MASTERARBEIT / MASTER'S THESIS

Titel der Masterarbeit / Title of the Master's Thesis

Reproductive Health in the Philippines

In Between Biopolitics and Religion

verfasst von / submitted by

Leonie Melissa Wick, BA

angestrebter akademischer Grad / in partial fulfilment of the requirements for the degree of

Master of Arts (MA)

Wien, 2023 / Vienna 2023

Studienkennzahl lt. Studienblatt / degree programme code as it appears on the student record sheet:	UA 066 656
Studienrichtung lt. Studienblatt / degree programme as it appears on the student record sheet:	Masterstudium CREOLE – Cultural Differences and Transnational Processes
Betreut von / Supervisor:	Univ.-Prof. Mag. Dr. Janina Meillan-Kehr

Table of Contents

1. Introduction **1**

1.1 From a Significant Piece of Art to a Unique Perspective on Motherhood 1

1.2 Foucault's Biopolitics 6

1.3 Structure of the Thesis 8

2. State of Research **9**

2.1 Anthropology of Gender 10

2.2 Anthropology of Reproduction 12

2.3 The "Right Population" 16

2.4 Summary 18

3. Methodology **21**

3.1 Access to the Field 21

3.2 The Sample – From Local Health Centers to Individuals 22

3.3 Research Methods 24

3.3.1 Participant Observation 26

3.3.2 Qualitative Interview 27

3.4 Data Evaluation Method 29

3.5 Feminist Research Approach 31

3.6 Limitations of the Research 33

3.7 Ethics and Reflection of the Research 34

3.8 Summary 36

4. In Between Religion, Culture, and Contraception **37**

4.1 "Sangpit sa Señor" 38

4.2 An Approach to Filipino Culture 39

4.3 From the Spanish Rule to the 1987 Constitution 42

4.4 Church – State Relations in the Philippines 43

4.5 Hints of a Catholic Culture 47

4.6 "They Will Give You Looks" 49

4.7 "Family Planning is for Families" 55

4.8 "The Child is a Secret" 58

4.9 The Husband and his Approval 63

4.10 Summary 66

5. In Between State Policies and Local Health Centers **68**
5.1 The Reproductive Health Law 69
5.1.1 Arguments for the Reproductive Health Law 72
5.1.2 Arguments Against the Reproductive Health Law 74
5.2 Reproductive Health Trends in the Philippines 76
5.3 Reproductive Health Services – Implementation and Recommendations 78
5.4 The Health Centers 79
5.5 Access to Free Contraception 82
5.6 Contraceptive Options and Requirements of Access 84
5.7 “Zero Unmet Need” 88
5.8 Reasons for the Discontinuation of Contraceptives 90
5.9 “Disadvantages of Sex Before Marriage” 92
5.10 Summary 99
6. Conclusion **100**
7. Limitations and Outlook **106**
8. Bibliography **107**

Appendix **115**
Table of Figures 115
Data Overview 116
Abstract 118

1. Introduction

1.1 From a Significant Piece of Art to a Unique Perspective on Motherhood

On a hot afternoon in Iloilo, the capital of the Iloilo region in Western Visayas, a group of fellow students and I made plans to visit the Museum of Contemporary Art with some students from University of Iloilo whom we had met during our research stay. We convened at the University of Iloilo and took a jeepney together to the museum. Jeepneys are old American jeeps converted into minibuses for public transport in the Philippines. After a bumpy and adventurous ride that had cost only a few cents, we arrived at the Museum of Contemporary Art in Iloilo, a large, beautiful, and magnificent building. Upon entering, we were greeted by a pleasantly chilly and well-maintained environment. After purchasing our tickets, we began our exploration of the museum. The students from Iloilo University informed us that this was one of their favorite places in the city, as it was so peaceful and filled with amazing art that they loved to discover. The museum had three floors to explore. As we wandered through the museum, the students shared a wealth of information about the different pieces of art. Camilla, one of the students, informed me that she visited the museum several times each month and had thus developed a substantial knowledge about the exhibited art. I was impressed by the students' expertise and thoroughly enjoyed the guided tour (Participant Observation 3, Pos. 14-15).

While admiring a painting, I stood next to Camilla, who offered to explain its significance to me. The piece was very interesting because it featured a fly's body with a human mouth instead of a fly's head, and crab claws for hands (Figure 1). Camilla revealed that this artwork was meant to represent the "Filipino Gossip Society", illustrating how gossip is a major issue in the Philippines and how often it causes people to harm one another frequently. The body of the fly shows the ability to "fly around" and thus spread the rumors everywhere through the gossip that comes out of the captured human mouth. The people being gossiped about are then hurt by the crab's claws.

In her description, she pointed out the widespread tendency of people to gossip and judge, especially when individuals deviate from the cultural norms and values that are strongly influenced by the Catholic Church in the Philippines. From her explanations

of the artwork, it was clear to me that she felt a strong sense of frustration over this social attitude. She also expressed how saddened she was by the way some Filipinos behave (Participant Observation 3, Pos. 15).
Although I had already chosen my research topic in advance, this situation with Camilla gave me an aha-experience. After that moment and during my research, my own observations and interviews confirmed a certain relevance of gossip and therefore her words stayed with me during my research and I was able to relate the information I had gathered during my research to this situation.

Figure 1: Piece of art in the museum of contemporary art in Iloilo
Source: Own representation

Change of scene. It was a warm and sunny afternoon on Malapascua, a small island situated northeast of Cebu Island. My friend and I took a stroll towards the north end of the island and enjoyed the stunning scenery. However, I couldn't help but notice the absence of any health center or medical facility on the island. We came across many unsupervised children during our walk, and it took us around 25 minutes to cover the length of the small island from south to north. We observed a significant contrast in housing conditions, ranging from wealthy residences to devastated huts destroyed by a recent typhoon. When we asked the locals about medical care on the island, they shook their heads in denial.

Eventually, we stumbled upon a beautiful place called “Neverland”, which was both a hostel and a restaurant. We met the owner, an Israeli who had built the place a few years ago. When he asked us what we were doing in the Philippines, I explained my research on reproductive health and contraception to him. He found the topic fascinating as well as very important and shared some insights into the situation on the island. He mentioned that many young girls on the island get pregnant, and some come to him for help and a place to stay because they are afraid to go home. When I asked him about medical care on the island, he informed me that there is no medical care available on Malapascua. The only medical care is situated 30 minutes away by boat on the mainland in a town called Maya.
The owner went on to explain that some pregnant young girls with money travel to the mainland to get an illegal abortion, but others who can't afford it have to “live with it”. In these cases, the babies are born in the houses without any medical assistance, relying solely on family help. Also, there is no medical care available for pregnant women or babies on the island.
We also had a detailed conversation about life on the island, during which he informed me about the significant issue of waste disposal. The island lacked proper means of waste disposal, as it had to be transported to the mainland, which was unaffordable for the residents. He shared his initiative to educate children about proper waste management and he invited us to be part of a beach clean-up with the children the following day. When we arrived at the beach the next day, we were welcomed by a large number of children who were already familiar of the process of collecting and disposing of trash in the designated bags. However, they gradually became distracted and playful, running around and laughing. Two girls approached my friend and me, and they asked us to hold their hands. They were very calm and held on tightly to us and began to call us “mummy”. At one point, the girl who was holding my hand pointed at my belly and asked if there was a baby inside. I replied that there was no baby in there, and she responded with relief, and said, "That is so good! Baby later”. This moment stuck with me, and I wondered how such thoughts came to her mind. It broke my heart to leave the children as they did not want us to go. This experience left a lasting impression on me, especially the encounter with two young girls who referred to us as "mummy". In particular the curious question of the one girl as to whether I had a baby in my belly, and her reaction to my answer, stayed with me. This led me to question the whereabouts of their parents, or if they even had any who cared for them and

reminded me of the information shared by the Israeli about the prevalence of early pregnancies (Participant Observation 17, Pos. 62-75) (Figure 2, 3).

Figure 2: A girl and me at Malapascua Beach
Source: Own representation

Figure 3: Children, my friend and me at Malapascua Beach
Source: Own representation

Although I was initially unaware of their significance, these two situations left a lasting impression on both my field research and myself. Among other findings, they provide valuable insights into two central themes of my Master's thesis.

The two scenarios represent different facets of human cultures and societies. Discussions and gossip about others are also common in my everyday life in Austria, while early pregnancies are not uncommon in my work environment at a gynecologist. In this thesis, however, the focus is on exploring Filipino culture and society.

The first scene reflects that talking about each other or "gossiping" is an important part of the Filipino society, as described by Camilla.

Besnier (1996), Brenneis (1989) and Haviland (1977) described this phenomenon as: "What a third party calls 'gossip' is "information exchange" for those who engage in it. A general working definition identifies it as the negatively evaluative and morally laden verbal exchange concerning the conduct of absent third parties, involving a bounded group of persons in a private setting." (Besnier 1996; Brenneis 1989; Haviland 1977, as cited in Besnier 2009, 12f.)

While the second scene offers an insight into a tendency to high population growth and early pregnancy in the Philippines.

Over the past decade to 2016, national demographic and health surveys in the Philippines have shown a steady increase of nearly 10 percent in pregnancy rates among women ages 15 to 19 (Herrin 2016, 1). The Updated Philippine Development Plan 2017-2022 is describing the population growth to increase. Despite a declining overall growth rate, the country's population will remain high due to its large population base (Updated Philippine Development Plan 2017-2022, 38). According to the World Bank (2023) the population of the Philippines increased in 2020 by 1.6 percent.

Both scenes open up two crucial aspects around the central question of this Master's thesis: *To what extent are women in the Philippines influenced in their reproductive behavior by health policies, local health centers and the Catholic Church?*

On the one hand Camilla's vivid description of the picture regarding the significance of talking about each other within Filipino society, makes it easy to imagine difficulties in accessing anonymous healthcare services. This issue becomes particular pronounced when certain actions go against the norms and beliefs upheld by the Catholic Church, as Camilla explains.

On the other hand, there is the encounter with the little Filipina who was concerned that I was carrying a baby. Her relief when I told her I wasn't sparks thoughts about problems of high youth pregnancies and overpopulation in the Philippines.

These two situations indicate the interplay between church and state and their influence on Philippine society and its reproductive behavior.

According to Ozaki et al. (2017), President Duterte has emphasized the importance of population control through modern family planning methods as part of his poverty reduction efforts. However, they also note that inadequate sexual health education and conservative sociocultural norms are significant barriers, as contraceptive methods are largely disregarded by the majority of the population. These challenges are exacerbated by the Philippines' predominantly Catholic population, where about 80 percent of people follow the teachings of the church (Ozaki et al. 2017, 683).

The situation described by Ozaki et al., which also matches with the encountered experiences, indicates some external control over the Filipino people: control by the church, enforced through faith, and control by the state enforced through laws, interventions, and local health centers, in addition to the control of Filipinos over each

other, which is exercised through talking about one another and the potential to spread rumors.
In this context, the concept of biopolitics, as theorized by Michel Foucault, provides a useful framework for understanding this external control, which will be discussed in more detail in the next section.

1.2 Foucault's Biopolitics

While I was researching on the mechanisms of control and reproductive control, I came across Foucault and the concept of biopolitics, which he defined in his work "*The Will to Know*"[1]. In this work, he describes a change in the exercise of power that began in the 17th century. Two interrelated poles developed. On the one side, the disciplining and optimization of the individual body and its powers and its integration into systems of economic control; on the other side, the regulation of the population, which Foucault calls the "social body". The focus is on the reproduction, health status, life expectancy and birth and death rates of population groups (Foucault 1978, 139).
Accordingly, both a biopolitics of population and anatomical politics of the human body were introduced. In what Foucault calls the "age of biopower", the management, organization and control of the body and life replaced the earlier exercise of power through physical violence and death, for example in the case of slaves. The control and submission of bodies and populations takes place through the emergence of various power structures. Examples include the political and economic focus on the health of populations, new institutions such as secondary schools and universities, and new surveillance technologies such as statistical surveys of populations, their living conditions, and their health (Foucault 1978, 140). One consequence of biopower, as defined by Foucault in his work "The Will to Know", is the growing importance of the norm, created by the legal system, which regulates the population not through physical sanctions but through the creation of norms, evaluations, and hierarchies (Foucault 1978, 144). Furthermore, Foucault introduces the concept of governmentality alongside the concept of biopower. He assumes that the aim of governments is to

[1] Foucault, Michel. *Sexualität Und Wahrheit : 1 : Der Wille Zum Wissen*. Frankfurt Am Main: Suhrkamp, 1988.

dispose of people and things, and thus to regulate all forms of life, bodies, and resources, and ultimately, through discipline, to create people whose bodies are compliant and useful. To achieve this goal, the modern state works to increase people's performance and vitality and thus their productivity (Foucault 2006, 168). According to Foucault, biopower is an indispensable instrument for the emergence of capitalism. Capitalism was only possible because the bodies of biopower were inserted into the contexts of production and the population was adapted to the economic processes (Foucault 1978, 141). The biopower of the state and capitalism leads to the appropriation of life by political power and regulates all collective life (Foucault 2006, 110). The techniques of exercising power thereby function as factors of division and the formation of social hierarchies (Foucault, 1978, 141).

The control described by Foucault, resulting from biopolitics, biopower and governmentality, can also exist in the Philippines. Control may be exercised through the values and norms of the Catholic Church in the Philippines, which may influence the reproductive behavior of Filipinos. In addition, the state may also seek to improve the country's economy through the control of reproduction, which can be implemented through laws and through local health centers.

In order to examine whether this is the case in the Philippines, I have created a research question and five sub-questions to give structure and focus to my research and this Master’s thesis. The questions are as follows:

Research question:

To what extent are women in the Philippines influenced in their reproductive behavior by health policies, local health centers and the Catholic Church?

Associated sub-research questions:

- Which cultural factors, that can be connected to the Catholic believes, influence the provision of free contraceptive services within the local health centers in the Philippines?
- To what extent does the Philippine government's biopolitics operate in local health centers, and how does it affect health service delivery and access to reproductive health resources?

- What challenges do health workers face in effectively distributing reproductive health services, and how do these challenges affect access to such services in the Philippines?
- How does sex education affect Filipinos' reproductive health knowledge and related behaviors?

The following section briefly describes the structure of this master thesis.

1.3 Structure of the Thesis

This Master's thesis consists of six chapters. In the first chapter the topic is introduced and the research question is defined. Chapter 2 examines the state of research and provides the broader theoretical context for the thesis, which bridges the fields of gender anthropology and the anthropology of reproduction. The subchapter "The Right Population" provides additional insights and examples of how populations can be formed.

Chapter 3 focuses on the methodology, describing access to the field, the sample and all the research methods used. The subchapter "Data Evaluation Method" explains how the data was analyzed using Mayring's content analysis and the program MAXQDA, and evaluates the feminist research approach. The chapter also discusses the limitations and ethics of the research as well as my own critical reflection.

Chapter 4 is the first of two empirical chapters. Based on the data collected, it analyzes the interrelationship of religion, culture, and contraception in the Philippines. It examines elements of Filipino culture, the Catholic Church's stance on contraception, the historical context of Spanish rule and the 1987 Constitution, and empirical data on the influence of the Catholic faith on access to contraception and family planning services.

The second empirical chapter examines the links between government policies and health centers and their impact on the reproductive behavior of Filipino women. It analyzes the Reproductive Health Law and the arguments for and against it, as well

as the Philippine Development Plan 2017-2022. The chapter provides insights on health centers, access to family planning, requirements for access to family planning, the role of the state in health centers, information on contraceptive side effects and misconceptions, and sex education.

The conclusion summarizes the main findings and answers the research question, while the limitations section outlines the constraints imposed by various factors. The outlook section suggests ideas for further research on the topic.

The following chapter illustrates the state of research within the topic of this Master's thesis, describing the anthropology of gender, the anthropology of reproduction, and the role of the state in shaping reproduction.

2. State of the Research

The following chapter provides an insight into the current state of research, beginning with the larger research field of gender anthropology and the anthropology of reproduction, followed by a description of four selected studies that represent research findings relevant to the topic of this Master's thesis and its guiding research question:

To what extent are women in the Philippines influenced in their reproductive behavior by health policies, local health centers and the Catholic Church?

The section "The Right Population" offers an anthropological perspective on how the authority of states over reproduction has grown

2.1 Anthropology of Gender

Under the influence of the women's movement in the 1970s, insights were gained into gender roles and inequalities, giving rise to the sub-discipline of feminist anthropology (Mascia-Lees & Johnson Black 2017, 7). Prior to this, most ethnographies were written by men, or by women who were trained by men, and who collected information mainly, from and about men in other societies (Mascia-Lees & Johnson Black 2017, 9).
Although anthropological work was also being done before the 1970s, it was not recognized as central to the discipline of anthropology. One of the most well known of these early pioneers is the anthropologist Margaret Mead, who popularized anthropology and made significant contributions to gender studies (Mascia-Lees & Johnson Black 2017, 8).
Alongside Margaret Mead, the French writer and philosopher Simone de Beauvoir was also an early advocate of studying gender. In her work *The Second Sex* (1953)[2] she writes that "woman is not born but made". This sums up her understanding of gender as a cultural construct - as the meaning given to the physical or biological characteristics that distinguish men from women (Mascia-Lees & Johnson Black 2017, 72).
The authors Margaret Mead and Simone de Beauvoir were among the first ones to address the issue of sexual inequality in different cultures, attempting to ground inequality either in biological or cultural universals or in specific, historically constructed social formations (Sanday 1991, 1). The variability in cultural definitions of femininity and masculinity was described by Margaret Mead in her book *Sex and Temperament* (1963, first published in 1935). She describes how almost all of the personality traits that label people as female or male are related to gender, for example, the manners, clothing and headgear that society assigns to one or the other gender at a given time (Mead 1963, 280).
In her book "The Second Sex", Simone de Beauvoir discusses the idea of universal sexual asymmetry. She presents three key points to explain how this idea relates to socio-cultural norms. First, she argues that all societies have a set of symbolic structures that define and delineate masculinity and femininity. These structures form a strict pattern of binary oppositions that are assumed to be fixed and based on a dialectic, for example a conflict between two opposing forces or ideas. Secondly, de

[2] Beauvoir, Simone de. (1953): The Second Sex, edited and translated by H. M. Parshley. New York.

Beauvoir assumes that this dialectic follows a universal pattern in which the masculine is linked to culture and the feminine to nature. And finally, she argues that this dialectic puts a man in a position of domination and exploitation of the woman, just as culture exploits nature (Sanday 1991, 2).

In addition, in her book *Feminism and Anthropology* (1988), social anthropologist Henrietta Moore addressed the important role of the state for feminists and social anthropologists. Demands such as equal pay for equal work, unrestricted access to contraception and abortion, equal educational opportunities, and various other demands illustrate the importance feminists place on the role of the state in regulating women's lives. She also describes how fertility and sexuality are also regulated through mechanisms such as marriage laws, legislation on homosexuality, adultery, abortion and rape, and population control programs. The development of these policies is shaped by prevailing assumptions and ideologies about the role of women, the desired dynamics between men and women, and the basic understanding of family dynamics (Moore 1988, 128).

The results of state policies can be highly contradictory. State policies designed to protect the well-being of mothers and children may discriminate against them if their lives do not conform to the social norms and beliefs on which these policies are based. Thus, the state not only regulates people's lives, but also defines gender ideologies and constructs notions of femininity and masculinity that dictate to society how women and men should behave and who they should be (Moore 1988, 129).

Moore explores the different dynamics between women and men in their interactions with the state. Despite constitutional provisions that protect women's democratic rights, inequalities between women and men as citizens persist. The contemporary state is based on the recognition of gender differences, and this distinction is manifested in the political system. Even where women have equal rights within the state, they often face significant obstacles that prevent them from exercising those rights (Moore 1988, 183).

Since this Master’s thesis is mostly about women in the Philippines and their reproductive behavior it is important to recognize gender as a social construct and to understand the impact of cultural norms and state policies on gender dynamics which have been described above.

The following section will introduce the anthropology of reproduction by considering reproduction not only as a biological process, but also as a social and cultural one. To

illustrate women's experiences of access to reproductive health in different countries, four relevant studies are described.

2.2 Anthropology of Reproduction

Whether we give birth, participate in the birth and care of others, or are born ourselves, everyone has a reproductive life. Reproduction is not only the biological process that makes us human, but also the social and cultural processes that make us human. Reproduction is a profoundly political project. Institutions, communities and individual groups have their own interests in reproduction and use all the means at their disposal to enforce their preferences. The anthropology of reproduction is therefore better defined as a socio-cultural anthropology of reproduction (Han & Tomori 2022, 2).

It is only in the last 30 years that anthropology of reproduction has been studied, although it has long been recognized as a major concern in social and cultural life. In the 1970s, feminists began to question the hierarchical division of gender roles and the assertion that their natural and universal basis lay in women's biological potential to bear children. Reproduction was primarily associated with women, and therefore, until recently, its discussion was assumed to refer to the 'female'. Today, the continuing vitality of the socio-cultural anthropology of reproduction is evident in a growing body of work that addresses the contexts, conditions and contingencies that characterize and influence women's, men's and peoples' experiences of reproduction (Han & Tomori 2022, 2).

To illustrate women's experiences of accessing reproductive health, its influences and barriers, four relevant anthropological studies, among others, are presented below. Their findings represent important components of the research topic of this Master's thesis.

In the paper "*I have no choice: Influences on Contraceptive Use and Abortion among Women in the Democratic Republic of Congo*", Swanson et al. (2019) explores the sociocultural factors that influence contraceptive use and abortion practices among women in the Democratic Republic of the Congo. The study was conducted in the Democratic Republic of Congo from May to August in 2015. During this period, 32 interviews with women and 10 interviews with health care providers were conducted. In terms of contraceptive use, the following was observed: Congolese women stated

that their husbands play an important role because they have to allow women to participate in family planning programs. Many women also said that they needed their husbands' permission to go to a health center to get contraceptives. One patient who intended to use contraceptives stated that she would face divorce if her husband found out (Swanson et al. 2019, 133). In addition, the parents of married couples play an important role because they want to have many grandchildren. Religion also plays an important role in the lack of contraceptive use, as the church teaches the exact opposite of reproductive health providers. Women who attend church tend not to use contraception (Swanson et al. 2019, 134).

This study by Swanson et al. (2019) shows that the self-determination of these Congolese women is limited by various sociocultural factors. They cannot decide over their own reproductive health as this is influenced and constrained by external factors such as marital dynamics, parental expectations and religious norms and beliefs.

The study “*Reproductive health behaviour and decision-making of Muslim women*” by Constanze Weigl (2010) is a similar study that took place in a low-income community called Nizamuddin Basti in New Delhi, India. This study was conducted from January to October 2007 and during a short visit in February 2008. Much of the study involved participant observation and semi-structured open-ended interviews with 40 women aged 20-45. In addition, expert interviews were conducted with reproductive health professionals, including doctors, nurses, government and non-government health workers, and local midwives (Weigl 2010, 25-27).

Weigl found that early marriage and sharing a household with in-laws is common in South Asia (Weigl 2010, 230). According to sociological and anthropological research, women in India have limited independence within their homes. Decisions regarding finances, family relationships, and choice of a spouse are made by men, leaving women with little autonomy in these matters. Women’s ability to make decisions about their own bodies and reproductive health is limited by the attitudes and actions of the men or in-laws in their families (Weigl 2010, 232f.).

As a result of poverty, women in this community were forced to use government reproductive health facilities, which provided reproductive health services free of charge, because they could not afford to pay for a private clinic. These facilities were characterized by an inadequate quality of care and an often coercive nature of service provision. These conditions of government services created problems for women's

reproductive choices and even turned some women away from government reproductive health facilities (Weigl 2010, 232).

In these facilities, a woman's consent to contraception or abortion was often encouraged or motivated by the Indian government, which viewed a woman's fertility as a burden. Women were all aware that their choices were largely shaped by the wider system of economic and social oppression in which they lived. Therefore, women did not have an ideal freedom of choice regarding their reproductive decisions (Weigl 2010, 235).

In her study, Weigl (2010) points out that women in Nizamuddin Basti have limited independence in their homes and over their own bodies. Because of their poverty, these women rely on government reproductive health facilities, where they experience inadequate quality of care, creating additional barriers to accessing reproductive health services. Collectively, these socio-cultural and systemic factors significantly limit the self-determination of women in the community and restrict their freedom to make independent reproductive decisions.

The study conducted by Nancy Stark, titled "*Contraceptive Decision-Making among Rural Bangladeshi Women*" (2000) explored the experiences of women in two villages in Bangladesh in the course of a year (Stark 2000, 180). The research included structured and unstructured interviews with 150 women between the ages of 15 and 75, as well as participant observation (Stark 2000, 181).

The study found that fertility control was crucial in the lives of village women, but that it caused conflict within their families. To avoid conflict, women used contraceptives in secret and had to get permission from their husbands or mothers-in-law to leave the house (Stark 2000, 185).

Older women in the villages used stories called "contraceptive parables" to communicate their views on contraceptive use and the consequences of disregarding religious beliefs and gender roles. Religion, society, and gender role expectations played an important role in controlling women's fertility (Stark 2000, 184). The most popular contraceptive method was Depo-Provera, administered by injection every three months. It was preferred because it left no visible marks and reduced concerns about forgetting to take a daily pill. The intrauterine device (IUD) was the least popular method because of its perceived intrusiveness. The study found that 75 percent of women used contraceptives for birth spacing. Community health workers used this

argument to encourage young women to use contraceptives because birth spacing was more socially acceptable than not having children (Stark 2000, 185).

Side effects were a common complication for women using contraceptives, affecting their independence (Stark 2000, 186). While some women made the decision to use contraceptives independently, others were motivated by community health workers. Women with direct access to contraception used methods that met their personal and reproductive goals, but their choices were not always supported by their social environment. They faced disapproval from family members and resistance from family planning staff when they discontinued a method (Stark 2000, 194).

Stark's (2000) study in Bangladesh highlights the limited autonomy women have in making reproductive health decisions due to cultural, religious, and social factors. It highlights the impact of gender roles, cultural beliefs, and social pressures on fertility decisions and contraceptive use. Women also face challenges related to contraceptive side effects, which affect their well-being and independence. Limited access to information and support is influenced by the behavior of health workers, further complicating reproductive health decisions.

Finally, Catherine Maternowska conducted the study "*A Clinic in Conflict: A political economy case study of family planning in Haiti*" (2000) in a clinic in Haiti from 1985 to 1995. She conducted an in-depth analysis of the clinic that aimed to place reproductive behavior in the broader context of Haiti's political economy and to provide a perspective on encounters in the clinic that would reveal reasons for resistance to contraceptive use that go beyond traditional public health (Maternowska 2000, 106). The basic method of this study was to observe clinical procedures and practices in the family planning center of the clinic. The participants in this study were the two doctors working at the clinic and women aged 15-45 who attended the clinic as new or continuing clients. Eleven staff members were also interviewed using a loosely structured interview guide (Maternowska 2000, 108).

In the clinic she observed, Maternowska discovered that the micropolitics of reproductive medicine shed light on how the family planning process can be an incredibly isolating and disempowering experience. Even those women who resist societal and family pressure and decide to use family planning do not receive support and encouragement for their choice. Instead, women's feelings of worthlessness and dehumanization are often reinforced by the authority wielded by medical providers during these encounters. For instance, one woman who expressed a desire to

discontinue her method was even referred as an ‘animal’. The pervasive directive power of doctors means that clients are routinely denied access to the information they need to make informed decisions about their own reproductive health (Maternowska 2000, 122).

The quality of the program which was observed in the hospital, did not empower women, but rather lead to a feeling of loss of agency as they are not given the tools or resources to make informed decisions about their own reproductive health, resulting in Haitian women turning away from these facilities (Maternowska 2000, 122). When the family planning program is presented as a political organism, it becomes clear that power relations in the clinic and in the community shape the way health care is provided and perceived. Including and analyzing the different levels of power, struggle and resistance clarifies why contraceptive use is so low in this community (Maternowska 2000, 123).

Maternowska's (2000) study in Haiti shows that the micropolitics of reproductive health care contribute to women feeling disempowered in their reproductive health decisions. It is difficult for women in Haiti to maintain control over their own reproductive health because the authoritarian power of health care workers creates imbalances and limits access to important information. Power dynamics within the clinic and the broader community have a significant impact on the delivery and perception of health care in this context.

The following section examines the impact of government institutions and policies on population and reproductive behavior.

2.3 The “Right Population”

The role of states in shaping reproduction has long been of interest to anthropologists. The term “political demography” was defined by Gail Klingman in 1988 to describe state intervention in fertility for political purposes. She explains that in socialist Romania, dictator Nicolae Ceauşescu, in power from 1965 to 1989, saw the production of an ever-growing human workforce as a key step in the state's efforts to realize its vision of industrialized modernity. Pronatalism therefore became official policy. “Natalism is an ideology that advocates a high birth rate within a community” (McKeown 2014, 2).

Contraception and abortion were criminalized in Romania. This led to a high maternal mortality rate as women desperately sought unsafe abortions or were forced to give birth despite medical objections. On the other hand, the Chinese state was concerned about the economic and social consequences of a rapidly growing population. Thus, China argued that demographic decline was essential to produce a 'quality' population to lift the country out of poverty, and in 1979 Den Xiopeng's government introduced a one-child policy. Political demography was not confined to socialist states, as governments of 'developing' countries also sought to achieve demographic profiles. These countries were often under pressure from international development organizations and global financial lending structures, which encouraged and sometimes forced their subjects to limit their fertility (Andaya 2022, 125).

In their paper entitled "Reproductive Governance in Latin America", Lynn Morgan and Elizabeth Roberts (2012) introduce the concept of "reproductive governance". This concept helps define how different groups such as the government, religious institutions, international financial institutions, non-governmental organizations and social movements use different tools such as laws, economic incentives, moral persuasion, direct violence and incentives to influence and regulate population practices and reproductive behavior. The authors explain that reproductive governance provides an analytical framework for examining changing policy priorities related to reproduction and population (Morgan & Roberts 2012, 241). Highlighting that reproductive control is essential to a range of moral regimes and diverse religious, economic and demographic agendas, reproductive governance refers to the "mechanisms through which different configurations of actors ... use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor, and control reproductive behaviors and population practices" (Morgan & Roberts 2012, 243).

With the rise of the modern state in the nineteenth century, this power of the state over its citizens, especially women, made it possible to produce the 'right population', which is also explained by Foucault's term 'biopower', explained in the introduction. The right population was defined as one whose 'quality' could be maintained by encouraging the 'right' kind of people to reproduce and which was free from undesirable factors (Lock & Nguyen, 2010, 144f.).

Two other aspects of the problematization of population are the use of biological criteria to justify drastic forms of intervention worldwide, and the resulting adoption of biological

contraceptive technologies to achieve political goals, sometimes by force. The result is that these technologies are the most widespread of all biomedical technologies, used by billions of people worldwide. When used voluntarily, they are seen by many, especially women, as emancipatory. However, their use can have predictable negative consequences (Lock & Nguyen, 2010, 144f.).
To summarize, states have a significant role in shaping reproduction, as illustrated by the concept of political demography. Because governments are not the only actors influencing people's reproductive behavior, Morgan and Roberts (2012) developed the concept of reproductive governance. This concept encompasses the various tools used by different actors, such as governments, religious institutions, and international organizations, to influence and regulate population practices and reproductive behavior. The emergence of the modern state gave it power over its citizens, especially women, to shape the "right population" based on desired characteristics. Foucault called this concept biopower.

2.4 Summary

This Master's thesis examines the factors that influence reproductive health in the Philippines, particularly those of the state, religion and local health centers. Since the sample and research question of this study focus on Filipino women, it is important to define the anthropological concept of gender as explained in the beginning of the chapter by the authors Beauvoir (1949), Mead (1935) and Moore (1988), to determine the role of women within the reproductive health system and access to contraceptives. It is important to reflect on the social and cultural roles in which women find themselves. The concept of gender in anthropology highlights the difference between men and women and the way they are perceived and categorized (Mascia-Lees & Johnson Black 2017, 72). Men are associated with culture, which is seen superior and dominant, while women are associated with nature, which is considered submissive and passive. This unequal relationship between the two categories leads to men having greater power and control over women and treating them as subordinate. Just as culture exploits nature for its own purposes, men exploit women for their own benefit (Sanday 1991, 2). This highlights the unequal power dynamic between the two genders and the ways in which gender influences social relationships and structures.

Henrietta Moore points out that fertility and sexuality are also regulated by state interventions such as marriage laws and population control programs. These policies are guided by an image of women that is shaped by an ideology about the role of women, the appropriate relationship between men and women, and the nature of the family (Moore 1988, 128). With these measurements women are put in position of being responsible for sexual and reproductive health as well as fertility.

According to Simone de Beauvoir women are closer to nature (Sanday 1991, 2) and therefore put in the position to be responsible for reproduction, while at the same time they cannot make their own decisions due to state laws and gender roles (Moore 1988, 128). Factors that make it difficult for women to access reproductive health services often include male partners or relatives, religion, health facilities and their services, and social and cultural factors (Swanson et al. 2019, 133; Weigl 2010, 235; Stark 2000, 184; Maternowska 2000, 123). On the other hand, the state often wants to put pressure on women to use reproductive health services and contraceptives in order to control the population. In this system of foreign domination and oppression to which women are subjected, there is little room for women to make their own reproductive health decisions (McKeown 2014, 2; Andayan 2022, 125). The concept of the anthropology of reproduction also shows that reproduction is not only a biological process, but also involves social and cultural processes and is a political project. Again, many people, institutions, norms, and opinions are involved in a woman's decision about her reproductive life.

The four studies by Swanson et al. (2019), Weigl (2010), Stark (2000) and Maternowska (2000) have been selected to illustrate the barriers women face in accessing reproductive health and contraception are relevant to this thesis because they all address the issues in accessing reproductive health services that are the focus of this Master's thesis. The studies address the private, religious, and institutional levels of oppression. In three of the four studies, patriarchal structures play an important role in women's access to reproductive health services and contraceptives (Swanson et al. 2019, 133; Stark 2000, 185; Weigl 2010, 232).

Women who decide to use contraceptives, even though they are not allowed, do so in secret because they are afraid that their husbands or in-laws will find out (Stark 2000, 185). Religion also plays an important role, as religious women are less likely to use contraception because of the church's opposition to artificial contraception (Swanson et al. 2019, 134; Stark 2000, 184). Older women cite religion and possible

consequences as an argument against using contraception (Stark 2000, 184). At the institutional level, the attitude of local public health centers, which are often used by poor women, plays an important role in access to reproductive health services (Weigl 2010, 232). Women reported experiencing poor quality services and a coercive approach to service delivery, as these health centers try to motivate women to use contraceptives to serve the government's population control goal (Weigl 2010, 235). At the same time, women experience unfriendly and disempowering behavior from health care providers. All these factors mean that women are marginalized and oppressed and are not promoted and supported in their sexual health and empowerment as they should be (Maternowska 2000, 122f.).

All of these findings are relevant to this Master's thesis because women in the Philippines face similar barriers to accessing reproductive health services. As mentioned earlier, the national level plays an important role in controlling women's fertility decisions and trying to produce the 'right population'. From pronatalism to one-child policies, the state is able to regulate its population (McKeown 2014, 2; Andaya 2022, 125). Considering how the government and development agencies can influence and control a population is also an important factor for the research question of this Master's thesis. It is important to find out what factors influence government control and what possibilities a government has, to control and influence the population in its growth. This is important because the government of the Philippines is also trying to shape its population. All the factors mentioned in this section form the basis of this Master's thesis and are important elements in answering the research question in the context of the Philippines.

The next section outlines the methods used to collect and analyze the empirical data.

3. Methodology

The following chapter describes the methods used to collect the empirical data in the Philippines. Detailed information about the research process, the access to the field, and the specific research methods used are outlined and the method of data analysis is also explained. The ethics as well as my own position in the research field and a limitation of the methods used are critically reflected.

3.1 Access to the Field

As a requirement for the Creole Master's program, all students are required to participate in a field research project. In line with this requirement, I chose the field research project on "Medicine and Health in the Philippines" under the supervision of Dr. Bernhard Hadolt. During the preparatory seminar, students were asked to choose a specific topic related to the seminar theme. Because I have been working as a gynecologist's assistant since 2018, I chose the topic "Reproductive Health and Contraception in the Philippines". This topic was not only in line with my professional experiences, but also had personal significance to me as a woman. My fieldwork was conducted from the 5th to the 29th of January in 2020 in different regions of the Philippines, focusing on the cities of Dumaguete and Moalboal on the islands of Negros and Cebu respectively. I also collected data in Iloilo on Panay Island, Malapascua Island northeast of Cebu and Cebu City on Cebu Island (Figure 4).
We were literally "thrown" into the field, as no interview dates had been set in advance, only an interview guide had been prepared and some ideas had been gathered about with whom and where the interviews could take place. My idea was that I could interview younger adults in a school or university. I also thought that it would be easy to ask Filipinos or Filipinas in the accommodation where I was staying if they would be willing to be interviewed. Beforehand, I had also thought about whether it would be possible to interview medical professionals, but I did not know whether this would even be possible and whether I would be able to access a health facility.
The research sample, which describes the interviewees, the individuals with whom I conducted informal conversations, and the areas in which I conducted participant observations, is described in the following section.

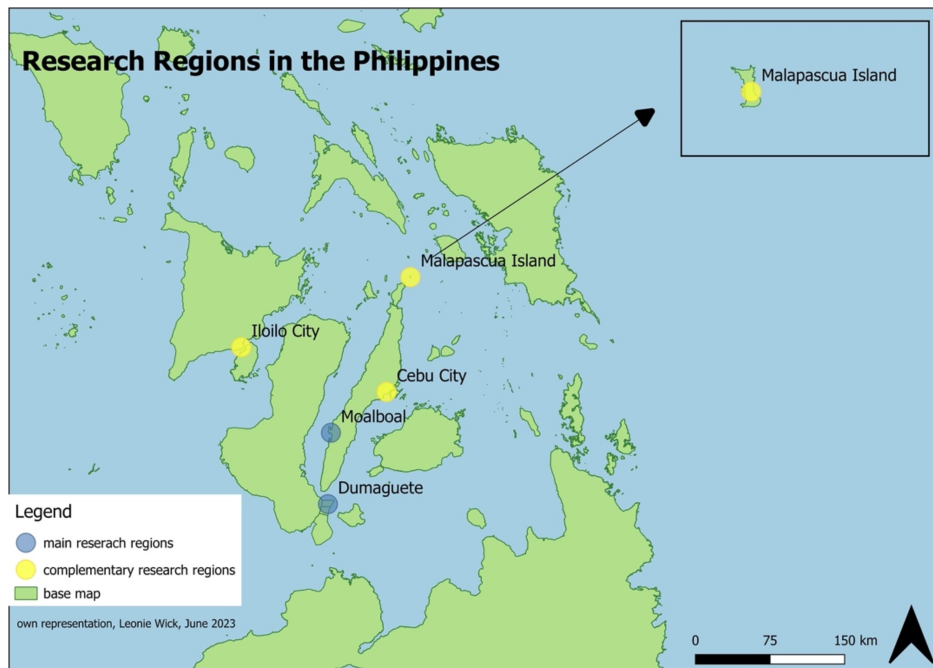

Figure 4: Map of the research regions in the Philippines
Source: Own representation

3.2 The Sample – From Local Health Centers to Individuals

Through Dr. Bernhard Hadolt's contacts with the University of Iloilo, we had the opportunity to meet students from the university. In a round of talks with the students, each of us presented their research topic, and when it was my turn to present my topic, it was met with great interest. When I asked if it was possible to get free contraceptives at the pharmacy, the students informed me that it was not possible and that it was only offered at hospitals (Participant Observation 1, Pos. 9). Through this information I was eager to find out whether I can interview health workers at the hospitals in the areas I would be researching. When I arrived at my first research area, the city of Dumaguete, I went to a pharmacy and asked the pharmacist if it was possible to receive free contraceptives here at the pharmacy, she confirmed what the students had told me before and explained that it is only possible to receive free contraceptives at the local “health centers” (Participant Observation 5, Pos. 20). With this information, I found out where the local health center in Dumaguete was and went there to see if I could interview the health staff and conduct participant observation - with success (Participant Observation 6, Pos.).

During my research I had the chance to visit three health centers to do participant observations as well as interviews with in total eight health workers, more precisely five nurses, two midwifes and one family planning manager. They were approximately from 25 to 50 years old. Besides one male, they were all female. From my interviews, I observed that the majority of participants were educated and belonged to a higher income class. This was evidenced by interviews with high school students, trained nurses at health centers, a hostel owner who had also pursued further education, and a man employed by a large company. The health center staff proved to be experts in providing information on contraceptive access and usage, while the private individuals provided insight into the cultural attitudes towards contraceptives.

I visited the Main Health Center and the Health Center Barangay in the city of Dumaguete, which is the capital city of the province Negros Oriental in the Central Visayas region of the Philippines. The third health center I visited was the Main Health Center of Moalboal, a municipality located on the west coast of the island of Cebu, also in the Central Visayas region.
Gaining access to the three health centers was relatively easy, as the health staff was accommodating and receptive to my research. I only needed to seek permission twice to conduct interviews and participatory observations. In Dumaguete, I approached the health officer in charge, and in Moalboal, I even had to request permission from the mayor. Despite the additional bureaucracy, both instances went smoothly, and I was granted access to the facilities for my research.
In addition to the interviews with health workers, I also had the opportunity to spontaneously interview private individuals during my research stay. I conducted two interviews with three students - one boy and two girls aged 17 and 18 - from Siliman High School in Dumaguete. I also interviewed a 33-year-old hostel owner in Dumaguete. Moreover, in Moaboal, I interviewed a 28-year-old man from Cebu who works at Amazon. Additional to the interviews, I had four informal conversations during my research period. These informal conversations took place partly in the context of participant observation or simply spontaneous conversations with people I met in the Philippines. Unlike the interviews, all the informal conversations were conducted without an interview guide. One of the four informal conversations was recorded; the other three were documented in observation logs.

One was with a 39-year-old bartender in Moalboal, another with students from the University of Iloilo who were about 22 years old, a third with a 40-year-old woman who worked in a hostel, and a fourth with a 40-year-old Israeli who ran a small hotel on Malapascua Island.
After completing my research in the Philippines and finishing the research paper due in the seminar “Medicine and Health in the Philippines”, I decided to expand the topic and do more research to be able to propose this topic as a Master's thesis.
Previously, I had planned to travel to the Philippines again to expand my adapted research and collect more interviews and observation protocols. Unfortunately, as the Covid pandemic had already started by then, it was no longer possible for me to visit the Philippines again to continue and expand my research. Instead, I had to work with the existing data I had collected and relate it to the relevant literature.
The following section describes the research methods used in the field research.

3.3 Research Methods

Before the field research started, I had studied the different methods of qualitative research. I premediated what kind of methods would provide useful data in order to answer my research question.
I used qualitative semi-structured interviews and participant observations defined by Mayring (2016), as two main data collection methods during my research in the Philippines. I chose these two methods because they are important research methods in qualitative research within cultural and social anthropology.
Prior to the start of the field research, I developed an interview guide, which underwent several adaptations and optimizations during the research period. The questionnaires were adjusted based on additional information discussed in each interview that was not initially considered. For instance, after an interviewee highlighted the state's role in population control through contraceptives, I added a question on the extent to which the state plays a role in contraceptive use.
After discovering that it was possible to conduct interviews at health centers, I created two separate interview guides during my stay - one for the health centers and one for individual subjects. To allow for more personal experiences and circumstances to be shared by the interviewees, both guides were semi-structured. The health center guide

primarily focused on information about access to contraceptives and contraceptive choices, as well as questions about their users. On the other hand, the individual guide contained more personal questions such as opinions about the contraceptives offered, their use, religiosity, and resulting viewpoints towards contraceptives. During the interviews, I took note of relevant reactions of the interviewees such as shyness or laughter. After each interview, I recorded my impressions, feelings, and a description of the interview situation in my field diary. I also used the diary to reflect on my position within the research and my feelings during the fieldwork. Not every conversation in the Philippines was an interview, I also had four relevant informal conversations, which provided interesting information on my research topic. These conversations were also recorded in my field diary.

For the field diary entries and all the notes, I wrote during the research, I followed the explanations and guidance provided by sociologist Robert M. Emerson et al. (2011). He explains that when ethnographers write a note, they are always interpreting and translating into text what they see. The process of writing down a day's experiences in a field note entry is often aptly called narrative. He also explains that field notes are more than a record of observations; they represent a way of life through the writing choices the ethnographer makes and the stories that are told (Emerson et al. 2011, 18ff.). He describes how ethnographers should record their first impressions and try to capture all scenes. Events that cause anger, sadness, shock, or happiness are always worth recording, as are conflicting feelings. The ethnographer must be sensitive and attentive when his or her own reaction differs from that of others. In this case, the reaction of others should not be evaluated, but the ethnographer should always note his or her own feelings and reactions. Before the ethnographer reacts, it is important to notice the reactions of others (Emerson et al. 2011, 24ff.).

The following section describes the participant observation method in more detail.

3.3.1 Participant Observation

Before conducting field research in the Philippines, I had no prior experience with the culture, people, or reproductive health and contraception in an academic context. I had never interacted with nurses or medical staff from the Philippines, nor had I previously engaged with Filipinas or Filipinos. As such, I was entering a completely new and unfamiliar area of research. To better navigate this uncharted territory, the method of participant observation was particularly important in defining and understanding the space I was entering.

Participant observation is a standard method in field research, where the observer is not seen as completely disconnected from the observations made, but rather participates in the social situation in which the subject is embedded. The observer is in direct personal relationship with the observed; data is collected while participating in situations of the natural life. The expectation is to be closer to the subject in order to capture more of the inside perspective (Mayring 2016, 80ff.).

During my field research in the Philippines, I conducted participant observations to gain insight into various aspects of the culture and people. These observations included recording the conditions in the health centers, informal conversations during spontaneous encounters, and visits to pharmacies and drugstores to look for contraceptives and tampons. I even documented the house of a woman I met during my stay. I made notes of almost every situation that made an interesting impression, regardless of whether it was directly related to my research topic, as it often turned out to be valuable information. For example, I took notes during spontaneous encounters with a Filipino I met during a boat tour or a Filipina who worked at the hostel I stayed at.

To record my observations, I used the notes app on my phone during the situation and later detailed them in my field diary. Additionally, I took some photos to support my written observations.

During one of my initial participant observations, I had the opportunity to engage in a discussion with a class from the University of Iloilo where we shared our individual research topics. I found it fascinating to see how the students responded to our topics, as they expressed that our research was focused on highly significant issues for the society of the Philippines. When I presented my topic on contraception, the girls in the class immediately expressed their views. They emphasized that contraception is an

incredibly important and sensitive topic in the Philippines, but due to the country's deeply ingrained Catholic values, it is often difficult to openly discuss such issues (see Participant Observation 1, Pos. 9).

In my field diary, I recorded all my observations, emotions, and the reactions of the subjects I observed, interviewed, and conversed with. These notes helped me gain a deeper understanding of the context surrounding the research topic and kept me organized throughout the research process. As I delved deeper into the topic of reproductive health and contraceptives in the Philippines, I realized that it was a complex issue not just for me as a researcher, but for Filipinos and Filipinas as well.

Throughout my research stay in the Philippines, I conducted a total of 13 participant observations and 12 field diary entries, which included both formal interview situations and informal conversations. During the interviews, I acted not only as an interviewer, but also as a participant observer, noting down the reactions and emotions of the interviewees. In addition, I documented the processes and arrangements, such as email exchanges and permission requests, that led to the interviews. Therefore, for each interview I conducted, I created an observation log and a field diary entry.

The following section describes the qualitative interview method in more detail.

3.3.2 Qualitative Interview

In addition to conducting participant observations, I also conducted qualitative interviews as part of my field research from January 5th to January 29th, 2020. To arrange an interview at the health center in Dumaguete, I simply contacted the head of family planning and arranged a personal appointment. For an interview at the Barangay Health Centre in Dumaguete, I got the center’s email address from the Dumaguete Health Centre and sent an email to make an appointment. To arrange an interview with the health center in Moalboal, I visited the center in person and asked permission to make an appointment. The interviews with the private individuals arose mostly from spontaneous situations. When I visited the University of Dumaguete, I randomly approached students and asked them if they wanted to do an interview with me. This led to the opportunity to interview 3 high school students, which resulted in two qualitative interviews. While visiting a hotel bar in Dumaguete, I met the hostel owner. We talked briefly and she asked me what I was doing in Dumaguete. I explained

my research project and she offered me an interview. She expressed a willingness to contribute to my work and a personal interest in the topic. As a result, we made an appointment for an interview. At a restaurant in Moalboal, I met a Filipino. He also asked me about my stay in the Philippines and I explained my purpose. He also offered me to interview him, so we made an appointment for the next day.
Surprisingly, all seven of the requested interviewees agreed to participate, and I was also able to have four informal conversations. This level of openness and willingness to discuss issues surrounding contraceptives and reproductive health was unexpected in a religious country, and it highlighted a need for people to express themselves that they may not be able to fulfill with other Filipinos due to prevailing shame and prejudices influenced by the church. It appeared that speaking with a foreigner provided a safer and more comfortable space for these conversations. This was my impression from the experience.
The interviews I conducted were semi-structured and involved a pre-designed interview guide that was adapted throughout my field research. At the beginning of each interview, I introduced myself and explained the purpose of my research and why I was interested in the topic of reproductive health. The interview guide was structured to first gather general information about the interviewees before delving deeper into the specifics of the research topic. I chose a semi-structured approach to allow interviewees the freedom to express their thoughts, making sure to avoid asking the next question directly and giving interviewees ample time to finish their thoughts, while ensuring that the interviews were already structured according to categories, which would facilitate evaluation and enable better comparison. In the following section, I will describe the categories in more detail.

To begin the interviews, I started with demographic questions, including their age, religion, relationship status, education, and whether they have children. From there, I moved on to general questions about their understanding of contraceptives, such as their knowledge and use of contraceptives, and what contraception means to them. Next, I inquired about their contraceptive education, including who educated them, their knowledge of Sexual Transmitted Diseases (STDs) and Human Immunodeficiency Virus (HIV), as well as how to prevent them. Cultural aspects were also discussed, such as the social acceptance of contraceptives, the role of religion in the use of contraceptives, when is the appropriate time to use contraceptives (before

or after having children), who is responsible for their use (the man or woman), and the role of the state in promoting contraceptive use. I then asked about access to contraceptives, including what types of contraceptives they have access to, the cost, and how long they have had access. The interviews also explored medical aspects, such as the side effects of contraceptives, knowledge of how the contraceptive pill works, illegal abortions, and whether they have had personal experiences or know someone who has had one, as well as their opinions on the legality of abortion in the Philippines.

While unstructured interviews may have lacked coherence and direction, semi-structured interviews allowed me, as the researcher, the flexibility to adapt and refine the interview guide as the research progressed.

As previously mentioned, my research focused on two distinct groups: health center staff and private individuals. These perspectives proved to be particularly insightful as they shed light on both the availability and distribution of contraceptives by health centers, as well as the perspectives of those individuals who are offered these contraceptives and the challenges, they face in using them.

The data evaluation method and the evaluation process are described in the next section.

3.4 Data Evaluation Method

After transcribing the interviews, I decided to analyze the data using the qualitative content analysis according to Mayring (2016). Since my interview guide was created using categories relevant to my research topic, I had a clear idea of the categories I needed to define in order to apply qualitative content analysis to the transcripts.

Content analysis breaks down the collected material into units, which are processed one after the other. At the center is a system of categories developed based on the theory of the material, that determines which aspects are to be filtered out of the material (Mayring 2016, 114).

Once the data had been transcribed and summarized, I proceeded to form categories from the collected data. Specifically, I used an inductive approach to category formation, which involved deriving categories directly from the material without relying on pre-existing theoretical concepts (Mayring 2016, 116f.). In other words, the

categories were not predetermined prior to the analysis of the data, but rather emerged organically from the data itself.

In the logic of content analysis, the categorization dimensions and the level of abstraction must be determined in advance. A selection criterion for the formation of categories must be established. This is a deductive element and must be justified with theoretical considerations on the object and goal of the analysis (Mayring 2016, 115f.). In order to determine the categorization dimensions and the level of abstraction in advance, I used the previously researched theory, the research question and the accompanying statements formulated for it.

The first step of the evaluation was to filter out important statements from the interviews. Then these statements were paraphrased, this means that they were cleansed of unimportant information followed by determining the level of abstraction, were the statement was reduced to such an extent that a category was formed. For example: I asked a man if it is expensive to buy contraceptives like condoms in the pharmacy, he answered that it is very cheap. Then I asked how the reaction of the people in the pharmacy is when he buys them. His answer: “eehm they act like they don’t care but you know deep inside their minds there is already a lot of judgements going on” (Interview 6). I paraphrased it to: Condoms are cheap, but people are judged buying it. Therefore, I made the categories "access", noting that access to condoms in pharmacies is easy and cheap, and I made the category “social acceptance”, noting that there is a judgmental reaction when one buys condoms. This gives the categories of access - easy and cheap and social acceptance - judgmental.

These statements were then combined into a category system. One by one, all important statements were checked and assigned categories. In the back-checking process, similar categories were then reduced again and combined into one. For example, from having a category which was called: judgmental behavior and cultural factors, I formed the category “social acceptance”.

Finally, I formed with the help of the MAXQDA qualitative data analysis software the following codes:

- Abortion and Morning-After Pill
- Contraceptive Methods and Access
- Government
- HIV and STDs
- Husband and Partner
- Occupation and Education
- Rape
- Reflection
- Religion
- Sex Education
- Side Effects
- Single and Childless Women
- Social Acceptance
- Personal Information
- General Information

The result of this analysis is thus a set of categories on a particular topic to which specific passages are assigned. The entire system of categories is interpreted in relation to the research question and its underlying theory (Mayring 2016, 117).
The next section explains the feminist research approach which has been used during the empirical data collection.

3.5 Feminist Research Approach

Since women are mostly in the center of my research topic, I chose a feminist research approach. That means that gender is positioned as the categorical center of inquiry and the research process (Hesse-Biber 2014a, 46). Feminist interviewing seeks to uncover knowledge that normally remains hidden. In this way, issues that shape the lives of women or other oppressed groups of people can be explored in depth (Hesse-Biber 2014,184). According to this definition, my research topic fits into this framework as I discuss the sensitive and unspoken issue of reproductive health and the barriers and challenges related to access to contraception, especially for women in the Philippines.
In feminist research, the role and positioning of the researcher is also of particular value. Power and authority play an important role here (Hesse-Biber 2014, 184f., 190). These authority and power relations within the research can be weakened by finding and highlighting common ground (Hesse-Biber 2014, 184f., 211). I have done this

when I have talked to women in the Philippines about the contraceptive pill and its side effects, and we have often agreed on the impact that these side effects have had on our lives. Nevertheless, it is also important in feminist research to openly communicate and discuss the differences between the researcher and the research partners (Hesse-Biber 2014, 184, 209ff., 216). I was able to do this by also talking to them about my experiences of accessing contraception and how this was also characterized by certain barriers, but not by male authority figures in my personal and private environment, as was sometimes the case with the female research partners.

Hierarchies and power relations can also be reduced through openness and directness (Hesse-Biber 2014, 190, 199). As I consider myself to be a very open and direct person, I tried to bring this quality into my interview situation so that the interviewees would feel comfortable talking to me. I did this by being very empathic and understanding to their experiences without being in any way judgmental. Even my body language, like nodding my head, showed my understanding.

According to Hesse-Biber (2014, 186ff; 199), unstructured or barely structured interviews and open-ended questions enable the researcher to perceive the experiences of the interviewees, to signal appreciation and to react more spontaneously and flexibly to what is said, thus pursuing a feminist research style. In the interview situation, according to Hesse-Biber, feminist researchers should let the interviewees tell their story in their own words (Hesse-Biber 2014, 185).

As the author points out, as a researcher you have to ask yourself how a higher level of trust or a closer relationship with research partners affects research. As described in her methodological handbook, the very low level of power and authority that this conveys and aims to achieve would remain despite everything. Because through the analysis and interpretation of the interview it is again in the hands of the researcher what and how something is defined (Hesse-Biber 2014, 199).

The next section reflects on the limitations of the research.

3.6 Limitations of the Research

The research methods described in the previous section are limited by several influencing factors.

Because gender is central to my research, the feminist research approach influenced my findings. My own female gender gave me greater access to the world of the women I interviewed. Because my research topic around reproductive health is a more private and sensitive topic, it is more difficult to enter this world from the outside. I think it was beneficial for me, not being part of the community, to be able to talk to the women about these issues because they knew that I would not condemn their attitudes or tell others in the community about them.

I believe that no foreign or local man would have had access to this private information from these women. Another positive factor was that, as women, we talked about reproductive health and related factors on a similar basis, since women tend to have similar problems. We were able to share our experiences and thus soften the authority and power relations that are usually stronger in interview situations.

The fact that the interview guides were semi-structured influenced the interviews in that it gave the interviewees room to speak more freely, allowing for more and unplanned findings to be collected.

The limited time available to conduct the fieldwork greatly influenced the results. For this reason, the sample was much smaller than expected for a Master's thesis. I mainly interviewed health center staff and some private individuals. It was not possible for me to interview people who visit these health centers with inquiries about reproductive health. Therefore, the results are biased by the views of health center staff and some private individuals. Due to lack of time, I was also unable to conduct more participant observations in the health centers, which would have been important to better define the approach and to learn about the behavior of both staff and patients. As a result, less information could be collected from different perspectives, and data could not be collected in as much detail as expected because more fieldwork could not be conducted due to the covid pandemic.

The following section presents the ethical aspects and my own connection to this research.

3.7 Ethics and Reflection of the Research

Researchers can influence their research field in many ways (Clarke 2014, 5). One's own behavior, biography or the social, economic, and political situation can have an impact on the interview situation and thus influence it and steer the questions in a certain direction (Hesse-Biber 2014, 200). It is therefore advisable to ask oneself to what extent the role as researcher influences the situations, answers, and analyses. This research was shaped by my interests and values and the research question itself, as well as by the choice of methodology (Hesse-Biber 2014, 202).

Conducting ethnographic research and communicating with people, both orally and in writing about them, entails a high degree of responsibility during and after the fieldwork. During my fieldwork I faced several obstacles, first and foremost to continuously recognize my own position in the field. Contraception is an area of great interest in the Philippines and is therefore discussed extensively. However, it is also a sensitive and confidential topic in the Philippines, attracting a lot of public attention and controversy due to the many different perspectives. Nevertheless, during my interviews I could detect a strong desire among the participants to talk openly about this topic on a personal level.

As an anthropology student, it is crucial to consider your position within the fieldwork and how to manage the data gathered through observation, writing, and analysis, as well as how to incorporate it into academic discourse.

When I entered the research field, I held a strong personal view on the subject of my research topic. I believed that free contraception in the Philippines would benefit the people, particularly women, by offering them greater sexual and reproductive freedom. However, at that time, I did not fully comprehend the complex factors involved in providing free contraception. During my initial interview at a health center, I held a firm personal conviction that I couldn't fathom why many individuals in the Philippines were resistant to using contraceptives. This perspective revealed my own position, shaped by my personal experiences and the structures that influenced me. However, I questioned why I couldn't understand why people in the Philippines were hesitant to use free contraceptives.

Growing up, I was primarily taught about ways to protect myself from pregnancy and sexually transmitted diseases. I was instilled with the significance of using contraceptives to lead a self-determined life. In Germany, this topic is typically

introduced at an early age, whether through school, family, or peers. Due to my mother's emphasis on protecting myself, I began taking the pill at age 16 without much awareness of the medication's nature. I accepted it as the norm and didn't question it, as I believed it was standard practice to use contraceptives. Having a well-formed opinion on the topic at the outset had a profound impact on my research, particularly during my time in the Philippines. However, upon reflection and thorough examination of relevant literature, I was able to gain a better understanding of each position.

While conducting interviews in the Philippines, my strong opinion undoubtedly impacted the interviewees' responses, and in the case of health centers, it may have reinforced their position. Nonetheless, through reflection and evaluation, I was able to develop a more nuanced understanding of the topic, allowing for a more insightful and comprehensive analysis of the research findings.

Throughout my research as well as the data collection, I was able to gradually adopt a more neutral position by continuously questioning and reflecting on my own biases. As I conducted more interviews and gained a deeper understanding of the circumstances surrounding the topic, I found myself less inclined to take sides and more interested in comprehending each position. These included the individuals who felt ashamed to go to health centers, the health centers that aimed to fulfill state-set goals by providing contraceptives, and the church, which vehemently opposed the use of artificial contraceptives.

I must acknowledge that I still struggle to remain impartial towards the church's position, as I was not raised with religious beliefs and find it troubling that a faith-based institution seeks to dictate people's reproductive behavior. Despite this, I have strived to maintain a balanced perspective throughout my research, allowing for a more nuanced and insightful analysis of the topic.

During my time in the Philippines, I couldn't help but notice that I was often treated differently than the locals. For instance, people would often offer to let me go first in the supermarket checkout line or offer me the front seat on the plane even though I had booked a different one. Additionally, I was surprised that nobody refused my requests for interviews. These circumstances were likely due to the fact that I am a white woman from a privileged and wealthy Western country. I was aware that my appearance and background would have a significant impact on my research, giving me an advantage in gaining interviews. In fact, I received praise for my fair skin and blonde hair, which I believe is a result of the belief in the Philippines that having lighter

skin provides more opportunities in life. Although I didn't want to be in that position, it was automatic. My mere presence in the Philippines also influenced the research, as there were some situations, such as attending medical lectures on reproductive health in health centers, where I was unable to participate and could only rely on descriptions of the process.

As someone who considers themselves empathetic and curious, I found it relatively easy to approach people and request interviews. Given my personal and professional involvement with the topic, I did not feel any embarrassment or discomfort discussing it. However, I sensed that my interviewees did not share the same level of ease when discussing contraception and sex. There was a certain level of shame and discomfort that was evident in our conversations. Despite this, my interviewees seemed to have a great desire to discuss the topic and share their experiences. In fact, some were so interested in the outcome of my research that they requested access to my findings after the project was completed.

3.8 Summary

To summarize, the empirical data of this Master's thesis was collected in the Philippines from the 5th to the 29th of January in 2020, focused on the cities of Dumaguete and Moalboal on the islands of Negros and Cebu. The sample for data collection consisted mainly of three health centers and their medical staff. I also had the opportunity to speak and spend time with students from the University of Iloilo. I also spoke with students from Siliman High School, two hostel owners, a hostel employee, and a young Filipino who worked at Amazon. The data collection methods for this thesis consisted of qualitative interviews, informal conversations, participant observation, and the feminist research approach. Mayring's (2016) qualitative content analysis was used to evaluate the data. First, the data was transcribed, and then categories were formed in several steps to give the data more structure and to be able to analyze it. Finally, I reflected on my own position within this research and the ethics surrounding it.

The following chapters of this thesis describe and evaluate the contents of the empirical data collected and analyze them in the context of the previous data of the research state.

4. In Between Religion, Culture, and Contraception

The following chapter is the first out of two empirical chapters within this Master's thesis and aims to demonstrate what influence the Catholic Church might have on contraceptive use and reproductive health and rights in the Philippines.
It addresses which cultural factors, that can be connected to the Catholic faith, might influence the provision of free contraceptive services within the local health centers in the Philippines.

The chapter begins by highlighting some aspects of the Filipino culture and some essential components linking their culture and their Catholicism. Then we go back in time and look at the period of Spanish rule to make its influence on the religion of today's Philippines tangible. Moreover, light will be shed on church-state relations and their controversies in the Philippines. Then insight is provided into the general attitude of the Catholic Church towards contraception reproductive behavior.
Finally, this chapter presents empirical data from interviews with health workers from health centers and individuals from the Philippines about their beliefs and religion regarding contraceptives and reproductive behavior, as well as related participant observations that were collected.
This data illustrates not only religion as an isolated influencing factor, but also its influence on overall socio-cultural behavior. As a result, data on the general social acceptance of contraceptive use, the treatment of childless unmarried, partnerless, and young women in accessing family planning, the issue of abortion and the morning-after pill and the significant role of male partners or husbands are evaluated.
The following section provides some insight into my own experience with religion in the Philippines.

4.1 “Sangpit sa Señor”

As our trip to the Philippines approached, Dr. Bernhard Hadolt told us about his knowledge of the Sinulog Festival, which is held annually on the third Sunday in January in Cebu City. He emphasized its importance as a religious festival for the Filipino people and recommended that we attend if we had the opportunity.
After two weeks of research and observation in Iloilo and Dumaguete, a group of us students traveled to Cebu City to experience the Sinulog Festival Parade on the 19th January 2020. When we arrived, we found a lively crowd dressed in bright colors and wearing headpieces with feathers (Figure 5). To mingle with the locals, we too bought headpieces, which were available on every street corner for a small fee.
We found a good spot to watch the parade and were amazed at the electrifying atmosphere. The crowd was exuberant and shouted "Pit Señor!" in unison. I was curious about the meaning of this chant and approached a woman in the crowd who explained that it is a shortened form of the Cebuano expression "Sangpit sa Señor", which means "to call and worship the King".
I also saw people holding up small figures in the air as well as big figures that were included in the parade, which I later learned were representations of the Santo Niño de Cebu (Figure 6), a Roman Catholic term for the baby Jesus[3], who is also referred to as the King. Another onlooker informed us that the Sinulog parade was also a competition, with the winning dance group receiving a prize of one million pesos. Groups from all parts of the Philippines had traveled to participate in the competition and danced tirelessly in heavy costumes under the blazing sun, only taking breaks to refresh themselves.
As we strolled through the side alleys, we saw younger Filipinos smearing themselves with paint and enthusiastically shouting "Pit Señor". We too were splattered with paint, although I personally avoided it as I didn't particularly like the feeling. After watching the parade for several hours, we returned to our hostel before going back to the festival in the evening. We were amazed that even at night, thousands of people were still taking part in the festivities, shouting "Pit Señor!" and smearing paint on everyone they met.
We noticed that there was no alcohol to buy, and a local explained to us that the sale of alcohol was banned in the area during the festival, as ordered by President Duterte.

[3] Santo Niño is the icon of the christ child in Cebu City (Bautista 2006, 291)

All in all, the Sinulog Festival Parade was an unforgettable experience and we felt privileged to have witnessed it first hand. That day, I became acutely aware of the importance of faith and religion for Filipinos (Participant Observation 15, Pos. 58).
The following section provides an insight into some norms and values according to family and beliefs within the Filipino culture.

Figure 5: Sinulog Parade in Cebu City
Source: Own representation

Figure 6: Santo Niño de Cebu
Source: Own representation

4.2 An Approach to Filipino Culture

Later in this chapter, when I look more closely at the analysis of the interview data, it will show how many of the interviewees used the concept of “Filipino culture” to underpin their attitudes towards, for example, judgmental behavior, adherence to church traditions, prenatal contraception, the taboo of contraception outside of a committed relationship, and the importance of spousal consent. But what is the Filipino culture really about? In this section I will try to approach and explain briefly important aspects the Filipino culture in accordance to the information the interview data revealed.

Around 105 million people lived in the Philippines in 2020 and is therefore Southeast Asia's second most populous country. The Philippines is an archipelago and includes 7,107 islands. Across the islands 170 languages are spoken with the language Tagalog being the main language. Two-thirds of the Filipinos and Filipinas can speak English fluently. The religion of the Philippines is reflected by the Spanish and US colonial influences and by the country's proximity to Muslim neighbors Malaysia and Indonesia. Over 81 percent of the population is Catholic, another twelve percent is Protestant or belongs to any evangelical group and five percent is Muslim (Dayley 2020, 147).

The catholic church is a significant political, economic, and social institution in the Philippines, with over 10.000 priests and nuns throughout the archipelago, the largest land holdings in the nation, and control over thousands of schools, hospitals, and parishes. The Church has played a crucial role in all aspects of Philippine life, divided between conservative, centrist, and progressive forces (Dayley 2020, 164).

The sociologist Stephen M. Cherry collected ethnographic data in the Houston Filipino American community in her book "Faith, Family, and Filipino American Community Life" (2014). By analyzing the information from this study, I will identify some of the tangible key values of Filipino culture.

After the Thanksgiving mass in Houston, the author asked one interviewee what was important to him as a Filipino. He briefly replied: "Faith and Family, it's that simple" (Cherry 2014, 24). France Viana who gives a seminar to help non-Filipinos understand Filipino culture, explained that to quickly become an expert on Filipino culture, you need to remember four key elements – family, face, faith and fiesta. She went on to clarify: "If there is one value universal to the Filipino, it is family". These families extend beyond biological relatives, according to Viana (Cherry 2014, 24). Viana went on to explain that the impact of the Spanish colonial history had an important influence on the Philippines. She described:

> "Faith is the 400-pound gorilla in the room of the Filipino social structure. At least externally, we faithfully observe all Catholic holy days, rituals, and feast days mixed with our own folk rituals. The Catholic Church is a big influence not only on our spiritual life but in our politics and economic affairs." (Cherry 2014, 25)

She clarified that Catholicism stands side by side with the family at the center, among all the forces that shape the Filipino community and its daily live (Cherry 2014, 25). The extended family remains the heart and institutional foundation of Philippine

society. Especially mothers still have a great deal of influence on the values, attitudes and cultural understandings of their own biological children (Cherry 2014, 37).

A women called Imee told Cherry (2014) that her family is rather small compared to Philippine standards and that there is always a great pressure on her to have more children. She explains that she loves her children but that she does not want more. She describes, “This is a real ethical bind … we know as Catholics that we should not use contraception but we do sometimes.” Furthermore she added: “I am pro-life; I was even part of a peaceful march to end abortion last year, but I can’t afford more children so we use contraception sometimes – it’s cheating I suppose.” (Cherry 2014, 39).

This ethnographic study by Stephen M. Cherry from 2014 shows one example and part of the values and norms that shape Filipino culture. This study shows how family and faith are important values in the Philippines. They publicly follow the rules of the Catholic Church, but sometimes have to do things that the Catholic Church does not support, such as using contraceptives to avoid having more children which they may not be able to afford.

It is important to note that the term culture can be perceived and defined from many different points of view. For example, Müller-Funk (2021) describes in his book "Kulturtheorie" that culture can be seen as the whole in which everything is culture except what is nature. Culture can also be seen as a totality of symbolic forms and habitual practices, where culture is everywhere but not everything. Or culture can be seen as a closed system, meaning that it is a delimited sphere (Müller-Funk 2021, 29). He also explains that culture is shaped by the creation of differences and the establishment of boundaries. In doing so, it not only justifies power and dominance, but also embeds them in its structure. They are linked to other forms of power: economic, social, political (Müller-Funk 2021, 33).

For this Master's thesis, however, I refer to Cherry's (2014) linking of Filipino culture to the Catholic religion, as this should suffice for the purposes of this Master's thesis. The power and importance of the Catholic Church in the Philippines dates back to Spanish colonization, which I will discuss in more detail in the next section.

4.3 From Spanish Rule to the 1987 Constitution

During the Spanish rule of the Philippines from 1521 to 1898, church and state were not separated. Both custom and law granted the Catholic Church direct authority consistent with the overarching goals of the Spanish crown. The Filipinos became a devoutly Catholic population during the three and a half centuries of Spanish rule. They practiced their religious devotions assiduously in their own homes and celebrated religious holidays with their extended families (Cherry 2014, 25-26).

Resistance to the Spanish rule arose in the late 1890s. The majority of Filipinos were not inherently opposed to religion or Catholicism, but rather to the clergy and the institutionalized Church. They sought to make Catholicism institutionally their own through changes in authority and church structure. During the period from 1898 to 1909, following the Philippine Revolution to gain independence from Spain and the tumultuous takeover of the islands by the United States in the Spanish-American War, the Philippines underwent profound and extensive changes, both religious and civic. American colonial rule brought new civic and cultural influences, including the legal separation of church and state (Pido, 1986; Alip, 1950; Deats, 1967 cited after Cherry 2014, 27).

The Republic of the Philippines has been governed by three constitutions. The first was the 1935 Constitution, adopted under American leadership, which gave the Philippines its independence from the United States. Subsequently, two important constitutions were adopted in the Philippines: the 1973 Constitution, ratified during the Marcos dictatorship, and the current 1987 Constitution, adopted under the presidency of Corazon Aquino. The constitutional separation of church and state has been maintained in all of these constitutions and is clearest in the current 1987 Constitution (Pangalangan 2015, 563).

The next section presents church-state relations in the Philippines over time.

4.4 Church – State Relations in the Philippines

Since it is beyond the scope of this Master's thesis to describe the entire political history of the Philippines, we begin in 1965, when Ferdinand Marcos was elected as president. In 1967, President Marcos, along with other world leaders, endorsed the UN Declaration on Population Policy, which included the following principle: “population must be recognized as a principal element in long-range national planning if governments are to achieve their economic goals and fulfill the aspirations of their people” (Concepcion, 1973).

In 1969, Marcos signed an executive order which established a study and advisory body called the Commission on Population (POPCOM). One of its main functions is to conduct population studies and develop policy and programmatic recommendations on population in the context of economic and social development (Herrin 2002, 13).

In 1969, the Catholic Bishops' Conference of the Philippines (CBCP) issued a statement on the government's population control policies. While the bishops acknowledged that the government could control high population growth through broad strategies such as increasing food production, improving educational opportunities, and managing internal migration, they opposed the government's specific "micro-measures" that advocated the promotion of contraceptives and sterilization as methods of family planning. Instead, the bishops emphasized the importance of educating couples about responsible parenthood as an appropriate approach to supporting family planning (CBCP, 1969).

In addition, the Bishops' Conference spoke out against the government's program in a pastoral letter published in 1973 entitled "On the Population Problem and Family Life. The bishops criticized the government for favoring artificial methods of family planning over natural methods. In addition, the bishops accused the government of offering financial incentives to health workers to distribute contraceptive pills and intrauterine devices (IUDs) (CBCP, 1973).

In 1986, the People Power Movement against the president and dictator Marcos, also known as the Epifanio de los Santos Avenue (EDSA) Revolution, occurred. Here, the Catholic Church had an enormous influence, which was not only in terms of institutional support but also as an expression of faith. The profound impact of the EDSA revolution was evident as even Marcos' troops were deeply moved and joined the countless Filipinos who flooded the streets. They hold up images of the Virgin Mary and the Santo

Niño, sang hymns and prayed the rosary fervently. Today, the Catholic Church in the Philippines occupies a decisive position in both the religious and social spheres, reminiscent of its influence during the second half of Spanish rule. The Philippines is on its way to becoming the largest English-speaking Catholic country in the world, and the third largest Catholic nation overall, as the number of Catholics continues to grow (Rodao & Rodriguez 2001 cited after Cherry 2014, 27f.).

In 1986, Corazon Aquino was sworn in as president (Genilo 2014, 1045). Due to President Aquino's personal religious beliefs and her close ties to the Church, there was a significant change in the government's family planning program. The policy underwent a remarkable shift: family planning was no longer seen primarily as a demographic measure, but as a health measure. In contrast to the Marcos-era approach, the Aquino administration emphasized the importance of preserving the right of parents to choose family planning methods consistent with their religious beliefs (Herrin 2002, 21).

The bishops received assurances that the government would provide only legally recognized methods of family planning (recognizing the illegality of abortion in the Philippines), would ban contraceptive methods known to be abortifacient, and would uphold individual freedom of conscience. Despite these assurances from the government, however, the bishops refused to engage in dialogue with the authorities (Genilo 2014, 1045).

In 1990, a pastoral letter was issued claiming that the government had adopted a population control program supported by international organizations and donors that promoted the concept of "zero population growth" (CBCP, 1990). The bishops expressed serious concern about donations of contraceptives, particularly those received from the U.S. Agency for International Development (USAID). The bishops' acceptance of these free contraceptives was perceived as collaboration with a broader U.S. strategy for global population reduction (Genilo 2014, 1045).

Under the administration of President Fidel Ramos (1992-1998), the family planning program underwent a significant shift in emphasis, with fertility and population reduction coming to the fore as essential elements in achieving sustainable development goals (Herrin 2002, 22). The church strongly opposed the Ramos program and organized protest rallies during major UN conferences such as the 1994 Cairo Conference on Population and Development and the 1995 Fourth World

Conference on Women. These conferences advocated greater access to family planning services and supplies (Genilo 2014, 1045).

During the administration of President Joseph Estrada (1998-2001), his government also pursued goals to slow population growth and reduce the birth rate (Herrin, 2002: 24). Throughout the Arroyo administration (2001-2010), the government took a particular stance in advocating natural family planning (NFP) as the only permissible method of birth control (Senate Economic Planning Office 2009, 3).

During her administration some legislators attempted to propose a Reproductive Health Bill the first time in 1999 and also various attempts in the following years until 2008, when the Reproductive Health Bill, House Bill 5043, obtained enough endorsement among the legislators to be discussed in congressional plenary session (Genilo 2014, 1046).

The passage of the law was delayed. Therefore, a new attempt to draft a new law had to be made in the next Congress (Genilo 2014, 1046). Upon taking office, President Benigno Aquino III (2010-2016) openly supported the passage of a reproductive health bill. He prioritized family planning as a health measure and showed a willingness to face opposition from the bishops. During the 15th Congress, another reproductive health bill, House Bill 4244, was introduced for consideration (Genilo 2014, 1046).

The Bishops' Conference released two important documents entitled “Choosing Life, Rejecting the RH Bill” (CBCP, 2011) and “Proclaiming Life...In Season and Out of Season” (CBCP, 2011a), pushing the Filipinos to reject the House Bill 4244. In the final stages of voting on the bill in late 2012, the bishops issued another pastoral letter, "Contraception is Corruption," urging lawmakers to vote against the reproductive health bill (CBCP, 2012).

On December 21, 2012, the President signed Republic Act 10354, and later on March 15, 2013, the laws implementing rules and regulations were approved. The Implementation of the law was delayed for more than a year while a group of Catholics challenged its constitutionality before the Supreme Court. On April 8, 2014, the Supreme Court ruled that the law was constitutional, with the exception of eight provisions that were deemed unconstitutional and therefore not approved (Genilo 2014, 1047).

The rise of Rodrigo Duterte as a prominent national political figure has ushered in a new era in the government's relations with the Catholic hierarchy. Duterte has repeatedly mocked the Catholic Church in his speeches, which has strained his

relationship with its leaders. Unlike previous presidents, regardless of their religious affiliation, Duterte has not sought the Church's blessing, signaling the emergence of a new secular elite in the country. Moreover, Duterte has made unprecedented public statements cursing the Pope (even if only in joke) and openly questioning and criticizing the Catholic Church and its teachings. In addition, Catholic leaders have openly and repeatedly criticized the president, especially on key public issues such as his anti-drug campaign and related human rights violations. As a result, Duterte's presidency has had the effect of blurring the conventional boundaries between politics and religion (Batalla; Baring 2019, 1f.).

The importance of religion in many societies cannot be underestimated. Its customs and practices have influenced population policies and the development of family planning initiatives. Religious beliefs and teachings have played a crucial role in shaping individual views and behaviors regarding family size, contraceptive use, and, to some extent, the reproductive rights of individuals and couples (Seltzer 2002, 128). The Catholic Church's position on population policy was expressed at the 1974 UN World Population Conference and subsequent UN Population Conferences in 1984 and 1994. In the course of discussions on the relationship between resources and population, the Church took the position that it is both morally wrong and pragmatically ineffective to consider population as the sole factor for economic and social change (Reich, 1995).

The Catholic Church considers contraception morally unacceptable because it can lead to undesirable consequences such as marital infidelity and the degradation of women (Burch and Shea, 1971). The Catholic Church has long opposed artificial methods of contraception in its teaching. This position was reaffirmed in 1930 when Pope Pius XI explicitly condemned contraception in his encyclical Casti Connubii (Noonan, 1986).

Pope John Paul reaffirmed opposition to contraception (except periodic abstinence), contraceptive sterilization and abortion in Humanae Vitae in 1968 (Burch, 1995). Over the past 35 years, the influence of religious considerations on family planning programs in developing countries has shown a variety of results. The pronouncements of various churches, particularly on contraception, have undeniably shaped population policies and programs in many Catholic countries, as well as individual behavior. Despite church teachings on contraception, family planning initiatives have gradually emerged

and expanded access in countries such as Latin America and the Philippines (Keely, 1994).

In conclusion, the Catholic Church has had and continues to have a significant influence on Philippine politics and society. This influence has been evident throughout the country's history, from Spanish colonization to modern politics. The teachings of the Catholic Church have often been at odds with government policy and administration, particularly on issues such as family planning and contraception. Despite being a secular state, the Philippines appears to remain largely as a Catholic state in practice, with over 81 percent of the population being Roman Catholic. The government's family planning program has faced opposition from the Church over the years, but the current administration has been more supportive of family planning as a health intervention. Even though the influence of the Catholic Church on the Philippine society is not likely to disappear soon. The following section examines the qualitative data collected on the Catholic Church and its socio-cultural factors on people's behavior regarding reproductive health and contraceptive use.

4.5 Hints of a Catholic Culture

To evaluate how the Catholic Church might have an influence on the reproductive behavior of Filipinos and Filipinas, I introduced questions about the Catholic faith and church into my interviews with both the private individuals and the health workers. The discussions that took place were not only about religion and the Catholic Church, but also about other factors related to faith. These included abortion, divorce, single and childless women, the role of husbands and partners, and general social attitudes towards contraception and reproductive health in the Philippines. By examining these issues, a deeper understanding can be gained of the complex interplay between faith and the socio-cultural context in which it operates.
When asked about the Catholic faith in general it turned out that, 12 out of 14 interviewees identified themselves with the Catholic faith (Interview 1, 186-189; Interview 2, 9-20; Interview 3, 16-22; Interview 4, 141-142; Interview 7, 309-315; Informative Conversation; 137-138).

Despite the majority being Catholic, two of my interviewees a man 28 years old and a woman 33 years old explained that they were brought up in the Catholic faith but have distanced themselves from it. Both live in a liberal environment as the woman owns a hostel, where mostly young tourists from all over the world stay and the man works at Amazon in Cebu City. The man is now an atheist and the woman believes in something but cannot define it (Interview 5, 9-23; Interview 6, 9-24).

At the beginning of the field research in the Philippines, our class visited the University on Iloilo and met some of the students studying anthropology there. Everybody in my class presented their research topic to the students of the University of Iloilo. All of them were very curious to hear our topics and when it was my turn to present my research topic some of the girls were immediately enthusiastic. They explained that the topic around contraception and reproductive health is a very important one in the Philippines. The students explained that the reason for its importance is that the Philippines is a very Catholic country and therefore nobody really talks about the issues around contraception and reproductive health. During the same conversation, the students told me that almost no Filipino woman uses tampons because it is not accepted and frowned upon in the Philippines. They mentioned that the reason for this is, that there is a believe that a tampon can destroy a woman's virginity. Despite this belief, the students told me that they still use tampons, but reported that tampons are hard to find and expensive. Tampons are only available in one particular drugstore in the Philippines, the students said. During the conversation the students appeared frustrated by the views of their home country. At the end of the conversation, they even apologized to me for their home country, explaining to me that it has a limited attitude towards contraception and reproductive health and that it is very patriarchal shaped, and that these circumstances discriminate women in a sexist way (Participant Observation 1, Pos. 9).

Throughout my research, it became increasingly evident that the Catholic Church holds significant power in the Philippines. This impression was reinforced by the data which has been collected. When I was on a boat to Apo Island for a snorkeling excursion, I had a brief encounter with a Filipino from Manila. He was around 40 years old and had a big rosary tattoo on his back. Because of his tattoo I approached him and asked him about the personal significance of the tattoo and his view of the Catholic Church in the Philippines. He immediately responded that the tattoo had a religious meaning for him, but he also expressed a critical stance towards the Catholic Church. When I inquired

further, he explained that his reservations stemmed from rumors surrounding the Catholic Church and its stance against divorce, contraception, and abortion. He also described how he believed that the Catholic Church had too much power in the Philippines and that it was trying to convert the mentality of the people completely towards the Catholic Church (Participant Observation 12, Pos. 51).

The issue of divorce in the Philippines was confirmed by a 39-year-old women who works at the hostel in Moalboal I stayed at. I had a brief conversation with her, she explained that she was only separated from her husband because a “divorce”, which is not really an official divorce, is very expensive in the Philippines (Participant Observation 18, Pos. 77).

The data examined the influence of the Catholic Church and socio-cultural factors on reproductive behavior in the Philippines. Most of the interviewees identified themselves as Catholic, while a few distanced themselves from the Catholic faith. As noted in the beginning of this chapter, over 81 percent of the Philippine population is Catholic (Dayley 2020, 147). The long Spanish rule from 1521 to 1898 could be an important factor in the current situation, where church and state were not separated and the church exercised considerable power (Cherry 2014, 25-26). This may explain why the Catholic Church still has a strong influence in the Philippines, which some Filipinos feel is excessive. According to some interviewees, the Catholic Church in the Philippines has considerable power and holds strong views on issues such as divorce, contraception, and abortion. The following section addresses the social acceptance of contraceptive use among my interviewees, and thus aims to provide insight into the general trend of acceptance of contraceptive use in the Philippines.

4.6 “They Will Give You Looks”

One afternoon in Dumaguete I went to a shopping mall to buy some things I needed. As I walked through the mall, I spotted a small pharmacy counter. There was a pharmacist working there, a woman about 50 years old. I decided to go up to the counter and ask her if the contraceptive pill was available for purchase in this pharmacy. The woman at the counter hesitated and rolled her eyes slightly before answering with a “yes”. I felt very uncomfortable at that moment, so I revealed to her, that I did not want to buy the contraceptive pill, but wanted to check out the different

types on offer. I also told her that I was doing research on the topic and that I was from the University of Vienna. From that moment on, the woman was very friendly and helpful. She showed me all the different types of pills available in the pharmacy and the prices. She even allowed me to take pictures of the packaging of the pills (Observation Protocol 5, Pos. 20) (Figure 7, 8).

Figure 7: Packaging contraceptive pill
Source: Own representation

Figure 8: Packaging contraceptive pill
Source: Own representation

At the beginning of my encounter with the pharmacist, I felt judged and ashamed by her annoyed reaction. This was the first time I had experienced what some of my interviewees had told me during interviews regarding the social acceptance of contraception and reproductive health. These experiences are described below.

During the conversation with the students from University of Iloilo the teacher asked the students if some of them had tried to get free contraceptives from the local health center. The students immediately responded with “no” and explained that everyone who wants to access contraceptives has to fill out a form with personal information and that the health workers would judge the situation. The teacher responded that she had heard similar information (Observation Protocol 1, Pos. 9).

During some of my interviews and some informal conversations, some Filipinos reacted cautiously when I explained my research topic. Others started giggling and whispering about the topic. During one interview I even thought that the interviewee was uncomfortable talking about this topic, so I apologized (Participant Observation 6, Pos. 24; Participant Observation 9, Pos. 44, 45; Participant Observation 15, pos. 58). These reactions showed me that there is a certain shame about talking about the issue around reproductive health and contraceptive use. Therefore, I asked my interviewees about their views on the social acceptance of contraceptive use in the Philippines. I got various answers, which are described and explored below.

At the Health Center of Dumaguete, I interviewed the midwife and the family planning manager, which were both aged between 45 and 55. When I asked them if they thought that the use of contraceptives was socially acceptable in the Philippines, the midwife answered that, as far as she knew, it was accepted in her circle and that she did not think that women were ashamed to ask for contraceptives and that they were very curious to learn about the advantages and the disadvantages (Interview 1, 152-157). When I asked her about young girls of around 20 years of age who want to access contraceptives at a pharmacy or a drugstore and whether this would also be socially accepted, she told me that "*the drugstore will give you maybe looks*" (Interview 1, 182). In another interview with two young girls from Siliman High School in Dumaguete, aged 17 and 18, one girl answered that she thought it was socially accepted in the Philippines to use contraception, but that it was based on religious beliefs (Interview 2, 105-107).

A 17-year-old boy who also studied at Siliman High School told me that he thought that it was socially accepted to use contraceptives when you already have children. When I asked him if he thought that it was acceptable to use contraceptives before having kids, he said: "*Well some people use contraceptives before having kids, yeah, that's what they do, that's what some doctors recommend*" (Interview 3, 93-106).

A 33-year-old woman who owns a hostel in Dumaguete where she meets young liberal people from many different countries also agreed to be interviewed and explained what she believes is the problem with social acceptance of contraceptive use in the Philippines. She explained that the problem with using contraceptives in health centers is that people are shy because they are afraid to go there.

"[…] if would go to the Barangay health unit, those barangay health workers will know my parents, my family and they will say: "ohh Tweety just asked for contraception", there is no anonymity here, they will always report, that is one problem about going to the public health centers, even if I have the option of free contraception I rather just buy it in a drugstore where nobody will report me, if you can afford it […]." (Interview 5, 202-212)

As she explained this to me, it was clear that she was very frustrated with the situation and the attitude of the health workers.

When I asked her if she ever was ashamed to admit that she used the contraceptive pill, she was clear and said that everyone in her circle was very open-minded and that there is not issue around this topic (Interview 5, 100-102).
A 28-year-old Filipino who works at Amazon in Cebu City and identifies as an atheist explained his thoughts about waiting until marriage to have sex. He explained that he did not think in such a traditional way. When I asked him if his parents ever talked to him about it, he was very specific, explaining, that it is a taboo topic in Filipino families. He further explained that if his parents ever had talked to him about this topic, they would have probably joked about it, but not had a serious conversation (Interview 6, 107-113). He told me that he knew about the option to receive free contraceptives, in the health centers, but stated that he had never went there before.

> "*No, I think it's because of the culture in the Philippines and that it is a taboo, people are looking at you and judge you every time, that's why I don't go there.*" (Interview 6, 117-124)

When I asked him directly if he thought that it was socially acceptable to use contraceptives in the Philippines, he explained that he didn't think it was socially accepted because of the traditional culture, which is still attached to the old times and the church (Interview 6, 136-139). He also told me that when he buys contraceptives in the pharmacy, the pharmacist pretends to not care, but he knows that "*deep inside their minds there is a lot of judgements going on.*" (Interview 6, 162-166)
During an interview with an around 30-year-old nurse at the health center of Moalboal I asked her why they use the term "family planning" for the term "contraception", she explained to me the following:

"*[…] here in the Philippines we are using the family planning method, […] here we consider the family and if we say family planning it is just not so rude like contraception, because if you say contraception, for the husband it's like oh you are using contraception because you don't want to get pregnant from me, I am your husband, is it because you have another man is that why you are protecting yourself? […] we are avoiding terms that are offending people, the word contraception is seen as a negative connotation, so we have another word as well "spacing" between having kids by using family planning, so always light terms, because the term "contraception" is negative*

already, that’s why they call it Reproductive Health Bill and not Contraception Bill.” (Interview 7, 260-274)

Given this statement, it seems that the health center wants to use terms that they perceive as mild for contraceptive use so as not to frighten or offend anyone by, as they said, using terms with a negative connotation. These different connotations seem to stem from a Catholic culture, where doing planning for your family and simply spacing out your births is much more acceptable than just preventing a pregnancy out of context. After all the prevention of a pregnancy could happen in any context, while family planning and spacing always implies the perquisite of a family being fulfilled. When health workers are trying to get Filipinos to use contraception, they cannot use a term that implies pregnancy avoidance and therefore use a culturally sensitive term such as family planning, which implies “planning a family”. This again shows how important it is for a woman in this culture to have children and start a family, as preventing pregnancy is not really accepted.

In conclusion, based on my personal experience at the pharmacy and the data collected from the interviews, it appears that there is a lack of widespread social acceptance regarding the use of contraception among the individuals interviewed and the situations observed. Instead, there seems to be a prevailing taboo and a sense of fear of being judged when it comes to discussing and dealing with this issue.
While a few interviewees expressed personal acceptance and openness to the issue, the majority of people I interviewed revealed deep-seated concerns in real-life situations. They shared a common fear of seeking contraceptives from pharmacies or local health centers because of concerns about potential judgment and gossip from others.
As the 28-year-old Filipino stated this judgmental attitude is tied to the traditional culture, which is still attached to the old times and the church (Interview 6, 136-139).
I would support this hypothesis because the attitudes, especially those of the health care workers, suggest that they are very traditional, just as the Church suggests. Contraceptives are accepted to plan the family, but not to prevent the creation of a family through the conception of children. Besides this hypothesis of mine, social acceptance was linked to religious beliefs by other interviewees.

This belief, propagated by the Catholic Church, ensures that women are more likely to have access to contraceptives if they want to plan a family, and not to prevent a family as a result. Here I would like to draw on the anthropology of gender, which has been discussed in the beginning of this thesis, because it seems that women are assigned to a role, that of wife and mother. As Simon de Beauvoir said, a "woman is not born but made". This explains her understanding of gender as a cultural construct that characterizes men and women according to their physical or biological characteristics (Mascia-Lees & Johnson Black 2017, 72).

However, two nurses at the health center in Dumaguete stated that there were no problems with social acceptance in accessing contraceptives at the health center (Interview 1, 152-157).

The term contraception seems to be very offensive to Filipinos, as the nurse in Moalboal explained, which again shows that contraception itself is not really accepted, but rather family planning is accepted as a term and in practice - planning a family and the need for contraception only for the purpose of spacing pregnancies (Interview 7, 260-274). Through these insights gained from the interviews, I realized that the access to contraceptives for my interviewees seemed to be limited by a judgmental attitude and a taboo surrounding the issue. This leads to a lack of social acceptance and privacy when seeking access through health centers, pharmacies, and drug stores.

As noted at the beginning of the thesis, Catherine Maternowska found in her study "A Clinic in Conflict: A political economy case study of family planning in Haiti" (2000), that women seeking access to family planning services were disempowered in health facilities. She described how the authorities in these facilities often made women feel worthless and dehumanized (Maternowska 200, 122). Rather than empowering women, this situation led to a sense of loss of agency. As a result, Haitian women turned away from these health facilities (Maternowska 2000, 123).

This study found that the barrier preventing women from seeking contraception at health centers in Haiti is not the judgmental attitude of health workers, which is likely rooted in their religious beliefs, as found in the empirical data in this Master's thesis, but rather their disabling behavior. The similarity between the two cases is that in both cases, the behavior and attitude of health workers can be a barrier to women seeking contraception at health centers.

The next section discusses the concept of family planning and what lies behind it in the Philippines.

4.7 “Family Planning is for Families”

The question of whether young, childless, or single women have access to contraceptives at health centers was also important to my research. Therefore, I asked the health workers at the health centers I visited and the private individuals I interviewed about this. Interestingly, the answers I received were all quite similar. These are described below.

During the interview at the health center in Dumaguete, the midwife and the head of family planning both around 40 years old, told me that it was not possible to provide contraceptives to childless women at this health center and that they would never provide contraceptives to childless women. I asked again, describing the situation in which a woman has no children yet and wants to prevent pregnancy in the near future, and asked if this was an acceptable case. They hesitated and finally said yes. However, I could tell that this case was not really acceptable to them. They also said that such a case was very unusual (Interview 1, 124-132).

A similar response was provided to me in the second health center I visited in Dumaguete. When I asked whether childless women would come to the health center to get contraceptives, the nurse replied that this case was very rare and that women usually come to get contraceptives after giving birth. When I asked further if a 20-year-old woman without children could come to the health center to access contraceptives, she replied only: “maybe they buy it on their own in the pharmacy” (Interview 4, 74-81). She further describes:

> “*[…] here we will not allow that one because in our mission we would like those families or those mothers who gave birth will have their spacing, so only mothers after delivery, so if we will give them family planning before, they will be a mother we would encourage them to have a teenage pregnancy.*” (Interview 4, 83-87)

When I asked her why she did not want to encourage people to have sex before having children, she answered, “maybe it’s our culture”. I further asked if this was connected to religion, and she said that it is part of it. In other words, she does not want to encourage sexual activity before people are ready to have children, citing cultural and religious reasons (Interview 4, 74-99).

The nurses at the local health center in Moalboal gave a similar answer, saying: "*[…] actually here in the Philippines it is very seldom for singles to have family planning*". When I asked why, she continued:

> "*In my opinion maybe it's about our culture, in our culture it is a taboo to use contraceptives if you have no permanent partners, because that's the culture of the Filipinos, maybe others will use contraceptives but not in the place where they live, because for them it would be very judgmental, because why are they asking for contraceptives when they don't have a permanent partner.*" (Interview 7, 43-53)

It was striking that the answer to my questions included the phrase "maybe it's our culture" several times. What exactly they meant by their "culture" was not made clear. With this statement, they seem to emphasize that their culture legitimizes them to view, value, and moralize a certain behavior. Therefore, I hypothesize that culture may be in the guise of religion. This hypothesis stands to reason, as 12 out of 14 interviewees identify with the Catholic faith and over 81 percent of the total population is Catholic (Dayley 2020, 147). It seems that the Catholic religion creates these values, norms and rules, e.g. that contraception and therefore sex is allowed, especially if the woman has a steady partner or already has children.
This is also evident in their pro-life stance, as the Catholic Bishops' Conference states in their pastoral letter that they reject the concept of contraception because it reveals an anti-life nature and is fatal to human life (CBCP, 2011).
These rules are legitimized by culture and not by religion, maybe because it is easier and quicker to say it is the because of the culture than to discuss the catholic religion and its rules.
Müller-Funk (2021) describes in his book "Kulturtheorie" the connection between culture and religion as follows: It is obvious to consider religion as the basis of any culture. "Culture" and "religion" are but two sides of the same coin. Culture is the material aspect, religion is the ideal aspect. What is modern about this view is the consideration that the power of beliefs, ideologies, and worldviews is not limited to the intellectual-historical heaven of ideas but enters into the lived culture of people. (Müller-Funk 2021, 35). As mentioned in the beginning of this chapter, culture is a phenomenon

which, as a construction, not only legitimizes power and domination, but is also an inscription of power and domination (Müller-Funk 2021, 33).
When I asked her if it was just about “culture” or if it was also about her own beliefs. She responded:

> “*I don’t know if it is a belief, for us health workers it is normal, but for their family and their friends it is a taboo, but here in health care we will accept any kind of clients that want to avail family planning.*” (Interview 7, 54-57)

She further explained that sometimes single women come to the health center and ask for condoms. I wondered if they had to tell the health workers that they were single. The nurse responded that they would ask if they had a partner. I did not understand why this was important, so I asked her for the reason. She replied: “Because the partner should know”. I therefore asked why it was important that the partner knows. She explained: “*The girl must inform the partner, if it’s part of the family planning, but if it’s for prevention only then we will give*” (Interview 7, 58-68).
I further asked why it was so important for a woman or a girl to inform her partner. She described the following: “*[…] in the Philippines you cannot be a family without a partner, so if we talk about family planning it’s for families if they are availing for family planning […].”* (Interview 7, 73-75)
Based on the statements of my interviewees, it can be said that according to their views or their attitudes, it is difficult for young, single, or childless women to obtain contraceptives in these health centers. This is due to the belief that family planning, and therefore contraceptives, are only for families, so one is required to have at least a partner or a child to have a family. This view comes from their "culture", as they have repeatedly said. This could mean, in particular, the Catholic faith, since they hold mainly Catholic values, such as planning a family and not preventing to have a family by using contraceptives.
The presence of a partner is seen as a prerequisite for family planning, as the health workers felt that only couples can start a family and are then qualified to use family planning services.
This section highlights the immense influence of the concept of family in the Philippines. As mentioned earlier in this chapter, Stephen M. Cherry's book “*Faith, Family, and Filipino American Community Life*” (2014) emphasizes the centrality of the

family in Filipino culture. According to interviewee Viana, “If there is one value universal to the Filipino, it is family” (Cherry 2014, 24). This cultural value may explain why unmarried and childless women have difficulties in accessing free contraceptives at health centers, as family planning is usually seen as a matter for established families. The next section addresses the issue of illegal abortion in the Philippines and explains the different perspectives of my interviewees on this controversial issue.

4.8 “The Child is a Secret”

My interview guideline also contained questions about abortion in general and the morning-after pill. Whenever I started to talk about this topic, I often felt that the topic was uncomfortable for my interviewees. Particularly in health centers, nurses and midwives were reluctant to discuss the issue when it was raised. It took persistent questioning on my part to elicit the information and opinions I was interested in.
When I spoke to a midwife and the family planning manager both around 40 years of age at the health center of Dumaguete, I asked them if it was possible to get the morning-after pill here. They immediately asked me if it was for abortion. I explained that it is not for abortion but only to shift the ovulation. They responded that they don’t have any knowledge about this (Interview 1, 133-139).
Later in the interview, I asked both of them if they knew of any abortion cases here and they explained that they didn’t have any records, and that the hospital might have some records of injured women. I further asked about their views on abortion in general and the midwife responded very sternly and seriously: “*It should be stopped*”. I asked her about cases where women are raped and become pregnant as a result of the crime, and whether this would be a good reason to have an abortion. She responded: “*Yes, actually we know these cases already, when someone is raped, the girl has usually been locked in the house by her parents and she will have the child*”. I asked them if they thought abortion should be legalized in such cases. The family planning manager explained that she thought it should be decided on a case-to-case basis and that it was very important for the mental health of a rape victim (Interview 1, 190-209).
It was shocking for me to hear that women who become pregnant as a result of rape are treated in this way and that it is then reported as if it were completely normal. From

a feminist point of view, this shows me that women are not protected here and are denied the right to decide about their own bodies.
In the second health center I visited in Dumaguete I also asked the midwife and the two nurses about their knowledge regarding the morning after pill and if it is available in this health center. They knew what I was talking about and responded, that they didn't have it in this health center and said that maybe the hospital or a private hospital had it. They added that it might be expensive and that the high price might be because the government doesn't offer it. I further asked about the legality of abortion in the Philippines and one of the nurses confirmed that it is illegal. She further explained that if a woman came for an abortion to the health center that they would not accommodate her and that they would refer her to the hospital. I answered that I think that this woman can't also have an abortion at the hospital because it is illegal. She confirmed and said, that they will refer her to a doctor. Furthermore, I asked if they would know any cases of women who wanted an abortion but couldn't have it (Interview 4, 124-133). The nurse explained:

> "*Yes, we have some news, last year we heard that someone just gave birth and just throw it in the garbage […] but they didn't give birth in the hospital they just gave birth with the help of a "Helo", someone that just uses hands, it's not a midwife or a doctor it's just someone from the community.*" (Interview 4, 134-139)

I was shocked to hear that a woman was forced to throw her child in the trash because she could not have an abortion, and how calmly the nurse told this story.
According to her description a "Helo" is like a healer. She confirmed to know about illegal abortions in general but no case in her area of living. She explained her opinion about abortion and if it should be legal in certain cases:
"*For us a child is a secret that's why we don't want to allow abortion especially because we are catholic here*" (Interview 4, 140-158). I further asked if she would think in some cases it would be acceptable, for example if a woman was pregnant with a disabled child which is likely going to die after birth. She was clear and said: "*No, maybe just advise to deliver and bury it probably*". When I asked about a rape case, she only responded: "*For us abortion is killing an innocent child*" (Interview 4, 140-158).

I was appalled at the significant disregard for women and their health in this discussion. The emphasis on childbirth, regardless of the challenges and health risks involved, completely disregards the position of women and places the unborn child above them. Looking at these statements from the perspective of feminist research, it can be said it seems like that they adopt a restrictive perspective aimed at controlling women's reproductive choices. This points to the presence of social and religious norms and structures that often prioritize control over women's bodies and choices. This results in a lack of agency and autonomy for women, as illustrated by the example of the woman who had been locked up in her home until her pregnancy was brought to term. However, the perspective of the family planning manager, who decides on the legality of an abortion on a case-by-case basis, shows that she recognizes the psychological impact and the importance of the mental health of rape victims.

In my interview with a 33-year-old hostel owner from Dumaguete, I learned that she grew up in a liberal family. Running her hostel now brings her in contact with people from different cultural backgrounds. We also talked about abortion and her opinion about it. She confirmed that abortion is illegal in the Philippines and further explained her own opinion.

> "*[…] for me it's a yes and no, if for myself the baby is still in my belly, now you can diagnose in the first three month if there are any disabilities within this child, if I would know that there is something wrong I am pro-abortion, I am against abortion when I am 17 or 18 years old, a teenager and I was pregnant and I don't want it, no I cannot get an abortion and then I will do all my best to feed that baby, it's my own responsibility, I am pro-abortion especially within gene disabilities and mental disabilities, it's such a burden for the family and then it's very unfair for the siblings also, here in the Philippines you don't get any support if you have a disabled child, you only get a 20 percent discount for things, that's it.*" (Interview 5, 281-292)

She has taken a clear position that she is pro-abortion and anti-abortion, and that this varies depending on the situation.
Subsequently, she shared with me information regarding an illegal drug commonly used for abortions in the Philippines.

> "*Yes, abortion is illegal but there are some women using the Cytotec Pill to have an abortion, the side effect is it can cause abortion, but it's not really for abortion, there is no proper abortion drug here, you can buy it in small pharmacies but it's an illegal selling, you will buy four pills and take two oral and two vaginal, […] there is a very strong bleeding, so if your body is not able to stop the bleeding it can cause severe bleeding and that is really dangerous.*" (Interview 5, 293-301)

She said that her friend had used the Cytotec pill for abortion because she was not ready to have a baby yet and that her partner hadn't wanted the child (Interview 5, 302-307). To the question if she knew about the illegal backstreet abortions in Manila, she responded that she had some information about if from the news. She explained, that it is a legal clinic and a licensed doctor works there, who also did abortions and that these were illegal. I further asked her about rape victims and if it should be legal for them to get an abortion in case of pregnancy, she said:

> "*Yes of course why should the woman suffer, even there is a legal drug for rape victims, if you declare it immediately, let's say I was raped an hour ago I can go to the hospital and get a medication for abortion, it is allowed to be given medication in this case.*" (Interview 5, 317-328)

I asked her if this is the morning after pill, she explains that it's not exactly the same but something similar (Interview 5, 317-328). Unlike the nurses at the health centers, she had a different perspective on rape cases and resulting pregnancies. She also gave me valuable insight into the process of reporting rape to the police and the resulting possibility of obtaining an abortion pill. I found great comfort in her pro-feminist stance on this issue.

A 28-year-old Filipino from Cebu City who works at amazon, also explained to me his position towards abortion and stated that he is pro-abortion because it should be everyone's own choice to decide. I asked him if he knew someone who had an abortion despite it being illegal in the Philippines. He said he knew a lot of these cases and also explained that it is done with the "Cytotec Misoprostol" medicine which can be bought at the black market which was not really a public space but "*[…] it's from a friends, friend, their friends […].*" (Interview 6, 186-201)

During an informal conversation with a woman that worked at the bar in the hostel I stayed at in Moalboal, wich was a liberal place with lots of diverse nationalities staying there, told me that she had tried to terminate her first pregnancy, but the pills she had been given were not the right ones and therefore the attempt had been unsuccessful, and she had had the baby (Informal Conversation Moalboal, 4-5).

In the health center in Moalboal the nurses I interviewed told me that they have never heard of the morning-after pill. After explaining to them what it is, they asked me if it is abortion and I explained that it only shifts the ovulation and that there is not, yet a baby formed when using this. One of the nurses said that this could be a good thing (Interview 7, 275-287).

To summarize the data collected through the interviews on abortion, it can be said that my interview partners certainly knew that abortion was illegal in the Philippines. The health workers in the health centers didn't know what the morning-after-pill was and usually thought at first it is similar to abortion. Some interviewees, mostly the staff in the health center, spoke out strongly against abortions and reported, for example, about a woman who was locked up at home after a rape and forced to continue her pregnancy, being denied access to an illegal abortion. In taking this stance, they clearly prioritized the unborn child over the pregnant woman, adopting an anti-feminist position that denied the woman agency and autonomy over her own body.

The other interviewees who mostly grew up more liberal or live in a liberal environment, said it should be seen on a case-to-case basis. One of my interviewees, who is a 28-year-old Filipino was without a question pro-abortion. A few of my interviewees told me about the drug "Cytotec" or "Cytotec Misoprostol" which can cause an abortion as a side effect, and is used a lot in the Philippines, sold illegally through pharmacies or friends.

The data I collected on abortion in the Philippines shows that the health workers interviewed strongly oppose abortions because of their religious beliefs. Despite the ban on abortion in the country, some women still resort to unsafe methods, putting their health at risk. Women and girls who become pregnant as a result of rape are in a severe situation. However, one respondent noted that it is possible for rape victims to obtain a legal abortion drug if they report the rape to the police immediately. Other interviewees reported that a woman who has been raped can be forced to carry the pregnancy to term against her will. The issue of abortion remains controversial in the Philippines due to deeply held beliefs and social norms.

As Stephen M. Cherry points out in his book Faith, Family, and Filipino American Community Life (2014), Catholicism and family are central to Filipino culture and shape daily life (Cherry 2014, 25). One of the interviewees, Imee, explained that despite the pressure to have more children, she cannot afford to do so and believes that using contraceptives is against her Catholic faith. However, she also participates in pro-life demonstrations and opposes abortion (Cherry 2014, 39). This attitude is related to the strong opposition to abortion in the Philippines, where even the morning-after pill is often considered as causing an abortion.
The next section highlights the importance of the husband in accessing contraception.

4.9 The Husband and his Approval

The role of the husband was not specifically part of my interview guideline but turned out to be an important one during the interviews I conducted. The husband or the partner was usually mentioned when we talked about a woman's decision to use contraception. I was curious to understand why the partner plays such an important role when it should be the woman who needs to make the decision over her own body. Asking this question, I got similar responses of my interviewees.
The first time I stumbled upon this issue was when I talked to the nurses of the second health center, I visited in Dumaguete. I asked the nurses If women could receive condoms at this health center.

> "*Yes, if the husband or the partner likes condom we will give them, before they come we will ask them if your partner agrees if you go on to pills or IUDs.*" (Interview 4, 66-69)

The interviewed nurses at the health center of Moalboal expressed a similar standpoint. One nurse explained to me that the contraceptive method which will be chosen by the woman needed to be approved by the partner as well. She legitimized this statement by explaining that the woman should inform the partner because it is called "family planning" and therefore the partner should know (Interview 7, 33-42).
Later in the Interview we again talked about the position of the husband in the process to receive contraception and one of the nurses explained the following:

> "*[…] in the Philippines you cannot be a family without a partner, so if we talk about family planning it's for families if they are availing for family planning that's why you have to inform, if the partner doesn't know which method the partner is using it will lead to misunderstandings because the male partner would think that his wife doesn't want him anymore, that his wife makes decisions of her own without knowing, so that's why in our Family Planning Form (FP1), there is a question in there: Does your partner know that you will avail the service, to make sure that there is no problem in availing family planning.*" (Interview 7, 71-80)

When I inquired about a situation where a woman chooses a family planning method that her partner does not approve of, I was told that the couple needed to find a solution together and sufficient time is provided to discuss the matter (Interview 7, 81-92). Furthermore, I asked her if she thinks that the male partner has a lot of power in deciding this.

> "*Actually, the purpose of family planning is for the benefit of the family and here in the Philippines a family is with a partner, that's why they inform each other, for me it's actually the woman's decision if she is ready to get pregnant or not and what kind of method she wants to use, but that kind of idea is not very known here in the culture of the Philippines because the husband should know.*" (Interview 7, 81-92)

One of the nurses interviewed was a man so I was curious what he as a man thought about this issue, therefore I asked him specifically what his opinion was.

> "*For me it is a good idea, because I must know what my partner is using because most important is you must agree for everything as a couple here.*" (Interview 7, 93-95)

He went on to explain that it was important to get the man's permission, which he claimed to be a consequence of the cultural reality in the Philippines. When I asked him if he could imagine the situation without the argument of the cultural reality and if

he thought that it were good to make your own decisions without the approval of the partner, he responded:
"*If we are not basing it on the culture, ehm, actually it is good to make your own decisions*" (Interview 7, 96-106).
In this situation, the fact that men have a say over a woman's body was legitimized with the argument of "culture". What exactly is meant by "culture" was not explained in detail. What was explained, however, is that if this debate were separated from the "culture," it would be okay for a woman to make her own decisions about her body. Therefore, I hypothesize that the "culture" mentioned by the interviewees is strongly linked to the Catholic Church and its values, such as the importance of the family.
Another nurse who took part in the interview explained then similarly:

"*For me it's really okay to make your own decision but if you are family, you should inform your husband about it to avoid misunderstandings, or your partner might think that you are having another partner or an affair.*" (Interview 7, 107-109)

The 33-year-old women who owns a hostel in Dumaguete confirmed the preceding points of views by explaining the following:

> "*[…] contraception is not only a decision of the mother they will seek for the decision of the father as well, family set ups in the Philippines are very patriarchal, the husband is the boss, unless the wife is a strong educated woman, but If the woman has no work and the only income is provided by the husband that is very difficult.*" (Interview 5, 255-263)

The interview data highlights the importance of the approval and permission of the husband or male partner when it comes to the access to contraception and family planning services in the Philippines. It was revealed that the permission and support of the husband or partner is often needed for women's access to contraception or family planning services. This may be a consequence of patriarchal family structures in the Philippines, where the husband is seen as the boss, as one interviewee mentioned. When asking why it was so important to get the permission of the partner it was argued that family planning always includes the partner and that it is tied to the Philippine culture. These structures show the importance to understand the concept of

gender as Simone de Beauvoir described in her book “The second Sex” (1953) that societies define femininity and masculinity through symbolic structures, which build a strict pattern of binary oppositions. Beauvoir argues that within this dialectic the man is put in a position of domination and exploitation of the woman (Sanday 1991, 2), as it can be argued in the case of accessing contraception in the Philippines, where the man is given the power or domination to decide over the woman’s body and her reproductive health decisions.
These power dynamics were similarly described in Swanson et al.'s (2019) study, "I have no choice: Influences on Contraceptive Use and Abortion among Women in the Democratic Republic of Congo," in which women also found themselves in a dependent position, having to ask their husbands for permission to participate in family planning programs (Swanson et al. 2019, 133). This problem also occurs in Constanze Weigl's (2010) study "Reproductive Health Behavior and Decision-Making of Muslim Women," in which she explains that women's ability to make decisions about their own bodies and reproductive health is limited by the attitudes and actions of the men or in-laws in their families (Weigl 2010, 233).

4.10 Summary

To summarize the collected empirical data and to answer the question:
“Which cultural factors, that can be connected to Catholic believes influence the provision of free contraceptive services within the local health centers in the Philippines?”, it can be said, that the majority of the persons interviewed stated to identify themselves with the roman catholic church. However, the catholic church was viewed as a critical by some interviewees, as it was seen to hold too much power on issues regarding divorce, contraception, and abortion.
The data revealed that there is a generally little social acceptance of contraceptive use among the interviewees and situations observed in the Philippines. Although some of the interviewees were open-minded about the issue, most expressed fear of condemnation and social stigma if they obtained contraceptives from pharmacies or health centers. However, two staff members at a health center in Dumaguete reported that there were no problems with social acceptance of contraceptives.

It emerged from the interviews that social acceptance was also related to religious beliefs. In addition, the term "contraception" was perceived as offensive by Filipinos, while “family planning” and “spacing” was more accepted.

This suggests that planning a family is more socially acceptable than using contraceptives to prevent children. This can lead to women being expected to be the fertile ones who plan and start a family to fulfill the traditional construct of mother, father and child. This pressure to conform to this traditional gender role can deprive women of the opportunity to explore other aspects of their personal ambitions, and sets an expectation that women will want to become mothers, without taking into account that desires and circumstances vary from person to person.

Both female and maternal roles are gender roles, which means that they can be defined as socially shared behavioral expectations directed at individuals based on their socially ascribed gender (Eckes 2008, 171).

Heidinger (2010) describes that recently, the call to bring children into the world has surfaced in public discussion, although cautiously, but clearly perceptible. If a woman decides against motherhood, she belongs to the selfish new generation that has recently been criticized in the public debate (Heidinger 2010, 148).

The data show that the lack of social acceptance and privacy associated with access to free contraceptives at health centers limits the access of the interviewees. It was reported by the health centers that young, single and childless women have a restricted access to contraceptives due to the belief or attitude that family planning is only for families. Having a partner or a child is considered a prerequisite for family planning, as only couples are considered qualified to access family planning services.

As for abortion, the interviewees knew that it was illegal in the Philippines. The examined data shows that the health providers interviewed strongly oppose abortions because of their religious beliefs and culture, which denies women autonomy and agency over their own bodies. However, some women still resort to unsafe methods to end their pregnancies, which can have serious health consequences.

The data show how important the consent and permission of the husband or male partner is for women's access to contraceptives in the Philippines. This might be due to patriarchal family structures and cultural norms.

As a result, women in the Philippines who seek access to free contraceptives at health centers appear to be constrained in their decisions about their own bodies by a variety of cultural factors. In particular, they often rely on a patriarchal system and must adhere

to social norms and expectations imposed on women and rooted in traditional gender roles in order to access these services.

Overall, it seems that there is a strong tendency toward deeply held beliefs and social norms, which may be related to the influence of the Catholic Church in the Philippines. These deeply held beliefs and related attitudes appear to have a significant impact on attitudes toward access to free contraceptives at health centers in the Philippines. These attitudes appear to limit access to family planning services at health centers and thus to free contraceptives.

The following chapter delves deeper into the analysis of reproductive health policies in the Philippines and highlights the Catholic Church's perspective on these policies. It also provides a comprehensive examination of empirical data on contraceptive accessibility, options and requirements, and the status of sex education among the interviewees.

5. In Between State Policies and Local Health Centers

The upcoming chapter, which is the second empirical chapter of this thesis, will delve into the historical context of the Reproductive Health Law in the Philippines, the arguments for its need, and some of the various oppositional positions against it. It will analyze the reproductive health trends according to the “Updated Philippine Development Plan 2017-2022”, to evaluate the current challenges the country faces in terms of reproductive health in the Philippines.

This chapter will present the empirical data which has been collected in three health centers in the Philippines. The research focused on the reproductive health services offered by the health centers, with particular emphasis on family planning services and contraception. The health workers provided valuable information regarding the services available, the requirements for accessing these services, as well as challenges and problems in providing reproductive health services. In addition, the level of experience with sex education was determined among my interviewees.

Accordingly, this chapter addresses the following sub- research questions:

- To what extent does the Philippine government's biopolitics operate in local health centers, and how does it affect health service delivery and access to reproductive health resources?
- What challenges do health workers face in effectively distributing reproductive health services, and how do these challenges affect access to such services in the Philippines?
- How does sex education affect Filipinos' reproductive health knowledge and related behaviors?

5.1 The Reproductive Health Law

In 1967, the President at that time Ferdinand Marcos joined other world leaders in signing the “Declaration on Population Policy”, which made reducing population growth a top political priority for economic and developmental reasons. By the 1970s, family planning had become an integral part of government development aid funded by the United States Agency for International Development (USAID). While the President Ferdinand Marcos had still tried to reduce the birth rate by distributing free contraceptives, after his fall the focus shifted to medical education and counseling. However, the goal remained the same: to politically steer the population towards lower growth rates. With the adoption of the UN's "Millennium Development Goals", the Philippines also committed to promoting gender equality, especially in the health sector (Prüller-Jagenteufel 2014, 269).
The Millennium Development Goals (MDGs) are a global mobilization effort to address social priorities such as poverty, hunger, disease, education, gender inequality, and environmental degradation. By setting measurable targets, the MDGs promote awareness, accountability, improved metrics, and public pressure (Sachs 2012, 2206). The Philippines faced the challenge of developing its own program when USAID ended its population program in 2003. And so, after a long period of preparation, the hot phase of the debate on the Reproductive Health Bill began in 2010. After the bill was presented to the House of Representatives in February 2011, a fierce media battle followed, in which the bishops and pro-life church groups were heavily involved. Despite massive opposition from the Catholic Church, which also exerted direct pressure on political leaders, the bill passed the House of Representatives and the

Senate by large majorities in December 2012, after being amended on some critical points, and was signed into law by President Aquino (Prüller-Jagenteufel 2014, 269-270).

Then, on March 15, 2012, the laws with implementing rules and regulations were enacted. The most important aspect of these laws is the obligation of the state and health care institutions to provide medically safe contraceptives to the public. To address the concerns of the Church, the law includes a provision that allows health care providers to refuse to provide contraceptives to their patients for reasons of conscience. Shortly after the law was passed, however, the Supreme Court issued a preliminary injunction to hear arguments from critics who claim the law violates the constitutional right to life (Parmanand 2014, 68).

A Supreme Court case challenging the constitutionality of the law delayed its implementation for more than a year. The Supreme Court declared the law as constitutional on the 8th of April 2014 (Genilo, 2014: 1047). The various versions of the proposed law, as well as the adopted text, undoubtedly state that abortion remains illegal and punishable. However, a multidimensional approach to responsible parenthood and family planning is sought, which is declared to be an integral part of the state's fight against poverty (Prüller-Jagenteufel 2014, 271).

The elements of the Responsible Parenthood and Reproductive Health Law from 2012 are the following:

(1) “Family planning information and services;
(2) Maternal, infant and child health and nutrition, including breast feeding;
(3) Prevention of abortion and management of post-abortion complications;
(4) Adolescent and youth reproductive health guidance and counseling;
(5) Prevention and management of reproductive tract infections (RTIs), HIV/AIDS and sexually transmittable infections (STIs);
(6) Elimination of violence against women and children and other forms of sexual and gender-based violence;
(7) Education and counselling on sexuality and reproductive health;
(8) Treatment of breast and reproductive tract cancers and other gynecologic conditions and disorders;
(9) Male responsibility and involvement and men’s RH;
(10) Prevention, treatment and management of infertility and sexual dysfunction;

(11) RH education for adolescents; and

(12) Mental Health aspect of reproductive health care.” (Cabral 2013, 26)

The law mandates that midwives be trained as skilled birth attendants, and that a sufficient number of midwives and other skilled attendants be employed in every city and municipality. Additionally, each city and province must establish and operate hospitals with qualified staff and adequate facilities for obstetric care. Government hospitals are required to provide family planning services, including ligation, vasectomy and intrauterine device (IUD) insertion, as contraception is considered an essential medicine and part of the National Drug Formulary. Reproductive health education should be age-appropriate and provided by trained teachers, while employers must respect the reproductive health rights of their employees and provide free reproductive health services and education. Discrimination against women in recruitment, regularization of employment status, or selection for redundancy is prohibited. Finally, community-based volunteer workers will receive updated training on reproductive health services and will have their fees increased by at least 10% upon successful completion of the training, thereby building their capacity to provide better care (Cabral 2013, 26-27).

The initial version of the Act provided penalties for individuals who engage in prohibited acts, such as intentionally withholding or obstructing the dissemination of information about programs and services offered under the Act, or knowingly providing false information. The law specifically prohibits the denial of an elective ligation, vasectomy, or other legally and medically safe reproductive health service to an adult based on a spouse's lack of consent or authorization. It also prohibits the denial of reproductive health services to an abused minor or an abused pregnant minor certified by an authorized officer or employee of the Department of Social Welfare and Development (DSWD) for lack of parental consent, especially when the parent is the perpetrator (Cabral 2013, 27). It is prohibited to refuse reproductive health services and information based on factors such as marital status, gender or sexual orientation, age, religion, personal circumstances or type of work. Health care providers have the right to conscientious objection based on their religious beliefs but must still ensure that the patient is referred to another health care provider within the same facility or one that is easily accessible, except in emergencies or serious cases. Refusal to provide appropriate initial medical care and assistance in emergencies and serious cases is

considered a criminal offense by hospitals and medical clinics. Finally, it is unlawful to require female applicants or employees to undergo involuntary sterilization, tubal ligation or any other form of contraception as a condition of employment or continued employment (Cabral 2013, 27).

These prohibited acts were changed after conservative groups and the Catholic Church challenged the constitutionality of the Reproductive Health Law. After lengthy deliberations, the Supreme Court finally ruled on the constitutionality of the law, taking more than a year to do so. The Court found the law generally constitutional but invalidated eight specific provisions. Among the invalidated provisions was the requirement of parental consent, except in cases involving minors who had previously experienced pregnancy (Melgar et al. 2018, 3). The law currently requires spousal consent, but there are no penalties for health care providers who bypass this requirement (Republic Act No. 10354). The Philippine Clinical Standards Manual on Family Planning, which was issued after the Supreme Court ruling, states “spousal consent is needed prior to undergoing permanent surgical contraceptive methods” (Philippine Clinical Standards Manual on Family Planning 2014, 5).
The fact that it was possible to change the Reproductive Health Act shows that the Church has a great influence on the debate about women's reproductive health in the Philippines.
The arguments for the importance of the reproductive health law will be analyzed in the next section.

5.1.1 Arguments for the Reproductive Health Law

Prüller-Jagenteufel (2014) explains in his book “Kirche, Ideologie und Politik” that access to family planning information and resources is a fundamental aspect of the human right to health care. It is not intended to be a means of government control over the population, but rather a means for individuals to make informed decisions about their family planning. The implementation of the Reproductive Health Bill, a measure to reduce the high rates of maternal mortality and abortion, is a crucial step in ensuring this right (Prüller-Jagenteufel 2014, 274).

A 2008 study by the Guttmacher Institute, a leading research and policy organization dedicated to advancing sexual and reproductive health and rights worldwide (Guttmacher Institute 2023), found that births and miscarriages resulted in the deaths of approximately 3,700 women, 1,600 of whom did not want to become pregnant. In addition, there were approximately 1,000 deaths and 90,000 hospitalizations due to illegal abortions in 2008 (Guttmacher Institute 2009, 2).

Comprehensive knowledge of pregnancy risks and contraceptive methods, as well as access to quality services and shared decision-making between men and women in pregnancy planning, would help women and their partners have safe pregnancies (Guttmacher Institute 2009, 3).

Prüller-Jagenteufel (2014) mentions that it is important to note that the Reproductive Health Bill does not condone abortion or the use of abortifacient drugs. Rather, it emphasizes the importance of making informed choices about family planning and provides individuals with the tools to do so. Furthermore, the Reproductive Health Bill does not violate the freedom of religion or conscience (Prüller-Jagenteufel 2014, 274). The free provision of reproductive health services should not only ensure their reproductive autonomy, but also contribute to poverty reduction (Prüller-Jagenteufel 2014, 275).

In terms of gender policy, the Reproductive Health Law states that: "Gender equality and women's empowerment are central elements of reproductive health and population and development." (Responsible Parenthood and Reproductive Health Act 2012, Sec.3 (m))

Prüller-Jagenteufel (2014) furthermore describes, that access to effective contraception is crucial, as demonstrated by the discrepancy between the average number of children Filipino women have and the number they desire to have. However, this gap is strongly influenced by social circumstances. Women in the wealthiest quintile, with an average of two births per woman, are relatively close to their desired family size. In contrast, women in the poorest quintile, who have almost six births per woman, far exceed their ideal number due to a lack of education and access to reliable family planning methods. By enabling women to plan their pregnancies and spacing more effectively, access to effective contraception can also reduce the number of high-risk pregnancies (Prüller-Jagenteufel 2014, 275f.).

As a further measure for women's health, the Reproductive Health Law stipulates that, notwithstanding the legal ban on abortion, medical care for post-abortion complications

and all other illnesses resulting from pregnancy and childbirth must be ensured for all sections of the population (Responsible Parenthood and Reproductive Health Act 2012, Sec. 3 (j)).

The provision that illnesses and complications are to be treated “in humane, nonjudgemental and compassionate manner in accordance with law and medical ethics” (Responsible Parenthood and Reproductive Health Act 2012, Sec. 3 (j)) has led opponents of the Reproductive Health Bill to accuse it of implicitly undermining the criminalization of abortion (Prüller-Jagenteufel 2014, 276).

Another gender policy measure is the extension of employee protection to reproductive autonomy: Pregnancy may not be a reason for dismissal and any pressure on employees to prevent pregnancy is prohibited (Responsible Parenthood and Reproductive Health Act 2012, Sec. 23, 3 (c)).

In addition to the arguments in favor of the Reproductive Health Law, the Catholic Church in the Philippines has several arguments against the law, which will be briefly evaluated in the next section.

5.1.2 Arguments Against the Reproductive Health Law

According to Amparita Sta. Maria's article "Titled Interpretations: Reproductive Health Law and Practice in the Philippines" (2019), the enactment of the Reproductive Health Law was heavily influenced by culture, religion, and tradition. Despite the law's aim to benefit women through the provision of comprehensive health services, its enactment, implementation, and interpretation were influenced by political and social dynamics embedded in Philippine culture and governance. The local government's efforts to implement the law have revealed the deeply rooted moral considerations that permeate the Philippine legal system. This has led to a distorted interpretation of the Reproductive Health Law and its provisions for comprehensive health services for women. The result challenges the fundamental principles of women's reproductive autonomy (Sta. 2019, 154-155).

Amparita Sta. (2019) concludes that the enactment of the Reproductive Health Law in the Philippines provided a framework for the promotion and protection of women's right to health. However, implementation of the law has been hampered by resistance from various executive and policy-making bodies, as well as distorted interpretations of the

law. This is due to a lack of appreciation of women's rights and a lack of awareness of international commitments and obligations. To achieve the goal of comprehensive and accessible reproductive and sexual health programs, it is necessary to challenge the boundaries constructed around the law by culture, religion and traditional values (Sta. 2019, 180-181).

In addition to political decision-makers, the Catholic Bishops' Conference of the Philippines has played an important role in criticizing the Reproductive Health law.

The criticism of the bill does not generally contradict the fundamental concerns, but questions individual theses and raises fundamental concerns in three areas (Prüller-Jagenteufel 2014, 277).

The link between contraception and abortion claimed by pro-lifers is also claimed in a document by the Catholic Bishops' Conference, where it is stated that the "contraceptive mentality", ultimately leads to an anti-life attitude that results in an increase in the abortion rate (CBCP, 2011).

Guaranteed access to family planning methods – including artificial contraception and artificial insemination – for the entire population is another point of contention. This means that, in principle, hospitals and health centers must be able to provide these methods (Prüller-Jagenteufel 2014, 277).

> "All accredited public health facilities shall provide a full range of modern family planning methods, which shall also include medical consultations, supplies and necessary and reasonable procedures for poor and marginalized couples having infertility issues who desire to have children" (Responsible Parenthood and Reproductive Health Act 2012, Sec. 7).

However, there is a restriction in relation to adolescents, and a conscience clause ensures that no health worker is obliged to dispense such drugs against his or her conscience. However, there is an obligation to refer to facilities that provide such means (Prüller-Jagenteufel 2014, 277).

In the debate, the Church is keen to make its pro-life position as clear as possible, as the pastoral letter of the Catholic Bishops' Conference's "Choosing Life" shows:

> “The very name ‚contraceptive’ already reveals the anti-life nature of the means that the RH bill promotes. These artificial means are fatal to human life, either preventing it from fruition or actually destroying it.” (CBCP, 2011)

To summarize, the Philippine Reproductive Health Law aims to provide comprehensive health services primarily to women, but its passage, implementation and interpretation have been influenced by cultural, religious, and traditional values. The Catholic Church has strongly criticized the law, arguing that contraception leads to anti-life attitudes that result in an increase in the abortion rate. The law guarantees access to family planning methods, including artificial contraception and artificial insemination, but there is a restriction on teenagers, and a conscience clause ensures that no medical staff will be forced to dispense such drugs against their conscience. Despite the challenges, the enactment of the Reproductive Health Law provides a framework for promoting and protecting women's right to self-determination over their reproductive health, and there is a need to challenge the boundaries that culture, religion and traditional values have erected around the law in order to achieve comprehensive and accessible reproductive and sexual health programs.
The following section will illustrate the reproductive health trends in the Philippines by taking a closer look into the Philippine Development Plan 2017-2022.

5.2 Reproductive Health Trends in the Philippines

The Philippine Development Plan (PDP) is prepared by the National Economic and Development Authority (NEDA), the country's main socio-economic planning agency. The PDP serves as the blueprint for the country's development agenda and provides the overall direction, policies, strategies and programs to achieve sustainable and inclusive growth. NEDA consults with various government agencies, civil society organizations and other stakeholders in the preparation of the PDP, which covers a six-year planning period (Philippine Development Plan 2017-2022, 5).

As outlined in the Updated Philippine Development Plan 2017-2022, there is a recognized need to improve sexual and reproductive health services to address the problem of adolescent and early pregnancy. The Department of Health (DOH) is committed to comprehensive sex education in schools, while both the DOH and the

Commission on Population and Development (POPCOM) are focused on intensifying and improving reproductive health services to address the unmet need for modern family planning (Updated Philippine Development Plan 2017-2022, 182). The unmet need for modern family planning is defined by the United Nations as:

> "Unmet need for family planning is defined as the percentage of women of reproductive age, either married or in a union, who have an unmet need for family planning. Women with unmet need are those who want to stop or delay childbearing but are not using any method of contraception." (United Nations 2014)

To address this unmet need, the Philippine Development Plan states that interventions at the community and facility levels will be implemented, and that family planning logistics will be improved so that family planning commodities are available at the point of use. Family planning skills training will also be provided to health service providers (Updated Philippine Development Plan 2017-2022, 182).

The Philippine Development Plan 2017-2022 explains that some progress has been made in easing the ethnographic transition, particularly in reducing the under-five mortality and female fertility (Updated Philippine Development Plan 2017-2022, 233). The "demographic transition is a long-term trend of declining birth and death rates, resulting in substantial changes in the age distribution of a population" (Tulchinsky & Varavikova 2014, 92).

According to the Philippine Development Plan key policies and programs to improve adolescents' access to sexual and reproductive health have been introduced and strengthened. Efforts have been made to remove legal obstacles to the full implementation of Republic Act (RA) No. 10354, commonly referred to as the Responsible Parenthood and Reproductive Health (RPRH) Act. In addition, efforts have been stepped up to meet the need for family planning services (Updated Philippine Development Plan 2017-2022, 233). This shows that the Reproductive Health Law has still not been fully implemented since the year 2012.

The Philippine Development Plan recognizes that the high incidence of adolescent pregnancy is a major challenge to the country's population growth and human capital development. The strategy proposed in the Philippine Development Plan to prevent unplanned or repeated pregnancies, sexually active adolescents, and children born prematurely includes the provision of age-appropriate sexual and reproductive health

services, including family planning. Efforts are directed towards the full implementation of Comprehensive Sexuality Education (CSE) in accordance with the Responsible Parenthood and Reproductive Health (RPRH) Act (Updated Philippine Development Plan 2017-2022, 238). This indicates that the Reproductive Health Law has not yet been fully implemented and that sex education for adolescents is not yet in place.

To summarize, the Philippines' updated development plan highlights the need to improve access to reproductive health services for adolescents, as the high number of adolescent pregnancies affects population growth. The plan aims to provide age-appropriate sexual and reproductive health and family planning to sexually active and post-partum adolescents.

However, the Reproductive Health Act requires parental consent for adolescents under the legal age to access family planning (Melgar et al. 2018, 3).

The next section illustrates the implementation and recommendations related to reproductive health services.

5.3 Reproductive Health Services – Implementations and Recommendations

One of the key components of the Reproductive Health Law is to provide family planning information and services to all citizens. State hospitals are required to provide family planning services, including ligation, vasectomy and intrauterine device (IUD) insertion, as contraception is considered an essential medicine and part of the National Drug Formulary (Cabral 2013, 26-27). The law made it illegal to refuse reproductive health services and information based on marital status, gender or sexual orientation, age, religion, personal circumstances or type of work, although all religious conscientious objections by health care providers must be respected (Cabral 2013, 27). It was also prohibited to require the consent of a woman’s spouse to receive reproductive health services. This was changed after conservative groups and the church challenged the Reproductive Health Law’s constitutionally. Among other provisions that were removed, also the spousal consent is now required (Melgar et a. 2018, 3; Republic Act No. 10345). The Updated Philippine Development Plan 2017-2022 addressed the need for targeting the unmet need of modern family planning by intensifying and improving reproductive health services.

The unmet need of modern family planning must also be addressed through intensification and improvement of reproductive health services (Updated Philippine Development Plan 2017-2022, 182). “Women with unmet need are those who want to stop or delay childbearing but are not using any method of contraception.” (United Nations 2014)

To solve this problem, improvements are needed in two areas. First, in the community and in health centers, and second, by ensuring that family planning products are easily accessible where and when people need them. In addition, health care providers should be trained in family planning (Updated Philippine Development Plan 2017-2022, 182).

The following section aims to examine these goals by the Philippine state by comparing them with the empirical data collected through interviews and participant observation in three health centers in the Philippines: The main Health Center of Dumaguete, the Barangay Health Center of Dumaguete and the Health Center of Moalboal. Data was collected on various aspects of reproductive health, such as access to contraceptives, the types of contraceptives available, the requirements for obtaining contraceptives, information on general reproductive health services, and the training or profession of the health workers interviewed. Data on the experiences of some of those I interviewed regarding sex education were also analyzed.

The next section describes health centers in the Philippines in more detail.

5.4 The Health Centers

The Philippines currently has about 3,900 primary health care facilities, of which 2,593 are Rural Health Units or Health Centers (RHU/HC). About 50 percent of Filipinos have access to an RHU/HC within a 30-minute travel time, highlighting the need for an additional 2,400 RHU/HCs by 2025, as identified by the Department of Health in 2020. Primary health care services are typically provided in municipalities and cities through RHUs or HCs, while hospitals are usually owned and operated by wealthy urban areas. In barangays or villages, basic health services, mainly health promotion and primary prevention, are provided by Barangay Health Stations (BHS), which function as extensions of RHUs (Department of Health 2020, ii; 19). The governance structure of the Philippine healthcare system is illustrated below (Figure 9).

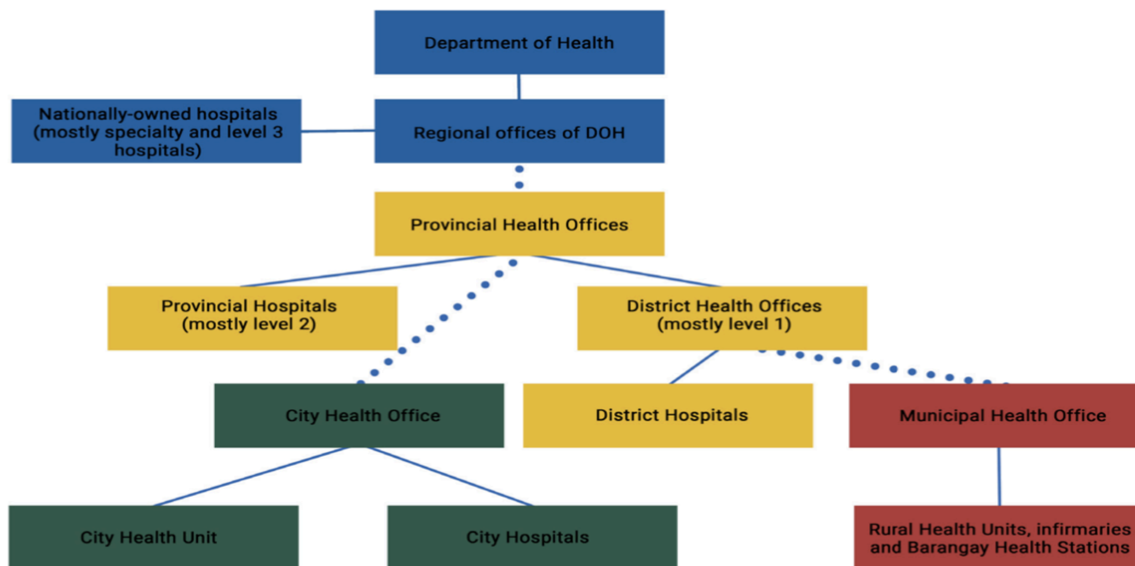

Figure 9: Governance structure of the Philippine health care system
Source: Department of Health 2020, p. 19

Compared to bigger city hospitals known to me, the health centers in Dumaguete and Moalboal are significantly smaller and provide more basic services (Participant Observation 6; 19, Pos 24; 85). This disparity may be due to the relatively small size of these municipalities, with populations of around 130,000 and 30,000, respectively. The Main Health Center in Dumaguete (Figure 10), for example, offers a range of activities including immunization, family planning, and prenatal care (Figure 11). The health center in the Dumaguete Barangay is smaller, consisting of two rooms in a small house, and appears to be suitable for minor emergency treatment (Participant Observation 10, Pos. 47). As primary health care facilities, these centers provide basic services, as stated by the Department of Health (2020, 19). Staff at the health center in Moalboal confirmed that they are not equipped to perform major surgery, including caesarean sections or high-risk pregnancy care, which requires patients to travel 1.5 hours to the nearest government hospital in the larger city of "Carcar" (Participant Observation 19, Pos 85). The family planning manager at the main health center in Dumaguete noted that each barangay or district has its own health center (Interview 1, 30-40)

Figure 10: Main health center of Dumaguete
Source: Own representation

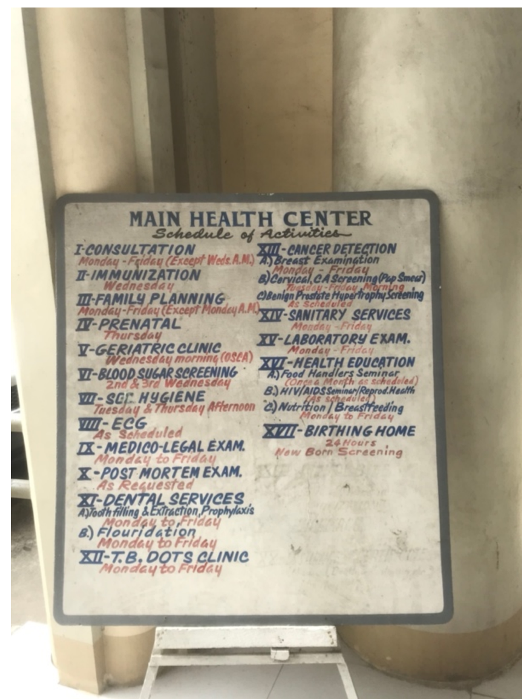

Figure 11: Schedule of Activities
Source: Own representation

During my research at the three health centers, I had the opportunity to interview one family planning manager, two midwives and five nurses. They were all trained in family planning in addition to their main job. At the main health center in Dumaguete, the midwife explained that she was a family health provider, which meant that she was responsible for providing contraception, counseling and screening (Interview 1, 7-19). Similarly, the three nurses at the health center in Moalboal mentioned that they were all trained in family planning and could dispense contraceptives (Interview 7, 6-23).

In addition to family planning services, the midwife at the main health center in Dumaguete also mentioned that they perform "PAP smear tests, which is the primary screening test for detection of precancerous cervical intraepithelial neoplasia and the early stage of invasive cervical cancer" (Sachan et al. 2018, 338), and visual inspections with acetic acid (VIA) to examine the cervix (Interview 1, 7-19). When I asked if a gynaecologist would perform these screenings, the midwife denied it and said that she is trained by the Department of Health to carry out these screenings and tests (Interview 1, 30-40). The next section describes access to free contraceptives at health centers.

5.5 Access to Free Contraception

Whenever we talked about the process of accessing family planning services in the health centers, I got similar answers in all of the three health centers. According to the midwife at the health center in Dumaguete, the process can be described as follows:

> "*Usually they come here especially after delivery or 42 days after delivery, the moment they get pregnant some midwives at the health centers are educating already the pregnant woman about contraception, within the 42 days they have already an idea what to use, any kind of contraception, but we only cater them the ones they choose, we will not choose for them we are only telling them the advantages and disadvantages about this kind of contraception.*" (Interview 1, 48-57)

According to her (Interview 1, 48-57), women typically visit health centers for family planning services after giving birth or 42 days after delivery. Additionally, some midwives provide contraceptive education prior to delivery so patients already have an idea of what to choose. The interviewee emphasized that they do not choose contraception for the patients, but only provide information on the advantages and disadvantages of each method.

Likewise, the midwife at the Dumaguete Barangay Health Center provided the following description of the process:

> "*I will have her sit down and I will ask what she wants, if she is looking for family planning, I will ask her what kind of family planning she wants, and if she says she don't know any family planning contraceptives, I will ask her what do you want the longer time or the shorter family planning like in how many years do you want to have a baby again, and if she says four years, I will advise her the IUD but if she want to have it shorter like condoms or pills, we will not decide what she wants, I will only tell her the advantages and disadvantages and the side effects about the family planning.*" (Interview 4, 18-27)

The midwife explains the family planning process and asks the woman which method she prefers. If the woman is unsure, she is asked how long she would like to wait before

having another child, assuming she already has children. The midwife emphasizes that the decision is ultimately the woman's, and not the midwives. She also explains the advantages and disadvantages of each method.
During my visit to the third health center in Moalboal, the description of access to contraceptives in the health centers was confirmed by the nurse working there, who described an identical process.

> "*First we will assess their knowledge about family planning, then after that we will explain all the family planning options with this flipchart this will guide us through, we will start with the normal cycle, the egg cell and the sperm cell, the anatomy of the male and the female, the menstrual cycle and the ovulation and then if there are no more questions we will explain the methods, starting with the non-permanent methods, the pills, the injections, the condoms and then for the longer methods the IUD, the implant, and then the permanent family planning methods, and after that we will assess what method they want to choose after the explanation, and if they choose the method we will ask if that method is approved by their partner as well*." (Interview 7, 23-34)

In all three health centers visited, the process of seeking family planning services is similar. Women usually visit the health centers during pregnancy or 42 days after delivery to seek family planning services. Some midwives provide education on contraceptive methods before delivery, and patients can choose the method they prefer. The health center in Moalboal takes a unique approach to educating patients about the basics of sex education by using a flipchart. According to the health workers, the decision about which method to use is ultimately up to the woman but attention is also paid to the partners or husbands' opinion and agreement, as discussed in section 4.9.
The following section assesses the contraceptive methods available and the requirements to access these contraceptives at the local health centers visited.

5.6 Contraceptive Options and Requirements of Access

My research, sought to determine the range of family planning and contraceptive options offered by the health centers. All three centers I visited confirmed that all available contraceptive methods are provided to patients free of charge (Interview 1, 140-147; Interview 4, 43-54; Interview 7, 254-256). At the Barangay Health Centre in Dumaguete, I was shown the various contraceptive methods available. First, they introduced me to the Depo injection, known as "Medroxyprogresterone Acetate Depo-Gestin", which they offer (Figure 12). Secondly, they showed me a contraceptive pill called "Ethinyl Estradiol Levonorgestrel Lady", which had a picture of a white Filipina on the packaging (Figure 13). They also showed me another pill called "Ethinyl Estradiol Levonorgestrel Ferrous Fumarate Trust Pill", which also had a picture of a white Filipina on the packaging. They showed me another pill, without packaging, called "Lynestrenol Exluton". Lastly, they showed me the "Manforce" condoms (Figure 14). They explained that they offer two types of contraceptive pills, one for breastfeeding women and another that is a combined oral pill. They also explained that the Intrauterine Device (IUD) is available for free, but that it can only be inserted at the Main Health Center in Dumaguete, the one she showed me was a copper IUD (Interview 4, 18-65) (Figure 15). The midwife at the main health center in Dumaguete confirmed that they provide the IUD insertion free of charge and that she is trained to the procedure (Interview 1, 58-90; 140-147). Similarly, the health center in Moalboal offers non-permanent methods such as contraceptive pills, injections, and condoms, as well as permanent options such as the IUD and the implant (Interview 7, 23-34). All of the health centers visited confirmed that contraception is available and free of charge, as mandated by the Reproductive Health Law (Cabral 2013, 26). Also they had a wide range of contraceptive options reaching from non-permanent methods to permanent methods.

Figure 12: Injection / Depo Provera
Source: Own representation

Figure 13: Packaging contraceptive pill
Source: Own representation

Figure 14: Manforce condoms
Source: Own representation

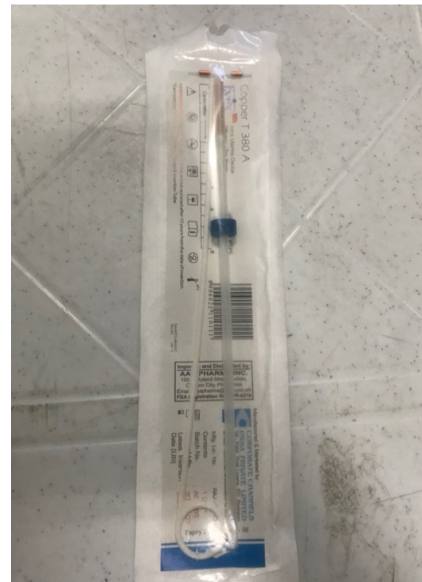

Figure 15: Intrauterine Device (IUD)
Source: Own representation

To access family planning and contraceptive services at the health centers, patients, or "acceptors" as they are called by the Main Health Center in Dumaguete, have to fill out the "Family Planning Form One" (FP Form 1) (Figure 16, 17). This form checks that the contraceptive method chosen is suitable for the acceptor. The form also asks for information about their medical history and their consent, which they must sign. Patients are asked for their address so that their barangay can be determined and they can be advised to the nearest health center (Interview 1, 58-90). If a woman chooses the contraception pill, she receives 28 pills for one cycle and must return to the health center for an examination and check-up using the FP Form 1. The form includes

questions about her medical history, menstrual cycle and any unpleasant side effects (Interview 4, 38-45). In addition, FP Form 1 requires patients to state their level of education, occupation, spouse's name, his highest level of education, his occupation and his average monthly income. Patients also have to indicate the number of children they have, whether they plan to have more children, and their reason for practicing family planning (Family Planning Form 1). The midwife explained that only women who have had children can receive an IUD at the main health center in Dumaguete (Interview 1, 173-180).

The process for obtaining contraceptives is similar at each health center visited. Patients cannot ask for contraceptives, but must first be consulted by health workers and undergo an examination using the Family Planning Form 1, which records all vital signs. This examination must be conducted every time patients seek contraception at the health center. For instance, women taking the contraceptive pill must visit the center every 28 days to receive a new blister pack and undergo a physical examination. Patients with an IUD do not need to visit as frequently, but need to be seen three weeks after the initial insertion, followed by appointments at four and six months later. After these initial check-ups, patients only need to visit the center once a year to monitor their IUD until it needs to be removed after ten years. IUDs are only available to women who have already had children.

In summary, the strict requirements for obtaining contraceptives at these three health centers demonstrate the high level of control that the centers exercise over their patients. Patients using the pill are required to obtain a new pack every 28 days, undergo a medical examination each time, and provide personal information about their family and reproductive intentions. Based on my observations, it seems that the state plays an important role in this process, using its position to gather information about the population and exert control over it.

With these findings, I would like to return to Foucault's biopolitics. As described at the beginning of this thesis, Foucault describes in his work "The Will to Know" a consequence of biopower, namely the growing importance of the norm created by the legal system, which regulates the population not through physical sanctions, but through the creation of norms, views and hierarchies (Foucault, 1978: 144). Along with the concept of biopower, Foucault introduces the concept of governmentality. He argues that the goal of governments is to dispose of people and things, that is, to

regulate all forms of life, bodies, and resources in order to ultimately create, through discipline, people whose bodies are docile and useful. To achieve this goal, the modern state works to increase the efficiency and vitality of people and thus their productivity (Foucault, 2006: 168). Women seeking contraceptives at health centers are required to fill out Family Planning Form 1 (Figure 16, 17), providing detailed personal information. This reflects the biopolitical aspect of monitoring and regulating individual reproductive choices. This form can be seen as a tool for health centers to collect information about a woman's medical history and personal circumstances, including occupation, education, income, and spouse information. This data collection is consistent with biopolitical mechanisms that aim to monitor and categorize women based on their marital status, fertility choices, and socioeconomic factors. By recording the number of children, reasons for family planning, and future childbearing plans, health centers exercise a kind of biopower by shaping and controlling reproductive behavior and population dynamics. The requirement that only women who have already given birth can receive an IUD (Interview 1, 173-180) also reflects a biopolitical regulation of reproductive choices based on certain criteria. This leads to a restriction that shows the state or the Catholic beliefs of health care workers intervening in the decision of who is eligible for certain contraceptive methods, thus exercising control over women's reproductive autonomy and bodies. The concept described by Foucault reflects the reality in the investigated health centers in the Philippines. Patients are subjected to a certain degree of control and management with the aim of optimizing their health. However, it cannot be denied that a significant part of this control is directed towards women and their reproductive behavior.

The following section highlights the government's goal of reducing the unmet need for contraception among the Filipino population to zero.

Figure 16: Family Planning Form 1 side A
Source: Own representation.

Figure 17: Family Planning Form 1 side B
Source: Own representation

5.7 “Zero Unmet Need”

During my research, I had the opportunity to discuss the government's views on reproductive health, family planning, and contraception with some of my interviewees. For example, when I interviewed two young girls from Silliman High School in Dumaguete, they revealed that they were aware of the issue of overpopulation in the Philippines, stating that “*[…] the government wants to have family planning and want them to think what is right and what is wrong.*” (Interview 2, 144-120)

I suspected that the government was promoting the use of contraceptives to regulate the population due to overpopulation problems, during my research. This view was also expressed by a nurse at the Dumaguete Barangay Health Center who said in an interview that the government provides free contraceptives to regulate the population (Interview 4, 119-123). Another interviewee also confirmed that the government promotes the use of contraceptives because of overpopulation problems (Interview 6, 167-177; 241-242).

The staff at the Moalboal Health Center stated that their goal was to train all staff in family planning and midwifery (Interview 7, 16-18). They also explained that under the Reproductive Health Law, the government wants to increase the number of people using family planning services and ensure that no one is left behind (Interview 7, 191-204). The health center uses premarital counseling sessions to educate couples about reproductive health and contraception (Interview 7, 205-211). When I asked the staff if they had any government targets to meet, they explained “the goal is zero unmet need”, which means “*that no families should have an unmet need of family planning, so their needs of family planning should meet, families should use family planning.*” (Interview 7, 254-259) Another interviewee stated: “*And about the Reproductive Health Bill, the president is really pushing us to do the work, we need to encourage the people.*” (Interview 1, 327-328) According to my interviewees, the government puts pressure on health centers to report monthly on the number of people using contraception, which creates a sense of pressure among the staff (Interview 7, 329-333). In fact, they reported that there were fewer than ten new family planning acceptors each month. To increase the number of acceptors, the staff at the health center of Moalboal came up with a solution: they promoted family planning by organizing a "Family Planning Day" throughout Moalboal, where they offered free transportation and food. As a result, they reported that on that day they had 90 new family planning acceptors (Interview 7, 334-341).

Some of the interviewees agreed with hypothesis that the government was promoting the use of contraception to regulate the population due to overpopulation problems. Health center staff in Moalboal stated that their goal was to train all staff in family planning and midwifery and to ensure that no one was left behind under the Reproductive Health Law. According to the interviewees the government pressures health centers to report monthly on the number of people using contraceptives. Overall, the government appears to be actively promoting the use of contraceptives and family planning services to regulate the population and ensure that everyone has access to these services. As mentioned in the section above, these strategies of the government to promote family planning and the use of contraception can be seen as a biopolitical action which aims to regulate the population growth. The governments involvement in surveillance and pressure on the staff of the health centers to report on contraceptive use reflects its interest in managing and controlling population trends. This interest of states in controlling population is also reflected in the term "political demography" used

by Gail Klingman in 1988 to describe state intervention in fertility for political purposes (Andaya 2022, 125).

In their 2012 work, Lynn Morgan and Elizabeth Roberts established the concept of "reproductive governance" which encompasses the mechanisms used by different actors, such as legislative control, direct coercion, economic inducements moral injunctions and ethical incitements to control and monitor reproductive behavior and population practices (Morgan & Roberts 2012, 241ff.). These two concepts can be applied to the Philippine government's approach to controlling and monitoring health centers and their health workers, and by extension, women who use contraceptives.

The next section evaluates the reasons for contraceptive discontinuation reported by health workers.

5.8 Reasons for the Discontinuation of Contraceptives

The staff reported that the reason for many patients to discontinue the use of contraception, is because of side effects they may experience with the method they have chosen. This appears to be a major problem for the health centers, as it seems to be one of the main reasons for less family planning acceptors, as one nurse explains the following:

> "*Even if I would say: this is only a temporary method and if you want kids after three years you can still get them, no they don't want it because of the side effects, even if their mood changes it's always related to the family planning they would still blame it for it, even headache, everybody can have a headache, but they will also judge the contraceptives, and as well other people will easily believe to their misconception.*" (Interview 7, 184-190)

She went on to describe how there are so many people who like to talk about the negative effects of contraceptives that every single issue is linked to the contraceptives. There are even posts on social media promoting the negative side effects of contraceptives. She made it clear that she did not understand why people would believe someone who is not an expert on side effects of contraception rather than health workers. The nurse explained that she thinks that people don't trust the health workers even though they would never give them anything that would harm

them, because health workers were licensed to protect them (Interview 6, 194-203). I asked her why people would not use a condom instead of hormonal contraception to avoid side effects, since a condom has no side effects. She explained that they didn't use condoms because their husband didn't want to use them. I followed this up by asking her about the side effects of the IUD, as there are usually not as many as with hormonal contraception (Interview 7, 348-351).

> "*Yes, I can tell you there is one woman who removed the IUD because she had heavy menstruation, and we explained to her that it is totally normal, but she refused, that even her husband doesn't like it and that her neighbor still got pregnant by using the IUD.*" (Interview 7, 351-355)

I could tell that she was very frustrated with this situation, and she even said that it was sad because they wanted to change the strong beliefs of the Filipinos and help them to self-determine their reproductive health (Interview 7, 356-359).
The staff reported that the side effects of contraceptives are a major problem and appear to them to be one of the main reasons for the lower uptake of family planning. According to the nurse many people do not trust health workers and prefer to believe misconceptions, as they named it, that are spread on social media. This led to frustration among health workers. Surprisingly, health workers did not mention any other factors that led to discontinuation or refusal of contraceptives. Women's lack of trust in health workers could also be due to the fact that they felt too regimented, having to visit the health center regularly, provide personal information, and undergo an examination in order to receive new contraceptives, as described in chapter 5.6. In addition, some of the interviewees felt that the service provided by these centers was characterized by moralizing and judgmental attitudes, which discouraged them from using these services. These findings were shared by other interviewees, as described in section 4.6. In addition, access is more difficult for single and childless women, which may also be a reason for reluctance or fear to use contraception, as described in section 4.7.
The next section assesses the level of sex education received by respondents and health care workers' attitudes toward comprehensive sex education.

5.9 “Disadvantages of Sex Before Marriage”

The Reproductive Health Law states that education and counseling on sexuality and reproductive health, and adolescent and youth reproductive health guidance and counseling should be implemented (Cabral 2013, 26). The Updated Philippine Development Plan 2017-2022 identifies a high number of adolescent pregnancies in the Philippines as a problem (Updated Philippine Development Plan 2017-2022, 182). This is to be addressed by strengthening sexual and reproductive health services. The Department of Health aims to assure a comprehensive sexual education in schools. The strategy calls for age-appropriate sexual and reproductive health services, such as family planning, to be provided to sexually active adolescents and women who have recently given birth (Updated Philippine Development Plan 2017-2022, 238).

Using the empirical data from the interviews with individuals and health professionals about sex education, as well as the observation protocols, the purpose of this chapter is to show the extent to which the interviewees received sex education and from whom, as well as their general views on sex education.

During an interview with two girls aged 17 and 18 from Siliman High School in Dumaguete, I asked them about their knowledge of contraceptives. One of the girls admitted to having limited information on the topic and denied having received comprehensive sex education in school. She explained that although sex education was taught in school, it lacked depth and only emphasized that sexual intercourse was normal within marriage. She described that the risks of pregnancy without using contraceptives was never mentioned in school, but that she learned about it from other sources such as the news and the internet. She also stated that her parents did not discuss sex with her, which she blamed on the fact that Filipino culture is not always open to such topics. However, she did mention, that she sometimes discussed the topic with friends in certain situations (Interview 2, 35-58).

During our interview, I asked the girls about their knowledge of different types of contraception. One of the girls replied that she knew about contraceptive medicines but had a limited understanding of other methods such as the Intrauterine Device (IUD), contraceptive injections and implants. She believed that these methods were not commonly used in the Philippines and were expensive. When I informed the girls that these methods were available in the Philippines, even free of charge in the health centers, both of them were surprised, as they were unaware of this fact. One of the

girls mentioned that she only knew about free condoms being distributed at health centers during certain activities. However, when I asked if they had ever been to a health center, they both replied with a steady "nooo" (Interview 2, 62-81).
During our discussion about sexually transmitted diseases (STDs) and human immunodeficiency virus (HIV), the girls mentioned that they had been taught about these topics in school. They explained that there is a lot of awareness about HIV in the Philippines as the country tries to educate teenagers who may not be fully informed about the issue. However, when I asked them if they knew how to prevent themselves from getting HIV and what contraceptive methods to use, they admitted that they did not know. I explained to them that condoms are the only contraceptive method that can protect them from HIV, and they expressed surprise that they had not known this before (Interview 2, 93-104).
During my research, I also had the opportunity to interview a 17-year-old boy at Siliman High School in Dumaguete. When we spoke about his knowledge of contraception, he admitted that he didn't know anything about it. However, when I probed further and asked if he had ever heard of it, he explained that he had heard people talk about it but had never really looked into it. He also said that he wasn't particularly interested in learning more about it (Interview 3, 34-44).
When I asked him if he knew what the contraceptive pill was, to which he initially said “no”, but then remembered that it was a method of preventing pregnancy. He recalled attending a sex education seminar at his high school, organized by the city to teach students "what to do and what not to do". But when I asked him if he or his girlfriend had ever used a contraceptive method, he said no (Interview 3, 47-55).

While discussing HIV and STDs he stated that he knew about them and how to prevent them. His suggestion for safe contraceptive methods to prevent these diseases was as follows: "Hmm... well, not having sex". When I asked if there were any other methods, he confirmed that this was the only possible method for him (Interview 3, 62-73).
Towards the end of our conversation, I informed him that contraceptives were available free of charge at health centers, and he admitted that he didn't know about this and that no one had ever told him about it (Interview 3, 107-113).
During my interview with a 33-year-old woman who runs a hostel in Dumaguete, we discussed her knowledge of reproductive health. As a trained nurse, she expressed that she had a good understanding of contraception. I was curious to know when she

first learned about contraception, and she shared that it was during high school when her open-minded father explained it to her. She told me that her father always answered her questions about sensitive topics, even those that were considered taboo. The woman even recalled that she had asked her father about the reproductive system when she was only 8 or 9 years old, and that he had given her accurate information about the meeting of the sperm and egg during sex, despite being a Roman Catholic. Interestingly, she mentioned that her mother had the opposite view and avoided such discussions (Interview 5, 67-86).

During the interview I asked if the woman was aware that there was a high risk of pregnancy if she did not use contraception. She confirmed that she was aware of this and that she had learned about it when she was 17, in her first year of college. Curious to know if she had acquired any knowledge on the subject before college, I asked if she had learned about it at school. She explained that her primary and secondary schools, as Catholic institutions, did not offer sex education. Instead, she relied on her friends, who were 10 years older than her, and her father, who had previously discussed contraception with her, to provide her with knowledge on the subject (Interview 5, 90-99).

She told me that her main reason for using contraception was to avoid the risk of contracting STDs or HIV. She told me that sexual health was discussed in her high school health class, but only briefly. She explained that they were taught about using condoms to protect themselves against these diseases, but the focus was more on drug addiction and sharing needles. She also mentioned that during her 4th year of high school, the National Bureau of Investigation (NBI) held talks to inform students about the transmission, effects and consequences of HIV and AIDS. She attributed this to the increased peer pressure to use drugs during this period and the importance of educating students on the issue (Interview 5, 111-125).

At the end of our interview, she emphasized that early sex education in schools was a key issue for her, as she believed it was the only way to bring about meaningful change in the system (Interview 5, 385-388).

During my interview with a 28-year-old man from Cebu City, we discussed his understanding of contraception. He explained that he understood contraception as anything that prevents pregnancy. When I asked if he was aware of other potential risks of sex, such as sexually transmitted infections, he seemed uncertain at first. In response to my question, he admitted that this was also an important consideration.

When I asked him about his education on the subject, he explained that he had taken a course during one semester in college, but that the subject had also been briefly mentioned in high school, but no proper education had been given. He could only recall a few specific contraceptive methods, including condoms, IUDs, and pills, but admitted that he once knew more that he had forgotten. He mentioned that he had only used condoms in the past, but not consistently. However, he was tested for HIV every two months through his work, which was a free service provided to him (Interview 6, 63-104). He mentioned that he was aware that contraceptives could be bought in a pharmacy and that they were also available for free at the health center (Interview 6, 117-120).

When I asked him about his understanding of how the contraceptive pill worked, he explained that he thought it changed hormone levels in the body. He also mentioned that there were potential side effects associated with using the pill, such as mood swings, acne, weight gain and increased susceptibility to illness (Interview 6, 182-185). He mentioned that he had access to contraceptives since he was not yet 18 years old, although he could not remember exactly the age when he first used it. He explained that he had been exposed to the concept of contraception at the age of 13, but at that time he had been only informed about preventing pregnancy and not about the risks of sexually transmitted diseases. He attributed this to his young age at the time (Interview 6, 250-254).

While staying in a hostel in Moalboal, I had the opportunity to talk to a 39-year-old Filipina woman. She was a mother of three and worked as a bartender in the same hostel. Despite her dedication to her job, her income was limited and she lived under modest conditions - she lived in a small house with her husband and two children. She confided in me that she knew nothing about contraception until she had her first child. According to her, none of her friends knew about it either, and none of them had ever used the pill. She explained that she was aware of the risk of pregnancy but thought that since nothing had happened the first time she had sex, she would be safe the next time. When asked about her menstrual cycle, she admitted that she did not know anything about it and just assumed that as long as she knew when her period was due, everything would be fine (Informal Conversation Moalboal, 8-17). She also shared that she had dated a man from Canada who stressed the importance of using contraception. At first, she thought he wanted her to use it because he didn't trust her about sexually transmitted diseases. Eventually she understood the importance of

contraception and started using it herself (Informal Conversation Moalboal, 91-94). Towards the end of our conversation, I asked her if she planned to teach her children about contraception. She replied in the affirmative, stating that she intended to educate all her children. She went on to explain that even her six-year-old daughter had some knowledge of the pill, and her teenage son carried a condom in his wallet (Informal Conversation Moalboal, 133-137).
During my visit to the health center in Moalboal, I interviewed three nurses and raised the issue of young mothers in the Philippines. I asked them what they were doing to address the problem. One of the nurses gave the following response:

> "*About this we have the healthy and young one's education and the responsible youth, we explain to them the pros and cons about pre-marriage sex, but not about family planning, it's only about to be a responsible teenager and what are the consequences.*" (Interview 7, 114-120)

She explained that the children were between 13 and 14 years old and that they would be taught about the process of fertilization between sperm and egg. They would not be taught how to prevent pregnancy. When I inquired about the lack of this component, she replied that she thought it was important in general, but that children at that age were not mature enough to process such information. Another nurse attributed this attitude to the influence of the Roman Catholic Church. I expressed my confusion at her reluctance to prevent teenage pregnancy through comprehensive sex education, to which she replied:

> "*Yes, but this is still not part of the education, we are limited to the education about how the baby is built, and it's not advisable for early young age to teach about contraception.*" (Interview 7, 121-136)

When I repeated my question about possible solutions to prevent teenage pregnancy among adolescents and children, one nurse suggested that the solution was "abstinence" (Interview 7, 137-145). Later in the interview, the nurses informed me about the "pre-marriage counseling" sessions that take place every Wednesday at the Moalboal Health Center. They explained the following:

> "*That's a strategy, so as soon as they want to get married they need to have the mandatory to have the counseling, so whenever they sign up for marriage at the city they need to make an appointment for the counseling, we will inform them about responsible parenthood and family planning and contraceptives, we will discuss everything around this topic.*" (Interview 7, 206-211)

The nurse went on to clarify that couples had to show proof of attending the premarital counseling before they could proceed with their marriage. When I asked her about the level of knowledge among the couples who had attended these counseling's, she informed me: "*They don't even know condoms, they don't know what pills are*" (Interview 7, 212-217).

The fact that couples who want to get married are required to attend a premarital seminar shows the power and control of the state. This power can be linked to Foucault's (1988) concept of biopower. According to Foucault, the biopower of the state leads to the appropriation of life by political power and thus regulates all collective life. (Foucault, 2006: 110). The state's regulation and requirement for couples to attend this seminar is a significant exercise of the state's power over its inhabitants.

As the interview came to an end, I asked the nurses if they would teach their own children about sex and protection when the time came. One nurse replied unequivocally that she would give her son full information on the subject. Another nurse stressed the importance of focusing on the younger generation and expressed hope that the health center's efforts would yield positive results in the future, if not immediately (Interview 7, 316-322).

During my visit to the health center of Moalboal, a nurse at the front desk showed me the flipcharts used in premarital counseling, which serve as a basic sexual education tool. The flipcharts cover a range of topics, including sexual organs, pregnancy and contraception (Participant Observation 19, Pos. 85). I also asked if she knew about sex education in schools, to which she responded that there wasn't any real sex education. Nurses from the health center would occasionally visit schools to discuss the "disadvantages of sex before marriage", which focused mainly on sexually transmitted diseases rather than contraception. According to her, this is the first time some students receive real sex education. Otherwise, some students would look online for information, which wasn't possible before the advent of the internet.

In summary, some of the interviewees plan to provide sex education to their children, but what that means varies between them. For some this includes teaching about contraception. But for many their idea of sex education for children is to teach abstinence before marriage, aligning more with the view of the Catholic Church.
Although the state wants to address the problem of adolescent pregnancy, its approach seems limited to providing age-appropriate sex education exclusively to sexually active adolescents or those who already have children. Although the Reproductive Health Act aims to provide sex education to all adolescents, the state seems to struggle with effective implementation, resulting in little or no exposure to comprehensive sex education among the interviewees. This problem seems to be exacerbated by the cultural aspect and the strong influence of the Catholic Church.
With the exception of one person, none of the interviewees appear to have received comprehensive sexuality education at school or at home. This person reported having an open-minded father who was willing to teach her in this area. The others relied on getting information from sources such as the news, the Internet, or friends. Health workers emphasize that comprehensive sex education is mandatory for couples getting married. For many Filipinos, this is their first encounter with education and information about responsible parenthood, family planning, and contraception. In this context, the state exercises a form of biopower over these couples, placing them in a position of dependency, since the premarital seminar is a mandatory requirement for marriage. Interestingly, the emphasis on comprehensive sex education seems to be more pronounced during the premarital period than during the school years.
Two of the interviewees mentioned that they received comprehensive sex education during their college years.
In particular, education about sexually transmitted diseases appears to be a high priority, as all interviewees who were asked about this topic demonstrated knowledge and felt that they had received adequate education on this topic during their school years.

5.10 Summary

To conclude this chapter, the data examined indicates that the three health centers provide access to reproductive health services as required by the Reproductive Health Law. The health centers are trained to provide family planning services and offer various contraceptive methods. Patients must meet strict requirements to receive these services, such as filling out a detailed form and undergoing regular medical examinations. This can lead to a sense of control and dependency of patients on the health centers. Health centers are also under pressure from the government to report the number of new patients each month, leading to a sense of control over health center staff. According to the health workers the side effects of contraceptives and related information spread on social media contribute to lower uptake of family planning.

In the scope of the sex education provided by schools, the interviewees reported, that they did not learn about the topics of contraception, instead, they educate themselves through the news, the Internet or through friends. The interviewee with the most comprehensive sex education during her youth was taught by her father.

Comprehensive sex education becomes mandatory when couples plan to get married, ab obligated by the Philippine government. For some Filipinos this is the first opportunity to learn about responsible parenting, family planning, and contraception. Two of the interviewees reported to have received comprehensive sex education in college. Finally, education about sexually transmitted diseases seems to be more important, as all of the interviewed people stated to have received education about HIV and STDs in school.

6. Conclusion

The aim of this Master's thesis was to determine the extent to which women in the Philippines are influenced in their reproductive behavior by health policies, local health centers and the Catholic Church. This was examined through qualitative interviews with health workers in the local health centers and private individuals, as well as participant observation and an extensive literature review. The data was evaluated by using the qualitative content analysis by Mayring (2016).

Foucault's biopower (1988) is a fundamental part of this thesis because it explains how the power of the state affects the population. According to Foucault, the legal system plays an important role in regulating the population not through physical sanctions, but through norms, views, and hierarchies (1978, 144). His concept of governmentality claims that the aim of governments is to regulate all forms of life in order to create healthy and productive people (Foucault 2006, 168).

To provide a comprehensive answer to the research question, it was crucial to examine the broader context surrounding it, particularly the position of women in society. An examination of the anthropology of gender was therefore essential, with a particular focus on gender inequality, a topic widely discussed by scholars such as Simone de Beauvoir, Margaret Mead and Henrietta Moore. De Beauvoir argued in "The Second Sex" (1953) that all societies have symbolic structures that rigidly define femininity and masculinity, with men occupying a position of dominance and power over women (Sanday 1991, 2). In "Sex and Temperament" (1963, first published in 1953), Margaret Mead explained how personality traits and social labels are closely related to gender. Henrietta Moore’s book "Feminism and Anthropology" (1988) addressed the significant role of the state in regulating women's lives, fertility and sexuality through laws based on assumptions and ideologies about women's roles in society (Moore 1988, 128).

It was essential to consider the anthropology of reproduction for a comprehensive investigation of women’s reproductive behavior in the Philippines.

Therefore, the results of four previous studies on similar topics were examined. These studies by Swanson et al. (2019), Weigl (2010), Stark (2000), and Maternowska (2000) found that several factors influence women's reproductive behavior, including seeking permission from their husbands to use family planning services and contraceptives, pressure from parents or in-laws to have many grandchildren, religious beliefs, poverty,

inadequate quality of government health facilities, gender role expectations, and perceptions of family planning as an incapacitating or political experience.
It was important to consider the role of government in shaping population. Lynn Morgan and Elizabeth Roberts (2012) discuss the concept of "reproductive governance", which encompasses the ways in which different groups, including government and religious institutions, use different tools, such as laws, to influence and regulate population practices and reproductive behavior (Morgan & Roberts 2012, 241). Examples include the past pronatalist policy of the Romanian dictator Nicolae Ceauşescu as and the more recent one-child-policy (1980-2016) of China (Andaya 2022, 125).

Stephen M. Cherry (2014) has noted that family and faith are the two pillars of Philippine culture (Cherry 2014, 24). According to Dayley (2020), over 81% of the population of the Philippines identifies as Catholic (Dayley 2020, 147). This is a result of the Spanish colonization of the Philippines from 1521 to 1898, during which the Catholic faith was introduced to the country (Cherry 2014, 25-26). It was not until 1987 that the Philippine constitution explicitly stated the separation of church and state (Pangalangan 2015, 563). Nevertheless, the Catholic Church in the Philippines continues to exert tremendous influence on state decisions today, as was most evident in the implementation of the 2012 Reproductive Health Law (Genilo 2014, Herrin 2012, Batalla & Baring 2019). Experiencing the Sinulog festival myself showed me the importance of the Catholic religion in the Philippines.

To answer the sub-research question: *Which cultural factors, that can be connected to the Catholic believes, influence the provision of free contraceptive services within the local health centers in the Philippines?* it can be concluded that the Catholic beliefs of health workers significantly influence the access to family planning services and contraception in the local health centers in the Philippines.
Almost all interviewees identified themselves as Roman Catholic, with the exception of a few who were critical of the Catholic Church. The data showed that social acceptance of contraception is low among the interviewees, with many individuals fearing judgment from health workers or pharmacists when accessing contraception. It seems natural that this lack of social acceptance, along with fear of judgment and lack of privacy can lead to limited use of reproductive health services. Health workers,

on the other hand, did not see social stigma as a significant barrier to accessing free family planning services at health centers.
The health centers confirmed that they only offer these services to families and not to young, single or childless women, a position that they base on the argument that a family must be formed before family planning services can be provided. As a result, women without families seem to have limited or no access to reproductive health services. In addition, the term contraception was observed to have a negative connotation, even being avoided. Instead, the term family planning is used, conveying the picture that these services are only for families. This picture resembles closely the concerns of the Catholic Bishop's Conference expressed in their pastoral letter "Choosing Life", were they stated that the name contraception reveals an anti-life stance (CBCP, 2011).
The observed requirement for a spouse's consent for reproductive health services in the health centers mirrors closely the amendments that were made to the Reproductive Health Law, such as the requirement of the spousal's consent (Republic Act No. 10354), evidencing a strong influence of the Catholic Church in reproductive health at the very practical level of the lived reality of Filipino women.
While health workers were opposed to abortion because of their religious beliefs, some private individuals believed that it should be decided on a case-by-case basis or even legalized. However, the data also shows that the illegality of abortion means that many women still resort to unsafe methods to terminate their pregnancies, which can lead to serious health consequences. The restricted access to abortion, shows that control over the female body takes precedence over the welfare of the woman. This control may have resulted from sociocultural norms.
To conclude, the belief is observed that access to family planning methods should be limited to families, which is consistent with the pro-life stance of the Catholic Church. This stance also extends to opposition to abortion, even in cases of rape, further underscoring the Catholic Church's stance on reproductive issues. In addition, it should be noted that the Catholic Church's requirement that men consent to contraceptive and family planning services is also of great importance to medical professionals in the Philippines, although they would not be penalized if they could not prove consent.

With regard to the sub-research question: *To what extent does the Philippines government's biopolitics operate in local health centers, and how does it affect health*

service delivery and access to reproductive health resources? it was observed, that there are certain requirements for accessing family planning services and contraceptives at health centers. The Reproductive Health Law, signed in 2014 after facing opposition from catholic critics who claimed it violated the constitutional right to life (Genilo 2014, 1047; Parmanand 2014, 68), guarantees the right to family planning information and services, reproductive guidance and counseling for adolescents and young people, and education and counseling on sexuality and reproductive health, among other provisions (Cabral 2013, 26). However, this access to reproductive health services is tied to numerous conditions.

The women who seek these services must provide detailed personal information about their socio-economic status and undergo a medical examination before receiving a contraceptive. Women who use the pill must return to the health center every 28 days for a medical examination and to receive the pill. These requirements result in a degree of state control over health centers and patients. This can be seen as biopolitics emanating from the government and applied to the population through the health center.

The government's efforts to increase family planning use and to ensure access to contraceptive services are reflected in its goal of "zero unmet need", meaning that every family that wants to delay or stop childbearing should use a contraceptive method (United Nations 2014). Health workers have reported that they are under pressure to improve their performance and to submit monthly reports on the number of new users of family planning services. This pressure suggests that they are expected to meet certain targets set by the government. These findings suggest that the Philippine government is actively promoting contraceptive use to regulate population size and maintain access to family planning services. It also highlights the government's exercise of biopower over health workers, as they are subject to external control and monitoring in their efforts to achieve these goals.

Concerning the sub-research question: *What challenges do health workers face in effectively distributing reproductive health services, and how do these challenges affect access to such services in the Philippines?* it was evaluated that health workers identified significant barriers to promoting family planning, even though they offer family planning services and a wide range of contraceptive options at the local health centers. The health workers reported that side effects contribute to low uptake of family

planning services and contraceptive discontinuation. Moreover, they stated that many Filipinos do not trust health workers and rely on information from non-professional sources, and especially information spread through social media. It is also possible for other factors to contribute to the low uptake of contraceptive use, like the scrutiny, the requirements for access and judgment that the interviewees reported to experience from health workers and their communities. These norms can place women in a submissive role and prevent them from making decisions about their own bodies and reproductive health.

Regarding the sub-research question: *How does sex education affect Filipinos' reproductive health knowledge and related behaviors?* it was identified that the sex education that private individuals reported to have received at school did not cover topics such as contraception and they had to rely on the news, the Internet or friends to get information. However, they did receive education about HIV and STDs, which seemed to be considered more important. Health workers mentioned that they occasionally visited schools to talk about the "disadvantages of sex before marriage", but that this mainly focused on the negative aspects such as STDs and that it did not cover contraception. These findings are underlined by a significant number of adolescent pregnancies, which were recognized as an urgent problem in the Philippine Development Plan 2017-2022 (p. 238). It was further mentioned that comprehensive sex education was only provided by the health center when a couple wanted to get married, as this was a requirement. For many Filipinos, this may be their first opportunity to learn about reproductive health. This requirement also shows a certain degree of control and power of the government over the Filipinos and a certain degree of dependence of the couples who can only get married if they fulfill this requirement.

With respect to the research question *"To what extent are women in the Philippines influenced in their reproductive behavior by health policies, local health centers and the Catholic Church?",* this work highlights many probable ways in which health policies, local health centers and the Catholic Church are playing important roles in shaping the reproductive behavior of women in the Philippines.
The Philippines is a predominantly Catholic country, and as such the Catholic Church's opposition to artificial contraception has a significant impact on the reproductive behavior of Filipino women. The Church's influence can be seen in many ways, from

shaping the government's reproductive health bill to determining who qualifies as a family and therefore has access to family planning health services. These deep-rooted attitudes are still strongly embedded in the beliefs of Filipino society today.
The Reproductive Health Act, intended to improve access to reproductive health services, was implemented against the Catholic Church's opposition, and only after making amendments demanded by the Catholic Church. However, despite the availability of family planning and contraceptive options in health centers, it seems that women and health workers face several barriers to accessing and providing these services. Interviewees expressed fear of being judged by health workers when obtaining contraceptives, and a lack of privacy is indicated due to the need to provide private information. The Husband's consent and the need to have children or be in a relationship can be additional barriers to family planning services. The government puts pressure on health workers to meet the goal of ensuring that every family has access to contraception. Accordingly, women find themselves in a submissive position, surrounded by judgmental attitudes, biopolitics, and gender role expectations.
In addition, sex education for adolescents and young adults is limited to information on HIV and STDs and discouraging premarital sex. Comprehensive sex education is only required when a couple wants to get married.

This Master's thesis highlights a complex interplay of factors: individuals who want to access family planning services but face obstacles for the reasons mentioned previously; the Catholic Church, which holds a pro-life stance, the health workers with a moral code similar to the stance of the Catholic Church, and the Philippine government, which wants to regulate the population through biopolitics and to provide family planning health services to all citizens. As a result, women find themselves in a difficult and harried situation, caught between the policies of health centers, the control of the government, and the power of the Catholic Church, which can have a profound effect on their reproductive choices and overall well-being.

7. Limitations and Outlook

This Master's thesis is based on data which has been collected during a research visit in January 2020 which lasted about 3.5 weeks due to the constraints imposed by the Covid pandemic. The study was conducted in five specific locations: Dumaguete, Iloilo, Moalboal, Malapascua, and Cebu City. Due to the short duration of the study, only three health centers were visited and a total of eight health workers were interviewed. Personal interviews were conducted with five individuals and informal conversations with four individuals. As a result, the research is limited to a smaller dataset than originally intended, as it was not possible to return to the Philippines to collect more data due to the outbreak of Covid in March 2020.

Therefore, this thesis provides a limited insight into the situation in the Philippines. Due to the data's limited extent a comprehensive and definitive answer to the research question cannot be provided and a further field research in the Philippines is recommended to achieve this goal. It is particularly important to pay attention to the experiences and views of women seeking family planning services at health centers. The upcoming Philippine Development Plan should be considered, to determine the extent to which the Reproductive Health Law has been implemented.

Reproductive health remains a controversial issue not only in the Philippines, but also in various countries around the world, as the factors discussed in this Master's thesis are not exclusive to the Philippines but are also found for instance in European nations. Overall, continuing this study and conducting similar studies is an essential step towards achieving women's sexual self-determination and gender justice worldwide.

Bibliography

Alip, Eufornio (1950). Political and Cultural History of the Philippines, Volume I and II. Alip and Brion Publications: Philippines.

Barnouw, Erik et al. (1989). International Encyclopedia of Communications. Eds. Vol 2, New York: Oxford University Press.

Batalla, E. V.; Baring, R. (2019). Church-state separation and challenging issues concerning religion. Religions, 10(3), 197.

Becker, R. and Kortendiek, B. (2008). Handbuch Frauen- und Geschlechterforschung : Theorie, Methoden, Empirie. 2., erweiterte und aktualisierte Auflage. Wiesbaden: VS Verlag für Sozialwissenschaften / GWV Fachverlage GmbH, Wiesbaden.

Besnier, N. (2009). Gossip and the Everyday Production of Politics. Honolulu: University of Hawaii Press.

Besnier, Niko. (1996). Gossip. In: Encyclopedia of Cultural Anthropology. David Levinson and Melvin Ember, eds. Vol. 2, pp. 544–547. New York: Henry Holt.

Brenneis, Donald L. (1989). Gossip. In: International Encyclopedia of Communications. Erik Barnouw et al., eds. Vol. 2, pp. 225–226. New York: Oxford University Press.

Burch, Thomas K. (1995). Book review of Robert McClory's Turning Point: The Inside Story of the Papal Birth Control Commission, and How Humanae Vitae Changed the Life of Patty Browley and the Future of the Church, in Population and Development Review, Vol. 21, No. 4, pp. 882–885.

Burch, Thomas; Gail A. Shea (1971). "Catholic Parish Priests and Birth Control - A Comparative Study of Opinion in Colombia, the United States, and the Netherlands," Studies in Family Planning, Vol. 2, No. 6, pp. 121–136.

Catholic Bishops Conference of the Philippines (CBCP) (1969). 'Statement of Bishops on Public Policy Regarding Population Growth Control', CBCP Online, July 4, 1969. https://cbcponline.net/statement-of-the-catholic-bishops-on-public-policy-regarding-population-growth-control/ [accessed 22.07.22]

Catholic Bishops Conference of the Philippines (CBCP) (1973). 'Pastoral Letter of the Catholic Hierarchy of the Philippines on the Population Problem and Family Life', CBCP Online, December 8, 1973. https://cbcponline.net/pastoral-letter-of-the-catholic-hierarchy-of-the-philippines-on-the-population-problem-and-family-life/ [accessed 22.07.22]

Catholic Bishops Conference of the Philippines (CBCP) (1990). 'Pastoral Letter on Population Control Activities of the Philippine Government and Planned Parenthood Associations', CBCP Online, October 7, 1990. http://cbcponline.net/love-is-life/ [accessed 22.07.22]

Catholic Bishops Conference of the Philippines (CBCP) (2011a). "Proclaim Life ... In Season and Out of Season", CBCP Online, July 22, 2011. http://cbcponline.net/proclaim-life-in-season-and-out-of-season/ [accessed 27.07.22]

Catholic Bishops Conference of the Philippines (CBCP) (2012). 'Contraceptives is Corruption,' CBCP News, December 15, 2012. https://cbcponline.net/contraception-is-corruption-a-cbcp-pastoral-letter-on-the-latest-decision-on-the-reproductive-health-bill/ [accessed 27.07.22]

Catholic Bishops Conference of the Philippines (CBCP), (2011). 'Choosing Life, Rejecting the RH Bill', CBCP Online, January 30, 2011, accessed 27.07.22. https://cbcponline.net/choosing-life-rejecting-the-rh-billa-pastoral-letter-of-the-catholic-bishops-conference-of-the-philippines/ [accessed 27.07.22]

Cherry, S.M. (2014). Faith, Family, and Filipino American Community Life. New Brunswick, NJ :: Rutgers University Press.

Clarke, Adele E. (2014). Feminism, Grounded Theory, and Situational Analysis Revisited. In: Hesse-Biber, Sharlene N. (HgIn.): Handbook of Feminist Research. Theory and Praxis. Thousand Oaks: SAGE. 1-27.

Concepcion, Mercedes B. (1973). “Philippine Population Policy and Program”, in Vitaliano R. Gorospe and Richard L. Deats, eds., 1973, The Filipino in the Seventies: An Ecumenical Perspective, Quezon City: New Day Publishers.

Dayley, R. (2020). ‘The Philippines’, in Southeast Asia in the New International Era. 8th edn. Routledge, pp. 147–176.

Deats, Ricahard (1967). Nationalism and Christianity in the Philippines. Southern Methodist University Press: Dallas, Texas.

Department of Health (2020). Philippine Health Facility Development Plan 2020-2040. Investing in resilient and sustainable health facilities towards Universal Health Care. Health Facility Development Bureau.

Eckes, Thomas (2008). Geschlechterstereotype: Von Rollen, Identitäten und Vorurteilen, in: Handbuch Frauen- und Geschlechterforschung: Theorie, Methoden, Empirie, hrsg. v. Ruth Becker und Beate Kortendiek (Geschlecht und Gesellschaft 35), Wiesbaden 2008. 171–182.

Emerson, Robert M.; Fretz, Rachel I.; Shaw, Linda L. (2011). Writing Ethnographic Fieldnotes. Chicago/London: The University of Chicago Press.

Finkle, Jason L.; C. Alison McIntosh (1994). The New Politics of Population: Conflict and Consensus in Family Planning, Vol. 20 (Suppl.), Population and Development Review.

Foucault et al. (2006). Geschichte der Gouvernementalität. 1, Sicherheit, Territorium, Bevölkerung: Vorlesung am Collège de France 1977 - 1978 / Michel Foucault. Hrsg. von Michel Sennelart. Aus d. Franz. von Claudia Brede-Konersmann u. Jürgen Schröder. Orig.-Ausg., 1. Aufl.. Frankfurt am Main: Suhrkamp

Foucault, M. (1978). The History of Sexuality. Volume I. An Introduction. New York: Random House.

Foucault, M. (1988). Sexualität und Wahrheit. 1, Der Wille zum Wissen. Neuaufl., 2. Auflage. Frankfurt am Main: Suhrkamp.

Genilo, E.M.O. (2014). ‘The Catholic Church and the Reproductive Health Bill Debate: The Philippine Experience’, In: The Heytrop Journal, pp. 1044-1055.

Guttmacher Institute (2009). Meeting Women’s Contraceptive Needs in the Philippines.
https://www.guttmacher.org/sites/default/files/pdfs/pubs/2009/04/15/IB_MWCNP.pdf [accessed 01.05.23]

Guttmacher Institute (2023). About. https://www.guttmacher.org/about [accessed 01.05.23]

Haviland, John B. (1977). Gossip, Reputation, and Knowledge in Zinacantan. University of Chicago Press: Chicago and London.

Heidinger, I. (2010). Das Prinzip Mütterlichkeit – geschlechterübergreifende soziale Ressource : Gegenstandstheoretische und handlungsorientierte Perspektiven. Wiesbaden: VS Verlag für Sozialwissenschaften / GWV Fachverlage GmbH, Wiesbaden.

Herrin, A. N. (2016). Education, earnings and health effects of teenage pregnancy in the Philippines. United Nations Population Fund.

Herrin, Alejandro N. (2002). Population Policy in the Philippines 1969–2002 (Makati City, Philippines: Philippine Institute of Developmental Studies, Discussion Paper Series 2002–08.

Hesse-Biber, S.N. (2014a). Feminist research practice: a primer. 2. ed. Thousand Oaks, CA [u.a.]: SAGE Publ.

Hesse-Biber, Sharlene N. (2014). Feminist Approaches to In-Depth Interviewing. In: Dies. (HgIn). Feminist Research Practice. A Primer. Boston: SAGE, 182-228.

Keely, Charles B. (1994). “Limits to Papal Power: Vatican Inaction After Humanae Vitae,” In: Finkle, Jason L., and C. Alison McIntosh, The New Politics of Population: Conflict and Consensus in Family Planning, Vol. 20 (Suppl.), Population and Development Review.

Levnison David; Melvin Ember (1996). Encyclopedia of Cultural Anthropology. Eds. Vol 2. New York: Henry Holt.

Maternowska, Catherine M. (2000). A clinic in conflict: A political economy case study of family planning in Haiti. In: Russell, A.: Contraception across cultures: technologies, choices, constraints. Oxford [u.a.]: Berg. Pp. 103-126.

Mayring, P. (2016). Einführung in die qualitative Sozialforschung: eine Anleitung zu qualitativem Denken. 6. Auflage. Weinheim Basel: Beltz.

McKeown, J. (2014). 'Natalism', In: God's Babies. United Kingdom: Open Book Publishers, p. 1.

Mead, Margaret (1963). Sex and Temperament, In: Three Primitive Societies. New York: William Morrow (orig. pub. 1935).

Melgar J, Carrera-Pacete J. (2016). Understanding Catholic fundamentalism in the Philippines: how conservative religious teachings on women, family and contraception are wielded to impede the reproductive health law and other reproductive health policies. Building new constituencies for women's sexual and reproductive health and rights (SRHR): Interlinkages between religion and SRHR. Likhaan Center for Women's Health Asian-Pacific Resource and Research Centre for Women (ARROW), Philippines.

Moore, H.L. (1988). Feminism and anthropology. 1. publ. Cambridge [u.a.]: Polity Press.

Morgan, L.M.; Roberts, E.F.S. (2012). 'Reproductive governance in Latin America', Anthropology & medicine, 19(2), 241–254.

Müller-Funk, W. (2021). Kulturtheorie: Einführung in Schlüsseltexte der Kulturwissenschaften. 3., aktualisierte und erweiterte Auflage. Tübingen: Narr Francke Attempto Verlag.

Noonan, John T. (1986). Contraception: A History of Its Treatment by the Catholic Theologians and Canonists, Cambridge, Mass.: Harvard University Press.

Pangalangan, Raul (2015). "Religion and the Secular State: National Report for the Philippines" (PDF). Religion and the Secular State: National Reports. International Center for Law and Religion Studies: 559-571 [accessed 05.04.23]

Parmanand, Sharmila (2014). Mapping the path to Philippine Reproductive rights legislation. Sings of Progress Admist Obstacles. In: Social Transformations Vol. 2, 1.Feb 2014, 61-80.

Pido, Antonio (1986). The Philipinos in America: Macro/ Micro Dimensions of Immigration and Integration. Center for Immigration Studies: New York

Platzer, J. and Zissler, E. (2014). Bioethik und Religion. Nomos Verlagsgesellschaft.

Prüller-Jagenteufel, G.M. (2014). ‘Kirche, Ideologie und Politik. Die katholische Kirche im Kampf um die Gesetzgebung zur reproduktiven Gesundheit“ auf den Philippinen’, in Bioethik und Religion. 1st edn. Nomos Verlagsgesellschaft mbH & Co. KG, pp. 269–292.

Reich, Warren Thomas, editor-in-chief (1995). Encyclopedia of Bioethics, revised ed., New York: Simon & Schuster Macmillan.

Republic Act No. 10354 (2012). https://www.officialgazette.gov.ph/2012/12/21/republic-act-no-10354/ [accessed15.03.23]

Republic of the Philippines: Responsible Parenthood and Reproductive Health Act (2012). https://doh.gov.ph/sites/default/files/policies_and_laws/RA10354.pdf [accessed 30.07.22]

Rodao, Florentino; Rodriguez, Felice Noelle (eds.) (2001). The Philippine Revolution of 1896. Ordinary Lives in Extraordinary Times , Quezon City: Ateneo de Manila University Press.

Sachan, P. L.; Singh, M.; Patel, M. L.; Sachan, R. (2018). A study on cervical cancer screening using pap smear test and clinical correlation. Asia-Pacific journal of oncology nursing, 5(3), 337-341.

Sachs, J. D. (2012). From millennium development goals to sustainable development goals. The lancet, 379(9832), 2206-2211.

Sanday, P.R. (1991). Beyond the second sex: new directions in the anthropology of gender. 2. paperback print. Philadelphia, Pa.: Univ. of Pennsylvania Press.

Seltzer, Judith R. (2002). The Origins and Evolution of Family Planning Programs in Developing Countries. 1st ed. Santa Monica: RAND Corporation.

Senate Economic Planning Office (2009). 'Promoting Reproductive Health: A Unified Strategy for Achieving MDGs', Policy Brief. https://legacy.senate.gov.ph/publications/PB%202009-03%20-%20Promoting%20Reproductive%20Health.pdf [accessed 15.09.22]

Sta. Maria, A. (2019). Tilted interpretations: Reproductive health law and practice in the Philippines. In Women's Health and the Limits of Law. Routledge. 152-181.

Stark, Nancy (2000). 'My Body, My Problem': Contraceptive Decision-Making among Rural Bangladeshi Women. In: Russell, A.: Contraception across cultures: technologies, choices, constraints. Oxford [u.a.]: Berg. 179-196.

Swanson, Jennifer M.; Hennik, Moique M.; Rochat, W. (2019). „I have no choice" In: African Journal of Reproductive Health, La Revue Africaine de la Santé Reproductive. March, Vol. 23, No. 1. 128-138.

The Philippine clinical standards manual on family planning (2014 edition). Department of Health; (2014). https://platform.who.int/docs/default-source/mca-documents/policy-documents/operational-guidance/PHL-RH-32-01-OPERATIONALGUIDANCE-2014-eng-Clinical-Standards-Manual-Family-Planning.pdf [accessed 23.04.23]

The World Bank Group (2023). Population growth (annual %) – Philippines. https://data.worldbank.org/indicator/SP.POP.GROW?locations=PH [accessed 24.05.23]

Tulchinsky, T. H., & Varavikova, E. A. (2014). Measuring, monitoring, and evaluating the health of a population. In: The New Public Health, 91.

Tulchinsky, T. H., & Varavikova, E. A. (2014). The new public health. Academic Press.

United Nations, Department of Economic and Social Affairs, Population Division (2014). World Contraceptive Use 2014 (POP/DB/CP/Rev2014). https://www.un.org/en/development/desa/population/publications/dataset/contraception/wcu2014/Metadata/WCU2014_UNMET_NEED_metadata.pdf [accessed 12.03.23]

Updated Philippine Development Plan (2017-2022). https://pdp.neda.gov.ph/updated-pdp-2017-2022/ [accessed: 28.03.23]

Weigl, Constanze (2010). Reproductive health behavior and decision-making of Muslim women : an ethnographic study in a low-income community in urban North India. Münster [u.a.]: LIT.

Appendix

Table of Figures

Figure 1:	Piece of art in the museum of contemporary art in Iloilo	2
Figure 2:	A girl and me at Malapascua beach	4
Figure 3:	Children, my friend and me at Malapascua beach	4
Figure 4:	Map of the research regions in the Philippines	22
Figure 5:	Sinulog Parade in Cebu City	39
Figure 6:	Santo Niño de Cebu	39
Figure 7:	Packaging contraceptive pill	50
Figure 8:	Packaging contraceptive pill	50
Figure 9:	Governance structure of the Philippine health care system	80
Figure 10:	Main health center of Dumaguete	81
Figure 11:	Schedule of Activities	81
Figure 12:	Injection / Depo Provera	85
Figure 13:	Packaging contraceptive pill	85
Figure 14:	Manforce condoms	85
Figure 15:	Intrauterine Device (IUD)	85
Figure 16:	Family Planning Form 1 side A	88
Figure 17:	Family Planning Form 1 side B	88

Data Overview

<u>Interviews</u>

Interview 1: Main Health Center Dumaguete – Family Planning Section
Interview 2: Siliman University Dumaguete – Two Female Highschool Students
Interview 3: Siliman University Dumaguete – One Male Highschool Student
Interview 4: Health Center Dumaguete Barangay
Interview 5: Hostel Owner Dumaguete
Interview 6: Filipino from Cebu City in Moalboal
Interview 7: Main Health Center Moalboal
Informal Conversation Moalboal: Filipina Bartender Hostel Moalboal

<u>Participant Observations</u>

Participant Observation 1: Informal Conversation with Students from Iloilo University
Participant Observation 2: Field Diary Entry
Participant Observation 3: Museum of Contemporary Art Iloilo
Participant Observation 4: Drug Store Iloilo
Participant Observation 5: Pharmacy Counter Dumaguete
Participant Observation 6: Main Health Center Dumaguete
Participant Observation 7: Interview Main Health Center Dumaguete
Participant Observation 8: Field Diary Entry
Participant Observation 9: Siliman University Dumaguete
Participant Observation 10: Health Center Barangay Dumaguete
Participant Observation 11: Field Diary Entry
Participant Observation 12: Field Diary Entry
Participant Observation 13: Field Diary Entry
Participant Observation 14: Interview Hostel Owner Dumaguete
Participant Observation 15: Sinulog Festival Cebu City
Participant Observation 16: Field Diary Entry
Participant Observation 17: Informal Conversation Israeli Hostel Owner Malapascua / Beach Cleanup with the Kids

Participant Observation 18: Informal Conversation with Hostel Staff Moalboal

Participant Observation 19: Main Health Center Moalboal

Participant Observation 20: Field Diary Entry

Participant Observation 21: Interview Filipino from Cebu City

Participant Observation 22: Notes

Participant Observation 23: Informal Conversation Filipina Bartender Hostel Moalboal

Abstract English

This Master's thesis examines the influence of health policies, local health centers, and the Catholic Church on women's reproductive behavior in the Philippines. Empirical data was collected between January 5th and January 29th in 2020. Data collection included qualitative interviews, informal conversations, and participant observation. The study focused mainly on the regions of Dumaguete and Moalboal in the Philippines. Since the Philippines is predominantly Catholic, the Catholic Church's opposition to artificial contraception has an important role in shaping the reproductive behavior of Filipino women. The Church's influence also extends to state legislation around reproductive health. Although the implementation of the Reproductive Health Act has improved access to reproductive health services, women still face barriers to accessing these services. Fear of judgment by health workers, lack of privacy, requirements such as spousal consent and the presence of a relationship or children demonstrate additional challenges to family planning services. In addition, state control and monitoring have an important role in access to family planning services and put pressure on health workers through its biopolitics. Sex education in the Philippines focuses primarily on HIV and STD prevention and discourages premarital sex. Comprehensive sex education is not required until couples are ready to marry, limiting educational opportunities for adolescents and young adults. This Master's thesis highlights a complex interplay of factors in which women seeking access to family planning services face barriers stemming from health center policies, government control, and the influence of the Catholic Church. Women face these influences, judgmental attitudes, biopolitics, and gender role expectations that significantly affect their reproductive choices.

Abstract Deutsch

In dieser Masterarbeit wird der Einfluss der Gesundheitspolitik, lokaler Gesundheitszentren und der katholischen Kirche auf das Reproduktionsverhalten von Frauen auf den Philippinen untersucht. Die empirischen Daten wurden zwischen dem 5. und 29. Januar 2020 erhoben. Die Datenerhebung umfasste qualitative Interviews, informelle Gespräche und teilnehmende Beobachtung. Die Studie konzentrierte sich hauptsächlich auf die Regionen Dumaguete und Moalboal auf den Philippinen. Da die Philippinen überwiegend katholisch sind, spielt die Ablehnung künstlicher Empfängnisverhütung durch die katholische Kirche eine wichtige Rolle bei der Gestaltung des Reproduktionsverhaltens der philippinischen Frauen. Der Einfluss der Kirche erstreckt sich auch auf die staatliche Gesetzgebung im Bereich der reproduktiven Gesundheit. Obwohl die Umsetzung des Gesetzes zur reproduktiven Gesundheit den Zugang zu reproduktiven Gesundheitsdiensten verbessert hat, stehen Frauen immer noch vor Hindernissen beim Zugang zu diesen Diensten. Die Angst vor einer Verurteilung durch das Gesundheitspersonal, der Mangel an Privatsphäre, Anforderungen wie die Zustimmung des Ehepartners und das Vorhandensein einer Beziehung oder von Kindern stellen zusätzliche Herausforderungen für Familienplanungsdienste dar. Darüber hinaus spielt die staatliche Kontrolle und Überwachung eine wichtige Rolle beim Zugang zu Familienplanungsdiensten und übt durch ihre Biopolitik Druck auf das Gesundheitspersonal aus. Die Sexualerziehung auf den Philippinen konzentriert sich in erster Linie auf die Prävention von HIV und Geschlechtskrankheiten und rät von vorehelichem Sex ab. Umfassende Sexualaufklärung ist erst dann erforderlich, wenn die Paare bereit sind zu heiraten, was die Bildungsmöglichkeiten für Jugendliche und junge Erwachsene einschränkt. Diese Masterarbeit beleuchtet ein komplexes Zusammenspiel von Faktoren, bei dem Frauen, die Zugang zu Familienplanungsdiensten suchen, auf Hindernisse stoßen, die sich aus der Politik der Gesundheitszentren, der staatlichen Kontrolle und dem Einfluss der katholischen Kirche ergeben. Frauen sind mit diesen Einflüssen, wertenden Einstellungen, Biopolitik und Erwartungen an die Geschlechterrolle konfrontiert, die ihre reproduktiven Entscheidungen erheblich beeinflussen.