large decline in the corresponding percentage for adolescent females. Figure 3 shows that despite attainment of higher education, the number of adolescent females (2.5 million) of the Philippine labor force is much lower than that of adolescent males (4.6 million). Adolescent female unemployment rate (23%) was higher than that of males (19%). Of the young women that worked, over 75 percent were self-employed.⁵

According to the POPCOM *State of the Philippine Population Report 2000*,⁶ the total number of unemployed Filipinos at the turn of the century reached 3.5 million; 50 percent of these were 15–24 year-olds, with many jobless youth inadequately educated or trained). The Philippine per capita gross domestic product (GDP) of US\$1,009 in 1999 was low compared with per capita GDPs in Southeast Asian neighbors such as Thailand (US\$1,949) or Malaysia (US\$3,429). Slow Philippine economic performance has been associated with rapid population growth, high dependency, few investments, and low productivity. One-third of the population and over 4.5 million families were classified as poor in 1997. Only three regions registered poverty rates lower than the national average: Metro-Manila and its two contiguous regions of Southern and Central Luzon.

The current economic situation in the country has led to increasing reliance on foreign currency earned through migrant labor. Around 2.6 million Filipinos are legally or illegally working overseas.⁷ There is a growing market for young Filipino women to be contracted into employment as domestic workers, factory workers, or nightclub dancers in Japan and other Asian countries.⁸

⁵ NSO and Macro International, 1999.

⁶ POPCOM, 2001.

⁷ POPCOM, 2001.

⁸ Many key informants alleged that such migrant labor positions were often thinly veiled fronts for prostitution. Despite age restrictions (18 years of age and older) on foreign employment, it is allegedly easy for the underaged to obtain fake identification in order to work overseas. If true, these have obvious ramifications for young Filipinos' sexual and reproductive health status.

Socio-cultural context

Many social and cultural factors combine to shape Filipino adolescents' SRH. These include a social system organized around tight-knit, extended family support networks, strong clan loyalty, and deference to and dependence upon parents and elders.⁹ Interview respondents particularly emphasized how related social concerns affect adolescents, such as the importance of marriage and childbearing in marriage, sexual socialization that easily provides room for the propagation of misinformation and fosters high-risk sexual behavior, gender norms that foster differences in acceptable sexual behavior, and tremendous geographic variation and cultural diversity.

The socio-sexual environment of adolescents has also been shaped by broad global factors. There is the pervasive role of religion; 90 percent of the country's inhabitants subscribe to Christianity (85% are Catholics). The United States' presence, which began in the 20th century, left a visible political and cultural imprint on Philippine society. At least two other factors are relevant in this respect; the worldwide phenomenon of "globalization" and rapidly expanding telecommunications exert tremendous sway over young Filipinos' lifestyles. Although much of the country remains underdeveloped, television and mobile telephones are not an uncommon sight outside urban centers. The consensus among those interviewed for this study was that Western influences and modern media are a major information source and behavioral influence on sexual and reproductive matters for Filipino youth. This was not necessarily seen as a welcome influence. A Manila-based population lobbyist remarked, "Kids are really confused. There are so many conflicting influences in contemporary Filipino society." A representative of a nongovernmental organization (NGO) in Davao City noted:

What is alarming to us [who work in ASRH] is the impact of [the Philippines] having committed itself to globalization. This is inevitable and in some respects very good. It means the opening of greater avenues to the rest of the world. But together with such contact comes sexual interaction both in terms of the acceptability of sexual activity as well as a market for prostitution. Such influences are combined with very little knowledge among the youth of sexual and reproductive issues.

Religion

The Catholic Church influences the state of Filipino adolescents' SRH status on many levels, including in terms of government/policy language and approaches, health service provision (affecting not only health care providers' attitudes but also their ability to provide service given the condemnation of the community), and to a slightly lesser extent the general societal discomfort with openly addressing issues concerning adolescent SRH needs.

Key informants explained that the Catholic Church has tremendous sway in government, particularly in which pieces of legislation receive attention and are ultimately passed. The Church's traditional opposition to sexuality and reproductive health education in schools has affected what can be taught and how, thus affecting the quality of the information available to young people. One informant in Manila noted, "*The Church makes moral pronouncements and moralizing stands [that] limit youths' exposure to sexual and reproductive education...So [youth] turn to the media.*" Department of Education, Culture, and Sport (DECS) officials stated that even the current family life education curriculum has had to be

⁹ Medina, 1991; Miralao and Engracia, 1989.

defended regularly against calls that the content will foster promiscuity among schoolchildren. One DECS informant noted,

[The department] has received a lot of flack from the Catholic Church, saying that such things [sexuality and population education] should not be taught to children who do not know about sex. They have even called this kind of curriculum pornography. I have been called so many times to Congress to assure them that it is not. And because of the Church, some parents will not be supportive either. And some school officials...

Through its stance on issues such as premarital sex and contraceptive use, the Church has also influenced SRH services for Filipino youth. “*The Church’s primary stand is that one should not have sex before marriage. According to this view, there is no point in providing reproductive health services to adolescents because by definition they are not sexually active,*” explained an informant in Cebu City. The result of such pressure is that in general, government-supported SRH services do not provide contraceptives to adolescent clients.

However, from the interviews collected during this field period, albeit brief, it appears that the influence of the Catholic Church extends only to certain levels. Assuredly, it is a significant political presence, thereby influencing legislation surrounding adolescent SRH and potentially the manner in which legislation is implemented on various programmatic levels. The following quote from a conversation about adolescents’ access to contraception is a good illustration of the extent of the Church’s influence even in government:

There is no way to prevent youth from buying it [over-the-counter (OTC) contraception] if they want it and have the money... There are people in government who are divided over the issue [of youth access to contraception]. Those who say it should be available are being true to themselves and recognizing what is really going on. They know what adolescents are doing in this day and age and what needs to be done to keep them healthy. Those who say it should not be available are just playing politics with the Church. The Church represents a significant [political] presence and a voting block...

On a social level, no information was collected suggesting that religious beliefs (i.e., Catholic doctrine) alone exerted an influence over individuals’ positions on adolescents’ need for better information, education, and communication (IEC) and access to services and the recognition that adolescents are sexually active and need to be treated as such. Certainly, there is discomfort on the part of parents, teachers, and health care providers with regard to addressing these issues, but it appears this comes as much from their own ignorance or shyness as it does from religious or moral opposition to adolescent sexual activity. Religion’s primary impact can be felt on the legislative/political and programmatic levels, not necessarily (or overtly) in the “cultural calculus” of average Filipino citizens themselves.

Sexual socialization

Key informants stressed that their peers and the media are the primary information sources and sexual socialization influences for young people. Noting recent work among Visayan youth suggesting that “*both boys and girls get [sexual and reproductive health] information from peers,*” a Davao City researcher expressed concern about the potential deleterious effect of sexual socialization through media exposure, “[The] media exposes youth to many conflicting messages about sex and to violence in society.

This is how youth learn to function in our society...” The director of a state university department made the following comment:

Youth themselves are very anxious to get information from parents first, which they never get. Youth want parents to be involved, but parents don't want to be involved. This is a big obstacle in terms of information sharing. What youth get now in terms of information is from their peers and the media. And this is likely to be incorrect and misleading... They get information from the wrong sources...

Parents: The quote above introduces the issue of parental involvement in Filipino adolescents' sexual socialization and education. The role of parents appears mixed. There is disagreement among parents concerning the extent to which they want to be involved and how much information they wish their children to obtain concerning such matters. Some were worried that giving too much information and access to contraception will lead to sexual promiscuity. While most parents appear to feel some level of SRH education is necessary to their children's well-being, they themselves do not wish to impart such information. This is unsurprising considering that, traditionally, parents have not been involved in their children's sexual education. Two respondents noted:

Parents have traditionally never played an obvious role [in sexual education]. Mothers feel they should, but they also show preferences for teachers and medical practitioners to educate their children [about such matters].

Even teachers do not have the proper information and resources to give the right facts to young people. Teachers are clinical in their approach and youth want a more human approach...” [Kids] want reproductive health issues to be addressed by their parents. Parents, though, do not feel they are capable of discussing such matters with their children. When they [parents] are asked if they favor reproductive health education and services for their kids, they are definitely supportive of this. [But] they feel awkward about talking to their children about such matters...

Interestingly, during an interview in Manila, one government official mentioned the Catholic Church's preference for parents and family to become more actively involved in children's SRH education. This was part of the rationale behind an increasing emphasis on the part of government IEC programs to focus on parents.

The Church is very keen to have children taught about sexuality matters primarily by their parents, as opposed to teachers or others. The Church feels that parents are the ones who see children's development and have the closest and most intimate tie to children in this regard, physically, mentally, and emotionally. Parents should be intimately involved because part of our cultural tradition is a strong extended family. If we can get parents to communicate better with their children then the broader family would benefit from this too. The circle of relatives and the community as a whole would benefit.

The following excerpt is from an interview in Cebu. It indicates the desire of parents to be an informed and accessible source of SRH information but that parents are likely ill-equipped to fulfill this expectation:

[W]e asked mothers who they thought was the most reliable information source on matters such as sex, etc. Mothers said they themselves should be the ones to do it [provide information]. Mothers often said they did talk to their daughters about these matters... But it may be a case of mothers interpreting their nagging about these topics as actual communication. Mothers consider this communication but daughters don't... Given [parents'] inability to talk about such issues they

[likely do not] have the capacity to do it well with their adolescent children... We also found that parents often resist sex education in schools. There is a notion that talking to adolescents about sex is tantamount to encouraging promiscuity among adolescents. This is one intervention point we have identified—that mothers also need to be involved in IEC activities.

Parents also appear to play a gender-specific role in young people's sexual socialization. Mothers remain silent on such issues while fathers and other elder male family members may assist young men in obtaining early sexual experiences. Several informants described the phenomenon of a young man's sexual "baptism" with a sex worker and male family members' assistance in this respect. Girls, however, are expected to wait until marriage to gain sexual experience with a spouse. Another interview in Cebu revealed the following about gender differences in sexual socialization:

[Gaining sexual experience] is different for boys and girls. Boys are initiated into adulthood by their father and/or uncles. They call it their 'baptism into adulthood or masculinity' by going to a prostitute for their first sexual experiences. That is part of tradition...

Regional interviews revealed that poverty could force parents to encourage daughters to engage in transactional sex, although this is not the norm. A member of an NGO in Cebu City that provides SRH care to youth who are engaged in some form of transactional sex stated that girls often keep their commercial sex activities a secret from their parents, but there are families who "support their daughters becoming involved in prostitution for financial reasons..."

Gender dynamics and (double) standards

This is another aspect of sexual socialization with direct impact on adolescent SRH. As described in the section above, it is acceptable and even expected of Filipino men to be sexually experienced prior to marriage. For women, a double standard exists concerning appropriate sexual comportment prior to and after marriage. This was described by an anthropologist at the University of the Philippines:

Young girls are supposed to control the pace of a relationship prior to marriage. The burden is on the girl to say no, to say how far they can go, [and] to decide what is permissible and what rules apply in a relationship. There is a certain rationale involved in that it is a girl's responsibility to anticipate and direct the timing of sex. And a lot of premarital sex is close upon or in anticipation of marriage, at least for girls...A girl learns to play the game and juggle the risks. She knows that if she goes all the way and the man doesn't marry her, her reputation is destroyed or ruined. After marriage, the role of the female changes...[Now] she has to give in to her husband's sexual preferences whenever he wants them. So in both situations she is disempowered.

This dynamic was confirmed during an interview in Cebu City concerning female sexual roles and comportment:

When you are married you are supposed to be sexually available to your husband whenever he wants it. But to a greater extent when you are unmarried you can put on the brakes and delay having sex, as the girl, who makes the decision to stop or wait. This doesn't necessarily mean that girls are empowered, though. Because among young people it is still the male who has more power. Girls who are afraid of losing their boyfriends if they don't sleep with them often give in anyway.

The dynamic described here has a number of ramifications for sexual and reproductive well-being. First, this scenario suggests it is likely that the male partner could be the source of sexually transmitted

infections (STIs) brought into the relationship. Second, the scripted nature of sexual relations among youth makes contraceptive use (at least prior to marriage) more difficult. Further, as noted in the quote above, this sort of sexual dynamic places a double-standard burden on the female regarding the timing and conditions under which sexual intercourse takes place in the context of her love relationship or her marriage.

Finally, while gender-based violence was not an overt theme in the interviews conducted during this fieldwork, it arose frequently enough to be flagged for concern. It appears that in certain cases it is considered socially acceptable to engage in various forms of coercion within marriage, and husbands' or fathers' violent reactions within the family context are not uncommon. As one key informant stated,

The issue of family violence should be put on the agenda of adolescent sexual and reproductive health concerns, at the very least in describing the environment in which they live. This affects families first and foremost, physically of course. But it affects youth, too, psycho-emotionally. [Family violence] is not normal behavior but it is happening. It has serious implications for youths' well-being and sense of stability. This is another reason why youth seek peers' affirmation and not their family members'.

The issue of gender-based violence and its context and consequences deserves further attention in future work on adolescent SRH in the Philippines. A 1999 study showed that 60 percent of young males drink, often with their “*barkada*” (group or gang), with the percentage who drink increasing with age.¹⁰ Soap operas often depict drunk husbands beating up their wives, but more research is needed on gender-based violence among married and unmarried adolescents, and the roles of other factors like drugs, alcohol or peer influence. It is also important to note that divorce is not officially recognized in the Philippines, largely due to the influence of the Catholic Church.

Sexual activity

An estimated 1.8 million adolescent males and nearly 700,000 females were sexually active in 2000.¹¹ Reportedly, only a small proportion of married youth of each sex (14% among males and 30% among females) reported no sexual experience before marriage.¹² Adolescent norms are changing and influencing youth behavior, including risk-taking—more are moving out of their homes to urban areas, having non-familial household arrangements, or going through a “younging” in their dating experiences (e.g., going steady, first date). The following is a typology of youth premarital experiences:

- 1) Committed sex – sex with a partner who subsequently becomes the marital partner. Two-thirds of married female and male adolescents belonged to this category.
- 2) Commercial sex – includes males with one time sexual experience only, repeated sex with only one partner, and those with multiple sex partners. Around 8 percent of adolescent males reported commercial sex experience.¹³ By age 21, 12 percent of young men have had the experience.
- 3) Casual sex – sex with a partner who did not subsequently become the marital partner and in which the transaction did not involve money. Sexually active, single male adolescents often reported their first premarital partner with a friend or acquaintance while female adolescents

¹⁰ Domingo and Marquez, 1999.

¹¹ POPCOM, 2001.

¹² Includes those who had commercial sex (asked of men only), premarital sexual relations with their spouse, eloped, or lived together. Xenos et al., 1999.

¹³ Adolescent females were not asked about commercial sex experience.

mentioned their boyfriends. The same pattern was noted among married adolescents, although in addition, males were more likely to report more than one premarital partner.¹⁴

Transition to adulthood and marriage

Several informants noted that the manner in which Filipinos are socialized into adulthood leads to an extended period of emotional and economic dependence on parents and elder family members, as evidenced by adult children cohabiting with parents at all levels of society. One informant went as far as describing young Filipino men as “Peter Pans” in attempting to convey their dependence on family and lack of maturity. With respect to SRH, it was suggested that this mode of socialization does not prepare young people for making appropriate sexual and reproductive choices. Nor does it endow them with the maturity necessary to handle being sexually active. One researcher, who was echoed by several others, noted:

Our culture creates very dependent youth. It is a very formal and obedient socialization with regard to authority. Kids are not taught to think for themselves or be prepared to make decisions on their own. They are not encouraged to speak out and question what adults say. There is no autonomy. This contributes to sexual risk, and such problems are amplified when youth are forced into marriage and parenting at a young age. There is a radical transition without preparation; and the [sexual risk] cycle just keeps going on and on. Another aspect of this dependence is economic. Economic realities make it hard to get jobs and thus it is not uncommon to see people into their 30s still living with and, to a certain extent, financially dependent on their parents, even in the middle classes.

Thus, another important aspect of SRH IEC should be life skills training in areas broader than sexuality and reproduction but that ultimately have an impact on youths’ sexual risk behavior and health status. Further, given the pressure on newly married couples to have children as soon as possible, young Filipinos potentially assume the responsibilities of adulthood and parenthood before they themselves are psychologically, emotionally, or financially able.

Cultural value of virginity

There is tremendous cultural value placed on virginity prior to marriage and fertility after marriage for Filipino women. With regard to sexual relations, this means that for women, sex is symbolic of serious love relationships so while it *can* happen prior to marriage, it most certainly should be linked to marriage. Most informants were of the opinion that while premarital sex is increasingly common, for the most part it happens under the aegis of an engagement; at the very least, from a woman’s viewpoint, sex is assumed to lead to marriage. Equally important in terms of social norms and acceptability is childbearing after marriage. It is of utmost importance to a couple to have a child as soon as possible after marriage, which has ramifications for SRH.

Marriage

Age at first marriage is relatively late in Philippine society, although some women marry early. About 10 percent of young women ages 15–19 and 45 percent of young women ages 20–24 were ever-married.¹⁵ Early marriage has been strongly associated with education; by age 24, about 80 percent of elementary-educated women are married compared with only 40 percent among those with a college education.

¹⁴ Xeno et al., 1999.

¹⁵ Raymundo and Ruiz, 1985; Balk and Raymundo, 1999.

Poverty also predisposes women to marry early. Premarital sex and pregnancy, however, tends to initiate or accelerate the process of marriage.

3

ARH ISSUES

Reproductive behavior

Teenage fertility is low in the Philippines. Fewer than 10 percent of women ages 15–18 have begun childbearing, although by age 24, one-third have already borne 2–3 children.¹⁶ Given their early start, these women will likely have large families. In terms of total births, young women ages 15–24 contributed 818,000 births in 2000.

Early pregnancy and birth intervals

One consequence of the value placed on fertility and the pressure to have children is rapid childbearing once married and short birth intervals. One informant made the following observation:

Inter-birth intervals are a problem in this society, especially with regard to the time between first and second birth. There is great pressure on newly married couples to have children right away. If this doesn't happen, you get even more pressure and stress, and remarks from the rest of the family. Both you and your husband get accused of being sterile.

An interview with a Davao-based researcher shed even greater light on how cultural, geographic, and even political factors contribute to short birth intervals and low contraceptive prevalence. The following describes this researcher's experiences in remote highland communities of Mindanao, many of which have been wracked with political violence in recent years:

[Narrow birth intervals among teen mothers] is a big problem here [Visayas and Mindanao]. The younger the girl, the shorter the birth interval. This is the case especially in upland and rural communities. In such places, women do not believe in spacing, much less contraception. They want to have as many children as possible. They want to populate themselves because of political agendas [representation]. Because of the unrest and violence in these areas things like spacing and contraception are not seen as priority issues. For example, in many places there is also no family planning because spacing or preventing are not considered important. Teenage women also tend to marry early in such areas. Because they are destabilized or forced from their homes, when they are in refugee areas they have little to do to keep themselves occupied. So they tend to get married. They marry earlier than they would otherwise. This is also one reason for early, accidental, or unplanned pregnancies. Because of their lifestyle, they cannot predict when they might be having sex, so they do not take measures to protect themselves...

Finally, one informant observed that not only birth intervals are problematic. Because initiation of sexual activity is often so closely tied to marriage, and marriage to child-bearing, the interval between sexual debut and first birth is also an issue that deserves attention.

Contraceptive use

Overall, ever-use of contraception among sexually active adolescents was low at 20 percent. Non-desire for pregnancy and high awareness of contraceptive methods were not enough for the young to use contraception. Among those who do use contraception, the more popular methods are the condom, withdrawal, and rhythm.

¹⁶ Balk and Raymundo, 1999.

However, the following quote illustrates multiple factors that converge to make contraception inaccessible for Filipino youth:

For the longest time contraception was only made available to married couples of reproductive age. And there was a denial of young people being sexually active. Then, post-Cairo there was the politically correct stance that we have to make contraceptive services available to young people. So the government suddenly says, "Okay, it is now available for young people." But the milieu simply does not allow it. The policy says you can go but... Even if you can provide supplies to all, it is a major task for a 16 year-old [to go to a clinic]. The environment does not allow them to...The culture says you are not supposed to be asking for it...

Condom use was one key topic during the interviews. Informants stressed that condoms are viewed with suspicion as these are often connected with HIV/AIDS infection and prevention, not contraception. As in many parts of the world, there are also (largely negative) gender-specific connotations of condom use and being associated with it. As one individual described, "*Condoms are traditionally seen as an object of illicit sexual behavior. Only sex workers use it.*" Another noted that condom use among youth is negligible—1 or 2 percent at most. Moreover, there are many sexual negotiation issues surrounding condom use that makes it unpopular, as described in two separate interviews in Davao City. A teenage volunteer peer educator at a Davao NGO said,

Condom use here [in Davao, but elsewhere as well] is still seen primarily as an HIV protection method, not family planning. Its contraceptive aspects are really secondary in terms of how people see it. There are also problems with what condoms mean in a social sense, which keeps people from using them. If you are a teenage girl and are found to have a condom in your purse, for example, you are promiscuous, bad, and evil. And of course youth won't want to be seen like that. Because you are a woman you shouldn't be having condoms with you. The answer [to why people don't use condoms in the Philippines] is cultural. As a woman you shouldn't be doing this...There is a stigma attached to condom use. Men are more likely allowed to this. Condom use is more acceptable for men. But it also has something to do with who is making the decision regarding the use of a condom. As a woman, you don't impose the decision or your preference on your partner. The male should be the one to suggest it. So there is a power relations aspect of condom use too. Condoms are taboo here in our community [suburb of Davao City]. Because of our parents... They don't like to see us having anything to do with condoms. I wouldn't keep one in my wallet. What if my mother looked and found it! I just don't know if we would be able to discuss it openly...

Many respondents said that most young people do not discuss or use condoms. One aspect of condom use that makes them unpopular with youth involves their social inaccessibility. The need to buy them in a public place—the other side of the counter in most pharmacies—seemed to make condoms out of young people's reach. Interviewees also said that young people do not seem to know enough about condoms to consider using them. There is also a perceived negative association with condoms; they are seen as "dirty, so people do not like to be seen using them."

Beliefs and misconceptions about the side-effects of contraceptive use create barriers to access. For example, one researcher stated, "People see contraception as potentially sterility-inducing. There is a belief that pills accumulate in the uterus and then become cancerous."

Abortion and unmet need for contraception

Estimates of induced abortions among adolescents reached 319,000 in 2000 and could approximate 400,000 by 2015. Large numbers of abortions among adolescents occur because of non-use of contraception to prevent unwanted or mistimed pregnancies. In 1998, 32 percent of girls ages 15–19 and 29 percent of those ages 20–24 who were currently married said that they wanted to postpone, space, or limit childbearing but were not using any form of contraception (Figure 5).

Commercial sex

Despite prostitution being illegal in the Philippines, two patterns of sex work were described by key informants: women of “escort” agencies and the so-called “freelancers.” The former work in entertainment establishments and are required to have a current “clean” health card from local health authorities to demonstrate that they are free of sexually transmitted and other diseases. Lack of updated health cards is legal grounds for such establishments to be closed down. There was, however, some disagreement among informants on how strictly these policies are enforced. Some were of the opinion that health inspections *are* carefully enforced. Others felt this was not the case; women could bribe local health officials to obtain clean health cards. Further, while these establishments were thinly veiled sites for transactional sex, such women often engaged in the *suki* system. That is, women had a number of regular clients or regular patronage relationships with men and thus relatively low partner numbers. Informally, we were told that condom use in these kinds of transactional sex settings was high—or at least higher than in other sex work settings.

The other predominant pattern of sex work is known as “freelancing.” Freelancers are described as working in neighborhoods and being supervised by much older men who act as pimps. In general, freelancers are much younger than women working in entertainment establishments. An officer of an NGO in Cebu that provides sexual health services for street children reported seeing a high proportion of freelancers, including male and female freelancers as young as 7 or 8 years old. Another matter of concern with regard to freelancers is their partners. As noted above, a young man’s early sexual experiences are often with a sex worker—usually freelancers.

Health workers of another NGO that caters almost exclusively to STI services for young freelancers confirmed that freelancers service a high proportion of male university students. During the study visit to the NGO, a 14 year-old female freelancer came for treatment of an STI. Freelancers in particular are allegedly prone to unsafe backstreet abortions. An official at one of the Cebu NGOs that deals with freelancers explained that girls often come to the clinic ostensibly for STI treatment when in fact they are seeking information on and referral for abortions. The official noted, “*They feel they HAVE to get rid of the pregnancy because it affects their work...In general, if there is no abortion the sex worker keeps the child and it ends up neglected and malnourished.*”

With regard to social change and its effect on sexual risk behavior in the form of transactional sex, an anthropologist in Cebu described a phenomenon known as *buntog*, which is best described as ritual exchange of sex within a youth peer group. *Buntog* was seen as resulting from youths seeking acceptance among peers in reaction to family breakdowns or stress.

Through studies it was found out that many of the young people who engage in this kind of activity leave their homes because they don’t feel loved or wanted. It is part of breakdown in family relations which leads to socially identified alternatives within a peer group to foster acceptance. Later it was discovered that this kind of behavior [buntog] often leads girls into prostitution, where they now exchange sex [not merely for social acceptance but also] for money, shelter, and food.

Other informants pointed to the fact that adolescent girls, sometimes adolescent boys, and even university students comprise an increasing proportion of commercial sex workers in areas such as Cebu and Davao. This is directly due to a combination of increased contact with other Asian countries (globalization), poverty, lack of a supportive home environment for young people, and inadequate sexual and reproductive knowledge. Nor was this phenomenon allegedly confined to urban areas.

Recently I asked some of the groups here in Davao who are working with [issues related to] prostitution what is the trend here in the city. The trend in Mindanao generally is that the age of new recruits is decreasing. They are getting younger and younger. And relating to this issue, what is alarming to us is that the country [the Philippines] has committed itself to globalization. In particular, Davao City is the gateway to, or the back door to, many Asian countries. It is part of a trade link. This opening also means the opening of avenues to greater interaction with the rest of the world. Together with this comes sexual interaction both in terms of sex being an acceptable practice among youth but also in the form of prostitution. This is combined with very little knowledge among youth of sexual and reproductive issues. And the result is disastrous...

[Youth] need more support, which includes education and support from all sides—parents, school, church. Side by side with this is the media, which gives youth conflicting messages about sex and reproduction and exposure to violence. Related to this is the situation of most youth growing up in poverty-stricken situations. All of this predisposes young people to become engaged in prostitution. We now know there are a lot of youth who get involved in prostitution in high school and at university. In the past, we thought this was primarily an urban dynamic but now through our [Visayan] studies we find that such avenues to prostitution are common in rural areas as well. Prostitution is also related to drugs; and drugs are found in rural areas as well...

Homosexuality and bisexuality

Another aspect of Filipino youths' socio-sexual environment with potential ramifications for their sexual and reproductive well-being is the practice of homosexuality and bisexuality in Philippine culture. Unsurprisingly, homosexuality is an uncomfortable subject in this country, seen as "sinful" by many and opposed by the Church. Although there is a growing gay lobby, it has yet to legally gain adequate recognition. Anti-gay discrimination bills are regularly introduced in Congress, only to be vetoed every time. One key informant described homosexuality as relatively common.

Homosexuality is much higher among youth than previously thought. To some extent the cult of [female] virginity feeds this. Young men do not have access to their girlfriends for sex, and thus they have sex with each other, even if they do not see themselves as gay by orientation. There is tremendous interfacing between heterosexual and homosexual networks within youth culture. We have had outbreaks of STDs in various cities which we were able to trace to young males having sex with the neighborhood bakla...

A *bakla* is a biological male who views himself as a female—"an institutionalized third gender who is a cross-dresser and effeminate." Given their self-orientation, *bakla* prefer straight (heterosexual) men as sexual partners. Thus, as the quote above suggests, such individuals are often partners for young heterosexual men who need sexual experience or want to have sex. The life history of a *bakla* consists of an early period of female self-identification and sex with men, later shifting to a more conventionally heterosexual lifestyle that may include a wife and children. However, even at this stage in the life of a *bakla*, an individual may still wish for and/or may continue having sex with men.

From a health perspective, several important points derive from both the fact that both homosexuality and *bakla* is part of the Philippine social fabric. First, given the conservative view of same-sex relations and practices, homosexual men face barriers to receiving appropriate SRH services and IEC. "If you are

openly gay, there are some things you can and cannot do. Very little sexual and reproductive health access is available if one is of a nontraditional gender orientation.” According to some researchers, a growing proportion of adolescents is openly gay, and “this is a large enough proportion of the youth population to be considered a significant issue.” Further, there is the issue of sexual crossover (heterosexual/homosexual network mixing) resulting from the *bakla* phenomenon. As noted in one of the above quotes, epidemiologically, this constitutes a bridge population—an avenue for STI networks to broaden significantly. It also calls into question the long upheld distinction between Pattern I (heterosexual) and Pattern II (homosexual) type HIV/AIDS transmission.

Risk of HIV/AIDS

Results from the 1994 YAFS II showed that young Filipino males and females are at risk of HIV.¹⁷ As observed up to age 25, 37 percent of Filipino men will have had sex before they marry with at least one other partner besides their wives. A nonnegligible proportion will have paid to have sex. Some will have had five or more sexual partners.

Drug use

Especially in regions south of the country, south of the Metro Manila area, many informants spoke of drug use (especially *Nobain*, *shabu*, and glue-sniffing, known in local slang as “rugby”) and prostitution as common problems among young people. Both were seen as symptomatic of factors such as globalization, increased telecommunication, the areas’ geographic location (close to other Asian countries), and general degradation of family structures. It is significant that these sorts of observations were confined almost entirely to regions outside of metro-Manila (Visayas and Mindanao), which are geographically closer to Indonesia than any other part of the country.

Drug use was an apparent part of young peoples’ lives in areas such as Cebu City and Davao. The primary forms of drug use were *Nobain*, an amphetamine painkiller, injected intravenously. It is especially popular among younger youth given its cheap price. Though it is officially only available through prescription, one researcher in Cebu City noted,

People...get it easily. It is cheap—1 mL, enough for a hit, is 30 pesos—and syringes can easily be found. This kind of practice was related to a Hep[atitis] B outbreak here a few years ago. There are shooting galleries in the neighborhood, but it is very secretive and you cannot get in. Even clients stick their arms into a hole and someone on the other side injects you...

Another popular drug among youth was called *shabu*, a white powder heated and then snorted (not cocaine). *Shabu* was more expensive than *Nobain* and for that reason especially popular among young working adults. A final type of drug abuse often found among youth was glue-sniffing, or “rugby” use.

¹⁷ Balk et al., 1999.

4 LEGAL AND POLICY ISSUES RELATED TO ARH

This section addresses policies relevant to adolescent SRH in the Philippines. Policy, defined as a government’s course of action, encompasses formally documented laws like constitutional provisions; legislation; executive and administrative orders; judicial decisions; ministerial, state, or district-level decrees; programmatic goals and guidelines, and standards of practice (operational policies) as well as customary laws and cultural norms and customs. Thus, policy can be stated explicitly in laws and other formal documentation as well as more implicitly in codes of conduct and practices. This broad definition of policy is particularly relevant to the adolescent SRH context in the Philippines, where factors such as church-state relations, change in government leadership, decentralization of health services, heavy reliance on NGOs for health services, and cultural, geographic, and ethnic diversity all influence both how adolescent SRH is conceptualized and acted upon.

Analysis focuses on *direct* policies or those specifically designed to influence population, health and reproductive health, ARH, HIV/AIDS, child survival and safe motherhood, and customary laws (such as puberty or sexual initiation rites). *Indirect* policies affecting ASRH include those regulating access to education at all levels (primary, secondary, tertiary), social services, marriage, employment, drug or pharmaceutical distribution and access, and age of consent/informed consent and customs such as intergenerational relations, gender relations, decision making surrounding health care and treatment, and codes of behavior that affect young people’s comportment. Several indirect policies affect youth, including Republic Act No. 386, which states that the legal age at marriage is 18, and the illegality of prostitution even if the practice is rampant.

Philippine Constitution: The 1987 Constitution states that it is the “right and duty” of parents to ensure the welfare of and instill proper moral development in their children.¹⁸ It also stipulates that the State has an obligation to help parents in this endeavor. Such emphasis has set the tone and focus of much policy and programming surrounding adolescent SRH in the Philippines, which has been described as “indirect and cautious.”¹⁹ The Constitution does not make any reference to youths’ sexual or reproductive rights.

Adolescent and Youth Health Policy: The Adolescent and Youth Health (AYH) Policy was issued by the DOH in April 2000 under Administrative Order No. 34-A series 2000. It recognizes adolescents and youth ages 10–24 as the priority group in terms of pressing health needs and states as its mission ensuring access to quality comprehensive health care and services for all Filipino youth and adolescents. This order provides for the creation of the AYH Sub-program under the Program for Children’s Health Cluster for Family Health. It also provides guidelines for the creation of public youth-friendly health service centers and specifies implementing mechanisms. Notably, access to contraceptive services and supplies (hormonals and condoms) is stipulated as a requirement within the guidelines for youth-friendly health services. Much of what is in the policy is further elaborated in the Adolescent and Youth Health and Development Program (AYHDP) described below.

AYHDP: Under UNDP’s fifth country program, the AYHDP is under the aegis of the DOH in partnership with other government agencies with adolescent concerns, such as the DECS and the Commission on Higher Education (CHED). Targeting youth ages 10–24, the AYHDP provides comprehensive implementation guidelines for youth-friendly comprehensive health care and services on multiple levels—national, regional, provincial/city, and municipal. The program extends beyond SRH to

¹⁸ Article II, sec. XII. The Constitution of the Republic of the Philippines, 1987.

¹⁹ Various key informants.

encompass all facets of adolescent and youth health, including mental and environmental health and special attention to HIV-related concerns.

Strategies employed to ensure integration of the AYHDP into the health care system and broader society include building a supportive policy environment; intensifying IEC and advocacy particularly among teachers, families, and peers; building the technical capacity of providers of care and support for youth; improving accessibility and availability of quality health services; strengthening multisectoral partnerships; resource mobilization and allocation; and improved data collection and management. Gender-sensitive approaches to adolescent SRH issues is also stressed in the program plan. The primary responsibility for implementation of the AYHDP, and its mainstreaming into the health system, falls to regional and provincial/city sectors. Guidelines cover service delivery, IEC, training, research and information collection, monitoring and evaluation, and quality assurance.

DOH operational policies: Adolescent (i.e., younger than 18) pregnancy is defined by the DOH as high-risk. However, no specific guidelines on how to deal with pregnant teenagers exist. The DOH established the Adolescent Health Sub-unit, as mandated in the Adolescent Health Policy Administrative Order, and is currently in charge of administering the new AYHDP. In 2000, the DOH also approved the National Family Planning Policy, which stressed the importance of family planning as a health and poverty reduction intervention. Key informants, however, expressed concern about the openness of government workers to provide ARH services. The following interview describes one woman's experience with health officials in the Central Visayas:

I asked the regional DOH office if there were any guidelines for rural health [workers] to deal with young unmarried teens if they come to the clinic asking for contraceptive services or information. The response was, 'she will be provided services, though it will be up to the moral discretion of the [health care provider]'. Policy-wise, if you look at the DOH guidelines, they will provide contraception services and supplies to adolescents or unmarried women. But the unwritten rule is that it is up to the [judgment] of health personnel. That is what we have seen among youth ...

5 ARH PROGRAMS

National HIV/AIDS Prevention and Control Program: Put in place through a series of republic acts and the Philippines AIDS Prevention and Control Act of 1998, this program addresses several targets, including HIV/AIDS education in schools (all levels: primary, secondary, tertiary, and technical institutions) organized by DECS, CHED, and the Technical Education and Skills Development Authority (TESDA); provision of HIV/AIDS education as part of health service delivery; HIV/AIDS education as part of human resource development in government and private offices; and protection of human rights such as medical confidentiality and access to schooling for HIV sero-positive students.

DECS Population Education Program: The National Population Education Program (POPED) tackles four basic components: (1) reproductive rights and health, (2) family life and responsible parenthood, (3) gender and development, and (4) population resources and environment. There is no direct policy forbidding pregnant adolescents to attend [secondary] school. A university researcher, however, expressed concern about whether schoolteachers are prepared to deal with ARH:

Even teachers do not have the proper information and resources to give the right facts to young people. Teachers are very clinical in their approach. They talk about reproductive organs whereas youth want a more human approach. But even teachers do not feel at ease in this role...

Population Awareness and Sex Education (PASE): PASE, authorized by Administrative Order No. 950, is a population and sexuality education program specifically targeted at out-of-school youth. The program is administered by the Bureau of Youth Welfare of the Department of Social Welfare.

An NGO family planning and reproductive health program: The guidelines of the Family Planning Association of the Philippines (FPOP) stipulate that all individuals of reproductive age (specified as ages 15–44) have the right to information, counseling, physical examinations, and contraceptive supplies, specifically condoms or contraceptive pills. Use of emergency contraception is limited to cases of rape or incest.

The POPCOM ARH program: One of the five programmatic areas of POPCOM is adolescence. The Adolescent Fertility Program addresses the fertility and sexuality-related needs of adolescents, with the main aim of reducing incidence of early marriage and teenage pregnancy.

Foundation for Adolescent Development (FAD): With few exceptions, nongovernmental adolescent SRH initiatives, such as university campus-based programs, include only IEC and referrals to government clinics if youth are in need of contraceptives. FAD's founder noted that when the university-based program was first founded, it included SRH services but dropped this component due to pressure from religious members of the organization's board, which considered service provision inappropriate.

Drug and pharmaceutical regulations: Many medications (including hormonal contraception and antibiotics) can be obtained over the counter (without a prescription) and, for the most part, relatively cheaply. Fake prescriptions can be obtained fairly easily for those medications that require a script. Many of those interviewed noted that given the barriers posed in the formal health care system, self-medication through pharmacies is adolescents' preferred mode to gain access to contraceptives as well as to obtain treatment for STIs. Describing the results of a recent study among adolescents in the Visayas, an anthropologist at San Carlos University noted, "Most of the time they [youth] self-medicate. This is a problem because it leads to improper use of medicines. We have had this in our recommendations [the

dangers of self-medication] from our studies since 1997, because almost all of our groups report self-medication.”

6

OPERATIONAL BARRIERS TO ARH

There was general agreement concerning the most pressing SRH concerns faced by Filipino adolescents: early sexual debut, particularly among males who have multiple partnerships and sex with sex workers; unprotected sex leading to early pregnancies, miscarriages, discharge, bleeding, and even STIs and HIV/AIDS; and ignorance and misinformation about SRH, including contraception.

Interviews pointed to obvious regional differences in the kinds of sexual and reproductive problems youth face. In the Metro-Manila area, the emphasis was on informational problems and early pregnancy, whereas in Visayan and Mindanao areas, specifically Cebu and Davao City, reported problems with increasing prevalence of adolescent prostitution (either engaging in it or patronizing it). These problems were not considered as confined only to urban areas. Interviews with those involved in adolescent SRH studies at both Ateneo University and San Carlos University noted their research clearly suggested such problems extended to rural areas.

Poor sources of IEC, subsequent reliance on media for such information, and poor inter-generational communication (with parents) were also cited as problems. Youths' need for better IEC was a constant and dominant subject, arising in nearly every interview conducted during the field period. Adolescents do not receive adequate SRH information, nor do they receive it from preferred sources.

Policy barriers to adolescent sexual and reproductive well being: Many operational barriers to SRH care and supplies exist for Filipino adolescents, including cultural stigma against (unmarried) youth using contraceptives, negative attitudes on the part of health service providers, pressure from the Church, and lack of adequate supplies at the local health system level.

Marital status used as basis for providing reproductive health services: Because of the sensitive nature of ARH issues in general in the Philippines, marital status instead of age has generally been the major factor determining how SRH programs are organized and provided. As the head of a prominent NGO working with youth and adolescents explained, a married adolescent would not be treated as a teenager but as an adult; access to SRH services is considered appropriate for married women. *“Politically, age is not really the issue in this country. It is always marital status. Even if you are 17 and married, they [health care workers] will say ‘Fine, you need family planning? That’s okay.’ Premarital sex is the issue, not age itself...”* However, despite resistance, there is clamor to focus attention on younger adolescents and to adopt the exact WHO definition of adolescence, which extends between the ages of 10 and 19.

Limited access to correct information: Among the greatest challenges for Filipino youth is access to correct and meaningful information on sexual and reproductive issues. Various governmental and nongovernmental programs have introduced SRH education in both formal and informal ways and with varying degrees of success. The POPED program, which covers sex and reproduction, is now a mandated component of the secondary school curriculum in the Philippines. However, most informants felt that POPED's approach is overly clinical and not meaningful for students. One NGO member observed of the current manner in which sexuality education is taught in Philippine schools, *“Sexuality is beyond reproduction, and the current curriculum does not reflect this.”* Said another informant, *“The feedback I get [from students] is that it [government sex education] is boring and flat, the fallopian tubes type of education.”*

Limited access to services and commodities: The lack of access to contraceptive services and supplies was among the most frequently articulated concerns with regard to adolescent SRH. Programs such as the

AYHDP do recognize adolescents' need for access to contraception. However, such steps do not necessarily guarantee that Filipino youths' contraceptive needs are met. Currently, few health care providers in the public sector cater to young people, who are being turned away from clinics when asking for contraceptive information and supplies. Among Filipino youth, the preferred means of obtaining contraceptives and treating sexual and reproductive ailments is self-medication through pharmacies that sell family planning commodities and medication (including antibiotics) to minors. Another avenue for obtaining treatment and family planning is through private clinics, though most are expensive for young people. Furthermore, self-medication risks improper use of medications and the fostering of resistant strains of diseases.

Limited awareness of pertinent policies: While the AYHP Administrative order was issued in 2000, few key informants knew of its existence. In fact, many key informants said that no ARH policy existed at the time they were interviewed.

Perceived lack of local authority to address adolescent health problems: Many key informants stated that a great obstacle to implementation is the incomplete decentralization of health services. Although decision-making power is in theory devolved to local government level, bureaucrats still do not feel this system has legitimacy and still want/wait for central government approval for action. This was particularly evident in the regional interviews, during which informants noted that local government unit (LGU)-level officials do not want to implement programs that would actually improve adolescents' access to information and services because they want confirmation from central/head offices in Manila. This is despite the fact that with decentralization, they technically have the authority to put various health programs in place.

Geographical differences in ARH needs: The varied needs of adolescents pose obvious challenges for policy and programming; what might fit for Metro Manila may not work for Visayan youth. Nor are the needs of young people in Manila or Quezon City necessarily similar to those living in Davao City, despite both being urban centers. Many of the needs of urban youth may differ from those in rural areas.

Moral or erroneous interpretations of policies affecting adolescent access: Key informants stated that health care providers' make "moral judgments" on whether their adolescent patients should receive reproductive health treatment and/or supplies. While guidelines such as those stipulated by the government for the AYH Policy and the AYHDP or by an NGO (FPOP guidelines), in theory guarantee access to services, in practice young people face many operational barriers to SRH services. These include lack of clear guidelines on how to deal with youth.

Barriers to pregnant adolescents attending school: While no policy exists on teenage pregnancy, young unmarried mothers face social and institutional pressures to discontinue schooling during pregnancy or after delivery. This may involve a principal asking her to leave school, parents' fear of stigma surrounding their (unmarried) daughter's pregnancy, or her own embarrassment once her condition becomes physically evident. A DECS official stated, however, that about one-half of pregnant teens do return to school. The actual ability to return to school depends on multiple factors. The same official described the following scenario:

Most likely a [pregnant school girl] would stay in school until five or six months, when she starts to show. But she would be made to feel very uncomfortable. The pressure is such that she would eventually drop out. She would be able to come back as long as no one saw that she was pregnant, as long as it was kept very hush-hush. [The school] cannot deprive her of her right to go back to school and finish, but if the principal knew [why she dropped out]... The stigma of her condition would pressure against this...

Finally, the thrust of social programs targeting Filipino youth has also limited what is known about young people. Good quality data are needed about the youth in various parts of the country. Adolescents are not a homogeneous group; younger adolescents have varied and sometimes more severe ARH needs than older ones. It is also important to describe ARH status not just as a medical issue but as a development issue as well.

7

RECOMMENDATIONS

A multisectoral approach to youth development: A strongly supported, well-coordinated, multisectoral development approach involving the government, nongovernmental organizations (NGOs), the private sector, religious groups, and other civil society representatives is needed to help assure a better quality of life for current and future adolescents—tomorrow’s adults.

Programs tailored to the local situation: The needs of adolescents in urban and rural areas and across regions in the country differ and should be taken into account when designing programs.

Improve the quality of and access to correct information: This was a major issue mentioned by many respondents. Young people, in order to make informed decisions about their reproductive health and disease and pregnancy prevention, require accurate information that is provided in an age-appropriate—and interesting—manner.

Limited access to services and commodities: As with information, the lack of access to contraceptive services and supplies creates barriers to good adolescent SRH. Programs such as the AYHDP that recognize adolescents’ need for access to contraception should be articulated to providers in order to encourage them to meet the ARH needs of adolescents. Not providing accurate information and services results in self-medication and increased number of abortions.

Disseminate the contents of pertinent policies: Awareness of policies such as the AYHP Administrative Order and the AYHDP should be raised among policymakers, program managers and providers, and clients.

Clear guidelines to providers: Providers often inject their own morality in deciding whether or not to serve youth, rather than following guidelines such as those stipulated by the government for the AYH Policy and the AYHDP or by an NGO (FPOP guidelines) that, at least in theory, guarantee access to services.

Clarify the authority of local governments to act: Local governments should not have to wait for confirmation from the central government before acting in this important area. Local governments should know that they have the authority to put various health programs in place.

Develop a policy to keep pregnant girls in school: Girls who get pregnant and want to finish school should not be shunned or “stigmatized” into dropping out, which currently happens to half of all girls who get pregnant while in school. Schools should develop clear guidelines to encourage young mothers to complete school.

Continue studying adolescents and young people: Good quality social science data are needed about the youth in various parts of the country.

Involve youth in developing policies and programs: Finally, the youth should be involved in policy and program development as they are the ones most affected by policy action or inaction or by program nonimplementation or missteps.

APPENDIX 1. Philippines Contact/Interview List

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APPENDIX 2. Data for Figures 1 through 5

1. Adolescent Population (15–24) (000's)					
	2000	2005	2010	2015	2020
Males	7,856	8,666	9,351	9,856	10,173
Females	7,589	8,360	9,006	9,484	9,813
2. Level of Education (%)					
	1993 Males	1993 Females	1998 Males	1998 Females	
No Education	1.3	1.4	1.2	1.1	
Primary	27.5	20.0	25.4	17.0	
Middle	50.3	52.6	50.1	53.9	
Secondary and Higher	20.7	35.4	23.2	27.8	
3. Employment (000's)					
	Males	Females			
Employed	3,740	1,962			
Unemployed	853	576			
4. Pregnancy Outcomes (000's)					
	2000	2005	2010	2015	2020
Total Pregnancies	1,337	1,480	1,603	1,697	1,761
Births	818	907	985	1,044	1,085
Abortions	319	351	378	398	412
Miscarriages	201	222	241	255	264
5. Unmet Need (%)					
	1993	1998			
Total Unmet Need (ages 15–19)	31.5	32.1			
Total Unmet Need (ages 20–24)	35.2	29.4			

Assumptions and Sources:

Figure 1. Adolescent population projections were made by entering the base year population estimates from the UN medium population projection, *World Population Prospects, The 2000 Revision*, into the POLICY Project's SPECTRUM Model and projecting the population to 2020.

Figure 2. Level of education for 1993 was taken from the 1993 Philippines Demographic and Health Survey (DHS) report, and for 1998 it was taken from the 1998 Philippines DHS report. The figures cited are a weighted average of household educational attainment statistics for 15–19 and 20–24 year-olds.

Figure 3. Employment statistics were taken from LABORSTA, the Labor Statistics Database operated by the International Labor Organization (ILO) Bureau of Statistics. Unemployment and labor force size (by age and sex) were taken from the ILO Yearbook of Labor Statistics. Labor force size is defined as the labor force economically active. The number of employed was estimated by subtracting the number unemployed from the labor force size.

Figure 4. Births, abortions, and miscarriages were calculated by multiplying the appropriate age-specific rates (i.e., total fertility rate (TFR), abortion, and miscarriages) by the estimated number of adolescent females (single-age population estimates were calculated using the SPECTRUM Model). Total pregnancies were calculated by summing the total number of births, abortions, and miscarriages. TFRs and age-specific fertility rates (ASFRs) for the base year were taken from the Philippines 1998 DHS report. TFR assumptions for future years were derived from the World Population Prospects data. Mortality and migration rates were derived from World Population Prospects data. The abortion rate was assumed to be 42 per 1,000 (Guttmacher Institute estimate). Since no age-specific rates were given for adolescents, the overall abortion rate for women was used. The miscarriage rate was assumed to be 15 percent (Guttmacher Institute estimate). Since no age-specific rates were given for adolescents, the overall miscarriage rate for women was used.

Figure 5. Levels of unmet need were taken from the 1993 Philippines DHS report and the 1998 Philippines DHS report.

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