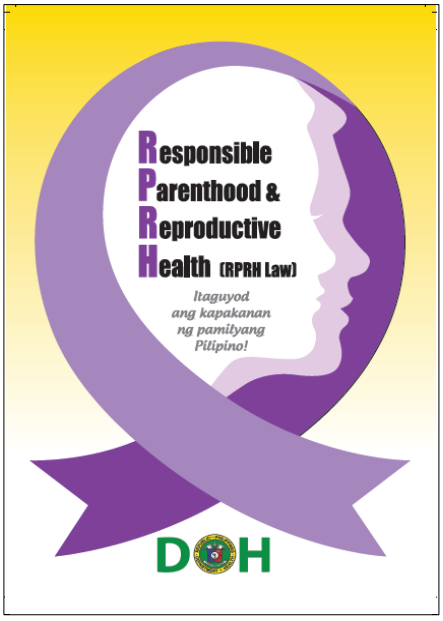

The 2nd Consolidated Report on the Implementation of the Responsible Parenthood and Reproductive Health Act of 2012 (R.A. No. 10354)

Message

The Department of Health (DOH) is pleased to present the 2015 Responsible Parenthood and Reproductive Health Law (R.A. 10354) Annual Report. The Report details the accomplishments and challenges in the implementation of the RPRH Law, particularly in dealing with the issues on the ground.

In compliance with the reporting requirements mandated by Section 21 of R.A. 10354 and Rule 15 of its Implementing Rules and Regulations, the Report describes the second year accomplishment of the DOH together with other agencies from national, regional, and local levels, civil society organizations, and development partners.

The report is presented along RPRH program elements or key result areas (KRA) on *maternal, neonatal, child health and nutrition*; *family planning*; *adolescent sexual reproductive health*; *sexually-transmitted infections and HIV/AIDS*; *gender-based violence*; and other RPRH elements.

For 2015, the organization and operationalization of the National Implementation Team (NIT) and its counterpart at the regional and local levels further strengthened the RPRH Law implementation. The mechanisms developed to ensure systematic coordination, planning, monitoring and evaluation systems and procedures especially at the national and regional implementation level also contributed significantly in the key accomplishments for the year.

The enactment of the RPRH Law, after 14 long years, is a victory of the Filipino people. Since its conception, the highlight of the RPRH Law is to reach every Filipino and give them the much needed information and services they rightfully deserve.

As such, we, at the DOH believes that the efforts exerted will significantly contribute in ensuring universal access for all women, men, and young people to comprehensive reproductive health care.

I trust that the Report documented the significant contribution of government and its stakeholders to the well-being of all Filipinos – empower couples to exercise their reproductive rights, and cultivate an environment for people to achieve their development goals.

HON. JANETTE LORETO-GARIN, MD, MBA-H
Secretary of Health

Executive Summary

This report describes the second year accomplishment of the Department of Health (DOH) together with the Commission on Population (POPCOM), other agencies from national, regional, and local levels, civil society organizations, and development partners in compliance with the reporting requirements mandated by Section 21 of R.A. 10354 and Rule 15 of its Implementing Rules and Regulations. It provides a description on how the provisions of the Responsible Parenthood and Reproductive Health (RPRH) Law and its Implementing Rules and Regulations (IRR) were operationalized and the different program results in 2015. Using the 2014 report as a baseline reference, this report highlights levels of accomplishment given the one year time frame.

This report marks several milestones: 1) It covers the 1st full year of implementation of the RPRH Law since the Law was declared mainly Constitutional by the Supreme Court in April 2014. 2) It started a special implementing mechanism in the DOH – the National Implementation Team (NIT) and Regional Implementation Teams (RITs) – that linked national and local health systems, and broadened the participation of other national agencies, civil society organizations, and development partners in a health program. 3) It marks the 1st time that the DOH is leading the logistics procurement, distribution, monitoring and evaluation, and management of Family Planning all the way to the (Local Government Units) LGUs. It is also the first time that there is focused attention on the 5 critical areas that were left "unfinished" as Millennium Development Goals (MDGs), but continue as Sustainable Development Goals (SDGs): Maternal and Newborn Health, Family Planning, Adolescent Reproductive Health, Sexually Transmitted Infections and HIV-AIDS, and Gender-Based Violence.

Despite legal obstacles to the full implementation of the law posed by the Supreme Court Temporary Restraining Order (TRO) on the certification of contraceptive products by FDA and the procurement, distribution and use of the progestin subdermal implants by government issued in June 2015, the RPRH program continues to be implemented with renewed vigor nationwide.

This Report describes key intersecting inputs: Health Budget and Financing and Governance, and is organized along the 5 Key Results Areas (KRAs) on Maternal Newborn, Child Health and Nutrition (MNCHN); Family Planning (FP); Adolescent Sexual Reproductive Health (ASRH); Sexually-Transmitted Infections and HIV/AIDS (STI and HIV/AIDS); and Gender-Based Violence (GBV) plus an initial treatment of other RH Elements, through Cervical Cancer.

One of the limitations of this report is that the status of KRA problems, described as objective outcomes, is based mainly on the 2013 National Demographic Health Survey. We are awaiting the next NDHs. The full value of the report, therefore, lies in the policies developed, the budgets invested, drugs and supplies procured, the trainings conducted, the demand generation and community education and mobilization activities done, the services provided, and the governance of the program.

The strengths of this year's come from the following: budget invested and absorbed, policies developed, demand-generation and community education and mobilization, and governance. A major weakness is the coverage and utilization of services –across all the KRAs; as a national average, but especially in some regions; and the lack of robustness and timeliness of field statistics. All the weak areas are addressed in the Challenges and Recommendations section of the Report.

Budget and financing

Based on partial reports in 2015, the total amount of money made available for RPRH amounted to approximately P40.7B. Fifty three percent of this amount came from the DOH budget. The remainder was contributed by other national agencies such as PhilHealth (as benefit claim payments) and POPCOM, development partners, and CSOs.

The DOH appropriated more than P21.74B to support the implementation of various RPRH programs from its 2015 GAA. It represents the following budget items:

- P3.27B for Family Health and Responsible Parenting (FHRP)
- P6.89B for Expanded Program on Immunization (EPI); and
- P11.25B for Health Facilities Enhancement Program (HFEP)
- P324M for National STI & HIV/AIDS Program
- P4.7M for Cancer Program

Marked progress was observed in the utilization of HFEP budget, from 57 percent in 2014 to 89 percent in 2015. Likewise increase in utilization was also observed for the other two budget line items: EPI budget utilization posted a 4 percent increase from 95 percent to 99 percent while FHRP expenditure rate increased from 61 to 78 percent.

The Commission on Population (POPCOM) appropriated around P240M from its budget for the conduct of RPRH demand generation activities. In addition to government budgets, development partners and Civil Society Groups spent P5.9B and P238M, respectively, to support RPRH implementation.

PhilHealth reimbursed more than 97 billion pesos (P97.03B) worth of claims in 2015. From the total benefit payment, at least PhP12.8B was paid for RPRH-related benefits. This amounts to 13 percent higher compared to the benefit payments for RPRH benefits made in 2014.

As of December 2015, more than 750 PhilHealth accredited public hospitals and infirmaries are accessible to PhilHealth beneficiaries. In addition to these, there are more than 2,500 accredited Primary Care Benefit providers and approximately 3 thousand accredited Maternity Care Package providers.

Governance

The National Implementation Team (NIT) and Regional Implementation Teams (RITs) created in 2015 served as the oversight and steering committee for RPRH implementation across the country. As provided in DOH AO No. 2015-0002, they served as venue to discuss and resolve issues confronting implementation of the RPRH Law at all levels. Moreover, they also served as the coordinating bodies at the national and regional levels in harmonizing work and financial plans for various RPRH programs and monitor progress of implementation. Among the key NIT accomplishments of 2015 are: the development of the Monitoring and Evaluation Framework for the 5 Key Areas on Reproductive Health (Maternal and Newborn Health, Family Planning, Adolescent Reproductive Health, STI and HIV-AIDS, and Gender-Based Violence), the development of PhilHealth benefit packages to improve access to services (such as the progestin subdermal implant and post-partum IUD), the active involvement of other national government agencies (such as the DSWD, DepEd, DILG, NAPC and PCW) in RPRH Law implementation; and the development of modalities for greater participation of civil society organizations and professional groups in government's RH program.

The Women, Men's Health Development Division and Children's Health Development Divisions (WMCHDDs) under the Disease Prevention and Control Bureau (DPCB) also provided technical oversight to the implementation of the RPRH Law. Through its various programs and resources, the WMCHDDs were able to provide national, regional, and local technical guidance on the conduct of capacity building and demand generation activities, and provision of care, including distribution of essential RPRH commodities. The DOH awaits the creation of the Family Health Bureau (FHB) as specified in the IRR of the RPRH Law to "provide 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 creation of the FHB is now awaiting the endorsement of Office of Organization, Position, Classification and Compensation Bureau (OPCCB) of DBM, to the Office of the President for final approval.

The DOH, in partnership with development partners, assisted LGUs in building models for organizing and strengthening functional RPRH service delivery networks. Salient features tested in operational models include mapping public and private health service delivery capacities at different levels, creating agreements on patient referral systems, organizing effective management teams, and establishing appropriate M&E mechanisms. Lessons learned from these models will serve as inputs in instituting an SDN mechanism to support RPRH program implementation.

The DOH, in collaboration with other agencies and development partners, provided assistance to local service delivery points in establishing a functional supply management and recording system. One example is the establishment of FP Logistics Hotline. This Hotline allows the DOH to quickly assess the status of stocks and monitor the distribution of FP commodities at the service delivery points. It also helps facilities track consumable commodities, especially drugs and medical supplies, which helped mitigate incidents of stock-outs.

POPCOM led in drafting the Planning, Monitoring and Evaluation (PME) Guide, which provided guidance not only for the development of RPRH work and financial plan for 2015, but also for monitoring progress of its implementation. More specifically, the PME identified the process of collection, consolidation and processing of data coming from the reports of the different agencies and units, CSOs and other implementation partners.

CSO participation was further developed and sustained, which provided complementary resources and services in the implementation of various RPRH programs. The DOH, POPCOM and other agencies involved in RPRH Law implementation collaborated and worked closely with several NGOs in the areas of policy issuances, securing budget and financing, community mobilization, capacity building activities, commodities procurement and delivery, service delivery, establishing governance mechanism, and other areas related to FP/RH/MNCHN program implementation.

The World Economic Forum's Gender Gap Report in 2015, ranked the Philippines 7th among 145 countries globally according to how well they are leveraging the female population based on economic, educational, health, and political indicators.

Status of selected RH performance indicators

With less than two years into its implementation, RPRH performance measures on impact and service utilization coverage show mixed results.

In terms of impact indicators, it was observed that maternal mortality ratios (MMR) have not substantially changed. MMR has remained almost at the same level as in the 1993 National Demographic and Health Survey (NDHS) and 2011 Family Health Survey (FHS) results at 209 and 221 per 100,000 LB. The 2013 NDHS result did not include data on MMR. However, a similar slow decline in MMR has also been observed with administrative data (i.e., Field Health Surveillance and Information System or FHSIS) from the DOH. While the DOH 2015 program reports show lower MMR at 78 per 100,000, this information is limited to partial reports coming from public facilities. It is to be noted that FHSIS covers only patient consulting public health facilitates. Thus, the poor who have no access to health care facility may not be included. Neither are those who access health services in private health facilities and private healthcare providers.

Administrative data on health program coverage showed that the number of pregnant women provided at least four pre-natal check-ups (4 ante-natal consultations or ANC) decreased from 78 percent in 2014 to 75 percent in 2015. Pregnant women attended by professional health workers during delivery (skilled birth attendance or SBA) decreased from 81 to 80 percent while women giving birth in health facilities (facility-based delivery or FBD) increased from 75 percent in 2014 to 80 percent in 2015.

Use of modern family planning (FP) methods among women of reproductive age (WRA) in 2015 DOH Program data at 44 percent, measured as Modern Contraceptive Prevalence Rate (mCPR), remained at almost the same level in 2013 at 39 percent. While the estimate total eligible population of WRAs grew annually by 1.90 percent for the period, national CPR grew at an annual rate of 1.78 percent only.

DOH also reported that infants below 12 months old with complete immunization (fully-immunized children or FIC) is at 77 percent as of the last quarter of 2015, which is below the 2014 accomplishment at 85 percent. Results of the survey conducted by the Food and Nutrition Research Institute (FNRI) in 2015 revealed that the prevalence for both underweight and stunting among under-five children has increased from 2013 to 2015. Prevalence of underweight children increased from 20 to 21.5 percent, while the prevalence of stunting increased from 30.3 to 33.4 percent within the same period.

Newly diagnosed cases of HIV/AIDS in 2015 increased by 30 percent from 2014 based on the Philippine HIV and AIDS Registry. A total of 7,829 newly diagnosed cases was reported in 2015. HIV prevalence continues to grow among key affected populations which include males/transgenders who have sex with males (M/TSM), people who inject drugs (PWID), and female sex workers (FSW). In 2015, condom use rate among MSMs was higher at 42 percent, compared to that in 2013 which was at 37 percent. This, however, is still below the program target of 80 percent.

In terms of STI among key affected populations, the Integrated HIV Behavioral and Serologic Surveillance (IHBSS) showed that 5 percent of M/TSM and 10 percent of FSW experienced having STI symptoms (discharge, ulcer, or warts) in the past 12 months in 2015. Hepatitis B prevalence among M/TSM is at 6.5 percent, freelance female sex worker (FFSW) (in Cebu City) is at 5.2 percent, PWID at 7.5 percent for male and 7.8 percent for female.

According to the 2013 NDHS, one in ten adolescent girls (15-19 years old) is either a mother already or pregnant with first child. This is equivalent to over 450,000 pregnant teen agers in 2013, corresponding to around 8 percent increase from 2003. Sexual initiation before age 18 among adolescent women was 19 percent (or over 860,000 adolescent women), up from 14.6 percent in 2003. The common observation is the rate of sexual activity and pregnancy among teenagers is increasing.

As of 2015, available information on GBV is limited. Cases of violence against women (VAW) from the Philippine National Police (PNP) reported an increase of 40 percent from 2009 to 2013. The 2013 NDHS results also showed that one in five women 15-49 years old experienced physical violence since age 15 and almost 6 percent in the past 12 months before the survey.

The 2010 Philippine Cancer Registry reported that cervical cancer ranks 5th in the estimated ten leading causes of cancer cases for both sexes and ranks second in the estimated ten leading Cancer among female. In terms of mortality, cervical cancer ranks 2nd among females.

Policies developed, issued and implemented

Various policies on the operationalization of the RPRH Law were developed and issued in 2015. Some of these policies are already in operation at the local level and several Regional Offices (ROs) and Local Government Units (LGUs) have also issued ordinances and resolutions adopting the RPRH Law in their localities.

This issuance of DOH Administrative Order (AO) No. 2015-0002, creating the National Implementation Team (NIT) and Regional Implementation Teams (RIT) provided mandate to the implementation teams at the national and regional levels in managing the policy process relevant to the RPRH Law and its IRR, and coordinating actions of partner agencies and organization supporting its implementation.

Other important policies issued by the DOH include AO No. 2015-0020 (Administration of Life-saving Drugs during Maternal Care Emergencies by Nurses and Midwives in Birthing Centers), AO No. 2015-0021 (Deployment of MDs Graduating from Residency Training Programs in DOH Hospitals), and Administrative Order No. 2015 – 0028

(Guidelines on the Implementation of the Universal Health Care High Impact Five (Hi-5) Strategy) as the DOH flagship program to intensify implementation of RPRH Law.

Some existing DOH policies on FP were likewise reviewed in 2015 for consistency with the IRR of RPRH law. Other agencies such as DSWD, DepEd, DILG, NAPC, PhilHealth and POPCOM have likewise issued policies supporting the implementation of the RPRH law particularly on FP.

DepEd provided policy support to the implementation of the RPRH Law by developing and proposing a memorandum on "Policy and Guidelines for the Comprehensive Water, Sanitation, and Hygiene in Schools (WinS) Program". This policy aims to ensure effective hygiene and sanitation especially on helping young girls deal with menstrual hygiene. In addition, DepEd has committed the development of Comprehensive Sexual Education (CSE) standards on Adolescent Health and Development (AHD) from K to 12 in 2015.

For STI & HIV/AIDS, the Guidelines on the Performance Evaluation of In-Vitro Diagnostic Reagents for HIV, Hepatitis B Virus (HBV), Hepatitis C Virus (HCV) and Syphilis Screening, Confirmatory and Disease Monitoring Test Kits were issued on 2015. Policies and guidelines were also issued on the Use of Antiretroviral Therapy (ART) among People Living with HIV and HIV-exposed Infants. In 2015, PhilHealth issued the amended Outpatient HIV/AIDS Treatment (OHAT) Package through Circular No. 011 s. 2015.

DSWD issued Memorandum Circular No. 6 s 2015, “Institutionalization of Women Friendly Space (WFS) in Camp Coordination and Camp Management”. WFS served as venue for the delivery of convergence support services to the youth and survivors of any forms of gender-based violence. Several local legislative bodies with the technical assistance of civil society organizations also developed policies to address gender-based violence.

In support of the cervical cancer management, the DOH issued Memorandum No. 2015-0120 which provides guidelines on the Conduct of Free Cervical Cancer Screening in DOH Hospitals.

Capacity building

The DOH with the assistance of other agencies and partners strengthened the capacity of health care providers to deliver various RPRH-related services. This involved the conduct of skills training courses on Maternal, Neonatal and Child Health and Nutrition (MNCHN) including Basic Emergency Obstetric and Newborn Care (BEmONC), Maternal Death Review, Essential Intrapartum and Newborn Care Training, Infant and Young Child Feeding (IYCF), Newborn Screening, Lactation Management, and Pregnancy Tracking. Health service providers were also trained on various FP skills, including FP Competency-Based Training (CBT) levels 1 and 2 (IUD insertion/removal, ligation, vasectomy, PSI insertion and removal).

For ARH, training activities on comprehensive skills development on adolescent health care for health care providers were conducted. Local service providers also benefited from participating in training activities on Adolescent Job Aid and peer counseling. The DOH, in partnership with other agencies, conducted various capacity building activities on STI and HIV/AIDS for health service providers, youth peer educators & counselors, including LGU officials and staff, and other stakeholders. GBV training on the 4Rs (recognizing, recording, reporting, referring) of women and children abuse were also provided for selected Protection Specialists and hospital personnel in 2015.

Training activities were also complemented with infrastructure and equipment upgrading support from the DOH for various national and local health facilities all over the country through its Health Facility Enhancement Program (HFEP). This Program accounted for 48 percent (or more than P11 billion pesos) of the total DOH budget appropriated for RPRH-related programs in 2015.

Demand generation, provision of health services and essential commodities

The DOH, in coordination with other government agencies, delivered RPRH services and commodities to families, especially the poor. These services include modern family planning services, safe delivery, newborn care, breastfeeding, nutrition, immunization, HIV counselling and testing, and cancer screening, among others. Other services also include establishment of Barangay Violence Against Women (VAW) Desk, and Women and Child Protection Units (WCPU) to address GBV concerns. Referral of clients and provision of these services were also made possible through the mobilization of community volunteers, national, regional, and local health workers, other allied professionals, in partnership with CSOs and other development partners on reproductive health.

Demand generation activities to promote service utilization were likewise conducted in 2015. These activities included communication campaigns, production and distribution of information, education and communication (IEC) and advocacy materials, capacity building for demand generation, deployment of trained service provider or community health volunteers, and multi media campaign activities. It included airing and publication of quad media, and the conduct of *Buntis Congress* and KP Caravan to implement Universal Health Care High Impact Five (UHC Hi-5) strategy of the DOH. These Hi-5 activities aimed at providing information and critical UHC interventions especially for the poor, creating high impact tangible outputs.

Other activities related to demand generation and service delivery are the conduct of Family Development Sessions (FDS), for 4P's beneficiaries RPFP classes, campaigns for HIV awareness and voluntary counseling and testing, Youth Camp and U4U Activities for adolescent and youth reproductive health, teen counseling on SRH, Youth Development Film Festival, and focus group discussions (FGD) on GBV, among others. Information dissemination to capacitate and reiterate the roles of the local government units (LGUs) in the implementation of RPRH Law was also conducted through the Union of Local Authorities of the Philippines (ULAP).

The DOH procured and distributed family planning/ maternal, neonatal, and child health and nutrition commodities to various public and private service delivery points throughout the country in 2015. Commodities provided to target beneficiaries include vaccines, vitamin A capsules, Zinc, ferrous sulfate and folic acid tablets, micronutrient powder, and iodine capsules. Commodities like pills, DMPA injectables, PSI and IUD from the DOH and donor agencies were also provided to eligible women as one of the critical components of FP services provision. The DOH allocated around P 6.89 billion pesos in 2015 for its Expanded Program on Immunization (EPI) under the WMCHDD, mainly for the procurement of vaccines under the program.

Delivery of STI & HIV/AIDS services involved provision of drugs and commodities which included antiretroviral drugs, drugs for STIs and opportunistic infections, HIV test kits and laboratory supplies, syphilis test kits, CD4 test kits, condoms and water-based lubricants. Hygiene kits for adolescents and iron tablets for girls complemented the delivery of ARH services in Teen Health Kiosks (THKs) in schools, RHUs and hospitals and Teen Mom Clinics, and Programs for Young Parents in hospitals.

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Acronyms

2PNC	**Two Post-Natal Consultation**
4ANC	Four Antenatal Care Visits
4Rs	Recognition, Recording, Reporting, Referral
4Ps	Pantawid Pamilyang Pilipino Program
AECID	Agencia Espanola de Cooperacion International Para el Desarrollo
AHD	Adolescent Health and Development
AIARHC	Albay Inter-Agency Reproductive Health Committee
AIDS	Acquired Immunodeficiency Syndrome
AJA	Adolescent Job Aid
ALL	Acute Lymphocytic Leukemia
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
BIHC	Bureau of International Health Cooperation
BNS	Barangay Nutrition Scholar
BTL	Bilateral Tubal Ligation
BWC	Brokenshire Woman Center
C4C	Communication for Communicators
C4RH	Filipino Catholic Voices for Reproductive Health
CBT	Competency-Based Training
CCT	Conditional Cash Transfer
CD4	Cluster of Differentiations
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHO	City Health Office
CHR	Commission on Human Rights
CHSI	Center for Health Solutions and Innovations
CHT	Community Health Team
CICP	Center for Innovation, Change and Productivity
CONAP	Continuing Appropriations
CPR	Contraceptive Prevalence Rate
CPU	Central Processing Unit
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
JRMMC	Jose Reyes Memorial Medical Center
DM	Department Memorandum
DMO	Development Management Officer
DMPA	Depot Medroxyprogesterone Acetate

DOH	Department of Health
DOH EB	Department of Health Epidemiology Bureau
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
EO	Executive Order
EPI	Expanded Program on Immunization
EPP	Estimation and Projection Package
ERPAT	Empowerment and Reaffirmation of Paternal Abilities
EU	European Union
FBD	Facility-based Delivery
FCSAI	Fundacion Espanol para la Coopercion
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
FWS	Female Sex Worker
FY	Fiscal Year
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 Development
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	Modern Contraceptive Prevalence
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
NTHC	National TeleHealth Center
NVAWDocS	National VAW Documentation System
OAE	Otoacoustic emissions device
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
PCB	Primary Care Benefit package
PCW	Philippine Commission on Women
PE	Peer Educators
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.
PNSCB	Philippine National Statistics Coordination Board
PNP	Philippine National Police
PNP-WCPC	Philippine National Police-Women and Child Protection Unit
PO	People's Organization
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
RNHeals	Registered Nurses for Health Enhancement and Local Service
RP-FP	Responsible Parenting and Family Planning
RPO	Regional Population Office
RPRH	Responsible Parenthood and Reproductive Health
RTI	Reproductive Tract Infection
SACCL	STD/AIDS Central Cooperative Laboratory
SBA	Skilled Birth Attendance
SC	Supreme Court
SHC	Social Hygiene Clinics
SK	Sangguniang Kabataan
SQAO	Status Quo Ante Order
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
SSESS	STI Sentinel Etiologic Surveillance System
STI	Sexually Transmitted Infection
SWRA	Sexually Active Women of Reproductive Age
TB	Tuberculosis
TD	Tetanus-Diphtheria
TFI	Tarbilang Foundation Inc.
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
UNESCO	United Nations Education, Scientific and Cultural Organization
UNICEF	United Nations International Children's Emergency Fund
UNFPA	United Nations Population Fund
UP	University of the Philippines
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
WCPC	Women and Child Protection Center
WCPMIS	Women and Child Protection Management Information System
WCPU	Women and Child Protection Units
WFS	Women Friendly Space
WHO	World Health Organization
WINS	Water, Sanitation, & Hygiene in Schools
WMCHDDs	Women and Men's Health Division 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
ZOTO	Zone One Tondo Organization

Budget and Financing

Budgetary Support from Department of Health

In 2015, the total budget allocated to implement the RPRH Law is around P40.7 B. With this amount, the national government budget continued to provide the largest share in funding the RPRH implementation. The DOH alone comprised more than half of this amount (53 percent) or around P21.74B from its 2015 budget. There was also substantial increase in the DOH budget allocation for RPRH-related line items compared last year.

Table 1 shows comparative allocation (2014 vs. 2015) of the DOH budget across line item budgets for RPRH implementation.

Table 1. Comparative DOH budget allocation for RPRH-related line items in 2014 and 2015

Line Item[1]	2014 Allocation (PhP)	2015 Allocation (PhP)	Difference
Family Health and Responsible Parenting (FHRP)	2,538,869,000.00	3,266,980,270.00	728,111,270.00
Expanded Program on Immunization (EPI)	2,441,933,000.00	6,892,396,900.00	4,450,463,900.00
Health Facilities Enhancement Program (HFEP)[2].	9,268,175,000.00	11,254,432,510.00	1,986,257,510.00
National STI & HIV/AIDS Program– Please inquire if the allocation for 2014 and 2015 are the same	324,267,139.00	324,267,139.00	0.00

Aside from the above budget line items, the DOH also appropriated P4.7M specifically for its cancer program. Forty-two percent of the budget was utilized for training.

Compared to its 2014 budget, there were improvements in the utilization of 2015 DOH budget for RPRH. As of December 31, 2015, the utilization rate for RPRH-related budget line items ranged from 78 to 89 percent. Table 2 shows comparative utilization rates of RPRH-related line items in 2014 and 2015.

Table 2. Comparative utilization rate of DOH budget for RPHR in 2014 and 2015

Line Item	2014 Utilization rate (percent)[3]	2015 Utilization rate (percent)
Family Health and Responsible Parenting (FHRP)	61	78
Expanded Program on Immunization (EPI)	95	99
Health Facilities Enhancement Program (HFEP).	57	89
National STI and HIV/AIDS	100	97

Overall utilization rates for the DOH 2015 budget were higher in EPI and HFEP than the FHRP line item. While the average utilization rate of 2015 budget for FHRP is 78 percent, Central Visayas, Eastern Visayas and Zamboanga Peninsula are below the 78 percent average. The 78 percent utilization rate of FHRP was due to procurement of

[1]Except for FHRP, the other two line items represent allocations for other DOH programs, and not solely for RPRH implementation
[2]HFEP budget allocation is intended for MNCHN and other programs of the DOH not only for RPRH implementation
[3]Source: The First Annual Consolidated Report on the Implementation of the Responsible Parenthood and Reproductive Health Act of 2012 (R.A. No. 10354)

commodities which was put on hold due to the Temporary Restraining Order (TRO) issued by the Supreme Court in June 21, 2015.

Table 3 shows utilization rates by region.

Table 3. Budget Utilization Rates (%) of RPRH-related items, by Region, 2015

Regional Office	FHRP	EPI	HFEP
DOH Central Office	78	100	91
NCR	78	19	82
CAR	93	100	67
I	87	50	63
II	81	100	68
III	92	99	27
IV-A	92	100	86
IV-B	81	89	100
V	93	59	90
VI	92	78	25
VII	65	85	87
VIII	70	69	81
IX	48	100	76
X	99	99	45
XI	91	41	73
XII	94	95	90
XIII	100	68	88
TOTAL	**78**	**99**	**89**

Financing Support from Other Sources

The Commission on Population (PopCom) appropriated around P 240M for RPRH implementation specifically for demand generation activities while the Philippine Commission on Women (PCW) allocated and spent at least P3.4M for the implementation of RPRH Law, specifically for gender-based violence (GBV) related items. Of which, majority of the budget was spent on demand generation and governance.

Various development partners allocated P5.9B to support the implementation of RPRH in 2015. Of this amount, more than 50 percent was allocated to support for the attainment of RPRH-related MDGs (i.e. Reduce child mortality, Improve maternal health, and Combat HIV/AIDS, malaria and other diseases). The development partners supported the DOH in providing technical assistance at the national, regional (i.e. Eastern Visayas and Cordillera) and local levels.

Table 4 shows budget support by major development partners for the implementation of RPRH Law.

Table 4. Budget support of development partners for RPRH Law implementation

Development Partner[4]	RPRH-related initiatives	Budget support (PhP)
World Health Organization	Nutrition	88,360,000.00
	Reproductive, maternal, newborn, child and adolescent health	44,661,703.00
UNICEF	JPMNH	88,801,368.00
	Maternal and Young Child Nutrition Security Initiative in Asia (MYCNSIA)	22,527,231.00

[4] The key development partners supporting the implementation of RPRH include, World Health Organization (WHO), United Nations International Children's Emergency Fund (UNICEF), Agencia Espanola de Cooperacion International Para el Desarrollo (AECID), World Bank (WB), United States Agency for International Development (USAID), Japan International Cooperation Agency (JICA), Fundacion Espanola para la Cooperacion (FCSAI), United Nations Population Fund (UNFPA), and European Union (EU).

Development Partner[4]	RPRH-related initiatives	Budget support (PhP)
AECID Phase 4	Contingency (Back-up Funds)	2,460,000.00
World Bank	GPOBA	164,250,000.00
USAID	Maternal and Child	510,702,000.00
	FP and RH	3,789,422,000.00
JICA	Strengthening Maternal and Child Health Services in Eastern Visayas	221,870,000.00
	Acute Respiratory Infections in Children	169,580,000.00
	Cordillera MNCHN	101,000,000.00
FCSAI	MNCHN	2,750,000.00
UNFPA	7th CP	337,520,000.00
EU	IP MNCHN	385,000,000.00
TOTAL		**5,928,904,302.00**

In 2015, Civil Society Groups reported that around P 238M of their budget was used for the implementation of RPRH Law. Of this amount, 90 percent was spent to support implementation of the Family Planning program. The financial support was also used for demand generation activities (e.g. Family Development Sessions, women's health congresses to raise awareness on FP, forums on ASRH, launched of ASRH hotline, etc.); capacity building (e.g. trainings for community health workers, training of trainors on GBV Prevention Response, training on FBCT 1 and 2, subdermal implant insertion, etc.); procurement (e.g. prenatal vitamins, FP commodities, patrol kits for GBV Watch Group members); and service delivery (e.g. prenatal and postnatal consultations, HIV counseling, adolescents counseling, outreach FP services, etc.).

Table 5. CSO Budget Allocation per Key Results Area

Key results area	Budget Allocation (PhP)
MNCHN	4,046,114.00
FP	214,778,346.00
ASRH	5,805,968.04
STI and HIV/AIDS	1,123,701.88
GBV and Others	12,531,494.00
Total	**238,285,623.92**

Social Health Insurance

Policies Developed

In 2015, eight RPRH-related policies were developed and implemented by PhilHealth. These policies have "*Tamang Sagot*" information sheet – a list of frequently asked questions, for PhilHealth members and other stakeholders. To further facilitate understanding of RPRH-related policies, PhilHealth Regional Offices organized orientation activities and discussed in details the operational mechanisms of the following policies:

- PhilHealthCircular 24 s. 2015 on the *"Social Health Insurance Coverage and Benefits for Women About to Give Birth Revision 1"* (Date Issued: June 11, 2015).

  This policy provides additional provision to the guidelines on "women about to give birth" issued in 2014. The 2015 version clarified the enrollment procedures and coverage of "women about to give birth" to social health insurance. For those who are not yet registered to PhilHealth; not eligible for benefits due to lack of qualifying contributions; and minors who are still dependents of their parents, may be referred to Medical Social Worker for assessment to Point of Care Enrollment (POC) Program. Members enrolled under POC are entitled to immediate availment of the benefits. However, pregnant women who are not qualified under POC Program, may still be covered through the provisions of Section 39b of the IRR of the National Health Insurance Act of 2013.

It expanded access to FP benefit packages such as IUD insertion and Non-scalpel Vasectomy (NSV) benefits. Hence, aside from accredited hospitals, infirmaries, and ambulatory surgical clinics (ASC); non-scalpel vasectomy (NSV) can be reimbursed in primary care facilities (i.e.PCB1 providers). Also through this policy, postpartum IUD (PPIUD) was made reimbursable as second case rate.

- PhilHealth Circular 11 s. 2015 on the *"Outpatient HIV/AIDS Treatment (OHAT) Package (PhilHealth Circular 19 s. 2010) Revision 1"*

  This policy provides additional provision to PhilHealth Circular 19 s. 2010, which provides guideline on accreditation and benefit delivery for OHAT. This policy revision defines reimbursement guidelines on OHAT in accordance with the "All Case Rate Policy" of PhilHealth by accredited health care providers. The package covers treatment, laboratory examinations based on specific treatment guidelines including Cluster of Differentiation (CD4) level determination test, viral load, and test for monitoring of anti-retroviral (ARV) drug toxicity, and professional fees of providers. Furthermore, the policy also specify that only HIV/AIDS cases confirmed by STD/AIDS Central Cooperative Laboratory (SACCL) or Research Institute for Tropical Medicine (RITM) requiring treatment shall be covered by the package. The No Balance Billing Policy applies to Sponsored and Indigent Members who were treated in OHAT accredited facilities.

  Also, satellite treatment hubs which are already accredited by PhilHealth are also qualified to file for OHAT claims and requires less documentary requirements. This was further clarified through PhilHealth Advisory 08-02-2015.The package may be availed only from PhilHealth accredited health care institutions that are DOH designated Treatment Hubs.

- PhilHealth Circular 38 s. 2015 on the *"Philhealth Subdermal Contraceptive Implant Package"*

  This package provides for the coverage of subdermal implant use for long acting reversible family planning method. The policy enumerates the services covered by the package such as consultation and counseling prior to the procedure; professional fee and use of the facility; medicine and supplies including the devise; and follow-up and counseling after the procedure. The whole package amounts to P3,000.00 per case. However, the Package may only be availed of in private hospitals, ambulatory surgical clinics and birthing homes.

- PhilHealth Circular 8 s. 2015 on the "Annex 2 – List of Procedure Case Rates (Revision 1.0) and Supplementary Guidelines for All Case Rates"

  The policy includes guidelines on usage of RVS Code 59409 in which the corresponding description is Vaginal Delivery only (with episiotomy); also referred to as complicated vaginal delivery. The said code will also be used for deliveries done vaginally for mothers with medical conditions or other indications that exempt them from the normal spontaneous delivery package.

- PhilHealth Circular 33 s. 2015 on the "*Implementation of Point of Care Program Revision 1"*

  The Point of Care (POC) Program provides mechanism of enrolling the poor who are not yet members of the NHIP. This policy is an amendment to the same policy issued in 2013. This revised policy on POC, expands the participating providers in implementing the program. In addition to hospitals, government primary care facilities such as infirmaries/dispensaries, maternity clinics/birthing homes, TB-DOTS clinics, Animal Bite Treatment Centers may participate in the program.

- PhilHealth Circular 32 s. 2015 on the Enrolment and Coverage of Emancipated Individuals and/or Single Parents below 21 years old from the NHTSPR Identified Poor Families as Indigent Members

This policy provides mechanism for individual below 21 years old who is listed in the NHTS PR, emancipated and/or single parent, enlisted and/or profiled by Health Centers/Rural Health Units or admitted in any institutional health care provider shall be enrolled in PhilHealth as indigent members. Likewise, an adolescent who is already a mother could already be enrolled as principal member

- PhilHealth Circular 36 s. 2015 on the Implementing Guidelines of PRevEnTS(Primary Care Revitalized and Enhanced Through Skills and Services) A Primary Care Booster Package – Revision 1

  This policy provides additional implementing guidelines on PRevEnTS (PhilHealth Circulars 29 s. 2013 and 16 s. 2014) for the availment of PRevEnts Package, processing of claims and for proper utilization of the fund for PhilHealth partners. PRevEnTS Package augments the resources of accredited PCB1 providers for capacity building of their personnel on programs that will facilitate or improve the effective implementation of PhilHealth's PCB, maternal, neonatal care packages. Fund from PREVENTS may be used to train the staff on Basic Emergency Obstetric and Neonatal care, use of visual acetic acid for cervical cancer screening and even family planning procedures.

Total PhilHealth Premium Contributions

In the 2015 Financial Statements Report, the premium collection for the NHIP rose by 11 percent amounting to P96.69B compared to last year. The reported premium collection of PhilHealth stood at P86.65B in 2014. In the 2015 premium collection, P36.26B came from the National Government as appropriated in the GAA for the NHTS poor members. Around P85.2M came from premium contributions of women who are about to give birth. From the premium collections, PhilHealth was able to reach 92 percent coverage rate of the projected population in 2015, including all of the 15.3M Indigent Members from the NHTS PR households. These figures are presented below in Table 6.

Table 6. Number of PhilHealth Sponsored Program Members and Dependents among NHTS Poor Households

Region	Members	Dependents
CAR	269,015	529,959
I	723,147	1,424,599
II	508,751	1,002,239
III	905,846	1,784,516
NCR	762,033	1,501,205
IV-A	1,054,210	2,076,794
IV-B	6,57,500	1,295,276
V	1,316,605	2,593,711
VI	1,429,310	2,815,740
VII	1,120,981	2,208,332
VIII	1,017,170	2,003,824
IX	1,154,773	2,274,903
X	966,070	1,903,157
XI	702,972	1,384,854
XII	816,583	1,608,668
XIII	575,120	1,132,986
ARMM	1,308,495	2,577,736
Total	**15,288,584**	**30,118,509**

Total PhilHealth Claims Paid

PhilHealth reimbursed a total of PhP97.03B. Of this amount 26 percent (PhP25.05B) was paid for the Government-Sponsored members. From the total benefit payment, at least PhP12.8B was paid for RPRH-related benefits. The

total benefit payment for RPRH-related benefits in 2015 is 13 percent higher compared to 2014. These figures are presented in Table 7.

Table 7. Number of PhilHealth Sponsored Program Members and Dependents among NHTS Poor Households, 2015.

Benefit Package	Number of claims filed in 2014	Total amount paid by PhilHealth in 2014 (PhP)	Number of claims filed in 2015	Total amount paid by PhilHealth in 2015 (PhP)
FP[5]	4,459	20,588,060.00	4,303	13,558,000.00
MNCHN[6]	1,207,705	8,274,657,081.00	1,765,269	11,559,820,395.00
Post-abortion care	25,617	258,690,120.00	38,353	394,149,570.00
STI and HIV	6,685	53,360,630.00	15,611	119,514,150.00
Breast and Gynecologic Conditions [7]	189,236	2,546,953,258.00	45,538	582,112,284.00
Men's Health[8]	8,126	110,440,402.00	12,336	130,107,730.00
Total	**1,441,828**	**11,264,689,551.00**	**1,118,642**	**12,799,262,129.00**

Top five surgical procedures paid by PhilHealth were related to RPRH services. These are: Normal Newborn Care Package, Normal Spontaneous Delivery Package (for hospitals), Maternity Care Package, Caesarian Section, and Vaginal Delivery with Complications. These RPRH-related benefits paid by PhilHealth accounted for 13 percent of the total claims paid.

In 2014, PhilHealth paid around 43 percent of the estimated 1.72 million women expected to give birth in facility. The number of paid claims in 2015 for women who gave birth in facility was higher in 2015 at 57 percent of around 1.75M women.

Table 8. Comparative estimates of deliveries and number of claims paid by PhilHealth in 2014 and 2015

Procedure	2014			2015		
	Estimates	Number of claims filed	Total amount paid by PhilHealth (PhP)	Estimates	Number of claims filed	Total amount paid by PhilHealth (PhP)
Vaginal delivery[9]	1,439,721	518,953	3,427,089,144.00	1,468,046	732,735	5,035,239,010
Cesarean delivery[10]	276,427	217,754	4,212,308,808.00	281,872	259,706	5,102,338,080.00
TOTAL	**1,716,148**	**736,707**	**7,639,397,952.00**	**1,749,918**	**992,441**	**10,137,577,090.00**

PhilHealth Accredited Health Facilities Providing RPR Services, 2015

As of December 2015, there were more than 750 PhilHealth accredited public hospitals and infirmaries accessible to its members and dependents (Please refer to Table 10 below). The number of Primary Care Benefit (PCB) and Maternity Care Package (MCP) has increased compared to the figures in 2014. There were 2,553 PCB and 2,981 MCP providers accredited with PhilHealth in various cities and municipalities in the country as shown in Table 9.

[5]Includes IUD, BTL, and NSV
[6]Includes deliveries (normal deliveries, cesarian sections, breech and complicated vaginal deliveries); antenatal care and pregnancy-related conditions; and infant and child health care (Newborn Care Package and Perinatal Conditions)
[7]Includes payment for medical case rates and procedures as well as cancer treatment (Z benefit packages)
[8]Includes reimbursement for procedures and treatment for diseases of male genital tract including Z benefit for prostate cancer
[9]Includes NSD, MCP, and vaginal deliveries with complications
[10]Includes primary CS and repeat CS

Table 9. Number of PhilHealth Accredited PCB and MCP Providers in Cities and Municipalities.

	2014		2015	
	PCB	MCP	PCB	MCP
Number of accredited outpatient clinics	2,438	2,645	2,553	2,981
Number of cities and municipalities with accredited clinics[11]	1,561	1,155	1,567	1,268
Proportion of accredited outpatient clinics	96%	71%	99%	80%

Source: PhilHealth Stats and Charts 2015, www.philhealth.gov.ph

Table 10 shows the number of PhilHealth accredited facilities by category per region.

Table 10. Number of PhilHealth - Accredited Health Facilities Providing RPRH Services, 2015.

Region	RHU/Health Center	Lying-in (Public)	Lying-in (Private)	Ambulatory Surgical Clinic	Hospitals (Public)	Hospitals (Private)	PCF (Public)	PCF (Private)
CAR	103	146	9	1	13	11	26	7
I	158	59	29	4	23	44	21	34
II	104	85	25	6	27	31	20	19
III	241	107	185	13	50	117	12	24
NCR	468	33	278	71	48	111	3	22
IV-A	183	100	250	12	50	151	19	33
IV-B	88	54	10	1	13	10	22	19
V	146	100	91	2	21	29	31	28
VI	182	111	47	4	34	26	27	4
VII	168	98	92	3	22	36	40	9
VIII	187	220	88	2	22	20	28	11
IX	92	93	8	2	12	27	17	9
X	112	122	52	2	22	42	16	29
XI	70	42	124	5	13	42	6	55
XII	60	42	63	3	11	43	16	35
ARMM	110	92	32	0	16	10	15	7
X	81	75	19	2	10	7	26	11
Total	**2,553**	**1,579**	**1,402**	**133**	**407**	**757**	**345**	**356**

Challenges and Recommendations

1. ***Limited absorptive capacity of DOH for incremental budgets***. The budget for Family Health and Responsible Parenting has increased more than fourfold from P0.5B in 2010 to P2.3B in 2016. While the additional funding has increased the scale and scope of programs particularly that of FP and Maternal and Child Health, the DOH has been unable to fully utilize its allocated budget for the year. In 2015, the DOH was only able to obligate 78% of its budget. The limited capacity to fully utilize budgets can be attributed to procurement delays. In addition, there is also wide variation in program performance and ability to absorb budgets at the regional level.

[11]A city or municipality may have more than one outpatient clinic accredited by PhilHealth to provide NHIP benefits and services. In the 2014 Stats and Charts of PhilHealth, there are 1,634 LGUs nationwide. However, as indicated in the 2015 Stats and Charts of PhilHealth there are 1,634 LGUs nationwide, however some PROs requested to exclude some LGUs in their area and the total eligible LGUs is 1,584.

Recommendations:

a) Develop an overall investment plan, at least for each region, which identifies priority investments to implement RPRH programs and activities. From this plan, identify investment items that can be managed through outsourcing and or through bulk procurement of services.
b) Identify barriers in the procurement system and institute mechanisms to fast-track and improve procurement process both at the central and regional levels.
c) Improve capacities at the regional level on outsourcing and management of contract through bulk procurement of technical services for various RPRH Programs
d) DOH Central Office needs to track disbursements linked to appropriation and allotment

2. Lack of a monitoring system to track ROs with low obligation and utilization rates

Recommendations:

a) Install a regular and systematic monitoring of the ROs with low obligation and utilization rates in order to stimulate spending and catch-up with regions that have better utilization rate. Regions that cannot reach their monthly benchmarks should be required to submit catch up plans.
a) The Program Planning and Budget Development Committee (PPBDC) should regularly convene to monitor accomplishments and targets in relation to budget utilization, and in the preparation of consolidated budget analysis and reports per office/unit and region specially for RPRH line-item budgets

3. Utilization of PhilHealth related FP benefits remains low

Recommendations:

a) PhilHealth to assess and identify gaps on the utilization rate, including coverage, availment and support value.
b) PhilHealth to improve its membership services by identifying specific strategies related to RPRH to inform their beneficiaries on the benefits and membership status on a sustained effort.

4. ***Other agencies are not yet explicitly allocating funding for specific RPRH activities*** Two years into its implementation, the spending on RPRH activities by national government agencies other than DOH, PhilHealth and POPCOM remain minimal. This could also be indicative of the status of implementation of RPRH programs for other national government agencies.

Recommendations:

a) NIT to convene key stakeholders (agencies at the national level) to plan and budget key activities related to RPRH implementation. Through the NIT, all agencies an partners at central and regional levels will jointly develop and overall investment plan that will serve as guide for identifying programs, project and activities, including its budget to implement the RPRH Law.
b) NIT to advocate for allocation of funds to support specific RPRH activities from other agencies using the RPRH Planning, Monitoring and Evaluation Guide

5. ***Uncertainty of RPRH budget allocation owing to the annual budget process***. The RPRH Law does not provide for a specific budget allocation for its implementation as this will be determined during the annual budget process. The recent P 1B budget cut experienced by the DOH is an example of how RPRH implementation can be derailed by oppositors to the law who are members of Congress.

Recommendations:

a) Identify non-negotiable agency budget items related to RPRH that should be protected from Congressional influence.
b) Through the NIT and with the support from legislative liaisons units of agencies involved in RPRH implementation, systematically support lobbying for the appropriation of RPRPH-related budget line items throughout the whole budget planning cycle, especially during budget deliberations in Congress until the budget is signed into a law as General Appropriations Act (GAA).Make the budget process and its developments transparent to the public in order to generate political support for the RPRH budget.

Governance

Creation of the RPRH National Implementation Team and the Regional Implementation Teams

In January 2015 the DOH issued Administrative Order 2015-0002, defining the responsibilities and functions of the RPRH National Implementation Team (NIT) and the Regional Implementation Teams (RITs). With this mandate, the NIT led in addressing several challenges in the implementation of the RPRH Law and its IRR.

Key issues confronting RPRH/MCH implementation through the management of NIT and RITs. Issues deliberated and resolved during the year include:

- Coordination on the development of work and financial plans to facilitate RPRH program implementation, and establishing a mechanism that will monitor output and status of RPRH program implementation by local and regional units, and other partner agencies. This was supported through the development of the Monitoring and Evaluation Framework for the 5 Key Areas of Reproductive Health
- Facilitate monitoring of FP commodity availability and addressing incidence of stock-outs through the different RITs.
- Dealing with the resistance of some LGUs in implementing RPRH Law and its IRR (e.g., local ordinance declaring Sorsogon City as Pro-Life City).

Creation of the Family Health Bureau

The IRR of R.A. No. 10354 mandates the DOH to reorganize its various programs on reproductive health into a unified bureau or office that shall have organizational components corresponding to: (1) standards development, policy, planning and financing; (2) capacity building; (3) advocacy and communication; (4) support to field operations; and (5) monitoring and evaluation and knowledge management.

In 2014, the DOH submitted to the Office of the President a proposed draft Executive Order (EO) creating a dedicated Bureau responsible for the implementation of the various RPRH programs. As part of its continuing effort to establish the Bureau, the DOH, in 2015, worked on revising and refining the proposed structure and responded to the comments of the Office of the President, and resubmitted the proposed revision in November, 2015. At present, the proposed structural mechanism is at the Office of Organization, Position, Classification and Compensation Bureau (OPCCB) of the DBM for endorsement to the Office of the President.

Under the revised structure, the FHB is expected to provide technical and coordination support for the systematic and integrated provision of reproductive health care to all citizens, prioritizing women, the poor, marginalized, and those in vulnerable or crisis situations. The FHB shall likewise serve as the policy, planning and coordinating body in the design and supervision of reproductive health care service financing, coordination, and delivery mechanisms.

Currently, the Women and Men's Health Development Division and Children's Health Development Division (WMCHDDs) under the Disease Prevention and Control Bureau (DPCB) provides technical oversight to the implementation of various RPRH programs. Through its various programs and resources, the WMCHDDs was able to mobilize national, regional, and local counterparts in providing technical guidance on the conduct of capacity building and demand generation activities, and provision of care, including distribution of essential RPRH commodities.

Development of Planning, Monitoring and Evaluation Guide

A Monitoring and Evaluation Committee was organized in the first quarter of 2015 to formulate the guidelines and monitoring templates to be used by the different implementing agencies and stakeholders in reporting the annual plans and accomplishments of RPRH-related programs.

For this purpose, the Commission on Population led in the development of a Planning, Monitoring and Evaluation (PME) Guide which provided framework not only for the development of work and financial plan for the RPRH programs, but also for the monitoring progress of its implementation. The PME Guide identifies the process in the collection, consolidation and processing of data coming from the reports from different agencies and units, CSOs and other implementation partners. In particular the PME guide was used in specifying the reporting requirements collected from various partner agencies, CSOs and RITs.

Establishing Data Accuracy for Recording and Reporting of RPRH program indicators through the DOH FHSIS Data Quality Check

Through the DOH, nationwide capacity building activities for data accuracy were conducted by the DOH for all LGU to institute a process for validating, updating and correcting data at the source prior to entering them into the summary tables, consolidation tables and final monthly, quarterly, annual reports. Through data quality check (DQC), the DOH was able to resolve issues on the validity of FHSIS reports coming from various local health facilities in the country.

Seventy four (74) percent of the total LGUs monitored were found to be regularly implementing data quality assurance for key RPRH indicators while the others have initiated training at the RHU level.

Table 11. Number of LGUs Implementing DQC Monitored in 2015.

	Number of LGUs implementing DQC	Total Number of LGUs Monitored	PERCENT
Luzon	327	384	85%
Visayas	148	289	51%
Mindanao	290	365	79%
TOTAL	765	1,038	74%

Strengthening provision of RPRH-related services through the establishment of functional service delivery network

A functional service delivery network (SDN) is a mechanism aimed at expanding access and strengthening of the continuum of care for women, children and families. Establishing the network requires a careful mapping and assessment of existing competencies of service providers and determination of gaps in service delivery capacities of facilities joining the network. In SDN, apart from public sector participation, the private health providers are also enjoined to voluntarily become part of the network and be engaged through a partnership agreement.

Box 1. Tacloban City health personnel explaining household profiling and health use plan planning during

The City Government of Tacloban with support from DOH RO VIII, PhilHealth RO 8 and development partners, developed a comprehensive plan to re-establish SDN in Tacloban City based on DOH DM 0313-2014, including provisions for ensuring sustainability and viability of the City Hospital and district health centers. In Sept2015, the profiling and health use plan development were done during FDS and house visits. More than 8 thousand NHTS have been profiled and assisted in the development of HUP and. More than 2 thousand individuals were referred to a health facility, and availed of the services from within the network of health providers

The DOH, in partnership with the development The DOH, in partnership with the development partners, assisted selected LGUs in the establishment of functional SDN.

In Luzon, selected provinces and cities are in various stages of establishing partnership agreement with the LGUs and partners (Cavite, Albay, Caloocan, Malabon, Quezon City and Southern Isabela), and formulation of process involving mapping of health facilities and referral mechanism (Nueva Ecija, Bulacan, Tarlac, Cagayan, Metro Tuguegarao and Gonzaga ILHZ, Northern Isabela, Benguet, Pangasinan, Taguig, Pasig, and Laguna).

In the Visayas, a total of nine (9) inter-local health zones (ILHZ) were likewise strengthened in Region VIII to serve as the key structure in the establishment of functional service delivery network. These ILHZs are in Leyte, Tacloban City, Eastern Samar, Southern Leyte and Northern Samar.

In Mindanao, six (6) SDN management structures in DOH Regional Offices of Mindanao have been established where 60 DOH-RO staff were trained as trainers on the use of the SDN Operational Guide issued by the DOH as Memorandum No. 2014-0313: Adoption of the Guidelines in Establishing Service Delivery Network. Twenty (20) SDN management groups across 58 LGUs in Mindanao engaged. Likewise, mapping of RPRH-related services were developed and eight public-private partnerships were initiated under the established SDN management arrangements.

A number of memoranda of agreement and understanding that allowed for adolescent and youth networks to be established, as well as local and regional youth councils to be strengthened, have been entered into by several stakeholders and key players in adolescent reproductive health. There has also been a significant increase in funding and technical support for ASRH programs, projects, and activities by various development partners.

Box 2. SDN initiative in Mindanao, the IP MNCHN

The IP MNCHN project initiated improving SDN in selected municipalities in Mindanao: Sinuda, Kitaotao, Bukidnon; Binicalan, San Luis, Agusan Sur; and Gawasan, Carmen, North Cotabato. It assisted these localities in improving service capacity in terms of facility upgrading, human resources and service delivery improvement. The SDN was formed in four sites during the 2nd half of 2014 and 1st quarter of 2015

Some 50 local (city, municipal, provincial) government units[12] have been assisted to formulate, implement and monitor adolescent and youth reproductive health initiatives. Specific assistance included documenting high rates of teenage pregnancies; strengthening capacity of service providers in health centers and schools; planning,

[12]This list includes Mayorga in Leyte, Mina in Iloilo, 25 PYP sites, 14 Luzon provinces - Benguet, Pangasinan, Cagayan, Isabela, Bulacan, Nueva Ecija, Tarlac, Batangas, Cavite, Laguna, Quezon, Rizal, Oriental Mindoro, and Albay, seven NCR cities (Caloocan, Malabon, Marikina, Pasig, Quezon City, Taguig, and Valenzuela), Baguio City, and Tanauan, Lipa and Batangas Cities.

coordination and execution of demand generation activities; and helping to set up the referral system for adolescent and youth reproductive health services.

Establishing LGU System for Recording and Tracking Commodity Availability at the Facility-level

The DOH, in partnership with its development partners, helped in building the capacity of service providers in the management and recording system of commodities in health facilities. In particular, it helped LGUs organize and update records on the quantity of commodities received, dispensed to clients, issued to frontline service providers (i.e., midwives in Barangay Health Stations), and in stock. It allowed LGUs track commodity availability and incidence of stock-outs, and respond to commodity gaps immediately.

In Luzon, a total of 1,812 health personnel in 593 RHUs and health centers were trained by the DOH, in partnership with the development partners, on supply management and recording system.

Box 3. Results of monitoring of commodity availability in selected health facilities in Luzon

Among the staff in 593 health centers who were trained, around 78 percent were fully implementing RHU/HC-level supply management and recording system. They were able to document commodities received, commodities issued to midwives and dispensed to clients, and commodities expiring in the next 6 months. Others have just initiated adopting the system and may need

DSWD Contributions

The National Advisory Committee (NAC) of the DSWD *Pantawid Pamilyang Pilipino Program* (4Ps) issued its NAC Resolution no. 23 Series of 2014, encouraging and monitoring of at least 70% male attendance of families and couples in the family development sessions (FDS) on Responsible Parenthood and Reproductive Health (RPRH) and Violence Against Women and Children (VAWC).

Likewise, to comply further on the RPRH Law, the DSWD issued the Memorandum Circular (MC) no. 6 Series of 2015 entitled "Institutionalization of Women Friendly Space (WFS) in Camp Coordination and Camp Management". The MC has been shared to all DSWD Field Offices for their guidance and reference in the implementation of services. The WFS will serve as a venue for the delivery of convergence support services to the youth and survivors of any forms of gender-based violence, started in 2012 and 2013. Services included in the WFS are pre-natal check-ups, breastfeeding counseling, reproductive health check-ups of women of reproductive age, provision of family planning commodities, and other medical services for women.

The DSWD enhanced its current Population Awareness and Family Life Orientation (PAFLO) Manual which is being used for the Unlad Kabataan Program. The manual includes the current youth activities, RPRH Law discussion, and teenage pregnancy prevention.

The DSWD, through 4Ps, with the support of donor agencies, initiated a research study entitled, *"Assessment of Behavioral and Social Outcomes of Pantawid Pamilya"*. The research aims to assess behavioral and social changes beyond the compliance of households to program requirements as well as determine how the positive impact of the program may be sustained after its implementation period.

CSO Participation

Engagement of Civil Society Organizations (CSOs) is one of the highlights of the 2015 implementation of the RPRH Law. Through the NIT, a wide array of CSOs – community-based organizations, women's groups, health professionals groups, media practitioners, lawyers, artists groups, faith-based groups and some business people - were actively involved in the full spectrum of Law implementation, from policy advocacy and policy-making, program-development, to service delivery, community mobilization, monitoring and evaluation. Many CSOs are working in the key areas of Family Planning and Adolescent Reproductive Health. Among the key CSO accomplishments are: FP service delivery, where CSOs accounted for the provision of services to over 500,000

clients, esp. long-acting methods, such as IUD and implant; the provision of ARH counseling and services in communities where parents supported ARH services; and public information and mobilization of public opinion against efforts to restrict access to RPRH services, for example through the Supreme Court TRO and the Sorsogon City Mayor's action that de-facto stopped FP provision by the city government.

Several CSOs have jointly supported strengthening local health systems for intrapartum, family planning, and postpartum care for example, in making SDN operational in selected Joint Programme on Maternal and Neonatal Health (JPMNCH) municipalities in the country: the UP-National Telehealth Center (NTHC) for the real-time/electronic health information system; Center for Innovation, Change and Productivity (CICP Learn) to help build systems at the ground level. UNICEF worked with the Zuellig Family Foundation (ZFF) for Health Leadership and Governance Program (HLGP). Through the Bureau of Local Health Systems Development and the DOH Regional Offices, HLGP aimed at improving service delivery on Maternal Health. This allowed participating LGUs to identify current challenges and design interventions that address them. A scorecard monitoring system was employed to establish baseline and monitor progress towards expected and desired goals.

CSO active participation was made possible through the AO on the NIT in 2015, which mandated the DOH to create an enabling environment for CSOs to maximize their contributions to the RPRH program, e.g. through PhilHealth support, training, and other modalities

Annex J-33 provides a complete list of CSOs and NGOs involved in the RPRH implementation.

Challenges and Recommendations

1. ***Weak data management and monitoring and evaluation systems***. There is a need to validate and check data that are being reported at the national level to prevent duplication and over-reporting or under reporting of data from the field. There is also a need for timely submission of core RPRH performance indicators. As of 2015, there were only few health facilities where DQC have been implemented. Many of the partner agencies and units have not fully complied with the reporting requirement as specified in the prescribed format and in the PME Guide. Actual level of accomplishment may have not been completely reflected, and critical implementation gaps may also have been completely missed. The DOH and other agencies need to strengthen and sustain its efforts in monitoring RPRH implementation across the different key result areas.

   Recommendations:

   a) Identify focal persons and develop the capacity for quality data management of DOH, LGU and private/CSO managers.
   b) Tap DMOs and NDPs to ensure timely submission of program reports.
   c) Harmonize and integrate data systems.
   d) Regularly update M&E framework and guide. The draft PME Guide itself also need to be regularly updated, particularly its specifications of the monitoring indicators. The list of process and outcome indicators in the Guide may need to be adjusted as some of those included in the list are only available in the national surveys which are mostly conducted every five years, or not routinely reported by agencies and units involved in RPRH implementation. Examples of these indicators include condom use at last high risk sex among key affected population, attitudes towards wife beating, prosecuted GBV cases, prevalence of sexual/ physical violence, among others.

2. ***Need for an overall implementation plan for all participating agencies, units, CSOs, and development partners.*** The lack of an overall RPRH implementation plan hampered the overall monitoring of the various efforts of the different implementing agencies and partners, including the consolidation of plans and accomplishment reports.

   Recommendations:

a) Develop "RPRH master plan" to be used as a guide for all agencies and partners involved in the execution of the different RPRH programs at different levels. Similar to the investment planning system of the DOH and the LGUs, the NIT can draw an overall plan that can be used as a blueprint for all agencies, LGUs, development partners, and CSOs in developing their own plans. It can also be used to indicate the type and amount resources that partners should provide for RPRH implementation, and to allocate limited resources for critical investment items.
b) Establish Family Health Bureau (FHB). The FHB will provide opportunity for the DOH to fully support the NIT and RITs in coordinating the execution of the different RPRH plans and programs. In particular, the establishment of FHB at the DOH can rationalize adequate number of technical staff and amount of resources needed to assist implementing units of the different RPRH programs

3. ***Supply and distribution mismatch*.** The DOH lacks complete information on the actual consumption of commodities at the service delivery points. Although, the DOH has instituted measures to track the distribution of commodities to the various services delivery points, a more effective system of reporting commodity consumption regularly from the field is necessary to have appropriate allocations during the distribution runs coming from the central office.

Recommendations:

a) Sustain investment in logistics reform at the DOH in order to prevent stock-outs and overstocking of essential RH, MNCHN supplies and commodities at service delivery points.
b) Establish logistics management system to track commodity distribution and utilization that is demand/request-based.
c) Provide infrastructure support for RPRH commodities (e.g. warehouse, transportation, etc.)
d) Provide a clear supply-chain mechanism in the delivery of FP Commodities from the national government down to Rural Health Units (RHUs). In this way, distribution of FP commodities on the ground can be more efficient and effective.

Key Result Area 1: Maternal, Newborn, Child Health and Nutrition

Status of MNCHN Performance Indicators

Various national surveys conducted since 1993 have shown persistently high maternal mortality ratio[13] (MMR). The MMR from the 2011 FHS at 221 per 100,000 livebirths (LB) is almost at the same level with the 1993 NDHS at 209 per 100,000 LB.

Table 12. MMR estimates from national surveys

Survey	MM Ratio (per 100,000 live births)	Period covered
NDHS 1993	209	1987-1993
NDHS 1998	172	1991-1997
FPS 2006	162	2000-2006
FHS 2011	221	2005-2011

Based on partial reports in 2015, the DOH has reported a much lower rate at 78 per 100,000 livebirths, suggesting limited data capture, mostly from public facilities. The DOH 2015 MMR report, although partial, is actually higher compared to the reported MMR in 2013 and 2014 of 63 and 76, respectively. There is still a wide variation in MMR levels among regions, with ARMM as having the highest rate at 153 per 100,000 followed by Regions V and XI, at 128 and 122 per 100,000 LB, respectively. The lowest 2015 estimate of MMR is observed in CAR at 42 per 100,000 LB.

Table 13. MMR and Live Births per Region

Region	LB (Number)	Number of Maternal Deaths	MM Ratio (per 100,000 LB)
CAR	35,739	15	42
NCR	215,117	129	60
I	87,921	42	48
II	63,085	40	63
III	143,668	105	73
IV-A	168,487	128	76
IV-B	44,671	30	67
V	110,281	141	128
VI	75,064	79	105
VII	60,611	28	46
VIII	89,006	88	99
IX	79,823	50	63
X	61,895	46	74
XI	94,836	116	122
XII	88,296	59	67
XIII	57,401	48	84
ARMM	19,657	30	153
National Average	**1,495,558**	**1,174**	**78**

Source: DOH National Safe Motherhood Program, 2015

Observed performance in service utilization indicators show mixed results. Based on DOH administrative data (FHSIS), the number of pregnant women provided at least four pre-natal check-up (4 ante-natal consultations or ANC) decreased from 78 percent in 2014 to 75 percent in 2015. Pregnant women attended by professional health

[13] MMR is reported 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 cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes" (WHO, 2016).

workers during delivery (skilled birth attendance or SBA) decreased from 81 to 80 percent while women giving birth in health facilities (facility-based deliveries or FBD) increased from 75 percent in 2014 to 80 percent in 2015.

Table 14. Selected Service Coverage Indicators per Region

Regions	No. of Total Deliveries	4 ANC (%)	FBD (%)	SBA (%)	2 PNC (%)
CAR	35,770	71	93	96	54
NCR	243,058	60	85	87	73
I	90,564	97	98	96	94
II	61,357	86	90	96	94
III	148,698	95	89	92	98
IV-A	168,654	63	72	74	75
IV-B	45,061	83	75	75	72
V	115,137	74	80	81	83
VI	82,516	86	86	89	91
VII	77,246	82	62	65	71
VIII	85,152	75	88	89	91
IX	74,229	94	85	89	96
X	61,826	84	84	87	92
XI	94,620	27	42	43	44
XII	88,580	78	80	84	81
XIII	57,508	73	90	91	78
ARMM[14]	19,870	91	37	46	46
National Average	**1,549,846**	**75**	**80**	**82**	**80**

Source: DOH National Safe Motherhood Program, 2015

In 2014, PSA reported a total of 1,748,857 registered births, noting that "Figures are not adjusted for under-registration." The total live births estimated by the UN Department of Economic and Social affairs in 2015 is much higher: 2,393,061. Of the total live births, 1,549,846 were covered in DOH facilities.

Based on partial reports, more than 1.1 million women completed 4 ANC. The overall trend for the number of pregnant women with complete pre-natal check-up, i.e., at least four ante-natal care or 4 ANC, slightly declined in 2015. Marked disparities exist in the coverage, with some regions covering above 90% (Region I, Region III, Region IX, and ARMM), while one region has a coverage below 50% (Region XI).

In 2015, approximately 1.2 million women gave birth in health facility or an FBD rate of 80 percent. While an increase over 2014, this this is still short of the 90 percent target set by the Department in the National Objectives for Health 2011-2016. Achieving the target of 90% are Region I (98 percent), CAR (93 percent), Region II (90 percent) and Region XIII (90 percent). FBD rates are lowest in the two Mindanao Regions, Region XI and ARMM, at 42 and 37 percent, respectively. Though, note that FBD in ARMM is still partial report, covering 2 of its provinces only.

In 2015, around the same number of women had access to professional health care providers during delivery (skilled birth attendance or SBA), and to at least two post-natal consultations (2 PNC) at 82 percent 80 percent, respectively. Regions I, II, and III were able to surpass or at least meet the DOH 2016 target of 90 percent. 2015 SBA rate is lowest in Region XI at 43 percent.

As reported in the 2014 RPRH implementation report, the country's infant mortality rate (IMR) is declining, from 29 to 23 per 1,000 livebirths as per NDHS in 2003 and 2013, respectively.

[14]Based on partial reports, covering 2 provinces only

The immunization program benefited more than 1.7 million children in 2015. DOH reported that fully-immunized children (FIC) rate is at 77 percent as of the last quarter of 2015, lower than the 2014 rate of 85 percent, and the 2016 NOH target of 95 percent. Low immunization rate in 2015 is attributed to lack of supply of pentavalent vaccines owing to problems in the procurement of these commodities.

According to FNRI, the prevalence for both underweight and stunting among under-five (0-59 months) children has increased significantly[15] from 2013 to 2015. Prevalence of underweight children increased from 20 to 21.5 percent, while the prevalence of stunting increased from 30.3 to 33.4 percent. However, there was a significant prevalence reduction[2] among 0-59 month old overweight children. Although not significant, there was also an observed increase in the prevalence in wasting among under-five children within the same period.

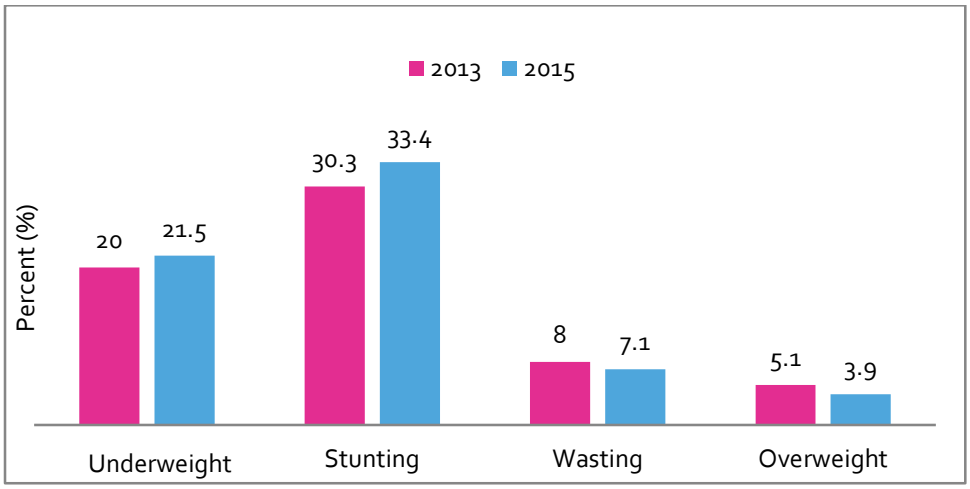

Figure 1. Prevalence of Malnourished Children, Under Five Years Old: Philippines (2013 vs. 2015), FNRI 2015

Policies Issued

Important DOH policies related to MNCHN issued in 2015 include AO No. 2015-0020 (Administration of Life-saving Drugs during Maternal Care Emergencies by Nurses and Midwives in Birthing Centers) allowing midwives and nurses in birthing centers to administer live saving drugs. Moreover, the DOH issued AO No. 2015-0021 (Deployment of Physicians Graduating from Residency Training Programs in Department of Health (DOH) - Retained Teaching and Training Hospitals) providing for the implementation of Section 6.05 of the RPRH Law, which will help augment health human resource requirements in government hospitals and other facilities located in underserved localities.

DOH Administrative Order No. 2015- 2015–0028 (Guidelines on the Implementation of the Universal Health Care High Impact Five (Hi-5) Strategy) and DOH AO No. 2015-0033 (Guidelines on the Implementation of Universal Health Care - High Impact Five Strategy for DOH Hospitals), are two of the important MNCHN policies issued and implemented by the DOH in 2015. These defined implementation of "special breakthrough services" focusing on the poor. These also provides for prioritization of direct service complemented with other interventions to reduce maternal, infant, and under-5 mortality, including reduction of HIV/AIDS prevalence and "establishment/strengthening of Service Delivery Network".

Other DOH policies on MNCHN issued in 2015 include the following:

- Department of Health Administrative Order No. 2015-0026: Implementing Guidelines for the Public Health Associate Department Program (PHADP)

[15] Statistically significant at p-value <0.05 (FNRI, 2016)

- Department of Health Department Circular No. 2015-0195: Frequently Asked Question on the Implementation of the Responsible Parenthood and Reproductive Health (RPRH) Act and its Implementing Rules and Regulations (IRR), in consideration of the Supreme Court Decision
- Department of Health Administrative Order No. 2015-0055: Management of Acute Malnutrition of Children Under 5 years

Annexes A-1, B-3, and C-4 summarize the status of policy requirements as specified by RPRH Law and its IRR.

Aside from national level policies, several regions and LGUs have developed, issued, and implemented policies to support the implementation of the RPRH Law and its IRR. Likewise, partner CSOs assisted relevant government agencies in the development of issuances on Maternal, Neonatal and Child Health with focus on ensuring quality SBA, access to BEmONC and CEmONC, including emergency transport provisions and availability of FP methods in all maternal facilities. CSOs provided support in policy development on Essential Intra-partum & Newborn Care (EINC), on the Health and Resilience of Women in disaster affected areas to address reproductive health during emergencies, among others.

Annex E-6 provides a list of the local and regional level policies related to the MNCHN components of RA No. 10354.

Demand Generation

Partner agencies implemented various activities to generate demand for MNCHN services. These activities include communication campaigns, production and distribution of IEC and advocacy materials, capacity building for demand generation, deployment of trained service provider or community health volunteers for demand generation, and multimedia campaign activities, among others.

The DOH through the Health Promotion and Communication Service (HPCS) developed a health promotion and communication plan to support the implementation of the RPRH Law. The plan specified communication strategies, which includes localization of key messages and provision of a timeline synchronized with RPRH-related activities. Moreover, the plan provided the overall guidelines in disseminating key RPRH messages through national campaign activities. The RPRH flyer was also developed and disseminated during these campaigns.

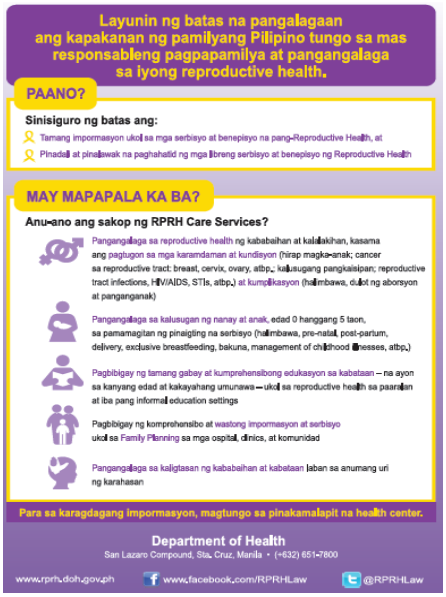

Figure 2. RPRH Flyer

The DOH-led maternal and child health communication campaigns reached 18.6 million men and women of reproductive age in 2015. Of this number, 56 percent, or 10.3 million correctly recalled the main message, "Regular check-ups for pregnant women to avoid complications and ensure health of the child."

The DOH also introduced RAIDERS or Reach & Innovate Desired Rational Scores to trace client defaulters for immunization, pre and post-natal care, exclusive breastfeeding and other MNCHN services. It served as an outreach link between the community and RHU.

Other demand generation activities including *Buntis Congress* and the KP Caravan/ Roadshows, and Family Development Sessions (FDS) were implemented in various localities in the country through the different Regional Offices of the DOH and other partner agencies and LGUs

As specified by the DOH in its Universal Health Care High Impact Five (Hi-5) Strategy, activities such as KP Caravan/Roadshows and *Buntis Congress* are "means of reaching target populations and improving access to

relevant health information, health services and commodities". The DOH launched the KP Roadshow or DOH on Wheels: *Kalusugan Pangkalahatan* since May 2014 in support of the administration's Aquino Health Agenda.

Buntis Congress was able to provide pregnant women and their partners key information on MNCHN care. It emphasized a "life cycle approach" in addressing health issues, including RPFP, oral health during pregnancy, PhilHealth enrolment, micronutrient supplementation, healthy lifestyle, vaccinations, and counseling on self-image development were all part of the activity. It also provided opportunities for target beneficiaries to avail services such as proper breastfeeding practices, newborn screening, and micronutrient supplementation. Moreover, identified high risk women were counseled and assisted in making birth plans, including referral to appropriate health facilities and providers through the conduct of this activity.

Family Development Sessions (FDS), through the 4Ps program of the DSWD, were also used as opportunity to encourage utilization of MNCHN services of beneficiary family members. FDS Sub-module 2.2, *"Pagiging Responsableng Magulang at Pagpaplano ng Pamilya"*, consists of four sessions on family planning and responsible parenthood.

The HPCS of the DOH in collaboration with WMCHDDs and CHANGE also spearheaded the maternal and child health quad media campaign focusing on the promotion of the importance of 4ANCs.

Box 4. Participants at the breastfeeding summit in Manila (Photo credit: www.PhilStar.com - file photo/Ernie Peñaredondo)

DOH continues to play a significant role in implementing and disseminating the critical provisions of RA 10028 and RA 10354 by supporting various activities that promote health of mother and children. This breastfeeding summit was held at City State Tower in

Another campaign initiated in 2015 was *"Happy Baby"* TV commercial which includes production and distribution of IEC materials such as Happy Baby poster, Happy Baby brochure, and Nanay and Baby book.

The DOH also placed ads or radio, TV and cinema on immunization, safe motherhood and breastfeeding. Social media accounts (website, Facebook and Twitter) on RPRH was developed to serve as platforms for accessing information on the RPRH law, including its programs, Frequently Asked Questions (FAQs), and IEC materials to increase awareness on the RPRH law. The DOH also conducted various media conferences (May 15-December 31, 2015) with press releases on RPRH, Safe Motherhood, Breastfeeding, Newborn Screening & Hearing, nutrition and Immunization.

The DOH and local health units conducted activities for the promotion of breastfeeding in 2015. The DOH initiated the integration of exclusive breastfeeding messages in FP/ RH communication campaigns, during ante- and post-natal care visits of mothers, and through the local immunization program when mothers bring their newborns to health facilities for vaccination. In the Visayas, an information campaign where text messages on maternal and child care including breastfeeding were sent to pregnant mothers was launched. Fifty three new breastfeeding community support groups (CSGs) were established and mobilized, bringing the total to 305. In Luzon, health providers and CSGs trained on lactation management were continuously monitored and coached by trained health workers to provide breastfeeding counseling to pregnant women. As a result, over 1 million women were reached with individual or small group level education on exclusive breastfeeding in 2015.

CSO partners also provided assistance in creating demand for MNCHN services through the conduct of various fora, community education campaigns, couples' sessions, parents' classes, exhibits on maternal health and maternal mortality. In 2015, demand generation activities organized by CSOs were able to reach more than two thousand women and young people from select communities in NCR, Palawan, Tawi-Tawi and Davao. They were also involved in the production and distribution of 40,000 pamphlets on Maternal Mortality and 3,000 copies of the policy brief on infant and young child health and nutrition as well as provided postpartum FP information for women

upon discharge. Other CSO activities on demand generation include sponsorship of radio and TV programs that discuss issues on maternal care and maternal mortality.

Annex F-10 provides a list of various demand generation activities on MNCHN supporting the implementation of RPRH law and its IRR.

Capacity Building Activities

The DOH, in partnership with other agencies at the regional and local levels, conducted various capacity building activities on MNCHN for health service providers. These activities were complemented by deployment of other health professionals to support provision of MNCHN services as specified in the RPRH Law. These activities consisted of training of health staff on various health programs related to MNCHN which includes emergency obstetric care and essential intrapartum and newborn care training, newborn screening, lactation management, and pregnancy tracking, among others.

Training activities for Service Delivery Teams on Basic Emergency Obstetrics and Newborn Care (BEmONC) were also offered to doctors, nurses and midwives working in or managing birthing centers. As of October 2015, the DOH reported that BEmONC training covered more than 1,600 facilities with trained BEmONC teams, equivalent to 94 percent of the total BEmONC facilities in the country. These BEmONC service delivery teams consisted of almost 2 thousand providers. Please see Annex F-11.

In 2015, the DOH conducted the following capacity building activities on MNCHN:

- Maternal Death Review training
- Training on Child Injury Prevention Program
- Interpersonal Communication Counselling Training on FP, MNCHN, and TB for NDP
- Lactation Management Training
- Essential Intrapartum and Newborn Care (EINC) Training
- Training on Pregnancy Tracking and FP Tracking Tool
- Training on Infant and Young Child Feeding (IYCF)
- Training on Newborn Screening (NBS)
- RPRH Budget Advocacy Training

Box 5. Maternal death review in Iloilo

In 2015, series of maternal death review sessions were conducted in Iloilo Province and Iloilo City covering 18 cases of maternal deaths. Immediate causes of death identified were cardiovascular conditions, respiratory failure, blood loss, and cerebrovascular bleeding. Fourteen out of the 18 maternal deaths were established to have been caused by not seeking or delaying the use of prenatal care, delivery services, including postpartum care. Moreover, those mothers who died failed to recognize danger signs

Assessment of these training programs conducted in selected sites showed: skilled birth attendants by training 425 health providers and 205 trainers of trainers on essential intrapartum and newborn care; 49 trainers and 343 health providers on lactation management; and 121 health professionals on BEmONC.

Post-training evaluations showed that out of 1,524 private and public sector midwives trained, 43 percent or 662 midwives were correctly practicing essential intrapartum newborn care. This is an improvement from last year's performance of 16 percent. In addition, 49 trainers and 343 health providers were trained on lactation management. Likewise, the capacity of 2,870 community health teams on interpersonal communication, pregnancy tracking, antenatal care, facility based delivery, and exclusive breastfeeding promotion was strengthened.

CSOs also provided assistance in capacity building activities on MNCHN for service providers, community health workers, barangay health workers, NFP practitioners and NGOs working on maternal and neonatal health on the topics of maternal care, maternal mortality, BEmONC, BLS, EINC, NBS, Teaching /Coaching on women's cycle pattern while breast feeding, gender, sexuality and reproductive health during emergencies, interpersonal communications and local health budget.

Annex F-12 provides a list of capacity building activities on MNCHN that were conducted through the different agencies at the regional and local levels.

Commodities Procured/ Delivered

RPRH implementing agencies and partners have procured and distributed various MNCHN commodities, drugs, supplies and materials to various facilities in the country. They also helped local service providers in in the delivery of MNCHN services to target beneficiaries, especially poor women and children.

Table 15. Micronutrient supplements from the DOH, 2015

Micronutrient supplement	Total number of target beneficiaries	Number of units procured and distributed
Vitamin A capsule 100,000 IU for 6-11 months	1,373,921	750,000 capsules
Vitamin A capsule 200,000 IU for 12-59 months	10,991,371	15,625,000 capsules
Iron Drops 15 mg elemental iron/0.6 ml for low birth weight infants	538,577	1,077,154 bottles
Ferrous Sulfate + Folic Acid tablet for anemic Pregnant women	1,513,857	272,494,260 tablets
Ferrous Sulfate + Folic Acid tablet for non-anemic pregnant women	673,845	121,292,100 tablets
Ferrous Sulfate + Folic Acid tablet for post- partum women clinically diagnosed with iron deficiency anemia	958,692	172,564,560 tablets
Ferrous Sulfate + Folic Acid tablet for 10-49 years old WRA clinically diagnosed with iron deficiency anemia	1,869,756	228,649,080 tablets
Micronutrient Powder for anemic 6-11 months	541,325	28,846,140 sachets
Iodine capsule for pregnant women	1,171,904	2,343,808 capsules
Iodine capsule for lactating women	1,004,489	1,737,404 capsules
Zinc	556,013	600,000 bottles
Oral rehydration salt	945,221	4,800,000 sachets

Source: DOH Children's Health Development Division, 2015

In 2015, DOH provided more than 12 million Vitamin A capsules for infant and children through the country as part of its micronutrient supplementation program. In the same year, the DOH also provided 600 thousand bottles of Zinc supplement together with reformulated oral rehydration solution salt for the management of diarrhea among children. Other micronutrient supplements provided by the DOH for target women and children include ferrous sulfate and folic acid tablet, micronutrient powder, and iodine capsule.

Aside from the MNCHN commodities procured and distributed through the DOH, its Regional Offices have reported providing vaccines, vitamin A capsule, ready to use therapeutic food, Mother and Baby book, ferrous sulfate and folic acid tablet, "Buntis" kits, among others, to complement the supply coming from the central office.

Annex F-13 provides a list of other MNCHN commodities, drugs, supplies and materials procured in 2015, per region.

Service Delivery

Maternal health services provided through the National Safe Motherhood Program of the DOH consist of basic packages of interventions that aim to provide safe delivery services for pregnant women and improvement in maternal health outcomes. These include pre-natal care, delivery services in health facility assisted by skilled health professionals, and post-natal care. Table 16[16] provides the accomplishment on maternal health services in 2015 as reported by the different partner agencies and CSOs.

[16] Based on the reports coming from regions as reported by the Regional Implementation Teams

Table 16. Coverage of maternal health services, 2015

Maternal Health Services	Expected number of clients	Actual number of clients	Percent covered
4 Antenatal care visits	1,549,846	1,156,611	75
Skilled birth attendance	1,549,846	1,277,333	82
Facility-based deliveries	1,549,846	1,241,621	80
2 Postnatal care visits	1,549,846	1,242,457	80

Source: DOH National Safe Motherhood Program, 2015

The WMCHDD Child Health and Nutrition Program of the DOH has initiated major activities to ensure that newborns survive to childhood and consequently have better health as they grow. Specifically, these activities refer to newborn screening for early identification of specific conditions, immunization against vaccine-preventable diseases, and vitamin A supplementation.

Table 17. Coverage of selected newborn, infant, and nutrition services, 2015

Newborn, infant, and child health and nutrition services	Eligible population	Actual number of clients	Percent covered
Newborn screening	1,800,000	1,386,775	77
Immunization (FIC)	2,335,666	1,790,415	77
Vitamin A Supplementation (6 – 59 months old)	15,012,241	9,511,754	63

Source: DOH Child Health and Nutrition Program, 2015

Newborn screening (NBS) is a procedure intended for early identification of infants who are affected by certain genetic, metabolic, or infectious conditions that may lead to morbidity or mortality if left untreated. The optional program includes screening of 28 congenital disorders. NBS Compliance to the procedures has improved since the implementation of RA 9288 at 77 percent coverage rate in 2015.

Table 18. Immunization rate per antigen, 2015

Vaccine	Rate (%)
BCG	63
Penta 1	52
Penta 2	50
Penta 3	49
OPV 1	65
OPV 2	64
OPV 3	64
Hepa B within 24 hours	40
Hepa B after 24 hours	5
Measles	66
MMR	52

Source: DOH EPI, 2015

The Expanded Program on Immunization (EPI) is a program that ensures that newborns are given the birth dose of hepatitis B and bacillus calmette guerin (BCG) vaccines. For children one year old and below, pentavalent vaccine (Penta), oral polio vaccine (OPV), pneumococcal conjugate vaccine (PCV) and measles, mumps and rubella vaccine (MMR) are given as part of the routine immunization. It guarantees the immunization of children against 7 vaccine-preventable diseases before the age of 12 months. The rate of fully-immunized children (FIC[17]) in 2015 is only at 77 percent. Measles vaccine (MV) immunization coverage is the highest among the vaccines

[17] A fully-immunized child (FIC) is a child who is immunized BCG, Penta 3, OPV 3, and Measles vaccines before reaching 1 year of age.

provided in 2015 at 66 percent, while OPV 3 is at 64 percent. Hepatitis B vaccine provided beyond 24 hours after birth has the lowest rate at 5 percent.

A study conducted by WHO and UNICEF revealed that the Philippines has eliminated maternal and neonatal tetanus (except in ARMM). Neonatal tetanus elimination means that there is less than 1 neonatal tetanus case per 1,000 LB.

Micronutrient Supplementation is meant to prevent deficiencies in vitamin A, iron, and iodine in the population, particularly among women of reproductive age and children, as these can have inter-generational consequences. For 2015, Vitamin A and Iodine, Ferrous sulfate and folic acid, micronutrient powder and Zinc were provided to more than 10 M eligible beneficiaries throughout the country.

Other services for infant and children include the Mother-Baby Friendly Hospital Initiative (MBFHI), Integrated Management of Childhood Illnesses (IMCI), and Breastfeeding and Infant and Young Child Feeding (IYCF).

MBFHI provides support to health facilities for the campaign on exclusive breastfeeding. The DOH has issued a guideline in 2007 revitalizing the Initiative in health facilities with maternity and newborn care services to boost the campaign on early initiation of breastfeeding and exclusive breastfeeding.

IMCI is a program designed to protect children from fatal complications of diarrhea and pneumonia through the provision of oral rehydration solution (ORS) with zinc and antibiotics. In 2014, at least 77% of children below 5 years old who had diarrhea and 96% who had pneumonia were affectively managed and prevented from the fatal complications of the infections. Breastfeeding and Infant and Young Child Feeding is another program for children that promotes breast feeding and proper nutrition.

Several Regional Implementation Teams (RITs) likewise reported other services complementing the MNCHN services described above. These complementary services include providing access to blood services for pregnant women during complicated deliveries for provinces in CARAGA, conduct of Pap smear for women in Naga City, and providing MNCHN outreach services to mothers and children through FDS under the 4Ps.

There were also MNCHN services provided through partner CSOs. More than 40 thousand normal spontaneous vaginal deliveries were attended by service providers from CSOs. Around 18 thousand newborn screening were conducted, and more than 37,786 services were provided on pre-natal, intra-partum and post-partum care; pap smears, sonogram and laboratory tests; breastfeeding support, and referrals, in Metro Manila and various regions.

Annex F-14 provides a list related MNCHN services as reported by various RITs.

Challenges and Recommendations

1. ***Stagnant MMR, which is higher in some regions, and which is associated with below-target coverage of basic maternal care services*** *(4 ANC, SBA, 2 PNC and FBD).* Total births attended in public facilities is less than total births, with the balance of births likely attended in private facilities or unattended by Skilled Birth Attendants. The latter are at greater risk of dying from unmanaged maternal complications.

   MMR is relatively high (over 100) in some regions, and actual deaths are high in urbanized regions. Key maternal health services declined, specifically 4 ANC and SBA; and all the national averages for the 4 maternal care services were short of the targets identified in the National Objectives for Health (2011-2016).

   Recommendations:

   a) Ensure adequate number of dedicated and trained midwives or SBAs proportionate to the estimated livebirths per town and province/city.

b) Strengthen the capacity of health providers to provide emergency care appropriate to their level, including through training and providing facilities with emergency obstetric medicines and supplies and emergency transport.
c) Continue to increase efforts in contracting private and NGO service providers in order to augment limited service capacity of local service providers. This should also be coupled with building the capacity of the DOH in the management of contracting out of services. This strategy can also address operational concerns on limitations in delivering services through the public sector including inaccessibility, lack of staff, supply shortages, fixed operating hours and limited incentives to further improve performance.
d) Strengthen the capacity of communities to identify, support and refer the most common life-threatening maternal complications.
e) Routinely undertake Maternal Death Reviews to analyse the medical and social causes of each maternal death undertake strategies in order to prevent a next one.
f) Reduce the risk of maternal mortality by reducing unintended pregnancy through the active promotion of Family Planning before and after a pregnancy, in all levels of health care.

2. ***Poor newborn, infant, child health and nutrition***. Even if infant and under-5 mortality rates are declining, the prevalence for both underweight and stunting among under-five children has increased, according to the FNRI. The rate of fully-immunized children (FIC) has also declined from 85% in 2014 to 77% in 2015.

Recommendations:

a) Assess the effectiveness of MNCHN programs, including Newborn, Infant and Child Health at the local level. This may involve unbundling health system components (health human resource, financing, logistics, governance, etc.) and identifying solutions together with other local stakeholders. Specifically, such assessment can identify operational constraints which prevent scaling up of effective strategies in demand generation, capacity building, and specific service delivery interventions.
b) Strengthen the integration in the local health service delivery of evidence-based newborn, infant and child survival strategies, including early initiation of breastfeeding, hygienic cord care, kangaroo care for preterm infants, vitamin A supplementation for infants from six months of age, and antenatal corticosteroids for preventing neonatal respiratory distress syndrome in preterm infants.
c) Actively promote breastfeeding for up to 2 years. Within the DOH organization and among its health facilities, it must promote the creation of an environment supportive of women who want to breastfeed, such as lactation stations, milk banks, etc.
Maintain links with child nutrition institutions and programs that research into and develop interventions for malnutrition, including the development and provision of dietary supplements.

Key Result Area 2: Family Planning

Family Planning Performance Indicators

Following 2013 to 2015 FHSIS reports, growth in national modern Contraceptive Prevalence Rate (mCPR) remained almost at the same level and has not been able to catch up with the increase in eligible population from 2013 to 2015. The total eligible population of women in reproductive age (WRA) grew annually by 1.9 percent for the period but CPR only increased at an annual rate of 1.78 percent. While the National Demographic and Health Survey (NDHS) results in 2013 showed a CPR of 40 percent, there were still 5.7 million women with unmet need for modern family planning awaiting 2018 NDHS.

According to 2013 NDHS, almost 99 percent of WRA know at least one method of FP. In terms of FP use, only 37.6 percent, which is equivalent to 5 million current FP users, are using any modern FP method. The most popular modern method is the pill (19 percent), followed by ligation (9 percent), and IUD (4 percent).

The use of modern FP method is increasing from 33.4 percent in 2003 to 34 percent in 2008 and 37.6 percent in 2013 (2013 NDHS).

Table 19. Current use rate of modern contraceptive method, 2003, 2008, and 2013

Method	2003 NDHS (%)	2008 NDHS (%)	2013 NDHS (%)
Any modern method	33.4	34.0	37.6
Pills	13.2	15.7	19.1
Ligation	10.5	9.2	8.5
IUD	4.1	3.7	3.5
Injectables	3.1	2.6	3.7
Male condom	1.9	2.3	1.9
Other modern method	0.5	0.5	0.9

The 2013 NDHS shows that the most current contraceptive users were provided information essential to making an informed choice: 66 percent were told about potential side effects or problems; 67 percent were advised what to do if they experience side effects or problems; and 68 percent were informed about other methods.

The public and private sectors provide an almost equal proportion of modern method users in the Philippines. The principal public sector sources for contraceptives are barangay health stations (serving 18 percent of current users), government hospitals (serving 17 percent of current users), rural health units/urban health centers (serving 12 percent of current users). Pharmacies are the principal private sector provider for contraceptives (serving 39 percent of current users), and private hospitals and clinics serving 8 percent of current users (2013 NDHS).

Despite the increasing trend in CPR, unmet need[18] for modern FP is still very high at 18 percent in 2013, where 7 percent want to space births and 11 percent want to stop giving birth. Women without any form of formal education have the highest level of unmet need (24 percent) and women with higher level of educational attainment the lowest (16 percent).

DOH administrative data (see Annex G-15) show that in 2015 the national CPR was reported at 44 percent which is higher than the 41 percent CPR reported in 2014.

[18]Unmet need for modern FP refers to women who want to space or limit births but are not using any method of contraception.

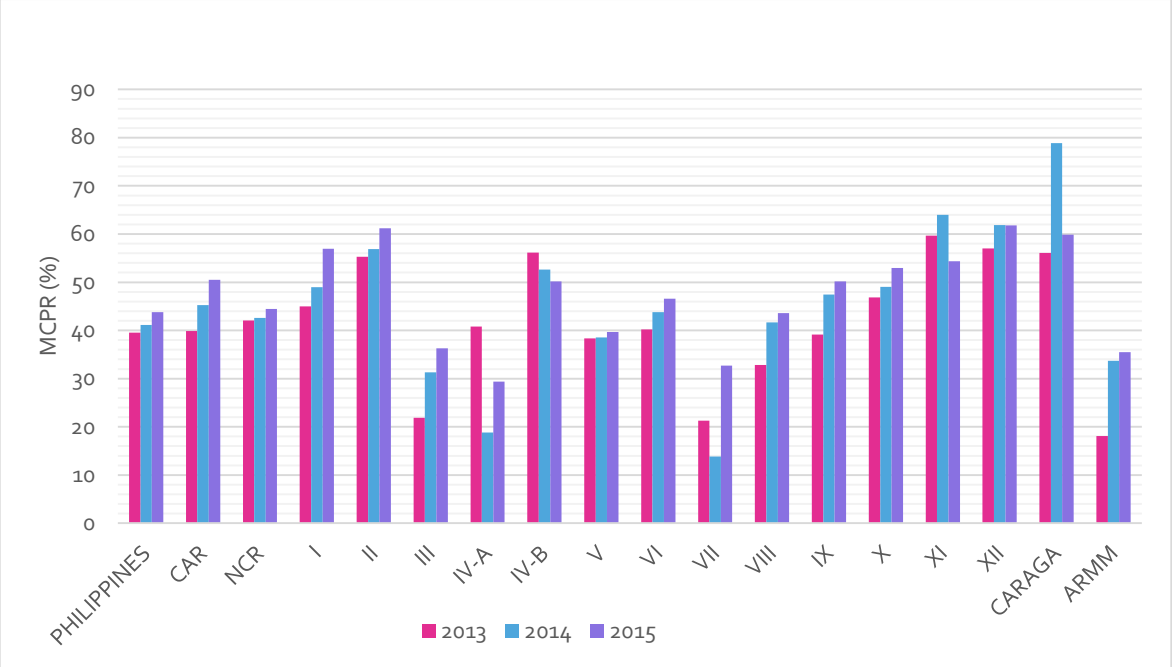

Figure 3. Modern Contraceptive Prevalence Rate (mCPR), DOH WMCHDD Administrative Data 2013-2015

The DOH Regional Offices reported (Figure 3) wide regional disparities in contraception use rate, from more than 60 in Regions II (61 percent) and XII (62 percent) to below 30 percent in Region IV-A (29 percent). It can also be observed that there are significant swings in data (e.g. sudden increases and drops) from 2014-2015 for Regions IV-A, VII and CARAGA. Eleven (11) regions showed an increased in CPR way above the national figure of the National mCPR of 44 percent. Regions I, IV-A and VII had significant increases in CPR in 2015 compared with the 2014 data. However, there were four regions who reported a decrease in CPR compared from the 2014 report. These are regions IV-B, XI, and CARAGA.

Table 20. Number of Current Users and mCPR by Region, 2015

REGION	Target Population	Total Current Users (WRA)	mCPR (%)
PHILIPPINES	**12,543,816**	**5,493,037**	**44**
I	622,782	354,731	57
II	426,898	261,271	61
III	1,392,200	505,339	36
IVA	1,814,801	533,605	29
IVB	370,269	185,727	50
V	719,368	285,247	40
VI	937,088	436,418	47
VII	916,518	299,793	33
VIII	539,277	234,963	44
IX	461,596	231,648	50
X	587,734	311,438	53
XI	608,509	330,598	54
XII	573,725	354,568	62
CARAGA	322,804	193,267	60
ARMM	433,595	153,841	36
NCR	1,599,424	710,858	44
CAR	217,228	109,725	51

Source: DOH WMCHDD Administrative Data, 2015

Table 21 shows us the trend on Modern Contraceptive Method Mix from 2013 to 2015. Data shows that the pills had increased from 36.9 in 2014 to 38.7 in 2015 and higher than the figure posted in 2013. However, it can also

be observed that CPR for IUD has dropped from 10.9 in 2014 to 8.0 in 2015. This is a reflection on certain factors affecting the provision of family planning services such as the lack of IUD commodities and instruments as well as provider training issues.

Table 21. Modern Contraceptive Method Mix, 2013-2015

Modern Method	% Share in 2013	% Share in 2014	% Share in 2015
Pills	38.3	36.9	38.7
DMPA	16.0	16.3	15.6
BTL	12.7	12.4	13.8
NFP-LAM	15.9	14.1	13.2
IUD	9.2	10.9	8.0
Condom	5.2	4.5	4.7
NSV	0.3	0.3	0.3
NFP-FAB	2.4	3.5	3.6
PSI	0.0	1.1	2.2
TOTAL	**100.00**	**100.00**	**100.00**

Source: DOH WMCHDD Administrative Data 2015

Figure 4 below shows the distribution of method mix from among the current users of family planning. In 2015, 5M women are using modern family planning methods. For the short acting methods, current use was highest for the pills (1,952,190) followed by the injectable/ DMPA (817,750), condom (251,593), Current users who accepted the long acting methods were reported for IUD (400,071), implants (100,869) prior to TRO, and the current users of permanent methods were reported at BTL(718,553), and NSV(12,863).

For the modern natural family planning (NFP), this has been divided into two clusters: (1) NFP-LAM (Lactational Amenorrhea Method); and (2) NFP-FAB (Fertility Based Awareness). In the same figure, note that NFP-LAM users was reported at 649,182 which needs further validation at the field level given the nature of how the clients are being reported without actual follow up of mothers after their initiation of breastfeeding until 6 months post-partum. NFP-FAB users were reported at 182,824.

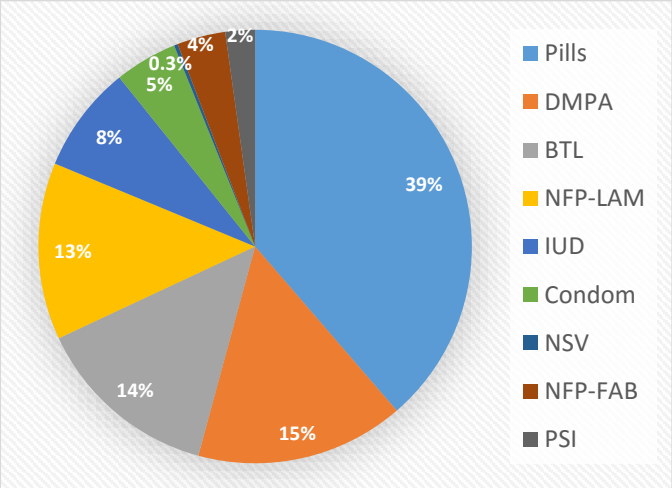

Figure 4. Current Users per Method Mix, DOH WMCHDD 2015

At the regional level, Figure 5 shows the method mix across the regions where we see that the use of oral contraceptive pill remains the most popular method of choice in the 16 regions. This is followed by DMPA and BTL. NSV remain to be the least popular method of choice as it pegged the lowest share of contraceptive use since 2013.

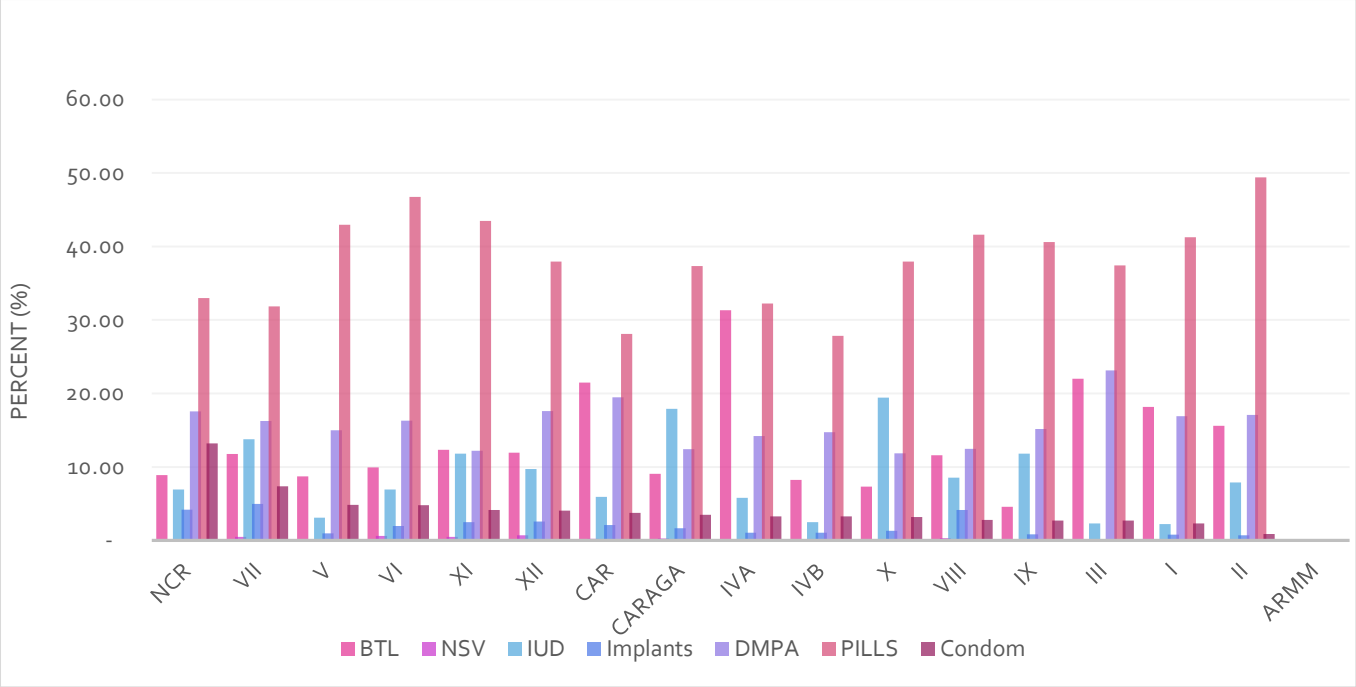

Figure 5. FP Method Mix per Region, DOH WMCHDD 2015

Policies Issued

In support of the various provisions under the RPRH Act and its Implementing Rules and Regulations, the DOH in coordination with other agencies and with technical assistance from CSOs and other development partners issued the following Administrative Orders (AO) related to Family Planning in 2015.

- Administrative Order No. 2015-0006 Re: Inclusion of Progestin Subdermal Implant as One of the Modern Methods Recognized by the National Family Planning Program. This AO provides for guidelines in introducing Progestin Subdermal Implant as a new family planning program method to both the public and private sector providers as well as program managers and key stakeholders. It specifically described the key elements on how it will be integrated in existing FP services in the field.

- Department Circular No. 2015-0300. Re: Clarification of Annex A Section 4 of Administrative Order 2015-0006 entitled "Inclusion of Progestin Subdermal Implant as one of the Modern Methods recognized by the National Family Planning Program". Note however that implementation is temporarily on hold due to the TRO issued by the Supreme Court and the DOH under the *Department Memorandum No. 2015-0216 Re: Temporary Restraining Order Regarding Reproductive Products and Implanon and Implanon NXT.*

- Administrative Order 2015-0037 Re: Guidelines on the Registration and Mapping of Conscientious Objectors and Exempt Health Facilities Pursuant to the Responsible Parenthood and Reproductive Health Act. The DOH issued these guidelines for the registration and mapping of conscientious objectors and exempt health facilities to ensure delivery of the full range of reproductive health services and minimize encumbrance to clients seeking such services.

- Department Memorandum No. 2015-0186 Re: Access to the Family Planning (FP) Commodities by DOH Regional Hospitals and Medical Centers and Provincial Hospitals. In support of the setting up family planning services in hospitals, this Department Memorandum was issued to provide guidance in the allocation and distribution of FP commodities to DOH retained hospitals

and medical centers and provincial hospitals. It also includes the allocation of FP commodities to Civil Society Organizations.

- Department Memorandum No. 2015-0174 Re: Reiteration of Compliance to the Policy On Informed Choice and Voluntarism in Delivery of Family Planning Services. The Department Memorandum directs all DOH Bureaus, Offices, Medical Centers and attached agencies and Regional Offices to organize the key staff and monitoring mechanism to observe compliance with the policy on Informed Choice and Voluntarism in the delivery of Family Planning services nationwide.

- Administrative Order 2015-0021 Re: Guidelines on the Deployment of Physicians Graduating from the Residency Training Programs in the Department of Health DOH) –Retained Teaching and Training Hospitals. This AO responds to the growing inequitable distribution of medical professionals in the urban and rural areas thru expanding its residency training programs as human resource for health complements in government hospitals in priority poor and underserved areas.

- Department Memorandum No. 2015-0341 Re: Reiteration of Access to Family Planning (FP) Commodities by DOH Regional Hospitals and Medical Centers, Provincial Hospitals and Civil Society Organizations (CSOs).This Department Memo further defines instrumentalities that will be used by Regional Offices in engaging the civil society organizations as partners in the delivery of FP services to include the use of appropriate forms such as the revised FP Form1, and the reporting forms for service utilization

- Department Memorandum No. 2015-0366. Re: Hiring of Consultants for the Fast Tracking of Service Delivery of Family Planning (FP) Services. The DM supports Section 6 of the RPRH IRR specifying the hiring and engagement of skilled health professionals for Maternal Health Care and Skilled Birth Attendance at the local levels with assistance from the DOH.

- Department Memorandum No. 2015-0357. Re: Use of the Revised FP Form 1. This DM provides instructions to all health providers on using the revised FP Form 1 as standard client record of family planning acceptors at the service delivery points.

- Department Memorandum No. 2015-0384. Re: Establishment of the Family Planning Logistics Hotline. This DM supports Section 8.10 on Tracking and Monitoring of health products purchased or received and distributed to local health systems. The FP Logistics Hotline monitors distribution and status of commodity stocks at the distribution points (local health service delivery points).

Other national agencies such as the DSWD and DILG also contributed to policy development covering FP concerns as specified in the RPRH IRR. DSWD has a finalized Memorandum Circular which deals with *Institutionalization of Women Friendly Space in Camp Coordination and Camp Management*. DILG has issued Memorandum Circular No. 2015-145: *Reiteration of Local Government Unit's Role and Function in the Implementation of RA No. 10354 or The RPRH Act Of 2012 and its IRR*. The circular addressed to all DILG field units and LGUs reiterate the observance of the RH Law's provisions to the LGUs. It also specifies that each LGU to designate a Reproductive Health Officer (RHO) and to submit all data related to RPRH implementation to the DOH.

The status of FP policy development by other agencies is provided in Annex D-5.

A total of ten (10) regional policies and forty (40) local policies that supported Reproductive Health and Family Planning in 16 Regions were reported. Thirteen (13) of the local policies were on the creation and designation of population officers/ creation of population offices. Other local policies were directed at strengthening Pre-marriage counseling (PMC) and engaging local civil societies as partners in the delivery of FP services. These policies were developed with technical assistance provided by the POPCOM, development partners as well as CSOs.

Demand Generation

Identification and response to high unmet needs across the different localities and population groups remain a challenge. Couples and individuals are said to have unmet need for modern FP if they signify their intention to space or limit their births but are not using any modern FP methods. Among the reasons for unmet need presented in the 2013 NDHS Survey are: concern about health risks or side effects; opposition to use, by either the client or her partner for personal or religious reasons; perception that they would not get pregnant because they had sex infrequently, or were breastfeeding; lack of knowledge about methods of contraception or where they could get them; and inability to obtain or afford contraceptives, among others. Lack of sustained effort to link demand generation, including information, education and communication (IEC) campaign at the community level, to service delivery is likely the main reason for the high level of unmet need for modern FP despite the demand generation interventions.

Demand generation activities can be divided into two major approaches. These are through 1) face to face approach, and 2) conduct of multi-media campaigns and other big events. Identifying clients with unmet need for modern FP is done during RPFP classes, "*Usapan Serye"*, PMC, and other demand generation activities.

In 2015, the Commission on Population (POPCOM), together with other agencies and partners continued its support of the identification of clients with unmet needs and referral for appropriate services thru the following activities.

Mobilization of Health Workers, Population Workers and Community Volunteers for FP .With POPCOM's Guidelines on Linking Demand Generation to Service Delivery, health workers, population workers and community volunteers are mobilized to conduct RPFP classes, identify couples and individuals with unmet need for modern FP and refer these clients to the nearest facilities for their needed FP services.

RPFP Classes. The RPFP classes are demand generation activities conducted under the *Kalusugan Pangkalahatan* (KP) and the *Pantawid Pamilyang Pilipino* Program (4Ps). This activity is spearheaded by POPCOM, in coordination with DSWD, and implemented at the community level by a team composed of a population worker, community volunteer and health service provider. A memorandum of agreement on data sharing was signed between POPCOM and DSWD to assist in planning for recipient families of the RP/FP FDS classes using Sub-module 2.2. House-to-house visits were also done by community volunteers to follow-up clients of their unmet need for modern FP and to accompany them to the nearest health facility.

For the first category of demand generation activities, POPCOM in partnership with DSWD and the LGUs, conducted RPRH classes for 4Ps beneficiaries which reached 599,310 clients. In addition, there were 101,425 NHTS Non-4Ps clients who were reached. POPCOM together with the LGUs also conducted Pre-Marriage Counseling (PMC) which reached 117,583 couples. Interactive sessions such as the "*Usapan Serye*" were able to reach around 25,063 clients. From these number of clients reached, POPCOM was able to identify 208,654 individuals with unmet need for modern FP. Of those who were identified with unmet needs 99,777 individuals were referred and served at the various health facilities.

POPCOM further reports that these activities were conducted in 55,493 barangay classes through the Regional Population Offices (RPO), LGUs and partners CSOs.

Table 22. Unmet Need for Modern Family Planning vis-a-vis Served Couples and Individuals

Region	No. of women with unmet need	Number of clients served with FP service	% of unmet need served
CAR	2,729	2,130	78
NCR	20,197	19,058	94
I	11,147	5,707	51
II	3,399	507	15
III	5,325	3,241	61
IV-A	16,878	5,680	34
IV-B	2,977	334	11
V	18,333	10,860	59
VI	18,526	12,536	68
VII	18,055	2,641	15
VIII	25,041	8,878	35
IX	12,875	9,055	70
X	9,245	998	11
XI	1,762	2,660	151
XII	2,750	4,659	169
XIII	26,312	2,284	9
ARMM	13,103	8,549	65
National	**208,654**	**99,777**	**48**

Source: POPCOM Database for 2015

In addition to these initiatives, the US Government (USG) assisted sites also reported the conduct of Usapan Serye in 28 provinces/ cities. "Usapan" sessions enable local health service providers to provide information, counseling services and commodities to clients with unmet need for FP and MNCHN information and services. These sessions are facility-based or outreach themed group discussions coupled with inter-personal communication and counseling and provision of services. These themed sessions include" *Usapang Pwede Pa"*, "*Usapang Tama Na"*, "*Usapang Buntis"*, and "*Usapang Maginoo"*. In 2015, over 441,777 men, women and youth were reached in various "Usapan" sessions conducted in the regional implementation sites assisted by development partners like the USAID. In Luzon, there were 137, 074 clients reached, in Visayas 228,315 clients and Mindanao 76,388 clients. Table 23 provides the number of clients reached through the "*Usapan Serye*".

Table 23. Number of clients reached thru *Usapan Serye* in USG-assisted Sites, 2015

	Youth (15-24 years old)	Men	Women	Total
Luzon	65,447	29, 204	42,423	137,074
Visayas	76,792	9,208	142,315	228,315
Mindanao	27,487	11,475	37,426	76,388
Total	169,726	49,887	222,164	441,777

Multimedia Campaign for Family Planning Services

The DOH developed an overall campaign strategy in 2014 promoting the implementation of the RPRH Law. The campaign was developed and launched in two phases. The DOH developed FP campaign message in 2015 with the theme **"***Ang Planadong Buhay ay Maayos na Buhay***"** targeting couples who either want to space or limit their children, and delivered through TV, radio and prints. CSOs and the private sector were encouraged to participate in this effort. The overall objective of the plan is to motivate target audiences to use modern FP methods for proper timing and spacing of pregnancies, and for achieving the desired number of children for a better quality of life. Phase 2 of the campaign focused on "debunking myths and misconceptions about FP methods" that included: production of the FP TV commercial and pull out videos that aimed to run simultaneously on mass media and community based health classes and *Usapan* sessions; development of IEC materials and job aids for health

service providers of FP; development of the flip-tarp which contains key health messages on FP and MCH as well as the RPRH law to be used in "*Usapan"* sessions and health classes in facilities and health centers.

The promotion also included use of social media such as Facebook, Twitter, YouTube, including through other forms such as billboards and mobile media gadgets. The multi-media campaign was complemented by Interpersonal Communication and Counseling (IPCC) by health workers, which is aimed at changing behaviors of individual clients on FP.

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

POPCOM offices were also engaged in quad-media (TV, radio, web and print) in reaching out to targeted audience for RPFP, through press releases, radio interview programs and television interviews as well as web-based communication through the maintenance of websites and social media accounts. The TV commercial "*Inakup, Arekup*" which was aired in 2014 was again aired in August 2015 in celebration of FP month.

FP demand generation was also intensified through multimedia awareness campaign. Press releases and advertisement on population issues and concerns, with emphasis on RPFP, were aired in local radio stations and published in local newspapers:

- *Overpopulation crisis: Filipinos projected to reach 101.4m in 2015; highest growth rate in SE Asia,* Posted on January 5, 2015, kickerdaily.com
- *Bilang ng mga Pinoy ngayong taon papalo na sa 101.4-M,* Jerald Ulep Posted in Latest News Monday, 05 January 2015, BomboRadyo
- *PH population expected to hit 101.4M in 2015* ,Nancy Almasco, Manila Channel
- *PSA, muling magsasagawa ng Population Census*, PTV4, News@1, August 24, 2015, YouTube.com
- *POPCOM celebrates family planning month*, Thursday, 27 August 2015 11:21, Zamboangatoday.com
- *PHL population now at 101.8M —National Census*, September 13, 2015 3:12pm, GMA Network
- *Davao reducing high rate of teenage pregnancy*, Thursday, October 22, 2015, Sun Star-Davao
- *Editorial: Peer counseling and teenage pregnancy*, Friday, October 23, 2015, Sun Star-Davao
- *"Gaano karami ang mga Pilipino?"*, PTV4, Radyo Bisyon, Video
- *Manila Bulletin receives award from POPCOM,* December 12, 2015
- *Bandila: Why Metro Manila may become unlivable in 4 years*, You-Tube.com

Promotional items were also produced and disseminated and materials in print, video, audio, and other media were fabricated in 2015. Copies of these materials were produced and distributed to LGUs, partner agencies and end-users. POPCOM produced and distributed the following IEC materials to diff partners: 900,000 copies of RPRH comics; 312,500 copies of five types of family planning brochures at 62,500 copies per type; 70,000 copies of family planning posters; and 120,000 copies of all family planning methods posters.

A series of dialogues was conducted between and among CSOs in order to map resources which could assist the government to facilitate actions directed to addressing demand for services for Reproductive Health and Family Planning. POPCOM issued Operations Guidelines to its Regional Offices for CSO Engagement for Addressing Unmet Needs for Modern Family Planning. A total of sixteen (16) Memoranda of Agreement were forged in 2015 with 5 CSOs covering 10 regions which undertook demand generation and service delivery. Said initiative will be sustained, improved, and expanded next year.

CSOs also assisted in conducting fora, community education, family health sessions, RPFP Classes, women's health congress, among others to raise awareness on FP. Most of the activities are linked to encouraging

participants to seek FP services. Through this arrangement, CSOs were able to provide FP services to 5,680 women, young people, and men from Manila, Malabon, Pasay, Bulacan, Laguna, Cagayan de Oro, Metro Cebu, Catbalogan, Iligan, Davao, Ozamiz, Palawan and Tawi-Tawi.

Capacity Building

The availability of trained and competent providers is an essential element to address unmet needs for family planning. The challenge is scaling up the number of competent providers due to inadequacies in establishing certified training institutions to support training activities nationwide. Efforts have been initiated in 2014 to engage and certify institutions as training partners of the DOH to implement Administrative Order 2014-0041: Guidelines on the Recognition of Training Providers by the DOH that was issued in October 2014. The Philippine Clinical Standards for Family Planning was updated by including the June 2015 MEC. This paved way for updating and revisions of FP competency-based training courses including the modules and materials which was approved in 2015.

The following training courses were offered by the DOH training centers and accredited training institutions in 2015:

- Competency-Based FP Training level 1 (FPCBT 1): Interpersonal communication, counseling, screening and provision of FP services for modern FP methods (COC, POP, injectables, condom and modern fertility awareness-based methods (NFP), LAM); counseling for other long acting and permanent methods.
- Competency-Based FP Training Level 2 (FPCBT 2): interval IUD insertion and removal; counseling, screening and provision of IUD insertion and removal during the interval period.
- Competency-Based FP Training level 2: Post-Partum IUD Insertion; counseling, screening and insertion of IUD during the immediate post-partum period.
- Competency-Based FP Training level 2: Minilap under Local Anesthesia; counseling, screening and provision of bilateral tubal ligation using the Minilap technique.
- Competency-Based FP training level 2: No Scalpel Vasectomy; counseling, screening and provision of Vasectomy using the No Scalpel Technique
- Competency-Based FP Training Level 1: NFP
- Training of Trainers (TOT): Didactic Training on Adult Learning Teaching techniques, facilitating, mentoring and coaching in class room and clinical setting and Competency-Based Practicum on Clinical Training Skills with actual conduct of the different CBT-FP Courses
- Refresher Course and Training of Preceptors for PPIUD and IUD practicum training

Training of trainers and health service providers in family planning and reproductive health were also conducted in USG-assisted projects. These projects are being implemented by regional implementing partners covering 28 provinces in Luzon, Visayas and Mindanao. In 2015, the projects reported training over 3,500 trainers and service providers in FPCBT1 and FPCBT2 (Table 24).

Table 24. Number of Trainers and Service Providers for FP CBT levels 1 and 2, 2015

	FP CBT 1		FP CBT 2	
	Trainers	Service Providers	Trainers	Service Providers
Luzon	148	494	52	324
Visayas	0	187	74	276
Mindanao	186	578	286	930
Total	334	1,259	412	1,530

Table 25 shows the total number of service providers trained on the various FP courses that were conducted by the DOH Regions, accredited training institution, development partners, CSOs and LGU in 2015. A total of 1570 service provider were trained in 2015. Of the total number, sixty percent (952) were trained on the basic FP CBT Level 1 training. Twenty percent were shared by FP CBT2 training for PPIUD (174) and interval IUD insertion (154) training while fifteen percent (242) were trained on the new program method Progestin Subdermal Implant insertion.

Table 25. Number of Service Providers Trained on the various FP Courses, 2015

Regions	Service Providers Trained						Total Number of Providers Trained
	FP CBT1	FPCBT2		PSI	BTL	NSV	
		Interval IUD	PPIUD				
Luzon	761	154	52	85	19	-	1071
Visayas	60	-	80	104	17	4	265
Mindanao	131	-	42	53	8	-	234
Total	**952**	**154**	**174**	**242**	**44**	**4**	**1570**

Source: Consolidated Reports from DOH Regional, Development and CSOs, 2015

Commodities Procured and Distributed

Since 2013, the DOH has been centrally procuring FP commodities that are then distributed to various service delivery points. In 2015, the DOH distributed FP commodities to public facilities like RHUs, hospitals, and CSO FP providers. The following are the quantity of commodities distributed by the DOH: 11,125,623 cycles of *Combined Oral Contraceptive (COC)* pills; 1,338,162 cycles of Progestin Only Pills (POP); 3,228,950 vials of DMPA or injectables; 82,918 IUDs; and 449,464 Progestin Subdermal Implants (PSI) (See Annex G-17 for the regional breakdown of distribution).

Some of the DOH Regional Offices procured various modern FP commodities to augment the supply coming from the DOH Central Office. The procurement, distribution and use of these commodities were in accordance with existing government rules and regulations. These also include recertification of FP commodities by the Food and Drugs Administration as non-abortifacient, as required by the RPRH Law.

In addition, UNFPA donated 74,546 subdermal implant (PSI) units to POPCOM, other DOH-retained hospitals, LGU health facilities and CSOs providing FP services. These were then translated to PSI users. Note, however, that in June 17, 2015, a Temporary Restraining Order (TRO) was issued by the Supreme Court preventing the DOH and all other agents and representatives from "*granting any and all pending application for reproductive products and supplies, including contraceptive drugs and devices; and procuring, selling, distributing, dispensing or administering, advertising and promoting the hormonal contraceptive Implanon and Implanon NXT*".

Distribution of Progestin Subdermal Implants were temporarily put on hold after the issuance of the TRO. The issuance of the TRO has affected not only the provision of PSI services at the service delivery level but eventually will impact on the availability of all FP commodities in the local market. This has to be addressed with urgency at the national level.

Commodities that were proposed for procurement in 2015 by the DOH are expected to be delivered in the 1st quarter of 2016 to the service delivery points. CSOs can also access and utilize DOH FP commodities delivered to the DOH Regional Offices as provided in the DOH Department Memoranda (DM) No. 2015-0186 and DOH DM No. 2015-0341 (See Annex G-17).

The DOH, with technical assistance from development partners established a Technical Working Group for Supply Chain Management. In addition to recommending evidence-based policy and operational reforms, USAID further assisted in establishing a tracking system for family planning commodities. Through the FP Hotline, reports from the field via emails, phone calls, short messaging system and Facebook posts, the Department of Health is alerted when there are stock outs and low stock levels in specific geographic areas and facilities, enabling a rapid response to replenish stocks. While the FP Hotline provides a quick assessment on commodity stock status on the service delivery level, however, there is a need to establish a more long term system that will be able to track field level consumption data to capture the commodities that are actually being required in the service delivery points. This way a more realistic way of computing allocation of FP commodities based on actual MFP needs will be more effective.

In 2015, there were a total of 1630 service delivery points listed as recipients of commodities that were allocated. The allocation was based from computing unmet needs (projected data) given the lack of information on the actual FP requirements from the field level.

Table 26 provides us with information on the status of FP commodities delivered in 2015. As of December 2015, 40 percent of the allocated FP commodities reached the designated service delivery points (SDP) per region 51 percent were reported in transit. There were 6 Regions who were able to reach 75 percent and above completion rate (Regions I, II, III, IV-B, XIII, and NCR).

Table 26. Report on Status of FP commodities delivered per Region, 2015

Region	No. of Recipients	Delivered	In-Transit	% of Completed Deliveries
I	125	109	16	87
II	93	80	13	86
III	130	104	26	80
IV-A	142	83	59	58
IV-B	72	53	19	74
V	114	54	60	47
VI	133	90	43	68
VII	132	23	109	17
VIII	143	0	108	0
IX	72	4	68	6
X	93	0	93	0
XI	49	33	16	67
XII	50	15	35	30
CARAGA	73	65	8	89
ARMM	115	69	46	60
NCR	17	15	2	88
CAR	77	0	77	0
TOTAL	**1630**	**797**	**833**	**49**

Service Delivery

In 2015, various efforts to have stronger links between demand generation and service provision were established. POPCOM continued to track identified clients with unmet needs who are referred for appropriate FP services in the communities. Based from POPCOM database, a total of 208,654 clients were identified with unmet needs through the various demand generation activities. This is being monitored through the use of reporting forms which are being accomplished at the local levels. Of this number of individuals, 99,777 were referred and served. These are validated by health service providers in the service facilities. Reports are then consolidated at the regional and central level.

The DOH through its Regional Offices also provided enabling mechanism to support the delivery of appropriate FP services to priority clients (NHTS poor) at the local levels in 2015.These support activities included training of service providers, procurement and distribution of family planning commodities to 1,630 of RHUs as FP service delivery points.

While service delivery initiatives are being supported, actual use of FP services and commodities is still hampered by the following operational issues:

- Gaps in the scale up of competent providers due to inadequacies in the monitoring and certification process brought about by the lack of training providers as post-training supervisors/ monitors
- Lack of appropriate instruments/ supplies to provide FP services (e.g. IUD kits) after training
- Lack of certain FP commodities (e.g. IUD) brought about by delays in the procurement process at the national level including product certification and recertification

- Poor recording and reporting of clients

Based on facility reports in US Government (USG)-assisted sites in 2015, there were 1,818 facilities (87 percent) who were providing counseling and FP services out of the 2, 084 facilities in the project sites. Facilities counted are those providing FP counseling by a provider trained on FPCBT1; providing at least two FP methods; and with a referral system in-place for methods not available in the facility.

Table 27. Facilities providing counseling and FP services in USG assisted project areas, 2015

Area	Total No. of facilities covered	Number of facilities providing counseling and FP services including referrals	%
Luzon	885	779	88
Visayas	452	418	92
Mindanao	747	621	83
Total	**2,084**	**1, 818**	**87**

In 2015 and with the issuance of policies engaging private sector in the service delivery networks, there were 13 CSOs (*PSPI, ZFF, Likhaan, ROH, PFNFP, ZOTO, PCPD, Kakammpi, TFI, C4RH, FriendlyCare, IMAP, BWC)* who were engaged by the DOH and POPCOM to provide FP services which opened more opportunities to expand service delivery from the public sector to the private sector groups. The CSOs provided clinic and outreach FP services in various areas in Luzon, Visayas and Mindanao. Some outreach FP services in partnership with various LGUs and LGEs nationwide. A total of 710,564 FP commodities and services were provided: Pills - 77,190; DMPA -47,542; IUD - 531,319 ; SDI - 13,535; condoms - 1,268; BTL - 21,105; NSV-528; NFP -14,785; all methods-329; referral for FP - 67; FP counselling - 2,896.

In support of the delivery of FP service in public and private facilities, PhilHealth reported on the following accreditation of service facilities/ providers of maternal health services including family planning. PhilHealth accreditation offers reimbursements to both providers and facilities to ensure quality health care delivery for RPRH in general and family planning in particular.

Table 28. Number of PhilHealth accredited institutions as of Dec. 2015

Facility	Number of accredited facilities
Hospitals	1,172
Infirmaries	715
Maternity Care Package providers	2,981
Primary Care Facility providers	2,553

Source: Stats and Charts 2015 PhilHealth, website: www.philhealth.gov.ph

Challenges and Recommendations

1. ***Legal barriers to the provision of FP supplies and services.*** One of the major challenges that the family planning program faced in 2015 is the issuance of the temporary restraining order (TRO) by the Supreme Court on June 17, 2015. Aside from the restrictions imposed on the provision of progestin subdermal implants (i.e. Implanon, Implanon NXT) as a new FP program method, it has also prohibited the Food and Drug Administration (FDA) from certifying and recertifying other FP commodities. As a result the other modern artificial methods that are expiring and would need recertification may not be available in the local market (both public and private). The DOH has requested the Solicitor General to petition the Supreme Court for immediate resolution of the case.

   Recommendations:

   a) Mobilize other sectors to lobby for the lifting of the TRO.
   b) Maximize the capacities of CSO and private providers to provide RPRH services including implants.

2. ***Lack of effective FP service delivery, especially in regions with low CPR.*** The challenge remains in linking identified clients with unmet MFP needs to access to appropriate service providers.

   Recommendations:

   a) Assess the problems being encountered in those areas reporting low CPR.
   b) Institute the enabling mechanisms/ support systems such as availability of trained and competent providers, availability of instruments/medical supplies in all service delivery points, both in the public and private sector.
   c) Accurate data recording and reporting of clients on a regular basis.
   d) Close monitoring to improve the regional performance in addressing unmet MFP needs.
   e) Strengthen public-private partnerships.

3. ***Variable training standards and requirements (e.g. requirements for certification of trained providers, provision of instruments after the training) and expedite FP training and licensing/accreditation.*** A major concern in the issuance of the training certification of service providers is the failure to conduct post-training evaluation to assess the competency of clients after their return to their respective posts. This is an operational issue brought about by the lack of training providers in the region, hence the scaling up of the number of competent and proficient service providers has not improved during the year. Also, there is no updated list of trained healthcare providers on FP.

   Recommendations:

   a) Encourage mentoring and supportive supervision process
   b) Invite and engage more private institutions or professional groups who are willing to be certified and accredited by the DOH as credible training providers.
   c) Ensure availability of instruments and commodities after the FP training
   d) Establish database of certified FP service providers

4. ***Lack of nationally-led behavior change communication campaign and effective demand-generation strategies***. Communication campaigns are quite costly. There were several demand generation activities that were conducted at all levels to promote FP program implementation. However, demand generation and the high level of awareness did not translate to behavioral change and utilization of service.

   Recommendations:

   a) Assessment of these communication approaches be conducted to determine which are most effective
   b) Re-strategize on which media will be most effective to reach the clients.
   c) Link every demand generation activity to service delivery
   d) Mobilize community stakeholders
   e) Support and replicate CSO best practices

KRA 3: Adolescent Sexual and Reproductive Health

Status of ASRH Performance Indicators

The Philippines has the third highest adolescent fertility or birth rate in Southeast Asia for the period 2006-2013 (Figure 6). Adolescent birth rates either declined or remained unchanged in Southeast Asian countries for two decades (1990-2010) except in the Philippines where the figure even went up from 51 to 54.1 births among 1,000 girls aged 15-19 years old for the period[19]. The 2013 National Demographic Health Survey (NDHS) – the most recent data available, showed that one in ten Filipina women 15-19 years old is either a mother already or pregnant with first child. This translates to over half a million teenage mothers for that year, a ten percent increase from the 2008 NDHS figure of over 460,500[20]. According to the World Health Organization (WHO), young mothers are more vulnerable to maternal deaths, stillbirths and other pregnancy complications. They may also put their child's life at risk as these young mothers are more likely to have low birth weight infants.

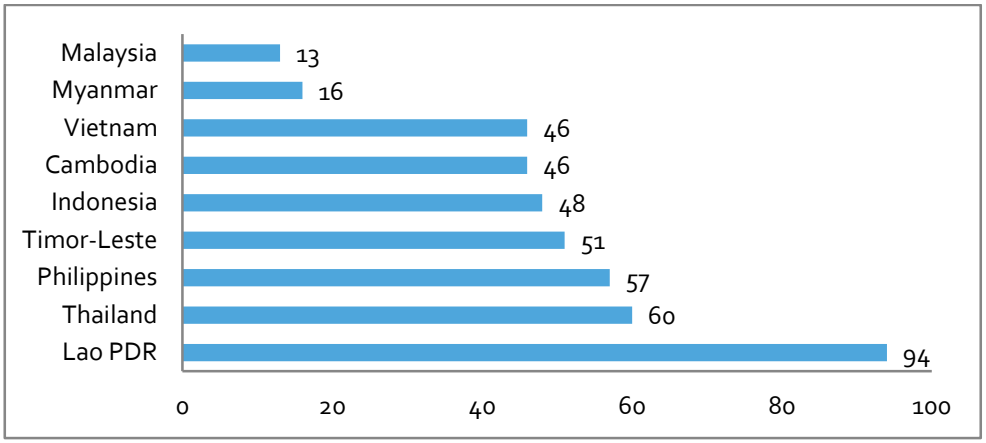

Figure 6. Adolescent Fertility Rates in Southeast Asia, ***DHS and MICS surveys, 2006-2013, UNDP Fertility Report, 2013***

While the 2013 NDHS reported a decline in the percentage of women aged 20-49 years old who had sexual initiation by age 15 from 2.7 percent in 2003 to 2.4 in 2013, the percentage of those who had first sexual encounter by 18 grew from 17.6 percent to 18 percent. The 2013 Young Adult Fertility and Sexuality Study (YAFSS) showed 78 percent of youths surveyed did not use any form of protection against sexually transmitted diseases during their first sexual intercourse.

On HIV/AIDS, the 2013 NDHS showed that only one percent of sexually active young women aged 15-24 years old were tested for HIV in the 12 months preceding the survey. Using the 2015 data of the HIV/ADIS Registry of the Philippines, less than half (43 percent) of the estimated 18,983 adolescents and young people with HIV infection were actually diagnosed (see Table 29). It was observed that only a few adolescents showed up in testing centers and those who were interested in having themselves tested were constrained by the required parental consent for HIV mandated by RA 8504 or the Philippine AIDS Prevention and Control Act of 1998

[19]Based on the United Nations Department of Economic and Social Affairs, Population Division (2013)
[20] First Annual Consolidated Report on the Implementation of the Responsible Parenthood and Reproductive Health Act of 2012; Figures based on 2008 and 2013 NDHS

Table 29. Estimated VS Diagnosed HIV Infections among Adolescents

	Age (in years)			
	15-17	18-19	20-24	TOTAL
Cumulative estimate of HIV infections by December 2015	5,735	3,824	9,424	18,983
Diagnosed with HIV	123	813	7,158	8,094
Diagnosed/Cumulative estimate	2%	21%	76%	43%

Source: DOH Epidemiology Bureau and HIV/AIDS Registry of the Philippines

The RPRH Act of 2012 identified three elements explicitly pertaining to adolescent sexual and reproductive health (ASRH):

- RH Element No. 4: Adolescent and youth reproductive health (AYRH) guidance and counseling at the point of care
- RH Element No. 7: Age- and development-appropriate education and counseling on sexuality and reproductive health, and
- RH Element No. 11: Age- and development-appropriate reproductive health education for adolescents in formal and non-formal educational settings

Successful integration of these elements in AYRH programs is expected to contribute to: (1) increased number of schools and other alternative learning facilities (including teen centers) providing minimum standards comprehensive sexual education (CSE) minimum standards; (2) reduced percentage of young women aged 15-24 years old who had sexual intercourse before age 15, and c) reduced percentage of youth who did not use any form of protection during sexual initiation. All these are expected to contribute to reducing adolescent birth rate – an ASRH impact specified in the RPRH Law Implementation: Planning, Monitoring and Evaluation or PME Guide 2015.Philippine performance in these areas in 2015, however, cannot be fully ascertained for various reasons.

First, the Department of Education (DepEd) has not yet developed the CSE minimum standards to be complied with by schools and alternative learning facilities. Secondly, data for the indicators on teenage girls who had sexual intercourse before the age 15, and use of protection by youth at sexual initiation are collected only every five years through the NDHS and YAFSS. Service delivery points in local government units may have data to track impact (e.g. number of teens who got pregnant in a year, completed at least 4 prenatal care visits) but these are not centrally consolidated and routinely collected. While critical indicators on FP/MNCHN such as antenatal care visit, facility-based delivery and use of modern family planning are annually submitted to the DOH Central Office, they are not age-disaggregated, preventing monitoring of MNCHN services provided to adolescents and young people.

Policies issued

In response to the need for the operationalization of policies listed under RH Element No. 4: AYRH guidance and counseling at the point of care, the DOH is developing the Manual of Operations for implementing AO 2013-0013 or the National Policy and Strategic Framework on Adolescent Health and Development (AHD), in consultation with health care providers and concerned stakeholders. It is expected to provide guidelines in translating national AHD strategies into local programs, projects and activities for reducing adolescent birth rate and improving adolescent health and wellbeing.

DepEd has already included CSE in its K-12 curriculum although it has not yet adopted the CSE standards developed by a panel of experts in consultation with teachers, parents, RH providers and the adolescents themselves. Teachers have yet to be trained on how best to deliver age-specific CSE within the K-12 curriculum. According to UNESCO, CSE that is scientifically accurate, culturally and age-appropriate, gender-sensitive and life skills-based can provide young people with the knowledge and skills to make informed decisions about their sexuality and lifestyle. It reduces risk-taking behaviors among those who are sexually active.

A related initiative at the local level is the five-year module on sexuality education developed by the Cavite Provincial Health Office (PHO) and IMAP based on K-12 health competency requirements. Private midwives were

tapped in demonstrating the use of the module during the Music, Arts, Physical Education and Health (MAPEH) subject in five public high schools. Panel survey results that the intervention significantly increased adolescents' willingness to talk about sex-related matters with responsible adults. A number of LGUs have already started to use this module.

In addition, DepEd developed its Policy and Guidelines for Comprehensive Water, Sanitation and Hygiene in Schools (WINS) Program in 2015. It was issued in 2016 to all private and public elementary and secondary schools nationwide including Learning Centers through DepEd Order No. 10, s. 2016. It aims to improve health outcomes among students through scalable school-based water, hygiene, sanitation and deworming program. It directs all concerned schools to have clean water as well as support mechanisms for handwashing and effective menstrual hygiene management, among others.

To expand delivery of ASRH services, the DSWD developed its Youth Development Session (YDS) module which is a parallel intervention to DSWD's *Pantawid Pamilyang Pilipino Program* (4Ps) Family Development Session (FDS). It aims to empower the youth, especially high school student beneficiaries by educating them on topics concerning self-esteem, personality, skills and even responsible parenting. Pilot modules on teenage pregnancy, substance abuse and changing bodies form part of the 11 modules to be undertaken in the YDS program nationwide. YDS is conducted once a month and will be used as a program conditionality. DSWD also enhanced its Population Awareness and Family Life Orientation (PAFLO) Manual for the "*Unlad Kabataan"* Program, which aims to help out-of-school youth and other disadvantaged youth to become self-reliant, economically productive and socially responsible. The Manual covers youth activities and discussions on the RPRH law as well as teenage pregnancy prevention.

A notable policy at the regional level to improve monitoring and evaluation of ASRH program is the National Economic and Development Authority (NEDA) resolution requesting PSA to direct its provincial offices to support POPCOM IX in building its database on teenage pregnancies. This is important given the lack of regular and reliable data on ASRH.

Demand generation

Most of the policies, programs, projects and activities pursued by national and sub-national government focused on the generation of demand for ASRH. These include among others, policies supporting the implementation of Interactive Peer Educations Sessions, the establishment of functional youth centers and support to youth events aimed at addressing issues of teenage pregnancies. POPCOM also launched its U4U Teen Trail initiative developed by UNFPA covering in-school and out-of-school youth, "*UsapTayo*", Festivals of Talents and film festivals to create awareness on adolescent health and youth development concerns.

At the forefront of demand generation for ASRH are proactive LGUs that have implemented programs aimed at making adolescents aware of health issues concerning them, instilling life skills that would enable them to make informed decisions, and linking them to available ASRH services at their communities. These programs include the conduct of Adolescent Health Summits, Youth Symposia on ASRH concerns, interactive peer education sessions, events that harness the youth's creativity in raising ASRH awareness and health information sessions that instill positive health seeking behaviors amongst adolescent mothers. Implementation of these local initiatives was supported by various civil society partners, concerned national government agencies and development partners.

Collaboration between the DOH and a US-based partner, a local academic institution and a local advertising agency strengthened the communication skills of DOH Regional Offices, PhilHealth, POPCOM Offices, and provincial as well as municipal health staff. One of the activities of this collaboration - the Communication for Communicators course – resulted in the development of 23 local communication projects on adolescent and youth reproductive health.

The DOH campaign "*Babae Mahalaga Ka"* is one of the few initiatives for increasing adolescent access to specific health services (i.e. cervical screening and HPV vaccination) that is backed by clear operational and institutional support.

Capacity Building

To translate the demand being generated for ASRH to actual service delivery, a number of capability enhancement activities for health care providers and peer educators/facilitators were conducted by the DOH, POPCOM, CSOs and development partners in 2015. Training on the use of the use of the Adolescent Job Aid (AJA) Manual covered 673 ASRH service providers. This manual is an essential tool for health workers to be able to provide comprehensive adolescent-friendly health services. The DOH also trained 194 health care providers on comprehensive skills development on adolescent health for health care providers, which supplements AJA. A number of Peer Educators and Counselors' Training on ASRH were also conducted targeting students, young people, school nurses and guidance counselors. Trained counselors and peer educators are key components for the operations of the Teen Centers and also facilitate the conduct of demand generation activities such the U4U Teen Trail.

POPCOM, in partnership with the LGUs and DepEd, likewise conducted trainings on the Learning Package on Parent Education on Adolescent Health and Development (LPPEAHD). This training educates and equips parents with the necessary knowledge on adolescent sexuality and other health-related concerns and provides them with the skills to effectively communicate such concerns to their children.

As part of ASRH information dissemination, various classroom advocacy activities and trainings on RH concepts were also conducted for youth volunteers, students and student leaders to help them recognize and understand the health risks involved in premarital sex, early marriages, teen pregnancies and other issues concerning young people – reinforcing responsibility for their behavior.

Service Delivery

The creation of Teen Centers led by POPCOM is a common response of various sectors across regions to the pressing sexual and reproductive health needs of the adolescents. These centers seek to provide adolescents with age-and-development-appropriate information through various IEC materials on ASRH. In Cavite, a three-pronged approach to reducing teen pregnancy is being pursued involving a health referral and service delivery network that includes school-based, RHU-based as well as hospital-based Teen Health Kiosks/Centers.

There are also efforts to provide ASRH services in hospitals. One of these is the Program for Young Parents (PYP) introduced in 25 hospitals all over the country[21]. It offers a comprehensive menu of obstetric, gynecological, and pediatric care, antenatal and postnatal care for the child-mother. Counseling services on exclusive breastfeeding and on healthy timing and spacing of pregnancy are likewise given, with emphasis on gender sensitivity and joint responsibility in child care. In the Visayas alone, PYP provided over 5,000 clients not only with obstetrical care, medical/pediatric care and nutritional support but psychosocial, personal advancement, and referral/networking services as well. DOH was able to provide FP and MNCHN services to adolescents through funding assistance from development partners. With USAID support, for instance, it provided nearly 11,000 adolescents and youth with age-appropriate maternal, neonatal, child health and nutrition/family planning counseling and referral services in selected service delivery points. Local government units (LGUs) and hospitals were likewise assisted in providing nearly 134,000 youth with FP counseling and other services.

[21]Includes General Emilio Aguinaldo Memorial Hospital, Bicol Medical Center, Iloilo Provincial Hospital, Jose Colmenares Memorial District Hospital, Cadiz District Hospital, Lorenzo D. Zayco Memorial District Hospital, Corazon LocsinMontelibano Memorial Reigonal Hospital, West Visayas Sanitarium, Abuyog District Hospital, Eastern Visayas Regional Medical Center, Vicente Sotto Memorial Medical Center, Saint Anthony Mother & Child Hospital, Cebu Provincial Hospital, Don Emilio Del Valle, Memorial Hospital, Governor CelestinoGallares Memorial Hospital, Cebu Provincial Hospital, Eversley Child's Sanitarium & General Hospital, Cebu Provincial Hospital, Lapu-lapu City Hospital, Bantayan District Hospital, South Cotabato Provincial Hospital, Cotabato Regional and Medical Center, Southern Philippines Medical Center, Brokenshire Hospital and General Santos City Hospital

With regard to other aspects of adolescent health, the DOH and DepEd launched a school-based immunization program giving tetanus –diphtheria (TD) and measles rubella (MR) vaccines to over 1.7 million Grade 7 students for "lifetime immunity" against tetanus. Parental/guardian consent was required for vaccination. Table 1 shows a 72 percent-coverage for both vaccines, with the highest coverage rate in Region 2 at 95 percent and lowest in ARMM (46 percent for MR and 48 percent for TD). Regions 4A, NCR, 3, 6 and 5 accounted for nearly half of the total number of Grade 7 students vaccinated with MR (609,744) and TD (610,153).

Table 30. School-Based Immunization Program Coverage (Grade 7 Students), 2015

Region	Actual Enrollees	Measles Rubella						Tetanus diphtheria					
		Vaccinated		Deferred		Refused		Vaccinated		Deferred		Refused	
		No.	%	No.	%	No.	%	No	%	No	%	No	%
Philippines	**1,719,924**	**1,234,985**	**72**	**75,637**	**4**	**300,737**	**17**	**1,236,812**	**72**	**75,755**	**4**	**301,119**	**18**
NCR	180,995	132,224	73	3,612	2	32,321	18	132,257	73	4,585	3	32,323	18
CAR	27,583	24,117	87	12	0	2,962	11	24,165	88	16	0	2,896	10
1	88,003	73,437	83	2,851	3	11,259	13	73,258	83	2,827	3	11,462	13
2	58,170	55,106	95	452	1	2,592	4	54,990	95	452	1	2,586	4
3	180,221	126,714	70	6,729	4	41,991	23	127,094	71	6,857	4	41,392	23
4A	213,527	146,831	69	15,320	7	45,241	21	147,239	69	13,916	7	45,336	21
4B	63,496	48,544	76	4,735	7	11,479	18	48,373	76	4,919	8	11,452	18
5	138,159	92,581	67	2,767	2	15,178	11	90,614	66	3,215	2	16,026	12
6	140,397	111,394	79	8,011	6	12,983	9	112,949	80	7,989	6	13,517	10
7	145,070	88,426	61	10,210	7	29,782	21	89,151	61	9,996	7	29,638	20
8	88,191	61,857	70	2,938	3	7,720	9	61,979	70	3,072	3	7,660	9
9	71,116	47,284	66	1,420	2	20,599	29	47,351	67	1,588	2	20,489	29
10	74,794	47,519	64	1,866	2	20,691	28	48,136	64	1,880	3	20,820	28
11	84,546	63,017	75	8,194	10	7,972	9	63,062	75	8,001	9	7,897	9
12	81,167	64,707	80	4,751	6	10,234	13	64,454	79	4,678	6	10,183	13
CARAGA	52,080	36,276	70	1,347	3	14,867	29	36,329	70	1,347	3	13,632	26
ARMM	32,409	14,951	46	422	1	14,101	44	15,411	48	417	1	13,810	43

Source: DOH EPI, 2015

The DOH likewise launched its human papillomavirus (HPV) vaccination campaign to save young girls from cervical cancer, the second leading cause of cancer deaths among women in the country. It is estimated that 12 Filipino women die of cervical cancer every day (DOH 2015) even though it can be prevented through early screening and treatment. Given that the cost of vaccine (PhP1,200 for two doses) has largely prohibited women, especially the poor, from getting immunized, the DOH targeted 362, 881 girls aged 9 to 10 years old in 20 poorest provinces in the country for vaccination. It was able to cover 63 percent of this target in 2015 (see Table 7). Regional coverage ranged from as low as 8 percent in Ifugao to as high as 100 percent in Pangasinan.

Almost all regions conducted Buntis Congress and Hi-5 Caravans where pregnant girls were provided with health information and services. Intensified CSOs efforts to provide adolescents with information and services related to maternal health, family planning, STI/HIV and gender-based violence (GBV) were also evident. Some CSOs procured FP commodities for distribution in clinics providing services to women of reproductive age including adolescents.

Table 31. HPV Immunization (1st Dose) Coverage in 20 Priority Provinces, 2015.

Priority Province	Target no. of girls for vaccination	No. of girls vaccinated with HPV 1st dose	1st dose vaccine coverage %
Apayao	1,255	1,109	88
Ifugao	2,412	202	8
Pangasinan	29,838	29,838	100
Quezon	22,906	14,152	62
Camarines Sur	27,560	17,034	62
Masbate	12,672	8,335	66
Iloilo	32,130	27,165	85
Negros Occidental	36,422	24,724	68
Negros Oriental	14,826	5,894	40
Cebu	46,004	14,686	32
Northern Samar	9,357	8,159	87
Eastern Samar	7,172	5,656	79
Leyte	22,838	17,206	75
Zamboanga del Sur	19,495	8,328	43
Davao Oriental	8,452	6,150	73
Sarangani	6,635	5,568	84
North Cotabato	18,056	15,269	85
Lanao del Sur	7,969	6,300	79
Maguindanao	16,000	6,412	40
Sulu	20,882	6,534	31
Total	**362,881**	**228,721**	**63**

Source: *DOH EPI, 2015*

Challenges & Recommendations

1. ***Lack of clear legal authority for managing/oversees ARH program implementation.*** Implementation of ASRH programs often needs multi-agency/sectoral support to be successful. However, despite the existence of the NIT and RITs as well as the RPRH law, certain adolescent health programs such as immunization are still met with opposition by implementing partners with different stand on RH.

   Recommendations:

   a) Develop clear legal and ethical justification for ARH service provision.
   b) DOH, in collaboration with partners, must oversee, monitor and evaluate the various initiatives on ASRH to ensure that they all lead to the desired outcomes of reducing risks to adolescents – such as teen pregnancies and sexually transmitted infections and HIV - and improving adolescent health.

2. ***Lack of evidence-based technical guidance to effectively direct ASRH program and strategies.*** As regards program thrust and direction, efforts to advance ASRH in 2015 leaned heavily towards capacity building activities for health care providers and peer educators as well as demand generation activities in the form of interactive learning sessions, symposia and congresses. However, there has been no meticulous evaluation of the effectiveness of these interventions as well as commonly undertaken service delivery initiatives such as Teen Health Centers in terms of their sustainability and potential to increasing adolescent access to recommended ASRH services, which still need to be specified by the DOH.

   Recommendations:

a) Develop evidence-based Manual of Operations to guide ASRH policy-making and programs
b) Train ASRH program managers

3. ***Non-specification of age-appropriate adolescent health services to be offered by health providers.*** Even though the National Standards and Implementation Guide for the Provision of Adolescent-Friendly Health Services has already been defined by the DOH since 2010, gaps still remain in its actual adoption and implementation at the local level. Several initiatives by LGUs and development partners were put in place based on the above mentioned standards but the health services offered to adolescents still vary across health facilities. The National Standards enumerated the services according to three core packages, namely Basic Essential Health Package, Adolescent Pregnancy Package, and STI/HIV Package but together with the AJA Manual, it failed to define the actual set of age- and sex-appropriate preventive services to guide health workers. This should also guide the RPRH NIT in identifying the ASRH indicators to be monitored on a more regular basis.

   Recommendations:

   a) Define standards and health service package for age- and development-appropriate ASRH service delivery with strong counseling component
   b) Appropriate funds and commodities according to the defined package of health services for ASRH

4. ***Unavailability of routinely collected age and sex disaggregated data on health service utilization.*** No separate reports on adolescents are generated from existing national reports on FP/MNCHN, STI/HIV AIDS, GBV and other RH services. Current limitations in ASRH-related data undermine rigorous analysis of program performance which should be guiding policy and investment decisions on ASRH.

   Recommendations:

   a) Develop age- and development-appropriate and gender-sensitive policies/issuances with corresponding budgetary allotment
   b) Develop recording mechanism to easily monitor the identified set of core ASRH services (e.g. may be reflected in a separate Target Client List or TCL for Adolescents and incorporated in the FHSIS).
   c) Link the monitoring and evaluation of output and outcome indicators for ASRH as defined in the RPRH M&E guide.

KRA 4: STI/HIV AND AIDS

Status of STI and HIV/AIDS Performance Indicators

HIV/AIDS

Aligning with the 2015-2020 Health Sector Plan (HSP) for HIV and STI, key STI and HIV/AIDS indicators were identified and reflected in the Responsible Parenthood and Reproductive Health (RPRH) Law Monitoring and Evaluation Framework. Table 21 shows the list of indicators and targets together with the latest available data from different HIV surveillance systems.

Table 32. STI and HIV/AIDS Indicators

Indicators	Targets	Latest Available Data	Data Source
HIV incidence among population		74 cases per 100,000 by end of December 2015	Estimation and Projection Package (EPP) Spectrum
Percentage of estimated People Living with HIV (PLHIV) diagnosed with HIV		72% 30,356 diagnosed HIV cases out of 42,159 estimated PLHIV by end of December 2015	EPP Spectrum HIV/AIDS and ART Registry of the Philippines (HARP)
Percentage of key affected population reporting use of a condom the last time they had sex	80% (2015)	Men who have Sex with Men (MSM) – 42% Male PWID or People who Inject Drugs – 15% Female PWID – 6% Registered Female Sex Worker (RFSW) – 82% Freelance Female Sex Worker (FFSW) – 63%	2015 Integrated HIV Behavioral and Serologic Surveillance (IHBSS) for MSM and PWID 2013 IHBSS for FSW
Percentage of key affected populations tested for HIV and got their results	40% (2015)	MSM – 14% Male PWID – 18% Female PWID – 18% RFSW – 78% FFSW – 45%	2015 IHBSS for MSM and PWID 2013 IHBSS for Female Sex Worker (FSW)
Percentage of ART eligible PLHIV who are started on antiretroviral therapy (ART)	90% (2016)	85%	2015 HARP (numerator); 2014 PLHIV Estimates (spectrum)
Percentage of Social Hygiene Clinics with no stock-out of condoms for the last six months	100%	100%	Program Data

Based on the 2015 IHBSS, condom use and testing rates among key affected populations were far below the targets. In terms of treatment, further strengthening of efforts is needed to reach the 90 percent target. Data from the HIV/AIDS and ART Registry of the Philippines (HARP) showed that a total of 7,829 newly diagnosed HIV cases were reported from January to December 2015. This was 30 percent higher compared to the same period last year. This brings the cumulative number of HIV cases diagnosed in the Philippines to 30,356 since January 1984.

Based on the HARP, 94 percent of the new HIV cases were transmitted through sex; 20 percent were male-female sex while 74 percent were male-male sex or males who have sex with both males and females. Less than one percent of the new HIV cases were from mother-to-child transmission, and around four percent were transmitted through sharing of infected needles among people who inject drugs (PWID).

The age group with the biggest proportion of cases has become younger: from 2000 to 2004, it was 30-39 years; from 2005 to 2009, it was 25-34 years; and from 2010 to 2015, it was 20-29 years. Notably, the proportion of People Living with HIV (PLHIV) in the 15-24 year age group has increased from 20 percent in 2005-2009 to 28 percent in 2010-2015.

The HIV epidemic continues to grow in the Philippines specifically among key affected populations which include males/transgenders who have sex with males (M/TSM), people who inject drugs (PWID), and female sex workers (FSW).

Every two years since 2005, the Integrated HIV Behavioral and Serologic Surveillance (IHBSS) is conducted by the Epidemiology Bureau of the Department of Health to monitor the magnitude of the HIV epidemic in the country among key affected populations (KAP). The most recent round of IHBSS was conducted in 2015 for M/TSM in 35 cities; males and females who inject drugs in 2 cities; males who work in entertainment establishments in 4 cities; female sex workers in 2 cities. The wider coverage IHBSS of freelance female sex workers (FFSW) and registered female sex workers (RFSW) implemented in 10 sentinel cities was conducted in 2013.

Findings of the different rounds of IHBSS showed an increasing HIV prevalence among M/TSM who have anal sex with males in all age groups from 15 to over 25 years between 2013 and 2015 (Figure 7). Specifically, findings showed that the rate of increase among 20 to 24 years old picked up from 4.0 percent in 2013 to 6.2 percent in 2015. There is also continuing increase in acceleration of HIV prevalence among 15 to 19 year olds from 2011 to 2015.

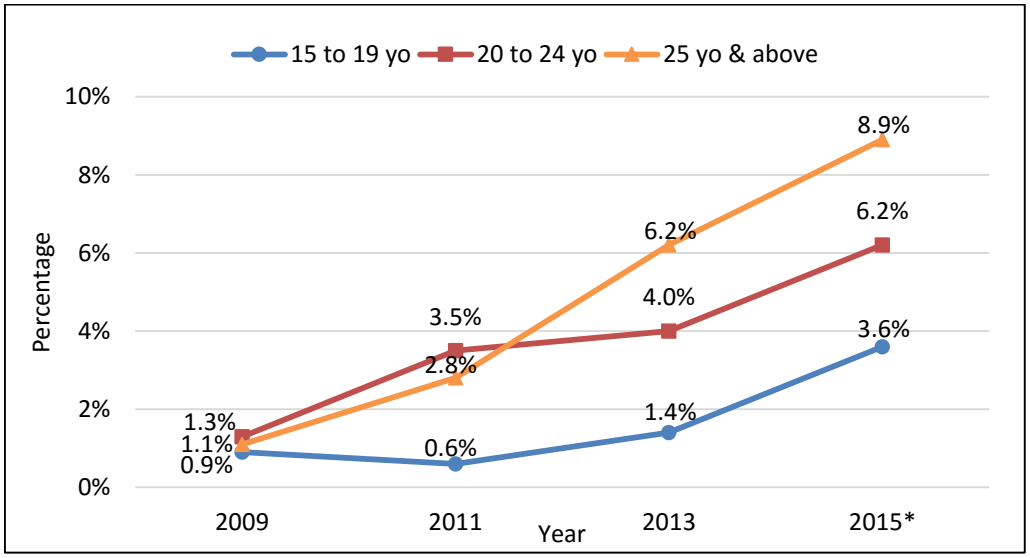

Figure 7. HIV Prevalence among M/TSM who have anal sex, 2015

Sexually-transmitted Infections

Aside from HIV, the IHBSS also gathered information about STI among key affected populations. The IHBSS showed that 5 percent of M/TSM and 10 percent of FSW experienced STI symptoms (discharge, ulcer, or warts) in the past 12 months.

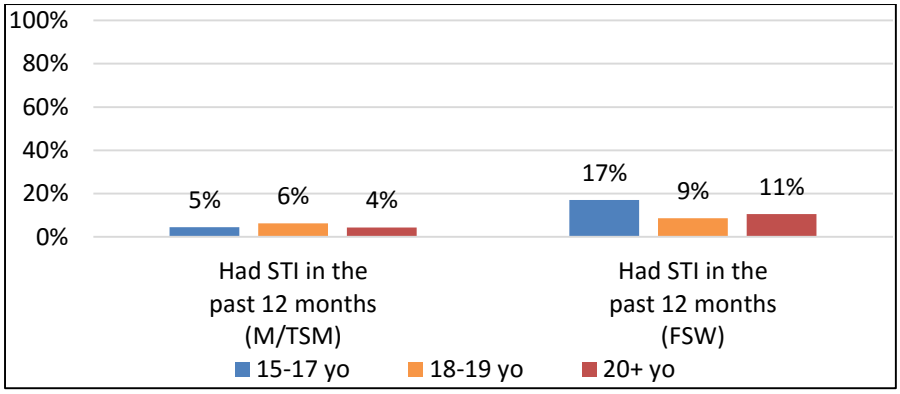

Figure 8. Proportions of key affected populations who had STI symptoms in the past 12 months

Syphilis prevalence has remained essentially unchanged among M/TSM and FSW since 2009, but has increased steadily since 2009. In 2015, Hepatitis B was included as one of the serologic component in the IHBSS. Its prevalence among M/TSM is at 6.5 percent, FFSW (in Cebu City) is at 5.2 percent, PWID at 7.5 percent for male and 7.8 percent for female.

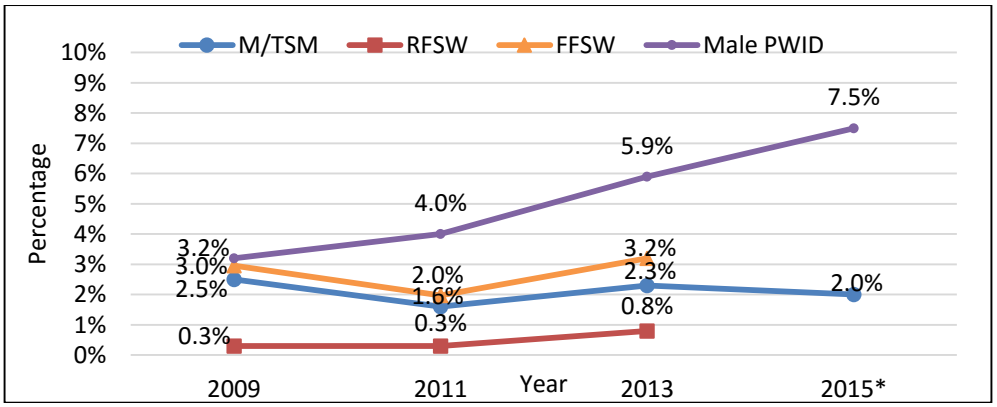

Figure 9. Syphilis prevalence among key affected populations

Table 33. Hepatitis B Prevalence among Key Affected Populations

Key Affected Population	Hepatitis B Prevalence, 2015 IHBSS
M/TSM	6.5%
FFSW (Cebu City only)	5.2%
Male PWID	7.5%
Female PWID (Cebu City only)	7.8%

Policies Issued

DOH policies related to STI HIV/AIDS issued in 2015 include clinical guidelines on diagnostics, management, and reporting, as well as management guidelines for treatment hubs and testing centers:

- DM No. 2015-0095: Adjustment of TB-HIV Cohort Reporting and Regional Coordination on HIV Testing Kits for NTP
- DM No. 2015-044: Designation of regional point-person for TB-HIV Collaboration
- DM No. 2015-0260: Revised Diagnostic Algorithm Using Xpert MTB/RIF
- DM No. 2015-0364: Pilot Implementation of the Rapid HIV Diagnostic Algorithm (RHIVDA) Testing Strategy to 5 Cities in 6 Selected Clinics and 2 DOH-Retained Hospitals
- DOH No. 2015-0139: Updated list of DOH-Designated Treatment Hubs and Satellite Treatment Hubs

- AO No. 2015-0005: Guidelines on the Performance Evaluation of In-Vitro Diagnostic Reagents (Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), Hepatitis C Virus (HCV) and Syphilis Screening Confirmatory and Disease Monitoring Test Kits
- DC No. 2015-0101: Initiation of Philippine Antiretroviral (ARV) Drug Resistance Surveillance

In order to encourage more people at risk to get tested for HIV, the DOH issued DM No. 2015-8843: "Declaring May 11-15, 2015 as National HIV Testing Week". The National HIV Testing Week coincides with the week preceding the Candlelight Memorial, and aims to promote and de-stigmatize HIV testing among key affected populations nationwide.

Philhealth also issued a revision to the Outpatient HIV/AIDS Treatment (OHAT) Package (PhilHealth Circular 19 s. 2010), which clarifies covered items under the benefit, namely drugs ad medicines, laboratory examinations based on the specific treatment guideline, including CD4 level determination test, viral load (if warranted), and tests for monitoring ARV drugs toxicity and providers' professional fees.

Regional and local policies on STI and HIV/AIDS issued, were mostly implementing guidelines on the establishment of HIV treatment /satellite hubs, and resolutions on the integration of STI prevention in AYRH advocacy programs.

The DOH has also been working with CSOs and other private sector partners, on technical discussions regarding the proposed amendments to the Philippine HIV & AIDS Law, which aim to harmonize evidence-informed strategies on prevention, treatment, care and support. This includes a proposal to allow minors aged 15 to 17 years old to agree to HIV testing and treatment without parental consent.

Annex A-2, B-3, and D-5 summarize the status of policy requirements as specified by RPRH Law and its IRR. Aside from national level policies, several regions and LGUs have developed, issued, and implemented policies to support the implementation of the RPRH Law and its IRR. Annex E-8 provides a list of the local and regional level policies related to the STI HIV/AIDS components of RA No. 10354.

Demand Generation

Demand generation activities include nationwide campaigns for HIV awareness and voluntary counseling and testing, which were held during the International AIDS Candlelight Memorial and National HIV Testing Week. These were participated by LGUs, national government agencies and CSOs. The National HIV Testing Week also featured the operation of an HIV testing hotline.

Information dissemination through the conduct of fora, high-impact events, media briefings, interactive learning sessions, and advocacy runs on HIV and AIDS were also held, participated by 23,798 participants from Manila, Quezon City, Rizal, Palawan, Cebu, Zamboanga, CAR, and other regions. Ten infomercials on HIV and AIDS were produced in 2015. Policy briefs were produced, with 3,000 copies distributed to partner agencies and the public.

There have also been regional, local, and CSO initiatives to reach most-at-risk populations through the conduct of regional HIV summits, peer education programs, "Gay Community Fora" promoting HIV awareness and condom use to those who are already sexually-active.

Activities directed for adolescent and youth reproductive health, such as Youth Camp, and U4U, have also integrated STI prevention/awareness. Audiences for other demand generation activities include people living with HIV & most-at-risk youths.

A pilot project which integrated STI HIV/AIDS awareness into the family planning program was implemented by the City Government of Angeles, in collaboration with the Center for Health Solutions and Innovations (CHSI), and UNFPA. Specifically, the project aimed to increase access for female entertainers to sexual reproductive health

information and services such as HIV, family planning and gender-based violence. Through this project, monthly learning sessions on HIV/STI, FP and GBV were conducted in eighteen entertainment establishments, including awareness raising activities through health events. As a result, female entertainers in Angeles City have started to regularly avail of services for SRH including Pap smear, as well as family planning commodities from barangay health centers and CSO clinics. The project has been found to have made good progress in introducing the topics and services of family planning and gender-based violence into the existing STI/HIV/AIDS prevention program.

Various other CSOs were also able to conduct numerous community outreach activities prioritizing at-risk populations. Stakeholders from media, business and labor sectors, students and youth, legislators, and faith-based organizations have also been mobilized to support advocacy activities. Video presentations on HIV/AIDS which have been developed in partnership with CSOs were shared via social media.

Annex H-20 provides a list of other regional/local/CSO demand generation activities on STI HIV/AIDS supporting the implementation of the RPRH law.

Data from IHBSS 2015 however, show that current reach for peer education and outreach services for behavior change among key affected populations, as shown by the IHBSS 2015 data.

Condom use rates among key affected populations were still below the 80 percent national target (Figure 10). Among the 15 to 19 year old M/TSM who engaged in anal sex in the past 12 months, only 35 percent used a condom the last time they had sex. Among the older age group, 45 percent used a condom at last anal sex. Among FSW, condom use at last sex with a male paying client in the past month ranged from 64 percent to 74 percent in different age groups. Further, condom use of male PWID at last sex with a male or female non-paying partner in the past 12 months is below 20 percent.

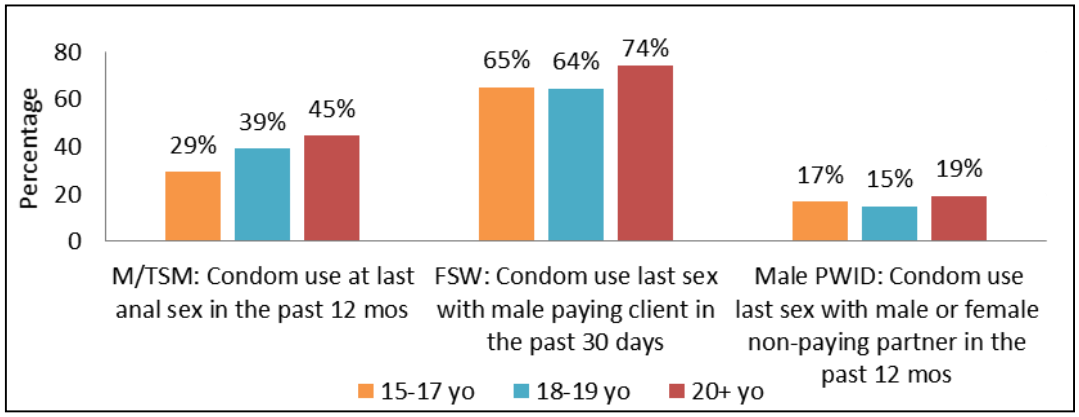

Figure 10. Condom use at last sex

Among M/TSM, most common reasons for not using a condom based on the IHBSS include unavailability of condoms (53 percent) and dislike for condoms (21 percent). Though the DOH procures condoms and social hygiene clinics (SHC) provide it for free, the IHBSS showed that only a small proportion of key affected populations received condoms from Social Hygiene Clinics (SHCs) or Peer Educators (PEs).

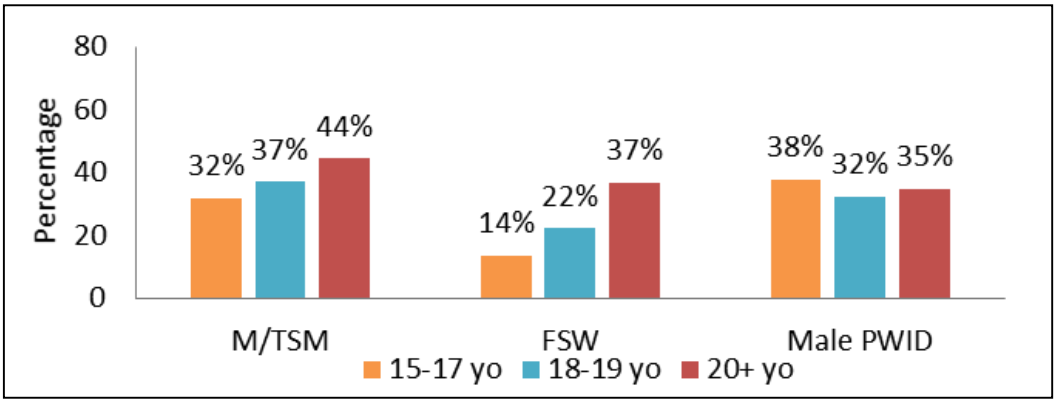

Figure 11. Comprehensive knowledge about HIV among key affected populations

The low proportion of key affected populations accessing HIV information may have influenced their low condom use and low levels of knowledge about HIV. The IHBSS showed that comprehensive knowledge on HIV transmission and prevention was less than 50 percent. Further, knowledge was lowest among 15 to 17 year old M/TSM and FSW at 32 percent and 14 percent, respectively compared to older age groups.

Significantly, the 2015 IHBSS showed that most M/TSM, FSW and PWID start engaging in high risk behaviors during their adolescent years (Figure 12). For M/TSM, age of first sex and first anal sex were 16 and 17 years old respectively, while age of first condom use was 18 years old. For FSW and PWID, age of first sex was 17 years old while age of first condom use was 20 years old. On the average, the gap between first sex and first condom use was 2 to 3 years. This finding is significant as further analysis showed that condoms are more likely to be used during subsequent sex acts when the M/TSM used a condom the first time he/she had sex.

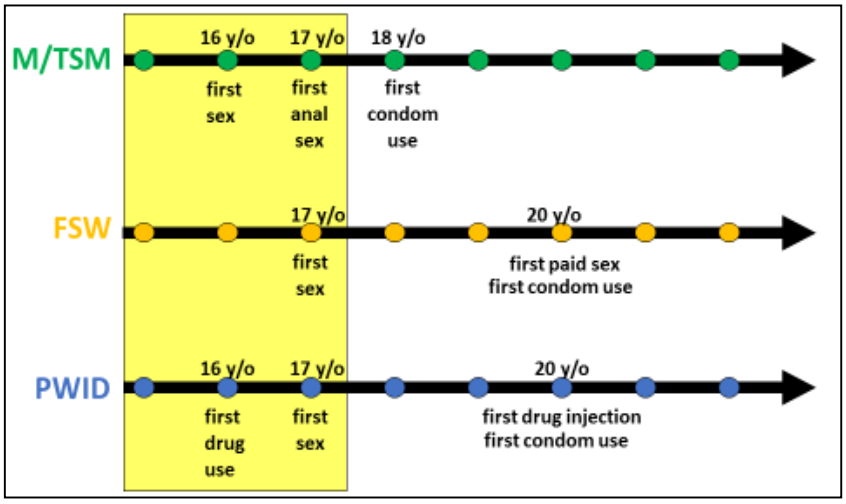

Figure 12. Start of high-risk behaviors among key populations

Capacity Building Activities

The DOH delivered various capacity building activities on STI and HIV/AIDS in 2015, which largely targeted towards the following: (1) direct health service providers, (2) youth peer educators & counselors, (3) LGU officials & staff, and other stakeholders.

Table 34 lists the capacity-building activities delivered by the DOH in 2015.

Table 34. Capacity Building Activities on STI HIV/AIDS Conducted by DOH

ACTIVITY	DESCRIPTION	TOTAL NUMBER
Training of Trainers on Basic STI and HIV Education	Trainers utilized the training module on HIV education developed by PNAC for roll-out to government and non-government agencies in support to the issuances of the Civil Service Commission and DOLE on implementing HIV program in the workplace.	27
Speakers Bureau Orientation on HIV and STI	Orientation to Regional Coordinators and Partners from CBOs on giving Basic STI and HIV Education to requesting partners and update on DOH policies on HIV.	24
HIV counseling and Testing Training PICT HCT (Full Course)	Participants were trained in providing pre and post HIV test counseling	451 662
HIV Primary Care Training	Members of the HIV and AIDS Core Team of hospitals and service providers from Social Hygiene Clinics were trained to provide primary care services on out-patient basis including provision of antiretroviral therapy.	75

Training activities on the following modules were also conducted by DOH ROs, LGUs, and CSOs:

- Gender and Age-Sensitivity Mainstreaming in HIV Programs for HIV Service Providers
- Implementation of Prevention of PMTCT Manual
- Interpersonal Communication Skills/ Behavior Change Communication
- Peer Educators Training

Civil society organizations also spearheaded the conduct of activities which focused on developing individual competencies in delivering actual service, patient counseling, and increasing awareness on HIV/AIDS among various stakeholders. Some of these organizations not only provided specific capability building activities dealing with M/TSMs, but also worked directly with local chief executives and local health officers to improve their awareness and response on addressing HIV & AIDS in their LGUs.

Annex H-21 provides a list of capacity building activities for the STI HIV-AIDS program that were conducted through the different agencies and CSOs at the regional and local levels.

Commodities Procured/ Delivered

Commodities, drugs, supplies and materials that were procured and delivered in 2015 include antiretroviral drugs, drugs for STIs and opportunistic infections, HIV test kits and laboratory supplies, syphilis test kits, CD4 testing; condoms and water-based lubricants.

In 2015, the DOH procured antiretroviral drugs amounting to around P220 M. The drugs are expected to be delivered on the 1st quarter of 2016. This supply is estimated to last until March 2017 and is sufficient for more than 15 thousand People living with HIV (PLHIV) needing antiretroviral therapy (ART). As of December 2015, the current number of PLHIV on ART is at 12,533.

Table 35. Commodities, drugs, supplies procured by DOH (national coverage)

Commodities procured/ delivered	Amount (in Php)	Particulars
Antiretroviral Drugs (including freight charges and tax)	184,914,814.72	Distributed to Treatment Hubs and Satellite Treatment Hubs
Drugs for Sexually Transmitted Infections (STI) and Opportunistic Infections (OIs)	14,953,400.00	Distributed to Social Hygiene Clinics of LGUs
HIV test kits and laboratory supplies	23,306,280.00	Distributed to Social Hygiene Clinics of LGUs
Syphilis Test Kits	3,500,000.00	Distributed to Social Hygiene Clinics of LGUs
CD4 testing	3,991,103.28	Distributed to Treatment Hubs and Satellite Treatment Hubs
Condoms and water-based lubricants	11,984,520.00	Distributed to partner LGUs, hospitals and CSOs

Annex H-22 provides a list of commodities, drugs, supplies and materials procured in 2015.

Service Delivery

STI and HIV services are available at various health facilities. Specifically, services for HIV counseling and testing and STI diagnosis and treatment are accessed at the Social Hygiene Clinics (SHCs) run by the local government units across the country. Further, provider-initiated HIV counseling and testing (PICT) is offered in facilities including TB-DOTS for TB patients in HIV high burdened areas (Category A and B), TB treatment centers and satellite treatment centers for Drug-Resistant TB patients, antenatal care facilities for all pregnant women in NCR and Cebu, and other government and private hospitals and private clinics. Also, community-based organizations and other CSOs provide prevention activities and link their clients for HIV counseling and testing and other HIV and STI services to the SHC. Blood service facilities that identify potential blood donors who have HIV risk refer them to HIV counseling and testing facilities.

A significant number of SHCs situated in NCR, Cebu, Davao, and General Santos City have also been capacitated to provide HIV primary health care for people living with HIV (PLHIV) as satellite treatment hubs, thus functioning as one-stop shop for HIV prevention, treatment, care and support services.

HIV clinical management including in-patient services are accessed by PLHIV at 22 treatment hubs strategically situated across the country. This number has increased from nineteen treatment hubs in 2014. The DOH will continuously expand the number of satellite treatment hubs and treatment hubs.

Antiretroviral drugs and other care and support services for people living with HIV can be accessed at the following DOH-designated treatment hubs and satellite treatment hubs across the country (Pease refer to Table 25):

Table 36. DOH-designated HIV/AIDS Treatment Hubs and Satellite Treatment Hubs

Region	DOH-Desginated Treatment Hubs
CAR	Baguio General Hospital and Medical Center
I	Ilocos Training and Regional Medical Center
II	Cagayan Valley Medical Center
III	Jose B. Lingad Memorial Regional Hospital James L. Gordon Memorial Hospital
NCR	Philippine General Hospital Research Institute for Tropical Medicine San Lazaro Hospital Makati Medical Center The Medical City
IV-B	Ospital ng Palawan
V	Bicol Regional Training and teaching Hospital
VI	Western Visayas Medical Center Corazon Locsin Montelibano Memorial Regional Hospital
VII	Vicente Sotto Memorial Medical Center Gov. Celestino Gallares Memorial Regional Hospital
VIII	Eastern Visayas Regional Medical Center
IX	Zamboanga City Medical Center
X	Northern Mindanao Medical Center
XI	Southern Philippines Medical Center
XIII	Butuan City Medical Center Caraga Regional Hospital
Region	**DOH-Designated Satellite Treatment Hubs**
NCR	Quezon City Klinika Bernardo Marikina City Health Office Manila Social Hygiene Clinic
VII	Cebu City Social Hygiene Clinic
XII	General Santos City Social Hygiene Clinic
VI	Dr. Rafael S. Tumbokon Memorial Hospital

Psychosocial care and financial support services were also provided by the DSWD for PLHIV and their Families.

Various CSOs have community-based clinics and hubs, which offer services such as counseling, diagnosing, and treatment of STIs, as well as direct treatment, care, and support services for PLHIVs. According to IHBSS 2015 data however, coverage for HIV services among key affected populations remains low.

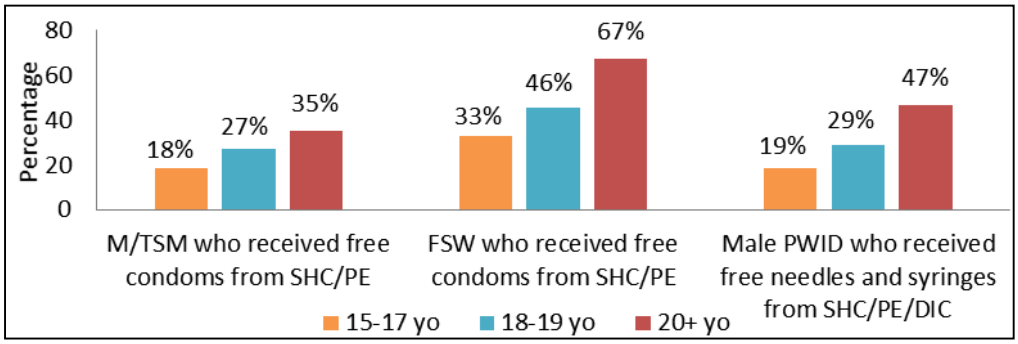

Figure 13. Proportion of key affected populations who received prevention commodities from SHC, PE, or DIC in the past 12 months

The SHCs together with PEs were able to reach less than half of the key affected populations in the country in the past 12 months. Among 15 to 17 year olds, only 14 percent of M/TSM, 19 percent of FSW, and 12 percent of male PWID received prevention commodities and also received information on HIV transmission, prevention, and testing. Though the proportion of key affected populations reached is higher among 20 year old and above at 31

percent among M/TSM, 54 percent among FSW, and 40 percent among male PWID, it still remained below the 80 percent national target.

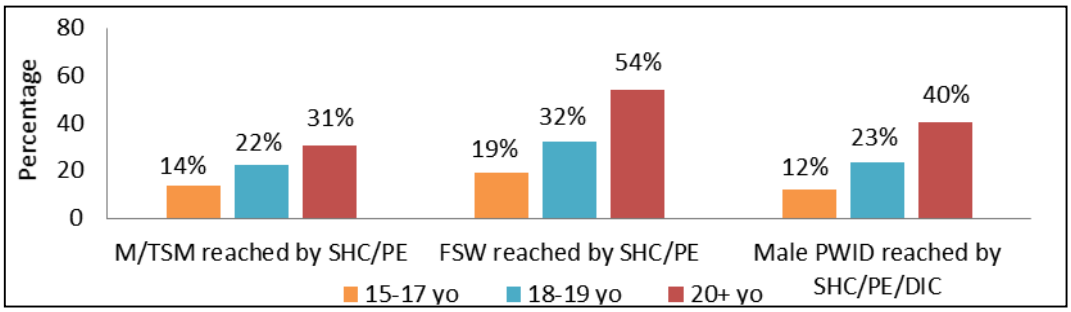

Figure 14. Access to HIV Interventions in the past 12 months

Testing has increased among key affected populations in the past years as seen in the IHBSS. From 2009 to 2015, percentage of key affected populations who got tested for HIV has increased from 40 percent to 62 percent among RFSW, 15 percent to 24 percent among FFSW, 4 percent to 44 percent among PWID, and 9 percent to 25 percent among M/TSM. However the proportion of those who know their status was still low at 50 percent among RFSW, 16 percent among FFSW, 33 percent among PWID, and only 19 percent among M/TSM.

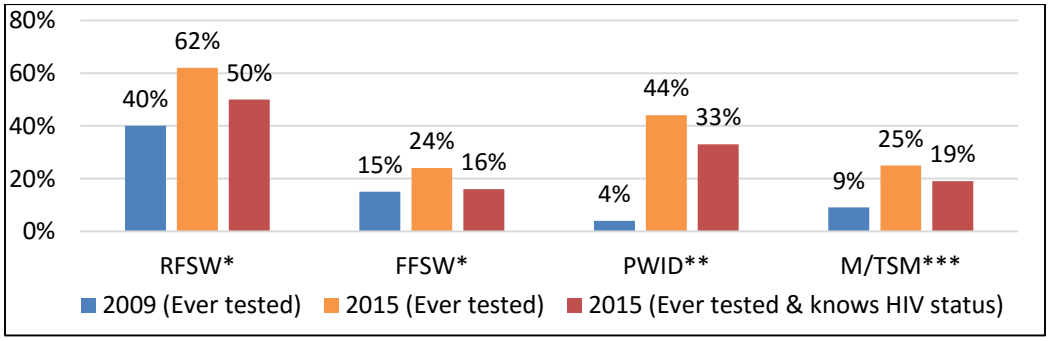

Figure 15. HIV testing among key affected populations

HIV testing is the key to linking PLHIV to care and providing treatment. Currently, it is still a challenge to the HIV/AIDS program particularly among adolescents. Estimated projections and the actual HIV cases diagnosed are that only 2 percent of 15 to 17 year old estimated PLHIV and 21 percent of 18 to 19 year old estimated PLHIV are diagnosed with HIV. This is very low compared to the 76 percent to 77 percent diagnosed of the estimated 20 years old and above PLHI.

There is also a need to improve prevention of mother to child transmission (PMTCT) services. In 2015, there were 20 newly diagnosed cases of HIV among children 0-14 years old, seventeen of which were acquired through mother-to-child transmission. However, only 19 percent of estimated new infections among children 0 to 14 years old were diagnosed in 2015. Among pregnant mothers estimated to have HIV, only 11 percent have been provided PMTCT in 2015. Hence, the need to improve access to antiretroviral treatment and other health care services for mothers and babies.

Table 37. HIV Diagnosis of children 0-14 years old

	2010	2011	2012	2013	2014	2015
Estimated new infections (0-14 years old)	75	79	86	96	104	105
Actual number of diagnosed (0-14 years old)	3	3	4	3	5	20
% diagnosed of estimated	4%	4%	5%	3%	5%	19%

Source: HARP December 2015 and EPP as of December 2015

Table 38. Provision of PTMCT Services (Source: HARP December 2015 and EPP as of December 2015)

	2010	2011	2012	2013	2014	2015
Estimated number of mothers needing PMTCT	229	244	260	276	294	334
Actual number provided with PMTCT	12	18	19	14	26	38
% provided PMTCT of estimated	5%	7%	7%	5%	9%	11%

Source: HARP December 2015 and EPP as of December 2015

Overall, there is an estimated 42,159 people living with HIV (PLHIV) in the country. However as of December 2015, only 30,356 were diagnosed and 12,533 are currently alive and accessing ART in the different treatment hubs in the country.

Table 39. Estimated vs Diagnosed HIV Infections by Age Group

	15-17 yo	18-19 yo	20-24 yo	25 yo& above
Cumulative estimate of HIV infections by December 2015	5,735	3,824	9,424	28,618
Actual ever diagnosed with HIV	123	813	7,158	22,098
% diagnosed of the estimated	**2%**	**21%**	**76%**	**77%**

Percentage of diagnosed versus estimated HIV infections (Table 39) is still below the UNAIDS 90-90-90 targets where 90 percent of estimated PLHIV should be diagnosed, 90% of all diagnosed should be started on ART, and 90 percent of all receiving ART will have durable viral suppression.

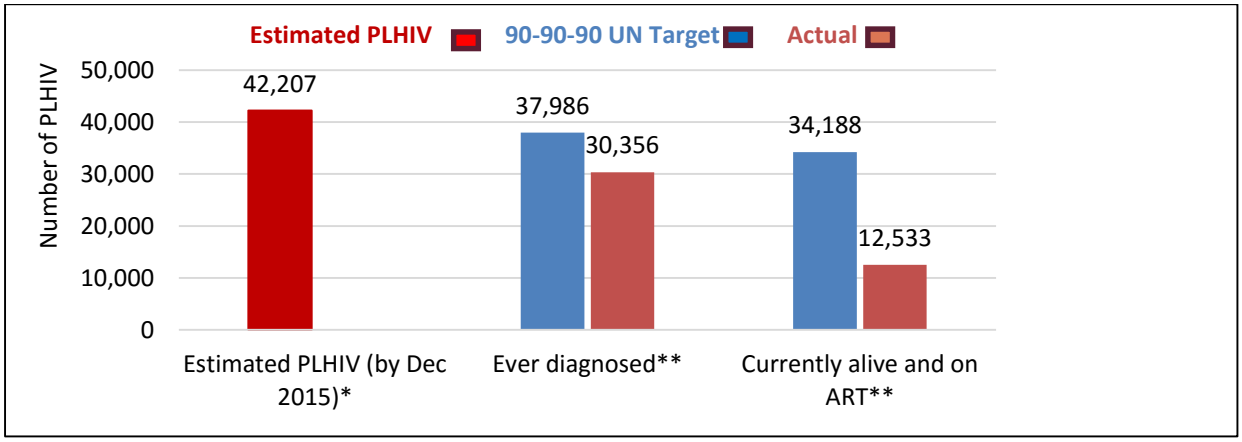

Figure 16. National HIV care cascade

Among those who had STI symptoms, only a small number of key affected populations consulted a public or private health facility. Specifically among younger M/TSM and FSW, there was a low percentage of access to STI services at 24 percent and 35 percent, respectively.

Challenges and Recommendations

1. ***Continuing growth of HIV epidemic specifically among key affected populations*** which include males/transgenders who have sex with males (M/TSM), people who inject drugs (PWID), and female sex workers (FSW) or people in prostitution.

   Recommendations:

   a) Conduct free HIV privacy-secure testing. To encourage voluntary HIV testing, free HIV privacy-secure testing should be offered and advertised. Results, including the confirmatory Western blot test, should available to the client within a reasonable period to avoid loss to follow-up.
   b) Diversify HIV testing options such as peer-led testing, simplify counseling tools, and further promote HIV services, given the low testing rates among MSM,.
   c) Conduct awareness campaign for the youth. Given the trend of increasing incidence among them, there is a need to intensify HIV and sexuality awareness campaigns for both in-school and out-of-school youth.
   d) Strengthen the integration of the HIV and AIDS program with the RPRH program. The integration should be facilitated in the National Implementation Team (NIT) and DOH Technical Working groups.

2. ***Poor service coverage due to stigma and discrimination – preventive, diagnostic and treatment - among key affected populations***

   Recommendations:

   a) Intensify audience-targeted-information awareness and prevention strategies. Information dissemination should be conducted, especially to those at risk regarding the nature of the disease, testing, prevention, access to treatment and follow-up. Regular community-wide announced conferences for information may be conducted in cities with concentrated epidemics.
   b) Intensify Condom campaigns. The DOH should take a firm stand on the role of combination prevention efforts in the control of epidemic. Condoms play a critical role in HIV prevention.

      Strengthen HIV program in the SDN. With the rising cases of HIV among children of female partners (vertical transmission) of injecting drug users in Cebu, the need to strengthen HIV component of the Service Delivery Network (SDN), and voluntary HIV testing among pregnant women in Cebu, have been raised. A review of the policy of prevention of mother to child transmission is already underway.

Formulate law amendments that would allow for the enforcement of needle exchange program, which is critical to eliminating shared needle transmission. Such a program, implemented in Cebu however, was suspended in May 2015, following a Senate public order and Dangerous Drugs Committee hearing. The “Harm Reduction Strategy” program was said to be in conflict with Section 12 of Republic Act 9165, or the Comprehensive Dangerous Drugs Act, which prohibits the possession of any paraphernalia intended for injecting dangerous drugs.

3. ***Need to augment funding for comprehensive STI-HIV preventive, diagnostic, and treatment programs***

   Recommendations:
   a) Restore budget for prevention.
   b) PhilHealth must pursue the OHAT benefit package, to clarify the issue of whether the package covers the cost of certain laboratory tests. This will offset the high cost of service delivery, particularly in private facilities.

Key Result Area 5: Gender – Based Violence

Status of GBV Program

"Elimination of violence against women and children and other forms of sexual and gender-based violence" is one of the 12 elements of Reproductive Health as provided in the RPRH Law. Section 3.01 of the its IRR defines *Violence Against Women (VAW)* or *Gender-Based Violence (GBV)* as all forms of violence inflicted on women on account of their gender. In the broadest sense, it is a violation of a woman's personhood, mental or physical integrity or freedom of movement. More specifically, it refers to any act of gender-based violence that results, or is likely to result, in physical, sexual, or psychological harm or suffering to women including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or private life.

It is important to note that, while GBV in this report is more generally understood as VAW and rightly so because of the nature of GBV, there is a need for a more comprehensive definition that encompasses issues relevant to persons of diverse sexual orientation and gender identity and expression (SOGIE) such as Lesbian, Gay, Bisexual, Transgender, Queer or Questioning and Intersex (LGBTQI) groups. Nonetheless, data for this are anecdotal and still missing.

Violence Against Women

The NDHS of 2008 and 2013 describe the prevalence of VAW in women aged 15 to 49. However, only 30 percent have sought help from service providers. Two out of five (38%) have remained silent about their abuse.

The survey information collected covered all forms of VAW- physical, sexual, emotional, spousal, and violence during pregnancy from their husbands/partners as well as by other family members or unrelated individuals. Additionally, the survey also included violence initiated by women against their spouse.

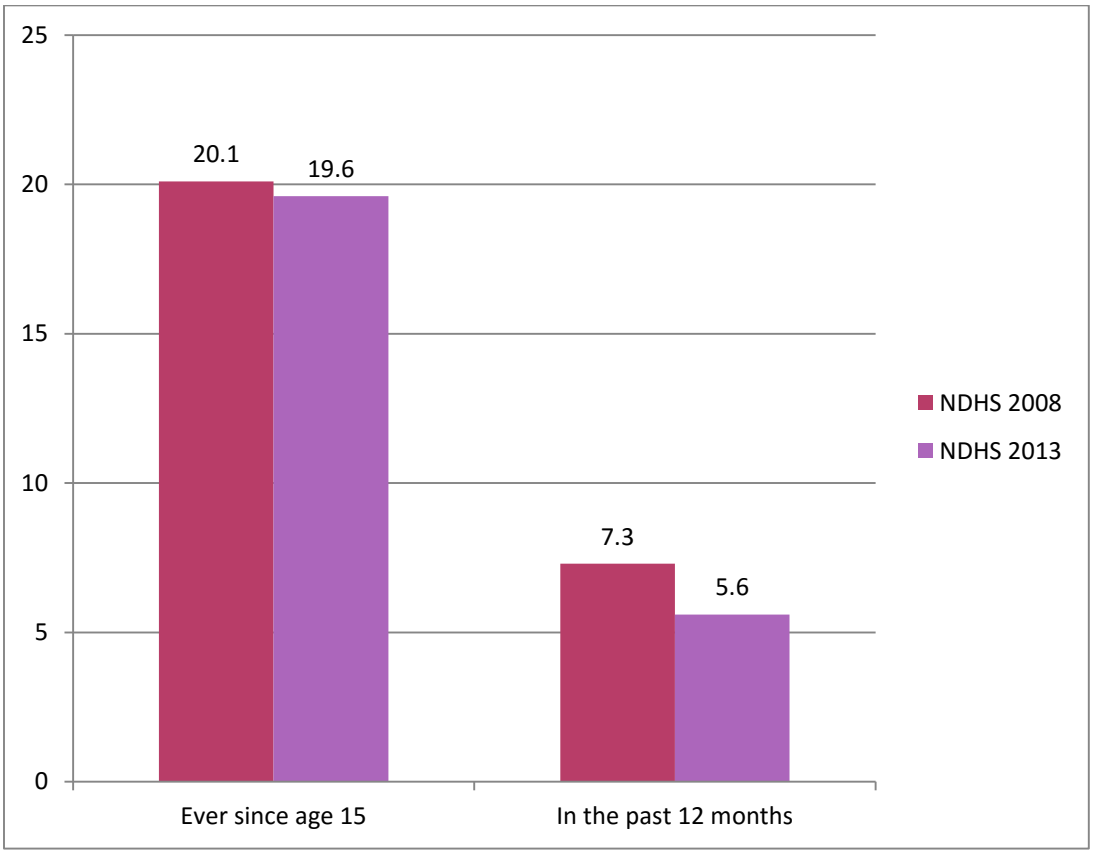

Figure 17. Percentage of Women 15-49 Years Old Who Have Experienced Physical Violence, NDHS 2008 and 2013.

The survey results showed that 20 percent of women 15-49 years old experienced physical violence since age 15 and almost 6 percent in the past 12 months before the survey (Figure 17). There was a slight decrease in the reported physical violence from the survey in 2008 compared to 2013, but this is not statistically significant. Ever-married women identified their current husbands/partners as the main perpetrators of physical violence. On the other hand, among never married women, their mothers or stepmothers were also reported as perpetrators (Annex I-25). The survey also conveyed that 4 percent of women interviewed experienced physical violence during pregnancy.

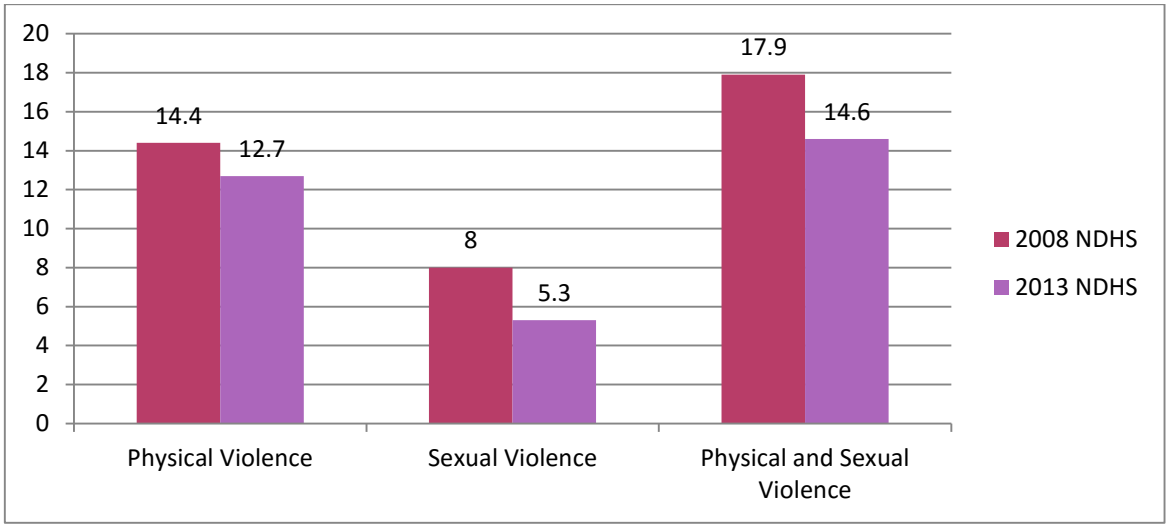

Figure 18. Percentage of Women 15-49 Years Old Who Experienced Spousal Violence, NDHS 2008 and 2013.

Figure 18 shows the comparison of results from the surveys performed in 2008 and 2013 of the percentage of women 15-49 years old who experienced physical, sexual, and both physical and sexual violence committed by their husband or partner. In 2008, around 18 percent of those interviewed experienced both physical and sexual violence perpetrated by their husband. A decrease was noted in 2013 in all forms of spousal violence. Meanwhile, the survey also probed if there were instances that the ever married women among the same age group instigated physical violence against their husbands. It was found out that 16 percent of these women have initiated physical violence and 8 percent have done so in the past 12 months. Women's initiation of such kind of aggression is more common among those who were also victims of violence.

Administrative data on VAW cases handled by the police, health and social workers and prosecutors have shown an increasing trend in reporting over the past years. The data suggest that more women are being emboldened to break their silence and seek help.

The number of VAW cases reported to the Philippine National Police-Women and Children Protection Center (PNP WCPC) increased by 40 percent in the past 5 years.

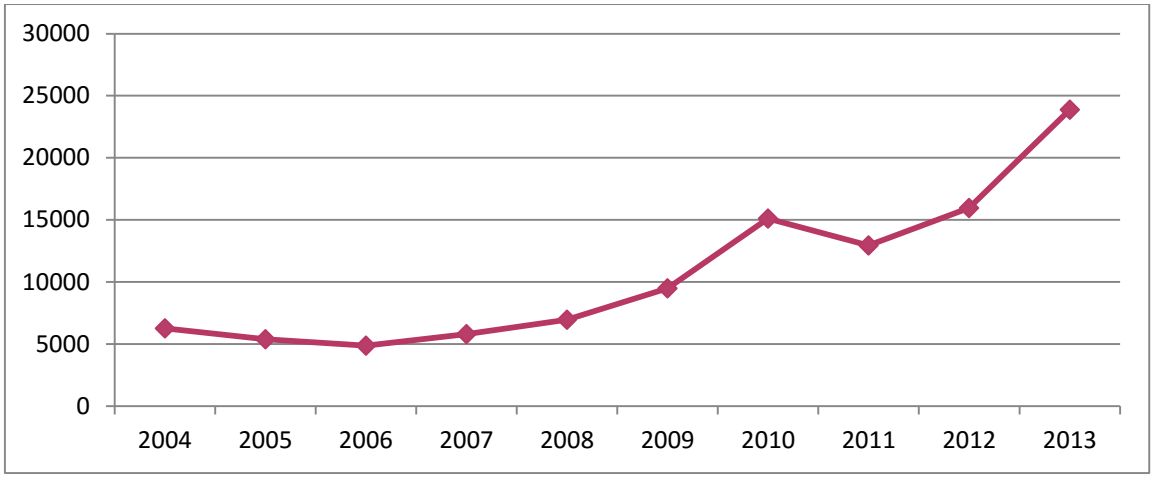

Figure 19. Annual Statistical Trend on Violence Against Women (all VAW cases), 2004 – 2013
Philippine National Police, 2013

The Philippine National Police – Women and Child Protection Center (PNP-WCPC) reported that for the past ten years from 2004-2013, there have been an increasing national trend of VAWC cases. These reported cases include rape, incestuous rape, attempted rape, acts of lasciviousness, physical injuries, sexual harassment, threats, seduction, concubinage, violation of Anti-Trafficking in Persons Act (RA 9208), abduction/kidnapping, and unjust vexation. Violation of RA 9262 or the Anti-Violence Against Women and Children Act ranked first among the different VAW cases recorded since 2004, followed by physical injuries and rape (Figure 20).

However, according to the Philippine Commission on Women (PCW), the trend is not conclusive of an increasing or decreasing incidence of VAW because data are based only on what was reported to PNP. Data collection from the intervention points for the victim-survivors i.e. social welfare offices, police women's desks, Women and Child Protection Units (WCPU) in hospitals and Barangay VAW desks have been challenging due to non-harmonized central reporting mechanism amongst concerned agencies. Although the rising trend may suggest that more Filipinos are speaking up and reporting abuse since awareness on laws and services is greater.

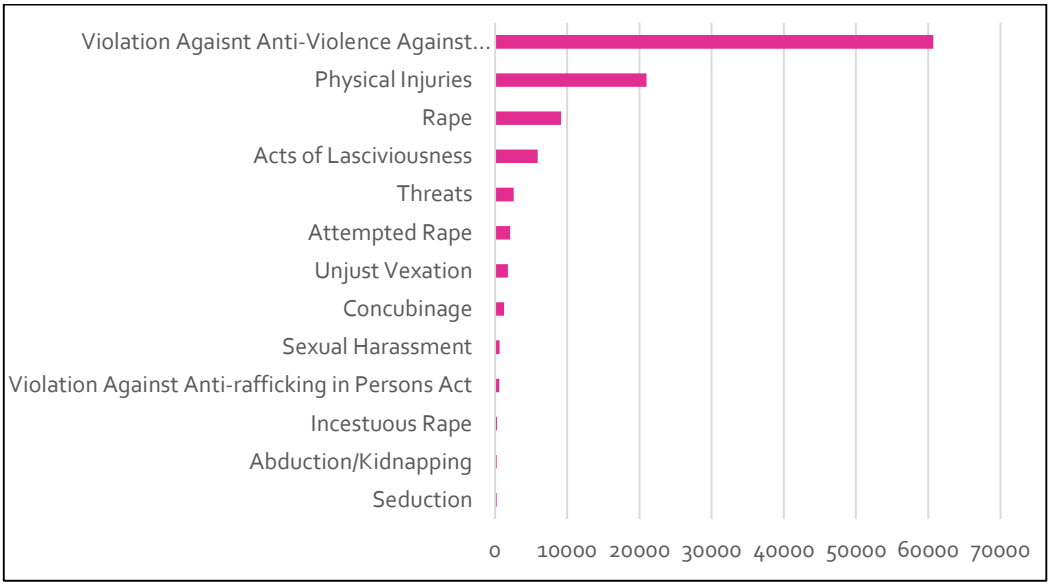

Figure 20. Number of the Different VAW Cases (2004-2013), *2013 PNP Report*

Among the regions, Western Visayas had the highest reported VAW incidence in 2013 accounting for 20.3 percent (4,833) of the total reported VAW cases nationwide. Davao ranked 2nd with 4,411 cases (18.5 percent), then Central

Visayas with 3,460 reported VAW cases, approximately 14 percent. The Autonomous Region of Muslim Mindanao posted the lowest reported VAW cases – 86 in 2013. These reported cases, however, do not necessarily reflect the real frequency of abuse in an area. It can be surmised that these regions with the highest reported cases of VAW are due to better information dissemination, well-established inter-agency response mechanisms to respond to cases, as well as active women civil society organizations working with in partnership with the government.

The Magna Carta of Women mandated the establishment of barangay VAW desks nationwide with the DILG in charge of monitoring them. As of December 2015, 36,577 or 87% of the 42,029 barangays have established VAW desks surpassing its target of 83% by the end of 2016. Whether these VAW desks are functional is being worked on by the DILG and the PCW. In 2015, Western Visayas was among the regions with the most VAW desks, 99 percent of its barangay complying. Meanwhile, ARMM had the fewest at only 11 percent.

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The Philippine Commission on Women reported that in 2013, the Department of Justice resolved 76 percent of the 18,215 cases of violation of RA 9262. The figure below shows that 67 percent were cases filed in court and the remaining 33 percent were either dismissed or given other actions. Moreover, DOJ also handled 9,445 rape cases, of which 76 percent were likewise resolved - 59 percent were filed in court, 14 percent were dismissed, and the remaining 3 percent were either suspended or deferred.

For the violation of the Anti-Trafficking in Persons Act (RA 9208), the Interagency Council on Anti-Trafficking (IACAT) reported that 80 percent of the victims were women. A 47 percent decrease of cases was noted in 2013 from 2012.

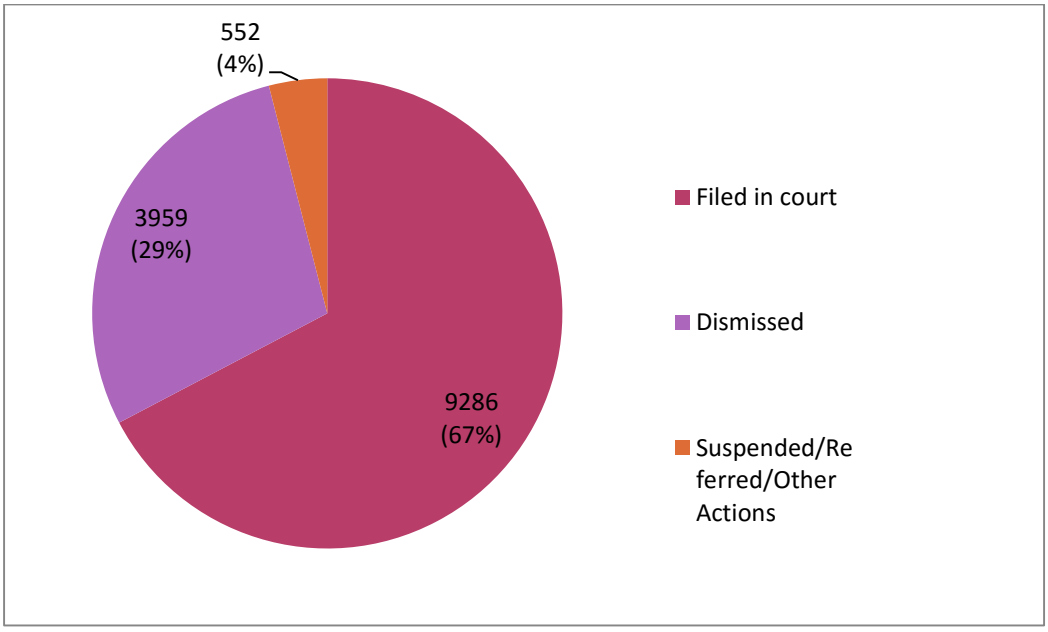

Figure 21. Number and Percentage of Cases of RA 9262 Resolved by the Department of Justice cited by the Philippine Commission on Women, **2013.**

Violence Against Children

The Department of Health through the Women and Children Protection Unit recorded 4,699 cases of violence against children nationwide. Figures 23, 24, and 25 summarize the statistics of violence against children.

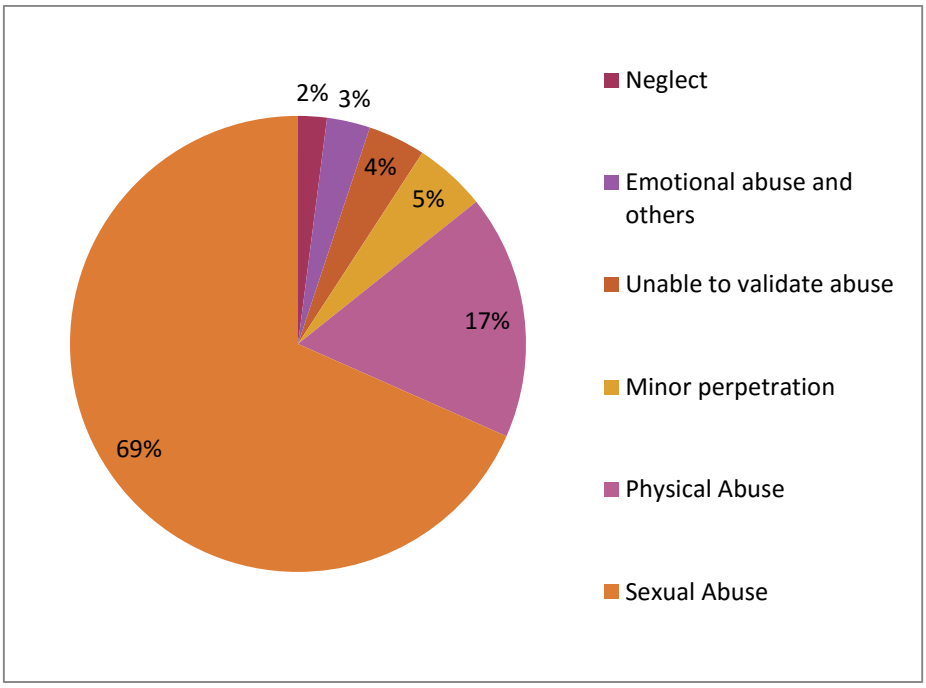

Figure 22.Percentage Distribution of VAC Cases by Type of Abuse, CPN 2014

The most common form of violence against children is sexual abuse that accounted for more than half of the total incidence, followed by physical violence and minor perpetration. This was frequently initiated towards teen girls. Boys on the other hand are more commonly abused physically. Both kinds of abuse are commonly initiated to 13-15 years old children.

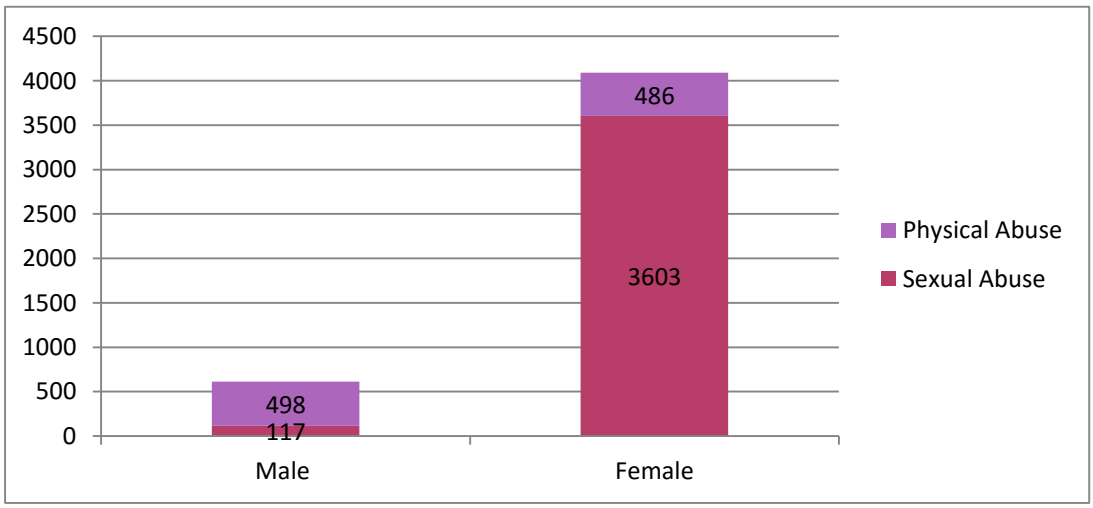

Figure 23. Distribution of VAC Physical and Sexual Abuse Cases by Gender, CPN 2014

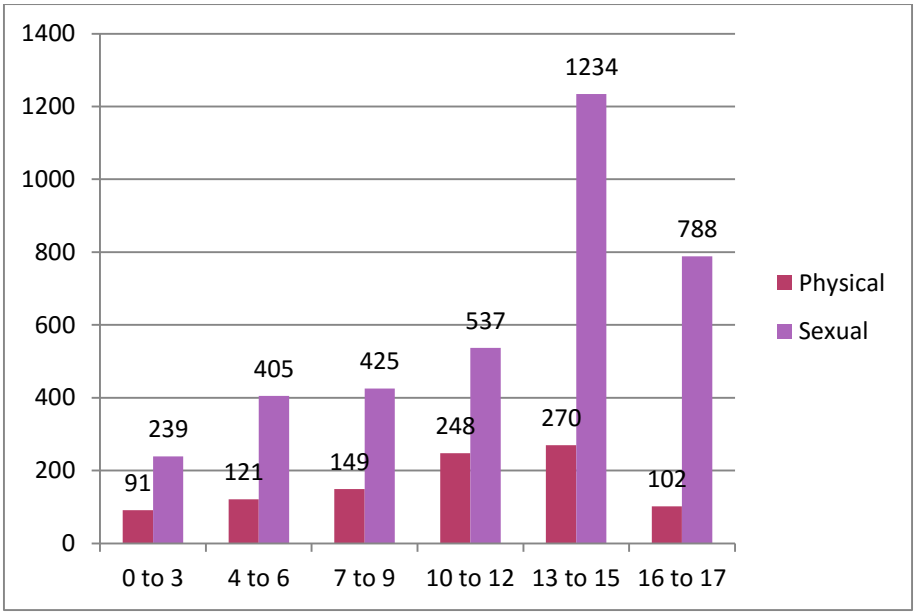

Figure 24. Distribution of VAC Physical and Sexual Abuse by Age Group, CPN 2014.

Philippine Initiatives to Eliminate Violence Against Women and Children

Specific government interventions from different agencies addressed gender-based violence. Non-governmental organizations also took part in providing technical assistance in drafting policy issuances, GBV reporting and data management systems, and support to victim-survivors of violence.

Policies Issued

Substantive gains have been achieved to recognize, respect, protect, fulfill, and promote the rights of Filipino women. One of the major accomplishments of the Philippine government in addressing gender – based violence before the enactment of the RPRH Law is the passage of several laws that address various forms of gender-based violence. National laws and policies related to VAW (Annex I-27) are:

- RA 7877 Anti – Sexual Harassment Act of 1995
- RA 8355 Anti – Rape Law of 1997
- RA 8505 Rape Victim Assistance and Protection Act of 1998
- RA 9208 Anti Trafficking in Persons Act of 2003
- RA 9262 Anti-Violence Against Women and their Children Act of 2004
- RA 9710 Magna Carta of Women of 2009
- RA 9775 Anti-Child Pornography Act of 2009
- RA 10364 Expanded Anti-trafficking in Persons Act of 2012
- RA 10398 An Act Declaring November 25 as National Consciousness Day to Eliminated Violence Against Women and Children
- Certain provisions under RA 3815 The Revised Penal Code

RA 9262 otherwise known as the Anti-Violence Against Women and their Children Act (VAWC) classifies VAWC as a public crime and penalizes physical, sexual, psychological and economic abuse against a woman in an intimate relationship. To ensure effective implementation of the law, RA 9262 mandated the creation of the *Inter-Agency Council on Violence Against Women and Their Children (IACVAWC)*. Twelve agencies were specifically tasked to formulate programs and projects to eliminate VAWC based on their respective mandates, develop capability programs for their employees to become more sensitive to the needs of their clients, and to monitor all VAW initiatives. These agencies are:

- Department of Social Welfare and Development (DSWD)
- Department of the Interior and Local Government (DILG)
- Civil Service Commission (CSC), Commission on Human Rights (CHR)
- Philippine Commission on Women (PCW)
- Department of Justice (DOJ)
- Department of Health (DOH)
- Department of Education (DepEd)
- Department of Labor and Employment (DOLE)
- Philippine National Police (PNP)
- Council for the Welfare of Children (CWC)
- National Bureau of Investigation (NBI)

Section 54 of the IRR of RA 9262 stipulates the Council's core functions as follows: (1) promotion of Anti-VAWC Act; (2) capacity-building of stakeholders; (3) development of comprehensive programs for victim-survivors; (4) networking with other stakeholders; (5) monitoring of the implementation of the Act; and (6) conduct of research to include the integrated approach to eliminate VAWC, nature and root causes of VAWC, battered woman syndrome, violence within lesbian relationships, violence committed against marginalized women, rehabilitation of VAWC perpetrators and documentation of good practices as bases for policy formulation and program development.

Administrative policies related to addressing GBV and VAWC include DSWD's Pantawid Pamilya Program through its National Advisory Committee (NAC), issued its NAC Resolution no. 23 s 2014 encouraging and monitoring of at least 70 percent of male attendance of families and couples in the family development sessions (FDS) on Responsible Parenthood and Reproductive Health and Violence Against Women and Children. In addition, Memorandum Circular No. 6 s 2015 entitled "Institutionalization of Women Friendly Space (WFS) in Camp Coordination and Camp Management" was also disseminated to DSWD field offices. The WFS will serve as a venue for the delivery of convergence support services to the youth and survivors of any forms of gender-based violence. Services included in the WFS are prenatal check-ups, breastfeeding counseling, reproductive health check-up, provision of family planning commodities, and other medical services for women.

PCW, DILG, CSC and CHED issued memorandum circulars annually to encourage all LGUs to commemorate the 18-day campaign to end violence against women by conducting activities that will reinforce the campaign. On top of this, DILG Region 2 also assisted the localization of RA 9710 Magna Carta of Women in the local governments of Cagayan and Batanes. Focusing on the establishment of VAW Desks in every barangay.

In 2015, local legislative bodies with the technical assistance of civil society organizations developed policies to address gender-based violence. The local government of Antipolo City passed their ordinance for the Code of Parental Responsibility for the Protection of Children's Right. Quezon City issued a policy on addressing street harassment as part of the Safe Cities Initiative of the United Nations Women Gender and Development Code. The institutionalization of the GBV Watch Group at the barangay level was done in Luzon, NCR, Rizal, Cavite, Laguna, Batangas, Romblon, Naga, and Eastern Samar.

Service Delivery

Critical services devoted to victims of violence are mandated in national and administrative policy issuances. The Magna Carta for Women (RA 9710) was signed into law to recognize, protect, and uphold the rights of women. One of its provisions is the creation of a Violence Against Women Desk in every barangay where victims of abuse can seek immediate assistance. A VAW desk is a physical facility that addresses VAW cases in a gender sensitive manner managed by a community member assigned by the punong baranagay. In 2010, a joint memorandum (JMC 2010 – 2) circular was issued by IACVAWC member agencies providing the *Guidelines in the Establishment of Barangay VAW Desk*. This mechanism assists the Punong Barangay to issue a Barangay Protection Orders per RA 9262 and refer women victims-survivors to access necessary services.

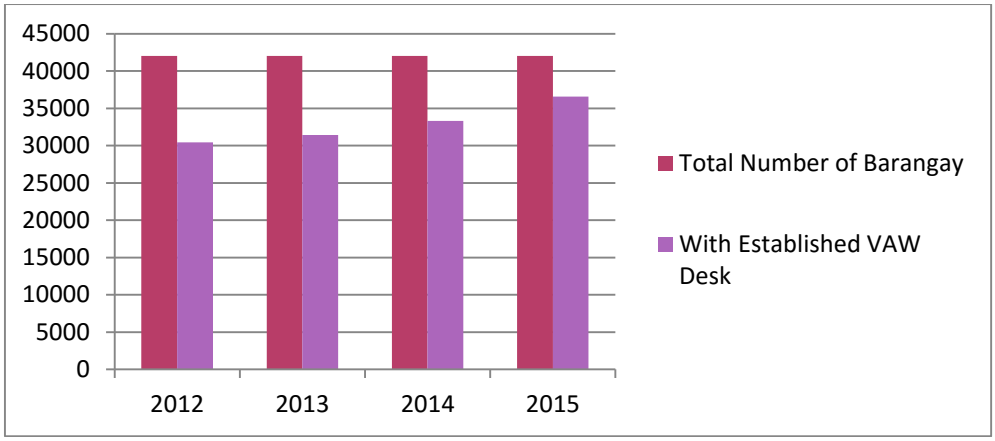

Figure 25. National Summary on the Establishment of Barangay VAW Desk, DILG 2015

The figure above illustrates barangay compliance with the establishment of VAW desk all over the country. In 2015, an additional 1,155 barangays conformed in establishing VAW desks. A 100 percent compliance was recorded in Regions I, II, IV-A, VII, and VIII (Annex I-31). Though 87 percent of barangays have established VAW desk, their functionality is currently being assessed with the development of an assessment and monitoring tool. Meanwhile, DILG continues to provide technical assistance to barangays on making the VAW Desks functional.

In providing a holistic and gender-sensitive health care for women and children who are victim-survivors of violence, the Department of Health issued an administrative order (AO No. 1-B s 1997) specifying the standards for the establishment of *Women and Child Protection Units (WCPU)* in all DOH-retained hospitals. Through the years, the provision of appropriate health care to victims of abuse has expanded to local government units. The objectives of the WCPU are the following:

- To ensure that women and children treated at DOH hospitals for injuries due to violence are given utmost care, concern and understanding;
- To create and sustain an environment within the hospital setting that is sensitive and friendly to women and children;
- To develop a systematic, gender-sensitive documentation and monitoring system; and
- To coordinate with other government and non-government institutions and organizations for a more organized approach to addressing other non-medical needs of victims and survivors of violence.

In 2014, there were 73 WCPUs, region 8 having the most number of units; 51 of which are hospital-based and 22 are attached to rural health units. The WCPU is composed of a multidisciplinary team - physician (OB-Gyne/MHO), social worker, and a WCPD police officer who have undergone training in the management of VAWC cases, primarily in the recognition, recording, reporting, and referral (4Rs).

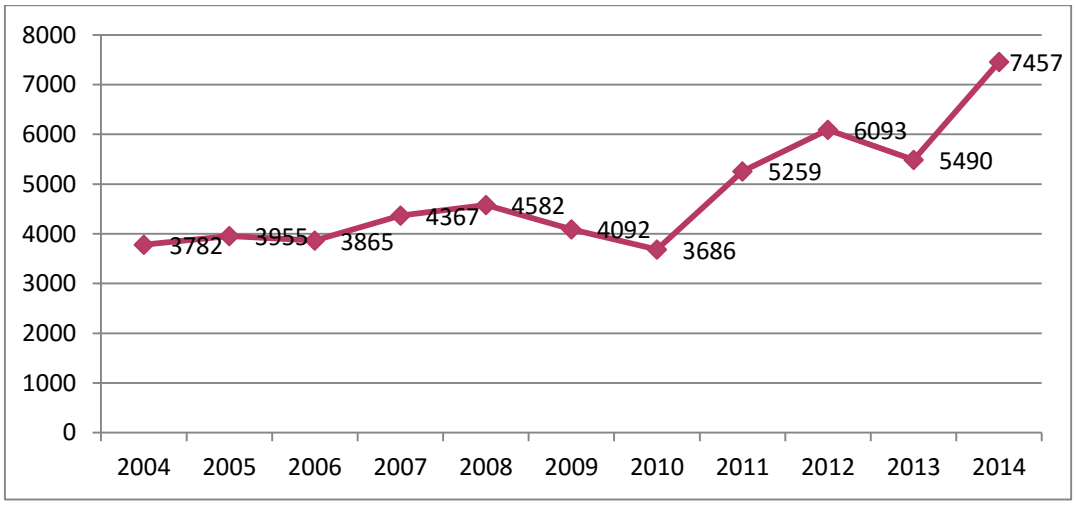

Figure 26. New VAWC Cases Served by WCPU (2004-2014), CPN 2014

From 2004 to 2014, there was a 51 percent increase of new cases served by WCPUs. The increase in reporting of cases could be attributed to the introduction of Women and Child Protection Management Information System (WCPMIS) in 40 municipalities wherein 56 social workers and IT personnel were trained.

Despite the availability of the WCPMIS developed by the Philippine General Hospital CPU, data collection on VAWC cases has remained a concern. A number of WCPUs in various parts of the country do not submit annual reports (Child Protection Network Annual Report, 2014). To address this problem, the *Violence Against Women and Children Registry System (VAWCRS)* was developed in 2015 by the Department of Health. System testing and training of VAWCRS users in 17 DOH hospitals as pilot sites were completed in the same year. VAWCRS is an online registry of patients seen in WCPUs to ensure uniformity of reports, timely follow-up of patients, and reliable data collection to guide program planning and implementation.

Other GBV-related services were provided by civil society organizations especially technical assistance to local government units. One of the services is the creation of GBV watch groups in Luzon and Eastern Samar municipalities. A total of 3,854 GBV survivors were counseled and referred to appropriate government or non-governmental institutions. The GBV Watch Groups ensure regular security patrolling, referral and/or accompaniment of GBV victim-survivors.

Demand Generation Activities

Demand generation activities were conducted by national and local governments as well as non-government organizations to raise gender-sensitivity awareness among employees, constituents, and community members. Advocacy campaigns were also initiated to enhance public consciousness to pertinent laws and possible actions to prevent victimization and re-victimization (Annex I-29).

Aside from women's empowerment programs to increase awareness and encourage reporting of VAW, men are also being organized to become more responsible and take active part in ending VAW.

Promoting Safe Communities: A Forum with Male Advocates Against Violence Everywhere. In relation to the national commemoration of the 18-day Campaign to End Violence Against Women, the Philippine Commission on Women organized a one-day forum aimed at bringing together male advocates nationwide from various organizations in an effort to bring about real and concrete changes to end VAW. The forum was co-organized with the Men Opposed to Violence against women Everywhere (MOVE).

KATROPA "Kalalakihang Tapat sa Responsibilidad at Obligasyon sa Pamilya" and MR GAD "Men's Responsibility in Gender and Development." The KATROPA program employs responsible parenthood and reproductive health classes which are tailor fitted and directed to men. This aims to embed progressive attitude and appropriate skills among men on their role in reproductive health specifically family planning decision making as well as maternal, child, and newborn care, STI & HIV/AIDS, gender equality and preventing Violence Against Women. In 2015, KATROPA Facilitator's Training and Training of Trainers were conducted among 700 participants while KATROPA Roll-Out Sessions and Orientations were attended by 1,500 men. Other notable activities conducted under this program are as follows: KATROPA Summit held for trained KATROPA advocates in the National Capital Region; KATROPA Motorcade and Symbolic Pledge event for the City of San Juan in the National Capital Region; KATROPA for Uniformed Personnel, PNP Santiago City (Region 2), PNP CARAGA Region, AFP 3rd Infantry Batallion (Region 3); KATROPA for Persons with Disabilities (Region 13).

Capacity Building

A number of capacity building activities on GBV were conducted nationwide in 2015. Among these activities are gender and development orientation among employees and mainstreaming of GAD activities organized in Luzon and Mindanao. Capacity building of Provincial Human Rights Action Team was conducted in Tarlac Provincial Health Office. CSOs assisted in the series of trainers' training in GBV prevention and response as well as the creation of GBV watch group in various regions (Refer to Annex I-30 for the list of capacity building activities).

Challenges and Recommendations

1. ***Dated and restricted laws on VAWC.*** While there is a wealth of Philippine laws enacted related to gender-based violence, these policies have to be studied and reviewed methodically since some of the provisions in earlier laws do not address new and emerging issues on GBV The Magna Carta for Women (MCW) IRR enumerates laws that must be reviewed and amended, including specific provisions of the Family Code of the Philippines and the Revised Penal Code. For instance, the Family Code automatically gives preference to the male's decision as husband or father in case of disagreement with the wife on matters affecting the family. Similarly, the Revised Penal Code contains provisions that impose criminal liabilities on women based on patriarchal notions of how women should behave, e.g. adultery vs concubinage; prostitution.

   Recommendations:

   a) Review and update of existing laws such as the Anti-rape Law, Anti-Sexual Harassment Law; the RPC provisions, the Family Code and the Anti-VAWC Act.
   b) Develop a definition of Gender Based Violence that goes beyond VAWC and encompasses developments and issues relevant to persons of diverse sexual orientation and gender identity and expression such as Lesbians, Gays, Bisexuals, Transgenders, Queers or Questioning, Intersex (LGBTQI).

2. ***Slow access to justice, legal remedies, and protection and related services***. Implementation of legal procedures is observed to be slow, tedious, and costly due to resource constraints, capability gaps, culture, and attitudes. To address this, agencies concerned have undertaken gender sensitivity and capacity development efforts, instituted monitoring mechanisms, and established gender- responsive procedures, standards, and facilities. For instance, women and child protection facilities have been created and operationalized in barangays, law enforcement agencies, social welfare agencies and hospitals

   Recommendation:

   a) Monitor and evaluate whether these efforts indeed make justice and services more accessible to women

3. ***Inadequate health and psychosocial care and support for victims-survivors due to lack of facilities and capacities, and lack of fully functional referral system among service providers***. Direct services to and empowerment of victims and survivors of VAW and human trafficking have been initiated through the Inter-Agency Council on Violence Against Women and Their Children (IACVAWC) and Inter-Agency Council Against Trafficking (IACAT), as well as their counterparts at the regional and local levels, with the help of CSOs, particularly in community-based shelters and services. These include implementing standards and monitoring mechanisms for operations, including the handling, recovery, and reintegration of victims-survivors of trafficking and VAWC. Notwithstanding these standards, LGUs involved in psychosocial care and support for victims-survivors do not have the required facilities and capacities, and the referral system among service providers is not always fully functional.

   Recommendations:

   a) Strengthen the Regional Committees on Anti-Trafficking and VAWC (RIACATVAWC) and the local counterparts (LCATVAWCS) to ensure that LGUs are capacitated to provide the health and psychosocial support to VAW victims-survivors
   b) Provide the necessary human and financial resources to effectively respond to cases of GBV at the local level, including creation of women and child-friendly facilities.
   c) Establish and strengthen the referral system at the regional and local levels for GBV cases.

4. ***Not all Barangay VAW desks are fully functional****. These VAW desks serve as a primary and initial intake point of victims-survivors of Gender-based Violence*. However, its functionality is still currently being assessed. The monitoring and evaluation mechanism is being developed. Furthermore, the constant replacement of local officials and barangay VAW desk focal persons who have been trained in giving appropriate interventions to VAWC victims hampers sustained and satisfactory provision of services for the victim-survivors.

   Recommendation:

   a) LGUs must strengthen the capability of the barangay VAW desk as well as the referral system at the LGU (LCAT-VAWC) to harmonize interventions with the national level for VAW victims-survivors.

5. ***Lack of dedicated WCPU staff and facility***. The Women and Child Protection Units under the health care system ensure that women and children examined and treated for injuries due to gender-based violence are given utmost care of health professionals. This was also developed in order to have a systematic, gender-sensitive documentation, and monitoring system, yet implementation gaps still persist. Despite the mandate issued by the Department of Health in AO 1-B s 1997 for the establishment of Women and Child Protection Units in all DOH-Retained Hospitals and its revised policy passed in 2013 (DOH AO 0011 s 2013) specifically stating the minimum requirements of a WCPU in all government hospitals, these institutions still lacks dedicated WCPU staff and physical facility that safeguards privacy, confidentiality, and safety of patients, their relatives, and WCPU staff. These requirements are very critical in the provision of both medical and psychological services for victims-survivors. According to a CPU Evaluation Study conducted in 2014, health personnel, specifically physicians, have poor assistance from the hospital in terms of attendance to out of town court hearings. Another setback is the non-existent halfway homes for victims of abuse coming from rural or geographically isolated areas referred for evaluation in tertiary hospitals in the cities.

   Recommendations:

   c) Provide adequate human resources and facility for functional WCPUs.
   d) Provide adequate budgetary allocation to the WCPUs, in addition to the GAD budget. This is in accordance with the Performance Standards and Assessment Tools for Services addressing violence against women.

6. ***Inadequate data and information for monitoring the state of GBV and victims' access to gender-responsive services***

   Recommendations:

   a) Strengthen the monitoring and evaluation mechanism for gender- responsive service delivery to victims of GBV/ VAW across service providers. In terms of information management, devise a mechanism to track VAW offenders through the establishment of an integrated criminal database. Implement VAW documentation system at the national and local levels to track the magnitude and progress of cases reported and handled by the service providers and avoid double counting of cases.
   b) Strengthen and harmonize monitoring by the concerned agencies – VAWCRS for WCPU, PCW's NVAWDocS, and WCPIMS of UP PGH CPU. Collect GBV data on marginalized women, women with disabilities, IP women and girls, Moro women and girls, women and girls with disabilities, and LGBTs.
   c) Issue a policy for the implementation of barangay VAW Desk monitoring and assessment tool and fast track the conduct of the assessment of the functionality of VAW Desks.
   d) Develop gender-sensitive client feedback system or scorecard to generate information on the level of client satisfaction with services provided by VAW service providers at all levels.

Other RH Elements: Cancer Control Program

Initiatives for Cancer Control

Prevention of Cancer, especially when integrated with the prevention of chronic diseases and other related problems (such as reproductive health, hepatitis B immunization, HIV/AIDS, occupational and environmental health), offers the greatest public health potential and the most cost-effective long term method of cancer control (WHO, 2007). It is within this premise that the RPRH Act of 2012 identified treatment of breast, reproductive cancers and other gynecologic conditions and disorders as one of the elements of reproductive health care.

In the Philippines, the Cancer Control Program of the DOH provides for preventive, curative, rehabilitative, and supportive care services to cancer clients and to those who are at high risk of developing the disease. It aims to reduce morbidity, mortality, and disability related to common preventable cancers.

Cervical cancer prevention is one of the priorities of the Cancer Control Program. This malignancy has remained a major public health problem worldwide. In the Philippine data from 1980 to 1995, the incidence rate of cervical cancer has remained relatively high at 20.5-26.4 per 100,000 women. An estimated 6,000 women are diagnosed with cervical cancer and 4,349 will die from the disease every year. The 2010 Philippine Cancer registry reported that cervical cancer ranks fifth in the estimated ten leading causes of cancer cases for both sexes and ranks second in the estimated ten leading Cancer among female. In terms of mortality, cervical cancer ranks 2nd among females.

One of the effective interventions for early detection of this malignancy and other related gynecologic disorders is cervical cancer screening. This screening program conducted by the Department of Health started in 2009 in 12 hospitals in the National Capital Region and has been expanding to other facilities nationwide. This intervention facilitates the capture of suspicious or precancerous lesions in order to prevent progression into an invasive stage.

In 2011, DOH Department Personnel Order No. 1985 s 2011 was issued for the launching of the Nationwide Free Cervical Cancer Screening among women 21 years old and above in all DOH hospitals for the month of May as part of the Cervical Cancer Awareness Month Celebration. The screening utilizes Visual Inspection using Acetic Acid Wash (VIA) that is one of the most cost effective and practical methods for cervical cancer screening among women of reproductive age in the country. The figure below summarizes the cervical cancer screening coverage for the past 5 years. Among the 4522 women screened for the past 5 years, almost 5 percent was positive for a suspicious malignant lesion. Once found to have suspicious lesions, patients are then subjected to cryotherapy for initial management and then referred for additional work-up, possible initiation of chemotherapy, or certain procedures that are deemed necessary. DOH Department Memorandum No. 2015-0120 provided the guidelines on the Conduct of Free Cervical Cancer Screening in DOH Hospitals.

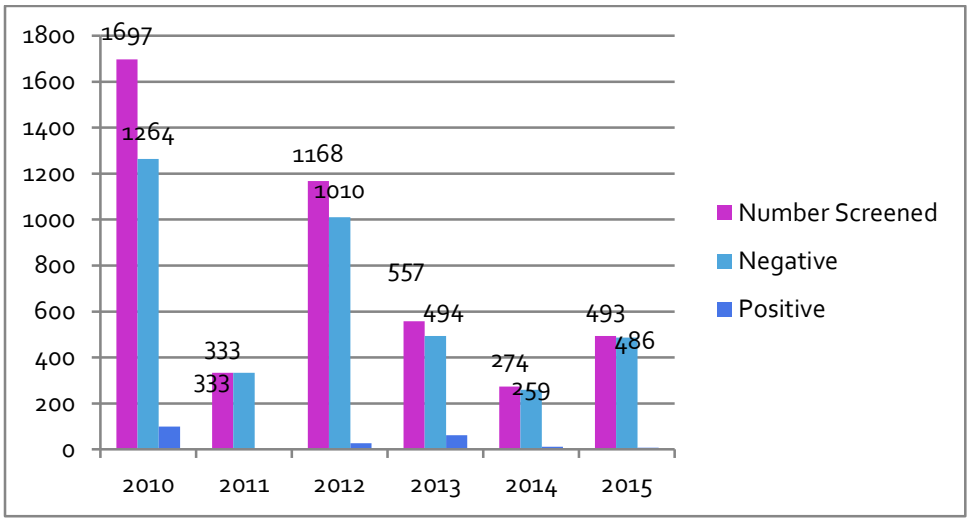

Figure 27. Cervical Cancer Screening Coverage, 2010-2015

In spite of the free cervical cancer screening nationwide, coverage remains insignificantly (0.13 percent) compared to the target in 2010 which was 80 percent. This accomplishment translated to 4 thousand women screened for five years out of the estimated 3 million eligible women. Factors identified for this poor accomplishment were low number of health workers trained in VIA especially in those communities that have difficult access to DOH hospitals. Tables 29, 30, and 31 summarize the accomplishments of the cervical screening coverage.

Table 40. Cervical Cancer Awareness Month Cervical Cancer Screening Coverage 2010-2013.

Year	Total Registered	Total Screened		Result			
		Actual Number	%	Negative		Positive	
				Actual Number	%	Actual Number	%
2010	1697	1364	80	1264	93	100	7
2011	333	333	100	333	200	0	0
2012	1168	1037	89	1010	97	27	3
2013	262	262	100	232	88	30	11
TOTAL	**3460**	**2996**	**87%**	**95%**	**157**	**157**	**5%**

Source: DOH, 2015

Table 41. Summary of Coverage of Cervical Cancer Screening during Human Resource Training, 2013-2015.

Year	Total Screened	Results					
		Positive		Negative		Suspected cancer	
		Actual Number	%	Actual Number	%	Actual Number	%
2013	295	262	89	32	11	0	0
2014	274	259	95	11	4	5	1.80
2015	493	486	99	7	1	0	0
TOTAL	**1,062**	**1,007**	**95**	**50**	**5**	**5**	**0.47**

Source: DOH, 2015

To address the low coverage of the screening, 6 trainings on VIA was conducted in various regions in 2015. There are 31 regional hospitals that have cervical screening program (Annex I-32). Among these hospitals, 94 physicians are trained. Capability building activities were likewise directed to local governments – 119 health personnel among 90 LGUs in NCR, Bicol, CARAGA, and ARMM received VIA training (Table 31).

Table 42. Cervical Cancer Training of Service Providers in LGUs, 2010-2015.

Regions	Local Government Units (RHU and LGU-owned Hospitals)	Number of Trained Health Personnel
NCR	26	43
BICOL	46	55
CARAGA	9	9
ARMM	9	12
Total	90	119

Source: DOH, 2015

Challenges and Recommendation

Limited data and information are available as basis for further developing program on cervical cancer. Intervention coverage of the different types of cancer is fairly low. In this report, only Cervical Cancer was taken into account due to unavailability of program statistics. Available data on cancer in the Philippines

underestimate the magnitude of the problem due to under reporting, lack of reliable death certificate information, and under diagnosis. In terms of prevention, information on the prevalence of risk factors for cancer is few. Furthermore, data figures on the proportion of the population receiving appropriate screening tests for the different types of cancer is deficient.

Recommendations:

a) Systematic efforts should be taken to increase reporting from regional, district and provincial hospitals, to improve physician performance on filling out death certificates, and to encourage health care worker and patient recognition of the signs of cancer (PCCP Assessment, 1996).
b) Systems should be established to improve reporting of morbidity and mortality from the local level. Reporting of cancer cases should be mandatory for all hospitals, pathology laboratories, and radiotherapy treatment units in the National Cancer Registry.
c) Develop a comprehensive plan on cancer prevention, specifically for cervical cancer. The Department should further develop a comprehensive plan on cancer prevention. Data collected from the national registry should be used for planning the DOH's cancer prevention and control programs and consequently its programmatic monitoring and evaluation mechanism. The plan must be inclusive across all types of cancer encompassing all age groups. Moreover, the comprehensive plan must highlight on policy issuances and adequate budget allocation that are fundamental in program implementation.

ANNEXES

Annex A. Policy Issuances in 2015

Table 1. MNCHN-Related Policies Issued in 2015

Policy	Issuance Reference/Date
1. Administrative Order on the Administration of Life-Saving Drugs During Maternal Care Emergencies by Nurses and Midwives in Birthing Centers In order to prevent maternal and neonatal deaths, this Order allows midwives and nurses in birthing centers to administer life-saving drugs such as oxytocin, magnesium sulfate, antenatal steroids, and antibiotics and other medicines for the management of pregnancy related complications.	AO 2015-0020 / May 11, 2015
2. Administrative Order regarding the Guidelines on the Deployment of Physicians Graduating from Residency Training Programs in the Department of Health Retained Teaching and Training Hospitals This order would provide the mechanisms in which Section 6.05 of the RPRH IRR will be implemented. By expanding the Residency Training Program in DOH-retained hospitals and Medical Pool Placement and Utilization Program to allow for the deployment of resident and specialist physicians, the DOH would be able to complement the health human resource requirements in other government hospitals in rural and underserved areas.	AO 2015-0021 / May 11, 2015
3. Administrative Order on the Guidelines on the Registration and Mapping of Conscientious Objectors and Exempt Health Facilities Pursuant to the Responsible Parenthood and Reproductive Health Act In accordance with the RPRH Law, this Order provides the standards and management protocols in which conscientious objectors and facilities exempted can register themselves and be mapped for program planning purposes. This would ensure that the delivery of the full range of reproductive health services would not be impeded at the service delivery points. It also allows for the appropriate referral mechanisms to avoid delays in service provision.	AO 2015-0027 / June 22, 2015
4. Administrative Order on the National Health Promotions and Communications Plan for RPRH Following the requirements outlined in the DOH's National Policy on Health Promotion, the Health Promotions and Communications Service is already working on the communications plan for RPRH. The guidelines include the policies in accepting sponsorships for RPRH advocacy, campaigns, and media placements, development and production of IEC materials, financing requirements, and the activities to be done during disasters and crisis situations.	Already covered by AO 2001-58; cite specific provisions or "policy statements"

Source: RPRH Inter-Agency Committee, 2015. The 1st Consolidated Report on the Implementation of RA 10354, 2014

Table 2. STI, HIV/AIDS-Related DOH Policies Issued in 2015

Policy	Issuance Reference/Date
1. **Guidelines on the Performance Evaluation of In-Vitro Diagnostic Reagents (Human Immuno Deficiency Virus (HIV), Hepatitis B Virus (HBV), Hepatitis C Virus (HCV) and Syphilis Screening, Confirmatory and Disease Monitoring Test Kits**	AO No. 2015-0005 / Feb. 9, 2015
2. **Designation of regional point-person for TB-HIV Collaboration**	DM No. 2015-0044 / Feb. 5, 2015
3. **Adjustment of TB-HIV Cohort Reporting and Regional Coordination on HIV Testing Kits for NTP**	DM No. 2015-0095 / Feb. 16, 2015
4. **Updated list of DOH –Designated Treatment Hubs and Satellite Treatment Hubs**	DM No. 2015-0139 / June 7, 2015
5. **Revised Diagnostic Algorithm Using Xpert MTB/RIF**	DM No. 2015-0260 / July 1, 2015
6. **Pilot Implementation of the Rapid HIV Diagnostic Algorithm (RHIVDA) Testing Strategy to 5 Cities in 6 Selected Clinics and 2 DOH-Retained Hospitals**	DM No. 2015-0364 / Oct. 10, 2015
7. **Initiation of Philippine Antiretroviral (ARV) Drug Resistance Surveillance**	DC No. 2015-0101 / Mar. 25, 2015

Source: RPRH Inter-Agency Committee 2015. The 1st Consolidated Report on the Implementation of RA 10354, 2014.

Annex B. Policies to be Developed in 2015

Table 3. MNCHN-Related Policies to be Developed in 2015

Policy	Status
1. Joint Memorandum Circular on the Annual RPRH Report (Section 15 of the RPRH IRR)	A draft Program Monitoring and Evaluation Guide was developed
A Monitoring and Evaluation Committee was already organized by the DOH in the first quarter of 2015 to formulate the guidelines and monitoring templates to be used by the different implementing agencies and stakeholders in reporting the annual plans and accomplishments of RPRH-related programs. The Committee is composed of M&E experts from DOH units, other government agencies, LGUs, development partners, and CSOs.	
2. Administrative Order on the Conduct of Fetal Infant Death Review	Still being developed
The DOH is currently developing the terms of reference and contract of the consultants who will develop the manual for fetal death reviews. The development of the Fetal Death Review Manual, which will follow the format of the MDR/ and IDR Manuals already developed by the DOH, is set to begin during the third quarter of 2015.	
3. Administrative Order on the Licensing Requirements for Mobile Health Care Services	Still being developed
This issuance would provide the standards and criteria for the medical services through an especially fabricated vehicle for specified areas with limited access to high quality RPRH services.	
4. Administrative Order on the National Policy on the Minimum Initial Service Package (MISP) for Reproductive Health in Health Emergencies, Natural, and Manmade Disasters	Still being developed
This enumerates the set of priority activities and services to be implemented in emergency situations that would reduce mortalities, morbidities, and disabilities through specific interventions. These interventions deal with mechanisms of coordination, gender-based violence prevention, sexually transmitted infections and HIV prevention, maternal and neonatal care services, and other services related to reproductive health.	
5. Department Memorandum Adopting the Manuals for Maternal Death Review and Infant Death Review	Still being developed
The DOH is already finalizing the manuals for the Maternal Death Review and the Infant Death Review, which would be used by the review teams at the LGU and regional level. The manuals contain the steps to be undertaken by the health professionals whenever maternal and infant deaths are reported. The roles of the health facilities, LGUs, and DOH offices are also outlined in the manuals.	

Source: RPRH Inter-Agency Committee 2015. The 1st Consolidated Report on the Implementation of RA 10354, 2014.

Annex C. Policies for Review and Updating

Table 4. Policies for Review and Updating in Different Key Areas

Policy
AO 2005-0014 or the National Policies on Infant and Young Child Feeding
AO 2007-0026 or the Revitalization of the Mother-Baby Friendly Hospital Initiative in Health Facilities with Maternity and Newborn Care Services
AO 2007-0039 or the Regulation of Birthing Homes
AO 2007-0045 or the Zinc Supplementation and Reformulated Oral Rehydration Salt in the Management of Diarrhea among Children
AO 2008-0029 or the Implementing Health Reforms for Rapid Reduction of Maternal and Neonatal Mortality
AO 2010-0015 or the Revised Policy on Child Growth Standard
Ao 2010-0010 or the Revised Policy on Micronutrient Supplementation to support achievement of 2015 MDG targets to reduce under-five and maternal deaths and address micronutrient needs of other population groups
AO 2010-0014 or the Administration of Life-saving Drugs and Medicine by Midwives to rapidly reduce maternal and neonatal morbidity and mortality
AO 2011-0014 or the Guidelines on the Certification of Health Facilities with Basic Emergency Obstetrics and Newborn Care (BEmONC) capacity
DM 2008-0106 or the Follow-up of Defaulters Immunization for Infants/ Children/ Pregnant Mothers
DM 2009-0108 or the Administration of 2nd dose Measles Vaccines to Children 15-23
DM 2009-0236 or the Immunization, Breastfeeding/ Infant and Young Child Feeding Practice and vitamin A Supplementation in Evacuation Centers
DM 2010-0161 or the Administration of Routine Second Dose Measles-Containing Vaccines for Children
DM 2011-0303 or the Micronutrient Powder Supplementation for Children 6-23 months
DM 2012-0013 or the Use of fortified products in hospitals and other food service institutions
DM 2013-0122 or the Micronutrient Powder and other Micronutrient Supplements
DC 2010-0147 or the Guidelines for Physicians on the Promotion, Protection, and Support of Breastfeeding
AO 2009-0016 or the Policies and Guidelines on the Prevention of Mother to Child Transmission (PMTCT) of Human Immunodeficiency Virus (HIV)
AO 2009-0006 or the Guidelines on Antiretroviral Therapy (ART) Among Adults and Adolescents with Human Immunodeficiency Virus (HIV) Infection
AO 2010-0028 or the Policies and Guidelines in the Conduct of Human Immunodeficiency Virus (HIV) Counseling and Testing in Community and Health Facility Settings

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

Source: RPRH Inter-Agency Committee, 2015. The 1st Annual Consolidated Report on the Implementation of R.A. No. 10354, 2014.

Annex D. RPRH-Related Policies of Other Agencies

Table 5. Policies of Other Agencies in Different Key Areas

Agency	Policy	Status
DSWD	Finalization of Memorandum Circular, "Institutionalization of Women Friendly Space in Camp Coordination and Camp Management"	Issued as DSWD Memorandum Circular No. 6 s 2015, "Institutionalization of Women Friendly Space (WFS) in Camp Coordination and Camp Management".
DILG	Memorandum Circular No. 2015-145: Reiteration of Local Government Units' Role and Foundations in the Implementation of RA 10354 Entitled "Responsible Parenthood and Reproductive Health (RPRH) Act of 2012" and its Implementing Rules and Regulations (IRR)	Issued/implemented
PhilHealth	Circular 038-2015 Subdermal implant insertion/ removal	Issued/implemented
PhilHealth	Circular 025-2015 Postpartum IUD insertion; BTL and NSV services in RHUs; Maternal Care Package, specifically accreditation of nurses as service providers	Issued/implemented
PhilHealth	Maternal care package, specifically the accreditation of nurses as providers	Still being developed

Annex E. Regional and Local Policies

Table 6. Regional and Local Policies on MNCHN in Support of RPRH Implementation

Region	Policy
NCR	Designing Financing Mechanisms to Promote Availment of Maternal Health Services
I	RDC ExCom Resolution No. 41, s. 2015: Issuance of resolution requesting the RDC-ExCom to enjoin all LGU's, Government Agencies and Civil Society Organization and Private Sector to support the implementation of the Responsible Parenthood and Reproductive Health Act of 2012.
III	IRR of Responsible Parenthood and Reproductive Health Act of 2012 (RA 10354)
III	NAC Resolution No. 23, 2014 - Mandatory Attendance of Couples to Specific Sessions in Modules 2.1 & 2.2 of the Family Development session
III	Memorandum of Agreement between Family Planning Organization of the Philippines and POPCOM Region III (Linking Demand Generation on Family Planning through the conduct of Family Development Sessions and Service Delivery
III	Memorandum of Agreement between Population Services Pilipinas Inc. and POPCOM Region III (Linking demand and Service Delivery on Family Planning
III	Pledge of Commitment of Local Population Office on KATROPA - supporting POPCOM Region III in the continuous conduct of KATROPA in their localities
III	Pledge of Support – Supporting the implementation of Philippine Population Management Program (PPMP) and Responsible Parenthood and Reproductive Health Act of 2012 (RA 10354) among partner agencies.
III	Board Resolution – stating the support of partner agencies in the implementation of PPMP and RA 10354
X	RDC-X Resolution No. 24 (s. 2015) Supporting the Regional Implementation Team of the R.A. 10354 or the Responsible Parenthood and Reproductive Health (RPRH) Act of 2012 (copy attached)
X	2. RDC-X Resolution No. 25 (s. 2015) Supporting the DOH High Impact Breakthrough (HIB) Plan/Projects
CARAGA	DOLE Admin. Order No. 221as reiteration of AO 385: "Setting Up Lactation Station for Mothers and Lactating Mothers
V	ROO No. 2015-0023 Creation of RIT for RPRH Law (March 11, 2015)
V	ROO No. 2015-0022 Recognition of FP and other health program training institution (March 23, 2015)
V	ROO No. 2015-0032 NDP deployment to barangays (May 13, 2015)
V	ROO No. 2015-0108 Guidelines for the Release and Utilization of Funds transferred to DOH-Retained Hospitals for the Implementation of FP/MNCHN/AYRH Program Strategies (Nov. 23, 2015)
V	ROO No. 2015-0130 Revised Guidelines for the Release & Utilization of Funds transferred to BMC for the conduct of FP/MNCHN Trainings (Dec 11, 2015)
CAR	Provincial Ordinance No. 167: An Ordinance Exempting Birthing Mothers from the Payment of all Hospital Services while confined in any of the Hospitals under the Operation and Management Control of the Provincial Government of Mountain Province

Region	Policy
CAR	Resolution No. 12-2011: A resolution enacting an ordinance requiring all pregnant women in the municipality to deliver in health facilities
CAR	Resolution No. 30, series - 2011: A resolution to enact an ordinance enforcing facility - based deliveries and discouraging giving birth outside of health facilities or not attended by a skilled health worker
CAR	Resolution No. 007 - 2012: A resolution enacting an ordinance making if mandatory for pregnant when within the barangay to give birth at the birthing center/barangay health station of Leneng, Kabugao, Apayao
CAR	Ordinance No. 2011-03: Ordinance enforcing the principal of facility based deliveries for pregnant mothers and discouraging giving birth outside of health facilities or not attended by an accredited midwife.
CAR	Resolution No. 085-2011: Resolution enacting an ordinance enforcing a facility based deliveries managed by skilled health professional.
CAR	Resolution no. 46 - 2011: Resolution enacting an ordinance discouraging the giving of birth outside any health facilities in the municipality or not attended by a physician or accredited midwife.
CAR	Municipal Ordinance No. 50.s. 2014: Requiring all pregnant women to undergo Pre-Natal Care, Facility Based Delivery and Post-Partum Care including Newborn and Child Care in the Municipality of Kibungan, Benguet and providing funds thereof amounting to Four Hundred Thousand Pesos.

Table 7. Regional and Local Policies on Family Planning in Support of RPRH Implementation

Region	Policy
I	RO1: RDC ExCom Resolution No. 41, s. 2015. Issuance of resolution requesting the RDC-ExCom to enjoin all LGU's, Government Agencies and Civil Society Organization and Private Sector to support the implementation of the Responsible Parenthood and Reproductive Health Act of 2012.
III	NAC Resolution No. 23, 2014 - Mandatory Attendance of Couples to Specific Sessions in Modules 2.1 & 2.2 of the Family Development session.
IVA	Memorandum of Agreement between POPCOM CALABARZON and the Civil Society Organizations (CSOs) Friendly Care (FC) and Population Services Pilipinas, Incorporated (PSPI)/Marie Stopes. It is a partnership agreement and collaboration with the FC and the Marie Stopes/PSPI to undertake the CSO Engagement project regarding Family Planning (FP) service delivery to women of reproductive age who had unmet need for FP in the provinces of Laguna, Rizal and Quezon.
IVB	Memorandum of Agreement between POPCOM and The Provincial Government of Occidental Mindoro on the Implementation of the 2015 Responsible Parenthood – Family Planning Barangay Classes under agreed terms and conditions signed last November 2015.
V	ROO No. 2015-0022 Recognition of FP and other health program training institution (March 23, 2015)
V	ROO No. 2015-0081 reconstitution of the Regional ICV Compliance Committee (October 13, 2015)

Region	Policy
V	ROO No. 2015-0023 Creation of RIT for RPRH Law (March 11, 2015)
V	ROO No. 2015-0081 reconstitution of the Regional ICV Compliance Committee (October 13, 2015)
V	Regional Memo 2015-0172 Use of the Revised Family Planning Form 1 (Dec 16, 2015)
V	Regional Memo 2015-0173 Establishment of FP Logistics Hotlines (Dec 16, 2015)
V	Revised RP-FP guidelines for UMFP referrals, RMSPDA Guidelines for LGUs, PMC Report guidelines
IX	Resolution No. IX-038-14: A resolution Supporting the Guidelines for Linking Unmet Need for Modern Family Planning with Service Delivery Network, passed during the RDC IX 146th Regular Meeting on 5 March 2014
IX	Regional Office order128-s.2015 Composition & Function of Regional Provincial ICV committee
IX	Resolution No. IX-007-2014: A Resolution to break PMC to two (2) consecutive sessions instead of the usual one (1) to intensify counselling of would- be couples and explain the responsibilities of attendees as would-be parents to their children
XI	RDC-X Resolution No.24 Series of 2015 (NEDA)
CARAGA	Revised RP-FP guidelines for UMFP referrals, RMSPDA Guidelines for LGUs, PMC Report guidelines
NCR	Issuance of Memorandum on the IRR of RPRH law implementation to the field; Memorandum Agreement on Sterilization Services for Referrals, Licensure and Accreditation

Table 8. STI HIV/AIDS-Related Regional and Local Policies in Support of RPRH Implementation

Region	Policy
III	Establishment of Premiere Medical Center as an HIV Treatment Hub
III	Establishment of Angeles City RHWC as a HIV Satellite Treatment Hub
III	Establishment of Ospital ng Lungsod del Monte as HIV Satellite Treatment Hub
CARAGA	Resolution No. 002 Series of 2014 adopting and supporting the Campaign on 101 XSX: 101 Ways to become Empowered Youth on the reproductive health and prevention of STIs among teens (Calan) AO 2014-059 Operational Plan for Adolescent and Youth Health in Baguio City Resolution passed on Youth Representative in the DRRM-CCA RDC Resolution on the Communication Plan

Table 9. GBV-Related Regional and Local Policies in Support of RPRH Implementation

Region	Policy	Particulars
II	Dept Memo 2015-125: Encouraging all LGUs to commemorate the 18-day Campaign to end violence against women by conducting activities that will reinforce the campaign	Region wide
CAR	Localization of Magna Carta of Women (JMC 2013-011)	3 LGUs of Cagayan and Batanes
IV A	Antipolo City Ordinance No. 2015-018 "An Ordinance Enacting the Antipolo City Code of Parental Responsibility for the Protection of Children's Right." An ordinance on the protection of children's right through the practice of responsible parenting	Antipolo City
NCR	Quezon City local policy on Addressing Street Harassment as part of Safe Cities Initiatives of UN Women based in Gender and Development Code of Quezon City reviewed and amended	Quezon City
NCR, IVA, IV B, V, VIII	Issuance of Barangay Ordinance institutionalizing the GBV Watch Group in Luzon, NCR, Rizal, Cavite, Laguna, Batangas, Romblon, Naga and Eastern Samar – ongoing	NCR, Rizal, Cavite, Laguna, Batangas, Romblon, Naga, and Eastern Samar

Annex F. Maternal, Neonatal, Child Health, and Nutrition

Table 10. Regional and Local Demand Generation Activities on MNCHN

Region	Demand Generation Strategy/ Activity	Particulars
XIII	Participation of the Pantawid Pamilya beneficiaries in Women's Month and Children's Celebrations	Regional; DSWD-13
XIII	Safe Motherhood and Family Week Celebration	Regional; DOH
XIII	Safe Motherhood Celebration / Buntis Congress for 6 cities	6 cities; DOH/LGUs
XIII	Awarding for the Best of the Best province	Regional; DOH
NCR	Tsekap Orientation (in coordination with DOH and POPCOM speaker)	PhilHealth
NCR	Buntis Party in NCRO Retained Hospitals	600 pregnant women from 17 LGUs; USAID/DOH-NCR
I	RP-RH Roll-out orientation conducted to ensure that all stakeholders and partner agencies get informed and involved. Every after orientation, was the commitment to support and strengthen the information dissemination of the Law at the municipal/barangay level.	Covered 3 provinces (Ilocos Norte, Ilocos Sur and Pangasinan) and 6 cities from February-October
I	Conduct of various advocacy and communication activities in the Universal Health Care – High Impact 5	DOH Region 1 and POPCOM Regional Office 1; 4 provinces in Region I; 5 KP Caravans and 4 Hi5 Summits conducted
I	Mother's classes on FP and MCHN: Organized and conducted a region wide information/education/communication campaign on responsible parenting and reproductive health and family planning emphasizing on the responsibility of a woman as a mother and wife.	

Region	Demand Generation Strategy/ Activity	Particulars
I	The Buntis Congress was instigated by DOH RO1 to reduce the incidence of maternal deaths, infant mortality, and teenage pregnancies in the region. WRA are provided with FP counselling. Pregnant women have been given prenatal check-up and ultrasound service.	Region I
I	Women's Health Advocacy: An advocacy to promote greater awareness among pregnant and "would be pregnant" mothers on maternal and infant health, safe pregnancy, good nutrition, delivery, post-partum care and breastfeeding.	Conducted through the City Government of Vigan
II	Conduct of Buntis Congress	615 participants
III	Buntis Congress	Camiling and Victoria, Tarlac; Provincial Health Office- Tarlac; 100 pregnant women per municipality
III	Parent Functional Literacy	Province of Tarlac; Provincial Health Office-Tarlac; 100 Aeta Mothers
III	High Impact Five Caravan	Province of Tarlac; Provincial Health Office-Tarlac; 250 mothers and Children
III	Conduct of FDS	Region wide; POPCOM Region III; 1,324 sessions conducted
III	Conduct of PMC	Region wide; POPCOM Region III; 910 sessions conducted
III	Conduct of Mother's Class/Usapan Serye/RPM	Region wide; POPCOM Region III; 154 sessions conducted
IV-A	Provision of ANC booklets: Booklet ni Nanay at Baby	Region wide
IV-A	Provision of IEC Materials	Region wide
IV-A	Women's Health Month Celebration (Forum/Lectures)	Region wide
IV-A	Buntis Congress: This is a 1-day activity where pregnant women and their partners were educated on proper nutrition and responsible parenthood. Breastfeeding, newborn screening and other services were provided for the participants. High risk women were counseled and aided in making birth plans and were referred to the health workers. This activity was conducted in Binangonan, Rizal.	POPCOM CALABARZON
IV-A	Family Development Sessions/RP-FP Classes, (Sub-Module 2.2)	A total of 67,136 couples attended the FDS/RP-FP classes
IV-B	Buntis Congress: It is a one-day activity where pregnant women, along with their partners will be educated on proper nutrition, responsible parenthood. Breastfeeding, newborn screening and among others. Through this activity, high risk women will be counseled and aided in making birth plans and will be referred to the health workers.	This activity was conducted at Buenavista, Marinduque last August 2015.

Region	Demand Generation Strategy/ Activity	Particulars
IV-B	Coduct of FDS sessions on sub-module 2.2. Pagiging Responsableng Magulang at Pagpaplano ng Pamilya conducted with partner faith-based CSOs: (Session 1 – Kahalagahan ng Pagpaplano ng Pamilya; Session 2 – Pagtutulungan ng Mag-Asawa sa Pagpaplano ng Pamilya; Session 3 – Mga Pamamaraan ng Pagpaplano ng Pamilya; and Session 4 – Pagiging Magulang at Pagiging Responssableng Magulang)	53, 119 Pantawid Pamilya beneficiaries attended FDS; with support from International Holistic Engagement for Life and Progress (iHELP Inc.), Lighthouse Christian Community Ministries Foundation Inc., and Local Population Officers under the PSWDO of Occidental Mindoro; 1,645 FDS on Sub-module 2.2 conducted
VII	Conduct of Buntis Congress	3 sessions; Bohol, Cebu, Neg. Or Province; DOH-LHSD-FHS; To be conducted. 14 sessions reported as accomplishment
X	Conduct advocacy to sustain the FP-ANC-EPI Integration to every municipality	Misamis Oriental
X	Conducted advocacy and promotional conference on proper management and strengthening referral of abortion cases.	Regional; Mindanao Health and POPCOM - 10; Done in partnership with Mindanao Health
X	Conducted "Couple's Party on Safe Motherhood/Roadshow Universal Health Care	Bukidnon, Misamis Occidental, Lanao del Norte, Camiguin; POPCOM - 10; with DOH-10
X	Hi5 and Safe Motherhood Congress	Cagayan de Oro; POPCOM - 10
V	Conduct of FDS, PMC and Mother's Class	8,191 classes held; 83,242 couples reached; Regional POPCOM V
V	Conduct of Family Development Sessions on Module 2.2	2,043 FDS conducted; 319,418 total attendees (30,305 males and 289,113 female; 6,815 couples; 3,324 indigenous people); Regional DSWD V
V	Conduct of Buntis Congresses	78 sessions; Regional DOH ROV
V	Conduct of KP Health Caravans	64 sessions; Regional DOH ROV
V	Women's Week Celebration	Naga City, Province of Camarines Sur, FPOP
V	Conduct of newborn screening (NBS) Awareness Campaign	2,965 participants; October-November 2015

Region	Demand Generation Strategy/ Activity	Particulars
IX	"Usapang Buntis" conducted	Dapitan City; Dapitan CHO; Buntis Kits was given by DOH. Lunch, decorations, token, Mrs.Buntis Pageant, free lab kits & contingencies-LGU.
IX	Various demand generation activities on MNCHN conducted: Community assemblies on safe motherhood conducted: Mother's class on safe motherhood conducted; Individual counseling on ANC; IYCF flip charts distributed; Mother and baby books distributed	Validate other info from RO IX re number of sessions conducted, beneficiaries, etc.
IX	Buntis congress conducted: Breastfeeding and Micronutrient Supplementation, Prenatal and immunization; Philhealth maternal package, Blood donation (c/o Red cross), Serbisyobilis, Dental, Free vitamins and milk for mothers, Family Planning, Free Laboratory, Mrs. Buntis 2015	Validate other info from RO IX re number of sessions conducted, beneficiaries, etc.
CAR	Special events such as Buntis Congress	DOH RO CAR, FPOP, and Luzon Health; covering Benguet, Mt. Province and 4 Municipalities in Benguet
CAR	UHC Caravan; Services Provided: Laboratory Services (Urinalysis, Blood Typing, Hgb/ Hct RPR/ Syphilis Testing), Dental Services, Ultrasound Services, Consultation (Pre-natal and prescription of medicines, Information Education Campaign (Family Health Diary, Dental, PHIC, Nutrition/ Breastfeeding, Family Planning, NBS), Family Planning Counselling, Pharmacy	DOH RO CAR; covering Benguet, Abra and Apayao
CAR	3. Participation in the City Pasadang Pambarangay (PPB)	FPOP; covering Barangays in the City of Baguio
CAR	4. Conduct of Mother's Classes in partnership with LGUs	FPOP; covering Baguio and La Trinidad

Table 11. Summary of BEmONC Training, October 2015

Region	CEmONC	BEmONC Facilities				BEmONC Teams			BEmONC Covered by Trained Teams	% Coverage of Trained Teams
		Total	RHU	BHS	Hospitals	Required	Trained	Accomplishment %		
Ilocos	19	123	102	6	21	123	128	104%	121	98%
Cagayan Valley	16	109	84	18	25	109	108	99%	100	92%
Central Luzon	27	171	146	21	25	171	184	108%	161	94%
CALABARZON	13	143	110	152	33	143	157	110%	140	98%
MIMAROPA	18	87	70	12	17	87	100	115%	76	87%
Bicol	17	144	111	41	33	144	224	156%	139	97%
Western Visayas	12	133	111	8	22	133	147	111%	126	95%
Central Visayas	34	109	97	1	12	109	118	108%	107	98%
Eastern Visayas	29	137	113	38	24	137	158	115%	131	96%
Zamboanga	10	108	94	25	14	108	127	118%	105	97%
Northern Mindanao	12	80	77	23	3	80	93	116%	76	95%
Davao	2	67	52	0	15	67	68	101%	57	85%
SOCSARGEN	9	55	40	17	15	55	65	118%	52	95%
CARAGA	14	75	57	13	16	75	93	124%	75	100%
CAR	10	91	62	96	29	91	126	138%	84	92%
ARMM	8	56	46	6	10	56	46	82%	39	70%
Metro Manila	3	47	46	0	1	47	54	115%	47	100%
TOTAL	253	1735	1418	477	315	1735	1996	115%	1636	94%

Source: DOH Safe Motherhood Program, 2015.

Table 12. Regional and Local Capacity Building Activities on MNCHN

Region	Capacity Building Strategy/ Activity
NCR	Lactation Management Training
NCR	Buntis 101
NCR	FP-MNCHN Consultative Meeting and updates
NCR	Training on Maternal and Neonatal Death Review Reporting System
NCR	Orientation on UHC High Impact Five Plan
NCR	Inter-Regional Meeting on MNCHN
NCR	Orientation on Maternal Death Review
NCR	Universal Health Care High Five Summit
I	Conducted symposium tackling women's health. The PHO also provided free medical checkup which includes free Pap smear, urine and blood testing while representatives from Technical Education and Skills Development Authority (TESDA) Norte will offered free haircut, make over and body massage at the La Tabacalera Function Hall, Laoag City.
I	Conducted trainings on 3 different hospitals. The training was conducted to enhance the service delivery skills of Health Providers in BEmONC facility.
I	Writeshop for Documentary Requirements of PhilHealth for MCP/NCP accreditation & DOH-LTO certification.
I	Training on Child Injury Prevention Program: This aims to enhance the knowledge and skills in the implementation of the Chill Injury Prevention Program for health workers and other responding agencies.
I	Interpersonal Communication Counselling Training o FP, MNCHN, and TB for NDP's to enhance the knowledge and learning of nurses under the Nurse Deployment Program regarding family planning and maternal and child health.
I	Conducted Basic Emergency Obstetric & Newborn Care (BEmONC) Skills Training Course in 3 different hospitals. The training was conducted to enhance the service delivery skills of Health Providers in BEmONC facility.
II	Diagnostic Workshop for Trained FP & BEmONC Health Service Providers
III	Maternal Health Updates for Government and Private Birthing Facilities
III	Training on Maternal Death Review and Reporting System for LGUs
III	Re-orientation on Maternal Death Review and Reporting System for LGUs
III	BEmONC Service Delivery Network Consultative Meeting
III	Maternal Death Review Conference
III	Training of Trainers- Lactation Management Training
III	Lactation Management Training
IV-A	RP-RH Budget Advocacy Training: The RP-RH Law calls for multi-stakeholder approach and enjoins all stakeholders to popularize the law to all segments of the population, including advocacy to LGU officials for necessary budgetary allocation. This training was for CSOs and Media Practitioners held in Batangas.
IV-A	MR GAD/KATROPA Training of Male Advocates: This a whole-day session intended to highlight the role of men in promoting maternal and child health and responsible parenting. The training was conducted in the provinces of Rizal, Cavite, Batangas and Laguna.
IV-B	Conducted RP-RH Budget Advocacy Training: The RPRH Law calls for multi-stakeholder approach and enjoins all stakeholders to popularize the law to all segments of the population, including advocacy to LGU officials for necessary budgetary allocation.
IV-B	MR GAD/KATROPA Training of Male Advocates: It is a whole day session intended to highlight the role of men in promoting maternal and child health and responsible parenting.
VII	Conducted Orientation on HPV Immunization
VII	Conducted BEmONC Team Approach training, and BEmONC for Midwives training

Region	Capacity Building Strategy/ Activity
VII	Conducted Lactation Management Education Training
X	Conducted "Couple's Party on Safe Motherhood/Roadshow Universal Health Care
X	Conducted Hi5 and Safe Motherhood Congress
IX	BEmONC Team Training
IX	BEmONC Training for RHMs
IX	Essential Intrapartum and Newborn Care Training
V	5 Batches of BEMONC Training for Midwives (139 health providers trained)
V	4 Batches Orientation for public and private birthing homes (250 pax oriented)
V	Training on Community Based Management of acute malnutrition (35 pax trained)
V	NBS Training with Actual Heel Prick (128 pax trained)
V	TOT on Lactation Management (20 pax trained)
V	MNDR Orientation (46 pax oriented)
V	Basic EPI Training (35 pax trained)
V	TOT on IYCF-CGS
V	G6PD Deficiency Parents' Forum
V	RPRH Law Orientation
V	RAIDERS Training (641 pax trained)
V	Training on IYCF (6 batches)
V	7 batches Training on KATROPA
V	7 batches Pre-Marriage Counseling (PMC) Training for PMC Counselors
XI	BeMoncTraining for RHMs
XI	BeMonc Refresher Course
XI	EINC Training
XI	Quality Assurance Package Training for Supervisor Nurses/ Midwives
XI	Orientation and Workshop on Pregnancy Tracking and FP Tracking Tool
XII	BeMoncTraining
XII	Newborn screening training
CAR	Conduct of Basic Emergency Obstetric and New Born Care (BeMonc) Training
CAR	Harmonized Basic Emergency Obstetric and Newborn Training
CAR	Conduct of Basic Emergency Obstetric and New Born Care (BeMonc) Didactics training
CAR	Conduct of Regional Maternal Neonatal, Death Review
CAR	Conduct of Integrated MNCHN PIR in all provinces and city in CAR
CAR	Conduct of Provincial Maternal Neonatal Death Review
CAR	Conduct of Maternal Neonatal Death Reporting System Training for all the health workers
CAR	Presented the MDG on Health to SUCs & other HEIS during the Regional Health Research Roadshows in Abra, Ifugao& Kalinga
CAR	Orientation on Suppelmentary Feeding to LGUs
CAR	Training on Child Injury Prevention and Control

Table 13. MNCHN Commodities, Drugs, Supplies and Materials Procured in 2015, Per Region

Region	Commodities procured/ delivered	Amount
XIII	Ferrous Sulfate + folic acid tablet for pregnant women	1,000,000
XIII	Grade 1-MR Immunization- 41,447 / 62% TD Immunization - 48,896/ 74% Grade 7-MR Immunization- 36,276 / 70% TD Immunization - 36,329/ 70%	3,000,000
NCR	Mother and Baby Book	4,308,000
IV-A	Emergency drugs procured; Drugs & Medical Supplies procures	1,136,700
IV-B	Buntis Kits	No amount indicated
X	Made Purchase Request of different FP Commodities, logistics and supplies for processing and bidding. Allocation and delivery of available FP commodities and supplies	
IX	Oxytocin	384,000
IX	Buntis Kits	2,429,910
V	Procurement of Safe Motherhood Logistics	500,000
V	Procurement of School-Based Immunization Commodities	400,000
V	Procurement of NBS Logistics (1000 NBS kits)	550,000
V	Procurement of buntis kits (7126 kits)	3,527,370
V	Measuring tools (184 height boards and 125 Salter weighing scales)	No amount indicated
V	Ready to Use Therapeutic Foods (8,250 sachets)	No amount indicated
CAR	Mother and Child Book	100,000
CAR	Maternal Kits (Dental Kits, Bath Soap, Alcohol, Sanitary Napkin, Adult Diaper, Thermometer Digital, Mittens and Caps for Newborn, Umbilical Cord, Newborn ID tags, Newborn Diaper, Baby Oil, Face Towel)	3,281,820
CAR	Ferrous Sulfate with Folic Acid, 60 mg/400mcg folic acid, 100 tablets	3,578,600
CAR	Vitamin A, 200,000 IU, 500 capsules/bottle	87,780
CAR	Family Health Diary	300,000
IX	Oxytocin	384,000
IX	Buntis Kits	2,429,910
IX	Various MNCHN drugs, commodities, supplies and materials: Ferrous sulfate + folic acid tabs, Vitamin A (200,000 IU) caps, Mother and baby books; ECCD cards, Terramycin ointments, Vitamin K amps, Oxytocin amps, Mefenamic acid caps, Cephalexin caps, Atropine sulfate amps, Calcium gluconate amps, Magnesium sulfate amps, Diphenhydramine amps, Epinephrine amps, Supplies and Materials	

Table 14. Complementary MNCHN Services Conducted in 2015

Region	Service Delivery Strategy/Activity
XIII	Assistance payment for blood screening to BC
XIII	Assistance to DOH Retained Hospital on blood needs
V	113 clients for Pap smear
CAR	Provision of Buntis kits for pregnant mothers
CAR	Conduct of on-site visits for Safe Motherhood in the health facilities
CAR	Accreditation of out-patient health facilities for Maternity Care Package
CAR	Poor families receiving CCT provided with regular immunization and health care, day care sessions, and access to preschools and grade school

Annex G. Family Planning

Table 15. Trend in Contraceptive Prevalence Rate 2013-2015

AREA	CPR (2013)	CPR (2014)	CPR (2015)
Philippines	**39.53**	**41.14**	**43.79**
NCR	42.04	44.91	44.44
CAR	39.88	45.28	50.51
I	44.99	48.96	56.96
II	55.26	56.89	61.20
III	21.88	31.28	36.30
IVA	40.8	18.85	29.40
IVB	56.18	52.61	50.16
V	38.36	38.53	39.65
VI	40.21	43.82	46.57
VII	21.28	31.69	32.71
VIII	32.81	41.65	43.57
IX	39.12	47.42	50.18
X	46.82	49.02	52.99
XI	59.68	63.98	54.33
XII	57.01	61.84	61.80
ARMM	18.11	33.56	35.48
CARAGA	56.08	78.87	59.87

Table 16. Number of Current User by Method, 2015

FP Method	No of Current User	% Method Mix
All MFP Methods	5,085,895	100.00
Pills	1,952,190	38.67
Injectable	817,750	15.56
BTL	718,553	13.82
NFP LAM	649,182	13.21
IUD	400,071	7.98
Male Condom	251,593	4.67
NFP- FAB	182,824	3.61
Implants	100,869	2.21
NSV	12,863	0.28

Source: FHSIS 2015.

Table 17. Family Planning Commodities Procured, 2014

Region	Central Allocation (Quantity)				
	PILLS (COC)	PILLS (POP)	DMPA Injectable	IUD	Implants
NCR	513,263	131,474	189,512	-	39,865
CAR	145,552	37,284	53,742	-	11,305
RO I	367,711	94,190	135,770	-	28,560
RO II	191,516	49,058	70,713	-	14,875
RO III	505,602	129,512	186,683	-	39,270
RO IV-A	612,851	156,984	226,283	-	47,600
RO IV-B	367,711	94,190	135,770	-	28,560
RO V	681,797	174,645	251,740	-	52,955
RO VI	582,209	149,135	214,969	-	45,220
RO VII	505,602	129,512	186,683	-	39,270
RO VIII	497,942	127,550	183,855	-	38,675
RO IX	513,263	131,474	189,512	-	39,865
RO X	482,620	123,625	178,198	-	37,485
RO XI	390,693	100,077	144,255	-	30,345
RO XII	467,299	119,700	172,541	-	36,295
RO XIII	352,389	123,625	130,113	-	27,370
ARMM	482,620	90,266	178,198	-	37,485
DOH-CO (Buffer)	339,360	37,700	171,465	-	105,000
TOTAL	**8,000,000**	**2,000,000**	**3,000,000**	**-**	**700,000**

Table 18. Donated Progestin Subdermal Implant (PSI) Units by UNFPA, 2015.

Partners	Number of PSI Units Distributed
Amang Rodriguez Medical Center	10
AMHOP RO2	56
Cotabato Regional Medical Center	292
Fabella	12,828
Friendly Care	1,008
Dr. Jose Reyes Memorial Medical Center	85
Laguna	130
LIKHAAN	5,600
MindanaoHealth	1,680
Muntinlupa	504
PHO Cagayan	504
POPCOM	2,096
Quirino Memorial Medical Center	342
Quezon City	929
Taguig	896
UNFPA Davao	200
Visayas Health	582
Grand Total	**28,750**

Table 19. Proposed 2015 Family Planning Commodities Procurement for Distribution in 2016.

Type of FP Commodity	Quantity
Pills (COC)	12,000,000
Pills (POP)	1,181,000
DMPA Injectables	3,000,000
IUD	500,000
Male Condoms	25,300,000
Standard Days Method (cycle beads)	12,500
Symptothermal method (charts)	143,000
Cervical Mucus Method (charts)	143,000
Basal Body Temperature (charts)	143,000

Annex H. STI, HIV/AIDS

Table 20. Regional/ local/CSO demand generation activities for the STI, HIV/AIDS Program

Region/LGU/CSO	Demand Generation Strategy/ Activity
II	AIDS Congress (World AIDS Day Celebration)
III	Conduct of Gay Community for a
III	HIV Awareness Campaign
III	Regional AIDS Assistance Team Meetings (3 Batches)
IV-A	Peer Education Program
IV-A	Program – (Prevention Treatment, Care and Support)-trainings/education and advocacy in Calamba (DepEd)
IV-A	Conduct of HIV/AIDS Lecture to Forum on HIV/AIDS and Teen Pregnancy in Cavite (DepEd)
IV-A	One Day HIV lecture and counseling and proper lecture for HIV/AIDS for counselors in Dasmarinas, Cavite (DepEd)
IV-A	Youth Camp (POPCOM Calabarzon)
IV-A	U4U Facilitator's Training
IV-B	Youth Camp
IV-B	U4U Facilitator's Training
IV-B	World AIDS Day Celebration among High School Students (Oriental Mindoro, Palawan)
IV-B	HIV/AIDS Awareness Campaign and Launching of Red Top Center in celebration of the National HIV Testing Week (May 11-15, 2015)
IV-B	Conduct of Voluntary HIV Counseling and Testing during the Health Summit in Connection with the High Impact Five Program of DOH in selected provinces (HI 5 Caravan)
V	Cupid Shoots Arrow on National Condom Week
V	International AIDS Candlelight Memorial
V	Forums on FP and STI/HIV AIDS Awareness
V	TB-HIV Summit
X	Orientation on STI/HIV/AIDS Workplace Policy and Education in selected LGUs (per DILGMC 2013-29 and CSC MC 2013-11)
XI	Orientation on STI/HIV/AIDS Workplace Policy and Education (per DILG MC 2013 29 and CSC MC 2013-11) and RA 10354
XI	Candlelight and Celebration
XII	International AIDS Candlelight Memorial
XIII	HIV and AIDS Orientation
PNGOC	Infographic on HIV/AIDS
	Photo campaign in celebration of Transgender Identities; platform for engaging transmen and transwomen
PNGOC	Sub-national forum on promotion of HIV screening and Launch of Visual Campaigns for National HIV Testing Week
PNGOC	Media, stakeholders, and community engagement for the National HIV Testing Week
PNGOC **TLY**	LoveYourself Pride Caravan promoting HIV awareness to the communities
PNGOC	World AIDS Day Neon Advocacy Run
Save The Children	Community and outreach events conducted Conduct of MARCY/YKAP workshop

Region/LGU/CSO	Demand Generation Strategy/ Activity
TLF	Outreach activities
TLF	Video development relating to HIV & AIDS and condom use
TLF	Condom promotion to gays, bisexuals, and transgender people
PSFI	Conduct of HIV orientation in different companies (BPOs, manufacturing, maritime & supply chain, schools/universities, Shell companies & contractors; dialogues/symposia with groups, contractors, etc.
PPAP	PLHIV testimonials in fora, symposia, and workshops
TUCP	Press conference in eliminating discrimination on PLHIVs
IPPRP	Conducted 3 demand-generation/outreach activities
ROH	Forum conducted in High School students sponsored by PNGOC
PLCPD	1 high-impact event at Zamboanga AIDS Congress, QC, and CAR with media briefing; distributed policy briefs on HIV

Table 21. Regional/Local/CSO Capacity Building Activities on STI, HIV/AIDS

Capacity Building Strategy/ Activity
HIV Orientation for Health Workers
Training on Mother-Child Transmission of Human Immunodeficiency Virus (HIV)
Enhanced Comprehensive STI Case Management Training and Related Service Packages
Enhancing STI/HIV and Health Services for Men Having Sex with Men (MSM) and Transgender
Provider-initiated counseling and testing training
Training on HIV/AIDS for LGU officials and functionaries
Training/TOT on HIV Counseling and Testing
Training on STI microscopy
HIV AIDS Core Team (HACT) Orientation and Training on Clinical Management
Training on Gram staining for Medical Technologists (Palawan and Romblon)
Orientation on HIV/AIDS for barangay officials (87 pax)
Seminar on Integrated STI, HIV and AIDS Prevention, Management, Counseling for Program Coordinators in Davao Region
100% CUP Training
Orientation and workshop on treatment adherence on antiretroviral drug
GAME: Gender and Age-Sensitivity Mainstreaming in HIV Programs for HIV Service Providers for QCSAC and QCHD staff Aimed to enhance the capacities of QCSAC members in HIV and AIDS issues of young people from key populations as well as young people of different genders
Development of PMTCT Implementation Manual Aimed to institutionalize the PMTCT trainings in the LGU among healthcare workers in the health centers. Ensure a clear and smooth implementation of the program, from case detection, referral, and treatment
Pilot Training for the PMTCT Manual Aimed to ensure that the manual captures the need of frontline health service providers
Conduct of BCC outreach activities (HIV 101, C&L demo and distribution, and referral to facility) by 343 peer educators assigned in 12 project sites. Conduct of HIV Counseling and Testing (Community & Facility based HCT) two to three times a week in each sites.

Capacity Building Strategy/ Activity
Training of Site Implementation Officer (SIOs) on Interpersonal Communication Skills on the following dates on February 22-24, 2015 at Regency Inn, Davao City with 13 SIOs; Training of Site Implementation Officer on Behavior Change Communication on a) March 10-13, 2015 at Alta Cebu Village Garden Resort & Convention Center, Cordova, Cebu with 17 pax b) May 30, 2015 at La Vista Pansol, Calamba, Laguna with 14 pax; Peer Education Training: Enhancement of Peer education on: a) March 22-28, 2015 at Apo View Hotel, Davao City with 24 PE and 2 SIOs b) April 13-16, 2015 at Marco, Cagayan de Oro City with 11 PE and 2 SIOs c) April 20-24, 2015 at Alta Cebu Village Resort & Convention Center, Cordova, Cebu with 19 Peer Educators and 3 SIOs d) May 11-15, 2015 at Bayview Park Hotel, Manila at Bayview Park Hotel, Manila with 26 Peer Educators e) May 25-29, 2015 at La Vista Pansol, Pansol, Laguna Conduct of Learning Group Sessions with 343 Peer Educators once a week in all sites with their 40 SIOs. Conduct of TA on the Support to strengthening Local AIDS Council in NCR & TFM sites outside NCR Strategy for condom promotion (no sell of condom and no repacking and selling of condoms) by TLF share Inc. TA on HCT Same Day Results by HAIN Inc. Reproduction of HCT Flipchart for HCT providers and HCT manual tool kit and Handbook
Trainings for Marine desk assistant students FORUM on Men's Health for Banaue Ifugao FORUM on Men's Health for Banaue Ifugao FORUM for the BHWs and Brgy. Officials of the Municipality of Malinao, Albay FORUM at Bicol University of Polangui Campus FORUM at Pentagon FORUM entitled "Fulfilling the Promise of the RPRH Law for Health Workers & Young People - Cebu" FORUM entitled "UP College of Medicine Responding to the Rapid Rise in Incidence of HIV/AIDS through Community Mobilization" Aimed to increase awareness on HIV/AIDS and link to existing services for prevention
Toyo Construction Company- Sta. Ana Manila- Basic HIV Concepts, RA 8504 and Primer on HIV and the Workplace policy, Testimonials of 2 PLHIVs, Assessment and Open Forum - Toyo Construction Company-Pasig same activity

Capacity Building Strategy/ Activity
- Resort World Manila-same activity - Kilusang Jolibee w/ TUCP same activity - Calamba Doctors Hospital-same activity
- Youth Speakers Training on Basic HIV and AIDS
- Pastoral and Diocesan Basic Training on HIV and AIDS
- Conduct of HIV 101/orientation and VCT at the workplace to the business sector- BPOs, manufacturing, maritime and supply chain in the key cities in Metro Manila, Palawan and Batangas - Conduct of HIV 101/orientation and VCT in schools/universities in Metro Manila, Palawan and Batangas City - Conduct of HIV 101/orientation and VCT at the work place for Shell companies and contractors - Conduct of Reproductive Health Workshops (including Gender and Development) in schools and communities (in partnership with Roots for Health and Universities)
Establish links with LGUS to be members of its Local AIDS Council Strengthen role of PSFI in DOLE-OSCH Business Coalition in Asia Technical Working Group TOT Training for the staff of PSFI to conduct HIV 101 incorporation in the LEAD workshop of PSFI Training workshop for the medical staff of Shell Companies in the Philippines (PICT), TOT for HIV 101 and Peer Educators Trainings (2 batches) Strengthen partnership with CBCP for Pastoral HIV 101 Training - Aimed to institutionalize workplace policies on prevention interventions among the business through linkages with Local Government Units
Outreach activities Video Development Learning Group Sessions On-site HIV Testing
Peer Educators Training
Outreach events
Community events
Conduct of MARCY/YKAP workshop
Support for Community-Based Organizations (CBOs) to coordinate and engage to conduct advocacy for demand generation for HIV services or for human rights (Advocacy Grant for HIV, SOGIE and HR)
Roll-out training of Peer Educators to formulate Peer Education Implementation Plan
Training of Peer Educators on Behavior Change Communication
M&E Training on Data Analysis and Utilization of strategic information in Manila

Capacity Building Strategy/ Activity
Workshop on local policy and budget development, advocacy, and engagement in Manila; Development of CBO Budget Advocacy Plans
Medical Technologist HIV Proficiency Training and VCT Services
Learning group session on STIs, HIV, and SOGIE
Young key affected population Assembly and Planning (2 separate activities)
Peer Educators' Training
Support to operations of TLY Anglo (an innovative approach to testing MSMs and other key affected persons) and other initiatives such as "U Caravan", Hotline, etc.; Support to other NGOs involved in TCS of PLHIVs
Training workshop (HIV Orientation & Peer Education) for the medical staff of Shell Companies in the Philippines (PICT) TOT
Training of LGUs on rHIVda funded by ASP
Training of union members in various industries
Competency Trainings with LCEs, MHOs, midwives, youth leaders; module development; Project Management and M&E

Table 22. Commodities, drugs, supplies and materials procured in 2015 by DOH Regional Offices

Commodities procured/ delivered	Amount (in Php)
HIV Testing Kits (4980 kits)	453,180
Syphilis Rapid Screen Test	200,000
HIV Test Kits	75,000
Azithromycin	57,000
Cefixime	57,800
Laboratory Supplies for VCT	25,000
Procurement of Medicines/Reagents for Social Hygiene Clinics	500,000

Table 23. STI, HIV/AIDS Service Provision Activities Conducted by CSOs

CSO	Total Number of Services Provided			Total Number of Clients Served	Coverage	Other Particulars	Cost
	VCT	STI	TCS				
Save	9,835		15,880	9,835 – MSM, TG, & PWID Tested; 15,880 – MSM, TG, & PWID assisted with ART		VCT includes MSM, TG, & PWID; Not all outreach activities were accompanied by MTs	P129,627 P93,347
TLF	128			128 clients		On-site HIV testing during outreach	P228,241
PSFI	12,305			12,305 clients (companies + universities)	Manila Palawan Batangas	11 schools engaged; Business Sector (BPOs, manufacturing, maritime, supply chain, Shell companies & contractors)	P3,680,000
PPAP			1,289	770 outpatients, 384 in-patients, 120 PLHIV patients, and 15 LGS fed in H4 Ward of San Lazaro Hospital	Manila	P93,000 supported by ISEAN-Hivos until April 2016	P135,000
FPOP				11,616 clients served on various STI, HIV & AIDS services		Lab tests, counselling, consultations & treatment	
PSPI		4,464	14,309	18,773 clients served on PSP and STI services	9 Cities	Manila, Urdaneta, Catbalogan, Davao, Iligan, CDO, Tacloban, Ozamis, Cebu	P359,253
FCF	452	4,908		5,360 clients served on VCT, Pap Smear and		Lubao, Masinag, Lagro, Shaw Cebu, Davao	

CSO	Total Number of Services Provided			Total Number of Clients Served	Coverage	Other Particulars	Cost
	VCT	STI	TCS				
				Gram Staining			
PLCPD					Congress Staff	Mass HIV VCT in Senate and HOR staff	
PCPD				Grant given to CSOs to conduct activities and services	Manila		P52,396
Likhaan		360	26	386 clients served on STI diagnosis & treatment, referral	Manila Bulacan		

Annex I. Gender-Based Violence and Others

Table 24. Summary of VAW Cases Reported to PNP, 2013

Reported Cases	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Rape	997	927	659	837	720	770	1042	832	1030	1259
Incestuous Rape	38	46	26	22	28	27	19	23	33	26
Attempted Rape	194	148	185	147	204	167	268	201	256	317
Acts of Lasciviousness	580	536	382	358	445	485	745	625	721	1035
Physical Injuries	3553	2335	1892	1550	1307	1498	2018	1588	1744	3564
Sexual Harassment	53	37	38	46	18	54	83	63	41	196
RA 9262	218	924	1269	2387	3599	5285	9974	9021	11531	16517
Threats	319	223	199	182	220	208	374	213	240	426
Seduction	62	19	29	30	19	19	25	15	10	8
Concubinage	121	102	93	109	99	99	158	128	146	199
RA 9208	17	11	16	24	34	152	190	62	41	45
Abduction/Kidnapping	29	16	34	23	28	18	25	22	20	23
Unjust Vexation	90	50	59	59	83	703	183	155	156	250
TOTAL	**6271**	**5374**	**4881**	**5729**	**6905**	**9485**	**15104**	**12948**	**15969**	**23865**

Source: PNP WCPC, 2013.

Table 25. Persons Committing Physical Violence Against Women, 2013.

Person	Marital Status		Total
	Ever Married	Never Married	
Current husband/partner	44.4	N/A	34.5
Former husband/partner	22.1	N/A	17.1
Current boyfriend	0.1	0.0	0.1
Former boyfriend	1.1	2.4	1.4
Father/ step-father	19.2	33.0	22.3
Mother/ step-mother	18.5	41.6	23.7
Sister/brother	9.2	18.5	11.3
Step-sister/brother	1.4	1.9	1.5
Other relative	6.4	N/A	8.3
Mother-in-law	0.6	N/A	0.4
Father-in-law	0.3	N/A	0.2
Other in-law	1.0	0.0	0.8
Teacher	0.0	0.7	0.1
Employer/ someone at work	1.4	2.1	1.5
Friend/acquaintance	3.9	17.1	6.8
Police/ soldier	0.0	0.1	0.0
Stranger	1.5	2.4	1.7
Other	4.1	6.3	4.6
Number of women	1668	481	2149

Source: NDHS, 2013.

Table 26. Persons Committing Sexual Violence Against Women, 2013

Person	Marital Status		Total
	Ever Married	Never Married	
Current husband/partner	55.2	N/A	44.5
Former husband/partner	29.9	N/A	24.6
Current/former boyfriend	5.0	42.1	11.5
Father/ step-father	0.9	0.0	0.7
Brother/step-brother	0.2	0.0	0.1
Other relative	6.1	14.0	7.5
In-law	1.0	N/A	0.8
Own friend/acquaintance	3.6	10.7	4.8
Family friend	2.0	4.3	2.4
Employee/someone at work	2.2	10.7	3.6
Priest/religious leader	1.2	7.1	2.3
Stranger	0.7	3.4	1.2
Other	3.3	7.6	4.0
Missing	0.2	0.0	0.1
Number of women who have experienced sexual violence	574	122	696

Source: NDHS, 2013.

Table 27 National Policies Related to Violence Against Women

Law	Title and Brief Description	Date of Approval
Republic Act 7877	**Anti-Sexual Harassment Act of 1995** provides criminal sanctions for acts constituting sexual harassment. The law also requires the employers or the head of the covered institutions to deter the commission of acts of sexual harassment and to provide for procedures for resolution, settlement or prosecution of acts of sexual harassment.	February 14, 1995
Republic Act 8353	**The Anti-Rape Law of 1997** - is a landmark legislation for Filipino women because it provided for a broader definition of the crime of rape and reclassifying it from a Crime Against Chastity to a Crime Against Persons.	September 30, 1997
Republic Act 8505	**Rape Victim Assistance and Protection Act of 1998** – An Act Providing Assistance and Protection for Rape Victims, Establishing for the Purpose A Rape Crisis Center in every Province and City, Authorizing the Appropriation of Funds Therefore, and for other Purposes	Feb 13, 1998
Republic Act 9208	**Anti-Trafficking in Persons Act of 2003** consonant with the state's obligation to protect the dignity of the individual, this law criminalizes the act of trafficking in persons especially of women and children for prostitution, sexual exploitation and slavery, among others.	May 26, 2003
Republic Act 9710	**Magna Carta of Women**—is comprehensive women's human rights law that seeks to eliminate discrimination against women by recognizing, protecting, fulfilling and promoting the rights of Filipino women, especially those in marginalized sector.	August 14, 2009
DILG Memo Circular 201261	**Guidelines in the establishment and management of a referral system on Violence Against Women (VAW) at the local government unit level** The Inter-Agency Council on Violence Against Women and Their Children (IAC-VAWC) has issued the "Guidelines in the Establishment and Management of a Referral System on Violence Against Women and Their Children at the Local Government Unit Level", pursuant to Section 54 of the Implementing Rules and Regulations (IRR) of RA 9262 also known as the Anti-Violence Against Women and Their Children Act of 2004.	March 28, 2012
CHED Memo s.2011	**Submission by all higher education institutions of reports on the compliance to Republic Act no. 7877 otherwise known as the "Anti-Sexual Harassment Act of 1995**	February 17, 2011
Proclamation No. 1172	**18 Day Campaign to End Violence Against Women**	Nov 17, 2006

Table 28. Women and Child Protection Units, 2014

Region	Hospital-based	LGU/RHU-based	Total Number of WCPU
CAR	3	0	3
1	3	1	4
2	2	0	2
3	7	0	7
4	5	2	7
NCR	7	0	7
5	3	7	10
6	5	0	5
7	2	2	4
8	3	10	13
9	2	0	2
10	2	0	2
11	2	0	2
12	3	0	3
13	1	0	1
ARMM	1	0	1
TOTAL	**51**	**22**	**73**

Source: Child Protection Network Annual Report, 2014.

Table 29. Demand Generation Activities Related to Gender - Based Violence.

Demand Generation Activities	Proponent/Reporting Agency
Gender sensitivity forum	FPOP
Women's week celebration	FPOP
Dissemination of RA 9062 and 90710	No reporting Agency
GAD Forum for Men	DOH, POPCOM CARAGA
KATROPA Session for PNP	POPCOM
Conducted series of community education sessions, forum, workshop on GBV, street harassment and women's rights, including as resource person on GBV with emphasis on SOGIE-based violence. Mobilized 1,367 community women and men, young people and advocates from Quezon City, Bulacan and Pampanga.	CSOs
Disseminated 50 copies of pamphlets on VAW, rape and sex trafficking to the women in Balangiga, Giporlos, Lawaan, and Quinapondan , Eastern Samar.	CSOs
Maximize radio program and TV internet that discuss issues and concerns on GBV	CSOs
Conducted End VAW community education series in Quezon City, Manila City, and Caloocan City participated in by 584 women, barangay officials, and young people	CSOs
Conducted End-VAW forums (anti-VAW laws) in the same cities participated in by 604 community women.	CSOs
Grand Launching for KATROPA	POPCOM;
International Men's Day	POPCOM

Table 30. Capability Building Activities Related to Gender - Based Violence.

Capacity Building Activities	Proponent/Reporting Agency
Training on Kalalakihang Tapat sa Responsibilidad at Obligasyon sa Pamilya (KATROPA)	POPCOM R2
Gender sensitivity training for Population Officers	POPCOM R2 DOH 11
Capacity Building of Provincial Human Rights Action Team (PHRAcT) of the Province of Tarlac	Tarlac PHO
Gender Based Violence- Legal Basis	DepEd Malolos
GAD Orientation for DOH Employees	DOH RO 3
Mainstreaming of Gender Development and Advocacy	NEDA R10
Continuing Education on GAD RPO 10 staff	POPCOM 10
Conducted series of trainings and training of trainers (TOT) in GBV prevention and response, organizing as GBV watch group for 165 community leaders, POs, NGOs, academe, Provincial DRRMO and regional DILG from Quezon City,Pasay, Pampanga, Antique, Bohol, Cebu, Leyte, Negros Oriental & Occidental, Samar, Northern & Eastern Samar, Romblon, Polomolok, Koronadal City, General Santos City; all from the province of South Cotabato and Tacurong City, Sultan Kudarat.	CSOs
IEC materials on Anti-Trafficking law and Anti-Violence Against Women were provided to the participants.	CSOs
Conducted three (3) intensive End-VAW seminars for 90 community women leaders of anti-VAW collectives in communities; organized community-based End-VAW collectives to assist women victims/survivors of violence and abuse. The collectives have 120 women members.	CSOs
(PAG Sessions 7-8: Violence Against Women; VAW Part II – Safety Planning) The participants were given information about abuse and how to identify them; given information on their rights and where to go to report or seek help when faced with such cases. Resource persons from Protection Units gave them tips on how to plan and stay safe when abuse or violence is at hand. In Ligao City, one WWD was able to report her husband's abuse. However, they reconciled and the case did not progress.	CSO

Table 31. National Summary on the Barangay Compliance in the Establishment of Barangay VAW Desk, 2010-2015

REGION	2011			2012			2013			2014			2015		
	Total Number of Barangay	With Established VAW Desk	%	Total Number of Barangay	With Established VAW Desk	%	Total Number of Barangay	With Established VAW Desk	%	Total Number of Barangay	With Established VAW Desk	%	Total Number of Barangay	With Established VAW Desk	%
I	3,265	1,782	55%	3,265	1,782	54.58%	3,265	1,782	54.58%	3,265	1,782	54.58%	3,265	3,265	100.00%
II	2,311	1,758	76%	2,311	1,758	76.07%	2,311	2,148	92.95%	2,311	2,196	95.02%	2,311	2,311	100.00%
III	3,102	2,315	75%	3,102	2,315	74.63%	3,102	2,315	74.63%	3,102	2,315	74.63%	3,102	2,315	74.63%
IV-A	4,011	4,011	100%	4,011	4,011	100%	4,011	4,011	100%	4,011	4,011	100%	4,011	4,011	100.00%
IV-B	1,458	906	62%	1,458	906	62.14%	1,458	1,451	99.52%	1,458	1,335	91.56%	1,459	1,426	97.74%
V	3,471	1,323	38%	3,471	1,323	38.12%	3,471	1,323	38.12%	3,471	1,323	38.12%	3,471	2,890	83.26%
VI	4,051	2,556	63%	4,051	4,034	99.58%	4,051	4,034	99.58%	4,051	4,034	99.58%	4,051	4,034	99.58%
VII	3,003	1,865	62%	3,003	2,962	98.63%	3,003	3,003	100.00%	3,003	3,003	100%	3,003	3,003	100.00%
VIII	4,390	2,237	51%	4,390	2,237	50.96%	4,390	2,237	50.96%	4,390	4,390	100%	4,390	4,390	100.00%
IX	1,904	1,266	66%	1,904	1,266	66.49%	1,904	1,266	66.49%	1,904	1,266	66.49%	1,904	1,266	66.49%
X	2,022	1,593	79%	2,022	1,737	85.91%	2,022	1,737	85.91%	2,022	1,737	85.91%	2,022	1,737	85.91%
XI	1,162	1,150	99%	1,162	1,150	98.97%	1,162	1,150	98.97%	1,162	804	69.19%	1,162	804	69.19%
XII	1,194	1,046	88%	1,194	1,046	87.60%	1,195	1,046	87.53%	1,195	1,046	87.53%	1,195	1,046	87.53%
XIII	1,310	912	70%	1,311	912	69.57%	1,311	912	69.57%	1,311	912	69.57%	1,311	912	69.57%
CAR	1,176	1,014	86%	1,176	1,014	86.22%	1,176	1,014	86.22%	1,176	1,014	86.22%	1,176	1,014	86.22%
NCR	1,705	1,697	99.53 %	1,705	1,705	100%	1,706	1,705	99.94%	1,706	1,493	87.51%	1,706	1,493	87.51%
ARMM	2,490	274	11%	2,490	274	11%	2,490	274	11%	2,490	660	26.51%	2,490	660	26.51%
TOTAL	**42,025**	**27,705**	**66%**	**42,026**	**30,432**	**72.41%**	**42,028**	**31,408**	**74.73%**	**42,028**	**33,321**	**79.28%**	**42,029**	**36,577**	**87.03%**

Source: DILG 2015

Table 32. Cervical Cancer Screening Coverage, 2010-2015.

Regions	Number of Hospitals	Number of Trained Health Personnel
I	2	6
II	1	3
III	2	7
IVA	2	5
IVB	4	5
V	2	3
VI	1	3
VII	1	3
VIII	1	4
IX	1	2
X	1	4
XI	2	5
XII	1	12
CARAGA	2	3
CAR	1	8
NCR	5	17
Negros Region	1	3
ARMM	1	1
Total	**31**	**94**

Annex J. Governance

Table 33. List of CSOs Involved in RPRH Implementation.

1. Associated Labor Unions-Trade Union Congress of the Philippines (ALU-TUCP)
2. Brokenshire Woman Center (BWC)
3. Damayang ng Maralitang Pilipinong Api (DAMPA)
4. Democratic Socialist Women of the Philippines (DSWP)
5. Family Planning Organization of the Philippines (FPOP)
6. Filipino Catholic Voices for Reproductive Health (C4RH)
7. *Forum for Family Planning and Development* Inc.
8. FriendlyCare Foundation
9. GALANG Philippines
10. Health Action Information Network (HAIN)
11. Integrated Midwives Association of the Philippines, Inc. (IMAP)
12. Interfaith Partnership for the Promotion of Responsible Parenthood, Inc. (IPPRP)
13. Kapisanan ng mga Kamag-anak ng Migranteng Manggagawang Pilipino, Inc. (Kakammpi)
14. Likhaan Center for Women's Health (Likhaan)
15. Philippine Center for Population and Development (PCPD)
16. Philippine Federation for Natural Family Planning (PFNFP-Filtao)
17. Philippine NGO Council on Population, Health and Welfare, Inc., (PNGOC)
18. Philippine Legislators' Committee for Population and Development Foundation (PLCPD)
19. Philippine Society for Responsible Parenthood (PSRP)
20. Pinagsamang Lakas ng Kababaihan, Kabataan at ibang Kasarian (PILAKKK)
21. Pilipinas Shell Foundation (PSFI)
22. Pinoy Plus Advocacy Pilipinas (PPAP)
23. Population Services Pilipinas, Inc (PSPI)
24. Project Red Ribbon Foundation (PRRF)
25. Sarilaya Inc.
26. Tarbilang Foundation Inc (TFI)
27. Ugat ng Kalusugan (UNK)
28. WomanHealth Philippines
29. Women with Disability taking Action on Reproductive and Sexual Health (W-DARE)
30. Zone One Tondo Organization (ZOTO)
31. Zuellig Family Foundation (ZFF)

Annex K. Budget and Financing

Table 34. Status of Philhealth Accreditation of DOH Designated and Satellite Treatment Hubs.

Status of Philhealth Accreditation	Hospitals/Clinics
DOH Designated Treatment Hubs Accredited by PhilHealth	Baguio General Hospital
	Ilocos Training and Regional Medical Center
	Cagayan Valley Medical Center
	Jose Lingad Memorial Regional Hospital
	James Gordon Memorial Hospital
	Philippine General Hospital
	San Lazaro Hospital
	Research Institute for Tropical Medicine
	Makati Medical Center
	The Medical City
	Ospital ng Palawan
	Bicol Regional Training and Teaching Hospital
	Western Visayas Medical Center
	Corazon Locsin Montelibano Memorial Regional Hospital
	Gov. Celestino Gallares Memorial Medical Center
	Eastern Visayas Regional Medical Center
	Southern Philippines Medical Center
	Northern Mindanao Medical Center
	Zamboanga City Medical Center
	Butuan Medical Center
	Caraga Regional Hospital
DOH Satellite Treatment Hubs Accredited by PhilHealth	Quezon City Clinica Bernardo
	Marikina City Health Office
	General Santos District Hospital
	Dr. Rafael Tumbukon Memorial Hospital
DOH Satellite Treatment Hubs Not Accredited by PhilHealth	Manila Social Hygiene Clinic
	Cebu City Social Hygiene Clinic

Table 35. Number of PhilHealth-Accredited Health Facilities Providing RPRH Services, 2015

Region	RHU/Health Center	Lying-in (Public)	Lying-in (Private)	Ambulatory Surgical Clinic	Hospitals (Public)	Hospitals (Private)	PCF (Public)	PCF (Private)
CAR	103	146	9	1	13	11	26	7
Ilocos Region	158	59	29	4	23	44	21	34
Cagayan Valley	104	85	25	6	27	31	20	19
Central Luzon	241	107	185	13	50	117	12	24
NCR	468	33	278	71	48	111	3	22
Calabarzon	183	100	250	12	50	151	19	33
Mimaropa	88	54	10	1	13	10	22	19
Bicol Region	146	100	91	2	21	29	31	28
Western Visayas	182	111	47	4	34	26	27	4
Central Visayas	168	98	92	3	22	36	40	9
Eastern Visayas	187	220	88	2	22	20	28	11
Zamboanga Peninsula	92	93	8	2	12	27	17	9
Northern Mindanao	112	122	52	2	22	42	16	29
Davao Peninsula	70	42	124	5	13	42	6	55
SOCCSKARGEN	60	42	63	3	11	43	16	35
ARMM	110	92	32	0	16	10	15	7
CARAGA	81	75	19	2	10	7	26	11
Total	**2,553**	**1,579**	**1,402**	**133**	**407**	**757**	**345**	**356**