Implementation Review of the RPRH Law: Local Service Delivery Component

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Summary

LGUs play important roles in delivery of RPRH services

There has been some progress along some dimensions of RPRH at the community level, but much is to be desired

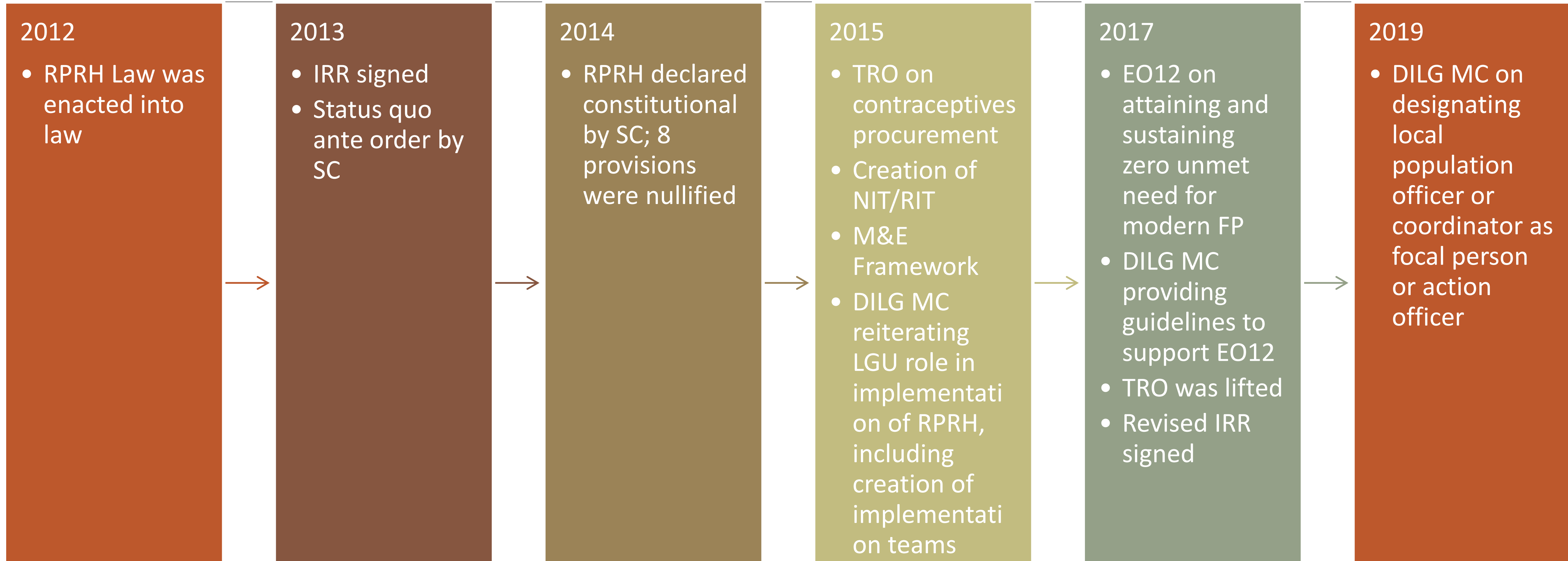
There is a need to focus on building required support to ensure delivery of minimum quality of service

RPRH Law (RA 10354)

Enacted in July 2012, but faced many legal obstacles

Landmark law that guarantees (a) universal access to medically safe, non-abortifacient, effective, legal, affordable, and quality reproductive health care services, methods, devices, supplies, (b) and relevant information and education that is (c) given free to underprivileged sectors

Timeline



Local governments play important roles in the delivery of RPRH services

LGU Roles under RPRH Law

Functional Area	General Responsibilities
Service Provision	Ensure the provision of the full range of RPRH health care services among local public health facilities, including all modern family planning methods
Health Human Resources	Maintain a sufficient number of skilled health staff in all local public health facilities for delivering RPRH services, and train health professionals in public health facilities to provide the full range of RPRH services
Health Facilities	Establish and upgrade local public health facilities for delivering RPRH services, especially emergency obstetrics and newborn care
Supplies, Products, and Equipment	Ensure local public health facilities have supplies and equipment for delivering RPRH services, through DOH provision and possibly through LGUs’ own procurement program

LGU Roles under RPRH Law

Functional Area	General Responsibilities
Service Delivery Network	Map and build local service delivery networks, including both public and private health facilities, with proper referral mechanisms for RPRH services
Health Promotion	Develop and implement RPRH health promotion, education, and communication plans
Maternal/Fetal /Infant Death Reviews	Conduct annual local maternal, fetal, and infant death reviews
Funding	Allocate sufficient local funds for RPRH implementation

What constitute RH care?

Family Planning

- Family planning information, supplies and services

Maternal and Child Health

- Maternal, infant and child health nutrition, including breastfeeding
- Proscription of abortion and management of abortion complications

Adolescent Sexual and Reproductive Health

- Adolescent and youth reproductive health guidance and counseling
- Education and counseling on sexuality and reproductive health
- Reproductive health education for adolescents

What constitute RH care?

Reproductive Tract Infections/Disorders and HIV/AIDS

- Prevention, treatment and management of RTIs, HIV and AIDS, and other STIs
- Treatment of breast and reproductive tract cancers and other gynecological conditions and disorders
- Prevention, treatment and management of infertility and sexual dysfunction

Gender-based Violence

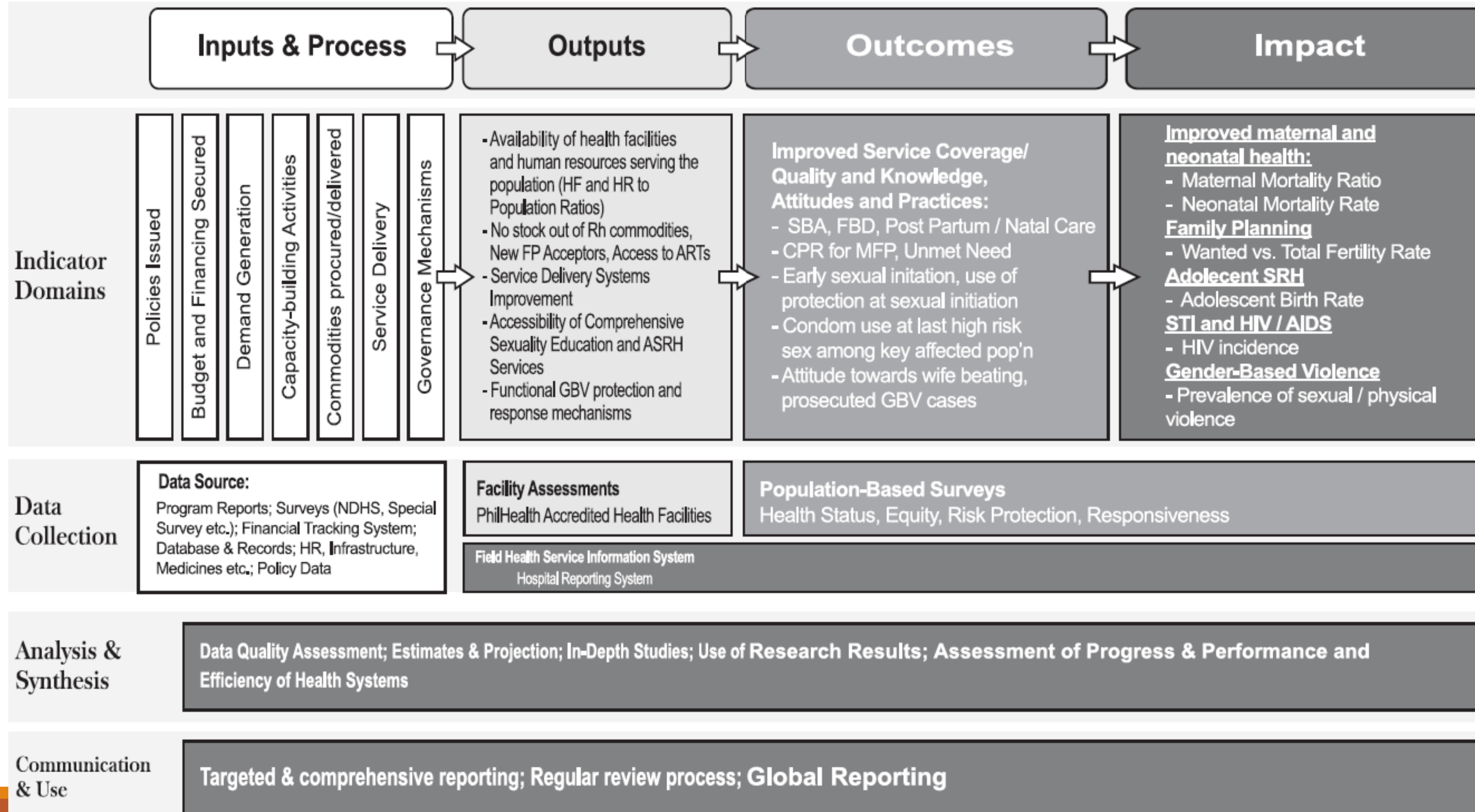
- Elimination of VAWC, and other forms of sexual and gender-based violence
- Male responsibility and involvement, and men’s reproductive health
- Mental health aspect of reproductive care

Objectives

Assess the service delivery mechanisms of RPRH-related programs *at the local government level*, and to identify *enabling factors, barriers, and bottlenecks* that affect the timely and efficient delivery of reproductive health services and commodities at the frontline

- What have we accomplished so far (Outcomes)?
- Are mandated services provided (Outputs)?
- Are mandated support built (Inputs)?

RPRH Logical Framework



From DOH and PopCom (2015) Planning, Monitoring and Evaluation Guide

Research Design

Mixed methods study

- LGU Online Survey
  - Provinces (23/81)
  - Municipalities (25/1488)
  - HUCs (16/146)
  - 56% average completion rate
- FGD/KII with program managers, frontline workers
  - Leyte and Davao del Norte
  - Originally included Benguet but dropped
- Thematic analysis of Quarterly RIT Minutes of Meetings
- Analysis of secondary data (BLGF, NDHS)
- Study plan/Instruments reviewed by St. Cabrini Medical Center - Asian Eye Institute (Ethics), and PSA (Survey design)

What have we accomplished so far?

Maternal and neonatal health

Key Result Area / Indicator	Baseline (Source Year)	Update (Source Year)	Target (Source)
A. MATERNAL AND NEONATAL HEALTH			
Maternal Mortality Ratio	86:100,000 (VSR 2013)	86:100,000 (VSR 2016)	50:100,000 (NOH 2011-2016)
Neonatal Mortality Ratio	13:1,000 (NDHS 2013)	14:1,000 (NDHS 2017)	10:1,000 (NOH 2011-2016)
Proportion of pregnant women with at least four antenatal care visits with skilled health provider	84% (NDHS 2013)	87% (NDHS 2017)	90% in 2016 (NOH 2011-2016)
Proportion of births attended by skilled health provider	72.8% (NDHS 2013)	84.4% (NDHS 2017)	90% by 2016 (NOH 2011-2016)
Proportion of births delivered in health facility	61% (NDHS 2013)	78% (NDHS 2017)	90% by 2016 (NOH 2011-2016)
Proportion of mothers receiving post-partum care by skilled personnel	60% (NDHS 2013)	74% (NDHS 2017)	85% by 2015 (UHC-HI-5)
Proportion of newborns receiving postnatal care by skilled personnel	42% (NDHS 2013)	74% (NDHS 2017)	85% by 2015 (UHC-HI-5)

Maternal and neonatal health

Key Result Area / Indicator	Baseline (Source Year)	Update (Source Year)	Target (Source)
A. MATERNAL AND NEONATAL HEALTH			
Ratio of hospitals to population	2.0:100,000 (PSY 2010)	1.2:100,000 (PSY 2015)	
Ratio of health professionals to population: Composite	34:10,000 (CPH 2010)	41:10,000 (CP 2015)	
Ratio of health professionals to population: Doctors	2:20,000 (CPH 2010)	3:20,000 (CP 2015)	
Ratio of health professionals to population: Nurses	14:20,000 (CPH 2010)	17:20,000 (CP 2015)	
Ratio of health professionals to population: Midwives	6:5,000 (CPH 2010)	1:5,000 (CP 2015)	

Family Planning

Key Result Area / Indicator	Baseline (Source Year)	Update (Source Year)	Target (Source)
B. FAMILY PLANNING			
Wanted fertility rate v. Total fertility rate	2.2 v. 3.0 (NDHS 2013)	2.0 v. 2.7 (NDHS 2017)	
Modern contraceptives prevalence rate among currently married women	38% (NDHS 2013)	40% (NDHS 2017)	65% by 2016 (NOH 2011-2016)
Unmet need for family planning - Women aged 15-49 - Women aged 15-49, lowest wealth quintile	 17.5% 21.3% (NDHS 2013)	 16.7% 18.1% (NDHS 2017)	Reduction of 2.25M among poor women aged 15-49 in 2015 (UHC-HI-5)
Proportion of WRA visited by health worker who talked about family planning - Women aged 15-49 - Women aged 15-49, lowest quintile	 25.9% 34.5% (NDHS 2013)	 20.2% 30.0% (NDHS 2017)	

Adolescent and youth reproductive health

Key Result Area / Indicator	Baseline (Source Year)	Update (Source Year)	Target (Source)
C. ADOLESCENT AND YOUTH REPRODUCTIVE HEALTH			
Adolescent birth rate	57:1,000 (NDHS 2013)	47:1,000 (NDHS 2017)	50:1,000 in 2018 (RPRH MEF)
Percentage of adolescents who had sexual intercourse before age 15	2.2% (NDHS 2013)	1.6% (NDHS 2017)	2.0% (RPRH MEF)
Percentage of adolescents age 15-19 who have begun childbearing	10.1% (NDHS 2013)	8.6% (NDHS 2017)	

STI and HIV/AIDS

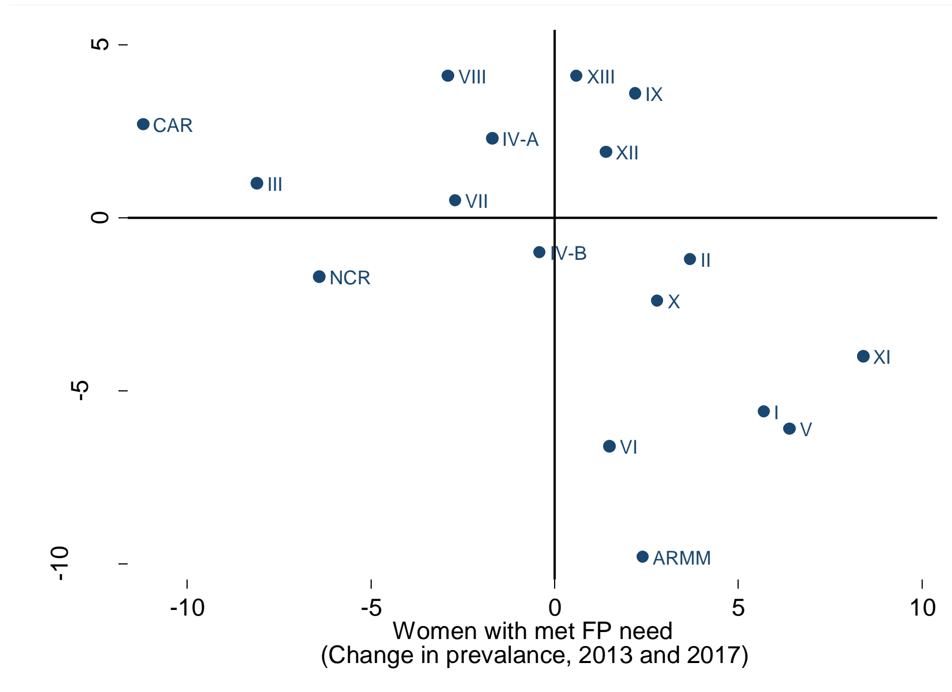
Key Result Area / Indicator	Baseline (Source Year)	Update (Source Year)	Target (Source)
D. STI AND HIV/AIDS			
Percentage of WRA who say that a healthy-looking person can have HIV and who reject the two most common local misconceptions	39.5% (NDHS 2013)	33.8% (NDHS 2017)	
Percentage of WRA who know where to get an HIV test	55.3% (NDHS 2013)	45.4% (NDHS 2017)	

Gender-based violence

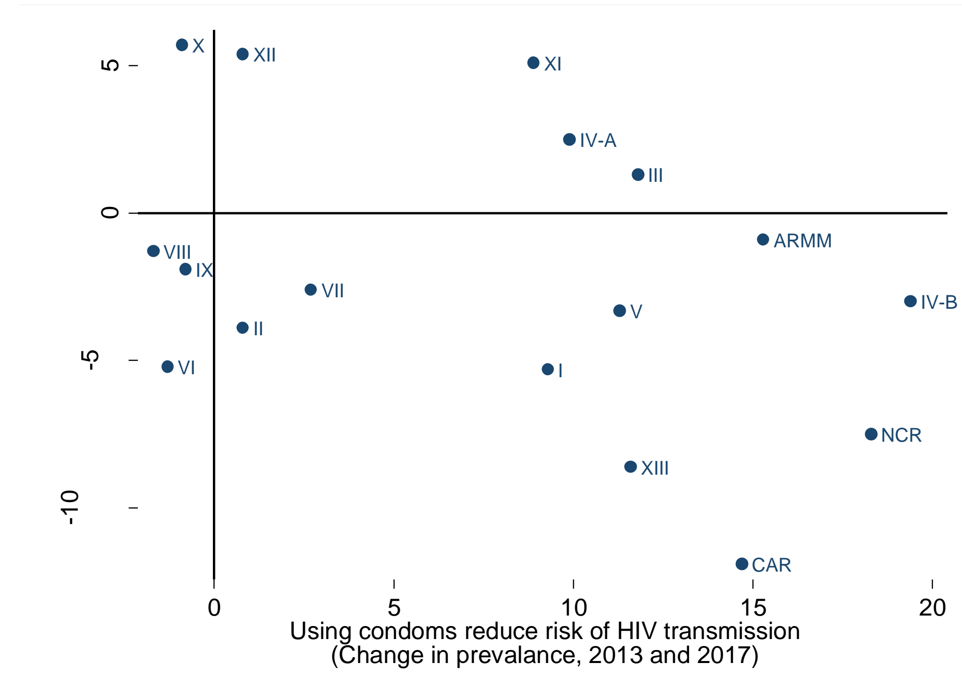
Key Result Area / Indicator	Baseline (Source Year)	Update (Source Year)	Target (Source)
E. GENDER-BASED VIOLENCE			
Prevalence of physical and/or sexual violence by any husband/partner in past 12 months among WRA	7.1% (NDHS 2013)	5.5% (NDHS 2017)	Decrease (RPRH MEF)
Prevalence of physical and/or sexual and/or emotional violence by any husband/partner in past 12 months among WRA	15.6% (NDHS 2013)	14.7% (NDHS 2017)	
Prevalence of sexual violence in past 12 months among WRA	2.7% (NDHS 2013)	1.6% (NDHS 2017)	
Percentage of WRA who agree that a husband is justified in hitting or beating his wife for specific reasons	12.9% (NDHS 2013)	10.9% (NDHS 2017)	Decrease (RPRH MEF)
Percentage of WRA who experienced physical and/or sexual violence, and never sought help or told someone	38.3% (NDHS 2013)	40.8% (NDHS 2017)	

Regional disparity in progress

DEMAND FOR FAMILY PLANNING

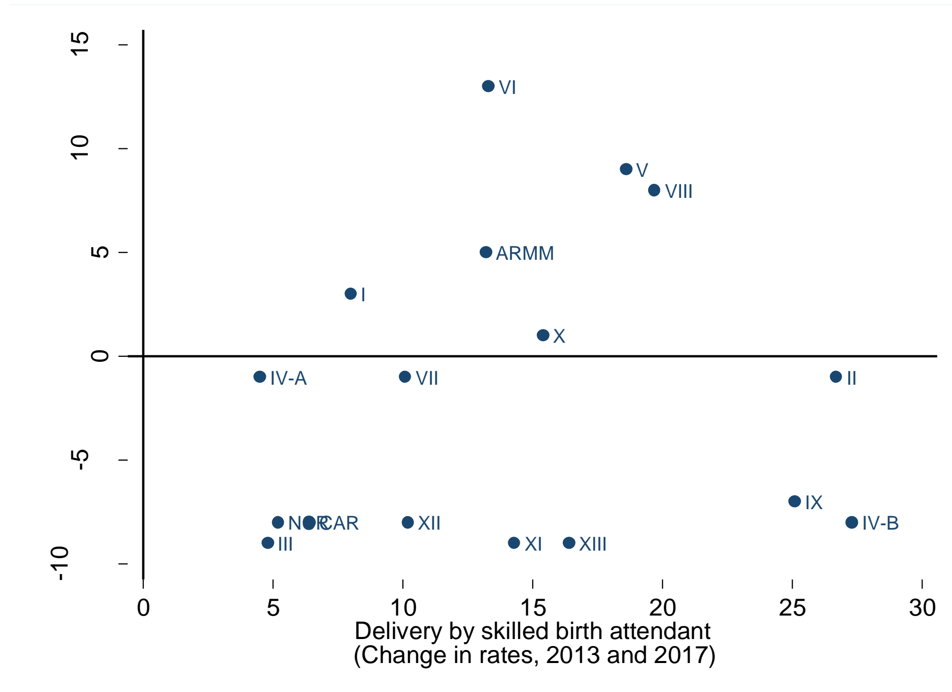


EARLY CHILD BEARING AND STI KNOWLEDGE

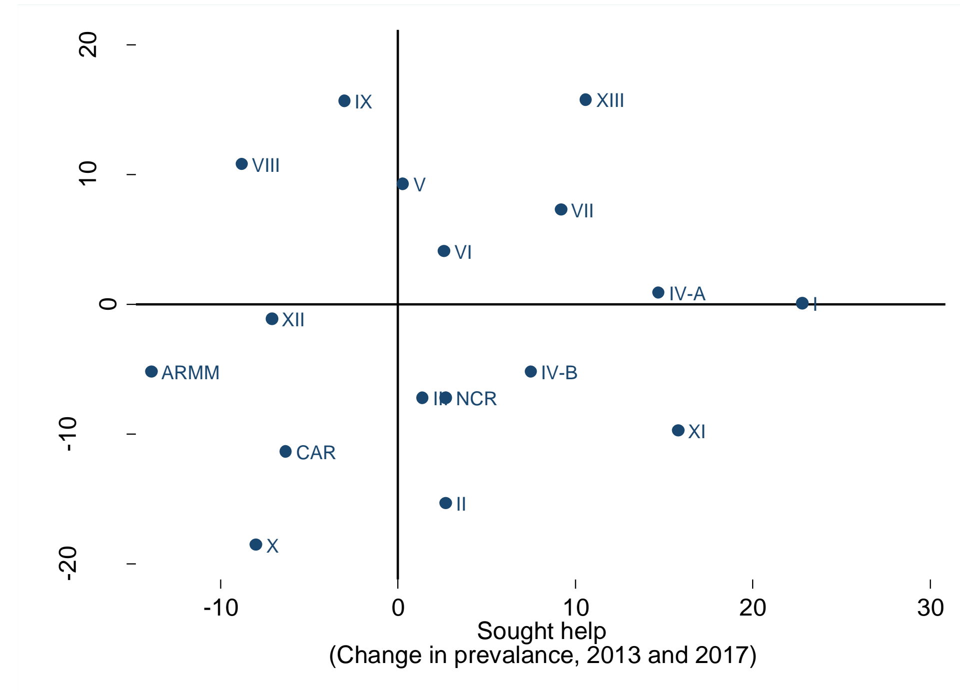


Regional disparity in progress

DELIVERY BY SKILLED ATTENDANT AND IMR



VAW AND HELP-SEEKING BEHAVIOR



Are the mandated services provided?

Service Provision

LGU Role: Ensure the provision of the full range of RPRH health care services among local public health facilities, including all modern family planning methods

RPRH services are largely part of LGU services even before RPRH Law

- RPRH law seen as a "formality" for implementation
- RPRH services are generally provided, or referral to other facilities if not provided (e.g. mental health services); None responded contracting services from private sector
- Immunization services provided once a week in most cases
- PMOC required before issuance of marriage license

Service Provision

While services are generally available, there appears to be material differences in the provision of mandated services

- Non-provision of some products and services: NFP supply (charts, digital thermometers, standard days method beads), resupply of condoms and oral contraceptive pills
- Not all LGUs have assigned poor to designated health care provider for RH services
- While there have been steps to cater to special needs of PWDs, some LGUs reported not being able to provide access to information, and adapt procedures for PWD needs

Service Provision *in Crisis Situations*

Most LGUs reported RH service package for crisis situations

- Many reported no changes in service delivery during crisis situation
- In evacuation centers: Medical/Psychosocial, not necessarily FP services

COVID-19 is a real-life test of RPRH service provision during a crisis

- Many reported no changes in service delivery, although some reported wholly or partially discontinuing delivery of RPRH services, including immunization; vasectomy; tubal ligation; other medical and surgical procedures; facility-based delivery; prenatal, postnatal and newborn care; IUD insertion and removal; case management of gender-based violence
- No regular PMOC, only “special” condensed sessions

Service Delivery Network

LGU Role: Map and build local service delivery networks (SDN), including both public and private health facilities, with proper referral mechanisms for RPRH services

Most respondents already mapped health care facilities in LGUs

Some LGUs do not include private sector in local SDN

- Among those that do, many did not respond how many
- Stated need to strengthen SDN and referral pathways
- Some are able to leverage on SDNs, e.g. private clinics providing IUD and DMPA from LGU to clients; case management at different levels of care (BHS → RHU → Hospital)

Health Promotion

LGU Role: Develop and implement RPRH health promotion, education, and communication plans

No stand-alone RPRH communication plan, but education and communications activities integrated in other programs

- Many rely on materials provided by national government (DOH, PopCom)
- Many programs for young adults (e.g. teen centers, peer education, etc.) but lack evaluation if effective

Some LGUs reported being able to tap social media (Facebook) and traditional media (regular radio plugs) platforms

Maternal and Fetal/Infant Death Reviews

LGU Role: Conduct annual local maternal, and fetal and infant death reviews in accordance with DOH guidelines

All respondents conducted maternal death reviews; Reports done mostly monthly, but others less frequently, e.g. in instances of maternal death

Not all LGUs reported conducting fetal/infant death reviews

Are the mandated support built?

Health Human Resource

LGU Role: Maintain a sufficient number of skilled health staff in all local public health facilities for delivering RPRH services, and train health professionals in public health facilities to provide the full range of RPRH services (NG to provide additional resource)

HRH in the public sector has not increased sufficiently to reach the WHO threshold of 23HRH/10,000 population to meet 80% delivery by skilled birth attendants

- Not much change in public sector-HRH density among LGUs since 2010
- Even with massive DOH augmentation program, still not enough

Public Sector-HRH Density

	Physicians			Nurses			Midwives			Composite		
	2010	2015	2018	2010	2015	2018	2010	2015	2018	2010	2015	2018
Philippines	0.3	0.3	0.3	0.5	0.6	0.6	1.8	1.7	1.6	0.2	0.2	0.2
NCR	0.3	0.5	0.5	0.5	0.8	0.8	0.8	1.0	0.9	0.3	0.5	0.4
CAR	0.6	0.6	0.5	0.9	1.6	0.9	3.9	3.9	3.8	0.3	0.2	0.2
I	0.3	0.3	0.4	0.4	0.6	0.8	3.0	2.1	2.3	0.2	0.2	0.2
II	0.3	0.3	0.3	0.7	0.6	0.6	2.6	2.3	2.4	0.2	0.2	0.2
III	0.3	0.3	0.3	0.5	0.6	0.5	1.6	1.6	1.3	0.2	0.2	0.1
IV-A	0.2	0.2	0.2	0.4	0.5	0.5	1.5	1.3	1.1	0.2	0.1	0.1
IV-B	0.3	0.3	0.3	0.5	0.6	0.6	2.2	1.8	1.9	0.2	0.2	0.2
V	0.3	0.3	0.2	0.5	0.5	0.6	2.0	1.8	1.7	0.2	0.2	0.2
VI	0.3	0.3	0.3	0.6	0.6	0.6	2.5	2.3	2.1	0.2	0.2	0.2
VII	0.4	0.4	0.3	0.6	0.9	0.7	2.3	2.4	2.2	0.2	0.1	0.2
VIII	0.4	0.4	0.4	0.5	1.2	0.6	2.1	2.2	2.0	0.2	0.2	0.2
IX	0.3	0.3	0.2	0.5	0.4	0.6	1.8	1.5	1.8	0.1	0.1	0.1
X	0.3	0.2	0.2	0.5	0.6	0.4	2.4	1.9	2.0	0.2	0.1	0.1
XI	0.0	0.2	0.2	0.0	0.3	0.3	0.0	1.4	1.3	0.0	0.1	0.1
XII	0.3	0.3	0.3	0.6	0.9	0.6	2.2	2.2	1.8	0.1	0.1	0.1
Caraga	0.3	0.3	0.2	0.5	0.6	0.4	2.5	1.9	1.5	0.3	0.1	0.1
ARMM	0.2	0.2	0.2	0.4	0.3	0.3	1.6	1.6	1.4	0.1	0.1	0.1

WHO threshold: 23HRH per 10,000 population to meet 80% delivery by skilled birth attendants

DOH augmentation and private sector are important to meet threshold

Public Sector-HRH Density *with augmentation*

	Without DOH-HRHDP			With DOH-HRHDP		
	2010	2015	2018	2010	2015	2018
Philippines	0.2	0.2	0.2	0.2	2.1	3.3
NCR	0.3	0.5	0.4	0.3	0.9	1.1
CAR	0.3	0.2	0.2	0.6	4.5	6.9
I	0.2	0.2	0.2	0.3	2.6	4.4
II	0.2	0.2	0.2	0.3	3.1	5.7
III	0.2	0.2	0.1	0.2	1.5	1.7
IV-A	0.2	0.1	0.1	0.2	1.1	1.7
IV-B	0.2	0.2	0.2	0.3	3.1	3.0
V	0.2	0.2	0.2	0.2	2.6	5.1
VI	0.2	0.2	0.2	0.2	2.2	2.5
VII	0.2	0.1	0.2	0.2	2.4	3.7
VIII	0.2	0.2	0.2	0.3	4.2	6.2
IX	0.1	0.1	0.1	0.2	2.6	5.3
X	0.2	0.1	0.1	0.3	2.8	4.0
XI	0.0	0.1	0.1	0.1	1.9	2.6
XII	0.1	0.1	0.1	0.2	1.9	4.3
Caraga	0.3	0.1	0.1	0.4	3.4	5.8
ARMM	0.1	0.1	0.1	0.1	3.3	4.8

Still not enough to reach the WHO threshold of 23HRH per 10,000 population to meet 80% delivery by skilled birth attendants

Highlights the importance of the private sector

Health Human Resource

Some LGUs reported not having trained HRH

- Nurses and midwives: CEmONC, Gender sensitivity, Family planning
- Some reported having BHW not having any training at all

FP services not provided by HRH despite having been trained

- Reasons cited: No client; Training certificate not yet awarded; No support equipment or supply; Need more practice; Religious reasons

Not all LGUs allowed trained and certified midwives to administer life-saving drugs (oxytocin, antibiotics, etc.)

Not all LGUs have designated RH Officer of the day

Health Human Resource

Some issues identified

- Fast turnover of personnel trained in RPRH services
- Need for training needs assessment for HRH retraining and retooling
- Heavy workload
  - Increasing workload from additional/changing/confusing mandates; Not enough HRH
  - Relies heavily on DOH augmentation for additional tasks (master listing, recording, etc.)
  - At times, services are interrupted to comply with reporting responsibilities
  - Multiple responsibilities among HRH, e.g. MHO+MNAO
- Difficulty in hiring (e.g. due to PS cap, finding skilled staff)
- Voluntary nature of appointment (among barangay frontline personnel)
  - Variable allowance depending on LGU; No hazard or transportation allowance
  - Unequal treatment among volunteer types (BHWs, BNS, BPVs)

Health Facilities

LGU Role: Establish and upgrade local public health facilities for delivering RPRH services, especially emergency obstetrics and newborn care (with NG providing additional support)

Many LGUs reported having established/upgraded public health facilities for RPRH services

None among respondents stated that they have mobile health clinics

- Government vehicle important to deliver service especially in GIDAs

Barangay Health Stations

	BHS			000 Population/BHS		
	2010	2015	2018	2010	2015	2018
Philippines	17,297	19,622	21,546	5.3	5.1	4.9
NCR	456	477	474	26.0	27.0	28.4
CAR	639	639	706	2.5	2.7	2.5
I	807	1,160	1,379	5.9	4.3	3.8
II	1,106	1,240	1,289	2.9	2.8	2.8
III	1,901	1,969	1,916	5.3	5.7	6.2
IV-A	2,086	2,248	2,576	6.0	6.4	6.0
IV-B	763	836	896	3.6	3.5	3.5
V	1,134	1,158	1,435	4.8	5.0	4.2
VI	1,776	2,059	2,038	4.0	3.7	3.8
VII	1,658	1,877	2,241	4.1	3.9	3.5
VIII	809	831	842	5.1	5.3	5.5
IX	681	702	770	5.0	5.2	4.8
X	1,026	1,085	1,212	4.2	4.3	4.0
XI	…	1,023	1,115	…	4.8	4.6
XII	987	1,115	1,148	4.2	4.1	4.2
Caraga	845	782	683	2.9	3.3	3.9
ARMM	623	421	826	5.2	9.0	4.9

BHS play an important role in RPRH service delivery: information, counseling, dispensing of health products, resupply of condoms and pills, referral to other facilities/GBV

At the national level, number of BHS increased by 2.8% annually, faster than population growth

Supplies, Products, and Equipment

LGU Role: Ensure local public health facilities have supplies and equipment for delivering RPRH services, through DOH provision and possibly through LGUs' own procurement program

Many LGUs reported having stock-outs for extended periods

- FP stock outs: Progestin only pill (15 to 180+ days); DMPA (15 to 180+ days); Intrauterine device (60 to 180+ days); Male condoms (2-60 days); Standard days method cycle beads (90 days); Digital thermometer (180+ days); Progestin subdermal implant (15-100 days) / No stock outs: Cervical mucus method charts, basal body temperature charts
- Vaccine stock outs among provincial LGUs: BCG (30-60 days), Hib (>180 days), Pentavalent (60 days), IPV (>180 days), PCV (180 days), MMR (30-90 days), syringe (30-60 days), Vitamin A (30-60 days)

The are stock outs but not “severe” – a couple of months

Supply of FP primarily from DOH, PopCom; some LGUs procure own supply, receive from CSOs/NGOs

- All respondents stated that they produce quarterly FP utilization reports, although some submit late; Confusion on where to submit (DOH or PopCom)
- Issue for GIDAs: FP commodities are for pick up at PHO in some LGUs

Supply of vaccines mainly from DOH; some LGUs procure own supply

Supply is important but also skilled people

- Case in point: HIV/AIDS kit not utilized because of lack of trained people

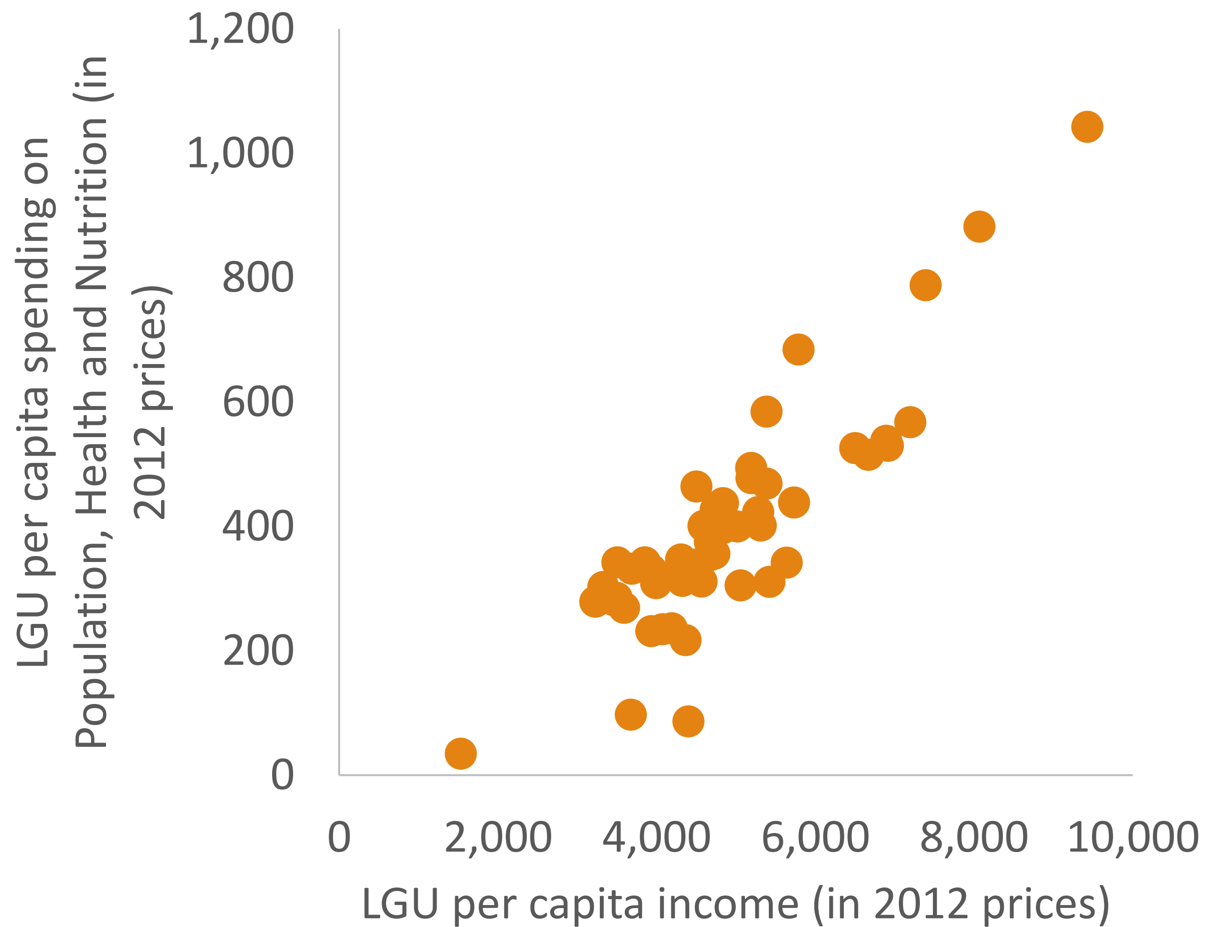
Funding

LGU Role: Allocate sufficient local funds for RPRH implementation

RPRH services by LGU financed mostly by general fund, GAD fund; some LGUs are able to access 20% LDF and LDRRM Fund, allocation for seniors and PWDs, SEF and trust funds

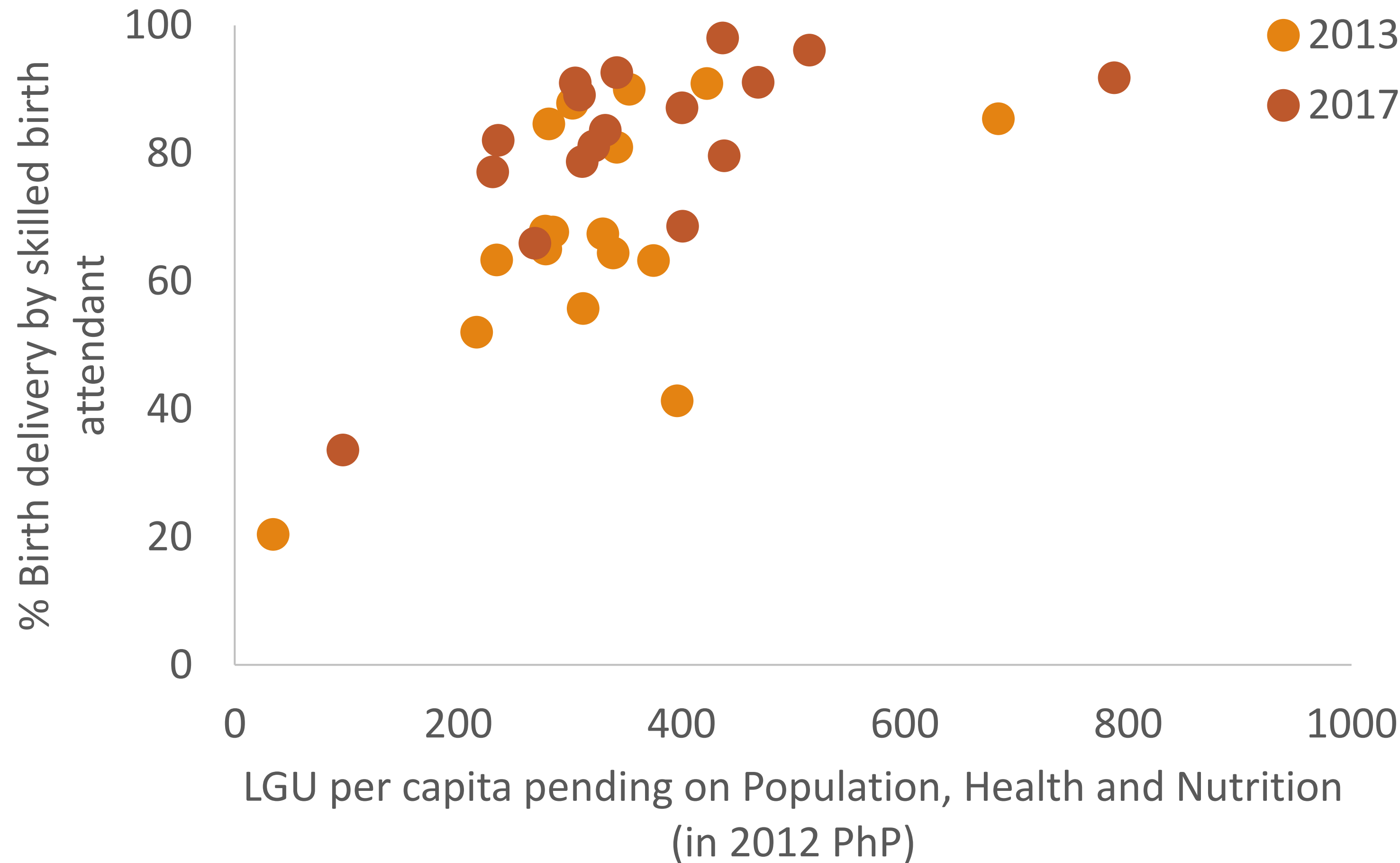
Very few respond to break down of RPRH-related spending: Difficult to assess how much exactly went to RPRH services?

LGU income and PHN spending



LGU spending on population, health and nutrition (forming a large part of RPRH services) increases with LGU income

LGU spending and RPRH outcome



Higher LGU spending on population, health and nutrition correlated with improved RPRH outcome

LGU income for local sources

	PhP Thousands (2012 prices)			% of Total Income			Annual Growth (%)		
	2010	2015	2019	2010	2015	2019	2010-15	2015-19	2010-19
Philippines	1.3	1.6	2.0	31.9	33.6	34.4	4.6	5.8	5.1
NCR	4.0	5.2	6.3	76.5	77.7	78.7	5.1	5.2	5.2
CAR	0.8	1.2	1.4	14.3	16.7	14.6	8.4	2.9	5.9
I	0.7	1.3	1.4	15.5	26.5	20.9	12.2	1.5	7.3
II	0.7	0.8	1.2	14.7	14.7	16.8	3.5	10.0	6.4
III	1.0	1.3	1.6	30.9	32.6	33.6	4.1	6.1	5.0
IV-A	1.4	1.6	2.1	41.8	41.2	41.7	2.6	6.2	4.2
IV-B	0.5	0.7	1.0	11.3	12.7	14.5	4.3	10.3	6.9
V	0.5	0.6	0.8	16.6	16.3	16.8	2.3	5.9	3.9
VI	0.7	1.0	1.3	20.0	24.3	24.7	8.0	5.5	6.9
VII	1.0	1.2	1.8	29.0	24.7	34.0	4.2	9.1	6.3
VIII	0.5	0.7	0.7	13.8	14.5	13.1	4.2	1.5	3.0
IX	0.5	0.6	0.7	11.8	16.1	14.0	4.2	1.1	2.8
X	0.9	1.1	1.4	21.1	23.9	24.4	4.8	6.0	5.4
XI	0.9	1.2	1.6	24.9	27.9	30.1	6.1	8.7	7.3
XII	0.6	0.6	0.7	13.6	16.6	17.2	0.2	5.5	2.5
Caraga	0.7	0.9	1.1	15.7	15.5	15.3	3.9	5.6	4.7
ARMM	0.1	0.1	0.1	4.0	2.1	2.0	4.3	3.9	4.1

Robust growth in real terms over the past decade

Except for NCR, still large reliance on external sources (i.e., IRA)

Governance

LGU Role: Mobilize Local Health Board or formally organize a local RPRH Law Implementation Team to coordinate and ensure implementation by LGU

Support of local chief executive very important

- Many respondents stated that their LCE is supportive, but may be selective (Focus on FP, not whole RPRH services)
- Important in financing, policy support
- Awards/Recognition (SGLG, Purple Ribbon) appear to work in building support, but resources are focused on traced indicators

Governance

Local Implementation Teams are not created or functional

- LCE is not supportive (e.g. request denied twice)
- No designated point person; Increased workload among members
- No coordination meeting; No budget allocation

Information system is crucial in monitoring progress

- Issues in timely delivery of reports: workload; difficulties in geography and technology; domino effect from delayed submissions from municipalities/component cities to province; many rely on DOH augmentation for data collection and encoding
- Indicators: too many, not clear, difficult to calculate

Conclusions and Recommendations

Conclusion

There has been some progress along some dimensions of RPRH

- Some successes in Adolescent and Youth Reproductive Health and in Gender-based Violence; but more to be desired for Maternal and Child Health, in Family Planning, and in STI and HIV/AIDS
- While services are generally available, there appears to be material differences in the provision of mandated services
- Many new initiatives by LGU that need to be documented and assessed
- Some growth in mandated support for RPRH (human resource, facilities, financing), but more may be needed

Recommendations

On building needed support for RPRH

- Forecasting demand, effective supply chain management are crucial in ensuring no stock-outs/overstocks
- Reliance on DOH-HHR augmentation may not be sustainable; Need to attract, develop, and maintain local talents funded by LGU
- Need to unburden critical HHR of reporting requirements to focus on service delivery; additional personnel may be needed to focus on reportorial duties (But who pays? Potential solution: Burden sharing based on benefits)

Recommendations

On delivery of services

- Need to ensure minimum quality of service per law (but this depends on available support and supply for service delivery)
- Innovation is welcome, but need to identify and focus on what works

On monitoring progress

- Need to streamline indicators given capacity to deliver
- Focus on what can be delivered effectively by different stakeholders, e.g. LGUs may focus on inputs and outputs (even outcomes already in FHSIS), while NG may focus on outcomes