

**International  
Institute of  
Social Studies**



***Impermeable: Assessing Evidence-Based Policymaking in  
Sexual and Reproductive Health in the Philippines***

A Research Paper presented by:

***Dana Michelle C. Del Rosario***

(Philippines)

in partial fulfilment of the requirements for obtaining the degree of  
**MASTER OF ARTS IN DEVELOPMENT STUDIES**

Major:

**Governance and Development Policy**

(GDP)

Specialization:

**Public Policy and Management**

(PPM)

Members of the Examining Committee:

Dr. Naomi van Stapele

Dr. Erhard Berner

The Hague, The Netherlands

December 2019

***Disclaimer:***

This document represents part of the author's study programme while at the International Institute of Social Studies. The views stated herein are those of the author and not necessarily those of the Institute.

***Inquiries:***

International Institute of Social Studies  
P.O. Box 29776  
2502 LT The Hague  
The Netherlands

t: +31 70 426 0460  
e: [info@iss.nl](mailto:info@iss.nl)  
w: [www.iss.nl](http://www.iss.nl)  
fb: <http://www.facebook.com/iss.nl>  
twitter: [@issnl](https://twitter.com/issnl)

***Location:***

Kortenaerkade 12  
2518 AX The Hague  
The Netherlands

# Contents

<i>List of Tables</i>	4
<i>List of Figures</i>	4
<i>List of Annexes</i>	4
<i>List of Acronyms</i>	4
<i>Abstract</i>	8
<b>Chapter 1 Introduction</b>	<b>9</b>
1.1. Statement of the Problem	9
1.2. Contextual Background	11
1.2.1. Sexual and Reproductive Health Politics in the Philippines	11
Historical Context and the Role of Religion	11
Changing Times, Changing Policies	12
1.2.2. Controversies on Abortion, Contraception Provision, and Sexuality Education for Adolescent Women	13
1.2.3. The Responsible Parenthood and Reproductive Health (RPRH) Law and the Universal Health Care (UHC) Law	14
1.2.4. The Department of Health (DOH) as Central Health Agency in a Decentralised Health System	21
1.3. Research Objectives	23
1.3.1. Research Questions	23
1.4. Limitations of the Study	24
1.5. Outline of the Study	24
<b>Chapter 2 Key Concepts in Evidence-Based Policymaking (EBPM) and the Analytical Framework of the Study</b>	<b>25</b>
2.1. The Role of Evidence in Public Health Policymaking and Evidence-Based Public Health	25
2.2. The Politics of Sexual and Reproductive Health Policymaking: Agenda-Setting and Policy Formulation	30
2.3. Combining Institutional Analysis and Development (IAD) and the Multiple Streams Approach (MSA) as a Framework for Analysing Evidence-Based Policymaking	32
2.3.1. Institutional Analysis and Development (IAD) Framework	32
2.3.2. Multiple Streams Approach (MSA) in Policy Process Analysis	34
<b>Chapter 3 Research Methodology</b>	<b>36</b>
3.1. Qualitative Approach	36
3.1.1. Desk Review of Policy and Programme Documents	36
3.1.2. Key Informant Interviews	36

3.2. Ethics and Positionality	37
3.3. Challenges in Data Gathering	37
<b>Chapter 4 Discussion and Analysis of Data</b>	<b>38</b>
4.1. Assessing Evidence-Based Policymaking in the DOH through the Institutional Analysis and Development (IAD) Framework and Multiple Streams Approach (MSA)	38
4.1.1 External and Internal Factors affecting Sexual and Reproductive Health (SRH) Policymaking in the DOH	39
4.3. Challenges Experienced by the Public Sector in Evidence-Based Policymaking	41
4.3.1. Political Challenges	42
4.3.2. Technical Challenges	42
<b>Chapter 5 Conclusions and Policy Recommendations</b>	<b>42</b>
<i>References</i>	<b>50</b>

## List of Tables

Table 1.1 Summary of Policies, Programmes, and Interventions on ASRH after the passage of the RPRH Law	19
Table 2.1 Phases in the Process and Corresponding Evidence Needs in Public Health Policymaking	30
Table 3.1 List and Coding of Key Interviews	37

## List of Figures

Figure 2.1 Domains influencing Decision-making in Public Health Policymaking	27
Figure 2.2 Framework for Institutional Analysis	33
Figure 4.1 Institutional Analysis in this study	40

## List of Annexes

Annex 1 Provisions pertaining to conscientious objection in the RPRH Law	47
Annex 2 Coding and Details of Key Informant Interviews	48
Annex 3 Programs and Services of the Department of Health (DOH) relative to the 12 Elements of the RPRH Law (As of 2017)	49

## List of Acronyms

ABR	Adolescent Birth Rate
AO	Administrative Order
ASRH	Adolescent Sexual and Reproductive Health
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
DBM	Department of Budget and Management
DILG	Department of Interior and Local Government
DC	Department Circular
DepEd	Department of Education
DO	Department Order
DOH	Department of Health
DSWD	Department of Social Welfare and Development
EBPH	Evidence-Based Public Health
EBPM	Evidence-Based Policymaking
EO	Executive Order
EU	European Union
FDA	Food and Drug Administration
FP	Family Planning
GAD	Gender and Development
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HRW	Human Rights Watch
IAD	Institutional Analysis and Development
ICPD	International Conference on Population and Development
IRR	Implementing Rules and Regulations
ISS	International Institute of Social Studies
JICA	Japan International Cooperation Agency
LGU	Local Government Unit
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Rate
MSA	Multiple Streams Approach
NEDA	National Economic and Development Authority
NDHS	National Demographic and Health Survey
PCW	Philippine Commission on Women
PhilHealth	Philippine Health Insurance Corporation
PopCom	Population Commission
PNAC	Philippine National Aids Council
PSA	Philippine Statistics Authority

RH	Reproductive Health
RPRH	Responsible Parenthood and Reproductive Health
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STDs/STIs	Sexually Transmitted Diseases/Sexually Transmitted Infections
UHC	Universal Health Care
UNDP	United Nations Development Programme
UNICEF	United Nations International Children's Emergency Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

## Acknowledgements

It has been a whirlwind year of being away from home, spending sleepless nights doing frantic reading, and doing early morning hurried walks to classes, but I do not regret a thing. Studying at the International Institute of Social Studies (ISS) has opened my eyes to the world. More than a year ago, I thought I was already mindful and aware, but nothing prepared me for what I had experienced in my time at Kortenaerkade 12, Den Haag.

Horace Mann once famously said that “education then, beyond all other devices of human origin, is the great equaliser of the conditions of men, the balance-wheel of the social machinery,” and nowhere has this been more true than at the ISS. It was liberating to have been able to interact freely with classmates, professors, and school officials and administrators without being censored or criticised for having a different view or opinion. In return, I learned to tolerate, accept, and understand others’ views and opinions, and in the process gained more knowledge about the world and myself—my position and my role—albeit how small it may be in the grand scheme of things. Needless to say, I owe this institution a great deal, and to whom I will always be grateful.

I take the liberty to extend my deepest gratitude to the people and institutions that have also helped me in this journey:

To my supervisor and second reader, Dr. Naomi van Stapele and Dr. Erhard Bernard, for your time, patience, and invaluable insights. I would not have been able to finish this paper without your support and interest in my work.

To Stephen (and Charlie & Max), for the technical help, and of course, for making life colorful. I’m thankful everyday for the chance to have a life with you in the future, and I am looking forward to the time we are on the same land again.

To my family, for always being my rock throughout all the challenges, and my anchor throughout all the best moments in my life.

To my 13D sorority sisters at UP Delta Lambda Sigma, thank you for being my constant ladies. I owe you girls a lot of *kwent*.

To my Den Haag ‘Brown Panthers,’ I’m lucky to have met you all. You made the stay in a cold, wet country worth it. I’m excited to see what we will achieve in the coming years.

To my classmates in ISS who have shared their culture and welcomed mine, it was great knowing you all. We will see each other again someday, somewhere.

To my respondents from the Department of Health (DOH), the Population Commission, and the UNFPA, thank you for giving me your time and expertise. I would not have finished my paper without your valuable responses.

To my friends at the DOH, and to my former boss, Secretary Francisco T. Duque III, for the good memories and for helping pave the way for me to study abroad.

To Batch XXVII, my colleagues at the Department of Foreign Affairs, who have been very supportive of my ‘thesis writing’ since day one, thank you. You all add fun and substance to everyday of cadetship.

And finally, to ISS, and the Dutch government’s Nuffic, for the opportunity to live and study in The Netherlands. You change countless lives with your Orange Knowledge Programme.

Altiora Peto!



## **Abstract**

Adolescents in the Philippines face many sexual and reproductive health risks, with women particularly more susceptible to bearing the consequences of these risks, including unintended pregnancies, maternal morbidity and/or mortality, and complications or death from unsafe illegal abortions. While the Responsible Parenthood and Reproductive Health (RPRH) Law has been deemed a step forward in ensuring that adolescents' sexual and reproductive health needs are met, policies ultimately determine the level and quality of service that is provided. This paper looks into sexual and reproductive health policymaking in the Philippines, as carried out by the Department of Health (DOH) under the framework of the RPRH Law and the more recent Universal Health Care (UHC) Law. It explores the dynamics within the Department, and identifies possible external and internal factors that affect policymaking. Ultimately, it examines the extent of the effects of these factors on evidence-based policymaking in sexual and reproductive health in the Philippines.

## **Relevance to Development Studies**

This research is a contribution to the literature on sexual and reproductive health politics and dynamics of health governance in developing countries. Particularly, it presents an interesting case of understanding the policy process in the field of sexual and reproductive health in the Philippines from the point of view of government policymakers. This paper also aims to understand the dynamics of evidence-based policymaking in the public health arena, or what is called evidence-based public health, and identify possible issues, in the hopes that research will, in its own way, contribute to reform and overall betterment of future public health policymaking in the Philippines.

## **Keywords**

sexual and reproductive health, adolescent sexual and reproductive health, public policy, public health, evidence-based policymaking, evidence-based public health, policy analysis, Philippines

# Chapter 1

## Introduction

“If women and men are to make appropriate use of available sexual and reproductive health services, they need more than instructions, inducements or admonishments. In many parts of the world, women may have little or no access to the kind of information on side-effects and risks that they need to make an informed choice - or, indeed, to safeguard their health.” (Cornwall 2002: 220)

The Philippines is quite a curious case to study in terms of gender, sexuality, and human development. While it is consistently ranked high as a gender equal country (the World Economic Forum ranks it 8th in its 2018 Global Gender Gap Index Report), and many Filipino women are highly successful in both public and private sectors (the Philippines has already had *two* female Presidents within the last thirty years), there exist many contradictions which prove that much work still needs to be done in the system, particularly in public health governance.

Perhaps the most obvious contradiction can be found in the inadequacy of sexual and reproductive health services. Even after the passage of the Responsible Parenthood and Reproductive Health (RPRH) Act of 2012, commonly referred to as the RH Law, there still exist strong state-sanctioned obstructions in women’s sexual and reproductive lives. Although many women still choose motherhood and marriage, their choices are in reality very restricted when it comes to sexual and reproductive health and family planning services: for example, abortion is still *unconditionally illegal*.

Filipino women, especially the young and vulnerable, continue to endure sexual and reproductive health issues, such as unplanned pregnancy and gender-based sexual violence, which greatly affect their future and participation in the economy, and yet a comprehensive sexual and reproductive health education is still not part of the formal education curriculum. Indeed, despite the implementation of the RPRH Law and institutionalisation of sexual and reproductive healthcare in the Philippines, and in the wake of the passage of the Universal Health Care (UHC) Law, policies are still lacking.

### 1.1. Statement of the Problem

Adolescents in the Philippines face many sexual and reproductive health risks, with women particularly more susceptible to bearing the consequences of these risks, including unintended pregnancies, maternal morbidity and/or mortality, and complications or death from unsafe illegal abortions. While the RPRH Law has been deemed a step forward in ensuring that adolescents’ sexual and reproductive health needs are met, policies ultimately determine the level and quality of service that is provided.

Adolescence is a risky period during which an individual experiences changes biologically, psychologically, and socially (Rankin et al. 2016: 7, citing Dick and Ferguson 2015), with sexual and reproductive health (SRH) playing a significant role in personal development, including future employment prospects and economic well-being, social or community status, and whether or not an adolescent reaches full potential (Rankin et al. 2016: 7, citing UNFPA 2014). During this period, adolescents encounter SRH risks and

challenges, including unplanned pregnancy and sexually transmitted diseases/infections (STDs/STIs).

Indeed, the numbers do not lie: as of 2017, the number of teenage pregnancies (those of 19 years and below) were recorded to have produced more than 200,000 live births (DOH 2017 Annual Report 2018). Only 35.8 percent of adolescents from 15 to 19 years old have access to any type of family planning method, including traditional ones, and only 29.7 percent have access to *any* modern method at all (DOH 4th Annual RPRH Report 2018: 7). Contraception use continues to remain low among women from poorer classes due to lack of access to and high costs of contraception, weak information dissemination, and strong opposition of conservative groups (Cabral 2014).

Furthermore, only 21.6% of adolescent women from 15 to 19 years old<sup>1</sup> with multiple partners use condoms, as condom use is currently being promoted as part of the HIV/AIDS prevention programme and not as a family planning method; and only 1 in 6 women in the same age group have comprehensive knowledge of HIV prevention (DOH 4th Annual RPRH Report 2018: 7). Based on most recent data, 9 percent of women aged 15 to 19 reported having been pregnant in 2017—higher than the recorded 7 percent in 1993, but slightly lower than the recorded 10 percent in both 2008 and 2013 (PSA and ICF 2018: 61). Nevertheless, adolescent pregnancies in the Philippines are higher than the average of 40 per 1000 women in Southeast Asia (Melgar et al. 2018: 2).

Although abstinence is still the primary method of preventing pregnancy among adolescents, data shows that the number of women aged 15 to 19 reporting to have engaged in sex increased from 9.1 percent in 1993 to 14.7 percent in 2013; however, the use of modern contraception in the same age group remains disproportionately low at 2.4 percent (up from 0.7 percent) in the same period (Melgar et al. 2018: 2). Even within adolescent partnerships, whether formal (legal) or informal (domestic), low contraception use can be observed; indeed, out of all age groups of married women, adolescents had the lowest rate of contraception use at 20.6 percent, with the highest unmet need at 28.7 percent (Melgar et al. 2018: 2).

Further, data on maternal death shows that adolescent pregnancies are a significant contributor to the high maternal mortality rate (MMR) in the Philippines.<sup>2</sup> Adolescent pregnancies have also been identified as contributing to early childhood deaths. The age of the mother, particularly if 18 and below, is associated with an increased risk of mortality in children below 5 years of age (Melgar et al. 2018: 2). Data from the Philippine Health System Review (PHSR) show that approximately 114 women die from birth complications per 100,000 live births as of 2015 data (Dayrit et al. 2018: 17).

---

<sup>1</sup> This study refers to data on adolescent women aged 15 to 19, based on the Department of Health's decision to monitor this age group for teenage or unplanned pregnancies (using the indicator Adolescent Birth Rate (ABR) in its Service Delivery Pillar), which was in turn based on WHO recommendation. Focusing on this age group makes it easier to carry out country comparisons. *See* DOH Administrative Order No. 2019-003, or 'The FOURmula One (F1) Plus for Health Monitoring and Evaluation (M&E) System.'

<sup>2</sup> The actual percentage of maternal deaths among women of 15 to 19 years cannot accurately be represented due to the way maternal death is recorded in the Philippines. (Melgar et al. 2018: 2)

Based on a recent assessment using World Health Organisation (WHO) indicators,<sup>3</sup> it has been determined that the RPRH Law and other related documents on sexual and reproductive health care provision are “strongly in agreement with the human rights of adolescents in contraception,” although there are existing laws and policies that were identified to “impose substantial restrictions on human rights” (Melgar et al 2018: 9). Clearly, the legal and policy framework are in place (notwithstanding the prohibition on emergency contraception and the criminalisation of abortion), and institutions exist to cater to the needs of adolescents, the supply side, yet data still show high unmet needs among adolescents, the demand side, particularly women between 15 to 19 years of age.

This paper looks into sexual and reproductive health policymaking in the Philippines, as carried out by the Department of Health (DOH) following the implementation of the RPRH Law, and the more recent passage of the Universal Health Care Law (UHC). It explores the dynamics within the Department, and identifies the external and internal factors that affect policymaking. Ultimately, it examines the extent of the effects of these factors on evidence-based policymaking in the context of sexual and reproductive health policies in the Philippines.

## **1.2. Contextual Background**

### **1.2.1. Sexual and Reproductive Health Politics in the Philippines**

#### *Historical Context and the Role of Religion*

The Philippines remains the most predominantly Catholic country in Asia, with 79.5 percent of its population identifying as Roman Catholic based on 2015 census data (Philippine Statistics Authority 2017). Issues on sexual and reproductive health are not often discussed, or when discussed, are usually in terms of health indicators, such as maternal mortality rate, or the prevalence of STIs. Discussions on controversial issues such as abortion or sexuality education are often highly politicised and subjected to religious influences, making it hard to implement policies that would address relevant pressing issues. A testament to this Roman Catholic influence is found in the 1987 Constitution of the Philippines. Article 2, Section 12 of the Constitution provides that the State “shall equally protect the life of the mother and the life of the unborn from conception,” reflecting the country’s strong ties to its religious values. This Constitutionally-mandated belief in protecting the ‘unborn’ has led to a repressive stance in many social policies, including the lack of sexual education in schools, the criminalisation of abortion, and the irregular distribution of contraception.

Despite such restriction in the Constitution, in the early 1990s it seemed like the Philippines was moving towards more progressive sexual and reproductive health policies when it adopted the framework set by the 1994 International Conference on Population and Development (ICPD). After the first cases of Human Immunodeficiency Virus (HIV) were recorded in the Philippines in 1984, the government responded to the outbreak by instituting more progressive health policies in the years that followed, including advocating condom use (HRW 2004). For a predominantly Catholic country, this was seen as a success: the number of reported HIV cases remained low in the years that followed. In a similar vein, however, the government was strengthening its campaign on advocating for

---

<sup>3</sup> Assessment was made against indicators from the 2014 *Ensuring Human Rights in the Provision of Contraceptive Information and Services* of the WHO. (Melgar et al. 2018)

natural methods of family planning to curb *population growth* and not to promote healthy sexuality.

Although the government's campaign on sexual and reproductive health in the early 1990s was successful, it was met with vehement opposition by the Catholic Church. Supported by the conservative movement, the Church condemned the use of contraception, denounced the message of pro-choice campaigns, and launched personal attacks against government officials who supported progressive policies. The government under then President Fidel Ramos (1992 to 1998) fought back against such resistance from the Church in favor of an evidence-based approach to resolve sexual health issues (HRW 2016).

### *Changing Times, Changing Policies*

In the late 1960s up until the mid-1980s, under President Marcos' dictatorship, the Philippine government embarked on a population growth reduction programme to promote socio-economic development in the country, with the introduction of fertility reduction by modern contraception as its primary strategy. After President Marcos was ousted, President Aquino, a devout Catholic, took over, and the Catholic church gained greater influence and was instrumental in limiting the programmes on contraception and family planning. While the ICPD was adopted in 1998 by the DOH, conservatives continued to lobby against a law on reproductive health and rights.

In the administrations that followed, the conservative movement, composed of the so-called *pro-life* groups, continued to perpetuate the restrictive beliefs and values encouraged by the Catholic church and embraced by traditionalist politicians, influencing all branches of government from the executive to the legislative and judiciary. Throughout the decades, these conservative beliefs have been used to block or deter progressive policies and initiatives in sexual and reproductive health, such as in the following well-known instances: i) banning of family planning services in the City of Manila and other local governments from 2000 until 2010 by decree of a *pro-life* Mayor;<sup>4</sup> ii) delisting by the Food and Drug Agency (FDA) of an emergency contraceptive pill and the drug *misoprostol* due to protests from pro-life groups between 2001 and 2002; iii) the decision of the Department of Health to promote 'natural' family planning methods from 2003 until 2010 under the administration of a conservative President; and, iv) the scrapping in 2009 of an adolescent sexuality education programme by the Department of Education (DepEd) after petitions from *pro-life* groups brought it up in litigation (Melgar et al. 2018: 9).

Additionally, the debate on abortion in the Philippines takes off from the constitutional definition of life and the interrelationship between religious values and social policymaking. In a controversial case<sup>5</sup> penned in 2014, the Supreme Court declared that life begins at the precise moment of fertilisation and not at implantation; thus, it ruled that the Implementing Rules and Regulations (IRR) of the RPRH Law had overstepped its bounds

---

<sup>4</sup> In 2015, the United Nations Committee on the Elimination of Discrimination against Women found in its decision (CEDAW/C/OP.8/PHL/1) that Executive Order 003, which took an "affirmative stand on pro-life issues", "resulted in a systematic denial of affordable access to modern methods of contraception and related information and services." (Social Protection and Human Rights 2015)

<sup>5</sup> *Imbong vs Ochoa*, G.R. No. 204819, April 8, 2014.

when it defined an ‘abortifacient’ as any drug or device that ‘primarily’ induces abortion. The Court deemed that such definition goes against the no abortion principle enshrined in the Constitution, as there are types of contraception that can act as abortifacients or prevent implantation, and ruled that only contraception that does not cause abortion nor prevent implantation should be included in the list of family planning supplies, the Essential Drugs List of the RPRH Law, and the Philippine National Drug Formulary System. The decision also struck down other provisions in the RPRH Law and its IRR, including those penalising health personnel, government employees, and health institutions that refuse or fail to provide services and programmes under the RPRH Law (Melgar et al. 2018).

### **1.2.2. Controversies on Abortion, Contraception Provision, and Sexuality Education for Adolescent Women**

In the last fifty years, the Philippines has adopted comprehensive health strategies and policies; however, many of these policies are not effectively translated into implementation primarily due to the country’s fragmented and decentralised health care system, including its service delivery and financing schemes (The World Bank 2017). Indeed, inequity in access to health services in the Philippines is determined by geographical region, urban or rural residence, wealth quintile, and gender and age: for example, young pregnant mothers in their first trimester (26.6 percent) from the poorest quintile (30 percent), living in rural areas (25 percent) in regions where the poverty incidence is high are less likely to have healthy pregnancies and more likely to be at risk (Dayrit et al. 2018: 17). Despite increasing access to healthcare services, adolescents’ unmet need for contraception, among others, still shows significance: in 2017, 27.9 percent of adolescent women aged 15 to 19 reported having unmet need for family planning (PSA and ICF 2018: 97).

While the passage of the RH law signified a shift in public opinion towards a more general acceptance of sexual and reproductive health, there are still challenges that persist, especially on the regulation of women’s sexuality and reproduction through the outright ban on abortion and the control of available contraception. As a signatory to international treaties that recognise and promote women’s health and rights, such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Philippines still needs to enact more policies that recognise women’s sexuality needs. Some provisions in existing laws and policies still impose restrictions on women’s health rights, including the requirement for parental and spousal consent to access contraception for those below the age of 18, and the prohibition on emergency contraception (alongside the requirement on the part of the government of certifying that contraception are not abortifacients).

The non-use of contraception, whether from lack of access to modern methods or from personal decision due to misconceptions and misinformation about its effects, has had a significant negative impact on women’s status: it has been found that there is a strong correlation between non-use of contraception and the incidence of unsafe abortion—indeed, a study showed that more than 50 percent of women who ended a pregnancy did not use any method of contraception thus causing the pregnancy (CRR 2010: 31). The unconditional criminalisation of abortion, which penalises both the woman undergoing an abortion and the person assisting the woman, has made it highly dangerous for women in the Philippines to exercise their right over their bodies by choosing to

terminate their pregnancies. Within the estimated 25 million women of reproductive age in the Philippines, unsafe abortion is cited as a leading cause of death (Upreti et al. 2018: 268). Annually, an estimated 610,000 Filipino women get abortions, with 100,000 hospitalised due to complications, and about 1,000 women dying from complications annually or roughly 3 women dying every day (Guttmacher Institute 2013: 3). About 17 percent of all unsafe abortions are estimated to be carried out on adolescent mothers (Conde 2005: no page).

In a traditional society such as the Philippines, the condemnation of abortion is deemed related to the concept of the gendered role of women in society as being a *life-giver* and a *mother*, and that those who choose not to have children are perceived as deviating from the norm (Guillaume and Rossier 2018). Similarly, sexuality is linked to a woman's decision to conform to the gendered role of being a *care-giver* and a *mother*, and thus, to undergo abortion is a manifestation of a deviant sexuality, especially *outside of marriage*. For adolescent women, the condemnation comes from the binary distinction between the *adult* and the adolescent “*person in transition*” who must be assisted in preventing pregnancy and remediating early childbearing's negative effects (Macleod 2003: 434).

Regarding sexual needs, the RPRH law recognises that adolescents have such, but that this should be addressed through provision of education and counseling. Although the RPRH Law explicitly provides for the provision of reproductive health services, it has no mention of contraception for adolescents, except that parental consent is mandatory for those below the legal age of 18. Further, the RH Law and its Implementing Rules and Regulations (IRR) prescribes the subjects that should be included in the ‘age- and development-appropriate reproductive health education,’ which tellingly does not explicitly include sexuality and contraception.

Further, the law provides that the flexibility in content, scope, and methodology can only be made after consultation with stakeholders such as parents, teachers, community associations, school officials, civil society organisations, and other interest groups (who were not identified); and that non-government schools can formulate their own curriculum on sexuality education and need not follow the DepEd's recommendation. Clearly, the RPRH Law provisions consider the interest of *pro-life* and other conservative groups that may oppose (as has been shown historically), any form of sexuality education in schools.

### **1.2.3. The Responsible Parenthood and Reproductive Health (RPRH) Law and the Universal Health Care (UHC) Law**

In 2012, after more than a decade of public argumentation and controversy, and in what was deemed a step towards the right direction, the Philippines passed the RPRH Law. Legally, the RPRH Law guaranteed universal and free access to modern contraception, especially for women who have no access to private health care. In reality, however, the RPRH Law is one of the least progressive reproductive health laws in the world: it reinforced the legal and criminal ban on abortion without any exceptions; it imposed a ban on purchasing dedicated emergency contraception by all national hospitals; and, it mandated that parental consent be required for minors (those below 18 years) to access contraception.

These legal restrictions continue to bring about stigma and continue to perpetuate the backward thinking to the detriment of Filipino women, especially poor and young

women. Sexual education is practically still a taboo, despite the growing problem on teenage and unplanned pregnancy, increased transmission of STIs among the youth, and the rising number of HIV/AIDS infection.

#### *Substantive Aspect*

As identified by the Department of Health (DOH), the key focus areas of the RPRH Law are the following: i) maternal, newborn, child health and nutrition, ii) family planning, iii) adolescent sexual and reproductive health, iv) sexually transmitted diseases, human immunodeficiency virus/acquired immunodeficiency disease syndrome (STD, HIV/AIDS), and, v) elimination of violence against women and children (DOH 4th Annual RPRH Report 2018: 3).

In the last half decade since the passage of the RPRH Law, the Philippine government has implemented policies and legislation that supported these key focus areas. There are, however, areas that are problematic, given the limitations on the law. Perhaps the most relevant to adolescent sexual and reproductive health is the provision of adequate sexuality education programmes on safe sex practices, which the Philippine government still has yet to accomplish. Despite the provision under the RPRH Law of “reproductive health and sexuality education” that can be achieved through a “lifelong learning process of providing and acquiring complete, accurate and relevant age- and development-appropriate information and education on reproductive health and sexuality through life skills education and other approaches,”<sup>6</sup> no sex education programme has been agreed upon between the DOH and the DepEd.

Under Rule 3, Section 3.01 (rr) of the RPRH Law, *reproductive health* is defined as:

“the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.”

It continues to add that:

“This implies that people are able to have a responsible, safe, consensual and satisfying sex life, that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. This further implies that women and men attain equal relationships in matters related to sexual relations and reproduction.”

*Reproductive health rights* is defined as:<sup>7</sup>

“the rights of individuals and couples, to decide freely and responsibly whether or not to have children; the number, spacing and timing of their children; to make other decisions concerning reproduction, free of discrimination, coercion and violence; to have the information and means to do so; and to attain the highest standard of

---

<sup>6</sup> Rule 3, Section 3.01 (uu)

<sup>7</sup> Rule 3, Section 3.01 (vv)



sexual health and reproductive health: Provided, however, That **reproductive health rights do not include abortion, and access to abortifacients.**” (Emphasis supplied)

Note that the position that abortion is illegal is highlighted in the above provision. *Sexual health*, on the other hand, is defined as:<sup>8</sup>

“a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free from coercion, discrimination and violence.”

Despite such inclusion in the definition, sexual health is lumped under “reproductive health care”<sup>9</sup> and the boundaries are not clearly specified, specifically:

“the access to a full range of methods, facilities, services and supplies that contribute to reproductive health and well-being by addressing reproductive health-related problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations.”

Thus, the provisions on sexual health mainly pertain to reproductive health, such as provided in the following:<sup>10</sup>

- “5. Prevention, treatment and management of reproductive tract infections (RTIs), HIV and AIDS and other sexually transmittable infections (STIs);
- 6. Age- and development-appropriate education and counseling on sexuality and reproductive health;
- x x x
- 10. Prevention, treatment and management of infertility and sexual dysfunction”

Despite the inclusion of *sexual health* in the definition, the law does not mention any specific provision on promotion of sexual health, particularly of adolescent women.

Interestingly, under SRH service provision, *conscientious objectors* are recognised, and defined in the RPRH Law as:<sup>11</sup>

“practicing skilled health professional who refuses to provide legal and medically safe reproductive health care within the scope of his or her professional competence, on the grounds that doing so is against his or her ethical or religious convictions.”

---

<sup>8</sup> Rule 3, Section 3.01 (aaa)

<sup>9</sup> Rule 3, Section 3.01 (ss)

<sup>10</sup> Rule 3, Section 3.01 (ss)

<sup>11</sup> Rule 3, Section 3.01 (i)

Note that conscientious objectors, or healthcare providers who have strong religious or moral objections to providing SRH services, are not required to provide the necessary SRH service to the requesting patient, or to refer the patient to a different healthcare provider upon refusal, as the Supreme Court has deemed unconstitutional this duty to refer.<sup>12</sup> While there are more conditions attached to this conscientious objection clause,<sup>13</sup> it admittedly causes inconsistencies in the delivery of ASRH services.

Additionally, the DOH has identified in its report several challenges in adolescents' access to quality ASRH services, particularly: i) non-inclusion of comprehensive sexuality education in school-based ASRH orientation; ii) barriers to access to family planning services at the service delivery level due to *conscientious objection* or provider bias, and lack of or limited knowledge and capacities to provide adolescent-friendly services; iii) lack of specific healthcare provider guidelines or manual for addressing the problem on closely spaced pregnancies among adolescents; iv) discrepancies in the overall quality of ASRH services nationwide; and v) unmet need of adolescents for family planning, particularly of teenage parents, owing to barriers in access to services (DOH 4th Annual RPRH Report 2018: 7). On the other hand, as of 2018 data, among the policy and legal interventions implemented by the DOH to address ASRH are the issuance and adoption of several program guides and manuals,<sup>14</sup> and the drafting and championing of several bills<sup>15</sup> in the Philippine Congress (DOH 4th Annual RPRH Report 2018: 7).

At the helm of the RPRH Law is the UHC Law, or Republic Act No. 11223, which was signed into law on February 2019, signifying the administration's further commitment to providing healthcare to all Filipinos. It is yet to be seen, however, if this move will further bolster the commitment to SRH and help address possible policy gaps. The UHC Law seeks to improve the four pillars of public health care in the Philippines as laid down by the government, namely: 1) Financing, 2) Service Delivery, 3) Regulation, and 4)

---

<sup>12</sup> As explained in the DOH Department Circular 2015-0195.

<sup>13</sup> The exact provisions pertaining to conscientious objection in the RPRH Law are provided in Annex 1.

<sup>14</sup> These include the following: 1) issuance of DOH Circular 2017-0165 on the national adoption of the Clinical Practice Guidelines for the Prevention, Diagnosis and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents in the Philippines; 2) issuance of DOH Department Memorandum 2017-0098 defining level of standards for Adolescent Friendly Facilities; 3) adoption and dissemination of Adolescent Health and Development Program Manual of Operations to program managers and implementers; and 4) updating of the Department of Education's curriculum from Kinder to Grade 12 (known as K-12) to meet the Comprehensive Sexual Education standards for the Philippines (DOH 4th Annual RPRH Report 2018: 7).

<sup>15</sup> These include the following: 1) Republic Act No. 11166, or the Philippine HIV and AIDS Policy Act, lowering the minimum age to 15 years for availment of HIV testing and counseling without needing parental consent for adolescents, from the current minimum age of 18 years, which came into law on July 2019; 2) House Bill 04742, or An Act Providing for a National Policy in Preventing Teen Pregnancies, Institutionalizing Social Protection for Teenage Parents, and Providing Funds Therefor, and counterpart Senate Bill 1482, or Prevention of Adolescent Pregnancy Act of 2017; 3) House Bill 05777, or An Act Strengthening the National and Local Health and Nutrition Programs for Pregnant and Lactating Women, Adolescent Girls of Reproductive Age and Teenage Mothers, Infants and Young Children in the First 1,000 Days (DOH 4th Annual RPRH Report 2018: 7).

Governance. The UHC Law also seeks to implement reforms in the mandates, jurisdiction, and core responsibilities of agencies that form part of the country's universal health care programme, primarily the DOH and PhilHealth. In other words, the UHC Law seeks to improve health care coverage in the Philippines, with the ultimate goal of providing universal health coverage for all Filipinos.

The UHC Law does not have any specific provisions on sexual and reproductive health, as it seeks to improve the overall healthcare system; however, the aims of the UHC Law will affect how the government prioritises health programmes and procures health services. Specifically, one of the proposed reforms of the UHC Law is to streamline the role of the DOH in population-based system, which means that overlapping roles and responsibilities between the DOH and PhilHealth will be resolved; thus, DOH will be responsible for population-based interventions and other health services, such as health promotion and immunisation programs, while PhilHealth becomes the single national purchaser and financier of individual-based health services, and central repository of data for local health systems (NEDA 2019: no page). This will result in a strengthening of evidence-based policymaking and decision-making to accurately capture the population's needs, as there will be more utilisation of data based on population needs, strengthened coordination among implementing agencies, and a global budgeting that is diagnosis-related and based more on lumped needs than on individual cases.

#### *Economic and Developmental Aspect*

When President Duterte assumed position in 2016, he signed Executive Order No. 5, series of 2016, which approved and adopted a long-term national development plan called *Ambisyon Natin 2040*, which aims for a “*matatag, maginhawa, at panatag na buhay para sa lahat*” (strongly-rooted, comfortable, and secure life for all)” (NEDA 2018: no page). Specifically, *Ambisyon 2040* has the following goal, that:

“By 2040, the Philippines is a prosperous middle-class society where no one is poor. People live long and healthy lives and are smart and innovative. The country is a high-trust society where families thrive in vibrant, culturally diverse, and resilient communities.” (NEDA 2018: no page)

This development plan further launched the 10-Point Socioeconomic Agenda as part of the medium-term Philippine Development Plan from 2017 to 2022. Included in the 10-Point Socioeconomic Agenda is the goal of promoting reproductive health by strengthening the implementation of the RPRH Law, specifically “to enable especially poor couples to make informed choices on financial and family planning” (NEDA 2018: no page).

The inclusion of family planning in the socioeconomic agenda amplifies the government's stand that reproductive health is family planning. To further bolster this, the government issued Executive Order No. 12, s. 2017<sup>16</sup> which provided a concrete policy support to the RPRH Law, and recognised the right of Filipinos to “freely and responsibly

---

<sup>16</sup> Otherwise known as *Attaining and Sustaining Zero Unmet Need for Modern Family Planning through the Strict Implementation of the Responsible Parenthood and Reproductive Health Act, Providing Funds Therefor and for Other Purposes*.

decide on the number of children they want,” as well as provided mechanisms needed to push forward the agenda of “zero unmet need for family planning” for poor households, and all Filipinos after 2018 (DOH 4th Annual RPRH Report 2018: 3).

Similarly, the financing of RPRH increased by 25% from Php29.7B in 2016 to Php37.4B in 2017, encompassing allocation for the specific Family Health and Responsible Parenting programme, as well as for the more general Expanded Program on Immunization, and Health Facilities Enhancement Program (DOH 4th Annual RPRH Report 2018: 4). The budget also covered other RPRH-related programmes of relevant agencies, such as the Commission on Population (PopCom), while additional budgets were allocated for gender and development (GAD) programmes of the Philippine Commission on Women (PCW), and the HIV/AIDS programme<sup>17</sup> of the DOH (DOH 4th Annual RPRH Report 2018: 4). The DOH has noted in its report that the budget increase may have been substantial, but it was only half of the projected budgetary need of Php8.1B for family planning programmes in 2017 (4th Annual RPRH Report 2018: 4).

The Philippines also received about Php10.2B from development partners for aid on RPRH-related projects, while social insurance reimbursement for RPRH-related benefits amounted to Php23.79B in 2017 (DOH 4th Annual RPRH Report 2018: 4). The development partners on RPRH programmes include the following: the European Union (EU), Global Fund, Japan International Cooperation Agency (JICA), the United Nations International Children’s Emergency Fund (UNICEF), the United Nations Population Fund (UNFPA), the United States Agency for International Development (USAID), and the World Health Organization (WHO) (4th Annual RPRH Report 2018: 20).

Table 1.1 below summarises the list of policies, programmes, and interventions related to ASRH that the DOH has implemented after passage of the RPRH Law:

**Table 1.1**  
Summary of Policies, Programmes, and Interventions on ASRH after the passage of the RPRH Law

Title of Document	Type of Document	Lead Implementing Agency	Date of Publication
RA No. 11148 and its Implementing Rules and Regulations, “An Act Scaling Up the National and Local Health and Nutrition Programs Through a Strengthened Integrated Strategy for Maternal, Neonatal, Child Health and Nutrition in the First One Thousand (1,000) Days of Life, Appropriating Funds Therefore and for Other Purposes,” otherwise known as the “ <i>Kalusugan at Nutrisyon ng Mag-Nanay Act</i> ” (Health and Nutrition of Mother and Child)	Law	DOH	May 2019
RA No. 11166: An Act Strengthening the Philippine Comprehensive Policy on Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency	Law	DOH-PNAC	Mar 2019

<sup>17</sup> This is included in the general umbrella of the DOH programme known as the *HIV/AIDS and STI Prevention, Emerging and Re-emerging Infectious Disease, Integrated Helminth Control, Food and Waterborne Diseases Prevention and Control, and National Dengue Prevention and Control Programs* (DOH FY 2018 Budget Folio: 30).

Syndrome (AIDS) Prevention, Treatment, Care and Support, and Reconstituting the Philippine National AIDS Council (PNAC), Repealing for the Purpose RA No. 8404, otherwise known as the 'Philippine AIDS Prevention and Control Act of 1998' and Appropriating Funds Therefore"			
Joint Memorandum Circular No. 2019-01: Policy Guidelines for the Intensified Implementation of the National Program on Family Planning	Implementin g policy	DOH, NEDA, PopCom	Feb 2019
AO 2018-003: National Policy on the Prevention of Illegal and Unsafe Abortion and Management of Post-Abortion Complications	Implementin g Policy	DOH	Feb 2018
Guidelines in the Implementation of Philippine Health Agenda's (PHA) Check-Up Service for All Filipinos	Technical guide	DOH	Dec 2017
Food and Drug Administration (FDA). Advisory 2017-302: Results of the FDA's Re-evaluation of Contraceptive Products for Recertification	Implementin g policy	DOH	Nov 2017
AO 2017-0019: Policies and Guidelines in the Conduct of Human Immunodeficiency Virus (HIV) Testing Services (HTS) in Health Facilities	Implementin g policy	DOH	Sep 2017
AO 2017-0005: Guidelines in Achieving Desired Family Size through Accelerated and Sustained Reduction in Unmet Need for Modern Family Planning Methods	Implementin g policy	DOH	2017
EO No. 12, s. 2017, "Attaining and Sustaining 'ZERO Unmet Need for Modern Family Planning' Through the Strict Implementation of the Responsible Parenthood And Reproductive Health Act, Providing Funds Thereof, and for other Purposes"	Implementin g policy	Office of the President	Jan 2017
K to 12 Curriculum Guide: Health (Grades 1 to 10)	Technical guide	DepEd	2016
AO No. 2016-0041: National Policy on the Prevention and Management of Abortion Complications (PMAC)	Implementin g policy	DOH	Nov 2016
AO No. 2016-0005: National Policy on the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) in Health Emergencies and Disasters	Implementin g policy	DOH	Feb 2016
AO No. 2015-0002: Creation of a National Implementation Team (NIT) and Regional Implementation Teams (RIT) for RPRH Law	Implementin g policy	DOH	Jan 2015
AO No. 2014-0046: Defining the Service Delivery Networks (SDNs) for Universal Health Care or <i>Kalusugan Pangkalahatan</i>	Implementin g policy	DOH	Dec 2014
AO No. 2014-0042: Guidelines on Implementation of	Implementin	DOH	Oct 2014

Mobile Outreach Services for Family Planning	g policy		
Clinical Standards Manual on Family Planning (2014 Edition)	Technical guide	DOH	2014
Postpartum Family Planning: Supplement to the Philippines Clinical Standards Manual on Family Planning (2014 Edition)	Technical guide	DOH	2014
AO No. 2013-0013: National Policy and Strategic Framework on Adolescent Health and Development	Implementin g policy	DOH	Mar 2013

Source: Compiled by author from the DOH website and other sources

In 2017, the DOH released Department Circular (DC) No. 2017-0301, which listed all the programs and services on SRH, relative to the 12 Elements<sup>18</sup> of Reproductive Health previously identified by the Department. Element number 4 pertains to “adolescent and youth reproductive health guidance and counseling,” and primarily involves Adolescent Health and Development Programs; interestingly, however, the services mentioned under it are mostly not directly dealing with reproductive health, save for one: “Healthy Young Ones project using information, education and communication (IEC) materials on anatomy and physiology, human development, sexuality, growth and development” (DOH DC No. 2017-0301).<sup>19</sup>

#### **1.2.4. The Department of Health (DOH) as Central Health Agency in a Decentralised Health System**

Healthcare in the Philippines is a dual system composed of the public and private sectors, with the public sector funded largely by taxes. The Department of Health (DOH) is the primary agency mandated to maintain the health system, provide and develop national health policies and plans, as well as implement and execute health programmes all over the country. The primary mandate of the DOH derives from Article II, Section 15 of the 1987 Philippine Constitution which provides that the State has the responsibility to “protect and promote the right to health of the Filipinos and instill health consciousness among them.”

---

<sup>18</sup> These 12 Elements are as follows: 1) Family planning information and services; 2) Maternal, infant and child health and nutrition including breastfeeding; 3) Proscription of abortion and management of abortion complications; 4) Adolescent and youth reproductive health guidance and counseling; 5) Prevention, treatment and management of reproductive tract infections, HIV and AIDS and other sexually transmittable infections; 6) Elimination of violence against women and children and other forms of sexual and gender-based violence; 7) Education and counseling on sexuality and reproductive health; 8) Treatment of breast and reproductive tract cancers and other gynecological conditions and disorders; 9) Male responsibility and involvement and men’s reproductive health; 10) Prevention, treatment and management of infertility and sexual dysfunction; 11) Age- and development- appropriate RH education for adolescents in formal and non-formal educational settings; and 12) Mental health aspect of RH care (Source: PopCom website, <http://www.popcom.gov.ph/23-faq/474-rprh-delivery-of-services>)

<sup>19</sup> The complete list of programs and services provided by the DOH for some of the 12 RH Elements can be found in Appendix 1.

Based on further mandates, the DOH must ensure that every Filipino achieves their optimal level of health by providing assistance to local government units (LGUs) through: i) effective implementation of programs, projects, and other services that promote health and well-being of the public; ii) prevention and control of diseases among populations-at-risks; iii) protection of individuals, families and communities exposed to health hazards and risks; and, iv) treat, manage, and rehabilitate individuals affected by disease and disability (Executive Order No. 102, s. 1999). Actual health service delivery, on the other hand, is done largely through facilities maintained by the central health office and LGUs.

In 1992, the Philippines underwent decentralisation through devolution when it implemented the Local Government Code (LGC), shortly after its implementation of the new Constitution in 1987. This devolution, defined as “the transfer of authority and responsibility for public functions” (Lakshminarayanan 2003: 96) from the central government to intermediate and local government, was motivated by the belief that it will hasten re-democratisation following the country’s subjugation under a decades-long authoritarian rule that ended in 1986. Specifically, decentralisation was touted as a support to democracy on the belief that it will promote local participation, increase responsiveness and attention to local problems, and include marginalised groups in policy considerations (Langran 2011: 361). Similarly, it was believed that decentralisation would resolve corruption problems and inefficiency as it gives local populations the role of ‘government watchdogs’ to whom elected officials are held accountable (Langran 2011: 361).

To implement the new system, the Department of Health (DOH) devolved its health service administration into the newly autonomous local governments throughout the country. The central office of the DOH continues to set national health goals and policies, while the local governments are tasked with implementing and delivering health services to their constituents. Specifically, more than 81 provinces are tasked with monitoring and supervising their own secondary and tertiary care hospitals, while around 1,500 municipalities within the provinces are responsible for managing health centers that provide primary care services. Health functions that have been devolved include operation of health facilities and hospitals, budgeting and managing of finances, hiring and managing of health personnel, and creation of locally-appropriate health programmes and initiatives (Melgar et al. 2018: 10).

In its earlier phase of implementation, a huge unintended consequence of devolution in the Philippine health system was a considerable decrease in the efficiency due to disruptions in service delivery (Lakshminarayanan 2003). For example, the distribution of all forms of contraception, such as condoms, injectables, intrauterine devices, and pills (all quite notably mostly donor-funded), remained with the DOH central office; the delivery of services providing these contraception, however, shifted from the central office to: 1) the municipal government for clinic-based and community-based methods, and 2) the provincial government for hospital-based methods. If a local government unit has decided not to provide contraception for political and religious reasons, such as due to traditional beliefs and Church influence, women are effectively denied their sexual and reproductive health and rights.

Another notable early effect was the weakening of the commitment of local government units to centrally-prioritised health issues, as under the decentralised system, the local government unit has considerable autonomy in deciding the fate of health

programmes initiated by the central office, and ultimately, the health of its constituents. (Lakshminarayanan 2003). Local governments are headed by elected officials, and thus, often do not have the same level of commitment and technical capacity as the civil servants in the central office to effectively provide health services and manage healthcare funding in their jurisdictions.

A marked increase in health inequities has also characterised decentralisation in the Philippines, partly caused by the differences in the priorities and accountability between the central office and the local governments, and partly by the lack of capacity-building, as the central and regional health offices were not able to provide the necessary training, technical supervision, and other support services to local governments. Being elected officials, local governments are more accountable to external (political) pressures when formulating policies, while civil servants in the central office are more inclined to use evidence-based research (Lakshminarayanan 2003).

Apart from the furtherance of the divide between private and public health services, this devolution, in effect, created a dual health system, comprised of the *national* and the *local*. Given the current changes in the legislative and policy direction on sexual and reproductive health in the Philippines and around the world, and the elimination of major roadblocks on the implementation of the RPRH Law (Melgar et al. 2018), and the recent passage of the UHC Law, much-needed policies on sexual and reproductive health remain crucial and highly-anticipated.

### 1.3. Research Objectives

The objective of this paper is to understand how evidence-based policymaking on sexual and reproductive health is carried out in the Department of Health (DOH), given the framework set by the Responsible Parenthood and Reproductive Health (RPRH) Law and the more recent Universal Health Care (UHC) Law. The paper also seeks to determine what the challenges are in SRH policymaking, specifically in the agenda setting and policy formulation phases of the policy cycle.

#### 1.3.1. Research Questions

The main research question that this paper thus seeks to answer is: **What factors affect the policymaking process on Sexual and Reproductive Health (SRH) in the Department of Health (DOH)?**

To provide a cogent structure to the analysis and data pertaining to the main research question, the following sub-questions are also addressed:

- i. Which external and internal factors constrain policymaking in sexual and reproductive health in the DOH?
- ii. How prevalent is evidence-based policymaking with regard to sexual and reproductive health in the DOH?
- iii. What challenges need to be addressed in the agenda-setting and policy formulation phases of policymaking, and what causes these challenges?



## 1.4. Limitations of the Study

This study only looked into the dynamics of policymaking given the implementation of the Responsible Parenthood and Reproductive Health (RPRH) Law and given the more recent Universal Health Care (UHC) Law, and determined the prevalence of evidence-based policymaking as a practice within the context of sexual and reproductive health. As there are multiple agencies and stakeholders involved in the policy cycle, this study only covered the DOH, its attached agencies, and other relevant government agencies and international organisations directly involved in policymaking in the DOH, thereby excluding non-governmental organisations (NGOs), civil society organisations (CSOs), and think-tanks who are considered in public consultations.

Furthermore, the focus of the analysis in this research is limited to the agenda setting and policy formulation phases of the policy cycle, with implementation, and monitoring and evaluation not touched upon as both deserve their own separate studies.

Due to time and resource limitations and the positionality of the researcher, this study did not look into the effects of possible policy gaps in service delivery and addressing unmet needs of women *per se*. This study also did not seek to find fault in and within the DOH, but rather looked into the dynamics within to identify possible institutional gaps in sexual and reproductive health policymaking. Lastly, this study did not provide absolute recommendations, but instead recommended practical solutions and actions toward a more effective policy process given the current political context of the Philippines.

## 1.5. Outline of the Study

This paper is divided into five (5) chapters. Chapter 1 includes the introduction, a contextual background on the topic and the nature of the research problem, a brief history of sexual and reproductive health in the global context and in the Philippines, and an overview of the major actors involved in policymaking in the DOH, as well as the research questions and the limitations of the study. Chapter 2 provides a discussion of the concepts used in this study, including evidence-based policymaking and evidence-based public health, and discussion of the analytical framework of Institutional Analysis and Development (IAD) and Multiple Streams Approach (MSA) within which findings of the research are discussed. Chapter 3 describes the methodology used for data gathering and analysis; while Chapter 4 presents findings on the research sub-questions divided per section, and discusses the challenges in evidence-based policymaking in the public sector in the Philippines. Chapter 5 then concludes the research, provides policy recommendations, and articulates the contribution of the research to development theory.

## Chapter 2

# Key Concepts in Evidence-Based Policymaking (EBPM) and the Analytical Framework of the Study

This chapter describes public health policy and evidence-based policymaking in two main themes necessary towards understanding the research findings. Specifically, it focuses on the following: i) evidence-based policymaking (EBPM) in public health and what is called *evidence-based public health* (EBPH); and ii) the politics of sexual and reproductive health (SRH) policymaking. The first theme digs into the practice of evidence-based policymaking in public health, with a glimpse into its role in policymaking in the context of the Philippines. The second theme delves into the political nature of SRH policymaking, particularly in the agenda setting and formulation phases. These two themes together contribute to the further understanding of the challenges in SRH policymaking in the Philippines, and how these challenges can be best addressed. The analysis is carried out in Chapter 4 using the Multiple Streams Approach (MSA) combined with the Institutional Analysis and Development (IAD) Framework.

The key focus of this thesis/report is on evidence-based policymaking in public health, specifically referred to as *evidence-based public health* (EBPH), defined as “the process involved in providing the best available evidence to influence decisions about the effectiveness of policies and interventions aimed at improving health and reducing health inequalities” (Killoran and Kelly 2010: 459). This chapter serves as a guide to understanding the process of evidence-based policymaking in public health: the main elements of an evidence-based policymaking approach, including its major concepts and dominant theories, applicable methods and processes for gathering and using evidence, and general practice on the use of evidence in public health policy. Specifically, the first section provides the relevant background issues, including i) definitions, overview of evidence-based policymaking, and other concepts intrinsic to EBPH; ii) several key characteristics of evidence-based policymaking; and iii) a summary of challenges and opportunities on EBPH.

## 2.1. The Role of Evidence in Public Health Policymaking and Evidence-Based Public Health

Global health research has been growing in the last few decades, and data shows that funding for research on health has grown more than five-fold in two decades—from US\$30B in 1986, to around US\$163B in 2005 (Liverani et al. 2013: 1); however, the use of evidence in health policymaking still faces many challenges. Indeed, policy practice is often not influenced by the best available evidence, or that research often finds little role in the policymaking process. To address this, the study of evidence use in public health policymaking has increasingly focused on identifying the challenges alongside the enabling factors that affect the use of research in policymaking (Liverani et al. 2013: 1).

How does policymaking in public health work? The formulation of public health policies, as with many decision-making processes in the practice of public health, is highly complex and dependent on various scientific, socio-economic, and political factors. As

with any policymaking in any field, central to the whole process is the analysis of the policy issue, which is carried out to understand the problem and determine the options for actions.

One set of methods, or a discourse, that informs the policy process (and not the eventual goals of the policy) is evidence-based policymaking (EBPM), which pushes for a more “rational, rigorous and systematic approach” (Sutcliffe and Court 2005: iii). The growing prevalence of EBPM is based on the premise that a policy based on systematic evidence produces better outcomes, as policy decisions made using evidence involves rational analysis (Sutcliffe and Court 2005). While the scope of what is considered ‘policy’ is often broad—it usually includes laws, rules and regulations, agency guidelines, as well as programmes and interventions—there is often an observable gap between what is effective based on research and the actual policies enacted and enforced (Brownson, Chriqui, and Stamatakis 2009: 1576). Thus, the use of evidence in public health policymaking<sup>20</sup> comes with many considerations.

Primarily, there are three key spheres of evidence-based policy as put forth by Brownson, Chriqui, and Stamatakis (2009: 1576): i) *process*, which provides a better understanding of the approaches that enhance policy adoption; ii) *content*, which pinpoints specific aspects of a policy that are most likely to be successful and effective; and, iii) *outcomes*, which provides details on the actual impact of policy.

Sutcliffe and Court (2005: iv) also identifies three main issues surrounding the use of evidence in policymaking: i) *the type of evidence used in the policymaking process*, taking into account quality, accuracy, objectivity, credibility, relevance, and other practicalities, such as cost of the policy implications; ii) *how evidence is incorporated into policymaking*, as policymaking involves different stages, varying evidence and mechanisms are required at each of these policy stages; and iii) *other factors apart from evidence that influences policymaking*, both at an *individual* level (such as in terms of the level of experience, expertise, and judgment of a policymaker) and at an *institutional* level (such as in terms of institutional capacity, and *constraints* that limit the effect of evidence in policy (such as resource scarcity and the pressure to process information quickly).

Then there is the need to define what can be considered as ‘evidence’ in ‘evidence-based policy’ (Killoran and Kelly 2010: 17), the scope of which is “wide and dynamic” and “rich and varied” (Sutcliffe and Court 2005: 3). Literature defines ‘evidence’ as scientific knowledge, although “anecdote, experience, and even propaganda” (Killoran and Kelly 2010: 17), and “personal experience and legal argumentation” can also comprise what counts as information (Parkhurst et al. 2018: 4). Brownson, Fielding, and Maylahn (2009: 177) define evidence “at the most basic level” as “the available body of facts or information indicating whether a belief or proposition is true or valid.” What can be considered evidence includes “expert knowledge, published research, existing research, stakeholder consultations, previous policy evaluations, the Internet, outcomes from consultations, costings of policy options, output from economic and statistical modelling (Sutcliffe and Court 2005: 3, citing the 1999 White Paper *Modernising Government* of the UK Cabinet Office). It is also important to sift through the body of available evidence to determine their importance, relevance, or weight to the policy process. Organisations

---

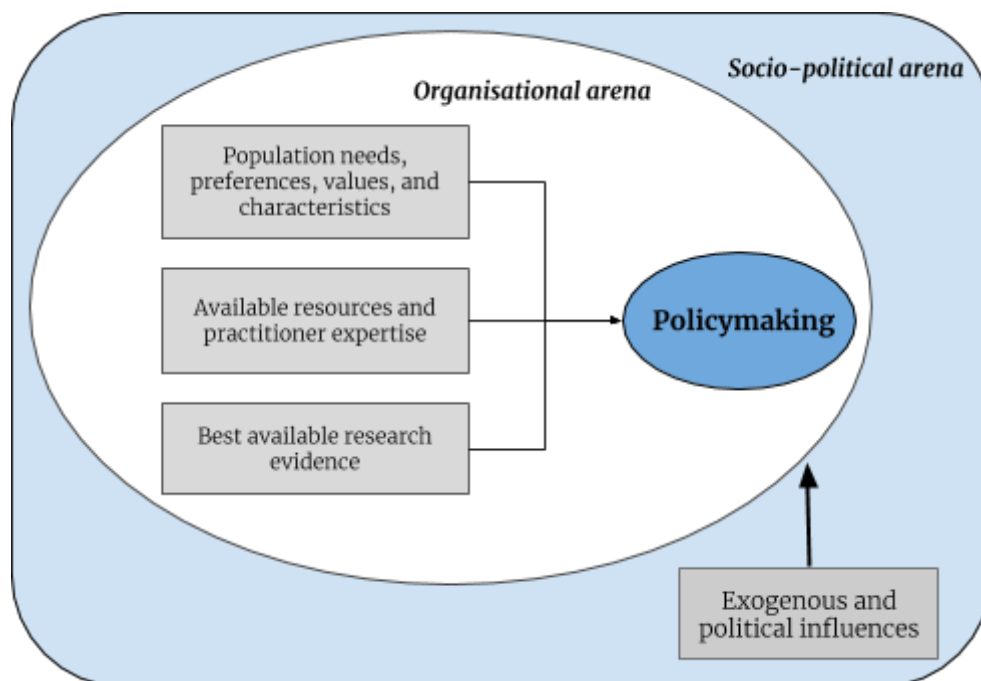
<sup>20</sup> For the purposes of analysis, the use of evidence is only explored in the agenda setting and policy formulation phases of the policy cycle in the context of the Philippines, which is discussed in Chapter 4 of this paper.

ultimately make hierarchical and value-based judgements in choosing which evidence to use, as well as how and at which stage of the policy process to use these evidence. Such decisions, according to Sutcliffe and Court (2005: 3), are “often deeply embedded in assumptions over validity and power.”

To effectively assess the value and usefulness of evidence, there is a need to develop an evidence database, which must take into account policy cultures and processes. For a public health practitioner, evidence includes both quantitative (epidemiological) and qualitative data (narrative accounts), and is usually derived from research, such as observation, theory, and experiment (Brownson, Chriqui, and Samatakis 2009: 1576). Evidence, however, is not always complete, though this does not render impossible evidence-based decision-making—indeed, the standard that is required is “the best evidence available not the best evidence possible” (Brownson, Fielding, and Maylahn 2009: 177, 179, citing Gray 1997).

In simpler terms, the main goal of evidence-based policymaking is to promote decision-making that is rational or backed by research rather than by use of opinion or ideology (Sutcliffe and Court 2005: 1). Using evidence is instrumental to the policy cycle, although it must be mentioned that using evidence in public policy comes with the acceptance that politics exerts an influence on the policy process, particularly on the relevance and use of evidence (Parkhurst et al. 2018). Indeed, policymaking is “neither objective nor neutral; it is an inherently political process” (Sutcliffe and Court 2005: iv).

**Figure 2.1**  
Domains influencing Decision-making in Public Health Policymaking



Source: Adapted from Spring et al., as cited in Brownson, Fielding, and Maylahn 2009

As shown in Figure 2.1 above, three domains influence policymaking within the environmental and organisational arena: i) the needs, preferences, values, and characteristics of the target population that determine what programs and interventions are

necessary; ii) available resources, such as time and money, and the expertise of policymakers and public health practitioners within the organisation (capabilities, training, leadership, etc.); and, iii) best available evidence data derived from research processes (Brownson, Fielding, and Maylahn 2009). Outside of the organisational arena is the socio-political arena that is known to affect policy- and decision-making processes of an organisation through exogenous (socio-economic and cultural) and political (decision-makers' preferences and biases) influences.

While it seems counterproductive to rely primarily on evidence alone in policymaking, using evidence has its advantages: i) it allows policymakers to rely on experience, particularly from past successes and failures; ii) it provides a basis for assessing whether a policy can actually achieve its desired outcomes; iii) it promotes efficiency, particularly in policy formulation; and, iv) it promotes a policy learning that helps future policymaking smoother (Killoran and Kelly 2010: 17). Other benefits of using evidence in policymaking are “higher likelihood of successful programmes and policies being implemented, greater workforce productivity, and more efficient use of public and private resources” (Brownson, Fielding, and Maylahn 2009: 176).

Furthermore, although evidence-based policymaking has its obvious advantages, there are also disadvantages that must be pointed out. First, there are huge costs associated with evidence gathering, particularly time and money—resources that are of particular importance to policymaking (Killoran and Kelly 2010: 17). Second, there is always the political risk of devising a policy that is subsequently shown to be unsuccessful, ineffective, and even harmful (Killoran and Kelly 2010: 17). Third, there is the possibility that evidence can be used as a mechanism through which “policy discourses can be shaped in favour of (or against) a particular outcome” by competing stakeholders participating in the process “in order to shape decisions” (Parkhurst et al. 2018: 8). Hence, Killoran and Kelly (2010: 9, citing Russell et al. 2008) pointed out that “it is ‘naively rational’ to assume that evidence can simply direct policy making in a linear way,” and even went as far as to argue that “‘evidence-based policy’ is nothing more than a slogan used to discredit opponents” (Killoran and Kelly 2018: 9, citing Hammersley 2013). Alongside these disadvantages are the barriers to implementing evidence-based policymaking, which include political situation, shortages in relevant and timely research, weak information systems, and deficits in resources, leadership, and other required competencies (Brownson, Fielding, and Maylahn 2009: 176).

Apart from acknowledging the inherently political nature of policymaking and recognising that evidence is a crucial element in policy debates, it must also be mentioned that evidence is not the only basis for policy decisions, and that it may not be enough to resolve all policy conflicts (Parkhurst et al. 2018: 4). Indeed, decision-makers sometimes do not rely on information or evidence, and often take decisions “even where ‘evidence’ is fragmentary and uncertain,” and that “policy-makers are pragmatic, mindful of community sentiment and stakeholder values” than they are concerned with feasibility and evidence quality (Head 2013: 397). To put it differently, policy decisions are often influenced by “politics, judgement and debate” rather than by empirical analysis, with what counts as evidence characterised as “diverse and contestable” (Head 2013: 398).

In extreme cases, non-reliance on evidence stems from a lack of resources or capacity to “collate and interpret evidence;” while in other cases, local evidence

interpretation is inappropriate due to lack of influence in the local context (Killoran and Kelly 2010: 21). Cairney summed it up best when he said that:

“the idea that ‘the evidence’ has a direct input to a small number of comprehensively rational policymakers in a clearly defined policy process... Policymakers have to make decisions in the face of uncertainty. No amount of available information or evidence can settle the matter for them. Rather, they decide who and what information to trust.” (2016: 30)

Thus, there must be a recognition that policymakers are not only bound by evidence, but by external factors that together make up the basis of decision. A continuing approach in gathering information and developing an understanding is important in evidence-based policymaking, and Buse et al. (2006: 2102) identifies four elements of policymaking central to this understanding: i) opportunities and constraints of specific sexual and reproductive health issues; ii) formal and informal processes through which decisions are made; iii) stakeholders affected by a proposed SRH policy or intervention; and, iv) interests, positions, and commitment levels of stakeholders to a specific SRH policy.

Some scholars try to delineate and classify evidence in policymaking, particularly on how it affects and influences decisions. Head (2008: 5) provides three classifications, or what is referred to as three ‘lenses’ or types of expert knowledge to understand evidence: i) systematic, technical, or scientific, research-based knowledge, ii) program management experience or practical implementation knowledge, and iii) political judgement or know-how. Sutcliffe and Court (2005: 4) suggested that policymakers should “take into consideration a wide breadth of sources of research, not just hard evidence.. to embrace a wide range of factors, such as voice and consultations, if the evidence is collected through a systematic process.”

Finally, it has been argued that evidence-based policymaking may have greater impact on developing countries where the practice is less established and policies are mostly not based on evidence (Sutcliffe and Court 2005), or where the policymaking process is highly politically-influenced, such as in the Philippines. It may prove somehow challenging to apply its tenets in the Global South, however, as EBPM “have largely been developed in a western, European American context,” and thus, its “conceptual approach arises from the epistemologic underpinnings of logical positivism, which finds meaning through rigorous observation and measurement” (Brownson, Fielding, and Maylahn 2009: 190). In developing countries, on the other hand, evidence is usually limited and linked to empirical observations, and oftentimes mismatched with the scope of the public health problem (Brownson, Fielding, and Maylahn 2009: 190), due to problems in resources and best practices.

As such, it becomes necessary to apply appropriate strategies and tactics that ensure the use of evidence in public health policymaking. Generally, what is needed is for stakeholders and actors to promote best practices through networks and inter-agency cooperation. Specifically, Buse et al. (2006: 2103) provides that “for research to achieve maximum effect, policy networks need the means and capacity to understand the decision-making environments,” with skillful political management thrown in as well.

## 2.2. The Politics of Sexual and Reproductive Health Policymaking: Agenda-Setting and Policy Formulation

Sexual and reproductive health is a need well-established especially in developing countries in the Global South, and considerable progress has been made since the 1990s in terms of relevant policies and programmes. In many countries, moral standards and cultural norms have largely influenced political and legal frameworks for sexual and reproductive health policymaking, with political factors often proving pivotal in the process (Buse et al. 2006: 2101).

According to Buse et al. (2006: 2101), political factors help determine national policy agendas on sexual and reproductive health, as well as which evidence will be included or excluded, which policy alternatives will be considered and subsequently adopted, and eventually the degree of implementation of the policy; thus, conflict can often arise on the determination of issues to be included in political agenda, while opportunities can arise when problems are already established and decision-makers are aware of workable solutions. Experience often shows, however, that agenda setting only progresses when “the politics of the situation are right” or when “decision-makers want to be seen to be taking action,” or when “the probable political costs are much lower than the potential benefits” (Buse et al. 2006: 2101). Ideally, health agendas should be set on the basis of existing evidence; however, experience proves that evidence are not often sufficiently considered, particularly in situations where there are conflicting cultural beliefs (such as in cases where sexuality is a taboo or is stigmatised); if the policy intervention is perceived to be difficult to implement, or if certain interest groups (e.g., *pro-life* groups) would be adversely affected by policy interventions; or if the subject of the policy are marginalised groups with little political clout, such as women and girls with the lowest socio-economic status (Buse et al. 2006).

In extreme cases, the existence of a technically-feasible, cost-effective intervention on a sexual and reproductive health issue does not guarantee the formulation or adoption of relevant policies; and in some cases, the reverse even proves to be the norm (such as when policies are adopted despite lack of sufficient evidence, or when evidence directly contradicts the intervention, or even when evidence suggests that the intervention might not work) because political factors have influenced the decision-making process (Buse et al. 2006: 2101). Table 2.1 below summarises the issues of evidence in the different phases of public health policymaking. From the table, it can be gathered that different phases of the policy cycle need different types of evidence, given the different goals of each phase.

**Table 2.1**  
Phases in the Process and Corresponding Evidence Needs in Public Health Policymaking

Policy Phase	Main Objective	Evidence Needs
Agenda-setting	Recognition and prioritisation of a public health issue	Evidence is needed to identify problems, or collection of evidence to show the gravity of an issue, such that policymakers are aware that the problem needs to be prioritised; key characteristics are credibility of evidence, as well as how evidence is communicated

Formulation	Determination of feasible policy options, and then selection of the best or preferred option	Policymakers must have a comprehensive understanding of the policy issue, and that the different policy options are as detailed as possible so as to make informed decisions on which policy option to implement; key characteristics are quantity and credibility of evidence
Implementation	Actual public health programmes, interventions, and initiatives	Focus is on available operational evidence to effectively improve initiatives, such as through analytic work, systematic learning through expert knowledge, technical skills, and practical experience, not neglecting action research and pilot projects; key characteristics are practicality and relevance across different contexts
Evaluation	Monitoring and assessing the process and impact of an intervention	Primary goal is to establish monitoring mechanisms, after which an evaluation procedure must be developed to determine and assess the effectiveness of the implemented policy, and to gather data for future decision-making; key characteristics are objectivity, thoroughness, and relevance, successfully fed into the continuing policy cycle

Source: Adapted from Sutcliffe and Court (2005: 6)

In the public sector at the level of the organisation, policymaking is guided by the prevailing knowledge and practices within an organisation (*information*), as well as by self-interest of actors (*interests*), by biases or principles (*ideologies*) that influence the values of decision-makers and their default response to certain issues, and by those empowered to make decisions; and that the environment (*institutions*) shapes the decision-makers' strategic or tactical use of evidence to support a position, or to delegitimise other positions that are not supported by evidence (Weiss 1977).

In reality, research and the evidence it produces often take lesser importance against prevailing sentiments or preconceived judgments and opinions of the policymakers, and some even view research "as the opposite of action rather than the opposite of ignorance" (Sutcliffe and Court 2005: 8). Indeed, the interaction between policymakers and researchers is confined to the limited divergence of their action arenas. Policymakers and researchers have different processes, priorities, agendas, different time scales, and even reward systems, and as a consequence, a gap exists (Sutcliffe and Court 2005: 8, citing Nutley 2003).

Thus, in order to better analyse evidence-based policymaking in the Philippine government, such as in the Department of Health (DOH), organisational contexts such as power dynamics and political interests must also be taken into account. This is discussed in the framework of the Institutional Analysis and Development (IAD) and Multiple Streams Approach (MSA) as presented in the next section.



## 2.3. Combining Institutional Analysis and Development (IAD) and the Multiple Streams Approach (MSA) as a Framework for Analysing Evidence-Based Policymaking

To examine the external and internal factors, actors, and practices within the Department of Health (DOH) as a government agency of interest and how these affect the use of evidence in policymaking, an institutional analysis was undertaken. Three groups of factors are identified as influencing healthcare policy: i) *ideas*, which include evidence, research and other kinds of information, as well as values of legislators, stakeholders, and the public; ii) *interests* of stakeholders, legislators, and policy advisors; and, iii) *institutions*, including previous policies, policy-making process, timeframes, decision-making (Bell 2009: 8, citing Lavis et al. 2002).

Similarly, three factors have been identified to affect the uptake of evidence-based public health: *leadership*, *organisational culture*, and *political system*. (Brownson, Fielding, and Maylahn 2009) These factors are further explored using the Institutional Analysis and Development (IAD) framework as developed Ostrom, and Kingdon's Multiple Streams Approach (MSA) to shed light on SRH policymaking in the Philippines.

### 2.3.1. Institutional Analysis and Development (IAD) Framework

To analyse and “synthesize the work of multiple participants, including those who are directly involved in the policy situation and have an interest in policy outcomes” (Polski and Ostrom 1999: 6), the Institutional Analysis and Development (IAD) Framework was developed. As a framework, its main purpose is to understand which factors influence the behaviour of actors within an action arena, specifically to understand the interplay of formal and informal rules, or what is referred to as ‘rules-in-use’ that affect an actor's behavior in the particular action arena. These rules-in-use, according to Polski and Ostrom (1999: 15), are the “minimal but necessary set of rules that are needed to explain policy-related actions, interactions, and outcomes.” On the other hand, an institution is defined as “a widely understood rule, norm, or strategy that creates incentives for behaviour in repetitive situations” (Polski and Ostrom 1999: 3, citing Crawford and Ostrom 1995), while an action arena is a “conceptual space in which actors inform themselves, consider alternative courses of action, make decisions, take action, and experience the consequences of these actions” (Polski and Ostrom 1999: 20).

Understanding which factors affect the behaviour of the actors in these arenas gives insight on how different organisational perspectives explain the use of evidence in policymaking in the DOH. In this analysis, the actors are the policymakers and officials from the DOH, PopCom of NEDA, and UNFPA, while the arenas to be analysed for sexual and reproductive health programmes are the policy agenda setting arena and the policy formulation arena, which were chosen because the focus of this study is on the importance of these three phases of the policy cycle on the overall determination of SRH programmes to be implemented.

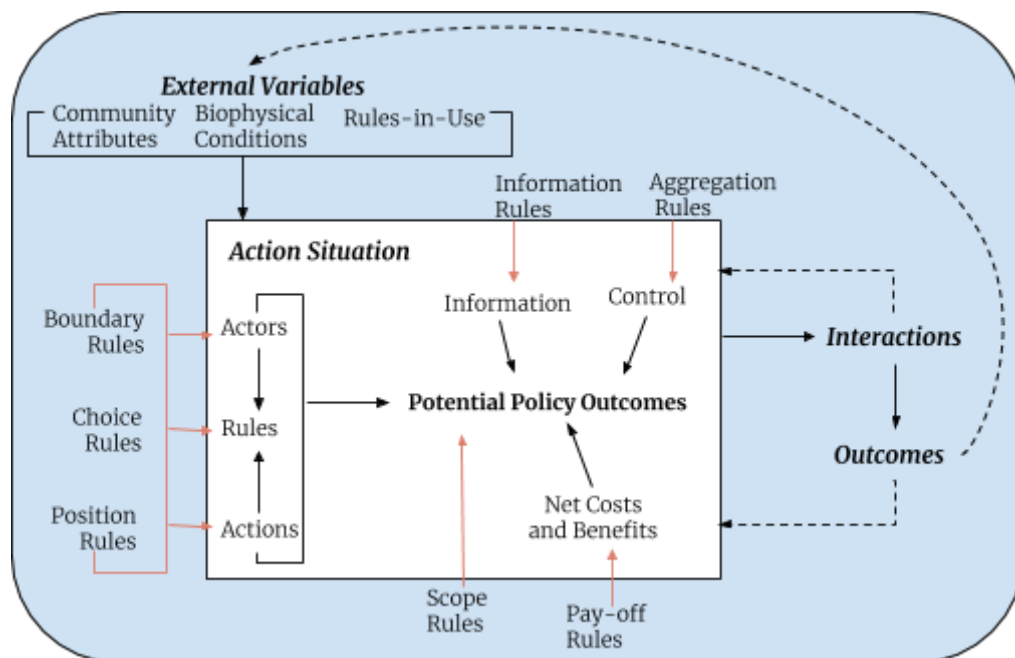
Three variables based on the IAD Framework that significantly affect the action arena, and which need to be taken into consideration to better understand the resulting patterns of behaviour and interactions among actors in the arena (Polski and Ostrom 1999) are analysed in this study: i) the physical and material conditions in the organisation; ii) the

community attributes, or demographic features of the organisation, as well as the policymakers' values and preferences; and iii) the rules-in-use, or the formal and informal operating rules in the organisation. Thus, the first step in analysing the policymaking process under the IAD Framework is to identify the conceptual unit, known as the action situation, which can be used to “describe, analyse, predict, and explain behavior within institutional arrangements” (Ostrom 2011: 11). Action situations are defined as the social spaces interaction, exchange of goods and services, problem solving, domination, conflicts, and struggles occur between actors (Ostrom 2011: 11). Figure 2.2 below shows the framework for Institutional Analysis that is used in this study.

In an action situation shown in Figure 2.2, the actor (or actors) can either be a single individual or a group functioning as a corporation, while action is behaviour that has a subjective and instrumental meaning to the actor. To fully analyse behaviour of actors, an implicit or explicit model must be used that will infer the likely behaviour of an actor in a particular action situation; specifically, it must make assumptions on how and what participants value; the resources, information, and beliefs they have; their information-processing capabilities; and the internal mechanisms used to decide upon strategies (Ostrom 2011: 12).

Rules, on the other hand, are the shared practices and understandings among actors on which actions or behaviour are required, prohibited, or permitted, and they come from concerted efforts, whether implicit or explicit (Ostrom 2011: 18). In addition to legislation and regulations from the central government, administrative measures and/or laws passed by regional, local, and special government units must also be considered. Thus, in order to make a more in-depth institutional analysis, the norms that individuals use in making decisions, and *working rules*, or the set of rules actors use to explain and justify actions to fellow actors, must first be understood (Ostrom 2011: 18).

**Figure 2.2**  
A Framework for Institutional Analysis



Source: Adapted from E. Ostrom (2011)

Which rules then are important for institutional analysis? The more complex the action situation is, the more specific the rules need to be to maintain structure (Ostrom 2011). The IAD framework provides a way to classify rules based on their effect on the elements in an action situation as shown in Figure 2.2, which serves as a guide in identifying the role and prevalence of evidence-based policymaking in the DOH given the action situation. To apply this in the context of public health policymaking, specifically on sexual and reproductive health, this framework discusses the dynamics within the action arena (agenda setting and policy formulation), and identifies the behaviour of the actors, the rules they follow, and the resources they utilise. This is then further combined with the Multiple Streams Approach (MSA) discussed in the next section to form a coherent and more comprehensive framework.

### **2.3.2. Multiple Streams Approach (MSA) in Policy Process Analysis**

For a more in-depth analysis of policymaking in the DOH, the IAD framework is combined with the Multiple Streams Approach (MSA) introduced by Kingdon, and this serves as an overall framework for analysing information obtained in this research.

The first step to applying the MSA is to reconcile it with the policy cycle employed in this study, so that it stretches beyond the agenda setting where it was originally used by Kingdon (Howlett et al. 2016: 71). Kingdon put forth that for policy change to occur, three separate streams—the *problem* stream, *policy* or *solution* stream, and *contextual* or *political* stream—must converge within a short policy window to solve the problem given the proposed solution (De Wals et al. 2019: 576-77). The strength of the MSA lies in its capacity to explain the complexities of policymaking while being simple enough to be understood by non-policy scholars. It is useful in explaining why policymakers choose some policy initiatives and disregard the others: the MSA looks into the processes that put a particular issue (from a sea of issues) on the political agenda.

In this approach, policymaking is understood to be a non-linear process influenced by three streams that operate on different dynamics (Kusi-Ampofo et al. 2015: 199), and policy entrepreneurs (for the purposes of this study, the policymakers in the DOH are considered policy entrepreneurs) have the important role of articulating these three streams in decision-making, or during a policy window, the timing and duration of which may be unpredictable (De Wals et al. 2019: 577). Policy entrepreneurs are not mere advocates for an issue, but are ‘power brokers’ in the policy process (Kusi-Ampofo et al. 2015: 203), as they play in the action arena and use the evidence, employ their skills, and control the resources to their advantage in pushing forth a policy agenda.

The MSA operates on a constructivist perspective, in that the problem has no pre-assigned value and is assigned importance in the stream; hence, interpretation of conditions (data and indicators) is required to properly identify and define the policy problem (Ritter et al. 2018: 1542). Space and importance is given to evidence, research, and other types of knowledge within the three streams, with evidence playing bigger roles in the problem and the policy streams (Ritter et al. 2018: 1542). Furthermore, evidence is not considered independently from its interpretation—in other words, “the data do not speak for themselves” (Ritter et al. 2018: 1542, citing Kingdon 1984); thus, there is always a need to translate the evidence into something that would transform it into actionable problems, or from “statements of conditions to statements of policy problems” (Ritter et al. 2018: 1542, citing Kingdon 1984).

Thus, in the Philippines where there is a dual health system, agenda setting and policy formulation has a lot of interactions, specifically within the action arena where the action situation occurs, and policymakers as rational actors behave bounded by organisational rules, guided by considerations (information, control, and costs and benefits), and influenced by external variables (politics, community attributes). Specifically applying MSA in this study, the problem stream is identified as the unmet need for sexual and reproductive health of adolescent women in the Philippines; the policy/solution stream is policymaking, specifically agenda-setting and formulation in the DOH, using the best available evidence on unmet need of adolescent women; and the contextual or political stream involves the behaviour of the actors (policymakers in this case), the organisational rules, and the external variables (from the IAD framework previously discussed) that may influence decision-making regarding SRH programs.

## **Chapter 3**

### **Research Methodology**

#### **3.1. Qualitative Approach**

This study was performed using qualitative methods as it gathered information on the interactions, processes, and attributes of a group of individuals and the institutions that govern them (O’Leary 2014: 13). In particular, the data needed to conduct the institutional analysis was collected through desk review and a number of key informant interviews.

##### **3.1.1. Desk Review of Policy and Programme Documents**

To collect data, a review of existing policy documents (including department and administrative orders, memoranda, and office circulars, etc.) of the DOH on sexual and reproductive health and rights in the Philippines was performed. National and regional reports published by DOH on the status of sexual and reproductive health programmes were reviewed, as well as relevant public documents pertaining to gender and development (GAD) programmes (as a broader category), and reproductive and women’s health, from other agencies, including the Population Commission (PopCom) under the National Economic and Development Authority (NEDA), the Philippine National Aids Council (PNAC), and international and donor organisations, including the United Nations Population Fund (UNFPA).

##### **3.1.2. Key Informant Interviews**

When seeking information on how people make decisions, or to better understand the context, in-depth interviews are appropriate (Hennink et al. 2011: 110). As an additional method of generating data, I went on fieldwork in the Philippines to conduct semi-structured interviews and in-person correspondences with several key informants from the government and from other organisations, specifically:

- i. Officials, policy officers, and researchers from DOH directly responsible or closely involved in agenda-setting and policy formulation, as well as researching and drafting policies to determine the government’s thrust and priorities when addressing sexual and reproductive health; and,
- ii. Officers from other government agencies, including PNAC, PopCom, UNFPA-Philippines, and WHO-Philippines to explore their views on the policymaking process on sexual and reproductive health in the Philippines.

The list of interview participants was developed through three main avenues: i) by consulting with former DOH employees to identify individuals in the appropriate positions; ii) by contacting relevant DOH offices to inquire if they could identify additional participants; and, iii) by asking participants at the end of the interview (respondent-driven sampling) if they can identify other participants that may have information relevant to the research. All interviews were conducted in both English and Filipino, the official languages of the Philippines, and the interviews were semi-structured. On average, the personal and

app-based interviews lasted about 40 minutes. Table 3.1 below shows the list and coding of key informant interviews.

**Table 3.1**  
List and Coding of Key Informant Interviews

Number	Office/Agency	Position	Code
<b>Department of Health (DOH)</b>			
1	Office of the Secretary	Executive Assistant/ Medical Officer	DOH-EA-1
2	Bureau of International Health Cooperation	Programme Officer	DOH-BIHC-1
3	Health Policy Development and Planning Bureau - Health Research Division	Research Fellow	DOH-HPDPB-1
<b>National Economic and Development Authority (NEDA)</b>			
4	Population Commission	Executive Director	NEDA-PC-1
<b>UN Population Fund (UNFPA) - Philippines</b>			
5	Population Development Division	Programme Coordinator	UNFPA-PDD-1

### 3.2. Ethics and Positionality

To fulfill ethical obligations to interview participants, I have informed them of my research in-person, through email, and through mobile messaging, and conducted my interviews in-person, and through email and phone calls. Certain considerations were mentioned in detail to the informants, such as whether they agree to have their names included in the paper or their interviews recorded. Because of the sensitivity of the topic, my participants opted out in having their names mentioned in the research, although they agreed to have the interview records kept for my personal use.

To maximise my positionality and at the same time minimise my bias as an employee of the Philippine government, particularly as a former employee of the DOH in the Health Secretary's executive team, I have further triangulated sources by using data from other researchers in the field of healthcare service delivery in the Philippines, and selected my interview informants not limited to only higher levels of position.

### 3.3. Challenges in Data Gathering

Given my positionality as a former DOH employee, it was not difficult to access information and request my participants for interview; however, it was challenging to find the most convenient time and medium (whether mobile phone call, in-person, or through exchange of messages) to conduct the interviews, given the busy schedule of the participants who were mostly high level officers in their units or agencies. There were officials from the DOH and donor organisations who initially agreed to do the interview through email, but eventually did not get back to me in time; while others took a long time to respond, and requested for personal interviews that were too late to be accommodated, and so the original list was winnowed down from 11 participants to five. It has also been challenging to find the appropriate and relevant documents from some of the mentioned organisations and institutions, as it involved sifting through dozens of publicly available documents from the DOH and the agencies and organisations mentioned in this study.

## Chapter 4

### Discussion and Analysis of Data

This chapter addresses the three sub-questions of this research, namely: i) which *external* and *internal factors* constrain policymaking in sexual and reproductive health in the Philippines; ii) how prevalent is evidence-based policymaking with regard to sexual and reproductive health in the Department of Health (DOH); and iii) what challenges need to be addressed in the agenda setting and policy formulation phases of policymaking, and what causes these challenges. An institutional perspective using the Institutional Analysis and Development (IAD) framework and Multiple Streams Approach (MSA) as discussed in Chapter 2 is used as an approach to answering these questions, with the aim of providing a better understanding of evidence-based policymaking on sexual and reproductive health in the Philippines.

#### **4.1. Assessing Evidence-Based Policymaking in the DOH through the Institutional Analysis and Development (IAD) Framework and Multiple Streams Approach (MSA)**

It is a common theme in policy studies to point out the significant lack of study of political institutions to help explain the use of evidence in policymaking, particularly in the public health sector; or more specifically, in relation to the role of institutions in shaping evidence use in public health policymaking. Indeed, there is growing recognition that the use of evidence in public health policymaking is not merely a technical problem involving knowledge exchange or translation, but is one that also involves political challenges (Liverani et al. 2013: 1); and that despite the “nature of political systems, the role of institutional structures, and the political contestation of policy issues as central to understanding policy decisions,” limited studies have been made on these issues (Liverani et al. 2013: 1). To increase the use of evidence in public health policymaking, it is important to understand the decision-making processes within an institution and the factors that influence it.

As with any decision-making process, there are considerable trade-offs that occur between actors who have competing values and interests; thus, to properly analyse policymaking, attention must be given to how an issue is politicised (Liverani et al. 2013: 2). In other words, the political stream must not be neglected. The political stream shows that policy decisions can be contested in many different ways, and that such contestations affect opportunity costs and operational variables, such as prioritisation, project duration, scope of intervention, and of course, budget. Indeed, public health policy issues are social issues that go beyond clinical data and indicators, and also involves questions of development, justice, equity, and even morality – all of which can influence decision making around any given body of health evidence (Liverani et al. 2013: 2). Given these considerations, an institutional perspective to analyse evidence use in SRH policymaking is employed in this study. The findings illustrate how the policy window for use of evidence provided opportunities as well as constraints to the policy process.

#### **4.1.1 External and Internal Factors affecting Sexual and Reproductive Health (SRH) Policymaking in the DOH**

This section looks into the factors involved in agenda setting and policy formulation with regard to SRH in the DOH, and the rules-in-use in the organisation, in the context of two action arenas (agenda setting and policy formulation), as an institutional approach to analysing how actors (policymakers) perceive and use evidence in policymaking. Figure 4.1 provides a summary of this institutional analysis. This examination of the role of evidence in the agenda setting and policy formulation phases of the policymaking cycle in the DOH shows the interplay of macro and micro domains of influence from the political stream, and sheds light into the multitude of influencing factors and the complex dynamics that pervade different facets of the policymaking process.

What influences use of evidence in agenda setting and policy formulation? Findings show that the policymakers in the DOH and PopCom have considerable agency and are able to rationally decide on SRH policy issues, as well as effectively use their skills in research, negotiations, and interpretation to identify issues that need to be prioritised. Similarly, policymakers are given the resources needed to successfully defend what they believe should be prioritised; albeit the resources may be insufficient, as in financial aspects.

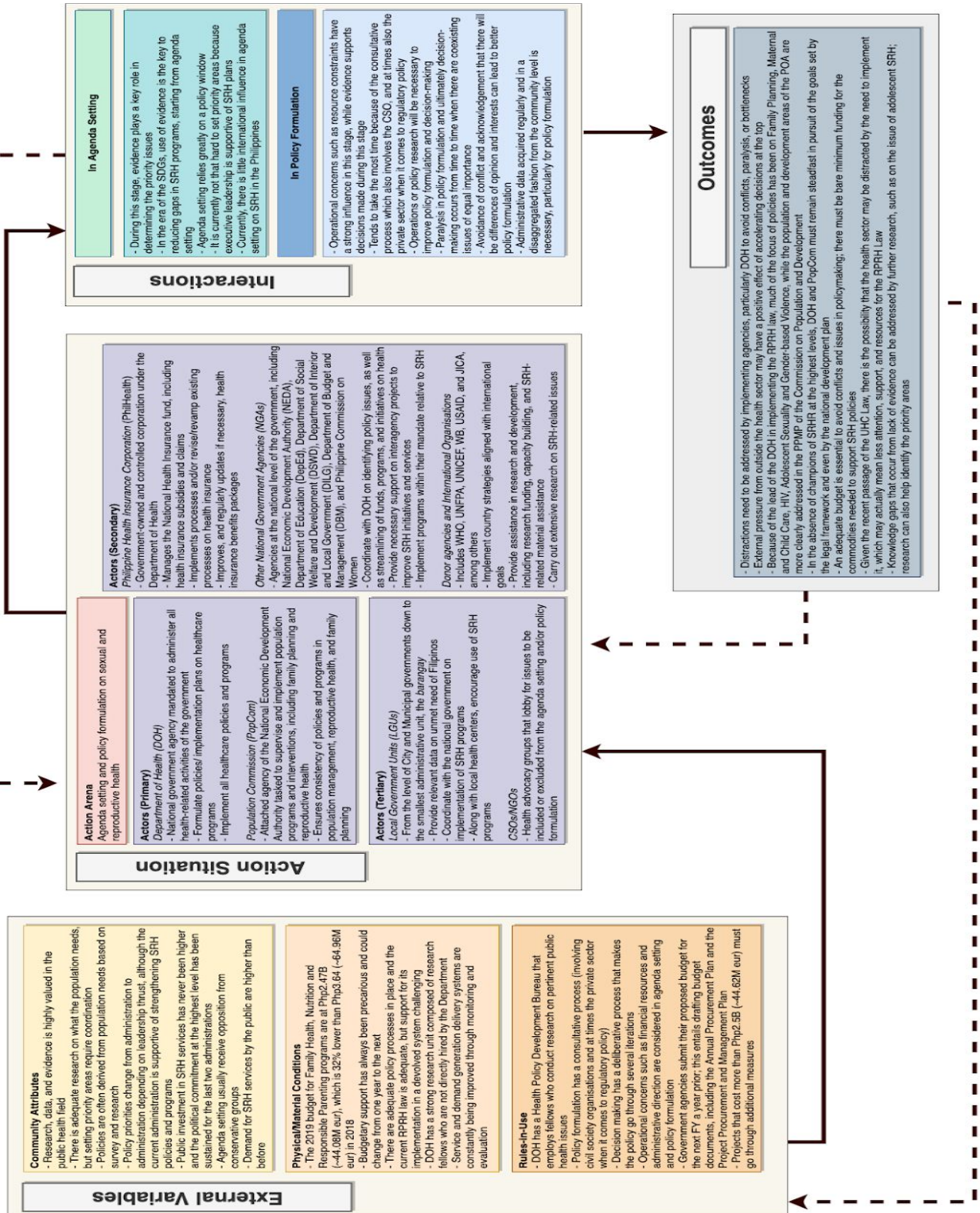
For example, Respondent NEDA-PC-1 mentioned that public investment in SRH services has never been stronger than in the last few years, and that current political commitment at the highest level of government (i.e., the Executive) has been sustained for at least the last two administrations. Respondent NEDA-PC-1 also identified that the current legal framework and guidelines in place are adequate, although support for actual policies to be implemented and service delivery are problematic, given the devolved health system in the Philippines. Further, Respondent NEDA-PC-1 identified that operational and political factors that affect SRH policymaking, including budgetary support which has always been precarious and could change from one year to the next, despite communicated support from the administration. Likewise, evidence is identified to have a huge role in the policy process, as communicated by all respondents, most especially by respondents DOH-HPDPB-1 and UNFPA-PDD-1. Respondent UNFPA-PDD-1 communicated approval on the current strategies being implemented in the policy process in the DOH, which is based on evidence culled from both local and global studies; while Respondent DOH-BIHC-1, who has experience attending international discussions on public health, communicated that evidence-based policymaking is well-practiced in the DOH, similar to international norms. It was raised by Respondent NEDA-PC-1, however, that despite (or notwithstanding) the presence of international organisations and donor agencies, their influence on agenda setting and policy formulation are limited.

The political context and competing policy priorities were identified to be influential external factors. While in many instances, political pressure has negatively affected agenda setting and policy formulation (such as in the case of illegality of abortion, and the less controversial case of temporary ban on contraception), it has been communicated by Respondent NEDA-PC-1 that external pressure from outside the public health sector may have the positive effect of accelerating decisions at the top (such as when CSOs and NGOs called for the lifting of the temporary ban on contraception). In addition, Respondent UNFPA-PDD-1 mentioned the influence of faith-based groups, particularly in opposing



SRH policies, such as in the case of sexuality education and contraception provision to adolescents.

**Figure 4.1**  
Institutional Analysis in this study



The process of agenda setting and policy formulation necessitates priority-setting and identification of the possible courses of policy action, mainly arrived at through interactions and socio-political processes. Evidence from research plays a huge role in determining public health issues that should be prioritised, and identifying the corresponding courses of actions that would most likely be effective. Respondent DOH-HPDPB-1 mentioned that research is very strong in the DOH, whose research arm is ‘outsourced’ in that the research fellows are not internal hires to prevent bias in research and evidence gathering and its subsequent use in agenda setting and policy formulation.

## **4.2. Challenges in Evidence-Based Policymaking in the Department of Health (DOH)**

There is an inherent assumption among researchers and non-policy practitioners that the widespread accessibility and availability, and good quality of evidence will inform or translate to good policy decisions. Criticised for being over-simplistic, this rationalistic view neglects the fact that the policy process is “non-linear, varied and complex” (Sohn 2018: 2). Decisions on public policy issues largely depend on factors outside of the sphere of evidence, and are usually determined by the ability of policymakers to interpret and assign meaning to such evidence, and ultimately, to translate it for use on the policy problem. Thus, an effective policy process is not merely about producing a good policy design, or the straightforward application of hard evidence in the policy context—it is about interpreting evidence given the context (policy, political, and operational). On the part of the policymaker, this involves the use of prior knowledge, training, norms, and organisational rules to properly and effectively assess the quality and value of the evidence, and determine whether it is politically and economically supportive of the policy issue (Sohn 2018: 2).

While it seems straightforward enough, in reality evidence-based policymaking is complicated—contextual forces such as the political situation and competing interests, alongside resource availability and budgetary constraints, shape policy decisions and outcomes—and unfortunately, the mere existence of the best available evidence does not guarantee its use. Indeed, evidence-based policymaking in public health in the Philippines faces many challenges that can be classified into two major groups: i) socioeconomic and political, and ii) technical and operational.

### **4.2.1. Socioeconomic and Political Challenges**

A policymaker’s behaviour, beliefs, and values, as well as that of the organisation’s, and other political-economic factors, including organisational rules-in-use and institutional culture are some of the major factors that influence how evidence is used to inform policy. In the Philippines, a largely Christian country, there are socioeconomic, cultural, and political constraints that make it difficult to set policy targets on SRH issues. There is often strong sentiments from conservative groups on sensitive SRH issues, such as abortion, contraception, and teenage pregnancy. Respondent UNFPA-PDD-1 mentioned that to effectively make SRH policymaking inclusive, the organisation involves faith-based groups in discussions, on SRH interventions, such as in the newly constituted Bangsamoro Autonomous Region in Muslim Mindanao (located in the southern part of the Philippines), where the UNFPA had already touched base with the *imams* to create a *fatwa* for RH issues.

Leadership and organisational culture also affect the use of evidence. Indeed, existing normative concepts such as values, moral convictions, religious, and cultural identity, or a sense of nationalism can influence the selection or translation of evidence in public health policy development (Liverani et al. 2013: 5). Competing values tend to create bottlenecks or paralysis in the process, as Respondent NEDA-PC-1 emphasised in the interview, citing the example of two pending projects that had the same policy issues, but whose focus were slightly different. While it could be argued that the framing of the policy issue affects the uptake of evidence to support it, leadership and values also affect whether research evidence will be recognised and ultimately utilised. As the current leadership in the Philippines is highly supportive of SRH programs, there is an increased use of research and evidence to support SRH policies.

Another aspect of leadership involves what are called ‘first order’ and ‘second order’ decision-making. It is argued that evidence is used more in ‘second order’ decisions, or those involving *how to do something*, rather than in ‘first order’ decisions, or those involving *whether to do something* (Liverani et al. 2013: 5). Second order decisions tend to address technical issues in the actual stage of developing a policy, *after* the decision to move forward with a chosen policy issue has been carried out (first order). Most second order decisions are carried out by government staff actually involved in developing parameters of the policy, such as programming and implementation details for execution, and usually work with technical committees, experts, and practitioners in the field who provide insights including best practices—in other words, second-order stage is “technical, formal, and publicly official, and evidence-use in this stage is essentially for policy development” (Sohn 2018: 3). This is observable in the context of the Philippines, particularly in policy formulation that comes after the agenda has been set, or after the first order decision to focus on a specific policy problem has been made. Indeed, two of the Respondents from the DOH are technical staff, and are thus involved in second order decision making, or actual policy research.

Lastly, the Philippines being a lower-income country, SRH issues are particularly relevant to international donors providing development aid. The priorities and guidelines set by these donors and other international organisations affect the use of evidence, especially on how research is prioritised and conducted, and the findings used and interpreted to permeate policy decisions. Donors oftentimes promote SRH interventions that are backed by strong evidence base, although these interventions may neglect local context, needs, and capabilities (Liverani et al. 2013: 5). In terms of SRH interventions, donor organisations have a strong presence in the Philippines; however, because evidence-based policymaking is in practice in the DOH and PopCom, international organisations work with the government to collect local data which are then used in designing locally- or country-appropriate interventions. Regarding this concern, Respondent NEDA-PC-1 communicated that the strong presence of international organisations do not affect agenda setting and policy formulation, but are usually felt in implementation, and in Monitoring and Evaluation (M&E). On the other hand, Respondent DOH-BIHC-1 commented that the research efforts in the DOH central office are aligned with the SRH priority areas and key research domains put forward and recommended by international organisations, particularly those relevant to achieving the SDG.

#### 4.2.2. Technical and Operational Challenges

Other key factors that influence uptake of evidence in policymaking involves widening the coverage, and are therefore beyond the scope of this study; however, these are still worth mentioning and looking into in the context of the Philippines: i) the system and form of government (influence of party systems called partylists in the Philippines; coordination and information sharing between the different branches of government; power struggles, imbalances, and hierarchies in government agencies; ii) perceived political legitimacy of SRH interventions given the sociocultural context; and iii) capacity, ‘institutional memory,’ and turnover of staff in government agencies.

In terms of technical and operational challenges, however, there were several factors identified. One is the availability of evidence. Two of the Respondents (DOH-HPDPB-1 and UNFPA-PDD-1) communicated concerns on the availability of evidence in two scenarios. First is the unavailability of evidence during decision-making, as research involves considerable time to be produced; thus, by the time evidence becomes available, priorities may have already been made, agenda may have been set, and the perceived value and usefulness of the data may have diminished. Second is the disconnect between researchers and policy practitioners, who usually come from opposite backgrounds and have therefore different values, skills, and interests. Oftentimes, evidence is too clinical and is therefore difficult for a policy practitioner from a non-clinical background to access and understand, resulting in a mismatch of identified issues and priority areas.

It is interesting to note that in the DOH, those involved in both research and policymaking process, including the actual policy practitioners, are mostly medical doctors or nurses by profession who have trained to be public health practitioners. Because of this demographic, the barrier between researchers and policy practitioners is not highly observable in the DOH; in fact, the disconnect only occurs when political appointees from non-medical or clinical backgrounds are involved in the policy process (such as lawyers and legislative liaisons in the department). Nevertheless, it is a concern and advocacy in the DOH that evidence be translatable to actual policy through constant and open communication of the purpose, value, and application of the evidence.

Another operational barrier to evidence-based policymaking is funding constraints within the organisation, considering the high cost of research to obtain relevant evidence. While the DOH relies on research and evidence produced internally by its research fellows and other units, as well as data and information from relevant government agencies, there is no process or functional guidelines in place that regulates the intra-agency use and inter-agency sharing of evidence. As such, there is not one unit that is tasked to ensure that coordination is maintained in collecting and compiling evidence within the agency, and between agencies. Indeed, the policy window is often unpredictable, and so decisions are reflective and often based on past practices, sentiments, and anecdotes, rather than proactive and based on current, available evidence.

Organisational leadership is another factor identified. Having a health minister that supports and promotes evidence use stimulates a similar value and preference within the organisation. Three of the Respondents (DOH-BIHC-1, DOH-HPDPB-1, and UNFPA-PDD-1) indicated that the support and promotion of evidence from higher level officials within the organisation, as well as outside it (i.e., the President as the Chief Executive) is a primary facilitator of evidence-based decision-making. Indeed, having such

kind of leadership is a necessary condition to creating a culture of evidence-based policymaking within organisations, notwithstanding the sector.

Budgetary consideration and support is also identified as a major factor. Two Respondents (NEDA-PC-1 and UNFPA-PDD-1) communicated that budget or fiscal support from the central government is essential to the research and policy process. Despite communicated support of the RPRH Law and corresponding SRH programs and policies, fiscal support has been precarious and changes from year to year, and the projected necessary budget of Php10B remains elusive. Without adequate fiscal support, only the bare minimum can be allocated for research, and thus, the policy process is affected.

Lastly, given the recent passage of the UHC Law, there is also a possibility that the health sector may be burdened by the implementation of such a gargantuan task. This means that budgetary and personnel resources may possibly be diverted to the UHC Law, thus, less prioritisation of policies and interventions relevant to the RPRH Law.

## Chapter 5

### Conclusions and Policy Recommendations

Evidence-based policymaking is not the answer in itself if it does not translate to practice. Indeed, evidence alone is useless if policymakers cannot make sense of it. Especially in the field of public health, clinical and evidence culled from research is only as good as its social interpretation. If the disconnect between data and interpretation is eliminated, the result is an abundance of information that is key not only to improving people's health, but to saving lives as well.

This study identified a number of factors that affect and influence evidence use in policymaking in the public health sector, specifically in agenda setting and policy formulation in the Department of Health (DOH). With the explicit recognition that policymaking is non-linear, and that politics plays a huge part in evidence-based decision-making despite the existence of clear and current research data, future studies must make more specific and concrete inquiries on the effects of different organisational and institutional factors on evidence use. These factors, as has been suggested previously, include the effect of the system and form of government, the effects of lack of coordination, information asymmetry, and power struggles between the different branches of government, the importance of institutional capacity, including 'institutional memory,' and the importance of capability of researchers and policymakers in government. Furthermore, sociocultural conditions must be explored as well, specifically the perceived political legitimacy of sexual and reproductive health (SRH) interventions and programs vis-à-vis international standards.

Does the use of evidence legitimise decision-making? Can the establishment of evidence-based guidelines promote policy change in institutions and organisations, regardless of political context? Given these considerations, what kind of institutional arrangements then would facilitate the uptake of evidence, regardless of political and organisational contexts? This study finds that smooth communication and coordination between researchers and policy practitioners, even in the context of a restrictive political window, will translate to positive identification of priority issues in SRH. Indeed, given the close coordination within the DOH (inter-unit, between research/policy and implementation units), and of DOH with relevant agencies such as NEDA/PopCom and DepEd, agenda setting and policy formulation usually goes smoothly, save for highly controversial SRH issues.

As has been described throughout this paper, policy decisions regarding public health issues, specifically on SRH, are not solely based on clinical data and purely rational considerations—it is in fact, highly influenced by competing interests and values, and subject to the power struggle between various actors, not to mention affected by other contextual and socioeconomic factors. As shown in the analysis, the Institutional Analysis and Development (IAD) framework worked perfectly with the MSA in identifying political and other exogenous factors affecting SRH policymaking, specifically considering evidence use. Given a good evidence base, it is possible to influence SRH policy even in a precarious policy window; however, to effectively apply evidence in policymaking, researchers and policy practitioners must not assume that the evidence will speak for itself. To facilitate a better understanding and use of evidence in policymaking, it is proposed that technical

guidelines on the use of evidence must be established in the DOH, in coordination with other agencies including NEDA/PopCom, DepEd, PNAC, and DSWD. Similarly, best practices on evidence use must be inculcated in the organisational culture, particularly on policymakers and researchers, so as to avoid miscommunication and misunderstanding on policy priorities. Further, for evidence and research to achieve maximum influence, policymakers must have the means and skills to interpret decision-making even in uncertain conditions.

Moreover, considering the huge role of political factors in SRH policymaking, many issues will remain contentious, and conservative groups will continue to advocate against them. As such, conservative and faith-based groups, and other interest groups must be included in consultations and advocacy to better understand their views and achieve a compromise that will be beneficial to the public. Specifically for adolescent SRH, social mobilisation of the youth must be encouraged, in order to stimulate advocacy and calls for rights, which in turn would serve as evidence to inform SRH interventions and strategies.

Lastly, merely calling for greater political will, promotion of policy dialogue, and identification of external and internal issues is not enough in the long-term effectivity of evidence-based policymaking. There must be a sustained effort to encourage the use and interpretation of evidence, so as to make it a best practice approach, by looking into the following aspects: formal and informal processes affecting decision-making; opportunities and constraints within specific SRH issues; actors and stakeholders that are affected by SRH policies and programs; and the behaviour of actors and stakeholders (including their influence, positions, interests, and degree of commitment).

To finally conclude, this study contributes to analysing evidence-based policymaking in the context of SRH, particularly in a developing country, by using the IAD Framework with the Multiple Streams Approach that has influenced countless policy studies before. As the overall analytical framework of this study, it helped answer the main and sub-research questions on which this study was conducted. While not comprehensive, this study was able to glimpse into the practice of using evidence in policymaking in a developing economy where SRH issues are still controversial. Indeed, it is with conviction that this study parts with the idea that given a good understanding of evidence and its value in policymaking, it would not be impossible to permeate even the most contentious policy issues.

# Annexes

## Annex 1

### Provisions pertaining to conscientious objection in the RPRH Law

All items in bold have been declared unconstitutional by the Supreme Court, and were therefore deleted:

“Section 5.23 *Private Skilled Health Professional as a Conscientious Objector*. In order to legally refuse to deliver reproductive health care services or information as a conscientious objector, a private skilled health professional shall comply with the following requirements:

- a) **Submission to the DOH of an affidavit stating the modern family planning methods that he or she refuses to provide and his or her reasons for objection;**
- b) Posting of a notice at the entrance of the clinic or place of practice, in a prominent location and using a clear/legible font, enumerating the reproductive health services he or she refuses to provide; and,
- c) Other requirements as determined by the DOH.”

“Section 5.24 *Public Skilled Health Professional as a Conscientious Objector*. In order to legally refuse to deliver reproductive health care services or information as a conscientious objector, a public skilled health professional shall comply with the following requirements:

- a) The skilled health professional shall explain to the client the limited range of services he/she can provide;
- b) **Extraordinary diligence shall be exerted to refer the client seeking care to another skilled health professional or volunteer willing and capable of delivering the desired reproductive health care service within the same facility;**
- c) **If within the same health facility, there is no other skilled health professional or volunteer willing and capable of delivering the desired reproductive health care service, the conscientious objector shall refer the client to another specific health facility or provider that is conveniently accessible in consideration of the client's travel arrangements and financial capacity;**
- d) Written documentation of compliance with the preceding requirements; and,
- e) Other requirements as determined by the DOH.

**In the event where the public skilled health professional cannot comply with all of the above requirements, he or she shall deliver the client's desired reproductive health care service or information without further delay.**

***Provided, That* skilled health professionals such as provincial, city, or municipal health officers, chiefs of hospitals, head nurses, supervising midwives, among others, who by virtue of their office are specifically charged with the duty to implement the provisions of the RPRH Act and these Rules, cannot be considered as conscientious objectors.”**

“Section 5.25 *Duty of Exempted Facilities and/or Conscientious Objectors to Refer*. In the event that a private health care facility invokes exemption, or a health care provider conscientiously objects to provide certain methods of modern family planning services, the facility or provider shall, within the same consultation hour, refer the patient seeking care and/or services to another specific provider and/or facility that is conveniently accessible and can provide the requested services; ***Provided, That*** the patient is not in an emergency or serious case as defined in RA 8344.”



**Annex 2**  
Coding and Details of Key Informant Interviews

No.	Office/Agency	Position	Interview Schedule	Code
<b>Department of Health (DOH)</b>				
1	Office of the Secretary	Executive Assistant/ Medical Officer	November 6, 7:00 am through email	DOH-EA-1
2	Bureau of International Health Cooperation	Programme Officer	October 5, 12:00 nn Antipolo City	DOH-BIHC-1
3	Health Policy Development and Planning Bureau - Health Research Division	Research Fellow	October 1, 8:00 am Pasay City	DOH-HPDPB-1
<b>National Economic and Development Authority (NEDA)</b>				
4	Population Commission	Executive Director	October 20, 11:25 am, through email	NEDA-PC-1
<b>UN Population Fund (UNFPA) - Philippines</b>				
5	Population Development Division	Programme Coordinator	October 6, 6:00 pm, through messaging app	UNFPA-PDD-1

### Annex 3

#### Programs and Services of the Department of Health (DOH) relative to the 12 Elements of the RPRH Law (As of 2017)

RH Element	Health Programs	Services Provided
1) Family planning (FP) information and services	<i>National Family Planning Program</i> - improve Contraceptive Prevalence Rate and reduce Unmet Need for Family Planning (FP)	<ol style="list-style-type: none"> <li>1) FP interpersonal communication and information and services</li> <li>2) Modern Natural FP methods: <ol style="list-style-type: none"> <li>a) Cycle Beads for Standard Day Method</li> <li>b) Digital thermometer for Symptothermal method</li> <li>c) Cervical Mucus Method Charts</li> <li>d) Basal Body Temperature Charts</li> <li>e) Teaching and Counseling on Lactational Amenorrhea Method</li> </ol> </li> <li>3) Modern Artificial FP methods: <ol style="list-style-type: none"> <li>a) Oral Contraceptive Pills (Progestin-Only Pills and Combined Oral Contraceptives)</li> <li>b) Injectables</li> <li>c) Male Condoms</li> <li>d) Subdermal Implants</li> <li>e) Copper Intrauterine Devices (IUD)</li> <li>f) Bilateral Tubal Ligation (BTL)</li> <li>g) Non-Scalpel Vasectomy (NSV)</li> </ol> </li> <li>4) PhilHealth Benefit Package for FP methods (IUD, NSV, BTL, Subdermal implants)</li> </ol>
2) Maternal, infant and child health and nutrition, including breastfeeding	<i>National Safe Motherhood Program</i> - reduce Maternal Mortality, promote facility-based deliveries, and increase skilled health professionals	<ol style="list-style-type: none"> <li>1) Pregnancy tracking</li> <li>2) Antenatal Care</li> <li>3) Provision of Tetanus Diphtheria Toxoid Vaccination during pregnancy</li> <li>4) Birth Planning</li> <li>5) Promotion of Facility-Based Delivery</li> <li>6) Promotion of Skilled Health Professional in child birthing</li> <li>7) Training for Basic Emergency Obstetric and Newborn Care (BEmONC)</li> <li>8) Provision of life-saving drugs (oxytocin, magnesium sulfate, antibiotics, maternal steroids, etc.) and other logistics through the Maternity Care Package (MCP) of PhilHealth</li> <li>9) Postnatal Care</li> </ol>
	<i>Newborn and Infant Health Program</i> - address newborn survival and reduction of newborn mortality	<ol style="list-style-type: none"> <li>1) Implementation of Essential Intrapartum Newborn Care (EINC) protocol</li> <li>2) Care for small babies using Kangaroo Mother Care, EINC and Emergency Obstetric and Newborn Care, and screening</li> <li>3) Promotion of exclusive breastfeeding of infants 0-6 months and complementary feeding for aged 6 months to 2 years and beyond through Infant Young Child Feeding (IYCF)</li> <li>4) Promotion of exclusive breastfeeding through Mother Baby-Friendly Health Initiatives (MBFHI) in health care facilities</li> </ol>

		<ul style="list-style-type: none"> <li>5) Promotion of breastfeeding in the workplace</li> <li>6) Lactation Management Training</li> </ul>
	<p><i>Nutrition Program - micronutrient supplementation of Vitamin A, iron and iodine to address Micronutrient deficiencies</i></p>	<ul style="list-style-type: none"> <li>1) Vit. A 1 00,000 IU for children 6-11 months old</li> <li>2) Vit. A 200,000 IU for children 12-59 months old</li> <li>3) Vit. A 200,000 IU for lactating women</li> <li>4) Iron folic acid tablet with 60 mg elemental iron and 400 meg folic acid for pregnant and lactating women</li> <li>5) Iron drops 15 mg for low birth weight infants</li> <li>6) Micronutrient Powder for children 6-23 months old</li> <li>7) Iodine for pregnant women in high iodine deficiency disorder endemic areas</li> <li>8) Calcium carbonate 500 mg for pregnant women</li> <li>9) Ready-to-Use Therapeutic Food (RUTF) sachet for severe acute malnourished children below 5 years old (F 75, F 100, RUTF)</li> <li>10) Ready-to-Use Supplementary Food for nutritionally-at-risk pregnant and lactating women and children 6-23 months old</li> </ul>
	<p><i>Child Development and Disability Prevention Program - promotion of children's development and prevention of disabilities through screening services and early detection</i></p>	<ul style="list-style-type: none"> <li>1) Basic newborn care, such as Eye Program prophylaxis; Umbilical cord care; Vit. K; and Thermal Care</li> <li>2) Newborn Screening tests for early disabilities through screening detection of congenital metabolic disorders services and early detection (such as phenylketonuria, galactosemia, congenital hypothyroidism, etc.)</li> <li>3) Newborn Hearing Screening tests to identify hearing loss in infants shortly after birth</li> <li>4) PhilHealth Newborn Care Package</li> </ul>
	<p><i>Management of Sick Children Program - Provision of IMCI medicines for diarrhea and pneumonia, and provision of therapeutic food for the management of severe acute malnutrition</i></p>	<ul style="list-style-type: none"> <li>1) Integrated Management of Childhood Illnesses (IMCI)</li> <li>2) Zinc syrup 20 mg</li> <li>3) Zinc drops for children 6 months to 5 years old</li> <li>4) Oral rehydrating solutions</li> <li>5) Amoxicillin 1 00 mg suspension</li> <li>6) Amoxicillin 250 mg suspension</li> </ul>
	<p><i>Oral Health Program - Addresses dental caries</i></p>	<ul style="list-style-type: none"> <li>1) Sealant Kit with Light Cure units</li> <li>2) Light cured composite kits</li> <li>3) Glass ionomer for atraumatic restorative treatment</li> <li>4) Fluoride varnish</li> <li>5) Essential Health Care Package 1: <ul style="list-style-type: none"> <li>a) Fluoride toothpaste 500 ml</li> <li>b) Kiddie toothbrush for ages 3-5 years old</li> <li>c) Germicidal soap 80 mg</li> </ul> </li> <li>6) Essential Health Care Package 2: <ul style="list-style-type: none"> <li>a) Cotton face towel</li> <li>b) Drinking cup</li> </ul> </li> </ul>

	<i>Expanded Program on Immunization</i> - address common childhood vaccine preventable diseases through immunization	<p>Vaccination for infants/children:</p> <ol style="list-style-type: none"> <li>1) Bacillus Calmette-Guerin (BCG) Vaccine</li> <li>2) Hepatitis B Vaccine</li> <li>3) DPT-HepB-HiB (Pentavalent) Vaccine</li> <li>4) Oral Polio Vaccine</li> <li>5) Measles-Mumps-Rubella (MMR) Vaccine</li> <li>6) Pneumococcal Conjugate Vaccine (PCV) 13</li> <li>7) Inactivated Polio Vaccine (IPV)</li> </ol> <p>Vaccination for adolescents and pregnant women:</p> <ol style="list-style-type: none"> <li>8) Tetanus Diphtheria Toxoid</li> </ol> <p>Vaccine Vaccination for senior citizens:</p> <ol style="list-style-type: none"> <li>9) Pneumococcal Polyvalent Vaccine</li> <li>10) Influenza Vaccine</li> </ol>
4) Adolescent and youth reproductive health guidance and counseling	<i>Adolescent Health and Development Program</i> - Improve access of adolescents to health information and services	<ol style="list-style-type: none"> <li>1) Tetanus Diphtheria Measles Rubella (Td - MR) Vaccination among Grade 1 and Grade 7 pupils in public schools</li> <li>2) Human Papillomavirus Vaccination among Grade 4 pupils (ages 9-13) in select public schools</li> <li>3) Institutionalization of Adolescent-Friendly Health Facilities</li> <li>4) Training on Adolescent Job Aid (AJA) for health workers in dealing with adolescent clients</li> <li>5) Adolescent Health Education and Practical Training (ADEPT) for health workers in dealing with adolescent clients</li> <li>6) Healthy Young Ones project using information, education and communication (IEC) materials on anatomy and physiology, human development, sexuality, growth and development</li> <li>7) Peer Education on adolescent health and development</li> </ol>
5) Prevention, treatment and management of reproductive tract infections (RTIs), HIV and AIDS and other sexually-transmissible infections (STIs)	<i>Human Immunodeficiency Virus (HIV)/ Sexually Transmitted Infection (STI) Prevention Program</i> - Reduce the transmission of HIV and STI among key populations, and mitigate the impact of HIV at the individual, family, and community levels	<ol style="list-style-type: none"> <li>1) Free Antiretroviral drugs</li> <li>2) Augmentation of drugs for STI</li> <li>3) Syphilis testing in STI clinics (Social Hygiene Clinic, HIV Primary Care Clinics)</li> <li>4) HIV testing and counseling</li> <li>5) Viral load test</li> <li>6) Free and focused provision of condoms and water-based lubricants</li> <li>7) Peer-led outreach activities and community-based HIV screening</li> <li>8) Treatment adherence counseling</li> <li>9) PhilHealth Outpatient HIV/AIDS Package</li> </ol>
6) Elimination of violence against women and children and other forms of sexual and gender-based violence	<i>Women and Children Protection Program</i> - address gender-based violence among women and children	<ol style="list-style-type: none"> <li>1) Provision of appropriate medical and psychological treatment for victims Violence Against Women and Children (VAWC) through the Women and Children Protection Units (WCPUs) in hospitals</li> <li>2) Medico-legal examination</li> <li>3) Forensic examination</li> <li>4) Gender-sensitive counseling</li> </ol>

		5) Expert testimony in court
8) Treatment of breast and reproductive tract cancers and other gynecological conditions and disorders	<i>Cancer Control Program</i> - reduce the impact of cancer and improve the well-being of Filipinos with cancer and their families	1) Visual inspection with acetic acid in primary healthcare facilities 2) Papanikolaou (Pap) Smear in hospitals 3) PhilHealth Z benefit package for RH-related cancers (cancer in the breast, prostate, cervix, etc.)

Source: Department of Health (DOH) Department Circular No. 2017-0301, 22 August 2017.

## References

- Bell, E.D. (2010) *Research for Health Policy*. Oxford: Oxford University Press.
- Brownson, R.C., J.E. Fielding and C.M. Maylahn (2009) 'Evidence-Based Public Health: A Fundamental Concept for Public Health Practice', *Annual Review of Public Health* 30(1): 175-201.
- Brownson, R.C., J.F. Chiriqui and K.A. Stamatakis (2009) 'Understanding Evidence-Based Public Health Policy', *American Journal of Public Health* 99(9): 1576-1583.
- Buse K., A. Martin-Hilber, N. Widyantoro, and S.J. Hawkes (2006) 'Management of the Politics of Evidence-Based Sexual and Reproductive Health Policy', *The Lancet* 368(9552): 2101-2013.
- Cabral, E. (2014) 'Reproductive Health Law in the Philippines', *Journal of the ASEAN Federation of Endocrine Societies* 28(1).
- Cairney, P. (2016) *The Politics of Evidence-Based Policy Making*. Basingstoke: Palgrave Macmillan.
- Center for Reproductive Rights (CRR) (2010) 'Forsaken Lives: The Harmful Impact of the Philippine Criminal Abortion Ban'. New York: Center for Reproductive Rights.
- Conde, C.H. (2005) 'Philippines Abortion Crisis' *The New York Times*, Accessed 2019 <<https://www.nytimes.com/2005/05/16/world/asia/philippines-abortion-crisis.html>>.
- Cornwall, A. (2002) 'Body Mapping: Bridging the Gap between Biomedical Messages, Popular Knowledge and Lived Experience', in A. Cornwall, and A. Welbourn (eds) *Realizing Rights, Transforming Approaches to Sexual and Reproductive Well-being*, pp. 219-231. London and New York: Zed Books.
- Corrêa, S. and S. Jolly (2008) 'Development's Encounter with Sexuality: Essentialism and Beyond', in A. Cornwall, S. Corrêa and S. Jolly (eds) *Development with a Body: Sexuality, Human Rights and Development*, pp. 22-41. London: Zed Books.
- Dayrit, M., L. Lagrada, O. Picazo, M. Pons and M. Villaverde (2018) 'The Philippines Health System Review', *Health Systems in Transition*, No. 2, Volume 8. New Delhi: World Health Organization, Regional Office for SouthEast Asia.
- De Wals, P., M.E. Espinoza-Moya, and D. Béland (2019) 'Kingdon's Multiple Streams Framework and the Analysis of Decision-Making Processes Regarding Publicly-Funded Immunization Programs', *Expert Review of Vaccines* 18(6): 575-585.
- DOH 'Department Circular No. 2015-0195' (2015). Philippines.
- DOH 'FY 2018 Budget Folio' (2017). Manila, Philippines: Department of Health.
- DOH '2017 Annual Report' (2018). Manila, Philippines: Health Policy Development and Planning Bureau, Department of Health.
- DOH '4th Annual RPRH Report' (2018). Manila, Philippines: Department of Health.
- DOH 'Administrative Order No. 2019-003' (2019). Manila, Philippines: Department of Health.
- DOH 'FY 2019 Budget Briefer' (2018). Manila, Philippines: Health Policy Development and Planning Bureau, Department of Health.

- Guillaume, A. and C. Rossier (2018). “L’avortement dans le monde. État des lieux des législations, mesures, tendances et conséquences (Translated by Paul Reeve)”, *Population* 73(2): 217-306.
- Guttmacher Institute (2013) “Unintended Pregnancy and Unsafe Abortion in the Philippines”, Fact Sheet. New York: Guttmacher Institute.
- Head, B. W. (2008) ‘Three Lenses of Evidence-Based Policy,’ *Australian Journal of Public Administration* 67(1): 1–11.
- Head, B. W. (2016) “Toward More ‘Evidence-Informed’ Policy Making—Speaking Truth to Power?,” *Public Administration Review* 76(3): 472–484.
- Hennink, M., I. Hutter, and A. Bailey (2011) *Qualitative Research Methods*. London: Sage Publication.
- Howlett, M., A. McConnell, and A. Perl (2017) ‘Moving Policy Theory Forward: Connecting Multiple Stream and Advocacy Coalition Frameworks to Policy Cycle Models of Analysis’, *Australian Journal of Public Administration* 76(1): 65-79.
- Human Rights Watch (2004) ‘Unprotected: Sex, Condoms and the Human Right to Health’ (2004), No. 6 (C), Vol. 16, Human Rights Watch.
- Human Rights Watch (HRW) ‘Fueling the Philippines’ HIV Epidemic Government Barriers to Condom use by Men Who have Sex with Men’ (a webpage of Human Rights Watch). Accessed April 21 2019 <<https://www.hrw.org/report/2016/12/08/fueling-philippines-hiv-epidemic/government-barriers-condom-use-men-who-have-sex>>.
- Killoran, A. and M.P. Kelly (2010) *Evidence-Based Public Health: Effectiveness and Efficiency*. Oxford: Oxford University Press.
- Kusi-Ampofo, O., J. Church, C. Conteh, and B.T. Heinmiller (2015) ‘A Multiple Streams Approach to Understanding Health Policy Making in Ghana’, *Journal of Health Politics, Policy and Law* 40(1): 195-219.
- Lakshminarayanan, R. (2003) ‘Decentralisation and its Implications for Reproductive Health: The Philippines Experience’, *Reproductive Health Matters* 11(21): 96-107.
- Langran, I. (2011) ‘Decentralization, Democratization, and Health: The Philippine Experiment’, *Journal of Asian and African Studies* 46(4): 361-374.
- Liverani M., B. Hawkins, and J.O. Parkhurst (2013) ‘Political and Institutional Influences on the Use of Evidence in Public Health Policy. A Systematic Review,’ *PLOS ONE* 8(10): 1-9.
- Meier, B.M. and L.O. Gostin (2018) *Human Rights in Global Health: Rights-Based Governance for a Globalizing World*. New York, NY: Oxford University Press.
- Melgar, J.L.D., A.R. Melgar, M.P.R. Festin, A.J. Hoopes, and V. Chandra-Mouli (2018) ‘Assessment of Country Policies Affecting Reproductive Health for Adolescents in the Philippines’, *Reproductive Health* 15(1): 1-13.
- ‘Millennium Development Goals’ (Last updated 2019) (a webpage of United Nations Development Programme). Accessed May 6 2019 <[https://www.undp.org/content/undp/en/home/sdgoverview/mdg\\_goals.html](https://www.undp.org/content/undp/en/home/sdgoverview/mdg_goals.html)>.
- NEDA (Last updated 2018) ‘Philippine Development Plan Brochure’ (a webpage of National Economic and Development Authority). Accessed October 5 2019 <<http://www.neda.gov.ph/wp-content/uploads/2018/02/PDP-Brochure.pdf>>.

- NEDA (Last updated 2019) 'EXPLAINER: Universal Health Care Law and what it Means to PH Development' (a webpage of National Economic and Development Authority). Accessed October 20 2019 <<http://www.neda.gov.ph/explainer-universal-health-care-law-and-what-it-means-to-ph-development/>>.
- Office of the President of the Philippines 'Executive Order No. 102, s. 1999' (1999). Manila, Philippines: Office of the President.
- O'Leary, Z. (2014) *The Essential Guide to Doing Your Research Project*. 2nd Edition. London: Sage.
- Ostrom, E. (2011) 'Background on the Institutional Analysis and Development Framework', *The Policy Studies Journal* 39(1): 7-27.
- Parkhurst, J.O. (2017) *The Politics of Evidence: From Evidence-Based Policy to the Good Governance of Evidence*. London: Routledge.
- Parkhurst, J.O., S. Ettelt, and B. Hawkins (2018) *Evidence Use in Health Policy Making: An International Public Policy Perspective*. Switzerland: Palgrave Macmillan.
- Philippine Statistics Authority (PSA) (2017) 'Philippine Population Surpassed the 100 Million Mark (Results from the 2015 Census of Population)' (Last updated 2017) (a webpage of Philippine Statistics Authority). Accessed May 14 2019 <<https://psa.gov.ph/content/philippine-population-surpassed-100-million-mark-results-2015-census-population>>.
- Philippine Statistics Authority (PSA) and ICF (2018) 'Philippines National Demographic and Health Survey 2017'. Quezon City, Philippines, and Rockville, Maryland, USA: PSA and ICF.
- Polski, M. and E. Ostrom (1999) 'An Institutional Framework for Policy Analysis and Design'. Accessed May 14 2019 <<http://www.atelierpolitique.fr/wp-content/uploads/2013/09/Article-PolskiOstromIAD.pdf>>.
- PopCom 'RPRH - Delivery of Services' (a webpage of the Population Commission). Accessed October 20 2019 <<http://www.popcom.gov.ph/23-faq/474-rprh-delivery-of-services>>.
- Rankin, K., J. Jarvis-Thiébaud, N. Pfeifer, M. Engelbert, J. Perng, S. Yoon, and A. Heard (2016) 'Adolescent sexual and reproductive health: an evidence gap map', 3ie Evidence Gap Map Report 5, International Initiative for Impact Evaluation (3ie).
- Social Protection and Human Rights (Last updated 2015) 'Women's Sexual and Reproductive Rights in the Philippines' (a webpage of Social Protection and Human Rights). Accessed August 25 2019 <<https://socialprotection-humanrights.org/legaldep/womens-sexual-and-reproductive-rights-in-the-philippines/>>.
- Sohn, J. (2018) 'Navigating the politics of evidence-informed policymaking: strategies of influential policy actors in Ontario', *Palgrave Communications* 4(49): 1-12.
- Sutcliffe, S. and J. Court (2005) 'Evidence-Based Policymaking: What is it? How does it work? What relevance for developing countries?', ODI Research Reports and Studies. London: Overseas Development Institute.



- Republic Act No. 10354, 'The Responsible Parenthood and Reproductive Health Act of 2012' and its Implementing Rules and Regulations (2012). Philippines.
- Republic Act No. 11166, 'The Philippine HIV and AIDS Policy Act' and its Implementing Rules and Regulations (2019). Philippines.
- Republic Act No. 11223, 'The Universal Health Care Act' and its Implementing Rules and Regulations (2019). Philippines.
- Ritter, A., C. E. Hughes, K. Lancaster, and R. Hoppe (2018) 'Using the Advocacy Coalition Framework and Multiple Streams policy theories to examine the role of evidence, research and other types of knowledge in drug policy', *Addiction* 113(8): 1539-1547
- The World Bank (2017) 'Philippines Health Financing Strengthening 2017', Project Information Document/Identification/Concept Stage (PID). Washington, D.C.: The World Bank.
- United Nations (UN) 'Human Rights and the 2030 Agenda for Sustainable Development' (a webpage of UN Human Rights Office of the High Commissioner). Accessed May 5 2019 <<https://www.ohchr.org/en/issues/SDGS/pages/the2030agenda.aspx>>.
- Upreti, M. and Jacob, J. (2018) "The Philippines' New Postabortion Care Policy", *International Journal of Gynecology & Obstetrics* 141(2): 268–275.
- Weiss, C. (1977) 'Research for Policy's Sake: The Enlightenment Function of Social Research', *Policy Analysis* 3(4): 531-545.
- Weiss, C. (1979) 'The Many Meanings of Research Utilization,' *Public Administration Review* 39(5): 426-431.