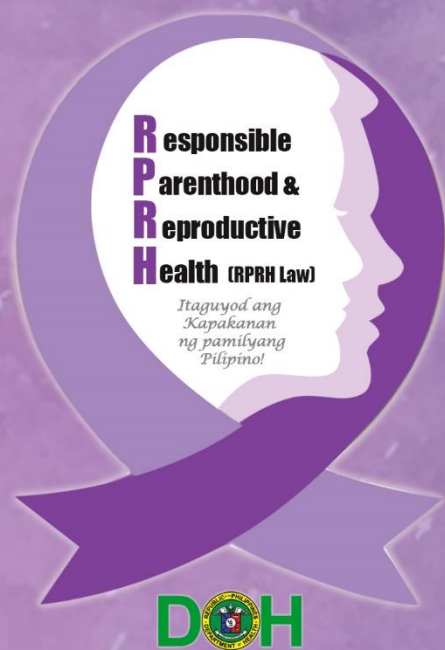


# 3<sup>rd</sup> Annual Report on the Implementation of the Responsible Parenthood and Reproductive Health Act of 2012

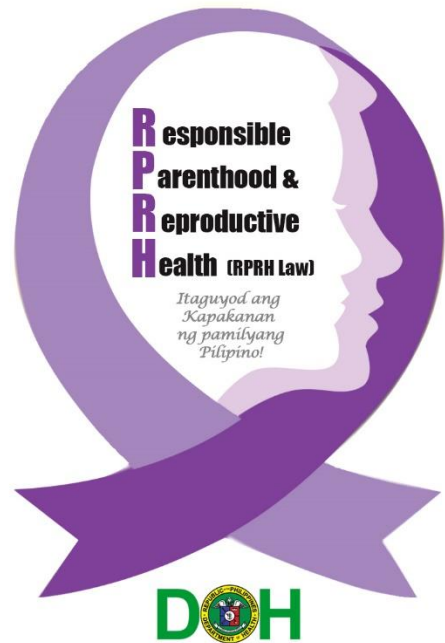


Prepared by the  
Department of Health and the Commission on Population

April 2017  
Manila, Philippines



# **3<sup>rd</sup> Annual Report on the Implementation of the Responsible Parenthood and Reproductive Health Act of 2012**



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Department of Health and the Commission on Population

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# ABOUT THIS REPORT

The 3<sup>rd</sup> Report on the Implementation of the RPRH Act of 2012 is submitted to Congress in compliance with the reporting requirements mandated by Section 21 of R.A. 10354 and Rule 15 of its Implementing Rules and Regulations. It contains the status and trends in RPRH outcome and health service utilization indicators, the policies and interventions developed and implemented, as well as the challenges and recommendations for the five key result areas (KRA) of the RPRH Law. It was submitted to the National Implementation Team, which is mandated to oversee implementation of the RPRH Law, and to the Secretary of Health, for approval prior to submission to Congress.

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The team expresses gratitude to the officials and staff of the following institutions and civil society organizations that have contributed to the report: Department of Education, Department of Justice, Likhaan Center for Women's Health, Philippine Commission on Women, UNFPA and USAID Implementing Partners.

List of CSOs:

1. Brokenshire Women's Center (BWC)
2. Center for Health Solutions and Innovations (CHSI)
3. Family Planning Organization of the Philippines (FPOP)
4. Forum for Family Planning and Development (FORUM)
5. FriendlyCare Foundation
6. Gender Watch Against Violence and Exploitation (GWAVE)
7. Health Action Information Network (HAIn)
8. Integrated Midwives Association of the Philippines (IMAP)
9. Kalusugan ng Mag-ina
10. Likhaan Center for Women's Health (Likhaan)
11. Philippine Center for Population and Development (PCPD)
12. Philippine Society for Responsible Parenthood (PSRP)
13. Pinagsamang Lakas ng Kababaihan, Kabataan at ibang Kasarian (PILAKKK)
14. Pambansang Koalisyon ng Kababaihan sa Kanayunan (PKKK)
15. Population Services Pilipinas, Inc. (PSPI)
16. Roots of Health (ROH)
17. The Project Red Ribbon Care Management Foundation (TRR)
18. WomanHealth Philippines
19. Zuellig Family Foundation (ZFF)

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# MESSAGE

The Department of Health (DOH) is pleased to present the 2016 Responsible Parenthood and Reproductive Health Law (R.A. 10354) Annual Report.

As the RPRH Law reached its fourth year of implementation, there have been challenges both in the national and local levels, but there were also gains that strengthened the engagement of all stakeholders to realize the aspirations elucidated in the law.

In compliance with the reporting requirements mandated by Section 21 of R.A. 10354 and Rule 15 of its Implementing Rules and Regulations (IRR), the Report details the achievements and setbacks in the implementation of the RPRH Law by the DOH and its partner agencies from the national, regional, local, and development partners.



The Report specifies the elements or key result areas (KRA) along RPRH programs on maternal, neonatal, child health and nutrition; family planning; adolescent sexual reproductive health; sexually-transmitted infections and HIV and AIDS; gender-based violence; and related concerns in reproductive health and rights.

For 2016, the National Implementation Team (NIT) that oversees the implementation of the RPRH Law and its counterparts at the regional and local levels expanded and strengthened its work significantly in safeguarding the gains that have been made in the coordination, planning, monitoring and evaluation systems and procedures in the national and regional implementation levels.

As we continue to gain ground in the midst of setbacks and challenges, let us always focus on the work ahead and be continually reminded that the RPRH Law was enacted four years ago to symbolize the quest of the Filipino people to live in an environment that provides all women, men and the youth universal access to comprehensive and rights-based reproductive health care.

This Report attests to the success of the Filipino spirit in achieving what is rightfully theirs and to their steadfast determination to advance their goals in development.

**Paulyn Jean B. Rosell-Ubial, MD, MPH, CESO II**  
**Secretary, Department of Health**

# OVERVIEW

The 3<sup>rd</sup> Report on the Implementation of the Responsible Parenthood and Reproductive Health Care (RPRH) Act of 2012 comes at a pivotal point as it coincides with the beginning of a new Administration. It also covers a critical juncture in the implementation of the law as the year 2016 also marked the conclusion of the National Objectives for Health (NOH) and the Philippine Development Plan 2011-2016, as well as the beginning of the Sustainable Development Goals (SDGs), the successor of the Millennium Development Goals (MDGs). These contain the country's development priorities and health targets including those on maternal and child health, nutrition, family planning, gender equality and human rights and collaboration – all of which are critical to the RPRH Law.

The first two years of implementing the RPRH Law focused on putting in place the needed policies and systems while the third year initiated attempts at scaling up the scope and reach of RPRH service delivery based on established platforms. Hence, it is in this year when operational issues and challenges from field implementation became more apparent.

The progress of RPRH implementation in terms of its five Key Result Areas (KRAs) is summed up as follows:

- 1. Maternal, newborn, child health and nutrition (MNCHN).** From 221 per 100,000 livebirths reported in the 2011 Family Health Survey, maternal mortality ratio (MMR) dropped to 204 per 100,000 live births in 2015 based on official National Nutrition Survey (NNS) estimate. The decline is more pronounced if the most recent NNS MMR of 149 per 100,000 live births is used<sup>1</sup>. However, the observed decline is not conclusive given the overlapping confidence intervals and large margins of error in the surveys. This means that greater effort is needed to reach the country's SDG target MMR of 70 per 100,000 live births by 2030. The country was also able to reduce under five and infant mortality. However, the persistently high neonatal mortality is slowing down its rate of decline. On nutrition, the prevalence of underweight and stunting went up in 2016.

Major initiatives pursued towards improvement of this KRA include DOH Administrative Order (AO) 2016-0035 "Guidelines on the Provision of Quality Antenatal Care in All Birthing Centers and Health Facilities Providing Maternity Care Services", the First 1,000 Days of life program to build a person's foundation for

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<sup>1</sup> In the absence of official documents adopting the 2015 NNS MMR of 149/100,000 live births, this report still makes reference to the official 2015 NNS estimate of 204/100,000 live births



growth and development, DOH Memorandum No. 2016-0163 “Scale-up Plan for the Implementation of the Philippine Integrated Management of Acute Malnutrition,” and AO 2016-0005 “National Policy on the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) in Emergencies and Disasters.”

High MMR persists to be the main challenge in improving MNCHN outcomes. Improvements in service utilization such as antenatal care, postpartum visit, facility-based delivery and skilled birth attendance did not reach the level necessary to make a substantial impact on health outcome indicators. These may be explained by factors such as limitations in personnel that prevent health centers from routinely monitoring MNCHN needs of households and scaling up service provision. Meanwhile, referral facility capacities suffer from the unavailability of health emergency transport, blood supply and drugs. Many local health facilities are unable to use their PhilHealth reimbursements for operations as the funds go to the local treasury. It is recommended that PhilHealth routinely monitor and enforce compliance of accredited health facilities to accreditation requirements to ensure continued provision of quality MNCHN care. In addition, PhilHealth should enforce reimbursement-sharing to ensure that a significant proportion of facility income from PhilHealth is used to improve facility operations.

- 2. Family planning.** Modern contraceptive prevalence rate slightly increased from 43.79 percent in 2015 to 45.05 percent in 2016 based on DOH administrative data. However, this is still below the 65 percent NOH target for 2016. Only 26 percent of the estimated 6 million women who wanted to space/limit pregnancies for the year were able to use FP methods. Existing platforms and capacities for identifying, locating, referring and serving women with unmet FP need are inadequate to fully cover the estimated eligible population. In addition, not all health facilities have a designated FP/RPRH Officer and if ever some have one, said staff is often burdened with competing tasks that have prevented full-time FP provision. These problems are compounded by the Supreme Court’s Temporary Restraining Order (TRO) on the procurement, sale, distribution/ administration and even promotion of hormonal contraceptive Implanon and Implanon NXT. The Supreme Court has also prevented the Food and Drug Administration (FDA) from certifying and recertifying contraceptive products and as a result, no certificate of product registration of certain types of contraceptives was renewed/approved in 2016. If the TRO remains, contraceptives will no longer be available in the market for both public and private use by 2020.

To address these issues, this report recommends concerted efforts to convince the Supreme Court to lift its restraining order on the use of the subdermal implants Implanon and Implanon NXT, and the registration and renewal of registration of contraceptives. Strong multisectoral support (to include the executive and legislative branches of government) is much needed to lobby for the lifting/resolution of the TRO. In addition, the promotion of FP services at the national and local levels by

various sectors (government, private sector and civil society) needs to be scaled up. Expansion of FP service delivery is also suggested through the engagement of (a) trained FP/RPRH providers in priority government health facilities (those with huge concentration of poor women with unmet FP need) and (b) private practitioners who can provide the service even beyond the reach and operating hours of government facilities.

- 3. Adolescent sexual and reproductive health.** The Philippines ranks third highest in Southeast Asia in terms of adolescent fertility rate with 57 births per 1,000 girls aged 15-19 years. The 2014 Civil Registration and Vital Statistics reported that 12 percent (210,000) of all deliveries recorded in the country belong to girls aged 10-19 years old. This contributes to poor health outcomes for both the adolescent mother and her child. Legislative measures were introduced in 2016 to help address this problem, including House Bill 4231 “An Act incorporating lessons on teenage pregnancy prevention and population education in the curriculum of basic education in the Philippines,” and Senate Resolution No. 169 “A resolution directing the Committee on Education, Arts and Culture to conduct an inquiry, in aid of legislation, on the status of the implementation of Reproductive Health education in schools.” “Sangguniang Kabataan (SK) Reform Act of 2015” and its IRR also provided for the creation of a Committee for ASRH and the allocation of funds for programs, projects and activities including those on ASRH. In addition, ASRH services were integrated in the MISP for SRH in Emergencies. DSWD also introduced Youth Development Sessions to orient adolescents on ASRH. On financial protection, PhilHealth issued Circular 2016-0019 providing PhilHealth benefits (including RPRH-related packages) to marginalized youth populations. Most ASRH initiatives focused on trainings for service providers and peers, and on IEC campaigns.

Attaining desired ASRH outcomes, however, is prevented by the limited number of facilities offering standard ASRH services, the low awareness of youth on available ASRH providers, and the legal constraints to adolescents’ access to SRH services. Meanwhile, provision of standard SRH information in schools has not yet been in place since teachers are not yet trained on the updated modules on Comprehensive Sexuality Education (CSE). It is recommended that PhilHealth review its policy confining reimbursements of adolescent deliveries to hospitals. To cover more adolescents, MCP-accredited facilities should also be allowed to have maternal services to adolescents reimbursed by PhilHealth. The standards or minimum requirements for ‘adolescent-friendly’ facilities should also be set to guide providers accordingly, followed by a review of the effectiveness of various trainings on ASRH, for instance, Adolescent Job Aid (AJA), Adolescent Health and Practical Training (ADEPT) on the quality of ASRH service provision. Training of teachers on the updated CSE training modules should also be fast tracked and CSE must be linked with useful information such as the directory of ASRH providers in area, the services they provide,

their clinic hours and other relevant details. A study on the knowledge, attitude, behavior and interest of adolescents may also have to be conducted to guide the design of a strategic ASRH program that will provide alternative mechanisms for identifying and reaching adolescents via their preferred mode and channels, not necessarily through conventional service delivery points such as health centers. Moreover, there is a need for legislation that will empower minors and permit them to get tested and treated for HIV/AIDS without having to obtain parental consent.

4. **HIV/AIDS.** A total of 9,264 newly diagnosed HIV cases were reported from January to December 2016. There is an increasing prevalence of HIV among key affected populations (i.e. males/transgendered males who have sex with males (M/TSMs), female sex workers (FSW) and people who inject drugs (PWID), especially among the younger age groups. One of the policies issued in 2016 is Department Circular 2016-0171 “Enhancing Linkage to Care of People Living with HIV,” which aims to immediately link clients with reactive HIV screening test for early treatment and management. Another is Administrative Order 2016-0035 “Guidelines on the Provision of Quality Antenatal Care in All Birthing Centers and Health Facilities Providing Maternity Care Services”, which includes an opt-out system, or health worker-initiated HIV counseling and testing for pregnant women. Strategies used to curb the rise in HIV cases include the pilot implementation of community-based screening, rollout of the Rapid HIV Diagnostic Algorithm (rHIVda) to earlier link clients to treatment, and establishment of additional treatment hubs for anti-retroviral therapy (ART).

Further work needs to be done to intensify awareness campaigns among the general population. Specifically, there is a need to expand youth access to STI/HIV information, age-appropriate reproductive health education, condoms and services. Legal barriers hampering access of minors to testing services and condoms in public health facilities, owing to the need for parental consent, need to be addressed.

5. **Elimination of violence against women and children (VAWC).** The Global Gender Gap Report 2016 ranked the Philippines 7<sup>th</sup> of 144 countries, narrowing the gap between men and women in terms of health, education, economic and political indicators. This high rank, however, masks the high number of cases of violence against women and children. In 2016, RA 10821 or the Children’s Relief and Protection Act was enacted to protect children and pregnant women as well as lactating mothers from abuse before, during and after disasters and emergency situations. The Commission on Human Rights, as Gender and Development Ombud, also developed the Gender Ombud Guidelines that define the scope of cases covered, the investigation protocols, and the system for referral and monitoring.

It is recommended that the following legislative agenda be pursued for the 17<sup>th</sup> Congress: (a) Amendment of the Anti-Rape Law, (b) Expansion of the Anti-Sexual Harassment Law, (c) Amendment of the Family Code Regarding Grounds for Legal Separation, (d) Amendment of the Revised Penal Code by enacting the Anti-Prostitution Law, and (e) Divorce Law.

The national government budget for RPRH implementation increased by 66 percent from PhP 20.5 billion in 2015 to PhP 34.02 billion in 2016, excluding reimbursements from PhilHealth. While this already appears to be a significant amount, it may need to be further increased in the succeeding years to fully cover the cost of scaled up RPRH implementation. Based on the National FP Costed Implementation Plan (CIP) 2017-2020, the estimated cost of full FP implementation for 2017 alone would already be PhP8.09 billion. Given the PhP0.23 billion proposed FP budget of the DOH for the year, PhP7.87 billion would still be needed to scale up FP.

The following challenges appear to cut across the different KRAs: (a) limited government capacity to manage programs at scale as shown by its inability to fully absorb budgets and accelerate service provision at required level; (b) weak research and development that leads to poor design of and implementation of programs, as shown by gaps in the understanding of specific drivers of diseases like HIV; (c) uneven LGU support that leads to variation in local performance on ASRH, MNCHN, FP and other RH services; (d) weak monitoring and evaluation system which impedes the regular collection and use of a standard set of reliable data needed to accurately monitor and evaluate performance across different KRAs, and (d) legal barriers such as the SC TRO that threatens the future supply of contraceptives, and prevents effective delivery of FP programs.

On the whole, efforts to improve the KRAs have led to mixed results. The utilization of MNCHN and FP services such as antenatal care, facility-based delivery, skilled birth attendance, postpartum care and FP showed improvements. However, these along with the development of policies, infusion of budget and implementation of various interventions by the different sectors have not yet translated to impacts significant enough to attain our targets on health outcomes, as specified in the SDG, NOH and PDP.

A possible explanation is that health strategies, programs and projects have relatively long gestation period, hence, it takes time before these are implemented at scale and their effects on RPRH outcomes are realized. It is also likely that poor health outcomes are indicative of bigger underlying problems like poverty and the fragmentation of service delivery and financing owing to devolution. In this case, a more comprehensive multisectoral approach may be necessary to see significant improvements in RPRH outcomes. Meanwhile, the high rates of maternal and neonatal mortality, adolescent pregnancy, increasing HIV prevalence and growing number of VAWC cases, among others,

underscore the need to revisit the direction and strategies being used in the last three KRAs.

Recently, the President issued Executive Order (EO) No. 12 mandating the attainment of couples' desired family size through the strengthening of the FP program and the empowerment of families against poverty. The DOH and POPCOM may use this as opportunity to exact stronger multisectoral commitments to aggressively scale up MNCHN, FP, ASRH, HIV and VAWC service delivery, with corresponding multi-year budgets to ensure uninterrupted service delivery in the short to medium term.

While collaboration mechanisms among various government agencies, private sector, CSOs and development partners have been forged, agency or institutional accountabilities have to be regularly monitored by an oversight agency to enforce and speed up compliance to their respective mandates in the RPRH Law.

## Acronyms

<b>2PNC</b>	<b>Two Post-Natal Consultations</b>
<b>4ANC</b>	Four Antenatal Care Visits
<b>4Rs</b>	Recognition, Recording, Reporting, Referral
<b>4Ps</b>	Pantawid Pamilyang Pilipino Program
<b>AECID</b>	Agencia Espanola de Cooperacion Internacional Para el Desarrollo
<b>AHD</b>	Adolescent Health and Development
<b>AIARHC</b>	Albay Inter-Agency Reproductive Health Committee
<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>AJA</b>	Adolescent Job Aid
<b>ALL</b>	Acute Lymphocytic Leukemia
<b>ANC</b>	Antenatal Care Visits
<b>AO</b>	Administrative Order
<b>ARH</b>	Adolescent Reproductive Health
<b>ARMM</b>	Autonomous Region of Muslim Mindanao
<b>ART</b>	Antiretroviral Therapy
<b>ARV</b>	Anti-Retroviral
<b>ASC</b>	Ambulatory Surgical Clinic
<b>ASRH</b>	Adolescent Sexual and Reproductive Health
<b>AYRH</b>	Adolescent and Youth Reproductive Health
<b>BEmONC</b>	Basic Emergency Obstetric and Newborn Care
<b>BHS</b>	Barangay Health Station
<b>BHW</b>	Barangay Health Worker
<b>BIHC</b>	Bureau of International Health Cooperation
<b>BNS</b>	Barangay Nutrition Scholar
<b>BTL</b>	Bilateral Tubal Ligation
<b>BWC</b>	Brokenshire Woman Center
<b>C4C</b>	Communication for Communicators
<b>C4RH</b>	Filipino Catholic Voices for Reproductive Health
<b>CBT</b>	Competency-Based Training
<b>CCT</b>	Conditional Cash Transfer
<b>CD4</b>	Cluster of Differentiations
<b>CEmONC</b>	Comprehensive Emergency Obstetric and Newborn Care
<b>CHO</b>	City Health Office
<b>CHR</b>	Commission on Human Rights
<b>CHSI</b>	Center for Health Solutions and Innovations
<b>CHT</b>	Community Health Team
<b>CICP</b>	Center for Innovation, Change and Productivity
<b>CONAP</b>	Continuing Appropriations
<b>CPR</b>	Contraceptive Prevalence Rate
<b>CPU</b>	Central Processing Unit
<b>CRVS</b>	Civil Registry and Vital Statistics
<b>CS</b>	Caesarean Section
<b>CSC</b>	Civil Service Commission
<b>CSE</b>	Comprehensive Sexual Education
<b>CSO</b>	Civil Society Organization
<b>CWC</b>	Council for the Welfare of Children
<b>DC</b>	Department Circular

<b>DepEd</b>	Department of Education
<b>DILG</b>	Department of Interior and Local Government
<b>JRMMC</b>	Jose Reyes Memorial Medical Center
<b>DM</b>	Department Memorandum
<b>DMPA</b>	Depot Medroxyprogesterone Acetate
<b>DOH</b>	Department of Health
<b>DOH EB</b>	Department of Health Epidemiology Bureau
<b>DOH-RO</b>	Department of Health – Regional Office
<b>DOJ</b>	Department of Justice
<b>DOLE</b>	Department of Labor and Employment
<b>DPCB</b>	Disease Prevention and Control Bureau
<b>DPO</b>	Department Personnel Order
<b>DSWD</b>	Department of Social Welfare and Development
<b>DQC</b>	Data Quality Check
<b>EINC</b>	Essential Intrapartum and Newborn Care
<b>EO</b>	Executive Order
<b>EPI</b>	Expanded Program on Immunization
<b>EPP</b>	Estimation and Projection Package
<b>ERPAT</b>	Empowerment and Reaffirmation of Paternal Abilities
<b>EU</b>	European Union
<b>FBD</b>	Facility-based Delivery
<b>FCSAI</b>	Fundacion Espanol para la Cooperacion
<b>FHB</b>	Family Health Bureau
<b>FDA</b>	Food and Drug Administration
<b>FDS</b>	Family Development Sessions
<b>FFSW</b>	Freelance Female Sex Worker
<b>FSW</b>	Female Sex Worker
<b>FGD</b>	Focus Group Discussion
<b>FHRP</b>	Family Health and Responsible Parenting
<b>FHS</b>	Family Health Survey
<b>FHSIS</b>	Field Health Surveillance and Information System
<b>FIC</b>	Fully Immunized Child
<b>FNRI</b>	Food and Nutrition Research Institute
<b>FP</b>	Family Planning
<b>FPCBT</b>	Family Planning Competency Based Training
<b>FPS</b>	Family Planning Survey
<b>FWS</b>	Female Sex Worker
<b>FY</b>	Fiscal Year
<b>GAA</b>	General Appropriations Act
<b>GAPR</b>	Global AIDS Response Progress Report (GARPR)
<b>GAD</b>	Gender and Development
<b>GBV</b>	Gender-based Violence
<b>GIDA</b>	Geographically Isolated and Disadvantaged Areas
<b>GPH</b>	Government of the Philippines
<b>GPOBA</b>	Global Partnership Output-Based Aid
<b>GRRB-IRH</b>	Gender-Responsive and Rights-Based Integrated Reproductive Health
<b>HARP</b>	HIV/AIDS and ART Registry
<b>HCT</b>	HIV Counselling and Testing
<b>HBV</b>	Hepatitis B Virus

<b>HCV</b>	Hepatitis C Virus
<b>HFEP</b>	Health Facilities Enhancement Program
<b>Hi-5</b>	High Five Strategy
<b>HIV</b>	Human Immunodeficiency Virus
<b>HIV/AIDS</b>	Human Immunodeficiency Virus /Acquired Immunodeficiency Syndrome
<b>HPV</b>	Human Papilloma Virus
<b>HSP</b>	Health Sector Plan
<b>HUP</b>	Health Use Plan
<b>IACAT</b>	Inter-Agency Committee on Anti-trafficking
<b>IACVAWC</b>	Inter-Agency Council on Violence Against Women and their Children
<b>IEC</b>	Information, Education, and Communication
<b>IHBSS</b>	Integrated HIV Behavioral and Serologic Surveillance
<b>IMR</b>	Infant Mortality Rate
<b>ILHZ</b>	Inter-Local Health Zones
<b>IPCC</b>	Interpersonal Counseling and Communication
<b>IPT</b>	Intimate Partner Transmission
<b>IRR</b>	Implementing Rules and Regulations
<b>IRR DC</b>	IRR Drafting Committee
<b>IUD</b>	Intrauterine Device
<b>IYCF</b>	Infant and Young Child feeding
<b>JICA</b>	Japan International Cooperation Agency
<b>JPMNCHN</b>	Joint Programme on Maternal, Neonatal, Child Health and Nutrition
<b>KAP</b>	Key Affected Population
<b>KP</b>	Kalusugan Pangkalahatan
<b>KRA</b>	Key Results Area
<b>KATROPA</b>	Kalalakihang Tumutugon sa Responsibilidad at Obligasyon Para sa Kalusugan ng Ina at Pamilya
<b>LAM</b>	Lactational Amenorrhea Method
<b>LAPM</b>	Long Acting Permanent Method
<b>LARC</b>	Long Acting Reversible Contraception
<b>LCAT-VAWC</b>	Local Committees on Anti-Trafficking and Violence Against Women and Children
<b>LCE</b>	Local Chief Executive
<b>LGBT</b>	Lesbian, Gay, Bisexual, Transgender
<b>LGBTQI</b>	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and Intersex
<b>LGU</b>	Local Government Unit
<b>LPPEAHD</b>	Learning Package on Parent Education on Adolescent Health and Development
<b>M/TSM</b>	Males/Transgenders who have sex with males
<b>M&amp;E</b>	Monitoring and Evaluation
<b>MAH</b>	Market Authorization Holder
<b>MAPEH</b>	Music, Arts, Physical Education and Health
<b>MARP</b>	Most At-Risk Population
<b>MBFHI</b>	Mother-Baby Friendly Hospital Initiative
<b>MCP</b>	Modern Contraceptive Prevalence
<b>mCPR</b>	Modern Contraceptive Prevalence Rate
<b>MCW</b>	Magna Carta for Women
<b>MDs</b>	Medical Doctors
<b>MDG</b>	Millennium Development Goal
<b>MEC</b>	Medical Eligibility Criteria



<b>MFP</b>	Modern Family Planning
<b>MHO</b>	Municipal Health Officer
<b>MMR</b>	Maternal Mortality Ratio
<b>MNCHN</b>	Maternal, Neonatal, Child Health and Nutrition
<b>MNFP</b>	Modern Natural Family Planning
<b>MOOE</b>	Maintenance and Other Operating Expenses
<b>MOU</b>	Memorandum of Understanding
<b>MOVE</b>	Men Opposed to Violence Against Women Everywhere
<b>MR</b>	Measles-Rubella
<b>MR GAD</b>	Men's Responsibilities in Gender and Development
<b>MRL</b>	Muslim Religious Leader
<b>MSM</b>	Men having Sex with Men
<b>MYCNSIA</b>	Maternal and Young Child Nutrition Security Initiative in Asia
<b>NAC</b>	National Advisory Committee
<b>NAPC</b>	National Anti-Poverty Commission
<b>NBI</b>	National Bureau of Investigation
<b>NCMH</b>	National Center for Mental Health
<b>NCR</b>	National Capital Region
<b>NDHS</b>	National Demographic and Health Survey
<b>NDP</b>	Nurse Deployment Program
<b>NEDA</b>	National Economic and Development Authority
<b>NGO</b>	Non-Government Organization
<b>NHIP</b>	National Health Insurance Program
<b>NHTS</b>	National Household Targeting System
<b>NHTS PR</b>	National Household Targeting System –Poverty Reduction
<b>NIT</b>	National Implementation Team
<b>NMR</b>	Neonatal Mortality Rate
<b>NNC</b>	National Nutrition Council
<b>NNS</b>	National Nutrition Survey
<b>NOH</b>	National Objectives for Health
<b>NSD</b>	Normal Spontaneous Delivery
<b>NSV</b>	Non-Scalpel Vasectomy
<b>NTHC</b>	National TeleHealth Center
<b>NVAWDocS</b>	National VAW Documentation System
<b>OAE</b>	Otoacoustic emissions device
<b>OB/GYNE</b>	Obstetrician and Gynecology
<b>ODA</b>	Official Development Assistance
<b>OFW</b>	Overseas Filipino Worker
<b>OHAT</b>	Outpatient HIV/AIDS Treatment
<b>OIS</b>	Opportunistic Infections
<b>ONAR</b>	Office of the National Administrative Register
<b>OPCCB</b>	Organization, Position, Classification and Compensation Bureau
<b>OSG</b>	Office of the Solicitor General
<b>PAFLO</b>	Population Awareness and Family Life Orientation
<b>PCB</b>	Primary Care Benefit package
<b>PNC</b>	Post-Delivery Checkup
<b>PCW</b>	Philippine Commission on Women
<b>PE</b>	Peer Educators
<b>PGH</b>	Philippine General Hospital

<b>PHA</b>	Public Health Assistant
<b>PHIC</b>	Philippine Health Insurance Corporation
<b>PHO</b>	Provincial Health Office
<b>PIA</b>	Philippine Information Agency
<b>PICT</b>	Provider –Initiated HIV Counseling and Innovators
<b>PLHIV</b>	People Living with HIV
<b>PME</b>	Planning, Monitoring and Evaluation
<b>PMTCT</b>	Prevention of Mother to Child Transmission
<b>PNGOC</b>	Philippine NGO Council on Population, Health and Welfare, Inc.
<b>PNSCB</b>	Philippine National Statistics Coordination Board
<b>PNP</b>	Philippine National Police
<b>PNP-WCPC</b>	Philippine National Police-Women and Child Protection Unit
<b>PO</b>	People’s Organization
<b>POC</b>	Point of Care
<b>POPCOM</b>	Commission on Population
<b>PPAs</b>	Programs, Projects and Activities
<b>PPMP</b>	Project Procurement Management Plan
<b>PPIUD</b>	Postpartum Intrauterine Device
<b>PSA</b>	Philippine Statistics Authority
<b>PSPI</b>	Population Services Pilipinas, Inc
<b>PREVENTS</b>	Primary Care Revitalized and Enhanced Through Skills and Services
<b>PTA</b>	Parent-Teacher Association
<b>PWID</b>	People Who Inject Drugs
<b>PYD</b>	Program for Young Adolescents
<b>PYP</b>	Program for Young Parents
<b>Q&amp;A</b>	Question and Answer
<b>RA</b>	Republic Act
<b>RFSW</b>	Registered Female Sex Worker
<b>RIT</b>	Regional Implementation Team
<b>RITM</b>	Research Institute for Tropical Medicine
<b>RH</b>	Reproductive Health
<b>RHMPP</b>	Rural Health Midwives Placement Program
<b>RHO</b>	Reproductive Health Officer
<b>RHU</b>	Rural Health Unit
<b>RNHeals</b>	Registered Nurses for Health Enhancement and Local Service
<b>RP-FP</b>	Responsible Parenting and Family Planning
<b>RPO</b>	Regional Population Office
<b>RPRH</b>	Responsible Parenthood and Reproductive Health
<b>RTI</b>	Reproductive Tract Infection
<b>SACCL</b>	STD/AIDS Central Cooperative Laboratory
<b>SBA</b>	Skilled Birth Attendance
<b>SC</b>	Supreme Court
<b>SHC</b>	Social Hygiene Clinics
<b>SK</b>	Sangguniang Kabataan
<b>SQAO</b>	Status Quo Ante Order
<b>SRH</b>	Sexual and Reproductive Health
<b>SRHR</b>	Sexual and Reproductive Health Rights
<b>SSESS</b>	STI Sentinel Etiologic Surveillance System
<b>STI</b>	Sexually Transmitted Infection

<b>SWRA</b>	Sexually Active Women of Reproductive Age
<b>TB</b>	Tuberculosis
<b>TD</b>	Tetanus-Diphtheria
<b>TFI</b>	Tarbilang Foundation Inc.
<b>THKs</b>	Teen Health Kiosks
<b>TOT</b>	Training of Trainers
<b>U4U</b>	Youth for Youth Activity
<b>UHC</b>	Universal Health Care
<b>UMFP</b>	Unmet Need for Modern Family Planning
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNESCO</b>	United Nations Education, Scientific and Cultural Organization
<b>UNICEF</b>	United Nations International Children's Fund
<b>UNFPA</b>	United Nations Population Fund
<b>UP</b>	University of the Philippines
<b>VAW</b>	Violence Against Women
<b>VAWC</b>	Violence Against Women and Children
<b>VAWCRS</b>	Violence Against Women and Children Registry System
<b>VIA</b>	Visual Inspection with Acetic Acid
<b>WB</b>	World Bank
<b>WCPC</b>	Women and Child Protection Center
<b>WCPMIS</b>	Women and Child Protection Management Information System
<b>WCPU</b>	Women and Child Protection Units
<b>WFS</b>	Women Friendly Space
<b>WHO</b>	World Health Organization
<b>WINS</b>	Water, Sanitation, & Hygiene in Schools
<b>WMCHDDs</b>	Women and Men's Health Division and Children's Health Development Division
<b>WRA</b>	Women of Reproductive Age
<b>YAFSS</b>	Young Adult Fertility and Sexuality Survey
<b>YDS</b>	Youth Development Session
<b>ZFF</b>	Zuellig Family Foundation
<b>ZOTO</b>	Zone One Tondo Organization

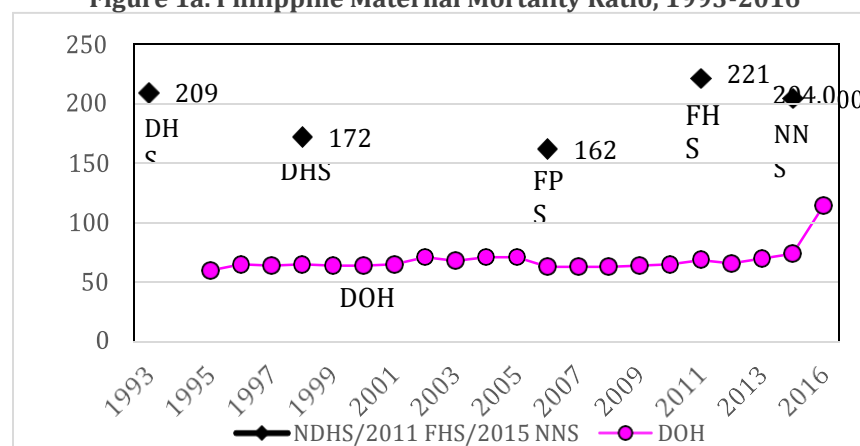
# KEY RESULT AREAS

## KRA 1: Maternal, Newborn, Child Health and Nutrition

### Status and trends

The DOH Field Health Survey Information System (FHSIS) reports showed that maternal mortality ratio (MMR) remained almost flat from 2006 to 2015. While it increased from 74 to 114 per 100,000 live births in 2016, the spike is most likely due to incomplete reports on live births for the year <sup>2</sup>. The MMR reported in national health surveys showed persistently higher figures, dropping from 221 to 204 per 100,000 live births from 2014 to 2015. A large drop in 2015 can be observed if the latest NNS MMR of 149 per 100,000 live births will be considered. However, this is not conclusive given the high margin of error in the estimation (see Fig. 1a).

Figure 1a. Philippine Maternal Mortality Ratio, 1993-2016



Source: Demographic Health Survey 1993 and 1998, Family Planning Survey 2006, Family Health Survey 2011, National Nutrition Survey 2015, DOH FHSIS 1994 to 2015 and DOH Safe Motherhood Program 2016

<sup>2</sup> Maternal Mortality Ratio (MMR) is computed as number of maternal deaths per 100,000 live births. Maternal death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any causes related to or aggravated by the pregnancy or its management but not from accidental or incidental causes (WHO, 2016).

The lower MMR reported in FHSIS mainly captures data from health facilities as submitted by LGUs and DOH Regional Offices. It is not based on population and does not have the large sample size necessary for a more accurate estimation of MMR. Notwithstanding estimation issues, both national health surveys and the FHSIS revealed the same thing: the Philippines is still off-track in terms of reducing MMR to 70 per 100,000 live births as targeted by the DOH in the SDGs. This means that a considerable number of women still die every year from pregnancy-related complications that are highly preventable.

Table 1.a shows that nearly half of the regions already met the target MMR of 70 per 100,000 live births. Regions IVB, V, VIII, XI and ARMM, however, reported high ratios that even exceed 100 maternal deaths per 100,000 live births. Program implementation and data accuracy may be checked especially in areas with outlier results. ARMM MMR, for instance, dramatically surged from 103 to 919 per 100,000 live births in 2016.

**Table 1a. 2015 and 2016 MMR, by region**

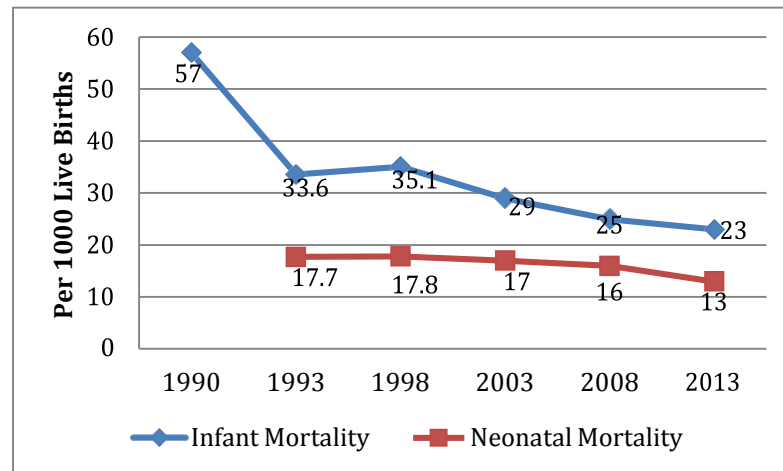
Region	No. of Live Births (LB)		No. of Maternal Deaths		Maternal Mortality Ratio (per 100,000 LB)	
	2015	2016	2015	2016	2015	2016
CAR	35,770	38,860	15	17	42	44
NCR	243,058	231,036	123	106	51	46
I	90,564	84,615	42	52	46	61
II	61,357	59,172	40	22	65	37
III	148,698	135,800	105	99	71	73
IV-A	201,137	157,083	134	110	67	70
IV-B	45,061	48,596	30	53	67	109
V	115,137	103,876	141	148	122	142
VI	121,001	98,964	100	76	83	77
VII	77,246	109,442	45	84	58	77
VIII	89,584	78,151	88	89	98	114
IX	74,229	69,127	48	40	65	58
X	61,826	61,509	46	42	74	68
XI	94,620	88,775	116	102	123	115
XII	88,580	76,978	59	32	67	42
XIII	57,508	46,229	48	39	83	84
ARMM	73,116	73,528	75	676	103	919
<b>PHL</b>	<b>1,678,492</b>	<b>1,561,741</b>	<b>1,255</b>	<b>1,787</b>	<b>75</b>	<b>114</b>

Source: DOH Safe Motherhood Program Report, 2015 and 2016

The leading causes of maternal mortality remain to be hemorrhage and hypertension, which account for about 70 percent of maternal deaths. These are highly preventable and can be abated by the provision of quality obstetric care and access to Comprehensive Emergency Obstetric and Newborn Care (CEmONC)-capable facilities.

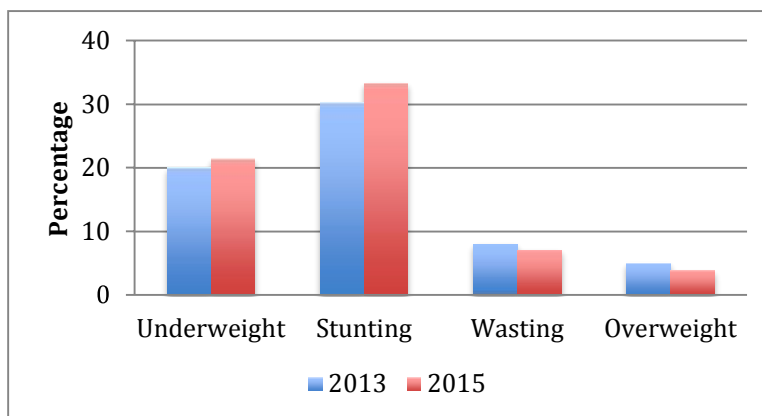
Philippine Statistics Authority (PSA) and the National Demographic and Health Survey (NDHS) data showed that infant mortality rate declined slowly from 25 to 23 per 1,000 live births from 2008 to 2013 – still falling short of the Millennium Development Goal (MDG) 2015 target of 19 per 1,000 live births. This can be attributed to the persistently high neonatal mortality that has remained relatively constant at 17 per 1,000 live births from 1993 to 2008 before declining to a rate of 13 per 100,000 live births in 2013.

**Figure 1b. Neonatal and Infant Mortality Rates, 1990-2013**



Sources: 1990 TWG on Maternal and Child Mortality, PSA-NSCB and NDHS 1993, 1998, 2003, 2008 and 2013

**Figure 1c. Prevalence of malnourished children 0-59 months**



Source: 2013 and 2015 NNS

In terms of nutrition, the prevalence of underweight and stunted children slightly increased from 20 to 22 and 30 to 33 percent, respectively, from 2013 to 2015, as shown in Figure 1c. Meanwhile, marginal decrease was reported in the prevalence of wasting and overweight among under-five children.

## Interventions

Service provision for maternal health is anchored on DOH AO 2008-0029 “Implementing Health Reforms for Rapid Reduction of Maternal and Neonatal Mortality.” This policy provides the strategy for rapidly reducing maternal and neonatal deaths through the provision of packages for maternal, newborn, child health, and nutrition (MNCHN) services. The MNCHN core package of services consists of interventions at each life stage: pre-pregnancy, pregnancy, delivery, post-partum, newborn and child care.

### Antenatal care

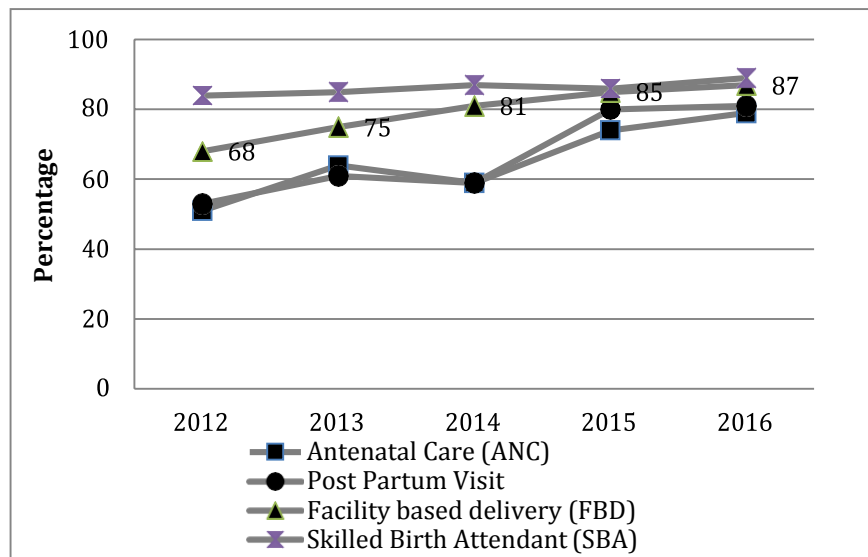
Antenatal care includes: (a) appropriately timed four prenatal visits throughout the course of pregnancy to detect and manage pregnancy-related complications, and identify those at increased risk of developing complications, (b) provision of macro and micronutrient supplementation (calcium, iron, folate, and iodine), (c) tetanus toxoid immunization, (d) counseling on healthy lifestyle, (e) breastfeeding promotion and counseling, (f) prevention and management of infection, and (g) oral health services, among others. To ensure access of pregnant women to standard ANC, the DOH issued AO 2016-0035 “Guidelines on the Provision of Quality Antenatal Care in All Birthing Centers and Health Facilities Providing Maternity Care Services.”

Demand generation activities were conducted in 2016 to encourage women to deliver in a licensed health facility. With the support of civil society organizations (CSOs), LGUs conducted “*Buntis Congress*” where pregnant women and/or couples were educated on responsible parenting, reproductive health, proper nutrition, what to expect during labor and delivery, breastfeeding and newborn screening. LGUs and CSOs also accelerated use of ANC through the provision of free routine laboratory procedures and ultrasound during advocacy campaigns like “*Buntis Congress*”, “*Usapang Buntis*” and community education, among others. These interventions also served as venue for disseminating information on PhilHealth enrolment and benefits.

In the barangays, community-level providers (e.g. barangay/volunteer health workers, traditional birth attendants, midwives and barangay council) provided both health navigation and basic service delivery functions. Navigation functions include tracking pregnant women, assisting them in developing birth plans, and facilitating their access to critical health services. It was only in 2016 that the DOH Safe Motherhood Program officially started collecting reports on the number of pregnant women, and those that developed birth plans. Based on these data, 81 percent of the 1,658,491 reported deliveries in 2016 were tracked, and 74 percent were reported to have birth plans.

DOH administrative data showed that the number of pregnant women provided with at least four pre-natal check-ups (ante-natal consultations or ANC) went up from 74 percent in 2015 to 79 percent in 2016 (see Fig. 1d), equivalent to approximately 1.3 million women. ANC rate is relatively lower compared to facility-based delivery (FBD) as it does not consider pregnant women who commenced ANC beyond the 1<sup>st</sup> trimester of pregnancy. Field reports revealed that women seek ANC only when quickening<sup>3</sup> is felt, which is usually at 20 weeks age of gestation or at the second trimester of pregnancy.

**Figure 1d. Maternal care service utilization indicators, 2012-2016.**



Source: DOH partial administrative data 2016 and FHSIS Reports 2012-2015

### Labor, Delivery and Post-partum Services

Service delivery networks (SDNs) were formed to facilitate access of pregnant women to appropriate health facilities. They consist of community volunteers, public and private birthing centers capable of providing Basic Emergency Obstetric and Newborn Care (BEmONC), and a referral hospital that can provide CEmONC. Box 1a shows how Tacloban City used its SDN not only to improve FBD and FP in the area but to increase revenues for sustaining hospital and RHU operations as well.

<sup>3</sup> Quickening is the perception of fetal movement beginning at 16 to 20 weeks (Cunningham, G. et al., Williams Obstetrics, 22<sup>nd</sup> edition, 2005.)



### Box 1a. Service delivery network amps up use of MNCHN services in Tacloban City

Typhoon Yolanda devastated the city of Tacloban in 2013 resulting in death and property casualties. The provision of health services was disrupted due to the destruction of health facilities in the area. In an effort to restore usual health operations, the DOH Regional Office 8 and PhilHealth Regional Office (PRO) 8 requested USAID to assist Tacloban City to re-establish the Service Delivery Network in Tacloban City Hospital (TCH) based on DM 2014-0313 entitled *Establishing Service Delivery Network*.

Four steps were followed in restoring SDN in Tacloban. First, NHTS and CCT beneficiaries were identified as the priority population. The presence of community health teams (CHT) were confirmed in the communities, since they are crucial in updating risk assessments and profiling of individuals in their respective communities. It is estimated that approximately 500 CHTs were needed to cover 10,000 NHTS households in Tacloban. Second, a map of health care providers that would serve the health needs of the population was identified. These health providers were assigned to serve specific populations. Third, a priority population was designated to specific health facilities. CCTs were informed through DSWD FDS activity, while NHTS households were informed by house-to-house visits of CHTs. Finally, CHTs and PLs monitor beneficiaries in terms of health service utilization through their individual Health Use Plans (HUP).

An SDN Network Business Plan was created to guide Tacloban City Hospital (TCH) and District Health Centers in improving service delivery and ensuring sustainability through financing. A SWOT analysis was initially done to evaluate the capacity of the said hospitals. This resulted in the development of an incentive scheme directed at providers to improve overall staff performance. To ensure non-stock out of commodities, outsourcing of supplies from the Philippine Society for Responsible Parenthood was done. In addition, costing exercises were provided to generate appropriate cost of TCH services, and determine the corresponding fee for each service.

A PhilHealth sharing scheme was mandated through EO NO. 16-12-015, *An order approving the PhilHealth reimbursements profit sharing scheme among personnel assigned at the public health facilities within the Tacloban City Service Delivery Network*. Service charges and PhilHealth reimbursements were directed towards a Trust Fund managed by the City Administration Office. This shall be used by the city for drug and supplies procurement, and structural improvement for health centers.

Using this scheme, more than 8,000 poor households were profiled using the prescribed HUP in a span of eight months; 60 per cent of WRAs identified during the profiling were categorized as new acceptors of modern family planning. In addition, 97 per cent pregnant women under the SDN availed themselves of the services of health facilities in giving birth. Furthermore, there was a noted significant increase in income of TCH in 2015, with an estimated Php19M PhilHealth benefit payments received from January to August 2016.

Currently, there are 3,102 BEmONC-capable health facilities nationwide - 1,759 of which are government-owned. BEmONC training is offered in 31 training centers, mostly DOH-run hospitals. Three of such hospitals offer the course in partnership with academic institutions such as Bicol University, Naga College Foundation Inc. and Misamis University. To date, there are 2 BEmONC training programs offered to health workers:

the 11-day training course for doctors and nurses, and the 7-day training for midwives. Ninety-five percent of birthing centers are now staffed by trained teams, with 52 percent evaluated to have competencies to perform BEmONC signal functions.

The DOH also issued AO 2016-0005 “National Policy on the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Health Emergencies and Disasters” to ensure provision of EmONC services including prenatal and post-partum care during disasters and emergencies. This policy also supports the strict establishment of a 24/7 referral system and clean delivery kits for pregnant women.

To augment existing LGU manpower complement for MNCHN services, the DOH deployed 4,201 midwives in 2016 under the Rural Health Midwives Placement Program (RHMP). This number is 30 percent higher than the 2015 level.

Skilled birth attendance (SBA)<sup>4</sup> went up from 82 percent in 2015 to 89 percent in 2016. FBD likewise increased from 80 to 87 percent in the same period (see Fig. 1d), which may be attributed to local health resolutions prohibiting deliveries at home as well as the provision of incentives to traditional birth attendants (TBA) and community health volunteers who bring to birthing clinics and hospitals pregnant women about to deliver. PhilHealth Maternity Care Package (MCP) and Newborn Care Package (NCP) likewise incentivized delivery in health facilities.

The rate of post-natal or post-delivery check-up (PNC)<sup>5</sup>, which should be done at least twice - within 24 hours and within 7 days after delivery, increased from 80 percent in 2015 to 86 percent in 2016 (see Fig. 1d). According to field reports, the low PNC rates may be due to disinclination of mothers, especially multigravida ones, to return to facilities owing to preoccupation with child care. PNC is important because most newborn and maternal deaths occur during or immediately after delivery. It is also a critical stage for promoting family planning and exclusive breastfeeding which is key to child health and survival.

### *Conduct of Maternal Death Surveillance and Response (MDSR) Training*

In 2016, all Safe Motherhood Program regional coordinators and Development Management Officers (DMOs) were trained on Maternal Death Surveillance and Response (MDSR) to complement the technical assistance provided by the national program manager to requesting Provincial Review Teams (PRTs). MDSR includes maternal death identification, reporting, review, and response, which can provide the essential information to stimulate and guide actions to prevent future maternal deaths and improve the measurement of maternal mortality.<sup>6</sup> The Program likewise provided MDSR

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<sup>4</sup> Also termed as Skilled Health Professional (SHP).

<sup>5</sup> Also termed as Post Partum Visit/Consultation.

<sup>6</sup> WHO, 2011.

coaching to PRTs upon request but it is only limited to 4 provinces per year due to limited number of staff.

A sample of maternal death review reports in 2016 revealed that gaps in health systems such as the unavailability of emergency transport, inadequacy of blood and drug supply in referral hospitals as well as delayed referral by lower level facilities significantly negated maternal and neonatal health outcomes. These gaps continue to be widespread despite the high rate of FBD and high PhilHealth accreditation rate for facilities.

On the whole, only Regions I and III attained the 90 percent DOH target for all maternal health service utilization indicators (see Table 1b). Program reports attributed this to strong local government support and proactive regional health staff assisting LGUs in program implementation. FBD rate for ARMM increased from 37 percent in 2015 to 52 in 2016 but it remains to be the region with the lowest FBD rate.

**Table 1b. Service Utilization Indicators per Region, 2016.**

Regions	Total Deliveries	At least 4 Antenatal Care Visits (%)	Facility-based delivery (%)	Skilled Birth Attendance (%)	2 Postnatal Checkup (%)
CAR	39,183	70	93	95	65
NCR	260,901	73	93	92	84
I	84,557	98	99	99	98
II	59,610	83	92	94	98
III	133,755	94	90	93	98
IV-A	214,878	70	88	91	85
IV-B	48,223	73	70	70	89
V	96,714	77	90	90	92
VI	101,328	66	90	91	72
VII	112,858	97	92	92	89
VIII	78,417	74	89	88	86
IX	69,489	80	86	86	93
X	61,826	84	84	89	92
XI	90,243	50	90	90	89
XII	85,713	85	84	86	40
XIII	46,105	62	71	71	70
ARMM	74,061	87	52	67	89
<b>PHL</b>	<b>1,658,491</b>	<b>79</b>	<b>87</b>	<b>89</b>	<b>86</b>

Source: DOH Safe Motherhood Program Data partial report, 2016

## Neonatal Health Services

### *Essential Intrapartum and Newborn Care (EINC) and the Unang Yakap Campaign (First Embrace)*

Neonatal care interventions are part of the MNCHN core package of services as provided for in DOH AO 2008-0029 “Implementing Health Reforms for Rapid Reduction of Maternal and Neonatal Mortality.” Services for newborn care are primarily anchored on the DOH *Unang Yakap (First Embrace)* campaign or the Essential Intrapartum and Newborn Care (EINC). EINC includes evidenced-based practices for safe and quality care of birthing mothers and their newborns, which are the simplest, most cost-effective preventive measure to significantly reduce newborn deaths.<sup>7</sup> The DOH AO 2009-0025 mandated the implementation of the EINC protocol in both public and private hospitals. In lieu of a separate training for frontline health workers on EINC, its curriculum was already incorporated in the BEmONC training. To date, 95 percent of birthing centers nationwide already have trained personnel on the EINC protocol.

CSOs, particularly *Kalusugan ng Mag-ina*, conducted training on Essential Intrapartum and Newborn Care (including Basic Newborn Resuscitation) for personnel of health facilities in geographically isolated and disadvantaged areas (GIDAs) and private health facilities. From 2010 to 2016, it has trained 13,329 health personnel (midwives, nurses, and physicians) nationwide on EINC and Basic Newborn Resuscitation skills. It has also conducted training of trainers, quality assurance training and mentoring workshops for 4,386 personnel.

### *Exclusive Breastfeeding*

Evidence indicates that skin-to-skin contact between mother and infant shortly after birth helps initiate early breastfeeding and increases the likelihood of exclusive breastfeeding for up to four months of life as well as the overall duration of breastfeeding.<sup>8</sup>

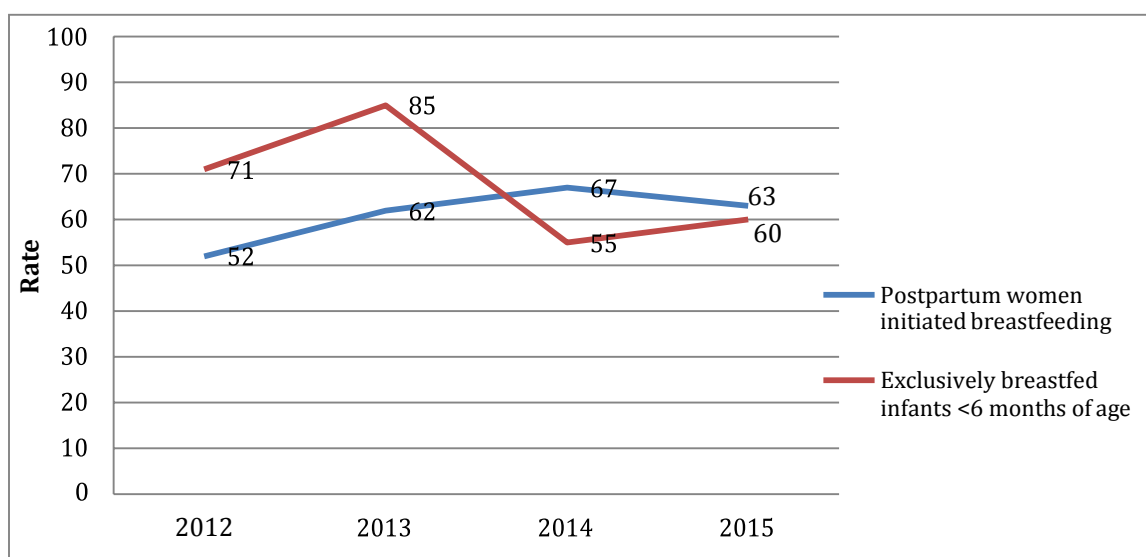
The low percentage of postpartum women who initiated breastfeeding within 90 minutes of delivery dropped even further from 67 percent in 2014 to 63 percent in 2015 (see Fig. 1e). Meanwhile, exclusive breastfeeding of infants less than 6 months dipped significantly from 85 percent in 2013 to 55 percent in 2014, possibly owing to several challenges in the implementation of the Milk Code (EO 51) and weak advocacy on breastfeeding. Slight increase was noted in 2015 as the rate climbed up to 60 percent.

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<sup>7</sup> WHO, 2017.

<sup>8</sup> WHO, 2017.

**Figure 1e. Breastfeeding Indicators, 2012-2015**



Source: DOH FHSIS 2012-2015

A joint report of DOH and WHO<sup>9</sup> in 2013 concluded that weak enforcement of policies has opened the door for milk companies to promote and market their products despite stringent regulations. Further, milk companies have built consensus on their position and offered partnerships and funding, often crossing the line in the legality of their actions. Correspondingly, the Joint Programme on Maternal and Neonatal Health (JPMNH)<sup>10</sup> report in 2015, revealed that during the monitoring of EINC, Infant and Young Child Feeding (IYCF), and Mother Baby-Friendly Hospital Initiative (MBFHI), findings supported that several hospitals in Region 12 and Quezon City<sup>11</sup> that were MBFHI-accredited are not complying with the Milk Code and IYCF policies. For this reason, JPMNH through the WHO conducted capacity building on lactation management to 105 health service providers in various facilities in their program implementation sites.

The Expanded Breastfeeding Promotion Act of 2009 (RA 10028) encouraged the establishment of human milk banks for storage of breast milk donated by mothers. In 2013, the DOH issued the Manual of Operations on the Philippine Human Milk Banking.

<sup>9</sup> Breastfeeding in the Philippines A Critical Review. WHO and DOH, 2013.

<sup>10</sup> The Joint Programme on Maternal and Neonatal Health (JPMNH or JP) of the Department of Health (DOH), the United Nations (i.e., United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), World Health Organization (WHO)) and the Australian government seeks to assist the Philippine Government in rapidly reducing maternal and neonatal deaths. The JPMNH was implemented from 2009-2016.

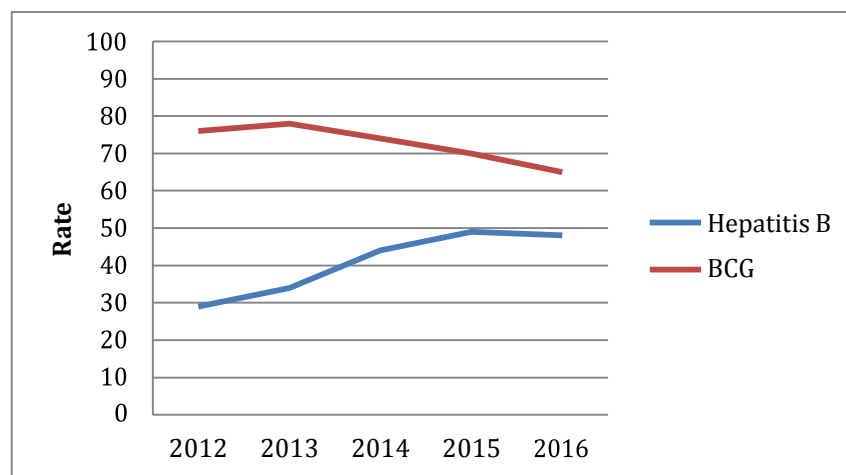
<sup>11</sup> Program implementation sites of the two-year Phase 2 Joint Programme on Maternal and Neonatal Health (JPMNH) in 2015 were: seven (7) municipalities (Aleosan, Arakan, President Roxas, Midsayap, Lebak, Kalamansig, and Malungon) and three (3) provinces (North Cotabato, Sultan Kudarat, and Sarangani) in Region 12 and District 2 of Quezon City in the National Capital Region.

To date, there are 12 public and private hospitals nationwide that have a functional human milk bank facility, to wit: Dr Jose Fabella Memorial Hospital, Philippine Children's Medical Center, Philippine General Hospital, Ospital ng Makati, St Lukes Medical Center, Quezon City General Hospital, The Medical City, Taguig District Hospital, Vicente Sotto Memorial Medical Center, Bicol Medical Center, and Zamboanga City Medical Center. In 2016, the Eastern Visayas Regional Medical Center launched the human milk bank in Tacloban City.

### *Immunization at Birth*

The National Immunization Program (NIP) instructs the provision of first dose of Hepatitis B (Hep B) and BCG to newborns within 24 hours after birth. Most recent DOH data, however, showed low coverage of both antigens. Coverage for BCG is higher compared to Hep B but it has started to decline beginning 2013 (see Fig. 1f).

**Figure 1f. Immunizations Given at Birth, 2012-2016.**



Sources: FHSIS 2012-2015 and EPI Program Report 2016

The DOH has employed various strategies to improve the birth dose of Hep B vaccination coverage, such as the enactment of Mandatory Child Immunization Law; inclusion of FIC as one of the indicators for Conditional Cash Transfer (CCT) program of the DSWD; scaling up of EINC in hospitals and lying-in facilities; inclusion in the PhilHealth Newborn Package; among others. As a result, Hep B coverage rate increased steadily since 2012 but started to plateau in 2015. The Hep B coverage at birth is relatively low compared to that of BCG. This was due to poor recording and reporting of Hep B vaccination especially in health facilities not trained on EINC. Further, practically 20 percent of all home births assisted by SBA do not follow Hep B administration policy.

Child protected at birth (CPAB) covers infants born to mothers who received two doses of tetanus toxoid one month before delivery. Current CPAB rate is at 85 percent. Maternal and neonatal tetanus are among the most common life-threatening consequences of unclean deliveries and umbilical cord care practices, and are indicators of inequity and access to immunization and other maternal, newborn, and child health services.<sup>12</sup> WHO and UNICEF already reported elimination of neonatal tetanus in the Philippines in 2015 except for ARMM.

## Infant health

### *National Immunization Program*

The National Immunization Program is committed to free immunization services and ensures that Filipinos, especially the poor, have access to recommended essential vaccines. The administrative coverage of fully-immunized children (FIC) has steadily decreased from 77 percent in 2013 to 64 percent (1.76 million infants) in 2016. Meanwhile, administrative coverage of most antigens improved in 2016, with Pentavalent vaccine reporting the highest coverage at 81 percent.

It can be recounted that in the 2015 RPRH Annual Report, the WHO and UNICEF officially documented that the Philippines has already eliminated maternal and neonatal tetanus in 16 out of the 17 regions, ARMM being the exception. In 2016, efforts to totally eliminate neonatal tetanus in ARMM and Region 9 were conducted through supplemental tetanus vaccine immunization targeting 80 percent of women of reproductive age. DOH reported a coverage of 86 percent in the first round – higher than the minimum 80 percent required by WHO.

Other operational challenges to the immunization program include the: (a) limited time devoted by midwives to finding and immunizing the target population group owing to preference for deliveries as well as competing demands from other public health programs, and the (b) high DOH estimate of target clients. Stock out of Pentavalent vaccine due to global procurement issues has likewise limited immunization coverage from 2015 until the 1<sup>st</sup> semester of 2016.

### *Integrated Management of Childhood Illness (IMCI)*

Integrated Management of Childhood Illness (IMCI) includes elements of prevention and treatment of the most common conditions affecting young children such as pneumonia,

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<sup>12</sup> WHO, 2017.

diarrhea and ear infection. In line with this, the DOH procured Zinc and Oral Rehydration Salt (see Table 1c) to protect children from complications of diarrhea.

**Table 1c. Commodities Procured for the Sick Child, DOH 2016.**

<b>Commodity for the Sick Child</b>	<b>No. of target beneficiaries</b>	<b>No. of units procured and distributed</b>
Zinc drops for 6-12 months	98,005	98,005 bottles
Zinc for 13-59 months	49,021	49,575 bottles
Oral rehydration salt	210,014	1,062,330 sachets

Source: DOH Family Health Office

## Nutrition

National government efforts in 2016 were geared toward ensuring adequate nutrition for the First 1,000 days of life. Studies show that this is a critical period for growth and development. In support of this, several bills were filed in Congress seeking to improve nutrition in the First 1,000 Days. One of these bills approaches the problem holistically through provision of health, nutrition, education and social welfare services among children 0-8 years old. It targets maternal malnutrition during pregnancy as a cause of stunting, and strengthens promotion of breastfeeding, complementary feeding as well as food fortification. In line with this, the DOH issued DM 2016-0163 “Scale-up Plan for the Implementation of the Philippine Integrated Management of Acute Malnutrition” to further strengthen its efforts on micronutrient supplementation, complementary feeding for infants and exclusive breastfeeding.

Part of the DOH ANC program is the provision of macro- and micronutrient supplementation for pregnant women and adolescent girls, which intends to help prevent deficiencies in calcium, iron, iodine, and folate in vulnerable populations. With Department Memorandum (DM) 2016-0161 “Calcium Supplementation for Pregnant Women,” the DOH has started to procure the commodity in 2016. It also procured other nutrient supplements to assist LGUs in providing micronutrients for vulnerable populations. Table 1d shows the estimated number of recipients of such supplements as well as the volume procured and distributed by the



**Table 1d. DOH-procured macro- and micronutrient supplements for women aged 10-49 years, 2016**

Nutrient Supplements <sup>13</sup>	Estimated no. of target beneficiaries	Number of units procured and distributed
Ferrous Sulfate + Folic Acid tablet	1,194,233	236,458,134
Iodine capsule	1,194, 233	2,627,313
Calcium carbonate	1,283,098	10,889,661

Source: DOH Family Health Office

In addition, the DOH procured micronutrient supplements for infants and children in 2016 (see Table 1e). In 2013, the National Nutrition Survey (NNS) reported that the prevalence of anemia in children 6 months to 1 year of age was 39.4 percent – still the highest in populations grouped by age. Still, this is a marked improvement over the 2003 (66.2 percent) and 2008 (55.7 percent) rates.

**Table 1e. DOH-procured micronutrient supplements for infants and children, 2016**

Micronutrient supplement	Total number of target beneficiaries	Number of units procured and distributed
Vitamin A capsule 100,000 IU for 6-11 months	1,400,099	1,540,109 capsules
Vitamin A capsule 200,000 IU for 12-59 months	11,200,793	30,836, 405 capsules
Iron Drops 15 mg elemental iron/0.6 ml for low birth weight infants	548,838	1,207,446 bottles
Micronutrient Powder for anemic 6-23 months old	513, 145	67,735,140 sachets

Source: DOH Children's Health Development Division

NNC is also drafting the Philippine Plan of Action for Nutrition (PPAN) 2017-2022, which is set to be released in 2017. PPAN embodies the country's medium term strategies for attaining national targets on nutrition.

## Challenges and Recommendations

### High MMR

- **Maternal deaths are still due to highly preventable causes.** These preventable causes are hypertension and hemorrhage, which can be allayed through timely and adequate obstetric care and postnatal services.

**Recommendations.** While a MNCHN Manual of Operations is available and includes packages from pre-pregnancy to post-natal care, there is a need to

<sup>13</sup> Calcium is a macronutrient while iron, folate, and iodine are micronutrients.

develop a comprehensive implementing guideline on the provision of antenatal care. The national operation of the policy on the Provision of Quality Antenatal Care in all Birthing Centers which was signed in September 2016 needs to be configured to local situations to appropriately guide Municipal and City Health Officers as well as other health staff providing maternity and newborn care. Furthermore, the 2008 MNCHN policy (Implementing Health Reforms to Rapidly Reduce Maternal and Neonatal Mortality) needs to be aligned to current approaches and the SDGs.

- **Challenges in the Family Planning program implementation.** Studies have shown that maternal deaths usually occur if pregnancies are unplanned; therefore family planning services should be in convergence with the maternal care program.

**Recommendations.** Contraceptives should be accessible to women and men of reproductive age; but most especially to sexually active adolescents (aged 10-19 years) and multigravid women. Family planning advocacies and services must be integrated during antenatal and post-natal care and in various entry points in health facilities.

- **Health system delays persist.** While service utilization indicators are marginally increasing compared to previous years, this does not translate to significant improvements of maternal and neonatal health outcomes. This might be probably due to health system delays like unavailability of emergency transport, lack of blood and drugs in referral hospitals and untimely decision-making for referral are common difficulties in implementation.

**Recommendations.** There is a need to assess the EmONC implementation in the country, specifically the conduct of training courses in various institutions and the post training mentoring, evaluation and monitoring. Secondly, use of donated ambulance and transportation services from the DOH and the Philippine Charity Sweepstakes Office should be monitored. Moreover, PhilHealth policies on claims reimbursements should be reviewed. The agency should also monitor and enforce the use of facility share in reimbursements to sustain its operations.

#### Increasing prevalence of under nutrition

- **Underweight and stunting rates are increasing.** While nutrition interventions are incorporated in various MNCHN strategies, nutrition program is sadly overlooked in contrast to maternal care and family planning programs. Interventions from the DOH are predominantly procurement of nutrition commodities for augmentation of LGU supplies for vulnerable populations.

**Recommendations.** Studies have shown that effective nutrition interventions should focus on pregnant and lactating women and children 0-2 years old. Therefore, all nutrition-related interventions integrated in the maternal, neonatal, infant, and child health must be highlighted through a strong IEC or behaviour change communication (BCC) campaign during antenatal and post-natal consultations. Promotion of appropriate infant and young child feeding practices especially exclusive breastfeeding must be strengthened through strategies proven to be effective like peer-to-peer counselling and coaching. The Health Promotion and Communication Services must intensify its campaign on proper nutrition specifically through television commercials, radio and social media to reach a wider segment of the vulnerable population.

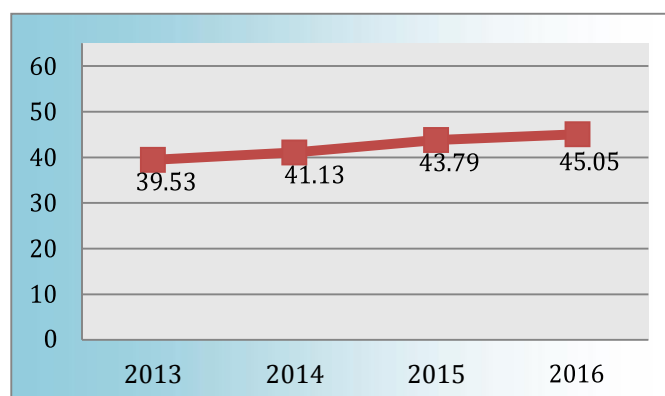
## KRA 2: Family Planning

### Status and trends

Modern contraceptive prevalence rate (mCPR) showed minimal increase over the past four years since the implementation of the RPRH law (see Fig. 2a). While mCPR rose from 43.79 percent<sup>14</sup> in 2015 to 45.05 percent<sup>15</sup> in 2016, it still fell short of the 65 percent-target in the NOH 2011-2016.

Fig. 2b shows that only Regions XII and CARAGA were able to meet the target on mCPR. Regions I, II and XI came close with a mCPR of more than 60 percent.

Figure 2a. Modern CPR, Philippines, 2013-2016

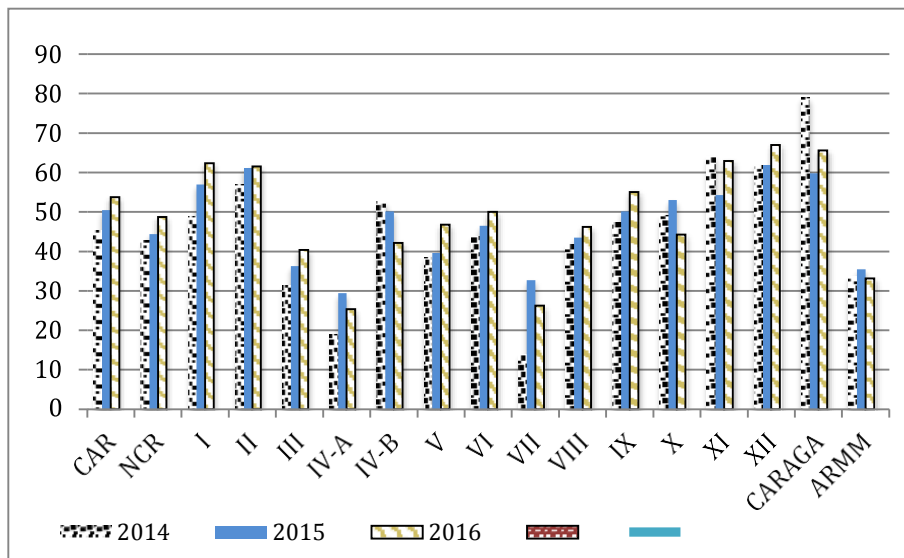


Sources: Field Health Service Information System Annual Reports 2013 and 2014; DOH administrative data

<sup>14</sup> Based on DOH administrative data

<sup>15</sup> Based only on DOH administrative data as of the third quarter of 2016; Computed by dividing the total number of current FP users (5.7 million) by the total number of eligible population (12.8 million), multiplied by 100

**Figure 2b. Modern CPR 2013-2016, by region**

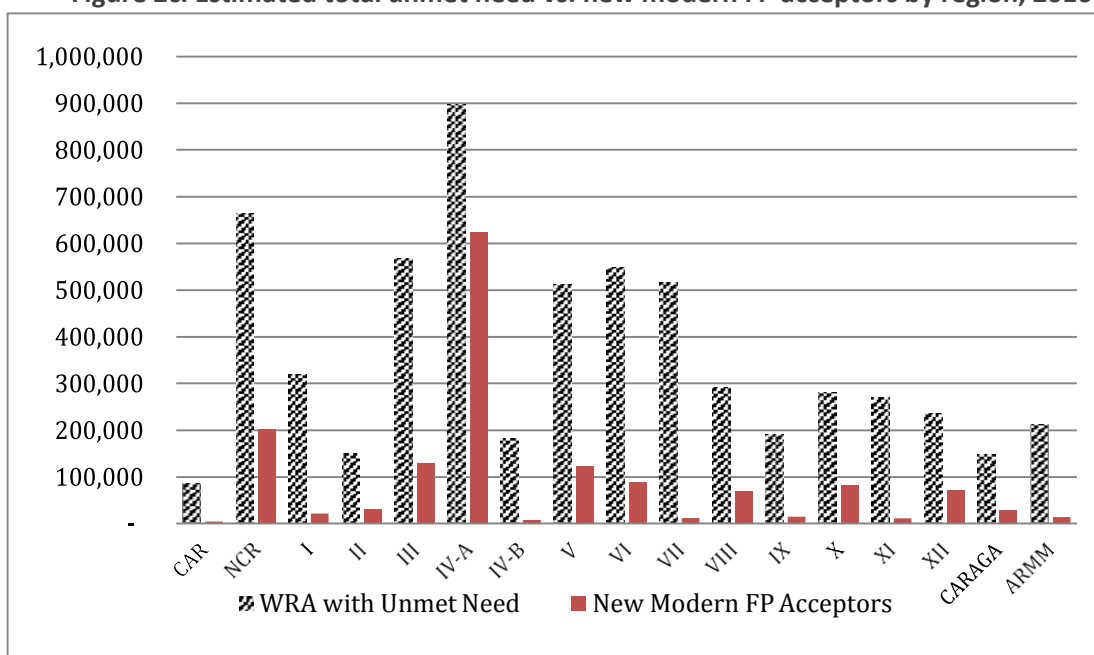


Source: DOH administrative data, 2016

Based on DOH administrative data, the number of new modern family planning (FP) acceptors tripled from over half a million in 2014 to more than 1.5 million in 2016. While this represents significant progress, this number covers only 26 percent of the estimated six million women with unmet need for modern FP method in 2016. Fig. 2c shows the huge gap between unmet need and new modern FP acceptors at the subnational level for the year.

Nearly half (48 percent or more than 2.8 million) of women with unmet need are concentrated in five areas: Regions IV-A, NCR, III, VI and VII, with Region IV-A topping the list. Difficulties in addressing unmet need seems to be a common problem in all regions as none was able to cover even half of the estimated total number of women with unmet need for FP. Region IV-A reported the highest coverage at 70 percent (623,409 women) while Regions IVB, VII and XI had the least coverage at only less than five percent. The average coverage rate for the country is only 19 percent.

**Figure 2c. Estimated total unmet need vs. new modern FP acceptors by region, 2016**



Source: DOH administrative data, 2016

Around 5.7 million women were reported to be using modern FP methods in 2016. Table 2a illustrates that women often used short-acting modern FP methods. Pills, which were used by 2.3 million women in 2016, continued to be the most commonly used as shown by its increasing share in the method mix from 2014. DMPA ranked second with 981,466 users, followed by female sterilization with 626,124 acceptors, and intrauterine device or IUD with 493,673 acceptors. Natural FP-Lactational Amenorrhea Method (NFP-LAM) appeared to have a considerable share at 9 percent but this figure is certainly bloated as it included those who merely initiated breastfeeding in health facilities, not strictly mothers who exclusively breastfed for six months post-partum. Meanwhile, male sterilization has been the least used and preferred method as shown by its 0.3 percent share in the method mix for the past three years. Progestin subdermal implant (PSI), which was provided for only two months owing to the TRO, even reported a bigger share than that of male sterilization with 108,535 acceptors in 2016.

**Table 2a. FP method mix, 2014-2016**

Modern Method	Share in 2014 (%)	Share in 2015 (%)	Share in 2016 (%)
<b>Pills</b>	36.9	38.7	41.8
<b>DMPA</b>	16.3	15.6	18.1
<b>Female sterilization</b>	12.4	13.8	11.6
<b>IUD</b>	10.9	8.0	9.1
<b>NFP-Lactational Amenorrhea Method (LAM)</b>	14.1	13.2	10.6
<b>Condom</b>	4.5	4.7	4.0
<b>Male sterilization</b>	0.3	0.3	0.3
<b>NFP -Fertility awareness-based (FAB) method</b>	3.5	3.5	2.5
<b>Progestin subdermal implant (PSI)</b>	1.1	2.2	2.0
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>

Source: DOH administrative data

## Interventions

One of the major reasons identified to have hampered delivery of FP services is the lack of a simple and sustainable mechanism for identifying and linking women needing modern FP services to ‘quality’ health providers. This brings to fore a whole gamut of issues concerning commodity availability and distribution, personnel FP training and competency assessment, demand generation and health care access. Various interventions were pursued by the DOH, POPCOM, the civil society and development partners in 2016 to address these issues.

To harmonize efforts on FP, POPCOM issued Board Resolution No. 2 S. 2016 “Adopting the Collaborative Framework and Strategies for the Implementation of the National Family Planning Program as a Public Health and Population Management Intervention.” It harmonizes the outcomes of both the family health and the population management programs, and defines the roles and strategies to be adopted by DOH and POPCOM in the implementation of the National FP Program.

The DOH supported the drafting of an EO attaining and sustaining ‘zero unmet need for modern FP’ through the strict implementation of the RPRH Act. It specifies the strategies for meeting this goal: (a) mainstreaming of RPRH concerns in local development planning and investment programming, (b) strengthening of DOH role in overseeing RPRH implementation, such as in the assessment of gaps in policy implementation and in the identification of interventions needed to ensure equitable and expanded access to RPRH services, and (c) enforcement of other agencies’ compliance to their RPRH mandate. A DOH AO corresponding to the EO was also prepared in 2016.

As part of its efforts to sustain FP provision, the DOH, together with development partners, developed the “National FP Costed Implementation Plan 2017-2020,” which

estimated a total of PhP7.87 billion-financial gap between the DOH budget for 2017 and its total budgetary requirements for FP. Full implementation of this Plan is expected to avert over 886,000 hospitalizations for abortion complications and nearly 3.2 million unintended pregnancies – equivalent to around PhP10.7 billion annual savings.

### Ensuring availability of FP commodities

Table 2b shows the FP commodities procured by the DOH in 2016, which can only cover 2.2 million women in one year. While this volume can meet the commodity needs of 96 percent of the 2.3 million<sup>16</sup> poor women who wanted to limit or space births in 2016, this is only sufficient for a third of the total estimated six million women who wanted FP for the year. The gap becomes even larger when the commodity needs of current FP users are taken into account.

**Table 2b. FP commodities procured in 2016**

Commodity	Quantity	Estimated no. of women that can be served in 1 year
Combined Oral Contraceptives (COC)	20,000,000 cycles	1,333,333
Depo Medroxyprogesterone Acetate (DMPA)	1,500,000 vials & syringes	300,000
Intra Uterine Device (IUD)	500,000 pieces	500,000
Sympto thermal method (STM)	143,000 charts	11,917
Cervical Mucus Method (CMM)	143,000 charts	11,917
Basal Body Temperature (BBT) Method	143,000 charts	11,917
Standard Days Method	12,500 cycle beads	12,500
<b>Total</b>		<b>2,181,583</b>

Source: DOH administrative data

DOH regional offices including DOH-ARMM were provided buffer stocks equivalent to 10 percent of the regional allocation, 5 percent of which may be accessed by CSOs and DOH-retained as well as LGU hospitals. Table 2c shows that the FP commodities were equitably allocated among regions in 2016 with those having the highest estimated unmet need for modern FP (Regions IVA, NCR and III) getting the biggest shares.

<sup>16</sup> Based on the DOH estimate of unmet need for modern FP among women of reproductive age belonging to poor households, as identified by the DSWD in the National Household Targeting System

**Table 2c. FP commodity allocation by region, 2016**

REGION	Pills-COC (cycles)	Pills POP (cycles)	DMPA (vials & syringes)	IUD
NCR	2,546,535	570,960	190,990	63,663
CAR	345,585	77,490	25,920	8,640
Region I	986,160	221,115	73,965	24,654
Region II	677,025	151,785	50,775	16,925
Region III	2,224,275	498,705	166,820	55,607
Region IV-A	2,925,945	656,025	219,445	73,148
Region IV-B	589,530	132,180	44,215	14,738
Region V	1,141,725	255,975	85,630	28,543
Region VI	1,485,585	333,075	111,420	37,140
Region VII	1,458,990	327,120	109,425	36,475
Region VIII	854,355	191,550	64,075	21,359
Region IX	735,540	164,910	55,165	18,388
Region X	938,265	210,360	70,370	23,457
Region XI	970,620	217,620	72,800	24,265
Region XII	919,560	206,175	68,965	22,989
CARAGA	512,460	114,900	38,435	12,812
ARMM	687,845	154,230	51,585	17,197
<b>TOTAL</b>	<b>20,000,000</b>	<b>4,484,175</b>	<b>1,500,000</b>	<b>500,000</b>

Source: DOH administrative data

Delivery of FP commodities was scheduled in three tranches but as of December 2016, only two tranches were made owing to delays in the contracting of the new forwarder. All 1,630 identified service delivery points (SDPs) in the first trimester and 93 percent of the 1,566 target SDPs in the second trimester of 2016 received their commodity allocations. The third tranche of transfer will be completed in 2017.

The FP Hotline introduced in 2015 to effectively track commodity logistics went in full swing under POPCOM supervision in 2016 when it covered 1,463 cities and municipalities. The Commission even designated FP logistics coordinators to monitor and fast track delivery of commodities to the different regions. Out of the 1,463 LGUs (MHOs/CHOs) reached by the FP hotline for the year, 176 reported having at least one incidence of commodity stockout<sup>17</sup> (see Table 2d). Stockout for progestin only pills (POP) was notably highest with more than half of LGUs reporting unavailability of said commodity. All reported stockouts were already addressed by the DOH as of December 2016.

<sup>17</sup> Volume of commodity is below three months' worth of supply



**Table 2d. FP Hotline report on commodity availability by region, as of December 2016**

Region	Total no. of LGUs	No. of LGUs covered	Coverage rate	No. of LGUs that reported stockouts	No. of LGUs w/ stockouts addressed	No. of LGUs that reported overstocks	No. of LGUs with stocks adjusted
NCR	17	17	100%	1	1	5	5
CAR	77	76	99%	7	7	32	32
Region I	125	125	100%	12	12	6	6
Region II	93	86	92%	21	21	12	12
Region III	130	112	86%	26	26	15	15
Region IV-A	142	142	100%	14	14	31	31
Region IV-B	73	72	100%	17	17	23	23
Region V	114	66	58%	6	6	33	33
Region VI	133	113	85%	15	15	41	41
Region VII	132	132	100%	14	14	32	32
Region VIII	143	126	88%	5	5	51	51
Region IX	72	70	97%	9	9	35	35
Region X	93	76	82%	7	7	48	48
Region XI	49	49	100%	0	0	5	5
Region XII	50	49	98%	5	5	22	22
CARAGA	73	73	100%	12	12	31	31
ARMM	118	79	67%	5	5	15	15
TOTAL	1634	1463	90%	176	176	437	437

Sources: DOH Logistics Management Division; FP Hotline report as of December 2016

As for overstocks<sup>18</sup>, 437 of 1,463 LGUs reached by the FP hotline reported oversupply of FP commodities, particularly combined oral contraceptive (COC) pills. The DOH adjusted succeeding commodity allocations correspondingly upon validation of reported stockouts/overstocks through inventory reports. Routine generation of consumption reports on the ground has prompted the DOH to start shifting towards consumption-based allocation.

<sup>18</sup> Volume of commodity exceeds six months' worth of supply

### Box 2a. A step backwards: TRO implications on contraceptive supply

The RPRH Act of 2012 intends to help accelerate delivery of RPRH services, including FP. However, while supporting policies and mechanisms to expand FP provision were developed, the Supreme Court TRO has restricted access to contraceptives, particularly subdermal implant, since it was issued in 2015. It threatens to result in the phase-out of all contraceptives before 2020 if it remains to be in effect.

Aside from preventing the procurement, sale, distribution and even promotion of the hormonal contraceptive Implanon and Implanon NXT (progestin subdermal implant, a long-acting reversible contraception), the TRO prohibited the Food and Drug Administration (FDA) from certifying and recertifying reproductive products and supplies. As a result, FDA was unable to renew the certificates of product registration (CPRs) of 15 of 48 contraceptive products in the Philippine National Formulary in 2016. Fourteen more CPRs will expire in 2017, another 14 in 2018, four in 2019 and one in 2020. This means that by November of 2020, artificial contraceptives will no longer be available in the market.

Women will have severely limited access to artificial contraceptives in both public and the private sectors even before 2020. CPRs for POPs and DMPAs will expire by 2017 and 2018, respectively. This cuts access of postpartum women to two most preferred FP methods, leaving them only with LARC as an alternative method for birth spacing. CPR for IUDs will be expiring by 2019. The last CPR to expire is that for contraceptive subdermal implants. As of December 2016, the DOH reported over half a million units of Implanon and Implanon NXT that cannot be dispensed and are about to expire by 2018. This means lost opportunities to protect over half a million women from mistimed pregnancy.

The TRO resulted in confusion on FP delivery, with certain local health offices and LGUs thinking that the prohibition applies not only to implant but to the implementation of the RPRH law in general. This prompted the DOH to issue DM No. 2015-0254 “Frequently Asked Questions (FAQs) and their Answers on the TRO regarding Reproductive Products and Implanon and Implanon NXT”, and DM 2016-0450: “Reiteration and Clarification on DM 2015-0254.” The latter focused on the different FP commodities covered by the FDA and the PSI service as well as training provision included in the TRO. Update on the status of the TRO is discussed at length in the Governance chapter.

## Accelerating access to FP services

### Promoting FP

With USAID assistance, the DOH launched a national FP campaign called *Wagi* from 2014-2016. It aims to improve the quality of understanding for modern FP methods among the target audience. The tracking studies conducted in relation to the campaign indicate that better understanding of the modern FP methods led couples to decide to consult a Health Service Provider (HSP) on the method suited to their needs. The campaign utilized the concept of “hiyang” or best fit to address fear of side effects. Testimonials of real couples with real FP success stories were utilized to correct misconceptions and allay fears associated with FP use. The whole *Wagi* campaign reached 17.6 million individuals. The share of the target population in the second phase

of the campaign that was concluded in 2016 rose from 69 percent to 82 percent.

### *Community-based demand generation and service provision*

In 2016, the DOH enhanced its strategies for linking women with unmet FP need to appropriate health providers. It drafted the Operational Guidelines on the Establishment of Service Delivery Network to provide DOH regional offices, program managers and LGUs with operational specifications to set up and manage their SDNs not only on FP but on other health programs as well.

Meanwhile, DOH ROs, POPCOM and CSOs have initiated efforts to link women with unmet FP need using the key principles of SDN earlier specified by the DOH in its MNCHN SDN: (a) identifying a priority group, (b) mapping of providers, (c) assignment of priority group to providers, and (d) monitoring of health service utilization of the priority group. Despite the phased-out DOH Central Office budgetary support for the mobilization of Community Health Teams<sup>19</sup> (CHTs), the initiative has been sustained by other DOH ROs who have continued to mobilize them to identify women with unmet FP and other health needs, and link them to health providers. POPCOM provided support to LGUs and worked with line agencies such as DILG and DSWD as well as the CSOs in the conduct of various community-based activities aimed at generating demand for FP such as RPRH classes, *Usapan Serye*, pre-marriage counseling and family development sessions (FDS) on responsible parenthood and family planning (RPFP). These efforts resulted in the identification of nearly 245,000 women with unmet need for modern FP, 63 percent (154,610) of which became new acceptors of modern FP.

The CSOs also provided postpartum FP services to women who gave birth in health facilities such as in lying-in clinics, and conducted FP outreach in urban slums – benefiting around 700,000 women.<sup>20</sup> With DOH-NCR funding support and under the coordinative supervision of PCPD, three NGOs – DSWP, FPOP and IMAP, delivered FP services in Caloocan and Taguig through a seven-month project that resulted in FP use by over 4,000 clients. This project provided lessons on joint FP implementation and monitoring by the DOH and CSOs, and helped identify effective funding modalities for FP. It served as the starting point for ongoing CSO partnerships with different regional offices of the DOH, specifically NCR, Region III, Region IVB and ARMM.

POPCOM set up its RP-FP Online Monitoring System to facilitate routine tracking of women with unmet need for FP, and timely reporting of data on FP utilization. This system stores client data up to the municipal level and is accessible to program partners. To date,

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<sup>19</sup> Community volunteers tasked to provide health navigational assistance to families, i.e. helping them assess their health needs and linking them to health providers; CHT mobilization is one of the innovations introduced to increase access to public health services

<sup>20</sup> Reports on postpartum FP services and FP outreach are currently being validated and standardized based on DOH reporting template

there are x number of couples and individuals with unmet need for modern FP services in the registry of which x number had been served.

The DOH sought to expand service provision through the drafting of an AO providing guidelines for the certification of freestanding FP clinics. The AO sets the minimum standards and services for these private FP facilities and prescribes the DOH procedures for their assessment and evaluation. It also opens an opportunity for their eventual PhilHealth accreditation.

### *FP in hospitals*

FP services were made available in selected government hospitals in the country in 2016 through DOH RO and development partner support. Following the DOH issuance of DM 2014-0312 “Guidelines in setting up FP services in hospitals,” the ROs with USAID assistance supported 73 regional medical centers and DOH-retained as well as LGU-owned/managed hospitals in Luzon, Visayas and Mindanao in assessing and strengthening their capacities to deliver the whole range of FP services. FP assessment as well as monitoring and reporting tools were developed to help set up the system in hospitals. In addition, key hospital personnel were trained on FP and provided with supportive supervision in setting up/strengthening FP delivery in their facilities.

As a result of these efforts, 44 percent (8,946) of 20,518 clients were provided with FP counseling through various classes being conducted in the hospital wards and the outpatient department (OPD); while, 58 percent (5,240) of those who were counseled became FP acceptors. Thirty-five out of the 51 hospitals began IUD provision and 40 have started offering PPIUD services. In Visayas, interval IUD users nearly doubled from 60 in 2014 to 118 in 2016. BTL-MLLA cases increased by 51 percent from 224 in 2015 to 338 in 2016. In Mindanao, LARC and LAPM users posted a 21 percent increase from 4,805 to 5,800 for the period.

### *FP in the workplace*

UNFPA-Philippines partnered with Avon-Philippines, Bagosphere, CARD-MRI and Hamlin Industrial Corporation to develop various modalities for engaging private companies in FP. The Employers Confederation of the Philippines (ECOP), the biggest organization of employers in the country, was engaged to capacitate partner companies in providing their employees with accurate FP information and expand their access to FP commodities. Human resource officers, company nurses, loan officers, FP trainers and program managers were trained to facilitate their workplace FP education sessions and if needed, provide counseling to individuals willing to use FP. The conduct of FP Education sessions across various sites reached a total of 720,000 member women of reproductive age.

CARD-MRI also initiated a workable model on Public-Private Partnerships on FP in partnership with the City Population Office of San Pablo, Laguna, linking orientation/information sessions to actual service delivery. It led to the conduct of outreach services that provided 200 women with implants and BTL services. However, these data are often not reflected in the FHSIS.

### Capacitating FP providers

One major obstacle in accelerating the provision of quality FP services is the limited number of health facilities with trained FP providers. Based on DOH RO and USAID initiatives, 5,470 public and private providers were reported to have been trained on FP Competency-Based Training (CBT) 1 as of end of 2016. Meanwhile, there were 6,215 providers trained on FP CBT 2 (including interval IUD, postpartum IUD and BTL-MLLA) for the same period.

Recurring issues in capacitating FP providers include the inadequacy of institutions that can provide FP training, and poor compliance to the required post-training evaluation for assessment of proficiency. AO 2014-0041 was issued two years ago to expedite the DOH process of certifying/recognizing FP training providers but this has not been implemented successfully in the regions. Only a few medical/training institutions in the regions meet the DOH criteria for a recognized training provider. As a result, government hospitals had to queue up for the earliest available schedule of training. Inadequacy of trained providers/experts to conduct post-training supervision and evaluation to complete the training certification process has likewise been an issue.

DOH DM No. 2016-0371 “Extension of the Certificate of Recognition for Individual Trainers of DOH on Modern Family Planning Method until December 2017” was issued to ensure continuous training of health service providers. It sought to temporarily address the fast turnover and inadequacy of trained FP providers, which have limited provision of FP services.

### Challenges and recommendations

#### High level of unmet need for modern FP

- **Imminent contraceptive phase out if TRO is not lifted.** The Supreme Court upholding of the TRO on subdermal implants and certification/recertification of FP commodities will eventually result in the expiration of Certificate of Product Registration of modern contraceptives, leading to the total phase out of FP commodities in the market before 2020. Without FP commodities, the country’s national FP plan is effectively put on halt.

**Recommendations:** Stronger multi-sectoral support spanning the executive and legislative branches of government, the private sector and civil society must be made to lobby for the immediate resolution/lifting of the TRO.

- **No national level FP communications strategy.** The absence of a national level FP communications strategy has led to sporadic, uncoordinated and fragmented manner of generating FP demand and delivering services – making it more difficult to scale up FP provision.

**Recommendations:** The DOH may partner with private communications and research outfit in designing and carrying out a strategic communications plan/strategy on FP at the national level. Building on the identified gaps in FP IEC and BCC, it should be able to provide a common set of ‘take-home’ messages for target groups to include not only clients with unmet need for modern FP, but planners and decision-makers as well as key implementers at the national and subnational levels. The plan should ensure consistency of FP campaigns with national development priorities and pronouncements.

- **Conventional approaches for finding women with unmet need for FP.** While the estimated number of women with unmet need for FP has gone disproportionately higher than the number of trained FP providers and referral facilities, platforms and mechanisms for identifying and reaching these women have remained essentially the same, e.g. through health centers and 4Ps FDS.

**Recommendations:** There is a need for public-private sector arrangements to cover a significant portion of women with unmet need, e.g. through mall-based FP clinics that can provide services beyond the operating hours of government facilities.

- **Weak link between FP supply and demand.** DOH initiatives to improve commodity logistics have led to faster delivery of FP commodities to service delivery points. Initial allocation has also been fairly equitable as it was condition on the number of poor households (using NHTS-PR). Despite this, there were still reports on stock outs and overstocking of commodities in rural health units/health centers.

**Recommendations:** The issue calls for a need to strongly link commodity and budgetary allocations at the central level with actual demand for FP services on the ground. As such, a unified FP monitoring system that will routinely track commodity supply, demand and utilization at subnational levels may have to be institutionalized. In addition, current systems on FP logistics, such as the FP Hotline, needs to be regularly reviewed and improved. At a more strategic level, policy pronouncements supporting couples’ desired family size must be backed up

by corresponding budgetary, policy and legal support to allow implementation of FP strategies.

- **LGU support for FP varies across localities.** Conflicting political stance on FP has led to different FP outcome levels across regions, especially given local autonomy which has blurred central-local relations.

**Recommendations:** The DOH through its Regional Health Offices can institutionalize its support to the local implementation of FP by maximizing the use of subnational level structures and mechanisms deemed critical in translating national level FP plans and strategies into concrete and operable local programs, projects and activities. Subnational structures such as the Regional Development Council and Provincial/City Councils may be tapped by the DOH as RPRH champions that can influence the mainstreaming of FPRP concerns in local plans and budgets and prompt needed inter-sectoral collaboration to accelerate FP delivery.

- **Need for a dedicated trained FP/RPRH focal points in health facilities.** The midwife is commonly designated to handle FP in health centers/RHUs. However, competing tasks in other programs such as mental health, MCH, non-communicable disease, etc. hinders full-time provision of FP in health centers/RHUs.

**Recommendations:** There may be a need to allot a separate budget for the deployment of dedicated FP focal points in hospitals and other service delivery points. There should also be a plantilla position for midwives in government hospitals to ensure that they are properly compensated. Currently, midwives can only be engaged by hospitals as nurse assistants. Alternatively, nurses engaged under the DOH Nurse Deployment Project (NDP) may be tapped as FP/RH Officers not only in health centers but in hospitals as well.

- **LGU difficulty in operationalizing SDN for FP.** LGUs have not been able to internalize the principles of an effective SDN despite previous DOH guidelines for such, e.g. MNCHN SDN. The SDN initiative, which should be able to identify and locate the target population, organize a network of capable service providers, effectively link target population to providers, and monitor referral, often stops at the signing of Memoranda of Agreement among various stakeholders.

**Recommendations:** There is a need for serious technical support for LGUs to be able to translate the SDN principles and strategies into sustainable operational networks that can help estimate, identify and locate the priority population for FP, map and assess the capacities of FP providers, match the priority population with quality providers, and monitor their health service utilization. The draft AO



prepared by the DOH to refine SDN arrangements needs to be revisited to ensure its responsiveness to local needs and concerns on FP. In addition to a national issuance, manuals/guidelines and best practices on FP SDN may be developed.

## KRA 3: Adolescent Sexual and Reproductive Health

### Status and trends

The Philippines has the third highest adolescent fertility in Southeast Asia with 57 births per 1,000 deliveries for girls aged 15-19 for the period 2006-2013. While adolescent fertility rates have declined in most countries in the Asia Pacific region, the same cannot be said for the Philippines. Both the 2013 NDHS and the 2013 Young Adult Fertility and Sexuality (YAFS) Study demonstrated steady increase of teenage pregnancy in the country with the former reporting an increase in the number of women aged 15-19 who have begun childbearing from 8 percent in 2003 to 10 percent in 2013, and the latter showing an increase in teenage fertility from 6.3% in 2002 to 13.6% in 2013. YAFS cited internet, social media and new information technologies as the most prominent factors that facilitate early sexual engagement.

Based on Civil Registration and Vital Statistics of the Philippine Statistics Authority (PSA), deliveries by teens remained high at 12 percent from 2012 to 2014 (see Table 3a). Region II reported the highest rate at 14.9 percent, followed by Region XI and Region XII, both at 14.1 percent, and Region X at 13.9 percent. The highest number of adolescent mothers who delivered came from Region IVA (28,605), NCR (26,606) and Region III (24,729).

According to the WHO, adolescent pregnant mothers are more likely to die compared to pregnant mothers in their 20s. Pregnancy during adolescence is associated with greater risk of health problems like nutritional anemia, predisposition to unsafe abortions, postpartum hemorrhage and mental disorders. Children born to adolescent mothers also suffer poorer health outcomes, including higher incidence of pre-term births, and higher infant morbidities and mortalities.



**Table 3a. Births by teen mothers by region, Philippines: 2012 – 2014**

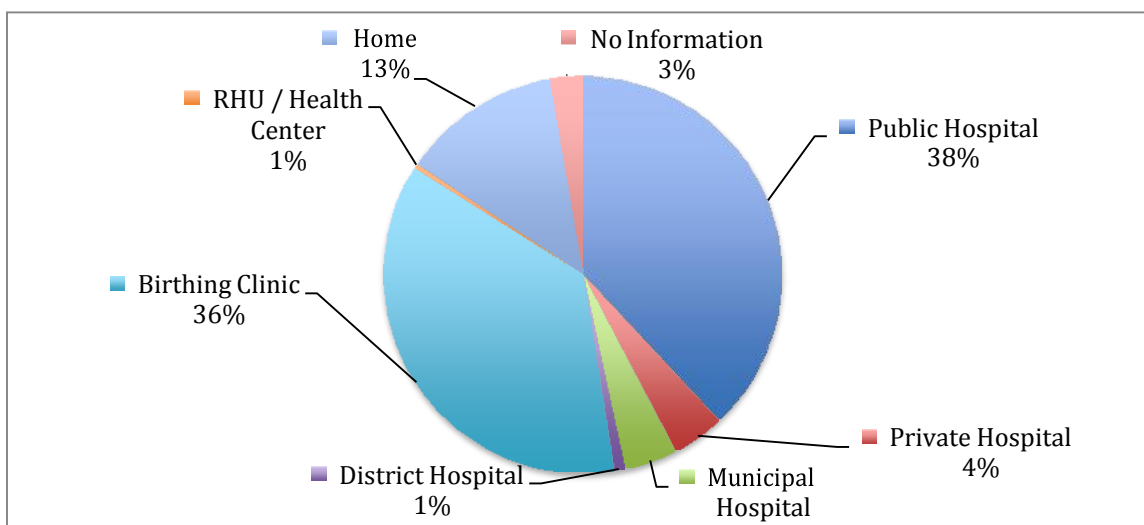
REGION	2012			2013			2014		
	Total births	Births by teens	%	Total births	Births by teens	%	Total births	Births by teens	%
PHILIPPINES	1,790,367	209,274	11.7	1,761,523	209,580	11.9	1,748,782	209,872	12.0
NCR	246,994	27,015	10.9	243,626	27,248	11.2	239,736	26,606	11.1
CAR	34,000	3,961	11.7	33,329	4,053	12.2	32,263	3,869	12.0
Region I	92,180	10,564	11.5	89,948	10,694	11.9	87,883	10,398	11.8
Region II	65,222	9,285	14.2	63,620	9,279	14.6	62,320	9,285	14.9
Region III	204,510	24,895	12.2	197,294	24,532	12.4	196,409	24,729	12.6
Region IV A	264,571	29,135	11.0	260,463	29,217	11.2	257,461	28,605	11.1
Region IV B	49,606	5,963	12.0	48,530	6,015	12.4	48,170	6,212	12.9
Region V	120,791	12,610	10.4	119,727	12,695	10.6	115,772	12,719	11.0
Region VI	126,333	12,985	10.3	123,987	12,957	10.5	119,231	12,736	10.7
Region VII	154,872	17,359	11.2	150,534	16,927	11.2	152,542	16,708	11.0
Region VIII	69,932	8,707	12.5	69,292	8,668	12.5	72,423	9,155	12.6
Region IX	59,649	7,400	12.4	58,106	7,117	12.2	60,729	7,861	12.9
Region X	86,483	11,522	13.3	87,676	11,644	13.3	86,143	11,971	13.9
Region XI	87,124	12,045	13.8	82,150	11,730	14.3	86,463	12,195	14.1
Region XII	75,146	10,169	13.5	80,983	11,161	13.8	76,119	10,721	14.1
ARMM	13,382	1,056	7.9	13,004	1,089	8.4	14,783	1,208	8.2
CARAGA	39,572	4,603	11.6	39,254	4,554	11.6	40,335	4,894	12.1

Source: Philippine Statistics Authority, Vital Statistics Division, 2014

Note: Highlighted entries = teenage pregnancy rates higher than the national average

Current policy on maternity care package coverage recommends that adolescent mothers should give birth in a hospital. However, a study by the Center for Health Solutions and Innovations (CHSI) commissioned by UNFPA in 2016 showed that only 42 percent of teen mothers delivered in hospitals, 36 percent in birthing clinics, and 13 percent at home. This may be attributed to difficulties in accessing Level 1 hospitals, particularly in rural communities, where teenage deliveries are being done in non-hospital birthing facilities, or in homes delivered by either a skilled or traditional birth attendant.

**Figure 3a. Percentage of teen births by facility type, 2015**



Source: Mapping of Teenage Birth Delivery in Selected UNFPA Areas, 2016. Center for Health Solutions and Innovations (CHSI), POPCOM and UNFPA

The impact of teenage pregnancies goes beyond physical health. A study on the economic impact of teenage pregnancies<sup>21</sup> shows that adolescents who have begun childbearing (65 percent) before age 18, are less likely to complete secondary education, when compared to adolescents who have not begun childbearing (72 percent) by 7 percentage points. This results to a significant decrease in total life earnings due to poverty and childbearing.

Barriers remain for adolescents' access to the full range of services to address their sexual and reproductive health needs. While the RPRH Law has mandated the provision of ASRH information and services at points of care, and the integration of Comprehensive Sexuality Education (CSE) in formal and non-formal educational settings, adolescents are still required to get parental consent to access modern contraception, including testing for HIV. A study made by the Center for Health Solutions and Innovations (CHSI) on Communications in 2016 showed that about 65 percent of teen respondents would be comfortable discussing FP with their parents/guardians but only 26 percent would be willing to talk about premarital sex.

<sup>21</sup> Herrin, A. (2016). *Education, Earnings and Health Effects of Teenage Pregnancy in the Philippines*. United Nations Population Fund

## Interventions

The DOH developed its Adolescent Health and Development strategy to provide operational guidance to implement AO 2013-0013 “National Policy and Strategic Framework on Adolescent Health and Development”. It also drafted a DM for developing standard monitoring tools for adolescent-friendly health facilities, and the manual of procedures for Adolescent Health and Development Program (AHDP).

Efforts were also made in 2016 towards ensuring the health and safety of adolescents in emergency situations. In coordination with the National Youth Commission (NYC), the DOH Health Emergency Management Bureau (HEMB) and UNFPA worked on the integration of Adolescent Sexual and Reproductive Health in Emergencies (ASRHiE) in the Minimum Initial Service Package (MISP) that was issued through DOH AO 2016-0005. ASRHiE serves as guidelines for service providers for handling the sexual and reproductive health (SRH) concerns of adolescents in emergency situations. It covers prevention of sexual violence, prevention and management of STI/HIV and AIDS and provision of maternal and newborn health.

Young people belonging to disadvantaged groups were likewise provided with health insurance coverage through PhilHealth Circular 2016-0019. It enrolls the marginalized youth populations including orphans, abandoned and abuse minors, out-of-school youth and street children as sponsored members. As such, they are entitled to primary preventive services, diagnostic examinations, drugs and medicines under the Primary Care Benefit Package (PCB).

The passage of Republic Act 10742 Sangguniang Kabataan (SK) Reform Act of 2015 as well as its Implementing Rules and Regulations (IRR) provided for the creation of a committee for ASRH (IRR Sec. 8F). Specifically, the law mandated the functional engagement of Local Youth Development Council, and the allocation of funds for programs, projects and activities including ASRH and gender sensitivity. However, no SK election has been held since the law was enacted.

## Governance initiatives for ASRH implementation

Provinces and municipalities issued policies and developed programs in support of ASRH implementation at the local level. The Municipality of Rizal, for instance, passed a Resolution in 2016 establishing the Adolescent Health and Youth Development (AHYD) Office, with fund appropriation for the hiring of officers handling adolescent health programs, projects and activities. The establishment of AHYD Office resulted in the coordinated and concerted implementation of AHYD programs in Cainta. Eastern Samar initiated the profiling of youth in Borongan City. Dinagat Island entered into a Memorandum of Agreement to establish a provincial Youth Center.

## ASRH education and awareness-raising

### *Comprehensive sexuality education (CSE) in schools*

The RPRH Law mandated the development of an age- and development-appropriate curriculum on reproductive health and gender-based violence. In relation to this, the Department of Education (DepEd) needs to review the K-12 Curriculum and update the Comprehensive Sexuality Education (CSE) modules to satisfy the minimum standards developed by the panel of experts on CSE, and meet internationally recognized standards on CSE.<sup>22</sup>

DepEd has already updated its CSE modules and integrated them in the K-12 Curriculum. There are four identified subjects that already articulated the essentials of CSE standards, namely Science, Health, Araling Panlipunan and Edukasyon sa Pagpapakatao. However, there is need to capacitate teachers to provide CSE in accordance with the standards. As of end of 2016, none of the regions reported having schools with personnel trained on CSE. DO 10, s. 2016: “Policy and Guidelines for the Comprehensive Water, Sanitation and Hygiene in Schools (WinS) Program” is the closest policy that DepEd has in place relevant to ASRH promotion in schools. Its scope, however, is very limited as it is only concerned with improving students’ knowledge and understanding of effective hygiene, including menstrual hygiene among adolescents.

To accelerate the integration of RH in formal education, Senator Paolo Benigno Aquino IV filed Senate Resolution No. 169, “A resolution directing the Committee on Education, Arts and Culture to conduct an inquiry, in aid of legislation, on the status of the implementation of Reproductive Health education in schools”. Partylist 1-ANG EDUKASYON also filed House Bill 04231, “An Act incorporating lessons on teenage pregnancy prevention and population education in the curriculum of basic education in the Philippines and appropriating funds therefore.”

Regional line agencies have likewise enacted policies supporting the implementation of ASRH in schools. NEDA Region VI Resolution No. 54, S 2016 and DepEd III Regional Memo No. 171, S 2016 supported the conduct of Youth Development Sessions (YDS) in secondary schools, which aim to tackle sensitive issues such as teenage pregnancy, reproductive health, peer pressure, substance abuse and pornography. YDS forms part of the DSWD’s Family Development Session (FDS) module for *Pantawid Pamilya*.

### *IEC activities on ASRH*

The numerous ASRH campaigns and Information, Education and Communication (IEC) activities of POPCOM in 155 LGUs reached 260,300 adolescents. One of these activities is

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<sup>22</sup> UNESCO, Future of Sexuality Education - US, and WHO sexuality standards

the Youth-for-Youth (U4U) Initiative - a Youth Hub Initiative that delivers critical information to Filipino teens through the use of online and mobile platforms. As of September 2016, U4U teen trail reached a total of 4,607,117 young Filipinos nationwide since its launch in 2015.

Other activities such as the World Population Day, Festival of Talents and the Adolescent Health and Development National Film Festival reached grade school and high school students all over the country. Regional activities such as BunTeens/Buntis Congress, U4U and ASRH Forum were also carried out to reach vulnerable and disadvantaged adolescent groups (e.g. teen moms, those belonging to the LGBT community, persons with Disabilities, Indigenous People).



U4U hopes to reach more teens with the support of celebrity ambassador Miguel Tanfelix

To encourage adolescents to visit health facilities, Regions I and V invested Php1.44 million for the purchase of Teen/Adolescent Kits, which benefited 1,545 adolescents. Teen kits are intended to promote good personal hygiene and proper grooming. DOH Region V also purchased Php 1 million-worth of Buntis Kits that were provided to 2,000 adolescent mothers. These were expected to serve as entry points for prompting adolescents to access ASRH information and services in health facilities.

The CSOs conducted more than 590 IEC activities (in-school and municipal-wide fora and peer education sessions) nationwide, reaching 39,079 adolescents from the following regions: CAR, NCR, V, VI, VII, VIII, IX, X, XI and XII. They also produced and distributed more than 24,300 IEC materials that included brochures on puberty and RH as well as primer on the rights and benefits of adolescents under the RPRH Law. The latter was printed in four major dialects – Bicolano, Cebuano, English and Tagalog.

In addition, CSOs such as Likhaan spearheaded the conduct of a National Conference of Health Practitioners on ASRH to support advocacy efforts towards better service delivery. This conference was attended by more than 150 healthcare professionals from all over the country.



The ASRH National Conference held on November 28-29, 2016 carried the theme: "What is the right thing to do? Adopting a Human Rights and Ethics-based Approach in the Provision of ASRH Care"

## Expanding service provision

### *Adolescent-friendly health facilities*

Establishment of adolescent-friendly health facilities is an important strategy in making sure that the demand generated from various ASRH promotion and IEC activities is adequately met.

There are currently 32 hospitals nationwide that provide a comprehensive menu of obstetric, gynecological, pediatric, antenatal and postnatal care for child-mothers in hospitals. Development partners assisted in building their capacities to ensure adherence to DOH adolescent-friendly health service (AFHS) standards. As a result, nearly 6,000 pregnant teens were registered in these facilities where they were provided with FP counseling and services. In 2016, most teen mothers opted for long-acting reversible contraceptives (LARCs) such as IUD/PPIUD. Other FP methods chosen were oral contraceptive pills, injectable, condom, Lactation Amenorrhea Method (LAM), and fertility-based methods. Box 3A illustrates the experience of Brokenshire Memorial Hospital in providing ASRH services to adolescents, including pregnant teens.

There were 67 LGUs with operational adolescent-friendly facilities in 2016. A total of 107 local government health facilities were reported to comply with the DOH standards for AFHS. On the whole, these facilities have catered to 164,662 adolescents needing SRH services.

Teen Centers were established in different parts of the country to provide adolescents with SRH information and services. The three satellite Teen Centers established in Region VIII have provided information and services to adolescents in Biliran, Eastern Samar, Leyte, Northern Samar, Southern Leyte and Samar. Services in these facilities include responsible sexual behavior counseling, life-skills guidance and referral to adolescent-friendly health facilities.



Representatives from the government, private sector and CSOs participate in the Teen Center Standards Validation Workshop on September 21, 2016

The CSOs operated nine Teen Centers nationwide, which have provided services to 6,541 adolescent clients. DepEd likewise expressed interest in setting up a Teen Center in all public schools, necessitating the development of operational guidelines with POPCOM. The draft standards for Teen Centers was validated by various stakeholders in a workshop held in 2016

### *ASRH in SDN*

The establishment of an SDN for ASRH Information and Services aims to effectively link demand generation strategies to service provision mechanisms within a locality. Six regions were reported to have established an SDN for ASRH in 2016: CARAGA and Regions II, IV, V, XI and XII.

NEDA issued a resolution mandating LGUs in Region VI to establish an SDN for ASRH in their respective localities. This resolution provided the foundation for the establishment of SDN for ASRH in all provinces of Region VI, forging partnership agreements among LGUs, schools and health facilities for the provision of ASRH information and services.

#### **Box 3A. P4Teens, Flying High**

In response to the increasing trend of adolescent fertility rate, the Brokenshire Memorial Hospital (BMH), under the wing of Brokenshire Women's Center (BWC), developed the Program for Teens (P4Teens) in cooperation with Likhaan Foundation, Inc., USAID-MindanaoHealth, Davao City Health Office and DOH Regional Office XI.

A framework was established to ensure adolescents undergo a continuum of reproductive health care. There are three entry points through which the adolescent could come in contact with the program. Depending on the point of entry, the emergency room nurses, out-patient services nurses, BWC midwives, and resident physicians ensure proper risk assessment through HEEADSS, and guidance and counseling. Abused adolescents undergo the same process, with referral to the Southern Philippines Medical Center for further counseling and interventions.

P4Teens devised different approaches for demand generation. These include routine psychosocial risk assessment using the HEEADSS format; creation of a TeenHotline; referral and enrollment of adolescents to the P4Teens Program; TeenMom Maternal Care Package; routine Family Planning and Maternal Care Health counseling to teenage mothers who gave birth, prior to discharge; community outreach to school youths and teenage mothers; and, P4Teens promotion through the Davao City Adolescent Health Technical Working Group.

A total of 666 adolescents were given reproductive health services since its inception in 2015. There were 96 clients provided with FP commodities (23 with implants, 55 with OCPs, 12 with IUDs, and 6 with emergency contraceptive pills). Despite a working framework for the program, there are still challenges in conducting the series of interventions identified.

### *HPV vaccination*

Cervical cancer is the second leading cause of cancer deaths among women in the country. The DOH aimed to protect girls, especially those belonging to poor households, from this illness through its human papillomavirus (HPV) vaccination campaign. In 2016,



the campaign provided first dose of HPV vaccine to 292,482 girls (81 percent) and second dose to 246,313 girls (68 percent) of the total target in priority provinces (see Table 3b).

**Table 3b. HPV vaccination in 20 priority provinces, 2016**

Region	Priority Province	No. of girls vaccinated - HPV 1st dose	1st dose vaccine coverage (in %)	No. of girls vaccinated - HPV 2nd dose (a)	2nd dose vaccine coverage (in (b))
<b>Total</b>		<b>292,480</b>	<b>81</b>	<b>246,313</b>	<b>68</b>
CAR	Apayao	1,255	100	1,109	88
CAR	Ifugao	1,471	61	879	36
1	Pangasinan	29,848	100	27,876	94
4A	Quezon	16,364	71	12,378	54
5	Camarines Sur	24,407	89	22,989	83
5	Masbate	12,672	100	10,100	80
6	Iloilo	29,325	88	28,844	87
6	Negros Occidental	28,190	77	25,863	71
7	Negros Oriental	13,702	92	11,997	81
7	Cebu	32,160	70	23,686	51
8	Northern Samar	9,631	100	7,811	81
8	Eastern Samar	7,335	100	6,105	83
8	Leyte	18,527	81	15,786	69
9	Zamboanga del Sur	15,141	78	11,976	61
11	Davao Oriental	6,311	100	5,237	83
12	Sarangani	5,568	84	4,643	70
12	North Cotabato	15,269	85	12,438	69
ARMM	Lanao del Sur	7,699	97	4,267	54
ARMM	Maguindanao	11,071	69	8,731	55
ARMM	Sulu	6,534	31	3,598	17

Source: DOH

### Capacity building activities

The regional line agencies and LGUs conducted numerous trainings for health service providers to effectively provide ASRH services. The DOH used the Adolescent Job Aid (AJA) as the primary reference guide for training health service providers. It has also initiated training health providers on Adolescent Health Education & Practical Training (ADEPT), an e-learning toolkit that aims to improve adolescent healthcare by bridging the communication gap between adolescents and healthcare providers.



Thirteen regions reported having LGUs with health service providers trained on ASRH, with Bicol Region reporting the most number of LGUs with trained providers, followed by CARAGA and Region IVA.

CSOs have also extended support for ASRH capacity building activities across nine regions in the country within specific provincial and municipal project sites. Through the combined CSO support, a total of 339 health service providers were trained on ASRH, apart from the conduct of 74 peer education trainings. CSOs that provided capacity building support to ASRH are the Family Planning Organization of the Philippines (FPOP), the Forum for Family Planning and Development (FORUM), Roots of Health, Likhaan Center for Women's Health, and the Center for Health Solutions and Innovations (CHSI). The Learning Package on Parent Education on Adolescent Health and Development (LLPED) stimulated an environment for parents to gain skills in engaging their adolescents and addressing their health and development concerns. Likewise, guidance counselors were also trained on mentoring and coaching.

The Sexually Healthy and Personally Effective (SHAPE) Adolescents training package used by POPCOM for training adolescents and youth were updated in 2016 to make them more responsive to the needs of today's Filipino adolescents. The package aims to disseminate accurate, appropriate and vital information on various concerns affecting the youth.

Adolescents were also trained as peer educators. There are currently 15 regions with reported trained peer educators in the LGUs. On the other hand, nine out of 17 regions have trained peer educators in schools. Trainings on peer education include Teen Chat Facilitator trainings, SPEED (Support-Promote-Empower-Engage-Development) for Youth, Youth Advocates Training, and Life Skills Encampment Training for Out-of-School Youth.

## Challenges and Recommendations

### Increasing teen pregnancies

The number of teenage pregnancies continues to rise in the Philippines. This can be explained by the lack of information on the risk associated with the early pregnancies as well as limited access to services for adolescents. The lack of information and limited access to services may be due to the following:

- **Ineffectiveness of IEC and awareness-raising campaigns in raising demand for ASRH services.** Despite the various health promotion and IEC activities, only a few adolescents access ASRH information and services. The relatively high percentage of deliveries by teenage mothers also indicates limited knowledge of the risks associated with early pregnancy.

**Recommendations:** The DOH may spearhead the review of existing communications plan and IEC activities on ASRH, followed by the development of a more strategic and targeted communications strategy aimed at improving adolescent knowledge, attitudes and practices on SRH. In addition, the availability and functionality of adolescent-friendly facilities with ASRH-trained service providers should be ensured.

- **Inability of minors to access family planning services without parental consent.** The required parental consent for minor adolescents is seen as a major barrier for the provision of health services to minors, particularly for modern contraceptives and HIV testing. This seriously hampers reproductive services provision among adolescents.

**Recommendations:** Mechanisms – whether legal or operational, should be put in place to ensure that while parental involvement is encouraged, minors are still entitled to specific RPRH services even without parental consent. This may be crafted within the context of providing standard ASRH services. Research and evidence should be able to provide technical justification for this proposal.

- **Non-reimbursement of MCP for adolescents who gave birth in non-hospital birthing facilities.** PhilHealth guidance on MCP mentions that all deliveries to teenage mothers should be done in Hospitals. Therefore, teenage mothers who gave birth in RHUs or birthing facilities are not entitled to reimbursements. This becomes an issue for some rural areas and GIDAs where access to hospitals is limited. It may prompt teenage mothers to just deliver at home where the risks maybe higher.

**Recommendations:** A review of the PhilHealth Maternity Care Package and Women About to Give Birth circulars, to possibly cover reimbursements of deliveries to teenage mothers in a non-hospital birthing facility with skilled birth attendants should be done.

- **Delay in the adoption and integration of CSE in K-12 curriculum.** Despite the RPRH law, CSE is not yet being taught in schools. It causes the country to miss on the important opportunity to provide the youth with non-judgmental and scientifically accurate SRH information while in school.

**Recommendations:** The Department of Education should accelerate efforts to integrate the updated CSE in the K-12 Curriculum. Teachers should be trained on CSE in 2017 to ensure provision of ASRH education consistent with international standards by 2018.

- **Lack of operational guidelines to guide the provision of ASRH.** There are unclear guidelines on the provision of ASRH services despite the existing AO on Adolescent Health and Development. There is a lack of a unified/ coordinated ASRH program strategy geared towards the reduction of teen pregnancies. Likewise, there is also an absence of a regular reporting mechanism for adolescent service provision in DOH. Moreover, efforts on demand generation do not fully translate to actual ASRH services.

**Recommendations:** The DOH should issue operational guidelines, with a unified demand generation strategy, that will harmonize the programs and activities of government agencies, development partners, and CSOs. Likewise, it is necessary to develop a suitable strategy for addressing the special needs of vulnerable adolescent groups.

## KRA 4: STI/HIV/AIDS

### Status and trends

Overall prevalence of HIV in the general population remains below 1 percent. However, prevalence among key affected populations is increasing as reported in the 2015 Integrated HIV Behavioral and Serological Surveillance (IHBSS). Specifically for men who have sex with men (MSMs), the prevalence of HIV breached the 5 percent<sup>23</sup> threshold in the following cities: Quezon City (11 percent), Cebu City (10.5 percent), Manila (6.3 percent) and Caloocan City (5.5 percent).

In terms of actual cases, data from the HIV/AIDS and Antiretroviral Therapy (ART) Registry of the Philippines (HARP) show that 9,264 newly diagnosed HIV cases were reported from January to December 2016. This translates to an average of 26 newly diagnosed cases per day. The total number of cases in 2016 is 18 percent higher than those reported in 2015. This brings the cumulative number of HIV cases reported in the Philippines to 39,622 since January 1984.

<sup>23</sup> A concentrated HIV epidemic is defined by UNAIDS with the following thresholds: an HIV prevalence rate of less than 1% in the general population, but more 5% in at least one high-risk subpopulation (i.e., MSM, injecting drug users, commercial sex workers, or clients of commercial sex workers)

**Table 4a. Demographics of diagnosed HIV cases- Philippines, 2016**

Demographic Data	Jan-Dec 2016	Cumulative (Jan 1984-Dec 2016)
Total Reported Cases	9,264	39,622
Asymptomatic Cases	8,151	35,957
AIDS Cases	1,113	3,665
Male	8,874	36,801*
Female	390	2,810 **
Age Range (Median)	1-75 (28)	1-82 (28)
Less than 15 years old	22	111
15 to 24 years old	2,625	10,720
25 to 34 years old	4,921	20,386
35 to 49 years old	1,510	7,240
50 years old and above	186	1,091
Pregnant WLHIV	63	
Newly started on ART	6,438	
Total PLHIV on ART		17,940
Reported Deaths	439	1969

\* No data available on sex for 11 cases

\*\* No data available on age for 74 cases

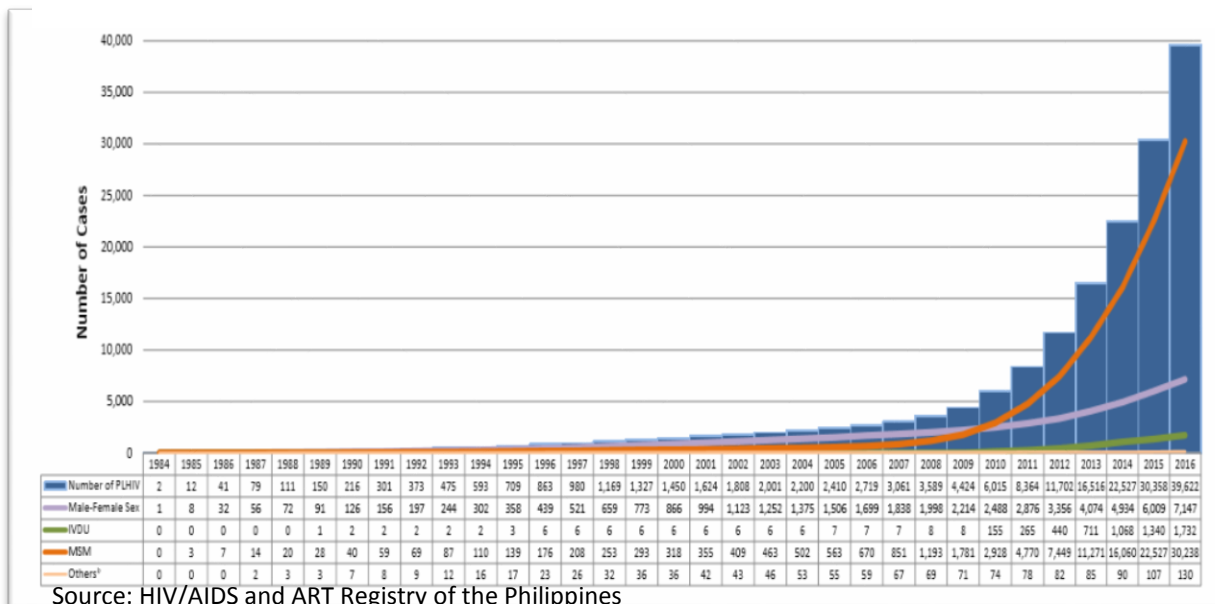
Source: HIV/AIDS and ART Registry of the Philippines

Among the new cases in 2016, 96 percent were transmitted through sexual contact. Eighty-seven percent of sexually transmitted cases were among MSMs <sup>24</sup>, while thirteen percent were transmitted through male-female sex. Around 0.2 percent of the new HIV cases were from mother-to-child transmission, and around four percent were transmitted through sharing of infected needles among people who inject drugs (PWID).

<sup>24</sup> MSM includes male-male sex and sex with both males and females

Figure 4a shows the cumulative number of HIV cases by mode of transmission from 1984 to 2016. The predominant mode of transmission has shifted from male-female sex from 1984 to 2009, to male-male sex from 2010 up to the present. HIV transmission through sharing of infected needles started to rise in 2010, which has become a potential threat for transmission to female partners of male PWIDs, and mother-to-child transmission.

**Figure 4b. Cumulative mode of HIV transmission by year (Jan 1984-Dec 2016)**



Source: HIV/AIDS and ART Registry of the Philippines

Note: N=39,622

Among the new cases in 2016, the regions with the most number of cases were NCR with 40 percent of the cases, Region 4A with 15 percent of the cases, Region 7 with 10 percent of the cases, Region 3 with 9 percent of the cases, and Region 11, with 6 percent of the cases. Nineteen percent came from the rest of the country, while 3 percent had no data on region. The predominant mode of transmission varied per region, with 48 percent of the MSM cases ever reported coming from NCR; almost all of the PWID from Region 7; and 41 percent of females who engaged in transactional sex from Region 3.

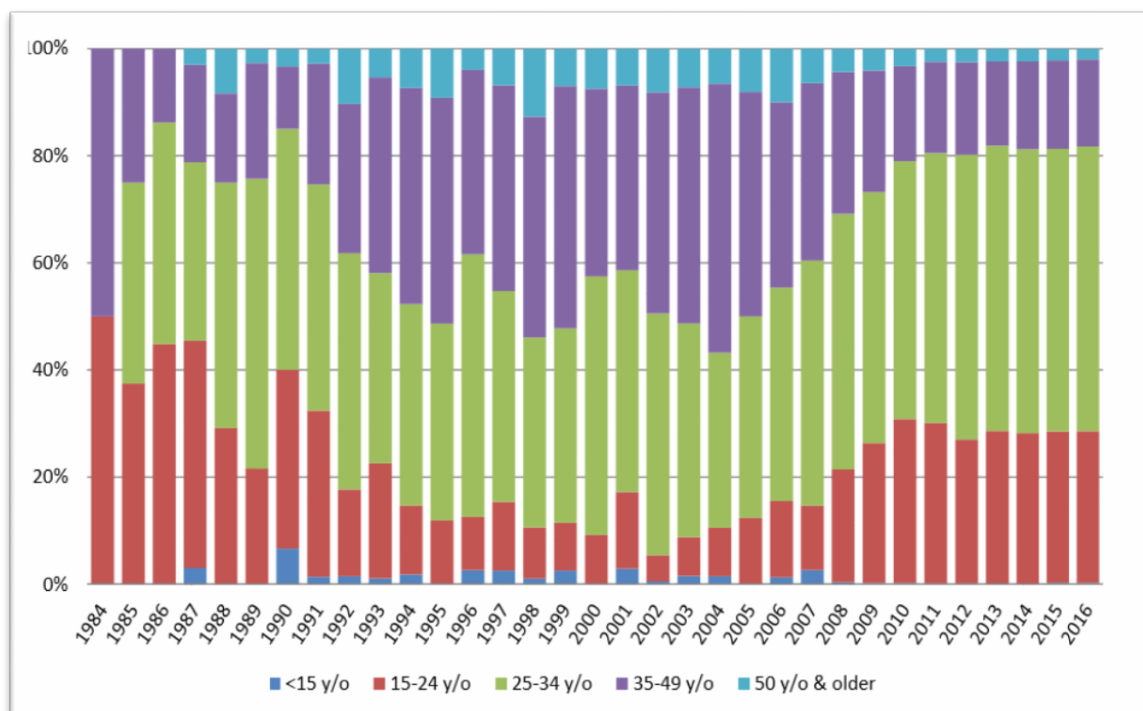
While males comprise majority of reported cases, the absolute number of cases among females has also been increasing. Among pregnant women, 63 were reported to have HIV in 2016. Twenty three children (0 to 10 years old) were diagnosed to be infected with HIV through mother-to-child-transmission. Such cases are more likely to increase if female patients are not linked to HIV care.

The age group with the highest proportion of cases has become younger (see Figure 4b: Distribution of HIV Cases by Age Group, January 1984 to December 2016). From 2001 to 2005, cases were mostly in the 35 to 49 age group. Starting from 2006, the proportion shifted to the 25 to 34 age group.

The proportion of HIV cases in the 15-24 year age group has increased from 25 percent in 2006-2010 to 28 percent in 2011 to 2016. Most cases in 2016 in this age group were sexually transmitted (98 percent); predominantly MSM (58 percent male-male sex; 30 percent sex with both males and females), with male-female sex comprising 10 percent of cases. Two percent of cases were transmitted by sharing of infected needles.

In 2016, 381 adolescents (10-19 years) were reported to have HIV, mostly infected through sexual contact (99 percent). This is consistent with the findings from the 2015 Integrated HIV Behavioral and Serologic Surveillance (IHBSS) where it was reported that those key affected populations start engaging in high-risk behaviors during their adolescent years. Among adolescents, there is a two to three- year gap between the start of high-risk behavior and initiation of protective factors, such as condom use. Findings show that a longer gap between first sex and first condom use, not only increases the risk of exposure to HIV, but also the decreases the likelihood of eventual condom use.<sup>25</sup>

**Figure 4c Distribution of HIV Cases by Age Group, January 1984 to December 2016<sup>26</sup>**



Source: HIV/AIDS and ART Registry of the Philippines

The following put adolescents at a higher risk: (1) gateway behaviors such as drinking alcoholic beverages and taking recreational drugs; (2) low condom use rates (35 percent of M/TSM during last anal sex; 11 percent of M/TSM during three most recent partners;

<sup>25</sup> The Growing HIV Epidemic among Adolescents in the Philippines. DOH Epidemiology Bureau, 2016.

<sup>26</sup> Figure from HARP December 2016

15 to 17 percent among PWIDs in past 12 months; 65 percent among FSWs); (3) low knowledge on HIV prevention and transmission (32 percent among M/TSM and 14 percent among FSW); (4) inadequate access to HIV prevention/services (only 37 percent of M/TSM believed that condoms are easy to get in the community, and only 46 percent had access to condoms, either from SHC or PE, friends, bought, or other sources); and (5) low testing rates (significantly lower among 15 to 17 year olds than other age groups; need for parental consent for this age group).<sup>27</sup>

A total of 439 deaths among people with HIV, were reported in 2016. Most (95 percent) were male, and more than half (53 percent) belonged to the 25 to 34 age group.

**Table 4b. Demographic data of reported deaths among PLHIV, 2016**

<b>Demographic data</b>	<b>Deaths in 2016 (January to December)</b>
Total reported Deaths	439
Male	415
Female	24
Less than 15 years old	2
15 to 24 years old	88
25 to 34 years old	235
35 to 49 years old	96
50 years old and above	18

Source: HIV/AIDS and ART Registry of the Philippines

In 2016, 550 blood units were confirmed positive for HIV by the Research Institute for Tropical Medicine (RITM). These units were discarded after initial screening at the blood banks and sent to RITM for confirmation. None of these blood units were transfused.

## **Interventions**

### **Commodities Procured**

Commodities procured in 2016 amounted to PhP 477 million. These include antiretroviral drugs, drugs for STIs and opportunistic infections, HIV test kits and laboratory supplies, syphilis test kits, CD4 testing kits, condoms, and water-based lubricants.

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<sup>27</sup> Ibid.

## Capacity Building

The DOH conducted various capacity building activities on STI and HIV/AIDS in 2016, which were largely targeted towards the following: (1) direct health service providers, (2) youth peer educators and counselors, (3) LGU officials and staff, and other stakeholders.

Training on HIV counseling and testing was done across regions, with a total of 917 health care providers trained. Training on Provider-Initiated Counseling and Testing (PICT) was also conducted for 441 TB Directly Observed Treatment, Short Course (DOTS)/Programmatic Management of Drug-resistant (PMDT) Health Care Providers nationwide.

## Information Dissemination/ Demand Generation Campaigns

Demand generation activities include nationwide advocacy campaigns for HIV awareness and voluntary counseling and testing. These include the celebration of the Philippine AIDS Candlelight Memorial and World AIDS Day Celebration, led by the DOH, Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Health Organization (WHO), LGUs, and CSOs. These events featured advocacy talks, interactive events to disseminate information, and the conduct of HIV testing campaigns.

Other demand generation activities conducted include LGBT and HIV beauty pageants, initiated by CSOs in partnership with the DOH, Research Institute for Tropical Medicine (RITM), and different Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and Intersex (LGBTQI) and HIV/AIDS organizations. Participating organizations were engaged to create their own HIV/AIDS programs, which included HIV education and awareness talks, HIV screening, peer counseling, and HIV/AIDS events and activities.

Regional, local, and CSO initiatives also targeted most-at-risk populations through the conduct of regional HIV summits, peer education programs, and “LGBT Community Fora,” promoting HIV awareness and condom use.

Online campaigns were also undertaken by the DOH and CSOs. For example, social photo media contests were organized to raise HIV awareness. DOH and partner CSOs were able to reach a wide audience through their social media accounts.

Activities directed for adolescent and youth reproductive health, such as Youth Camp, and U4U, have also integrated STI prevention/awareness, and targeted most-at-risk youths.

The DepEd and the Commission on Higher Education have been working with the DOH to finalize the curriculum for Comprehensive Sexuality Education, which will include



information on methods of prevention of sexually transmitted infections through condom use.

CSOs have been providing technical assistance in the drafting of other local HIV/AIDS ordinances, (i.e., creation of local AIDS Council) in Region IVB (Palawan), Region V (Tiwi, Albay), and Region VI (Iloilo).

### Screening/Testing Services

Free and confidential HIV testing, and STI diagnosis and treatment are offered in Social Hygiene Clinics (SHCs) run by LGUs and treatment hubs nationwide. Further, provider-initiated HIV counseling and testing (PICT) was made available and was offered in facilities including TB-DOTS for TB patients in HIV high burden areas, TB treatment centers and satellite treatment centers for Drug-Resistant TB patients, antenatal care facilities for all pregnant women in NCR and Cebu, and other government and private hospitals and private clinics.

Also, community-based organizations and other CSOs provide prevention activities and link their clients for HIV counseling and testing, and other HIV and STI services to the SHC. Blood service facilities that identify potential blood donors who have HIV risk are referred to HIV counseling and testing facilities.

Community-based screening was also undertaken by DOH, in partnership with CSOs. An example of such an initiative by The Project Red Ribbon focused on four programs: 1) LGBTI Community, which conducted training for partner bars/organizations in Baguio and Cebu City; 2) company partnership program, wherein the CSO partnered with a leading Business Process Outsourcing (BPO) to implement community-based screening in more than 17 sites nationwide, and trained in-house nurses for basic HIV information, screening, reporting, and referral; 3) LGU Partnership Program, which capacitated barangay health workers to conduct house-to-house visits and barangay mapping for HIV screening; 4) faith-based partnership program, wherein screening was conducted among the constituents of the National Council of Churches and its partner churches. Those who turned out to be reactive were linked to care and subsequently started on antiretroviral therapy.

In addition, the DOH is currently studying the feasibility of adopting HIV self-testing as a strategy for improving testing rates and preventing treatment delays. Considerations being weighed however, include logistical constraints and the lack of service of counselors who could help those who test positive for the disease.

To address legal barriers to voluntary HIV testing for minors at least 15 years old in the absence of parental consent, several bills were filed to amend the Philippine AIDS Prevention and Control Act of 1998 (RA 8504). These bills however, were not passed in

the 16th Congress. Under the 17<sup>th</sup> Congress, several bills were again filed to amend this law.

### **Prevention of Mother-to-Child Transmission**

DOH also issued A.O. 2016-0035: Guidelines on the Provision of Quality Antenatal Care in All Birthing Centers and Health Facilities Providing Maternity Case Services, which provides for an opt-out system, or a health worker-initiated HIV counseling and testing for pregnant women. This aims to make ANC as a key entry point for prevention of mother-to-child transmission of HIV (PMTCT) services. Implementation arrangements however, are still under discussion among stakeholders.

Meanwhile, the DOH is still updating A.O. 2009-0016: “Policies and Guidelines on the Prevention of Mother to Child Transmission (PMTCT) of Human Immunodeficiency Virus (HIV).”

### **Preventive/ Treatment Services**

Condom promotion/distribution has been undertaken by DOH in partnership with several CSOs nationwide.

CSOs such as CHSI, FPOP, TRR, Ugat ng Kalusugan, FriendlyCare, and Likhaan have been providing condoms and lubricants, as well as services such as HIV counseling/testing/referral, STI detection and management in their clinics and project areas.

#### **Box 4a. Integrated SRH and HIV services in AngelesCity**

A pilot project using an integrated HIV and Sexual/Reproductive Health (SRH) model was implemented by the City Government of Angeles, in collaboration with the Center for Health Solutions and Innovations (CHSI), and UNFPA.

Specifically, the project catered to entertainment workers (EWs), and provided them with reproductive health information and services such as HIV, family planning and gender-based violence. Moreover, EWs were tapped as peer educators to monitor and follow up on information and FP services accessed by fellow EWs. Through this project, 35 Learning Group Sessions (LGS) were conducted in different establishments, raising awareness on HIV/STI, FP and gender-based violence.

A total of 12 peer educators, named Angeles Angels, were trained to monitor FP practices, condom use, gender-based violence, and HIV testing, using a Peer Educator Monitoring Journal.

As a result of the above interventions, EWs were reported to have increased awareness of rights; with 4,305 EWs reached by LGS and HIV information, 13% increase in new FP acceptors, and improved reporting of gender-based violence.

Challenges noted in implementation of the project include, high turnover rate among peer educators, and need for follow-up services for the EWs.

In 2016, the DOH issued Department Circular 2016-0171: Enhancing Linkage to Care of People Living with HIV (PLHIV). It aims to ensure linkage to care of clients with reactive HIV screening test, providing an interim solution to the long turn-around time of confirmatory HIV testing, which was previously identified as a barrier to prompt referral and management. The guidelines provide for immediate assessment of clients with reactive HIV screening test, and linkage to treatment hubs, satellite treatment hubs, and HIV primary care clinics for early treatment and management. This is facilitated by the rollout of the rHIVda (Rapid HIV Diagnostic Algorithm).

**Table 4c. HIV treatment hubs in the Philippines**

Region	DOH-Designated Treatment Hubs
CAR	Baguio General Hospital and Medical Center
I	Ilocos Training and Regional Medical Center
II	Cagayan Valley Medical Center
III	Bataan General Hospital (Bataan HAVEN) Jose B. Lingad Memorial Regional Hospital/ Bahay Lingad James L. Gordon Memorial Hospital/L.E.A.D. Shelter Premiere Medical Center (TAHANAN sa Premiere)
NCR	Philippine General Hospital Research Institute for Tropical Medicine San Lazaro Hospital Makati Medical Center The Medical City/ I-REACT Clinic
IV-A	Batangas Medical Center Laguna Medical Center
IV-B	Ospital ng Palawan
V	Bicol Regional Training and teaching Hospital
VI	Western Visayas Medical Center
NIR	Corazon Locsin Montelibano Memorial Regional Hospital
VII	Vicente Sotto Memorial Medical Center Gov. Celestino Gallares Memorial Regional Hospital
VIII	Eastern Visayas Regional Medical Center
IX	Zamboanga City Medical Center
X	Northern Mindanao Medical Center
XI	Southern Philippines Medical Center
XIII	Butuan Medical Center CARAGA Regional Hospital

**Table 4c. HIV treatment hubs in the Philippines (continued)**

Region	DOH-Designated Treatment Hubs
<b>DOH-Designated Satellite Treatment Hubs</b>	
II	Veterans Regional Hospital
III	Ospital ng Lungsod ng San Jose del Monte Angeles City HIV Satellite Treatment Hub (“Bale Angeleno”)
IVA	Damarinas City Health Office I (SHC)
VI	Dr. Rafael Tumbokon Memorial Hospital- Kalibo, Aklan
VII	Cebu Social Hygiene Clinic
XII	General Santos City Social Hygiene Clinic
NCR	Pasig Treatment Hub (PATH) Klinika Bernardo Manila Social Hygiene Clinic Marikina City Satellite Treatment Hub

Source: HIV/AIDS and ART Registry of the Philippines

Of the 39,622 diagnosed with HIV, 17,940 are currently alive and accessing ART in the 40 treatment hubs and satellites in the country while 6,438 PLHIV were newly started on ART in 2016.

HIV clinical management including in-patient services are accessed by PLHIV at 26 treatment hubs strategically situated across the country (see Table 4c). Of these treatment hubs, four were established in 2016 (Bataan HAVEN- Bataan General Hospital and TAHANAN sa Premiere- Premiere Medical Center in Region III; Batangas Medical Center and Laguna Medical Center in Region IVA).

Antiretroviral drugs and other care and support services for PLHIV can be accessed at 40 treatment hubs and satellite treatment hubs across the country (see Tables 4c and 4d):

**Table 4d. Other facilities providing HIV care in the Philippines**

Regions	Facility
3	Tarlac Provincial Hospital
4A	Antipolo Social Hygiene Clinic Bacoor Social Hygiene Clinic
NCR	Bernardo Social Hygiene Clinic Klinika Project 7 Las Pinas Social Hygiene Clinic Mandaluyong Social Hygiene Clinic Muntinlupa Social Hygiene Clinic Pasig Social Hygiene Clinic RITM Satellite Clinic- Mandaluyong (Love Yourself Anglo) Taguig Social Hygiene Clinic Valenzuela Social Hygiene Clinic
11	Davao Reproductive Health and Wellness Center
12	South Cotabato Provincial Hospital

Source: HIV/AIDS and ART Registry of the Philippines

Satellite treatment hubs include SHCs that have been capacitated to provide HIV primary health care for PLHIV. These function as one-stop shop for HIV prevention, treatment, care and support services and provide for decentralized outpatient clinical management, including ART.

However, field reports indicate challenges in ensuring adherence to ART among PLHIV. On the side of the patients, these include difficulties in returning for scheduled follow-up consultations, and avoidance of facilities close to where they live, for fear of discrimination and stigmatization in the community. Hence, the program has ensured availability of supplies and confidentiality of clients in decentralized treatment centers that are accessible to clients.

Meanwhile, PhilHealth is conducting a review of the Outpatient HIV/AIDS Treatment (OHAT) benefit package, to expand the coverage of certain laboratory tests.

### **Psychosocial and Welfare Assistance**

Provision of welfare benefits have been provided by the DSWD, in partnership with CSOs. For example, indigent PLHIV have been provided medical and financial assistance (PhP 5,000 per client), livelihood assistance (PhP 10,000 per client), educational assistance (PhP 5,000 per semester per client), and burial assistance. CSOs have also been referring clients to the DSWD LGU to avail of the PWD ID, which provide discount benefits in hospitals, pharmacies, and establishments nationwide. Indigent clients were also provided assistance in obtaining blood units. Other forms of assistance included provision

of temporary shelter, food allowances, transportation to and from treatment hubs, or allowance while looking for jobs. Enrollment of indigent PLHIV has also been facilitated, which enables them to avail of the OHAT package. The Duyan Program is also a CSO initiative which provides assistance for medical needs of children with HIV.

Psychosocial counseling services were also provided to PHLIV by the DSWD, and in partnership with CSOs. These were in the form of support group talks, direct one-on-one counseling, online and phone counseling, and family counseling. Health and fitness programs and vocational/skill training were also conducted.

## Challenges and Recommendations

### Increasing HIV prevalence among key affected populations, especially the young

- **Presence of social barriers to access.** While HIV prevalence remains low in the general population, it is increasing among key affected populations especially among the young. This may be partly due to social barriers to service access such as stigma and discrimination.

**Recommendations:** There is a need to intensify awareness campaigns among the general population, and in areas with high concentration of cases, and among most-at-risk populations. Access to condoms also needs to be improved by removing stigma, correcting misconceptions and identifying preferred/convenient channels for condom access.

- **Limited access of adolescents to HIV/STI information and services.** The young population's inadequate knowledge of HIV/STI and limited access to services maybe due to lack of a CSE module in schools, lack of youth-friendly treatment centers, and laws prohibiting condom access and testing services to minors in the absence of parental consent.

**Recommendations:** To address this issue, it is recommended that age-appropriate reproductive health education and information campaigns for HIV/STI prevention be strengthened. Such efforts should also be able to reach out-of-school youth. Moreover, there is a need to lobby for the passage of amendments to the AIDS Law to allow minors to undergo voluntary testing even without parental consent. Legal barriers restricting access of minors to condoms in public health facilities (in the absence of parental consent) should be addressed.

- **Incomplete data to measure HIV burden and understand transmission dynamics.** There is difficulty identifying those infected in sub/populations who prefer to be

hidden due to stigma, discrimination and punitive laws, or in populations who are not concentrated in specific areas. Data on the HIV burden is limited to the HIV registry and the IHBSS which is done only in selected sites. There are few studies assessing the effectiveness of specific interventions for improving access to preventive, diagnostic, and treatment services among key affected populations.

**Recommendations:** In response to these issues, the scope of IHBSS may be expanded to include other sites. Funds may also be allocated for the conduct of studies/operations research to establish evidence on the effectiveness of specific interventions (e.g. HIV self-testing, condom provision through existing channels, creation of KAP-friendly facilities and harm reduction strategy for PWID) and amend relevant laws and policies as needed.



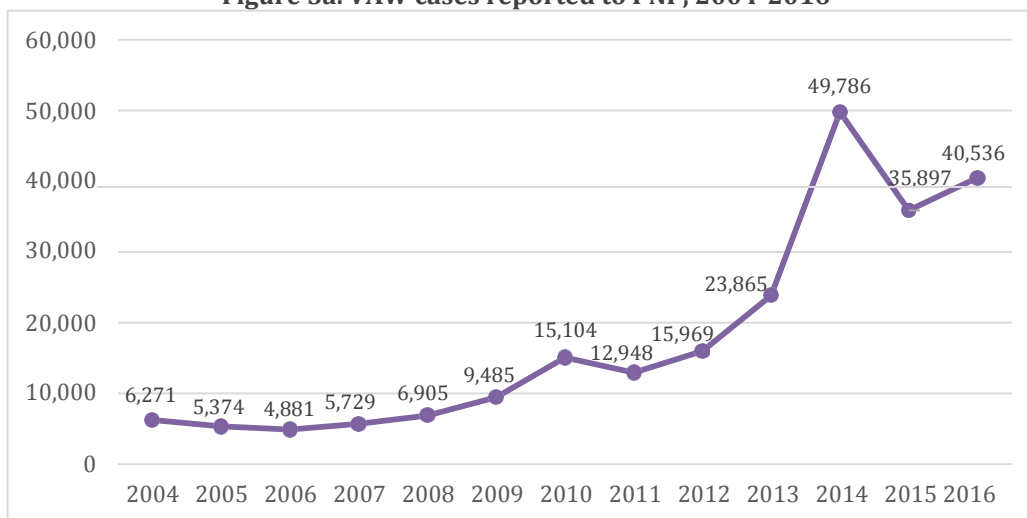
# KRA 5: Elimination of Violence Against Women and Children

## Status and trends

The Philippines has made great strides in narrowing the gap between women and men. It ranked seventh among 144 countries in the Global Gender Gap Report 2016 by the World Economic Forum. The annual report looks at progress towards equality between men and women in four key areas: educational attainment, health and survival, economic participation and opportunity, and political empowerment. Although the country has fully closed its gender gap in educational attainment, and health and survival, violence against women sub-indices continue to be a problem.

The number of VAW cases seen by the Philippine National Police (PNP) has been increasing since 2004 but had a steep decline in 2015 and a slight uptake in 2016. The trend, however, is not conclusive of an increasing or decreasing VAW incidence in the country because the data are based only on the cases reported to PNP, which include rape, violence against women and their children (VAWC), acts of lasciviousness, and anti-sexual harassment among others.

Figure 5a. VAW cases reported to PNP, 2004-2016

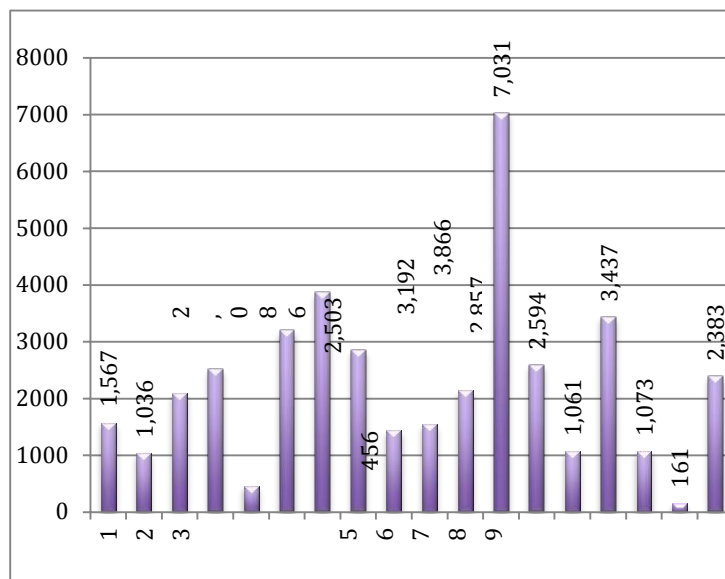


Source: PNP

Among the different regions, Region XI posted the highest reported VAW cases in 2016 with 7,031 cases, which is 59 percent higher than the reported cases last year. This accounts for 17.3 percent of the total 40,536 reported VAW cases nationwide for the same period. It is followed by Region VI (3,866 cases), Negros Island Region (3,437 cases)

and Region V (3,192 cases). ARMM posted the lowest reported VAW with 161 cases, which comprises only 0.4 percent of the total reported cases in the country.

**Figure 5b. Reported VAW Cases to PNP by Region  
As of December 2016**

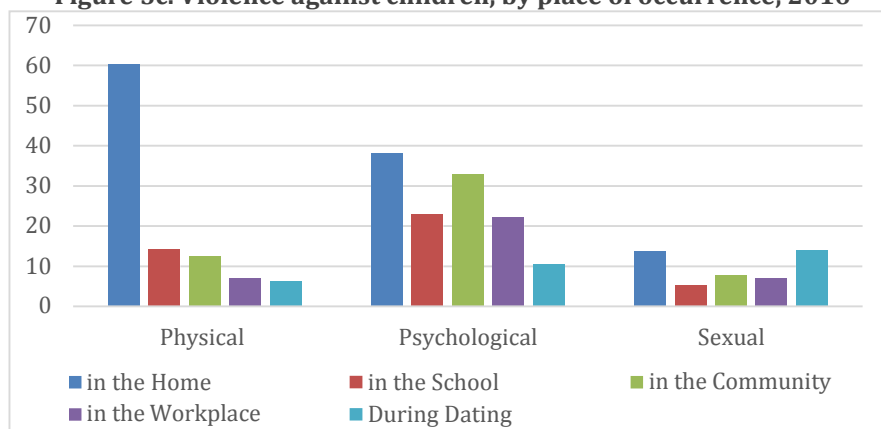


Source: PNP

These reported cases, however, do not truly capture the real picture of abuse in an area. High reported VAW cases may indicate effective awareness campaigns, well-established inter-agency response mechanisms and possibly, empowered women emboldened to break their silence and seek help from authority.

Children also experienced violence in one form or another. The National Baseline Study on Violence against Children (NBSVAC) published in 2016 by the UNICEF and the Council for the Welfare of Children (CWC) showed that nearly 79 percent of respondents aged 13 to less than 18 years have experienced violence in their lifetime, be it at home, in school or in the workplace. Violence is more prevalent among boys at 82 percent than among girls at 78 percent. About 3 in 5 respondents experienced physical abuse, psychological abuse or bullying, and 1 in 5 experienced sexual violence.

**Figure 5c. Violence against children, by place of occurrence, 2016**



Source: NBSVAC 2016

Abuse – be it physical, psychological or sexual, frequently occurs at home (see Fig. 5c). Next to home, physical abuse is most likely to happen in school, psychological abuse in the community, and sexual abuse during dating.

There were 2,575 rape and 34,891 violence against women and children (VAWC) cases reported in 2016. VAWC cases increased from 30,872 in 2015 to 34,891 in 2016 (see Table 5a). Physical abuse and psychological abuse were the most common forms of violence experienced by women and children in both years.

**Table 5a. Cases of violence against women and children, 2015 and 2016**

Case	Cases reported in 2015	Cases reported in 2016	Cases Filed in Court in
<b>Rape (RA 8353)</b>		<b>2,575</b>	<b>577 (22%)</b>
Consummated Rape		1897	443 (23%)
Incestuous Rape		127	23 (18%)
Attempted Rape		551	111 (20%)
<b>VAWC (RA 9262)</b>	<b>30,872</b>	<b>34,891</b>	<b>2,643 (8%)</b>
Physical Abuse	21,967	23,478	1,817 (8%)
Sexual Abuse	229	147	18 (12%)
Psychological Abuse	6,709	8,728	439 (5%)
Economic Abuse	1,967	2,466	369 (15%)

Source: PNP WCPC

A significant proportion of rape (78 percent) and VAWC (98 percent) cases were not filed in Court in 2016. Field reports revealed that many of the victims do not pursue court cases due to trauma, lack of social support and prolonged, costly judicial process.

The Department of Justice (DOJ) had an average disposition rate of 86 percent for the 25,848 cases of rape, human trafficking and VAW in 2016. Only half of rape and VAW

cases were decided by the Court but conviction rates were at 82 percent and 81 percent, respectively.

**Table 5b. Summary of VAW and related cases handled by DOJ, 2016**

Case	Rape	Trafficking in Persons	VAW
No. of carryover	1,646	132	3,809
No. of newly received	7,326	378	12,557
Total handled	8,972	510	16,366
Information filed in Court	7361	473	9821
Disposition rate (in %)	85	88	85
Decided cases (in %)	49	29	50
Success rate or Conviction (in %)	82	68	81

Source: DOH National Prosecution Service

## Interventions

The PCW spearheaded the development of “*Agenda ni Juana*”, which include: (a) improved access to justice by victims of abuse and violence, especially women belonging to vulnerable groups, (b) expanded access to affordable comprehensive women's health care and services, (c) improved convergence of efforts in building peaceful, safe and violence-free communities, and (d) institutionalized provision of women and child-friendly spaces in evacuation centers.

Related to agenda item (d), the Children’s Relief and Protection Act (R. A. 10821) was enacted in May, 2016 to protect the fundamental rights of children before, during, and after disasters and other emergency situations. The law mandates the implementation of a comprehensive program of action that provides children and pregnant/lactating women with support necessary for their immediate recovery and protection against all forms of violence, cruelty, discrimination, neglect, abuse, exploitation and other acts prejudicial to their interest, survival, development and well-being.

The DSWD initiated its Women Friendly Space (WFS) project in recognition of women’s need for private space especially during disasters where sexual violence, child trafficking and prostitution became unintended consequences of the lack of privacy in evacuation centers. The project includes orientation of men, including the police in WFS sites, on VAW, sexual exploitation, trafficking and gender-based violence (GBV).

In terms of LGU support, 56 of 81 provinces, 69 of 142 cities, and 578 of 1,489 municipalities in the country have passed their respective GAD Codes. A GAD Code is a local legislation that consolidates local ordinances related to women and gender equality, and guides LGUs in identifying local policies, plans and programs to address gender issues.

### Awareness-raising to prevent VAW

The PCW spearheaded the conduct of annual activities that help recognize and eliminate VAWC. The 18-Day Campaign to End VAW, which elevates VAW as an issue of national concern, reached 93,227 women and 32,606 men, according to field reports. PCW reported 2,953 attendees from NGAs, LGUs and CSOs during the launch of the campaign. Meanwhile, the National Women's Month Celebration which had the theme "*Kapakanan ni Juana, Isama sa Agenda!*" in 2016 resonated the call for gender-balance in leadership and decision making positions both in the public and private sector, the inclusion of women's concerns in the government's development agenda, and the capacitation of women and girls to reach their ambition.

Initiatives in the previous years encouraging male involvement in the prevention of VAWC were likewise continued in 2016: DSWD's "Empowerment and Reaffirmation of Paternal Abilities Training" (ERPAT) program as well as POPCOM's "Men's Responsibility in Gender and Development" (MR GAD) and "*Kalalakihang Tapat sa Responsibilidad at Obligasyon sa Pamilya*" (KATROPA). ERPAT seeks to improve the knowledge, attitude, and skills of fathers in performing their paternal roles and responsibilities. Similarly, MR GAD emphasizes the role of men in FP, shared parenting and in maintaining good family relations. KATROPA strengthens the role of men in the elimination of gender-based violence particularly at home. POPCOM reported a total of 816 men who participated in MR GAD and related programs, and 72,259 men who attended KATROPA orientations in 2016.

The CSOs also implemented various awareness campaigns that reached 2,220 women and 234 men. Part of such campaigns is the Men Opposed to Violence against Women Everywhere (MOVE), which consists of men who committed themselves to be actively involved in the elimination of VAW. Its members come from various organizations, including the government, private sector, academe and non-government organizations. MOVE organizes and capacitates men from all over the country who do not only detest VAW but are also willing to pro-actively work towards its eradication. MOVE groups were organized in Quezon Province, Aklan, Sultan Kudarat, Northern Samar and Southern Leyte. Similar groups were likewise formed by NAPOLCOM and DSWD.

### Capacitation of concerned providers

To enhance awareness and improve the capacity of its personnel toward gender-responsive handling of investigation and prosecution of gender-related cases, the DOJ conducted orientation-seminars and trainings on human rights and gender sensitivity. From 2012 to 2016, 384 male and 407 female justices and lawyers of the Supreme Court, Sandiganbayan, Court of Appeals, and lower courts, attended gender sensitivity trainings and seminars on the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW). In addition, 10,443 court interpreters, court social workers, clerks of

court, lawyers and aspirants to judicial posts attended seminars related to women and children's rights, and 3,898 judges, lawyers, prosecutors, personnel of the court and other government agencies, barangay officials, and CSO members participated in seminars on trafficking in persons.

The PNP also offered training programs for Women and Child Protection Center (WCPC) officers, NBI investigators and prosecutors. It trained 60 service responders of Patrol 117 in 2016 to ensure provision of gender-responsive services. CSOs also trained 107 service providers on the 4Rs (Recognizing, Reporting, Recording and Referring) of VAW and on other VAWC programs and modules including paralegal trainings.

The DSWD likewise conducted training of trainers on Comprehensive Intervention Against Gender-Based Violence (CIAGBV) and Women Friendly Spaces (WFS) for Luzon, Visayas and Mindanao. CIAGBV aims to enhance the capacities of personnel handling VAW cases through community-based gender awareness training, paralegal training, VAWC training, case-handling for barangay officials, and advocacy campaign.

There were 1,160 service providers (government and private sector doctors and mental health professionals, social workers and police officers) from 48 LGUs that were capacitated on 4Rs. In addition, 458 public and 28 private service providers from different LGUs were capacitated on other VAW programs and modules.

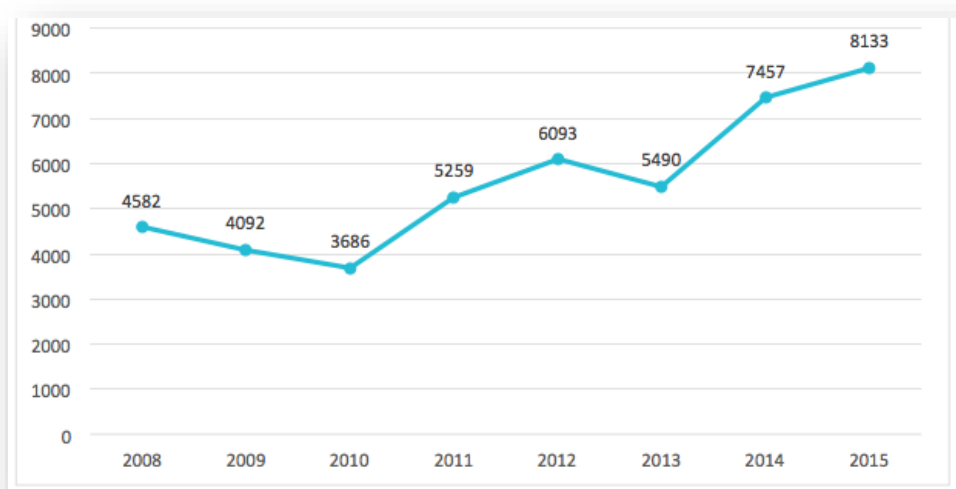
In addition to trainings, the Gender Ombud Guidelines developed by the Commission on Human Rights (CHR) in 2015 was published in 2016. The CHR was designated as the country's Gender Ombud under the Magna Carta of Women. The set of guidelines identifies the types of violations/complaints that may be investigated by the Commission, specifies the investigation protocol as well as the referral and monitoring system it needs to follow, and determines the activities it can undertake.

### **Provision of social protection services**

Victim-survivors of VAWC who need medical attention were referred to the Women and Children Protection Units (WCPUs) in health facilities. The WCPUs of 70 DOH-retained hospitals attended to 2,514 VAWC cases in 2016. The number only reflects the cases reported to the VAWC Registry System of the DOH, which was launched in 2016, and does not include the cases seen in LGU and private health facilities.

In the past years, there is a notable increase in the number of VAC cases served by WCPUs of hospitals throughout the country. The trend, however, is not conclusive of an increasing or decreasing VAC incidence because the data only captured clients who went to WCPUs for medical services, not the total number who experienced VAC.

**Figure 5d. Cases of violence against children served by WCPUs, 2008-2015**



Source: [Child Protection Network Foundation, 2015](#)

As of 2016, there are 84 WCPUs established in 48 provinces and 9 independent cities across the Philippines. While the DOH aims to have at least one WCPU per province, only 51 of the 81 provinces have public or private health facilities with a functional WCPU. Only 36 LGUs have Women and Children Protection Program as well as functional crisis intervention facilities or centers for VAW/GBV victim-survivors.

In addition to WCPUs, there are also barangay VAW desks to help address VAWC concerns at the community level. The Magna Carta of Women mandated the DILG to oversee the establishment of barangay VAW desks nationwide. Pursuant to the Joint Memorandum Circular of DILG, DSWD, DepEd, DOH and PCW, every barangay shall have a VAW desk. As of end of 2016, 37,042 (88 percent) of 42,036 barangays have established VAW desks<sup>28</sup>, which is above the 83 percent target for the year. All barangays in six regions (Regions I, II, VI, VII, VIII and XII) have established VAW desks. Laggards in this area (i.e. with less than 70 percent of barangays with VAW desks) are Regions IX, XI and ARMM, the latter being the lowest at 26.5 percent.

DSWD provides psychosocial and economic services to VAW victims including those with disabilities and victims of trafficking in persons, through its center-based and community-based facilities and its rape crisis centers. For 2016, DSWD reported four registered Social Welfare and Development Agencies (SWDAs) catering to women and children. There were also 23 registered and licensed, and 19 accredited SWDAs with programs and services catering to trafficked victims nationwide. In terms of rehabilitation of victim-survivors, 3,533 women benefited from center-based services and 329,185 from community-based services.

<sup>28</sup> DILG-National Barangay Operations Office, December 2016

**Table 5c. VAW Desks by region, as of end of 2016**

Region	Total Number of Barangays	With Established VAW Desks	%
CAR	1,176	1,014	86
NCR	1,706	1,493	88
I	3,265	3,265	100
II	2,311	2,311	100
III	3,102	2,315	75
IV-A	4,018	4,011	100
IV-B	1,459	1,369	94
V	3,471	2,890	83
VI	3,389	3,389	100
VII	2,446	2,446	100
VIII	4,390	4,390	100
IX	1,904	1,266	66
X	2,022	1,737	86
XI	1,162	804	69
XII	1,195	1,195	100
XIII	1,311	1,287	98
ARMM	2,490	660	27
NIR	1,219	1,202	99

Source: DILG National Barangay Operations Office

## Challenges and Recommendations

### Increasing incidence of VAWC cases

- **Legal limitations that inhibit the rights of women and children.** Certain laws such as the Family Health Code provision on legal separation, the Anti-Rape Law and other similar legislations need to be updated/expanded in scope to eliminate bias against women and advance women empowerment.



**Recommendations:** Since addressing these issues is beyond the scope of the health sector, it is recommended that PCW coordinate the filing of Women's Priority Legislative Agenda in the 17<sup>th</sup> Congress. These include the following: (a) Amendment of the Anti-Rape Law, (b) Expansion of the Anti-Sexual Harassment Law, (c) Amendment of the Family Code Re Grounds for Legal Separation, (d) Amendment of the Revised Penal Code by enacting the Anti-Prostitution Law, and (e) Divorce Law.

- **Unresolved/unaddressed rape and VAW cases.** While data already showed increasing incidence of VAWC, underreporting remains to be a problem given the reluctance of victims to report cases of abuse owing to trauma, drawn-out and costly litigation procedures, and lack of knowledge of available facilities (e.g. Barangay VAW Desks, WCPUs) that can help them deal with the case through provision of counseling, medical, social and referral services.

**Recommendations:** The problem may need a more aggressive intervention geared towards linking victims to a strong support system by strengthening the referral system and establishing a help line that will not only protect them but enable them as well to file and pursue the case in court.

# Financing

## National Government budget for RPRH

The National Government budget for RPRH programs amounted to over PhP 34 billion in 2016, based on DOH, POPCOM and PCW allocations. This is 66 percent higher than the PhP 20.47 billion RPRH budget of the previous year. The DOH remained to be the main source of funds with its total budget allocation of PhP 33.74 billion in 2016 comprising 99 percent of the national government budget for RPRH for the year.

**Table 6a. National government budget for RPRH**

Agency	2015 Budget Allocation (in Php)	2016 Budget Allocation (in Php)	Percent Change
<b>DOH</b>	<b>20.23</b>	<b>33.74</b>	<b>67%</b>
Family Health and Responsible Parenting (FHRP)	3.27	2.27	-31%
Expanded Program on Immunization (EPI)	3.34 <sup>29</sup>	3.99	19%
Health Facilities Enhancement Program (HFEP)	13.30	26.90	102%
National AIDS/STD Prevention and Control Program (NASPCP)	0.32	0.58	81%
<b>POPCOM</b>	<b>0.24</b>	<b>0.28</b>	<b>17%</b>
<b>PCW</b>	<b>0.003</b>	<b>0.003</b>	<b>0%</b>
<b>Total</b>	<b>20.47</b>	<b>34.02</b>	<b>66%</b>

Sources: DOH, POPCOM and PCW

Apart from the above budget, the DOH also appropriated PhP 120 million for the operation of the Philippine National AIDS Council, and PhP 3.6 million for Cancer Program, such as training on cervical cancer screening using visual inspection with acetic acid (VIA) wash in Regions I, IV-B, VI and IX.

<sup>29</sup> The 2<sup>nd</sup> RPRH Annual Report showed PhP 6.9 billion budget for EPI line item. This included allocation for Dengue vaccines amounting to PhP 3.56 billion.

The budget for the HFEP more than doubled from PhP11.2 billion in 2015 to PhP27 billion in 2016. The budget for the NASPCP likewise saw a big boost as it increased by 81 percent in 2016. For EPI, the budget also increased by 19%. But the budget for the FHRP declined by 31 percent partly due to the non-approval of the proposed budget for the procurement of contraceptives.

Table 6b shows an improved utilization rate in FHRP line item from 78 percent in 2015 to 83 percent in 2016. EPI line item also showed a good utilization rate at 98 percent in 2016 from 99 percent in 2015. On the other hand, HFEP line item showed decline of 21 percentage points in utilization rate (from 89 percent in 2015 to 68 percent in 2016). This was due to delay in the release of DBM Special Allotment Release Order (SARO) to the Department of Public Works and Highways (DPWH) to implement HFEP projects of the DOH. Likewise, the utilization rate in NASPCP line item decreased by 22 percentage points due to lower actual price of commodities procured in 2016 (i.e. ARV drugs, drugs for STDs, test kits, condoms, etc.) as compared to the estimated costs.

**Table 6b. Comparative utilization rate of DOH budget line items for RPRH in 2015 and 2016**

Line Item	2015 Utilization Rate (percentage)	2016 Utilization Rate (percentage)
<b>Family Health and Responsible Parenting (FHRP)</b>	78	83
<b>Expanded Program on Immunization (EPI)</b>	99	98
<b>Health Facilities Enhancement Program (HFEP).</b>	89	68
<b>*National AIDS/STD Prevention and Control Program (NASPCP)</b>	97	75

\* Under the Other Infectious and Emerging and Re-emerging Disease budget line item

POPCOM and PCW reported high budget utilization rates in 2016, with the former utilizing 99 percent of its PhP280 million budget for FP demand-generation and other RPRH-related activities while the latter utilizing 89 percent of its PhP3.23 million budget for the implementation of RPRH-related activities in its workplan. Around 35 percent of the budget spent by PCW went to service delivery, particularly on gender-based violence elimination.

## Social health insurance

### Total PhilHealth premium contributions

The total premium collection<sup>31</sup> of PhilHealth rose by four percent from PhP99.76 billion in 2015 to PhP103.79 billion in 2016. Out of the total amount collected, PhP48.84 billion

<sup>31</sup> 2016 PhilHealth Financial Statement

came from the National Government for the premium contribution of the NHTS-PR households and approximately PhP186 million came from premium contributions of women who are about to give birth, a 45 percent increase from PhP85.2M in 2015.

Through the premium collection, PhilHealth was able to reach 91 percent coverage rate of the 2016-projected population. Nearly half (43.48 million) of the 93.4 million beneficiaries of PhilHealth were indigents coming from NHTS-PR<sup>32</sup> households. Western Visayas Region comprised majority of Sponsored Program members and dependents among NHTS poor households.

#### Total PhilHealth reimbursement paid

PhilHealth paid at least PhP20.3 billion as reimbursement for RPRH-related benefits. This comprises 20 percent of its total reimbursements. Benefit payment for RPRH-related services in 2016 is 85 percent higher compared to 2014, and 59 percent higher than the 2015 level (see Table 6c).

The steady improvements seen in PhilHealth utilization may be attributed to regular “*Alamin at Gamitin* (ALAGA Ka)” Program and “Project REACHOUT” activities by PhilHealth Regional Offices. “ALAGA Ka” program is a national awareness campaign that aims to reach out to all Filipinos to inform them of their membership registration, health insurance benefits and claims reimbursement. Meanwhile, Project REACHOUT seeks to enhance the relationship between PhilHealth and health care providers. This initiative facilitates dissemination of information to health care providers, particularly on new PhilHealth policies concerning benefits, membership and claims reimbursement.

Part of the top packages paid by PhilHealth in 2016 is related to RPRH: Newborn Care Package, Normal Spontaneous Delivery Package (for hospitals), Maternity Care Package, Caesarian Section, and Vaginal Delivery only (with episiotomy). Of the 8.3 million total claims paid by PhilHealth, 2 million (24 percent) comprised claims for these packages. Among regions, NCR had the highest reimbursement in maternal health and family planning amounting to PhP2.2 billion and PhP242 million, respectively.

The number of maternal-related claims paid by PhilHealth in 2016 is more than half (59 percent) of the estimated 2.2 million<sup>33</sup> women expected to give birth during the year. This translates to 59 percent utilization rate for maternal-related benefit packages, which is 2 percentage points higher than the 2015 utilization rate.

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<sup>32</sup> PhilHealth Stat and Charts 2016 [www.philhealth.gov.ph](http://www.philhealth.gov.ph)

<sup>33</sup> NDHS Data 2013 proportion of WRA with a live birth less than 12 months prior to the survey is 8.19%.

**Table 6c. PhilHealth payments for Selected RPRH-related benefit packages<sup>34</sup>**

Benefit Package	Total amount paid by PhilHealth in (in PhP B)		
	2014	2015	2016
Fp <sup>35</sup>	0.02	0.01	1.32
MNCHN <sup>36</sup>	8.00	11.55	16.34
Post-abortion care	0.25	0.39	0.57
STI and HIV	0.05	0.12	0.24
Breast and Gynecologic Conditions <sup>37</sup>	2.50	0.58	1.32
Conditions of Male Genital Tract <sup>38</sup>	0.11	0.13	0.47
<b>Total</b>	<b>10.93</b>	<b>12.78</b>	<b>20.26</b>

#### PhilHealth-accredited health facilities providing RPRH services, 2016

As of December 31, 2016, there were 421 accredited public hospitals and 1,637 accredited public MCP providers accessible to its beneficiaries (see Table 6d). The majority of MCP providers and hospitals are located in NCR region. This may explain the high claims payment in maternal and family planning PhilHealth benefits in NCR.

<sup>34</sup> PhilHealth Corporate Planning Department

<sup>35</sup> Includes IUD, BTL, and SDI

<sup>36</sup> Includes deliveries (normal deliveries, cesarian sections, breech and complicated vaginal deliveries); antenatal care and pregnancy-related conditions; and infant and child health care (Newborn Care Package and Perinatal Conditions)

<sup>37</sup> Includes payment for medical case rates and procedures as well as cancer treatment (Z benefit packages)

<sup>38</sup> Includes reimbursement for procedures and treatment for diseases of male genital tract including Z benefit for prostate cancer

**Table 6d Number of PhilHealth-accredited Health Facilities Providing RPRH Services, 2016<sup>39</sup>**

Region	RHU/Health Center	MCP Provider (Public)	MCP Provider (Private)	OHAT	Ambulatory Surgical Clinic	Hospitals (Public)	Hospitals (Private)
CAR	93	140	8	1	1	14	11
Ilocos Region	146	67	31	1	6	23	45
Cagayan Valley	90	84	31	2	6	26	32
Central Luzon	237	111	193	6	17	50	118
NCR and Rizal	494	46	323	10	76	56	136
Calabarzon	112	84	198	2	6	36	94
Mimaropa	114	71	45	2	2	27	54
Bicol Region	127	102	96	1	2	21	29
Western Visayas	143	111	47	3	4	34	27
Central Visayas	148	96	95	3	4	22	37
Eastern Visayas	167	238	88	1	2	23	23
Zamboanga Peninsula	85	93	9	1	2	12	28
Northern Mindanao	98	120	55	1	3	22	45
Davao Peninsula	61	43	123	1	6	13	41
SOCCSKARGEN	54	46	65	1	3	11	44
ARMM	118	113	36	0	0	21	10
CARAGA	77	72	22	2	2	10	8
<b>Total</b>	<b>2,364</b>	<b>1,637</b>	<b>1,465</b>	<b>38</b>	<b>142</b>	<b>421</b>	<b>782</b>

There are 3,102 MCP-accredited providers at present, including public and private providers. Out of the 1,634 cities/municipalities, 90 percent (1,463) already have MCP-accredited providers, a 10 percentage point increase from 2015. Accreditation levels across regions vary widely with all LGUs in NCR and Eastern Visayas having MCP-accredited providers on one hand, and a number of LGUs in Regions I, IVB, VII and X not having even a single MCP-accredited provider on the other hand.

### Financing support from other sources

CSOs spent Php309 million in 2016 for activities supporting the implementation of the RPRH law, such as through demand generation as well as service provision for MNCH, FP, ASRH, STI/HIV/AIDS and GBVs. A huge portion of its expenditure (88 percent) went to FP service provision.

Development partners including AECID, Global Fund, JICA, KOICA, UNFPA, UNICEF, USAID and WHO allocated Php11.2 billion to support the implementation of various RPRH-related projects. This amount, however, covers the entire project duration, which can be up to five years. Annual cost breakdown of these projects is not available as of writing

<sup>39</sup> Source: PhilHealth Accreditation Department

except for USAID and UNFPA. USAID allotted PhP828 million for FP and RH, and PhP92 million for maternal and child health programs while UNFPA allotted PhP183 million for reproductive health and rights.

## Challenges and Recommendations

### Social health insurance coverage not fully maximized by the target NHTS households

- **PhilHealth covers less than two-thirds of the estimated number of deliveries during the year.** Despite the efforts of PhilHealth to encourage and inform health care providers and members of its various benefits including those related to RPRH, the number of maternity-related claims is just 69 percent of the estimated number of women that gave birth during the year.

**Recommendations:** PhilHealth should assess the operational and procedural barriers that hinder members' utilization of benefits. Results of the assessment should then guide the refinement of PhilHealth strategies, policies and programs related to benefit package availment especially for RPRH. It also needs to strengthen its implementation of the No Balance Billing (NBB) policy to cover all member sectors, especially Sponsored Program members, and their qualified dependents availing themselves of MCP, NSD, ANC and NCP packages in accredited public and private birthing facilities. Moreover, PhilHealth needs to work towards the intensification of its "ALAGA KA" Program in all barangays, scaling up its information dissemination efforts to increase awareness of members on their PhilHealth benefit packages. With regard to accreditation, it should intensify its support to health care providers in terms of addressing operational and policy bottlenecks that hinder accreditation of their facilities.

It is also recommended that the DOH review current policy and operational issues on facility licensing requirements, which is a prerequisite for PhilHealth accreditation

# Governance

## Operation of the RPRH National Implementation Team and Regional Implementation Teams

Pursuant to DOH AO 2015-0002, the National Implementation Team (NIT) continued to provide strategic leadership in RPRH implementation. The NIT held 17 meetings that typically involved 40 participants representing its core membership, non-voting observers from various CSOs and development partners as well as other resource persons.

In addition to its regular meetings, the NIT also convened nine Technical Working Groups (TWGs) that cover the following areas of concern: Monitoring and Evaluation, Logistics, Adolescent Sexuality and Reproductive Health, Financing, Local Governance, Health Promotion and Communication, Civil Society and Private Sector Engagement, Training, and Research. These TWGs are convened on an as needed basis to discuss specific issues raised to the NIT.

Regional Implementation Teams (RITs) were convened to coordinate RPRH implementation at the regional level. During a national level meeting of RIT representatives in August 2016, it was reported that majority of RITs have already begun meeting regularly to come up with unified work and financial plans for 2016, monitor status of RPRH Law implementation, and prepare the 2016 accomplishment report.

The succeeding sections briefly describe the many concerns that the NIT tackled in 2016. Also described were the actions taken and challenges encountered in addressing specific RPRH concerns:

### Policy formulation and review

The NIT reviewed and endorsed several policies on RPRH implementation that were issued by the DOH. Among these include: 1) AO 2016-0041 “National Policy on the Prevention and Management of Abortion and its Complications”, 2) AO 2016-0005 “National Policy on the Minimum Initial Service Package for Women’s Health in Health Emergencies and Disasters.”<sup>40</sup> The NIT, through its various members, also participated in the drafting and consultation process leading to the issuance of AO 2016-0038 “The

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<sup>40</sup> Following the issuance of this policy, a Joint Memorandum Circular to be issued by the DOH, DILG, DSWD and OCD for the provision of RH services during emergencies is also being developed



Philippine Health Agenda 2016-2022” that sets the strategic direction for health under the Duterte Administration. In particular, the PHA identified various RPRH, especially family planning and maternal and childcare services as health entitlements of Filipino families that the State will guarantee for its provision. In addition, the NIT also worked on the drafting of administrative order on freestanding FP clinics<sup>41</sup>.

The NIT also coordinated the provision of technical inputs by DOH and POPCOM to the Office of the President on the drafting of an Executive Order<sup>42</sup> on addressing unmet need for modern FP. The technical inputs provided by the DOH and POPCOM recommended focusing efforts to meet unmet need among the poor in the first two years of the Duterte Administration. In line with this, members of the NIT also began preparing for the issuance of a corresponding DOH AO<sup>43</sup> to facilitate implementation of the EO once issued. The NIT also participated in the preparation of the DOH budget, particularly in providing advice to DOH in responding to challenges on the allocation for the Family Health and Responsible Parenthood line item.

On the other hand, the Department of Interior and Local Government issued Memorandum Circular 2015-145 “Reiteration of LGUs Role and Functions in the Implementation of RA 10354 entitled Responsible Parenthood and Reproductive Health (RPRH) Act of 2012” and its Implementing Rules and Regulations (IRR)” that was disseminated on January 4, 2016. The issuance enumerated the roles and responsibilities of local governments in taking the lead for local implementation of the RPRH Law. In addition, the issuance also mandated the regular reporting of performance and the passing of local legislation to ensure consistency of local policies with the RPRH Law.

#### Response to Supreme Court TRO on the use of subdermal implants

As reported in the 2<sup>nd</sup> RPRH Annual Report, the Supreme Court (SC) issued a Temporary Restraining Order last June 2015 preventing the DOH and the FDA from: (a) granting any and all pending application for reproductive products and supplies, including contraceptive drugs and devices; and (b) procuring, selling, distributing, dispensing or administering, advertising and promoting the hormonal contraceptive Implanon and Implanon NXT.<sup>44</sup> The NIT coordinated efforts of DOH, FDA and POPCOM in assisting the

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<sup>41</sup> AO 2017-0002 “Guidelines on the Certification of Freestanding Family Planning Clinics” dated February 2, 2017”

<sup>42</sup> Executive Order No. 12 “Attaining And Sustaining “Zero Unmet Need For Modern Family Planning” Through The Strict Implementation Of The Responsible Parenthood And Reproductive Health Act, Providing Funds Therefor, And For Other Purposes” was later signed on January 9, 2017

<sup>43</sup> DOH issued Administrative Order 2017-0005 “Guidelines in Achieving Desired Family Size through Accelerated and Sustained Reduction in Unmet Need for Modern Family Planning Methods”. The draft AO calls for the implementation of an accelerated strategy focusing on the most populated provinces in each of the 17 regions in the country.

<sup>44</sup> GR 217872, 17 June, 2017.

Office of the Solicitor General file for a Motion for Reconsideration last November 6, 2015, including its subsequent motions to lift the TRO.

The Supreme Court denied the motion to lift the TRO last August 24, 2016. The SC decision stated that the TRO on the use of Implanon and Implanon NXT remains in effect. Among many others, the SC instructed DOH and the FDA to comply with the following: (a) that the Food and Drug Administration revise its protocol for the certification of contraceptives as non-abortifacient following elements of due process prescribed in the case of *Ang Tibay v CIR*<sup>45 46</sup>; (b) subject all contraceptives to the revised certification procedures; and (c) that in case of reasonable doubt, the FDA should rule in favor of the unborn child as provided for in the Constitution<sup>47,48</sup> and the RPRH Law. On the other hand, the DOH was specifically instructed to revise the IRR of the RPRH Law following the SC decision handed down in 2013, as well as submit a procurement plan for family planning commodities. The DOH and FDA, through the Office of the Solicitor General, filed a motion for reconsideration dated October 24, 2016 that was followed by a Motion to Intervene by the CSOs filed in November 14, 2016<sup>49</sup>. To date, the SC has yet to act on the motion for reconsideration that was filed. As mentioned earlier in this report, the product registration of several contraceptive products has already expired and therefore, could not be sold anymore in the market.

The NIT, through its members and civil society network, has continuously lobbied for the lifting of the TRO that included activities such as a signature campaign that was able to gather 140,000 signatures so far. The signature campaign called for the immediate lifting of the TRO on the use of subdermal implants and restrictions imposed on the recertification of contraceptives as non-abortifacient. The DOH also started working on the Purple Ribbon Award that will provide recognition to LGUs that displayed exceptional performance in RPRH implementation. Lastly, the conduct of the First National Conference on Family Planning also served as a platform where various RH practitioners

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<sup>45</sup> 69 Phil. 635 (1940).

<sup>46</sup> Cardinal rights of parties in administrative proceedings: (1)The right to hearing which includes the right to present one's case and submit evidence thereof; (2)The tribunal must consider the evidence presented; (3)The decision must have something to support itself; (4)The evidence must be substantial; (5)The decision must be rendered on the evidence presented at the hearing, or at least contained in the record and disclosed parties affected; (6)The tribunal or body or any of its judges must act on its or his own independent consideration of the law and facts of the controversy and not simply accept the views of a subordinate in arriving at a decision; (7)The board or body should, in all controversial questions, render its decision in such a manner that the parties to the proceeding can know the various issues involved, and the reason for the decisions rendered.

<sup>47</sup> Section 12, Article II of the 1987 Philippine Constitution, it is the duty of the State to protect and strengthen the family as a basic autonomous social institution and equally protect the life of the mother and the life of the unborn from conception.

<sup>48</sup> DOH however, also has to anticipate that when the TRO is resolved, petitioners like ALFI can perpetually file TROs against each issuance of CPR citing that contraceptives are abortifacients given the provision in the Constitution on the protection of life of the unborn from conception.

<sup>49</sup> A Motion for Urgent Resolution was also filed by the Office of the Solicitor General in March 6, 2017.

and advocates discussed the current state of family planning implementation in the Philippines.

## **Strategies for scaled up RPRH provision**

### **Introducing Age and Development Appropriate Sexuality Education in Schools**

DepEd has integrated age and development appropriate sexuality education within the K to 12 program. However, there is still need to fully map out its components with corresponding sexuality education standards that was approved in May 2016. DepEd has initially scheduled the training of teacher-trainers in April 2017. Full nationwide implementation is expected starting in school year 2018- 2019. Related to the mandate of implementing comprehensive and age appropriate sexuality education in schools, the DOH and DepEd agreed that provision of RH services will be done through health facilities under a formal referral arrangement.

### **Designation of RH Officers through the Nurse Deployment Program**

The RPRH Law mandated the designation of a RH officer from among the staff of a health facility. Assigning an RH officer is difficult for some facilities as their staff is already assigned other duties. To address the lack of personnel in health facilities, DOH will continue to hire nurses. For 2017, DOH is planning to hire 15,000 nurses for deployment to 1,600 LGUs in 2017. The NIT recommended that RH officers could be designated from among these nurses, especially those with experience in delivering family planning services.

### **Creation of a dedicated bureau for RPRH implementation**

The IRR of R.A. No. 10354 mandates the DOH to reorganize its various programs on reproductive health into a single unit. In 2014, the DOH submitted to the Office of the President a proposed draft EO creating a dedicated Bureau for the implementation of the various RPRH programs. The DOH proposal was revised in 2015 and remains under review by the Office of Organization, Position, Classification and Compensation Bureau (OPCCB) of the DBM for endorsement to the Office of the President.

At present, RPRH programs are spread across the different offices of the Office for Technical Services of the DOH. For example, family planning, maternal healthcare are under the Women and Men's Health Development Division (WMHDD) while child health programs such as newborn screening, micronutrient supplementation, etc. are under the Children's Health Development Division (CHDD). Both divisions are under the Disease Prevention and Control Bureau (DPCB). However, the current staff complement of both divisions are limited, as it is just a functional structure composed of staff from the Women

and Men's Health Development Division and the Children's Health Development Division of the Disease Prevention and Control Bureau (DPCB).

### Expanding CSO Participation

The RPRH law and its IRR established the CSOs role in the implementation of the RPRH Law. The NIT paved the way for the representation and participation of CSO groups in the NIT. CSOs are also members in several RITs. In addition, CSOs also engage LGUs in various capacities such as being members of local councils like the Provincial Family Health Council of Palawan. On the other hand, CSOs like the Zuellig Family Foundation assisted 69 LGUs in regions 5, 8, 11, 12, 13, and CAR for the roll out of FP technical roadmaps that were developed to guide and monitor FP program implementation.

Many policies have been issued that promoted wider participation of CSOs in RPRH implementation. These policies include those that allowed CSOs to participate in the NIT/RIT, have access to DOH-procured FP commodities supplies, be eligible to attend government funded trainings as well as enter into formal engagement with DOH and POPCOM as partners in service provision, demand generation and advocacy on MNCH, FP, ASRH, STI/HIV and AIDS and GBVs nationwide.

Specifically, the NIT facilitated the development of a mechanism for DOH and POPCOM to hire CSOs in providing FP information and services. This arrangement initially encountered challenges in terms of the funding modality. To address this, the DOH issued Department Orders (DO Nos. 2016-0233 & 2016-0244) which allowed for the sub-allotment of Php16 million for NCR, Regions 3, Region 4B (Palawan) and ARMM to engage CSOs for RH/FP services and activities. Several CSOs also partnered with POPCOM regional offices in the provision of demand generation and FP services. For example, CSOs conducted FDS sessions and participants with FP needs were linked to CSOs providing FP services.

The DSWD issued Joint Resolution Number 2015-001 and its accompanying Supplemental Guidelines for CSO accreditation to provide guidance on the engagement of CSOs that implement programs and projects utilizing government funds. Included in the guidelines is an accreditation process for CSOs that became a barrier to CSO engagement. For example, in 2016 POPCOM had at least six (6) CSO partners for demand generation activities in the regions and DOH had eight (8) CSOs to address unmet need for modern FP. However, towards the end of 2016, only one (1) CSO was accredited by DSWD. The rest of the CSOs worked with DOH and POPCOM under a Memorandum of Agreement (MOA) with reimbursement as mode of payment. This meant that CSOs needed to produce outputs first before they can be reimbursed of their expenses. This proved difficult for many CSOs that did not have the capacity to frontload expenses. Despite the difficulties, the CSOs worked with the government on FP outreach services for a period of six (6) months and served 3,000 new modern FP acceptors. This issue was addressed by Section 65 of the 2017 GAA that allows government agencies like DOH and POPCOM to

accredit CSOs they intend to engage as implementers of programs. The DOH and POPCOM are developing the guidelines for CSO accreditation<sup>50</sup>.

The DOH likewise facilitated civil society involvement in RPRH implementation through DM No. 2016-0359 on the “Recognition to the Population Services Pilipinas Inc. (PSPI) as Partner in the Implementation of the Responsible Parenthood and Reproductive Health (RPRH) Law.” This Memorandum recognizes the PSPI as partner in the fulfillment of women’s reproductive health and rights.

CSOs also actively engaged the DOH, POPCOM and various LGUs in the implementation of the RPRH Law. As described in earlier sections, CSOs helped deliver RPRH services either as project partners or as contractors of government. In addition, CSOs also actively participated in the NIT as well as various RITs nationwide. CSOs also helped strengthen local governance such as through the Health Leadership and Governance Program (HLGP) that aims to reduce inequities in health through better leadership in health in its project sites covering 30 provinces and 700 municipalities.

## Monitoring and evaluation

The NIT facilitated the development and adoption of the Planning, Monitoring and Evaluation (PME) Guide for RPRH. This guide provided a framework for the development of work and financial plans for the various RPRH programs and for the monitoring of progress of its implementation. The PME Guide identifies the process in the collection, consolidation and processing of data coming from the reports from different agencies and units, CSOs and other implementation partners. In particular the PME guide was used in specifying the reporting requirements collected from various partner agencies, CSOs and RITs. To jumpstart its adoption, POPCOM and DOH conducted workshops in 16 regions<sup>51</sup> to orient regional staff and representatives from the provinces on the Guide and its instruments.

## Challenges and Recommendations

### Restrictive environment for RPRH service scale-up

- **Legal barriers to RPRH implementation.** While the passage of the RPRH Law provided much needed mandates for RPRH implementation, several legal barriers exist that prevent its full implementation. In addition to the TRO issued by the Supreme Court, there are several laws that limit access to services such as: the

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<sup>50</sup> POPCOM Guideline GL-OED-001 “accreditation of Civil Society Organizations as Implementing Entity of POPCOM Funds” was signed on March 8, 2017.

<sup>51</sup> Only Region X was not able to hold an orientation workshop by the end of 2016 due to scheduling difficulties. The region was oriented on the PME Guide in February 2017.

need for parental consent for minors to avail of HIV testing and other services as provided for in the Philippine AIDS Law and the RPRH Law. In addition, inter-LGU cooperation is difficult to muster owing to the devolved health system as mandated under the Local Government Code.

**Recommendation:** Addressing these barriers will require either getting a favorable ruling from the judiciary or amending existing legislation. Aside from the need for technical evidence to justify these proposals, there is also need to build strong public support to push for these changes in the light of competing interests.

- **Weak inter-sector collaboration as well as central-local relations.** As RPRH implementation proceeds, closer coordination is needed with different government agencies, the LGUs, private sector, CSO and development partners. However, current inter-agency committees and existing joint circulars are not often enough to ensure coordinated efforts on the delivery and financing of RPRH services. The level of LGU commitment to RPRH-related initiatives on the ground contributes to the success or failure of program/project implementation and service utilization. Local chief executive (LCE) opposition to FP, for instance, can dampen efforts on demand-generation as well as service provision. The autonomy of LGUs further compounds the problem given their authority to decide over delivery of basic social services in their localities.

**Recommendation:** While the NIT was able to demonstrate this capacity to guide and coordinate the development of policies to facilitate RPRH implementation, the RITs need to be strengthened in performing the same leadership and coordination functions for RPRH implementation at the subnational level. Specifically, it is recommended that DOH and POPCOM, make use of the implementation of EO 12 and AO 2017-0005 as the proving ground for scaling up implementation of RPRH programs, starting with family planning. Implementing said policies provides various opportunities to improve coordination mechanisms, drive the development of unified work and financial plans, push for the development and implementation of customized strategies and interventions, promote standard reporting of performance on a regular basis and lead to the creation of dedicated units to handle implementation. In the process of implementation, lessons can be generated that can serve as template for the implementation of other RPRH programs, not just family planning. The implementation of EO 12 can also serve as platform for the introduction and scale up of various governance initiatives at the central and local level.

### Limited capacity to regularly monitor and evaluate RPRH outcomes and outputs

- **Inability of the current RPRH M&E system to routinely track performance on RPRH implementation.** Monitoring performance in RPRH implementation has just started with the development of the PME and the conduct of orientation for its use in all regions. However, issues were raised as to the number and appropriateness of its indicators in measuring the country's performance in RPRH implementation.

**Recommendation.** The NIT, through DOH and POPCOM, needs to coordinate the further refinement of the RPRH M&E system to ensure its responsiveness to the needs of the NIT, planners and decision makers. The DOH can capacitate staff on the use of the revised PME guide and tools by providing coaching and mentoring support, eventually gaining ground to require submission of reports in its desired format and frequency for use in performance assessment, planning and budgeting. Findings from such reports may be used as starting point for ensuring data quality checks and for rewarding good performers. It is further suggested that implementation of EO 12 and AO 2017-0005, particularly in terms of its reporting requirements, be used as means to build this capacity among program staff.

- **Unreliable administrative data owing to data gaps and estimation inaccuracies.** With the intent of timeliness, the current data collection mechanism of DOH is for program managers or their staff to directly gather reports from coordinators at the regional level. This does not go through the Field Health Survey Information System (FHSIS) maybe because of system glitches, implementation, and feedback problems creating a disharmony of various information within the department.

**Recommendation:** There is a need to harness the current technological advances in information systems. Investment on a platform or an information portal that would allow linking of the data from the RHUs/CHOs/PHOs, DOH-attached agencies, and other government agencies must be done. Moreover, a single DOH bureau, specifically the Knowledge Management and Information Technology Service (KMITS) must be spearheading the efforts to harmonize information. While DOH provided computers at the local level for FHSIS utilization, human resource capability and immediate feedback mechanism from the regional office for system enhancement and repair are existing limitations, among others.







