

2017



4th ANNUAL RPRH REPORT



maternal, newborn, child health and nutrition; family planning; adolescent sexual and reproductive health; STI/HIV/AIDS; and elimination of violence against women and children.



Message from the Secretary

The Department of Health (DOH), together with our partners, is pleased to present the 4th Annual Report on the Implementation of Republic Act No. 10354 or the Responsible Parenthood and Reproductive Health Act of 2012 (RPRH Law).

This Report is prepared in compliance with the reporting requirements mandated under Section 21 of the RPRH Law and Rule 15 of its Implementing Rules and Regulations.

This Report details the accomplishments and challenges on the five elements or key result areas of Reproductive Health (RH), namely: 1) maternal, neonatal, child health and nutrition; 2) family planning; 3) adolescent sexuality and reproductive health; 4) sexually-transmitted infections and HIV/AIDS; 5) gender-based violence; and other related concerns in reproductive health and rights.

This year, the RPRH Law reached its fifth year of implementation since its passage in 2012. And with the publication of the 2017 Philippine Demographic and Health Survey, we shall see the gains in terms of health outcomes and impacts of our endeavors and investments in RH, as well as bottlenecks and setbacks in this year's implementation. Challenges are always part of the race in our undertakings, be it personal or professional. Our endeavor to solve these challenges has led us to partnerships with a wide array of stakeholders from various sector, and this serves as the RPRH Law's strong suit – ***its power to forge collaborative partnerships to resolve common problems, and to achieve the aspirations and promises stipulated in the RPRH Law.***

The RPRH Law is a landmark legislation that has laid down the foundation in fulfilling the reproductive health and rights of all Filipinos towards better health outcomes and sustainable development.




FRANCISCO T. DUQUE III, MD, MSc



Acknowledgment

The Department of Health (DOH) and the Commission on Population (POPCOM) submit this 4th Annual Report on the Implementation of Republic Act No. 10354 or the Responsible Parenthood and Reproductive Health (RPRH) Act of 2012, in compliance to Section 21 of said law and Rule 15 of its Implementing Rules and Regulations. This document presents the status of RPRH outcomes in the country, the progress of service delivery as well as utilization, and the challenges and recommendations along five key result areas (KRAs) – (1) maternal, newborn, child health and nutrition; (2) family planning; (3) adolescent sexual and reproductive health; (4) sexually-transmitted infections and HIV/AIDS; and (5) elimination of violence against women and children.

The DOH and POPCOM spearheaded the preparation of this report, with technical guidance from Esperanza Cabral, Yolanda Oliveros, and Junice Melgar. The writing team is composed of Jocelyn Ilagan, Joyce Encluna, Jan Llavado and Rhodora Tiongson, with technical inputs from DOH, Diego Danila, Zenaida Recidoro, Dennis Almonte, Rita Mae Ang-Bon, Romeo Catbagan, Ken Raymund Borling, and from PhilHealth, Abigail Estrada; from POPCOM, Lydio Espanol, Joyce DP Hilvano, Rosemarie Hubag, Desiree Concepcion Garganian, Darlynn Remolino, Linadores Delicana, Mark Magas, Vanessa Tria Estigoy, Karro Kevin Cruz; and, from Philippine Commission on Women, April Torres and Hanna Abiog.

The team acknowledges the following who provided information and insights in the drafting of the report: Joy Salgado and Erick Bernardo from Likhaan; Angelito Umali and Jose Roi Avena from UNFPA; Noemi Bautista from USAID-LuzonHealth, Jose Rodriguez, Gerry Cruz and Grace Viola from USAID-VisayasHealth and Martha Cayad-an from USAID-MindanaoHealth. It also expresses gratitude for the contribution of the following Civil Society Organizations:

- Catholics for Reproductive Health (C4RH)
- Democratic Socialist Women of the Philippines (DSWP)
- Family Planning Organization of the Philippines (FPOP)
- Forum for Family Planning and Development (FORUM)
- FriendlyCare Foundation
- Health Action Information Network (HAIN)
- Integrated Midwives Association of the Philippines (IMAP)
- Likhaan Center for Women's Health (Likhaan)
- Philippine Center for Population and Development (PCPD)
- Philippine Legislators' Committee on Population and Development (PLCPD)
- Pinagsamang Lakas ng Kababaihan, Kabataan at ibang Kasarian (PILAKKK)
- Population Services Pilipinas, Inc. (PSPI)
- Philippine Society for Responsible Parenthood (PSRP)
- Roots of Health (ROH)
- Zuellig Family Foundation (ZFF)

Executive Summary

The Fourth Annual Report on the Implementation of the Responsible Parenthood and Reproductive Health Act of 2012 (RPRH Law) presents the progress in the delivery and utilization of essential health services to the public in 2017, along the following key result areas: (a) maternal, newborn, child health and nutrition, (b) family planning, (c) adolescent sexual and reproductive health, (d) sexually transmitted diseases, human immunodeficiency virus/acquired immunodeficiency disease syndrome (STD, HIV/AIDS) and the (e) elimination of violence against women and children. It examines the factors that have facilitated or impeded the delivery of comprehensive RPRH services to Filipinos and proposes recommendations for the improvement of implementation of its provisions and the attainment of target outcomes in RPRH law.

Policy and governance

The national government made significant strides in the policy and legislative arena in the first year of the new Administration to support the implementation of RPRH law. Strengthening of the RPRH law implementation gained national prominence with its inclusion in the Administration's 10-Point Socioeconomic Agenda, and the issuance of Executive Order No. 12 on "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". This, by far, has been the most tangible policy support to the law as it explicitly recognizes the right of Filipinos to freely and responsibly decide on the number of children they want, and correspondingly provides mechanisms to accelerate the implementation of critical actions to attain and sustain "zero unmet need for family planning" of all poor households in 2018, and of all Filipinos thereafter.

In the legislative front, DOH compliance with Supreme Court (SC) requirements – particularly its procedural requirements for Food and Drug Administration (FDA) certification/recertification of contraceptives as non-abortifacient, effectively lifted the Temporary Restraining Order (TRO) issued in 2015 on contraceptives. Had the TRO remained, there would no longer be contraceptives available in the market by 2020, further aggravating the already high unmet need for family planning. The DOH also prepared a bill to increase access of the vulnerable, particularly at-risk youth, to HIV/AIDS testing and counseling through House Bill 6617 or the proposed Philippine HIV and AIDS Policy Act. It seeks to lower the minimum age requirement for HIV testing and counseling from 18 to 15 years. It was already approved by the House of Representatives and is now for Second Reading in Senate as of this writing.

The National Implementation Team (NIT), which was created in 2015 as the oversight and steering committee for the implementation of the RPRH law implementation, continued to serve as platform for resolving issues confronting the effective delivery of RPRH services. It formed special Task Forces to lead concerned government units in complying with the SC directives, particularly: (a) amendment of the RPRH Implementing Rules and Regulations, (b) certification/recertification of FP commodities, (c) management of RH logistics, and (d) dissemination of information on the list of RH programs and services. Regional Implementation Teams were set up to guide and coordinate the implementation of the law at the subnational level.

The DOH already developed a proposal for the creation of the Family Health Bureau (FHB) as mandated by the RPRH IRR, which reads: “expand organizational structure that will ensure provision of the needed technical guidance and coordination support for the systematic and integrated provision of reproductive health care to all citizens, prioritizing women, the poor, and the marginalized population groups”. The DOH should address the issues posed by the Office of Organization, Position, Classification and Compensation Bureau (OPCCB) of the Department of Budget and Management (DBM), the latter will be endorsing it to the Office of the President for approval.

Budget and Financing

The indicative national government budget for RPRH increased by 25% from PhP29.7 billion in 2016 to PhP37.4 billion in 2017, based on adjusted allotments of concerned government agencies. It particularly covers allocations for Family Health and Responsible Parenting (FHRP), Expanded Program on Immunization (EPI), and Health Facilities Enhancement Program (HFEP) of the DOH, as well as the RPRH-related programs of the Commission on Population (POPCOM). Additional budgets for RPRH include those on gender and development-related activities of the Philippine Commission on Women (PCW), and HIV/AIDS program of the DOH, which has been lumped under Other Infectious Diseases and Emerging and Reemerging Disease Including STD, HIV/AIDS, Dengue, Food and Water-Borne Diseases. While the increase in RPRH budget to PhP37.4 billion in 2017 may have seemed big enough, the PhP4.3 billion FHRP budget, for instance, is just half of the needed PhP8.1 billion-estimated budget for FP alone in 2017, based on the National Costed Implementation Plan (CIP) 2017-2022.

The absorptive capacity of concerned government agencies have improved with higher budget utilization rate of 95% in 2017 compared to 90% in the previous year. Development partners also spent around PhP10.2 billion in aid on projects contributing to RPRH implementation. In terms of social health insurance, PhilHealth reimbursed PhP23.79 billion in 2017 for RPRH-related benefits – 15 percent higher than in 2016. There were 763 PhilHealth-accredited public hospitals and infirmaries accessible to PhilHealth beneficiaries as of end of December 31, 2017. In addition to these, there were 2,455 accredited Primary Care Benefit (PCB) providers and 3,243 accredited public and private Maternity Care Package (MCP) providers all over the country to cater to PhilHealth beneficiaries.

Progress on the Key Result Areas (KRAs)

1. Maternal, Newborn, Child Health and Nutrition (MNCHN)

Status and trends. Use of maternal health care services significantly improved from 1998 to 2017: (a) The percentage of pregnant women delivering in health facilities rose from 34% to 78%, and deliveries attended by doctors, nurses and/or midwives increased from 56% to 84%; (b) Antenatal care (ANC) increased from 77% to 87%. However, maternal mortality ratio remains high at 114 per 100,000 live births based on the United Nations estimates and DOH Field Health Information Survey (FHSIS) estimate of 74-114 per 100,000 live births. The FHSIS is based mainly on data obtained from public health facilities. Nonetheless, both data sources showed that the Philippines is still far from attaining its Philippine Development Plan (PDP) 2017-2022 target of 90 per 100,000 live births, even farther from the Sustainable Development Goal (SDG) target of 70 per 100,000 live births. Mothers die mostly of conditions that are highly preventable with quality obstetric care. Meanwhile, infant, child and under-5 mortality rates decreased from 1998 to 2017 but the decline has been sluggish since 2008. There were also more malnourished children in 2015 than in 2013 based on national nutrition surveys, with the prevalence of underweight children 0-59 months increasing from 20% to 21.5%, and those stunted from 30.3% to 33.4%.

Interventions. Major interventions to improve MNCHN services include: (a) DOH modification of the global standard for Basic Emergency Obstetric and Newborn Care (BEmONC) to consider health system limitations, (b) assistance to improve local health system through DOH investments in health facility infrastructures and human resource, and assistance in the setting up of service delivery networks (SDN), (c) allocation of Php3 billion for the point of service enrolment of pregnant women under PhilHealth Circular on Social Coverage of Women About to Give Birth Revision 1, (d) revision of Republic Act 7392 or the Philippine Midwifery Act of 1992 to expand and update the scope of practice of midwives to include the performance of at least four BEmONC signal functions, (e) issuance of a policy on the prevention and management of abortion complications, (f) support to the implementation of the Early Essential Newborn Care (EENC), exclusive breastfeeding, immunization and Integrated Management of Childhood Illnesses (IMCI), (g) administration of Bacillus Calmette-Guerin (BCG) vaccine and the first dose of Hepatitis B to neonates within 24 hours after birth, and (h) development of the Philippine Plan of Action for Nutrition 2017-2022 as well as implementation of the Philippine Integrated Management of Acute Malnutrition Scale Up Program.

Challenges and recommendations. Health system inefficiencies have contributed to the death of mothers from preventable causes such as hemorrhage and eclampsia, and neonatal deaths which account for 60 percent of infant deaths. To help address this, the following actions may be undertaken: (a) advocacy for the amendment of the Midwifery Act of 1992 to allow midwives to perform the 8 BEmONC signal functions (Philippine version) for better MNCHN service coverage especially in areas where doctors are not readily available, (b) evaluation of the capacities of BEmONC and CEmONC training institutions as well as those of health providers in delivering BEmONC and CEmONC services, (c) review of MNCHN policies, particularly Administrative Order 2008-0029 Implementing Health Reforms for Rapid Reduction of Maternal and Neonatal Mortality, (d) review and refinement of the monitoring, evaluation and reporting system for MNCHN programs, (e) mandate on the conduct of maternal death review nationwide, and (f) collaboration with LGUs on the strengthening of service delivery networks for MNCHN.

2. Family Planning (FP)

Status and trends. Contraceptive use among currently married women increased from 24.9% in 1993 to 40.4% in 2017, however the country lagged behind certain Asian countries in terms of annual average increase in contraceptive prevalence rate (CPR) especially beginning 2013. Unmet need for FP decreased from 30% in 1993 to nearly 17% in 2017 but the rate of decline has likewise slowed down since 2013. In terms of magnitude, there were 2.6 million currently married women and 5.1 million unmarried women who wanted to use FP but were not able to do so in 2017. Total demand for FP (including those by current FP users and those with unmet need) stood at 71%, equivalent to 11.1 million women.

Interventions. Efforts to improve FP service delivery consist of the following: (a) issuance of EO 12 on “Zero Unmet Need for Modern Family Planning through the Strict Implementation of the RPRH Act of 2012”, and DOH Administrative Order 2017-0005: “Guidelines in Achieving Desired Family Size through Accelerated and Sustained Reduction in Unmet Need for Modern Family Planning Methods”, which encouraged the aggressive implementation of the FP program in 2017, and led to actual service provision of around 617,000 of the estimated 3.7 million women with unmet need in priority areas were provided with modern FP method/services, as well as regular data generation, (b) DOH procurement and distribution of FP commodities to DOH regional offices and government health facilities, (c) tracking of FP commodity stock status at service delivery points through the FP Hotline, (c) conduct of demand-generation activities by the DOH, POPCOM and civil society organizations (CSOs), (d) training of health providers on FP Competency-Based Training (CBT), and (e) setting up of a Focal Point system for the Philippine Action for the Acceleration of Family Planning or the FP 2020 – a global partnership that upholds the rights of women and girls to decide freely and for themselves on the number of children they want.

Challenges and recommendations. The major issues identified on FP are as follows: (a) incongruity of FP program indicators and targets to what the country can realistically achieve in five years given current health system structure and capacities, (b) low coverage of the estimated number of women with unmet need for FP, (c) difficulty in scaling up FP service provision, (d) commodity stock outs owing to delays in FP commodity procurement and distribution, and (e) weak monitoring of budgets and resources for RPRH activities. The following actions are proposed to address these: (a) review and adjustment of FP Program indicators and targets using the recent 2017 NDHS, (b) assessment of gaps in FP demand generation and service utilization, and harmonization of DOH and POPCOM efforts in the promotion and provision of FP services, (c) assistance to LGUs in assessing health provider capacities and in mapping as well as engaging government and private health providers in delivering FP services, (d) evaluation of the DOH procurement and logistics management system, (e) fast tracking of the creation of a fully-staffed FP Unit to spearhead the implementation of EO 12.

3. Adolescent Sexuality and Reproductive Health (ASRH)

Status and trends. There were fewer young Filipino women aged 15-19 years who have begun childbearing in 2017 (8.6%) compared in 2013 (10%) based on the NDHS. While this means 60,000 fewer teen pregnancies in 2017, there are still almost half a million (420,000) teens who have already begun childbearing. Unmet need for FP is highest among this age group at 28%, compared to only 13% to 18% in older age groups. Unmet need of teen mothers for FP is particularly high, which possibly explains the increasing percentage of repeat pregnancies among this group. It is estimated that over 1.4 million young women who want to limit or space child birth are unable to use any FP method. The pill remains to be the most widely accessed FP method at 16%, followed by injectables at 6% and IUD at 3.4% among adolescents. Next to the pill, traditional methods, mostly withdrawal, remain to be a popular choice among the young generation. Among the 15-19 years old women with multiple partners, only 21.6% use condoms and only one in six have comprehensive knowledge of HIV prevention.

Interventions. Major efforts to improve the policy and legal environment to expand access of adolescents to ASRH services consist of the following: (a) issuance of DOH Circular 2017-0165 on the nationwide adoption of the Clinical Practice Guidelines for the Prevention, Diagnosis and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents in the Philippines, (b) issuance of DOH Department Memorandum 2017-0098 which defines the levels of standards for Adolescent Friendly Facilities, (c) adoption and dissemination of the Adolescent Health and Development Program (AHDP) Manual of Operations to program managers and implementers, (c) updating of DepEd K-12 curriculum to meet the Comprehensive Sexual Education (CSE) standards for the Philippines, and (c) drafting and championing of the following bills: (i) House Bill 6617 or the proposed “Philippine HIV and AIDS Policy Act which lowers the minimum age for the availment of HIV testing and counseling without the need for parental consent from 18 to 15 years, (ii) House Bill 04742 or “An Act Providing for a National Policy in Preventing Teen Pregnancies, Institutionalizing Social Protection for Teenage Parents, and Providing Funds Therefor” and its counterpart Senate Bill 1482 “Prevention of Adolescent Pregnancy Act of 2017”, (iii) House Bill 05777 or “An Act Strengthening the National and Local Health and Nutrition Programs for Pregnant and Lactating Women, Adolescent Girls of Reproductive Age and Teenage Mothers, Infants and Young Children in the First 1,000 Days”. Mechanisms for the provision of quality ASRH services in selected health facilities were likewise developed by the DOH with the assistance of development partners.

Challenges and recommendations. The following issues continue to beset full access of adolescents to quality ASRH services: (a) exclusion of comprehensive sexuality education in school-based ASRH orientation, (b) barriers to adolescent access of FP services at service delivery points owing to provider bias and limited knowledge and capacities to provide adolescent-friendly services, (c) lack of specific provider guidelines and protocol for preventing closely spaced pregnancies among adolescents, and (d) huge disparities in the quality of ASRH provision nationwide. The following actions are being proposed to resolve these problems: (a) Collaboration among the DOH, DepEd and CHED in conducting IEC activities focused on parent-based ASH interventions in schools, (b) reorientation of health providers for a non-judgmental provision of ASRH services and for a more comprehensive choice of FP methods for adolescents – to include not only short-acting but long acting reversible contraception as well; (c) development of standard core messages and protocol for providers to encourage teen mothers to avoid early marriage, prevent repeated or closely spaced pregnancies, and finish their education, and (d) packaging of capacity building activities with post-training supportive supervision by recognized mentors.

3. Sexually-Transmitted Infections and HIV/AIDS

Status and trends. The Philippines remains to be a low-HIV prevalence country but alarmingly, its number of HIV cases has been one of the fastest growing in Asia and the Pacific. There were 11,103 cases reported in 2017 or 31 newly diagnosed HIV cases per day, almost double of the 17 recorded cases per day in 2014. NCR has the most number of reported cases, accounting for 35% of the total number of cases, followed by Regions IVA, III, VII and XI. Sexual contact, mostly involving males having sex with males, is the predominant mode of transmission. HIV in the young population (15 to 24 years old) continues to rise with 31% of documented cases in 2017 coming from this age group.

Interventions. The following policy and legislative measures were pursued in 2017 to reduce HIV/AIDS: (a) drafting of House Bill 6617 on the proposed revisions to the Philippine AIDS Prevention and Control Act of 1998 or RA 8504 (discussed in the section on ASRH), (b) adoption of the 6th AIDS Medium Term Plan (AMTP) 2017-2022 – a five-year strategic plan for national and subnational HIV/AIDS implementation, and (c) issuance of the following: (i) DOH Administrative Order (AO) 2017-0011 “Policy on the Prevention and Control of Viral Hepatitis under the National HIV/AIDS and STI Prevention and Control Program”, (ii) DOH AO 2017-0019 “Policies and Guidelines in the Conduct of HIV Testing Service in Health Facilities, and (i) Department Circular 2017-0273 “National HIV/AIDS and STI Program Recommendations for Testing, Diagnosis, and Treatment of Chronic Hepatitis C Among People Living with HIV”. The DOH, CSOs, LGUs and development partners continued to conduct demand-generation activities to improve HIV prevention, with the DOH even providing free condoms and making HIV screening and testing more available in all government-owned social hygiene clinics.

Challenges and recommendations. The rapidly increasing number of persons living with HIV and the country’s weak social protection measures especially for the most vulnerable population groups continue to challenge the prevention of HIV/AIDS. The following actions are being proposed to address these issues: (a) review and enhancement of current national communication plan on HIV/AIDS by the DOH, National HIV/AIDS and STI Prevention and Control Program, DepEd and CHED, focused on adolescents, (b) elimination of barriers to testing, addressing delays on confirmatory results by strengthening the implementation of the Rapid HIV Diagnostic Algorithm (rHIVda), which cuts the long waiting time for the patients to transition to Antiretroviral (ART) therapy as those considered “provisional positive” are immediately linked to care, (c) amendment of Department Circular 2016-0171 “Enhance Linkage to Care of People Living with HIV” to include provision on reintegration, and (d) expansion of the Outpatient HIV/AIDS treatment (OHAT) package to include case detection, treatment adherence support and treatment of opportunistic infections.

5. Elimination of Violence Against Women and Children (VAWC)

Status and trends. The country remains to be in the top 10 most gender equal countries in the world, although it slid in its rank from 7th in 2015 and 2016 to 10th in the Global Gender Gap Report 2017. It finally reduced the gender gap in educational attainment but continued to grapple with inequalities in gender representation in third level positions in government. Violence against women still persists as one in every four women aged 15-49 has experienced physical, emotional, or sexual violence by their husband or partner. The percentage of women affected by VAW slightly increased from 25.9 percent in 2013 to 26.4 percent in 2017, but the number of VAW cases reported to the Philippine National Police (PNP) declined from 39,819 in 2016 to 32,613 in 2017. Women aged 20-24 years who have only attained elementary education and are residing in rural areas are most likely to be affected by VAW.

Interventions. Major interventions to eliminate VAWC include the following: (a) drafting of the Inter-Agency Council on Violence Against Women and Children (IACVAWC) Strategic Plan for 2017-2022, (b) advocacy of Women’s Priority Legislative Agenda, which includes a bill on “Increasing and Harmonizing Maternity Leave for Those in the Government and Private Sectors”, which increases maternity leave from 60 to 100 days, (c) adoption of local gender and development (GAD) codes by 696 LGUs to address gender issues, (d) establishment of VAW desks in nearly 90 percent of the total 42,036 barangays nationwide, and (e) establishment of Women and Child Protection Program (WCPP) and training of providers on recognizing, recording, reporting and referring (4Rs) VAWC in 597 LGUs.

Challenges and recommendations. A major issue affecting the elimination of VAW and GBV is the limitation of local resources to cover the cost of comprehensive services and legal assistance that LGUs are mandated to provide to victims of abuse, in accordance with the Magna Carta of Women. There may be a need to review the scope of assistance required from LGUs in this respect, and to identify potential partners as well as resources that can be tapped to holistically address the needs of victims of abuse.

Table of Contents

Message from the Secretary	1
Executive Summary	2
List of Acronyms	11
Governance and Policy	16
Budget and Financing	19
Key Result Areas (KRA)	
KRA 1: Maternal, Neonatal, Child Health, and Nutrition	26
KRA 2: Family Planning	41
KRA 3: Adolescent Sexuality and Reproductive Health	71
KRA 4: Sexually-Transmitted Infection and HIV/AIDS	84
KRA 5: Elimination of Violence and Women and Children	95



List of Acronyms

4Rs	Recognition, Recording, Reporting, Referral
4Ps	Pantawid Pamilyang Pilipino Program
AHD	Adolescent Health and Development
AIDS	Acquired Immunodeficiency Syndrome
AJA	Adolescent Job Aid
ANC	Antenatal Care Visits
AO	Administrative Order
ARH	Adolescent Reproductive Health
ARMM	Autonomous Region of Muslim Mindanao
ART	Antiretroviral Therapy
ARV	Anti-Retroviral
ASC	Ambulatory Surgical Clinic
ASRH	Adolescent Sexual and Reproductive Health
AYRH	Adolescent and Youth Reproductive Health
BEmONC	Basic Emergency Obstetric and Newborn Care
BHS	Barangay Health Station
BHW	Barangay Health Worker
BNS	Barangay Nutrition Scholar
BTL	Bilateral Tubal Ligation
CCT	Conditional Cash Transfer
CD4	Cluster of Differentiations
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHO	City Health Office
CHR	Commission on Human Rights
CONAP	Continuing Appropriations
CPR	Contraceptive Prevalence Rate
CRVS	Civil Registry and Vital Statistics
CS	Caesarean Section
CSC	Civil Service Commission
CSE	Comprehensive Sexual Education
CSO	Civil Society Organization
CWC	Council for the Welfare of Children
DC	Department Circular
DepEd	Department of Education
DILG	Department of Interior and Local Government
DM	Department Memorandum
DMPA	Depot Medroxyprogesterone Acetate
DOH	Department of Health
DOH-RO	Department of Health – Regional Office
DOJ	Department of Justice
DOLE	Department of Labor and Employment
DPCB	Disease Prevention and Control Bureau
DPO	Department Personnel Order
DSWD	Department of Social Welfare and Development
DQC	Data Quality Check

EINC	Essential Intrapartum and Newborn Care
EO	Executive Order
EPI	Expanded Program on Immunization
EU	European Union
FBD	Facility-based Delivery
FHB	Family Health Bureau
FDA	Food and Drug Administration
FDS	Family Development Sessions
FFSW	Freelance Female Sex Worker
FSW	Female Sex Worker
FGD	Focus Group Discussion
FHRP	Family Health and Responsible Parenting
FHS	Family Health Survey
FHSIS	Field Health Surveillance and Information System
FIC	Fully Immunized Child
FNRI	Food and Nutrition Research Institute
FP	Family Planning
FPCBT	Family Planning Competency Based Training
FPS	Family Planning Survey
FSW	Female Sex Worker
GAA	General Appropriations Act
GAPR	Global AIDS Response Progress Report (GARPR)
GAD	Gender and Development
GBV	Gender-based Violence
GIDA	Geographically Isolated and Disadvantaged Areas
GPH	Government of the Philippines
GPOBA	Global Partnership Output-Based Aid
GRRB-IRH	Gender-Responsive and Rights-Based Integrated Reproductive Health
HARP	HIV/AIDS and ART Registry
HCT	HIV Counselling and Testing
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HFEP	Health Facilities Enhancement Program
Hi-5	High Five Strategy
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immunodeficiency Virus /Acquired Immunodeficiency Syndrome
HPV	Human Papilloma Virus
HSP	Health Sector Plan
HUP	Health Use Plan
IACAT	Inter-Agency Committee on Anti-trafficking
IACVAWC	Inter-Agency Council on Violence Against Women and their Children
IEC	Information, Education, and Communication
IHBSS	Integrated HIV Behavioral and Serologic Surveillance
IMR	Infant Mortality Rate
ILHZ	Inter-Local Health Zones
IPCC	Interpersonal Counseling and Communication
IPT	Intimate Partner Transmission
IRR	Implementing Rules and Regulations
IRR DC	IRR Drafting Committee



IUD	Intrauterine Device
IYCF	Infant and Young Child feeding
JICA	Japan International Cooperation Agency
JPMNCHN	Joint Programme on Maternal, Neonatal, Child Health and Nutrition
KAP	Key Affected Population
KP	Kalusugan Pangkalahatan
KRA	Key Results Area
KATROPA	Kalalakihang Tumutugon sa Responsibilidad at Obligasyon Para sa Kalusugan ng Ina at Pamilya
LAM	Lactational Amenorrhea Method
LAPM	Long Acting Permanent Method
LARC	Long Acting Reversible Contraception
LCAT-VAWC	Local Committees on Anti-Trafficking and Violence Against Women and Children
LCE	Local Chief Executive
LGBT	Lesbian, Gay, Bisexual, Transgender
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and Intersex
LGU	Local Government Unit
LPPEAHD	Learning Package on Parent Education on Adolescent Health and
M/TSM	Males/Transgenders who have sex with males
M&E	Monitoring and Evaluation
MAH	Market Authorization Holder
MAPEH	Music, Arts, Physical Education and Health
MARP	Most At-Risk Population
MBFHI	Mother-Baby Friendly Hospital Initiative
MCP	Maternity Care Package
mCPR	Modern Contraceptive Prevalence Rate
MCW	Magna Carta for Women
MDs	Medical Doctors
MDG	Millennium Development Goal
MEC	Medical Eligibility Criteria
MFP	Modern Family Planning
MHO	Municipal Health Officer
MMR	Maternal Mortality Ratio
MNCHN	Maternal, Neonatal, Child Health and Nutrition
MNFP	Modern Natural Family Planning
MOOE	Maintenance and Other Operating Expenses
MOU	Memorandum of Understanding
MOVE	Men Opposed to Violence Against Women Everywhere
MR	Measles-Rubella
MR GAD	Men's Responsibilities in Gender and Development
MRL	Muslim Religious Leader
MSM	Men having Sex with Men
MYCNSIA	Maternal and Young Child Nutrition Security Initiative in Asia
NAC	National Advisory Committee
NAPC	National Anti-Poverty Commission
NBI	National Bureau of Investigation
NCMH	National Center for Mental Health
NCR	National Capital Region
NDHS	National Demographic and Health Survey

NDP	Nurse Deployment Program
NEDA	National Economic and Development Authority
NGO	Non-Government Organization
NHIP	National Health Insurance Program
NHTS	National Household Targeting System
NHTS PR	National Household Targeting System –Poverty Reduction
NIT	National Implementation Team
NMR	Neonatal Mortality Rate
NNC	National Nutrition Council
NNS	National Nutrition Survey
NOH	National Objectives for Health
NSD	Normal Spontaneous Delivery
NSV	Non-Scalpel Vasectomy
OB/GYNE	Obstetrician and Gynecology
ODA	Official Development Assistance
OFW	Overseas Filipino Worker
OHAT	Outpatient HIV/AIDS Treatment
OIS	Opportunistic Infections
ONAR	Office of the National Administrative Register
OPCCB	Organization, Position, Classification and Compensation Bureau
OSG	Office of the Solicitor General
PAFLO	Population Awareness and Family Life Orientation
PNC	Postnatal Care
PCW	Philippine Commission on Women
PGH	Philippine General Hospital
PHA	Public Health Assistant
PHIC	Philippine Health Insurance Corporation
PHO	Provincial Health Office
PIA	Philippine Information Agency
PICT	Provider –Initiated HIV Counseling and Innovators
PLHIV	People Living with HIV
PME	Planning, Monitoring and Evaluation
PMTCT	Prevention of Mother to Child Transmission
PNGOC	Philippine NGO Council on Population, Health and Welfare, Inc.
PNP	Philippine National Police
POC	Point of Care
POPCOM	Commission on Population
PPAs	Programs, Projects and Activities
PPMP	Project Procurement Management Plan
PPIUD	Postpartum Intrauterine Device
PSA	Philippine Statistics Authority
PSPI	Population Services Pilipinas, Inc.
PREVENTS	Primary Care Revitalized and Enhanced Through Skills and Services
PTA	Parent-Teacher Association
PWID	People Who Inject Drugs
PYD	Program for Young Adolescents
PYP	Program for Young Parents
Q&A	Question and Answer
RA	Republic Act
RFSW	Registered Female Sex Worker



RIT	Regional Implementation Team
RITM	Research Institute for Tropical Medicine
RH	Reproductive Health
RHMPP	Rural Health Midwives Placement Program
RHO	Reproductive Health Officer
RHU	Rural Health Unit
RP-FP	Responsible Parenting and Family Planning
RPO	Regional Population Office
RPRH	Responsible Parenthood and Reproductive Health
RTI	Reproductive Tract Infection
SBA	Skilled Birth Attendance
SC	Supreme Court
SDG	Sustainable Development Goals
SHC	Social Hygiene Clinics
SK	Sangguniang Kabataan
SQAO	Status Quo Ante Order
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
STI	Sexually Transmitted Infection
SWRA	Sexually Active Women of Reproductive Age
TB	Tuberculosis
TD	Tetanus-Diphtheria
THKs	Teen Health Kiosks
TOT	Training of Trainers
U4U	Youth for Youth Activity
UHC	Universal Health Care
UMFP	Unmet Need for Modern Family Planning
UNAIDS	United Nations Programme on HIV/AIDS
UNICEF	United Nations International Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VAW	Violence Against Women
VAWC	Violence Against Women and Children
VAWCRS	Violence Against Women and Children Registry System
VIA	Visual Inspection with Acetic Acid
WB	World Bank
WCPU	Women and Child Protection Units
WFS	Women Friendly Space
WHO	World Health Organization
WINS	Water, Sanitation, & Hygiene in Schools
WMCHDD	Women, Men, and Children's Health Development Division
WRA	Women of Reproductive Age
YAFSS	Young Adult Fertility and Sexuality Survey
YDS	Youth Development Session
ZFF	Zuellig Family Foundation



Policy and Governance

Operation of the RPRH National Implementation Team and Regional Implementation Teams

DOH Administrative Order 2015-0002 mandated the creation of the National Implementation Team (NIT) and Regional Implementation Teams (RITs) for Republic Act 10354 or the Responsible Parenthood and Reproductive Health Act of 2012 (RPRH Law). In 2017, the NIT continued to take on its role of overseeing the implementation of the law through its provision of technical guidance to the DOH and coordination with concerned government agencies or units, civil society organizations (CSO), the private sector and development partners in expanding and fast tracking the delivery of RPRH services.

The NIT helped eliminate legal barriers to the full implementation of RA 10354, particularly through the creation of special Task Forces to respond to the Supreme Court procedural requirements for eventual lifting of its Temporary Restraining Order (TRO) issued in 2015. These special Task Forces were assigned in the a) amendment of the Implementing Rules and Regulations of the RPRH Law, b) formulation of DOH guidelines on procurement and distribution of FP commodities, c) formulation of Food and Drug Administration (FDA) guidelines on certification/recertification of FP products, and d) dissemination of information on RH programs and services. In November of 2017, the TRO was deemed lifted when the said procedural requirements were complied, and the FDA resolved that contraceptive products were non-abortifacient.

In addition, the NIT provided technical inputs to the revision of the Implementing Rules and Regulations of the RPRH, regularly monitored FP commodity stock outs and facilitated their distribution to areas where they were needed. CSOs were tapped in the provision of PSI while the TRO on contraceptives was still in effect.

At the subnational level, the RITs were convened to lead, oversee and monitor the local level implementation of RPRH Law.

Strengthening the legal and policy environment for RPRH

The lifting of the Supreme Court TRO to the DOH and FDA with regards to contraceptives in 2017 may be considered a major feat in implementing the RPRH. The TRO, which was issued in 2015, halted the procurement, sale, distribution/administration and even promotion of hormonal contraceptives *Implanon* and *Implanon NXT*, and prevented the FDA from certifying and recertifying contraceptive products. Had the TRO remained, contraceptives would have no longer been available in the market by the year 2020. The TRO was deemed lifted with the FDA compliance to Supreme Court due process requirements for certifying/recertifying contraceptives as non-abortifacient. This entailed modification of its guidelines for contraceptive certification/recertification, revision of RA 10354 IRR to reflect such guidelines, conduct of Summary Hearing, and issuance of public advisory on the recertification of contraceptives.

Another major effort to address legal constraints in RPRH service involves the drafting of House Bill 6617 or the proposed Philippine HIV and AIDS Policy Act, which seeks to prevent the spread of HIV and AIDS in the country. It proposes to lower the minimum age requirement for the availment of HIV testing and counseling without the need for parental consent from 18 to 15 years, and allows persons below 15 years who are pregnant or engaged in high-risk behavior to avail of such services provided that they are assisted by a licensed social worker. This initiative, which intends to make HIV services easily accessible to the younger vulnerable population, was already approved in the House of Representatives and is already scheduled for Second Reading in Senate.

Another major boost in the implementation of the RPRH law is the issuance by President Rodrigo Duterte – Executive Order No. 12 on “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”. This clearly reiterates national support to RPRH Law as it recognizes the right of Filipinos to: (a) decide freely and responsibly on their desired number and spacing of children, within the context of responsible parenthood and informed choice, and (b) access their needed reproductive health care information and services. It instructs DOH, POPCOM, DILG and other concerned government agencies to collaborate with the LGUs in locating individuals with unmet need for FP, capacitating local structures relevant to the provision of reproductive health care, conducting intensive community-based demand generation, referral and FP service provision, and collaborating with CSOs and private sector in attaining zero unmet need for modern FP for all poor households by 2018, and for all Filipinos thereafter.

Efforts were also made to improve social health insurance coverage not only of the poor but of financially capable Filipinos as well. PhilHealth issued PhilHealth Circular 0025 s. 2017 on the Guidelines on the Implementation of Point of Service (POS) and Parallel Implementation of Point of Care (POC) – Revision 1, which fully covers the actual value of health services (covered by PhilHealth) availed by patients who are incapable of paying their PhilHealth membership, according to DOH indigence classification. The poor, in this case, includes even those not covered by the Department of Social Welfare and Development (DSWD) National Household Targeting Survey or NHTS. In case of minors, indigence of parents or guardians is determined and if proven to be financially incapable, they are registered by the government health facility in the National Health Insurance Program. Meanwhile, those financially capable shall be enrolled based on their financial capability at the POS to be covered as regular PhilHealth members. They shall be eligible to avail of All Case Rates (ACR) upon payment of annual premium. The 2017 General Appropriations Act or GAA appropriated Php3 billion for Universal Health Coverage intended to cover all Filipinos.

Challenges and Recommendations

There is still no single agency solely in charge of the nationwide implementation of RPRH in the country. The DOH, POPCOM and the LGUs are directed to take full charge of implementing the RPRH Program, in collaboration with various concerned government agencies. Within the DOH, the RPRH programs are also dispersed across various divisions and bureaus. This setup has led to fragmentation in operations and service delivery.

Recommendation: Conduct an assessment of the organizational structure, mandates and operations of agencies, bureaus and units concerned with the nationwide implementation of RPRH Programs. The IRR of RA 10344 mandates the DOH to reorganize its various programs on RH into a single unit, and the

results of such assessment may serve as guide in determining the appropriate structure and arrangement needed for a more cohesive approach to RPRH policy development, program management, service delivery and logistics management.

The RPRH Monitoring and Evaluation (M&E) tool has not been fully utilized in generating timely and reliable information to monitor the progress of RA 10354. The indicators in the M&E tool are defined differently by the regional offices/data collecting units, and the system for regular data collection, monitoring, analysis and reporting is not yet fully in place.

Recommendation: Review the design of the RPRH M&E tool to determine its relevance to the needs of POPCOM and the DOH, especially in terms of their compliance with national government reporting requirements, such as those required by RPRH Law and EO 12 on Attaining Zero Unmet Need on FP. This study may also be used to determine the possibility of harmonizing similar reports to avoid duplication in reporting, which has become a burden for local health providers/personnel to accomplish. Alternatively, the DOH/POPCOM may consider outsourcing regular data collection and RPRH output monitoring to provide regular, updated and reliable information that can guide high level decision-making on RPRH.

Budget and Financing

Budgetary Allocation for the RPRH Law Implementation

The total indicative national government budget for the implementation of the RPRH Law in 2017 amounts to PhP37.4 billion, which is 25% higher than the 2016 budget. The DOH remains to be the main source of funds with its 99.7% (PhP37.2 billion) share in the total RPRH allocation, consisting of funds for the following budget line items: Family Health and Responsible Parenthood (FHRP), Expanded Program on Immunization (EPI), and Health Facility Enhancement Program (HFEP). HFEP comprises 69% of its total allocation for RPRH (see Table 1a). The DOH allocation for RPRH is 39% of its total budget in the 2017 General Appropriations Act (GAA) which is PhP95.27 billion. Meanwhile, the Commission on Population (POPCOM) budget of million for RPRH covers funding for its adolescent health, population and development and RPRH programs, which is 30% of its P423 million-budget in the 2017 GAA.

Despite the higher budget allocation for RPRH resulting from substantial increases in the FHRP and EPI budgets as well as the substantial amount allocated for facility construction, upgrading and equipping under HFEP, the national government still managed to increase its obligation rate from 73% in 2016 to 95% in 2017. HFEP showed the greatest improvement in spending performance with its obligation rate increasing sharply from 68% to 95% for the period.

Table 1a. Indicative National Government Budget Allocation and Obligation for RPRH, 2016 and 2017

Agency/Program	2016 Adjusted Allotment for RPRH (in PhP million)	2016 Total Obligation (in PhP million)	2017 Adjusted Allotment for RPRH (in PhP million)	2017 Total Obligation (in PhP million)
DOH	29,700.56	21,607.01 (73%)	37,248.20	35,534.89 (95%)
Family Health and Responsible Parenthood	2,275.07	1,851.88 (82%)	4,265.50	3,850.00 (91%)
Expanded Program on Immunization	3,999.75	3,910.65 (98%)	7,104.30	7,083.70 (99%)
Health Facility Enhancement Program	23,425.74	15,844.48 (68%)	25,878.40	24,601.19 (95%)
POPCOM	280.00	227.20 (99%)	423.00	423.00 (100%)
TOTAL	29,980.56	21,834.21 (73%)	37,671.20	35,957.89 (95%)

Source: General Appropriations Act 2017, DOH Consolidated Appropriations, Obligations and Balances as of the Quarter Ending December 2016 and 2017 and POPCOM



Other allocations for RPRH implementation include the PhP10.8 million-budget of the Philippine National AIDS Council (PNAC) as well portion of the HIV/AIDS, health promotion and communication, and health human resource budgets of the DOH. Said portion of the budget allocated and spent on RPRH-related programs and activities, however, cannot be readily determined given the aggregated program budgets.

In addition to government budget, development partners allocated around PhP10.2 billion in 2017 to support the implementation of RPRH¹. More than half of this amount went to FP/RH/MNCHN programs. USAID, for instance, allotted PhP4.8 billion for activities aimed at improving health systems and removing barriers to FP/MNCHN use. Technical assistance was also provided to the DOH in implementing RPRH-related programs at the national, regional (i.e. Luzon, Visayas and Mindanao) and local (i.e. Cordillera) levels. Development partners that actively supported the implementation of the RPRH law include the European Union (EU), Global Fund, Japan International Cooperation Agency (JICA), United Nations International Children's Emergency Fund (UNICEF), United Nations Population Fund (UNFPA), United States Agency for International Development (USAID) and the World Health Organization (WHO).

Social Health Insurance

PhilHealth membership and premium collection

PhilHealth reported 96.7 million registered beneficiaries in 2017, which already comprises 93% of the country's projected population for the year. This number includes the 32 million indigent members and dependents from the National Household Targeting Survey for Poverty Reduction (NHTS-PR) households². Indigent program members are concentrated in Western Visayas, Central Visayas and Zamboanga Peninsula (see Table 1b).

Based on its 2017 Financial Statements Report, PhilHealth premium collection increased by 3% from PhP103.79 billion in the previous year to PhP106.6 billion - PhP33.9 billion of which came from the 2017 GAA allocation for NHTS members' premium contributions. Approximately PhP228 million was derived from the premium contributions of women who are about to give birth (WATGB), PhP577 million from the premium collection under the POC, and PhP3 billion from the 2017 GAA as budgetary support to PhilHealth to cover the actual value of benefits availed by the POS patients³. WATGB premium contributions increased by 18% while premium collection under the POC decreased from PhP748 million in 2016 possibly because of the introduction of the POS.

¹ Written communication dated April 2, 2018 from BHIC. This letter includes matrix of development partners' budget for reproductive health.

² Source: Corporate Planning Department, PhilHealth

³ POS patient refers to patient or in case the patient is a minor, the parent or the guardian who is classified as financially incapable. He/she shall be registered into the NHIP by the government facility



Table Ib. Number of Indigent Program Members and Dependents Among NHTS Poor Households⁴

Region	Members	Dependent
CAR	265,463	333,031
Ilocos Region	643,351	893,886
Cagayan Valley	477,255	690,414
Central Luzon	853,670	1,220,239
NCR	755,680	789,227
CALABARZON	610,665	796,002
MIMAROPA	839,310	1,057,374
Bicol Region	991,876	1,551,692
Western Visayas	1,566,633	1,519,355
Central Visayas	1,265,638	1,108,732
Eastern Visayas	1,082,703	1,561,532
Zamboanga Peninsula	1,134,921	1,181,267
Northern Mindanao	1,063,918	1,050,809
Davao Peninsula	346,490	666,861
SOCCKSARGEN	823,278	943,460
ARMM	966,446	1,508,568
CARAGA	642,145	828,406
Total	14,329,442	17,700,855

Benefit Payment

Total benefit payment improved over the years. Its 2017 Financial Statements Report indicated that PhilHealth reimbursed a total of Php115 billion. Of this, Php43.035 billion or 30% was paid for Government-Sponsored members and at least Php23.8 billion for RPRH-related benefits. Benefit payment for RPRH-related services steadily increased in the last four years from Php11.3 billion in 2014 to Php23.8 billion in 2017. Benefit payment for RPRH-related services is 15% higher in 2017 than in 2016 (see Table Ic).

PhilHealth benefit payment remains biggest for the MNCHN package. PhilHealth benefit payment for MNCHN steadily increased from P8.3 billion in 2014 to nearly Php22 billion in 2017. Meanwhile, benefit payment for FP increased over Php1.3 billion in 2016 from Php13.6 million 2015, then dropped to Php44.4 million in 2017. The unusually high benefit payment in 2016 may be due to the counting of claims for multiple procedures involving FP services performed with other procedures such as CS and BTL as well as NSD and IUD insertion. In 2017, such claims were already counted under the MNCHN package. Benefit payments on FP only considered purely FP procedures, unlike in the previous year. Among the five RPRH-related services, the FP package received the least amount of PhilHealth benefit payment.

⁴ Source: Awaiting official transmittal of data

Table 1c. Benefit Payment for RPRH-Related Services for 2014, 2015, 2016 and 2017⁵

Benefit Package	Total Amount Paid (in PhP million)			
	2014	2015	2016	2017
FP ⁶	21.00	13.60	1,315.42	44.35 (277.62) ⁷
MNCHN ⁸	8,274.70	11,560	16,340.10	21,953.00
Post-abortion care	258.70	394.15	569.60	240.63
STI and HIV	53.36	120.00	242.00	338
Breast and Gynecologic Conditions ⁹	2,547.00	582.11	1,329.00	1,165.80
Men's Health ¹⁰	110.44	130.11	472.34	46.13
Total	11,265.20	12,799.97	20,268.46	23,787.91

Source: PhilHealth 2017 Financial Statements Report

Use of PhilHealth benefits

Use of PhilHealth benefits improved with PhilHealth initiatives to expand NHIP coverage, such as through the POC and POS as well as through the regular conduct of “*Alamin at Gamitin (ALAGA Ka)*” Program and “Project REACHOUT”. Increase in the number of PhilHealth-accredited facilities also allowed greater access of PhilHealth benefits by members and their dependents.

Facility Accreditation

There were more PhilHealth-accredited facilities that provided RPRH services in 2017. These include 763 public hospitals and infirmaries; 2,455 Primary Care Benefit (PCB) providers in cities and municipalities all over the country; and 3,243 public and private MCP providers.

Table 1d shows that the ratio of PhilHealth-accredited PCB providers to total cities and municipalities declined from 97% in 2016 to 94% in 2017, which is partly due to LGU difficulty in complying with the accreditation requirement for physician. Meanwhile, MCP ratio to total cities and municipalities remained almost unchanged at 91%. Table 1e presents the actual number of PhilHealth-accredited PCB and MCP providers in the country from 2014 to 2017.

⁵ Source: PhilHealth Corporate Planning Department and MDG

⁶ Includes IUD, BTL and NSV (2014-2015), IUD, BTL, NSV and SDI (2016-2017)

⁷ Procedures that are multiple (deliveries with FP procedures) were already included under MCHN counts

⁸ Includes deliveries (normal deliveries, caesarian sections, breech and complicated vaginal deliveries); antenatal care and pregnancy-related conditions; and infant and child health care (Newborn Care Package and Perinatal Conditions)

⁹ Includes payment for medical case rates and procedures as well as cancer treatment (Z benefit packages)

¹⁰ Includes reimbursement for procedures and treatment for diseases of male genital tract including Z benefit for prostate cancer

Table Id. Number of PhilHealth Accredited PCB and MCP Providers in Cities and Municipalities, 2016 and 2017

	2016 ¹¹		2017 ¹²	
	PCB	MCP	PCB	MCP
Number of accredited outpatient clinics	2,557	3,102	2,455	3,243
Number of cities and municipalities with accredited clinics ¹³	1,578	1,463	1,541	1,493
Percentage to total number of cities and municipalities	97%	90%	94%	91%

Source: PhilHealth data, 2016 and 2017

Table Ie. Number of PhilHealth-Accredited MCP and PCB Providers: 2014, 2015, 2016 and 2017

Year	MCP	PCB
2014	2,645	2,438
2015	2,981	2,553
2016	3,102	2,557
2017	3,243	2,455

Source: PhilHealth data 2014-2017

Table Ie indicates a steady increase in the number of MCP providers but this number remains inadequate to fully cover all cities and municipalities in the country. The same trend is seen on PCB until 2017.

Enabling policies

PhilHealth developed four RPRH-related policies with accompanying “*Tamang Sagot*” – a list of frequently asked questions for better understanding of PhilHealth members and other stakeholders. PhilHealth Regional Offices organized orientation activities on the ground to ensure uniform understanding of these policies, which include:

1. *PhilHealth Circular 002 s. 2017 on the Adoption of the Enhanced Benchbook for Hospitals and Non-Hospital Facilities (Date Issued: January 10, 2017)*. This policy was issued to strengthen the implementation Quality Assurance Program for all accredited HCIs, promoting improvement in health service delivery which is expected to lead to patient satisfaction and better health outcomes. It is consistent with the Corporation’s mandate to implement quality assurance as

¹¹ Source: The Third Annual Consolidated Report on the Implementation of the Responsible Parenthood and Reproductive Health Act of 2012 (R.A. No. 10354)

¹² Statistics of Accredited Health Care Providers as of December 31, 2017. Accreditation Department, PhilHealth with concurrence of Corporate Planning Department (per SMS dated April 11, 2018)

¹³ A city or municipality may have more than one outpatient clinic accredited by PhilHealth to provide NHIP benefits and services. There are 1,634 LGUs nationwide.

provided for in RA 7875, as amended. The Benchbook shall be applicable not only to hospitals but to Ambulatory Surgical Clinics, Free Standing Dialysis Clinics, Maternity Lying-in Clinics, Oncology Centers, Primary Care Facilities (PCF) and Rural Health Units as well. PhilHealth shall use the Benchbook as reference or guide for identifying Centers of Excellence (COE).

2. *PhilHealth Circular 006 2. 2017 on Strengthening the Implementation of the No Balance Billing Policy (Revision 1) (Date issued: January 20, 2017).* This policy provides clarification on covered PhilHealth members that are eligible for NBB (i.e. Indigent, Sponsored, Kasambahay, Senior Citizen and Lifetime). It also provides a list of private institutions and the corresponding PhilHealth benefits that they provide, including services covered by the NBB policy. Participation of hospitals in the NBB shall be subject to PhilHealth approval. RPRH-related services that may be considered for the NBB scheme include those on MCP, ANC, NSD, private birthing facilities for example, private birthing facilities may apply NBB policy for the following services such as MCP, ANC, NSD, NCP, family planning procedures for NBB eligible members and dependents.
3. *PhilHealth Circular 0023 2. 2017 on the Accreditation of Nurses for Maternal and Child Health Services (Date issued: August 25, 2017).* This policy provides standards and guidelines on the accreditation of nurses for MCP, NSD, and NCP in accredited birthing homes. It includes supplemental requirements for nurses who will provide FP services.
4. *PhilHealth Circular 0025 s. 2017 on the Guidelines in the Implementation of Point of Service Program (Revision 1) (Date issued: September 13, 2017).* The POS Program as provided for in the 2017 GAA, aims to address the gaps in the coverage of both financially capable and financially incapable Filipinos, and ensures 100% availment rate especially by the poor. A total of PhP3 billion was allotted in the 2017 GAA as budgetary support to PhilHealth to cover the actual value of benefits availed by POS patients. PhilHealth shall bill the Department of Budget and Management on a quarterly basis, the actual cost of availment of POS Patients. However, if the patient or in case the guardian of the patient is financially capable, the patient shall be eligible to avail All Case Rates upon payment of annual premium as prescribed by the Corporation and shall be eligible for Z Benefits subject to existing rules for availment.

Challenges and Recommendations

Low use of PhilHealth FP benefit package. While NHIP coverage is nearly universal, members, especially those with expressed need for FP, are not maximizing the use of FP benefit package.

Recommendation: Investigate barriers to members' FP benefit availment. PhilHealth may review its current membership services to determine gaps in FP package utilization and consequently develop corresponding strategies to increase members' use of their FP benefit. Examine the operational constraints to provider compliance with PhilHealth FP accreditation requirements as well and extend appropriate technical, policy and budgetary assistance to facilitate their accreditation.

Need for sustained mechanisms to improve use of RPRH-related benefits. While PhilHealth has been actively issuing policies to continuously improve use of RPRH services, not all health providers have uniform interpretation of such policies. Moreover, members are likely to be unaware of the implications

of those policies on their use of RPRH services. Conduct of PhilHealth IEC activities for providers and members are far between and at times, arbitrary.

Recommendation: Review PhilHealth issuances on facilitating: (a) membership availment of RPRH-related benefit packages, and (b) provider reimbursements for RPRH services. Once demand and supply bottlenecks are identified, PhilHealth may issue clarificatory or supporting guidelines to remove constraints to benefit availment and provider reimbursement. PhilHealth may also have to ensure timely dissemination of its policies and guidelines to field implementers, and set up mechanisms for regular communication with service providers as well as community mobilizers to help dispel confusion and misinterpretations on various RPRH-related issuances such as that on separate accreditation requirements for IUD service providers.

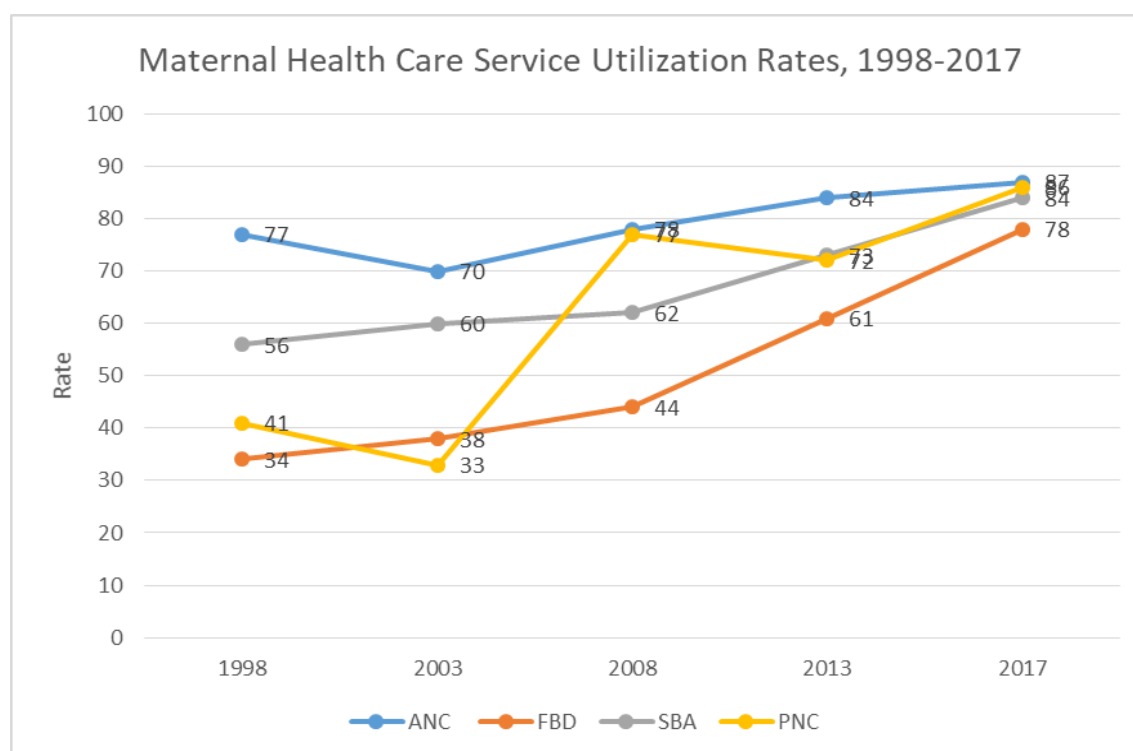
KRA 1: Maternal, Neonatal, Child Health, and Nutrition

Status and Trends

Maternal health

The Philippine National Health Demographic Surveys (NDHS) showed that maternal health care service utilization generally improved but most regions failed to reach national targets for MNCHN. NDHS results showed an increasing trend in facility-based delivery (FBD) and skilled birth attendance (SBA) as well as in the use of antenatal care¹⁴ (ANC) and post-natal care¹⁵ (PNC). Fig. 1a shows the trend in the utilization of maternal health services from a series of national surveys spanning multiple periods – 1998, 2003, 2008, 2013, and 2017.

Figure 1a. Maternal Health Care Service Utilization, 1998-2017



Source: NDHS, 1998-2017.

¹⁴ At least four antenatal care visits to or by skilled health personnel, with the first visit occurring during the first trimester of pregnancy.

¹⁵ Post-partum visits or check-up by skilled health personnel within 2 days after delivery.

The FBD increased from 34% in 1998 to 78% in 2017. SBA or deliveries attended by doctors, nurses or midwives likewise went up from 56% to 84% over this period. Improvements were also observed in the same period for ANC and PNC which increased from 77% to 87% and 41% to 86%, respectively. These developments can be attributed to the availability of maternal health services in the country especially in geographically isolated and disadvantaged areas (GIDAs).

Despite general improvements in maternal health service utilization, wide regional disparities persist. Only the National Capital Region (NCR) was able to reach the 90% DOH target for all maternal health service utilization indicators. Regions 1, CAR and VII attained the national target for ANC visit, SBA, and PNC. All regions, except Region IX and the Autonomous Region of Muslim Mindanao (ARMM), are delivering ANC services to at least 90% of pregnant women in the region with Eastern Visayas covering almost 100% of its target clients. Meanwhile, 22% of pregnant women still give birth at home or in other places outside health facilities. Around 80% of these women are concentrated in NCR, CAR and Regions I, II, III, VII, and VIII. ARMM remains to be the region with the lowest utilization of maternal health care services. Its SBA and FBD are at a low 34% and 29%, respectively.

Table 1a. Maternal Care Service Utilization Rates, by Region, 2017

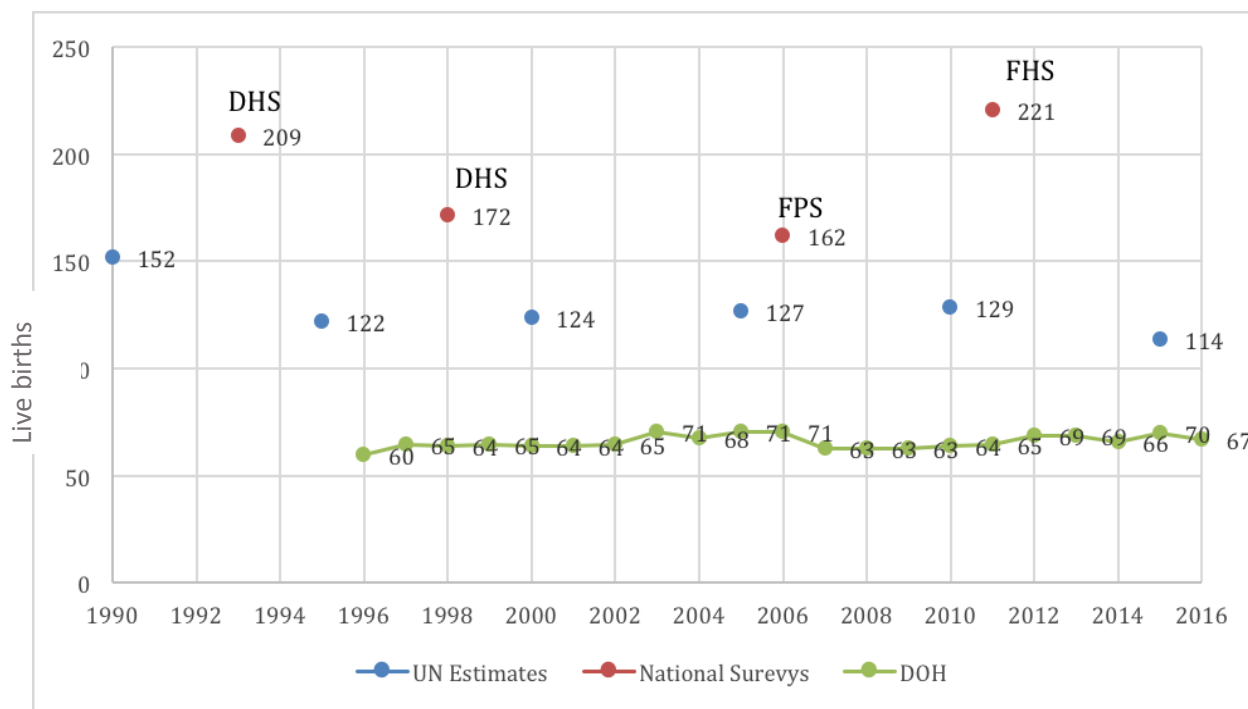
	At least 1 ANC Visit¹⁶	Skilled birth attendance	Facility-based delivery	Post-natal care within 48 hours
Philippines	94	84	78	86
NCR	93	96	92	97
CAR	95	92	86	95
I	98	98	87	94
II	95	91	83	88
III	94	93	85	74
IVA	97	89	77	93
IVB	93	69	66	86
V	96	84	73	93
VI	92	81	78	87
VII	96	91	85	90
VIII	99	87	85	90
IX	88	77	72	63
X	94	79	76	69
XI	92	82	74	91
XII	92	66	64	78
XIII	95	80	77	73
ARMM	69	34	29	64

Source: NDHS, 2017.

¹⁶ Regional data on NDHS 2017 for ANC only showed “at least one ANC visit.”

While maternal health care service indicators made significant improvements, data from various sources recorded a plateauing of Maternal Mortality Ratio (MMR)¹⁷ from 1993 to 2016. The WHO, in their *Trends in Maternal Mortality: 1990 to 2015* report, documented that the Philippines made *no progress*¹⁸ for the past 15 years since 1990. Similarly, national health surveys constantly reported higher figures of MMR at 209 per 100,000 live births in 1993 and 221/100,000 live births in 2011 (see Figure 1b). Improvements in MMR were noted in DHS 1998 and FPS 2006 at 172 and 162 per 100,000 live births but their results remain inconclusive given the high margin of error of estimation¹⁹. Further, while DHS 1998 and FPS 2006 showed progress, these numbers are still higher than the UN estimates.

Figure 1b. Maternal Mortality Ratio, 1990-2016



Source: Demographic Health Survey 1993 and 1998; Family Planning Survey 2006; Family Health Survey 2011; UN Estimates 1990, 1995, 2000, 2005, 2010, and 2015; and DOH FHSIS 1996-2016.

Meanwhile, the DOH Field Health Statistics Information System (FHSIS) showed a lower MMR at 67 per 100,000 live births in 2016. It should be noted that the lower MMR reported in the FHSIS was primarily obtained from public health facilities, mostly city/municipal health offices and partly government-owned hospitals. DOH-retained hospitals and tertiary hospitals do not generally submit data to DOH FHSIS as these facilities have a separate reporting system – the Hospital Management and Information System (HOMIS). Hence, FHSIS is not based on population and does not have the large sample size necessary for

¹⁷ 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).

¹⁸ *No Progress* is one of the categories (includes achievement of MDG, Making progress, Insufficient progress, No progress) of countries based on evidence of progress in reducing MMR between 1990 to 2015.

¹⁹ RPRH Annual Report, 2016.

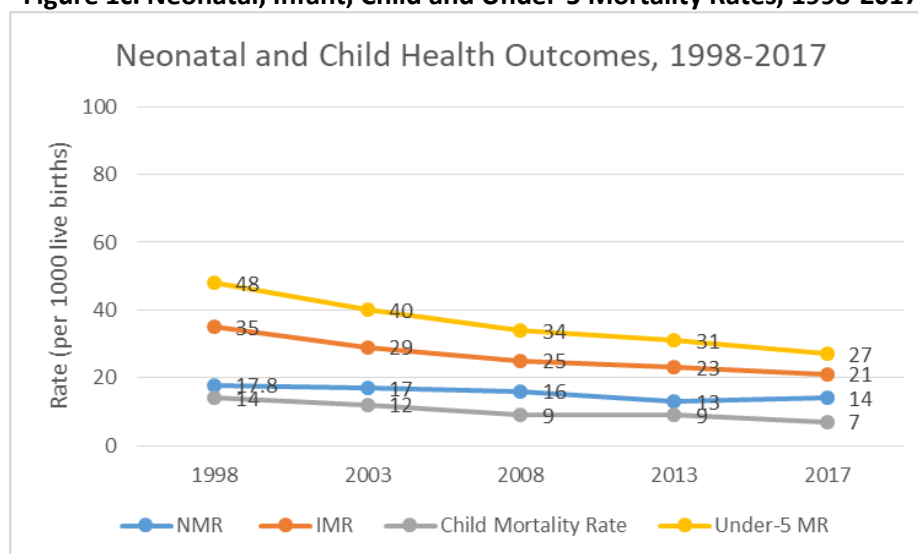
a more accurate estimation of MMR. Nonetheless, both data sources show that the Philippines is far from reaching the Philippine Development Plan (PDP) target of 90 per 100,000 livebirths nor the Sustainable Development Goal (SDG) target of 70 per 100,000 livebirths. This translates to a significant number of women dying every day mostly from preventable pregnancy-related complications.

The leading causes of maternal mortality are preventable and can be averted by quality obstetric care from Emergency Obstetric and Newborn Care (EmONC) capable-facilities. Maternal death reviews conducted in 2016, showed that 87% of 108²⁰ deaths reviewed in 43 provinces and cities were due to post-partum hemorrhage, pregnancy-induced hypertension, and sepsis which are all highly preventable complications. Various health system gaps were identified as contributory to the causes of maternal mortalities: unavailability of emergency transport and communication, lack of awareness in the navigation within the health system, untracked pregnancies, no antenatal care, unplanned pregnancies, and unavailability of blood in hospitals.

Neonatal and child health

Infant and child health outcomes showed improvements for the past two decades. NDHS documented a constant decreasing trend in newborn, infant and under-5 mortality rates from 1998 to 2017. Infant mortality rate (IMR) showed a slow decline from 35 per 1,000 live births in 1998 to 21 per 1,000 live births in 2017. The sluggish decrease in IMR can be associated to a similarly slow decline in neonatal mortality rate (NMR) in 20 years from 17 in 1998 to 14 per 1,000 live births in 2017. A decreasing trend is also noted for child and under-5 mortality rates. The 2017 NDHS reported a child mortality rate of 7 per 1,000 live births, and a higher under-5 mortality rate of 27 per 1,000 live births (see Figure 1c). Despite the minimal improvement in child health outcomes, the Philippines strives to achieve its SDG target of reducing neonatal mortality rate to 12 per 1,000 live births, and its under-5 mortality rate to 25 per 1,000 live births by 2030.

Figure 1c. Neonatal, Infant, Child and Under-5 Mortality Rates, 1998-2017



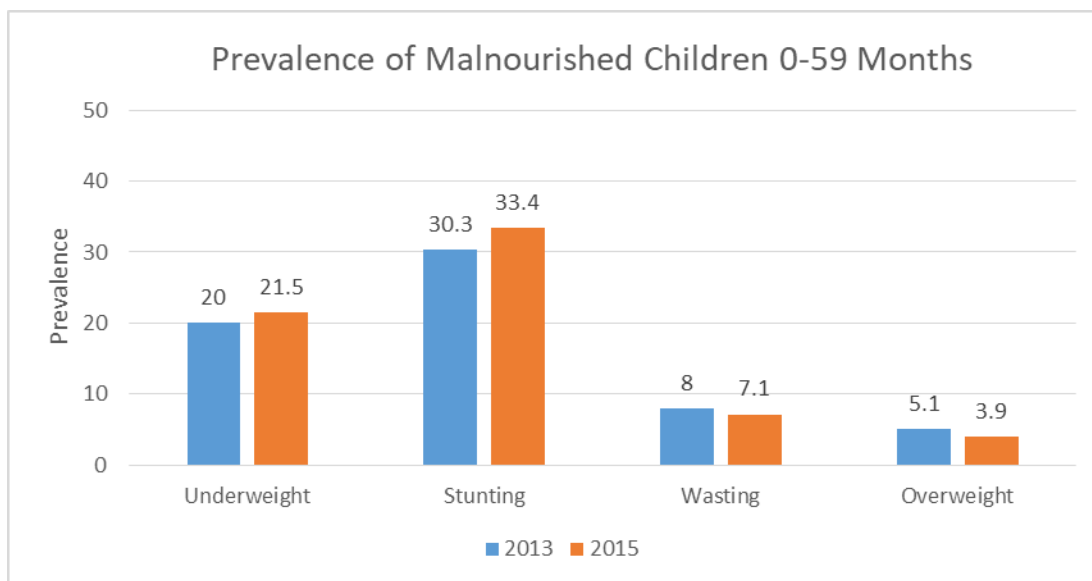
Source: NDHS, 2017

²⁰ Maternal death review report in the 2016 RPRH Annual Report reflects partial accomplishment, hence the numbers are different.

Nutrition

Malnutrition prevalence in children continue to rise. National Nutrition Surveys (NNS) showed higher prevalence of malnutrition, particularly underweight and stunting. Underweight prevalence increased from 20% in 2013 to 21.5% in 2015. Similarly, the prevalence of stunting went up from 30.3% to 33.4% over the period. Conversely, a minimal decrease is noted in the prevalence of wasting (severe acute malnutrition) and overweight among under-five children.

Figure 1d. Prevalence of Malnourished Children 0-59 Months



Source: National Nutrition Survey, 2015

Interventions

Assistance to the improvement of local health systems

While the provision of basic health services has been devolved to local government units (LGUs), the DOH continued to leverage its technical, budgetary and human resources for improved local health performance. Improving local health systems enables LGUs to organize, setup and sustain the delivery of MNCHN core package of services in every life stage from pre-pregnancy, pregnancy, delivery, post-partum, newborn, and child care as stipulated in DOH AO 2008-0029: “Implementing Health Reforms to Rapidly Reduce Maternal and Neonatal Mortality”. This policy encourages all women to access quality prenatal care and deliver in health facilities. It also seeks to provide them with post-natal care and their babies with newborn and child care.

Under HFEP, the DOH allocated Php100 billion for the construction of: (a) rural health units with provision of birthing facility, (b) new barangay health stations with birthing homes, and (c) new buildings

for hospitals. It also included provision of new equipment, fixtures and instruments (e.g. such as delivery table, hospital beds, autoclaves) necessary for the operation of the facility.

In terms of human resources, the DOH allocated PHP37 billion for the deployment of 27,911 health professionals in 2017 – 96% (26,816) of whom were directly involved in the provision and monitoring of MNCHN services at the local level.

Table 1b. Number of Deployed Professionals Assisting in the Delivery of MNCHN Services, 2017

Professionals	Number
Doctors to the Barrio	400
Physician Augmentation	81
Nurse Deployment Program	16,927
Rural Health Midwives Placement Program	4,549
Family Health Associates	611
Universal Health Care Implementers	1,477
Public Health Associates	2,771
Total	26,816

Source: DOH Health Human Resource Development Bureau, 2017.

In support to local health systems, the DOH supported LGUs in the organization, establishment and mobilization of service delivery networks (SDN). It issued Administrative Order 2017-0014 which redefines SDN and presents it as an important strategy for the full provision of MNCHN services. It is imperative that different health care providers within a locality are organized into a well-coordinated MNCHN service delivery network to provide the needs of the population and ensure a continuum of care and information. There are three levels of care in a MNCHN SDN: (1) Community-level service providers; (2) Basic Emergency Obstetric and Newborn Care (BEmONC); and (3) Comprehensive Emergency Obstetrics and Newborn Care (CEmONC)²¹.

In terms of health information, the Safe Motherhood Program of the DOH assists the regional offices and LGUs in conducting Maternal Death Surveillance and Response (MDSR) to requesting Provincial Review Teams (PRTs). The review or the verbal autopsy can provide essential information to stimulate and guide actions to prevent maternal deaths and improvement of maternal health²². The review is not limited on understanding the clinical cause of death of the deceased, rather it gives emphasis on the gaps of the health system and the social determinants of health that contributed to the mortality. In 2016, there were 108²³ deaths that were reviewed across 43 localities. The review revealed that 87% of the mothers died from preventable causes namely post-partum hemorrhage, pregnancy-induced hypertension, and sepsis. Health system gaps (i.e. unavailability of transportation, unavailability of blood, delayed referral) and social determinants of health were largely contributory to maternal health outcomes. Notwithstanding the availability and accessibility of maternal care services, these gaps continue to be prevalent all over the country.

²¹ DOH, 2011.

²² WHO, 2011.

²³ Maternal death review report in the 2016 RPRH Annual Report reflects partial accomplishment, hence the numbers are different.

In terms of financing, PhilHealth pays PhP8,000 for births delivered in birthing homes and infirmaries, and PhP6,500 for deliveries in hospitals, with the PhP1,500 unbundled for the provision of ANC. It also pays PhP1,750 for the Newborn Care Package (NCP) which covers the four core steps of the essential newborn care protocol and routine newborn care interventions (i.e. Vitamin K, erythromycin eye ointment, birth doses of Hepatitis B and BCG vaccines, newborn screening, and newborn hearing screening test). With UNICEF support, the DOH and PhilHealth launched the Z Benefit Package for Pre-term and Low Birth Weight Infants as part of the Department's commitment to reduce newborn mortality, complications of premature births, and low birth weight.

Health facilities were licensed by DOH and accredited by PhilHealth as Maternity Care Package (MCP) to enable clients to avail of maternal health care services for free. Of the 3,243 MCP-accredited birthing centers reported as of end of 2017, almost half (49%) are privately-owned and 51 percent are government-run facilities situated in 1,493 LGUs. The income generated by the facilities especially public birthing clinics and hospitals from Philhealth reimbursements are expected to be used to sustain their operations and improve service delivery. Some municipalities, for example, use their PhilHealth reimbursements to pool resources for emergency referral of complicated maternal cases to higher level facilities. Other municipalities use it to provide incentive to traditional birth attendants for bringing pregnant clients to health facilities to deliver. In certain government-owned birthing facilities, the share of personnel in PhilHealth reimbursements is pooled to fund their overtime payment and night shift differential pay.

Pre-pregnancy services

Pre-pregnancy services include provision of iron and folate supplementation, counseling and provision of family planning (FP) methods, and prevention and management of infection and lifestyle-related diseases. They highlight the provision of modern FP methods to address unmet need of women and prevent unplanned pregnancies, especially adolescents that can expose them to unnecessary risk due to early pregnancy and childbirth. Unplanned pregnancies are also associated with poorer health outcomes for both mother and newborn²⁴. Effective provision of FP services can potentially reduce maternal mortality by around 20 percent²⁵.

Antenatal care services

Antenatal care (ANC) visits provide women and their families appropriate information and advice for a healthy pregnancy, safe childbirth, and postnatal recovery including newborn care, promotion of early and exclusive breastfeeding, and assistance on deciding future pregnancies²⁶. Further, ANC aims to monitor the status of health of the mother and baby for early diagnosis of any pregnancy-related problems or complications.

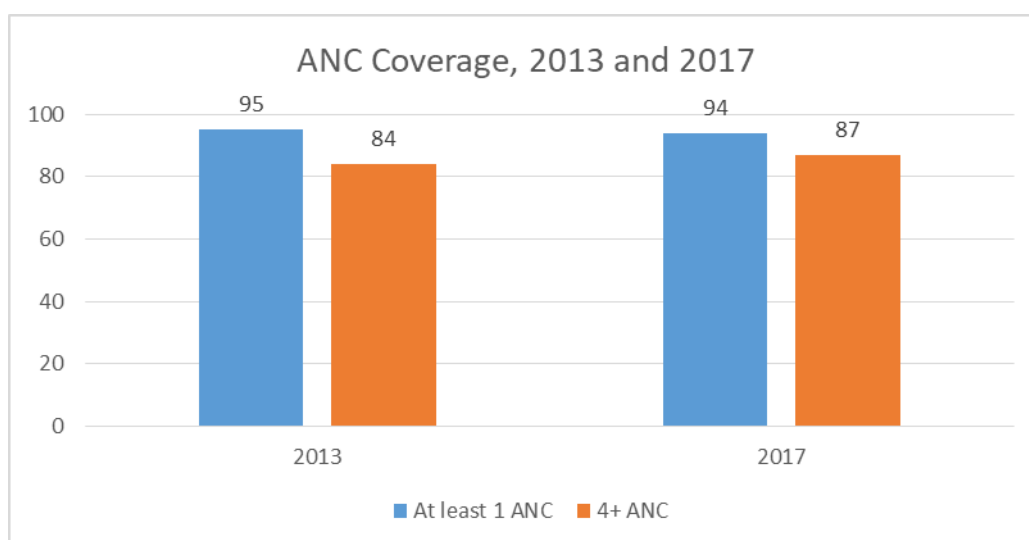
²⁴ DOH, 2011.

²⁵ Donnay, 2000.

²⁶ WHO, 2006.

The WHO recommends at least 4 ANC visits, with the initial visit happening within the first trimester. In the Philippines, national health surveys showed that while 94% of women are seeking prenatal care, they only visit the health facility at least once, hence essential interventions are not provided during the entire course of pregnancy. In 2017, only 87% of women have adequate ANC visits, 7-percentage points lower from 1-ANC visit. At least 6% of women did not have ANC consultation at any time during pregnancy. The 2017 NDHS also revealed that there is no significant difference in ANC visits among women residing in urban and rural areas, suggesting accessibility and availability of maternal care services in both cities and far-flung localities. The low 4-ANC coverage rate may explain the low FBD rates. Studies have shown that ANC is an opportunity to promote the use of skilled attendance at birth, facility-based delivery, and family planning.

Figure 1e. Antenatal Care Visit, 2013 and 2017.



Source: NDHS, 2013 and 2017

Another factor that may influence antenatal care visit is the tracking of pregnancies in the community. Community-level providers i.e. traditional birth attendants, barangay/volunteer health workers, community health teams, or other members of the barangay council, identify and list pregnant or suspected pregnant women. This list is then submitted monthly to the midwife in-charge of the barangay. The midwife conducts home visits and the women are encouraged to visit the health center for a comprehensive prenatal check-up. The community health workers likewise assist these clients develop their birth plans and navigation through the service delivery network. Of the 1.7 million reported deliveries in 2017, 68% were tracked and 61% developed birth plans. CSOs and private groups tracked additional 18,194 pregnancies and identified 9,535 women with birth plans. The low number of tracked pregnancies indicates the need to improve the navigation functions of community health providers.

Part of the ANC services is the administration of tetanus toxoid immunization to mothers to prevent neonatal tetanus. 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 services²⁷. In 2017, 80% of women received tetanus toxoid immunization. ***The WHO and UNICEF officially reported that the Philippines has eliminated neonatal tetanus in 2017.***

Demand generation activities were conducted to encourage women to deliver in health facilities and to disseminate information on PhilHealth benefits, and given information on FP should they decide to space or limit pregnancy after delivery. Rural/city health units conduct *Buntis* or Family congress regularly throughout the year wherein pregnant women or couples are informed on reproductive health and responsible parenthood. A total of 129 community education sessions on MNCHN were conducted by CSOs in various cities/municipalities in the country. They also distributed 22,626 maternal and child health educational materials in 11 regions. These demand generation activities are important to improve “healthcare-seeking behavior” and not just “health-seeking behavior” per se. This means that mothers, WRAs, couples, or families are encouraged to seek consultation from skilled health professional and not from traditional birth attendants (TBAs). While cultural practices are important in the holistic management of a client especially during pregnancy, correct and accurate clinical management is of utmost importance. TBAs can be part of the community-level providers who can assist clients navigate within the health system. Gaps in creating demand may stem from the lack of a harmonized national demand generation strategy from the DOH to support LGUs in designing, implementing, and evaluating appropriate demand side interventions directed to a specific target areas or population. Another gap is the absent of measurement tools or metrics for the monitoring and evaluation of these activities.

The DOH continues to procure commodities for antenatal care i.e. Iron tablets and Calcium Carbonate for WRA. This supplements are specifically given to pregnant and lactating women to prevent anemia and osteopenia, and poor fetal mineralization. Calcium supplementation is also important to promote fetal growth and prevent low birth weight. Studies also suggest that it has beneficial effects in reducing the risk of pregnancy-induced hypertension.

Table 1c. Procured Commodities for Antenatal Care and Lactating Women, 2017.

Commodity	Target Beneficiary		Cost
Iron Tablets with 400mg folic acid	Pregnant/Lactating women	457,367,300	Php 274,420,380.00
	WRA	100,236,100	Php 60,141,660.00
Calcium Carbonate	Pregnant women	539,913,000	Php 782,873,850.00

Source: DOH, 2017.

Labor, delivery, and post-partum services

Basic and Comprehensive Emergency Obstetric and Newborn Care (BEmONC/CEmONC), the second and third level of care in the MNCHN SDN, are critical in reducing maternal and neonatal mortalities. Frontline skilled health personnel, specifically midwives stationed in birthing homes, should be capable

²⁷ WHO, 2017.

in providing BEmONC services, while referral hospitals are expected to provide CEmONC. The WHO defines the BEmONC 7 signal functions, to wit: (1) administration of parenteral antibiotics; (2) administration of uterotonic drugs; (3) administration of parenteral anticonvulsants; (4) manual removal of placenta; (5) removal of retained placenta; (6) performance of assisted vaginal delivery; and (7) basic neonatal resuscitation. Caesarean delivery and provision of blood transfusion in addition to the 7 signal functions define the Comprehensive Emergency Obstetric and Newborn Care (CEmONC). The WHO also recommends that 5 health facilities (4 BEmONC and 1 CEmONC) should cover no more than 500,000 population, and services should be available 24/7. Currently, there are 3,102 BEmONC-capable facilities of which 57% are public health facilities. BEmONC training is offered in 31 accredited training institutions all over the Philippines.

In 2014, a study²⁸ on the evaluation of the BEmONC implementation in the country conducted in selected United Nations Population Fund (UNFPA) sites²⁹ showed that there are a lot of challenges in BEmONC implementation. These challenges include non-performance of the signal functions, issues with the training curriculum, conduct of training, and post-training evaluation, lack of logistical supply in the facility, and management issues, among others. The study revealed that only 4 of the 95 assessed BEmONC facilities were able to perform all the 7 signal functions. While not all signal functions, specifically, manual removal of retained products of conception, are within the scope of practice of midwives, it was anticipated that the study will reveal that at least 5 of the 7 signal functions were practiced by all skilled health personnel as these are fundamental skills required from frontline skilled health personnel delivering MNCHN services. However, only 5.3% of the total facilities assessed performed 5 of the 7 signal functions. The study also revealed that there are problems with the conduct of training. Majority of the respondents answered that during the return demonstration³⁰ there were no or very limited opportunities to perform required procedures even if the training is conducted in a tertiary or in DOH-retained hospitals. Post-training evaluation, supposedly conducted 6 months after the BEmONC training, was not routinely done by the training institutions. Unavailability of supplies, for example of emergency medicines, was noted to be a prevalent problem in the entire study sites.

While the study documented the challenges in performing the 7 signal functions, the DOH actually modified the BEmONC signal functions suitable to the capacity of the Philippine health system. The changes were done following consultation with specialty societies i.e. Philippine Obstetrical and Gynecologic Society (POGS), midwives associations, and the Professional Regulation Commission (PRC). The modified BEmONC signal functions for non-specialist doctors, nurses, and midwives include:

- a. Parenteral administration of loading dose of antibiotics
- b. Parenteral administration of loading dose of anticonvulsant
- c. Parenteral administration of uterotonics
- d. Manual removal of the placenta
- e. Manual removal of the products of conception
- f. Assisted vaginal delivery using low outlet forceps
- g. Imminent breech delivery
- h. Parenteral administration of loading dose of maternal steroids for preterm labor

²⁸ Australian Aid and UNFPA, 2014. *BEmONC Functionality: Baseline Assessment of Facilities in Selected UNFPA Sites*

²⁹ Quezon City, Albay, Camarines Norte, Sarangani, Sultan Kudarat, and North Cotabato

³⁰ Similar with the Objective Structured Clinical Examination (OSCE)

- i. Essential newborn care to include newborn immunization and newborn screening
- j. Newborn resuscitation
- k. *Hospital BEmONC are mandated to provide blood transfusion services (the training is part of a special training program under the National Voluntary Blood Program)*³¹

The modifications to the BEmONC global standard were made in consideration to health system limitations, to wit: (1) health workers in the BEmONC facility is not prepared to perform the signal functions which is one of the findings of a nationwide assessment conducted in 2007; (2) almost all public health primary level facilities are headed by a non-specialist doctor and were not trained to handle even basic complications in obstetrics and pediatrics; (3) the current breed of nurses and midwives were not trained on BEmONC-competency as globally defined. While the nurses can perform these functions, the law requires that they be closely supervised by a trained doctor. The midwifery law does not allow the midwives to perform any of the signal functions (RA 7392 Article 3 Section 23); (4) while DOH conducts the 11-day BEmONC Skills Training Program for the health team, the training duration is considered not enough to develop BEmONC proficiency given the fact that the Training Centers are used by nursing and midwifery students as well; and (5) The health facilities designated to provide BEmONC are likewise not ready to provide all the 6 signal functions. While DOH is investing on their upgrade, procurement for infrastructure and equipment takes time, sometimes, longer than usual.³²

To answer some of the difficulties in EmONC implementation, the DOH together with various midwifery associations and the Board of Midwifery of the PRC continued the efforts to revise Republic Act 7392 or the Philippine Midwifery Act of 1992. The primary objective of the revision is to expand and update the scope of practice of midwives which will include the performance of at least the 4³³ signal functions of the BEmONC. The revisions will harmonize the provisions of the RPRH Law which allow midwives to administer life-saving drugs and to consistently perform the Active Management of the Third Stage of Labor (AMSTL)³⁴. While series of meetings have been conducted in 2017, the technical working group is still in the process of looking for legislators to sponsor the bill.

In the same year, the NIT pushed for the issuance of the policy on the Prevention and Management of Abortion Complications to allow midwives to perform removal of retained products of conception through manual vacuum aspiration (MVA). While, the Administrative Order was signed, some of the midwifery groups disputed the provisions of the policy as it was beyond their scope of practice. This policy was then held in abeyance and was planned to be revised. In 2017, the Safe Motherhood program of the DOH organized and led the consultations and workshops with various professional groups and the PRC to revise the policy. A new policy will be issued in 2018 requiring post-abortion care to be completed in a hospital by a specialist.

³¹ National Safe Motherhood Program, DOH. Excerpt from the report on the *National Agenda to Accelerate the Achievement of MDG 5* by Dr. Marilen J. Danguilan.

³² Ibid.

³³ Except manual removal of placenta, removal of retained placenta, and performance of assisted vaginal delivery.

³⁴ AMTSL – administration of uterotonics soon after birth; delivery of the placenta by cord traction; and uterine massage.

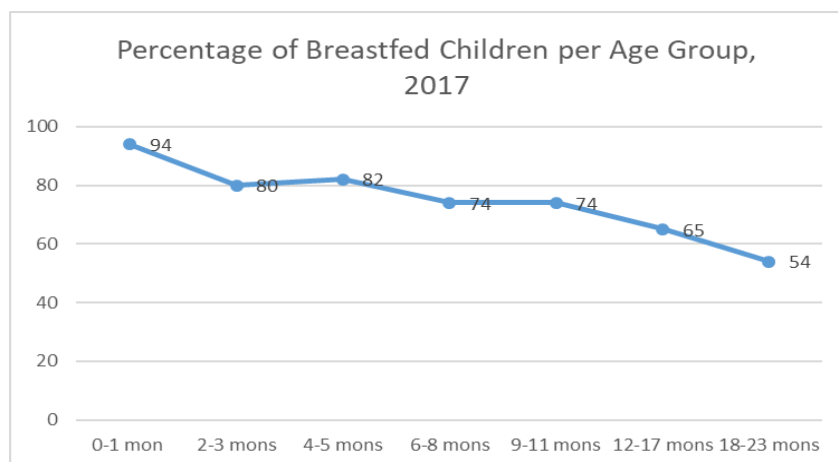
Newborn, infant, and child care services

The different child health and nutrition programs of the DOH continue to provide technical assistance to the 17 DOH Regional Offices and the LGUs in the implementation of the neonatal, infant, and child health care services which includes: (1) Essential Intrapartum and Newborn Care (EINC); (2) Care for small babies (preterm and low birth weight infants), (3) Infant and Young Child Feeding (IYCF), aside from promotion of exclusive breastfeeding; (4) immunization; (5) Integrated Management of Childhood Illnesses (IMCI), (6) Integrated Management of Acute Malnutrition, (7) micronutrient supplementation, and (8) child development, disability prevention and rehabilitation

Exclusive breastfeeding

Optimal breastfeeding practices benefit both the mother and her newborn. Early initiation of exclusive breastfeeding immediately afterbirth aids in uterine contraction, thus reducing the risk of post-partum hemorrhage. Exclusive breastfeeding for the 1st six months of life, provides the ideal amount and form of nutrients and protects the child from life-threatening illness and some non-communicable diseases.

Figure 1f. Proportion of Currently Breastfed Children per Age Group, 2017.



Source: NDHS, 2017

The 2017 NDHS reported that only 63% of children were exclusively breastfed within the first 6 months of life. The proportion of breastfed children decreases as the age increases as shown in Figure 1f. The NDHS also revealed that there is no significant difference between the survey results in 2013 and 2017 showing the proportion of bottle-fed children.

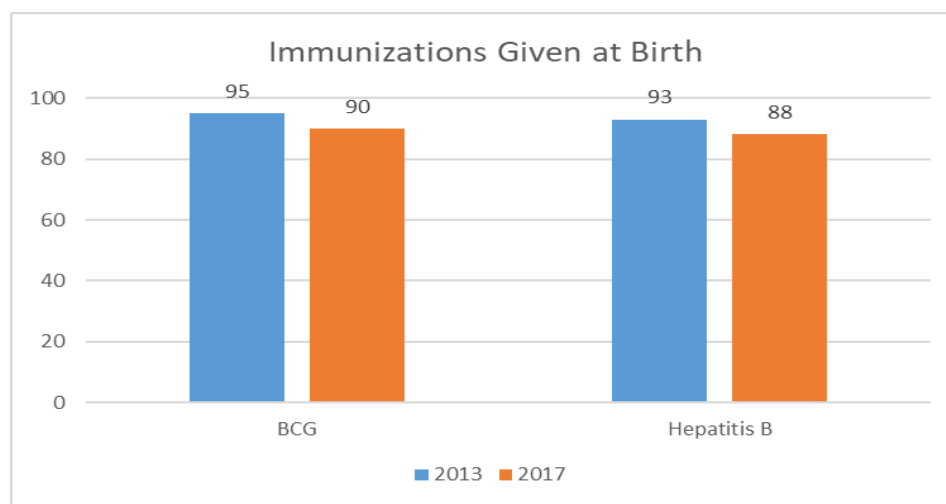
Part of the breastfeeding advocacy is to support the conduct of the “*Hakab Na!*”, a gathering of mothers to promote exclusive breastfeeding and provide a support group to breastfeeding mothers. In 2017, more than 2,000 mothers assembled at the Araneta Coliseum to join the *Hakab Na!* and participated in the “Big Latch On” wherein all the mothers simultaneously breastfeed their babies. This activity is an annual breastfeeding campaign of the Facebook group Breastfeeding Pinays held during the Breastfeeding Awareness Month and the World Breastfeeding Week. It was the culminating activity of the ASEAN Breastfeeding Forum, as one of the commemorative celebrations of the Philippines hosting of ASEAN. Aside from Breastfeeding Pinays, LATCH Philippines, a non-government organization regularly conducts breastfeeding support group sessions and breastfeeding classes to expectant mothers in The Medical City and in key highly urbanized cities in Visayas and Mindanao. The group also trains

breastfeeding peer counselors since 2006. In 2016, they trained their 7th batch of peer counselors composed of mothers from various professions.

Immunization

The DOH directs the administration of the Bacillus Calmette-Guerin (BCG) vaccine and the first dose of Hepatitis B to neonates within 24 hours after birth. **The NDHS showed that the coverage of Hepatitis B and BCG immunizations given at birth marginally decreased in 2017.** While BCG coverage is still at 90%, missed opportunities to protect children from extra pulmonary forms tuberculosis persists. Practice in the field shows that some neonates are not vaccinated with BCG at birth as the BCG vial procured by the DOH is multi-dose. At least 8 babies should be collectively gathered for one vial to be opened. However, in some regions, adjustments on vaccine allocation was done to allow opening of the vial for one neonate. For the Hepatitis B coverage, one of the reasons of the slight decrease is the inclusion of Hepatitis B in the Pentavalent vaccine³⁵ given to babies at 6 weeks from birth. This causes confusion in the implementation in the LGUs, hence, it is recommended that a policy issuance be issued to reiterate the administration of the birth dose of Hepatitis B.

Figure 1g. Hepatitis B at Birth and BCG Immunization Coverage, 2013 and 2017.

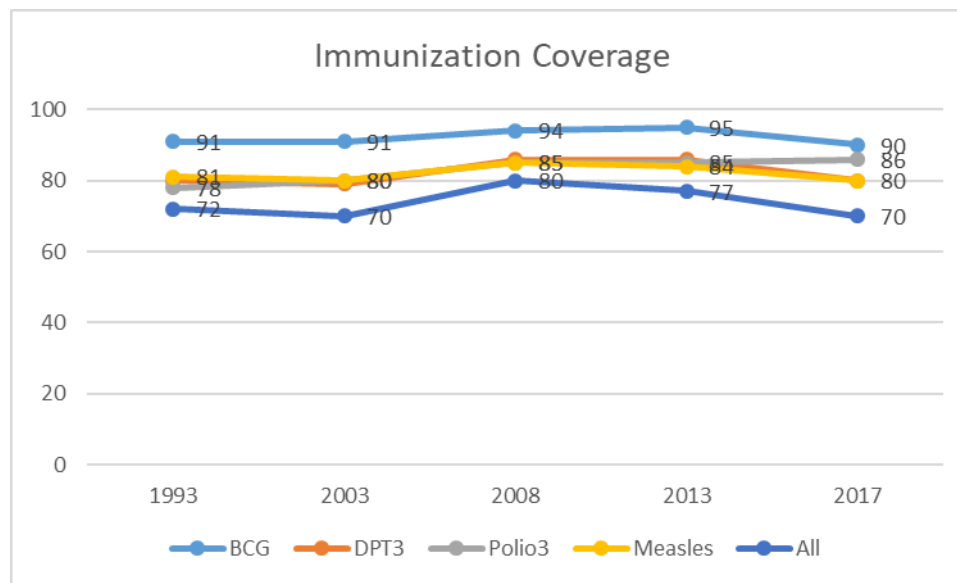


Source: NDHS, 2013 and 2017

The DOH targets a 95% immunization coverage among 1-year old children. **However, immunization coverage across 5 health surveys starting in 1993 to 2017 showed a decreasing trend except for Polio which increased by 1 percentage point in 2017 (Figure 1h).** The persistent decline increases the risk of outbreaks and re-emergence of infectious fatal diseases.

³⁵ Diphtheria, Pertussis, Tetanus (DPT), Hepatitis B, and Haemophilus Influenza (HiB)

Figure 1h. Trend of Immunization Coverage, 1993 to 2017.



Source: NDHS, 2017

Nutrition

The National Nutrition Council (NNC) officially released the Philippine Plan of Action for Nutrition (PPAN) 2017-2022 which is considered as an integral part of the Philippine Development Plan and the Duterte Administration 10-point Socioeconomic Agenda. The PPAN contains nutrition-specific and nutrition-sensitive programs to address the persistent prevalence of malnutrition in the country. It includes 5 strategic thrusts, to wit: (1) focus on the first 1,000 days of life; (2) complementation of nutrition-specific and nutrition-sensitive programs; (3) intensified mobilization of LGUs; (4) reaching GIDAs and communities of indigenous people; and (5) complementation of national and local governments. The 2017-2022 PPAN has made infant and young child feeding as one of the programs under PPAN, aside from Philippine Integrated Management of Acute Malnutrition (PIMAM).

The Department of Health is currently on its 2nd year of implementation of the Philippine Integrated Management of Acute Malnutrition (PIMAM) Scale-Up Program. Following the development of the Severe Acute Malnutrition (SAM) Manual of Operations and Training Modules in 2016, the DOH has been gradually supporting regions and provinces in establishing PIMAM programs through capacity building activities and provision of commodities to be used in the management of SAM. In 2016, 17 provinces were identified as priority areas for commencing PIMAM program implementation. For this reporting year, the scale-up was expanded to include 21 additional provinces. Since 2016, eight SAM Training of Trainers (TOT) have been conducted wherein nutrition personnel from the priority provinces were invited. A total of 290 health and nutrition personnel have been trained on the said TOT.

Challenges and Recommendations

Maternal mortality ratio is still above the national target despite improvements in maternal care services. Further, neonatal deaths contribute 60% of the infant deaths.

While quantitative measures of ANC, SBA, FBD, and PNC showed progress, evidence shows that a number of women are still dying. Maternal death review showed that preventable causes i.e. hemorrhage, eclampsia remain as the leading cause of maternal mortality. Further, health system delays e.g. unavailability of emergency transport and communication contributed to maternal deaths.

Recommendations:

- a) Strengthen the advocacy on the revisions of the Midwifery Act of 1992. Efforts should be amplified in finalizing the amendments to legitimately allow midwives to perform their duties in delivering maternal care, specifically the 7 signal functions of BEmONC.
- b) Evaluate BEmONC and CEmONC implementation in the entire country and the barriers of EmONC delivery. The evaluation should include assessment of training institutions, review of the midwives' and medical doctors' BEmONC curriculum, listing of BEmONC and CEmONC-capable professional and facilities, and assessment of the quality of care in delivering BEmONC services. CEmONC-capable facilities should also be included in the evaluation. These facilities should be appraised in terms of capacity, availability of human resources i.e. Obstetricians and Anesthesiologist, and availability and access to blood services. It is also recommended that the Safe Motherhood program should map out the BEmONC- and CEmONC-capable providers and facilities and identify service delivery networks/interlocal health zones that lack an EmONC-capable facility.
- c) Review MNCHN policies, in particular, the implementation of AO 2008-0029 *Implementing Health Reforms for Rapid Reduction of Maternal and Neonatal Mortality*.
- d) Assess the quality of maternal and neonatal care services in the country.
- e) Issue a policy on the mandatory review of ALL maternal deaths in the country. Efforts must be made in communicating with the POGS especially at the provincial level to assist in the conduct of maternal death reviews.
- f) Pursue and collaborate efforts with the Bureau of Local Health System Development (BLHSD) of the DOH to establish and mobilize service delivery networks. This shall include the strengthening of the Barangay Health Worker implementation at the local level.
- g) Identify and address effectively the barriers of breastfeeding, and the whole infant and young child feeding.
- h) Strengthen the delivery of family planning services in the country through improvements of FP advocacy, promotion, and integration during pre-pregnancy, antenatal care, post-natal, and post-abortion care services.
- i) Develop a national demand generation strategy with appropriate metrics directed at specific target and populations.
- j) Develop monitoring and evaluation systems for the MNHCN strategies and improve the mechanisms of reporting from the field so data can be used in an appropriate and timely manner.
- k) Create strategic research agenda for maternal and neonatal care in the next 5-years. Recommendations b and c should be included in the first year.

KRA 2: Family Planning

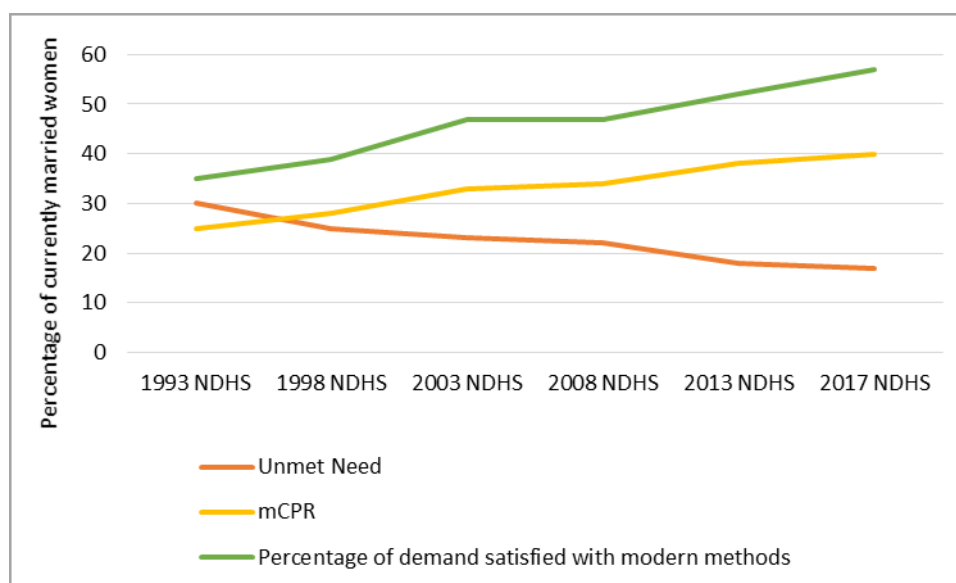
Status and Trends

The DOH provides free FP commodities to women of reproductive age (WRA). One of the foci of FP in 2017 is the lifting of the Supreme Court TRO of the progestin subdermal implants - *Implanon* and *Implanon NXT* and the issuance of the certificates of product registration for the other 49 contraceptive products. This was a triumph of the DOH and of all FP advocates as all women are now able to exercise their reproductive health right and choose the FP method that they prefer.

Family Planning needs among married women are slowly being met over the years

The trends for the past NDHS has indicated positive results on Family Planning Program performance as revealed in Figure 2a. It will be noted that there is a decline in the unmet need for FP from 30% in 1993 to 17% in 2017 among currently married women. The percentage of these women using modern contraceptive methods had increased from 25% in 1993 to 40% in 2017 over the same period. It is further noted that the percentage of the demand for family planning that is satisfied with modern contraceptive methods has increased from 35% in 1993 to 57% in 2017.

Figure 2a. Trends in unmet need, modern contraceptive use, and percentage of demand satisfied with modern methods (1993-2017)

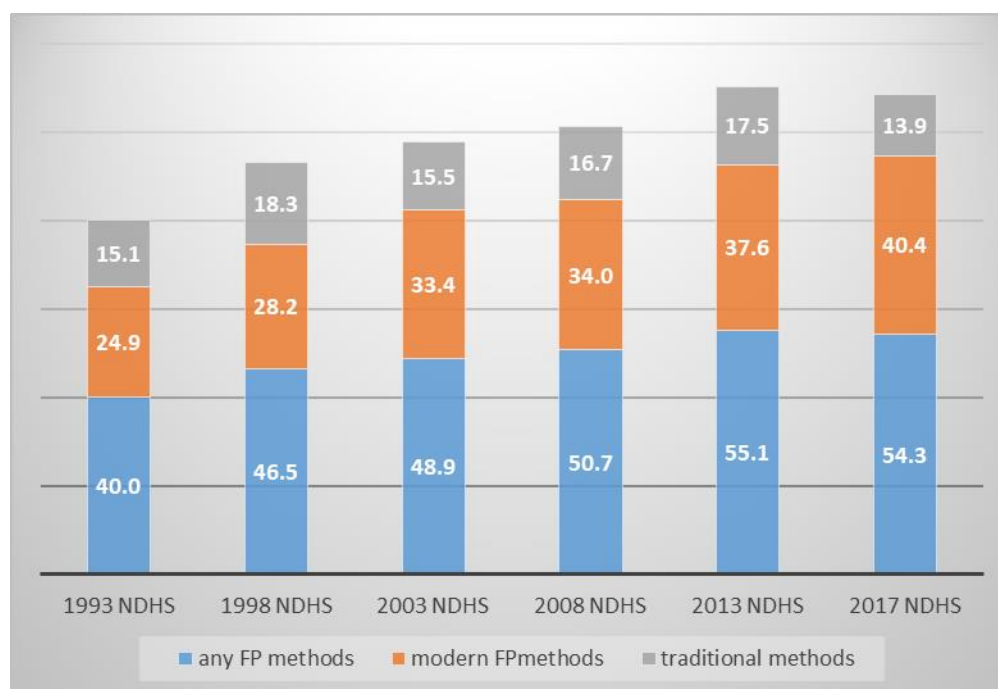


Source: NDHS, 2017

Trends in Modern Contraceptive Prevalence Rate (mCPR)

According to the NDHS report, contraceptive use for modern FP among currently married WRAs increased from 24.9% in 1993 to 40.4% in 2017. Figure 2a showed that mCPR had increased at an average of 0.6 percentage points per year from 24.9% in 1993 to 40.4% in 2017.

Figure 2b. Trends in Contraceptive Method Use 1993-2017



Source: NDHS 2017

Compared against the average annual mCPR increase in other Asian countries from 1970-2015³⁶, the Philippines' mCPR growth is sub-par compared to Vietnam (1.32 yearly), Bangladesh (1.31), Thailand (1.30), Indonesia (1.25), South Korea (1.13), Sri Lanka (0.92), India (0.88), and Malaysia (0.83).

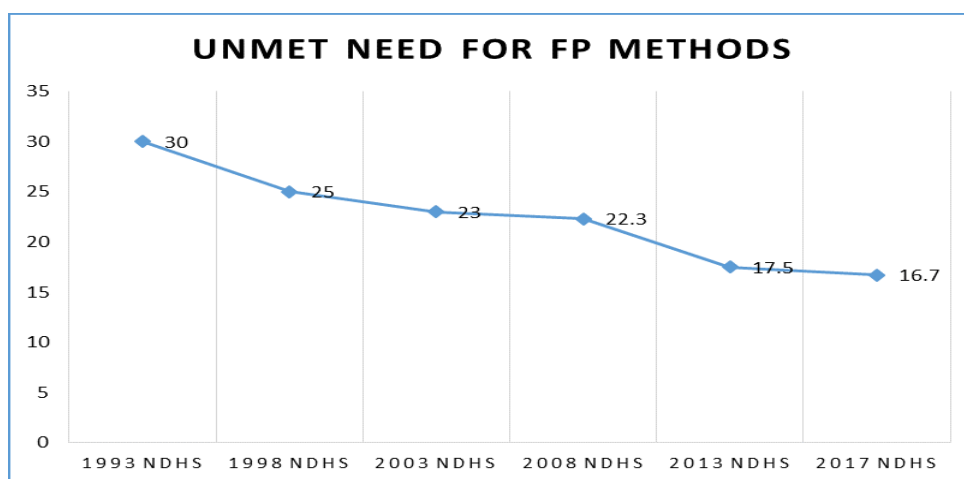
Implications for Philippines' mCPR goal under the Philippine Development Plan (PDP) 2017-2022: The PDP aims to achieve an mCPR of 65% by 2022 or a 5 percentage points increase annually from 2017 to 2022 to reach the target mCPR in the PDP. Following regional (Asia) and country trends, however, this benchmark would seem too ambitious and unrealistic. Assuming an "aggressive" and "accelerated" mode of FP Program implementation, it would be more realistic for the country to benchmark a 1 percentage point annual increase leading to an mCPR of 45.4% by 2022.

Trends in Unmet FP Needs

Unmet FP needs are slowly declining over the past years. Figure 2c shows a decreasing trend on unmet need for FP among currently married women from 30% in 1993 to 17% in 2017. Note, however, that there were significant plateaus that was observed from periods 2013 to 2017. Unmet need for family planning decreased at an average of 0.55 percentage points per year.

³⁶ 2016 data from the UN's Dept. of Economic and Social Affairs

Figure 2c. Trends on Unmet Needs for FP Methods (1993-2017)

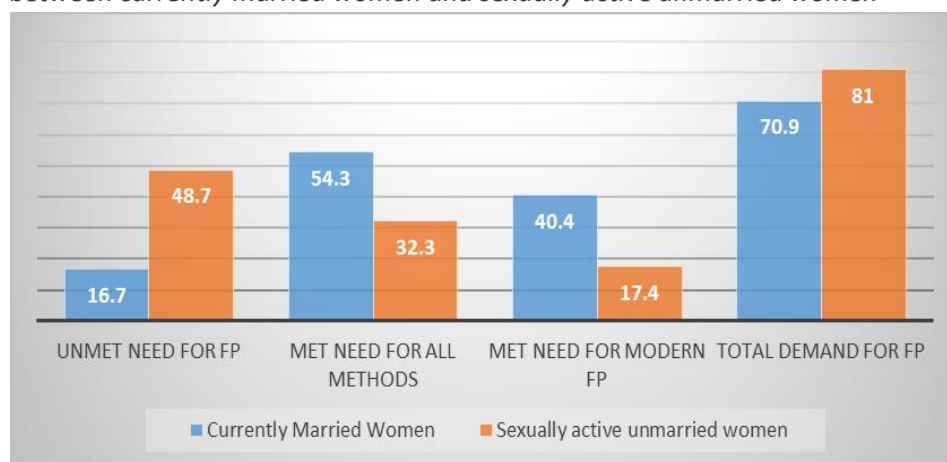


Source: NDHS 2017

There is a high demand for Family Planning for both married and unmarried WRA

Based on the 2017 NDHS and given the census data³⁸, the total demand for FP stood at 70.9% among currently married women, equivalent to 11.1 Million. Of those currently married, 16.7% or 2.6 Million have an unmet need. For the unmarried women (assuming that they comprise 10.5 Million who are sexually active), the total demand for FP was 81%, with an unmet need that is particularly high at 48.7% or 5.1 Million. This brings to a total an estimate of 7.7 million WRA with unmet need for family planning.

Figure 2d. Comparison of Unmet Needs for FP, Current Use, and Total Demand between currently married women and sexually active unmarried women



Source: NDHS 2017

³⁸ Based on 2015 census, there are 26,107,365 women of reproductive age. The 2017 NDHS, revealed that 59.9% of WRA (15,638,312) are either married or living together while the rest (10,469,053) are either never married (35.8% of total WRA), divorced/separated (3.2%) or widowed (1.1%).

More underprivileged women of reproductive age are able to access modern FP services.

Figure 2e below showed that there was significant increase in the use of modern contraceptive methods among the lowest quintile from 33 percent in 2013 to 43.8 percent in 2017. This is also observed for the second quintile from 40.3 percent in 2013 to 46.2 percent in 2017. We can infer that there are more poor women who were able to access modern family planning services and methods which has been the government's thrust under its current mandates. The 2017 NDHS also revealed that the highest source of modern contraceptive methods are coming from the public sector specifically at the Barangay Health Stations at 24.5 percent where women have better access. On the other hand, the middle quintile remained steady while the fourth and the highest quintile showed a decrease on the use of modern family planning methods. Perhaps a study on why the rich women (highest quintile) have the lowest mCPR and yet have the best desired to actual fertility rate can be carried out.

Figure 2e. Comparison of 2013 and 2017 Use of Modern Contraceptive method by Wealth Quintile



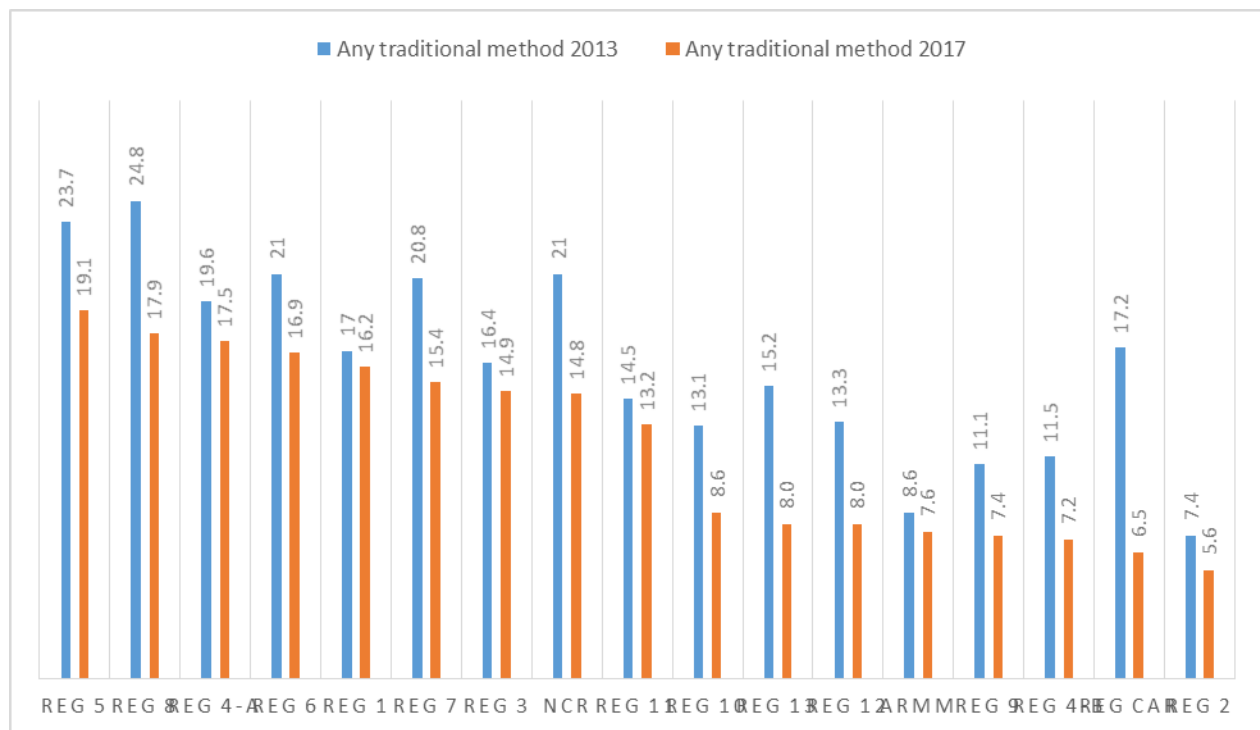
Source: NDHS 2017

More women are now using modern FP methods over traditional methods.

Traditional method use has slowly declined from 18.3 percent in 1998 to 17.5 percent in 2013. Note however, that there was a significant decline from 17.5 in 2013 to 13.9 in 2017. This can be a reflection of the efforts in reaching out and educating women on the use of more effective contraceptive methods which has been an advocacy of the program for the past several years. This can also be seen as an effect of the RPRH Law that states the use of modern methods as legal and a right of an individual to avail of modern FP services.

Figure 2f below shows a comparison of 2013 and 2017 regional breakdown on traditional method use. A significant decline on the use of traditional method is shown in CAR from 17.2% in 2013 to 6.5% in 2017. While there was a marked decline on traditional method use at the national level, 8 out of the 17 regions still showed a high percentage of traditional method use above the national percentage of 13.9%, while 6 regions reported almost no change in the use of traditional method (Regions I, II, III, IVA, XI, and ARMM).

Figure 2f. Comparison of Traditional Method use in 2017



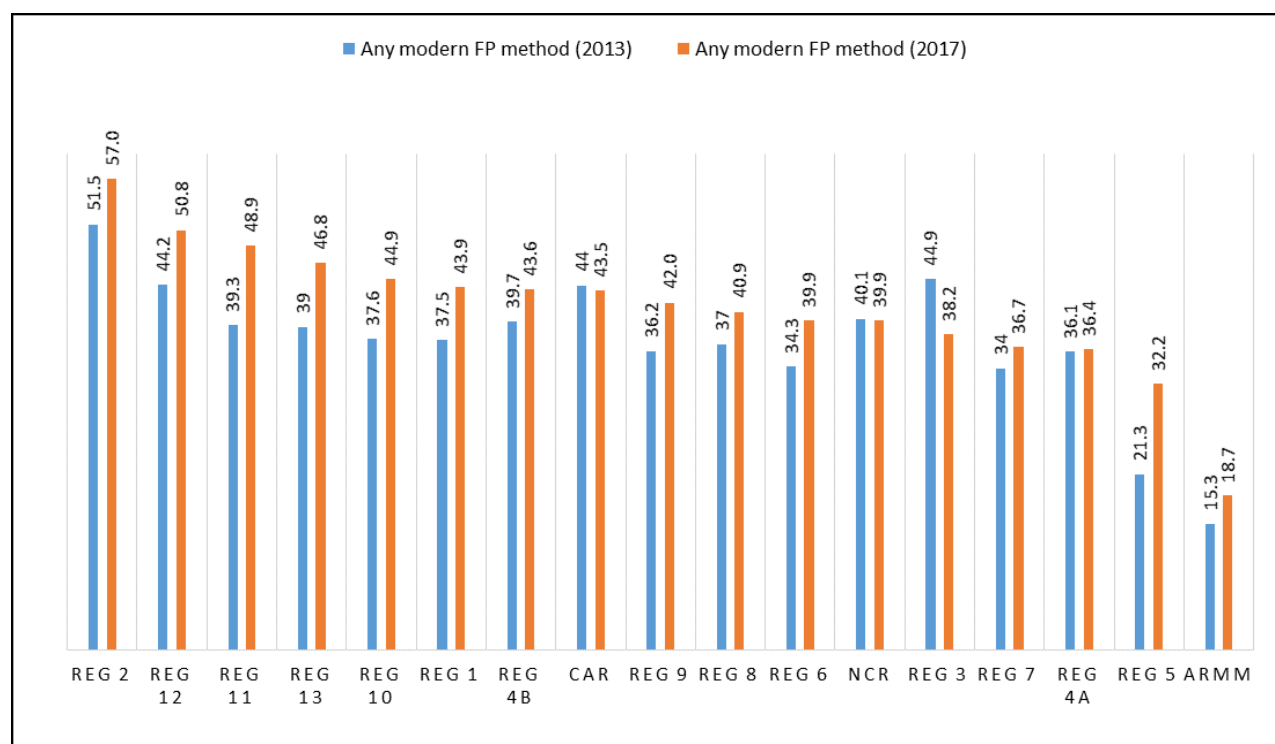
Source: NDHS 2013, 2017

Majority of the Regions reported a high mCPR performance than the national average as reported in the 2017 NDHS and the DOH Administrative Data of FP Current Users.

At the regional level, 11 out of 17 regions had mCPR performance that was equal or above par the national average of 40%. These are Regions II (57.0%), XII (50.8%), XI (48.9%), CARAGA (46.8%), X (45%), I (44%), IVB (43.6%), IX (42%), VIII (41%), VI (40%), and NCR (40%). The mCPR of Regions VII (36.7%), IV-A (36.4%), V (32.2%), and ARMM (18.7%) were still below the national average. The figure on mCPR shows consistency with the decreasing trend in traditional method use as shown in the previous figure.

A comparison on modern FP use in 2013 and 2017 is presented in Figure 2h to show the changes on mCPR. It is observed that majority of the regions had an increase in the mCPR report from 2013. Significant change can be observed in Region 5 who had more than 10 percentage point increase from 21.3 in 2013 to 32.2 in 2017. For regions CAR, NCR, and Region IVA the figure remained almost unchanged while Region III showed a marked decline in mCPR from 44.9 in 2013 to 38.2 in 2017.

Figure 2g. Contraceptive Prevalence Rate by Region, 2017 (NDHS)



Source: NDHS 2017

Significant change in unmet need reduction at the regional level

When compared to 2013 NDHS results, (Figure 2i below) significant reductions were observed in ARMM from 27.6 percent in 2013 to 17.8 percent in 2017. The same pattern was also observed in Region 5 from 27.4 percent in 2013 to 21.3 percent in 2017. It has to be noted, however, that Region 5 has the second highest unmet need for modern FP in 2017, only next to Region 9 at 24.6 percent. Region 6 also showed a reduction from 20 percent in 2013 to 13.4 percent in 2017 likewise in Region 1 from 19.3 percent in 2013 to 13.7 percent in 2017.

In 2017, Regions 9 (24.6%), Region 5 (21.3%), and Region 4A (20.1%) showed the highest figures on unmet need for family planning. NCR (12.3%), Regions VI (13.4%), XI (13.5%), I (13.7%) were among the regions who had the lowest proportion of WRA with unmet need for FP.

Significant change in unmet need reduction at the regional level

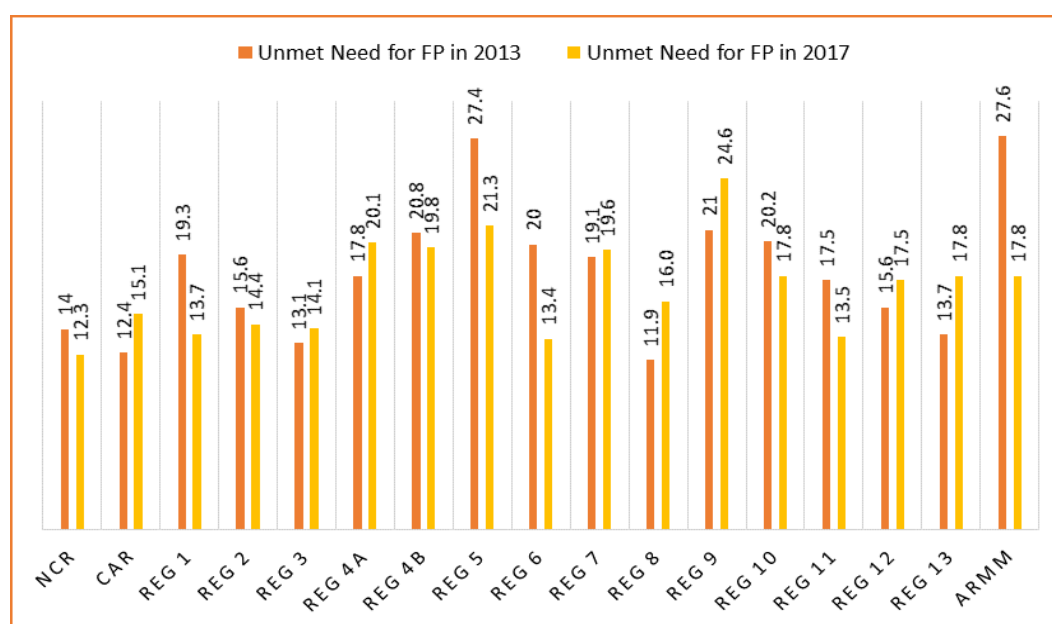
When compared to 2013 NDHS results, (see Figure 2h) significant reductions were observed in ARMM from 27.6% in 2013 to 17.8% in 2017. The same pattern was also observed in Region V from 27.4% in 2013 to 23.1% in 2017. However, note that Region V also presented with the second highest figure for unmet need in 2017 at 21.3%. Region VI also showed a reduction from 20% in 2013 to 13.4% in 2017, likewise in Region I from 19.3% in 2013 to 13.7% in 2017.

Regions IX (24.6%), V (21.3%), and IVA (20.1%) showed the highest figures on unmet need for family

planning. NCR (12.3%), Regions VI (13.4%), XI (13.5%), I (13.7%) were among the regions that had the lowest proportion of WRA with unmet need for FP.

For Regions CAR, III, IVA, VII, VIII, IX, XII, and XIII (CARAGA), there were increase in unmet need for FP from 2013 to 2017 which can possibly be a result of an increase in the population of WRA being covered.

Figure 2h. Regional breakdown of Unmet Need for FP



Source: NDHS 2017

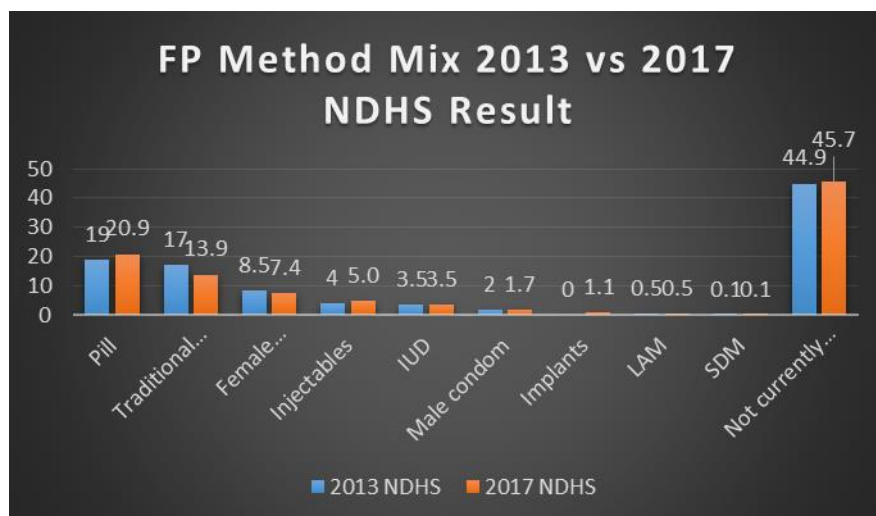
Note that while unmet need for family planning can be observed to be decreasing in some of the regions however, the change in mCPR rates may not always correspond to an increase (e.g. CPR may be low yet unmet need may be high or vice versa).

Contraceptive Method Mix

More women of reproductive age use oral contraceptive pills as their method of family planning

In terms of method mix, 1 out of 5 (20.9%) of currently married WRAs in 2017 still used oral contraceptive pills with a significant increase from the 2008 result of 15.7 percent and a slight shift from the 2013 level of 19.1 percent. Further study may need to determine whether the pill is actually the preferred choice of the client or an option based on availability of method in the health facilities. The 2017 NDHS study also revealed that more women want to limit their children but due to unavailability might have opted to use a different FP method. The use of injectables also registered a gradual positive trend from 2.6 % in 2008, to 3.7 % in 2013, to 5.0 % in 2017. (see Figure 2j)

Figure 2i. FP Method Mix Difference 2013 vs 2017



Source: NDHS 2013, 2017

Female sterilization continues to decline over the years despite women wanting to limit their children

Female sterilization continued to gradually decline from 9.2% in 2008, to 8.5% in 2013, and to 7.4% in 2017. It was also noted from the results of the 2017 NDHS, 53% of WRA had expressed that they want no more children and indicates the need for more permanent FP methods. This implies the need for the Program to identify strategies and enabling mechanisms to support the provision of permanent methods of FP in appropriate health facilities including those in the GIDA areas.

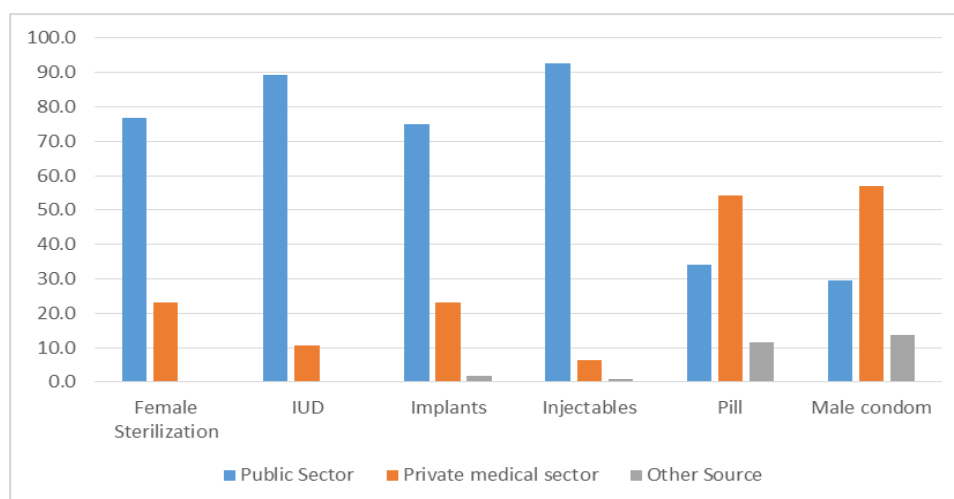
Use of the Subdermal Implant as a new modern method of contraception is becoming popular

The report on the sub-dermal implants which registered a utilization of 1.1% for 2017 was being noted. This implies that the new FP method became more acceptable among women despite the restrictions from the TRO of the Supreme Court imposed in the public health sector. This gives a signal to the Family Planning Program on the potential requirements of subdermal implant use in the public health facilities now that the TRO has already been lifted. The use of IUDs (3.5%) and male condoms (1.7%) remained low and hardly moved from the 2013 figures.

More women are able to access modern FP methods thru public health facilities

According to the NDHS, the public sector remains to be the main source of FP methods among women using modern contraception. BHS posted as the highest source of commodities at 24.5% while government hospitals registered at 17.3%.

Figure 2j. Source of Modern FP Methods



Source: NDHS 2017

Report on the 2017 Status of EO12 Implementation and accomplishment³⁹

In an effort to push further the agenda of RPRH Law implementation in the country, President Rodrigo Duterte issued an Executive Order 12, entitled “Zero Unmet Need for Modern Family Planning through the Strict Implementation of the Responsible Parenthood and Reproductive Health Act 2012, providing funds therefor, and for other purposes”, which pushed for an aggressive and accelerated mode of FP Program implementation in January of 2017. The operational guidelines was pursued under DOH Administrative Order 2017-0005: Guidelines in Achieving Desired Family Size through Accelerated and Sustained Reduction in Unmet Need for Modern Family Planning Methods. The EO 12 aims at addressing unmet needs for modern FP of all poor households (2 Million) by 2018 and the rest of WRA (6 Million) the years after.

The key implementation strategies were identified to ensure that objectives will be achieved as benchmarked. These included the identification of priority province per Region with high burden of unmet need for modern FP; mapping out of the poor families with unmet need through various forms of demand generation activities; scaling up of capacity building to ensure that FP service providers are competent and are able to provide modern FP counseling and services during post-partum period; conduct of outreach FP services in the GIDAs; and providing modern FP services in regular public health facilities (both primary care and hospital facilities).

The DOH also issued Department Memorandum No. 2017-0273 and 2017-0273-A, which provided the EO 12 Monthly Reporting Matrix that was used by the key stakeholders namely: DOH, POPCOM, LGUs, USAID, UNFPA and CSOs in submitting the accomplishment reports and monitoring the progress of its implementation. This section also includes reports from the priority provinces who were able to provide

³⁹ Note to the Reader: The report on the status of EO12 reflects only the accomplishments in 2017 which are mostly administrative data gathered from the regions/ provinces by program management at the national office. It is not comparable to the NDHS 2017 survey since the survey covered a review of five years after the last NDHS was conducted (period 2013-2017)

their data that covers the following key enabling pillars: a) demand generation, b) service delivery, c) capacity building, d) logistics support, e) governance and policy, and f) budget and financing.

The analysis of the succeeding section of the EO 12 report was based from administrative data that was generated by both the DOH and POPCOM using current M&E reporting systems.

Number of WRA reached and identified with unmet need for modern FP in 2017

One indicator that measures the status of EO 12 implementation looks at the number of WRA reached and identified with unmet need for modern FP, and eventually accepted a modern method of FP. The benchmark was based on Costed Implementation Plan (CIP) for FP, which estimated unmet needs of 60% WRA belonging to the 1st to 3rd economic quintiles. It is estimated that a total of 3.7 Million WRA have unmet need for modern FP which needs to be reached and identified, and be given appropriate FP services by the year 2020⁴⁰. This figure was higher than what has been indicated under EO 12 of 2 Million WRA (poorest) to be targeted by 2018. Further, it is only about a little more than half (66%) of the total estimated WRA of 6 Million women with unmet MFP need. However, the current reports are unable to disaggregate the poorest women from the rest of WRA.

Regional Performance

At the regional level, there were 1.6 Million WRA who were identified with unmet need for modern FP

Based on the data at the Regional⁴¹ level, the total number of WRA that was actually identified with unmet need for modern FP was 1,637,451 by end of 2017. This number gives us the region-wide coverage of Program implementation including the CIP estimated target among the 22 priority provinces⁴². The Regional figure reported almost half the number (44%) of the CIP estimated number of WRA with unmet need for modern FP which is 3,716,193. The performance had increased from an initial report of 31% in June 2017⁴³.

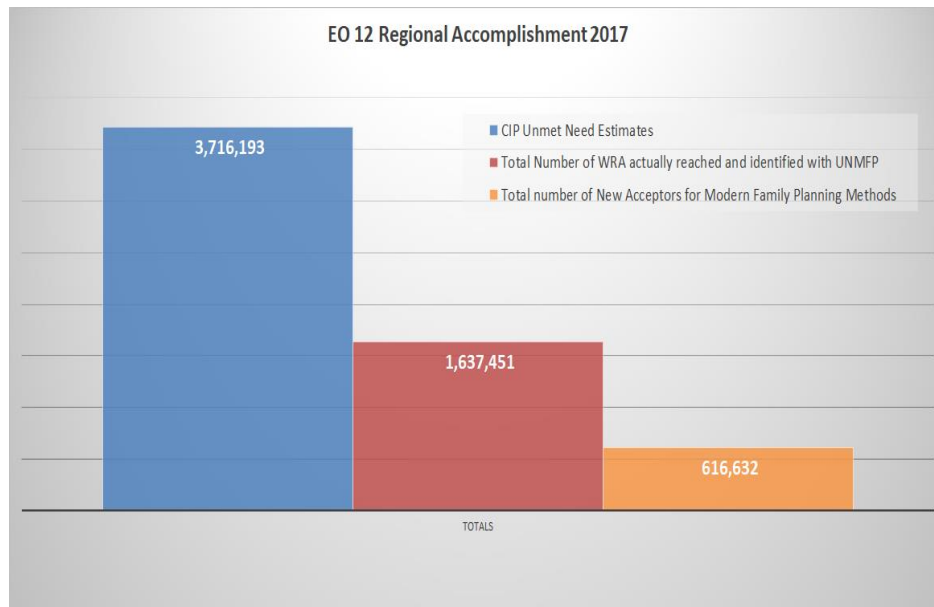
⁴⁰ Based from International commitment on FP2020 Global Movement

⁴¹ Data from both the regional and provincial levels should be consistent since the Regional report should just indicate the performance of the priority provinces. However, it was noted that the Regional performance reflected figures that were much bigger than those indicated from each of their respective priority province. It can be deduced that some regional reports may have included of WRA from provinces outside the priority areas in their reports.

⁴² DOH –FHO data on the list of 22 priority provinces had a total of 1,057,107 estimated number of WRA with unmet MFP needs

⁴³ EO12 Initial Progress Report, Jan to June 2017

Figure 2k. Total number of WRA identified with Unmet MFP Need



Source: DOH FHO Monthly Reporting Matrix, 2017

There were 8 out of the 17 Regions which were able to actually reach more than 50% of their CIP estimated number of WRA with unmet need for modern FP as reflected in the Table below.

Table 2a. Regions that Reached More than 50% of their Estimated Unmet Need for Modern FP in 2017

Regions	CIP Unmet Need Estimates	Total Number of WRA actually reached and identified with UNMFP	Percent
Region 06	277,350	288,588	104
Region 01	184,969	181,968	98
SOCSARGEN	167,273	136,105	81
Region 09	133,582	98,528	74
Region 10	172,573	118,767	69
Region 02	127,017	83,279	66
Region 05	213,338	116,890	55
ARMM	139,161	71,922	52

Source: DOH FHO Monthly Reporting Matrix, 2017

More than half a million WRA with unmet need for modern FP accepted a method in 2017

Of the 1,637,451 WRA reached and identified, more than half a million (616,632) WRA accepted a modern method of FP as indicated in the Figure 2k. However, this is only 38% of those who were actually reached and identified with unmet need for modern FP, reflecting a wide gap between the

demand generation and FP service provision in various health facilities. This may be due to several factors such as, but not limited to, availability of trained and competent FP service providers, availability of appropriate FP commodities in service delivery points, poor recording and reporting of clients, poor access of clients to FP services, or even some consequences of legal impediments such as the TRO issued by the Supreme Court.

EO 12 has also specified reaching all the poor households by 2018, however, the current reports are unable to disaggregate poor and the non-poor and therefore unable to account how many poor women were actually reached in 2017.

Performance in the Priority Provinces

Almost fifty percent of WRA with unmet need for modern FP were reached and provided modern FP services in the priority areas.

Under the implementation of EO 12 and DOH Administrative Order No. 2017-0005, there were 22 priority provinces that were identified including the 5 provinces in ARMM. Of the 22 priority areas, 18 provinces provided their accomplishment reports for 2017. The program did not receive report from the provinces of Cebu, Davao del Sur, Lanao del Sur, and Maguindanao as of this writing. For the 18 priority provinces that have reported, a total of 468,126 WRA (49%) of the 963,386 estimated WRA with unmet needs for MFP were reported to have been actually reached and identified with unmet need for modern FP.

Table 2b. Percentage of WRA reached and identified with unmet MFP in the priority provinces and accepting a modern FP Method

Priority Province	Region	CIP Unmet Need Estimates	Total Number of WRA actually reached and identified with UNMFP	Total number of New Acceptors for Modern Family Planning Methods
Pangasinan	Region 1	108,812	85,445	84,065
Negros Occidental	Region 6	91,903	56,882	15,066
Sulu	ARMM		48,029	10,014
Pampanga	Region 3	80,894	47,807	24,184
Camarines Sur	Region 5	71,857	45,234	82,039
Cagayan Valley	Region 2	44,137	38,446	4,185
Bukidnon	Region 10	52,082	22,435	3,802
North Cotabato	SOCSARGEN	50,777	21,346	10,484
Quezon	Region 4A	68,325	16,790	12,392
Basilan	ARMM	12,755	14,608	1,053
Palawan	Region 4B	31,262	13,822	3,732
Cavite	Region 4A	135,367	13,358	23,576
Leyte	Region 8	63,471	12,904	2,202
Agusan Del Sur	CARAGA	25,785	11,416	10,852
Zamboanga Del Sur	Region 9	37,194	9,513	2,271
Manila	NCR	65,512	6,193	11,398
Tawi Tawi	ARMM	14,379	3,073	698
Abra	CAR	8,875	825	143
Totals		963,386	468,126	302,156

Source: DOH FHO Monthly Reporting Matrix, 2017

Sixty-five percent of WRA in the priority provinces were able to access and accepted a modern FP method

Of the 468,126 WRA reached and identified with unmet need, 302,156 (65%) women accepted a modern FP method. The province of Pangasinan registered the highest accomplishment of 98% (84,065) WRA provided with modern FP method out of the 85,445 reached and identified with unmet need for modern FP. Next is the province of Agusan del Sur which reported 95% (10,852) WRA were provided modern FP services, and Quezon province reported reaching and providing modern FP to 73% of WRA reached and identified with unmet need.

Interventions

Demand Generation

Demand generation activities are very critical in increasing access to modern FP services, thus, health workers, population workers and community volunteers are mobilized to conduct Responsible Parenthood and Family Planning (RPFP) classes, identify couples and individuals with unmet need for modern FP, and refer these clients to the nearest facilities to avail their preferred FP method.

The flagship program of POPCOM's RPFP program component is the conduct of RPFP classes under the *Kalusugang Pangkalahatan* and the *Pantawid Pamilyang Pilipino Program*(4Ps). Delivery of quality and adequate information on RPFP is made possible through various stakeholders, assisted by the Regional Population Offices. There were 93,124 RPFP classes conducted and more than 1.2 million couples/individuals attended. RPFP classes served as venue for FP service demand generation. There were 282,254 (22%) WRA who were identified with unmet need for modern FP, and 233,792 (83%) WRA were referred to and served at various health facilities by FP service providers.

Capacity Building

For the past years, capacity building on FP program has been one of the major interventions made by the DOH together with the initiatives from the LGUs and assistance from developmental partners to ensure that quality FP services are accessible and available to individuals and couples with potential unmet need for modern FP.

As of December 2017, 992 LGUs in the country have trained public health providers on Family Planning Competency-based Training (FPCBT) Level I, while 205 LGUs have trained private FP providers. A total of 7,364 are FPCBT Level I-Graduates, of which, 6,786 (92%) are from the public health sector while the remaining 578 (8%) are private practitioners.

Priority was given also in increasing the number of facilities (particularly Hospitals) and providers trained on FPCBT Level II (Intrauterine Device (IUD) both Interval and Post-Partum; bilateral tubal ligation by minilaparotomy under local anesthesia (BTL-MLLA); progestin subdermal implant (PSI); non-scalpel vasectomy (NSV); and natural FP) that would significantly aid in responding to WRA with unmet need for limiting. Moreover, per CIP 2020, 40% of estimated WRA with unmet need are expected to have their get FP services through post-partum FP. Based on DOH and key partners' data as of 2017, 379 LGUs reported with trained public providers on FPCBT Level II which totals to 2,379 personnel, while 147 LGUs reported with 412 FPCBT Level II-Graduates who are private practitioners. It was also reported that

there are 103 provinces with public hospitals providing BTL-MLLA services, while 53 provinces have private facilities offering BTL-MLLA.

Table 2c. Number of WRA Reached, identified and accepting a new modern method of FP

	CIP Unmet Need Estimates for Priority Provinces	Total Number of WRA actually reached and identified with UNMFP	% Reached and Identified	Total number of New Acceptors for Modern Family Planning Methods	% New Acceptors versus WRA identified with unmet MFP
<i>Provincial Totals:</i>	963,386	468,126	49%	302,156	65%

Service delivery

MFP Services Delivered in the Priority Provinces

There were 3 strategies that were being reported in the EO12 Monthly Reporting Matrix where clients can be offered MFP counseling and services: a) post-partum FP, b) outreach missions, c) regular public health facilities. Table 2e___ shows the number of clients who were served through these channels.

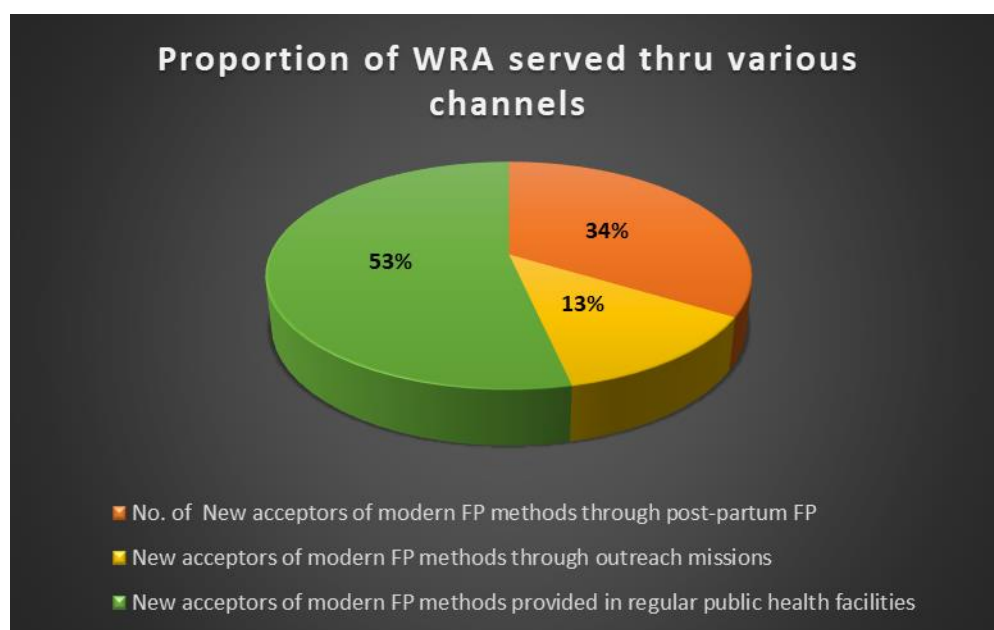
The implementation in the priority provinces, appears to be no different from the current mode of program implementation. Based from the data gathered, it seems that it will take 5 years to meet CIP targets and several years to meet EO12 and AO2017-0005 targets. It is important to understand the factors that lead to no difference in rate of performance in these sites to inform implementation in other areas

Table 2d. Number of WRA reached and provided with MFP services thru various channels

Priority Province	Region	CIP Unmet Need Estimates	Total Number of WRA actually reached and identified with UNMFP	No. of New acceptors of modern FP methods through post-partum FP	New acceptors of modern FP methods through outreach missions	New acceptors of modern FP methods provided in regular public health facilities	Total number of New Acceptors for Modern Family Planning Methods
Basilan	ARMM	12,755	14,608	542	88	423	1,053
Sulu	ARMM		48,029	3,319	2,057	4,638	10,014
Tawi Tawi	ARMM	14,379	3,073	252	97	349	698
Abra	CAR	8,875	825	47	45	51	143
Agusan Del Sur	CARAGA	25,785	11,416	522	321	10,009	10,852
Manila	NCR	65,512	6,193	3,726	3,454	4,218	11,398
Pangasinan	Region 1	108,812	85,445	37,244	10,754	36,067	84,065
Bukidnon	Region 10	52,082	22,435	1,597	346	1,859	3,802
Cagayan Valley	Region 2	44,137	38,446	1,415	117	2,653	4,185
Pampanga	Region 3	80,894	47,807	7,034	3,901	13,249	24,184
Cavite	Region 4A	135,367	13,358	689	191	22,696	23,576
Quezon	Region 4A	68,325	16,790	108	35	12,249	12,392
Palawan	Region 4B	31,262	13,822	644	2,219	869	3,732
Camarines Sur	Region 5	71,857	45,234	32,406	10,481	39,152	82,039
Negros Occidental	Region 6	91,903	56,882	8,073	2,303	4,690	15,066
Leyte	Region 8	63,471	12,904	845	284	1,073	2,202
Zamboanga Del Sur	Region 9	37,194	9,513	765	211	1,295	2,271
North Cotabato	SOCARGEN	50,777	21,346	2,659	871	6,954	10,484
Totals		963,386	468,126	101,887	37,775	162,494	302,156

Source: DOH-FHO Monthly Reporting Matrix 2012

Figure 2l. Proportion of Clients Served in Different FP Channels



Source: DOH FHO Monthly Reporting Matrix 2017

Majority of women in the priority areas are able to access the regular public health facilities

Public health facilities remain as the main source where clients are able to access modern FP methods. From the total number of clients who were reached, 302,156 accepted a method. A total of 162,494 (54%) accessed through the public health facilities, 101,887 of clients (34%) accepted a method during the post-partum period while 37,775 (13%) of clients were served during FP outreach missions. While the report reflects clients' preference on accessing modern FP services through the regular public health facilities, the provision of modern FP methods during the post-partum period has begun to rise. Unfortunately, the monitoring reports were unable to provide the method mix of contraceptive use during the post-partum period. The information would have given us some more details (e.g. use of LAM, POPs, IUD) that can further be linked to commodity status. The program may need to consider procurement options in so far as post-partum FP methods are to be made available.

FP Logistics/ Supply chain management

The table below shows the FP supplies procured by the DOH in 2017, which only covered 224,615 women in one year. However, these FP supplies are in addition to the 2016 DOH central office inventory that were allocated in 2017 to meet the demand of couples and individuals who wants to limit or space the birth of their children.

Table 2e. FP Commodity Procured in 2017

Commodity	Quantity	Estimated no. of women that can be served in 1 year
Depo Medroxyprogesterone Acetate (DMPA)	2,305,125	153,675
Standard Days Method (SDM) Cycle beads	14,185	14,185
Digital thermometer (DT)	14,200	14,200
Cervical Mucus Methods charts	170,220	14,185
Basal Body Temperature charts	170,220	14,185
Sympto-thermal Method charts	170,220	14,185

Source: 2017 DOH-DPCB Work and Financial Plan

The DOH allocated the following FP commodities to the RHUs and CHOs based on their quarterly accomplished and submitted FP commodity inventory and consumption report form to the FP logistics hotline. IUDs and PSIs were delivered to the DOH Regional Offices while other commodities such as pills, DMPA injectable and male condoms were directly delivered to the RHUs & CHOs. The DOH Regional Office allocations were intended for DOH hospitals and medical centers, LGU hospitals, CSO stocks and for replenishment of RHUs and CHOs needs.

Upon lifting of the Supreme Court TRO to the DOH on the use of Implanon and Implanon NXT supplies in November 10, 2017, the DOH - Disease Prevention and Control Bureau (DPCB) allocated the remaining 304,378 Implanon NXTs to the following DOH regional offices, DOH retained hospitals, NGOs and CSOs (Table 2f and 2g).

Table 2f. Progestin Subdermal Implant allocation list to DOH Regional Office and DOH Hospitals

Name of Facility	Quantity
DOH NCRO	10,000 rods
DOH RO III	10,000 rods
DOH CALABARZON	15,000 rods
DOH MIMAROPA	20,000 rods
DOH RO V	50,000 rods
DOH RO VI	6,000 rods
DOH RO VII	10,000 rods
DOH RO IX	578 rods
DOH XII	10,000 rods
DOH ARMM	16,000 rods
Dr. Jose Fabella Memorial Hospital	10,000 rods
TOTAL	167,578 rods

Source: DOH FHO Administrative data

Table 2g. Subdermal Implant allocation to CSOs and Development Partners

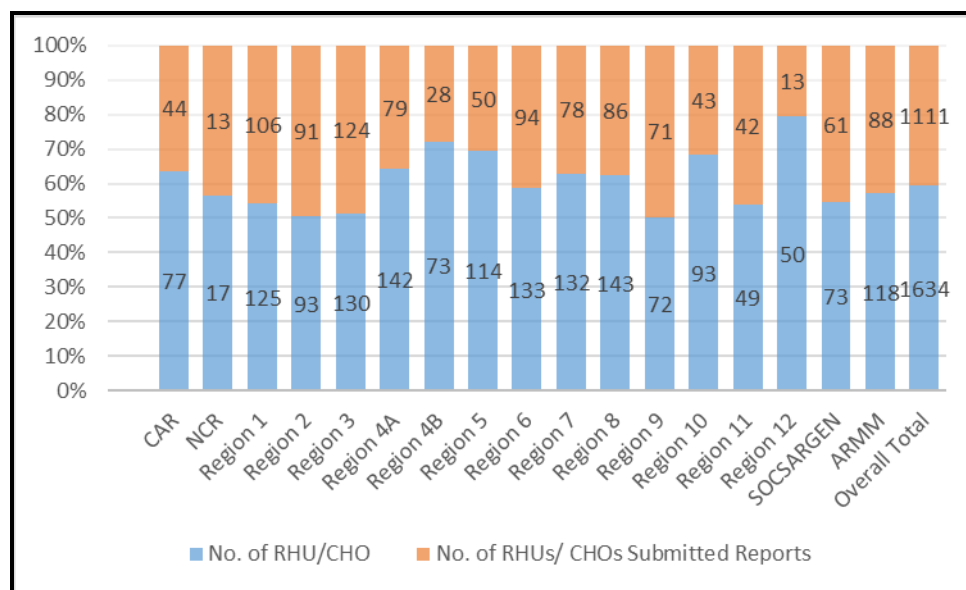
Name of CSOs	Quantity
LIKHAAN	20,000 rods
FriendlyCare	5,000 rods
Democratic Socialist Women of the Philippines (DSWP)	5,000 rods
Family Planning Organization of the Philippines (FPOP)	11,000 rods
International Development Leadership and Learning Corporation (IDLLC)	2,500 rods
Population Services Pilipinas Inc. (PSPi)	32,300 rods
Integrated Midwives Association of the Philippines (IMAP)	50,000 rods
Roots of Health (ROH)	5,000 rods
VisayasHealth	10,000 rods
TOTAL	140,800 rods

Source: DOH-FHO Administrative Data

Tracking FP Commodity Stock Status at the implementation level

The FP Hotline serves as the monitoring system that tracks the status of FP commodities across the service delivery points nationwide. The supply chain management remains to be a challenge as reflected in the stock status reported in 4th quarter of 2017.

Table 2h. Status on submission of consumption/ inventory reports (by Region)



Source: FP Hotline, POPCOM 2017

It will be noted that only 68% of Main RHUs/CHOs have reported on their inventory/consumption reports (1,111 of the total of 1634 reporting facilities) for the quarter. Regular submission of Inventory and consumption reports are crucial in maintaining an effective supply chain management.

Status on FP Commodity Stock outs⁴⁴

Majority of the public health service delivery points still experience commodity stock-outs and overstocks which reflects operational issues in the supply chain management. According to the FP Hotline monitoring, there were 942 out of 1111 (85%) of RHUs/CHOs have stock outs in one or more FP commodity (see Table 5 Annex).

Luzon had a high percentage of RHUs/CHOs reporting stock outs of FP commodities that reached 88%. Region 5 reported with the highest number of facilities that experienced stock out (96%) or 48 out of 50 who submitted reports. Three other regions reported more than 90% of facilities experiencing stock outs (Regions 1, 3, 4A). Visayas reported 77% of their facilities have FP commodity stock outs mostly in Region 8 at 84% (72 out of 86 facilities. Mindanao reported an 82% of stock outs in their facilities with Region 12 experiencing the highest percentage at 92% (12 out of 13 facilities). The following FP commodities were reported stocked out from service facilities (by rank):

- ⇒ 798 out of 942 or 85% RHUs had stock out of IMPLANTS. This can still be a result of barring the distribution of subdermal implants in compliance to the Temporary Restraining Order of FP certification/ re-certification of commodities including Implanon and Implanon NXT. The TRO was only lifted in the last quarter of 2017.
- ⇒ 352 (37%) of RHUs had stock out of POP. A closer examination on the nature of the stock out for POP should be monitored. The reason is that POP's are recommended for post-partum women while they are breastfeeding in the first 6 months. However, it is important that clients are followed up and given advise to shift to COCs which are more effective after 6 months.
- ⇒ 232 (25%) of RHUs had stock outs of COC.
- ⇒ 192 (20%) of RHUs had stock out of DMPA.
- ⇒ 179 (19%) of RHUs had stock out of IUD. It is important that IUDs are always available in all levels of health care facilities given its advantage for long term use and immediate provision during the post-partum period.
- ⇒ 157 (16%) of RHUs had stock out of CONDOM nationwide.

Status on FP Commodity Overstocks⁴⁵

The FP Hotline also reported that 953 out of 1111 or 86% of RHUs/CHOs are over- stocked with one or more FP commodity. The breakdown on the status of overstocks from the service delivery points were:

- ⇒ 564 out of 953 (55%) of RHUs had overstock of DMPA
- ⇒ 511 (54%) of RHUs had overstock of COC

⁴⁴ Definition of a Stock out: An SDP is considered "Stock out" if at least 1 type of FP commodity is at zero balance, but does not necessarily mean no other FP methods are available.

⁴⁵ Definition of Overstock: An SDP is considered "Overstocked" if at least 1 type of FP commodity is overstocked (more than 6 months' worth of supply), even if other commodities are no longer available.

- ⇒ 424 (44%) of RHUs had overstock of IUD
- ⇒ 422 (44%) RHUs had overstock of POP
- ⇒ 64 (7%) of RHUs had overstock of IMPLANT
- ⇒ 639 (67%) of RHUs had overstock of CONDOMS

Ensuring the adequacy of FP commodities at service delivery points is a reflection of how well the supply chain management is maintained. Determining the right allocation of FP commodities for distribution would prevent commodity stock outs as well as overstocking. Preparing the allocation list for FP commodities requires regular reporting of consumption and inventory of stocks available at the service delivery points. Unless this is being practiced regularly, it will be difficult for a centrally based procurement and distribution system to make the necessary corrections and adjustments in the allocation and distribution of commodities, and will find difficulty in shifting towards a demand driven approach in the logistics system.

Another factor affecting the supply chain is the timely delivery of the FP commodities. Currently the distribution of commodities follows a system through a contracted 3rd party logistics provider. The current practice follows the procedure of centrally procured goods from the various programs are being “pulled together” prior to distribution which compromises the timing of delivery. The distribution problem had resulted to several quarters of delay which translates to stocking out of certain FP commodities. Unless the supply chain management of the entire DOH logistics system is addressed, the program will continue to have problems on the availability of adequate stocks at the service delivery points.

An Innovation on Logistics Management

Track and Trace: End-to-end visibility for the Contraceptive Logistics Management Information System utilizing barcoding technology

The effectiveness of the National Family Planning Program to deliver on the needed services for clients at various levels of the health care delivery system is hinged upon the efficiency of the supply chain system. Situations wherein clients are not being served at designated service delivery points due to stock outs or unavailability of commodities should at most be prevented or mitigated. Up-to-date program and logistics data are needed for defining allocation, distribution and procurement of commodities and are very critical in the overall supply chain decision-making process.



In 2017, an operational study, being conducted by the Philippine Society for Responsible Parenthood (PSRP) with support from the UNFPA, called Barcode Track and Trace Project was pilot tested in select number of clinics from 2016 to 2017.

Phase 1 of the project was implemented in 2016 in 24 clinics operated by CSOs belonging to the Family

Planning Consortium to establish proof of concept and tested out the system in one type of FP commodity, the Progestin Subdermal Implant. In 2017, the DOH approved the scale up of the project covering 80 public clinics in 3 regional sites, and expanding the capacity of the system to accommodate 4 more contraceptive products, i.e. COC, POP, IUD and Injectables.

The Barcode Track and Trace structure operates at different levels of the supply chain, utilizing a mobile application through smartphone acting as an optical scanner for barcodes, and a data capture software that manages information for decision-making. The system was able to demonstrate real-time recording of receipts at the central warehouse and clinic levels, real-time recording of utilization at the clinic level, and real-time FP commodity stock status at all levels of the supply pipeline.

The pilot testing has effectively proven the concept of realizing improved accuracy, integrity and speed of data capture that would significantly improve timely management of logistics information by program and logistics managers, and likewise reduce incidence of wastage and pilferage. The system could be made inter-operable with any existing electronic-logistics management information system (eLMIS) and could accommodate multiple types of commodities as long as it is barcoded with embedded information, that is to be the global practice in the country with the issuance of FDA Circular No. 2015-011 on “The Adoption of Unique Global Product Identification Number for Drug Products”.

Further enhancement of the system is planned for the next phase of implementation in 2018 that would seek to further scale up the project implementation to 450 public clinics, and accommodate commodities that have been additionally procured by LGUs, on top of those provided by the DOH.

CSO Involvement and Contribution

Reporting CSOs have conducted a total of 8,053 FP demand generation activities in the form of community education sessions, fora, mobilizations, etc., which was attended by more than 27,500 men and women. Notable of these activities is the 2nd National Family Planning Conference which was able to gather 1,200 delegates to provide various stakeholders with a platform to share best practices in demand generation and service delivery. In addition, CSOs have also produced IEC materials such as booklets and were distributed in various RH-related activities. From these activities, more than 39,000 women with unmet need were reached.

In terms of capacity building, there were 1,433 newly-trained CSO health service providers on FPCBT 1 and 2 (Implant and IUD) in 2017. This is in addition to the existing 630 health service providers rendering actual FP services with majority (395) providing IUDs.

A total of 335,357 women and men of reproductive age were provided with family planning services. Long-acting reversible contraceptives (LARCs) such as progestin subdermal implants and IUDs were the preferred method of choice with a total of 157,045 and 114,216 acceptors, respectively.

While majority of the CSOs utilized commodities provided by the DOH, which include contraceptive pills, both combined oral and progestin-only, progestin-only injectables, and copper IUDs, it was only in

November 2017, when the Supreme Court TRO on implants was lifted, that CSOs were able to acquire and utilize progestin subdermal implants of the DOH.

To augment the demand for implants, the DOH provided 132,800 units of subdermal implants to eight 8 CSO partners. The PSRP, through its partnership with the UNFPA, has provided a total of 97,674 progestin subdermal implants.

Technical Assistance from Development Partners

Philippines Action for the Acceleration of Family Planning: Progress towards FP2020

Family Planning 2020 (FP2020) is a global partnership that was instated during the 2012 London Summit on Family Planning. FP2020 supports the rights of women and girls to decide freely and for themselves, whether when and how many children they want to have. The global movement is currently operationalized in 69 of the world's poorest countries, which include the Philippines, with the aim of expanding access to FP information, services and supplies to an additional 120 million women.

A Focal Point system is being implemented in the country, comprised of DOH, USAID, UNFPA and Likhaan Center for Women's Health, Inc. as the CSO representative, that works collaboratively on strategies, priorities and activities towards the attainment of country goals on addressing unmet need for family planning and increasing contraceptive use for modern FP.

For the 2017 implementing period, the Philippines identified 6 priority areas of intervention, anchored on the country's CIP for FP for the year 2017 to 2020. The priority areas and progress are as follows:

1. Mitigate effect of TRO by maximizing FP delivery of available stocks and engaging alternative service delivery points while addressing Supreme Court TRO

- The Supreme Court TRO was deemed lifted when the DOH published the Revised IRR of the RPRH Law on Oct. 29, 2017 and the FDA issued Advisory No. 2017-302 on Nov. 10, 2017 declaring all contraceptive products in question to be non-abortifacient. Relative to the advocacy for its lifting, CSOs were mobilized to conduct various advocacy activities and in gathering signature petitions that were submitted to the Supreme Court.
- With regards to the logistics management system, to prevent stock-out of FP commodities, the DOH has undertaken system enhancement of its National Online Stock Inventory Reporting System (NOSIRS). The FP Program of the DOH is also conducting an operational study on Commodity Logistics Management Information System (CLMIS) using barcoding of FP commodities through UNFPA support. USAID's implementing partners monitor stocks of FP commodities in 2,274 assisted facilities, and trained 2,090 health service providers in supply chain management to analyze and monitor stock levels of contraceptive supplies as well as make timely requests for needed commodities.

- To support alternative service delivery approaches through CSOs and the private sector, UNFPA through the Family Planning Consortium was able to serve an additional 97,678 women acceptors of progestin subdermal implants in 2017. To support capacity building for FP, USAID supported skills training of a total of 6,323 health workers for FPCBT level 1 and 1,415 on LARC/PM.

2. Standardize and harmonize FP data collection, monitoring and evaluation, from the basic centers to the cities and provinces, up to the regions and the Family Health Office of DOH

- In the interim of strengthening the FP-CLMIS, the FP Logistics Hotline has continuously been operationalized to monitor distribution and utilization of FP commodities and supplies.
- Technical assistance is being provided to DOH by UNFPA and USAID to develop FP M&E Tools for data and logistics. UNFPA supported the pilot implementation of an FP-CLMIS Tool using barcoding technology called Track and Trace, and the conduct of Lot Quality Assurance Sampling (LQAS) to provide relevant information on contraceptive use and unmet need for modern FP in the priority provinces of DOH for reporting progress implementation of EO 12 on Zero Unmet Need for Family Planning. USAID provided technical assistance to 41 provinces and 15 cities to ensure quality of family planning data.
- Capacity building for Family Health Associates (FHAs) was provided on quality data and logistics recording, reporting and analysis.
- High impact and proven effective interventions and practices were documented as good practices for possible replication and scale-up. These included good practices on service delivery network, *Usapan* series, FP in hospitals, adolescent and youth RH services, Track and Trace that uses barcoding technology for logistics management, LQAS that offers a simpler way of monitoring FP program progress, Business Action for Family Planning, and a baseline and end line study on access to information and services on family planning among women in poor areas in Manila.

3. Quickly assess human resources per region/province if adequate to meet demands, esp. for LARCs and sterilization and make human resource plan accordingly

- The DOH deployed a total of 1,211 registered nurses as FHAs tasked in FP service delivery, and monitoring and reporting.
- DOH Administrative Order No. 2016-0038 laid down the policy framework which aims for universal health coverage through the establishment of network of health facilities from primary to specialty health facilities.
- UNFPA and USAID supported trainings on LAPM, such as for Progestin Subdermal Implant service delivery, FPCBT Level 2, including supportive supervision and mentoring. A self-instructional manual on FPCBT for FHAs was likewise developed.
- The DOH has sub-allotted funds amounting to more than Php 40 Million to its Regional Offices to support RPRH activities such as CSO engagement in ensuring delivery of FP services.

4. Provide FP+ (facility-based, outreach and PPFP) in regions with the highest burden on unmet need including young people

- In 2017, the Philippine Government, through its Health Facility Enhancement Program of DOH, allotted Php 694 Million for the enhancement of Barangay Health Stations; Php 1.17 Billion for Rural Health Units and Urban Health Centers; and Php 8.55 Billion for Public/LGU Hospitals.
- USAID developed models on service delivery networks for adolescent and youth and worked with 32 hospitals to establish program for young parents. Established and strengthened 35 school-based adolescent-friendly spaces, with approximately 80 percent linked to health facilities. Trained 987 health professionals to provide age appropriate adolescent- and youth-friendly health services. We have assisted 60 facilities to be AY friendly.
- UNFPA supported alternative service models for public private partnerships relative to FP service delivery through the BAFP Project and the engagement of the Family Planning Consortium and PSRP; Relative to addressing teenage pregnancy, UNFPA has provided upstream policy support to the proposed Teenage pregnancy bills, supported the National Youth Commission in organizing and convening the National Teen Pregnancy Council, and supported the DepEd through evidence based researches to inform the implementation of Comprehensive Sexuality Education.
- Through 2017 Public-Private Partnership project of DOH, partner CSOs provided FP services to 11,086 poor beneficiaries. Of which, 7,400 received subdermal implants; 2,159 received contraceptive pills; 1,100 received injectables; 126 received condoms, 203 received IUD; 93 received BTL; and 5 received NSV.

5. Ensure sustainable and adequate funding in the implementation of FP Program

- The DOH, POPCOM and CSOs continue on the advocacy for higher FP budget to be allocated for Family Planning.
- On expanding social health insurance coverage and client reach for family planning, guidelines were developed for the accreditation of free standing FP clinics. This will likewise serve as basis for PhilHealth in developing additional benefit packages for family planning.
- Through USAID's grants to Zuellig Family Foundation, we have assisted five provinces in health care financing and governance to sustain their FP programs. Furthermore, technical assistance was provided to more than 2000 health facilities for them to be compliant to PhilHealth accreditation and alongside the development of local policies on the use of Philhealth reimbursement.

6. Enhance CSO activities to promote gender and rights-based FP

- Ongoing advocacy for CSOS to adopt rights based FP program, especially among marginalized groups, and monitoring activities on violations of the right to family planning
- Ongoing partnerships with the RH Advocacy Network (RHAN) with various community mobilization activities conducted, and participation in the RPRH Law National Implementation Team providing inputs to DOH guidelines.

Other Contributions from the USAID Regional Implementing Partners:

Technical Assistance from USAID's Regional Implementing Partners (LuzonHealth, VisayasHealth, Mindanao Health) have contributed to the overall accomplishment of the FP program in 2017. Together with their counterparts (Region/ LGUs), the following are the highlights of these accomplishments:

- As of 2017 a total of 264,799 New Acceptors for Long Acting Reversible Contraceptives/ Permanent Methods were provided. To date, the project was able to serve a total of 768,351 in the USG project sites
- 747,888 women of reproductive age (15-49) who were or whose partner was counseled by a health provider on FP in the last twelve months adding to the 4.3M already reached and counseled in the project sites
- 181,016 youth (15-24 years old) provided with FP information/counseling and/or services in USG-supported sites which added to the 798,701 reached and served in the previous years
- An additional of 797 Service delivery points were providing FP counseling and service to couples, men, women, youth and adolescents of both sexes in USG sites. Currently, there are 2,484 facilities providing the services
- 1,381 public and private providers trained on FPCBT1 (a total of 6,644 providers in the project sites were capacitated); 782 public and private providers trained on FPCBT2 (a total of 6,644 providers were capacitated in the project sites to date)
- 176 LGUs in the project sites are with functional referral mechanism adding to the existing total of 401 LGUs with functioning SDN
- 817 LGUs with mechanisms to track or map unmet need for FP in the public and private sector

Assistance on Governance Mechanisms

Data on FP had previously been beset with inaccurate data reports that restrained its usefulness for program planning and measuring actual program accomplishments. Capacity building for data quality checks had been rolled out to all regions in order to institutionalize mechanisms for regular analysis of reported data on FP. The highest number of reports came from ARMM with 118 / 123 LGUs (95.9%), followed by Region V with 114 / 120 LGUs (95%) and Region III with 130/137 LGUs (94.9%) who have reported that data quality checks had been regularly done in 2017.

Challenges and Recommendations

Impractical FP Program Targets

With the most recent results of the NDHS (2017), the FP Program may need to review and adjust the indicators based on what can be achieved realistically in the next 5 years or in 2022. Strengthening support systems and enabling mechanisms to support the priority LGUs with the highest unmet MFP will be pursued in close partnerships with Department of Interior and Local Government (DILG) and other agencies to ensure that LGUs are effectively assisted.

Disconnect between Demand Generation and Service Utilization

1. Review current approaches/strategies and their effectiveness in reaching out to identify clients with unmet need for modern FP. It is necessary to identify the gaps in those WRA who were identified with unmet need but chose not to access FP services. Factors that affect the link between demand generation and service utilization should be determined so that there will be no missed opportunities. The wide variation in program implementation in the field may need thorough analysis to harmonize efforts from both POPCOM and DOH activities.
2. Provide technical assistance to LGUs in determining and mapping out available modern FP services and providers, both from public and private sectors, within the SDN. Incentives such as PhilHealth reimbursements through accreditation and certification of private-owned health facilities should be supported.
3. Strengthen FP service provision in hospitals and birthing facilities where they can provide post-partum FP, i.e. LARC as well as permanent methods. Provide necessary support, such as human resource, capability building, logistics, etc.
4. Ensure functionality of SDN through regular assessment of capacity of the affiliate facilities in delivering FP service required in their catchment area. Monitor the proper referral mechanisms and follow up of FP clients (i.e. from hospitals to primary level facilities) to ensure continuity of FP use.

Challenge in the Timely Distribution of FP Commodities

1. Assess and evaluate the current procurement and logistics management system of the DOH to address the perennial problem of delays in distribution of not just FP commodities but other health goods as well as.
2. The FP Logistics Hotline should prioritize regular monitoring of FP stock status of the 22 priority provinces identified in the AO 2017-0005 to meet the 2018 target in EO 12. Status should be made available regularly to the FP focal person of DOH Central and Regional Offices to address the logistics problem instantaneously.
3. Assess the current status of regional and provincial warehouses that can accommodate the FP commodities. The DOH can explore the possibility of increasing buffer stocks at the regional and provincial level.

Lack of Human Resource at the DOH Central Office to Implement the National FP Program and Monitor Implementation of EO 12

1. Expedite the creation of the FP Unit with adequate staff complement to fully and effectively implement the EO 12 and AO 2017-0005, and the National FP Program as a whole. The Unit should lead in the conduct of review of operational gaps/concerns of the priority areas and prepare a national technical assistance plan to address these. This would ensure that all requirements by these areas will be appropriately supported (both technical and funding

assistance). A program implementation review of the 22 priority provinces and their regional counterparts should be pursued to determine the operational concerns behind the performance reflected in the reports submitted.

2. FP Unit should coordinate with the Field Implementation and Monitoring Cluster (FIMC) of the DOH to discuss the monitoring plan to track progress of FP implementation and provide technical assistance to the 22 priority provinces. The plan shall include the review of all existing tools and checklist on the various components that are critical in the implementation of the FP program. The information may include but not limited to the following data: a. clients reached through demand generation activities; b. strategies being implemented; c. clients provided with services at the service delivery points to include both public and private facilities; d. status of logistic requirements (in coordination with the FP Logistics Hotline); e. service delivery networks/ referral systems; f. CSO participation. Exploring the possibility of contracting a 3rd party technical service provider to monitor the field performance accomplishments to facilitate gathering of critical information from field.
3. Prioritize monitoring and schedule of field visits to areas with highest unmet need for modern FP. Prepare the reports on results of monitoring visits and provide feedback to the DOH Central Office FHO for immediate intervention and technical support.
4. Assess the existing M&E tools of DOH and POPCOM and simplify the current indicators of EO 12 and RPRH KRA 2 to facilitate timely submission of field reports. DOH and POPCOM should agree on one database that should be maintained to track these indicators. This would prevent duplication of numbers and accomplishments. Technical assistance should also be provided at the sub-national levels to harmonize data coming from DOH and POPCOM Regional Offices including reports from hospitals, private sectors including the CSOs.
5. DOH and POPCOM should have a point of convergence/ collaboration to maximize efforts in providing assistance to the implementation level. This can be clearly established at the regional/ provincial level to minimize missed opportunities in terms of providing modern FP services to those clients identified with unmet need.

Best Practices

Engaging MRLs to address gender and cultural barriers to FP use in ARMM

The Regional Darul-Ifta of ARMM, with technical assistance from MH, has developed a sermon guide or khutba that will help imams when they lead Islamic worship services at the masjid. The guide was pre-tested and approved by USAID and are set for translation into local dialects (Maguindanao and Maranao).

In addition, in partnership with DOH-ARMM, the Muslim Religious Leaders (MRLs) are being engaged to help shape and promote positive behaviors among Muslim males on health, promoting peace, and in

mainstreaming moderate views on family planning in the context of birth spacing and protecting women's health among their respective constituents. A team of MRLs/local imam/a'immah are capacitated and organized as resource persons during community mobilization sessions (community health events, Usapan sessions, FDS sessions, REACH (++) in ARMM. This is critical in the aftermath of the recent crisis that befell the communities of Marawi City and Lanao Del Sur and continued rumblings of unrest in various parts of Maguindanao.

MH Support to Conflict Affected Areas:

REACH(+) activities supported in the 8 conflict affected areas namely all the 5 provinces of ARMM, Zamboanga City, Isabela City in Region 9, and Cotabato City reached 2,017 men, and 14,359 WRA of which 2,183 are adolescent/youth. These supported activities resulted to providing antigens to a total of 4,714 infants; Vitamin A to 3,441 clients; 1834 WRA provided with FP services of their choice on site and 84 referred for LAPM methods; and 14,134 provided with information on exclusive breastfeeding.

In addition, support to Marawi and its corridors (Lanao del Sur, Lanao del Norte, Iligan City) is given equal technical support with the establishment of Iligan-based regional office with 3 technical staff, an admin/finance officer and a driver, aimed at supporting partner LGUs to increase reach of health/FP/AY/MNH/psychosocial services to affected IDPs and host communities through outreach services, and help them restore their capacity to deliver essential health services. Establishment of Iligan-based office facilitated the coordination with LGU and other humanitarian partners, with the following initial results: i) supported capacity building cum outreach resulted to 88 informed clients accessed LARC/PSI services, 8 LARC/PSI-trained HSP supportively supervised and now for certification, and additional 9 HSPs trained on LARC/PSI; ii) series of consultations with LGUs and partners resulted to 20 identified priority facilities/areas to help restore the delivery of essential health services, initiated procurement of requested supplies such as dignity kits, maternity packs, aqua tabs and water tanks; and iii) outreach services generated 11 BTL acceptors, 2 IUD and 290 LARC/PSI in Lanao del Norte; 3 IDPs in Iligan accessed SDI services; and 3,071 IDPs in Marawi were reached with various health services. These are in addition to provision of 12,000 jerry cans, 51,000 aquatabs during the conflict and after Typhoon Vinta.

CSOs' Advocacy on AY Program in CAA Provinces

Sustained partnership with 23 CSOs in CAA provinces/cities spread across in ARMM (9), Zamboanga Peninsula (9) and CARAGA (5). In ARMM, these CSOs are continuously engaged on advocacy for health governance and are capacitated on demand generations for AYRH concerns.⁴⁶ All of these local partners were capacitated on Teen Facilitation to assist their respective RHUs in the demand generation activities for AYRH and link them to AY service provisions. Specifically, the local CSO partners' work cover advocacy, ASRH information, risks assessment, referral, and progress tracking for the health and

⁴⁶ These are Tarbilang Foundation in Bongao, Tawi Tawi, Sulu Provincial Women's Council and Kalimayahan Foundation (Jolo, Sulu), Isabela Foundation for Basilan, Bubong OSY Council (Bubong, Lanao del Sur) and Al Mujadillah Development Foundation (Marawi City), and for Maguindanao - UNYPHIL (Buluan), Upi Youth for Governance Program (Upi) and Bangsamoro Women and Children (Datu Piang).

development of OSYs and young parents, through outreach and public-private multi-sectoral partnership. Advocacy work of five (5) of these local CSOs already led to the issuances of Executive Orders by LCEs of Lamitan City of Basilan, Bongao, Tawi, Bubong, Lanao del Sur and Maguindanao's Buluan and UPI municipalities. These issuances contain provisions of establishing AY Friendly facilities as well as strengthening the demand generations for quality services that will address the needs of adolescents and youths in their communities.

From Service to Program: Systematizing Hospital-Based Family Planning

The Bicol Regional Training and Teaching Hospital (BRTTH) is a DOH-licensed and PhilHealth-accredited tertiary level training and teaching hospital located in Albay Province. Apart from Albay, it also serves the contiguous Province of Sorsogon and the island provinces of Catanduanes and Masbate, and even some residents of Camarines Sur. The hospital was recently certified as ISO 9001:2015. It was licensed as a 250 bed capacity-hospital but actual capacity runs from 480 to 500 beds.

BRTTH's journey to systematizing hospital-based family planning was not easy. The following realities prompted BRTTH to continually improve its family planning services.: a) FP Clinic of BRTTH has been operational since 1990 but its services were limited only to commodity-based methods and BTL under spinal anesthesia, b) passive mobilization of itinerant team, and c) discontinuance of FP service provision from 2008 to 2012. During this period, there was a limited number of providers for long-acting/permanent methods, there were no trained and certified trainers for FPCBT Levels I and II, no BTL room and no written hospital order and policies on FP, no specific budget allocation for FP services/program, no regular and permanent staff designated for Family Planning service/program, no definite schedules for advocacy activities, and no standard recording and reporting form used for FP services.

To address these concerns, BRTTH has recalibrated its programs and services through enhanced capacity development. Management of the FP Program was moved from the OB Department to the Public Health Unit which now provides a full range of FP services. The DOHRO V provided funds for the establishment of the BTL room, medical equipment and staff augmentation.

The BRTTH now has a fully operational BTL room manned by a permanent staff. There were 10 additional OB-GYN doctors certified as BTL-MLLA service providers. The BRTTH has also been certified/recognized by the DOHRO V as a training institution for FPCBT1, FPCBT2 (PPFP/PPIUD and BTL-MLLA), and the Basic FP eCourse for Physicians.

Demand generation was further intensified as part of the institution's commitment to attain "zero unmet need." Training in FP counselling for staff from different hospital departments was conducted. An orientation on FP in the Hospital initiative was conducted for hospital staff from the administrative section, engineering and maintenance, housekeeping/utility, security, grounds-men, medical staff, nursing staff and other ancillary departments was also done.

BRTTH is one of the hospitals in the country with an active and operational Public Health Unit (PHU). With support from the pro-active coordinators and stakeholders, the BRTTH PHU has established an FP Program and committed to ensure its sustainability. In this regard, BRTTH has put in place the following: a) an organized Family Planning Technical Working Group, b) Hospital Order (No. 2017-001) creating the

FP Hospital Management Team, c) FP recording and reporting tools in compliance with DOH DM 2014-0312, and d) an ISO- and PHIC-compliant e-recording and reporting system. The BRTTH has also become the apex referral facility for the Albay SDN.

Other initiatives of the BRTTH to strengthen its FP Program include: a) regular mobilization of an itinerant team, b) establishing partnership with LGUs, academe, NGOs, and other stakeholders, c) integration of FPCBT2 in the OB/GYN residency program, d) integration of FP in the Annual Work Plans, and e) use of PHIC reimbursements for the replenishment of FP supplies and as support to other operational expenses of the hospital.

Together with DOHRO V, Bicol University College of Medicine, and LuzonHealth, the BRTTH also capacitated health service providers from the Provinces of Albay, Sorsogon, Catanduanes and Masbate. To date, BRTTH has facilitated two batches of FPCBT Level I --- one batch for health service providers from Camarines Sur and Camarines Norte, and another batch from the neighboring provinces of Camarines Sur and Camarines Norte.

Available hospital data for the period July 2016 to June 2017 showed a notable increase in the coverage of clients provided with FP information, counseling, and services. There were 7,849 clients provided with FP information, and out of this number, a total of 2,402 (31%) were counselled and 1,932 (80%) accepted a method. This has significantly contributed to the reduction of FP unmet need in the region. The remaining 20 percent were either referred back to the RHUs (mostly postpartum, either to continue with LAM or to avail of other modern FP methods/commodities).

Mobilizing Satisfied Users as Providers of FP Information to Support Healthy Behaviors [With Technical Support from Visayas Health]

Significance/background: According to a family planning (FP) program review by Joshi (February, 2011), “elements of successful FP programs include those built around the goal of empowering individuals and families to make informed and responsible choices; those which are designed to address socio-cultural and economic barriers and those which respond to specific local situations.” Related, a study among Polish women (Colleran and Mace, 2015) showed that social networks positively affect the decision to use a method—either kin networks or those with other women—with the magnitude of the effect increasing with more contraceptive users in the community. These influencers can help inform availability of FP services and its benefits.

The Philippines 2011 Family Health Survey showed that among women who do not use contraception, fear of side effects and health concerns are cited as the top two method-related reasons, at 16 and 15 out of 100 women, respectively. These are barriers to FP use. The value of satisfied FP users in dispelling myths and misconceptions is examined in this study.

Program intervention/activity tested: The unmet need reduction strategy (UNRS) included mapping potential satisfied users (SUs) of FP using facility data. Recruitment, mentoring, and mobilization of SUs followed the mapping exercise. Coaching SUs included engaging the Understanding-Showing-Experiencing-Doing approach and orienting SUs on the use of information, education, and communication materials. After identifying women with unmet need in their communities, SUs shared their FP experiences and invited potential clients to visit health centers. In coordination with supported health centers offering designated FP days, clients received informed and comprehensive counseling and, if they chose to adopt a method, were provided with their preferred FP method.

Methodology: The province of Leyte in Eastern Visayas, Philippines, adopted USAID/VisayasHealth's UNRS mobilizing FP SUs in November 2016 against a backdrop of high unmet need for FP in its catchment area, particularly for limiting family size. Under the leadership of the provincial health office, a province-wide phased approach was used to orient all 43 local health offices to the UNRS strategy. Facility data were collected prior to employing SUs (November 2015 to October 2016) and compared with data during the implementation period. An FP day tracker was set up to monitor output from these events, including the numbers of FP days conducted, SUs mobilized, and clients served, by method.

Results/key findings: From November 2016 to December 2017, all 43 health offices conducted at least one FP day; of these, 28 health offices have consistently employed FP SUs. As of end of December 2017, a total of 703 SUs of intrauterine devices and implants were mobilized, and 88 providers received coaching and skills updating support from the project.

The number of clients adapting long-acting reversible contraceptives (LARCs) pre- and post-UNRS were compared. Results showed that 409 clients were served pre-intervention. In contrast, from the start of the intervention period up until December 2017, a total 4,422 clients were served, representing an almost five-fold increase in the number of clients adapting LARCs.

In Leyte today, FP days are twice-monthly events at the health centers. Efforts are being expanded to the rest of the other municipalities to recruit and mentor SUs who can help provide accurate information on LARCs to relatives, friends, neighbors, and associates who are not yet utilizing modern FP methods. Their numbers are continuously expanding as new acceptors also express an interest and willingness to reach out to other women with an unmet need. On FP days, services are also provided to clients who opt for other FP methods.

Program implications/lessons learned: Leyte's experience shows how employing SUs was successful in generating more clients; in part, this has contributed to addressing unmet FP needs in the province. Satisfied users are willing to help others in taking care of their reproductive health by providing behavior-changing information on FP. More clients were accepting FP services through available FP services in the community, implying that a positive change in health seeking behavior toward FP services has occurred.

KRA 3: Adolescent Sexuality and Reproductive Health

Status and Trends

Teen pregnancy

Teen pregnancy is on the decline but nearly half a million young Filipino women are already a mother or pregnant with the first child. Adolescent fertility rate⁴⁷ dropped from 57% to 47% based on the 2013 and 2017 NDHS, respectively, but it remained high among young women in rural areas and those with lower level of educational attainment. The percentage of teens in this age group who have already had live birth or are pregnant with their first child during the NDHS interview declined from 10% to 8.6% over the period, which translates to about 60,000⁴⁸ fewer teen pregnancies nationwide. Nonetheless, the number of those who have already begun childbearing remains high at over 420,000⁴⁹. Davao, Northern Mindanao and SOCCSKARGEN regions posted the highest fertility rates which are about double the national rate (see Table 3a).

Table 3a. Teenage Pregnancy and Motherhood

Region	Percentage of women aged 15-19 years old who:		% Percentage who have begun childbearing
	Have had a live birth	Are pregnant with first child	
NCR	4.6	1.0	5.6
CAR	2.8	0.7	3.5
Ilocos	9.8	3.4	13.2
Cagayan Valley	5.4	2.3	7.8
Central Luzon	7.5	1.2	8.9
CALABARZON	7.1	2.1	9.2
MIMAROPA	7.8	1.4	10.3
Bicol	4.0	0.4	4.4
Western Visayas	4.9	0.5	5.3
Central Visayas	6.3	1.1	7.4
Eastern Visayas	5.1	1.6	6.9
Zamboanga Peninsula	6.8	0.6	7.5
Northern Mindanao	11.6	1.6	14.7
Davao Region	15.9	2.1	17.9
SOCCSKSARGEN	11.8	2.4	14.5
CARAGA	5.7	2.5	8.2
ARMM	6.8	1.7	8.5
Philippines	7.0	1.5	8.6

Source: 2017 NDHS

⁴⁷ Defined as the number of births per 1,000 women aged 15-19 years

⁴⁸ Estimated using the 2013 and 2017 NDHS rates on the number of young women who have begun childbearing and the PSA projected population of 15-19 years old women in 2010 and 2015.

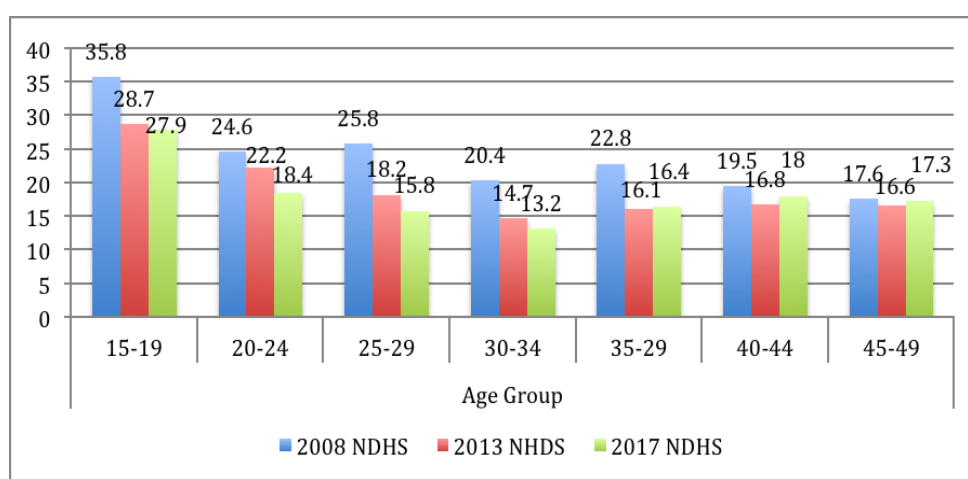
⁴⁹ Ibid.

“Having children this early in life exposes adolescent women to unnecessary risks. Their chance of dying is twice as high as that of a woman who waited until her 20s to begin childbearing. In addition, early childbearing greatly reduces the likelihood of a girl advancing her education”.⁵⁰

Unmet need for family planning

Unfortunately, in the Philippines, there are many young women who want to stop or delay pregnancies but are not using any method of contraception. Unmet need for FP has declined among the different age groups since 2008 (except for women 35 years and above) but it remains highest among the youngest (15-19) age group. Unmet need for FP among these young women stood at 28% in 2017, compared to only 13%-18% in older age groups (see Fig. 3.a). This translates to over 1.4 million young women who want to limit or space childbirth but are unable to use an FP method. Unmet need for FP is highest in Zamboanga Peninsula (25%) and lowest in NCR (12%).⁵¹

Fig. 3.a. Percentage of Women with Unmet Need for Family Planning by Age Group, 2008-2017



Source: 2008, 2013 and 2017

Closely spaced pregnancies among teenage mothers

Based on research⁵², teenage mothers have the lowest birth intervals (median of less than 24 months) and expose themselves and any more babies to greater risks if subsequent pregnancy is not prevented. A study conducted by the Philippine Statistics Authority (PSA) in 2014 showed that the percentage of subsequent pregnancies among women below 20 years increased from 4.5% in 2000 to 6.5% in 2010 for second order births, and from 0.7% to 1% for third order births (see Figure 3.b). This indicates unmet need for family planning. While there is a desire to limit or space births longer, such desire is not matched by the corresponding use of contraception.

⁵⁰ Population Reference Bureau: 2013

⁵¹ 2017 NDHS

⁵² J. Natividad. Journal of the ASEAN Federation of Endocrine Societies. Teenage Pregnancy in the Philippines: Trends, Correlates and Data. 2013.

Fig. 3.b. Live Births Among Women Below 20 Years Old, 2000-2010

Year	First Baby			Second Baby			Third Baby		
	All Ages	Under 20 Years Old		All Ages	Under 20 Years Old		All Ages	Under 20 Years Old	
		Number	Percent		Number	Percent		Number	Percent
2000	534,322	104,340	19.5	412,993	18,714	4.5	292,394	2,078	0.7
2001	533,615	105,630	19.8	403,883	18,492	4.6	284,053	1,973	0.7
2002	529,115	102,264	19.3	395,811	18,391	4.6	275,674	1,882	0.7
2003	429,583	85,022	19.8	317,401	5,183	4.8	217,362	1,632	0.8
2004	559,775	112,828	20.2	409,786	19,861	4.8	281,429	2,021	0.7
2005	576,894	120,917	21.0	407,125	20,694	5.1	272,506	1,992	0.7
2006	582,763	129,830	22.3	404,065	21,664	5.4	265,380	2,166	0.8
2007	625,887	146,229	23.4	426,211	24,075	5.6	279,550	2,317	0.8
2008	651,159	158,285	24.3	440,053	25,356	5.8	283,173	2,451	0.9
2009	650,789	165,857	25.5	439,645	26,841	6.1	272,676	2,560	0.9
2010	655,980	175,345	26.7	456,158	29,381	6.4	281,519	2,827	1.0

Source: Reolalas, A. Teenage Pregnancy in the Philippines: Trends, Correlates and Data. Journal of ASEAN Federation of Endocrine Studies. Philippine Statistics Authority. 2013.

Use of FP method

Only 35.8% percent of adolescents 15-19 years old have access to any type of FP method (including traditional ones) in 2017 and an even smaller percentage (29.7%) have access to any modern method. Pills remain to be the most widely accessed FP method (16%), followed by injectables (6%) and IUD (3.4%), among adolescents.⁵³ It was not established whether the reason for the high use of pills is largely because of personal preference or merely due to its availability at service delivery points. Use of traditional methods (6.1%), mainly withdrawal (5.4%), remains high despite various ASRH information, education and communication (IEC) activities advocating for modern FP. Progestin-only subdermal implant (PSI), which is being offered to teenagers who are non-pregnant or post-partum, still accounted for 1.9% of FP use despite the Supreme Court TRO on the method. Among 15-19 years old women with multiple partners, only 21.6% are using condoms. Condom is currently being promoted by the DOH as part of its HIV/AIDS prevention program and not as an FP intervention. Only one of six or 16% of women aged 15-19 years have comprehensive knowledge of HIV prevention, with the proportion of knowledge increasing with age and education. Young women in Ilocos and Cagayan Valley are least likely to be knowledgeable about HIV prevention.⁵⁴

In terms of maternal care, the 2017 NDHS showed that use of antenatal care by young mothers in their most recent pregnancy dropped from 96% in 2013 to 91.4% but facility-based deliveries as well as skilled birth attendance among this group improved from 63.4% to 76.1% and from 74.7% to 83.4%, respectively over this period.

⁵³ 2017 NDHS

⁵⁴ Ibid.

Interventions

Policies and legislative measures

The DOH developed and disseminated the Adolescent Health and Development Program (AHDP) Manual of Operations (MOP) to guide program managers on the implementation of the National Policy and Strategic Framework on Adolescent Health and Development. The MOP includes tools such as the Standards for Adolescent-Friendly Health Services, Competency Training on Adolescent Health for Health Service Workers, Adolescent Job Aid, and Guidelines for the Implementation of Adolescent Immunization.

It also issued a number of policies to support the implementation of AHDP:

1. Department Circular 2017-0165 on the nationwide adoption of the Clinical Practice Guidelines on the Prevention, Diagnosis and Treatment of Opportunistic Infections in Human Immunodeficiency Virus-infected Adults and Adolescents in the Philippines. This was developed by the Philippine Society for Microbiology and Infectious Diseases, the National AIDS/STI Prevention and Control Program and other professional organizations in 2016 in response to the increasing trend of HIV/AIDS among the younger population.
2. Department Personnel Order 2017-2776 creating the Technical Working Group (TWG)⁵⁵ for Adolescent Health and Development. It designated the DOH as lead convener agency for the health concerns of adolescents, and the National Youth Commission (NYC) as co-lead convener for their non-health concerns. The said TWG revised the 2013 AHDP strategic framework, and developed the logical as well as the monitoring and evaluation framework of the program based on the Philippine Youth Development Plan.
3. DM 2017-0098 defining the levels of compliance to standards for Adolescent Friendly Facilities into three categories (i.e. Level 1, Level 2 and Level 3). It standardizes the provision of adolescent health services in the different levels of health facilities to ensure delivery of quality care to young people.
4. DM 2017-0290 (issued with DepEd DO 59, s. 2017 dated November 27, 2017) on complementary guidelines on the Weekly Iron Folic Acid (WIFA) supplementation for female adolescent learners in public high schools. WIFA is a component of the Menstrual Health Management Project of DepEd for female students in Grades 7 to 10 including those enrolled in the Alternative Learning System. The DOH provides the supplies for WIFA, which is usually conducted in July-September (first round) and January-March (second round). It aims to address the 8th NNS finding in 2013 which showed that one in ten or 10.2% of adolescents aged 13-19 years have anemia.

⁵⁵ Composed of the DOH, NYC, the Commission on Higher Education (CHED), POPCOM, the Council for the Welfare of Children (CWC), DepEd-School Health Division, DepEd-Curriculum Development Division, Department of Social Welfare and Development (DSWD), Department of Interior and Local Government (DILG), Likhaan, Family Planning Organization of the Philippines (FPOP), Technical Education and Skills Development Authority (TESDA), Women's Health Philippines, Save the Children, ACT!2015 Alliance, Youth Peer Education Network, Society of Adolescent Medicine in the Philippines, Inc., and Micronutrient Initiatives

In addition to these policies, DepEd continued its efforts to update its module on Comprehensive Sexuality Education (CSE) to meet the CSE Standards for the Philippines developed by a panel of external experts convened by Likhaan Center for Women's Health, Inc. in 2016. It also started developing guidelines for the integration of the updated CSE in the K-12 curriculum and with UNDPa assistance, assessed the readiness of teachers in providing CSE. The RPRH law and EO 12 instruct DepEd to implement a gender-sensitive and rights-based CSE in the school curriculum.

At the subnational level, LGUs in most regions also issued policies to help implement the AHDP, mainly through the establishment of information and service delivery network, provision of reproductive health care, regulation/ban on the sale of cigar, cigarettes and liquors, setting of curfew hours, and localization of child protection policies. San Vicente, Ilocos Sur, for instance, issued an ordinance creating the Adolescent and Youth Health Council in the Municipality of San Vicente, Ilocos Sur. Meanwhile, Sugpon, Ilocos Sur followed with its ordinance developing the youth as partner in community development through trainings on Adolescent Fertility Management and Leadership.

To help remove legal constraints to RPRH implementation, the DOH worked towards approval of the following:

1. House Bill 06617: "The Philippine HIV and AIDS Policy Act". It proposes to make HIV testing and counseling available to: (a) a person 15 years and above without the need for parental consent, (b) any person aged below 15 years who is pregnant or engaged in high-risk behavior, provided that she is assisted by a licensed social worker, and (c) person below 15 years or has impaired legal capacity, with consent obtained from the child's parents or legal guardian, or from a licensed social worker in case the parents or guardian refuses to give consent. It was approved by the House of Representatives in December 2017 and its counterpart Senate Bill 1390 already underwent first reading and interpellation.
2. House Bill 04742: "An Act Providing for a National Policy in Preventing Teenage Pregnancies, Institutionalizing Social Protection for Teenage Parents, and Providing Funds Therefor". This bill calls for the development of a national plan of action and investment plan for the prevention of teenage pregnancy, organization and mobilization of a service delivery network for adolescent health and development, CSE for adolescents and their parents/guardians, mandatory establishment of local teen centers, regulation of access of minors to pornographic materials and obscene shows, access to reproductive health services, social protection for teenage mothers or parents, designation of February as Month for Public Awareness on Preventing Teenage Pregnancy, integration of Teenage Pregnancy prevention program in SK Programs, and prevention of adolescents' involvement in other risky behaviors that are facilitative of engagement in sexual activities. It was approved by the Committee on Population and Family Relations in May 2017 and its counterpart Senate Bill 1482: "Prevention of Adolescent Pregnancy Act of 2017" already underwent hearing from the Committees on Health and Demography, Youth, Finance, and Women, Children, Family Relations and Gender Equality.
3. House Bill 05777: "An Act Strengthening the National and Local Health and Nutrition Programs for Pregnant and Lactating Women, Adolescent Girls of Reproductive Age and Teenage Mothers, Infants and Young Children in the First 1,000 Days". It aims to address the cyclical nature of undernutrition, address stunting, and bolster the delivery of health and nutrition services to adolescent girls, especially teen mothers, at facility and community levels. It was approved by the House of Representatives in September 2017 and its counterpart Senate Bill 01537: "Healthy

Nanay and Bulilit Act” already underwent first reading, interpellation and a period of individual amendments.

Demand Generation activities

POPCOM, DOH and the CSOs continued the Youth for Youth (U4U) – a youth hub initiative that delivers critical information to Filipino teens through the use of online and mobile platforms. Implemented in almost all regions, it has already reached over 4.6 million young Filipinos nationwide since its launch in 2015. Other demand-generation activities include the following:

1. Parent Teen Trail. It is a POPCOM-WHO initiative that introduces an alternative and interactive version of the Learning Package for Parent Education on Adolescent Health and Development (LPPED-AHD) that can be implemented by schools, communities and other partners.
2. Knowledge and Basic Service Access Terminal (KABSAT). This initiative in CAR mobilizes information and service facility hubs to form a single online functional network that provides integrated and effective delivery of AHD services.
3. Adolescent Health and Development Classes. This activity harmonizes health and population strategies and activities for a more holistic provision of information and services to teens. It was pursued by Region VI to accelerate the implementation of EO 12. Trained peer educators together with health and population workers conducted classes using the Healthy Young Ones as well as the Sexually Healthy and Personally Effective (SHAPE) modules. They profiled teen participants to obtain basic information and identify their problems as well as their needed services. Profile data were consolidated, assessed and referred to the appropriate service providers through the Information and Service Delivery Network (ISDN) established in the LGU.
4. Adolescent Health Connect (AH Connect) through SMS and social media with hotline. DOH Regional Office VI partnered with the University of the Philippines Visayas in undertaking this project, which establishes a 24/7 adolescent-friendly helpline for the youth aged 10-24 years using social media. This is expected to reach more youth who are mostly digitally wired, based on the recent results of the Young Adult Fertility and Sexuality (YAFS) Survey.
5. Heart to H.E.A.R.T. (HIV/AIDS and sexually transmitted infections; Early sexual encounter; Adolescent fertility; Reproductive health; and Teenage pregnancy). It is a campaign aimed at creating awareness on the increasing number of HIV/AIDS incidence and teenage pregnancy in the country.
6. Annual Summer Kids Peace Camp. In Region XII, Cotabato allocated a total budget amounting to Php 8.7 million for this province-wide activity. This activity involves the Grade 5 pupils in all public and some private schools. These pupils were trained on the following: adolescent development, peace and culture, peace building, intra-faith sharing, disaster preparedness, life skills, and community immersion.

Commonly conducted activities in almost all regions include the Festival of Talents, Film Festival, Teenage Pregnancy Symposia, Youth/Adolescent Summit/Camp, Breaking the Barriers on AHD, Peer Education, Film Showing, Teen Forum, Teen Moms Congress, Bonjing E. Camp, ASEAN Youth Forum and ASRH Classes.

To increase national awareness on ASRH concerns, the DOH Health Promotion and Communication Services, in partnership with Net25 Eagle Broadcasting Corporation, aired for 13 successive Sundays a segment on Healthy Young Ones in the teen advocacy TV show TRIBE. The TV segments featured young “Buddy” doctors discussing #HealthGoals for adolescents and topics such as child abuse, drug abuse,

malnutrition, body image and hygiene, food sanitation, family planning and safe motherhood, drowning, bullying and suicide, dangers of social media, and youth violence. Episodes of these segments were uploaded on YouTube TRIBE Net 25. The topic on teenage pregnancy had the highest number of views.

At the subnational level, the LGUs, together with CSOs, produced additional IEC materials (e.g. tarpaulins, flipcharts, brochures, videos, leaflets and flyers) and procured furniture and equipment (e.g. tables, chairs and televisions) to be used in Teen Centers/Hubs. Advocacy activities were persistently conducted to get budgetary, administrative as well as political support from local officials for the implementation of AHD.

Capacity Building

Capacity building activities enhance the skill of health service providers and help transform their mindset, attitudes and practices in a way that allows them to provide quality adolescent health and development services at all levels of health facilities. POPCOM, DSWD, DepEd, development partners and CSOs as well as local government units collaborated in conducting the following training for health providers in 2017:

1. Adolescent Job AID and Adolescent Health Education and Practical Training (ADEPT) for health service providers. The DOH worked hand in hand with various local government units to develop a pool of adolescent-friendly health service providers who can attend to the sexual and reproductive health needs of young people. A total of 140 LGUs in Luzon, 608 in Visayas and 47 in Mindanao produced a pool of over 10,200 health service providers trained on AJA and ADEPT. Development partners such as USAID, the Family Planning Organization of the Philippines (FPOP) and Save the Children Foundation assisted the DOH and LGUs in the conduct of said training.
2. Healthy Young Ones. The Healthy Young Ones is a health education campaign of the Department of Health, in partnership with Ypeer Pilipinas, to increase the knowledge of adolescents on the topics of puberty, reproductive system, menstruation, gender and development, reproduction and responsibility, sexually-transmitted infections, and HIV and AIDS. The campaign is steadily being conducted in 568 local government units nationwide, with a total of 671 trained health service providers doing the rounds of Healthy Young Ones sessions in different elementary and secondary schools.
3. Peer Education Program on Adolescent Sexual and Reproductive Health. YAFS 2013 indicated that 37.6% of young people relied on their friends for information when confronted with problems on fertility, sexuality and HIV and AIDS. The peer-to-peer approach on ASRH allows them to discuss these important reproductive health issues in casual setting with knowledgeable peers without the risk of being criticized or ridiculed. POPCOM-Region VII used this platform for its Ladderized Peer Education Training, which develops the knowledge and basic competency skills of youth advocates through four stages of training anchored on the SHAPE Module. Those who completed the training were tapped by POPCOM as peer educators or peer helpers in its various IEC activities and training. Based on the RIT Accomplishment Report, there are 1,908 trained peer educators in CAR, NCR, Regions I, II, III, 4A, 4B, V, VI and VII who assisted in educating 39,817 young people on ASRH through various platforms in 2017. POPCOM-Region VI eventually adopted this ladderized approach in training.

A similar initiative called the Peer Education on ASRH Program was also widely implemented in Mindanao, resulting in the training of 865 peer educators from 310 LGUs on various training programs such as Teen Care: An Interpersonal Communication and Counseling Training on Adolescent Health and Development, True Love Waits, Training of Trainers on Getting Along with You and Me (GAYM), and SHAPE training. In-school peer educators were mobilized in 1,053 public schools and 21 private schools in Region 12. Currently, there are 1,492 peer educators in public schools and 170 in private schools. Youth and summer camps held in various regions in the Visayas and Mindanao gathered more than 200 peer educators who shared their experiences and insights on outreach services, particularly in terms of providing accurate information on ASRH to their peers.

4. Responsible Adolescence Campaign through the conduct of Responsible Adolescence Seminar (RAC-RAS). Implemented in South Cotabato, this IEC/advocacy campaign incorporates a research component that promotes the formulation of appropriate and relevant youth development plans and programs that use accurate information and respond to specific health and development needs of the youth. South Cotabato trained 449 peer educators in the RAC-RAS network in 2017, 209 of whom got actively involved in youth development planning and budgeting as well as networking with LGU and CSO partners.
5. CSE Training for Teachers. DepEd rolled out the CSE training for teachers in Mindanao regions, particularly in SOCCSKSARGEN. As a result, 144 teaching personnel from 61 public elementary and secondary schools were trained on the CSE module. In addition, DepEd, together with DOH and POPCOM, also trained guidance counselors on ASRH and CSE in 230 public and private schools in CARAGA and Region 12. The CSE training sensitizes teaching and non-teaching personnel in recognizing and proactively addressing the SRH concerns of in-school adolescents. FPOP supported government efforts on CSE training rollout through its FPOP Cares Project, which conducted Teachers Training on CSE for K-12 Curriculum for 107 teachers of public secondary schools in Region 12. In Cebu, POPCOM-Region VII, in partnership with DepEd and Cebu Provincial Government, started the AHD Integration Workshop where ASRH concepts and life skills are integrated into the instructional plan (iPlan) of MAPEH, Filipino and other subjects in the secondary schools in the DepEd divisions of Bogo and Naga cities.

Service Delivery

Implementation of AHD Program

The DOH continued to implement the AHD Program, which focused on ASRH concerns (i.e. sexuality, reproductive tract infections including STDs/HIV/AIDS, responsible parenthood and maternal and child health) and on issues related to communicable diseases, mental health (including substance use and abuse), and intentional/unintentional injuries among young people. The program was implemented mainly through the provision of quality gender-responsive, biomedical and psychosocial services as well as IEC and counseling services to adolescents, and capacity building of health and non-health providers on the delivery of adolescent-friendly services. The DOH also pursued activities to strengthen partnership and networking with concerned agencies and organizations on AHD, mobilize resources for the program, and improve its monitoring and evaluation.

Provision of ASRH services in health facilities

A. Hospitals

Selected health facilities continued to provide adolescent-friendly services in 2017. Through USAID's VisayasHealth support, Eastern Visayas Regional Medical Center (EVRMC) and Iloilo Provincial Hospital (IPH), for instance, set up individual records of their Program for Young Parents (PYP) clients. This allowed them to follow up on their young clients for prenatal consultations and *Usapan* or education sessions with Rural Health Unit (RHU) midwives, and to regularly report on the number of clients who: (a) enrolled and delivered in the hospital, (b) accepted a birth-spacing method, and (c) returned for pre- and postnatal care. The teen moms and their families are assisted by social workers to comply with the documentary requirements of social insurance so they can avail of its benefits. The EVRMC has a unique six-bed maternity ward which is solely for teen moms. It is situated in the same wing where the prenatal, *Usapan* and counseling rooms are.

Hospital-based ASRH services include: (a) counseling, nutritional assessment, maternal care services (prenatal, natal and post-natal); (b) family planning, (c) STIs including HIV & AIDS, (d) RH assessment and counselling such as fertility awareness, menstrual health issues counseling, Pap Smear and pelvic exam, (e) dental assessment, (f) micronutrient supplementation (iron supplements are given for free to clients when there are available samples), (g) social and legal services (the hospital refers clients in need to LINGAP for financial and other assistance from the city government), and (h) referral of clients with substance abuse problems to other facilities (e.g. the PSYCHIA Centre, a government facility). A total of 382 adolescent-friendly health facilities present in CAR, NCR, Regions I, II, III, IV-A, V, VI, VII, VIII, IX, X, XI and XII, as well as CARAGA were reported to have served almost half a million (478,252) adolescents in 2017.

EVERMC, IPH and Brokenshire Woman Center met most of the 2010 National Standards for Adolescent-Friendly Health Services with their gender-responsive and rights-based provision of ASRH care.

B. Teen Centers/Kiosks/Health Quarters

The creation of Teen Centers (led by POPCOM) is a common response to address the sexual and reproductive health needs of adolescents. These centers seek to provide adolescents with age-and-development-appropriate information through various IEC materials on ASRH. In Cavite, USAID's LuzonHealth introduced a three-pronged approach to reduce teen pregnancy by involving a health referral and service delivery network that includes school-based, RHU-based as well as hospital-based Teen Health Kiosks/Centers (THK/THC). These facilities provide clinical/medical services, referrals for health services, and information, education and counseling on adolescent sexuality and reproductive health. The establishment of these Teen Centers was initiated by the NGOs, such as the defunct Foundation for Adolescent Development Inc. (FAD), FPOP and Baguio Center for Young Adults (BCYA) as well as the academe in collaboration with the LGUs, the Sangguniang Kabataan (SK), and donor agencies like UNFPA, GIZ (formerly GTZ), Packard Foundation, and Ted Turner Foundation, among others.

POPCOM Regional Offices reported a total of 72 Teen Centers all over the country in 2017, 48 of which are school-based and 24 are community-based. Teen Centers and Kiosks in Regions CAR, II, III, IV-A, IV-B, V, VI, VII, IX and XI served more than 30,000 adolescent clients in 2017, providing them with ASRH information, counselling and referral services. With POPCOM support, several Teen Centers were also set up in secondary schools to expand access of teenagers to adolescent-friendly health information and

services including psycho-social support. Some school-based Teen Centers are stand-alone multi-purpose centers while others are placed beside school clinics or guidance counselling office or near both facilities so that young people can be easily referred to the pertinent personnel for their health and psycho-social needs. Their location, size and facilities vary depending on the availability of school space and the support of the institution as well as the LGU. In Iloilo Province, for instance, the Governor provided substantial funds to set up Teen Centers in 43 secondary schools with technical support from the Provincial Population Office and POPCOM.

Community-based teen centers were also set up inside or near health centers as these were deemed “advantageous in addressing health issues of adolescents because of their proximity to referral facilities”. Most school and community-based teen centers get regular funding support from LGUs, such as those in Quezon City, Marikina, Iloilo and Davao, which are annually funded by their local government. Marikina Youth and Adolescent for Health and Wellness Center (MYHAWC), for instance, is able to operate well because of local fund support. It is equipped with a full-time midwife who also serves as Youth Coordinator and it has a visiting doctor for medical consultation and dental services. The Center provides pregnancy test and counselling, pre- and postnatal care, FP counselling, Pap smear examination, breast examination, STI management, HIV testing and counselling, dental services and information and education campaigns. It has peer educators who provide school-to-school education drives, community outreach and other IEC activities. Peer educators are given scholarship grants, monthly stipend of PhP500 each, and transportation allowance for outreach activities.

Quezon City Teen Health Quarter or QC THQ provides almost similar services, with the addition of life skills development and leadership training. It is headed by a medical doctor who is at the same time the barangay health center’s medical officer – assisted by a nurse, midwife and two health educators. Pregnant adolescents are counseled and referred to the city’s Comprehensive Emergency Obstetric and Newborn Care (CEMONC)-capable hospital for delivery. Prior to their enrolment at the hospital, the pregnant teenager is reportedly already enrolled by PhilHealth’s “Gabayan ng Batang Ina” project. Davao City’s Barangay 21-C Teen Center functions similarly. It has a regular consultation day for prenatal consultation services by the midwife for pregnant teenagers of varying ethnicities (Muslims, migrants and settlers) from the large urban poor community. All pregnant teenagers are referred by the midwife to the District Clinic for simple laboratory tests and for referral to the regional hospital. The midwife goes to the regional hospital every Friday to pick up all the records of the women who delivered in the regional hospital including those of the teenage mothers. The mothers are provided with postnatal care at the barangay health center. They are regularly followed up in their homes by a group of barangay health workers.

The problem is that not all Teen Centers/Health Quarters, drop-in centers, adolescent reproductive health (ARH) corners and *tambayans* enjoy regular funding and political support from LGUs. Some of these facilities are not also able to sufficiently provide adolescents with ASRH information, counseling and services including referral to higher level facilities. USAID conducted a study in 2017 which delved more deeply into the issues affecting the effectiveness of THKs.

Governance and financing

POPCOM, in collaboration with LGUs, DepEd and CSOs, has implemented the Information Service Delivery Network (ISDN) to provide adolescents with accurate information, counselling services and

referral to the nearest service facilities. ISDN refers to the network of facilities, institutions, and providers within the province-, district, municipality/city-wide health and social system offering information, training, and core packages of health and social care services in an integrated and coordinated manner. Through ISDN, different agencies such as DepEd, NYC, DSWD, DOH, POPCOM, PNP, and CSOs are regularly convened to discuss issues and concerns related to teenage pregnancy, STI/HIV/AIDS among adolescents, drug addiction, smoking, and other risky behaviors among adolescents. The DOH and POPCOM Regional Offices reported a total of 72 ISDNs in 2017: 32 in Luzon, 2 in Visayas and 38 in Mindanao. They served nearly half a million adolescents through various health information and counseling services.

In terms of financing, PhilHealth's no-balance billing (NBB), care package and point-of-care enrolment appear to be practiced widely in the hospitals. In health facilities such as EVRMC and IPH, the teen moms and their families are assisted by the social workers to comply with the social insurance's requirements, although they still incur out-of-pocket expenses for their transportation, food and miscellanies.

Challenges and Recommendations

Missed opportunity for enabling in-school adolescents to make informed choice about their sexual and reproductive health. Sexuality education in public schools has been limited to menstrual hygiene, neglecting a range of topics critical to CSE such as sexuality and family planning. As a result, CSE falls short of enabling adolescents in schools to make informed decisions about their sexuality and lifestyle. It also fails to take advantage of the opportunity to link the youth to ASRH services available in the community.

Fast track the updating of DepEd CSE module to make it consistent with the country's CSE standards developed by a panel of experts. Teachers should be provided with adequate training on CSE, including the age-appropriate manner by which it should be taught. DepEd and the Commission on Higher Education (CHED), together with DepEd and POPCOM, may also spearhead the conduct of parent-based ASRH interventions, e.g. IEC activities that are focused on the parents of the target youth in schools. Put emphasis on the need for a more purposeful and strategic parenting approach that recognizes the early pregnancy risks faced by teens resulting from lack of accurate information on sexuality. CSE should also include useful information on adolescent-friendly health facilities in the community offering comprehensive ASRH information and services.

High unmet need of adolescents, especially teen parents, for family planning owing to access barriers. Sexually active adolescents face many barriers to obtaining contraceptive services and commodities, including provider bias and capacity constraints, limited contraceptive options and regulatory constraints (e.g. requirement for parental consent for minors prior to accessing FP services).

Support the conduct of training and provide the needed investments to facilitate health provider compliance to the standards for adolescent-friendly facilities specified in DOH DM 2017-0098. Said training may consider capacitating health providers on accurate assessment of the sexual and reproductive health needs of adolescents, protocol for the provision of ASRH care, and provider orientation/reorientation on ASRH-related laws and policies critical to service

delivery. Reinforce training through supportive supervision, job aids, and mentorship to change provider attitudes and behavior. With respect to service delivery particularly involving teen mothers, health providers must be able to provide them not only with the commonly offered short-acting FP methods but with long-acting reversible contraceptives (LARCs) as well, which are often not presented as options for adolescents.

Lack of clear messages and guidelines for preventing closely spaced pregnancies among pregnant adolescents or teen parents. While the DOH Adolescent Health and Youth Development Program Manual of Operations includes the provision of postnatal care in the adolescent-friendly health services to be provided by health facilities, standard guidelines and protocol for preventing repeat births among adolescents are lacking.

Study the barriers to the use of contraception among cohabiting or married teens and single teen parents, and use these to develop clinical practice guidelines specific to the care of pregnant adolescents and teen parents. These guidelines may detail evidence-based practice for caring for teenage women through all stages of pregnancy and during intra-partum as well as post-partum care. Standard health action messages to be provided in health facilities may also be developed to encourage teen mothers to prevent repeat pregnancy so they can finish their education and realize their full economic potential.

Best Practice in ASRH: Program for Young Parents – Giving Second Chances to Teen Moms

USAID supported the DOH in the implementation of the Program for Young Parents (PYP) in selected health centers in Visayas to help prevent teen pregnancies. In 2017, 26 PYP Centers served 6,223 teenage mothers - 3,591 of whom were able to attend at least four antenatal care visits, 4,681 delivered in PYP centers, and 5,126 were able to initiate breastfeeding soon after delivery. About 60% or 2,913 availed of an FP method, with intrauterine device (interval and postpartum) and implants accounting for 37% and 3%, respectively.

Two provincial local governments took up the initiative to set up PYP Centers in other facilities – Cebu and Leyte. Cebu Province is in the process of transforming 11 other hospitals into adolescent-friendly facilities, while Leyte Province has set up additional six (6) PYP Centers. USAID developed a Manual of Operations to facilitate replication of the procedures for setting up PYP Centers in other areas. It contains the detailed steps and tools needed to establish and operate PYP centers in other areas. In Visayas, at least one advanced PYP Center was created in a selected referral hospital for each region to demonstrate how the Center is set up and run: Iloilo Provincial Hospital in Region VI, Cebu Provincial Hospital in Region VII, and Eastern Visayas Regional Medical Center as well as Abuyog District Hospital in Region VIII.

To defray costs related to the intervention (materials, transportation and meal allowance of peer educators, etc.), engaged facilities are urged to include operation of the PYP in their Annual Operating Budget. Apart from subsidy from local government budgets, the PYP Centers are encouraged to facilitate enrolment of PYP clients to PhilHealth, so that the facilities can claim reimbursements and use the funds for sustaining the intervention. This project won the Government of the Philippines 2017 Good Practice Award for Best Strategy on Achieving Desired Outcomes, particularly on preventing immediate repeat pregnancies among teen women.

USAID's Health Policy Development Program supported DOH Regional Office-V in undertaking a similar initiative in Camarines Sur, which turned Bicol Medical Center (BMC) into an adolescent-friendly facility that addresses the health care needs of pregnant teens and at the same time a regional resource center for handling pregnant adolescents. The project introduced a mechanism for transferring DOH Regional Office funds to a DOH-retained tertiary hospital for the provision of health services for teens, and for engaging a private academic institution – Naga Colleges Foundation, in the development of protocols for adolescent health service provision and in the conduct of IEC activities for preventing teen pregnancy. Full-time dedicated staffs have been assigned to BMC-Teen Wellness Center to focus on the provision of age-appropriate health services to young clients. This initiative more than doubled consultations in the Center from 114 in 2016 to 258 in 2017 (only includes counts as of August), and increased hospital admission rates for teen deliveries by two percent.

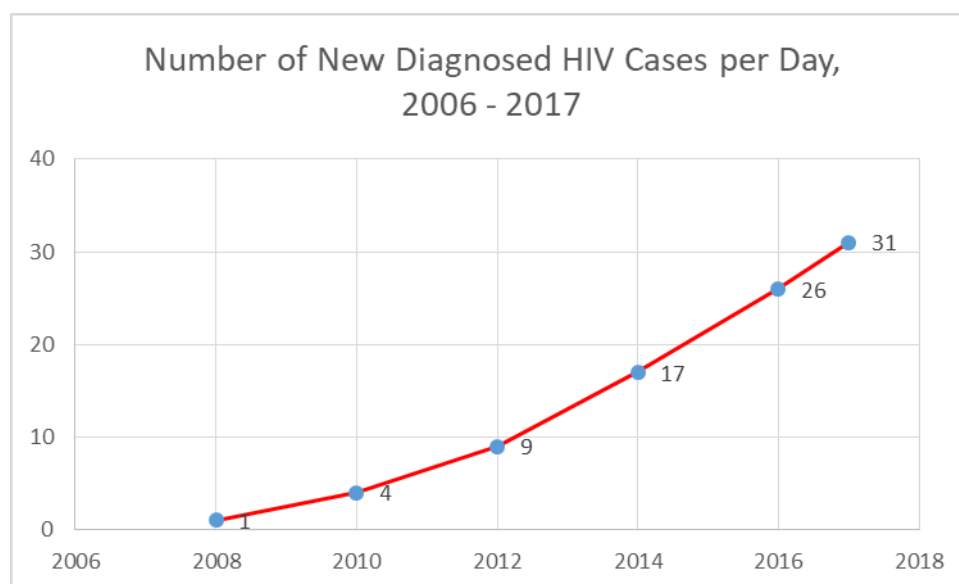


KRA 4: Sexually-Transmitted Infections and HIV/AIDS

Status and Trends

While the Philippines remains a low-HIV prevalence country, it is considered as one with the fastest growing number of cases in Asia and the Pacific⁵⁶. The HIV/AIDS and ART Registry of the Philippines (HARP) documented that in 2017 there were 11,103 total reported cases. This translates to 31 newly diagnosed HIV cases per day, almost double of the 2014 recorded cases at 17 per day. (see Fig. 4a)

Figure 4a. Trend of the new diagnosed HIV cases, 2006 - 2017.

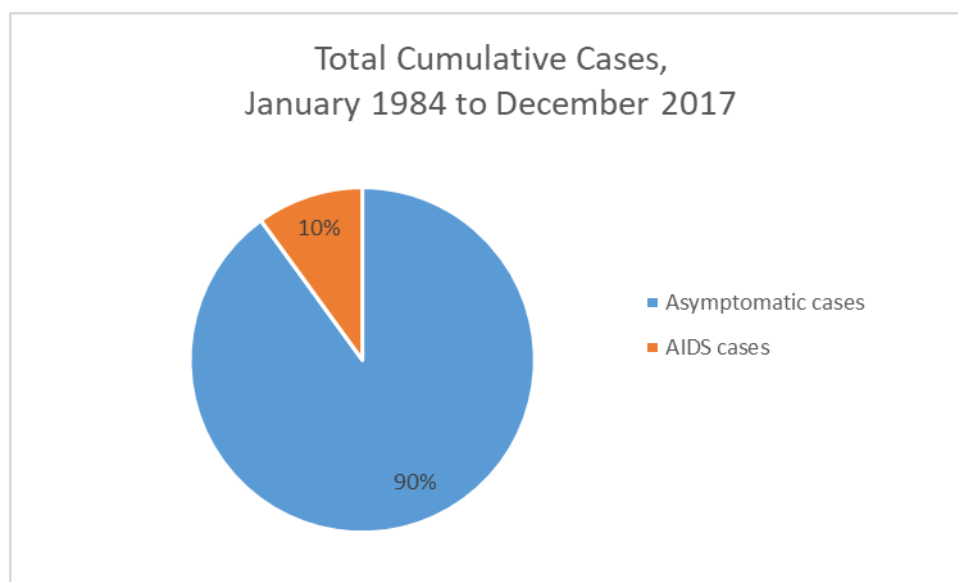


Source: HARP, 2017

In terms of total cumulative cases, there were 50,725 diagnosed cases since January 1984 to December 2017; 90 percent of which (45,645) were asymptomatic and 49 percent (24,754) were on anti-retroviral therapy (ART). (see Fig. 4b) The same report also stated that the total death among People Living with HIV (PLHIV) for the same period were 2,466. In 2017 alone, HARP documented 497 deaths.

⁵⁶ UNAIDS, 2017.

Figure 4b. Total Cumulative Cases, Jan 1984 to December 2017.

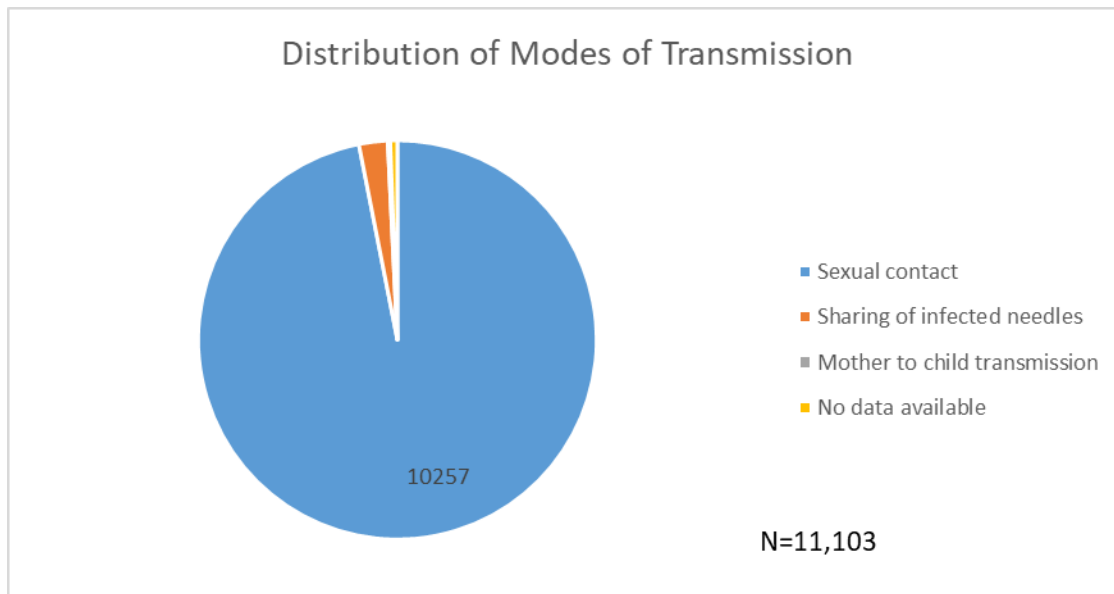


Source: HARP, 2017.

NCR has the most number of reported cases accounting for 35 percent of the total. This is followed by Region 4A (15 percent), Region 3 (11 percent), Region 7 (7 percent), and Region 11 (4 percent). The remaining 21 percent of the cases came from the other regions.

Sexual contact remains to be the predominant mode of transmission for HIV/AIDS. Ninety-two percent (10,257) were transmitted through sexual contact among the total reported cases in 2017. Sixty-one percent of these cases were males having sex with males (MSMs), while 30 percent were having sex with both males and females, and the remaining 9 percent were engaging in male to female sex alone. Other modes of transmission were sharing of infected needles (2 percent) and mother to child transmission (0.2 percent). There were no reported cases for needle prick injuries and transmission through blood/blood products. The predominant mode of transmission varies per region. Almost half (45 percent) of cases with sexual contact through MSM ever reported were from NCR; 99 percent of the injecting drug users were from Region 7; and 36 percent of females engaged in transactional sex were from Region 3. (see Fig. 4c)

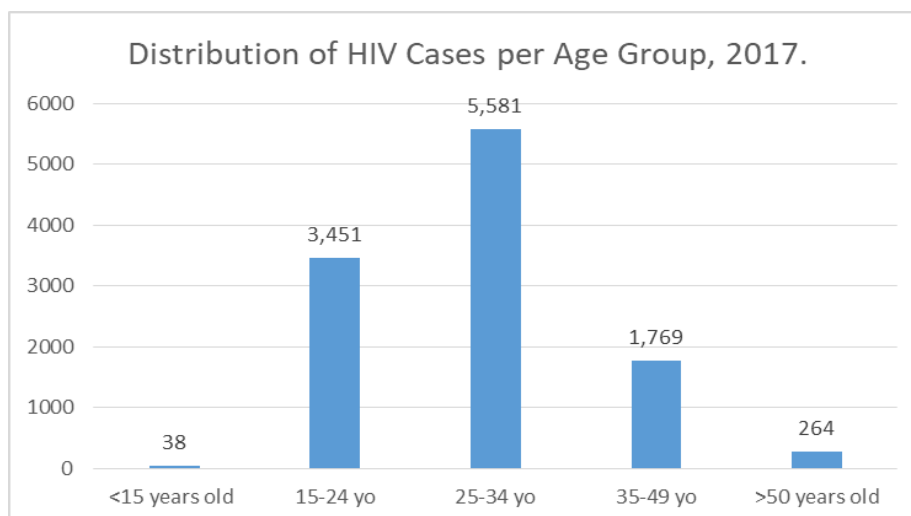
Figure 4c. Distribution of modes of transmission, 2017.



Source: HARP, 2017.

For the past years, a third of the newly diagnosed cases were among the young population, specifically between 15-24 years old (see Fig. 4d). For 2017, the actual reported cases among this age group is 3,451 or 31 percent; 38 cases were children less than 15 years old. Overseas Filipino Workers account for 6 percent of the newly diagnosed cases in 2017, 93 percent were males and all were infected through sexual contact. For those engaging in transactional sex, there were 1,125 cases reported. Fifty-two percent of which paid for sex only, 33 percent of accepted payments for sex, and 15 percent were engaged in both. For pregnant women living with HIV, 75 cases were reported in 2017.

Figure 2d. Distribution of HIV Reported Cases per Age Group, 2017.



Source: HARP, 2017.

Policies Issued

The most important and critical policy intervention tendered in 2017 is the proposed revisions to the Philippine AIDS Prevention and Control Act of 1998 or RA 8504 passed as House Bill (HB) 6617 or the Philippine HIV and AIDS Policy Act. This bill was approved by the House of Representatives and is currently in the Senate for deliberation. While the House of Representative approved amendments to RA 8504, there are critical elements that are absent in the provisions of HB 6617 that must be considered to reach key populations. For example, while HB 6617 lowered the requirement for parental consent for counselling and testing at 14 years old, provision of HIV treatment services still requires consent from parents for ages 15 to 17 years old. This provision makes medical management inaccessible to adolescents, considering that this age group has increasing prevalence of HIV.

The Philippine AIDS Prevention and Control Act of 1998 or RA 8504 is the legal framework of the HIV/AIDS response in the country. The rationale for proposing changes of this milestone legislation is primarily to make it responsive to the shift of HIV epidemiological trends (FSW to MSMs) in the country. During the law's enactment in 1998, the main drivers of the HIV epidemic were sex workers and overseas Filipino workers. More than a decade later, a new profile of the HIV epidemic has outpaced RA 8504 with provisions unable to address the current HIV situation.

Another challenge of the HIV law is the national HIV response coordinated by the Philippines National AIDS Council (PNAC). PNAC is a multi-sectoral, central recommendatory, planning, and policy-making body mandated by Law to oversee a comprehensive and integrated HIV/AIDS prevention and control program in the Philippines⁵⁷. The Council is supported by a Secretariat, whose function is to support the PNAC plenary in its policy-decision making, ensure the availability and utilization of strategic information for program planning, coordination and monitor implementation of sector-specific responses and provision of administrative support to PNAC⁵⁸. While PNAC is a multi-sectoral institution, it is also an attached agency of the Department of Health which means that it has limited if not lack of independent financial resources. Further, PNAC, conveyed that one of the challenges of the Council is the inadequate mainstreaming of HIV and AIDS in agency programming. Most government agencies do not have a focal unit on HIV and AIDS response, which limits the extent of HIV and AIDS mainstreaming in agency.

Additional issues related to RA 8504 are as follows: (1) conflicting provisions of laws governing drug users with RA 8504; (2) lack of provision supporting harm reduction strategies for injecting drug users (IDU); (3) deficient on provisions that protects MSMs, transgender population, and people who inject drugs (PWID).

To adequately strengthen the implementation of the HIV/AIDS Prevention and Control Program, PNAC and NASPCP issued strategic plans for the next 5 years of program implementation. The plans are anchored with the global recommendation that envisions *Zero New Infections, Zero Discrimination, Zero AIDS-Related Death*. In 2015, NASPCP released the Health Sector Plan for HIV and STI 2015 to 2020 (HSP). This serves as a guide to the health sector in addressing the changing epidemic situation of the key affected individuals and communities⁵⁹. In 2017, the PNAC issued the 6th AIDS Medium Term Plan

⁵⁷ PNAC, 1999.

⁵⁸ PNAC Country Report, 2008.

⁵⁹ The Philippine HIV/AIDS Health Sector Plan 2015-2020.



2017-2022 (6th AMTP) which guides the national response of the HIV/AIDS program. The AMTP defines the results to be achieved for the next five years and provides broad strategic directions for national, regional, and local multi-sectoral AIDS response in coordination with civil society organizations and the people living with HIV community.

The DOH also issued policies in 2017, to wit:

- **AO 2017-0011 Policy on the Prevention and Control of Viral Hepatitis of the National HIV, AIDS and STI Prevention and Control Program.** This AO provides the policies for the prevention and control of Viral Hepatitis under the National HIV/AIDS and STI Prevention and Control Program. This issuance identified the elements and components of Viral Hepatitis prevention and control which includes: (1) advocacy and awareness; (2) robust research and information system; (3) halting transmission of Viral Hepatitis; (4) access to effective hepatitis treatment; and (5) monitoring and evaluation.
- **AO 2017-0019 Policies and Guidelines in the Conduct of Human Immunodeficiency Virus (HIV) Testing Services in Health Facilities.** This issuance provides the most current guideline in the conduct of HIV Testing Services (HTS) in health facilities based on the WHO Consolidated Guidelines on HTS released in 2015.
- **DC 2017-0273 National HIV/AIDS and STI Program Recommendations for Testing, Diagnosis and Treatment of Chronic Hepatitis C among People Living with Human Immunodeficiency Virus.** This department circular updates the protocol on the conduct of routine testing, diagnosis, and treatment of Hepatitis C among PLHIV following the 2016 WHO guidelines for the Screening, Care, and Treatment of Persons with Chronic Hepatitis C Infection.

NASPCP is on the process of finalizing the rapid HIV diagnostic algorithm (rHIVda) policy. This policy responds to the bottlenecks in HIV testing service provision i.e. access to free and confidential HIV testing and rapid HIV testing (results released in 72 hours) that hampers higher coverage. The DOH has yet to issue the community-based screening policy which allows a peer-led screening.

An important policy gap that has yet to be addressed and prioritized is the policy on the prevention of high-risk behaviors and HIV/AIDS among adolescents. From January 1984 to December 2017, there were 2,033 cases reported among 10 to 19 years old. In December 2017 alone, 66 adolescents were diagnosed with HIV. During adolescence, 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 decreases the likelihood of eventual condom use (DOH-EB, 2016). Thus, strengthening of the HIV prevention and control among this age group is imperative.

Demand Generation

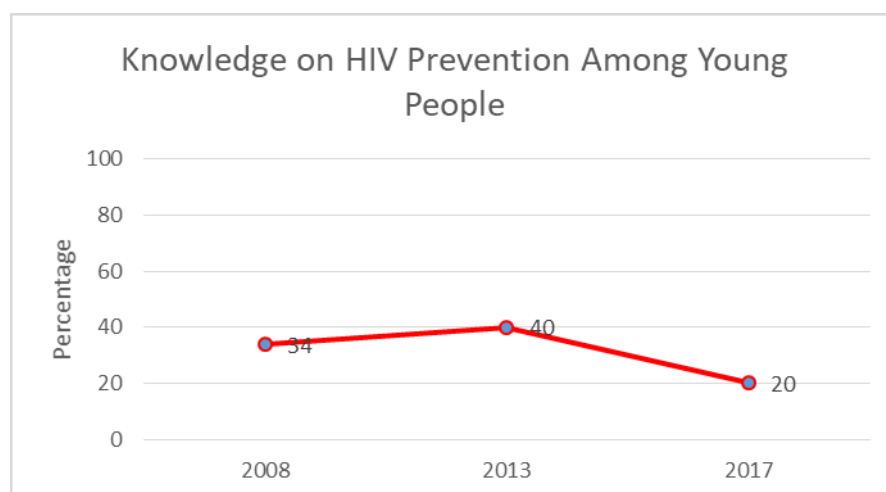
Demand generation activities are generally aimed to increase awareness and knowledge on the prevention and control of HIV/AIDS. This includes national campaigns for HIV awareness and advocacy, voluntary counseling and testing, and recognition of best performing facilities in the provision of HIV services. The DOH Regional Office (RO) VII together with local government units, CSOs, stakeholders, and partners commemorated the Annual International AIDS Candlelight Memorial last May 2017 held at the Cebu Provincial Capitol Social Hall with the theme: “Ending AIDS Together.” The commemoration was simultaneously conducted in three other provinces – Bohol, Negros Oriental, and Siquijor. The

activity aimed to remember the people who lost their battle with AIDS and raise awareness to end stigma and discrimination for PLHIVs. Other national campaigns include: World AIDS Day and National HIV summit.

Information dissemination on HIV conducted in 2017 were also integrated in different activities such as KATROPA, orientation on Recovery Champions (drug surrenders), and during the ASEAN Youth Forum. In Region 12, the DOH RO recognized the best performing hospitals and HIV/AIDS core team during the Gawad ng Pulang Laso event and was given a cash price of Php 10,000.

Despite various demand creation interventions, knowledge on HIV/AIDS is relatively low. The 2017 NDHS documented that 62 percent of WRAs interviewed have correct knowledge on HIV prevention i.e. consistent use of condoms and limiting sexual intercourse to one uninfected partner. However, among the young population ages 15 to 24 years old, comprehensive knowledge⁶⁰ is at a low 20 percent (see Figure 4e). This is a significant decrease by half from the 2013 NDHS report. However, it should be noted that the survey involved women of reproductive age and not key population. Nonetheless, knowledge of the general population pertaining to HIV/AIDS is still inadequate.

Figure 4e. Comprehensive Knowledge on HIV Prevention among Young People, 2017.



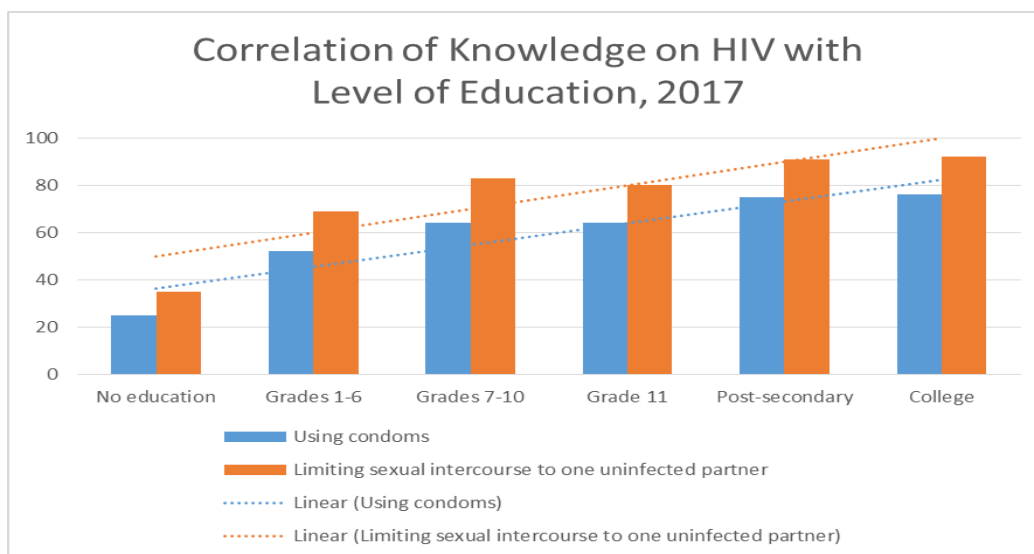
Source: NDHS, 2017.

National health surveys documented that level of education is directly correlated with knowledge on HIV prevention. The surveys also showed that education has a negative association with early initiation of sexual activity. This means that as the level of education increases, knowledge on HIV increases and the age of first sexual intercourse is higher compared to those who have low educational attainment. This

⁶⁰ Comprehensive knowledge on HIV prevention is defined as knowing that both condom use and limiting sexual intercourse to one uninfected partner are HIV prevention methods, knowing that a healthy-looking person can have HIV, and rejecting the two most common local misconceptions about HIV transmission: that HIV can be transmitted by mosquito bites and by sharing food with a person who has HIV infection.

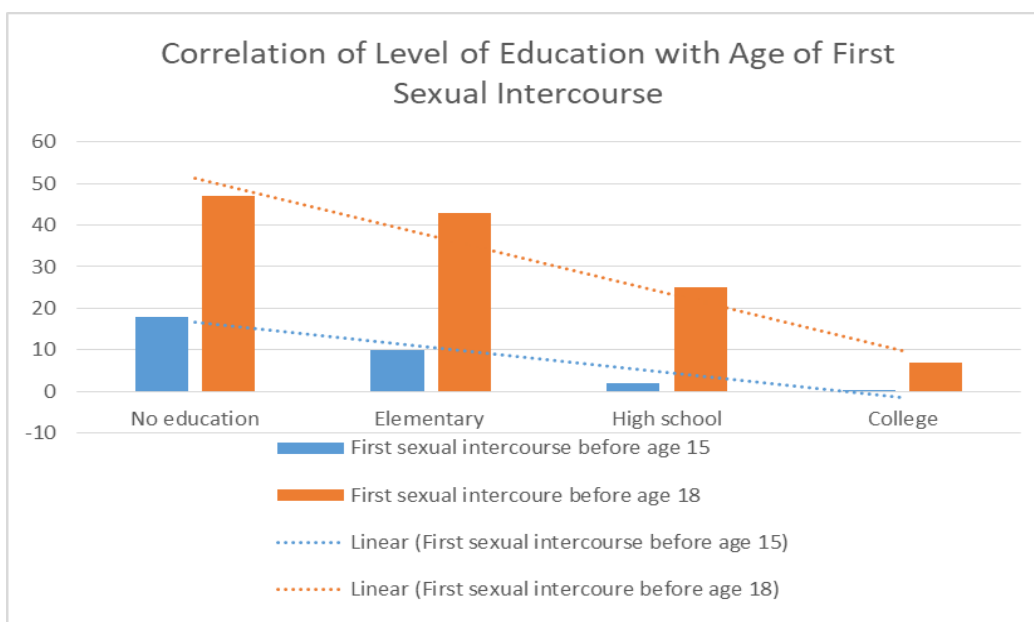
data shows that education is important in the prevention and control of HIV/AIDS. School-based interventions can be explored as part of demand generation activities. (see Figs. 4f & 4g)

Figure 4f. Relationship of the Knowledge on HIV with Level of Education, 2017



Source: NDHS, 2017.

Figure 4g. Relationship of Level of Education with Age at First Sexual Intercourse, 2013.



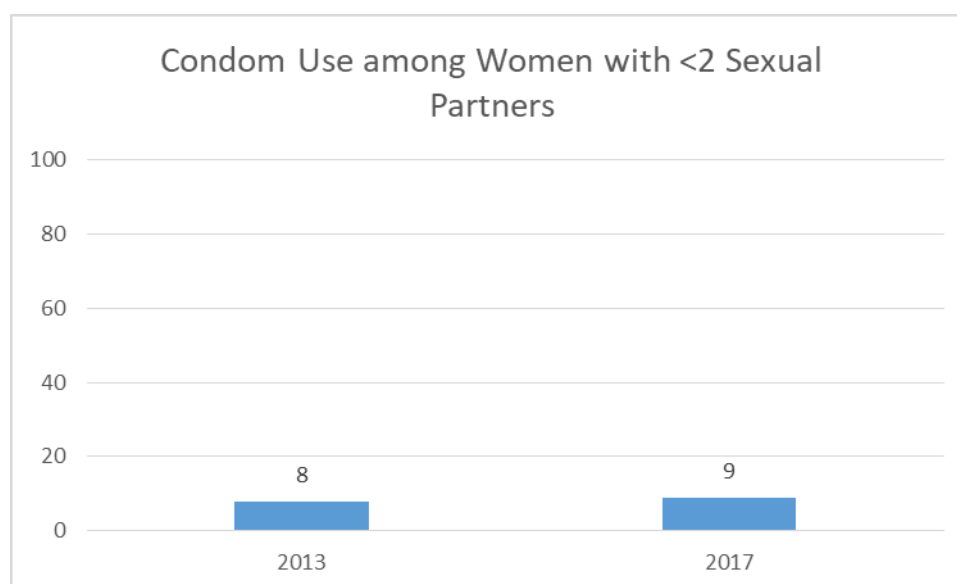
Source: NDHS, 2013.

Service Delivery

The service delivery component of the HIV/AIDS prevention and control program includes: (1) preventive services for KP; (2) screening and testing; (3) treatment and adherence to treatment; (4) re-integration to the community; and (5) integration of existing disease specific services i.e. HIV-TB integration. The service delivery is guided by the Health Sector Plan 2015-2020 which provides the list of interventions for each specific life stage.

The DOH continues to provide free condoms to key populations through government-owned social hygiene clinics or primary HIV care facilities and treatment hubs as part of the preventive interventions. Primary HIV care facilities were formerly known as satellite treatment hubs that provide out-patient primary care service to PLHIV, which includes anti-retroviral therapy, HTS, clinical management, patient monitoring, and other care and support services. Treatment hubs on the other hand, are hospitals with an organized HIV and AIDS Core Team (HACT) that renders in-patient and out-patient services. Currently, there are 60 treatment hubs in all regions except for ARMM, and 25 primary HIV care facilities distributed in NCR, Regions 3, IVA, 7, 8, 11, and 12.

Figure 4h. Condom Use Among Women with More Than 2 Sexual Partners.



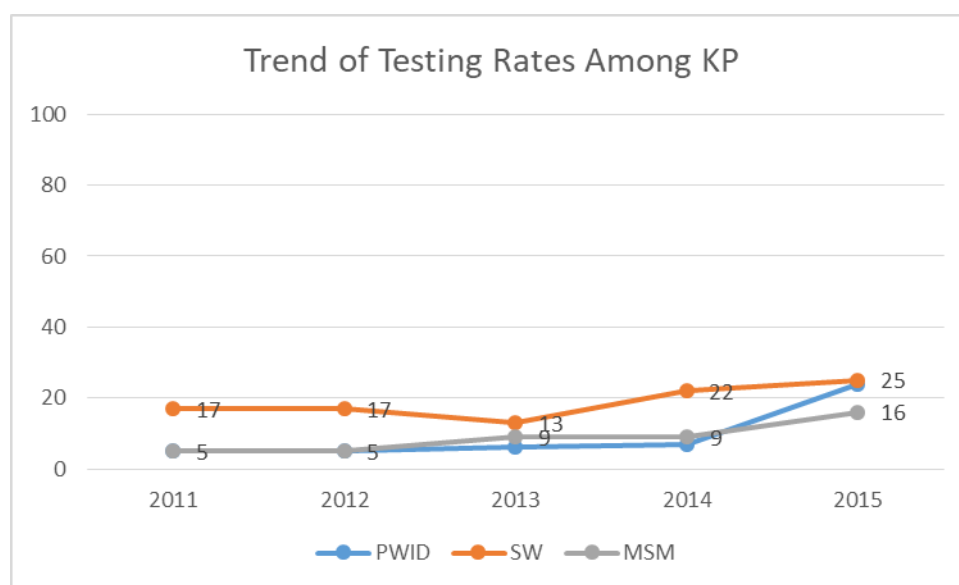
Source: NDHS, 2017

While condoms are provided with no cost to clients, condom use among key population is low as reported in the IHBSS conducted in 2015. The survey showed that condom use among M/TSM at last anal sex for the past 12 months is only at 29, 39, and 45 percent for 15-17, 18-19, and 20 years old, respectively. While the condom use for female sex workers was reported to be higher at 68 percent on an average across the three age groups, it is still below the national target of 80 percent. The 2017 NDHS reports a similar trend. Among women who had more than 2 sexual partners in the past 12 months, only 9 percent reported using a condom during their last sexual intercourse. (see Fig 4h) Another gap in HIV

prevention that can be associated with low condom use is the report on stock-outs of condom in social hygiene clinics in some regions. Problems on unavailability of condoms at the local government units may have stem from the procurement of condoms from the national government. Currently, the National Family Planning program of the DOH procures condom for NASPCP. Considering that procurement is done in a separate office, problems on forecasting and allocation ensue.

Testing coverage has slowly progressed over the years; however, numbers are still low. Among MSMs, testing rates remained flat in 2011 to 2012, and then declined in 2013. A slight increase was noted in 2014 and 2015, with testing rates at 22 and 24.6, respectively. (see Fig. 4j)

Figure 4i. Testing Rates Among Key Populations, 2011-2015.



Source: IHBSS 2015 and aidsonline.org.

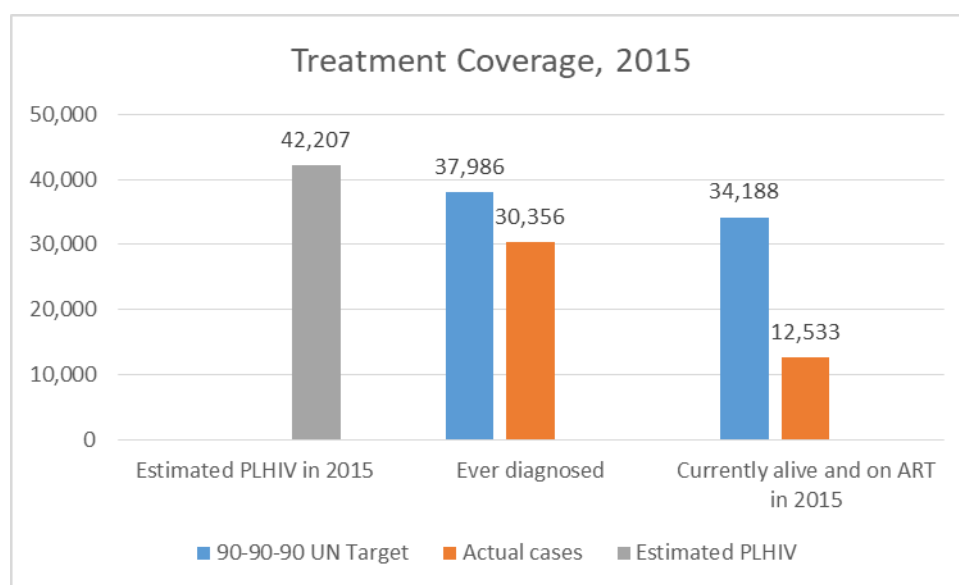
Bottlenecks in HIV testing services that hamper higher coverage can be attributed mainly to: (1) accessibility of free and confidential HIV testing and (2) non-use of rapid HIV diagnostic algorithm (rHIVda) with results released in 3 days. Administrative Order 2017-0019 which provides the policies and guidelines in the conduct of HIV testing services in health facilities comprehensively discussed protocol on HTS but does not explicitly convey that rHIVda results can be obtained after 72 hours. The conventional HIV testing protocol requires a confirmatory test that takes around 4 weeks before the result is released. Further, the conduct of free HIV testing is usually done in government-owned social hygiene clinics and in some private SHCs, however, not all cities have social hygiene clinics or primary HIV care facilities. These problems may lead to significant losses to follow-up, missed opportunities, and further transmission of HIV. Currently, the policy on rHIVda and operational guidelines on community-based screening are already on its final stage of development and may be released in 2018.

In terms of PWID, testing rates for this specific KP showed improvements over the years. While improvement is evident, it is still recommended that harm reduction interventions should be

implemented at scale. The Global Fund report in 2014 showed that PWID sites are few considering that needle-sharing is an important driver of the epidemic. This can be attributed to the lack and inconsistent laws on harm reduction. For example, the Comprehensive Dangerous Drugs Act of 2002 has a provision making it illegal to possess equipment or paraphernalia fit for administering or injecting drugs.

First and second line anti-retrovirals (ARV) have been procured by the Department of Health since 2010 to ensure access and good treatment outcomes of KPs. (Fig.4j) In the same year, the Philippine Health Insurance Corporation introduced the Outpatient HIV/AIDS treatment (OHAT) package. It was later revised to align with the “All Case Rate Policy” of the Corporation through PhilHealth Circular 011-2015.

Figure 4j. Treatment Coverage, 2015.



Source: IHBSS, 2015.

The OHAT package aims to increase the proportion of the population with access to an effective AIDS treatment and patient education measures⁶¹. The package’s annual reimbursement is set at thirty thousand pesos and released in 4 quarterly payments notwithstanding the number of patient consults. This benefit covers laboratory examinations, cluster of differentiation4 (CD4) level determination test, viral load, drugs, medicines, monitoring of anti-retroviral drugs toxicity, and professional fees.

In terms of integration of disease-specific services, the DOH approved policies on the *Prevention of Mother to Child Transmission (PMTCT) of HIV* and the *Revised Guideline in the Collaborative Approach of TB and HIV Prevention and Control*, issued as Administrative Orders 2009-0016 and 2014-0005, respectively. For the management of TB and HIV co-infection, treatment hubs administer treatment for TB co-infection and refer clients to the nearest TB DOTS center for co- management and to obtain free TB drugs⁶².

⁶¹ Philhealth, 2015.

⁶² UNAIDS, 2017.

The DOH issued Department Circular 2016-0171 entitled *Enhance Linkage to Care of People Living with HIV*. This policy guarantees the continuity of care of clients who tested positive for HIV to be referred to treatment care facilities. However, this issuance lacks provision on specific interventions on the re-integration i.e. referral to institutions offering home-based care, psychosocial support and counselling, and routine screening and management of mental health disorders. These interventions aid adherence to ART and improve health outcomes of PLHIVs.

Challenges and Recommendations

Rapidly increasing number of PLHIVs. The total number of PLHIVs from January 1984 to December 2017 is 50,725 of which 22 percent were only diagnosed in 2017. This translates to 31 newly diagnosed HIV cases per day, almost double of the 2014 recorded cases at 17 per day.

Recommendations:

1. Expedite amendment and harmonization of laws to make it responsive to the current HIV epidemic.
2. Develop health promotion strategies and a national communication plan with focus on the young population. Efforts to engage with the Department of Education to implement the Comprehensive Sexuality Education should be strengthened. A strong collaboration between the Adolescent Health Program of the Women, Men, and Child Health Development Division and the National HIV/AIDS and STI Prevention and Control Program is highly recommended.
3. Develop community-based strategies in the prevention of HIV/AIDS. This shall include information and education, task-shifting and peer-led, testing, community-based comprehensive services for PWID, and other community-based outreach services;
4. Eliminate barriers to testing, address delays on confirmatory results, and ensure that rHIVda is implemented to lessen missed opportunities and follow-up losses;
5. Amend DC 2016-0171 *Enhance Linkage to Care of People Living with HIV* to include provision on reintegration i.e. referral to institutions offering home-based care and psychosocial support and counselling and routine screening and management of mental health disorders;
6. Consider expanding the OHAT package that will include case detection and treatment adherence support.

Poor support to key populations in terms of lessening stigma and discrimination. While the Philippines has a law for violence against women and children, the country lacks a law on the protection of key populations.

Recommendations:

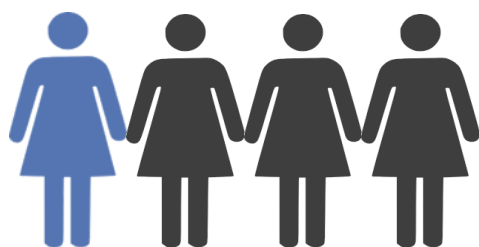
1. Explore the challenges of KP in the social environment specifically on stigma and discrimination.
2. Develop laws on the protection of key population against violence and discrimination.

KRA 5: Elimination of Violence and Women and Children

Status and Trends

The Philippines remains to be in the top ten most gender equal countries in the world. In the Global Gender Gap Report 2017 by the World Economic Forum, the Philippines landed in the 10th place, from being 7th place for two consecutive years. Despite the drop, the country remains to be the most gender equal country in Asia. While the Magna Carta of Women envisions that the number of female in third level positions in government shall be incrementally increased to achieve a fifty-fifty (50-50) gender balance, there are still wage difference between men and women for similar work done.

It is important to note that in the education aspect, more women are studying than men thus closing the gender gap in educational attainment; but, there is still a need to address 21% of the overall gender gap.



Source: 2017 NDHS Key Indicators

Violence Against Women still continue to persist despite the presence of relevant laws that aim to protect women. Based on the 2017 National Demographic and Health Survey, it was revealed that one in four women aged 15-49 has experienced physical, emotional, or sexual violence by their husband or partner. Twenty percent of women has ever experienced emotional violence, 14% has ever experienced physical violence, and 5% ever experienced sexual violence by their current or most recent husband or partner.

The 2017 National Demographic and Health Survey (NDHS) reflected collected information on the extent of violence against women in the country. The report looked into the women's experience of physical, sexual and emotional violence from their husbands or partners.

The report indicated that about one in four (26.4 percent) of ever-married women have experienced abuse from their husband or partner, whether physical, sexual or emotional abuse. (see Table 5a) This is slightly higher than the 2013 data at 25.9 percent.

One in five (20%) of women has ever experienced emotional violence, 14 percent has ever experienced physical violence, and 5 percent ever experienced sexual violence from their current or most recent husband or partner. Emotional violence continues to be the most prevalent form of violence as indicated in both 2013 and 2017 NDHS reports.

Table 5a. Percentage of ever-married women age 15-49 who have ever experienced emotional, physical or sexual violence committed by their husband/partner

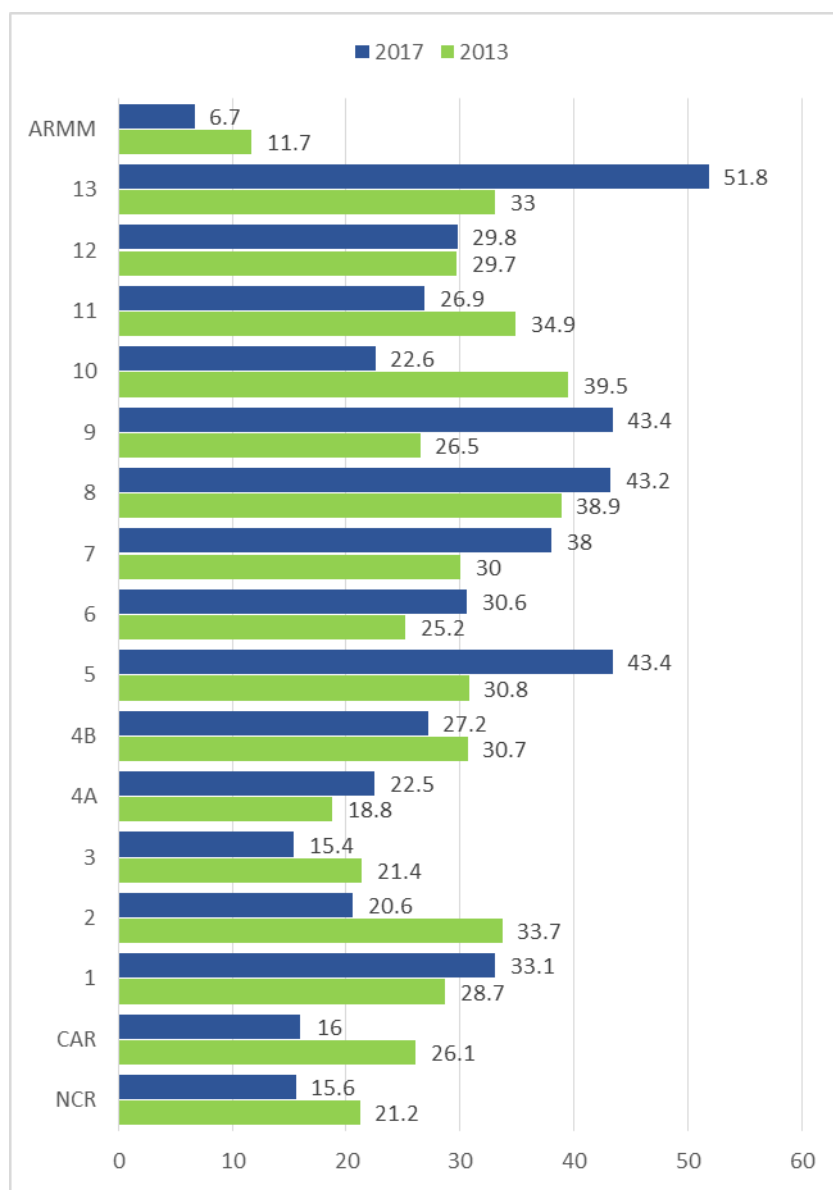
Forms of Violence	2013	2017
Physical	12.7	13.5
Sexual	5.3	5.2
Emotional	21.5	20.4
Any physical, sexual or emotional	25.9	26.4

For both reports, the percentage of ever-married women who have experienced violence from their husbands in any form declined slightly with women's ages. Looking into the age group of these women, higher incidences of any form of spousal abuse occurs in 3 out of 10 among ever married women in the age group 20-24 years old. (see Table 5b) Also, higher incidences have been noted to occur among those who are in rural and whose status are divorced, separated, or widowed for both 2017 and 2013. Spousal violence is more prevalent among those with lower level of education.

Table 5b. Percentage of ever-married women age 15-49 who have ever experienced any emotional, physical or sexual violence committed by their husband/partner

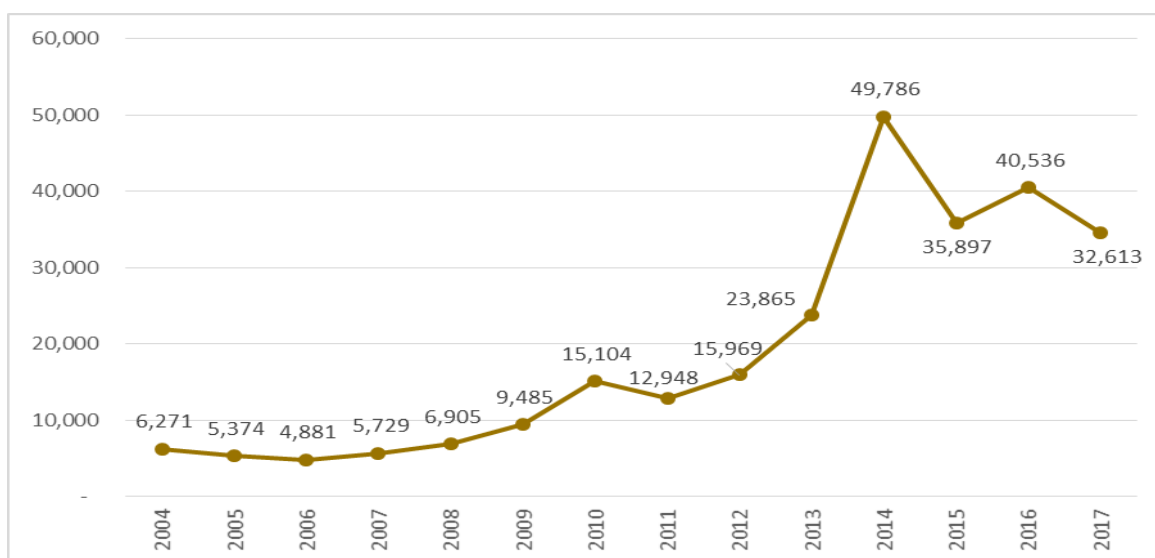
Background Characteristic	2013	2017
Age		
15-19	27.5	26.4
20-24	29.7	29.5
25-29	26.0	26.6
30-39	25.1	25.9
40-49	25.1	25.7
Marital Status		
Married or living together	23.8	24.4
Divorced/separated/widowed	50.0	53.4
Education		
No education	23.2	20.8
Elem/Grades 1-6	29.2	30.4
High school/Grades 7-10	27.2	29.4
Post-secondary	-	22.1
College	21.7	19.2
Residence		
Urban	25.7	25.5
Rural	26.1	27.1

Figure 5a. Percentage of ever-married women 15-49 who have every experienced any form of spousal violence (emotional, physical or sexual violence) from their husband/partner, NDHS 2013 & 2017



Reports gathered by the Philippine National Police (PNP) from 2004 to 2017 showed a drastic increase in VAW cases in 2014 followed by a drastic downward dip in 2015 which similarly reflected reported incidences in 2017. This report includes cases on rape, violence against women and their children, acts of lasciviousness, photo and video voyeurism, and sexual harassment, among others. (see Fig. 5b)

Figure 5b. Trends in the Reporting of VAW Cases to PNP (2004-2017)

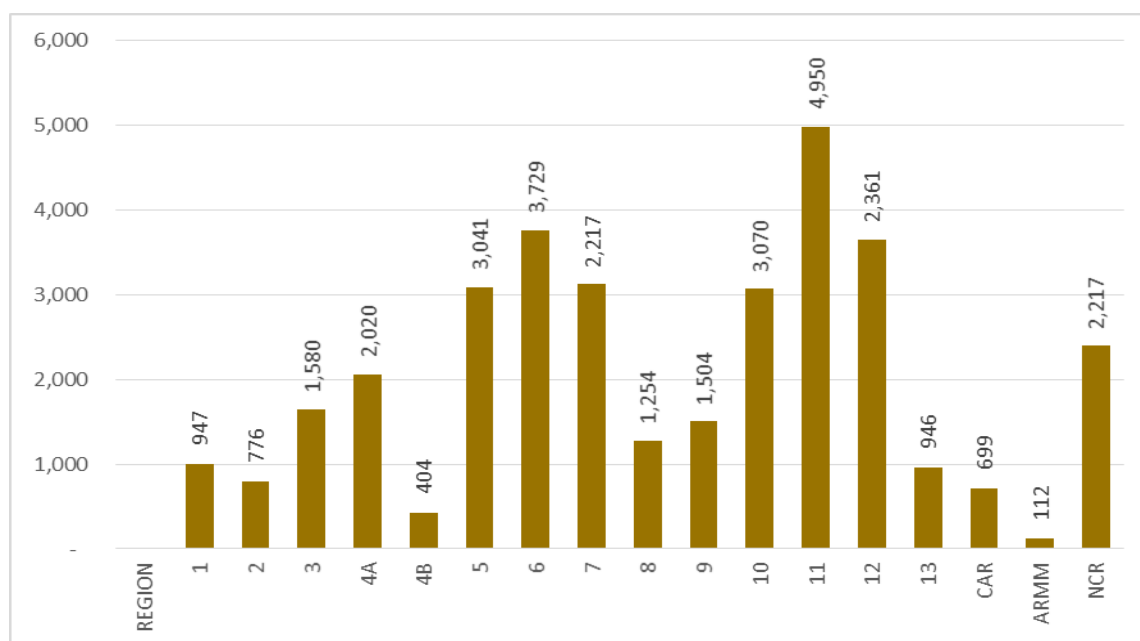


Source: PNP-Women and Children Protection Center (PNP-WCPC)

This 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.

The number of reported VAW Cases in 2017 is highest in Region XII (Davao) at 4,950 which represents to 14.4% of the reported incidences. This is followed by incidents reported in Region VI (Western Visayas) at 3,729 and Region VII (Central Visayas) at 3,072 representing 10.9% and 10.6%, respectively. (see Fig. 5c)

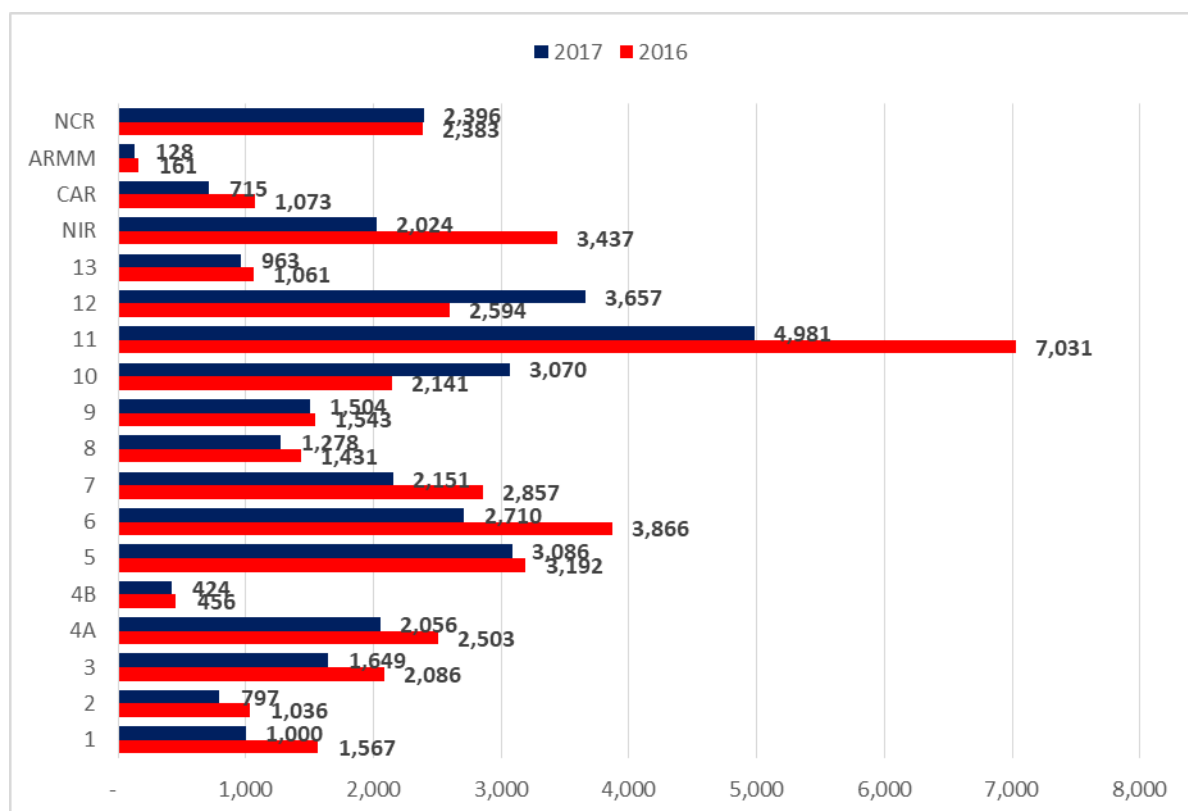
Figure 5c. Reported VAW Cases to PNP by Region as of December 2017



Source: PNP-Women and Children Protection Center (PNP-WCPC)

Comparing this data to the previous year, significant declines in VAW cases have been seen in Regions XI and VI. Meanwhile, ARMM remains to be the region with the lowest VAW reported cases to 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. (see Fig. 5d)

Figure 5d. Reported VAW Cases to PNP by Region (2016 & 2017)



Source: PNP-Women and Children Protection Center (PNP-WCPC)

In 2016, there were 39,819 VAW cases reported. Notably though, in 2017, VAW cases decreased to 32,613 which shows a difference of 7,206. (see Table 5c)

Table 5c. Reported Data on VAW (by type, 2012-2017)

Reported Data on VAW (by type, 2012-2017)						
Cases	2012	2013	2014	2015	2016	2017
Rape	1,030	1,259	2,010	2,078	1,897	1,998
Incestuous Rape	33	26	36	47	127	70
Attempted Rape	256	700	635	700	551	598
Acts of Lasciviousness	721	2,127	1,871	2,127	2,030	2,061
Sexual Harassment	41	93	103	93	99	107
VAWC	11,531	16,517	31,937	41,587	34,819	27,712
Concubinage	128	146	199	349	381	313
TOTAL	13,758	19,549	36,941	47,013	39,819	32,859

Source: PNP-Women and Children Protection Center (PNP-WCPC)

Interventions

In 2017, there were 346 out of 43,751 LGUs had issued or amended local policies to address VAW or GBV with a total of 814 local policies created. In addition, 553 LGUs conducted 44,644 IEC or awareness campaign activities on VAW/GBV reaching a total of 286,902 Filipino women and 134,079 Filipino men.

Moreover, 696 LGUs in the country have passed their respective local 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.

In addition, the Inter-Agency Council on Violence Against Women and their Children (IACVAWC) drafted the IACVAWC Strategic Plan for 2017-2022. The Strategic Plan serves as a guidepost of the council members and other stakeholders in addressing VAWC and other forms of gender-based violence. It is crafted to serve as basis for the agencies in identifying their programs, projects, and activities related to VAW. The council members also started in cascading the plan in different regions through the Regional Inter-Agency Council on Violence Against Women and their Children (RIACAT-VAWC). This will help them in identifying their Projects, Activities, and Programs for the next five years.

Awareness-Raising to Prevent VAWC

The PCW spearheaded the conduct of annual activities that help recognize and eliminate VAWC. The 18-Day Campaign to end VAW, which had the theme “VAW-free community Starts with Me,” elevates VAW as an issue of national concern. PCW reported over 900 attendees from NGAs and private organizations during the launch of the Campaign.

As part of the observance of the 18-Day Campaign to End VAW, PCW in partnership with other government agencies, launched the “VAW Experiential Museum” on November 24, 2017. The three-day interactive museum, held at the PETA Theatre in Quezon City, illustrated through theater arts the struggles of women who were abused in the home, workplace, streets, and online. These put on stage the excellent performance of UST’s Artistang Artlets, MAPUA Tekno Teatro, and Youth Advocates Through Theater Arts (YATTA) of Dumaguete City, under the supervision of the Philippine Educational Theater Association (PETA).

Around 900 individuals from various NGOs, public and private agencies participated in the event. The viewers were expected to be moved with their senses stimulated as they see, hear, and feel up-close how VAW happens in various places like schools, offices, public places, online, communities, and even at home. This initiative aimed for viewers to recognize the issue, develop in them compassion for victim-survivors, and generate commitment to never commit, condone, or remain silent about VAW.

The “VAWfreePH” was also launched during the kick-off program of the 2017 18-Day Campaign to End VAW at the PETA Theatre on November 24, 2017. VAWfreePH is an android-based personal safety mobile app that gives women and girls a practical tool to fight VAW. It is developed through the partnership of PCW and the Technological Institute of the Philippines-Quezon City. This mobile app includes unique features that can be used during emergency and in other crisis situations. It can send a discreet short messaging system or SMS to three pre-selected contacts alerting them of user’s exact location using global positioning system (GPS). It also has an SOS button that when tapped, triggers the mobile phone’s flashlight and sound alarm to gain public attention. Another feature of the app is the audio recording and image capture functionalities for evidence recording. Users can likewise initiate fake calls to get out of unwanted and threatening situations. VAWfreePH makes reporting very easy using the one-button dialing to 911 emergency helpline.

Aside from the emergency features, this mobile app can help user search for the nearest hospitals and police stations where VAW victim-survivors can seek help and ask for assistance. This app also includes a directory of helplines and a list of service providers where they can seek help and support. Apart from the safety and emergency features of the app, VAWfreePH provides public awareness on existing women’s human rights laws such as the RA 9262 or Anti-Violence Against Women and Their Children, and RA 8353 or the Anti-Rape Law, among others. Access to these information helps empower our communities to attain a safer environment for women.

PCW continues to undertake the “Orange Your Icon for 18 Days Advocacy Initiative” which aims to strengthen the anti-VAW advocacy by enjoining new audiences to join the cause to end VAW. Now on its third year in the Philippines, the objective is to attract the public’s curiosity on why major landmarks or icons nationwide are colored orange, thereby providing opportunities for advocates to explain the Anti-VAW advocacy. By participating in this initiative, government offices and private organizations are declaring their support to the anti-VAW advocacy and zero-tolerance for VAW to the public’s attention.

Moreover, PCW developed and disseminated videos on “VAW: The Unspoken Words” using free-verse poetry and images to make the public understand the difficult experience of VAW victim-survivors. A total of five videos were produced narrating various forms of VAW in the Home, in the Workplace, in the School, in Public Spaces and Online Harassment. Agencies were given access to download these videos which were also shown throughout the duration of the Campaign.

Relevant brochures and fliers on GAD-related laws were re-printed and distributed. A total of 29,000 brochures and fliers were distributed to agencies on RA 9710 (The Magna Carta of Women), RA 9262 (Anti-VAWC of 2004), RA 9208 (Anti-Trafficking in Persons Act of 2003), RA 8353 (The Anti-Rape Law of 1997), and RA 7877 (Anti-Sexual Harassment Act of 1995), among others.

PCW continues to undertake its legislative advocacy initiatives through Women's Priority Legislative Agenda (WPLA). WPLA is a set of proposed topics of bills that seek to amend or repeal discriminatory provisions of existing laws and moves for the formulation and adoption of new legislations that promote women's empowerment and gender equality. The WPLA for the 17th Congress, composed of 12 legislative agenda, is a result of a series of consultations with various local women's groups in three key cities in Luzon, Visayas, and Mindanao and a careful deliberation based on specific criteria to strategically address women and gender equality issues and concerns across the country.

One of the legislative agenda is the "Increasing and Harmonizing Maternity Leave for those in the Government and Private Sectors." It aims to increase the existing maternity leave from 60 days to 100 days to give women employees' sufficient time to rest, recuperate and regain their full health. When enacted, the law hopes to contribute to the promotion of infant and child health by encouraging mothers to breastfeed their babies.

Initiatives in the previous years encouraging male involvement in the prevention of VAWC were likewise continued in 2017: 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 family planning, 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 275 men who participated in MR and JR GAD and related programs, and 5,187 men who attended KATROPA sessions in 2017.

The CSOs also implemented various awareness campaigns that reached 3,837 women. 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.

Other initiatives

PCW in partnership with DOH, DepEd, University of the Philippines Manila, DDB Group Philippines, and Modess Philippines collaborated in holding the #MenstruationMatters: A Forum on Menstrual Hygiene held at the UP Manila Theatre. Over 230 individuals from public and private schools, national government agencies, and non-government organizations joined the forum which debunked myths and misconceptions on menstruation as it promoted menstrual health management.

Moreover, the APEC Healthy Women, Healthy Economies (HWHE) policy toolkit is an initiative of the representatives from various APEC economies, industries and NGOs with the Philippines (through DOH, PCW, and DOLE) and Merck, as among its pioneers. The toolkit aims to address women's health issues to improve their participation in the economy in the five-bucket categories, namely: Workplace Health and Safety, Health Access and Awareness, Sexual and Reproductive Health, Gender-based Violence, and Work-Life Balance.

On January 10, 2018, the HWHE Initiative Summit was conducted to share the journey of the implementation of the HWHE with its initial undertakings, challenges and lessons learned; and to provide an avenue in strengthening stakeholders' participation. PCW participated in this undertaking and provided technical inputs in enhancing the HWHE toolkit, particularly on Gender-Based Violence category. This includes the strengthening of anti-gender discrimination and sexual harassment policies, functional mechanisms, and job design and layout in the workplace.

Capacity Building of Concerned Service Providers

Five hundred-fifty-eight (558) LGUs with private and public providers conducted 4Rs (recognizing, recording, reporting and referring) of VAWC to 4,430 public providers and 1,729 private providers. In 2017, there are 323 provinces with 646 LGUs which have established women and children protection program (WCPP) and dedicated coordinators trained on 4Rs. There are 597 LGUs with functional intervention centers/ temporary shelters/ half-way houses or centers for VAW/GBV victim-survivors.

Provision of Social Protection Services

Section 9C of Republic Act 9710 or the Magna Carta of Women mandated the establishment of a Violence Against Women's (VAW) Desk in every Barangay to ensure that violence against women cases are fully addressed in a gender-responsive manner. As of December 2017, 37,686 or 89.65% out of 42,036 barangays have established their VAW desks. All barangays in six regions (Regions I, II, VI, VII, VIII, and XIII) have already established their VAW desks. Similar with the previous year's data, the Autonomous Region in Muslim Mindanao still has the lowest compliance, which is at 26.51%. (see Table 5d)

Table 5d. Barangay Compliance on the Establishment of VAW Desk

Barangay Compliance on the Establishment of VAW Desk			
Region	Total Number of Barangays	With Established VAW Desk	Percentage
I	3,265	3,265	100.00%
II	2,311	2,311	100.00%
III	3,102	2,315	74.63%
IV-A	4,018	4,011	99.83%
IV-B	1,459	1,449	99.31%

V	3,471	3,326	95.82%
VI	3,389	3,389	100.00%
VII	2,446	2,446	100.00%
VIII	4,390	4,390	100.00%
IX	1,904	1,266	66.49%
X	2,022	1,737	85.91%
XI	1,162	919	79.09%
XII	1,195	1,182	98.91%
XIII	1,311	1,311	100.00%
CAR	1,176	1,014	86.22%
NCR	1,706	1,493	87.51%
ARMM	2,490	660	26.51%
NIR	1,219	1,202	98.61%
TOTAL	42,036	37,686	89.65%

Source: DILG-National Barangay Operations Office

Challenges and Recommendations

1. There remains a big gap in terms of reviewing and establishing local policies to address VAWC or GBV as reflected in the report. There is a need to strengthen inter-agency collaboration to assist local governments in ensuring that local policies are in place to respond to VAWC and GBV.
2. The Inter-Agency Council on Violence Against Women and their Children (IACVAWC) drafted the IACVAWC Strategic Plan for 2017-2022 which needs to be finalized and disseminated. The Strategic Plan serves as a guidepost of the council members and other stakeholders in addressing VAWC and other forms of gender-based violence. It is crafted to serve as basis for the agencies in identifying their programs, projects, and activities related to VAWC. A review and analysis of subnational plans should also be pursued so that the critical interventions will have appropriate technical assistance and funding support.
3. In addition to criminal proceedings, the Magna Carta for Women further provides that the victims of abuse “shall be provided with comprehensive health services that include psychosocial, therapeutic, medical, and legal interventions and assistance towards healing, recovery, and empowerment (Sec. 17).” The law places a huge demand on local officials to provide various services which they may have no resources nor capacity to address these areas. There is a need to review the scope of technical assistance that will be required by LGUs to provide the comprehensive health services in so far as addressing VAWC and GBV.

