Evaluation of the Sixth UNFPA Country Programme to the Philippines
2005-2010

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Acronyms

3RG Reproductive Rights Resource Group
AECID Agencia Española de Cooperación Internacional para el Desarrollo
ARH Adolescent Reproductive Health
ARMM Autonomous Region of Muslim Mindanao
AUSAID Australian Agency for International Development
BCIC Bohol Crisis Intervention Centre
CCA Common Country Analysis
CEDAW Convention on the Elimination of All Forms of Discrimination against Women
CERF Central Emergency Response Fund
CHD Centre for Health Development
CO Country Office
CP Country Programme
CPAP Country Program Action Plan
CPD Country Program Document
CPR Contraceptive Prevalence Rate
CSR Contraceptive Self-Reliance
DILG Department of Interior and Local Government
DKT International NGO promoting family planning
DMPA Depot Medroxyprogesterone Acetate
DOH Department of Health
DOJ Department of Justice
DSWD Department of Social Welfare
EC European Commission
FPS Family Planning Survey
GAD Gender and Development
GBV Gender-based violence
HAPPI Harmonized Approaches for Population and Poverty Integration
HAPPIER Harmonizing Approaches in Population Management, Poverty Reduction, Integrating Environmental Resources
HAPPIEST Harmonizing Approaches in Population Management, Poverty Reduction, Environmental Sustainability and Innovations in Science and Technology
HB 3773 Responsible Parenthood and Population Management Act Of 2005
HB 5043 Reproductive Health and Population Development Act of 2008
IACAT-VAWC Inter-Agency Committees on Anti-Trafficking and Violence against
ICPD International Conference on Population and Development
IEC Information Educational and Communication Materials
JICA Japan International Cooperation Agency
LGU Local Government Unit
Executive Summary

Background and Situational Analysis

In the Philippines, over the last 40 years or so, concerns about the population issue and, more recently, reproductive health have received varying levels of attention depending on the specific Government at the time and opposition from the Catholic Church hierarchy and other influential groups in the country. In 1970, the National Population Program was launched following the creation in 1969 of the Commission on Population (POPCOM). The programme’s principal thrust was the reduction of fertility and its core strategy was the provision of family planning (FP) services using a clinic-based and contraceptive-oriented approach.

The population of the country in 2007 was recorded at 88.6 million. While there has been a steady decline in the total fertility rate from 6.0 children per woman in 1970 to 3.3 children per woman in 2006, absolute increases in population have been substantial (from 27.0 million in 1960), impacting adversely on the achievement of Millennium Development Goals (MDGs). Demand for contraception is high even among the poor but access is inadequate and, hence, unmet need remains substantial.

Since 1969 UNFPA has provided assistance to the Philippines. Initially this focused on family planning, population education, and advocacy for population and development. From 1995 there was a major paradigm shift from family planning to reproductive health. The Sixth Country Programme (CP) covering 2005 to 2009 (and extended to 2011) has two major concentrations – one at a central level focusing on policy issues and the second at field level supporting efforts principally to improve the reproductive health situation in three municipalities in each of 10 provinces.

The overall intention of the CP was “to improve the reproductive health (RH) status of the Filipino people through better population management and sustainable human development”. The efforts at a provincial level were intended to demonstrate successful arrangements for the implementation of RH care which would be appropriate for more widespread replication throughout the programme and in non-programme provinces.

Evaluation Purpose, Audience and Methodology

This is an end-of-programme evaluation and aims to provide information principally for key stakeholders, particularly the Country Office, including the UNFPA Regional programme managers, regarding the design, strategies and operations likely to improve the performance of the Seventh CP in the Philippines.

The evaluation team made considerable efforts to gather relevant information including: review of a large number of programme reports and other documents; extensive field visits to programme sites; discussions with a wide range of partners, beneficiaries and other stakeholders involved and associated with the programme; limited focus group discussions with stakeholders; and review of the 2006 baseline and the 2010 end line surveys.

Main Conclusions

UNFPA has been successful in implementing the Sixth Country Programme. This is
impressive because it happened despite the ambivalent and often unfavourable policy environment in the country with respect to population policy and reproductive health. In addition, the UNFPA CP has had relatively limited resources available.

Partly due to UNFPA’s advocacy, the issue of population policy as an imperative which remains contentious in the Philippines has generated over the past several months lively public debate focusing on RH legislation. In spite of strong protestations from the Catholic Church hierarchy against the RH bill which had considerable influence on the national political leadership, UNFPA succeeded in supporting national advocacy efforts of civil society. All this has contributed to raising the national and local public awareness and discourse on population and development, reproductive health, gender, and youth concerns. At the local level, multisectoral partnerships and the implementation of complementary projects proved particularly effective in sensitizing communities and households to population, RH and gender issues.

In the UNFPA-supported provinces RH ordinances and resolutions have been enacted. Several of these local legislations are similarly titled and worded as they are patterned after earlier legislations. The use of such a template has been useful in speeding up the RH legislation process. Twenty-two out of 41 pilot Local Government Units (LGUs) have enacted gender and development (GAD) ordinances.

Resulting from UNFPA-supported efforts of local advocates, a number of LGUs have been adopting and implementing RH/FP activities. For instance, local legislations mandating facility-based births with trained midwives are already enforced in the pilot areas. New structures have been built and equipped and improved services can be availed of in these communities. Birthing, violence against women (VAW) and Teen Centres have been established in strategic locations in municipalities and barangays where there were none before.

UNFPA support in the three municipalities in the 10 Programme provinces has contributed significantly to improving the availability of maternity care through, for instance, training of doctors, midwives and nurses, equipping birthing stations, rural health units (RHUs) and hospitals and community mobilisation. The end line survey results show improvements in several indicators in the programme supported municipalities, including prenatal care, attendance by a skilled birth attendant at delivery and deliveries in health facilities.

The 2008 National Demographic and Health Survey shows a contraceptive prevalence rate (CPR) for modern methods of 34 per cent, with unmet need having increased from 2003 to 22 per cent. The consequences of inadequate access to contraception have profound implications particularly for poor women and families. More than half of all pregnancies in the Philippines are unintended and poor women are especially likely to need assistance in preventing unintended pregnancy. The estimated numbers of unsafe abortions have increased in recent years and in some areas this may reflect the difficulties women experience in obtaining modern contraceptives as a result of supply-side constraints adversely affecting health care provision. UNFPA has provided limited support to improve the provision of modern contraceptives.

The CP has supported several successful initiatives to improve the RH of young people, including establishment of 16 school-based and 21 community-based Teen Centres which
cater to adolescent reproductive health (ARH) needs in terms of information, healthy lifestyle promotion, positive coping mechanisms (life skills), and some basic health services. Through UNFPA support, many young people have gained access to reliable information and life skills enabling them to make informed decisions that affect their lives through strengthening peer education programs including the creation of: peer education modules; capacity building; conduct of outreach activities; and trainings.

UNFPA has supported measures to address gender based violence (GBV) including the creation of supportive structures, tools and materials, capacity building, documentation, advocacy and networking. Training activities were conducted for social workers and other service providers with the use of various manuals and tools developed with CP support. These capacity-building activities include gender sensitization, service provision, referral system, performance standards and assessment, advocacy and networking. Awareness and prevention of VAW have been raised as a result of a number of advocacy and networking activities in the pilot sites.

Gender mainstreaming accomplishments include the passage of local GAD Codes or ordinances, the development of training manuals for the other Sixth CP components, and capacity building. As of 2009, the pilot sites have developed eight provincial and 14 municipal GAD Codes to promote women’s human rights and empowerment, gender-responsive development, and gender equality.

In Mindanao UNFPA support to six provinces has been associated with improvements in RH care in several municipalities with increases in the percent of women with complete pre-natal visits, per cent of births attended by skilled birth attendants, and the contraceptive prevalence rate.

The results of the end-line survey carried out in May and completed in October 2010 show improvements in several relevant key indicators. While it is difficult to attribute a causal relationship from changes in coverage rates for certain RH services in the municipalities included in the 10 Programme provinces, there are several instances where there appears to have been generally beneficial changes in key aspects of care.

The CP emphasised that quality of interventions and services are crucial. There is a series of issues related to quality of care in the RH services in municipalities supported through the CP. In several respects, the CP has helped provide the environment for providing good quality RH: essential equipment have been supplied including delivery tables and other supplies; the medical, nursing and midwifery staff have been trained in basic and comprehensive essential obstetric care and other aspects of RH. In addition, several RHUs have been accredited by PhilHealth for either the out-patient or maternity packages. However this can be rather misleading and assessments including direct observation in several RHUs indicated variable quality of care. In some maternity units standard guidelines were not followed. These inadequacies very probably contribute to lower effective utilization of these important services than is achievable and should be a matter of concern. They indicate that the Sixth CP has probably not made as large a contribution to the provision of high-quality RH care as it might have.

The wide geographical spread of major parts of the CP over a large number of sites imposes significant challenges to effective and efficient implementation. There are difficulties in ensuring adequate monitoring and provision of technical support from those responsible in
the CO for RH, HIV and AIDS, Family Planning, Adolescents/Youth, PDS and Gender. Monitoring supportive visits to provinces by technical people in the CO could be strengthened.

The CO has been very successful in raising additional funds for activities not supported from regular resources. The budget from regular resources for the CP originally approved by the Executive Board was US$ 20 million (US$12 million for RH, US$5 million for PDS and US$2 million for Gender). Over the years 2005-2009, US$ 20,902,006 was provided from regular UNFPA resources and during the same period over US$ 9 million was mobilized from multi-bi sources. A large proportion of these additional resources has been for joint UN programmes and humanitarian assistance.

Sustainability

The Sixth CP has garnered the support of national and local institutions. The CP has successfully supported important interventions designed to improve the well being, particularly of women and young people in some of the poorest 30 municipalities in the country. It is likely that many of the interventions will have an effect lasting longer than the timescale of the CP. However, there are issues related to supporting only three municipalities in a province and the spread of the 10 provinces throughout the country. For the number of municipalities covered the overhead costs in terms of provincial UNFPA staff are high. It is possible that sustainability would have been increased if national execution with funding provided directly to Government Centres for Health Development (CHDs) and provinces for implementation of agreed plans similar to the procedures followed by certain other agencies.

If the CP had included fewer provinces but covered all municipalities within them and used national execution, then the technical people within the CO would need to spend time on field monitoring and support visits to programme sites which is in their terms of reference.

Relevance

- Did the programme focus on the most critical issues related to the promotion of the ICPD agenda?
- Did the CP address the rights of people in relation to reproductive health, population and development, gender equality and humanitarian response?

The CP focussed on crucial issues related to the ICPD Programme of Action. This is notable because the Evaluation Team heard repeatedly that other UN agencies and donors while acknowledging the importance of the central tenets of the ICPD made it clear that they had preferred to let UNFPA be the main (and at times only) voice advocating these crucial issues. In all three CP components emphasis was given to issues related to Reproductive Rights (RRs). The CP made considerable efforts to convince influential people and others of the importance of population and development, reproductive health, gender and humanitarian issues to the improvement of the life of individuals and of the country in general.

- Did the overall programme design remain relevant to national and local priorities, given changing circumstances?

The overall design of the Country Programme was relevant to national and local priorities but given the wide spread of CP resources over 10 provinces the chance of demonstrating lasting
positive effect was limited. Resources for programme implementation at a field level were spread thinly across 30 municipalities and one city. There were UNFPA staff in each of the Programme provinces who assisted implementation but with their withdrawal it is uncertain whether efforts to improve RH will continue.

Impact - Effectiveness

- How effective is the Sixth CP in achieving its objectives?

This is principally a qualitative end of Programme evaluation and consequently conclusions on effectiveness and impact can only be inferred. The results of the endline survey suggest substantial improvements in RH and other relevant indicators in provinces supported by the Sixth CP. The Evaluation Team considers that it is likely that the CP has made substantial contributions to improving the situation with regard to PDS, RH and gender issues in the country as a whole and particularly in the municipalities of the Programme provinces. Overall, six of the eight outputs set in the Country Programme document have been met but the second and third outputs of the RH component were only partly delivered. It is extremely difficult to make definitive conclusions regarding the likely impact of the CP on the RH status of people living in the areas covered by the field activities. However given the CP inputs have improved the availability of RH care and crucial skills and knowledge it is likely that the CP has had a positive impact.

- What factors influenced the success and effectiveness of the programme? What factors hindered programme effectiveness?

Factors facilitating CP success

In many respects, there was a popular and encouraging demand and support for the projects under the CP. The interest and support were frequently at the community, local political level, and at the level of many national policymakers and technical people. In several provinces there were committed and informed local governors and mayors who welcomed and actively supported PDS, RH and gender issues. It was also notable in Mindanao that the cooperation of stakeholders, including Muslim Religious Leaders (MRLs) facilitated the successful implementation of the CP. This was supplemented by good coordination and networking with partners and stakeholders but, above all else, the most important facilitating factor was the heightened awareness and firm commitment of people.

- Did the CP investments in Mindanao deliver the expected results?

In many respects implementation of the Programme in municipalities supported in the provinces in Mindanao posed the greatest challenges. Consequently, it is even more impressive that the CP achieved outputs to almost a similar degree as in the other Programme provinces.

- What was the impact of the Sixth CP on the lives of communities in Sixth CP sites in terms of reproductive health, gender equality and population and development, as well as humanitarian response?

As is clearly stated in the evaluation matrix this evaluation is not an impact evaluation. However, in the judgement of the Evaluation Team it is possible that the CP has led to
improved health outcomes in the target populations with regard, for example, to improved prenatal and delivery care and access to services for gender-based violence. There are many other factors in the Programme municipalities which could affect these items including LGU support, NGO initiatives and community mobilisation. A similar situation also applies to humanitarian support provided by UNFPA.

Efficiency:

- What measures did the CP introduce to improve cost efficiency of the Programme and did they have an effect? How did the CP improve accountability, transparency and risk management and what was the effect?

Given the regular resources available to the UNFPA Sixth Country Programme, what has been achieved is appreciable. However, given that these resources are spread so thinly over central activities in Manila and 10 provinces and one city, it is very difficult to be definitive about precise results attributable to UNFPA support. However, the Evaluation team identified several specific examples of cost-sharing where the CP had particularly used cost-efficient procedures in for instance cost-sharing schemes between UNFPA and the LGU in the pilot municipalities to sustain the birthing clinics indicate efficient utilization of resources.

- How did the CP utilize existing local capacities of duty-bearers and claim-holders in programme implementation?

In several of the Programme provinces there are examples of where the Programme has influenced involvement of duty-bearers and claim-holders as a result of UNFPA support in, for instance, participatory governance from barangay to municipal levels. In Asipulo, Ifugao, prioritization of projects are products of public consultation. Public participation in projects is also through contributions of labour by able-bodied constituents. Moreover towards the end of a project, there is again public consultation where people assess and grade the project.

Main Recommendations for the 2012-2016 Country Programme

UNFPA and other international organizations should make it clear to the national and local governments that the role of programmes of assistance is merely catalytic – to get things started but later to be taken over and sustained by national and local agencies. The Seventh UNFPA Country Programme should fit within the mandate identified in UNFPA’s Strategic Plan and take account of the findings of the progress report considered by the Executive Board in June/July 2010.

In the preparation of the Seventh UNFPA Country Programme, consideration should be given to issues raised in UNFPA’s Strategy Toward Middle-Income Countries (MICs)¹. In particular, the need to ensure close interagency co-ordination and harmonisation within the UN and with other development partners in order to reduce transaction costs and duplication and to increase efficiency. When considering the three modalities of engagement set out in the Strategy it is likely that the second modality is the most appropriate to follow for the Seventh UNFPA Country Programme of targeted and catalytic UNFPA funding, programmes

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and services. This modality would require strengthening national capacities to implement the ICPD agenda, while entailing evidence-based selectivity and only a nominal technical contribution from UNFPA. It would indicate a far greater stress placed on using national execution and slimming down the UNFPA presence and involvement in CP implementation. This could cover:

- continuation of support at the central level for PDS, RH and Gender policy development;
- recommendations on areas for support under the three components are included in the full report of the evaluation including those common to RH as whole and those specific to maternal health, HIV & AIDS, family planning ARH, and violence against women and children;
- deliberately include young people’s concerns;
- more consciously integrate or functionally link PDS, RH and Gender issues right at the design stage;
- in view of the unfortunate regularity of events resulting in humanitarian disasters in the country, UNFPA should consider including as an integral part of the Seventh CP (particularly in the RH component) to build capacity in disaster response and management and support in contingency planning;
- concentrating field support throughout fewer provinces based on indicators of high need such as low Human Development Index, high Maternal Mortality Ratio and high Poverty Incidence;
- quality contraceptive services enable women and couples to make choices about pregnancy, have healthy babies and care for their families. UNFPA should consider increasing support to the Department of Health in the design and implementation of a comprehensive Reproductive Health Commodity Management System;
- following national execution modalities and working through Regional Government structures. This could be more efficient, effective and lead to improved sustainability. It would require more intensive use of UNFPA technical staff based in Manila in regular monitoring and supportive visits to Programme provinces;
- activities should be in line with the Accra Agenda for Action agreed at the Third High-Level Forum on Aid Effectiveness of September 2008 to accelerate and deepen implementation of the Paris Declaration on Aid Effectiveness and avoid duplication of donor efforts;
- a sustainability plan that coincides with a gradual exit phase from Programme provinces should be included at the CPAP design stage.

Assuming the continuation of the three components in the Seventh Country Programme, then in order to increase the effective implementation of the technical aspects of all three components of the CP, it is important that:

- management of implementation of the CP should concentrate on substantive issues which affect the quality of the activities and realisation of the outputs rather than being reactive to immediate day-to-day issues;
- UNFPA Technical staff in the Country Office should be given responsibility for implementation of the issues in the areas of their expertise and be accountable for monitoring and reporting to the relevant Assistant Representative;
- the management of the Country Office should ensure that the most effective possible use is made of the technical skills of programme staff including providing support to field implementation;
• regular supportive visits to Programme provinces should be made by CO technical staff; efforts to improve the integration of activities in the different CP components need to include critically reviewing activities and, if necessary, rescheduling them to ensure that they complement one another.

Efforts should be made to ensure the indicators and targets identified in Country Programme Documents are specific, measurable and, as far as possible, continuous rather than dichotomous variables. In line with recent decisions of UNFPA’s Executive Board, budget provision should be included in the Seventh Country Programme for regular Monitoring and Evaluation (M&E) functions. Efforts should be made to ensure that baseline and end-line indices are aligned with the programme procedures and M & E indicators. Process documentation research, operational research and social, economic, and anthropological studies should be supported during programme implementation to be able to explain programme effects on targeted population by involving local and provincial institutions.

As mentioned in the 2009 UNFPA Evaluation Policy, the UNFPA Regional Asia and Pacific Office should consider providing support and technical advice to the monitoring and evaluation activities of the Philippines Country Office. This should ensure that, at the planning stage for the Seventh Country Programme, adequate results frameworks are developed for the Programme, including a national evaluation capacity building component with the full and active participation of national counterparts in the evaluation process, and in future evaluations seeking increased involvement in joint evaluations with partners and donors.

Steps should be taken to ensure that the Seventh CPAP design is:

• integrative by conducting participatory planning to determine which aspects of the programme could be mainstreamed with the different components, strategies, and activities; and
• inclusive of monitoring and summative evaluation of the different structures, capacity building, and tools that were developed by national and local partners to ensure compliance, quality assurance, and sustainability.
1 UNFPA and Evaluation

1.1 According to UNFPA’s Policies and Procedures it is mandatory for an evaluation of a Country Programme (CP) to be carried out before a new CP is approved by the Executive Board (UNFPA 2003). UNFPA has repeatedly emphasised the importance of assessing whether support provided to countries through country programmes has resulted in anticipated and particularly beneficial outputs. In June 2010 UNFPA's Executive Board will consider a biennial report on evaluation (see UNFPA 2010) which notes in the evaluative work of UNFPA the importance of ‘improving quality will require an enhanced culture of evaluation and accountability for results within UNFPA’ and emphasises the importance of ‘capacity development to support such a culture will need to be negotiated with commitments to joint evaluations and strengthened national ownership of evaluation. A systematic management response and follow-up to evaluation recommendations will ensure that UNFPA maximizes the effective use of its resources in achieving its goals.’

1.2 A major constraint for conducting all forms of evaluations of UNFPA CPs has been the unavailability of any relevant baseline and end-line data and regular monitoring information on programme implementation. UNFPA is taking targeted measures to ensure that these data are available for all new country programmes (see UNFPA 2008 a). UNFPA is a member of the United Nations Evaluation Group (UNEG) (see http://www.uneval.org/) and through this Group participates in defining internationally recognized evaluation standards including those for relevance, effectiveness, efficiency, sustainability and the use of best practice evaluation methodology.

1.3 In 2009 UNFPA agreed to a comprehensive evaluation policy for the Population Fund. The new policy was endorsed at the Executive Board annual meeting in June 2009 and highlighted the importance of evaluation and “…with the goal of further strengthening results-based management by building a robust evaluation function in UNFPA” (UNFPA 2009 b). The policy makes regional offices accountable for providing support and technical advice to the monitoring and evaluation activities of country offices through regional monitoring and evaluation advisers and ensuring that, at the programme planning stage, adequate results frameworks are developed for programmes, including a national evaluation capacity building component.

1.4 The UNDG as an integral and important part of UN reform places great emphasis on developing agency country programmes as part of the larger UNDAF exercise (see www.undg.org especially CCA/UNDAF Guidelines, programming best practices, evaluative information network, agency evaluation officers, Globalnet and UNDG Coordination Practice Area). Evaluation of agency country programmes should take place as part of a wider evaluation of the total Country UNDAF (UNDG 2005).

2. Scope and Objectives of the Evaluation of the Sixth UNFPA Philippines Country Programme

2.1 The Country Office decided to undertake a final evaluation of the overall implementation of the Sixth Country Programme and to identify lessons learnt (see appendix for the Terms of reference for the evaluation). The findings, together with the updated version of the Situation of the Population and Reproductive Health Analysis are expected to serve as critical inputs to the strategic formulation of the Seventh UNFPA Country Programme (2012-2016). The intended audience for the evaluation is principally the UNFPA
Country Office and stakeholders and partners who have been involved in implementation of the Country Programme in order that lessons can be learnt for future collaboration.

2.2 There are many potential approaches to evaluation of programmes such as a UNFPA CP. Ultimately three aspects are potentially important: have the inputs provided under the Country Programme achieved the outputs (or deliverables) identified at the beginning of the programme and if not why and what lessons might be learnt to improve similar support in the future and specifically in the next CP for the years 2012-2016?

2.3 The present evaluation will answer these questions and those set by the Country Office (see ToRs in appendix). The approach taken to the CP is set out in UNFPA’s evaluation tool kit (UNFPA 2004). It sees evaluation as ‘a management tool which is a time-bound exercise that attempts to assess systematically and objectively the relevance, performance and success of ongoing and completed programmes and projects. The main objective of programme evaluation should be to inform decisions on operations, policy, or strategy related to ongoing or future programme interventions’.

2.4 Given the nature and size of the Country Programme, an end of Programme Evaluation approach has been used. This is defined by UNFPA as: ‘a type of evaluation that examines the extent to which a programme is operating as intended by assessing ongoing programme operations. An end of programme evaluation helps programme planners and managers identify what changes are needed in design, strategies and operations to improve future performance’ (UNFPA 2004).

3 Methods Used in the Evaluation

3.1 The evaluation is largely based on discussions with implementing partners and observations and information gathered during field visits. The framework of analysis used by the Evaluation Team was agreed with the CO at the Team’s first meeting on the 7th of June and is an end of programme evaluation (a copy of the analysis is included in appendix).

3.2 Six major sources were used to obtain information for the evaluation:

1. Review of documents:
   - programme documents and reports e.g. the UNFPA CPD 2005-2009, the CPAP 2005-2009, the Philippines UNDAF 2005-2011, Annual Work Plans; Annual and Bi-annual Programme reviews; the latest Standard Progress Reports; the 2003 and 2008 National Demographic and Health Surveys, programme and project reports including, annual component and project Standard Progress and Accomplishment reports; research reports. Programme plans: annual and quarterly plans, specific topic plans e.g., advocacy; project proposals; training guides and manuals, technical protocols. Assessment tools, IEC and advocacy materials;
   - non-programme documents, including those from partner agencies, Local Government Units/agencies, documents from national and local publications.

2. Extensive field visits were made to the provinces where the Programme is being implemented. Interviews were held with stakeholders and partners at project sites and where possible relevant data were reviewed.

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2 A list of the main documents consulted is given in the appendix.
3 A list of the field visits made by members of the evaluation team is included as an appendix.
3 Extensive interviews with implementing partners and other stakeholders.
4 Focus group discussions of stakeholders in Mindanao.
5 Review of a compilation of key activities supported by the Country Programme\textsuperscript{4} e.g. listings of: consultancies undertaken in support of CP implementation, Regional Office (CST) or HQ technical missions undertaken in support of CP implementation, Studies/ surveys undertaken in support of CP implementation, National meetings/conferences held in support of CP implementation, IEC/advocacy materials prepared in support of CP implementation, Training sessions and workshops undertaken in support of CP implementation, Field monitoring visits.
6. Comparison of the results of the baseline survey carried out in 2006 and the endline survey carried out in May and completed in October 2010.

3.3 This evaluation builds on the findings of the Mid-Programme review findings and recommendations.

4. **Country Background and Context\textsuperscript{5}**

4.1 The Philippines comprises 7,107 islands with three main island groups: Luzon, Visayas, and Mindanao. The country is divided into local government units (LGUs). The provinces are the largest political unit in the governmental structure of the Philippines. These are subdivided into cities and municipalities, which are composed of barangays. The barangays are the smallest local government unit. Provinces are grouped into regions which have more or less homogeneous characteristics and are subnational administrative divisions that serve primarily to organize the provinces for administrative convenience. The National Capital Region, however, is composed of four special districts. Most government agencies have regional offices instead of individual provincial offices, usually (but not always) in the city designated as the regional centre. The regions do not possess a separate local government except for the Autonomous Region in Muslim Mindanao (ARMM) with an elected regional assembly and governor.

4.2 In the 1990s, economic reforms led by President Ramos stimulated business and foreign investment to the country, which resulted in high economic growth; however, this was interrupted by the Asian financial crisis in 1997. The administration under President Arroyo brought substantial progress in restoring macroeconomic stability. Economic growth has averaged 5 percent per annum since 2001. New revenue measures and tightened expenditures helped avert the fiscal crisis and resulted in declining fiscal deficits, narrowing debt and debt service ratios, and increased spending on infrastructure and social services. The Philippine economy grew at its fastest pace in three decades in 2007 with real GDP growth at 7.1 percent. However, the global financial crisis of 2008 slowed growth to 3.8 percent in 2008.

4.3 In 1970, the Philippine government launched the National Population Program following the creation in 1969 of the Commission on Population (POPCOM). The programme’s principal thrust was the reduction of fertility and its core strategy was the provision of family planning services using a clinic-based and contraceptive-oriented

\textsuperscript{4} The CO was asked to prepare tabulations of activities supported under the components of the CP as these were not easily available from a routine programme monitoring system. Unfortunately this was only partly completed.

approach. To improve access to services, a community-based approach was later adopted to extend and integrate family planning services with other development activities in rural areas. However, the weak economic situation of the country in the early 1980s and during the Aquino administration affected logistical aspects of the programme. In addition, the programme was faced with institutional instability because of changing POPCOM leadership, opposition from the Catholic Church hierarchy, and local criticism of its demographic targets. In response, the programme changed its emphasis to family welfare and development and broadened its scope to include family formation, status of women, maternal and child health, child survival, and mortality and morbidity. Other areas covered under the programme were population distribution and urbanization, internal and international migration, and population structure. The programme adopted a two-pronged strategy: 1) integration of population and development (POPDEV), and 2) responsible parenthood and family planning (FP/RP). During this period, institutional and operational responsibility for the family planning programme was transferred to the Department of Health (DOH) as part of promoting maternal and child health and other health initiatives. Responsible parenthood and family planning was then transformed into a health programme and was called the Philippine Family Planning Program.

4.4 In 2000, the PPMP Directional Plan for 2001-2004, which was based on the Population and Sustainable Development framework, was prepared and finalized under former President Estrada. The plan promoted responsible parenthood within the context of sustainable development, with emphasis on the health rationale of family planning and the exercise of reproductive health and sexual rights. The plan also responded strongly to the problem of unmet need for family planning to achieve an overall desired number of children of 2.7 and replacement-level fertility of 2.1 children per couple in 2004.

4.5 To contribute to President Arroyo’s poverty alleviation programme, the POPCOM Board of Commissioners updated the PPMP Directional Plan of 2001-2004 through the development of a PPMP Strategic Operational Plan (SOP) for 2002-2004. As an expansion of the Population and Sustainable Development framework, the PPMP SOP focused on addressing unmet need for family planning among poor couples, and the sexuality and fertility information needs of adolescents and young people, especially those who are poor. The SOP aimed to concentrate on three strategic action areas, namely, service delivery, information, education, and communication or advocacy, and capacity building. As the Arroyo administration declared natural family planning as the focus of reproductive health services, the DOH issued Administrative Order No. 125 or the National Natural Family Planning (NFP) Strategic Plan for 2002-2006 with the policies, standards, strategies, and activities for mainstreaming NFP methods. In 2006, President Arroyo gave full responsibility of implementing the Responsible Parenthood and Natural Family Planning Programme to the DOH, POPCOM, and the local government units. The Responsible Parenthood and Natural Family Planning Programme primarily promote natural family planning, birth spacing (three years birth spacing) and breastfeeding. Currently, the PPMP includes four major areas: 1) Population and Development Planning, 2) Reproductive Health/Family Planning, 3) Adolescent Health and Youth Development, and 4) Resource Generation and Mobilization.

4.6 The population of the country in 2007 was recorded as 88.6 million. There has been a steady decline in fertility in the Philippines in the past 36 years. From 6.0 children per woman in 1970, the total fertility rate (TFR) in the Philippines declined to 3.3 children per woman in 2006. However the 2010 population in the Philippines continues to suggest that population growth impacts adversely on the achievement of MDGs. Poverty incidence is higher as
family size increases. The poorest people tend to have the highest fertility rate and as population grows rapidly, corresponding pressures are exerted on the already-declining natural resource base of the country. And this decline threatens the health and well-being of the majority of the country’s citizens. Alleviating poverty becomes more difficult when a large sector of disadvantaged people do not have access to basic social services such as health care, education and safe drinking water.

4.7 During the period 1969-1994, UNFPA assistance focused on family planning, population education, and advocacy for population and development. From 1995 to 1999, there was a major paradigm shift from family planning to reproductive health. In 2000, the Department of Health issued an administrative order creating a reproductive health programme. The Department also created the Adolescent and Youth Health Development Programme in 2001. The Fifth CP (2000-2004) aimed to integrate reproductive health services in accordance with the Programme of Action of ICPD.

4.8 The Philippines is in transition from the Macapagal-Arroyo administration to a new one under President Benigno S. Aquino III. It is more likely that the new government will better address the persistent challenges to the country posed by population, gender and reproductive health issues. This could include more adequate appropriations for reproductive health and family planning concerns besides a more resolute push for the passage of the Reproductive Health Bill in the 15th Congress.

5 The Sixth UNFPA Philippines Country Programme

5.1 The Sixth UNFPA programme of assistance to the Philippines covers the period 2005-2009. In 2009, the Executive Board approved the extension of the CP for further two years (2010-2011) in response to a request of the Philippine Government to harmonize planning cycles. In the formation of the CP it was agreed that the Sixth CP would have two major concentrations – one at a central level focussing on policy issues and the second at field level supporting efforts principally to improve the reproductive health situation of people.

5.2 The Programme responds to UNDAF 2005-2009 areas of cooperation: 1) macroeconomic stability and broad-based and equitable development; 2) basic social services; 3) good governance; and 4) environmental sustainability. The main characteristics of the Sixth CP were to be pro-poor, gender-responsive, culture-sensitive, rights-based, and demand driven. Conflict prevention and peace-building efforts were to be integrated in the activities supported in the five Programme provinces of Mindanao.

5.3 The overall intention of the CP was “to improve the reproductive health status of the Filipino people through better population management and sustainable human development”. The substantial efforts at a provincial level were also to be able to demonstrate successful arrangements for the organisation and implementation of RH care which would be appropriate for more widespread replication throughout the Programme and in non-programme provinces. The design of the Country Programme had a very strong and explicit ‘pro-poor’ emphasis.
Map 2: Location of 10 Provinces and One City Supported under the Sixth UNFPA Country Programme
5.4 The Country Programme has three components: population and development strategies, reproductive health, gender and culture. In addition while not a separate component, special attention has been given to provinces in the Southern Philippines with the establishment of Southern Philippines UNFPA Office in Davao, Mindanao. The planned Country Programme regular budget of US$20 million was split with 25 percent for the PDS component, 15 percent for Gender and Culture and 60 percent (US$12 million) for Reproductive Health.

5.5 The RH component supported activities at central policy level and in the 10 Programme provinces aimed at encouraging increased demand for and utilization of reproductive health services and information particularly by the poor and vulnerable women and adolescents. The PDS component was planned to principally contribute to an enhanced policy environment that supports population and reproductive health programmes, particularly for the poorest and most vulnerable. The Gender and Culture component aimed to help strengthen institutional mechanisms and socio-cultural practices to promote and protect the rights of women and girls and advance gender equity and equality.

5.6 Ten provinces (Ifugao, Mt. Province, Masbate, Bohol, Eastern Samar, Sultan Kudarat, Sulu, Tawi-Tawi, Lanao del Sur and Maguindanao) and one city (Olongapo City) were jointly identified by the National Economic and Development Authority (NEDA), POPCOM, DOH and UNFPA (see map 2). The selection was based on a set of criteria reflecting high levels of need (high incidence of poverty; high maternal mortality ratio; low contraceptive prevalence rate; low life expectancy at birth; and poor functional literacy). These sites as well as the list of implementing partners (i.e., National Government Agencies, Local Government Units and non-governmental organizations) are given in the Country Programme Action Plan (CPAP). Within each of the 10 provinces three municipalities were selected using similar criteria reflecting high need for improvements in RH status.

5.7 In 2007 a ‘mid-term’ review of the Sixth Country Programme was undertaken highlighting programme gains, documenting lessons learned and recommending improvements in the implementation of the overall programme and the thematic components.

5.8 The population and development strategies component has three outcomes and three outputs. The outcomes are: 1) an enhanced policy environment that supports population and reproductive health programmes, particularly for vulnerable and poor populations; 2) improved utilization of age- and sex-disaggregated population data; and 3) national, subnational and sectoral policies, plans and strategies that take into account population and development linkages.

5.9 The three outputs are:

Output 1: Relevant government institutions, NGOs and private-sector groups are able to identify poor and vulnerable groups and to formulate, implement, analyse and monitor pro-poor policies, programmes and projects in reproductive health. Five output indicators were identified:
- Reproductive health law passed;
- Adolescent reproductive and sexual health policy and programme defined;
- National reproductive health budget allocated;

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6 See appendix for actual budgets and expenditures over the period 2005 to June 2010.
• Methodologies and tools for pro-poor reproductive health policy-making developed.
• Population and development strategies and reproductive health integrated into Philippine MDG report and the medium-term Philippine development plan.

Output 2: Enhanced national capacity to conduct policy studies and research that link population with poverty and that utilize sex-disaggregated population data. Two indicators were identified:
• Policy studies and research utilizing databases for planning and decision-making;
• Maternal mortality and migration surveys done.

Output 3: Upgraded capacities to integrate population and reproductive health dimensions into environmental policies, plans and programmes. Two output indicators were identified:
• Integration of population dimensions into environmental plans and protocols;
• Increased use of family planning by poor and vulnerable communities in fragile ecosystems.

5.10 According to the CPAP7 the reproductive health component has two outcomes and three outputs. The first outcome relates to ‘increased demand for and utilization of comprehensive, high-quality reproductive health services’, and the second has to do with “increased access to comprehensive, high-quality reproductive health services and information”.

5.11 The three outputs are:
Output 1: Empowered women, men and adolescents with identified needs and appropriate mechanisms for reproductive health information and services. Two output indicators were identified:
• Percentage increase in the number of women, adolescents and men with knowledge on core reproductive health information and services;
• Percentage increase in the number of community networks of women organized to advocate reproductive health issues.

Output 2: Increased availability of high-quality, integrated gender-sensitive core reproductive health information and services for women, adolescents and men. Four output indicators were identified:
• Percentage increase in health facilities providing high-quality, integrated core reproductive health information and services, and accredited with PhilHealth;
• Percentage increase in poor women/households covered by social health insurance for reproductive health services;
• Number of municipalities with 50% reduction in maternal deaths;
• Integration of adolescent reproductive and sexual health into formal and non-formal education.

Output 3: Improved management systems and practices for genderized integrated reproductive health service delivery. Three output indicators were identified:
• Social franchises for contraceptives and reproductive health commodities issued;

7 Some outcomes, outputs and indicators are stated slightly differently in the CPD and the CPAP.
• Transparent and cost-efficient administrative and financial systems and procedures installed;
• Effective reproductive health monitoring and evaluation systems established.

5.12 The gender component has two outcomes and two outputs. The first outcome aims to achieve enhanced enabling environment to promote and protect the rights of women and girls and to advance gender equity and equality and the second outcome is on strengthened socio-cultural practices to promote and protect the rights of women and girls and to advocate gender equity and equality.

5.13 The two outputs are:

**Output 1**: Enhanced capacity to mobilize resources and to formulate, implement, evaluate and monitor policies and programmes to ensure reproductive rights and to combat gender-based violence and harmful practices. This output has the following indicators:

- Implementing guidelines on the delivery of GBV services
- Performance standards and protocol on the delivery of psychosocial, medical and legal services for VAW
- Working referral network on GBV cases
- Functional RIACAT, PIACAT and MIACAT VAW networks
- Number of reported, filed, and resolved VAW cases
- Percent of budget allocated for gender concerns by national agencies
- Percent of program staff in PopCom and DOH with capacity to integrate gender and rights concerns in population and RH programs and services

**Output 2**: Gender and rights-based concerns mainstreamed in the existing socio-cultural practices. The following indicators were identified for this output:

- Identified discriminatory provisions/practices in the ways communities address GBV and access to RH services
- Percent of women who can discuss RH with partners
- Percent of men who perceive FP as equal responsibility of women and men
- Percent of women and men who believe women have the right to refuse unwanted sex
- Framework for the integration of gender and rights concerns vis-à-vis existing cultural practices

6 Review of Implementation of the PDS Component of the Country Programme

6.1 The PDS component links the issues of population and reproductive health to various areas of concern such as poverty and hunger, environment, education, and women’s empowerment and rights. To meet the goals of the Sixth Country Programme, PDS activities and projects are carried out along the lines of three mutually-reinforcing strategies, namely: (a) advocacy; (b) research and knowledge management; and (c) capacity-building or training. Five projects under the PDS component are implemented by multi-sectoral and multi-disciplinary partnerships among national government agencies (NGAs), local government units (LGUs), non-government organizations (NGOs), and private agencies.

**Advocacy**
6.2 Project 202 (P202) is the main advocacy project that aims to mobilize wider support for population and reproductive health policies and programs, thereby contributing to the goal of achieving a policy environment supportive of PopDev and RH. The project blends communication and media strategies with networking and partnership-building towards the passage of policy and programme reforms in population, RH, and gender.

6.3 At the start of the Sixth Country Programme, advocacy activities under P202 were implemented jointly by the POPCOM\(^8\), the Forum for Family Planning and Development (the Forum)\(^9\), PLCPD\(^10\), PNGOC\(^11\), and ECOP\(^12\). By 2008-09, however, changes were made in the administrative arrangements of PDS which had implications for the conduct of P202 advocacy activities. While POPCOM remained the component manager of PDS, P202 advocacy activities were contracted out by UNFPA to an NGO consortium comprising the Forum, PLCPD, PNGOC, and ECOP. To distinguish the activities conducted by the NGO consortium from that by POPCOM, the former henceforth carried the descriptive title: *Increasing Demand for Improved Policies on PopDev, Gender, and RH at National and Local Levels*; on the other hand, the POPCOM-led activities retained the project descriptive title: *Linking Population, RH, Gender and Poverty*.

6.4 Nonetheless, activities implemented under P202 – whether by the NGO consortium or POPCOM – aim at achieving the output\(^13\) and the output indicators\(^14\) specified in the CPAP. Such advocacy activities have been clustered around the following.

6.4.1 Networking and Partnership Building

a. Grand alliance-building and multi-sectoral partnerships/networks:

- Establishment of advocacy networks among various sectors, i.e., businesses, local and national legislators, RH alliances/NGOs, NGAs, and media, etc.;
- Sustained participation and involvement of sectoral networks/partners in PopDev, RH, and Gender advocacy campaign;
- Creation and mobilization of local multi-sectoral advocacy teams and task forces at provincial, municipal levels;
- Establishment of Inter-Faith Partnership on Responsible Parenthood as alliance for faith-based organizations on Population and Human Development;
- Reactivation and expansion of membership of ECOP’s Population/Family Welfare Management Committee.

b. Discussion and coordination among partners:

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\(^8\) Target groups of the POPCOM’s advocacy efforts are: LGUs (10 Pilot Provinces, 30 municipalities and 1 city)

\(^9\) Target groups of the Forum’s advocacy efforts are: Academe, national champions, national media.

\(^10\) Target groups of the PLCPD’s advocacy efforts are: Faith-based groups, national and local legislators

\(^11\) Target groups of the PNGOC’s advocacy efforts are: NGOs, POs, local media

\(^12\) Target groups of the ECOP’s advocacy efforts are: Business Chambers, Industries.

\(^13\) Achieving the goal of a policy environment supportive of population and RH is expected to result in the ability of relevant government institutions, NGOs and private sector groups to identify poor and vulnerable groups and formulate, implement, analyze, and monitor pro-poor and gender-responsive policies, programmes, and projects on PopDev and RH.

\(^14\) The indicators of having achieved the goal of a supportive policy environment are: functional grand alliance of RH advocates; proportion of institutions/agencies able to integrate, analyze, implement and monitor PopDev, RH, and gender dimensions in their respective policies, programs, and projects; proportion of national/sectoral and local plans that integrate PopDev, RH and gender concerns; and existence of methodologies and tools for pro-poor, gender-responsive and rights-based RH policy-making developed.
• Orientation and recruitment of national and local legislators as advocates for PopDev, RH, Gender;
• Formation and regular convening of Technical Working Group among NGAs, NGOs, basic sectors, LGU leagues, and UNFPA;
• Coordination activities with implementing partners for harmonization of activities, tools, and systems for planning, implementation, monitoring and evaluation.

6.4.2 Intensive Advocacy Campaigns
a. Legislative advocacy for HB 3773/HB 5043
b. Mainstreaming PopDev, RH, and Gender in the electoral agenda;
c. Lobbying for laws and policies supporting PopDev, RH, and Gender:
   • Provincial and municipal resolutions in support of HB 3773;
   • Legislative and executive orders in response to PopDev challenges and RH issues;
   • CSR policy and budget at national and local levels;
   • Passage of local ordinances (provincial, municipal, and barangay-level) in support of PopDev, RH and Gender (including GAD and VAWC Codes);
   • Enactment of implementing rules and regulations (IRRs) for ordinances passed.
d. Lobbying to support PopDev and RH programs
   • Allocation in national budget for procurement of FP commodities;
   • Allocation in local budgets for procurement of contraceptive commodities;
   • Enrolment of indigent households in PhilHealth by LGUs;
   • Construction of birthing, VAWC, teen centers;
   • Establishment of small-grant facility for LGU projects using CBMS.

6.4.3 Popularisation
a. Media mobilization and special events for PopDev, RH and Gender programmes, projects, and activities:
   • Publication and distribution of IEC materials;
   • National and local media symposia;
   • Multi-media appearances of champions;
   • Production of audio-video materials, documentaries, etc.
   • Media coverage of events.
b. Identification of best practices for documentation, recognition, and replication:
   • Media awards;
   • Compendium of Good Practices.

6.5 Table 6.1 (see appendix) provides specific examples of PDS P202 advocacy activities implemented by the NGO consortium and POPCOM in line with the goal of achieving a policy environment supportive of population and RH.
6.6 Meanwhile, P204 (Support to Poverty Reduction) aims to reconcile and integrate the government’s population management and poverty alleviation programs and is sub-titled Development of Harmonized Approaches for Population and Poverty Integration. As implemented by NAPC, the project has evolved from a HAPPI framework (integration of population-poverty reduction projects) to HAPPI*ER which adds environment resource sustainability. Its latest development is emergent HAPPI*EST which integrates S&T innovations into the strategy framework for harmonizing the government’s anti-poverty programmes.

6.7 Among the objectives of P204 is to empower LGUs in providing informed choices to their constituents on responsible parenthood and family planning, environmental protection and sustainable development. Table 6.2 (see appendix) shows examples of advocacy activities of P204.

6.8 While P202 and P204 are concerned with PopDev and RH advocacy at the national and local levels, P201 (ICPD Integration through PopDev and Advocacy) and P103 (Localizing the MDGs: Improving the Capacity of LGUs to Deliver Population and Reproductive Health Information and Services at the Local Level) focus their activities in the Sixth Country Programme Pilot Areas.

6.9 Advocacy activities implemented under P201 by the pilot LGUs have focused on passage of local RH and Gender legislation, establishment of youth centres and barangay birthing centres, and PopDev integration in local plans. The 10 pilot local governments have enacted several ordinances, executive orders, and resolutions resulting from the efforts by the local advocacy teams. Under P103, the DILG provides assistance to the LGUs to address MDGs in their development planning and service delivery. Table 6.3 (see appendix) presents specific examples of advocacy activities at the local level.

Research and Knowledge Management

6.10 Apart from creating a policy environment supportive of population and RH programmes (Outcome 1) through advocacy, the PDS component of the Country Programme is concerned with generating evidence-based knowledge that is necessary for national and local planning (Outcome 2) and with enhancing capabilities in integrating PopDev (Outcome 3). Actually, activities in line with building evidence-based knowledge through research are incorporated in most PDS projects.

6.11 Without a doubt, the generation of data or evidence base for PopDev, RH and gender planning, policy and programme formulation is an important strategy for PDS, as shown in Table 6.4 (see appendix) presenting projects and activities that employ the research or knowledge management strategy.

Capacity-Building

6.12 Complementing research and knowledge management for advocacy purposes is capacity-building. P203 aims to increase awareness and appreciation of population and development for integration into national and sectoral plans. To this end, trainings have been conducted since the start of the Sixth Country Programme on topics such as:

- strategic leadership
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- advocacy,
- gender-responsive PopDev planning,
- community-based Integrated RH/FP and Coastal Resource Management,
- male peer education,
- couple peer education,
- youth peer education,
- community-based distribution, etc.

6.13 To upgrade capacities to formulate and implement PopDev, RH, and gender-responsive development plans, policies, and programmes. These capacity-building activities have involved training of trainers (TOTs), roll-out trainings, and local trainings in all the pilot areas. Training participants are LGU and regional level partners, planners from local and national government agencies, municipal and barangay advocates.

6.14 As previously described, P204 (Support to Poverty Reduction) is implemented by NAPC. In line with its promotion of the HAPPI, HAPPI*ER, and HAPPI*EST strategy framework to harmonize anti-poverty programmes, capacity-building is a necessary strategy. Similarly P103, which is concerned with localizing the MDGs, requires training to improve information and service delivery. Table 6.5 (see appendix) provides specific examples of capacity-building activities.

Major Achievements

6.15 As indicated in the various documents of the PDS projects, discussed by implementing partners, and validated during field visits to Bohol and Masbate, there have been important and notable developments in the PopDev, RH, and Gender situations in the pilot areas resulting from advocacy, research and knowledge management, and capacity-building activities.

Public awareness and sensitivity

6.16 There is increased favorable public awareness about and sensitivity to PopDev and RH issues, as evidenced by several surveys\(^{15}\) and further buttressed by the results of the 10 May 2010 national and local elections. For instance, national and local candidates supportive of population policy (i.e., PopDev) and RH in particular, who were actively campaigned against by the Catholic Church hierarchy and other conservative religious groups won, while the so-called “pro-life” candidates favoured by these conservative groups lost. In all likelihood, legislators and politicians in general would now be less risk-averse vis-à-vis the passage of RH or population policy legislation.

6.17 As evidenced by the activities implemented by the PDS component of the Sixth Country Programme, the sustained communication efforts of national and local networks of advocates for PopDev and RH over the years have undoubtedly contributed to public awareness. National print media regularly carry news items, feature articles, opinion columns, and advertisements on PopDev, RH, Gender, commitments to ICPD and MDG 5.

\(^{15}\) For instance, in his column entitled *All local opinion polls support the RH bill* (Philippine Daily Inquirer, June 27, 2009), Dr. Mahar Mangahas cited findings of the SWS surveys commissioned by the Forum (national survey of adults in September 2008, surveys of persons of reproductive age in Manila, Paranaque, and Cebu from December 2008 to March 2009) and the Bohol survey done by the Holy Name University conducted from April to May 2009.
Over the broadcast and on-line media are talk shows, documentaries, and infomercials about the issues. Likewise, the entertainment-oriented media including film and music have been used for advocacy. Even the creative arts have been venues for sensitizing to issues of PopDev, RH, and Gender.

6.18 At the local level, the strategy of multi-sectoral partnerships and implementation of complementary projects at the local level have proved useful in raising consciousness about the important links between population, poverty and development – and, hence, the critical importance of the RH bill – among communities and households.

6.19 Further, the popular perception that UNFPA was an agency interested in family planning or RH, i.e., merely pushing contraceptives (IUDs, pills, and condoms) has changed to one involved in promoting population and development, i.e., human development.

Legislation

6.20 The RH bill (HB 5043 in the 14th Congress had earlier similar versions, i.e., HB 3773 in the 13th, HB 4110 in the 12th, and HB 8110 in the 11th) was well on the way to passage, if not for dilatory tactics employed by administration-connected legislators and given the coup de grace by the national leadership’s intervention. However, all is not lost for the RH bill because, owing to heightened awareness and impatience of the citizenry, active preparations are already afoot for re-filing the bill in the upcoming 15th Congress. Meanwhile, proposed amendments have been made to the midwifery law.

6.21 In the absence of a national RH bill, local government units at the provincial, municipal, and barangay levels have passed RH ordinances and resolutions. Several of these local legislations are similarly titled and worded as they are patterned after earlier legislation. The use of such a template has been useful in speeding up the RH legislation process.

6.22 At this time, there are a good number of local ordinances and resolutions on PopDev and RH. Moreover, most pilot LGUs have enacted their GAD ordinances. (Copies of these ordinances and resolutions are available in the UNFPA office.)

Physical Changes in RH Service-Delivery Landscape in the Pilot Areas

6.23 Resulting from lobbying efforts of local advocates, a number of LGUs have been adopting and implementing RH/FP activities. For instance, local legislations mandating facility-based births with trained midwives are already enforced in the pilot areas. Consequently, new structures have been built and improved services can be availed in these communities:

1. *Construction of Birthing, VAWC, and Teen, and Rehab Centres.* Structures have been built in strategic locations in barangays and municipalities where there were none before. According to persons met in the visits to pilot sites in Bohol and Masbate, mere presence of these structures was already “tremendous” improvement in these rural communities. Particularly in the communities in Bohol and Masbate that were visited for this evaluation, these Centres have become convergence points, like the youth centres where students and out-of-school youth avail of services while watching videos, playing musical equipment, and using other facilities.
2. Upgraded facilities and services in provincial, municipal, and barangay-level health units. Where LGUs provided the physical structure to avail of UNFPA-supplied equipment, these service-delivery units are recognized for their quality services at low cost. If you build it, they will come (following the classic Say’s law; “Supply creates its own demand” – a noted principle in economics). This is evident in Carmen, Bohol which “has a sprawling health facility offering first-class service for low fees”\(^{16}\). Dr. Josephine Jabonillo, Carmen MHO, said that since the municipal health unit’s renovation, there has been “an onslaught of clients” seeking their services daily. During the field visit, a client of the health unit said that the facility looked like a “first-class private hospital.” The upgrading of the municipal health unit has also resulted in a renewed sense of purpose among the health workers themselves, an observation volunteered by Placer, Masbate MHO and RH Focal Person, Dr. George Galindes. He noted that before the improvement of facilities, his medical team had little to do as clients were few and medical supplies were almost always lacking. Hence, they simply whiled away time with inconsequential activities. With new facilities, he and his team gladly offer services 24/7 to a steady stream of clients. Fame is an added offshoot of the improvements in clinic facilities and services. Galindes adds that he and his team are famous and favored in the municipality as they are easily recognized and regarded highly.

3. A midwife in every barangay. For a few pilot communities\(^ {17}\), this has become a reality. For others\(^ {18}\), it is goal that is regarded reachable.

Innovations in Processes and other Good Practices

6.24 Advocacy, research/knowledge management, and capacity-building strategies have resulted in several innovative processes and good practices. For instance:

1. Innovations:
   a. Simplifying the processing of VAW victims. Masbate has simplified the protocol for the processing of victims of violence. As documented by NAPC and validated by the field visit, Masbate VAW centres offer integrated services where doctor, social worker, and police are together during the interview with the victim and processing of the complaint. This simplified procedure has been the focus of visits by agencies, teams, and individuals from other provinces.
   b. Alternative Community Health Insurance. In the very remote community of Paracelis, Mt. Province, community health insurance was put up. As documented by NAPC, there is a one-time membership payment of PhP20 and then annual dues of PhP 250 per household (regardless of HH size). Households can then avail of medical assistance at PhP750 for outpatient and PhP1,000 for in-patient services. Additionally, the community has set up its own financially successful Botika ng Barangay.


\(^ {17}\) For one, Talibon municipality in Bohol has 26 midwives in 25 barangays.

\(^ {18}\) Carmen, Bohol currently has 18 midwives for its 29 barangays. Palanas, Masbate is working to reach the one midwife per barangay.
c. Pregnancy tracking. Pilot communities have instituted their own mechanisms in line with MDG5. For instance in one particular community, Pinagpagan (Mt. Province), NAPC has documented the community health team’s pregnancy tracking protocol. That is, the assignment of a “family partner” from among the health team ensures individualized, sustained, and focused health care will be afforded the pregnant mother and infant.

2. Best practices
   a. Talibon, Bohol as model for NSV (Non-Sapel Vasectomy) acceptance. MHO Dr. Francisco Ngoboc has done almost 200 NSVs and is now entertaining the requests of neighbouring municipal health officials for training on NSV. Talibon’s NSV program has enjoyed full support from the LGU through its local executive, Mayor (outgoing) Januario Item.
   b. Participatory governance from barangay to municipal levels. In Asipulo, Ifugao, prioritization of projects are products of public consultation. Public participation in projects is also through contributions of labour by able-bodied constituents. Moreover towards the end of a project, there is again public consultation where people grade the project.
   c. Political will to support RH: Municipal funding of the RH component of the Coastal Resource Management Plan in Ubay, Bohol. The CRM and the reef rehabilitation programmes in Ubay, Bohol integrate Population-Health-Environment issues. The successes of the Ubay program have attracted national recognition (e.g., an entry in the Galing Pook Awards) and international media attention (i.e., CNN and LA Times). Mayor Dr. Eutiquio Bernales, a hands-on RH advocate now on his third term as local executive, has fully supported the programme.

Networks of advocates at the National and Local Levels: Capacitated, Empowered, Willing and Passionate

6.25 Unlike the previous Government, the new national leadership (President Benigno C. Aquino III) is favorably disposed toward PopDev, RH and Gender issues. With the new Government’s thrust toward universal health care, if complemented by political will of local officials, the above-cited innovative processes and good practices in PopDev and RH should be replicable in other areas. The emergence of national and local advocates who are true believers in PopDev and RH is a major achievement. These advocates will likely help a great deal in fostering the introduction and sustainability of the innovative processes and good practices in other places. Having worked together over the years, these advocates share common goals and exhibit enthusiasm (despite failures) to continue advocacy efforts. The camaraderie they have developed is palpable and directly observable. One NGO partner in the national advocacy pointed out that “the level of enthusiasm and passion of lead NGOs on RH issue” is indeed very high.

Community-Based Data System in Place with Potential to Drive Needs-Based Planning

6.26 The CBMS makes possible evidence-based policymaking, programme design and implementation at the same time that it empowers local community residents to participate in the processes of policy formulation and implementation. It has several features:
   - It is LGU-based;
   - It taps existing LGU personnel as monitors;
   - It has a core set of indicators.
6.27 CBMS makes possible “the ability to monitor the poverty situation at the community level (which) could help the Government in taking the necessary steps in improving the standard of living of every Filipino,” as noted by Sec. Domingo Panganiban of the NAPC. Expectations regarding the use of CBMS are high. Ms. Sylvia Carvajal of the DILG, which implements the CBMS capacity-building activities at the LGU level, points out that local executives appear enthralled by the data base system.

Documentation

6.28 A compendium of good practices and the many policy papers, evidence-based advocacy materials in both print and electronic formats are likewise achievements of the PDS Sixth Country Programme.

Shortcomings of the Current PopDev Component

6.29 While the PDS component has done quite well, there have been pitfalls in the way projects have been implemented - thereby affecting the quality and impact of the outputs.

Conflict of policy and programme perspective with POPCOM as PDS head

6.30 While the NGO partners have been more assertive and vocal in its advocacy for the RH bill, POPCOM’s identity as a government institution has constrained it from being equally forceful. Hence, POPCOM as PDS Component manager became a problematic situation, given that it could not advocate beyond the previous Government’s current NFP-only RH policy.

Insufficiency of Local Level Champions and Coordination issues

6.31 Despite the capacity-building for advocacy, local champions are still insufficient in number and largely lacking in stature. NGO advocacy partners acknowledge the lack of the likes of RH champions like Representatives Edcel Lagman, Janet Garin, and Risa Hontiveros-Baraquel at the local level to answer directly (face-to-face) and unequivocally issues raised by local constituents and objectors. Moreover, coordination problems have been cited regarding synchronizing local advocacy programs with national efforts. As observed by a representative from PNGOC, local partners need to be nurtured and/or strengthened.

6.32 In general, the population programme could still use more high-profile or prominent PopDev partners and RH champions at the national and local levels – to further boost the usual core of known advocates who are regularly seen on TV, heard from radio or are quoted by print media.

Lack of preparedness for events that slowed down RH bill campaign

6.33 In technical and management matters, the NGO Consortium – whether as individual NGOs or as a group – has shown to be quite effective and innovative in implementing various advocacy activities. To ensure systematic and efficient advocacy, they have used a variety of strategies and tools (e.g., political mapping of support for RH). However, the Consortium

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19 In his key note address during the 5th Community-Based Monitoring System National Conference in January 2008 at the Manila Hotel.
acknowledges that it was still ill-prepared for the unforeseen (e.g., political) events that hampered the passage of the RH bill.

**Constraints on Advocacy Directed at the National Government Executive Level**

6.34 Considering the urgent need for a national RH bill, it was unfortunate that the implementation of advocacy strategies and activities directed at the executive level was seriously constrained owing to the unfavourable or lukewarm attitude of the previous national leadership to importance of addressing the population issue.

**Reluctance to Use or Inadequate Utilization of CBMS Data by LGUs**

6.35 Resource problems hounded the implementation of CBMS (commitment of LGU counterpart) in pilot LGUs. Reasons included unreliable electrical supply and absence of qualified technical staff in the plantilla. Moreover, some LGUs do not want to use CBMS data because they want to push their own political agenda.

6.36 Such reluctance may indicate that PopDev understanding is still unclear or weak. It has also been cited that there is weak engagement with DILG at the local level, especially in ARMM.

**Missed opportunities**

6.37 Specific issues for RH legislation advocacy were missed out, e.g., the budgetary provision. With the next battleground in local RH legislation being the drafting of the IRRs, there is an obvious need for new strategies. Moreover with reports that LGUs (non-pilot areas) are taking steps backward from their RH policies, continuous monitoring is clearly called for.

**Challenges to PopDev as Goal - The nature of PopDev**

6.38 In general, PopDev issues/concerns are essentially long-term in nature, not directly or immediately palpable, unlike water, food, power, basic healthcare and education, which attract more urgent attention from national leadership, politicians, policymakers and society-at-large.

**Roadblocks posed by Conservatives and so-called pro-life groups**

6.39 “The need for population management – long settled elsewhere in the developing world, even in the poorer countries – remains contentious in the Philippines. This is evident in the public debate on a population policy instrument – namely, the Reproductive Health (RH) bill – that has heated up over the past several months.

6.40 “Those opposed to the bill assert that the Philippines does not have a population problem and that the focus of public attention should instead be on the corruption problem. They argue that a large population resulting from rapid population growth is in fact good for the economy. They add that attempts to slow population growth are ill-advised as they would only hasten the onset of the “demographic winter” or the problem of ageing currently

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20 This section is quoted from Ernesto M. Pernia, “Is Population Management Needed in RP?,” February 2010 (Processed).
experienced by the advanced countries. Moreover, the Catholic Church hierarchy and conservative religious groups assert that the RH bill is pro-abortion and is thus anti-life. This is because, in their view, modern contraceptives – which the RH bill proposes to make available along with the traditional methods (including “natural family planning”) – are abortifacient.

6.41 “Those in favour of the (Reproductive Health) bill cite the conventional argument that slower population growth is more conducive to economic growth, poverty reduction, and preservation of the environment. Economic growth is facilitated by higher private and public savings – owing to slower growth of the youth dependents – required for investment in human capital (i.e., spending on education and health care per person) and infrastructure. Slower population growth combined with faster economic growth lead to more significant poverty reductions and inequality improvements. And slower population growth lessens the stress on the environment.

6.42 “Based on surveys at both the national and local levels, the majority of Filipinos regard rapid population growth as a hindrance to development, requiring policy intervention. But the government appears immobilized owing to opposition from Catholic Church hierarchy and other conservative groups. Yet, according to the same surveys, the influence of the Catholic hierarchy on fate of political leaders appears overrated.

6.43 “What seems to obtain in the Philippines is a case of a soft state and a hard church – a situation that seems to be at the root of the country’s inability to achieve demographic transition cum economic development at par with its dynamic Asian neighbours. The reality seems to be that a well-organized, single-issue vocal opposition overrides the views of the silent majority. The Church and the State need to arrive at a mutual understanding on the issue of population in relation to development, as has long happened in other Catholic countries.”

Incentive Incompatibility for Politicians at National and Local Levels

6.44 “The national government’s current approach to leave the adoption of population policy and implementation of family planning programmes to local government units (LGUs) is ill-advised and is likely to fail. It represents poor governance, to begin with.

6.45 “In the first place, local government leaders typically wait for signals or directives from the national leadership as far as major policies are concerned. In other words, if national leaders are lukewarm about a major issue, why should local leaders even bother about it? What is worse, managing population growth at the local level may be incentive-incompatible with internal revenue allotments (IRA) which increase with population size, as well as with political careers that rise with larger constituencies. Indeed, there are thus far only a handful of LGU executives (some of them supported by the UNFPA program) who take the population issue seriously.

6.46 “Secondly, there are negative spillovers involved, since LGU territorial boundaries are not closed and people are geographically mobile. Thus, a town or province with successful population management, good economic performance, and adequate infrastructure

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21This section is also quoted from E. M. Pernia (February 2010).
and social services would find itself swamped with migrants from poorly performing towns or provinces.

6.47 “Third, population policy cannot be local in scale or scope because varying fiscal resources and technical capabilities among LGUs militate against its consistent and effective implementation.

6.48 “For these reasons, the national government cannot simply pass the buck on this important responsibility to LGUs. It must assume leadership in coming up with an unequivocal and coherent national population policy, backed by adequately funded family planning programs that provide accurate information and enable easy access to all methods of choice, especially for the poor. Then, it must enjoin all LGUs to carry out the programmes on the ground.”

Reaching broad-based agreement or consensus among various sectors and individuals

6.49 Punitive measures in local (and national) RH bills are contentious issues among legislators and executives. For example:

1. Ubay Municipal Mayor Dr. Eutiquio Bernales (an RH champion) pointed out that a municipal ordinance requiring all mothers to give birth at designated birthing centres sets the penalty for non-compliance (PhP 500) much lower than the fees (PhP1,500) charged by the centre. He has returned the ordinance to the council for revision of penalties.
2. Masbate (out-going) Governor Dr. Elisa Kho questions a resolution penalizing traditional hilots. A resolution providing for alternative livelihood for hilots may be better.

Change of National and Local Government Executives

6.50 Change of leaderships might impact on existing structures, partnerships, and personnel of the programs and projects.

Continuing Need for LGU Technical Support

6.51 As expressed by Masbate provincial officials, it has just been recently that improvements in the PopDev, RH and Gender environment accruing from the Sixth Country Programme implementation have been felt. The first years of the Programme comprised a learning and awareness-raising period.

6.52 The provision of technical support appears to be a continuing need. With new sets of officials taking over local executive positions, orientations on PopDev, RH, Gender, ICPD and MDGs will again be needed as will other forms technical assistance such as integrated development planning and drafting legislation.

6.53 For another, it may be necessary to monitor LGU implementation and use of CBMS for planning. CBMS makes it possible to collect and organize information at the local level for use by local units, NGAs, and NGOs. While key indicators are reportedly easy to collect and process, there are reported problems related to CBMS implementation. These difficulties are related to basic resource constraints (e.g., fluctuating electrical supply) as
well as more technical problems (e.g., lack of technology-literate manpower, lack of appreciation for integrated planning). Also, the operationalisation of the HAPPI*EST framework remains a challenge.

7.0 Review of Implementation of the RH Component of the Country Programme

7.1 UNFPA’s 6th CP deliberately chose five of the 10 elements of DOH’s reproductive health service package which were identified eleven years ago when the department created the Philippine RH program with the goal of achieving universal access to quality RH care through Administrative Order DOH A.O. No.43 s.1999 entitled Reproductive Health Policy which was signed on 24 April 2000 by former DOH Secretary Alberto G. Romualdez. It provided the RH framework within the Health Sector Reform Agenda (HSRA). This policy was the country’s response to the watershed 1994 ICPD Program of Action. The five focused RH elements of the 6th CP are Maternal and child health and nutrition (MCHN)\(^22\), family planning, prevention and management of reproductive tract infections (RTI) including sexually-transmitted infections (STI) and HIV & AIDS, adolescent reproductive health (ARH), and the prevention and management of violence against Women and Children (VAWC).\(^23\)

7.1.1 Four of these five RH elements—MCHN, FP, RTI/STI/HIV/AIDS, and ARH— were selected by DOH as the core elements for the service package which should be provided by the country’s public health facilities. The continuing burden of high maternal mortality ratio (MMR) and infant mortality rate (IMR), low contraceptive prevalence rate (CPR) high STI rates and increasing number of HIV & AIDS and teenage pregnancy cases, provided the rationale for this choice. The reduction of this burden is incorporated into the 1999 Integrated RH policy which was issued to ensure that primary to tertiary government and private health institutions would incorporate an “effective and efficient referral system.”\(^24\)

7.1.2 In 2007, an accompanying integrative RH framework was formulated which illustrated how public, private and community efforts could synchronize their efforts in the promotion and provision of RH services. At the core of the concentric framework is a culture, gender-responsive and rights-based perspective that would guide the health’s sector’s approaches in governance, financing, regulation, and service provision.\(^24\)

7.1.3 When the country ushered into the 21st century, the DOH’s RH goals of reducing maternal mortality ratio (MMR) and infant mortality rate (IMR), improving CPR, controlling the spread of HIV and AIDS, and attending to ARH needs, were noted to be congruent with four of the eight 2000 Millennium Development Goals, i.e., Goal 3 (Gender equality and empowerment of women), Goal 4 (Reduce child mortality rate), Goal 5 (Improve maternal health), and Goal 6 (Combat HIV & AIDS, malaria, and other diseases).

7.1.4 As early as 2000, the Safe Motherhood Policy (A.O. No. 79, s. 2000) and the National Objectives for Health (NOH) of the DOH already targeted a maternal mortality ratio (MMR) of 86 by 2004 and a neonatal mortality rate (NMR) of 4 deaths per 1,000 live-births. The

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\(^22\) UNFPA supports maternal and neonatal health only. Child health and nutrition is supported by UNICEF.

\(^23\) The other five RH elements are: Prevention and Management of Abortion and its Complications (PMAC), Prevention and Management of Breast and Reproductive Tract Infections Cancers and other gynecological conditions, Education and Counseling on Sexuality and Sexual Health, Men’s Reproductive Health (MRH) and involvement, and Prevention and Management of Infertility and Sexual Dysfunction.

\(^24\) Ramos, Rebecca. 2007 Reproductive Health in 6th CP Intensive Mid-Term Evaluation Report—volume 2. UNFPA, Manila Philippines
pledge of support by former President Gloria Macapagal-Arroyo and DOH Secretary of Health Francisco Duque III to attain the MDG targets during the 2005 UN Summit provided a stronger impetus for DOH and partner local government units (LGUs) to formulate work plans which were geared towards their achievement by 2015.

7.1.5 Thus, UNFPA commissioned a situational analysis on maternal health and advocated on the progress made and the need for evidence-based interventions to achieve the MDG 5 targets. These concerns were thoroughly discussed by the members of the DOH-Executive Committee, other key officials and development partners. In 2008, the DOH issued a policy (A.O. No. 29, s. 2008) on Maternal, Neonatal, Child Health and Nutrition (MNCHN) with the subsequent issuance of its manual of operations as a flagship program of the government to rapidly reduce maternal and neonatal deaths.

7.1.6 UNFPA’s lead partner for MNH, FP, prevention of STI/HIV and AIDS is the Department of Health (DOH), a long-standing collaborator in previous country programs. Because of the Philippines’ decentralized system of governance in the provision of basic health services, the role of DOH is confined to the formulation and issuance of health policies, development of RH and health-related standards and protocols, designing of training tools and materials, and the challenge of building the capacity of devolved health and related personnel. In partnership with its regional offices, the DOH conducts RH training for trainers who usually cascade their knowledge and skills to the provinces and the municipalities. The ten selected provinces and 30 municipalities of the 6th CP are the main suppliers or providers of RH information and services to the constituencies in these areas.

7.1.7 An affiliate of DOH, the Philippine Health Insurance Inc. (PhilHealth) was tapped to provide social insurance coverage, including family planning benefits for the population, through the accreditation of health facilities in the pilot sites.

7.1.8 UNFPA also collaborated with national and community-based NGOs and CSOs to raise awareness, set up appropriate support mechanisms and demand for RH services at the national level and in the pilot sites. Because of the perceived public sensitivity to ARH, the provision of comprehensive and reliable RH information through the public school system was viewed as a better strategy to reduce adolescent pregnancy and risks to STI/HIV & AIDS through life skills approach and youth-friendly interactive strategies. Thus the Department of Education, Culture & Sports (DepEd) was tapped as the major partner for this RH element.

7.1.9 VAWC was pursued by UNFPA through the 6th CP Gender & Culture (G & C) component because of its close link to MDG 3 (Gender equality and women’s empowerment). Its lead partner is the Philippine Commission on Women or PCW (formerly known as the National Commission on the Role of Filipino Women). PCW in turn collaborated with the Department of Social Welfare and Development’s (DSWD) social

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25 MDG 5 has two sets of targets. MDG 5A targets the reduction of MMR by three quarters between 1990 and 2015 and raising the proportion of births attended by skilled health personnel. MDG 5B, on the other hand, aims to achieve by 2015 universal access to RH by increasing contraceptive prevalence rate (CPR) particularly the reduction of unmet need for FP and use of modern and effective FP methods, reduction of adolescent birth rate, and raising antenatal care coverage to at least four visits. MDG 6 also has two sets of targets. MDG 6A’s target is to halt and reverse the spread of HIV and AIDS by 2015 through the reduction of HIV prevalence among population aged 15-24 years, increase condom use at last high-risk sex, and increase the proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS. MDG 6B aims to increase the proportion of population with advanced HIV with access to anti-retroviral drugs.

workers who are based in the 10 provinces and 30 municipalities. The results of their collaboration are discussed in the G & C section of this report.

7.1.10 The partners formulated their work plans and indices which they could realistically achieve over a period of five years. The main strategies focused on capacity building, development of tools and materials, upgrading of health facilities and provision of equipment, medicine & supplies, advocacy and networking to link the users to health facilities and providers. Linking the community-based claim-holders (demand generation) to RH information and service provision by the duty-bearers (supply) to forge partnerships with selected community-based NGOs and CSOs that are actively advocating for an integrative approach to RH was another vital approach of the 6th CP.

7.1.11 A baseline survey was conducted in 2006 in the pilot municipalities with plans of utilizing the goal, outcome and process indicators for planning, monitoring, evaluation, advocacy and resource mobilization. The findings of this study were obtained in mid-2006. To measure program effects on the pilot municipalities, an end-line survey was undertaken in May and completed in October 2010.

Maternal Health

7.1.12 The reduction of maternal mortality ratio (MMR) has been in the agenda of the public health system in the past decades because the Philippines has one of the highest MMR in Southeast Asia. In the early nineties, the Philippine point estimate of MMR was 209 maternal deaths/100,000 live births and it fell to 172 in 1998. However, it stagnated and even plateaued at 162 (95% CI: 128-196) in 2006. This translates to an estimate of around 4,600 women dying annually. Thus no less than 11 women die every day leaving around 30 motherless children. Because of difficulties in accessing reproductive health services especially by rural poor women in this socially and geographically-disparate country, it is unlikely that the Philippines would attain the MDG 5 target of reducing maternal mortality by 75 per cent (or 52 MMR) in 2015.

7.1.13 High maternal mortality is experienced by the poorest women who deliver at home and are unattended by skilled birth attendants. The 2008 NDHS found that 38 per cent of child births are not attended by skilled health professionals while 56 per cent of deliveries continue to take place at home. While almost 47 per cent of maternal deaths are unclearly classified, the three other major causes of maternal mortality in the country clearly include hypertension complicating pregnancy, childbirth and puerperium (29%), postpartum haemorrhage (15%) and pregnancy with abortive outcome (8%). All these problems are preventable and can be addressed through adequate continuum of medical care such as the presence of skilled birth attendants during delivery and immediate postpartum period with seamless access to emergency obstetric care (EmOC), when necessary, and access to family planning and reproductive health services27.

7.1.14 The concern for maternal condition during delivery becomes even more important because of its strong association with neonatal and/or perinatal deaths. Of the 25 IMR per 1,000 live births, neonates who die within 28 days account for 57.9 per cent of all infant deaths; 46.1 per cent of these newborn die within their first week of life (NDHS 2008).28

28 National Demographic Health Survey. National Statistics Office, Manila
7.1.15 Recognizing the strong association of maternal and neonatal/perinatal mortality, former Secretary of Health Esperanza Cabral issued on May 14, 2010 Administrative Order 2010-0014 entitled “Administration of Life-Saving Drugs and Medicine by Midwives to Rapidly Reduce Maternal and Neonatal Mortality.” This policy, and further issuance related to RH Commodity Security (RHCS) as safety nets for the poor, provides a framework for skilled midwives to carry out their tasks effectively especially for complicated cases to ensure the survival of mothers and newborns. This recent DOH move implies that maternal and child health will remain as an important agenda for many years. Thus the goals and strategies of UNFPA 6th CP for RH particularly maternal health care and family planning will continue to be relevant in the country.

Measures to address maternal and neonatal health

7.1.16 The actions utilized for maternal health include capacity building, development of tools and materials, upgrading of health facilities and the provision of equipment, medicine, and supplies, advocacy and networking to link demand with supply including financing through PhilHealth and other community initiatives.

7.1.17 Capacity building utilizing DOH tools and materials. The DOH with its regional CHD conducted training for trainers who subsequently rolled out their RH knowledge and skills to the local health providers in the pilot sites. These training activities included Community-Managed Maternal and Neonatal Care, Life Saving Skills, Basic Emergency Obstetrics and Newborn Care (BEmONC) with Integrated Management of Pregnancy and Childbirth, Competency-based Skills Training on FP, Syndromic Approach to Sexually-Transmitted Infections (STI), and Adolescent and Youth Health Development. Relevant tools and materials were developed by DOH with the health partners, including the private sector, training institutions, academe and professional societies (e.g., POGS, PSNM/PPS, midwives groups, etc.), for these training activities.

7.1.18 The capacity-building activities also included the application of Maternal Death Review (MDR) or Audit, an important qualitative approach to obtain detailed information about different factors that contribute to maternal deaths at various levels. This periodic exercise which involved health professionals and other pertinent sectors in the health system could lead to the formulation of appropriate measures to address the gaps in health services and ultimately, contribute to the reduction of maternal (and newborn) mortalities.

7.1.19 To develop the gender, culture and rights-based perspective that is essential in extending health services to varied population segments including indigenous peoples and Muslims, a manual entitled Gender-responsive Integrated RH Manual was developed by DOH with PCW (formerly NCRFW). This was utilized in building the capacity of the regional trainers and was reportedly rolled out to the pilot sites.

7.1.20 To hasten the acceptance and development of RH services in the pilot sites, UNFPA supported the attendance to local and international conferences and arranged observation study tours for some LGU officials and health providers to visit selected 5th CP provinces (e.g., Capiz, Aklan, Nueva Vizcaya, Cagayan, North Cotabato) which were designated as models for replication of good practices in the provision of RH information and services. The participants’ exposure to these conferences and model provinces provided them with new perspectives of how they could effectively implement their respective work plans. When
some local officials returned to their municipalities, they began applying what they learned from their sharing sessions and immersion in these outstanding provinces, e.g., establishment of birthing clinics, community-based savings, blood donation and transport system and teen centres.

7.1.21 Upgrading of health facilities, provision of equipment, medicine, and supplies. The LGUs are mainly responsible for upgrading their municipal health facilities including the construction or renovation of necessary infrastructures such as birthing clinics, rural health units or hospital sections. The DOH standards and guidelines and PhilHealth accreditation requirements must be observed in upgrading health facilities.

7.1.22 UNFPA’s counterpart in this partnership was to provide essential equipment such as examining and delivery tables/beds, medical instruments, resuscitators, weighing scales, stethoscopes, delivery kits, basic commodities, etc. This was done only when the upgraded health facilities observed the DOH and PhilHealth requirements and standards. In a number of places, the LGUs also provided their RHUs and birthing clinics with basic medicines, drugs and other needs such as cotton, gauze, drapes and the like from their own funds or PhilHealth reimbursements.

7.1.23 The types of equipment UNFPA provided to the health facilities were generally suited to the social and cultural contexts of the claim holders especially in pilot areas that are serving indigenous people (e.g. in Ifugao and Mountain Province) and faith-based groups (e.g., Muslims in ARMM). LGUs were encouraged to upgrade or build maternity waiting homes which had homey ambience and facilities to make the mothers feel that they have not left their homes (e.g., inclusion of kitchen to allow pregnant women and their family members to cook). In Maguindanao, the homey settings showcased the walay nawalian, i.e., the collaboration of the midwife-traditional birth attendants (TBA)-Muslim Religious Leaders (MRL) and the barangay health worker (BHW) in maternal and neonatal care.

7.1.24 UNFPA was also sensitive to the contexts of the health facilities. In Barangay Health Stations/Birthing Facilities where there were problems with electricity, simpler equipment such as foot-operated, manual, gas or battery-operated equipment were provided.

7.1.25 In 2008, UNFPA distributed different types of equipment to 110 health facilities particularly to 11 hospitals, 25 Rural Health Units (RHU), and 74 Barangay Health Stations or birthing clinics. In the first half of 2010, additional equipment and supplies were provided to 36 hospitals in the 6th CP and UN Joint Program sites.

7.1.26 Advocacy and networking to link demand and supply. To link the target municipalities to the maternal and other RH services that are offered by the health facilities, UNFPA partnered directly with LGUs, national and local NGOs/CSO, and community “RH champions” to raise awareness about gender, RH and rights, women’s empowerment, the need for quality maternal and child health such as pregnancy tracking and other RH services. They mobilized women’s or reproductive health teams, organized waiting homes or livelihood activities such as goat and hog-raising and food-processing to address chronic poverty especially in indigenous communities. They partnered with LGUs to advocate for policy change about maternal care and facilitated the dissemination of municipal and village RH ordinances. The NGOs that immersed in the municipalities of some pilot provinces were:

29 Funding for the Indigenous people’s livelihood project was provided by New Zealand AID.
1/ Eastern Samar and Bohol: *Linangan ng mga Kababaihan (Likhaan)*; 2/ Sultan Kudarat and Lanao del Sur: Institute of Primary Health Care (IPH); 3/ Ifugao: the Baguio Center for Young Adults, Inc. (BCYA); 4/ Mt. Province: Philippine Health Social Science Association (PHSSA); 5/ Sulu and Tawi-tawi: Neighbors.

**Accomplishments**

7.1.27 A total of 105 medical doctors, 105 nurses, and 111 midwives from the pilot sites participated in most of the capacity-building activities, implying that their competencies have improved to enable them to manage their health facilities and offer culture and gender-responsive services.

7.1.28 The referral system at all levels has been strengthened through public-private partnership among local providers and specialists, mentoring, knowledge-sharing and including morbidity-mortality reviews. A number of provincial hospital personnel received capacity enhancement on EmONC and essential newborn care (ENC) services and were upgraded with carefully selected set of equipment and logistics to comply with standards as CEmONC facilities. Complicated deliveries are referred directly to the nearest public or private hospitals.

7.1.29 All RHUs of 30 municipalities of the pilot provinces and one city were accredited by PhilHealth (i.e., based on required infrastructure, equipment and health management system) as Outpatient Benefit (OPB) provider health facilities. An OPB covers support for consultation, minor surgery, basic laboratory services, smoking cessation, and family planning counselling. Furthermore, 24 of the 30 RHUs and 5 MHCs are PhilHealth Maternity Care Package (MCP) accredited. The MCP, supports a maximum of four spontaneous vaginal childbirths at P6,500 (USD 150) per delivery. As of last year, all the RHUs of Ifugao, Eastern Samar, Sultan Kudarat, and Tawi-Tawi are accredited as Philhealth MCP facilities. Maguindanao which targeted for 3 MCPs in 2008 doubled this target with additional catchment facilities in 2009. Furthermore, twelve government hospitals in the pilot provinces which were provided with health equipment by UNFPA are PhilHealth-MCP accredited institutions.

7.1.30 As a result of the advocacy conducted by LGUs, NGOs, and communities, local policies and other initiatives that are supportive of maternal and child health were developed. This include the a/ development of municipal RH codes or ordinances, b/ passage of barangay or village-level resolutions or ordinances encouraging pregnant women to go to a health facility for antenatal care, deliver under the care of a skilled birth attendant, and utilize a health facility for childbirth (in some places like Sagada, Mountain Province and Sultan Kudarat, the husbands are encouraged to accompany their wives during childbirth); c/ organizing communities for livelihood programs such as goat-raising, food-processing, fund raising to establish *botika sa barangay* (drug depot), and d/ development of several innovative actions or good practices that are supportive of RH (see UNFPA compendium of Good Practices on Reproductive Health, July 2010).

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30 UNFPA Compendium of Good Practices on Reproductive Health, July 2010
### Table 7.1.1 Philhealth insurance accreditation as Maternity Care Package (MCP) Rural Health Units (RHU)

<table>
<thead>
<tr>
<th>6th CP pilot sites (N.B. all RHU are OPB accredited)</th>
<th>PHIC-MCP 2006 Target</th>
<th>Accredited 2009 Accomplishment</th>
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<tr>
<td>Olongapo</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Mt. Province</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Ifugao</td>
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<td>3</td>
</tr>
<tr>
<td>Masbate</td>
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<td>2</td>
</tr>
<tr>
<td>Bohol</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Eastern Samar</td>
<td>3</td>
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</tr>
<tr>
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</tr>
<tr>
<td>Lanao del Sur</td>
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</tr>
<tr>
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</tr>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>35</strong></td>
<td><strong>24</strong></td>
</tr>
</tbody>
</table>

Source: FHSIS from 30 municipal health offices of 10 pilot provinces.

7.1.31 Some of the good practices which the UNFPA supported in the pilot sites are as follows: a/ The “walking blood bank” in Llorente, Eastern Samar to directly respond to postpartum haemorrhage, a common cause of maternal death in the country. With support from UNFPA and the LGU, the rural health unit (RHU) began this project by determining the blood types of all residents in every barangay in the municipality. The results were compiled into a blood directory which could provide information for potential blood donors. It also encouraged blood donation from the personnel of Armed Forces of the Philippines, municipal employees, RHU staff and the youth. The collected blood was stored in the provincial hospital’s blood bank and reserved mainly for Llorente’s pregnant women. Community learning sessions were organized informing couples about safe pregnancies and consequence of maternal deaths caused by haemorrhage, eclampsia and septic abortions. Llorente intends to sustain this effort by establishing a Municipal and Barangay Blood Councils, updating the blood directory, and conducting regular blood donation.

7.1.32 Olongapo City in Zambales, on the other hand, does not only provide services to its urban residents but also to indigenous people (IP) called Aeta who were resettled in two rural barangays after the eruption of Mt. Pinatubo in 1991. The Aeta in these two villages held many cultural beliefs and practices about childbirth, had large families, and practiced unsafe deliveries through traditional birth attendants. Olongapo City’s RH Task Force in partnership with UNFPA collaborated to develop “a functional model aimed at increasing access of indigenous women to acceptable, low-cost and effective” RH services. The Aeta women were encouraged to consult and give birth in a health facility. They were also counselled about FP and motivated to plan birth spacing in “a manner compatible with their practices and situation.” With support from LGU officials, BHWs, midwives, and nurses were mobilized to conduct FGD with the Aeta and to disseminate RH information to all the IP’s homes. Complementing this effort was the establishment of a fully-operational BEmONC.
facility which encouraged health facility delivery. The city government also provided PhilHealth indigent cards to the Aetas. To encourage more facility-based delivery, a voucher scheme that guarantees birthing for free at the health facility was distributed in August 2009. Women were also assured to receive a comprehensive maternal and neonatal care package including immediate referral to a tertiary hospital for complicated births. This scheme is guided by the city’s Ordinance on Facility-based Deliveries. The Aeta are currently responding to the support extended to them because more women are consulting the health facility and are giving birth there.

7.1.33 A third good practice which addresses chronic poverty is the micro-financing scheme called Buntis (Pregnant) Baby Bank (BBB) in Masbate. Started in one of the Masbate municipalities, the BBB assists a pregnant woman financially by encouraging her and her relatives to save coins in a bamboo tube while promoting pre-natal and post-natal visit to the health facility. The bamboo tube alongside her personal and health profile are kept by the BBB coordinator at the RHU safe and could be withdrawn only for childbirth purposes. This scheme generates substantial contributions and fostered sharing, improved provider-client relationship, instils planning and saving, and addresses poverty. Two municipalities are adopting the BBB and it is being implemented at the barangay level.

7.1.34 The replication and convergence of emerging good practices to non-CP sites. UNFPA together with the UN Coordinating Office, WHO and UNICEF, and the assistance from the Australian AID, was able to forge a stronger partnership with the Department of Health (DOH) to deliver as One UN through a Joint Program on Maternal and Neonatal Health (JPMNH) by rapidly reducing maternal and newborn deaths in selected areas during the transition phase (2009-2011) with the aim of fully operationalizing this partnership from 2012 to 2016. Based on each agency’s comparative advantage, the 3 UN and partner agencies have been intensifying their support to province and city-wide investments for health in 6 provinces (i.e., 3 UNFPA-assisted areas: Ifugao, Eastern Samar and Lanao del Sur having the 6th CP pilot municipalities) and 8 urban poor areas on JPMNH. UNFPA is focusing on linking capacity enhancement of health professionals (duty-bearers) and claim-holders on reproductive health, especially FP, including EmONC referral system in a continuum of care approach; WHO on health systems strengthening with norms, standards and M and E; and UNICEF on child health and nutrition, especially in the GIDAs.

7.1.35 UNFPA has also generated similar support on maternal-newborn death reduction beginning 2010 with funding assistance from Agencia Española de Cooperación Internacional Para el Desarrollo (AECID) on a province-wide investment for health with focus on the 3-pronged strategies (i.e., easy access to FP/RH services, continuum of care by skilled birth attendants/health professionals especially during delivery and immediate post-partum period; and EmONC, when necessary). The three AECID-supported provinces are Masbate, Sultan Kudarat and Surigao Del Norte.

7.1.36 Achievement of goal or outcome indicators. This section describes the performance of the 6th CP municipalities in the 10 provinces and one city on four outcome indicators particularly 1/ completed (at least four) prenatal visits to a health facility, 2/ births attended by a skilled health professional, 3/ use of a health facility for childbirth, and 4/ postnatal care during the last birth among mothers who gave birth in the past five years. Data for the first three goal indices were obtained from the facility health service statistics from years 2006 to

31 UNFPA Compendium of Good Practices on Reproductive health, July 2010
2009 and from the 2006 baseline and 2010 end-line surveys from the 30 municipalities of the 10 pilot provinces and one city. These are utilized in describing possible program effects. Face-to-face interview method was used by both surveys. The fourth goal indicator was obtained only from the baseline and end-line surveys.

7.1.37 The 2006 baseline survey and the 2010 end-line surveys had the same research design and interview schedule. The data collection for the 2006 baseline survey was directly supervised by UNFPA program staff and it covered 14,812 households with a sample size of 36,924 individuals. The 2010 end-line survey was directly implemented by the Demographic Research and Development Foundation (DRDF). A total of 31,312 individuals (15,136 males and 16,176 females) were interviewed. An additional 5,158 households from extension areas were included in the end-line survey, giving a total of 40,560 eligible respondents from 21,428 households. However, for comparability sake, these additional households were excluded in the analysis for the 6th CP. Olongapo City was only included during the 2010 endline survey.

7.1.38 The results obtained from the two data sources are separately analyzed to show patterns in the claim holders’ reported behaviour on the foregoing indices at the facility level and in the larger community. Their trends can be described for similarities and differences but they cannot be directly associated because of differences in methodology and data sources.

7.1.39 A fifth index, reported maternal deaths, which were provided by UNFPA’s provincial coordinators is presented with caution because this goal/impact indicator has no adequately reported denominator and the factors explaining the statistics were not available.

7.1.40 **Completed pre-natal visit.** The first part of this section describes the findings concerning pregnant women who completed (at least four) pre-natal visits as reported and obtained from the facility service statistics. The second part describes results obtained from the 2005 baseline and 2010 end-line surveys.

7.1.41 **Data from facility health service statistics.** The figures on Table 1 show an increasing trend in the absolute number of pregnant women who completed at least four visits for pre-natal care at the 30 municipalities’ health facilities. Increments (in %) are computed by using data from 2006 as the base year and 2009 as the end year. The results show that Masbate exhibited the highest rate of increase (70%) for women who had complete prenatal check up, followed by Mt. Province (65%), and by Lanao del Sur (44%), an ARMM province.

7.1.42 The performance of the three pilot municipalities in Eastern Samar declined by 100 clients between 2006 and 2009. The performance of Sultan Kudarat’s municipalities on complete prenatal care went up from years 2006 to 2008 and declined in 2009. This reduction could probably be explained by some women’s uptake of modern FP methods. It is likely that the mothers who were attended by skilled birth attendants in previous deliveries were counselled about FP after delivery. In Sulat municipality of Eastern Samar, for example, it was noted by the UNFPA provincial coordinator that the number of pregnant women declined because the pill and injectable users had increased. In Maydolong and Llorente of same province, it was noted that more women had chosen BTL as FP method.

7.1.43 The proportion of mothers with full pre-natal care in the ARMM provinces showed fluctuating patterns especially between years 2008 and 2009. The uptake of complete pre-
natal care for Tawi-tawi’s pregnant women gradually increased from 2006 to 2009. In 2006, Sulu had over 5,000 women who completed antenatal care and this increased in 2007. However, the number declined in the next two years. Lanao del Sur’s figures gradually increased from 2006 to 2008 but these went down in 2009. There was a negative uptake of complete pre-natal care in Maguindanao between years 2006 and 2009. The decline in total performance of the pilot municipalities in three ARMM provinces could not be attributed to improved uptake of FP methods (see FP section) but to the poor peace and order situation in these areas, difficult terrain and to the social and cultural beliefs and practices of the women concerning pregnancy and childbirth.

Table 7.1.2. Number of pregnant women from the municipalities of 6th CP pilot provinces and one city who completed (four) antenatal visits, 2006 to 2009 (facility service data)

<table>
<thead>
<tr>
<th>City/Province</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>Difference Between 2006 and 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Olongapo</td>
<td>5610</td>
<td>6351</td>
<td>6118</td>
<td>6694</td>
<td>1084 19.3</td>
</tr>
<tr>
<td>Mt. Province</td>
<td>489</td>
<td>571</td>
<td>641</td>
<td>811</td>
<td>322  65.8</td>
</tr>
<tr>
<td>Ifugao</td>
<td>1024</td>
<td>773</td>
<td>1123</td>
<td>1166</td>
<td>142  13.9</td>
</tr>
<tr>
<td>Masbate</td>
<td>2201</td>
<td>1954</td>
<td>2305</td>
<td>3754</td>
<td>1553 70.6</td>
</tr>
<tr>
<td>Bohol</td>
<td>3395</td>
<td>3854</td>
<td>4397</td>
<td>4820</td>
<td>1425 42.0</td>
</tr>
<tr>
<td>Eastern Samar</td>
<td>1097</td>
<td>1038</td>
<td>1139</td>
<td>997</td>
<td>-100</td>
</tr>
<tr>
<td>Lanao del Sur</td>
<td>1192</td>
<td>1520</td>
<td>1770</td>
<td>1,719</td>
<td>527 44.2</td>
</tr>
<tr>
<td>Maguindanao</td>
<td>3015</td>
<td>3156</td>
<td>4122</td>
<td>3002</td>
<td>-13</td>
</tr>
<tr>
<td>Sultan Kudarat</td>
<td>3382</td>
<td>3878</td>
<td>4103</td>
<td>3960</td>
<td>578 28.0</td>
</tr>
<tr>
<td>Sulu</td>
<td>5519</td>
<td>7349</td>
<td>6909</td>
<td>6338</td>
<td>608 11.0</td>
</tr>
<tr>
<td>Tawi-Tawi</td>
<td>1951</td>
<td>1784</td>
<td>2077</td>
<td>2909</td>
<td>958 49.1</td>
</tr>
<tr>
<td>Total</td>
<td>22776</td>
<td>25306</td>
<td>27945</td>
<td>28665</td>
<td>5889 25.9</td>
</tr>
</tbody>
</table>

Source: FHSIS from 30 municipal health offices of 10 pilot provinces.

7.1.44 Findings from the 2006 baseline and 2010 end-line population-based surveys. In general the baseline and end-line surveys showed that in eight out of 10 pilot provinces, there was improvement in the proportion of pregnant women who had at least four prenatal visits to a health facility the last time they were pregnant. Olongapo City has no baseline data so there is no basis for comparison.

7.1.45 Eighteen municipalities of the six pilot provinces particularly Bohol, Eastern Samar, Ifugao, Masbate, Mt. Province, and Sultan Kudarat exhibited marked improvements for this indicator. The municipalities in the ARMM provinces of Maguindanao and Lanao del Sur showed slight improvements. Only Sulu municipalities’ low uptake in 2006 further declined in 2010.
7.1.46 It is noted that in the 2006 baseline survey, the pregnant mothers from the municipalities of Bohol, Eastern Samar, Mt. Province, and SK who claimed that they had completed their antenatal visits, actually had high head start of over 60 per cent. Their performance during the end-line survey was even more remarkable because three- to four-fifths of the women who were surveyed recalled that the last time they were pregnant, they had at least four antenatal visits to their health facilities. However, the completed antenatal care findings from the two NDHS surveys were much higher than the performance of the pilot sites except for the municipalities of Bohol (84.8%) and Mt. Province (78.1%) in 2010 end-line survey (NDHS 2003 ANC, 70.4%; NDHS 2008 ANC, 77.8%).

7.1.47 Among the pilot provinces, Masbate’s pilot municipalities showed a remarkable improvement from an uptake of 33.2 per cent in 2006 to 62.1 per cent in 2010 or a marked improvement of 28.3 per cent. This could be a reflection of the multi-sector support extended to the pregnant women including its BBB micro-financing in the municipalities of this province.

7.1.48 Although the data from the facility service statistics and the population-based surveys are not directly comparable, it can be inferred from both sets of information that positive changes in the antenatal care behavior of pregnant women in the pilot sites occurred. They also showed that the non-ARMM municipalities performed better than the ARMM municipalities, as would be expected.

7.1.49 Births attended by skilled health professionals/birth attendants (SHP/SBA). The results from the facility service statistics and the 2006 and 2010 population-based surveys about deliveries attended by SBA are as follows.

7.1.50 Data from the field health service statistics. The proportions of women whose childbirths were attended by SBA showed an increasing trend in the aggregate—from 62 per cent in 2006 to 71 per cent in 2009. As of 2009, nine out of 11 pilot provinces reported high percentages of deliveries that were attended by skilled health providers, ranging from
65% in Masbate to 91% in Ifugao. Note that the proportions given here covered all births delivered per year in all three municipalities of each of the 10 pilot provinces.

7.1.51 The high proportion of Ifugao’s deliveries by SBA could be attributed to the LGU’s commitment and the active involvement of multi-sector stakeholders to support the effective implementation of the Provincial Ordinance 2006-33 known as the Reproductive Health and Responsible Parenthood Ordinance. This legal framework paved the way for improvements in the provision of a comprehensive RH and Responsible Parenthood program in the province. Four RHUs have been accredited to provide maternal care package (MCP) while 11 others have been accredited by PhilHealth to provide outpatient benefit (OPB) package. Sixty percent of its midwives have been trained in life-saving skills. Support systems such as the Ayod (hammock) community health teams are now formalized and are active collaborators in promoting the health facility referral system in the municipalities.32

7.1.52 Among the other provinces, Sultan Kudarat exhibited the most dramatic increase in the use of a SBA because it almost doubled its performance from 34 per cent in 2006 to 63 per cent in 2009. This was followed by Eastern Samar which showed an increase of 28 per cent from 49 per cent in 2006 to 77 per cent in 2009. The high performance of Olongapo City has remained constant in the past four years.

7.1.53 The proportion of deliveries by SBA in two ARMM provinces particularly Sulu and Lanao del Sur considerably declined from years 2006 to 2009 (-17 % for Sulu and -12% for Lanao del Sur). It is interesting to note that in 2006, more than one half of the child births in these two provinces were delivered by SBAs and the figures rose to almost two thirds in 2007 and then declined in the next two years. This downward trend could be attributed to a number of factors which may include the continuing and escalating internal conflict in these areas, the reduction of the number of skilled health providers, the absence of technical supervisors and to socio-cultural beliefs and practices including the preference for traditional birth attendants (TBAs) by the pregnant women and their families.

7.1.54 The performance of Tawi-tawi, a province comprising of a number of small or isolated island municipalities, increased by 12 per cent in 2009 from its base figure of 63 per cent in 2006. The upward trend could perhaps be attributed to the relatively peaceful situation in the province than its neighbouring province of Sulu and to the local chief executives and health officials’ commitment to extend RH services to the women and their families even in far-flung islands. Despite the continued internal strife in Maguindanao, the use of SBA/SHP for deliveries increased by eight per cent. Refer to Table 7.1.4.

7.1.55 Findings from the 2006 baseline and 2010 end-line surveys. The surveys appear to reinforce the findings of the facility service statistics. Maguindanao showed a slight reduction in SBA-attended deliveries. Sulu and Tawi-tawi reduced SBA-attended deliveries by half of their 2006 baseline data. Olongapo exhibited very high proportion (94.4%) of women utilizing SBA during delivery in 2010 but it has no basis for intertemporal comparison because it was not part of the 2006 baseline study.

32 UNFPA Compendium of Good Practices on Reproductive Health, July 2010
Table 7.1.4. Percent of births attended by skilled health professionals (SHPs) in the municipalities of 6th CP pilot provinces and one city, 2006 to 2009 (facility service statistics)

<table>
<thead>
<tr>
<th>Province/City</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>Increase/ Decrease between 2006 - 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bohol</td>
<td>74</td>
<td>81</td>
<td>83</td>
<td>86</td>
<td>12</td>
</tr>
<tr>
<td>Eastern Samar</td>
<td>49</td>
<td>57</td>
<td>72</td>
<td>77</td>
<td>28</td>
</tr>
<tr>
<td>Ifugao</td>
<td>78</td>
<td>58</td>
<td>83</td>
<td>91</td>
<td>13</td>
</tr>
<tr>
<td>Lanao del Sur</td>
<td>55</td>
<td>60</td>
<td>49</td>
<td>43</td>
<td>-12</td>
</tr>
<tr>
<td>Maguindanao</td>
<td>69</td>
<td>61</td>
<td>68</td>
<td>77</td>
<td>8</td>
</tr>
<tr>
<td>Masbate</td>
<td>60</td>
<td>71</td>
<td>53</td>
<td>65</td>
<td>5</td>
</tr>
<tr>
<td>Mt. Province</td>
<td>65</td>
<td>67</td>
<td>71</td>
<td>78</td>
<td>13</td>
</tr>
<tr>
<td>Sultan Kudarat</td>
<td>34</td>
<td>41</td>
<td>58</td>
<td>68</td>
<td>34</td>
</tr>
<tr>
<td>Sulu</td>
<td>51</td>
<td>64</td>
<td>45</td>
<td>34</td>
<td>-17</td>
</tr>
<tr>
<td>Tawi-tawi</td>
<td>63</td>
<td>61</td>
<td>69</td>
<td>75</td>
<td>12</td>
</tr>
<tr>
<td>Olongapo City</td>
<td>85</td>
<td>86</td>
<td>88</td>
<td>87</td>
<td>2</td>
</tr>
</tbody>
</table>

Source: FHSIS from 30 municipal health offices of 10 pilot provinces

7.1.56 In terms of percentage increase between the baseline and end-line surveys, Masbate’s pilot municipalities which started with only 35.3 per cent in 2006 increased to 52.9 per cent with an increment of 17.6 per cent. It is followed by the municipalities of Bohol (increment of 16.3%) and by Sultan Kudarat (16%) by Eastern Samar (16.1%) and Mt. Province (10.1%).

7.1.57 It is noted that in 2006, the two Northern Luzon provinces, i.e., Ifugao (76.7%), and Mt. Province (63.6%), and Bohol (62.9%) already have high proportions of women who were patronizing SBA during childbirth. Their percentages were higher than the findings of 2003 NDHS (59.8%). In 2010, more pilot provinces exceeded the 2008 NDHS findings of 62.2 per cent. These provinces were Ifugao (79.4%), Bohol (79.2%), Mt. Province (73.7%), and Eastern Samar (63.1%).

7.1.58 The low performance of neighbouring Lanao del Sur ( + 4.9%) and Maguindanao (-0.7) could be attributed to the ongoing conflict situation in these provinces and to the social and cultural beliefs and practices concerning the use of SBA. The findings of the 2003 and 2010 NDHS noted that the ARMM women had the highest patronage of traditional birth attendants during delivery.

7.1.59 Facility-based deliveries. Another important indicator, delivery at a health facility, was obtained from both the facility health service statistics and from the baseline and end-line survey.

7.1.60 Data from facility service statistics on facility-based deliveries (FBD). Although the health service statistics have shown that the majority of the deliveries were attended by skilled health professionals, not all deliveries took place in a health facility. This implies that
Table 7.1.5. Births attended by skilled health professionals in the municipalities of 6th CP pilot provinces and one city, 2006 Baseline and 2010 End-line surveys

<table>
<thead>
<tr>
<th>UNFPA Site</th>
<th>2006 Baseline (n=7,001)</th>
<th>2010 End-line (n=6,436)</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bohol</td>
<td>62.9</td>
<td>79.2</td>
<td>16.3</td>
</tr>
<tr>
<td>E. Samar</td>
<td>53.0</td>
<td>63.1</td>
<td>10.1</td>
</tr>
<tr>
<td>Ifugao</td>
<td>76.7</td>
<td>79.4</td>
<td>2.7</td>
</tr>
<tr>
<td>Lanao del Sur</td>
<td>30.6</td>
<td>35.5</td>
<td>4.9</td>
</tr>
<tr>
<td>Maguindanao</td>
<td>40.4</td>
<td>39.7</td>
<td>-0.7</td>
</tr>
<tr>
<td>Mascate</td>
<td>35.3</td>
<td>52.9</td>
<td>17.6</td>
</tr>
<tr>
<td>Mt. Province</td>
<td>63.6</td>
<td>73.7</td>
<td>10.1</td>
</tr>
<tr>
<td>S. Kudarat</td>
<td>43.4</td>
<td>59.4</td>
<td>16.0</td>
</tr>
<tr>
<td>Sulu</td>
<td>27.7</td>
<td>14.4</td>
<td>-13.3</td>
</tr>
<tr>
<td>Tawi-tawi</td>
<td>33.2</td>
<td>19.0</td>
<td>-14.2</td>
</tr>
<tr>
<td>Olongapo</td>
<td>-</td>
<td>94.4</td>
<td>-</td>
</tr>
</tbody>
</table>

*Total number of births attended by skilled health professionals
Source: UPPI-DRDF 2010

there were several home deliveries that were attended by skilled health providers. The findings from the facility service statistics showed that overall, there was a 20 per cent increase in facility-based deliveries between years 2006 and 2010 that could promote easier access to emergency obstetrics and newborn care and the immediate postpartum care.

7.1.61 Among the 6th CP municipalities in the 10 provinces, the major behavioural change took place in Masbate, (by 50%), Bohol (48%), Sultan Kudarat (48%) and in Eastern Samar (39%). Bohol LGU’s policy of investing in one midwife/barangay (village) and in SK’s Isulan municipality has most likely contributed to the high-performance of these areas. Likewise, the municipalities of Eastern Samar more than doubled its performance (from 21% in 2006 to 60% in 2009). These dramatic changes in the use of health facilities in the municipalities of these provinces could be attributed to the presence of available and upgraded birthing clinics or EmONC facilities, acceptability of the interventions, the support extended by the LGUs and the public health referral system, and the effects of the continual advocacy, support and social mobilization efforts of community-based NGOs, health teams/volunteers and other stakeholders in these areas.

7.1.62 Good practice: In the municipality of Sulat, Eastern Samar, the women’s health teams and barangay health workers (BHWs) task force called Bantay Buntis (Watch pregnant women) identifies pregnant women and motivates them to have antenatal and post-partum care and to deliver at a health facility. For expectant mothers who hail from far-flung communities, a waiting home was developed to serve as their temporary shelter when their delivery schedule is near. Village officials also provided counterpart emergency funds to ensure safe deliveries. In one barangay/village, pregnant women who chose to give birth at the RHU is given P500 (USD 10) as emergency support for their transportation expense by their LGU to go to the health facility. This money is cours ed through its Barangay Health Emergency Response Team (BHERT). This LGU also passed an ordinance for contraceptive self-reliance (CSR) strategy on FP and allocated P100,000 for contraceptives. Its RHU which conducts a periodic maternal death review, is PhilHealth accredited and has received a
seal for *Sentrong Sigla*(Center of Excellence) Level II mark from DOH for delivering quality health services. As a result of the LGU and community support, majority of the women in this area are reportedly patronizing SBA and health facilities for childbirth. Their uptake of modern FP methods has also improved.

7.1.63 The 6th CP municipalities from the Cordillera provinces of Northern Luzon showed no change or had minor changes in the number of births at health facilities implying that a large proportion of the deliveries even by skilled health providers took place elsewhere or at the households. This could perhaps be attributed to the social and cultural beliefs and practices about child birth, to travel on foot in a difficult or rugged terrain and the geographical distance of the birthing and EmONC facilities from these far-flung areas especially among the IPs.

7.1.64 There is, however, one exceptional village in the Municipality of Lagawe, Ifugao. This is Barangay Boliwong which dramatically changed the traditional health-seeking behavior of pregnant women. Because of the confluence of events, i.e., the passage of an ordinance on safe motherhood practices promoting safe deliveries in a preferred birthing position with skilled birth attendants in a facility, the support of UNFPA to the health system, advocacy of the ordinance to various stakeholders, the uptake of deliveries by skilled health providers in 2009 went up to 95 per cent. In the first two months of 2010, childbirths attended by skilled birth attendants were reported at 100 per cent.33

7.1.65 Maguindanao and Lanao del Sur showed slight increases in the proportion of mothers who delivered at health facilities. Sulu and Tawi-tawi exhibited similar trends in their performance because deliveries at health facilities slightly rose from 26 per cent in 2006 to 32 per cent in 2007. This trend, however, declined to 22 per cent in 2009.

7.1.66 Findings about births at health facility from 2006 baseline and 2010 surveys. The findings from the 2006 baseline and 2010 end-line surveys appear to support the findings of the facility health service statistics. Except for Sulu and Tawi-Tawi which had no data and Olongapo which had no baseline information—the other eight provinces showed increasing incremental change in the patronage of health facilities at delivery.

7.1.67 It is noted that in 2006 only the municipalities of two provinces surpassed the 2003 NDHS findings of 37.9 per cent. These were the Northern Luzon provinces—Mt. Province (51.9%) and Ifugao (50.5%). In the 2010 end-line survey, the performances of the pilot municipalities in five provinces and Olongapo City were higher than the 2008 NDHS (44.2%). These provinces were Ifugao, Bohol, Mt. Province, Eastern Samar and Sultan Kudarat.

7.1.68 The municipalities in the pilot provinces with high percentage increase between the baseline and end-line surveys are: Eastern Samar (43%), Bohol (32.1%), Sultan Kudarat (28%), and Masbate (23.7%). It is interesting to note that only 14.4 per cent of Eastern Samar’s deliveries in 2006 took place at health facilities, but in 2010 this went up to 57.4 per cent. This dramatic behavioural change could be attributed to the LGU-NGO/CSO investments, community partnerships and to the innovations that encouraged pregnant women to deliver at their health facilities.

33 UNFPA Compendium of Good Practices on Reproductive Health, July 2010.
Table 7.1.6. Facility-based deliveries of the municipalities of the 6th CP pilot provinces and one city, 2006-2009 (facility service statistics)

<table>
<thead>
<tr>
<th>City/Province</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>Diff. between 06 &amp; 09 (Percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Olongapo</td>
<td>58</td>
<td>58</td>
<td>61</td>
<td>63</td>
<td>5.0</td>
</tr>
<tr>
<td>Mt. Province</td>
<td>53</td>
<td>55</td>
<td>62</td>
<td>53</td>
<td>0.0</td>
</tr>
<tr>
<td>Ifugao</td>
<td>38</td>
<td>31</td>
<td>44</td>
<td>40</td>
<td>2.0</td>
</tr>
<tr>
<td>Masbate</td>
<td>9</td>
<td>18</td>
<td>19</td>
<td>59</td>
<td>50.0</td>
</tr>
<tr>
<td>Bohol</td>
<td>22</td>
<td>30</td>
<td>56</td>
<td>70</td>
<td>48.0</td>
</tr>
<tr>
<td>Eastern Samar</td>
<td>21</td>
<td>31</td>
<td>31</td>
<td>60</td>
<td>39.0</td>
</tr>
<tr>
<td>Sultan Kudarat</td>
<td>15</td>
<td>27</td>
<td>48</td>
<td>56</td>
<td>44.0</td>
</tr>
<tr>
<td>Lanao del Sur</td>
<td>29</td>
<td>34</td>
<td>32</td>
<td>34</td>
<td>5.0</td>
</tr>
<tr>
<td>Maguindanao</td>
<td>24</td>
<td>22</td>
<td>41</td>
<td>47</td>
<td>23.0</td>
</tr>
<tr>
<td>Sulu</td>
<td>26</td>
<td>32</td>
<td>22</td>
<td>23</td>
<td>-3.0</td>
</tr>
<tr>
<td>Tawi-Tawi</td>
<td>26</td>
<td>32</td>
<td>22</td>
<td>23</td>
<td>-3.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>29</td>
<td>34</td>
<td>40</td>
<td>48</td>
<td></td>
</tr>
</tbody>
</table>

Source: FHSIS from 30 municipal health offices of the 6th CP 10 pilot provinces.

7.1.69 Similar observations are noted for the municipalities of Bohol, Masbate, and Sultan Kudarat. Less than one third of pregnant women in 2006 in Bohol’s pilot municipalities used health facilities for delivery but in 2010, this proportion doubled. In SK, less than one fourth of the pregnant women used a health facility for delivery but in 2010, one half utilized a facility.

Table 7.1.7 Births at health facility of municipalities in 6th CP 10 pilot provinces and one city, 2006 Baseline and 2010 End-line survey

<table>
<thead>
<tr>
<th>NDHS</th>
<th>UNFPA Site</th>
<th>2003: 37.9% 2008: 44.2%</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNFPA Site</td>
<td>2006 (n=7,099)</td>
<td>2010 (n= 6,124)</td>
<td>Difference</td>
</tr>
<tr>
<td>Bohol</td>
<td>30.1</td>
<td>62.2</td>
<td>32.1</td>
</tr>
<tr>
<td>E. Samar</td>
<td>14.4</td>
<td>57.4</td>
<td>43.0</td>
</tr>
<tr>
<td>Ifugao</td>
<td>50.5</td>
<td>63.1</td>
<td>12.6</td>
</tr>
<tr>
<td>Lanao del Sur</td>
<td>21.4</td>
<td>26.0</td>
<td>4.6</td>
</tr>
<tr>
<td>Maguindanao</td>
<td>23.6</td>
<td>39.4</td>
<td>15.8</td>
</tr>
<tr>
<td>Masbate</td>
<td>15.3</td>
<td>39.0</td>
<td>23.7</td>
</tr>
<tr>
<td>Mt. Province</td>
<td>51.9</td>
<td>59.2</td>
<td>7.3</td>
</tr>
<tr>
<td>S. Kudarat</td>
<td>22.0</td>
<td>50.2</td>
<td>28.0</td>
</tr>
<tr>
<td>Sulu*</td>
<td>a</td>
<td>a</td>
<td>-</td>
</tr>
<tr>
<td>Tawi-tawi*</td>
<td>a</td>
<td>a</td>
<td>-</td>
</tr>
<tr>
<td>Olongapo</td>
<td>74.1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: UPPI DRDF 2010

* Numbers of births for cases with less than 25 are not included
* Total number of births delivered at health facilities
health facility. In Masbate, only 15.3 per cent of its three municipalities’ pregnant women patronized the health facilities; in 2010, the proportion rose to 39 per cent. Statistical analysis for Sulu and Tawi-tawi provinces was not undertaken because their municipalities had less than 25 cases for this indicator and no per cent distribution could be derived from them.

7.1.70 Postpartum or post natal care during the last birth in the past five years, 2006 and 2010 surveys. No data about mothers availing of post natal care from health facilities during their last childbirth in the past five years was obtained from the facility service statistics. However, the 2006 and 2010 population-based surveys included this important indicator because this has implications in preventing postnatal morbidities and mortality. Both baseline and end-line surveys asked the mothers the question of whether or not they consulted a health facility three days after giving birth. However, only the end-line survey asked the question of whether or not the mothers had completed two post-natal consultations.

7.1.71 The overall pattern obtained from the 2006 and 2010 surveys indicates that the proportions of mothers who completed four antenatal visits increased in nine out of 10 provinces. The findings on postnatal behavior of the mothers do not sustain this pattern. Only half of the 6th CP municipalities and provinces showed an increase in the proportions of women who sought postnatal care three days after childbirth.

7.1.72 The 2010 end-line survey found that three out of five mothers in the municipalities of Bohol, Eastern Samar, Masbate, Sulu, and Tawi-tawi claimed that they had completed two postnatal visits. The remarkable increase of 26 percent among mothers in the municipalities of Sulu is surprising considering the reductions noted from the baseline and end-line surveys among mothers who completed four antenatal visits. No data were available for these indices from Olongapo City.

Table 7.1.8 Mothers Who Availed of Post-natal Care during the last birth in the past five years in the municipalities of the 6th CP 10 pilot provinces and one city, 2006 Baseline and 2010 End-line Surveys (%)

<table>
<thead>
<tr>
<th>Province/City</th>
<th>With Two Check-ups Baseline 2006</th>
<th>With Two Check-ups End-line 2010</th>
<th>Post-Natal Availed of Check-up Three Days Baseline 2006</th>
<th>Post-Natal Availed of Check-up Three Days End-line 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bohol</td>
<td>--</td>
<td>60.4</td>
<td>46.7</td>
<td>65.5</td>
</tr>
<tr>
<td>E. Samar</td>
<td>--</td>
<td>68.1</td>
<td>56.8</td>
<td>67.9</td>
</tr>
<tr>
<td>Ifugao</td>
<td>--</td>
<td>48.6</td>
<td>64.2</td>
<td>62.8</td>
</tr>
<tr>
<td>Lanao del Sur</td>
<td>--</td>
<td>30.9</td>
<td>30.0</td>
<td>27.4</td>
</tr>
<tr>
<td>Maguindanao</td>
<td>--</td>
<td>37.7</td>
<td>54.1</td>
<td>31.4</td>
</tr>
<tr>
<td>Masbate</td>
<td>--</td>
<td>65.1</td>
<td>41.5</td>
<td>61.1</td>
</tr>
<tr>
<td>Mt. Province</td>
<td>--</td>
<td>55.6</td>
<td>62.3</td>
<td>45.0</td>
</tr>
<tr>
<td>S. Kudarat</td>
<td>--</td>
<td>41.3</td>
<td>47.5</td>
<td>41.4</td>
</tr>
<tr>
<td>Sulu</td>
<td>--</td>
<td>63.4</td>
<td>39.9</td>
<td>66.3</td>
</tr>
<tr>
<td>Tawi-tawi</td>
<td>--</td>
<td>60.5</td>
<td>49.1</td>
<td>55.2</td>
</tr>
<tr>
<td>Olongapo</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td><strong>Total number of mothers</strong></td>
<td><strong>Baseline</strong> 6,564</td>
<td><strong>End-line</strong> 6,554</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: UPPI-DRDF 2010
7.1.73 Despite differences and limitations of health service statistics and the two population-based surveys, it can be said although not conclusively, that the 6th CP has had positive effects on the pregnant women’s uptake of complete pre-natal care/antenatal visits and use of skilled birth attendants and health facility during delivery, including the reduction of unmet need and increasing CPR-modern as reported in subsequent FP section. Both information sources appear to have similar findings. Among the three indicators, however, the use of health facility at delivery had the lowest proportion of users implying the need to address the challenge that home delivery is still widely practiced especially among indigenous peoples of the Cordilleras and the Muslim women of the ARMM. Unlike survey results for complete antenatal visits, the findings for postnatal care (the fourth indicator) showed slight increments and reductions for health consultation three days after delivery among mothers’ last childbirth in the past five years. Overall, non-ARMM municipalities performed better than those from the ARMM provinces.

7.1.74 **Reported maternal deaths from health facility service statistics.** The UNFPA 6th CP municipal health offices of the 10 pilot provinces provided absolute numbers of reported maternal deaths from years 2006 to 2009. However, no denominator or the total number of women who gave birth in each municipality was provided, including the causes and locations of death.

7.1.75 The total number of reported maternal deaths in the pilot municipalities from 2006 to 2009 was 139 (33 in 2006, 37 in 2007, 40 in 2008, and 29 in 2009). There was no explanation why the number of deaths increased on the first three years of the program and then declined in 2009. Among the pilot provinces, Tawi-tawi had the most number of maternal deaths (35 mothers or 25.2%) and most of these were reported in Bonggao, the capital town. It was unclear whether or not the women who died in Bonggao were locals or referred from the nearby island municipalities.

7.1.76 The municipalities with the second highest maternal mortality (in four years) were from Sultan Kudarat (22 mothers or 15.8%). The third highest (18 mothers or 12.9%) were from the municipalities of Masbate. Bohol and Olongapo municipalities had 11 maternal deaths each (7.9%) while Eastern Samar and Sulu municipalities had 10 each (7.2%). The municipalities of Lanao del Sur had nine maternal deaths (6.5%) and Maguindanao had six (4.3%). The least number of maternal deaths were from the municipalities of Mt. Province (4 mothers or 2.9%) and Ifugao (3 mothers or 2.2%).

7.1.77 The good performance in the goal indicators and good practices for maternal health could probably explain why the municipalities in Mt. Province and Ifugao had the lowest maternal deaths from 2006 to 2009. It is, however, difficult to explain the performance of the ARMM provinces. Tawi-tawi municipalities showed relatively better performance in the goal indicators than the municipalities of other three provinces. Yet Tawi-tawi’s municipalities had the most number of maternal deaths while the other three provinces reported lower figures. Lanao del Sur reported an increasing number of maternal deaths from 2006 to 2008 but in 2009 no one died. How is this possible in a province with high home deliveries and low usage of SBA at childbirth?

7.1.78 **During the May 2010 Southern Philippine Office meeting involving all partners from the pilot provinces, Dr. Kadil Sinolinding, Jr., DOH Secretary of Health in the ARMM cautioned the participants about the reliability of maternal death statistics from the ARMM because of the cultural practice of burying the dead the next day and many especially in the**
hinterlands do not bother to report the death to the Vital Registry. Therefore, the figures from the ARMM could be the result of under reporting.

7.1.79 To come up with a better explanation of maternal deaths from the future sites of the CP, it is best to have a reliable denominator and to determine the factors that caused maternal mortality. It would be useful if these could be associated with findings from the maternal death reviews and from the population-based surveys especially with the goal indicators.

7.1.80 Maternal health, the core sub-component of RH, has utilized participatory and innovative approaches with numerous health and non-health actors at the national, provincial, and municipal levels, to ensure that pregnant women would have complete or at least four visits for antenatal care, utilize skilled birth attendants at delivery, deliver at birthing facilities, and consult a SBA or a health facility within three days after delivery, so that they will ultimately survive childbirth. The activities to attain the output and outcome indicators are most relevant in attaining MDG 5 targets.

7.1.81 Although they are not comparable nor conclusive, the findings from the facility-based service statistics and the baseline and end-line surveys indicate that the interventions in the pilot municipalities of the 10 poorest provinces could have contributed in the uptake of modern maternal care services among pregnant women from rural poor settings. Except for Tawi-Tawi, the ARMM municipalities did not perform as well as the non-ARMM provinces in the four indicators and this could be attributed to the peace and order conditions and other social and cultural factors in this region. The development of innovative and good practices that are worth replicating for the 7th CP are indications of the effectiveness of the interventions.

7.1.82 The cost-sharing schemes between UNFPA and the LGU in the pilot municipalities to sustain the birthing clinics indicate efficient utilization of resources. The involvement of PhilHealth in accrediting the RHU and hospitals as MCP to be entitled for reimbursements could sustain the costs of maternal services. The articulated support from the LGU and their communities through barangay resolutions or ordinances and allocation of recurrent budgets could also ensure sustained support for women who utilize modern maternal care services.

Issues

7.1.83 While the maternal health interventions have shown beneficial effects on pregnant women in the municipalities, a number of issues related to quality of care, systematic monitoring and evaluation, efficiency and sustainability are raised.

7.1.84 Quality of care provided by health personnel and the birthing clinics. Several health providers have participated in a number of health training activities that were initiated by DOH and its partners. However, there has been no systematic or regular assessment of these providers’ competencies and their utilization of the skills supposedly gained from the training workshops. There were also no measures to determine their gender-responsiveness in the facilities that they serve. Several birthing clinics at barangay health stations have been established in the 30 pilot municipalities to encourage women to deliver in these facilities. However, there has been no systematic assessment of the quality of care extended by these health facilities. A member of the evaluation team who is a medical professional noted that in a few birthing facilities that he was able to visit, life-saving drugs such as oxythocin was not stored according to standards while sanitation practices needed improvement.
7.1.85 Field monitoring not systematically undertaken. Although many valuable activities have taken place in the pilot sites, monitoring of the performance in the field through the use of measurable indices was not systematically undertaken. The 6th CP relied heavily on the accomplishment reports of the provincial program coordinators but data to measure performance over time are not readily available at the CO. Statistics on maternal mortality, a critical outcome indicator, are submitted but these are not carefully documented and explained. Thus even in the process of trying to find attribution of program effects for this assessment, the facility service statistics for the earlier years of the program were corrected by some PPC—implying that there were problems with monitoring at the field level.

7.1.86 Many baseline and end-line survey indicators not directly linked to program interventions. The indicators of the baseline data were intended to be used and monitored during the field interventions but they did not seem to synchronize except for the most essential indicators, i.e., complete antenatal care, delivery by skilled birth attendant, and childbirth at health facility, CPR, and unmet need for FP. The focus of the HIV and AIDS sub-component, for example, was on MARPs yet the questions asked for the general population were on their awareness of HIV and AIDS and about transmission and control of the disease. VAWC queries focused on the general population’s experience about domestic violence but no reference was made on the establishment of the GAD crisis centers and its utility. While there is value to utilize NDHS indicators for UNFPA’s population-based surveys, direct attribution to the interventions from the general population’s perspectives could not be explained because these were excluded in the surveys.

7.1.87 Sustainability of interventions. There is no doubt that in the 30 pilot municipalities a number of innovations and good practices were utilized and are worthy of emulation for the next country program. However, supporting only three out of so many municipalities in one province may not create the desired multiplier effect or impact in these social settings. This largely depends on whether the other municipalities and the provinces have the wherewithal and commitment to replicate the good practices that the pilot municipalities are demonstrating. A whole province approach which was used by the 5th CP would have greater impact and sustainability.

7.2 Family Planning

7.2.1 The sixth CP recognized the need to “…strengthen family planning services, including the provision of modern safe and effective methods of contraception” This was based on robust information from studies including the National Demographic and Health Survey of 2003 which found that the contraceptive prevalence rate was comparatively low at 28 percent for modern methods and unmet need was high at 17%.

7.2.2 The 2006 Family Planning Survey confirmed the situation with a CPR of 36 percent and an unmet need for modern methods of 16 percent.

7.2.3 In recent years CPR has ‘plateaued’ at around the mid-30s with the 2008 National Demographic and Health Survey (NDHS) finding a CPR for modern methods of 34 percent.

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with unmet need having increased from 2003 to 22 percent\textsuperscript{36}. At the same time use of traditional methods has increased slightly to 17 percent. For all women of reproductive age contraceptive prevalence of modern methods was very low at 22 percent. Contraceptive use varies widely by residence and region with slightly higher rates among urban women at 35 percent with fewer rural women using modern contraceptives (32 percent). Contraceptive use is considerably lower among married women in the ARMM at 15 percent although in Davao CPR is higher at 45 percent.

7.2.4 CPR varies markedly by education and to a lesser extent by ‘wealth’ with women with no education having a usage of 9 percent and women in the poorest quintile 26 percent. Thus it is among the poorest that access to FP is particularly limited.

7.2.5 The pill is the most popular method (at 16 percent), followed by female sterilization (10.5 percent), IUD (3 percent), injectables (3 percent) and male condom (3 percent). In 2008 when the NHDS was carried out just over a half (51 percent) of contraceptive users were obtaining their supplies from private medical sources and 46 percent from government hospitals, rural health units and barangay health stations and supply units.

7.2.6 While the use of modern contraceptives has remained at a relative low level of around 34 percent with continuing high and increasing unmet need for modern contraception at 22 percent, levels of knowledge of family planning are universal and not an issue; access is the problem. At least 90 percent of currently married women have heard of the pill, male condoms, injectables and female sterilization. On average currently married women know of eight methods of contraception.

7.2.7 The consequences of poor access to contraception have profound implications for women and families in the Philippines. More than half of all pregnancies in the Philippines are unintended and poor women are especially likely to need assistance in preventing unintended pregnancy. The 35 percent of women aged 15–49 who are poor account for 53 percent of unmet need for contraception\textsuperscript{37}. It is estimated that the numbers of unsafe abortions have increased in recent years and “the increase in the level of induced abortion seen in some areas may reflect the difficulties women experience in obtaining modern contraceptives as a result of social and political constraints that affect health care provision. Policies and programs regarding both post abortion care and contraceptive services need improvement\textsuperscript{38}”. Based on the Guttmacher study (2006), an estimated 473,000 abortions occur annually. This means that one third of women who experienced an unintended pregnancy ended up with abortion. The majority of women who experienced abortion are married, Catholic, and poor. The reasons why women resort to abortion are the following: cite economic cost of raising a child (72 percent); say they have enough children (54 percent); and report that the pregnancy occurred too soon after their last one (57 percent).

7.2.8 The Sixth Country Programme set as an output of the RH component “improved management systems and practices for reproductive health service delivery”. It highlighted systems for providing steady and regular supplies, particularly to the local government unit


level including health centres, rural hospitals and primary health-care providers. It was planned that this would be achieved by:

(a) improved contraceptive logistics management and distribution;
(b) the franchising, on a pilot basis, of private outlets for contraceptives and other reproductive health commodities; and
(c) self-reliance initiatives for contraceptives, including budget allocations by local government units, increased involvement of the private sector and social marketing efforts.

7.2.9 This emphasis on the private sector as being the main solution to improving contraceptive use was similar to the approach taken by USAID. From 2003 USAID phased out the provision of contraceptives beginning with condoms and in 2009 the last shipment of 300,000 pieces of IUDs was made. The Agency has continued to provide technical support for family planning and through its communications strategy the strengthening of counselling and inter-personal skills.

7.2.10 In a similar way the UNFPA CP did not initially include support for the provision of contraceptives. With the phase out of USAID’s provision of contraceptives and the implementation of the Government’s Contraceptive Self-Reliance (CSR) strategy it was intended that LGUs would become self-sufficient in the procurement of contraceptives. However the implementation of this strategy has varied substantially between different municipalities with many providing very meagre resources if any at all for contraceptives. UNFPA successfully lobbied for amending the CSR Policy to include RHCS.

7.2.11 UNFPA has provided some support for improving the LMIS. This has included: incorporating RH Commodity Security concepts in the Manual of Operations of MNCHN; FP-Competency Based Modules (Level 1) were rolled out in UNFPA provinces and elsewhere in the country; facilitated accelerated Certification of Product Registration on certain contraceptives; facilitated increased access to permanent methods (NSV and BTL) through CMEN, Friendly Care and Voluntary Surgical Team; and training in the use of the UNFPA developed computer system CHANNEL, but the Evaluation Team heard that several people who received this training are working in places without computers.

7.2.12 The CP has also provided some assistance for the social marketing of contraceptives. In 2007 UNFPA support began for the subsidized sale of a limited range of contraceptives in 30 municipalities through franchises of ‘pop-shops’. These were organized by the social marketing International NGO DKT with limited funding from UNFPA. The extent to which the ‘pop shops’ are functioning is unclear and warrants further study. In 2007 UNFPA began to assist with the procurement of contraceptives39 and their distribution through an ‘RH Commodity Bridging Programme’ with the League of Municipalities and the League of Cities and support from the UNFPA Headquaters’ Trust Funds. Initially support was provided to 50 municipalities and this has risen by 2010 to 458 out of 750 poor municipalities in 57 provinces and 31 of the 59 cities.

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Table 7.2.1: CPR in municipalities of 6th CP pilot provinces, 2006 to 2009 (%)

<table>
<thead>
<tr>
<th>City/Province</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Olongapo</td>
<td>43</td>
<td>39</td>
<td>39</td>
<td>38</td>
</tr>
<tr>
<td>Mt. Province</td>
<td>28</td>
<td>28</td>
<td>36</td>
<td>43</td>
</tr>
<tr>
<td>Ifugao</td>
<td>42</td>
<td>30</td>
<td>35</td>
<td>39</td>
</tr>
<tr>
<td>Masbate</td>
<td>17</td>
<td>29</td>
<td>32</td>
<td>40</td>
</tr>
<tr>
<td>Bohol</td>
<td>22</td>
<td>28</td>
<td>30</td>
<td>33</td>
</tr>
<tr>
<td>Eastern Samar</td>
<td>23</td>
<td>30</td>
<td>35</td>
<td>41</td>
</tr>
<tr>
<td>Sultan Kudarat</td>
<td>47</td>
<td>48</td>
<td>50</td>
<td>63</td>
</tr>
<tr>
<td>Lanao del Sur</td>
<td>18</td>
<td>30</td>
<td>26</td>
<td>31</td>
</tr>
<tr>
<td>Maguindanao</td>
<td>44</td>
<td>40</td>
<td>24</td>
<td>30</td>
</tr>
<tr>
<td>Tawi-Tawi</td>
<td>22</td>
<td>26</td>
<td>24</td>
<td>28</td>
</tr>
</tbody>
</table>

Source: FHSIS from 30 municipal health offices of 6th CP pilot provinces

7.2.13 In response to widespread stockouts of contraceptives, over the period 2007 to 2010 UNFPA has procured the following quantities of contraceptives: 2008-2009 1,415,376 condoms, 3,959,475 cycles of pills (3,899,475 microgynon and 60,000 exluton), 814,000 vials of hormonal injectables (DMPA) and 40,000 pieces of copper-T IUDs. These have been distributed to LGUs. The effect of these initiatives has been variable regarding improvements in the CPR but in most UNFPA supported municipalities there have been increases in the CPR for modern methods (see for example tables 7.2.1, 7.2.2 and figure 7.2.1).

Table 7.2.2: Contraceptive Prevalence Rate Modern Methods, UNFPA Pilot Municipalities in Lanao del Sur, 2005-2009

<table>
<thead>
<tr>
<th>Year</th>
<th>Bubong</th>
<th>Kapatagan</th>
<th>Marantao</th>
<th>Whole Province</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>20</td>
<td>22</td>
<td>6</td>
<td>31</td>
</tr>
<tr>
<td>2006</td>
<td>22</td>
<td>24</td>
<td>8</td>
<td>33</td>
</tr>
<tr>
<td>2007</td>
<td>53</td>
<td>27</td>
<td>10</td>
<td>34</td>
</tr>
<tr>
<td>2008</td>
<td>55</td>
<td>9</td>
<td>13</td>
<td>15</td>
</tr>
<tr>
<td>2009</td>
<td>51</td>
<td>26</td>
<td>27</td>
<td>19</td>
</tr>
</tbody>
</table>

7.2.14 The CPR from the 2006 baseline and 2010 end-line surveys appear to reinforce the findings from the municipalities’ facility-based service statistics. The surveys also obtained data for any FP method and modern methods. The findings on Table 7.3.3 show that there have been considerable increases in the uptake of any FP method among the women from the municipalities of eight provinces and Olongapo City. The findings of the 2010 end-line survey showed a decline in the performance of the municipalities of Maguindanao. The Masbate municipalities had the highest CPR increment among all provinces’ municipalities.
The CPR for any method of Ifugao, Mt. Province, and Sultan Kudarat municipalities were higher than the NDHS findings in 2003 (48.9%) and 2008 (50.7%). Olongapo City also surpassed the 2008 NDHS CPR for modern methods.

7.2.15 The surveys also showed that the CPR for modern methods of the municipalities of the non-ARMM provinces increased. The municipalities of Ifugao, Mt. Province, Sultan Kudarat, and Olongapo had higher percentages than the NDHS findings for usage of modern methods in 2003 (33.4%) and 2008 (34%). The two surveys showed that the municipalities of Masbate had the highest increment for modern FP methods. See table 7.2.3.

7.2.16 The two surveys also obtained data about unmet need for FP from the pilot provinces. The findings showed that eight out of 10 provinces had declining proportions of females with unmet need for FP. Remarkable reductions are noted in the municipalities of the pilot provinces of Eastern Samar, Ifugao, and Masbate. The proportion of unmet need for Mt. Province’s municipalities seemed to have plateaued for the two surveys (from 18.2 to 18.1%). Olongapo City has no baseline data but its unmet need is lower than the NDHS findings in 2008 (22.3%). The municipalities Lanao del Sur and Tawi-tawi slightly reduced their unmet need for FP. Only Sulu and Maguindanao municipalities, however, had increased proportions of females with unmet need for FP.

7.2.17 During the baseline survey, all the municipalities from the 10 pilot provinces exhibited higher unmet need than the NDHS 2003 findings. During end-line survey, however, the
Table 7.2.3. Contraceptive prevalence rate of currently married females 15–49 Years Old, from municipalities of 6th CP pilot provinces, 2006 Baseline and 2010 End-line Surveys (%)

<table>
<thead>
<tr>
<th>municipalities of 6th CP pilot provinces</th>
<th>NDHS 2003</th>
<th>NDHS 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philippines</td>
<td>ANY METHOD</td>
<td>MODERN METHOD</td>
</tr>
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<tr>
<td>UNFPA Sites</td>
<td>Baseline 2006 (n=18,578)</td>
<td>Endline 2010 (n=16,176)</td>
</tr>
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<tr>
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<td>48.7</td>
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<tr>
<td>Ifugao</td>
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<tr>
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<tr>
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<td>32.5</td>
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<tr>
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<td>31.1</td>
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<tr>
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<tr>
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<tr>
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<td>8.6</td>
<td>13.9</td>
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<td>Tawi-tawi</td>
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<tr>
<td>Olongapo City</td>
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<td>50.5</td>
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</tbody>
</table>

Source: UPPI-DRDF 2010

7 municipalities of five pilot provinces’ unmet need for FP were lower than the NDHS 2008 findings. Among the ARMM provinces, only Lanao del Sur’s municipalities had higher percentage of unmet need than the 2008 NDHS findings.

7.2.18 Advocacy activities under the PDS component of the Country Programme have further strengthened demand and the political environment for modern contraceptives but there continue to be problems at several levels in the availability and accessibility to modern contraception⁴⁰.

7.2.19 Information gathered during this evaluation during visits to rural health centres in several provinces indicates multiple deficiencies in access to family planning services. These include poor compiling and maintaining of client records at health facilities, totally inadequate storage and stock control of contraceptives at service delivery points, irregular procurement and distribution and low use of the ‘pop-shops’. The pop-shops were initially

Table 7.2.4. Percent of females 15 – 49 years old with unmet need for family planning, from municipalities of 6th CP pilot provinces, 2006 Baseline and 2010 End-line Surveys (%)

<table>
<thead>
<tr>
<th>UNFPA Sites</th>
<th>NDHS 2003</th>
<th>NDHS 2008</th>
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<tbody>
<tr>
<td>Philippines</td>
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<td>22.3</td>
</tr>
<tr>
<td>ARMM</td>
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<tr>
<td>UNFPA Sites</td>
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<td>End-line 2010 (n= 16,176)</td>
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<td>Ifugao</td>
<td>20.3</td>
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<tr>
<td>Lanao del Sur</td>
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</tr>
<tr>
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<td>Tawi-tawi</td>
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<tr>
<td>Olongapo City</td>
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<td>21.3</td>
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</tbody>
</table>

designed for clients who could afford to pay for contraceptives as part of the country’s response to the CSR policy. Free contraceptives were to be provided for poor women who could not afford to pay for contraceptives. Because there was a problem with market segmentation, i.e., the LGUs could not identify who the poor were so they gave contraceptives to everybody. The Evaluation Team were informed that in most areas covered by the CP around 70 percent of the population was ‘indigent’ and eligible for the provision of free contraceptives. Staff at RHUs said that when FP clients were asked if they wanted to purchase contraceptives from the ‘pop shops’ or obtain them free, they usually opted for free contraceptives. This explains the low use of the pop-shops. The consultancies of Villar$^{41}$ (2006) and Ahmed$^{42}$ (2010) to a limited extent consider the low use of ‘pop shops’ but this could be studied in more detail in the remaining year and a half of the Sixth CP.

7.2.20 It is understood that many of these deficiencies are recognized and the Department of Health plans (as of June 2010) to revitalize the LMIS for FP and other MNCHN commodities. This is part of the DOH plan to procure 10 percent of the country's FP commodity requirements and through existing national support to local governments using the MNCHN ‘Performance Based Grants’. The DOH is organizing an inter-agency Task Force on LMIS to ensure systematic implementation of efforts to revitalize the DOH LMIS. A multi-disciplinary team will review the Contraceptive Logistics Management Information System (LMIS) and the Commodity Distribution System used by DOH for other supplies. USAID will probably provide technical assistance to the DOH in carrying out a study which examines the cost-effectiveness of using DOH Regional Offices as distribution points for DOH procured commodities. Initial proposals have been made for pre-testing of the proposed system after which it is hoped that the Reproductive Health Commodity Monitoring system will be extended to cover the whole country.

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$^{41}$ Villa E, 2006. An assessment of the RH commodity situation in the Philippines, September to December 2005
$^{42}$ Ahmed et al. 2010. WHO-UNFPA RHCS Assessment.
7.3 Adolescent Reproductive Health

7.3.1 Worldwide, the reproductive health and well-being of adolescents and young people aged 10 to 24 have been central to UNFPA’s mission and agenda. The Fund sees the need to urgently address the SRH needs of young people because they are most vulnerable and at greater risk of engaging in practices that would have immediate and long-term negative impact on their health and well being.

7.3.2 As of 2006 young Filipinos aged 10 to 24 comprise 30.2 per cent of the Philippine population. By year 2025, 2.1 million more young people will be added to the already bulging population of the country. The UPPI-DRDF 2002 Young Adult Fertility Survey (YAFS) of 20,000 young people aged 15-24 found that about a quarter of their respondents have already engaged in premarital sex and most of their sexual encounters were unprotected.

7.3.3 The NDHS 2008 survey found that the fertility rate of adolescents aged 15-19 is 9.9 per cent while those between ages of 20-24 is 46.8 per cent. Of the country’s total unmet need for FP (of 22 %) the highest proportions were from young women between the ages of 15-19 and from the lowest wealth quintile and rural women and men in the Autonomous Region of Muslim Mindanao (ARMM). A high proportion of unmarried pregnant women in this age category reportedly resort to abortion. Furthermore, a large segment of poor women and girls continue to suffer from gender-based violence particularly sexual abuse and trafficking.

7.3.4 Despite the alarming increase of HIV cases in the country, the reported comprehensive knowledge of young people about the disease is low and many continue to hold incorrect information about prevention and control. The Philippine HIV & AIDS Registry of the DOH National Epidemiology Center as of March 2010 reported that 850 young people are now living with HIV in the country and the numbers are not declining.

7.3.5 The provision of correct and comprehensive ARH information and quality services to young people has been a contentious arena because of the pressure of the Catholic hierarchy and conservative quarters in government and other social institutions. The continued deprivation of young people from obtaining complete and reliable ARH information and quality care deny them of their human right to become productive and healthy members of society. The disturbing statistics about the ARH situation is indicative of the young people’s inability to make informed choices and to access social and health services. The 6th CP’s ARH response to meet young people’s urgent need for reliable information and health services through strategic gender-responsive and rights-based interventions could not have been most appropriate in these trying times.

7.3.6 A sub-component of RH, ARH has two desired outcomes 1/ increase demand for and utilization of comprehensive quality RH and 2/ increased access by male and female adolescents to obtain comprehensive, high quality RH services and information. The expected outputs of the first outcome include evidence that the proportion of male and female young people aged 10 to 24 are practicing life skills and are increasing their utilization of ARH services from teen centers/hubs, school clinics, and from other public and private facilities. The expected outputs for the second outcome are the enhanced capacity of duty

44 March 2010 Philippine HIV and AIDS Registry by the Department of Health National Epidemiology Center.
bearers to provide RH information and services and improved RH knowledge, attitude, behavior, practices and skills among young people.

7.3.7 The measures or strategies used by UNFPA for ARH were: a/ advocacy and support for policy dialogue, b/ institutionalization of ARH life skills in the public school system and in communities, c/ capacity building, d/ the development of tools and materials for public elementary and high school teachers, in-school and community-based teen wellness centers; e/ development of standards on adolescent friendly health services, and f/ creation of supportive structures such the Youth Advisory Panel (YAP) and Y-PEER.

7.3.8 UNFPA’s ARH program has a number of partners. For the institutionalization of ARH life skills education for in and out-of-school youth and school-based teen wellness centers at the public school system, the major collaborator is the Department of Education (DepEd). UNFPA also partnered with the Girl Scouts of the Philippines in extending informal ARH education to the members. For the establishment and maintenance of the community-based teen wellness centers in the pilot municipalities, the LGU and public health providers are the main partners. The Department of Health is the collaborator for the development of the Adolescent Friendly Health Services standards. The major partner for the development of youth policy and advocacy is the Philippine National Youth Commission (NYC). UNFPA also created the Youth Advisory Panel (YAP) and the Youth Peer Educators Network (Y-PEER) Pilipinas, the entity that provides technical support on peer education to the Girl Scouts of the Philippines.

7.3.9 During the first two years of the country program, UNFPA worked with community-based organizations such as Kaugmaon, Advocates for Youth, Remedios AIDS Foundation and Zone One Tondo Organization (ZOTO) to raise awareness and encourage health seeking behaviour among young people. ZOTO in particular, used infotainment or the song, dance and theatre medium to channel key ARH messages to the youth. A ZOTO band was organized which produced two CDs of socially-relevant songs. Likewise, a dance and theatre group was formed which performed in many UNFPA advocacy activities.

Accomplishments

7.3.9 Advocacy and supporting policy dialogue. UNFPA supported the National Youth Commission (NYC) in the development of The Medium-Term Youth Development Plan (MTYDP) of 2005 to 2010. In the formulation of the MTYDP, the NYC conducted nationwide consultation meetings with various youth groups to validate the results of its World Bank-supported National Youth Assessment Study. The results of the year-long consultation process were presented to over 200 young people during the 5th National Youth Parliament conference. This was also the occasion when the 2005 to 2010 MTYDP was reviewed and approved by the delegates.

7.3.10 The MTYDP has five core areas particularly youth value formation, participation, health, youth groups, and employment. It also includes policy directions, approaches, and strategies, monitoring and evaluation indicators, implementing schemes for the five core areas, and a 10-point youth policy agenda. Policy agenda 5 and 6 were the most relevant for UNFPA and these were also the most contentious among the 10 MTYDP policy agenda. Policy agenda 5 states the need to “ensure the acceptability, accessibility, availability and affordability of culturally and gender-sensitive/ responsive and user-friendly health services for adolescents and youth, particularly with regard to adolescent health and youth
development,” while Policy agenda 6 specifies the need to “reduce the incidence of risk behaviors among Filipino youth.”

7.3.11 The MTYDP was endorsed by the Social Development Committee (Res 1, series of 2005) and adopted through Executive Order No. 438 signed by former President Gloria Macapagal Arroyo on 27th of June 2005.

7.3.12 UNFPA continued its support to NYC particularly for initiatives that were related to policy agenda 5 and 6. The assistance included the a/ 6th National Youth Parliament (NYP) where ARH was substantively discussed by young people, b/ the advocacy of National Confederation of Youth Advocates for the adoption and integration of 6th NYP resolutions which were related to ARH, and c/ training of young leaders from the field to advocate and lobby for youth-responsive policies particularly for SRH issues.

7.3.13 The confederation of youth advocates were limited to the municipalities of only three of the 10 pilot provinces particularly Ifugao, Eastern Samar, and Sultan Kudarat. With funding and technical support from UNFPA, the NYC and these confederations prepared Local Youth Development Plans and advocated for the establishment of Local Youth Development Councils. As a result of these efforts, the Sangguniang Kabataan (official or government youth councils) in these areas reportedly provided support for ARH programs.

7.3.14 Institutionalization of ARH life skills in the public school system. The DepEd-UNFPA project to institutionalize ARH through life skills-based education falls under the 6th CP strategic plan to promote ARH and prevent HIV & AIDS. It focuses on the Filipino adolescent and young people aged 9 to 24 years old or to those who are from fourth grade to fourth year secondary school. Out-of-school young people within these ages are also covered. This project is implemented in all the municipalities of the 10 pilot provinces. Three DepEd bureaus are involved in this project—Bureau of Elementary Education (BEE), Bureau of Secondary (BSE) Education, and Bureau of Alternative Learning System (BALS). The BALS attends to out-of-school students who would like to complete their secondary education through the use of DepEd’s alternative learning tools.

7.3.15 DepEd started the project in 2005 by preparing the ARH-enhanced curriculum teaching materials particularly the exemplars for elementary school teachers and Toolkits for secondary school teachers. RH life skill topics were integrated in three elementary school subjects and into eight subjects in secondary school. The BALS did not have any difficulty in implementing the ARH life skills teaching materials but the elementary and secondary school bureaus encountered strong opposition from the Catholic hierarchy and other conservative sectors who were combating the passage of the RH bill. Thus the project for the formal schools was held in abeyance for two years.

7.3.16 The resumption of the project took place in July 2008 after DepEd held an “reorientation, assessment and consultation” meeting in Baguio City involving superintendents, supervisors, ARH focal persons, and over a hundred elementary and secondary school principals. Representatives from UNFPA and the Presidential Council for Values Formation (PCV), and some Protestant bishops also attended this gathering (the Catholic bishops were invited but no one came). It was decided that upon return to their respective provinces, the school heads would conduct school-based training for their teachers about the content and application of the ARH teaching tools. The trained teachers subsequently implemented the project in their respective classes in the grade and secondary
schools. To facilitate the monitoring of the ARH focal persons in the different provinces, the school heads and their trained teachers agreed to fill out feedback sheets. DepEd printed the trial version of the teaching materials while UNFPA took charge of their distribution to the pilot provinces’ municipalities.

7.3.17 In February to March 2009, an evaluation was conducted in Olongapo City, the municipalities of Ifugao, Mt. Province, Masbate, Eastern Samar and Bohol concerning the implementation of the teachers’ teaching tools based on their usefulness, alignment with the curriculum, congruence, acceptability, and overall packaging. The ARMM provinces and Sultan Kudarat were not included for security reasons. The respondents were the school heads, teachers, and students from the six pilot divisions. The survey results showed that both sets of teachers’ tools were rated as “very good” for ARH life-skills development. The suggested activities, assessment tools and source materials which utilized the integrated approach for teaching-learning process were acceptable and were perceived as appropriate, ‘doable’ and useful. There were suggestions to improve the exemplars and Toolkits and these focused on the need for more training and provision of appropriate visual aid.45

7.3.18 The BALS found the ARH life-skills useful not only for the out-of-school students but also for RH counseling, advocacy and networking in the communities. It was suggested that the ARH life skills educational tools should be shared with community learning centers, the RHU, and other health centers. The participating schools further recommended that with LGU support, the project should be expanded to other municipalities in the different provinces and capacity building could be handled by the trained school heads.46 In May 2010, the BALS institutionalized peer education in their regular programs.

7.3.19 As of October 2009, a total of 877 elementary teachers and 646 high school teachers were trained with the use of the Facilitators’ Manual on ARH Curriculum (Teachers’ and Instructional Managers’ Training Manual). The project has served 24,851 elementary pupils and 39,742 secondary students for school years 2008-2009 and 2009-2010. Although only two years in operation, the school heads and trained teachers noted that there is remarkable improvement in their students’ awareness and knowledge about the importance of ARH. Although the impact of the project may take a longer period to take effect, there are immediate observable results that are reflective of the young people’s decision-making and practices. In an interview with a school supervisor in Bohol, for example, it was disclosed that one of the principals in a municipal school that she was overseeing, was very pleased with the ARH project because for the first time in his many years as school principal, there was no pregnant adolescent among his students. He attributed this directly to the ARH lessons and the presence of the teen wellness center in his institution.

7.3.20 From January to June of 2010, DepEd’s ARH life skills based education was once again the center of controversy. The Catholic hierarchy and the conservatives were combative and were demanding that the project be reviewed. This was also a period when renewed advocacy for the RH bill was conducted by UNFPA’s PDS partners. With evidence from their two years of experience in project implementation, DepEd’s national and provincial officials appeared more confident in holding dialogues with the Catholic hierarchy and other sectors. A provincial school supervisor from Bohol who was interviewed for this evaluation

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said that she was asked by the Catholic bishop of the province to present the ARH life skills project. She said that she was going to tell the bishop about the positive effects of the project on the students in some municipalities. She said that what they were teaching the students were not new but their presentation of the ARH topics were much more integrative and interactive. She blamed the media for fueling the controversy by labeling the entire project as “sex education,” instead of an ARH life-skills strengthening endeavor.

7.3.21 After the new President of the Philippines appointed a religious brother from a prestigious private Catholic as Secretary of Education, there were apprehensions that the ARH life-skills curriculum would be halted again. However, after a series of discussions within DepEd and dialogues between DepEd and the Catholic hierarchy and conservative sectors, the controversy apparently died down and the project is being rolled out to other provinces. The Catholic hierarchy was partly appeased because of the assurance that schools would not provide contraceptives to students.

7.3.22 Establishment of Teen Wellness Centers. To complement DepEd’s Enhanced ARH Life Skills-based curriculum, UNFPA partnered with Australian Aid (AusAid) and supported a total of 16 school-based and 21 community-based Teen Wellness Centers (TWC) in the municipalities of the 10 pilot provinces. These facilities were established at different periods between years 2007 to 2009. The services extended by the TWC included the provision of information on sexual, RH and rights, counseling, and referral services to health and other related community facilities (e.g., Women and child protection units or the GAD crisis centers).

7.3.23 The TWC has three models. The first one utilizes the Foundation for Adolescent Development (FAD) model (a Manila-based NGO) that has developed a franchise system for LGUs for using its system and tools for ARH information and services. This model is being used by the municipalities of Bohol. It provides materials and training for service providers and peer educators. An issue confronting Bohol’s municipalities is how they could sustain their operation once the franchise has expired because not all LGUs could afford to continue paying the franchise fee.

7.3.24 The second model is the school-based TWC which is usually located at a secondary school and managed by a guidance counsellor or a school nurse or a teacher with the assistance of peer educators. The schools provide the space for the TWC while UNFPA and AusAid’s counterpart include audio-visual equipment, computers, and ARH information materials (flyers, books, magazines, educational DVD). Peer educators assist the school-based TWC in providing information and related services to students. The school nurse or guidance counsellor and the peer educators could have participated in some training activities about ARH that were conducted by school heads or from other trainers within and outside the schools. Students are encouraged to utilize the TWC and participate in developing its mission, objectives, work plan and implement activities that promote ARH. The school-based TWC usually provides information and counseling services. Young people who seek assistance for gender-based or domestic violence problems or SRH problems are referred to the RHU or the GAD crisis centers for assistance.

7.3.25 The third model is the community-based TWC. This model is designed to enhance the ARH life skills education of in- and out-of-school students in the pilot sites. The construction or upgrading of the TWC infrastructure is the responsibility of the LGU while ARH information and health services are provided by the RHU. UNFPA and AusAID’s
counterpart is the provision of audio-visual equipment, computer, and educational materials including films and DVD. The community-based TWC is managed by a LGU-hired personnel who is either given the title of a community relations officer or community organizer. The facilities also have few peer educators or facilitators who are supported by the LGU.

7.3.26 In the initial phase of the ARH program, a number of school and community-based TWC personnel and peer educators received training from the UNFPA-initiated capability building activities. Currently some of the TWC personnel obtain their training from the RHU health providers and from school heads and ARH focal persons. Peer educators gathered youth leaders together and facilitate the formulation of their TWC mission, vision, objectives, organizational structure, rules, and work plans, and implement advocacy and related activities. Young people who access the TWC could utilize the audio-visual facilities and educational materials, obtain counseling services, and if needed, the referral services to the RHU or the GAD crisis centers and other related agencies.

7.3.27 From September to December 2009, Dr. Carolyn Sobritchea evaluated 32 school-based and community-based TWC from the municipalities of the pilot provinces through a self-administered questionnaire and qualitative study of Eastern Samar and Sultan Kudarat’s municipalities. Her major findings were as follows. Almost all the TWCs which were involved in the project accomplished their terms of reference. The immediate result is the “increasing participation of adolescents in TWC activities and their positive appreciation of the ASRH skills and knowledge acquired.” However, the TWC have varying capacity to carry out their programs and services. Some TWC are very dynamic and determined to implement their work plans, others need more assistance to develop their programs and services. It also noted that school-based TWC are better managed than community-based TWC because of the assistance extended by school heads and teachers. The study further noted that more young people appear to utilize the facilities and services of the community-based TWC than the school-based TWC.

7.3.28 The TWC’s facilities needed more improvement particularly the space for counseling services and the toilets. The service providers and adolescents recommended that the following needs are addressed: 1/ more capability-building activities, 2/ provision of additional educational learning and advocacy materials; 3/ assistance to examine, develop and strengthen their policies, programs and services, 4/ support for designing and implementing M & E system.\(^{47}\)

7.3.29 Standards for Youth-Friendly ARH services. Through a Department Personnel Order No. 2006-2895 issued by former DOH Secretary of Health Francisco T. Duque III the membership of the Technical Committee for Adolescent Health and Youth Program (AHYP) was re-constituted. Its members are from different DOH units, PhilHealth, UNFPA, FAD, German Technical Cooperation, Plan Philippines, and the Philippine Society for Adolescent Medicine. The AHYP technical committee’s functions are to develop or revise policies on AHYP, technical support to standardize training modules for teen centers and related training activities, recommend guidelines, quality improvement activities for teen center initiatives, periodic monitoring and evaluation of AHYP implementation, and develop mechanisms for networking with other government agencies, NGOs, CSO, LGU and other support groups. The technical committee is supposed to develop and finalize the protocol for youth-friendly

\(^{47}\) Sobritchea, Carolyn I. An Assessment of the Teen Wellness Centers in UNFPA-assisted Areas in the Philippines. N.p. 2010. Print
ARH services. The completion of the standards may take a longer period because there are still some issues that must be resolved. One of these issues is the absence of standards for preventive measures which are crucial in addressing high-risk behaviors of young people.

7.3.30 Establishment of Youth Advisory Panel (YAP) and Youth Peer Educators Network (Y-PEER) Pilipinas. The YAP has been a regular part of program discussions of UNFPA and its partners on issues related to ARH. The Y-PEER Pilipinas, on the other hand, has continually expanded its network and has provided technical assistance on Peer Education initiatives within UNFPA areas as well as with the national partners. The first International Coordinator from Asia and Pacific is from Y-PEER Pilipinas. Although the network has few meetings, the members are connected through internet discussions. One of the important partners of the Y-PEER is the Girl Scouts of the Philippines (GSP).

7.3.31 The GSP is the leading organization for the character development of girls and young women aged 4 to 21. It supports the holistic development of young girls and women to enable them to effectively assume their responsibilities in society. Because of their vulnerability to STI, teenage pregnancy, unsafe abortion, and early marriages, GSP decided in 2003 to include ARH matters in its program.

7.3.32 In its first year of program implementation, GSP noted that its own personnel and scout leaders did not have the capability and the necessary tools and materials to carry out the ARH work plans of the program. In 2004, financial assistance was provided by the Philippine HIV & AIDS NGO Support Program (PHANSuP) for the production of the IEC materials mainly on HIV & AIDS and ARH for trainers, troop Leaders and the GSP members. These materials were found useful for the foregoing training and in informing the girl scouts about HIV and ARH.

7.3.33 In 2008, UNFPA supported the revision and printing of 200 copies of manuals for the training of 180 trainers/ troop leaders and for the training of 1,000 Girl Scouts about ARH. A thousand ARH badges were made available to every trained girl. A year later, GSP enhanced its ARH program by conducting a national-level training of trainers about peer education for 180 adult and young women scout leaders. These trained scout leaders subsequently conducted training on ARH in six regions, namely: Northern Luzon, Central Luzon, Southern Luzon, Visayas, Eastern and Western Mindanao. These regional activities trained 4,000 adult scout leaders and 6,500 young girl scout leaders.

7.3.34 These training activities are being scaled up this year with additional support from UNFPA. Advocacy within the GSP and in the larger community about ARH issues would also be undertaken. Advanced trainings are currently provided for the first batch of scout leaders who received peer education training. At the GSP’s annual national seniors and cadet conference, issues related to the MDGs and climate change were discussed and a one-day session on ARH and climate change was held. A special training for peer educators would also be provided to assist young scout members who are victims of sexual abuse.

7.3.35 Several activities have been undertaken by the ARH partners nationally in schools and in communities to ensure access and provision of ARH information and services for young girls and boys, adolescents and young adults. There is no doubt that these activities are relevant to attaining the goals of the 6th CP and to the MDGs. Immediate and promising positive effects from these ARH initiatives are observed in the municipalities of the pilot provinces. There are ARH services that clearly link up young people to the other components
of the 6th CP particularly their involvement in advocacy for ARH and HIV prevention, and for referral services to GAD crisis center among survivors of gender-based violence.

7.3.36 Because these initiatives are fairly recent, their impact on ARH is yet to be felt by the target beneficiaries. The efficient use of resources is noted particularly in the cost-sharing schemes between UNFPA, the participating schools, LGU, and communities in the establishment and management of teen wellness centers and in conduct of school-based teachers training on the use of the enhanced ARH life-skills education tools.

7.3.37 While favorable effects may be observed in the pilot provinces’ municipalities, it is uncertain how some of these initiatives would be scaled up when funding is no longer forthcoming in the provinces. The sustainability of providing young people with continued access to ARH information and services hinges on the commitment and continued support by the various partners. It is hoped that the national leadership and the other partners would continue to stand up to the pressures from society’s conservative sectors. Their sustained support in strengthening young people’s RH life skills will no doubt have long-term favorable consequences on the next generation’s reproductive health and well-being.

Issues

A number of issues were noted from the activities of the ARH partners.

7.3.38 The MTYDP 2005-2010 has provided the legal framework for the creation of the Local Youth Development Plans and establishment of Local Youth Development Councils. However, since its approval in 2005, many LGU are reportedly unaware of its existence. Perhaps because of financial and other logistical requirements, only a few LGU who are knowledgeable about this policy are supportive of its localization.

7.3.39 The Sangguniang Kabataan (youth legislative council) which is supportive of the MTYDP’s localization and ARH programs are confronted with the fact that its local leaders must be elected every three years particularly during barangay-level elections. The changing local youth leadership implies renewed advocacy about ARH to obtain the support from newly-elected youth officials. A system is needed to orient these new youth leaders about ARH so that they would be effective ARH advocates their respective locale.

7.3.40 While it is commendable that DepEd empowered their school heads from the municipalities of the pilot provinces to conduct school-based training for their teachers on enhanced life skills-based education, there is concern about the quality of the training and the varying capacity of the teachers to impart the ARH messages from the exemplars and the ARH toolkits. There is also some apprehension about how knowledgeable and sensitive the trainers are about gender, culture and rights-based ARH information and services. The quality and substance that the teachers will impart are crucial inputs to the formation of young people. There is therefore a need to revisit the training design prepared by the school heads and the monitoring and evaluation scheme of the project. This becomes more imperative when DepEd would cascade the ARH life-skills education to all regions in the country.

7.3.41 The school-based and community-based teen wellness centers have varying facilities and capacities to provide ARH information and services. A particular concern is the training of peer educators and how this could be sustained by the teen wellness centers. In the initial
phase of the establishment of the teen wellness, capacity building for the peer educators and
ten wellness managers was provided by UNFPA and some partners. Apparently this is no
longer the practice and training is either provided by the schools or by the local health
providers and community organizers. There is therefore a need to revisit the training design
for TWC personnel and to develop a standard tool (content and process) for capacity
development. The turnover of peer educators is a concern and how they would be sustained is
an issue that must be addressed.

7.3.42 The sub-component ARH has varied projects and partners yet its monitoring and
evaluation is not in place. Except for the number of teachers who received training to impart
ARH life skills education and the number of grade school and high school students who had
the life skills education, no available data could be readily obtained about the performance of
ARH. ARH indicators are not covered in the baseline and end-line surveys either. More
measurable indices should be developed because the output indicators of proportion of male
and female… “practicing life skills” and “enhanced capacity of duty bearers…” need further
operationalization.

7.4 HIV and AIDS

7.4.1 Up until 2008, HIV in the Philippines was spreading slowly and its prevalence rate
was less than one percent of the adult population. Despite this seemingly “low and slow” HIV
transmission rate, however, predictions were made that the country is likely going to have an
epidemic because of its high STI rates, unprotected sex and other related risky practices
especially among sex workers and their clients, males who have sex with males, and injecting
drug users.

7.4.2 From January 1984 to August 2010, the HIV/AIDS Registry reported that the
Philippines has a total 5,472 HIV cases. In the past eight months of 2010, the country has had
1,048 new cases. A large majority (91%) of these new cases are males who were mostly
between 20 to 29 years old. Close to one third (31%) were young people aged 15-24. The
predominant mode of transmission is through sexual intercourse. A total of 323 persons died
from AIDS between 1984 to August 2010.

7.4.3 In January 2010, former Secretary of Health Dr. Esperanza Cabral was alarmed over
the rapid rise of HIV cases since the disease emerged in the country 26 years ago. She said
that from January until November 2009, the Philippines had 60 new monthly HIV cases. In
December this number doubled to 126 and in January 2010, it went up to 143 new cases. The
new cases were mostly males who have sex with males who fell between the ages of 25 to 29.
Dr. Cabral predicted that within three years, there would be 30,000 new HIV infections in the
country.48 A related alarming news was that in Metro Cebu, a few female sex workers who
were injecting drug users were found to be HIV positive. These developments imply that HIV
and AIDS would be an area that would require greater attention in the next country program.

7.4.4 The Philippine AIDS Medium-Term Plan from 2005 to 2010 has specified that for
HIV and AIDS, a comprehensive and targeted prevention program should focus on the most-
at-risk populations (MARPs) particularly female sex workers and their male clients, males
who have sex with males, and injecting drug users, and to those that are vulnerable and at risk

48 Reuters, Thu March 4, 2010
of acquiring the disease which include Overseas Filipino Workers (OFW), out-of-school youth, and street children.

7.4.5 UN agencies have signified their commitment to support the country’s initiatives to halt the spread of the disease. Before 2008, UN agencies had provided technical to financial assistance to address the MARPs’ needs in their program sites. Based on the UNAIDS Division of Labor in 2008, UNFPA became the lead agency that is responsible for providing support to institutions and groups that are concerned about the welfare of female sex workers and in-school youth. To facilitate support to the foregoing population segments, UNFPA collaborated with the Department of Health, the pilot LGUs and a number of NGOs that are working with MARPs and other vulnerable populations.

7.4.6 The measures that UNFPA utilized to assist the foregoing populations were capacity building, development of training tools, advocacy and networking.

Accomplishments

7.4.7 The achievements of UNFPA’s program on HIV and AIDS including STI could be gleaned from its work with DOH, the LGUs in the pilot provinces, and with selected NGOs.

7.4.8 Capacity-building. A major contribution of UNFPA is its support to the DOH’s National AIDS/STI Prevention and Control Program to conduct the training entitled Enhanced Comprehensive STI management using the Syndromic Approach for health providers in the 10 pilot provinces and one city. As a result, RHU health personnel who joined the training were reportedly able to correctly identify and manage STI cases.

7.4.9 In addition, the HIV and AIDS proficiency training session for medical technologists was also conducted in municipalities of Mt. Province, Bohol, Ifugao, and Sultan Kudarat to strengthen these health workers’ capacity to identify HIV cases.

7.4.10 To create an enabling environment for local responses to AIDS, UNFPA also assisted the municipalities of the provinces of Eastern Samar, Bohol and Sultan Kudarat through the technical assistance provided by Positive Action Foundation of the Philippines, Inc. (PAFPI). Olongapo City, on the other hand, obtained technical support from the AIDS Society of the Philippines (ASP).

7.4.11 PAFPI, an NGO comprising of non-HIV and HIV-positive people and their families, partnered with the LGUs in the municipalities of Eastern Samar and Bohol and conducted training for peer educators among their HIV-positive colleagues. PAFPI has also linked with the provincial local AIDS council which is responsible for overseeing the pilot municipalities in their HIV and AIDS activities.

7.4.12 UNFPA has engaged the AIDS Society of the Philippines (ASP) in Olongapo City and Davao City (a non-pilot site) to target males who are having sex with males (MSM) especially young people. This effort also led to building the capacity of the City Local AIDS Council members and supported the establishment of a ‘hot line’. It has also trained MSM groups about STI, HIV and AIDS. Those who joined the training are now conducting their own capacity-building activities. ASP’s efforts were brought to the attention of the local AIDS councils through its advocacy that MSM are important part of MARPs who should be given assistance for HIV prevention.
7.4.13 UNFPA extended support to the pilot municipalities of Mt. Province through the Action on Health Initiatives (ACHIEVE). In collaboration with the LGU, capacity-building activities were conducted for OFWs to become peer educators. A majority were returning female domestic helpers. Some of these trained peer educators subsequently provided information about HIV and AIDS to other OFWs’ wives. The latter are reportedly more able to understand their risks of acquiring the disease. As a result of these activities, the LGU revisited their local AIDS plan and identified specific measures to strengthen their program for OFWs.

7.4.14 The Training Research Information Development (TRIDEV) has conducted capacity-building workshops on HIV and STI for truckers who are mostly clients of sex workers and who are at risk of acquiring HIV. This project was implemented in Batangas and Tarlac, both non-pilot provinces, in collaboration with the Truckers Association, national government agencies (NGA) and LGUs. TRIDEV has developed a mechanism to refer truckers to health providers that are geographical proximate to the truck stations for counseling and other related services. This intervention reportedly improved the truckers’ awareness, knowledge and practices about HIV and STI prevention. In line with strengthening local AIDS Council, TRIDEV further facilitated the establishment of the Barangay Local AIDS Council to ensure that HIV prevention is implemented in the smallest political administrative unit.

7.4.15 Development of tools. Two HIV & AIDS tools were developed in collaboration with members from NGA, NGO and other CSO. One was a draft manual of operations (MOP) for returning HIV-positive OFWs’ reintegration in their communities. This tool would provide useful guidelines for LGUs on how develop appropriate assistance to returnees. The draft MOP would be pilot tested and the results would be used to improve the manual. The final MOP will be endorsed by the Department of Labor and the Department of Health.

7.4.16 The other tool that was developed was the interactive CD on STI, HIV and AIDS which was designed as a teaching aid for service providers. The interactive CD on STI and HIV is considered by UNFPA as a good product. This innovative teaching tool was designed to help a resource person prepare innovative and interesting visual aid. The CD could be used as a complementary tool for other modules of the same topics and contents. Seventy per cent of the CD covers informative trivia games which could be used to gauge seminar participants’ comprehension of HIV and AIDS. The remaining part of the CD focuses on selected topics about gender and sexuality, HIV & AIDS prevention, treatment, care, and support, and STI case management (or the STI Syndromic Approach). The fun infused into the learning tool is meant to sustain the interest of seminar participants and reinforce knowledge retention about STI, HIV and AIDS.

7.4.17 The CD’s contents will be updated as needed to keep up with new learning techniques and technology. The interactive CD was developed in partnership with the EDS Innoventions, an IT company. In recognition of its innovative learning approach, the interactive CD became a finalist in the 2009 Outstanding Client Application on Social Development of the Center for International Trade Expositions and Missions, an attached agency of the Department of Trade and Industry. The interactive CD has been distributed in the ten pilot provinces and one city, and currently, it is used by teachers, health service providers and young people.

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49 UNFPA Compendium of Good Practices on Reproductive Health, July 2010
7.4.18 Advocacy and networking. In a number of pilot areas, World AIDS Day and Candlelight Memorials were observed through the LGUs, NGOs and with some functioning local AIDS councils and task forces.

7.4.19 Among the LGUs that partnered with UNFPA, only the city of Olongapo developed and implemented a comprehensive prevention program on STI and HIV which are protective of MARPs especially the sex workers. The local HIV and AIDS Council and a task force ensure that the HIV and AIDS response is in place. With UNFPA’s support, the city is implementing an HIV prevention strategy within its RH program through a health card system. A card holder could obtain services from its Social Hygiene Clinic with the proviso that she attends the HIV and AIDS orientation seminar that is regularly conducted by the City Health Office. Health card owners feel that they are partners of the program rather than just mere beneficiaries.

7.4.20 The City Health Office also partnered with bar owners and established the Association of Bar Owners. This group facilitated the conduct of RH lectures for sex workers, the implementation of the 100 per cent condom use campaign, and the regular monitoring of program activities.

7.4.21 UNFPA and the city of Olongapo also collaborated with Buklod, a local NGO that promotes the welfare of both establishment-based and freelance sex workers to link them with the services available at the City Health Office’s Social Hygiene Clinic. Teen wellness centers were likewise established in partnership with the Department of Education and the Sangguniang Kabataan (government youth council) to provide ARH information and peer counseling services to young people. The city has also involved the local gay community in disseminating HIV and AIDS information to high school students. It is noted that the collaborative efforts in Olongapo City is contributing to the reduction of STI cases as well as in monitoring HIV cases.

7.4.22 UNFPA also supported projects for establishment-based and freelance female sex workers in Cabanatuan City and Daet Municipality in Camarines Norte (non-pilot sites), which resulted to the creation of an organization of sex workers. This group facilitated the sex workers’ access to obtaining HIV and STI services from the local health facilities.

7.4.23 Recognizing the importance of youth participation in HIV prevention and the increasing number of infected young people, UNFPA provided technical assistance for the national advocacy activities of the Youth AIDS Filipinas Alliance (YAFA), a group of young people living with HIV. An HIV and AIDS caravan was organized by YAFA in partnership with some Visayan regional schools and several stakeholders. This activity aimed to promote the provision of correct information about HIV prevention. Furthermore, three young HIV-positives who were afraid to disclose their HIV status due to stigma and discrimination were encouraged to publicly admit that they had HIV and to talk about their experiences to other young people.

7.4.24 Moreover, UNFPA has funded special projects on leadership training targeting HIV-positive communities, through Pinoy Plus (mostly male PLHA) and the Babae Plus (all female PLHA). The training sessions have reportedly improved the foregoing sectors’ self esteem and confidence to speak out and discuss HIV issues during dialogues and forums with various groups. At present, more young HIV-positive women are reportedly receiving
invitations from schools and other organizations as speakers at HIV gatherings and other related activities.

7.4.25 From 2007 to 2009, UNFPA has been part of the 1st Joint UN Programme on HIV and Migration (JPHAM) in the Philippines. The Joint Program was designed to address international-level HIV and migration issues based on the country’s commitments to the global and regional conventions, declarations and agreements. The program provides comprehensive package of national and local development interventions on HIV prevention, treatment, care and support for Overseas Filipino Workers (OFW) and their communities. The program was implemented in three selected provinces particularly Cavite, Bohol and Maguindanao-Shariff Kabunsuan, because these places have the most number of OFW. The results are presented as official policy statements in bilateral negotiations with destination countries. The HIV and migration policies will also be implemented at the national level. The JPHAM also conducts advocacy and promotion activities in the foregoing sites to promote HIV awareness and behavioral change among OFWs and their families.

7.4.26 UNFPA’s three-year support to JPHAM had tangible deliverables particularly a/ the creation of the Cavite AIDS Task force and the development of a local policy to strengthen the task force including budgetary allocation for HIV-related activities; b/ the recognition of Cavite’s Provincial Health Office for establishing an HIV-positive group among residents with HIV; c/ the revitalization of Bohol’s Local AIDS Council; c/ a draft operations manual for an effective re-integration of OFWs into their communities.

7.4.27 Lessons learned from JPHAM would serve as a guide in developing future UN joint programs not only in HIV and AIDS but also for other relevant development issues that are concerned with the plight of the OFW and other most-at-risk populations.

Results of the 2005 baseline and 2010 end-line surveys

7.4.28 Municipal health providers, LGUs, community health teams including women’s groups, youth leaders and advocates, public school heads and teachers, school and community-based teen wellness centers of the pilot provinces have advocated or promoted HIV and AIDS in their communities and institutions. They reportedly participated in World AIDS Day and Candlelight memorial ceremonies to bring to their communities’ attention about the importance of HIV and AIDS. To determine whether the municipalities in these areas are aware of HIV and AIDS, the baseline and end-line survey included two questions about the disease. The first question was whether or not the respondent has heard of HIV and AIDS. The second question focused on the respondent’s knowledge about the disease.

7.4.29 Whether or not the respondents have heard of HIV and AIDS. In general, a majority of the nine provinces have heard of HIV and AIDS in both surveys (baseline range 65.4 % in Tawi-Tawi to 95.4 % in Eastern Samar; end-line range, 59.6% in Sulu to 97.8 % in Olongapo City and in Eastern Samar). Among the ARMM provinces, Sulu exhibited the lowest proportions of respondents who have heard of the disease. During the baseline, only one third had heard of HIV and AIDS but this increased to 59.6 per cent in the end-line survey.

7.4.30 Respondents who were aware and had comprehensive knowledge about HIV and AIDS. The high awareness of the respondents about the disease was not matched by their knowledge of the disease in both surveys. During the baseline survey, less than 10 per cent of the respondents of the municipalities from six of the 10 provinces had comprehensive HIV
and AIDS knowledge. The municipalities in four provinces had percentages of less than 20 per cent. The proportion of respondents with comprehensive HIV and AIDS knowledge in all areas increased during the end-line survey. These increments, however, mostly less than 10 per cent. A majority continue to harbor erroneous knowledge like HIV could be transmitted through mosquito bites and by touching someone with the disease. The implication of this finding is that substantive promotion about HIV and AIDS is wanting and should be an important measure in combating the disease (see Table 7.4.1).

Table 7.4.1 Respondents who have heard of HIV and AIDS and who have comprehensive knowledge about HIV and AIDS from the municipalities of the 6th CP pilot provinces and one city, 2006 Baseline and 2010 End-line Survey (%)

<table>
<thead>
<tr>
<th>UNFPA Site</th>
<th>Percent who have heard of HIV/AIDS</th>
<th>Percent who have comprehensive knowledge of HIV/AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2006 Baseline (n = 36,924)</td>
<td>2010 End-line (n = 31,312)</td>
</tr>
<tr>
<td>Bohol</td>
<td>90.6</td>
<td>96.4</td>
</tr>
<tr>
<td>Eastern Samar</td>
<td>95.9</td>
<td>98.3</td>
</tr>
<tr>
<td>Ifugao</td>
<td>83.0</td>
<td>91.9</td>
</tr>
<tr>
<td>Lanao del Sur</td>
<td>77.6</td>
<td>78.8</td>
</tr>
<tr>
<td>Maguindanao</td>
<td>66.4</td>
<td>77.5</td>
</tr>
<tr>
<td>Masbate</td>
<td>81.1</td>
<td>87.2</td>
</tr>
<tr>
<td>Mt. Province</td>
<td>84.1</td>
<td>93.4</td>
</tr>
<tr>
<td>Sultan Kudarat</td>
<td>84.7</td>
<td>78.0</td>
</tr>
<tr>
<td>Sulu</td>
<td>33.4</td>
<td>59.6</td>
</tr>
<tr>
<td>Tawi-tawi</td>
<td>60.0</td>
<td>59.2</td>
</tr>
<tr>
<td>Olongapo City</td>
<td>--</td>
<td>97.5</td>
</tr>
</tbody>
</table>

7.4.31 The pattern of responses among male and female respondents appear to be similar to the general trends, i.e., high proportion of awareness but low comprehensive knowledge about HIV and AIDS (see Tables 7.4.2 and 7.4.3). The end-line survey, however, showed that there were improvements in the proportion of male and female respondents with comprehensive knowledge about HIV and AIDS. The female respondents of the end-line survey from the municipalities of four provinces, i.e., Bohol (29.8%), Olongapo City (25.9%), Mt. Province (25.2%), and Ifugao (24.5%), surpassed the 2008 NDHS findings (22%) in this aspect. It is worthwhile to note that Bohol municipalities and Olongapo City, have participated in technical support extended by UNFPA’s NGO partners. The proportions of men with comprehensive knowledge about HIV and AIDS from these areas were also higher than the NDHS 2008 findings.

7.4.32 Issues. There is no doubt that the work of UNFPA in the HIV and AIDS arena is relevant to the current HIV and AIDS situation of the country and it is slowly making inroads in the municipalities of the pilot provinces. There were also innovative efforts among NGO partners to reach out to MARPs. Except for Olongapo City, however, the municipalities and provinces have yet to develop gender-responsive and rights-based comprehensive
Table 7.4.2. Male respondents who have heard and have comprehensive knowledge about HIV and AIDS from the municipalities of the 6th CP pilot provinces and one city, 2006 Baseline and 2010 End-line Surveys (%)

<table>
<thead>
<tr>
<th>UNFPA Site</th>
<th>Percent who have heard of HIV/AIDS 2006 (n=18,346)</th>
<th>Percent who have Knowledge of HIV/AIDS 2006 (n=18,346)</th>
<th>Percent who have heard of HIV/AIDS 2010 (n=15,136)</th>
<th>Percent who have Knowledge of HIV/AIDS 2010 (n=15,136)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bohol</td>
<td>88.8</td>
<td>8.2</td>
<td>96.9</td>
<td>23.8</td>
</tr>
<tr>
<td>Eastern Samar</td>
<td>95.4</td>
<td>15.5</td>
<td>97.8</td>
<td>15.8</td>
</tr>
<tr>
<td>Iloilo</td>
<td>79.2</td>
<td>15.8</td>
<td>89.6</td>
<td>17.1</td>
</tr>
<tr>
<td>Lanao del Sur</td>
<td>83.0</td>
<td>2.3</td>
<td>81.4</td>
<td>18.3</td>
</tr>
<tr>
<td>Maguindanao</td>
<td>69.5</td>
<td>16.1</td>
<td>77.7</td>
<td>14.5</td>
</tr>
<tr>
<td>Masbate</td>
<td>92.4</td>
<td>6.9</td>
<td>88.5</td>
<td>13.9</td>
</tr>
<tr>
<td>Mt. Province</td>
<td>84.3</td>
<td>14.2</td>
<td>92.7</td>
<td>16.7</td>
</tr>
<tr>
<td>Sultan Kudarat</td>
<td>89.3</td>
<td>6.6</td>
<td>85.6</td>
<td>12.3</td>
</tr>
<tr>
<td>Sulu</td>
<td>34.3</td>
<td>4.2</td>
<td>59.6</td>
<td>9.0</td>
</tr>
<tr>
<td>Tawi-tawi</td>
<td>54.6</td>
<td>4.4</td>
<td>64.9</td>
<td>16.2</td>
</tr>
<tr>
<td>Olongapo City</td>
<td>----</td>
<td>----</td>
<td>97.8</td>
<td>25.6</td>
</tr>
</tbody>
</table>

Source: UPPI-DRDF 2010

Table 7.4.3. Female respondents who have heard and have comprehensive knowledge about HIV and AIDS from the municipalities of the 6th CP pilot provinces and one city, 2006 Baseline and 2010 End-line Surveys (%)

<table>
<thead>
<tr>
<th>UNFPA Site</th>
<th>Percent who have heard of HIV/AIDS 2006 (n=18,578)</th>
<th>Percent who have Knowledge of HIV/AIDS 2006 (n=18,578)</th>
<th>Percent who have heard of HIV/AIDS 2010 (n=16,176)</th>
<th>Percent who have Knowledge of HIV/AIDS 2010 (n=16,176)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bohol</td>
<td>92.3</td>
<td>12.2</td>
<td>95.8</td>
<td>29.8</td>
</tr>
<tr>
<td>Eastern Samar</td>
<td>96.3</td>
<td>16.9</td>
<td>98.7</td>
<td>17.5</td>
</tr>
<tr>
<td>Ifugao</td>
<td>86.8</td>
<td>8.1</td>
<td>94.2</td>
<td>25.2</td>
</tr>
<tr>
<td>Lanao del Sur</td>
<td>72.1</td>
<td>4.8</td>
<td>76.1</td>
<td>13.0</td>
</tr>
<tr>
<td>Maguindanao</td>
<td>63.3</td>
<td>13.2</td>
<td>77.3</td>
<td>14.8</td>
</tr>
<tr>
<td>Masbate</td>
<td>92.7</td>
<td>11.2</td>
<td>85.9</td>
<td>16.0</td>
</tr>
<tr>
<td>Mt. Province</td>
<td>83.8</td>
<td>18.7</td>
<td>94.2</td>
<td>24.5</td>
</tr>
<tr>
<td>Sultan Kudarat</td>
<td>80.1</td>
<td>12.4</td>
<td>70.3</td>
<td>10.6</td>
</tr>
<tr>
<td>Sulu</td>
<td>32.3</td>
<td>1.7</td>
<td>54.2</td>
<td>12.4</td>
</tr>
<tr>
<td>Tawi-tawi</td>
<td>65.4</td>
<td>2.5</td>
<td>53.4</td>
<td>1.9</td>
</tr>
<tr>
<td>Olongapo City</td>
<td>----</td>
<td>----</td>
<td>97.1</td>
<td>25.9</td>
</tr>
</tbody>
</table>

Source: UPPI-DRDF 2010

intervention programs for the prevention and control of the infection especially among the MARPs. It is encouraging that most people from the pilot municipalities have heard of HIV and AIDS but few have a good understanding of the nature of the infection especially its transmission routes and prevention. Because the prevalence of the disease is rising rapidly especially among the MARPs, there is a need to develop a more strategic approach for a concerted action to halt the spread of HIV.
UNFPA’s Humanitarian Response Strategy for RH and SGBV

7.5.1 Akin to a number of countries located within the Pacific “ring of fire”, the Philippine archipelago is beset with several natural disasters to include an annual average of 20 typhoons, volcanic eruptions, earthquakes, landslides, floods, and tsunamis. The country also suffers from frequent human-made catastrophes particularly urban fire and accidents occurring on land, sea and air.

7.5.2 Aside from perennial environmental calamities and disasters, Mindanao, the country’s second largest island grouping which comprises six regions, has had a long history of internal armed conflict because of the presence of Filipino Muslim separatist groups, terrorists, bandits, and private armies particularly in the Autonomous Region of Muslim Mindanao (ARMM). Family feuds and election-related violence frequently occur in this social setting. The ARMM has a population of around three million Filipino Muslims who reside in six provinces particularly Basilan, Sulu, Tawi-tawi, Lanao del Sur, Maguindanao, and Shariff Kabunsuan.

7.5.3 The termination of the Memorandum of Agreement on Ancestral Domain in August 2008, intensified the enmity between the state and the separatist group Moro Islamic Liberation Front (MILF) displacing several thousand people in the contiguous provinces of Central Mindanao particularly in two ARMM provinces, i.e., Lanao del Sur and Maguindanao and in the neighbouring provinces of Lanao del Norte, North and South Cotabato, and Sultan Kudarat. The internally-displaced populations (IDP) are housed in evacuation centers and are struggling to survive with some support from the state and from agencies that are providing complex humanitarian emergency assistance.

7.5.4 Thirty two years ago, the Philippine government through Presidential Decree No. 1566 established a National Disaster Coordinating Council (NDCC) to respond to recurring environmental calamities. The NDCC is a policy making and coordinating body which is responsible for disaster management in the country. It has installed a nationwide system of disaster coordinating councils. It advises the President of the Republic about natural disasters and when a state of calamity should be declared in devastated areas. The Secretary of Defense chairs the NDCC and all department secretaries are members. It is coordinated by the Office of Civil Defense (OCD).

7.5.5 The passage on May 10, 2010 of the Philippine Disaster Risk Reduction and Management Act of 2010 (RA 101211) replaced the NDCC with the National Disaster Risk Reduction Program (NDRRP). Its Implementing Rules and Regulations (IRR) have recently been approved.

7.5.6 To respond to emergencies, UN heads of agencies created a country level Inter-Agency Standing Committee (IASC) comprising of UN and NGO/INGO members. Recently renamed as the Humanitarian Country Team (HCT), its membership has now included the donor community. For better coordination and distribution of responsibilities as well as accountability, the HCT formed 11 clusters or sections with corresponding UN and government lead agencies per cluster. WHO leads the health cluster while UNFPA is deputy cluster lead for reproductive health. DOH is the partner lead government agency. Recently created and led by UNHCR, the Protection cluster has two sub-clusters: the child protection

51 UNFPA’s assistance for Humanitarian Issues is also discussed in paragraphs 12.8-12.15.
UNFPA’s response measures

7.5.7 UNFPA’s main strategy for its humanitarian response to disasters and armed conflict is the implementation of the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH). Its goal is to “reduce mortality, morbidity, and disability in crisis-affected populations” and the specific objectives are to: 1/ facilitate coordination and implementation, 2/ prevent and manage sexual violence, 3/ reduce maternal and neonatal mortality and morbidity, 4/ reduce unplanned and unwanted pregnancies, especially among young girls, 5/ reduce STI/HIV/AIDS transmission, and 6/ plan for comprehensive RH services.

7.5.8 In Central Mindanao, however, the MISP is reportedly insufficient. Comprehensive RH services must be provided at the evacuation camps amidst ongoing armed conflict. The primary target beneficiaries are the IDP particularly pregnant women, mothers, adolescents, neonates and men displaced by natural calamities and armed conflict. The secondary target beneficiaries are health emergency and SRH coordinators from DOH, DSWC, social workers, IDP team members, other humanitarian workers in government and NGOs.

Accomplishments

7.5.9 UNFPA’s involvement in humanitarian emergencies started when it partnered with regional and provincial health offices in providing RH and hygiene kits and generators in Bicol after a strong typhoon in December 2006. After two super typhoons in 2009, this progressed to deploying NGOs which conducted medical missions by providing information, prenatal and post-natal check-ups, psycho-social and FP counseling, and distribution of medicine particularly ferrous sulfate to IDPs.

7.5.10 In Mindanao, UNFPA initially provided RH and hygiene kits through the provincial health offices. Support is now provided through the mobilization of IDP teams in major evacuation enters and these groups are responsible for collecting data, reporting health emergencies and SGBV violence, holding IEC sessions about RH and rights, and the deployment of a mobile hospital and laboratory which is managed by a team of doctor, midwife, and laboratory technician. To expand coverage, UNFPA has partnered with two international NGOs, *Medecins sans Frontieres* and Save the Children, by providing them with RH and hygiene kits for evacuees outside UNFPA’s areas.

Issues

7.5.11 The Country Office’s three-year experience in responding to Mindanao’s internal armed conflict, natural calamities and disasters, has contributed to formulating UNFPA’s Humanitarian Response (HR) strategy to these adversities. Despite this accomplishment, the HR has an ad hoc status and no regular funds are allocated to its activities. Its support is drawn from multi-bi contributions and the total funding of US$1,822,389 was obtained from two major donors: the Central Emergency Respond Fund (CERF) of OCHA and the Government of Spain through AECID. Because of its ad hoc status, the HR personnel are contracted staff. The current HR Field Coordinator and UNV are given only six month appointments and their salaries are provided by the foregoing donors.
7.5.12 Because natural calamities and disasters and internal armed conflict will no doubt continue to displace many poor and marginalized populations especially pregnant women, neonates, and adolescents, UNFPA’s HR should be integrated into the regular program in the next CP. Among the UN agencies of the HCT, UNFPA is the only one that is partnering with DOH in attending to the IDP’s RH and SGBV needs. This is a role that should be institutionalized in the CO. A HR program plan has been designed and this should be considered for the next CP.

8 Review of Implementation of the Gender & Culture Component of the Country Programme

8.1 Despite worldwide recognition that Filipino women hold higher social status than many women in the developing world, a considerable proportion especially from rural and urban poor communities continue to experience gender discrimination and abuse because of varying social and cultural norms, beliefs and practices. As a consequence, many disadvantaged women continue to suffer from poor sexual and reproductive health and this is reflected in their high fertility, morbidity and mortality rates, unmet need for modern FP methods, low access to skilled health professionals, and high intimate partner and other types of violence.

8.2 The Gender & Culture component of the Sixth CP deliberately focused its strategic action on gender-based violence (GBV) particularly violence against women (VAW) because of the recognition that this reproductive health element affects several RH elements in all phases of the life span. Globally and nationally, VAW has been acknowledged as a serious social and public health problem that should be addressed by governments, the private sector, the donor community, and civil society. The 1994 ICPD, the 1995 Beijing Women’s conference and CEDAW have asserted the need to strategically combat VAW with a human rights framework to hasten women’s empowerment and gender equality. In the past two decades, national legislations have been formulated for the protection of women from all forms of violence within and outside their homes. The inclusion of children particularly the girl child in these laws is a recognition that this powerless population segment must be part of the strategic programming to combat VAW.

8.3 The Gender and Culture component of the Sixth CP aims to “contribute to strengthening of institutional mechanisms and socio-cultural practices to promote and protect the rights of women and girls and advance gender equity and equality.” It is directly associated with the attainment of MDG 3 (Promote Gender Equality and Empower Women) and MDG 5 (Improve Maternal Health). To attain the Gender & Culture component’s goal, the UNFPA partnered with the Philippine Commission on Women (PCW), the Department of Social Welfare (DSWD), and the local social welfare offices in 10 pilot provinces and 30 pilot municipalities. They developed outcomes and output indicators that they could realistically attain from 2005 to 2009. Different strategies were utilized to address VAWC, to mainstream gender, and to change the socio-cultural beliefs and practices that impede gender equity and equality.

Accomplishments

8.4 UNFPA’s partners reported that they have completed almost all their deliverables for the Sixth CP. They believe that what they have established in the pilot sites are and will
continue to be relevant because of the continued violence against women and children. The findings of the UPPI-DRDF 2010 end line survey and the 2008 National Demographic & Health Survey showed that a considerable proportion of women have experienced physical and other types of violence from their intimate partners and other perpetrators.

Measures to address GBV

8.5 The measures to address GBV include the creation of supportive structures, tools and materials, capacity building, documentation, advocacy and networking.

8.6 Creation of supportive structures. The major structures established by the Gender & Culture partners are the Inter-Agency Committees on Anti-Trafficking and Violence against Women and Children (IACAT-VAWC) at different levels of governance (regional, provincial, municipal and even at the barangay or village level) and the b/ gender intervention crisis centres in the pilot sites.

8.7 The members of the IACAT-VAWC are social workers, health providers, local government officials, and law enforcers particularly the police and legal officers. These inter-agency committees are responsible for developing strategic plans and in monitoring trafficked and VAWC cases. There are four regional and three provincial inter-agency councils that have approved strategic plans and budgets.

8.8 The IACAT-VAWC members have participated in various capacity-building activities to include a/ orientation about Republic Act (RA) 9262 (Anti-Domestic Violence Law) and RA 9028 (Anti-Trafficking Law) and other related VAW laws and in b/ the use of various tools for service provision, reporting, referral, and documentation. The committees reportedly meet on designated schedules and are communicating regularly about GBV cases. If the designated focal person or social worker could not convene the regular meeting, the members are consulted individually about GBV cases.

8.9 Eight pilot provinces have functioning Gender and Development (GAD) crisis intervention centres in the pilot municipalities. All three Lanao municipalities and Sulu province, however, have semi-functioning centres while two Maguindanao municipalities (S. Aguak and Ampatuan) and a Sultan Kudarat municipal crisis centres are reportedly not operating. Efforts are being exerted to make these facilities functional (Source: SPO reports). This issue is further discussed in para 8.35.

8.10 UNFPA’s support for the establishment of the GAD crisis intervention centres include basic equipment (e.g., beds, tables, chairs), information and training manuals, and training for service providers. The local government units’ counterpart support are the facilities’ human resources and the infrastructure which serves as the survivors’ temporary shelters. A provincial or municipal social worker usually manages these crisis centres. Except for the ARMM, the social workers and other service providers’ compensation is covered by the LGU. Some municipal crisis centres are currently under construction or undergoing renovation but they continue to function even if their facilities are in this condition.

8.11 Bohol, for example, has a provincial crisis intervention centre (the BCIC) in the capital city. The three pilot municipalities’ crisis centres serve as its satellite facilities which attend to VAW survivors in their respective areas. The social workers and their partners...
provide the necessary assistance at their levels (such as health care, police and village protection, temporary shelter, food) but if the survivors would need rehabilitation and long-term assistance (e.g., legal aid for their cases) they are brought to the BCIC. The survivors at BCIC are also provided with orientation about women’s rights, reproductive health, and the legal process (they are encouraged not to withdraw their cases) and other life skills including alternative informal education and scholarships to study in local public schools. The BCIC social workers collaborate with the provincial social welfare and development office, health department (which provides health services, psychological assessment and counselling), the police and government prosecutors in attending to the survivors’ needs. It also receives some support from other donor institutions and individuals (e.g., scholarships). It, however, sees the need for a resident psychologist who can provide rehabilitation support to highly-traumatized survivors.

8.12. Similar VAW centers are also present in the province of Masbate. Its Women and Child Protection Unit and VAW one-stop centers at the pilot municipalities were established with strong support from the LGUs and from the multi-sectoral members from the government, the NGO/CSOs, and the communities. An important achievement of Masbate is its centralized database reporting system for VAW cases that is implemented in 21 municipalities. As a result, there was an increase in the number of reported VAW cases and the number of survivors who utilized the WCPU and VAW centers increased. (Compendium of Good Practices on RH, UNFPA July 2010).

8.13 Development of training tools. Eleven manuals or modules were developed by the different partners to enhance the capacity of the social workers and other service providers in the pilot sites. The social workers who were interviewed in selected pilot sites noted that the “apex” of these training tools is the manual on Gender-responsive Case Management. This tool has provided the social workers with vital information and mechanisms to manage women and child survivors in their facilities. The DSWD, the national agency that authored this manual, is currently preparing a compendium of good practices that are written by social workers from different crisis centers for publication in 2011.

8.14 Aside from the foregoing manuals, the Gender & Culture partners developed a set of performance standards and assessment tools for services addressed violence against women (VAW) in the Philippines. These tools were intended for the following partner agencies: a/ DSWD: Psycho-social services; b/ DOH: Medical and hospital-based services; c/ PNP: Investigatory procedures; d/ DOJ: Legal and prosecution services; and e/ DILG-LGU: Anti-VAW services at the barangay (village), municipal, city and provincial levels. International and national legal mandates and commitments guided the development of these protocols alongside evidence from scientific studies and consultations with various partners. The performance standards and assessment tools have received international recognition as good practices in managing GBV survivors.

8.15 Capacity building. Several training activities were conducted for the social workers and other service providers with the use of various manuals and tools. These capacity-building activities include gender sensitization, service provision, referral system, performance standards and assessment, advocacy and networking, and the management of perpetrators. The training activities conducted for social workers from pilot communities

52 Masbate is one of the pilot provinces of the National VAW Documentation System under the Joint Multi-Stakeholder Programme to Eliminate VAW in the Philippines.
53 UNFPA Compendium of Good Practices on RH, July 2010
appeared to have multiplier effects. Some social workers from pilot areas in Maguindanao and from Bohol, for example, said that non-UNFPA municipal social workers often participated in their training activities because they believed that these capacity-building activities could enhance their skills in managing VAWC cases. Their expenses were reportedly covered by their LGU or by DSWD. Two non-UNFPA municipalities in Bohol have established their own crisis intervention centres after they participated in the pilot sites’ training activities.

8.16 Referral system. Guidelines for the creation and management of a referral system on anti-trafficking and VAWC at the LGU level were developed to ensure that a functional and harmonized referral system is in place in the pilot areas. Seven pilot sites have established their own referral and reporting system. Non-pilot municipalities in Masbate are reportedly utilizing the referral system in their respective areas.

8.17 Harmonized documentation of VAW cases. Under the Joint Multi-Stakeholder Programme to Eliminate Violence Against Women (VAW) in the Philippines, the Philippine Commission on Women in coordination with the Inter-Agency Council on Violence Against Women (IAC-VAWC) developed the National VAW Documentation System. It is a secure web-based system that facilitates and integrates the collection of standardized data on violence against women from concerned government agencies, local government units and other service providers handling VAW cases. It has the ability to remove double counting of data and track the survivors. The harmonization was initially pilot tested in the province of Bohol, Olongapo City, and the National Capital Region (NCR) 54. The pilot testing was expanded to seven additional areas with the counterpart funds of PCW and support from the Agencia Española de Cooperacion Internacional para el Desarrollo (AECID).

8.18 In a visit by one of the Evaluation Team to the Bohol Crisis Intervention Centre, the social workers informed the evaluator that they have compiled and reconciled the data of GBV cases from various sources and they were waiting for the software from PCW to enable them to encode the information. They said that they would use the findings not only for harmonization but also for planning and the expansion of satellite crisis centres in municipalities with high GBV cases.

8.19 Advocacy and networking. Awareness and prevention of trafficking and VAW have been raised as a result of a number of advocacy and networking activities in the pilot sites. These activities usually take place during women’s month (March), and the 18-day campaign to end VAW. Youth advocacy teams, women, men and multi-sector gender advocates are mobilized to conduct awareness-raising campaigns such as parades, radio programs, distribution of VAW flyers, seminars, and training activities. The new NGO called Men Opposed to Violence Against Women Everywhere (MOVE) which was initiated by PCW is actively raising nationwide awareness and support to combat VAW. It has volunteers from Congress, national government agencies, the academe, and from civil society. It has also established chapters in the pilot sites and in institutions of higher learning. It also networks with other all-male groups that are engaged in advocacy to combat VAW.

Gender mainstreaming

54 Specifically, the Philippine National Police, Women’s Crisis Center and HAVEN.
Gender mainstreaming accomplishments include the passage of local GAD Codes or ordinances, the development of training manuals for the other Sixth CP components, and capacity building. Based on PCW’s December 2009 report to the NPMC, most provinces and municipalities have passed GAD Codes to promote women’s rights and empowerment, gender-responsive development, and gender equality. The municipalities and provinces with GAD Codes are: Ifugao, Mt. Province, Olongapo, Masbate, E. Samar, Bohol, Sultan Kudarat and Maguindanao. Those with pending provincial GAD codes are the municipalities and provinces of Lanao del Sur, Sulu and Tawi-Tawi. UNFPA’s multi-sectoral partners in the pilot provinces provided the impetus and sustained advocacy which resulted in the passage of these local ordinances.

Bohol’s GAD Code, for example, includes a preamble of principles, policies, the legal bases, and a definition of terms and acronyms. It also covers provisions on VAW, reproductive health, the role of women in governance, labour and employment, environment & natural resources, education, media and arts, trade, industry & tourism, regulations, GAD office & resource centre, provisions for implementation, transitory provisions (convening the GAD Council and funding), and final clauses.

A number of pilot provinces were able to access some GAD funds from their LGU (5% of a government agency’s budget as mandated by law is allocated for GAD). This indicates that some local partners are competent in preparing GAD plans and budgets and in advocating for support from their LGU. The GAD amounts obtained varied, ranging from 100,000 to 27.2 million pesos in 2008. Bohol, reported the largest GAD funds (P 27.2 million pesos in 2008) obtained from its provincial budget (Source: PCW and DSWD progress report January to June 2009). It is noted, however, that many pilot provinces’ GAD funds are either underutilized or unspent.

To integrate gender in reproductive health, the PCW and DOH collaborated in preparing the manual entitled Gender-responsive and Rights-based Integrated Reproductive Health Service Delivery which was used to develop the capacity of regional health trainers. The DOH key informants, however, said that after the regional trainers’ training, they did not know how this tool was used in the pilot sites. It was reportedly utilized in training ARMM RHU providers but not in other sites. It is worthwhile to mention that the DOH personnel have had training on gender from PCW and it is currently mainstreaming gender planning and budgeting in the preparation of its 2011 operational plans. Some difficulties, however, were expressed about what activities would be most appropriate to obtain GAD funds from the health department, especially for the finance and administrative units.

The PCW also collaborated with the Commission on Population (PopCom) in writing the Gender-responsive Population and Development Guide. This was used to build the capacity of trainers from DILG. According to PopCom, the process of preparing this manual has served as an impetus to seriously pursue its institutional gender mainstreaming activities. It has conducted a gender-KAP survey of its national and regional personnel, and did an institutional gender analysis with the help of external resource persons. It has also begun building the skills of its personnel in gender planning and budgeting for the appropriate utilization of its GAD budget to promote gender equity and equality within its institution and its target beneficiaries. PopCom is planning to assess its training tools on pre-marriage counselling, ARH, and responsible parenthood to determine how gender sensitive these manuals are.
From 2005 to 2007, two NGOs were tapped to provide support in mainstreaming gender in RH & Rights. The Reproductive Rights Resource Group (3RG) partnered with UNFPA in designing the sexual and reproductive rights framework. This framework covered 13 reproductive rights including the right to development. It has served as a valuable guide in developing appropriate training tools for seminars involving Muslim Religious Leaders and women groups in Mindanao. Towards the last six months of their contract, 3RG was asked to do the same activities with CAR’s indigenous people but their engagement was limited to discussions about RHR and gender.

EnGendeRights, on the other hand, developed the Feminist Paralegal Training Course. With its partners in health and legal professions, this NGO conducted a series of workshops for service providers and law enforcers in the pilot sites.

UNFPA in partnership with other UN Agencies in a UN Joint Programme to Facilitate the Implementation of the CEDAW, has pursued a legislative agenda on women’s rights through the Magna Carta of Women bill. This legislation was signed on August 14, 2009 with the intention to “respect, protect, fulfil and promote all human rights and fundamental freedoms of women particularly the poor and marginalized.” It also includes provisions for “comprehensive, culture-sensitive, and gender-responsive health services and programs” in all stages of the woman’s life span, including reproductive health. UNFPA supported two regional consultations and a public awareness campaign for the preparation of the Magna Carta’s implementing rules and guidelines (IRR). The MCW-IRR was launched on 8 July 2010. Support in tracking the implementation of this legislation should be pursued in the future.

Strategies used to address social and cultural practices

To address social and cultural practices that tolerate VAW especially in the ARMM, the PCW in partnership with UNFPA Project Management Unit in the Commission on Population (POPCOM), Regional Sub-Committee on Gender and Development (RSCGAD) and other stakeholders particularly women groups and Muslim Religious Leaders, are in the process of developing the ARMM GAD code. An important provision of the GAD code is discouraging child marriages. Changing this norm has important implications on reproductive health particularly the delay of first pregnancy and childbirth and ultimately, a reduction in maternal mortality.

To reduce discriminatory provisions in the Code of Muslim Personal Laws (CMPL), UNFPA’s Southern Philippines Office coordinated with the Tarbilang Foundation, an ARMM-based NGO, in partnering with Muslim Religious Leaders (MRL) of the Assembly of the Darul Ifta (House of Islamic Opinions). The MRL formulated 15 gender and RH Khutba (Islamic sermon) with funding from the Agencia Espanola Cooperacion Internacional para el Desarrollo (AECID). The dissemination of the Khutba was designed to “clarify contentious perceptions on the rights and roles of Muslim women in marriage, family, property, governance, legal, and institutional concerns.” Their development was part of the on-going gender advocacy in the ARMM and compliance to the CEDAW’s recommendation to strengthen the partnership with Muslim communities to remove CMPL discriminatory provisions and to address women’s need for health and other basic services. The 15 Khutba were pretested in selected mosques and the results were used to improve the materials (by adding related hadiths, a tradition of Prophet Muhammad) and to plan for the training of the MRLs on how to use these materials. The core messages of the Khutba were
illustrated in posters to facilitate the dissemination and understanding of the messages. They were translated from English to five Moro languages in partnership with MRL consultants, the academe and other Islamic scholars. Female MRLs were given initial training on the delivery of Nasihat or the informal Khutba or Islamic sermon conducted during community meetings. The MRL who read the khutba and their followers reportedly found the messages valuable in changing the followers’ perceptions and behaviour concerning gender and RH.55

8.30 A network of faith-based organizations (FBO) on population and development issues in humanitarian areas was created through the coordination of the Philippine Centre for Population and Development to encourage FBO to work together on gender equity and reproductive health.

Facilitating factors

8.31 The foregoing accomplishments can be attributed to a number of social and political factors, namely: (a) the presence of numerous international agreements, national laws, and local policies which provided legal mandates in designing the training manuals and protocols; (b) the numerous gender resource persons who are willing to assist local partners; (c) supportive gender and RH champions from national government agencies, local government units, the civil society, the private sector and local communities; (d) service providers who continually update their knowledge and skills in managing VAW cases and are committed to apply what they have learned in their VAW facilities; (e) the cooperation among members of inter-agency committees on anti-trafficking and VAW; (f) the ability of some pilot sites to mainstream gender and culture into RH and PDS strategic plans and activities; and (g) dynamic multi-sector advocacy teams that raise awareness and support to combat GBV (PCW report January to June 2009).

8.32 Effects of the G & C component on the pilot areas. To determine whether or not the various strategies used by the component of G & C might have some effects on the perceptions and lived experiences about VAW among the women and men from the pilot municipalities, the responses to two questions from the 2006 baseline and 2010 end-line surveys were examined.

8.33 These questions were: a/ Whether or not it was justified to inflict physical violence if the wife refuses to have sex with the husband, and b/ whether or not the respondent experienced any physical violence in the past 12 months.

8.34 Table 7.6.1 shows that the proportion of respondents, both females and males, who approved of husbands inflicting harm on the wife if she would refuse to have sex with him. The findings indicate a declining trend of approval to this question between the 2006 and 2010 surveys. It is interesting to note that about a quarter (23%) of the male respondents and close to two fifths (37.7%) of the female respondents agreed with this query during the 2006 baseline study. In the 2010 end-line survey, the agreement among the male respondents declined to 16.6 per cent. Only over one tenth (12.8%) of the female respondents agreed with this question during the end-line survey. Could these changes be attributed to the GBV

55 UNFPA Compendium of Good Practices in RH, July 2010
advocacy by the multi-sectoral committees, community-based RH teams, NGOs and other stakeholders?

8.35 It is interesting to note that the other two ARMM provinces, particularly Maguindanao and Sulu, had considerable proportions of women and men agreeing to this question in 2006. But in 2010, the proportion of respondents who agreed to this question dropped considerably. Tawi-tawi appeared to be different from the other ARMM provinces because the men and women who agreed with this question in 2006 were few and were further reduced during the 2010 survey.

8.36 Because men were asked the question concerning physical violence experienced in the past 12 months in both surveys, the pattern of their responses could be compared. In 2006, one fifth of the male respondents from Ifugao municipalities admitted that they had experienced physical violence. The proportion declined by one half during the 2010 survey. Over one tenth of the municipalities of the Lanao del Sur and Sultan Kudarat male respondents also agreed with the statement in 2006 but the proportions declined in the 2010 study. It is interesting to note that in 2006, the municipalities of Sulu and Mt. Province had few men who admitted to having experienced violence. However, in 2010 the proportions increased (the municipalities of Sulu from 1.6 to 17.9%; Mt. Province from 4.0 to 15.3%). Over one fifth (22.2%) of Olongapo’s male respondents in 2010 admitted that they did experience violence but it had no baseline data for comparison. It is not, however, clear whether the physical violence inflicted upon these men emanated from their wives/partners or from other people or relatives.

8.37 The female respondents were asked this question only in 2010. More female than the male respondents admitted to having experienced physical violence in the past 12 months. Close to two fifths (37%) of the Olongapo women disclosed that violence was inflicted on them in the past year. This was followed by one fifth of the female respondents in the municipalities of Maguindanao. Less than one fifth of the women from the municipalities of

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Table 7.6.1. Respondents who agreed with the question that the partner/husband is justified to inflict physical violence if wife refuses to have sex, from municipalities of 6th CP pilot provinces, 2006 Baseline and 2010 End-line survey

Source: UPPI-DRDF 2010-11-3
Mabate, Bohol, and Eastern Samar gave positive answers to this question. Tawi-Tawi and Sulu had the lowest proportions of females from the pilot municipalities who reported that they experienced physical harm in the past 12 months.

8.38 The G & C component’s action plan was implemented as designed in the Sixth CP. It was perceived as relevant by the national and local partners because it established the necessary measures (i.e., interagency committees, crisis centers, training tools and standards, policies, advocacy and networking) to enhance the capacity of duty bearers (social workers, health providers, the police, prosecutors, and local government units) to respond with greater sensitivity to the needs of abused women and children in the pilot areas. The end line survey and the 2008 NDHS demonstrated that a considerable proportion of women have experienced varying types of violence from intimate partner and other male perpetrators. This implies

Table 7.6.2. Respondents who experienced physical violence in the past 12 months, from municipalities of 6th CP pilot provinces, 2006 Baseline and 2010 End-line survey

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<th>Females</th>
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<td>2010 n=15,136</td>
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Source: UPPI-DRDF 2010

that the structures and mechanisms that were installed in the pilot sites are vital to the continued prevention of VAW and in attending to the survivors’ needs. The lessons obtained from the implementation of these GBV measures could provide useful models for other provinces to enable their duty bearers to respond to GBV cases in their respective locale.

8.39 Although G & C had the smallest budget among the three Sixth CP components, the funds were utilized efficiently to produce the planned outputs. Cost-sharing schemes with the LGU to establish gender crisis intervention centres, partnering with other UN agencies (e.g. advocacy for the passage of the Magna Carta of Women, the UN Joint Program to Facilitate the Implementation of the CEDAW Concluding Comments), and with the other program components’ training and advocacy activities (especially in fully-integrated pilot areas), and obtaining support from local donors (e.g. scholarships for sexually abused female children and adolescents, training on crafts and livelihood in the Bohol province) were examples of how the G & C maximizes the use of its small allotment. There were, however, some difficulties in obtaining funds on time especially in an ARMM province because all three Sixth CP components’ funds are held by the IPHO’s office. The social worker believed that it would be sufficient if the G & C funds assigned to her institution are deposited to the provincial social welfare office for quick release and use. This scheme was done for funds received by DSWD from other donors, e.g., UNICEF.
8.40 The G & C partners perceived that the measures that have been initiated in the pilot sites were effective because these enhanced the knowledge and ability of the service providers (the supply side) to provide more gender-responsive support to their clients. There is also a growing demand, albeit slowly, among abused women and children for services extended by crisis intervention centers. It has also led to greater involvement of men in raising awareness about VAW through MOVE and the MRL’s development of several khutba which promote gender equality, RH and rights, among others. Social workers from non-UNFPA municipalities are also participating in several training activities for the pilot service providers and are reportedly apply what they learned in their work. Some have even pushed for the establishment GAD crisis intervention centers in their communities and utilized the referral system of the pilot sites.

8.41 The GAD codes which were developed in partnership with many committed local gender and RH champions and advocates from the public sector and civil society—have potentials in sustaining the measures that were installed in the pilot areas. Through gender planning and budgeting, stakeholders could advocate for recurrent GAD budgets from their respective provinces and municipalities. Some pilot provinces have already successfully demonstrated that they are able to tap the provincial governments’ GAD funds for their G & C activities. To further sustain the facilities, the inter-agency committees and the crisis centers could mobilize trained community volunteers (e.g. students of social work and psychology) to assist the service providers.

Issues

A number of issues, however, surfaced during the implementation of the Gender and Culture component and these are as follows.

8.42 Inadequate integration of Gender & Culture in RH and PDS. Operationally, it is noted that the integration of Gender and Culture strategies and activities into the other components of the Sixth CP at the national level and in a number of pilot sites is not adequate. Few teams from pilot provinces (Bohol, Ifugao and Masbate) have fully mainstreamed Gender and Culture into the two components. A key informant mentioned that at the national level the strategic actions of the three components were designed separately and there was no consultation about where and how the partners could collaborate or share resources. During the regular reporting of accomplishments, each component’s major partners simply presented their reports without any discussion about integration.

8.43 In many pilot communities, it was noted that the three components also operated in silo. RH would pursue its program of activities and no collaboration often took place with G & C and PDS. In some pilot areas like Bohol, the project team reportedly struggled for two years before they saw areas for integration in the three components. At present, the Bohol team thinks that they are fully integrated because the focal persons of the three components often carry out their strategic planning and implementation together. They even share financial and human resources in activities where two or three components interact.

8.44 Need for continued monitoring and evaluation of VAW structures and tools. The inter-agency councils, the GAD crisis intervention centres, and the numerous valuable training manuals and tools including the performance standards that were applied by pilot provinces and municipalities should be systematically monitored to ensure compliance, quality assurance and sustainability. In an interview with a PNP female officer, it was
learned that she has no space in the police station for survivors. She has a women’s desk but this is simply a desk and all conversations during investigation could be heard within and outside the station. So she often took survivors to the municipal crisis intervention centre to assure the clients of privacy and confidentiality. The social worker in one municipality complained about her work load and the absence of a computer in her office to facilitate the encoding of confidential GBV data.

8.45 GAD crisis intervention centres’ uptake and number of trafficked and VAW cases filed are low especially in ARMM and CAR. In the years that the GAD crisis intervention centres have been operating, it appears that few VAW survivors have utilized the facilities (often less than 50 cases in one year). Fewer still are cases that are filed against perpetrators because of family pressure, poverty, and to the culture of silence and preference to utilize customary laws and practices in resolving VAW cases by Muslims and CAR indigenous peoples (IPs). These practices may not always consider gender equity and equality.

8.46 Capacity mapping of trained social workers. Because of the number of training activities and social workers (from UNFPA and non-UNFPA sites) who reportedly joined the capacity-building activities, there is a need to determine the number of social workers who have received training versus the total number of social workers in the various sites. This will help to better plan the capacity-building activities of these front line service providers for future programming.

8.47 The need to involve female MRL and Muslim women NGOs. The involvement of male MRL in the preparation and reading of the khutba is laudable to effect some changes in the mindset of Muslims about gender and RH; it is also reinforcing male dominance in this social setting. Few women religious leaders are reportedly trained to deliver the Nasihat or the informal khutba during community meetings, there is a need to tap more female MRL and Muslim women NGOs so that they could engage more women groups in discussing gender, RH and Rights in their communities.

8.48 How to hasten the passage of the ARMM GAD Code and revision of the Code of Muslim Personal Laws (CMPL) and repeal discriminatory provisions to effect some changes on women’s empowerment and rights especially raising the female’s age of marriage, i.e., discouraging child marriage because of its direct association to maternal health and survival.

8.49 Uneven capacity of provincial and municipal partners to undertake gender analysis and to prepare appropriate GAD plans and budgets. Although GAD codes have been passed in a number of municipalities and provinces, underutilization or unspent GAD funds was noted. This was attributed to limited skills of local partners to undertake GAD analysis and to prepare GAD plans and budgets and advocacy to obtain LGU support.

8.50 The need to review various local GAD, RH and health codes to determine how these ordinances complement one another. The presence of GAD codes, RH codes, and health codes in several provinces and municipalities is laudable but there is a need to determine how these various ordinances actually complement each other— since they are all concerned about gender equity and equality, reproductive health and rights especially among poor and marginalized women and their families.

8.51 Support to institutionalize MOVE. Men Opposed to Violence Against Women Everywhere (MOVE), this newly-registered NGO that raises awareness among men and boys
to combat VAW, relies mainly on volunteers from government and non-government organizations to carry out its mandate. These volunteers are influential because they are affiliated with Congress, the military, the police, national government agencies, the health sector, the academe, local government units, and youth groups. But their loose organizational structure might not sustain the noble intentions of the recruited volunteers in this entity.

8.52 Local (provincial) research/academic institutions hardly tapped for G & C research during program implementation. Although baseline and end line surveys are undertaken with the assistance of state university research institutions to determine demographic, reproductive health, and social changes in the pilot sites of the Sixth CP. It is noted that process documentation and operations research during program implementation to provide a better explanation of program effects on the targeted communities are hardly conducted. Provincial academic and research institutions in the pilot sites are not harnessed to undertake such studies.

9 Review of Implementation of the Sixth Country Programme in Mindanao

9.1 The evaluation of UNFPA sixth country programme in Mindanao focuses at the activities undertaken; the accomplishments or gains obtained; the challenges in the implementation and management; and discussion of implications of results.

9.2 The initial coverage of the Mindanao programme is 5 out of 10 pilot provinces, namely: Lanao del Sur, Maguindanao, Sulu, Tawi-Tawi, and Sultan Kudarat. The first four belong to the Autonomous Region of Muslim Mindanao (ARMM), the last is a part of Region 12. Surigao del Norte being a recent addition (the programme implementation started in 2009) was excluded in this evaluation.

9.3 In each pilot province, three municipalities were chosen on the basis of established criteria (cf. Country Programme Action Plan, 2005). Three thematic components: reproductive health, population and development strategies, and gender and culture, define the thrust and foci of the UNFPA programme. In its life span, from 2005-2009, activities, and outputs as well as measures that pinpoint to the realization of outcomes revolve around the three thematic components. In 2009 however, humanitarian response become an integral part of the programme.

The Mindanao Situation

9.4 To provide context-specific background, a brief description of Mindanao situation is necessary. To begin with, Mindanao is a land of contrast, of bounty and of poverty. Although rich in natural resources—its fauna and flora—the exploitative and exhaustive use of its resources has widened the gap between the affluent and the poor.

9.5 The cultural heritage of the various ethnic groups weave an interesting cultural mosaic, providing strands of commonality and diversity, resulting to pluralistic communities that are supposed to gain from each other in strength and in so doing diminish individual weaknesses. Today, Mindanao is mired in poverty. Most of its six regions rank low in the hierarchy of human development indexes and high on poverty incidence. The World Bank report indicated heavy health needs of Mindanao people. Reliance is on services of primary health facilities in the barangay level and extensive utilization of traditional healers (World Bank, 2001). The necessary identified improvements were recommended to be in the areas
of facility operational schedules, reduction of waiting time and availability of medicines, supplies, equipments and skilled staff.

9.6 The disadvantaged position of Mindanao is glaringly evident in income, education, health, and other services. This is exacerbated by conflict situation and natural disasters. The former can be differentiated into 4 types: political/ideological, land conflict, ethno-religious and clan feuds (rido). In the beginning of the 20th decade, large number of households in Lanao del Sur, Lanao del Norte and Basilan were affected by a conflict situation (Cabaran, 2006). In all of these disaster events which happened in the recent years, it is the communities under the ARMM that were greatly affected. Displacement of families and creation of makeshift evacuation centres become common occurrence in war torn communities.

9.7 In August of 2008, escalation in the armed conflict brought about by breakdown in peace negotiation between the Moro Islamic Liberation Front (MILF) and the government caused the displacement of about 365,000 people (Southern Philippine Office report, 2009). The displacements created an emergency situation of which humanitarian response was imperative. Moreover, the displacement of people due to conflict was further exacerbated by occurrence of severe windstorm that inundated low-lying evacuation areas resulting to flood of long duration.

9.8 Studies after studies documented violation of reproductive rights and neglect of reproductive health needs in emergency situations. Children, the elderly, and women suffer the most from armed conflict (UNDP, 2002; National League for Democracy, 2000; Goswami, 1999; Toole and Waldman, 1997). Reproductive health needs for preventive and curative care include services related to safe motherhood, family planning, prevention of unsafe abortion, prevention and treatment of sexually transmitted diseases, and prevention and management of the consequences of sexual violence (Watanuki in Women in Actions, 1999).

9.9 Study of Jamasali (2002) among Tausog women captured reproductive health needs during conflict situation. Impact was pronounced in family planning, pregnancy and childbirth, and pre and postnatal care. In a separate study (Cabaran, 2006), the unmet needs of women from 960 households in sample conflict areas were high: 11.6 percent for family planning, 13.3 percent for pre and postnatal care, and 14.7 percent for birth delivery.

9.10 To further provide reproductive health scenario, selected variables and indicators on reproductive health is presented in Table 9.1. The comparison is between the country performance vis-à-vis the ARMM. The focus on the latter is based on the rationale that 4 out of 5 UNFPA initial pilot provinces are under the ARMM region.

9.11 The figures indicate the disadvantaged position of ARMM in maternal and infant health, more so on family planning. The contraceptive prevalence rate is dismally low in comparison with the country estimate. The data show no improvement in contraceptive use; this is further reflected in the increase of unmet needs for family planning.
Table 9.1: Selected Reproductive Health Indicators by Source of Data

<table>
<thead>
<tr>
<th></th>
<th>Philippines</th>
<th>ARMM</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR</td>
<td>162</td>
<td>264</td>
<td>2006 FHSIS</td>
</tr>
<tr>
<td>NMR</td>
<td>17</td>
<td>18</td>
<td>2003 NDHS</td>
</tr>
<tr>
<td>TFR</td>
<td>3.5</td>
<td>4.2</td>
<td>2003 NDHS</td>
</tr>
<tr>
<td></td>
<td>4.3</td>
<td></td>
<td>2008 NDHS</td>
</tr>
<tr>
<td>CPR: any method</td>
<td>48.9</td>
<td>18.7</td>
<td>2003 NDHS</td>
</tr>
<tr>
<td></td>
<td>50.7</td>
<td>15.1</td>
<td>2008 NDHS</td>
</tr>
<tr>
<td>CPR: modern method</td>
<td>33.4</td>
<td>11.6</td>
<td>2003 NDHS</td>
</tr>
<tr>
<td></td>
<td>34.0</td>
<td>9.9</td>
<td>2008 NDHS</td>
</tr>
<tr>
<td>Unmet Needs for FP</td>
<td>17.3</td>
<td>27.4</td>
<td>2003 NDHS</td>
</tr>
<tr>
<td></td>
<td>22.3</td>
<td>32.7</td>
<td>2008 NDHS</td>
</tr>
<tr>
<td>Birth Delivery at Home</td>
<td>61.4</td>
<td>88.4</td>
<td>2003 NDHS</td>
</tr>
<tr>
<td></td>
<td>55.5</td>
<td>85.1</td>
<td>2008 NDHS</td>
</tr>
<tr>
<td>Hilot Assisted Birth Deliveries</td>
<td>37.1</td>
<td>76.6</td>
<td>2003 NDHS</td>
</tr>
<tr>
<td></td>
<td>36.4</td>
<td>80.3</td>
<td>2008 NDHS</td>
</tr>
</tbody>
</table>

The Strategies and Activities of the Sixth Country Program in Mindanao

9.12 The earlier section details the specific goals of the programme, the outcomes expected from each component, the outputs, strategies and activities. To avoid repetition and redundancy, the description will refrain from describing them, instead summary on what had been done by the programme in each component will be presented.

9.13 The overall strategies are wide ranging; they include capability-building; community organizing, networking, and partnership-building; advocacy, information dissemination; development of local policies and plans; research and monitoring; and humanitarian response. The translation of these strategies into activities produces an array of actions and events which lead to both objective and subjective accomplishments.

9.14 To mention a few under each of the specific strategy, the list below tells of multi-prong approaches which somehow indicate the weaving and intersecting effects to both the demand and supply sides of the programme interventions.

9.15 Capability-Building
- Gender-based Violence trainings of service providers, Muslim religious leaders, and elementary and high school teachers (ARH)
- trainings on BeMONC, STI/HIV and AIDS
- post-traumatic counselling for IDPs

9.16 Community Organizing/Networking and Partnership-Building
- Organization and mobilization of Muslim religious leaders
- Pre-marriage counselling in Islam
- Midwife-Walyan (TBA) – BHW – MRL Partnership in advocacy and delivery of RH Services
- Creation, mobilization and utilization of Mindanao support groups/networks e.g. satisfied FP users, Y-Factor, RH on wheels, FLORH, Rainbow, Gay and Proud
- Formation of advocacy teams (WHT, LATs, MRLs) and provision of support to make it functional

9.17 Advocacy/Information Dissemination
- Radio programs/radio guesting
- Production and dissemination of IEC materials
- Support the popularization of the Khutba

9.18 UNFPA Activities related to Development of Local Policies and Plans
- support and provide assistance to formulation of GAD and RH codes
- support on the CSR

9.19 Humanitarian Response
- Provision of Minimum Initial Services Package (MISP) for sexual and reproductive health during the armed conflict
- Conduct of rapid assessment on affected areas to gauge their immediate needs in RH
- Deployment of RH medical missions including information dissemination
- Distribution of RH and hygiene kits
- Organization and capacity building of IDP teams
- Training of humanitarian workers in MISP
- Administration of psycho-social counselling services

The Accomplishments of the Sixth Country Programme in Mindanao

9.20 Ideally, in an evaluation of a project, the “before” and “after” condition between areas with and without project intervention is examined to show the extent of change. Moreover, the need to weed out rival explanations to the observed change is imperative. Quantitative measures of change are usually presented as evidence that demonstrate the impact of the project. To gain deeper insight on the “why” and the “how” of project implementation, qualitative data are likewise desired.

9.21 The evaluation of the sixth country programme in Mindanao utilized both quantitative and qualitative mode of analysis. The sources of data are the service records from the UNFPA-Southern Philippines Office (SPO) and the 2006 Baseline and 2010 Endline Surveys.

9.22 RH Accomplishments. Four RH indicators reflecting performance of the Sixth Country Programme in project sites are selected. These are: percent of pregnant women who during the last five years completed four (4) antenatal visits in their last pregnancy; percent of birth deliveries assisted by skilled health professionals; percent of facility-based birth deliveries; and contraceptive prevalence.

9.23 Completion of four (4) antenatal care visits. Data from two sources (Tables 9.2.1 and 9.2.2) show higher figures reported by facility service records compared with the survey results. Moreover, the difference between periods indicate disparate pattern of change. The
overall picture, however, is an increase in the percent of pregnant women who declared to have completed the required antenatal check-ups.

Table 9.2.1: Percent of women with complete prenatal visits, UNFPA project sites, 2005 - 2009 (n=15 project sites)

<table>
<thead>
<tr>
<th>Provinces</th>
<th>2005</th>
<th>2009</th>
<th>Percent Increase/Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lanao del Sur</td>
<td>59.3</td>
<td>82</td>
<td>22.7</td>
</tr>
<tr>
<td>Maguindanao</td>
<td>76.2</td>
<td>92.2</td>
<td>10.0</td>
</tr>
<tr>
<td>Sulu</td>
<td>67.3</td>
<td>70.0</td>
<td>2.7</td>
</tr>
<tr>
<td>Tawi-tawi</td>
<td>50.67</td>
<td>67.67</td>
<td>17.0</td>
</tr>
<tr>
<td>Sultan Kudarat</td>
<td>53.2</td>
<td>56.4</td>
<td>3.2</td>
</tr>
</tbody>
</table>

Table 9.2.2: Percent of pregnant women who during the last five years completed four (4) ante-natal care visits, 2006 Baseline and 2010 Endline survey, UNFPA-assisted project Sites

<table>
<thead>
<tr>
<th>Provinces</th>
<th>2006</th>
<th>2010</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lanao del Sur (average of 3 sites)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Bubong</td>
<td>33.8</td>
<td>34.5</td>
<td>0.7</td>
</tr>
<tr>
<td></td>
<td>(n=196)</td>
<td>(n=172)</td>
<td></td>
</tr>
<tr>
<td>- Kapatagan</td>
<td>28.2</td>
<td>22.3</td>
<td>-6.4</td>
</tr>
<tr>
<td></td>
<td>(n=230)</td>
<td>(n=220)</td>
<td></td>
</tr>
<tr>
<td>- Marantao</td>
<td>36.9</td>
<td>40.3</td>
<td>3.4</td>
</tr>
<tr>
<td></td>
<td>(n=103)</td>
<td>(n=160)</td>
<td></td>
</tr>
<tr>
<td>Maguindanao (average of 3 sites)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Ampatuan</td>
<td>32.5</td>
<td>37.0</td>
<td>4.5</td>
</tr>
<tr>
<td></td>
<td>(n=217)</td>
<td>(n=148)</td>
<td></td>
</tr>
<tr>
<td>- Shariff Aguak</td>
<td>19.0</td>
<td>22.1</td>
<td>3.1</td>
</tr>
<tr>
<td></td>
<td>(=310)</td>
<td>(n=181)</td>
<td></td>
</tr>
<tr>
<td>- North Upi</td>
<td>41.8</td>
<td>56.6</td>
<td>14.8</td>
</tr>
<tr>
<td></td>
<td>(n=240)</td>
<td>(n=212)</td>
<td></td>
</tr>
<tr>
<td>Sultan Kudarat (average of 3 sites)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Isulan</td>
<td>61.2</td>
<td>75.3</td>
<td>14.1</td>
</tr>
<tr>
<td></td>
<td>(n=193)</td>
<td>(n=209)</td>
<td></td>
</tr>
<tr>
<td>- Lebak</td>
<td>71.0</td>
<td>73.9</td>
<td>31.8</td>
</tr>
<tr>
<td></td>
<td>(n=209)</td>
<td>(n=252)</td>
<td></td>
</tr>
<tr>
<td>- Senator Ninoy Aquino</td>
<td>70.6</td>
<td>80.6</td>
<td>10.0</td>
</tr>
<tr>
<td></td>
<td>(n=229)</td>
<td>(n=252)</td>
<td></td>
</tr>
<tr>
<td>Sulu (average of 3 sites)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Jolo</td>
<td>34.4</td>
<td>32.1</td>
<td>-2.3</td>
</tr>
<tr>
<td></td>
<td>(n=216)</td>
<td>(n=140)</td>
<td></td>
</tr>
</tbody>
</table>
- Luuk
- Parang

<table>
<thead>
<tr>
<th>Province</th>
<th>2005</th>
<th>2009</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lanao del Sur</td>
<td>55</td>
<td>43</td>
<td>-12.0</td>
</tr>
<tr>
<td>Maguindanao</td>
<td>69</td>
<td>77</td>
<td>8.0</td>
</tr>
<tr>
<td>Sultan Kudarat</td>
<td>34</td>
<td>68</td>
<td>34.0</td>
</tr>
<tr>
<td>Sulu</td>
<td>51</td>
<td>34</td>
<td>-17.0</td>
</tr>
<tr>
<td>Tawi-tawi</td>
<td>63</td>
<td>75</td>
<td>12.0</td>
</tr>
</tbody>
</table>

Table 9.3.1: Percent of births attended by skilled health professionals (SHPs), UNFPA-assisted project sites, 2006-2009 (n=15 project sites)

9.24 An interesting pattern can be gleaned from the survey data (Table 9.2.2). Out of the 15 project sites, 11 municipalities have shown increases in the span of five years with Lebak in Sultan Kudarat and Bongao of Tawi-tawi as top performers. Kapatagan in Lanao del Sur, Ampatuan in Maguindanao, and Jolo and Luuk in Sulu record a decline of pregnant women who completed the four required antenatal care check-ups. It is not farfetched to surmise that the completion is hampered by conflict situation. Access to antenatal care is jeopardized by sporadic armed conflict that occurs intermittently in these areas.

9.25 Birth deliveries assisted by Skilled Health Professionals (SHPs). Facility-based service data records higher percentage of births delivered by SHPs compared with survey figures. Increase is highest in Sultan Kudarat in both data sources. Sulu and Lanao del Sur is shown to have considerable percentage decline; this, however, is not supported by the survey data in which improvement is seen in both areas.

9.26 Across municipalities in the survey result (Table 9.3.2), commendable performance of the Sixth Country Programme is indicated by percent upswing in Marantao, Lanao del Sur, Lebak and Sen. Ninoy Aquino of Sultan Kudarat. Municipalities with peace and order problem and those far-flung places (e.g. Shariff Aguak) show decline on birth delivered by SHPs. An interesting observation is on survey data from Bongao, Tawi-tawi. Over one-third of their pregnant women have completed four antenatal care visits nevertheless a substantial number were not attended by SHPs during their birth delivery.
Table 9.3.2: Percent of birth deliveries assisted by skilled health professionals (SHPs), UNFPA project sites, 2006 Baseline and 2010 Endline surveys

<table>
<thead>
<tr>
<th>Provinces</th>
<th>2006</th>
<th>2010</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lanao del Sur (average of 3 sites)</td>
<td>26.2</td>
<td>35.0</td>
<td>8.8</td>
</tr>
<tr>
<td>- Bubong</td>
<td>32.7</td>
<td>41.9</td>
<td>9.2</td>
</tr>
<tr>
<td>- Kapatagan</td>
<td>12.3</td>
<td>15.2</td>
<td>2.9</td>
</tr>
<tr>
<td>- Marantao</td>
<td>33.7</td>
<td>47.8</td>
<td>24.1</td>
</tr>
<tr>
<td>Maguindanao (average of 3 sites)</td>
<td>32.7</td>
<td>37.7</td>
<td>5.0</td>
</tr>
<tr>
<td>- Ampatuan</td>
<td>34.1</td>
<td>39.6</td>
<td>5.5</td>
</tr>
<tr>
<td>- Shariff Aguak</td>
<td>25.8</td>
<td>17.6</td>
<td>-8.2</td>
</tr>
<tr>
<td>- North Upi</td>
<td>38.3</td>
<td>56.0</td>
<td>17.7</td>
</tr>
<tr>
<td>Sultan Kudarat (average of 3 sites)</td>
<td>33.6</td>
<td>56.2</td>
<td>22.6</td>
</tr>
<tr>
<td>- Isulan</td>
<td>62.7</td>
<td>76.1</td>
<td>13.4</td>
</tr>
<tr>
<td>- Lebak</td>
<td>5.9</td>
<td>35.5</td>
<td>29.6</td>
</tr>
<tr>
<td>- Senator Ninoy Aquino</td>
<td>32.2</td>
<td>57.0</td>
<td>24.8</td>
</tr>
<tr>
<td>Sulu (average of 3 sites)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Jolo</td>
<td>30.7</td>
<td>37.4</td>
<td>6.7</td>
</tr>
<tr>
<td>- Luuk</td>
<td>9.1</td>
<td>5.1</td>
<td>-4.0</td>
</tr>
<tr>
<td>- Parang</td>
<td>9.8</td>
<td>9.8</td>
<td>0.0</td>
</tr>
<tr>
<td>Tawi-tawi (average of 3 sites)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>- Bongao</td>
<td>34.8</td>
<td>18.1</td>
<td>-16.7</td>
</tr>
<tr>
<td>- Mapun</td>
<td>18.5</td>
<td>17.1</td>
<td>-1.4</td>
</tr>
<tr>
<td>- Panglima Sugala</td>
<td>7.5</td>
<td>10.3</td>
<td>2.8</td>
</tr>
</tbody>
</table>

9.27. **Facility-based deliveries.** Data from service records on place of delivery obtained by UNFPA Southern Philippines Office from rural health units are not at par with the survey results (Tables 9.4.1 and 9.4.2). For the beginning 2006 period, higher figures were reported from service delivery records. It can be deduced that these are captured births delivered at the facility. Sultan Kudarat indicated a near four-fold increase while in Sulu and Tawi-tawi, the predominant place of birth delivery is at home. This is not surprising against the background of peace and order situation and on the dearth of health personnel who are serving and willing to serve in the project sites.

9.28. The survey data provided promising scenario in the shift of health-seeking behaviour on where to deliver a child. All areas show increases of facility-based deliveries. Sultan Kudarat posted a decline of one-third of home deliveries from 2006 to 2010. Sulu and Tawi-tawi are providing evidence of preference to facility-based delivery albeit such extent of preference is not dramatic.

9.29. **Family Planning.** Contraceptive prevalence rate is a common measure of family planning methods use. Rates are examined at different levels (provincial and municipal) and by category of methods (any method and modern method). The contraceptives prevalence rates in Table 9.5.1 compares the provincial CPR (inclusive of the pilot municipalities) and the municipal CPR of 15 project sites. The positive rates in latter somehow weed out poor performing municipalities which are included in the provincial estimates.
Table 9.4.1: Percent of facility-based deliveries, UNFPA-assisted project sites, 2006 -2009 (n=15 project sites)

<table>
<thead>
<tr>
<th>Provinces</th>
<th>2006</th>
<th>2009</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lanao del Sur</td>
<td>29</td>
<td>34</td>
<td>5.0</td>
</tr>
<tr>
<td>Maguindanao</td>
<td>24</td>
<td>47</td>
<td>23.0</td>
</tr>
<tr>
<td>Sultan Kudarat</td>
<td>15</td>
<td>56</td>
<td>44.0</td>
</tr>
<tr>
<td>Sulu</td>
<td>26</td>
<td>23</td>
<td>-3.0</td>
</tr>
<tr>
<td>Tawi-tawi</td>
<td>26</td>
<td>23</td>
<td>-3.0</td>
</tr>
</tbody>
</table>

Source: FHSIS from 30 municipal health offices of the 6th CP 10 pilot provinces.

Table 9.4.2: Percent of facility-based deliveries, UNFPA-assisted project sites, 2006 Baseline and 2010 Endline surveys

<table>
<thead>
<tr>
<th>Provinces</th>
<th>Home hospital, health center, and private clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2006</td>
</tr>
<tr>
<td>Lanao del Sur</td>
<td>81.6</td>
</tr>
<tr>
<td>Maguindanao</td>
<td>84.0</td>
</tr>
<tr>
<td>Sultan Kudarat</td>
<td>88.7</td>
</tr>
<tr>
<td>Sulu</td>
<td>87.8</td>
</tr>
<tr>
<td>Tawi-tawi</td>
<td>92.6</td>
</tr>
</tbody>
</table>

Table 9.5.1: Contraceptive Prevalence Rates, Modern Methods UNFPA project sites, 2005 -2009 (n=15 project sites)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lanao del Sur</td>
<td>33</td>
<td>13.4</td>
<td>-19.6</td>
<td>18.1</td>
<td>28.0</td>
<td>9.9</td>
</tr>
<tr>
<td>Maguindanao</td>
<td>44</td>
<td>30</td>
<td>-14.0</td>
<td>31.3</td>
<td>50.7</td>
<td>19.4</td>
</tr>
<tr>
<td>Sulu</td>
<td>4.0</td>
<td>10.0</td>
<td>-6.0</td>
<td>14.7</td>
<td>15.0</td>
<td>0.3</td>
</tr>
<tr>
<td>Tawi-tawi</td>
<td>22.0</td>
<td>28.0</td>
<td>6.0</td>
<td>20.0</td>
<td>23.7</td>
<td>3.7</td>
</tr>
<tr>
<td>Sultan Kudarat</td>
<td>44.6</td>
<td>53.4</td>
<td>8.4</td>
<td>51.7</td>
<td>61.0</td>
<td>9.3</td>
</tr>
</tbody>
</table>
9.30. Contraceptive prevalence rates obtained from the two surveys for currently married couple on any method capture the magnitude of FP acceptors as well as the change over the span of five years. In 2006, Sultan Kudarat and Maguindanao project sites respectively posted rates four times and five times higher than the other areas. However, while Sultan Kudarat performance improved, Maguindanao rates backslide by 3 percentage points. However, some data discrepancy is observed; Maguindanao provincial rates obtained from FHSIS indicate decline from 2006 to 2009; the same source posted a dramatic increase of 19 percent for municipal level but such an increase is not supported by the survey data. A possible explanation could be that the provincial CPR reflects uneven contraceptive performance among different municipalities.

9.31. There are more places with low CPR compared with those municipalities with high rates. The municipal CPR is expected to be higher; these are the FP acceptors who are clients of health centers and are monitored by health center personnel. The survey data are derived from sample households that include couples who are clients of private hospitals and clinics. Surprisingly Sulu shows dramatic improvements--a three-fold increase in contraceptive use.

9.32. Examination of contraceptive prevalence rates for any method and modern method (Table 9.5.2 and 9.5.3) on both 2006 and 2010 surveys follows expected pattern. Comparatively, CPR for modern method is lower than any method; this translates to the expectation that a considerable number of currently married couples still preferred the traditional method of contraception.

9.33. The dramatic increase (15 percent) in Sulu on any method use is drastically cut to only 1 percent difference between surveys. This implies that Sulu couples’ contraceptive use is predominantly traditional methods, notably in the municipality of Parang.

Table 9.5.2: Contraceptive prevalence rates (both males and females), any method UNFPA-assisted, 2006 Baseline and 2010 Endline surveys

<table>
<thead>
<tr>
<th>Provinces</th>
<th>2006</th>
<th>2010</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lanao del Sur (average of 3 sites)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Bubong</td>
<td>8.9</td>
<td>18.7</td>
<td>1.4</td>
</tr>
<tr>
<td>- Kapatagan</td>
<td>17.0</td>
<td>11.2</td>
<td></td>
</tr>
<tr>
<td>- Marantao</td>
<td>14.8</td>
<td>15.1</td>
<td></td>
</tr>
<tr>
<td>Maguindanao (average of 3 sites)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Ampatuan</td>
<td>33.4</td>
<td>20.1</td>
<td>-3.1</td>
</tr>
<tr>
<td>- Shariff Aguak</td>
<td>25.2</td>
<td>20.2</td>
<td></td>
</tr>
<tr>
<td>- North Upi</td>
<td>37.6</td>
<td>46.7</td>
<td></td>
</tr>
<tr>
<td>Sultan Kudarat (average of 3 sites)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Isulan</td>
<td>50.7</td>
<td>60.4</td>
<td>8.4</td>
</tr>
<tr>
<td>- Lebak</td>
<td>34.2</td>
<td>53.3</td>
<td></td>
</tr>
<tr>
<td>- Senator Ninoy Aquino</td>
<td>55.7</td>
<td>52.2</td>
<td></td>
</tr>
<tr>
<td>Sulu (average of 3 sites)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Jolo</td>
<td>16.3</td>
<td>24.3</td>
<td>14.8</td>
</tr>
<tr>
<td>- Luuk</td>
<td>3.8</td>
<td>4.6</td>
<td></td>
</tr>
<tr>
<td>- Parang</td>
<td>2.3</td>
<td>38.0</td>
<td></td>
</tr>
</tbody>
</table>
Table 9.5.3: Contraceptive prevalence rates (both males and females), modern methods
UNFPA-assisted, 2006 Baseline and 2010 Endline surveys

<table>
<thead>
<tr>
<th>Provinces</th>
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<th>2010</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
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<td>7.6</td>
<td>8.6</td>
<td>1.0</td>
</tr>
<tr>
<td>- Bubong</td>
<td>6.5</td>
<td>10.7</td>
<td></td>
</tr>
<tr>
<td>- Kapatagan</td>
<td>6.8</td>
<td>6.2</td>
<td></td>
</tr>
<tr>
<td>- Marantao</td>
<td>9.5</td>
<td>8.8</td>
<td></td>
</tr>
<tr>
<td>Maguindanao (average of 3 sites)</td>
<td>26.6</td>
<td>22.8</td>
<td>-3.8</td>
</tr>
<tr>
<td>- Ampatuan</td>
<td>30.6</td>
<td>17.1</td>
<td></td>
</tr>
<tr>
<td>- Shariff Aguak</td>
<td>22.0</td>
<td>16.8</td>
<td></td>
</tr>
<tr>
<td>- North Upi</td>
<td>27.2</td>
<td>34.4</td>
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<tr>
<td>Sultan Kudarat (average of 3 sites)</td>
<td>40.6</td>
<td>47.4</td>
<td>6.8</td>
</tr>
<tr>
<td>- Isulan</td>
<td>44.0</td>
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<td></td>
</tr>
<tr>
<td>- Lebak</td>
<td>29.1</td>
<td>46.4</td>
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<tr>
<td>- Senator Ninoy Aquino</td>
<td>48.7</td>
<td>45.1</td>
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</tr>
<tr>
<td>Sulu (average of 3 sites)</td>
<td>5.7</td>
<td>6.7</td>
<td>1.0</td>
</tr>
<tr>
<td>- Jolo</td>
<td>12.1</td>
<td>13.9</td>
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</tr>
<tr>
<td>- Luuk</td>
<td>3.7</td>
<td>2.9</td>
<td></td>
</tr>
<tr>
<td>- Parang</td>
<td>1.4</td>
<td>3.2</td>
<td></td>
</tr>
<tr>
<td>Tawi-tawi (average of 3 sites)</td>
<td>8.4</td>
<td>11.6</td>
<td>3.2</td>
</tr>
<tr>
<td>- Bongao</td>
<td>15.1</td>
<td>11.1</td>
<td></td>
</tr>
<tr>
<td>- Mapun</td>
<td>5.4</td>
<td>13.8</td>
<td></td>
</tr>
<tr>
<td>- Panglima Sugala</td>
<td>4.6</td>
<td>9.9</td>
<td></td>
</tr>
</tbody>
</table>

9.34. Given the increases in contraceptive prevalence rates for both any methods and modern methods, does this translate to reduction in unmet needs? The reduction as seen in Table 9.6 is not as dramatic as expected. Maguindanao and Sulu registered an increase in unmet needs notably in the municipalities of Ampatuan and Shariff Aguak in Maguindanao and in Parang, Sulu. It is interesting to note that in Parang, Sulu increase in contraceptive prevalence rates for any method has corresponding increase in unmet need.

9.35 PDS Accomplishments. In terms of population and development strategies, the most prominent accomplishment is in the formulation, implementation and institutionalization of RH and GAD codes, and the adoption and making the CSR policy functional. Impressive performance is seen in the RH code, while adoption of CSR policy is not popular.
### Table 9.6: Percent distribution of currently married women with unmet needs for family planning, UNFPA project sites, 2006 Baseline and 2010 Endline surveys

<table>
<thead>
<tr>
<th>Provinces</th>
<th>2006</th>
<th>2010</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lanao del Sur (average of 3 sites)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Bubong</td>
<td>39.5</td>
<td>35.7</td>
<td>-1.3</td>
</tr>
<tr>
<td>- Kapatagan</td>
<td>40.4</td>
<td>47.8</td>
<td></td>
</tr>
<tr>
<td>- Marantao</td>
<td>38.9</td>
<td>31.3</td>
<td></td>
</tr>
<tr>
<td>Maguindanao (average of 3 sites)</td>
<td></td>
<td></td>
<td>-2.9</td>
</tr>
<tr>
<td>- Ampatuan</td>
<td>27.3</td>
<td>37.4</td>
<td></td>
</tr>
<tr>
<td>- Shariff Aguak</td>
<td>29.5</td>
<td>30.7</td>
<td></td>
</tr>
<tr>
<td>- North Upi</td>
<td>23.2</td>
<td>20.6</td>
<td></td>
</tr>
<tr>
<td>Sultan Kudarat (average of 3 sites)</td>
<td></td>
<td></td>
<td>-3.3</td>
</tr>
<tr>
<td>- Isulan</td>
<td>25.9</td>
<td>13.6</td>
<td></td>
</tr>
<tr>
<td>- Lebak</td>
<td>25.5</td>
<td>23.6</td>
<td></td>
</tr>
<tr>
<td>- Senator Ninoy Aquino</td>
<td>16.8</td>
<td>21.1</td>
<td></td>
</tr>
<tr>
<td>Sulu (average of 3 sites)</td>
<td></td>
<td></td>
<td>-2.5</td>
</tr>
<tr>
<td>- Jolo</td>
<td>34.0</td>
<td>29.2</td>
<td></td>
</tr>
<tr>
<td>- Luuk</td>
<td>29.0</td>
<td>29.1</td>
<td></td>
</tr>
<tr>
<td>- Parang</td>
<td>22.9</td>
<td>35.1</td>
<td></td>
</tr>
<tr>
<td>Tawi-tawi (average of 3 sites)</td>
<td></td>
<td></td>
<td>-8.8</td>
</tr>
<tr>
<td>- Bongao</td>
<td>36.8</td>
<td>29.8</td>
<td></td>
</tr>
<tr>
<td>- Mapun</td>
<td>30.8</td>
<td>31.4</td>
<td></td>
</tr>
<tr>
<td>- Panglima Sugala</td>
<td>54.7</td>
<td>34.8</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Local Law, Policy, Strategy</th>
<th>TARGET</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>RH CODES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Provincial</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>15 Municipal</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>GAD CODES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Provincial</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>15 Municipal</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>CSR POLICY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Provincial</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>15 Municipal</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

9.36 Gender and Culture Accomplishments. The major focus of this component is on gender-based violence. The series of activities undertaken yielded a structural set-up that acts not only as watchdog on violation of women’s right but also as a prime mover on educating men, women, adolescents, and indigenous people.

9.37 The interagency network of councils from region down to the barangay levels is widespread in all pilot areas. In advancing the rights of women and children, and in being vigilant on sex and labour trafficking, the councils likewise increased people’s awareness, and knowledge on gender equality, RH as well as reproductive rights.
9.38 The network activities draw dynamic and responsive engagement of various groups. It motivated the Muslim Religious leaders (MRLs) to work on the popularization development of the 15 Khutbas on gender.

9.39 Moreover in reaching out to the Muslim population, working jointly in advocacy work and in other endeavours, somehow bridge the social distance between Muslim and Christian spawned and reinforced by many conflict episodes that breeds distrust and hostility.

9.40 Accomplishments in Humanitarian Response. These were significant and are discussed in paragraphs 7.5.3, 7.5.7, 7.5.8, and 7.5.10.

Assessment of the Sixth Country Programme

9.41 Given the discussion of the activities and accomplishments of the programme, an assessment from various stakeholders is imperative to know the relevance, effectiveness, efficiency and sustainability of the programme. Immersed in the field and with rich insights borne out of the experience, these stakeholders are the front-liners who have the depth and breadth of knowledge about the programme.

9.42 A total of 44 respondents who provided the assessment include 23 partners and focal persons (provincial health officer, municipal health officer, social welfare administrators, provincial or municipal administrators, population and development coordinators, public health nurses, rural health midwives and Muslim religious leader); 13 beneficiaries; and 8 UNFPA-SPO project officers and coordinators.

9.43 Relevance. The Sixth Country Programme is adjudged by the respondents to be relevant because it is aligned with the ICPD agenda, the concern on population growth and sustainable development. Moreover, the programme is believed to be highly relevant towards the realization of the MDG targets. It is also in consonance with national and local priorities; the desired outcomes from the three components are basically what local governments aim to address.

9.44 The design and foci are deemed consistent with local development projects/programs. While the local governments are addressing population and reproductive health issues, competing priorities, however, take precedence in terms of resources and manpower. Hence the sixth country programme assistance and efforts is not just much welcome but viewed as an important modality in strengthening the promotion of population and RH concerns.

9.45 Moreover, the emphasis on rights is relevant simply because respondents believed this is not adequately address by a number of local government and the knowledge of the populace on what constitute their rights is deficient.

9.46 The programme triggers action, it places into the centre stage of governance the concerns on health: of mothers dying while giving birth when they should not, about the child survival being jeopardized, and on egalitarian relationship between men and women. According to one respondent, “The CP acts as catalyst for change and provides impetus for LGUs to allocate resources in complement to the financial assistance given.”
9.47 The relevance of RH component is seen from different perspectives. “It initiated a change in the mindset especially among the Muslims,” said a provincial health officer. This implies observed change in rational orientation, reflecting the beginning of internalization of values.

9.48 A municipal health officer in Maguindanao enunciates the relevance in terms of their service delivery, “The intervention enables us to reach out to the hinterland, especially to the indigenous peoples who live in geographically isolated areas who are most in need of RH services.” This somehow attributes to the CP its contribution in paving the way for wider coverage and for reaching out to the marginalized and isolated people.

9.49 The beneficiaries (mostly mothers who are members of satisfied family planning users club) understand the programme relevance in terms of knowledge gained and of having time for themselves. “We were taught the proper way in child care and how to plan our family. Family planning allows us to have time for ourselves, time for personal grooming, learn gainful activities and the opportunity to earn money to be able to send our children to school.”

9.50 The relevance of the PDS component is seen in the sharing behaviour in the local governance and greater sensitivity to the needs of the people. A meaningful partnership with religious and tribal leaders is observed, forged through the creation of inter-agency councils. The manner of decision making by consensus of these interagency councils is attributed to have yield greater participation.

9.51 In the implementation of population and development strategies and in capacitating local executives and policy-makers, the utilization of age and sex disaggregated data become more pronounced. Respondents from the local government think this provides direction, enable them to identify who are to receive and what RH information and services to be given. Moreover, the age and sex disaggregated data are use in planning, budgeting and in preparation of annual accomplishments.

9.52 The relevance of gender and culture component lies on its focus on the rights of women and reproductive health. The highlight on safeguarding pregnant mothers and newborns strike a realization that indeed immediate and concerted efforts to bring down the maternal and neonatal mortality are imperative.

9.53 The strategies employed, e.g. advocacy and community-initiative building resulted to partnership of various groups contributing to the furtherance on the promotion of gender sensitivity and equality. Dynamism is infused into the partnership so that advocates on violence against women and children gain not only in numbers but in strength and influence. According to a handful of respondent advocates, they become more vigilant on monitoring and detecting cases of sex and labour trafficking.

9.54 As an offshoot to all of the gender activities undertaken, respondents are in accord that gender mainstreaming in local development plans is in place. In the process of planning, project implementation, and even in the prioritization of development interventions, gender is being mainstreamed. Moreover, it is worthwhile to note that municipal officials who are respondents averred the inclusion of gender, RH and population and development strategies in discussion of issues and political concerns.
9.55 **Perceived Effectiveness.** To get some measure of effectiveness, respondents were asked to rate the sixth country program in the scale of 1 to 10 where 1 is the lowest and 10 is the highest. The responses yielded an average score of 7 which can be considered high. The perceived effectiveness hinges on the belief that the programme is more focused.

9.56 The effectiveness of RH component is seen in the great improvement on the capacity of health personnel in the delivery of health services. The capacitating through numerous trainings and seminars produces a cadre of dedicated and committed health workers and advocates.

9.57 Respondents are also in accord that the sixth country program contributed to an improved health facilities and acquisition of equipments. Although quality of services is still a desirable, the improvement resulted to better access and greater utilization of health services.

9.58 The effectiveness of the PDS component is observed on local policymakers and executives, giving focus on vital issues related to RH and gender, utilization of population data in planning, and the inclusion of environmental concerns in the local development agenda.

9.59 The activities under this component produced an enlightened administrators and policy-makers, who now have capacities and skills in gender mainstreaming. These leaders also attained visibility in spearheading people’s involvement, in developing teamwork among various groups and in linking the 3 components.

9.60 The effectiveness is also gauged through the appreciation and utilization of data generated; the use of age and sex disaggregation albeit respondents expressed concern on data accuracy and the need for data validation.

9.61 The gender component is perceived to be effective because of the inclusion of gender in local executive and legislative agenda. It also capacitates local policymakers and executives to plan, review and address governance problems through gender lens.

9.62 Factors deemed to facilitate effectiveness include: cooperation of stakeholders, coordination and networking, and commitment of people. The logistical support given by the sixth country program is acknowledged to contribute to the effectiveness. In terms of tools and processes, the monitoring and evaluation procedures and the consultative and consensus-building ways were identified to account why the programme is considered effective.

9.63 However, there are factors that somehow posed as hindrances and impediments; these are difficulties entrenched in the geographic location of pilot areas, in the culture and tradition of people and in peace and order situation. A handful of municipalities are difficult to reach, travel to and from these places took time and money.

9.64 The cultural practices and tradition of indigenous people which they strongly adhere to, and the patriarchal mental mindset is a challenge to programme focal persons and implementers. The sporadic conflicts that erupt between feuding Muslim clans and the armed encounters between the military and the rebel groups caused setbacks to the progress and to the activities of the programme.
9.65 The programmatic hindrance identified by respondents is the delay in the release of funds which affect the schedule of implementation. It distorts the work plan and the timely submission of deliverables.

9.66 Respondents expressed their being wary with the change in the political leadership; they are uncertain if the newly elected leaders will be supportive of the promotion of the three components and if the gains and accomplishment of the sixth country programme be sustained.

9.67 Cost-Efficiency. A question was asked on what are the measures instituted by the programme to insure cost-efficiency. The respondents considered deliberation of the appropriateness of interventions during the planning stage an efficient measure, whether such interventions will have return of investment or not. Another measure which they claim to be cost-wise efficient is the counter-parting scheme or complementation between the programme and the local government units. The pooling together of resources insures that the funding will yield better results and wider coverage.

9.68 The management procedures including strict compliance to liquidation requirements and regular evaluation of what have been accomplished vis-à-vis the targets enable focal persons and implementers to gauge where they are and where are they going. Furthermore, instituting the financial and audit team are declared by respondents to contribute to cost-efficiency. Accountability and transparency are built-in in the planning, implementation, and evaluation of results. Expenditures and accomplishments are monitored and liquidation of expenses after conduct of every activity is required.

9.69 Sustainability. Is the programme sustainable? Will it continue to flourish without the support of UNFPA? Will there be back slide in gains and accomplishment?

9.70 The responses affirmed the hope for sustainability of the programme, however this positive view is tainted with doubts. To date, the sixth country programme has the support of national and local government, the academe, non-governmental organizations and the civil society. Significant strides had been made in capacitating health providers, in the provisions of health facilities and equipment and in putting in at the centre stage of governance the 3 programme components. A strong community network and partnership have been established and are functional. All of these are considered by respondents as pillars in the programme sustainability albeit it will surely be affected without the support and assistance of UNFPA.

9.71 The momentum is already there, in some areas they have already made a takeoff in the promotion of the three components but they still have a long way in reaching a plateau. Other areas have initial successes which need to be fed and fuelled by assistance and support. The dynamism in the promotion of RH, gender equality and population and development has to be maintained through vigorous and responsive engagement.

10 UNFPA and Implementation of the UNDAF56; Joint UN Programmes and South to South Co-operation

UNFPA and UNDAF

10.1 When the UNDAF for the Philippines covering 2005-2009 was agreed the UN Country Team set out a series of monitoring and evaluation procedures and milestones. The UNDG would be responsible for the review and validation of the cooperation between organisations on the UNDAF priority areas in order to ensure that individual Agency country programme documents reflected such objectives as appropriate. It would also ensure the effective functioning of a series of Technical Working Groups covering the priority areas identified for support. UNCT meetings were established at a high level for information exchange and to strengthen partnerships, as well as improve coordination and collaboration of the United Nations System as a whole. Effective inter-Agency collaboration was to be included in all Agency workplans and reviews. A mid-term and end of cycle evaluation was planned.

10.2 In 2004, the UNCT and its partners in the Government and civil society prepared the second United Nations Development Assistance Framework (2005-2009) for the Philippines, to align with national planning processes and to benefit from the new Medium-Term Philippines Development Plan (MTPDP). At the request of the government the 2005-2009 UNDAF has been extended to a 2012 start. UN agencies developed their two-year ‘transitional’ programme to cover the period of 2010 and 2011.

10.3 During the second quarter of 2010 an evaluation of the UNDAF process and implementation is being carried out. The draft report of the evaluation became available in late June57. The results of this evaluation have implications for future collaboration of UN agencies in the period leading up to and covering MDG delivery in the UNDAF 2012-2016, Joint UN programming and the UN ‘Delivering as One’ in the Philippines.

10.4 Because development is a process, the UNDAF was meant to be a living document to adapt to changes in the country’s economic, social and political situation. A monitoring and evaluation (M&E) plan was put in place by the UNCT to track the changes and measure progress in achieving the desired results, which was expected to be carried through the results based management approach.

10.5 During the 2005-2009 cycle, UNDAF Annual Reviews were conducted for the years 2005 and 2006 and a Triennial Comprehensive Policy Review (TCPR) Country Consultations on Capacity Development took place in 2007. Internal UNDAF theme group reviews were carried out as part of the annual UNDAF reviews. However the 2005 and 2006 annual reviews were delayed and did not follow the UNDG guided time schedule. Instead of occurring in the last quarter of the year, they were conducted respectively in the first quarters of 2006 and 2007. Consequently, most agencies had to develop their Annual Work Plans without inputs from the annual reviews. The Resident Coordinator’s annual progress reports also could not fully benefit from the annual reviews for the same reason. The mid-term review, which was due in 2007, became redundant, as the second UNDAF annual review was conducted in the same year. However, the TCPR consultation provided some useful insights about the performance of the UNDAF.

10.6 The M&E framework of the UNDAF has lot of problems. Agencies at annual reviews reported that their M&E frameworks are not harmonised with the UNDAF M&E framework58. In 2006, following the recommendations of the 2005 UNDAF annual review, a

58 The 2006 annual UNDAF review noted that among the UN agencies, the programme framework of UNDP adheres most closely to the
monitoring and evaluation task force was established under the UN Programme Support Group to assist the M & E requirements for the UNDAF and MDGs and to harmonize agency M & E systems. The task of revising the UNDAF M&E framework and aligning the agency M&E systems with it was begun. However it was never completed. There has not been any consistent monitoring of implementation of the UNDAF and of UNFPA’s contribution. If UNFPA and the UN as a whole is serious about results based management, performance management and ‘delivering as one’ then it will be crucial that in the future a workable monitoring system which objectively reflects implementation and achievement or not of Programme outputs is established.

10.7 In 2006 the UNRC in the Philippines started preparing for the transition to a ‘one UN’. An assessment was undertaken as part of the preparation. The assessment recommended three critical steps for initial preparations for a One UN programme: (1) to strengthen the UNDAF mechanism in two area; (a) UNDAF Results Matrix and (b) UNDAF M&E System; (2) to develop a results based and harmonized UNDAF M&E system by strengthening agency M&E systems for RBM; and (3) supporting the functions of UNDAF theme groups. These recommendations were in line with the findings of the 2005 UNDAF annual review. Since then the UN system in the Philippines has made some efforts to strengthen the UNDAF mechanism. In 2007, the NEDA affirmed its commitment for a One UN System in the Philippines by 2010, as a ‘pilot’ for the second round of countries, and, to implement the principles of the Paris Declaration on Aid Effectiveness.

10.8 The UNDAF evaluation found many problems with implementation of UN joint programmes in the country. These essentially centred around the following issues: agencies often regarded joint programmes as a mere resource mobilization strategy without thorough assessment of internal and partners’ capacities to deliver the required outputs; lack of trust among the member agencies and poor consultation processes; poor involvement of partner agencies at all phases of the programme, namely, planning, implementation, and monitoring; lack of ownership; differences between UN agencies in implementation modes and administrative and financial systems.

10.9 Decisions made in September 2008 as part of the Accra Agenda for Action at the Third High-Level Forum on Aid Effectiveness ‘to accelerate and deepen implementation of the Paris Declaration on Aid Effectiveness’ included that ‘the effectiveness of aid is reduced when there are too many duplicating initiatives, especially at country and sector levels’. In addition the need to reduce ‘fragmentation of aid by improving the complementarity of donors’ efforts and the division of labour among donors, including through improved allocation of resources within sectors, within countries, and across countries’ were highlighted.

UNFPA and Joint UN Programmes

10.10 Joint UN programmes involving UNFPA are outside the scope of the evaluation of the Sixth Country Programme, however UNFPA has been successful in participating, initiating and taking the lead in the establishment of several Joint UN Programmes in the Philippines. The experience of UNFPA’s participation in UN Joint Programmes has been fruitful in building on synergies between the joint programmes and the CP as well as leveraging of resources for priority RH concerns. These joint programmes are a means to

design of the UNDAF.
achieving the objectives of the Country Programme through a methodology of UN System proposals. These augers well for co-operation of UN agencies in the ‘One UN’ during the next programme cycle.

10.11 The experience gained by UNFPA from the implementation of the CP in the 10 pilot province sites and one city has led to the leveraging of additional resources for RH care. UNFPA organised formulation of a strategy paper for the Joint Programme on Reducing Maternal and Neonatal Mortality and which led to USS2.6 million for UNFPA to manage. This Joint Programme involves UNFPA, UNICEF and WHO in interventions to improve provision of maternal and neonatal care in several provinces. It is funded by the Australian Aid for International Development (AusAID) and is being implemented by the (DOH). The Evaluation Team heard some comments from the implementing partners regarding tensions in collaboration between the UN agencies which will hopefully be resolved before the assessment is undertaken regarding whether to continue funding after the initial 18 month period.

10.12 UNFPA’s gender supported activities led to the development of the Joint Programme on Eliminating Violence against Women which is harmonising the VAW documentation system and created a multi-sectoral pool of anti-VAW advocates. UNFPA is the lead on this joint programme and government partners include the National Commission on the Role of Filipino Women (NCRFW), Department of Social Welfare and Development (DSWD), Department of Justice (DOJ), and Civil Service Commission (CSC).

10.13 The Joint UN Programme on HIV and Migration (JPHAM) was formed in 2006 as the first initiative on Joint Programming addressing development issues in the spirit of “UN delivering as One” in the Philippines. The programme started implementation in 2007 and currently is in its third phase of operations in 2010. Other UN agencies participating in the JPHAM are UNICEF, UNDP, UNAIDS, ILO, WHO, UNRC and UN-Habitat. UNFPA is the managing agent of the joint programme and the lead UN agency for Programme Area One – Community- based Support to Selected Areas (Cavite, Bohol and Maguindanao). This Joint Programme built on work carried out as part of the Sixth UNFPA CP.

10.14 UNFPA is also involved in other joint UN initiatives including issues concerned with Youth, Employment and Migration where the Fund (based on experience gained in the Sixth CP) has facilitated the mainstreaming in the educational curriculum of gender issues and life skills. UNFPA was the head of the Advocacy Technical Working Group of the UNCT.

10.15 Ensuring close and meaningful collaboration with UN agencies that in certain areas have similar mandates will be very important in the development and implementation of the UNFPA Seventh Country Programme as a part of the UNDAF and the UN Delivering as One. The Seventh Country Programme will be developed within the UNDAF 2012-2016 and under the overall context of the Government’s Medium-term Philippine Development Plan 2010-2016 (MTPDP) and the Updated Regional Development Plans (RDPs).

**UNFPA and South to South Co-operation**

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60 Preparations for the UNDAF have already begun.
61 See presentation by Dennis Arroyo, Director, National Planning and Policy, National Economic and Development Authority on April 7, 2010.
10.16 The CP has taken part and contributed to several South-to-South initiatives. These include:

- participation in the strengthening of RHCS (as a resource for LMIS and CHANNEL Training) taking place with UNFPA co-ordination in all Asia Pacific countries with UNFPA CPs;
- gender Programming including Gender Budgeting with Vietnam;
- assistance in developing the Midwifery Curriculum in the Democratic Republic of Timor-Leste;
- assistance in developing Country Population Assessment in the Democratic Republic of Timor-Leste;
- the Philippine Youth Advisory Panel model and Y-PEER have been used as a reference for several other countries in the region;
- expertise on HIV Programming has been shared with Mongolia;
- assistance in the implementation of HACT has been provided to the UNFPA Offices in Afghanistan and Indonesia.

10.17 The Evaluation Team were unfortunately not able to undertake an assessment of the usefulness of the UNFPA supported South to South co-operation. However in view of the potential importance of South to South co-operation for UNFPA future support, it is suggested the CO together with APRO should consider reviewing in detail the experience gained. This could be carried out under a consultancy during the remaining months of the Sixth CP and involve developing questionnaires to gather information from both those providing the technical assistance and those in the receiving countries.

11 Monitoring Implementation of the CP and Assessment of Overall Achievement of the Targets Set in the CPD and CPAP 2005-2009

11.1 The Country Programme Action Plan emphasised the importance of effective monitoring of CP implementation as a ‘critical results-based management function’. It also stated that an ‘M&E framework’ would be established and the ‘Results and Resources Framework (RRF)’ would be used ‘to provide the bases for tracking performance across the years of implementation’ together with the ‘Planning and Tracking Tool’ and ‘Monitoring and Evaluation Calendar’.

11.2 These planning and tracking instruments have not been used in the way intended and in many ways this is understandable because most of the 16 indicators identified for monitoring the CP are either dichotomous or very difficult if not impossible to measure. Most indicators identified in the Country Programme document for tracking implementation of the PDS and gender components are concerned with particular deliverables such as the ‘passing of the Reproductive Law’, the ‘allocation of national reproductive health budget’, ‘maternal mortality and migration studies done’ or ‘gender-related policies and programmes formulated’. For the RH component the output indicators were potentially more quantifiable such as ‘percentage increase in the number of women, adolescents and men seeking reproductive health information and services in government health facilities, teen centres, schools and clinics in the workplace’ or ‘percentage increase in health facilities providing high-quality, integrated core reproductive health information and services’. These and similar indicators included in the RRF have problems in that they are composite and this is compounded by there not being relevant baseline data for these composite indicators at the start of the Programme.
11.3 The CO supported results based management (RBM) training for national and local partners in 2006 and 2007 to further a common understanding of this important issue and to help ensure that the CP was implemented along RBM lines. During the first two years of the CP UNFPA staff located in the Programme provinces developed logframes and identified indicators to use in monitoring implementation of the three Programme components. UNFPA Programme staff in the provinces have, in collaboration with their colleagues in the provincial administration also developed items for tracking implementation of the PDS and Gender components in their specific provinces\(^{62}\). To an extent similar indicators as those identified in the baseline survey have been used by Programme provinces to monitor coverage of specific items of RH care annually. These are reported at annual provincial and the national Programme review meetings\(^{63}\).

11.4 The Evaluation Team was informed that at the CO level a ‘workplan monitoring tool’ has been used to list activities under each project supported under the three components of the CP. However following several requests to the CO Monitoring and Evaluation Officer to be shown the ‘workplan monitoring tool’, this was not forthcoming. It also proved difficult to obtain figures on provision and coverage of CP supported activities in the Programme provinces. These were not easily available in the CO and requests had to be made by the CO RH and M&E Officers several times to each province. In addition the monitoring of the Country Programme has relied on semi-annual and annual programme reviews in each of the 10 provinces where implementation is compared with annual work plans. Standard Progress Reports are prepared annually for each component and these contain reports of activities implemented. The Country Programme is reviewed as a whole in an annual programme review meeting. Provinces send to the Government Department of Health reports on utilisation of health services and these are then made available more widely. However the Evaluation Team do not consider these constitute a dynamic and meaningful monitoring system for implementation of the CP.

11.5 Repeated unsuccessful requests were made of CO staff and in particular the Country Office M&E Officer for a description and demonstration of the CP monitoring system and for ‘printouts’ of CP indicators and CP activity implementation status successively for each of the Programme municipalities by years 2005, 2006, 2007, 2008, 2009 and first quarter of 2010. The Evaluation Team were informed that a formal monitoring system has not been established. It appears no meaningful monitoring system has been established which would enable a more thorough assessment and tracking of changes in coverage and other important results and for tracking implementation of the CP. Such an M&E system could be invaluable in monitoring the success of implementation of the CP. The CO is about to release a ‘Monitoring and Evaluation Manual’\(^{64}\). This could be used in the next CP.

11.6 If such a monitoring system had been established during the present CP then it would have been far easier to have generated the data requested under the evaluation. In addition the evaluation could probably have been far more definite about conclusions concerning what worked and how.

11.7 The annual ‘Sixth National Programme Management Committee Meeting’ brings together key partners involved in implementing the CP. At this meeting reports are given on

\(^{62}\) See Standard Progress Reports and presentations made at six monthly provincial programme review meetings.

\(^{63}\) See Standard Progress Reports and presentations made at six monthly provincial programme review meetings.

CP activities and also changes in relevant indicators. The report of the Management Committee Meeting held in December 2009 indicates that most items identified at the beginning of the CP have been successfully delivered.

11.8 Several of the provinces where the CP is being implemented have undertaken community based surveys in their three programme municipalities on topics such as pregnant women and their use of maternity services. Each Programme province prepares annual reports which include a range of figures for a number of RH services covering the three Programme municipalities in each province and usually comparative figures for the province as a whole. Unfortunately many of these are given as numbers using a particular service and not as rates; consequently without a denominator it is impossible to say if increasing numbers reflect rising coverage. A few provinces have established a ‘community based management information system’ and can provide information on certain rates over time. For instance in Eastern Samar it is possible to see an increase in the CPR in the three Programme municipalities from 2005 to 2009 which is probably at a faster rate than in the province as a whole (see table 11.1). Similarly for the Programme municipalities in the Southern Philippines there have been increases in coverage of antenatal attendance of women making four or more visits (see table 11.2). These are very encouraging indications of improved maternal care coverage.

11.9 The Country Office carried out a baseline study in 2006. This was undertaken in the 30 Programme municipalities (10 for each of the Programme provinces). Data were collected on: fertility, maternal deaths, antenatal attendance, births attended by skilled birth personnel, use of teen centres by adolescents, family planning, domestic violence, and HIV and AIDS. This study has provided information on the situation in the municipalities and cities supported under the CP.

Table 11.1: Contraceptive Prevalence Rate for Modern Methods in Programme Municipalities and the Whole Province, Eastern Samar

<table>
<thead>
<tr>
<th>Year</th>
<th>Municipality</th>
<th>Whole province</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sulat</td>
<td>Maydolong</td>
</tr>
<tr>
<td>2006</td>
<td>34.2</td>
<td>20.2</td>
</tr>
<tr>
<td>2007</td>
<td>41.2</td>
<td>32.8</td>
</tr>
<tr>
<td>2008</td>
<td>42.0</td>
<td>42.0</td>
</tr>
<tr>
<td>2009</td>
<td>49.5</td>
<td>52.8</td>
</tr>
</tbody>
</table>

11.10 An endline survey was completed in May and the full results became available in October 2010. The Country Office should be complemented on supporting both the 2006 baseline and the 2010 endline surveys.

11.11 While it is difficult to attribute a causal relationship between changes in coverage rates for certain RH services in the municipalities included in the 10 Programme provinces and Olongapo City there are several instances where there appear to have been generally quantifiable beneficial changes in key aspects of care.

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Table 11.2: Percent of Pregnant Women with at least Four Prenatal Visits, Pilot Municipalities, Southern Philippines

<table>
<thead>
<tr>
<th>Province</th>
<th>Year</th>
<th>Lanao del Sur Municipality</th>
<th>Maguindanao Municipality</th>
<th>Sulu Municipality</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Bubong</td>
<td>Kapatagan</td>
<td>Marantao</td>
</tr>
<tr>
<td></td>
<td>2004</td>
<td>87</td>
<td>56</td>
<td>56</td>
</tr>
<tr>
<td></td>
<td>2005</td>
<td>82</td>
<td>55</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>2006</td>
<td>54</td>
<td>59</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td>2007</td>
<td>92</td>
<td>84</td>
<td>64</td>
</tr>
<tr>
<td></td>
<td>2008</td>
<td>90</td>
<td>83</td>
<td>68</td>
</tr>
<tr>
<td></td>
<td>2009</td>
<td>85</td>
<td>89</td>
<td>72</td>
</tr>
</tbody>
</table>

11.12 As is made clear in earlier sections of this report there have been appreciable improvements in several of the key indicators relevant to achieving not only the CP outputs but also the CP outcomes. For instance in most of the municipalities supported by the Programme there have been improvements in the rates of prenatal visits, births attended by a skilled birth attendant and deliveries in health facilities (see paragraphs 7.1.36-7.1.61, 7.1.66-7.1.69). However the situation with regard to rates of postnatal care are far more equivocal (7.1.70-7.1.73). It is significant the contraceptive prevalence rate has increased in almost all Programme provinces (see paragraphs 7.2.13-7. 2.17 for a discussion of results from routine date sources and the baseline and end line surveys). The responses to questions covering attitudes to ‘violence against women’ in the two surveys show that levels of ‘approval’ of husbands inflicting harm on their wife have declined (see paragraphs 8.34-8.37). More worrying are the results concerning knowledge of HIV and AIDS. While most people (at around 70 per cent overall) included in the 2006 and 2010 surveys had heard of HIV and AIDS far fewer people had a ‘comprehensive’ knowledge of HIV and AIDS. The percentage of people having a ‘comprehensive’ knowledge of HIV and AIDS increased in all Programme provinces but remained at around 20 per cent (see paragraphs 7.4.29-7.4.31).

11.13 The results from service statistics and the baseline and end line surveys strongly suggest that the CP has been successful in achieving important changes in key PDS, RH and Gender concerns. However, given various interventions or factors, besides the Sixth CP inputs, simultaneously at work during the 2006-2010 interval – e.g., direct or indirect
interventions from local governments, civil society and NGOs, multilateral and bilateral donor agencies (e.g., infrastructure, education and health, or agriculture projects), ICT, remittances and regular communication from overseas Filipino workers to their families, etc. – caution needs to be expressed ascribing quantitative slices of those changes to the Sixth CP. In other words, while the survey results are generally instructive, neither the baseline nor the endline survey was designed to determine the specific, much less quantitative, impacts of the Sixth CP for purposes of the end of Programme evaluation. A more focused, in-depth (perhaps, less costly socio-anthropological) investigation of the process, output, outcome and qualitative impact of the CP inputs could have been more appropriate and edifying and should be considered supporting as part of the Seventh CP. Many baseline and end line survey indicators were not directly linked to CP interventions. While there is value to utilize NDHS indicators for UNFPA’s population-based surveys, direct attribution to the interventions from the general population’s perspectives could not be explained because these were excluded in the surveys (see paragraph 7.1.86).

11.14 The CP emphasised that quality of interventions and services are crucial. The outcomes of the reproductive health component state:

(a) increased demand for and utilization of comprehensive, high-quality reproductive health services; and
(b) increased access to comprehensive, high-quality reproductive health services and information.

The second output similarly emphasised quality issues and stated ‘increased access to high-quality, comprehensive, client-oriented and gender-sensitive reproductive health information and services for women, adolescents and men.

11.15 There are a series of issues related to quality of care of RH services in municipalities supported through the Country Programme. In several respects the CP has helped provide the environment for providing good quality RH: essential equipment has been supplied including delivery tables and other supplies; the medical, nursing and midwifery staff has been trained in basic and comprehensive essential obstetric care and other aspects of RH. In addition several rural health units have been accredited by PhilHealth for the either the out-patient or maternity package (see table 11.3). More specifically In Eastern Samar 14 out of the 24 rural health units in 2010 (this includes non-UNFPA supported RHUs) are accredited for the maternity package and the main reason for the non-accreditation of RHUs is that a midwife and/or doctor are not permanently working there.

11.16 However this can be rather misleading. During visits by members of the Evaluation Team to rural health units the actual quality of care observed was variable: some were providing good quality but the quality was poor at many units. For instance oxytocic drugs were not stored in the refrigerator; some delivery rooms were not clean; antenatal, delivery and family planning logbooks were not correctly maintained; screening for maternal syphilis which is included in the national antenatal package is not being carried out; and contraceptives were very poorly stored.
Table 11.3: Accreditation of RHUs in Programme Municipalities Regarding Out-patient Benefit or Maternity Care Package of the Philippine Health Insurance Scheme (PhilHealth)

<table>
<thead>
<tr>
<th>Sixth CP sites</th>
<th>2006 target</th>
<th>2009 Accomplishment</th>
<th>PhilHealth accredited (percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ifugao</td>
<td>3</td>
<td>2</td>
<td>66</td>
</tr>
<tr>
<td>Mountain Province</td>
<td>3</td>
<td>2</td>
<td>66</td>
</tr>
<tr>
<td>Masbate</td>
<td>3</td>
<td>2</td>
<td>66</td>
</tr>
<tr>
<td>Bohol</td>
<td>3</td>
<td>3</td>
<td>100</td>
</tr>
<tr>
<td>Eastern Samar</td>
<td>3</td>
<td>3</td>
<td>100</td>
</tr>
<tr>
<td>Olongapo City</td>
<td>5</td>
<td>2</td>
<td>40</td>
</tr>
</tbody>
</table>

11.17 In some maternity units standard guidelines were not followed and for instance the partograph was not being used and in other instances unnecessary procedures were apparently being carried out such as episiotomy in normal deliveries. These inadequacies very probably contribute to lower effective utilisation of these important services than is achievable and should be a matter of concern. They strongly indicate that the Sixth CP has very inadequately contributed to providing high-quality RH care.

11.18 It is interesting that a study supported by the Country Programme in Ifugao Province[^66] identified issues related to poor quality (including ‘comfort rooms are unclean’, ‘some equipment is not sterile’, ‘some midwives are rude’, women ‘don’t like doctors cutting their perineum’ and ‘not enough free medicines (and contraceptives) available’.

11.19 There are several examples of the Department of Health, WHO, academic Faculties of Medicine and others in the Philippines embracing evidence-based maternal care such as the SEACORD initiatives[^67]. While UNFPA CO staff have been involved in the development of clinical guidelines they appear not to have been involved in some of these exciting developments of evidence based RH care.

11.20 Several research studies (see appendix 9) have been supported under the Sixth CP and


have contributed to refining interventions and co-ordination of the three components.


12.1 The Sixth UNFPA Country Programme consists of three components (RH, PDS and Gender and Culture) which support activities at a central level mainly concerned with policy and a major set of inter-related activities at a local level in three municipalities in each of 10 provinces and one city. As discussed earlier the selection of the provinces and municipalities was based on explicit criteria of high need for RH care.

12.2 The spread of sites covered by the CP and maybe further accentuated by the fact that quite reasonably they were selected to be particularly worthy of support has set challenges for the management of the CP. In each of the Programme provinces a UNFPA Office has been established staffed by a Provincial Programme Officer (or Co-ordinator) and an Admin/Finance Assistant with a larger Office in the Southern Philippines for co-ordinating support to the Programme provinces in that part of the country.

Co-ordination and Integration of Programme Components

12.3 The nature of the CP with considerable geographical spread of field activities involving 10 provinces and one city has necessitated a somewhat complex management structure. The Southern Philippine Office and associated provinces are accountable to one of the UNFPA Assistant Representatives (based in Manila) and the other six provinces and the programme city of Olongapo to the other Assistant Representative (based in Manila).

12.4 The Mid Programme Evaluation\(^6\) recommended that the CO “review, analyze and make strategic changes, as soon as possible, in the structure and management systems of the programme to achieve integration, efficiencies and synergies within and across components”. To an extent this has taken place but the Evaluation Team consider it remains an issue and while some structures have been changed harmonisation of activities and integration within and across components could be strengthened. Fortnightly meetings occur in the Manila Office to exchange information on technical and other Programme issues. Annual workplans are prepared for each component and province. Provinces submit quarterly and annual reports. There are twice yearly Programme review meetings including an annual Country National Programme Management Committee review meeting. Despite these attempts to integrate implementation of the three components the Evaluation Team consider they continue to work to an extent as separate ‘silos’. At a provincial level annual and quarterly workplans are prepared together with provincial and municipality colleagues. These are submitted to the UNFPA Country Office. Frequently the actual ceiling of funds available for support of individual provincial activities is decided very late in the year. Revisions of provincial UNFPA plans are carried usually by the CO with the Evaluation Team understand limited discussion with provincial UNFPA staff. Availability of funds for provincial activities is frequently delayed until towards the end of the first quarter of the year.

12.5 Provinces hold twice yearly Programme Implementation Review meeting. These bring together people working in the Programme municipalities together usually with those

from non-programme municipalities and are a very valuable opportunity where experiences are shared between the three components and with others. They provide a very important example of where the components can be co-ordinated and good practices shared for possible replication in non-programme municipalities (see paragraphs 7.1.34, 7.1.62-65 for examples of where the CP has disseminated good practices).

12.6 These are all important administrative arrangements for co-ordinating and attempting to integrate implementation of the three components of the CP. Major parts of the Country Programme are widely spread over a large number of sites (three municipalities in 10 provinces and one city). This imposes significant challenges to effective and efficient implementation. The UNFPA overhead costs for supporting implementation in a few municipalities in 10 provinces are high in relation to resources provided. For instance in all Programme provinces for relatively limited inputs UNFPA has established ‘field offices’ with UNFPA staff of a programme co-ordinator and admin/finance officer. In the Southern Philippines UNFPA has a larger office to co-ordinate UNFPA support for six provinces. This number and spread of field programme sites poses difficulties on the CO in ensuring adequate monitoring and provision of technical support from those responsible in the CO for RH, HIV and AIDS, FP, Adolescents/youth, PDS and Gender. Monitoring supportive visits to provinces by technical people in the CO take place infrequently. Although those staff designated with a direct ‘area’ responsibility for liaising with two to three Programme provinces regarding planning and implementation issues do visit ‘their’ provinces but this usually consists of attending meetings.

12.7 The Evaluation Team were informed by CO staff, staff of partner NGOs and other agencies that the micro-managing style in the Country Office detracts from effective implementation of the CP. It unnecessarily ties technical UNFPA staff to their desks in Manila and limits their technical support to largely attending meetings in Manila. This is unfortunate as they have expertise which should be made available to the Programme implementing sites.

Assistance for Humanitarian Issues

12.8 The UNFPA Sixth Country Programme did not specifically identify the need to provide assistance to people (and in particular women and children) affected by natural disasters or those resulting from armed conflict. However given the location of the country, the Philippines is prone to natural disasters including earthquakes, volcanic eruptions, typhoons and their resultant effects like tsunamis, landslides and floods. In addition in the Southern Philippines there has been a longstanding conflict between the Government and the separatist Moro Islamic Liberation Front (MILF) and the terrorist Abu Sayyaf Group (see paragraphs 9.19, 9.31 to 9.34 for further discussion of humanitarian assistance provided by UNFPA in the Southern Philippines). Since August 2008 these have resulted in large numbers of internally displaced people in the provinces of Maguindanao, North and South Cotabato, Sultan Kudarat and Lanao Norte and Sur.

12.9 UNFPA’s humanitarian response programme began in December 2006 to address the RH needs of the internally displaced families in the Bicol Region which was devastated by a

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69 For instance see: the Compendium of Good Practices of 6th CP on RH such as community involvement on maternal care, safe motherhood for indigenous peoples, blood supply system and microfinancing,

70 See also paragraphs 7.5 to 7.5.12 for a more detailed discussion of UNFPA’s Humanitarian Response Strategy for RH and SGBV and 9.19, 9.32 to 9.34 for discussion of UNFPA Humanitarian Assistance provided in Mindanao.
series of super-typhoons. Funding was provided by the UN’s Central Emergency Response Fund (CERF) and assistance in the form of RH and hygiene kits was provided to around 227,500 IDPs of whom 7,500 were pregnant women. Further funding for reproductive health services was provided to UNFPA by the Spanish Government’s development cooperation arm, AECID, through the FLASH Appeal issued by the UNCT for the Bicol Region.

12.10 The non-signing of the Memorandum of Agreement on Ancestral Domain led to the outbreak of hostilities in Central Mindanao in August 2008. This created another humanitarian situation far more complex than the one in the Bicol Region. Through another rapid response project from CERF, UNFPA starting in late 2008 has provided RH assistance to IDPs in 10 areas in Mindanao: Maguindanao, Lanao Sur Lanao Norte, Sultan Kudarat, North Cotabato, South Cotabato, Saranggani, Shariff Kabunsuan, Iligan City and Basilan. This assistance continues.

12.11 Humanitarian assistance has been provided by UNFPA to the displaced people in the Southern Philippines and has consisted of:

- Provision of Minimum Initial Services Package (MISP) for sexual and reproductive health during the armed conflict;
- Conduct of rapid assessment on affected areas to gauge their immediate needs in RH;
- Deployment of RH medical missions including information dissemination;
- Distribution of RH and hygiene kits;
- Organization and capacity building of IDP teams;
- Training of humanitarian workers in MISP;
- Administered psycho-social counselling services.

12.12 The activities under the rubric of humanitarian response in the Southern Philippines yielded accomplishments which save lives, alleviated reproductive health needs, provided immediate assistance on pregnant and mothers who had newly given birth, and to some extent prepared people and health providers for future calamities. The Minimum Initial Services Package (MISP) is a boon to people in the evacuation centres. Built-in into the package is the conduct of trainings for emergency response and psycho-social counselling. A number of service providers and stakeholders were trained and were equipped with necessary skills to handle trauma cases.

12.13 In order to prepare for disaster events, the Internally Displaced Persons (IDPs) were organized into teams. They were of great help in the distribution of RH and hygiene kits containing basic necessity. Likewise, the UNFPA-SPO produced IEC materials and video documentaries that underscore the importance of providing RH service to women during natural disasters and in conflict situations. More importantly is the establishment of a database which provides a mechanism to track pregnant IDPs and birth deliveries in the last 5 months.

12.14 In September 2009 tropical Storm Ondoy made landfall in Luzon’s Quezon Province and the monsoon rains caused the worst flooding in Manila and surrounding regions for over four decades. An estimated 80 percent of Manila was under water, with floodwaters in some areas reaching a height of six metres. Almost five million people were affected by the storm and accompanying floods with many being evacuated to centres. In October 2009 Typhoon Parma brought heavy rains and landslides to Northern and Central Luzon and the Cordillera Administrative Region with Pangasinan Province being particularly badly affected and several million people being displaced from their homes.
12.15 In each of these humanitarian disasters UNFPA has mobilized resources and responded as quickly as possible. The assistance provided by UNFPA has been well organized and effective; however in certain instances the response could have been quicker if contingency funding and supplies had been immediately available.

**Resource Mobilisation**

12.16 The CO has been very successful in raising additional funds for activities not supported from regular resources. The budget from regular resources for the CP originally approved by the Executive Board was US$ 20 million\(^71\) (US$12 million for RH, US$5 million for PDS and US$2 million for Gender). Over the years 2005-2009 US$ 20,902,006 was provided from regular UNFPA resources and during the same period over US$ nine million was mobilized from multi-buy sources (see appendix for details)\(^72\). A large proportion of these additional resources have been for joint programmes, humanitarian assistance and for the procurement of contraceptives.

12.17 The successful implementation of the provincial part of the CP has been instrumental in demonstrating the approach supported by UNFPA of the importance of complementary interventions of improving the supply of RH services and at the same time supporting community demand creation.

13 **Sustainability**

13.1 The Sixth CP has garnered the support of national and local institutions. There are instances where UNFPA-assisted programmes were able to trigger resource mobilization among its partners. However, it remains to be seen if the same institutions would be willing to replicate the programme without the attendant UNFPA presence or support.

13.2 The CP has successfully supported very important interventions designed to improve the well being, particularly of women and young people in some of the poorest 30 municipalities in the country. It is likely that many of the interventions will have an effect lasting longer than the timescale of the CP for instance through PHILHEALTH accreditation for maternity care and out-patient benefit. However there are issues related to only supporting three municipalities in a province and the spread of the 10 provinces throughout the country.

13.3 However there are specific instances where likely sustainability is more problematic. For instance regarding ARH as noted earlier (see paragraph 7.3.37) while favorable effects may be observed in the pilot provinces’ municipalities, it is uncertain how some of these initiatives would be scaled up when funding is no longer forthcoming in the provinces. The sustainability of providing young people with continued access to ARH information and services hinges on the commitment and continued support by the various partners. It is hoped that the national leadership and the other partners would continue to stand up to the pressures from society’s conservative sectors. Their sustained support in strengthening young people’s RH life skills will no doubt have long-term favorable consequences on the next generation’s reproductive health and well-being.

\(^{-71}\) Excluding funds for programme support.

\(^{-72}\) This does not include funds for the Joint UN Programmes which UNFPA is a central partner.
13.4 For the number of municipalities covered the overhead costs in terms of provincial UNFPA staff\(^73\) are high. As discussed earlier (see paragraph 7.1.87) given that only three municipalities in each province are covered by the CP, it is very difficult to conclusively show results. It would have been far more efficient and probably effective to have concentrated on fewer provinces and to have covered the whole province rather than in the present situation between 10 and 20 percent of municipalities in any province.

13.5 In order to have increased the possibility of sustainability it is also probable that the likelihood of this happening would have been increased if national execution had been followed in the provinces. All local provincial government people spoken to during this evaluation spoke highly of and appreciated the work of the UNFPA staff working in the Programme provinces. The presence of UNFPA employed staff in the programme provinces has almost certainly increased the pace of implementation of the CP but probably at the cost of decreasing local ownership of the changes being implemented. In addition sustainability would probably have been more likely if the CP had involved regional Government (CHD) offices.

13.6 If the CP had included fewer provinces but covered all municipalities within them and used national execution then the technical people within the CO would need to spend time on field monitoring and support visits to programme sites which is in their terms of reference. This would be an effective use of this important UNFPA technical resource and could have been co-ordinated with the CHD.

14 Conclusions

Relevance

- Did the programme focus on the most critical issues related to the promotion of the ICPD agenda?

14.1 As is made explicit in many earlier sections of this report there is no doubt that the CP focussed on crucial issues related to the ICPD Programme of Action. This is particularly notable because the Evaluation Team heard repeatedly that other UN agencies and donors while acknowledging the importance of the central tenets of the ICPD (PopDev, R and RH, and gender issues) made it clear that they had preferred to let UNFPA be the main (and at times only) voice advocating these crucial issues.

14.2 From discussions with the UNRC and the staff of other UN agencies it appears that this will change under the UNDAF 2012-2016 and the UN delivering as One. The evaluators understand that ICPD and particularly RR and RH as part of assistance to achieve MDG5 will be a major priority in the period covered by the next cycle of UN assistance leading up to and covering the time for delivery of the MDGs.

14.3 In the Sixth CP RH Component, UNFPA showed resilience and strategic creativity in harmonizing its programme with the Department of Health and other UN agencies, and was able to focus on the critical issues related to the ICPD agenda via showcases of attempts to integrate RH/FP/HIV and AIDS, PDS, Youth, and GBV interventions in specific provincial sites. The provincial coverage, though limited, provides a real-time glimpse and deepened

\(^{73}\) As well as the larger Southern Philippine UNFPA office in Davao.
appreciation of the multidimensional challenges that the Philippines faces in meeting its
target to reduce the maternal mortality ratio in 2015 while also including universal access to
reproductive health services.

14.4 The presence of women’s health teams and RH sentinels74 as well as the creative
innovations in the programme sites such as the Maternity Waiting Home in Eastern Samar
attest to the changed outlook or mindset that women of reproductive age, their husbands and
families now have about maternal health.

14.5 Similarly, on HIV and AIDS, the active presence of local AIDS councils, peer
educators, and conscious weaving of HIV and AIDS into RH discourses show that the HIV
and AIDS concerns are now being gradually manifested in mainstream health agenda and
discussions.

• Did the CP address the rights of people in relation to reproductive health, population and
development, gender equality and humanitarian response?9

14.6 The Country Programme focussed on the most critical issues related to the promotion
of the ICPD agenda. In all three components emphasis was given to issues related to
Reproductive Rights. As is apparent from earlier sections, the CP made considerable efforts
to convince influential people and others of the importance of population and development,
reproductive health, gender and humanitarian issues to the improvement of the life of
individuals and also the country.

• Did the overall programme design remain relevant to national and local priorities, given
changing circumstances?

14.7 The overall design of the Country Programme was relevant to national and local
priorities but given the wide spread of CP relatively meagre resources over 10 provinces the
chance of demonstrating lasting positive effect was challenging. The likelihood of
demonstrating successful arrangements for the organisation and implementation of RH care
which would be appropriate for more widespread replication throughout the Programme and
in non-programme provinces was possible. Unfortunately (as described in several earlier
sections) in many instances insufficient attention was given to monitoring, evaluating and
documenting innovations supported by the CP. Consequently it is difficult to give a definite
answer on whether the lessons learnt in support of implementation of RH, PDS and gender
activities in three municipalities in each of 10 provinces are adequate. It will be instructive to
see the results of the assessment of implementation of the first 18 months of the Joint UN
Programme on Reducing Maternal and Neonatal Mortality due to be carried out in the next
few months.

14.8 The UNFPA Office assisted in implementation with the CSR policy however the
limitations of this could have been recognised earlier in the Programme and certainly by the
mid-term of implementation. These issues were highlighted in the reports by Villa and
Seetharam carried out in 2006 and 200775. Villa in 2006 noted the importance of “UNFPA’s
involvement in the commodity security in the country revolves around its strategic role as

74 Group of trained volunteers who closely monitor the health of pregnant women and take charge of bringing the expectant
mothers to a lying-in clinic when delivery is near. RH sentinels receive no monetary compensation for their services.
75 See: Villa E, 2006. An assessment of the RH commodity situation in the Philippines, September to December 2005, and Seetharam and
guardian of the poor sector’s continuous access to quality RH products and services.” Among the recommendations for UNFPA made by Villa were to: “establish a monitoring and evaluation scheme to identify clients who may have been deprived of FP services”; “continue the various strategies to generate the demand for FP/RH products and services which are being introduced in the UNFPA sites” including “installation of a referral system to help those current FP users whose methods are supply-dependent and who want to shift to permanent methods”; “adapt tools and systems as appropriate in their respective areas of application”; “UNFPA may want to introduce the CCM to the UNFPA sites as a tool for managing the stocks at their level”. In 2007 Seetharam and Villa recommended that UNFPA “assist in:

- ‘triggering’ the finalisation of the comprehensive action plan;
- ‘bridging’ the resource gap for contraceptives to be provided at subsidized prices to the poorer clients through the local health outlets in the least developed LGUs and for a specified period;
- ‘expanding access’ through social marketing channels at affordable prices.

14.9 In addition they proposed that “UNFPA could:

- support the establishment of a central focal point to facilitate the procurement, distribution and monitoring of supplies of contraceptives to LGUs at subsidized prices using the existing delivery networks of DOH at the provincial and municipality levels;
- support CSR orientation and training to the provinces where UNFPA programmes operate so as to build their capacity for planning, implementation and monitoring of CSR implementation and in ensuring access to affordable contraceptives through health outlets at LGU levels; and
- strengthen support for the promotion of other modern methods (BTL, IUD and NSV) in response to clients wanting to switch to other methods in a culturally sensitive manner”.

14.10 From visits to RHUs and other health units in Programme municipalities and following discussions with DOH and CHD officials, UNFPA Programme staff particularly at the provincial level and provincial and municipal LGU staff, it appears that these recommendations for UNFPA have only partly been implemented.

14.11 It is difficult to understand why the CP did not include provision for the procurement of contraceptives from early in the Country Programme. It was obvious from 2003 that USAID was tapering down support for the provision of contraceptives and from 2009 ceased any support. This reduction in access to free contraceptives almost certainly resulted in the stagnating of CPR at a low level, an increase in unmet need and increase in the use of traditional methods. This situation was clear from 2006 and confirmed in 2008 in the two large surveys undertaken in these years. This could have been the trigger for changes in the content of the CP and the provision of substantial focused assistance for a contraceptive logistics management system including the procurement of contraceptives. Although the political environment for assisting with FP was harsh UNFPA probably could have been more supportive to improving the situation. Unfortunately to a great extent five years have been lost.

14.12 While supplies of some contraceptives have been provided from non-regular UNFPA
evaluation of the unfpa sixth country programme, philippines 2005-2010

resources, this has not been sufficiently co-ordinated with a strengthening of the logistics system. Although some support has been provided for items related to improving the provision of family planning it was insufficient.

impact - effectiveness:

• how effective is the sixth cp in achieving its objectives?

14.13 this is principally a qualitative end of programme evaluation and consequently conclusions on effectiveness and impact can only be inferred. however the results of the endline survey indicate that there have been substantial positive changes in several indicators among people living in the provinces supported by the sixth cp. while it is not possible to be dogmatic about the effectiveness of the country programme in delivering the outputs set for it and contributing to achievement of the cp outcomes, as is made clear in earlier sections of this report the team consider that it is likely that the cp has made contributions to improving the situation with regard to population and development, reproductive health and gender issues in the country as a whole and particularly in the municipalities of the programme provinces. overall six of the eight outputs set in the country programme document have been largely met but the second and third outputs of the rh component were only partly delivered. it is extremely difficult to make definitive conclusions regarding the likely impact of the cp on the rh status of people living in the areas covered by the field activities. however given the cp inputs have improved the availability of rh care and crucial skills and knowledge it is possible that the cp has had a positive impact.

14.14 the sixth cp rh component was effective in that it was able to address the needs for enhanced capacity at the national and local levels. clearly, unfpa supported and funded technical capacity-building programmes for doctors, midwives, and other health service providers, hiv and aids peer counsellors, rh and hiv and aids advocacy groups. it also provided medical equipment and supplies to hospitals, birthing centres, and lying-in clinics in rural health units and barangay health stations.

14.15 however there are some caveats as has also been made clear earlier. this particularly relates to the non-passage of the reproductive health bill (but of course this was out of the control of unfpa but it was set as one of the indicators for the first pds output). in addition there were major limitations with access to family planning and contraceptive prevalence. once again there were several aspects of this that were out of the control of unfpa, but increased use of fp was identified as an indicator for the third pds output. the third rh output highlighted the importance of ‘improved management systems and practices for reproductive health services’. there are also concerns about the quality of care being provided at rhus, birthing centres and hospitals in the municipalities supported under the cp. the cp emphasised the importance of providing quality rh services. unfpa has provided essential equipment, trained key health workers and supported community awareness initiatives to improve understanding of the importance of rh care (particularly maternal and fp services). this has consequently facilitated the possibility of providing good quality rh care. however limited attention has been given to helping ensure that the actual care which people use is of a good quality.

76 effectiveness is a measure of the extent to which a programme achieves its planned results (outputs, outcomes and goals) and impact (as positive and negative long term effects on identifiable population groups produced by a development intervention, directly or indirectly, intended or unintended. these effects can be economic, socio-cultural, institutional, environmental, technological or of other types. see: unfpa 2004. programme manager’s planning monitoring & evaluation toolkit. division of oversight services.
• What factors influenced the success and effectiveness of the programme? What factors hindered programme effectiveness?

Factors facilitating CP success

14.16 In many respects there was a popular and encouraging demand and support for the issues included in the CP. This was frequently at the community, local political level and many national policymakers and technical people. In several provinces there were committed and informed local governors and mayors who welcomed and actively supported RR and RH issues. It was also notable in for instance Mindanao that working closely and the cooperation of stakeholders, including MRLs facilitated successful implementation of the CP. This was supplemented by good coordination and networking with partners and stakeholders but above all else the most important facilitating factor was the commitment of people.

14.17 The facilitating factors for the RH component were the receptiveness of national and local partners to UNFPA support for capacity-building activities. On the other hand, UNFPA needs to tightly screen participants for training and to establish mechanisms for tracking the post-training performance (i.e., quality, quantity of cases handled/solved, client-provider relationship, level of professional confidence, etc.) of trained personnel. It has been noted, for example, in some instances that participants sent out for the EmONC training lack the requisite background or have zero delivery cases.

14.18 It seems clear that there is now a heightened and broad awareness about PopDev including Gender, leading to widespread and strong demand for FP and RH services.

14.19 There are many factors which have facilitated implementation of the gender component. These include: the (a) presence of numerous international agreements, national laws, local policies, and training tools and protocols which are supportive of gender equity and equality, and women’s empowerment; (b) numerous gender resource persons who are willing to assist the local partners; (c) supportive gender and RH champions from national government agencies, local government units, the civil society, the private sector and local communities; (d) service providers who continually update their knowledge and skills in managing VAW cases and are willing to apply what they learned in their VAW work; (e) strong cooperation among members of inter-agency committees on anti-trafficking and VAW; (f) G & C mainstreamed into RH and PDS strategic plans and activities in some pilot sites; and (g) strong information, education and advocacy to combat VAW in the pilot sites.

Factors hindering CP effectiveness

14.20 In many respects population and development issues/concerns are essentially long-term in nature, not directly or immediately palpable, unlike water, food, power, basic healthcare and education, which attract more urgent attention from national leadership, politicians, policymakers, and society-at-large consequently their very nature means that progress in accepting their importance will be slow.

14.21 There have been notable roadblocks in the country regarding opposition to RH issues. These have been posed by Conservatives and so-called pro-life groups. What seems to obtain in the Philippines is a case of a soft state and a hard church. A well-organized, single-issue vocal opposition is trampling the silent majority. The Church and the State need to arrive at
mutual understanding on the population issue vis-à-vis development, as has long happened in other Catholic countries.

14.22 There are issues of incentive incompatibility for politicians at both national and local levels which have hindered the uptake of Population and RH concerns. Managing population growth at the local level may be incentive-incompatible with internal revenue allotments (IRA) which increase with population size, as well as with political careers that rise with larger constituencies. Negative spillovers are involved, such that a town or province with successful population management, good economic performance, and adequate infrastructure and social services would find itself swamped with migrants from poorly performing towns or provinces. Varying fiscal resources and technical capabilities among LGUs militate against its consistent and effective implementation.

14.23 The change of national and local government executives has also affected implementation of the CP. Leadership changes impact on existing structures, partnerships, and personnel of the programmes and projects.

14.24 For the RH component at the programme sites, effectiveness was hindered by poor health-seeking behaviours, the peace and order situation in some Programme sites, unpreparedness of local chief executives to deal with RH and HIV and AIDS issues or health issues in general, poor relationship between LGU officials and implementing partners of UNFPA, and prevailing cultural, personal/family, and religious beliefs.

14.25 The inadequacy of the monitoring, data collection and process documentation resulting in poor feedback and the apparent incompatibility, in some respects, of the baseline and endline data may not capture evidence of effectiveness. Some implementing partners think that there are already “existing baseline and endline instruments” that should have been examined and considered instead of UNFPA creating new ones.

14.26 The lack of immediate technical support from UNFPA Country Office experts in the field and the presence of UNFPA provincial coordinators who are not organic to the LGUs may have also impeded effectiveness. This can be resolved if the UNFPA also works closely through the Centres for Health Development.

14.27 Wide acceptance of the UNFPA mandate has been hindered by lack of sufficient involvement of the UNFPA technical staff in monitoring implementation of interventions under all three components, but probably most importantly the RH activities. In several provinces the Evaluation Team was informed that delay in agreeing/endorsing provincial programme workplans and in the release of funds by the CO had hindered programme implementation.

14.28 Several issues hindered the full incorporation of gender issues supported by the CP. Many of these issues probably also apply to other components as well. The lack of integration of gender and culture issues in RH and PDS limited the adoption of key concerns. There has been very little monitoring and summative evaluation of structures and tools and this could have helped identify specific limiting factors. In several provinces there was confusion about different VAW laws. With GAD Codes, there was uneven capacity of provincial and municipal partners to undertake gender analysis for GAD planning and budgeting; presence of GAD Codes, RH Codes, and Health Codes and how they complement each other. If the capacity of partners to prepare GAD plans and budgets had been
strengthened this would probably have increased their implementation. Attention could have been given to harmonize the different codes—GAD, RH, and Health—and how these relate to the Magna Carta of Women could make it easier to operationalise them.

14.29 A general concern is that the rich expertise in local (provincial) research/academic institutions has hardly been tapped to help clarify issues and to support implementation.

14.30 Several NGOs such as MOVE rely on volunteers, and have no permanent coordinating and this limited their important contributions.

14.31 In addition there are several factors which applied to a lesser or greater extent in programme provinces. There limitations in human resources for instance shortages of midwives and doctors to work in the more remote RHUs. Several of the Programme municipalities are remote and island areas making coverage difficult. Lack of sufficient attention to provision and delivery of quality RH care probably affected effective coverage. Some LGUs were unable or unwilling to allocate sufficient resources for key items and inadequate negotiation skills among provincial technical departments for resource mobilization. With a change in political leadership there have been different priorities. There is also wide spread weak data validation resulting in problems in data consistency and accuracy.

14.32 Often there is confusion about the different VAW and RH ordinances and frequently a single municipal social worker has multiple responsibilities. Capacity mapping of trained social workers vs. total number of SWs in pilot sites.

- How did the M and E tools adopted by the programme contribute to programme effectiveness?

14.33 As has been discussed earlier the monitoring tools used by the Programme had limited overall utility. However at the provincial level the schemes developed and reported on regularly have provided an important platform to review progress with implementation of activities and review utilisation and in some instances coverage of crucial RH services.

- Did the CP investments in Mindanao deliver the expected results?

14.34 In many respects implementation of the Programme in municipalities supported in the provinces in Mindanao posed the greatest challenges. Most of the issues mentioned above regarding hindering factors applied to an even greater extent in Mindanao. Consequently it is even more impressive that the CP achieved it outputs to a similar degree as in the other Programme provinces.

14.35 It was felt that paying attention during the planning stage of interventions to the most cost efficient way of using the resources in the Programme municipalities and effective negotiations for complementation/counter-parting from LGUs together with transparent accounting and auditing facilitated implementation. Accountability and transparency are built into the planning, implementation, and assessment of results. Expenditures and accomplishments are monitored, liquidation for expenditures after conducting every activity is required together with a review of accomplishments vis-à-vis target.
14.36 There were certain issues specifically relevant to Mindanao. While the male MRL involved in the programme have been extremely important in endorsing critical RR, RH and gender issues in for instance their Friday sermons, it would have assisted implementation if there were more female MRL. This could have facilitated programme implementation. There is also a need to strengthen the involvement of MRL and IPs in gender and RH and to pursue the completion of ARMM GAD Code and Muslim Personal Laws.

- **What was the impact of the Sixth CP on the lives of communities in Sixth CP sites in terms of reproductive health, gender equality and population and development, as well as humanitarian response?**

14.37 As is clearly stated in the evaluation matrix (see appendix) this evaluation is not an impact evaluation. Such an evaluation would have required a different approach and level of funding. However in the judgement of the Evaluation Team it is likely that the CP has led to improved health outcomes in the target populations, for instance with regard to improved prenatal and delivery care and access to services for gender-based violence. In several Programme sites there were increases in utilisation of crucial RH services, e.g. completed perinatal visits, contraceptive prevalence, births attended by a skilled birth attendant. While catalytic the UNFPA inputs were relatively small and spread over 30 municipalities. There are many other factors in the Programme municipalities which have affected these items including LGU support, NGO initiatives and community mobilisation. A similar situation also applies to humanitarian support provided by UNFPA.

**Efficiency:**

- **What measures did the CP introduce to improve cost efficiency of the Programme and did they have an effect? How did the CP improve accountability, transparency and risk management and what was the effect?**

14.38 Given the regular resources available to the UNFPA Sixth Country Programme (equivalent to just over US four million per year for programming. See appendix for details), what has been achieved is appreciable. However given that these resources are spread so thinly over central activities in Manila and 10 provinces and one city it is very difficult to be definite about precise results attributable to UNFPA support.

14.39 No measures were identified by the CO staff which had been introduced to improve cost-efficiency. However in Mindanao the evaluation team were reassured to gather from focus group discussions with stakeholders that they were very sure that the regular and transparent reporting of budgets and expenditures had greatly enhanced efficient implementation of the Programme.

14.40 The Evaluation identified several instances of where The CP used measures to improve cost efficiency of the CP. For instance the cost-sharing schemes between UNFPA and the LGU in the pilot municipalities to sustain the birthing clinics indicate efficient utilization of resources (see paragraph 7.1.82) Similarly the cost-sharing schemes between UNFPA, the participating schools, LGU, and communities in the establishment and management of teen wellness centers and in conduct of school-based teachers training on the use of the enhanced ARH life-skills education tools is a cost efficient use of UNFPA resources (see paragraph 7.3.36) An example of the perceived effectiveness of CP support was from G & C partners that the measures which have been initiated in the pilot sites were effective because these
enhanced the knowledge and ability of the service providers (the supply side) to provide more gender-responsive support to their clients (see paragraph 8.40).

14.41 The “silo” mindset seems to affect the full implementation of the Sixth CP (others claim that sometimes it appears “too projectised”). Indeed, some partners do not seem to have a full appreciation of how the Programme components work together towards a common goal. Some partners appear to only work or focus on the “silo” that they were given funds/resources for, but are unable to articulate or express how their work fits into the overall scheme.

14.42 On the other hand, some partners who were eager to do integration think that they have been “pigeon-holed” or clustered into a sub-component and hence, are not fully tapped for their potential to help cross-pollinate ideas about RH. They consider this has resulted in an over-fixation on some issues (e.g., legislative advocacy) to the detriment of dealing with other pragmatic and parallel opportunities (e.g., service delivery, budget negotiations, advocacy work with the LGUs) that could have also advanced the cause of RH.

14.43 Some partners say that they are only being tapped when needed (e.g., as conduits). There is a lack of serious continuing dialogue or engagement, and they said that they would have appreciated receiving updated reports or information about what is happening, what has happened to the projects, and the status of integrating the Programme components.

- How did the CP utilize existing local capacities of duty-bearers and claim-holders in programme implementation?

14.44 In several of the Programme provinces there are examples of where the Programme has influenced involvement of duty-bearers and claim-holders as a result of UNFPA support. For instance participatory governance from barangay to municipal levels. In Asipulo, Ifugao, prioritization of projects are products of public consultation. Public participation in projects is also through contributions of labour by able-bodied constituents. Moreover towards the end of a project, there is again public consultation where people grade the project.

Recommendations and Possible Strategies for the Next Programme Cycle 2012-2010

15.1 The recommendations of the Evaluation Team are of two main categories: 1) those which apply to the whole Country Programme; 2) specific issues under the CP components.

Issues Related to the whole Country Programme

UNDAF and Joint UN Programmes

15.2 The Seventh UNFPA Country Programme will be developed within the UNDAF 2012-2016 and under the overall context of the Government’s Medium-term Philippine Development Plan 2010-2016 (MTPDP) and the Updated Regional Development Plans (RDPs). The United Nations together with Government has decided that the 2012-2016 UNDAF will be implemented as ‘One UN’.

77 Preparations for the UNDAF have already begun and UNFPA is a member of these extensive consultations.
78 See presentation by Dennis Arroyo, Director, National Planning and Policy, National Economic and Development Authority on April 7, 2010.
15.3 Three critical steps for initial preparations for a One UN programme have been identified: (1) to strengthen the UNDAF mechanism in two areas, (a) UNDAF Results Matrix and (b) UNDAF M&E System; (2) to develop a results based and harmonized UNDAF M&E system by Strengthening agency M&E systems for RBM and; (3) supporting the functions of UNDAF theme groups. The UN system in the Philippines has made some efforts to strengthen the UNDAF mechanism. In 2007, the NEDA affirmed its commitment for a One UN System in the Philippines by 2010, as a ‘pilot’ for the second round of countries, and, to implement the principles of the Paris Declaration on Aid Effectiveness. These developments clearly have substantial implications for the work of UNFPA in the Philippines and specifically for the preparation of the UNFPA Seventh Country Programme document. Decisions made in September 2008 as part of the Accra Agenda for Action at the Third High-Level Forum on Aid Effectiveness ‘to accelerate and deepen implementation of the Paris Declaration on Aid Effectiveness’ included that ‘the effectiveness of aid is reduced when there are too many duplicating initiatives, especially at country and sector levels’. In addition the need to reduce ‘fragmentation of aid by improving the complementarity of donors’ efforts and the division of labour among donors, including through improved allocation of resources within sectors, within countries, and across countries’ were highlighted.

15.4 It is important that UNFPA and the UN as whole use their more limited funding to leverage funds and act as a catalyst to support specific high priority issues which often do not receive the attention that they objectively justify, such as reproductive health.

15.5 UNFPA and other international organizations should make it clear to the national and local governments that the role of their programmes of assistance is merely catalytic – to get things started but later to be taken over and sustained by national and local agencies. Towards greater and more real development impact, the UN and other donor agencies should be more serious about closely coordinating and harmonizing their aid programmes such that “the whole will be greater than the sum of its parts”.

15.6 The Seventh UNFPA Country Programme should fit within the mandate identified in UNFPA’s Strategic Plan and take account of the findings of the progress report considered by the Executive Board in June/July 2010. However the present strategic plan runs from 2008 to 2011 and presumably a new strategic plan will be prepared in the near future and will have a similar framework including the monitoring, evaluation and reporting component and will provide the framework for UNFPA accountability and reporting during 2012-2016.

15.7 During discussions by members of the Evaluation Team with the UN Resident Co-ordinator, the WHO Country Representative and staff from UNICEF, each spontaneously said that Reproductive Health and Rights will be a high priority for the United Nations in the build up to the delivery of the Millennium Development Goals and consequently MDG5. This provides a great opportunity for UNFPA to press for further implementation of the ICPD Programme of Action with a supportive UN framework.

15.8 Joint UN programmes involving UNFPA are outside the scope of this evaluation of the Sixth Country Programme, however ensuring close and meaningful collaboration with
UN agencies that in certain areas have similar mandates will be very important in the development and implementation of the UNFPA Seventh Country Programme as a part of the UNDAF 2012-2016 and the UN Delivering as One. It will be interesting to see the results of the assessment which is to be carried out by AusAID the donor for the Joint UN Programme for Maternal and Neonatal Health Programme involving UNFPA, UNICEF and WHO. The real test of how successful the Joint Programme will be when it is assessed.

15.9 There is an opportunity to seriously consider the trade-off: between spreading support thinly with the consequent problems in demonstrating feasibility or concentrating assistance in a few provinces. In addition the Seventh Country Programme has to consider whether to continue to support the current pilot provinces/municipalities/cities or shift its support to other similarly situated or deserving areas. The former approach would strengthen or deepen what has been initiated, while the latter would likely spread thinly limited resources.

15.10 In the preparation of the Seventh UNFPA Country Programme consideration should be given to UNFPA’s Strategy toward Middle-Income Countries (MICs). In particular the need for close interagency co-ordination and harmonisation within the UN and with other development partners in order to reduce transaction costs and duplication and to increase efficiency. When considering the three modalities of engagement set out in the Strategy it is likely that the second modality is the most appropriate to follow for the Seventh UNFPA Country Programme of targeted and catalytic UNFPA funding, programmes and services. This modality would require strengthening national capacities to implement the ICPD agenda, while entailing evidence-based selectivity and only a nominal technical contribution from UNFPA. It would indicate a far greater stress placed on using national execution and slimming down of the UNFPA presence and involvement in CP implementation. This could include:

- continuation of support at the central level for PDS, RH and Gender policy development;
- deliberately include young people’s concerns;
- more consciously integrate or functionally link PDS, RH and Gender issues right at the design stage;
- in view of the unfortunate regularity of events resulting in humanitarian disasters in the country, UNFPA should consider including as an integral part of the Seventh CP (particularly in the RH component) to build capacity in disaster response and management and support in contingency planning;
- concentrating field support throughout fewer provinces. One province could be selected from Luzon, Visayas and Mindanao based on indicators of high need such as low Human Development Index, high Maternal Mortality Ratio and high Poverty Incidence;
- following national execution modalities and working through Regional Government structures. This could be more efficient, effective and lead to improved sustainability. It would require more intensive use of UNFPA technical staff based in Manila in regular monitoring and supportive visiting to Programme provinces;
- in line with the Accra Agenda for Action agreed at the Third High-Level Forum on Aid Effectiveness of September 2008 to accelerate and deepen implementation of the

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Paris Declaration on Aid Effectiveness and avoid duplication of donor efforts, it is strongly recommended that positive steps should be made to ensure there is no geographical or technical overlapping or duplication of support provided by UNFPA to that given by other agencies and donors (UNICEF, JICA, EC, World Bank and USAID) covering similar issues.

- a sustainability plan that coincides with a gradual exit phase from Programme provinces should be included at the CPAP design stage.

15.11 Assuming that the three components will be continued in the Seventh Country Programme, then in order to increase the effective implementation of the technical aspects of all three components of the CP, it is important that:

- management of implementation of the CP should concentrate on substantive issues which affect the quality of the activities and realisation of the outputs rather than being largely reactive to immediate day-to-day issues;
- UNFPA Technical staff in the Country Office should be given responsibility for implementation of the issues in the areas of their expertise and be accountable for monitoring and reporting to the relevant Assistant Representative;
- the management of the Country Office should ensure the most effective possible use is made of the technical skills of programme staff including providing support to field implementation.
- regular supportive visits to Programme provinces should occur by CO technical staff. Efforts to improve the integration of activities in the different CP components need to include critically reviewing activities and if necessary re-scheduling them to ensure they complement one another.

15.12 Efforts should be made to ensure the indicators and targets identified in Country Programme Documents are specific, measurable and as far as possible are continuous rather than dichotomous variables.

15.13 In line with recent decisions of UNFPA’s Executive Board budget provision should be included in the Seventh Country Programme for regular M&E functions. These should include: baseline and endline surveys; regular monitoring activities including field visits by technical staff; and the establishment and maintenance of databases for output and other relevant indicators, which are comparable between different areas covered (e.g. municipalities and provinces) across the country and to track implementation of CP activities.

15.14 As mentioned in the 2009 UNFPA Evaluation Policy, the UNFPA Regional Asia and Pacific Office should provide support and technical advice to the monitoring and evaluation activities of the Philippines Country Office and ensure that, at the planning stage for the Seventh Country Programme, adequate results frameworks are developed for the Programme. This should include a national evaluation capacity building component, ensuring the full and active participation of national counterparts in the evaluation process and in future evaluations seeking increased involvement in joint evaluations with partners and donors.

15.15 Steps should be taken to ensure that the Seventh CPAP design is:

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integrative by conducting participatory planning to determine which aspects of the Programme could be mainstreamed with the different components’ strategies and activities;

- inclusion of monitoring and summative evaluation of the different structures, capacity building, and tools that are developed by national and local partners to ensure compliance, quality assurance, and sustainability;

Specific issues under the CP components

- Population and Development Strategies

15.16 The Seventh UNFPA Country Programme should focus on the supply side at the national and local levels. It bears restating the famous Say’s law: “Supply creates its own demand”. That is to say, not only will expanding the supply of FP/RH services satisfy existing unmet needs, it would also result in greater demand for them, thereby leading to greater desire for smaller-sized families among the poor and near-poor.

15.17 Consideration should be given to shifting the thrust of advocacy to activities that make citizens demand more strongly of their national and local leaders and representatives to push for the supply-side of FP/RH, such as passing the RH bill and making sure that it is adequately budgeted and properly implemented on the ground. This could include more focused targeting of free primary health care and FP/RH services to the poor. There are indications that the non-poor and relatively well-off are also availing themselves of these services resulting in a crowding-out of the poor and more deserving clients.

15.18 The capacities of leaders should be enhanced to ensure that they are able to work with young people. This could help ensure that governments invest in young people so that support is aligned to adolescent reproductive health. Partnerships should be built with the Sangguniang Kabataan to mainstream ARH and to become ARH champions

- Reproductive Health

15.19 Given that the achievement of MDGs is a high priority for UNFPA in the Philippines, UNFPA should be in the vanguard and fully participating in quality assurance initiatives, development of evidence-based maternal care and guideline development and promulgating their dissemination.

15.20 As indicated in section 7.6.1 the sub-components of RH—maternal health, HIV and AIDS, FP, ARH, and VAWC—have common and sub-component specific challenges that could be addressed in the next country programme. The following matrix presents the common challenges and future directions of these RH sub-components. It also covers the specific sub-component challenges and under future directions items to be considered for possible inclusion in the Seventh Country Programme.

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Future Directions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/ Inadequate integration of PDS, RH, G &amp; C at different program phases.</td>
<td>1/ Ensure that an integrative framework is designed at the planning &amp; implementation phases of the CP</td>
</tr>
</tbody>
</table>

| Common to all sub-components & VAW | | |
|-----------------------------------|---------------|
| 1/ Inadequate integration of PDS, RH, G & C at different program phases. | |

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<table>
<thead>
<tr>
<th>Challenges</th>
<th>Future Directions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/ No systematic monitoring and process evaluation system from planning, implementation and completion phases of the sub-components to ensure program attribution and accountability.</td>
<td>2/ Build the M &amp; E system with partners using measurable indicators and clear targets at the planning and implementation phases of all components of the 7th CP.</td>
</tr>
<tr>
<td>3/ Need to synchronize/harmonize indicators of baseline and end-line surveys with intervention or process indices for program attribution and accountability.</td>
<td>3/ Ensure that the baseline and end-line indices are aligned with the process and M &amp; E indicators.</td>
</tr>
<tr>
<td>3/ Quality assurance of the facilities and competencies of the duty bearers of the birthing clinics, the teen centers, the GAD crisis centers, and other related facilities and groups (e.g., waiting homes, police women’s desks, interagency committees) are wanting.</td>
<td>3/ Utilize current standards or formulate new standards, guidelines or protocols with partners for quality assurance of the different facilities and competencies of the duty bearers.</td>
</tr>
<tr>
<td>4/ How to ensure that the good practices are utilized or mainstreamed in the pilot provinces and in the future CP sites;</td>
<td>4/ Include the RH good practices in the future interventions</td>
</tr>
<tr>
<td>4/ Interventions in three municipalities may not create the desired PDS-RH-G &amp; C impact in each of the 10 geographically-dispersed provinces.</td>
<td>4/ Reduce the number of poor provinces and cover all the municipalities for broader impact</td>
</tr>
<tr>
<td>5/ Absence of process documentation research, operations research, and social, economic, and anthropological studies about various interventions-- calls for involvement of local/provincial research institutions.</td>
<td>5/ Include PDR, OR, and social, economic, and anthropological studies during program implementation to be able to explain program effects on targeted population by involving local and provincial institutions.</td>
</tr>
<tr>
<td><strong>Sub-component specific</strong></td>
<td></td>
</tr>
<tr>
<td>Maternal health</td>
<td></td>
</tr>
<tr>
<td>6/Limited documentation and explanation of maternal deaths that occurred in the pilot municipalities.</td>
<td>6/ Link program implementation and M &amp; E with periodic maternal/perinatal death reviews at the health facility or sub-national levels</td>
</tr>
<tr>
<td>7/ Need address continued low usage of birthing clinics/facilities among indigenous and Muslim women.</td>
<td>7a/ Community advocacy about MDG 5 and value of mother’s life in partnership with IP male and female elders, MRL and other stakeholders should be</td>
</tr>
<tr>
<td>Challenges</td>
<td>Future Directions</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>HIV &amp; AIDS</td>
<td></td>
</tr>
<tr>
<td>8/ Mainstreaming comprehensive STI/HIV &amp; AIDS program absent in most pilot municipalities and provinces except Olongapo City; 9/ Align UNFPA’s efforts on HIV and AIDS with the next Philippine AIDS Medium Term Plan (PAMTP) for 2011 to 2016 to sustain its activities as the lead UN agency for the prevention of HIV among female sex workers and the youth</td>
<td>8/ Targeted advocacy on LGUs to develop comprehensive AIDS program; sponsor LGUs and local health providers to observation study tours to Olongapo City 9/ Actively participate in the preparation of the next PAMTP and present MARPs agenda especially for FSW and the youth. 10/ Inclusion of advocacy strategies to raise knowledge about HIV transmission and prevention with various community-based partners and facilities.</td>
</tr>
<tr>
<td>10/ Need to enhance IEC in communities to correct wrong notions about HIV transmission and prevention. 11/ How to build in operations research on some HIV interventions.</td>
<td>10/ Inclusion of advocacy strategies to raise knowledge about HIV transmission and prevention with various community-based partners and facilities. 11/ Identify HIV program areas for operations research</td>
</tr>
<tr>
<td>FP</td>
<td></td>
</tr>
<tr>
<td>12/ Need to increase support (if possible with other donors) to DOH in the design and implementation of a comprehensive RH Commodity Security and Logistics Management Information System (RHCS-LMIS). 12b/ Need to cover a range of modern and highly effective contraceptives together with essential and emergency RH drugs</td>
<td>12/ Include FP support to DOH for the design and implementation of RHCS-LMIS</td>
</tr>
<tr>
<td>ARH</td>
<td></td>
</tr>
<tr>
<td>13/ Inclusion of ARH indicators in baseline and end-line surveys, teen wellness centers</td>
<td>13/ Develop measurable youth indices for integration in baseline and end-line surveys</td>
</tr>
<tr>
<td>14/ How to raise LGU awareness and support for MTYDP to establish local youth councils</td>
<td>14/ Support youth groups and other stakeholders to advocate to support the MTYDP and establish LYCs</td>
</tr>
<tr>
<td>Challenges</td>
<td>Future Directions</td>
</tr>
<tr>
<td>------------</td>
<td>------------------</td>
</tr>
<tr>
<td>15/ How to strengthen MTYDP and SK partnership as advocates for ARH</td>
<td>15/ Continue support and technical assistance to strengthen NYC’s partnership with SK, train young people in ARH policy advocacy, development of local youth development programs and councils, and confederations of youth</td>
</tr>
<tr>
<td>16/ Need to sustain teen wellness centers</td>
<td>16/ Develop sustainability plan with DepEd, LGU, RHU, DOH-AHYP in the remaining months of the 6th CP about the continued operations of school and community-based teen wellness centers.</td>
</tr>
<tr>
<td>17/ Need to hasten the development and release of the standards for ARH-friendly information and services</td>
<td>17/ Remind DOH technical committee for AHYP the need for an ARH-friendly standards</td>
</tr>
</tbody>
</table>

### Gender and Culture

15.29 Consideration should be given to including the following items related to gender in the next Country Programme:

- inclusion of monitoring and process evaluation of the measures to address GBV (inter-agency committees on trafficking and VAWC, the crisis centres, the tools and capacity building activities) which were developed by national and local partners to ensure compliance, quality assurance, and sustainability;
- ensure that more Muslim and IP women NGOs and female MRL are tapped in advocacy for women’s empowerment, RH and RRs, and gender equality. Pursue the development of ARMM GAD Code and the Regional Code of Customary Laws to discourage child marriage;
- provide adequate training to local partners about gender analysis, planning, budgeting and advocacy to effectively access GAD funds from local government units;
- undertake capacity mapping of social workers to determine the proportion of trained social workers who can be tapped to roll out the programme in other locations;
- roll out the harmonization of documentation of VAW cases to all pilot and non-pilot areas to obtain reliable data about GBV cases in the country;
- inclusion of refresher training for service providers and partners about the different VAW laws to ensure accuracy of classification of GBV cases;
- orient the gate keepers of customs and traditions particularly male and female MRL and IP leaders about the GAD crisis centres’ services and the country’s laws and ordinances in order to increase the demand for these facilities’ services;
• ensure that more female MRL are tapped in advocacy for women’s empowerment, RH and RRs, and gender equality;
• pursue the development of ARMM GAD Code and the Code of Muslim Personal Laws to discourage child marriage;
• assist in action to institutionalise MOVE;
• determine how the various local codes complement each other and how they could these be best harnessed to obtain support for GAD-related projects and activities;
• undertake process documentation and evaluation for the different activities of local partners by engaging provincial research institutions and graduate students.

Humanitarian Assistance

15.30 In view of the unfortunate regularity of events resulting in humanitarian disasters in the country, UNFPA should consider including as an integral part of the Seventh CP (in the RH component if it is decided there should be such a component) to build capacity in disaster risk reduction and management and support contingency planning, training of staff and maintaining stocks of RH kits and other supplies to respond rapidly to any future emergencies.
Appendices

1. Tables from PDS section

Table 6.1: P202 Advocacy Activities

<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>PROJECT NO./TITLE</th>
<th>IMPLEMENTING PARTNER(S)</th>
<th>ACTIVITIES</th>
</tr>
</thead>
</table>
| ADVOCACY | P202: INCREASING DEMAND FOR IMPROVED POLICIES ON POPDEV, GENDER, AND RH AT NATIONAL AND LOCAL LEVELS | NGO CONSORTIUM: Forum PLCPD PNGOC ECOP | • Identifying champions  
• Political mapping of support and opposition to PopDev and RH among national legislators  
• Networking/coalition building/alliance formation:  
  o Participation in all major international meetings for Legislators and CSO.  
  o Creation of the Alliance for Choice and Empowerment (A ForCE)  
  o Coordination and networking with other NGO alliances and coalitions  
  o Planning/participation in, conduct of:  
    ▪ National Conference at PICC,  
    ▪ National Media Symposium,  
    ▪ Concluding workshop of ICPD stakeholders,  
    ▪ Cine Indie for the MDGs,  
    ▪ Sustained Media Promotion (local/national)  
    ▪ Multi-sectoral RTDs on 2007-2008 FP budget  
• Awareness-raising and commitment-building to RH and PopDev through intensive advocacy campaigns:  
  o Production of IEC materials  
  o Publication of ICPD@15 materials and conduct of special events  
  o Identifying and building national and local level champions  
  o Expansion of number of sectors actively advocating RH, Gender and PopDev through:  
    ▪ National Media Symposium participated in by media people from 17 provinces (Forum);  
    ▪ Local media allies (PNGOC and TAMA);  
    ▪ Multi sectoral forums in support of the RH bill in Masbate City, Zamboanga City, GenSan, and Pangasinan (PNGOC);  
    ▪ Regional consultations (PLCPD and Interfaith);  
    ▪ Forums on RH among business sectors in Batangas, Zamboanga, Pangasinan and GenSan (ECOP)  
  o Mainstreaming RH, Population and Gender in the electoral agenda of 2007 candidates  
  o Assistance in Policy Formulation in the 9 areas  
  • Implementation of cohesive and comprehensive communication and media campaigns on ICPD@15, MDG5, and RH:  
    o Monthly *Usapang PopDev* (national) and *Usapang RH* (province/local), |
### Table 6.2: P204 Advocacy Activities

<table>
<thead>
<tr>
<th>GOAL/OUTCOME: An enhanced policy environment that supports population and RH programmes, particularly for the poorest and most vulnerable.</th>
</tr>
</thead>
<tbody>
<tr>
<td>OUTPUT: Relevant government institutions, NGOs and private sector groups are able to identify poor and vulnerable groups and formulate, implement, analyze, and monitor pro-poor and gender-responsive policies, programmes, and projects on PopDev and RH</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>PROJECT No./TITLE</th>
<th>IMPLEMENTING PARTNER/S</th>
<th>ACTIVITIES</th>
</tr>
</thead>
</table>
| ADVOCACY | P204: SUPPORT TO POVERTY REDUCTION (DEVELOPMENT OF HARMONIZED APPROACHES) | NAPC | • Networking and partnership building:  
  o Formation of Technical Working Group among NGAs, NGOs, basic sectors, LGU leagues, and UNFPA  
  o Regular convening of TWG for consultation and validation workshops  
  o Continuing networking for establishment of small-grant facility for LGU projects using CBMS  
  o Continuing coordination with implementing partners for harmonization of tools and systems for planning, implementation, monitoring and evaluation.  
  • Drafting and evolution of harmonized approaches, frameworks, strategies and operational guidelines for validation and advocacy for adoption among NGAs and LGUs:  
    o Population-poverty reduction (HAPPI),  
    o Population-poverty reduction-environment resource sustainability (HAPPI*ER), and  
    o Population-poverty reduction-environment resource sustainability-science & technology innovations (HAPPI*EST).  
  • Field validation and identification of LGU good practices for documentation, recognition, and replication. |
Table 6.3: P201 and P103 Advocacy Activities

<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>PROJECT NO./TITLE</th>
<th>IMPLEMENTING PARTNER/S</th>
<th>ACTIVITIES</th>
</tr>
</thead>
</table>
| ADVOCACY     | P201: ICPD INTEGRATION THROUGH POPDEV AND ADVOCACY | PILOT LGUS            | • Organization and mobilization of local advocacy teams/Advocacy core teams in the pilot areas for:  
  o Integration of PopDev planning approach in local planning  
  o Construction and furnishing of facilities for health care delivery, adolescent concerns, etc.  
• Political mapping of support and opposition to PopDev and RH among local legislators  
• Drafting and passage of provincial and municipal RH and/or Gender Codes in UNFPA pilot areas  
• Ratification of IRRs for local ordinances |
|              | P103: LOCALIZING THE MDGS; IMPROVING CAPACITY OF LGUS TO DELIVER POPULATION AND RH INFORMATION/ SERVICES | DILG PILOT LGUs       | • Strengthening enabling environment for MDG localization:  
  o Setting-up structure for consultation and linkages with strategic partners  
  o Development and duplication of IEC and advocacy activities and materials  
• Improving LGU service delivery levels and standards:  
  o Search for MDG Local Champions on RH  
  o PopDev Good Practices Awards |

Table 6.4: PDS Research and Knowledge Management Activities

<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>PROJECT NO./TITLE</th>
<th>IMPLEMENTING PARTNER/S</th>
<th>ACTIVITIES</th>
</tr>
</thead>
</table>
| RESEARCH AND KNOWLEDGE MANAGEMENT | P103: LOCALIZING THE MDGS; IMPROVING CAPACITY OF LGUS TO DELIVER POPULATION AND RH INFORMATION/ SERVICES | DILG CBMS TEAM LGUS    | • Installation of computerized community-based monitoring system (CBMS)  
• Implementation of CBMS  
  o Orientation and briefings on CBMS and rider questionnaire  
  o Training of enumerators on CBMS  
  o Data encoding and map digitizing  
  o Data processing, mapping and analysis |
|              |                                    | DILG (BLGD) POPCOM     | • Formulation of Rationalized Planning System (RPS) sourcebook as guide to harmonize NGA processes and technical assistance on planning and budgeting. |
|              | P204: SUPPORT TO POVERTY REDUCTION (DEV’T OF) | NAPC                   | • Monitoring and appraisal of PopDev integration in anti-poverty programs of NGAs  
• Rapid assessment of poverty and population programs and policies of LGUs and extent of PopDev integration efforts |
### Harmonized Approaches

<table>
<thead>
<tr>
<th>P201: ICPD Integration through PopDev and Advocacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>POPCOM NGOs</td>
</tr>
</tbody>
</table>

- SWS surveys on RH (Manila, Paranaque and Cebu)
- Conduct and/or support to major population, RH and gender research and studies, for example:
  - ICPD@15
  - State of Philippine Population Report 4 (International Migration)
  - Situation of Philippine Population and Reproductive Health Analysis (SPP-RHA)
- Production, publication, and duplication of various materials:
  - ICPD@15 Philippine Country Report
  - IEC materials for RH Bill
- Gender-responsive PopDev Planning Guide used in TOTs, roll-out trainings and other capacity-building activities at national and local levels

### Table 6.5: P203, P204, and P103 Capacity-Building Activities

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Project No./Title</th>
<th>Implementing Partner/s</th>
<th>Activities</th>
</tr>
</thead>
</table>
| Capacity Building | P203: Research and Training in Population | POPCOM, Olongapo City, ICOMP, UP CMC | - Trainings on Advocacy Skills for PopDev, RH and Gender:
  - TOTs, resulting in 71 advocate trainers from LGUs and regional level partners
  - Roll-out training, resulting in 160 local advocates
- Trainings on Gender-responsive PopDev Planning:
  - TOTs, resulting in 54 trainers/planners from various government agencies nationwide. (Due to rigid passing criteria, only 21 of the 54 trainers have been accredited as PopDev trainers.)
  - Roll-out training at the local level, resulting in 105 local planners
  - TOT focused on Community-Based Integrated RH/FP and Coastal Resource Management.
- Roll-out training on Community Health Outreach Program, resulting in more than 200 trained peer educators, community-based distributors, RHU staff, BHWs. |

| P204: Support to Poverty Reduction (Dev’t of Harmonized Approaches) | NAPC | - HAPPI activities: Poverty and population integration in development planning:
  - Drafting and provision of inputs/comments to proposed IRR of RA 8425 (Social Reform Agenda and Poverty Alleviation Act)
  - Localization of HAPPI framework and strategies/Mainstreaming PopDev at the local level
  - Direct technical assistance and coaching to LGUs:
    - Orientation of pilot provinces and municipalities on HAPPI project, its relevance on the achievement of national and international goals and target |

**Goal/Outcome:** National, sub-national and sectoral policies, plans and strategies take into account population and development linkages.

**Output:** Upgraded national and sub-national capacities to formulate and implement gender-responsive development plans, policies, and programmes that take into account population, RH, and poverty linkages.
| P103: Localizing the MDGs: Improving Capacity of LGUs to Deliver Pop and RH Information / Services | DILG CBMS TEAM LGUs | - Identification of issues/gaps related to PopDev integration into pro-poor and development programs, plans, and policies in LGUs
- Drafting of action plans on how to mainstream and sustain PopDev integration efforts of national and local agencies’ programs and projects
- Drafting of LGU action plans integrating PopDev and poverty reduction.
- HAPPI*ER activities: Poverty reduction, population management, and environmental resource sustainability
  - Conduct of national level orientations and discussions on KALAHI framework and core strategies, Accelerated Hunger Mitigation Program, Gender-Responsive Population and Sustainable Development Framework, etc.
  - Field validation and identification of LGU good practices for documentation, recognition, and replication.
- Organization and strengthening of provincial MDG mobile teams to provide technical assistance on:
  - Integrating MDGs in LGU planning and budgeting
  - Benchmarking local MDG target and indicators
- Capacitating LGUs in institutionalizing and maintaining CBMS through installation of computerized CBMS database
- Training technical staff of LGUs and regional DILG staff with information and skills related to CBMS. |
Evaluation of the UNFPA Sixth Country Programme, Philippines 2005-2010

2. A: Evaluation ToRs

Terms of Reference
Consulting Team for the Final Evaluation of the Sixth Country Programme

Background

The UNFPA’s Sixth Country Programme (CP) of Assistance to the Government of the Philippines will be completed in December 2011 after seven years of implementation. The programme’s overall goal is to improve the reproductive health status of the Filipino people through better population management and sustainable human development.

The Sixth Country Programme of assistance consists of three thematic areas: reproductive health, population and development, and gender and culture. As to expected outcomes, RH aims to contribute to increased demand for and utilization of high-quality, gender-responsive, rights-based, sustainable, and integrated reproductive health services and information by the poor and vulnerable women, adolescents and men by strengthening the demand and supply sides of the programme. PDS, on the other hand, is expected to contribute to an enhanced policy environment that supports population and reproductive health programmes, particularly for the poorest and most vulnerable. Gender and culture aims to contribute to strengthening of institutional mechanisms and socio-cultural practices to promote and protect the rights of women and girls and advance gender equity and equality. Expected outputs for each thematic component are spelled out in the Country Programme Action Plan.

UNFPA’s sixth cycle of programme assistance to the Philippines, covers the period 2005-2009. In 2009, the Executive Board approved the extension of the country programme for another two years (2010-2011) in response to a request of the Philippine Government to harmonize planning cycles. The Executive Board approved a total amount of US$26 million (US$20 million for regular resources and $6 million from multi-bi resources) for the Sixth Country programme for five years. An estimated annual budget ceiling of $4 million is expected for the next two years (2010-2011).

The Sixth CP’s ten provinces (Ifugao, Mt. Province, Masbate, Bohol, Eastern Samar, Sultan Kudarat, Sulu, Tawi-Tawi, Lanao del Sur and Maguindanao) and one city (Olongapo City), were jointly identified by the National Economic and Development Authority (NEDA) and the UNFPA based on a set criteria. These pilot sites as well as the list of implementing partners (i.e., National Government Agencies, Local Government Units and non-governmental organizations) are stated in the Country Programme Action Plan (CPAP), the implementation of which is regularly monitored through the CPAP Tracking Tool. The three (3) afore-cited thematic components have their respective indicators.

In May 2005, data for selected base line indicators were gathered from the thirty municipalities of the Sixth CP provinces. An assessment of the Reproductive Health Commodity Security in the Philippines was undertaken in early 2006. A year after (in 2007),

85 To date, multi-bi resources obtained exceeded the $6 million target.
86 Comprising 30 municipalities, selected pilot sites in some UNFPA provinces have been expanded to cover all municipalities.
an intensive evaluation of the Sixth Country Programme was undertaken highlighting programme gains, documenting lessons learned and recommending improvements in the implementation of the overall programme and the thematic components. In addition, an assessment of the implementation of the UNFPA-supported teen centres was undertaken in 2009. From mid-May to September 2010, data for the same set of selected base line indicators will be gathered from all the original thirty (30) municipalities of the Sixth Country Programme and Olongapo City. Once collated, the data will be used to provide the end line information and compared with the baseline data for the Sixth CP sites. Moreover, province-wide baseline data will also be collected for the AusAid and AECI funded UN Joint Programme on Maternal and Neonatal Health (JPMNH) provinces of Ifugao, Eastern Samar, Lanao del Sur, Maguindanao, Masbate, Surigao del Norte, and Sultan Kudarat.

A final programme evaluation is proposed to be conducted to determine the gains and lessons learned from the Sixth country programme. The findings, together with the updated version of the Situation of the Population and Reproductive Health Analysis are expected to serve as critical inputs to the strategic formulation of the 7th Country Programme (2012-2016). This evaluation and formulation of the next country programme will have to consider the changes in the development environment at the global and national levels, arising from the Paris Declaration for Aid Effectiveness, the Accra Agenda for Action, UN Reform, as well as policy reforms by the Government of the Philippines. It should also consider the government’s latest Medium Term Philippine Development Plan (2010-2016) as well as the UNFPA’s Strategic Plan, Strategy for UN Reform, Middle Income Countries Strategy, the Country Analysis as well as the UN Development Assistance Framework (2012-2016).

Evaluation of Sixth CP Outcomes and Guide Questionnaires

The Sixth CP evaluation will cover the following seven (7) Country Programme Outcomes for RH, PDS and Gender.

**Reproductive Health (RH)**

Outcome 1: Increased demand for and utilization of comprehensive, high quality reproductive health services;

Outcome 2: Increased access to comprehensive, high quality RH services and information;

**Population Development and Strategies (PDS)**

Outcome 3: An enhanced policy environment that supports gender-responsive population and reproductive health programmes, particularly for vulnerable and poor populations;

Outcome 4: Improved utilization of age-and-sex-disaggregated population data in the areas of reproductive health, gender and poverty;

Outcome 5: National, sub-national and sectoral policies, plans and strategies take into account population and development linkages;

**Gender**

Outcome 6: Enhanced enabling environment to promote and protect the rights of women and girls and to advance gender equity and equality; and

Outcome 7: Strengthened socio-cultural practices to promote and protect the rights of women and girls and advocate gender equity and equality.
After a review of the available progress and a series of consultations for each of the three thematic groups (RH, PDS and Gender), the evaluation team will be asked to focus on the following identified issues.

1. the relevance of the programme design given the circumstances and existing information at the time of formulation, i.e., the extent to which the sub-programme outputs were derived from an accurate assessment of needs, and if component programme activities proposed would contribute to the achievement of the outputs as well as the responsiveness of programme inputs to outputs; did the activities and outputs add value to the national policies and programmes?;

2. the results of Mindanao investments made by UNFPA – are they delivering the expected results?;

3. the degree of achievement of the component programme outputs and progress made towards achieving programme outcomes given the changes in the global and national policy environment, using the validated results of conducted surveys and evaluation, and identifying reasons for this progress and/or discrepancies between plans and achievements;

4. the implementation of component programme activities, in quality and quantity and to the extent of possible, the impact on the programme beneficiaries;

5. the complementarity, coordination and integration of RH, PDS, gender and culture, and humanitarian response programme implementation;

6. the adequacy and effectiveness of the monitoring and evaluation tools of the programme, including the baseline and end line survey instruments;

7. the effectiveness and efficiency of UNFPA-supported service delivery points in meeting programme objectives, e.g., hospitals, rural health units, birthing facilities, teen centres, VAW centres, and STI/HIV clinics using the Performance Standards and Assessment Tools for services.;

8. the sustainability of the programme and thematic component achievements after completion of the programme period.

9. lessons learned and best practices; and

10. resources mobilized based on the programme achievements.

Key recommendations for UNFPA’s next country programme (2012-2016) should also be included in the consultants’ final report.

A more detailed description of the research questions for each focus area will later be developed with the Team.

**Evaluation Team Composition**

A team of Consultants will be contracted by UNFPA to evaluate the programme as a whole as well as the RH, PDS and Advocacy, and Gender and ARH components of the Sixth CP, and based on the key findings, suggest possible areas of support for the 7th Country

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87 Dr. Carol Sobritchea’s 2009 assessment report on teen centers will be used as reference.
Programme (2012-2016). The Local Team will be composed of experts in each of the thematic areas of (1) Reproductive Health, (2) Population and Development Strategy and Advocacy, and (3) Gender and Adolescent Reproductive Health, with him or her representing one of the areas. In addition, a local expert that can handle all the thematic areas for Southern Philippines will also be part of the team. A member of the UNFPA Youth Advisory Panel (YAP) will be included in the evaluation of the overall management and thematic working groups to ensure inclusiveness and meaningful involvement of the YAP. This team will be led by an International Team Leader who will guide the whole process, bring in the global and regional (Asia and the Pacific) perspective, and ensure the quality of evaluation and presentations.

International Team Leader:
1. Provide global and regional perspective to the Sixth CP Evaluation;
2. Responsible for the overall quality of the CP evaluation and ensure timeliness of deliverables;
3. Elaborate an analytical framework for the evaluation and lead in translating analytical framework into data collection and analysis tools;
4. Continuously review the work of individual members, provide guidance and ensure a coordinated analysis;
5. Synthesize, consolidate and integrate the three thematic programmes of assistance into one integrated and coherent final evaluation report; and
6. Prepare and submit a final evaluation report for the Sixth CP.

Thematic Experts (RH/PDS/Gender):
1. Undertake a thematic evaluation of the assigned thematic component (RH, PDS and Gender);
2. Responsible for providing inputs to the evaluation report through the preparation of their respective thematic chapters evaluating the Sixth CP programmes;
3. Provide inputs to the overall programme evaluation through analysis of UNFPA’s programme vis-à-vis national priorities; and
4. Review the analytical and evaluation framework and suggest revisions/changes as deemed appropriate.

Southern Philippine Expert:
1. Assess the specific contributions of the Mindanao provinces including humanitarian response in the attainment of the Sixth CP outcomes and outputs;
2. Evaluate what specific strategies worked and did not work in the cultural and political context of Mindanao;
3. Identify gaps in program implementation and recommend how these can be addressed;
4. Identify opportunities which could be explored and risks which should be minimized; and
5. Provide fresh perspective on how humanitarian response can be better integrated in the implementation of the regular CP in Mindanao.
UNFPA YAP Advisor:
1. Report existing mechanisms and policies (relevant to reproductive health and rights of the young people) developed/ established for the duration of the country program;
2. Identify gaps and areas of improvement of the ARH program and integration of youth lens to the different thematic areas of Sixth CP;
3. Identify ARH good practices within the Sixth CP sites; and
4. Provide suggestions and perspectives in making the ARH program more responsive to the needs of young people.

Methodology and Expected Outputs:

The Consulting Team will primarily conduct their evaluation through a document review of all printed outputs, annual and project monitoring reports, intensive evaluation results, the assessment results of RHCS and teen centres, and researches, guidelines and standard protocols supported by UNFPA under the Sixth Country Programme. This will be supplemented by key informant interviews of UNFPA management and staff, DOH, POPCOM, PCW officials, selected 88 local government officials, non-governmental organizations, other UN agencies (including UNICEF and WHO), other development partners (World Bank, ADB, EU, AusAID, AECI, USAID, and JICA) and community beneficiaries. Where quantifiable indicators are lacking, a qualitative assessment is made.

There will be two phases: the preparatory/design phase and the actual evaluation phase. The tools for assessment will be submitted by the Consulting Team and will be reviewed and approved by the Country Office (in consultation with APRO).

The Consulting Team is also expected to produce an evaluation summary in PowerPoint presentation for the stakeholders’ consultation in July 2010, and to the National Programme Management Committee meeting and a camera-ready Final programme Evaluation Report in mid July 2010 that is acceptable to UNFPA.

UNFPA Support:

Overall guidance will be provided by the UNFPA Representative and technical supervision by the Assistant Representatives. UNFPA will provide the Consulting Team with all the necessary documents, data bases and reports and refer them to web-based materials. The M and E specialist will be assigned as the Consulting Team’s counterpart and coordinator to follow up on documents, data/information and logistics needed. UNFPA will liaise with the thematic component managers in ensuring that the thematic component reports are provided to the Consulting Team as these are critical inputs to the programme evaluation. UNFPA management and staff will make themselves available for interview and technical assistance. A room will be provided to the Consulting Team during the duration of the engagement.

88 Possibly one province in Luzon, one in Visayas, and one in Mindanao.
Consultations will also be undertaken during the course of the evaluation/key evaluation stages to provide inputs and validate findings. Stakeholder consultations will include National Government agencies (NGAs), Civil Society Organizations (CSOs) and other UN Agencies and Development Partners.

The UNFPA Asian and Pacific Regional Office (APRO) will provide support in several stages. At the preparatory stage, the terms of reference of the consulting team, methodology (including the analytical framework) and the detailed work schedule will be reviewed and approved by the Country Office (in consultation with APRO). APRO will assist in the stakeholder’s workshop as a resource person to discuss preliminary findings and the draft report. For the actual evaluation phase, APRO will review the draft reports of the consultant. The APRO will also provide a combination of on-site and off-site support.

Timeframe:

This project shall commence on 01 June 2010. It will be output-based, but must be completed on or before 15 July 2010 from the date of this contract. The specific activities are shown below.

<table>
<thead>
<tr>
<th>Activity</th>
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</table>

*A high-level committee chaired by the National Economic and Development Authority and co-chaired by UNFPA, which sets the country programme’s annual priorities

Payment of Consulting Fees
Consulting Fees will be inclusive of travel costs to three sites – one in Luzon, one in Visayas and one in Mindanao.

Payment to each Consulting Team members will be in three tranches:
First Payment (40 percent of total) – Upon approval of detailed evaluation design and as mobilization fee;
Second payment (30 percent of total) – After the submission of the first draft; and
Third payment (30 percent of total) – After the submission and acceptance of the evaluation report and 7th CP programme design.

Outputs (in English)
- Evaluation Design
- Final Evaluation Report

Approved:

Suneeta Mukherjee
Representative

15 April 2010
B: The evaluation matrix: Agreed at First Team Meeting Held on Monday Sixth June and Copies Given to CO and APRO. Evaluation Design for UNFPA’s Sixth Country Programme to the Philippines

Introduction

The UNFPA’s Sixth Country Programme (CP) of Assistance to the Government of the Philippines will be completed in December 2011 after seven years of implementation. The programme’s overall goal is to improve the reproductive health status of the Filipino people through better population management and sustainable human development.

The Sixth Country Programme consists of three thematic areas: reproductive health, population and development, and gender and culture. The reproductive health (RH) outcomes aim to contribute to increased demand for and utilization of high-quality, gender-responsive, rights-based, sustainable, and integrated reproductive health services and information by the poor and vulnerable women, adolescents and men. This was to be achieved through strengthening the demand and supply sides of the programme. The Population and Development Strategies (PDS) are expected to contribute to an enhanced policy environment that supports population and reproductive health programmes, particularly for the poorest and most vulnerable. The Gender and Culture component aims to contribute to strengthening institutional mechanisms and socio-cultural practices to promote and protect the rights of women and girls and advance gender equity and equality. Expected outputs for each thematic component are detailed in the Country Programme Action Plan (CPAP).

UNFPA’s Executive Board approved a total of US$26 million (US$20 million from regular resources and $6 million from multi-bi resources) for the Sixth Country Programme for five years 2005-2009. An estimated annual budget ceiling of $4 million is expected for the next two years (2010-2011).

Support is provided under the Sixth CP to ten provinces (Ifugao, Mt. Province, Masbate, Bohol, Eastern Samar, Sultan Kudarat, Sulu, Tawi-Tawi, Lanao del Sur and Maguindanao) and one city (Olongapo City). These locations were jointly identified by the National Economic and Development Authority (NEDA) and UNFPA based on a set criteria. For each province, three municipalities have been supported under the Sixth Country Programme. During the two-year extension of the programme, all barangays (villages) in the three municipalities were all covered. With the introduction of the Joint Programme on Maternal and Neonatal Health (JPMNH), the whole province of Ifugao, Eastern Samar, Lanao del Sur, and Maguindanao were covered with AusAid support while the provinces of Masbate, Sultan Kudarat, and Surigao del Norte (an additional province) were supported by funds from AECID.

Objectives of evaluation of the Sixth Country Programme

As mandated by UNFPA’s Policies and Procedures a final programme evaluation will be conducted to determine the gains and lessons learned from the Sixth Country Programme. The findings, together with the updated version of the Situation of the Population and

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89 To date, multi-bi resources obtained exceeded the $6 million target.
Reproductive Health Analysis will serve as critical inputs to the formulation of the Seventh Country Programme (2012-2016). The evaluation and formulation of the next country programme will have to consider the changes in the development environment at the global and national levels, arising from the Paris Declaration for Aid Effectiveness, the Accra Agenda for Action, UN Reform, as well as policy reforms by the Government of the Philippines. It should also consider the government’s latest Medium Term Philippine Development Plan (2010-2016) as well as the UNFPA’s Strategic Plan, Strategy for UN Reform, Middle Income Countries Strategy, the Country Analysis as well as the UN Development Assistance Framework (2012-2016).

The main objectives of the programme evaluation are:

- To assess the effectiveness and efficiency of the Sixth Country Programme in achieving the outcomes and outputs set for it;
- To inform decisions on operations, policy, and strategy related to the Seventh Country Programme interventions.

Where:

- effectiveness is achievement of main programme objectives, including material and capacity support to partners at various levels;
- efficiency is the extent to which the programme design has been able to deliver effective outcomes in terms of programme objectives at least cost.

Secondary objectives are:

- To give stakeholders the opportunity to have a say in programme output and quality;
- To enable corporate learning and contribute to the body of knowledge on what works and what does not work and why;
- To improve programme quality and management.

The Sixth CP evaluation will cover the following seven Country Programme Outcomes for RH, PDS and Gender and Culture.

Reproductive Health (RH)
Outcome 1: Increased demand for and utilization of comprehensive, high quality reproductive health services;
Outcome 2: Increased access to comprehensive, high quality RH services and information;

Population Development and Strategies (PDS)
Outcome 3: An enhanced policy environment that supports gender-responsive population and reproductive health programmes, particularly for vulnerable and poor populations;
Outcome 4: Improved utilization of age-and-sex-disaggregated population data in the areas of reproductive health, gender and poverty;
Outcome 5: National, sub-national and sectoral policies, plans and strategies take into account population and development linkages;

Gender and Culture
Outcome 6: Enhanced enabling environment to promote and protect the rights of women and girls and to advance gender equity and equality; and
Outcome 7: Strengthened socio-cultural practices to promote and protect the rights of women and girls and advocate gender equity and equality.
The Country Office has identified the following issues for the evaluation to focus on:

8. “the relevance of the programme design given the circumstances and existing information at the time of formulation, i.e., the extent to which the sub-programme outputs were derived from an accurate assessment of needs, and if component programme activities proposed would contribute to the achievement of the outputs as well as the responsiveness of programme inputs to outputs; did the activities and outputs add value to the national policies and programmes?;

9. The results of Mindanao investments made by UNFPA – are they delivering the expected results?

10. the degree of achievement of the component programme outputs and progress made towards achieving programme outcomes given the changes in the global and national policy environment, using the validated results of conducted surveys and evaluation, and identifying reasons for this progress and/or discrepancies between plans and achievements;

11. the implementation of component programme activities, in quality and quantity and to the extent of possible, the impact on the programme beneficiaries;

12. the complementarity, coordination and integration of RH, PDS, gender and culture, and humanitarian response programme implementation;

13. the adequacy and effectiveness of the monitoring and evaluation tools of the programme, including the baseline and end line survey instruments;

14. the effectiveness and efficiency of UNFPA-supported service delivery points in meeting programme objectives, e.g., hospitals, rural health units, birthing facilities, teen centres, VAW centres, and STI/HIV clinics using the Performance Standards and Assessment Tools for services.;

15. the sustainability of the programme and thematic component achievements after completion of the programme period.

16. lessons learned and best practices; and

17. resources mobilized based on the programme achievements.”

The evaluation will answer these questions and in addition will assess the effectiveness and the efficiency of the UNFPA Country Programme in achieving the outcomes and outputs set for it. Specifically it will undertake a critical assessment of the overall achievements of the Country Programme as a whole and of the three Country Programme components. Including:

- Was the Country Programme design appropriate to the country needs?
- Did the Country Programme implement activities as planned?
- Were the mechanisms developed for implementation of the CP sound and effective?
- What are the main achievements of the Country Programme.
- To what extent were the indicators and targets set in the CPD and CPAP 2005-2009 achieved?
- How adequate was monitoring of implementation of the CP?
- How did implementation of the UNFPA CP relate to the UNDAF?
- What were the main bottlenecks in implementation of the Country Programme?
- What are the main lessons learnt during implementation of the CP?
- Based on lessons learnt from implementation of the current CP, what strategies are recommended to address similar issues during planning for the next programme cycle 2011-2015.
A judgment about the likelihood that the CP has had an impact and led to distinctively improved health outcomes in the target populations will be made.

Strategic Approach to the Evaluation of the Sixth UNFPA Country Programme

There are many potential approaches to evaluation of programmes such as a UNFPA CP. Ultimately three aspects are potentially important: have the inputs provided under the Country Programme achieved the outputs (or deliverables) identified at the beginning of the programme and if not why and what lessons might be learnt to improve similar support in the future and specifically in the next CP for the years 2011-2016?

The approach taken to evaluation of the CP is that set out in UNFPA’s evaluation tool kit (UNFPA 2004). It sees evaluation as ‘a management tool which is a time-bound exercise that attempts to assess systematically and objectively the relevance, performance and success of ongoing and completed programmes and projects. It should provide information on whether underlying assumptions used in programme development were valid, what worked and what did not work and why. The main objective of programme evaluation should be to inform decisions on operations, policy, or strategy related to ongoing or future programme interventions’.

The evaluation will be carried out in the context of UNFPA’s Strategic Plan 2008-2011 and the recent UNFPA Evaluation Policy, and the standards set by the UN Evaluation group of which UNFPA is a member.

The main purpose of UNFPA’s Evaluation Policy is to:
- increase the use of results in decision-making by management;
- improve programme effectiveness;
- strengthen national evaluation capacity;
- contribute to the systematic utilization of evaluation findings; and
- support organizational learning.

Specific roles and responsibilities for evaluation are delineated in UNFPA’s recent evaluation policy, with the goal of increasing the use of evaluation results in planning and implementing UNFPA activities.

Methodology

Five consultants will undertake the evaluation and will use four major sources to obtain information for the evaluation:
- Review of documents:
  - Programme documents and reports e.g. the Country Programme Action Plan, Management Tools (Tracking Tools), CP Strategy Paper, the CP Logical Framework;

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http://www.uneval.org/papersandpubs/documentdetail.jsp?doc_id=22
programme and project reports including, annual component and project Standard Progress and Accomplishment, mission, field and training reports; research reports: community assessment, studies supported by CP component. Programme plans: annual and quarterly plans, specific topic plans e.g., advocacy; project proposals; training guides and manuals, technical protocols, assessment tools, IEC and advocacy materials; minutes of meetings and internal memoranda.

- Non-programme documents, including those from partner agencies, Local Government Units/agencies, documents from national and local publications.
- Field visits and interviews at project sites and where possible collection and/or review of relevant data. Field visits will be made to randomly selected municipalities/provinces in order to determine consistency between what is reported on paper or narrated in interviews and what is actually happening on the field. Observations will also be made to assess facilities and equipment assisted and/or provided by the Programme and to meet with organizations of local implementers and associations established or supported by the programme at the pilot barangays and municipalities/cities.
- Extensive interviews with implementing partners and other stakeholders.
- Review of a compilation of key activities supported by the Country Programme e.g. listings of: consultancies undertaken in support of CP implementation, Regional Office (CST) or HQ technical missions undertaken in support of CP implementation, Studies/ surveys undertaken in support of CP implementation, National meetings/conferences held in support of CP implementation, IEC/advocacy materials prepared in support of CP implementation, Training sessions and workshops undertaken in support of CP implementation, Field monitoring visits undertaken in support of CP implementation, Study tours/attendance at international meetings undertaken in support of CP implementation.

Initial information collected in Manila will be consolidated and then validated through the national and field level interviews and small group discussions. At the Local government Unit (LGU) level interviewees will include local chief executives, local legislators, focal persons, barangay clients, and local UNFPA staff. At the national level, national partners from the NGAs and NGOs and UNFPA Manila personnel will be included in the interviews.

Each of the five members of the evaluation team will undertake at least two field visits to assess CP outcomes and outputs at the provincial and municipal level. Field visit sites will be areas not

<table>
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<tr>
<th>MATRIX of SUGGESTED EVALUATION QUESTIONS</th>
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<td>Thematic Components</td>
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<tr>
<td>Evaluation Issues</td>
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<td>Relevance</td>
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<td>How did the RH interventions contribute to</td>
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<td>What rights does the programme advance under CEDAW, the</td>
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xvii
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<tr>
<th>Effectiveness</th>
<th>How effective is the Sixth CP in achieving its objectives?</th>
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<td></td>
<td>What factors influenced the success and effectiveness of the program? What factors hindered programme effectiveness? How did the M and E tools adopted by the programme contribute to programme effectiveness? Did the CP investments in Mindanao deliver the expected results?</td>
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<tr>
<td>To what extent has the Sixth</td>
<td>To what extent has the Sixth CP enhanced national</td>
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**Attainment of MDGs 5 (improving maternal health) and 6 (halt and reverse the spread of HIV) targets?**

- Laws, ordinances, executive/administrative orders, religious decrees, etc. have been filed/passed/implemented, and how have they contributed towards creating an environment for effective population and RH programme implementation, including budget allocations for contraceptives?

- Are RH and gender priorities integrated into national and local development plans, including MDG reports and sectoral plans?

- Were research studies, surveys and evidence-based activities conducted, and how have they contributed towards improved utilization of age- and sex-disaggregated data in the areas of reproductive health, gender and poverty?

- Are there national, sub-national and sectoral policies, plans and strategies that take into account the linkages of population, poverty, environment and other development issues?

**Millennium Development Goals and other international development commitments?**

- How did gender interventions add value to the promotion of gender equality and gender mainstreaming at the national and local levels?
| Efficiency | What measures did the CP introduce to improve cost efficiency of the Programme and did they have an effect? |
| Efficiency | How did the CP improve accountability, transparency and risk management and what was the effect? |
| Efficiency | How did the CP utilize existing local capacities of duty-bearers and claim-holders in programme implementation? |
| Sustainability | Is the programme supported by national/local institutions? Do these institutions demonstrate leadership commitment and technical capacity to continue to work with the programme or replicate it? |
| Sustainability | Did national and local governments allocate sufficient resources to guarantee that achieved results will be sustainable? |
| Sustainability | Did the Sixth CP develop capacities of implementing partners in resource mobilization? |
| Sustainability | Was the CP able to improve the quality of service delivery points for RH, PDS, gender, and humanitarian response? |
| Sustainability | What other evidence is (are) available for sustainability of programmes? |
| Impact | What was the impact of the Sixth CP on the lives of communities in Sixth CP sites in terms of reproductive health, gender equality and population and development, as well as humanitarian response? |
| Impact | What were the lessons learnt and “good” practices established by the CP? Could these good practices be replicated elsewhere? |
| Impact | How did the programme improve the RH status of the communities in the CP sites? |
| Impact | How did the programme improve the policy environment for population and development issues? |
| Impact | To which extent efforts have been successful to stop harmful/discriminatory practices against women? |
| Impact | What are the positive and negative changes |
Evaluation of the UNFPA Sixth Country Programme, Philippines 2005-2010

produced directly or indirectly by the programme on the opportunities of different groups of women?

Timeframe:

The evaluation will begin on the 1st June 2010 and be completed on or before 15 July 2010. The specific activities are shown below.

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*A high-level committee chaired by the National Economic and Development Authority and co-chaired by UNFPA, which sets the country programme’s annual priorities*

Tentative Structure of Report of Evaluation

Indicative length 100 pages (excluding annexes).

Very First Draft Table of Contents for Report
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Team members
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Major Conclusions.
Major Recommendations for the 2011-2015 Country Programme

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UNFPA and evaluation

Scope and objectives of the evaluation of the Sixth UNFPA Philippines Country Programme
Methods used in the evaluation

Content of the Sixth UNFPA Country Programme

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Critical assessment of the overall achievements of the RH component of the Country Programme
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Were the component activities implemented as planned?
Were the mechanisms developed for implementation of the component sound and effective?
Achievements

4. Review of implementation of the PDS component of the Country Programme
Critical assessment of the overall achievements of the PDS component of the Country Programme
Was the component design appropriate to the country needs?
Were the component activities implemented as planned?
Were the mechanisms developed for implementation of the component sound and effective
Achievements

5. Review of implementation of the gender and culture component of the Country Programme
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Was the component design appropriate to the country needs?
Were the component activities implemented as planned?
Were the mechanisms developed for implementation of the component sound and effective?
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8. Main achievements of the Country Programme

9. Assessment of overall achievement of the targets set in the CPD and CPAP
   2005-2009 and the M&E system for the current programme

10 The Country Programme and UNDAF

11 Monitoring implementation of the UNDAF and the UNFPA Country Programme

12 Sustainability

10. Bottlenecks in implementation and lessons learnt from implementation of the
current CP and recommended strategies to address them during the new
programme cycle 2010-2015

Appendices
People seen
Places visited
Documents consulted
Instruments used

Initial documents: copies given to all team members
York: Division for Oversight Services, August 2004. Tool 2: Defining evaluation; Tool 3
Purposes of evaluation.
UNFPA 2007. Strategic plan, 2008-2011: Accelerating progress and national ownership of
3. **The Evaluation Team**

**Godfrey JA Walker**, MB, BS, MD, MSc, D Obstet, FFPH has over 30 years experience in epidemiology, international public health and reproductive health. He has undertaken evaluations including cost-effectiveness studies, randomised controlled trials and UNFPA and other Country Programme evaluations. He was a senior lecturer in the Evaluation and Planning Centre at the London School and Tropical Medicine. From 1989 to 1993 he was Manager of WHO’s Safe Motherhood Operational Research Programme. In 2005 he retired from UNFPA. He continues to undertake evaluative work for the Cochrame Collaboration.

**Magdalena C. Cabaraban**, Ph.D. Research and teaching are her major undertakings in the past 30 years in Xavier University-Ateneo de Cagayan. Active in advocacy, she founded Women’s Forum of Region 10 and spearheaded considerable number of advocacy work. In the area of research, her expertise includes: proposal preparation; research design; sampling design and sample selection; construction of research instruments, design of data processing operations; production of tables, data analysis and report-writing. Teaching in both the graduate and undergraduate programs of the Department of Sociology/Anthropology of Xavier University-Ateneo de Cagayan, subjects handled include research methods, migration analysis, introductory and intermediate statistics, women’s concern, gender and development, survey analysis and inter-ethnic relation. A number of research grants were obtained from Family Health International (FHI), Ford Foundation, WHO, European Commission, World Bank, UN Multi-Donor Programme, USAID, UNICEF, JICA, Academy for Educational Development (AED), and from the Philippine government agencies.

**Napoleon K Juanillo Jr**, Ph.D. is Professor and Program Director of the Leadership and Managerial Excellence in Health Systems of the Health Unit-Ateneo Graduate School of Business at the Ateneo de Manila University. He also serves as Dean of the College of Arts and Sciences at San Beda College and is the Director of Research, Planning and Development Center of San Beda College. He has extensive experience over more than 30 years in health systems, strategic communication and advocacy, program monitoring and evaluation and quality assurance. He has undertaken many consultancies with international organisations including WHO, the World Bank, ILO and USAID and with local organisations including the Philippine Health Insurance Corporation.

**Lady Nancy C. Lisondra**, RN, a dynamic youth leader and advocate, is the chairperson of the UNFPA Philippines - Youth Advisory Panel, and the Assistant Youth Coordinator of the Family Planning Organization of the Philippines. In these roles she has been influential in bringing a youth perspective to RH. She is currently taking her Masters in Nursing at the University of the Philippines.

**Ernesto M. Pernia**, Ph D, is Professor of Economics at University of the Philippines, and a member of the boards of the University of San Carlos, the Philippine-American Academy of Science and Engineering, and a few NGOs involved in development work. Until recently, he was Lead Human Development Economist at the Asian Development Bank. Previously, he was Regional Adviser on population and employment policy research at the ILO based in Bangkok. He has over 30 years of experience in development economics, population and human resources, and macroeconomics. He has been a consultant to various international organizations, including the U.N. agencies and the World Bank.
Pilar Ramos-Jimenez, Ph D., has over 25 years of experience in social development and health social science research, teaching, training and networking. She was Program Officer for Sexuality and Reproductive Health (SRH) of The Ford Foundation Jakarta Field Office, University Fellow and Professor at De La Salle University (DLSU), and Program Coordinator of the Philippine Social Science Council. She has served as consultant for several international and local organizations. She is currently a Resident Consultant of the Philippine NGO Council on Population, Health, and Welfare, Inc.
4. **People met**

**Dr Godfrey Walker**

1. **UNFPA Country Office**

Suneeta Mukherjee, UNFPA Country Representative, Philippines  
Rena Dona, Assistant Representative  
Florence Tayzon, Assistant Representative  
Emmanuel L. Genio, NPO M&E  
Maria O. de Guzman, Programme Assistant  
Anna Maria Leal, NPA, Family Planning  
Dr. Hendry Plaza, NPO Reproductive Health  
Dr. Vicente Jurlano, NPO PDS/Advocacy  
Dr. Jovanni Temploneuvo, NPPP STI/HIV/AIDS  
Pamela Marie Averion, NPO Gender and Culture  
Emee Lei Albano, Youth Advocate  
Dr. Yolanda Oliveros, UNFPA consultant and Department of Health

2. **Other UN**

Ms. Jacqui Badcock, UNDP Resident Coordinator  
Dr. Marinus Gotink, UNICEF Chief Health and Nutrition  
Dr. Soe Nyunt U, WHO Philippines Country Office Representative  
Dr. Mariella S. Castillo, WHO Philippines Technical Officer, Maternal and Child Health  
Dr. Florence V. Tienzo, WHO Philippines Programme Management Officer

3. **Country Programme Provinces**

   a. **Ifugao Province**

Hector Follosco, UNFPA Provincial Programme Officer Ifugao  
James Bustamante, UNFPA Administration and Finance Office,  
Jane Tillay, ASRH Implementing Partners, Ifugao Provincial Sustainable Development Directorate  
Lalli Cawilan, ASRH Implementing Partners, Ifugao Provincial Sustainable Development Directorate  
Young People, Nayou Teen Centre  
Engr. Carmel Buyuccan, Provincial planning and Development Officer and Provincial Focal Person for UNFPA Sixth CP  
Hon. Teodoro Baguilat, Congressman and Former Governor  
Dr Cherry Namujhe, Municipal Health Officer, Lagawe and Focal Point for RH component of UNFPA Sixth CP  
Elsa Pagal and other staff, Boliwong Birthing Clinic  
Davis Pulau, Chair and other members Ayod Community Health Team  
Cecille Ughigyou, Provincial Social Welfare and Development Directorate
b. **Eastern Samar Province**

Bel Dado, Provincial Programme Officer  
Beth, Mortiz, AFA-UNFPA  
Hon. Ben Evardone, Congressman and Former Governor  
Dr. Marian Isiderio, PHO-Eastern Samar  
Dr. Samuel Baldono, MHO-Maydolong  
Dr. Nilda Anistoso, MHO-Sulat  
Dr. Myra Cecilia Grata, MHO-Llorente  
Dr. Mercia Moscosa, MHO San Policarpio  
Dr. Marilyn Umil, MHO Oras  
Dr. Rowie Romuar, MHO Dolores  
Dr. Nilda Anistoso, MHO Sulat  
Dr. Ethel Lagria, RHP Borongan 2  
Dr. Samuel Baldono, MHO Maydolong  
Dr. Myra Cecilia Grata, MHO Llorente  
Dr. Nelsie Labro, MHO Balangkayan  
Dr. Dennis Navidad, MHO Hernani  
Dr. Jener Camposano, MHO Quinapondan  
Mr. Bonifacio Ramento, ALS DEpEd  
Mr. Danilo Beato, Nurse  
Mr. Abner Aclao, ASRH Alternate FP  
Mr. Leo Tomenio Jr., ASRH FP Sulat  
Ms. Joanna Mae Baldono, ASRH FP Maydolong  
Mr. Hermenegildo Oraya, PYAP President Borongan  
Mr. Gil Rebamontan, PWDO  
Ms. Josie Limbo, MSWDO Sulat  
Ms. Lucia Cardona, MSWDO Llorente  
Ms. Reina Montes, MSWDO Maydolong  
Dr. Maria Isiderio, PHO 1 RH/FP  
Ms. Teresita Dala, FP Corodinator PHO  
Ms. Edna Tumandao, Midwife IV PHO  
Dr. Lilia Daguinod, Chief of Hospital, FAMH  
Ms. Marianita Cablao, PDS FP Province  
Hon. Edita Sepulveda, SP Member Province  
Mr. Samson Nervez, PDO IV Province  
Mr. Abito Bonga, PDS FP Llorente  
Ms. Susan Bocco, Nirse Salcedo  
Ms. Ermalyn Ador, Programme Assistant  
Ms. Miriam Guerrera, Programme Assistant  

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**c. RPMC – Davao City**

**HEALTH SECTOR**

Dr. Kadiil Sinolingding - Secretary, DOH-ARMM  
Dr. Lourdes C. Plaza - CHD-CARAGA

**Provincial Health Officers**

Dr. Tahir B. Sulaik - Maguindanao
Dr. Sukarno Asri - Tawitawi
Dr. Farah Tan-Omar - Sulu
Dr. Alinader Minalang - Lanao del Sur
Dr. Henry Lastimoso - Sultan Kudarat
Dr. Ramie Hipe - Surigao del Norte
Dr. Gina Macapeges – Chief of Technical Division-Maguindanao

Reproductive Health Coordinators
Maura Bueno - Maguindanao
Senona Pasigna - Tawitawi
Fatima Espinosa - Sulu
Alliah Matuan - Lanao del Sur
Lily Derecho - Sultan Kudarat
Rosanna Enano - Surigao del Norte
Jam Dimaren - DOH-ARMM
Mary Joy Chui - CHD 12

DOH-FIMO
Asec Paullyn Jeanne Ubial - DOH-FIMO Vis-Min Chairperson
Dr. Sharon Valdez – MO V

DEPARTMENT OF SOCIAL WORK & DEVELOPMENT
Regional Level
Pombaen Kader Karon - Acting Secretary – DSWD-ARMM
Ma. Violeta Jennelyn Yap - Regional SW IV

Provincial Level
Belinda Adil - Tawi-Tawi
Nestor Delasas - Tawi-Tawi
Lydia Angngagao - Maguindanao
Jhohansen Derogougan - Lanao del Sur
Evangeline Golveque - Sultan Kudarat

LOCAL GOVERNMENT UNITS
Engr. Manuel Lastimoso - Provincial Administrator, SK
Amelia Cachero - PDS Focal Person, SK
Pesigue C. Tomawis - Lanao del Sur
Nestor Delasas - Tawi-Tawi
Jane Labrador - Maguindanao
Myrna A. Alfonso - RPDO-ARMM
4. Other Stakeholders and key people

a. USAID

Marichi de Sagun, Office of Population, Health and Nutrition (OPHN) Project Management Specialist
Reynalda Perez, Office of Population, Health and Nutrition (OPHN) Project Management Specialist

b. European Union

Rita R Bustamante, Programme Officer, Operations Section
Anja Bauer, Task Manager Health, Operations Section

c. Spanish Aid

Bella Fernandez, Program Officer for Social Development
d. Department of Health (DOH)
   Hon. Esperanza I. Cabral, Secretary of Health

**Ms Lady Nancy Lisondra:**

Ifugao

Lagawe, Ifugao
Jeneckson Aben, Peer Educator, Caba Youth Center
Jay ar Bala-oy, Peer Educator, Caba, Lagawe, Ifugao Community-based
Norma Umlano, Midwife

Lamut, Ifugao

Jovalyn Git-ang, Peer Educator, Datngon Youth Center
Joylyn Ballanian, Peer Educator, Ifugao State University (Main Campus)
Rogelio Buhle, Peer Educator, Nayon, Lamut
Wilson Domingo, Staff in-charge

Asipulo, Ifugao

Eunice Ann B. Puguon, Principal, Ephoshan Youth Center
Divina Laggoy, Peer Educator, Haliap NHS
Jornalyn Pinkihan, Peer Educator, Main Campus
Clarisa Daulayan, Peer Educator, Haliap, Asipulo
Alfredo Donato, Peer Educator, Haliap, Asipulo
Junia Lugmayo, Peer Educator, Haliap, Asipulo
Charibel B. Pugong, Peer Educator, Panyagudan Youth Center
Kenneth D. Dupingay, Peer Educator, Panyagudan Youth Center
Aubrey D. Bantiya, Peer Educator, Panyagudan Youth Center
Quinschel B. Pinkihan, Peer Educator, Panyagudan Youth Center
Kherwin B. Remandaban, Peer Educator, Panyagudan Youth Center
Emilia U. Matabye, Peer Educator, Panyagudan Youth Center
Richard P. Gomultin, Peer Educator, Panyagudan Youth Center
Jose B. Ballatong, Peer Educator, Panyagudan Youth Center

Dalmeg Youth Center

Sonia Tayaban, Peer Educator
Rosemil D. Ommas, Peer Educator
Marcelo Liwayan, Peer Educator
Junia Sosil, Peer Educator
Andres Garcia, Peer Educator

Panpephedan Youth Center

Aida T. Pana, Officer-in-Charge
Marivel M. Carias, Officer-in-Charge Adviser
Gertrude Dumanop, Peer Educator
Desirey Calyaen, Peer Educator
Jeff Ti-ocean, Peer Educator
Ceralia Polito, Peer Educator

**Provincial Sustainable Development Office**

Miriam G. Baguidudol, PPO IV, PDS Focal Person

**Masbate**
**DepEd, Masbate**
Dr. Leah Pili, ARH Focal Person
Rocolito Cantre, ALS Coordinator
Elnie Tamayo, Alternate ARH Focal Person
Hermino Baldemoro, Provincial Administrator

**Dimasalang Mayor’s Office**

Sheeba Cabrera, Municipal Administrator
Romila Masong, ARH Alternate Focal Person
Ghenlhe Sanches, Gender Focal Person
Rebecca Bolonias, PDS Focal Person

**Dimasalang Community TWC**

Aiza Ibañez, Peer Educator
Jonathan Legnes, Peer Educator

**The RYTERS (Responsible Youngsters) Teen Center, Dimasalang National High School**

Erlinda Gaviola, Principal
Cherry Almazor, School Nurse
Ron Ephraim Roluna, Peer Educator

**Palanas Central High School - BALS Center in School**

Mrs. Son, ARH Focal for Palanas Elementary School
Greg P. Olivar, Principal
Evaluation of the UNFPA Sixth Country Programme, Philippines 2005-2010

Palanas RHU
Dra. Imee Delavin, MHO/RH Focal Person
Sheila Brioso, Nurse
Julius Atacador, Nurse/Alternate
Perla Abenir, Midwife

Palanas VAWC Center
Marcion Gigante, Gender Focal Person/MSWDO
Josie Coniconde, Alternate Focal

Palanas TWC
Eng. Didel Olofernes, PDS Focal/Teen Center Coordinator

Palanas Municipal Office
Hon. Silvestre A. Alvarez, Mayor
Engr. Romson A. Mijares, Municipal Administrator
Engr. Fidel G. Olefernes, PDS Focal Person
Julius Arkhe Atacador, Nurse
Mr. Son, Secretary of the Mayor
Ms. Mildred Sajo, ALS Coordinator
Chita Capellan, ARH Focal Person

Rondina-Atendido (Nabangig) National High School
Donna Pogado, Guidance Counselor/Teen Center Coordinator
Angelo Joseph S. Samson, Peer Coordinator
Charles John A. Belarmino, Peer Coordinator
Elmer A. Carmelo, Jr., Peer Coordinator
Chloebert R. Tan, Peer Coordinator
Jayson A. Lampano, Peer Coordinator
Arjay M. Osayan, Peer Coordinator
Mara A. Villa, Peer Coordinator
Jay Ann Logro, Peer Coordinator
Krisha Mae Atendido, Peer Coordinator
Merry Apple Serrano, Peer Coordinator
Monette A. Bello, Peer Coordinator
Jenjen C. Moriles, Peer Coordinator
Jescid Grace V. Tabuang, Peer Coordinator
Glydel Joy Bulasmino, Peer Coordinator
Sarah C. Tiong, Peer Coordinator
Cataingan TWC, Cataingan National High School

Ms. Madel, TWC Coordinator/Adviser

Meeting with Matangangtang, Placer Teachers, Masbate PPMU

Crescente U. Solis, T-1 DepEd
Edelen O. Noval, T-1 DepEd
Ramon V. Revaldo, Principal 1
Joey V. Pardeño, T-1 DepEd
Daisy B. Yordan, T-1 DepEd

Milagros Elementary School East District

Sir Petronio Besonia, Principal

Milagros West Elementary School

Marcelino Pevida, Principal

Exit Meeting, Masbate PPMU

Ma. Elnie L. Tomayo, ARH Alternate-DepEd
Dr. Lea Pili, ARH Focal Person-DepEd
Amy B. Danao, PSWDO Gender Focal Person
Mariene D. Pecson, PDS Focal Person
Neise A. Eulphan, Alternate Gender Focal Person

Sultan Kudarat

Department of Education, Division Office
Kahar H. Macasayon, PhD, CEO VI, Schools Division Superintendent

Kalawag Elementary School, Isulan, Sultan Kudarat

Eric Balancio, Principal
Ronald F. Ramirez, Teacher 1
Grade 6, Section 1

Bambad National High School, Isulan, Sultan Kudarat

Rosalie E. Estrellan, Principal
Lenith C. Linda, T III – TLE
Julie Fe Legayada, Peer Educator
Mara Riza Lope, Peer Educator
Myra Rose F. Casandara, Peer Educator
Jezelle Mae Beramo, Peer Educator
Jennet Ann Lope, Peer Educator
Korelyn Frugalidad, Peer Educator
Jussel Krisna Linda, Peer Educator
Irish Baston, Peer Educator
Jeavy Mae Ebanos, Peer Educator
April Lee Picara, Peer Educator
Raymond Flores, Peer Educator
James Patrick Hare, Peer Educator
Sheena Daroy, Peer Educator
May Loryne Buendicho, Peer Educator
Cyztelle Pearl Depacto, Peer Educator

Kulaman Central Elementary School, Senator Ninoy Aquino, Sultan Kudarat

Herman C. Pallado, Principal
Queenie P. Gacad, Adviser
Hanz Nikko G. Cataluña, Peer Educator
Julie Ann P. Belandres, Peer Educator
Jan Reynaldo M. Nalaunan, Peer Educator
Ianne M. Nalaunan, Peer Educator
Cristylyne C. Navos, Peer Educator
Paula Mae M. Castronuevo, Peer Educator
Joash M. Castronuevo, Peer Educator
Jeannievieve P. Siman, Peer Educator
Gleazel Nae L. Nacional, Peer Educator
Sanny C. Caniel, Peer Educator
Glennbelle Guia F. Sajor, Peer Educator
Jhenerose M. Siglos, Peer Educator

Kulaman Community Teen Center, Senator Ninoy Aquino, Sultan Kudarat

Antonio Morales, Barangay Councilor
Esmeraldo Morales, Barangay Councilor
Gene Galino, Barangay Councilor
Edgar Sodusta, Barangay Councilor
Cecelia Baylon, Barangay Councilor
Ernie Sumagaysay, Barangay Councilor
Marjomae Idio, Barangay Councilor
Tony Morales, Barangay Councilor
Alex Rodriguez, SK Councilor
Jorge Dela Torre, SK Councilor
Ginger Montalez, SK Councilor
Gapok National High School, Senator Ninoy Aquino, Sultan Kudarat

Mr. Diadologo, Principal  
Airen Celino Demavivas, Peer Educator  
Rejean May Gose, Peer Educator  
Janette Rivera, Peer Educator  
Kimberly Celino, Peer Educator  
Melrose Laguna, Peer Educator  
Richard Mark Cadion, Peer Educator  
Karl Cesar Loblano, Peer Educator

Dr. Pilar Ramos-Jimenez:

Maguindanao
Ms. Lydia U. Angagalao, Social Welfare Officer III, Municipal Social Welfare Office, Talayan Municipality, DSWD-Maguindanao (also provincial focal person)
Dr. Tahir Suleik--IPHO (former ARMM Secretary of Health), Maguindanao
Ustadz Maher A. Malaguial—Vice President, Muslim Religious Leader (MRL), Maguindanao at IPHO office;
Ms. Jurma A. Tikmasan—Gender & Culture Adviser for SPO
Ms. Marilou M. Diestro—Municipal Social Welfare Officer III, Upi,Maguindanao

Bohol:
Provincial focal persons & coordinators
Dr. Reymoses Cabagnot – Provincial Health Officer and RH Focal Person
Ms. Josefina J. Relampagos – Provincial PDS Focal Person
Ms. Carmelita M. Tecson - Provincial Social Welfare and Development Officer-in-Charge, Bohol Crisis and Intervention Center (BCIC) Manager and Gender Focal Person
Ms. Elizabeth Castolo – Department of Education Province Focal Person
Ms. Josiane T. Pepito – Provincial RH Coordinator
Donna Belle Diones Mante—Bohol Crisis Intervention Center Social Worker
Helen A. Garcia—BCIC Finance Officer

Carmen Municipality focal persons & coordinators
Dr. Josephine Jabonillo – Mun. Health Officer and RH Focal Person
Ms. Violeta Balaba – RHU Nurse and RH Coordinator
Mr. Vicente Buaya – ARH Coordinator
Mr. Fermin Balili – MPDC and PDS Focal Person
Engr. Rita Francisco – MPDC Staff and PDS Coordinator
Ms. Ma. Olga Bigno – MSWDO and Gender Focal Person
Ms. Taciana Espejo – Mun. Accountant and Finance Focal Person
Mother and son survivors of domestic violence—names are confidential

Ubay Municipal Focal Persons & Coordinators
Hon. Eutiquio M. Bernales – Municipal Mayor and Municipal Programme Manager
Dr. Ritchie M. Del Mar – Mun. Health Officer and RH Focal Person
Ms. Laarni Torrevillas – RHU Nurse and RH Coordinator
Ms. Gemma B. Reyes – RHU Nurse and ARH Coordinator
Ms. Emma Ayag – MSWDO OIC and Gender Focal Person
Ms. Joy Abay-abay – THQ Community Relations Officer
Ms. Juanaria Miel—THQ Community Relations Officer
Ms. Josephine Espera – Mun. Budget Officer and Finance Focal Person
Ms. Marifel R. Bernales—Principal, Uban Central Elementary School
Ms. Reynita C. Haduc—Principal, Camambogan National High School
Mother and daughter clients of GAD Crisis Center—names are confidential

Talibon Focal Persons & Coordinators
Dr. Francisco Ngoboc, Jr. – Mun. Health Officer and RH Focal Person
Ms. Eugenia Jasmin – RH Coordinator
Ms. Natividad G. Abastas—RHU Staff
Mr. Mario Autentico – ARH Coordinator
Ms. Joannevit Avenido – MPDC Staff and PDS Coordinator
Ms. Zosima Gabison – MSWDO and Gender Focal Person
Mr. Enrique Carusos, Jr.—Supervisor, Talibon District 1
Mr. Juan S. Torregosa—Principal, Talibon District 1
Ms. Loyda Posadas—Guidance Counselor, San Jose National High School

National Government and Non-Government Agencies
Mary Alice G. Rosero—Chief, Policy Development and Advocacy Division, OIC-Project Manager, Philippine Commission on Women (PCW)-UNFPA Proj. Management Staff
Mia Ventura—former Deputy Director, Philippine Commission on the Role of Filipino Women (telephone interview)
Raymond Jay L. Mazo, Jr.—Technical Assistant for RH (UNFPA), Family Health, National Center for Disease Prevention and Control (NCDPC), Department of Health
Ms. Cecil de Luna—Supervising Health Officer, Bureau of International Health Cooperation, Department of Health
Ms. Carole Bandahala—Chief Health Program Officer, Family Health, NCDPC, Department of Health
Mr. Donald Amado M. Caballero—National President, Supervising Legislative Staff Officer II, Committee on Revision of Laws, House of Representatives, Batasan Complex, Quezon City
Ms. Carmen P. Gomez, RSW—Project Officer, Department of Social Welfare (DSWD)-UNFPA Sixth CP
Ms. Gemma B. Gabuya—Director III, Department of Social Welfare and Development, Social Technology Bureau
Atty. Clara Rita A. Padilla, J.D.—Executive Director, EnGendeRights, Inc.
Ms. Alexandrina Marcelo—Executive Director, Reproductive Rights Resource Group-Philippines (3RG) via telephone interview

Dr. Ernesto M. Pernia:

Bohol

UNFPA

Dr. Vicente Jurlano, PDS National Programme and Area Officer for Bohol
Ma. Solita J. Virtudazo, PPC Bohol
Evaluation of the UNFPA Sixth Country Programme, Philippines 2005-2010

Glecyl Anne S. Bretana, AFA Bohol

Bohol Provincial Office

Hon. Erico Aumentado, Governor
Atty. Handel Lagunay, Legal Officer, Governor’s Office
Mr. Antonietto Pernia, Chief of Staff, Governor’s Office
Dr. Raymoses Cabagnot, PHO and RH Focal Person
Ms. Josefina J. Relasonmpagos, Provincial PDS Focal Person
Ms. Constancia O. Tunacao, PSWDO and Gender Focal Person
Hon. Edgar Chatto, Governor-elect
Hon. Dan Lim, Incumbent and re-elected Mayor, Tagbilaran City
Ms. Josiane T. Pepito, Provincial RH Coordinator

Ubay, Bohol

Hon. Eutiquio M. Bernales, M.D., Municipal Mayor
Engr. Dionisio V. Boiser, MPDC and PDS Focal Person
Dr. Retchie del Mar, MHO and RH Focal Person
Eng’r Carlota B. de la Cruz, MPDC and PDS Focal Person
Ms. Laarni P. Torrevillas, RHU Nurse and RH Coordinator
Ms. Gemma Reyes, RHU Nurse and ARH Coordinator
Ms. Josephine B. Espera, Municipal Budget Officer and Finance Focal Person
Ms. Joy AbayAbay, THQ Community Relations Officer (ComRel)
Ms. Emma Ayag, MSWDO OIC and Gender Focal Person
Mr. Kenneth Trajano, THQ Staff (Peer Educator)
Ms. Lolita Mabaloc, Finance Assistant
Ms. Mercedes M. Batawan, RHM
Mr. Teodulfo del Rio, Barangay Captain, Hunayhunay
Ms. Felicitas Sinuangan, Barangay Secretary, Hunayhunay

Talibon, Bohol

Dr. Francisco Ngoboc Jr., MHO and RH Focal Person
Ms. Eugenia Jasmin, RH Coordinator
Mr. Mario Autentico, ARH Coordinator and THQ ComRel
Eng’r Eduardo Avenido, MPDC and PDS Focal Person
Ms. Joennavit Avenido, MPDC Staff and PDS Coordinator
Ms. Zosima Gabisan, MSWDO and Gender Focal Person
Ms. Natividad G. Abastas, RH Staff
Mr. Gelacio Evardo, RHU Staff

Carmen, Bohol

Mr. Vicente Rama, LGU Staff
Ms. Fabiola L. Balaba, RHU Nurse and RH Coordinator
Ms. Taciana ESpejo, Municipal Accountant and Finance Focal Person
Ms. Ma. Olga Bigno, MSWDO and Gender Focal Person
Mr. Fermin Balili, MPDC and PDS Focal Person
Eng’r Rita Francisco, MPDC Staff and PDS Coordinator

xxxvi
Dr. Josephine B. Jabonillo, MHO and Overall Focal Person

Local Executive

Hon. Dan Lim, Mayor Tagbilaran City
Business Sector
Mr. Hans Schoof, Businessman, owner of Peacock Garden Hotel and Resort, Baclayon, Bohol

Masbate

UNFPA
Joy Alcantara, PPC-Masbate

Masbate Provincial Office

Dr. Elisa Kho, Governor
Ms. Marlene Descon, Provincial PDS Focal Person
Ms. Amy Danao, PSWDO and Gender Focal Person

Dimasalang, Masbate

Ms. Sheeba Cabrera, Municipal Administrator and LGU Focal Person
Dr. Napoleon Menicies, MHO and RH Focal Person
Ms. Ghenlhe Sanchez, MSWDO and Gender Focal Person
Ms. Romila Masong, RHU Midwife and Alternate RH Focal Person

Palanas, Masbate

Eng’r Romson Mijares, Municipal Administrator and LGU Focal Person
Dr. Imee Delasin, MHO and RH Focal Person
Ms. Marcion Gigante, MSWDO and Gender Focal Person
Ms. Minda Mendoza, RHU Midwife
Ms. Perla Abenir, RHU Midwife

Placer, Masbate

Dr. Lily Lim, Municipal Administrator and PDS Focal Person
Dr. George Galindes, MHO and RH Focal Person
Ms. Monina Lorete, RHU Nurse and Alternate RH Focal Person
Ms. Magdalena Delino, MSWDO and Gender Focal Person
Ms. Nerly Bedrejo, Alternate Gender Focal Person

NGO Consortium

Mr. Ramon San Pascual, Executive Director PLCPD
Dr. Junice Melgar, Executive Director LIKHAAN
Mr. Paolo Antonio Fernando, Project Officer PNGOC
Ms. Chi Vallido, Advocacy Officer FORUM
Mr. Benjamin de Leon, President FORUM
Ms. Elizabeth Angsioco, Chair RHAN
Mr. Roberto Ador, Executive Director FPOP
Mr. Luis Pedroso, Consultant PopCom

PDS National Project Implementors

Commission on Population

Mr. Tomas Osias, Executive Director
Mr. Luis Pedroso, Consultant

NAPC

Hon. Domingo Panganiban, Secretary
Hon. Dolores deQuiros-Castillo, Asst. Secretary
Ms. Thea Bohol, Project Officer

DILG

Ms. Prescilla Mejillano, Acting Director Local Government Planning Department
Ms. Anna Liza Bonagua, Local Government Planning Department
Ms. Sylvia Carvajal, Local Government Planning Department

Dr Magdalena Cabaraban:

Sultan Kudarat

Arnen Kasak, Provincial Programme Coordinator, UNFPA-SPO
Manuel Lastimoso, Provincial Administrator, Sultan Kudarat
Lily Derecho, RH Coordinator, Sultan Kudarat
Dr. Rex Archangel Lamprea, Provincial Health Officer, Sultan Kudarat
Dr. Henry Lastimoso, Asst. Provincial Health Officer, Sultan Kudarat
Evageline Golveque, Provincial Social Welfare Officer, Sultan Kudarat
Alvin Travilla, Social Welfare Officer, Isulan, Sultan Kudarat
Rhodora Antenor, Municipal Health Officer, Isulan, Sultan Kudarat
Odette S. Viray, Administrative Officer, Isulan, Sultan Kudarat
Herminia F. Fabit, Public Health Nurse, Lebak, Sultan Kudarat
Pelma Corazon Peloibillo, Municipal Social Officer, Lebak, Sultan Kudarat
Elsie Joy Villareal, Planning Assistant, Senator Ninoy Aquino, Sultan Kudarat
Dr. Maricris Idio, Municipal Health Officer, Senator Ninoy Aquino, Sultan Kudarat
Hernahe Cristobal, Social Welfare Officer, Senator Ninoy Aquino, Sultan Kudarat
Cresyn P. Nismal, Municipal Social Welfare Officer, Senator Ninoy Aquino, Sultan Kudarat
Rachel T. Sabejon, Public Health Nurse, Senator Ninoy Aquino, Sultan Kudarat
Angeles Garaygay, DepEd District Supervisor, Sultan Kudarat
Armando Magaway, Municipal Planning and Dev’t Coordinator, Lebak, Sultan Kudarat
Perpetua Domantay, Rural Health Midwife, Isulan, Sultan Kudarat
Cecilia Gampong, Municipal Social Welfare Officer, Isulan, Sultan Kudarat
Reza Jean Alpas, Municipal Health Nurse, Isulan, Sultan Kudarat
Analyn Lusvigno, FP User, Isulan, Sultan Kudarat
Juvelyn Zamora, FP User, Isulan, Sultan Kudarat
Profiteza Lastimoso, BHW/BNS, Isulan, Sultan Kudarat
Concepcion Japitana, BHW, Isulan, Sultan Kudarat
Salvacion R. Reyes, BHW, Isulan, Sultan Kudarat
Lolita Lasanas, BHW, Isulan, Sultan Kudarat
Emily Levsan, BHW, Isulan, Sultan Kudarat
Mary Jane Gonzales, RH Advocate/Educator, Isulan, Sultan Kudarat
Jocelyn Tabongcay, FP User, Isulan, Sultan Kudarat

Maguindanao
Dr. Elizabeth Samama, Asst. Provincial Health Officer, Maguindanao
Dr. Gina Macapeges, Chief Technical Division, Maguindanao
Dr. Noel Cantero, Municipal Health Officer, Ampatuan, Maguindanao
Dr. Tahir Sulaik, Provincial Health Officer, Maguindanao
Maura C. Bueno, RH Coordinator, Maguindanao
Dr. Carmelo Esberto, Municipal Health Officer, Upi, Maguindanao
Paulo Tagara, Municipal Planning and Dev’t Coordinator, Upi, Maguindanao
Jacqueline Gamit, Rural health Midwife, Upi, Maguindanao
Abe G. Salipada, MRL, Maguindanao
Jackerie S. Baganian, Municipal Planning and Dev’t Coordinator, Sahriff Aguak, Maguindanao
José G. Bañaga, Municipal Planning and Dev’t Coordinator, Ampatuan, Maguindanao
Marjoria Palao, Social Welfare Officer, Maguindanao
Maria Lourdes Tacsagon, FP User, Upi, Maguindanao
Dina Grajedo, FP User, Upi, Maguindanao
Maria Teresa Escalon, FP User, Upi, Maguindanao
Nilda Alquizadas, FP User, Upi, Maguindanao

UNFPA-Southern Philippine Office (SPO)
Dr. Jackie Kitong, Team Leader, UNFPA-SPO
Prof. Jurma Tikmasan, PDS/Gender Adviser, UNFPA-SPO
Shalimar Limba, Provincial AFA – Maguindanao, UNFPA-SPO
Roxanna Epe, UNFPA-SPO
Elsa Gravidez, Provincial AFA – Sultan Kudarat, UNFPA-SPO
Ahmad Hairon, UNFPA-SPO
Jose Salopesa, PPC – Maguindanao
Richard Atamosa, PPC – Tawi-Tawi
Paul Nixon Chua, UNFPA – SPO
Arnen Kasan, PPC – Sultan Kudarat
Joel Tammang, PPC – Sulu
Dionesio Alave, SPO Admn/Finance Assistant
Ronnel Villas, SPO Humanitarian Response Coordinator
5. **Places visited**

**Dr. Godfrey Walker**

5. UNFPA Country Office, Makati City  
6. UNDP, Makati City  
7. UNICEF, Makati City  
8. Country Programme Provinces  
   a. Ifugao Province  
   b. Eastern Samar Province  
      i. Sulat, Eastern Samar  
      ii. Maydolong, Eastern Samar  
      iii. Llorente, Easter Samar  
   c. Department of Health – Center for Health Development Region 8, Tacloban City  
   d. UNFPA SPO – Davao City  
9. Other Stakeholders and key people  
   a. USAID, Pasay City  
   b. European Union, Makati City  
   c. Spanish Aid, Makati City  
   d. Department of Health (DOH), Sta. Cruz, Manila

**Ms. Lady Nancy Lisondra**

1. UNFPA, Makati City  
2. Ifugao  
   a. Lagawe, Ifugao  
   b. Lamut, Ifugao  
   c. Asipulo, Ifugao  
   d. Tinoc, Ifugao  
3. Masbate  
   a. Masbate City, Masbate  
   b. Dimasalang, Masbate  
   c. Palanas, Masbate  
   d. Placer, Masbate  
4. Sultan Kudarat  
   a. Isulan, Sultan Kudarat  
   b. Senator Ninoy Aquino, Sultan Kudarat

**Dr. Pilar Ramos-Jimenez**

1. UNFPA, Makati City  
2. Maguindanao  
   a. Shariff Aguak, Maguindanao  
3. Bohol  
   a. Tagbilaran City, Bohol  
   b. Carmen, Bohol  
   c. Ubay, Bohol  
   d. Talibon, Bohol  
4. National Government Agencies and Non-government Organizations (NGAs and NGOs)
a. Philippine Commission for Women (PCW), Malacañang Palace, San Miguel, Manila
b. Commission on Population (PopCom), Mandaluyong City
c. Department of Health (DOH), STA. Cruz, Manila
d. House of Representatives (Congress), Batasan Complex, Constitutional Hills, Quezon City
e. Department of Social Welfare and Development (DSWD), Batasan Complex, Constitutional Hills, Quezon City
f. Engenderrights, Quezon City
g. 3RG, Quezon City

Dr. Ernest Pernia
1. UNFPA, Makati City
2. Bohol
   a. Tagbilaran City, Bohol
   b. Ubay, Bohol
   c. Talibon, Bohol
d. Carmen, Bohol
3. Masbate
   a. Masbate City, Masbate
   b. Dimasalang, Masbate
c. Palanas, Masbate
d. Placer, Masbate
4. NGO Consortium
   a. Philippine Legislators Committee on Population and Development (PLCPD), Quezon City
   b. Linangan ng Kababaihan (LIKHAAN), Quezon City
   c. Philippine NGO Council on Population, Health and Welfare (PNGOC), Pasay City
d. Forum for Family Planning and Development (FORUM), Quezon City
e. Reproductive Health Network (RHan), Quezon City
f. Family Planning Organization of the Philippines (FPOP), Quezon City
g. Commission on Population (PopCom), Mandaluyong City
5. PDS Implementors
   a. National Anti-Poverty Commission (NAPC), Quezon City
   b. Department of Interior and Local Government (DILG), Quezon City
c. Commission on Population (PopCom), Mandaluyong City

Ms. Magdalena Cabaraban
1. Sulatan Kudarat
   a. Isulan, Sultan Kudarat
   b. Lebak, Sultan Kudarat
c. Senator Ninoy Aquino, Sultan Kudarat
2. Maguindanao
   a. Shariff Aguak, Maguindanao
   b. Ampatuan, Maguindanao
c. Upi, Maguindanao
3. UNFPA Southern Philippine Office (SPO), Davao City

Dr. Napoleon Juanillio
1. Bohol
   a. Ubay, Bohol
   b. Talibon, Bohol
   c. Carmen, Bohol
Documents consulted:

a) List of Materials and References made available to the Sixth CP Final Evaluation Team

27. UNFPA. 2009. PDS Annual Report. Manila, Philippines
44. UNFPA. 2009. 2008 Situation of the Philippine Population and Reproductive Health Analysis. UPPI and DRDF. Manila, Philippines
50. UPPI.2006. UNFPA Sixth CP Baseline Report. Quezon City Philippines

b Gender and Culture Documents

Flyers/brochures
1. Bohol Crisis Intervention Center of the Provincial Government of Bohol and DSWD
2. Men Oppose to VAW Everywhere (MOVE) flyer

Provincial and Municipality Ordinances/Codes


Handouts

1. Gender & Culture Component. UNFPA Philippines Country Office
2. Gender Component January to June 2009 Progress Report power point presentation by National Commission on the Role of Filipino Women and Department of Social Welfare and Development
7. Accomplishment Report Gender Component UNFPA Sixth Country Programme—Bohol
8. UNFPA-SPO Progress Report as of Year 2009
10. UNFPA’s Participatory Gender Audit (PGA) 2010: Final Report: Executive Summary

Electronic copy

2. Rights-based Approach. Power point presentation. 3RG. N.D.
3. Autonomous Region in Muslim Mindanao: Seeing the light through the words of MRLs

Training manual


Performance Standards and Assessment Tools for Services Addressing Violence Against Women in the Philippines. A joint publication of NCRFW, UNFPA, DSWD, DOH, PNP, DOJ, and DILG. Manila: National Commission on the Role of Filipino Women. 2008 5 volumes PNP for investigatory services or procedures; DOH for medical or hospital-based services; DSWD for psychosocial services; DOJ for legal/prosecution services DILG and the LGUs for anti-VAW services at the barangay, municipal, city and provincial levels.

c) Journal articles


Summary of Key Activities Supported by Component and Project under Implementation of Sixth UNFPA Philippines Country Programme

a. Consultancies undertaken in support of CP implementation
b. CST or HQ technical missions undertaken in support of CP implementation
c. Studies/ surveys undertaken in support of CP implementation
d. National meetings/conferences held in support of CP implementation
e. IEC/advocacy materials prepared in support of CP implementation
f. Training sessions and workshops undertaken in support of CP implementation
g. Field monitoring visits undertaken in support of CP implementation
h. Study tours/attendance at international meetings undertaken in support of CP implementation
i. Equipment
j. Technical support
k. Supporting documents and actions
### Evaluation of the UNFPA Sixth Country Programme, Philippines 2005-2010

**UNFPA 6TH COUNTRY PROGRAMME**

**PROJECT BUDGET BY COMPONENT (2005-2010)**

(In US Dollars)

<table>
<thead>
<tr>
<th>PROJECT</th>
<th>DESCRIPTION</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
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<td>1</td>
<td>PHL6R104 ASRH Policy Implementation</td>
<td>91,901.00</td>
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<td>PHL6R203 Maternal Care and EOC</td>
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<td>PHL6R205 Youth-Friendly RH Info Services</td>
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<td>10</td>
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<td>11</td>
<td>PHL6R301 Awareness about SRH, RR,Gender</td>
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<td>177,770.00</td>
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<td>PHL6R302 Capacity to Express Concerns</td>
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<td>13</td>
<td>PHL6R303 Male Involvement in RH/RR</td>
<td>50,289.00</td>
<td>28,054.00</td>
<td>34,317.00</td>
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<td>PHL6R304 Life Skills Education for Youth</td>
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<td>Sub-total</td>
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<td>3,968,618.00</td>
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<tr>
<th>PROJECT</th>
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<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
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<td>1</td>
<td>PHL6P103 Capacity to Monitor FCPD MOGS</td>
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<td>73,568.00</td>
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<td>4</td>
<td>PHL6P203 Research &amp; Training in POPDEV</td>
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<td>147,905.00</td>
<td>123,259.00</td>
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<td>110,000.00</td>
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<td>5</td>
<td>PHL6P204 Support to Poverty Reduction</td>
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<td>3,465.00</td>
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<td>Sub-total</td>
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<td>587,569.00</td>
<td>522,900.00</td>
<td>416,613.00</td>
<td>256,692.00</td>
<td>434,919.00</td>
<td>408,219.00</td>
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<th>PROJECT</th>
<th>DESCRIPTION</th>
<th>2005</th>
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<th>2007</th>
<th>2008</th>
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<th>2010</th>
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<td>PHL6G104 Women's Right to Raise Awareness</td>
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<td>Sub-total</td>
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<td>405,497.00</td>
<td>522,900.00</td>
<td>416,613.00</td>
<td>256,692.00</td>
<td>434,919.00</td>
<td>408,219.00</td>
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<th>PROJECT</th>
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<th>2006</th>
<th>2007</th>
<th>2008</th>
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<td>PHL6A101 PCA (Umbrella)</td>
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<td>Sub-total</td>
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<td>3,859,627.00</td>
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**Note:**
- 2005 to 2009 are final budget and expenditure
- 2010 represents budget allocation
## UNFPA 6TH COUNTRY PROGRAMME
### PROJECT BUDGET BY COMPONENT (2005-2010)

**In US Dollars**

<table>
<thead>
<tr>
<th>PROJECT CODE</th>
<th>DESCRIPTION</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
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<td>PHL6R207</td>
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<td>STI/HIV AIDS Info Services</td>
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<td>PHL6R209</td>
<td>JP on HIV/AIDS</td>
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<td>PHL6R302</td>
<td>Capacity to Express Concerns</td>
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<td>Male Involvement in RH/RR</td>
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<td>PHL6G101</td>
<td>Women's Right to Raise Awareness</td>
<td>-</td>
<td>10,122.00</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>10,122.00</td>
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<tr>
<td>PHL6A101</td>
<td>PCA (Umbrella)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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</tbody>
</table>

| TOTAL       | 548,469.00 | 932,098.00 | 1,316,828.00 | 1,545,741.00 | 2,401,503.00 | 2,904,563.00 | 9,649,202.00 |

**Note:** 2005 to 2009 are final budget and expenditure. 2010 represents budget allocation.
## UNFPA Sixth COUNTRY PROGRAMME

### EXPENDITURE BY ACTIVITY
(2005-JUNE2010)

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>EXPENDITURE</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROG. MANAGEMENT</td>
<td>6,620,922</td>
<td>20%</td>
</tr>
<tr>
<td>COMMODITIES/MEDICAL EQUIPMENT AND SUPPLIES</td>
<td>7,972,303</td>
<td>24%</td>
</tr>
<tr>
<td>ADVOCACY/IEC MATERIALS</td>
<td>5,958,830</td>
<td>18%</td>
</tr>
<tr>
<td>RESEARCH &amp; STUDIES</td>
<td>4,634,646</td>
<td>14%</td>
</tr>
<tr>
<td>CAPACITY BUILDING</td>
<td>7,313,015</td>
<td>22%</td>
</tr>
<tr>
<td>INDIRECT COST</td>
<td>604,896</td>
<td>2%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>33,104,612</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
9 List of Studies and Publications supported by UNFPA 6th CP


UPPI. 2006. *UNFPA 6th CP Baseline Report*. Quezon City, Philippines
