COUNTRY PROFILE

ON UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH:

PHILIPPINES

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1. Introduction

Context: social determinants

The Philippines is the 12th most populated country in the world with 98.4 M people in 2013 and growing at the rate of 1.7% per year (UN Population Division, 2013). Many are young: 33% were 0-14 years old while 20% were 15-24, according to the 2010 census by the Philippine Statistics Authority (PSA, August 2012). Urbanization is the trend, with 45.3% of the population residing in urban areas in 2010, areas which are growing at an average annual rate of 4% compared to the 0.4% decline in rural areas (PSA, June 2013).

The Philippines is a lower middle income country with an "emerging economy." GDP growth has been increasing—though slowly and erratically—reaching 7.2% in 2013, reportedly the second highest in Asia for that year according to Arsenio Balisacan, Director General of the National Economic and Development Authority (2014). He, however, acknowledged that the government will not be able to meet its target of reducing poverty from 25% in 2012 to 17% by 2015.

The country is an archipelago with over 7,100 islands, many of which are remote and referred to as GIDAs (geographically isolated and disadvantaged areas). The islands are home to over 11 million indigenous peoples belonging to over 110 ethno-linguistic groups, according to the National Commission on Indigenous Peoples (n.d.). It is also considered a natural disaster "hot-spot," with about 50% of its total area and 81% of its population vulnerable to typhoon, flooding and earthquake; making it the third country most prone to disaster, after Vanuatu and Tonga (Senate Economic Planning Office, 2013).

Simple literacy for all people 10 years old and above was 96% in 2008, but higher for females (PSA, "Statistics: Education"). Highly educated Filipino women made the Philippines rank 5th among 135 countries in gender equality, according to the Global Gender Gap Index in 2013. However, there continue to be gaps between men and women, and between women with resources and those without (Phil. Commission on Women, 2014).

The Philippine health system is "devolved" to over 1,700 local government units with huge autonomous powers under the Local Government Code of 1991. The law was intended to facilitate local participation and accountability, but the results are mixed. In a study entitled "Decentralisation and its Implications for Reproductive Health," Lakshminarayanan (2003) asserted that decentralisation "could exacerbate inequities, weaken local commitment to priority health issues and decrease the efficiency and effectiveness of service delivery by disrupting the referral chain." She said that such effects "pose a particularly serious threat to accessibility and delivery of reproductive health services, some of which (e.g. family planning) are controversial and thus susceptible to local pressures, and others of which (e.g. emergency obstetric care) require a functioning and effective health system." Widely variable policies and cumbersome bureaucracy affect greatly the access to RH services.

The total government allocation to health comes from three sources—the national government, local government units and the national social health insurance system run by the Philippine Health Insurance Corp. (PhilHealth), which was formed

Table 1. Philippine national health accounts

	1995	2005	2012*
Government spending on health as aproportion of total health expenditure	39.5	38.4	37.7
Government spending on health as a proportion of GDP	1.4	1.5	1.7
Out of pocket expenditure as proportion of total health expenditure	50.0	51.9	52.0

** Latest available*
Source: (WHO, Global Health Expenditure Database)

in 1995. However, out-of-pocket spending remains the single biggest source of funds for health, accounting for half of all expenses (see Table 1). From 1995 to 2012, out-of-pocket share increased by 2 percentage points, while government share fell by almost the same amount. Government health spending as a proportion of GDP grew marginally by 0.3 percentage points during the same period.

Under President Aquino's Universal Health Care thrust, however, there is a dramatic increase in investment in health. Action for Economic Reforms (AER) reports that with the revenues from a new law increasing "sin taxes" on alcohol and tobacco (Republic Act [RA] No.10351, 2012), the budget of the Department of Health (DOH) was jacked up from PHP53 billion in 2013 to 83.7 billion in 2014—the "single largest increase ever for the DOH" (AER, 2014). AER cites health secretary Enrique Ona as pledging to put the funds into PhilHealth insurance premiums for the poor and non-poor, upgrading of government hospitals and health facilities, expanding public health programs, and hiring health workers to implement the Universal Health Care program. With this infusion, PhilHealth also increased its appropriation for the enrolment of indigent families under the government's National Household Targeting System for Poverty Reduction from PHP2.63 billion in 2013 to 35.34 billion in 2014 (PhilHealth, "Strategic Initiatives Profile"). The increased funding for the DOH will be continued in 2015 if the proposed PHP86.58 billion budget is approved by the legislature (Department of Budget and Management, 2014).

2. The status of sexual and reproductive health in the Philippines

Contraception

The total fertility rate (TFR) in the Philippines has been declining since Family Planning (FP) was started as a government program in 1971. However, the Philippines' rate of 3.1 was among the highest in Asia in 2012 (World Bank, "Data: Fertility Rate"). There was a gap of over 3 children between the TFR of women in the richest and poorest quintiles in 2008 (see Table 2). There was also a gap between actual and desired fertility, which was higher in the poorest than in the richest women. These equity gaps have been present since the 1993 DHS and improved only slightly 15 years after.

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Table 2. Total fertility rates by selected characteristics

	1993 DHS	1998 DHS	2008 DHS	2013 DHS*
Actual TFR, poorest women	6.5	6.5	5.2	N/A
Actual TFR, richest women	2.2	2.1	1.9	N/A
Wanted TFR, poorest women	4.3	4.1	3.3	N/A
Wanted TFR, richest women	1.9	1.8	1.6	N/A

** All mention of "2013 DHS" refers to a Preliminary Report only*

Source: (1993, 1998, 2008 and 2013 DHS authored by the Philippine Statistics Authority (previously the National Statistics Office) and ICF Int'l. (previously Macro Int'l. and ORC Macro), in 1994, 1999, 2009 & 2013)

Table 3. TFR, contraceptive prevalence rate (CPR) and unmet need for contraception

	1970s*	1980s*	1993 DHS	1998 DHS	2008 DHS	2011 FHS**	2013 DHS
TFR	6-5	5-4	4.1	3.7	3.2	3.1	3.0
CPR, modern methods, married women 15-49	11-17	19-22	24.9	28.2	34.0	36.9	37.6
CPR, any method, married women 15-49	17-39	32-36	40.0	46.5	50.7	48.9	55.1
Unmet need, married women 15-49	N/A	N/A	26.2	19.8	22.3	19.3	N/A

** From various surveys cited in the 1993 Philippine DHS*
*** 2011 Family Health Survey*
Source: (PSA: May 2012, October 2012 & May 2013)

Use of modern contraceptives has slowly increased, but its steepest rise occurred between 1993 and 1998 (Table 3). Hardly any growth occurred between 2001 (33%) and 2008 (34%), based on various surveys of the PSA (2013 May). This stagnation reflects the policy of Pres. Gloria Arroyo, a close ally of the Catholic Church hierarchy who opposed reproductive health and favored only “natural family planning” (Melgar J, Melgar A & Cabigon, 2012). Unmet need has decreased between 1993 and 1998, but remains unstable until 2011.

While the 2013 DHS shows an apparent increase in CPR compared to a 2011 survey (Table 4), the increase is marked for traditional methods (5.5 percentage points increase), and negligible for modern methods (0.7). After the pill, which is used by 19.1%, the next method with the highest use is withdrawal (12%). Both indicate women’s and men’s strong desire to avoid pregnancy, as also demonstrated by unmet need, and their inability to access more effective and convenient methods.

Table 4. Current use by method, married women of reproductive age

	1993 DHS	1998 DHS	2008 DHS	2011 FHS	2013 DHS
Any method	40.0	46.5	50.7	48.9	55.1
Any modern method	24.9	28.2	34.0	36.9	37.6
Pill	8.5	9.9	15.7	19.8	19.1
IUD	3.0	3.7	3.7	3.1	3.5
Injectables	0.1	2.4	2.6	3.4	3.7
Condom	1.0	1.6	2.3	1.2	1.9
Female sterilization	11.9	10.3	9.2	8.6	8.5
Male sterilization	0.4	0.1	0.0	0.1	0.1
Other modern	0.0	0.2	0.4	0.6	0.1
Traditional	15.1	18.3	16.7	12.0	17.5

The generally low use of modern contraceptive methods in the Philippines is not compatible with a social context that is theoretically associated with moderate use: midlevel income, high literacy, urbanization and women's empowerment.

While there are many hindrances to universal access to quality family planning (FP) information and service, the key barrier is the absence of laws and policies enabling access. A loud and relentless opposition to FP on religious grounds has made all branches of government—executive, legislative and judiciary—wary of strongly institutionalizing the program. Even the newly-minted Responsible Parenthood and Reproductive Health Act of 2012 (RA 10354, more popularly known as the RH Law), which mandates access to FP services, especially for the poorest, could potentially limit the contraceptives in the program to only those proven to act prior to fertilization (Imbong v. Ochoa, 2014). Minors are also not allowed access to contraceptives without their parents' written consent.

Because of active opposition by anti-FP legislators in the House of Representatives and Senate, the yearly budget deliberations are contentious and the resulting appropriations are small—PHP400 million in 2011 (Ager, 2010) and PHP500 million in 2012 (IRIN news, 2012). After the RH Law was declared generally "not unconstitutional" by the Supreme Court in April 2014 (Imbong v. Ochoa), it is hoped that Congress would pass a bigger budget; yet this is not certain.

Other factors barring access to FP is the fragmented health system, which makes difficult the standardization of FP services, the procurement of supplies, the deployment of an adequate number of skilled providers, and their provision of quality FP services.

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Maternal health

There are two parts to maternal health: the first and most urgent aspect is mothers' survival from life-threatening complications of pregnancy and delivery; the second is the maintenance of health during pregnancy for the long-term wellbeing of women and their babies. This discussion focuses on the first aspect.

The rate of mothers' dying from pregnancy complications is measured by the Maternal Mortality Ratio (MMR). In the Philippines, there is currently a dispute on the true value of the MMR based on four conflicting sources of data (see Table 5 and Figure 1). Two sources come from the Philippine Statistics Authority (PSA): estimates using the Direct Sisterhood Method (DSM) done in surveys in 1993, 1998, 2006 and 2011; and vital statistics records from the civil registration system. A third source comes from the DOH's Field Health Service Information System (FHSIS), which is derived from reports of local government health units collected from the villages and collated at the provinces and regions. The fourth comes from the WHO and other UN agencies, which uses a statistical model with three "predictor variables": GDP per capita, general fertility rate and skilled birth attendants.

The estimates based on the registered deaths and births in the civil registry and the FHSIS are the lowest. However, both systems are characterized by incompleteness and inaccuracies in data classification and counting. The lower limit of the DSM and the upper limit of the WHO estimates slightly overlap. The PSA, which determines the country's official statistics, used the DSM estimate of 221 maternal deaths per 100,000 live births in assessing the country's MDG 5 performance (PSA,

Table 5. MMR: latest data from various sources

Agency	Method	Period	MMR	Range
PSA (May 2014)	Direct Sisterhood Method	2004-2011	221	182-260
PSA (2013)	Registered maternal deaths & live births	2010	95	N/A
DOH (2011)	Field Health Services Information System	2011	67	N/A
WHO, Unicef, UNFPA, World Bank, UN Pop. Division (2014)	Modeled estimate	2013	120	81-190

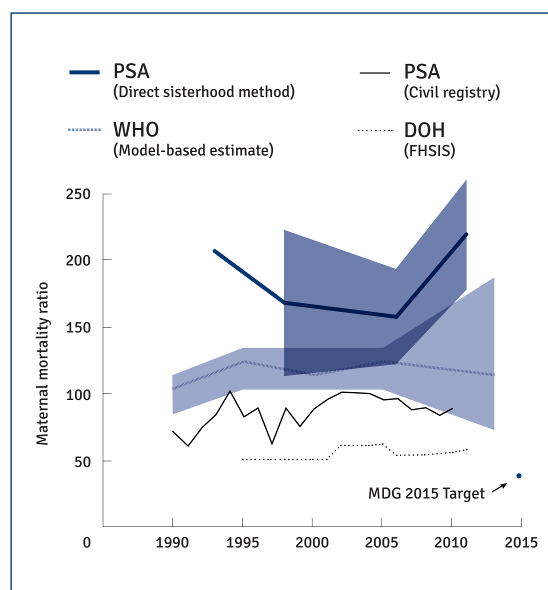
2014). It ranks as “low” the country’s probability of achieving the goal of 52 MMR by 2015, based on the current rate of progress.

Despite the variation in estimates, all four sources confirm a lack of progress in MMR reduction over the last two decades. This record is dismal compared to most other countries. The latest joint report by the WHO, UNICEF, UNFPA, World Bank and UN Population Division (2014) reveals that the whole world managed a 45% decline in MMR between 1990 and 2013 (46% decline within the developing regions), while the Philippines registered a 15% increase. The report characterized 11 countries as “on track” to achieve the MMR-reduction target of the MDG by 2015; a further 63 countries as “making progress”; 13 countries as having made “insufficient progress”; and 2 countries—the Philippines and Guyana—as having “no progress” (p. 2 & pp. 36-43).

The absence of progress in MMR reduction is confirmed by the country’s poor performance in other proxy indicators, notably access to skilled birth attendance (SBA), access to emergency obstetric care (EmOC) access, including post abortion care (PAC), adolescent fertility rate (AFR), and CPR.

SBA has increased slowly by a total of 20 percentage points over the past 20 years, but only by 0.3% from 2011 to 2013 (see Table 6). The current figure of 73% is far from the DOH target of 90 by 2016 (DOH, 2012, Chapter 5). In 2008, there was a wide equity gap between the SBA of the

Figure 1. Maternal mortality ratio from various sources, Philippines 1990-2013



Source: (PSA: March 2007, May 2014 & “Summary of principal vital statistics in the Philippines: 1903-2010”; WHO, “Trends in maternal mortality: 1990 to 2013”; DOH, “FHSIS Annual Reports” (1995-2011))

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Table 6. Maternal health indicators*

	1993 DHS	1998 DHS	2008 DHS	2011 FHS** & 2013 DHS***
Maternal mortality ratio (MMR) using direct sisterhood method	209 (1987-1993)	172 (1991-1997)	162 (1999-2006)	221 (2004-2011)**
Skilled attendance at birth (SBA)	52.8	56.4	62.2	72.7***
SBA, poorest quintile	21.9	21.2	25.7	N/A
SBA, richest quintile	91.8	91.8	94.4	N/A
ANC 1 visit only	6.5	5.3	3.0	3.1**
ANC 4 or more visits	52.1	61.3	77.8	84.3***
Had any postnatal care	N/A	58.6	91.0	84.0**
Caesarean section (CS) delivery	5.9	5.7	9.5	N/A
CS, poorest quintile	1.8	1.2	1.3	N/A
CS, richest quintile	15.8	16.1	27.7	N/A

** Except for MMR, data refers to births 5 years preceding survey*

richest and the poorest quintiles: 94% vs. 26%. The figures meant that while the richest women were delivering attended mainly by doctors, the poorest women were left in the hands of unskilled birth attendants, unable to cope with life-threatening emergencies that mainly happened during delivery or shortly after.

Access to EmOC, which is measured by the availability, distribution, utilization and quality of EmOC facilities (WHO, 2009) has not been systematically assessed. The DOH has invested at least PHP8.43 billion in the Health Facility Enhancement Program (HFEP) from 2007-2010 (Abesamis, 2010, as cited in Romualdez et al, 2011). Yet Lavado et al in their study in 2012 assert that the HFEP investments were neither rationalized nor maximized. There is also no information regarding the availability of EmOC in the facilities that were improved.

The Cesarean Section (CS) rate, which is a proxy indicator for Comprehensive EmOC (CEmOC), has been increasing incrementally and averaged 9.5% in 2008, which is within the standard rate prescribed by the WHO of 5-15% (WHO, 2009). However, a wide gap in access existed: 27.7% for the richest quintile and 1.3% for the poorest (see Table 6). This equity gap has widened significantly even as average access increased between 1993 and 2008. The irony is that while the richest women were getting CS that they did not need, the poorest women were unable to access CS that might have saved their lives.

Post Abortion Care (PAC) is part of Basic Emergency Obstetric Care (BEmOC). Yet many hospitals do not offer PAC even if the Reproductive Health Program of the DOH (1998) included the Prevention and Management of Abortion Complications (PMAC) and the department had an Administrative Order instructing its regional hospitals to provide PMAC, including “humane and nonjudgmental counseling” (DOH, 2000).

The PMAC program also ensured patients' access to FP services. The PMAC program is a necessary response to the 610,000 estimated abortions every year, which occur despite the restrictive abortion law, and which are associated with 100,000 hospital confinements for complications, and 1,000 deaths (Hussain & Finer, 2013).

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Antenatal and postnatal care has yet to be maximized to help mothers' survival. In the 2008 DHS, 77% of the poorest women received antenatal care, 58% were informed about the dangers of maternal complications, and only 26% delivered assisted by a skilled birth attendant. These suggest that antenatal care is not enough to motivate the poorest women to seek SBA at delivery. Postnatal care is critical for women, especially within 24 hours after delivery, as they could develop and die of postpartum hemorrhage. Postnatal care is thus prescribed within 24 hours after delivery; and additional post natal contacts by the third day, 7-14 days after birth, and 6 weeks after birth (WHO, 2013). However, the DOH postnatal care protocol provides it within 72 hours and on day 7 after delivery (DOH, March 2011). The actual provision of postnatal care within 24-hours after delivery is low: 56% of all newly delivered women and 49% of the poorest women in the 2008 DHS.

While there is the MNCHN policy and substantial HFEP budget, significant barriers to maternal care for maternal survival remain. One is the lack of skilled birth attendants, especially for poor and hard-to-reach barangays (villages). In 2008, the DOH reported there were 17,473 midwives in the public sector (DOH, 2012, Chapter 4), which is over 24,000 short of the 42,000 needed to comply with the DOH standard of one midwife per barangay. In 2011, the government started its program of annually deploying nurses and midwives to localities to augment their primary health care centers or hospitals (DOH, November 2011). Ten thousand nurses were initially deployed, then 11,500 nurses and 1,000 midwives. However, over 12,000 barangays are still left without additional personnel, and the temporary deployment does not automatically lead to long-term commitment from both providers and local governments. Without enough human resources, the health facilities that have been established or improved under HFEP are not guaranteed of becoming functional and being utilized by patients.

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Adolescent and young people's sexual and reproductive health (SRH)

The adolescent fertility rate (AFR) is high and has slightly increased in 2013 (see Table 7). The percentage of teens with children or pregnant doubled from 1993 to 2011. Teen pregnancy or motherhood was 5 times greater among poorest teens than among the richest during the same period. Use of modern contraceptives hardly increased from 2011 to 2013, although there was a large increase in traditional methods. Because the provision of FP methods and services for adolescents has been and is currently opposed by conservative quarters, the increase in the use of traditional methods might be due more to the lack of access to modern methods than to a preference for traditional methods.

The percentage of teens with children or pregnant doubled from 1993 to 2011. Teen pregnancy or motherhood was 5 times greater among poorest teens than among the richest during the same period.

Table 7. SRH indicators for girls 15-19

	1993 DHS	1998 DHS	2008 DHS	2011 FHS* & 2013 YAFS**	2013 DHS
All					
Ever had sex (%)	8.1	9.1	13.6	N/A	N/A
Ever used a modern method (%)	1.2	1.8	3.5	N/A	N/A
Gap between ever had sex & ever used modern method (larger=worse, %)	6.9	7.3	10.1	N/A	N/A
Adolescent fertility rate (AFR, live births/1000)	50	46	54	54*	57
Had children or is currently pregnant (%)	6.5	7.2	9.9	13.6**	N/A
Had children or is currently pregnant, poorest (%)	15.4	19.0	18.5	N/A	N/A
Had children or is currently pregnant, richest (%)	2.2	1.3	3.8	N/A	N/A
Married (includes cohabiting)					
Using any modern method	9.6	11.4	14.3	19.8*	20.6
Using any traditional method	6.8	10.4	11.6	8.8*	15.9
With unmet need	32.8	31.4	33.7	37.0*	N/A

*** Young Adult Fertility and Sexuality Study of the Demographic Research and Development Foundation (DRDF) and the University of the Philippines Population Institute (UPPI)*

In a 2013 presentation by Administrator Carmelita Ericta of the National Statistics Office (now the Philippine Statistics Authority), she stated that in 2010, there were 208,000 registered births to mothers 19 and below, an increase from 126,000 in 2000, with 15% of the mothers on their second to fifth child. Girls 14 and below had 1,260 births.

The rise in teen pregnancy and motherhood rates can be explained by the rise in sexual activity among teen-agers combined with the lack of access to modern contraceptives. In 1993, there was a 7 percentage point gap between those who ever had sex and those who ever used a modern contraceptive method. This gap increased to 10 percent in 2008 (see Table 7). Among married or cohabiting teens, this gap is evident in the large unmet need for FP measured at 37% in 2011, a rate that exceeded women in the Autonomous Region of Muslim Mindanao (ARMM), the most disadvantaged region in the Philippines (PSA, May 2012) The significant reliance on traditional methods, 16% in DHS 2013, could also be contributing to unintended pregnancy and unsafe abortion in adolescents.

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The RH Law allows age and development appropriate RH education for all adolescents in public and private schools, as well as in alternative learning systems. The Department of Education's kindergarten to Grade 10 curriculum discusses puberty changes in Grade 5, reproductive health issues, including HIV and unintended pregnancy in Grade 8, and the RH Law and AIDS Laws in Grade 10 (DepEd, 2013). However, the RH Law stipulates that RH services, including contraceptives and condoms, can only be provided "with the consent" of their parents. This explicit legal admonition can aggravate the stigma on adolescents' expression of sexuality and bar their access to the sexual and reproductive health services they need.

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HIV and AIDS

The Philippines' HIV and AIDS registry recorded its first two cases in 1984, which grew slowly to 118 new cases in 1994. From 1995 to 2005, new HIV cases grew at an average annual rate of 6%. In four of those 11 years, year-on-year declines were even recorded. However, from 2006 to 2013, a rapid and consistent upward shift in growth occurred. During the last eight years, new HIV cases grew an average of 48% per year. From 309 new cases in 2006, 4,814 new cases were recorded in 2013. If the 48% annual growth holds for another 8 years, there will be 111,000 new cases in the year 2021 alone.

Although the HIV incidence is low, the growth trend is disturbing. UNAIDS (2012) has red-flagged the Philippines together with eight others as the few countries with greater than 25% increase in the incidence rate of HIV infection among adults from 2001 to 2011. In contrast, 12 countries were classified as stable; 14 countries decreasing by 26-49%; and 25 countries decreasing by 50% or more.

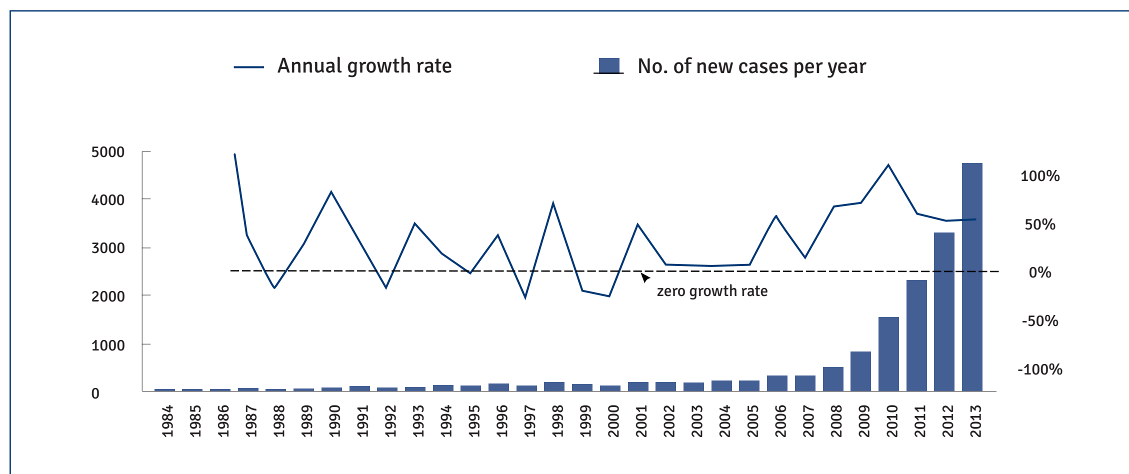
Table 8. New HIV and AIDS cases

	1998-1994	1995-2005	2006-2013	Total
Average annual new cases recorded	54	165	1,763	551
Average annual rate of growth	*	6%	48%	21%
Total new cases	593	1,817	14,106	16,516
AIDS (among new cases)	202	520	784	1,506
Number of years	11	11	8	30

** Fluctuates widely due to very small starting number*

Source: (calculated from the "Philippine HIV and AID Registry," DOH 2013)

Figure 2. Growth of HIV and AIDS



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Of the 19,330 persons in the registry at the end of June 2014, 90% are males and the median age is 28, with 70% between 20 and 34. The mode of transmission is mainly through sexual contact (93%), and a very small proportion through injecting drug use (5%). Sexual transmission is 25% through heterosexual contact, 29% through bisexual contact, and 46% through men having sex with men (DOH, 2014). In a cultural setting where sexuality discussions and the use of condom are taboo, the sexual mode of transmission—heterosexual, homosexual or bisexual—cannot be de-emphasized.

The government has a program that includes surveillance, public information, promotion of protective sexual behaviors and antiretroviral treatment. In 2014, the Philippine National AIDS Council (PNAC), the multisectoral body tasked with coordinating the program provided the following figures:

- 48% of sex workers reached by prevention programs;
- 47.4% of sex workers reporting the use of condoms with their most recent client;
- 12.6% of sex workers received an HIV test in the past 12 months and know their results;
- 22.6% of men having sex with men reached by prevention program;
- 40.7% of men reporting use of condom the last time they had anal sex with a male;
- 9.3% of men having sex with men who received HIV test in the past 12 months and know their results;
- 7.6% of HIV positive pregnant women who received antiretroviral therapy (ART) to prevent mother-to-child transmission partner;
- 19.8% of eligible adults and children currently receiving ART; and
- 86% of adults and children with HIV known to be on treatment 12 months after initiation of ART.

The generally low accomplishment rates, except for sustained treatment after 12 months, can explain the rapid advance of the epidemic.

A major barrier to the HIV program cited by PNAC in its report is the lack of adequate funding; the program received only PHP464 million. Human Rights Watch, an international human rights organization monitoring countries' compliance with human rights standards cited "official resistance to condom promotion" in its 2004 report (Human Rights Watch, 2004) and "restricted access to condoms" in its 2011 report (Human Rights Watch, 2011). The PNAC program's inability to resist the Catholic Church's lobby against a strong sexuality education and condom campaign has substantially weakened the program's effectiveness.

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Availability of sexual and reproductive health services at different levels of care

The availability of sexual and reproductive health services in the different levels of the health system is determined by the organization of the system, the laws and policies that define SRH entitlements and government obligations, health human resources, funding, and the political will of government officials. The structural issues were described by the current DOH administration in the following terms: "Health service delivery was devolved to local governments in 1991, and for many reasons, it has not completely surmounted the fragmentation issue. Health human resources struggle with the problems of underemployment, scarcity and skewed distribution. There is a strong involvement of the private sector comprising 50% of the health system but regulatory functions of the government have yet to be fully maximized" (DOH, 2012, Chapter 1). Citing the National Statistical Coordinating Board figures of 2007, the DOH described total health expenditures as being at 3.5-3.6% of GDP, with out-of-pocket having the largest share at 57%.

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The DOH laid out a Reproductive Health Program with 10 elements in 1998, including maternal and child health and nutrition; family planning; STIs and HIV-AIDS; cancers of the reproductive tract; infertility, sexual dysfunctions and gynaecologic problems; prevention and management of abortion complications (PMAC); sexuality education; adolescent reproductive health (ARH); violence against women and children (VAWC); and men's responsibility and reproductive health (DOH, 1998). However, due to the conservative Arroyo administration from 2001 to 2010, the DOH gradually dismantled the RH Program by removing the elements pertaining to family planning and sexuality. It removed ARH from the "Child Health and Development Plan of 2001-2004" (DOH). On the prodding of the "pro-life" group, Abay Pamilya, the DOH through its attached agency, the Bureau of Food and Drugs, banned the emergency contraceptive, Postinor (levonorgestrel 750 mcg) first in 2001, and sustained the ban in 2003, contrary to the majority opinion of a Technical Committee the DOH itself convened to study the first decision (DOH, "Postinor"). The DOH also did nothing to stop local governments from banning modern contraceptives, such as in the city of Manila in 2000 (Likhaan, ReproCen & Center for Reproductive Rights, 2007) Moreover, the DOH, through the Commission on Population, another attached agency, launched in 2006 the Responsible Parenting Movement (RPM) tasked, "in response to the directive of the President...to formulate and carry out an aggressive and systematic strategy to promote responsible parenting and natural family planning in the country (Comm. on Population, "Responsible Parenting Movement"). After the DOH (2000) laid down the PMAC policy and program, the subsequent administration did not follow it up.

The result is the limited supply of critical RH services, like FP, ARH, PMAC, and condom campaign in the HIV program—to projects, instead of programs; to NGOs and some local governments supported by international development agencies, instead of a nationwide machinery.

The new RH Law and its Implementing Rules and Regulations (IRR of RA 10354, 2013), mandate the provision of a range of services including prenatal and postnatal care, skilled birth attendance, basic and comprehensive emergency obstetric care, family planning, VAWC counselling and referral, ARH counselling, RTIs and STIs, and post-abortion care in a Service Delivery Network (SDN) of public and private providers, from the barangay to the hospital levels. The law also mandates PhilHealth to prioritize the enrolment of indigent families, develop a regular Reproductive Health Package, as well as another for serious and life-threatening RH conditions like AIDS, cancers and emergency obstetric complications.

The RH law must be supported to enable its rapid and full implementation through the deployment of a sufficient number of adequately-trained and paid health providers; the sustained provision of RH drugs and supplies; the clustering and integration of services at a higher level, e.g. the district, for greater efficiency; and yearly provision of enough funds for the key elements of the program. The national RH movement that mobilized for the passage of the RH law must continue to mobilize in support of the law's implementation and against efforts to derail it.

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3. Recommendations

1. The DOH and its attached agencies—PhilHealth, the Food and Drugs Administration and the Commission on Population—should lead the prompt and full implementation of the RH Law:

    - The DOH must popularize the RH Law and Implementing Rules and Regulations reflecting the amendments from the Supreme Court decision.
    - The DOH and Local Government authorities must develop a mechanism for the effective coordination of DOH and local government implementation.
    - The DOH must delineate, in the national health budget, specific allocations for key RH elements, notably: maternal and newborn care, family planning, STI and HIV-AIDS, post-abortion care, adolescent RH and VAWC. In each sub-program, priority should be given to hire long-term personnel where they are lacking, such as skilled birth attendants and providers of emergency obstetric care; procure equipment and provide for recurring RH supplies, especially different contraceptives, condoms and emergency obstetric medicines; and conduct public information campaigns that will de-stigmatize taboo issues and create enlightened RH policies, for example, on adolescent sexuality and fertility, medical barriers to contraception, unsafe abortion, sexual orientation and practices of LGBT.
    - The DOH must develop a strategic approach for adolescent RH services, which is compliant with the Supreme Court decision of requiring parental consent for minors.
    - The DOH, per IRR, must develop a map or directory of RH providers in a given area, including their capabilities, availabilities and cost of care, which should be accessible to patients to inform them accordingly. This directory should also include the names of providers and facilities that are not providing services because of "conscientious objection."

- The DOH, per IRR, must ensure the designation of RH officers in all health facilities for purposes of helping patients navigate the health system and receive and process patient's complaints.
- The DOH must develop functional partnerships with CSOs and private sector organizations—academics, practitioners, advocates, sectoral leaders—that can provide technical inputs to the SRH program, while also fostering a multisectoral stakeholders' movement that will ensure universal access to RH services.

2. PhilHealth needs to ensure financial assistance to the poorest and most marginalized patients:
   - PhilHealth must ensure the enrolment of the poorest, poor and near poor before the end of 2014. The list of these enrolees must be popularized in their respective localities so that they can fulfil the requirements and claim the benefits as needed.
   - PhilHealth must also develop communication strategies for the poor, in a language that is understandable, to explain the programs, spell out the steps needed for access and the responsibilities of individuals, and to clarify common questions about the program.
   - PhilHealth, per IRR, needs to develop an RH benefit package to include routine services and supplies, such as FP services and supplies, and HIV prevention, testing and antiretroviral therapy.
   - PhilHealth, per IRR, must also develop a benefit package for serious and life-threatening RH conditions, like emergency obstetric conditions, reproductive tract cancers and AIDS.
   - PhilHealth can also develop a Women's Health Care Benefit Package that will guarantee Sexual and Reproductive Health Services for all women of the Philippines.

3. Civil Society Organizations (CSOs) must advocate for universal access to SRH services as a key aspect of Sexual and Reproductive Rights (SRR).
   - CSOs must initiate public discussions and debate on taboo subjects, like adolescent sexuality and fertility, unsafe abortion, and sexual orientation and gender identity to foster greater understanding of these issues and expand access to services.
   - CSOs must use their various talents and skills—as artists, educators, researchers, writers, lawyers, health professionals, and others—to advocate and achieve a higher level of SRH for this country.
   - CSOs must lead in the independent monitoring of the access to SRH, identifying and reporting weaknesses and violations, in order to correct errors and improve access to SRH
   - CSOs must help address structural barriers to SRH, like poverty, gender discrimination, poor governance, and religious fundamentalism by integrating these concerns in SRH and participating in solutions to address them.
   - CSOs must lead in the further elaboration of SRH services consistent with SRR and to guard against efforts to derail and undermine existing programs.

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About Likhaan

Likhaan Center for Women's Health is an organization of grassroots and professional activists dedicated to transforming health policies and programs for women based on social justice, equity and human rights. Established in September 1995, our core issues include maternal mortality, contraception, abortion, sexual autonomy, and health care access for the poor.

Likhaan has three core programs: organizing and capacitating community women and youth leaders, developing women-sensitive primary and secondary health care, and advocating for law and policy reforms at local and national levels. In the context of Likhaan's three core programs, our thrust is to continue advocating for health policies and programs that will respond to the needs and preferences of poor women. These include the implementation of the Reproductive Health Law. Likhaan is also actively engaged in developing a package of national health reforms towards "Universal Health Care."

These core advocacies are complemented by community organizing and the operation of Women's Clinics. Community organizing develop community leaders' capacity to learn and promote basic health knowledge and skills and engage with local governments to get effective health and social services. The Women's Clinics provide needed services and demonstrate that a Primary Health Care approach that is sensitive to women's needs and rights and that welcomes the participation of community women is both effective and sustainable.

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