
Assessing beyond Politics: A Review on the Implementation of RH Law in Eastern Samar, Philippines

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ABSTRACT

This research documented individual and/or systemic accounts of acts or omissions, structures, policies or practices which result to denial of, and serve as barriers in accessing reproductive health services in the rural-poor province of Eastern Samar, Philippines. Using a thematic analysis, findings revealed that barangay health workers are not regularly given allowance and under threat of politicking and termination; FP and RH services are affected by natural hazards, lack of supply, facilities and equipment, and needs to be intensified and strategically disseminated; young pregnant women refuse to undergo pre & post-natal services, experienced difficulty in accessing PhilHealth services and are sometimes monetarily charged in availing FP and RH services; barangay health services and stations need more budget allocation; and lack of medical personnel giving satisfactory services. There is much to do to improve the RH Law implementation in the ground and local leaders play an active and crucial role in the efficiency and effectiveness of this legislation.

Keywords: *reproductive health, Philippines; assessment; women; sexual health*

INTRODUCTION

Study on reproductive health rights reveals a wide range of socio-economic and demographic factors which affect women's empowerment, education and reproductive health rights (Hossain et al., 2010). Many other social, racial, political and institutional dimensions feed on each other, and together block hope for progress among people on the margins. Two critical dimensions are gender inequality, and inequalities in realizing sexual and reproductive health and rights; the latter, in particular, still receives inadequate attention. Neither explains the totality of inequality in the world today, but both are essential pieces that demand much more action. Without such action, many women and girls will remain caught in a vicious cycle of poverty, diminished capabilities, unfulfilled human rights and unrealized potential (UNFPA, 2017).

The country's decentralized form of government also means that the responsibility of imposing any legislation put in place by Duterte's administration lies with local government actors (Lasco, 2017). The most vulnerable members of society who are most in need of access to services, a goal which would require \$10 per women per year to reach the poorest 60% of women in the country is not achievable with the current budget despite increases in funds since the executive order came into effect (Cabral, 2018).

Given these dilemmas, this qualitative study examined the effectiveness and implementation of the Magna Carta of Women and Reproductive Health Law in the rural-poor province of Eastern Samar, Philippines and presents data on major issues of RH Law implementation in the province. The author documented individual and/or systemic accounts of acts or omissions, structures, policies or practices which result to denial of, and serve as barriers in accessing reproductive health services.

RELATED LITERATURE

For purposes of this paper, sexual and reproductive health rights (SRHR) will be defined by two key concepts: the right to make decisions on reproduction and sexuality free from discrimination, coercion and violence; and the right to the highest standard of sexual and reproductive health (RH). The concepts are derived from paragraph 7.3 of the International Conference on Population and Development's Programme of Action (UN, 1994) and paragraph 96 of the Beijing Platform for Action (UN, 1995).

The Philippines is signatory to many human rights instruments that are the basis of sexual and reproductive rights, such as the International Covenant on Civil and Political Rights; the International Covenant on Economic, Social and Cultural Rights; the Convention on the Elimination of all Forms of Discrimination Against Women; the Convention on the Rights of the Child; the International Conference on Population and Development Programme of Action; the World Conference of Women Platform for Action; and the UN General Assembly Special Session's Declaration of Commitment on HIV/AIDS (CHR, n.d.; Parmanand, 2014). The UN Development Programme in 2010 assessed that gender equality in the Philippines was "well advanced" with over a hundred laws on women and women's rights (PCW, n.d.).

Among the internationally agreed human rights central to human well-being is the right to sexual and reproductive health. This right was endorsed by 179 governments in the 1994 Program of Action of the International Conference on Population and Development. The Program of Action stated that individual rights and dignity—including the equal rights of women and girls, and universal access to sexual and reproductive health and rights—are necessary for the achievement of sustainable development (UNFPA, 2004 & 2017).

Rumblings of reproductive health policy were first heard in the government with the establishment of a population commission back in the 1960s as a measure of population control to manage high fertility rates and alleviate poverty. Ever since, backlash from the Catholic Bishops' Conference of the Philippines (CBCP) has been unrelenting.

One of the biggest obstacles to sexual and reproductive health rights in the Philippines is the Catholic hierarchy and its doctrines against abortion, contraception, divorce, adolescent sexuality, and LGBT rights (Dacanay, 2013; Melgar et al., 2014). The Responsible Parenthood and Reproductive Health Act, commonly RPRH or RH Law for short, was passed in 2012 – 14 years after a first version of the bill was presented to congress under belligerent opposition campaigns from the CBCP. The act mandated that contraceptives be made available for free and that information about family planning be made easily accessible at public hospitals.

The Law has three focal concerns: maternal and newborn health care, family planning and adolescent reproductive health education (Secs. 5-9 & 14). However, due to religious objections,

the RH Law contains provisions that hamper universal access to RH services. Among others, these are: the stringent criterion that contraceptive action must not involve the “prevention of the fertilized ovum to reach and be implanted in the mother’s womb”; the wide latitude to providers, including religious and private hospitals, to refuse to provide and refer non-emergency RH services on grounds of “conscientious objection”; the prohibition of minors to access FP services from public facilities; the exclusion of emergency contraceptive pills from government procurement, distribution and use; and the non-punishment of providers who insist on spousal consent for RH services or parental consent in the case of children victims of parental abuse. Given the newness of the law and the mixed entitlements and restrictions, it is important to popularize its key contents and implications, and to actively involve SRR advocates and other citizens in the monitoring and implementation of the law. As for the restrictive aspects of the law, strategies for correcting these must be studied and undertaken. Efforts must also be undertaken to address the actions of the opposition (Melgar et al., 2014).

RESEARCH LOCALE

The research was conducted in three municipalities of Eastern Samar with a total of 36 respondents from barangay Sto. Nino, Quinapondan; barangays Paya, Gigoso and Poblacion 7, Giporlos; and barangay San Miguel, Balangiga. The respondents’ age ranged from 18 – 70 years old of whom 10 are barangay health workers, 8 uses implanon contraceptive and the rest use a mix of natural and artificial family planning methods.

The percentage of family poverty incidence in 2015 is 37.4% or a total of 37,919 poor families in Eastern Samar. Pulling Eastern Samar down is its very low income index score of only 0.095. The HDI is a summary measure for assessing long-term progress in three basic dimensions of human development: a long and healthy life, access to knowledge and a decent standard of living (UNDP, 2018). On the other hand, the proportion of women in the province is 48% from the total population of 465,426 (PSA, 2015).

The province of Eastern Samar is located in a region which is prone to natural hazards (NEDA, 2018). Super typhoon Haiyan, locally known as Yolanda, devastated Eastern Samar in 2013 resulting in death and property casualties and disrupting the provision of health services due to the destruction of health facilities in the area.

METHODOLOGY

Anchored on a qualitative research design, this case study gathered primary data using FGDs, key informant and household interviews as well as inputs of key stakeholders from various government agencies during the Public Consultation held by the Commission of Human Rights in August 2016. The information were supplemented by secondary data from official government reports obtained through desk research. Particularly, the Third Annual Report on the Implementation of the Responsible Parenthood and Reproductive Health Act of 2012 served as the main document through which secondary data on RH was obtained.

On the other hand, raw data generated by the author together with the help of representatives from the Gender Equality and Women’s Human Rights’ Center (GEWHRC), investigators and lawyers from CHR Region 8 and UNFPA were coded, organized and analyzed by the author and

was used as primary data from Eastern Samar. The field work included ocular inspection of selected municipal/ barangay health centers, interview with states and non-state reproductive health services providers and visit to specific communities to inquire into the enjoyment of the right to reproductive health as provided by the RPRH Law.

Using a content analysis, data were presented from the national level vis-à-vis provincial/local level. Content analysis is applied in qualitative, quantitative, and sometimes mixed modes of research frameworks and employs a wide range of analytical techniques to generate findings and put them into context. Content analysis was utilized because it is a systematic, rigorous approach to analyzing documents obtained or generated in the course of research (White, M. & Marsh, E., 2006; Downe- Wamboldt, 2009; and Hsieh and Shannon, 2005).

FINDINGS AND DISCUSSIONS

A total of 36 informants participated who came from 5 barangays of the aforementioned municipalities. For purposes of standard monetary conversion, 50.00 Philippine Pesos (PHP) is equal to 1.00 US Dollars. Overall, majority of the respondents feel contented with the reproductive health and family planning services that they avail in their Barangay Health Stations and Clinics/Centers. Contraceptive medicines and devices are available such as pills, condoms, IUDs, and implanon, of which pills remain the most in demand contraceptive. All women informants concurred that the customer's satisfaction of any kind of contraceptives is a cases-to-case basis or what they call '*depende kung saanhiyang*'. Every women has to find the right contraceptive services which favor their health and is comfortable to use.

After the onslaught of typhoon Haiyan, the UNFPA distributed RH and hygiene kits and medicines. BHWs and other women in the community are actively involved in the Gender Based Violence Watch Group trainings, a project of the UNFPA and DSWD. Lastly, local ordinances prohibiting childbirth delivery in houses are implemented.

However, even if most RH and FP services can be accessed for free by the residents there are still issues concerning the proper and holistic implementation of the RH Law. Below are the major issues generated from the informants;

a. Zero to Lack of Allowance/Stipend for Barangay Health Workers: Primary health care is participatory and focuses on empowering the community and making people capable of helping themselves. BHWs voluntarily act as health educators, community organizers, and primary health care providers in their local communities. However, there is little to no allowance or stipend given to the barangay health workers. In one of the barangays the allowance of BHWs go as low as PHP90 (USD1.80)/month with the highest at PHP600 (USD12.00)/month. There is also unevenness in terms of BLGU counterpart for the BHW allowance because some LGUs provide monetary counterpart while some do not. Also, not all BHWs receive stipends. New BHWs do not receive such allowance. An informant shared that they sometimes receive their allowance quarterly which is often times delayed.

"Diri kami tananngan BHW nakakakarawat hit sweldo. An mga bag-o palawaray pa kami sweldo. Tapos tag PHP250.00 (USD5.00) la it amon allowance kada month. Maguol man it pagiging BHW pero kay asya man ito tam trabaho."

(BHWs do not receive any salaries. The newly-hired BHWs are yet to receive any allowance of only PHP250.00 (USD5.00) per month. Being a barangay health worker is very tiring but we cannot do anything about it because it is our job.)

b. Hospital's Refusal of Patients: According to UNFPA (2017), in many developing countries, women who are poor, in the bottom 20 per cent of the income scale, and particularly those who are in rural areas, are far less likely to have access to contraceptives and to care during pregnancy and birth than their wealthier urban counterparts. There were accounts of women refused in admission/check up by a public hospital in Eastern Samar because they come from another municipality. There was a case where a mother was refused a consultation services for his kid (>1 yr. old) because by the time they arrived at the hospital it was already 3 o'clock in the afternoon. They were then referred to a community clinic which was smaller and has less facilities and personnel. The declined patient was forced to go home and endured the severe cough with over-the-counter medicines as remedies. The travel time from the house of the patient to the said public hospital is 20-30 minutes with travel costs ranging from PHP50 (USD1.00)-PHP100 (USD2.00).

"Waraytalaganiramgakonsiderasyon ha amon. Nagtitinuoknalaako kay naluluoytalagaakohanakanak."

(They really didn't care about us. I was just crying hard because I really pitied my child that time.)

An informant shared that most often than not, the reason why hospitals refused patients, especially those pregnant and nearing their delivery date, is because the hospital do not have the records or medical history of the patient since they do not originate from the place.

c. Natural Disasters affect the provision of Family Planning services in Barangay Health Stations: All of the women interviewed attested that natural disasters like that of typhoon Yolanda not only affected their properties but also affected the provision of health services, including that of Reproductive Health in their communities. Majority of the health care buildings were destroyed during the onslaught of typhoons *Yolanda*, *Ruby* and *Seniang*. The stocks of medical facilities including contraceptives were damaged. Some informants shared that because of this, some who have the capacity opted to just buy in their local pharmacy while those who can't afford live in a situation where they feel fearful of unexpected and undesired pregnancy.

"Han pagbagyo, tanannganamonmga supplies dinhi ha center puronagkahuhulosngannagkaguguba."

(When the typhoon hit, all of our supplies here in the health center got soaked and destroyed.)

d. Lack of proper and adequate info dissemination to citizens regarding FP and RH services: The author was able to interview women who've had contraceptive implants after the onslaught of typhoon Yolanda. While there were women who said that they are '*hiyang*' or satisfied/favoring their usage of "implanon", there were women who opted to extract the implant because they experienced headaches, hunger, nausea, and cease of menstrual flow. It was found that these women do not entirely know the possible side-effects of this contraceptives. They were only introduced to the product but did not undergo a seminar of its effects and possible conditions thereby perpetuating a feeling of uncertainty and unease to the lives of these women.

At least two women shared that they wanted to have their implanon removed because of the rumors or gossips that they are hearing from other women in the community. Making information and services more widely available and accessible will lead to better reproductive health outcomes (UNFPA, 2017).

e. Women are financially charged in availing FP and RH services: Because of the not-so-good effects experienced by an informant, she decided to extract the *implanon* from her body. However, she was charged in doing so. The informant shared that she went to a public hospital in one of the municipalities to ask for help in extracting the *implanon* from her body. Upon doing so, she paid PHP1500. She said that when she got the *implanon* it was free but when she decided to remove it, the fee was expensive.

There was also an informant who shared that there was a time after Yolanda where she went to the Rural Health Unit to avail of contraceptive pills but she was asked to pay PHP10.00 (USD0.20)-PHP20.00 (USD0.40). This payment is mainstreamed as ‘donations’ to the RHU or BHS. Even though these women go to the clinic with the intention of getting free pills, because of this so-called ‘donation’ some become hesitant in getting the pills basically because they don’t have the money to ‘donate’ for it.

This should be addressed because access to family planning services is a foundational element, not just of reproductive health, but of social and economic equality, since unintended pregnancy constrains opportunities that women would otherwise have for education, civic participation and economic advancement (UNFPA, 2017).

f. There is a need to include and actively engage the men in the RH and FP agenda: Most men in the locality do not know the importance of proper family planning and RH services and the benefits they and their families can gain from it. This causes a one-sided effort in maintaining good RH services usage in the community. An informant shared that there is a strong need to engage men, together with their partners in advocacy activities and information dissemination seminars. The men in the community need to understand the reproductive cycle of their wives so as to have mutual understandings in whatever family planning and reproductive health services they want to avail.

g. Lack of Family Planning and Reproductive Health Supplies, Facilities and Equipment: BHW informants shared that their BHS is experiencing a scarcity of RH and FP medicines. Though they received FP and RH medicines, like pills, from UNFPA after typhoon Yolanda, these supplies are not replenished. The Department of Health through the Municipal Health Office is yet to give them new supplies. These BHWs are fearful that the stock they have is only good for a month at most. Another informant shared that it is difficult for them to refer pregnant mothers who are at risk for critical childbirth delivery because they do not have a community-owned health transportation vehicle and they live in the outskirts of town. The road is bumpy and communication services is difficult to find. These at-risk pregnant mothers were forced to deliver in the BHS with insufficient facilities and skilled personnel who can deal with critical and life-and-death birthing situation.

h. Lack of Medical Personnel: Births assisted by skilled attendants, such as midwives, are a mark of access to reproductive health care and a recommendation of the World Health

Organization for all births (UNFPA, 2017). An informant accentuated that their municipality has insufficient medical personnel, i.e. community doctor. For example, one municipality with over 30 barangays, excluding 'sitios' or far flung villages, only has one community doctor. This doctor is only available during weekdays and is often out because of various trainings and seminar he/she attends to. This becomes a problem because every day, at least one pregnant woman is in a risky delivery situation. Moreover, community nurses cannot regularly visit all of the barangays because of its overwhelming number. These personnel could only do so much and is in need of help to lessen the load or number of barangays assigned to them.

- i. Low Budgetary Allocation to Barangay Health Services:** There is a strong need to engage the local political officials, especially in the barangay, in mainstreaming the importance of the proper implementation of the RPRH Law and put it in the budget allocation and priority projects of their barangay.
- j. Difficulty in Accessing PhilHealth Services especially to Young Pregnant Mothers:** There was a respondent who shared that when she was about to give birth, it became difficult for her to avail the PhilHealth services because she was under aged during the time.
- k. No Incentives for the Referral System:** A BHW worker in Balangiga shared that they do not have or do not know any policy giving incentives to anyone referring a pregnant woman to deliver in a birthing facility. She has been a BHW for over 30 years and a 'manghihilot' in the past. However, when the law declared that mother delivering babies at home will be penalized, she stopped her 'hilot' services and refer the mothers to the clinic herself.
- l. Usage of theimplanon despite the TRO:** There are still women who use the *implanon* contraceptives even if the Supreme Court has issued a Temporary Restraining Order (TOR) against the drug. The BHWs and other BHS personnel have no knowledge about the TRO. The BHW shared that there was even a time where the community doctor administered the implant him/herself.
- m. Refusal of some women in availing Pre- and Post-Natal Services:** According to a midwife in one of the municipalities, the common cause why there is still the presence of childbirth mortality is because some women consciously refuse in visiting BHS and hospitals to avail pre- and post-natal services. Aside from cases where some women are in critical situation because of serious illness or health condition prior to pregnancy, some women opt to go to the hospital in the last instance thereby putting their and their baby's situation at risk.
- n. Unsatisfactory Customer-Service Delivery of Medical Personnel:** An informant shared that in some cases, women chose not to go to the BHS or community hospitals because of the oftentimes rude and insensitive customerservice they receive from some medical personnel. Some women experienced verbal abuse and mistreatment from these personnel and influencing women instead opt to go to 'manghihilots' or native masseur/healer to avail the indigenous natal care services.

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- o. Politicking and Termination BHWs:** An informant shared that the political situations in their community affect the survival of BHWs. She said that when the elected barangay officials do not like the BHW or was not on his/her party during election, this official expels the trained BHW and assigns a new one. This affects the service delivery of BHWs in the community because the skilled and knowledgeable ones are fired and new ones who are untrained and inexperienced conduct family planning seminars and other services, thereby, giving insufficient information and unsatisfactory services to the locales.

CONCLUSIONS AND RECOMMENDATIONS

Overall, the FP and RH services are present and available for everyone in the municipalities of Balangiga, Giporlos and Quinapondan, Eastern Samar. Examples of these are contraceptive medicines and devices like IUDs, condoms, injectable, *implanon*, and pills which is the most in demand. Health examinations and interviews as well as counselling with the clients are done before prescribing any medication. The data generated in Eastern Samar, informants in revealed that satisfaction on any contraceptives is a cases-to-case basis or “*depende kung saan ‘hiyang’ angbabae*”.

In the policy arena, there is no policy crafted and promulgated prohibiting the disbursement and procurement of FP and RH services in its respective clinics, BHS, medical facilities and even the local pharmacies. These RH and FP medicines are catered with family planning programs, counselling and pre- and post-natal care seminars like the encouragement of breastfeeding, immunizations and vaccines. On the other hand, as reflective on the report of Jimenez-David (2014), LGBT rights have yet to find support in our legislature, despite bills that have been filed in the Congress, while the right of minors or young people below the age of 18 to access RH services without parental permission or knowledge was denied by the Supreme Court in its decision on the RH Law. For better planning and implementation, the DOH must also develop a map or directory of RH providers in a given area that should be made available to the public. an important role in the implementation of the RH Law is the public health insurance system, through PhilHealth, since it will enable patients or clients seeking RH services to access these services with little worry or trepidation.

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