



2014

The First Annual Consolidated Report on the Implementation of the Responsible Parenthood and Reproductive Health Act of 2012 (R.A. No. 10354)

Department of Health
Department of Education
Department of Interior and Local Government
Department of Social Welfare and Development
Commission on Population
Food and Drugs Administration
National Anti-Poverty Commission

National Youth Commission
Philippine Commission on Women
Philippine Health Insurance Corporation
Philippine National AIDS Council
Development Partners
Civil Society Organizations

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 - Food and Drugs Administration (FDA)
 - Philippine Health Insurance Corporation (PHIC)
 - Philippine National AIDS Council (PNAC)
- ❖ Other Government Agencies:
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LEGAL MANDATE FOR THE ANNUAL CONSOLIDATED REPORT OF RPRH IMPLEMENTATION

PER SECTION 21 OF R.A. 10354 AND RULE 15 OF ITS IMPLEMENTING RULES AND REGULATIONS

“Reporting Requirements. – Before the end of April each year, the DOH shall submit to the President of the Philippines and Congress an annual consolidated report, which shall provide a definitive and comprehensive assessment of the implementation of its programs and those of other government agencies and instrumentalities and recommend priorities for executive and legislative actions. The report shall be printed and distributed to all national agencies, the LGUs, NGOs and private sector organizations involved in said programs.

The annual report shall evaluate the content, implementation, and impact of all policies related to reproductive health and family planning to ensure that such policies promote, protect and fulfill women’s reproductive health and rights.”




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ACRONYMS AND ABBREVIATIONS

4ANC	Four Antenatal Care Visits
4Ps	<i>Pantawid Pamilyang Pilipino</i> Program
AABR	Automated Auditory Brainstem Response
AIARHC	Albay Inter-Agency Reproductive Health Committee
ADB	Asian Development Bank
AIDS	Acquired Immunodeficiency Syndrome
AJA	Adolescent Job Aid manual
AO	Administrative Order
ARH	Adolescent Reproductive Health
ARMM	Autonomous Region of Muslim Mindanao
ASEAN	Association of Southeast Asian Nations
ASRH	Adolescent Sexual and Reproductive Health
AYHD	Adolescent and Youth Health and Development
AYRH	Adolescent and Youth Reproductive Health
BEmONC	Basic Emergency Obstetric and Newborn Care
BHS	Barangay Health Station
BHW	Barangay Health Worker
BNS	Barangay Nutrition Scholar
BTL	Bilateral Tubal Ligation
C4C	Communicators for Communication
CCT	Conditional Cash Transfer program
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHO	City Health Office
CHT	Community Health Team
CPR	Contraceptive Prevalence Rate
CRVS	Civil Registry and Vital Statistics
CS	Cesarean Section
CSO	Civil Society Organization
DC	Department Circular

DepEd	Department of Education
DILG	Department of Interior and Local Government
DJRMMC	Dr. Jose Reyes Memorial Medical Center
DM	Department Memorandum
DMPA	Depot Medroxyprogesterone Acetate
DOH	Department of Health
DPCB	Disease Prevention and Control Bureau
DPO	Department Personnel Order
DSWD	Department of Social Welfare and Development
EPI	Expanded Program of Immunization
ERPAT	Empowerment and Reaffirmation of Paternal Abilities
EU	European Union
FBD	Facility-based Delivery
FDA	Food and Drug Administration
FDS	Family Development Sessions
FHRP	Family Health and Responsible Parenting
FHS	Family Health Survey
FHSIS	Field Health Surveillance and Information System
FIC	Fully Immunized Child
FP	Family Planning
FPCBT	Family Planning Competency Based Training
FPS	Family Planning Survey
GAA	General Appropriations Act
GAD	Gender and Development
GBV	Gender-based Violence
GPH	Government of the Philippines
HFEP	Health Facilities Enhancement Program
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
IEC	Information, Education, and Communication
IHBSS	Integrated HIV Behavioral and Serologic Surveillance
IMR	Infant Mortality Rate
IPCC	Interpersonal Counseling and Communication

IRR	Implementing Rules and Regulations
IRR DC	IRR Drafting Committee
IUD	Intrauterine Device
JICA	Japan International Cooperation Agency
KATROPA	<i>Kalalakihang Tumutugon sa Responsibilidad at Obligasyon Para sa Kalusugan ng Ina at Pamilya</i>
LAPM	Long Acting Permanent Method
LARC	Long Acting Reversible Contraception
LCAT-VAWC	Local Committees on Anti-Trafficking and Violence Against Women and Children
LCE	Local Chief Executive
LGBT	Lesbian, Gay, Bisexual, and Transsexual
LGU	Local Government Unit
M&E	Monitoring and Evaluation
MAH	Market Authorization Holder
MARP	Most At-Risk Population
MBFHI	Mother-Baby Friendly Hospital Initiative
MDG	Millennium Development Goal
MFP	Modern Family Planning
MHO	Municipal Health Officer
MMR	Maternal Mortality Ratio
MNCHN	Maternal, Neonatal, Child Health and Nutrition
MNFP	Modern Natural Family Planning
MOU	Memorandum of Understanding
MR	Measles-Rubella
MR GAD	Men's Responsibilities in Gender and Development
MRL	Muslim Religious Leader
MSM	Men having Sex with Men
NAPC	National Anti-Poverty Commission
NCMH	National Center for Mental Health
NCR	National Capital Region
NDHS	National Demographic and Health Survey
NDP	Nurse Deployment Program

NGO	Non-Government Organization
NHIP	National Health Insurance Program
NHTS	National Household Targeting System
NMR	Neonatal Mortality Rate
NNC	National Nutrition Council
NNS	National Nutrition Survey
NOH	National Objectives for Health
NSD	Normal Spontaneous Delivery
NSV	Non-Scalpel Vasectomy
OAE	Otoacoustic emissions device
OFW	Overseas Filipino Worker
ONAR	Office of the National Administrative Register
OSG	Office of the Solicitor General
PCB	Primary Care Benefit package
PCW	Philippine Commission on Women
PHA	Public Health Assistant
PHIC	Philippine Health Insurance Corporation
PHO	Provincial Health Office
PIA	Philippine Information Agency
PNSCB	Philippine National Statistics Coordination Board
PO	People's Organization
POPCOM	Commission on Population
PPMP	Project Procurement Management Plan
PSA	Philippine Statistics Authority
PTA	Parent-Teacher Association
PYP	Program for Young Parents
Q&A	Question and Answer
RH	Reproductive Health
RHMPP	Rural Health Midwives Placement Program
RHO	Reproductive Health Officer
RHU	Rural Health Unit
RNHeals	Registered Nurses for Health Enhancement and Local Service
RP-FP	Responsible Parenting and Family Planning

RPO	Regional Population Office
RPRH	Responsible Parenthood and Reproductive Health
RTI	Reproductive Tract Infection
SBA	Skilled Birth Attendance
SC	Supreme Court
SK	<i>Sangguniang Kabataan</i>
SQAO	<i>Status Quo Ante Order</i>
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
SSESS	STI Sentinel Etiologic Surveillance System
STI	Sexually Transmitted Infection
SWRA	Sexually Active Women of Reproductive Age
TD	Tetanus-Diphtheria
TOT	Training of Trainors
U4U	Youth for Youth Activity
UMFP	Unmet Need for Modern Family Planning
UNFPA	United Nations Population Fund
VAWC	Violence Against Women and Children
VIA	Visual Inspection with Acetic Acid
WB	World Bank
WHO	World Health Organization
WRA	Women of Reproductive Age
YAFSS	Young Adult Fertility and Sexuality Survey

EXECUTIVE SUMMARY

This report describes the consolidated accomplishments of the Department of Health (DOH), its attached agencies, other government agencies, local government units (LGUs), development partners, and civil society organizations (CSOs) in the first year of implementing the Responsible Parenthood and Reproductive Health (RPRH) Law. Overall, the DOH and its partners were able to:

- set the baseline indicators to track effectiveness of RPRH implementation;
- set strategic policy directions with the promulgation of the IRR;
- provide operational instructions through issuance of guidelines to implementing agencies;
- secure budgets and other funds to finance RPRH implementation;
- procure and distribute commodities;
- implement activities to generate demand;
- develop capacity through various training programs;
- provide a wide range of RH services to clients and beneficiaries; and
- establish governance mechanisms to coordinate and manage RPRH implementation.

Baseline status of RPRH. The RPRH Law was passed to ensure universal access to RH services as a means to reduce maternal and child mortality in the country. Maternal mortality has remained persistently high over the past decades, making it unlikely for the Philippines to reach its Millennium Development Goal (MDG) of reducing maternal mortality by two-thirds in 2015. On the other hand, child mortality is declining, but its rate of decline is slowed down by high neonatal mortality. High maternal mortality result from high levels of unmet need for various RPRH services such as modern family planning and safe delivery services for women and mothers. High levels of unmet need among sexually active teens also explain the increasing number of teen pregnancies. In the case of child mortality, limited access to essential newborn care could explain the high number of neonatal deaths while unmet needs for micronutrient supplementation and vaccination lead to morbidity from highly preventable diseases. The prevalence of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) remains below one percent of the general population but is rapidly increasing among most at risk populations, particularly among men having sex with men (MSMs) in major urban centers like Quezon City and Cebu and Davao. These and other indicators covering other RPRH elements such as reproductive tract cancers, will serve as basis for tracking the progress of implementing the RPRH Law.

Strategic policy direction. In order to provide strategic direction and guidance to the implementation of the RPRH Law, the DOH in partnership with other agencies and CSOs promulgated the RPRH Implementing Rules and Regulations (IRR) last March 18, 2013. However, before the law and its IRR could take effect, the Supreme Court (SC) issued a *Status Quo Ante* Order (SQAQO) on the basis of 14 petitions assailing the constitutionality of the RPRH Law. The Office of the Solicitor General (OSG), with assistance from the DOH, partner agencies, CSOs, and development partners, successfully defended the constitutionality of the law, except for eight items. The law finally took effect on April 8, 2014 when the SC lifted the SQAQO.

Operational instructions. To jumpstart implementation of the law, the RH Law IRR mandated the issuance of 61 guidelines or policies within the first 120 days of implementation. Some of these guidelines were covered by existing issuances and would only require updating, while others require the development of new policies. Of these new policies, 14 have been published last 2014 through the various issuances developed by the DOH and other agencies mandated to implement the RPRH Law. Another 11 guidelines from DOH and 10 from other agencies are in the pipeline for issuance in 2015. Aside from this, DOH is also set to update around 30 existing guidelines to comply with the law and its IRR's provisions. Several LGUs have also issued their own

ordinances and resolutions to adopt and implement the RPRH Law in their localities. The DOH, together with other agencies, CSOs, and development partners assisted these LGUs in developing these local RPRH policies.

Budgets and financing. While the implementation of the RPRH Law was suspended by the SQAQ, the DOH and other government agencies were unable to define specific line items in the 2014 General Appropriations Act (GAA) in support of RPRH implementation. After the law took effect, the DOH identified its budget line items for (1) Family Health and Responsible Parenting, (2) Expanded Program for Immunization, and (3) Health Facilities Enhancement Program as the main sources of funding for RPRH-related activities. In addition, other government agencies such as the Commission on Population (POPCOM), Department of Education (DepEd), Department of Social Welfare and Development (DSWD), and Department of Interior and Local Government (DILG) have also made use of existing budget line items to finance the implementation of RPRH-related activities. LGUs were also known to have used existing budget line items to finance RPRH implementation in their respective localities. Meanwhile, the Philippine Health Insurance Corporation (PHIC) made use of existing benefit packages to reimburse RPRH-related services. Likewise, development partners assisted the DOH and other government agencies in RPRH implementation through its current country programs. CSOs also raised their own funds to provide much needed support and services to RPRH implementation.

Supply of commodities. The DOH, with assistance from development partners, also procured and then distributed family planning/ maternal, neonatal, and child health nutrition (FP/MNCHN) commodities to various LGU facilities and partner providers in the private sector.

Demand generation. To generate demand for RPRH services, the DOH, in partnership with other agencies, development partners, and CSOs implemented various health promotion and communication activities like the mass media campaign on modern family planning (MFP) and nutrition. The DOH, together with partners, also produced and distributed information materials for various audiences across the country. LGUs, with assistance from DOH and other partners, also deployed 225,001 community health team members that did home visits to provide information and guidance to NHTS poor families in the use of services. Other agencies also implemented various types of information campaigns, such as holding RPRH classes during Family Development Sessions (FDS) for Pantawid Pamilyang Pilipino Program (4Ps) recipients of DSWD. The modules used in these classes were developed by POPCOM. The DepEd also developed materials and conducted orientations on adolescent and youth reproductive health (AYRH) for its teachers and staff. CSOs have also launched their own information and advocacy activities with LGUs and families, as part of providing information and services to underserved populations.

Development of capacity. The DOH and other agencies also helped strengthen the capacity of health care providers, especially those at the LGU level, by supporting various training courses. These training courses covered programs that deal with the delivery of services such as MFP, emergency obstetrics and neonatal care, adolescent and youth reproductive health (AYRH), and breastfeeding and neonatal care among others. Capacity building activities for demand generation and advocacy for RPRH were also implemented.

Delivery of services. LGUs, together with the DOH and other partners stepped up the implementation of various RPRH programs in order to deliver services to families, especially among the poor. These services include MFP, safe delivery, newborn care, breastfeeding and immunization among others.

Governance, coordination, and management. Last November 2014, the DOH and its partner agencies, CSOs, and development partners have initiated the establishment of an inter-agency committee to coordinate RPRH implementation. This was in response to a recommendation from the POPCOM Board of Commissioners that an inter-agency committee be created to coordinate the implementation of the law. In addition, as soon as the law took effect, the DOH began work on the proposal to establish a unified bureau for RPRH implementation, pursuant to Section 12 of the RPRH IRR. This proposal was submitted to the Office of the President last July 24, 2014. Later in the year, the DOH received comments from the Office of the Executive Secretary and the Department of Budget and Management. The DOH has prepared a revised proposal for submission in 2015. Lastly, DOH, its partner agencies, and CSOs also implemented 12 research projects in 2014 to generate evidence and lessons to guide RPRH implementation. In addition, the DOH has also strengthened the information system for RPRH, starting with the registry systems for family planning and cancer.

Challenges and next steps. The first year of RPRH implementation has made use of substantial resources to finance various efforts to develop policies, generate demand, deliver services, develop capacity, and manage implementation. However, various challenges to RPRH implementation have also been identified. In particular, the current level of investments and existing capacities are still insufficient to implement RPRH at the scale mandated by law. These and other challenges will be addressed in the subsequent years of RPRH implementation.

BASELINE INDICATORS OF RPRH IMPLEMENTATION

1. This section provides the baseline status of the implementation of the RPRH Law in terms of key health outcome and impact indicators. These indicators will serve as basis for evaluating the effectiveness of implementing the RPRH Law. Data for these indicators were obtained from various sources, such as the 2013 National Demographic and Health Survey (NDHS), the 2013 Young Adult Fertility and Sexuality Survey (YAFSS), current DOH and PhilHealth administrative data, and reports and surveys done by various development partners.
2. FP/MNCHN health outcome and impact indicators have moved sideways in the past five years. Maternal deaths have remained high, owing to persistently high levels of unmet need for modern FP, although facility based deliveries have been increasing. It was also observed that the number of teen pregnancies increased, indicating that current interventions are not adequately reaching this client group. While child mortality is declining and MDG targets in reducing deaths among children will be met, neonatal mortality remains high. Immunization rates have also slightly declined between 2008 and 2013.
3. The MDG 5 goal for the Philippines is to reduce Maternal Mortality Ratio (MMR)¹ by three quarters, from 209 in 1993 to 52 by 2015. This indicator target was based on national surveys that employ the Sisterhood Method. It can be noted that while MMR has been declining across time, it is still unlikely for the Philippines to reach its MDG target. This is because MMR has remained unchanged between 2006 and 2011². It can also be noted that the declining trend for MMR is consistent with other alternative measures of maternal mortality, such as the Civil Registry and Vital Statistics (CRVS) records, and the DOH Field Health Services Information System (FHSIS) as shown in Table 1. However, the different levels of maternal mortality reported across the three systems are indicative of the extent that each system is able to capture data on maternal deaths. The advantage with using survey-based information to estimate the maternal mortality ratio is the active search of deaths in households. This minimizes but does not eliminate underreporting. The use of CRVS to measure MMR is challenged with issues of unreported deaths and misclassification of what would be otherwise considered as maternal deaths. To address underreporting, the Maternal Mortality

¹ MMR is reported in terms of number of deaths per 100,000 live births

² The NSO reported that while the reported MMR figure for 2011 is higher, the difference is not statistically significant with 2006 levels statistically significant given the overlap in the confidence intervals around the point estimates of the two surveys.

Estimation Inter-agency Group has recommended the adjustment of CRVS figures by 50 percent. The lower figures from FHSIS can be attributed to limited data capture as this mostly consist of reports from government health facilities.

Table 1. Maternal Mortality Ratio (2006 to 2011).

Year	Survey-based	Civil Registry	DOH
1993	209	92	N.A.
1998	172	97	65
2006	162	103	63
2011	221	84	69
2012	N.A.	81	66

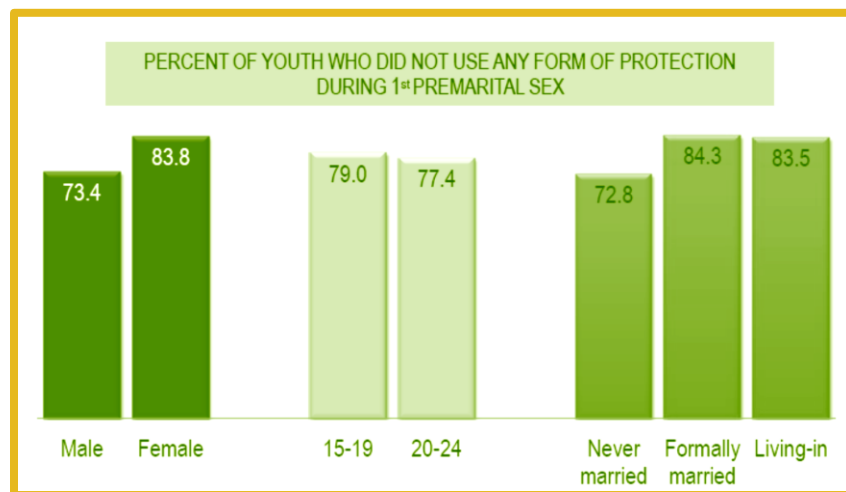
(Sources: Survey based: FPS 2006, FHS 2011; Civil registry: CRVS; DOH: FHSIS)

4. The gradual decline in MMR may not be due to fewer maternal deaths and is driven by the increasing number of live births. Data from the CRVS in the past two decades show that actual counts of maternal deaths have essentially remained the same since 1990. The average number of deaths per year has been estimated at 1605 and ranging from a low of 1142 in 1990 to a high of 1797 deaths in 2003. This highlights the need to also track the actual number of deaths, as measuring MMR (which is a ratio) alone could mask the reality that almost the same absolute number of women die each year from pregnancy related complications.
5. The high maternal mortality is due to persistently high levels of unmet need for modern FP. It is estimated that 5.7 million women were at risk of having unplanned pregnancy in 2013. Previous efforts at reducing this problem appear to be inadequate, with only half a percent decline in unmet need for modern FP being between 2008 and 2013. What is also alarming is that between 2008 and 2013, regions 4a, 5, 10, and 11 have registered double digit increases in the number of women at risk of unplanned pregnancies (see Annex A). Unplanned pregnancy increases a woman's likelihood of dying from pregnancy complications as well as impact on the socio-economic welfare of families.
6. Modern contraceptive prevalence rate (CPR) has improved very slowly in the last twenty years, from 24.9 in 1993 to 37.6 percent in 2013. The CPR for all methods was 56 percent in 2013, still below the DOH National Objectives for Health (NOH) 2011-2016 target of 65 percent in 2015. While the use of modern FP methods (i.e., supply methods) has increased by 16 percent between 2008 and 2013, there still remain 5.7 million women with unmet need for modern family planning (MFP). Another cause for concern is that access to long acting permanent methods (LAPM) such as bilateral tubal ligation (BTL) and intrauterine devices (IUDs) has declined (See Annex B).
7. Furthermore, when disaggregated by age group, unmet need for modern FP among women aged 15-19 has increased by 15 percent, while it has increased by almost 50 percent for those aged 40-49 (See Annex C). These observations imply that if we are to be successful in reducing maternal deaths,

efforts to reduce unmet need for MFP should focus on both the teens and the 40 and above age group.

8. High unmet needs owing to the lack of awareness and access to reproductive health services among teenagers has led to a 10 percent increase in the number of pregnant teens aged 15-19, between 2008 and 2013. As shown in Annex D, over 500,000 teens aged 15 to 19 are childbearing, already had a live birth, or are currently pregnant with their first child. Around 37 percent of these pregnant teens are concentrated in Metro Manila and its surrounding regions. The regions observed to have had large increases in teenage pregnancies from 2008 to 2013 are regions 6, NCR, 2, and CARAGA.
9. The 2013 Young Adult Fertility and Sexuality Survey (YAFSS) also reported a 150 percent increase in the rate of teen pregnancies, from 4.4 percent in 2002, to 11 percent in 2013. The rapid increase in teen pregnancies could also be explained by the increasing prevalence of sexual activity among teenagers, from 23 percent in 2002, to 32 percent in 2013. A cause of concern is that 73 percent of males and 84 percent of females did not use any form of contraception during their first sexual intercourse (see Figure 1).

Figure 1. Percent of youth who did not use any form of contraception during 1st sexual activity



(Source: YAFSS 2013)

What is particularly disturbing with increasing fertility among teenagers is that the number of maternal deaths is also increasing among those aged 15 to 19. As shown in the table below, the live births among 15 -19 year olds has been increasing while that of other age groups either declined or remained the same. Maternal deaths on the other hand have been increasing for the age groups of 15-19, 25 to 29, and 30 to 34. Particularly for the 15-19 age group, the increase in maternal deaths appear to outweigh the increase in live births, thus resulting to an increase in the MMR of this age group.

Table 2. Annual growth rates of Live Birth and Maternal Deaths

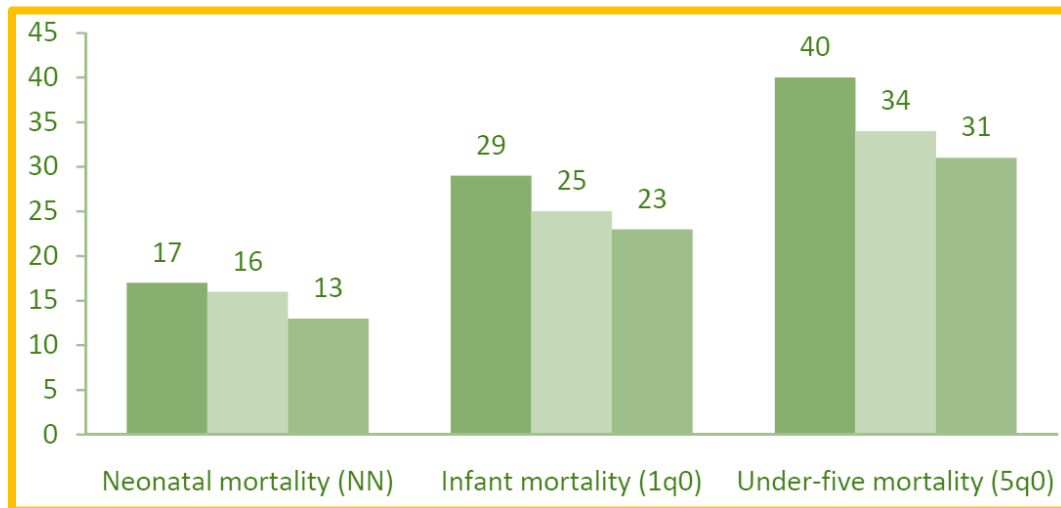
Age Group	1995-2000		2000-2005		2005-2010	
	Live births	Maternal deaths	Live births	Maternal deaths	Live births	Maternal deaths
10-14	-2.82%	-100.00%	1.44%	N.A.	10.30%	5.92%
15-19	3.39%	5.48%	2.70%	6.20%	7.61%	5.25%
20-24	1.55%	1.86%	-0.89%	1.90%	1.54%	-0.88%
25-29	0.34%	0.72%	-0.80%	1.61%	-0.67%	0.47%
30-34	1.90%	2.18%	-2.14%	-0.60%	0.88%	0.76%
35-39	1.73%	1.39%	-0.94%	0.00%	-0.78%	-2.30%
40-44	2.82%	8.64%	-1.80%	-3.91%	0.55%	-0.22%
45-49	2.68%	8.73%	-2.44%	-1.63%	-1.48%	-7.27%

(Source: Computed from PSA CRVS)

10. The overall trend for pregnant women completing four antenatal care (4ANC) visits in the Philippines continues to improve. However, there appears to be a lot of missed opportunities to generate demand, provide services, and ensure adherence to proper care, when seen in terms of lower FBD rates. Regions 1, 4B, 9, and 10 may also need special attention due to a decline in the number of women having 4ANC visits between 2008 to 2013 (see Annex E).
11. The Philippines also registered a 60 percent increase in the number of facility-based deliveries (FBD) between 2008 and 2013. However, this remains below the 90 percent FBD rate target that was set by the DOH in its NOH 2011-2016. Triple digit percentage increases were also observed in regions 12, CAR, 2, and 5. The poorest quintile was also reported to have the largest reported increase in facility-based deliveries, which could be attributed to improvement in targeting (see Annex F).
12. The increase in FBD also raises issues on quality of care, as birthing homes (i.e. non-hospital facilities) registered the largest increase in FBD. They account for close to a 300 percent increase in deliveries (see Annex G).
13. This increase in facility-based deliveries also has a critical equity angle. As shown in Annex H, the rate of FBD in private facilities, which is comprised mostly of birthing homes, has increased by over 700 percent, between 2008 and 2013, in the poorest quintile.
14. Although infant mortality is decreasing, the decline has been slow, from 35 deaths per 1,000 live births in the 1998 NDHS to 23 deaths per 1,000 live births in the 2013 NDHS. In the latest survey, more than half of infant deaths occurred during the first month of life. Infant and under-5 mortality was highest among children living in rural areas and SOCCSKSARGEN, among those whose mothers have less education or are in the lowest wealth quintile, and among those born to mothers aged 40-

49 and mothers with a high number of children. Children born after short birth intervals also have higher mortality. Despite this, the Philippines is likely to meet the MDG in reducing child mortality. The trend in neonatal mortality, infant mortality, and under-five mortality as captured by the succession of surveys can be seen in Figure 2.

Figure 2. Neonatal Mortality, Infant Mortality, and Under Five Mortality Rates, 2003, 2008, and 2013



(Source: NDHS 2003, NDHS 2008, and NDHS 2013)

15. As reported in the 2013 NDHS, only half of children were breastfed within one hour of birth. Furthermore, among children age 6-59 months, 85 percent received vitamin A supplements, while only 38 percent received iron supplements in the 7 days prior to the survey.
16. Based on the results of the National Nutrition Survey (NNS) 2013, the growth stunting prevalence among children aged 0-5 years significantly decreased, from 34 percent in 2011, to 30 percent in 2013. According to the National Nutrition Council (NNC), stunting is caused by long-term food and nutrient deprivation that retards physical growth and cognitive development, and increases the risk of illnesses. The three regions with the highest stunting burden and that are significantly higher than the national average are regions 5, ARMM, and 9. There was also a significant decline in stunting among children aged 5-10 years, from 34 percent in 2011, to 30 percent in 2013, and among adolescents aged 11-19 years, from 36 percent in 2011, to 32 percent in 2013.
17. On the other hand, only a slight decrease in underweight prevalence among children aged 0-5 years was recorded, from 20.20 percent in 2011, to 19.90 percent in 2013. Moreover, the wasting/thinness among children aged 0-5 years significantly went up, from 7.30 percent in 2011, to 7.90 percent in 2013. According to the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO), severe wasting among young children is associated with nine times higher risk to mortality, compared to mildly wasted and well-nourished children³.

³ Child Growth Standards and the Identification of Severe Acute Malnutrition in Infants and Children: A Joint Statement by World Health Organization and the United Nations Children's Fund. Published in Geneva, Switzerland, 2009.

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18. In contrast to this, the prevalence of overweight condition among children aged 0-5 years showed an increase from 2.50 percent in 2005, to 5 percent in 2013. The highest rates of increase were noted in the wealthiest quintiles of regions 4A, NCR, and 3. Likewise, the prevalence of overweight condition among older children, adolescents, and adults were observed to be highest among the wealthiest quintile.
 19. As reported in the 2013 NDHS, vaccination coverage (excluding hepatitis B) for children age 12-23 month has slightly increased from 72 percent in 1993 to 77 percent in 2013. Vaccination rates that are below desired herd immunity levels increase the risk for possible outbreaks. In 2013, the fully immunized child (FIC) rate among infants was reported to be at 62 percent. This is eight percentage points lower than the reported FIC rate in 2008. In terms of absolute numbers, close to 700,000 infants were not fully immunized in 2013, most of whom are concentrated in regions 2, 4A, 5, 6, and 7 (see Annex I).
 20. According to the World Health Organization's Cancer Country Profiles, the incidence of prostate cancer in the Philippines was 4,858 in 2014. For Filipino women, the incidence was 18,327 for breast cancer, 6,670 for cervix and uterine cancers, and 2,425 for ovarian cancer. Based on vital statistics reports from 2004-2009, the third leading cause of mortality in the Philippines were malignant neoplasms. In terms of mortality, prostate cancer was responsible for 3,128 deaths in 2014. On the other hand, breast cancer caused 7,728 deaths and cervical and uterine cancers caused 2,120 deaths in the same year⁴.
 21. The Philippines remains to be a low burden country for HIV/AIDS, with less than one percent prevalence in the general population. However, the epidemic is rapidly spreading among specific population groups and areas. Findings from the 2013 Integrated HIV Behavioral and Serologic Surveillance (IHBSS) showed that HIV prevalence has increased, from 1.68 to 2.93 percent among men who have sex with men (MSM). Syphilis rates have also increased slightly (see Table 3). Most MSMs who are also HIV positive are found mostly in the major urban centers like Quezon City, Cebu, and Davao. Low condom use during anal sex among MSMs has been cited as the main reason for the rapid spread of HIV among this most at risk population (MARP). Condom use among MSMs has increased only slightly, from 35 percent in 2011 to 37 percent in 2013.

⁴ Source: WHO Cancer Country Profile: Philippines (2014). Available in the World Wide Web: http://www.who.int/cancer/country-profiles/phl_en.pdf?ua=1

Table 3. Prevalence of HIV and Syphilis among MSM

	Percent Prevalence by Age			
HIV Prevalence	15-17 years old	18-24 years old	25 years and older	TOTAL
2011	0.00	1.84	2.03	1.68
2013	0.85	2.47	4.41	2.93
Syphilis Prevalence				
2011	1.02	0.69	2.86	1.57
2013	0.42	1.24	3.54	1.95

(Source: IHBSS 2013)

22. Data from the Philippine HIV and AIDS Registry show that a total of 6,011 HIV/AIDS cases have been reported in 2014. This brings the cumulative number of cases reported in the Philippines to 22,527 since 1984.

PART I

POLICIES ISSUED

I. PROMULGATION OF THE IMPLEMENTING RULES AND REGULATIONS (IRR) OF RA 10354

After fourteen years of extensive and thorough debates, the Bicameral Conference Committee of the Senate and the House of Representatives passed the consolidated Senate Bill No. 2865 and House Bill No. 4244 on December 19, 2012. Two days after, the President signed the measure into law. It then became known as Republic Act No. 10354, or “The Responsible Parenthood and Reproductive Health Act of 2012”. In accordance with Section 30 of the said law, it was published in *The Philippine Star* and *The Manila Bulletin* on January 2, 2013, which rendered it to be in full force and effect by January 17, 2013.



Image 1. The bicameral conference committee meeting that consolidated HB 4244 and SB 2865 last December 19, 2012. (Image courtesy of the Philippine Daily Inquirer, “Bicam reconvenes to iron out ‘kinks’ in RH bill”. Available in the World Wide Web through <http://newsinfo.inquirer.net/326837/bicam-reconvenes-to-iron-out-kinks-in-rh-bill#ixzz3XLKzO5S>)

A. THE IRR DRAFTING COMMITTEE AND TECHNICAL ADVOCACY WORKING GROUP

Section 26 of the law provides that the IRR Drafting Committee be composed of the following:

“the DOH Secretary or his/her designated representative as Chairperson, the authorized representative/s of DepED, DSWD, Philippine Commission on Women, PHIC, Department of the Interior and Local Government, National Economic and Development Authority, League of Provinces, League of Cities, and League of Municipalities, together with NGOs, faith-based organizations, people’s, women’s and young people’s organizations... At least four (4) members of the IRR drafting committee, to be selected by the DOH Secretary, shall come from NGOs.”

In compliance with the above section, the Office of the Secretary of Health invited the concerned agencies and non-government organizations to send official representatives to the Drafting Committee (DC). The list of the members of the IRR DC can be found in Annex 1.A.



Image 2. The Drafting Committee and Technical and Advocacy Working Group of the Responsible Parenthood and Reproductive Health Act's Implementing Rules and Regulations

In anticipation of the law’s effectivity and the technical support requirement of the DC, the DOH convened an internal Technical and Advocacy Working Group (TAWG) through a DPO 2013-0343 dated January 7, 2013 (Annex 1.B). While the DC is primarily tasked to draft the IRR and ensure its promulgation, the TAWG organized, facilitated, and documented the proceedings of technical consultations that were conducted as part of its support to the drafting process.

The RPRH IRR’s DC and TAWG also crafted their Rules of Procedure prior to the drafting of the main text of the IRR itself. The Rules of Procedure had 10 Rules with 45 Sections, all of which spelled out

the composition of the DC and the TAWG, the roles and functions of both, the schedule and conduct of meetings, the process of decision making, filing of motions, and promulgation of the IRR. The full text of the RPRH IRR Rules of Procedures may be found in Annex 1.C.

B. PUBLIC CONSULTATIONS ON THE RPRH IRR

Prior to its finalization, the working draft of the IRR was made available through the DOH website for review and comment by the public. Aside from this, public consultations were held in Manila, Cebu, and Davao wherein orientations on the current draft were done and comments and suggestions from the public were solicited and later incorporated in the draft IRR. The public consultations were attended by local officials, legislators, representatives from government agencies, non-government organizations involved with health and women's rights, maternal and child health advocates, youth groups, lesbian/gay/bisexual/transgender groups, faith-based organizations, educational institutions, private enterprises, media groups, and health workers. The proceedings of the public consultations were made available online.

C. FINALIZATION AND PROMULGATION OF THE IRR

After the IRR was finalized by the DC, it was endorsed to the principals of the various government agencies and non-government organizations for approval. A public signing ceremony was conducted on March 15, 2013, at the Baseco Compound in Manila, days before the deadline of the IRR's promulgation set by the law. The final version of the IRR was published in the Official Gazette last March 18, 2013.



Image 3. Signing of the RPRH IRR at Baseco Compound last March 15, 2013

In compliance with Section 18.04 of the IRR, the final and signed version was received by the Office of the National Administrative Register (ONAR) at the UP Law Center on March 19, 2013. It was also published in the *Philippine Daily Inquirer* and *The Philippine Star* on March 20, 2013. The IRR was supposed to take effect fifteen (15) days after it was published, but it was affected by the *Status Quo Ante* Order (SQAQO) issued by the Supreme Court a day before its publication in the newspapers.

II. CONSTITUTIONALITY OF RA 10354 AND ITS IRR UPHELD BY THE SUPREME COURT

There were fourteen (14) petitions filed before the Supreme Court (SC) assailing the constitutionality of RA 10354. Acting on them, the Court issued a 120-day *Status Quo Ante* Order (SQAQO), dated March 19, 2013. The SQAQO, which would have officially ended on July 17, 2013, was extended indefinitely by the SC on July 16, 2013. In response to the issues raised by the petitioners, the Office of the Solicitor General (OSG), with assistance from the Department of Health, filed a Consolidated Comment last May 9, 2013. In addition to this, several Comments-in-Intervention were also filed at the Supreme Court in support of the law.

The Supreme Court then scheduled oral arguments which took place from July 9-August 27, 2013. Aside from the OSG, officials from the Department of Health, other agencies, CSOs, and members of the RPRH IRR DC and TAWG were also present during the oral arguments. They made themselves accessible to the OSG in between sessions to provide technical support, as necessary.

On April 8, 2014, during its summer session in Baguio City, the Supreme Court declared RA 10354 and Its IRR to be “Not Unconstitutional”, except for eight (8) items. The provisions in the law and IRR which were affected by the SC Decision can be found in Annex 1.D.

Following the SC Decision and the go signal for full implementation, the DOH, together with its attached agencies, proceeded to draft the guidelines and deliver the services required by the law and its IRR.

III. DEVELOPMENT OF OPERATIONAL GUIDELINES AND POLICIES RELATED TO RA 10354

A. POLICIES AND GUIDELINES DEVELOPED IN 2014

A total of sixty one (61) specific operational guidelines have been required from the Department of Health and other government agencies, based on the RPRH IRR. Some of these guidelines are already available and would just need to be updated by the implementing agencies. On the other hand, some of the law and IRR's provisions require that new guidelines be drafted. The following is a list of policies developed by the DOH and other agencies in 2014, categorized according to the twelve (12) elements of reproductive health.

RH ELEMENT #1: FAMILY PLANNING INFORMATION AND SERVICES WHICH SHALL INCLUDE AS A FIRST PRIORITY MAKING WOMEN OF REPRODUCTIVE AGE FULLY AWARE OF THEIR RESPECTIVE CYCLES TO MAKE THEM AWARE OF WHEN FERTILIZATION IS HIGHLY PROBABLE, AS WELL AS HIGHLY IMPROBABLE. THE PROVISION OF INFORMATION ON FERTILITY CYCLES INCLUDES INFORMATION ON THE FULL RANGE OF MODERN FAMILY PLANNING METHODS.

1. DOH Administrative Order 2014-0041 or the *"Guidelines on the Recognition of Training Providers of the DOH"* (Date issued: October 30, 2014)
 - This issuance reiterates the designation of DOH Regional Offices as training centers for capacitating health providers to ensure their continuing professional education, so that the public are assured of receiving quality and up-to-date medical care. In order to respond to the demand in training activities, this Order enables qualified institutions, whether public or private, to be engaged by the DOH to deliver the capacity building services to the health personnel.
2. DOH Administrative Order 2014-0042 or the *"Guidelines on the Implementation of Mobile Healthcare Services for FP"* (Date issued: October 30, 2014)
 - This issuance provides the guidelines needed for the conduct of mobile outreach services delivering reproductive health care to people who reside within jurisdictions of requesting LGUs, or in geographically isolated and disadvantaged areas (GIDAs). It indicates the minimum services to be provided, the equipment and supplies required, and the competencies of the personnel assigned. It also enumerates the coordination mechanisms, roles and responsibilities of the different government offices, financing options, and reporting requirements.
3. DOH Administrative Order 2014-0043 or the *"Guidelines on the Estimation of Unmet Need for Family Planning"* (Date issued: October 30, 2014)

- This issuance describes the step-by-step process of computing unmet need using data from national surveys and programs, such as the National Demographic Health Survey and National Household Targeting System for Poverty Reduction. DOH field offices, LGUs, and even the private sector can make use of the method described in the issuance for planning purposes.
4. DOH Department Memorandum 2014-0311 or the *“Adoption of the Family Planning Clinical Standards Manual 2014 Edition”* (Date issued: October 27, 2014)
 - This issuance formally adopts the revision made to the Family Planning Clinical Standards Manual of the DOH. Some sections were added and updated in the 2014 edition, including the new section on informed choice and voluntarism, use of combined oral contraceptives and progestin-only injectables, correction of misconceptions about each family planning method, new family planning methods such as subcutaneous DMPA and subdermal implants, guidelines on long term and permanent methods, contraception for victims of sexual violence, contraception in disaster and crisis situations, and sexually transmitted infections.
 5. DOH Department Memorandum 2014-0312 or the *“Guidelines in Setting-Up Family Planning Services in Hospitals”* (Date issued: October 27, 2014)
 - This issuance indicates the minimum requirements in providing family planning services in hospitals. An enumeration of the basic services to be provided, the equipment and supplies required for the service, and the minimum competencies of the personnel required to perform the service are present in the guidelines. The management requirements, coordination mechanisms, and monitoring and reporting of the services provided are also indicated in the guidelines for ease of implementation.
 6. POPCOM issuance entitled *“Guidelines to Reduce Unmet Need for Modern Family Planning”* (Date issued: May 5, 2014)
 - This guideline focuses on the demand generation activities which can be conducted in order to reduce unmet need. This is different from the unmet need guidelines issued by DOH, which focuses on the computation of the indicator. Demand generation activities identified in the guidelines include the conduct of family planning classes, distribution of IEC materials, and mobilization of health workers to follow-up the utilization of services of clients who have expressed unmet need for family planning.

RH ELEMENT #2: MATERNAL, INFANT AND CHILD HEALTH AND NUTRITION, INCLUDING BREASTFEEDING

1. DOH Administrative Order 2014-0046 or *“Defining the Service Delivery Networks (SDNs) for Universal Health Care or Kalusugan Pangkalahatan”* (Date issued: December 29, 2014)
 - This issuance clarifies the definitions of the terms used in establishing a functional SDN.

2. DOH Administrative Order 2014-0045 or the *“Guidelines on the Implementation of the Expanded Newborn Screening Program”* (Date issued: November 19, 2014)
 - This issuance increases the number of disorders in the newborn screening panel from six (6) to twenty-eight (28). These include hemoglobinopathies, amino acid disorders, organic acidurias, fatty acid oxidation disorders, carbohydrate metabolism disorders, biotin metabolism disorders, cystic fibrosis, and endocrine disorders.
3. DOH Administrative Order 2014-0035 or the *“Implementing Guidelines on the Setting-up of Newborn Screening Continuity Clinics”* (Date issued: October 20, 2014)
 - This issuance provides the standards to be used in setting up Newborn Screening Continuity Clinics and Birth Defects Continuity Clinics for the referral and management of all newborns who tested positive for disorders during screening.
4. DOH Administrative Order 2014-0026 or the *“Guidelines for the Implementation of the Public Health Assistants Deployment Program”* (Date issued: September 3, 2014)
 - This issuance provides the qualifications, tasks, deployment, and compensation guidelines for Public Health Assistants (PHAs). PHAs are tasked to assist in the implementation of the MNCHN and EPI programs. They are also tasked to conduct health education and training in their areas of assignment.
5. DOH Department Memorandum 2014-0233 or the *“Immunization on Pentavalent (5in1) Vaccine for Infants and Children with Incomplete/ Missed Dose”* (Date issued: July 30, 2014)
 - This issuance describes the prescribed protocol of the DOH in providing the missed pentavalent vaccine doses to infants or children aged two years or less.
6. DOH Department Memorandum 2014-0200 or the *“Protocol on collecting blood samples for Newborn Screening”* (Date issued: June 27, 2014)
 - This issuance modifies the blood sample collection protocol in the Newborn Screening Program in order to account for the testing of maple syrup urine disease, a metabolic disorder caused by the deficiency or absence of the branched chain ketoacid dehydrogenase enzyme.
7. DOH Department Memorandum 2014-0228 or the *“Updates to Routine Adolescent Immunization 2014”* (Date issued: July 22, 2014)
 - This issuance provides for the coverage of adolescents aged 13 years old, including both in-school and out-of-school youths, to avail of immunization services.
8. DOH Department Memorandum 2014-0313 or the *“Adoption of Guidelines in Establishing the Service Delivery Network”* (Date issued: October 27, 2014)
 - This issuance indicates the process of establishing the service delivery network for the delivery of reproductive healthcare services. The steps include the identification of needs of the priority population, mapping of available healthcare providers, designation of populations to facilities, and monitoring and evaluation mechanisms.

It also includes a sample Memorandum of Understanding to ensure that both private and public hospitals would be included in the network.

9. DOH Department Circular 2014-0199 or the *“Frequently Asked Questions (and their Answers) regarding the Decision of the Honorable Supreme Court in the Consolidated Case of Imbong v. Ochoa (G.R. No. 204819) on RA No 10354 (RPRH Law)”* (Date issued: May 14, 2014)
 - This issuance enumerates the provisions of the law and IRR affected by the Supreme Court Decision, and summarizes the implications of the Decision to policy and field operations. The Department of Health has just issued an addendum to this issuance this April 2015, which provides the responses to questions posed by field personnel and other stakeholders from the first year of the law’s implementation.
10. DOH Department Circular 2014-0150 or the *“Guidelines for Universal Newborn Hearing Screening Program (UNHSP) Implementation”* (Date issued: March 21, 2014)
 - This issuance officially prescribes the use of the Newborn Hearing Manual, which includes the facility and clinical standards, training requirements of personnel, and roles and responsibilities of government agencies and health providers.
11. PhilHealth Circulars 34 s. 2006, 20 s. 2007, and 07 s. 2009 on the *“Newborn Care Benefit Package”*
 - This benefit package covers essential newborn care services, including metabolic newborn screening tests, newborn hearing test, and the first dose of Hepatitis B and BCG immunizations. The whole package amounts to Php 1,750.00.
12. PhilHealth Circular 10, s. 2012 on the *“Primary Care Benefit Package 1”*
 - The PCB1 package covers services related to the integrated management of childhood illness, such as medications for asthma, acute gastroenteritis with or without mild dehydration symptoms, and mild and low risk upper respiratory tract infections. It also includes Visual Inspection with Acetic Acid (VIA) for cervical cancer screening, digital rectal exam for prostate cancer, and breast examination. The package is currently available to indigent and sponsored program members
13. PhilHealth Circular 35 s. 2013 on the *“Implementing Guidelines on Medical and Procedure Case Rates”*
 - This Circular provides the guidelines on the mechanisms in which PhilHealth will provide payments to accredited facilities through case rates. The case rates related to reproductive health services include the insertion of IUDs, vaginal delivery, breech extraction, vaginal delivery after cesarean section, and surgical management of ectopic pregnancies. For indigent and sponsored members, the No Balance Billing policy applies.
14. PhilHealth Circular 22 s. 2014 on the *“Social Health Insurance Coverage and Benefits for Women About to Give Birth”* (Date issued: October 9, 2014)
 - This policy provides for the coverage of pre-natal, delivery, and antenatal services of women about to give birth. It enumerates the different services which can be availed in PhilHealth accredited facilities, such as the Maternal Care Package,

Normal Spontaneous Delivery Package, Antenatal Care Package, and Newborn Care Package. It also enumerates other covered services such as intrapartum monitoring or labor watch with or without antenatal care, cesarean section, complicated vaginal delivery, breech extraction, vaginal delivery after cesarean section, intrapartum care, normal delivery and post-partum care, bilateral tubal ligation, and IUD insertion. This policy expanded the reimbursement of services for all normal deliveries. It also allowed the reimbursement of IUD insertions in RHUs and midwife-managed clinics. With this policy, all pregnant women can automatically avail of benefits for giving birth and newborn care through Point of Care Enrollment and advance payment of premium.

15. DSWD also incorporates RPRH-related modules in its Family Development Sessions (FDS). One of these is the Enriched Modular Package for Women, which includes a set of modules on maternal health and nutrition, parent-child interactions, birth spacing, and breastfeeding. The FDS also included a Parent Effectivity Session which focuses on effective parenting for couples

RH ELEMENT #3: PROSCRIPTION OF ABORTION, AND MANAGEMENT OF ABORTION COMPLICATIONS

The DOH is set to review existing guidelines on the management of post-abortion complications per Administrative Order 45-B s. 2000 or the *“Prevention and Management of Abortion and its Complications (PMAC) Policy”*.

RH ELEMENT #4: ADOLESCENT AND YOUTH REPRODUCTIVE HEALTH GUIDANCE AND COUNSELING AT THE POINT OF CARE

There are also 259 regional provincial, and local policies issued with the assistance of POPCOM’s field units. These localized issuances are variations of the following:

- a. regulations mandating landlords to put in place interventions that would prevent minor lodgers from engaging in risky behaviors;
- b. designation of Population Officers in LGUs and requiring these officers to participate in LGU committees;
- c. designation of Reproductive Health Officers in LGUs;
- d. guidelines on Teenage Pregnancy Prevention;
- e. creation of Pre-marriage Counseling Teams;
- f. integration of Parent Education, Adolescent Health, and Youth Development in Regular Parent-Teacher Activities; and
- g. endorsement of the use of the Population and Development Education and Teaching Modules.

RH ELEMENT #5: PREVENTION, TREATMENT AND MANAGEMENT OF REPRODUCTIVE TRACT INFECTIONS (RTIS), HIV AND AIDS AND OTHER SEXUALLY TRANSMITTABLE INFECTIONS (STIS)

1. DOH Administrative Order 2014-0005 or the *“Revised Policies and Guidelines in the Collaborative Approach of TB and HIV Prevention and Control”* (Date issued: February 3, 2014)
 - This issuance addresses the increasing trend of HIV-TB co-infections by providing separate guidelines for screening and management of HIV among confirmed TB cases and screening and management of TB among HIV-infected individuals. It also provides the recording and reporting mechanisms for TB-HIV cases and monitoring of the clinical status of patients. Furthermore, the issuance reiterates the importance of quality assurance and infection control in facilities handling HIV and TB cases. The joint capacity building of health professionals handling TB and HIV, together with the enhanced coordination and increased roles and responsibilities of health facilities and government agencies, are included in the guidelines.
2. DOH Administrative Order 2014-0031 or the *“Policies and Guidelines on the Use of Antiretroviral Therapy (ART) among People Living with Immunodeficiency Virus and HIV-Exposed Infant”* (Date issued: September 23, 2014)
 - Considering the increasing number of people living with HIV and number of infants born to HIV-infected mothers, this issuance indicates the timing of antiretroviral therapy based on the patient’s age and immunologic/clinical status. It also provides the different therapy regimens, required counseling, performance of other laboratory tests, and guidelines for monitoring ARV toxicity and response to treatment. Guidelines for the management of co-infections are also included in the issuance.
3. DOH Department Memorandum 2014-0134 or *“Reporting of Sexually Transmitted Infections (STIs) Cases among Minor Clients”* (Date issued: April 29, 2014)
 - The issuance integrates the reporting of STI cases among minors to the monthly STI Sentinel Etiologic Surveillance System (SSESS).
4. PhilHealth Circular 19 s. 2010 on the Outpatient HIV/AIDS Benefit Package
 - This package, worth Php 30,000.00 per year, covers drugs and medicines, laboratory examinations, including Cluster Difference 4 (CD4) level determination test and test for monitoring of anti-retro viral drugs (ARV) toxicity, and professional fees of providers.

RH ELEMENT #6: ELIMINATION OF VIOLENCE AGAINST WOMEN AND CHILDREN AND OTHER FORMS OF SEXUAL AND GENDER-BASED VIOLENCE

1. DOH Department Order 2014-0169 on *“Implementing the Child Protection Policy in the Department of Health”* (Date issued: October 3, 2014)

- This issuance details the Code of Conduct for all DOH staff in terms of Child Protection, creates the Technical Committee on Child Protection, and specifies the roles and responsibilities of each agency unit to ensure that the policy is strictly adhered to.
2. Philippine Commission on Women (PCW) Memorandum Circular 2014-02 or the *“Implementation of the Women’s Empowerment, Development and Gender Equality Plan, 2013-2016 (Women’s EDGE Plan)”*.
 - This plan was developed through a multi-agency effort. Agencies convened by PCW submitted specific strategies related to the provision of RPRH service. These were also developed with the support of DOH.
 3. In support of RPRH Law implementation, the National Anti-Poverty Commission (NAPC) has provided technical inputs to the 2014 UN General Assembly review of the International Conference on Population and Development Program. Aside from this, it has also endorsed six (6) RPRH and Anti-Violence Against Women and Children (VAWC) ordinance drafts to ten (10) provincial governments. NAPC has also assisted in drafting ordinances on Local Committees on Anti-Trafficking and Violence Against Women and Children (LCAT-VAWC) Systems in Albay, Camarines Norte, Masbate, and Eastern Samar. NAPC has also assisted the province of Sorsogon and the municipality of La Trinidad in harmonizing their GAD Codes with the Magna Carta of Women and with the RPRH Law and its IRR.

RH ELEMENT #7: AGE- AND DEVELOPMENT-APPROPRIATE EDUCATION AND COUNSELING ON SEXUALITY AND REPRODUCTIVE HEALTH

POPCOM Memorandum on the *“AYHD Program Implementation Guidelines for 2015”* (Date issued: October 16, 2014)

- These guidelines specify activities which are targeted to reduce the incidence of teen pregnancies and the health risks associated with the condition, such as maternal death, abortion, STI, HIV/AIDS, and gender-based violence. Some of the activities include the conduct of coordination workshops with partner agencies on the sexual and reproductive health education modules, assessment and evaluation of adolescent health information campaigns, information dissemination activities of reproductive health-specific data from NDHS 2013 and YAFSS 2013, and the development of M&E protocols for maternal deaths and incidence of abortion among minors.

RH ELEMENT #8: TREATMENT OF BREAST AND REPRODUCTIVE TRACT CANCERS AND OTHER GYNECOLOGICAL CONDITIONS AND DISORDERS

PhilHealth Circulars 30 s. 2012 and 02 s. 2013 on the PhilHealth Z Benefit Package

- The package includes coverage for early stage breast cancer (Stage 0 – IIIA), low to intermediate risk prostate cancer, and cervical cancer (Stage I-IV). For breast cancer, covered services include mastectomy, lumpectomy, radiation therapy, histopathology, and chemotherapy. On the other hand, the services covered for

prostate cancer include surgery and radiation therapy. Lastly, covered cervical cancer services include histopathology, cervical and cone biopsy, loop electrosurgical excision procedure, chemotherapy, radiotherapy, and brachytherapy. Aside from the said procedures, hospital board and operating room fees, drugs and laboratory exams, and professional fees for the entire course of treatment are covered by the package.

RH ELEMENT #9: MALE RESPONSIBILITY AND INVOLVEMENT AND MEN'S REPRODUCTIVE HEALTH

1. DSWD also conducts Empowerment and Reaffirmation of Paternal Abilities (ERPAT) sessions during the FDS. These sessions emphasize the importance of knowledge, attitudes, and skills which fathers should develop in order to improve the performance of their paternal roles and responsibilities.
2. POPCOM Office Order 85 s. 2014 on the *"Guidelines for Mainstreaming of MR GAD/KATROPA at the Local Level"* (Date issued: October 14, 2014)
 - This covers the activities and financing requirements for the implementation of the Men's Responsibilities in Gender and Development/ *Kalalakihang Tumutugon sa Responsibilidad at Obligasyon Para sa Kalusugan ng Ina at Pamilya* (MR GAD/ KATROPA) Program in LGUs.

RH ELEMENT #10: PREVENTION, TREATMENT AND MANAGEMENT OF INFERTILITY AND SEXUAL DYSFUNCTION

Since this a new requirement under the RPRH Law, the DOH has yet to develop guidelines regarding the provision of services that would address infertility and sexual dysfunction conditions.

RH ELEMENT #11: AGE- AND DEVELOPMENT- APPROPRIATE REPRODUCTIVE HEALTH EDUCATION FOR ADOLESCENTS IN FORMAL AND NON-FORMAL EDUCATIONAL SETTINGS

1. The Department of Education Order No. 17, s. 2014 or the *"DepEd Guidelines on the Abot-Alam Program"* (Date issued: March 27, 2014)
 - This issuance is an interagency convergence effort which targets the out of school youth. It contains RPRH education modules, which would be updated based on the provisions of RA 10354 and its IRR.
2. Aside from DepEd Order No 17 s. 2014, the agency also began to develop guidelines for the Integration of Adolescent Reproductive Health and Sexuality Education, HIV/AIDS Education and Gender and Development in the K to 12 Basic Education Curriculum, including formulation of Comprehensive Sexuality Education Standards.

RH ELEMENT #12: MENTAL HEALTH ASPECT OF REPRODUCTIVE HEALTH CARE

The DOH, together with the National Center for Mental Health, is developing specific guidelines that would enhance the provision of reproductive health care services to clients with mental health conditions.

B. GUIDELINES AND POLICIES BEING DEVELOPED OR UPDATED BY THE DEPARTMENT OF HEALTH AND OTHER AGENCIES

The DOH is also drafting thirty (30) new issuances needed for RPRH implementation. The list and descriptions of these policies can be found in Annex 1.E.

Moreover, the DOH is set to update its RPRH-related policies and guidelines issued prior to the passage of the law. These will be reviewed and updated to ensure their consistency with the provisions of the RPRH Law and its IRR. A list of these policies per RH-element can be found on Annex 1.F.

Other agencies are also continuing to develop policies and guidelines for the implementation of the RPRH Act and its IRR. A list of these policies can be found in Annex 1.G.

PART II

BUDGET AND FINANCING SECURED

I. BUDGETARY SOURCES OF RPRH FUNDING

The SQAQ on the RPRH law and its IRR was still in effect when the 2014 GAA was passed. This prevented DOH and other agencies mandated to implement the RPRH Law from having specific budget line items to be used for RPRH implementation. After the law and its IRR were declared to be not unconstitutional in the second quarter of 2014, the DOH along with other agencies identified specific line items within their existing budgets as sources of RPRH funding.

A. BUDGETARY SUPPORT FROM THE DOH

The DOH identified the following line items as main sources of funding for RPRH implementation:

- 1) PhP 2.52 Billion from Family Health and Responsible Parenting (FHRP);
- 2) PhP 2.53 Billion from Expanded Program on Immunization (EPI); and
- 3) PhP 9.27 Billion from the Health Facilities Enhancement Program (HFEP).⁵

These budgets were allocated across central office units and 16 regional offices, including ARMM.

The FHRP budget was used, among others, to centrally-procure FP/MNCHN commodities such as family planning supplies and micronutrient supplements for mothers and children; conduct capacity-building activities for skilled health professionals; deploy community health teams; and assist LGUs in implementing RPRH programs. The HFEP was used to finance the infrastructure and equipment upgrading projects for Barangay Health Stations, Rural Health Units and District Hospitals. These projects consisted of new construction or upgrading of existing facilities that would enable them to function as clinics, birthing homes/lying-in clinics and hospitals that provide the full range of FP/MNCHN services such as modern FP services, pre-natal, safe delivery and post-natal services, and provision of other child health and nutrition services. The EPI was mainly used for the central procurement of vaccines for infants and mothers.

Other program line items were also used to implement RPRH-related activities. These include those that concern HIV/AIDS, cancer program, health promotion and communication, and health human resources, among others. However, the exact spending for RPRH cannot be disaggregated, as these budgets are also used by other DOH programs.

⁵ This amount covers only the upgrading of BHS, RHUs/CHOs and LGU district hospitals only. These facilities were upgraded primarily to improve their capability to deliver RPRH services, particularly related to FP/MNCHN.

As of December 31, 2014, the utilization rate for RPRH-related budgets ranged from 57 to 95 percent. Table 4 below shows the summary of the budget allocation and utilization of these selected line items:

Table 4. Budget allocation for selected RPRH-related line items and budget support with utilization rates for 2014.

Line Item ⁶	Allocation (Php)	Utilization rate (percent)
Family Health and Responsible Parenting (FHRP)	2,538,869,000	61
Expanded Program on Immunization (EPI)	2,441,933,000	95
Health Facility Enhancement Program⁷ (HFEP)	9,268,175,000	57

(Source: DOH 2014)

The low utilization rate for FHRP is due to non-procurement of remaining FP commodities that have yet to be certified as non-abortifacient by the Food and Drug Administration. The recertification process was delayed, as the law took effect only on April 8, 2014. Further delays were also due in part to late submission of requirements for recertification to the FDA. In addition, the low utilization can also be explained by the preference of implementing many activities such as trainings and seminars in house, instead of outsourcing to third party providers. On the other hand, the low utilization rate for HFEP is attributed to delays in the bidding process, handled mostly at the level of LGUs.

For its 2014 HFEP, the DOH has completed the upgrading of 164 Barangay Health Stations with another 254 projects ongoing, 105 Rural Health units with another 145 projects ongoing, and 26 district hospitals with another 117 projects ongoing. (Annex 2.A).

B. BUDGETARY SUPPORT FROM OTHER AGENCIES

The Commission on Population (POPCOM) spent around Php 198M from its budget to conduct demand generation activities at the grassroots level in their Responsible Parenthood and Family Planning (RP-FP) classes, Family Development sessions, and pre-marriage counseling sessions. POPCOM also developed tools/guidelines to improve access of beneficiaries of the services, and implemented advocacy and social mobilization activities at the community level, printing of information and education campaign materials, and roll-out of implementation of RPRH on Family Planning for Muslims and indigenous people.

The Department of Education spent close to Php 2.5M, or three percent out of their Php 83M Health and Nutrition Services line item for the Training of Trainers (TOT) on Increasing Awareness on HIV-AIDS in the Workplace, as well as on the TOT for mental health on the psychosocial approach during humanitarian situation that involved 100,000 teachers and 70,000 DepEd workers. Furthermore, DepEd also invested heavily in curriculum development for the K to 12 program. This includes the enhancement of comprehensive sexuality education, as provided for in the law.

LGUs also spent for RPRH activities such as procurement of commodities, hiring of staff, and health promotion and communication, social mobilization, and travel and communication expenses relative to capacity-building activities conducted by the DOH and partner agencies, among others. However, these amounts cannot be disaggregated from available financial reports.

⁶ Except for FHRP, these line items represent allocations for various health programs, and not only for the implementation of the RPRH Law provisions

⁷ This figure only includes the infrastructure upgrading projects for BHSs, RHUs, and district hospitals

II. FINANCING SUPPORT FROM DEVELOPMENT PARTNERS AND CSOs

In addition to government budgets, development partners and their CSOs also aligned their existing support to DOH programs that include RPRH implementation.

The key development partners for RPRH implementation include, in alphabetical order, Asian Development Bank (ADB), European Union (EU), Japan International Cooperation Agency (JICA), United Nations Population Fund (UNFPA), United States Agency for International Development (USAID), World Bank (WB), and World Health Organization (WHO). These development partners assisted the Government of the Philippines (GPH) by providing technical assistance to programs at the national, regional, and local levels; supplementing commodities that are lacking or insufficient in various regions, provinces, or facilities, whether on a specific project-based areas or geographic location; developing capacities for health workers to deliver the full range of reproductive health services; and assisting in knowledge management and in health promotions and communications.

Close to a fifth of all foreign assistance support are directed at RPRH-related programs. The combined amount for RPRH implementation across various development partners is roughly at PhP 4B, covering the period from 2011 to 2017. The breakdown of development partner support across selected RPRH elements is as follows:

1. Family Planning/RH/MNCHN (PhP 1.014B);
2. Facilities Upgrading for RH/FP/MNCHN (PhP 2.418B); and
3. HIV/AIDS (PhP 0.5B).

Various CSOs also reported aligning their programs with RPRH implementation. This implies that portions of their budgets were spent for RPRH-related activities such as advocacy and communications, service delivery, and capacity building. These activities were funded by various sources such as endowments, grants from development partners and other NGOs, DOH support funds, LGU counterparts, and in some cases, user fees.

III. SOCIAL HEALTH INSURANCE FUNDING FOR RPRH

A. TOTAL PHILHEALTH PREMIUM CONTRIBUTIONS

The total premium collection for the NHIP in 2014 was PhP 81.45B. Of this amount, PhP 35.295B came from the DOH budget as full national premium subsidy for NHTS poor families. These premiums allowed the NHIP to reach a coverage rate of 82.1 percent of the entire population in 2014, including all of the 14.7M Sponsored Members from the NHTS PR households (see Annex 2.B).

B. TOTAL PHILHEATH CLAIMS PAID

In 2014, PHIC paid a total of PhP 78.2B in benefits, of which PhP 25.56B was paid for the Sponsored Program. At least P11.3B was paid for RPRH-related benefits. This includes five of the top 10 surgical procedures, namely Normal Spontaneous Delivery, Caesarian Section, Maternity Care Package, Vaginal Delivery, Dilatation & Curettage amounting to PhP 8.2B. This amount accounts for 786,375 out of the 6.6M claims or 11.9 percent of total claims paid. Table 5 below is a summary of selected benefit claims payment made by the PhilHealth. Further details are provided in Annex 2.C.

Table 5. Selected PhilHealth claims and payment for RPRH-related benefit packages.

Benefit package	Number of claims filed	Total amount paid by PhilHealth
FP⁸	4,459	20,588,060
MNCHN⁹	1,207,705	8,274,657,081
Post-abortion care	25,617	258,690,120
STI and HIV	6,685	53,360,630
Breast and Gynecologic Conditions^{10*}	189,236	2,546,953,258
Prostatic conditions¹¹	8,126	110,440,402
TOTAL	1,441,828	11, 264,689,551

(Source: Philhealth 2014)

⁸ Includes IUD, BTL, and NSV

⁹ Includes normal deliveries and cesarean sections

¹⁰ Includes reimbursement for procedures such as hysterectomy, D&C, as well as cancer treatment among others

¹¹ Includes treatment of prostatic conditions including prostate surgery

PART III

COMMODITIES PROCURED AND DELIVERED

I. CERTIFICATION OF CONTRACEPTIVE PRODUCTS AS NON-ABORTIFACIENT

The FDA, in coordination with the OSG, convened an Expert Review Group last June 2014 to assess if the contraceptives available in the Philippine market are non-abortifacient, based on the criteria set by the SC Decision. The FDA issued a letter to all contraceptive Manufacturing Application Holders (MAHs) in the country to submit their applications for re-certification last July 15, 2014. The FDA also called for public comments last October 2014. As of November 10, 2014, a total of 50 applications were received by the FDA for re-certification. On November 28, 2014, 38 of these products were certified as non-abortifacient with the rest still undergoing review.

II. AMOUNT AND TYPE OF FP COMMODITIES PROCURED AND DISTRIBUTED

In 2014, the DOH distributed commodities procured with its 2013 budget amounting to PhP 289.2B (Annex 3.A). The DOH also received donated commodities from development partners consisting of 529,050 vials of DMPA and 10,000 units of subdermal implants that were used for the training of health care providers. The procurement, distribution and use of these commodities were in accordance with the existing mandates of the DOH, as the provision requiring recertification of commodities as non-abortionifacient was not yet effective with the SQAO still in effect. When the Supreme Court declared the RPRH Law to be not unconstitutional, DOH then initiated the process of recertifying contraceptives and postponed its procurement for 2014. Once the commodities were recertified, DOH procured PhP 794.9B worth of FP commodities using its 2014 budget (Annex 3.B). These commodities are expected to be delivered to DOH beginning January 2015.

PART IV

DEMAND FOR SERVICES GENERATED

I. MULTIMEDIA CAMPAIGN ACTIVITIES

Based on the IRR of the RPRH Law, the DOH and the LGUs shall initiate massive and sustained nationwide communication campaigns to raise the level of public awareness on the protection and promotion of responsible parenthood and reproductive health and rights. The CSOs and the private sector are also encouraged to participate in this effort.

Health Promotion and Communication (HPC) messages on RPRH were delivered by DOH and partner agencies through mass media (radio, TV, print), social media (Facebook™, Twitter™, Youtube™), traditional and mobile media like billboards, and LRT/MRT advertisements to raise public awareness. Reinforcing the mass, social, traditional and mobile media were interpersonal communication and counseling (IPCC) and health events provided and organized by the health service providers and volunteers in the school, workplace, and community settings. IPCC ensured that desired RPRH behaviors are practiced by the intended target beneficiaries or clients.

The Department of Health, in partnership with development partners, has come up with a national communication campaign with the objective of increasing demand for the life-saving and life-enhancing services of family planning. The communication plan was to be implemented in two phases:

1. Phase One (2014) will re-launch Family Planning as a brand equated with the benefit of a better quality of life; and
2. Phase Two (2015) will debunk myths and misconceptions to promote family planning methods.

In particular, the DOH employed several innovations in the implementation of this communication campaign on FP. The HPC messages were developed using best available evidence such as from national surveys. The materials were also developed to be specifically directed at NHTS poor households, as priority beneficiaries for RH services to be provided by the government. The timing, intensity, and frequency of delivery of the HPC materials were also calibrated to ensure that the materials would reach the maximum number of audience. To determine the impact of these HPC messages, the DOH and partner agencies employed monitoring and evaluation methods similar to those used by mass media outfits in the country.

A. THE “INAKUP, AREKUP” TV COMMERCIAL

For the first phase of the campaign, family planning was re-launched as a brand equated with a better benefit of quality of life. A TV commercial was made the centerpiece, because even among the lowest quintiles, TV ownership is still high at 84 percent, in contrast with radio ownership, which is a far second at only 70 percent.

Based on a true story, “Inakup, Arekup” highlighted the difficulties faced by families who have problems in planning the number and spacing of their children. The commercial was aired in major networks from May 2014 to July 2014 with a total of 10 weeks on air. After 10 weeks of airing “Inakup, Arekup” in major local networks, 74 percent of the audience (or around 70 million) were exposed to the material at least three times. Of these, 71 percent correctly recalled the message that FP secures a better quality of life for the family (refer to Annex 4.A for the graphs showing the different findings of the survey done regarding this TVC).

As more people recognized the ad, more people gained a better opinion on FP, from 78 percent at week 1, to 86 percent by end of week 10. They were, in fact, persuaded to use it. People who were persuaded to use FP grew from just 60 percent in the first week of airing, to 75 percent by end of week 10.

The commercial also earned several media awards such as a silver award in the category, “Advocacy Communications: Reverence for Family Unit or Marriage or Responsible Parenthood” at the 4th Araw Awards 2014 and in the Hildegarde Awards for Women in Media and Communication in the Advertising Category.



Image 4. Still from "Inakup, Arekup"

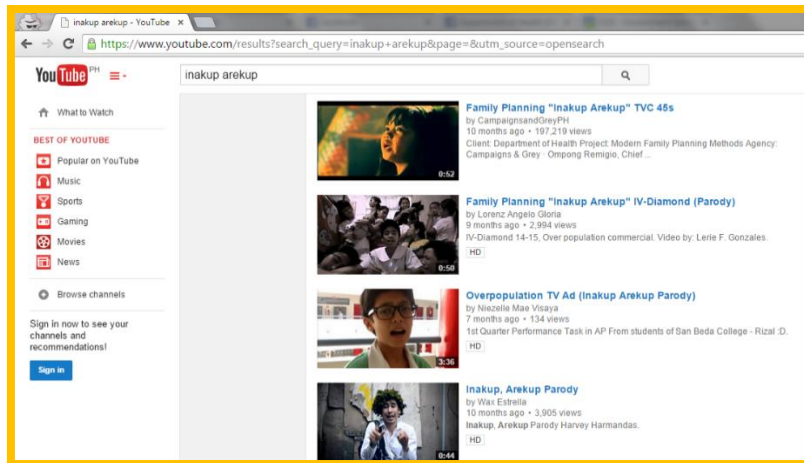


Image 5. “Inakup Arekup” on YouTube

B. TELEVISED REPRODUCTIVE HEALTH DISCUSSIONS

A *Pinoy MD* guesting was done by the DOH last September 20, 2014. Set in Fabella Hospital, the interview discussed different family planning methods, benefits, as well as common myths and misconceptions about it.

In *Salamat Dok*, the entire episode last September 27, 2014 was devoted to family planning. It featured a couple with 21 children being interviewed for their insights on having a big family and plans of using FP in the future. There were also doctors from the DOH conducting an FP medical mission in the background.

Family Planning was also featured in two local magazine shows: *Failon Ngayon* (ABS CBN) and *Kapuso Mo, Jessica Soho* (GMA). *Failon Ngayon*’s episode on the Philippines’ 100 millionth baby and FP was aired last August 2, 2014. On the other hand, *Kapuso Mo, Jessica Soho*’s special feature on FP was aired last August 3, 2014.

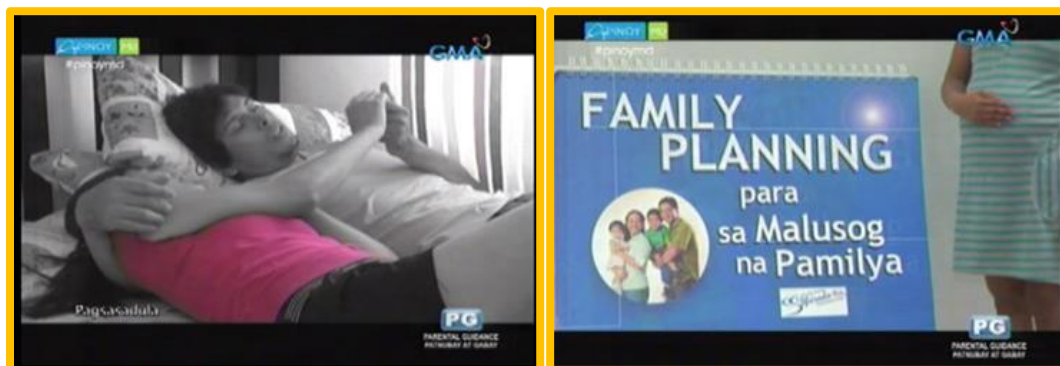


Image 6. Image stills from Pinoy MD’s Family Planning episode (GMA 7)

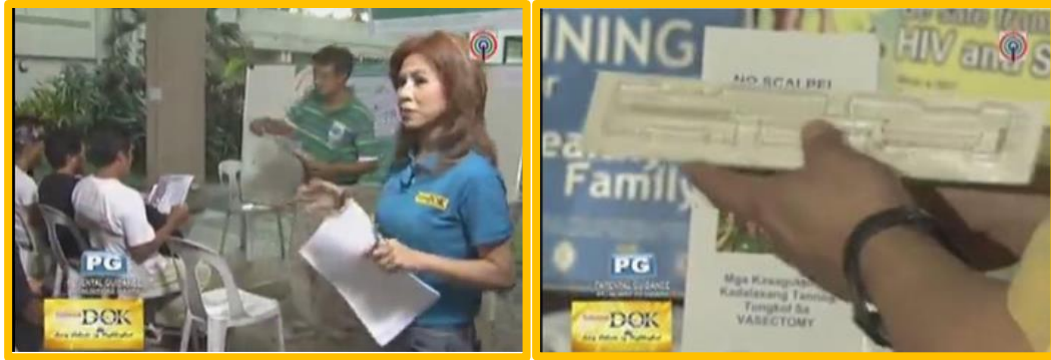


Image 7. Image stills from Salamat, Dok's Family Planning Episode (ABS CBN)



Image 8. Image stills from Failon Ngayon's 100 Millionth Pinoy Episode (ABS-CBN)



Image 9. Image stills from Kapuso Mo, Jessica Soho's 100 Millionth Pinoy episode (GMA 7)

C. PRINT COLLATERALS

Complementary print materials to promote family planning methods and to correct common myths and misconceptions were also developed. Individual brochures, posters, and banners on natural, temporary, long-term, and permanent family planning methods were produced and distributed (see Annex 4.B). These materials were distributed to health facilities even before the airing of the “Inakup, Arekup” advertisement. This synchronized approach added to the effectiveness of the campaign, and are especially needed because the mass media campaign has finite resources, and cannot be on air all-year-round.

POPCOM also reproduced and disseminated 50,000 copies for each of the five types of brochures mentioned above. Communication materials for adolescents like standee tarpaulins titled “Isip-isip Bago Unzip” and “Preventing Teen Pregnancy” were also developed by DOH and development partners.

D. TEN KUMAINMENTS CAMPAIGN (POPULARIZATION OF THE NUTRITIONAL GUIDELINES FOR FILIPINOS)

The National Nutrition Council (NNC), the Philippines policy-making and coordinating body on nutrition under the Department of Health, launched in 2014 its popular version of the Nutritional Guidelines for Filipinos called the “10 Kumainments”. The guidelines aims to promote positive nutrition practices to prevent malnutrition and encourage the adoption of a healthy lifestyle. The messages were aired on TV (GMA 7, GNN), radio (DZBB, DZRH, DZXL, DWWW, DZMM) and in the 25 *nutriskwela* radio stations of NNC. Regional launch activities have also been conducted. The TVC and radio ads were also supplemented with collaterals like 10 *Kumainments* Bread Tablet, posters and fans, refrigerator magnet, and standee (see Annex 4.C).

E. 100 MILLIONTH PINOY PROJECT

100 Millionth (100Mth) Pinoy Project was initiated by POPCOM to highlight 12:05 A.M. of July 27, 2014 as a symbolic time and date for the Philippines, wherein the 100 Millionth Pinoy was born. The project was implemented to raise awareness among different segments of the population on reproductive health issues and concerns, and in recognition of the challenge to attain the right and need of 100 million Filipinos to quality life. The 100 babies born on or after 5:54 am of July 27, 2014 were identified from 81 Provinces and 19 Cities nationwide. Families of the said children were given starter kits amounting to five thousand pesos (Php 5,000.00), along with the commitment to assist them in ensuring the development of their babies to become productive individuals in the future. PhilHealth’s lifetime enrolment and inclusion in the 4Ps for those qualified were also facilitated for the families of the 100 babies. Media interviews and media guestings for the event, from July 23 to August 9, 2014, garnered a total of 88 outputs on radio, TV and print media. Media monitoring for reach as regards to print registered 14,582,109 readers.

F. THE U4U TEEN INITIATIVE

The U4U teen trail initiative is a collaborative project which is undertaken by POPCOM, together with UNFPA and the private sector. The project uses online and mobile technologies to educate Filipino teens about preventing teen pregnancy and sexually transmitted infections. It maintains an interactive and dynamic website and an Interactive Voice Response System wherein, through the internet and mobile phone system respectively, youth are able to access critical information on the

abovementioned issues. Furthermore, a caravan-type U4U celebration with activities including youth concert/show of talents, panel board exhibits, orientations, peer counsellor/advocate trainings and others was done nationwide in different schools and government centers. As of December 2014, the activity has reached 20,027 teens.

G. REPRODUCTIVE TRACT CANCER AWARENESS CAMPAIGNS

The DOH also conducted several reproductive tract cancer awareness campaigns last 2014. Several advocacy and service delivery activities were performed during the National Cancer Awareness Week in January 2014, the World Cancer Day in February 2014, Cervical Cancer Awareness Month in May 2014, and the Prostate Cancer Awareness Month in June 2014. Cancer screening services, such as the visual inspection using acetic acid (VIA) for cervical cancer and digital prostate cancer screening in 65 public hospitals were done during the awareness months.

H. OTHER DISSEMINATION ACTIVITIES

Department of Health's Disease Prevention and Control Bureau (DPCB) and POPCOM held a number of Young Adult Fertility and Sexuality Study (YAFSS 4) Dissemination Forums. Regional dissemination forum activities reached a total of 2,832 teens, parents, community, and school based stakeholders.

DOH-DCPB likewise organized the Teen Pregnancy Summit, to generate policy recommendations to address teen pregnancy. Around 300 participants from LGUs, DepEd, DSWD, NYC, development partners, the academe, and CSOs participated in the event.

I. COMMUNICATION AND ADVOCACY INITIATIVES OF CSOS

Civil Society Organizations (CSOs) organized press conferences to raise awareness on the RPRH law and demand for its implementation. Media coverage on the issues was featured in national and local media. There were also two radio programs and one internet video that discussed the topics on sexual and reproductive health rights (SRHR), women's issues and the RPRH law. Anchored by NGO women and run for one hour daily, these radio programs reached Luzon, Visayas and parts of Mindanao. One radio program has 15,000 followers. Radio plugs on gender-based violence were also produced.

CSOs also organized a wide range of advocacy activities on the topics of the RPRH law. These activities mobilized 12,798 multi-sectoral groups – young people, peer educators,

women, LGBTs, interfaith groups, academe, media, OFWs, health professionals, business groups, local officials, and legislators.

The CSOs also produced 147,250 copies of IEC materials on RH Law and Rights, adolescent reproductive health (ARH), Family Planning, VAWC, GBV, Q&A on religious opposition, conscientious objection on RH, gender equality and sexuality, and budget on RH. These materials were in various formats: booklet, primer, briefer, comics, fans and posters. They were disseminated to the various groups nationwide. An RPRH law primer was also produced in English and translated in five local languages – Tagalog, Hiligaynon, Cebuano, Bicolano and Ilocano. Furthermore, an advocacy manual on RH, Adolescence, faith-based ASRH and VAWC were also produced for community women leaders and young people.

II. MOBILIZATION OF HEALTH WORKERS FOR DEMAND GENERATION

The LGUs, in partnership with DOH and other agencies have implemented many activities aimed at increasing demand for various health services, including modern FP. The programs or activities reported in this section encompass RH as well as other health programs of government.

The deployment of various types of health workers as described in this section highlights their demand generation contributions. However, nurses and midwives also perform direct service delivery functions as described below.

A. DEPLOYMENT OF COMMUNITY HEALTH TEAMS (CHTS), PUBLIC HEALTH ASSISTANTS (PHAS), NURSES, AND RURAL HEALTH MIDWIVES

Part of the strategy of LGUs, in increasing the demand for and utilization of health services is the deployment of Community Health Teams (CHTs) at the barangay level. CHTs are tasked to generate demand from the NHTS households for critical health services, such as maternal and child health and nutrition services and treatment of infectious diseases like tuberculosis. Each CHT is ideally composed of five members, which includes the local midwife, BHWs, Barangay Nutrition Scholars, and parent leaders. The CHT members are tasked to visit assigned households¹² in order to provide information, assess health needs, assist in the development of health use plans, and guide households in using and financing services. However, reports on the extent of deployment and the effectiveness of CHTs have been mixed. An initial assessment undertaken by DOH in 2013 focused on operational challenges but was not able to assess the extent of deployment and validate reports on the contribution of CHTs in reducing unmet needs, especially among the poor.

Aside from the CHTs, the DOH also deployed public health assistants to help the field offices in performing administrative and demand generation functions. The initial deployment of twelve (12) PHAs per region was accomplished in the last quarter of 2014. The PHAs were also tasked to collect and report data related to the MDG programs and to increase the awareness and demand of the community for the services under the Expanded Program on Immunization. The ROs deployed their PHAs to provinces and municipalities in their areas based on the most number of NHTS and the performance of the area in terms of MDGs.

DOH also helped augment the service delivery staff of LGU health facilities through the deployment of nurses under the Nurse Deployment Program (NDP). The succeeded the Registered Nurse for Health Enhancement and Local Service (RN*Heals*) program implemented in 2013. The nurses under the NDP were deployed in Rural Health Units, birthing homes, barangay health stations, and Level I LGU hospitals in Conditional Cash Transfer (CCT) areas of DSWD and handle both demand generation and service delivery functions.

¹² A typical CHT member handles around 20 households.

The DOH also augmented the lack of midwives in primary health facilities through the RHMPP. The midwives under the program are tasked to focus on assisting in the delivery of MNCHN programs of the DOH, particularly the facility-based delivery, EPI, and FP. Focus on these services intend to improve the overall health indicators such as MMR, CPR, and FIC. Some of these midwives are also tasked with supervising CHTs.

Table 6 summarizes the national accomplishments of the above programs in terms of the number of deployed personnel. A summary of the regional deployment status of these programs is found in Annex 4.D, while the specific number of households visited by CHTs in 2014 can be found in Annex 4.E. Finally, the regional deployment data of NDPs is in Annex 4.F.

Table 6. Number of CHTs, NDPs, RHMPPs, and PHAs deployed in 2014.

Program	Target	Deployed	Percent Deployed
CHT members	270,000	225,001	83.3
NDPs	11,000	11,292	102.6
RHMPP	2,700	2,700	100.0
PHAs	204	204	100.0

(Source: DOH 2014)

B. FAMILY DEVELOPMENT SESSIONS

DSWD conducts Family Development Sessions (FDS) with CCT families in the different barangays. The FDS is intended to increase demand for certain services, and empower couples and families in making the right decisions for themselves. Aside from the module on RFPF conducted with POPCOM, there were also modules that focused on women and children's health, including means to access pregnancy, childbirth, and nutrition services. Another module focused on parenting, which was discussed during the Parent Effectivity Session. Sessions on ERPAT (Empowerment and Reaffirmation of Paternal Abilities) were also conducted to highlight the importance of knowledge, attitudes and skills of fathers in performing their paternal roles and responsibilities.

The national turn-out for FDS compliance in the last quarter of CY 2014 was 3,953,324 or 95 percent of the 4,195,944 Pantawid Pamilya beneficiaries.

C. RESPONSIBLE PARENTHOOD AND FAMILY PLANNING CLASSES

The RFPF classes is a demand generation activity conducted under the *Kalusugan Pangkalahatan* (KP) and the *Pantawid Pamilyang Pilipino* Program (4Ps). A memorandum of agreement on data sharing was signed between POPCOM and DSWD to assist in planning for recipient families of the RP/FP FDS classes using Submodule 2.2. Information on responsible parenting and family planning benefits including methods available is imparted to class recipients. Such activity is geared towards identifying unmet need, FP commodity demand generation, as well as possible linking of demand to service delivery. For 2014, a total of 755,908 couples were reached both for the 4Ps and non-4Ps areas, through 47,889¹³ barangay classes conducted through the Regional Population Offices, in

¹³ Figure is sum of RFPF classes conducted in FDS, USAPAN, and PMC

partnership with other local stakeholders such as LGUs and CSOs among others. A regional breakdown of the accomplishment is provided in Annex 4.G.

D. KP ROADSHOWS

The DOH launched the KP Roadshow or *DOH on Wheels: Kalusugan Pangkalahatan* last May 2014 in support of the Aquino administration's health agenda. The Roadshow was intended to showcase the various programs of the health sector on women, children, adolescents, men, and senior citizens. The Life Cycle Approach in addressing health issues was emphasized in the roadshows. FP, oral health during pregnancy, Philhealth enrolment, micronutrient supplementation, healthy lifestyle, vaccinations, and counseling on self-image development were all part of the activity. By December 2014, there have been a total of five Roadshows done in Regions 6, 7, 8, CARAGA, and NCR, involving 13 towns.



Image 10. KP Roadshow Bus.

(Image courtesy of the World Health Organization. Available at the World Wide Web through: <http://www.wpro.who.int/entity/philippines/mediacentre/features/kproadshow.jpg>)

E. MOBILIZATION ACTIVITIES CONDUCTED BY OTHER GOVERNMENT AGENCIES AND CSOS

NAPC attended a "Run for Exclusive Breastfeeding" Activity last year. This was part of their GAD organizational-focused activity. DepEd conducted Consultative Fora last September and November 2014 for Public Mental Health Promotion, with participants from various regions and ARMM.

Different CSOs have also conducted home visits, community education sessions, parents'/mothers' classes, small group discussion, peer education sessions on RH, sexuality, relationships, ARH, FP, teen pregnancy, STIs/HIV and AIDS, VAW, and RH law orientation. These activities were participated by 69,909 community women and young people from various communities across the country. Through these activities, 3,138 women availed of regular pre-natal check-ups, FP supplies, VAWC counselling, medical, and legal assistance.

PART V

CAPACITY BUILDING ACTIVITIES IMPLEMENTED

I. CAPACITY BUILDING FOR SERVICE DELIVERY

The mandate to ensure that adequate supply of health service providers who are competent and equipped with adequate skills and knowledge for service delivery is repeatedly mentioned in the RPRH law and its IRR. The DOH, together with other partners, have conducted various capacity building activities to ensure that a sufficient pool of competent health professionals and other RH workers are available to serve the Filipino people. These efforts at capacity building are also complemented by deployment programs to augment the number of health service providers in the LGUs and other government health facilities.

A. MATERNAL AND CHILD HEALTH

In order to improve the services as well as indicators for Maternal and Child Health, trainings on Basic Emergency Obstetric and Newborn Care (BEmONC) for RHUs and birthing homes were done by the DOH. The training includes a module on Essential Intrapartum Newborn Care (EINC) that includes breastfeeding.

In 2014, the DOH conducted the following capacity building activities for the enhancement of child health services:

1. Basic Course for Health Workers on Child Injury Prevention
 - This was conducted as a pretesting of the module on Child Injury prevention. The modules include a session on the policies surrounding child injuries, epidemiology of the different types of injuries, child injury prevention principles, situational analysis application, prioritization criteria and identification, program planning, program development, program implementation, and monitoring and evaluation. The pretest included 44 participants from DOH ROs, LGU PHOs and CHOs, hospitals and other health facilities, Philhealth, and development partners.

2. Newborn Hearing and Screening Certification Course

- The Newborn Hearing and Screening Certification Course was intended to orient and train health professionals in adhering to Department Circular 2014-0150 or the Guidelines for Universal Newborn Hearing Screening Program (UNHSP) Implementation. The course was conducted in three batches, and was attended by 111 participants, including those from the DOH ROs, LGU facilities, and private providers. The course provided the participants hands-on practices in using the otoacoustic emissions device (OAE) or automated auditory brainstem response (AABR) on newborns, training on counselling parents and guardians on the importance of newborn hearing screening, implication of results, PhilHealth benefit packages for newborns, and on accomplishing and transmitting the Newborn Hearing Screening Registry Form.

3. Mother-Baby Friendly Hospital Initiative (MBFHI) Assessor's Course

- The course includes a discussion of laws and DOH policies relevant to MBFHI and a discussion of the structure, contents, and use of the assessment tool that would enable health workers to assess the capacities of health facilities delivering maternity and newborn care services to see if they comply with certification requirements. In June 2014, the course was attended by 44 participants from the DOH Regional Offices and DOH ARMM.

4. Kangaroo Mother Care (KMC) Orientation Workshop for DOH-retained Hospitals

- This course conducted in two batches presented the standards of small baby care in DOH-retained hospitals and other LGU facilities. The trainings of trainors and implementers were attended by 46 participants, including neonatologists, pediatricians, obstetric gynecologists, nurses, and medical social workers.

B. FAMILY PLANNING

DOH, together with CSOs and development partners, also trained healthcare professionals on Family Planning through its FPCBT1 and FPCBT2 courses. These courses discuss the different FP methods such as IUD, progestin subdermal implant, MNFPs, BTL and NSV. In 2014, a total of 1,055 healthcare providers were trained on various short acting methods, including natural modern FP under FP CBT1. The number trained on FPCBT2 is also shown in Table 7.

Table 7. Number of Healthcare Providers trained in FPCBT 1 and FPCBT 2 in 2014.

	Methods included	# of Trained Healthcare Providers
FPCBT1	Short-acting Method (both artificial and natural)	2,444
FPCBT2	Long-acting Reversible Contraception	2,770
	Modern Natural Family Planning (MNFP)	512
	Long-acting Permanent Method	295

(Source: DOH, development partners, and CSO reports)

C. ADOLESCENT AND YOUTH REPRODUCTIVE HEALTH

On adolescent concerns, the DOH developed the Adolescent Job Aid (AJA) including a manual for the training of health workers on adolescent health. There were a total of 32 AJA trainings conducted nationwide that had 1,280 participants representing 833 RHUs and CHOs. Annex 5.A summarizes the regional data on number of RHUs with trained Healthcare providers on AJA.

D. CAPACITY-BUILDING ACTIVITIES FOR SERVICE DELIVERY WITH REGARD TO OTHER ELEMENTS OF REPRODUCTIVE HEALTH

1. GENDER AND RH TRAINING IN HOSPITAL

The DOH conducted an orientation on the Administrative Order No. 2013-0011 or the Revised Policy on the Establishment of WCPUs in Government Hospitals, and Administrative Order No. 2013-0005 or the National Policy on the Unified Registry Systems of the DOH last 2014. Aside from the orientation, training on the forms and how to use the VAWC Registry System was also conducted. The sessions held across the country were attended by 189 WCPU personnel and DOH Regional Office VAWC coordinators.

2. COMMUNICATION FOR COMMUNICATORS SCHOOL

The DOH, in partnership with USAID and other development partners, implemented a six-month blended course for the communication, leadership, and strategic planning skills of government health professionals. A total of 86 DOH, LGU and project staff graduated in 2013. The course is currently on its 2nd year of implementation.

3. INTERPERSONAL COMMUNICATION AND COUNSELING

The Department of Health, together with development partners, created a job aid for health service providers on health teaching and counseling activities. The integrated flipchart covers topics on Family Planning, MNCHN, Tuberculosis, and PhilHealth. A total of 3,253 service providers from regional, provincial, and municipal health offices were trained on the use of the job aid.

4. REPRODUCTIVE TRACT CANCERS TRAINING

As of December 31, 2014, the DOH has trained 113 doctors, nurses, and midwives, and 10 non-communicable disease regional coordinators for the prevention and control of cervical cancer. Cervical Cancer Prevention and Control Training Centers have also been established in the DOH-retained hospitals of 14 out of 17 regions.

B. CAPACITY BUILDING FOR DEMAND GENERATION AND ADVOCACY

Complementing efforts to build capacity for service delivery are programs to help RH workers to generate demand for services as well as advocate for support to RPRH activities. In 2014, POPCOM developed the capacity of Muslim Religious Leaders and other influentials in support of RPRH. The DOH and other partners also implemented other capacity building activities to help service providers and other RH workers develop the capacity to generate demand for services.

A. FAMILY PLANNING

1. SOUTH-SOUTH COOPERATION (SSC) INITIATIVE FOR GOOD PRACTICES IN FAMILY PLANNING, REPRODUCTIVE HEALTH, AND GENDER MAINSTREAMING.

As part of cooperating efforts in knowledge sharing and highlighting best practices existing in the region, the POPCOM, together with UNFPA, conducted this program with other ASEAN nations. These activities include the internship in Indonesia of municipal teams, and training of 25 Muslim religious leaders (MRLs) from ARMM to learn supply and demand strategies in family planning done by the country. The participants were also oriented on the Muslim Fatwa for FP and the implementation of RPRH programs.

2. MARRIAGE COUNSELLING FOR MUSLIM FILIPINOS

Furthermore, POPCOM, together with the National Center for Muslim Filipinos (NCMF), developed a supplemental guide for counselling Muslim Filipinos. The supplemental guide was used to capacitate Muslim Religious Leaders (MRLs) and Muslim couple counsellors. For 2014, 25 MRLs underwent Training of Trainers for Muslim Filipino Marriage Counselling. A roll out training for marriage counsellors for Muslim Filipinos was undertaken with 77 Counsellors.

B. ADOLESCENT REPRODUCTIVE HEALTH

In 2014, 3,218 adolescent peer health educators were trained on AYRH. This includes adolescent and youth reproductive health guidance and counseling at the point of care.

C. HIV AND AIDS

The Department of Education conducted a Training of Trainers on HIV and AIDS Education and Prevention in the Workplace for 138 teaching personnel. Information on prevention of transmission HIV and AIDS, improvement of health-seeking behavior, and lessening of stigma and discrimination associated with the disease are emphasized in the training.

D. CAPACITY-BUILDING ACTIVITIES FOR DEMAND GENERATION CONCERNING OTHER ELEMENTS OF REPRODUCTIVE HEALTH

1. KATROPA (KALALAKIHANG TAPAT SA RESPONSABILIDAD AT OBLIGASYON SA PAMILYA)

The program underscores among men their responsibility to their families on reproductive health, in line with one of the elements of reproductive health care as set forth in the law. Topics include those on gender equality, responsible parenthood, family planning, violence in the family and violence against women and children, healthy living, relationship with one's wife, ensuring the health of one's pregnant wife, HIV/AIDS, and other Sexually Transmitted Infections. Starting September 2014, the training of trainers for these sessions included 43 participants. As of December 2014, the sessions garnered a total of 207 attendees.

2. NATIONAL COMMUNICATION PLANNING WORKSHOP OF POPCOM

To effectively communicate the components of the Philippine Population Management Program (PPMP), POPCOM coordinated the conduct of this workshop, attended by information officers of both Central and Regional Population Offices. The aim of the activity was to deliver appropriate skills and knowledge in order to develop and enhance competencies needed to advocate and communicate the thrust of PPMP. It has resulted in the development of communication plans for RPPF, AHYD, and GAD.

3. BREASTFEEDING COUNSELOR TRAINING

The DOH Health Promotion and Communication Service (HPCS) has also conducted a series of trainings that capacitated 550 health workers on breastfeeding counselling in five regions of the country.

4. CAPACITY BUILDING ACTIVITIES OF CSOs

CSOs have also conducted a series of trainings for 950 community RH leaders, young people, community health promoters, RH sentinels, and local officials on the topics of patients' rights, common emergencies in pregnancy and childbirth, comprehensive sexuality education, faith-based ASRH, prevention and interventions on teen pregnancy, VAW, gender, FP, RH, and advocacy in Manila, Caloocan, Quezon City, Antipolo, Albay, Baguio, Kalinga, Apayao, Mt. Province, Abra, Cebu, Negros Oriental, and Palawan.

PART VI

DELIVERY OF RPRH SERVICES

I. SERVICE DELIVERY SYSTEM FOR RPRH

The health service delivery system for RPRH in the Philippines is decentralized, with multiple levels where care is provided from the community to highly specialized hospitals. Typical primary care facilities in the community include barangay health stations (BHS) and rural health units (RHU)/health centers of the government health care delivery system. These facilities are usually staffed by a complement of mostly midwives in BHSs; and midwives, nurses and a doctor in RHUs/health centers. These facilities are expected to provide appropriate information on the 12 elements of RPRH, dispense a specified number of health products, make appropriate referrals to other facilities in the SDN, and recognize, report, and refer cases of gender-based violence.

Birthing facilities, often operated by a public- or private-sector midwife, provide the next level of care for RH services. These are either stand-alone facilities or attached to BHSs and RHUs, to deliver safe delivery services, newborn care, postnatal care, and family planning services including NSV, BTL, and insertion of IUD or subdermal implants.

Hospitals are the next level of care where, in addition to the services provided by primary care facilities, there are also diagnostics and management of reproductive tract infections (RTIs); case management for gender-based violence; medical and surgical procedures for definitive management of breast and reproductive tract cancers, other gynecological conditions and disorders, and male reproductive health concerns; basic diagnostics for infertility, with provision for referral to appropriate reproductive endocrinology/infertility treatment centers; and specialist management of reproductive mental health conditions.

II. STATUS OF DELIVERING RPRH SERVICES

The following accomplishments in terms of delivering RPRH services^{14,15} were obtained from program reports submitted by LGUs and consolidated at the DOH regional offices. These program reports represent mainly the performance in public sector facilities and constitute only a portion of the actual accomplishments as some regions are not yet done with their 2014 reports. In addition, the figures cited here are still being validated by the respective regions with their LGUs. The final and official figures for these indicators will be published in the Field Health Surveillance and Information System (FHSIS) annual report for 2014.

A. DELIVERY OF FAMILY PLANNING SERVICES

FP service delivery follows the life cycle approach, which focuses on the health needs of a woman at major life stages – pre-pregnancy, pregnancy, delivery, postpartum, newborn care, and child care. Family planning is deemed an integral part of a woman’s pre-pregnancy and postpartum life stages.

In 2014, a total of 5, 749, 793¹⁶ clients were provided modern family planning services through the combined efforts of the DOH, CSOs, and development partners. With an estimated 9,232,127 women of reproductive age that are current users or have unmet need for modern FP, this figure represents 62 percent of expected FP clients in the country.

B. DELIVERY OF MATERNAL HEALTH SERVICES

Maternal care services focus on the provision of safe delivery services to pregnant mothers. This includes the continuum of antenatal care, delivery services, and postnatal care. In 2014, LGUs together with CSOs served the following:

¹⁴ The 12 elements of reproductive health care, as defined in the IRR Sec.3.01 (ss).

¹⁵ These are program level data that are mostly from the public sector, which are still being completed and will need validation.

¹⁶ These represent partial accomplishments as not all regions have been able to submit their 2014 FP reports

Table 8. Delivery of Maternal Health Services for 2014

RPRH services	Expected number of clients ¹⁷	Actual number of clients ¹⁸	Percent covered
4 antenatal care visits	974, 011	755, 153	78
Skilled birth attendance ¹⁹		788, 018	81
Facility based births		735, 117	75
Postnatal care visits		842, 340	86

(Source: DOH 2014)

C. DELIVERY OF NEONATAL, INFANT, AND CHILD HEALTH AND NUTRITION SERVICES

MNCHN services also include newborn screening, immunization, micronutrient supplementation, exclusive breastfeeding up to 6 months, and integrated management of childhood illnesses. The table below shows the partial accomplishments for 2014.

Table 9. Delivery of neonatal, infant, and child health and nutrition services in 2014

RPRH services	Expected number of clients	Actual number of clients ²⁰	Percent covered
Newborn screening	1,783,896	1,029,628	58%
Immunization (FIC)	2,285,501	1,950,236	85%
Vitamin A supplementation	12,291,584	6,898,584	51%

(Source: DOH 2014)

On the other hand, the Expanded Program on Immunization (EPI) aims to provide maximum immunity against the seven vaccine preventable diseases in the country before the child's first birthday. The fully immunized child (FIC) must have received one dose of Bacillus Calmette Guerin (BCG 1) for TB meningitis protection, three doses of Diphtheria-Pertussis-Tetanus (DPT)-Hepatitis B (HepB)- Haemophilus Influenzae Type B (HIB) vaccine, three doses of oral polio vaccine (OPV), two doses of Hepatitis B vaccine (HepB), one dose of the measles vaccine or the Measles-Mumps – Rubella (MMR) vaccine before the child is 12 months of age. Pregnant mothers are also given at least two doses of the Tetanus Toxoid (TT) vaccine to protect them and their newborns against maternal and neonatal tetanus.

On September 2014, the DOH performed supplemental immunization activities (SIA) for the MMR

¹⁷ This figure represents only the expected number of pregnant women in the regions that have submitted reports. Based on population estimates, there are at least 2 million women that become pregnant each year.

¹⁸ These data represent partial accomplishments as not all regions have been able to submit their 2014 reports on MCH.

¹⁹ Includes all births attended by skilled birth attendants regardless of place of delivery whether at home or in a facility.

²⁰ These data represent partial accomplishments as not all regions have been able to submit their 2014 reports on micronutrient supplementation and newborn screening. The EPI report on fully immunized children is complete for all regions.

and OPV to provide additional doses of these vaccines to all the under-five children nationwide. Supplemental immunization activities have been identified as one of the immunization strategy to reach children for vaccination especially for those that were missed during their routine immunization schedule and/or as an opportunity for under-immunized children to be protected. The DOH performs these SIA in three or five year intervals. With a target of 11, 485, 540 children under five years of age, the DOH was able to vaccinate 10,402,489 or achieve 91 percent of the measles-rubella coverage. On the other hand, out of the 13,483,025 children to be vaccinated with the oral polio vaccine, the DOH was able to reach 11,861,133 children and achieve 88 percent of the target.

The national vaccine coverage under the program for 2014 is found on Table 6C, while the regional accomplishments in coverage can be found in Annex 6.A."

Table 10. EPI Vaccine Coverage for 2014²¹

EPI Vaccine	Expected number of clients	Actual number of clients	Percent covered
BCG	2,285,501 ²²	1,912,207	84
DPT-HEPB-HIB(1)		1,897,222	83
DPT-HEPB-HIB(2)		1,817,074	80
DPT-HEPB-HIB(3)		1,744,002	76
OPV1		1,982,143	87
OPV2		1,948,292	85
OPV3		1,897,113	82
HEPB Birth dose		1,177,823	52
HEPB >24Hrs		174,051	8
Measles		1,940,770	85
MMR		1,414,983	62
TT2+		441,606 ²⁴	16
	2,696,605 ²³		

(Source: DOH 2014)

Except for immunization, the reported accomplishments are partial accomplishments coming from regions that were able to submit their 2014 accomplishments. It can be noted in the table above that while FIC rates are slightly below the target of 90 percent, coverage for specific vaccines also vary, with higher rates observed among those administered earlier in infancy.

No data is currently available to show progress in exclusive breastfeeding among mothers. However, in order to strengthen the practice of exclusive breastfeeding, DOH continuously implements the certification of DOH Mother-Baby Friendly Hospital Initiative (MBFHI) launched in 1991, and has emphasized that Lactation Management Training is a requirement in the issuance of License to Operate for birthing facilities. To date, there are 70 MBFHI facilities nationwide.

²¹ As of April 17, 2015, only 10 out of 17 regions have submitted their 2014 report on these indicators.

²² Children 0-12 months

²³ Pregnant women

²⁴ Only includes reports from six (6) regions; awaiting reports from the 11 other regions

D. DELIVERY OF AYRH SERVICES

Preliminary data coming from development partners show that about 34,207 adolescents were provided information and counselling in health facilities, teen health kiosks in schools, and other public events. In addition, DOH has also provided vaccination services against Human Papillomavirus (HPV), Tetanus-Diphtheria (TD) and measles-rubella (MR) as part of its AYRH program activities. To date, a total of 1,132,546 adolescents have received vaccination for TD and MR; and 7,798 girls have received vaccination for HPV.

The DOH health information system specifically for the 10-19 age group is also being reviewed and improved to capture the actual services rendered to this age group for other health services, so that the Department can strategically address the increasing trend of reproductive health concerns among the adolescents and youth.

Government hospitals also conduct Program for Young Parents (PYP) activities, which enroll all mothers who are 24 years old or younger. These PYP activities, which are being implemented in various public hospitals throughout the country, include safe delivery services, family planning counselling and services, and breastfeeding counseling. As of December 2014, 1,316 clients have been served through the PYPs in Region VII, while 409 have been served by the PYPs in Iloilo City.

E. DELIVERY OF RTI, HIV/AIDS, STI PREVENTION, TREATMENT, AND MANAGEMENT

In 2014, a total of 6,011 clients were tested positive for HIV/AIDS, a 30 percent increase from 2013 figures. Of these, 5,468 were asymptomatic, whereas 543 already had AIDS. Forty-one percent of cases came from NCR.

As of December 2014, there were 8,481 People Living with HIV/AIDS (PLWHA) presently on Anti-Retroviral Therapy. These are the combined numbers of adult and pediatric patients currently enrolled and accessing Anti-Retroviral drugs in the 19 treatment hubs of the DOH. The figure does not include those who have died, left the country, or decided to stop taking ART drugs

F. DELIVERY OF POST-ABORTION CARE SERVICES

Post-abortion care is being delivered in most hospitals in the country, but is currently not being reported as a program indicator.

G. DELIVERY OF SERVICES FOR WOMEN VICTIMS OF VIOLENCE OR GENDER-BASED VIOLENCE (GBV)

GBV refers to all forms of violence inflicted on women on account of their gender, which may result in physical, sexual, or psychological harm or suffering.

The DOH maintains Women and Child Protection Units (WCPUs) in 70 DOH-retained hospitals, 28 LGU hospitals/RHUs, and Municipal Health Offices. These are multi-disciplinary teams of trained physicians, social workers, mental health professionals, and police providing

comprehensive medical and psychological services to women and children who are victims of violence.

H. DELIVERY OF SERVICES FOR REPRODUCTIVE TRACT CANCERS

In 2014, DOH provided Human Papillomavirus (HPV) vaccines in selected secondary public schools (Baguio City and Cebu City) as an introductory phase of a program that would be rolled out in 2015.

To strengthen screening for cervical cancers, the DOH, in collaboration with PhilHealth, scaled up implementation of an expanded outpatient package. The package includes visual inspection with acetic acid (VIA), which is reimbursable through PCB1 (Primary Care Benefit 1) of the NHIP. A series of Training of Trainers for VIA have been conducted by DOH to expand the pool of skilled providers nationwide. In 2014, 274 women were screened, of which 11 tested positive for cervical cancer.

I. DELIVERY OF SERVICES FOR REPRODUCTIVE MENTAL HEALTH

The National Mental Health Program of the DOH aims to protect the rights and freedom of persons with mental diseases, and reduce the burden and consequences of mental ill-health, mental and brain disorders and disabilities. Training of providers, provision of information materials, and inter-agency collaboration were done to enhance service provision that enables the early recognition and treatment of mental health problems. DOH is also in the process of integrating reproductive health components into the program in compliance with the provisions of the RPRH law.

In December 2014, DOH conducted *Linggo ng Kabataan* activities in selected municipalities and cities nationwide. This included sessions on depression awareness and suicide prevention among adolescents.

III. FUNCTIONALITY OF FACILITIES PROVIDING RPRH SERVICES

The RPRH Law identified the 5.2 million NHTS poor households as priority population for the delivery of RPRH services. From these households alone, the following services will be needed in a year:

- as many as four million will need modern family planning;
- about one million will get pregnant;
- around 850,000 will deliver via normal spontaneous vaginal delivery;
- roughly 150,000 will have complications that would need emergency care; such as cesarean section; and
- at most, one million babies will be born.

Based on these needs from NHTS poor households alone, there will be at least 1,600 modern FP clients that will be seen in one year in each of the roughly 2,500 rural health units of the country. On the other hand, the 150,000 complicated pregnancies can be readily attended to in the district and provincial hospitals of LGUs and DOH regional medical centers.

While the workload may appear manageable, the accessibility of the facilities, presence of trained providers and availability of commodities vary widely across these facilities. Results from the four rounds of KP Operations Monitoring (KP OM)²⁵ show that:

- RHUs serve an average of 30 to 74 new modern FP acceptors per month
- 60 to 84 percent of RHUs surveyed had trained providers on FP CBT1
- 37 percent to 47 percent of RHUs experienced stock outs of FP commodities
- 51 to 53 percent of RHUs surveyed manage normal deliveries
- 17 to 21 percent of district hospitals surveyed are capable of doing cesarean sections

In terms of access to PhilHealth accredited facilities, there were 738 public hospitals and infirmaries accredited by PhilHealth as of December 31, 2014. Added to this were 2,438 accredited outpatient clinics for the Primary Care Benefit (PCB) Package located in 1,523 or 93 percent of cities and municipalities. However, only 1,155 or 71 percent of cities and municipalities have accredited outpatient clinics for the Maternity Care Package (MCP). The number of PhilHealth accredited facilities by category per region can be found in Annex 6.B

²⁵ The conduct of KP OM is mandated under DO 2014-0109 “Guidelines for the Implementation and Use of KP Operations Monitoring”. This quarterly survey is intended to provide the DOH management with sufficient information to track KP implementation at the operational level to allow for corrective actions and interventions. The reference period covered by the four rounds of the survey is from July 2013 to June 2014.

Given these findings, it is likely that there will be areas where the RHU or district hospital may either be inaccessible to many clients or would be unable to provide the needed services. These indicate that current capacities and effort in providing RPRH services are still inadequate to meet the scale and scope of services mandated by the law.

PART VII

GOVERNANCE MECHANISMS ESTABLISHED

I. CREATION OF THE RPRH INTER-AGENCY COMMITTEE

While the Department of Health and other agencies has been implementing Reproductive Health programs since the 1980s, there was need to create an inter-agency committee composed of government agencies mandated by RA 10354 to implement the law and its IRR. To ensure the engagement of all stakeholders and provide transparency in the law's implementation, the inter-agency committee would also include representatives from civil society organizations and observers from development partners. The inter-agency committee shall coordinate the actions of said agencies and CSOs in the areas of policy development, capacity-building, advocacy, education, information, health service delivery, field operations and monitoring and evaluation. Inter-agency committees shall be present both at the national and regional levels to ensure effective collaboration and coordination.

The POPCOM Board of Commissioners, chaired by the DOH, recommended last August 26, 2014 the creation of an inter-agency committee to coordinate the efforts of government agencies in implementing the RPRH Law and its IRR. This was followed by a series of consultations led by the DOH to set-up the inter-agency committee in the fourth quarter of 2014. In addition, the CSOs held a forum to nominate their representatives to the inter-agency committee. By end of 2014, the draft Administrative Order creating the inter-agency committee, that will be called the RPRH Law National Implementation Team (RPRH Law NIT) and its regional counterpart, the RPRH Law Regional Implementation Teams (RPRH Law RITs), was drafted for signature of the Secretary of Health. The NIT shall be composed of the following:

1. Department of Health (DOH)
2. Commission on Population (POPCOM)
3. Food and Drugs Authority (FDA)
4. DOH – Disease Prevention and Control Bureau (DOH-DPCB)
5. National Economic Development Authority (NEDA)
6. Department of Education (DepEd)
7. Department of Social Welfare and Development (DSWD)
8. Department of Interior and Local Government (DILG)
9. Philippine Health Insurance Corporation (PHIC)
10. National Anti-Poverty Commission (NAPC)

11. Philippine Commission on Women (PCW)
12. National Council on Disability Affairs (NCDA)
13. Union of Local Authorities of the Philippines (ULAP)
14. Likhaan, as CSO representative.

The NIT shall also liaise, in behalf of the Secretary of Health, with the Congressional Oversight Committee (COC) on Reproductive Health Act. The NIT shall also assist the Department of Health in preparing the annual consolidated report on implementation, pursuant to Sec 21 of the Law.

II. CREATION OF THE REPRODUCTIVE HEALTH BUREAU

Section 12.01 paragraph (h) of the RH Law IRR mandated the Department of Health to reorganize the various programs on RH into a unified bureau or unit that shall have an organizational structure that corresponds to the following functions:

- standards development, policy, planning and financing;
- capacity building;
- advocacy and communication;
- support to field operations; and
- monitoring and evaluation and knowledge management.

When the RPRH Law took effect, the DOH through its Family Health Office worked on the design, structure and functions of a proposed bureau for RPRH. On July 24, 2014, the DOH submitted to the Office of the President a draft Executive Order (EO) creating a dedicated Responsible Parenthood and Reproductive Health Bureau. The draft EO has been proposed based on the need for well-coordinated actions at the national, sub-national, and local levels in the implementation of services related to the RPRH law. Given the context of a devolved health system with a large private sector, existing resources will also have to be reconfigured under a dedicated body to manage, support and monitor implementation.

A distinct RPRH Bureau would also address current organizational weaknesses, and allow the DOH to recruit more skilled staff with the appropriate technical competencies. The initial funds for the new bureau will be sourced from the existing DOH line items in the 2015 GAA, namely: the Family Health and Responsible Parenting, and Expanded Program on Immunization.

Comments from the Office of the Executive Secretary and the Department of Budget and Management were received later in the year. As of year-end, the DOH has prepared a revised memo and organizational structure for submission to the Office of the President.

III. RPRH GOVERNANCE OF OTHER GOVERNMENT AGENCIES

A. PHILHEALTH RPRH GOVERNANCE INITIATIVES

PhilHealth has an MDG group dedicated to address the financing requirements of services related to the achievement of health-related MDGs. The Corporation is also planning to create a dedicated Technical Working Group for the enhancement and development of RPRH-related benefit packages.

B. DSWD RPRH GOVERNANCE INITIATIVES

One of the roles of DSWD indicated in Section 12.03 paragraph (a) of the RPRH IRR is to synchronize and harmonize existing mechanisms in identifying the poor and marginalized households and areas (e.g. NHTS-PR, NAPC priority municipalities, CBMIS, etc.). In response to this, DSWD began to merge the National Household Targeting Office (NHTO) with the Information and Communications Technology Management Service (ICTMS) to strategically support the DSWD's social protection and poverty alleviation strategies.

IV. HEALTH LEADERSHIP AND GOVERNANCE OF LGUs

Local Government Units as the main implementers of health programs have demonstrated commitment to improve the health outcomes in their jurisdictions. Implementation of various RPRH governance related strategies in the different regions were mostly concentrated in adopting national policies and dissemination down to local health facilities and staff. These issuances came in the form of MOUs among concerned regional government agency units and LGUs. Some LGUs also institutionalized local RPRH Committees or similar coordinating bodies. Specific resolutions or strategies were also adopted in some areas. These included the following:

1. Establishment of Adolescent Health Program and Council which established Youth Centers;
2. Integration/ Institutionalization of the parenting education on Adolescent Health and Development (AHD) in the regular Parents-Teachers Association (PTA) Activities;
3. Creation of local AIDS Council;
4. Call for the utilization of the remaining *Sangguniang Kabataan* funds on AHYD advocacy;
5. Guidelines on inclusion of young/teen mothers in PhilHealth services;
6. Free audiovisual presentation of POPCOM's independent film "Crossroads" in some Cinemas in Mindanao; and
7. Creation of local councils to coordinate different stakeholders implementing RH activities such as the Albay Inter-Agency Reproductive Health Committee (AIARHC).

To scale up and sustain these initiatives, LGUs requested technical assistance from national government agencies, development partners, private sector, and CSOs to improve their local health system and make it more responsive to the needs of the community, particularly for maternal and child health and family planning services among others. In response to this, the Health Leadership and Governance Program (HLGP) of the DOH, in partnership with development partners, and the private sector, served as a venue to strengthen leadership and governance capacities of local chief executives and local health leaders at the provincial, city and municipal level. The HLGP highlights the importance of strong and committed leadership as viable strategy to influence the improvement of health systems for sustainable reproductive health programs. As of December 2014, 28 provinces, 516 municipalities, and 9 cities are currently enrolled in the program.

V. RPRH RELATED RESEARCHES

In response to Section 19, paragraph (b), item (5) of RA 10354, the DOH, CSOs and other agencies have conducted 12 studies related to RPRH in 2014. The following are summaries of the RPRH-related studies conducted in 2014, categorized into five closely related components of reproductive health.

A. REPRODUCTIVE HEALTH

1. National Demographic Household Survey 2013 (funded by the DOH and USAID; implemented by Philippine Statistics Authority)
 - The latest NDHS was implemented in 2013, covering a national sample of approximately 15,000 households and more than 16,000 women of reproductive age. It collected information on a variety of health-related topics such as fertility, family planning, and maternal and child health. In terms of the health-related MDGs, the latest NDHS reports an infant mortality rate of 23, an under five mortality rate of 31, the proportion of 1 year-old children immunized against measles at 83.9, the percentage of births attended by a skilled health personnel at 72.8, contraceptive prevalence rate among females at 55.1, adolescent birth rate at 57.1, at least one antenatal care visit at 95.4 percent, four antenatal care visits at 84.3 percent, unmet need for family planning at 17.5 percent, and condom use during last high-risk sex at 8.1 percent.
2. Mapping of Perceptions, Positions, and Interventions on Sexual and Reproductive Health Rights (SRHR) Among Some Religious and Lay in the Philippines (conducted by CSOs)
 - The study was done in order to determine the overlaps in the perceptions and positions of religious and lay personnel in terms of SRHR. Determining these would enable the formulation of interventions that would build upon the common ground of these parties. The study was done through a series of focus group discussions and interviews nationwide involving 88 respondents, which include the members of the clergy, nuns, lay leaders, and the laity. The range of topics covered by the study include perceptions on feminism, equality and women empowerment, the RPRH Law, contraception, divorce, abortion, women's autonomy, homosexuality, violence against women, rape (including marital rape), protection of girls, ordination of Women in the Catholic Church, and celibacy. In the initial qualitative assessment of the data, it was found that some of the respondents, especially among those who oppose the RPRH Law, hold several misconceptions and myths about reproductive health. It also found that adherence to the institutional position was very strong among the priests in this study, but there was some openness among the nuns, lay leaders, and lay members. The data obtained from the study would further undergo quantitative analysis so that more specific interpretations and recommendations can be made.

3. Country Profile Reports on Access to Reproductive Health Services and the Achievement of Sexual and Reproductive Rights (Conducted by CSOs)
 - The country profile report on access to RH services reviewed and analyzed current data on maternal health, contraception, adolescent RH, HIV/AIDS, and the availability of RH services at different levels of care. Recommendations on how DOH, PhilHealth, and CSOs can address the gaps in services were also provided. Aside from RH services, a country profile report on reproductive rights was also prepared. The latter report includes an inventory of reproductive health policies, legislation and policies on marriage, gender identities, and violence against women and children. It also provides recommendations to government agencies, Commission on Human Rights, Philippine Commission on Women, and CSOs.
5. *Ala Tsamba sa RH (Kalagayan, Suliranin, at Panawagan ng mga Kababaihan sa Payatas)* (Conducted by CSOs)
 - This is a comprehensive report on the RH baseline survey among 629 women of reproductive age in Payatas B, Quezon City. The study found that although 84 percent of the women think that their delivery should be attended to by a medical doctor, only 0.6 percent of all births were attended by medical doctors, 61 percent by midwives, 46 percent by nurses, while the rest of the deliveries were in the presence of a traditional birth attendant or a neighbor/ family member. It was also found that even though 94 percent of the women preferred to give birth in a medical clinic or hospital, only 40 percent of the births were facility-based. It was also noted that 46 percent of the respondents reported their first pregnancy to be during 16-20 years of age. Other findings include knowledge and use of contraceptives, incidence of VAWC, incidence of abortion, and knowledge of HIV/AIDS and other STIs.

B. FAMILY PLANNING INFORMATION AND SERVICES

1. A Cohort Study and Implementation Research on the Use of Subdermal Implants as a New Family Planning Program Method of the Department of Health (Conducted by DOH and USAID)
 - This multi-phase study aimed to assess the factors that may affect the integration of the subdermal implant as a new method in the national family planning program in Cavite. Particular objectives included assessing the operational issues and determining the factors that affect the acceptance and continued use of subdermal implants among its intended users.
2. KAP Baseline study on access to information and services on FP among women in poor areas in Manila (Conducted by CSOs)
 - This study aimed to identify the most prevalent problems that discourage or prevent women from using modern FP methods, establish the baseline level of key FP indicators, and describe barriers to the access and utilization of FP services among 518 women of

reproductive age in the districts of Tondo, San Andres, and Port Area. Among the findings of the study include the high 5.4 fertility rate of women in the sample, which is a couple of percentage points higher than their reported desired fertility rate, which is 3.0. The study also recorded a high desire for limiting and spacing of children among the women sampled, with only eight percent wanting to have another child in the immediate future and 22 percent wanting to have another child later. The contraceptive prevalence rate among those sampled was 42 percent, while 60 percent of those sampled reported their desire to use contraception. The study also reported that women's misconception of MFP methods and fear of side effects affected their choice and use of family planning methods.

C. MATERNAL, INFANT AND CHILD HEALTH AND NUTRITION, INCLUDING BREASTFEEDING

1. Achievement of the MDGs in KP Context: A review of current evidence (Conducted by the DOH)
 - The review was primarily aimed in determining whether government policies and interventions contribute to narrowing the equity gaps in achieving the MDGs
2. Research partner in the development of an action-research to improve access to quality SRH programs for Women with Disability in the Philippines (Conducted by CSOs)
 - This study aimed to generate data on the experiences of women with disabilities in relation to their access to RH programs. It was conducted through a household survey with 3,509 respondents, RH-specific survey questionnaire with 253 women with disabilities respondents, in-depth interviews with 37 women with disabilities, eight focus group discussions, and 20 key-informant interview with health providers and program implementers. Upon analysis of the results, it was found that women with disabilities had difficulty in accessing reproductive health care services due to the lack of information on available services and facilities offering the services, perceived cost of care, negative attitudes of healthcare providers, and logistical difficulties in accessing health facilities, including the absence of personal assistance while availing of services. It was also found that compared with their age-matched controls, women with disability were less likely to access antenatal and postnatal care by a skilled birth attendant, access to emergency obstetric care, have awareness of HIV and STI testing, and were less likely to desire wanting another pregnancy.

D. ADOLESCENT AND YOUTH REPRODUCTIVE HEALTH GUIDANCE AND COUNSELING AT THE POINT OF CARE

1. Young Adult Fertility and Sexuality Study 4 or YAFSS4 (Funded by the DOH and UNFPA, implemented by UP Population Institute and Demographic Research and Development Foundation, Inc.)

- YAFSS4 is a series of cross-sectional surveys on sexuality and fertility, risk behaviors, and their determinants among Filipino youth aged 15-24. The survey was deployed in a nationalized and regionalized sample in the country. The 2013 survey found that 32 percent of young Filipinos between the ages 15 to 24 have had sex before marriage, and that of these, 78 percent reported that their first sexual encounter was unprotected. The survey also found that 7.3 percent have engaged in casual sex, while 5 percent of the males in the survey report having sex with another male. The survey also found that 13.6 percent of girls aged 15-19 was already a mother, while 2.6 percent were pregnant with their first child when they were interviewed. This data on teenage pregnancy is almost double than the 6.9 percent reported by the preceding YAFSS conducted in 2002.
2. Parental Involvement in Adolescent Health and Development in Metro Manila and Bohol (Conducted by POPCOM)
- This study aimed to assess parenting style and its differentials across individual characteristics, spousal relationship factors and family characteristics and compare parental attitude and involvement in the health & development of adolescent children. The study includes a series of focus group discussions and surveys in 1067 households in Metro Manila and 780 households Bohol. The study found that while almost all parents agree that they have an important or very important role in addressing the sexual issues of their adolescent children, they have limited level of knowledge on adolescent health, available health service providers specializing on adolescent concerns, and available health services to address the health concerns of their adolescents including RH. It was also found that there is very little discussion of sex and related issues at home. Both parents and adolescents are reluctant to initiate a discussion on the matter home and a significant proportion think sex education should be taught in school. The study also found that there is gap in the age when parents think it is appropriate to discuss matter on sex with their children (at age 15 for mothers and age 16 for fathers) and the age when their children start to ask them questions about sex (sons: at ages 12-14 & daughters: at ages 13-14).

E. PREVENTION, TREATMENT AND MANAGEMENT OF REPRODUCTIVE TRACT INFECTIONS, HIV AND AIDS AND OTHER SEXUALLY TRANSMITTED INFECTIONS

1. Provision of Encoding Services and Data Processing Assistance for the 2013 Philippine Integrated HIV Behavioral and Serologic Survey or IHBSS (Conducted by DOH)
- The DOH provided technical assistance for the 2013 IHBSS by making the questionnaire responses available in computer readable media and in a format suitable for statistical analysis, thereby enhancing accessibility of the data and making it easier for intended users to analyze the data.

2. 2014 Philippine Integrated HIV Behavioral and Serologic Survey or IHBSS (Conducted by DOH)

- IHBSS is a series of cross-sectional studies conducted every two years in populations at elevated risk of HIV and other sexually transmitted infections (STIs). It aims to track prevalence of HIV and STI, risk behaviors, and access and utilization of HIV and STI programs and services. Special sampling and recruitment methods are employed by the survey, including time location sampling (for MSM and FSW) and respondent-driven sampling for IDU. Data obtained in the 2013 survey indicate an overlap among the most-at risk populations. In Cebu, 31 percent of female IDU are also FSW, 12 percent of freelance FSW inject drugs, and 11 percent of male IDU are also MSM. Other common risk factors shared across the most-at-risk groups include low levels of condom use with casual and regular sex partners, high prevalence of having sex while under the influence of alcohol, early age of sexual debut at age 14 years or younger, and forced or involuntary sex at first sexual intercourse in some cases. Aside from this, only between 25 percent and 41 percent of the most-at-risk populations had a thorough understanding of HIV prevention and transmission, and a large majority of them who were living with HIV are unaware of it due to minimal levels of HIV testing. Although the majority of the most-at-risk populations earn less than the minimum wage in NCR, less than 33 percent of them are enrolled in PhilHealth.

PART VII

CHALLENGES AND RECOMMENDATIONS

This section discusses the key challenges to implementing the RPRH Law and its corresponding recommendations. Based on an assessment of the RPRH situation in the initial year of implementation, ten key challenges were identified that affect the delivery of RPRH services and ultimately, the attainment of desired health outcomes. These challenges include those concerning service delivery, demand generation, supply chain management, budget and financing, policy formulation and monitoring and evaluation. Corresponding recommendations were then formulated in response to the challenges by taking into consideration the time, capacity and resource constraints to implementation. It can be noted that most of the challenges identified pertain to the delivery of FP/MNCHN services. However, this does not mean that there are no challenges confronting the implementation of programs concerning the other RPRH elements.

CHALLENGE 1: UNMET NEEDS FOR RPRH SERVICES REMAIN HIGH AND VARY ACROSS AREAS AND POPULATION GROUPS

Desired health outcomes like maternal mortality have essentially moved sideways over the years owing to persistently high levels of unmet need for services such as modern family planning, safe delivery, and child health services among others. The high levels of unmet need can be attributed to many factors such as limited information and poor health seeking behavior, limited access to facilities especially in far-flung areas, lack of trained personnel, especially in government health facilities, various missed opportunities in providing care, owing to weak links between programs²⁶ as well as limited access to financing. The burden of unmet needs also appears to be concentrated in certain areas, especially where NHTS poor households are more concentrated. These indicate that the issuance of landmark policies like the RPRH law and increased investments in the health sector have yet to be translated into improved delivery of services and ultimately, better health outcomes, especially for the poor.

²⁶ Missed opportunities happen when clients are not prompted or offered other health services during consults with providers. For example, mothers bringing children for immunization can be informed and counselled on modern FP use and vice versa.

RECOMMENDATION:

DOH and other agencies mandated to implement the law need to develop a strategy that will focus implementation in areas where the burden of unmet needs is highest and where the poor are most concentrated. Focusing interventions in selected high burden areas will allow DOH and other agencies to maximize gains in RPRH implementation without dissipating limited resources. This strategy will include specific guidance on how DOH, LGUs and other agencies can install RPRH services in these high burden areas such as by setting up RPRH service delivery networks that include both public and private providers.

CHALLENGE 2: SCOPE AND SCALE OF SERVICE DELIVERY IS LIMITED MAINLY THROUGH PUBLIC SECTOR

The high levels of unmet needs for various RPRH services indicate that current programs are unable to reach all the intended beneficiaries. One reason is that most RPRH services, such as modern family planning and vaccinations are still delivered mainly through the public sector. Among the many limitations in delivering services through the public sector include inaccessibility, lack of staff, supply shortages, fixed operating hours and limited incentives to further improve performance.

RECOMMENDATION:

DOH together with LGUs, can enter into contracts with private providers and CSOs to deliver RPRH services. The public sector can expand its reach by tapping into the network of private providers as “force multipliers” in RPRH implementation. In addition, the public sector can also maximize the flexibility and efficiency in these sectors in terms of hiring and deploying staff, operating in more client-friendly locations and schedules and in introducing incentives to improve performance.

CHALLENGE 3: CAPACITY BUILDING EFFORTS FOR RPRH STILL LIMITED TO PUBLIC SECTOR

The lack of trained providers has been cited as one of the important reasons why access to RPRH services is limited. Even if substantial numbers of public sector health providers and staff of other agencies have been trained on various RPRH programs, these represent but a fraction of providers and workers that will need capacity building for various RPRH skills. Many RHUs still report not having trained health workers in skills such as FP CBT 1 and CBT 2. In addition, many private providers, particularly single practice midwives that operate most birthing homes have yet to be trained on BEmONC. The training backlog is caused by the limited number of training opportunities, currently done mostly in-house by DOH staff and trainers from government training institutions.

RECOMMENDATION:

The DOH can expand the network of training providers by setting up an accreditation mechanism that will recognize private training institutions like universities and CSOs. This will help expand access to training institutions, especially at the regional level. This will also allow current program staff to focus on managing programs, especially as RPRH implementation scales up to the rest of the country.

CHALLENGE 4: WEAK LOGISTICS SYSTEMS NEGATE GAINS FROM DEMAND GENERATION AND CAPACITY BUILDING

The lack of commodities at service delivery points negate whatever gains were achieved from various demand generation and capacity building efforts. Commodity stock outs not only deny clients with much needed services but also make it harder to convince to avail of services in the future. The stock outs are due to weaknesses throughout the whole supply chain from the forecasting of commodity requirements all the way to tracking utilization. Budget constraints also prevent the DOH from procuring sufficient commodities to cover the needs of the NHTS poor and other clients in the public sector. While DOH has taken the right direction in reforming its logistics system, these reforms are still being put in place. At the same time, DOH is also expanding the scale and scope of distributing centrally-procured commodities as mandated by the RPRH law.

RECOMMENDATIONS:

DOH needs to increase its procurement levels to meet the estimated requirements, especially of poor families. It also needs to account for additional commodities needed to deal with emergencies and calamities. The procurement volumes, however, need to be tempered with the expected number of clients that will be generated by various demand generation efforts. DOH also needs to invest in installing logistics reforms that will shift its current push down system to a demand-driven supply chain. To fast track installation of reforms, the DOH needs to carefully weigh options in terms of what supply chain functions to retain in house and what it will outsource to private providers that have the advantage of modern technology, experience and wider supply chain network. Outsourcing these services will however require DOH to clearly define key performance indicators and set up a performance monitoring mechanism for its providers.

CHALLENGE 5: LINK BETWEEN DEMAND GENERATION AND SERVICE PROVISION IS WEAK

The deployment of CHTs and the use of FDSs for Pantawid Pamilya beneficiaries were used as platforms in some regions to provide poor households with information and to identify clients with unmet needs for various RPRH services. There were, however, mixed reports concerning the extent at which CHTs were deployed and how effective they were as navigators. On the other hand, while FDSs allowed agencies to reach *Pantawid Pamilya* beneficiaries, not all of the clients with expressed needs have been reportedly served by providers.

RECOMMENDATIONS:

It is recommended that DOH formally evaluate the deployment of CHTs to validate reported deployment and contributions to demand generation. In particular, places where deployment is low and areas where there is documentation of CHT contributions to the reduction of unmet need will have to be studied to generate lessons for future implementation. The DOH, in partnership with other agencies, especially POPCOM, DSWD and LGUs can strengthen the link between FDS and service provision by deploying service providers during sessions.

CHALLENGE 6: EFFORTS IN HEALTH PROMOTION AND COMMUNICATION NOT SUSTAINED

The DOH has introduced innovations to improve its health promotion campaigns for RPRH. These allowed more families to hear and understand various RPRH messages, including convincing many to avail of services. These health promotion efforts however are few and far between, not to mention being implemented within a short period of time owing to resource constraints. This leaves a missed opportunity to further inform and influence behavior of families given the availability of mass media and social networking platforms.

RECOMMENDATION:

DOH and other agencies can jointly develop health promotion campaigns, pool their limited resources and coordinate the implementation of health promotion activities, such as media campaigns. This will allow wider audience reach and more sustained delivery of RPRH messages as means to influence behavior change.

CHALLENGE 7: ABSORPTIVE CAPACITY FOR INCREMENTAL BUDGETS FOR RPRH IS LIMITED

The expanded fiscal space has led to increases in the budget of various government agencies, especially DOH. While utilization rates of these budgets continue to improve, substantial amounts from the budgets remain unspent at the end of the year. These unspent budgets mean further delay in delivering much needed services to intended beneficiaries, especially the poor.

RECOMMENDATION:

DOH and other agencies can further improve absorptive capacity for incremental budgets by packaging its various activities into projects that can be outsourced to the private sector. A common example is the numerous training programs currently done in house which could be outsourced to training institutions.

CHALLENGE 8: UTILIZATION OF NHIP BENEFITS RELATED TO FP IS LOW

Apart from budgets, an important source of financing for RPRH services is PhilHealth. However, utilization of various PhilHealth benefit packages, particularly for family planning remains low. The low utilization of benefit packages can be attributed to several factors which include: the lack of information of members about their membership status and benefit entitlements, limited access to accredited facilities and low support value for packages, especially those concerning catastrophic conditions (e.g. malignant neoplasms, HIV/AIDS)

RECOMMENDATIONS:

PhilHealth can improve the utilization of its various RPRH related benefit by informing members, especially those in the Sponsored Program of their membership status and benefits. PhilHealth, in partnership with DOH, LGUs and DSWD can tap the CHTs and FDS sessions as platforms to inform and remind Sponsored members. PhilHealth can also review and revise its accreditation systems to expand

the network of accredited providers. For example, allowing the reimbursement of no scalpel vasectomy in RHUs and doctor's clinics rather than limiting this only in ambulatory surgical clinics.

CHALLENGE 9: GUIDANCE ON THE IMPLEMENTATION OF THE RPRH LAW NEEDS TO BE FORMALIZED AND STRENGTHENED

In its initial year of implementation, DOH and various agencies have started efforts to coordinate various inter-agency efforts in implementing the RPRH law. However, this inter agency mechanism has yet to be formalized and the terms of engagement of each stakeholder still need to be defined. In addition, the various agencies tasked with implementing the law have begun issuing policies and guidelines required by the IRR. However, 20 of these policies and guidelines have yet to be issued.

RECOMMENDATIONS:

DOH as the lead implementing agency for RPRH needs to issue guidelines to formalize the creation of the inter agency committee to coordinate RPRH implementation. These guidelines will specify, among others, membership to the inter agency committee, the mandate of the inter agency committee, the powers and responsibilities of its members and its operating procedures. This inter agency committee shall also coordinate the process of prioritizing, drafting and vetting the various policies and guidelines that need to be issued by specific agencies as well as set timelines and benchmarks for issuing these. The inter agency committee shall also ensure that the policies and guidelines issued by the various agencies are properly disseminated to implementing units.

CHALLENGE 10: RPRH PERFORMANCE MONITORING AND INCENTIVE MECHANISMS HAVE YET TO BE DEFINED

The DOH and other agencies mandated to implement the RPRH law have yet to define a performance monitoring mechanism that will define indicators for measuring performance in RPRH implementation. An incentive mechanism to promote compliance to RPRH mandates is also lacking.

RECOMMENDATIONS:

The DOH, through the inter agency coordination mechanism for RPRH will lead the development a performance monitoring and incentive mechanism for RPRH implementation. The said mechanism will describe what indicators will be used as performance measures, how these indicators will be measured, how often these would be collected, how these will be analyzed and reported. The development of this performance monitoring mechanism will help guide implementers on what adjustments can be made to improve implementation as well as guide oversight mechanisms to ensure that RPRH implementation is on track. Complementary to the development of a performance monitoring mechanism is the installation of an incentive mechanism that will recognize and reward good performance. This is critical as delivery of RPRH services is done mainly through autonomous local government unit health systems, and increasingly, through private providers and CSOs.

ANNEXES

BASELINE INDICATORS OF RPRH IMPLEMENTATION

ANNEX A Number of Women at Risk of Unwanted Pregnancies

	2013			2008			Percent Change		
	Current pregnancy not wanted	Women who are not pregnant, not wanting a child and not using MFP	Woman at risk of unplanned pregnancy	Current pregnancy not wanted	Women who are not pregnant, not wanting a child and not using MFP	Woman at risk of unplanned pregnancy	Current pregnancy not wanted	Women who are not pregnant, not wanting a child and not using MFP	Woman at risk of unplanned pregnancy
PHILIPPINES	297,950	5,385,708	5,683,658	429,446	5,284,921	5,714,367	-30.620	1.907	-0.537
CAR	5,325	78,435	83,760	3,545	81,800	85,345	50.228	-4.113	-1.856
1. Ilocos Region	12,243	286,759	299,002	17,720	273,699	291,419	-30.907	4.772	2.602
2. Cagayan Valley	8,992	134,477	143,470	14,147	144,778	158,925	-36.437	-7.115	-9.725
3. Central Luzon	30,836	509,980	540,815	38,112	531,610	569,722	-19.091	-4.069	-5.074
NCR	42,528	670,636	713,164	51,143	758,875	810,019	-16.845	-	-11.957
								11.628	
4A. Calabarzon	33,079	824,556	857,635	42,563	718,096	760,659	-22.283	14.825	12.749
4B. MIMAROPA	8,379	149,172	157,551	16,065	156,637	172,702	-47.844	-4.765	-8.773
5. Bicol Region	16,348	416,960	433,308	40,782	321,659	362,441	-59.915	29.628	19.553
6. Western Visayas	25,432	476,254	501,686	27,068	446,195	473,262	-6.043	6.737	6.006
7. Central Visayas	22,775	455,361	478,136	41,216	397,563	438,779	-44.744	14.538	8.970
8. Eastern Visayas	13,016	233,963	246,979	29,969	271,839	301,808	-56.569	-	-18.167
								13.933	
9. Zamboanga Peninsula	16,238	157,436	173,674	15,126	208,449	223,575	7.355	-	-22.319
								24.473	
10. Northern Mindanao	13,150	240,246	253,396	20,603	203,471	224,074	-36.176	18.074	13.086
11. Davao Peninsula	17,591	234,095	251,685	21,019	208,625	229,645	-16.312	12.208	9.598
12. SOCCSKSARGEN	10,601	208,908	219,509	15,705	237,308	253,013	-32.500	-	-13.242
								11.967	
ARMM	8,480	190,616	199,096	13,858	181,336	195,195	-38.809	5.117	1.999
CARAGA	12,938	117,853	130,792	20,804	142,981	163,785	-37.808	-	-20.144
								17.574	

Source: NDHS 2008 and 2013

ANNEX B
Number of Women with Unmet Need for Modern Family Planning (UMFP)

	2013 (counts of women in thousand)				2008 (counts of women in thousand)				Percent Difference			
	Not SWRA*	No need for MFP**	MFP user	UMFP***	Not SWRA*	No need for MFP**	MFP user	UMFP***	Not SWRA*	No need for MFP**	MFP user	UMFP***
Philippines	11,505	2,151	5,948	5,684	10,052	2,082	5,095	5,714	14.45	3.31	16.73	(0.54)
By age group												
15-19	4,430	186	119	303	4,063	199	76	264	9.04	(6.77)	57.29	14.67
20-24	2,257	533	709	866	1,810	481	600	727	24.71	10.79	18.02	19.06
25-29	1,012	481	1,031	859	911	546	976	1,133	11.01	(11.82)	5.65	(24.19)
30-34	768	474	1,328	963	626	420	1,072	1,045	22.64	12.92	23.92	(7.77)
35-39	712	272	1,164	954	670	254	1,067	1,022	6.32	6.84	9.09	(6.72)
40-44	897	152	1,021	946	727	135	834	899	23.43	13.20	22.34	5.28
45-49	1,429	53	577	793	1,246	47	471	625	14.72	11.89	22.47	26.96
*Not sexually active, infecund, or missing in terms of unmet categorization												
**No need for MFP means woman wants to have a child/children												
***UMFP is unmet need for modern FP												

Source: NDHS 2008 and 2013

ANNEX C
Source of Modern Family Planning Methods Requiring Supply or Service

2013 (Number of users, counts in thousands)								
	Total	Female sterilization	Male sterilization	Pills	IUD	Injectables	Implants	Condoms
Total Users (Philippines)	5,834	1,365	17	2,988	541	578	3	343
Public sector	2,756	1,025	9	753	443	473	3	50
Private sector	3,045	323	6	2,227	92	104	-	293
Others	6	3	2	-	-	2	-	-
Missing	28	13	-	8	6	-	-	-
2008 (Number of users, counts in thousands)								
	Total	Female sterilization	Male sterilization	Pills	IUD	injectables	Implants	Condom
Total Users (Philippines)	5,025	1,389	7	2,333	556	380	-	360
Public sector	2,330	1,014	5	518	450	319	-	24
Private sector	2,685	370	2	1,812	105	61	-	335
Others	5	4	-	-	-	-	-	2
Missing	5	2	-	2	2	-	-	0
Percent change								
	Total	Female sterilization	Male sterilization	Pills	IUD	injectables	Implants	Condom
Total Users (Philippines)	16.10	-1.75	154.85	28.08	-2.87	52.26	n.a	-4.84
Public sector	18.28	1.10	98.34	45.30	-1.52	48.27	n.a	104.38
Private sector	13.39	-12.63	215.29	22.85	-12.96	70.60	n.a	-12.31
Others	22.63	-10.00	n.a.	n.a.	n.a.	n.a.	n.a	-100.00
Missing	413.16	652.46	n.a.	299.50	289.71	n.a.	n.a	n.a.

Source: NDHS 2008 and 2013

ANNEX D
Number of Teenage²⁷ Pregnancies by Region

	2013				2008				Percent Difference		
	WRA 15 to 19	Women 15-19 yo who have had a live birth	Women 15-19 yo pregnant with 1st child	Total number of teenage mothers 15-19 yo*	WRA 15 to 19	Women 15-19 yo who have had a live birth	Women 15-19 yo pregnant with 1st child	Total number of teenage mothers 15-19 yo	Women 15-19 yo who have had a live birth	Women 15-19 yo pregnant with 1st child	Teenage mothers 15-19 yo*
Philippines	5,043,715	383,194	122,887	506,082	4,584,114	334,380	126,144	460,524	14.60	-2.58	9.89
CAR	94,857	3,744	1,486	5,230	87,025	3,444	3,470	6,914	8.71	-57.18	-24.36
1. Ilocos Region	237,628	16,588	8,984	25,573	223,436	12,877	9,189	22,066	28.82	-2.23	15.89
2. Cagayan Valley	171,026	19,086	2,855	21,942	159,607	3,961	9,634	13,596	381.82	-70.36	61.39
3. Central Luzon	530,793	46,442	16,571	63,013	477,304	32,442	8,330	40,772	43.15	98.93	54.55
NCR	630,357	47,395	9,479	56,874	575,907	23,854	9,647	33,502	98.69	-1.74	69.77
4A. Calabarzon	682,737	56,404	10,496	66,900	586,076	67,160	16,405	83,565	-16.02	-36.02	-19.94
4B. MIMAROPA	153,144	11,243	5,004	16,247	139,770	15,788	2,643	18,432	-28.79	89.31	-11.85
5. Bicol Region	293,901	19,876	7,319	27,195	273,292	1,6342	5,820	22,162	21.63	25.75	22.71
6. Western Visayas	382,693	29,145	3,864	33,009	357,911	14,443	3,569	18,012	101.8	8.27	83.26
7. Central Visayas	370,701	19,229	6,384	25,613	339,177	28,984	11,254	40,237	-33.66	-43.27	-36.34
8. Eastern Visayas	219,746	8,943	3,577	12,521	206,121	14,772	3,782	18,554	-39.46	-5.42	-32.52
9. Zamboanga Peninsula	198,530	10,948	7,285	18,233	180,875	18,257	6,204	24,460	-40.03	17.43	-25.46
10. Northern Mindanao	246,533	20,085	7,260	27,345	222,598	14,513	8,991	23,504	38.39	-19.26	16.34
11. Davao Peninsula	251,034	22,002	12,940	34,942	227,643	17,674	8,229	25,903	24.49	57.25	34.9
12. SOCCSKSARGEN	244,682	22,130	11,058	33,188	216,110	19,213	12,373	31,587	15.18	-10.63	5.07
ARMM	199,441	12,968	3,839	16,806	185,038	21,672	2,113	23,785	-40.16	81.66	-29.34
CARAGA	135,914	16,965	4,486	21,451	126,222	8,984	4,489	13,473	88.83	-0.07	59.21
By Wealth Quintile											
Lowest (poorest)	810,720	74,600	17,202	97,893	657,232	65,216	18,571	89,230	14.39	-7.37	9.71
Second	1,011,684	74,569	28,679	98,929	849,566	66,387	24,252	91,354	12.33	18.25	8.29
Middle	1,007,068	78,458	25,599	103,660	878,785	68,714	29,245	94,960	14.18	-12.47	9.16
Fourth	1,054,585	79,134	28,602	104,814	1,001,602	67,873	27,647	93,678	16.59	3.45	11.89
Highest (richest)	1,159,658	76,433	22,805	100,785	1,196,929	66,190	26,428	91,303	15.48	-13.71	10.39
Total	5,043,715	383,194	122,887	506,082	4,584,114	334,380	126,144	460,524	14.6	-2.58	9.89

Source: NDHS 2008 and 2013

²⁷ Teenage mothers=women aged 15 to 19 who had begun child bearing (total of those who had a live birth and pregnant with 1st child)

ANNEX E

Number of pregnant women undergoing Four ANC visits in a given year, by region

	2013		2008		Percent Difference	
	With 4ANC	No 4ANC	With 4ANC	No 4ANC	With 4ANC	No 4ANC
Philippines	1,943,675	432,294	1,782,992	529,203	9.01	-18.31
CAR	34,545	9,998	16,849	11,784	105.03	-15.16
1. Ilocos Region	83,584	28,127	86,952	41,425	-3.87	-32.10
2. Cagayan Valley	61,721	23,435	47,743	41,823	29.28	-43.97
3. Central Luzon	214,132	41,375	170,570	60,987	25.54	-32.16
NCR	245,355	27,807	210,094	46,785	16.78	-40.56
4A. Calabarzon	279,666	37,764	244,613	76,416	14.33	-50.58
4B. MIMAROPA	48,976	26,317	51,973	32,002	-5.77	-17.76
5. Bicol Region	117,323	32,545	105,236	41,194	11.49	-20.99
6. Western Visayas	170,560	29,419	129,333	28,138	31.88	4.55
7. Central Visayas	153,696	22,748	123,516	18,140	24.43	25.40
8. Eastern Visayas	71,913	14,724	68,649	35,990	4.75	-59.09
9. Zamboanga Peninsula	69,743	7,637	79,882	23,134	-12.69	-66.99
10. Northern Mindanao	88,295	18,039	89,797	15,607	-1.67	15.59
11. Davao Peninsula	98,788	14,890	97,621	21,161	1.20	-29.63
12. SOCCSKSARGEN	96,837	28,767	81,945	21,971	18.17	30.93
ARMM	44,799	61,118	62,812	53,285	-28.68	14.70
CARAGA	63,743	7,584	51,336	23,434	24.17	-67.64

Source: NDHS 2008 and 2013

ANNEX F
Number of Facility Based Deliveries, by Wealth Quintile

	2013		2008		Percent Difference	
	FBD	Non-FBD	FBD	Non-FBD	FBD	Non-FBD
By Wealth Quintile						
Lowest	313,423	376,688	88,325	567,697	254.85	-33.65
Second	353,198	184,817	174,917	381,123	101.92	-51.51
Middle	392,973	86,060	233,800	188,169	68.08	-54.26
Fourth	351,607	38,092	306,538	106,842	14.7	-64.35
Highest	272,058	7,054	242,459	22,325	12.21	-68.40
Total	1,683,259	692,710	1,046,039	1,266,156	60.92	-45.29

Source: NDHS 2008 and 2013

ANNEX G
Number of Pregnancies by Place of Delivery, by Region

	2013		2008		Percent Difference	
	FBD	Non-FBD	FBD	Non-FBD	FBD	Non-FBD
Philippines	1,683,259	692,710	1,046,039	1,266,156	60.92	-45.29
CAR	37,207	7,335	15,840	12,793	134.89	-42.66
1. Ilocos Region	99,468	12,243	56,530	71,847	75.96	-82.96
2. Cagayan Valley	49,458	35,697	21,542	68,024	129.59	-47.52
3. Central Luzon	197,953	57,553	135,481	96,076	46.11	-40.10
NCR	233,905	39,257	189,791	67,087	23.24	-41.48
4A. Calabarzon	236,656	80,774	174,708	146,321	35.46	-44.80
4B. MIMAROPA	36,998	38,295	29,405	54,571	25.82	-29.82
5. Bicol Region	102,745	47,123	50,629	95,801	102.94	-50.81
6. Western Visayas	141,123	58,856	73,352	84,120	92.39	-30.03
7. Central Visayas	142,309	34,135	75,595	66,060	88.25	-48.33
8. Eastern Visayas	70,286	16,351	38,513	66,126	82.50	-75.27
9. Zamboanga Peninsula	47,867	29,514	26,764	76,251	78.85	-61.29
10. Northern Mindanao	70,495	35,839	37,845	67,558	86.27	-46.95
11. Davao Peninsula	74,424	39,253	54,738	64,044	35.96	-38.71
12. SOCCSKSARGEN	74,133	51,470	21,789	82,126	240.23	-37.33
ARMM	19,680	86,237	16,919	99,178	16.32	-13.05
CARAGA	48,551	22,777	26,598	48,171	82.53	-52.72

Source: NDHS 2008 and 2013

ANNEX H
Number of Facility-based Deliveries by Type of Facility, by Region and by Wealth Quintiles

	2013					2008					Percent Change				
	FBD				Home*	FBD				Home*	FBD				Home*
	All FBD	Govt hospital	Other public	Private		All FBD	Govt hospital	Other public	Private		All FBD	Govt hospital	Other public	Private	
Philippines	1,683,259	889,669	357,307	436,283	692,710	1,046,039	559,427	90,720	395,892	1,266,156	60.92	59.03	293.86	10.2	-45.29
CAR	37,207	29,272	3,298	4,638	7,335	15,840	13,693	-	2,147	12,793	134.89	113.77	n.a.	115.98	-42.66
1. Ilocos Region	99,468	61,017	26,008	12,443	12,243	56,530	47,593	1,766	7,171	71,847	75.96	28.21	1372.84	73.51	-82.96
2. Cagayan Valley	49,458	34,471	7,630	7,357	35,697	21,542	12,410	1,485	7,647	68,024	129.59	177.78	413.80	-3.79	-47.52
3. Central Luzon	197,953	121,821	20,297	55,836	57,553	135,481	80,532	13,932	41,017	96,076	46.11	51.27	45.68	36.13	-40.10
NCR	233,905	122,677	19,628	91,599	39,257	189,791	83,231	7,554	99,006	67,087	23.24	47.39	159.85	-7.48	-41.48
4A. Calabarzon	236,656	120,391	40,037	76,228	80,774	174,708	73,830	7,054	93,824	146,321	35.46	63.07	467.55	-18.75	-44.80
4B. MIMAROPA	36,998	20,240	11,920	4,838	38,295	29,405	21,436	2,225	5,744	54,571	25.82	-5.58	435.76	-15.77	-29.82
5. Bicol Region	102,745	49,093	37,355	16,298	47,123	50,629	30,320	9,127	11,182	95,801	102.94	61.91	309.30	45.75	-50.81
6. Western Visayas	141,123	70,598	56,835	13,690	58,856	73,352	44,340	16,920	12,091	84,120	92.39	59.22	235.91	13.22	-30.03
7. Central Visayas	142,309	55,019	37,877	49,413	34,135	75,595	35,280	3,588	36,727	66,060	88.25	55.95	955.71	34.54	-48.33
8. Eastern Visayas	70,286	34,330	27,740	8,217	16,351	38,513	32,524	4,516	1,473	66,126	82.5	5.55	514.32	457.66	-75.27
9. Zamboanga Peninsula	47,867	22,970	20,107	4,790	29,514	26,764	19,418	3,749	3,597	76,251	78.85	18.29	436.29	33.14	-61.29
10. Northern Mindanao	70,495	35,983	14,859	19,653	35,839	37,845	16,841	10,268	10,736	67,558	86.27	113.67	44.71	83.05	-46.95
11. Davao Peninsula	74,424	35,184	6,767	32,474	39,253	54,738	28,033	-	26,705	64,044	35.96	25.51	n.a.	21.60	-38.71
12. SOCCSKSARGEN	74,133	37,810	12,111	24,213	51,470	21,789	4,990	3,596	13,204	82,126	240.23	657.76	236.79	83.38	-37.33
ARMM	19,680	9,973	2,720	6,987	86,237	16,919	2,262	-	14,657	99,178	16.32	340.95	n.a.	-52.33	-13.05
CARAGA	48,551	28,823	12,118	7,609	22,776	26,598	12,696	4,940	8,962	48,171	82.53	127.02	145.30	-15.090	-52.72

Source: NDHS 2008 and 2013

ANNEX I
Estimated Number of Fully Immunized Children, by Region

	2013		2008		Percent difference	
	FIC	Not FIC	FIC	Not FIC	FIC	Not FIC
Philippines	1,337,035	747,603	1,523,226	370,542	-12.22	101.76
CAR	29,019	5,673	26,778	5,113	8.37	10.96
1. Ilocos Region	62,106	39,620	72,506	23,128	-14.34	71.31
2. Cagayan Valley	39,196	32,504	53,045	13,859	-26.11	134.53
3. Central Luzon	156,468	70,750	159,264	45,188	-1.76	56.57
NCR	199,340	49,449	189,285	37,599	5.31	31.51
4A. Calabarzon	225,174	68,858	220,695	31,766	2.03	116.77
4B. MIMAROPA	45,020	23,988	44,458	18,510	1.26	29.59
5. Bicol Region	84,271	51,789	90,144	36,303	-6.51	42.66
6. Western Visayas	-	146,051	124,979	11,564	-100.00	1163.01
7. Central Visayas	101,837	50,907	115,747	23,922	-12.02	112.80
8. Eastern Visayas	65,122	32,389	73,433	18,024	-11.32	79.70
9. Zamboanga Peninsula	56,242	25,038	60,353	13,742	-6.81	82.21
10. Northern Mindanao	68,197	36,218	78,269	16,004	-12.87	126.30
11. Davao Peninsula	75,418	30,723	80,971	15,310	-6.86	100.68
12. SOCCSKSARGEN	69,444	31,671	69,088	20,616	0.52	53.62
ARMM	15,572	37,326	15,031	34,042	3.60	9.65
CARAGA	44,609	14,647	49,180	5,853	-9.29	150.26

Source: NDHS 2008 and 2013

ANNEX 1.A **Members of the RPRH IRR Drafting Committee**

1. DOH Secretary Enrique Ona and his representative, Undersecretary Madeleine Valera as Chairperson;
2. DepEd representatives Undersecretary Alberto Muyot and Dir. Ella Naliponguit;
3. DSWD representative Dir. Gemma Gabuya;
4. DILG representative Mr. Pablo de Castro;
5. NEDA representatives Asst. Dir. Myrna Clara Asuncion and Ms. Arlene Ruiz;
6. PhilHealth representative Dr. Francisco Soria;
7. PCW representatives Ms. Nharleen Millar and Ms. Kristine Delgado;
8. League of Provinces of the Philippines representative Ms. Angelica Sanchez;
9. League of Cities of the Philippines representative Mr. Jeremy Nishimori;
10. League of Municipalities of the Philippines representative Atty. Reynate Orseo;
11. Likhaan Center for Women's Health representative Dr. Junice Melgar;
12. Reproductive Health, Rights, and Ethics Center for Studies and Training representative Atty. Elizabeth Pangalangan;
13. Women's Health Care Foundation, Inc. representative Dr. Marita Reyes;
14. Philippine Obstetric and Gynecological Society representative Dr. Raul Quillamor;
15. Philippine Medical Association representative Dr. Santiago Del Rosario;
16. Bishops-Businessmen's Conference for Human Development representative Ms. Isabelita Palanca; and
17. Alliance of Young Nurse Leaders and Advocates International representative Mr. Alvin Dakis

(Source: Department of Health)

ANNEX 1.B
Department Personnel Order No. 2013-0343



Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

January 7, 2013

DEPARTMENT PERSONNEL ORDER
No. 2013 - 0343

SUBJECT: Creation of the DOH Technical and Advocacy Working Group in charge of doing preparations for consultations and other pertinent procedures for the logistics of the Implementing Rules and Regulation (IRR) on the Responsible Parenthood and Reproductive Health Act of 2012 (RA No. 10354)

On December 21, 2012, President Benigno C. Aquino signed the Responsible Parenthood and Reproductive Health Act of 2012 or RA 10354 (RP-RH Law) which takes effect on January 17, 2013. The Implementing Rules and Regulations (IRR) of this landmark law is to be promulgated within sixty days from its effectivity. The Department of Health is the lead agency in promulgating the rules and regulations for the effective implementation of this Act.

In view thereof, technical and advocacy working groups in the Department of Health are created to do preparations for consultations and other pertinent procedures for the Implementing Rules and Regulations of the RP-RH Law. The working groups shall be composed of the following:

Chairperson:

Assistant Secretary Enrique Tayag, MD	-	Support to Service Delivery Technical Cluster
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Members of Technical Working Group:

Dr. Honorata Catibog	-	NCDPC
Dr. Rosalie Paje	-	NCDPC
Ms. Zenaida Recidoro	-	NCDPC
Dr. Florencia Apale	-	NCDPC
Ms. Ma. Penelope T. Santiago	-	Legal Service
Dr. Giovanni Roan	-	PHIC
Atty. Ronald De Veyra	-	FDA
Ms. Rosalinda D. Marcelino	-	POPCOM
		NAPC Representative
Dr. Pretchel Tolentino	-	IHRDB
Dr. Cynthia Rosuman	-	BHFS

Members of the Advocacy Working Group:

Dr. Ivanhoe Escartin	-	NCHP
Ms. Rose Aguirre	-	NCHP
Mr. Anthony Roda	-	NCHP
Ms. Edna Nito	-	NCHP

Ms. Rowena Bunoan	-	NCHIP
Mr. Michael Mamaril	-	NCHIP
		Legal Service Representative
Dr. Irma Asuncion	-	NCDPC
Dr. Melissa Sena	-	NCDPC
Ms. May De Guzman	-	MRU
Mr. Lolito Tacardon	-	POPCOM

Secretariat:

The Health Policy Development and Planning Bureau of DOH shall serve as the secretariat for this endeavor with the Legislative Liaison Division as the administrative secretariat.

The working groups shall meet every Wednesday and/or Friday.

Under this Order, all expenses incurred in the discharge of functions shall be chargeable against the funds of HPDPB and NCDPC subject to its availability and the usual accounting and auditing rules and regulations.

This order shall take effect immediately.


ENRIQUE T. ONA, MD
 Secretary of Health

Annex 1.C
Rules of the RPRH Act IRR Drafting Committee

Pursuant to Section 26 of Republic Act No. 10354, otherwise known as “The Responsible Parenthood and Reproductive Health Act of 2012” or the “RPRH Act”, the following Rules are hereby adopted and shall be known as the “Rules of the RPRH Act IRR Drafting Committee”.

RULE I

The IRR Drafting Committee

SECTION 1. The RPRH Act IRR Drafting Committee (Committee) shall have the Secretary of Health (SOH) or his/her designated member of the Department of Health (DOH) Executive Committee as Chairperson.

SEC. 2. The Members of the Committee shall be authorized representatives of the following agencies/organizations enumerated in Section 26 of the RPRH Act:

- a) Department of Education (DepEd)
- b) Department of Social Welfare and Development (DSWD)
- c) Philippine Commission on Women (PCW)
- d) Philippine Health Insurance Corporation (PHIC)
- e) Department of the Interior and Local Government (DILG)
- f) National Economic and Development Authority (NEDA)
- g) League of Provinces of the Philippines (LPP)
- h) League of Cities of the Philippines (LCP)
- i) League of Municipalities of the Philippines (LMP)

Provided, That in addition to the above Members, the SOH may invite at least four (4) others from non-government organizations (NGOs) to become Members. It is understood that no employer-employee relationship is created by the extension of such invitation.

SEC. 3. Except for the SOH or his/her designated representative, the Members of the Committee representing the above-mentioned agencies and organizations shall establish their authority to act as representatives by presenting written certification to that effect from their principals/organizations expressly naming the authorized representative and one (1) alternate who will act in that representative's absence: Only the authorized representative of each agency/organization or the alternate in his absence, shall be considered a member of the Committee for purposes of exercising the prerogatives granted to Committee Members.

SEC. 4. Committee Members sitting in an *ex-officio* capacity representing agencies/organizations as provided for in the RPRH Act may be replaced at the discretion of the respective heads of their sending agencies/organizations.

SEC. 5. The objective of the Committee shall be to draft and subsequently promulgate the Implementing Rules and Regulations of Republic Act No. 10354, otherwise known as “The Responsible Parenthood and Reproductive Health Act of 2012”.

SEC. 6. There shall be a Technical and Advocacy Working Group (TAWG) and Secretariat to provide complete staff work support to the Committee, jointly headed by a member of the DOH Executive Committee designated by the SOH.

The TAWG shall provide technical support to the Committee by providing the necessary references, advising on technical matters and assisting in the drafting of the IRR provisions. The TAWG shall likewise organize, facilitate, and document proceedings of technical consultations that will be conducted as part of its support to the drafting process. In addition, the TAWG shall assist the Chairperson or his/her designee in providing statements to media and other entities as may be necessary.

The Secretariat shall be responsible for documenting the entire drafting process. It shall likewise be responsible for receiving, safeguarding, reproducing, and distributing required documents, and for the performance of all other secretariat/staff work required for the Committee. Confidentiality of documents shall be ensured subject to specific guidelines to be defined separately by the TAWG and Secretariat.

RULE II

The Chairperson, His/Her Duties and Powers

SEC. 7. The SOH or his/her duly designated representative shall be the Chairperson of the Committee.

SEC. 8. The Chairperson shall declare the opening and closing of the meetings, direct the discussions, accord the right to speak, put questions to the vote, and announce decisions. The Chairperson shall likewise rule on points of order and, subject to these Rules, shall have complete control of the proceedings at any meeting and over the maintenance of order.

SEC. 9. The Chairperson may propose to the Committee the limitation of time to be allowed to each speaker, the limitation of the number of times each Member may speak on any question, the closure of the list of speakers, or the closure of the debate.

SEC. 10. The Chairperson may also propose the suspension or the adjournment of the meeting, or the adjournment of the debate on the question under discussion. Such proposals of the Chairperson shall be considered as adopted unless immediately rejected by majority of the Members present.

RULE III

Committee Meetings

SEC. 11. The Committee shall meet at ten o'clock in the morning on Wednesdays, at the National Kidney and Transplant Institute (NKTi) or at an alternative venue to be selected by the Chairperson:

Provided, That the Chairperson may call special meetings upon his/her own initiative; *Provided, further*, That a Member with the concurrence of a majority of all the Committee Members of record may also call for special meetings.

Notices for special meetings shall be sent two (2) days before the schedule of a special meeting through written invitation, phone call or electronic mail specifying the date, time, place and purpose of the said meeting.

SEC. 12. In cases of *force majeure*, the occurrence of an emergency or of any event which may prevent the convening of the Committee, the Chairperson may postpone the holding of the meeting.

RULE IV

Quorum

SEC. 13. Fifty percent plus one (50% + 1) of the Members of the Committee shall constitute a quorum. And in its

absence, a smaller number may adjourn from meeting to meeting.

SEC. 14. Should the question of lack of quorum be raised, the Chairperson, without debate, shall immediately proceed to a verification thereof by causing the reading of the roll of the Members and announcing forthwith the result.

RULE V

Conduct of Meetings

SEC. 15. Committee Members must submit their comments on the Working Draft or any matters relative to the forthcoming Committee meeting to the Secretariat no later than noon of the day before the scheduled meeting.

Late submissions (reckoned by the receiving date and time in the case of hardcopies, or the sending date and time in the case of electronic mail) or matters introduced only within the meeting itself shall be given least priority and may be discussed only after the discussion on items on the agenda and submissions done on time have been completed.

SEC. 16. The Secretariat shall prepare for each session an Order of Business in which shall be listed:

- a) Ecumenical Prayer.
- b) Roll call.
- c) Reading and Approval of the *Minutes* of the previous meeting.
- d) Reference of Business:
 - 1. Reports of the TAWG on previously proposed IRR provisions needing further technical analysis/recommendations.
 - 2. Reading and discussion of newly proposed IRR provisions submitted on time.
 - 3. Referrals to the TAWG of newly proposed IRR provisions needing further technical analysis/recommendations.
- e) Reading and immediate referral (no discussions) to the TAWG of newly proposed IRR provisions submitted late.
- f) Unfinished business.
- g) Approvals and/or directives.

SEC. 17. No person may speak without having previously obtained the permission of the Chairperson. The Chairperson shall call upon persons in the order in which they ask for the floor.

SEC. 18. The Chairperson may call a speaker to order if the remarks of the speaker are not relevant to the subject under discussion.

SEC. 19. Committee Members shall treat each other with courtesy and shall follow proper decorum during Committee meetings.

SEC. 20. Observers may be allowed by the Secretary of Health to sit in the Committee meetings. Observers shall register with the Secretariat their intention to attend at least one (1) day before the Committee Meeting. The seats available for observers shall be equitably allocated.

SEC. 21. Observers may only participate in discussions upon being explicitly recognized by the Chairperson, and shall do so within a certain time limit as prescribed by the Chairperson, which in no case may exceed five (5) minutes. Observers are nevertheless encouraged to course through their contributions to the Committee Secretariat, to which they may submit position papers or proposals.

SEC. 22 The Committee may invite experts or resource persons, who can provide inputs pertinent to the drafting process. The invitation for experts or resource persons may be made by the Chairperson on his/her own initiative, or upon request of the Committee Members. However, the Chairperson may limit the number of such experts or resource persons to be invited to each meeting. An expert or resource person appearing before the Committee shall only be allowed to address the same upon being recognized or called by the Chairperson.

RULE VI

Decision-Making

SEC. 23. If a motion made and duly seconded does not receive any objections from any Member of the Committee, then the same shall be considered as passed or adopted.

SEC. 24. If a motion made and duly seconded receives at least one (1) objection from any Member of the Committee, the same shall be subjected to discussion and/or debate at the discretion of the Chairperson, within a certain time limit. After the discussion and/or debate, if the objection is still manifested, the Chairperson shall call for a vote.

SEC. 25. Each Member of the Committee shall have the right to vote. A Member shall have one (1) vote, and may represent his/her principal/organization only.

SEC. 26. "Voting" shall be understood as casting an affirmative or negative vote, discounting abstentions and non-voting. Voting on any question shall be by show of hands. Nominal voting or any other means shall only be allowed when the same has been requested by at least one (1) Member, and acceded to by a simple majority of the Members present, provided that the Members meet the quorum.

SEC. 27. Other than the submission of prepared explanations to the Secretariat, Members shall not be given time during meetings to explain their votes during nominal voting.

SEC. 28. A vote of two-thirds (2/3) of all the Members present in a meeting with a valid quorum shall establish the decision of the Committee in all matters. The Secretariat shall see to it that the records of the Committee shall always reflect the manner by which the Committee arrived at a decision.

SEC. 29. A vote of two-thirds (2/3) of all the Committee Members shall be required for overturning a matter previously decided by the Committee. Any proposal for amendment of a previous decision shall be put to a vote only if seconded by at least one (1) other Member.

SEC. 30. Where upon voting, the Committee fails to meet the required number of votes, the Chairperson shall call for a run-off election between the choices obtaining the two (2) highest numbers of votes, provided that the combined votes for such choices constitute a majority.

SEC. 31. Observers present during the Committee meetings shall not be allowed to vote on any matter for decision by the Committee. Neither shall observers be allowed to approach or address any Member of the Committee at any time while the meeting is ongoing

RULE VII

Motions

SEC. 32. Motions may be presented orally. A majority of the Members present may require that they be done in writing and read by the Secretariat before proceeding to their consideration.

SEC. 33. The sponsor of any motion or measure may withdraw or modify it before its amendments or resolution, or before a nominal vote is ordered on the same; but a motion to reconsider duly seconded may not be withdrawn without the consent of the Member who seconded the said motion.

SEC. 34. While a motion or bill or resolution is being discussed, no other motion shall be entertained except the following and in the order in which they appear below:

- a) Motion to adjourn.
- b) Motion to suspend the session.
- c) Motion to call an executive session.
- d) Motion to lay on the table any business.
- e) Motion to postpone indefinitely the consideration of any business.
- f) Motion to postpone the consideration of any business to another date.

All motions to adjourn or suspend a session or to hold executive sessions shall be resolved without debate.

RULE VIII

Reading and Inclusion of Certain Documents

SEC. 35. The reading and inclusion of any document in the Record of the Committee as well as in the Minutes may be put into motion by a member with his/her brief explanation ordered upon request of a Member after his/her brief explanation of the object of his/her request; but if objected to, the motion shall be submitted to a vote without debate.

SEC. 36. The reading and inclusion of documents that are not of relevance to the Committee's discussion or in the public interest shall not be allowed.

SEC. 37. No written explanation of vote, speech or any other document shall be included in the Record as well as in the Minutes if the member manifesting his interest to have the same included fails to submit such document within three (3) days from the time he made the manifestation.

RULE IX

Promulgation of the Implementing Rules and Regulations

SEC. 38. Upon the finalization of the Implementing Rules and Regulations, the Committee Secretariat shall organize consultations with stakeholders wherein the final draft shall be presented.

SEC. 39. The Chairperson or his/her representative shall be the official spokesperson of the Committee in communicating to the general public.

SEC. 40. The Committee Secretariat shall document the inputs obtained from such consultations, and shall consolidate the same for dissemination to each Committee Member.

SEC. 41. After the period of consultation, the Committee shall meet to discuss possible amendments or revisions to the Committee draft considering the inputs from the public consultations.

SEC. 42. Upon adoption of a final draft, the same shall be open for signature by all the Committee Members. A simple majority of all Committee Members of record shall constitute a decision to promulgate the Implementing Rules and Regulations of RA 10354.

RULE X
Final Provisions

SEC. 43. If there is no Rule applicable to a specific case, the precedents of the Legislative Department of the Philippines shall be resorted to, and as supplement to these, the Rules contained in Robert's Rules of Order.

SEC. 44. These Rules may be amended by means of a motion, which should be presented at least one (1) meeting before its consideration, and the vote of two-thirds (2/3) of all Committee Members shall be required for its approval.

SEC. 45. These Rules shall take effect on the date of their adoption and shall remain in force until they are amended or repealed.

ANNEX 1.D

List of Provisions of the RPRH Law and IRR Affected by the April 8, 2014 Supreme Court Decision

SC Decision Dispositive Portion #	Affected Provisions in the RPRH Law	Affected Provisions in the RPRH IRR
1a. The requirement to refer patients seeking MFP methods is restricted	Section 7	Sections 5.21, 5.22
1b. Parental consent is needed for minors to access MFP methods	Section 7	Sections 4.06, 4.07
2. Health care providers not disseminating information on RH cannot be punished	Section 23(a)(1)	Sections 5.24, 16.01(a)(1)
3. Health care providers requiring the consent of the spouse before married individuals can undergo RH procedures cannot be punished	Section 23(a)(2)(i)	Section 16.01(a)(2)(i)
4. Health care providers not referring non-emergent patients for RH services or information cannot be punished	Section 23(a)(3)	Sections 5.24, 5.25, 16.01(a)(3)
5. Any public officer hindering full RH implementation or not supporting RH cannot be punished	Section 23 (b)	Section 5.24
6. Any conscientious objector cannot be required to render <i>pro-bono</i> RH service to be accredited by PhilHealth	Section 17	Section 6.11
7. An abortifacient is any drug or device that can destroy a fetus or prevent the implantation of a fertilized ovum	-	Sections 3.01(a), 3.01(j)
8. Health service providers requiring parental consent from minors not in emergencies or serious situations cannot be punished	Section 23(a)(2)(ii)	Sections 4.07, 16.01(a)(2)(ii)

(Source: Supreme Court Decision on the Consolidated Cases of Imbong versus Ochoa)

ANNEX 1.E
RPRH Policies Currently Being Developed by the DOH

A. POLICIES TO BE ISSUED IN 2015

- 1. Administrative Order on the Licensing Requirements for Mobile Health Care Services**
 - This issuance would provide the standards and criteria for the medical services through an especially fabricated vehicle for specified areas with limited access to high quality RPRH services.
- 2. Administrative Order on the Administration of Life-Saving Drugs During Maternal Care Emergencies by Nurses and Midwives in Birthing Centers**
 - In order to prevent maternal and neonatal deaths, this Order allows midwives and nurses in birthing centers to administer life-saving drugs such as oxytocin, magnesium sulfate, antenatal steroids, and antibiotics and other medicines for the management of pregnancy related complications.
- 3. Administrative Order on the Guidelines on the Registration and Mapping of Conscientious Objectors and Exempt Health Facilities Pursuant to the Responsible Parenthood and Reproductive Health Act**
 - In accordance with the RPRH Law, this Order provides the standards and management protocols in which conscientious objectors and facilities exempted can register themselves and be mapped for program planning purposes. This would ensure that the delivery of the full range of reproductive health services would not be impeded at the service delivery points. It also allows for the appropriate referral mechanisms to avoid delays in service provision.
- 4. Administrative Order on the National Health Promotions and Communications Plan for RPRH**
 - Following the requirements outlined in the DOH's National Policy on Health Promotion, the Health Promotions and Communications Service is already working on the communications plan for RPRH. The guidelines include the policies in accepting sponsorships for RPRH advocacy, campaigns, and media placements, development and production of IEC materials, financing requirements, and the activities to be done during disasters and crisis situations.
- 5. Administrative Order regarding the Guidelines on the Deployment of Physicians Graduating from Residency Training Programs in the Department of Health Retained Teaching and Training Hospitals**
 - This order would provide the mechanisms in which Section 6.05 of the RPRH IRR will be implemented. By expanding the Residency Training Program in DOH-retained hospitals and Medical Pool Placement and Utilization Program to allow for the deployment of resident and specialist physicians, the DOH would be able to complement the health human resource requirements in other government hospitals in rural and underserved areas.
- 6. Administrative Order on the Guidelines on the engagement of Privately Owned Health Facilities and Privately Practicing Health Professionals in the Service Delivery Network**
 - This issuance would provide specific guidelines for the implementation of the Section 2.01 (m) of the RA 10354 in encouraging public-private partnerships in the delivery of RPRH services. This would include the inclusion of the private sector in the service delivery network by engaging it to provide counselling, laboratory and diagnostics, medical and surgical, capacity building, and other services related to RPRH.

7. **Administrative Order on the National Policy on the Minimum Initial Service Package (MISP) for Reproductive Health in Health Emergencies, Natural, and Manmade Disasters**
 - This enumerates the set of priority activities and services to be implemented in emergency situations that would reduce mortalities, morbidities, and disabilities through specific interventions. These interventions deal with mechanisms of coordination, gender-based violence prevention, sexually transmitted infections and HIV prevention, maternal and neonatal care services, and other services related to reproductive health.
8. **Department Memorandum Adopting the Manuals for Maternal Death Review and Infant Death Review**
 - The DOH is already finalizing the manuals for the Maternal Death Review and the Infant Death Review, which would be used by the review teams at the LGU and regional level. The manuals contain the steps to be undertaken by the health professionals whenever maternal and infant deaths are reported. The roles of the health facilities, LGUs, and DOH offices are also outlined in the manuals.
9. **Curriculum for the training for Counseling and Referral of Adolescents (Section 5.29 of the RPRH IRR)**
 - This curriculum would build on the existing Adolescent Job Aid Manual training and expand it to incorporate the new requirements in providing adolescent reproductive health services consistent with the RPRH Law, its IRR, and related guidelines recently issued.

B. POLICIES TO BE DEVELOPED IN 2015

10. **Joint Memorandum Circular on the Annual RPRH Report (Section 15 of the RPRH IRR)**
 - A Monitoring and Evaluation Committee was already organized by the DOH in the first quarter of 2015 to formulate the guidelines and monitoring templates to be used by the different implementing agencies and stakeholders in reporting the annual plans and accomplishments of RPRH-related programs. The Committee is composed of M&E experts from DOH units, other government agencies, LGUs, development partners, and CSOs.
11. **Administrative Order on the Conduct of Fetal Infant Death Review**
 - The DOH is currently developing the terms of reference and contract of the consultants who will develop the manual for fetal death reviews. The development of the Fetal Death Review Manual, which will follow the format of the MDR/ and IDR Manuals already developed by the DOH, is set to begin during the third quarter of 2015.

ANNEX 1.F

Existing DOH Policies to be reviewed and updated in Accordance with RA 10354 and its IRR

RH Element #1: Family planning information and services which shall include as a first priority making women of reproductive age fully aware of their respective cycles to make them aware of when fertilization is highly probable, as well as highly improbable. The provision of information on fertility cycles includes information on the full range of modern family planning methods.

1. AO 50-A s.2001 or the National Family Planning Policy
2. AO 132 s.2004 or the Creation of the DOH Natural Family Planning Program & its Program Management
3. AO 2006-0008 or the Guidelines on Public-Private Collaboration in Delivery of Health Services Including Family Planning for Women of Reproductive Age
4. AO 2011-0005 or the Guidelines on Ensuring Quality Standards in the Delivery of Family Planning Program and Services through Compliance to Informed Choice and Voluntarism
5. AO 2012-0009 or the National Strategy Towards Reducing Unmet Need for Modern Family Planning as a Means to Achieve MDGs on Maternal Health

RH Element #2: Maternal, infant and child health and nutrition, including breastfeeding

1. AO 2005-0014 or the National Policies on Infant and Young Child Feeding
2. AO 2007-0026 or the Revitalization of the Mother-Baby Friendly Hospital Initiative in Health Facilities with Maternity and Newborn Care Services
3. AO 2007-0039 or the Regulation of Birthing Homes
4. AO 2007-0045 or the Zinc Supplementation and Reformulated Oral Rehydration Salt in the Management of Diarrhea among Children
5. AO 2008-0029 or the Implementing Health Reforms for Rapid Reduction of Maternal and Neonatal Mortality
6. AO 2010-0015 or the Revised Policy on Child Growth Standard
7. AO 2010-0010 or the Revised Policy on Micronutrient Supplementation to support achievement of 2015 MDG targets to reduce under-five and maternal deaths and address micronutrient needs of other population groups
8. AO 2010-0014 or the Administration of Life-saving Drugs and Medicine by Midwives to rapidly reduce maternal and neonatal morbidity and mortality
9. AO 2011-0014 or the Guidelines on the Certification of Health Facilities with Basic Emergency Obstetrics and Newborn Care (BEmONC) capacity
10. DM 2008-0106 or the Follow-up of Defaulters Immunization for Infants/ Children/ Pregnant Mothers
11. DM 2009-0108 or the Administration of 2nd dose Measles Vaccines to Children 15-23
12. DM 2009-0236 or the Immunization, Breastfeeding/ Infant and Young Child Feeding Practice and vitamin A Supplementation in Evacuation Centers
13. DM 2010-0161 or the Administration of Routine Second Dose Measles-Containing Vaccines for Children
14. DM 2011-0303 or the Micronutrient Powder Supplementation for Children 6-23 months
15. DM 2012-0013 or the Use of fortified products in hospitals and other food service institutions
16. DM 2013-0122 or the Micronutrient Powder and other Micronutrient Supplements
17. DC 2010-0147 or the Guidelines for Physicians on the Promotion, Protection, and Support of Breastfeeding

18. MC 2011-0055 or the IRR of RA No. 10028 entitled "An Act Expanding the Promotion of Breastfeeding, Amending for the Purpose RA No. 7600, Otherwise Known as An Act Providing Incentives to All Government and Private Health Institutions with Rooming-In and Breastfeeding Practices and for Other Purposes" dated August 22, 2011

RH Element #3: Proscription of abortion, and management of abortion complications

1. AO 48-b s. 1999 or the Guidelines in the Prevention and Management of Iatrogenic and Post-Abortion Infections in DOH Retained Hospitals and Medical Centers
2. AO 45-B s. 2000 or the Prevention and Management of Abortion and its Complications (PMAC) Policy

RH Element #4: Adolescent and youth reproductive health guidance and counseling at the point of care

1. AO 34-A s.2000 or the Adolescent & Youth Health Policy
2. AO 138-A s.2000 or the Amendment to Sub-sections 2, 3, 4, 5 under Sec. III providing for the Specific Guidelines of AO # 34-A s. 2000
3. AO 2013-0013 or the National Policy and Strategic Framework on Adolescent Health and Development

RH Element #5: Prevention, treatment and management of reproductive tract infections (RTIs), HIV and AIDS and other sexually transmittable infections (STIs)

1. AO 2009-0016 or the Policies and Guidelines on the Prevention of Mother to Child Transmission (PMTCT) of Human Immunodeficiency Virus (HIV)
2. AO 2009-0006 or the Guidelines on Antiretroviral Therapy (ART) Among Adults and Adolescents with Human Immunodeficiency Virus (HIV) Infection
3. AO 2010-0028 or the Policies and Guidelines in the Conduct of Human Immunodeficiency Virus (HIV) Counseling and Testing in Community and Health Facility Settings

RH Element #6: Elimination of violence against women and children and other forms of sexual and gender-based violence

1. AO 2013-0005 or the National Policy on the Unified Registry Systems of the Department of Health (Chronic Non-Communicable Diseases, Injury Related Cases, Persons with Disabilities and Violence Against Women and Children Registry System)
2. AO 2013-0011 or the Revised Policy on the Establishment of Women and their Children Protection Units in all Government Hospitals

RH Element #7: Age- and development-appropriate education and counseling on sexuality and reproductive health

The DOH has developed Adolescent Job Aid manuals to aid the health workers in providing counselling to adolescents on various health concerns, from physiologic changes during puberty, hygiene and menstruation, and teenage pregnancy.

RH Element #8: Treatment of breast and reproductive tract cancers and other gynecological conditions and disorders

1. AO 2011-0017 or the Implementing Guidelines for the Department of Health (DOH) Medicines Access Program for Early Stage Breast Cancer (Stage I-IIIa)

RH Element #9: Male responsibility and involvement and men's reproductive health

1. AO 2006-0035 or the National Policy and Strategic Framework on Male Involvement in Reproductive Health

RH Element #10: Prevention, treatment and management of infertility and sexual dysfunction

Since this a new requirement under the RPRH Law, the DOH has yet to develop guidelines regarding the provision of services that would address infertility and sexual dysfunction conditions.

RH Element #11: Age- and development- appropriate reproductive health education for adolescents in formal and non-formal educational settings

Currently, the DOH is set to provide technical assistance to DepEd in the development of teaching modules in relation to the provision of age and development appropriate RPRH education

RH Element #12: Mental health aspect of reproductive health care

1. AO 8 s.2001 or The National Mental Health Policy
2. AO 2007-0009 or the Operational Framework for the Sustainable Establishment of a Mental Health Program
3. AO 2007-0009-A or the Amendment of Administrative Order No. 2007-0009 dated March 9, 2007 entitled "Operational Framework for the Sustainable Establishment of a Mental Health Program"

ANNEX 1.G
Policies Being Developed by Other Agencies

1. PhilHealth

In order to provide adequate focus to the development of RPRH-related benefit packages, PhilHealth has formed an RPRH Technical Working Group composed of PhilHealth staff, representatives from other agencies, CSOs, and technical experts. The RPRH TWG is currently studying the development or enhancement of the following packages:

- a. Subdermal implant insertion/ removal;
- b. Postpartum IUD insertion;
- c. Revising the HIV/AIDS Outpatient Treatment Package and Inpatient Benefit Package;
- d. BTL and NSV services in RHUs; and
- e. Maternal care package, specifically the accreditation of nurses as providers

2. DSWD

The DSWD is finalizing the Memorandum Circular entitled “Institutionalization of Women Friendly Space in Camp Coordination and Camp Management”. It will be issued to all DSWD Field Offices and other partner agencies upon the approval of the DSWD Secretary. A WFS Manual of Operations, which was drafted based on the pilot implementation of the program last 2012 and 2013, is also available. Services included in the WFS include pre-natal check-ups, breastfeeding counselling, reproductive health check-ups of women of reproductive age, provision of family planning commodities, and other medical services for women.

The agency also plans to enhance its current Population Awareness and Family Life Orientation (PAFLO) Manual which is being used for the Unlad Kabataan Program. The planned inclusions to the current manual are sections on current youth activities, RPRH Law discussion, and teenage pregnancy prevention.

3. DepEd

Policies geared towards development of support programs that will complement the Adolescent Reproductive Health and Sexuality Education in Schools are also being developed. Some of these guidelines, which are now being reviewed by the DepEd Secretary, are the following:

- a. Comprehensive Policy To Strengthen Guidance And Counseling In School And The Workplace At The Department Of Education
 - This Order strengthens the specific roles and responsibilities of licensed guidance counselors, school health personnel, key policy decision makers, and select accredited teacher-counselors in providing counselling services to both school personnel and students. It establishes the standards, content of counselling services, and the mechanism in which these services are to be delivered.
- b. Guidelines For The Implementation Of The Water, Sanitation And Hygiene In Schools (Wins) Program
 - This guideline would support the teaching of health and hygiene concepts, which includes menstrual hygiene management and its benefits. Aside from strengthening related modules

in the K to 12 curriculum, it would also require the posting of hygiene-related Information Education Materials (IEC) in all toilet facilities and other strategic places inside school premises.

4. DILG

The DILG prepared a draft Memorandum Circular entitled “Support to the Implementation of RA No. 10354, Popularly Known as The Responsible Parenthood and Reproductive Health (RPRH) Act Of 2012”. The circular addressed to all DILG field units and LGUs reiterate the observance of the RH Law’s provisions to the LGUs. It emphasizes the need for each LGU to designate a Reproductive Health Officer (RHO) and to submit all data related to RPRH implementation to the DOH. The circular is now awaiting the signature of the DILG Secretary.

5. DOLE

The Department of Labor is set to update the following issuances in order to ensure compliance with RA 10354:

- a. Department Order 56 s. 2003 or the Establishment of the Family Welfare Program in Enterprises,
- b. Administrative Order 209 s. 2004 or the Checklist for Priorities to the Family Welfare Program Implementation, and
- c. Department Advisory 03 s. 2009 or Intensifying the Implementation of the Family Welfare Program

Aside from the guidelines issued by the DOLE, the agency has also cooperated with the DOH in including RPRH services in enterprises by issuing AO 2008-0012 or the “Department of Health (DOH) Partnership with Department of Labor and Employment (DOLE) for Strengthening Support for Workplace Health Programs”

6. CSOs

Several CSOs are assisting in the development of policies related to RPRH Law implementation, such as the Comprehensive Sexuality Education Standards (CSES). The CSES contains theoretical standards, such as the minimum content and skills associated with behavior indicators that are adapted to the Philippine socio-cultural context. This will be used by DepEd in the development of the curriculum for age and development appropriate RPRH education, for both the public, private, and non-formal educational systems. The CSES will be presented to DepEd for endorsement and approval during the second quarter of 2015.

BUDGET AND FINANCING SECURED

Annex 2.A
Status of DOH-Implemented 2014 HFEP Infrastructure Projects

REGION	ONGOING			COMPLETED		
	BHS	RHU	HOSPITAL	BHS	RHU	HOSPITAL
CAR	2	1	2	15	3	5
1. Ilocos Region	0	0	2	9	8	3
2. Cagayan Valley	24	37	13	16	3	0
3. Central Luzon	2	18	0	16	17	0
NCR	0	20	0	0	20	0
4A. Calabarzon	3	3	17	12	7	11
4B. Mimaropa	23	2	0	0	0	0
5. Bicol Regon	76	2	10	56	13	2
6. Western Visayas	18	5	7	5	3	0
7. Central Visayas	5	1	25	0	0	1
8. Eastern Visayas	2	0	1	0	0	0
9. Zamboanga Peninsula	25	9	5	0	0	0
10. Northern Mindanao	16	16	12	24	26	4
11. Davao Peninsula	9	16	2	1	3	0
12. SOCCSKSARGEN	32	13	17	10	2	0
ARMM	0	0	0	0	0	0
CARAGA	16	2	4	0	0	0
TOTAL	253	145	117	164	105	26

(Source: DOH HFDB 2014)

Annex 2.B
Number of PhilHealth Sponsored Program Members and Dependents
Among NHTS Poor Households

REGION	MEMBERS	DEPENDENTS
CAR	248,306	489,975
1. Ilocos Region	702,643	1,386,505
2. Cagayan Valley	504,059	994,645
3. Central Luzon	882,998	1,742,394
NCR	871,018	1,718,754
4A. Calabarzon	611,898	1,207,440
4B. Mimaropa	877,064	1,730,684
5. Bicol Region	1,206,834	2,381,410
6. Western Visayas	1,340,254	2,644,683
7. Central Visayas	1,094,782	2,160,301
8. Eastern Visayas	1,013,646	2,000,197
9. Zamboanga Peninsula	812,553	1,603,387
10. Northern Mindanao	996,357	1,966,082
11. Davao Peninsula	877,671	1,731,882
12. SOCCSKSARGEN	1,052,068	2,076,014
ARMM	1,015,223	2,003,309
CARAGA	599,146	1,182,277
TOTAL	14,706,520	29,019,939

(Source: PhilHealth 2014)

Annex 2.C
Number of Claims and Benefits Paid for Selected PhilHealth benefit packages Related to RPRH, 2014

Selected RPRH-related Services	Number of claims filed	Total amount paid (in PhP)
IUD	1,355	7,478,300
NSV	20	120,000
BTL	2,246	21,667,180
Vasotomy, vasovasorrhaphy	2	16,220
BTL	29,038	566,521,360
CS w/ BTL	96,449	1,892,270,070
MCP	165,788	1,285,775,583
NSD	202,668	1,035,342,556
NSD w/ BTL	2,246	21,667,180
Vaginal Delivery	62,313	574,658,460
CS, Primary	90,637	1,754,054,240
Breech	3,749	45,533,390
VBAC	2,448	29,884,810
CS, Repeat	92,863	1,820,499,220
Newborn Care Package	439,038	696,680,150
Post-partum hemorrhage	4,859	50,979,594
Treatment of ectopic pregnancy	168	28,379,290
Sepsis of the Newborn	72,928	930,265,938
Jaundice of the newborn	68,000	936,670
D & C for incomplete abortion	19,522	215,759,060
Threatened abortion	6,095	42,931,060
HIV package OHAT	6,340	47,550,000
In-patient HIV	206	4,760,060
Chlamydia	8	44,360
Gonococcal infection	113	829,900
Syphilis	18	176,310
Fractional D & C	42,919	476,023,354
Mastectomy	10,773	214,835,620
Myomectomy	1,703	37,416,420
Hysterectomy, TAHBSO	20,379	614,439,110
Malignancy in the female	37,512	442,416,616

Selected RPRH-related Services	Number of claims filed	Total amount paid (in PhP)
Cervical cancer Radiotherapy	1,174	23,075,000
Z-Package Prostate Cancer	2	200,000
Z-Package Breast Cancer	180	15,600,000
Malignancy in the male	7,868	100,757,372
Prostate cancer brachytherapy	9	243,120
Breast Cancer (M+F)	74,596	723,147,138
Radiotherapy	118,467	626,454, 521
Chemotherapy	74,400	553,551,034
TOTAL	1,759,099	14,276,485,745.00

(Source: PhilHealth 2014)

COMMODITIES PROCURED AND DELIVERED

Annex 3.A
FP Commodities Delivered to Regions, 2014

Region	Pills (cycles)	DMPA (vials and syringes)	IUD (pcs)
CAR	198,534	33,275	6,202
1. Ilocos Region	533,484	86,975	16,284
2. Cagayan Valley Region	267,414	43,250	8,260
3. Central Luzon	714,852	115,850	21,865
NCR	892,401	158,650	23,212
4A. CALABARZON	1,028,583	140,800	26,406
4B. MIMAROPA	527,742	85,100	16,284
5. Bicol Region	990,264	159,900	30,297
6. Western Visayas	832,494	133,825	24,756
7. Central Visayas	706,911	115,875	21,859
8. Eastern Visayas	722,784	116,725	22,055
9. Zamboanga Peninsula	770,214	122,150	23,275
10. Northern Mindanao	714,237	114,400	21,835
11. Davao Region	577,266	92,700	17,514
12. SOCCSKSARGEN	658,887	106,825	20,615
ARMM	917,286	136,075	23,064
CARAGA	506,208	82,775	19,035
TOTAL	11,559,561	1,845,150	342,818

(Source: DOH DPCB 2014)

Annex 3.B
Planned Procurement of FP Commodities Using the 2014 Budget

Region	PILLS cycles				DMPA (vials & syringes)		Intrauterine Device (IUD pcs)		Subdermal Implant (units)	
	PILLS (COC)		PILLS (POP)							
	Quantity	Total Cost	Quantity	Total Cost	Quantity	Total Cost	Quantity	Total Cost	Quantity	Total Cost
CAR	145,552	2,547,014.45	37,284	3,355,533	53,742	2,041,127.43	9,405	205,970	11,305	5,652,500
1. Ilocos Region	367,711	6,434,574.79	94,190	8,477,136	135,770	5,156,532.45	23,760	520,344	28,560	14,280,000
2. Cagayan Valley	191,516	3,351,338.48	49,058	4,415,175	70,713	2,685,693.98	12,375	271,013	14,875	7,437,500
3. Central Luzon	505,602	8,847,529.40	129,512	11,656,062	186,683	7,090,232.11	32,670	715,473	39,270	19,635,000
NCR	513,263	8,981,589.24	131,474	11,832,669	189,512	7,197,659.87	33,165	726,314	39,865	19,932,500
4A. CALABARZON	612,851	10,724,279.65	156,984	14,128,560	226,283	8,594,220.74	39,599	867,218	47,600	23,800,000
4B. MIMAROPA	367,711	6,434,574.79	94,190	8,477,136	135,770	5,156,532.45	23,760	520,344	28,560	14,280,000
5. Bicol Region	681,797	11,930,765.70	174,645	15,718,023	251,740	9,561,070.58	44,053	964,761	52,955	26,477,500
6. Western Visayas	582,209	10,188,075.29	149,135	13,422,132	214,969	8,164,509.71	37,619	823,856	45,220	22,610,000
7. Central Visayas	505,602	8,847,529.40	129,512	11,656,062	186,683	7,090,232.11	32,669	715,451	39,270	19,635,000
8. Eastern Visayas	497,942	8,713,487.06	127,550	11,479,455	183,855	6,982,804.35	32,175	704,633	38,675	19,337,500
9. Zamboanga Peninsula	513,263	8,981,589.24	131,474	11,832,669	189,512	7,197,659.87	33,164	726,292	39,865	19,932,500
10. Northern Mindanao	482,620	8,445,367.38	123,625	11,126,241	178,198	6,767,948.84	31,185	682,952	37,485	18,742,500
11. Davao Region	390,693	6,836,736.81	100,077	9,006,957	144,255	5,478,815.72	25,245	552,866	30,345	15,172,500
12. SOCCSKSARGEN	467,299	8,177,265.20	119,700	10,773,027	172,541	6,553,093.32	30,195	661,271	36,295	18,147,500
ARMM	482,620	8,445,367.38	90,266	8,123,922	130,113	4,941,676.93	31,184	682,930	37,485	18,742,500
CARAGA	352,389	6,166,455.11	123,625	11,126,241	178,198	6,767,948.84	22,770	498,663	27,370	13,685,000
Buffer Stock	339,360	5,938,460.64	37,700	3,393,000	171,465	6,512,240.70	5,007	109,653	105,000	52,500,000
TOTAL	8,000,000	139,992,000	2,000,000	180,000,000	3,000,000	113,940,000	500,000	10,950,000	700,000	350,000,000
Source: DPCB 2014. Procurement of Pills (POP) is for issuance of NTP until April 20, 2015. Procurement of DMPA and IUD is pending re-certification of these commodities as non-abortifacient by the FDA.										

DEMAND FOR SERVICES GENERATED

ANNEX 4.A Survey Results of “Inakup, Arekup” Campaign

Fig. 4.A.a: Cumulative audience reach of “Inakup, Arekup” advertisement over a 10 week period

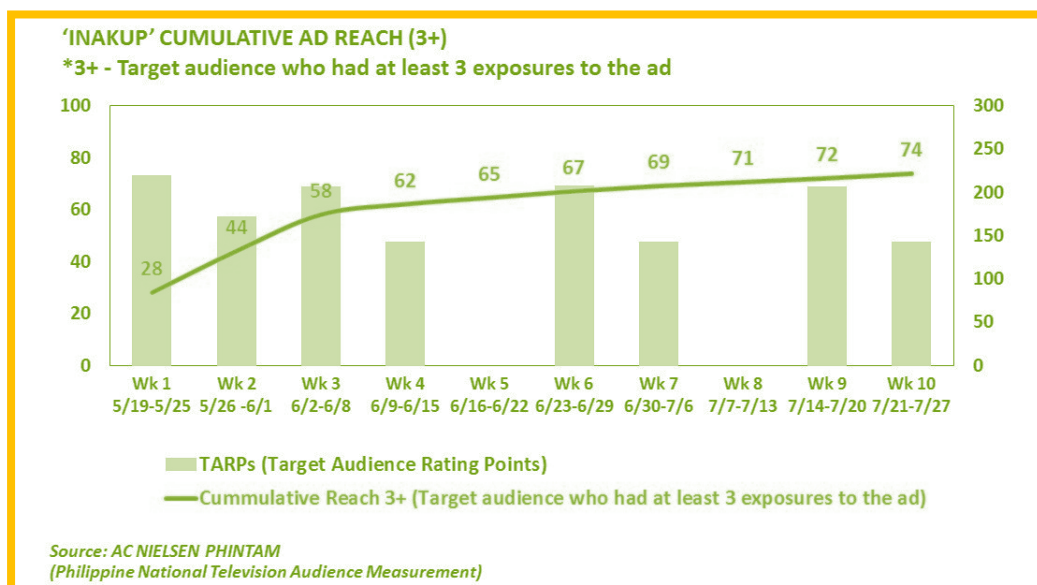


Fig. 4.A.b: Correct message recall of audience of “Inakup, Arekup” advertisement over a 10 week period

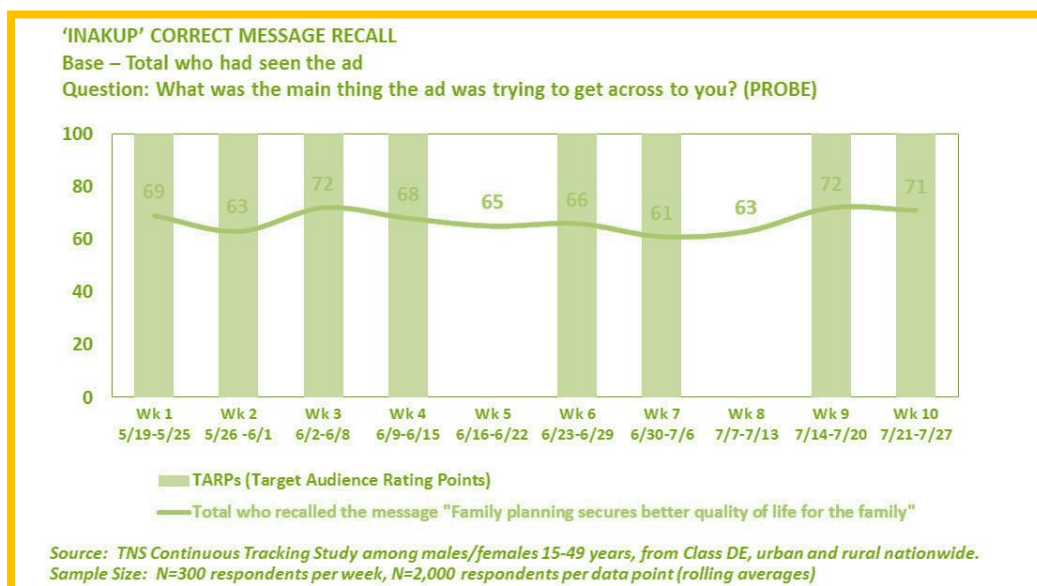


Fig. 4.A.c: Positive opinion change of audience of “Inakup, Arekup” advertisement on family planning over a 10 week period

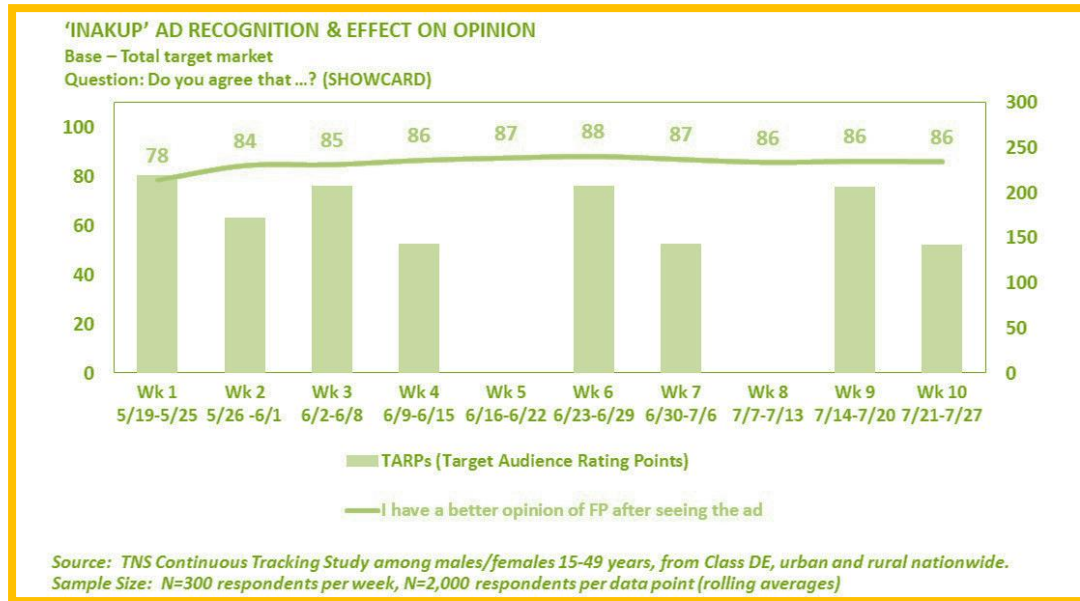
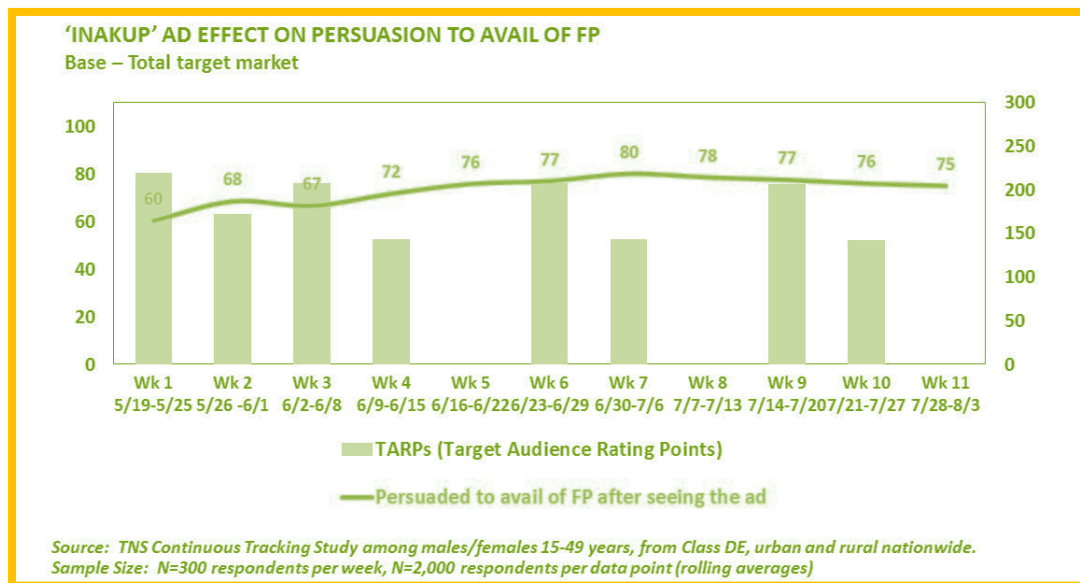


Fig. 4.A.d: Positive behavior change of audience of “Inakup, Arekup” advertisement on availing family planning service over a 10 week period



Annex 4.B.

Various DOH Information, Education and Communication Materials on Modern Family Planning

Fig 4.C.a: Family Planning Poster 1

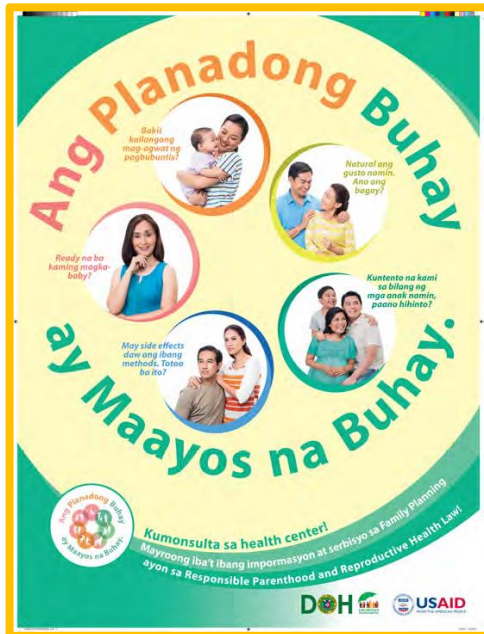


Fig 4.C.b: Family Planning Poster 2



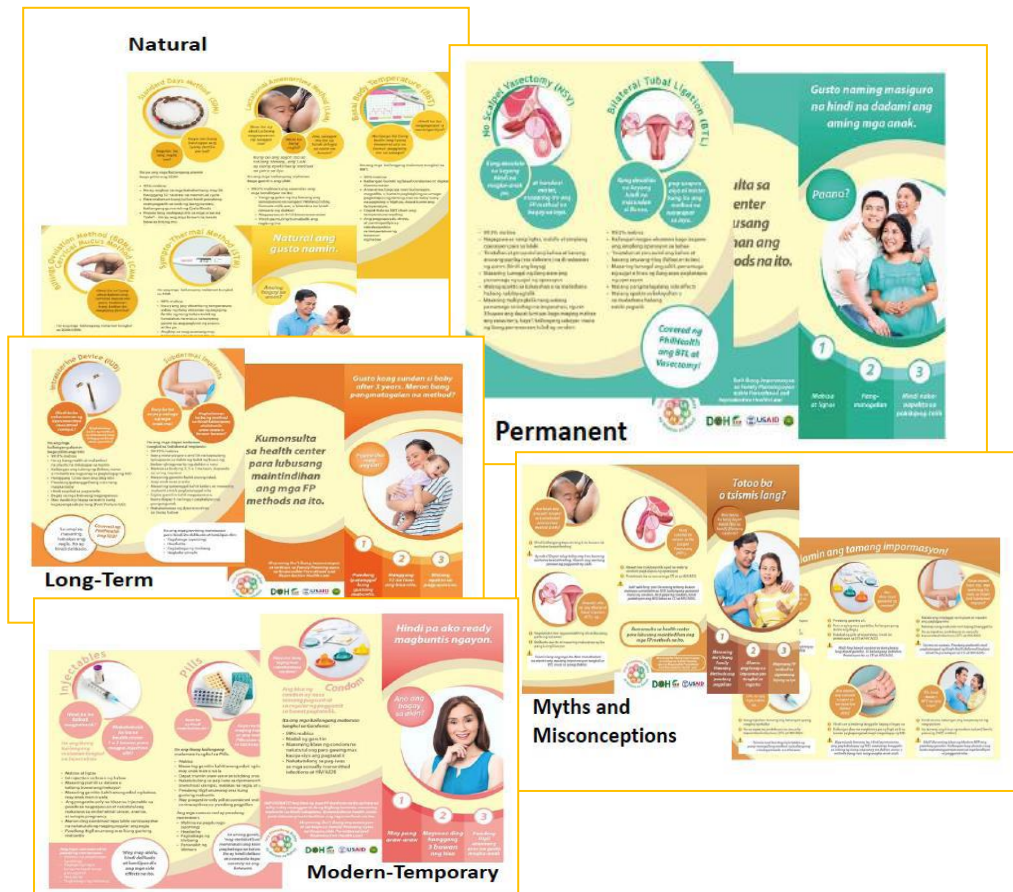
Fig 4.C.c: Family Planning Poster3



Fig 4.C.d: Family Planning Poster4



Fig 4.C.e: Family Planning Brochures



Annexes 4.C

IEC Materials from Ten Kumainments Campaign



Figure 4.B.a Ten Kumainments Logo and Tablet

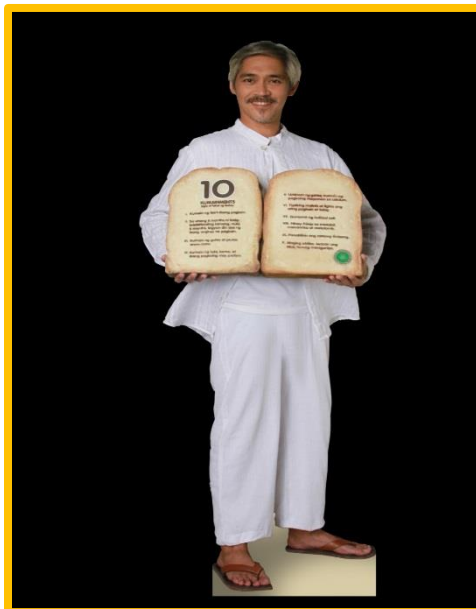


Figure 4.B.b Ten Kumainment's Mang Moi Standee holding the tablets

Annex 4.D
Status of Deployment of CHTs, NDPs, RHMPPs, and PHAs, 2014

REGION	CHT MEMBERS	Nurse Deployment Program	Rural Health Midwives Placement Program	Public Health Assistants
CAR	6,665	396	125	12
1. Ilocos Region	13,971	636	150	12
2. Cagayan Valley	5,125	508	160	12
3. Central Luzon	15,746	909	140	12
NCR	3,739	154	100	12
4A. CALABARZON	20,449	841	130	12
4B. MIMAROPA	13,437	511	120	12
5. Bicol Region	18,870	888	245	12
6. Western Visayas	18,035	881	260	12
7. Central Visayas	15,264	962	240	12
8. Eastern Visayas	17,171	1,260	190	12
9. Zamboanga Peninsula	14,492	550	150	12
10. Northern Mindanao	14,618	716	220	12
11. Davao Region	10,860	403	200	12
12. SOCCSKSARGEN	10,558	422	104	12
ARMM	15,251	744	50	12
CARAGA	10,750	511	116	12
TOTAL	225,001	11,292	2,700	204

Source: DOH DPCB and HHRDB, 2014

Annex 4.E
Number of Households Visited by Community Health Teams, 2014

REGION	NHTS-PR HHs VISITED		
	Number of NHTS-PR HHs	No. of NHTS-PR HHs Visited	Percent
CAR	79,816	100,375	125*
1. Ilocos Region	247,882	360,375	145*
2. Cagayan Valley	118,118	106,654	90
3. Central Luzon	322,622	303,847	94
NCR	316,823	229,739	73
4A. CALABARZON	389,811	367,738	94
4B. MIMAROPA	242,633	200,999	83
5. Bicol Region	461,242	307,041	67
6. Western Visayas	385,518	355,065	92
7. Central Visayas	314,654	211,516	67
8. Eastern Visayas	335,208	30,428	9
9. Zamboanga Peninsula	369,239	115,074	31
10. Northern Mindanao	338,749	253,329	75
11. Davao Region	272,933	233,542	86
12. SOCCSKSARGEN	296,043	206,748	70
CARAGA	232,301	199,683	86
ARMM	531,526	147,307	28
TOTAL	5,255,118	3,729,460	71

Source: DOH DPCB 2014; *may have included non-NHTS PR households

Annex 4.F
Deployment Status of the Nurse Deployment Program, 2014 per region

REGION	Target No. of Nurses	Actual No. Deployed / Hired	Percent Deployed
CAR	400	396	99
1. Ilocos Region	654	636	97
2. Cagayan Valley	508	508	100
3. Central Luzon	913	909	99
NCR	155	154	99
4A. CALABARZON	873	841	96
4B. MIMAROPA	513	511	99
5. Bicol Region	900	888	98
6. Western Visayas	883	881	99
7. Central Visayas	964	962	99
8. Eastern Visayas	874	1,260	144
9. Zamboanga Peninsula	559	550	98
10. Northern Mindanao	720	716	99
11. Davao Region	404	403	99
12. SOCCSKSARGEN	422	422	100
ARMM	746	744	99
CARAGA	512	511	99
TOTAL	11,000	11,292	102

Source: DOH HHRDB 2014

Annex 4.G
Number of Classes/Sessions Held and Couples Reached Through RFPF Classes

Region	Number of Classes/Sessions held	Number of Couples of Reproductive Age reached
CAR	959	14,737
1. Ilocos Region	1,997	49,815
2. Cagayan Valley	1,111	20,309
3. Central Luzon	3,332	54,132
4. Tagalog Region	4,618	98,649
NCR	4,695	50,584
5. Bicol Region	6,383	71,559
6. Western Visayas	4,280	62,945
7. Central Visayas	767	12,033
8. Eastern Visayas	4,493	46,317
9. Zamboanga Peninsula	1,486	24,504
10. Northern Mindanao	2,563	58,772
11. Davao Peninsula	1,367	19,593
12. SOCCSKSARGEN	1,889	25,161
ARMM	5,498	116,039
CARAGA	2,451	30,759
TOTAL	47,889	755,908

Source: PopCom 2014

CAPACITY BUILDING FOR DEMAND GENERATION IMPLEMENTED

Annex 5.A.
Number of RHUs with Staff Trained on AJA, 2014

Regions	Number of RHUs with Trained Staff
CAR	96
1. Ilocos Region	61
2. Cagayan Valley	34
3. Central Luzon	24
NCR	9
4A. CALABARZON	111
4B. MIMAROPA	9
5. Bicol	45
6. Western Visayas	52
7. Central Visayas	38
8. Eastern Visayas	33
9. Zamboanga Peninsula	63
10. Northern Mindanao	17
11. Davao Region	38
12. SOCCSKSARGEN	50
ARMM	0
CARAGA	51
TOTAL	833

Source: DOH DPCB 2014

UTILIZATION OF RPRH SERVICES ENSURED

Annex 6.A EPI Accomplishment Report 2014

CHDs	Eligible	BCG		DPT-HEPB-HIB(1)		DPT-HEPB-HIB(2)		DPT-HEPB-HIB(3)		OPV1		OPV2		OPV3		HEPB Birthdose		HepB> 24 Hrs		Measles		MMR		FIC	
	Pop.	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
CAR	39,496	35,433	90	33,977	86	33,488	85	32,807	83	33,999	86	33,699	85	33,609	85	25,964	66	3,598	9	33,836	86	24,898	63	33,771	86
1	114,005	76,521	67	92,358	81	90,307	79	88,144	77	87,910	77	88,675	78	88,146	77	61,319	54	4,143	4	95,480	84	87,990	77	93,117	82
2	78,887	54,953	70	63,529	81	63,715	81	68,751	87	63,112	80	63,058	80	61,670	78	30,560	39	7,481	9	62,110	79	46,896	59	62,389	79
3	255,380	222,671	87	200,907	79	177,356	69	180,120	71	216,466	85	217,771	85	207,352	81	97,060	38	38,176	15	219,284	86	182,544	71	197,393	77
4A	329,894	244,321	74	266,821	81	250,601	76	232,695	71	271,787	82	260,394	79	242,273	73	137,318	42	26,388	8	255,095	77	182,345	55	237,212	72
4B	68,155	58,280	86	59,314	87	56,383	83	54,280	80	62,439	92	60,851	89	58,055	85	27,073	40	-	-	37,441	55	20,178	30	57,515	84
NCR	289,314	247,246	85	245,729	85	234,985	81	222,979	77	246,104	85	241,296	83	236,081	82	174,330	60	30,489	11	254,440	88	146,186	51	246,686	85
5	132,758	126,108	95	124,660	94	119,617	90	115,368	87	128,341	97	124,956	94	120,742	91	68,893	52	7,023	5	123,694	93	123,694	93	123,711	93
6	173,232	102,451	59	108,791	63	107,617	62	101,429	59	112,554	65	114,438	66	112,728	65	75,957	44	9,526	5	115,317	67	85,046	49	111,595	64
7	168,732	188,453	112	182,731	108	173,902	103	159,968	95	191,392	113	189,250	112	180,284	107	154,699	92	11,406	7	188,399	112	155,763	92	180,016	107
8	100,546	86,843	86	83,511	83	83,511	83	73,691	73	93,571	93	89,123	89	83,125	83	50,354	50	6,373	6	83,351	83	37,537	37	80,281	80
9	78,923	81,876	104	57,906	73	57,292	73	52,677	67	77,598	98	76,105	96	74,521	94	60,472	77	4,937	6	78,440	99	55,714	71	78,456	99
10	105,452	101,223	96	103,411	98	103,332	98	102,968	98	108,335	103	107,075	102	104,371	99	60,079	57	6,083	6	111,079	105	75,802	72	110,798	105
11	109,672	117,737	107	101,823	93	97,622	89	96,705	88	103,558	94	100,477	92	98,579	90	67,872	62	4,455	4	97,616	89	77,615	71	101,123	92
12	101,652	80,353	79	89,712	88	88,878	87	86,588	85	92,529	91	90,450	89	87,460	86	34,487	34	1,946	2	95,465	94	49,685	49	94,954	93

CHDs	Eligible	BCG		DPT-HEPB-HIB(1)		DPT-HEPB-HIB(2)		DPT-HEPB-HIB(3)		OPV1		OPV2		OPV3		HEPB Birthdose		HepB> 24 Hrs		Measles		MMR		FIC	
	Pop.	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
ARMM	79,812	39,585	50	31,965	40	29,282	37	27,744	35	41,685	52	40,525	51	39,687	50	16,306	20	10,854	14	41,319	52	25,042	31	35,260	44
CARAGA	59,592	48,153	81	50,077	84	49,186	83	47,088	79	50,763	85	50,149	84	50,430	85	35,080	59	1,173	2	48,404	81	38,048	64	52,561	88
TOTAL	2,285,501	1,912,207	84	1,897,222	83	1,817,074	80	1,744,002	76	1,982,143	87	1,948,292	85	1,879,113	82	1,177,823	52	174,051	8	1,940,770	85	1,414,983	61.9112817	1,896,838	83

Source: DOH 2014

Annex 6.B
Number of PhilHealth-accredited Health Facilities Providing RPRH Services, 2014

Region	PhilHealth-accredited Facilities					
	RHU/Health Center	Lying-in (Public)	Lying-in (Private)	Ambulatory Surgical Clinic	Hospitals (Public)	Hospitals (Private)
CAR	103	91	10	1	13	12
1. Ilocos Region	64	48	28	4	23	43
2. Cagayan Valley	106	82	26	4	21	31
3. Central Luzon	123	92	184	13	51	117
NCR	368	27	186	46	30	71
4A. CALABARZON	117	69	189	5	28	93
4B. MIMAROPA	131	68	30	1	26	52
5. Bicol Region	146	83	75	3	20	30
6. Western Visayas	181	101	44	4	34	27
7. Central Visayas	118	73	80	3	21	35
8. Eastern Visayas	173	207	74	2	22	20
9. Zamboanga Peninsula	94	91	10	2	10	25
10. Northern Mindanao	110	96	50	2	22	42
11. Davao Region	62	38	124	3	10	46
12. SOCCSKSARGEN	60	35	56	3	10	39
ARMM	103	76	27	0	9	8
CARAGA	29	60	18	2	10	8
TOTAL	2,194	1,355	1,346	127	380	762

Source: PhilHealth 2014