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THE FADE-AWAY EFFECT

Findings from a Gender Assessment of Health Policies and Programs in the Philippines

This publication was prepared by Rachel Kiesel and Elisabeth Rottach of the Health Policy Project.

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HEALTH POLICY PROJECT

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ABBREVIATIONS

ARMM	Autonomous Region of Muslim Mindanao
CHD	Center for Health Development
DAWN	Development Action for Women Network
DOH	Department of Health
EDGE	empowerment, development, and gender equality
GAD	gender and development
GAD RCO	Gender and Development Resource and Coordinating Office
GBV	gender-based violence
GFPS	gender focal point system
GPM	gender, policy, and measurement
HPP	Health Policy Project
LGBT	lesbian, gay, bisexual, and transgender
LGU	local government unit
MCW	Magna Carta of Women
MNCH	maternal, neonatal, and child health
MNCHN	maternal, neonatal, and child health and nutrition
MR GAD	Male Responsibility in Gender and Development
NCD	noncommunicable diseases
NDHS	National Demographic and Health Survey
NEDA	National Economic Development Authority
PCW	Philippine Commission on Women
PPGD	Philippine Plan for Gender-Responsive Development
RH	reproductive health
TB	tuberculosis
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development
WCPU	women and child protection unit
WHO	World Health Organization
WPRO	World Health Organization Western Pacific Region

INTRODUCTION

Health programs and donors in the Philippines and throughout the world increasingly recognize the importance of addressing gender inequality to improve health outcomes for women, men, and children. In 2012, the U.S. Agency for International Development (USAID) adopted the Gender Equality and Female Empowerment Policy, with the goal of "improving the lives of citizens around the world by advancing equality between females and males, and empowering women and girls to participate fully in and benefit from the development of their societies." The Country Development Cooperation Strategy (2012–2016) of USAID/Philippines stresses the critical importance of gender-related issues to development. In keeping with this strategy, USAID/Philippines is exploring new and more effective ways to address gender concerns in its health programs.

To support these priorities and strengthen gender integration efforts in the Philippines, the Gender, Policy, and Measurement (GPM) program of the Health Policy Project (HPP) conducted a gender assessment of health-related laws, policies, and programs, in collaboration with USAID/Philippines staff and stakeholders (see Annex A). The analysis was designed to help the health office of USAID/Philippines determine how the government, donors, and nongovernmental organizations are responding to gender inequality, norms, and barriers.

This report presents the gender assessment's results. It analyzes the country's resources and capacity to develop and implement gender-responsive health programs, suggesting entry points and opportunities for investing in gender equality for improved family planning and maternal, neonatal, and child health (MNCH) outcomes. The report also recommends ways to incorporate gender-integrated interventions in the country's health portfolio: for example, adapting or developing tools and training materials and adopting strategies for monitoring and evaluating gender-integrated programs.

METHODS

HPP/GPM conducted a review of literature on gender and health in the Philippines, a desk review of the country's health policies and programs, and key informant interviews with USAID, government, and civil society stakeholders. In order to analyze the programs that emerged, we developed a checklist of gender-responsive characteristics and ranked programs based on scores. We validated these findings by means of a series of key informant interviews with stakeholders from the national to the grassroots level.

Search 1: Gender and Health Literature

HPP/GPM's review built on a gender assessment that multilateral donors and the National Commission on the Role of Filipino Women conducted in 2008. We used the following search terms: "gender," "women's empowerment," "male involvement," "decision making," "gender-based violence," "leadership roles," and "Philippines" combined with "family planning," "contraceptives," "maternal health," "neonatal health," "child health," and "tuberculosis."

The initial search uncovered 231 references published from 2007 to 2013. HPP/GPM staff reviewed the abstracts and, when necessary, the full articles to determine relevance. To be considered, they had to meet at least one of the following criteria:

1. **Gender.** The document presents data or otherwise describes gender relations in the Philippines. Articles do not have to be related to health. Articles in this group include those related to gender-based violence (GBV).
2. **Health.** The document presents data or otherwise describes health status or a health situation related to family planning, MNCH, or tuberculosis (TB) in the Philippines.
3. **Intervention.** The document addresses family planning, MNCH, or TB intervention studies, pilots, or small-scale projects in the Philippines.
4. **Program.** The document addresses family planning, MNCH, or TB programs in the Philippines under the aegis of the government or donors.
5. **Policy.** The document addresses family planning, MNCH, or TB policies in the Philippines.

This screening yielded 123 items:

- 31 articles related to gender
- 46 articles related to health
- 9 articles on an intervention
- 3 articles on policy
- 34 program documents

Search 2: Gender and Health Policies and Programs

After searching for key health-related policy documents and implementation reports generated by the Government of the Philippines, multilateral donors, and nongovernmental organizations, we assessed the programs that emerged for their awareness of and responsiveness to gender inequality and the gender context. We also searched for health programs with a specific focus on family planning and MNCH in the Philippines. In addition to the material we found through this search, consultation with USAID/Philippines yielded several national-level policies and key documents, such as gender and development (GAD) guidelines and codes.

Ultimately, we assessed 83[1] documents, as follows:

- 12 Republic acts
- 2 briefs (policy)
- 1 administrative order
- 8 evaluations (programs)
- 5 guidelines
- 7 plans or implementation plans
- 2 implementation reports
- 1 objective-setting document
- 1 policy analysis
- 1 policy development report
- 43 program documents

During subsequent conversations with USAID/Philippines, several national level policies and key documents were incorporated into the analysis, such as gender and development (GAD) guidelines and codes.

After an initial review, we categorized the policies and programs described in these documents by health domain, responsible agency, year adopted, and level of financing for implementation. These categories are an adapted version of those in a World Health Organization (WHO) assessment tool (see Annex C).

All policies and programs were then analyzed using an assessment checklist that the HPP/GPM team adapted from guidance offered by the Pan-American Health Organization (2009), USAID (2011), and WHO (2011) (Annex D). Each policy and program was scored based on this assessment checklist.

Key Informant Interviews

The initial desk review highlighted gender integration barriers and raised questions about the status of policy implementation and program success. To validate the findings and to learn more, HPP/GPM staff conducted a series of key informant interviews with stakeholders at the national and grassroots levels, from the public and private sectors, and in all three regions of the Philippines. The HPP/GPM team, in collaboration with USAID/Philippines, developed interview guides (Annex E) tailored to each of the stakeholder groups. From February 9–22, 2014, we interviewed 90 stakeholders in Luzon, Visayas, and Mindanao (see Annex F).

[1] The 83 documents include the three policy documents and 34 programs documents uncovered during the first search. For details on them all, see Annex B.

FINDINGS

The next four sections present the results of the gender analysis. The first section describes the context of gender and health in the Philippines. It identifies the normative, socioeconomic, and political variables and power dynamics that impede and facilitate access to and use of the country's health services. The second section analyzes the gender-responsiveness of national-level policies and related gender mainstreaming mechanisms. The third section discusses policies and policy making structures of local government units (LGUs). The last section analyzes health programs implemented by government, donors, and civil society organizations.

Gender and Health Context

Demand- and supply-side barriers to health

The Philippines has made substantial progress in improving the health and welfare of its citizens over the past decade. Child mortality rates declined from 80 deaths per 1,000 live births in 1990 to 34 deaths per 1,000 in 2008 (National Statistics Office [NSO], Philippines and ICF Macro, 2009; United Nations Development Programme, n.d.), and the country is on track to achieve Millennium Development Goal 4: reduce child mortality. The proportion of women receiving antenatal care from a skilled health provider has increased from 88 percent in 2003 to 91 percent in 2008. Knowledge of contraceptive methods is high: almost all women know at least one method (NSO, Philippines and ICF Macro, 2009). Men also are aware of contraceptive methods and generally hold favorable views of family planning (Clark et al., 2007). However, the country still faces significant challenges to reduce maternal and infant mortality rates, malnutrition, and TB.

The low use of health services hinders efforts to improve health outcomes. Nationally, more than half of pregnant women deliver at home, which leads to delays in identifying and managing complications and making referrals (World Health Organization Western Pacific Region, or WPRO, 2011). In the Autonomous Region of Muslim Mindanao (ARMM), the share of home-based deliveries is even greater: 85 percent (NSO and ICF Macro, 2009). Disrespectful care, inconvenient location of health facilities, and unaffordable cost are often cited as reasons women prefer to deliver at home (Philippine Commission on Women, 2014; Sobel et al., 2010). The Women's Empowerment, Development and Gender Equality (EDGE) Plan 2013–2016 (Philippine Commission on Women, 2014) cites a 2012 study in which women reported that they refuse to give birth at a health facility, because healthcare providers lack sensitivity and treat them poorly. This finding was corroborated by our key informants, who repeatedly cited disrespectful care as a barrier to facility-based births. They stated that women are often verbally abused, scolded, or treated disrespectfully for such reasons as forgetting their paperwork, becoming pregnant too soon, having "too many" children, or crying out during labor. In such situations, a healthcare provider attributes a patient's problems to her ignorance, lack of information, lack of initiative, or lack of discipline, thus failing to consider other factors having to do with social structures and the health system that contribute to health behaviors and decisions. In another study, women reported that obtaining money (83 percent), transportation (48 percent), and a companion (35 percent) were barriers to facility-based births (Sobel et al., 2010).

Women reported similar barriers to accessing general health services. In the 2008 National Demographic and Health Survey (NDHS), women cited money (55 percent), distance (27 percent), transportation (26 percent), and concern that no provider would be available (37 percent) as some of the problems they face in accessing healthcare. In the ARMM, the most commonly reported barriers to accessing health services were money (73 percent) and distance (65 percent). A study by Hu et al. (2012) used qualitative data to document how Filipina women near Quezon City make decisions about TB testing and treatment:

> *Women described that in seeking care they are imposing both an immediate and future financial burden on their family. First, when a woman goes to a clinic, her "time is spent falling in line for the checkup" instead of earning money for the day. Furthermore, women are afraid that initiating the process of diagnosis will incur more costs for their family: fare money for travel to clinics, time spent in seeking care instead of working, and cost of treatment. In the end, a woman may "regret how much she would spend to know her health.*
>
> ~ Hu et al, 2012

Men also have trouble accessing healthcare, but their health needs and the barriers they encounter are different. Men are disproportionally affected by noncommunicable diseases (NCD) and TB. The National TB policy (2010–2016) reports that TB cases are more than two times more common among males than females. A study by Tupasi et al. (2006) found that women are more likely than men to be cured following TB treatment, but the researchers could not identify any clinical variable that predicted cure. As for NCDs, WHO (2011) reports that Filipino men's mortality rate for all NCDs is 711.6 per 100,000 while women's mortality rate is 482.8 per 100,000. Cardiovascular disease and diabetes pose the greatest threats to men's health, at 394.8 deaths per 100,000. Key informants reported that men do not regularly access healthcare because the hours of health clinics usually overlap their work schedules. In addition, key informants stated that reproductive health is typically considered a "woman's issue" and services are not male-friendly. Earlier research has also documented these gender-related and service provision factors that influence men's access to healthcare (Lee, 1999; Clark et al., 2007).

Healthy timing and spacing of pregnancies contributes to the healthiest outcomes for mothers and children. Among married women of childbearing age, 51 percent use any form of contraceptive and 34 percent use a modern method. Twenty-two percent have an unmet need for contraceptives, and the trend seems to be rising. (The share was 17 percent in 2003.) Although 63 percent of births are planned, 20 percent are mistimed and 16 percent are not wanted. In the ARMM, only 15 percent of women use any method, 10 percent use a modern method, and 33 percent have an unmet need for contraceptives.

Many factors contribute to this low uptake of contraceptives. In one study, women reported method-related concerns such as fear of side effects as their main reasons for not using contraceptives (NSO, Philippines and ICF Macro, 2009). Our key informants consistently cited the Catholic Church's opposition as the reason for low uptake of contraceptives. They stated that the church exerts political and personal pressure, challenging family planning champions as well as family planning acceptors. Interestingly, in the 2008 NDHS, only 3 percent of women reported religious prohibition as the main reason they did not intend to use contraceptives in the future. Undoubtedly, a combination of factors—not just one—contributes to the country's low contraceptive prevalence rate. According to our key informants, factors in addition to religious opposition are poor access to health services, the historical absence of a national law providing for contraceptive access,[2] and a highly decentralized health system, which creates a patchwork of laws and ordinances related to family planning. The end result is inconsistent and limited access to contraceptive services and commodities.

Adolescents and single women, in particular, are affected by the restricted access to reproductive health information and services. The recent Young Adult Fertility and Sexuality Study shows that adolescent pregnancy has more than doubled in the past 10 years (Demographic Research and Development

[2] The key informant interviews were conducted in February 2014. At that time, the Responsible Parenthood and Reproductive Health Act of 2012 (Republic Act 10354), which guaranteed access to contraception, sexual education, and maternal care, was being contested in the Supreme Court. On April 8, 2014, the Supreme Court of the Philippines ruled that the family planning law is constitutional. However, it struck down eight provisions as unconstitutional.

Foundation, 2014). The study found that the proportion of unmarried adolescents having sex is increasing. Moreover, the majority of adolescents reported that their first sexual encounter was unprotected.

The barriers to reproductive health services for adolescent girls and single women are great. The study's key informants reported that single women seeking reproductive health services are not only denied but condemned. Adolescent girls, in particular, face severely restricted access to contraceptive information and services. Although the Commission on Population has a manual on how to provide information and counseling to adolescents, health workers among our key informants reported that they would not be comfortable talking to adolescent girls about sex and contraceptives if the girls weren't married or hadn't already been pregnant. Moreover, sex education has not been taught in schools. However, with the recent passage of the reproductive health law (explained in the footnote below), schools must now provide age-appropriate sexual and reproductive health information to adolescents and youth. Finally, parents do not commonly discuss issues related to sex and contraceptives with their children. A study by Irala et al. (2009) found that most Filipino adolescents do not discuss topics related to sexuality with their parents, but they are interested in learning more about the topic. Another study by Cruz and Cruz (2013) found that parents with adolescents often have negative views of sex education for youth. They said they do not discuss sex with their children for two reasons: their children are too young, and such discussions are "too vulgar and embarrassing." The lack of information about reproductive health and contraceptives and the difficulty accessing contraceptive supplies increases the risk of unintended pregnancy for adolescents and young women (Hussain and Finer, 2013).

Gender norms

Gender-based norms of traditional roles and practices create differences between women's and men's reproductive and economic roles and household responsibilities. They also create differences in access to and use of health services and subsequent health outcomes.

Gender as a social construct

Gender is a social construct that refers to the attributes, behaviors, roles, and responsibilities that a particular society considers appropriate for females and males. Gender norms influence men's and women's preferences, decisions, and behaviors related to health and play a significant role in access to healthcare. Recognizing the dimensions of inequality that result from traditional gender norms may aid in determining barriers to healthy behaviors and improving access to health services (Baral, et al., 2010; Furuta and Salway, 2006; Namasivayam et al., 2012).

Box 1. Gender refers to the economic, social, political, and cultural attributes and opportunities associated with being women and men. The social definitions of what it means to be a woman or a man vary among cultures and change over time. Gender is a sociocultural expression of particular characteristics and roles that are associated with certain groups of people with reference to their sex and sexuality.

~ Interagency Gender Working Group, n.d.

Gender norms, roles, and practices must be considered if health policies and programs are to serve women, men, and children effectively and equitably. Gender norms are reinforced from an early age, shaping girls', boys', women's, and men's beliefs and perceptions of appropriate ways to act. Throughout childhood, families and communities enforce gender roles through toys, games, and the division of household chores. These socialization processes teach boys to be strong, self-confident, and rational men and teach girls to be caring and nurturing women (Medina, 2001, as cited in Osteria, 2010).

Differences in how women and men are expected to act often create unequal opportunities to access and use resources and derive benefits from policies and services. Both gender differences and gender inequalities can give rise to inequities between men and women in access to healthcare and health status.

For example, norms around femininity discourage women from being assertive and influential decisionmakers—a role that would help them protect their health and well-being. Likewise, norms of masculinity discourage men from displaying such perceived signs of weakness as accessing healthcare or participating fully in childrearing and exhibiting caring and nurturing behaviors.

Traditional gender roles and changing norms

Constructions of gender prescribe women's and men's roles in the family, community, and society. In the Philippines, as in many other countries, women traditionally are responsible for managing the household and domestic work, as well as childrearing. Women respond to household and community crises, finding ways to support the family (Tan, 2008, as cited in Osteria, 2010). Men, in contrast, are the main breadwinners, responsible for supporting the family economically. In addition, men are responsible for household repairs and maintenance projects (Osteria, 2010).

Economic pressures across the Philippines, however, are beginning to influence this family structure. For example, appreciation of women's economic contributions to the household is growing (Osteria, 2010). In fact, a study of women's and men's workloads in rural areas (Hill, 2011) found that norms now emphasize that a responsible mother is both a household caretaker and an alternative income earner. This expansion of women's roles into the economic sphere has not prompted a corresponding expansion of men's roles into the domestic sphere. Therefore, women are increasingly dealing with the double burden of earning and housekeeping. In Naga City, for example, the study found that women typically work 17 hours a day (only 10 of those hours paid) while men typically work 10 hours. Women participating in the study reported that their domestic responsibilities and demanding schedules are a source of mental and physical stress, anxiety, and fatigue.

Conflict also disrupts traditional gender roles. In conflicts such as *ridos (*feuds between families or clans), men are often targeted, and remain at home for security. During these times, women will undertake activities outside the home typically performed by men, such as earning money. Although social observers cite mobility and economic participation as indicators of women's empowerment, most women in this situation did not consider their activities a sign of empowerment but, rather, an added strain (Dwyer and Cagoco-Guiam, 2012).

Power dynamics

Decisions about spending family income, accessing healthcare, and using contraceptives illustrate the power dynamics between women and men within their households. Power dynamics are reflected in the level of control over decision making, which typically entails some indirect or direct negotiations between women and men. Power dynamics are also reflected in the perpetration of intimate partner violence, which involves the use of force, abuse, or coercion against an intimate partner.

Decision making

Women's participation in household decisions and their use of family planning methods have a positive correlation. Likewise, the more women participate in household decisions, the more likely they are to receive postnatal care from a health provider (NSO, Philippines and ICF Macro, 2009). Moreover, the more autonomy women have to make decisions, the longer their intervals from birth to conception are (Upadhaya and Hindin, 2005). From 86 to 94 percent of Filipina women report that they participate in decisions concerning their own healthcare, daily and major household purchases, and visits to family or relatives. Half of married Filipina women say they make their own healthcare decisions, while 44 percent say they decide jointly with their husbands. In the ARMM, women's participation in decisions about their own healthcare is slightly lower: 84 percent (NSO, Philippines and ICF Macro, 2009).

Women and men share many household decisions in the Philippines and traditionally, wives also influence decisions about how to spend household income by managing the family budget (Medina,

2001). Many researchers view control of household finances as an indicator of women's empowerment. However, Eder (2006) cautions against making this assertion without looking deeper into household power dynamics. He argues that seemingly egalitarian relations may not actually be so. For example, the discretionary power of women who manage the household budget may in fact be slight, because income does not cover even basic needs. Likewise, women may not be free to refuse their husbands' requests for money.

Although the literature demonstrates that women have a high degree of decision-making power at the household level, this study's key informants noted that in one particular situation—whether or not to adopt a permanent female contraceptive method, such as tubal ligation—women may be sidelined. Many informants said that doctors are likely to require the consent of a woman's husband or even other family members before agreeing to perform this surgical contraceptive procedure. Misconceptions of the legal requirements for performing tubal ligations may be the reason for this. A study by Mello et al. (2006) found that health providers believed (wrongly) that the Philippines Family Code requires spousal consent for surgical sterilization, and routinely sought consent to be in compliance.

Gender-based violence

Whereas decision-making authority is negotiated at least to some extent, GBV manifests as force, abuse, control, and coercion. Stemming from established gender norms and inequality, such violence involves women, men, and children. One common form of GBV is intimate partner violence, which can occur within heterosexual and same-sex couples. Women and men both suffer from this.

According to the 2008 NDHS, 24 percent of women between the ages of 15 and 49 in the Philippines reported that they had experienced physical or sexual violence since the age of 15. The main perpetrators were their husbands. Moreover, 29 percent of ever-married women said they had experienced some form of violence by a husband or partner and 16 percent reported having initiated physical violence against their husbands. Women who experienced spousal violence themselves were more likely to initiate violence against their husbands (40 percent) than women who had not experienced spousal violence (12 percent).

A study by Fehringer and Hindin (2013) in Cebu identified three types of motives for intimate partner violence: reactivity (anger), retaliation/self-defense, and control (influencing the spouse's behavior). Control of the spouse's behavior was a more common motive for violence by husbands than by wives, who more frequently reported retaliation as a motive. Another study, also conducted in Cebu, found that women were more likely than men to be injured as a result of violence. Among women reporting the use of violence, 3.4 percent had hurt their husbands enough to require medical attention, whereas 7.3 percent said their husbands had hurt them enough to require medical attention (Ansara and Hindin, 2009).

Survivors of intimate partner violence have little recourse in the Philippines. The society is family-oriented, and sociocultural and religious norms dictate that husbands and wives should stay together, even in the midst of violence or other conflict (Asian Development Bank et al., 2008). This norm can create a cycle of violence, because focusing on reconciliation may do nothing to stop the violence or protect the victim. Divorce is not legal, but separation or annulment is allowed in some circumstances, including the repeated use of violence (Family Code Ex. No. 209). In the ARMM, the Code of Muslim Personal Laws (Presidential Decree 1083) determines the legal process for divorce. Under the code, women may use the legal system to file for divorce on the grounds of unusual cruelty. Men, however, may divorce their wives at will, without stating grounds or going to court.

In Cordillera and the ARMM, intimate partner violence is considered a private matter to be settled by families or clans, which may explain why the legal systems there deal with fewer cases than in the rest of the country (Asian Development Bank et al., 2008). Other regional variations exist, as well. In the

ARMM, 47 percent of women believe that a husband is justified in beating his wife under certain circumstances, such as going out without telling him or neglecting the children. This contrasts starkly with the national figure: 14 percent (NSO, Philippines and ICF Macro, 2009). Moro women commonly marry young—a form of GBV. Under the Code of Muslim Personal Laws, the legal age of marriage for girls is 15, but with parental consent, it is 12. The prevalence of early marriage in the ARMM is unknown, because few births and marriages are registered. Nisa Ul-Haqq Fi Bangsamoro (Women for Justice in the Bangsamoro, a nongovernmental organization) surveyed 593 respondents who were married before the age of 18 (cited in IRIN, 2010). The main reasons they gave were religious considerations, followed by cultural and economic factors. According to a presentation by this organization (NisaUl-Haqq Fi Bangsamoro, n.d.), 34 of the respondents reported that they had been kidnapped and forced into marriage.

Socioeconomic factors

Disparities between Filipina women and men exist in education, employment, and income—socioeconomic factors that influence health service access and use. Disparities in education and employment do not follow patterns that are typical elsewhere in Asia and globally. In education, boys experience greater disparities than girls. Both sexes are hampered by disparities in economic participation.

Education and employment

Educational attainment is a determinant of health. For example, the 2008 NDHS showed a negative relationship between education and fertility. The fertility rate of women who have attended college (2.3 children per woman) is about half that of women who have attended only elementary school (4.5 children per woman). The Philippines has succeeded in achieving parity in primary education—an achievement that should be celebrated. Unfortunately, inequities in secondary and tertiary education exist that discriminate against both girls and boys, but in different ways. Boys' enrollment rate for secondary school (53.7 percent) lags behind girls' (63.5 percent). A similar discrepancy exists in tertiary education. Dropout rates are high, but more boys quit school than girls. Studies show that boys do so in order to work more hours to supplement family income (Albert et al., 2012; David et al., 2009; Maligalig et al., 2010; United Nations Education, Scientific and Cultural Organization, 2010). According to these same studies, boys report a lack of interest in school, which may also account for their lower enrollment rates. Regionally, the largest gender disparities in secondary education are in the ARMM and Zamboanga (Albert et al., 2012).

Whereas boys are at a disadvantage in their enrollment rates, both sexes confront gender bias related to fields of study. For example, few women take engineering or technology classes and few men take nursing (Asian Development Bank et al., 2008). This bias deters both women and men from choosing career paths that fall outside socially constructed gender norms.

A gender gap also exists in labor force participation, because fewer women than men work. Moreover, women workers report gender-based discrimination: sexual harassment, difficulty in obtaining maternity leave, and gender bias in promotions (Asian Development Bank et al., 2008). Because women tend to work in private households or in services, they are likely to experience the poor terms of employment common in these sectors.

> *…women are more likely to hold lower quality employment or vulnerable employment (own-account work and unpaid contributing family member), which typically offers fewer opportunities for decent work and social protection. This has resulted in a vulnerable employment gender gap.*
>
> ~ Asian Development Bank, 2013

Gender differences also exist in overseas employment. The recent feminization of overseas labor migration means that women account for 48 percent of overseas Filipino workers (NSO, Philippines, 2013). Women are most likely to be employed as laborers and unskilled workers, while men are most likely to be employed in trade and related work, and as plant and machine operators and assemblers.

Political participation

The Philippines has made substantial progress in increasing the political participation of women over the past 20 years. The country has elected two female heads of state and women occupy 27 percent of congressional seats (Inter-parliamentary Union and UN Women, 2014). Nonetheless, women still face substantial inequity in political empowerment. In 2007, women held just 17 percent of all elected positions (Philippine Commission on Women [PCW], n.d.). Moreover, top posts in the government favor men by a two-to-one ratio. Our key informants reiterated the imbalance in political power, reporting that even women who do get elected to Parliament or other positions are often "seat warmers" for male relatives. One informant spoke of the challenge for women to participate in politics, given the Philippines' transactional culture, referring to it as a "man's world."

Increasing women's political power is a critical strategy for improving the health status of women and children (Ballington, 2008; Swiss et al., 2012). One key informant pointed out that historically, male political leaders have made the decisions about women's health and reproductive rights. In recent years, women's participation in these decisions has increased, but more progress is needed.

Gender-Responsiveness of National Policies

National gender mainstreaming mechanisms

Several national frameworks promote gender and development in the Philippines: the Philippine Plan for Gender Responsive Development (PPGD) 1995–2025; the Magna Carta of Women (MCW; 2009); and the Women's EDGE Plan 2013–2016 (mentioned previously). These laws and policies outline a clear gender approach based on equality and human rights. The PPGD articulates a vision of promoting gender equality so that women and men can enjoy their full potential; the MCW aims to eliminate discrimination against women by protecting and promoting women's rights; and the Women's EDGE Plan promotes rights-based approaches to development. However, the assessment revealed a fade-away effect. As strong as these gender frameworks are, policymakers and implementers do not apply them consistently. As a result, the frameworks lose their power, first when they are translated into health policies and guidelines and again when they are adopted and operationalized by LGUs.

Box 2. Resources to Support Gender and Development Planning Processes

- Harmonized Gender and Development Guidelines
- Guidelines for the Preparation of Annual Gender and Development Plans and Budgets and Accomplishment Reports to Implement the Magna Carta of Women, Joint Circular no 2012-01
- GAD Code Guidelines
- Gender Mainstreaming Resource Kit
- Barangay VAW Handbook
- Performance Standards and Assessment Tools for Services Addressing Violence against Women in the Philippines
- Gender-responsive LGU Self-assessment Manual
- Guidelines in the Establishment and Management of a Referral System on Violence against Women at the Local Government Level

All tools are available from PCW: http://pcw.gov.ph/publications.

The PCW and a gender focal point system (GFPS) are the main mechanisms for gender mainstreaming throughout the Philippines. The GFPS requires all sectors of government at all levels

throughout the country to integrate GAD in all of their activities. To support this mandate, the PCW and partners such as the National Economic Development Authority (NEDA) have issued circulars, guidelines, and resources to help national departments and LGUs operationalize GAD in policy making, budgeting, and programs. Joint Circular (2012-01) provides guidelines for preparing annual GAD plans, budgets, and reports of accomplishments. The Harmonized Gender and Development Guidelines helps government agencies and donors integrate gender concerns in development programs. This resource outlines a practical process and related tools to integrate gender throughout the project cycle: project identification and design, assessment of projects for funding, and monitoring and evaluation. NEDA has developed a companion training manual for these guidelines to help government agencies and donors strengthen their capacity to use the guidelines effectively.

Operationalizing the MCW has some limitations. For example, gender audits—a requirement of GAD—are not being universally conducted, even at the national level, as evidenced by NEDA, which is only now preparing to conduct its first audit. Also, the GAD guidelines stipulate an allocation of at least 5 percent of agency budgets for GAD programs, projects, and activities. Despite national guidance by PCW, agencies demonstrate a lack of clarity on how to identify and implement activities that are GAD-focused. Moreover, although PCW has taken a significant leadership role in promoting gender mainstreaming, national level policies are often developed by the Department of Health (DOH) and the Department of Social Welfare and Development and implemented at the local level through the Department of Interior and Local Governance. Several of the study's key stakeholders mentioned that limited collaboration among these departments hinders implementation of a comprehensive and actionable GAD system.

National health policies

To assess the gender-responsiveness of national health policies, HPP/GPM staff applied a checklist and gave each policy a score ranging from 0 (no gender integration) to 11 (full gender integration). Scores were further categorized as low (0–3), medium (4–7), and high (8–11). When we analyzed the scores, we found that policies on average scored a medium level of gender-responsiveness (see Table 1).

Table 1: National Policy Scores

National-level Act or Policy	Scoring
Philippine Population Management Program Directional Plan 2011–2016	High
The 5th AIDS Medium Term Plan: 2011–2016 Philippine Strategic Plan on HIV and AIDS	
The Responsible Parenthood and Reproductive Health Act of 2012 (Republic Act No. 10354)	
National Objectives for Health Philippines, 2011–2016	Medium
Implementing Rules and Regulations of Republic Act 10354, otherwise known as the Responsible Parenthood and Reproductive Health Act of 2012	
MNCHN Strategy Manual of Operations	Low
National Policy and Strategic Framework on Adolescent Health and Development	
National Health Insurance Act of 2013 (Republic Act No. 106060)	
Administrative Order No. 2010-0036: The Aquino Health Agenda: Achieving Universal Health Care for All Filipinos	
Guidelines for the Implementation of Policy and Program on Tuberculosis (TB) Prevention and Control in the Workplace	

Policies that addressed family planning scored in the middle to high range (5–11), with the Philippine Population Management Program Directional Plan 2011–2016 scoring highest, at 11. Gender is mainstreamed throughout this strategic planning document (see Box 3). For example, male engagement is incorporated in the plan through the MR GAD (Male Responsibility in Gender and Development) program, which aims to increase gender-sensitivity and male involvement in reproductive health. This document also incorporates other important health domains, such as reproductive health and GBV.

Box 3. Characteristics of an Effective Gender-Responsive Policy

What does a gender-responsive policy look like? The Philippine Population Management Program Directional Plan for 2011–2016 is a good example. It incorporates gender considerations in its guiding principles, goals and objectives, program strategies, and monitoring and evaluation plan.

- **Guiding principles.** Of the plan's seven guiding principles, one focuses on gender equality and women's empowerment. Moreover, the plan is grounded in the Magna Carta of Women and its goals are stated in the context of human rights, equity, and gender equality.
- **Recognition of gender inequality as a determinant of health.** The plan identifies such gender barriers as women's lack of sexual decision making and negotiation, the fact that men generally prefer more children than women do, women's lack of socioeconomic advancement, and poor women's economic dependence on their husbands.
- **Gender-focused goals and objectives**. Two objectives of the plan's responsible parenthood and reproductive health component aim to 1) increase men's participation in and responsibility for the practice of family planning and other reproductive health concerns and childrearing, and 2) promote adequate development of responsible sexuality, permitting relations of equity and mutual respect between the genders.
- **Strategies to reduce gender inequality**. To meet the different needs of women and men, the plan proposes a strategy to customize the gender-sensitive and gender-responsive training packages for health service providers and professionals. To reduce gender inequality, the plan proposes to increase the gender sensitivity of male and female adolescents and youth, eliminating gender barriers such as rigid notions of masculinity and femininity, which interfere with healthy and responsible sexual behaviors.
- **Gender indicators**. The monitoring and evaluation plan collects sex-disaggregated data and also proposes indicators to capture progress toward removing gender barriers, such as men's low involvement in family planning and reproductive health.

An assessment of the policies by health domain using this checklist revealed stark contrasts in gender integration and responsiveness. For example, some MNCH policies, such as those published by NEDA and the PCW, had a high level of gender integration. Others, such as the Department of Health's maternal, neonatal, and child health and nutrition (MNCHN) operational guidelines, did not. The department designed its MNCHN strategy to address high rates of maternal and newborn mortality in order to meet the country's Millennium Development Goal commitments, and the strategy has high priority nationally and regionally. It focuses on improving the quality of the following facility-based maternal health services: basic and comprehensive emergency obstetric and newborn care, antenatal care visits, and essential newborn care. Despite the aim to improve the health of women and children, the strategy does not demonstrate awareness of gender inequality as a determinant of health, nor does it propose action to overcome gender barriers, such as ensuring respectful care at delivery or engaging fathers as partners. Moreover, the monitoring plan has no sex-disaggregated indicators. For these reasons, the MNCHN strategy received a score of 2.

Key informants elaborated on another area for improvement in the MNCHN strategy: the need for gender training programs for service providers—essential for operationalizing gender-responsive programming. The strategy mentions gender-sensitivity in the "MNCHN Provider Competencies Necessary for Adequate Delivery of MNCHN Core Package of Services" for all service-delivery levels (community and basic and comprehensive emergency obstetric and newborn care). However, the strategy offers no gender training guidelines or materials. Indeed, key informants throughout our interviews spoke of the lack of comprehensive gender training in the public sector.

The Philippine Health Insurance Corporation (PhilHealth) was established as the national health insurance program in 1994 under Republic Act 7875 (and subsequently revised in 2012 as Republic Act 10606). PhilHealth is one of three main thrusts for achieving universal health coverage under the Aquino Health Agenda. The desk review, which analyzed the Republic Acts, as well as the related implementing rules and regulations of 2013 and the Aquino Health Agenda, found that PhilHealth is largely gender-blind. That is, it does not recognize or address the different situations and needs of women and men. Key informants said that, as the program has evolved, it has taken on more gender-responsive dimensions. For example, special provisions were put in place to provide free medical care to the poor through the distribution of PhilHealth cards by local mayors and *barangay* (village) captains. Initially, these cards were distributed only to men, who were viewed as the heads of their households. Recent modifications, however, have allowed for distribution of cards (or duplicate cards) to women. Likewise, the Women's EDGE plan notes:

> *Gender-responsive measures for social protection were initiated by PhilHealth through the issuance of Board Resolution No. 1479, S 2011, approving the implementation of the partial subsidy scheme for woman microentrepreneurs, small self-employed and underground economy workers, and PhilHealth Board Resolution 1613, stipulating the prioritization of unmarried mothers and pregnant women in guaranteeing access to health insurance.*

To increase the gender-responsiveness of PhilHealth, the Women's EDGE plan recommends expanding coverage to unmarried couples and those with more than four children; women with disabilities; indigenous women and children; Moro women and children; and lesbian, gay, bisexual, and transgender (LGBT) people.

In recent years, several policies focusing on GBV have gained national attention, leading to the establishment of desks throughout the Philippines to deal with violence against women and children, as well as women and child protection units (WCPUs) that interface with the Philippine National Police. The national policies that established these mechanisms scored low in our analysis. For one thing, they failed to support men who are victims of intimate partner violence (Fehringer and Hindin, 2009). For another, key stakeholders told us of challenges with data collection, funding, and roles and responsibilities. Moreover, there is wide variation in the functionality of the desks for violence against women and their children and of WCPU departments.

This study also assessed significant national HIV and AIDS policies: the National Workplace Policy on STD/HIV/AIDS, the Revised Philippine HIV and AIDS Policy and Program Act of 2012, and others. Their scores ranged from low to high; the reasons for this variation in gender-responsiveness are unclear.

The policy that has sparked the most debate has yet to be fully implemented. The Responsible Parenthood and Reproductive Health Act of 2012 (Republic Act 10354), more commonly referred to as the RH (reproductive health) law, has been heavily publicized through its 14-year development. It fills a longstanding gap in the national reproductive health framework to ensure access to reproductive health information and services. In the absence of a national policy on reproductive health, women's, men's, and adolescent's reproductive rights have been severely restricted. Women and girls have been disproportionally affected by this policy gap—particularly girls who become pregnant outside of marriage. In April 2014, the Supreme Court promulgated its decision (with concurring and dissenting opinions) in the consolidated case of Imbong v. Ochoa (G.R. No. 204819). The Supreme Court upheld the RH law as constitutional but declared eight provisions unconstitutional.

As a result, barriers in access to reproductive health services persist. For example, the Supreme Court ruled that minors can receive family planning counseling but must have parental consent for commodities and procedures. In a culture where premarital sex is not widely accepted but increasingly practiced, and

where open communication between parents and children about sex is rare, it is reasonable to infer that the RH law will do little to improve adolescent girls' and boys' access to services. Adolescent girls, who face the most severe consequences for unprotected sex, both biologically and socially, are disproportionally affected by the lack of access.

Another provision of the ruling allows service providers to classify themselves as "conscientious objectors" on religious grounds. These objectors are not required to provide family planning counseling or services. Moreover, they are not required to refer clients or patients to a nearby facility, unless the patient is in an emergency or life-threatening situation. In areas where care is difficult to access, this barrier can be significant, and may mean that patients of these providers will have no access to family planning.

The personal resistance of elected officials at all levels also challenges implementation of the RH law. Key informants said that because it took 14 years for the law to be passed and reviewed in court, many top and local officials put off making plans to implement it. The law overrides local ordinances that severely restrict access to reproductive health and family planning services, but as long as they are on the books they will interfere with the law's implementation. Fortunately, the Supreme Court decision clarified that so long as the national government sends resources for local governments to implement the law, local governments must do so. Furthermore, natural persons (healthcare providers or public officers) can be conscientious objectors but LGUs as bodies corporate cannot. Once the implementing rules and regulations are revised to reflect the Supreme Court decision, a coordinated multisectoral effort led by the Department of Health (DOH) will be necessary.to implement the RH law. Civil society must be engaged to educate women and men in their rights to access family planning.

Across all of the health areas reviewed, key informants consistently spoke of challenges in implementation—especially in policy monitoring. Often, policies developed at the national level are not articulated well for implementation at the regional and local level. This challenge is exacerbated in a decentralized system in which regional and local ordinances may contradict each other or add layers of complexity to a national policy. During the desk review, HPP/GPM analyzed several implementing rules and regulations, which are intended to address such challenges. These documents consistently scored lower on gender-responsiveness than the policies themselves. For example, the Anti-Violence Against Women and Their Children Act of 2004 (Republic Act 9262) scored a 4 (scale from zero to 11) and its implementing rules and regulations scored a 1. Similarly, the Responsible Parenthood and Reproductive Health Act of 2012 (Republic Act 10354) scored eight and its implementing rules and regulations scored a 5. This pattern may reflect the decreasing involvement of champions and advocates after a law passes, highlighting the need for advocates to stay engaged through the implementation phase. The details of implementing a gender-responsive policy are crucial, because they can limit the gender-responsiveness of the policy itself.

Although we focused mainly on national family planning, reproductive health, and MNCH policies, we did look at other health domains. We assessed the major national level TB and HIV policies and found them to be largely gender-blind, rather than gender-responsive. Key informants mentioned concern about the inclusion of the lesbian, gay, bisexual, and transgender community in health programs and policies. We found a few policies responsive to this community's needs but none was operationalized, with guidelines.

Gender-Responsiveness of Regional and Local Government Unit Systems and Policies

The Philippines has a highly decentralized health system, which gives all but one of the LGUs significant autonomy to manage health services and programs. The exception is the ARMM, whose health service is

headed by a dedicated secretary in the Department of Health. The HPP/GPM team was not able to conduct a systematic desk review of all local policies. Instead, the team used the stakeholder interviews to identify examples of successes and challenges in operationalizing and implementing gender and health policies at local levels.

The GFPS, mandated by the Magna Carta of Women, is intended to be the main mechanism for gender mainstreaming at local levels. The PCW monitors and oversees it. However, because the PCW does not have local branches, its capacity to monitor and strengthen the GFPS is limited and, not surprisingly, the system's implementation and capacity varies across localities.

In Quezon City, for example, the system is functioning well. There, the Gender and Development Resource and Coordinating Office (GAD RCO), established in 2002, coordinates gender mainstreaming in all municipal policies and programs. It also mentors departments to formulate GAD plans and activities. Quezon City has 142 *barangays* and 90 percent have a focal point for GAD. The office helps to strengthen the gender focal points through capacity building, training, and monitoring the GAD plans of departments and *barangays*. Key informants reported that the GAD RCO is highly active and influential in promoting the GAD agenda (see Box 4).

Box 4. A City's Gender Policy Success

Government leaders and civil society advocates have allied in Quezon City to establish a stable and influential system for gender-responsive governance. Since its inception in 2002, the Gender and Development Resource and Coordinating Office has made the following achievements:

- Passed a city gender and development code
- Established and expanded free legal services for survivors of violence and other abuses
- Increased the city's family planning budget from 6 million pesos to 10 million pesos
- Passed a landmark ordinance on reproductive health and population management
- Integrated gender criteria and concerns for the city's Socio-Economic Action Plan 2011-2015
- Conducted field validations of GAD-related mechanisms in *barangays*
- Organized information caravans to increase community awareness of the MCW and GAD code

According to key informants, Quezon City's GAD RCO succeeded because strong civil society and champions within government pushed to establish and fund it. They said this "recipe for success" in promoting gender equality in local health governance is in place in other locations, as well.

Another good example of gender-responsive local government is Bacolod City. Its Provincial Council of Women, formed in 1995, is not directly related to the GFPS but also promotes gender-responsive governance. According to our key informants, a coordinated effort by women legislators achieved passage of the ordinance that established the council. Then the Development Action for Women Network (DAWN) Foundation, a local nongovernmental organization, conducted gender-sensitivity training with local legislators. After the training, the council's officers were elected. The council then initiated training on women in politics, to encourage greater involvement of women in the legislature. Subsequently, the women's council has undertaken other initiatives engaging youth and addressing violence against women. After 18 years of the women's council, the key informants report that women are stronger and more involved in decision making related to laws and policies that affect them the most.

Box 5. A Province's Gender Policy Success

The Davao del Norte gender and development (GAD) program is implemented by the provincial government in coordination with civil society, churches, and schools. Institutionalized by executive order, the GAD team's members represent departments and offices responsible for gender mainstreaming.

The province has achieved many GAD-related successes across sectors throughout the life of the program. In the health sector, a gender-based analysis identified the marginalization of men in traditionally women-centered health services as a significant gender gap in the family planning program. To address it, the government refocused the reproductive health program to involve men, which led to the creation, by provincial ordinance, of a male reproductive health clinic in every rural health unit, city health office, and district hospital across the province. As a result of this effort, the province's family planning prevalence rate in one year (2001) increased from 60 percent to 72 percent. As of 2010, it was 74 percent.

Source: Philippine Commission on Women. Available at: http://pcw.gov.ph/foothold-empowerment-gad-program-davao-del-norte.

In contrast to Quezon City and Bacolod City, other locations have had some trouble establishing a functioning gender-responsive governance system. For example, in Davao City, the Center for Health Development (CHD)—the local branch of the DOH—has a team of two to promote GAD in local policies and programs. The team members have many responsibilities, limited time, and limited funding to carry out their duties. They are supposed to monitor the WCPU, but say their heavy workload makes it hard to follow through. To date, the CHD has conducted an orientation for reproductive health units on sexual harassment and launched a child care program. While these accomplishments are commendable, they contrast sharply with those of Quezon City's GAD RCO. Even so, the team is optimistic that it will be able to do more and ramp up its level of influence on local policies.

At the provincial level, the Davao del Norte Provincial Health Office, in Mindanao, reported a burgeoning GFPS (see Box 5). Despite the system's achievements, the staff is struggling to move its GAD agenda forward. For one thing, the focal points have fast turnover. For another, some men say gender is for women and so they have no interest in hearing about it. These challenges are common throughout the country. One key informant reported that the situation is starting to change, though, and that the province now has "GAD fever." Like the CHD team in Davao City, the Mindanao team expects to increase its influence and impact over the next year.

In addition to financial and human resources, another common challenge in mainstreaming gender at the LGU level is the absence of monitoring and accountability mechanisms. Regional offices of the Department of Interior and Local Governance are responsible for approving and monitoring the GAD plans and budgets of LGUs. In practice, though, monitoring is consistently lacking and LGUs are not held accountable for the GAD commitments. Although civil society organizations could make up for this lapse by monitoring gender policies themselves, one key informant reported that in the Philippines, most do not take on this role. One possible explanation is that advocacy by civil society organizations and nongovernmental organizations is compartmentalized. Usually, organizations are involved only in the development, implementation, and monitoring of policies and programs related strictly to their issues of interest. An organization concerned with children will actively monitor a village's *barangay* child protection council and one concerned with health will actively monitor the functionality of a local health board. Thus, the monitoring of gender policies will be the province only of the few organizations concerned with gender mainstreaming more broadly.

Conceptual misunderstanding of gender also hampers gender mainstreaming at the LGU level. The HPP/GPM team observed that policymakers and program managers generally view GAD to be about women. In particular, as national policies are operationalized into local policies, HPP/GPM interviewers observed that the concept of gender transforms from "promoting equality so that women and men can

enjoy their full potential" (as represented in the Philippine Plan for Gender Responsive Development) to developing policies, programs and services for women. Key informants often cited examples of a GAD policy or program that increases services for women, or benefits women. Anecdotally, HPP/GPM staff heard examples of how local GAD budgets were used to support beauty contests or parades. However, our discussions with GAD focal points and health teams did not turn up evidence to support these reports. Perhaps such events were held earlier, when GAD was first introduced, and the stories live on. Moreover, the interview team did not perceive that GAD budgets have been poorly used deliberately, but rather that institutions can veer off-track when they try to adhere to the 5-percent GAD budget requirement without understanding the rationale behind GAD. Few institutions base their GAD plans on a systematic assessment of the gender context and the institution's policies and programs. Overall, there is a need to increase the capacity of the GFPS to understand and articulate a deeper understanding of gender concepts and translate those concepts into policies and programs that promote gender equality.

As a result of all of these challenges, the gender-responsiveness of LGU policies is inconsistent. The MCW states that LGUs should develop and pass GAD codes. Not all have done so, however, for lack of financial and human resources. Also, some policies cited as gender-responsive are in fact gender-blind. For example, some LGUs have passed local ordinances requiring women to deliver at health facilities. Instead of analyzing the reasons that lead women to deliver at home and not in a health facility or with a skilled birth attendant and developing strategies to effectively address these factors, they impose sanctions on mothers and traditional birth attendants who deliver at home. Such ordinances are well-meaning in their aim to reduce maternal and newborn deaths, but they ignore the gender-based barriers to health services that women face.

In some instances, local ordinances not only fail to address gender barriers to health services but actually create them. For example, in Manila City, an ordinance banning contraceptives was passed in 2000 by former Mayor Lito Atienza. In the absence of a national law to standardize and create universal access to contraceptive services, LGUs have full autonomy to draft and implement their own policies. The Manila City ordinance, which has since been relaxed slightly, disproportionally affects the health of women by reducing their access to vital health services and limiting their ability to control their own reproductive health.

Despite the obstacles to gender-responsive policy development and implementation by LGUs, the HPP/GPM team identified many promising practices. Their chief characteristics, as noted above, are a strong civil society that promotes gender equality in policies and programs and gender advocates and champions within government. Sharing and networking among LGUs can disseminate these kinds of promising practices.

The Autonomous Region of Muslim Mindanao

The ARMM endures vast inequities in income and health in comparison with the rest of the country. It is the poorest region in the Philippines, with poverty rates ranging from 29.8 percent to 53.7 percent, as compared with 26.5 percent for the country as a whole (World Bank, 2013). The fertility rate and unmet need in the ARMM are among the highest in the Philippines. Antenatal care use is low and most women deliver at home, without the assistance of a skilled birth attendant. Moreover, the ARMM has the highest under-five mortality rate in the country (NSO, Philippines & ICF Macro, 2009). Use of health services is particularly low, partially because of long distances to health facilities, unaffordable cost, and poor quality of services (Philippine Commission on Women, 2014; Sobel et al., 2010). However, cultural and religious barriers also decrease the uptake of services such as modern family planning methods (Nisa Ul-Haqq Fi Bangsamoro, n.d.).

These challenges are exacerbated by decades-long conflict (World Bank, 2013). Clan violence or feuds (*rido*), banditry, kidnapping, and the ongoing struggle for self-determination among Moro groups has

resulted in the displacement of an estimated 3 million in the ARMM (Cagoco-Guiam, 2013; Dwyer and Cagoco-Guiam, 2012). Most are Muslim women and children (Nisa Ul-Haqq Fi Bangsamoro, n.d.; UN Women). Health services in the camps for internally displaced persons are virtually nonexistent, contributing to high maternal mortality rates and increased vulnerability to disease among children. For families still in their communities, mobility is severely compromised. For example, outbreaks of clan violence confine people to their homes and make it impossible for them to go to work, to school, or to a clinic when they need healthcare (Dwyer and Cagoco-Guiam, 2012).

During clan violence, men are especially vulnerable, because they are the main targets for revenge. The presence of armed men in a community makes women afraid to go out. Once displaced, women report that the lack of a safe, private place for bathing or dressing increases their fears of sexual harassment or assault (Dwyer & Cagoco-Guiam, 2012). More pressing, trafficking of women and children in the ARMM—especially sex trafficking of young women—is common (Cagoco-Guiam, 2013; Nisa Ul-Haqq Fi Bangsamoro, n.d.). Natural disasters, such as Tropical Storm Bopha (Pablo), in December 2012, create instability that makes women and children equally as vulnerable to trafficking (Bruno, 2012).

The ARMM Regional Legislative Assembly enacted a GAD code in 2010 to empower women and girls and ensure their equal access to resources and participation in development efforts. The code stresses the political rights of women and increases access to health services for women and men, including insurance coverage through PhilHealth. In episodes of armed conflict, the code calls for a gender-aware humanitarian response for women's protection and security. In addition, the code recognizes the needs of survivors of violence and trafficking and proposes "women's and children's protection desks" to handle cases of violence against women and children, including trafficking. Furthermore, the code stipulates 18 as the minimum age for marriage. It creates an avenue for advocacy to change the Code of Muslim Personal Laws, which permits Muslim males to marry at 15 and Muslim females to marry at the age of puberty.

The GAD code and the Code of Muslim Personal Laws take the same position on polygyny. Despite evident gender issues related to polygyny, such as threats to the property rights of women and children, abandonment, unequal treatment of wives and their children by the husband, and lack of support, there is anecdotal evidence that the practice exists (Nisa Ul-Haqq Fi Bangsamoro, n.d.). The Code of Muslim Personal Laws states:

> *Notwithstanding the rule of Islamic law permitting a Muslim to have more than one wife but not more than four at a time, no Muslim male can have more than one wife unless he can deal with them with equal companionship and just treatment as enjoined by Muslim Law and only in exceptional cases.*

In December 2012, members of the ARMM's Regional Legislative Assembly passed the Reproductive Healthcare Act of 2012. The bill recognizes the need to promote and guarantee gender equity and women's empowerment as a health and human rights concern. The guiding principles of the bill ensure that women and couples have access to family planning and other reproductive health services, such as skilled birth attendants, emergency obstetric care, reproductive health supplies and medicine, and in crisis situations, access to maternal and newborn healthcare. The act is fairly comprehensive in its promotion of services and information for reproductive health, but it focuses on married women and couples and does not refer to the needs of adolescent girls and unmarried women. In 2003, Muslim leaders issued a fatwa on family planning and reproductive health, aimed at promoting a better understanding and appreciation of family planning to improve the quality of life of Muslim women and their families and the reproductive health of Muslim women (Nisa Ul-Haqq Fi Bangsamoro, n.d.; UNFPA, 2012). Like the reproductive health bill, though, the fatwa emphasizes married women.

In addition to the fatwa on family planning and reproductive health, in 2008, the Assembly of the Darul Ifta launched a handbook of *khutbas*, or Islamic sermons, on 15 gender and reproductive health issues based on the teachings of the Quran. The *khutbas* explain and clarify longstanding issues and challenges regarding the rights and roles of Muslim women in marriage, family, property, governance, and legal and institutional settings and contexts. The handbook is intended not only to help Muslim leaders understand these issues themselves but also to explain them to the faithful during Friday prayers, couples counseling, and other community gatherings (UNFPA, 2012).

Gender-Responsiveness of Programs and Materials

Throughout the Philippines, government- and donor-funded programs support the implementation of national and local policy. For this analysis, the HPP/GPM team assessed gender integration in several family planning, reproductive health, and MNCH programs. Interviews with key informants gave us a rich understanding of even more programs. The sample of programs analyzed for this assessment is by no means comprehensive, but it is representative of the priorities of national, regional, and local governments and international donors. Our findings can be generalized to other programs that we did not assess.

Box 6. Programs Receiving a High Rating

- Building Capacities on Women's Economic Empowerment: Department of Science and Technology, Department of Trade and Industry, Philippine Health Insurance Corporation, and Technical Education and Skills Development Authority (Philippine Commission on Women, 2012)
- Expanding Social Protection for Women in Microenterprises and in the Informal Economy: The Partial Subsidy Scheme of PhilHealth 2007–2013 (Philippine Commission on Women, 2012)
- Final performance evaluation of the Private Sector Mobilization for Family Health, Phase II 2009–2014, or PRISM2 (U.S. Agency for International Development)
- The Enabling Environment for Women's Economic Empowerment Featuring Results of the GREAT Women Project from 2007–2013 (Philippine Commission on Women, 2013)
- Women and Children Protection Program 2012 (Department of Health)
- Enhanced and Rapid Improvement of Community Health in Mindanao (EnRICH) program. Final report 2002–2007 (ACDI/VOCA)
- The Western Pacific Regional Child Survival Strategy 2006 (World Health Organization and United Nations Children's Fund)

For this analysis, HPP/GPM developed a checklist for gender-responsiveness (similar to the one for the policy analysis) and ranked programs according to their scores. Fifteen programs scored low (between 0 and 2), six scored medium (between 3 and 5), and seven scored high (between 6 and 8). The PCW's programs scored highest. Many of the programs with low scores lacked a gender analysis to inform program design or strategies to reduce gender inequalities (for example, constructive male engagement in maternal health programs) and recognized only women as beneficiaries.

Key informants reported that some low-scoring programs have promising gender-integrated practices. For example, the Pantawid Pamilyang Pilipino Program, implemented by the Department of Social Welfare and Development, provides cash transfers to poor families if they attend family development sessions. Previously, only women were required to attend these sessions; now men must go, too.

The Usapan—"conversation"—modules developed under the USAID-funded PRISM2 project are another example. These have identified gender barriers that prevent women from choosing to access family planning. Women said the main barrier was obtaining their husbands' consent; husbands were not

actively involved in the Usapan program. EngenderHealth's VisayasHealth program adapted the Usapan modules and addressed this problem by developing a Usapan action card for men. The card encourages men to be involved in family planning and maternal health, by demonstrating actions they can take to support their wives in family planning and maternal health decisions.

Men, notably husbands, have not been systematically engaged in GAD in the Philippines. One promising program is MR GAD, which the Philippines Commission on Population has implemented and is piloting in six *barangays* (see Box 7). The three-day trainings aim to improve men's understanding of gender and increase men's involvement in the GAD process. They are usually held late in the day, to avoid conflict with men's work schedules. The difficulty of accommodating work schedules was often cited in our interviews as the primary reason for not engaging men in family planning, reproductive health, and MNCH programs. Informants said this is also a gender barrier in men's access to healthcare: men do not seek care for themselves because services generally are not available after working hours. Quezon City dealt with this challenge by opening the Clinica San Bernardo—a men's "sundown clinic," which opens at the end of the workday. The clinic concentrates on HIV services but also provides basic health services. This model is a promising practice for improving men's access to health services, and has great potential to be scaled up.

Gender-responsiveness is an issue at all service delivery levels, according to our literature review and interviews, especially in the often-overextended public facilities.

Box 7. Male Responsibility in Gender and Development

Few avenues exist in the Philippines for men to be involved in promoting reproductive health and gender equality. For this reason, the Health Resource Management Group and its partners developed a community-based project called Male Responsibility in Gender and Development (MR GAD). The objectives of MR GAD are to engage men as advocates and champions of gender and reproductive health concerns; build the capacity of community-based service providers to deal with survivors and perpetrators of violence; teach men skills to manage their own gender and reproductive health issues to reduce violence and risky behavior; and encourage safe sex and responsible parenthood choices. Results show that MR GAD has been effective in engaging men as partners, advocates, and champions in gender and reproductive health activities in the six pilot *barangays* in Davao City. The program has:

- Improved referral systems for reproductive health and domestic violence
- Improved the *barangays*' compliance in issuing GBV protection orders (Three of six pilot *barangays* reported 100-percent compliance in issuing such orders for women reporting physical violence by their husbands or partners.)
- Increased the confidence of social services staff in their ability to counsel about domestic violence
- Increased budget appropriations for the construction or renovation of counseling rooms for women who have experienced violence

MR GAD has expanded to 15 *barangays* in Davao City and the Philippines Commission on Population has adopted the model to support implementation of its responsible parenthood and reproductive health program.

Source: Ilagan, Gail Tan. 2011. "Men's Responsibilities in Gender and Development (MR GAD) Philippines." In *Engaging Men and Boys in Gender Equality: Vignettes from Asia and Africa*. Ampang, Malaysia: International Council on Management of Population Programmes.

Evidence from the global literature shows that incorporating gender sensitization and related skills in health provider training can be an effective strategy to improve the quality of health services (Bartel et al.,

2010; Satharet et al., 2005;Varkey et al., 2004). Overall, pre- and in-service training programs for health personnel in the Philippines do not systematically address gender. The private sector, however, offers promising programmatic approaches to gender integration. Staff at the Davao-based Brokenshire Hospital and the Davao Doctors Hospital told us how these facilities integrate gender in all hospital trainings and in core curriculum modules for the local medical schools. They also engage men in antenatal care, delivery, and post-partum care. Anecdotal evidence suggests that couples delivering in these facilities are more interested in post-partum family planning, as a result.

Integrating gender-sensitive healthcare in the curriculum of public health-sciences schools is challenging. However, gender champions, both in the colleges and universities and in national regulatory bodies and national associations, can be a powerful force for change.

Community health teams, central to the Aquino Health Agenda, provide another vehicle for promoting gender equality and male engagement in health. The teams link underserved Filipino families to the health service delivery network and support them in accessing PhilHealth benefits. For the teams to become forces for change, their position as community leaders and mobilizers must be strengthened. Global research shows that community health workers can be effective in engaging men and improving health outcomes (Palabrica-Costella et al., 2001; Lundgren et al., 2005; Midhet and Becher, 2010.)

In 2010, Republic Act 10121 was passed, which among other things affirmed the need to carry out disaster risk-reduction and management and to develop a framework for national disaster risk reduction and management. The following year, the National Disaster Risk Reduction and Management Plan 2011–2028 presented guidelines for dealing with disasters, in four thematic areas: disaster prevention and mitigation, disaster preparedness, disaster response, and disaster rehabilitation and recovery. Related national plans and policies are the Philippine Development Plan 2011–2016, the National Climate Change Action Plan, and the National Security Policy. All of these touch on the need to reduce vulnerabilities to natural disasters, either by taking action against climate change or by mitigating the impact of disasters (National Disaster Risk Reduction and Management Council, 2011). After Typhoon Yolanda, in 2013, the government released guidelines dictating the development of local disaster preparedness plans. The 2011 national disaster plan mentions gender mainstreaming as a cross-cutting concern. It states the government's commitment to promote gender-sensitive analysis of vulnerabilities and capacities in disaster situations, but offers no firm guidelines or recommendations. Among the plan's specific outputs and activities, the only one that even remotely considers gender is the provision of adequately equipped facilities that set aside areas for lactating mothers (National Disaster Risk Reduction and Management Council, 2011).

The lack of attention to gender in national policies and programs for disaster risk-reduction is troubling, given the wide range of gender-related issues that come into play during and after natural disasters. For example, once a disaster hits, constraints on a woman's freedom to leave her home may hinder self-rescue (International Federation of Red Cross and Red Crescent Societies, 2010). Conversely, according to anecdotal evidence from Tacloban City, where some of Yolanda's worst damage occurred, many evacuation centers had more women than men, because men stayed behind to try to protect the house, animals, and land (Women Create Life, 2014). The lack of such basic skills as swimming or climbing trees may reduce women's chances of surviving a disaster (International Federation of Red Cross and Red Crescent Societies, 2010). Most concerning is the widespread threat of GBV and human trafficking in emergency situations (UNFPA, 2014). For example, after Typhoon Pablo, in 2012, cases of GBV and trafficking (in particular, sexual trafficking of adolescent boys and girls) increased. With Typhoon Yolanda, overcrowded and insecure evacuation centers with inadequate bathing and bathroom facilities and a lack of privacy put people at greater risk for GBV. Moreover, large influxes of police, military, and aid workers, a limited number of female police, and rapid flows of displaced persons made GBV,

including sexual exploitation and trafficking, likelier still (Charot and Dunn, n.d.). In such settings, vitally needed maternal and reproductive health services are hard to provide and sustain (Oxfam, 2013).

The gender-responsiveness of USAID-funded projects varied. This study turned up strategies such as the Usapan series, the use of sex-disaggregated data, and inclusion of gender-sensitivity in trainings. However, several program representatives said they need simple tools to provide guidance on integrating gender in programs and assessing the results. The agency's requirement for gender action plans to accompany annual workplans has helped implementers define their gender-related objectives clearly and link them to activities and monitoring indicators. The structure and format of the action plans submitted is inconsistent, though. More important, there is no clear mechanism for integrating gender-related activities into the workplans, nor is there a mechanism for monitoring the gender action plans' implementation.

Although many promising gender-integrated programs emerged from our analysis, their scale-up has been limited. One reason is the highly decentralized government system, which makes regional and local buy-in necessary for endorsement and resource allocation. Scale-up in this system will likely require a long and coordinated effort. Another obstacle—arguably easier to address—is that promising practices are not shared. When the HPP/GPM team asked key respondents if they had discussed their good results with anyone outside of local circles, they generally had not. Better networks are needed for communication of promising practices.

CONCLUSION

The gender assessment reveals that the MCW, the PPGD, and the Women's EDGE Plan give the Philippines a strong national framework for promoting GAD. The MCW and PPGD uphold "the role of women in nation building" and ensure equality of women and men. The MCW's implementing rules and regulations further strengthen gender mainstreaming efforts, by establishing gender-responsive governance structures: primarily the PCW and the GFPS. As the country's GAD policies move from development to implementation and from the national level to LGUs, their commitments weaken. Most national health policies integrate gender concerns, but the degree to which they do so is inconsistent across health areas. Moreover, these health policies—like the GAD policies—become less gender-responsive when translated into operational plans. Finally, LGUs have trouble translating national GAD policies into local policies and programs, because of capacity gaps in human and financial resources, the absence of monitoring and accountability mechanisms, and a weak conceptual understanding of gender. Therefore local health policies exhibit varying degrees of gender-responsiveness. All of these barriers exist within the context of an active and influential Catholic Church, which exerts political and personal pressure to block family planning champions and acceptors.

RECOMMENDATIONS

Overarching Recommendations

National government agencies and local government units

- Strengthen adolescent health policies and programs to incorporate lines of action to address the different needs and challenges of adolescent girls and boys in accessing sexual and reproductive health services.
- Translate the PPGD's and MCW's framework for promoting gender equality and women's empowerment into the policies, implementing rules and guidelines, and programs of all government agencies. The PCW and partners should issue practical guidance and a tool to help agencies operationalize the PPGD's framework for gender equality and women's empowerment when they draft health policies and GAD policies.
- Strengthen MNCH policies, by incorporating awareness of how gender influences healthy behaviors and access to health services and by developing lines of action to address gender barriers.
- Strengthen the DOH's ties to the PCW, drawing on the commission for technical assistance with policy development and implementation. This should increase the gender-responsiveness of MNCH and reproductive health policies. Likewise, develop a stronger network of gender focal points within the health system. Sharing promising practices and strategies and increasing opportunities for capacity-building can make policies, programs, and implementation more gender-responsive.
- Develop sex- and age-disaggregated standards, indicators, and operational guidelines that define gender-sensitive health service standards for family planning, reproductive health, MNCH, and TB and operationalize the guidelines, by incorporating the gender-sensitive service standards into training modules for health providers.
- Strengthen capacity for mainstreaming GAD in health programs, by disseminating the Harmonized GAD Guidelines and training agencies to follow them. PCW and NEDA are positioned to reenergize this effort. Additionally, PCW and NEDA can issue criteria for what constitutes a GAD health activity and what does not: specifically, how to make GAD activities gender-responsive.
- Consider adopting a systematic approach to expand and institutionalize the gender-responsive policies and programs of the DOH and its partners. The GFPS is a possible structure for scale-up.
- Strengthen the DOH's partnership with the PCW, in keeping with the multisectoral coordination that characterizes the Philippine system for gender-responsive governance. The PCW should provide technical input (including the drafting of implementing rules and regulations) early in the policy development process, to ensure that GAD is effectively mainstreamed and operationalized in all health policies and programs.
- Revitalize and strengthen local health boards as a way to promote civil society and interaction with LGUs around gender, health, and development.
- Establish the position of coordinator in provincial health offices to support, strengthen, and coordinate the WCPUs.

Civil society organizations

- Increase GAD policy monitoring at the LGU level. Civil-society organizations will need tools and training to effectively monitor development and implementation of GAD and health policies.
- Conduct GAD training for legislators and other policymakers to cultivate gender champions and advocates within government.
- Advocate the removal of local policies that create barriers in access to reproductive health services by women and men. Identify a gender and health champion within government to coordinate and push advocacy issues.
- Establish or strengthen gender and health coordination networks to ensure the sharing of promising practices and lessons learned.

Actionable Recommendations for USAID Implementing Partners

Strengthen demand for essential family planning and maternal and child health services

Research-related activities

All formative, operations, and policy research activities are opportunities to explore women's and men's preferences for accessing health services, barriers to healthy behaviors, and underlying gender dynamics that influence health. Projects should take advantage of research opportunities to increase understanding of how gender norms and women's and men's access to and control over resources, decision-making power, roles and activities, and legal rights and status influence health decisions and outcomes.

- Conduct formative research on entry points for engaging men in family planning and MNCH. Examples of areas to explore are when men seek services from different types of health providers, in workplaces, and places of leisure; attitudes and preferences related to quality of care for family planning and MNCH services; motivations and barriers to using contraceptives; and motivations and barriers to accessing child health services and supporting their wives to use maternal health services. As men become more involved, women's right to confidentiality and autonomy in decisions about their health could be jeopardized. Therefore, formative research on women's preferences for engaging their partners in family planning and MNCH is equally important.
- Incorporate questions about gender dynamics and gender equality in policy research. Use a gender analysis framework to identify and analyze gender-barriers to reproductive and child health. The Health Policy Project's simple "Integrating Gender into Scale-up Mapping Tool" should be helpful.

Social and behavior change communication activities

Social and behavior change communication can promote and sustain good family planning and MNCH practices. Messages to address gender barriers to health can be incorporated in ongoing SBCC activities, such as interpersonal communication and counseling, community mobilization, community outreach, and mass media campaigns.

- Incorporate messages in mass media and other behavior change communication materials that promote equitable partnerships and respectful relationships between women and men and affirm the role of men as supportive and caring fathers.
- Include couples counseling skills to promote equitable decision making regarding family planning, MNCH, and reproductive health during interpersonal communication training programs with midwives and other health providers.

- Reduce stigma that discourages adolescent girls and boys from accessing reproductive health and family planning services. For example, integrate strategies to confront provider bias and providers' stigmatizing attitudes and behaviors through training in interpersonal communication and counseling; use community health teams to mobilize communities in support of adolescent sexual and reproductive health; and integrate messages about adolescent sexual and reproductive health in mass media campaigns.
- Encourage constructive male engagement in family planning and MNCH issues, by providing outreach and information to men at health clinics, workplaces, and places of leisure. The communication messages must address men's attitudes, preferences, and motivations related to family planning and MNCH. Various communication channels may be used to reach men. One opportunity is to recruit men to join the community health teams. It is important to ensure that men's involvement does not diminish women's rights to confidentiality and to independent decisions about their health and access to services.

Strengthen family planning and maternal and child health service delivery

Strengthening service delivery is central to improving family planning and MNCH outcomes. To improve capacity for gender-sensitive family planning and MNCH services, integrate gender in existing pre- and in-service training curricula and programs for health service providers. The training should sensitize providers to the gender barriers that males and females face in accessing family planning and MNCH services as well as strategies that providers can use to provide equitable services to male and female clients.

- Integrate gender-sensitivity throughout the DOH competency-based family planning trainings. Collaborate with the DOH and the PCW to define gender-sensitive health services. Operationalize this definition, by identifying the gender competencies that providers and health facilities should have.
- Adopt the Respectful Maternity Care Charter, which addresses disrespect and abuse experienced by women seeking maternity care. The charter's seven articles clarify the rights of childbearing women and serve as a platform for improvement. Healthcare providers and advocates can use the charter and related training materials to improve the quality of health services.
- Strengthen partnerships with the private sector to reach adolescents with critical reproductive health information and services. Pay special attention to girls who have not yet been pregnant–a severely underserved population group.

Improve implementation of family planning and maternal and child health policies and systems

Many opportunities exist to help the Government of the Philippines strengthen the gender-responsiveness of health systems, policies, and programs. At the national level, projects can provide technical support to integrate gender considerations into national policies and implementing rules and regulations. At the LGU level, projects can provide technical support to operationalize the GAD guidelines in order to design and implement health policies, services, and programs that are more responsive to the different needs of women, men, and adolescents.

- Provide technical assistance to the DOH to strengthen the gender-sensitivity of health policies, primarily PhilHealth, MNCHN guidelines, and guidelines on provision of healthcare for adolescents and youth. In addition to providing direct technical assistance, strengthen coordination with the PCW and GAD focal points and national agencies in order to facilitate peer-to-peer learning and strengthen gender-responsive governance structures.

- Conduct orientations, trainings, and coaching on GAD planning and budgeting processes, using the Harmonized GAD Guidelines. These orientations and trainings can be incorporated in existing training and coaching events, by including GAD content in the agenda. Another option is to invite the CHD, LGUs, and gender focal points to participate in gender-related trainings. Last, provide technical assistance to design information and management systems that collect sex-disaggregated data.
- Engage civil society organizations at all levels to participate in gender and health policy advocacy and monitoring.
- Mobilize communities to protect the right of women to respectful maternity care, by adopting the Respectful Care Charter and holding a public hearing or using the community scorecard method.

Strengthen the gender-sensitivity of tuberculosis programs

The evidence on gender-integrated programming for TB is scant. Nonetheless, given the gender disparities in prevalence and treatment of TB, a gender-aware approach to designing and implementing TB programs is warranted.

- Conduct more detailed research on barriers that men and women each face in preventing TB and accessing TB services
- Develop program strategies to respond to the different needs, preferences, roles and responsibilities of women and men. Use the Harmonized GAD Guidelines to integrate gender throughout the project cycle.

ANNEX A: GENDER ANALYSIS OF HEALTH POLICIES AND PROGRAMS IN THE PHILIPPINES

Concept Note, Health Policy Project

Asia/Middle East Gender, Policy, and Measurement Program, September 19, 2013

Background

The Gender, Policy, and Measurement (GPM) program, funded by the USAID Asia and Middle East (A/ME) Bureaus, is collaborating with USAID health programs and other partners in the A/ME regions to enhance the scale-up of best practices in family planning and maternal, neonatal, and child health. The GPM program works to address gender inequality and implement supportive policies and systems that augment the sustainability of scale-up initiatives. GPM also measures the impact that gender integration and policy implementation have on scale-up of health innovations, a critical step in determining the efficacy of its actions. It is through this lens of scale-up that GPM proposes to conduct the following scope of work.

Scope of Work

International health programs and donors in the Philippines and throughout the world increasingly recognize the importance of incorporating strategies to address gender inequality into programs to improve health outcomes for women, men, and children. To strengthen gender integration efforts in the Philippines, USAID has expressed interest in working with GPM to conduct a gender analysis of health-related policies and programs in the Philippines. The purpose of the analysis is to review available information on health-related laws, policies and programs in the Philippines to assess their responsiveness to gender inequality, norms, and barriers. The assessment will help to identify entry points and opportunities for investing in gender equality for improved family planning and maternal, neonatal, and child health outcomes. The analysis will be instrumental to help the USAID/Philippine's health office determine whether its selected gender indicator aligns appropriately with its current health strategy and is responsive to the current gender context.

The assessment will be conducted in a participatory fashion by GPM with USAID/Philippines and key stakeholders. It will include a gender analysis of the key government, donor, and NGO programs and policies on health. The assessment will include an analysis of the country's resources and capacity to develop and implement gender-responsive health programs. The assessment will provide USAID/Philippines with recommendations on ways to incorporate gender-integrated interventions into its health portfolio, including tools and training materials to be adapted or developed, and strategies for monitoring and evaluating gender-integrated programs.

Proposed Process/Activities

1. GPM staff conduct a desk review, to include
    a. A brief review of the gender and health context to identify the normative, socioeconomic, and political variables and power dynamics that impede and/or facilitate access to and utilization of health services in the Philippines. GPM's review will build on the gender assessment that was conducted by multilateral donors and the National Commission on the Role of Filipino Women in 2008.

   b. A review and analysis of key health-related policy documents and implementation reports to understand the extent to which health policies are responsive to and address the gender context.

   c. A review of key health programs with a specific focus on FP/MNCH in the Philippines. Programs implemented by the Government of the Philippines, multilateral donors, and nongovernmental organizations will be reviewed and assessed for their awareness and responsiveness to gender inequality and the gender context. To the extent possible, this review will also assess the level of resources committed to gender-integrated programs and services.

2. In collaboration with USAID/Philippines, GPM staff conduct a stakeholder mapping exercise, to determine governmental, nongovernmental, donors, and other stakeholders who are involved in gender and/or health programming, as well as key stakeholders to engage.
3. GPM staff develop tools and questionnaires to guide discussions with key stakeholders on their knowledge, skills, experiences, and recommendations on integrating gender into health policies and programs.
4. GPM staff travel to the Philippines to conduct in-country interviews and participatory analysis of findings.
5. Following travel, GPM staff compile and finalize a report with the findings and recommendations from the desk review, interviews, and participatory analysis.
6. GPM staff travel to the Philippines to facilitate dissemination of results through a technical consultation. Final format for the technical consultation will be decided in collaboration with USAID/Philippines. Possible themes and formats include

   a. Skills-building workshop to apply key findings from the gender analysis on health policies and programs with USAID/Philippines and relevant bilateral partners

   b. Workshop with USAID/Philippines health staff to develop a gender integration action plan for current and future health programming

   c. Actionable guidance on gender-focused monitoring and evaluation (M&E)

Anticipated Products

1. Final report with findings and recommendations from the desk review, interviews, and participatory analysis
2. Final report from the technical consultation
3. Gender M&E guidance document

Estimated Timeline

Dates	Activities/Deliverables	Location
Phase I	**Desk review and tool development**	
September 2013	Scope of work to USAID/Philippines	DC
September–October 2013	Desk review	DC
October–November 2013	Stakeholder mapping with USAID/Philippines	DC or Manila
October–November 2013	Tool and questionnaire development for in-country interviews with relevant stakeholders	DC
Phase II	**Data collection, analysis, and dissemination**	
November 2013	In-country interviews	Manila and/or other relevant sites
November 2013	Participatory analysis of findings	Manila
December 2013–January 2014	Report drafting and finalization	DC
February 2014	Dissemination of results and technical consultation	Manila and/or other relevant sites

Anticipated travel

Staff	Trip	Dates	Purpose	Notes
2 HPP staff	RT DC-Philippines	November 2013	Meet with USAID/ Philippines staff, conduct key stakeholder interviews, participatory analysis	
2 HPP staff	RT DC-Philippines	February 2014	Technical consultation and dissemination of findings with USAID/Philippines staff	

Budget

To be determined, but expected to be covered with existing HPP/GPM funding.

ANNEX B: COMPLETE LIST OF POLICIES AND PROGRAMS REVIEWED

Policies

Title	Expanded Breastfeeding Promotion Act of 2009 [Republic Act No. 10028]
Published by	Congress of the Philippines
Year	2009
Timeframe	2009–2010
Title	Climate Change Act of 2009 [Republic Act No.. 9729]
Published by	Congress of the Philippines
Year	2009
Timeframe	2009–2010
Title	The Revised Philippine HIV and AIDS Policy and Program Act of 2012
Published by	Congress of the Philippines
Year	2012
Timeframe	N/A
Title	National Health Insurance Act of 2013 [Republic Act No. 106060]
Published by	Congress of the Philippines
Year	2013
Timeframe	N/A
Title	National Health Insurance Act of 1995 [Republic Act No. 7875]
Published by	Congress of the Philippines
Year	1994
Timeframe	N/A
Title	Omnibus Rules and Regulations Implementing the Migrant Workers and Overseas Filipinos Act of 1995, as amended by Republic Act No. 10022
Published by	Congress of the Philippines
Year	2009
Timeframe	N/A
Title	The Responsible Parenthood and Reproductive Health Act of 2012 [Republic Act No. 10354]
Published by	Congress of the Philippines
Year	2012
Timeframe	N/A

Title	Expanded Anti-Trafficking in Persons Act of 2012 [Republic Act No. 10364]
Published by	Congress of the Philippines
Year	2013
Timeframe	N/A
Title	Anti-Violence Against Women and Their Children Act of 2004 [Republic Act No. 9262]
Published by	Congress of the Philippines
Year	2004
Timeframe	N/A
Title	The Magna Carta of Women [Republic Act No. 9710]
Published by	Congress of the Philippines
Year	2009
Timeframe	N/A
Title	Administrative Order No. 2010-0036, entitled "The Aquino Health Agenda: Achieving Universal Health Care for All Filipinos"
Published by	Department of Health
Year	2011
Timeframe	N/A
Title	Addressing the Inequality in our Penal Law on Adultery and Concubinage: Enacting the Anti-Marital Infidelity Law
Published by	Philippine Commission on Women
Year	2013
Timeframe	N/A
Title	PCW Policy Briefs (Women's Priority Legislative Agenda)
Published by	Philippine Commission on Women
Year	2012
Timeframe	N/A
Title	The Environment and Social Management Guidelines: Ensuring Environmentally-Sound and Gender- Sensitive Enterprises
Published by	National Economic and Development Authority and Philippine Commission on Women
Year	2012
Timeframe	N/A
Title	Gender and Development (GAD) Checklists
Published by	Philippine Commission on Women
Year	2010
Timeframe	N/A

Title	Harmonized Gender and Development Guidelines for Project Development, Implementation, Monitoring and Evaluation (second edition)
Published by	National Economic and Development Authority and Philippine Commission on Women
Year	2010
Timeframe	N/A
Title	Harmonized Gender and Development Guidelines for Project Development, Implementation, Monitoring, and Evaluation: Training Manual
Published by	National Economic and Development Authority
Year	2007
Timeframe	N/A
Title	Guidelines for the Implementation of HIV and AIDS Prevention and Control in the Workplace Program
Published by	Department of Labor and Employment Republic of the Philippines.
Year	2010
Timeframe	N/A
Title	Guidelines for the Implementation of Policy and Program on Tuberculosis (TB) Prevention and Control in the Workplace
Published by	Department of Labor and Employment
Year	2005
Timeframe	N/A
Title	Barangay VAW Desk Handbook
Published by	Philippine Commission on Women
Year	2012
Timeframe	N/A
Title	Department Order 2011-0188 (Kalusugan Pangkalahatan) Execution Plan and Implementation Arrangement
Published by	Philippine Health Insurance Corporation
Year	2011
Timeframe	N/A
Title	Philippines Second Women's Health & Safe Motherhood P079628: Implementation Status Results Report, Sequence 16
Published by	Rosadia, R. A. F.
Year	2013
Timeframe	N/A

Title	Annual Reports of PhilHealth
Published by	Philippine Health Insurance Corporation
Year	2012
Timeframe	N/A
Title	National Objectives for Health Philippines, 2011–2016
Published by	Department of Health
Year	2012
Timeframe	2011–2016
Title	MNCHN Strategy Manual of Operations
Published by	Department of Health
Year	2011
Timeframe	N/A
Title	Quezon City Council Ordinance No. 2191, series of 2012: An Ordinance Creating a Quezon City Protection Center for Women, Children and Lesbians, Gays, Bisexuals and Transgenders (LGBTs) Who Are Victims/Survivors of Violence and Abuse, Adopting a Comprehensive Program Thereof and for Other Purposes
Published by	Quezon City Council
Year	2012
Timeframe	N/A
Title	Philippine Development Plan 2011–2016
Published by	National Economic and Development Authority
Year	2011
Timeframe	2011–2016
Title	The 5th AIDS Medium-Term Plan (2011–2016): The Philippine Strategic Plan on HIV and AIDS
Published by	Philippine National AIDS Council
Year	2011
Timeframe	2011–2016
Title	Philippine Population Management Program Directional Plan 2011–2016
Published by	Commission on Population
Year	2011
Timeframe	2011–2016

Title	2010–2016 Philippine Plan of Action to Control TB (PhilPACT)
Published by	Department of Health
Year	2010
Timeframe	2010–2016
Title	The Philippine National Action Plan on Women, Peace & Security (2011 to 2016 Plan for the Implementation of UNSCR1325 and 1820 in the Philippines)
Published by	Office of the Presidential Advisor on the Peace Process
Year	2011
Timeframe	2011–2016
Title	Implementing Rules and Regulations of the National Health Insurance Act of 1995 (Republic Act No. 7875 as Amended by Republic Act No. 9241)
Published by	Congress of the Philippines
Year	2004
Timeframe	N/A
Title	Implementing Rules and Regulations of Republic Act 10354, otherwise known as The Responsible Parenthood and Reproductive Health Act of 2012
Published by	Department of Health
Year	2013
Timeframe	N/A
Title	Implementing Rules and Regulations RA 9262 Anti-Violence Against Women and Their Children Act of 2004
Published by	Congress of the Philippines
Year	2004
Timeframe	N/A
Title	National Monitoring and Evaluation Plan: Fifth AIDS Medium-Term Plan, 2011–2016
Published by	Philippine National AIDS Council
Year	2012
Timeframe	2011–2016
Title	National Workplace Policy on STD/HIV/AIDS
Published by	Department of Labor and Employment
Year	2002
Timeframe	N/A

Title	Comprehensive and Unified Policy for TB Control in the Philippines (C.U.P. 2004)
Published by	Department of Health
Year	2004
Timeframe	N/A
Title	Mainstreaming GAD in Local Policy Making: Development of the Ifugao GAD Code Implementing Rules & Regulations
Published by	Philippine Commission on Women
Year	2012
Timeframe	N/A
Title	The Influence of Local Policy on Contraceptive Provision and Use in Three Locales in the Philippines
Published by	Lee, R. B., L. P. Nacionales, et al.
Year	2009
Timeframe	N/A
Title	Plan Framework of the Philippine Plan for Gender-Responsive Development 1995–2025
Published by	Philippine Commission on Women
Year	1996
Timeframe	1995–2025
Title	Accounting for Gender Results: A Review of the Philippine GAD Budget Policy
Published By	Miriam College Women and Gender Institute
Year	2010
Timeframe	N/A
Title	Revised Policy of the Establishment of Women and Their Children Protection Units in All Government Hospitals
Published By	Department of Health
Year	2013
Timeframe	N/A
Title	Anti-Sexual Harassment Act
Published By	Congress of the Philippines
Year	1995
Timeframe	N/A
Title	National Policy and Strategic Framework on Adolescent Health and Development
Published By	Department of Health
Year	2013
Timeframe	N/A

Title	Women's Empowerment, Development and Gender Equality Plan (Women's EDGE Plan)
Published By	Philippine Commission on Women
Year	2013
Timeframe	N/A
Title	Pantawid Pamilyang Pilipino Program Act of 2010
Published By	Senate of the Philippines, Republic Act
Year	2010
Timeframe	N/A

Programs

Title	Impacts of an Early Stage Education Intervention on Students' Learning Achievement: Evidence from the Philippines
Published by	World Bank
Year	2013
Timeframe	2000–2006
Title	Philippines Conditional Cash Transfer Program: Impact Evaluation 2012
Published by	World Bank
Year	2013
Timeframe	Started in 2008
Title	Planning for Life: Final Evaluation
Published by	International Youth Foundation
Year	2009
Timeframe	2007–2009
Title	Philippines - National Sector Support for Health Reform Project
Published by	World Bank
Year	2013
Timeframe	2006–ongoing
Title	The Population-Level Impacts of a National Health Insurance Program and Franchise Midwife Clinics on Achievement of Prenatal and Delivery Care Standards in the Philippines
Published by	*Health Policy*
Year	2009
Timeframe	1998–ongoing

Title	Philippines: The KALAHI-CIDSS Impact Evaluation: A Synthesis Report
Published by	World Bank
Year	2013
Timeframe	2002–?
Title	Final Performance Evaluation of the Private Sector Mobilization for Family Health Phase II (PRISM2) Project
Published by	Social Impact, Inc.
Year	2013
Timeframe	2009–2014
Title	USAID/Philippines: Performance Evaluation of the Family Planning and Maternal and Child Health Portfolio
Published by	GH Tech Bridge II Project
Year	2012
Timeframe	2006–2011
Title	A Systems Approach to Improving Maternal Health in the Philippines
Published by	World Health Organization
Year	2012
Timeframe	2006–2013
Title	Conditional Cash for Better Maternal Health
Published by	IRIN News Asia
Year	2012
Timeframe	2008–ongoing
Title	Fishing for Families: Reproductive Health and Integrated Coastal Management in the Philippines
Published by	Wilson Center
Year	2008
Timeframe	2001–?
Title	Expanding Social Protection for Women in Microenterprises and in the Informal Economy: The Partial Subsidy Scheme of the PhilHealth
Published by	Philippine Commission on Women
Year	2012
Timeframe	2007–2013

Title	Comprehensive Pilot Intervention Plan Against Gender Violence in Caraga (CoPIPAGV 13)
Published by	Program website
Year	2009
Timeframe	2008–2011
Title	Women and Children Protection Program
Published by	DOH
Year	2012
Timeframe	2007–ongoing
Title	The Enabling Environment for Women's Economic Empowerment Featuring Results of the GREAT Women Project from 2007–2013
Published by	Philippine Commission on Women
Year	2013
Timeframe	2007–2013
Title	Scaling Up Integrated Population, Health and Environment Approaches in the Philippines: A Review of Early Experiences
Published by	Population Reference Bureau and World Wildlife Fund
Year	2008
Timeframe	N/A
Title	From Young Rural Intenders to Ready-to-Limit Pragmatists: Segmenting the Family Planning Market to Improve Behavior Change Interventions in the Philippines
Published by	Abt Associates
Year	2009
Timeframe	N/A
Title	Gender Assessment of the Australian Philippines Aid Program: Background Paper for Philippines Country Program and Strategy Evaluation
Published by	AusAID
Year	2012
Timeframe	?
Title	AWARENESS Project. Philippines Country Report, 2002–2007
Published by	Georgetown University Institute for Reproductive Health
Year	2008
Timeframe	2002–2007

Title	Philippines: Final Country Report
Published by	John Snow, Inc.
Year	2007
Timeframe	2004–2006
Title	Social Franchising: It's Helping DKT International's Customers Secure Better Access to High Quality, Affordable Family Planning
Published by	DKT
Year	2011
Timeframe	2005–2011
Title	Enhanced and Rapid Improvement of Community Health in Mindanao (EnRICH) Program: Final Report
Published by	ACDI/VOCA
Year	2007
Timeframe	2002–2007
Title	Philippines Public Health P115184: Implementation Status Results Report, Sequence 02
Published by	World Bank
Year	2013
Timeframe	2012–2015
Title	Philippines Government-Sponsored Health Coverage Program for Poor Households
Published by	World Bank
Year	2013
Timeframe	2000–ongoing
Title	Philippines Second Women's Health and Safe Motherhood Project
Published by	World Bank
Year	2009
Timeframe	2005–2015
Title	Making the Philippine MDG Report Gender-Responsive: The UNIFEM CEDAW South East Asia Programme 2005–2008
Published by	United Nations Development Fund for Women, Committee on the Elimination of Discrimination against Women
Year	2009
Timeframe	2000–2015

Title	Building Capacities on WEE: National Government Agencies: DOST, DTI, PhilHealth and TESDA
Published by	Philippine Commission on Women
Year	2012
Timeframe	N/A
Title	Building Capacity for Evidence Generation, Synthesis and Implementation to Improve the Care of Mothers and Babies in South East Asia: Methods and Design of the SEA-ORCHID Project Using a Logical Framework Approach
Published by	BMC Medical Research Methodology
Year	2010
Timeframe	2004–2008
Title	USAID's Growth with Equity in Mindanao (GEM-3) Program: Gender Action Plan
Published by	U.S. Agency for International Development
Year	2008
Timeframe	N/A
Title	MCH Program Description: Philippines
Published by	U.S. Agency for International Development
Year	2008
Timeframe	
Title	Best Practices at Scale in the Home, Community and Facilities: An Action Plan for Maternal, Neonatal, and Child Health and Nutrition, October 2011 to September 2016
Published by	U.S. Agency for International Development
Year	2011
Timeframe	2011–2016
Title	USAID/Philippines: External Evaluation of the Tuberculosis Portfolio (2006–2011)
Published by	U.S. Agency for International Development (GH Tech Bridge Project)
Year	2012
Timeframe	2006–2011
Title	People's Initiative to Counteract Misinformation and Marketing Practices: The Pembo, Philippines, Breastfeeding Experience, 2006
Published by	Journal of Human Lactation
Year	2009
Timeframe	?

Title	The Western Pacific Regional Child Survival Strategy: Progress and Challenges in Implementation
Published by	Journal of Pediatrics and Child Health
Year	2012
Timeframe	2006
Title	Integrating Population, Health, and Environment (PHE) Projects: A Programming Manual
Published by	CDM International
Year	2007
Timeframe	N/A
Title	Global Health Initiative: Strategy Document
Published by	USAID
Year	2012
Timeframe	2012–2016
Title	Tango II: Final Report Project Summary
Published by	John Snow, Inc.
Year	2005
Timeframe	1995–2005

ANNEX C: POLICY INVENTORY TOOL

Existing policy or strategy	Coordination mechanism for implementation	Gender integration (describe)	Check all that apply								
			Officially adopted?	Financing for implementation exists?	FP	RH	MNCH	TB	HIV	GBV	Other
Title: Published by: Year: Timeframe:	Lead responsible body: Partners:										

Adapted from: World Health Organization. 2012. "Landscape Analysis on Countries' Readiness to Accelerate Action in Nutrition: Country Assessment Tools." Available at: http://www.who.int/nutrition/publications/landscape_analysis_assessment_tools/en/.

ANNEX D: POLICY AND PROGRAM ANALYSIS CHECKLISTS

Checklist 1: Policies and Guidelines

Gender-responsiveness checklist: Health policies and guidelines in the Philippines		Y/N/NA*
In the formulation process		
1.	Were consulting bodies specializing in gender matters consulted before or during the formulation of the policies?	
2.	Are gender equity and equality explicitly incorporated as values/principles in the plan's introduction, guiding principles, or other front matter?	
3.	Are the rights of women, adolescent girls, and/or sexual minorities protected in the policy?	
In the description of the general state of health of the population		
4.	Are sex-disaggregated data used/presented?	
5.	Is gender equality considered a health determinant?	
6.	Does the description reflect gender-based constraints in access to services?	
In the health problems prioritized in the plan; in the settings; in the instruments supporting development of the plan		
7.	Are specific objectives proposed to reduce gender inequalities?	
8.	Are lines of action proposed to meet the different needs of women and men?	
9.	Are lines of action proposed to reduce gender inequalities?	
10.	Do the lines of action proposed exclude one sex in areas that are traditionally thought of as relevant only for the other sex, such as maternal health or occupational health?	
11.	Is the collection of sex-disaggregated data included in the monitoring and evaluation (M&E) plan?	

* Not available.

Checklist 2: Programs

Gender-responsiveness checklist: Health programs in the Philippines		Y/N/NA*
1.	Was sex-disaggregated data consulted to inform development of the project or program?	
2.	Was a gender analysis conducted to inform development of the project or program?	
3.	Does the program consider family or household dynamics, including different effects and opportunities for individual members, such as the allocation of resources or decision-making power within the household?	

4.	Are program objectives proposed to reduce gender inequalities?	
5.	Do program strategies seek to reduce gender inequalities?	
6.	Does the program exclude one sex in areas that are traditionally thought of as relevant only for the other sex, such as maternal health or occupational health?	
7.	Does the M&E plan collect sex-disaggregated data?	
8.	Does the M&E plan include indicators to measure gender-related outcomes?	

* Not available.

Checklist 3: U.S. Agency for International Development (USAID)

Gender-responsiveness checklist: USAID procurements		Y/N/NA*
1.	Is gender included in the statement of work/program description of the procurement request?	
2.	Does the procurement request incorporate gender-sensitive indicators?	
3.	Does the procurement request specify gender-related qualifications for management and/or technical personnel?	
4.	Does the procurement request integrate gender into the evaluation/selection criteria to correspond with applicable technical components?	
Gender-responsiveness checklist: USAID Mission strategy development and planning		
5.	Was a gender assessment of USAID's portfolio conducted? In addition, or alternatively, was a gender analysis of the country context conducted?	
6.	Do Mission strategies and plans integrate findings of gender assessment and/or analysis: that is, do they address gender constraints and opportunities?	
7.	Do Mission strategies and plans support gender integration by strengthening gender training of Mission staff?	
8.	Do Mission strategies and plans ensure that the conclusions of any gender assessment and/or analysis are integrated in project/activity planning?	

* Not available.

Checklists adapted from

Pan American Health Organization, 2009. *Guide for Analysis and Monitoring of Gender Equity in Health Policies.* Available at: http://new.paho.org/hq/dmdocuments/2009/Guide_Gender_equity_.pdf

U.S. Agency for International Development. 2011. "USAID Gender Integration Matrix: Additional Help for ADS Chapter 201." Available at: http://www.usaid.gov/ads/policy/200/201sac.

World Health Organization (WHO) Regional Office for Europe. 2010. "Checklist for Assessing the Gender Responsiveness of Sexual and Reproductive Health Policies: Pilot Document for Adaptation to National Contexts." Available at: https://www.k4health.org/toolkits/igwg-gender/checklist-assessing-gender-responsiveness-sexual-and-reproductive-health.

WHO. Gender Assessment Tool. 2011. Available at: http://www.who.int/gender/documents/health_managers_guide/en/.

ANNEX E: INTERVIEW GUIDES FOR KEY INFORMANTS

Opening words for all interviews

Greetings

Purpose of the session

HPP, with support from USAID, is conducting a gender analysis in the Philippines to help inform future health programming by USAID and implementing partners. The purpose of the analysis is to review available information on health-related laws, policies, and programs in the Philippines to assess their responsiveness to gender inequality and norms-related barriers. **The assessment will help to identify entry points and opportunities for investing in gender equality for improved family planning and maternal, neonatal, and child health outcomes.** The assessment will include an analysis of the country's resources and capacity to develop and implement gender-responsive health policies and programs.

For the purposes of this interview, **gender** refers to the roles, relations, attributes, constraints, and opportunities associated with being masculine or feminine.

Based on your expertise, you have been selected to participate in a brief (60-minute) guided discussion to identify opportunities and challenges, as well as lessons learned pertaining to gender integration in the Philippines. Your participation is voluntary, and your responses will be kept confidential, and you have the right to refuse to respond to any question.

(Ask for permission to record the conversation. If permission is granted, turn on the tape recorder.)

Thank you for your participation!

Key informant interview questions: U.S. Agency for International Development

1. Who provides the major "push" on addressing gender inequality in the country? Donors? The government? Women's groups? Coalitions? Are any groups pushing back against these efforts?
2. Where have you seen progress in addressing gender inequalities? Are there any programs that provide especially strong examples and model good practices?
3. Which NGOs [nongovernmental organizations] work with males and females to promote gender equality? What kinds of activities are they doing? Which NGOs have the strongest capacity in working with males and female on gender equality?
4. Which are the major offices/branches of government/departments of the (national/provincial/local) government that have accountability for translating the GoP [Government of Philippines] gender equality policies into practice? How committed and how powerful are these offices?
5. What is the status of implementation of the major pieces of Philippine legislation related to gender equality that form the context for USAID's work? These are 1) the Magna Carta of Women, 2) Anti-Rape, 3) Anti-Sexual Harassment, 4) Anti-TIP [Trafficking in Persons], 5) Women in Nation Building Act, 6) Gender and Development Budget Policy, 7) Plan for Gender-Responsive Development, and, 8) Establishment of Women and Their Children Protection Units in All Government Hospitals.
6. What is USAID's role in supporting implementation of the GAD [gender and development] planning and budget policy?
    a. What does the policy require of USAID, if anything?
    b. How does USAID comply with the policy?
7. How does the Mission ensure technical capacity in conducting gender analyses across offices and in building the capacity among Mission staff to do gender analyses? How does the Mission respond to gender assessment findings?
8. Is there a gender working group or committee at the Mission? Are there any cross-donor gender working groups in which USAID participates? If so, what is the overall goal/objective of the multi-donor working group/s? How often do they meet and how do the working groups contribute to addressing gender issues/disparities in the country? How do the working groups contribute to building capacity of the government to address gender issues/disparities? What is the role of USAID in such working group/s, and what has it achieved so far?
9. How were you involved in drafting Mission Order 205 on Gender Equality and Female Empowerment? How was the health office involved? Can you give me examples of how the USAID health office is implementing Mission Order 205? What have been the successes and challenges in implementing the order? Are there other gender strategies or policies adopted at the mission level that guide your work?
10. How does the USAID Gender Equality and Female Empowerment Policy contribute to the government's overall effort to address gender issues/disparities?
11. Is there a gender focal point within the mission or health office? If YES: What is this person's role? What percentage of this person's LOE [level of effort] is dedicated to fulfilling this role? Is this role included in the person's job description?
12. Have you ever participated in any gender-related training? (If NO, skip to the next question.)
    a. If YES: Describe the training (year, who was involved, who led the training, how many hours, etc.).

   b. What were some of the key highlights of the training?
   c. Do you feel that this training was sufficient?
   d. If NO: What kind of training would you like to participate in with regard to integrating gender into your work?

13. Has any of your staff ever participated in any gender-related training?
   a. If YES: Did staff report finding the training useful? Sufficient? Worthwhile?
   b. If NO: Why have staff never had the opportunity to participate in gender-related training?
14. To what extent do you think the projects in your current health portfolio are addressing gender inequality and gender-based violence in ways other than including women as targets for services?
15. Do you have anything else to add, that you think would be important for us to take into consideration?

Key informant interview questions: National-level government stakeholders (informants who are not affiliated with the Philippine Commission on Women)

1. In your work in FP [family planning] or MNCH [maternal, neonatal, and child health], what would you say are the major gender equality issues that affect women's and men's 1) health and 2) access to services?
   a. Have these obstacles changed over time?
2. How do the (Department of Health, National Economic Development Authority) policies address the inequalities mentioned? Name specific policies and explain how they address inequalities between women and men.
   a. How well implemented is (name policy)? What works well? What could be improved?
   b. Are there any actors opposed to this policy? Why are they opposed?
   c. Are there any inequalities that are not addressed well by any laws or policies?
3. Have you identified issues specific to women or men (or girls and boys) that prevent them from participating in or benefiting fully from your programs as they have been implemented?
   a. If YES: What are these and how have you tried to address them? What was the result of these efforts?
   b. To what extent do you think services in your sector are addressing gender inequality in ways other than including women as targets for services?
4. Are you aware of any existing gender laws and policies in the Philippines or executive/administrative policies or guidelines from your office?
   a. If YES: Please name them. How do you apply each of these policy frameworks in your work?
      i. Examples of laws include the Magna Carta of Women, Anti-Rape, Anti-Sexual Harassment, Anti-TIP, and the Women in Nation Building Act. Examples of office policies/guidelines include gender budgeting, gender-responsive planning, GBV prevention, and the creation of women health action teams.
   a. Does your department conduct annual GAD planning and budgeting? Please describe what this process entails.

   b. As a part of the GAD planning process, has your agency conducted a gender audit? What were the results? How were any gaps addressed?
   c. What percentage of your budget is allocated to GAD? What kinds of activities fall under the GAD category?

5. Are there any policies or programs that provide especially strong examples and model good practices in promoting gender equality in the Philippines?
   a. Are there any policy gaps that need to be addressed?
6. How do you collect or use sex- and age-disaggregated data to monitor policy and program implementation? If gaps or inequalities are identified, how do you address them in your work?
7. What government offices or departments do you work with to develop or implement health policies? (Probe for PCW, Women and Children Protection Units, and other bodies responsible for promoting gender equality.)
   a. How effective would you say these partnerships are? What improvements in outcomes resulted from these partnerships, if any?
8. Tell me about your involvement in the Inter-Agency Council on Violence Against Women and Their Children. What are some of the main accomplishments of the council? What have been some challenges?
9. Has your (department or agency) established a gender and development focal point system?
   a. Who participates in this system?
   b. What is the overall role of the system? What is the system's role in policy formulation and implementation, if any?
   c. How might the system be strengthened as a gender champion?
10. Have you participated in any gender-related trainings?
   a. If YES: Describe the training (what year; who was involved, who led the training, how many hours, etc.).
   b. What were some of the key highlights of the training?
   c. Do you feel that the training was sufficient?
   d. What kind of training would you like to participate in with regard to integrating gender equality into your work?
11. Has any of your staff ever participated in any gender-related training?
   a. If YES: Did staff report finding the training useful? Sufficient? Worthwhile?
   b. If NO: Why have staff never had the opportunity to participate in gender related training?
   c. Do you have any training materials that you can share with us?
12. **Ask DOH only:** How well do the existing Women and Their Children Protection Units function?
   a. Probe regarding organizational structure, facilities and supplies, personnel, services, and research. (Refer to policy for standards for each of these areas.)
13. **Ask DOH only:** What is the status of implementing the newly revised AO [administrative order] on Women and Child Protection Units?
   a. What are some successes in implementation?

   b. What are the challenges?

14. Do you have anything else to add that you think would be important for us to take into consideration?

Key informant interview questions: Informants affiliated with the Philippine Commission on Women

1. What would you say are the major obstacles to gender equality that affect women's and men's 1) health and 2) access to services?
   a. Have these obstacles changed over time?
2. What are the key gender equality policies, strategies, and action plans specifically addressing FP/MNCH?
   a. What successes have you seen in implementation? What are some major challenges?
   b. Are there any gaps or areas in FP/MNCH that are not addressed well by any laws or policies?
   c. What are your main policy priorities over the next five years?
   d. How will these policy priorities support DOH as the main agency for health?
3. How effective would you say the gender and development focal point system is?
   a. Which systems, in which agencies or departments, are particularly effective? Why?
   b. How might other systems be strengthened?
4. How well-implemented is the GAD planning and budget policy?
   a. What successes have you seen?
   b. What are the challenges?
   c. What are some typical activities that are included in the GAD plans?
5. How well do the existing Women and Child Protection Units function?
   a. Probe regarding organizational structure, facilities and supplies, personnel, services, and research. (Refer to policy for standards for each of these areas.)
6. What is the status of implementing the newly revised AO on Women and Child Protection Units?
   a. What are some successes in implementation?
   b. What are the challenges?
7. What government offices or departments do you work with to develop or implement health policies?
   a. How effective would you say these partnerships are?
   b. What improvements in outcomes resulted from these partnerships, if any?
   c. What assistance does your office provide to DOH in terms of addressing gender issues/disparities in policy development and implementation? What works well? What could be improved?
8. Tell me about your involvement in the Official Development Assistance Gender and Development Network. What are some of the main accomplishments of the network? What have been some challenges?

9. Tell me about your involvement in the Inter-Agency Council on Violence Against Women and Their Children. What are some of the main accomplishments of the council? What have been some challenges?
10. How do you collect or use sex- and age-disaggregated data to monitor policy implementation? What successes and challenges have you faced in monitoring how policies impact women and men differently?
11. Does your agency have a gender strategy? If so, how was it developed? (Ask for a copy of the strategy.)
12. Have you participated in any gender-related trainings?
    a. If so, describe the training (who was involved, who led the training, how many hours, etc.).
    b. What were some of the key highlights of the training?
    c. If so, do you feel that the training was sufficient?
    d. If not, what kind of training would you or your staff like to participate in with regard to integrating gender into your work?
13. Has any of your staff ever participated in any gender-related training?
    a. If YES: Did staff report finding the training useful? Sufficient? Worthwhile?
    b. If NO: Why have staff never had the opportunity to participate in gender-related training?
    c. Do you have any training materials that you could share with us?
14. Do you have anything else to add that you think would be important for us to take into consideration?

Key informant interview questions: Local Government Units (LGUs)

1. In your work in FP or MNCH, what would you say are the major gender equality issues that affect women's and men's 1) health and 2) access to services?
    a. Have these obstacles changed over time?
2. How do national and LGU-level policies address the inequalities mentioned? (Summarize responses from Q.1.) Name specific policies and explain how they address inequalities between women and men.
    a. How well-implemented is (name policy)? What works well? What could be improved?
    b. Are there any actors opposed to this policy? Why are they opposed?
    c. Are there any inequalities that are not addressed well by any laws or policies?
3. Have you identified issues specific to women or men (or girls and boys) that prevent them from participating in or benefiting fully from your programs as they have been implemented?
    a. If YES: What are these and how have you tried to address them? What was the result of these efforts?
    b. To what extent do you think services in your sector are addressing gender inequality in ways other than including women as targets for services?
4. How do you collect or use sex- and age-disaggregated data to monitor policy and program implementation? If gaps or inequalities are identified, how do you address them in your work?

5. Are you aware of any existing gender laws and policies in the Philippines or executive/ administrative policies or guidelines from your office?
    a. If YES: Please name them. How do you apply each of these policy frameworks in your work?
        i. Examples of laws include the Magna Carta of Women, Anti-Rape, Anti-Sexual Harassment, Anti-TIP, and the Women in Nation Building Act. Examples of office policies/guidelines include gender budgeting, gender-responsive planning, GBV prevention, and the creation of women health action teams.
    b. Does your LGU conduct annual GAD planning and budgeting? Please describe what this process entails.
    c. As a part of the GAD planning process, has your agency conducted a gender audit? What were the results? How were any gaps addressed?
    d. What percentage of your budget is allocated to GAD? What kinds of activities fall under the GAD category?
6. Are there any policies or programs that provide especially strong examples and model good practices in promoting gender equality in the Philippines?
    a. Are there any policy gaps that need to be addressed?
7. What government offices or departments do you work with to develop or implement health policies? (Probe for PCW, Women and Children Protection Units, and other bodies responsible for promoting gender equality.)
    a. How effective would you say these partnerships are? What improvements in outcomes resulted from these partnerships, if any?
8. Has the LGU established a gender and development focal point system?
    a. Who participates in this system?
    b. What is the overall role of the system? What is the system's role in policy formulation and implementation, if any?
    c. How might the system be strengthened as a gender champion?
9. Have you participated in any gender-related trainings?
    a. If YES, describe the training (what year, who was involved, who led the training, how many hours, etc.).
    b. What were some of the key highlights of the training?
    c. Do you feel that the training was sufficient?
    d. What kind of training would you like to participate in with regard to integrating gender equality into your work?
10. Has any of your staff ever participated in any gender-related training?
    a. If YES: Did staff report finding the training useful? Sufficient? Worthwhile?
    b. If NO: Why have staff never had the opportunity to participate in gender-related training?
11. How well do the existing Women and Their Children Protection Units function?
    a. Probe regarding organizational structure, facilities and supplies, personnel, services, and research. (Refer to policy for standards for each of these areas.)

12. What is the status of implementing the newly revised AO on Women and Child Protection Units?
    a. What are some successes in implementation?
    b. What are the challenges?
13. Has a VAW [Violence against Women] desk been established in your *barangay*? How well does the VAW desk function? What do you see as the key successes and challenges?
14. Do you have anything else to add that you think would be important for us to take into consideration?

Key informant interview questions: Donors

1. What are the gender-based constraints that affect the health of males and females and their access to services? How do these vary by region or province?
2. As a donor, what are your major contributions to addressing these gender-related obstacles to health? How are other donors contributing?
3. Are you aware of any existing gender laws and policies in the Philippines or executive/administrative policies or guidelines from your office?
    a. If YES, what are these laws and policies and how do you contribute to implementation?
    b. What is the role of donors in implementing the GAD planning and budget policy?
4. How active are you in the Official Development Assistance Gender and Development Network? How effective is this network in coordinating efforts to address gender inequality?
5. What additional government structures do donors interact with to coordinate and plan health programming? What about specifically to address gender-related issues?
6. Where have you seen progress in addressing gender inequalities? Are there any policies or programs that provide especially strong examples and model good practices?
7. As a donor, does your government have a specific gender equality policy? If YES: Does this policy include female empowerment? Does it include efforts to prevent and respond to gender-based violence?
8. Do you have a gender strategy at the organizational or project level? If so, how was it developed? (Ask for a copy of the strategy.)
9. Have you participated in any gender-related training?
    a. If so, describe the training (who was involved, who led the training, how many hours, etc.)
    b. What were some of the key highlights of the training?
    c. If so, do you feel that the training was sufficient?
    d. If not, what kind of training would you or your staff like to participate in with regard to integrating gender into your work?
10. Has any of your staff ever participated in any gender-related training?
    a. If YES: Did staff report finding the training useful? Sufficient? Worthwhile?
    b. If NO: Why have staff never had the opportunity to participate in gender-related training?
11. Do you have anything else to add that you think would be important for us to take into consideration?

Key informant interview questions: NGOs and USAID implementing partners

1. In your work in FP and MNCH, what would you say are the major gender issues impacting women's and men's access to and use of health services? Have these changed over time?
2. Please give a brief overview of your program(s) and major projects. Do they include any components specifically designed to address gender inequalities? Any specific components designed to address gender-based violence? (Probe for various gender barriers and strategies to overcome these barriers. Targeting women as beneficiaries does not qualify as "addressing gender.")
3. Have you identified issues specific to women or men or to girls and boys that prevent them from participating in or benefiting fully from your programs as they have been implemented? If YES: What are these and how have you addressed them?
4. Do you have any "good practice" examples from your programs with respect to integrating attention to gender issues?
5. Are you aware of any existing gender laws and policies in the Philippines or executive/administrative policies or guidelines from your office?
    a. If YES: What are these laws and policies? How do your projects and programs support the implementation of these policies?
        i. Examples of laws include the Magna Carta of Women, Anti-Rape, Anti-Sexual Harassment, Anti-TIP, and the Women in Nation Building Act. Examples of office policies/guidelines include gender budgeting, gender-responsive planning, GBV prevention, and the creation of women health action teams.
6. How does your organization work with government agencies in addressing gender issues/disparities? How about other NGOs?
7. Is there someone on your staff who is responsible for ensuring that attention to gender equality is integrated across your organization's portfolio or within specific activities? If YES: What is their role? If NO: Why not?
8. Does your organization have a gender equality strategy? How and when was it developed? How is it being implemented?
9. In your program, do you collect sex- and age-disaggregated data? If gender gaps or inequalities are identified, how do you address them in your work?
10. Have you participated in any gender-related training?
    a. If so, describe the training (who was involved, who led the training, how many hours, etc.).
    b. What were some of the key highlights of the training?
    c. If so, do you feel that the training was sufficient?
    d. If not, what kind of training would you or your staff like to participate in with regard to integrating gender into your work?
11. Has any of your staff ever participated in any gender-related training?
    a. If YES: Did staff report finding the training useful? Sufficient? Worthwhile?
    b. If NO: Why have staff never had the opportunity to participate in gender-related training?

12. To what extent do you think the projects in your current health portfolio are addressing gender inequality and gender-based violence in ways other than including women as targets for services?
13. Do you have anything else to add that you think would be important for us to take into consideration?

Stakeholders and Partners in Gender Integration

Stakeholder	Main function	Main activities or focus areas

Interview guides adapted from

Interagency Gender Working Group and Population Reference Bureau. 2013. *A Practical Guide for Managing and Conducting Gender Assessments in the Health Sector*. Available at: http://www.igwg.org/publications.aspx.

MEASURE Evaluation. 2011. "Tools for Data Demand and Use in the Health Sector." Available at: http://www.cpc.unc.edu/measure/tools/data-demand-use/data-demand-and-use-strategies-and-tools.html.

World Health Organization, 2012. "Landscape Analysis on Countries' Readiness to Accelerate Action in Nutrition: Country Assessment Tools." Available at: http://www.who.int/nutrition/publications/landscape_analysis_assessment_tools/en/.

ANNEX F: RECORD OF THE GENDER, POLICY, AND MEASUREMENT (GPM) TEAM: 31 INTERVIEWS

February 8–22, 2014, Philippines—Team members: Rachel Kiesel, Elisabeth Rottach, Mardi Mapa-Suplido

Date	Time	Activity	Venue	Met with (actual)
Monday, Feb. 10	9–11 a.m.	Meet with U.S. Agency for International Development (USAID) Office of Health at U.S. Embassy	Conference room 320–321, NOX2 Building, US Embassy	• Judy Chen • Tata Anonuevo • Helen Hipolito • Dr. Milton Amayun • Ma Paz De Sagun • David Dereck Golla VI • PRM - Fatima Verzosa
	11:30–12:30 p.m.	Courtesy call with USAID Mission Director and/or Deputy Director		• Gloria Steele • Reed Aeschliman
	1–2:30 p.m.	Meet with National Economic Development Authority (NEDA)	4th floor conference room of DDG Esguera, NEDA Ortigas	• Dir. Erlinda Capones – Social Development • Ed Aranjuez
	3–5:30 p.m.	Meet with Philippine Commission on Women (PCW)	PCW in Malacanang	• Miyen Versoza – PCW Executive Director • Mel Silva – PCW Deputy Executive Director for Operations • Nharleen Millar – PCW Technical Services Chief • Anette Baleda – PCW Policy Development and Advocacy Chief • Christine Saquiban –Protective Services, Department of Social Welfare and Development (DSWD) • Luvy Villanueva – GREAT Women Project • Mary Grace Madayag – Philippine National Police, Women and Children Protection Center • Josephine Sasuman – PCW • Cherry Mae Tadeo – PCW office of the executive director

Date	Time	Activity	Venue	Met with (actual)
Tuesday, Feb. 11	9–11 a.m.	Meet with Department of Health (DOH)	Resource Learning Center Conference Room, Health Policy Development and Planning Bureau, Bldg. 3, DOH	• Dr. Maryann Bello –Division Chief, Bureau of International Health Cooperation (BIHC) • Ria de Guzman –Senior Health Planning Officer, Health Policy Planning and Development Bureau (HPDPB) • Dr. Melissa Sena – Medical Specialist • Josephine Salansang – Gender and Development (GAD) Focal Point/Planning • Antonina Cueto – Planning Officer, HPDPB • Brenda Panganiban – BIHC • Ligaya Catman – Safe Motherhood Program • Grace Fernando - Administrator, Human Resources
	1:30–4 p.m.	Small group discussion with USAID-funded health projects	PRISM2 Conference Room, 3rd floor, Rockwell Center, Ortigas Avenue, Pasig City	• Lem Marasigan – Deputy Chief of Party (DCOP), PRISM2 • Dianne Arboleda – Gender, PRISM2 • Dr. Alex Herrin – Chief of Party (COP), Luzon Health • Dr. Babes Benabaye – DCOP, Luzon Health • Allan Millar – USAID Health Policy Development Program, Phase 2 (HPDP2) • Eugene Caccam – Gender, IMPACT Foundation
	4:30–5:30 p.m.	Meet with GAD Focal Point of Quezon City (QC)	GAD office, QC Hall	• Marilou Cerilla – Monitoring Officer, GAD Resource and Coordinating Office (RCO) • Cariza Anne Laguardia – Programs, GADRCO • Anna Fajardo – Administrative Officer, GADRCO
Wednesday, Feb. 12	10–11:30 a.m.	Meet with health/gender civil society organizations (CSOs)	QC Science Interactive Center	• Atty. Claire Padilla – Executive Director, Engender Rights
	1–2 p.m.	Meet with Quezon City Health	QC Hall	• Dr. Anonieta Inumerable – City Health Officer
	2:30–3:30 p.m.	Meet with health/gender CSOs	Likhaan Office, Mindanao Avenue, QC	• Dr. Junice Melgar – Executive Director, Likhaan Center for Women's Health, Inc.
	4–5 p.m.	Meet with health/gender CSOs	University of the Philippines (UP) Alumni Building, UP Diliman	• Ben de Leon – President, Forum for Family Planning and Development

Date	Time	Activity	Venue	Met with (actual)
Thursday, Feb. 13	2–5.p.m.	Meet with the Provincial Council of Women of Negros Occidental	Technology and Livelihood Development Center office, Provincial Capital, Bacolod City	• Marie June Castro – Pilipina • Wenonah Martyr – District 2, LHZ • Allore Tambanillo – Pontevedra • Eden Ligason – La Castellana
Friday, Feb. 14	9–11 a.m.	Meet with PRISM2 and private partner	L'Fisher Hotel	• Ruby de Paula – Prism 2, Local Market Area Manager (LMAM) • Edith Villanueva – President, Sugar Industry Foundation, Inc. (SIFI)
	11 a.m.–Noon	Meet with Visayas Health (VH) and provincial health office (PHO) partners		• Dr. Joni Dichosa – Regional Technical Advisor for Western Visayas, VH • Lucille Titular – Provincial Coordinator, VH • Marissa Santiago – Provincial Maternal Coordinator, PHO • Maria Celia Fuentebaja – Family Planning Coordinator, PHO
	1:30–2:30 p.m.	Visit the Teresita L. Jalandoni Provincial Hospital	Barangay Lantad, Silay City	• Dr. Girlie Pinongan – Hospital Chief • Violence against Women Coordinator (VAWC) • Women and Child Protection Unit (WCPU) social worker
	3–5 p.m.	Visit a PRISM2 SIFI project site	Barangay Concepcion, Talisay	• William Malan – Barangay Captain • Barangay Kagawad for Health • Barangay Midwife • 6 Family Wellness Action Team (FWAT) members
Monday, Feb. 17	9–10:30 a.m.	Meet with Autonomous Region of Muslim Mindanao (ARMM) regional government and health officials	Seda Abreeza Hotel	• Dayang Jumaide – Assistant Secretary, DOH, ARMM • Dr. Sharifa Pearlsia Danz – Assistant Regional Secretary, Department of the Interior and Local Government (DILG), ARMM
	10:30 a.m.–Noon			• Irene Tillah – Executive Director, Regional Commission on Bangsamoro Women

Date	Time	Activity	Venue	Met with (actual)
	1:30–3 p.m.	Small group discussion with Mindanao CSOs	Seda Abreeza Hotel	• Atty. Alpha Pontalan – Nisa Ul-Haqq Fi Bangsamoro
	3–4:30 p.m.			• Dr. Darleen Estuart – Head, Brokenshire Women Center
Tuesday, Feb. 18	9–10:30 a.m.	Meet PRISM2 and MindanaoHealth partners	PRISM2 office	• Dr. Fides Ababon – Family Planning Organization of the Philippines/Davao and Jerome Foundation
	10:30 a.m.–Noon			• Lorna Mandin – Officer in Charge, Davao City Integrated Gender and Development Division • Dr. Lady Castillo – PRISM2 LMAM • Dr. Dolly Castillo – MindanaoHealth COP • Dr. Jun Naraval – Gender, MindanaoHealth
				• Flor "Choi" Lucas – Davao del Norte PHO • Denver Caparida – DOH Center for Health Development (CHD)
	1–3 p.m.	Visit health project site	Davao City	• Erlinda Padilla – Owner/midwife, EUP Family Care and Maternity Clinic • Dr. Amy Bretana – Pediatrics Consultant, WCPU of the Southern Philippines Medical Center
Wednesday, Feb. 19	9–10 a.m.	Meet with donor agencies	Oxfam offices – Metro Manila	• Jing Pura – Gender Justice Coordinator, Oxfam
	10:30–11:30 a.m.		World Bank (WB): Saranggani Room, 25th Floor, One Global Place	• Dr. Bobby Rosadia – Health team, WB • Dr. Bakhuti Shengelia – Health team lead, WB
	1–2 p.m.		RCBC	• Pamela Averion – Gender-Based Violence Coordinator, United Nations Population Fund
	2–3 p.m.		Joint United Nations Programme on HIV/AIDS (UNAIDS) office, 3rd Floor, Rizal Commercial Banking Corporation	• Bai Bagasao – Country Manager, UNAIDS

Date	Time	Activity	Venue	Met with (actual)
	4–5 p.m.	Meet with Commission on Population (POPCOM)	Mandaluyong	• Rose Marcelino – Deputy Executive Director, POPCOM • Lyneth Monsalve – Officer in Charge,, Administrative Division, POPCOM • Lota Layser – Director, Regional Population Office IV, POPCOM
Thursday, Feb. 20	9–10 a.m.	Meet with DSWD	DSWD	• Cynthis Lagasca – Chief, Planning and Monitoring Division (PDPB) • Jennifer Joy Dumaraos – Planning Officer, Pantawid Pamilyang Pilipino Program (4Ps), PDPB
	11 a.m.–Noon	Meet with gender CSOs	Room 130, Fonacier Hall, UP Alumni, UP Diliman	Woman Health: • Princess Nemenzo – National Coordinator • Mercy Fabros – Advocacy and Campaign Coordinator • Mayi Fabros – Young Women Collective Coordinator
Friday, Feb. 21	9–11:30 a.m.	Meet with USAID GPM team to discuss initial results of assessment and next steps	U.S. Embassy / USAID Office: Claire Phillips Conference Room	• USAID Office of Health o Judy Chen o Tata Anonuevo o Milton Amayun • Allan Millar – HPDP2

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