POPULATION AND REPRODUCTIVE RIGHTS

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Human rights has been a passionate cause of many. But when we speak of human rights we generally refer to tortures, abuses of people in detention, deaths imposed by capital punishment or termination of life of the unborn.

Very few are aware that human rights are also violated when women die because of too frequent or too many pregnancies, or when they live tortured by the fear of another pregnancy, by an unwanted pregnancy, by a rape, by the absence of health care and information when they are pregnant or when they give birth.

The Philippine Constitution mandates that the State shall defend the right of spouses to found a family (Art. XV. Sec. 3 (1)), and that the State shall ensure the fundamental equality before the law of women and men (Art. II. Sec. 14). So men and women have the equal protection of the law—and therefore the State—to be able to enjoy the right to life, liberty, and human dignity.

But it is only the woman who gets pregnant for nine months each time (4 1/2 years of her life for five pregnancies), and so it is the woman who is more involved personally in the reproductive process. Men are expected to be in charge of production, although we know that women are also active participants in production, besides reproduction. Many times, she alone is responsible for both. A men's deposition of sperm in a few minutes may be his only involvement in the reproductive process.

Reproductive Rights are therefore essentially more the concern of a woman; they are central to her total life and the quality of that life.

What are these Reproductive Rights?

These are:

1. The right to reproductive health;
2. The right to fertility management;
3. The right to reproductive health information and services.

These reproductive rights are due to all women and men, regardless of age, color, race, status, ability and/or disability, religious and political beliefs. They are recognized by our Philippine Constitution, as well as by International Conventions and Declarations to which our government is a signatory.

The first right is the Right to Reproductive Health.

This means the right of women to be healthy before, during and after giving birth to each child.

Are Filipino women prepared physically (not to mention emotionally and mentally) for a pregnancy?

Are they healthy enough to be able to survive childbirth, recover from it, and be physically ready to take care of the newborn along with the children they already have (plus their husbands), and then bear another one?

Let us look at some facts.

A 1987 FNRI (Food and Nutritional Research Institute) survey showed that almost half (45.2%) of pregnant and half (50.6%) of lactating women are anemic. More than one third of non-pregnant and non-lactating women (but who are nevertheless at risk of becoming pregnant or who already have had several pregnancies), ages 13 to 59, also had iron deficiency, almost twice the rate found among males. Compared with their study in 1982, these rates have increased tremendously.

The prevalence of goiter which is caused by iodine deficiency, has also increased from 1982 to 1987. For pregnant women ages 13 to 20 years old, the rate was 3% in 1982. This jumped to 17.6% in 1987. For pregnant women 21 to 49 years of age, the increase was from 3.2% to 12.4% in five years. Allowing for better data collection, the increase is nevertheless great.

Protein and calorie intakes per capita per day were found to have been decreased between the two survey periods. Pregnant women who need to have six times the nutritional requirements of other groups were getting hardly 3/4 of the recommended dietary allowance.

Many of our women are undernourished or malnourished, and lack other essential elements besides iron and iodine. They also lack Vitamins A and C particularly during pregnancy. Likewise growing girls lack calcium which is needed for proper development of their pelvic bones, so important in childbirth.

Many die because of repeated trauma to their bodies. They contract tuberculosis (76,958 women were reported to have had TB in 1987), the number one cause of death among women from all age groups starting from the early age 15 years up to 69.

Or they die due to complications of "normal delivery", the number two cause of death among 10 to 14 year old girls in 1985, outranking deaths due to accidents. It should be noted that this cause of death was number 10 in 1980 while accidents was then number 8. And in 1985 as well as in 1980, postpartum hemorrhage was one of the top 10 causes of death among women ages 20 to 39 years.

About 2000 Filipino women die yearly (at least five women a day) due to causes related to or aggravated by pregnancy or childbirth. And this rate is highest in Manila (two times the national rate), among the urban poor, also in remote rural communities, for mothers below 15 years of age[1].

Dr. Hafden Mahler, then WHO Director General, pointed out in 1987 that the most striking fact about maternal health in the world today is the extraordinary difference in maternal death rates between industrialized and developing countries...the widest disparity in all statistics of public health.[2] In 1985 the Philippines had the 3rd highest maternal mortality rate in Asia. The risk of dying for a pregnant Filipino woman is still 100 times more than for her counterpart in developing countries, where the average lifetime risk for a woman to die of pregnancy related causes is only between 1 in 4000 and 1 in 10,000. More than half of our currently estimated 30 million women population are of reproductive age (15 to 49 years) and are at risk of becoming pregnant and of dying from that pregnancy.

How does population growth affect our enjoyment of our reproductive health rights?

Our women are not so much concerned that our growth rate is 2.4%, that in 30 years or so, we will have doubled our total population. But they are concerned that the money that they have buys less and less food for their family—so they try to stretch this amount—and they eat less, just so their children and husband would have more. They are already undernourished and deficient in many elements. So when they become pregnant again, their need for more nutrients for their own bodies and for their growing fetus, becomes even more acute. They then become more prone to chronic diseases, chronic fatigue, mental disorders, and may be driven to commit suicide (a Philippine General Hospital study of attempted

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[1]. National Commission on the Role of Women, *The Philippine Development Plan for Women*, 1989-1992

[2]. R. Cook, "Reducing Maternal Mortality: A Priority for Human Rights Law" in *Legal Issues in Human Reproduction* ed. Sheila McLean (Brookefield: Grower, 1989).

suicides had more females than males). Small amounts of blood loss during childbirth would be dangerous or even fatal to them.

And if they survive that last childbirth, is there enough food and nutrients and rest period for them to recover, to breastfeed, and take care of the newborn and the rest of the family?

What is the State doing to protect and promote the right to health of the people (Phil. Const. Art. II. Sec. 15)?

Do we have enough resources for the growing number of people who need essential foods and for our women to remain healthy before, during, and after pregnancy?

And if she is a "working woman", is the State protecting her by providing safe and healthful working conditions, taking into account her maternal functions, and such facilities and opportunities that will enhance her and enable her to realize her full potential in the service of the nation (Phil. Const. Art. XIII. Sec. 14)?

Working women should include the women in our homes (housewives), domestic helpers here and abroad, and prostituted women, many of whom are pushed into these occupations due to the growing population in their own homes. We know that many of the working women in factories (like those within the Export Processing Zone Authority) and in service establishments and agencies, e.g. health, hotel, restaurants and other services where women predominate, (and I will not be surprised if there were more women victims of the recent earthquake in these establishments) are exposed to many hazardous conditions, factors and elements detrimental to their reproductive and other functions. These factors lead to more miscarriages, stillbirths, infertility problems, behavioral disorders and other diseases, specifically STDs, like gonorrhea (more females than males are reported to have gonorrhea, and this is more difficult to diagnose among women), syphilis, and AIDS which is increasing among females in the Philippines. Or they give birth to babies with congenital defects, low birth weight, cancer, etc.

The health of the fetus is an indicator of the health of the mother. In the Philippines, foetal mortality is still about 10 per 1000 live births--9.8% higher than in 1978.[3] About 50 infants per 1000 live births die before their first birthday, 1/3 of these within their first six days of life. This means roughly 16,000 babies per year.

What can a woman do to be able to protect her reproductive health?

One thing she can do is to exercise her right to manage her fertility. This is her second reproductive right; to be able to determine if, when, how, and by whom she would become pregnant.

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[3]. UNICEF, *The Situation of Children and Women in the Philippines,* 1987.

This right is found in our Philippine Constitution, Art. XV, Sec. 3(1): "The State shall defend the right of spouses to found a family in accordance with their religious convictions [not the beliefs or pronouncements of religious leaders] and the demands of responsible parenthood." And these demands, I believe, are spelled out in the subsequent provisions which state the rights that the State is mandated to protect;

(2) the right of children to assistance, including proper care and nutrition, and special protection from all forms of neglect, abuse, cruelty, exploitation, and other conditions prejudicial to their development;

(3) the right of the family to a family living wage and income:

Section 4 further provides that the family has the duty to care for its elderly members.

The right of spouses to found a family does not mean only a right to give birth. This should include the bearing as well as the raising of the family, and maximizing the chances of surviving these processes.[4]

Article 16. Section 1(e) of the United Nations Convention on the Elimination of All Forms of Discrimination Against Women or CEDAW to which the Philippines is a signatory, obliges the State parties to ensure that men and women have the same rights to decide freely and responsibly the number and spacing of their children.

Although this right belongs to both spouses, again, it is the woman's life and health (or quality of her life) that is affected most by any violation of this right.

Since our new Family Code provides that there should be equality between men and women in terms of decision-making, we should expect that a woman does not need her husband's consent if she want tubal ligation. A man is not asked for his wife's consent if he gets a vasectomy.

Does the Filipina really have a choice to determine if and when she would become pregnant?

It is estimated that 2.4 million legally-married Filipino women do not want any more children.[5] A 1987 study revealed that 63 percent of Filipino urban poor women of reproductive age no longer want additional children. Of those pregnant during the survey, 41 percent admitted that their pregnancy was unwanted. This could mean that out of 1.4 million babies born yearly, 574,000 are un-

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[4]. Cook, *op. cit.*

[5]. Department of Health, *An Overview of the Philippine Demographic Situation and Population Development Program,* July 1990.

wanted.[6] This number falls within the estimated 155,000 to 750,000 induced abortions per year estimated by Dr. Martin de la Rosa in a paper[7] he presented at the recent WHO Conference on Safe Motherhood held in Manila. The DOH-Family Planning Service's 1990 Health and Family Planning Situationer cites that 62% of women eligible for family planning did not desire to be pregnant, and 2/5 did not plan their last or current pregnancies. It also stated that half of mothers surveyed tended to favor only 2 to 3 children.

One consequence of unwanted or unintended pregnancy is the birth of an unwanted child, and this may result in neglect, abuse, exploitation of the child, and an addition to the 1.2 million streetchildren we have today.[8] One option which has been offered is the giving up of the baby for adoption. I know that this may lead to a lot of unhappy and painful experiences for many years for the birthmother, the adopting family, and the child, who if you believe some news reports, may end up being sold for questionable and horrifying purposes.

Another consequence of the failure of a woman to prevent pregnancy is induced abortion. Jalbuena et. al. in their study of maternal deaths at UP-PGH[9] expressed their anger and frustration at the death of the women who died from induced abortion (16% of maternal deaths). They emphasized that these were most wasteful since their deaths could have been prevented by contraception. Dela Rosa concluded that the fact that 73% of those who underwent induced abortion were aware of the risks of this procedure yet proceeded to have it, illustrates the desperation of these women. Back-alley abortions often lead to hemorrhage and infection, and weaken further or kill the already malnourished and sickly women. The dilemma which these women face is not simply a choice between the life and health of the mother and that of the unborn, but they have to contend also with their responsibilities toward their living children as well as the elderly they must care for.

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[6]."5 M Filipino Babies Unwanted Yearly," *Philippine Star,* February 17 1989, p. 14.

[7]."Induced Abortion: Is it Really a Problem?" in *Proceedings of the National Conference of the National Conference on Safe Motherhood,* September 3-4, 1987, pp. 37-44.

[8]. N. Rueda, "RP has 1.2 M Street Children," *Philippine Daily Inquirer,* May 8, 1989., p. 1.

[9]. "Septic Abortion: a Report on 709 Cases, JPMA (May-June 1978), pp. 185-197.

Studies show that there is an increasing trend of cases of induced abortion in hospitals (among top seven causes of discharges in 1987 and number two cause in 1988 in all government medical centers and regional hospitals):

One reason why people (read : men) want to have more children is that these would contribute to family productivity and serve as old age security. So when an infant dies, they tend to want to quickly replace that child. The mother has a greater risk of death due to the closely spaced births. Women who become pregnant within two years after the last delivery, below 18 or about 35 years of age, or who have already had more than four deliveries are considered high risk mothers. In Jamaica, compared to women having their second child, those with fifth to ninth births are 43% more likely to die. In rural Bangladesh, fourth or fifth births have a risk of maternal deaths almost twice that of having the second or third one.[10]

The Filipina would want to choose if and when she becomes pregnant. Because many times she cannot, the growth of population in her own house, including the elderly she has to care for, increases and so do the daily needs of her family. Again, she gives birth to another Filipino, one of the 1.4 million newborns each year, and in the process, she may be one of the 2000 who die that year.

Many times, she is also unable to choose by whom she would become pregnant--she is raped by a stranger, or by someone she thought she could trust including her own father or uncle, or by her husband when he gets drunk and who beats her up if she refuses his advances because she is very tired or actually sick or is afraid of getting pregnant again.

The third reproductive right is the right to have the necessary information and service before, during, and after pregnancy, labor, and delivery.

Article XIII, Sec. 11 of the Philippine Constitution promises that "the State shall adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services available to all the people at affordable cost." One of the priorities for these services are the women.

The UN Women's Covenant (CEDAW, Art. XII. Sec. 10) also provides "that State parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access

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[10]. Cook, *op. cit.*

to health care services, including those related to Family Planning." Section 2 adds that "State parties shall ensure to women, appropriate services in connection with pregnancy, confinement and the postnatal period, granting free services where necessary as well as adequate nutrition during pregnancy and lactation."

Do our Filipino women have access to these services?

Documents show that 50 to 100 mothers often line up as early as seven in the morning to avail of prenatal services.[11] But only 65% of eligible women receive prenatal services and 47% receive delivery care from the Department of Health (DOH).[12]

Only 62% of all deliveries are attended by trained personnel, more in the urban than rural area.[13] Most (75%) deliveries take place at home.[14] Of these, 60% are attended by traditional birth attendants. In 1986, it was estimated that there was an average of one rural health physician (RHP) for every 800 pregnant women, one rural health midwife per 173 pregnant women, and one specially-trained obstetrician for every 496 high risk pregnancies.[15] A community survey showed that 20% of mothers were identified to have high risk pregnancies. This would mean about 400,000 Filipino women out of the 2 million pregnant per year. Seventy percent of them are in the rural areas, being served by only 30% of our health personnel, both government and private. No wonder 6 out of 10 Filipinos die without any form of medical attendance.

In 1987, only 15 hospital beds (public and private) were available per 10,000 Filipinos.[16]Only 21% (6-28%range) of households are within three kilometers of a government health facility while 32.8% are near (less than three kilometers) a private one.[17] And while deliveries and abortions increasingly are the most common cause of hospitalization, only 20 to 25% of beds are reserved for

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[11]. Asian and Pacific Development Centre, *Asian and Pacific Women's Resource and Action Series: Health* (Kuala Lumpur: APDC, 1989).

[12]. F. Bacalzo, "Maternal Health Services: Are They Available?" in P*roceedings of the National Conference on Safe Motherhood,* Sept. 3-4, 1987, pp. 37-44.

[13]. Department of Health, *The Philippine Population Program (1990-1994),* July 1990.

[14]. *Philippine Development Plan for Women,* 1989-1992.

[15]. F. Bacalzo, *op. cit.*

[16]. National Economic and Development Authority, *The 1987 Philippine Statistical Yearbook.*

[17]. Department of Health, The Philippine National Health Survey, 1981.

them. So many obstretric wards have 2 to 3 patients sharing one bed to rotation. Many patients have to go home within a few hours after giving birth in the hospitals.

Epidemiologic and related data have shown how reproductive health care can reduce maternal, infant, and child mortality. Absence of health services for these underprivileged and vulnerable groups leave them and their families always at risk of sickness and death.[18] The death of a mother is specially quite tragic when she leaves a number of very young and often sickly children behind, in contrast to the death of one child. However, maternal and child health programs (MCH) are actually oriented 80% to the child and only 20% to the mother.[19]

The World Health Organization has suggested that to achieve Health for All by the year 2000. 5% of GNP of each country should be allocated to health. And the International Covenant on Economic, Social, and Cultural Rights (UN. 1986), Art. XII. Sec. 1 states that every one has a right to the enjoyment of the highest attainable standard of physical and mental health. It obliges State parties to use their health resources according to utilitarian ideals. Therefore, Rebecca Cook argues that inappropriate use of health resources is not merely unwise but illegal.

Is our DOH budget sufficient for the needs for our health services for our growing population?

In 1983, the budget for health was 4.4% of the national budget. In 1987, it became 3.72% while in 1990, this dropped to 3.2% (2.4% of our GNP). Although per capita budget increased per year in absolute figures, this has not kept up with inflation. This year (1990), the DOH provides P120 per Filipino, equivalent to 30 centavos a day.[20]

How about access to information, particularly on the special needs of women, including family planning?

It has been found that about 4.8 million out of 8.6 million Filipino couples, had no knowledge of how to manage their fertility or prevent conception, although 2.4 million of the legally married women did not want any more children.[21] Women experience diffi-

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[18]. Cook, *op. cit.*

[19].E. Dayrit, "Reducing Maternal Mortality: A Priority for Human Rights Law" in *Proceedings of the National Conference on Safe Motherhood,* Sept. 3-4, 1987, pp. 69-70.

[20]. M. Tan, S. Pineda and M.C.Alfiler, "The DOH Budget Aiming for Efficiency and Equity," *Health Alert* (December, 1989), pp. 222-224.

[21].S. Estrada-Claudio, "Population Planning: a Review" in *Health Alert* (May, 1989), pp. 173-177.

culties in consulting health professionals regarding their health needs, specially on sex matters. Myths regarding sexuality still abound.[22] Clearly, there is a need for more health information and educational activities. And since only four to six out of 10 children who enter grade one finish elementary school,[23] many of them, particularly the girls, are unable to gain proper and adequate knowledge on how to take care of their bodies and control or manage their fertility. These girls become mothers when they should still be going to school or playing child games. But there they are bearing and rearing their children, deprived of their right to health information as well as health services and not able to fulfill their full potential to serve the nation.

It is not difficult to conclude that population growth has made health services, health manpower and other resources inadequate, inaccessible, and unavailable to many of our women, specially those at high risk. Rural women are also at high risk because they are so far from health services. This is due to lack of transportation, blood replacement facilities, and trained health manpower for early identification, management, or referral of the high risk, and substandard health facilities. Women do not receive quality reproductive health services which include scientifically based practice, adequate technical skills, comprehensiveness, humane orientation, and responsiveness to the needs of individual women from birth to death. In rural communities, Filipino women die so early or live without even knowing that they have a right to good health. They may have no alternative to early marriage and therefore repeated pregnancies. And teenage pregnancies are increasing in the Philippines, contributing to the high death rates due to complications in pregnancy and childbirth. Their only salvation is either the grave or menopause.

There are at present various bills and resolutions in Congress that will definitely impinge on the reproductive rights of women by limiting their choices for family planning methods. Some of these resolutions are SRN 286, 326, and 450, principally authored by Senator Lina, and HRN 1048 by Congressman Antonio Aquino. The latter disputes the importance of Family Planning, saying that "...the delivery of clinical services for family planning purposes cannot be considered an indispensible component of basic health services that the State is mandated to deliver..."

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[22] See Institute for Social Studies and Action (ISSA) and Women's Health Care Foundation (WHCF), *Controlling our Fertility,* June 1990 and *Taking Care of our Health and Lives as Women,* June 1990.

[23] Freedom from Debt Coalition, *Women Want Freedom from Debt: A Primer,* July 1989.

There are other bills which view abortion as a crime, and therefore impose many penalties, including penalties on the women victims who are driven by their misery to abortion as a last resort. Abortion actually puts these women at risk to many complications, not to mention death. And yet, the proposed bills of these legislators tend to increase the need for abortion because of unprotected sex that would result in unintended or unplanned or unwanted pregnancies. Abortion is termination of pregnancy. How can there be abortion if there is no pregnancy? The solution, then, to the problem of increasing incidence of abortion is to help women and men prevent pregnancy.

I have presented three reproductive rights: the right to reproductive health, to fertility management, and to health information and services. These rights are vital components of our rights, and our government is mandated to uphold these rights for our women and men. I have also cited some evidences to show how population has affected our exercise of these rights.

My conclusions and recommendations are integrated in a position paper recently formulated by an alliance of 21 women organizations. The statement follows.

WOMEN NGOs STAND ON HEALTH AND FAMILY PLANNING

Fertility management is the regulation of one's capacity to reproduce, which includes the management of problems on infertility. Fertility management must be taken in the context of reproductive rights which is to us, a basic human right. In order to achieve self-determination women must be guaranteed their right to choose if, when they will become pregnant and how many children they will have regardless of race, class, age, disability, religious and political affiliation. Because reproductive rights are basic human rights, the State must:

1. insure this right is not violated by programs and policies that would seek to dictate on women's bodies by denying them the right to decide on their fertility in the hope of decreasing or increasing the number of children an individual should have. The government must maintain the principle of separation of church and state in the light of the strong lobby of the Catholic Church to deny self-determination to women.
2. insure that all conditions and support systems that would allow women to practice this right are in place. These include availability of and adequate information on all safe, accessible and affordable contraceptions, child care support, and comprehensive health care for women regardless of age and status.

The violation of reproductive rights endangers all other basic human rights. Conversely, the violation of other human rights of women eventually imperil their reproductive rights.

The question of informed choice can only be fully realized through a total education program that is meant to enlighten the entire citizenry on the issues of reproductive rights and freedom. This means that the government and all major institutions must also pay particular attention to young children and men in their educational efforts.

Because women's bodies and women's rights are the focus of population programs, women must be made major participants in all phases of policy and program formulation and implementation. Women's voices should be decisive in this regard.

As such, we believe that in terms of

I. Policy and Program Scope:
   1.1. Fertility management and health services must be made available to women of all ages and status, including young girls, menopausal women, single women, non-marrying women, girls and women survivors of rape and incest.
   1.2. Programs designed to help women manage their fertility should also address men's equal responsibility on birth control and unwanted pregnancies.

2. Program Services:
   2.1. Comprehensive reproductive health services must be provided to women throughout their whole life cycles; from childbirth to pubescence to menopause and beyond. These should include their nutritional needs. MCH and safe motherhood, breastfeeding and special needs and problems that have to do with their menstruation, infertility, reproductive tract infections and STDs.
   2.2. All individuals of reproductive age must have access to safe, effective and affordable methods to manage their fertility. Necessarily, this includes adequate information on the risks and prospects of each method.
   2.3. Support systems must be made available and affordable to individuals in need of child care facilities, and economic and educational upliftment. This also means that maternity/paternity leaves are ensured for employed parents.
   2.4. Family planning programs should have a strong education component with an orientation and training on gender sensitivity and gender-fairness for all policy-makers,

program beneficiaries and implementors, and the media. It cannot be overemphasized that education programs must be in the context of enabling individuals to make intelligent and informed decisions on issues.

2.5. Objective researches must be done continously on the side effects as well as on the safety of the different contraceptive methods. Research on indigenous and traditional methods of fertility management should also be given attention and priority by the government.

3. Approaches and Strategies

3.1. Women's groups should actively participate in the annual policy and program review of government agencies, particularly in programs that affect women's health. They should also be consulted in the development of major education, information and training materials to ensure that all major materials produced and distributed are gender-sensitive and gender-fair. This also calls for the participation of women's groups in the development of the training curriculum for trainors and implementors of all government programs for women.

3.2. Government should give due recognition, support and protection to women NGOs (non-government organizations) with projects/activities on women's reproductive health but also guarantee that women NGOs will retain their autonomy and independence in carrying out their work.

FROM AN ALLIANCE OF 21 WOMEN NGOs
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