PEOPLE COUNT

PLCPD POLICY BRIEF

Investing in Reproductive Health and Family Planning

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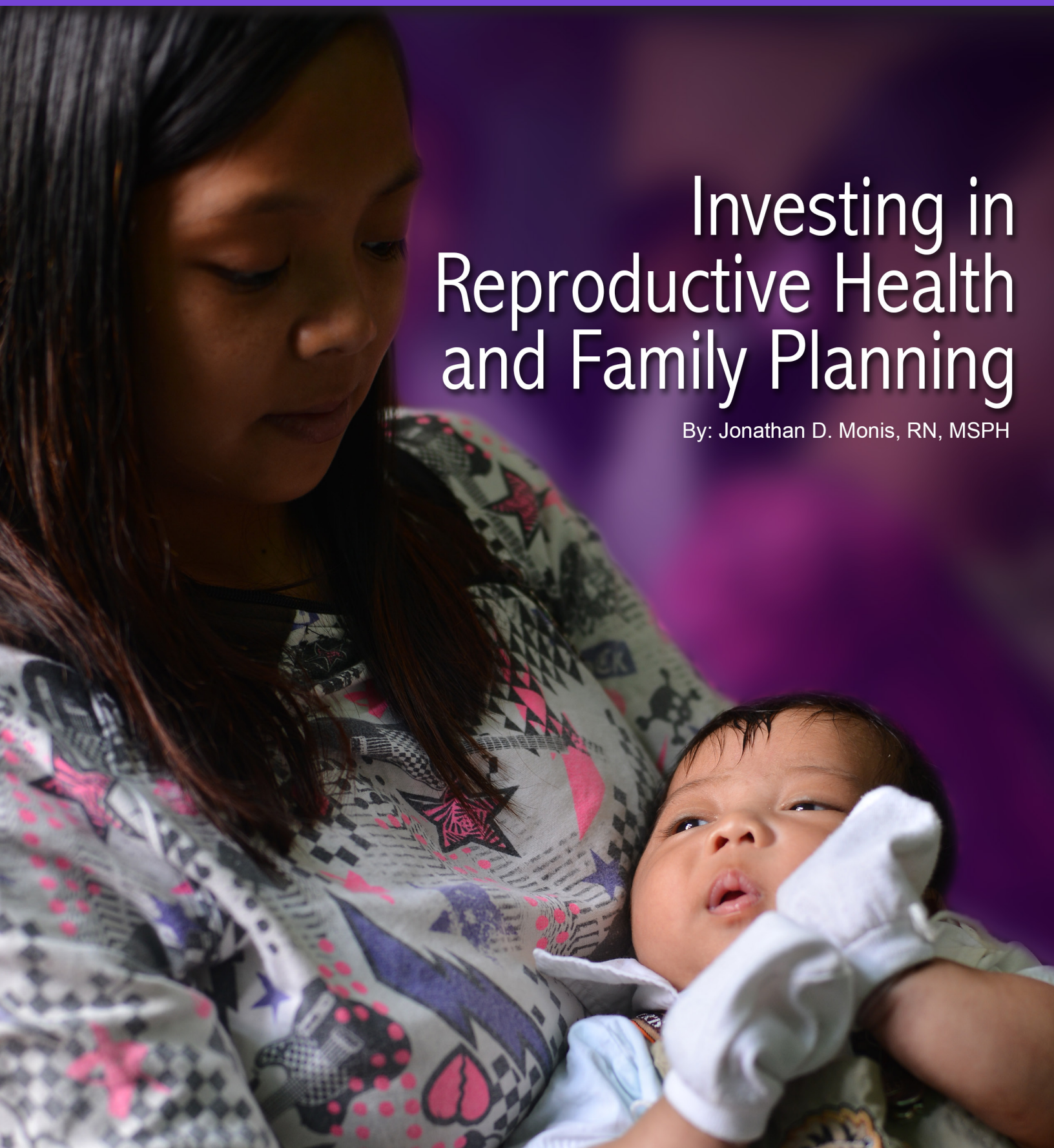


Introduction

The Philippines is considered to be one of the best countries to be a woman. This is because the country is relatively advanced when it comes to various measures that aim to close gender gaps and promote gender equality, including economic empowerment, political participation and leadership, and education, among others. Despite this positive standing, sexual and reproductive health (SRH), a critical area of closing gender gaps, has been stagnant for decades.[1] In 2015, while the Philippines had concluded the implementation of the Millennium Developmental Goals (MDGs), it failed to attain the committed maternal health indicators.[2] As of 2015, the country's maternal mortality ratio stood at 221 per 100,000 live births (MDG target was 52) and contraceptive prevalence rate was at 49%. According to the Department of Health, seven million Filipino women have unmet needs for family planning. Moreover, the rates of teenage pregnancy and increase in HIV cases, which affect mainly children and youth during critical stages of development, are rising to uncontrollable levels and adding up another layer to perennial reproductive health challenges.

As a response to the aforesaid challenges, the Philippines passed the Reproductive Health bill, which was signed by the President and enacted into law in 2012 as Republic Act No. 10354 or the Responsible Parenthood and Reproductive Health (RPRH) Law of 2012. This law provides a legal and policy framework to adequately address sexual and reproductive health challenges in the country. For one, the RPRH Law mandates the State to make available comprehensive reproductive health information and services. It likewise goes beyond the bounds of the health sector as it recognizes the importance of whole-of-society approaches to realizing universal access to reproductive health. However, the task of implementing this law has been considered as gargantuan with the continuing challenges from religious opposition, health system limitations, the country's complex geographical features, vulnerability to the impact of climate change, and devolved set up of health care provision. The result is uneven progress and widespread disparities within and among groups, which could be witnessed often among the rich and poor; the marginalized and vulnerable populations who need the most help are also the most underserved.

Apart from policy and legislation, another critical aspect towards realizing the goal of universal access to sexual and reproductive health services is financing. Improving reproductive health requires a robust and efficient health financing system with increased and sustained funding that is fairly distributed based on needs and socio-economic status. In the context of Universal Health Coverage (UHC), reproductive

health services shall be accessible and shall be able to protect people from impoverishment and financial crises secondary to health costs.

However, the battle towards financing the reproductive health program remains a challenge given the competing health priorities and divisive view on reproductive health. The 2016 budget for Family Health and Responsible Parenting of the Department of Health (DOH) has been reduced to PHP 2.275 Billion, from 3.274 billion of previous year, affecting mainly the budget to procure family planning commodities. This budget decrease was done so despite the clear and growing need for reproductive health services and stagnating reproductive health indicators.

Given the foregoing account on the current status of reproductive health in this jurisdiction, one may ask: Is investing in reproductive health worthy?

It is posited that reproductive health is a fundamental human right. While an end in itself, there is also sufficient and clear evidence to argue that reproductive health is central to eradicating poverty and improving social, economic, and environmental development. It is vital in achieving the Sustainable Development Goals (SDGs), the successor to the MDGs. In fact, family planning, one of the elements of reproductive health, is

one of the 10 greatest public health achievements in the 20th century.[3] Nonetheless, it is rarely being prioritized as a development strategy.

This policy brief attempts to argue for and show evidence of the cost effectiveness and the importance of investing in reproductive health. It is intended to guide policymakers, planners, implementers, and other decision makers on sexual and reproductive health in the Philippines. It covers the important issues in healthcare financing that affect the financial sustainability of reproductive health services and programs. Likewise, various mechanisms, for efficient and effective resource mobilization and spending, will be recommended through global and local evidence.

Falling Short of the MDG 5 Targets

Maternal Health Trend: Data disaggregation of MMR, CPR, and other proxy indicators

The maternal mortality ratio (MMR, or the number of maternal deaths per 100,000 live births) and contraceptive prevalence rate (CPR) are indicators of progress sensitive to the health and welfare of women. If women have no access to family planning, they are disenfranchised of their entitlements to decide for their own body. Unplanned pregnancy, resulting from the unmet need for family planning, adds burden to women and their families due to physical and psychosocial adjustments of childrearing. Maternal deaths

may be uncommon, but it is a very tragic event for a family and the community they live in. One death that could have been prevented is too many. The number of maternal deaths is sensitive to the strength of the health system in a given community.

Since 1990, MMR has declined by 45% worldwide.[4] The acceleration of MMR reduction happened as countries committed to the MDGs in 2000. On another hand, the global Contraceptive Prevalence Rate among women aged 15 to 49 increased from 55% in 1990 to 64% in 2015. Meanwhile in Southeast Asia, the MMR declined by 57% between 1990 and 2013 while births assisted by skilled health personnel, which is a known predictor of MMR, have reached 82%. As may be observed, the CPR in said region is comparable to the aforementioned 2015 global average. However, despite these developments that indicate remarkable progress in the field of reproductive health, there are also data indicating that RH-related MDG targets were still not achieved—and disparities in figures are more glaring if observed across wealth quintiles.

In the Philippines, the last MDG Progress Report shows that the CPR increased by 8.9% in 2011 from the 1990 baseline of 40%.[5] Nonetheless, the 2011 Family Health Survey indicates that the MMR increased to 221, from 162 in the 2006 survey. The 2011 figure is even higher than the baseline of 211 in 1990. Also, there is a wide disparity on the MMR estimates as compared to different data sources. The Field Health Services Information System (FHSIS) of the DOH reported an MMR of 74 in 2014[6] while estimates by the United Nations (UN) and World Bank for the same year amounted to 120.[7]

Aside from the confusion in the data, the wealth quintile disaggregation shows disparities in terms of access to family planning. The unmet need for long-acting and permanent contraceptives are highest among the poorest groups and those from the rural areas, where access due to geographic constraints remain to greatly affect health service provision.

Disparities in figures regarding MMR, CPR, and other proxy indicators affect and pose challenges to policy development and planning in reproductive health. In the absence of uniform and reliable indicators, or lack of data altogether, it is hard to monitor and evaluate the efficacy and effectiveness of policies and program strategies. This is so because such figures demonstrate sensitivity of the maternal health indicators to the progress of a country's health system in place, particularly health information system.

An account of vulnerable groups

Another emerging concern is the increasing number of pregnancy among children and adolescents. It is alarming to note that adolescent fertility has declined in all countries in Asia Pacific except in the Philippines, where notable increase has

been observed. According to the 2013 Young Adult Fertility and Sexuality (YAFS) Study, roughly 14% of girls aged 15 to 19 are either pregnant or already mothers—doubling the rate recorded in 2002.[8] The result of the survey came after the passage of the RPRH Law, which requires a written consent from any parent or guardian to access family planning commodities. Culturally, young Filipinos rarely discuss sex with their parents. Thus, asking for parental consent to accessing reproductive health services poses a serious barrier towards a truly universal access to reproductive health services.

In terms of HIV transmission and infection, which beset the sexual and reproductive health of individuals all over the world, several breakthroughs have occurred over time. For one, the improvement in anti-retroviral therapy (ART) has reduced AIDS-related deaths by 42%.[9] In addition, there has been a decline in the number of HIV cases globally.

Notwithstanding such breakthroughs, the Philippines is one of the very few countries with more than 25% increase in the rate of new HIV infections over the last decade. In 2015, children and adolescents comprise one out of four newly discovered HIV cases for the month, and for the entirety of all reported cases since the occurrence of the first infection in the 1980s.[10] Consequently,

policymakers and other stakeholders should also give attention and direct their efforts to respond to increasing number of HIV cases in the country.

Sexual and reproductive health issues mainly affect the youth, as well as the adolescents. The increasing teenage pregnancy rates and HIV cases among these groups are alarming and damaging to their development and productivity. Inability to harness the potentials of the youth will have an impact on the social and economic development of the country. Hence, concrete and swift action must be put forward to reverse it. These issues, which exacerbate even more the perennial reproductive health challenges of stagnating CPR and MMR, clearly show the years of neglect on investing in reproductive health development.

Considering all the foregoing, it is advised that to regain the momentum in maternal mortality reduction, as well as to achieve the indicators for reducing child mortality, equitable financing schemes must be focused on improving accessibility to reproductive health services while taking into account geographical and cultural challenges and other considerations.

National and International Legal Framework of Reproductive Health

In the domestic sphere, the 1987 Philippine Constitution upholds women's rights to life, health and equality. As provided in Section 15 thereof, "The State shall protect and promote the right to health of

the people and instill health consciousness among them." Thus, the provision of full package of reproductive health services, including modern contraceptives, is among the duties of the government to the Filipino people. Moreover, the existing national laws such as the RPRH Law in 2012, Magna Carta of Women in 2009, Local Government Code in 1991, and the Philippine AIDS Prevention and Control Act in 1998, mandate access to reproductive health.

In September 2015, nations all over the world came together to seal the Sustainable Development Goals (SDGs). The SDGs set forth commitments on 17 goals, unlike MDGs with only eight goals. However, some experts are concerned with increasing the development priorities, which has massive financial implications. The SDG implementation would require trillions of dollars a year.[11] For others, it is not seen as an issue but an opportunity, since this new development agenda is more comprehensive and offers wider opportunities for integration and cross-sectoral collaboration.

In the SDGs, reproductive health targets are found in SDG3 (health) and SDG5 (gender equality and empowerment). The SDGs recognize the International Conference on Population and Development (ICPD), as well as the Beijing Platform for Action, as legal and technical frameworks. The ICPD broadened the scope of reproductive health from being population control-focused to becoming more inclined and receptive of other social development concerns such as advancement of women, women empowerment, and mainstreaming of family planning into a broader package of reproductive health care. The Philippines is a party to ICPD, Beijing Platform for Action, and the SDGs.

Aside from the ICPD and Beijing Platform for Action, the Philippines also ratified other international conventions that recognize sexual and reproductive health and rights such as the International Covenant on Economic, Social, and Cultural Rights (ICESCR) in 1976, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1979, and the Convention on the Rights of the Child (CRC) in 1989, to name a few. Therefore, in conformity with its international covenants and undertakings, the government should uphold and safeguard—to the fullest extent—the exercise of sexual and reproductive health and rights among Filipinos. Aside from reproductive health, these international conventions spell out a comprehensive framework for human rights, women's rights, and gender equality.

Reproductive Health as a Cost Effective Development

Strategy

The economic growth, employment, health, and education that fuel human development cannot be fully realized without better access to family planning and other reproductive health services, as access to family planning is important to achieve one's fertility goal at the individual level, and to manage the growth of the population vis-à-vis the resources available to the society at the macro-level. Inability to invest in human capital because of insufficiency of resources aggravates poverty, political instability, and insecurity. Evidence shows that speedy population growth that does not match the resources available to sustain the population may slow or reverse the benefits of economic growth. A study had shown that if only the birth rate worldwide fell by five per 1,000 in 1980s, there would have been one-third decrease in the number of people thriving below the poverty line.[12] Growing population requires expansion of health facilities, construction of schools and classrooms, and creation of more jobs to keep up with the increasing demand for social services. It also contributes to the depletion of resources and other challenges related to food security and financial stability of vulnerable and marginalized population. Rapid population growth also affects youth employment if a country cannot fully invest in education. Bulging of low-skilled and uneducated laborers is faced with high unemployment in many developing countries including the Philippines.

Another impact of reproductive health is the nurturing role of women. In the Philippines, caring roles for children and sick are considered the prime responsibility of mothers. When mothers die, or are being afflicted with any disability, task shifting happens. Children, mostly girls, may drop out from school to assume caregiving roles and manage the household. The death of a mother has economic implications, maternal and newborn deaths result to annual productivity losses amounting to US$15 billion, worldwide.[13]

Women who lack education are inclined to having more number of children. It is really ironic that those who have lesser resources are burdened with childrearing, which pulls poor families further down to the trap of poverty and results in intergenerational poverty. If only these women would have better control over their financial decisions and household income, they are more likely to spend 90% of their income for the welfare and future of their children, as compared to men at 30-40%.[14] This shows indirect impact of investing in women on the country's economic development.

These surrounding and implicating issues just show how reproductive health and family planning are central to the country's development. Neglect on these challenges and issues poses significant threats to poverty reduction and other social development programs. However, despite such critical impact, the political will and initiative to invest in reproductive

Health Expenditure by Source of Funds, 2012 to 2013

SOURCE OF FUNDS	AMOUNT (in million pesos, at current prices)		Growth Rate
	2012[1/]	2013	
GOVERNMENT	**89,934**	**99,684**	**10.8**
National Government	55,694	62,827	12.8
Local Government	34,240	36,857	7.6
SOCIAL INSURANCE	**52,457**	**60,365**	**15.1**
Employees' Compensation [2/]	112	74	(33.9)
PRIVATE SOURCES	**324,618**	**358,984**	**10.6**
Private Out-of-Pocket	269,419	296,539	10.1
Private Insurance	7,086	9,247	30.5
Health Maintenance Organizations	32,273	36,535	13.2
Private Establishments	11,603	11,752	1.3
Private Schools	4,236	4,911	15.9
REST OF THE WORLD	**3,987**	**7,235**	**81.5**
Grants	3,987	7,235	81.5
ALL SOURCES	**471,108**	**526,342**	**11.7**

[1/] Revised
[2/] The abrupt decrease is due to SSS' temporary stoppage of processing of payment of medical services relative to the enhancement of the automated processing of Employees Compensation Medical Reimbursement claims.

health has been lacking for several years. This lack of action is counterproductive, as pieces of evidence are piling up on the direct and indirect returns of investing in reproductive health.

According to Copenhagen Consensus, SDG targets 3.7 and 5.6–both about ensuring universal access to reproductive health, are among the targets with evidence of more than 15 times higher the benefit than its costs.[15] Specifically, a dollar of investment in family planning yields a benefit of $90-150 due to reduced maternal, neonatal, and infant mortalities, as well as income growth including life cycle, distributional, and intergenerational benefits. The estimation of Guttmacher Institute and United Nations Population Fund (UNFPA) demonstrates direct yield of $1.47 from reduced pregnancy-related care costs per $1 spent for contraceptive services.[16] Another study shows that anti-retroviral therapies (ARTs) given to people living with HIV and AIDS will have gains of $10 for every dollar funding. Thus, prioritizing reproductive and sexual health at a national level will have positive impact in the economy. It will also accelerate progress towards achieving the SDGs.

Reproductive Health Spending

The previous sections argue the importance of reproductive health in the development of our country and provide evidence on the cost effectiveness of reproductive health as a development strategy. However, the topic of financing and investments requires answering the following policy questions: (1) Who spends for it? (2) How much would the investment be? (3) How much is the gap?

These questions will be the pillars of the upcoming discussions.

(1) Who spends for reproductive health services?

One way of knowing the financing and spending dynamics of the country is by examining the Philippine National Health Accounts (NHA). The NHA is the framework of the country's health expenditures. It tells information about the total health expenditure, the sources of spending, and the schemes of health financing as well as the services it is provided for. Table 1 shows the summary of the National Health Accounts by source of fund. The table illustrates that the country's total health expenditure increased by 11%, from PhP 471.1 billion in 2012 up to PhP 526.3 billion in 2013.16 Private sources specifically out-of-pocket expenditures remain to be the largest driver of the total health expenditure, which contribute 68.2% of health spending, while the government accounts for only 18.9%. The Official Development Assistance (ODA) on health, which comprises grants and loans obtained from donor agencies, only account to less than 1%.

NHA provides good information on how the universal health

Percent distribution of users of modern contraceptive methods age 15-49 by most recent source of method according to method, Philippines 2013

Source	Female sterili-zation	Pill	IUD	Inject-ables	Male condom	Total
Public sector	**75.1**	**25.2**	**81.9**	**81.7**	**14.4**	**47.2**
Government hospitals	66.7	0.2	10.4	1.9	0.0	16.7
Rural health unit/Urban health center	8.4	0.2	10.4	1.9	0.0	12.2
Barangay health station	0.0	17.7	32.9	47.8	9.2	17.5
Barangay supply/Service point officer/ BHW	0.0	1.1	0.0	1.3	0.4	0.8
Other public	0.0	0.0	0.7	0.1	0.0	0.1
Private medical sector	**23.7**	**68.1**	**16.6**	**17.5**	**72.2**	**47.8**
Private hospital/clinic	22.8	0.9	12.2	6.0	0.9	7.7
Pharmacy	0.0	66.5	0.0	7.0	70.8	38.7
Private doctor	0.8	0.4	3.2	1.5	0.0	0.9
Private nurse, midwife	0.0	0.1	1.0	2.2	0.0	0.9
NGO	0.0	0.1	0.3	0.7	0.0	0.2
Industry-based clinic	0.0	0.0	0.0	0.0	0.4	0.0
Other private	0.1	0.1	0.0	0.0	0.0	0.0
Other source	**0.0**	**6.5**	**0.3**	**0.5**	**13.4**	**4.4**
Puericulture center	0.0	0.1	0.3	0.0	0.0	0.1
Store	0.0	5.7	0.0	0.5	10.7	3.6
Church	0.0	0.0	0.0	0.0	0.0	0.1
Friends relatives	0.0	0.7	0.0	0.0	2.7	0.6
Other	0.2	0.0	0.0	0.3	0.0	0.1
Missing	1.0	0.3	1.1	0.0	0.0	0.5
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Number of women	**867**	**1,911**	**352**	**366**	**220**	**3,755**

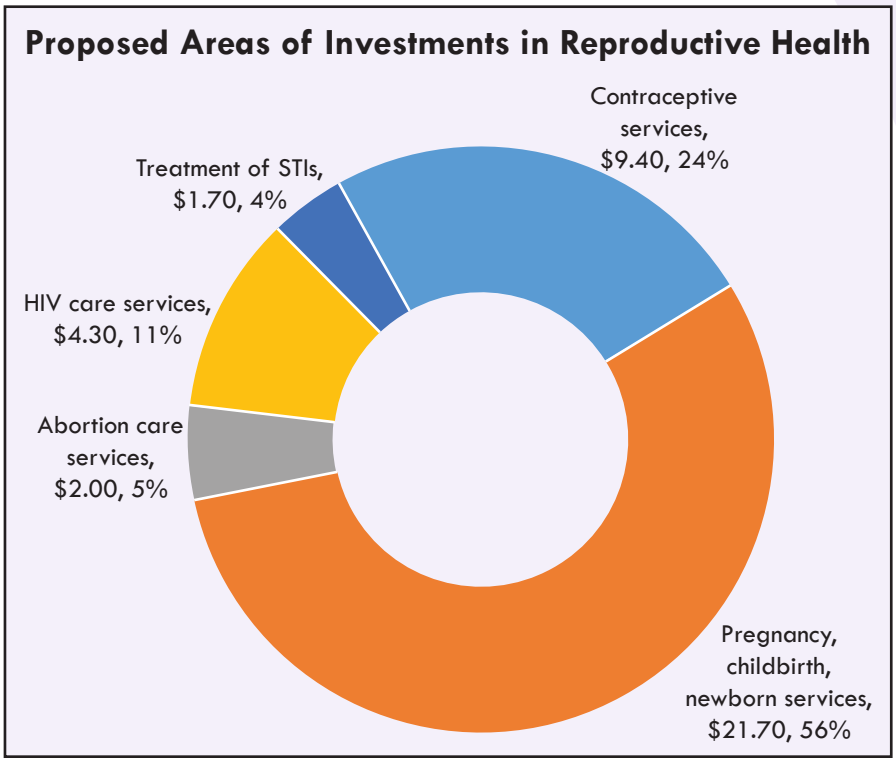
Note: Total includes other modern methods (male sterilization, implants, basal body temperature, Mucus/ Billings, symptothermal and standard days) but extrudes lactational amenorrhea method (LAM)

from 13% in 2003 to 19% in 2013. Sterilization such as bilateral tubal ligation and no-scalpel vasectomy comes second among modern contraception albeit a decreasing trend has been noted. In terms of sources, private sector is the main source of pills and condoms, which are mainly purchased over-the-counter. Meanwhile, the government provides majority of services for female sterilization, intrauterine device (IUD), and injectables. In terms of cost, only 18% of the family planning commodities and services are availed for free. The rest are paid by the users.

Using the above data, it may be assumed that majority of reproductive health spending in the country comes from the pockets of Filipinos despite the increased coverage of health coverage and other health financing strategies fare in reducing risks of financial hardships especially from catastrophic diseases. In the context of reproductive health, universal health coverage is the strategy to improve financial accessibility to services. However, NHA has no specific data on reproductive health spending.

With regard to contraceptive utilization, the results of the 2013 Philippine National Demographic and Health Survey (NDHS) show that pills are the most commonly used contraception in the country (Table 2).[18] It has been increasing

Proposed Areas of Investments in Reproductive Health



insurance and budget for reproductive health. However, we can project a better picture on the equity dimension of financing if we have data disaggregation on income quintiles, age and urban-rural classifications, since the reproductive health programs are targeted.

(2) How much investment? How much is the gap?

Since the RPRH Law is the country's blueprint for addressing the reproductive health needs of the country, it has to be costed upon to have an idea on the amount of the required investment to meet the commitments set forth in the law. Yet, there has been no comprehensive costing developed for RPRH. Hence, to provide an estimate as to how much investment is needed for comprehensive and full-range reproductive health services, existing modeling can serve as a basis.

In 2014, *Adding It Up*, a publication of UNFPA and the Guttmacher Institute, estimated that the global investment for reproductive health in post-MDG era will require around $39 billion, annually.[19] This translates to $25 per woman of reproductive age or $7 per person in a developing country. Figure 2 shows the included package of reproductive and sexual health services for women and newborn.

The Adding It Up Model, in some way, covers major components of RPRH Law. It can be a good alternative for costing purposes. However, adjustments are necessary in order for it to conform with the country's situation. Specifically, since abortion is restricted in the country, we can devote only in post-abortion care services, which are already integrated in the Comprehensive Emergency Obstetric Newborn Care (CEmONC) that is being rolled out as part of the maternal and neonatal health services. A minimal cost may also be needed for sensitivity training of health workers, as women reported receiving verbal and physical assaults from health workers due to stigma on abortion.[20] Moreover, the cases of HIV and AIDS among pregnant women and newborn are below 100, to date. Integration between HIV and maternal and newborn health services can be explored to reduce costs from developing a separate structure to cater to the needs of pregnant and newborn living with HIV.

Using the $7-per-population recommendation from UNFPA and GI, deducting the costs needed for HIV and abortion services, the country will require an investment of PhP276.36 (USD1=PhP47) per person per year. The 2015 National Census of a 100.98 million population signifies that the government needs to spend around 27.91 billion pesos, annually or around 15% of the 2013 total government health expenditure. In 2013, PhilHealth paid more than 800,000 maternal and neonatal services through availment of the maternity care, normal spontaneous delivery, Caesarean section and neonatal care packages, or a total of 6.1 billion pesos.[21] The DOH budget for reproductive health in 2015 was around 3.27 billion pesos, while the Population

Commission has allocated 300 million pesos in the same year.[22] Although, there has been no account yet of the local budget for reproductive health, the current government expenditure for reproductive health is far from the international reference.

Health System Barriers to Reproductive Health

Health financing is one of the six building blocks of the health system. Issues on health information systems, health human resources, governance, regulations and service delivery affect health financing, vice versa. Therefore, one should apply health system thinking to understand better the relationship and dynamics that affect the optimal delivery of reproductive health services. Through a careful consideration of health system's building blocks, one could identify where it breaks down, and what type of integrated solutions will strengthen the overall system for efficient spending and effective delivery of reproductive health services.[23]

One of the health system issues mentioned earlier is the untimely and unreliable data on MMR, wherein we showed how different information sources produce varying MMR results. Aside from reliability of the MMR data, the weak logistics information systems weaken supply chain as it results in unpredictability and uneven distribution of supply of reproductive health products. According to reports from local government units (LGUs), there are health facilities with stock outs of family planning commodities, while others have supplies beyond the needs of their clients within their catchment areas. The weak supply chain system affects mainly pills and injectables, both of which necessitate consistent use or administration in short time intervals. Undersupply or untimely delivery of these commodities leads to unmet need for family planning, while oversupply results in wastage and unnecessary use.

To date, there are efforts to reform the health information systems by installing computer-driven technologies to provide real-time health information reports from service delivery points. However, poor information technology infrastructure, coupled with the complex geographical features of the Philippines, makes it challenging to cascade these technologies in remote areas. Moreover, different partners introduce different types of technologies. While the assistance of partners are found to be useful in the delivery and reporting of data at the local level, the challenge lies in the interoperability or the ability of different information software and systems to communicate and exchange information, when these data sets have reached the national office. The Philippine Health Information Exchange of the DOH aims to put an interoperable layer to standardize these data sets. However, it is still in progress.

In terms of governance, majority of the family planning supplies in health facilities come from the national government. In a devolved set-up such as the health sector, LGUs must assume responsibility to ensure sustenance of sufficient quantities of family planning supplies, especially for the users without means to pay for their contraceptives. However, the personal views of local chief executives affect the reproductive health programs in LGUs. In 2015, Sorsogon City Mayor Sally Lee signed an Executive Order declaring the city as "pro-life." While, in 2000, former Manila City Mayor Lito Atienza issued Executive Order 0003, banning the distribution of modern contraceptives in health centers. These are only a couple examples that show the dangers of reproductive health programs being at the whims of local chief executives.

Aside from local policy barriers, at the national level, a limitation of the RPRH Law to ensuring universal access is the provision that requires parental consent for minors to access family planning services. Given the situation that sex and sexuality is hardly being discussed at home or engaging in early sexual activities is considered as an immoral and unacceptable act, it is imaginable among young Filipinos to bring their parents to the nearest health facility to access family planning.

The issuance by the Supreme Court of a temporary restraining

order (TRO) on public procurement, promotion, and distribution of contraceptive implants poses a challenge to the implementation of RPRH Law. Implants seem to have gained popularity, especially among poor mothers and girls, because of its convenience and long-term efficacy. The TRO likewise hinders the issuance of the certificate of product registration of other reproductive health products. The certificate of product registration is important for market entry of reproductive health products and for accepting foreign donations. Without the product registration, the supply of family planning in the country is threatened to extinction as long as the TRO is in effect.

The widespread divisive view on RH among policymakers and decision makers threatens the sustainability of reproductive health programs, especially family planning and post-abortion care. If the new leadership is not in favor, the reproductive health services become disrupted, thus, further widening disparities in access to services among Filipinos. Disregard for evidence to favor personal conviction in policy decisions proves to be deleterious to women and the marginalized who need the services the most. Moreover, reliable data are important ingredient of good public health policies, plans and other decision-making platforms. Health data shape public health priorities and strategies as they track the progress of the health interventions. Improving these health system obstacles will improve financing and delivery of reproductive health services.

Policy Options and Recommendations

Given the different issues and concerns surfaced, the following are the policy recommendations for careful consideration:

Enhancing the Planning and Budgeting for RH

Develop multi-year national action plans. The DOH may develop a comprehensive multi-year planning and costing of RPRH Law to provide clearer idea on how much is the funding gap based on the set of activities to be implemented in a medium term. A good plan identifies components or activities with technical and budget deficits, which can be augmented through external support such as ODAs, private sector and non-governmental organizations. Laying down the plans to partners promotes alignment of their activities with the national strategy, thereby reducing duplication and promoting complementarity.

Financing multi-year plan should also incorporate periodic, public and independent monitoring and evaluation mechanisms to track the achievement of commitments and efficiency of spending.[24] At the moment, the RPRH National Implementation Team serves as the main coordinating and monitoring body of the law implementation. However, coinciding with the medium-term plan assessment, an independent audit must be conducted.

Encourage integration of RH in other sectoral agenda. Through the DOH and in coordination with other national government agencies, the budget for the implementation of RPRH Law must be integrated within the

national health strategies and appropriations. As discussed, the impact of reproductive health transcends the health sector. Stronger impact from synergistic approaches can be expected should reproductive health be mainstreamed in other sectoral plans such as youth, education and economic agenda. The process of development must be participatory, taking into account the inputs of the relevant stakeholders such as women and the youth, and keeping in mind equity approaches through considerations for hard to reach segments of society.

Improving Financing of RH Programs and Services

Increase mobilization of public revenues for reproductive health. One effective strategy to augment yearly appropriations of RH is through hypothecation or earmarking of public revenue. Hypothecated taxes "are those whose revenue is designated to be spent on a particular program or use."[25] It is being encouraged by the World Health Organization to maximize fiscal space to achieve universal health coverage. The landmark passage of Sin Tax Law in 2012 is a good example on how taxation policy can be a cost-effective public health strategy to augment healthcare financing. The Sin Tax contributes more than Php 100 Billion to health budget yearly. Moreover, the price increase of tobacco and alcohol products alters spending behavior of consumers, thereby reducing consumption and delaying debut of use.

President Duterte, in one of his speeches, announced to allot a portion of PAGCOR revenues for health and education.[26] In 2015, the institution raised 47.21 billion pesos.[27] DOH may consider allocating a portion of this hypothecated or earmarked revenue to support reproductive health programs, especially the line item for the procurement of family planning supplies, which always faces abysmal scrutiny from anti-RH policymakers during budget deliberations. Earmarking shall ensure predictive funding for family planning. Nonetheless, advocates need to be mindful, as hypothecated taxes for RH can be used to justify budget suspension or flow restriction for family planning and other reproductive health services in other financial mechanisms.

Expand PhilHealth's RH packages. While drastic increase in the health budget is observed at the national level, total health expenditure is still largely driven by household spending. PhilHealth, being the government-owned and controlled corporation that deals with health care financing, has a huge role in ensuring universal access to reproductive health services and reducing out-of-pocket expenditures. To date, PhilHealth purchases reproductive health services such as normal spontaneous delivery, Caesarean section, newborn care, and select long and permanent family planning methods. There is also existing treatment package for HIV/AIDS but other STIs are not covered at the moment.

To improve PhilHealth's enrolment coverage and service utilization among the poor, the Point of Care and No Balance Billing were developed. Point of Care enrolls poor and other eligible individuals under the Sponsored Program to automatically avail of the PhilHealth entitlements. On the other hand, No Balance Billing promises that Sponsored members shall leave the hospital without balances on cases covered by PhilHealth. A challenge in implementing these programs lies with the awareness of the members on their entitlements, especially among the sponsored members under the Pantawid Pamilya Pilipino Programs (4Ps). The 2015 survey of National Anti-Poverty Commission (NAPC) shows that "seven in ten indigent mothers went to a health facility to give birth, but only four in ten used their PhilHealth card for maternal care services" because of the out-of pocket costs, information gap and preference for home delivery and lack of accredited facilities.[28] There are also government hospitals that are not fully implementing the No Balance Billing. PhilHealth has to improve its enrolment coverage especially in remote areas as well as hard to reach sectors such as the informal economy. Its service coverage has to include other basic reproductive health concerns such as STIs.

Re-think results-based financing strategy. DOH also employed

different incentive mechanisms to spark health performance of LGUs, given a devolved set up. The LGU Scorecard is a program of the Department of Health that incentivizes LGUs' achievement of select outcome and impact level indicators such as CPR, MMR and facility-based deliveries.

Aside from the LGU scorecard, DOH utilized performance-based grants (PBGs) as an operational element for the implementation of the Maternal, Neonatal and Child Health and Nutrition (MNCHN) strategy in 2009. The PBG models developed include combination of demand side and supply-side incentives to improve facility-based deliveries and curb maternal deaths. After years of implementation, an impact evaluation of these PBGs shall be done in order to gauge the success of the PBGs and document lessons learned should DOH pursue a results-based financing in the future.

Enhancing the Policy Environment towards Efficient Spending and Implementation

Improve spending efficiency. The increased budget allocation for DOH and PhilHealth, mainly from Sin Taxes, shifts the challenge to efficient spending. Moreover, the procurement delays as well as complicated financial policies governing RH public disbursements affect the efficiency of spending. During the 2016 budget deliberation, the Senate argued that the trend of underutilization of RH budget was her main reason for slicing a billion to the proposed 2016 RH budget.29 This is despite knowing that the RH budget allocations have always been insufficient, and the maternal health situation is not improving significantly. The efficient spending of health budget is becoming a growing challenge for DOH, which is somehow expected to an agency with sudden exponential budget increase. To better understand the situation, the DOH may commission an in depth analysis of to identify health system deadlocks.

Improving other health system components will not only improve health spending but will directly impact reproductive health service delivery provision. Developing an efficient logistics inventory system of family must be prioritized in order to address unmet needs optimally and prevent wastage of family planning commodities.

Institutionalize contraceptive self-reliance among LGUs. The DOH adapted the Contraceptive Self Reliance (CSR) Strategy in 2001, in which self-financing of contraceptives among LGUs are encouraged. However, to date, DOH is still procuring the majority of family planning supply of the public sector. CSR aims to enhance the ability of the LGUs to forecast demand, procure, and deliver quality family planning.[29] Its strategy lies with the actors that govern the CSR policies and programs as well as the internal and external environment in which the policies are promoted.

To improve self financing of family planning, the policy on CSR must be reinforced. LGUs must develop their own ordinances that direct predictive and sufficient funding to support procurement of family planning commodities and other reproductive health programs. The role of LGUs, who have the jurisdiction over the majority

of the primary care facilities, is critical in addressing the financing gaps and in ensuring that the services are accessible to the marginalized and hard-to-reach populations.

Revisit the devolution of healthcare system. The healthcare system has been the most affected sector since the Local Government Code was issued in 1991, as it transformed the health governance approach extensively. Through the years, the devolution has always been criticized as the transfer of power to the LGUs failed to bring about progress in health outcomes in the local communities. Instead, local politics negatively affected health governance. On the other hand, those local chief executives with strong health inclination appear to bring positive changes in their respective localities. These different levels of progress are said to contribute to the widening of disparities of health outcomes across the country.

In this regard, legislators must revisit the Local Government Code and look at existing evidence of weaknesses in the implementation of the Local Government Code, specifically its provisions on decentralization of the healthcare system. This is to identify the best governance approach that would suit the implementation of the health reforms in the country.

Notwithstanding the governance structure, LGUs have to step up in ensuring and sustaining the access to family planning.

Strengthen Intersectoral Collaboration for Monitoring, Advocacy, and Demanding Accountabilities

The TRO of Supreme Court remains to be the biggest threat to the implementation of RPRH Law both in public and private sectors. To date, it has been in effect for a year already. Decades of collaboration between government agencies, champion legislators, NGOs, international organizations and private sector became instrumental in the passage of RPRH Law despite strong opposition. This partnership has been tested again when Supreme Court issued a TRO in the implementation of RPRH Law in 2013. Activating coordinated inter-sectoral collaboration is again needed for juridical advocacy to lift the TRO.

Conclusion

The policy brief tackled different areas that affect the investments and spending of reproductive health in the country. We discussed legal frameworks and global evidences that uphold the importance of investing in reproductive health in social and economic development of our countries.

With regard to the investments aspects, the Philippines has to increase its reproductive health allocation to accelerate our progress based on the Adding It Up model. Although this type of international modeling can give us an idea on the investment gaps, our country needs still to come up with our own multi-year investment modeling based on the implementation of the RPRH Law to paint a more accurate picture.

On the other end, while advocating for increased budget allocation in different financing streams is important to address investment gaps, equally important is the spending efficiency and addressing implementation deadlocks. Health system approach is one way to identify implementation deadlocks by looking at the complementarity and synergistic effect of each health system building blocks.

In financing the reproductive health, our goal is to reduce the out of pocket spending for the essential reproductive health services especially among the poor and the marginalized groups. PhilHealth and the LGUs are the major players in realizing this goal. In a devolved setup, the LGU has to step up and increase their allocation to reproductive health. PhilHealth must increase its enrollment coverage and expand its service packages.

In our commitments towards the SDGs, the policymakers and other decision makers have to realize that the health and welfare of women are still at the heart of this development agenda. Therefore, reproductive health is a smart investment.

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