Economic And Psychosocial Influences of Family Planning on the Lives of Women in Western Visayas

Final Report

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TABLE OF CONTENTS

LIST OF TABLES

TABLE NO. **PAGE**

PAGE

PAGE

LIST OF ACRONYMS

BBT	Basal Body Temperature
BHS	Barangay Health Station
BHW	Barangay Health Worker
BSPO	Barangay Service Point Officer
BNS	Barangay Nutrition Scholar
CBD	Community Based Distributor
CPR	Contraceptive Prevalence Rate
CPU	Central Philippines University
CU	Current Users
DMPA	Depot – medroxyprogesterone acetate
DSWD	Department of Social Welfare and Development
DOJ	Department of Justice
DOH	Department of Health
FHI	Family Health International
FGD'S	Focus Group Discussions
FP	Family Planning
FPOP	Family Planning Organization of the Philippines
IAC	In-country Advisory Committee
IMABP	Iloilo Multisectoral Alliance – Bantay Panimalay
ISSA	Institute of Social Studies and Action
IUD	Intrauterine Device
- LAM	Lactational Ammenorrhea Method

LGU	Local Government Unit
LPP	Local Performance Program
MCH	Maternal and Child Health
MWRA	Married Women of reproductive Age
NAWASA	National Water Severage Authority
NFP	Natural Family Planning
NGO	Non – Government Organization
NDS	National Demographic Survey
NSCB	National Statistical Coordination Board
NSO	National Statistics Office
OM	Ovulation Method
PCF	Population Center Foundation
PO	Private Organization
POPCOM	Population Commission
PMA	Philippine Medical Association
PNA	Philippine Nursing Association
PNP	Philippine National Police
PTA	Parent Teacher Association
PU	Previous Users
RHU	Rural Health Unit
RHM	Rural Health Midwife
RHP	Rural Health Physician
RHN	Rural Health Nurse

SES	Socioeconomic Status
SPSS	Statistical Package for Social Sciences
SSRI	Social Science Research Institute
STD'S	Sexually Transmitted Disease
TFR	Total Fertility Rate
USAID	United States Agency for International Development
WHO	World Health Organization
WRC	Women's Resource Center
WSP	Women's Studies Project
YMCA	Young Women's Christian Association

CHAPTER I

INTRODUCTION AND STUDY OBJECTIVES

Background and Rationale of the Study

As in many developing countries, the initial family planning initiatives in the Philippines have been concentrated on addressing the country's rapid population growth. In the 1970s the country's population was growing at a rate of 3.08 percent annually (NSO, 1990) and the total fertility rate (TFR) was recorded at six children per woman (NDS 1993). Since this demographic situation has been viewed as one of the major causes of the country's poverty and slow economic development, most family planning programs in the 1970s focused on fertility reduction. To attain this program objective, contraceptive use was aggressively promoted through the provision of free or subsidized family planning services, including family planning counseling and information, clinical services, contraceptive supplies, and motivation.

In the last two decades, the total fertility rate in the country has declined from 6.0 in the 1970s to 5.0 in the 1980s and to 4.1 in 1990s. Correspondingly, population growth rate has also decreased, although slowly, from 3.08 percent in 1970 to 2.75 percent in 1980 to 2.3 percent in 1990 (NDS, 1993). The changes in the country's demographic trends were accompanied by changes in population policies and family planning program thrusts and strategies. The 1980s saw the entry of expanded family planning programs that addressed not only fertility reduction, but also the improvement of the health and welfare of the family planning target beneficiary, the woman and her family.

Given the focus of early family programs in developing countries in the 1970s and 1980s most family planning research in these areas examined the woman's fertility behavior and patterns of contraceptive use and the correlates of or factors that influence these two variables. Despite the shift in the thrust of more recent family planning programs to the improvement of the health and welfare of the family planning users, research conducted through the 1980s and even in the early 1990s continued to search for explanations for the low prevalence of contraceptive use.

A review of the findings of two decades of family planning research by Ross and Frankenberg (1993) confirms the predominance of research on fertility and contraception during this period. In the Philippines, the same issues have been the focus of many family planning studies as revealed in the Annotated Bibliography of Philippine Population Literature published by the Population Center Foundation (PCF) in 1984.

Most evaluation studies of family planning interventions during this period examined family planning acceptance and practice as determinants of intervention effectiveness. Studies of the effect of family planning on the lives of the women, if any, are still very limited. Although most family planning promotion strategies emphasize the social and economic advantages and benefits of family planning to the woman and her family and promise better quality of life to the users, especially the woman, little has been done to find out whether these benefits have truly been realized.

The gradual increase in the prevalence of contraceptive use from 17 percent in the 1970s (NDS, 1973) to 40 percent in the 1990s (NDS, 1993) and the declining fertility may be viewed as indications of success of the country's family planning programs. With the practice of family planning, the users may have successfully avoided unwanted pregnancies, spaced their pregnancies or births and thus, had only as many children as they thought they could afford. When these results are achieved, one question still remains, however: " Has the practice of family planning really led to the enhancement of the users', particularly the women's, quality of life?"

Systematic investigations to answer the above questions are few. Conception (1995) reported that in the Philippines, very few studies have been conducted on the impact of family planning on the lives of women. Most of the earlier attempts have looked only into the health impacts of family planning, particularly on the health of the mother and/or the child. The 1993 National Demographic Survey (NDS, 1993) provided some data on the health impact of contraceptive use. Ross and Frankenberg's (1993) review of family planning research, done mostly in developing countries in the last two decades, reported findings on relationships between contraception and health, which corroborate the NDS findings. Other studies with objectives, other than to determine the impact of family planning on women's lives, have also shown some specific family planning consequences on the lives of women, but these findings are not usually highlighted because these consequences were not the main concern of the studies (Alcantara, 1990; Domingo, Raymundo and Cabigon, 1994).

It will also be noted that many of the studies, which revealed some impact of family planning on health and other aspects of the woman's life, were conducted for reasons other than determining family planning impact. Most of the available studies on family planning impact were conducted in other developing countries (Ross and Frankenberg, 1993). On the other hand, many of the Philippine studies in this area were either part of a bigger study or based on secondary analysis of data from big national surveys, like the 1990 Census on Population and Housing of the NSO and the 1993 NDS, which were conducted for other purposes. So far, the impact of family planning on women's lives has often been analyzed using proxy indicators, based only on whatever data are available.

To gain support for a family planning program in a country, its advocates should demonstrate the program's consequences on the lives of the beneficiaries. There is no reason for continuing an intervention if its objectives are not being realized, and the best way to determine this is through empirical study. Results of such studies must be available to program managers and service providers, as well as the beneficiaries so that they can use the data for their own specific purposes. The program managers can use these data in program planning and implementation, especially in setting directions and in developing more effective strategies for program implementation. Service providers need data to guide them in improving service delivery. From the findings of this study, beneficiaries of the family planning program can learn from the experiences of others.

With limited information on the impact of family planning practice on women's lives, it is not yet clear whether or not family planning practice has really benefited the women socially or economically. Although the decline in fertility has been found to be associated with reduced health risks for the mothers and their children, it is not clear whether decline, which is assumed as partly due to family planning practice, has really improved the woman's quality of life. The desire to shed light on this issue impelled the proponents to conduct this study.

The basic question that this study addresses is has family planning practice improved the quality of life of the women acceptors? If so, in what aspects are the improvements experienced or felt and to what extent? Improved quality of life in this study is examined in terms of economic (gainful occupation); social (education, training, and community participation); and psychological (life satisfaction, self-esteem and Decision-making participation) aspects.

Objectives of the Study

This study was conducted by the Social Science Research Institute (SSRI), Central Philippine University, in collaboration with the Women's Resource Center (WRC), between 1995 and 1997 in order to determine the association between family planning use and various aspects of the lives of married women of reproductive age (MWRA) of Western Visayas. More specifically, the study aimed to:

1. describe the association of family planning practice with selected economic characteristics of the women, such as their work status, type of work they were engaged in and gainful work participation between pregnancies;

2. describe the association between family planning use and selected social characteristics of women, such as education and training, and participation in social organizations and community activities;

3. describe the association between family planning use and selected psychological characteristics of women, such as satisfaction with life, perceived self esteem and Decision-making participation;

4. describe women's and men's perceptions about how family planning has improved women's lives with respect to selected characteristics of family planning experience and use; and

5. describe the incidence of domestic violence among the women and certain factors associated with their experience with violence.

Research Hypothesis

The following hypotheses were tested in this study:

1. Family planning practice is associated with the women's educational achievement and attendance in training after marriage.

2. Family planning practice is associated with the women's employment status and nature of work.

3. Family planning practice is associated with the women's extent of participation in community organization/activities.

4. Family planning practice is associated with the women's satisfaction with life.

5. Family planning practice is associated with the women's participation in Decision-making.

Theoretical and Conceptual Framework

The benefits of family planning, especially to women and their families, have been used to justify the need for its promotion and practice. It has been argued that family planning practice can affect various aspects of women's lives, among them are her health, economic and social conditions, and her personal autonomy (psychological). Since the health benefits of family planning have been adequately documented (Committee on Population, 1989), only the economic and social and psychological benefits of family planning are addressed by this study.

The economic benefits women can derive from family planning may be in terms of labor participation or employment. Although family planning may not automatically or directly provide women work and income, its effects on the childbearing experiences of the woman may enhance her employment opportunities and chances of promotion. In societies where women generally forsake the labor market in favor of childbearing and child rearing responsibilities, women are often times discriminated against in the employment sector. Hong and Seltzer (1994) posit that if women can postpone or space childbearing, their chances of getting employed and of being promoted can be improved.

Podhista, et. al. (1991) explained that even in some societies where female employment is socially encouraged, many women still could not work because "working and mothering are incompatible". Because of expensive childcare, instead of hiring baby sitters, women quit work to do full-time "mothering." In this regard, women who are able to successfully space their pregnancies may enjoy a significant advantage over those who have frequent childbearing.

In the social context, family planning practice can be expected to contribute favorably to the enhancement of a woman's social life. The social benefit of family planning on women may be realized through the "acquisition of knowledge and skills" (Hong and Seltzer, 1994). When a woman is able to control the timing and number of births through family planning, she may also be able to get additional education and/or training. Those who married early and/or those whose schooling may have been aborted by marriage or childbearing can go back to school after marriage or between child births, if they postpone or space child birth. Consequently, spaced and/or limited number of pregnancies will give women more opportunities to participate in social or community activities.

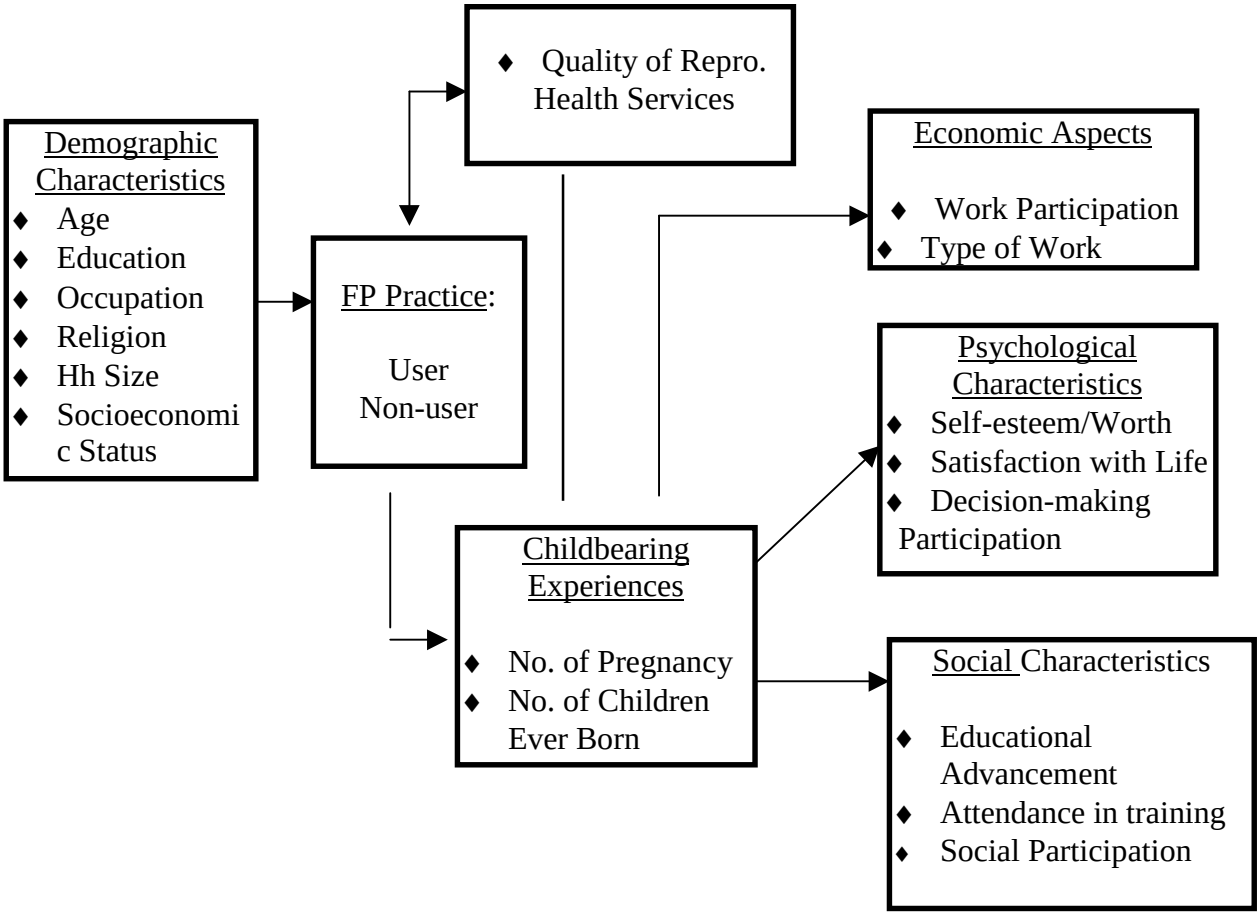
Family planning practice may also allow women to exercise more autonomy in the family and control over their own life. Hong and Seltzer (1994) explained that this expected psychological benefit of family planning might work through "improved knowledge and skills, income and work, and exposure to a broader network of contacts." Research evidence has shown that a woman's work and earnings give her some degree of autonomy (Dixon, 1995 and Yourself, 1982, as cited by Hong and Seltzer, 1994). Oppong (1990) reported that in Ghana, earning women tend to have enhanced power role.

An improvement in autonomy may also improve self-esteem. From Bruce's (1990) standpoint, a woman's self esteem can be increased when she gains better professional standing and when she can move freely in the community and participate in Decision-making, not only in matters affecting her, but also in other matters.

The expected benefits of family planning in the lives of women may also be enhanced or tempered by their experiences with the family planning or reproductive health program. When a woman receives quality service, can relate well with the service provider and is satisfied with the quality of services she receives, it is more likely that her response to family planning would be more favorable than that of someone who does not get the kind and quality of services the needs.

Figure 1. Conceptual Framework on the Influence of Family Planning on the Economic and Psychosocial Lives of Women.

The diagram below illustrates the conceptual framework of the study.



The Study Area: Western Visayas, Philippines

Western Visayas or Region VI is located in Central Philippines between two inter-island bodies of water; namely, the Sibuyan Sea and the Visayas Sea. The region is composed of four provinces in the island of Panay, the western province in the island of Negros and the island province of Guimaras. The provinces in Panay Island are Aklan, Antique, Capiz and Iloilo. Western Visayas has a total land area of 20,232 square kilometers representing 6.7 percent of the total land area of the Philippines. The map of Western Visayas is shown in Figure 1.

The total population of Western Visayas in 1995 (NSO, 1995) was 5,776,938, 50.2 percent of which were males and 49.8 percent were females. The region's population, like that of the whole country, is predominantly young, with nearly half of the population belonging to the dependent age group.

The population growth rate of Western Visayas was estimated at 1.4 percent. Its population density was 285.7 persons per square kilometers.

Family planning practice in Western Visayas, which is measured by contraceptive prevalence rate (CPR), was recorded at 49.3 percent in 1995. It slightly decreased to 46.8 percent in 1996 (NSO Family Planning Survey, 1995 and 1996). For both periods, the CPR of Western Visayas was slightly lower than the national figures (50.7 percent for 1995 and 48.1 percent for 1996).

The government Family Planning Program of Western Visayas is being implemented through the Department of Health (DOH) services network that includes the district hospitals, the Rural Health Units (RHU), the Barangay Health Stations (BHS) and the City health Offices. There are more than 200 RHU-based and hospital-based family planning clinics in the region (DOH, 1995). In addition, there are also many private clinics that provide family planning services in the region. Private physicians or private organizations run most of the private clinics.

CHAPTER II

RESEARCH METHODS: DESIGN, SAMPLING, DATA COLLECTION, ANALYSIS AND INFORMATION DISSEMINATION

Design

The survey design was used in this study. In addition, qualitative approaches, particularly, key informant interviews and focus group discussion (FGD) were used both to supplement and complement the survey findings.

The survey involved personal interview of around 1,100 randomly selected married women of reproductive age (MWRAs) in Western Visayas, whose age's range from 15-49 years. Key informant interviews and Focus Group Discussions (FGD) were conducted to generate qualitative information expected to aid in the formulation of the survey questionnaire and also to validate and further enrich the survey findings.

Sampling

The target population of the survey consisted of MWRAs (15-49 years old) in Western Visayas, distributed in the six provinces in the region, namely; Aklan, Antique, Capiz, Guimaras, Iloilo, and Negros Occidental. The survey respondents were drawn using a multi-stage stratified random sampling technique. The six provinces were stratified into three groups, based on population size and/or level of development and from each group one sample province was randomly picked to represent the stratum. Group I consisted of Negros Occidental and Iloilo, the two biggest and most developed provinces in the region; Group II consisted of Aklan and Capiz, two adjacent provinces in the Island of Panay representing the moderately developed provinces, and Group III consisted of the provinces of Antique and Guimaras representing the less developed provinces.

Based on NSO estimates, the MWRAs constitute approximately 12 percent of the total population. With reference to the 1995 population of the Region VI, the total number of MWRAs was estimated to be about 693,232. Using the formula below (Parel, et. al., 1985), a sample size of 370 per province or a total of 1,104 for the whole region was arrived at.

Where: n = sample size
N = total population
Z = the Z-value at the 95 percent confidence level adopted (1.96)
d = the tolerable/permissible sampling error for the confidence level adopted (0.05)
p = the proportion of the population who are FP users (.40)

The sizes of the provincial groupings and of samples are presented in Table 1 and the sampling procedures followed are described below.

Table 1. Sampling Distribution of MWRAs in the Provincial Groupings.*

Provincial Groups	Estimated No. of MWRAS*	Computed Sample Size*
Negros and Iloilo	512,971	369
Aklan and Capiz	125,771	368
Antique and Guimaras	69,133	367
Total For Region VI	708,875	1,104

*Projected from the 1990 NSO data.

Drawing of survey sample. The first stage of sampling involved the selection of sample provinces. From each group of provinces, a sample province was drawn using the "lottery" technique. The sample provinces drawn were Iloilo for the first group, Aklan for the second group and Antique for the third group.

In stage two, the sample municipalities were selected. The municipalities/ communities in each sample province were stratified into three geographical classifications, namely; urban, rural-coastal and rural-agricultural. From each stratum, one sample municipality was drawn using simple random sampling. Urban municipalities/ communities are the commercial centers, while the rural communities are those outside the commercial centers. In cases where a municipality/community was both coastal and agricultural, it was classified according to its dominant characteristic determined its classification. One sample municipality was drawn from each group.

Stage three involved the drawing of sample *barangays* (villages). From each sample municipality, two sample *barangays* were randomly selected through “lottery,” one from the *poblacion* or town proper, and another from outside the town proper.

The sample MWRAs was drawn in the final stage. The required sample size for each province (Table 1) was proportionately allocated to the sample municipalities and the municipal sample was proportionately allocated to the sample *barangays*. From each sample *barangay* a list of MWRAs was secured from the *barangay* health centers, this being required by the local health office from each Barangay Health Station (BHS) which is manned by the Rural Health Midwife (RHW) and a volunteer health worker (BHW.). When the list was not available, a list was prepared with the help of volunteer barangay health workers (BHW). The sample MWRAs were drawn from the *barangay* list using systematic sampling with a random start.

Selection of Focus Group Discussion (FGD) participants. The FGD participants were purposively selected. Nine pre-survey and 27 post-survey FGDs were conducted, one in each sample municipality in the first round and three per municipality in the second round; one for women's groups and NGOs, another for men, and another for non-respondent women. Eight to ten participants per FGD were predetermined and invited to attend the group discussion.

Selection of key informants for in-depth interview. The key informants for the in-depth interviews were purposively selected FP service providers (both private and public), members of women's groups, members of non-government organizations (NGO) involved in family planning and reproductive health initiatives, and some husbands of FP users as well as of non-FP users. The FP service providers selected had provided family planning services in the last six months prior to survey. Services include counseling, provision or distribution of family planning supplies, motivation and/or referral of MWRAs, insertion of IUD, administration of injection, or ligation.

Data Collection

Instrumentation. A structured interview schedule was used in the survey interview of MWRAs. The survey instrument consisted of two parts: the core questionnaire, which was common to all the research teams involved in the Women's Studies Project (WSP) in the Philippines and the study-specific questionnaire. The core instrument was prepared by the research teams involved in the WSP during a workshop on questionnaire construction and subsequent consultations with consultants and advisers.

The study-specific instrument for the Region VI study includes questions specific to Western Visayas, which are not included in the core questionnaire. The preparation of the questions was guided by the study objectives, operationalized variables and identified indicators.

Since interviews were to be in the dialect of the respondents, the survey instrument, first formulated in English, was translated to *Ilonggo* for Capiz and Iloilo and to *Aklanon* for Aklan respondents. A two-way translation was conducted. A native speaker of each dialect translated the original English version to the dialect; then another translator back-translated the dialect version to English. The original and the translated English versions were compared and questionable items were revised.

An instruction manual containing both general and specific instructions for the survey instruments was prepared to guide the interviewers in asking questions and recording responses.

For validation purposes, the survey questionnaire was referred to consultants with specialization in demography, public health, family planning, gender, reproductive health, and social science research. It was also presented for review and acceptance to the Ethical Review Committee. The instrument was then field-tested on 15 MWRAs who were not part of the study sample. Questions consistently skipped or not completely answered in the pre-test were improved.

The WRC members met to discuss the proposal and the members' participation in the research implementation.

Recruitment and training of interviewers and supervisors. Interviewers and field supervisors were recruited through poster announcements, specifying the qualifications of interviewers to be hired, such as: a) college degree, b) health research background, c) willingness to do fieldwork, d) outgoing personality, and e) fluency in the English language and in the dialect of the respondents. Based on their bio-data, a short list was prepared and those who qualified for the short list were personally interviewed. From these candidates, nine interviewers and three field supervisors were selected.

A two-day training session was conducted for the interviewers and supervisors. The training included an orientation on the Women's Studies Project (WSP), lecture-discussion on the interviewing process, an item by item study of the survey questionnaire, role playing of interviews, and field exercise. The interviewers and supervisors were also oriented on their respective roles and functions and on relationships between interviewers and supervisors, and relationships among interviewers.

Gender sensitivity training for interviewers, supervisors and FGD facilitators. The data collectors were also given a two-day gender sensitivity training session on gender sensitivity. A consultant-trainer conducted lectures and discussions on gender and instructed the participants on how to conduct gender sensitive interviews and FGDs. Various possible interview situations were analyzed and appropriate gender-sensitive responses to these situations were discussed. The trainees were also advised on how to respond to some expressed needs of respondents, such as counseling, referrals, and the like. They were cautioned, however not to give any direct personal advice for which they have not been prepared. Referral sheets containing names of agencies/individuals involved in women's concerns, which the women can approach for assistance, were to be left with the respondents after the interview.

For their culminating activity, the training participants viewed a movie on violence against women, entitled: "*Ika-labing-isang Utos Ng Dios: Mahalin Mo and Iyong Asawa*" (The Eleventh Commandment of God: Love Your Wife). After the film showing, the participants' reactions to the movie were sought and discussed from a gender perspective.

The survey. Field workers were divided into three teams, each consisting of three interviewers and one supervisor. Each team was assigned to cover one province; the members stayed in the field during the whole duration of the survey.

The field supervisors coordinated and monitored fieldwork and reported directly to the research associate in charge of data collection or directly to the Project Director. The field supervisor was responsible for: a) resolving or reporting field problems to the research office, b) calling on local health officials and/or local executives to seek permission for the conduct of the study in the area, c) reviewing completed interviews and making sure that questionnaires were properly and completely accomplished, and d) spot-checking interviews and monitoring call backs.

Focus Group Discussion (FGD). The FGDs were conducted for two purposes:

1. to find out how certain socio-psychological concepts are perceived or understood by the prospective respondents of the study, and

2. to generate additional and more detailed information that could enrich, validate, or clarify survey findings, particularly on the impact of family planning on the lives of women.

Two rounds of FGDs were conducted, one before and one after the survey. The pre-survey FGDs were conducted to establish realistic and objective measures of psycho-social indicators, like "quality of life," "self-esteem" and "self-image." The results were used as bases for operationally defining the psychosocial variables and in the formulation of the survey instruments. On the other hand, the post-survey FGDs were used to generate perceptions and views of other women (non-respondents, members of women's groups, etc.), men (husbands of MWRAs), and FP service providers on the effect of family planning on lives of women they know. The FGD results were also expected to shed light on the variations of the women's family planning experiences and responses to these, with respect to residence (rural-urban); education (educated-uneducated); employment status (employed-unemployed) and other relevant factors.

Trained facilitators conducted FGDs and documentors using prepared FGD guides. The FGD facilitators were trained on how to open, moderate, probe, and facilitate group interaction. FGD simulations were conducted to provide facilitators practice before actual fieldwork.

FGD schedules were pre-arranged and probable FGD participants were identified and invited in writing to attend the FGDs in coordination with the local health office or the Rural Health Units (RHUs). Neutral FGD venues were also identified.

Each FGD group had at least eight to ten participants who were seated in circular fashion to facilitate group interaction. The discussion started with an explanation of the FGD by the facilitators, who also encouraged the participants to express their views openly, and to comment and/or ask questions on the subject to be discussed. A note taker and a tape recorder documented FGD proceedings.

In-depth interviews. The in-depth interviews were conducted after the survey. The women's groups and NGOs represented in the in-depth interviews were operating in the municipalities and involved in family planning or any reproductive health initiatives. The male key informants in each municipality were two husbands of FP users and one husband of a non-user who agreed to share their ideas.

Quality control. The following activities/strategies were undertaken to ensure data quality: 1) training of interviewers, 2) preparation and use of instruction manual for the interview, 3) close supervision and monitoring of data collection, 4) spot checking during field interview, 5) field editing of completed interview schedules, and 6) office editing.

The referral sheet. One unique component of the data collection phase of this study was the distribution of a referral sheet to all the study respondents. The sheet contained a list of organizations/offices/agencies where the respondents could go for help, especially for problems involving family planning, family relationships, reproductive health, domestic violence, sexual abuse, or psychological anxiety due to any of the above problems or other related reasons. The

supervisors in consultation with local offices and agencies prepared the lists. The interviewers explained the purpose of the list to the respondents.

Data Processing and Analysis

The quantitative data were computer-processed using the SPSS PC+ software. A coding manual was prepared to guide data processing.

Completed in-depth interviews and FGD documents--tape recorded FGD proceedings and documentor's notes--were transcribed, summarized. And categorized. Categories of responses and FGD participants' views and perceptions were prepared based on commonality/variations of content.

Data analysis involved descriptive association and regression. To describe the respondents' general characteristics, such as their socio-demographic characteristics, family planning practices, family planning experience and their perceptions regarding the economic, social and psychological consequences of family planning on their lives, percentage distributions were used together with an appropriate measure of central tendency depending on the level of measurement of the statistical variable. The Z-test for difference between proportions was used to determine if a significantly higher proportion of family planning users tended to pursue further professional, economic and social advancement and have better satisfaction with life compared with the non-users.

Appropriate tests for association were used to ascertain if family planning practice, methods used, quality of family planning services received and selected antecedent variables, such as education of the women, income, residence and household size, were associated with the women's economic, social and psychological advancement. The qualitative data generated through in-depth interviews and FGDs were summarized and analyzed in relation to the survey findings. The qualitative data were used mainly for descriptions.

Information Dissemination and Research Utilization

The information dissemination activity of the study is a continuous process. From conceptualization to completion of the study, information about it -- objectives, processes, and progress of activities and results -- has been continuously disseminated. When the study started, the approved proposal was presented to the members of the Women's Resource Center for discussion and reaction. As the conduct of the study progressed, the project status and some initial findings were periodically reported to and shared with ISSA, FHI, and concerned agencies and women's groups in Region VI.

Preliminary findings of the study were also presented during consultation meetings with consultants, FHI advisers, WSP researchers, ISSA staff, and members of the WSP In-country Advisory Committee (IAC). The preliminary findings of the study made up the core message in the 1997 Justice Calixto Zaldivar Memorial Lecture delivered by one of the principal investigators in September 1997 at Central Philippine University. More than 300 students, faculty members, alumni and guests attended the lecture.

One big event, in which the results of the study on domestic violence were presented, was the Iloilo Women's Congress held on November 28, 1997? This was attended by more than 3,300 women from various sectors in the Province and City of Iloilo. The data became the basis of a policy paper entitled "Combating Domestic Violence in the City and Province of Iloilo," which was submitted to the City and Provincial Governments of Iloilo by the Iloilo Multisectoral Alliance: Bantay *Panimalay* (IMABP), sponsor of the policy paper.

A Regional Research Symposium featuring the study was conducted on January 19, 1998, where the study's major findings were presented. This was attended by more than 50 participants representing offices, agencies, and organizations involved or interested in women's concerns. Copies of research abstracts were put in envelopes given to each participant. In the workshop that followed the presentations and the open forum, participants were divided into sectoral groups and each group prepared policy/program recommendations and action plans in response to the findings of the study. The final copies of the workshop outputs were sent to the various offices represented in the symposium for consideration and action. A poster/photo exhibit and exhibits of women's books and of women's studies were put up in the session hall.

Further information dissemination activities will be conducted upon the acceptance of the final report by the FHI. Other strategies of information dissemination proposed to be used are:

1. distribution of the final research report to institutions and agencies;

2. publication and distribution of research digest to offices/agencies, women's groups, and individuals that may find the information useful,

3. publication of the research report in a national or international professional journal,

4. publication of the research abstract in a national or local daily, or featuring major research findings in a radio program or TV program,

5. preparation and distribution of posters translating/illustrating the major findings of the study in short and "catchy" messages.

Copies of the final report were distributed to local, national, and international agencies/institutions or groups. In addition, simplified and shorter versions of the report, in the form of a monograph were given out to regional and local health offices, family planning agencies, national and local women's groups, and private family planning service providers.

Ethical Considerations for the Protection of Human Subjects

The CPU Research Ethics Committee (REC) reviewed and passed the proposal for the research and monitored the conduct of the study. The committee was regularly informed about the progress of the study. The REC was composed of a theologian, a social worker whose graduate studies focused on psychology and who had much experience in feminist counseling, an engineer, a life science teacher, a home economics teacher with graduate work on child development, a statistician, an

anthropologist-sociologist, a female lawyer, an educator who chairs The Women's Resource Center, a nurse, a psychiatrist and a housewife. Their comments and suggestions were considered in the final revision of the research proposal and the survey questionnaire.

An informed consent was sought from the study respondents. Through a letter attached to the questionnaire and read to them by the interviewers, the purpose of the study was explained and permission to interview the respondent was sought. It was emphasized that the respondent had the option to refuse to be interviewed. If she consented, she was also given the option not to give her real name. Interview arrangements depended on the respondent's preferences. The letter also stressed that all information provided by the respondents would be treated with confidentiality.

CHAPTER III

THE MWRAS OF WESTERN VISAYAS: BACKGROUND CHARACTERISTICS, PREGNANCY AND CHILDBEARING EXPERIENCES AND FAMILY PLANNING PRACTICES

Background Characteristics of MWRAs

Table 2 shows the distribution of married women of reproductive age (MWRAs). By selected background characteristics, namely, age, educational attainment, occupational status, residence, and religion.

Age. The MWRAs of Western Visayas were 34.3 years old on average. Nearly half of them were between 31 and 40 years old (44.8 percent), about a third (32.6 percent) were 30 or below, while 26.4 percent were above 40. The data indicate that the proportion of women in each age group tended to decline with increase in age. Compared with earlier national and regional population data, the proportion of women below thirty years old is lower than the 54.8 percent in the 1993 NDS, 54.1 percent in the 1955 FPS, and the 51.9 percent in the 1996 FPS. These confirm the slowly changing age structure demonstrated by the national population trend reported by the NSO since 1993. The data further show that the *Non*-users were slightly younger on average (33.5 years old) than the FP users (35.0 years old). There was also a greater proportion of women below 30 years old among the FP Users than among the *Non*-users (34.7 percent and 23.7 percent, respectively).

Educational attainment. The highest educational attainment reported by one in three currently married women was some years in high school or complete high school (33.2 percent). About the same proportion had reached or completed college education (35.3 percent), while only a few had obtained vocational education (8.7 percent). One in five women (22.2 percent) had only reached or completed elementary education. More FP users (80.7 percent) than non-users (73.5 percent) who were high school and college educated, an indication of higher education of the former.

Occupation. The data further show that four in ten married women (41.1 percent) were gainfully working at the time of the survey, while six (58.9 percent) were not. There were more unemployed women among the non-users than among the FP users (63.3 percent and 54.9 percent, respectively). Most of the working women were engaged small-scale and seasonal in nature, such as sales (13.8 percent), technical jobs (12.7 percent) and service-related work (6.5 percent). Some, but less than 5 percent, were engaged in farming (3.5 percent), handicraft/ processing (1.8 percent), and clerical work (1.7 percent). No significant variation in the type of activities performed was observed between the FP users and non-users.

Table 2. Percentage Distribution of Respondents According to Age, Education, Occupation and Personal Characteristics by Family Planning Practice.

Indicators	Family Planning Practice		
	Non-users (n=521)	FP Users (n=579)	Total (n=1100)
Age			
Below 20	1.7	0.2	0.9
20-29	32.7	23.5	27.8
30-39	40.5	48.8	44.8
40-49	25.2	27.6	26.4
Mean Age (in Years)	33.5	35.0	34.3
Educational attainment			
No formal education	0.6	0.5	0.5
Elementary	25.9	18.8	22.2
High school	33.4	33.0	33.2
Vocational	8.8	8.6	8.7
College and above	31.3	39.1	35.3
Occupation			
None	63.3	54.9	58.9
Professional/Managerial	11.9	14.7	13.3
Sales/Business	11.1	16.2	13.8
Farming/Fishing	4.2	2.8	3.5
Clerical work	1.2	2.2	1.7
Craft/production process	1.7	1.9	1.8
Service/sports	6.5	7.0	6.9
Others	0.0	0.2	0.1
Residence			
Rural	39.9	30.2	34.8
Urban	60.1	69.8	65.2
Religion			
Roman Catholics	82.1	80.3	81.2
Non-Roman Catholics	17.9	19.7	18.8

Residence. Urban dwellers (65.2 percent) outnumbered the rural dwellers (34.8 percent) among the survey respondents. The urban dwellers were from villages within a city or town proper, while the rural dwellers were from outside the city or the town proper. As mentioned earlier the study sample was randomly drawn from two rural *Barangays* and one urban *Barangay* in each community covered by the study. The survey population of the 1996 Family Planning Survey (FPS, 1996) was more or less similarly distributed.

Religion. As in most parts of the Philippines, most of the respondents were Roman Catholics (81.2 percent). Only 18.8 percent were non-Catholics. The predominance of Roman Catholics was found among both non-users and FP users (82.1 and 80.3 percent, respectively).

Household Characteristics

Household size. The average household size of the MWRAs was 5.6 members (Table 3). This is nearly the same as the average household size of Western Visayas in 1995, which was 5.7 (NSCB, 1996). This figure, however, is slightly higher than the 1993 national figure, which was 5.3 (NDS, 1993). The distribution further shows that more than two-thirds of the women's households (67.8 percent) had five or more members: 38.9 percent had five or six members and 28.9 percent had seven or more members. It is interesting to note that the households of FP users had slightly more member's (5.9) than those of the non-users (5.3). Higher proportions of FP users (74.5 percent) than non-users (60.5 percent) were in households with five or more members.

Sex composition of household members. On the average, there were 2.8 males and also 2.8 females in the households of the women. This indicates a 1:1 sex ratio. The average number of members of either sex did not differ very much between households of FP users and non-users. This fact reflects the national as well as the regional situation (NSC, 1995).

Number of children of school age. On average, there were around two to three children of school age in every household of the MWRAs. Most households of both FP users and non-users had one or two school children at the time of the survey (2.5 and 2.4, respectively). There were slightly more FP users (46.2 percent) than non-users (41.0 percent) who had three or more school-aged children.

Table 3. Percentage Distribution of Respondents According to Household Characteristics.

Indicators	Family Planning Practice		
	Non-users (n=521)	FP Users (n=579)	Total (n=1100)
Household size			
1 – 2	5.2	0.5	2.7
3 – 4	34.4	25.0	29.5
5 – 6	36.9	40.8	38.9
7 and above	23.6	33.7	28.9
Mean	5.3	5.9	5.6
No. of male household members			
None	.2	0.9	1.0
1-2	52.8	40.8	46.5
3-4	35.9	44.4	40.4
5 and above	10.2	14.0	12.2
Mean	2.6	3.0	2.8
Total no. of female household members			
1-2	50.5	43.5	46.8
3-4	40.5	42.3	41.5
5 and above	9.0	14.2	11.7
Mean	2.6	2.9	2.8
No. of children of school age			5
1-2	59.1	53.8	5.9
3-4	32.7	38.5	36.1
5 and above	8.3	7.7	8.0
Mean	2.4	2.5	2.5

Housing Characteristics

In this study, house ownership, source of drinking water, type of toilet facility, ownership of household durables, and materials for flooring, walls and roof were used as indicators of the socioeconomic status (SES) of the women's households. A weighted score was assigned to every category of each indicator and a composite score representing the SES of every respondent's household was derived. The SES of the households was then categorized as "low," "average," or "high." The data are presented in Table 4.

House ownership. The data show that more than two-thirds of all the women's households (71.3 percent) owned their dwelling units. There were more home owners among the FP Users than among the non-users (76.9 percent vs. 65.1 percent).

Electricity and water source. About three in four households had electricity (73.1 percent) at home. Comparatively, there were slightly more households who had electricity among the FP users than among the *Non*-users (75.5 percent vs. 70.4 percent). As to source of drinking water, one in three households had piped-in water (36.4 percent). This facility was available to nearly the same proportion of FP user and non-user households (38.2 percent and 34.5 percent, respectively). One in four households obtained water from public pumps or artesian well (25.3 percent).

Type of toilet. The most common toilet facility in the study areas was the water sealed type (64.7 percent). Only 13.1 percent of the households had flush toilets. Comparatively, there were more households with water-sealed toilets among the FP users
(68.6 percent) than among the non-users (60.5 percent). More open pit toilets were found among the latter than among the former (20.3 percent vs. 15 percent).

Ownership of household durables. The most common household durable owned by the households was a radio (83.3 percent), which was usually, the most common source of public information, and entertainment of households. One of two households also owned a television (49.0 percent), while one in three had a refrigerator (33.5 percent) or a bicycle (36.0 percent). These household durables were present in more households among the FP users than among the non-users.

Housing materials. The houses of nearly half of the respondents' households were made of temporary materials, such as wood, bamboo and/or thatched materials (47.7 percent). One in three households had semi-concrete houses (32.1 percent), while about one in five had houses made of concrete (18.5 percent).

Socioeconomic status of households. Based on the SES classification derived from the scores obtained by the respondents, slightly more than half of all the households had "average" SES (57.9 percent); however, more than a third of the households had "low" SES. Only a few (2.8 percent) had "high" SES. Although the FP users had a slightly higher average SES score than the non-users, and there were slightly more of the former than of the latter with "average" and "high" SES, the difference in means between the two groups is not statistically significant. This implies that, on the average, the two groups had more or less the same socioeconomic status. The distribution, however, shows that a much bigger proportion of non-users had "low" socioeconomic status than of FP users (44.7 percent and 34.4 percent, respectively) and a much bigger proportion of FP users than non-users had "average" SES.

Table 4. Percentage Distribution of Respondents by Housing Characteristics and SES Status.

Indicators	Non-Users (n=521)	FP Users (n=579)	Total (n=1100)
Household ownership			
Owned	65.1	76.9	71.3
Rent	4.4	3.5	3.9
Stay for free	30.3	19.7	24.7
Others	6.2	0.0	0.1
Source of drinking water			
NAWASA	34.5	38.2	36.4
Public pump/artesian well	30.3	20.7	25.3
Deep well with pump *(tasok*/private)	14.4	19.2	16.9
Deep well (public)	16.5	18.9	17.8
Spring/river/rain	3.6	2.8	3.2
Others	0.6	0.5	0.5
Electricity facilities			
With electricity	70.4	75.5	73.1
With no electricity	29.6	24.5	26.9
Type of toilet facility			
None	4.2	2.4	3.3
Flush toilet	13.4	12.8	13.1
Water-sealed toilet	60.5	68.6	64.7
Open pit	20.3	15.0	17.5
Others	1.5	1.2	1.4
Household appliances	70.4	75.5	73.1
Electricity	80.2	86.0	83.3
Radio	43.6	53.9	49.0
Television	30.3	36.4	33.5
Refrigerator	35.5	36.4	36.0
Bicycle	15.2	17.1	16.2
Motorcycle	3.8	4.5	4.2
Car/jeepney			
Main material for flooring, walls &roof:			
Concrete	20.0	17.3	18.5
Semi-concrete	28.4	35.4	32.1
Temporary	48.9	46.6	47.7
Scrap materials	2.7	0.7	1.6
Socioeconomic status (SES)			
Low (Score of 3-11)	44.7	34.4	39.3
Average(Score of 12-20)	52.0	63.2	57.9
High(Score of 21 and above)	3.3	2.4	2.8
Mean	12.56	13.31	12.96

Pregnancy and Childbearing Experiences of the MWRAs

This section discusses information on age at marriage, number of pregnancies, fertility rate, number of live births, child mortality, and experience with unwanted pregnancy.

Age at Marriage

As shown in Table 5, the average age at marriage of the survey respondents was 23.3. This is slightly higher than the 1993 national and the Western Visayas median age at first marriage which was 21.4 (NDS, 1993). The data further show that 29 percent of the women got married before reaching the age of 21. Slightly more than half of them were married between 21 and 30 years of age, while only 7.6 percent got married at a later age. The FP users got married at a slightly younger age, on the average, (22.9 years old), than the non-users (23.8 years old). Moreover, a higher proportion of FP users than *Non*-users got married before reaching 31 years old (87.3 percent vs. 77.0 percent). Apparently, women are marrying at a later age in 1996 than during the earlier years.

Age at marriage and women's education. Table 6 shows that women with college education tended to marry later (24.7 years old) than those with high school education (22.4 years old), those with elementary education only (22.6 years old), and those with no formal education (23.4 years old). This indicates that as women advance in education, they tend to marry at a later age. This may be explained by the fact that women who had gone to college and earned a degree have more and better opportunities and options than those who had less education. A college graduate would likely seek employment after graduation and, thus postpone marriage until they find a job. Since most college degrees in the Philippines take four to five years to finish, one would usually graduate from college at the age of 21 or 22. When a woman luckily finds a job within a year or two after graduation in college, she may further postpone marriage for another couple of years in order to enjoy the "benefits of her toils" or to "save for the future." On the other hand, women with less education have few options. After finishing elementary or high school, they may either remain at home to take care of younger siblings and/or the household chores or start working to help augment the family income and marry young. The positive association between age at marriage and education of women find support in earlier studies (NDS, 1993).

Age at marriage and women's occupation. Another factor that seems to have some bearing on age at marriage is occupation. The working women tended to marry later than the *Non*-working women (24.2 and 22.7 years old, respectively). This was true irrespective of family planning use, as shown by the higher mean age at first marriage of the working women than that of the working ones both among the FP users (25.2 percent vs. 23 percent) and the non-users (23.5 percent vs. 22.4 percent). Studies confirm the delaying influence of work on age at marriage (NDS, 1993; David, 1995). Many working women who enjoy their work and/or believe that they can be better workers or enjoy their work more if they do not have a family to take care of or worry about would opt to postpone marriage. Working women who believe that "working and mothering are not compatible" may also decide to marry later or not to marry at all if their priority is work over marriage.

Age at marriage and women's residence. The data further show that the MWRAs in the rural areas of tended to marry about one year earlier than their urban counterparts (22.7 and 23.5 years old, respectively). The same pattern was found in earlier studies (NDS, 1993). The rural-urban differential was observed both among FP users and non-users. Better economic and social opportunities in the urban than in the rural areas may tend to discourage early marriage. Women in urban areas have more opportunities to pursue higher education because there are many schools in the cities/urban centers, many of which offer night classes. There are also more working opportunities for women in the urban than in the rural areas, but since most of these jobs are far from their homes, being married and having children can pose many difficulties to the working women. This could be one reason why working women in urban areas delay marriage.

Age at marriage and number of children. The data reveal that number of children tended to increase as age at marriage decreased. This is evidenced by the lower reported age at marriage of women with five to six (22.4 years old) and those with seven or more children (21.2 years old) than those who had less children (1-2=24.1 years old, 3-4 = 23.2 years old). This is expected because women who marry young will have longer fecund years. Unless they use a method to limit pregnancy, their probability of having more children than those who marry at a later age is greater.

Number of Pregnancies

On the average, the MWRAs have had about four pregnancies. The distribution in Table 7 shows that slightly more than one-third (35.1 percent) of the women had experienced three to four pregnancies, and nearly the same proportion (32.2 percent) had one to two pregnancies only. One in four women (29.8 percent), however, had five or more pregnancies. Comparatively, the FP users had more pregnancies, on the average, (4.1), than the non-users (3.5). This may be partly explained by the fact that the FP users, as reported earlier, married earlier than the non-users and/or they may have started using family planning after they reached their desired number of children. This suggests that family planning practice is more of a reactive than a proactive behavior among the MWRAs. As revealed by many family planning studies in the Philippines, most Filipino couples desire to have three or four children (NDS, 1993; David and Chin 1993; David, 1994). Moreover, the fact that the non-users were younger than the FP users further supports the hypothesis that their non-use of family planning may be due to not having completed their families. Number of pregnancies was also found to decrease with increase in age at marriage. This further confirms the negative association between age at marriage and number of children ever born.

Table 5. Percent Distribution of MWRAs by Age at Marriage and Family Planning Practice.

Age at First Marriage	Non-Users (n=521)	FP users (n=579)	Total 11000
20 and below	26.4	31.3	29.0
21-30	50.7	56.0	53.5
31-40	7.9	6.4	7.1
41 and above	0.7	0.2	0.5
Mean*	23.8	22.9	23.3

Table 6. Mean Age At First Marriage by Family Planning Practice and Selected Characteristics of the MWRAs.

Characteristics	Mean Age at First Marriage		
	Non-users (n=521)	FP users (n=579)	Total (n=1100)
Educational attainment			
No formal education	25.5	22.0	23.4
Elementary	23.1	22.0	25.6
High School and vocational	22.9	22.0	22.4
College and above	25.4	24.2	24.7
Occupation			
Working	25.2	23.5	24.2
Non-working	23.0	22.4	22.7
Residence			
Rural	22.9	22.4	22.7
Urban	24.4	23.0	23.5
No. of children ever born			
0	25.5	27.0	25.5
1-2	24.5	23.7	24.1
3-4	23.5	23.1	23.2
5-6	22.7	22.3	22.4
7 or more	21.5	20.8	21.1

Number of Children Ever Born

As in most national studies on population (NDS, 1993), number of children ever born or current parity was used in this study as a basic measure of fertility. Table 7 shows that, on the average, the MWRAs in Western Visayas had three to four (3.5) children ever born. The data show that,

while slightly more than one-third of the women (36.0 percent) had only one or two children, about the same proportion (35.5 percent) also had three or four, and a quarter (25.1 percent) had five or more children. Thirty-seven of the women did not have children at the time of the study.

The fact that the number of births was less than the number of pregnancies suggests that there might have been pregnancy loss among some women, either through spontaneous (miscarriage) or induced (intentional) abortion. As in the case of number of pregnancies, the FP users also had more live births than the non-users (3.8 vs. 3.2). The variation in the number of pregnancy between the FP Users and non-users may also be due to the same reasons for the variation in the number of live births between the two groups. Compared with earlier figures, it appears that the number of children ever born to couples has not changed much since 1993. NDS reported an average of 3.6 children ever born to a couple in 1993, while the 1996 NSO Family Planning Survey showed an average of 3.5.

The data in Table 8 show that the mean number of children increased with the age of the MWRAs. Women who were 41 years old or older obtained a mean of 4.6, those who were 31 to 40 had an average of 3.7 children, while those who were 21 to 30 years old had an average of 2.4 children. The teen-aged women had an average of 1.3 children. The same direction of association between age and number of children ever born has been found in previous national surveys (NDS, 1993; NSO FPS, 1996).

Table 7. Distribution of Respondents by Childbearing Experiences by Family Planning Practice.

Indicators	Non-users (n=521)	FP Users (n=579)	Total (n=1100)
Number of pregnancies			
None	6.0	0.2	2.9
1 – 2	38.4	26.6	32.2
3 – 4	32.6	37.3	35.1
5 and above	23.0	35.9	29.8
Mean	3.5	4.1	3.8
Number of children ever born			
None	6.9	0.3	3..4
1 – 2	42.8	29.5	36.0
3 – 4	30.1	40.4	35.5
5 and above	20.2	29.7	25.1
Mean	3.2	3.8	3.5

In relation to education, women with high school education or higher tended to have fewer children than those with only an elementary education. The data, however, do not support the negative association between work and number of children. While previous studies showed that working women tended to have fewer children than non-working women, the results showed that

both the working and the non-working women among the survey respondents had an average of 3.5 children ever born.

The study confirmed earlier findings (NDS, 1993; 1996 NSO FP Survey) that rural women generally have more children than urban women (3.7 vs. 3.4). The cross tabulations further confirmed that irrespective of age, educational attainment, occupation, and residence, the FP users had more children than the non-users.

Table 8. Mean Number of Children Ever Born by Family Planning Practice of MWRAs and Age, Educational Attainment, Occupation and Residence.

Indicators	Mean No. of Children Ever born		
	Non-users (n=521)	FP Users (n=579)	Total (n=1100)
Age			
Below 20	1.4	1.7	1.3
21-30	2.4	2.5	2.4
31-40	3.4	4.0	3.7
41 and above	4.4	4.8	4.6
Educational attainment			
No formal education	1.3	4.7	3.0
Elementary	4.4	4.6	4.5
High School and Vocational	3.0	3.8	3.4
College and above	2.5	3.2	2.9
Occupation			
Working	3.2	3.7	3.5
Non-working	3.2	3.8	3.5
Residence			
Rural	3.5	3.9	3.7
Urban	3.0	3.7	3.4

Family Planning Practice Among the MWRAs

Six indicators of family planning practice were examined in this study: the use or non-use of family planning, the reasons for their FP decision, the methods used by FP users, duration of use, problems experienced in the use of FP, and intentions to use FP.

Family Planning Use

Table 9 shows that 52.6 percent of the 1100 MWRAs interviewed in this study were using or had used a method to delay or prevent pregnancy, while 47.4 percent were not. The current FP users constitute 36.9 percent of the MWRAs. The most common FP method used by the FP users the

pill. This was used by almost a quarter of the FP users (24.9 percent). Female sterilization (tubal ligation) ranked second to the pill (24.0 percent), followed by injectables (13.5 percent). The traditional family planning methods, such as, rhythm, calendar method, abstinence and withdrawal, were practiced by nearly a quarter of the women (22.9 percent). Billings, BTL, and LAM which are considered by the Department of Health (DOH) as modern natural family planning (NFP) methods were reportedly being practiced by a combined total of 3.1 percent of the FP users.

The data above confirm the popularity of the pill as a means of contraception among women in Western Visayas. The most recent surveys on contraceptive use in the region, particularly in the provinces of Iloilo and Capiz (Iloilo LPP Cluster Survey, 1997 and Capiz LPP Cluster Survey, 1997) revealed the same results. National population surveys revealed that the FP users' choice of FP method has not changed much in the last decade, as indicated by family planning data since 1990 (NDS, 1990 1993; NSO, 1990, 1995, 1996).

The data also confirm the unpopularity of male contraceptives, the condom and vasectomy. Only 26 (6.4 percent) of the MWRAs interviewed reported the use of the condom and only one reported that her partner had been vasectomized. Family planning literature has reported the consistent unpopularity of male contraceptives. The 1993 NDS figure on condom use was only 1.0 percent, the NSO data showed a 1.1 percent condom use, and the 1996 NSO figure reported 1.6 percent. In all these surveys the practice of male sterilization has been negligible.

An interesting observation, however, is revealed by the data, namely, the increasing trend in the use of injectables and female ligation. The survey data show an acceptance rate for tubal ligation of 23.9 percent among the survey respondents. The 1993 NDS reported a use rate of 11.9 percent, while the 1996 NSO FP survey reported 10.6 percent acceptance of the method. While injectables scarcely attracted users in the early 1990s (NDS, 1990 and NDS 1993), the percentage of users of this contraceptive is obviously improving, as shown by a higher percentage of users of this method (13.5 percent) among the survey respondents than among their counterparts in earlier surveys (1993 NDS and 1995 and 1996 NSO FP surveys).

Table 9. Percentage Distribution of MWRAs According to Family Planning Practice and Method Used.

Indicators	Number	Percent (n=1100)
MWRAs who had ever used Family Planning	579	52.6
MWRAs currently using Family Planning	406	36.9
FP method used by current FP users:		
Pills	101	24.8
IUD	18	4.4
Injection	55	13.5
Foam tablets, jelly, cream, aerosol, etc.	2	0.5
Condom	26	6.4
Tubal ligation (female sterilization)	97	23.9
Vasectomy (male sterilization)	1	0.2
Abstinence, Calendar, Rhythm & Withdrawal	93	22.9
LAM, Mucus Method	12	3.0
Others	1	0.3
Total	406	100.0

Reasons for Choice of a Family Planning Method

On the whole, the choice of FP method among the FP users is greatly influenced by the women's perception of the "effectiveness" of the method (26.4 percent), its "absence of side effects" (25.4 percent), and "convenience" in using the method (22.9 percent). Other reasons given were: "recommended by the doctor" (14.8 percent), familiarity with the method (6.9 percent), accessibility (7.9 percent), and low/no cost (8.4 percent). Apparently, the basis for choice of a contraceptive has not changed much, since these are the usual reasons given by women for their method preference.

The reasons for the choice of a method varied depending on the method used. "Effectiveness" of a method was the most common reason given by those who had tubal ligation (43.9 percent) and those using IUD (27.8 percent). Among the users of the pill, injectable, and LAM, "convenience," emerged as the most popular reason for their choice of these methods (38.6 percent, 34.5 percent, 41.7 percent, respectively). The users of condom and those adopting traditional FP methods preferred these methods because of "absence of side effects." (61.5 percent and 45.3 percent, respectively).

Nearly a quarter of those who elected to have tubal ligation chose the method because it was "recommended by the doctor " (22.4 percent), while the "low cost" of pills encouraged 27.7 percent of the pill users to use the contraceptive.

Table 10. Percentage Distribution of Family Planning Users According to their Reasons for Choice of a Method and by Method Used (Multiple Response).

Reasons	Pill (101)	Con-dom (26)	IUD (18)	Inject-able (55)	Steril-ization (98)	LAM (12)	Trad./ others (95)	Total (406)
Convenience	38.6	11.5	22.2	34.5	11.2	41.7	12.9	22.9
Effectiveness	22.8	19.2	27.8	21.8	43.9	00.0	20.0	26.4
Absence of side effects	12.9	61.5	22.2	18.2	13.3	33.3	45.3	25.4
Recommended by doctor	11.9	3.8	16.7	12.7	22.4	00.0	8.4	13.1
Free/Not costly	27.7	15.4	16.7	16.4	1.0	16.7	5.3	12.6
Others	11.9	19.2	27.8	23.6	12.4	25.0	20.2	17.0

Satisfaction with Family Planning Method Used

Table 11 indicates that the majority of the FP users (64.8 percent) expressed great satisfaction ("very satisfied") with the FP method they were using, while only 5.7 percent were "very dissatisfied" with their chosen method. There were 28.3 percent who were "somewhat satisfied," and 0.7 percent who were "somewhat dissatisfied."

The women's level of satisfaction varied according to the method they were using. The data show that the majority of the FP users of all methods, except those using condom, were "very satisfied" of the method they were using (55.6 percent to 89.8 percent). The highest proportion of the "very satisfied" users were those who had tubal ligation (89.8 percent), while the highest proportion of the "dissatisfied" and "very dissatisfied" users were those using condom (23 percent). Only 34.7 percent of the condom users admitted that they were "very satisfied" with the method. Further inquiry on what makes an FP user satisfied with a method revealed that a method's effectiveness was the most important consideration.

Table 11. Percentage Distribution of Family Planning Users According to their Level of Satisfaction in their Use of a Specific Method.

Level of Satisfaction With an FP Method	Pill (101)	Con-dom (26)	IUD (18)	Inject-able (55)	Steril-ization (98)	LAM/ Billing (12)	Trad./ others (95)	Total (406)
Very satisfied	63.4	34.7	55.6	63.6	89.8	66.7	51.6	64.8
Satisfied	30.7	42.3	38.9	27.3	9.2	25.0	38.9	28.3
Slightly dissatisfied	5.9	19.2	5.6	5.5	2.0	8.3	6.3	5.7
Very dissatisfied	0.0	3.8	0.0	3.6	0.0	0.0	2.1	1.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Problems Experienced by the MWRAs in the Use of a Family Planning Method

Of the 406 current FP users, only 20.2 percent admitted having experienced problems with FP use (Table 12). Among the problems mentioned, dizziness was the most common complaint (30.5 percent), followed by headache (22 percent), irritability (19.5 percent) and weight gain (14.6 percent). Other problems reportedly encountered, but mentioned by less than ten percent of those who met problems were: chest pains (9.8 percent), hypertension (7.3 percent), heavy bleeding (6.1 percent), amenorrhea (6.1 percent), painful periods (6.1 percent), and weight loss (3.7 percent).

Further inquiry revealed that dizziness, headaches, and weight gain were experienced mostly by pill users, while most of those who experienced heavy bleeding were those using injectable. Users of injectable, however, were aware that heavy bleeding could occur during the initial stage of their use of the method, because the FP service provider explained this to them. Nevertheless, some still got worried and some even considered dropping out. Follow-up consultation with the service provider allayed their fears.

It will be noted that almost all the problems mentioned by the women were side effects of the method they were using. The 1993 NDS also identified side effects as the most reported problem of FP users. The same reason was given for discontinuance of contraception use among women in the Philippines (NDS, 1993).

Table 12. Percentage Distribution of MWRAs According to Current Method Used Family Planning Practice.

Problems	Number	Percent
MWRAs who had experienced problems with current FP	(82)	20.2
Problems encountered with the current method (Multiple response)		
Irregular menstruation	6	7.3
Heavy bleeding	5	6.1
Ammenorhea	5	6.1
Painful periods	5	6.1
Intermenstrual pains	3	3.7
Dizziness	25	30.5
Blurred vision	2	2.4
Chest pains	8	9.8
Hypertension	6	7.3
Vaginal discharges	2	2.4
Headaches	18	22.0
Weight gain	12	14.6
Weight loss	3	3.7
Irritability	16	19.5
Others	28	34.1

Intentions to Use or Not to Use Family Planning in the Future

Information on intention to use FP method in the future can be used as basis of forecasting potential demand for FP services. Data on intention not to use and reasons for this are useful in identifying targets for program implementation.

The FP users' intentions to continue using FP. Table 13 reveals that a high majority of the current FP users (88.9 percent) intended to continue using the family planning method they were currently using. The top three reasons given for their decision was: 1) they were already used to the method (52.3 percent), 2) the method is effective (23.5 percent) and 3) the method is free from side effects (23.3 percent). Nearly a fifth (19 percent) intended to continue because it is convenient. Other reasons mentioned, but by less than 10 percent of the potential continuing users were: "doctor's advice," "easy to get supply," and "method is free/inexpensive." The data imply the continuous demand for FP services and the need to respond to this demand. In responding to this need, service providers must take into consideration the preferences of the women.

The non-users' intention to use FP in the future. Of those who were not using FP at the time of the survey, 16.9 percent expressed the intention to use a FP method in the future. The two most preferred methods of those who expressed intention were pills (36 percent) and injectables (26.4

percent). There were 11.3 percent who declared a plan to have tubal ligation, while 5.9 percent wanted to use IUD. The other methods had very few prospective users.

The data confirm that the pill is still the method most preferred by the MWRAs, not only among current FP users, but also among prospective FP users. The male-oriented FP methods still remain unpopular and the least chosen. What is interesting is the increasing acceptability of injectables, which may be attributed to the promotion efforts of the Department of Health of this method. The most common reason given for the choice of a particular method for future use was perceived "effectiveness" of the method. 19.9 percent and 11.8 percent, of the prospective users also mentioned "Convenient" and "absence of side effects", respectively. It will be noted that these were also the most common reasons given for choice of a FP method among the ever-users.

The fact that women put emphasis on the effectiveness and freedom from side effect in their choice of a method, it is important that service providers provide choices of the more effective methods and those with no or with the least side effects on the user. Expected side effects and how to deal with them must be thoroughly explained to the prospective users so that they will not get scared once they experience them.

Table 13. Percentage Distribution of Current Users Who Plan to Continue Using the Family Planning Method.

Indicators	Number	%(n=406)
Current users who plan to continue using the FP method used	361	88.9
Reasons why a woman plans to continue using the method she is currently using (Multiple response)		
Used to the method already	189	52.3
Convenient	70	19.4
Effective	85	23.5
Free from side effects	84	23.3
	35	9.7
Recommended by doctor		
Easy to get supply	19	5.3
Free/inexpensive	21	5.8
Not against religion	11	3.0
Others	38	10.5
DK	13	3.6

Table 14. Percentage Distribution of Non-users Who Intended to Use Family Planning in the Future.

Indicators	Number	Percent
Non-users who intend to use FP methods in the future	186	16.9
FP methods non-users intend to use		
Pills	67	36.0
IUD	11	5.9
Injection	49	26.4
Foam tablets, jelly, cream, aerosol	3	1.6
Condom	5	2.7
Tubal ligation	21	11.3
Vasectomy	1	0.5
Periodic abstinence	1	0.5
Calendar	15	8.1
Rhythm	3	1.7
Withdrawal	7	3.8
LAM	1	0.5
Mucus Method/BBT	1	0.5
Others	1	0.5
Not yet sure	4	2.2
Reasons for preference of a particular FP method	(186)	
Convenient	37	19.9
Effective	86	46.3
Free from side effects	22	11.8
Doctor's advice	3	1.6
Trial Curiosity	9	4.8
Accessibility	5	2.7
Familiarity	12	6.4
Free/Inexpensive	2	1.1
Others	10	5.4

Availability and Utilization of Family Planning Services

The expected benefits of family planning in the lives of women may be enhanced or tempered by their experiences as users of family planning or reproductive health program. When a woman receives quality service, can relate well with the service provider and is satisfied with the quality of services she receives, it is more likely that her response to family planning would be more favorable than that of someone who does not get the kind and quality of services she needs.

According to Feigenbaum (1983, as cited by Roberto, 1991), the perceptions and experiences of service quality of a family planning acceptor are "shaped by how the acceptor's expectations are satisfied." The measure of quality of service depends therefore on the acceptors' satisfaction with the service and its components, which generally include: 1) service personnel, namely, the doctor, the nurse, the midwife, and the volunteer worker; 2) the service outlet and facilities, including location of the clinic and its structure, and appearance; and 3) service performance, which include the processing of a client's visit, request for referral, request for supply or resupply and request for other services.

This study examined three main elements about FP services, namely, availability of FP services, the MWRAs' main sources of FP services and their experiences in obtaining FP services in these sources. Their preferred services and service providers were also studied.

Available Family Planning Services

Ocular inspection of FP clinics and in-depth interviews with health service providers in the study areas revealed that FP services were available in almost all cities and municipalities in Western Visayas. These services were being provided in almost all-local government health clinics, which exist in almost all municipalities in the region. In some areas, there were government hospitals and some private clinics, which provided FP services. In urban centers, private physicians and/or private clinics also served FP clients.

In the municipalities, the Main Health Clinic/Center or the Rural Health Unit (RHU) which served as the main health facility was usually strategically located at the center of the town. All the nine municipalities covered by the study in Western Visayas had an RHU, which provided among others FP services. There were also private clinics where FP services were available.

A physician, nurses, midwives, a dentist and a sanitary health inspector manned the government health centers/clinics. Some clinics, especially those in the city had more physicians and nurses, some even had a medical technologist. All clinics also had an organized group of *Barangay* Health Workers or BHWs who assisted the midwives in health program campaign, FP motivation and follow-up.

Women's Utilization of Family Planning Services

Table 15 shows that the majority of the 1100 MWRAs interviewed (64.8 percent) had asked for or received FP service/s. Among the 579 FP users, 94.1 percent had availed of family planning service/s. It is interesting to note that almost one-third of the non-users also asked or received FP services. Based on in-depth interviews with women and FP service providers, the most common type of service/s received by FP users were counseling, free family planning supply, physical examination/ consultation, FP counseling, and pre or post natal care. Most of the non-users who had availed of FP services received FP counseling, pre or postnatal care or had physical examination at the clinic.

The main source of FP supplies or services of the women was the government sector, particularly the RHU or the main health center, the government hospital or the *Barangay* Health Station (80.2 percent). There were more FP users than non-users who had availed of FP services obtained service from the government sector (83.9 percent and 68.5 percent, respectively). On the other hand, there were more non-users (28.6 percent) than FP users (15.5 percent) who had availed of FP services from the private sector, like a private clinic, physician or private hospital. National and regional FP studies also showed that the government clinics and hospitals constitute the main supply points of FP services in the Philippines (David and Vencer, 1997; DOH, 1996; Jeremillo, 1996; and NDS, 1993).

Problems Experienced by MWRAs with Family Planning Services

The MWRAs did not have many problems regarding family planning service. Only 8 percent reported having experienced difficulties while seeking FP services, among them were shortage of FP supply and limited types of available services. While shortage of FP supplies was reported by about the same proportion of non-users and the FP users, more non-users than FP users reported complaint about limited services. On the other hand, there were more FP Users (29.4 percent) than non-users (4.3 percent) who reported unfriendliness and incompetence of service providers. Distance of the source of family planning service posed as a difficulty to six of the 23 non-users and three FP users.

The data also revealed that nearly all the FP users (95.3 percent) received the FP method they wanted, the last time they requested for it (Table 16). Only 27 did not receive what they requested. Most requests not granted were those for pills. The failure to provide the method requested was attributed to unavailability of method (31.8 percent), lack of supply (25 percent), and contraindications or possible health risks to the client (20.4 percent).

Some of those whose requests were not granted received another method and they were satisfied with the substitute method because it worked effectively for them.

Table 15. Percentage Distribution of Respondents According to their Access to and Experiences in their Utilization of Family Planning Services.

Indicators	Family Planning Practice		
	Non-user (n=521)	FP Users (n=579)	Total (n=1100)
MWRAs who received FP services	32.2	94.1	64.8
Place where FP service/s were obtained	(n=168)	(n=545)	(n=713)
Government sector (Gov't Clinic, hospital)	68.5	83.9	80.2
Private sector (Private Clinic, NGO)	28.6	15.5	18.7
Others	3.0	0.7	1.3
MWRAs who had experienced problems with FP services	13.7(23)	6.2(34)	8.0(57)
Problems experienced (Multiple Response)	(n=23)	(n=34)	(n=57)
Dirty place	4.3	8.8	7.0
Long waiting time	4.3	17.6	12.3
Distance from house	26.1	8.8	15.8
Inconvenient clinic schedule	17.4	11.8	14.0
Unfriendliness/disrespect of staff	4.3	23.5	15.8
Incompetence of staff	0.0	5.9	3.5
Limited number of services	34.8	8.8	19.3
Shortage of supplies	60.9	67.6	64.9
Others	30.4	23.5	26.3

Table 16. Percentage Distribution of Respondents as to Family Planning Methods Requested but not Granted and Reasons for not Granting Requested Methods.

Indicator	Family Planning Practice	
	Number	% (n=579)
Percent of FP users who received the method they last requested	552	95.3
Percent of MWRAs whose requested method was not granted	44	7.6
FP methods not granted/provided	(44)	
Pills	35	79.5
Injection	1	2.3
Condom	2	4.5
Tubal Ligation	4	9.1
Calendar	1	2.3
LAM	1	2.3
Reasons given for not providing the requested method		
Method not available	14	31.8
Lack of supply	11	25.0
Health contraindication	9	20.4
Legal restriction	2	4.5
Another method more suitable	1	2.3
Did not have husband's consent	1	2.3
Others, specify	5	11.4
Don't know	1	2.3

Characteristics of Family Planning Services Considered Important by the MWRAs

The MWRAs considered important friendly/respectful staff (40.1 percent), competent staff (35.0 percent). About one-third (32.5 percent) of them said that availability of a wide range of FP services/methods (32.5 percent) is also important. Table 17 shows that one-fifth of the women (21.6 percent) also considered it important that the FP clinic is clean (21.6 percent) and has a convenient schedule (19.8 percent). Accessibility and short waiting time were also mentioned by 15.7 percent, and 13 percent of the women, respectively. The FP users and the non-users had more or less the same expectations of the quality of FP services/ facilities. Both groups identified similar priority characteristics of the FP facility or service: competent staff (37.3 percent and 32.4 percent respectively), friendly/respectful staff (40.8 percent and 41.2 percent, respectively) availability of a wide range of services (34.9 percent and 29.9 percent, respectively).

The data confirm Roberto's (1991) findings that attitude and behavior of service personnel, quality of service outlets (location, structure and appearance), and service performance (type and

availability of services they need) are the focus of expectations of FP clients. Roberto concluded that Filipino FP clients are satisfied with the service when they are "attended to with care, kindness, or cordiality" or "when they can easily approach a health provider without feeling threatened and anxious." He added that Filipino FP clients usually expect "kind," "approachable," and "accommodating" doctors, nurses, and/or midwives.

The importance the MWRAs gave to accessibility of a FP clinic was also reflected in Roberto's study. The FP clients studied preferred clinics which "are near their homes," or "easy to reach." The FP clients in the study also expected "Availability of FP supply and services when needed".

Table 17. Distribution of Respondents According to Characteristics of Family Planning Service Which They Consider Important (Multiple Response).

Characteristics of a Good FP Service/s Service Facility	Family Planning Practice		
	Non-users (n=521)	FP Users (n=579)	Total (n=1100)
Cleanliness	19.0	24.0	21.6
Convenient schedule	15.9	23.3	19.8
Short waiting time	10.7	15.0	13.0
Accessibility/Nearness to homes of clients/patients	14.6	16.8	15.7
Provision of a wide range of services/methods	29.9	34.9	32.5
Affordable services	12.5	11.1	11.7
Adequate space/not crowded	7.3	8.6	8.0
Competent staff/service providers	32.4	37.3	35.0
Friendly/respectful service providers	39.3	40.8	40.1
Others	7.5	11.2	9.5

It was noted that the MWRAs' expectations of the FP service/facility are quite basic and simple. In fact, these expectations are also among the basic requirements of any health office/clinic. Patients or clients are expected to be treated with kindness and respect. They have the right to safety and privacy; therefore, clinics should be clean and safe. Clinics should also have private rooms for physical examination purposes. Since the family planning program of DOH promotes freedom of choice, every clinic must also provide a wide variety of choices of FP methods. The fact, however, that the MWRAs have raised these minimum requirements to the "ideal" suggests that they may have gotten used to substandard health services and/or facilities that by just having the minimum would already be "ideal" for them.

Women's Preference as to Sex of an Family Planning Service Provider

The preference for a female FP service provider tended to be the norm among the MWRAs. Table 18 shows that the majority of the women expressed preference for women to conduct the following services: breast examination (67.7 percent), pelvic examination (69.5 percent), pap smear (69.6

percent), IUD insertion (69.6 percent) and STD diagnosis (69.6 percent). Most of them, however, did not have any particular sex preference, in regard to the sex of provider who would give them injections. Less than half (44.6 percent) of them expressed partiality for women to do the task, but the rest said that it was okay for men to give them injections. The women also differed in their preference for a FP adviser or counselor. While slightly more than half (53.6 percent) of them said that it is important that this task be performed by women, the rest did not consider this matter important.

The women perceived that their husbands' preference as to the sex of the FP service providers tended to match their own preferences. According to the majority of the respondents, their husbands would also consider it important that women perform most of the specified FP services. A small majority of the respondents perceived that their husbands considered it important that breast examination (58.7 percent), pelvic examination (59.3 percent) pap smear (57.8 percent), IUD insertion (59 percent) and STD diagnosis (55 percent) be done by women only. Less than half of the women reported that their husbands would prefer women to give "injection" (45.6 percent) and counseling (47.8 percent). The FP users and the non-users tended to share the positions regarding the sex of the providers. These positions were the same as those held by their husbands.

Consistent with their expressed preference for women as FP service providers, the majority of the women intended to refuse a FP service if a man (60.6 to 80.3 percent) provided it. The women's and their husbands' partiality to female FP service providers is understandable. Filipino women are still generally conservative and tend to be prudish in regard to body exposure or physical contact.

Table 18. Percentage Distribution of Respondents Who Considered it Important that Given Specific Services be provided by Female Providers.

FP Services	Non-users (n=521)	FP Users (n=579)	Total (n=1100)
MWRAs who consider it important that the following services be provided by female providers			
Counseling	55.7	51.8	53.6
Breast exam	72.9	66.8	69.7
Pelvic exam	73.1	66.3	69.5
Pap smear	72.7	66.8	69.6
Injection	48.2	41.5	44.6
IUD insertion	72.6	67.0	69.6
STD diagnosis	68.5	60.4	64.3
MWRAs whose husbands consider it important that the following services be provided by female providers			
Counseling	50.1	45.8	47.8
Breast exam	61.8	56.0	58.7
Pelvic exam	62.2	56.6	59.3
Pap smear	61.6	54.4	57.8
Injection	48.8	42.8	45.6
IUD insertion	61.6	56.6	59.0
STD diagnosis	59.5	50.9	55.0
MWRAs who will not refuse if the following FP services were provided by male providers	77.7	82.6	80.3
Counseling	55.9	67.5	62.0
Breast exam	54.7	66.8	61.1
Pelvic exam	54.9	65.8	60.6
Pap smear	71.4	81.2	76.5
Injection	54.3	66.1	60.5
IUD insertion	58.0	69.4	64.0
STD diagnosis			

CHAPTER IV

ECONOMIC AND PSYCHOSOCIAL INFLUENCE OF FAMILY PLANNING ON WOMEN'S LIVES

The influence of family planning on the lives of the MWRAs in Western Visayas was examined in five aspects of a woman's life: work status, community participation, education and training, Decision-making participation, satisfaction with life and domestic violence. The analysis involved description and comparison and regression.

Family Planning Practice and Participation in Paid Work Among Women In Western Visayas

Background

One of the aspects of a woman's life, which is expected to be affected by her reproductive behavior, is her employment status. In many societies, female employment is becoming more a necessity than a choice because of changing views, and values and economic demand. Many married women who desire to work, however, cannot work because of the conflict of work and mothering responsibilities. It has been argued, however, that if a married woman can postpone or space childbearing through family planning, her chances of getting employed, and of being promoted if she is already working, can be improved. Whether this holds true among the MWRAs of Western Visayas is a question that this study attempted to answer.

Specifically, two concerns are addressed in this section: 1) whether or not family planning practice is associated with a MWRAs involvement in gainful work /employment status and 2) the perceptions of the MWRAs as well as the perceptions of their husbands, and of family planning providers regarding the influence of family planning on the economic situation or activities of the MWRAs.

Family Planning and Women's Employment

Table 19 shows that 41.1 percent of the MWRAs were engaged in remunerative work at the time of the survey. Comparatively, there were significantly more FP users than non-users who were gainfully working (45.1 and 36.7, respectively). When certain variables were considered, the positive influence of family planning practice on the employment status of the women consistently emerged, however, under certain conditions, family planning practice did not significantly differentiate the FP users from the non-users in terms of their participation in paid work.

The advantage of the FP users over the non-users in regard to labor participation was sustained even when religion of the woman was controlled. The difference between percentages of working FP users and working non-users, however, was statistically significant only among the Roman Catholics. There were 9.5 percent more working Roman Catholic FP users (45.2 percent) than working Catholic non-users (35.7 percent). There were also more working FP users (44.7

percent) than working non-users (41.3 percent) among the non-Roman Catholics, but the difference in proportion between the two groups was not statistically significant at 5 percent level.

When age of MWRAs was considered, the employment advantage of the FP users over the non-users was maintained in all age levels, however, the differences between the proportions of working FP users and working non-users in all levels were not statistically significant. Specifically, among MWRAs who were 20 years old and below, there were 10.8 percent more employed women among the FP users than among the non-users. Among those who were between 21 and 30 years old, there were 5.8 percent more employed FP users than working non-users, while among those who were 31 to 40 years old, there were 7.4 percent more working FP users than non-users, while among those who were 41 years old or more, there were 3.7 percent more working FP users than working non-users. This seems to suggest that the age of the women is a mediating factor in the relationship between family planning practice and working status of the women. It tends to suppress the extent of association between family planning and work status.

When educational attainment was considered, the proportion of working FP users remained consistently higher than that of working non-users in all education levels, except among women with no formal education. The difference between proportions, however, was statistically significant only for those with at least high school education (10.6 percent, Z = 2.583), although it was not among those with only elementary education (5.3 percent, Z=0.854) and those with college education (3.2 percent, Z=0.635). The limited work opportunities for women with low educational attainment and the fact that the college-educated are likely to be employed may have concealed the influence of family planning practice among women belonging to these two education categories.

The positive influence of family planning on the work participation of the MWRAs was sustained even when residence was controlled. The data show that there were more working FP users than working non-users in both rural and urban areas. There were 9.0 percent more working FP users (than working non-users in the rural areas and 7.2 percent more working FP users than non-users in the urban areas. The difference in proportions, however, was significant only among the urban dwellers. The small variation in labor participation of the FP users and non-users in the rural areas may be ascribed to the limited work opportunities for women in these areas. This may be due also to the fact that most of the women farm workers, whether FP users or non-users, are wives of small farm owners/tillers, and they are likely to be engaged in paid work when work on the farm they own or till for their landlords is done. Available work for women in the rural areas are mostly seasonal, intermittent, and low-paying, such as farming, vending, and service-related jobs, types of occupation which non-users can do just as well as the FP users.

Table 19. Percentage Distribution of MWRAs According to Labor Force Participation and Family Planning Practice Controlling for Selected Variables.

Variables	Non-users (n =521)*	FP Users (n=579)	Total (n=1100)	Z-test Values
MWRAs who were currently working for pay	36.7(191)	45.1(261)	41.1(452)	2.842**
Employment status according to certain variables:				
Age				
Below 20	5.9(17)	16.7(6)	8.7(23)	0.664
21-30	23.5(179)	29.3(157)	26.2(336)	1.203
31-40	41.7(211)	49.1(281)	45.9(492)	1.638
41 and above	52.6(114)	56.3(135)	54.6(249)	0.584
Religion				
Roman Catholic	35.7(429)	45.2(465)	40.6(894)	2.907**
Non- Roman Catholic	41.3(92)	44.7(114)	43.2(206)	0.491
Educational attainment				
No Formal Education	66.7(3)	33.3(3)	50.0(6)	0.868
Elementary	34.1(135)	39.4(109)	36.5(244)	0.854
High School and Vocational	21.8(220)	32.4(241)	27.3(461)	2.583**
College and Above	58.3(163)	61.5(226)	60.2(389)	0.635
Barangay				
Rural	32.7(208)	41.7(175)	36.8(383)	1.819
Urban	39.3(313)	46.5(404)	43.4(717)	1.940**
Household size				
1-2	63.0(27)	66.7(3)	63.3(30)	0.129
3-4	38.0(179)	48.3(145)	42.6(324)	1.859
5-6	33.3(192)	42.4(236)	38.3(428)	1.944**
7 and above	34.1(123)	45.6(195)	41.2(318)	2.066**
Number of pregnancies				
0	38.7(31)	100.0(1)	40.6(32)	7.007**
1-2	42.0(200)	48.1(154)	44.6(354)	1.145
3-4	28.8(170)	41.2(216)	35.8(386)	2.570**
5-6	37.1(70)	51.1(135)	46.3(205)	1.944**
7 and above	40.0(50)	38.4(73)	39.0(123)	0.178
Number of children ever-born				
0	44.4(36)	50.0(2)	44.7(38)	0.154
1-2	38.6(223)	48.0(171)	42.6(394)	1.872
3-4	29.9(157)	41.5(234)	36.8(391)	4.000**
5-6	39.1(64)	48.2(112)	44.9(176)	1.180
7 and above	41.5(41)	45.0(60)	43.6(101)	0.349

*Figures enclosed in parenthesis are frequencies.
** Statistically significant at 5 percent level.

The data support the hypothesis that family planning is significantly associated with the MWRAs' participation in paid work. Although the practice of family planning may not directly result to a woman's participation in the labor force, it is clearly a facilitating factor. Limited work opportunities for women, however, tend to diminish or even conceal the benefits of family planning on women's labor force participation. Low educational attainment can also reduce the favorable influence of family planning on the women's work participation because this further decreases their ability to compete for the limited number of better-paying jobs.

Participation in Gainful Work Between Pregnancies

When data on employment between pregnancies were examined, it was found that there were more FP users than non-users who were able to work between pregnancies. Table 20 shows that there were 11.9 percent more FP users than non-users who were able to work for pay between their first and second pregnancies (46.0 percent vs. 34.1 percent). Between the second and third pregnancies, there were 5.8 percent more FP users than non-users who were able to work, while between third and fourth pregnancies, 12.5 percent more FP users were able to join the work force.

The data further show that there were more FP users than non-users who were engaged in profession/managerial and business-related jobs. This implies that they had better opportunities than the non-users to engage in better-paying jobs outside the home. Between their first and second pregnancies, there were 9.9 percent more FP users than Non-users who were engaged in professional/managerial work, while there were 4.1 percent more FP users than non-users who were involved in business-related employment.

Between their second and third pregnancies, 17.2 percent more FP users than non-users were involved in professional and managerial jobs, while between their third and fourth pregnancies, 8.9 percent more FP users than non-users were engaged in the same type of work. More non-users than FP users, however, were engaged in farm-and service-related jobs during periods between pregnancies. It seems that non-users tended to engage in seasonal or part-time jobs that allow them to work near their homes. The proximity of their work to their homes enables them to do some house chores and/or childcare. In some cases, mothers who are engaged in farm work or service-related jobs, like laundry for a neighbor sometimes bring their small children to work. Their mothers even while working can watch children.

The data suggest that having small children limits a woman's opportunities to engage in paid work outside the home or far from her home. Since childcare in Filipino homes is dominantly a woman's responsibility, she usually takes care of the children when they are young. A woman already working before childbirth is sometimes forced to quit work after childbirth especially when she cannot find nor afford to hire a baby sitter. Mothers who cannot trust their babies, especially their first born, to a caregiver, usually quit work when the baby is still small.

Table 20. Distribution of MWRAs by Employment Status Between Pregnancies and Family Planning Practice.

Employment Status Between Pregnancies	Non-users (521)	FP users (579)	Total (1100)	Z-test Values
MWRAs who were employed/worked for pay between first and second pregnancies	34.1(651)	46.0(324)	38.1(975)	3.569**
Type of work	(222)	(150)	(372)	
Professional/Technical (practice of profession)	28.8	38.7	32.8	1.978**
Managerial/Administrative	1.4	2.7	1.9	0.844
Sales/Business (engaged in buying/selling)	23.9	28.0	25.5	0.882
Farming/Fishing	13.1	4.7	9.7	2.949**
Clerical work	3.6	5.3	4.3	0.767
Transport and communication	0.5	0.7	0.5	0.241
Craft/Production process	5.4	4.7	5.1	0.304
Service/Sport	23.0	12.0	18.5	2.839**
Others	0.5	3.3	1.6	1.826
MWRAs who had worked/employed for pay between second and third pregnancies	29.9(455)	35.7(252)	32.0(707)	1.566
Type of work	(136)	(89)	(225)	
Professional/Technical (practice of profession)	19.9	37.1	26.7	2.792**
Managerial/Administrative	0.7	2.2	1.3	0.877
Sales/Business (engaged in buying/selling)	24.3	25.8	24.9	0.253
Farming/Fishing	16.2	5.6	12.0	2.656**
Clerical work	3.7	4.5	4.0	0.293
Transport and communication	0.7	0.0	0.4	0.979
Craft/Production process	5.1	6.7	5.8	0.492
Service/Sport	28.7	13.5	22.7	2.864**
Others	0.7	4.5	2.2	1.644
MWRAs who had worked/employed for pay between third and fourth pregnancies	28.1(324)	40.6(175)	32.5(499)	2.794**
Type of work	(91)	(71)	(162)	
Professional/Technical (practice of profession)	22.5	31.4	26.4	1.265
Managerial/Administrative	0.0	2.9	1.3	1.456
Sales/Business (engaged in buying/selling)	23.6	34.3	28.3	1.490
Farming/Fishing	20.2	7.1	14.5	2.521**
Clerical work	2.2	4.3	3.1	0.735
Transport and communication	0.0	1.4	0.6	1.004
Craft/Production process	4.5	4.3	4.4	0.062
Service/Sport	25.8	14.3	20.8	1.858
Others	1.1	0.0	0.6	1.006
MWRAs who had worked/employed for pay between fourth and fifth pregnancies	29.7(209)	45.8(118)	35.5(327)	2.890**
Type of work	(60)	(54)	(114)	
Professional/Technical (practice of profession)	16.7	24.1	20.2	0.980
Managerial/Administrative	0.0	3.7	1.8	1.440
Sales/Business (engaged in buying/selling)	25.0	29.6	27.2	0.550
Farming/Fishing	25.0	7.4	16.7	2.655**
Clerical work	0.0	1.9	0.9	1.023
Transport and communication	1.7	7.4	4.4	1.449
Service/Sport	30.0	20.4	25.4	1.190
Others	1.7	5.6	3.5	1.100

*Figures enclosed in parenthesis are frequencies.

** Statistically significant at 5 percent level.

Family Planning Practice and Work Participation Controlling for Other Variables: Regression Analysis

To determine the effect of family planning practice, considering duration of practice, on work participation, when other variables are held constant, a regression analysis was done. Work participation was measured as nominal data and categorized simply as working or non-working. Family planning practice, on the other hand, was measured in terms of duration of use of family planning, with the non-users classified under zero duration. The reference variable for duration of use is current users who have used FP continuously for 24 months or more.

The results of the regression analysis, which are shown in Table 21, show that the log odds of the non-users are 0.6743. Since it is less than 1.0, it can be interpreted that the non-users are less likely to work compared with the FP users. Since the regression coefficient is negative (-. 3940), there is a 39.4 less probability that the non-users can work, compared with their FP user counterparts. The above data indicate that the influence of family planning practice on the participation of the women in paid work is favorable even when other factors are held constant.

The regression results further confirm that, irrespective of a woman's age, place of residence, religion, educational attainment, and other variables, family planning practice has a positive effect on work participation of women. The data support the argument that when a woman can space or limit her pregnancies she will have better opportunities to work for pay because she has more time for work when she is not saddled with reproductive responsibilities.

The analysis also showed that each of the variables controlled in the regression had significant influence on the women's work participation. The women's participation in paid work significantly increased with age, household size, educational attainment and socioeconomic status. This means that as women grow older and have more children, it is more likely that they will work for pay. Moreover, women with high school and college education had better chances of working than those who had completed elementary education only. Women with high socioeconomic status also had better chance of participating in the labor force that those with low status.

From the results of the analysis, it can be deduced that the need for women to work and earn income is more evident when they already have children. As more and more children are born to a couple, the need for women to join the work force is increased. Mothers who believe that parenting is a joint responsibility of the husband and the wife feel the responsibility of helping her spouse to help in augmenting the income of the family in order for them to meet the needs of the family.

Table 21. Regression Analysis of Women's Work Participation and Selected Variables.

Independent Variables	Regression Coefficient	Log Odds	Significance
Age	.0675	1.069	.0000**
Residence			
Rural	.0761	1.079	.6136
Urban*			
Household size	-.1183	.8884	.0157**
No. of children ever born	.0288	1.029	.5744
Religion			
Non-Roman Catholic	.1391	1.149	.4318
Roman Catholic*			
Education			
Elementary	-.3850	.6804	.0693
High school	-.9046	.4047	.0000**
College*			
Postgraduate	2.0313	7.623	.0105**
Vocational	-.9883	.3722	.0002**
Duration of FP use			
Non-FP users	-.3940	.6743	.0203**
PU for 24 mos. & above, but not CU	-.4256	.6533	.1339
PU, for less than 24 mos. But not CU.	-.1094	.8963	.4573
PU stopped, then CU 24 mos. & above	.4266	1.532	.0087**
PU stopped, then CU, less than 24 mos.	-.4550	.6344	.0685
CU, continuous for 24 mos. & above **			
CU, continuous for less than 24 mos.	-.0497	.9515	.2759
Cannot recall	-.00004	1.000	.3776
Socioeconomic status	.1159	1.122	.0000**
Constant	-3.0342	0.0481	.0000

* Reference category
CU - Current users
PU - Previous users
**Statistically significant at 5 percent level

The favorable consequence of family planning on work participation of the MWRAs is further supported by other survey information. MWRAs who were practicing family planning were asked about the benefits of family planning. Table 22 shows that the majority of the respondents declared that family planning has allowed them to spend more time at their work (88.3 percent), be more efficient in their work (84.8 percent), advance in their work position (75.5 percent) and earn more money/income (85.0 percent). This may be explained by the fact that childcare requires time and effort. When a woman has many or closely spaced children, she allocates more time to childcare and housework, thus reducing her time for gainful work. Since mothers are the main care giver of young children, having a sick child can cause a working mother to be late in her work or be absent from work.

Table 22. Distribution of Family Planning Users According to their Perceived Benefits of Family Planning in their Lives in Relation to Work Participation.

Perceived Benefits	Frequency (n=579)	Percentage
Family planning has allowed MWRA to:		
Spend more time in work	511	88.3
Be efficient in their work.	491	84.8
Advance in work position.	437	75.5
Earn more money/income	492	85.0

Qualitative Data on the Influence of Family Planning on Work Participation of Women: Perceptions of MWRAs, Husbands, and Family Planning Providers

The survey results were strongly supported by the qualitative data of this study. The FGD and in-depth interview participants, both men and women, tended to favor wives' working for pay. The male participants shared the women's view that women should work if they want to. They also believe, that by working, women can help augment their family income. They also agreed that having many children and closely- spaced pregnancies are common reasons why mothers cannot work even if they want to. Being the one mainly responsible for childcare, a mother cannot easily leave the house when the children are still small unless she has a full-time baby sitter. With the high cost of baby sitters, however, a mother would rather stay at home to attend to her mothering responsibilities.

The husbands agreed with their wives that when pregnancies are spaced or when the number of children is limited, it is easier for their wives to decide to work fulltime outside the house; otherwise, they have to wait until their children are grown up. The men and the women also perceived that working women with many children or those who have closely-spaced pregnancies often suffer from physical as well as emotional exhaustion because of the multiple burden of employment, housework, and child care, especially when their children are still of pre-school age.

Most women desire to work for economic and also for psychological reasons, according to key informants. They acknowledged the economic and psychological advantages of working for pay.

They underscored the fact that if women work, they can contribute to the family coffers, and in difficult situations, economic partnership of the husband and the wife is "more of a necessity rather than a choice."

The women also emphasized that among the psychological benefits of earning money is the enhancement of their self-esteem or self-worth. When they have their own money, they think highly of themselves. Some say that they feel more secure when they have work because they can buy what they want to buy, either for themselves or for any member of the family, without asking for money from their husbands or parents.

Members of women's groups expressed unanimously that employment "empowers women" because through their work they can express themselves and participate in Decision-making in and outside the home. According to them, self-expression and Decision-making participation develop self-esteem.

The wives also expressed that they desire to work for self-fulfillment. Some key informants confided that having more children than the number they desire limits their economic opportunities. They stressed that their children are their priorities in life, thus, even if there are opportunities for work or promotion, if the work assignment makes them neglect their child care responsibility, they have second thoughts in accepting the assignment.

The husbands shared their wives' perception that the wife's time is usually concentrated on child care and household chores and that the presence of small children at home increases their responsibilities and burden. Some men expressed that they prefer their wives to stay at home than work outside the home when the children are still of pre-school age, even when household help is available.

The following case illustrates how family planning enhanced the economic opportunities and improved the quality of a woman.

> Salve was 21 years old when she married Alexis. After graduation from college, they decided to get married when Alexis found a good-paying job. Salve also wanted to work, but within two months after their wedding, she got pregnant. Two months after the birth of their baby, however, Salve got pregnant again. She was unprepared for this. Since she was breastfeeding, they did not expect to be pregnant so soon. As a result, Salve's was again not able to find work. After the birth of their second child, the rising cost of living and child care further intensified Salve's desire to work. Realizing, that she could never work unless she stopped having babies, she discussed with Alexis the possibility of family planning to prevent or postpone a third pregnancy. They visited a doctor for advice. Since they planned to have a third child, they were prescribed pills. That was six years ago. Salve was still on pills during the survey and she was working. When her second child turned two, Salve applied and was hired as an accounting clerk in a private firm. With a steady income, she felt better that she could help meet the financial needs of her family. She also felt better that she could buy things for herself without asking for Alexis'

permission. Salve concluded that she could not have worked at all if she had not practiced family planning.

Mary, a fish vendor with seven children has her own story to tell about how family planning improved her quality of life.

> When Mary married Andres, a fisherman from Aklan, she was convinced that a wife's functions were to "bear children," "serve her husband," and "take care of the children and the house;" and the husband's role was to "provide for the family." After 13 years of marriage and the births of seven children, however, she realized that Andres alone could not financially support the family. His income from fishing was barely enough to cover even the basic needs of the family. Mary had long realized that she needed to work to help augment the family income, but with the children so closely spaced, she did not find the time to do so. When her seventh child was born, the eldest was only about 13 years old. She had heard about family planning from the BHW in their community, but being devout Roman Catholics, she and Andres did not attempt to use any method to prevent/postpone pregnancy. The numerous visits of the BHW in their home never changed their mind about family planning, until they could no longer ignore their economic difficulties. Mary decided to do something to help. Since Andres was a fisherman, the couple decided that Mary could sell fish in the morning and then in the afternoon. To find time to do this, however, they had to stop having children. They met with the BHW who referred them to the RHU where they obtained family planning advice and contraceptives. During the survey, Mary was earning about 100 pesos daily by vending fish.

The above data confirm the positive influence of family planning on the work participation of women. The study supports the hypothesis that the women's opportunities to work tend to be enhanced by FP practice. Their being able to limit the number of their children or space their pregnancies may have allowed them to have more time to work for pay. This study also supports the position of Hong and Seltzer (1994) that women's chances of getting employed are enhanced by family planning practice as evidenced by the favorable association between family planning practice and work participation of MWRAs.

Family Planning Practice and Participation in Community Activities among Women in Western Visayas

Background

The possible effect of family planning practice on a woman's performance in her societal roles, such as her involvement in community activities, is the focus of this section. Specifically, the study examined the possible association between FP practice and participation in community activities. It is predicted that a contracepting woman will have greater control over her fertility, and thus, will have fewer children and more time to do things she wants to do. Having spaced pregnancies or limited number of children, she can be spared some of her domestic

responsibilities and be able to utilize some of her time in meeting her social needs or discharging her social responsibilities.

Given the fact, however, that there are certain mediating factors that may intervene in the relationship between community involvement and family planning practice, some of the possible mediating variables were controlled in the analysis.

Association between Family Planning and Community Participation

Table 23 shows that only 484 or 44.0 percent of the 1100 MWRAs interviewed had been involved in community activities during or before the survey. Probably the need to take care of the home and family and to earn a living kept the 56 percent in the home or work area. There were significantly more family planning users than non-users (49.7 percent vs. 37.6 percent) who were actively involved in community activities. The most common community activities participated in by the women were community development activities (50.6 percent). The data further show that more than one-third of the women involved in community activities was also active in church activities (39.3 percent) only. One in every four socially active women was engaged in health-related activities; this is a worrisome fact since, on the whole, medical care for the family, especially for the children, is often neglected for economic reasons. One in five was involved in programs of local cooperatives. The data show that significantly more FP users than non-users were involved in health-related activities. The differences between the proportions of non-users and of FP users who were engaged in the other types of community activities were not significant.

Table 23. Percentage Distribution of Respondents According to How They Regarded Participation in Community Activities and Extent of their Participation.

Indicators	Non-users (n =521)*	FP users (n=579)	Total (n=1100)	Z-test
Percent of MWRAs who participated in community activities	37.6	49.7	11.8	4.074**
Community activities participated in	(196)	(288)	(484)	
Mother's club	12.8(25)	11.1(32)	11.8(57)	0.196**
Women's group	10.7(21)	19.4(56)	15.9(77)	1.015
Church activities	40.3(79)	38.5(111)	39.3(190)	0.250
Community development	46.4(91)	53.5(154)	50.6(245)	1.077
Other health-related activities	17.9(35)	56.5(87)	25.2(122)	4.606**
Local cooperative programs	23.5(46)	22.6(65)	22.9(111)	0.111
HIV/AIDS Prevention	0	1.4(4)	0.8(5)	
Others	11.2(22)	7.3(21)	8.9(43)	0.443
Percent of MWRAs who believed that "it is good for women to participate in community activities"	93.5 (487)	97.8 (566)	95.7 (1053)	3.467**
Reasons				
To be informed of what is happening in the community	21.9(109)	25.6(145)	24.1(254)	0.689
To be able to help and cooperate in the Activities of the *barangay*	38.4(187)	40.5(229)	39.5(416)	0.436
To develop personality	13.8\(67)	13.2(75)	13.5(142)	0.104
To be able to share ideas.	11.5(56)	13.2(75)	12.4(131)	0.294
Because women are more responsible/ approachable/ willing to work	6.9(34)	7.1(40)	7.0(74)	0.034** 0.017**
To have pastime and leisure time	6.6(32)	6.5(37)	6.6(69)	0.115
To have participate in Decision-making	4.1(20)	3.4(19)	3.7(39)	0.507
To have more friends and acquaintances	10.1(49)	7.1(40)	8.4(89)	0.084
Others	6.9(34)	6.4(36)	6.6(70)	0.293
Don't know	2.5(12)	0.7(4)	1.5(16)	

*Figures enclosed in parenthesis are frequencies
**Statistically significant at 5 percent level.

On the whole, the majority of the MWRAs believed that it is beneficial for women to be involved in community activities. There was significantly more FP users than non-users who were of this belief (97.8 percent vs. 93.5 percent). Yet only 44 percent of them actively participated.

The most common reasons given by the women for their active participation in community activities were: 1) participation will enable them to help in the activities of their communities (39.5 percent); 2) participation will keep them posted on what's going on in their community (24.1 percent); 3) development of their personality(13.5 percent); and 4) opportunity to share their ideas with other people (12.4 percent). The FP users and the non-users had about the same reasons. This is shown by the insignificant differences between proportions of the two groups who cited each reason for thinking that "community involvement is good."

Only three of the reasons are related to leisure, entertainment, and social acceptance: personality development, pastime and leisure, and to have friends and acquaintances. Can it be that the pressures of economic and home chores, mentioned above, somehow make the women overlook their need for these social pleasures?

Family Planning Practice and Participation in Community Activities, Controlling for Selected Variables

When age of MWRAs was controlled, the edge in community participation of the FP users over the non-users was maintained in the 21-to-30 and 41- and- above age groups, but not in others (Table 24). The more active involvement in community activities of the FP users prevailed both among the Roman Catholics and non-Roman Catholics (50.8 percent and 36.8 percent, respectively). Variation in educational attainment of the MWRAs did not alter either the greater participation of the FP users over that of the non-users in community involvement. In all educational groups, there were still significantly more FP users than non-users who were active in community activities (Z values =1.96 for the elementary educated group, 3.03 and 4.98 for the high school and college-educated groups, respectively).

When the MWRAs were grouped according to residence, however, advantage in community participation of the FP users over the non-users was maintained only among the urban dwellers (49.3 percent vs. 34.8 percent) but not among the rural dwellers. More FP users than non-users were involved in community activities among the rural dwellers; however, the difference between the proportions was not statistically significant. Probably because the community activities, like church activities, community development projects and health classes, are also the only sources of diversion/ entertainment in the rural areas, FP users and non-users alike tend to engage in as many of them as they have time to. In the city, the community activities are more numerous and varied and those who have more time to engage in these activities are those who have more leisure time. So in the urban areas, the advantage of the FP users is more evident than it is in the rural areas.

Table 24. Percentage Distribution of MWRAs by Participation in Community Activities and Family Planning Practice, Controlling for Certain Variables.

	Family Planning Practice			
Community Participation	**Non-users (n =521)**	**FP users (n=579)**	**Total (n=1100)**	**Z-test**
Percent of MWRAs who participated in community activities	37.6 (196)	49.7 (288)	44.0 (484)	4.074**
Community participation controlling for certain variables:				
Age				
Below 20	29.4(17)	50.0(6)	34.8(23)	0.887
21-30	27.4 (179)	38.9(157)	32.7(336)	2.244**
31-40	44.1(211)	52.0(281)	48.6(492)	1.742
41 and above	43.0 (114)	57.8(135)	51.0(249)	2.353**
Religion				
Roman Catholic	36.8(429)	50.8(465)	44.1(884)	4.261**
Non- Roman Catholic	41.3 (92)	45.6(119)	43.7(206)	0.620
Educational attainment				
No Formal Education	0.0(3)	0.0(3)	100.0(6)	
Elementary	26.7(135)	38.5(109)	32.0(244)	1.961**
High School and Vocational	30.5(220)	44.0(241)	37.5(461)	3.029**
College and Above	37.1(163)	61.9(226)	59.9(389)	4.985**
Barangay				
Rural	41.8(208)	50.9(175)	46.0(383)	1.785
Urban	34.8(313)	49.3(404)	43.0(717)	3.956**
Household size				
1-2	44.4(27)	100.0(3)	50.0(30)	5.815**
3-4	36.9(179)	40.0(145)	38.3(324)	0.570
5-6	41.1(192)	49.6(236)	45.8(428)	1.765
7 and above	31.7(123)	56.4(195)	46.9(318)	4.494**
Work status				
Working	52.9(191)	60.5(261)	57.3(452)	1.613
Non-working	28.8(330)	40.9(318)	34.7(648)	3.255**
Number of children ever born				
0	44.4(36)	100.0(1)	45.9(37)	6.714**
1-2	38.8(224)	43.6(172)	40.9(396)	2.414**
3-4	38.9(157)	50.9(234)	46.0(391)	4.187**
5-6	32.8(64)	50.9(112)	44.3(176)	5.589**
7 and above	27.5(40)	60.0(60)	47.0(100)	3.895**

*Figures enclosed in parenthesis are frequencies

** Statistically significant at 5 percent level.

Similarly, irrespective of work status, there was still more FP users than non-users who were involved in community activities. This is demonstrated by significantly higher proportion of FP users than non-users who were involved in community activities both among the working and non-working MWRAs. The same pattern was noted when household size and number of children were controlled.

The findings of this study support the hypothesis that family planning practice is associated with women's participation in social and community activities. The data suggest that family planning practice tends to improve women's involvement in community affairs and social activities. The assumption that women with fewer children have more time to participate in social/public activities is borne out by this study (Hong and Seltzer, 1994).

Family Planning Practice and Participation in Community Activities, Controlling for Selected Variables: Regression Analysis

Table 25. Shows the regression of family planning practice on selected variables. The data show that the log odds of those who never used family planning are 0.7218. Since it is less than 1.0, it can be deduced that the non-users are less likely to participate in community activities compared with the FP users. Since the regression coefficient is negative (-. 3259), the log odds of .7218 means that there is 27.82 percent less probability that the non-users will participate in community activities compared with FP users, keeping all the other variables constant.

The data further show that duration of family planning use does not significantly predict participation in community activities, since the regression coefficients between participation and each category of duration of family planning practice were not significant at the 5 percent level. Irrespective of FP use duration, the FP users were more likely to be involved in community activities than those who had never used family planning.

The data further show that most of the variables controlled had significant bearing on women's community participation. With respect to age, the data show that participation in community activities of the MWRAs significantly increases with age. This means that as women grow older, their likelihood to participate in community activities also improves. Work participation was also found to be significantly related to community participation. Working women have a greater likelihood to participate in community activities than non-working women. The MWRAs in the rural areas also tended to participate more in community activities than their urban counterparts.

Educational attainment and socioeconomic status of the respondents were also both noted to have significant bearing on the MWRAs' community participation. College-educated women tended to be less likely to participate in community activities compared with their less-educated counterparts. This may be explained by the fact that the survey instrument did not include some categories of community activities held in the city. Listed in the interview schedule are community activities organized for the non-professional, unemployed women. City organizations, such as the Young Women's Christian Association (YWCA), Lions Professionals, and other professional organizations in the city were not included. The way sampling procedures were carried out made it unlikely to include lawyers, who are members of lawyers' organization. Women who are members of professions seek membership in professional groups like the

Philippine Nursing Association (PNA) and the Philippine Medical Association (PMA).

Table 25. Regression Table for Participation in Community Activities in Relation to Selected Variables.

Independent variables	Regression Coefficient	Log Odds	Significance
Age	.0200	1.020	.0536**
Residence			
Rural	.4095	1.506	.0042**
Urban*			
Household size	.0247	1.025	.5815
No. of children ever born	.0147	1.014	.7623
Religion			
Non-Roman Catholic	-.0455	.9555	.7855
Roman Catholic*			
Occupation			
Working*	.5992	1.697	.0000**
Non-working			
Education			
Elementary	-.8874	.4117	.0000**
High school	-.5375	.5842	.0020**
College*			
Postgraduate	.3988	1.490	.4695
Vocational	-.5742	.5631	.0204**
Duration of FP use			
Never-FP users	-.3259	.7218	.0455**
PU, not CU -24 mos. & above	.2909	1.337	.2880
PU, not CU, less than 24 mos.	.0247	1.025	.8581
PU stopped, then CU 24 mos. & above	.1386	1.148	.3326
PU stopped, then CU, less than 24 mos.	-.0928	.9113	.5971
CU, continuos for 24 mos. & above *			
CU, continuos for less than 24 mos.	-.0200	.9801	.6403
Cannot recall	.00002	1.0000	5353
Socioeconomic status	.0426	1.0430	.0413**
Constant	-1.5219	.2182	.0012

* Reference category
**Significant at the 5 percent level
CU - Current User
PU – Previous User

Community participation, however, was not significantly related to number of children ever born and household size. This seems to negate the assumption presented earlier that women with fewer children have more time for community activities; however, the fact that the FP users in this study may have already "completed" families should be borne in mind.

When directly asked what benefits the FP users derived from their practice of family planning, 92.6 percent declared that the practice of family planning provided them more time for leisure (Table 26). Moreover, 83.4 percent of the FP users reported that because they were practicing family planning, they have been able to participate in community activities, while 75.5 percent reported that it allowed them to take leadership roles in their community. Three out of four also said that they were satisfied with their involvement in community activities.

Table 26. Distribution of Family Planning Users according to their Perceived Benefits of Family Planning in Relation to their Involvement in Community Activities.

Perceived Benefits of Family Planning	Frequency (n=579)	Percentage
FP practice has allowed MWRAs to:		
♦ Participate in community activities	483	83.4
♦ Take leadership role in community activities	437	75.5
♦ Be satisfied with involvement in community activities	440	76.0
♦ Have more leisure time	536	92.6

Qualitative Data on the Influence of Family Planning on Community Participation of Women: Perceptions of MWRAs, Husbands, and Family Planning Providers

The FGD and in-depth interview results confirmed the survey findings that family planning practice tended to enhance the women's participation in community activities. The male and female FGD participants and interview respondents agreed that spaced pregnancies and fewer number of children provided women free time to "relax and socialize" with their neighbors or community folk Some respondents stressed that child rearing, being socially prescribed as a woman's role, takes so much of their time and prevents them from getting involved in community activities. Because they had washing, cooking, or child care to do, they could not attend meetings and social activities.

This is apparent in the cases illustrated below:

> Edith, a working mother of five, spends eight hours a day, seven days a week working as a teacher in public school. On Saturdays and Sundays, she does the laundry and cleans the

house. Her household help does some of the household chores and at the same time baby sits the youngest child when Edith is at work. In the evenings, Edith tries to "squeeze in" some time to tutor her elementary school children. Her friends and officemates sometimes invite her to play bowling on Friday evenings, after work, but she often begs off because of the work at home. She admitted that she sometimes envy her friends who could relax and enjoy when they wanted to. According to her, she does not mind working at home and taking care of their children, but admitted that things would be easier if she has only two or three children. She reported that her sister who has only two children is actively involved in many social activities.

Cristina is a mother of four children whose ages raged from two months old (youngest) and four years old (oldest). When she was not yet married, she was very active in community affairs. Things, however, changed after she got married. According to her, her community participation was restricted by her successive four pregnancies within the span of six years. She related that:

> *"Kay tam-an ka-ikit ang akon pagpamata, halos tanan nga oras ko para lang sa balay kag sa pag-atipan sang mga kabataan. Kon kis-a kulang pa gani ang akon mga tini-on sa olobrahon. Wala kid ako tiempo sa paglingalingaw. (Because my children were so closely spaced, I spent most of my time at home taking care of them and doing the household chores. Sometimes, my time is not enough to do all my work that I can hardly find time to relax and enjoy.")*

Mario, the husband of Jane, a young college-educated mother of three pre-school children, had this to say:

> *"Sang naga-eskuwela pa ang akon asawa, student leader Na siya. Youth leader man siya SA barangay. , Luyag niya tani nga padayunan ang pag bulig SA barangay sang nag-asawahay kami ugaling mabudlay kay magagmay pa ang mga kabata-an. Siyempre dapat nga pasulabihon niya ang iya obligasyon sa balay kag kabata-an." ("When my wife was still studying she was a student leader. She was also a youth leader in the barangay. When we got married she wanted to continue her community involvement, but she lacked time to do that because the children are still small. I expect her to give priority to our home and our children.")*

Remy, a community health volunteer (BHW) for five years and at the same time the wife of the Barangay Captain attributed her active involvement in community activities to family planning. She declared that:

> "*If I did not start practicing family planning after the birth of my third child, I could not have effectively performed my role as a BHW and a wife of a barangay leader. Because I do not have so many children I find time serving my barangay. I am the president of the BHW organization in their community. I received the "Most Outstanding BHW" award, and I am also active in the "Clean and Green Project" and the "Feeding Program" of our barangay."*

Husbands agreed that their wives deserve to relax and enjoy through socializing with friends and participating in community activities if they want to, but they also expect their wives "to give priority to their responsibilities at home." The men also confirmed that work at home and childcare prevent women from getting involved in community affairs.

Members of women's groups expressed the women's need to socialize. They expressed that women should not be confined at home to do household chores. Some mentioned that they can only enjoy some recreation, like playing "mahjong" or visiting friends, if they do not have small children to care for or when the children are already grown up.

The women articulated that involvement in social/community activities has improved their personality because they were able to learn from others new ideas, new styles of dressing, new ways of doing things. In turn, they were also able to share their own ideas with others.

Family Planning Practice and Educational Advancement among Women in Western Visayas

Background

Educational advancement is used as an indicator of improvement in a woman's social status. This study attempted to determine whether family planning practice contributes to a woman's pursuit for educational advancement, which was measured using two indicators: a) attendance in training and b) going to school between pregnancies. It is assumed that when a woman practices family planning and is able to limit the number of her children or space pregnancies, her chances to seek educational advancement through attendance in training or further education may improve. If she married at an early age, the marriage or pregnancy may have interrupted her studies. If, after the birth of a child, she decides to postpone another pregnancy through family planning, she may find time to go back to school to resume her studies, or she can attend training to improve her knowledge and skills.

Attendance in Training of MWRAs after Marriage

Table 27 shows that nearly a quarter of all the MWRAs had attended training (27.5 percent). The data show that a significantly higher proportion of FP users (29.9 percent) than non-users (24.8 percent) had attended seminars or training after marriage. The big majority of both trained FP users and non-users were able to attend only one training (68.2 percent and 79.1 percent, respectively), but there were significantly more FP users than non-users who were able to attend two or more training (31.5 percent vs. 20.9 percent)

The most common types of training attended by both the trained FP users and non-users the MWRAs were in relation to personal development (42.1 percent). Nearly the same proportion of the two groups obtained training in this area (43.4 percent and 41.0 percent) respectively). Other types of training attended by fewer MWRAs were in relation to health (21.8 percent), family planning (15.9 percent), livelihood and skill development (14.9 percent), human resource development (12.6 percent) and social development (11.9 percent).

The advantage of the FP user over the non-users in terms of attendance in training remained evident even when other variables were controlled, although not in all categories. When age was controlled, the training advantage of the FP users over the non-users was sustained among women who were more than 30 years old, but not among those who were younger. The data in Table 28 also show that attendance in training tended to increase with age. Of those who had been trained, more than half (61.0 percent) were more than 30 years old, about half of whom (31.3 percent) were in their forties.

Table 27. Percentage Distribution of Respondents According to Type of Training Attended and Family Planning Practice (Multiple Response).

Indicators	Non-users (n =521)	FP users (n=579)	Total (n=1100)	Z-test
Percent of MWRAs who attended training(s)	24.8(129)	29.9(173)	27.5(302)	1.989**
Percent of MWRAs who never attended	75.2(392)	70.1(406)	72.5(798)	1.619
No. of training attended	(n=129)	(n=173)	(n=302)	
One	79.1	68.2	72.8	1.853
Two or more	20.9	31.8	27.2	1.986**
Type of training				
FP training	15.5	16.2	15.9	0.066
Personnel and development training	43.4	41.0	42.1	0.272
Livelihood and skill training	14.0	15.6	14.9	0.149
Human resource development training	11.6	13.3	7.9	0.156
Health –related training	14.7	27.2	21.8	1.202
Social training	13.9	10.4	11.9	0.322
Others	3.1	4.0	3.6	0.079

** Statistically significant at 5 percent level.

When education of the women was considered, the training advantage of the FP users over the non-users was also sustained, but not in significant degree. It was noted that attendance in training was higher among women with college education than those who were elementary or high school-educated only (49.4 percent vs. 11.5 percent and 17.8 percent, respectively). The motivation to go back to school after marriage or children is expected to be greater for women who have already started college, because of the shorter time they need to finish their degree. College education is also less structured than high school in terms of schedule and therefore, it is much easier for a married woman to make adjustments with her schedule for study and household or work responsibilities.

The data also show that there was more FP users than non-users who had attended training both among the working and the non-working working. Work, however, tended to suppress the influence of family planning practice on the attendance in training of the women. The differences

in proportions between the FP users and non-users both among the working and among the non-working women did not reach a significant level. It was also noted that the working women tended to have better training attendance than those who were not working. Working women generally have better exposure and better access to training opportunities.

Table 28. Percentage Distribution of MWRAs According to Attendance in Training And Family Planning Practice, Controlling for Certain Variables.

Attendance in Training	Non-FP User (n =521)	FP Users (n=579)	Total (n=1100)	Z-test Values
Percent of mwras who attended training(s)	24.8	29.9	27.5	1.986**
Attendance in training controlling for certain Variables:				
Age	5.9(17)	0(6)	4.3(23)	1.032
Below 20	23.5(179)	22.3(157)	22.9(336)	0.261
21-30	26.1(211)	32.4(281)	29.7(492)	1.531
31-40	27.2(114)	34.8(135)	31.3(249)	1.300
41 and above				
Educational attainment	0(3)	0(3)	0(6)	
No Formal Education	11.1(135)	11.9(109)	11.5(244)	0.194
Elementary	15.9(220)	19.5(241)	17.8(461)	1.015
High School and Vocational	48.5(163)	50.0(226)	49.4(389)	0.292
College and Above				
Work status	39.3(191)	44.1(261)	27.7(894)	1.025
Working	16.4(330)	18.2(318)	26.6(206)	0.606
Non-working				
Religion	25.2(429)	29.9(465)	42.0(452)	1.575
Roman Catholic	22.6(92)	29.8(114)	17.3(648)	1.178
Non- Roman Catholic				
Barangay	23.6(208)	31.4(175)	27.2(383)	1.703
Rural	25.6(313)	29.2(404)	27.6(717)	1.076
Urban				
Household size	33.3(27)	33.3(3)	33.3(30)	0.000
1-2	26.3(179)	28.3(145)	27.2(324)	0.401
3-4	26.6(192)	30.5(236)	28.7(428)	0.891
5-6	17.9(123)	30.3(195)	25.5(318)	2.598**
7 and above				
Number of pregnancies	38.7(31)	0(1)	37.5(32)	4.424**
0	31.0(200)	32.5(154)	31.6(354)	0.280
1-2	20.6(170)	30.6(216)	26.2(386)	2.267**
3-4	17.0(120)	26.9(208)	24.7(328)	2.214**
5 and above				
Number of children ever born	44.4(36)	0(2)	42.1(38)	5.362**
0	28.7(223)	33.3(171)	30.7(394)	0.976
1-2	22.3(157)	30.8(234)	27.4(391)	1.894
3-4	13.3(105)	25.6(172)	20.9(277)	1.965**
5 and above				
Socioeconomic status	13.3(233)	16.1(199)	14.6(432)	0.817
Low (Score of 3-11)	32.8(271)	35.2(366)	34.2(637)	0.633
Average (Score of 12-20)	52.9(17)	85.7(14)	67.7(21)	2.144**
High (Score of 21 and above)				

* Figures in parentheses are frequencies.

**Significant at 5 percent level

There were more FP users than non-users who had attended training among both the Roman Catholic (29.9 percent vs. 25.2 percent) and non-Roman Catholics (29.8 percent vs. 22.6 percent) and among both the urban dwellers (29.2 percent vs. 25.6 percent) and the rural dwellers (31.4 percent vs. 23.6 percent). The difference in proportions between the FP users and non users, however, was not statistically significant in both categories of religion and residence.

The favorable influence of family planning practice on training attendance of the MWRAs remained obvious even when household size, number of pregnancies and number of children were controlled. The proportions of women who have attended seminars in all categories were higher for the FP users than for the non-users, although the difference in proportions was significant only among those who belonged to households with seven or more members (Z=2.598), those who had 5 or more pregnancies (Z=2.214), and those with 5 or more children ever born (Z=1.965).

The data further show that attendance in seminars or training decreased with an increase in the number of children or pregnancies. This is evidenced by the decreasing proportion of women who attended training as the number of pregnancies or children increased. The same pattern was observed for both the FP users and the non-users

Attendance in training, also improved with increase in socioeconomic status (SES) of the MWRAs. This is reflected by a higher proportion of women reporting attendance in training among those with "high" SES (67.7 percent) than those who with "average" SES (34.2 percent) and those with "low" SES (14.6 percent). The same pattern was observed both among the FP users and the non-users. There were more FP users than non-users in each socioeconomic level who had attended training/seminars, but the difference between the two groups was statistically significant only among those with "high" 85.7 percent vs. 52.9 percent, Z=2.144).

Educational Advancement Between Pregnancies

Table 29 reveals that 49 of the 1100 MWRAs were able to go back to school after the birth of their first child. Of those who did, 30 were FP users while 19 were non-users. Proportionately there were 1.6 percent more users than non-users who were able to go back to school to pursue further studies after their first pregnancy. Most of those who went back to school attended college (59.2 percent), while about one-fourth (22.4 percent) attended high school. There were eight (16.3 percent) who went to graduate school. Although there were more non-users (63.1 percent) than FP ever users who studied in college, there were substantially more FP users who sought further instruction after giving birth to their first born.

Twenty MWRAs were able to pursue educational advancement between their second and third pregnancies; 18 of who pursued college education and graduate education, combined. Twelve of these were FP users while six were non-users.

Table 29. Distribution of MWRAs According to Educational Advancement Between Pregnancies and Family Planning Practice.

School Attendance Between Pregnancies	Non-users (521)	FP Users (579)	Total (1100)
Percent of MWRAs who studied between first and second pregnancies	3.6(19)	5.2(30)	4.5(49)
Course			
Elementary	0	1	1
High School and vocational	6	5	11
College	12	17	29
Post Graduate level	1	7	8
Percent of MWRAs who studied between second and third pregnancies	1.3(7)	2.2(13)	1.8(20)
Course			
Elementary	0	1	1
High School and vocational	1	0	1
College	6	6	12
Post Graduate level	0	6	6
Percent of MWRAs who studied between third and fourth pregnancies	0.4(2)	1.9(11)	1.2(13)
Course			
Elementary	0	1	1
High school and vocational	0	2	2
College	2	4	6
Post graduate level	0	4	4
Percent of MWRAs who studied between fourth and fifth pregnancies	0.4(2)	0.7(4)	0.5(6)
Course			
Elementary	0	0	0
High School and vocational	0	2	2
College	1	0	1
Post Graduate level	1	2	3

Thirteen MWRAs also studied between their third and fourth pregnancies, eleven FP users, and two non-users. Ten of them (eight FP users and two on-users) pursued college education or graduate school, while the other three (all FP users) attended secondary or elementary school. Even after their fourth pregnancy, six MWRAs went back to school, four FP users and two non-users. Four attended college or graduate school, while two took up high school or vocational courses.

The data support the hypothesis that a woman's chance of going back to school to pursue a higher education or resume interrupted schooling is enhanced if she is able to control or space pregnancies. A woman whose studies have been aborted by early marriage or other reasons can find time to go back to school if she is spared the burden of child care resulting from closely spaced childbirth's (Hong and Seltzer, 1995). School attendance after marriage will be easier if the gap between pregnancies is long enough to allow women sufficient time to study.

Family Planning Practice and Attendance in Training Controlling for Selected Variables: A Regression Analysis

Regression analysis was done to determine the effect of family planning practice on the women's attendance in training when the influence of other variables is held constant. Attendance in training was measured as a nominal data categorized as "have attended training after marriage" and " have not attended training after marriage." Family planning practice, on the other hand, was measured in terms of duration of use of family planning, with the never-users classified under zero duration. The reference variable for duration of use is current users (CU) who have used FP continuously for 24 months or more.

The regression analysis in Table 30 shows that the log odds of those who had never used family planning is 0.8942 . Since it is less than 1.0, it means that the non-users are less likely to take advanced training than are the FP planning users. The negative regression coefficient means that the non-users have 10.58 percent less likely to attend training than the FP ever-users.

The regression findings validate the cross tabulation and the association analysis results, showing more FP users than non-users who were able to attend training. The data suggest that FP use tends to improve a woman's chance of attending training after marriage. This supports the framework that when a woman is able to space her pregnancies she will have more time for personal development, like going back to school or attending a training.

The regression analysis further exhibited that college-educated women have a greater likelihood of attending training or pursuing advanced education after marriage than their high school or elementary-educated counterparts. Similarly, working women were more likely to attend training or pursue higher education than those who were not working. The likelihood of attending training was also greater among women with "high" socioeconomic status than among those with "average" and "low" socioeconomic status. This further confirms the facilitating role of college education, work and "high" socioeconomic status in the attainment of a woman's educational/ professional pursuits.

Table 30. Regression Table for Attendance in Training and Family Planning Practice Controlling for Selected Variables.

INDEPENDENT VARIABLES	DEPENDENT VARIABLE		
	Attendance in Training		
	Regression Coefficient	Log Odds	Significance
Age	.0133	1.013	.3035
Education			.
Elementary	-1.455	.2334	.0000**
High school	-1.151	.3163	.0000**
College*			
Postgraduate	.0798	1.083	.8739
Vocational	-.4804	.6185	.0694
Work status			
Working*	.8195	2.269	.0000**
Non-working			
Barangay			
Rural	.4279	1.534	.0111
Urban*			
Religion			
Non-Roman Catholic	-.1253	.8822	.5249
Roman Catholic*			
Household size	.0222	1.022	.6707
No. of children ever born	-.0752	.9275	.2113
Duration of FP use			
-Never-FP user	-.1118	.8942	.5603
-PU, not CU for 24 mos. & more	.3188	1.375	.2999
- PU, not CU for less than 24 mos.	.0566	1.058	.7303
- PU stopped, then CU for 24 mos. & above	-.0195	.9806	.8984
-PU stopped, then CU for less than 24 mos.	.0512	1.052	.7990
-CU, continuous for 24 mos. & more*			
-CU, continuous for less than 24 mos.	.0014	1.001	.9778
-Cannot recall	-.00009	1.0	.1018
Socioeconomic status	.0873	1.091	.0003**
Constant	-2.3417	0.0961	.0000**

* Reference category
CU - Current user
PU - Previous user
**Statistically significant at 5 percent level.

Qualitative Data on the Influence of Family Planning on Educational Advancement of Women: Perceptions of Women, Men and Health Service Providers

The experiences and observations shared by the key informants and FGD participants further validate the survey findings that family planning indeed improves a woman's opportunities for educational advancement. Men and women alike admitted that the burden of child care, which is still primarily a woman's function in Filipino homes, prevents women to pursue further educational advancement. Non FP users who have children born less than two years apart personally testified to the difficulties of pursuing one's personal interest, like going back to school between child births. On the other hand, some women were able to go back to school after marriage or between child births because the practiced family planning.

FGD participants and key informants shared that many women they knew (a relative, friend, family member) had been able to go back to school after delivering their first baby or between pregnancies, but this became possible only because the women consciously spaced their pregnancies through family planning. Take the case of Janilyn and Butch, FGD participants in separate sessions.

> Janilyn was a 22-year-old mother who married Butch, her boyfriend since high school, at the age of 18. They got married early because Janilyn got pregnant when she and Butch were in their second year in college.. Both having no work yet, they lived with her parents after their marriage. After their baby was born, Janilyn's mother offered to support her studies if she wanted to go back to school. Butch's parents also made the same offer. They took the challenge and decided not to have a second baby yet so they could concentrate on their studies. The parents of both were supportive and they convinced the two to practice family planning. With the help of the Municipal Health Officer, they chose to use pills. At the time of the FGD, their first-born was already two years old, and both of them were in their junior year in college already. They have not decided yet when to have a second child.

Two FGD participants who were college teachers (one male and one female) reported that they had married students who had gone back to school after their first baby was born and did not have another baby until after they finished their studies. There were also experiences shared about attending skills training or taking up vocational courses in between pregnancies in order to engage in livelihood projects or activities.

> Celia, a high school graduate, realized after marriage that she needed to work to help augment their family income, her husband being a wage laborer only. When she learned that a technical vocational college in Iloilo City was offering free short-term classes in dressmaking in their municipality, she decided to enroll. She was able to do so because her two children were already grown up. The couple decided to have two children only because of their economic difficulties. They were using IUD and condom, combined. After her training Celia started sewing dresses for her neighbors and friends. Later she was able to maintain regular customers. She said that she is so pleased that she has an income of her own and is able to help support her family.

The men agreed that women who want to go back to school after marriage should be given the opportunity to do so, but stressed that they can do this only if they "do not have small children at

home to care for." The husbands share the view that mothers should take care of their young children, especially when there is no "house help" to take care of them. They agreed that "it is alright for mothers to attend training or go back to school if they can afford it, but only when the children are already grown up."

Member of women's groups felt quite strongly that women should get education if they want to be respected and in order for them to be empowered and have better economic opportunities. They believed that the knowledge and skills acquired through education will have a lasting impact on women's lives. Though indirectly, family planning practice can heighten a woman's aspiration for higher education because with few children or spaced pregnancies, she will have time to study and do well in school.

> When Cynthia finished college, she aspired to pursue graduate studies. Her marriage to Randy two years after graduation and her subsequent pregnancy with their first baby prevented her from going back to school. Three more babies came one after the other in a span of five years and Cynthia's dream to enroll in graduate school fell apart. Her predicament also prevented her from seeking employment. She felt that her college education was useless. Her self-esteem declined. After the birth of their fourth child, Cynthia, with Randy's approval, submitted for tubal ligation. A year after, she enrolled in graduate school. At the time of the survey, she was completing her academic requirements for a master's degree in business administration and preparing to take the comprehensive examination at the end of the school year.

In each of the three illustrations above, family planning practice obviously facilitated the fulfillment of the women's aspiration for educational advancement.

Family Planning Practice in Relation to A Women's Satisfaction With Selected Aspects Of Life

Background

Has the use of FP improved the economic and psychosocial aspects of the lives of FP users? This section discusses the extent to which family planning has affected women's satisfaction or dissatisfaction with 14 aspects of life.

Both Maslow and Rogers emphasized the concept of self-actualization. They believe that a human being can be truly satisfied and feel truly content only if he/she is self-actualized; i.e., he/she has become everything that he/she is capable of becoming. It is generally understood that no human being can fully attain the goal of self-actualization because it is a process, not an end stage. Only a small number come close to being all that one is "destined for." But this fact should not stop anyone from striving for self-actualization. In the existing gender ecology, women should not be discouraged from striving to be self-actualized.

To attain self-actualization, women should first fulfill sufficiently their needs for physical safety, belonging/love, and self-esteem. Since these needs are those that people, especially women in a

developing country like the Philippines, are struggling to fulfill, 14 aspects of life related to these needs were presented to the 1100 MWRAs. They were asked to indicate how satisfied they were in respect to these aspects. They were asked to check 4 if they were very satisfied, 3 if they were satisfied, 2 if they were dissatisfied, 1 if they were very dissatisfied.

The 14 aspects selected for study were related to or reflected the needs, fears, concerns, and beliefs that surfaced during the FGD sessions with the MWRAs. Self-actualizers are described as people who accept themselves and others, so relationships with one's partner, with family members, with neighbors, with significant others in and outside the home, and with God were included in the list of needs. In this analysis, it is assumed that when a woman is highly satisfied with her health and that of her children, with the extent to which her ambitions (for herself and her children) have been met, with her work, with her leisure activities, with her relationship with significant others in and outside her home, and with physical and social living conditions, her self-regard and her perception of how others regard her are also high.

The analysis of the satisfaction scores was done to find out whether FP users were more satisfied with certain aspects of life than were never-users. In keeping with the assumption already mentioned, the more satisfied group would be considered as having greater self-esteem. The benefits of FP use would be diminished if such use did not enhance the quality of life of women, one element of which is self-esteem.

MWRAs' Family Planning Practice and Satisfaction with Life

Table 31 shows that, on the whole, the women interviewed were satisfied with their lot, rather than dissatisfied. The lowest mean satisfaction score obtained was 2.68 (mean of never-users), indicating satisfaction since it is greater than 2.5, mid-score between 2 (dissatisfied) and 3 (satisfied). This lowest score was in regard to aspiration for children, in which the users also had the lowest mean. The highest mean was 3.73 obtained by the users in "relationship with God," the aspect in which the never-users also had the highest mean score. The fact that women interviewed showed satisfaction rather than dissatisfaction with these important aspects of their lives despite the harsh economic realities that prevail in the country invites some questions. Did the women merely give socially acceptable answers, as usually feared by some social researchers? Or do Filipino women, having girded themselves for a difficult life tend to be satisfied with their present situation, since this seems to be the lot of the masses? Or have the pervasive harsh realities in a country where the theology of martyrdom may have cultivated self-abnegation and great capacity to bear present difficulties with the hopes of bliss in the afterlife, developed a people who accept their fate and therefore tend to be satisfied with their lot?

Whatever the answers to these questions, a comparison of the satisfaction levels of users and never-users would still yield data needed to shed light on the differences that Family Planning use has effected in the lives of the Filipino women.

In all the 14 aspects, the FP users registered greater satisfaction than did the never users. The former had an overall score of 3.15 and the latter obtained 3.06. The difference between the overall scores was significant at .05 level of significance; t-test yielded a value of 7.81. This significant difference was also borne out by the satisfaction scores obtained on one of the 14

aspects that might be considered the anchor item: "life on the whole." On this item, the never-users obtained a mean score of 2.99 while the ever-users got 3.11. The difference between these scores was significant (t-value was 4.50).

However, the differences between the mean scores of never-users and the ever-users were not significant in regard to children's health, job, leisure, house relationships with friends and neighborhood conditions (physical and social). However, it should be noted that in all six aspects, both the users and non-users are still "satisfied." Comments on these four aspects are given in the latter part of this report.

An interesting finding is the very high Z-value (26.39) of the difference between the scores of the two groups of MWRAs in their satisfaction with their relationship to God. Were those who decided to use FP methods, especially among the Catholics who comprised the majority of the sample, women who were already secure and satisfied with their relationship to God and therefore had the courage to do what they thought was right for themselves and their families, despite religious sanctions and social timidity to promote FP use?

Table 31. Mean Distribution of Respondents According to Satisfaction Scores for the 14 Areas and Family Planning Use.

Satisfaction Areas	Non-users (N=521)	FP users (n=579)	Total (n=1100)	Z-tests Values
Your life as a whole	2.9942	3.1071	3.0536	4.5041**
You own health	3.0806	3.1848	3.1355	4.7519**
Children's health	3.0755	3.1163	3.0976	0.6905
Your leisure/recreational activities	3.1113	3.1710	3.1427	1.5319
Your marital relationship with partner	3.2797	3.3843	3.3358	5.7426**
Your family life apart from marital relationship	3.0729	3.2349	3.1582	12.201**
Your ambitions for self	2.8580	2.9672	2.9155	4.2165**
Aspirations for children	2.6804	2.8042	2.7476	4.8921**
Your job	3.0737	3.1004	3.0891	0.1125
The house you live in	2.7754	2.8566	2.8182	2.1927**
Family living conditions	3.0499	3.1313	3.0927	2.8938**
Your relationship with friends outside family	3.2284	3.2902	3.2609	2.2033**
Physical & social conditions of neighborhood	2.9923	3.0553	3.0255	1.6118
Your involvement in religious life/relationship with God	3.5470	3.7314	3.6439	26.386**
Mean of total satisfaction score	3.0566	3.1541	3.1079	7.8057**

** Statistically significant at 5 percent level.

Table 32. Mean Distribution of Respondents According to Satisfaction Scores for the Eight Re-grouped Areas and Family Planning Use.

Satisfaction Areas	Never-user (n=521)	FP Users (n=579)	Total (n=1100)	Z-Values
Your life as a whole	2.9942	3.1071	3.0536	4.4051**
Your marital relationship with partner	3.2863	3.3843	3.3389	5.7426**
Your job	3.0737	3.1245	3.1029	0.1125
Your involvement in religious life				
relationship with God	3.5470	3.7314	3.6439	26.386**
Self	2.9776	3.0864	3.0348	6.3141**
Children	2.8878	2.9611	2.9274	2.6123**
Family	3.0024	3.0984	3.0530	5.6414**
Other categories	3.1104	3.1727	3.1432	2.2922**

** Statistically significant at 5 percent level.

The findings about the four aspects on which the FP users did not significantly differ with the non-users in satisfaction indicate areas where more improvement needs to be done for as far as these are concerned greater self-esteem, confidence, and an easier life resulting from having fewer children to take care of and worry about, have not yet been sufficient to alleviate or overcome their worries about these aspects. These aspects (children's health, job, leisure, physical and social neighborhood conditions) are closely associated with financial conditions. Since medical care, especially medicine, is expensive, children's health is still a worry for parents. Both working and non-working mothers still have to contend with tedious housework, since labor-saving services like LPG stoves and washing machines (for clothes and dishes) are still out of reach of the majority, and the recreational activities most accessible to them are television and gambling, and merry-making activities that accompany fiestas and big holidays like Christmas.

Until the FGD group leader asked about their leisure activities, the MWRAs in the FGD sessions did not bring up leisure activities; even when the leader did so, only a few mentioned reading, going to movies, and going out on picnics. Family outings that were often mentioned in response to questions about leisure activities were shopping trips to the big department stores or malls, which are really fully pleasurable activities only to the children, for the mother still has to make use of these trips to procure household necessities.

Watching their children at play, visiting with the other women in the neighborhood, and resting *kon matapos ang ulobrahon* (when the house chores are done) were often what the women called pastimes. Bowling alleys and artistic hobbies are clearly not part of their world. And since the majority of the MWRAs interviewed belonged to the lower middle class or lower, as do the majority of the Philippine population, and since, in the Philippines, only middle class, and lower class families with home members working abroad have homes complete with household appliances, it is not surprising that the user MWRAs did not find their neighborhood physical and social conditions much more satisfactory than their non-user counterparts.

Family Planning Practice and Satisfaction with Life: Regression Analysis

In the regression analysis, the 14 aspects were collapsed into only eight categories. The following categories were retained as separate: "life as a whole," "marital relationship," "job," and "religious life," but "children's health" and aspiration for children" were combined as "children;" and "own health" and "aspiration for self " and "leisure" were combined as "self." "Others" included "house one lives in," "social and physical," and "neighborhood conditions." Satisfaction scores for the eight collapsed categories are shown in Table 32.

Regression analysis, shown in Table 33, reveals that a woman's age, household size, and number of children ever born do not have any significant bearing on her satisfaction with each of the eight aspects of life. When the respondents were classified according to type of residence, rural dwellers had lower satisfaction scores on "life as a whole," the anchor item, but in regard to seven aspects taken separately, the analysis showed that urban and rural dwellers were approximately equally satisfied.

The regression results also showed that MWRAs belonging to a higher SES level registered a significantly higher satisfaction of life as a whole compared with MWRAs belonging to a lower SES. Looking at the seven aspects of life, significant differences in satisfaction with self, children, and family was found in favor of those with higher SES. On the other hand, their satisfaction with religion, relationship with partner and job did not significantly vary according to level of SES.

Relative to MWRAs who were currently using FP continuously for 24 months or more, MWRAs who never used FP consistently showed less satisfaction with life as a whole and all the other aspects of life, but statistically significant differences were found for satisfaction with life as a whole, religion, self, and family.

Table 33. Regression Table for Satisfaction Scores and Family Planning: Controlling for Selected Independent Variables.

INDEPENDENT VARIABLES	DEPENDENT VARIABLES: Satisfaction Scores for Specific Aspects in the Life of a Woman															
	Life as a whole		Religion		Relationship/ partner		Job		Self		Children		Family		Others	
	B	Sig.	B	Sig.	B	Sig.	B	Sig.	B	Sig.	B	Sig.	B	Sig.	B	Sig.
Age	-.0017	.6987	.0018	.5286	-.0061	.0863	.0083	.2094	-.0010	.7641	-.0010	.7742	-5.988	.8556	-.0028	.3945
Barangay																
Rural	-.1247	.0321	.0103	.7925	.0099	.8336	.1118	.1989	-.0426	.3609	.0187	.7029	.0673	.1219	.0571	.1987
Urban*																
Household size	-.0212	.2473	-.0064	.6026	-0154	.3095	-.0121	.6496	-.0115	.4324	-.0094	.5462	-.0132	.3367	.0051	.7122
No. of children ever born	.0173	.3807	-.0061	.6441	.0158	.3316	.0085	.7691	.0109	.4905	-.0036	.8277	.0062	.6750	.0085	.5712
Religion	.1084	.1135	.1021	.0269	.1117	.0435	.1219	.2196	.1435	.0091	.1624	.0049	.1695	.0010	.1170	.0256
- Non-Roman Catholic																
- Roman Catholic*																
Occupation																
Working*	-.0446	.4546	-.0646	.1072	-.0162	.7416	-.8788	.2854	-.0606	.2056	-.0326	.5182	-.0649	.1459	-.0162	.7215
Non-working																
Education																
Elementary	-.1233	.1515	-.0703	.2238	-.2015	.0043	-.4169	.0006	-.1052	.1274	-.0551	.4475	-.0669	.2975	-.0874	.1838
High school	-.1741	.0171	-.0806	.1009	-.1889	.0015	-.2065	.0580	-.1177	.0446	-.0993	.1061	-.0932	.0877	-.1671	.0028
College*																
Postgraduate	.3781	.0704	.1657	.2381	.0878	.6020	.1966	.3591	.3174	.0585	7.792	.9964	.1756	.2610	.1172	.4630
Vocational	-.1342	.1913	-.1788	.0097	-.1396	.0946	.0651	.6947	-.1025	.2139	-.0859	.3239	-.0632	.4103	-.0477	.5435
Duration of FP use																
- Never-user	-.1347	.0464	-.1681	.0002	-.1068	.0519	-.0463	.6259	-.1244	.0220	-.1064	.0612	-.1213	.0166	-.0030	.9526
-PU, not CU -24 mos. & above	-.1131	.3159	.1121	.1396	.0489	.5955	-.1341	.3874	-.0753	.4054	-.0346	.7130	.0387	.6466	.1858	.0315
- PU, not CU, less than 24 mos.	-.0427	.4593	-.0200	.6063	-.0680	.1462	-.1029	.2118	-.0630	.1742	-.0662	.1700	-.0868	.0448	-.0386	.3824
- PU stopped, then CU 24 mos. & above	.0535	.3533	.0129	.7376	-.0028	.9516	.0282	.6593	.0272	.5564	-.0454	.3446	.0100	.8150	.0197	.6547
- PU stopped, then CU, less than 24 mos.	.0521	.4643	.0391	.4135	.0041	.9425	-.1464	.3219	.0808	.1572	.1103	.0634	.0902	.0903	.1102	.0431
-CU, continuous for 24 mos. & above *																
-CU, continuous for less than 24 mos.	-.0237	.1818	.0074	.5361	-.0031	.8282	9.711	.9724	-.0124	.3836	-.0193	.1933	-.0185	.1633	.0156	.2509
-Cannot recall	-3.916	.0415	-2024	.1170	-8.065	.6020	-3.107	.2109	-3.026	.0497	-1.309	.4233	-1.435	.3177	-1.477	.3142
Socioeconomic status	.0246	.0043	.0120	.1381	.0126	.0702	.0227	.0599	.0253	.0002	.0224	.0023	.0234	.0003	.0214	.0012
Constant	3.077	.0000	.3612	.0000	3.572	.0000	1.725	.0490	2.929	.0000	2.843	.0000	2.916	.0000	2.929	.0000

* Reference category
B Regression coefficient
Sig –Values below .05 is significance at 5 percent level.

CU - Currently using
PU - Previously Using

Keeping all other variables constant, the non-working women registered consistently less satisfaction with each of the eight aspects of life compared with the working ones, although the difference was not significant. When all variables, except education, were controlled, the elementary and high school-educated MWRAs were found to be less satisfied than the college-educated group, while post-graduate MWRAs tended to be more satisfied with all aspects of their life than those with lower education. Elementary and high school-educated MWRAs were significantly less satisfied with their relationships with their partner and with their job compared with the MWRAs with college education. MWRAs with high school education were significantly less satisfied with "life as a whole" compared with MWRAs with college education.

Qualitative Data on The Influence of Family Planning Practice On MWRAs' Self-esteem: Perceptions of Women, Men and Health Service Providers

The self-esteem of FP users and non-users was ascertained in FGD sessions and in-depth interviews with women other than the respondents, husbands of MWRAs, service providers, and other community folks. The data generated in these discussions and in-depth interviews are used to supplement the survey data on women's satisfaction. The qualitative information is summarized according to topics or subtopics related to personal autonomy, self-esteem, and satisfaction in life.

On what is important in the lives of women. What people consider important or desirable represents their values. Generally these values are dictated by social prescriptions and may vary depending on various internal and external factors. The MWRAs' perceptions about what is important to them are no exception. They vary, but there were commonalties --and also uniqueness identified which can help in understanding better the women's reproductive behaviors and response to family planning.

The qualitative data underscore the importance of family to the women key informants and FGD participants. They commented that "as long as they have a good and happy relationship with their husband and their children are adequately provided for, they are already happy." This perception is shared by both FP users and non-users. Although the women admitted that "it is nice to look sexy, well-dressed, beautiful or well made-up," these are not as important to them as their family, especially their children.

When asked to comment on whether the use of family planning makes a difference, there were non-users with many children who saw or felt no difference between them and their FP user-counterparts. Some of them commented "*Kon happy ka man lang sa imo bana, wala rason nga magkabalaka." (If you are happy with your husband, there is no need to feel anxious, envious or small.)*

On the benefit of family planning on women's lives. There was a clear consensus not only among the women FGD participants, but also among the men that family planning "helps women have an easier life." Although some woG5 men observed that "there are women who can take care of themselves despite their many children," the general impression gathered was that "FP users had an easier life and thought of themselves more highly" than their non-contracepting

counterparts. This impression is reflected by the following comments of key informants and FGD participants, quoted below.

"The woman who uses FP method is not afraid to engage in sex"

"With FP method, a woman can rest more and enjoy relaxation and can have time to work out or go ballroom dancing."

"FP users can make better decisions because they are not harried by children's constant demand for attention."

"An FP user can have more time to take care of her health, she has more resistance and can take care of her children better."

"After spaced pregnancy, her body has regained strength and resistance, she can maintain her good look as her husband will not leave her or seek other women."

"When a woman has several children, one coming immediately after another, she soon looks old because taking care of the children requires most of her waking hours. She has no time "sa pag- social-social." ("She has no time for any social activity.) "Maskin maghusay lang sang iya buhok, wala na tiempo." ("She hardly has time even to comb her hair.") "Unahon mo guid ang bata." ("You need to take care of the baby first.")

"The woman who has spaced her pregnancies or has few children looks better than one with many children "kay indi na gani siya makapang-lipstick, kay kulang gani ang kwarta sa gatas, sa kaugalingon pa (because she can't wear lipstick -- there is not enough for milk, much less for lipstick!)"

" One can look great, when one is not heavy with child. "Bisan ano mo ka make-up, kay daku imo tiyan." ("Even if you put on make-up, how can you look sexy when your tummy is big!")

"When I am not pregnant, I regain my sexy figure."

"An FP user has more opportunity to be beautiful. Look at Vilma Santos! (a very popular movie actress, who is envied by many women especially of the masses because she not only is beautiful and talented but also married to a good-looking rich politician) She reports she can bathe and take care of her person only towards afternoon because she has first to take care of her baby. (Vilma Santos has many helpers to help her, if necessary!)"

"If you have many children, how can you find time to take care of yourself."

Perceptions of women with many children. In reply to the question, "When you see a friend so well dressed and made up, how do you feel?" A MWRA with nine children said,

> *"Siguro makasiling ako, kon indi guid madamo ang akon mga kabata-an, siguro makapagusto man tani, ano abi kay ako naburo sa balay." (If I didn't have these many children, probably I could also do what I like to do. As it is, I am forced to be confined at home.)"*

A non-FP user said,

> *"Before I was good looking, but now losyang na. (Already wasted and carelessly dressed).*

Another non-FP user said,

> *"A non-user affectado guid. Indi siya maka-party. Indi niya maatipa-nan ang iya kaugalingon. (She is really adversely affected. She has no time for parties and she does not have time for herself.)*

A 41-year-old non-FP user said,

> *"Indi na guid kasarang magpa-seksi, kay pito na ang akon kabata-an." ("I am no longer able to become sexy after having had seven children. I just hope I can send my children to school to improve our lot.")*

Perceptions of Family Planning Users. A FP user, in her attempt to stress the importance of having the number of children one wants, said:

> *"When you do not have so many children, you can take care of yourself. You feel different and bag-o guid ang panulok mo sa imo kaugalingon (you have a higher regard for yourself) when you can dress up and make yourself up. You feel secure with your figure, your appearance, your life in general." ("Kon magpagwapa ka ang mga kabataan mo naga-appreciate man sa imo.")*
>
> *"Ti daw maayo man ang pamatyag mo." ("When you take time to beautify yourself, the children appreciate your good looks, so you feel great.") "Daw kalu-oy tulukon kag nagasalamihay ang babaye nga wala naga family planning." ("The non-user appears pitiful -- she looks disheveled and carelessly dressed.")*

A mother of one child said,

> *"Ako simple lang, pero secure sa familia kag sa self ko." I live simply (probably referring to other women's concern with good looks and being made up), but I feel secure (in relationships) with my family and with myself.*

She added that before she used a FP method,

> *"… by the time my husband returned from work I was still unable to comb my hair or even change my panty--no time. Now I have time to put on lipstick and make myself beautiful. If you maintain your health and looks, you feel happy." "FP user gains more confidence and feels equal to others." "You can plan better for your children's future."*

Another said,

> *"I have time for my hobbies (playing the piano)."*

Family Planning Practice and Decision-making Participation Among Women in Western Visayas

Background

Decision-making participation has often been used as a gauge of personal autonomy. Davis and Stromm (1985) pointed out that "participation in Decision-making gives a person power and influence." Decision-making is also believed to enhance human values and to meet a person's need for self-fulfillment and self-esteem. When a woman, however, is burdened with a multitude of household and reproductive responsibilities (Eviota, 1993), it may be difficult for her to meet her need for self-fulfillment and self-esteem. In addition, socially prescribed norms regarding role divisions and Decision-making domains in Filipino homes limit a woman's authority over many aspects of home life, including those which affect her personally, like working outside the home, going to other places outside of the community, having a baby, and family planning use.

A woman practicing family planning is assumed to have better control over the timing and spacing of pregnancies and childbirth. This advantage can give her a better chance for personal advancement that can enhance her Decision-making participation, and therefore her personal autonomy.

Decision-making participation of the MWRAs in four decision areas was examined in this study, namely, a) working outside the home, b) going to other places, c) using family planning, and d) having another baby. The MWRAs' Decision-making participation in these areas was ascertained by asking them who actually made the decision in these areas and whom they perceived as the ideal decision-maker in these areas. The influence of family planning on the Decision-making participation of women, considering the confounding effects of certain variables, was also determined.

Actual Participation of MWRA in Decision-making in Four Areas

On whether MWRA can work outside the home. The data in Table 34 show 77.1 percent of the MWRAs were involved in deciding whether they should work outside the home or not. Nearly half of them (47.4 percent) decided on this matter jointly with their husbands, while 29.7 percent

reported that they themselves decide on this matter. In nearly a quarter (22.2 percent) of the cases, however, the husband alone decided on this matter.

The data further show that a significantly higher proportion of FP users (52.5 percent) than non-users (41.7 percent) reported that they decided jointly with their husbands on whether or not the wife can work outside the home. It is interesting to note, that there were more non-users (31.9 percent) than FP users (27.8 percent) who reported that they themselves decided independently of their husbands, but there were also more non-users (25.5 percent) than FP users (19.2 percent) who reported that their husbands were the sole decision-makers regarding this aspect.

The data confirm the common observation that in societies where the main breadwinner is usually the husband, and women, especially the married ones, are generally home-based, the husbands' approval of what the wife does is considered important. In certain cases, even if a wife is educated and wants to work, her husband may not allow her to work if he earns enough to support the family. David (1995) made the same observation among married college faculty members of two universities in Iloilo City. She found that most of the married female faculty members sought their husband's permission on whether they should continue or stop working after their marriage or whether they should work at all.

On whether MWRA can go to other places. The data also show that the decision on whether the wife can go to other places outside of the community was usually decided jointly by the husband and the wife, as reported by 58 percent of the MWRAs. On the other hand, 21.0 percent of the MWRAs said that they make an independent decision on this issue, while 20.4 percent claimed that it is their husband who decides on this.

The data also show that a significantly higher proportion of FP users (62.0 percent) than non-users (53.6 percent) reported a joint husband-wife decision making process on whether or not a MWRA can go to other places. The tendency to decide on the matter themselves, independently of their husbands, was slightly higher among the non-users (22.6 percent) than among the FP users (19.5 percent), however, a significantly higher proportion of non-users (23 percent) than FP users (18 percent) admitted that their husbands independently decide on the issue.

The husband's consent is generally expected in Filipino homes when family members travel outside the community because of the notion that it is men's responsibility to take care of the family members, especially the women because they are often perceived as needing protection. Leaving the home is even more difficult for women who have small children because of the major role they play in childcare. Although studies have shown that men's involvement in child care in many parts of the world has already been increasing (Engels and Leonard, 1995) mothers still hesitate to leave their very young children in the care of their husbands or other members of the family for hours.

Leaving the home may be demanded of a woman by her profession or work or by her need for a "break" or to fulfill a desire or dream. This she can easily decide, if she is single. If she is married, however, she may still need the approval of her husband , especially when young children are involved. The desire or the need of women to work seems easier to fulfill when they do not have many young children to attend to.

On the use of family planning. The majority of the MWRAs (69.8 percent) shared with their husbands the Decision-making role in regard to the use of family planning. Nearly one-fifth (19.8 percent) of the women said that they make independent decision on this matter, while 9.1 percent claimed that it is their husbands alone who decides on this,

The data further show that participation in Decision-making varied relative to family planning practice. A significantly higher proportion of FP users than non-users reported a joint husband-wife Decision-making pattern (75.8 percent vs. 63.1 percent). There were also slightly more non-users than FP users who reported that they decided independently on the matter, although the difference between proportions was not statistically significant. On the other hand, a significantly higher proportion of non-users than FP users (12.9 percent vs. 5.7 percent) reported the husband's dominant role in Decision-making in regard to family planning use.

The data confirm results of previous studies that in family planning decisions, husband-wife participation still tend to be the norm in the Philippines (David, 1996; Tubelleja, 1977; Lozare, 1974; Ho Nguyen, 1973). The studies further showed that although the decision to accept family planning s generally a joint husband-wife responsibility, the choice of a method to use usually rests on the wife. However, when conflicts in decisions occur, the husband usually has a greater influence than the wife does in the making of a final decision.

On having another baby. Whether or not to have another baby is another reproductive matter that was commonly decided jointly by most husbands and wives in Western Visayas. This Decision-making pattern was reported by more than two-thirds of the survey respondents. There were 19.7 percent who claimed that they decide solely on the matter, while 11.0 percent declared that their husbands independently decide on this. As in the cases of the three other decision areas already discussed, a significantly higher proportion of FP users (72.2 percent) than non-users (63.0 percent) reported that they share with their husbands the responsibility of deciding on whether or not they should have another baby. The proportion of women who reported that they decide on their own regarding this matter did not significantly differ between the FP users and the non-users (18.1 percent vs. 21.5 percent). There were, however, significantly more non-users than FP users who reported that their husbands alone decide on the matter.

The joint husband and wife pattern in making decision regarding reproductive matters, such family planning use and number of children, is well-documented (David, 1996; Nguyen, 1973; Tubelleja, 1977). Studies also revealed that work participation and adequate education of the woman tend to enhance her Decision-making participation in reproductive decisions. Even in countries where a man's dominant role in family life is dictated by customs, women's participation in reproductive decisions is improved by their involvement in paid work, as in the case of Egyptian women (Guhl and Llyod 1994) and by improvement in their educational attainment, as in the case of Chinese women (Jin, 1995).

Table 34. Distribution of Respondents According to Perceived Actual Decision-making Participation in Certain Areas and Family Planning Practice.

Decision Areas and Decision-makers	Non-Users (n=521)	FP Users (n= 579)	Total (n=1100)	Z-Values
A. Whether wife can work outside the home				
Husband	25.5	19.2	22.2	2.505**
Wife	31.9	27.8	29.7	1.484
Both	41.7	52.5	47.4	3.605**
Others	0.8	0.2	0.5	1.388
Not applicable	0.2	0.3	0.3	0.333
B. Whether wife can go to other places				
Husband	23.0	18.0	20.4	2.050**
Wife	22.6	19.5	21.0	1.258
Both	53.6	62.0	58.0	2.825**
Others	0.6	0.3	0.5	0.736
Not applicable	0.2	0.2	0.2	0.000
C. On the use of family planning				
Husband	12.9	5.7	9.1	4.099**
Wife	21.9	18.0	19.8	1.615
Both	63.1	75.8	69.8	4.596**
Others	0.4	0.3	0.4	0.279
Not applicable	1.7	0.2	0.9	2.517**
D. On having another baby				
Husband	13.8	8.5	11.0	2.783**
Wife	21.5	18.1	19.7	1.412
Both	63.0	72.2	67.8	3.265**
Others	0.4	0	0.2	1.447
.Not applicable	1.3	1.2	1.3	0.149

**Statistically significant at 5 percent level

Based on the above information, it can be deduced that the women's role in making decisions regarding work, travel and childbearing is still strongly linked with their husbands'. The joint husband-wife Decision-making pattern still prevails. The wife's autonomy in making decisions on matters concerning her work and activities outside the home is still not very evident. What probably points to the positive effect of FP use on the Decision-making participation of the MWRAs is the fact that the differences between proportions of the non-users and FP users who reported that their husbands solely decide on the four areas considered was significant, while the differences between the proportions of those who reported that solely the wives made the decision was not. In other words, FP practice did not significantly affect a woman's likelihood to independently decide regarding working outside the home, traveling to other places, using family planning, or having another baby. The fact also, that significantly higher proportions of FP users than non-users reported that these matters are jointly decided by them together with their husbands further indicate that FP users were more likely to participate in making decision on these important areas than non-users.

The edge of FP users over the non-users in their extent of participation in Decision-making in the four areas considered implies the important contribution of family planning practice in improving women's participation in Decision-making.

MWRAs Choices of Ideal Decision-makers

To determine the MWRAs' perception regarding the ideal decision-makers on certain areas, they were asked who ideally should decide on wives working outside the home, their traveling to other places, family planning use, and on having another child.

Table 35 shows that that the majority of the MWRAs perceived that making decisions regarding a woman's work outside the home, her outside travel, family planning practice and having another child should be joint responsibilities of the husband and the wife (67.5 percent, 76.7 percent, 79 percent, and 79.9 percent, respectively.

In regard to the FP users and non-users' choices of the person who should make the decisions in the four areas, the significant differences between these were in regard to three areas: going to other places, use of family planning method, and having another baby, with greater proportions of the users (79.6 percent, 82 percent and 82.4 percent, respectively) reporting joint participation. Among the non-users, only 73.5 percent, 75.6 percent and 77.2 percent, respectively, considered joint participation ideal. The difference between the proportions of the two groups choosing joint participation as ideal was not statistically significant relative to work outside the home (69.4 percent vs. 65.5 percent), though the proportion of the FP users was slightly higher. That the users would like greater autonomy in deciding whether or not to use FP method is also shown by the significant difference between the proportions of the users (2.4 percent) and of non-users (6.3 percent) who chose husbands as ideal decision-makers in this matter.

The data show that the MWRAs' actual participation in Decision-making in the four decision areas is relatively consistent with what they perceive as ideal. David (1996) among female faculty members in four universities in Iloilo City observed the same pattern, one of the urban centers in Western Visayas.

Family Planning Practice in Relation to Actual Decision-making Participation of MWRAs, Controlling for other Variables: Regression Analysis

Regression analysis was done to determine the influence of family planning practice on Decision-making participation when other variables are held constant. Two measurements of Decision-making participation of the MWRAs in the areas of working outside the home, traveling to other places, using family planning and having a baby were examined in relation to family planning practice. One measure was simply participation, which was treated as a nominal variable categorized as, "participates" and participation" and "does not participate." Participation may either be independent or jointly with the husband. Another measure of Decision-making participation was independent Decision-making participation, which was also treated as a nominal variable categorized as: "decides independently" and "does not decide independently." Family planning practice, on the other hand, was measured in terms of duration of use of family

planning, with the never-users classified under zero duration. The reference variable for duration of use is current users who have used FP continuously for 24 months or more.

Table 35. Distribution of Respondents According to Perceived Ideal Decision-making Participation in Certain Areas and Family Planning Practice.

Decision Areas And Perceived Ideal Decision-maker	Non-users (n=521)	FP users (n= 579)	Total (n=1100)	Z-test
A. Wives working outside the home				
Husband	13.8	11.1	12.4	1.352
Wife	20.5	19.2	19.8	0.539
Both	65.5	69.4	67.5	1.378
Others	0.2	0.3	0.3	0.333
B. Whether you can go to other places				
Husband	11.1	8.5	9.7	1.445
Wife	15.0	11.7	13.3	1.604
Both	73.5	79.6	76.7	2.385**
Others	0.4	0.2	0.3	0.600
C. Use of family planning method				
Husband	6.3	2.9	4.5	2.672**
Wife	16.9	14.7	15.7	0.998
Both	75.6	82.0	79.0	2.593**
Others	1.2	0.3	0.7	1.703
D. Having another baby				
Husband	8.8	6.0	7.4	1.766
Wife	12.9	10.5	11.6	1.234
Both	77.2	82.4	79.9	2.144**
Others	1.2	1.0	1.1	0.317

**Statistically significant at 5 percent level.

Family Planning and Participation in Decision-making: Either Independently or Jointly with their Husbands

On working outside the home. The regression analysis presented in Table 36 reveals that MWRAs who never used FP methods had 44.65 percent less likelihood, compared to that of FP users (24 months and more), of deciding on their own or together with their husband on the matter of working outside the home. From among the ever-users, duration of use did not show any significant effect on the variation of Decision-making participation regarding this matter, except for those who have been using family planning for less than 24 months who had 40.06 percent less probability of deciding this issue compared to the non-users.

The variable age, residence, household size, number of children ever born, religion, education and socioeconomic status did not have any significant influence on the participation of women in deciding whether or not to work outside the home. It is not surprising that the probability of

working MWRAs actually deciding whether or not a woman should work outside the home almost triple that of the MWRAs who were not working.

On going to other places. The findings showed that the MWRAs who never used family planning tended to be 52.06 percent less likely to decide on whether or not to go to other places compared to MWRAs who were current FP users, even when the effect of other variables are controlled.

The data further show that Decision-making participation regarding going to other places was found to significantly vary according to residence, occupation, socioeconomic status and duration of FP use, but not according to age, household size, number of children ever born, religion, and education. Women residing in the rural areas were more likely to get involved in making a decision to go to other places compared to those residing in the urban areas.

The working MWRAs had almost double the likelihood of deciding whether or not to go to other places than did the non-working ones.

On having another baby. The data show that family planning practice did not significantly influence the MWRAs' participation in deciding on the matter of having another baby. Of the nine independent variables considered in the regression analysis, only socioeconomic status was found to have a significant bearing on Decision-making participation on this matter. Relative to a woman of lower SES, a woman of a higher SES tends to participate in making decisions regarding having another baby more than one with a lower status. The likelihood that any MWRA would do this is 10.7 percent more than would another MWRA who belongs to the next lower SES level.

On use of FP. As to who decides whether or not to use FP, the data further reveal that Decision-making participation regarding this aspect varied significantly according to present state of whether or not a woman actually use family planning and socioeconomic status. Never-FP users were 76. 66 percent less likely to participate in making decision regarding the use of family planning than current users whom have used FP for 24 months or more. MWRAs belonging to the higher level of SES were 8.12 percent more likely to participate in deciding whether or not to use family planning compared to MWRAs belonging to a lower SES.

MWRAs' participation in deciding whether or not to use FP did not show any variation according to age, residence, household size, number of children ever born, religion, work status, education, and duration of FP use.

Family Planning Use and Independent Decision-making among MWRA

On working outside the home. The regression analysis presented in Table 37 reveal that MWRAs who never used FP methods had 44.4 percent less likelihood compared to that of current users (24 months and more) of deciding this issue themselves. From among the ever-users, duration of use did not show any significant effect on the variation of Decision-making participation regarding working outside the home.

The variable age, residence, household size, number of children ever born, religion and education did not have any significant influence on the participation of women in deciding whether or not to work outside the home. It is not surprising that the probability of working MWRAs actually deciding whether or not a woman should work outside the home was double that of the MWRAs who were not working.

As socioeconomic status increases, there is less likelihood that a MWRA would decide on her own to work outside the home. A MWRA at any level of SES would have 6.03 percent less likelihood of participating in participating is idea, compared to another MWRA who belongs to the next lower level of SES.

The negative association between socioeconomic status and independent Decision-making involvement of women regarding work outside the home negates the hypothesis that an improvement in the socioeconomic status of a woman enhances her autonomy to make decisions regarding her work outside the home.

On going to other places. The data further show that a woman's independent role in making a decision regarding going to other places was found to significantly vary according to residence and occupation, but not according to age, household size, number of children ever born, religion, education, socioeconomic status, and duration of FP use. MWRAs residing in the rural areas were less likely to decide on their own to go to other places, compared to MWRAs residing in the urban areas. The working MWRAs had almost double the likelihood of deciding whether or not to go to other places than did the non-working ones.

On having another baby. Of the nine independent variables considered in the regression analysis, only the variable age and occupation were found to have a significant bearing on Decision-making participation in regard to having another baby. Relative to a younger woman, an older woman herself is more likely to make the decision herself regarding having another baby. The likelihood that any MWRA would do this is 34.7 percent more than would another MWRA who is a year younger than she is.

With regard to occupation, a working MWRA is 50.3 percent more likely to make this decision herself (having another baby) than a non-working one, when type of residence, household size, number of children ever born, religion, education, socioeconomic status, and duration of FP use are kept constant.

On use of FP. As to who decides whether or not to use FP, the data reveal that independent Decision-making participation regarding this aspect varied significantly according to work status occupation and socioeconomic status. Compared with non-working MWRA, the working MWRAs were 61.1 percent more likely to decide on their own regarding FP use. MWRAs belonging to the higher level of SES were 5.13 percent less likely to do this, compared to MWRAs belonging to a lower SES.

The MWRAs' independent involvement in deciding whether or not to use FP did not vary according to age, residence, household size, number of children ever born, religion, education, and duration of FP use.

In summary, when other variables are held constant, the favorable effect of family planning in the independent Decision-making participation of women is significant only in regard to work outside the home.

Table 36. Regression Table for Decision-making Participation and Selected Variables.

Independent Variables	DEPENDENT VARIABLES: Decision-making Participation											
	Working Outside the Home			Going to Other Places			Having Another Baby			Use of Family Planning		
	Regress Coef.	Log Odds	Sig	Regress Coef	Log Odds	Sig	Regress Coef.	Log Odds	Sig	Regress Coef	Log Odds	Sig
Age	.0170	1.0171	.1764	.0134	1.013	1.013	-.0124	.9876	.4900	-.0013	.9987	.9373
Residence												
Rural	-.0324	.9681	.8444	.5504	1.734	.0017	-.0679	.9343	.7751	.2563	1.292	.2587
Urban**												
Household Size	-.0477	.9535	.3630	-.0231	.9772	.6681	-.0787	.9243	.2896	-.0547	.9468	.4390
No. of children ever born	.0521	1.0535	.3704	.0204	1.021	.7258	.0911	1.095	.2643	.0260	1.026	.7255
Religion												
Non-Roman Catholic	.3371	1.4008	.1039	.0528	1.054	.7921	-.1285	.8794	.6397	.3923	1.480	.1716
-Roman Catholic*												
Occupation												
Working	1.0014	2.7220	.0000**	.5974	1.817	.0011	.0759	1.079	.7646	.3993	1.491	.1007
Non-working*												
Education												
Elementary	-.1425	.8672	.5690	-.1238	.8836	.6190	-.0971	.9075	.7801	-.1013	.9037	.7539
High School	-.2051	.8145	.3269	.0014	1.001	.9948	.2230	1.250	.4883	.4339	1.543	.1528
College*												
Postgraduate	1.2576	3.5168	.2342	-.1549	.8565	.8160	.4869	1.627	.6508	.6782	1.970	.5253
Vocational	-.2159	.8058	.4557	-.1111	.8949	.7098	.0933	1.098	.8385	-.3025	.7390	.4282
Duration of FP Use												
PU for 24 mos. & above, but not CU	-.5915	.5535	.0423**	-.7351	.4794	.0207	-9396	.3908	.0833	-1.455	.2334	.0065**
PU for less than 24 mos. but not CU	-.6161	.5401	.1156	-.5937	.5523	.1583	-.9364	.3920	.1599	-.5539	.5747	.4314
PU stopped, then CU, 24 mos. & above	-.1398	.8696	.4875	-.1601	.8521	.4575	-.0115	.9885	.9767	-.1556	.8559	.6715
PU stopped, then CU, less than 24 mos.	.4247	1.5292	.2285	.1428	1.153	.5926	1.627	5.088	.6607	-.4385	.6450	.1053
CU, continuous for 24 mos. & above	-.5119	.5994	.0066**	-.3785	.6849	.0394	-.2873	.7503	.3361	.9795	2.663	.7314
CU, continuous for less than 24 mos.	-.0342	.9664	.5918	-.0956	.9089	.1599	-.1648	.8481	.1467	-.0950	.9093	.4135
Cannot recall	-.0001	.9999	.0112**	-.0002	.9998	.0030	-.0002	.9998	.0221**	-.0002	.9998	.0132**
Socioeconomic status	.0097	1.0097	.7007	.0669	1.069	.0091	.1006	1.106	.0075**	.0780	1.081	.0222**
Constant	.7647		.1724	.2981		.6038	2.454		.0055**	2.112		.0055**

CU - Current users *Reference category

PU - Previous users **Statistically significant at 0.5 level

Table 37. Regression Table for Independent Decision-making of the MWRA and Selected Variables.

Independent Variables	DEPENDENT VARIABLES: Wife Decides Independently in the Following Areas											
	Working Outside the Home			Going to Other Places			Having Another Baby			Use of Family Planning		
	Regress Coef.	Log Odds	Sig.	Regress Coef.	Log Odds	Sig.	Regress Coef.	Log Odds	Sig.	Regress Coef.	Log Odds	Sig.
Age	.0880	1.009	.4299	.0153**	1.015	.2139	.0336	1.034	.0073**	.0109	1.010	.3862
Residence												
Rural	-.2293	.7950	.1245	-.3797	.6840	.0267**	-.2268	.7970	.1897	-.1759	.8387	.3024
Urban**												
Household size	.0373	1.038	.4201	-.0660**	.9417	.2795	-.0721	.9304	.2100	-.0745	.9282	.1906
No. of Children ever born	-.0140	.9860	.7771	.0545**	1.0560	.3376	.0482	1.049	.4046	.0930	1.097	.1063
Religion												
Non-Roman Catholic	.1259	1.134	.4631	.1146	1.1210	.5502	-.3084	.7346	.1434	-.3472	.7066	.1020
-Roman Catholic*												
Occupation												
Working	.8109	2.249	.0000**	.6924	1.9980	.0000**	.4080	1.503	.0166**	.4770	1.611	.0051**
Non-working*												
Education												
Elementary	-.0443	.9566	.8387	-.1747	.8347	.4807	-.1814	.8341	.4662	-.3425	.7099	.1716
High School	.0387	1.0394	.8360	.1951	1.2150	.3448	.0150	.9851	.9433	.0113	1.011	.9569
College*												
Postgraduate	-.3557	.7006	.5123	-1.7080	.1811	.1009	-.9547	.3849	.2147	-.9216	.3978	.2308
Vocational	.0256	1.0259	.9237	.0661	1.0680	.8242	-.1901	.8268	.5515	-.3257	.7220	.3182
Duration of FP Use												
Never User	.3680	1.444	.0356**	.2392	1.2700	.2101	.3076	1.360	.1193	.2926	1.339	.1354
PU for 24 mos. & above, but not CU	.0695	1.0719	.8127	.0467	1.0470	.8819	-.0150	.9851	.9634	.1492	1.160	.6380
PU for less than 24 mos. but not CU	.1588	1.172	.2745	.0318	1.0320	.8451	.1922	1.2110	.2289	.0018	1.001	.9916
PU stopped, then CU, 24 mos. & above	.0547	1.056	.6999	-.1486	.8619	.3963	.0847	1.0880	.5905	-.2839	.7528	.1816
PU stopped, then CU, less than 24 mos.	-.2285	.7956	.3925	-1.1380	.3202	.5111	-1.1235	.3251	.5198	-1.122	.3253	.5186
CU, continuous for 24 mos. & above*												
CU, continuous for less than 24 mos.	.0433	1.044	.3464	-.0560	.9455	.3295	-.0490	.9521	.4218	-.0409	.9599	.4776
Cannot recall	-.00002	1.0	.6964	.0001**	1.0000	.8025	.000009	1.0000	.8752	.00005	1.0	.2779
Socioeconomic status	-.0621	.9397	.0047**	-.0372**	.9634	.1264	-.0320	.9655	.1970	-.0526	.9487	.1351
Constant	-1.0488	.3503	.0344	-1.5349	.2154	.0058	-2.0548	.1280	.0003	-1.1048	.3312	.0490

CU - Current users, PU - Previous users, *Reference category, **Statistically significant at 0.5 level

Qualitative Data on the Influence of Family Planning on Decision-making Participation of MWRA: Perception of Men, Women and Health Service Provider

Qualitative data further validate the survey findings that Decision-making regarding working outside the home, traveling to other places, having another baby and using family planning is still basically a joint husband-wife responsibility. The role women have in Decision-making is generally enhanced by work participation or education, however, the shared Decision-making pattern still prevails.

The qualitative data also confirm that even in shared Decision-making process, the husband still has a greater say in the final decision, especially when a couple could not arrive at a common decision through the participative process. Even when the wives are involved in Decision-making, they still give in to their husband's wish if they could not agree on a common decision, just to maintain harmony in their relationship. It is a common belief that a wife who goes against the wishes of her husband is generally perceived as "having no respect for her husband." The case of Eleonor best illustrates this.

> Eleonor is a commerce graduate and was working as a bank teller when she married Joshua, a bank manager. After their wedding, they discussed the possibility of Eleanor quitting her job since Joshua was earning enough to support her and their future children. Eleanor expressed her desire to continue working because she was enjoying her job. She said that she hates to think of herself staying idle. After a lengthy discussion, however, Joshua told Eleonor: *"mas luyag ko nga diri ka lang sa balay kag atipanon mo ang aton panimalay kag ang aton mga anak sa ulihi." (I would rather that you stayed home and take care of the house and our future children than work.")* Eleanor confided that even though she loved her job so much, she still quit her post because she did not want to displease Joshua. In her words, *"Bisan ano ko kaluyag nga mag-obra, nag-untat na lang ako kay basi maglain pa ang bu-ot sang akon bana*." *("Even though how much I liked my job, I stopped working because I did not want to hurt my husband.")* She added that, *"Indi ako maka pa-indi sa akon bana kay ginarespeto ko s'ya." (I cannot go against the wish of my husband because I respect him.)*

The joint husband-wife pattern in Decision-making, particularly in regard to reproductive matters like family planning practice and having another baby was confirmed by both men and women key informants as still the most common practice. Both groups agreed that there is a need for spouses to share the Decision-making responsibility on this matter because "both reproductive process and outcome involve the husband and the wife." The following comments reflect the varied views of the FGD participants:

According to Nelly, a mother of three:

> *"Kay kami man nga mag-asawa ang nagahimo sang bata kag kami man ang mapadalagko sa ila, kinahanglan gid nga estoryahan anay bag-o desisyonan." Indi puede nga isa lang ang magadesisyon." (Since the two of us (husband and wife) are involved in reproduction and we are the ones who bring up the children, it is important that we talk about the matter before making a decision on whether we*

will have another baby or not or whether we will practice family planning. It cannot be the decision only of one.)

The reaction of Jose, a married farmer with five children was:

> *"Natural lang ina nga desisyonan sang mag-asawa ang parte sa pagpamata kag pag family planning. Indi puede nga ako lang o ang akon asawa lang ang maga desisyon, kay kon ano ang matabo, amon man guihapon nga duha problema. ("It is natural that the issue of having children and family planning be decided by both the husband and the wife. It should not be decided either alone because if something wrong happens it will be the problem of both of us.")*

There were cases reported where the husband decided on his own regarding having another child without consulting his wife and insisted on doing what he likes despite his wife's resistance due to her difficult childbearing experiences. One such case was Jocelyn, a young mother of five children, all delivered by caesarian section, because she was eclamptic. She was still a college undergraduate when Alvin, a medical doctor, got her pregnant. Jocelyn relayed that:

> *"My husband wanted to have at least five children, but during the birth of our first born, I had an eclampsia, so I had a caesarian delivery. When my doctor warned me to space and limit my pregnancies, my husband, being very dominant ignored the warning. When he wanted me to have another baby, he would "just do it" (sex) without even asking me, directly or indirectly. When I resisted, we would quarrel and he would beat me. The forced sex and beatings continued until I had all the five children my husband wanted.*

The FGD results also confirmed the survey findings that a woman's participation in paid work and her level of education are important considerations in her participation in Decision-making.

CHAPTER V

DOMESTIC VIOLENCE AMONG MARRIED WOMEN OF REPRODUCTIVE AGE (MWRA) IN WESTERN VISAYAS PHILIPPINES

Background

Domestic violence is any form of abuse of family members, which may include spousal abuse, elderly abuse, child abuse, and sibling abuse. (Wayne County Domestic Violence Handbook) Violence is an act committed with a deliberate or perceived intention of hurting another person. It is revealed by a behavior designed to control the victim through abusive means. Violence may be in the form of physical abuse (battering), sexual abuse (sexual harassment and rape), and/or psychological abuse (verbal abuse, emotional abuse and economic deprivation).

Domestic violence is a serious social problem existing in all societies all over the world. The most common victims of domestic violence are married women and their usual perpetrators are their husbands or partners. The incidence of violence against women in many countries is high and still increasing. In the United states, it is estimated that two to four million women suffer from domestic violence each year and one in four cases involve family relations. In Canada, her partner abuses data provided by doctors, lawyers, social workers and police records showed that one in ten women. Studies on domestic violence in Chile, Brazil, Peru, and Mexico show that 33 to 80 percent of reported cases of violence in these countries were women abused by their husbands or partners (Soroptimist International, Domestic Violence: Strategies for Action, n.d.).

In the Philippines, more and more cases of domestic violence are reported. An analysis of reported cases in courts in three major cities, namely; Manila, Cebu, and Davao and in the Department of Social Work and Development (DSWD) institutions in the National Capital Region (Luzon), Region VII (Central Visayas) and Region XI (Southern Mindanao) revealed that in 1992 alone, 373 cases of domestic violence were reported. In 62 percent of the cases, the victim was a married woman. In Western Visayas, particularly in the Province of Iloilo, the number of cases of domestic violence filed by the police, courts and institutions from 1992 to 1996 increased from 265 to 365. Most of the victims were also married women and the usual perpetrators were husbands or partners (GRF Foundation, 1997).

It has been theorized that men abuse women “because it is an effective way of gaining and keeping control over another and through violence, the violator gets what he wants quickly and completely.” Women tend to be vulnerable to be victims of domestic violence because in many societies, they are expected to be subordinate or subservient to men.

This study attempted to examine the incidence of domestic violence among the MWRAs of Western Visayas and identify certain factors associated with their experience with violence.

Incidence of Domestic Violence

The data in Table 38 show that more than one-third of MWRAs (37.4 percent) in Western Visayas had experienced physical or psychological abuse, once or more times. Very slightly more FP ever-users (38.0 percent) reported abuse than non-FP users (36.8 percent).

Women reported having been hurt physically or psychologically by somebody at home. Psychological/emotional abuse was much more common than physical abuse. Nearly three-fourths (73.9 percent) of the psychologically abused women had been violated two or more times, while slightly more than half of those who had been physically abused had been hurt the same number of times.

Table 38 shows that of all those who reported having been physically abused, the most common reported perpetrator was the husband (83.0 percent of 47 cases). This corroborates findings of earlier studies on domestic violence (Larrain and Rodrigues, 1993; Martin, SL, et. al., 1995; Oropesa and Hogan, 1994).

There were non-users than FP users who reported experience with physical violence (14.1 percent and 9.21 percent, respectively). On the other hand, there were more FP ever-users than non-uses who reported experience with psychological violence (71.8 percent vs. 66.1 percent, respectively). The differences between proportions of FP users and non-users in both cases, however, are not statistically significant. This means that family planning use does not have a significant bearing on the women's experience with domestic violence.

Assistance Received by Victims of Domestic Violence

Of the 412 women who had been victims of domestic violence, only 24 admitted having asked for help. They most commonly sought help from friends (29.2 percent). The *barangay* captain's intercession was also sought; the *barangay* leader usually settled the quarrel by advising the husband "not to hurt his wife again" and/or telling the wife to "forgive the husband." Many of the victims of domestic violence suffered in silence and got very limited help or support or none at all. Institutions or organizations concerned with protecting victims of domestic violence exist in Region VI, but actual interventions are limited.

Records of the Department of Justice (DOJ), DSWD, Philippine National Police (PNP), and social institutions in Region VI attest that many cases of domestic violence remain unreported. An inventory of cases of domestic violence filed/reported or referred to the DOJ, PNP and social institutions in the Province of Iloilo from 1992 to 1996 (Gerry Roxas Foundation, 1997) showed that during this period, 1,536 cases of violence had been reported. Of this number, 350 cases had been filed in courts, 124 cases had been referred to social institutions and 1,062 cases had been reported to the PNP. The fact that one in three MWRAs in Region VI had reported experience with domestic violence suggests that many of the victims did not receive any help.

Table 38. Percentage Distribution of MWRAs According to Experience with Domestic Abuse by Family Planning Practice.

Indicators	Non-users (n=521)	FP Users (n=579)	Total (1100)	Z-Values
Experience with abuse				
Not abused	63.15(329)	62.00(359)	37.4(688)	0.39
Abused	36.85(192)	38.00(220)	37.4(412)	0.39
A. Abused physically	14.1	9.1	11.4	1.58
No. of times	(27)	(20)	(47)	
Once	48.10	50.00	48.9	0.50
Rarely (2-3 times)	25.90	30.00	27.7	0.11
Regularly (4 or more times)	25.90	20.00	23.4	0.48
B. Emotionally/psychologically abused	66.1	71.80	69.2	1.25
No. of times	(158)	(127)	(285)	
Once	23.6	19.00	21.1	0.94
Rarely (2-3 times)	66.1	72.80	64.8	1.22
Regularly (4 or more times)	10.2	8.20	9.1	0.58
C. Both physically and psychologically abused	19.80	19.10	19.4	0.18
No. of times	(38)	(42)	(80)	
Once	7.90	7.10	7.5	0.14
Rarely (2-3 times)	55.30	45.20	50.0	0.91
Regularly (4 or more times)	36.80	47.60	42.5	0.98

Table 39. Frequency Distribution of MWRAs According to Experience with Domestic Abuse by Family Planning Practice by Identity of Perpetrator.

Indicators	Non-users (n=521)	FP Users (n=579)	Total (n=1100)	Z-test Values
Percentage of abused MWRAs	36.85(192)	38.00(220)	62.6(412)	0.39
Perpetrators of physical abuse	(27)	(20)	(47)	
Husband	88.90	75.00	83.0	1.22
Other male relatives	0.00	20.00	8.6	2.24**
Mother	3.70	5.00	4.2	0.21
Others	7.40	0.00	4.2	1.47
Perpetrators of emotionally /psychologically abused	(158)	(127)	(285)	
Husband	58.30	74.00	74.4	2.81**
Father	9.40	6.90	2.8	0.76
Other male relatives	11.90	7.50	4.9	1.24
Male friend	0.80	1.20	0.4	0.34
Mother	8.70	4.40	2.1	1.44
Other female relative	15.00	8.80	6.3	1.59
Female friend	1.60	1.20	1.1	0.28
Others	10.30	19.0	56.8	2.11**

Perceived Causes of Domestic Violence

Domestic violence has been attributed to various reasons, the most common of which were: wife's refusal to have sex with husband, jealousy, drunkenness, wife's nagging, quarrel or arguments over financial matters, and husband's philandering. Husbands under the influence of liquor usually inflicted physical violence. Among the violent acts of husbands against their wives were slapping, boxing, hitting the head, throwing objects at the wife, or pushing her against the wall.

Psychological abuse was noted to be more common than physical abuse. The most frequently reported psychological abuse experienced by the women from their marital partners were: "cursing," insults, ridicule in the presence of other people, including belittling remarks like "*waay-waay ka guid o wala ka pulos nga asawa*" (you're nothing or you're a useless wife). There were cases reported where the husband would tell his friends about his sexual adventures and experiences with his wife and other women. Many women, however, seemed to take these insults or verbal abuse lightly. Some even tried to justify violence by saying, "it is natural for their husbands to get angry especially when they are drunk" and "their violence is tolerable or forgivable."

Sometimes a husband whose sexual advances were refused by his wife would scold, hurt, or beat a child/children to get back at the wife. Some husbands reportedly refused to talk to the wives or

angrily went out of the house. To avoid quarrels or unnecessary outbursts, the wives most often gave in to the husbands' desires, even if this would risk pregnancy.

Selected Factors Related to Women's Experience with Domestic Violence

As seen in Table 40, experience with domestic violence was higher among women who had elementary education than those with high school and college education (45.5 percent vs. 36.2 percent and 34.2 percent, respectively). This implies that women with inadequate education are more likely to be victims of domestic violence than one with adequate education. This may be so because an educated woman can explain, argue or negotiate better with her husband than one who has inadequate education.

The data further show that violence tended to increase as number of children increased. This is indicated by a higher proportion of women with 7 or more children (45.5 percent) who reported experience with domestic violence than those with fewer children (34.5 percent and 40.9 percent). Household size was also found to be related to experience with domestic violence. Women belonging to families with seven or more members (usually children) tended to experience domestic violence (39.3 percent) more than those with only three or four household members (36.7 percent). Bigger family size may increase the probability of household tensions that contribute to domestic violence. A big family has greater needs than a small one. When these needs are not met because of limited resources, tension can build up which can result to violence if not resolved. Tension is also more likely to occur in big households than in small households because more people occupy more physical and psychological space. Families living in houses, which do not provide adequate physical and psychological space for the members, are likely to experience friction that can lead to violence.

The socioeconomic status of the family tended to be associated with the women's experience with domestic violence. A greater proportion of women with low socioeconomic status than those with higher socioeconomic status had experienced domestic violence (40.7 percent vs. 35.5 percent). Since poor families are expected to have more problems and therefore more pressures than families who are economically stable, they are more likely to be victims of domestic violence than the latter. Arguments over financial matters could lead to a quarrel between family members and possibly result to domestic violence. Domestic violence was also higher among urban dwellers than among rural dwellers (38.9 percent vs. 34.7 percent). Pressures in urban life are usually greater than those in rural areas.

Since the FP users were significantly more educated, and were more likely to work than the non-users, they may have felt more economically independent and more confident of themselves to refuse their husbands' advances. We can speculate that they may have been more likely to refuse their husbands' advances. Denied of sexual satisfaction, husbands may become frustrated and resort to violence.

Table 40. Percentage Distribution of Respondents According to Experience on Domestic Violence and Personal Characteristics of the MWRAs.

Personal Characteristics	Experience with Domestic Violence		
	Abused (n=412)	Not Abused (n=688)	Total (n=1100)
Age			
Below 30	34.8	65.2	32.6
31 and above	38.7	61.3	67.4
Education			
No formal schooling	16.7	83.3	0.5
Elementary	45.5	54.5	22.2
High school and vocational	36.2	63.8	41.9
College and above	34.2	65.8	35.4
Residence			
Rural	34.7	65.3	34.8
Urban	38.9	61.1	65.2
Work status			
Non-working	37.2	62.8	58.9
Working	37.8	62.2	41.1
No. of children ever born			
None	28.9	71.1	3.5
1-2	34.5	65.5	35.8
3-4	37.6	62.4	5.5
5-6	40.9	59.1	16.0
7 and above	45.5	54.5	9.2
No. of pregnancies			
None	28.1	71.9	2.9
1-2	34.5	65.5	32.2
3-4	36.8	63.2	35.1
5-6	41.0	59.0	18.6
7 and above	44.7	55.3	11.2
Household size			
1-2	40.0	60.0	2.7
3-4	36.7	63.3	29.5
5-6	36.4	63.6	38.9
7 and above	39.3	60.7	28.9
Religion			
Non-Roman Catholic	35.3	64.7	18.8
Roman Catholic	38.0	62.0	81.2
Socioeconomic status			
Low	40.7	59.3	39.3
Average	35.3	64.7	57.9
High	35.5	64.5	2.8

MWRAs' Experience with Sexual Abuse

Table 41 reveals that 27 of the MWRAs reported that they were physically forced by their husbands to have sex with them, 16 among the FP ever-users and 11 among the non-users. Although most of the women recognized that one of their responsibilities as wives is to respond to the biological needs of their husbands, there are times when they do not feel like responding to the sexual advances of their husbands/partners. They may not be in the mood, not feeling well or just anxious because they "are not safe." Husbands of some of the women could not accept being rejected by their wives and had forced themselves on their wives.

The data further show that about 39 percent of the MWRAs experienced domestic violence during pregnancy, 31.3 percent among the non-users and 45.5 percent among the FP users. It would be interesting to know whether some women believe that their use of family planning contributed to their being subjected to violence. This, however, was not addressed by this study.

In relation to their sexual relationships with their husbands, nearly half of the MWRAs (42.6 percent) admitted that they were afraid to refuse their husbands' sexual advances. The most common reason they stated was that they did not want refusal to lead to dispute. Slightly more than one third 36.6 percent opted not to disagree with their husbands due to fear. They were afraid that their refusal might cause their husband to beat them or to get mad at them.

Among those who had been sexually abused by their husbands or someone else, 24 were able to tell somebody about it or had asked help from someone. The most common person the MWRAs sought help from were friends (29.2 percent), followed by mother (16.7 percent) and other relatives (16.7 percent).

More FP users (6) than non-users (1) sought the help of friends to solve their problems. The most common type of help sought by the victims was counseling. Very few sought legal assistance mainly because they did not want to appear in court or expose themselves to embarrassment. This gives credence to the low figures on reported cases to the police and those brought to court or social institutions that help abused women.

Table 41. Percentage Distribution of Respondents According to Experience with Sexual Abuse and Help Sought and Received.

Indicator	Family Planning Practice		
	Non-users (n=521)	FP Users (n=579)	Total (n=1100)
No. of MWRAs physically forced to have sex by husband	2.1(11)	2.8 (16)	2.5 (27)
No. of MWRAs who experienced abuse during pregnancy	11.0(60)	17.0 (100)	15.0(160)
No. of MWRAs ever told /asked for help from someone	4.1 (8)	7.3 (16)	5.8 (24)
Where MWRAs asked for help (No. of MWRAs)	(8)	(16)	(24)
Friend	1	6	7
Mother	1	3	4
Sister	1	2	3
Husband	1	2	3
Other relatives	2	2	4
Barangay captain	0	1	1
Others	2	0	2
Type of help Rrceived (Multiple Response)	(8)	(16)	(24)
Counseling	6	16	22
Legal assistance	1	1	2
Others	2	0	2)
No. of MWRAs who were afraid to disagree w/ husband	36.3 (189)	35.8 (207)	36.0(396)
Reasons why wife is afraid to disagree with husband	(n=189)	(n=207)	(n=396)
(Multiple response)	42.3	54.1	48.5
It might cause dispute	11.1	9.2	10.1
Husband is irritable	18.5	13.0	15.7
Husband gets easily angry	9.0	5.8	7.3
His decisions always prevail	5.3	5.3	5.3
Wife respects husband	10.6	11.1	10.8
Afraid that husband might beat/batter wife	13.8	13.5	13.6
Others			

Qualitative Data on Domestic Violence

Greater details about domestic violence were unraveled during FGD and in-depth interviews. Women, who initially hesitated to talk about their experience, or that of someone they knew, openly discussed the issue when someone in the group started admitting that she was a victim of violence or that she knew someone who was. The interviews and discussions confirmed that domestic violence is a reality that many women live with. Described in this section are some experiences with domestic violence or observations made by key informants and FGD participants.

The data revealed that most of the domestic violence experiences admitted by the key informants were inflicted by their husbands, happened at home, and usually occurred when their husbands were under the influence of liquor. There were cases, however, when violence happened even when the husband was sober, but they were not as frequent as when the husband was drunk. Mary, an FGD participant, said that her husband almost always shouted at her neighbor Linda, especially in the evenings when the husband came home drunk. Many other similar testimonies were shared.

Based on the discussions, shouting and cursing at the wife by a drunken husband seems to be taken lightly by some women who view shouting and cursing as "natural" behavior of a drunk. This is reflected in the following comments:

> *"Kon makainom gani ang bana ko, madali mag-init ang iya ulo, kag dayon singgit. Ti ginapasenya ko lang na s'ya kay nakainom mo." (If my husband is drunk, he gets easily irritated and has the tendency to shout at anyone at home, but I try to understand his behavior because he was drunk."*

> *"Anhon mo kay amo gid man ina ang mga lalaki, kon makainom madali ma-akig. Wala ko na lang ginatubay agud wala gamo." (What can you do; men are really like that when they they're drunk, they easily get mad. I do not mind them to avoid trouble.)*

What is interesting in the reports of the women, is the variation in their perceptions about domestic violence. Although they feel hurt when they are cursed or verbally abused by their spouses, this kind of offense "can be easily forgiven." When physical abuse, however, is inflicted, the physical hurt is further aggravated by the embarrassment the victim suffers. Elena,. a farmer's housewife, was accustomed to her husbands' scolding and cursing that even "misses" the noise when her husband is quiet. She said that she does not get embarrassed when her husband gets mad at her, but she could hardly forget the only time that her husband beat her up. She could not hide the bruises because she had to work in the field with her husband.

Cristina, a young office employee, views psychological abuse as more painful than physical abuse. She related that when she discovered that her husband was having an affair with an officemate, she could not believe it and she felt so hurt because she could not find any reason why her husband should be unfaithful to her. She described her feelings as:

> *"Daw tabunan ako sang langit. Maayo pa kon gin sakit niya ako, kay madula lang na dugay-dugay ang kasakit. Pero ang kasakit sang iya ginhimi sobra gid ya." (As if heaven fell on me. It would have been better if he beat me because the pain will vanish easily, but the hurt caused by his infidelity is too much to bear.)*

As described earlier, beating is the most common type of physical violence committed at home takes many forms. Claire reported that her friend Nieva was boxed and kicked by her husband because the latter suspected that Nieva was having an affair with his "*kumpare*" (i.e. friend).

It was noted that some women even justify their husband's violent actions and attribute to themselves or to others the cause of such behavior, as if hurting them is the appropriate action. Statements like the following are good illustrations.

> *"Okay lang.. Ano abi kay wala ako nakaluto dayon." (It is okay, you see I really failed to cook at once.)*

> *"Na-agahan abi ako sa sugalan, amo na nga na-akig ang akon bana kag napa-agyan ako." (My husband got mad at me and hurt me because I was home in the early morning already from playing mahjong.)*

A female key informant telling about a neighbor's experience with abuse commented that:

> *"Dapat lang man nga tindakan siya, kay wala man ga pati sa bana niya nga indi na s'ya magsugal." (She should really be beaten up because she does not follow her husband when he says that she should not gamble anymore.)*

A wife of a popular professional shocked her friends and acquaintances when she described the details of how her husband would poke a gun at her head when he was mad and scare her with his curses even in front of visitors when he got drunk. She said that she could not run away because of their five young children.

Refusal to have sex with the husband has been identified as a common cause of a husband's anger that often also leads to physical violence. Eva reported that when she refused her husband's advances, he would beat her. On the other hand, Lyra's husband does not beat her if she refuses his advances, but would insult her about her past and remind her that "if not for him, she would not have gotten out of poverty."

It was learned that many victims of domestic violence do not seek help because they are ashamed to do so. Family quarrels are usually considered private affairs and making it known to others, even to authorities, would be embarrassing not only to the victim, but also to the perpetrator and their families. Often, cases are settled amicably by an arbiter, either a family member or a *barangay* official or a religious leader. Diana's husband raped her daughter repeatedly. After confronting her husband about the incident when her daughter confessed to her about it, the husband instead got mad at her and beat her, accusing her of making up stories. She reported the case to the police. The husband was arrested, but later Diana begged the police to release him and decided not to file a case against him because "it will embarrass the whole family."

The results of this study confirm that women are the most common victims of domestic violence and that their husbands are the most common perpetrators. As in many parts of the country and the world, violence against women in Western Visayas exists in all socioeconomic levels, however, the risks are greater among women who are economically and socially disadvantaged. The fact that most of the victims of domestic violence among the MWRAs in Western Visayas are not gainfully employed and have inadequate education makes them more vulnerable than

their economically and socially privileged counterparts. Economic dependence of women and their lack of knowledge and skills reinforces their powerlessness to negotiate or bargain with their partners in times of conflict. This powerlessness also makes them helpless and fearful preventing them to fight back or to seek for help when they are abused.

The data attest to the fact that when families are big and resources are limited, the likelihood of domestic violence increases. Congestion and unmet needs tend to breed tension and frustration which could lead to aggression or domestic violence. In the home, women and children who are perceived to be weak are often victimized by the stronger aggressor, most likely, men.

It is interesting to note that some women justify the violent actions of their husbands and even blame themselves for their partners' behavior. Some of the cases illustrated indicate that a woman's supposed offense or transgression of her role as a wife is used to justify domestic violence. On the contrary, when men commit the same transgressions, they can easily get away with their actions with simple excuses like, "What can I do, I am just human," or "I could not control myself because I was drunk." There may be wives who also beat their husbands, but this is a rarity among Filipinos. In fact, wives who scold or nag their husband further face the risk of being abused.

The data indicate that men wield their power and authority over women through domestic violence and this power and authority also prevents women from seeking help because of fear. The problem of domestic violence is further aggravated by society's indifference and tolerance as indicated by the lack of effort in the part of institutions to punish perpetrators and the usual approach of treating cases of domestic violence as private matters rather than public crimes.

CHAPTER VI

SUMMARY, CONCLUSIONS, POLICY IMPLICATIONS AND RECOMMENDATIONS

This study was in 1995-97 by the Social Science Research Institute (SSRI), Central Philippine University, in collaboration with the Women Resource Center (WRC) and the Family Planning Organization of the Philippines (FPOP), Iloilo Chapter, in order to determine the association between family planning use and various aspects of the lives married women of reproductive age (MWRA) of Western Visayas. Aspects included were work participation, education and training, participation in community activities, satisfaction with life, perceived self-esteem, and Decision-making participation. The study further aims to determine incidence of domestic violence among the women and certain factors associated with their experience with violence.

The study has the following hypothesis:

1. Family planning practice is associated with women's participation in paid work, and nature of their work.

2. Family planning practice is associated with women's educational achievement and participation in training after marriage.

3. Family planning practice is associated with women's participation in community organization/activities.

4. Family planning practice is associated with women's satisfaction with life and Decision-making participation.

Research Methodology

To answer the study objectives, interviews were conducted with 1100 married women of reproductive age (MWRA) and 50 key informants. Nine pre-survey and 27 post-survey Fads were conducted with women, men, community leaders, and members of women's groups and family planning service providers.

The study areas and the survey sample of 1100 respondents were selected using stratified random sampling. From each of the three sample provinces, (Iloilo, Aklan and Antique) in Western Visayas, three municipalities were drawn, one coastal, one agricultural, and one urban community. In each sample municipality three baronages were randomly selected, one from the town proper, and two from outside the town proper. In each sample barangay, an FGD and several key informant interviews were conducted.

The survey questionnaire, the FGD and in-depth interview guides were prepared reviewed and finalized in close consultation with researchers involved in the FHI-WSP, FHI advisers, consultants and representatives of women's groups both at the local and national levels. The instruments were translated into the dialect of the study participants.

Data were collected by trained interviewers and FGD facilitators who were also provided gender sensitivity training.

Major Findings and Conclusions

Background Characteristics of the MWRAs

A typical married woman of reproductive age in Western Visayas is in her early thirties, Roman Catholic, and a non-working urban dweller with at least some high school education. A little more than half (53 percent) of these women are FP users and the rest are a non-user.

A MWRAs household is basically of average size (mean=5.6), composed of the same number of males and female. On the average, a MWRA has one to two children of school age. Household characteristics do not vary between FP users and non-users. MWRAs family is an owner of a house made of temporary materials, but with piped-in water, electricity, and water-sealed toilet. The household probably owns a radio. FP users were more likely owned these amenities than non-users. Generally, a MWRA has an average socioeconomic status.

Pregnancy and Childbearing Experiences of the MWRAs

The MWRAs' age at first marriage was 23.3 years. Rural dwellers tended to marry earlier than urban dwellers and the non-working women tended to marry earlier than working women. Women with college education also tended to marry later than those with lower educational attainment. College graduates opt to marry later because they usually work first and earn money before they settle down. Women who married early had more children than those who married late.

The women had on the average, almost four (3.8) pregnancies and between three and four (3.5) children ever born. This discrepancy is explained by pregnancy loss among some women. FP users had slightly more pregnancies and more children ever born compared to non-users. This suggests that they probably use FP because they had already reached their desired number of children.

The mean number of children ever born was higher for older women compared to younger; for rural dwellers compared to urban dwellers; and for elementary educated women compared to those with at least a high school education. Women's work status did not seem to influence their number of children ever born.

Family Planning Practice of MWRAs

Slightly more than half (52.6 percent) of the MWRAs were either current users or had been users of FP methods. The most popularly used FP method was the pill. The most unpopular were condom and vasectomy, both male-oriented methods. The most common reason for choice of FP methods was its effectiveness as perceived by the MWRAs. The most common complaint about the methods they were using was dizziness.

The choice of FP method is greatly influenced by the women's perception of the "effectiveness" of the method, its "absence of side effects," and "convenience" in using the method. Apparently,

the basis for choice of a contraceptive has not changed much, since these are the usual reasons given by women for their method preference.

The majority of the FP users were "very satisfied" with the method they were using; a large majority intended to continue with it. Among the non-users, some intended to use FP, most probably pills, in the future.

One-fifth of the FP users had experienced problems with FP use. The most common complaints reported were headache, irritability, and weight gain. Other problems mentioned, but by only a few were chest pains, hypertension, heavy bleeding, amenorrhea, painful periods, and weight loss. Dizziness, headaches, and weight gain were experienced mostly by pill users, while heavy bleeding more common among users of injectable. Follow-up consultation with the service provider allayed their fears of side effects.

A high majority of the current FP users expressed intention to continue using the family planning method they were currently using. They intended to do so because they were already used to the method, the method is effective, and/or the method is free from side effects.

Availability and Utilization of Family Planning Services Among the MWRAs

FP services were available in almost all cities and municipalities in Western Visayas. These services were provided in almost all local government health clinics in almost all municipalities in the region. Government hospitals and some private clinics also provided FP services.

In the municipalities, the Main Health Clinic/Center or the Rural Health Unit (RHU) served as the main health facility. All the nine municipalities covered by the study had and RHU. Every RHU had a physician, nurses and midwives. Some also had a dentist and a sanitary health inspector and a medical technologist. Most RHUs also had an organized group of *Barangay* Health Workers or BHWs who assist the midwives in health program campaign, FP motivation and follow-up.

The majority of the MWRAs had received FP services, the most common of which were contraceptives, prenatal care and counseling. The main source of FP supplies or services of the women was the government sector, particularly the RHU or the main health center, the government hospital or the *Barangay* Health Station.

Nearly all the FP users received the FP method they requested. Sometimes FP supplies were not available at the clinic and clients were given alternative methods.

The MWRAs considered important friendly/respectful staff and competent staff. They wanted a wide range of FP services/methods and preferred that FP facilities are accessible and require short waiting time only.

The preference for a female FP service provider tended to be the norm among the MWRAs. They preferred women to conduct breast examination, pelvic examination, Pap smear, IUD insertion, and STD diagnosis. They did not have any particular preference, in regard to the sex of the provider of injections. The women perceived that their husbands' preference as to the sex of the FP service providers tended to match their own preferences.

Family Planning Practice and Participation in Paid Work Among the MWRAs

FP practice was found to be significantly associated with MWRAs' participation in paid work. FP users were more likely to be engaged in paid work than non-users. Qualitative data confirmed that FP practice allowed women to participate in paid work and helped them become more efficient workers. It also reportedly increased their opportunities for economic improvement. Husbands agreed that spaced pregnancies and fewer children allowed their wives to spend more time for paid work and to earn more money.

The favorable influence of family planning practice on work participation of women prevailed even when age, residence and educational attainment, number of children, religion and household size were controlled. FP practice consistently increased
The FP users probability of being employed.

Work participation of FP users increased with age, family size, and number of children. For more reasons not adequately ascertained, the working FP users also had big families and many children. Since child care and household chores are traditionally women's roles, the working FP users are obviously burdened by their multiple responsibilities of production, reproduction and household management.

Most of the working FP users were engaged in traditional, seasonal, and low-paying jobs, and most of the income they derived from their work was contributed to household expenses. Very little, if any, was spent for personal purposes.

Family Planning Practice and Educational Advancement among the MWRAs

A significantly higher proportion of FP users than non-users had attended seminars or training after marriage. The most common types of training attended by both the trained FP users and non-users were in relation to personal development.

Variation in the FP user and the non-users' attendance in training remained evident even when other variables were controlled. Attendance in training also tended to increase with age, educational attainment and socioeconomic status of the woman, but tended to decrease with increase in the number of children or pregnancies. This was true of both FP users and non-users. More FP users than non-users were able to attend training or study between pregnancies.

The regression analysis showed that the non-users are less likely to attend training or advance professionally than were the FP ever- users. The data suggest that FP use tended to improve a woman's opportunity for pursuing more education/training. This fact implies greater opportunity for paid work participation/advancement.

Family Planning Practice and Community Participation among MWRAs

FP practice was found to increase a woman's participation in community activities; as indicated by a significantly higher proportion of FP users than non-users were involved in community activities. Men and women said- that with family planning, women have more time to get involved in activities outside the home. The women found community activities relaxing; these allow them to socialize and interact with other people. The women also claimed that social

participation gave them satisfaction and increased their self-worth because they could be more useful outside the home.

Women's involvement in community activities was often concentrated on socio-civic community activities, such as PTA, beautification, religious, and health-related activities. The women had very minimal involvement in political and economic organizations, as evidenced by the fact that only a few women were community leaders or officers of political/economic organizations. If they were organization members or officers, they usually held traditional or positions that did not involve important Decision-making.

Family Planning Practice and Women's Satisfaction with Life

On the whole, the women were satisfied with their lives. In all the 14 aspects of life considered, the FP users registered greater satisfaction than did the never users. The significant difference between the users and non-users was borne out by the satisfaction scores obtained on the anchor item "life on the whole." The differences between the mean scores of never-users and the ever-users, however, were not significant in regard to children's health, job, leisure, and house relationships with friends and conditions (physical and social) of one's neighborhood.

Regression analysis revealed that a woman's age, household size, and number of children ever born did not have a significant bearing on her satisfaction with each of the eight aspects of life, when the 14 aspects were collapsed into eight broader categories. MWRAs with high SES were significantly more satisfied with life as a whole than those with lower SES. On the other hand their satisfaction with religion, relationship with partner and job did not significantly vary according to level of SES.

Relative to the MWRAs, who were currently using family planning continuously for 24 months, MWRAs who had never used family planning consistently showed less satisfaction with life as a whole and with all the other aspects of life. This suggests that women who practice family planning are more satisfied in life than those who do not use family planning.

Comparatively, rural dwellers had lower satisfaction scores compared with urban dwellers, on "life as a whole," the anchor item, but in regard to seven aspects taken separately, the urban and rural dwellers were approximately equally satisfied. When all variables except education were controlled, the elementary-school-educated women were found to be less satisfied with their partners and their jobs than those with better education. FGD and in-depth interview results reveal the general impression that FP users had an easier life and thought of themselves more highly than their non-user counterparts.

Family Planning Practice and Decision-making Participation of MWRAs

Significantly more FP users than non-users shared Decision-making with their husbands on matters regarding the four areas considered, namely; whether the woman can work outside the home; whether she can travel to other places, whether she can use family planning; and whether she should have another baby. Non-users were more likely than users to report that their husbands independently made decisions in the four areas.

Most of the women believed that making decisions regarding a woman's work outside the home, traveling to other places, family planning practice, and having another child should be joint responsibilities of the husband and the wife.

As socioeconomic status increases, there was less likelihood that a woman would adhere to the idea that Decision-making regarding work outside the home should be borne by the wife alone. . Decision-making participation regarding going to other places was found to vary significantly according to residence and occupation, but not according to age, household size, number of children ever born, religion, education, socioeconomic status, and duration of FP use.

Women residing in the rural areas was less likely to decide on their own to go to other places compared with women residing in the urban areas. The working woman was almost doubly likely to decide whether or not to go to other places than did the non-working one.

Of the nine variables, only age and occupation were found to have a significant bearing on Decision-making participation in regard to having another baby. Relative to a younger woman, an older woman herself tended to make the decision regarding having another baby. A working woman was more likely to decide herself on having another baby than a non-working one.

Domestic Violence among the Women of Western Visayas

Domestic violence is a common problem for women in Western Visayas. Regardless of FP practice, more than one-third of the women had been victims of physical, psychological violence or both. The usual assailants were husbands partners of the victims.

Most domestic violence happened when the perpetrator was under the influence of liquor. Among the perceived causes of violence was jealousy, quarrels due to infidelity, or arguments over financial and other family matters. The most commonly reported acts of physical abuse were beating, boxing, slapping or kicking, while the most common psychological abuse was verbal insult, infidelity and the like. Many of the reported causes of domestic violence are facilitators rather than causes.

Some wives had been forced to have sex by their husbands even if they did not want to. This had happened to some during pregnancy.

Women engaged in paid work and in community activities were not exempted from suffering from domestic abuse. Like many of their non-working counterparts, one in three of working and/or socially active women experienced abuse.

The abused women, did not usually have anyone to turn to for help, except friends and relatives and sometimes the barangay captain who usually attempt to amicably settle the case and ask the wife to "forgive the husband."

Policy Implications and Recommendations

1. The favorable influence of family planning on the economic and psychosocial life of women suggests a continuous promotion of an effective family planning program that provides

integrated FP services that address the needs of women in all sectors, especially the working women. The services should be available to working women after working hours.

2. To reach a wider audience, the use of print and broadcast media in the promotion of family planning should be maximized. Radio and television programs should be aired and shown in popular regular programs which already have a wide audience where discussions on family planning and its possible effects s on the lives of women and their families. Discussions may also include domestic violence and how wife batterers may seek counsel, if they want to avoid further violence..

3. Radio, television and public fora should also conduct discussions that will help women understand their reproductive rights and how they can avoid behaviors that incite men to inflict violence on women

4. Women's access to leadership positions in community/political affairs must be enhanced. Government as well as private organizations must be mandated to allot a certain percentage of leadership positions and jobs on various levels, to women. For example, local government units must be mandated to allot a certain percentage of local positions to women.

5. There should be gender reorientation for couples, local leaders and the community in general, to re-examine stereotypes and values regarding gender roles and division of labor. The government's pre-marriage counseling program should be improved and organized so that applicants will take this requirement seriously. The orientation must include discussion, not only of family planning but also of gender roles and division of labor, especially in the domestic area; i. e. responsibilities for parenting and child care, and marital responsibilities.

6. Women's groups, civic and social organizations as a whole, should do advocacy work to develop awareness of women's concerns, such as their reproductive role, rights and responsibilities. They should advocate that school and mass media set up educational programs for better understanding of the psychology of men and women. Programs should especially help youth understand their sexuality better. Misunderstanding of real masculinity and femininity are may lead to unhappy sexual relationships, in and out of the marriage context, and to unfortunate, unhappy partnerships conducive to sexual violence.

7. The Commission on Higher Education should mandate that college topics like family planning, rights of women, gender issues, and reproductive health should be incorporated in basic health-related subjects and in appropriate social science courses in high school and college. Teachers should use research findings in their instruction as reference or illustration materials. To make students aware of existing economic and social problems in the country, teacher should require students to conduct small exploratory investigations.

8. The fact that many women, even those who are working, were abused, underscores the need for programs for women that address not only their economic and health needs but also her psychological needs. Schemes/mechanisms that can minimize if not eliminate domestic violence and/or immediately respond to the needs of victims of domestic violence must be developed and established in the community. Adequate health and feminist counseling services must be available and accessible for victims of domestic violence. Government and non-government agencies should work hand in hand to address this problem

9. Women's groups /organizations that now hold seminars on gender sensitivity and gender issues, especially during Women's month, (March) should regularly organize seminars on women's health, including family planning; marital relationships and domestic violence.

10. Women's groups should do advocacy work on members of the clergy (priests and pastors) to deliver sermons that touch on family wellness, responsible parenthood and marital relationships.

11. More advocacy work is needed to promote equal access to work opportunities for men and women. Creation of more jobs will also open up work opportunities for women, so that more women can hope to be more financially independent, a status that has empowering effects on women, making them more assertive in Decision-making regarding their own sexuality, their reproductive and productive roles and making them less liable to be victims of domestic violence.

12. Since home chores especially child care, are still heavy burdens of women because labor saving devices and support groups are beyond the economic reach of most women, the community in general should seriously begin to adopt the cooperative scheme which has proved to be helpful in the economic area, like buying and selling goods -- groceries, fertilizers, etc. In addition to cooperative schemes that may reduce shopping and marketing chores of the women, the cooperative scheme on home chores and childcare can also be adopted.

13. Work environments should be made more women-friendly. For example, they could have day care or drop-in centers where wives can leave their children. If they do not need to worry about their children during work hours, their attendance, punctuality, and performance will improve, so better-paying jobs will be opened to them, and promotions and other incentives usually enjoyed only by men will also be enjoyed by them.

14. Scholarships in courses and training programs that prepare for better paying jobs like technology should be made equally accessible to female and male students.

15. There should be laws requiring companies/institutions to show proof that they give women equal chance to be employed, to occupy Decision-making positions, and to get promoted.

16. Since child care and household chores are still women's responsibilities, work outside the home further multiplies their burden. To lessen the women's domestic workload, policies and programs must promote role sharing between the men and the women at home.

17. Organized women can be provided loan/technical assistance for entrepreneurial activities. NGOs can be tapped to help provide these services.

18. Since domestic violence is a fact of life in Western Visayas, Women's Desks set up in police stations should be staffed with gender-sensitive workers, some of whom should be men who emotionally stable and of sufficient masculinity so that if the opportunity arises, they can adequately counsel wife-batterers.

Recommendations for Further Research

1. Operations research, specifically interventions studies on reproductive health advocacy, marital counseling, male involvement in FP efforts, LGU involvement in health and gender programs, and other related concerns should be seriously considered. While many health and family planning interventions have been implemented, the monitoring and assessment of their effectiveness and cost are limited.

2. Studies on men's family planning knowledge, attitudes, and practice and their actual and desired involvement in family planning programs should be conducted. In-depth interviews of men who do not want their wives to use FP methods should be done, paying attention to their reasons, including fears and reservations, and suggestions for alternative strategies to prevent unwanted pregnancies.

3. Quasi-experimental studies on the impact of family planning practice on specific aspects of women's lives, such as those considered in this study are needed. This should be done in collaboration with local health or population office personnel in order for them to better understand the usefulness and functions of operations research in program implementation.

4. Causal comparative studies are needed on women who are victims of domestic violence and those who are not. They should be comparable in terms of age, age at first marriage, and husband's occupation, SES, educational attainment, area of residence, religion, and work status and number of living children. In-depth interviews should be used to discover how larger or smaller families differ, using such variables using such variables as family composition, aspirations of husband and wife, Decision-making participation, personality of wife and husband (based on personality inventory) and other factors that may surface during the interviews.

5. Case studies of battered women and batterers should be done. One can learn from them what verbal and non-verbal behaviors of women drive men to violence and whether or not the husbands are under the influence of drugs or alcohol. It would be interesting to look into the profile of battered wives and examine their personality assessment, their perception of why their husbands subject them to violence, and their level of self-esteem. A profile of their husbands and their own personality assessment would also be drawn.

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APPENDICES

APPENDIX A: SURVEY QUESTIONNAIRE

FAMILY PLANNING: ITS ECONOMIC AND PSYCHOSOCIAL INFLUENCE ON THE LIVES OF MARRIED WOMEN OF REPRODUCTIVE AGE IN WESTERN VISAYAS

Interview Questionnaire

Identification Codes:

Country _____ |____|____|____|____|

Religion_____ |____|____|____|____|

Province _____ |____|____|____|____|

Municipality _____ |____|____|____|____|

Barangay _____ |____|____|____|____|

What kind of place is this community?

City …….... 1
Town proper …….. 2
Barangay …… 3

Name of Respondent:

_____

Complete Address of Respondent:

_____

Respondent Number:

|____|____|____|____|

Interviewer's ID No.:

|_____||_____|

Hello, my name is _____ and working with Social Science Research Institute, along with Family Planning International is doing a research study on women's lives, family planning and reproductive health.

You have been randomly selected to participate in this study.

We would like to ask you some questions about your life and your family, the babies you have had, and the work you do inside and outside of your house.

This interview will probably take a while. If you do not have time to do the interview right now, we can arrange to come back at a later time. You can refuse to answer any questions or series of questions if you choose. However, I would like to assure you that all that is said during the interview will be strictly confidential and that the information collected from you will be used only in scientific reports without any mention of your name.

Information gathered from the study will be used to improve programs that promote the well being of women. So we hope you will give accurate answers. If you do not understand the meaning of any of the questions, please do not be afraid to ask. Do you have any questions right now? Do you agree to participate in the survey?

Interviewer's Visit

Call Record	Date	Time		Interviewer's Name	Results of Call	Appointment		
		Start	End			Date	Time	Place
First Call								
Second Call								
Third Call								

Codes for Result of Call

1 - Completed interview
2 - Inaccessible/temporarily away
3 - Outright Refusal
4 - Several calls, failed to contact
5 - Others (specify) _____

BLOCK A
Life-cycle Stage and Other Personal Factors

A.1 Interview started at:	Hour : |___|___| Minute: |___|___|

A.2. Please list the usual members of this household. Start with the person you consider to be the head of the household. **(MENTION NAMES)** from the household head of the family. (Ask Q. A.3 to A.7 for each of their names as you question.)

A.3. How old is _____ **(MENTION NAME OF MEMBER)**

A.4. Is _____ male or female**? (MENTION NAME OF MEMBER)**

A.5. How is _____ related to the household head?

A.6. How much education has _____ had?

A.7. **(OF MEMBERS WHO ARE SIX TO 20 YEARS OLD)** Is _____ attending school now?

A.8. For those not in school, ask, why this member is not attending school.

Not interested ……... 1
No money/ can't afford …… 2
Working for pay ……... 3
Helping/working at home (farm, taking care of siblings/ baby, etc.) ……... 4
Health problem …… 5
Cannot tackle mentally …… 6
Others specify, _____ 88

TABLE 1. HOUSEHOLD CHARACTERISTICS

Line Number	A.2 Name of HH Member	A.3 Age	A.4 1=Male 2=Female	A 5 Relation to HH Head	A.6 Educational Attainment	A.7 Attending School Now	A.8 Why
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

A.9. The next questions apply to you.

[IF AFTER ASKING THE FIRST QUESTION, IT IS DETERMINED THAT THE RESPONDENT IS MARRIED OR HAS A REGULAR PARTNER, ASK THE QUESTION FOR THE PARTNER AFTER ASKING THE QUESTIONS FOR THE RESPONDENTS].

Questions	Answers and Codes
A.9.1 Are you married or living with a man, widowed, divorced or longer living together? **(If Married, Ask If Husband Is Living With Them At Present Or Is Away).**	Married, spouse present ……. 1 Married, spouse absent …….. 2 Living in …… 3 Widowed ……... 4 } SKIP TO A.9.3 Separated ……... 5 } " " No longer living together ... 6 } " "
A.9.2 **If Ever Married, Ask:** How old were you when you (your husband) got married for the first time?	Respondent |_____|_____| Husband |_____|_____|
A.9.3 What is your (your husband's) current occupation?	Respondent |_____|_____| Husband |_____|_____|
A.9.4 Have you (your husband) received any training for specific skills or jobs?	Respondent Husband No ……. (SKIP TO A.9.8)……. 0 Yes ……. 1
A.9.5 If yes, what kind of training?	Respondent |_____|_____| Husband |_____|_____|
A.9.6 How long was that training in days? weeks, months, years?	Respondent Husband Days _____ _____ Weeks _____ _____ Months _____ _____ Years _____ _____

A.9.7 In what year did you (your husband) have the training?	Respondent |___|___|___|___| Husband |___|___|___|___|
A.9.4 What is your (your husband) religion?	Respondent Husband None ……. 0 Catholic …… 1 Protestant ……. 2 Muslim ……. 3 Buddhist …….. 4 Jewish …….. 5 Others, specify _____ 96
A.9.5 What is the primary language spoken in your household? (Answer according to local situation- for use where ethnicity or language defines groups which differ on gender norms)	Tagalog …… 1 Ilonggo ……. 2 Kinaray-a ……. 3 Akeanon …….. 4 Cebuano …….. 5 Others, specify _____ 88
A.9.6 How long have you (your husband) lived in the present location? (**Enter No. Of Months Or Years)**	Respondent Months |___|___| Years |___|___| All my life ……..…….. 77 Husband Months |___|___| Years |___|___| All my life …… 77
A.9.7 Where (what kind of place) were you born? (criteria re: population will be determined)	City …….. 1 Town ……... 2 Barangay ……. 3

A.10. The following questions refer to your household and its facilities.

Questions	Answers and Codes
A10 .1 Do you or your family own this house, or pay rent for it, or staying here for free?	Own …….. 1 Rent …….. 2 Stay for free …….. 3 Don't know …… 96 Others, (specify) _____ 88
A 10..2 What is your usual source of drinking water?	NAWASA ….....…… 1 Public pump/artesian well….....….. 2 Dug well w/ pump….....…. 3 Deep well .(public)….....….. 4 Deep well (private) ….....…… 5 Spring/River/Rain ….....….. 6 Others, specify _____ 88

A.10..3 What kind of facility do your household have?	None .....…… 0 "Flush" toilet.....….... 1 "Water-sealed" toilet .....…… 2 Latrine.....….... 3 Open pit .....….... 4 Others, (specify) _____ 96
A. 10.4 Does your household have?	Wala May-ara Electricity …… 0 1 Radio ……... 0 1 Television …… 0 1 Refrigerator ……. 0 1
A 10..5 Does any member of your household own?	Wala May-ara Bicycle …… 0 1 Motorcycle …….. 0 1 Car …….. 0 1
A 10.6 If interview was done in respondent's house: observe, rather than question: Determine the materials used for the floor/walls. **If Interview Was Done Somewhere Else, Ask The Respondent:** What is the main material used in the construction of your house/ (categories should reflect low, medium, and high socioeconomic status in the country)	Concrete: (Mostly cemented) …… 1 Semi concrete: (concrete and wood) ……. 2 Temporary: (Nipa, hatch, bamboo) ……... 3 Others, specify_____4

BLOCK
PREGNANCY AND CHILD LIFE EVENT

B2.1 Tell me about your pregnancies. Did the pregnancy result in live birth, still birth or miscarriage?	B2.2 If live birth, in what month / year was (name) born. If still birth or miscarriage, in what month / year did the pregnancy end? If live birth >2.3 If still birth or miscarriage >2.11-	B2.2 If live birth, what name was given to your baby?	B2.3 If live birth, what name was given to your first, next baby?	B2.4 Record single or multiple birth status.	B2.5 Is (name) a boy or a girl?	B2.6 Is (name) alive?	B2.7 If Alive, How old was (name) on his/her last birthday?	B2.8 If Alive, is (name) living with you?	B2.9 If Dead, how old was (name) when he/she died? If 1 yr., probe how many month?	
1= Live birth 2=Still Birth 3=Miscarriage	Code month 1-12	Code last 2 digits of year			1=Single 2=Multiple	1=Boy 2=Girl	0 = No go to 2.9 1=Yes	Record age in completed years	O = No 1=Yes	Record days if less than 1 month. 1 .. Days 2 -Mo. 3- Yrs.
Ever Used FP										
Ever Worked for Pay										

A
BEARING EXPERIENCE
HISTORY

B2.10 Have you ever breastfed (Name)? If yes, for how long?	B.2.11 Were you married when you had this pregnancy?	B.12 Have you been married more than once? If yes, which husband is the father of (Name)?	B.13. During the time (after the last pregnancy and before this pregnancy, did you use an FP method? If yes, what method?	B.14. During the time (after the last pregnancy) and before this pregnancy, did you work for pay?	B.15. What was your job during this interval? Indicate job description.	B2.16 During the last (after the last pregnancy and before this pregnancy, did you go to school?	B.17. What did you do during this interval? Describe course of study and indicate code.
Record months 00-Never	0- No > 2.13 1-Yes	1-First 2-Second- Etc. 9-NAP	00-No See Code list	0-No> Go to next pregnancy 1> Yes	Write description and code. See code list.	0-No – Go to next pregnancy 1 Yes	Indicate code of course/grade
			Mark ‘X’ here if ever used family planning: |_____|	Mark ‘X’ here if ever worked for pay: |_____|			

BLOCK C
FAMILY PLANNING PRACTICE

C.1 Do you know of any methods to delay or avoid pregnancy? **(DO NOT PROMPT)**
C.2 What methods do you know of? **(PROMPT)**
C.3 Where you could obtain this method or supply?
CIRCLE CORRESPONDING ANSWERS ON THE TABLE BELOW

FP Methods	Spontaneous (C.1) CODE:0=NO 1=YES	Prompted (C.2) CODE: 0=NO 1=YES	Where to obtain (C.3) Use CODE LIST of D.1
Pills	0 1	0 1	
IUD	0 1	0 1	
Injection (Depo-Provera)	0 1	0 1	
Diaphragm	0 1	0 1	
Foam tablets ,jelly, cream, aerosol (Neosampoon)	0 1	0 1	
Condom	0 1	0 1	
Tubal ligation	0 1	0 1	
Vasectomy	0 1	0 1	
Periodic abstinence	0 1	0 1	
Calendar	0 1	0 1	
Rhythm	0 1	0 1	
Withdrawal	0 1	0 1	
Pagpasuso (LAM)	0 1	0 1	
Basal Body Temperature (BBT)	0 1	0 1	
Mucus Method (OM)	0 1	0 1	
Symptothermal Method	0 1	0 1	
Others, specify _____	0 1	0 1	
C.5 What were the reasons why you got pregnant?	Method failed …… 1 Forgot to use method ……. 2 Unable to obtain a supply …….. 3 Partner didn't pull out in time ……... 4 Took a chance during known/suspected fertile Period .. 5 Pressured/forced to have unprotected sex …….. 6 Don't know ……. 96 Others, (Specify) _____ 88		
C.4. Have you ever become pregnant at any time when you wish you hadn't?	Never .....(SKIP TO C.12)..... 0 Yes, once ..... 1 Yes, more than once 2		
C.5 What did you do about it? (Probe: Did you do anything to interrupt the last pregnancy you did not want?)	Had the child ..... 1 Miscarriage ..... 2 Had an abortion ..... 3 Others, (Specify) _____ 88		

C.6 Were you in school the last time you had an unintended pregnancy (unwanted pregnancy)? If yes, did you continue?	Continued school with only a brief (or no) Interruption ……. 1 Left school (for more than 6 months) then returned …….. 2 Left school and have never returned …… 3 N/A (Not Applicable) Not in school at the time …….. 4 Others, (Specify) _____ 88
C7 Were you working the last time you had an unwanted pregnancy? If yes, did you continue working?	Continue work with only a brief (or no) interruption? . 1 Stopped working (for more than 6 months) but then returned …… 2 Stopped working and have never returned ……... 3 N/A (Not Applicable). was not working at the time … 4 Others, (Specify) _____ 88
C.8 Were there other effects of the unwanted pregnancy on your life? C.8a If yes, what ? (Probe partner relations, family problems, other children, etc)	No ……. (SKIP TO C.12)……... 0 Yes …….. 1
C.9 Have you ever become pregnant at a time when your husband (partner) wished you hadn't?	Never …… 0 Once ……. 1 More than once ……. 2
C.10 Can you still bear children?	No …… 0 Yes ……(SKIP TO C.12) …… 1 Yes, but I have no partner ……(SKIP TO C12) …….. 2 Yes, but my partner is infertile or sterilized ……(SKIP TO C12) …… 3 Don't know ……. 99
C.11 Why can't you bear children?	Post-menopausal …….. 1 Always infertile …… 2 "Infertile" now because of health problems …….. 3 Sterilized …….. 4 Don't know ……. 99 Others, (Specify) _____ 88
C.12 Do you believe that breastfeeding usually delays the return of menstrual period? If yes, does it prevent pregnancy even after a woman's menses have returned?	No …… 0 Yes, throughout lactation (even after menses) ……... 1 Yes, but only during amenorrhea ……. 2
C.13 Have you ever relied on breastfeeding to prevent pregnancy?	No …… 0 Yes, throughout the course of lacta …….. 1 Yes, but only during amennorhea …… 2 Others, specify _____ 88

CHECK EVENT HISTORY. IF EVER USED FAMILY PLANNING CONTINUE WITH QUESTIONNAIRE. IF NEVER USED FAMILY PLANNING SKIP C.27

C.14 Did you ever get pregnant while using a method or doing something to delay or avoid pregnancy, and if so, how many times did this happen?	No ……(SKIP to C16) …… 0 Yes, Once …… 1 Yes, more than once …… 2
C.15 Why do you think this happened?	Method failed …….. 1 Forgot to use method ……... 2 Unable to obtain method ……. 3 Partner didn't pull out in time ……. 4 Took a chance during fertile period …… 5 Pressured/ forced to have unprotected sex ….. 6 Don't know …….. 99 Others, specify_____ 88
C.16 are you or your partner using a method now or doing something so that you won't get pregnant?	No ……(SKIP TO C.27) …….. 0 Huo …….. 1
C.17 What method are you using so that you won't get pregnant? (Check all mentioned) **IF RESPONDENT ANSWERS NFP METHOD, PROBE FOR THE SPECIFIC TYPE OF NFP METHOD.**	Pills ……. 1 IUD ……. 2 Injection (Depo-Provera) …… 3 Foam tablets, jelly, cream, aerosol ……... 4 (Neosampoon) …… 5 Condom …….. 6 Tubal ligation ……. 7 Vasectomy …….. 8 Periodic Abstinence …… 9 Calendar …… 10 Rhythm …….. 11 Withdrawal1 …….. 12 Breastfeeding (LAM) …… 13 Basal Body Temperature(BBT) ……. 14 Mucus Method (OM) ……. 15 Symptothermal ……... 16 Others, specify _____ 96
C.18 Are you satisfied or dissatisfied with this family planning method? **(ASK TO WHAT EXTENT IS SHE CONTENTED OR NOT CONTENTED.)**	Very satisfied ……... 1 Somewhat satisfied …….. 2 Somewhat dissatisfied ……. 3 Very dissatisfied …….. 4
C.19 How about your husband/partner, is he satisfied or dissatisfied with this method?	Very satisfied ……... 1 Somewhat satisfied …….. 2 Somewhat dissatisfied ……. 3 Very dissatisfied …….. 4

C.20 Why are you using this method? **(PLEASE PROBE)**	Limit …… 1 Space ……... 2 Convenient …….. 3 Effective …….. 4 No side effects ……. 5 Doctor's advice ……... 6 Trial/curiosity …….. 7 Easy to get supply …… 9 Free/Inexpensive …… 10 Others, specify …… 96
C.21 Are you having any health problems that you may think may be due to using this method?	No ……(SKIP TO C.25) ……. 0 Yes ……... 1
C.22 What are the main health problems you believe you are experiencing this method? **CODE UP TO THREE IN ORDER OF MENTION** |____|____| |____|____| |____|____|	Irregular menstruation …….. 1 Heavy bleeding …… 2 Amenorrhea ……. 3 Painful periods ……. 4 Intermenstrual pain ……. 5 Dizziness ……. 6 Blurred vision …….. 7 Chest pains …….. 8 Hypertension …….. 9 Varicose veins …… 10 Vaginal discharges …….. 11 Headaches …….. 12 Weight gain ……... 13 Weight loss …… 14 Hair loss ……. 15 Irritability ……16 Don't know …… 88 Others, (Specify) _____ 96
C.23 Are you experiencing any Non-health-related problems in using this method?	No ……(SKIP to C.27) ……. 0 Yes ……. 1
C.24 What are these Non-related-health problems you are experiencing? **CODE UP TO THREE IN ORDER OF MENTION** |____|____| |____|____| |____|____|	Inconvenience …… 1 Inconvenience of getting more supplies ……. 2 Husband/partner doesn't like the method ……... 3 Husband/partner doesn't like me to use FP …… 4 Messy to use ……... 5 Hard to hide from children …… 6 Affects ability to work ……7 Lack of privacy …….. 8 Don't know …….. 88 Others, (Specify) _____ 96

C.25 Do you plan to keep using this method?	No = 0 Yes = 1
C.26 Why?	

FOR NON-USERS OF FAMILY PLANNING:

C.27 Do you intend to use a method to delay or avoid pregnancy at any time in the future?	No …….. (SKIP to BLOCK D)…….. 0 Yes …….. 1
C.28 What method do you intend to use?	Pills …… 1 IUD …… 2 Injection (Depo-Provera) …… 3 Diaphragm …….. 4 Foam tablets, jelly, cream, aerosol (Neosampoon) …… 5 Condom …….. 6 Tubal ligation …….. 7 Vasectomy …….. 8 Periodic Abstinence…… 9 Calendar…… 10 Rhythm …… 11 Withdrawal……12 Breastfeeding (LAM) ……13 Basal Body Temperature (BBT) …….. 14 Mucus Method (OM) ……... 15 Symptothermal …….. 16 Don't know …….. 88 Others, specify _____ 96
C.29 Why would you use this method?	Limit …….. 1 Space …….. 2 Convenient …… 3 Effective ……... 4 Free from side effects …… 5 Doctor's advice …….. 6 Trial/curiosity …….. 7 Accessibility …….. 8 Familiarity …… 9 Free/Inexpensive …….. 10 Other, specify _____ 96

C.30 What disadvantages do you anticipate in using this method?	None …….. 0 There are side effects…..…….. 1 Against religious beliefs .....…… 2 Husband's opposed .....…….... 3 Cannot limit childbearing.....…… 4 Spacing is impossible .....…… 5 Inconvenient .....…….... 6 Ineffective .....……. 7 Mothers' health is not protected .....…… 8 Inaccessibility of getting supply .....…… 9 Others, specify _____ 96 Don't know .....…… 88
C.31 What the main reasons why you are not using method a method now or do not intend to use a method in the future? **(ONLY FOR NON-USERS NOT INTENTING TO USE FP.) CODE UP TO THREE IN ORDER OF IMPORTANCE** |_____|_____| |_____|_____| |_____|_____|	Wants children ....…… 1 Lack of knowledge .....……. 2 Partner opposed .....……. 3 Costs too much .....……. 4 Side-effects .....……. 5 Health concerns .....…… 6 Hard to get supply.....…….. 7 Religious objection .....…….. .8 Opposed to family planning .....…….. 9 Fatalistic .....…… 10 Infrequent sex .....……. 11 Other people opposed….....…… 12 Difficult to get pregnant .....…… 13 Menopausal/had hysterectomy .....…… 14 Inconvenient .....…… 15 Not married .....…… 16 Husband is away/migrated for employment ... 17 Others, (Specify) _____ 96 Don't know ..…….. 88

BLOCK D
EXPERIENCE WITH FAMILY PLANNING PROGRAMS

D.1 What family planning services have you ever used? (Answers will vary by local setting, but large groupings should be maintained.)	No..... (SKIP TO D.67).....…. 0 Yes .....…. 1 **Public Sector** Government hospital .....….. 11 Government health center .....….... 12 Family planning clinic .....….. 13 Mobile clinic .....….... 14 Field worker .....….. 15 **Medical Private Sector** Private hospital/clinic .....…… 21 Pharmacy .....…… 22 Private doctor .....……. 23 Mobile clinic .....…… 24 Field worker .....…… 25 **Other Private Sector** Shop .....…… 31 Church .....…… 32 Friend /relatives .....……. 33 Hilot .....…… 34 Others, (Specify) _____ 88
D.2 Where /Which family planning service you have used more recently.?	Use Code number as above or…… |___|___| Never used family planning Services..... (SKIP TO D.6)...…….. 00
D.3 Have you experienced any problems with the family planning services you have **used most recently?** What were these problems? **CODE UP TO THREE IN ORDER OF IMPORTANCE** |_____|_____| |_____|_____| |_____|_____|	No problems .....…… 0 Dirty .....…… 1 Long waiting time .....…… 2 Far from my house .....……. 3 Rarely open/inconvenient hours ....…….. 4 Staff unfriendly/not respectful.....…..….. 5 Staff didn't seem competent.....…….. 6 Didn't offer many services .....…….. 7 Shortage of supplies .....…….. 8 Other, (Specify) _____ 96
D.5 Did you ever switch from one type of family planning service to another?	No (skip to D.7) .....……. 0 Yes 1
D.6 Why did you switch from the earlier family planning service? **CODE UP TO THREE IN ORDER OF IMPORTANCE** |_____|_____| |_____|_____| |_____|_____|	Dirty .....……. 1 Long waiting time .....……. 2 Far from my house .....……. 3 Rarely open/inconvenient hours.....…….. 4 Staff unfriendly/not respectful.....…….. 5 Staff didn't seem competent.....……. 6 Didn't offer many services .....…….. 7 Shortage of supplies.....……. 8 Others, (Specify) _____ 96

D.7 Considering both facilities and personnel, what characteristics of family planning services would consider to be the most important? (Code up to three in order of importance.) **CODE UP TO THREE IN ORDER OF IMPORTANCE** |_____|_____| |_____|_____| |_____|_____|	Clean.....…… 1 Convenient hours .....…… 2 Short waiting time .....……. 3 Close to my house.....…….. 4 Wide range of services/methods ....…… 5 Affordable .....……. 6 Not too busy/crowded .....…….. 7 Competent staff.....…….. 8 Friendly staff.....……. 9 Staff treats me with respect .....…….. 10 Other, (Specify) _____ 96
D.8 What are your suggestions for making family planning services more suited to your needs? **IF NEVER USED FP SERVICES, ASK:** Are there any changes or improvements to available services that would make it more likely that you would make it more likely that you would use them? **[PROBE IF RESPONDENT SAYS SHE DOESN'T KNOW]** **CODE UP TO THREE IN ORDER OF IMPORTANCE** |_____|_____| |_____|_____| |_____|_____|	Nothing.....…. 0 Clinic closer to my house .....…. 1 More doctors .....…. 2 More other staff .....…. 3 Longer hours at the clinic .....…. 4 More frequent visits by field workers ….. 5 More methods available (specify) _____ 6 More services available (specify) _____ 7 More information .....….. 8 More time with the counselor.....….. 9 More time with the doctor .....….. 10 Less expensive .....…. 11 Provide transportation.....…. 12 Others, (specify) _____ 96
D.9 Is it important or not important for you and for your husband/partner to have a female service provider for the following health services: **CODES:** 1 = important 2 = not important 3 = don't know	Resp. Husband Counseling .....…….. |____| |____| Breast exam .....……... |____| |____| Pelvic exam. .....……... |____| |____| Pap smear .....…… |____| |____| Injection.....…… |____| |____| IUD insertion. .....…….. |____| |____| STD diagnosis .....…….. |____| |____| Other, specify _____ |____| |____|
D.10 Would you refuse to use services if they were provided by a male provider: **CODES:** 0 = No 1 = Yes 2 = Depends	Respondent Counseling ……... |____| Breast exam ……. |____| Pelvic exam ……..…… |____| Pap smear ……..... |____| Injection …… |____| IUD insertion ……... |____| STD diagnosis ……. |____| Others, specify _____ |____|

D.11 From where have you received information on family planning methods? **DO NOT READ RESPONSES.** **CODES:** 0 = No 1 = Yes	Healthcare providers .....……. |____| Family or friends.....…… |____| Community leaders .....……. |____| Media (radio, T.V, & newspaper)…….. |____| Printed materials .....……. |____| Others, (specify) _____ |____|
D.12 With whom have you ever discussed family planning methods? **DO NOT READ RESPONSES.** **CODES:** 0 = No 1 =Yes	Current husband/partner.....…….. |____| Mother .....….. …….. |____| Other family members.....…….. |____| Friends.....……. |____| Doctor or other healthcare provider …….. |____| Others, specify _____ |____|
D.13 Are you satisfied with the amount of information you have received on the contraceptive methods you have used?	No.....…….. 0 Yes..... (SKIP TO D.15).....……1
D.14 What additional information would you like to receive to help you in your contraceptive Decision-making? **CODE UP TO THREE.** |_____|_____| |_____|_____| |_____|_____|	Menstrual cycle .....…… 1 How the method works .....…….. .2 Side effects .....…… 3 Effectiveness .....…… 4 Safety.....……. 5 How to use the method .....……. 6 Follow-up .....…….. 7 Where to get a method .....…….. 8 Others, specify _____ 96

CHECK EVENT HISTORY. EVER USED FAMILY PLANNING, CONTINUE. IF NEVER USED FAMILY PLANNING SKIP D.28

D.15 The last time you requested a family planning method, did you receive the method you wanted?	No..... (SKIP TO D.17).....…… 0 Yes .....……. 1
D.16 Were you ever refused a method that you wanted to use?	No..... (SKIP TO D.22).....…… 0 Yes .....…….. 1

D.17 Which method did you want to use that you refuse to use?	Pills..... 1 IUD..... 2 Injection (Depo-Provera)..... .3 Diaphragm……..……. 4 Foam tablets, jelly, cream, aerosol (Neosampoon) ..... 5 Condom..... 6 Tubal ligation..... 7 Vasectomy..... 8 Periodic Abstinence..... 9 Calendar..... 10 Rhythm..... 11 Withdrawal..... 12 Breastfeeding (LAM)..... 13 Basal Body Temperature(BBT). ..... 14 Mucus Method (OM)..... 15 Symptothermal..... 16 Don't know ..... 88 Others, specify _____ 96
D.18 What reason was given that you could not use this method?	Method no available ..... 1 Temporarily out of supply ..... 2 Health contraindication..... 3 Legal restriction (age, parity, etc.) ..... 4 Health worker determine another method was more suitable ..... 5 Did not have husband's consent..... 6 Others, specify _____ 96 Don't know 88
D.19 Were you able to obtain a different family planning method at that visit?	No..... (SKIP TO D.21)..... 0 Yes 1
D.20 Were you satisfied or dissatisfied with the method you did receive? Would you say you were/are very satisfied, somewhat satisfied, somewhat dissatisfied or very dissatisfied?	Very satisfied ..... 1 Somewhat satisfied ..... 2 Somewhat dissatisfied ..... 3 Very dissatisfied..... 4
D..21 How satisfied were you with the way you were treated at the clinic?	Very satisfied ..... 1 Somewhat satisfied ..... 2 Somewhat dissatisfied ..... 3 Very dissatisfied..... …. 4
D.22 Have you ever switched from using one contraceptive method to another?	Never..... .(SKIP TO D.24)..... 0 Once ..... 1 More that once 2

D23 For the most recent switch, what is the main reason you switched methods?	Side effects from previous method ....…… 1 Forgot to take previous method .....…… 2 Previous method messy.....…..……. 3 Previous method inconvenient.....…..……. 4 Wanted a longer term method. .....….. ….... 5 Partner is now responsible for FP .....……... 6 Cost issues .....…..……. 7 Husband/partner didn't like the method...……. 8 Method failed .....……. 9 Not satisfied with the provider .....……. 10 Provider persuaded me to switch .....…..…… 11 Method no longer available/supply problems.....…….. 12 Others, specify _____ 13

MEN AND FAMILY PLANNING

D.24 In your opinion, have men in your community become more involved in FP over the years in the following ways? **CODES:** 0 = No 1 = Yes	More likely to talk to wife/partner about how many children to have .....…… |____| More likely to talk to wife/partner about FP.....…… |____| More Supportive wives/partners using FP…… |____| More likely to use FP themselves.....……. |____| Husbands/partner willing to use FP.....…… |____| Self .....….....…….. |____| Others, specify _____ |____|
D.25 Do you think it is the responsibility of men to	**CODES:** 0 = No 1 = Yes Use contraceptive methods themselves if their wife/partner prefers? .....…..…… |____| Support their wives/partners use of contraception.....…… |____| Support their wives/partners use of contraception by paying for contraceptives or treatment of side effects? .....…..…… |____| Encourage their wives/partners going to the health center for checkups.....…….. |____| Support heir wives/partners going to the health center for health problems .....……... |____| Support their wives/partners going to the health center by doing household chores .....…….. |____| Avoid engaging in sexual intercourse outside of the primary relationship .....…..……... |____| Others, specify _____ |____|

D26. Do you think men in your community share these views?	Never..... 0 Rarely ..... 1 Most of the time ..... 2 Always..... 3 Almost always ..... 4 Don't know..... 88
D27. If you feel their views differ from yours, in what way do they differ?	

CHECK QUESTION D.3. IF CURRENTLY USING FAMILY PLANNING, CONTINUE.
IF NOT CURRENTLY USING FAMILY PLANNING, SKIP TO E.1

D.28 Does your current FP source provide services for men?	0= No (SKIP TO D..30) 1= Yes 8= Don't know (SKIP TO D..30)
D.29 What services do they provide for men? **CODES:** 0 = No 1 = Yes	Counseling ..... |___| Condoms ..... |___| Vasectomy ..... |___| STD Screening ..... |___| Treatment ..... |___| Others, specify ..... |___|
D.30 Have you ever seen any male clients in this health center or FP clinic?	No ..... 0 Yes 1
D.31 Are you or would you be comfortable seeing men at the FP clinic? (Judge the respondent's response whether comfortable or not: If she says "Wala ah; okey lang", she is comfortable. If she giggles, or "Nasaw-ahan or Naham-ot", she is uncomfortable.	Comfortable ..... 1 Not Comfortable 2
D.32 Is there any services/programs that your health center offers?	None..... (SKIP TO BLOCK E)..... 0 Yes 1
D.33 If yes, in what ways? In your opinion, how could the FP program or health center better involve men? **CODE UP TO THREE IN ORDER OF IMPORTANCE** |_____|_____| |_____|_____| |_____|_____|	Nothing ..... 0 Provide more services for men ..... 1 Provide more information for men ..... 2 Have special hours for men..... 3 Have more male counselors ..... 4 Promote male methods..... 5 Make men feel more comfortable in the health center..... 6 Have more radio/newspaper/TV ads for men ..... 7 Others, specify _____ 96

BLOCK E
OTHER REPRODUCTIVE HEALTH SERVICES

E.1 What comes to mind when you think of the term "reproductive health?" **(WAIT FOR SPONTANEOUS RESPONSES. THEN ASK ABOUT REMAINING ITEMS:** Do you think the following are part of the reproductive health? **CODE :** 0 = No 1 = Yes	Spont. Prompted Ability to bear children (fertility) …… |___| |___| Ability to choose the no. of children I want to have (decider) …… |___| |___| Ability to have satisfying sex life …… |___| |___| Physical, mental and social Well being.....…….…….. |___| |___| Anything else , Specify _____|___| |___|
E..2 Have you ever received any of the following services at the [health center]? If response is "no", **ASK:** Would you like to receive this service? **CODES:** 0 = No 2 = Yes	Received Like to received Pap smear .....…… |____| |____| Blood tests .....…… |____| |____| Breast exam .....…… |____| |____| Pelvic Exam .....……|____| |____| Reproductive Tract Infection/ STD exam …….....…….…….. |____| |____| Reproductive Tract Infections/ STD treatment……. |____| |____| Infertility counseling ....…….…….. |____| |____| Infertility treatment .....…….. |____| |____| Prenatal care .....……. |____| |____| Postnatal care .....…… |____| |____| Nutrition counseling .....…… |____| |____| Child health care (well or sick) ….. ……. |____| |____| Other, specify _____ |____| |____|
E. 3. Are there any other women's health services that I haven't mentioned that you would like to receive?	No (SKIP TO F.1) .....…… 0 Yes .....…… 1
E.4. What other reproductive health services would you like to receive?	
E.5 . Would you prefer to receive these services in the same location as you receive Family Planning services or at another location?	No _____ Yes_____

CHECK QUESTION C.1. IF EVER USED FAMILY PLANNING SERVICES, CONTINUE.
IF NEVER USED FAMILY PLANNING SERVICES, SKIP TO F.1

E.6 At what other location would you prefer to receive services?	With family planning services ..... (SKIP TO E.8).....……..…… 1 At another location .....…… 2
E.7 Where did you receive these services?	

E.8 Why would you prefer to receive these services in the same location as you receive FP services?	

BLOCK F
INDIVIDUAL, PSYCHOLOGICAL AND PHYSICAL FACTORS

F.1 How would you rate the following aspects of your life? Are you satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied? **CODES:** 1= Very satisfied 2= Satisfied 3= Somewhat satisfied 4= Somewhat dissatisfied 5= Very dissatisfied	Your life as a whole ..... |____| Your own health ..... |____| Your children's health ..... |____| Your leisure/recreational activities with family..... |____| Your family life as a whole ..... |____| Your relationship with your partner ..... |____| Your ambitions for your self..... |____| Your aspirations for your children ..... |____| The house you live in..... |____| The way your family is living..... |____| Your physical and social condition with your neighborhood/community ..... |____| Your job (if employed/working or business)..... |____| Your relationships with friends outside of your family..... |____| Your involvement in religious life..... |____|
F.2 Do you have any health problems which limit your normal activities, such as at your job, or taking care of your household and children.	No…..... (SKIP TO F.5)…..... 0 Yes …..... 1
F..3 What are these health problems?	
F.4 Please tell me about how you felt when you came home the first time with a contraceptive method? (**PROBE:** Did you feel relieved? Like you had more control over your life? Did you feel guilty about using FP? Were you afraid of side effects?)	

CHECK Q. C.1 IF EVER USED FAMILY PLANNING , CONTINUE. IF NEVER USED FAMILY PLANNING, SKIP TO G.1

F.5 Has using family planning made your life worse in any way?	No..... (SKIP TO G.1)..... 0 Yes 1
F.6 What problems? **(PROBE REGARDING RELATIONSHIP WITH HUSBAND OR FAMILY, EFFECT ON HEALTH, RELIGION, OTHERS)**	Changes of relationship of couples ..... 1 Changes of relationship between parents and children ..... 2 Costly ..... 3 Conscienced by religion 4

	Ashamed with people .....…….. 5 Health problems .....…….. 6 Others, specify _____ 88
F.7 Has using family planning made your life better in any way?	No..... (SKIP TO G.1).....……. 0 Yes .....…… 1
F.10 How has family planning made your life better? What are these?	Children can be taken care of .....…….…... 1 Mother's health can be protected .....…… 2 Husband/Partner can be taken care of .....……... 3 Household's chores can be taken care of ……. 4 Others, specify _____ 88

BLOCK G
FAMILY AND HOUSEHOLD ROLES PARTNER AND HOUSEHOLD COMMUNICATION

G.1 Given your present circumstances (e.g. income, employment, partner relations, et.), are you happy with the number of children you have now, would you like to have more, or do you wish you didn't have so many?	Right number..... (SKIP TO G.3).....…… 1 Wants more .....…… 2 Wants fewer.....…….. 3
G.2 Why do you wish you had **(MORE/FEWER)** children?	
G.3 How about your husband/partner, is he happy with the number of children you have now, would he like to have more, or does he wish you didn't have so many?	Right number .....…….. 1 Wants more .....…… 2 Wants fewer .....…… 3
G.4 Why do you think your husband wishes you had **(MORE/FEWER)** children?	
G.5 Has wanting different numbers of children been a source of tension between you and your husband/partner?	No..... (SKIP TO G.8).....…..…….. 0 Yes .....…….. 1
G.6 How has the tension between you and your/partner been resolved/how do you deal with it?	No .....…..…... 0 Talk with it .....…..…… 2 Ignore .....…… 3 Exchange words/quarreled .....……... 4 Asked guidance/opinion from counselor ...…… 5 Others .....……. 6
G.7 Has tension/trouble causes between you and your husband's/partner's family?	No..... (SKIP TO G.9).....…….. 0 Yes .....…….. 1
G.8 How has the tension between you and your husband's/partner's family been resolved/how do you deal with it?	No .....…..…... 0 Talk with it .....…… 2 Ignore .....…… 3

	Exchange words/quarreled .....……..… 4 Asked guidance/opinion from counselor ...…….. 5 Others .....…… 6

CHECK EVENT HISTORY. IF EVER USED FAMILY PLANNING, CONTINUE. IF NEVER USED FAMILY PLANNING SKIP TO G.35.

G.9 Now that you are using family planning, do you find it easier or more difficult to talk to your husband/partner about household matters, or is there no difference?	Easier .....……. 1 More difficult .....…….. 2 No difference .....……. 3
G.10 Do you feel that using family planning has helped you have the number of children you want?	No .....……. 0 Yes..... (SKIP TO G.14).....……... 1
G.11 If no or only partly, why not?	
G.12 Do your husband/partner know that you use family planning?	No .....……. 0 Yes..... (SKIP TO G.16).....……... 1
G.13 Why does your husband/partner **NOT** know that you use family planning?	
G.14 Have you ever asked your husband/partner how he feels about FP?	No .....……. 0 Yes..... (SKIP TO G.16).....……... 1
G.15 Has your husband/partner told you how he feels about FP?	No .....……. 0 Yes..... (SKIP TO G.16).....……... 1
G.16 How does your husband/partner feel about FP or what do you think his opinions are? **(MULTIPLE RESPONSE: PROBE FOR AS MANY AS THREE ANSWERS)** |____|____| |____|____| |____|____|	Supports FP .....……. 1 Does not support FP .....……. 2 Thinks it is good for the country.....……. 3 Thinks it is good for my health .....……. 4 Worries about my health .....……. 5 Agrees for me to use it but not him .....……. 6 Does not agree for me to use it.....…….. 7 Agrees that it is good to have few children ……... 8 Uses it himself or would consider using it …… 9 Don't know regarding FP .....…….. 88 Others, specify_____ 96
G.17 If he is not using a method himself, does your husband/partner help or hinder your use of FP, or does he have no effect?	Using method himself.....…….. 0 Helps.....…… 1 Hinders.....……. 2 Has no effect.....……. 3
G.18 Have you ever asked your husband/partner to use a family planning method himself?	No .....…..….. 0 Yes .....……. 1
G.19 Is your husband/partner used FP now?	No .....……. 0 Yes .....……. 1

G.20 Has your husband/partner ever used FP?	No ..... 0 Yes 1
G.21. If yes, What method has he used most recently? (Record/write the method/s mentioned)	Never used a method ..... 0 Condom ..... 8 Vasectomy ..... 10 Periodic Abstinence ..... 11 Withdrawal ..... 12 Others specify _____ 96
G.22 Would you like your husband/partner to use FP?	No ..... 0 Yes 1
G.23 When you decided to use FP, did you tell other household members?	No ..... 0 Yes 1
G.24 Do the following members of your family know that you use FP? Do they approve or disapprove? **READ CATEGORIES CODES:** Knows: 0 = No 1 = Yes Agrees: 1 = Agree 2 = Disagree 3 = No opinion 00 = NAP	Knows Approves Husband..... |____| |____| Mother..... |____| |____| Mother-in-law ..... |____| |____| Father..... |____| |____| Father-in-law ..... |____| |____| Children ..... |____| |____| Priest/ Pastor ..... |____| |____| Others, Specify _____ |____| |____|
G.25 Have you ever stopped using a family planning method because your husband/partner or another person wanted you to stop?	No..... (SKIP TO G.28)..... 0 Yes 1
G.26 Who made you stop using a method of FP?	Husband/partner ..... 1 Mother..... 2 Mother- in-law..... 3 Father..... 4 Father-in-law..... 5 Children..... 6 Priest/Pastor ..... 7 Male Grandparent..... 8 Female Grandparent..... 9 Brother ..... 10 Sister..... 11 Brother in law..... 12 Sister-in-law..... 13 Others, specify _____ 96
G.27 Why did that person make you stop using the method of FP?	Wanted me to have more children ..... 1 Worried about my health ..... 2 Religious opposition to FP ..... 3 Others, specify _____ 96

PARENTING

G.28 Do you think that using FP has allowed	More time 1

you to spend more time or less time, or has it made no difference to the time you spend with your children?	Less time ..... 2 No difference 3
G.29 Has FP affected your aspirations for your children?	No..... (SKIP TO G.31)..... 0 Yes 1
G.30 Why do you think your use of FP has affected or will affect your children's future?	
G.31 Would you advise a daughter to use FP?	No ..... 0 Yes..... 1
G.32 Would you advise a son to use FP?	No ..... 0 Yes..... 1

SEXUALITY AND SEXUAL BEHAVIOR

G.33 If there have been times when you and your current husband/partner didn't use FP, did you have sexual relations more often, less often, or about the same?	More often ..... 1 Less often ..... 2 About the same amount..... 3
G.34 Do you feel that using your current FP method affects your sexual relations in any other ways?	No effect ..... 1 Makes it more spontaneous ..... 2 Makes it less spontaneous..... 3 I don't worry about pregnancy ..... 4 My husband worries I am having sex outside of marriage ..... 5 I enjoy sex more ..... 6 I enjoy sex less ..... 7 I am less interested in having sex..... 8 I am more interested in having sex 9

QUESTIONS FOR NEVER-USERS OF FAMILY PLANNING

G.35 In your own knowledge, do the following people approve family planning **CODES:** 1 = Approve 2 = Disapprove 3 = No opinion 8 = Don't know	Husband/ partner..... |____| Mother..... |____| Mother-in-law ..... |____| Father..... |____| Father-in-law ..... |____| Children ..... |____| Priest/Pastor..... |____| Grandmother..... |____| Grandfather..... |____| Brother ..... |____| Sister..... |____|
G.36 How do you think your partner/other close relatives would react if you began using FP.	

BLOCK H
COMMUNITY AND SOCIETY ROLES

EMPLOYMENT STATUS

CHECK EVENT HISTORY. IF CURRENTLY EMPLOYED FOR PAY, CONTINUE WITH QUESTIONNAIRE.
IF NOT EMPLOYED, SKIP TO H 8.

H.1 Is your current paid work at home or outside the home?	At home ……..... 1 Outside the home ……..... 2
H.2 What type of work?	Employed (working for others).....… 1 Self-employed.....….... 2
H.3 How satisfied are you with your employment situation	Very satisfied.....….. 1 Somewhat satisfied.....….. 2 somewhat dissatisfied.....….... 3 Very dissatisfied.....….... 4
H.4. How are you paid?	Wage, non-contractual/permanent ……..... 1 Wage, contractual .....…….... 2 In probation period…..... 3 By the piece ...……..... 4 Commission ...…..... 5 in kind ……... 6 For self-profit (self-employed) .....…… 7 Unpaid worker .....…… 8 Wage, irregular.....……. 9 Dk .....… 88 NA .....…… 99 Others, specify _____ 96
H.5Do you supervise other workers? If yes, how many?	No. of people wholly or partially supervise. |____|____| Enter "00" if supervises no one
H.6 What do you normally do with the money you earn? **PROBE: IF ANSWWER IS SPENDING, ASK WHERE THE MONEY IS SPENT**	

H.7 Do you have any of the following benefits through your employment? **CODES:** 0 = No 1 = yes	Sick leave ..... Vacation ..... Maternity leave ..... Retirement/pension ..... Health insurance ..... Life insurance..... Disability insurance ..... Childcare ..... Educational benefits ..... Bonuses, specify _____ Allowances ..... Housing ..... Food ..... Hazard pay ..... Loan benefits ..... Others, specify _____	|___| |___| |___| |___| |___| |___| |___| |___| |___| |___| |___| |___| |___| |___| |___|
H.8..Do you know of any loan sources in your community?	No ....(SKIP TO H.10)..... Yes	0 1
H.9 What /who are these loan sources?	Banks..... Private lenders..... Lending corporation..... Others, specify _____ DK.....	1 2 3 88 99
H.10 Have you ever participated in any loan programs?	No (SKIP TO H,15)……..... Yes	0 1
H.11 What type of loan is this? Coding as per investigator		
H12 For what did you use the loan amount?	Spend the money for self..... Spend the money for husband..... Spend the money for children..... spend the money for household needs..... Others, specify.....	1 2 3 4 88
H.13 Is this loan source for women only?	No ..... Yes	0 1
H.14Is the husband's approval a requirement for the loan?	No ..... Yes	0 1

PARTICIPATION IN COMMUNITY ACTIVITIES

H.15 Do you think it is good for women to participate in community activities?	No ..... Yes	0 1

H.16 Why?	
H.17 Do you participate in any community activities?	NO..... (SKIP TO H.19) .....……... 0 Yes 1
H.18 What kinds of activities do you participate in? **CODE UP TO THREE.** |____|____| |____|____| |____|____|	Mother's club .....….. 1 Women's group.....…. 2 Church activities.....…. 3 Community development .....…. 4 HIV/AIDS prevention .....… 5 Other health-related activity.....…… 6 Local cooperative programs .....….. 7 Others, specify _____ 96
H 19. do you ever go to the bazaar/market/department store alone?	Never.... .....…. 0 sometimes .....….. 1 Always.....….. 2 Depends .....….. 3

COMMUNITY STATUS

H 20 Among the women in your community, who do you think is the most admirable How is this woman different from other women?	
H.21 What are the traits of a woman you find pitiful?	
H.22How do people perceive women who use family planning ? Do they perceive them to have high status or low status, or does family planning have no effect on status?	High Status.....….....…. 1 Low status…..... 2 Depends …..... 3 No effect on status.… …(SKIP TO H.24)..... 4
H.23 Why do you think women who use family planning have high/low status in the community?	

SECURITY IN OLD AGE

H.24 What do you think a person needs to feel secure in their old age? **CODE UP TO THREE.** |____|____| |____|____| |____|____|	Sufficient money ..... 1 A husband/ partner..... 2 At least one child..... 3 Many children..... 4 At k least one son..... 5 Many sons..... 6 At least one daughter ..... 7 Many daughters..... 8 A place to live..... 9 Good health..... 10 Others, specify _____ 96
H.25 When you are old, what do you expect to be your major source or sources of financial support? **CODE UP TO THREE.** |____|____| |____|____| |____|____|	Son(s)..... 1 Daughter(s)..... 2 Other relatives..... 3 Savings..... 4 Land ..... 5 Rent/Dividend/Interest..... 6 Pension ..... 7 Own earnings ..... 8 Government aid..... 9 Others specify _____ 96
H.26 Do you think women who use family planning and have limited their number of children will have more security or less security in old age?	More security..... 1 Less security..... 2 Number of children is less important than other factors..... 3 Don't know 99
H.27 Why do you think women who use FP will have (more/less) security?	

EFFECTS OF FAMILY PLANNING ON LIFE

CHECK EVENT HISTORY. IF EVER USED FAMILY PLANNING,CONTINUE
IF NEVER USED FAMILY PLANNING, SKIP TO H. 32

H.28 Do you think that using FP has/will allow you to **(ASK EACH QUESTION)** **CODES:** 0 = No 1 = Yes	Obtain more education?.....…….. |_____| Obtain more job training?….....…….|_____| Spend more time at your work..…….....……..|_____| Be more efficient in your work?.....…….……..|_____| Advance in your position at work……..|_____| Earn more income.....……..|_____| Be more satisfied in your work.....……..…|_____| Have more leisure time? .....……..|_____| Participate in loan program in your community.....….....……..|_____| Participate in community activities?……..|_____| Take a leadership role in community activity.....….……..|_____| Be more satisfied with these community activities? .....……...…|_____|
H.29Do you think your life would be different now if you had not used FP?	No..... (SKIP TO H.31).....…...……...0 Yes.....….…….1
H.30 Please tell me how you think your life would be different if you had not used FP?	

QUESTIONS FOR NON-USERS OF FAMILY PLANNING

H.31 Do you think your life would be different now if you had used FP?	No.....…. 0 Yes .....…. 1
H.32 Please tell me how you think your life would be different if you had used FP.?	
H.33Do you have anything else to add on the effect, either positive or negative, that your childbearing experience has had on your life?	
H.34. Have you ever attended	

BLOCK I
HOUSEHOLD DECISION-MAKING

I.1 Who you think is the best (ideal) person to make the decision: Husband.....….....….1 Wife.....….…..….....2 Both.....….….....3 Mother.....……4 Father.....…….5 Mother -in-law.....……6 Father-in-law….....……7 Others, specify _____ 96	Planning meals.....…… |_____| Buying food..... |_____| Buying household goods & furnishings... |_____| Buying clothes for children.....…. |_____| Sending children to school.....… |_____| Taking children to a clinic.....….. |_____| Going to the clinic for your own illness... |_____| Going to clinic for husband's/ partner's Illness.....…… |_____| Buying medicines for children.....….. |_____| Buying medicine for you.....….. |_____| Buying medicine for husband/partner.....…..... |_____| Whether you can work outside the home. |_____| Whether you can travel outside(the neighborhood/town)…….….... |_____| Using family planning.....…..... |_____| Choosing Husband/wife for son or daughter.....…..... |_____| Others (please specify)…….. |_____|
I..2 Who actually makes the decision in your household? Husband .....1 Wife .....2 Both .....…3 Mother .....4 Father .....5 Mother -in-law 6 Father-in-law ……6 Others, specify _____7	Planning meals.....….... |_____| Buying food..... |_____| Buying household goods & furnishings .. |_____| Buying clothes for children..... |_____| Sending children to school..... |_____| Taking children to a clinic..... |_____| Going to the clinic for your own illness.. |_____| Going to clinic for husband's/ partner's Illness ..... |_____| Buying medicines for children...,,..... |_____| Buying medicine for you..... |_____| Buying medicine for husband/partner..... |_____| Whether you can work outside the home..... |_____| Whether you can travel outside (the neighborhood/town)…..... |_____| Using family planning..... |_____| Choosing Husband/wife for son or daughter..... |_____| Others (please specify) _____ |_____|

IF ANSWER TO Q .I.1 IS OTHER THAN HERSELF OR JOINTLY BETWEEN HUSBAND AND WIFE, ASK:

I..3 are you able to make this decision? I can make the decision …… 1 I cannot make the decision ……2 Don't Know …….. 88	Planning meals..... |_____| Buying food..... |_____| Buying household goods and furnishings |_____| Buying clothes for children..... |_____| Sending children to school.....… |_____| Taking children to a clinic...…..... |_____| Going to the clinic for your own illness... |_____| Going to clinic for husband's/ partner's illness.....…… |_____| Buying medicines for children....…..... |_____| Buying medicine for you.....…..... |_____| Buying medicine for husband/partner….. |_____| Whether can work outside the home..…. |_____| Whether you can travel outside (the neighborhood/town)..... |_____| Using family planning..... |_____| Choosing Husband/wife for son or daughter..... |_____| Others (please specify) …… |_____|

IF ANSWER IS " I CANNOT MAKE THIS DECISION" NO TO ANY OF THE TASKS IN Q.9.3, ASK Q.9.4

CODES:

Nothing……..…….	1
My decision will not prevail.....…….	2
My husband will disagree..….....…….…….	3
Other members of my family will get angry.....……..	4
I cannot make that decision.....……..	5

I. 4 What prevents a woman like you from making this decision.? What could happen if you tried to make this decision?

Planning meals.....……...	|_____|
Buying food.....…….....	|_____|
Buying household goods and furnishings.....…….....	|_____|
Buying clothes for children.....…….....	|_____|
Sending children to school.....…….....	|_____|
Taking children to a clinic.....……...…...	|_____|
Going to the clinic for your own illness.....…….....	|_____|
Going to clinic for husband's/ partner's illness.....…….....	|_____|
Buying medicines for children.....…….....	|_____|
Buying medicine for u.....…….....	|_____|
Buying medicine for husband/partner.....…….....	|_____|
Whether you can work outside the home.....…….....	|_____|
whether you can travel outside(the neighborhood/town) .....…….....	|_____|
Using family planning.....…….....	|_____|
Choosing Husband/wife for son or daughter.....…….....	|_____|
Others (please specify) .....…….....	|_____|

BLOCK J
DOMESTIC VIOLENCE AND SEXUAL HARASSMENT

J.1 Now I want to talk with you about something that can be difficult to discuss. Sometimes during difficult times tensions develop within your relationship and you may have misunderstandings and arguments. Sometimes these quarrels can be very painful..	No..... (SKIP TO J.5).....……	0
	Yes.....….	1
	If YES:?	
	Physical.....…….	1
	Emotional /Psychological.....……...	2
	Both physical and emotional/psychological....…….....	3
Has any member of the household ever beat, hit or give you pain? **(IF YES: :PROBE FOR ANY KIND OF DOMESTIC VIOLENCE PHYSICAL, EMOTIONAL AND OR PSYCHOLOGICAL**		

J.2 **EACH TYPE OF VIOLENCE ASK: DID THIS HAPPEN FAIRLY , REGULARLY OR RARELY?**	Regularly (four or more times)…….....….....	3
	Rarely (2 to 3 times).....……....	2
	Once.....……....	1
	Not happening.....……..	0
J. 3 If yes, Who did this to you? **(MULTIPLE RESPONSE) PROBE MORE THAN JUST ONE MEMBER OF THE FAMILY** Husband.....……1 Father.....……...2 Other male relative.(specify)_____3 Male friend.....……..4 Mother.....……. 5 Other female relative (specify)_____ 6 Female friend.....7 Others specify_____ 96	Type Doer Physical Emotional/Psychological Others	
J.4 Did this happen while you were pregnant?	No.....…….	0
	Yes.....……	1
J.5 Have you ever been physically forced to have sex with your husband?	No..... ....(SKIP TO J.10).....…….	0
	Yes.....……	1
J.6 Have you ever been physically forced to have sex with someone else?	No..... ...(SKIP TO J.10).....…….	0
	Yes.....…….	1
J.7 Did you ever tell anyone about any of this in an attempt to get help? If yes, Who? **CIRCLE ALL THAT APPLY**	No.....…….	0
	Friend.....……	1
	Mother.....……	2
	sister .....…….	3
	Husband.....……	4
	Other relative (specify) _____	5
	Brgy. captain.....…….	6
	Policeman.....…….	7
	Priest/Pastor.....…….	8
	Hilot.....……..	9
	Doctor.....……..	10
	Others, specify _____	96
J.8 Was that person able to help you	No..... ...(SKIP TO J.10).....…….	0
	Yes.....…….	1
J.9 What type of help?	Counseling.....…….	1
	Medical Assistance.....	2
	Legal Assistance....……....	3
	Board/Lodging.....……....	4
	Others, specify _____	96
J.10 are you afraid to disagree with your husband because he will be angry with you?	No.....……...	0
	yes.....……	1

J.11 Why?	
J.12 How often did this happen to you?	No.....…… 0 Yes, frequently.....…… 1 Yes, not often..... 2 Yes, varies.....…….. 3
J.13. How do you usually resolve your disagreement?	Couple compromise.....……..... 1 Husband got his way.....……..... 2 Wife got his way.....……... 3 Husband just go away.....……... 4 Wife just go away.....……. 5 Others, specify_____ 96

Thank you for participating in this study and for taking time to answer the questions

14 Interview ended at :	Hour : |____|____| Minute : |____|____|

END OF INTERVIEW

APPENDIX B
FGD GUIDE QUESTIONS
(PRESURVEY AND POSTSURVEY FGDS)

FAMILY PLANNING: ITS ECONOMIC AND PSYCHOSOCIAL INFLUENCE ON THE LIVES OF MARRIED WOMEN OF REPRODUCTIVE AGE (MWRA) IN WESTERN VISAYAS, PHILIPPINE

FOCUS GROUP DISCUSSION (FGD) GUIDE

I. BACKGROUND AND GENERAL INSTRUCTIONS FOR FGD FACILITATORS

A. Objective of FGD

1. To generate perceptions and views of members of women's groups/NGOs, MWRAs, husbands of MWRAs and other community folks regarding the effect of FP practice or non-practice on the lives of women they know.

2. To generate insights on the influence of FP on the lives of different groups of women; rural and urban, more educated and less educated, employed and unemployed, etc.

B. Number of FGDs and FGD Participants

1. A total of 27 FGDs will be conducted, three in each sample municipality in the three sample provinces. The three FGD groups will consist of:

2. Women who are members of women's groups or NGO/POs in the locality who are involved in women's concerns.

3. Selected husbands of FP users/non-users

4. MWRAs who are either FP user or non-user who are not part of the survey sample and some community residents who know a MWRA using FP.

5 to 8 individuals who will be invited in advance will participate each FGD in. The FGDs will be conducted in a central place accessible to participants. The atmosphere must be conducive to group interaction.

C. Organizing FGDs

1. In coordination with the RHU or barangay officials, identify 5 to 8 individuals for each group.
2. Find and arrange for a possible venue where group interaction can be conducted with minimum disturbance.

3. Set the date of the FGD.

4. Invite identified participants to attend the FGD either personally or in writing. Explain to them the purpose of the FGD and why their presence is important.

5. On the scheduled day of the FGD, arrive in the place earlier than the participants.

6. Welcome them as they arrive, and interact with them informally as you wait for the others to come.

7. When at least 5 participants have arrived, let them sit in such a way that they can see each other and interact freely with each other.

8. Write the topics to be discussed in a wide paper or on a board, if one is available.

9. Make sure that you have conferred with your documentor about the FGD process and how documentation will be done (tape recorder and note taking).

10. Make sure the tape recorder is working

D. <u>FGD Preparation</u>

1. Welcome participants and thank them for coming.

2. Introduce yourself and your documentor to the group. Explain the purpose of the FGD and the FGD Process. If participants do not know each other, you may provide name tags.

3. Let the participants introduce themselves by giving their names and sharing a little about themselves (age, work, number of children, etc).

4. Encourage everyone to be open and to freely share their ideas regarding the topic/s being discussed.

E. <u>FGD Proper</u>

1. Facilitators should serve as moderator and therefore , must guide the flow of discussion, rather than provide the needed information or monopolize discussion. Do not offer your advice, views or opinions regarding the subject or topic being discussed, as these might influence the views of participants.

2. Keep discussion free flowing and spontaneous.

3. Probe if answers are short or vague. Ask the participants to further explain what they mean. You may say, "What do you mean?" Why do you think so? "Are there some more?" "Do you still have something more to say?"

4. Encourage participants to react to others' opinions. You may motivate them by saying: "What do you think of her opinion/comments?" "Do you agree with what she said?" "What do you think?"

5. Show in your face that you are interested in what a participant is saying. You may nod if you think she wants affirmation. Do not contradict a participant. Do not argue with her even if her idea is against yours. You are there to facilitate not to give your own opinion.

6. Write on the board or on a wide paper that you want the group to focus on during the discussion.

7. At the end of the discussion, recap the major issues and points discussed. If you want to verify some points previously said, do it before the group disperses.

8. Thank the participants.

II. FGD GUIDE QUESTIONS: PRESURVEY FGDS

A. <u>Women's Views Re: Quality of Life in General</u>

1. What is "good quality of life" or "poor quality of life?"
2. What should a person possess, or achieve in order for them to have "good quality of life".
3. At present, how do you assess your quality of life? What make/s this so? Are you satisfied with your life at present? Why?
4. Do you want your life to improve? What do you need to improve their present condition?
5. What specific aspects of your life do you want improved? How do you think you can achieve this?

B. <u>Specific Aspects of Women's Quality of Life</u>

1. What are the things you want to do but which you cannot do? Why can you not do them? How do you feel when you cannot do it/them?

2. If there is any person that you can be like, who is this person, and why do you want to be like him/her?

3. What are the things/events that can/will make you happy? contented? Why do these make you happy? contented?

4. Do you want to be in control of things around you or things that affect you or your family? Why? If no, who do you think should have control over these? What do you need or should have in order to have control over things?

5. Do you sometimes feel insecure, uncomfortable with other people, or with what you did or what you are doing? What makes you feel insecure or uncomfortable? Why do they make you insecure/uncomfortable?

6. Which of these things are important to you or to your family? How important are they and why?
   a) Money
   b) Children and their welfare
   c) Education (of mother, father, children, etc.)
   d) Health and Physical life of mother, father, children. What is good health of good physical life?
   e) Work (What work does she want to do or not to do?)
   f) Relationship with husband, children and others (What kind of relationship would she with husband, with children?)

B. <u>Aspirations in Life</u>

1. What are the things in life you want to attain or was attained?
   Like:
   a) physical
   b) relationship with husband, children and other members of the family
   c) relationship with other people (not related to you)
   d) economic status
2. After having done work at home, what do you do?
3. If there is a chance, do you want to go back to school?
4. Look up as a role model.
5. Leisure activities if permitted or if given the chance to do so.
6. Talents fully developed?

III. FGD GUIDE QUESTIONS: POSTSURVEY FGDS

A. <u>The Participants' Understanding Of Family Planning (FP)</u>

1. Main purpose/s of FP.
2. Methods of FP

B. <u>Participants' View/Attitudes Towards Family Planning</u>

1. On whether or not eligible couple should practice FP and why.
2. On the benefits of FP
3. On the disadvantages of FP

C. Participants' Perception Regarding Effects of Family Planning on Women's Lives

1. On Women's Work and Income:

a. On their decision to work or not to work
b. On their choice of activity or work to do or place to work in
c. On their capacity to earn money
d. On how and where to spend their money, if they have any.
e. On whether non-use of FP limited woman's opportunities to work and earn money and to buy the things she want for herself or for her children

2. On Women's Professional, Educational Or Social Advancement

a. On whether FP has allowed them to study or to attend additional training
b. On whether FP has allowed them to practice their profession
c. On whether FP has allowed them to participate in community organizations and activities
d. On whether non-use of FP prevented women to advance professionally or to participate in community activities and why

3. On Women's Relationship with Husband and Family

a. On whether FP affected the amount and quality of time spent by MWRA with husband, children and other family members.
b. On nature of communication with husband and children
c. On quality of sexual relation with husband.
d. On wife's participation in Decision-making regarding FP and sexual activities.

4. On Woman's Physical and Health Care, Self-esteem and Decision-making Participation

a. On time spent by women on personal (physical) and health care
b. On health status and physical appearance
c. On self-esteem or self-worth
d. On Decision-making participation

D. On Role of Men and Women in Family Planning and Decision-making Participation

1. On men as FP targets, especially on the use of male-oriented FP interventions
2. On men as FP motivators: communicators and counselors to friends, co-workers, family members
3. On the role of men and women in household and FP Decision-making : Who decides what?

E. On Domestic Violence and Sexual Harassment: Observations and Experiences

1. Experience with Domestic Violence (victims, perpetrators)
2. Perceived causes of domestic violence (men's and women's views)
3. Assistance sought, received and needed
4. Assessment of services available
5. Relationship between family planning and domestic violence

THE END