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The Hindrances of the Philippines' Responsible Parenthood and Reproductive Health Act of 2012: A Comparative Analysis between Region 12 and BARMM

Dissertation submitted by

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Abstract

The promotion of Sexual Reproductive Health and Rights (SRHR) is the current trend worldwide. It aims to uphold the basic health rights of people, especially women, to acquire the sexual reproductive health (SRH) services they need. Given its newness as a global policy, it has been subjugated by varying factors such as religion, culture, among others. In Philippines' case, this is accurate as it underwent several challenges in formulating and implementing its own SRH policy—the Responsible Parenthood and Reproductive Health Act of 2012. Thus, this paper aims to tackle the effects of different factors toward the individuals and SRH policy, and to analyze the degree of these effects.

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1. Introduction

This study focuses on understanding the dynamics of Sexual Reproductive Health (SRH) policy and what it entails upon its application. Theoretically, SRH policies are the solution to ensure the quality of sexual reproductive health rights among individuals, lessen sexually transmitted diseases (STDs) and human immunodeficiency viruses (HIVs) and to prevent unwanted pregnancies. Promoting a healthier and more inclusive SRH is necessary. However, the concept of contraceptives under SRH has faced numerous barriers upon its formulation and implementation that led to its demise. Economical, sociocultural and religious factors play conflicting roles in relation to SRH policies; leading some societies and individuals alike to be skeptical about its application. This unfolded an ineffective SRH policy that inevitably led to constant policy re-evaluations and neglect of SRH services.

Evidently, less-developed governments are reluctant to promote family planning. The probable reasons may be related to the abovementioned barriers that anchors the SRH policy process (Ashford 2001). This is the case with the Philippines' Responsible Parenthood and Reproductive Health Act of 2012 or RPRH law—a developing country with conflictual SRH policy formulation process. The pro-life stance of the local Roman Catholic church in the Philippines resulted to policy divide during and past policy formulation (i.e., pro-bill versus anti-bill) (Dela Rama 2019). In effect, the RPRH law had to undergo alterations to devise a compromise acceptable with religious aspect (e.g., excluding abortion) (Melgar et al. 2018). This resulted to the construction of legal patterns that excluded adolescent group and solely focused on educational programs to abstinence-only framework. The SRH behaviours of the population of interest is assumed to be underdeveloped; therefore, lowering the effectiveness of the SRH policy. Even with the implementation of the RPRH law, there was still a strong influence of conservative beliefs that promoted the negative perception of artificial contraceptives among the population, especially to local officials. This fostered a sociocultural behaviour that neglects available SRH services and its implementation. On economic aspect, the RPRH law challenges the capacity of the national government to supply and disseminate SRH services, especially for local government units (LGUs) (Department of Health 2018a). Additionally, the low educational attainment among Filipinos (Philippine Statistics Authority 2018) may also further lower the contraceptive prevalence rate. This imposes a challenge in implementing RPRH law when considering the gravity of the said barriers. Regardless of the

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existing barriers, the Philippines' ability to adopt the RPRH law shows the presence of political willingness (Melgar et al. 2018).

The effects of these SRH barriers have already been stated in Mari Nagai et al. (2019) research on Philippines' contraception; wherein it cited the numerous missed opportunities to provide family planning due to SRH barriers (e.g., social norms). Furthermore, it stated that most women in the study are more inclined to use traditional methods as they have health concerns about the usage of modern contraception and are more inclined to use traditional methods, such as abstinence. .

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2. Theoretical Framework

2.1 Conceptualization of Sexual Reproductive and Health and Rights (SRHR)

The concept of SRHR is a rights-based approach concerned with upholding sexual reproductive health rights of individuals. It began when the UN highlighted the issue of population growth on the international agenda during the World Population Conference of 1954 in Rome and 1965 in Belgrade. However, the initial discussions were focused more on population growth rather than human rights (Berro Pizzarossa 2018). It was focused on the speculation of rapid population growth and its negative consequences in the future. It is likely that the fear stemmed from the Malthusian theory, whereas population growth (demand) will always exceed food production (supply), which could lead to the scarcity of resources if not regulated quickly (Malthus 1798)—therefore, a threat to economic development or famine (Ashford 2001). Such notions have led to the participation of governments in formulation of policy measures such as family planning. In the 20th century, the reproductive policies were primarily zeroed in on reducing the population growth rate.

At the turn of the 21st century, perception shifted focus to consider the normative aspect of human life (Ashford 2001). Family planning was no longer solely focused on population control, it provided an avenue to attain human rights, particularly for emancipation of women (i.e., access to maternal healthcare, right to determine number of children) (United Nations 2014a). The adoption of the World Population Plan of Action during the Bucharest World Conference on Population of 1974 and the International Conference on Population Development (ICPD) of 1994 signified the mandatory inclusion of SRHR and discouraged coercive implementation approaches. It stressed the importance of human rights (or SRHRs) in SRH policies, where individuals and couples have the capacity to decide the number of children and availability of access to reproductive health benefits (Berro Pizzarossa 2018). Consequently, rights-based approach in the development of SRH services was promoted as it is deemed more effective (World Health Organization 2016). The inclusion of social development and reproductive healthcare (e.g., prevention of sexually transmitted infections, safe childbearing) should be present when conducting population policies among states, removing focus on pure population control or fertility control (Ashford 2001; Berro Pizzarossa 2018). All these social inclusive developments are reflected in the ICPD Program of Action (PoA).

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2.2 How states formulate and implement SRH policy

Employing top-down approach, the UN was able to successfully set the policy agenda of population growth and provide a normative approach that would supposedly guide member-states on its SRH policy formulation and implementation (Sen, Germain, and Chen, 1994). With the policy refocused, the redefinition of policy and program objectives are dedicated to target individuals rather than the national demography (Ashford 2001). However, according to Lori Ashford (2001), although governments have different SRH policy approaches, most are applying on human-rights based approaches. Some may follow the international standards according to the ICPD of 1994, but others may even exclude the normative aspect of SRH policy and solely focus on policies that reduce population growth rate (Berro Pizzarossa 2018). This is due to the different capacities among countries that forces governments to use a prioritization model rather than satisfying the whole coverage of the ICPD PoA (Ashford 2001). Fortunately, countries that agreed to conduct the components under the ICPD PoA have received adequate financial support to enhance current resources for health sector reformation (Hardee and Smith 2000). Such endeavor was necessary to assist low- to mid-level countries.

For example, Brazil's Reproductive Health and Health System Reform of 1984 includes all elements under the ICPD PoA with the following related major principles: a.) universal access, b.) comprehensive care, c.) equitable distribution to all groups, d.) decentralized authority of SRH services to non-state actors, communities and LGUs, and e.) public accountability (Corrêa, Piola, and Arilha 1998). In effect, these principles empowered the targeted individuals or groups through the inclusive policy participation, the distribution of reproductive health services and expansion of contraceptive choices. By this empowerment, Brazil's SRH policy structure has been tailored according to the preferences and capacity of the demand units (e.g., women, youth). This resulted to increased utilization and access of SRH services (i.e., abortion, contraceptives) and improved participation of health agents and integration with municipal-level primary health services (Ashford and Makinson 1999). Brazil, abiding the ICPD PoA's directives, aligned its population and development policies in accordance with ICPD recommendations and was able to achieve both slowdown of the population growth and adaptation of SRHR (Ashford and Makinson 1999). Brazil's case highlights that the presence of political willingness during policy process is equally important for SRH policy success.

In contrast, China's former One-Child Policy – a national-level reproductive policy enforced in 1979 – lacked the social development aimed in the ICPD PoA. It put more emphasis on curbing population growth rate rather than social development of the SRHR. It included the

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following mandatory programs: a.) intensive sexual education, b.) IUD insertion for women after first born, c.) sterilization for couples after the second birth, and d.) abortion for third pregnancy (Gietel-Basten, Han, and Cheng 2019). **T**here were certain considerations (e.g., origin from rural areas, hazardless of work) given to other citizens who can have up to two children. Upon analyzing the results, it is evident that the population growth rate have declined drastically with hundreds of millions of births averted (Gietel-Basten, Han, and Cheng 2019). China's approach was considered as one of the strictest SRH policy implemented because it disregarded SRHR and used coercive means of accomplishing the targeted population rate. Moreover, it showed that there were negative implications that followed – mostly related to physical and psychological well-being of individuals or families that had to undergo the one-child policy program, especially among those who lost their only child (i.e., *shidu fumu*) (Wei, Jiang, and Gietel-Basten 2016).

The results of the two case studies illustrate the contrasting approaches: a.) direct population growth rate reduction through strict state policy regulations and enforcement, and b.) indirect population growth rate reduction through human-rights based approach. Moreover, it must be taken into account that the success of policy may depend on the country's objective. The successful correlation of Brazil's national reproductive policy with the elements of the ICPD PoA overtime is an evidence of plausible policy alignment and integration. It demonstrates that empowering and providing opportunities to individuals allow the SRH policy to progress more effectively to adapt to the preference and need of the country (i.e., prioritization). Ultimately, underscoring social development is key in realizing reproductive health goals. According to Vijayan K. Pillai and Arati Maleku (2015), there is a positive relationship between social development or human development and reproductive health, where both interchangeably positively affect each other. Therefore, proving that the five principles of the ICPD PoA (e.g., universal access) are perquisites for a successful implementation of a comprehensive reproductive health approach (Corrêa, Piola, and Arilha 1998). The SRH policy is already conveniently integrated and encouraged in Brazil's societies that allows for its utilization. On the other hand, China's reliance on its own national reproductive policy highlighted that strict implementation process could immediately lower the population growth rate but with future negative outcomes. According to the impact analysis of Gietel-Basten, Han, and Cheng (2019) on one-child policy, enforcement of population controls are not always the most effective way when compared to other methods, such as setting demographic rules and regulations (e.g., minimum age of marriage, birth spacing for couples) as it had small differences regarding

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results to total fertility rate. Evidently, it shows how some countries may have different triangulations for SRH policy creation that could either focus on population growth rate or according to the SRHR concept.

2.3 Barriers to contraceptive utilization

The aforesaid cases show that different policy processes may cause different outcomes on how reproductive health services are created, formulated and enforced. In turn, this affects the utilization rate of the SRH program regarding supply and demand by citizens. However, the policy process is not the sole contributor to the SRH policy effectiveness. Based on studies, the other factors involved in sexual and reproductive health and behavior are economic capacity, educational attainment, household income, sociocultural tolerance and religious acceptance of each country (Ashford 2001).

According to Vijayan K. Pillai and Arati Maleku (2015), economic development is an influencing variable to reproductive health and social development. The implication suggests that improvement in income from economic development can contribute to public health which includes reproductive health. This stresses the interconnected relationship of economic development and reproductive health. To illustrate, the reproductive health gap between developed and developing countries have recorded to be high (Pillai and Maleku 2015). This is attributed to the fact that low-income countries have limited capabilities in administering the programs under the ICPD PoA reproductive policy standards due to weak logistics, costs of contraceptives, supply of reproductive healthcare workers and weak government institutions (Filmer, Hammer, and Pritchett 2000). Accordingly, the policy implementation process becomes ineffective and futile, especially when the targeted persons and areas with high fertility rates have accessibility issues (Filmer, Hammer, and Pritchett 2000). Furthermore, the developing country status may also reflect the disparity of individual and/or household's income given the incidence of poverty and low educational attainment. This also implies that socioeconomic position and educational attainment of an individual are both contributing factors to the utilization of family planning programs and contraceptives (e.g., condoms, pills) (Pazol et al. 2015; Nethery et al. 2019; Agha 2000; Radulovi 2006). As it constrains individuals, the difficulty of tackling unmet needs in certain areas of the country consequently increased. Dependency of developing countries to external support for local SRH policy (or other complementary policies) entails the support from developed countries and non-state actors (e.g., civil society organizations) (Ashford 2001) may be required to maximize effectiveness. In contrast, high-income countries are more abled in creating the ideal SRH

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policy that can cover both social development and population control but would likely focus on SRHR.

Based on previous researches, a.) personal and household income and b.) educational attainment, which are both affected by economic aspect, have a correlated relationship with contraceptive utilization. According to the findings of Sohail Agha (2000), Elisabeth Nethery et al. (2019), Karen Pazol et al. (2015) and Olivera Radulović et al. (2006), the impact of income and education have direct influence on the level of utilization, especially when it comes to the family planning choices between traditional (e.g., withdrawal method, menstrual calendar) or modern (e.g., pills, condoms) contraceptive. Assuming that both have different degree of effectiveness, its efficiency will also depend on users utilizing it. However, the use of modern contraceptives was proven to be more effective than traditional contraceptives (unsafe) (Radulović et al. 2006).

In this scenario, income refers to the capacity of an individual to afford the various contraceptives available in the market that are either subsidized or not. Mentioned in Agha's research regarding SRH policy in Pakistan, a developing country at the time of the study (United Nations 2014b), the constraints of income will very well affect the contraceptive choices and usage while demand was present. People in Pakistan prefer family planning regardless of socioeconomic position. This was reflected when individuals shifted from modern to traditional contraception. For instance, low-income individuals and/or households will choose to use traditional contraceptives if the prices of condoms (modern contraceptive) would suddenly increase; therefore, showing the demand for modern family planning. Meanwhile, higher income individuals and/or households with substantial capacity in terms of income and education (i.e., secondary to college education) are always likely to use modern contraceptives. Agha concludes that disparity of socioeconomic positions has different causalities on family planning: traditional versus modern. But most are likely to prefer modern contraception. Accordingly, the increase of income will lead to the use of modern contraceptive methods (Agha 2000). Concurrently, this similar scenario could happen to developed countries like Canada. According to Elizabeth Nethery et al., low socioeconomic status has an effect on type of contraceptives utilized. Nethery illustrated a pattern wherein higher income leads to utilization of more effective modern methods such as oral contraceptive; whereas lower income individuals tend to rely on contraceptives that are recorded to be less effective like condoms and injectables. Hence, income can be a financial barrier to the full access of existing modern family planning methods that could exclude lower-income individuals and households

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(Nethery et al. 2019). Ultimately, subsidizing contraception services for easier access is equally important in increasing utilization.

Educational attainment means the degree of education an individual had finished, which can range from primary to higher degree. Based on the observational cohort study assessment of Radulović et al., women's educational attainment has an impact on the knowledge and usage of varying contraceptives. To illustrate, the influence of education level has been found to have different results on different aspects such as: (a) source of information about contraception, (b) opinion about the most efficient method of contraception, (c) use of protection from unwanted pregnancy, (d) selection of contraception method. There was always a difference among primary, secondary, and higher level of education; whereas higher education always had the utmost advantage in terms of proper contraceptive information and utilization than primary education. To demonstrate, the source of information for primary educated persons were reliant on partners; while secondary and higher education would refer to newspapers and online media. At the same time, the opinion on efficiency of contraceptive was divided between condoms (modern) and pull-out method (traditional). There is a big percentage from secondary and higher education and a small percentage from primary education which believe that condoms are more efficient than withdrawal. However, there is a high percentage from primary education that believed the pull-out method was better. Thus, it can predicted that the use of protection from unwanted pregnancy was low for primary education and high for secondary and higher education. Additionally, it shows that the selection of contraception method is also affected as primary education have high tendency to choose traditional methods rather than modern methods which was almost equally utilized by both secondary and higher education. The results showcase that educational attainment is an important indicator to assess the utilization of family planning. Similarly, men's educational attainment is equally important as male knowledge on contraceptive could lead to male-controlled methods (e.g., male sterilization or condoms) (Gubhaju 2010). To tackle the issues sprouted by educational attainment, it is necessary to use 'contraceptive education' or 'educational intervention' to reinforce the gaps (Pazol et al. 2015). According to Pazol et al., educational intervention could increase knowledge that would lead to informed decisions and increase effectiveness of contraceptive utilization.

Other factors that act as barriers to contraceptive utilization are religion and sociocultural aspects. History has previously showed that religion has already provided the definition and conceptualization of gender roles and sexual framework for its devotees, specifically by

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Muslim and Christian religions. Its framework has already constructed the 'morality' regarding sexual designations for both male and female in accordance to its belief system (Arousell and Carlbom 2015). This 'morality' may also extend to the norms about sexual activities which can only be conducted before marriage, and of course, marriage defined under most religion would be between two heterosexual couples. Hence, the relationship of religion and sexuality and reproductive health are both strongly interlinked. With this, unmarried and homosexuals may find it hard to utilize modern contraceptives due to the religious stigma that it entails (i.e., pre-marital sex is frowned upon). Such occurrences lead to discrimination and disregard of the rights of women, transgender and homosexuals alike (Cense, de Neef, and Visscher 2018). The utilization and coverage of SRH programs is consequently affected as some individuals may be reluctant to avail artificial practices and may prefer the traditional method (e.g., abstinence) to avoid negative sexual outcomes and stigmatization by conservative social norms (Hall, Moreau, and Trussell 2012; Cense, de Neef, and Visscher 2018). According to the findings of Kelli Stidham Hall, Caroline Moreau, and James Trussell (2012), frequent religious attendance of young women are associated with less sexual activity and contraceptive use; while infrequent religious attendants are more likely to use SRH services. This implies that sexually active religious young women are more prone to risk of unwanted pregnancies and sexual transmitted diseases given that most of these women may lack comprehensive sex education (less likely to receive) and choose not to use modern contraceptives. The result leads to a probable assumption that religious influence have a "social control effect on reproductive behaviors" that encourages natural contraceptive methods or lessen sexual intercourse and discourages pre-marital sex, especially among adolescents (Hall, Moreau, and Trussell 2012); and another factor may be that some SRH services may be promoting abortifacient products that may cause harm to "life" in which case religion is against. In any case, this increases misconceptions of family planning services and contraceptive products as "an act of sin" (Mir and Shaikh 2013; Hirsch 2008), deterring the utilization of artificial or modern contraceptives while promoting traditional contraceptives. Even if comprehensive sexual education will be provided among adolescents, it will focus more on abstinence-based approach that will promote no sexual intercourse before marriage. But it should be noted that each religion may have different perspectives and acceptable practices (Arousell and Carlbom 2015). Nonetheless, religious institutions play a huge role in transforming and influencing the SRH policies and social characteristics.

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Similarly, in terms of sociocultural aspect, women (or unmarried women), youth and homosexuals are likely to receive condemnation for accessing or receiving programs under the SRH policy. This may lead to less demand from the intended targets (Kinaro et al. 2019; Griffin, 2006). This condemnation is a result of conflictual relationship of cultural norms and values and of certain populations and SRH services. Additionally, it may be considered the after-effect of religious influence that contributed to the construction of these social norms. In this aspect, the degradation of SRHR of these individuals will be a problem for the demand side of the SRH program as it is excluding the potential primary users. Such problems may have originated from factors connected with sociocultural aspects such as early marriage, only males decide on sexuality matters, misconceptions of modern contraceptives among others (Kinaro et al. 2019). There are empirical evidences that show the relationship between sociocultural and religious beliefs have effects on health behaviors and beliefs, and health intervention (Al-Busaidi 2017; Fagan 1996; Herd 1996; Biddlecom, Casterline, and Perez 1997; Arousell and Carlbom 2015). The relationship usually develop a social norm and/or sexual behaviors that oppose the utilization of SRH services. For example, the findings of Joyce Wangui Kinaro et al. (2019) show that some cultural practices instigate the encouragement of early marriages among adolescents, which also impel girls to engage in sexual activity. As a result, preference of using traditional methods may overcome the opportunities provided by modern methods, leading to lower demand of SRH services.

Ultimately, there are many complexities entailing the SRH policy given the diverse set of factors that exist among actors in the contemporary world. The SRH policy of one country cannot be the same with another country. This would mean that SRH policy requires flexibility for its adaptation within certain areas.

2.4 Information-Motivation-Behavioural Skills Model

The scope of discussion can be arranged according to the Information-Motivation-Behavioural Skills model – an analogical tool and intervention-making strategy. Through the model's theoretical framework, we can summarise how these barriers affected the sexual and reproductive health behaviour of individuals and in turn, may increase or decrease the effectiveness of SRH policies. Therefore, it is important to note that the influence of the barriers to the SRH behaviour is equally crucial in understanding the dynamics of contraceptive prevalence rate.

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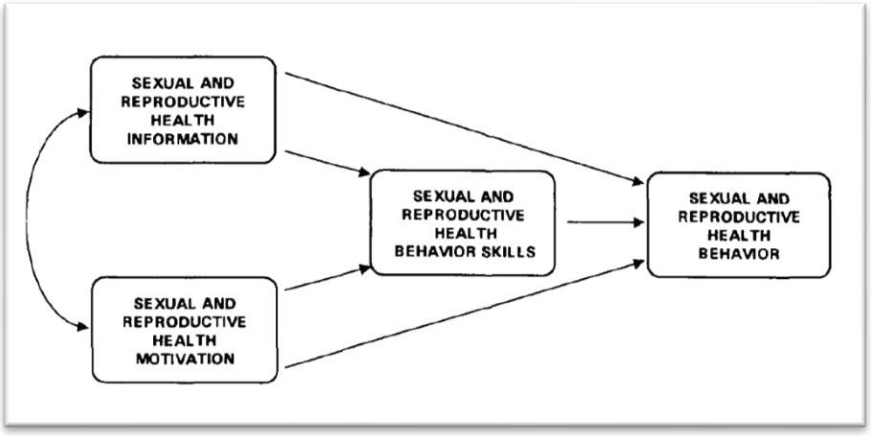
Primarily, the theory depicts that 'information', 'motivation' and 'behavioural skills' are factors that are conceptually and empirically connected to the performance of SRH behaviours (Fisher and Fisher 1998). To expound, the SRH information assists in providing knowledge, but it needs the motivation to act on the information, as well as the behavioural skills to act effectively. In other words, the interaction of these three determinants is essential for initiation and maintenance of sexual and reproductive health behaviour. Both SRH information and motivation are independent variables to SRH behavioural skills, though the former and latter can be directly linked to the SRH behaviour; as do the SRH behavioural skills can also be directly stimulating the SRH behaviour (Fisher and Fisher 1998; Seif, Kohi, and Moshiro 2019).

Figure 1. The Information-Motivation-Behavioural Skills Model of Sexual and Reproductive Health Behaviour



Source: Fisher and Fisher 1998

Through this model, the identification and understanding of sexual and reproductive health behaviours' determinants and their relationship to each other will lead to the conceptualization of a proper sexual and reproductive health solution or intervention across SRH behaviours and the populations of interest (Fisher and Fisher 1998). Since the three factors are thought to be generalizable determinants of SRH behaviour across health behaviours and populations of interest, the IMB model is then assumed to be applicable to the different aspects (e.g., race, religion, culture) of individuals or populations. Therefore, it assumes that different aspects may provide specific contents of SRH information, motivation and behaviour that are fundamentally important to finding specific solutions or interventions for current SRH behaviours. This way, the IMB model provides the flexibility necessary when analysing the context of certain behaviours and populations – a model that identifies constructs that are needed for behaviour

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change (Seif, Kohi, and Moshiro 2019; Bazargan et al. 2010). In the study of Bazargan et al. (2010), the IMB model was proven to be effective when it comes assessing risky sexual behaviour and in depicting the SRH behaviour of specific population of interest in accordance to the three components (e.g., information, motivation and behaviour skills).

As mentioned, the IMB model helps translate the level of impact of each barrier to contraceptive utilization. For instance, according to William A. Fisher and Jeffrey D. Fisher (1998), the SRH information defined under the IMB model should focus on providing scientific, relevant and concise information that could help develop practice of preventive behaviour, as well as information regarding available contraceptives. Henceforth, it enhances the educational attainment gap specifically for primary educated group. Moreover, it increases the awareness of the available subsidized modern contraception among low-income households – as they may find access to modern contraception and other SRH services to be expensive, wrong, and/or have zero knowledge about it. In doing so, it will lead to the development of the population's SRH behaviour that could be tuned to conduct preventive measures through availing and utilization of contraceptive methods. This opposes the promotion of educational interventions such as abstinence-based curricula which could be counter-intuitive. Abstinence-based curricula focuses more on abstinence as the sexual behaviour among teenagers rather than giving preventive information on how to access and use contraceptive methods. A comparative study between comprehensive sex education and abstinence-only education have shown that the latter was less likely to reduce unintended pregnancies (Stanger-Hall and Hall 2011). In addition, the IMB model also emphasizes the exclusion of sexist and frightening information that could provoke risky SRH behaviours. It shows the negative effects of abstinence-based curricula that could lead to risky sexual behaviour. Therefore, the type and execution of information dissemination is vital, especially when tackling adolescent behaviours. This way, barriers of educational attainment can be tackled with the revision of SRH information, while also attempting to transform and/or disregard religious and cultural aspects that may be negatively influencing the SRH educations on specific populations.

On the other hand, the SRH motivation factor is equally important in depicting individual actions in engaging in sexual activities, whether the sexual behaviour is motivated and responsive to use contraceptive measures or preventive approaches. Therefore, it considers the three types that formulates SRH motivation: a.) personal motivation (i.e., attitude to sexual behaviours), b.) social motivation (i.e., social norms) and c.) responses to sexual cues helps in motivating the SRH behaviour (Fisher and Fisher 1998). Conditioning these factors will allow

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the development of safer sexual behaviour, and in turn, lead actions to use preventive measures against unwanted pregnancies and diseases/infections. For example, sexual arousal must be conditioned to practice safer sexual behaviour and to condition anxiety when conducting sexual intercourse (Fisher and Fisher 1998). This indicates how the normative influence of religious and sociocultural aspects that negatively influence the usage of modern contraceptives can be overcome by transforming these variables to a belief system and goal-oriented motivation towards personal or family health and safety (e.g., prevention of pregnancy, STDs, cervical cancer).

Finally, the SRH behaviour skills refer to the ability of an individual to objectively perform or execute the sexual preventive action or SRH behaviour, as provided by the SRH information and motivation before the engagement of sexual intercourse, while also having the self-efficacy to conduct and maintain the SRH behaviour in various situations (e.g., uncooperating sexual partner) (Seif, Kohi, and Moshiro 2019; Fisher and Fisher 1998). Upon instilling strong SRH behaviour skills, the SRH behaviour can be automatically conditioned to identify sexual cues and properly execute the utilization of SRH services. However, depending on the severity of the barriers on the information and motivation component, the development of the SRH behaviour skills and SRH behaviour may have differing outcomes that could either be promoting preventive sexual behaviour or risky sexual behaviour. In effect, it may increase or decrease the CPR in the long-term, respectively. Therefore, the use of the IMB model is predicted to be useful in studying the variables influencing contraceptive utilization, as well as to locate proper specific SRH interventions.

2.5 Summary

With regards to contraceptive utilization, it seems the variables mentioned: policy process, economic (education and income), sociocultural and religious aspects are clearly affecting the components under the SRH behaviour which are information, motivation, and behavioural skills. These variables can influence the actions and mindset of individuals when discussing or engaging in sexual activity. The policy process factor allows the dissemination and access of SRH services that builds the foundation for developing a healthier SRH behaviour. However, the policy process, specifically on rights-based approaches of SRH policies, may be impeded by the identified barriers which can further evolve the SRH policy according to the normative standards of the dominant group or even ignore SRH policies totally (e.g., preferring abstinence education, immorality of abortion, misconceptions of artificial contraceptives).

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Consequently, the development of SRH behaviours may vary due to the different characteristics an individual has acquired overtime. For instance, SRH information can be inadequate if sexual education focuses on abstinence rather than proper practices. Concurrently, SRH motivation may be insufficient to avoid unsafe sexual practices. This leads to ineffective SRH behaviours that could sprout numerous unintended outcomes such as unwanted pregnancy. These barriers may lead to different contraceptive choices: traditional or modern contraceptives, perhaps due to misconception or normative values.

Henceforth, it can be hypothesized that these variables mentioned in the theoretical framework may the factors affecting the current SRH policy of the Philippines, namely the RPRH law. Leading to the insufficient implementation process. Such barriers may lead to insufficiencies in the future if not tackled immediately.

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3. Methodology

Since the implementation of the RPRH, there have been different outcomes regarding modern contraceptive prevalence rate. Current findings show that there are disproportionate results from different regions. Thus, a comparative analysis would be necessary to locate both problem and solution.

To investigate why modern contraceptive prevalence rate may differ per area in the Philippines, this paper will compare modern contraceptive prevalence rate by region and if factors such as income, educational attainment, religion and sociocultural would affect local demand. The objective is to locate the significant factors that are directly or indirectly influencing local demands to maximize the utilization of the programs under the RPRH bill.

The data are collected from official government reports, civil society reports, news articles and other literatures regarding the SRH policy in the Philippines. The selected official government reports are used in collating quantitative evidence regarding the impact of the RPRH law to contraceptive utilization and provide a description of the components under the policy. These include the final Revised Implementing Rules and Regulations (IRR) of the RPRH law and official reports from the Department of Health (DOH), Commission on Population and Development (POPCOM), Field Health Services Information System (FHSIS), Philippines Statistic Authority (PSA) and LGUs regarding the population growth rate and contraceptive prevalence rate relationship of the two selected regions: Region 12 or South Cotabato, Cotabato, Sultan Kudarat, Sarangani and General Santos (SOCCSKSARGEN) and Bangsamoro Autonomous Region of Muslim Mindanao (BARMM). This paper is also supplemented with quantitative and qualitative findings of other reports and studies regarding recommendations and barriers of the RPRH law, such as media and civil society reports. With these findings, it would be easier to identify the similar variables that are either contributing to the development of SRH behaviour and contraceptive utilization within the selected population.

For the first section of the empirical analysis, a qualitative analysis of the programs under the RPRH law that are specifically related to contraceptive distribution and utilization will be conducted. It will analyze whether there are existing barriers and/or social norms included within the legal framework that may impede the distribution and access of modern contraception. Specifically, it aims to assess whether the features under the RPRH law are efficient in providing access and supplies of SRH services to sexually active individuals,

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ranging from adolescent to adult. Afterwards, other unintended effects will also be analyzed. In doing so, this paper will also gain insight on the slow growing demand for modern contraceptives in the legal and policy aspect, as well as its application to the selected regions.

In this case, the documents reviewed were the RPRH annual reports and final IRR of the RPRH law. The latter contains all the details required to understand the policy content of the SRH law in the Philippines, which contains the details on the specific SRH services like family planning; while the former will be utilized to analyze the implementation process of SRH programs and to further supplement the background of the RPRH law. It will focus on the contraception components of the RPRH law, namely Family Planning and Adolescent Sexual and Reproductive Health (ASRH). Subsequently, the details under the said components shall be analyzed through the lens of the theoretical framework. In doing so, the data used are from assessments that studied the degree of normative values and legal provisions that are inferred to be barriers under the RPRH law. Additionally, news articles were also included to assess the situation of the SRH services in the country. It includes the implementation issues faced that could express the gravity of the barriers (e.g., religious aspect).

The second section will conduct a "lens" or "keyhole" comparative analysis of the modern contraceptive prevalence rate of two regions in the Philippines, namely SOCCSKSARGEN and BARMM. This method shall focus on the BARMM region as the lens of the comparative analysis. Therefore, the BARMM lens is used to understand the differences with SOCCSKSARGEN region, as well as other regions. Currently, it is observed that both populations of interest have different modern contraceptive prevalence rate outcomes. For instance, SOCCSKSARGEN had a higher CPR than BARMM which have been recorded to have a low modern contraceptive prevalence rate. To understand these CPR outcomes, the study will proceed in analyzing the contexts of each regions. This is to see whether the variables that are classified as 'barriers' (e.g., educational attainment, income) and 'indicators' (e.g., SRH behaviour) are presently affecting the rise or reduction of "unmet needs", and to gauge the degree of influence towards the population and SRH services.

The reports from the NDHS, FHSIS and PSA documents are used to identify the quantitative differences of the two selected regions regarding total fertility rate and contraceptive utilization, as well as choices between traditional and modern methods. Furthermore, it includes quantitative data affecting the former and latter, such as educational attainment and income. On the other hand, the report of the DRDF on youth sexual behaviour and literatures

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regarding social norm of Filipino Muslims are used as quantitative and qualitative data that are focused on describing the sociocultural and religious aspects under the regions. Other data also include information from the Philippine News Agency, SOCCSKSARGEN and BARMM regional news that shall update the progress of the LGU's implementation of RPRH law. The interpretation of the findings shall entail the combination quantitative and qualitative data. For instance, the quantitative data is used to describe the huge disparity of the regions with regards to the SRH background of the two regions, and then aligning it with qualitative data to help the formulate inferences. Similarly, the format shall follow the sequence of the theoretical framework.

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4. Empirical Analysis

4.1 RPRH Act of 2012

Background of the Philippine SRH policy

The bill's objectives are based on the following areas: a.) Maternal, Newborn, Child Health and Nutrition; b.) Family Planning; c.) Adolescent Sexual and Reproductive Health or ASRH; d.) Sexually Transmitted Infections and HIV/AIDS; and e.) Elimination of Violence Against Women and Children. These five areas aim to provide sexually active women and/or mothers, families, and adolescent individuals with the proper reproductive health related medicines and guidance. The implementation process has included the allocation of contraceptive, health facilities, and assistance from medical workers. To tackle the financial constraint that may be entailed from the SRH policy, the endeavors are being processed by both the public and private sector. In which case, both public and accredited private hospitals will handle the distribution of SRH services. Taking into account that the Philippines does not allow the legal practice of abortion, reproductive health rights does not include abortion and access to abortifacients (i.e., emergency contraceptives) (Department of Health 2017b). Therefore, modern contraceptives and other SRH related supplies are reviewed to prevent the inclusion of abortive contraceptives that may cause harm to "unborn" life.

The family planning program caters to couples and individuals that wish to limit the number of children through responsible means. At this point, age may vary from adolescent to adult but are under the scope of 'women of reproductive age' (WRA). It will allow families to gain information and the access regarding reproductive health that is required. The access is related to both forms of traditional and modern contraceptives. In line with this, the following targets have been provided: increase modern contraceptive prevalence rate (modern contraceptive prevalence rate) among all women from 24.9% in 2017 to 30% by 2022 and to reduce the unmet need for modern family planning from 10.8% in 2017 to 8% by 2022 (Department of Health n.d.). Modern contraception or modern methods of family planning (MFP) would mean the use of pills, sterilization, condoms, implants, IUDs, injectables and among other artificial methods; while traditional contraception or natural family planning (NFP) includes the dependency on periodic abstinence or calendar method, withdrawal, and folkloric methods (Marquez, Kabamalan, and Laguna 2017).

Under the program are the following components that are vital to accomplishing the set targets: (a) free FP commodities, (b) demand generation through community-based management

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information system, (c) availability FP in hospitals and other health facilities, (d) financial security in FP. Currently, these components are established to enable the access for FP commodities through public and accredited private hospitals and other health facilities, especially in areas where access to these commodities are difficult or even inaccessible. Some private hospitals operating under religious groups may apply for exemption in providing modern FP services (Sec. 5.22). Even so, such components may contribute to the decrease of unmet needs of Filipino families. To ensure that needs are met, the budget and supply allocation will be extended to local public hospitals per region to guarantee adequate supply for consumers wanting to utilize while also giving LGUs the power to formulate own strategies. Similarly, this includes the FP services that will be provided through outreach missions like the mobile healthcare service (MHCS), which will use vehicles to extend access to the Geographically Isolated and Disadvantaged Areas (GIDAs). Therefore, expanding FP services and developing supply chain that will increase demand coverage. However, married couples are encouraged, though not legally required, to gain spousal consent for these endeavors, especially when it is related to sterilization methods (International Planned Parenthood Federation 2017). Simultaneously, the use of the information system is utilized for the promotion, development and dissemination of medical information and to consolidate relevant data of current FP users and potential clients, as well as the advocation of FP (Department of Health n.d.).

On the other hand, the ASRH program is aimed towards the young individual transitioning from childhood to adulthood, specifically whom are aged between 10 to 19 years old. Similarly, it has the same opportunities as provided in the Family Planning program but in the aspect of adolescent fertility. For instance, the access to reproductive information, contraceptives and health facilities in all regions. However, the RPRH law only allows the distribution and utilization of SRH services and modern contraceptives to young individuals with parental consent (Fontanilla 2015). Parental consent would mean the acquirement of consent from parent or guardian. Moreover, the ARSH program also includes additional components, such as job and nutritional aids for young individuals. In another aspect, the program focuses on the inclusion of a gender-sensitive and rights-based comprehensive sexuality education (CSE) program and adolescent reproductive counseling in the educational process from elementary to high school that will increase awareness and knowledge regarding reproductive health activities. However, the dissemination of SRH information must be aged appropriate. Although the usual concentration of the educational curricula and counseling programs are on abstinence

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type guidance rather than SRH information on access and usage of contraception (Melgar et al. 2018), there are several programs included to increase awareness. Although, the usual concentration of the educational curricula and counseling programs are on abstinence type guidance rather than SRH information on access and usage of contraception (Melgar et al. 2018) For example, You-for-You U4U Teen Trail Initiative's goal is to prevent early sexual intercourse among teenagers (Commission on Population and Development n.d.; U4U n.d.). This is also evident in the Department of Education Order No. 31, s. 2018 on "Policy Guidelines on the Implementation of the CSE", where no explicit mention of contraceptives practices was present.

Analysis

Upon analyzing the details above, there are three probable predictions that can be deduced in line with the theoretical framework. Firstly, like Brazil's SRH policy, the construction of the RPRH law indicates the political willingness in adopting the ICPD PoA and expresses the country's commitment in upholding the rights to reproductive health or SRHR. In fact, according to the RPRH Annual Reports of 2014 to 2018, the national government budget allocation has been increasing yearly from USD293 million in 2014 to USD849 million in 2018. However, the adoption process has excluded provisions regarding abortion and any related abortifacient contraceptive products (e.g., emergency contraceptives); therefore, expressing the strong influence of religion in the legal framework. Regardless, the law permits an ample opportunity for contraceptive utilization through its rights-based approach. Hence, the SRH services under the Family Planning and ARSH programs may eliminate the income barrier that may influence contraceptive utilization according to the socioeconomic status of an individual or household. Concurrently, the inclusion of SRH information dissemination under the law may very well tackle the educational attainment barrier by the increase of awareness on the availability of SRH services, as well as the variety of modern contraception methods available.

Secondly, the dominance of the religion in the country illustrates its potency in influencing the RPRH legal framework, specifically on the protection of "unborn" life for abortifacient products. According to Junice Melgar et al. (2018), these restrictive parts of Filipino norms are due to conservative beliefs and values that are sourced from the Catholic hierarchy and other "pro-life" groups. Melgar have identified these provisions to be restrictive due to the previous impacts in the implementation process. In fact, there have been existing cases that impeded the implementation process. Particularly, there was a temporary restraining order (TRO) on the

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procurement and distribution of the hormonal contraceptive 'Implanon' and 'Implanon NXT' imposed on the Department of Health (DOH) in 2015. At the same time, prohibiting the Food and Drug Administration (FDA) from "granting any and all pending application for reproductive products and supplies, including contraceptive drugs and devices" (Geronimo 2015). The TRO lasted for two years from 2015 to 2017. Such controversy has resulted to the shortages of modern contraceptives; therefore, contributing to the already high unmet need for FP (Department of Health 2017a). Hence, it could be expected that this provision may continue to impede the administrative capabilities of the DOH, resulting to the slow progress of SRH distribution and access. This will be problematic for LGUs as SRH supply allocation are rooted from the central government.

Thirdly, the social norms imbedded within the RPRH law, in effect of the strong religious component, have lowered the standards of proper SRH information and motivation for adolescents. This is reflected with the focus of adolescent CSE on abstinence-based curriculum and the requirement of parental consent for SRH services. This social norm is related to the "purity culture" in which promotes the preservation of virginity (to be "pure") upon marriage, while tagging adolescent engaging in early sexual activities as "sinners" (Cepeda and Ines 2016). Consequently, it stigmatizes pre-marital sex among adolescents and the notion of homosexual relationships. Furthermore, marriage can only be conducted legally at the age of eighteen years old and must be strictly heterosexual. As a result, it implicitly nudges an abstinence-type behavior since it is likely difficult to acquire parental consent (International Planned Parenthood Federation 2017). However, this 'parental consent' provision can be signified as barrier since Filipino adolescent behavior seemed to be already engaged in pre-marital sex. Based on the National Demographic and Health Survey (NDHS) of 2017 by the Philippine Statistics Authority, the average total fertility rate (TFR) among adolescents of aged 15-19 from 1993 to 2017 was around 51%. Another indicator is the increase percentage of 20.3% in 2013 from 8.5% in 1994, that find it less important of virginity at marriage for woman (DRDF 2013). This proves that besides the notion of the purity norm, sexual engagements among young peers exists and may continue to do so. In which case, this highlights the importance of the CSE for youths. The effect of social norms on the CSE seemed evident with the lack of explicit guidelines regarding SRH information on usage of modern contraceptives. According to Melgar, the aim of the CSE framework leans more on reconstructing the adolescent SRH behavior towards abstinence (priority behavior) than using condoms, especially for those who have not yet had sexual encounters. The reason for this type of

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approaches is the concern that the dissemination of SRH information regarding modern contraceptives may be interpreted as a promotion to engage in sexual intercourses (Melgar et al. 2018; Department of Health 2012). It can be predicted that the adolescent TFR may continue to persist due to this type of restrictive proponents, in terms of access and information.

With the analysis, it is clear the RPRH law promotes a healthier sexual and reproductive environment in the Philippines. The rights-based approach provides openings for potential improvements and adjustments. Although, the effects of the religious and sociocultural aspects within the legal framework has proven to be barrier towards positive reproductive behavior. This is especially true when referring towards Filipino adolescents whom must be the foundation of this SRH services. In comparison, to the 1971 Philippines population policy which was less enforced and prioritized by previous presidential administrations and LGUs that led to the exclusion of modern contraceptives in some areas, the RPRH law can be tagged as a more successful policy process (Lee, Nacionales, and Pedroso 2009).

4.2 SOCCSKSARGEN and BARMM

Comparative Analysis

The Philippines has three geographical divisions: Luzon, Visayas and Mindanao. The selected regions of SOCCSKSARGEN and BARMM are both located in Mindanao and are in fact neighboring regions. The Philippines is predominantly Roman Catholic but there is also a percentage of Muslims which are located mostly in Mindanao, this includes the former and latter regions. Whereas BARMM is wholly dominated by Islamic communities, while SOCCSKSARGEN is same but with more Catholic. According to the PSA (2017b) the BARMM region contains 3,451,644 Muslims and 197,564 Roman Catholics; while SOCCSKSARGEN has 1,032,824 Muslims and 2,319,832 Roman Catholics. In general, Roman Catholics and Muslim, as well as other religions are integrated within parts of the Mindanao region. While Roman Catholicism (or Christianity) and Islamism are varying religious concepts, they have both expressed skepticism about the access and knowledge to SRH services (e.g., contraceptives, information) that are usually counter to their religious beliefs, old traditions and norms, especially when it comes to abortion and sexuality. Therefore, it is no surprise that both religions have been recently influential to governments to oppose “abortion and rights of people with diverse sexual orientations and gender identities” (Cense, de Neef, and Visscher 2018; British Broadcasting Corporation 2009).

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A brief background on the Muslim community in the Philippines: The Muslim Filipino's culture has been the oldest traditions since the Spanish colonial period of the Philippines. It was these individuals who were successful in resisting Spanish occupation and Christianization, therefore, retaining most of their religious and cultural identity as the 'Moro' people (Majul 1966; Caballero-Anthony 2007). Currently among the Moro communities, there are thirteen Islamized ethno-linguistic groups living in Mindanao. Where each group have the same religious beliefs but may have different customs and traditions. In this case, the Moro people living in the region compromises of multiple sub-groups or "clans", where at times these clans had a conflictual history with the national government and among each other or even among Christian communities (Stark 2003). Usually these conflicts have led to numerous armed encounters, especially between the Moro groups, that are identified either secessionist or terrorist factions, versus the Philippine Army. In the end, the Moro groups in the dominant Muslim areas, were able to formally establish the Autonomous Region of Muslim Mindanao (ARMM) region in 1989 (Eder 2010), which is now known as Bangsamoro ARMM or BARMM. Not all Muslim communities are solely located in the BARMM region though, there are other minority groups in different parts of Mindanao such as SOCCSKSARGEN. This expresses the strong willingness to preserve Filipino Muslim religion and traditions, a preservation of the Moro identity, especially since they are a minority group in the Philippines. The determination also led to the application of the 'Code of Muslim Personal Laws of the Philippines' or 'Muslim Code' in the Philippine constitution. The code applies to all Filipino Muslims in the country (GOVPH 1977). Within these 'Muslim Code' is the inclusion of the old cultural and religious customs that are supervised by the Shari'ah court (International Planned Parenthood Federation 2017). Although some provisions may differ from the Philippine constitution, it is noted that under the 'Muslim Code', the legitimate marrying age for Muslim males would be fifteen years old; while the female counterpart is based on the age of puberty or upwards. As opposed to the national law, the legal age would be eighteen years old (International Planned Parenthood Federation 2017).

Like the Catholic religion, the courtship and marriage hold a high degree of importance in the Filipino Muslim culture and tradition, but with a slight difference. For instance, besides the unity of male and female partners, marriage can be used as a form of alliance of families. This means the existence of arrange marriage is prevalent among Filipino Muslim families or clans. Also, it is also includes bride-gift as a form of proposed union, where it is to "compensate the

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bride's family for the loss of a woman-member and to reimburse the cost of her upbringing" (Gowing 1979; 'Muslim Culture & Arts' n.d.).

It is tempting to assume that the provision could be conflictual to the RPRH law as just like what occurred with the Roman Catholic church (as mentioned in the analysis of RPRH law). However, this is not the case. In fact, the BARMM Department of Health and the Assembly of the Regional Darul Ifta' in the BARMM (RDI-BARMM) have already issued a "Fatwa" (i.e., Islamic rulings) in November 2019. This means that the health programs under the RPRH law has now been formally contextualized with Islamic teachings in the Philippines and shall be implemented according to Islam (Philippine News Agency 2019). In turn, the "fatwa" must be abided by all Filipino Muslims and will guide them for accessing of the SRH services. Though, this to clarify that the RPRH program has already been initiated in BARRM since RPRH implementation process. Based on Ali Mohammad Mir and Gul Rashida Shaikh (2013), Muslim scholars have agreed that Islamic teachings and SRH services, such as using contraceptives, do not conflict with each other. Hence, allowing individuals to decide on the number of children. However, this application may only apply to married couples rather than unmarried adolescent individuals.

Currently, both regions have already initiated process for the implementation of the RPRH components during the duration of the RPRH law implementation. Until now, both have shown political willingness through continued adaptation of respective their respective jurisdiction. For BARMM, it was expressed through the "fatwa" for SRH services; while SOCCSKSARGEN have recently further strengthened its FP program in cooperation with the Commission of Population and Development that has provided guidelines and strategies for the implementation of the national program for FP (Regional Development Council XII n.d.). However, the progress for each have been varying even if both regions are geographically near each other.

The Philippines have similar outcomes when it comes to the relationship of contraceptive utilization (dependent variable) and the mentioned barriers (independent variable). For instance, the barriers of the level of income, educational attainment and religion have affected the degree of contraceptive usage and choices between traditional and modern methods. According to Maria Paz Marquez, Maria Midea Kabamalan, and Elma Laguna (2017), women who have the following characteristics: lowest quintile, with primary and secondary education (although primary are more likely than secondary education), Catholic are likely to use

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traditional contraceptives (i.e., withdrawal) than modern contraceptives. Interestingly, Catholics are found to be more likely to use of withdrawal than non-Catholics. Other findings procured are from the PSA NDHS reports of 2013 and 2017 found that 'no education' subgroup was recorded with the lowest contraceptive utilizers for FP program with 29.3% in 2013 and 26.7 in 2017; while for subgroups with educational attainment from primary, secondary and tertiary education have higher percentages with 50 to 58 percentage range. This illustrates the applicability of both education and income as independent variables.

The findings of the two selected regions are varying in terms of percentage modern contraceptive utilization. In the Family Planning (FP) program, SOCCSKSARGEN have recorded to be the second highest utilizer of modern contraceptives with a modern contraceptive prevalence rate of 75.6%, while BARMM the lowest with a modern contraceptive prevalence rate of 41.1% in the Philippines (Table 1) (Department of Health 2018b). Even when assessing the family planning among married women in BARMM, the sum for both traditional and modern contraception users under the FP program of 2017 only accounted at 26.3% (using traditional and modern methods), while the remaining 73.7% are not currently using any form of the FP methods, leads to assume that there are other methods being used or just stop using contraception altogether (Table 5). Therefore, BARMM would still be rated the lowest contraception utilizer among other regions. In comparison with SOCCSKSARGEN which has a 58.8% of married users (Table 5).

Yet, the total fertility rate (TFR) for BARMM region is at 3.1 and SOCCSKSARGEN at 3.4 children per woman in 2017; though from 2008 to 2017, BARMM had a continuous drop from 4.3 to 3.1, in comparison with SOCCSKSARGEN which had a fluctuating trend of 3.6 (2008), 3.3 (2013) and 3.4 (2017) (Table 1). Noting that SOCCSKSARGEN was the only region recorded to have an increased in TFR between 2013 to 2017 (Juan, Laguna, and Pullum 2019). The high TFR of SOCCSKSARGEN may be due to the high teenage pregnancy of 15-19 years old with 14.5%, the figure is the third highest among other regions; while BARMM was place at fourth place with 8.5% of teenage pregnancy (Table 6) (Philippine Statistics Authority 2017a). On the other hand, it can be inferred that the downward fertility rate of BARMM may have been due to the armed conflict that occurred in BARMM's province of Marawi City that started in 23 May 2017, since it was ranked the most populous among other provinces (Philippine Statistics Authority 2016). Nevertheless, what is concerning is the consistently low modern contraceptive utilization of BARMM whereas SOCCSKSARGEN seemed to have an increasing rate.

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Table 1. Regional description of SOCCSKSARGEN and BARMM Region

Regional Description[1]	Population of Region XII – SOCCSKSARGEN	Population of the BARMM
GDP (2018)	6.9	7.2
Total Population (TP) (2015)	4,545,276 (4.5 of TP of PH)	3,781,387 (3.7 of TP of PH)
Average Annual Growth Rate (2010-2015)	1.94 (higher than 2.46 of 2000-2010)	2.89 (higher than 1.51% of 2000-2010)
Total Fertility Rate (TFR) from 2008-2017		
• 2017	3.4 (fluctuating)	3.1 (decreasing)
• 2013	3.3	4.2
• 2008	3.6	4.3
mCPR by Region, as of 2018	75.63	41.13

Source: NDHS 2017 (PSA) and FHSIS 2018 (DOH)

The obvious reasons behind the low utilization of modern contraception in BARMM is related to the inadequate reception or exposure to FP messages, which is further supplemented with the prominence of low educational attainment and due of being the lowest wealth quintile. In fact, BARMM is recorded to have the lowest figures in exposure to FP messages, educational attainment and wealth quintile when compared to the rest of the Philippines' regions. Leading to assume that ways of acquiring SRH information regarding the FP program or modern contraceptives would be gained through medical professionals/fieldworkers or centers, or none. However, according to the NDHS 2017 report there was 76% of women in BARMM whom were non-users of FP that didn't discuss family planning within the period of visit by fieldworkers or during visit to health facilities.

Table 2. Exposure to FP messages for women of age 15-49

	Population of Region XII – SOCCSKSARGEN	Population of the BARMM
2017		
Radio	45.3	16.7
Television	62.4	34.3
Newspapers/magazines	17.3	2.6
Mobile phone	8.1	0.4
Internet	25.4	4.3
None of these media sources	29.5	62.4

Source: NDHS 2017 (PSA)

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Table 3. Educational Attainment and Wealth Quintile

	Population of Region XII – SOCCSKSARGEN		Population of the BARMM	
Educational Attainment (Completion)				
2017	Male	Female	Male	Female
Higher Education	15.9	18.2	10.5	13.3
Secondary	12.5	16.6	6.4	10.0
Primary	10.8	10.6	10.5	12.0
None/Incomplete education or don't know	60.8	54.6	72.7	64.7
Wealth quintiles				
Lowest	38.1		70.6	
Second	25.4		20.4	
Middle	17.8		6.7	
Fourth	10.6		2.1	
Highest	8.1		0.7	

Source: NDHS 2017 (PSA)

Therefore, it can be inferred that the low demand for FP programs by married women with 44% and sexually active unmarried women with 25.7% in BARMM was due to the lack of SRH information or motivation (Table 4). Hence, it led to the low modern contraceptive prevalence rate of 18.7% and 15.3%, respectively (Table 5). In comparison to the demand of SOCCSKSARGEN and the rest of the regions, whereas SOCCSKSARGEN accounted higher with 76.3 for married women and 53.9% for unmarried women, even recording SOCCSKSARGEN as the second highest demand for FP among married women and third highest among unmarried women (Table 4). Therefore, translating a high modern contraceptive prevalence rate of 50.8 in 2017. On the other hand, the overall range for demand among married and unmarried women from the rest of the regions were each at 65.2% to 77% range. Overall, this illustrates the lowest demand position of BARMM when compared with SOCCSKSARGEN and the rest of the regions. As a result, it led to the low utilization FP programs and/or modern contraceptives, therefore, leaving most communities to rely on traditional types of contraception.

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Table 4. Demand for FP among sexually active women of age 15-49, as of 2017

	Population of Region XII – SOCCSKSARGEN	Population of the BARMM
2017		
Married Women	76.3	44.0
Unmarried Women	53.9	25.7

Source: NDHS 2017 (PSA)

Table 5. Contraceptive Utilization among married women age 15-49

	Population of Region XII – SOCCSKSARGEN	Population of the BARMM
2017		
Traditional method	8.0	7.6
Modern method	50.8	18.7
Not currently using any type of contraception	41.1	73.7
2013		
Traditional method	13.3	8.6
Modern method	44.2	15.3
Not currently using FP	42.5	76.1
2008		
Traditional method	13.7	5.2
Modern method	41.4	9.9
Not currently using any type of contraception	44.9	84.9

Source: NDHS 2008, 2013 and 2017 (PSA)

Though, the effects of religion and sociocultural aspects may also have contributed to the low demand and utilization. These barriers could be reflected in the TFR of each region, where it can indicate the gravity of sexual behaviors among individuals. To reiterate, pre-marital sex in the Philippines has been stigmatized due to the religious beliefs, namely Islamic and Christian religions. Therefore, promoting a "purity" culture that promotes abstinence-based behaviors before marriage and importance of preserving one's virginity. In assessing the weight of these two barriers, it necessary to study the attitudes and beliefs of the youths as it can automatically reveal the type of community they belong. In this instance, the high TFR of SOCCSKSARGEN was due to high teenage childbearing with 14.5 that was the third highest in the country, whereas BARMM had only 8.5 in 2017 (Table 6). According to the 2013 Youth Adult Fertility and Sexuality Study in the Philippines or (YAFS4 2013), "premarital first sex" among male and female youth of 15-24 years old is more prevalent in SOCCSKSARGEN than BARMM. In which SOCCSKSARGEN had 25.2% for male and 20.6% for female, whereas BARMM scored lowest with 6.2% and 7.1%, respectively. With regards to "sexual initiation" in general, BARMM was recorded the lowest with only 15.6%, while SOCCSKSARGEN with 20.2% and highest was at 30.6% (DRDF Inc. 2013). There are two ways to describe the low figure for BARMM, a.) it may be due to the common practice of early marriage among most adolescent

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and b.) the youth practice the social norms of "purity" culture. As mentioned, early marriage exists in Filipino Muslims communities, to illustrate, "marital first sex" in BARMM was recorded highest with 20.9% for male and 31.4% for female when compared with SOCCSKSARGEN and the rest of the region, while SOCCSKSARGEN was only at 3.4% and 16.5%, respectively. In terms of social norms, the BARMM youths of age 15-24 were the strongest supporters for traditional values among other Filipino youths, which were also remained supportive but not overwhelmingly. The BARMM youth have remained supportive of the following sociocultural views: a.) traditional beliefs and values on the importance of virginity, b.) the unacceptability of premarital sex, and c.) the need to marry when confronted with premarital pregnancy (DRDF Inc. 2013). Henceforth, the youths in BARMM are more likely to follow an abstinence-base type behavior in the duration of their adolescent life or until marriage. This may not be according the SRH behavior under the IMB model since SRH motivation and knowledge are somewhat based on the sexual abstinence in the region.

Table 6. Adolescent Fertility

	Population of Region XII – SOCCSKSARGEN	**Population of the BARMM[2]**
Percentage who have begun childbearing of women age 15-19, as of 2017	14.5	8.5
Sexual Initiation of Adolescents aged 15-24, as of 2013	20.2	15.6

Source: NDHS 2017

In this case, it seems the high modern contraceptive prevalence rate and TFR in SOCCSKSARGEN can only mean that youth SRH behavior may be paving away from abstinence-type. This means sexual engagements are becoming prevalent due to less importance given to virginity or high acceptance of modern contraceptives, which are usually both affected by religious and sociocultural aspects. It is probable that the high modern contraceptive prevalence rate (75.63%) is contributed from the proper SRH information and motivation variable disseminated. Although, it may need supplementation as the TFR, including teenage fertility, are both estimated to be high in the country (Philippine Statistics Authority 2017a). It is also likely that educational attainment and wealth quintile has allowed more access to SRH information that have develop SRH motivation and behavior.

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5. Conclusion

In conclusion, the process of SRH policy may have varying outcomes when equating the policy process and barriers to contraceptive utilization (i.e., economical, sociocultural and religious aspects). The policy process is required to set the foundation for the distribution and access of SRH services of the targeted region. This phase allows the formulation SRH policy that are supposedly adjusted to the preferential characteristics of the population for social acceptance and utilization. Therefore, highlighting that political willingness is an important factor for policy success, especially during the implementation stages of the SRH policy. Moreover, the policy approach is also equally vital. For instance, the apporach must be a rights-based type as it is more inclusive of SRHR, and it simplifies the integration of SRH policy in societies (i.e., preference). In this case, the rights-based approach may tackle the barriers mentioned, such as the sociocultural aspect that may neglect certain groups (e.g., homosexuals, unmarried). Yet, the rights-based approach may be overshadowed by the "social preferences" of certain societies. Therefore, unable to include stigmatized groups. This illustrates the severity of the barriers to contraception as it may still effectively disrupt the effectiveness of SRH policy, therefore, leading to misconceptions and disregard of the opportunities under the SRH services. At the same time, it may also transform the legal aspects that could be excluding certain groups. For example, the low-income homosexual adolescent groups may not be able to access government SRH services due to limited capacity and stigmatization. The influential extent of these barriers leads the lowering of demand and dislike for SRH policy. As a result, leading to an SRH behavior that will ignore SRH services, therefore, making SRH policies ineffective.

The empirical analysis shows that the barriers of contraception severely influenced the SRH policy in the Philippines. It is obvious when studying both the RPRH law and the Philippine societies. The political engagement of the Catholic church almost declined the formulation and passing of the RPRH law, and even during the implementation process it was constantly disrupted. This was caused by the sociocultural and religious aspect in the Philippines. The legal framework of the RPRH law shows that it has been heavily influenced by these aspects, as it is reflected under its provisions. This evident with the inclusion of parent consent for unmarried adolescents aged 15-19 in availing SRH services and the focus on abstinence-based curriculum. Educational attainment and income have also been constant barriers since SRH information and motivation becomes lower as the former and latter also declines. This means that misconceptions and misinformation about SRH services may arise and income limitations may affect contraceptive choices if modern contraceptive are inaccessible or expensive. In that

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case, same patterns can be found in comparative analysis between BARMM and SOCCSKSARGEN. The analysis found that BARMM having the lowest variables regarding educational attainment and wealth quintile, and while expressing high importance on social and religious norms have resulted to the lowest utilizer of SRH services under the RPRH law; whereas SOCCSKSARGEN had opposite results that had a higher utilization of SRH services, especially to modern contraceptives. This may only mean that BARMM's communities are reluctant in availing SRH services which reflects an SRH behavior that is against the utilization of contraceptives, especially modern contraceptives. Even though the Muslim code does not prohibit the usage of SRH services and products, the communities seemed to be still skeptical either due to the lack of adequate SRH information or it is counter to their social norms. On the other hand, SOCCSKSARGEN being higher than BARMM and second highest in the Philippines suggest that the barriers of contraceptive utilization are adequately being overcome. However, the high TFR indicates that more effort must be put in improving the three components under the IMB model that forms a healthy SRH behavior: SRH information, motivation and behavior skills.

The findings show that the Philippines' SRH policy is still facing the mentioned barriers that can result to the stagnation of the implementation and it may even be counterintuitive. Even if there's been a positive increase in the modern contraceptive prevalence rate in some regions like SOCCSKSARGEN, this could have been further doubled if the RPRH law was not so limiting. For example, the elimination of parental consent and the refocusing of the SRH curriculum to contraceptive utilization may have contributed. In effect, it may also have increased in BARMM. Overcoming these barriers must be based on the IMB model of SRH behavior where it could be the foundation for a responsible SRH behavior that would avoid unwanted pregnancies, STDs and HIVs. It is understandable that culture and religion will still be important among Filipino communities, however, the inclusion of relevant SRH information and the development of SRH motivation and SRH behavioral skills can be the start-up of a healthier SRH behavior.

However, older generation may find it hard to accept due to the instilled normative values. Thus, SRH policy in the Philippines must focus on the youth to develop a new SRH behavior that can be instilled to further generations. With the current technological era, I can deduce that future adolescent generations will be often exposed to sexual contents that may instigate sexual interactions and enable communication with random individuals to plan and engage the sexual

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activity. Therefore, the SRH behaviors must be enhanced to have proper reactions (e.g., using condoms, thinking of the consequences).

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