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An Assessment of National-Level Governance of the Philippines' Responsible Parenthood and Reproductive Health Law: Trends and Ways Forward

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Abstract

In 2012, the Philippines passed the Responsible Parenthood and Reproductive Health (RPRH) Act. The law aimed to educate and empower Filipinos to make choices regarding their reproductive health (RH), improve the lives of families, and promote sustainable human development for the nation. Key to realizing this vision, was multisectoral coordination among national government agencies (NGAs), local government units, civil society organizations and multilateral donors. The law is a culmination of efforts among these sectors to provide access to RH services to a country clamoring for greater access to RH information and commodities.

Since then, the RPRH Law has expanded RH care all over the country. Unmet need for family planning (FP) methods has continued to shrink, closing the gap with the country's goal of zero unmet need. In the years following the passage of the law, adolescent fertility rate began to decrease from the highest it has been since 1971.

Despite these accomplishments, other RH outcomes stagnated or fell behind. In 2015, the country failed to meet its Millennium Development Goals for reducing maternal mortality, lowering HIV/AIDS incidence, and improving child health and nutrition. Moreover, the country's RH outcomes lag behind those of its low-and-middle income neighbors.

Given its wide scope, understanding the progress made by the RPRH Law requires an acknowledgement of the many movers that set its machinery in motion. In this paper, we analyzed the governance role played by NGAs to facilitate the implementation of the RPRH Law over the last eight years. We focused on nine components of governance, namely, Organizational Presence, Policy Infrastructure, Financing, Human Resources, Stewardship, Coordination, Monitoring & Evaluation, and Accountability, in their RPRH activities.

While NGAs had accomplished or at least begun to accomplish most of their mandates and responsibilities stipulated in the RPRH Law and Implementing Rules and Regulations (2017 revision), performance was siloed within implementing units of agencies, with little interagency coordination. Despite the vision for multisectoral RH services, programs focused on biomedical and healthcare interventions, particularly in the area of FP. Moreover, national-level governance for RPRH implementation focused on specific programs and their operational concerns. Fragmented governance activities result from a lack of integrated plans and coordination mechanisms in the nine governance components to bridge NGAs' efforts across sectors.

Keywords: Philippines, Responsible Parenthood and Reproductive Health Act, reproductive health, governance, public administration

Disclaimer: This article/report reflects the points of view and thoughts of the authors', and the information, conclusions, and recommendations presented are not to be misconstrued as those of the Department of Health (DOH). Furthermore, this article/report has not yet been accepted by the DOH at the time of writing. The material presented here, however, is done in the spirit of promoting open access and meaningful dialogue for policy/plan/program improvement, and the responsibility for its interpretation and use lies with the reader.

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Executive Summary

In 2012, the Philippines passed Republic Act 10354, the Responsible Parenthood and Reproductive Health (RPRH) Act. **The law aimed to educate and empower Filipinos to make choices regarding their reproductive health (RH), improve the lives of families, and promote sustainable human development for the nation**. Key to realizing this vision, was multisectoral coordination among national government agencies (NGAs), local government units (LGUs), civil society organizations (CSOs) and multilateral donors. The law is a culmination of efforts among these sectors to provide access to RH services to a country clamoring for greater access to RH information and commodities.

Since then, the RPRH Law has expanded RH care all over the country. Unmet need for family planning (FP) methods has shrunk from 30% in 1993 to 17% in 2017 [1], closing the gap with the country's goal of zero unmet need. In the years following the passage of the law, adolescent fertility rate decreased from 5.7% in 2012, the highest it has been since 1971, to 4.7% in 2017 [2].

Despite these accomplishments, other RH outcomes stagnated or fell behind. In 2015, the country failed to meet its Millennium Development Goals for reducing maternal mortality, lowering HIV/AIDS incidence, and improving child health and nutrition. Given the maternal mortality ratio of 121 maternal deaths per 100,000 live births [3], (about 2,400 women and girls annually [4]) the country stands to once again fail to meet its Sustainable Development Goal nearly half this number [5]. Between 2010 and 2017, HIV incidence increased 174% [6], one of the fastest-growing in the region. As recent as 2020, a third of Filipino children were stunted [7], putting the Philippines among the top ten countries with the highest rates of stunting in the world.

RH outcomes that have seen improvement may be further enhanced by interventions that target the most vulnerable sectors. The poorest women are five-times more likely to have begun childbearing in their teenage years, have 2.5 times more children, and have on average one child more than what they desire [1]. Education is another important factor as despite increases in the contraceptive usage or prevalence rate (CPR), only 54% of married women use contraceptives [1]. Moreover, the gap between the total fertility rate and wanted fertility rate has narrowed only slightly, from 1.0 to 0.7 children [1] in the last 20 years.

Given its wide scope, understanding the progress made by the RPRH Law requires an acknowledgement of the many movers that set its machinery in motion. In this paper, we analyzed the **governance role played by NGAs** to facilitate the implementation of the RPRH Law over the last eight years. We focused on nine components of governance, namely, **Organizational Presence, Policy Infrastructure, Financing, Human Resources, Stewardship, Coordination, Monitoring & Evaluation, and Accountability**, in their RPRH activities.

While NGAs had accomplished or at least begun to accomplish most of their mandates and responsibilities stipulated in the RPRH Law and Implementing Rules and Regulations (IRR) (2017 revision), performance was siloed within implementing units of agencies, with little interagency coordination. Despite the vision for multisectoral RH services, programs focused on biomedical and healthcare interventions, particularly in the area of FP. Moreover, national-level governance for RPRH implementation focused on specific programs and their operational concerns.

Fragmented governance activities result from a lack of integrated plans and coordination mechanisms in the nine governance components to bridge NGAs' efforts across sectors.

Organizational Presence and Policy Infrastructure

- **RPRH functions were attached to existing NGA units with the closest roles to RPRH.** Most NGAs did not have dedicated focal units for RPRH implementation. **DOH had the largest organizational presence for RPRH**, but had difficulty organizing all its RPRH activities into one bureau (as was mandated by the IRR). Without a lead RPRH unit, its RPRH functions were spread out across the agency, making it difficult to coordinate and streamline activities.
- **The RPRH Law and IRR helped legitimize RPRH in NGAs** and facilitated implementation by strengthening priority for its programs and justifying greater resource allocation for RPRH activities. **However, little integration was done between RPRH and other laws that complemented RPRH provisions**. Instead, most RPRH policies and guidelines pertained to local implementing units or service providers; seldom were RPRH policies made to formalize RPRH activities in NGAs. This was a barrier to cohesive implementation among stakeholders.
- In this context of the country's decentralized government**, top-heavy NGA central offices were prescriptive,** channeling their programs to regional offices and single LGUs with fewer staff that needed to implement multiple programs assigned by each agency.

Financing and Human Resources

- **NGA's RPRH budget may be disadvantaged in the Department of Budget and Management's budgeting process**. The budget for the National FP Program was particularly vulnerable to political interference. DOH financing for RPRH was short-term (assured for only one year at a time), and largely focused on FP and Maternal, Neonatal, and Childhood Health and Nutrition. Visible expenditures in other agencies for RPRH follow this trend, contributing to a lack of establishing back-end systems that build on several years of investments.
- **NGAs had four ways to mitigate funding weaknesses for RPRH:** (1) multilateral donors, (2) attempting program convergence budgeting in 2019, (3) POPCOM cross-funding other agencies through augmentation funds requested under Executive Order 12 "Attaining and Sustaining "Zero Unmet Need for Modern Family. Planning," and (4) utilizing Gender and Development funds.
- **In NGAs, the quantity of workforce was insufficient to fulfill RPRH mandates**, especially in regional offices and lower administrative levels with heavier responsibilities. **Human resources for RPRH in NGAs required additional skills and expertise** to more effectively fulfil their RPRH mandates.

Stewardship and Coordination

- **The National Implementation Team (NIT) has not fulfilled its potential as a venue for interagency leadership and coordination.** Many agencies were underutilized, and meetings were duplicative and micro-operational. As a result, an implicit multisectoral vision for RPRH did not translate into a strategic operational plan among implementers, leading NGAs to focus on individual programs.

- **Within agencies, inconsistent political priority for RPRH in NGAs disrupted momentum** and hampers plans for long-term implementation, though this has since improved. **CSOs and POPCOM emerged as visible leaders in RPRH, but their roles for RPRH must be better delineated** for expectation-setting and accountability.

Monitoring & Evaluation and Accountability

- **The RPRH Planning, Monitoring, and Evaluation (PME) Guide presented indicators as a checklist to be completed, without a unifying theory of change** or framework across sectors. M&E systems for agencies' programs could be harmonized to remove duplication, bottlenecks, and unclear processes in NGA and LGU reporting. **However, NGAs have built or encountered innovations and good practices** that can be adopted to streamline M&E for RPRH.

- **The lack of an implementation roadmap with clear timelines and point persons for progress led to reliance on self-regulation and weak formal accountability** to Congress and the Office of the President. Accountability among NGAs for RPRH was weak and based mostly on courtesy. The DOH and NIT have not been able to win the buy-in of other agencies, weakening joint accountability across agencies for multisectoral RPRH implementation. LGUs had weak accountability to NGAs, which only have soft power over LGUs. Thus, NGAs were perceived as having more responsibility to ensure the success of RPRH.

Moving Forward

Over the past eight years of governance, RPRH implementers established their own programs and a coordinating body to promote RPRH demand among Filipinos. Now these efforts have come to fruition and **implementation must shift away from highly prescriptive, centralized, and siloed planning to better respond to present local demand for RH services**. **Ultimately, these recommendations align with current socio-political shifts**, such as the passing of the Universal Healthcare (UHC) Law and the 2019 Mandanas ruling. These landmark policies aim to equip and empower LGUs with the autonomy to deliver a range of government services to their constituents. They are a reflection of Filipino's desire to choose which services they deem appropriate to their context, over a one-size-fits-all approach implemented by a distant national government.

Our policy recommendations focus on horizontally integrating NGAs' RPRH activities, streamlining these into a comprehensive set of basic RH services for easy uptake by LGUs, and NGAs' educating and empowering LGUs to provide these basic services as well as make specific policies and programs based on the needs of local communities. Improving national-level RPRH governance is preparation for allowing NGAs to coordinate with and capacitate LGUs to fulfil their role as full implementers of RPRH service delivery, and responding to the needs of the public, to whom all RPRH implementers are accountable.

A detailed summary of recommendations to be taken in the short (1 year), medium (3 years), and long term (5 years) is presented in **Table 25**.

A. Short-term solutions

These solutions aim to equip the NIT as an oversight body and harmonize NGA's understanding of their RPRH roles in the next year.

- In the coming year, **the NIT should be capacitated with human and infrastructure resources to act as an objective overseer of implementation**. The NIT, together with NGAs, can then develop a unified strategy and operational plan for RPRH, revise M&E guidelines, and establish the infrastructure that encourages transparent and multi-sectoral collaboration.
- **Agencies should not relaunch RPRH implementation but maximize existing strengths in implementation**. This will entail evaluating their RPRH activities and formally institutionalizing RPRH in NGA structures and operations, so that RPRH activities can be planned and evaluated from an agency-wide perspective, while managers can focus on the targets of their individual programs.
- **NGAs must also secure LGU buy-in to RPRH** through educating local chief executives, leveraging the RPRH Law and IRR, and exploring incentives (financial and otherwise), to push NGAs and LGUs to dedicate personnel and resources to RPRH. Subsequently, NGAs can begin to move away from service delivery and distribution towards governance functions.

B. Medium- and Long-term solutions

These solutions aim to institutionalize RPRH in the operations of NGAs and LGUs.

- **RPRH financing can incorporated into UHC Law implementation**, using social health insurance as a stable source of funding protected from political interference. NGAs, particularly DOH and PhilHealth, should first address duplications and gaps in the current financing scheme to identify key the RPRH expenditures to finance.
- **DOH should shift the procurement of cheaper RPRH and FP commodities to LGUs**. More expensive commodities can be consolidated through a centralized electronic procurement system, with DOH as a central purchaser to maintain economies of scale.
- **Implementers should pursue public-private partnerships to expand RPRH workforce and service delivery at all levels**. At the central and regional levels, private actors like CSOs, which not constrained by large, slow-moving bureaucracies, can continue to advocate for RPRH among lawmakers. At the LGU, the private sector can augment RPRH workforce for service delivery and provide technical expertise to educate and train local implementers.
- While LGUs take on more service delivery functions and NGAs shift to more governance and support functions, **the NIT must continue to track their progress transparently and provide both with accurate and timely data to inform decision-making**, maintaining accountability to the Office of the President, Congressional Oversight Committee, and all Filipinos.

The goal for RPRH moving forward is to consolidate and institutionalize RPRH operations at the national level, so that a clear operational vision may be communicated and executed by LGUs. National implementers must capacitate LGUs and **normalize RPRH as a set of comprehensive, integrated, basic social services that fulfill the reproductive health rights and needs of the Filipino people throughout their life course.**

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Abbreviations

AO	Administrative Order
ASec	Assistant Secretary
ASRH	Adolescent Sexual and Reproductive Health
BEmONC	Basic Emergency Obstetric and Newborn Care
BHS	Barangay Health Station
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHED	Commission on Higher Education
CIP	Costed Implementation Plan
CSE	Comprehensive Sexuality Education
CO	Central Office
CoA	Commission on Audit
COC	Congressional Oversight Committee
CSO	Civil Society Organizations
DBM	Department of Budget and Management
DepEd	Department of Education
DILG	Department of Interior and Local Government
DO	Department Order
DOH	Department of Health
DOLE	Department of Labor and Employment
DPCB	Disease Prevention and Control Bureau
DPO	Department Personnel Order
DSWD	Department of Social Welfare and Development
EO	Executive Order
EPI	Expanded Program on Immunization
FDA	Food and Drug Authority
FDS	Family Development Sessions
FHB	Family Health Bureau
FHO	Family Health Office
FHRP	Family Health and Responsible Parenting
FHS	Family Health Survey
FP	Family Planning
GAD	Gender and Development
GFPS	GAD Focal Point System
GIDA	Geographically Isolated and Disadvantaged Areas
GBV	Gender-Based Violence
HFEP	Health Facilities Enhancement Program
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
HPCS	Health Promotion and Communication Service
HPV	Human Papillomavirus
HR	Human Resources
IAC-VAWC	Inter-Agency Committee on Violence Against Women and Children
IUD	Intrauterine Device
IPCR	Individual Performance Commitment and Review Form
IRR	Implementing rules and regulations

JMC	Joint Memorandum Circular
KII	Key Informant Interview
KMITS	Knowledge Management and Information Technology Service
KRA	Key Result Area
LADD	Local Administrative Development Division
LCE	Local Chief Executive
LGC	Local Government Code
LGU	Local government unit
LIKHAAN	Likhaan Center for Women's Health Inc.
LMIC	Low- and middle-income countries
MOA	Memorandum of Agreement
MC	Memorandum Circular
MDG	Millennium Development Goal
MDR	Maternal Death Review
MHCS	Mobile Health Care Services
MMR	Maternal Mortality Rate
MNCHN	Maternal, newborn, childhood health, and nutrition
NAPC	National Anti-poverty Commission
NASPCP	National AIDS and STD Prevention and Control Program
NDHS	National Demographic and Health Survey
NEDA	National Economic Development Authority
NFFP	National Family Planning Program
NGAs	National Government Agencies
NGO	Non-Government Organizations
NIP	National Immunization Program
NIT	National Implementation Team
NYC	National Youth Council
OGF	Operating and Governance Framework
OP	Office of the President
OSY	Out-of-School Youth
PER	Public expenditure review
PCW	Philippine Commission on Women
PHADP	Public Health Associates Deployment Project
PhilHealth	Philippine Health Insurance Corporation
PHO	Provincial Health Office
PME	Planning, Monitoring, and Evaluation
POPCOM	Commission on Population and Development
PRC	Philippine Regulatory Commission
PSA	Philippine Statistics Authority
RA	Republic Act
RH	Reproductive Health
RHU	Rural Health Unit
RIT	Regional Implementation Team
ROI	Return-On-Investment
RPFP	Responsible Parenthood and Family Planning

RPRH	Responsible Parenthood and Reproductive Health Law
RO	Regional Office
RTI	Reproductive Tract Infections
SA	Social Accounting
SC	Supreme Court
SDG	Sustainable Development Goal
SDN	Service Delivery Network
SHI	Social Health Insurance
SMP	Safe Motherhood Program
SO	Specific Objective
SOP	Standard Operating Procedure
SQAO	Status Quo Ante Order
SRH	Sexual and Reproductive Health
SROI	Social Return-On-Investment
STI	Sexually-Transmitted Infections
TA	Technical Assistance
TESDA	Technical Education and Skills Development Authority
TFR	Total Fertility Rate
TRO	Temporary Restraining Order
TWG	Technical Working Group
UHC	Universal Health Care
UNFPA	United Nations Populations Fund
USAID	United States Agency for International Development
USec	Undersecretary
UWFP	Unified Working Financial Plan
VAWC	Violence against women and children
WHO	World Health Organization
WMCHDD	Women and Men’s Health and Children’s Health Development Division

An Assessment of national-level governance of the Philippines' Responsible Parenthood and Reproductive Health Law: trends and ways forward

Valerie Gilbert Ulep, Jhanna Uy, Vanessa Siy Van, and Joy Bagas

1. Introduction

1.1. The Responsible Parenthood and Reproductive Health Law of 2012

The RPRH Law of 2012 presented an **important shift in the way the Philippine state viewed the role of women, the family, and reproductive health, in poverty alleviation and the socio-economic development of the nation**. It declared universal access to reproductive health (RH) services as instrumental rights **integral to the rights to life, health, and sustainable human development** [1]. It envisioned enabling families to care for and invest in all their members, contributing to a healthier, happier, more productive Philippine population. To this end, the state took **a comprehensive vision for services necessary** in a woman's life cycle, for male responsibility to be intrinsic to responsible parenthood and family planning, for programs that ensure children are well-nourished and do not die early from preventable causes, for reproductive and sexual health education to empower their choices as adolescents, and for access to quality and affordable health care for sexually-transmitted diseases, fertility, and cancers.

From the first proposed RH bill in 1999, the RPRH law faced more than a decade of challenges in the legislature. Despite strong opposition, 83% of Filipinos supported the RPRH Bill in 2012 when the national debate was at its peak [2]. Many saw it as an opportunity for empowerment, with 73% of Filipinos wanting information on all methods of FP, expressing their demand for fulfilment of their reproductive rights [2]. Through the **concerted and tireless efforts of NGAs and CSOs,** the RPRH law was passed in December 2012 and its IRR in early 2013.

1.2. Macro-trends that will Influence Demand for RPRH Services

Certain socio-demographic shifts in the Philippines will shape the priorities of RPRH implementation in the years to come. National-level policymakers must take note of trends in demographics, health, and relevant social and political issues that affect the sexual and RH needs of the population. These shifts will necessitate multisectoral programs in poverty reduction, education, and health service delivery to bring about improvements in RH outcomes like the total fertility rate (TFR), maternal mortality rate (MMR), sexually-transmitted infections (STIs) incidence rate, and the gender gap. LGUs' are poised to play a bigger role in service provision in the coming years, highlighting the need for NGAs' to facilitate their governance roles.

There will be need for RH services beyond the delivery of healthcare. One such example is in family planning (FP). In the years leading to the passage of the RPRH Law fertility management programs were not as widespread or accessible as today. As such, though the population is projected to increase from 105 million in 2015 to 118 million by 2025 [3], population growth has decreased from 2.9% per year in 1960 to 1.7% as of the 2015 Philippine Census [4]. This is attributed to declines in TFR from 4.1 children per woman in 1993 to 2.7 in 2017 [4]. Unmet need for FP methods has shrunk from 30% in 1993 to 17% in 2017, but the gap between TFR and

wanted fertility rate has only narrowed slightly from 1.0 to 0.7 in the last 20 years (**Figure 1**) [5]. Despite an increasing trend in the contraceptive usage or prevalence rate (CPR), only 54% [5] of married women use contraceptives. Thus, though women and households have benefitted from greater access to FP services, **better RH education and more opportunities for women outside the household may yet further drive down the TFR**.

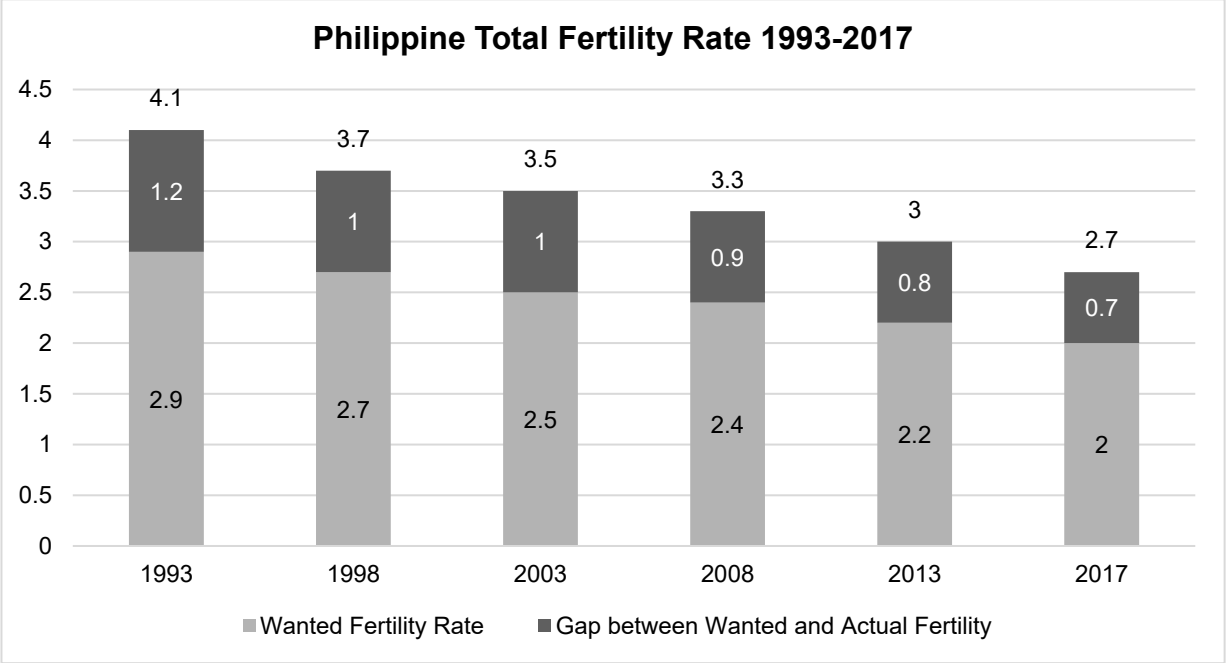

Figure 1. Philippine Total Fertility Rate compared to Wanted Fertility Rate
Source: Philippine National Demographic and Health Survey 2017 [5]

Longstanding socioeconomic disparities also remain challenges to RPRH. Compared to women of the richest income quintile, the poorest women are five-times more likely to have begun childbearing in their teenage years (3% versus 15%), have 2.5 times more children (1.7 versus 4.3), and have on average one child more than what they desire (1 versus 2) [5]. **Both of these are compounded by rapid urbanization and rural-urban migration.** More than half of Filipinos live in cities with the urban population growing quickly at 4.1% per year since 2010, **with parallel growth in urban slums** [16, 17]**.** The urban poor have heightened risk for domestic violence, undesired pregnancies and abortion, high maternal and child mortality, and sexually transmitted infections (STIs) [18]. **NGAs and local chief executives (LCEs) will need to account for the greater need for SRH services in this subpopulation** in the broader development agenda if they want to ensure healthy and productive cities [18].

Another subpopulation whose demand for RPRH services will increase is the youth. The share of the working age population is expected to increase while the share of under-15 is projected to decrease [6]. However, a major obstacle to maximizing this demographic window for socio-economic development is adolescent pregnancy. Though adolescent birth rate of 54 births per 1,000 women of 15-19 years in 2008 declined to 47 births per 1,000 in 2017 [5, 13–15], the percentage of women 15-19 years who have begun childbearing has hovered at 9% to 10%

between 2008 to 2017 (**Figure 2**) [5, 13, 14]. Early childbirth may deter adolescents from making the most of their economic opportunities. As such, aside from comprehensive sexual and RH education, **youth-focused development programs, as well as the continued creation of jobs, will be needed to improve the lives of young Filipinos and their future families**.

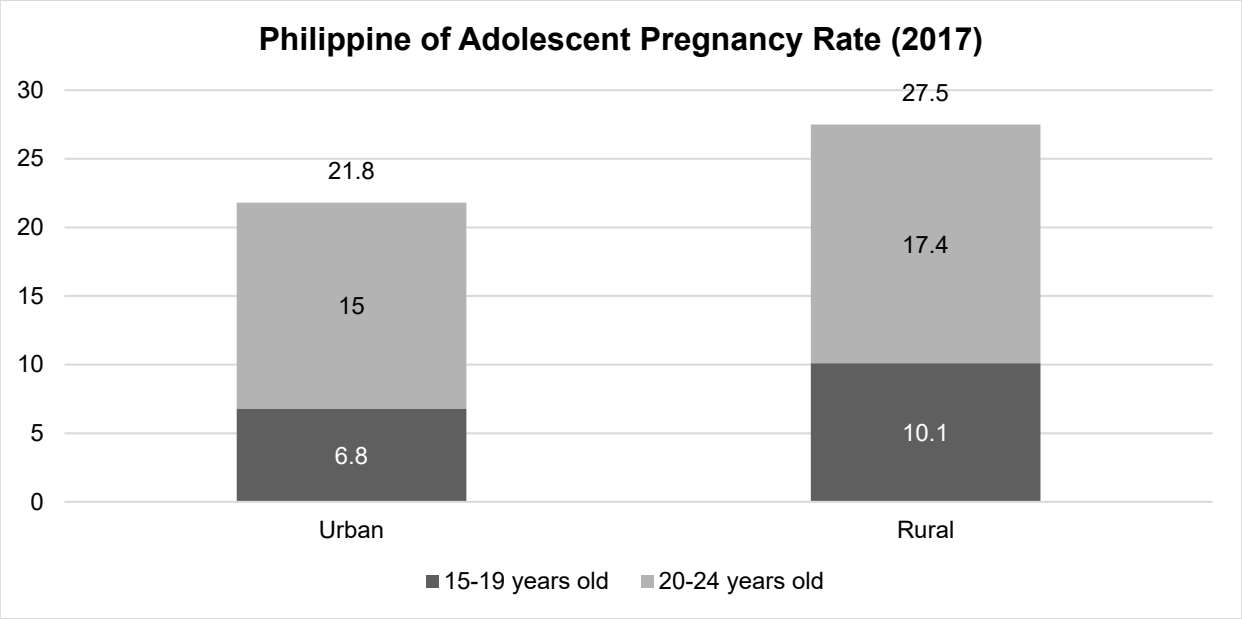

Figure 2. Philippine Adolescent Fertility Rate, Urban compared to Rural
Source: Philippine National Demographic and Health Survey 2017 [5]

RH services must also respond to an aging population. As the health of the Filipino population has generally improved, Filipinos now have a life expectancy of 71 years, an increase in average lifespan of 15 years compared to the 1960s [8]. Maintaining their RH will entail **social security for the elderly who have retired the workforce, as well as health services that cater to diseases of old age such as reproductive tract cancers and age-related hormonal changes**.

Concurrently, existing efforts to improve long-established RH outcomes should be strengthened. For example, the country's under-five mortality decreased three-fold from 103.6 deaths per 1,000 live births in 1960 to 28.4 in 2018 [9, 10]; breastfeeding is also widespread practice among 93% of mothers [5]. Additionally, in 2018, the country enhanced its HIV/AIDS law [8] to provide a better response to vulnerable populations. Despite these gains, the Philippines has still to make substantial leaps in RH. In 2015, the country failed to meet its Millennium Development Goals for reducing maternal mortality, lowering HIV/AIDS incidence, and improving child health and nutrition [11]. Given the maternal mortality ratio of 121 maternal deaths per 100,000 live births (**Figure 3**) [3], (about 2,400 women and girls annually [4]) the country stands to once again fail to meet its Sustainable Development Goal nearly half this number of 70 maternal deaths per 100,000 live births [5]. Between 2010 and 2017, HIV incidence increased 174% [6], one of the fastest-growing in the region. As recent as 2020, a third of Filipino children were stunted [7], putting the Philippines among the top ten countries with the highest rates of stunting in the world.

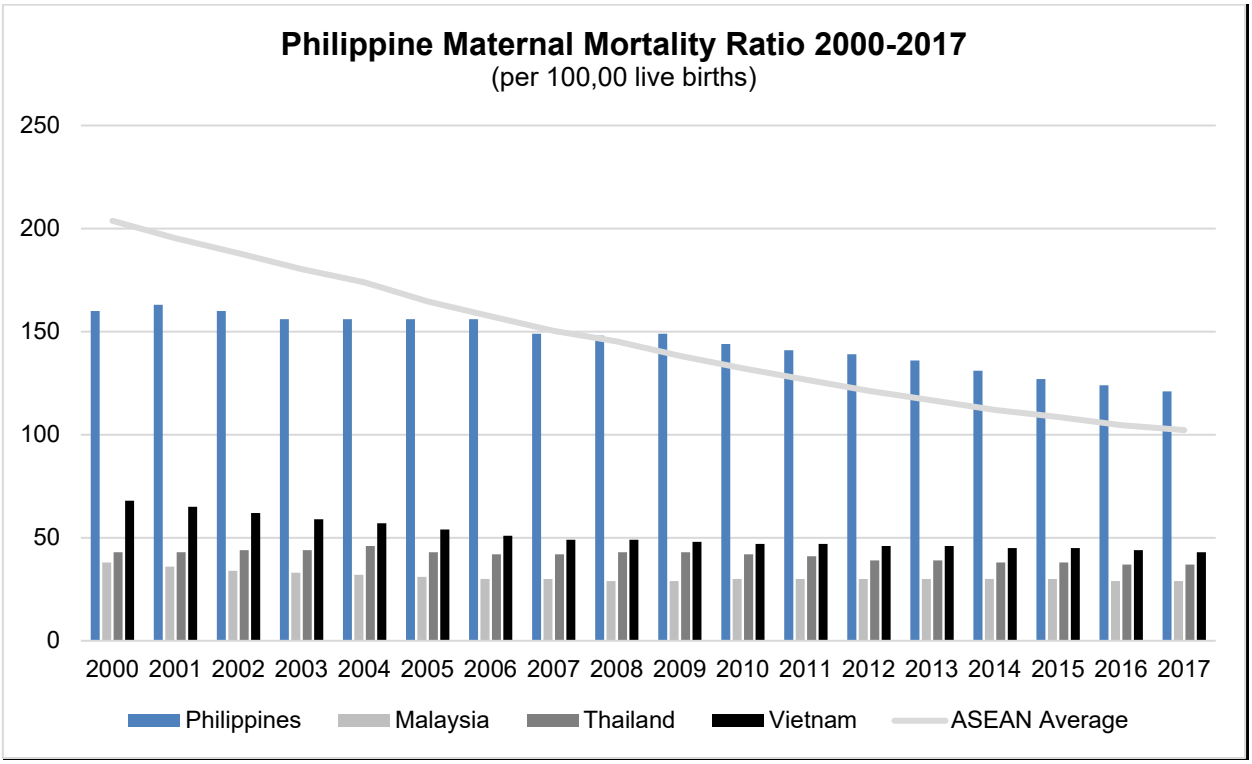

Figure 3. Philippine MMR compared to ASEAN Average
Source: World Bank Data [3]

The slowing improvements in maternal, child, and RH outcomes in the past years [12], **emphasize the need and opportunities for reform and innovations in RPRH implementation in the next decade**. These will require understanding the underlying factors leading up to healthcare access. In the case of maternal health, for instance, financial constraints were the main reason mothers did not avail of antenatal health care [5]. Those who reported difficulties accessing care were adolescent women, women with no education, and women from the poorest households [5]. **Thus, RPRH interventions must be as interconnected as are the socio-economic problems that make them such a pressing concern for the country**.

Based on current political trends, **LGUs will play a prominent part in implementing existing and forthcoming RPRH interventions**. In February of 2019, the country signed the Universal Health Care Act (RA 11223 6/2/2021 4:09:00 PM), which highlighted the importance of strengthening local health systems to expand access comprehensive and holistic healthcare. In May of the same year, the Supreme Court reaffirmed the Mandanas ruling of 2018, which decided that LGUs would have greater internal revenue allotment from two-fifths of the national taxes to implement local projects. Such legislation build upon national impetus for the devolution of governing power to LGUs from the Local Government Code of 1991 (RA 7160 [9]). **As more service delivery functions are delegated to LGUs, NGAs must in turn facilitate a smooth transition of responsibility, equipping LGUs with technical, financial, and human resources capacity**.

1.3. Significance of the Study

Moving into the next five years of implementation to address these contemporary challenges, improvements in RPRH governance must center around mustering **multi-sectoral coordination at the national level with a holistic framework that goes beyond viewing RPRH as primarily a health sector issue to one acknowledging its vital role in promoting rights and population development**. This means tackling more **structural elements** of RPRH such as empowering and educating women and the youth in their sexual and reproductive rights, as well as poverty reduction to bridge the gaps in RPRH disparities. It requires a shift to a systems approach and institutionalizing and integrating RPRH seamlessly into NGA and LGU operations while accounting for the decentralization in governance and service delivery systems. Programmatic and siloed implementation must shift to a seamless and modern system of delivering reproductive health services to all.

All these **require strengthening strategic direction, coordination, accountability, and innovation among line agencies, and addressing fragmentation and bottlenecks in operations and resources.** An evaluation of the governance of the full implementation of the RPRH implementation is thus a timely opportunity to generate information to this end.

2. METHODS

2.1. Concept of Governance

This chapter briefly describes the framework and methods used in evaluating how **RPRH governance in NGAs facilitated progress in RPRH implementation in the past 5 years.**

Adapting a definition of governance from Deloitte's Operating and Governance Framework (OGF), a commonly used governance framework in financial service institutions, **governance** can be defined as the exercise of power by decision makers or leaders to **manage and implement operations, resources, and processes** such that activities can be **coordinated strategically to respond the dynamic needs of constituents** [19].

Moreover, though implementation is led by the health sector, RPRH is a **multi-sectoral and multi-actor effort**, **requiring good governance in all involved NGAs and stakeholders.** It involves strategic and collaborative oversight across sectors, strong accountability for assigned mandates, delineated operational roles and responsibilities, clear lines of reporting and information sharing, sufficient financial and human resources, and the policy infrastructure to support decision-making that acts in accordance with RH needs of Filipinos.

2.2. Conceptual Framework

The evaluation of RPRH governance looked into **9 components based** on the conceptual framework illustrated in **Figure 1.**

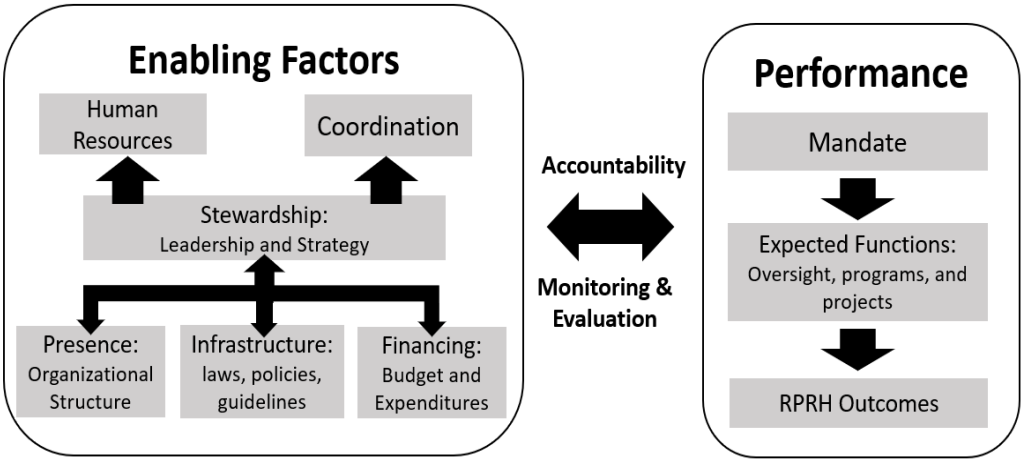

Figure 4. Conceptual Framework for RPRH Governance
Source: Deloitte Development LLC [10]

Performance in RPRH governance was assessed in terms of whether NGAs made progress in fulfilling their assigned mandates described in the RPRH law and IRR. Performance manifests in implementation of expected functions based on mandates, which then theoretically contribute to positive impacts on RH outcomes in the long term.

Performance of implementing agencies is attributable to several **enabling factors**. Central to all efforts to implement RPRH mandates is **stewardship** which is the presence and quality of leadership and the ability to direct overall implementation to a more strategic direction. Stewardship determines how an agency's foundational enabling factors of **organizational**

structure, policy infrastructure, available financing, and human resources are allocated or made responsive for RPRH implementation. Good stewardship can rally the foundational factors for RPRH in NGAs to **coordinate** efficiently and effectively within their organizations and across collaborating agencies to carry out mandates.

The critical link between **performance** and **enabling factors** is the conduct of regular **monitoring and evaluation** to evaluate progress in RPRH implementation and **accountability mechanisms** that hold NGAs answerable to this progress in fulfilling their mandates. These two are important feedback mechanisms to help improve the management, operations, and decision making in implementing agencies for RPRH.

2.3. Data Collection and Analysis

The study collected qualitative data and triangulated findings from three main sources: (1) key informant interviews, (2) review of official documents, and (3) a review of literature.

Key informant interviews (KIIs) were conducted with **20 respondents** involved in RPRH governance at the central level from NGAs and civil society, holding positions within their organizations of program manager and above (**Table 1).** Two respondents were from the regional offices (ROs) of the Department of Health (DOH) and Commission on Population and Development (POPCOM). KIIs were planned with the Food and Drug Administration (FDA) and the National Anti-Poverty Commission (NAPC); however, these were not pursued as they remained unresponsive to our requests and because data collection reached a saturation point wherein no new information or themes emerged with additional interviews.

Table 1. Organizations included in KIIs and Number of Respondents

Organization	Number of Respondents
Department of Health (DOH)	6
Commission on Population (POPCOM)	4
Philippine Health Insurance Corporation (PhilHealth)	1
Department of Education (DepEd)	1
Department of Social Welfare and Development (DSWD)	2
Department of Interior and Local Government (DILG)	1
Philippine Commission on Women (PCW)	2
Civil Society / Private sector	2
United Nations Population Fund (UNFPA)	1

KIIs explored how agencies adapted their **organizational structure**, roles, and units for RPRH activities based on their RPRH mandates. Implementing agencies were also asked about the **leadership** for RPRH within the organization and how this translated to **capacity-building** efforts for **financial resources** and **RPRH workforce.** Finally, agencies were asked to evaluate their **performance** on RPRH-related activities such as **demand-generation** and **procurement**, based on their **monitoring and accountability mechanisms** and metrics. They then enumerated major challenges to accomplishing their mandates, faced both internally and externally while **coordinating** with other organizations.

Patterns, trends, similarities, and differences in answers for each element of the conceptual framework were identified and analyzed using **qualitative thematic analysis**. To note, we present translated quotes from KIIs and redact portions of the translations that may lead to identification of the respondents.

A **review of official documents** such as the RPRH Law, IRR, policy issuances, and official reports was done to confirm if agency mandates were implemented, and what persistent challenges were experienced. The documents were scoped for annual recommendations to improve RPRH implementation and how these were acted upon over the succeeding years.

These data were further verified and supported with a **review of secondary literature**. The review looked at studies that documented or evaluated the activities of implementing NGAs for RPRH. Additional literature validated if findings from KIIs and review of documents were common in the setting of Philippine governance or multi-sectoral governance. Lastly, the literature review also determined **best practices and recommendations** that may contribute to solving the challenges in RPRH governance based on cases from other countries.

Three researchers independently synthesized these data to arrive at results for each specific objective. A workshop was then conducted to discuss and achieve consensus on results.

With these data, this study looked into the enabling factors of governance, their links with each other, and how these led to the NGAs' progress in implementing the RPRH Law.

2.4. Organization of the Report

The following sections of this report are divided into **five (5) chapters**.

- **Chapter 3** gives an assessment of the performance of NGAs in carrying out their RPRH mandates and what progress has been made in the twelve (12) RPRH elements.
- **Chapter 4** covers the foundational enabling factors of presence or organizational, policy infrastructure, financing, and human resources for RPRH.
- **Chapter 5** describes the stewardship and coordination among various NGAs involved in RPRH implementation.
- **Chapter 6** discusses feedback mechanisms of performance or M&E and accountability.
- **Chapter 7** synthesizes the narrative of RPRH implementation in the past 5 years and provides a framework to structure all the recommendations within this report.

3. Performance

As the starting point of this study, the performance objective aims to assess the progress of NGAs in the **conduct of mandates, roles, and responsibilities described in the RPRH law and IRR**. RPRH implementation is multi-sectoral in nature and different agencies were given mandates aligned with their capabilities, resources, and the sectors they serve. As such, this section takes stock of accomplishments and efforts of **individual agencies as well as across agencies** in terms of programs and initiatives for the 12 RPRH elements.

In the chapters after this one, foundational factors to performance, namely, presence, financing, workforce, and human resources, are discussed extensively to better understand the reasons for persistent challenges affecting performance.

(1) Generally, agencies were able to complete mandates that did not require interagency coordination.

Mandates considered were based on the **RPRH Law and IRR (2017 revision)**. **Policy issuances after 2013** such as executive orders and joint circulars were also included.

Table 2 below qualitatively evaluates the completion of RPRH mandates assigned to NGAs in terms of progress as **"not done"** (to be implemented), **"doing"** (some implementation activities), **"done"** (completed).

Table 2. Completion of RPRH mandates listed in IRR (2017 revision)

DONE	DOING	NOT DONE
DOH Governance: Guidelines		
4.01 Service Delivery **4.04** Informed Choice **4.08** Care for GBV Survivors **4.12, 4.13** Policies on Life-Saving Drugs in Maternal Emergencies **5.07** FP Services at Establishments/Enterprises **5.08** Mapping SDN Facilities **5.22, 5.23** Exempting Private Providers **6.01, 6.03-6.05** Contracting and Training Health Professionals **8.03** Procurement of FP **10.10** LGU Awards/ Recognition **14.01** MDR, FIDR	**5.07** FP Services at Establishments/Enterprises **5.11** Match Populations to Facilities in the SDN **5.14** Assistance to LGUs for MHCS Vehicles **5.17** Identification of Facilities for Upgrading **5.19** Support to LGUs **5.27** Training Counsellors of Adolescents **6.06** CEmONC Curriculum **6.07, 6.08** Training BHWs **10.02** Health Promo Plan **12.01 except h** DOH duties	**5.13** Standards of MHCS **5.18, 5.20** M&E for LGU Fund Utilization and SDN **6.02** Determine no. of Skilled Health Professional **10.06** M&E for New Health Promo Plans
DOH Governance: Non-Guidelines		
5.09, 5.10 Mapping Health Facilities and Priority Populations in the SDN **8.02** Budget to Procure FP **9.03, 9.04** Funds for Health Facilities and Public Awareness	**6.10** TA to Engage Private Providers in LGUs **14.07** MDR, FIDR Panel **15.03** Streamline Reporting	**8.07, 8.10** Monitoring System for Procurement **12.01-h** RH Bureau in DOH

DOH Service Delivery

DONE	DOING	NOT DONE
4.11 Life-Saving Drugs in Maternal Care Emergencies **4.15** Maternal and Newborn Health Care in Crisis Situations **5.21** Assist Private FP Services **7.02, 8.01, 8.08** FP Logistics **13.02** RPRH in Anti-Poverty **15.01** Reporting Requirements	**4.05-4.07** Access to FP (including minors) **4.09** PWD-SRH Programs **4.10** Responding to Unmet Need **5.02, 5.05** RH Care in SDN **5.12** MHCS **6.09** SBCC Materials **10.01** Health Promotion	
Other Implementers		
5.10 Identify Priority Populations in the SDN (**DSWD**) **12.03, 12.04** Duties (**DSWD**) **7.04, 7.05, 7.08, 7.12** RH Product Certification (**FDA**) **7.06** Harmonize Standards (**FDA**) **9.06-9.08** Financing RH (**PhilHealth**) **10.07, 12.04** CSO Participation (**Cross-Cutting**) **11.02** Curriculum Development (**DepEd**)	**4.02**, **5.03, 5.15, 5.16, 8.09, 10.05** Service Delivery (**LGUs**) **5.07** FP Services at Establishments/Enterprises (**DOLE**) **9.01, 9.02** Appropriations (**Cross-Cutting**) **10.04** NGAs Assist DOH **10.08, 10.09** Health Promo in NGAs' Programs (**Cross-Cutting**) **9.05** Funding for RPRH Ed (**PRC/CHED/TESDA/DepEd**) **11.01, 11.05, 11.06** Provision of RPRH Education (**DepEd**)	**4.14** Integrate RH in Health Professional Curriculum (**PRC/CHED/TESDA**) **6.11-6.13** Pro-Bono Services Requirements (**PhilHealth**) **7.07** Guidelines for FP Product Requirements (**FDA**) **7.09, 7.10** Post-Marketing Surveillance Unit (**FDA**) **11.04** Training Educators (**DepEd**)

Sources: Annual Accomplishment Reports 2014-2018, KIIs, Secondary Literature Review

Accomplishments. NGAs were able to fulfill most mandates that required intra-agency coordination. A significant portion of these mandates were **one-time, fairly straightforward tasks** assigned to DOH. Examples include the creation of guidelines and standards for service delivery and private-sector engagement, and hiring and training skilled health professionals (IRR Section [Sec] 4 and 6).

Other major accomplishments were for initiatives whose **entire project cycle was handled solely by one implementing unit**. Maternal, infant, and fetal death reviews (Sec 14) may be related to oversight, evaluation, and support functions falling under the DOH Safe Motherhood Program (SMP). In general, MNCHN-related targets were implemented as mandated by the IRR, building on the long history of efforts for MNCHN.

For other agencies, major accomplishments were mostly for mandates falling **under the jurisdiction of its main agency functions, or continuing existing efforts**. An example is the FDA's role in certifying FP commodities and including them in the Philippine National Drug Formulary and Essential Medicines list (Sec 7.04, 7.05, 7.08, 7.12).

Another example is **PhilHealth** with its core function of benefit package development [20]. They were able to fulfill their mandates of having packages and case rates covering HIV/AIDS (Outpatient HIV/AIDS Treatment package), breast and reproductive tract cancers (Z-benefits), menopause-related conditions (case rates), and long acting and permanent contraception (e.g. IUD-insertion, vasectomies, and subdermal implants). Based on KIIs with DOH and PhilHealth, the lack of benefit packages for short-acting contraceptives, such as pills is a conscious choice to delineate financing between the DOH and PhilHealth.

An **exception to the trend** appears to be the implementation of the **Gender and Development Program (GAD)** (Sec 9), which cuts across agencies. GAD is a system of programs to consolidate and institutionalize gender and development efforts within agencies. However, including GAD is part of a trend, where **mandates from older policies were added to the RPRH IRR**. GAD originated from the Magna Carta of Women, passed in 2009 [21], and was already being implemented prior to RPRH. The success of GAD may then be attributed to the preceding years of gender mainstreaming efforts by individual agencies.

Partial Accomplishments. NGAs were not able to fully implement tasks that entailed **inter-agency coordination or interfacing with several layers of bureaucracy within the same agency.** However, these are the activities that are instrumental to building necessary **systems infrastructure** that support the sustainability of RPRH implementation.

An example of **delays from coordination between two or more agencies is the logistics management for the FP supply chain.** In the backend, **DOH** is still only starting to establish a computerized procurement system to track FP supplies (Sec 8.10) and has a long procurement process. This affects the mandate of the **FDA** to oversee the compliance of FP suppliers with respect to proper handling, storage, and distribution, and the conduct of post-marketing surveillance (Sec 7.09, 7.10).

The Commission on Audit (CoA) found that there was excessive procurement and overstocking of FP commodities, with many undelivered and expired (**see Box 4, page 28** for more details) [22]. **POPCOM's** and **LGUs'** roles in FP distribution are the front-end components of the service delivery network (SDN) for FP. The overstock of FP means there are recurring **supply-demand mismatches between DOH procurement and POPCOM/LGU distribution**.

An example of **delays within agencies** is that **DOH** has not been able to formulate annual M&E plans, targets, and resources for its national multimedia campaigns (Sec 10.06). The technical contents come from the Disease Prevention and Control Bureau (DPCB), the design of the materials is handled by the Health Promotion and Communication Service (HPCS), and M&E is generally the responsibility of the Epidemiology Bureau (EB) or Knowledge Management and Information Technology Services (KMITS).

Another example is the rollout of the **Department of Education's (DepEd) Comprehensive Sexuality Education (CSE)** curriculum. DepEd was mandated to create a developmentally- and age-appropriate RPRH curriculum for the K-12 Basic Education Curriculum.

The DepEd respondent explained that integration of RPRH concepts into the K-12 curriculum began even before the passing of the RPRH law. Since the law was signed, DepEd has been moving to enhance the integration and deepen its messaging.

> *"For a long time already [CSE subject matter is present] … we really ensure that it's there… The difference, of course, is that the integration is now enhanced, since it's a mandate now… It needs to be clear to teachers that [RPRH concepts] are integrated into this particular learning competency, because it's not all quarters that have them … so that children's knowledge about themselves as someone becoming a woman or a man, will be deepened …" - DepEd respondent*

The timeline of progress for this deeper integration is started in 2016 (**Figure 2**). DepEd is slated to pilot CSE in 3 regions with high incidence of teenage pregnancy in 2021. The DepEd

respondent rated the **completion of CSE roll-out with a score of 4 on a scale of 1 to 10,** with 10 being full implementation. The respondent **attributes the delays to a lack of dedicated funds for CSE** in DepEd's general appropriations.

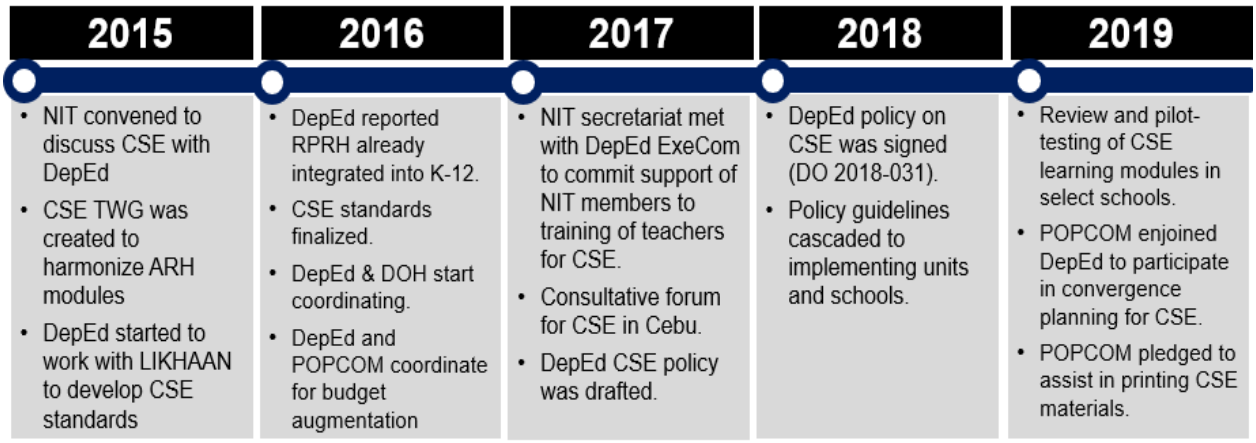

Figure 5. Timeline of DepEd CSE Progress

Source: NIT minutes

The incomplete implementation of some mandates requiring coordination across sectors may have contributed to the **recurring challenges over the years** (**Box 1**).

Unresolved challenges on governance were consistently reported. These include issues relating to stewardship, M&E, financing, and coordination. highlighting the **difficulty in multi-agency planning and cooperation**.

Issues faced by specific KRAs and their respective recommendations follow a trend that **focuses on service delivery, specific programs, and operational concerns**. Only in later years is a systems-view taken. Structural challenges such as planning, stigma, and priority setting are brought up only in 2018. Recommendations remain **siloed within individual agencies**, though they are meant to address problems that cut across NGAs and sectors.

Box 1. Recurring Challenges in RPRH Annual Accomplishment Reports 2014-2018

The National Implementation Team (NIT) is an interagency body composed of implementers of the RPRH law, including NGAs, CSOs, and multilateral organizations. Each year, the NIT Secretariat publishes an annual accomplishment report (AR) for RPRH implementation. Persistent challenges and recommendations are identified in **Governance and Financing** across all sectors, and the five **Key Result Areas** (KRAs):

- Maternal, Neonatal, and Child Health and Nutrition (MNCHN),
- Family Planning (FP),
- Adolescent Sexual and Reproductive Health (ASRH),
- Violence Against Women and Children (VAWC), and
- Sexually Transmitted Infections and HIV/AIDS (STI-HIV/AIDS)

These challenges are summarized in **Table 3**.

Table 3. Annual Trends and Issues Identified in RPRH Implementation

Area	Issues	Years Identified				
		2014	2015	2016	2017	2018
Cross-cutting	No overall plan or a "single agency solely in charge of nationwide implementation"	◉	◉	◉	◉	◉
	Weak M&E and data management	◉	◉	◉	◉	◉
	Weak link between demand generation and service provision; Weak logistics system	◉	◉	◉	◉	◉
	Limited scope and scale of service delivery through public sector	◉	◉	◉		◉
	Capacity-building efforts of NGAs like DOH are limited to public sector	◉	◉	◉		◉
	Uncertainty of RPRH budget; Limited absorptive capacity for incremental budgets	◉	◉			
	Low utilization of RPRH benefits; Lack in clarity for reimbursements and guidelines	◉	◉	◉	◉	◉
MNCHN	Limited access to services and stagnant/high MMR and IMR due to preventable causes	◉	◉	◉	◉	◉
	Poor newborn, infant, child health and nutrition		◉	◉		◉
FP	High unmet need varying across population groups; LGU difficulty operationalizing FP SDN	◉	◉	◉	◉	
	Variable training standards and requirements for FP licensing or accreditation; Few HHR in facilities for competing priorities		◉			
	Legal barriers to providing FP (i.e. TRO)		◉	◉		
	Impractical FP targets and planning, including resolution of bottlenecks				◉	◉
ASRH	Lack of clear legal authority and evidence- based technical guidelines to direct ASRH programs and strategies		◉	◉	◉	◉
	Unavailability of routinely collected age and sex disaggregated data on health service utilization		◉	◉		◉
	Delay in adoption of CSE in K-12; limited IEC on ASRH for parents; Ineffective awareness campaigns to raise demand for ASRH services			◉	◉	◉
	High unmet need of adolescents; Minors need parental consent to access FP services; Lack of youth-friendly treatment centers; Stigma					◉
VAWC	Laws with dated or discriminatory content; Gaps in local policies to address VAWC or GBV		◉		◉	◉
	Inadequate research and monitoring for GBV- and gender-responsive services		◉			◉
	Lack of comprehensive package of services for survivors (psychosocial, legal, and support)		◉			◉
	Unaddressed cases and slow access to justice		◉	◉		◉
	Lack of service provider capability (barangay VAW desks, WCPU in hospitals)		◉			◉
	Prevention of VAWC is not a priority					◉
STI-HIV/AIDS	Continuing growth of HIV epidemic; rising cases among children (vertical transmission)		◉		◉	
	Limited access to HIV/STI services and info		◉	◉		◉
	Lack of data and research on HIV		◉	◉		

	Lack of laws to protect subpopulations from discrimination and stigma	◉

Sources: RPRH Annual Accomplishment Reports 2014-2018

(2) Performance has focused on individual programs, with the most visible programs being in family planning and adolescent sexual reproductive health.

Table 4 shows the programs and initiatives of relevant implementing agencies for each of the 12 RPRH elements **as reported in the annual ARs from 2014-2018**.

Consistent with the **five (5) KRAs** chosen by the NIT, **majority of reported programs are FP**, **MNCHN**, **HIV/AIDS**, **ASRH**, and **VAWC**. Other elements related to reproductive tract cancers, male involvement, infertility, abortion complications, ASRH services, and mental health, did not have as many programs (as confirmed by DOH respondents).

Table 4. RPRH Elements with Major Programs Published in Annual ARs 2014-2018

RPRH Element	Agency	Programs
1. Family planning information and services	DOH	National Family Planning Program
	POPCOM	Responsible Parenthood and Family Planning Program Usapan Serye (with DOH, DSWD)
	DOLE	Family Welfare Program
	DSWD	Family Development Sessions, Pre-Marriage Counselling
2. Maternal, infant, and child health and nutrition, including breastfeeding	DOH	National Safe Motherhood Program Expanded Program on Immunization Buntis Congress, Unang Yakap Campaign
	DSWD	Residential and Non-Residential Care Programs Supplementary Feeding Program
	DepEd	Weekly Iron Folic Acid (WIFA) supplementation
	DOLE	Lactation Stations Program
	CSO	Hakab Na
3. Proscription and management of abortion and its complications	None reported in the accomplishment reports.	
4. Adolescent youth and reproductive health guidance and counseling at the point of care	CSOs, POPCOM, UNFPA, USAID, Private	Teen Centers
	DepEd	ASRH Program
	DOH	Adolescent Friendly Facilities
5. Prevention, treatment, and management of reproductive tract infections (RTIs), HIV and AIDS and other sexually transmissible infections (STIs)	DOH	STI-HIV AIDS Program Philippine AIDS Candlelight Memorial World AIDS Day Celebration
	DSWD	Financial Assistance for PLHIV
	CSO	Duyan Program, LGBT and HIV beauty pageant Financial Assistance for Children with HIV HIV summits, “Gay Community Fora”, Heart to H.E.A.R.T Peer education programs
	DSWD	Assistance to individuals in Crisis Situations Women and Children Friendly Space

RPRH Element	Agency	Programs
6. Elimination of violence against women and children and other forms of sexual and gender-based violence	POPCOM	Katropa
	DOH	Women and Child Protection Program
	CSO	Men Opposed to Violence against Women Everywhere (MOVE) (with NAPOLCOM and DSWD) Sexual Health and Empowerment (SHE) project Forum on safe public spaces against sexual harassment
	PCW	National Women's Month Celebration 18- Day Campaign to End VAW, VAW Experiential Museum Male Advocates Assembly on Eliminating GBV VawFreePh Personal Safety Mobile App Promoting Safe Communities: A Forum with Male Advocates Against Violence Everywhere
	PNP	Women and Children Protection Desks (WCPD)
	DILG, LGU	Barangay VAW-Desk Women and children protection program
7. Education and counseling on sexuality and reproductive health	DOH Region 7	Adolescent Health Connect (AH Connect) through SMS and social media with hotline
	NAPC	Gender Sensitivity Training
	POPCOM	Gender Sensitivity Training Peer Education Program on Adolescent Sexual and Reproductive Health- Sexually Healthy and Personally Effective (SHAPE) Adolescents Teen Chat Facilitator trainings, SPEED (Support-Promote-Empower-Engage-Development) for Youth, Youth Advocates Training, Life Skills Encampment Training for Out-of-School Youth Teen Moms Congress
8. Treatment of breast and reproductive tract cancers and other gynecological conditions	DOH	HPV Vaccination Program Cancer Care Program
9. Male responsibility and involvement and RH	POPCOM	Mr. GAD, Katropa
	DSWD	Empowerment and Reaffirmation of Paternal Abilities
10. Prevention, treatment and management of infertility and sexual dysfunction	None reported in the accomplishment reports.	
11. Reproductive health education for adolescents in formal and non-formal education settings	DSWD	Residential and Non-Residential Care Programs (for abused adolescents) Unlad Kabataan Program ARH in FDS module
	NYC	Sine Kabataan
	DepEd	Abot Alam Program for OSY Comprehensive Water, Sanitation and Hygiene in Schools Festival of Talents Menstrual Health Management Project of DepEd for female students in Grades 7 to 10 including those in ALS #MenstruationMatters: A Forum on Menstrual Hygiene (with DOH and others) Comprehensive Gender and Health Education for Youth (CGHEY) for Madrasah (with POPCOM)
	POPCOM	U4U Teen Trail (with UNFPA)

RPRH Element	Agency	Programs
		Parent Teen Trail-Learning Package for Parent Education on Adolescent Health and Development (LPPED-AHD)
	DOH	Healthy Young Ones
12. Mental Health Aspect of Reproductive Care	DOH	Integrated in the Safe Motherhood Program and Responsible Parenthood and Family Planning Program

Sources: Annual Accomplishment Reports 2014-2018

ASRH. Elements 4 and 11 pertain specifically to adolescents and explicitly mention counseling and education. Though element 7 refers to RH education in general, 5 out of 7 programs target adolescents. Combined, ASRH has 21 reported programs, more than any other element.

Looking closely at the programs, the **majority are one-off events,** such as **forums** (Teen Moms Congress, #MenstruationMatters), **competitions** (Sine Kabataan, Festival of Talents), **seminars** (Trainings), and **modules** (ARH in FDS, CGHEY). These events expose or educate adolescents at the point of contact, but sustained impacts cannot be assessed.

There were a **few initiatives that act as building blocks for much longer-term interventions**, such as SHAPE, a toolkit developed by POPCOM for mainstreaming ASRH in different programs and settings to engage with the youth [23]. Another is DepEd's Abot Alam program (DepEd DO 2015-017), which identifies out-of-school youth and links them to various employment, education, or entrepreneurship opportunities. DOH's Adolescent-Friendly Facilities is another good example. The program tries to address structural biases against adolescents accessing RH services through cooperating with and empowering LGUs [24].

VAWC. Element 6 has the second-highest number (16) of reported programs. However, **VAWC programs have been a major concern of agencies since 2004,** when the Anti-VAWC Act was passed. Through the same law, the Interagency Council on VAWC (IAC-VAWC) was created, with member agencies, some of which are also part of the NIT, required to develop programs and community-based mechanisms to mainstream the care and support of assault survivors [25]. IAC-VAWC's earliest strategic plan in 2007 enshrines this. The number of VAWC programs **may be the result of agencies' coordination efforts coming to maturation** and is consistent with the trend of including mandates from older policies in the RPRH ARs.

HIV/AIDS and STIs. Element 5 covers not only sexually transmitted infections (STI), but also reproductive tract infections (RTI). However, **all 10 reported programs reported targeted HIV/AIDS**, one type of STI. The Philippines has also had an HIV law since 1998 (RA 11166) [26] and HIV/AIDS has been a major priority since the MDGs, so it's programs may be attributed to maturation, similar to those of VAWC.

DOH, DSWD, and CSOs have programs mitigating the impacts of HIV (HIV/AIDS Program, Financial Assistance of PLHIV, Duyan Program), though **no programs explicitly address structural causes and indirect consequences of HIV/AIDS across the lifecourse**.

MNCHN. Despite having only 9 reported programs for its element, **the majority of MNCHN programs are sustained, long-term efforts that are permanent features of health facilities, schools, and workplaces** (SMP, EPI, Unang Yakap, Fortification, Lactation Stations, Feeding Program). Putting maternal, infant, and childhood health together has integrated three life stages, providing some continuity to the programs implemented.

Multiple respondents attributed the maturation of the MNCHN program to uncontested political priority and financing by DOH, PhilHealth, and donors that predate the RPRH law.

> *"In terms of priority? I guess MNCHN in general is really at the highest of priority [of DOH], but I would also say that HIV is beginning to receive attention also, because of the leadership too of our Secretary of Health." - Respondent 18*

Family Planning. Despite having the fewest number of reported programs, **FP programs are nationwide in scope, some required by the RPRH law, and all but one are regularly implemented.** Similar to MNCHN, FP takes a large share of investments in RPRH within DOH (**Table 12, page 47** in the Financing section).

FP has been the focus of multi-agency efforts in the NIT since the RPRH law was passed (as will be seen in the Stewardship and Coordination section)**,** because **FP was the area that the NIT and CSOs felt had the most challenges.** While MNCHN programs had longstanding uncontested support from elected officials, **FP has a long history of controversy** starting from the struggle to pass the law and a Supreme Court status quo ante order (SC SQAO) just four days after the signing of its IRR that delayed its implementation until it was found "not unconstitutional" in April 2014 [27]. From 2015 to 2017, the SC then imposed a temporary restraining order (TRO) on the certification of contraceptive products by FDA and the procurement, distribution and use of the progestin subdermal implants [28].

"But in the NIT, the focus I think [is FP] because FP is like the problem. I guess if you will check the agenda of the NIT, FP is like the main topic. Maybe because it is problematic but it also means you are not paying attention equally."	*"We don't feel the weight of other programs because the NIT meetings rarely touch on them. They are so focused on Family Planning. I attended one forum. Another attendee asked me why they always talk about family planning. So I just answered, FP is a big problem because a large sector is against it."*	"*Of all the elements the problematic one is family planning... because of the different interpretation of the different LGUs that the essence of the RPRH law is of family planning. The others [i.e. elements] they can manage but the family planning, it's a very sensitive program that even their local chief executives are sometimes not supportive of."*
Respondent 3	*Respondent 10*	*Respondent 11*
"Yes, because we felt that those [FP and ASRH] are the important elements of the RPRH law that were very controversial and needed to be pushed. I mean, you know that gynecologic cancers, etcetera, etcetera, nobody questions those things. So the Department of Health has programs for those. So we felt that some things were not our priority. We were just going to let the Department of Health continue with their programs there. What needed to be pushed was really family planning and adolescent reproductive health. So that was the focus from the very beginning." - Respondent 17		

This focus has been bolstered by the support of the Office of the President (OP) given in 2017 and renewed in 2019 to fully implement the national FP program.

> *"So mainly it's about family planning… that is because of the mandate of the president. The president is connecting family planning with poverty alleviation. So, it's not just a health concern, but it's about alleviating poverty. Well on teenage pregnancy, to be declared by the president as a national social emergency, it is still related to family planning… The president is also saying that in his State of the Nation Addresses." - Respondent 11*

RPRH implementation has been programmatic. Current implementation may thus be described as **siloed,** focusing on programs and certain elements without accounting for how each program or element feeds into each other and the whole. Consequently, there is an **unequal balance of attention and efforts to building integrated interventions** and the systems required to implement them.

There is **still no comprehensive package of RPRH services** in the Philippines. Despite the mandate to develop the integrated package. Various RPRH services are still demarcated by the units and agencies that pilot them - as reflected by how they are reported in the annual ARs.

Some RPRH implementers have become aware of this problem and are realizing the need for **multi-agency collaboration** that understands how different programs affect one another.

"*It seems like even if this element is connected to reproductive health, more often than not, we do not see the connection. I observe we deal on matters separately so when you say reproductive health, the discussion is confined to them [health agencies].* *But for the other elements, we also admit that we sometimes view them without the health lens when actually we should also see, for instance, eliminating violence against women by access to reproductive health."*	*"I think that because of [NGAs'] mandate they have to deliver certain programs. But then there's not much effort to put them in one picture… there's nothing like a recommendation that we are supposed to go in one direction even if we are implementing different programs for different elements in the RH… I think that should be one of the recommendations, that different agencies should talk to each other and come up with the overall picture. There should be a big picture that really [shows] these are interconnected…"*
Respondent 2	*Respondent 11*

Multiple international guidelines have highlighted the importance of integrated service delivery and a comprehensive package of services when responding to **multi-sectoral problems that require interdependent interventions** [25, 26]. Beyond healthcare provision, it is the system's investments in education, communication, governance, and financing, that enable RPRH to meet its goals of poverty reduction and holistic sustainable human development.

The example in **Box 2** shows the integrated nature of RPRH in adolescent maternal mortality.

Box 2. Need for Integrated Interventions to Address Adolescent Maternal Mortality

A major contributor to maternal mortality is adolescent pregnancy [29], which can easily be labeled a symptom of unmet need for FP. However, the provision of FP commodities alone has not efficiently addressed rising rates of adolescent fertility in the Philippines.

> *"When it comes to adolescents, no MHO will let himself/herself forgo asking for [parental] consent, because under the law, there should be [parental] consent… If it is about family planning and it is an adolescent, the parent must be there. Because even among our colleagues-- the doctors who have reported cases and tell me about them-- children of doctors, adolescents. Their stomach hurts, they get brought to the hospital, they get looked at by [their parents'] colleague in the hospital. And then, they noted, [the adolescent] was, in fact, pregnant. The doctor can even get mad at her. So, when it's like that, it's really necessary that I stick to, 'This is the law. We have to follow the law.' Even if civil society says so much about [parental consent] not being needed. Because even the MHO is also looking for protection. If the law says, 'there*

must be consent,' even if the adolescent delivered children twice, but is still below 18 years old, you have to ask them for consent." - DOH respondent

The case above illustrates the **underlying factors that hinder investments in FP from translating into reductions in adolescent pregnancy and maternal mortality**.

Adolescents can obtain FP services, such as commodities and counselling, only with the consent of their parents or guardians. Previous studies have shown that the requirement of parental consent not only leads to adolescents avoiding preventive FP services, but also impedes them from seeking timely medical care during the critical months of pregnancy, increasing pregnancy-related risks. In the example above, even though the adolescent mothers were children of doctors, they delayed seeking medical care and informing their parents [30, 31]. Given the legal boundaries in the Philippines for adolescent access to contraceptives, **ASRH must involve educating parents**.

Another structural factor that adolescent mothers face is the stigma from healthcare workers. Among conservative healthcare providers, contraceptive usage among adolescents is still linked to notions of sexual promiscuity. Attitudes of healthcare workers may be a significant barrier to accessing sexual and RH services [32]. Thus, **ASRH must involve sensitivity training for health workers**.

Moreover, adolescent pregnancy is often viewed in terms of adolescent mothers, as was illustrated in the anecdote. However, the lack of programs targeting male involvement in pregnancy greatly diminish the effectiveness of pregnancy prevention programs [33]. Research shows that both male and female child abuse are also significant risk factors in adolescent pregnancy [33–35]. **Programs targeting male responsibility and VAWC are crucial to ASRH**.

As multi-sectoral efforts are important, it is relevant to **analyze the preceding factors of governance to understand and address current gaps in performance and implementation**. The succeeding chapters explore how RPRH has not yet been institutionalized in NGAs' organizational structure (Presence) and policies (Infrastructure), the resource constraints (Financing and Human Resources), and the leadership efforts to mitigate them and direct overall implementation (Stewardship and Coordination). Feedback mechanisms (Monitoring and Evaluation and Accountability) are discussed to complete the policy implementation process and offer recommendations (Synthesis and Recommendations Framework).

4. Foundations of Performance

4.1. Presence (Organizational Structure)

Presence focuses on **organizational structures of NGAs** and whether they are **responsive to their RPRH mandates**. **Organizational structure is the formal framework** by which organizations group and coordinate job tasks, delineate hierarchies of authority and supervision, and define relationships between units [36]. It influences the allotment of financial and human resources, the speed and flow of information, and ease of stewardship and coordination among organizational units. Hence, **presence serves as the first foundational factor** as all activities are built on and affected by the backbone of its organization structure.

To assess the responsiveness of organization structures to RPRH, we looked at whether NGAs made **formal or informal changes to their structures for RPRH to better implement their mandates.** The assessment looked into COs, ROs, and the NIT.

(1) RPRH functions and activities were attached to existing agency units with roles closest to RPRH in content or mandated function in the IRR.

Majority of the NGAs interviewed did not make formal changes to their organizational structures in response to their RPRH mandates. This makes sense for agencies that are not DOH since RPRH is not their core function and their organizational structure is optimized for their own mandates and priority programs.

Table 5 lists the main units in NGAs that handle RPRH for the agency. To name a few:

PhilHealth attached RPRH activities to its MDG Benefits Product Team who were already developing benefits related to MNCHN prior the RPRH law's passing. The team was initially created as an ad hoc team for MDG-related targets in 2013, coinciding with the release of the RPRH IRR. PhilHealth was then able to align the MDG Benefits Product Team with RPRH-related mandates when the NIT called upon agencies to send representatives. See **Box 7** (page 58) in the Human Resources section for more details on how PhilHealth integrated RPRH horizontally into their structure and operations.

DepEd assigned CSE to a focal person in the Curriculum Standards Division of the Bureau of Curriculum Development as the "heart of the Department [of Education] is the curriculum" (DepEd respondent).

In **DILG**, RPRH was attached to Local Administrative Development Division (LADD) to a staff that handles GAD in LGUs and the social services sector.

PCW assigned RPRH to the Planning, Monitoring, and Evaluation (PME) Division since the unit handles GAD and the focal persons handle the health agenda.

DOH and POPCOM have the biggest presence for RPRH. DOH will be discussed in more detail in the next subsection (Subsection 2).

POPCOM is notable in that since its **entire organizational structure is geared towards** the Population Management Program, all units in the agency work for **RPRH.** Moreover, the **Executive Director, POPCOM's highest office, serves as a focal person for RPRH implementation in interagency matters** such as the NIT (see Subsection 4 for details).

Table 5. Main units in NGA Central Offices with programs or activities for RPRH

NGA*	Main units with RPRH activities	Official Functions of Unit	Responsibilities for RPRH
POPCOM	Policy Analysis and Development Division	Coordinate POPCOM programs with stakeholder Formulate population and development policies Plan, advocate and monitor and evaluate population programs	Co-manage the family planning program with DOH Co-chair the NIT with DOH and fulfill secretariat roles Collaborate with LGUs and NGAs for the implementation of RPRH strategies Adopt the attainment of zero unmet need for modern family planning as a population management strategy
PhilHealth	MDG Benefits Product Team	Develop, enhance, and monitor utilization of benefits for MDG Develop and revise policies for accreditation of facilities Coordinate with other units within PhilHealth to facilitate rollout of benefits: Standards and Monitoring, Member Management, Corporate Planning, Corporate Communication	Facilitate development and roll out of FP and MNCHN benefit packages Develop licensing and accreditation policies for FP and MNCHN providers
DepEd	Bureau of Curriculum Development	Develop and manage national education policy framework on curriculum development Develop basic and special curriculums and policies/guidelines for their management and localization	Develop and integrate CSE in basic education curriculum Coordinate with other bureaus for pilot testing, teacher training, and roll out of CSE nationwide
DSWD	Program Management Bureau	Ensure the responsive and efficient implementation of social welfare and development (SWD) programs, projects, and services for the vulnerable and marginalized sectors.	Across units: Coordinate with DOH review and implement guidelines and standards for the care of victim-survivors of gender-based violence.
	Social Technology Bureau, Standards Bureau	Develop and enhance customer-driven social protection technologies Fulfill the regulatory and quality	Regularly provide the DOH and LGUs with the updated list of poor identified through the NHTS-PR.

NGA*	Main units with RPRH activities	Official Functions of Unit	Responsibilities for RPRH
		assurance roles of the DSWD along the development of quality assurance measures in the management of social welfare and development agencies.	Facilitate retooling of service providers, particularly the local social welfare development officers, through the DSWD field office
	4Ps National Program Management Office	Execute all plans, policies, tasks and activities in the implementation of 4Ps	Inclusion of RPRH seminars in Family Development Sessions
DILG	Local Administrative Development Division	Communicate programs to local government Ensure compliance of LGUs to policies and laws	Ensure LGU compliance in implementing the RPRH Law Ensure compliance of LGU reporting on RPRH implementation Provide guidelines on LGU implementation
	Bureau of Local Government Supervision	Oversee the performance of Local Governments in Governance, Administration, Social and Economic Development and Environmental Management	Include RPRH indicators in Seal of Good Local Governance
PCW	Policy Development, Planning, Monitoring, and Evaluation Division (PDPMED)	Develop GAD policies, guidelines, national plans GAD oversight in and technical inputs to NGA policies, plans and programs Develop and advocate for gender-responsive laws (e.g. Women's priority legislative agenda) Monitor implementation of GAD policies, gender-related laws, and Magna Carta of Women	Participate in the NIT Influence programs, projects and policies to address women's health concerns Advocate women reproductive health and sexual rights Advocate GBV-VAWC policies and programs Gender mainstreaming in RPRH health service delivery Advocate utilization of GAD budget for RPRH programs and projects

Source**:** Agency websites and KIIs

***** DOH is discussed in more detail in the next subsection.

To note, there **have been changes in the organizational structures for some NGAs** as a **result of other laws and policies** after the passing of the RPRH law in 2012. These restructurings in

service of the NGA's core mandates may have potential effects on RPRH implementation. A summary of notable changes is listed in **Table 6**.

An **example of an inadvertent negative effect** was DepEd's rationalization program to better implement the K-12 Basic Education Program. Before rationalization, DepEd was organized by level of education (Elementary, Secondary, and ALS Education) and coordination could be done within bureaus. Post-rationalization dissolved the Population Education Program unit and organized the Curriculum Development Bureau along functional lines. RPRH implementation thus has to pass through four bureaus (i.e., Curriculum Development, Learning Delivery, Education Assessment, Learning Resources) before full implementation can occur.

An **example of a potential positive effect** is POPCOM's transfer from the DOH to the National Economic Development Authority (NEDA). Such a transfer recognized the POPCOM's potential as an agency to oversee the RPRH law's broader goals of harnessing the population dividend for socio-economic development, especially in LGUs.

Table 6. Changes in Structure triggered by other Laws & Potential Implications for RPRH

Changes	Rationale	Potential Effect on RPRH
DepEd - 2015 Functional structure from Educational Levels structure (DepEd Order 2013-53)	Rationalization program to streamline and focus core functions for the implementation of the K-12 Basic Education Program	Population Education Program unit dissolved (initial creation was via DepEd DO 1994-62) More inter-bureau coordination and units to pass through to implement CSE
POPCOM - 2018 Transfer from DOH to NEDA (EO No. 71 of 2018)	Strengthen development and implementation of population-related efforts in pursuit of socio-economic development reforms.	Strengthen agency's operations for population and development in LGUs and NGAs Decrease in DOH's human resources for RPRH
DILG - 2018 PCW moved from OP to DILG (EO No. 67 of 2018)	Rationalization of OP Strengthen community-level implementation of Magna Carta Law	Better coordination and visibility with LGUs for GAD and advancing women's concerns (e.g. access to RPRH services)
DSWD - 2018 NAPC transferred from OP to DSWD (EO No. 67 of 2018)	Rationalization of OP Convergence of agency mandates and functions	Harmonize efforts and strengthen targeting for poverty alleviation programs (e.g. RPRH demand generation)
Department of Trade and Industry (DTI)-2018 TESDA moved from OP to DTI (EO No. 67 of 2018)	Rationalization of OP Convergence of agency mandates and functions	Better linkage of out-of-school youth skills development programs to employment programs for population development

Informally attaching or "folding in" RPRH functions to existing units underlines a **programmatic instead of a holistic approach to RPRH implementation in NGAs**. This is especially true in NGAs with RPRH mandates split among many units, such as DOH (see next subsection) and

DepEd. Most agencies are large functionally-organized bureaucracies and units assigned to RPRH tasks may be separated in the organizational structure. They are more likely to implement their own programs independently with minimal integration. This limits RPRH's access to resources such as finances, staff time, and leadership priority in the agency, as RPRH does not have a distinct "home" unit or "identity" in the agency.

In this regard, **agencies with at least some dedicated or semi-dedicated units for RPRH are more responsive to RPRH implementation.** They are able to give RPRH priority because it is formally recognized as part of their tasks. Aside from PhilHealth and POPCOM (discussed in the prior pages), the **DSWD GAD technical working group (TWG) is a good example of how units from different divisions and bureaus can be integrated in pursuit of holistic implementation of mandate**. Although the TWG was created to institutionalize GAD, it **has RPRH-related functions, looking at RPRH as a gender concern cutting across the different programs** in different DSWD units (see **Box 3**).

Box 3. Integrating DSWD units for GAD and RPRH through a TWG

DSWD formally creates special TWGs through **administrative orders (AO) approved by the incumbent department Secretary.** The DSWD GAD TWG was created via AO 2012-005 and then member units were better specified in an amendment via AO 2018-015. The DSWD GAD TWG is chaired by an Assistant Secretary (ASec). and composed of office representatives responsible for gender-related planning, budgeting, and monitoring and evaluation (**Table 7**).

Table 7. Composition and Roles of DSWD's GAD TWG

Bureau	Role
Policy Development and Planning Bureau	Technical assistance to DSWD units on the development of GAD Plans and Budget and monitoring for GAD ARs
National Program Management Office	Ensure funding and timely implementation of gender mainstreaming initiatives and programs
Capacity Building Bureau	Capacity development programs on gender equality and women's empowerment for DSWD employees; Mandatory gender sensitivity training; ensure capacity building is linked with individual performance contracts and development plans
Human Resource Development Bureau	Gender mainstreaming guidelines for DSWD staff; Develop policies and coordinating mechanisms for the security of women and frontline respondents
Social Marketing Service	Advocacy activities and development of gender-fair information, education, and communication materials for DSWD staff and stakeholders
Protective Service Bureau	Technical assistance to Field Offices to ensure gender mainstreaming is incorporated into protective service programs
Disaster Response and Management Bureau	Ensure gender mainstreaming in disaster relief and response management (e.g. humanitarian assistance, women and girls displaced by conflict, gender-based violence, psychosocial support programs)

Source: DSWD AO 2018-015

Each bureau in the GAD TWG has assigned strategic roles and these are **included in the personnel's Individual Performance Contract (IPC)** (DSWD AO no.15 s. 2018, Item VI, item 18). The TWG is **headed by an Undersecretary (USec) and it is tasked to report to the head of secretary, executive committee (ExeCom), or management committee (ManCom)**. Its secretariat is housed in the Policy Development and Planning Bureau.

The GAD TWG reduces the processes and decision steps needed to implement GAD-related projects and programs. For gender-related concerns, the secretariat convenes only this TWG to coordinate and collaborate. **The outcomes of the collaboration are presented to the ExeCom or ManCom for faster approval, refinement, or rejection**; this skips the process of needing to go through each office and getting their approvals separately.

(2) The DOH has the biggest presence for RPRH, but it is having difficulties in organizing a single bureau for RPRH implementation as specified in the IRR.

Section 12.01h of the RPRH IRR stipulates that DOH must:

> "Reorganize the various programs on reproductive health into a unified bureau or office that shall have an organizational structure that corresponds to the functions of a) standards development, policy, planning and financing; b) capacity building; c) advocacy and communication; d) support to field operations; and 3) monitoring and evaluation and knowledge management."

This provision is important as it **envisions integrating functional units and consolidating human resources within the DOH to formally focus on RPRH implementation.**

Since the IRR was passed, DOH is still working to push for the creation of its "**Family Health Bureau (FHB)**." The 2015 and 2017 RPRH ARs record that the DOH submitted its proposal, but until today it is still awaiting "endorsement of the Office of Organization, Position, Classification and Compensation Bureau of the DBM, before it can be sent to the Office of the President for final approval." Nevertheless, it is commendable that DOH **consolidated its RPRH programs as much as possible within the Women Men Health Development Division (WMHDD) and Child Health Development Division (CHDD)** in response to its RPRH mandates and to facilitate the coordination between related programs.

At present, **the majority of the RPRH programs are found under the Disease Prevention and Control Bureau (DPCB)** but are in different divisions with different chiefs (**Figure 3**). WMHDD covers the most RPRH elements: FP, ASRH, WCPP, Safe Motherhood, and Men's Health. IDPCD has the STI-HIV AIDS Program while the LRDD has the Cancer Control Program. Lastly, ENCDD handles the Mental Health Program.

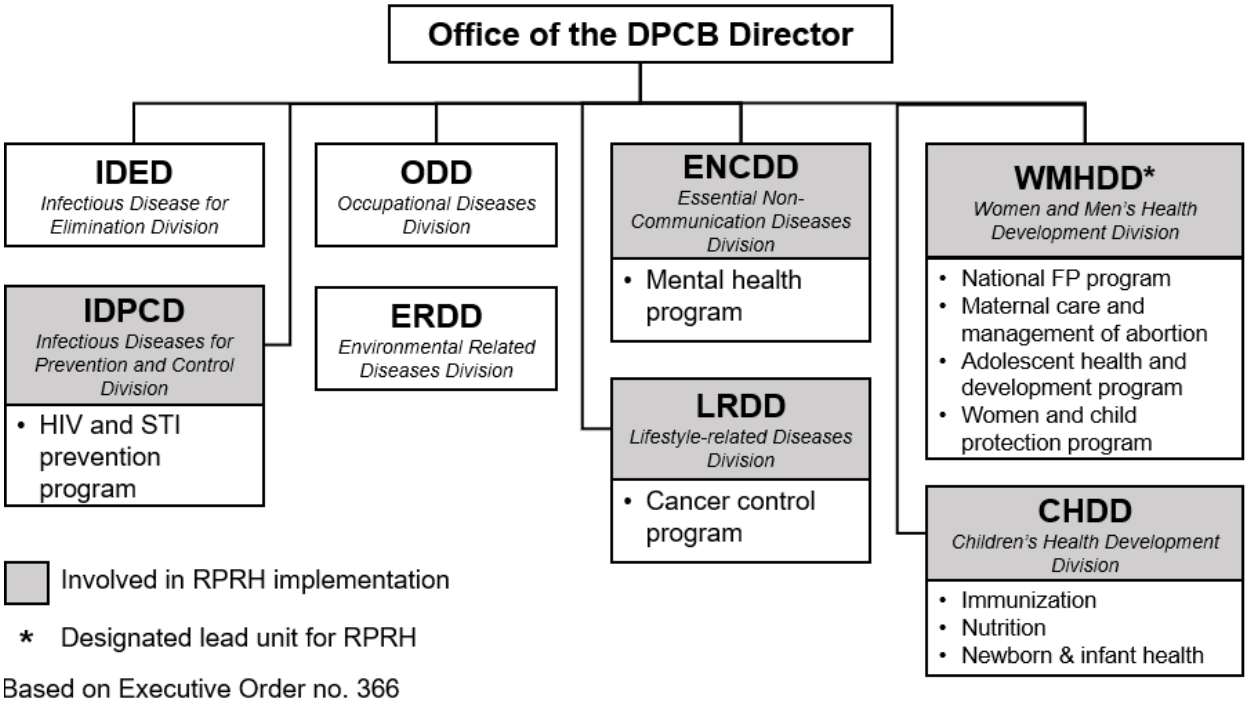

Figure 6. RPRH-related units in the DOH Disease Prevention and Control Bureau

Source: DOH Budget Folio 2018 [11]

Without a formal "lead unit" or "head unit" in DOH for RPRH, the role was added on to the functions of the division chief of WMHDD. But the reach of a division chief is largely confined to his/her programs. Moreover, RPRH elements still exist as separate "programs" even if they are under one division. This thinking may reinforce programmatic implementation of RPRH. To be fair, DOH respondents express that they have realized the need to work together and integrate their programs and have started doing so within and across divisions.

DOH still has other RPRH functions that are not in DPCB (Figure 4). These are mostly support functions mandated by the IRR such as M&E (KMITS and EB), regulation and licensing of health facilities (Health Facilities and Services Regulatory Bureau [HFSRB]), capital investments in LGU health infrastructure (Health Facilities Development Bureau [HFDB]), health human resource deployments (Health Human Resources Development Bureau [HHRDB], and procurement and supply chain logistics (Logistics Management Division [LMD]).

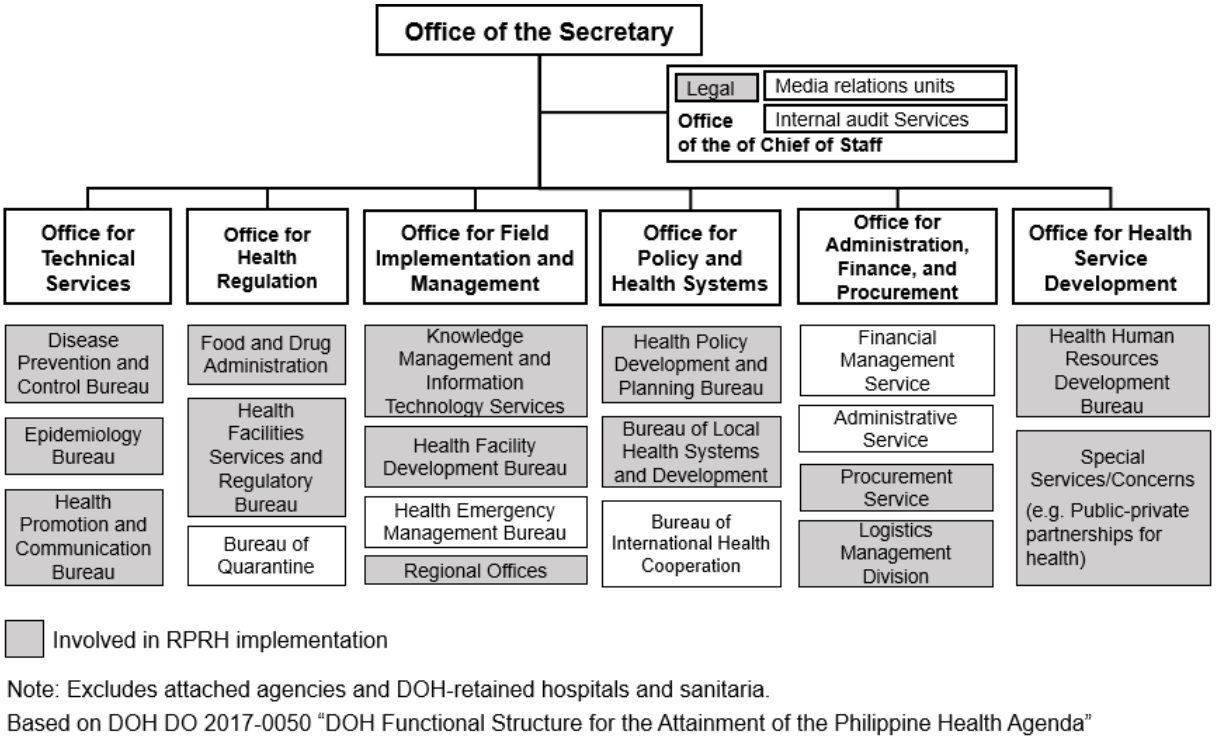

Figure 7. DOH units with RPRH-related activities
Source: DOH Budget Folio 2018 [11]

These support units are in separate clusters under their own ASecs or USecs. **Communication between bureaus and across clusters is difficult and slow because of multiple levels of bureaucracy** necessary for the approval of requests. Each cluster has their own timelines and approval processes, adding to delays in internal transactions and resource access among units implementing RPRH.

See **Box 4** below for an example of flow of information, communication, and coordination in terms of supply chain in DOH.

Thus, the creation of the FHB is crucial to streamline RPRH activities and processes in DOH, as well as better integrate existing RPRH activities horizontally across units and bureaus without infringing on existing organizational arrangements.

Box 4. Coordination for Commodity Procurement within DOH

The general steps for DOH's procurement of FP commodities is given below. The procurement process is relevant to DOH's procurement and logistics role in the FP program. Each year, commodity procurement in DOH has many decision and coordination points.

1. FP program acquires data from KMITS and EB to calculate the needed quantity of commodities.
2. Then the FP program creates terms of references and bidding documents in coordination with procurement services (PS) with the concurrence of the Legal (LS) and Financial and Management Services (FMS). PS will post the invitation to bid to start the procurement process.
3. The procurement process involves convening the Central Office Bids and Awards Committee (COBAC) and follows several steps (**Figure 5**). After issuing a notice of award, the FP program and PS coordinate with LS to finalize the contract and issue the notice to proceed.

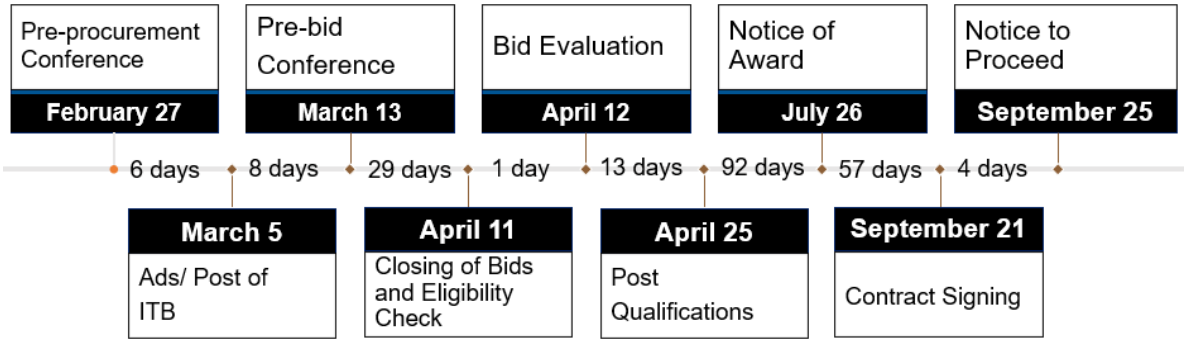

Figure 8. Sample 7-month DOH Procurement Process for DMPA in 2018

Source: DOH Procurement Monitoring Report for 2018

4. PS and the FP program then coordinate with the Logistics Management Division (LMD) for delivery of commodities to central warehouses and distribution to ROs. For every delivery, the supplier has to coordinate with the FP program and LMD. PS and Family Health Office (FHO) has to coordinate with FMS to pay the supplier for every satisfied delivery.

According to the DOH, the entire process for FP, which includes the **annual** procurement process, may take around **1 to 1.5 years at minimum**.

The CoA called out the DOH in 2019 for "ineffective or poor procurement planning and inventory management practices" that if not addressed "would have chilling effects on the implementation of newly signed Republic Act No. 11223, also known as the Universal Health Care (UHC) Act" [22]. In particular, DOH has difficulty entering into contracts with bidders and issuing notices to proceed within the prescribed timelines of the RA 9184 "Government Procurement Reform Act."

Units in DOH gave the following explanations to CoA for this issue:

- WMHDD: Delayed distribution was due to poor management of the supply chain by PS and LMD and poor communication and coordination with LGU recipients.
- PS: Overstocking was due to poor procurement planning of LMD and delays of DOH programs in preparing purchase requests.
- LMD: Delayed distribution was due to non-submission of regional allocations by DOH programs.

  FMD: Unrecorded transactions were due to incomplete and untimely submission of documentation from LMD and other others, often "after several months have lapsed."

(3) In the context of decentralization and a multi-sectoral perspective, NGAs have top-heavy structures with parallel mechanisms to push down programs from COs to smaller and smaller units with heavier burdens for implementation.

As with the majority of government programs and the Local Government Code (LGC) of 1991, the RPRH law is being implemented in a decentralized setting. The RPRH IRR and related policies, mandate COs to formulate programs, provide technical assistance, and perform oversight functions for LGUs. LGUs are then primarily in charge of actual implementation and direct service delivery to constituents.

Central Office. From the top at the CO level, a **single program may seem easy to manage**, since the program designers at the CO level delegate to the 17 ROs, which in turn delegate it to 5 to 7 provinces which then manage the 10 to 20 cities or municipalities in their jurisdiction (**Figure 6**).

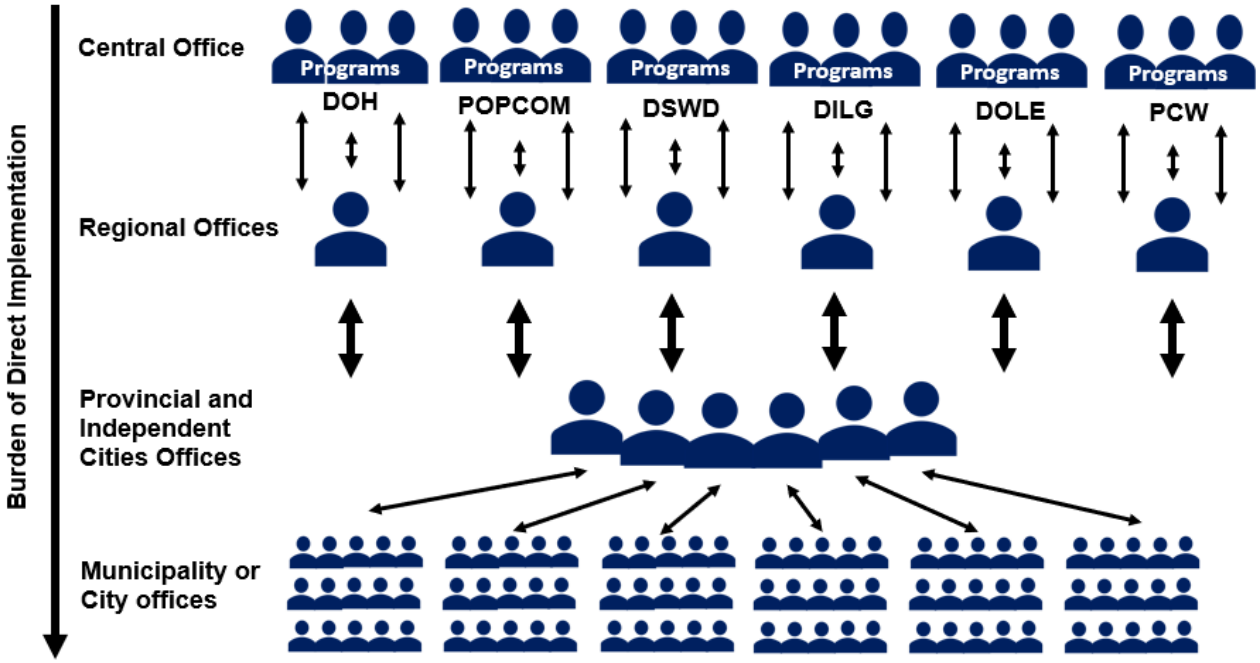

Figure 9. Representation of Organizational Structures from Central to LGU Level

Regional Office. Because of the nature of government plantilla positions and rationalization programs [37], the **organizational structure at the ROs is lean with fewer staff despite more responsibilities for oversight and support to LGUs**. Multiple KII respondents from COs mentioned that their counterparts at the ROs handle many programs and lack staff (see Human Resources section). ROs do not only **push down programs** from the central level. They are also **responsible for bringing data and feedback from the many LGUs under their jurisdiction all the way back to the COs**.

However, most **NGAs do not have an organizational structure that extends to LGUs**, and their structure stops at the RO. A **truncated organizational structure at the regional level** has implications on information flow, coordination, and accountability (as will be seen in later sections). The structure is particularly challenging for coordination between program designers and program implementers. For example, COs and ROs are not assured that information has actually reached LGUs, and communication from the LGU to the CO is not guaranteed. It can also

help explain mismatch between supply of commodities from CO and LGU demand (as discussed in the Performance section).

Some NGAs have tried to address shortcomings of the small RO presence by **channeling their issues and directives through DILG** which has staff up to the city or municipality level. Although DILG's mandate is to ensure LGU compliance in RPRH implementation, this is not an ideal setup, as it overwhelms DILG systems and capacity. For instance, despite using DILG channels some respondents stated their uncertainty regarding the LGUs' receipt of their orders to implement priority programs.

> *"One time, they [NIT Members] like updates on a monthly basis but we have none because updates will come from the LGUs. That's why LGUs are saying the heaviest burden for implementing all the laws was on them. They have too many reports to accomplish competing for the time and effort to implement. You see, we have so many policies. LGUs are yet to internalize the latest policy which requires a report, and then a new one will be issued. To think, LGU officials are not permanent staff. That's the challenge." - Respondent 6*

LGU. The reality of decentralization is that there are multiple programs per NGA and multiple NGAs (**Figure 6**). As LGUs are the smallest unit for implementation, a single LCE must understand, study, integrate, and implement all national directives. Thus, it is understandable that just a handful of programs from each of the NGAs may challenge priority-setting and resource allocation at the local level. Structures at the LGU level just for RPRH can prioritize service delivery and monitoring.

> *"Dr[redacted] Head of City Population Management Office and FP Coordinator in [redacted] City also shared the advantage of having a Population Office in line with the reporting of the KRA accomplishments... Although their office was still lodged under the City Health Department, their office was tasked to consolidate the reports related to the RPRH Law." - RIT Minutes, 2019*

(4) The NIT and its various TWGs serve as the interagency structure for the RPRH law's implementation. Its composition can be streamlined to better harmonize and strategize implementation.

The implementation of RPRH is multi-sectoral in nature as the law recognizes that RRPH issues are health, social, economic, and development issues. Therefore, there is a need for different NGAs to come together to implement the RPRH Law.

Membership. The **NIT and RITs** were thus formed through **DOH AO 2015-002**. The NIT and RITs were envisioned as an interagency body whose **members are NGAs, CSOs, multilaterals, academe, and the private sector. Table 8** lists the members of the NIT. Meanwhile, the specific composition of RITs may vary by region depending on the local contexts. For example, the CAR-RIT includes the Department of Agriculture and organizations catering to the needs of its indigenous populations.

Secretariat. To note, the NIT and RIT **do not have their own staff complement**. The secretariat role is shared among DOH, POPCOM, and the Likhaan Center for Women's Health Inc. (LIKHAAN) at the national level. POPCOM houses the NIT and RIT secretariat in its national and regional offices by virtue of its Executive Director being the head secretariat (DOH AO no.

2015-002). To note, LIKHAAN has served three terms (2015-present) as the elected lead convenor and representative of at least 48 CSOs working for RPRH.

NIT Representatives. Permanent NIT representatives from NGAs were identified by name to foster accountability through **DOH Department Personnel Order (DPO) 2015-002**.

Since its inception, the NIT has been **chaired by former Secretary of Health** Dr. Esperanza I. Cabral. The **co-chair** seat is designated for an **ASec or USec from DOH.** This post is currently held by USec Myrna C. Cabotaje of the Public Health Services Team (2018 - present); it was held previously by ASec Paulyn Jean Ubial of the Health Regulation Team. **POPCOM Executive Director** Dr. Juan Antonio A. Perez III has been **vice chair** since 2015.

As the NIT is expected to act as an interagency body to manage, plan, and coordinate operations for RPRH, it needs the commitment of high level officials in implementing NGAs. To this end, the DOH AO 2015-0002 specified that **NGA representatives to the NIT be preferably the rank of Assistant Secretary**, not lower than Director rank, and alternate representatives as least a Division Chief. In reality, the **regular attendees of the NIT were mostly division chiefs** with the exception of DOH and POPCOM.

Table 8. Members of RPRH National Implementation Team

Group	Members	
Public sector	DOH (various bureaus) POPCOM PhilHealth Food and Drug Authority DepEd DSWD DILG PCW	National Anti-Poverty Commission (NAPC) NEDA National Council on Disability Affairs Union of Local Authorities of the Philippines (ULAP)
Civil Society	LIKHAAN Democratic Socialist Women of the Philippines (DSWP)* Population Services Pilipinas Inc.(PSPI)*	
Multilaterals and Academe	United Nations Population Fund (UNFPA)* United States Agency for International Development (USAID)* University of the Philippines - School of Economics (UPecon)*	
Private sector	Zuellig Family Foundation*	

* These groups are active in the NIT based on minutes of the meeting, but they were not specified in Administrative Order 2015-002.

Technical Working Groups. The NIT has **nine (9) TWGs** established through **DOH DPO 2016-2230** (**Table 9**) with one for the KRA on ASRH and the rest for cross-cutting matters like financing, training, and health promotion.

The **TWG roles and composition can be further streamlined and made strategic**. The TWGs may have **too many members**. The number of members range from 6 (Logistics) to 19 (M&E TWG), with 6 of 9 TWGs having more than 10 members. Meetings are much more effective with a small core group of around 5 to 8 people to maintain the quality of discussion [38]. **Membership is also repetitive** with DOH-WMHDD present in all TWGs and chairing or co-chairing 6 of 9 TWGs. Likewise, POPCOM is a member of 6 and chairs or co-chairs 3 TWGs. Meetings for multiple TWGs may take away staff time for implementation activities.

Table 9. NIT TWGs, their Responsibilities, and Members

TWG	Responsibilities	Members
1. PhilHealth and Financing	Review and recommend enhancements to or new PhilHealth policies Document and disseminate LGU best practices in utilizing PhilHealth trust funds for RPRH Coordinate with other TWGs for efforts to increase utilization of RPRH services/benefits	Chair: PhilHealth Co-Chair: DOH-WMHDD DOH-HPDPB, DOH-HFSRB, POPCOM ROs of DOH, PhilHealth, and POPCOM Family Planning Organization of the Philippines (FPOP), LIKHAAN, Philippine Society for Responsible Parenthood (PSRP), Integrated Midwives Association of the Philippines (IMAP) UNFPA, USAID, UPecon
2. Monitoring and Evaluation (M&E)	Develop, review RPRH M&E framework, guidelines, reporting systems at all administrative levels M&E for implementation of national and local RPRH based on Work and Financial Plan Prepare RPRH Annual AR	Chair: POPCOM Co-Chair: DOH-WMHDD DOH-BLHSD, LMD, EB, KMITS PSA, PhilHealth, DILG, DSWD, DepEd, ULAP RO representatives for DOH (III, IV-A, IV-B, NCR) and POPCOM (III, IV-A, IV-B) FPOP, LIKHAAN, PSPI, ZFF UNFPA, USAID, UPecon
3. Local RPRH Governance	Recommend LGU incentive mechanisms to promote RPRH compliance Promote use of RPRH dashboard to monitor LGU performance Review functionality of service delivery networks (SDN) for RPRH	Chair: DOH-BLHSD Co-Chair: DILG DOH-Office for Health Operations, WMHDD POPCOM, DSWD, ULAP LIKHAAN, FPOP, PLCPD, DSWP UNFPA, USAID, ZFF
4. Logistics	Technical assistance (TA) to DOH CO and ROs and LGUs for RPRH commodities supply chain Address distribution issues of RPRH commodities to LGUs, facilities, CSOs Review DOH logistics management systems and RPRH logistics hotlines to prevent delays and stockouts	Chair: DOH-LMD Co-Chair: POPCOM DOH-WHDD UNFPA, USAID, UPEcon
5. Adolescent Sexual and Reproductive Health (ASRH)	Review and harmonize CSE modules and ASRH standards and guidelines by various NGAs Fast track CSE implementation in schools and communities Formalize link between school, community, CSOs, and health facilities as a SDN for ASRH	Chair: DepEd Co-Chair: POPCOM DOH-WMHDD DSWD, NYC LIKHAAN, PLCPD, DSWP, FPOP UNFPA, USAID Note: Popcom was later elected as chair
6. Research/ Knowledge Management	Research agenda for RPRH Document and disseminate best practices, including in GIDAs and disaster situations Maintain database of reference materials for RPRH (e.g. reports, IEC materials) Protocols for assessing effectiveness of communication initiatives	Chair: DOH-WMHDD Co-Chair: DOH-HPDPB FPOP, PSRP USAID, UPecon Philippine Center for Population Development (PCPD)

TWG	Responsibilities	Members
7. Training	Review and harmonize existing training designs for RPRH capacity building programs Propose mechanisms for smoother PhilHealth accreditation process of facilities and providers	Chair: PSRP Co-Chair: DOH-WMHDD DOH-HHRDB, NCDA LIKHAAN, FriendlyCare, IMAP, PSPI Philippine League of Government and Private Midwives Inc USAID, PCPD
8. Health Promotion and Communication	Overall and annual RPRH communication plan, budget, and social and behavioral change materials Manage and monitor existing RPRH information, education, and communication materials (IEC) Orient and train on IEC materials and sessions for RPRH demand generation linked to SDN	Chair: DOH-HPCS Co-Chair: POPCOM DOH-WMHDD LIKHAAN, DSWP, FPOP UNFPA, USAID
9. CSO/Private-Sector engagement	Mechanisms for public-private partnerships and collaboration among NGAs and CSOs Institutionalize joint public-private sector reporting for RPRH performance	Chair: NIT CSO-Representative (LIKHAAN) Co-Chair: WMHDD POPCOM DSWP, FPOP, FriendlyCare, IMAP, PSPI, PSRP UNFPA, USAID, ZFF, PCPD Doctors without Borders

Source: DOH Department Personnel Order No. 2230 series of 2016

Below are **proposed changes** for each TWG:

- The **PhilHealth and Financing TWG**'s functions should focus on PhilHealth financing to service providers. The role of this TWG can be more strategic as a general **Financing TWG**. It can be a venue where NGAs, CSOs, and donors can **unify financial plans and line items to consolidate the needed resources** for holistic RPRH implementation. These can include *NGA convergence budgeting, better utilization of GAD budgets for RPRH, allotment of funds for PPPs, PhilHealth pipeline of benefits for RPRH, strategies to encourage LGU funding, and donor funding* for areas that NGAs cannot fund.

  The members of this TWG can be **budget officers of NGAs** (e.g. DOH-HPDPB) who are in charge of defending the budget to Congress. There should also be **one CSO representative** who consolidates and conveys all CSO concerns on financing.

  An additional member could be a representative from the **Department of Budget and Management (DBM)**. Several NGA respondents noted that there were challenges because of DBM's absence in the NIT. The interconnectedness of RPRH line-items is not reflected in individual NGA budget proposals. This has led to DBM approving certain line items in the budget, but not others related to RPRH (discussed at length in Financing).

- The **M&E TWG** can be composed of M&E program officers (who have mastery of their own agency's M&E systems) and the data analysis arm of the secretariat. The RO representatives can be removed to avoid duplication with their RIT responsibilities. Instead, RITs should include their monitoring reports and operational issues in their minutes that the secretariat consolidates and distributes to the appropriate NGA or NIT TWG for action. Part

of the TWG's responsibilities could also be the release of data on progress on RPRH of the NIT, RITs, and LGUs to the public.

- The **Local Government TWG** can focus on operational **needs of LGUs in RPRH implementation and systematize best practices and interventions**. Topics could be required assistance from NGAs, grassroots advocacy to gain LCE buy-in and ownership for RPRH, or pushing for effective local RPRH policies.

  The RIT minutes can be a vital source of information for this. An RIT noted that LGUs do not really have a plan for RPRH services since they are only assessed via their CPR or the number of policies they have issued. A best practice that can be widely adopted is political mapping every election to gauge support for RPRH (2019 CAR-RIT minutes).

  This TWG should have strong DILG and DOH-BLHSD presence and include CSOs and the private sector. **LGUs are also significant actors whose presence is not adequately reflected in the structure of the NIT.** The following organizations representing LCEs under ULAP may be included and called upon as needed:

  - League of Mayors (requests for resources and assistance)
  - League of Councilors (policy-related matters)
  - League of Governors (provincial matters)

  The League of Cities is capable of real-time tracking of ordinances, programs, and activities of all cities in the Philippines as applied in the COVID-19 LGU watch.

- The **Logistics TWG** is largely confined to the DOH supply chain for FP commodities. There are other components of the supply chain that are important. For instance, the **FDA's role of** fast tracking clearance for internationally procured commodities and M&E of links in the supply chain is equally important. Aside from the public sector, the **private sector supply chain and role of CSOs** for RPRH commodities are equally important.

  Out of the 71 (main) NIT meetings, 41 included FP logistics and inventory updates in the agenda (see Stewardship and Coordination section). The recurrence of supply chain management concerns should be confined and addressed by the members of the Logistics TWG to free up the NIT meetings for other multi-sectoral agenda.

- The **ASRH TWG** was initially created to accelerate the implementation of DepEd's CSE. However, instead of focusing on one KRA or element of RPRH, this TWG could be transformed into an **Integrated Service Delivery TWG** who will coordinate for the delivery of a comprehensive package of RPRH services across the life course, including complete staff work necessary (e.g. creation of policy, manual of operations, standards).

  The membership of this TWG could be **directors of bureaus** who handle most of the RPRH activities under USecs or ASecs who consolidate agency-level plans or RPRH

- The **Research/Knowledge Management TWG should be dissolved**. Its responsibility for a research agenda and dissemination can be assigned to the M&E TWG as part of its feedback cycle and based on knowledge gaps revealed by regular monitoring of RPRH operations. The database for reference materials and information materials can be housed in the Health Promotions TWG.

- The **Training TWG** should be converted into **an expert TWG of health providers (e.g. doctors, midwives, nurses)** for **standards, accreditation, and content and innovative**

mode of capacity building. The original role of harmonizing training guidelines and facilitating PhilHealth accreditation should be part of the complete staff work of the Integrated Service Delivery TWG. The Training TWG can then be tapped for technical assistance and feedback. For example, the DOH Academy is a source of continuing professional development for licensed health professionals serving the Philippines. The Training TWG can help design and pretest any new training modules for RPRH services for the DOH academy and provide feedback on which can be done through e-learning.

- The **Health Promotion and Communication TWG** can be transformed into a **Social Technology TWG** made up of **communication and information officers.** The Social Technology TWG will use both strategic communications and new digital technologies (e.g. internet, mobile phone messaging, social media, apps, voice, video messaging, and telemedicine) to better change population behavior's for RPRH [39–41].

  A representative from the **DSWD's Social Technology Bureau (STB)** and **Philippine Information Agency (PIA)** should be included. Both DSWD-STB and PIA have arms for research and evaluation of communication-related policies and projects.

- It is recommended that the **CSO/private sector engagement TWG be dissolved**. Rather, the responsibility for **public-private partnerships should be part of the Integrated Service Delivery TWG** and the responsibility for **joint public-private sector reporting** be included in the **M&E TWG.** The CSO representatives can more strategically incorporate their feedback and collaboration points in these TWGs instead of a separate TWG. For example, DOH AO 2017-005 indicated that CSOs should report to local public facilities and have representation in RITs.

Recommendations

(1) DOH and NIT can institutionalize and strengthen RPRH within implementing agencies by creating guidelines for an RPRH focal unit within agencies.

RPRH operations of NGAs specified with mandates in the RPRH law can be integrated through an RPRH focal unit that cuts across agency units. This can be specified in the RPRH IRR and may follow the **precedent of RA 9710 or the Magna Carta of Women which mandates a GAD Focal Point System (GFPS)** to be established within government units to pursue gender mainstreaming. PCW then followed through by providing Memorandum Circular (MC) No. 2011-01 with guidelines for institutionalization of the GFPS in government units and offices.

The RPRH focal unit would formalize RPRH tasks and functions across offices and **ensure that activities are aligned with RPRH mandates as a whole and not only on a program-by-program basis**. The focal unit should be **headed by an ASec or USec who represents the agency in NIT meetings** and may report to the head of the NGA or ExeCom to expedite decision making for RPRH.

The **integration of RPRH into the GFPS can also be explored** (similar to DSWD's GAD TWG in **Box 3, page 25**) to avoid the need for an entirely new coordinating body. Currently, GAD's focus is on gender equality and gender-based violence (GBV) - one element of RPRH.

(2) While waiting for the establishment of the Family Health Bureau in the DOH, RPRH should be housed in the office of the Assistant Secretary or Undersecretary of the Public Health Services Team answerable to the head of agency and ExeCom.

Nowhere is the prior recommendation more important than in the DOH. The DOH RPRH unit needs to include all RPRH programs in the DPCB as well as supporting subunits in other bureaus (e.g. KMITS, EB, LMD) The **Asec or USec must be the champion for RPRH** with a holistic view of RPRH implementation, breaking away from the current program-based approach and working to integrate RPRH services across the life course. A higher-level focal point, accountable to the highest bodies within the DOH, can better command allocation of resources and facilitate communication by being able to directly approach or advocate to other USecs or ASecs housing the support units.

Efficiency gains and the **difference between an agency with a streamlined RPRH unit and one without** can be seen by comparing the research team's experience with data collection for DOH and DSWD. **Figure 7** has two SIPOC (Supplier-Input-Process-Output-Customer) diagrams that summarize the **processes the PIDS team, as a "customer," underwent to obtain the "output" of program data and KIIs**. The research team encountered more processes for data collection in DOH. In particular, approval from USecs and directors from different clusters was first necessary before contacting individual offices of program managers to schedule KIIs. This is in comparison to DSWD where all arrangements for data and KIIs were routed only through the DSWD GAD TWG and one main liaison.

Suppliers	Inputs	Processes	Output	Customers
Department of Health				
WHMDD	Program knowledge	Approval of DPCB director	KIIs Program data	PIDS research team
IDPCD	Program knowledge	Approval of project managers	KIIs Program data	
FMD	Obligations and expenditures data	Approval of USec. Approval of director of accounting	Registry of allotment and disbursements for DOH programs	
Procurement	Procurement monitoring reports	Approval of Procurement Services program manager	Procurement monitoring reports	
Department of Social Welfare and Development				
GAD technical working group	Program knowledge of RPRH integration in 4Ps, Social Technologies, Pre-marriage counselling,	Submission of research proposal Clearance from TWG GAD secretariat inform and arrange with relevant TWG members	KIIs Program data	PIDS research team

Figure 10. SIPOC Diagram of Data Collection Process with DOH & DSWD for the Study

(3) <u>Review and revise the structure of the NIT and NIT TWGs</u> to facilitate interagency management of RPRH implementation.

First, introducing **full-time NIT Secretariat to serve as third-party objective planners and evaluators of RPRH implementation** will ease the burden of interagency national-level planning from individual agencies who are preoccupied with meeting their agency targets, of which RPRH is only one. Having an impartial body within the NIT can also foster better coordination, M&E, and accountability among agencies (see sections on Coordination, Monitoring and Evaluation, and Accountability).

Second, the **structure and composition of the NIT and its TWGs can be reviewed** (as was listed in subsection 4 before recommendations for Presence).

From a big picture perspective, the **NIT, NIT TWGs, and RPRH TWGs in NGAs** can be more **formally organized as a matrix structure** (see **Figure 8**).

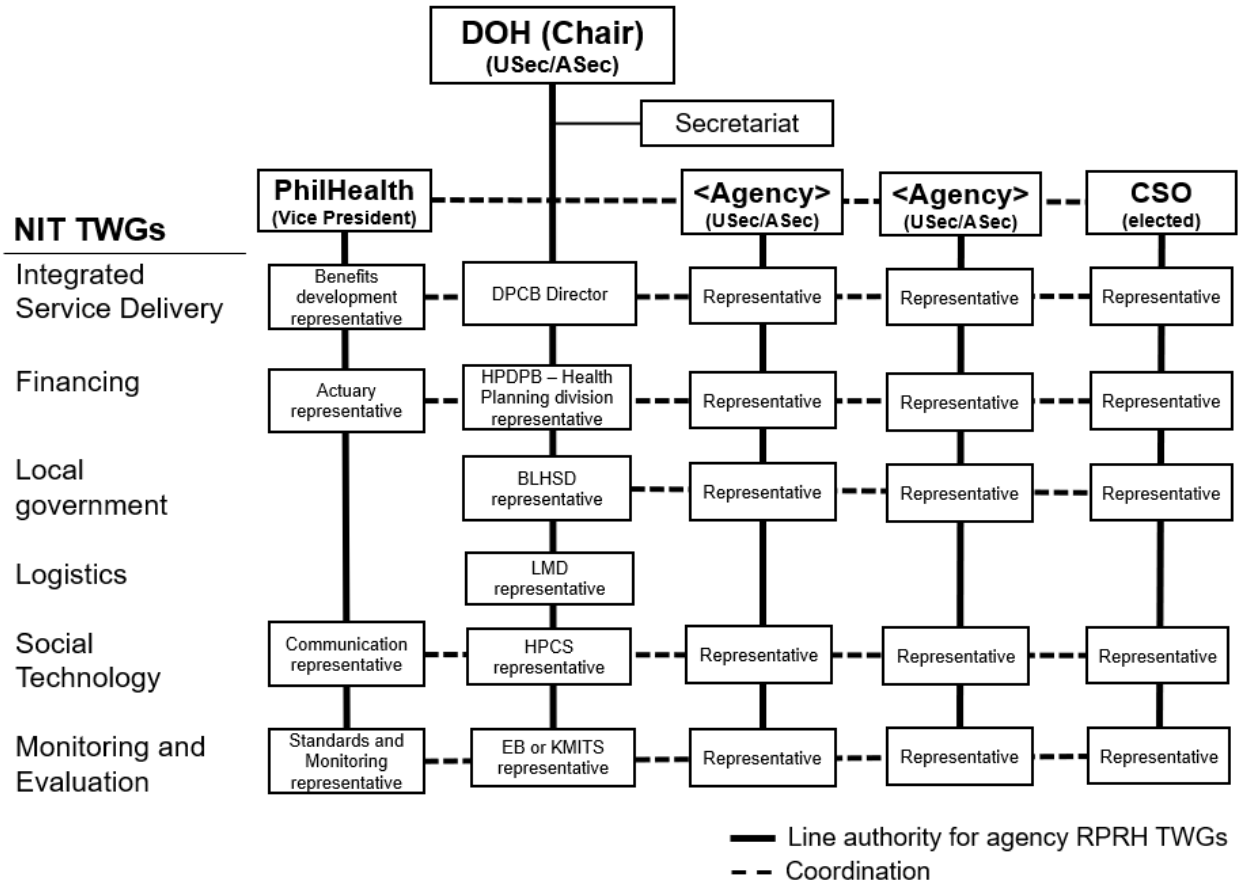

Figure 11. Proposed matrix structure for the NIT, NIT TWGs, and RPRH TWGs

The **structure** may have the following characteristics:

- At the top, the **NIT is chaired by the DOH ASec/USec and the members are the ASecs/USecs** from other NGAs who head their RPRH units. This includes the lead convenor of the CSOs.
- The **independent and dedicated secretariat serves all NGAs and will be tasked to do all administrative work**, follow-ups, and consolidation of documents and agreements in the main NIT and the NIT TWGs.

- **One member from each organization's RPRH unit (columns) sits in the NIT TWG (rows) of their expertise** (e.g. financing officers in Financing TWG). It is possible that an NGA may not be involved in some TWGs where they do not have operations in. It is ideal that each TWG have **as few people as possible, around five to eight.**
- The RITs are linked to the NIT and its TWGs through the **secretariat** who **consolidates RIT minutes and reports** and distributes it to the appropriate TWGs for action.

The **flow and delineation of work** to improve efficiency may be as follows:

- The most frequent meetings should occur in the **RPRH focal units of NGAs who will work out the operational details** for assigned RPRH mandates and agreements from the NIT and NIT TWGs.
- The point persons of the RPRH units, with the blessings of their agency ASec/USecs will then meet to **coordinate with other members of the NIT TWGs to come up with joint strategies, plans, and recommendations.**
- The **secretariat** can consolidate and synthesize the plans from each TWG and report it to the NIT with all the ASecs/USecs for **final decisions, approval, and buy-in** to allocate resources and manpower. The secretariat can also send the materials *in advance* to the NIT decision makers so that questions can be collated and answered by the TWGs before the actual NIT meeting to maximize the time of ASecs/USecs.

4.2. Infrastructure

Infrastructure for governance refers to the laws and policies related to the design and implementation of the RPRH law. These include:

- **Internal infrastructure** within agencies to direct RPRH implementation,
- **Interagency infrastructure** such as joint memorandum circulars (JMC), and
- **Externally-directed policies** such as program guidelines and standards for LGUs and service providers.

Infrastructure is an important foundation in implementation: From helping ensure RPRH becomes a priority, to the way budgets are utilized and how success is measured, infrastructure is necessary to **institutionalize and formalize roles, goals, processes, activities, and performance standards for RPRH operations in implementing NGAs.**

(1) The signing of the RPRH law and IRR has helped legitimize RPRH in NGAs and facilitated overall implementation.

The following are **high level policy infrastructure** that respondents cited most frequently:

- RPRH law (2012) and IRR (2013),
- Philippine Development Plan (PDP) 2017-2022, Chapter 13 "Reaching for the Demographic Dividend," and
- Executive Order (EO) 12 of 2017 on "Attaining and Sustaining Zero Unmet Need for Modern Family Planning.

Based on KIIs, the **law and IRR** in themselves have **helped give RPRH attention within agencies**, even if they are not necessarily the top priority. This is especially true for **DOH, POPCOM, and PhilHealth** where the law and the IRR have served as the supporting rationale for programs, funding, and marketing to LCEs.

Meanwhile, **PDP 2017-2022**, the medium-term roadmap for inclusive growth in the Philippines, cemented the implementation "vision" for the law where the RPRH plays a **vital role in national socio-economic development and harnessing the population dividend.**

> *"Full implementation of the RPRH law, coupled with adequate investment in the youth's human capital, on the other hand, will enable the country to reap the dividend starting possibly in the 2030s through the 2040s." - PDP, chapter 13*

Lastly, **EO 12** promulgated by the Office of the President in 2017 indicated the support of the highest executive office to intensify efforts for RPRH implementation and FP, including reiteration of RPRH mandates of different NGAs.

Prominent examples from KIIs of how infrastructure facilitated RPRH implementation are:

- **POPCOM** received PHP 377,600,000 of augmentation funding in 2019 from DBM (2018 unprogrammed appropriations under RA 11260) for RPFP demand-generation activities - equivalent to 100% of its regular appropriations.

- The **DOH SMP** is able to require LGUs and their facilities to conduct MDRs because of provisions in the IRR.
- **PhilHealth** has used these policies as a strong rationale when presenting to its Board of Directors for new RPRH benefits like the Subdermal Contraceptive Implant Package (Circular 2015-38). They also use the law as rationale for new accreditation guidelines to facilitate access to RPRH services such as "Accreditation of Free-Standing FP Clinics" (Circular 2018-05).
- Beyond the public sector, the law has also formalized **CSOs** as important partners in RPRH operations, giving them a place in not only service delivery, but also in planning, policy making, M&E, and accountability (RPRH IRR section 12.01).

While the law and IRR gave agencies reason to pursue RPRH activities, there were **inadvertent effects of the law on two DOH initiatives**.

- The DOH previously had a program for **adolescents to access RH and FP services**. Now the law and IRR require parental consent before minors can access contraceptives even if they already had a previous pregnancy.
- The DOH devised a **contraceptive self-reliance (CSR) strategy in 2004** in response to USAID gradually ceasing its donations for FP commodities and stopping entirely in 2008. From 1993 to 2003, USAID supplied 80% of the country's contraceptives [42–44].

  CSR aimed to slowly replace the supply of donated contraceptives to **domestic sources,** focusing on expanding **private sector involvement** (for those who could afford it) and **local government procurement** (giving priority to the poor)**.**

  Consequently, due to the provision in Section 9 of the RPRH law that "DOH shall procure, distribute to LGUs and monitor the usage of family planning supplies for the whole country," **LGUs may have become over-reliant on DOH who have faced challenges protecting the budget for FP commodities in the past.**

"Our LGUs, they used to buy the contraceptives. They started buying then suddenly the RPRH Law came, they went back to the past practice, wasting the behavior change. Although not all LGUs had started buying, but I feel like they were getting there. We were teaching them and training them to be self-reliant."	*"Although we encouraged them [LGUs] through CSR, the contraceptives self-reliance approach, they're relying on DOH but DOH also has difficulty because their budget was being slashed by the policymakers."*
Respondent 10	*Respondent 11*

Further quantitative studies may assess the effect of the law's provisions on access to FP for adolescents and LGUs attitudes and perceptions on centralized procurement of FP supplies.

(2) Most RPRH policies and guidelines pertain to local implementing units or service providers, but not NGAs as a whole. Some NGAs do not have policies to formalize and institutionalize RPRH activities in the agency.

Over the five RPRH ARs a total of 104 policies and guidelines were listed, covering the years 2012 to 2019. **NGAs focused on policy and guideline development in the first two years of implementation after lifting of the SC TRO** while scaling up RPRH service delivery started in the third year [45]. Thus, the **majority of the policies were developed in 2014** (26; 25%) **and 2015** (37; 36%), with few policies in 2012 and 2013 (4, 4%) and a decreasing number in 2016 (10; 10%), 2017 (13; 13%), and 2018 (14; 13%).

Table 10. Reported RPRH-related per agency by RPRH element, 2012 to 2018 presents the number of policies per agency by RPRH element. The **majority of the policies were for FP (24, 23%), MNCHN (21, 24%), and HIV/AIDS (25, 20%).** Policies for sexuality and adolescent RH education, VAWC, and policies that cut across elements (e.g., service delivery networks, gender mainstreaming) had 10 policies each (10%).

Proscription of abortion and management of complications, treatment of gynecological cancers and disorders (from DOH) and male RH and responsibility (from POPCOM) had one policy each. There were **no listed policies** for the treatment of **infertility and sexual dysfunction** or **mental health aspects of RPRH.**

Table 10. Reported RPRH-related per agency by RPRH element, 2012 to 2018

	Agency								
RPRH Element	**DOH**	**POPCOM**	**PhilHealth**	**PCW**	**DepEd**	**DSWD**	**DILG**	**Multiple**	**Total**
1. FP	16	3	2	0	0	0	3	0	24 (23%)
2. MNCHN	18	0	5	0	0	1	1	0	25 (24%)
3. Proscription of abortion and management of complications	1	0	0	0	0	0	0	0	1 (1%)
4./7./11. Sexuality and Adolescent RH education and counselling	3	1	1	0	4	1	0	1	11 (10%)
5. HIV/AIDS, STIs, RTIs	18	0	3	0	0	0	0	0	21 (20%)
6. VAWC and GBV	1	0	0	0	0	5	3	1	10 (10%)
8. Treatment of gynecological cancers and disorders	0	0	1	0	0	0	0	0	1 (1%)
9. Male RH and responsibility	0	1	0	0	0	0	0	0	1 (1%)
10. Infertility and sexual dysfunction	0	0	0	0	0	0	0	0	0
12. Mental health aspect of reproductive care	0	0	0	0	0	0	0	0	0
Across elements (e.g. service delivery networks, gender mainstreaming, disaster situations)	4	0	3	1	0	1	1	0	10 (10%)
Total	61 (58%)	5 (5%)	15 (14%)	1 (1%)	4 (4%)	8 (8%)	8 (8%)	2 (2%)	104

Source: RPRH Accomplishment Reports 2014-2018, KIIs with NGA respondents

The majority of policies issued were **implementing guidelines** (59, 57%) in the form of standards and protocols and **national strategies and frameworks for programs** (12, 11%) for FP, acute malnutrition, HIV/AIDS and STIs, and UHC and SDNs (**Table 11**). DOH issued most of both, following its duties as lead implementer in the law and IRR to provide technical guidance for nationwide RPRH implementation.

Table 11. Reported RPRH-related policies per agency by type of document, 2012 to 2018

	Agency							
Type of Document	**DOH**	**POPCOM**	**PhilHealth**	**PCW**	**DepEd**	**DSWD**	**DILG**	**Total**
Implementing guidelines	46	3	0	0	1	8	1	59 (57%)
National strategies and frameworks	11	0	0	1	0	0	0	12 (11%)
Internal policy within NGA to direct implementation*	3	2	0	0	3	0	0	8 (8%)
PhilHealth benefits	-	-	12	-	-	-	-	12 (11%)
PhilHealth accreditation	-	-	3	-	-	-	-	3 (3%)
LGU directives for implementation	0	0	0	0	0	0	5	5 (5%)
Announcements for events (e.g. National FP conference)	1	0	0	0	0	0	2	3 (3%)
Joint agency policies † *	XX	X	0	X	X	XX	XX	2 (2%)

Source: RPRH Accomplishment Reports 2014-2018, KIIs with NGA respondents

† The two joint agency policies are (a) DILG-DOH-DSWD-POPCOM-PSA JMC No. 01 "Revised Pre-Marriage Orientation and Counseling (PMOC) Program Implementing Guidelines of 2018" and (b) IAC-VAWC resolution 2018-02 where all council members commit to fund contents of the IAC-VAWC strategic plan for 2017-2022.

* Indicates which NGAs participated in the joint policy. "X" is participation in one, while "XX" is participation in both

Directional infrastructure that formalizes and institutionalizes RPRH in NGAs is important to unify NGA units' implementation of assigned mandates.

There were **eight listed internal policies within NGAs to direct RPRH operations**. Most of these **did not pertain to RPRH mandates as a whole**. **Within the DOH**, its **two internal policies that addressed RPRH wholly were on the SC TRO** and how it would affect policy and field implementation (DC 2015-0199 and MC 2015-0195). A concrete directional policy within DOH for VAWC is Department Order (DO) 2014-0169 on "Implementing the Child Protection Policy in the Department of Health." The DO provides for the creation of a Technical Committee on Child Protection and specifies roles for various DOH units.

DepEd illustrates a good practice in the creation of internal directional policies to institutionalize mandates and programs and lay out the roles of all DepEd units. In **DO 2018-031 "Policy guidelines on comprehensive sexuality education,"** DepEd lays out the agency commitment and framework to fulfil the CSE mandate (Section 4), identified relevant tasks and all accountable parties (Section 5.F), and required that budget allocations be included for CSE at the central, regional, division, district, and school level (Section 7). Accountable parties include 9 units in its CO, 6 units in ROs, its divisional offices, and schools. According to the KII respondent, a **DO is the "strongest instrument" for implementation** within DepEd - along with, of course, support of agency top officials and partner implementers.

(3) There are other laws that can support or complement RPRH provisions for certain elements, but there is little integration among laws and IRRs.

Based on NIT meetings minutes (see Stewardship and Coordination section), discussions on how to interface with other laws that may affect RPRH implementation are not done regularly. They are only brought up tangentially by some member agency. This subsection gives examples of laws that may have potential implications for RPRH implementation.

A **notable law passed prior to RPRH** is the **Anti-VAWC Act of 2004** (RA 9262) which aims to "protect the family and its members particularly women and children, from violence and threats to their personal safety and security." The anti-VAWC law and its IRR mandate essential legal, social, and medical services for VAWC victim-survivors and the creation of a IAC-VAWC, an interagency coordinating body similar to the RPRH NIT.

Given the anti-VAWC law and the IAC-VAWC, it would be prudent to **review areas of duplication** between the IAC-VAWC and RPRH NIT. For example, DOH, DSWD, DILG, and DepEd are part of both bodies. If what these NGAs discuss in the IAC-VAWC and RPRH NIT are similar, then it may be **more efficient for the RPRH NIT to remove VAWC from their purview.** Otherwise, the RPRH NIT might **find a niche to prioritize and contribute to IAC-VAWC operations** such as integrating the VAWC services of NGAs across life stages.

Many new laws that focus on individual RPRH elements such as the Kalusugan at Nutrisyon ng Mag-Nanay Act (2018), Philippine HIV and AIDS Policy Act (2018), Mental Health Act (2018), and National Integrated Cancer Control Act (2019) are relevant to RPRH. Each of these laws mandates a set of services and interventions. As such they must be **considered when building a comprehensive RPRH package covering all 12 elements**.

There may be laws that **cut across RPRH elements** that affect the organization of health systems and local service delivery. In particular, aside from giving LGUs more autonomy for health services, the **UHC law presents an opportunity for PhilHealth to finance RPRH services at the primary health care level**. Organized health care provider networks may also **expand private sector and CSO involvement in service delivery,** augmenting the public sector and providing access to different target subpopulations. Lastly, the increased LGU internal revenue allotments via the **Mandanas ruling** could be used by **LCEs to procure commodities like short-acting contraceptives**, which may ease DOH's burden of centralized procurement and may help in addressing supply-demand mismatches.

"*For the citizens that cannot reach it [RH service] on a day-to-day basis, we are actually hoping [they can reach it] through Universal Health Care. We advocate that RPRH become more visible in the UHC."*	*"Within the context of the UHC, that's already the direction… [UHC] ensures the financial support for the access of family planning services. The private can be driven to participate more."*	"*In 2017, there was an AO on the primary care benefit with lifestage-specific services. We patterned issuance for UHC on that."*
Respondent 3	*Respondent 12*	*Respondent 14*

"*The thrust of universal health care is to integrate the programs in the many structures that we have. With UHC, at a health center … integrated services mean that at the first contact of the client the RHU should have the capacity to provide FP services, HIV diagnostic and other programs. So that's the way to make sure that a holistic approach to client management iis being given. Before, they work in silos,*

TB DOTS, social hygiene, rabies. But new diseases keep coming in. Who will take care of the patients if that's the system? It's better to really integrate." - Respondent 18

Lastly, there are **laws that focus on the welfare of specific subpopulations** such as the Act Expanding the Benefits and Privileges of PWDs (2016) and the Solo Parents' Welfare Act (2000) that mandate DSWD, DOH, CHED, DOLE, and DILG, among others, to develop a "comprehensive package of social development and welfare services" for single parents. These laws may indicate the need to give PWDs and single parents special attention or RPRH services.

If the RPRH law's role in the fulfillment of RH rights and socio-economic development are to be achieved, the NIT and member NGAs need to **consider how to integrate the implementation of related laws** under the umbrella of RPRH and **the programs and projects resulting from the laws**, so that they can be implemented cohesively by stakeholders and LGUs.

Recommendations

(1) NGAs and CSOs should leverage the law and IRR as an advocacy tool when selling the law and its implementation to LGUs and other NGAs.

COs have cited major benefits from having a formal law which they can refer to for funding and political priority. Given that the next step in implementation is to increase the responsibility of LGUs for RPRH implementation, the law, particularly sections on LGUs' roles and mandates, can be used to strengthen and deepen LGU commitment and buy-in to RPRH. In particular, **regular orientation for LCEs as a routine activity** with respect to electoral turnovers can cement RPRH not only as a priority, but as a **core part of an LGU's basic set of services**.

Advocacy in NGAs can also be a strategy to bring in NGAs who may have a role in RPRH implementation but are not included in the NIT or its TWGs such as TESDA, PRC, and DBM.

(2) After or concurrent with multi-agency strategy planning for RPRH within the NIT, NGAs should create their own agency-level policy infrastructure to institutionalize strategies and operationalize RPRH.

Directional infrastructure will integrate RPRH activities within an NGA and direct them to strategic goals, rather than just the program goals. This could involve making arrangements in the organizational structure and tying RPRH into individual performance commitments, similar to how DSWD institutionalized GAD (review **Box 3, page 25**)

To accomplish this, each agency begins with context-setting, mapping existing RPRH activities, identifying responsible units and any agency strengths and gaps. Based on these, an **NGA strategic plan for RPRH,** in line with the multi-agency strategy, can be made (see Stewardship and Coordination recommendations for more details).

All of these can be then formalized within the agency through a **department or administrative order** (e.g., DepEd DO 2018-31, DOH DO 2014-169, DSWD AO 2018-15).

(3) NIT and RPRH focal units' meeting agendas should include a review of new and existing laws to identify duplication, gaps, or synergies for RPRH implementation.

Another task of the NIT secretariat could be to identify and track new and old laws that may affect RPRH implementation. Then these could be discussed in agency RPRH units, the NIT, or NIT TWGs where their effect on planned or ongoing RPRH activities can be assessed. A more systematic study of the implications of the laws mentioned and other laws that may not have been given as examples is recommended.

4.3. Financing

Financing refers to **allocations and expenditures for RPRH** at the national level. This section discusses the challenges in financing RPRH implementation and the implications of the current trends and patterns in funding allocations for performance.

Due to difficulties in data collection, the analysis focused primarily on DOH expenditures from 2017, 2018, and continuing appropriations for 2019 for the following three programs: (1) Family Health, Nutrition and Responsible Parenting, (2) Expanded Program on Immunization, and (3) Public Health Management. This was supplemented with claims data from PhilHealth, expenditure information from RPRH accomplishment reports, available GAD accomplishment reports, and the KIIs with different NGA respondents.

(1) The RPRH budget for central agencies may be disadvantaged in the DBM budgeting process and the budget for the National Family Planning Program (NFPP) is particularly vulnerable to political inference.

The RPRH budget is only one component of annual agency budget proposals in the DBM's **national budgeting process**. This process, however, is heavily dependent on economic and financial targets set beforehand. As such, **RPRH, which operates on long-term social investments, is at a disadvantage during the budgeting process** (**Box 5**)**.**

Box 5. RPRH Disadvantaged at National Budget Preparation Stage

The annual budget process has four stages: budget preparation, budget authorization, budget execution, and budget accountability. Issues arise as early as budget preparation.

Targets. Prior to submission of proposals by departments or agencies, the **Development Budget Coordinating Committee (DBCC) first sets the fiscal priorities for the year**, the "overall economic targets, expenditure levels, and budget framework." The DBCC consists of the **DBM, BSP, DOF, NEDA,** and a representative from the **OP** [46, 47].

By virtue of its members, **the DBCC is financially-oriented**. **Though the national budget serves a purpose for national development** [48]**, the budget process is focused on economic gains from the agenda-setting phase**. NEDA was made part of the DBCC for a social development perspective; however, the **majority of DBCC members are from the financial sector**, and outnumber NEDA.

> ***Respondent 12:*** *Congress is trying to resolve [this] by giving NEDA a say in the budget process also… Rather than the development side, knowing and saying where to invest after all the studies, it is... the earning side, the financial side. DBM is the one that brings in and controls the money. They have the say, rather than [experts in] development.*
> ***Interviewer:*** *Do you have a thrust in development?*
> ***Respondent 12:*** *Yes, but that has been watered-down to some extent.*

In development literature, it has long been established that economic development is not synonymous with human development [48, 49]. Since the **gains in RPRH are not easily measured in monetary terms**, it does align well with strictly economic priorities.

Ranking. NGAs prepare budget estimates for each activity and **rank them according to the capital budgeting approach (CBA),** which **compares investments based on their future financial returns**. Using CBA, a project is favorable if its net income-to-cost ratio is higher than another's. The use of CBA places RPRH-related line-items at a disadvantage. **Investments in health, education, and systems infrastructure often do not see direct financial returns in the short-term**.

By improving quality of life, RPRH empowers and enables individuals to become more productive members of society. **The linkages in different NGAs that contribute to this are not as clearly traced**; therefore, **RPRH activities may rank deceptively low.**

Hearings. NGAs must then present their budget proposals to DBM technical panels.

> *"We are really on our own when we go to DBM… Because it's all up to DBM. Usually, we have 10 priorities. These are the priority [items] for the program: Number 1, 2, 3… Then, number 10 is probably IT equipment. They usually choose the lowest-ranking priorities." - Respondent 12*

As members of the **DBM panels are not RPRH experts,** this may have led to a focus on monetary benchmarks for budget approvals. However, this also means that many RPRH services, which are meant to work together, are separated during the budget hearings, when **some RPRH budget items are approved over others based on monetary assessment**.

The **effects of NGAs' dependence on DBM's budgeting strategy** are twofold:

(1) RPRH activities are viewed as **unattractive investments and underfunded**, and
(2) RPRH activities are **compartmentalized instead of integrated.**

After this, revised proposals are presented within agencies, approved by the president, and sent to Congress for the budget authorization phase.

The **DOH's NFPP budget for commodities,** which comprise a chunk of DOH's budget for RPRH, **is particularly vulnerable to political interference**. In 2016, it experienced a PHP 196 million budget cut in the bicameral conference [50]. The SC TRO also prevented DOH allocation and disbursement of funding for implants and contraceptives for the duration of its effect (June 2015 to November 2017). This is most clearly seen in DOH's FP budget in 2017 where it had no allocation for implants and its PHP 267 million allocation for pills and injectables were not expended (**Table 12** and **Table 13**). With another PHP 195 million budget cut for 2020 [51], the DOH projects it will not have a stock of implants for 2021.

Table 12. RPRH-related Public Expenditures of DOH WMHDD CHDD (PHP millions)

	2017		2018		2019	
KRA	Obligated	Disbursed	Obligated	Disbursed	Obligated	Disbursed
FP	282.18	5.45	152.76	141.02	172.23	130.00
MNCHN	10,183.47	9,039.09	8,388.02	8,336.15	816.41	782.93
ASRH	15.38	12.72	18.06	17.82	INC	INC
STI-HIV	86.96	18.00	9.41	9.39	INC	INC
GBV	0.92	0.91	0.23	0.19	INC	INC
Men's RH	-	-	0.98	0.92	-	-
Others	339.44	167.13	381.23	282.31	142.09	34.52
Total	**10,908.35**	**9,243.30**	**8,949.81**	**8,786.97**	**INC**	**INC**

Source: DOH Registry of Allotments, Obligations, and Disbursements from 2017, 2018, 2019 for the following three programs only: (1) Family Health, Nutrition and Responsible Parenting, (2) Expanded Program on Immunization, and (3) Public Health Management.

INC - Data for 2019 is incompletely, only data for continuing appropriations from 2018 were acquired. That is, 2019 general agency appropriations are not included.

Table 13. Breakdown of WMHDD and CHDD Commodities Expenditures (PHP millions)

	2017		2018		2019	
Commodity Type	Obligated	Disbursed	Obligated	Disbursed	Obligated	Disbursed
FP - contraceptives	267.0	0.00	133.1	133.1	172.2	130.0
SMP - Life-saving drugs	305.2	75.5	35.6	36.4	3.30	INC
EPI - vaccines and safe injection supplies	7,987.2	7,669.7	6,665.6	6,618.9	757.0	735.8
Nutrition	1,618.9	1,116.2	1,329.3	1,399.3	INC	INC
Oral health	419.03	224.6	303.5	54.8	INC	INC
Total	**10,597.3**	**9,086.0**	**8,467.1**	**8,242.5**	**INC**	**INC**

Source: DOH Registry of Allotments, Obligations, and Disbursements from 2017, 2018, 2019 for the following three programs only: (1) Family Health, Nutrition and Responsible Parenting, (2) Expanded Program on Immunization, and (3) Public Health Management.

INC - Data for 2019 is incompletely, only data for continuing appropriations from 2018 were acquired. That is, 2019 general agency appropriations are not included.

(2) DOH financing for RPRH is short-term, programmatic, and largely focused on FP and MNCHN. Visible expenditures in other agencies for RPRH follow this trend.

Looking first within the lead implementer, DOH, (**Table 13**) **the majority of the funding of DOH's WMHDD and CHDD goes to MNCHN and FP commodities**. The single largest allocations were for vaccines and safe injection supplies (e.g. syringes) followed by Nutrition (e.g. supplementary foods and micronutrients).

PhilHealth has also remained a stable source of financing for FP and MNCHN, funding service delivery in health facilities and local governments (**Table 14**).

Table 14. PhilHealth Disbursement of RPRH-related Funding (in PHP millions)

Category	2016	2017	2018
Family Planning (long-acting methods)	302.22	369.02	356.22
Antenatal and Pregnancy-related care	516.16	528.06	538.02
Newborn Care	1,752.61	1,816.84	1,653.31

Source: PhilHealth Claims Data 2016-2018.

Full implementation of the RPRH law, however, requires **systems investments. Support infrastructure** like information technology and education are interconnected and require consistent investments to achieve results. DOH respondents admit; however, that there is a **limited budget for back-end support systems or inputs** [52, 53]. The costed implementation plan (CIP) for FP for 2017 - 2020 [54], for example, is mostly allotted for commodities, **and was not able to include capacity-building, implementation support, and other infrastructure** due to budget constraints**.** This contributes to insufficiencies in back-end systems like logistics and trained FP providers which contribute to supply-demand mismatches in facilities.

> *"There is really no capacity building for FP coordinators. So for example, there was really no support for family planning coordinators for family planning data analysis - like everything is a punch to the moon [original: suntok sa buwan]. Support on understanding what contraceptive prevalence rate means … The national or central office hasn't been able to do it for the longest time. That is one of their clamor." - a DOH respondent*

This trend of limited investments in back-end inputs for RPRH **could possibly be mirrored in other implementing NGAs given the DBM budgeting process** (as discussed in the preceding subsection). The interconnected nature of RPRH is difficult to reflect in individual proposals and where financing is viewed in terms of budget-line items instead of a network of RPRH activities. The unpredictability of which line-items will be funded may also lead to fragmented funding. Unfortunately, data on these expenditures from other agencies could not be acquired for confirmation and deeper analyses.

On the matter of **RPRH funding in other agencies**, RPRH ARs may give some insight since individual agencies submit data for inclusion in the reports.

From **Table 15**, **contributions of agencies that are not DOH or POPCOM are not systematically or regularly reported.** For instance, PCW's allocation for GBV-related items was highlighted in 2015 and 2016, but they were not mentioned in other years. Additionally, LGUs financial expenditure for RPRH was acknowledged only in the first AR.

Table 15. Major RPRH Budgetary Sources 2014-2018 based on ARs

	2014	2015	2016	2017	2018
DOH Sources*	FHRP (PHP 2.5B) HFEP (PHP 9.3B) EPI (PHP 2.4B)	FHRP (PHP 3.3B) HFEP (PHP 11.3B) EPI (PHP 3.3B) NASPCP (PHP 324M)	FHRP (PHP 2.3B) HFEP (PHP 26.9B) EPI (PHP 4B) NASPCP (PHP 580M)	FHRP (PHP 4.3B) HFEP (PHP 25.9B) EPI (PHP 7.1B)	FHRP (PHP 3.6B) HFEP (PHP 30.3B) EPI (PHP 7.4B)
Other Agencies	POPCOM (PHP 198M) DepEd (PHP 2.5M)	POPCOM (PHP 240M) PCW (PHP 3.4M)	POPCOM (PHP 280M) PCW (PHP 3.2M)	POPCOM (PHP 423M) PNAC (PHP 10.8M)	POPCOM (PHP 517M)
LGUs	Only activities	No mention	No mention	No mention	No mention
Development Partners	FP/MNCHN (PHP 3.4B) HIV/AIDS (PHP 0.5B)	FP (PHP 3.8B) MNCHN (PHP 1.6B) RH (PHP 504M)	No mention	FP/RH/ MNCHN (PHP 10.2B)	No mention
CSOs	No mention	FP (PHP 214M) MNCHN (PHP 23M)	No mention	No mention	No mention

***** FHRP - Family Health and Responsible Parenthood, EPI - Expanded program on Immunization, HFEP - Health Facilities Enhancement Program, NASPCP - National AIDS/STD Prevention and Control Program
Source: Annual Accomplishment Reports 2014-2018

The way expenditures are reported in the AR **may also give the outward impression to the public and COC that funding for RPRH is sufficient**. For example, DepEd does not have dedicated funding for CSE. In the annual ARs; however, it appears that financing for RPRH is very large because what is reported is the billions of pesos of PhilHealth benefit payments, DOH's HFEP (physical infrastructure) and EPI (vaccines), and more than half of POPCOM's agency budget spent on RPFP.

Overall, the irregular way that financial contributions of other agencies to RPRH are reported, **may emphasize the health-sector-centric approach to RPRH** and the heavy responsibility placed on DOH to implement RPRH activities. The **strong association between RPRH and FP and MNCHN may also make it difficult for non-health agencies to draw a clear connection between their activities and RPRH**.

Moreover, as the NIT has not been able to create a unified annual work and financial plan for nationwide implementation of law, there are **parallel financing tracks** for the same activities which **may result in inefficiencies and confusions for financial accountability**.

This is best illustrated in the financing for **Family Planning services** (**Table 16**).

DOH CO procures the majority of FP commodities because of its mandate in the IRR. A single buyer also has greater purchasing power for FP devices sold by one or few international companies. However, DOH ROs can also procure FP commodities and LGUs if supplies from DOH are insufficient for their locality (DOH DC 2015-0195). Overall, there is a **heavy burden on DOH CO to coordinate the FP supply chain.**

Table 16. Financing tracks for select FP activities and their Implications

RPRH Activity	Financing Scheme*	Implications
Procurement of FP commodities	Priority clients Identified by DSWD (4Ps) NAPC (NHTS-PR) Procured by DOH CO (based on IRR) DOH RO (if needed) POPCOM (with concurrence of DOH) LGUs (if desired)	Commodities for clients identified by DSWD are procured by DOH-CO Commodities for clients identified through NHTS are procured by DOH-ROs Mismatch between supply and distribution Confusing inventory and logistics management Heavy responsibility of coordination of allocation given to DOH-CO
Paying for FP Commodities and professional services at point of care	DOH (funding CSOs) PhilHealth (benefit packages) POPCOM (service delivery initiatives and funding CSOs) CSOs (as private providers) Multilateral donors (grants to CSOs) LGUs (public facilities)	Confusions between DOH and PhilHealth regarding the delineation between population-based (e.g. short-acting and long-acting methods) and individual-based FP (e.g. long-acting methods) when FP in general has high externalities Double payment by DOH (procures commodities) and PhilHealth (benefit package) for FP services POPCOM caravans drain POPCOM CO CSO foregone or non- reimbursements of PhilHealth benefits LGU-CSO Tension for PHIC reimbursements
Hiring of Human Resources	DOH (deployment programs) POPCOM Local Population Officers LGUs (health care workers and population officers)	Lack of HR at LGU level leads to reliance on CSOs for service delivery and DOH deployments Confusion of LGU local population officers whether to report to DOH or POPCOM

Source: DOH DC 2015-0195 RPRH FAQ and KIIs

Another complicating issue between **DOH and PhilHealth** is that the UHC law places population-based health services under jurisdiction of DOH (Sec 17) while individual-based health services are PhilHealth's responsibility (Sec 18). However, **the distinction between individual- and population-based is not clear**, leaving the distinction up to the interpretation of the two NGAs.

DOH procures both short-acting and long-acting FP commodities as a population-based service because of its high externalities [55]. However, **PhilHealth reimburses the expensive long-acting methods, including the cost of the commodity** (e.g.implants) [Circular 2015-038] as an individual-based service. So, the government **may pay twice for one service** for long-acting methods. PhilHealth is aware of this issue and is trying to limit reimbursement to professional fees when commodities are known to be from DOH (NIT 58th, 61st, 63rd meetings).

> *"We have to put a delineation… Okay, if we don't pay for the pills categorically, then we don't finance them. It's supposed to be them [DOH] or LGUs. The delineation of roles still needs to be fixed… Because... even in financing the subdermal implants, DOH still procures some of them but we also pay for the subdermal implants. There's duplication… But for the other [contraceptives], for which we don't have benefits [packages] yet, like pills, a clear delineation should be made."*
>
> *- Respondent 8*

(3) NGAs have found four ways to try and mitigate funding weaknesses for RPRH.

First, the NGAs tapped **multilateral donors** like UNFPA and USAID as is common with other national initiatives. Over the years, billions were contributed by development partners to **FP, MNCHN, HIV/AIDS** as well as TA on research or M&E (review **Table 15**, page 49; NIT minutes).

Second, **Program Convergence Budgeting (PCB)** for DOH, POPCOM, DepEd, and DSWD **was attempted in 2020** upon the recommendation of the Cabinet of Secretaries. PCB is an innovation introduced by the DBM to promote interagency collaboration for joint programs and projects serving the same goals. This unfortunately did not push through. While DOH and POPCOM submitted budgets, the required commitment of a third agency did not materialize.

Third, **POPCOM** has played a major role in cross-funding the programs and activities of other agencies by **requesting for budget augmentation under the aegis of EO 12** prioritizing the full implementation of the RPRH law and the NFPP. POPCOM was able to acquire PHP 377,600,000 of augmentation funding in 2019 from DBM. POPCOM has asked for augmentation for 2020, including PHP 100 million pesos for DepEd's CSE. More examples of POPCOM funding other NGAs' RPRH activities are presented in **Table 17**.

Table 17. Multi-Agency RPRH Programs and Activities Funded by POPCOM

Programs, Projects, Activities	Amount and Stakeholders
RPFP Training of Trainers for DOLE HRDs and FP Focal Persons (Luzon, Visayas, Mindanao) (2019)	Amount: P408,226 Other agencies involved: DOLE
Development of Comprehensive Gender and Health Education for Youth for Madrasah Education (2019)	Amount: P882,953.86 Other agencies involved: DepEd, BARMM
Pre-Marriage Orientation and Counselling Regional Forums and Module Development (2019)	Amount: P1,889,901.00 Other agencies: DILG, DSWD, LGUs
Training of Trainers on Pre-Marriage Orientation and Counseling (2018)	Amount: P605,820.00 Other agency: DSWD
Orientation of RPFP in the Workplace	Amount: P168,400.00 Other agencies involved: NEDA, DSWD, DOLE
Orientation of RPFP in the Workplace (specific region)	POPCOM Regional Office Amount: P46,900 Other agency: DOLE
Funds given to DILG for ASRH and population Projects (specific region)	POPCOM Regional Office Amount: P126,000 Other agencies: DILG, LGU
Augmentation to CSE budget of Php 360M	Amount pledged: P100M Other agency: DepEd

Source: POPCOM Accomplishment Reports 2017-2019

Lastly, **GAD** funds in NGAs (Section 25 of IRR) were another source of funding. To illustrate, **Table 18** shows expenditures that contribute to RPRH but are not necessarily reported or highlighted in the RPRH ARs. There is **further potential to maximize the use of GAD budgets for RPRH**, especially in sectors that address structural issues of RPRH that.

Table 18. Summary of 2017 GAD Accomplishment Reports of select NGA Central Offices

Agency	Summary of Central Office GAD Activities for 2017
DSWD *GAD as Share of Total Agency Budge*t: 53.8% *GAD Budget*: PHP 82.02B *GAD Utilization*: 83.0%	Programs, Projects, Policies KALAHI-CIDDS 4Ps Social Pension for Indigent Recovery and Reintegration Program for Trafficked Persons Senior Citizens Sustainable Livelihood Program Service delivery, Activities Upgrading shelters for survivors of GBV and VAWC Target vulnerable VAWC survivors (crisis situations and PWDs) Educating clients on gender sensitivity and GAD-relevant laws RH counselling for 4Ps beneficiaries Capacity-building: GAD training and advocacy for DSWD staff Governance: Setting up GFPS to monitor DSWD GAD activities, Conducting regular GAD TWG meetings
DILG *GAD as Share of Total Agency Budget*: 0.7% *GAD Budget*: 554.61M *GAD Utilization*: 3.53%	Programs, Policies: Distribution of GAD technical guidelines to LGUs Activities: Monitoring LGU-compliance Local Committees on Anti-Trafficking and VAWC (LCAT-VAWC) Barangay VAW desks Capacity-building: GAD training and GAD events for DILG staff Governance: Developed GAD M&E framework for Magna Carta of Women
NAPC *GAD as Share of Total Agency Budget*: 2.0% *GAD Budget*: 9.02M *GAD Utilization*: 44.6%	Programs, Projects, Policies: Gender sensitivity training for marginalized women, Sustainable farming training for women agricultural workers Activities: Legal and psychosocial outreach services to women inmates Capacity-building: GAD training and events for NAPC staff, GAD focals, and consultants Governance: Policy issuance within NAPC for GAD, RPRH Law, Magna Carta of Women, Set-up GAD Center in NAPC
CHED *GAD as Share of Total Agency Budget*: 4.95% *GAD Budget*: 316.57M *GAD Utilization*: 90.8%	Programs: Portion of GAD to Student Financial Assistance Programs (StuFAP), Established Committee on Decorum and Investigation (CODI) Service delivery, Activities: Capacity-building in HEIs on GAD issues Paralegal services and counselling for VAW survivors Capacity-building: GAD training for central and regional staff, GAD focals Governance: Established GAD database to monitor CHED programs, Identified GFPS members, Set-up GAD Center in CHED
TESDA *GAD as Share of Total Agency Budget*: 1.49% *GAD Budget*: 431.56M *GAD Utilization*: 6.1%	Programs: Integrated GAD in Technical-Vocational Education and Training Activities: Business-capital financing and language training for women Capacity-building: GAD training/events for staff, GAD focals, partners Governance: Generated reports from GAD database to monitor and inform programs

Source: GAD Accomplishment Reports 2017.

To note; however**,** the mitigation strategies mentioned are still unsustainable and unpredictable, **subject to the will of donors and the buy-in of agencies**.

Recommendations

(1) Present and measure the gains for RPRH through a social accounting approach in DBM assessments of NGA budget proposals.

At its core, RPRH is a basic social policy. Social policies address social, demographic, and economic challenges through programs at every life stage [56]. RPRH is concerned with **social impacts, of which financial gains are only one part** [57]**.** RPRH activities of NGAs are **social investments which cannot be accurately measured by traditional indicators** such as the return-on-investment (ROI) [58].

As more countries and companies recognize the importance of social investment, and the enormous impacts it can have, **social accounting** has gained more widespread use. Social accounting (SA) is a method to identify the positive and negative impacts of an organization's activities on individuals, the environment, and society [59].

One measure of SA is the **social return-on-investment (SROI)**. The SROI views a social service activity over a period of 5-10 years, **incorporating social and economic value of a particular intervention**. The steps of SROI analysis are presented in **Box 6**.

Box 6. Calculating the Social Return-on-Investment

SROI analysis posits that social activities generate significant cost savings for the government in the long-term. Cost savings can take many forms, such as decreased public expenditure or increased public revenue through taxes.

Benefits. From the policy or program design stage, the social benefits of the activity are first identified using a logic model or theory of change framework.

Inputs. Implementers should identify the inputs required to support the activity over the period being evaluated. These inputs are then quantified as a monetary sum.

Cost-Savings. The cost savings to the government that will arise from the social service are then identified and then monetized.

Discounting. The annual inputs and annual cost-savings are then discounted to original investment timeframe using net present value or discounted cash flow analysis.

SROI Ratios. SROIs for different interventions may then be compared and evaluated [60, 61].

An intervention that used SROI to inform decision-making was a proposal to scale up a course to prevent sexual assault in a U.S. university. The pilot program had been attributed to declines in sexual assault of 19% women and 36% for men who had taken the training. SROI analysis showed that if the program were scaled to 2.6 million students over 5 years, almost 40,000 cases of sexual assault would be avoided. In the U.S., the lifetime cost of rape was estimated at "122,461 USD per victim, or a population economic burden of 3.1 trillion USD," due to medical costs, lost in work productivity, criminal justice activities, and other costs like victim properly loss or damage [62].

Since government sources paid for about a third of this lifetime burden, the **social returns of scaling up an anti-sexual assault policy would drastically reduce costs for government, individuals, and society in the long-run**.

To be truly oriented towards national development, and the vision of the PDP, budget prioritization must include SA approaches. Though SA cannot quantify all benefits accrued by the success of the social service, it can **identify direct non-monetary benefits that may usually be overlooked**. This can steer budget allocation towards social services with great impacts, such as RPRH programs and activities.

(2) The NIT must conduct regular public expenditure reviews, report budget deficits publicly, and utilize convergence budgeting. This will inform the overall costing strategy across agencies and improve financial management accountability.

A **public expenditure review (PER)** evaluates how government spending was planned, allocated, and executed to achieve specified goals or outcomes. PERs are useful in informing fiscal management, areas for policy reform, and future budgetary planning. Specifically, a PER is conducted to improve the following aspects of government expenditure [63, 64]:

- **Economy -** the extent to which spending meets planned expenditures and allocations,
- **Efficiency -** optimal outputs delivered for specified inputs, and
- **Effectiveness -** whether investments produce outcomes specified in strategic plans.

A thorough assessment of financing and expenditure informs the alignment of financing, priorities, service delivery goals, purchasing decisions and indicators. Regular PERs can identify **best, contestable and wasted buys** [65, 66]. The NIT can then be in charge of **prioritizing and direction-setting** (see Stewardship) **for best or most cost-effective buys with the limited resources**. The PER can also help **avoid overlooking the costs needed to build systems**. Some examples include investing in electronic M&E systems in NGAs and LGUs, and not spending on recurring costs with limited impact such excessive demand-generation activities when the supply chain is not ready.

To achieve the goals of population development, all sectors involved in RPRH, including DBM, should have the same **understanding of how financing impacts intersectoral indicators**. This will inform budget negotiation, realignment, or even forecasting and realigning of targets and commitments during the DBM budget process

After a strong case to invest in RPRH to all agencies has been made, **program convergence budgeting and utilization of the GAD budget** (the full 5% of general appropriations) should be explored and executed. These include **convergence planning, multi-year procurement plans, resolving parallel financing schemes that lead to inefficiencies, talks about which agencies can cover what with unprogrammed money**.

Lastly, these reviews **can be reported to COC for accountability and justifying increases in RPRH funding**. This necessitates agencies' submitting their comprehensive financial data at the line-item level for review.

(3) DOH and PhilHealth should establish a unified accounting framework for RPRH and FP financing to address duplications and gaps in financing under universal health care and shift procurement of commodities to LGUs where possible.

An **accounting framework for health care financing** encourages **fiscal efficiency** by identifying the structure and key transactions of a country's health financing system [67]. Such a framework also promotes **financial accountability**, by presenting a "clear and transparent picture" of the health care financing schemes, their revenues, and their key institutional units.

Health care financing schemes. DOH and PhilHealth must **study the financing streams and arrangements for RPRH and FP in the country.** These include out-of-pocket expenditures of households, private health insurance, social health insurance (SHI), government agency financing, and multilateral donations. **Table 16** (page 50) is a starting point**.**

As the country looks towards financing RPRH in the long-term as a core part of the socio-economic development agenda, a reliable, efficient, and sustainable financing scheme is needed. A possible model can be taken from many Latin American and Caribbean (LAC) countries, which have skillfully **used SHI in UHC as a stable source of RPRH financing.**

Much like the Philippines, a purely tax-funded healthcare system was insufficient to meet the needs of lower-middle income LAC countries [68]. However, SHI schemes have been a great source of expanding financial protection. As was presented in **Table 14** (page 48), PhilHealth was a fairly stable source of financing for RPRH and FP despite budget cuts in DOH.

As recommended in evaluations of LAC models, **PhilHealth** can review its existing benefit packages and **create a pipeline of benefits and an essential RPRH services package covering all elements**, paying attention to integrate them into primary health care.

Types of revenues. The second step is to identify and classify the types of revenues from each healthcare financing scheme to provide information on the mix of private and public expenditures necessary to support RPRH.

The country's SHI has two main schemes: contributory and subsidized. The contributory scheme is financed through formal sector payroll contributions while the subsidized scheme is financed by the taxes to the government to enroll informal workers, the poor, and indigents. Knowledge on the proportion and distribution of each type of revenue informs the government of its capacity to both finance and provide health care services. It can focus on **prioritizing subpopulations who cannot afford RPRH services** as is mandated in the RPRH law and IRR (Section 2.01g).

Institutional units. Institutional units refer to the **source of revenues** (e.g., households and corporations), or **financing agents** who collect revenue or purchase services (e.g., LGUs, DOH, PhilHealth, CSOs, etc.).

Based on **Table 15**, DOH and PhilHealth must **clearly delineate who should pay for which RPRH services under the individual-based versus population-based classifications** instituted in the UHC law to avoid inefficiencies like double payments to service providers. Both must also be firm about **what LGUs must pay for**.

For FP in particular, the arrangement among institutional units is **public procurement and financing and primarily public service delivery**, especially for long-acting methods (**Table 19**).

Table 19. Source of Modern Contraceptive Methods among users aged 15-49 years, 2017

Modern Contraceptive Method	Public Sector	Private Sector	Other sources
Female sterilization	76.9%	23.1%	0%
Intrauterine device	89.2%	10.5%	0%
Injectables	92.7%	6.3%	0.9%
Implants	75.0%	23.2%	0%
Pills	34.2%	54.3%	11.6%
Male condom	29.5%	56.9%	13.6%

Source: National Demographic Health Survey, 2017

Under UHC where LGUs are expected to be better funded and empowered to manage their SDNs, DOH should further explore the following:

- How **DOH can let go of the procurement of RPRH commodities and expand private sector delivery as much as possible**. While centralized procurement is sensible for economies of scale for the more expensive commodities (e.g., implants) or commodities with international monopolies [69], it may distract DOH from its core maintenance of policy, oversight, and TA. FP is also especially vulnerable to budget cuts at the national level, which when it occurs, impacts the supply chain of the entire country.

  The DOH-SMP is the best example for this. Because of comprehensive maternal and child health benefit packages, public and private providers were incentivized to join the SDNs, expanding private sector service delivery for MNCHN, shifting procurement of supplies to LGUs and facilities, and increasing access for end-users.
- How DOH can **shift procurement of cheaper RPRH and FP commodities to LGUs** according to local utilization trends, financed by PhilHealth or their internal revenue allotments. Shifting procurement may help avoid delays from central-level procurement and distribution and increase access to RPRH services. Overall, it empowers the LGU and its constituents, who dictate their own demand for RPRH.
- How, for the more expensive methods, the **DOH and provinces can use framework contracting agreements coupled with continued innovations in electronic procurement** (i.e., modernized Philippine Government Electronic Procurement System) [70]**.** Under such agreements, central purchasing bodies (i.e., DOH) consolidate the demand of multiple contractors (e.g., provinces) under one electronic procurement process. This could save time and money and remove the burden of funding from DOH.
- How all these can be done using a **phased approach with clear segmentation of target populations** to ensure that **during the transition period, this will not adversely impact the poorest subpopulations**.

4.4. Human Resources

This section focuses on the **available workforce that manage and direct implementation of RPRH mandates at NGA COs**; it also touches lightly on ROs and LGUs. In any endeavor, a **sufficient number** of human resources with the **skill sets necessary to carry out the tasks assigned to them** are crucial to success.

(1) For the majority of NGAs, the quantity of human resources (HR) at central offices is insufficient to fulfill RPRH mandates. This is more apparent in regional offices and lower administrative levels where implementation responsibilities are heavier.

Central Offices. **Understaffing** in RPRH activities is a major challenge in COs. This was echoed by KIIs across NGAs.

Majority of NGAs assign only **1 to 3 people** to carry out RPRH mandates**. Often RPRH is an add-on** to existing core responsibilities **without proportionate increases in staff.** For example, DepEd has two (2) focal persons for CSE, but their primary responsibility in the past years was the K-12 Basic Education program. Likewise, there are two (2) RPRH point persons in PCW, but they also serve as the secretariat for the IAC-VAWC, develop GAD policies, provide oversight in NGAs for GAD, and monitor the implementation of the Magna Carta of Women (R.A. 9710).

This is **especially worrying for the DOH** as they have the most mandates as the lead implementer. For most DOH programs, there is only **one manager and one job order staff**. These two staff are **expected t create and strategize program standards, policies, guidelines, interventions, capacity-building, and monitoring for the entire country.**

> "*My counterpart in Malaysia … she does not do anything but do* [redacted] *only… But me, I am a program manager, I do everything, including this. And now, the* [redacted] *[initiative], that is still me. That is the biggest challenge here in [DOH] central. Because when we had re-engineering [for rationalization], we reduced and reduced. The first concept that we would be like WHO, we will be providing technical assistance. But in the course of providing technical assistance, there's so many things attached… you should also know how to make things run and operate. You have to run the operations of a program. Only one [staff per DOH program]." - Respondent 10*

A particularly heavy mandate for only two staff is oversight for the FP procurement and supply chain nationwide. Fortunately, the DOH received an additional five (5) staff for its FP program this year (2020). This also underscores the need to establish the FHB as bureaus have twice the staff complement of a division.

To reiterate, the **NIT**, the interagency body dedicated to RPRH governance and implementation, also **does not have dedicated staff.** Instead, DOH, POPCOM, and LIKHAAN share secretariat duties. The lack of full-time staff means that NIT functions are expected to be carried out by staff of the member agencies who are already balancing multiple functions and mandates.

Regional Offices and Local Governments. Decentralization further complicates RPRH implementation in that the organizational structure is lean at the ROs and LGUs. Accordingly, there are fewer and fewer human resources in lower administrative units with greater responsibilities for RPRH implementation and service delivery.

Multiple **CO respondents mention how their RO counterparts have heavier workloads and provincial and city/municipal counterparts even more so**. This is also evident in DILG where there is usually only one person in the LGU trying to communicate directives to an LCE from DILG and other agencies who asked DILG to issue a circular

"We have regional [counterparts], maybe roughly 8 to 9 technical officers addressing regional coordination divisions. You can just imagine how full their calendars are just to give technical assistance… They also attend to LGUs."	*"At least in our bureau, we just have to focus on social services, that's it. But in the regional office, the number of people is the same number with how many we are in this bureau, but handling the programs of four bureaus, even more than four. We only have one person in the LGU implementing everything. I don't think that person will not be confused."*	*"At the regional level, my counterpart does not only manage [redacted] but also Family Planning, Adolescent Health and EPI. The regional counterpart handles a lot of programs. As we devolve the programs, the counterparts handle more. One of our regional coordinators, he manages everything. That's too heavy."*	*"At the regional, the coordinator handles 1 to 3 programs. Sometimes, there are four programs at the province level. It's also the same load at the barangay level. There is only one midwife at the barangay level and she implements 30 DOH programs more or less."*
Respondent 1	*Respondent 6*	*Respondent 10*	*Respondent 14*

To illustrate, an NGA like the **DOH CO has around 9 programs for RPRH elements across two (2) dedicated divisions (i.e., WMHDD and CHDD) and other disease-related divisions within the DPCB**. RPRH *and non-RPRH programs* are funneled through RO coordinators of the Family Health cluster and Disease Prevention and Control cluster. Each RO coordinator handles three (3) to four (4) programs and must then advocate and provide TA to multiple provincial health offices (PHO). The PHO likewise receives instructions for RPRH and non-RPRH programs from the DOH and agencies like POPCOM with health-related programs. One PHO is then expected to follow up on all the cities and municipalities for all of the programs they are to implement. Overall, city and municipal chief executives will receive RPRH and non-RPRH directives from more than 10 NGAs.

> *"The NGAs want the LGUs to implement and prioritize the programs all at once. It is deafening for the LGUs. They do not know what to do first." - Respondent 6*

An **adequate number of HR is necessary to ensure** there are focal persons **prioritizing progress in these areas**. When a small work force leads to one person managing multiple programs, RPRH functions may not receive the priority needed to ensure that governance and service delivery goals are met. This is especially true for LGUs because if all many programs are pushed down as "priorities," then nothing is really a priority.

Nevertheless, **there were NGAs who were able to work within these constraints** to advance implementation of RPRH-related programs within their agencies (**Box 7**).

Box 7. Cases of select NGAs maximizing human resources for RPRH

- The **DOH's SMP** is an example of a **mature program with successful decentralization** and where the current workforce at the CO level was expressed as adequate. The program spent the past decade slowly integrating MNCHN programs into local health systems through system-wide

reforms [71, 72]. Aside from investments in health facilities for emergency obstetric and newborn care and health provider capacity building, it largely shifted financing to PhilHealth and commodities procurement to LGUs. **DOH CO staff for this program now focus on formulating national policy and TA to regions and local implementers, instead of noncore functions** like procurement and supply chain for commodities.

- Compared to DOH, **POPCOM** is a relatively **small agency prioritizing four (4) core programs**. Even with only a handful of personnel at the CO level, each can focus on a program or directive. Likewise, **hiring staff at the ROs in the form of job order personnel was a priority** such that there are around a total of 20 to 40 staff depending on the region. This has allowed POPCOM to augment DOH in community-based demand generation for the NFPP.
- Lastly, **PhilHealth's** approach was to **integrate RPRH functions into existing processes and routine operations** and where there was already clear delineation of tasks between units at the CO and between the CO and field offices. It was a matter of **including RPRH-related packages as part of existing plans and pipelines** and giving it a strong rationale to be prioritized - which was provided by the law and IRR.

  PhilHealth **aligned its existing MDG benefits product team of three people** to develop RPRH-related packages **as an official function.** The team is able to spend around 50% of their time on developing and improving packages for FP, MNCHN, and HIV/AIDS. **Benefit development teams** are primarily involved in **policy making** which include backend staff work (e.g., standards, costing, package design) and developing implementation guidelines. The benefits development team are also the **focal people who coordinate with various other divisions in PhilHealth** to push routine M&E (Standards and Monitoring Department), communication to stakeholders (Corporate Communications Department and Member Management Group), and resolution of bottlenecks with benefits payouts (field offices).

(2) Human resources for RPRH in NGAs require additional skills and expertise to more effectively fulfil their RPRH mandates.

In the realm of **governance, tasks are already complex** and include leadership and direction-setting, supervision, and planning, managing and monitoring, coordinating across agencies, and many more functions essential to RPRH implementation. A matching of positions and skill sets leads to personnel being able to maximize their time and effort for the greatest gains in RPRH implementation. For instance, if staff specializing in management were given technical tasks, the outcome would be inferior, *and* their skills would not have been fully utilized.

Since **RPRH is multidisciplinary**, covering multiple elements that cut across agencies and sectors, **RPRH implementers in NGAs and especially DOH as the lead implementer** need not only technical skills in their specific field, but also, **leadership, advocacy, and systems-thinking skills to be able to convince and influence other NGAs** to collaborate and optimize service delivery mechanisms across sectors [73].

As a direct consequence of insufficient quantity of human resources, some **NGAs require additional technical expertise to carry out their RPRH mandates** since some existing RPRH activities extend beyond the usual expertise available within the agency (**Box 8**).

Box 8. Key examples of Additional Technical Expertise Required in Select NGAs

- The **DOH-FP** program is a peculiar case in that part of its core RPRH mandate is the centralized procurement and national oversight of the supply chain for FP commodities. While the DOH has a procurement and supply chain division, their core function as an agency is in policy, TA, and regulation [74]. While the DOH-FP program manager is clearly a technical expert in FP in line with DOH's core function, she is not (nor should she be) necessarily a supply chain expert.
- **POPCOM**'s recent move from DOH to the NEDA as an attached agency to improve POPCOM's implementation of "population-related plans, policies, programs and projects in pursuit of socio-economic development reforms and programs" (EO 2018-071) highlights the need to bolster its Population Development and Integration program. The program may need to be supplemented with in-house population economists and demographers if it aims to harness population dynamics for sustainable development the demographic dividend.
- **DILG** is tasked with monitoring LGU compliance to the RPRH law, but they do not have experts on RPRH. Consequently, they can at most act as "messengers" of directives and reports between NGAs and LGUs (DILG respondent).

  DepEd is mandated to integrate RPRH into formal and informal learning systems. DepEd heavily relies on TA from CSOs and multilaterals (NIT minutes). They may need additional full-time staff with expertise on CSE for children and adolescents to expedite and pursue innovations in the implementation in light of local contexts, changing population dynamics, and socio-cultural trends.

To address such gaps in skill sets, requires **either hiring staff specifically for those roles or training existing staff.** Continual workforce development is crucial to providing HR with the necessary technical knowledge for implementation. Being unable to systematically and regularly improve the quality of workforce leads to bottlenecks, which lead to foundational factors like funding, governance, and infrastructure, not translating into long-term gains, because those operationalizing them cannot make the most of them. A lack of training in updated leadership and management practices, in particular, contribute to the issues agencies face for forward-thinking and succession planning.

Recommendations

(1) NGAs should pursue public-private partnerships (PPPs) as an explicit strategy in expanding the RPRH workforce at the central and regional level.

The RPRH IRR and ARs recommend PPPs for RPRH implementation. The fact that it is a recurring recommendation means that PPPs have not yet been fully maximized as a strategy to expand the workforce for RPRH. **There have been precedents with CSOs helping fill HR gaps not only in service delivery, but advocacy and technical expertise** (NIT minutes)**.** Between 2015 and 2017, CSOs lobbied for the lifting of the SC TRO, and delivered implanon service delivery functions that DOH was barred from. **NGAs can take advantage of the small size, speed, and flexibility of CSOs,** compared to NGAs, which have large organizational structures with additional layers of bureaucracy meant to serve the entire country.

(2) The RPRH IRR may be revised to include provisions for an RPRH focal unit within NGAs who are visibly responsible for progress in NGA RPRH mandates.

Along with this, there can be an exploration of **financial incentives and policies that can push NGAs and LGUs to dedicate personnel to RPRH** - at least in the early term when building up RPRH in the agency. Again, a model that can be followed is that of the GAD program. GAD mandated the creation of a GFPS to go along with an earmarked budget and incentives for good GAD performance.

(3) There needs to be concerted efforts to align staff mix with assigned RPRH mandates and strategies to carry out these mandates in NGAs.

Quantity and skill mix of availability staff for RPRH must be thoroughly reviewed to evaluate how many additional staff and what skills are missing to carry out RPRH mandates vis-a-vis the wider implementation strategy in the NGA. Then hiring strategies at the CO and RO levels must align. Examples of additional staffing needs for some NGAs were given in **Box 8** (page 60).

(4) As part of wider reforms in government organizational structure within the context of decentralization, expansion of the workforce in ROs and especially LGUs, who are responsible for direct service delivery, should be a priority.

Understaffing and underfinancing in a decentralized system are perennial problems not unique to RPRH. As early as 2005, multilateral reports have shown that there is a "disconnect between national and regional/provincial planning" [75]. LGUs in particular do not have the resources to fully implement the numerous programs they are tasked with delivering. Following the 2019 Mandanas ruling, it was acknowledged that LGUs need more resources if they are to fulfil the functions expected of them [76]. Aside from being entitled to a share of national taxes, LGUs must be provided additional staffing for plantilla positions.

5. Stewardship and Coordination

Stewardship refers to the **presence and quality of leadership** and ability to **direct implementation strategically**. In particular, this section focuses on:

- Political priority for RPRH within agencies which may affect allocation of resources,
- Leadership in implementation among NGAs and in the NIT, and
- Concrete multi-sectoral vision and strategy to operationalize RPRH.

Stewardship links the foundational factors from the preceding chapter and feedback mechanisms. Through good stewardship, staff, units, and NGAs know what should be done, how best to do them, and are provided the necessary resources and skills to do so.

In the **multi-sectoral work** that is required by the RPRH law, stewardship directly affects the **coordination** among actors within and across NGAs. Coordination can bring together the human and financial resources among agencies, optimize their use, minimize duplications, streamline processes, and exploit avenues for synergistic collaboration.

Strong stewardship and coordination are necessary to ensure that NGAs work towards the common goal of implementing the **RPRH law as a whole** and not merely as isolated programs.

(1) The NIT can be a venue for interagency stewardship and coordination, but it has not been able to fulfill its potential for these purposes.

Purpose of NIT. The idea for an **interagency body for stewardship and coordination for** RPRH implementation resulted from a recommendation from the POPCOM Board of Commissioners chaired by DOH last August 26, 2014. After a series of DOH-led consultations, the NIT was created by the DOH in the fourth quarter of 2014 as "a structure to manage the implementation of the law" after the lifting of the SC SQAO in April 2014.

Based on **DOH AO 2015-02**, the NIT has the following **notable functions:**

- Manage the review, development, modification, consolidation, and dissemination of RPRH-related DOH policies and guidelines.
- Coordinate actions of RPRH implementing agencies in areas such as policy development, capacity-building, advocacy, M&E, field operations, and service delivery.
- Craft unified annual and financial plans across implementers for nationwide RPRH implementation.
- Monitor the implementation and impact of the law and provide regular reports (e.g. recommendations to Secretary of Health [SoH], annual report for Congress)
- Liaise with the COC on behalf of the SoH

The NIT was also **envisioned to have a strong leadership and advocacy role for multi-sectoral RPRH implementation.** This included deciding priority investments through a Master Investment Plan for RPRH that will "identify non-negotiable agency budget items for RPRH protected from Congressional influence" and be used to "lobby for the appropriation of RPRH budget items throughout the planning cycle for GAA" [27]

Perception of NIT's Purpose. For nearly all respondents, it is clear that the NIT is perceived as a **coordinating body for interagency discussions and recommendations.** What is **unclear to members is the NIT's role in stewardship and is being coordinated**. KII respondents from different implementers had varying answers on these fronts:

"*NIT is supposed to lead the coordination of the implementation by the different agencies and CSOs. Including monitoring, making sure the logistics are there, the human personnel through health-systems approach."*	*"The goal of the NIT was really good. it's a coordinating body because all agencies are represented there… It's a very big group wherein each and every meeting, there are repetitive issues, but we don't talk about strategies."*	*"Do they implement? I see that perhaps they can provide recommendations on how to better implement the programs."*	*"I think NIT is like a coordinating committee only or a body when there is a problem on one sector, it should be the NIT since it has a lot of members, It is a venue to discuss problems"*
Respondent 3	*Respondent 7*	*Respondent 10*	*Respondent 18*

"The idea of creating the NIT was good. It should be an avenue for the stakeholders to come in together to provide recommendations. The term national implementation team is really a misnomer because it's not an implementation team… but more of an advisory body, supposedly our recommendatory body."	*"The members of the NIT felt that they should be more of an advisory group rather than an implementing team…but in essence you are just providing some policies, directions"*	*"The NIT was set-up to make sure that all the different agencies that have commitments to the RPRH would deliver. It's on the implementation side, it's not going to develop new policy. Because the IRR was already written up."*
Respondent 17	*Respondent 12*	*Respondent 4*

Most respondents stated that the NIT is for coordinating **operations:** determining problems and pinpointing the NGA in charge, reporting accomplishments, discussing possible improvements in interventions, monitoring the commodities supply chains, and raising partner CSO concerns and identifying available resources for them.

A respondent stated that the NIT is for **reviewing policy:** checking policies to add or adjust. However, *another respondent from the same agency* mentioned that the NIT was set up for **accountability for implementation** - to ensure agencies deliver on their RPRH commitments - with less emphasis on policy. Lastly, a few respondents mentioned that the NIT **should be converted to a policy advisory body**.

NIT Meeting Agendas. This lack of clarity in the NIT's purpose is reflected in the NIT discussions from 2014 to 2019. **Table 20** presents an analysis of the agenda of the NIT meetings. Of the 79 NIT meetings, 71 transcripts were obtained for analysis. The frequency of an agendum was determined by counting the number of meetings where it was discussed. To note, **more than half of the meetings** discussed reviews and revisions for policies (70%), FP Logistics and Inventory (58%), and RPRH communication and health promotion (51%)**.** Other topics were more or less discussed with the same frequency over the years.

Overall, the NIT **meetings over the past six (6) years were largely micro-operational with little discussion on strategy, coordination, plans, or cross-NGA issues.** This corroborates with the sentiments of some respondents that the NIT is just a venue where stakeholder issues and concerns are raised as they occur, rather than the body that actively addresses root problems and ensures implementation meets targets.

Table 20. NIT Agenda and their Frequency of Discussion in the 71 NIT Meetings

Agenda: Areas of RPRH Implementation	2014 (n=3)	2015 (n=12)	2016 (n=21)	2017 (n=16)	2018 (n=13)	2019 (n=6)	Total (n=71)
Policy reviews and revisions *19 on proscription on abortion and management of complications (DOH AO 2018-03)* *5 on requiring an ambulances for hospital licensing (DOH AO 2018-01)* *5 on PhilHealth accreditation of standalone FP clinics (Circular 2018-05)*	2	4	17	10	10	5	48
FP Logistics *Supply chain management issues (e.g. stockouts), use of remaining progestin subdermal implants given SC TRO, and inventory counts*	-	8	11	7	11	4	41
RPRH Communication and Health Promotion *National FP Conference, events, DOH-HPCS presentations on communication plan*	-	3	9	10	11	3	36
Monitoring and Evaluation *FP Form 1, Annual report, data requests*	-	8	15	6	4	1	34
Legal Restrictions - SC-TRO	-	-	3	13	9	-	25
CSO Funding *Process of accreditation of grant funding*	-	-	4	6	10	5	25
Capacity Building for Healthcare Providers *Training for FP, MNCHN, interpersonal communication and counseling; Accreditation of Training providers*	-	3	4	6	5	5	23
Accreditation of Healthcare Providers *Standardized certification programs and accreditation of CSOs, private providers*	-	3	4	6	5	5	23
RPRH Service Delivery *Various discussions on quality and access*	1	4	3	6	8	-	22
PhilHealth Claims/Reimbursements	-	4	5	6	3	3	21
RPRH Budget *DOH budget cuts, augmentation, convergence budgeting*	-	3	7	4	2	1	17
Sorsogon “Pro-Life City” (LGU issue)	-	4	9	2	2	-	17
ASRH TWG (organizational challenge) *Functionality and leadership*	-	9	-	5	2	-	16
RIT (organizational challenge) *Functionality, reporting issues*	-	1	8	-	4	2	15
Service Delivery Network *PhilHealth facility accreditation and issues on DOH facility standards (e.g. need for ambulance)*	-	5	5	1	2	-	13
Quantity of Healthcare Providers *Deployments for nurses and family health associates*	-	1	4	1	6	-	12

Source: NIT minutes of meetings from 2014 to 2019

Notable observations are:

- Some of the **recurring agenda could have been addressed within one or two agencies outside of the NIT** (e.g. CSO coordinating with PhilHealth about resolving late disbursements, CSOs requesting funding via agreements with individual agencies, regular updates on stock of FP commodities via email).
- For **Financing**, there were 17 meetings that discussed NGA budgets for RPRH, but these did not result in convergence budgeting or a unified work and financial plan (UWFP). Meanwhile, there were 25 and 21 meetings discussing availability of funding and PhilHealth reimbursements for CSOs delivering FP and MNCHN services.
- The issue with Sorsogon City (see **Box 9** for more details) was discussed in 17 meetings from 2015 to 2018. New NIT interventions or infrastructure to address advocacy and non-compliance in LGU did not result from these discussions.

Box 9. NIT actions to resolve issues with RPRH implementation in Sorsogon City

On February 2015, the mayor of Sorsogon City declared the LGU as a "Pro-Life City" through EO 2015-03, restricting the distribution of modern FP in public health facilities and limiting FDS discussions to natural FP methods [77]. The DOH RO for region 5 noticed the significant drop in modern CPR in the city through DOH's quarterly M&E, and reported this to the NIT and DOH CO for action.

The challenge would stay with the NIT for the next four years. In 2015, the NIT looked to sue or file an administrative case against the mayor, collecting position papers from other NGAs and evidence from CSOs. Attempts to file legal cases in 2016 with the Solicitor General or an administrative case via the DILG were dismissed due to insufficient evidence. CSOs attempted to try pushing the case through women's groups while the DILG and NIT decided to focus on engaging the LGU in dialogues. Due to the persistent efforts of DOH, POPCOM, DILG, and CSOs in advocacy, the mayor eventually allowed distribution of modern FP commodities in public facilities, but declined to retract the city ordinance.

Overall, this experience shows that systematic investigation and intervention protocols following M&E findings are crucial for quicker response by defining details such as:

- Which NGA or NIT member is primarily responsible for investigating lapses in LGU implementation of the RPRH law?
- What types and how much evidence are sufficient to be able to file a suit or administrative case for RPRH law violations?
- What kinds of interventions should be deployed in which order of escalation or appropriateness for the root problem (e.g. dialogue with mayor, capacity-building and technical assistance, grassroots advocacy, filing an administrative case, court suit)?
- Is the issue widespread? If so, what policies can be developed to address it?

There also needs to be protocols for the NIT to institutionalize learnings to more systematically address implementation challenges. This could include mechanisms to regularly flag LGUs for targeting (e.g. intake of reports from NGAs and CSOs), which then trigger the investigation protocols, the program of interventions, and policy development.

One reason for a micro-operational focus is that **NIT meetings proceed through an agenda established from the content of the previous meeting**. The start of each meeting is always a review of the previous meeting. Then the NIT follow-ups on all issues until they are resolved, even if they can be addressed within individual agencies. The **lack of strategic pre-planned meeting agenda** leads to a **disproportionate focus on some topics, such as FP** for which operational and logistical issues are bound to arise because of its massive supply chain.

FP as a topic has been brought up in almost every single NIT meeting while other elements are discussed minimally (see Table 21). Even the second and third most frequent elements, MNCHN and Adolescent RH education (i.e., CSE), are raised only half the time. The mental health aspects of RH have not been discussed despite the Mental Health Act in 2018.

Table 21. NIT Agenda by RPRH Element and their Frequency in the 71 NIT Meetings

	RPRH Element	Frequency (n=71)
1	Family Planning	60
2	Maternal Neonatal Child Health and Nutrition	32
11	Adolescent RH Education in formal and non-formal settings (i.e. CSE)	30
4	Adolescent youth and RH guidance and counseling	27
3	Proscription of abortion and management of abortion complication	15
7	Sexuality and RH education and counselling	14
6	VAWC and GBV	12
5	HIV/AIDS, STIs, and RTIs	11
8	Treatment of breast and reproductive tract cancers and other gynecological conditions and disorders	3
9	Male responsibility and involvement and men's RH	2
10	Prevention, treatment, and management of infertility and sexual dysfunction	1
12	Mental health aspect of reproductive care	0

Consequently, the focus on FP, MNCH, and CSE **may contribute to the absence of other agencies and their higher-level decision makers in NIT Meetings**. Without a strategic agenda, **only agencies who have a clear purpose and benefit from NIT meetings or those who are the main implementers of the focus topics attend**, steering the discussion towards their interests. For example, CSOs are very active in the NIT to get information on funding and commodities and convey requests or policy revisions. PhilHealth attends to get feedback on circulars and to troubleshoot operations on the ground. Meanwhile, DSWD (mostly interested in VAWC and poverty alleviation) and DOH officers for other programs rarely attend.

This may **contribute to the slow progress** in implementation of other elements and sectors since they are not prioritized in the NIT. The absence of high-level officials from other NGAs may signify diminishing political priority for RPRH as RPRH is not made explicitly relevant to their sector. Moreover, as NIT representatives are not ASec/USec-level (as preferred in the NIT AO), they are not in a position to speak or decide for the agency; they must first go through the proper chain of command and seek approval from their supervisors.

NIT's Potential. There were several instances, however, where the NIT showcased its potential as an interagency stewardship and coordinating body as initially envisioned. In the examples below, NGAs and CSOs worked together to resolve issues or identify points of collaboration through the NIT:

- The efforts of the NIT and its members to resolve the SC TRO involved DOH, FDA, POPCOM, PCW, multilaterals, and CSOs. Aside from intense lobbying efforts from these stakeholders and working to get FP commodities recertified by the FDA, the **NIT looked for ways to ensure that existing stocks of implants would not be wasted**.

  They rightly identified that only DOH was restricted by the TRO and that multilaterals and CSOs could deliver the implants to women (NIT 28th meeting). Though this was not without difficulties, involving reworking systems in the DOH ROs (for CSO accreditation) and PhilHealth (for reimbursements). At the service delivery level, there were issues in referral systems due to lack of trained implant providers and funds to pay population coordinators. **At least 150,000 implants were used before their expiration date**.

- Through talks between DSWD and POPCOM, DSWD agreed to let NGAs use DSWD guidelines to accredit their respective CSO partners, **addressing delays in CSO accreditation** (NIT 42nd meeting).

- DOH and POPCOM were able to identify issues in the FP supply chain to determine **areas where POPCOM could assist** (e.g., commodities distribution, stock monitoring in facilities). They also divided tasks for the NFPP, with DOH focusing on national strategy and POPCOM on community-based demand generation, since POPCOM has a larger staff complement relative to the number of programs it implements.

- Doctors without Borders presented their school-based immunization campaigns for Human Papillomavirus Virus (HPV) (a common STI that causes precancerous lesions and may lead to uterine cancer). DOH asked DepEd if they could implement this in schools. This eventually led to the school-based HPV immunizations campaigns for female Grade 4 students aged 9 to 13 (DOH DM 2017-003). The two agencies also worked together to implement a Weekly Iron Folic Acid supplementation program for female adolescent students (DOH DM 2017-0290 and DepEd DO 2017-0290).

These examples highlight that **NIT can be an important body to foster a sense of interconnectedness among RPRH implementers.** If **optimized for its original and envisioned purpose**, the NIT has great potential to accelerate progress and ensure a multi-sectoral perspective to RPRH implementation.

(2) Although an implicit vision for RPRH exists, there is no explicit or concrete strategic plan to operationalize this vision among implementers.

Multiple KII respondents cite that **theirs and the NIT's vision for RPRH implementation is the law, IRR, or PDP chapter 13**. That is, a **rights-based approach** to providing RH services that empowers families to make decisions about their households to invest in the health and education of members. A clear example of trying to apply this vision is the shift of the NFPP's strategy from a supply-side to a demand-driven model. The former entailed flooding the market with modern FP commodities to remove cultural stigma and increase demand. Now, given greater social acceptance for FP, the demand-driven model accounts for local need and couple's preferences for FP methods; this includes moving from providing mostly short-acting contraceptives to long acting and permanent methods [78].

"We really want to make or build a government or an environment that is receptive or at least conducive for women to enjoy [their RPRH] rights."	*"I think our vision is the law. We have a common vision."*	*"What must be consistent is a right-based family planning RH program to meet the demand, the rightful demand of women and men for reproductive health rights."*	*"The vision is to see Flipino women, all of them, be able to exercise their reproductive health rights and be able to access goods and services that will promote their reproductive health rights."*
Respondent 1	*Respondent 3*	*Respondent 4*	*Respondent 17*

Although NIT members have a broad ideal for RPRH implementation based on the law, there is **no shared operational vision for integrated and RPRH service delivery.** Such an operational plan would include, for example, a strategic plan for RPRH across NGAs, a defined comprehensive package of RPRH services covering all elements and life stages, and ways for NGAs to link, finance, and deliver the package on the ground or in communities.

"The vision is still anchored on the IRR and the law. But as to the plans, schedules, timelines, there is nothing like that."	*"It's very difficult for them to interact with each other. It's like they are there only when we put together the accomplishments [report]. But working together, that is really very seldom - that the commitment of 'ok let's find time so that your efforts and my efforts can be seen in one program implementation,' is very seldom really."*	*"What I am seeing is only the PME (Implementation: Planning, Monitoring, and Evaluation Guide). There is a vision for modern RPRH, but it is per program - it is just not sewn all together to be able to say that this is RPRH implementation."*
Respondent 8	*Respondent 11*	*Respondent 13*

Consequently, the **absence of an interagency RPRH framework** in the NIT and a **unified RPRH framework within agencies** (review Infrastructure section) has led agencies to carry out their **mandates in siloes** and in ways most congruent with their existing functions and programs. This has led to the gaps in Performance, Presence, Human Resources, and Infrastructure discussed previously; as well as gaps in Monitoring and Evaluation and Accountability that will be discussed in the next chapter of this report. The **fragmentation in implementation** has been cited as an annual challenge in the ARs since 2014.

There are **three important implications** to fragmented implementation of the RPRH law.

First, there are **underutilized agencies and sectors**. Since NGAs focus on their own mandates, they do not utilize the expertise and cooperation of other agencies who may not have projects at the forefront of RPRH implementation but are crucial links in building back-end support systems.

In particular, the **primary visible actors** for RPRH have been **DOH, POPCOM, DepEd, PhilHealth, and CSOs,** by virtue of the focus on FP, NIT meeting topics, and what is highlighted in the RPRH ARs. Two examples of underutilization of other agencies are:

- The RPRH IRR mandates **FDA** (Section 7.08 and 7.09) to conduct post-marketing surveillance for all reproductive health products, inspecting logistics outlets, and investigating complaints of failed products. However, the **FDA is not included in the FP and logistics supply chain TWG and has not been active in the NIT after the SC TRO was lifted** and its role in accrediting FP commodities was completed**.**
- **CHED, TESDA, and PRC** (Section 4.14, 11.05) have mandates for integrating RPRH information into formal and informal curriculums. CHED and PRC in particular must integrate this in training curriculums for RPRH health care providers. Collaboration among these agencies in **curriculum content, TA, or innovative methods to expedite provider training** has not been in meeting discussions.

Second, this leads to **duplicative membership and meetings in various interagency groups** at the CO level that **take limited staff time away from implementation activities**.

"Personally, my challenges are when the meetings happen all at the same time, because I am handling so much… If I need to consider all the reports, I have [redacted] RH law, I will not be able to do it."	*"I do a lot of work with [redacted] I sometimes joke I will put a table there because they have so many activities … and all these activities should be co-created with us. I attend the board of commissioners meeting, … the executive committee meetings…"*	*"Actually, the members and representatives are the same people. Each agency has one [redacted] [program] point person. S,o whenever NYC would call for a meeting, it's the same person who attends the NIT… And then in the proposed [redacted] bill, it has provision to put up a commission or council. We said, the same representatives will attend these councils, and there are too many councils so other agencies find it difficult to attend all."*
Respondent 6	*Respondent 7*	*Respondent 14*
"Exactly in the TWC [technical working committee] … it's the same DILG team people, it's the same DSWD representatives in these meetings … It's challenging and it's difficult since these interagency [bodies] have different plans… So, I wish the NIT may submit itself to the direction of the [redacted] council so the workforce will not be diluted. For example, there's a person or two each [redacted] program and they have to attend council meetings every 2 months. Even if there are no daily meeting, but you know the preparation would take [time and effort]." - Respondent 18		

Third, the lack of seamless integration at the CO level also results in the **fragmented coordination of programs and initiatives downwards to ROs and LGUs**. And since NGAs conceptualize programs vertically, **coordination through the levels of administration (RO to province to LGU and vice versa) is slow, inefficient, and ultimately untimely** with parties unsure if messages reach intended recipients.

"We can go directly to the LGUs ... but there's courtesy since we have the regional office. Why would we go directly to the LGUs? But if we really need to expedite the thing, we sometimes communicate directly to the LGUs and CC the region."	*"In terms of coordination with [redacted] [another CO unit], it's easy to coordinate, it's just that they will also tell you "oh they [regional offices] did not submit it yet." ... The data takes so long from bottom to top, it takes so long for the validation at the bottom."*	"*Actually, it's still separate [communication of programs and policies from CO to RO]. That is one of our challenges here. That is why when it reaches the regional level, we try to integrate everything ... so our LGU partners won't have difficulties… That is the intervention we do… I am not sure if other regions do it, too."*
Respondent 6	*Respondent 13*	*Respondent 16*

Moreover, **interpretation of messages and issuances may vary, and clarifications take time** to address. For example, CSOs repeatedly reported that: (a) PhilHealth frontline officers interpret and therefore apply reimbursement eligibility differently in different LGUs and (b) POPCOM and DOH memos (e.g., CSO accreditation and grants) are not understood and applied uniformly across ROs. A last striking example is that DILG officers at regional and provincial offices did not fully understand the RPRH MC (DILG MC 2015-145) until POPCOM funded and provided orientations for them in 2019.

"The bottleneck within Philhealth is the interpretation of policies from the central office to the implementing units like the regions. Those assigned to review the claims, survey the facilities and frontline workers who are giving information to the members, have different policy interpretations"	*"Actually, last year, we oriented these [redacted] officers so they can follow up on LGUs. We learned that they are not aware that LGUs have many roles in the RPRH Law. So when we oriented them they were like "there's a lot we should ask the LGUs to deliver in terms of RPRH Law implementation."*	*"This was our challenge ... we would want to hire a consultant to assist us in RPRH service provision [in the RO] ... but we saw that the CSO accreditation [guidelines] is very limiting and there were concerns on how they would be certified…* *At our level we wanted to certify them ourselves and we would just submit to the central office for their approval. Then what happened was that Sec. [redacted] signed it then apparently it's not allowed… it went against the procurement act…"*
Respondent 8	*Respondent 9*	*Respondent 16*
"And then there are various interpretations on what is written, and they could be wrong. There's a lot of misinterpretations. Even now, many are saying they can provide services to adolescents who already gave birth, but others are saying if you will check the law it is not allowed. There are also others who expressed 'we fear providing the services because we might get jailed.' They do not even know that the law has no provision on imprisonment, or they will get penalized. I can't gauge their level of understanding; do they really understand, or they don't. So, these are the confusions." -Respondent 11		

As the information cascade to the local levels takes time, there may be **new guidelines at the central level by the time LGUs receive and adjust** to the first set of guidelines.

> *"Then our plans at the national level changed. Because we know that the trickling down of the policies of the national [offices] is so slow, it's so difficult to push policy [down] the system, up to the bottom. It hasn't even gotten to the bottom yet, then you will be changing it again - just what will you expect will happen?" - Respondent 9*

To be fair, the **DOH has admitted to these problems and are moving to fix the lack of a comprehensive RPRH implementation plan**. As the DOH's number one priority for RPRH in 2020, they had planned to have a workshop with the help of POPCOM and multilateral donors. This workshop would produce a National Implementation Plan for interagency stewardship and coordination as well as a corresponding agency-level plan within DOH. Unfortunately, these plans have been put on hold because of the COVID-19 pandemic.

(3) Inconsistent political priority for RPRH in NGAs prevents momentum and long-term implementation.

Political priority for RPRH within and among agencies is important to ensure sustained efforts and resources for RPRH. **In the KIIs, respondents cite that RPRH has been a high priority** because of the law, PDP Chapter 13, EO 12, and its inclusion in the current administration's 10-point socioeconomic agenda. But **this was not evident in the sufficiency of financial and human resources for RPRH, the necessary policy infrastructure for NIT and agencies, or even regular attendance in NIT meetings** (discussed previously). Thus, in general, **political priority for RPRH in agencies is inconsistent**, even if it has improved.

A reason that respondents put forward was that **the initial momentum** that came with signing the RPRH law **was lost during the SC TRO** in 2015. Though the TRO only applied to the FP element of RPRH and was eventually lifted in 2017, respondents cited that interest had died down by then.

> *"Any public policy...There should be an agreement between Executive and Legislative. Unfortunately, that agreement was forged in 2012... The sustainability of that agreement on the policy has probably eroded over time. If one or the other has less interest with implementing the policy, it will be very difficult for the policy to push through. The third element that complicated the RPRH law was when the Judiciary was involved [in the TRO]. You see here the interplay of three branches of government in one public policy... In the end, they ended up agreeing, but there were 4 years - 1½ years status quo ante order, 2 years TRO. All of those militated to erode the consistency of the public policy."* - *Respondent 4*

Another reason is that **the lead implementer DOH and the NIT leadership were not able to garner buy-in and ownership for RPRH in other NGAs.** On paper and in KIIs, DOH is regarded as the leader of RPRH implementation: DOH has the most mandates in the IRR and the most budget for RPRH given its task to procure FP commodities nationwide. The DOH, however, has not been able direct RPRH implementation and advocate to other sectors **due to its own problems of erratic political priority for RPRH**.

Compounded by the lack of an FHB and subsequent difficulty in interoffice coordination for RPRH (review Presence section), there have been **frequent changes in DOH's upper and middle management that affect the priority and continuity plans**. In the past 8 years since RPRH was passed, the DOH has seen **four secretaries** [79]:

- Dr. Enrique T. Ona (June 2010 - December 2014),
- Dr. Janette P. Loreto-Garin (December 2015 - June 30, 2016),
- Dr. Paulyn Jean B. Rosell-Ubial (July 2016 - October 2017), and
- Dr. Franciso Duque III (October 2017 - present).

According to a respondent who has been in the DOH for at least a decade, there have been **six undersecretaries** who have held RPRH: Dr. Madeleine de Rosas-Valera (2012 to 2013), Dr. Janette P. Loreto-Garin (2013 to 2015), Dr Vicente Y. Belizario (October 2015 to June 2016), Dr. Gerardo V. Bayugo (July 2016 to 2018), Dr. Herminigildo Valle (2018), and finally Dr. Myrna C. Cabotaje (2018-present). Along with the changing of top-level officials come **changes in division chiefs and program managers, and difficulties in succession planning and ensuring comprehensive endorsements.**

Shuffles in leadership also occur in other agencies and LGUs. At the very least, cabinet secretaries are replaced every presidential election (6 years) and LCEs, every local elections (3 years). Each secretary and LCE has their own forte and priorities; **while RPRH activities do not halt, they may not be the top of agenda.**

"Because there is only one program manager per program. That disadvantage is we do not have a succession plan. If I leave, retire, who will replace me? I am not able to train anyone. I am with one job order [staff] … If I will leave, say I will retire next year, then a replacement will be given to me January or December. The whole December, I will be orienting. I don't expect that he/she will learn everything in just one month."	*"Yes, because for example, one top level official - this is the priority for him or her - but when there is a change in leadership … there are other priorities here from the goal [of RPRH]."*	*"But of course, we cannot say that RPRH services that we support or advocate stopped. I cannot say that, it's just that there are really priorities per administration."*
Respondent 10	*Respondent 13*	*Respondent 15*

A clear example of how each secretary has different priorities is given by a **DSWD** respondent:

- Sec. Corazon "Dinky" Soliman (June 2010 - June 2016) - prioritized integration of RPRH into the 4Ps program and in its Family Development Sessions (FDS)
- Sec. Judy Taguiwalo (July 2016 - August 2017) - sustained priority for 4Ps and RPRH
- Sec. Emmanuel Leyco (August 2017 - May 2018) - focus was in his forte of fiscal management and administration
- Sec. Virginia Orogo (May 2018 - October 2018) - prioritized is anti-illegal drugs
- Sec. Rolando Bautista (October 2018 - present) - priority is anti-illegal drugs

Thus, there is **all the more need for DOH to solidify internal stewardship and then have strong regular and systematic advocacy to convince newly installed leaders in other sectors** to give RPRH priority during their terms**.**

(4) <u>CSOs and POPCOM emerged as visible leaders</u> in RPRH implementation. Their strategic roles and scope of functions for RPRH must be better delineated for expectation-setting and accountability.

<u>CSOs.</u> The RPRH law and IRR recognize CSOs as partners in implementation (Section 12.04). KIIs and NIT minutes identify CSO **contributions in following areas**:

Advocacy. At the **national-level**, CSOs pushed for the passing of RPRH law, related laws (e.g. PCW's Women's Priority Legislative Agenda), and lifting the TRO. Their continued attendance in the NIT gives a **client-side perspective to RPRH programs.**

"*These civil society organizations are really grounded on what women really need … So, I think it's really the push of civil society organizations and of course the need of women for these family planning methods and reproductive health care in general."*	*"There is the PLCPD, The Philippine Legislators Committee Population and Development. They are at the senate and the congress level advocating for the full implementation of the RPRH law and so every time that there are bills that are being prepared … they are there to make sure that there is support by getting more people to rally for a certain bill ... So over the years PLCPD has been there ..."*
Respondent 7	*Respondent 11*

At the **local-level**, CSOs serve as **grassroot links to clients**. They educate and organize women, especially in poor and vulnerable sectors, for local demand generation. Moreover, an NGA respondent cited that CSOs **help appeal to LCEs** who are resistant to RPRH.

"For instance, one LGU returns the subdermal implants. CSOs can outsmart that kind of bottleneck. They will tell us, 'we will take care of that' because they have engagements at the barangay-level."	*"One of the drawbacks of the RPRH law on the HIV/AIDS program is the negative awareness on access to condoms… the LGUs became too aware that those 18 years old below are not allowed to access condoms. Because they fear the law... there are certain service providers who have poor confidence in dispensing condoms for FP or HIV. But there are ways to correct this for progressive LGUs with CSO engagements"*
Respondent 1	*Respondent 18*

Service Delivery. CSOs are also private providers delivering RPRH services, augmenting LGU service delivery. This is especially evident in their distribution of FP supplies, RH counselling, management of women's shelters, and education of community members.

> *"Some CSOs are our partners here in the region. Their main task is to augment service provision and demand generation in areas lacking service providers and demand generators. One concrete example of CSO engagement happens in the [redacted]" - Respondent 16*

Technical Assistance. CSOs offer TA to NIT and NGAs, such as reviewing and developing DepEd's CSE curriculum

> *"There must be a holistic view because you cannot have the curriculum and have no materials to support the curriculum such as lack of trained teachers and monitoring and evaluation system. You have to address all these things after establishing the standards. So, what happened with the CSE, have you heard about LIKHAAN? They convened us some time in 2014 and we crafted the curriculum standards of comprehensive sexuality education using different international references and research based references from UNESCO, WHO." - Respondent 5*

Watchdog. CSOs provide vocal feedback on RPRH implementation, pushing NGAs to deliver on their RPRH mandates or commitments.

> *"Well, the NIT, through its civil society organizations, can help in monitoring and surveillance on the ground: where the money is being used whether the beneficiaries are actually being benefited and they can [give] feedback to the department and to the auditing firms."*
>
> *- Respondent 17*

However, there is a need to **better manage CSO interests** as well as **reconcile the expectations and perspectives of CSOs and NGAs**.

In the NIT, **CSOs play two different roles**. On the one hand, they try to serve as a **macro-level partner in implementation and a third party "watchdog"** to hold NGAs accountable. On the other, they **have their own interests as private providers.**

CSOs sometimes push their own **micro-operational agenda in the NIT**. CSOs see NIT as a **venue to get funding and information** relevant to field operations, such as MNCHN- and FP-related programs, CSO accreditation, and requests for FP commodities or NGA grants.

In one example, CSOs brought up how some LGUs directed 4Ps beneficiaries to public facilities for deliveries because they had PhilHealth reimbursements (39th and 40th NIT meeting). CSOs highlighted that beneficiaries should have the choice to access private providers, and the importance of free market competition. Because of their direct representation in the NIT, which LGUs do not have, they can directly request for support from COs. Their recommendation prompted NGAs to clarify the issue with LGUs.

"The NIT has pros and cons. The pros are the engagement with CSOs, so the needs of CSOs are discussed, and I think that is a really big thing for CSOs. It's a powerful engagement tool for them and at the same time they can raise their concerns. They also get immediately informed about the available budget and services. *The cons are the warring perspectives, it is different for CSOs and it is different [for agencies] … so sometimes there are times when they don't meet eye-to-eye."*	*"They are asking for funding support on the implementation of their different programs related to RH... I think they are pressuring the DOH, but the DOH until now does not have their own accreditation process. But basically aside from having their own funding sources they would like to access the government resources."*
Respondent 1	*Respondent 11*

Because of pushing CSO interests, **some NGA respondents felt that the NIT became a "sumbungan ng bayan"** (English: place to complain or rant), where CSOs give non-constructive criticism and badger NGAs to deliver on commitments immediately. This has resulted in some representatives not attending NIT meetings.

"In the NIT meetings, DOH usually gets verbally beaten up. They always get asked to deliver this and that, especially coming from the CSOs."	*"We used to have monthly meetings and you would have an NIT checking on progress. DepEd always gets asked about their progress … She [NIT chair] really uses her influence to whip up people … It seems like they do not want repetitive follow ups."*	*"The goal of the NIT was really good, it was to be a coordinating body because all the agencies are there. But what happened eventually to the NIT was it became a place for complaints and grievances. No, it's true. It's a place for CSOs to question or rant about why regulations are like [this and that] … it's a very big group and each and every meeting what happens is issues are brought up over and over again, but we haven't been able to talk about strategies."*
Respondent 1	*Respondent 3*	*Respondent 7*

"I don't like to attend NIT meetings … It stresses me out every time I attend. If the indicators are not good, it seems like it's my fault. They will tell you, you are incompetent, you are inefficient. Do you want to hear those? I don't want to hear those because that is not true….

They always like to rant and to criticize... There's no problem with criticizing if you say it constructively. Every time we meet with them, I am careful with my words because I might hurt them. We are even very careful with our powerpoint presentation. But they will just criticize us carelessly ..

How do we make so that we jive? … I have many colleagues, we do not want to attend. We do not want to sit there because it's like a revalida - one where they shame you.

Why am I being scolded by them [CSOs] when they are supposedly my partners? Why do they insult me when they are supposedly helping me?" Respondent 10

"DOH people feel like they are being dictated during NIT Meetings. Sometimes they are frustrated to the extent that they feel that CSOs are too demanding. NGAs are being overwhelmed by the presence of the CSOs who are sometimes extreme in their stand on certain issues. So yeah CSO`s are a really very critical force in making sure that we implement accordingly stated on the IRR"	*"In terms of the CSE, I think DepEd started to become inactive in the NIT because they always get follow-ups on the CSE. It's also difficult on DepEd's part because they have their own policy to consider... There seems to be bureaucratic processes and this may be worse since the decision maker is not the one who attends. So there are many layers of decision to consider."*	*"The idea of creating the NIT was good. It should be an avenue for the stakeholders to come in together to provide recommendations … But what really happens, it became a venue for partners to air their rants, their complaints, their concerns. So it doesn't seem like a recommendatory policy body."*
Respondent 11	*Respondent 12*	*Respondent 17*

Two factors contribute to the NIT becoming an unconducive environment for coordination.

First, **CSOs expect NGAs to deliver on commitments as quickly as they do. CSOs are detached from the bureaucracy that NGAs must constantly navigate,** with smaller constituencies and smaller organization sizes, without accountability to multiple offices. On the other hand, **NGAs are considerate of each other's context** of multiple mandates, limited resources, and bureaucratic processes.

"If [you are part of] government, it's ok because you understand because you belong to the same bureaucracy, you know the problems and challenges."	*"Before when we had monthly meetings, they want members to have progress to report. Which is on the part of the government agency member, is really impossible to have an update in the next month… The processes of government are not that fast, as much as we want to give it, we are not able to give it immediately."*
Respondent 1	*Respondent 11*

Second, **CSOs and NGAs have different constituencies**. NGAs must oversee programs for the entire country, while CSOs work closely with individuals and communities.

> *"For civil society there is a difference because, for example, they cater to a small barangay. Of course, they can do what is very ideal because it is only one barangay… We manage for the whole Philippines. There are differing personalities, we talk to different stakeholders. There are those that are hard to get along with, there are also easy ones." - Respondent 10*

CSO reactions to two DOH programs highlight the difference in perspectives:

- In **MDRs**, DOH licensing requirements for birthing centers included having ambulances because it is critical to ensuring mothers reach hospitals quickly in emergencies. CSOs protested in the NIT that this was a restrictive policy since facilities in poor LGUs or GIDAs would not be able to afford an ambulance.

- In the DOH MNCHN Strategy Manual of Operations (2009), the management of septic abortion could be done in Basic Emergency Obstetric and Newborn Care (BEmONC) facilities. BEmONC facilities are upgraded barangay health stations, rural health units or district and community hospitals.

  However, DOH AO 2018-003 on **prevention and management of abortion complications (PMAC)** only allows this in Comprehensive Emergency Obstetric and Newborn Care (CEmONC) facilities. CEmONC facilities are secondary or tertiary hospitals (e.g. departmentalized district, provincial and regional hospitals). CSOs argued that poor women would have a hard time accessing services from hospitals (NIT 42nd, 62nd and 66th meeting).

In both cases, DOH and CSOs had the same interest**,** to protect mothers. However, the lack of expectation-setting and conflict management led to straining their relationship. **Such incidents within NIT hamper collaborative problem solving between the public and private sectors**.

> *"CSOs and government have somewhat different natures… that's why you have to agree that, yes we need to implement RPRH, but there will be differences sometimes. At the end of the day, our goal in the NIT is to implement the law. We will all see each other at the finish line."*
>
> *- Respondent 1*

POPCOM. POPCOM has had the same Executive Director since 2013 and has avoided the inconsistent RPRH priority accompanying repeated leadership changes.

Because its highest office promotes RPRH and represents the agency in NIT meetings, POPCOM has become a leading figure in RPRH implementation. Aside from intensive efforts for its home programs, POPCOM has been **working closely with NGAs to help them fulfill their RPRH mandates**.

POPCOM has done this in three major areas: Financing, Coordination, and Stewardship.

Financing. **Table 17** in the Financing section presented POPCOM's financing contributions, such as augmenting DepEd's CSE for special populations, funding DILG regional staff orientations for ASRH projects, and even offering transportation to NIT members to attend the orientation for the newly developed PME Guide.

"POPCOM would convene us for budgeting for RPRH. Actually, they gave us [redacted] million last year, but we weren't able to use it. I think it was called a convergence meeting."	*"Because like for the RH law, POPCOM gives us funding."*	*"We can access funding support from POPCOM for training. It is a very big thing that our USec sits [in the POPCOM Board of Commissioners] because he/she is able to talk directly to Doc Jeepy [Dr. Juan Antionio A. Perez III]."*
Respondent 5	*Respondent 6*	*Respondent 20*

Coordination. POPCOM has utilized its Board of Commissioners (BoC) to expedite coordination for RPRH activities. POPCOM's BoC is chaired by NEDA's Director-General and includes the department secretaries of nine other agencies (DOH, DILG, DOLE, DA, DAR, DepEd, DSWD, DTI, DPWH), five of which are also NIT members.

- Through the BoC, POPCOM and the SoH worked out the creation of the NIT/RITs.
- With DILG, DOH, and DSWD in the BoC, POPCOM was able to revise the pre-marriage orientation and counselling guidelines to better align with the Family Code and PD 79, formalized in DILG-DOH-DSWD-POPCOM-PSA JMC 2018-01.
- POPCOM also used the BoC as an opportunity to insert orientation for RPFP into other NGA programs, like orientations for NGA employees, fisherfolk and farmer folk beneficiaries of the DA, and overseas Filipino workers through DOLE.
- POPCOM used the BoC to ask for DSWD's inputs on RPRH-related policies since the latter is not a regular attendee of NIT meetings.
- It was POPCOM who approached DILG Secretary Eduardo Año to allow NGAs to accredit their CSO partners using DSWD guidelines to expedite the process. POPCOM has since created a centralized system to accredit and provide grants to its CSO partners working on RPFP.

Stewardship. POPCOM has cultivated a reputation as a leader for RPRH. The POPCOM Executive Director has served as the NIT's vice chair and head secretariat since it was created. POPCOM has dedicated staff in the NIT and RITs. POPCOM chairs or co-chairs three NIT TWGs and is a member in three others (review **Table 9** in Presence, page 32). Alongside DOH, POPCOM pushed the NIT to resolve the Sorsogon case (review **Box 9**, page 12) by coordinating with DILG,

DOH, and CSOs, leading up to the Executive Director directly speaking with the mayor during a conference (NIT 35th meeting).

POPCOM's role as a steward for national implementation originates in its taking initiative. Even prior to the formalizing of its co-management role for NFPP in DOH-NEDA-POPCOM JMC 2019-01, POPCOM had already been assisting DOH in NFPP operations (**Table 22**).

In particular, POPCOM tried to address DOH's difficulties in supply chain monitoring and limited manpower for community-based demand generation.

Table 22. POPCOM Initiatives for the NFPP (2014 - 2018)

Year	POPCOM's Initiatives for NFPP
2014	Assisted DOH in drafting the AO for the creation of NIT and RITs
2015	Assisted DILG on the conduct of data appreciation workshops in LGUs Assisted DSWD in revising the FP module of FDS Conducted FP demand generation activities for non-4Ps clients Contracted FriendlyCare and PSPI to link demand generation with service delivery Collaborated on FP communications planning in partnership with WHO
2016 (TRO)	Established FP Logistics Hotline to address overstocking and stockout problems Formed a joint proposal with DOH-FHO on sharing of funds Engaged CSOs for FP demand generation among service providers Assisted DOH in reimbursing expenses related to the provision of implants Co-created the costed implementation plan for FP with FHO, ZFF, and UNFPA Established RPFP Online System for RHUs and CSOs to access the list of Unmet Need Proposed the creation of TWG for Legal to address bottlenecks in FP Conducted a signature campaign to lift the TRO Oriented RITs on RPRH M&E Lobbied for EO12 at the Executive level to counter SC TRO
2017	Augmented HR gaps by prioritizing CSO funding in LGUs with no local population office Conducted IPCC trainings with FHO, Change Project, and USAID Funded FDA to hire consultants to expedite the recertification of contraceptives Helped DOH in FP demand generation and service delivery in NCR LGUs with low CPR
2018	Developed criteria for assessing RITs and TA that NIT could provide them Conducted FGDs and KIIs with RITs to assess their functionality

Source: NIT Minutes 2014-2018

DOH and POPCOM divided their NFPP roles in the JMC based on their strengths. DOH has **technical expertise and budget to procure,** while POPCOM has **manpower and a strong presence in LGUs**. Thus, DOH agreed to focus on high-level strategy, standards, and procurement, while POPCOM took demand generation, distribution, and monitoring FP stock.

Region 3	"POPCOM was tasked to coordinate ahead of time with DOH CHD, DOH Hospitals and Provincial/HUC FP Coordinators regarding FP-related initiatives to determine the support that can be extended by concerned stakeholders, DOH CHD was also tasked to prepare the allocation of commodities while POPCOM will distribute the commodities at the provincial level. POPCOM Logistics Officer to closely coordinate with Provincial/HUC FP Coordinators."
Region	"POPCOM was tasked to assist DOH in the delivery of FP commodities, and to provide a copy of the number and the type of FP commodities delivered directly to Rural Health Units

4a	(RHUs), the Provincial Health Offices (PHOs) and the Provincial Health Team Offices. FP Logistics Coordinator of POPCOM IV – CALABARZON was also tasked to coordinate the pick-up and distribution of said FP supplies (PSI and COC)."
Region 5	"FP commodities that were delivered by DOH CHD to the Provincial Health Offices, it is the respective RHUs that pick up their supplies. POPCOM V will assist in the delivery of the supplies to Geographically Isolated and Disadvantaged Areas (GIDA)."
Region 6	"CHO and MHO representatives raised the issue on the low turn out of FP reports from Health. Suggesting that population workers trained by POPCOM to help monitor and submit quarterly FP commodity report. She stressed that it is better if the BHW is the BPV as well."
Region 12	"DOH pharmacists assist in ensuring proper inventory of FF commodities for now. But there is a concern however, on their sustainability according to a PHO. DOH XII asked if it is possible that the role of Regional FP Logistics be cascaded to the provincial population

Source: RIT minutes, quarter 4 of 2019

All these are commendable and show how committed POPCOM is in championing RPRH implementation. However, their stewardship role can be improved.

First, **POPCOM has no formal accountability for the FP supply chain.** Only DOH is accountable to the COC and OP for the performance of the FP supply chain. POPCOM has courtesy accountability to DOH but is no longer part of DOH.

Second, the **division of labor between DOH and POPCOM for the NFFP fragments DOH's FP functions and adds another layer of bureaucracy during coordination.**

"It starts with the joint memorandum circular ... So there are two columns there, the role of DOH and the role of POPCOM, but in some instances there are gray areas... So sometimes POPCOM is doing the role of DOH like profiling ... and in some cases POPCOM is also doing the role of the DOH side like providing the services. *So in some instances they cross the line of borders and that creates confusion at the local government level. So even at the level of the regions sometimes those delineations are not clear, ... So unless they are really clear directives from the national level. The way to do it is there are now discussions among the RDs to make sure that they clarify the roles and of course with the mediation from the central office."*	"*In the region our relationship with POPCOM is very good, we don't have any issues in the implementation - maybe it's different in the central office ... We also talk about the implementation roles of our offices and understand our respective roles. There's confusion in the LGUs, because of shared responsibilities. At the LGU level, the boss of the implementers are the LCEs. However, there are delineation issues. For instance, a program coordinator would say they are accountable to DOH, one coordinator would say they are accountable to POPCOM. So we correct that when we go to the LGUs. We tell them that they are not DOH nor POPCOM but they are LGUs implementing the programs of these two agencies with their direction and standards."*
Respondent 11	*Respondent 16*

The **artificial delineation of roles** has also caused confusion in LGUs such as dual lines of reporting for FP (see **Table 23** on page 91 in Monitoring and Evaluation). Some examples are:

- **Population officers with dual roles.** Some population officers are also health workers who must implement and report about both DOH and POPCOM's initiatives.

- **No units to lodge population officers**. Some LGUs did not know where to house their population programs and officers when POPCOM moved to NEDA (CAR and Region 6 RIT, 2019)
- **Unclear Provider of Training**. A number of RITs (Region 6, 5, 12) sought clarification on who should be providing the TA for monitoring and reporting of FP supplies.
- **Unclear Responsibility for Financing**. Region 6 LGUs requested computers for FP monitoring. DOH and POPCOM ROs have yet to discuss who would shoulder the costs (RIT minutes, 2019)
- **Lack of technical staff in POPCOM for responsibilities.** Provincial population officers objected to POPCOM's tasks of monitoring and evaluating the skills learned by FP service providers in training, because POPCOM lacked the technical expertise to do the task, especially staff without health backgrounds (Region 12, 2019). Region 5 sought similar clarifications as this role was done by DOH prior.

Third, the arrangements have led to **confusions about who sets the direction for the NFPP** among stakeholders.

"*The problem was the tension between POPCOM and the DOH. Who really gives commands for RPRH? Well, the confusion is who sets the direction. Even for FP, I don't know if they have settled this already. The POPCOM CPR target is 65 while the DOH target for all women is 20. Of course we are more leaning towards DOH's stance because we agree with evidence.* *For example, when DOH says that the strategy for FP will be in post partum service provision by making sure that patients are counseled on FP, how will POPCOM implement that. Even in ASRH, POPCOM has a problem. WHO says that sexually active adolescents should be given access to contraceptives, but for POPCOM adolescent pregnancies are products of moral degradation ... So these are the messaging and strategies that we don't really know who is in command.***"** *- Respondent 3*

"For health agencies like DOH and PhilHealth ... [they] do not actually want to limit the population. That may not be the case POPCOM and NEDA. But for health agencies, it's health outcomes…"	*"The co-management was viewed by DOH personnel as hand holding because they cannot do their job. That's how they perceived it at first."*	*"I think what happened there why there was a draft executive order giving the family planning program to POPCOM is because they saw that DOH is not doing what they should be doing. They are not meeting their goals So POPCOM will help DOH reach their goals."*
Respondent 8	*Respondent 13*	*Respondent 17*

Fourth, two of POPCOM's flagship programs (RPFP and AHD) and many of its initiatives in teenage pregnancy and GBV are **duplicative of DOH-WMHDD programs.** POPCOM respondents admit that they do not have staff with technical expertise for these programs, and so they need to coordinate heavily with DOH for TA, standards, and guidelines.

POPCOM's approach to population development is highly FP-centric and respondents frequently refer to PD 79 "Revised Population Act of 1971" to justify its role co-managing the NFFP and to expand its role in FP service delivery. This is in contrast to its **move as an attached agency from DOH to NEDA** and where EO 71 in December 13, 2018 named the agency the "Commission on Population and Development" mandated to "formulate and adopt policies on population as it relates to economic and social development."

According to its 2019 Citizen's Charter, POPCOM acknowledges its mandate "to be the central policy- making, planning, coordinating and monitoring agency for the Philippine Population Management Program (PPMP)" [80]. Yet, two of its three major objectives refer to FP and teenage pregnancy. Moreover, POPCOM respondents stated that 60% of the operating budget is for RPFP while 40% is divided between POPDEV, AHD, and GAD.

KIIs reveal that **POPCOM's leadership recognizes its role in population development** (e.g. studying and managing how population trends [e.g. urbanization, increasing incomes, migration] affect economic growth and development) and the conundrum that current operations highly focus on the population management aspect via FP [81]. They cite that this **can be explained by the history of their agency**.

POPCOM was initially mandated from 1967-1971 to be a "central coordinating and policy making body of the government in the field of population [82]." In 1972, its mandate was expanded to manage and deliver the NFFP through PD 79. POPCOM was then attached to different agencies over time: DSWD (1986), OP (1990), NEDA (1991), and then DOH (2003). **Throughout these multiple moves, and during its stay in DOH, the NFFP became more focused on health** and less towards development. Ultimately, POPCOM's resources as an agency for development has not been maximized

Recommendations

(1) Update and make the roles of POPCOM (oversight for population development) and CSOs (link to communities) more strategic.

POPCOM. Given POPCOM's return to NEDA last 2018 and its strength as an agency that can reach other NGAs and LGUs, **it is recommended that POPCOM direct its efforts towards the social and economic aspects of population development.**

POPCOM should shift away from a very FP- and health-focused approach that inadvertently duplicates and fragments DOH programs and functions to **become a policy oversight agency directing, weaving together, and advocating for population development agenda in NGAs and LGUs while accounting for shifting population dynamics and trends** (e.g. demographic dividend, urbanization, migration and mobility, climate change). In this way, POPCOM fills a niche that is distinct from DOH which, by virtue of its mandate, may take a biomedical focus to the multi-agency agenda it leads.

This includes **leaving behind co-management for the NFFP and responsibilities to the FP logistics and supply chain**. Moreover, instead of developing a new parallel supply chain in POPCOM, it may be overall more prudent for the government to invest the funds in overhauling and upgrading existing DOH logistics systems instead. On this matter, DOH is aware that significant reforms in its LMD are necessary.

Formalizing this new role in the RPRH IRR can help POPCOM maximize its strengths and legitimize its activities and assign POPCOM accountability to OP and COC in these areas.

CSOs. The full potential of CSOs as national and local partners for RPRH implementation and representation remains untapped. In particular, the following need to be resolved in NIT:

- **Conflicts between NGA and CSOs** in expectations and perspectives which include ground rules and norm setting for delivering feedback and openness to compromise.
- **Lack of clarity of CSOs' role in the NIT** such as expectations on what can be discussed in NIT meetings (i.e., not micro-operational aspects of field implementation) and what macro-level input is expected for CSOs who attend NIT meetings.
- Management of **CSO interests** such that they do not use the main NIT meetings, for example, to persistently push their agenda (e.g., FP, acquisition of resources). CSO issues can be first synthesized by CSO representatives and handled in appropriate TWG venues or existing NGA mechanisms.

In general, the **strength of CSOs for RPRH implementation is in their strong ties to communities and their flexibility as small and private organizations** to better respond to the needs of their localities. They provide insights that NGAs do not always have about implementation from the perspective of target clients.

Two **strategic roles** for CSOs to take advantage of these strengths could be:

- CSOs can help expedite the **development of NGA interventions and make them more responsive to local contexts**. For example, CSOs and NGAs can design interventions (e.g. LCE capacity-building for RPRH) together by building on NGA technical expertise and CSO experiences on the field. Then, CSOs may pilot test these in different LGUs in the country. CSOs may then offer feedback on best practices, nuances of what is applicable in different LGUs, and what the sufficient components of an effective program could be.
- As **watchdog and advocate in local governments**, CSOs play an important role in educating the public and coalition building on the ground which may help generate community demand and accountability for RPRH services in LGUs. It may be possible, for example, to assign certain LGUs to CSOs to build LCE capacity and political priority for RPRH and also assist the NIT in monitoring compliance to RPRH implementation.

On the whole, increasing public-private partnerships with CSOs and collaborating on more strategic initiatives will help alleviate the burden of implementation on the government and may expedite RPRH implementation.

(2) Together with other sectors, DOH and the NIT must develop a unified strategy and operational plan for implementing NGAs and CSOs.

More than an implicit vision, DOH, NIT, and other stakeholders must understand how to operationalize multi-agency efforts for RPRH. So that this task will not be neglected, the IRR may explicitly include provisions to mandate the creation and regular updating of an interagency RPRH strategic and operational plan covering all elements and relevant sectors.

The unified strategy and operational plan need to at least **include the following**:

- An **articulation of how each stakeholder, sector, and RPRH element link together to contribute to RPRH outcomes and impacts**. This should go **beyond the biomedical perspective and address social determinants and social development** (e.g. poverty, culture, behavior).

  For example, other sectors contribute greatly to maternal and child health: It requires education (DepEd) to empower women and men to take care of themselves and access services like family planning (DOH). Planned families can help couples have productive careers and there is a need for family-friendly policies in businesses and governments (DOLE). Steady income and a safe environment can then allow families to invest in the health and welfare of their children which then may collectively reap long-term benefits for social development (NEDA).

- A **vision of the integrated and comprehensive service delivery from a client's perspective** across the life course. This includes defining the menu of RPRH services that must be available at the LGU level.

- **Strategies, goals, and priorities** that maximize agency mandates and strengths to be able **to achieve the vision.** This should go beyond individual programs and **include support systems and inputs** (e.g., financing, monitoring, human resources).

- A plan on how all this will be **operationally linked and delivered** at the LGU level. For example, how referrals between DOH, DSWD, CSOs, and DepEd should occur if they were key players, in say, identifying VAWC in school settings.

Box 10 below highlights the essential components and proposed steps in developing a multi-agency strategy and a cohesive package of interventions for RPRH.

The result of this process could be a **5-year multi-agency roadmap which provides a general idea of each implementer's interventions**. NGAs can then take this road map to develop their own agency-level plans and move towards the **deployment phase** where they design **specific programs**, timelines, metrics, earmark staff and resources, and develop manuals and tools for LGUs. Agencies can then regularly report progress to the NIT, which can work to consolidate the programs for coordinated roll out to LGUs.

Box 10. Proposed Process of Developing Multi-Agency Interventions for RPRH

The **following elements and steps in making a roadmap** can ensure stewardship and operations are steered towards meeting RPRH goals and objectives. Throughout this cycle, data must be collected and gathered to inform the next implementation cycle [83, 84].

1. **Clearly defined goals, priority areas, and strategies.** It must be first clear to agencies what the end goal and priority problems are and how they can be achieved.
    a. Identify **boundary conditions** or the scope to be covered. For example, since there is a dedicated law, strategic plan, and council for VAWC, what aspects of VAWC will RPRH operations cover to avoid duplication?
    b. A **situation analysis** must be done to have a better understanding of NGA and stakeholder mandates, strengths, weaknesses, and current status of RPRH in different sectors.
    c. Further research must then be taken to understand the **main causes** underlying weaknesses in outcomes, including how outcomes vary by geography or socio-demographics and how these **trends may change over time**.
    d. From this, **priority areas and populations** can be identified. This is important in the context of limited funds for RPRH. This way, RPRH progress is holistic across elements and the NIT can direct its focus to investments that have system-wide, long-term gains.
    e. **Goals and targets** can then be set both in the long-term and medium-term with respect to the RPRH elements using a proper **logic framework**.
    f. **Agencies and actors** that should be involved in implementation efforts can be identified along with assigned roles, needed resources, and accountabilities.
2. **Common points for collaboration and intervention.** Agencies need to find venues to mutually address specific RPRH priorities and identify points of contact in service delivery.
    a. NGAs need to **catalogue and analyze all existing RPRH efforts and resources**, including but not limited to financing, workforce, stewardship, coordination, monitoring and evaluation. Here stakeholders must have a common understanding of each other's service delivery points and operations from the central to LGU level.
    b. The NIT must then **gaps where additional RPRH activities or resources are needed** and **which agencies have mandates that closely align with these**.
    c. The information from 2a and 2b can then be used to identify **which agencies could work together to mutually address specific RPRH priorities**.
3. **Develop comprehensive and integrated interventions.**
    a. **Interventions must then be clearly defined** among all stakeholders, evidence-based, and include their short-term goals and how these contribute to overall RPRH outcomes.
    b. **An RPRH package or menu of services** that can be adapted based on context can be designed and marketed to LGUs for full RPRH implementation. This package will include all of the services identified in the previous step 2.
    c. **Monitoring and evaluation and research agenda** should be integrated from the start of interventions to tweak interventions and operations or develop new ones as necessary to meet client expectations and needs.

(3) Strengthen the NIT's presence and role in stewardship and coordination, and do not reduce it to a policy advisory body.

As KII respondents note, there is a need for interagency collaboration and innovation. The **NIT should not be reduced into a policy advisory body**. If its problems are addressed, it can be a strong **tool that can manage the macro-vision of RPRH** implementation in the country, spurring different sectors to action, and ensuring that goals are accomplished in an integrated manner .

First, it must **level off with all members that the NIT *is* a stewardship and coordinating tool** and align the perceptions about this role. The NIT in this capacity can serve to coordinate both **operations and policies** and uphold interagency **accountability for implementation**.

The NIT **should not be addressing micro-operational issues on an ad-hoc basis**. Those that can be resolved within an agency alone should be left up to them. The NIT must have **clear, pre-planned meeting agenda**. **Attendance of high-level officials** who have the ability to decide on agency commitments must be guaranteed as much as possible in the specific meetings that require their presence (based on the pre-planned agendas).

There needs to be **expectations setting on what representatives must contribute** and what pre-work needs to be done before meetings. This can be based on maximizing the strengths and mandates of members with attention to bringing dormant NGAs into the foray. For example, the stakeholders below can be primarily **responsible for the following inputs in the NIT:**

- DOH - Lead for technical matters in health interventions.
- POPCOM - Lead in technical matters for population development in NGAs and LGUs.
- PhilHealth - Lead in creating and designing the pipeline of benefits for the comprehensive package of RPRH services.
- DSWD - Lead in VAWC and poverty alleviation.
- PCW - Lead in identifying and advocating for RPRH legislative agenda.
- DepEd and CHED- Lead in integrating RPRH in schools (curriculum development and provision of education)
- TESDA - Lead in vocational programs and opportunities for teenage parents.
- CSOs - Lead in advocacy to LGUs, Congress, and the Executive.
- Multilaterals - Lead in mustering donor funding and filling gaps in TA.
- Academe - Lead in developing and carrying out multi-year research agenda.

These are just a few suggestions and they may be better refined by the NGAs themselves after a careful study of their mandates and how they think they can best contribute to the NIT.

Lastly, **NIT should be provided with the resources and accountability to undertake the roles required of it.** The NIT needs **policy infrastructure** where the modified NIT and its responsibilities can be mandated in the IRR, expanding the initial provision (Section 4) that NIT reports annual accomplishments to the OP and COC.

The NIT should be equipped with **human and financial resources** (e.g. dedicated NIT secretariat and budget) to cover its original mandates (e.g. M&E for the impact of the law and creating UWFPs) and any new functions (e.g. creation of research agenda, coordinating plans of various agency units for implementation, synthesizing RIT challenges from the field).

(4) DOH and the NIT need to develop strategies and interventions for engaging and securing buy-in of other sectors/agencies and LGUs.

The continued buy-in of each NGA is a necessary prerequisite for RPRH implementation. After a roadmap is developed by the NIT and its members, DOH and other sectors can more clearly see how they fit into national RPRH implementation. However, DOH and the NIT **must not be complacent and be aware of their tendencies towards health imperialism.**

Health imperialism is a concept in global health literature where the health sector approaches the multi-sectoral initiatives it leads in a siloed manner, focusing on a particular condition or health service (e.g., FP) [73, 85, 86]. The health sector assumes that health interests predominate and if other sectors are aware and educated on their role, they will be motivated to prioritize health despite not having accountabilities for health outcomes.

This means that **just because there is the RPRH law, IRR, or a common framework, LGUs and other NGAs may not automatically see the value of RPRH in their sectors.** Given changes in leadership over electoral cycles, maintaining stewardship in various NGA CO, ROs, and LGUs entails **systematic advocacy to "sell" RPRH to all stakeholders.**

Such advocacy may necessitate **routine interventions such as:**

- Leadership and interpersonal skills training for DOH staff to be able to manage multi-sectoral collaborations and stakeholders' interests,
- Political mapping and stakeholder analyses,
- Developing tailored communication plans that frame RPRH benefits from the point of view of incumbent NGA and LGU leaders (using political and stakeholder research),
- Capacity-building and succession planning for RPRH in NGAs and LGUs after electoral turnovers or leadership changes.

(5) Investments and innovations in communication channels can greatly improve coordination efforts between COs, ROs, and LGUs.

The fragmented push of NGA programs and messages down parallel communication channels and administrative levels needs to be addressed. Channels need to ensure messages reach their intended recipients accurately and in a timely manner - from COs to LGUs and vice versa. Moreover, ensuring information reaches LGUs and that LCEs understand the information should be part of program priorities at the CO and RO levels whenever new directives are released.

One area for improvement is **streamlining content for communication**. For example, DILG can be an efficient channel for communicating to LGUs if the messages are at a manageable volume. Instead of sending multiple MCs per program, NGAs can consolidate related policies into a coherent omnibus. RPRH services across NGAs can be introduced as a **comprehensive package of services with omnibus guidelines and training** making it easier for ROs to communicate to LGUs and LGUs to digest as a basic social service.

As face-to-face orientations and workshops are usually resource-intensive (e.g., time, staff, funding), **new information communication technologies can be used** such as e-platforms, e-explainers, cloud storage platforms, and online courses. These can be reused over time with

minimal revisions and can track which LCEs have completed orientation. Attendees can also submit questions through the platforms and receive clarifications more quickly. NGAs can monitor recurring LGUs' issues through text analysis technology.

6. Feedback Mechanisms

6.1. Monitoring and Evaluation

Monitoring refers to the collection of information on implementation activities [87]. These include data on **inputs and outputs** such as finances, equipment, supplies, and activities. **Evaluations** take place periodically with the goal of understanding why and how implementation has succeeded or failed. Evaluations look at **outcomes and impacts** associated with inputs and activities, focusing on whether goals are achieved. Together, M&E allows managers and decision makers to **resolve issues as they occur** and **inform future changes** in how inputs and outputs must be adapted to better achieve overarching goals

This section discusses findings on **M&E mechanisms** for RPRH implementation across NGAs, including:

- **Frameworks** and indicators to direct implementation of goals,
- **Mechanisms** to collect data to track progress in inputs (e.g., policies, financing) and resulting outputs (e.g., RPRH guidelines, programs, activities), and
- **Analyses** and use of data to measure overall progress in implementation

Overall, M&E is an important **feedback tool and key input to accountability.** It helps evaluate if organizational structures, budgets, workforce, stewardship, and coordination activities are effectively and efficiently directed toward RPRH performance.

(1) The PME Guide is the official interagency M&E framework for the RPRH law. However, its indicators are presented more as a checklist to be completed, without a unifying framework and theory of change across NGAs.

The PME "tool for the NIT and RIT to carefully evaluate the different programs and projects of various implementing partners in the country" [88] as well as harmonize activities, simplify reporting, and address challenges of implementation. It was envisioned by the NIT to be the "steering wheel in the attainment of the 2030 Agenda for Sustainable Development" [88].

At the core of the PME is the **RPRH Law Results Monitoring and Evaluation Framework** (**Figure 9**). The structure of the PME follows a **logic model** attempting to map out and show how inputs and outputs link to desired RPRH outcomes and impacts.

The PME guide and framework **focuses on five (5) KRAs:** (a) MNCHN, (b) FP, (c) ASRH, (d) STI and HIV/AIDS, and (e) GBV. Outputs and outcomes are tied to meeting these impact indicators, such as *accessible CSE and ASRH services* leading to *later sexual initiation and use of protection at sexual initiation*, ultimately to reduce *adolescent pregnancy rate.*

Monitoring. The development of M&E strategies and tools was mandated in the RPRH law and IRR (section 12.01.o). The NIT requires member NGAs to submit **Work and Financial Plans (WFP) quarterly and ARs** (**Figure 10**) annually.

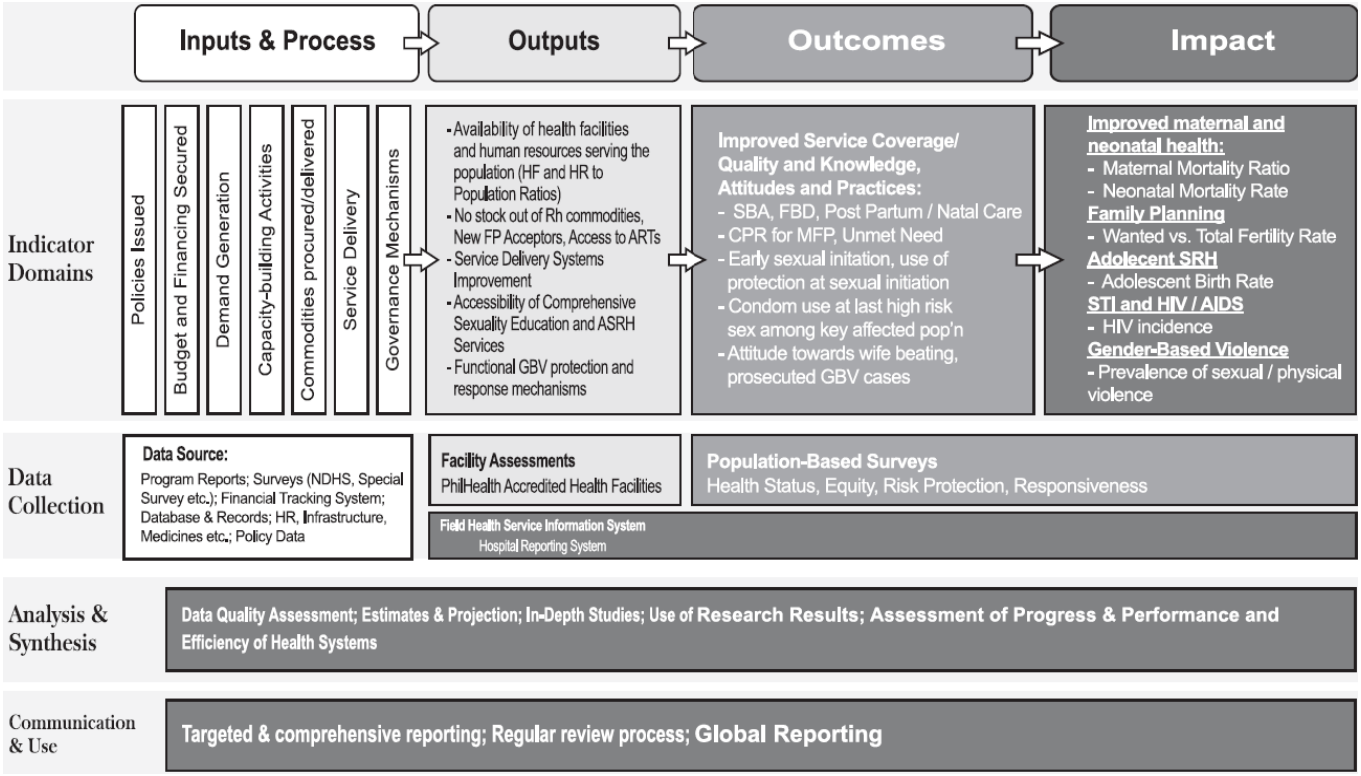

Figure 12. RPRH Law Results Monitoring and Evaluation Framework

Source: RPRH PME Guide, 2015

NATIONAL/REGIONAL IMPLEMENTATION TEAM FOR RESPONSIBLE PARENTHOOD AND REPRODUCTIVE HEALTH
WORK AND FINANCIAL PLAN FOR (Year)

NAME OF AGENCY/ORGANIZATION_____

Program/Activities/Projects under Key Result Area _____ (1)	Accomp. (2b)	Time line (quarter) (3)				Budget and Financing Secured			Coverage of Project *(Regional, Local, please specify provinces or localities if possible)* (5)	Bureau/Div. / Office to report (6)	Remarks
		1st	2nd	3rd	4th	Budget Alloc. (4a)	Budget Expend. (4b)	Budget Source (4c)			
A. Policies Issued											
B. Demand Generation											
C. Capacity Building Activities											
D. Commodities procured/delivered											
E. Service Delivery											
F. Governance Mechanism											
G. Others											

Figure 13. Template for RPRH Accomplishment Report

Source: RPRH PME Guide, 2015

To note, the **PME guide was developed by the NIT's DOH and POPCOM in 2015**. This means that by the time the PME was published, implementation had already begun in several agencies, and systematic, multiagency M&E was not placed into the design of RPRH implementation from

the start. Ideally, M&E should have been made at the design stage of implementation and integrated into the backbone of the entire operations [87].

Looking closely at the PME guide and framework, there is **no clear unifying theory of change (ToC) that shows how each RPRH element and stakeholder (i.e., NGAs, CSOs, LGUs) link together to contribute to RPRH outcomes and impacts.** Inputs and processes measured in the PME framework are not anchored on an explicit strategy to achieve impacts **nor is there a multiagency roadmap of expected progress and achievements** - reflecting the weak stewardship for overall RPRH implementation.

The **required reports and input/process indicators reflect the lack of underlying strategy and unified operational vision**. **The indicators are broad and do not have specified owners**. As such, there is no clear expectation for what NGAs should actually accomplish for RPRH implementation in their sector and by when.

The first column of the accomplishment report highlights the idea that all NGA RPRH activities must **respond to a specific KRA** (**Figure 10).** This has two important implications.

- First, the **focus of an NGA's implementation is left up to individual agencies**, which may make them **prioritize efforts on certain KRAs**. Although the PME certainly allows for activities which fall under "other" RPRH elements, the current system sends a message that the five (5) KRAs are the priority despite there being 12 RPRH elements.
- Second, this reinforces the **silo-ed and programmatic way of thinking about RPRH implementation** even when the RPRH elements are deeply interconnected and progress in one element may require progress in several others.

Input/ Process		
Pillars	Indicators	Target
Policies Issued	No. of national and local policies supporting and hindering ASRH services	Executive Orders, Administrative Orders, Memorandum Circulars, Ordinances, etc.
Demand Generation	No. of municipalities conducting IEC activities on ASRH	All municipalities
	No. of adolescents reached by IEC activities on ASRH	
Capacity Building	No. of municipalities w/ trained health service provider on ASRH (AJA, Healthy Young ones)	All municipalities
	No of schools with trained guidance counsellor on ASRH	All Public High Schools
	No. of schools w/ peer educators trained on ASRH	All Schools
	No. of municipality w/ peer educators trained on ASRH	All municipalities
	No. schools w/ personnel trained on CSE	All Schools
Commodities Procured	No. of RHus w/ no stock out of iron supplement for girls	All RHUS
Service Delivery	No. of adolescents who availed of ASRH services (disagregated by number referred by peeer educatior)	
	No. of Municipalites w/ adolescent friendly health facility based on DOH standards	All Municipalities
Governance Mechanism	No of Provinces with functional SDN for ASRH information and Services	All Provinces

Figure 14. Input and Process indicators for Adolescent Sexual and Reproductive Health
Source: RPRH PME Guide, 2015 (page 39)

Evaluation. Gathered **monitoring data and produced reports** (i.e. annual accomplishment reports) have **limited use in planning or taking corrective action.**

The second column on the **accomplishment report** is to be filled out with "the objectives [from column one] translated into measurable and/or quantifiable results." The **measures and indicators are supply-side in nature** (see sample for ASRH in **Figure 11**). Therefore, the targets being met are based on **activities of the implementers without counting quality of progress or acknowledging what the outputs are oriented towards.** For example, instead of counting the number of policies for ASRH services, a better indicator could be the number of LGUs with policies that have a plan, allocated resources, and identified services for ASRH.

Part of the problem lies in **difficulties in data collection and data analyses**. It has been noted that there are **noncompliance and partial or untimely submissions** of WFPs and ARs in LGUs See **Table 23** for reasons compiled by RIT.

Table 23. Reported difficulties in compliance to submissions for RPRH monitoring

Problems	Reported Causes
Governance	Irregular participation of DILG in some RIT Role of DILG in monitoring LGU compliance is not clear Provincial implementation team not functional One province requires data privacy clearance
Lack of dedicated unit or personnel for RPRH reporting	Province-level No designated person in the provincial health office to consolidate/follow-up No deployed DOH Family Health Associates or POPCOM officers City/Municipal-level Lack of staff to consolidate reports from facilities No local population officer or permanent RPRH focal person LGU does not know which unit to lodge RPRH in
Difficulty in accomplishing M&E forms and templates	Different understanding of indicators that result in prolonged data validation Definition of unmet need, new acceptor, demand generation activities (e.g. number of people reached vs. number of events) Calculation of CPR: multiplier, Women of reproductive age (WRA) vs Married women of reproductive age (MWRA) Inclusion of some LGUs of indicators not aligned with PME Revisions mean reports must go through consolidation and approvals process again from city/municipality to province to region. Health workers lack of training Limited data management skills in province Lack of training on standards (ICD-10) and M&E processes Non-medical staff sometimes assigned to RPRH
Multiple reporting systems, templates, and forms	Separate reporting to FHSIS (DOH), POPCOM RPFP Online System, POPCOM Data Capture Form FHSIS unable to fully capture data of patients going to facilities Health workers confused on what forms should be accomplished: Annual WFP, quarterly ARs, data capture form, EO 12 reporting matrix DOH FP Logistics report and POPCOM Logistics report DOH FP form 1 and POPCOM RPFP form

Source: RIT Minutes 2015-2020

Hence, it is difficult to calculate performance indicators given that the collected data may not provide a full picture of RPRH implementation in the country. The volume of **reports and limited human resources** also mean that the monitoring **data cannot be analyzed in detail** to generate in-depth insights to feedback to NGAs and LGUs, making it hard to evaluate if activities of NGAs and LGUs are contributing to the desired impacts.

> *"It's saddening that every year you see that the data is incomplete. If it was just complete, then it would be so nice to be able to say that at least 90% LGUs have been implementing RPRH. But you can't say this because you can't see it in the data.*
>
> *In the targets, it's written that 100% of LGUs should have an accredited facility. But how do you get the percentage if there is no submission. So if you look at the RPRH annual reports, what is written is that two provinces; we can't put the "4 out of 81 provinces". It's so ugly, right? … We make the universe the number who implement instead. But for monitoring, it would have been nice to evaluate the performance out of the 81 provinces or out of the 1,600 municipalities … So out of the 81 provinces, how many can give the full range of RPRH services." - Respondent 9*

The **RPRH Annual Accomplishment Report** has become more **a list of accomplishments** of whatever was submitted to the NIT secretariat**.** This report is **not able to give a direct indication of RPRH progress or performance**. For example, the NIT is mandated to review expenditures

for RPRH in all member agencies, but the ARs primarily report expenditures for select DOH programs, POPCOM, and PhilHealth. Given these challenges; however, it is still **commendable that the NIT is able to process the data to some extent to identify key challenges and recommendations for RPRH**.

LGU Reporting. For these reasons, the **PME and its required reports are treated by** agencies and **LGUs as a reporting requirement rather than a planning tool.** DILG, POPCOM, and DOH highlighted the difficulty of their roles in monitoring RPRH compliance. A few people with many responsibilities are unable to constantly follow-up and process the data.

> *"What we tell LGUs when we orient them on reporting is that they do the reporting not just to submit something, but for planning purposes. Because if they will just do the report to submit to us, that would not be effective… If they do the report they can track their progress towards implementing their annual operations plan. That is what we are telling them, but* ***they still have not internalized it*** **(emphasis added). -** *Respondent 9*

Another reason is that **"compliance"** to RPRH implementation for LGUs is not clearly defined, and there is **no roadmap for LGUs on what should be accomplished** in terms of RPRH service delivery. Lastly, DILG is only able to **measure whether or not reports have been submitted** (i.e., Yes/No monitoring indicator) as it does not have experts in RPRH and do not have a complete grasp of what must be monitored.

Emerging and Recurring Challenges. Should issues arise in implementation, there are **no systematic protocols to investigate or conduct research to resolve them**. Based on NIT meeting minutes, issues are brought up and resolved in an ad-hoc manner.

The PME guide also does not stipulate how feedback and learnings from these challenges can be documented and institutionalized in NIT or NGA operations. This can be one reason why challenges and recommendations listed in the RPRH ARs repeat. Examples of recurring challenges in governance are not having a unified vision for RPRH implementation and the duplication of reporting systems (see **Table 23**, page 91 in Monitoring and Evaluation section for more details) which are not discussed much in NIT meetings.

In summary, NIT M&E and the PME guide suffer from what the World Health Organization (WHO) identifies as four failures that reduce the impact of stakeholder activities [89]:

- A "**conceptual failure**" occurs when stakeholders are not provided a means to understand how their actions fit into the ToC or causal model.
- This leads to a "**delivery chain failure**," since activities are not always in line with desired impacts and "do not reach the actors intended across sectors."
- "**Control strategy failure**" then arises with the inability to hold different stakeholders to account for outcomes.
- Ultimately, there is a "**public health system failure**," since the data being collected does not directly translate to improving RPRH implementation, and implementers are unable to "develop the competencies needed to govern" to implement the RPRH law."

(2) Agencies also have their own M&E systems for their programs. There are good opportunities for integration and harmonization to remove duplications, bottlenecks, and unclear processes in NGA and LGU reporting.

Each NGA has M&E and data collection systems for its priorities and programs. There are, however, often **duplications among NGAs**, which consequently generate **duplicative reporting requirements and inefficient parallel reporting schemes for LGUs**.

For example, due to some problems with the timeliness of DOH's field health service information system (FHSIS), the POPCOM secretariat created a separate data capture form for LGUs in 2015 to meet deadlines for the RPRH ARs every April 30th. Moreover, DOH programs sometimes collect their own (unofficial) program data through regional program coordinates, separate from FHSIS. There were also issues in DOH and POPCOM having two separate forms with similar content to register couples with unmet need for FP in LGUs.

To be fair to the agencies, data management and harmonizing information systems are difficult, resource intensive, and time-consuming. **The NGAs have been moving to share data, improve their information systems, and streamline reporting.** For example, POPCOM and DOH now share data with each other and with CSOs on couples with FP needs to expedite targeting of community-based demand generation and service delivery (JMC 2019-01). DSWD, PCW, PNP, and hospitals have attempted to harmonize their databases for GBV multiple times, but found it difficult to completely remove double counts of cases because of the lack of unique identifiers. Nevertheless, PCW committed to share available GBV data with the NIT in 2019.

Another aspect to note is that the required **RPRH WFP and ARs may duplicate and/or overlap heavily with other required LGU plans or reports** like GAD, the Local Investment Plan for Health, and the Local Development Plan. One respondent stated that **LGUs are overly burdened with reports** and may spend more time filing reports than implementing programs. LGUs are, in fact, mandated to submit at least 33 plans to various NGAs (**Table 24**). Those highlighted in the table below represent reports related to RPRH elements which could be integrated with RPRH reporting to reduce the reporting burden on LGUs.

Table 24. Local Plans mandated by NGAs

NGA Mandated Plans	Other Sector/Thematic Plans
1. Action Plan for the Protection of Children	1. Nutrition Action Plan
2. Aquatics and Fisheries Management Plan	2. ICT Plan
3. Annual Culture and the Arts Plan	3. Local Shelter Plan
4. Anti-Poverty Reduction Plan	4. Plan for the Elderly
5. Local Coconut Development Plan	5. Plan for Health and Family Planning
6. Local Diseases Risk Reduction and Management Plan	6. Coastal Management Plan
7. Food Security Plan	7. Information Strategy and Management Plan
8. Forest Management Plan	8. People's Plan
9. Gender and Development Plan	9. Business Plan/Strategy
10. Integrated Area Community Public Safety Plan	10. Capacity Development Agenda/HRMD Plan
11. Local Entrepreneurship Development Plan	11. Transportation Management Plan
12. Sustainable Area Development Plan	
13. Local Tourism plan	

14. Small and Medium Enterprise Development Plan
15. Strategic Agriculture and Fisheries Development Zones Plan
16. Solid Waste Management Plan
17. Watershed Management Plan
18. Ancestral Domains Sustainable Development and Protection Plan
19. Plan for PWDs
20. Forest Land Use Plan
21. Local Climate Change Action Plan
22. Peace and Order Public Safety Plan

Source: Sicat et al., 2019 [90]

With the sheer number of reports required by different NGAs, there is also information loss associated with inefficiencies from **multiple lines of upward reporting and layers of bureaucracy from the LGU to COs in a decentralized system**. From the perspective on the ground, an **LGU must report to its provincial office and sometimes directly to NGAs about different things with differing channels, formats, frequencies, and deadlines**. The truncated, understaffed structure at the RO level, and the need for reports to be consolidated by provincial offices, limits the ability of NGAs to acquire data from several LGUs. This leads to reliance on national surveys for data (e.g., NDHS) or slow M&E systems (e.g., FHSIS) which cannot be administered as often as necessary for planning.

Thus, these problems may have contributed to NGAs at the CO level not **having a clear picture of LGU capacity and operations for RPRH**.

Interviewer: So does that mean that you do not know if the RPRH law is being implemented in LGUs? "*No, we cannot say because we do not have copies of the [LGU] UWFP [unified work and financial plan], but if we could get that hopefully from DILG - their AOPs [annual operational plan], there LYMPH Local Investment Plan for Health - and we can identify the programs related to RPRH that we can easy exist. That exists, that really exists because MNCHN, Family Planning."* *Respondent 9*	*"As of now, we have no data yet on the level of participation of LGUs, but we assumed that they have these services."* *Respondent 12*
"There's a disconnect from the national government to the local government. For you to improve your implementation, you need to invest in local government. ... And the national government must be made to go to local governments, so they can see what is the reality. That is really it if they want to be collaborative. It really is that the national government is not immersed in the community. It's embarrassing that they don't know where the poor are, the people they are supposedly serving. *Respondent 15*	

(3) There are innovations and good practices that NGAs have built or encountered that can be adopted to streamline M&E for RPRH.

Best practices for M&E were found on two fronts. First, some NIT members do focus on indicators to track the **quality of progress in implementation** and not merely the number of outputs/activities or presence of reports.

- **PhilHealth** regularly reviews performance commitments to find and solve issues in implementation before these are brought up in multi-agency meetings. This is supported by constant efforts to upgrade their IT systems and solve problems in reporting. Some indicators they focus on are benefit utilization, accreditation, collection efficiency, and turnaround time for claims.
- The **DOH SMP** conducts systematic and regular MDRs to develop better policies and insight for possible interventions. Through these reviews, it was found that a significant number of maternal deaths occurred during the first and the fifth pregnancy. Hence, DOH, through AO 2019-0026, issued guidelines that these women cannot be solely under the care of midwives or nurses but must be attended by physicians and specialists in health facilities capable of CEmONC.
- **LIKHAAN** as a CSO doing grassroots advocacy and service delivery focuses on the quality of RPRH implementation in their communities. These include:
    - Community surveys to monitor community awareness of RPRH rights
    - Tracking if attendance to their educational events led to availing RRH services
    - Monitoring client satisfaction (e.g., waiting time, medicines availability)
    - Evaluating and calibrating interventions to attract adolescents to the clinic

Second, there have been **innovations in data collection** for monitoring reports or indicators.

- **DILG** launched the **Full Disclosure Policy portal version 2** (https://fdpp.dilg.gov.ph/) last year (2019) to better **streamline data uploading from LGUs**. It currently covers fourteen (14) reports, including the Annual GAD AR and the utilization of the "20% of the internal revenue allotments" for development projects.

  Though still under construction, DILG is also trying to make the submitted data more analyzable through an "infographic report" feature that will summarize and visualize the submitted LGU data for interested users.

- **UNFPA** introduced **Lot Quality Assurance Sampling** (LQAS) as a method to measure CPR and unmet need for modern FP in DOH priority provinces, to feed into reporting on implementation of EO 12 on zero unmet need for modern FP (RPRH AR, 2017). LQAS facilitates timely and inexpensive population-based surveys and it can capture both the public and private sector data. It has been increasingly used in other countries to monitor population coverage for RH services [91, 92].

Recommendations

(1) The RPRH PME Results Monitoring and Evaluation Framework needs to be revised as a cross-sectoral framework with a clear ToC based on the multi-agency plan and strategy for RPRH.

The PME guide and M&E framework should be revised ***after a multi-agency roadmap and strategy*** has been cemented (as discussed in the Stewardship and Coordination section). Based on the plan's outlined priorities, envisioned package of services, delineations of roles and responsibilities, and identified avenues for collaborative intervention, the NIT must **synthesize and articulate the underlying ToC** and develop the corresponding **cross-sectoral logic model covering all stakeholders and RPRH elements.**

An explicit **ToC** or causal model for operations gives a **formal analysis of the causes and possible solutions to the problem**. For adolescent pregnancy, a ToC might be that unplanned teenage pregnancies are caused by low self-esteem that decreases ability to negotiate sexual relations, lack of knowledge of and access to RH services, and school retention (**Figure 12**). Moreover, the ToC emphasizes that longer term impact does not end at reducing teenage pregnancies, but at improving productivity and quality of life in adulthood.

A theory-driven **logic model** is then important to map out how interventions (i.e. inputs and processes, outputs) are expected to affect outcomes and impacts [84]. A logic model addressing each concept from the ToC is given in **Figure 13**. The logic model outlines the strategy of peer counsellors and volunteer counsellors and that counselling sessions not only cover RH knowledge but also self-confidence and decision-making skills. The monitoring does not end at counting the number of counselling sessions but tracking improvements in counselled skills and sexual behaviors.

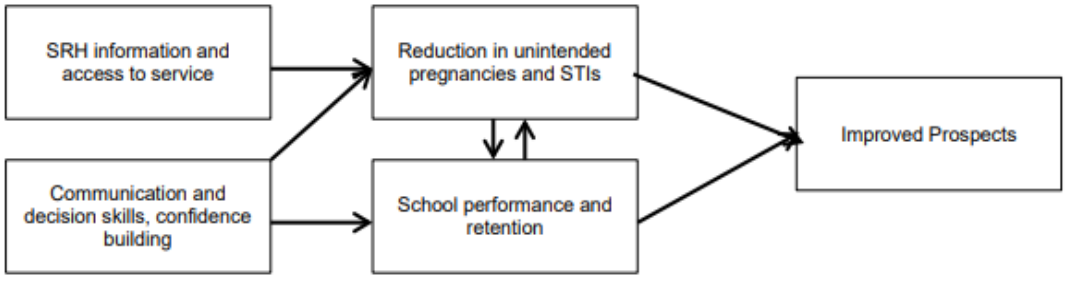

Figure 15. Example of a Theory of Change for Teenage Pregnancy.

Source: Brest, 2003 [93]

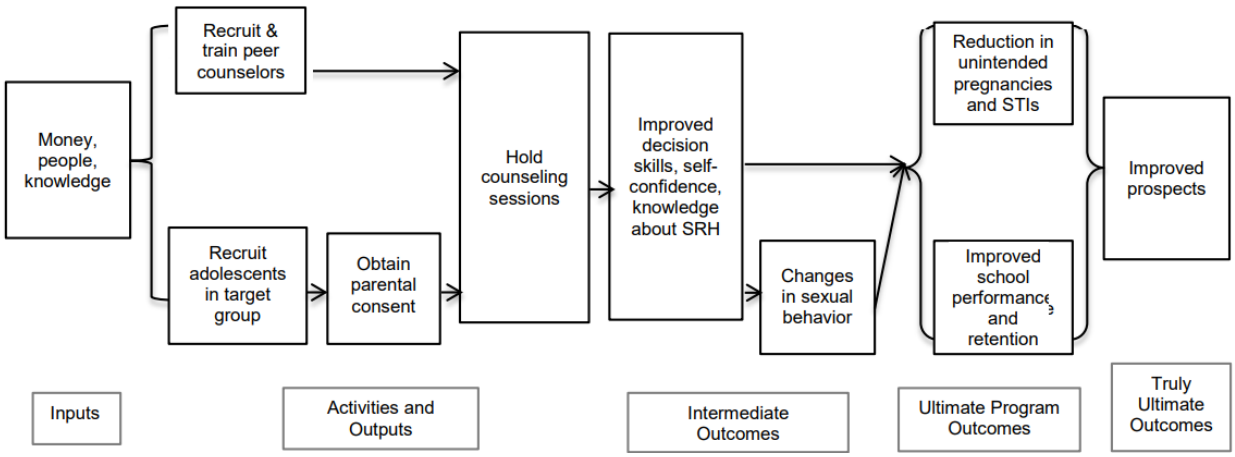

Figure 16. Example of a logic model for addressing Teenage Pregnancy via Counselling
Source: Brest, 2003 [93]

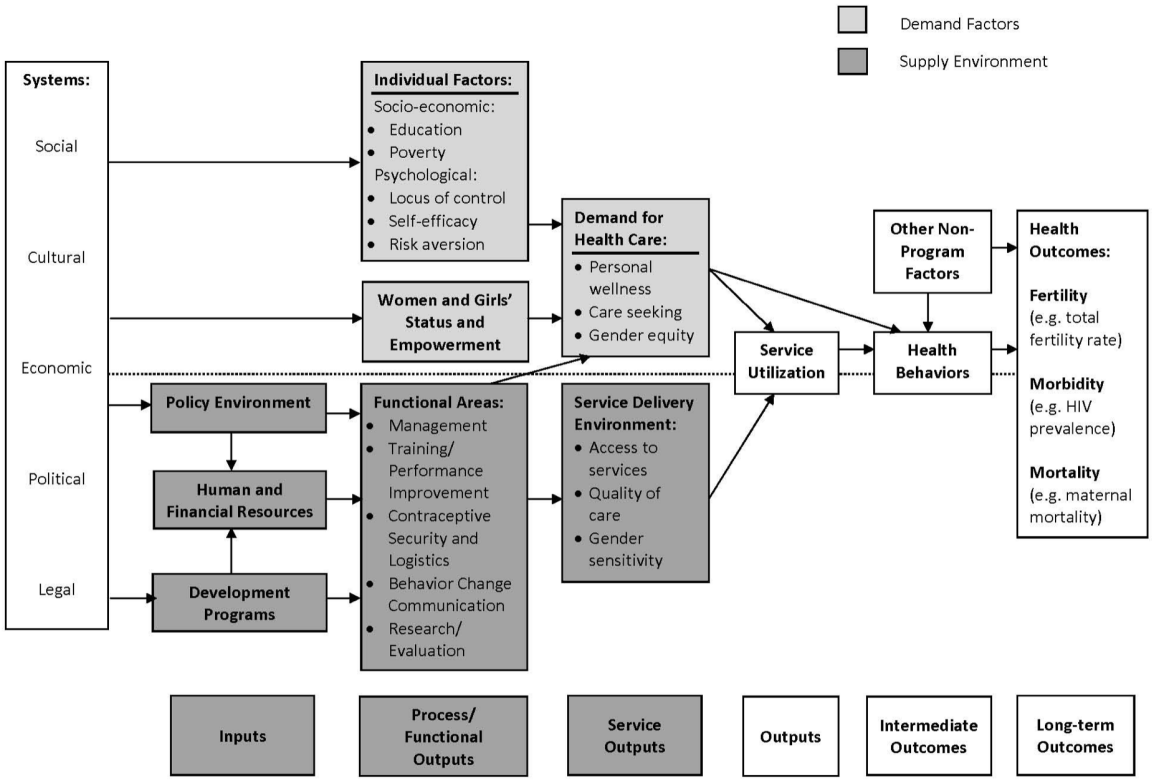

Figure 17. Example of a logic model for RPRH in general
Source: MEASURE Evaluation, n.d. [94]

A sample of a more **macro-perspective logic model** by MEASURE Evaluation is given in **Figure 14.** The framework emphasizes two points which are not captured in the PME:

- The environmental context of social, cultural, economic, political, and legal systems *outside of the health sector* affect RPRH operations. For instance, gender norms and inequalities may influence women and adolescent health seeking behaviors.
- Both supply- and demand-side factors (e.g., individual characteristics like self-efficacy) must be addressed to improve utilization of RPRH services.

With a macro-perspective, the impact indicators should **account for the broad vision of the RPRH law** of **poverty reduction and sustainable population development.** Then **indicators** for each link in the logic chain should be defined and **assigned to specific NGAs.** These must include indicators beyond activities (issuances and programs) of agencies alone, covering **their outcomes and impacts from the client perspective**.

All of this needs to be developed through **consensus meetings with NIT members and RPRH stakeholders**. This should be followed by **pilot testing, orientation, and capacity building** in NGA COs and ROs. This way actors at all levels of administration understand their role in RPRH operations and how their efforts contribute to the both the sector they are primarily responsible for and the bigger picture of RPRH implementation.

(2) Define explicit operational criteria for what it means for an LGU to be compliant with the RPRH law.

Aside from a ToC and logic model at the national level, it would also be important to develop one for **local implementation.** The criteria should also be pilot tested and LGUs oriented properly before full implementation. These **operational criteria for compliance** to LGU mandates should then be made more explicit through the IRR, provided again that they are **written with input from LGUs and with full knowledge of their constraints and capacities**, accounting for the necessary TA and support from the COs and ROs.

(3) Investments in building a quality M&E for RPRH must be a priority in the NIT and member agencies.

Building M&E systems is difficult, expensive, and time-consuming, but it is no less urgent or important than immediate tasks like providing TA and service delivery.

The importance of investments in M&E for RPRH must be **formalized in the policy infrastructure.** The multi-agency plan should stipulate **human resources and budget allocations** to this end. The PME guide may operationalize this by including process protocols for research, development, and pilot testing of M&E systems. These include, but are not limited to data architecture, digital data collection, data quality reviews, data analyses, and data sharing and flow of data *across* - not just within - involved agencies. See **Box 11** for an example on the DOH National TB Control Program's M&E systems and investments.

Data sharing and streamlining of reports required of LGUs should be a high priority. There are multiple opportunities for data sharing and harmonizing reports that are more frequent and faster than NDHS or FHSIS. The GAD, Community Based Monitoring System [95], and the LIPH, are well-established examples. RPRH WFP and ARs could be channeled with GAD plans and make use of the DILG online Full Disclosure policy portal.

In the interim, while waiting for improvements in M&E systems which may take some years, there is potential to use LQAS and tap CSOs with community networks for indicators with spotty data and to capture data in the private sector.

Box 11. The DOH National Tuberculosis (TB) Control Program's M&E System

Before 2015, the National Tuberculosis Program (NTP) had three electronic information systems. This required navigating system ownership and data management processes (e.g. data validation, quality checks) at the CO and RO levels. In health facilities, health workers had to encode for each system and submit duplicative reports.

The NTP decided to unify these systems through one **Integrated TB information system (ITIS).** IT would consolidate program indicators such as drug susceptible TB, drug resistant TB, TB in children, TB in prisons, TB/HIV, stock Inventory, private facilities that used to be sourced from different systems.

ITIS was officially rolled-out in the health system in 2015 after **five years of concerted effort and scale up** by the National Tuberculosis Program Management Office (NTPMO).

- 2011 - ITIS was conceptualized
- 2012 - Pilot testing in three regions
- 2013 to 2014 - Gradual expansion to other regions, first offline version was launched, and user manual was included in the TB Manual 5th Edition
- 2015 - DOH AO 2014-0024 was issued, and nationwide trainings were conducted

ITIS was made **interoperable with other existing systems** such as iClinicsys (Integrated Clinic Information System), eFHSIS (Electronic Field Health Services Information System), PViMS (Pharmacovigilance Monitoring System), GX Alert, TB Consult, and PhilHealth e-claims system. It was also made **flexible to account for available LGU resources or preferences**: it can be used online and offline, and on desktops, laptops, tablets, or smartphones. It also has an automated referral system notifying TB facility personnel on incoming patients referred by another facility, migrating patient referred data between facilities as well.

ITIS is a **centralized database that consolidates data from all covered facilities and streamlines reporting**. The DOH-NTP is the system owner while KMITS is in charge of its maintenance. **Data consolidation and validation does not follow the usual FHSIS system** of consolidating at the city/municipality-level then provincial-level, then regional-level before reaching DOH CO. It **removed the requirement of having reports signed by LCEs through DOH AO 2016-0034** which has a provision that states that clicking the "Send as Official Report" button and the "approved" button in the system is enough to signify that transmitted data are official. **Periodic data quality checks and validations are done in ITIS facilities and implementers through a third party**. The CO, ROs, PHOs, and city/municipal health officers also have **access to regularly updated program indicators** and they can **track if the assigned TB personnel was not able to encode on time.**

To address the **quick turnover of personnel and the lack of manpower to do regular training**, a lot of **knowledge products are developed by the DOH in partnership with the Philippine Business for Social Progress (PBSP)**. ITIS has an electronic manual, a dedicated chapter in the TB manual, and an e-learning course hosted by the PBSP.

6.2. Accountability

This section looks into **formal and informal mechanisms of accountability** used in RPRH implementation.

- **Formal accountability** mechanisms refer to instituted and agreed upon attributions of responsibility for activities and their consequences [96]. These include official agreements and protocols for ensuring compliance and mechanisms to address the failure to meet goals such as penalties accompanying violations.
- **Informal accountability** mechanisms refer to ad-hoc or unofficial arrangements to attribute or assign responsibility [97]. These may rely on verbal agreements and interpersonal or interorganizational norms and expectations.

Accountability accompanies the authority and resources granted to RPRH implementers at all administrative levels for their mandates. The section touches upon the following:

- **Compliance** of NGAs and LGUs to set agreed-upon responsibilities and standards,
- **Transparency** in performance and progress, and
- **Answerability and enforceability** via incentives and sanctions for performance.

(1) Accountability for RPRH implementation among NIT member agencies is weak.

On paper, implementers, particularly the DOH, are accountable to the **COC and OP** (Section 13.01 and 15.01 of the IRR). **In practice,** the accountability of the NIT and its members for implementation of the RPRH law as a whole relies heavily on **self-regulation**.

"To tell you the truth I don't think many of the congressmen and the senators actually read the report. So, we present and then told them this is what we should do, and they say yes. After that we have to wait whether that yes becomes actionable."	*"We are passing the annual report, but I do not know if the COC is reading it.*
Respondent 9	*Respondent 11*

In this matter, the **PME guide serves as one main tool holding NGAs accountable for multiagency implementation of the RPRH law**. However, since there is no roadmap and timeline of expected progress (see Stewardship and M&E sections), it is also up to the NIT members to hold themselves accountable for fulfilling any internal plans annually.

These plans are not usually communicated publicly or to the COC and OP. The lack of transparency means that the **actual progress of implementation or problems in implementation may not be accurately reflected in the annual ARs**.

"Because if you are there [in the NIT meetings], you wouldn't want to make your agency look bad. Even if I am stressed, I cannot embarrass my agency. They [NIT member representatives] always boast about the accomplishments of their department, what have they done, what they are doing."	*"We report what we have but don't present out of how many [i.e., the denominator]. Because they will get back to us [to ask], but we are the ones reporting. Would we report something that may throw ourselves under the bus? We report what has been done, but we indicate the set of challenges where we have fallen short in implementation in the report…"*
Respondent 6	*Respondent 9*

In this sense, the COC and OP as mechanisms for accountability and support for NGAs are not fully maximized. The public is also not entirely privy to the goings-on of RPRH progress within agencies, except for the annual ARs.

A contributing factor to this could be that **there are no full-time NIT personnel to act as arbiters without having a professional investment in the performance of an individual agency**. Although there are sometimes independent reviews of RPRH implementation, such as this study, evaluation and feedback to trigger accountability must be more regular, timely, and systematic. This was acknowledged by NIT members, as the PME envisioned quarterly assessments of progress to improve responsiveness of implementers.

(2) Accountability in NGAs is mostly vertical chain-of-command with weak joint accountability for RPRH implementation.

Implementing NGAs and other stakeholders perceive **DOH to be the face of accountability for RPRH** to COC and OP as the designated lead implementer in the law and IRR. DOH is aware of this perception, and some respondents cite that they are **accountable to DOH** for their progress in RPRH implementation.

"DOH, because DOH is really that lead agency of the NIT, that's why it's really to DOH we have to report to."	*"It should be DOH because they are the one in charge of reproductive health insofar as the reproductive health law is concerned."*	*"We are accountable to the Secretary of Health because the NIT is a creation of the Secretary of Health and we are supposed to help the Secretary of Health in the implementation of the RPRH law. Because the RPRH law main agency that is going to implement it is the Department of Health."*
Respondent 5	*Respondent 12*	*Respondent 17*

Realistically speaking, however, **DOH does not have the formal authority to hold other agencies accountable** as there are no arrangements or mechanisms made in the IRR, law, or joint policies/issuances for it. Rather, DOH is reliant and limited to **"courtesy accountability" of NIT member agencies** to their RPRH mandates - as is common in interagency initiatives.

> *"Inter-agency approach is really just courtesy, respectful of your own mandate. But if this is a hindrance, maybe it's more of the focus of the agency …*
>
> *They have their own mandates and reproductive health is just one of those mandates. Like support to DepEd, CSE, it is just one the mandates. You cannot tell the Secretary, "why are you not doing your role here?" That is the limitation somehow, not a hindrance, but I think you shouldn't remind them because they know their functions." - Respondent 12*

On this front, **DOH as the lead implementer has not been able to foster a sense of joint accountability** and ownership for RPRH. This may be due to several reasons:

- **Accountability for RPRH within DOH itself is fragmented.** While the WMHDD is the main division assigned to RPRH, functions are spread across other bureaus and clusters. There is no single unit accountable for RPRH within DOH.
- As a downstream effect of the lack of stewardship, the **DOH has no high-level buy-in or formal interagency agreements** to use as a basis to push other NGAs to perform.
- As an effect of weak M&E, the DOH is **unable to link nonperformance in other NGAs to formal accountability mechanisms in the COC and OP**.

Consequently, and as is the norm, staff working on RPRH in NGAs see themselves **primarily accountable to their direct superiors and agency secretaries**. This agency-centered accountability **relies heavily on NGA stewardship and priority** given by overseeing officials or units. If RPRH is not a priority of high-level officials in an NGA, staff also do not prioritize RPRH as it is not what their superiors will be holding them accountable to.

To again note, strong external pressure for NGA action usually comes from prompting by CSOs which are largely informal mechanisms with weak regulatory influence.

> *"The venue for that actually, to remind them [of their functions], is the NIT - supposedly the inter-agency collaborative body. But just courtesy because you cannot push an agency to do its own, to push implementation. But their accountability is to the people, because they are not doing their role." -Respondent 12*

(3) Similarly, LGUs have weak accountability to NGAs as they only have soft power over LGUs. In terms of perception, visible accountability of the success of implementation rests more on NGAs.

As a result of the LGC of 1991, LGUs are granted autonomy in local governance and service delivery for RPRH. Weak LGU accountability for national government programs and laws are not unique to RPRH implementation [98–101].

Some NGA respondents cite that **despite LGUs being directly responsible for RPRH implementation, the failure of LGUs to improve outcomes and impacts fall on NGAs.** That is, inadequate service delivery and bad outcomes is often largely attributed to NGA - in particular DOH as the lead and visible implementer.

> *"When a mother dies, who do the people blame? It's DOH right? It's not the local - it's not Mayor Isko Moreno - it's always the Department of Health, right? If the Maternal Mortality Rate falls or rises or adolescent pregnancy rises, it's not the other NGAs that are blamed, it's the Department of Health… But the reality - it's just that I want to put on the table that health outcomes are not the sole responsibility of the Department of Health." - Respondent 7*

A DOH RO respondent commented that part of RO staff's Individual Performance Commitment and Review Forms (IPCR) are outcome indicators of LGUs under their jurisdiction. This may codify the perception that NGAs are largely responsible for the failures of LGU implementation. On the other end of the spectrum, NGAs may be attributed the credit for good LGU performance despite not being direct implementers.

"The IPCR indicates your performance. If you look at it logically, the individual performance indicator is equivalent to your personal performance.

Now, if you are looking at an indicator where I am not a direct implementor, I think it is not fair to engage me with the indicators of what others should achieve but for which I am not the one doing [the direct implementation]. It's also unfair to them because I am getting the credit [if they do well] that is really not me or I did not do it…" -Respondent 13

NGAs are highly reliant on **incentive and recognition programs** (a form of soft power) to motivate LGUs to comply and perform for RPRH. Example incentives schemes are the DOH's Purple Orchid Awards for FP, Seal of Good Local Governance and, POPCOM's Population and Development Awardees. Moreover, **despite the IRR having a section for penalties** (Section 17.03), the lack of operational criteria for compliance, what constitutes a violation of the law, and mechanisms for investigation and filing for alleged violations, may make it difficult to implement the sanctions and compel LGUs to comply.

Interviewer: What if the LGU does not take your recommendation or comply? What is your recourse? *"We just remind them. Because - there is nothing in the RH law that is saying we will punish the LGU.* *Usually, we do not sanction the LGU. We have a program if you know the [redacted]? That is the award, it's like we just reward them, give LGUs incentives."*	*"At the end of the year, we account [for the] LGU's accomplishments based on their assigned target and whether they accomplished or not, but we cannot force them to achieve the assigned target for whatever reason.* *I don't know, but we have recognition…For example, ... we rank them and the top 3 we give plaque of appreciation and then cash… So, we are just recognizing those who are performing well but we cannot punish those who will not perform."*	*"I'm not sure if it's a direct accountability or not, but they also have their LGU scorecards. They use those scorecards for their evaluation with DILG. I'm not sure whether it's being used as a form of an indicator for an awarding, but I think if you don't perform there then it's nothing, too. It's still incentives-based, you get to be recognized if you have this kind of program, but if you don't - it's okay. You can move on with your life."*
Respondent 6	*Respondent 11*	*Respondent 16*

"Now at least you can always say [the RPRH law requires it], but either way it is ok. What I mean is, if there was no RPRH law, it would just be fine. But with the RPRH law, it is at least better.… Because I can always say, for example if I will ask for a requirement … Report of your [redacted], what are your findings, did you act on them? I always say, you have to that because that is in the law.

Although the RPRH does not really have punishments, right? That is why I end up saying that it's just like the same [before there was a law]. You need to really convince the LGU that in doing this, you benefit... Because if you will say "you will be punished if you don't do that." there is nothing like that [in the RPRH law]. If I am the doctor, I would not follow that, there is no punishment anyway."

Respondent 10

Recommendations

(1) The accountability of all agencies as implementers in RPRH must be emphasized, and an independent NIT auditor for regular operations may be useful to strengthen accountability in NGAs.

Accountability should be **formalized through providing the NIT and RITs with policy infrastructure and workforce** to monitor and enforce accountability and explicitly link performance with formal accountability mechanisms like the CoC or OP.

If the revised PME is built based on consensus, this will represent the standards NGAs agree upon to judge their progress. These standards should then be the basis of the **AR:** they should compare **progress with the current status of RPRH against the roadmap and timelines** of implementation. Reports should assess the appropriateness of inputs, activities, and processes of programs, and not just recount what was done on an output- based reporting. This aligns with requirements of Section 15.01 of the IRR.

To shift away from self-regulation and reliance on the five-year reviews, an **independent and impartial NIT audit unit** such as that employed by POPCOM's BoC should be able to build, harmonize, and maintain the M&E system for RPRH. This unit's responsibilities can include data collection, data analyses, and prompt identification of challenges and recommendations for specific agencies. The auditors can also and **develop and implement formal mechanisms to systematically investigate issues and issue corrective action**. A similar independent auditing **should also take place for RITs**. Standard monitoring reports, with included analyses, must be accessible to LGUs, so that LGUs can be directed to specific areas for improvement instead of endless reports without in-depth feedback.

(2) Institutionalize the multi-agency nature of RPRH implementation by holding all agencies accountable to the COC or CoA.

Even if DOH has the greatest number of RPRH mandates, revisions could be made to make it more explicit that other NGAs are also accountable to the COC and OP. The **NIT/RIT auditors and its dedicated staff should report to COC and the OP** about the progress in RPRH implementation for all NGAs based on the agreed upon interagency roadmap.

It was also recommended by an expert informant, that agencies should be given the financial resources they need to carry out their RPRH mandates and then existing mechanisms such as those of the CoA could be used to make NGAs answerable for these resources.

"Because if it is true that you have a law, then the first thing you will do is provide a budget, right? Provide a budget so that there will be adequate personnel, adequate medicines, logistics."	*"I will give them what they ask for and make them account for it. So if the Department of Education says I need 500 million pesos in order to push comprehensive sexuality education, give it to them and if they don't do anything about it then put them, make them accountable for it."*
Respondent 3	*Respondent 17*

Visible accountability can be **explicitly attached to offices of high-level officials** who can serve as the "face" of accountability in each NGA for RPRH. Ideally, these officials would be attendees of the NIT meetings. This helps ensure that the chain-of-command accountability within agencies is still respected, and that agreed-upon plans have the commitment of those in the position to make decisions. This is feasible when taken together with recommendations to lodge RPRH focal points at the ASec or USec level.

(3) Sanctions and penalties for noncompliance in the IRR should be enforced so local chief executives can be held accountable for any nonperformance.

NGA members and DILG must have the ability to make LGUs answerable for noncompliance to their RPRH mandates. As a continuation to M&E recommendations to define operational criteria for LGU compliance/violations, the DILG, DOH, and the NIT must flesh out systems and protocols to investigate and file cases for alleged violations. Sanctions and penalties for noncompliance that may be enforced at the end of this formal accountability mechanism include suspension of LCEs, fines, and forfeiture of retirement benefits (RPRH IRR, Rule 16). This is, of course, after soft interventions to address noncompliance in LGUs have been considered (e.g. advocacy, dialogue, assistance in technical and financial resources provided).

(4) A visible RPRH dashboard (or other forms of public reporting) to track RPRH progress against multi-agency strategies and plans should be made available to all NGAs, LGUs, CSOs, and the public.

To complement the prior recommendations, the NIT/RITs can publicize the progress of various actors in RPRH implementation. A **dashboard updated regularly and patterned according to the revised PME** can be one way to make transparent the commitments and obligations agencies and LGUs are accountable to the people for. The NIT, at one point, planned to do this using a Facebook page, but it has not yet materialized.

In this regard, **CSOs may be tapped to enforce accountability** through the public dashboard or more formal mechanisms like the **CoA's Citizen Participatory Audit program.** This allows civil society (i.e. CSOs, private sector, media, donors) to conduct **social audits and community monitoring** to not only make government answerable for its progress, but also work with them to solve challenges and bottlenecks in implementation [102, 103]. The dashboard may thus serve to promote **social accountability of agencies and LGUs to the public** (i.e. vertical accountability) **and civil society** (i.e. horizontal accountability).

This aligns with the **long history of civil society engagement** in RPRH in the Philippines and other countries [102]. In fact, CSOs, with the support of international donors, initiated most of the social accountability projects in the country in response to weak public accountability [104]. Moreover, it **capitalizes on that fact that public officials have strong internal motivation to perform** and fulfill their social contract with the citizens they serve.

7. Synthesis and Recommendations Framework

In the past eight years, agencies tried to accomplish their RPRH mandates by folding RPRH functions into bureaus and units that already existed in their organization structures. Since challenges were concentrated in FP, NGAs focused on making up ground in the area. This resulted in a **siloed, programmatic, and FP-centric approach to implementation, casting prescriptive centrally-designed policies to LGUs with individual needs and contexts.**

However, the RPRH elements are intertwined and require multidisciplinary and system-wide governance. The absence of dedicated RPRH units and the lack of formal policies to institutionalize RPRH in NGAs have contributed to difficulties mustering interagency coordination. Weak system-wide leadership was not able to mitigate an unpredictable budget and insufficiencies in the workforce for RPRH. Weak accountability between COs and LGUs, and among NGAs, was facilitated by fragmented and short-term M&E frameworks that relied on self-regulation instead of strong formal accountability to Congress or the OP.

Implementation over the last eight years can be said to have been in the **launch phase.** In acknowledging the current gaps of implementation, implementing agencies have tried to establish areas for collaboration and integration.

The **next five years must see greater investments in building systems to consolidate and horizontally integrate each implementer's existing RPRH infrastructure and programs.** Facilitated by a visible and strong NIT, agencies must now focus on improving, collaborating, and setting-up systems responsive to population needs to sustain and integrate RPRH fully into the social fabric and operations of NGAs and LGUs beyond just the law.

Stewardship will be the key to how agencies, given their mandates and activities, can adapt and update them, filling the gaps in implementation collaboratively and in an efficient manner. Good stewardship brings implementers **onto the same page for the vision** of RPRH, **institutionalizing** a shared operational vision in each agency and working to be able to empower LGUs to implement the law fully and have tangible impacts in the lives of Filipinos.

Well-defined multilateral partnerships among NGAs, LGUs, and the private sector to provide RPRH services should be supported by monitoring and evaluation at every step, and accountability mechanisms made transparent to the public.

As a country in the first decade of its RPRH implementation, the Philippines' challenges to better RPRH performance are not unique. **Governance issues** remain major challenges in RH implementation worldwide. Three major governance trends are identified among low- and middle-income countries (LMICs) that reinforce compartmentalized implementation [105].

These are illustrated in **Box 12** Drawing upon the similarities in context and solutions, the Thai case presents an empirical reflection of the findings and recommendations of this paper.

Box 12. RPRH Performance in Thailand

Context [106]. Thailand's national government, like that of the Philippines, is **decentralized**

National agenda are set and carried out by 20 **ministries of the executive branch**. Ministries have administrative offices at the central, provincial, and local levels.

Local administrators are elected by residents, and **local administrative units** (LAUs) operate under the principle of **autonomy,** able to "adopt their own policies dealing with their governance, administration, personnel administration, and finance."

Like in the Philippines, **NGOs and civil society groups** play a large role in the "service provision of social welfare services, especially to low-income women."

National RH Policy. Sexual and reproductive health were recognized as key components of Thailand's National Health and Development Policy since 1997, when the **National Reproductive Health Policy** (NRHP) was signed [107].

The government chose **10 areas** to highlight the multi-faceted nature of RH.

- Family Planning
- HIV/AIDS
- Adolescent Reproductive Health
- Maternal and Child Health
- Infertility
- Reproductive Tract Infections
- HIV/AIDS
- Abortion
- Malignancies of the Reproductive Tract
- Sex education, Sexuality, Reproductive Health and Responsible Parenthood, and
- Sexual health issues among those who are past reproductive age and the elderly

The NHRP envisioned participatory solutions to RH issues, including the provision of **high-quality RH services and increasing awareness of the importance of RH**. The government's implementing strategy was to "provide fully **integrated and coordinated services**, so all implementing agencies concerned may jointly plan their operational plans."

Implementation Challenges. However, **RH operations were not integrated across agencies** [106, 108]**.** An example of compartmentalized implementation is noted below [108]:

> *"Within the MOPH, for example, the program of integrated reproductive health services falls within the purview of the Division of Reproductive Health in the Department of Health. At the level of macro- implementation, management responsibility is under the Bureau of Health Service System Development in the Office of the Permanent Secretary. Only recently, in order to be able to sign on to international agreements, the MOPH appointed a high-ranking technical person, though not yet a formalized body, to follow up on social issues related to reproductive health (i.e., gender and sexuality). Meanwhile, social and legal issues related to reproductive health are still the main responsibility of the Office of Women's Affairs and Family Development in the newly established Ministry of Social Development and Human Security."*

Moreover, a **lack of capacity and funding** arose due to **shifting commitments and unpredictable priority among government agencies**. This in turn led to difficulties involving target groups and capacity-building for government workers and NGOs.

Governance Solutions. Thailand took several steps to address gaps in NRHP implementation. The issues

they identified were consistent with those experienced by many LMICs.

1. **Lack of a human rights framework** [109]. In The 2nd National RH Development Policy and Strategy (2017-2026), the government recognized that **the entire direction of implementation had to respond to current RH trends**, in particular, the TFR.

   The Thai government observed that **underlying factors** such as better education, better jobs, and higher income, especially among women, led to **greater gains in reducing TFR than what the national FP program alone could have achieved.**

   SRH policy direction was adjusted to focus on providing a better quality life to those born. Implementers explicitly based their success and impact indicators on **human rights and the social determinants of reproductive health**.

2. **Focus on health services**. Thai implementers recognized that compartmentalized implementation was a major challenge to be addressed. The roles and relationships of each actor outside the health sector needed to be taken into account upon realizing that **an FP-centric approach was no longer appropriate**.

   Other sectors invested in **population development even at the pre-reproductive age** (i.e. infants and children), created **flexible work environments** that supported family formation and childrearing, developed the **quality of the population up to adulthood**, to promote **inclusive, equitable, and sustainable development.**

   For a decentralized country, this also translates to improving coordination among the different levels of decentralization through **leadership capacity-building**.

3. **Ineffective coordinating bodies.** To address its multi-sectoral governance issues, Thailand established the **National Reproductive Health Development Committee** in 2009 to **integrate and coordinate** ministries, NGOs, and civil society groups.

   The creation of a multi-agency coordinating body must be supported by means to **enforce implementation decisions** across sectors. Monitoring and public reporting were identified as "powerful tools" for **quality evidence generation and usage,** which strengthens the health literacy of the public and multi-sectoral governance [110].

The implementation of the **Health for All Scheme** as part of the Thai 2002-2006 Development Plan anticipated greater gains in NRHP, to "open opportunities for all sectors of society to play a role and use their own potential in developing a healthy society"

As more countries introduce **UHC**, a common recommendation is to tie in RPRH, acknowledging that RPRH "needs and concerns are not relegated to convenient but rigid silos, but are centrally included in the systemic changes that UHC promotes." This entails a review of financing mechanisms, regulations and standards, monitoring and accountability mechanisms, comprehensive integrated services, adequate trained human resources, and multisectoral commitment to RPRH.

The case of Thailand underscores that effective SRH implementation requires an **impartial multi-sectoral coordinating body, a life-course-based approach to RH services**, and **a human-rights-based vision for sustainable development**.

A similar shift in perspective must also occur in the Philippines, to reroute FP-centric, fragmented implementation into one that channels efforts into systems beyond healthcare programs and services.

Recommendations Framework

In the next 5 years governance improvements in the following areas are crucial to the success of RPRH implementation:

- NIT governance over the different implementing agencies
- NGA governance over their individual agencies
- NGA governance over LGUs and other service providers

NIT Level. The NIT must integrate RPRH efforts across agencies and facilitate multi-sectoral stewardship and collaboration.

The **first step to maximize NIT as an oversight body** is to clarify its role in implementation and level off expectations and expected contributions of CSOs and each NGA (including POPCOM's role in governance). Then NIT can be used for **horizontal integration of RPRH initiatives across sectors and agencies.** This requires equipping the organization structure of the NIT with **dedicated full-time staff and independent auditors** to reflect its roles.

The NIT Secretariat should first study the current RPRH landscape and laws, and tailor recommendations for the creation of a **unified working and financial plan**. Resources include PDP, UHC law, NGAs' ARs, policies related to RPRH, and best practices in literature.

The plan should harmonize all implementers' understanding of the law at the multi-agency level of the NIT to break out of compartmentalized implementation. In this model, all implementers must have their stake in RPRH clearly stated and operationalized, focusing on how agency action can contribute to RPRH **impacts**. The **plans must consider integrations with other laws** like the UHC, Mental Health, and Kalusugan ng Magnanay.

The roadmap should include but is not limited to:

- **A comprehensive package of RPRH services across agencies**, that is available, accessible, acceptable, equitable, and evidence-based,
- **Innovations for existing RPRH activities and programs**,
- **Accelerating work on neglected RPRH elements**,
- **Agency strategies that institutionalize these above three items**, mapping out their current activities and roles and how to delineate manpower and resources to commit.

NIT Secretariat must set up guidelines, infrastructure, and an M&E system that encourages multi-sectoral collaboration and formalizes strategies for engaging other agencies, the private sector, and the public.

NIT auditors must conduct regular PERs and set up mechanisms to address noncompliance. Even if each agency has its own programs to contribute to RPRH, gaps, duplications, and contradictions should be identified and corrected.

To mitigate the unpredictable budgeting process, the **NIT must involve the DBM**. With convergence financing, the **NIT can identify best buys and rally NGAs to defend financing decisions via long-term multi-agency plans**.

NIT should emphasize that M&E is for data analysis and data utilization. The PME must be revised to be a meaningful M&E framework across sectors based on a clear theory of change. Continuous R&D for innovations in communication and transparency promote greater accountability among implementers and especially the public.

NGA Level. NGAs must mirror efforts to integrate and institutionalize RPRH activities at their level, to provide the necessary resources for implementation and promote accountability.

COs should establish an RPRH focal unit lodged in an ASec or USec level office to develop the agency's own strategic roadmap for RPRH and oversee progress to fulfil it.

NGAs must be willing to cooperate in convergence budgeting to efficiently allocate resources for RPRH and transparently earmark expenditure for RPRH. Agencies should also proactively improve RPRH financing and HR arrangements. **DBM's** processes must more closely reflect its mandate to achieve development goals. In the short term, DBM must be involved in the NIT, and in the long-term make **use of social accounting approaches to better account for the value of RPRH line items**.

DOH-CO should shift most procurement functions to LGUs and relieve DOH-ROs of procurement responsibilities. Framework contracting agreements can be explored for the more expensive commodities that require economics of scale.

PhilHealth can be tapped as a source of sustainable RPRH financing through the SHI by **creating a pipeline of benefits for RPRH across the life-course.**

RPRH focal units must review the workforce needed for RPRH at the CO and ROs. NGAs can augment their RPRH workforce through various policies, incentives, and PPPs.

These efforts culminate in implementing multi-sectoral strategies such as **the creation of a comprehensive package of RPRH services**, and others in the NIT.

Horizontal integration among NGAs is supported by comprehensive M&E and strong accountability. **NGAs must revise their M&E tools in accordance with the agency UWFP, develop policies and invest in infrastructure for data sharing and management.**

Clearly defined plans within and among agencies promote accountability and transparency, that streamline NGA processes and improve implementation in the long run.

NGA to LGU Level. NGAs must empower local-level implementers to widen their scope of operations, supported by capacity-building and reinforcing accountability.

Moving forward, LGUs will be expected to fulfil even more functions than they are now. NGAs must be more sensitive to the impact of their policies on the LGUs.

NGAs must first secure LGU buy-in to RPRH by leveraging the RPRH Law and IRR. Then they must consolidate **and streamline policy infrastructure to ease communication of top-down RPRH programs to ROs and LGUs.**

NGAs must develop LGU technical capacity by shifting their functions towards technical leadership, regulation, and leadership capacity building, and away from service delivery and procurement. To support its governance functions, **NGAs should also invest in innovations to streamline communication between CO, RO, and LGU levels.**

Once the revised PME is implemented, **M&E data should be made available to LGUs for decision-making and transparency.** This way, **LGU compliance is defined and NGAs can formally enforce sanctions** for non-compliance and failure to deliver on RPRH mandates.

A summary of the RPRH Recommendations Framework is presented as a Swimlane Roadmap in **Table 25.** Recommended governance activities are divided into major areas of governance, to be accomplished in the **short-term (1 year), medium-term (2-3 years), long-term (5 years).**

Table 25. Swimlane Roadmap of RPRH Recommendations

Area	Short-Term (1 year)	Medium-Term (2 - 3 years)	Long-Term (5 years)
Presence	**Organization Structure Changes in NIT**		
	NIT: Establish full-time dedicated NIT Secretariat	**NIT Secretariat:** Review and implement revisions in NIT and NIT TWG structure	**NIT Secretariat:** Consolidate RPRH efforts across agencies for the next 5-year review
	Creation of RPRH Focal Units in NGAs		
	NIT Secretariat: Create Guidelines for an RPRH Focal Unit within NGAs **DOH:** Provide technical assistance for RPRH Focal Unit Guidelines	**NGAs:** Create RPRH focal unit within NGA **RPRH Focal Unit:** Take inventory of the NGA's RPRH activities, including their input resources and outputs	**RPRH Focal Unit:** Submit annual reports to NIT of how NGA's activities align with NIT RPRH strategic plan
Infra-structure	**Institutionalize RPRH Focal Units in NGAs**		
	NIT: Advocate IRR revisions to include provision for RPRH focal units within NGAs	**NGAs:** Institutionalize RPRH Focal Unit with policy infrastructure (e.g. AOs, Department Orders) **RPRH Focal Unit:** Develop internal policy infrastructure for RPRH Focal System within NGA	**NGAs and RPRH Focal Units:** See other Recommendations
	Harmonization of RPRH-related Laws		
	NIT Secretariat: Identify and review new and existing laws for synergies with RPRH **NIT Secretariat:** Recommend areas for multi-agency streamlining of RPRH activities based on Infrastructure Review	**RPRH Focal Unit:** Based on NIT's Infrastructure reviews, assess NGAs' RPRH activities in light of new and existing laws **RPRH Focal Unit:** Recommend areas for streamlining NGA's RPRH activities and programs based on internal Infrastructure Review	**NIT Secretariat:** Consolidate results from Infrastructure Reviews to recommend future RPRH-related laws or revisions to existing laws **NIT Secretariat:** Consolidate NIT and NGA Infrastructure review findings for next 5-year review
	Onboarding LGUs for Greater Role in RPRH Implementation		
	NGAs: Leverage law and IRR as advocacy tools to onboard LGUs and NGAs	**NGAs:** Consolidate and streamline policy infrastructure for ease of communication between CO, ROs, and LGUs	
Financing	**Implement Convergence Budgeting among NIT members**		
	NIT Auditors: Conduct regular PERs for NGA expenditures and report results to COC	**NIT Secretariat:** Develop and implement Guidelines for annual convergence financing among NGAs	**NIT Secretariat:** Consolidate RPRH financing trends, including deficits for next 5-year review

Area	Short-Term (1 year)	Medium-Term (2 - 3 years)	Long-Term (5 years)
	Make a Case for Financial Investment in RPRH		
	DBM: Involve DBM in fiscal dialogues with NIT **NIT Secretariat:** Based on PERs and research, regularly identify best buys in RPRH activities for investment of NGAs	**NIT and NGAs:** Lobby for protected items in the national budget allotted to RPRH activities **NGAs:** Earmark budget allocations for RPRH and utilize convergence budgeting	**DBM:** Shift to using social accounting approaches for NGA budget proposals
	Clarify Financing Roles between DOH and PhilHealth		
	DOH: Shift procurement functions to LGUs except for expensive seldomly-used RPRH commodities **DOH:** Relieve DOH-ROs of procurement functions	**LGUs:** Use new procurement functions to justify increasing LGU budgets	**DOH and LGUs:** Market complete availability of RPRH commodities to private providers to expand the SDN
	PhilHealth: Review existing benefit packages for RPRH	**PhilHealth:** Develop RPRH benefit packages for areas with gaps across the life-course	**PhilHealth:** Market comprehensive RPRH benefits packages to private providers to expand the SDN
Human Resource	**Expand Quality and Quantity of RPRH Workforce**		
	RPRH Focal Unit: Review quantity and quality of RPRH workforce needed at CO and ROs for RPRH tasks	**NGAs:** Pursue PPPs as an explicit strategy to expand RPRH workforce for central and regional functions	**NIT, NGAs, LGUs:** Push for reforms in government expanding workforce in regional offices and LGUs
	NGAs: Explore financial incentives and other policies to push NGAs and LGUs to dedicate more personnel to RPRH		
Steward-ship and Coordi-nation	**Develop a Unified Strategic Plan for RPRH**		
	NIT Secretariat: Develop NIT and RIT policy infrastructure for their roles in stewardship and coordination **NIT Secretariat:** Develop unified strategy and operational plan for RPRH implementers	**NIT Secretariat:** Clearly define roles and expectations of each RPRH implementer (e.g., POPCOM and CSOs) **NGAs:** Implement UWFP and develop annual unified strategy and operational plan for their agency	**NIT Secretariat:** Track progress on the implementation of the UWFP and consolidate results for the next 5-year review
	Promote Multi-Sectoral Governance Strategies		
	NIT: Advocate IRR revisions to include and update provisions for multi-sectoral strategies	**NGAs:** Shift functions of COs from service delivery to focus on TA, Regulation, Leadership Capacity Building **NGAs:** Implement multi-sectoral strategies (e.g., create comprehensive package of RPRH services)	
	Invest in Communication Innovations for Coordination		
	NGAs: Invest and implement communication innovations between COs, ROs, and LGUs (e.g., e-communication, e-explainers, etcetera)		

Area	Short-Term (1 year)	Medium-Term (2 - 3 years)	Long-Term (5 years)
M&E	**Revise RPRH Monitoring Tools**		
	NIT Secretariat: Revise PME Guide to have a clear ToC based on the multi-sectoral strategy for RPRH with input from RPRH implementers **NIT Secretariat:** Define explicit operational criteria for LGU RPRH compliance, with input from NGAs and LGUs	**NGAs:** Adjust M&E tools for individual programs and activities in accordance with revised PME Guide **NIT Secretariat:** Report on national-level indicators and include analysis of inputs, outputs, outcomes, and impacts in each annual accomplishment report	**NIT, NGAs, and LGUs:** Implement Revised PME Guide **NIT, NGAs, and LGUs:** Emphasize rigorous data analysis and regular data usage for NIT-, NGA-, and LGU-decision making **NIT Secretariat:** Consolidate annual ARs for the next 5-year review
	Build M&E Infrastructure for Quality Data Collection		
	NGAs: Develop M&E policies and invest in M&E infrastructure for data sharing and data management	**NIT Secretariat:** Develop an RPRH dashboard visible to all stakeholders, especially the public **NIT Secretariat:** Publicize progress of various actors through the RPRH dashboard	
Account-ability	**Creation of NIT Auditing Unit**		
	NIT Secretariat: Create an independent NIT auditing unit with dedicated workforce and policy infrastructure	**NIT Auditors:** Institute reporting of all agencies' annual progress to the COC or CoA for accountability	**NIT Auditors:** Regular review and reporting of all agencies' RPRH progress
	Establish and Enforce Formal Accountability Mechanisms		
	NIT Secretariat: Develop mechanisms to address noncompliance with input from NIT members and LGUs	**NIT Auditors and NGAs:** Enforce sanctions and penalties for non- compliance of LCEs and NGAs based on the IRR and explicit criteria such as submitted agency or LGU strategic plans and other policy infrastructure and guidelines	

Ultimately, the goal for RPRH moving forward is to consolidate and institutionalize RPRH operations at the national level, so that a clear operational vision may be communicated and executed by LGUs. National implementers must capacitate LGUs and **normalize RPRH as a set of comprehensive, integrated, basic social services that fulfill the reproductive health rights and needs of the Filipino people throughout their life course.**

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List of NGA Policies

#	Issuance Name	Agency	Type	Number	Date
1	Guidelines on the Recognition of Family Planning Training Provider of the DOH	DOH	AO	2014-0041	10/30/2014
2	Guidelines on the Implementation of Mobile Outreach Services for Family Planning	DOH	AO	2014-0042	10/30/2014
3	Guidelines on the Estimation of Unmet Need for Family Planning	DOH	AO	2014-0043	10/30/2014
4	Adoption of the Family Planning Clinical Standards Manual 2014 Edition	DOH	DM	2014-0311	10/27/2014
5	Guidelines in Setting-Up Family Planning Services in Hospitals	DOH	DM	2014-0312	10/27/2014
6	Guidelines to Reduce Unmet Need for Modern Family Planning	POPCOM	Implementing Guidelines	No. 01	05/05/2014
7	Defining the Service Delivery Networks (SDNs) for Universal Health Care or Kalusugan Pangkalahatan	DOH	AO	2014-0046	12/29/2014
8	Guidelines on the Implementation of the Expanded Newborn Screening Program	DOH	AO	2014-0045	11/19/2014
9	Implementing Guidelines on the Setting-up of Newborn Screening Continuity Clinics	DOH	AO	2014-0035	10/20/2014
10	Guidelines for the Implementation of the Public Health Assistants Deployment Program	DOH	AO	2014-0026	09/03/2014
11	Immunization on Pentavalent (5in1) Vaccine for Infants and Children with Incomplete/ Missed Dose	DOH	DM	2014-0233	07/30/2014
12	Protocol on collecting blood samples for Newborn Screening	DOH	DM	2014-0200	06/27/2014
13	Updates to Routine Adolescent Immunization 2014	DOH	DM	2014-0228	07/22/2014
14	Adoption of Guidelines in Establishing the Service Delivery Network	DOH	DM	2014-0313	10/27/2014
15	Frequently Asked Questions (and their Answers) regarding the Decision of the Honorable Supreme Court in the Consolidated Case of Imbong v. Ochoa (G.R. No. 204819) on RA No 10354 (RPRH Law)	DOH	DC	2014-0199	05/14/2014
16	Guidelines for Universal Newborn Hearing Screening Program (UNHSP) Implementation	DOH	DC	2014-0150	03/21/2014
17	Newborn Care Package And Normal Spontaneous Delivery And Maternity Care Package	PhilHealth	Circular	2006-34, 2007-20, 2009-07	10/02/2009
18	Primary Care Benefit Package 1	PhilHealth	Circular	2012-10	03/06/2012
19	Implementing Guidelines on Medical and Procedure Case Rates	PhilHealth	Circular	2013-35	12/17/2013
20	Social Health Insurance Coverage and Benefits for Women About to Give Birth	PhilHealth	Circular	2014-22	10/09/2014
21	Revised Policies and Guidelines in the Collaborative Approach of TB and HIV Prevention and Control	DOH	AO	2014-005	04/03/2014

22	Policies and Guidelines on the Use of Antiretroviral Therapy (ART) among People Living with Immunodeficiency Virus and HIVExposed Infant	DOH	AO	2014-0031	09/23/2014
23	Reporting of Sexually Transmitted Infections (STIs) Cases among Minor Clients	DOH	DM	2014-0134	04/29/2014
24	Outpatient HIV/AIDS Benefit Package	PhilHealth	Circular	2010-019	8/2/2010
25	Implementing the Child Protection Policy in the Department of Health	DOH	DO	2014-0169	10/3/2014
26	Implementation of the Women's Empowerment, Development and Gender Equality Plan, 2013-2016 (Women's EDGE Plan)	PCW	MC	2014-02	01/28/2014
27	AYHD Program Implementation Guidelines for 2015	POPCOM	Memorandum		10/16/2014
28	Z benefits package	PhilHealth	Circular	2012-30, 2013-02	02/12/13
29	Guidelines for Mainstreaming of MR GAD/KATROPA at the Local Level	POPCOM	Office Order	2014-85	10/14/2014
30	Guidelines on the Abot-Alam Program	DepEd	DO	2014-0017	03/27/2014
31	Social Health Insurance Coverage and Benefits for Women About to Give Birth Revision 1	PhilHealth	Circular	2015-25	06/11/2015
32	Outpatient HIV/AIDS Treatment (OHAT) Package (PhilHealth Circular 19 s. 2010) Revision 1	PhilHealth	Circular	2015-11	6/24/2015
33	Subdermal Contraceptive Implant Package (insertion/removal)	PhilHealth	Circular	2015-38	12/27/2015
34	Annex 2 – List of Procedure Case Rates (Revision 1.0) and Supplementary Guidelines for All Case Rates	PhilHealth	Circular	2015-8	06/01/2015
35	Implementation of Point of Care Program Revision 1	PhilHealth	Circular	2015-33	11/30/2015
36	Implementing Guidelines of PRevEnTS (Primary Care Revitalized and Enhanced Through Skills and Services) A Primary Care Booster Package – Revision 1	PhilHealth	Circular	2015-36	12/23/2015
37	Inclusion of Progestin Subdermal Implant as One of the Modern Methods Recognized by the National Family Planning Program	DOH	AO	2015-0006	02/09/2015
38	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	DOH	DC	2015-0300	09/07/2015
39	Guidelines on the Registration and Mapping of Conscientious Objectors and Exempt Health Facilities Pursuant to the Responsible Parenthood and Reproductive Health Act	DOH	AO	2015-0027	06/22/2015
40	Access to the Family Planning (FP) Commodities by DOH Regional Hospitals and Medical Centers and Provincial Hospitals	DOH	DM	2015-0186	

41	Reiteration of Compliance to the Policy On Informed Choice and Voluntarism in Delivery of Family Planning Services.	DOH	DM	2015-0174	
42	Guidelines on the Deployment of Physicians Graduating from the Residency Training Programs in the Department of Health DOH) –Retained Teaching and Training Hospitals.	DOH	AO	2015-0021	05/11/2015
43	Reiteration of Access to Family Planning (FP) Commodities by DOH Regional Hospitals and Medical Centers, Provincial Hospitals and Civil Society Organizations (CSOs)	DOH	DM	2015-0341	
44	Hiring of Consultants for the Fast Tracking of Service Delivery of Family Planning (FP) Services	DOH	DM	2015-0366	
45	Use of the Revised FP Form 1	DOH	DM	2015-0357	
46	Establishment of the Family Planning Logistics Hotline	DOH	DM	2015-0384	
47	Institutionalization of Women Friendly Space in Camp Coordination and Camp Management	DSWD	MC	2015-006	04/29/2015
48	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	DILG	MC	2015-145	12/29/2015
49	Policy and Guidelines for Comprehensive Water, Sanitation and Hygiene in Schools (WINS) Program	DepEd	DO	2016-10	02/19/2016
50	Creating the National Implementation Team (NIT) and Regional Implementation Teams (RIT)	DOH	AO	2015-0002	01/26/2015
51	Administration of Life-saving Drugs during Maternal Care Emergencies by Nurses and Midwives in Birthing Centers	DOH	AO	2015-0020	05/11/2015
52	Guidelines on the Implementation of the Universal Health Care High Impact Five (Hi-5) Strategy	DOH	AO	2015-0028	06/23/2015
53	Guidelines on the Implementation of Universal Health Care - High Impact Five Strategy for DOH Hospitals	DOH	AO	2015-0033	07/22/2015
54	Implementing Guidelines for the Public Health Associate Department Program (PHADP)	DOH	AO	2015-0026	06/23/2015
55	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	DOH	MC	2015-0195	
56	National Guidelines on the Management of Acute Malnutrition of Children Under 5 years	DOH	AO	2015-0055	12/18/2015

57	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	DOH	AO	2015-0005	02/09/2015
58	Designation of regional point-person for TB-HIV Collaboration	DOH	DM	2015-044	
59	Adjustment of TB-HIV Cohort Reporting and Regional Coordination on HIV Testing Kits for NTP	DOH	DM	2015-0095	
60	Updated list of DOH-Designated Treatment Hubs and Satellite Treatment Hubs	DOH	DM	2016-0139	05/24/2016
61	Revised Diagnostic Algorithm Using Xpert MTB/RIF	DOH	DM	2015-0260	
62	Pilot Implementation of the Rapid HIV Diagnostic Algorithm (RHIVDA) Testing Strategy to 5 Cities in 6 Selected Clinics and 2 DOH-Retained Hospitals	DOH	DM	2015-0364	
63	Initiation of Philippine Antiretroviral (ARV) Drug Resistance Surveillance	DOH	DC	2015-0101	
64	Declaring May 11-15, 2015 as National HIV Testing Week	DOH	DM	2015-8843	
65	Adopting the Collaborative Framework and Strategies for the Implementation of the National Family Planning Program as a Public Health and Population Management Intervention	POPCOM	Board Resolution	2016-0002	
66	Extension of the Certificate of Recognition for Individual Trainers of DOH on Modern Family Planning Method until December 2017	DOH	DM	2016-0371	
67	Guidelines on the Provision of Quality Antenatal Care in All Birthing Centers and Health Facilities Providing Maternity Care Services	DOH	AO	2016-0035	09/19/2016
68	Scale-up Plan for the Implementation of the Philippine Integrated Management of Acute Malnutrition	DOH	DM	2016-0163	
69	National Policy on the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) in Emergencies and Disasters	DOH	AO	2016-0005	02/26/2016
70	Calcium Supplementation for Pregnant Women	DOH	DM		
71	Benefits (including RPRH-related packages) to marginalized youth populations	PhilHealth	Circular	2016-0019	08/04/2016
72	Enhancing Linkage to Care of People Living with HIV	DOH	DC	2016-0171	07/07/2016
73	Operational guidelines for EO 12 (multiagency)	DOH	AO	2017-0005	03/30/2017
74	Guidelines on implementation of AO No.005 Achieving Desired Family Size Through Accelerated and Sustained Reduction in	DILG	MC	2017-85	07/05/2017

	Unmet Need for Modern Family Planning Methods				
75	POPCOM integrated Philippine Population Management Program initiatives	POPCOM	Board Resolution	2017-007	
76	Nationwide adoption of the Clinical Practice Guidelines on the Prevention, Diagnosis and Treatment of Opportunistic Infections in Human Immunodeficiency Virus-infected Adults and Adolescents in the Philippine	DOH	DC	2017-0165	
77	Technical Working Group (TWG) for Adolescent Health and Development	DOH	DPO	2017-2776	
78	Defining the levels of compliance to standards for Adolescent Friendly Facilities into three categories (i.e. Level 1, Level 2 and Level 3). It standardizes the provision of adolescent health services in the different levels of health facilities to ensure delivery of quality care to young people	DOH	DM	2017-0098	
79	Complementary guidelines on the Weekly Iron Folic Acid (WIFA) supplementation for female adolescent learners in public high schools	DOH	DM	2017-0290	
80	Guidelines on the Weekly Iron Folic Acid (WIFA) Supplementation for Female Adolescent Learners in Public High Schools	DepEd	DO	2017-059	11/27/2017
81	Prevention and Control of Viral Hepatitis of the National HIV, AIDS and STI Prevention and Control Program	DOH	AO	2017-0011	07/05/2017
82	Policies and Guidelines in the Conduct of Human Immunodeficiency Virus (HIV) Testing Services in Health Facilities	DOH	AO	2017-0019	09/15/2017
83	National HIV/AIDS and STI Program Recommendations for Testing, Diagnosis and Treatment of Chronic Hepatitis C among People Living with Human Immunodeficiency Virus	DOH	DC	2017-0273	08/09/2017
84	Guidelines for Accreditation of Free-Standing Family Planning (FP) Clinics	PhilHealth	Circular	2018-005	05/18/2018
85	Policy Guidelines on the Implementation of Comprehensive Sexuality Education	DepEd	DO	2018-0031	07/31/2018
86	Department of Health License to Operate (DOHLTO) as Mandatory Requirement for Accreditation of Birthing Homes and Maternity/Lyingin Clinics Starting CY 2018	PhilHealth	Circular	2018-002	05/15/2018
87	Enhancement of Newborn Care Package	PhilHealth	Circular	2018-0021	12/21/2018
88	Accreditation of Stand-Alone HIV Treatment Hubs and Satellite Treatment Hubs as Providers of PhilHealth Outpatient HIV /AIDS Treatment (OHAT) Package	PhilHealth	Circular	2018-004	06/07/2018

89	Revised Policies and Guidelines on the Use of Antiretroviral Therapy (ART) among People living with Human immunodeficiency virus (HIV) and HIV-exposed infants	DOH	AO	2018-0024	10/24/2018
90	Updated list of DOH-designated HIV treatment hubs and primary HIV care facilities.	DOH	DM	2018-0031	
91	Guidelines in the establishment and management of a referral system on Violence Against Women (VAW) at the local government unit level	DILG	MC	2012-61	03/28/2012
92	LGU Attendance to the 1st National Family Planning Conference	DILG	MC	2016-156	11/2/2016
93	Guidelines in Monitoring the Functionality of Violence Against Women (VAW) Desk in Every Barangay	DILG	MC	2017-114	08/30/2017
94	LGU Attendance to the Conduct of the 2nd National Family Planning Conference (NFPC)	DILG	MC	2017-148	11/3/2017
95	Retention of Barangay Violence Against Women Desk Persons	DILG	MC	2018-144	08/28/2018
96	Adoption of Revised PMC Program Implementing Guidelines of 2018	DILG	MC	2018-182	10/26/2018
97	Designation of Local Population Officers and Mobilization of Community Officials, Volunteers and Workers to intensify the implementation of FP	DILG	MC	2019-100	07/08/2019
98	Guidelines in the Implementation of the Counseling Services for the Rehabilitation of Perpetrators of Domestic Violence (CSRPDV)	DSWD	AO	2014-002	04/30/2014
99	Enhanced Guidelines in the Implementation of the Comprehensive Intervention Against Gender-Based Violence (CIAGV)	DSWD	AO	2015-012	07/17/2015
100	Guidelines on the Implementation of the Protective Services Program	DSWD	MC	2015-004	03/06/2015
101	Amendment to M.C. No. 04 Series of 2015 entitled: "Guidelines on the Implementation of the Protective Services Program"	DSWD	MC	2015-016	06/25/2015
102	Guidelines in the Implementation of the Recovery and Reintegration Program for Trafficked Persons	DSWD	MC	2015-020	12/09/2015
103	Reducing Vulnerabilities of Malnourished Children and Providing Health Support to Pregnant and Lactating Women in Select Areas in Autonomous Region of Muslim Mindanao (ARMM)	DSWD	MC	2018-013	07/31/2018
104	Enhanced Guidelines on the Implementation of the Family Development Sessions of the Pantawid Pamilyang Pilipino Program	DSWD	MC	2018-022	10/10/2018
105	Amendment Guidelines in the Accreditation of Pre-Marriage Counselors	DSWD	MC	2019-001	01/08/2019

106	Commitment of all Council members (DSWD, CSC, CHR, PCW, CWC, DILG, DOJ, PNP, DOH, DepEd, DOLE and NBI) to include in their annual agency appropriations starting 2019 onwards the funding requirement to implement programs and services in the Strategic Plan for 2017-2022	Multiple - IAC-VAWC	Resolution	2018-02	
107	Pre-Marriage Orientation and Counseling (PMOC)	Multiple - DILG, DOH, DSWD, POPCOM, PSA	JMC	2018-01	10/18/2018
108	Guidelines in the Establishment of a Violence Against Women (VAW) Desk in Every Barangay	Multiple - DILG, DSWD, DepEd, DOH		2012-01	12/9/2010
108	National policy on the Prevention of Illegal and UNsafe Abortion and Management of Post-Abortion Complications	DOH	AO	2018-0003	02/06/2018
109	Policy guidelines for intensified implementation of National Program on FP	Multiple - DOH, NEDA, POPCOM		2019-01	02/15/2019

9. Index of Results and Recommendations