Reproductive Choices of Rural and Urban Poor Communities

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Abstract

Socioeconomic status determines, among other factors, Filipino women's access to contraception, with Filipino women in the lowest income quintile having the least access to it. This paper explored the impact of reproductive health law as a policy agenda on women's reproductive health, with a focus on those living in four purposively selected rural and urban poor communities. The Reproductive Justice Framework was employed in the context of reproductive health care, as was Martin Fishbein's and Icek Ajzen's (1980) Theory of Reasoned Action and Behavior. Issues on inequality, inadequate financing, successful opposition to contraception, and a lack of clear national standards were revealed. No significant differences exist among the four locales studied in terms of overall scores in physical risk, psychological risk, and financial burden. However, the urban sample showed higher levels of mental distress than the rural one. Within the urban poor sample, the respondents from one area were seen as less willing to have more than two children, even as their husbands are less willing to support their attempts at birth spacing and are perceived to be less understanding of the psychological risks that the women face. Knowledge and acceptance of the reproductive health law can be increased by locally targeted information campaigns directed to both wives and husbands.

Keywords: policy analysis, development communication, reproductive health, rural communities, urban poor communities

Historically, national and local Philippine reproductive health policies have demonstrated little concern for individuals. Under former President Marcos, the Department of Health (DOH) furthered its goal of population management through forced sterilization and intrauterine

device (IUD) implantation without Filipino women's consent or knowledge (Warwick, 1982). In 2012, the 15th Philippine Congress attempted to correct low income Filipino women's lack of access through the passage of The Responsible Parenthood and Reproductive Health Act of 2012 or Republic Act No. 10354 (the Reproductive Health Act), which specifically cited various Constitutional provisions as its foundational bases (Santiago, 2012).

Filipino women in the lowest income quintile (NSO, 2008), have expressed frustration (Agence France-Presse, 2013) that they do not have sufficient access to modern contraception (NSO & USAID, 2008), the tool that would allow them to effectuate these rights. Further, their lack of access highlights structural barriers and power imbalances, with the result that mostly higher-income women get access to contraceptives. This inequality becomes starkly evident when government officials treat low-income women's fertility as a development marker or evidence of the success or failure of economic policies (Bill & Melinda Gates Foundation, 2012). Although Philippine law suggests that the government has the responsibility to ensure contraceptive access (Philippine Constitution, 1987), the lowest-income Filipino women have extremely limited access to contraceptives, which are integral to their ability to decide whether and when to have children, and how to parent the children they do have (UN, n.d.).

Filipino women's access to contraception varies according to their socioeconomic status. Ruth Macklin (2012) posits that throughout the world, a woman's status determines whether she has access to contraception, and how governmental policies and providers' actions affect her use of contraceptives. While birth control is available in the Philippines, the cost is prohibitive for the lowest-income women (Weiss, 2012). By explicitly prohibiting government funding or inadequately funding contraception, the national and local governments have effectively restricted access to contraceptives (Letter from Center for Reproductive Rights to the United Nations Committee against Torture, 2012).

Lack of access to contraception has worsened Filipino women's health. The estimated Philippine birth rate in 2013 is 24.62 births per 1,000 (CIA, 2013), which the World Health Organization describes as one of the highest in Asia. The maternal mortality rate increased to 2.21 women's deaths per 1,000 live births in 2011 from 1.62 deaths in 2006 (USAID Philippines, n.d.). In 2012, 51% of married women between the ages of 15 and 49 used some form of birth control (NSO), with only 34% using an artificial method. Across the Philippines, 22% of married women have an unmet need for family planning (NSO & USAID, 2008).

According to the World Health Organization (as cited in Fathalla, 1998), reproductive health means requires at a minimum that (1) people be able to reproduce; (2) they be able to regulate their fertility; (3) have knowledge of the consequences, whether personal and social, of their choices in regard to reproduction; and (4) access to the means of effecting these choices. People need information to exercise the right to reproductive health and choice effectively.

The main objective of this study is to explore the impact of the Philippine Reproductive Health Law (RA 10354), as a policy agenda, on women in selected areas in the Philippines. The following measures were looked at: (1) levels of physical, psychological, and financial risks among the women in these communities; (2) the use of natural and artificial family planning methods; and (3) understanding of the Reproductive Health Law. Recommendations were made in regard to increasing understanding of, acceptance of, and compliance with the Reproductive Health Law in both urban and rural areas.

Study Framework

Fishbein and Ajzen's Theory of Reasoned Action (1975, 1980) forms part of the theoretical backdrop of this study. Traditional attitude-behavior research, many of which found weak correlations between attitude measures and performance of volitional behaviors, drove the formulation of this theory. The theory's locus of utility is in the prediction of volitional behaviors, that is, behaviors that are not spontaneous, impulsive, or habitual. Individual and normative factors

influence these volitional behaviors. For this study, behavior can be defined as whether the respondents individually practice the fundamental and specific provisions in Republic Act 10354.

The Theory of Reproductive Justice was also used to buttress this research. The inclusion of this framework is to prove the point that because of gender and reproductive health law, reproductive oppression and contraceptive access of women operate in tandem to produce unequal levels of volition across women of different income strata, thus depriving those in the lowest rungs of their reproductive rights. This factor subsequently leads to shaping and influencing women's understanding of, acceptance of, and conformity with RA 10354.

Reproductive Justice Theory is born out of the desire to transform a narrow focus on legal access and individual choice, incidentally the focus of mainstream organizations, to one of a broader analysis of racial, economic, cultural, and structural constraints on political power. For long-term systemic change to occur, there is a reliance on the leadership of communities most impacted by reproductive oppression (Forward Together, n.d.). The difference in the quality of leadership in communities appear to contribute to the aforementioned unequal distribution of volition across women and the resulting differences in the practice of their reproductive rights. This difference in leadership quality also ties in with the concept of individual and normative factors in the Theory of Reasoned Action.

Methodology

The research was situated across two phases in four *barangays.* Barangays UP Campus and Naparaan were the locations for the first phase, with 61 survey respondents from each milieu. The second phase was localized in Barangays Payatas and Batasan Hills, both in Quezon City, the Philippines, again with 61 survey respondents from each place.

Barangay UP Campus is a highly urbanized community situated in the heart of Quezon City; it has greater and higher influence forces than the other barangays given the location of the country's premier state

university, the University of the Philippines, within its confines. It also is home to middle-class and upper-middle class subdivisions. Barangays Payatas and Batasan Hills, however, while located in the same city, have vastly different circumstances. They are both highly populated with large slum communities and informal settlement issues. Places like these, though situated at the heart of Metropolitan Manila, are sites of reproductive oppression, neglect of women's rights, and the highest number of urban-poor households.

Meanwhile, Barangay Naparaan is a rural area in the town of Salcedo, in Eastern Samar province. Agriculture is the main source of income of its residents, with a majority of the populace being coconut farmers and vegetable growers. At the time of the study, Barangay Naparaan was still recovering from damage wrought by super typhoon Yolanda (international name: Haiyan) a year before.

A survey instrument comprised of 55 questions using a five-point Likert Scale was then administered to the women-respondents in each barangay who fit the study's judgment sampling parameters on August 2014 for Study 1 and on May 2015 for Study 2 milieus. Ethical considerations were taken into account, with the anonymity of the respondents and confidentiality of their answers maintained. The two settings of the study are integrated in a way that there was only one survey instrument used and separated on the grounds that each group of women-respondents reside in different areas with various socio-cultural influence and socio-economic background. The Mann-Whitney-Wilcoxon test) for independent samples and t-tests for independent samples at the 95% confidence level were used.

Table 1 on the next page provides a summary of the study's variables, measures, and indicators:

TABLE 1. *Variables, Measures, and Indicators Used in the Study*

Putative Variables	*Measures*	*Selected Indicators*
Reproductive Oppression of Women	Physical Risks Psychological Risks Financial Burden	High-risk pregnancies, maternal deaths, anxiety and mental health issues, financial issues
Contraceptive Access	Use of Natural and Artificial/Modern Family Planning Method	Risk perception, religious and cultural factors, health care provider efficacy
Policy Agenda	The Responsible Parenthood and Reproductive Act of 2012 (RA 10354)	Level of understanding, acceptance, and conformity

Results and Discussion

The composite scores of the respondents in terms of Physical Risk, Psychological Risk, and Financial Risk show no significant differences between urban and rural groups. As for specific aspects of these risks, only mental distress was found to be higher in the urban sample (M=1.8, SD=1.34) than in the rural one, $t(120)=2.2191$, $p=0.0284$. No significant difference was found in regard to the groups' access to contraceptives, whether natural or artificial.

As for the comparison of Barangays Batasan and Payatas in Quezon City, Metro Manila, the Philippines, significant differences using the Mann-Whitney U were found in the following specific dimensions: (1) choice to have no more than two children, $U=1387.5$, $p=0.021$; (2) birth spacing, $U=1412.5$, $p=0.02$; (3) husband's understanding of pregnancy-related risks, $U=1388.5$, $p=0.022$; and (4) awareness of Reproductive Health Law, $U=1348$, $p=0.009$. Translating these statistical results into a cogent summary, it can be said that the Payatas sample showed more awareness of the Reproductive Health Law than the Batasan group, and

that the women from the former group are more convinced than the latter group in regard to having no more than two children. However, more husbands from the Payatas group tend not to allow birth spacing. In addition, more husbands from the Payatas group are perceived by their spouses as not being aware of the risks faced during the pregnancy.

In spite of the respondents' awareness of the Reproductive Health Law, acceptance of it is low. The factors behind such low acceptance are: (1) the belief that periodic abstention from sex, i.e., rhythm or natural family planning method, is sufficient and the best way to regulate fertility; (2) the influence of the Catholic Church, a normative factor; and (3) the prohibitive sustained cost of using artificial planning methods. However, periodic abstention may be problematic, given variable menstrual cycles and spouses' libidinal drives. While a discussion on the ethics of the pro-life movement is beyond the scope of this research, it appears that the privilege this movement affords to natural family methods may not be salutary to women at all.

Conclusions and Recommendations

The answers obtained by the study yielded more questions to be answered by subsequent research. Changes in the method and procedures of subsequent studies may serve to validate the findings of this study or open them to further examination.

Given that no significant differences were found in the overall risk profiles of the communities that were studied, focus may be directed to specific dimensions of these risk factors. Specifically, the mismatch between the preferences of women and their spouses as regards number of children and birth spacing suggests that reproductive health programs can also be targeted towards husbands.

The understanding by women and their husbands of the Responsible Parenthood and Reproductive Health Act of 2012 and other healthcare programs of the Department of Health alongside with Barangay Health Clinics and the Local Government Units can be increased through regular information sessions and seminars. Such a

campaign will support thriving, culturally distinctive rural communities in the Philippines to speed up the delivery of services and to further leverage innovative reproductive health practices across rural and urban contexts. RH law providing a uniform approach of sexuality education, the literacy campaign must use regional applications to enhance and break down geographic barriers, and address rural isolation and end rural reproductive health care challenges.

It appears that the addition of intercultural communication and/or socio-anthropological theories can help in explaining more clearly the beliefs and behaviors of respondents. Given the context of the Reproductive Health Law Framework, the Theory of Reasoned Action and Behavior with Reproductive Justice Framework as additional theoretical backdrop of the study can be used in designing information campaigns and a communications management plan. Such campaigns can address the target audience's understanding of the RH Law.

Campaigns can also increase the level of acceptance of the RH Law. Specifically, a central challenge for the Philippine government is to mitigate the influence of the Catholic Church and other pro-life organizations on less privileged women; such influence creates an enabling atmosphere for other reproductive health and rights abuse. *O*rganizations can design campaigns adapting the culture, language, mores, norms and ethnicity of fragmented groups of women.

References

Agence-France Press. (2013). *Philippines Birth Control Law Is Too Late for a Mother of 22*. Retrieved from http://www.thenational.ae/news/world/asia-pacific/philippines-birthcontrol-law-is-too-late-for-a-mother-of-22.

Ajzen, I., & Fishbein, M. (1980). *Understanding attitudes and predicting social behavior*. Englewood Cliffs, NJ: Prentice Hall.

Bill & Melinda Gates Foundation. (2012) Family Planning: A Unique Opportunity for Change. Retrieved from http://www.youtube.com/watch?v=FJ81C85Dyq4.

CIA. *Country comparison: Birth rate*. The World Factbook. Retrieved from http://www.cia.gov/library/publications/the -world-factbook/fields2054.html.

Convention on the Elimination of All Forms of Discrimination Against Women, (2013) *Reporting*. Retrieved from http://www.un.org/womenwatch/daw/cedaw/reporting.htm.

Fathalla, M. (1998). *Health and being a woman.* Forty-third session of the UN Commission on the Status of Women United Nations, New York.

Fishbein, M., & Ajzen, I. (1975). *Beliefs, attitude, intention and behavior: An introduction to theory and research.* Reading: Addison-Wesley.

Forward Together (formerly Asian Communities for Reproductive Justice). (n.d.). *What is Reproductive Justice?* Retrieved from http://strongfamiliesmovement.org/what-is-reproductive-justice.

Letter from Center for Reproductive Rights to the UN Committee Against Torture. (2012).

Macklin, R. (2012). *Ethics in global health: Research, policy, and practice*. Oxford: Oxford University Press.

National Statistics Office & USAID. (2008). Philippines demographic and health survey: Key findings. Retrieved from http://www.measuredhs.com/pubs/pdf/SR175/SR175.pdf.

Philippine Constitution (1987). Article II, Section 15.

Republic Act 10354. (2012). *Reproductive Health Act of 2012*. Philippines.

Santiago, M.D. (2012, December 29). *Leave no woman behind: Why we fought for the Reproductive Health Bill.* CNN. Retrieved from http://www.cnn.com/2012/12/29/opnion/philippines-reproductive-health-bill-santiago/.

United Nations, Contraceptive prevalence rate, 54, *available at* http://www.un.org/esa/sustev/natlinfo/indicators/methodology_sheets/health/contraceptive_prevalence.pdf.

USAID Philippines. (n.d.). *Maternal and Child Health Integrated Program ("MCIP") Philippines*, http://blog.usaid.gov/tag/maternal-and-child-health-integrated-program/.

Warwick, D. (1982). Bitter Pills: *Population policies and their implementation in eight developing countries*. Cambridge: Cambridge University Press.

Weiss, K. (2012, July 22). *Philippines birth control: Filipinos want it, priests don't*. L.A. Times. http://www.latimes.com/world/population/la-fg-population-matters5-20120729-html-htmlstory.html