The Philippines' Prioritized Action 2018 – 2020

Contents

The Philippines' Prioritized Actions 2018-2020

Prioritized Actions for Focal Point and in-country stakeholder	Institution/ person responsible	Timeline					
		18	2019				20
		Q4	Q1	Q2	Q3	Q4	Q1
The DOH-DPCB should address the issues posed by the DBM for the creation of Family Health Bureau	DOH-DPCB						
Review and update the CIP to include investment in strategies in reaching the adolescents and youths, calibrate targets and budget, and further strengthen provisions for FP leadership, the development of DOH Family Health Bureau, budget for increasing awareness on PhilHealth benefit packages, and the deployment of health human resources (i.e. FHAs)	DOH-DPCB and NIT						
The NIT shall designate a TWG for RH Law defense as well as plans	DOH-DPCB and NIT						

Assist in the education of LCEs about FP and their obligations to ensure it under the RH Law	DOH, NIT, Focal Points, DILG						
Ensure annual allotment of mobilization fund for the conduct of outreach missions by LGUs and CSOs. Further, ensuring funding for the procurement of ancillary supplies especially for the delivery of invasive FP procedures.	DOH-DPCB						
Expand membership of PhilHealth TWG to include DOLE, NEDA etc. for CIP-based budget advocacy.	NIT, DOH						
Institutionalize zonal training institutions for FP and engage private training institutions.	DOH-DPCB						
Draft DOH guidelines for including FP for legally qualified adolescents based on the 2013 AO on AYHD and the RH Law;	DOH						
Partnership with CSOs in the provisions of FP services for adolescent;	DOH, CSOs						
Establishment of referral system between schools and private clinics for adolescents FP need	DOH						
Expansion of the program, "Teen Moms" to other hospitals and birthing facilities	DOH						
Conduct of social community engagements towards normative change through youth/adult partnerships and peer-to-peer exchanges	CSOs and Youth Organizations						
Ensure full implementation of the CSE guidelines; technical assistance support from stakeholders	DepEd, DOH, Focal points						
Strengthening the DOH FP supply chain management system	DOH, Focal Points						
Strengthen RIT functionality	NIT, DOH						

Annex 1.
Country Profile: FP2020 Focal Point Team & In-Country Coordination

<table>
<tr><td rowspan="4">List of Focal Points</td><td>Government</td><td>Dept of Health</td></tr>
<tr><td>Donor</td><td>UNFPA, USAID</td></tr>
<tr><td>Civil Society</td><td>Likhaan</td></tr>
<tr><td>Youth</td><td>PSORHN</td></tr>
<tr><td>FP Stakeholders
(institutional and/or individual)

<u>Note</u>:
Please list key FP stakeholders e.g.:
- Government agencies with FP in their mandate
- Civil society organizations (national and international) working on FP in country
- Multi-lateral and donor agencies working in FP
- Youth organizations
- etc.</td><td colspan="2">Members of the NIT for RPRH Law
Government Agencies:
Department of Health (DOH)
Philippine Health Insurance Corporation (PhilHealth)
Department of Education (DepEd)
Department of Social Welfare and Development (DSWD)
Department of the Interior and Local Government (DILG)
Department of Labor and Employment (DOLE)
National Economic and Development Authority (NEDA)
Commission on Population (POPCOM)
Food and Drug Administration (FDA)
Philippine Statistics Authority (PSA)
Philippine Commission on Women (PCW)
National Youth Commission (NYC)
National Anti-Poverty Commission (NAPC)
National Council on Disability Affairs (NCDA)

Civil Society Organizations
Philippine Legislators' Committee on Population and Development Foundation (PLCPD)
Union of Local Authorities of the Philippines
Democratic Socialist Women of the Philippines
EnGendeRights, Inc.
Family Planning Organization of the Philippines (FPOP)
FriendlyCare
Integrated Midwives Association of the Philippine (IMAP)
Likhaan Center for Women's Health
Médecins Sans Frontières or Doctors Without Borders
Philippine Center for Population Development (PCPD)
Philippine League of Government and Private Midwives Inc (PLGPMI)</td></tr>
</table>

	Philippine Society for Responsible Parenthood (PSRP) Philippine Society of SRH Nurses (PSORHN) WomanHealth Zuellig Family Foundation RH Agenda Saligan Catholics for RH **Multi-Lateral and Bilateral Donor Agencies** World Health Organization United Nations Population Fund United States Agency for International Development

CURRENT MECHANISMS FOR IN-COUNTRY COORDINATION of FP work (beyond Focal Points)				
Mechanism	**Convening/ Coordinating Body**	**Members**	**Frequency**	**Notes on efficacy**
Multi-stakeholder consultations	National Implementation Team (NIT) for RPRH Law	All National Government Agencies, CSOs, and development partners cited in the above FP Stakeholders	Monthly	Resolves operational, technical and legal bottlenecks, and also serves as the steering committee that catalyzes actions from its member agencies.
Mutli- stakeholder consultations	Regional Implementation Team (RIT)	Regional and local (provincial/city) teams	No set timelines	Theoretically transmission of policies, coordination and problem-solving (as above)
Technical working groups	TWGs of the RPRH Law NIT	Groups of government, non-government agencies and other stakeholders with specific concern	As the need arise	Discuss technical issues and formulate appropriate guidelines for RPRH program implementation
Please list additional opportunities to improve coordination:				

Annex 2. Identification of Challenges & Prioritization of Actions

The Philippines' FP2020 Commitments

COMMITMENT 1: The Philippines will establish a national policy on RH and population development, and allocate funds to implement the policy.

The issuance of the Philippine Republic Act No. 10354 also known as the Responsible Parenthood and Reproductive Health (RPRH) Law in 2012 is considered as a landmark legislation in the country's law-making history and has laid down the foundation in achieving reproductive health and rights of all Filipinos. The 0-10 Point Socioeconomic Agenda of the current administration, President Rodrigo Duterte, acknowledged the full implementation of the RPRH Law as an essential policy measure in achieving the targets set by the Philippines in the Sustainable Development Goals (SDG) 2030 and Ambisyon Natin (Our Ambition) 2040.

As a result, President Duterte issued Executive Order (EO) No. 12, entitled "Attaining and sustaining 'Zero Unmet Need for Modern Family Planning' through the strict implementation of the Responsible Parenthood and Reproductive Health Act" in January of 2017. The Order intensifies and accelerates the implementation of critical actions necessary to address the unmet need of Filipinos for modern family planning (mFP). The Order also directs all executive agencies to allocate resources and solicits support in this initiative. The Philippine Department of Health (DOH), as the lead agency, issued an operational guideline for the said Order. This guideline specifies the activities of which the local government units shall adopt in order to operationalize the EO and achieve its objectives.

In 2017, Philippine Development Plan (PDP) 2017-2022 was formally introduced. The PDP is the country's medium-term plan geared towards achieving SDG and Ambisyon Natin. The Family Planning was identified one of the essential interventions in realizing the country's demographic dividend.

COMMITMENT 2: As of 2017, the Philippines commits to $78 million for commodities, demand generation activities, contraceptive security, policy development, advocacy and mitigation of TRO and partnerships with CSOs and private groups.

Since the start of the FP2020 campaign in 2012, the Philippine Government through the Family Planning Program of DOH has allotted a total budget of PhP 3.5 Billion or US$ 67 Million for the procurement of FP commodities alone. The DOH provides FP commodities free of charge to all women and men of reproductive age following the principles of informed choice and voluntarism with preferential access to the poor.

In 2017, more than PhP 189 Million or US$ 3.6 Million were sub-allotted to all 17 DOH Regional Offices to support activities related to the implementation of the EO No. 12, such as conduct of capability building activities for FP service providers, setting up of FP services in hospitals, engagement of CSOs and private groups in the demand generation and FP service delivery, and support for transport/delivery of FP commodities and warehousing at the service delivery points. Also, a supplemental fund was appropriated to all DOH Regional Offices and DOH ARMM, which covered expenditures for the provision of Family Planning related activities. Total appropriation amounted to Php 165 Million or US$ 3.17 Million.

One of the major highlights in 2017 is the lifting of the Supreme Court's Temporary Restraining Order (TRO) to the DOH and Food and Drug Administration (FDA), particularly the DOH from utilizing its progestin subdermal implant supplies - Implanon and Implanon NXT, and the FDA from issuing certificates of product registration of contraceptive products. The TRO was deemed effectively lifted on Nov. 10, 2017 when the DOH promulgated the revised Implementing Rules and Regulations of the RPRH Law, and the FDA re-certified all 49 contraceptive products and determined them to be non-abortifacient.

COMMITMENT 3: The Philippines commits to provide family planning services to poor families with zero co-payment, and to upgrading public health facilities and increase the number of health service providers who can provide reproductive health information. The Philippines will work with partners to provide information and training.

The DOH-procured FP commodities are provided to women and men of reproductive age free of charge with preferential access to the underprivileged and marginalized population. The country's health insurance program administered by the Philippine Health Insurance Corporation (PhilHealth), an attached agency to the DOH, strengthened its No Balance Billing (NBB) Policy with the issuance of PhilHealth Circular 006 2. 2017 in January of 2017. This policy provides clarification on covered PhilHealth members that are eligible for NBB (i.e. Indigent, Sponsored, Kasambahay (housekeepers), Senior Citizen and Lifetime). It also provides a list of private institutions and the corresponding PhilHealth benefits that they provide, including services covered by the NBB policy.

In September of the same year, a guideline in the implementation of Point of Service (POS) Program was issued through PhilHealth Circular 0025 s. 2017 which fully covers the actual value of health services availed by patients who are incapable of paying for their PhilHealth membership in accordance with the DOH indigence classification. This program runs in parallel with the Point of Care (POC) Enrolment Program which automatically enrolls qualified non-PhilHealth members with the hospital shouldering the annual premium contribution of PhP 2,400. These policies envisioned a true financial risk protection to all

Filipinos especially the poor. Accompanying the PhilHealth circulars/policies are "Tamang Sagot" (Right Answers) – a list of frequently asked questions about the benefits for better understanding of PhilHealth members and other stakeholders.

To increase access and encourage clients on availing long-acting reversible and irreversible family planning methods, PhilHealth benefit packages for the following FP procedures were developed: contraceptive subdermal implant, Intrauterine Device (IUD), Bilateral Tubal Ligation (BTL), and No-Scalpel Vasectomy (NSV). In 2017, a total of PhP 44 Million (or US$ 852 Thousand) was paid by the PhilHealth for the said FP procedures. To date, there are 763 PhilHealth Accredited public hospitals and infirmaries and 3,243 Maternal Care Package (MCP) providers both from public and private entitled for PhilHealth reimbursements. These cover 91% of the total number of cities and municipalities in the country. To encourage participation of private health institutions and CSOs, especially those who could not qualify for MCP accreditation, the DOH and PhilHealth issued a guideline on the accreditation of Free Standing FP Clinics. Accredited Free Standing FP Clinics were able to reimburse for IUD, NSV, and contraceptive subdermal implant insertion following the NBB Policy.

One of the strategies identified to attain zero unmet need for mFP is the augmentation of human resource for the delivery of FP services, and monitoring and reporting. The DOH deployed a total of 1,424 Family Health Associates (FHAs). FHAs are licensed nurses tasked to provide assistance in the implementation of the RPRH Law, specifically in improving access and delivery of FP services. They were deployed in priority provinces and cities identified with the highest unmet need for FP.

Summary of Philippines' Costed Implementation Plan (CIP)

Prioritized areas:

1. Demand generation activities to identify women including poor, adolescents, and marginalized populations with unmet need for modern family planning (door-to-door campaign) and link them directly to FP service delivery
2. Conduct of family planning outreach missions
3. Strengthening of modern family planning services for post-partum women in hospitals and birthing facilities

Step 1. From the above commitment(s) and/or CIP priority area(s) which is your country having the greatest difficulty in making progress on? (*the table below can be extended, if you'd like to cover more than three*)

COMMITMENT 1: The Philippines will establish a national policy on RH and population development, and allocate funds to implement the policy.

The RH Law is frequently challenged and undermined by conservative Catholic groups, using the courts (e.g. Supreme Court and Court of Appeals) and local executive and legislative bodies (e.g. Sorsogon City). With the former president who had a conservative view of family planning now heading the Philippine House of Representatives, together with other anti-RH legislators, it can embolden others in national and local government offices to oppose FP policies in different ways.

The enactment of the RPRH Law, however, does not guarantee adequate funding from the Philippine government for the annual FP commodity requirements of the population. Further, in a decentralized form of government, the political support and influence of the local chief executives (LCEs) are of huge factors that will make-or-break the FP program.

COMMITMENT 2: As of 2017, the Philippines commits to $78 million for commodities, demand generation activities, contraceptive security, policy development, advocacy and mitigation of TRO and partnerships with CSOs and private groups.

The $78M (PhP3.9B) commitment is based on the CIP estimates of the total budget requirement for all FP program management. However, getting a substantial appropriation from Congress is not easy because of the domination of anti-RH legislators in the Appropriations Committee who have cause drastic reductions in DOH proposed budgets (e.g. in 2015 when PhP 1B disappeared during the Bicameral deliberations). As a result, the base budget for FP was decreased.

Despite the increase in budget allotment of the DOH for the procurement of FP commodities (from year 2012-2015), the problem boils down to the Department's absorptive capacity due to the following issues:

1. Lack of human resources at the DOH Central, Regional Offices, and at the primary health care levels to oversee and implement FP Program.
2. Unforeseen bidding failures in the DOH procurement process of FP commodities.
3. Limitations set by the government auditing rules and laborious process in engaging CSO partners in the provision of FP services, especially in GIDAs.

COMMITMENT 3: The Philippines commits to provide family planning services to poor families with zero co-payment, and to upgrading public health facilities and increase the number of health service providers who can provide reproductive health information. The Philippines will work with partners to provide information and training.

A structural problem is the fragmentation of health service provision, including FP, particularly at the primary care level. This is because of the 1991 Local Government Code that resulted in the devolution of health services. At the primary care level, FP is the prerogative of over 1,600 "autonomous" local government units (LGUs) who hire the human resources, deploy them to priority programs and provide the ancillary health supplies for these programs. DOH is mandated to provide technical guidance, build and improve facilities, and provide logistics –e.g. vaccines and contraceptives - for some public health services. Because of this delineation of responsibilities in the Law, LCEs may choose not to prioritize FP by not allocating personnel, ancillary supplies and budgets, even though FP is a national program and mandated in the RH Law. Hence, there may not be adequate number of FP service providers, esp. trained FP service providers in LGUs.

Other operational problems are:

1. Myths, misconceptions, and black propaganda against FP remained to be the primary reasons why intended users may not use FP
2. Inadequate healthcare providers to conduct FP counseling and services especially in GIDAs
3. Demand generation activities are seldom linked to provision of services
4. Weak supply chain management that results to stock outs or overstock of commodities
5. The RPRH Law prohibitions to minors from accessing FP services without parental consent particularly in public health facilities

Step 2. What progress toward each commitment/CIP priority *(listed in Step 1)* has been made? What efforts have been made?

COMMITMENT 1: The Philippines will establish a national policy on RH and population development, and allocate funds to implement the policy.

The RH Law is currently supported and elaborated further by several executive and administrative orders, the most important of which is the president's executive order, EO No.12 which urges national government agencies other than the DOH –e.g. the National Economic and Development Authority, Dept. of Labor and Employment, National Youth Commission, and many others to get more actively involved in reducing the unmet need for FP. The DOH itself has issued several administrative orders (AOs) since the RH Law was passed, including its IRR which mandates the integrated provision of FP services at

the village, town, and hospital levels. Other relevant DOH AOs include the deployment of mobile services, ensuring informed and voluntary consent, allowing the use of contraceptive implant, allowing the accreditation of stand-alone FP clinics so they can charge FP services to social health insurance, the creation of service delivery networks, etc. The law has also ordered the Dept. of Education (DepEd) to develop a curriculum that integrated Comprehensive Sexuality Education, which DepEd will be finalized by September 2018.

COMMITMENT 2: As of 2017, the Philippines commits to $78 million for commodities, demand generation activities, contraceptive security, policy development, advocacy and mitigation of TRO and partnerships with CSOs and private groups.

There was continued DOH funding for contraceptive commodities, even though this was short of the CIP budget for commodities (around 600M); and though the other items in the CIP were not funded at the DOH Central Office – e.g. management, promotion, outreach services, etc.

For the inadequate human resources at the DOH Central and Regional Offices, the DOH is lobbying for the creation of a Family Health Bureau that will ensure effective and efficient implementation of the National FP Program. The bureau is envisioned to have full complement of technical and support staff at the Central DOH. All other health programs of the RPRH Law will be under the said bureau.

To augment the human resource at the local level, the DOH deployed a total of 1,424 Family Health Associates to support the delivery of FP services, and monitoring and reporting of progress and accomplishments.

COMMITMENT 3: The Philippines commits to provide family planning services to poor families with zero co-payment, and to upgrading public health facilities and increase the number of health service providers who can provide reproductive health information. The Philippines will work with partners to provide information and training.

In line with the provision of the RPRH Law, the country's FP Program ensures preferential access to the poor and marginalized groups. Families who are identified under the National Household Targeting System (NHTS) and are classified in the poorer quintiles are included in the Conditional Cash Transfer (CCT) program and are provided information, counseling and referral to FP services by the Dept. of Social Welfare and Development (DSWD).

The social health insurance agency (PhilHealth) has included surgical and long-acting contraceptives among its benefits and the utilization of these benefits are progressively

increasing. DOH continues to augment the inadequate human resources of LGUs by its annual deployment of doctors, nurses and midwives, some of whom are trained in FP. There is continuing training of providers in FP Competency-Based Training Levels 1 (hormonal and fertility-awareness-based methods) and 2 (intermediate and long-acting methods, except implant) and special course on implant.

Progress on the EO No. 12 "Zero Unmet Need for Modern Family Planning" campaign of the Philippines as of August 1, 2018. Of the 3.72 million individuals estimated to have unmet need for family planning, 3.24 million (or 87%) were actually reached and identified.

Of the 3.24 million individuals identified with unmet need for FP, 1.04 million (or 32%) individuals have accepted FP methods. Of which, more than half (54%) received the FP service through routine service delivery, 14% have availed through the FP outreach missions, and 32% were through post-partum family planning in hospitals and birthing facilities.

Step 3. What are the key challenges or blockages faced when trying to accelerate progress towards the above selected commitments? Where does there seem to be resistance? What are the root causes of those *challenges and blockages*?

3.1. KEY CHALLENGES AND BLOCKAGES (e.g. operational, technical, political)
FP2020 COMMITMENT 1: The Philippines will establish a national policy on RH and population development, and allocate funds to implement the policy • Challenge 1: Opposition of conservative catholic groups to FP manifested through court cases and executive orders which subtract from, suspend or derail implementation of the RH Law and FP Program • Challenge 2: Difficulties in transmission of the RH Law and related policies from National Offices to the field implementers • Challenge 3: Administrative bottlenecks among key implementers of the Law, e.g. DOH and DepEd. It includes commodity procurement and distribution problems, inadequate human resources in technical positions, laborious bureaucratic processes, etc.

FP2020 COMMITMENT 2: **As of 2017, the Philippines commits to $78 million for commodities, demand generation activities, contraceptive security, policy development, advocacy and mitigation of TRO and partnerships with CSOs and private groups.**

- Challenge 1: Opposition in Congress to FP budget by conservative religious legislators, esp. those in Committee on Appropriation
- Challenge 2: Weak FP budget advocacy by government and partners
- Challenge 3: DOH's poor absorptive capacity due to administrative problems. Programmatic management is not optimized due to limited capacity to cover wide range of priorities and challenges.

FP2020 COMMITMENT 3: The Philippines commits to provide family planning services to poor families with zero co-payment, and to upgrading public health facilities and increase the number of health service providers who can provide reproductive health information. The Philippines will work with partners to provide information and training.

- Challenge 1: Fragmentation of the health system and service delivery- within the public system, of the private and nongovernment system, and between the public and private/NGO systems
- Challenge 2: Lack of enabling environment for FP service delivery in many LGUs because of LCEs lack of capacity or support for FP– e.g. lack of FP providers, lack of prioritization by government officials, lack of budget, weak M&E, etc.
- Challenge 3: Varying support at different administrative level of the government for FP program –some administrations prioritize FP, others oppose

Commitment//CIP priority 1

CIP Priority Strategy 1: Demand generation activities to identify women including poor, adolescents, and marginalized populations with unmet need for modern family planning (door-to-door campaign) and link them directly to FP service delivery

Low uptake of FP services from the demand generation activities despite having unmet need for FP - only 32% have actually accepted an FP method. Demand generation activities are often not linked to FP service delivery.

Commitment//CIP priority 2

CIP Priority Strategy 2: Conduct of family planning outreach missions

Only 14% of the new acceptors received the appropriate mFP services through the outreach missions, which is only 4% of the total number of individuals identified with unmet need for mFP.

This is due to unsystematic approach during outreach activities. For instance, outreach teams going to an area without prior segmented demand generation activities and community preparation.

Commitment//CIP priority 3

CIP Priority Strategy 3: Strengthening of modern family planning services for post-partum women in hospitals and birthing facilities

Only 33% of the new acceptors of FP availed their preferred method in the hospitals and birthing facilities, which is only 11% of the total number of individuals identified with unmet need for mFP.

3.2. ROOT CAUSES PER CHALLENGE LISTED ABOVE

(i.e. What are the root causes of the challenges faced in accelerating progress towards the listed commitments? Please reference the guidance note below.

Step 3.2. Guidance note: This step can be done through asking 5 "why questions"

5 WHY questions: an iterative interrogative technique used to explore the cause-and-effect relationships underlying a particular challenge. The primary goal of the technique is to determine the root cause of a challenge or problem by repeating the question "Why?" Each answer forms the basis of the next question. Here is an example:
-Community based health workers (CBWs) are not yet in place at the district level (the challenge)
a. Why? - CBWs have not received a basic training yet (First why)
b. Why? - District health offices have not yet received the updated training manual from the central level (Second why)
c. Why? - Budget cuts for the training department at the Ministry delayed training manual development at the central level (Third why)
d. Why? - Health minister was not successful in budget negotiation with the Ministry of Finance for this fiscal year (Fourth why)
e. Why? – According to feedback, supporting documents for budget negotiation were not sufficient (e.g. policy briefs, visualized data summary) to allow the Health Minister to show the impact and urgency of the program (Fifth why, a root cause)

COMMITMENT 1: The Philippines will establish a national policy on RH and population development, and allocate funds to implement the policy.

CHALLENGES	ROOT CAUSES

• Challenge 1: Conservative Catholic groups' opposition to Family Planning manifested through court cases and executive orders which subtract from, suspend or derail implementation of the law	Family Planning is considered abortifacient, harmful and against family values by conservative Catholic leaders and Catholic religious doctrines
• Challenge 2: Difficulties in localization of the RH Law and related policies from national offices to the field implementers	Lack of DOH investment in communication technology and human resources
• Challenge 3: Administrative bottlenecks among key implementers of the RH Law, e.g. DOH and DepEd. It includes procurement and distribution problems, lack of adequate human resources in technical positions, bureaucratic processes resulting to delays, etc.	a. Inefficient procurement policies b. Weak supply chain management c. Inadequate human resources which result from lack of government investment or prioritization
COMMITMENT 2: As of 2017, the Philippines commits to $78 million for commodities, demand generation activities, contraceptive security, policy development, advocacy and mitigation of TRO and partnerships with CSOs and private groups.	
• Challenge 1: Opposition in Congress to FP budget by conservative religious legislators, esp. those in Committee on Appropriation.	Conservative Catholic leaders and Catholic religious doctrines
• Challenge 2: Weak FP budget advocacy by government and partners	Weak budget advocacy for FP because of lack of information on the value and benefits of properly-funded FP program and lack of advocacy skills.
• Challenge 3: DOH's poor absorptive capacity due to administrative problems	Lack of human resources with technical skills to manage FP program due to lack of investment or prioritization by the leadership
• Challenge 4: Programmatic management is not optimized due to limited capacity to cover wide range of priorities and challenges.	There is insufficient technical staff at the DOH Central and Regional Offices that limits their provision of technical assistance and supervision to the LGUs. Why? The proposed Executive Order that was supposed to create a Family Health

	Bureau (merger of former Family Health Office and the POPCOM) was vetoed by the Department of Budget and Management (DBM). Why? The POPCOM has just been rationalized and the timeframe for the completion of its Rationalization Program should be considered. Why? The DOH has yet to resubmit the revised proposal or clarification to the DBM. Why? The DOH needs to review and respond to comments of the DBM to pursue this undertaking.
FP2020 COMMITMENT 3: The Philippines commits to provide family planning services to poor families with zero co-payment, and to upgrading public health facilities and increase the number of health service providers who can provide reproductive health information. The Philippines will work with partners to provide information and training	
• Challenge 1: Fragmentation of the health system- within the public system, of the private and nongovernment system, and between the public and private/NGO Systems • Challenge 2: Lack of enabling environment for FP service delivery in many LGUs – e.g. lack of FP providers, lack of prioritization by government officials, lack of budget, etc. • Challenge 3: Varying/ national and local government officials' support toFP program –some administrations prioritize FP, others do not	Local Government Code or the Devolution Law of 1991 a. Devolution Law that emphasizes LCE autonomy to the extent of not investing in health, including FP b. LCEs who are not aware of the value and benefits of FP because of the lack of information c. LCEs who adhere to conservative Catholic teachings a. National government officials lack information on the value and benefits of FP b. Some government officials adhere to conservative Catholic doctrines

Commitment//CIP priority 1 **CIP Priority Strategy 1**: Demand generation activities to identify women with unmet need for modern family planning (door-to-door campaign)	
Challenges	**Root Causes**
CIP 1: Low uptake of FP new acceptors from the demand generation activities despite having unmet need for FP - only 32% have actually accepted FP method. Demand generation activities are seldom linked to FP service delivery.	CIP 1.1. Low uptake of FP new acceptors from the demand generation activities despite the need for FP due to: a. clients' reluctance to avail and accept FP method because of fear of side effects and misconceptions b. circulation of wrong and inaccurate information about FP in various media by the anti-RH groups c. weak health promotion and communication plan for FP CIP 1.2. Insufficient health service providers with appropriate skills on FP due to: a. delays in conducting post-training evaluation and supervision that will lead to providers' certification b. not all provinces or municipalities have training institutions/providers on FP c. unfilled positions which limit the number of health providers at the primary facilities and hospital CIP 1.3. Weak FP supply chain management due to: a. poor forecasting of FP requirements b. allocation not based on utilization c. delayed delivery limited storage and warehousing d. delayed and incomplete reporting of FP inventory utilization
Commitment//CIP priority 2 **CIP Priority Strategy 2**: Conduct of family planning outreach missions	
CIP 2. Only 14% of the new acceptors received the appropriate FP services through	CIP 2.1. Limited number of outreach missions conducted due to:

the outreach missions, which is only 4% of the total number of individuals identified with unmet need for FP.	a. lack of trained FP providers b. insufficient mobilization fund to conduct the outreach missions.
Commitment//CIP priority 3 **CIP Priority Strategy 3:** Strengthening of modern family planning services for post-partum women in hospitals and birthing facilities	
CIP 3. Only 33% of the new acceptors received FP services in the hospitals and birthing facilities, which is only 11% of the total number of individuals identified with unmet need for FP.	CIP 3.1. Missed opportunities in FP among postpartum women in birthing facilities and hospitals due to: a. few hospitals have established FP services in the facility b. Lack of dedicated and trained health service providers for PPFP c. no designated area for PPFP service delivery d. inadequate fund allotment for PPFP services e. lack of awareness on PhilHealth benefit packages for FP

Step 4. What actions are required to tackle the root causes (in 3.2 above) for the identified challenges? Where does the greatest opportunity stand to influence the system, overcome resistance and accelerate changes?

4.1. What is needed in order to tackle the root causes for the identified challenges/blockages (listed in 3.2 above)? Based on your assumptions about what could work well and what will not, think about all possible actions/interventions	
COMMITMENT 1: The Philippines will establish a national policy on RH and population development, and allocate funds to implement the policy.	
Root Causes	**Actions/Interventions to be Taken**
1.1.Family Planning is considered abortifacient, harmful and against family values by conservative Catholic leaders and Catholic religious doctrines 1.2. Lack of government investment in communication	1.1.a. Popularize evidence on non-abortifacient, safety, and pro-family benefits of FP 1.1.b. Prepare legal defense against legal challenges in the Courts or in LGUs 1.1.c. Popularize progressive Catholic position on FP 1.2.a. Advocate to DOH to invest more in communication technology and human resources for FP 1.3.a&b. Advocate for reforms in procurement policies

technology and human resources 1.3. a. Inefficient procurement policies 1.3.b. Inefficient product suppliers 1.3.c. Inadequate human resources which result from lack of government investment or prioritization	to make procurement more efficient, including attracting suppliers with quality products 1.3.c.. Same as 1.2.a
Commitment 2 : As of 2017, the Philippines commits to $78 million for commodities, demand generation activities,contraceptive security, policy development, advocacy and mitigation of TRO and partnerships with CSOs and private groups.	
2.1. Conservative catholic leaders and catholic religious doctrines 2.2. Weak budget advocacy for CIP on FP because of lack of information on the value and benefits of properly-funded FP program and lack of advocacy skills 2.3. Lack of human resources with technical skills to manage FP program due to lack of investment or prioritization by the leadership 2.4. The DOH needs to review and respond to comments of the DBM to pursue the creation of a Family Health Bureau.	2.1.a. Same as 1.1.a to 1.1.c 2.2.a. Engage stakeholders who will advocate for CIP-based FP budgets per the requirements of the General Appropriations Law (currently annually) 2.2.b. Inform DOH policymakers about the value and benefits of CIP for FP 2.2.c. Assist DOH in advocating for CIP-based budget in Congress 2.3.a. Same as 1.2.a. –for DOH to invest in human resources with technical skills to manage FP program 2.4.a. The DOH-DPCB should address the issues posed by the DBM
COMMITMENT 3: The Philippines commits to provide family planning services to poor families with zero co-payment, and to upgrading public health facilities and increase the number of health service providers who can provide reproductive health information. The Philippines will work with partners to provide information and training	
	3.1.a. Advocate for the passage of the Universal Health Care bill.

3.1. Local Government Code of 1991 3.2. Devolution Law that emphasizes LCE autonomy to the extent of not investing in health, including FP	3.2.a. Educate LCEs about the RH Law's provisions on prohibited acts of government officials through the Local Government Academy of the DILG.
3.2.1 LCEs' lack of awareness on the value and benefits of FP and adhere to conservative Catholic Teachings.	3.2.1.a. Educate LCEs about the RH Law's provisions on prohibited acts of government officials through the Local Government Academy of the DILG.
3.2.2. National Government Officials lack information on the value and benefits of FP and adhere to conservative Catholic doctrines	3.2.2.a. National Government Officials –should be educated about relevant provisions in RH Law, and about the value and benefits of FP.

Commitment/CIP priority 1

CIP Priority Strategy 1: Demand generation activities to identify women with unmet need for modern family planning (door-to-door campaign)

Root Causes	Actions/Interventions to be Taken
CIP 1.1. Demand generation activities are seldom linked to FP service provision due to: a. potential FP clients' reluctance to avail and accept FP method despite having unmet need for FP because of fear of side effects and misconceptions about FP. b. circulation of wrong and inaccurate information about FP in various media by the anti-RH groups. c. weak health promotion and communication plan for FP.	CIP 1.1.a. Develop and implement health promotion and communication plan for FP
CIP 1.2. Insufficient health service providers with appropriate skills on FP, especially counselling due to: a. delays in conducting post-training evaluation and	CIP 1.2.a. Develop an alternative or blended learning system for training.

supervision that will lead to providers' certification. b. Not all provinces or municipalities have training institutions/providers on FP. c. Government policies that limit the payment of honoraria/training fees especially in public health facilities hinder the establishment of training institutions. CIP 1.3. Weak FP supply chain management due to: a. Poor forecasting of FP requirements b. Poor allocation c. Delayed delivery d. Limited storage and warehousing e. Delayed and incomplete reporting of FP inventory utilization	CIP 1.2.c. The DOH should review and develop a guideline on the payment of training centers on FP modelled after the guidelines of BEmONC training fees. CIP 1.3.a. Improve supply chain management a. Forecasting based on need and utilization b. Rational allocation c. Timely delivery d. Adequate storage and warehousing e. Timely and complete reporting of FP inventory utilization
Commitment//CIP priority 2 CIP Priority Strategy 2: Conduct of family planning outreach missions	
CIP 2.1. Limited number of outreach missions conducted due to a. lack of trained FP providers b. insufficient mobilization fund to conduct the outreach missions.	CIP 2.1.a. Develop an alternative or blended learning system for training. CIP 2.1.b. Ensure annual allotment of mobilization fund for the conduct of outreach missions by LGUs and CSOs. Further, ensuring funding for the procurement of ancillary supplies especially for the delivery of invasive FP procedures.
Commitment//CIP priority 3 CIP Priority Strategy 3: Strengthening of modern family planning services for post-partum women in hospitals and birthing facilities	

CIP 3.1. Missed opportunities in FP among postpartum women in birthing facilities and hospitals due to: a. few hospitals have established FP services in the facility b. lack of dedicated and trained health service providers for PPFP c. no designated area for PPFP service delivery d. inadequate fund allotment for PPFP services e. lack of awareness on PhilHealth benefit packages for FP	CIP 3.1.a. Advocate to Chiefs of hospitals for the establishment of FP services. Provide support to build the capacity of hospital in setting up FP programs through staff training, policy development, referral system and recording and reporting

4.3. How can all focal points and other stakeholders best leverage their influence to support these interventions to accelerate progress? (Refer back to the stakeholder list above)

ACTION 1: The Focal Points and NIT for RPRH Law will support in strengthening the LEADERSHIP and GOVERNANCE in FP in every administrative level through the following Actions/Interventions:

1.1.a. Popularize evidence on non-abortifacient, safety, and pro-family benefits of FP.
1.1.b. Prepare legal defense against legal challenges in the Courts or in LGUs
1.1.c. Popularize progressive Catholic position on FP
2.4.a. The DOH-DPCB should address the issues posed by the DBM for the creation of a Family Health Bureau
3.1.a. Advocate for the passage of the Universal Health Care bill. 3.2.a. Educate LCEs about the RH Law's provisions on prohibited acts of government officials through the Local Government Academy of the DILG.
3.2.1.a. Educate LCEs about the RH Law's provisions on prohibited acts of government officials through the Local Government Academy of the DILG.
3.2.2.a. National Government Officials –should be educated about relevant provisions in RH Law, and about the value and benefits of FP.

ACTION 2: The Focal Points and NIT for RPRH Law will support in improving the country's FP COMMODITY SECURITY through the following Actions/Interventions:

1.2.a. Advocate to DOH to invest more in communication technology and human resources for FP

1.3.a. Advocate for reforms in procurement policies to make procurement more efficient, including attracting suppliers with quality products
2.2.a. Engage stakeholders who will advocate for CIP- based FP budgets per the requirements of the General Appropriations Law (currently annually)
2.2.b. Inform DOH policymakers about the value and benefits of CIP for FP 2.2.c. Assist DOH in advocating for CIP-based budget in Congress
2.3.a. Same as 1.2.a. –for DOH to invest in human resources with technical skills to manage FP program
CIP 1.3.a. Improve supply chain management
a. Forecasting based on need and utilization
b. Rational allocation
c. Timely delivery
d. Adequate storage and warehousing
e. Timely and complete reporting of FP inventory utilization

CIP 2.1.b. Ensure annual allotment of mobilization fund for the conduct of outreach missions by LGUs and CSOs. Further, ensuring funding for the procurement of ancillary supplies especially for the delivery of invasive FP procedures.

ACTION 3: The Focal Points and NIT for RPRH Law will support in improving the country's FP SERVICE DELIVERY especially the poor, adolescents, and marginalized populations through the following Actions/Interventions:

CIP 1.1.a. Develop and implement health promotion and communication plan for FP
CIP 1.2.a. Develop an alternative or blended learning system for training.
CIP 1.2.b. Establish zonal training institution.
CIP 1.2.c. The DOH should review and develop a guideline on the payment of training centers on FP modelled after the guidelines of BEmONC training fees.
CIP 3.1.a. Advocate to Chiefs of hospitals for the establishment of FP services

4.4. To what extent are these interventions focused on the following three themes of the workshop? Please list those that you would like to discuss/learn more (from other countries' experiences and/or technical partners) at the October workshop	
1. Strengthening leadership/improving political will	Action 1 are policy-driven approaches to provide stakeholders with accurate and correct information on FP, its benefits to the women's health, and its contribution for socio-economic development. These actions/interventions also aim to mobilize all RH advocates and stakeholders to rally around the DOH's FP program which is regularly attacked by RH opponents. These call on different

	stakeholders to popularize FP information, including progressive Catholic positions and to have a legal defense group ready for any court case. It also aims to address the current organizational weakness in DOH, particularly in managing the National FP Program.
2. FP Financing	Action 2 aims to ensure FP commodity security for the country's need through the CIP as complemented by PhilHealth benefit packages, and mobilizes multi-sectoral support for FP budget advocacy to Congress through the NIT. The actions listed thereto envision to strengthen the DOH FP supply chain management – ensuring demand for FP is met and stock-outs and overstocking are prevented.
3. Reaching youth and adolescents a. Adolescents b. Youth	Action 3 ensures demand and supply for FP are tallied – through the development of health promotion and communication plans, and availability of appropriately trained FP providers and the services including FP commodities. Action 3 can be enhanced so it focuses not just on the poor but also adolescents, including minors. Right now, the DOH has no guidelines on contraceptive services for adolescents not encumbered by legal prohibitions e.g. those 18 and 19 (the age of majority); those who have their parents' consent; those who consult in NGO or private facilities not explicitly covered by the prohibition; and those in emergency situations where consent is not required e.g. those who encounter life-threatening complications during delivery. It is important for DOH to develop these guidelines as soon as possible.