"Despite the passage of the Responsible Parenthood and Reproductive Health Law (RA 10353), challenges to its implementation remain – resulting in the denial of and barrier to women's reproductive health and rights. The results of the CHR's National Inquiry on RH provides insight on the implementation of RH law from a human rights perspective and as a result of a grounded and consultative process aimed at making the voices of women heard.

"Let our voices be heard"

Report of the Commission on Human Rights Philippines' National Inquiry on Reproductive Health and Rights

Commission on Human Rights Philippines
Gender Equality and Women's Human Rights Center
UPSAAC Bldg, Commonwealth Ave. UP Diliman Complex, Quezon City

THE COMMISSION ON HUMAN RIGHTS' NATIONAL INQUIRY ON

Reproductive Health Rights

(MARCH - MAY 2016)

THE COMMISSION LAUNCHES THE NATIONAL INQUIRY ON REPRODUCTIVE HEALTH. THE INQUIRY COVERS:

- 15 REGIONAL CONSULTATIONS
- 5 FACT-FINDING & PUBLIC HEARINGS
- COLLECTION OF SUBMISSIONS / ACCOUNTS OF DISCRIMINATION/ DENIAL OF RH SERVICES OR INFORMATION

COMMISSIONER KAREN GOMEZ-DUMPIT

COMMISSIONER GWENDOLYN PIMENTEL-GANA

WE WILL EXAMINE THE EFFECTIVENESS & IMPLEMENTATION OF MAGNA CARTA OF WOMEN AND RESPONSIBLE PARENTHOOD & REPRODUCTIVE HEALTH LAW.

WE WILL DOCUMENT INDIVIDUAL AND SYSTEMIC DENIAL / CHALLENGES / BARRIERS TO R.H. SERVICES AND INFORMATION.

WE WILL ANALYZE. WE WILL RECOMMEND.

LET OUR VOICES BE HEARD, AND LET OUR STORIES COUNT. TOGETHER, WE CALL AND WE CLAIM REPRODUCTIVE JUSTICE!

WHY RH?

PH AT 120 DEATHS PER 100,000 LIVE BIRTHS - UNDP, 2015

MAGNA CARTA GUARANTEES RH RIGHTS (2009)

UN CEDAW INQUIRY: PH COMMITTED GRAVE AND SYSTEMATIC RH VIOLATION WITH E.O. 003 & E.O. 030 (2015)

IT MUST:
- IMPROVE ACCESS TO RH SERVICES
- PROVIDE QUALITY POST-ABORTION CARE
- REVIEW, REPEAL DISCRIMINATORY LAWS
- STRENGTHEN MACHINERIES

R.H. LAW CONSTITUTIONAL

- SUPREME COURT, 2014

BUT: 8 KEY PROVISIONS VOIDED

S.C. ISSUES T.R.O. AGAINST IMPLANON (2015)

R. H. LAW UNCONSTITUTIONAL! - CHURCH GROUPS, 2013

E.O. 003 "PRO-LIFE" MANILA - ATIENZA, 2000

E.O. 030 NO FUNDS FOR ARTIFICIAL BIRTH CONTROL - LIM, 2011

E.O. 3 SORSOGON CITY, "PRO-LIFE" CITY - LEE, 2015

KEEPING TRACK. PHILIPPINES STRUGGLES TO LOWER MATERNAL MORTALITY RATE (MMR)

1 BILLION BUDGET CUT FOR CONTRACEPTIVES

BARANGAY HEALTH CENTER

Welcome!

I HAD AN ABORTION, BUT I'M AFRAID TO SEEK POST-ABORTION CARE. I MIGHT BE IMPRISONED!

I'VE HAD ENOUGH! I WANTED A TUBAL LIGATION, BUT MY HUSBAND REFUSED TO GIVE HIS CONSENT.

I DON'T HAVE ACCESS TO PILLS ANYMORE. OUR MAYOR DECLARED SORSOGON A "PRO-LIFE" CITY.

I'M PREGNANT AND DEAF. I CAN'T UNDERSTAND WHAT HAPPENED DURING MY PRE-NATAL CHECK-UP.

I TRAVELLED THIS FAR, ONLY TO BE DENIED R.H. SERVICES!

I HAVE R.H. NEEDS TOO!

I CAN'T GIVE BIRTH IN THE LYING-IN. I LIVE 3 MOUNTAINS AWAY.

likha

Resolution Adopting the CHR National Inquiry Report on RH

Republika ng Pilipinas
Komisyon ng Karapatang Pantao ng Pilipinas
(Commission on Human Rights of the Philippines)

RESOLUTION
CHR (V) No. AM2016-146

The Commission **RESOLVES** to **ADOPT** the Reproductive Health (RH) Inquiry report, as submitted by the Gender Equality and Women's Human Rights Center (GEWHRC).

SO RESOLVED.

Done this 31st day of August 2016, Quezon City, Philippines.

JOSE LUIS MARTIN C. GASCON
Chairperson

KAREN S. GOMEZ-DUMPIT
Commissioner

GWENDOLYN L.L. PIMENTEL-GANA
Commissioner

LEAH C. TANODRA-ARMAMENTO
Commissioner

ROBERTO EUGENIO T. CADIZ
Commissioner

ATTESTED BY:

MARIA ASUNCION I. MARIANO-MARAVILLA
Commission Secretary

Commission Secretariat
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rose/31H2016

Insights and Reflections on the CHR National Inquiry on RH

Commissioner Karen S. Gomez-Dumpit

I would begin this insights and reflection by giving thanks to all who participated in the activities of the Commission on Human Rights' National Inquiry on Reproductive Health and Rights. To our fifteen regional offices who conducted the regional consultations, to the five CHR regional offices, particularly regions V, VIII, IX, X and NCR who undertook the fact finding and public hearings, to the different organizations, government agencies and individuals who made the consultations productive and meaningful. I am thankful too, to the members of the community who participated during the fact finding and public hearings who opened their doors, their hearts and minds, and shared their stories, specially our partners Likhaan Center for Women and Sarilaya. Thank you for braving many obstacles not just political, but also economic and physical barriers to your being with us in the fact finding and public hearings.

First, let me share my reflections, particularly the negative ones. Because we are in human rights work we always look for what's lacking, we look or gaps and we always look at the glass half empty.

I witnessed different forms of discrimination during the conduct of the National Inquiry on RH. I have seen discrimination on the basis of disability, economic status, SOGI, ethnicity and discrimination on the basis of perhaps religious belief. More than discrimination, I am disturbed by another 'D,' one that is more deliberate. In some of the areas I have seen the "deliberate disregard" for women's choices, the disregard of women's right to have a choice. This disregard I have seen from one particular local government unit. I am specifically disturbed by the disregard and disrespect for women in Sorsogon City were we have seen how women were not allowed the wide range of choices even when they are in fact available. I am disturbed with Sorsogon because the situation does not only affect family planning they are also targeting vaccinations for our children.

It is disturbing because we would want to see a local government unit that would create an enabling environment. Local Government Units are mandated to provide the whole range of reproductive services, not to favor one over the other, especially when the services and resources are available. While we have established that the Department of

Health has taken strides in filling the gap left by the local government unit, I find it very disturbing that an LGU, particularly the Sorsogon City, has made itself a barrier to women's access to the whole range of contraceptives and to services that are supposed to be readily available. This 'disregard' we have also seen in the TRO imposed on Implanon. We have seen how women who favored Implanon were affected by the TRO, and were forced to resort to other methods despite their preference for Implanon. We have likewise seen how government health workers themselves are prevented from dispensing available supplies due to the prohibition.

The third 'D' is disinformation. There are many factors why one develops cancer. In Sorsogon City there is direct campaign connecting cancer to artificial contraceptives. There is disinformation that includes public announcements and different media. As CHR we see the need to correct, address, and bring to attention of duty bearers these rampant 'disinformaiton'/ 'misinformation' as they directly affect women and couples who are considering artificial family planning methods. When women are deprived of correct information on reproductive health and rights, there is also a violation of women's rights.

The fourth 'D' is familial, societal, and government dynamics that influence and impact on the enjoyment of reproductive health rights. These dynamics can either create an enabling environment or act as barriers to women's access to and enjoyment of reproductive health services.

We have observed for instance that the implementation of the RH law is largely uneven, and largely dependent on the political will and support of local government units.

We have also observed that our culture sometimes bars us from the attainment and enjoyment of our rights and sometimes they actually clash with human rights principles. In some instances, policy measures supposedly intended to protect women end up further discriminating them.

Specifically, the Commission's National Inquiry has documented the trend of penalizing and levying fines on women and families who choose home birthing through the passage of provincial, municipal or city ordinances. While the Commission is aware of the good intentions of these ordinances, while we see the importance of safe deliveries, there are also clashes with the beliefs of some indigenous peoples and adverse effects to women from geographically isolated areas without access to facilities. These are dynamics which affect enjoyment of RH services and which were discussed during the Inquiry. In some cases, we have documented good models including the provision of

culturally sensitive services and facilities and of efforts to bring services to those living in inaccessible areas. We hope to have more of these.

There is also dynamics in the family that says contraception should be based on the couple's decision, with the decision of the husband often times prevailing. In these cases, male spouses become barriers and couples are unable to arrive at a joint decision. We have documented instances where women who stood and took a stand for themselves were beaten after, those whose explanations of "we have to, because we cannot afford to bring up one more child" were met with violence. We have to ensure that in these cases, there should be protection and remedies for these women. We have to ensure that women are able to choose without fear of being subjected to different forms of violence.

In sum, discrimination, disrespect, disregard, disinformation and dynamics bring about many practices and policies that turn into barriers leading to the disempowerment of women, violation of their human rights, and violation of specific laws like the Magna Carta of Women and the Responsible Parenthood and Reproductive Health Law.

In terms of context, we must include in the discussion the plight of our health workers --- in the government, in NGOs and in communities. During the inquiry and the fact finding we heard the complaints of doctors, midwives, nurses, and many Barangay Health Workers (BHWs). As volunteers, BHWs cater to the entire community receiving minimal and sometimes no allowance at all. BHW allowances are dependent on the LGU, and their appointment are often politicized. They are however very significant in the delivery of health services in the community level. Overburdened and underpaid, BHWs continue to partner with the LGU and the DOH in delivering services to the community, a task that should be duly recognized and compensated. In the case of doctors, nurses and midwives, we've often heard that there simply aren't enough. The standard patient to doctor, nurses or midwife ration is often unmeet, especially in the case of Doctors. In Sorsogon, for instance, one doctor is in charge of eight RHUs. She sees 200 clients a day. If we divide this by 8 hours, without any break at all, you will only get to see a patient for 25 or 35 seconds. These are realities on the ground. And while we've heard many accounts that health workers often mistreat persons with disability and indigenous peoples, we also know that many of these health workers are also in dire circumstances that do not create an enabling environment for them to mind their manners when dealing with patients. Not excusing such attitude, the Commission sees the urgency of addressing

the needs of health workers, the strengthening of the Magna Carta for Health Professionals, and regularizing/professionalizing BHS.

Throughout the Inquiry, I have come to realize that despite the discrimination, disregard, disinformation and dynamics that lead to disempowerment, there are packets of good practices that we can learn from as a responsible member of the community and as part of national government to replicate. Let me share two good things, two packets of good practice that I think should be commended in this report.

One is the Nurse Deployment Program in Sorsogon. One of the things I'd like to appeal to is for DOH to continue with the program. The NDP will end in November or December of 2016. I hope that the DOH can continue the program including that of midwives, and to vigorously continue the program in areas where there are clear barriers, especially when the barrier is the LGU itself.

Second is the presence of NGOs. While the State is primary duty bearer in fulfilling the rights of women to reproductive health, the presence of NGOs has been crucial in many ways. The presence for example of FPOP, Likhaan, PKKK and Sarilya in communities were very important not only through the dispensation of commodities and services, in providing information and in leading advocacies but also as observatories, as monitor. We consider you our eyes, and our partners to be able to monitor in order to push for an enabling environment for women to have a choice, and for the realization of women's human rights.

I say that we have to widen the choices for women seeing that they are gatekeepers for RH in the family, I do not discount the participation of men. This is my last point, we cannot ignore the critical responsibility of men in the family. We cannot discount the importance of having men who are RH advocates, and who could show and illustrate that families and couples make informed decision. We need models and advocates to show that that men are not barriers but partners in realizing RH in the family, with women, children and men. We also need to see more acceptors on the method of family planning that are geared for men like vasectomy and to send the clear message that RH concerns men too.

These are my reflections, as a woman who journeyed in the Commission's National Inquiry on Reproductive Health. As a woman, I am thankful for the opportunity to have listened to the stories of many women all over the country and for the opportunity to take home learnings from the stories and accounts I have heard. As the Focal Commissioner

on women, I welcome the opportunity of properly documenting and vigorously analyzing policies, practices, and gaps that impact the enjoyment of women's reproductive health, and the opportunity as well to gain lessons, draw recommendations. We see this Inquiry as part of the fulfillment of our role as Gender Ombud. Through the regional consultations, the fact finding, and the public hearings, we have documented the issues and the gaps in the implementation of the law, we have made appropriate recommendations.

Through the findings and recommendations of these report, we are hoping to create concrete changes in the lives of Filipino women and girls.

Commissioner Gwendolyn Ll. Gana-Pimentel

A National Inquiry in the Age of Post-truth politics

I would like to express my sincerest thanks to the participants of the National Inquiry of Reproductive Health that was conducted by the Commission on Human Rights. The inquiry allowed the CHR to gain valuable insights on the opportunities and challenges that have marked the implementation of the Reproductive Health Law. Through the nation-wide consultation done in Manila, Legaspi, Zamboanga City, Tacloban City and Cagayan De Oro City, we have been fortunate enough to be able to hear very detailed stories of the most vulnerable and marginalized sectors in our society such as the poorest of the poor, rural women, indigenous women, women with disabilities, lesbians, Bisexual, and Transwomen, women in the informal economy, elderly women, girl children and women who are internally displaced.

We have been fortunate to have been joined by experienced service providers who identified key issue areas where capacities must be improved so as to ensure that quality reproductive health services are delivered to the most vulnerable and marginalized. I have sensed their frustration as well as their continuing sense of commitment to care for the Filipino women despite of the almost herculean task that have been laid before them. I would also very much like to take this opportunity underscore several key reflections about our national inquiry namely:

The National Inquiry on the Reproductive health law is notable for its timeliness and relevance in light of our present political milieu that William Davies aptly calls the Age of Post-Truth Politics. As Davies so succinctly puts it, "we are in the middle of a transition from a society of facts to a society of data. During this interim, confusion abounds surrounding the exact status of knowledge and numbers in public life, exacerbating the sent that the truth itself is being abandoned." Arguably, the implementation of the Magna Carta for Women and to a greater extent the Reproductive health law has been weakened by conditions present in this era.

The biases and misconceptions that people particularly duty-bearers might have about Reproductive Health matters must be not be allowed to continue much less influence government policy. The stakes are simply very great to permit archaic mindsets to impose their will on our marginalized sectors even though facts do not conform to their worldviews.

It is my fervent hope that the results of our National Inquiry will help key influencers in our country see the continuing challenges to the implementation of the Magna Carta for Women and Reproductive Health Law and move them to utilize their significant political capital in galvanizing the rest of the nation to support the full implementation of these key pieces of legislation.

That our National Inquiry opens the eyes of the public to the harrowing reality that the Philippines despite of our initial public health efforts continue to have one of the highest maternal mortality rates in the Asia-Pacific Region. Scientific data has shown that countries that have progressed to the ranks of high development are those which have significantly lowered their rates of maternal mortality. Thus, I cannot stress enough, that we all must do more in this area if we wish to see our country reach OECD levels of development in our lifetime.

That our reproductive health policies should be evidence-based and that the "pro-life ordinance" such as those promoted in some local government units should reconsider their policy stance in light the data that our inquiry has generated.

As the designated Gender Ombud, the Commission on Human Rights of the Philippines offers to the nation this report as we continue to march towards greater development and equality for our beloved country!

Pursuant to the mandate of the Commission on Human Rights as a National Human Rights Institution (NHRI) and as the Gender Ombud under the Magna Carta of Women (RA 9710), the Commission responded to the calls of women's organizations and reproductive health advocates bewailing the continuing challenges and barriers in the enjoyment of women's right to reproductive health. The decision to undertake the a National Inquiry process was made in the context of these continued challenges despite the passage of the Responsible Parenthood and Reproductive Health (RPRH) Law and the Supreme Court decision upholding its constitutionality. Maternal mortality in the country remains high, the City of Sorsogon adopted a 'Pro-Life" ordinance resulting in denial of RH information and service, and the Supreme Court issued a temporary restraining order on some contraceptives.

I. OBJECTIVES AND STRATEGIES

On 1 March 2016, the Commission launched the National Inquiry on Reproductive Health and Rights with funding support from the United Nations Populations Fund. A national inquiry is an effective strategy adopted by NHRIs in addressing systemic violations of human rights – based on evidence from individual cases, but also embracing an examination of the laws, policies, and programs (or lack of them) which have given rise to violations in question. In conducting the National Inquiry on RH, the Commission sought to (1) Examine the effectiveness and implementation of laws (MCW and the RPRH Law), and related issuances; (2) Document individual and/or systemic accounts of acts or omissions, structures, policies or practices which result to denial of access to reproductive health services; (3) To focus on the denial of and barriers to reproductive health services as experienced by the most vulnerable and marginalized; (4) To document the barriers and problems experienced by service providers, both state and non-state, in providing reproductive health services, particularly to those most vulnerable and marginalized. The process also aims to provide an analysis of women's access to reproductive health on the basis of the State's treaty obligations and mindful of

highlighting the intersectionality of women's discrimination through the accounts provided by the written submissions, the fact finding, and the public hearings.

The Commission adopted a broad-based, inclusive, transparent, participatory and consultative approach in the conduct of its National Inquiry on Reproductive Health. The participation of representatives from marginalized groups and the accessibility for persons with disabilities was ensured during the national inquiry processes. In addition to government as duty bearers and reproductive health advocates, indigenous peoples, moro women, Lesbian, Gays, Bisexual, Transgender and Intersex (LGBTI) organizations, the elderly, the youth, Persons Living with HIV (PLHIV), internally displaced persons (IDPs), informal settlers, migrant workers, prostituted women and other marginalized groups were consulted during the national inquiry process.

National Inquiry in Numbers

From the launch in 1 March 2016, the National Inquiry has conducted fifteen (15) regional consultations[1] on CEDAW and Magna Carta of Women with Special Focus on reproductive health; fifteen (15) days of fact-finding missions in five (5) cluster areas: (1) National Capital Region; (2) Legaspi-Sorsogon; (3) Zamboanga City; (4) Tacloban-Leyte-Samar, and (5) Cagayan de Oro-Bukidnon. Five (5) public hearings were likewise conducted in these areas.

The National Inquiry consulted a total of 1,263 individuals, 551 during the Regional consultations and 712 during the fact finding and public hearings. It covered 5 regions, 13 cities/municipalities, 23 barangays, 29 government health facilities, and 89 statements under oath. Some 80 individual oral/written submissions were gathered and 7 submissions from organizations.

[1] The 15 regional offices of the CHRP conducted "Regional Consultation on CEDAW and Magna Carta of Women with special focus on Reproductive Health" within their areas of jurisdiction the whole month of March 2016. The consultations covered: Access to Justice and VAW; Issues of Women in Marginalized sectors; Issues in relation to displacement and development aggression, and last, the reproductive health and rights. The consultations gathered a total of 551 individuals including 33 indigenous peoples, 32 persons with disabilities, and 27 LGBTs.

II. LEGAL FRAMEWORK

In the conduct of the National Inquiry, the Commission was guided by its mandate as a National Human Rights Institution and by its role as Gender Ombud under the Magna Carta of Women. It was likewise guided the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the views of experts on Reproductive Health and Rights including the CEDAW Committee's views on the Inquiry in the City of Manila, and the provisions of the Magna Carta of Women and the Responsible Parenthood and Reproductive Health Law

CEDAW and Expert views on Reproductive Health and Rights

The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) was adopted by the United Nations General Assembly in 1979. Described as the International Bill of Rights for Women, CEDAW prohibits all forms of discrimination against women including discrimination in the access of health care services. Specifically, Article 12 of the Convention seeks to eliminate discrimination in access to health care and underscores the necessity for appropriate, gender-specific healthcare services such as those related to pregnancy, and post-natal period. A key criterion of compliance with Article 12 is access, which presupposes the availability of sustainable services, including information about services[2]. The CEDAW Committee has identified legal and regulatory barriers to access to health including criminalization of medical procedures, contraception, and abortion[3]; it has also stressed that women's access to services is dependent on their possession and comprehension of necessary information;[4] it also urged health ministries to ensure that women possess knowledge of available services and how to obtain them[5], and for States to ensure access to health care, irrespective of geographic location.[6]

On reproductive and sexual health services, the CEDAW is the first human rights treaty that explicitly requires State parties to ensure access to family planning[7]. Under

[2] Cook and Undurraga, Article 12 in CEDAW a Commentary (2015), p. 318
[3] Id, p. 319
[4] Id, p. 319 citing GR 24
[55] Id, p. 319 citing CO Kyrgystan, CEDAW/C/KGZ/CO/3? (2008)
[6] Id, p. 319 citing CO Syrian Arab Republic, CEDAW/C/SYR/CO/1(2007)
[7] Art. 12 (1), 10 (h), 14 (2) (b), and 16 (1) (e) of CEDAW

GR 24 of the Convention, the Committee required that "appropriate measures are taken to ensure women's access to services in the areas of family planning, pregnancy, confinement and post-natal period and to sexual and reproductive health services.[8]" It stressed that "State parties' failure to remove barriers to women's effective access to reproductive and sexual health services constitutes discrimination against women[9]."

This view has been reiterated in the CEDAW Committee's views in its inquiry in the City of Manila. In its views released in 2015, the Committee concluded that the Philippine government is accountable for grave and systematic violations of women's rights under the CEDAW especially their rights to health [Art 12] and family planning [Art. 16 (1)(e); Art. 10 (h)] in the issuance of the "Pro-Life" EO. It then called on the State to respect, protect, and fulfill women's reproductive rights and address the unmet need for contraception by ensuring universal and affordable access to the full range of sexual and reproductive health services, commodities and related information, including by legalizing access to emergency contraception. The Committee has issued a robust set of recommendations, which include urging the Philippines to revoke executive orders 003 and 030, decriminalize abortion, and sensitize government representatives towards eliminating ideological barriers that limit women's rights.

Magna Carta of Women (RA 9710)

The Magna Carta of Women (Republic Act 9710) is the most comprehensive Philippine legislation upholding women's rights. It provides legal basis for the enforcement of specific civil, political, economic, social and cultural rights of women. Enacted in 2009, it is described as the Filipino women's bill of rights.

As the fulfillment of the Philippines' commitment to CEDAW, the MCW prohibits discrimination against women by recognizing, protecting, fulfilling and promoting all human rights and fundamental freedoms of Filipino women. It reiterates the duty of the State, as the primary duty-bearer, to protect women against discrimination and violation of their rights, and to promote and fulfill their rights in all spheres.

[8] GR Par. 2
[9] GR Par. 11,14, and 17

With respect to health, the law highlights the state's obligation to provide for a comprehensive, culture-sensitive, and gender-responsive health services and programs covering all stages of a woman's life cycle, and which addresses the major causes of women's mortality and morbidity. Section 17 of the law enumerates the services that need to be provided: maternal care; family planning; youth sexuality education; prevention and management of reproductive tract infections; infertility and sexual dysfunction; services for women and children victims of violence; and care of the elderly women.

The law underscores the obligations of the State, its agencies and instrumentalities, and local government units, to implement its provisions. It designated the Commission as the Gender and Development Ombud mandated to advocate for the promotion and protection of women's human rights. In the Commission's Gender Ombud Guidelines, one of the discriminatory acts under the Magna Carta of Women which it can investigate, monitor, and take cognizance of is discrimination in relation to right to health, including reproductive health.

The Responsible Parenthood and Reproductive Health Act (RA 10354)

The Responsible Parenthood and Reproductive Health Act of 2012 (Republic Act 10354) or RPRH Law gives a special focus on the reproductive health rights of women. It underscores the state's obligation to provide universal access to medically-safe, non-abortifacient, effective, legal, affordable, and quality reproductive health care services, methods, and commodities; and to eradicate discriminatory practices, laws and policies that infringe on a person's exercise of reproductive health rights.

The law enumerates the elements of reproductive health care, as follows:

1) Family planning information and services which shall include as a first priority making women of reproductive age fully aware of their respective cycles to make them aware of when fertilization is highly probable, as well as highly improbable;
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 (RTIs), HIV and AIDS and other sexually transmittable infections (STIs);

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) Reproductive health education for the adolescents; and

12) Mental health aspect of reproductive health care.

The law highlights the need to ensure effective partnership among national government, local government units (LGUs) and the private sector in the design, implementation, coordination, integration, monitoring and evaluation of programs that enhance the reproductive health of the people. It also stresses the obligations of the DOH and the LGUs to give effect to its provisions.

III. NATIONAL INQUIRY FINDINGS

In broad strokes, the National Inquiry has documented the uneven implementation and support for the RH law, primarily due to decentralization and the autonomy of local governments units which has largely fragmented the delivery of health services.

The National Inquiry on Reproductive Health show that the RPRH is not being implemented uniformly, and that there are national and local policies and practices that negatively impact women, especially the most marginalized. The National Inquiry documented policies passed by local government units which show disregard for and disrespect of women's choice of family planning methods and commodities despite availability of resources. In some local government units, existing policies deny allocation of resources for artificial family planning methods and/or provide punitive penalties for

practices which affect accessibility and availability of Reproductive Health services and information. In so doing, the Philippines falls short in its obligations under CEDAW, specifically its obligation to "ensure women's access to services in the areas of family planning, pregnancy, confinement and post-natal period and to sexual and reproductive health services.[10]"

On the basis of the objectives of the National Inquiry, the following are the Commission's Findings:

1. UNEVEN IMPLEMENTATION AND SUPPORT OF RPRH BY LOCAL GOVERNMETN UNITS AND EXISTENCE OF DISCRIMINATORY AND LEGAL BARRRIERS

Uneven implementation of RPRH by Local Government Units

The results of the National Inquiry reveal that local government units show varying degrees of support for the implementation of the law from full support and political will to outright refusal to implement provisions of the RH law.

- In Quezon City and the City of Marikina, the LGUs have shown full support to the RPRH Law. In Quezon City, the Gender and Development Ordinance reiterated the provisions of the RPRH law, while in Marikina, they have enacted a Contraceptive Self Reliance Ordinance which accords One Million pesos (PhP1,000,000) annually for contraceptives. This is in addition to that provided by the DOH.

- In the City of Manila, while Executive Order 003 has been superseded by EO 030, the latter order continues to bar local funding for artificial contraceptives. Mayor Atienza's EO declaring Manila City a "Pro-Life City" has been superseded by a subsequent EO by Mayor Lim. The said EO, while not prohibiting the distribution of artificial contraceptives, explicitly stated that the City of Manila will not provide local funding for artificial contraceptives.

- In Sorsogon City, Mayor Sally Lee issued EO 03 which declared the City a "pro-Life City" last 2 February 2015. The National Inquiry established that the issuance of

[10] GR Par. 2

the EO resulted in the withdrawal of all artificial contraceptives in city and community health facilities. There is outright refusal to implement the RPRH law, particularly with respect to provision of artificial contraceptives and in according women the whole range of reproductive health services and information. Accounts of women acceptors of artificial Family Planning commodities, the nurses deployed by the Department of Health, and RH Civil Society Organizations in Sorsogon City attest to the denial of RH commodities, the stigma accorded to both acceptors of and providers of artificial contraceptives, and the financial and psychological burden of the EO on women, especially the marginalized. Reports of misinformation on artificial Family Planning commodities were also documented.

Since the "pro-life" declaration, the Commission has documented reports of denial of family planning commodities, the added financial burden on women who have to purchase commodities, unwanted pregnancies, women giving up their babies for adoption, and of women from far flung barangays whose RH needs remain unmet. To the present, the women of Sorsogon City continue to be deprived of artificial family planning commodities from the City. Their needs, are instead supplemented by efforts of the National Government through the Department of Health (DOH).

Policy and Legal Barriers to RPRH

Other local policies were also found to be contradicting the RPRH law and weakening its effective implementation. The policies that served as barriers to the implementation of the law were the following:

- the TRO on Implanon issued by the Supreme Court. The TRO remains in place depriving women acceptors of the method while supplies of Implanon amounting to millions are in danger of being wasted. This is despite the fact that many health service providers and women from the community prefer Implanon as an FP commodity;
- the required consent from parents for adolescents to access RH services and to have themselves tested for HIV. RH CSOs and Lesbians, Bisexual, Transgender and Intersex advocates highlight the impact of the required

consent and how it deprives sexually active adolescents and those who are at risk of HIV of information and needed services

- the practice of requiring husbands' consent for their wives' availment of RH services, particularly IUD insertion and tubal ligation. While third party consent, including spousal consent is not provided by the RPRH law, the decision in *Imbong vs. Ochoa*[11] has been interpreted by some service providers as establishing spousal complaint for TBL;
- the absolute ban on abortion, which has led to unsafe abortions and to stigma in the access and availability of Post Abortion Care (PAC);
- the absence and unavailability of emergency contraceptives, while not expressly prohibited, the use and access to emergency contraceptives specially among victims of sexual violence is not among the available choices and information provided by government health facilities;
- the provision in the contracts of nurses in the NDPs of Region X providing dismissal in case of pregnancy, while DOH-X claims that the prohibition exists for the protection of women, this constitutes gender based discrimination prohibited by the MCW;
- the criminalization of traditional and indigenous home births in many local government ordinances, while DOH claimed that penalization of home births was not adopted as a policy, the proliferation of Maternal, Neonatal, Child Health and Nutrition (MNCHN) ordinances with provisions penalizing home births resulted from LGU interpretation of their issuances. This highlights the lack of reconciliation regarding the implications of the RH Law on traditional RH practices and the need for clarity of issuances to avoid possible misinterpretation at the LGU level. While there is a DOH initiated IP MNCHN in some pilot areas, information and needed services it does not cover other IP areas, making IP women and IP traditional birth attendants in other areas susceptible to penalties in violation of existing ordinances.

The decision in *Imbong vs. Ochoa*[12] and the declaration of the Supreme Court in upholding the rights of 'consciencious objectors' and the voiding of penalties for government officers refusing to implement the RPRH law also barred full implementation of RPRH. The ruling has been invoked by Sorsogon City's Mayor Lee in refusing to implement the law, and it is used by some government health facilities and health service providers in seeking parental consent for minors and in refusing tubal ligation for married women without the consent of their husbands.

[11] G.R. No. 204819 (April 8, 2014).
[12]

The Department of Health: Challenges amidst decentralization and legal barriers

During the course of the National Inquiry, the Commission has documented the efforts undertaken by the Department of Health (DOH) in the implementation and monitoring of the RPRH law and the challenges it faces. As a policy setting body and as the lead in monitoring the RPRH law through the National and Regional Implementation Monitoring Teams, the DOH has taken the lead in providing implementation guidelines for RPRH. With respect local government units, it has partnered with the Department of Interior and Local Government (DILG) in the issuance of Memorandum Circular 2015-145 which reiterates the roles LGUs in the implementation of the RPRH.

Despite policy guidelines, however, the National Inquiry has shown that there is uneven implementation and support to RPRH and related DOH issuances and directives. In Sorsogon City, despite the efforts of the DOH and the Regional Implementation Team to reach out and dialogue with the Mayor on the implementation of RH and dispensation of artificial contraceptives, the Mayor's resolve not to dispense artificial contraceptives remains. Efforts were unsuccessful and the LGU continued to return boxes of artificial family planning commodities, some of them according to accounts, have expired or are about to expire. In order to address unmet needs and amidst the limitations imposed by decentralization, the DOH responded through the training of nurses from NDPs and tasking them with dispensation of artificial FP commodities in Sorsogon City. Partnerships with CSOs like Family Planning Organization of the Philippines (FPOP) were also forged to supplement the absence of commodities from the LGU facilities. It must be stated however that such measures are temporary and limited in coverage. The NDPs deployed are under contract and are tasked to cover five (5) barangays at a time; on the other hand, CSOs, while able to provide RH services in Sorsogon City, they are subject to attacks by the LGU. One of the staff of FPOP, for instance, has been branded as the 'number one abortionist' in Sorsogon City.

On ordinances criminalizing and penalizing home births, the DOH explains the same as a misinterpretation of LGUs of the Departments encouragement of facility based deliveries. With the proliferation of such ordinances, and the outcry of indigenous groups and women in GIDA areas, representatives from the DOH admit the need to review and for once clarify the Department's stand. It is clear from the Inquiry that the absence of

clear policy guidelines on home births and the enactment of ordinances, the practice will continue, posing threats of penalty for women, especially those who are most marginalized. As pointed out during validation, however, there is a need to blange this with the priority goal of addressing maternal mortality.

Aside from barriers posed by decentralization, the DOH is likewise constrained by legal barriers in the implementation of the RPRH law. Specifically, the Supreme Court's issuance of TRO on Implanon and the impact of the SC ruling on *Imbong vs. Ochoa*. While the latter upheld the constitutionality of the RPRH law, it voided 8 key provisions including penalties for government officials refusing to implement the RPRH on the basis of 'conscientious objection.' It has likewise been used by many health service providers as requiring spousal consent for RH services like tubal ligation.

While decentralization and autonomy of LGUs is enshrined in current laws, the views of the CEDAW committee in the Manila Inquiry is clear that it cannot be made an excuse to renege on the State's obligation under CEDAW. Despite autonomy and decentralization, the Committee has made clear that "decentralization of power through devolution does not in any way negate or reduce the direct responsibility of the State party to fulfil its obligation to respect and ensure the rights of all women within its jurisdiction[13]." It added that safeguards and mechanisms must be in place to ensure that "decentralization or devolution does not lead to discrimination with regard to the enjoyment of rights by women in different regions.[14]"From the foregoing, it is clear that as part of its obligation under CEDAW, including the obligation to eliminate barriers that women face in accessing health services, it is the State's obligation to review and revoke discriminatory policies, legal and regulatory barriers to women's enjoyment of RH rights.

2. *DESPITE PASSAGE OF AND CURRENT NATIONAL IMPLEMENTATION OF THE RPRH LAW, CHALLENGES CONTINUE ON DE FACTO AVAILABILITY, ACCESSIBILITY, SUFFICIENCY, AND ADEQUACY OF RH SERVICES AND INFORMATION*

In terms of Availability, Accessibility, Sufficiency and Adequacy of RH Services and Information, the National Inquiry documented experiences which ranged from excess in terms of commodities, to inadequacy, insufficiency, and inaccessibility in the provisions of RH commodities and services for women who are vulnerable and most marginalized –

[13] CEDAW/C/OP.8/PHL/1
[14] Id

lesbian, bisexual and transgender women, women with disabilities, Moro and Indigenous women, and women living in geographically inaccessible areas. In many instances, health facilities are inaccessible or absent in geographically inaccessible areas, and in cases where they are present and accessible, challenges are posed as to the sufficiency of facilities and equipment and of the supplies of the commodities available.

Interviews in government health facilities and with government health workers and service providers often yielded positive results with claims that there is an excess of RH commodities and goods. In all government facilities visited, except in Sorsogon City, the Barangay Health Stations and Rural Health Units were able to show and share with the Commission the full range of family planning commodities available. Most shared that they have not yet experienced the effect of the PhP1 Billion cut on RH commodities and that the lack of supplies they experience are not from lack of available supply but a matter of timely seeking re-supply from RHU's and the DOH. There were however admissions from government health service providers and health workers that facilities and equipment are sometimes lacking or inadequate and could still be improved in BHS, RHUs and lying in clinics. There is also acknowledgment from health workers that there is difficulty in meeting the standards of doctor/nurse/midwife ratio to population served. More often than not, human health resources are insufficient and are overburdened in the areas/LGUs that they serve.

From the perspective of rights holders and women from the community, the National Inquiry interviews continue to reveal inconsistency on the de facto or actual availability, accessibility, sufficiency, and adequacy of RH services and information. In the 15 regional consultations, while there is a consensus that RH goods and services were generally available and that LGUs, except Sorsogon City, are supportive, participants continue to bewail lack of information regarding RH services and on issues of actual accessibility of goods and services. Across the five cluster areas and the 15 Regional Consultations, accounts of health centers seeking donations were still documented; some claimed it is already tantamount to selling. There were also accounts of health centers refusing to dispense and provide RH commodities by reason of discrimination and at times favoritism, partisanship or kinship. There were accounts of unethical and unprofessional behavior of health workers, and of delays in referral resulting in maternal deaths. In the island provinces of Mindanao, there were accounts that health centers lack personnel due to security reasons, and there were various accounts of the absence of

available/free transportation from one health facility to another. Inadequate facilities were also cited particularly the sharing of beds in Manila, Tacloban and in Zamboanga City. Accounts that some RH services were unable and/or refused in some facilities were also reported; only hospitals admit patients needing Post Abortion Care, and some hospitals, according to accounts and submission, even refuse such services.

RH information and Engagement

Regarding the provision of RH information and the availability of information including information on all RH services, people's experiences in all areas pointed to its improvable status. While the DOH, POP Com and the health workers from the Barangay and the Local Government Units provide RH information on a daily basis, including house to house visits by volunteer barangay health workers, accounts of lack of information on RH services continue. Women continue to be unaware of the available RH services, and men continue to lack engagement in RH. There is recognition that information dissemination should include men in the RH agenda and a rethinking of RH as not the sole concern of women. It has been noted that a recurring experience among areas is the low participation of men in the RH agenda, whether in terms of policies, programs and processes, or in the context of making decisions between partners. In Mindanao, concerns have been raised on the failure to engage indigenous and religious leaders in the RH agenda and to engage them in information dissemination on RH. Sexuality and RH education have also been raised as lacking and inconsistent in many areas, pointing to the need for strengthened RH and Sexuality education.

Specific to other RH services, the results show uneven focus and availability of services and information, other aspects of RH are often left behind, particularly raised were: HIV and STD, mental health as part of RH care, remedies in cases of VAW, services targeting LGBTIs, education and counseling on sexuality and reproductive health, reproductive tract cancers, and management of infertility and sexual dysfunction. It has been pointed out as well, the need to address the health needs of women in all stages of the life cycle, noting the absence of focus for elderly women and the invisibility of the needs of lesbians, bisexuals and transwomen.

3. BARRIERS IN ACCESSING RH SERVICES INCLUDE LACK OF INFORMATION AND MISINFORMATION ON RH, BREAKDOWN OF SERVICE DELIVERY NETWORKS, RELIGIOUS AND CULTURAL BARRIERS, AND UNPROFESSIONAL AND/OR UNETHICAL PRACTICES OF HEALTH SERVICE PROVIDERS

In addition to policies which served as barriers to the full implementation of the RH law, the National Inquiry also documented other barriers and denial of access to RH services and information.

Lack of/ Misinformation on RH

One of the barriers identified throughout the cluster areas is the lack of information on RH and/or misinformation. Instances of misinformation due to religion or culture have also been documented which were shown to have affected women and men's willingness to access RH services. Despite claims by government health workers and service providers on information being conducted, interviews continue to reveal that some women are unaware of the available services and commodities specially those living in geographically inaccessible and disadvantaged areas. In some cases, while women are generally aware of the available RH services, they are unwilling to avail of services due to misplaced religious beliefs or cultural practices. For instance, while a *'fatwa'* has been issued on the acceptability of RH in Islam, not all Moro women are aware of the same. For IPs, while elders claim that it is not against the culture of IP's, some women refuse to avail of RH services believing it is against their culture or that there is need seek the consent of their husbands. These led to recommendations on the need to improve information dissemination not only on the available RH goods and services, but also to include men, traditional and religious leaders in the RH agenda.

In the case of Sorsogon City, the Commission found that the misinformation being undertaken by the City through sponsored radio programs and 'Pro-Life' conventions were found to have affected women's willingness to avail of RH services and goods. The misinformation included claims that artificial contraceptives cause cancer and associating contraceptive use with abortion. Active religious resistance to artificial RH commodities have also been found in Sorsogon City and in some areas of Leyte and Samar.

Breakdown of Service Delivery Networks

The National Inquiry also documented breakdown in the service delivery network and coordination among government hospitals, rural health units, and lying in clinics which often resulted to maternal deaths. For many women living in geographically inaccessible areas and whose pregnancies are complicated, referral to major government hospitals are required. However, several accounts have been documented of lying ins and RHUs needing to refer patients to government hospitals but were faced with challenges on transportation, coordination, and the absence of needed facilities to respond to the emergency. Complaints have been gathered as well on the attitude of some government health service providers and the lack of professionalism resulting to the low morale of referring midwives and nurses and the patients' lack of trust and confidence in the ability of government hospitals to respond to their needs.

Unprofessional/unethical practices of health workers

In addition to the issues/attitudes of health workers and health service providers, common unprofessional and unethical practices surfaced including requiring donations for RH goods and services that are supposed to be free; mistreating women seeking Post Abortion Care, refusing services to a woman seeking surgery due to her transgender identity, her disability, or HIV Status, delaying or refusing medical services to women for various reasons including concerns over lack of records to their lack of capacity to pay. All these served as barriers to women's effective access to RH services and information.

In General Recommendation 24, the CEDAW Committee discussed State obligation in the provision of RH services and in the elimination of barriers to access of RH services, it explicitly stated that States should report on the "measures taken to eliminate barriers that women face in gaining access to health care services and what measures they have taken to ensure women timely and effective access,[15]" the Committee identified the following barriers as among those that the State has to address as part of its obligation under CEDAW, they are: "requirements or conditions that prejudice women's access such as high fees for health care services, the requirement of preliminary authorization by spouse, parent of hospital authorities, distance from heath facilities and absence of

[15] GR 24, CEDAW Committee, Women and Health, par. 21

convenient and affordable public transport[16]." It strongly recommended that the State ensure the removal of all barriers to women's access to health services, including RH services. Failure to do so could constitute a breach of the State's obligation under CEDAW.

4. ***LACK OR INADEQUATE RESPONSE TO THE INTERSECTIONAL VULNERABILITEIS OF WOMEN FROM THE MARGINALIZED SECTORS AND IN SPECIFIC VULNERABLE SITUATIONS***

The National Inquiry purposively conducted targeted data gathering on the availability, accessibility, adequacy and affordability of RH services and information for vulnerable and marginalized women. The barriers and denial of RH services and information provided above were likewise experienced by women in the vulnerable and marginalized sector, but these were further exacerbated by their different vulnerabilities and different experiences of discrimination brought about by situations which render them vulnerable.

Discriminatory Policies render marginalized women more vulnerable

In the five cluster areas, the Commission found that women from the marginalized sector are most vulnerable to the effects of discriminatory policies that hinder full access to RH Services.

In Sorsogon City, the Mayor's "Pro-Life" EO and the resulting pull out of artificial contraceptives affected women living in geographically isolated and disadvantaged areas, those who are in the informal sector, and those who are dependent on their husbands and without means to purchase their own contraceptives. EO 003 further discriminates against these vulnerable/marginalized women as it requires them to pay for contraceptives they could have received for free were it not for the adoption of the EO and the pull out of contraceptives. The stop gap measures implemented by the DOH through the Nurse Deployment Program helped in providing unmet needs of women in Sorsogon City, but as a stop gap measure, it is not sustainable. With the EO in place, women in Sorsogon specially the most marginalized and in GIDA continue to face barriers in accessing RH services and information.

[16] Id

The TRO on the Implanon also has the same effect, as it deprives women free access to the commodity. In NCR for example, women who are informal settlers prefer Implanon with its effectivity lasting for three (3) years, however, the TRO prevents them from obtaining free Implanon shots. With the TRO in place, government facilities are prohibited from dispensing Implanon and while private clinics and CSOs can continue dispensing and administering Implanon, they do so for a fee – an amount that women in the informal sector and from the urban poor cannot afford.

On the absolute prohibition of abortion and the absence of emergency contraception, the submissions from Center for Reproductive Rights and EngendeRights have made clear that such polices mostly impact the poor, marginalized, and vulnerable women. The prohibition casts a stigma on women who've suffered from abortion and in effect results in the denial of post abortion care which the RPRH law assures. The stigma and criminalization of abortion has also led many poor women to resort to unsafe abortions. Documentation on women who've suffered from unsafe abortions and who were unable to access PAC was compiled and submitted to the Commission by CRR. EngendeRigths further submits and as echoed by participants during the public hearing that the absence of emergency contraceptives fail to protect women and girls who are victims of sexual violence. Their absence limits the autonomy of women and girls over their bodies and result to unwanted pregnancies as a result of sexual violence.

On the proliferation of ordinances criminalizing and penalizing traditional and indigenous home births, the women who mostly bear the brunt of these measures were found to be Moro and Indigenous women and women who live in geographically inaccessible and disadvantaged areas. While these ordinance were adopted to encourage facility based delivery and to address increase of maternal mortality, the effect of the measure has been discriminatory to Moro and Indigenous women, it has also resulted to the imposition of penalities and criminalization of women from GIDA areas for the failings of the State specifically for the State's failure to bring health centers and facilities to far flung areas and to women who need them most.

The National Inquiry documented instances where maternal deaths resulted during transit and due to the distance of facilities and the fear/refusal of traditional and indigenous birth attendants to assist home deliveries. The Commission documented accounts of traditional birth attendants refusing to help women because of fear of imprisonment and there are submissions of IP women who were forced to travel

distances to go to the health facilities for fear of imprisonment. In the submission of Lilak Purple Action for Women, they forwarded the declaration of Indigenous women denouncing the continued adoption of ordinances penalizing home births and calling for respect of the traditional birthing practices of Indigenous women. A Council of Elders in Bukidnon likewise issued a resolution calling for the repeal of the Provincial Ordinance penalizing home births as being discriminatory to IP women. During the course of the fact finding and public hearing, the Commission were informed of ordinances penalizing home births in Marikina City, Quezon City, Brooke's Point Palawan, Midsalip, Midsayap, Province of Bukidnon, Municipality of Minalin Pampanga, Mac Arthur Leyte, Sultan Kudarat, Talisay City Cebu, Dingle and Estancia, Ilo-ilo. Aside from the twelve (12) identified by the Commission, there is a strong possibility that more of these ordinances exist.

The situation, however, is far from simple. Together with the complaints of criminalization and penalization of traditional and indigenous birth attendants, the Commission also received submissions showing the dangers posed by delayed referral or outright refusal to resort to facility based delivery and also accounts of the dangers posed by unskilled birth attendants. In a study[17] submitted by Likhaan Center for Women on access to emergency obstetric care among urban poor in Malabon, key causes of maternal deaths were identified. The causes of maternal deaths include significant delays in seeking medical care ("the first delay") and the harmful practices of traditional birth attendants (TBAs). They also noted that women with obstetric complications faced serious barriers at the admissions process of tertiary government hospitals, once admitted, however, most managed to get life-saving interventions. Likhaan Center for Women thus recommends the need to place greater focus on addressing the "first delay" and preventing harmful practices by unskilled birth attendants.

To be consistent with its obligation under CEDAW, the State must review and the soonest repeal discriminatory policies which restrict, pose as barriers to women's access to RH services and information. In the same vein, serious consideration must be accorded

[17] Likhaan Center for Women. A Report on the Project "Investigating Responses to Obstetric Complications and Access to Emergency Obstetric Care Among Urban Poor Women in Malabon, Philippines"

to address maternal mortality due to late referrals, in-transit, and in the hands of untrained TBAs, as raised by Likhaan Center for Women.

Lack of access to RH services and facilities and Denial of RH services

Accessibility of RH services and information has been highlighted throughout the National Inquiry particularly with women with disabilities, Moro and Indigenous Women and women in GIDA. This was also discussed specific to women who are displaced as a result of development aggression, armed conflict or in the context of natural disasters which render women, specially marginalized women, more vulnerable.

In the NCR and Cagayan de Oro-Bukidnon cluster, the lack of accessibility of government health centers and facilities for women with disabilities have been raised. Submissions and sworn testimonies of PWDs complain of the seeming invisibility of the needs of PWDs, the absence of facilities like examination tables, the absence of interpreters in police stations and in courts for PWD victim-survivor of violence against women, and the absence of interpreters as well in health centers and government health facilities. PWDs also complain of not being informed of the processes affecting them and of the disregard for their decision because of their disability. A submission also recounted the denial of health services on the basis of her disability, a clear case of discrimination.

Women in GIDA, including Moro and IP women, and rural women complain of the distance of health facilities and the lack of transport. Due to distance from City centers, information on available RH services fail to reach them, and in instances that they do, they are often faced with further barriers like the distance of facilities and absence of transportation, the absence of required birth registration and health records, religious and cultural barriers - -all of which affect access and availability of RH services. Accounts from Regional Consultations also showed the discriminatory practices of health care workers targeting IP women, specifically accounts of degrading treatment and verbal abuse on the basis of being indigenous was reported in Tuguegarao[18]. There were also reports that IP women were delisted from the State's 4P's, Pantawid Pamilya program as they were unable to comply with the reporting requirement – this, as pointed out by IP

[18] RO consulation in Tuguegaro reported a doctor addressing an IP woman and syaibg "Ang baho ng puki ninyo, hindi ko maibuka para sa inypo" (your vagina stinks so much I cannot ask you to open your legs).

representatives, highlight the cycle of marginalization that IP women are being subjected to.

Violence Against Women

In case of violence, the National Inquiry has shown that many women, particularly those from the marginalized sector suffer and are vulnerable from violence at various levels: in the family, in the community, and in the hands of institutions. In several cases, while information is available on the remedies in cases of VAW, women are faced with issues of access, lack of sensitivity of the duty bearers, and the lack of understanding of the multiple and intersecting forms of discrimination experienced by women from the marginalized sector.

In the NCR public hearing and the submissions from the PDRC highlight the prevalence of gender based violence against deaf women in the hands of family members, neighbors and members of the Community and the absence of interpreters in the government agencies tasked to respond to the violence. The absence of interpreters, the lack of access crucial to deaf women's access to remedies, are by themselves institutional violence. Other forms of institutional and systemic violence include the 'invisibility' of the concerns of deaf women, women with mental disabilities and other disabilities in accessing remedies in cases of VAW.

Also in NCR, women who are informal settlers in Tondo provided accounts of the violence they experienced at the hands of intimate partners, from their own neighbors, and from the State in cases of demolition. Their case highlights not only the lack of access to remedies for VAW inside the family but also the difficulty of accessing remedies in cases where the perpetrators are State actors – those who demolish their shanties and leave trails of abuses. An individual submission from the informal settlers recount how they were tear gassed during demolition and how State hospitals dismissed them when they sought medical care.

For LBTs, complaints have been raised on the insensitivity and/or ignorance of duty bearers in responding to violence experienced by LBTs. Protocols addressing stigma and discrimination against LBTs are not in place and as stressed in the submission of

Rainbow Rights[19], response to violence against LBTs are often lacking and their health needs, often invisible in State programming. Specifically, Rainbow Rights reported the different forms of violence experience by LBT in the family, community and from institutions. The forms of violence included physical violence, verbal and emotional violence, violence in the name of religion, violence in schools and sexual violence. Rainbow Rights reported the absence of data on violence against LGBTs and the 'significant invisibility and devaluation' the community experience when reporting and seeking remedies for violence.

For women in the context of development aggression, displacement due to armed conflict and disasters, the National Inquiry reiterated their vulnerability to abuse and exploitation, particularly to trafficking. It has been raised that the State is unaware of specific needs of women, children, the elderly in displaced communities which result in the failure to provide needed services. It has been raised as well that in cases of violence in the context of displacement and development aggression, much remain undocumented, unreported, and therefore unaddressed.

Invisibility of issues and specific vulnerabilities of women in the marginalized sector

As previously pointed out, adequate response to the intersecting vulnerabilities of women, particularly Moro and Indigenous women, women in in geographically inaccessible areas, women with disabilities, lesbian, bisexual and transwomen is lacking.

The issues of Indigenous women on the penalization and criminalization of traditional and indigenous home births have been largely ignored – with more and more LGUs enacting ordinances as their interpretation of the DOH's encouragement of facility based delivery, and without express prohibition/policy guideline from the DOH against these issuances.

For Moro and IP women, mostly in GIDA, and women with disabilities access to reproductive health services remain challenging. Geographic distance or in some cases absence of health facilities, the lack or absence of health service providers, failure to provide accommodation for needs of PWDs, and failure to take into account cultural sensitivities have been complained of.

[19] Rainbow Rights Project. Kwentong Bebot. Lived Experiences of Lesbians, Bisexual and Trangender Women in the Philippines

For LBTs, the stigma borne by their sexual orientation and gender identity continue to hinder sensitive delivery of reproductive health services and information. In the same vein, access to reproductive health services and general health services of persons with HIV are affected by the stigma attached to HIV and the lack of awareness and training of health workers on HIV.

In areas where displacement is prevalent, the constant complaint has been the failure to take into consideration and prioritize the reproductive health needs of women and their protection from violence and trafficking. For the IDPs in Zamboanga and in Tacloban, despite having been resettled either in transitory or in permanent shelters, access to reproductive health services and information, to health facilities, and to transportation to health facilities have been consistently complained of. Complaints have been documented that the needs of women during displacement have not been adequately met.

The National Inquiry also documented the concerns of girl children and LBTs, and those who are at risk of HIVs. Concerns have been repeatedly raised on the required parental consent for RH services and HIV testing for minors, and how these are linked to the rise of teenage pregnancy and the increase in the number of girl children at risk.

While programs of DOH and LGUs on teenage mothers have been documented with the conduct of guidance and counselling sessions and *'buntis'* summit or *'batang ina'* summit, accounts have been consistent that the number of teenage pregnancy is increasing. It has been expressed during the National Inquiry that the requirement of third party consent, particularly consent of parents in the access of RH services, does not help curb or address the increase of teenage pregnancy. The increasing number of teenage pregnancy also calls for the review of the effectivity of the current efforts/programs towards adolescent and youth reproductive health guidance and counseling, education and counseling on sexuality and reproductive health and reproductive health education for the adolescents.

Other women in the marginalized sector whose RH needs have not been adequately responded to in terms of policy, programming, and services include prostituted women, elderly women and LBTs, solo mothers, migrant workers and their families, rural women, and women in the informal sector. It has been recommended during consultations that the specific needs of these women and as they intersect with

other forms of discrimination be duly accorded attention to in the State's responses and delivery of health services, including reproductive health services.

5. ***GOVERNMENT AND PRIVATE HEALTH SERVICE PROVIDERS CONTINUE TO FACE CHALLENGES INCLUDING POLICY AND LEGAL BARRIERS, UNSUSTAINABLE HUMAN RESOURCE MANAGEMENT; LACK OF SUPPORT; POLICY, RELIGIOUS AND CULTURAL RESISTANCE; AND ABSENCE OF HEALTH SEEKING BEHAVIOR AMONG CLIENTS***

The National Inquiry has established that both government and private health service providers continue to face challenges in the implementation of the provisions of the RPRH law.

Policy and legal barriers to RH likewise affect health service providers and health workers. The issuance of the TRO on Implanon by the SC, the voiding of key RPRH provisions, the passage 'Pro-Life EO' are some of these policy and legal barriers. Specific to Region X, another policy barrier, one that is explicitly discriminatory against women nurses and midwives exist – the prohibition against pregnancy. The latter, while reportedly enacted to protect women nurses and midwives during pregnancy has resulted to discrimination against women nurses, who unlike their male counterparts, can become and do become pregnant during the course of their contract with DOH. Raised during the Inquiry, the DOH committed to review these policies to make them non-discriminatory and human rights compliant.

Another barrier found by the Commission is the unsustainability of Health Human Resource Management. In all of the cluster areas visited during the fact-finding, the Commission documented the temporary nature of the appointments of midwives and nurses in Barangay Health Stations and Rural Health Units. LGU midwives complained of being contractual for ten years with contracts renewed every six months. The NDPs and the midwives deployed to different areas shared that their contracts will be ending in December of 2016. A doctor that the fact finding team interviewed shared the number of patients he sees every day, sometimes reaching up to 250; he then complained that his request for additional doctors to the barrio was denied. In all areas, the ratio of doctor to population, or nurse/midwife to population were often not complied with. These posed barriers to government health service providers. These are also related to the various complaints raised regarding the attitude and unprofessional demeanor of health service providers/workers which may be caused by the stress experienced in challenging work environment.

The National Inquiry was able to document as well the uneven support for Barangay Health Workers. Some barangays and LGUs are supportive of BHWs, providing substantial separate allowance, in other cases the allowance is granted on a quarterly basis and in an almost negligible amount. Reports have been made as well that the appointment and provision of allowances of BHS have been subject to much politicizing on the ground. The recommendation for the standardization of allowances for BHWs and for the professionalization of their services are very well grounded.

Another challenge for health services providers is the lack or inadequate support. Accounts have been made during the Inquiry on how many health workers are overworked and underpaid, with some forced to work under conditions that threaten their physical security. Reports were made that Barangay Health Stations, RHUs and some municipal and provincial health facilities have insufficient supplies that again prevent health workers and health services providers from performing their job. The question of salary and regularization of health service providers and health workers also indicate this lack or inadequate support. In some cases, some health workers face criminal cases for negligence. This poses a challenged for health workers who lack legal and financial support in such instances.

Health service providers and health workers both public and private are likewise faced with challenges brought about by religious and cultural beliefs, misinformation and misconception of RH, and the absence of health seeking behavior among the clientele. During the inquiry, health service providers and health workers echo the challenges posed by religious opposition and resistance to RH in the delivery of RH services. They also elaborated on how some women refuse to avail of RH services and FP commodities with the misplaced belief that RH is against their culture. It has been pointed out that most of these barriers are based on misconceptions on RH and could well be addressed by more comprehensive information dissemination at the community level and by engaging religious and cultural leaders.

Good Practices

Throughout the conduct of the National Inquiry, the Commission has likewise documented good practices both at the community and the local government level to the national level. These good practices deserve recognition and strengthened implementation:

- Strong national and local government partnerships and cooperation with civil society organization in the implementation of RPRH law. This is seen in most of the cluster areas, where CSOs become partners of both DOH and LGU in implementing RPRH, providing both services and information. In Sorsogon City, where the Mayor refuses to dispense FP commodities, CSOs are crucial in filling the gap in the supply of commodities; In Mindanao where government health workers face challenges in far flung islands and areas, CSOs on the ground provide RH services and information;
- Deployment of nurses, midwives and doctors under the DOH program NDP, MDP and Doctors to the Barrio. The function of these professionals in supplementing the health human resource of LGUs is crucial in the implementation of RPRH. In Sorsogon City, where the Mayor bans artificial contraceptives, NDPs are able to address unmet needs of women and mothers;
- MNCHN ordinances in Basey, Samar, which focuses on providing incentives for facility based delivery for the mother and the birth attendant/*hilot* instead of the imposition of penalties and fines;
- The pilot areas of IP MNCHN in Bukidnon, and the practice in one of the municipalities in Bukidnon of creating half-way houses for IPs mother and their husbands or relatives, so they can wait for the delivery near health facilities;
- The culturally sensitive practice of one of the Lying-Ins in Cagayan de Oro, particularly in Brgy Tinagpoloan; The Lying in allows traditional/indigenous birth attendants to attend to and deliver the babies of IP women inside the Barangy Health Station Lying In clinic for as long as the delivery is supervised by the Barangay midwife. They also allow the IPs to conduct their ritual in the vicinity of the BHS.
- The programs of POP COM, DOH and PCW to engage men in the RH agenda and in the fight against violence against women
- Strong and active National and Regional Implementation Team coordination and regular meetings. This result to the ability to immediately address complaints regarding availability and accessibility of RH services. Some RITs have invited CHR representatives to sit in their meetings. Willingness of NIT and RITs to work on recommendations of the National Inquiry has likewise been expressed;
- The practice of a principal in one of the public schools in Brgy. Pontod, Cagayan de Oro wherein he incorporated RH and sexuality lessons in the curriculum as a response to the alarming rise of teenage pregnancy among high school girls. The incorporation of RH and sexuality lessons resulted in lower number of pregnancy in his high school.

CONCLUSION

The National Inquiry which ran from March to May 2016 attempted to provide a grounded analysis into women's enjoyment of reproductive health and rights as provided under CEDAW, the MCW, and the RPRH law. While the National Inquiry covered 15 regional consultations and 5 fact finding and public hearings, the results are limited with the participants consulted and interviewed, and the facilities visited. As presented, the National Inquiry has shown that despite the passage of the RPRH law, and despite of the decision of *Imbong vs. Ochoa* which upheld the law's constitutionality, implementation

and support for the law remains uneven. The Inquiry has shown the varying degrees of support for the RPRH from different LGUs, ranging from full support to outright refusal. The Inquiry has likewise shown how this is linked to decentralization and the autonomy of LGUs, and the limits set on the mandate of the DOH in the delivery of RH information and services.

Aside from the uneven support in the implementation of the RPRH law and how it resulted in the fragmented delivery of RH services, the Commission was also able to identify existing discriminatory policies and legal barriers in the enjoyment of women's right to reproductive health under CEDAW. These discriminatory policies and legal barriers render marginalized women more vulnerable in their access to RH services.

The National Inquiry also found that health service providers continue to face barriers and challenges in the implementation of the RPRH and that women from marginalized sector continue to complain of different barriers in accessing RH services and information as responses remain lacking or inadequate, and unable to give due consideration to the intersectional vulnerabilities of women from marginalized sectors and in specific vulnerable situations.

While good practices are in place, and the Commission specifically commends the work being undertaken by the National and Regional Implementation Team on RH, the National Inquiry points to areas where responses have to be strengthened in order for the State to comply with its State obligations under CEDAW, and the promises of the RPRH law.

The Commission recalls CEDAW and its GR 24 on health, where it is clear on what constitutes State obligation when it comes to reproductive health.

The Convention burdens the State with the obligation of eliminating discrimination against women in their access to health care services, throughout their life cycle particularly in the areas of family planning[20]. General Recommendation 24 reminds the State of its obligation to respect, protect, and fulfil women's right to health care, including reproductive health, and the concurrent obligation to ensure that legislation, executive action, and policy comply with these three obligations[21]. For the fulfilment of its obligations under CEDAW, GR 24 further recommends that state parties *"should implement a comprehensive national strategy to promote women's health throughout their*

[20] GR 24, p.2
[21] GR 24, p.12

lifespan. This will include interventions aimed at both the prevention and treatment of diseases and conditions affecting women, as well as responding to violence against women, and will ensure universal access for all women to a full range of high-quality and affordable health care, including sexual and reproductive health services."

In view of the foregoing, and order to assist the State in complying with its obligation with CEDAW and in fulfilling the promise of the RPRH law, the Commission's National Inquiry submits the following recommendations.

RECOMMENDATIONS:

For the Legislature:

1. **To review the Local Government Code of 1991 and the provisions providing for decentralization and local autonomy and to take into account the effect of decentralization in the delivery of health services, including reproductive health services and information; Alternatively, in view of the anticipated shift to Federalism, that legislators take into consideration the delivery of basic services, including reproductive health services, *"balancing authority and responsibility between central and local levels to attain both gains in national health priorities."***

   As pointed out by the CEDAW Committee, the current fragmentation in the delivery of health services must be addressed and it must be ensured that "decentralization or devolution does not lead to discrimination with regard to the enjoyment of rights by women in different regions.[22]"

2. **To review and strengthen the Magna Carta for Health Professionals. The Inquiry highlighted how unsustainable the current human resource management is and the inadequate support for health service providers and workers. Ensuring the implementation of the RPRH law requires looking after the welfare and benefits of health service providers and workers. The legislature may consider re-filing of a proposed law on the professionalization and provision of standardized allowances for Barangay Health Workers, ensuring that these volunteer posts are not politicized.**

3. **To include in its review of the RPRH law the problem posed by the decision of "Imbong vs. Ochoa" particularly on the scope of 'conscientious objector' and the absence of accountability of public officials refusing to implement the RPRH law. The problem brought about by the SC decision in "Imbong vs. Ochoa" has been brought into the front by the refusal of**

[22] Id

Sorsogon City Maryor Lee to implement the RPRH law. The legislature may consider an amendatory legislation to address the dilemma posed by "Imbong."

4. **To review the provisions on abortion, taking into consideration the studies forwarded by CRR and EngendeRights and other women's organizations and on how the continuing criminalization of abortion affect provision of post abortion care; The legislature may likewise note CEDAW Committee views on the matter.**

5. **To review the consent requirements for HIV testing of minors. The National Inquiry documented the barriers posed by the consent requirement in girl children and minor's access to HIV testing, thus putting the more at risk of HIV.**

For the Executive:

Department of Health, POP Com, DOJ, NEDA, other relevant agencies and the members of the Implementation Team on RH

6. **For DOH and the National and Regional Implementation team to continue the close monitoring of the implementation of the RPRH law particularly addressing the fragmentation in the delivery of health services and for the NIT and RIT to establish a community based monitoring of the implementation of the law in order to address issues raised on the de facto accessibility, availability and adequacy of RH services and information;**

7. **For the DOH and the National Implementation Team on RH to pursue the filing of administrative case against Mayor Sally Lee of Sorsogon for her refusal to implement the RPRH law, and to provide the Commission with updates on the efforts of the Department and the NIT in addressing the situation in Sorsogon City;**

8. **For the DOH to continue its pursuit in seeking the lifting of the TRO on implanon considering the clamour of women and to consider as well the establishment of partnerships with CSOs in unloading implanon supplies which are about to expire;**

9. **To address the proliferation of MNCHN ordinances penalizing home births by issuing a policy against the criminalization of home births and instead conduct broad-based consultations with health professionals, traditional and indigenous birth attendants, and indigenous peoples with the end of putting in place a human rights based and sustainable strategy towards safe deliveries;**

10. **To continue the Nurse, Midwife, Doctors Deployment programs as these have been found to be effective in ensuring the delivery of much needed health services in the community level. To recommend that these nurses, midwives and Doctors be provided plantilla positions in the LGU for more sustainable human resources management.**

11. **To immediately issue a policy guidance prohibiting contracts with provisions that dismiss nurses and midwives due to pregnancy. The provisions of the Magna Carta of Women prohibit all forms of discrimination against women.**

12. **In view of the uneven imposition of the consent requirements regarding IUD insertion and TBL, for the Department to issue a policy upholding women's autonomy over her body, and dismissing the need for the consent of relatives or spouse. This is in line with GR 24 CEDAW Committee which requires the State to eliminate barriers to women's access to health including third party requirements;**

13. **To include among its strategies in the implementation of RPRH the strengthened engagement of men in the RH agenda and engagement with religious and indigenous leaders; This addresses the complaints raised on the lack of men's engagement on RH, and of for cultural and religious sensitive discussion of RH vis-à-vis women's right to RH;**

14. **To review the functionality of the service delivery network and protocols of referral, and to put in place procedures for accountability to enable women and health service providers to file complaints and seek remedies when necessary;**

15. **To address unethical and unprofessional conduct of health service providers and government health workers by strengthening training on medical ethics and administrative accountability of health professionals, human rights including basic GST, SOGIE, intersectionality and the basic principles of non-discrimination. To strengthen as well accountability mechanisms, ensuring accessible information on complaint mechanisms and assistance.**

16. **To issue a policy and to provide corresponding budget in order to address the inadequate or lack of accessibility of health facilities and services for women with disabilities. While reports have been shared the training of health workers for sign language, response should be institutional, and the accessibility should be ensured at all levels and for all kinds of disability;**

17. **To ensure that programs for the implementation of RPRH recognize the specific needs of the marginalized sectors, and ensure the sustained**

availability of RH goods and services especially for the marginalized sectors; and

18. **To strengthen the conduct of information dissemination particularly including gender, sexuality and human , SOGIE as part of the content in addition to strengthened and inclusive advocacies not only focusing on RH and sexuality for adolescent and youth but also on VAW, PLHIV, RH for LGBTIs, the elderly and PWDs; Continuing training for health service providers should be conducted in view of the findings that some lack confidence to practice and have not been provided training opportunities;**

19. **Education campaigns should likewise be conducted to increase awareness of the community people on women's reproductive health and the RH goods and services available in Barangay Health Centers, as well as services available during displacement and development aggression. These activities will not only inform community members about these goods and services but encourage them to avail these, especially those in the far-flung areas.**

20. **To ensuring Reproductive Health Services in emergency situations, particularly addressing the needs of the most vulnerable. Absence of RH goods and services, lack of accessible health facilities, and/or unavailability of health professionals such as doctors, nurses, and midwives during disaster and emergency situations was highlighted in the Regional Consultations, particularly Regions 2, 3, 6, and 12;**

21. **For the Department of Justice and the Department of Social Welfare and Development, to ensure gender sensitive handling of cases of violence against women, including violence against LBTs, and on GBV, trafficking and prostitution in the context of armed conflict, displacement, and development aggression.**

22. **For the DSWD to ensure that women in GIDA, particularly IP and Moro women are not discriminated in accessing program benefits and to review the requirement of 4Ps making them culturally sensitive and conscious of the difficulty faced by IP women in complying with requirements particularly those from GIDA and who are displaced.**

For Local Government Units (LGUs)

23. **For the City of Sorsogon to comply with the provisions of CEDAW, the MCW and the RPRH law by providing access to women of the whole range of reproductive services and information; To recall its EO 03 in view of**

the its effect of de facto denial of women's right to access the whole range of reproductive health services and information;

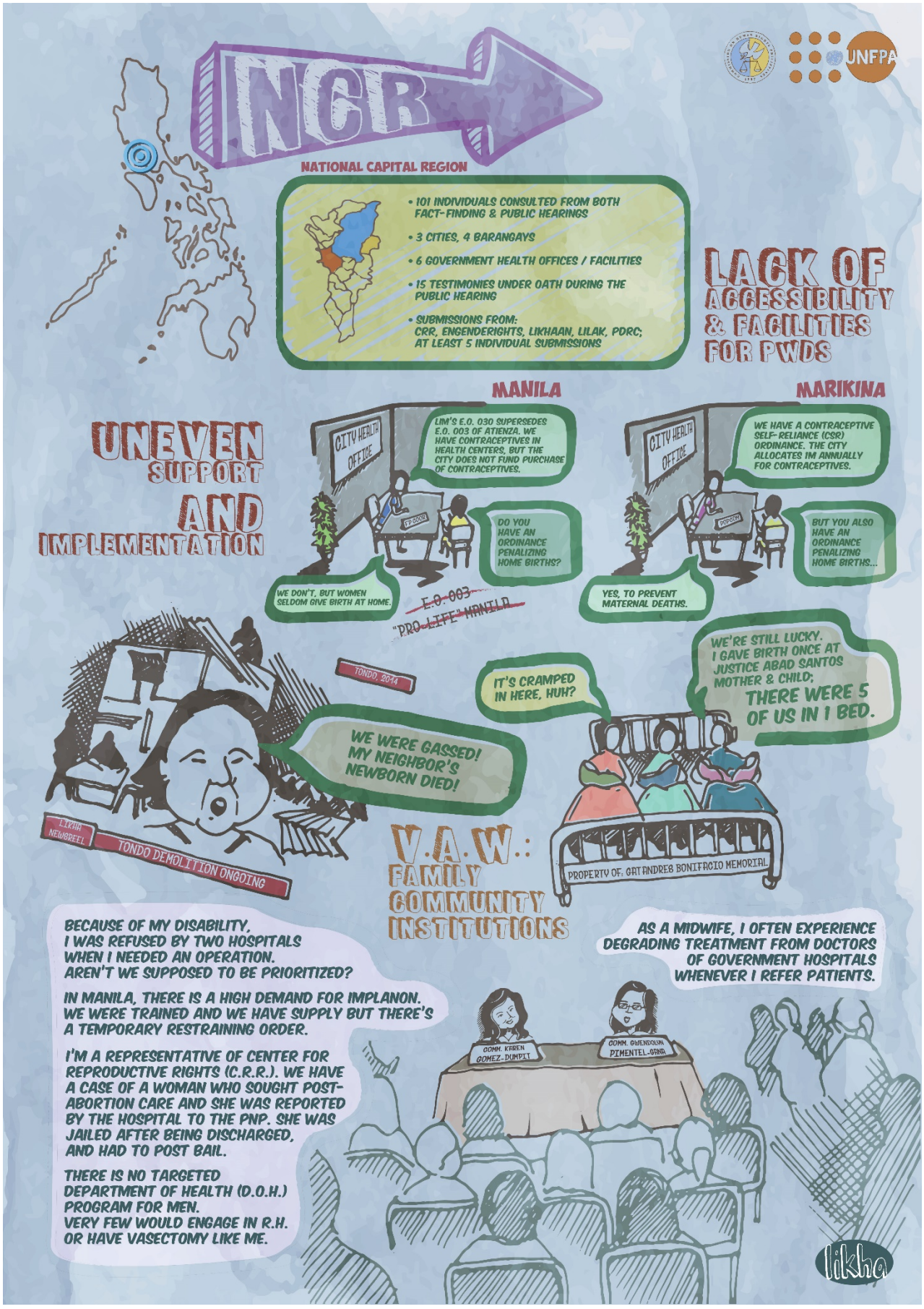
24. **For LGUs with existing MCHN ordinances penalizing home births to amend the same by removing penalties and fines, and instead provide incentives for facility based deliveries and for LGUs contemplating the enactment of a MNCHN ordinance to avoid criminalization, and instead provide incentives for facility based compliance;**

25. **For LGUs to exercise political will in the implementation of RH, specifically by complying with DILG memorandum circular 2015-145 reiterating the roles of LGUs in the implementation of RPRH law; intensified information dissemination on RH, with balanced and accurate information on both natural and modern FPO methods; providing standardized allowances for Barangay Health Workers; filling up *plantilla* positions for public health workers in the LGUs and prioritizing regularization of contract health service providers/workers; establishing community based monitoring of the RPRH law and cooperating fully with the RITs in the monitoring of RPRH in their jurisdictions; establishing health centers in far flung areas to ensure access to health services;**

For the Supreme Court and Lower Courts

26. **To consider conducting a study and/or review of the *"Imbong vs. Ochoa"* and the TRO on Implanon vis-à-vis the State's Commitment under CEDAW, particularly women's access to reproductive health.**

27. **To ensure that the justice system is gender sensitive and responsive to the intersecting vulnerabilities of women from marginalized sector and in specific vulnerable situations through continuous training of judges and personnel in all levels of the judiciary and to ensure accessibility of Courts for women with disability including the provision of sign language interpreters, local language translators, and the adoption of protocols in cases of persons with diverse SOGIE;**


NCR
NATIONAL CAPITAL REGION
• 101 INDIVIDUALS CONSULTED FROM BOTH FACT-FINDING & PUBLIC HEARINGS
• 3 CITIES, 4 BARANGAYS
• 6 GOVERNMENT HEALTH OFFICES / FACILITIES
• 15 TESTIMONIES UNDER OATH DURING THE PUBLIC HEARING
• SUBMISSIONS FROM: CRR, ENGENDERIGHTS, LIKHAAN, LILAK, PDRC; AT LEAST 5 INDIVIDUAL SUBMISSIONS
LACK OF ACCESSIBILITY & FACILITIES FOR PWDS
UNEVEN SUPPORT AND IMPLEMENTATION
MANILA
MARIKINA
CITY HEALTH OFFICE
LIM'S E.O. 030 SUPERSEDES E.O. 003 OF ATIENZA. WE HAVE CONTRACEPTIVES IN HEALTH CENTERS, BUT THE CITY DOES NOT FUND PURCHASE OF CONTRACEPTIVES.
DO YOU HAVE AN ORDINANCE PENALIZING HOME BIRTHS?
WE DON'T, BUT WOMEN SELDOM GIVE BIRTH AT HOME.
E.O. 003
"PRO-LIFE" MANILA
WE HAVE A CONTRACEPTIVE SELF-RELIANCE (CSR) ORDINANCE. THE CITY ALLOCATES 1M ANNUALLY FOR CONTRACEPTIVES.
BUT YOU ALSO HAVE AN ORDINANCE PENALIZING HOME BIRTHS...
YES, TO PREVENT MATERNAL DEATHS.
TONDO, 2014
WE WERE GASSED! MY NEIGHBOR'S NEWBORN DIED!
LIKHA NEWSREEL
TONDO DEMOLITION ONGOING
IT'S CRAMPED IN HERE, HUH?
WE'RE STILL LUCKY. I GAVE BIRTH ONCE AT JUSTICE ABAD SANTOS MOTHER & CHILD; THERE WERE 5 OF US IN 1 BED.
PROPERTY OF: GAT ANDRES BONIFACIO MEMORIAL
V.A.W.: FAMILY COMMUNITY INSTITUTIONS
BECAUSE OF MY DISABILITY, I WAS REFUSED BY TWO HOSPITALS WHEN I NEEDED AN OPERATION. AREN'T WE SUPPOSED TO BE PRIORITIZED?
IN MANILA, THERE IS A HIGH DEMAND FOR IMPLANON. WE WERE TRAINED AND WE HAVE SUPPLY BUT THERE'S A TEMPORARY RESTRAINING ORDER.
I'M A REPRESENTATIVE OF CENTER FOR REPRODUCTIVE RIGHTS (C.R.R.). WE HAVE A CASE OF A WOMAN WHO SOUGHT POST-ABORTION CARE AND SHE WAS REPORTED BY THE HOSPITAL TO THE PNP. SHE WAS JAILED AFTER BEING DISCHARGED, AND HAD TO POST BAIL.
THERE IS NO TARGETED DEPARTMENT OF HEALTH (D.O.H.) PROGRAM FOR MEN. VERY FEW WOULD ENGAGE IN R.H. OR HAVE VASECTOMY LIKE ME.
AS A MIDWIFE, I OFTEN EXPERIENCE DEGRADING TREATMENT FROM DOCTORS OF GOVERNMENT HOSPITALS WHENEVER I REFER PATIENTS.
COMM. KAREN GOMEZ-DUMPIT
COMM. GWENDOLYN PIMENTEL-GANA
likha


SORSOGON
LEGASPI CITY & SORSOGON CITY
• 91 INDIVIDUALS CONSULTED FROM BOTH FACT-FINDING AND PUBLIC HEARINGS
• 2 CITIES, 5 BARANGAYS
• 6 GOVERNMENT HEALTH OFFICE/ FACILITIES
• 21 TESTIMONIES UNDER OATH DURING THE PUBLIC HEARING
• AT LEAST 25 INDIVIDUAL SUBMISSIONS
• 1 PENDING CASE AGAINST MAYOR SALLY LEE WITH CHR-5
REFUSAL TO IMPLEMENT R.H. LAW
WILL MAYOR LEE FEED MY CHILDREN? WILL SHE SEND THEM TO SCHOOL IF I GET PREGNANT? I'D RATHER GO WITHOUT RICE THAN WITHOUT PILLS.
40 PHP - RICE
42 PHP - LADY PILLS
40 PHP - FARE TO CITY CENTER (BACK & FORTH)
... I DON'T HAVE ENOUGH FOR PILLS YET
THE NDPS HAVE TO UNDERSTAND. THEY CAN'T GIVE OUT PILLS HERE. THE MAYOR WILL BE FURIOUS.
YEAH, I CAN'T RISK MY JOB. 10 YRS. HERE, AND I'M STILL UNDER CONTRACT.
TEXT ME WHEN YOU RUN OUT OF SUPPLY. I HAVE 4 OTHER BARANGAYS TO ATTEND TO.
THANK YOU SO MUCH! I'M SO AFRAID OF GETTING PREGNANT AGAIN. MANY OF MY NEIGHBORS GOT PREGNANT SINCE THE E.O.
HEY! THAT'S NOT ALLOWED!
PILLS AND INJECTIBLES CAUSE CANCER YOU WILL GO TO HELL!
VACCINES ARE DANGEROUS! THEY CONTAIN FORMALIN
MISINFORMATION
COULD IT BE TRUE? WILL I HAVE CANCER? WILL I GO TO HELL? SHOULD I STILL VACCINATE MY CHILDREN?
THE MAYOR CALLED ME THE NO.1 ABORTIONIST IN THE CITY DURING THE "PRO-LIFE" SUMMIT.
FAMILY PLANNING ORGANIZATION OF THE PHILS. (F.P.O.P.)
MY CLIENT TOLD ME THAT AFTER THE BARANGAY HEALTH CENTERS STOPPED DISPENSING PILLS, SHE GOT PREGNANT. IT WAS HER 8TH CHILD; SHE DECIDED TO GIVE IT UP FOR ADOPTION.
ANOTHER TOLD ME HER NEWBORN DIED, SHE SAID IT WAS UNWANTED AND UNPLANNED.
WHEN THE NDPS STARTED DISPENSING CONTRACEPTIVES LAST NOVEMBER, THE NUMBER OF ACCEPTORS WAS VERY LOW. WITH DOH'S HELP, WE ARE PICKING UP – BUT WE ARE STILL UNABLE TO REACH FAR FLUNG AREAS.
-N.D.P. NURSE
(NURSE DEPLOYMENT PROGRAM)
MY CLIENTS TELL ME TO WRAP THE PILLS IN PLASTIC, THEY ARE AFRAID TO BE SEEN NEAR OUR OFFICE. THEY ARE AFRAID THE MAYOR WILL FIND OUT. IT'S LIKE I'M SELLING ILLEGAL DRUGS.
-F.P.O.P.
(FAMILY PLANNING ORGANIZATION OF THE PHILS.)
COMM. KAREN GOMEZ-DUMPIT
COMM. GWENDOLYN PIMENTEL-GANA
WE FROM D.O.H. TRIED SEVERAL TIMES TO CONFER AND HOLD DIALOGUES WITH MAYOR LEE —TO NO AVAIL. SHE STANDS BY HER E.O, SHE RETURNED CONTRACEPTIVES ISSUED BY D.O.H.
A4. ACCORDING TO THE CITY HEALTH OF SORSOGON, THEY CONTINUE TO PROVIDE FP SERVICES, BUT THEY DO NOT DISPENSE ARTIFICIAL CONTRACEPTIVES. THEY ARE FOCUSING INSTEAD ON INFORMATION DISSEMINATION. THE MAYOR RESPONDED TO THE COMPLAINT FOR VIOLATION OF MCW AND R.P.R.H. – SHE INVOKES HER RIGHT AS A 'CONSCIENTIOUS OBJECTOR'
-C.H.R. INVESTIGATOR
likha


ZAMBOANGA
ZAMBOANGA CITY
• 294 INDIVIDUALS CONSULTED FROM BOTH FACT-FINDING AND PUBLIC HEARINGS
• 1 CITY, 6 BARANGAYS
• 8 GOVERNMENT HEALTH OFFICE/ FACILITIES
• 16 TESTIMONIES UNDER OATH DURING THE PUBLIC HEARING
• AT LEAST 42 INDIVIDUAL SUBMISSIONS
DENIAL OF RH SERVICES AND DISCRIMINATION OF INDIGENOUS PEOPLES & INTERNALLY DISPLACED PERSONS
I CAN'T GET TESTED WITHOUT MY PARENTS' CONSENT. IF THAT'S THE CASE, I'D RATHER NOT GET TESTED.
MY PARTNER AND I HAVE R.H. NEEDS TOO, BUT WE FACE STIGMA AND DISCRIMINATION FROM A HETERONORMATIVE SOCIETY.
I WANT TO GET TESTED FOR H.I.V. BUT THERE ARE NO R.H. SERVICES AND INFORMATION IN THE PROCESSING CENTER FOR DEPORTEES.
I'M IN LABOR. PLEASE TAKE ME TO THE HOSPITAL RIGHT AWAY.
YOU NEED TO PAY Php800 FOR GAS.
MASEPLA TRANSITORY SITE
PAY HIM. IN AYALA, WHEN MY RELATIVE'S BREAST TUMOR RUPTURED, NO AMBULANCE WOULD COME. WE HAD TO CONTACT THE POLICE JUST SO WE COULD GET AN AMBULANCE.
ZAMBOANGA CITY MEDICAL CENTER
I'VE BEEN HERE SINCE 10AM. IT'S BEEN 8 HOURS. I GAVE BIRTH IN THE JEEPNEY AND THEY HAVEN'T ATTENDED TO ME AND MY BABY YET.
EMERGENCY
INSUFFICIENCY, INADEQUACY OF GOODS, SERVICES AND FACILITIES
MY CHILD IS DYING AND THE RED CROSS HERE JUST GAVE ME ORESOL.
THEN YOU NEED TO BRING YOUR BABY TO A HOSPITAL RIGHT AWAY.
I WENT TO ZAMBOANGA CITY MEDICAL CENTER, BUT THEY TOLD ME TO GO HOME AND OBSERVE FURTHER. I DON'T KNOW WHAT TO DO. MY BABY'S FADING AWAY!
WE WORK IN ISLAND PROVINCES. IN BASILAN, SULU, AND TAWI-TAWI, THE CHALLENGES INCLUDE: RELIGIOUS AND CULTURAL BELIEFS, POOR ACCESS TO RH FACILITIES AND AMENITIES IN ISLAND PROVINCES -- THERE ARE HEALTH CENTERS WITH NO HEALTH WORKERS, AND THERE IS A CONSTANT SECURITY RISK.
-PINK (PINAY KILOS)
THE STIGMA, ISOLATION AND POOR EDUCATIONAL BACKGROUND OF THE INDIGENOUS PEOPLE ESPECIALLY THE BADJAOS AFFECT THEIR AVAILMENT OF RH SERVICES AND INFORMATION, THEY FACE VARIOUS FORMS OF DISCRIMINATION
-HUMAN DEVELOPMENT AND FAMILY SERVICES
IT IS IMPORTANT TO WORK WITH THE TRIBAL LEADERS IN IMPLEMENTING THE RH LAW. IT IS UNTRUE THAT IPS ARE RELUCTANT IN ENGAGING THEMSELVES IN FAMILY PLANNING. THERE IS JUST A NEED TO ENGAGE TRIBAL LEADERS AND ELDERS
-I.P. MANDATORY REPRESENTATIVE
COMM. KAREN GOMEZ-DUMPIT
COMM. GWENDOLYN PIMENTEL-GANA
I ONCE BROUGHT MY 3-YEAR OLD CHILD TO THE CITY HEALTH OFFICE FOR TREATMENT. I WAS REQUIRED TO PAY A TOTAL OF PHP80.00; PHP50.00 FOR AN I.D. AND PHP30 CONSULTATION FEE.
-INTERNALLY DISPLACED PERSON
FAMILY PLANNING IS NOT TABOO IN ISLAM. WE HAVE A FATWA ON FAMILY PLANNING. BUT NOT ALL MUSLIM WOMEN KNOW THIS. WE GO TO COMMUNITIES AND EDUCATE.
-NURUSALAM, MUSLIM WOMAN BARANGAY HEALTH WORKER
likha


TACLOBAN/PALO, LEYTE - SAMAR
REGION VIII
• 76 INDIVIDUALS CONSULTED FROM BOTH FACT-FINDING AND PUBLIC HEARINGS
• 5 CITIES / MUNICIPALITIES, 6 BARANGAYS
• 5 GOVERNMENT HEALTH OFFICE/ FACILITIES
• 21 TESTIMONIES UNDER OATH DURING THE PUBLIC HEARING
• AT LEAST 5 INDIVIDUAL SUBMISSIONS
INADEQUATE SUPPORT FOR HEALTH WORKERS AND SERVICE PROVIDERS
WELCOME BARANGAY HEALTH WORKERS!
HA! YOU'RE LUCKY. I GET PHP 350.
YOU SHOULD BOTH BE HAPPY. I GET PHP 60.
HOW MUCH ALLOWANCE DO YOU RECEIVE FROM YOUR BARANGAY AND THE LOCAL GOVERNMENT?
I ONLY RECEIVE PHP 600/MONTH.
THE CHURCH ACCEPTS ONLY NATURAL FAMILY PLANNING!
RELIGIOUS RESISTANCE
PLEASE HURRY! MY BABY'S VERY SICK. WE WERE REFUSED IN BALANGIGA AND TOLD TO GO TO TACLOBAN.
YOU GET AN ALLOWANCE?!
BUT YOU TOLD ME YOU WILL BE READY FOR MY DELIVERY TODAY!
I'M SORRY. WE CAN'T ADMIT YOU HERE. WE DON'T HAVE THE NEEDED EQUIPMENT REQUIRED BY YOUR DISABILITY.
BREAKDOWN OF SERVICE DELIVERY NETWORK AND COORDINATION
I WAS REFUSED BY THE HOSPITAL IN SAMAR, AND HAD TO TRAVEL TWO HRS. TO TACLOBAN. MY CHILD DIED AT THE EASTERN VISAYAS REGIONAL MEDICAL CENTER (EVRMC).
-MOTHER FROM QUINAPONDAN, SAMAR
DURING MY FIFTH PREGNANCY, MY WATER BROKE, BUT THE DOCTORS AND NURSES FROM EVRMC SENT ME OUT OF THE DELIVERY ROOM. I GAVE BIRTH IN THE HALLWAY OF THE HOSPITAL.
ON MY EIGHTH DELIVERY, THE NURSES WERE RUDE, CURT, AND INATTENTIVE. I DESPISE EVRMC.
-INTERNALLY DISPLACED PERSON, WOMEN'S SHELTER, TACLOBAN CITY
POST-YOLANDA, AND IN OUR HOUSE-TO-HOUSE VISITS TO COASTAL AREAS, EVACUATION CENTERS, AND RELOCATION SITES, THERE WAS NO MENTION OF HYGIENE KITS OR R.H. COMMODITIES FROM THE DEPARTMENT OF HEALTH. MOST CAME FROM INTERNATIONAL NON-GOVERNMENT ORGANIZATIONS..
-FREEDOM FROM DEBT COALITION, LEYTE
COMM. KAREN GOMEZ-DUMPIT
COMM. GWENDOLYN PIMENTEL-GUNA
HUMAN HEALTH RESOURCE REMAINS A CHALLENGE. AT PRESENT, ONE DOCTOR ATTENDS TO 150-200 PATIENTS A DAY. WE REQUESTED FOR ADDITIONAL DOCTORS TO THE BARRIO, BUT WE WERE REFUSED.
-NURSE; BAS-EY, SAMAR
THE HIGH DEATH RATE IN HOSPITALS IS AN ISSUE OF ACCESS; NOT AVAILABILITY.
-PROFESSOR; UNIVERSITY OF THE PHILIPPINES - VISAYAS
THE CHURCH IS NOT THE ONLY CHALLENGE. LACK OF INFORMATION AND AWARENESS REMAIN BARRIERS TO THE IMPLEMENTATION OF RPRH LAW.
-EASTERN VISAYAS NETWORK OF NGOS
likha

As part of the Commission on Human Rights' National Inquiry on Reproductive Health, 5 Public Hearings and 15 days of Fact Finding were conducted in five cluster areas: National Capital Region, Legaspi-Sorsogon City, Zamboanga City, Tacloban-Leyte-Samar and Cagayan de oro-Bukidnon. This report consolidates the results of the fact finding and public hearings.

Fact Finding and Public Hearing Report

Part of the Commission's National Inquiry on RH

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EXECUTIVE SUMMARY

The Commission on Human Rights (CHR) as a National Human Rights Institution and as Gender Ombud under the Magna Carta of Women conducted a National Inquiry on the Reproductive Health and Reproductive Rights between March and May of 2016. A national inquiry is a proactive and cost-effective strategy adopted by the National Human Rights Institute to investigate a large number of complaints and systematic violations of human rights. The inquiry aims to document related experiences of women, communities, health service providers, health centers, local governments, civil society organizations, and other stakeholders to surface issues on reproductive health and reproductive rights that still need to be addressed.

The National Inquiry consisted of three interrelated parts: the launch on March 1, 2016 which included a call for submissions to the Inquiry; the Regional Consultations on the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) and the Magna Carta of Women (MCW) with special focus on Reproductive Health (RH) conducted during the entire month of March; and the Fact Finding and Public Hearing conducted during the months of April and May 2016 in 1) National Capital Region, 2) Legazpi-Sorsogon, 3) Zamboanga City; 4) Tacloban-Leyte-Samar, 4) Cagayan de Oro-Bukidnon.

During the course of the Fact Finding and Public Hearings, the Commission has consulted a total of 712 individuals. It has conducted 5 public hearings, 15 days of fact finding in 5 regions covering 13 cities/municipalities and 23 Barangays. It has also visited 29 government health office/facilities and has heard 89 testimonies under oath. It has gathered more or less 95 individual submissions and 7 submissions from organizations.

The organizations that forwarded submissions to the National Inquiry were: Center for Reproductive Health and Rights, EngendeRights, Lilak Purple Action for Women, Rainbow Rights, Philippine Deaf Resource Center, and Philippine Alliance for Philippine Alliance of Persons with Chronic Illness.

The present document reports the results of the fact finding and public hearings in each of the five cluster-areas and of the submissions received by the Commission in relation to the four objectives of the National Inquiry.

- **On the *Effectiveness and Levels of Implementation of RH Services and Information***

  The results of the Fact Finding and Public hearing showed uneven implementation of the RH law primarily due to decentralization and autonomy of local government units. This resulted in the fragmented delivery of reproductive health services. The fact finding and the public hearings reveal that local government units show varying degrees of support for the implementation of the law from full support and political will to outright refusal to implement provisions of the RH law. Full support for RH law

is shown in Marikina City with its Contraceptive Self Reliance Ordinance; in Manila City, the "Pro-Life" EO 003 of Mayor Atienza was superseded by EO 030 of Mayor Lim. However, while the EO 030 does not prohibit artificial contraceptives, it continues to bar local funding for artificial contraceptives. In Sorsogon City, there is outright refusal to implement the law with the adoption of Mayor Sally Lee's "Pro-Life Ordinance" resulting in the denial of access to artificial contraceptives, resulting in unmet needs of women in Sorsogon City.

Policy Barriers to RHRH

Other local policies were also found to be contradicting the RH law and weakening its effective implementation. The policies that served as barriers to the implementation of the law were the TRO on Implanon issued by the Supreme Court, the required consent from parents for adolescents and from husbands for their wives on availing certain RH goods and services, the absolute ban on abortion, the absence and unavailability of emergency contraceptives, and the criminalization of traditional and indigenous home births. The latter highlights the lack of reconciliation regarding the implications of the RH Law on traditional RH practices.

The decision in Imbong vs. Ochoa and the declaration of the Supreme Court in upholding the rights of consciencious objectors and the voiding of penalties for government officers refusing to implement the RPRH law also barred full implementation of the RPRH law. The ruling has been invoked by Sorsogon City's Mayor Lee in refusing to implement the law, and it is likewise used by some government health facilities and health service providers in seeking parental consent for minors and in refusing tubal ligation for married women without the consent of their husbands.

Role of DOH, Monitoring of RPRH, Role of CSOs

With respect the role of the Department of Health and of the monitoring of the implementation of the Reproductive Health Law, the fact finding and public hearings documented the efforts being undertaken to monitor the implementation of the RPRH law through the Regional and National RPRH Implementation Team. The Inquiry also documented practices by National Government Agencies such as POP Com and DSWD in incorporating RH in their programs such as 4Ps as well as the efforts being undertaken to engage men in the RH agenda. Effective partnerships with civil society organizations in the delivery of RH services and information have been documented in all of the areas visited. The CSOs were recognized as partners of the local government and national government in the implementation of RH law, and in far flung areas such as in the island provinces in Mindanao, CSOs often fill the service delivery gap by both National and Local Government Units.

In the case of Sorsogon City and of the Mayor's refusal to dispense artificial contraceptives, the Commission found that despite the prohibition of artificial contraceptives by the City of Sorsogon, the Department of Health has undertaken

measures to mitigate the impact of the "Pro-Life Ordinance" by deploying nurses and midwives and by ensuring availability of artificial contraceptives through the Nurse Deployment Program (NDP) and partner NGOs. However, such measures are temporary as the NDPs are under contract, not integral to the LGUs, and they are required to serve several barangays at a time. The delivery of RH services by the NDPs are likewise constrained by the Mayor's outright prohibition and they expressly discouraged/prevented from making use of LGU facilities such as Barangay Health Center and Rural Health Units in dispensing family planning commodities. The Commission has documented several accounts of women from far flung barangays and those who cannot afford to spend for transportation to the city proper whose RH needs remain unmet as direct effects of the Mayor's "Pro-Life" Executive Order.

Availability, Accessibility, Sufficiency and Adequacy of RH Services and Information

In terms of Availability, Accessibility, Sufficiency and Adequacy of RH Goods and Services, the Commission documented experiences which ranged from excess in terms of commodities as in the case of Marikina, to inconsistency in the provisions of these goods, facilities and services to their inadequacy, insufficiency, and inaccessibility, particularly to women who are vulnerable and most marginalized – lesbian, bisexual and transgender women, women with disabilities, Moro and Indigenous women and women living in geographically inaccessible areas. In many instances, health facilities are inaccessible for women in geographically inaccessible areas, and in cases where they are accessible, challenges are posed as to the sufficiency of facilities and of supplies of the commodities available.

Interviews in government health facilities and with government health workers and service providers often yielded positive results with claims that there is an excess of RH commodities and goods. In all government facilities visited, except in Sorsogon City, the Barangay Health Centers and Rural Health Units were able to show and share with the Commission the full range of family planning commodities available. Most shared that they have not yet experienced the effect of the PhP1 Billion cut on RH commodities and that the lack of supplies they experience are not from lack of available supply but a matter of timely seeking re-supply from RHU's and the DOH. There were admissions however that facilities could still be improved in barangay health centers, RHUs and lying in clinics. There is also acknowledgment that standards of doctor/nurse/midwife ratio to patients/clients served is not followed in all of the facilities visited.

Accounts from interviews with community members and CSOs continue to reveal inconsistency in the availability, accessibility, sufficiency and adequacy of RH services and information. Across the five cluster areas, accounts of health centers seeking donations were still documented, there were also accounts of health centers refusing to dispense and provide RH commodities by reason of discrimination and at times favoritism, there were accounts of unethical and unprofessional behavior of health workers, and of delays in referral resulting in maternal deaths, in the island provinces of Mindanao, there were accounts that health centers are unmanned due to security

reasons, and there are various accounts of the absence of available/free transportation from one health facility to another. Inadequate facilities were also cited particularly the sharing of beds in Manila, Tacloban and in Zamboanga City.

RH information and Reception of RH Goods and Services

Regarding Public Reception of RH Goods and Services, people's experiences in all areas pointed to its improvable status. While POP Com and the health workers from the Barangay and the Local Government Units provide RH information on a daily basis, including house to house visits by volunteer barangay health workers, accounts on lack of information on RH services continue. There is recognition that information dissemination should include men in the RH agenda and a rethinking of RH as not the sole concern of women. It has been noted that a recurring experience among areas is the low participation of men in the RH agenda, whether in terms of policies, programs and processes or in the context of making decisions between partners. In Mindanao, concerns have been raised on the failure to engage indigenous and religious leaders in the RH agenda and to engage them in information dissemination on RH. Sexuality and RH education have also been raised as lacking and inconsistent in many areas, pointing to the need for strengthened RH and Sexuality education.

- **On *The Denial and/or Barriers in Accessing RH***

In addition to policies which served as barriers to the full implementation of the RH law, the Commission's fact finding and public hearing also documented other barriers and denial of access to RH services and information.

One of the barriers identified throughout the cluster areas is the lack of information on RH and/or misinformation due to religion or culture which affect women and men's willingness to access RH services. Despite claims by government health workers and service providers on information dissemination being conducted, interviews continue to reveal that some women are unaware of the available services and commodities specially those living in geographically inaccessible and disadvantaged areas. In some cases, while women are generally aware of the available RH services, they are unwilling to avail of services due to religious beliefs or cultural practices. While a 'fatwa' has been issued on the acceptability of RH in Islam, not all Moro women are aware of the same. For IPs, while elders claim that it is not against the culture of IP's, some women refuse to avail of RH services without consulting with elder or without consent and agreement of their husbands. These led to recommendations on the need to improve information dissemination not only on the available RH goods and services, but also to include men, traditional and religious leaders in the RH agenda. In the case of Sorsogon City, the Commission found that the misinformation being undertaken by the City through sponsored radio programs and 'Pro-Life' conventions were found to have affected women's willingness to avail of RH services and goods. The misinformation included claims that artificial contraceptives cause cancer and associating contraceptive use with abortion. Active religious

resistance to artificial RH commodities have also been found in Sorsogon City and in some areas of Leyte and Samar.
The fact finding and public hearing also documented the breakdown in the service delivery network and coordination among government hospitals, rural health units and lying in clinics which often resulted to maternal deaths. For many women living in geographically inaccessible areas and whose pregnancies are complicated, referral to major government hospitals are required. However, several accounts have been documented of lying ins and RHUs needing to refer patients to government hospitals but were faced with challenges on transportation, coordination, and the absence of needed facilities to respond to the emergency. Complaints have been gathered as well on the attitude of some government health service providers and the lack of professionalism resulting to the low morale of referring midwives and nurses and the patients' lack of trust and confidence in the ability of government hospitals to respond to their needs.

In addition to the issues/attitudes of health workers and health service providers, common unprofessional and unethical practices surfaced including requiring donations for RH goods and services that are supposed to be free; mistreating women seeking Post Abortion Care, refusing services to a woman seeking surgery due to her transgender identity, her disability, or HIV Status, delaying or refusing medical services to women for various reasons including concerns over records to their lack of capacity to pay. All these served as barriers to women's effective access to RH services and information.

- **On the *Availability, Accessibility, Adequacy and Affordability of RH Services for Vulnerable/Marginalized Women***

The fact finding and public hearing purposively conducted targeted data gathering on the availability, accessibility, adequacy and affordability of RH services and information for vulnerable and marginalized women. The barriers and denial of RH services and information provided above were likewise experienced by women in the vulnerable and marginalized sector, but these are further exacerbated by their different vulnerabilities and different experiences of discrimination.

Discriminatory Policies render marginalized women more vulnerable

In the five cluster areas, the Commission found that women from the marginalized sector are most vulnerable to the effects of discriminatory policies that hinder full access to RH Services.

In Sorsogon City, the Mayor's "Pro-Life" EO and the resulting pull out of artificial contraceptives affected women living in geographically isolated and disadvantaged areas, those who are in the informal sector, and those who are dependent on their husbands and without means to purchase their own contraceptives. EO 003 further discriminates against these vulnerable/marginalized women as it requires them to pay for contraceptives they could have received for free were it not for the adoption

of the EO and the pull out of contraceptives. The stop gap measures implemented by the DOH through the Nurse Deployment Program helped in providing unmet needs of women in Sorsogon City. However, being a stop gap measure, the NDPs are not sustainable and women, especially the most marginalized and those in GIDA areas are unable to access both RH services and information.

The TRO on the Implanon also has the same effect, as it deprives women free access to the commodity. In NCR for example, women who are informal settlers prefer Implanon with its effectivity lasting for three (3) years, however, the TRO prevents them from obtaining free Implanon shots. They simply cannot afford to purchase Implanon on their own. Women who are economically capable of purchasing Implanon are not affected by the TRO as it can still be purchased and is dispensed in private clinics.

On the absolute prohibition of abortion and the absence of emergency contraception, the submissions from Center for Reproductive Rights and EngendeRights have made clear that such polices mostly impact the poor, marginalized, and vulnerable women. The prohibition casts a stigma on women who've suffered from abortion and in effect results in the denial of post abortion care which the RH law supposedly assures. The stigma and criminalization of abortion has also led many poor women to resort to unsafe abortions. Documentation on women who've suffered from unsafe abortions and who were unable to access PAC was compiled and submitted to the Commission by CRR. EngendeRigths further submits and as echoed by participants during the public hearing that the absence of emergency contraceptives fail to protect women and girls who are victims of sexual violence. Their absence limits the autonomy of women and girls over their bodies and result to unwanted pregnancies as a result of sexual violence.

On the proliferation of ordinances criminalizing and penalizing traditional and indigenous home births, the women who mostly bear the brunt of these measures were found to be Moro and Indigenous women and women who mostly live in geographically inaccessible and disadvantaged areas. While these ordinance were adopted to encourage facility based delivery and to address increase of maternal mortality, the effect of the measure has been discriminatory to Moro and Indigenous women, it has also resulted to the imposition of penalities and criminalization of women from GIDA areas for the failings of the State specifically for the State's failure to bring health centers and facilities to far flung areas and to women who need them most.

We have documented accounts of traditional birth attendants refusing to help women because of fear of imprisonment, we have submissions of IP women who were forced to travel distances to go to the health facilities for fear of imprisonment. In the submission of Lilak Purple Action for Women, they forwarded the declaration of Indigenous women denouncing the passage of these ordinances and calling for respect of the traditional birthing practices of Indigenous women. A Council of Elders in Bukidnon likewise issued a resolution calling for the repeal of the Ordinance

penalizing home births as being discriminatory to IP women. During the course of the fact finding and public hearing, the Commission has counted at the minimum twelve (12)ordinances all over the country which penalize home births.

Lack of access to RH services and facilities and Denial of RH services

Accessibility of RH services and information has been highlighted throughout the fact finding and public hearings particularly with women with disabilities, Moro and Indigenous Women and women in GIDA.

In the NCR and Cagayan de Oro-Bukidnon cluster, the lack of accessibility of government health centers and facilities for women with disabilities have been raised. Submissions and sworn testimonies of PWDS complain of the seeming invisibility of the needs of PWDs, the absence of facilities like examination tables, the absence of interpreters in police stations and in courts for PWD victim-survivor of violence against women, and the absence of interpreters as well in health centers and government health facilities. PWDs complain of not being informed of the processes affecting them and of the disregard for their decision because of their disability. A submission also recounted the denial of health services on the basis of her disability, another, the denial of Philhealth benefits on account of chronic illness, clear accounts of discrimination which compounded by the women's already marginalized status.

Violence Against Women

In case of violence, the Fact Finding and Public Hearing has shown that many women, particularly those from the marginalized sector suffer and are vulnerable from violence at various levels: in the family, in the community, and in the hands of institutions. In several cases, while information is available on the remedies in cases of VAW, women are faced with issues of access, lack of sensitivity of the duty bearers and the lack of understanding of the multiple and intersecting forms of discrimination experienced by women from the marginalized sector.

In the NCR and in the submissions from the PDRC highlights the prevalence of gender based violence against deaf women and the hands of family members, neighbors and members of the Community and the absence of interpreters in the government agencies tasked to respond to the violence. The absence of interpreters, the lack of access crucial to deaf women's access to remedies, are by themselves institutional violence. Other forms of institutional and systemic violence include the 'invisibility' of the concerns of deaf women, women with mental disabilities and other disabilities in accessing remedies in cases of VAW.

Also in NCR, women who are informal settlers in Tondo also provided an account of the violence they experience – at the hands of intimate partners, from their own neighbors, and form the State in cases of demolition. Their case highlights not only

the lack of access to remedies for VAW inside the family but also the difficulty of accessing remedies in cases where the perpetrators are State actors – those who demolish their shanties and leave trails of abuses.

Invisibility of issues and specific vulnerabilities of women in the marginalized sector

As previously pointed out, adequate response to the intersecting vulnerabilities of women, particularly Moro and Indigenous women, women in in geographically inaccessible areas, women with disabilities, lesbian, bisexual and transwomen is lacking.

The issues of Indigenous women on the penalization and criminalization of traditional and indigenous home births have been largely ignored – with more and more LGUs enacting ordinances as their interpretation of the DOH's encouragement of facility based delivery, and without express prohibition from the DOH against the enactment of these ordinances.

For Moro and IP women, mostly in GIDA, and women with disabilities access to reproductive health services remain challenging. Distance or in some case absence of health facilities, the lack or absence of health service providers, the failure to provide accommodation for needs of PWDs, and failure to take into account cultural sensitivities have been complained of.

For LBTs, the stigma borne by their sexual orientation and gender identity continue to hinder sensitive delivery of reproductive health services and information. In the same vein, access to reproductive health services and general health services of persons with HIV are affected by the stigma attached to HIV and the lack of awareness and training of health workers on HIV.

In areas where displacement is prevalent, the constant complaint has been the failure to take into consideration and prioritize the reproductive health needs of women, their protection from violence and trafficking. For the IDPs in Zamboanga and in Tacloban, despite having been resettled either in transitory or in permanent shelters, access to reproductive health services and information, to health facilities, and to transportation to health facilities have been consistently complained of. Complaints have been documented that the needs of women during displacement have not been adequately met.

- **On *Barriers/Challenges Encountered by State and Other Health Service Providers***

  The National Inquiry has established that both government and private health service providers continue to face challenges in the implementation of the provisions of the RPRH law.

  Policy and legal barriers to RH likewise affect health service providers and health workers. The issuance of the TRO on Implanon by the SC, the voiding of key RPRH provisions, the passage 'Pro-Life EO' are some of these policy and legal barriers. Specific to Region X, another policy barrier, one that is explicitly discriminatory against women nurses and midwives exist – the prohibition against pregnancy. The latter, while reportedly enacted to protect women nurses and midwives during pregnancy has resulted to discrimination against women nurses, who unlike their male counterparts, can become and do become pregnant during the course of their contract with DOH. Raised during the Inquiry, the DOH committed to review these policies to make them non-discriminatory and human rights compliant.

  Another barrier found by the Commission is the unsustainability of Health Human Resource Management. In all of the cluster areas visited during the fact-finding, the Commission documented the temporary nature of the appointments of midwives and nurses in Barangay Health Stations and Rural Health Units. LGU midwives complained of being contractual for ten years with contracts renewed every six months. The NDPs and the midwives deployed to different areas shared that their contracts will be ending in December of 2016. A doctor that the fact finding team interviewed shared the number of patients he sees every day, sometimes reaching up to 250; he then complained that his request for additional doctors to the barrio was denied. In all areas, the ratio of doctor to population, or nurse/midwife to population were often not complied with. These posed barriers to government health service providers. These are also related to the various complaints raised regarding the attitude and unprofessional demeanor of health service providers/workers which may be caused by the stress experienced in challenging work environment.

  The National Inquiry was able to document as well the uneven support for Barangay Health Workers. Some barangays and LGUs are supportive of BHWs, providing substantial separate allowance, in other cases the allowance is granted on a quarterly basis and in an almost negligible amount. Reports have been made as well that the appointment and provision of allowances of BHS have been subject to much politicizing on the ground. The recommendation for the standardization of allowances for BHWs and for the professionalization of their services are very well grounded.

  Another challenge for health services providers is the lack or inadequate support. Accounts have been made during the Inquiry on how many health workers are overworked and underpaid, with some forced to work under conditions that threaten their physical security. Reports were made that Barangay Health Stations, RHUs and some municipal and provincial health facilities have insufficient supplies that again

prevent health workers and health services providers from performing their job. The question of salary and regularization of health service providers and health workers also indicate this lack or inadequate support.

Health service providers and health workers both public and private are likewise faced with challenges brought about by religious and cultural beliefs, misinformation and misconception of RH, and the absence of health seeking behavior among the clientele. During the inquiry, health service providers and health workers echo the challenges posed by religious opposition and resistance to RH in the delivery of RH services. They also elaborated on how some women refuse to avail of RH services and FP commodities with the misplaced belief that RH is against their culture. It has been pointed out that most of these barriers are based on misconceptions on RH and could well be addressed by more comprehensive information dissemination at the community level and by engaging religious and cultural leaders.

Recommendations from the fact finding and public hearing include continued monitoring of the compliance to MCW and the RH Law, augmentation of funds for the implementation of the RH Law, review of policy on abortion, increased and integrated efforts at educating communities and capacitating implementers on RH, engagement of traditional or religious leaders in the promotion of RH, the enhanced engagement of men in the RH agenda and implementation, the recognition of the specific needs of marginalized sectors, and ensuring the sustained availability of RH goods and services especially for the marginalized sectors.

INTRODUCTION AND RATIONALE OF THE INQUIRY

The Philippines signed and ratified in 1981 the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW). Since then, various legislations recognizing, affirming and promoting women's human rights were enacted. Recently, two ground-breaking laws were passed, the Magna Carta of Women (MCW) and the Responsible Parenthood and Reproductive Health Law (RPRH).

Despite the various progressive laws, women in the Philippines continue to face significant challenges and discrimination. In the area of reproductive health, the Philippines has one of the highest rates of maternal mortality in the Asia and the Pacific Region at 120 deaths per 100,000 live births[1], and is off-track to achieve the Millennium Development Goal 5. The CEDAW Committee, in its 36th session in 2006, expressed concern over this, noting the number of deaths resulting from induced abortion, high fertility rates, inadequate family planning services, low rates of contraceptive use, and the difficulties of obtaining contraceptives. It also noted the lack of sex education especially in rural areas, and expressed concern over the high rate of teenage pregnancies. Hence, in its list of issues, the CEDAW Committee has dedicated a substantial portion on health, particularly on how the State has taken adequate measures to "ensure access to health services for all women, in particular rural women, women with disabilities, indigenous women and Muslim women".

While the passage of the RPRH law was a significant step towards the promotion of reproductive health rights, its implementation continues to face obstacles. The constitutionality of the law was immediately challenged upon its passage, and while the Supreme Court upheld its constitutionality, a Temporary Restraining Order (TRO) was issued in June 2015 on the procurement of contraceptives and on the dispensation and administration of implants and implant NXT. To date, the TRO has not been lifted. In addition, the 2016 DOH budget amounting to one billion pesos for contraceptives was removed during the deliberations of the Senate and House of Representatives bicameral conference committee. In the local government, an Ordinance criminalizing the dispensation of family planning commodities is pending in the City Council of Sorsogon. The City Mayor issued in February of 2015 a "pro-life" resolution and contraceptives were pulled out from health centers depriving women of reproductive health services.

This July, the Philippines will once again be under review by the CEDAW Committee for its sixth and seventh consolidated report. For this July 2016 review, the Commission on Human Rights intends to submit its independent report. As a National Human Rights Institution (NHRI), the Commission monitors the compliance of the State with its treaty obligations, including CEDAW. As Gender Ombud under the Magna Carta of Women, the Commission likewise monitors the implementation of the MCW and other related laws on women like the RPRH Law.

[1] UNDP. 2015. *Human Development Report*. Comparative data shows an average of 72 deaths per 100,000 live births for East Asia and the Pacific Region.

For this report, the Commission conducted a **National Inquiry on Reproductive Health Rights,** focusing on the issues as identified by the CEDAW Committee in the List of Issues (LOI), and with a special focus on reproductive health rights particularly of marginalized groups. The activity was with funding support from the United Nations Populations Fund (UNFPA), and in coordination with civil society organizations (CSOs) such as Likhaan Center for Reproductive Health Rights and other CSOs focusing on Reproductive Health Rights.

The objectives of the National Inquiry on Reproductive Health included:

1. Examine the effectiveness and implementation of laws (MCW and the RH Law), and related issuances by the DOH on Reproductive Health;
2. Document individual and/or systemic accounts of acts or omissions, structures, policies or practices which result to denial of access to reproductive health services or which hinder and serve as barriers in accessing reproductive health services;
3. To focus on the denial of and barriers to reproductive health services as experienced by the most vulnerable and marginalised, particularly the poorest of the poor, rural women, indigenous women, women with disabilities, Lesbian, Bisexual and Transwomen, women in the informal economy, elderly women, girl children and women who are internally displaced and/or those who are not beneficiaries of the Department of Health's 2015 Family Planning Funds;
4. To document the barriers and problems experienced by service providers, both state and non-state, in providing reproductive health services, particularly to those most vulnerable and marginalized;
5. To provide an analysis and to report on women's access to reproductive health in the light of the State's obligations under CEDAW and the provisions of the MCW and the RH Law;
6. To relate women's right to reproductive health to other rights under CEDAW and to highlight the intersectionality of women's discrimination through the accounts provided by the written submissions, the fact finding, and the public hearings;
7. To provide concrete recommendations to the State and the concerned agencies to address individual and systemic/structural barriers to women's access to reproductive health services;

The National Inquiry consisted of three interrelated parts:

1. The Launch of the National Inquiry on 1 March 2015 at the Commission on Human Rights and the official call for submissions from individuals and/or organizations documenting their experiences with respect to denial of/ discrimination and barriers in accessing reproductive health services. This may be in the form of acts or omissions resulting to denial and/or discrimination in accessing reproductive health rights. These may be policies, practices which deny, hinder of prevent access to reproductive health, single and isolated incidents or systemic acts of violations and discrimination.
2. Regional Consultations through its fifteen (15) regional field offices on CEDAW and Magna Carta with particular focus on Reproductive Health Rights to be conducted in March; The Regional Consultations will be conducted by the Commission's Regional Offices with guidance from GEWHRC and the UNFPA; Individuals with specific

concerns and submissions on the RH Inquiry may likewise submit the same through the Commissions' fifteen (15) Regional Offices;

3. Fact Finding and Public Hearings in five select areas in the country to be conducted the whole month of April. The select areas are: Metro Manila, Legaspi City, Tacloban City, Cagayan de Oro City and Zamboanga City. Two days will be devoted to fact finding and one day for the public hearing. The Public Hearing for Metro Manila will be on 4th of April; in Legaspi, April 14; in Zamboanga, April 21; in Tacloban, April 25 and in Cagayan de Oro, April 29. Individuals, organizations with specific concerns on RH and particularly falling within the scope of the Inquiry are encourage to participate and attend.

Specific to the Fact Finding and Public Hearings, four specific objectives were identified. These objectives were also the issues that guided the conduct of the fact finding and the public hearings:

1. To review the effectiveness and implementation of the Magna Carta of Women and RH laws and related issuances by the DOH on reproductive health;
2. To document and examine individual and/or systemic accounts of omissions, structures, policies, and/or practices which result to denial of access to reproductive health services or which hinder and serve as barriers in accessing RH services;
3. To examine the barriers to RH services experienced by the most vulnerable and marginalized, i.e. the urban poor, rural women, indigenous women, women with disabilities, Lesbian, Bisexual and Transwomen, women in the informal economy, elderly women, girl children, and women who are internally displaced and/or those who are not beneficiaries of the DOH's 2015 Family Planning Funds; and
4. To document the barriers and problems experienced by service providers, both state and non-state, in providing reproductive health services, particularly to those most vulnerable and marginalized.

SUMMARY INFORMATION ON THE FACT FINDING

The National Inquiry conducted fact finding missions aimed to address the key objectives or the inquiry. The missions conducted with the Commission's Regional offices sought to document and solicit information from women, particularly the most marginalized and vulnerable, as well as from government and non-government health service providers. The women interviewed represented different sectors such as Indigenous Peoples (IPs), Internally Displaced Peoples (IDPs), rural agriculture, fishery, urban poor, women from the informal sector, home-based workers, private and public labor, Persons with Disabilities (PWDs), and People Living with HIV (PLHIV). State and non-state service providers were also part of the inquiry.

The fact finding process included the following:

- Ocular visit of select city/municipal/barangay health centers;
- Interview with state and non-state reproductive health service providers; and
- Visit to specific communities to inquire into the enjoyment of the right to reproductive health services and information as provided by the Responsible Parenthood and Reproductive Health (RPRH) Law.

The fact finding teams, armed with Mission Order from the CHR Central Office, and with guidance from partner Civil Society Organizations (CSOs) and the Regional Gender Focal Person (GFP), visited specific municipalities and barangays for the mission.

The fact finding team was composed of the following:

- The Gender, Empowerment, and Women's Human Rights Council (GEWHRC);
- The investigators/lawyers and Regional Gender Focal Persons (GFP) of the Region involved;
- UNFPA representative;
- CSOs or community members in the area to be visited.

For each major area, they were composed by the following:

Area	Team
NCR	1. Director Dr. Renante A. Basas – Director, HRCMO 2. Atty. Krissi Shaffina Twyla A. Rubin - Office in Charge, Gender Equality and Women's Human Rights Center 3. Mr. Felix Lumayag - Investigator 4. Ms. Maribel Ong - Investigator 5. Ms. Clair Bacani - Investigator 6. Ms. Joan Rodriguez (first day) - Investigator 7. Two UNFPA representatives 8. Radigunda R. Laman, Documenter

LEGAZPI-SORSOGON	1. Dr. Renante A. Basas – Director, HRCMO 2. Atty. Krissi Shaffina Twyla A. Rubin – Office in Charge, Gender Equality and Women's Human Rights Center 3. Ms. Karen Mae O. Bantang – Planning Officer II, GEWHRC 4. Ms. Mary Janice B. Ceneta – Special Investigator II, CHR 5 5. Mr. Ramon Raul L. Velasco – Special Investigator I, CHR 5 6. Mr. Diosdado L. Morada – Admin Aide III/ Driver, CHR 5 7. Dr. Gina Pangilinan and Ms. Thea Arcella Bohol of the UNFPA, joined the team as observers on the first day of the task.
LEYTE-SAMAR	Eleven investigators composed of CHR National, CHR Region 8, UNFPA, and Sinirangan Bisayas Development Consulting representatives
CAGAYAN DE ORO	1. Atty. Krissi Shaffina Twyla A. Rubin - Office in Charge, Gender Equality and Women's Human Rights Center 2. Dr. Renante A. Basas – Director, HRCMO 3. Jerefe D. Tubigon-Bacang – GFPS, CHR 10 4. Pilipinas C. Palma – GFPS, CHR 10 5. Fides Teresa M. Cabana – GFPS, CHR 10 6. Maria Theresa R. Neri, GFPS, CHR 10 7. Artemio B. Timogan - Lawyer/investigator, CHR 10 8. Malucar P. Baliton-Isidra - Lawyer/investigator, CHR 10 9. Raymundo L. Cajes - Lawyer/investigator, CHR 10 10. Tito Valdehueza - Lawyer/investigator, CHR 10
ZAMBOANGA	Team 1 1. Atty. Cristina Marie Eugenie J. Jimenez – Attorney IV, CHR 9 2. Brendo D. Morales, Eusebio B. Tangon, Dexter L. Ando – Special Investigators, CHR 9 Team 2 1. Atty. Arbee A. Arquiza – Attorney IV, CHR 9 2. Reymundo L. Iturralde, Raul S. Quiboyen, Bernardito B. Patino III – Special Investigators, CHR 9 Team 3 1. Atty. Judelyn T. Macapili – Attorney V, CHR 9 2. Shemeline P. Vela – Special Investigator, CHR 9 3. Daniel S. Paculanang – Information Officer, CHR 9

The table below indicates the particular areas where the fact finding was conducted.

Area	Municipality/ Barangay
NCR	Brgy. Sta. Elena, Marikina City; Brgys. Zone 20, Slip-O, R-10, Parola, Isla Putting Bato, City of Manila; Brgy. Tatalon, Quezon City
LEGAZPI-SORSOGON	East District – Brgys. San Lorenzo, Bibincahan; West District – Brgys. Macabog and Pangpang; Bacon District – Brgys. Poblacion, Burabod, and Caricaran; andBrgy. Balogo within Sorsogon City
LEYTE-SAMAR	Municipalities of Palo and Basey, and Tacloban City in Leyte; and municipalities of Quinapondan, Balangiga and Giporlos in Eastern Samar
CAGAYAN DE ORO	Brgys. Maluko, Manolo Fortich, Bukidnon; and Brgy. Tinagpoloan, Cagayan de Oro City
ZAMBOANGA	Brgys. Masepla, Taluksangay, Ayala, Sangali, Tulungatung and Mangusu

The fact finding was conducted for at least two days in each of the five identified major areas. The table below indicates the schedule of fact finding in each major area.

Area	Schedule
NCR	April 6-7, 2016
LEGAZPI-SORSOGON	April 12-13, 2016
LEYTE-SAMAR	April 22-24, 2016
CAGAYAN DE ORO	April 27-28, 2016
ZAMBOANGA	April 13-14 and April 19-20, 2016

SUMMARY INFORMATION ON PUBLIC HEARING

The public hearings were held after the fact finding from each area. Below is the schedule of the five public hearing sessions.

Area	Schedule
NCR	April 8, 2016
LEGAZPI-SORSOGON	April 14, 2016
LEYTE-SAMAR	April 25, 2016
CAGAYAN DE ORO	April 29, 2016
ZAMBOANGA	April 21, 2016

Various government offices (GOs), non-government organizations (NGOs), and women representing different sectors were present during the public hearing. The table below summarizes information about its participants.

Area	Participants
NCR	Thirty one (31) participants coming from the community on Tondo; the Philippine Commission on Women (PCW); Integrated Midwives Association Phils., Inc.; Philippine Federation for Natural Family Planning, Inc.; Catholics for RH; Association of PWD in Brgy. Holy Spirit; KAKAMMPI; Cooperative CMEN; Center for Reproductive Rights (CRR); GalangPhils., Inc.; Achieve, Inc.; Monash University; Rainbow Rights; Department of Interior and Local Government (DILG); Radio Ventos 846; PBS-DWBR; and CHR Central.
LEGAZPI-SORSOGON	Forty (40) participants coming from the Department of Health (DOH); the Family Planning Organization of the Philippines (FPOP); MIDAS, Bicol University; Radio Siram; DZGB AM; Social Action Center-Legazpi; Diocese of Legazpi Commission on Family Life; Process; and CHR-V.
LEYTE-SAMAR	Participants came from CHR-VIII, DOH, UPV-Tacloban College, Eastern Visayas Network of NGOs and POs (EVNet), St. Paul's School of Professionals (SPSS), Leyte Family Development Org. Multi-Purpose Cooperative, FDC-Tanauan, Leyte, Brgy. Quinapondan, E. Samar; Brgy. PayaGiporlos E. Samar; Brgy. 92 Apitong, Tacloban City; Brgy. 25, Women's Shelter, Tacloban City; SB Dev't Consulting; Ridgeview Resettlement Area; nurses from Palo, Leyte and Basey, Samar; Leyte Family Development Org. Multi-Purpose Cooperative, POPCOM, CSWDO, DSWD, Brgy. Senior Citizens, Brgy. San Jose Association; and PAGASA Youth Association of the Philippines.

CAGAYAN DE ORO	Fifty nine (59) participants were present, representing GOs as well as NGOs. These included: PKKK, K-PLUS, DAWN, PCW, DSWD, POPCOM, DOH, DILG, CHR Central, CHR-10, and LGUs. Representatives of ID and, IP groups were also present.
ZAMBOANGA	Ninety six (96) participants coming from HDES; Pinay Kilos (PINK); MICNET; NORUS-SALAM;IDPs of Brgy. Taluksangay and Masepla 3;City Health Office (CHO); Population Commission (POPCOM); Zamboanga City Medical Center (ZCMC); National Commission of Indigenous People (NCIP); Department of Social Work and Development (DSWD); Brent Hospital; and CHR-IX.

NATIONAL INQUIRY IN NUMBERS

Participants/Individuals consulted: 1,263
551 in the RO consultations;
712 from the Fact Finding and Public Hearings

Events: 15 Regional Consultations, 5 Public Hearings, 15 days of fact finding

Total Areas: 5 regions and covering
13 cities/municipalities and 23 Barangays

Total Government Health Office/Facilities: 29

Total Testimonies: 89 Statements under oath

Total submissions: 95 Individual submissions;
7 submissions from organizations

The results of the fact finding and public hearings are set out in this document according cluster-areas covered. Responses are organized according to common issues and concerns as follows:

1. *Effectiveness and Levels of Implementation of RH Services and Information*

   This will include discussion on policies that support or limit/restrict the implementation of the RH law, including existing local or national policies that facilitate and create an enabling environment for the full implementation of the RH Law. It looks into the institutional capacity of government agencies to fulfill their

mandates under the RH law and the general availability, accessibility, sufficiency and adequacy of RH Goods and Services.

2. *The Barriers to Accessing RH Services and Information*

   This covers the documentation and examination of individual and/or systemic accounts of omissions, structures, policies and/or practices that resulted to denial of access to RH services of information and/or which served as barriers in accessing services. It also looks into the capacity of institutions to provide RH services and information, the policies that enable or restrict delivery of RH services and information and the existing processes and practices that bar full implementation of the RH law.

3. *Availability, Accessibility, Adequacy and Affordability of RH Services for Vulnerable/Marginalized Women*

   As the inquiry particularly seeks to address the experiences of the most vulnerable and marginalized, specific inquiries are made to look into the barriers to RH services experienced by the most vulnerable and marginalized, i.e. the urban poor, rural women, indigenous women, women with disabilities, Lesbian, Bisexual and Transwomen, women in the informal economy, elderly women, girl children, and women who are internally displaced and/or those who are not beneficiaries of the DOH's 2015 Family Planning Funds. This looks into policies that address or fail to address the specific situations of vulnerable/marginalized women and on the intersecting and compounded forms of discrimination that exacerbate their experiences and sufficiency of the State's responses.

4. *To document the barriers and problems experienced by service providers, both state and non-state, in providing reproductive health services, particularly to those most vulnerable and marginalized*.

   Health service providers both public and private face various challenges in the implementation of the RH law. This section covers and documents the experiences of health workers and health services providers, including an examination of policies that enable or restrict delivery of information and services, the institutional and capacity-related challenges, as well as cultural and religious challenges they encounter in the implementation of the RH law.

After the presentation of the issues on the basis of the fact finding and public hearings conducted per cluster area, the recommendations gathered during the conduct of the national inquiry will likewise be presented.

NATIONAL CAPITAL REGION

NCR in Numbers:

101 individuals consulted from both Fact Finding and Public Hearings

3 cities, **4** barangays

6 government health office/ facilities

15 testimonies under oath during the Public Hearing

Submissions from: CRR, EngendeRights, Likhaan, Lilak, Philippine Deaf Resources Center (PDRC), Philippine Alliance of Persons with Chronic Illness, and Rainbow Rights

At least **5** individual submissions

The Fact-finding for the National Capital Region (NCR) was conducted on April 6 & 7, 2016 in the cities of Marikina, Manila, and Quezon. Specific areas included Brgy. Sta. Elena Health Center, Marikina City Health Center in Marikina; Manila City Health Office, Lanuza District Health and Lying-In Clinic, Brgys. Zone 20, Slip-O, R-10, Parola, and Isla Putting Bato in Manila; and Brgy. Tatalon in Quezon City.

The fact-finding was enriched with written submissions from the Center for Reproductive Rights (CRR), EnGendeRights, Philippine Deaf Resource Center (PDRC)/Deaf Resources Philippines, Philippine Alliance of Persons with Chronic Illness, Lilak Purple Action for Women and Rainbow Rigths.

The Public Hearing was conducted on April 8, 2016 in Quezon City. In attendance were a total of 31 participants, including representatives from the Philippine Commission on Women, Integrated Midwives Association Phils., Inc., Philippine Federation for Natural Family Planning, Inc., Catholics for RH, Association of PWD's Holy Spirit, Kakammpi, Cooperative CMEN, CRR, GalangPhils., Inc., Achieve, Inc., Monash University, Rainbow Rights, Department of Interior and Local Government, Radio Ventos 846, PBS-DWBR, LGUs and the CHR. Residents of Tondo, Manila were also present.

In the conduct of fact finding and public hearing for the National Capital Region, part of the focus and context of the fact finding team and the inquiry Commissioners were the previous issuances of the City of Manila. During the time of Mayor Atienza, Manila City was declared a "Pro-Life City" which resulted in the prohibition of artificial contraceptives. This issuance was superseded by EO 030 by Mayor Lim. While the latter does not prohibit the distribution of artificial contraceptives, it continues to prohibit local government funding for artificial

contraceptives. In 2014, the CEDAW Committee issued its finding on EO 003 as having "violated women's rights to non-discrimination and health, which require the government to ensure women's equal access to family planning services." The committee recommended the following: improve the access to contraceptives in communities, provide quality post-abortion care, to all public health families, review the discriminatory laws against women, strengthen existing machineries and establish mechanisms to ensure compliance and obligation and lastly, train health care providers on sexual and reproductive health services.

In the conduct then of the fact finding and public hearing, part of the Commission's objectives is to inquire as well on the implementation of the CEDAW Committee's view. Based on the data from both the fact-finding mission and the public hearing, the following findings are issues surfaced:

EFFECTIVENESS AND LEVELS OF IMPLEMENTATION OF RH SERVICES AND INFORMATION

1. UNEVEN IMPLEMENTATION AND EXISTENCE OF POLICIES THAT HINDER ACCESS TO RH SERVICES AND INFORMATION

The fact finding in Manila, Quezon City, and Marikina City highlighted the uneven support and implementation of the RPRH law. Some LGUs are found to be more pro-active, while other LGUs allow implementation but lack support in terms of separate allocated funding for commodities and facilities. The unevenness in the implementation of the law can be seen in terms of policy and in actual practice at the level of barangay and the City-LGU level.

In terms of policy, for instance, the Commission found that the City of Marikina passed a Contraceptive Self Reliance Ordinance (CSR) which mandates the allocation of 1 Million pesos annually in support of the implementation of the RH Law. In Quezon City, a Gender and Development Code has been adopted which commits full support for RH law. However, other local policies are not as supportive. In the City of Manila, while EO 003 of Atienza which declared the City of Manila as a "Pro-Life City" was already superseded by EO 030, the latter EO passed by Mayor Lim continue to bar the provision by the City of Manila of funding for artificial contraceptives. Upon inquiry, and as discussed in the Public Hearing, the decentralization in the delivery of health services has resulted to the unevenness in the support and implementation of the law and has resulted in the fragmented delivery of health services and information.

Aside from these local policies, the Commission has also documented existing policies that affect full implementation of the law. We have noted the issuance by the Supreme Court of a Temporary Restraining Order on Implanon and we have documented that the same disproportionately affected not only women who wish to avail of Implanon but also health service providers in the City of Manila and in Marikina who are trained in administering Implanon, and who have boxes of supplies of Implanon but are prohibited from dispensing the same. Other policies that hinder implementation of the RPRH law include the practice of seeking spousal consent for tubal ligation which is practiced in some areas in Marikina, and

the criminalization of abortion --- which result in stigma and discrimination against women who suffered from abortion, thereby affecting access to post abortion care; the absence of emergency contraceptives for women who have been victims of sexual violence; and the criminalization of home births in both Quezon City and Marikina.

The submission of CRR further reports how the criminalization of abortion weakens and defeats the purpose of post-abortion care as the criminalization of abortion raises the stigma and affects the actual availability of post abortion care. Criminalization of abortion also engenders inhumane treatment from health service providers and justifies the denial of emergency contraception and PAC. The submission of EnGendeRights forwards the same observation, with the added emphasis that the implications of anti-abortion laws on reproductive health especially affects survivors of gender-based violence (GBV) who may be confronted with unwanted pregnancy. The lack of safe and legal abortion services as well as the unavailability of emergency contraception thus defeats the purpose of the RH Law.

In terms of HIV, the existing requirement for parental consent for HIV testing of minors have been identified as another barrier to the full implementation of the RH law. Achieve has pointed out during the public hearings that the requirement of parental consent has driven away minors who otherwise would have wanted to be tested and who are at risk. Achieve shared that the youngest person they have tested positive for HIV is 15 years old, and since there is still an incubation period, the earlies that the minor could have contracted HIV was at 12.

2. INCONSISTENT AVAILABILITY, ACCESSIBILITY, SUFFICIENCY AND ADEQUACY OF RH SERVICES AND INFORMATION

In Marikina and Manila, city and barangay health providers consistently cited the availability and accessibility of RH goods and services, which also caters to the specific needs of persons with disabilities (PWDs), lesbians, gays, bisexuals and transgenders (LGBTs), HIV victims, and internally displaced persons (IDPs). These also include house-to-house visits, counseling and education on RH and HIV even in schools, and PAC. Women from Marikina also attested to being able to avail of contraceptives for themselves and vaccination for their children, as well as RH counseling for minors.

However, there are cases when these goods and services are not available and instance where government health facilities were found to be inadequate and insufficient.

On the availability of RH services and commodities, interviews with government health workers and service providers would reveal that they have ample supply of commodities. In the City of Manila for example, it was shared by the Family Planning Officer and the City Health Officers that unlike the time of E0 003 of Mayor Atienza, artificial family planning commodities are already available. Contraceptive prevalence rate in the City has also increased. In Marikina, the officials also

Accounts on these include the experience of a woman in Marikina who shared during the fact finding that once paid visit to the health center and was told that there were no more pills available; the account of a health worker in a lying-in clinic in Manila who admitted that they do not provided Post Abortion Care since such services are provided by hospitals and the acthat they do not have PAC services; the account of a resident in Tondo who observed of Gat Andres Bonifacio Hospital that maternity beds cater to 3 to 5 pregnant women at a time; the case of a mother in Tondo who was not able to access FP services so that she reached having 8 children; the account of a senior citizen from Brgy. Tatalon in Quezon City attesting to the lack of a health center in their area by 2015 but of a health center in neighboring Victoria Avenue that has sufficient number of health workers and adequate RH goods and services.

During the public hearing, Likhaan also emphasized how a "pro-life" stance on RH remains the status quo among service providers. There are still cases when women cannot access contraceptives or other FP services.

While women cited being able to avail of free RH goods and services; there were also accounts of policies that prevented them from fully benefiting from these. In Marikina, women who wanted to undergo certain services, were required to secure the consent of their husband or immediate relatives, the strict implementation of which was affirmed by the Marikina CHO. As one health worker explained about IUD injectable: "Ma-aavail basta may consent ang mag-asawa. [Pag walang consent,] hindi pwede. [Paghiwalay na, annulled na sila, wala na silang pakialamanan sa isa't isa,] relatives pipirma sa consent."

The TRO on Implanon also prevented women from accessing effective contraceptives both in Marikina and Manila. Home birthing, still practiced by some women, is penalized both in Marikina in Manila.

The Marikina CHO also cited initial insufficiency of RH supplies from the DOH which led to continued teenage pregnancy and population growth in the city. In response, the Contraceptive Self-Reliance Ordinance was issued through which the city funded contraceptive needs to complement the supply from the DOH. Information drive in schools was also improved for students and teachers.

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to being able to avail of contraceptives for themselves and vaccination for their children, as well as RH counseling for minors.

However, there are cases when these goods and services are not available. These include the experience of a woman in Marikina, who during a visit to the health center found that there were no pills available; the account of a health worker in a lying-in clinic In Manila saying that they do not have PAC services; the account of a resident in Tondo who observed of Gat Andres Bonifacio Hospital that maternity beds cater to 3 to 5 pregnant women at a time; the case of a mother in Tondo who was not able to access FP services so that she reached having 8 children; the account of a senior citizen from Brgy. Tatalon in Quezon City attesting to the lack of a health center in their area by 2015 but of a health center in neighboring Victoria Avenue that has sufficient number of health workers and adequate RH goods and services. During the public hearing, Likhaan also emphasized how a "pro-life" stance on RH remains the status quo among service providers. There are still cases when women cannot access contraceptives or other FP services.

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4. IMPROVABLE PUBLIC RECEPTION OF RH GOODS AND SERVICES

Three issues fall under this cluster. They are the following.

Improvable use of FP goods and services. From Sta. Elena Health Center in Marikina, data show that 64,843 women avail of FP; between the ages of 15-49, 23% use FP methods or 12,781 from 55,116 persons for January to March 016; while teenage pregnancy persists. In Manila, 19 maternal deaths were recorded in 2015, although this is in face of maternal risk factors beyond the provisions of the RH Law.

Varied preferences and use of FP methods. In both Marikina and Manila, women prefer pills over other contraceptives. Some Manilenyas prefer natural FP as opposed to taking contraceptives. *Low participation of men.* Accounts from NGOs including Likhaan and Cooperative Non-Scalpel Vasectomy (CNSV) highlighted how men generally have the decision-making privilege between spouses on FP and RH, but opt not to use them. There is much resistance on the use of condoms and undergoing vasectomy. According to Dr. Paraso of the CNSV, "Sa totoo lang, wala pang program ang DOH for males. Yet…yung decision nasa lalaki...ang hirap kunin silang participants…Pero meron din siyang culture, hindi lang ang pagapavasectomy. Nawawala ang pagkalalaki. Walang lalaking pumupunta yet sumusurrender yong babae sa asawa."

THE DENIAL AND/OR BARRIERS IN ACCESSING RH

1. WEAK INSTITUTIONAL/ HUMAN RESOURCE CAPACITY

In Manila, the incapacity of the barangay to implement the RH Law or support the city's efforts is a challenge. Among VAW Desks, issues also include:

- insufficient seminars/trainings for barangay council and VAW desk volunteers on RA9262, MCW and related others
- lack of seminars/training on proper case handling of VAW cases by barangay VAW desk officers
- lack of regional facility for victims/survivors of human trafficking and gender-based violence.

2. UNPROFESSIONAL/UNETHICAL HEALTH WORKER PRACTICES

Particular to Manila, health workers note a "Pro-Life" status quo even after the amendment of EO 003. In Marikina, women seeking PAC are scolded before being rendered the appropriate services. The CRR further emphasized the widespread practice in NCR of denying or delaying PAC due to the criminalization of abortion, which includes forcing women to admit they had abortion before attending to them.

The group Integrated Midwives also raised the hostility of doctors towards them when they bring emergency cases of pregnancy to the hospitals especially when mothers require delivery but do not have a medical record with them.

AVAILABILITY, ACCESSIBILITY, ADEQUACY AND AFFORDABILITY OF RH SERVICES FOR VULNERABLE/MARGINALIZED WOMEN

1. INSUFFICIENT POLICY RESPONSE FOR VULNERABLE/MARGINALIZED SECTORS

Among women in Poverty. The lack of television or radio among poor households is a deterrent to proper dissemination of information on RH. The lack of a proper response to

the need of the urban poor for information can lead to misconceptions about RH or FP. For women living in the urban poor, the RH is simply out of reach.

Among migrant workers. Onsite problems include cultural practices that violate RH rights, such as the use of a stick to poke around the vagina as diagnostic tool for medical concerns; the lack of protection from unsafe sexual practices by MSM; and the lack of protection from abuse from employees.

Among the youth. Cases include the continued persistence of teenage pregnancy and risky sexual behaviors. The requirement of parental consent for access to RH goods and services of minors is cited as a related issue. Compound issues of sexual relations involving adolescents in times of conflict or natural disasters were also raised by Ms. Maria Tanyag of Monash.

2. LACK OF ADEQUATE RESPONSE TO INTERSECTING OF VULNERABILITIES

More often than not, women experience overlapping situations that increase their vulnerabilities from primarily being members of one sector.

Among the urban poor communities affected by demolition. Women in Tondo cite housing demolition protocols that involve hazardous elements such as the use of teargas. In one occasion, a pregnant woman as well as a young child in the community being demolished were harmed by the use of this chemical and they were not provided adequate medical attention in the health center. Financial constraints also keep women from accessing specific services such as newborn screening which can cost P600 to P1550. Some health centers in Quezon City also ask for payment for RH goods and services (P20 for pills, P200 for injectibles, P100 for check up). Health workers in Manila also note the tendency of new mothers not to return for post-partum care.

Among IDPs. In cases of evacuation in Marikina, a medical team surveys the needs of the affected families; however there was the case of how only condoms could be distributed and mainly in individual packs rather than in kits since affected families were only 10-50.

Among survivors of GBV. Cases include a GBV survivor in Manila, who is also confronted with extreme poverty, who found it difficult to access their RH needs, as a battered wife who had a total of 18 children, 3 abortions, and 3 suicide attempts experienced; and a rape and murder case of a minor also in Manila which received no help from the local government. The plight of GBV survivors is worse when their abuser may be their spouse or parents, yet are confronted with the policy on seeking parental or spousal consent on certain RH goods and services.

Among PWDs. The PWD Association of Brgy. Holy Spirit n Quezon City shared accounts of hospitals refusing to accept pregnant PWDs because of the lack of appropriate facilities; PWDs also lack access to information on their RH rights. The plight of PWDs can also be compounded by GBV, as is the case of a woman in Brgy. Holy Spirit whose husband not only

refuses to use contraceptive methods other than the withdrawal method but justifies his violence towards her with suspicions of infidelity when she gets pregnant. Such is the story of Ms. Michelle Balce, who married at age 16 and after giving birth to her fourth child, decided to undergo ligation – but her husband did not agree. She started using pills but because she failed to take them regularly she again got pregnant with her fifth child. She then tried injectables but her husband does not want her to take those things. He physically abused her; her husband thinks she is having an affair since they are using withdrawal method but still she gets pregnant. She shifts from one method to another because she has no money to afford it. From the health center, pills cost 20 PHP, injectibles cost 200 PHP, and check-ups cost 100 PHP.

The Philippine Deaf Resource Center (PDRC) and Deaf Resources Philippines, from 400 cases 68% of which involved female deaf parties in 15 regions from 2006-2012, forwards the following issues:

- Insufficient number of court interpreters
- Rape the most common charge both among cases with deaf respondents and deaf complainants
- Females the majority among complainants for rape, including among minors

In GBV cases, majority of perpetrators are hearing and include neighbors, brothers in law, acquaintances and teachers, frequent site of violence is home of the deaf complainant

> The problems are summed up in the following: 1) how the legal mandate for RH and anti-VAW render women & girls with disabilities as "completely invisible," 2) how data generation is not appropriately disaggregated to reflect that there is higher prevalence among PWD group compared to those without disabilities; and 3) how there are no state mechanisms for inclusion of PWDs in policy making.

Among women seeking PAC. Aside from the stigma against them, women seeking PAC also do not have access to redress when met with violations of their right under the RH Law since abortion is criminalized. Numerous are cases of women who were denied or delayed of PAC services; or who were detained for the being implied to having abortion; or who pleaded guilty to abortion in order to avoid prosecution.

Among people with chronic illnesses. In a case documented by the Philippine Alliance of Persons with Chronic Illness of a woman who struggled with breast cancer, the following barriers were present: lack of volunteer interpreter, dependence of the woman informal work, experience with service delay (medical processing not fast enough), lack of government support (donation from LGU of P500 – could have been more if she was voter), and lack of access to proper medical attention resulting to death (costs were beyond her capacity). All these led to woman dying within a year after diagnosis without treatment. Underlying these are issues of the violation of the right to work, health, social protection; the faulty DOH policy for free chemotherapy that excluded the woman given the advanced stage of her cancer; the limited services by PhilHealth Z package covering only mastectomy

surgery for advanced stages of breast cancer; and the absence of a policy for end of life/hospice care.

Among people with HIV (PLHIV). Achieve, Inc. pointed out that while the RH Law provides for PLHIV, it is weak on mother-child association. Only PGH is accredited to deliver a child from a mother who is HIV-positive. Cases include the refusal of a myoma operation to an HIV victim and the death of a pregnant woman who was refused delivery at the UERM.

Among LGBTs. While health centers are generally welcome to providng RH goods and services to LGBTs, Achieve, Inc. pointed out that there is a lack of perspective for transwomen in particular. The required parental consent is also a barrier for LGBTs' access to these goods and services, an issue that links with concern over the spread of HIV.

BARRIERS/CHALLENGES ENCOUNTERED BY STATE AND OTHER HEALTH SERVICE PROVIDERS

1. UNSUPPORTIVE POLICY ENVIRONMENT

The TRO on Implanon and the occasional insufficient supplies both in Manila and Marikina bar health workers from fully implementing the RH Law.

2. PRESENCE OF CULTURAL AND RELIGIOUS RESISTANCE

Service providers also find that the community's superstitious beliefs, tendency to slack off on post-partum care, and tendency to neglect mechanics of contraceptive methods are challenges to carrying out RH goods and services.

Additionally, according to service providers, clients have poor health-seeking attitude. They will not take the medicine even if they are available. They also tend to believe *chismis* than believe the information from the BHW. They would rather listen to their neighbors (who may be wrong about RH and contraception). Attitude and perceptions of masculinity also lead to misconceptions about RH services for men, including vasectomy.

There are also cases where health workers received counter charges for alleged criminal negligence. Deaths were blamed on them. Health workers interviewed also reiterated the need for continuous training. Some doctors and health workers are no longer confident to attend to RH concerns due to lack of practical and updated training.

LEGAZPI-SORSOGON

Fact-finding in Legazpi-Sorsogon was conducted from April 12-13, 2016 in East District – Brgys. San Lorenzo, and Bibincahan; West District – Brgys. Macabog and Pangpang; Bacon District – Brgys. Poblacion, Burabod, and Caricaran; and in Brgy. Balogo within Sorsogon City.

Interview was the core method employed in gathering information. The task is supplemented by ocular visits to Sorsogon Provincial Health Office, City Health Office in East District, and selected barangay health centers. House to house visits, pharmacy inquiry, and test buy of RH goods were also conducted. The Office of the Family Planning Organization of the Philippines was also visited.

Most significant about this area in relation to RH is its "Pro-Life" Ordinance. Executive Order No. 3 series of 2015, entitled "AN EXECUTIVE ORDER DECLARING SORSOGON CITY AS A PRO-LIFE CITY," was issued by Hon. Mayor Sally A. Lee and took effect on February 2, 2015. EO 003 was sourced out from Sections 12 and 15 Article II and Section 3(2) Article XV of the Philippine Constitution, the Universal Declaration of Human Rights, and the Magna Carta of Women (RA 9710). This order neither elucidates what a "PRO-LIFE" city is nor provides particulars on how or why it should be called as such.

From this EO 3, the proposal of Hon. City Councilor Emmanuel Diolata entitled, "An Ordinance Declaring Sorsogon City as a Pro-life City and Providing For its Guidelines and Policies" was developed. Although the proposed ordinance has not been approved to date, the effect of the EO was to prefer natural family planning method from the natural artificial and modern artificial methods putting in a dilemma the availability, accessibility, and comprehensibility of application of RA 10354. Women's rights to RH were hampered when the DOH-LGU's distribution program was interrupted. These are among the critical issues confronting the full implementation of RA 10354. Despite the call of the DOH V, DILG V, CHRV, and POPCOM V to look into the current situation and reexamine the actions in order to provide uninterruptedly full, comprehensive, and accessible RH goods and services among the women-clientele, the LGU's disposition is unchanged. Just the same, the barriers remain in Sorsogon City, complemented by the invocation of Supreme Court's ruling on the unconstitutionality of some provisions of RH Law and the TRO which is still in effect.

The public hearing was conducted in April 14, 2016, in the nearby town of Daraga. A total of 40 participants were present, with representatives from the following GOs and NGOs: Department of Health, Family Planning Organization of the Philippines, Bicol University, MIDAS, Radio Siram, DZGB AM, Social Action Center-Legazpi, Diocese of Legazpi Commission on Family Life, Process. Representatives from LGUs and personnel from CHR-V were also in attendance.

The fact-finding mission and public hearing followed the regional consultation conducted in March 30, 2016 in Legazpi City.

EFFECTIVENESS AND LEVELS OF IMPLEMENTATION OF RH SERVICES AND INFORMATION

1. IMPLEMENTATION OF POLICY CONTRADICTORY TO RH LAW

The implementation of EO 3 in Sorsogon City renders RH goods and services lacking and/or insufficient. Cases include women from all five barangays prior to the issuance of EO 3 were able to access various RH goods and services which include information and counseling services. In response, women were forced to allocate their money for the purchase of contraceptives, with pills ranging from P39 to P50 per cycle and injectibles that reach P170. This meant they had less money for other needs such as food. Those who could not afford contraceptives entailed higher risk of unwanted pregnancy. One mother in Bibincahan who had seasonal income narrated that it is very difficult for her to buy an injectable because the price is about P103.00 pesos in the local or commercial drugstore. Pills are cheaper at P38.00 pesos, but she feels they is not suitable for her body.

Inability to access contraceptives result to women with unwanted pregnancies resorting to unsanctioned and potentially harmful methods of abortion. For example, a mother testified that her neighbour told her about drinking an abortive herbal concoction or *pampalaglag*. The child was not aborted, but the woman was terrified of her body's experience in drinking the concoction. The respondent added that there were other stories circulating of women resorting to abortion to prevent having too many children whom they could not afford to care for.

The fact finding results show that there is implied and partial contraception ban because of the EO issued by the Mayor. The EO resulted in the withdrawal of FP commodities in City health facilities and there is preference for natural methods and active discouragement on the use of modern contraceptives. As a result of the EO, contraceptives (pills, cycle beads for standard days method) were pulled out from CHO and returned to the Provincial Health Office in Sorsogon. To supplement the lack, the DOH deployed the nurses to dispense FPs in the affected areas in Sorsogon City.

2. PRESENCE OF SUPPORT FROM ALTERNATIVE SERVICE PROVIDERS

In light of EO 3, the Nurse Deployment Project (NDP) of the DOH and the FPOP serves as alternative sources for RH goods and services which residents of Sorsogon may access. This was affirmed during the public hearing, where members of the NDP shared that they would distribute RH goods in safe venues. This however, remains a temporary alternative that cannot substitute main state health providers.

3. INACCESSIBLE RH GOODS AND SERVICES

Ms. Irene Derilo, a health worker from Brgy. San Lorenzo-Bibincahan observe that women who live farther from the health center have less chances of availing limited RH goods. Five rural-agricultural workers she is in charge of have to use branded pills because of the

withdrawal of RH goods. Most of them preferred not to buy the contraceptives instead since each cycle costs P43.00 which is more than a kilo of rice. When the DOH continued supplying RH goods, these women found difficulty in accessing the commodities because when they arrived at the barangay health center, the goods were already disposed of and nothing was left for them.

4. IMPROVABLE PUBLIC RECEPTION OF RH

In Sorsogon City, data from 2015 show a quarterly increase in RH users in Dr. Fernando B. Duran Sr. Memorial Hospital from 9.5% to 20% to 21% to 22% of the 23,860 population of eligible users. For maternal health services, almost half of 5,011 eligible users in 2014 availed of these services.

- Among pregnant women, 37% had at least 4 prenatal visits, 50% received were given TT2 Plus, and 23% received complete iron with folic acid
- Among postpartum women, 65% had at least 2 visits, 62% initiated breastfeeding within 1 hour, 34% received complete iron
- Among lactating women, 62% received Vitamin A.
- Of 3,296 live births, 89% of the children were protected at birth
- Of 3,301 deliveries, 97.55% were facilities-based.

THE BARRIERS TO ACCESSING RH

1. INCAPACITATION OF INSTITUTIONS/HUMAN RESOURCES

EO 3 serves deprives service providers of the capacity to implement the RH Law. Cases include the pullout of RH commodities from DOH and the proliferation of information against modern FP methods. This was affirmed during the public hearing as per the accounts of NDP members.

AVAILABILITY, ACCESSIBILITY, ADEQUACY AND AFFORDABILITY OF RH SERVICES FOR VULNERABLE/MARGINALIZED WOMEN

1. DISCRIMINATORY EFFECT OF LOCAL RH POLICY ON VULNERABLE/ MARGINALIZED SECTORS

Since EO 3 pulled out RH commodities from the DOH, women are forced to either buy modern contraceptives or turn to natural FP method, especially those who cannot afford to buy from drugstores, which exposes them to higher risk of unwanted pregnancy. Cases include a mother from Brgy. Bibincahan who had to resort to natural FP but who found it difficult to carry out since her husband would not comply with the methods especially when under the influence of liquor. This was affirmed during the public hearing where nurses from the NDP cited unwanted pregnancy among the poor, and their struggle in expenses.

BARRIERS/CHALLENGES ENCOUNTERED BY STATE AND OTHER HEALTH SERVICE PROVIDERS

1. RESTRICTIVE POLICY ENVIRONMENT

Health workers are unable to provide RH goods and services according to the RH Law because of EO 3. They find themselves in a dilemma between the two policies on RH. For NDP nurses, distribution of RH goods from the DOH had to be discreet or in 'safe' venues. As NDPs openly defy the 'Pro-Life' Ordinance, they also risk their personal security.

According to one nurse:

"May takot po ang mga midwives lalo na po iyong mga contractual para mag dispense ng commodities…doon po nakatago sa bodega, hindi ginagalaw…ang ginagawa po namin, pag may dumadating na client, either doon sa puno ng mangga, sa labas po, basta outside po ng facility. Ang medyo risk langdoon ay ang privacy ng client." Another nurse added, *"May mga times nanaka-encounter po ako na pag nagfi-field kami at magbibigay kami ng commodities, may nagsasabi ng 'Oy, bawal yan!' Medyo mahirap din po."*

2. LACK OF SUPPORT FOR HEALTH WORKERS

The CHO of Sorsogon City cited the lack of training on providing RH services for employees in health centers as a factor that hindered the quality of their implementation. Apart from that, health service providers are antagonized by through the "Pro-Life" Ordinance. As Catherine Tumalad of the FPOP recounted, "Noong January 28-30, nagkaroon ng Summit ang Pro-Life…doon din sinabi nila na ang FPOP is NO. 1 abortionist in the Philippines."

Other issues which affect delivery or RH services raised during the Public Hearing are as follows:

1. Nurse deployment is not a continuing program. Their contract will end in June 2016. They were told it is renewable and until December 2016. Who will dispense FP commodities and services once the NDPs were pulled out?
2. Facility based delivery and deliveries attended by skilled-birth attendants is not made mandatory for all pregnant women. Maternal deaths is at 11 and 4 came from Sorsogon City. From January to May 2016 there were 7 maternal deaths in the entire provinces and one came from Sorsogon City. (Cause: eclampsia)
3. Maternal and fetal death reviews are not used to improve service delivery, despite the data being reported to the Mayor. Recommendations to resume distribution of FP goods for the sake of the marginalized and vulnerable sectors of women were ignored
4. Local health providers were not given adequate training of on life-saving skills. The training should not be only for nurses. DOH assured them that BHWs and midwives will receive training. Nurses are trained to dispense injectables. The CHO request for training for BHW and midwives and all health workers involved in RH prior to redistribution or reintroduction of artificial and natural FP methods.

5. Lack of adequate information re FP services and commodities. There is a radio program, PADABA FM, that says oral contraceptives cause cancer because of its mercury content, formalin, etc, which is actually very disturbing. There are advertisements saying, "Ako si___ gumagit ako ng ____ for __xxx__ months at nagkaroon ako ng cancer". (I am (state name). I used contraceptives (state how long). I developed cancer). Those who are not well-educated on these matters will believe the advertisements. In one of the interviews, there is a pregnant respondent who refrains from using contraceptives because she heard in the radio that they cause ovarian cancer. She would rather feed her many children than spend what little she has for chemo therapy.
6. Inaccessibility of local facilities for FP service delivery because distribution in the premises of the health unit is prohibited. Health workers are in danger of losing their jobs once found to distribute or dispense artificial FP goods.

3. PRESENCE OF CULTURAL AND RELIGIOUS RESISTANCE

In Sorsogon City, EO 3 is motivated by religious convictions of the mayor, citing biblical passages as rationale for the ordinance According to POPCOM Director Lynne Abellera, Mayor Sally Lee was also quoted to have declared as prayer in face of an incoming threat of typhoon in Sorsogon, "Spare Sorsogon City and I will declare Sorsogon a pro-life city."

LEYTE-SAMAR

Fact-finding for Leyte-Samar was conducted on April 22-24, 2016, in the following areas: municipalities of Palo and Basey, and Tacloban City in Leyte; and municipalities of Quinapondan, Balangiga and Giporlos in Eastern Samar.

Public hearing for Tacloban was conducted on April 25, 2016. Participants included residents of Brgy. Quinapondan, E. Samar; Brgy. Paya Giporlos E. Samar; Brgy. 92 Apitong, Tacloban City; and Brgy. 25, Women's Shelter, Tacloban City. There were also representatives from the CHR-VIII, DOH, UPV-Tacloban College, Eastern Visayas Network of NGOs and POs (EVNet), St. Paul's School of Professionals (SPSS), Leyte Family Development Org. Multi-Purpose Cooperative, FDC-Tanauan, Leyte; SB Dev't Consulting; Ridgeview Resettlement Area; nurses from Palo, Leyte and Basey, Samar; Leyte Family Development Org. Multi-Purpose Cooperative, POPCOM, CSWDO, DSWD, Brgy. Senior Citizens, Brgy. San Jose Association; and PAGASA Youth Association of the Philippines.

Results of the data gathering under the four issues in RH are as follows.

EFFECTIVENESS AND LEVELS OF IMPLEMENTATION OF RH SERVICES AND INFORMATION

1. LACK OF POLICY SUPPORT

There is no reported local policy that directly facilitated or hindered the implementation of the RH Law. However, there is a general sense of a lack of support from the government, as Prof. Lyn Mangada of the UPV Tacloban College commented on the effectiveness of RH implementation. "We are talking here about behavior change, we are asking people to change their behavior but [the] government is not also changing."

2. PRESENCE OF SUPPORT FROM ALTERNATIVE SERVICE PROVIDERS

In the surveys that UPV Tacloban College conducted, there was no mention that DOH distributed hygiene kits, with the task being carried out instead by NGOs

3. INADEQUATE RH SERVICES

Information dissemination is ineffective in the area. According to Mr. Ravas of SPSS, most patients do not understand the programs of the DOH although they are available in print. EVNet added that there is low awareness of the RH Law, with information only limited to the beneficiaries of the 4Ps program.

Other services are also inadequate. According to Prof. Lim-Mangada of UPVTC, the high death rate in hospitals is an issue of access and not of availability. According to Mr. Ravas of EVRMC, based on their research a lot of pregnant women who are admitted in EVRMC do not have

medical records coming from their RHUs. There was also a case of a child who died in EVRMC because of the neglect of the medical staff, and a woman who had to look for another hospital where she could give birth in after being refused by the Leyte Progressive Hospital for lack of available facilities and equipment There was a case of a woman who had to give birth in a stretcher in the hallway of Tacloban City Hospital when the doctors and nurses sent her out of the delivery room even after her water bag had already ruptured.

4. IMPROVABLE PUBLIC RECEPTION OF RH

There is low participation of men in the RH agenda. The SB Development Consulting made this observation, following it with the need to include and engage with men regarding RH law. A nurse from Samar added that some women do not want family planning because their husbands do not allow them, while some are willing but are hesitant because they are afraid of their spouses.

THE BARRIERS TO ACCESSING RH

1. WEAK INSTITUTIONAL/ HUMAN RESOURCE CAPACITY

There is a lack of coordination among government service providers. According to Mrs. Garrido of the LFPDOMPC, some programs of the RH are not properly implemented because of the relationship gap between the authorities, the agencies concerned, and the people. She said, “Looking at the reports handed to us is not enough because most often than not, it does not reflect the reality in the communities.”

2. UNPROFESSIONAL/UNETHICAL HEALTH WORKER PRACTICES

Unethical treatment of patients was observed of some health workers in the area. According to Mr. Ravas of SPSS, a number of patients are reluctant to avail of health care services because of the rude and unwelcoming disposition of health care, such as in RHU. A woman had a similar experience in EVRMC during her eighth pregnancy where the nurses were rude, curt, and inattentive to her. Some hospitals also refuse to admit patients, according to the SB Development Consulting.

3. PRESENCE OF CULTURAL RESISTANCE

Discrimination against non-allies in politics is common in the area. Mr. Ravas of SPSS cited a case filed by a group of senior citizens to the Ombudsman against the RHU personnel of San Policarpio E. Samar regarding the non-issuance of PhilHealth and OSCA cards because they are not politically aligned with the incumbent Mayor.

AVAILABILITY, ACCESSIBILITY, ADEQUACY AND AFFORDABILITY OF RH SERVICES FOR VULNERABLE/MARGINALIZED WOMEN

1. LACK OF POLICIES FOR VULNERABLE/MARGINALIZED SECTORS

RH goods and services can be inaccessible for the urban poor. Health centers can be too far from residents, as in the case of a woman from the Block Ridgeview Resettlement Area, so that the children in their barangay who are getting sick do not immediately get medical aid.Ms. Evelyn Cabling of Quinaondan, Samar recounts her experience: *"Nung naisip ko na manganganak na ako, pumunta ako sa Balangiga District Hospital pero sabi ng doctor ko na hindi pa ako manganganak dahil hindi pa stretched yung cervix ko. So pinauwi kami dahil sabi niya na yung lumabas na tubig sa akin ay ihi lang. Pero kinabukasan biglang sumakit ang tiyan ko sabay labas ng bata. Paglabas ng bata napansin ng BHW na Malaki yung pusod. Tapos sinamahan kami ng midwife na nagpa-anak sa akin sa ospital dahil nga natatakot sila sa laki ng pusod ng anak ko. Nung pumunta kami sa ospital ni-refer din naman kami sa EVRMC dahil hindi daw nila kayang matugunan yung kondisyon ng anak ko. Pagdating naming sa EVRMC, grabe na man yung trato nila sa amin. Tatlong beses nilang kinunan ng dugo yung anak ko dahil lagi daw nawawala yung sample na dugo ng anak ko. Hindi kami nakakahingi ng result dahil iba-iba yung nag-duduty."*

2. LACK OF ADEQUATE RESPONSE TO INTERSECTING VULNERABILITIES

Services for IDPs are inadequate. According to Ms. Duma of the FDC during their roving and house-to-house visits in coastal areas, relocation sites, and evacuation centers, the constituents did not mention any hygiene kits and other RPRH commodities coming from the DOH. She personally encountered an MHC personnel who refused to give her medicine for her husband who was at the time suffering from hypertension. In times of disasters, provision of RH goods and services are affected.

BARRIERS/CHALLENGES ENCOUNTERED BY STATE AND OTHER HEALTH SERVICE PROVIDERS

1. LACK OF SUPPORT FOR HEALTH WORKERS

Ms. Duma of the FDC said that funds received by BHWs are insufficient. She explained, *"Nakaka-avail lang sila ng incentives or honorarium after 3 months so paano yan? Kaya hindi nagwowork at effective. Dahil kulang na kulang kahit funds po ay wala. Dapat iyon ang bibigyan ng importansya. Bigyan ng malaking sweldo dahil nagtatrabaho para sa ating kalusugan."* This is consistent with the observation by the SB Development Consulting who pointed out that there is an uneven distribution of the stipends of the BHWs. Funding support is also a challenge for CSOs advocating for RH.

A nurse from Samar cited that there is also lack of human health resource: one doctor serves 150 to 200 patients; 1 nurse serves 20,000 patients; and 1 midwife serves 5,000 patients –

daily. They requested for DTBs but they were not prioritized because they are near Tacloban City.

2. PRESENCE OF CULTURAL AND RELIGIOUS RESISTANCE

Barriers and/or challenges according to a nurse in Palo include the blatant campaign by some institutions against them such as the priest of Palo Cathedral. Some residents want to try FP but they hesitate because they are being influenced by the Church.

CAGAYAN DE ORO

The fact finding mission was conducted in Bukdinon and Cagayan de Oro. On April 27 the fact finding team went to Barangay Maluko, Manolo Fortich, Bukidnon and interviewed members of the United Rural Women of Maluko – Pambansang Koalisyon ng Kababaihan sa Kanayunan (URWM-PKKK) as well as the Nurse and Barangay Health Workers of the Barangay Health Center. The team also went to the Manolo Fortich Rural Health Unit and interviewed the Rural Health Physician and Midwives of the Lying-In center. In the morning of April 28 the team interviewed indigenous women including a traditional birth attendant in Barangay Tinagpoloan, Cagayan de Oro City. In the afternoon, the team went to the City Health Office and the Northern Mindanao Medical Center.

Public hearing for CDO was conducted on April 29, 2016. A total of 59 participants were present, representing GOs as well as NGOs. These included: PKKK, K-PLUS, DAWN, PCW, DSWD, POPCOM, DOH, DILG, CHR Central, CHR-10, and LGUs. Representatives of IDP, IP groups were also present.

Results of the data gathering under the four issues in RH are as follows.

EFFECTIVENESS AND LEVELS OF IMPLEMENTATION OF RH SERVICES AND INFORMATION

1. LACK OF RECONCILIATION OVER RH POLICIES, PROGRAMS, AND PROCESSES

As shared by an IP Volunteer BHC Traditional Birthing Assistant (Hilot) regarding her practice by a midwife, it is their tradition that IPs must first perform a ritual before the government can implement a project. However, she felt that the government implemented programs (including the RH program) without the consent of the IPs, thus disregarding their tradition. There was one IP who had a stroke and they believe it was a punishment from their gods for disrespecting their traditions. She explained that the mandate prohibiting traditional hilot to perform their work and the requirement that all deliveries must be done at the health center destroys their culture. She also argued that a fellow IP should be the one educating the IPs on contraceptive methods and there must be consent from IP leaders. It was also reported that one of the effects of the national program 4Ps was to encourage IPs to bear more children to maximize the financial assistance they receive; as a result, the IPs population tripled in 30 years.

2. INCONSISTENT AVAILABILITY, ACCESSIBILITY, SUFFICIENCY AND ADEQUACY OF RH GOODS AND SERVICES

Cases include the lack of pills at the health center from May to July 2015; the unavailability of IUD in the health center; the lack of an ambulance vehicle for emergencies; and the lack of medicine during transport of patients.

There were also cases of walk-in clients to hospitals who did not undergo counseling, and whom the Medical Center found too complicated to treat because there would be no record of the patients' medical condition.

Cases also include how RH is not implemented during disasters or calamities since the people are more concerned with basic needs and services such as food and shelter. In addition, there is concern over the lack of privacy when taking a bath in evacuation centers. Another case is the lack of ambulance necessary for emergencies. People are also uninformed of services particularly regarding teenage pregnancy. POPCOM also cited that women are still dying because of pregnancy complications including home deliveries.

3. IMPROVABLE PUBLIC RECEPTION OF RH

There is low participation of men in the RH agenda. Observations include how no male goes to the barangay health center for vasectomy or to avail of any RH services.

THE DENIAL AND/OR BARRIERS IN ACCESSING RH

1. WEAK INSTITUTIONAL/ HUMAN RESOURCE CAPACITY

Cases include the account of a Family Planning Coordinator that there is a lack for doctors who can perform vasectomy.

There is also a lack of coordination mechanisms among service providers. For the NMMC, this leads to late referrals that pose serious concern, such as referred patients that are already on the brink of death or patients suffering from toxic and serious medical conditions.

The number of health workers is also insufficient. For every three barangays, only one midwife is assigned. From the account of ICCW, there is only one medical doctor for every 20,000 people, one midwife for every 7,000 people, and one BHW for every 960 households.

2. UNPROFESSIONAL/UNETHICAL HEALTH WORKER PRACTICES

Cases include barangay health centers asking for "donations" from patients. There is also the account of a Family Planning Coordinator on the attitude of some health workers who may not be well-versed on RH.

3. PRESENCE OF CULTURAL RESISTANCE

The ICCW noted that there is difficulty in encouraging women for checkups.

AVAILABILITY, ACCESSIBILITY, ADEQUACY AND AFFORDABILITY OF RH SERVICES FOR VULNERABLE/MARGINALIZED WOMEN

1. DISCRIMINATORY EFFECT OF RHPOLICIESONVULNERABLE/MARGINALIZED SECTORS

Among IP birth attendants, it was raised how women are disadvantaged with the prohibition of their practice, compounded by the physical inaccessibility (as much as 15 kilometers) of health centers, lying-in clinics, and hospitals. The inadequacy of health service was also raised, along with the deprivation of quality health service from IP birth attendants who have never had women die in their care and the deprivation of the option services that are guaranteed of availability, accessibility and affordability. In the case of an IP woman who welcomed modern FP program, she was forced to avail of RH goods and services through private service providers given that health centers could not accommodate her medical condition nor give her the immediate and adequate medical attention she required.

The promotion of population control also goes against the values of IPS regarding the sustainability of the population to ensure guardians of their ancestral domain.

Women from the urban poor also experience inconsistent provision of RH goods and services such in the case of a woman in Calaanan Relocation Site who had to pay for her second Implanon when it had been free during her first visit. Another woman in the same site had to pay for contraceptive through "donations" but during pregnancy delivered her babies without paying through PhilHealth. A woman in Macabalan always had to pay for contraceptives and check-ups.

The youth, especially those with sexually transmitted diseases (STDs), face challenges of parental intervention when it comes to RH services such as mandatory parental consent and breaches of confidentiality of their medical information.

Other cases include law prohibitions of HIV testing for patients below 18 years of age. Women cannot avail of family planning services without the consent of their husband, and teenage mothers cannot avail it without the consent of their mothers. Along with traditional methods of birthing, IP birth attendants are prohibited from delivering infants along.

2. LACK OF ADEQUATE RESPONSE TO INTERSECTING VULNERABILITIES

Among PWDs. These include accounts from KAGAY-AN PLUS of communication barriers between deaf massage therapists and clients. DAMOR claims that doctors do not directly talk to pregnant deaf women to give explanation because of communication barriers. Cases include a deaf mother who had a miscarriage without fully understanding why, and whose second pregnancy incurred communication problems resulting to the need for a Caesarian Section operation. There is also a gap in communications between deaf and community. If there is a deaf who wants to avail the projects, there is no interpreter available or if there is one available they have to pay for it and the deaf do not gain any information during the visits of Barangay Health Workers. There is also no explanation for the prescribed medicine given to deaf patients. No government agency provides for interpreters. The situation is even more challenging for PWDs who also happen to have HIV; in fact, they are more vulnerable to HIV

because they lack access to information on HIV. PWDs who may also be involved with MSM are even further at risk.

Among IDPs. Cases include the experience and observation of a woman in the Sendong Relocation Site where specific needs such as protection from GBV, information and education on RH particular to the context of IDPs, and emergency facilities.

Among PLHIV. Persons Living in HIV (PLHIV) do not have access to condoms in the health center. These are only distributed in social hygiene centers. But there is also a problem with the availability of condoms in centers since some centers run out of stock. Health institutions also has HIV stigma. PLHIV also experience discrimination from medical staff.

Among prostituted women. Efforts of NGOs including TISAKA and ALAGAD Mindanao have thus far ensured that prostituted women are given adequate RH services especially information about proper hygiene, contraception, and STDs and HIV. At the same time, discriminatory practices are still observed in the CHO against trafficked and prostituted women and children such as verbal degradation upon their visit to the CHO as well as refusal to provide them HIV testing services.

BARRIERS/CHALLENGES ENCOUNTERED BY STATE AND OTHER HEALTH SERVICE PROVIDERS

1. UNSUPPORTIVE POLICY ENVIRONMENT

Cases include the TRO on Implanon which inhibits service providers from fully implementing the RH Law.

2. LACK OF SUPPORT FOR HEALTH WORKERS

No training is provided for health workers. Barangay local officials are not properly equipped with knowledge on HIV for which the DOH has to conduct an orientation. There is also a lack in proper training for working with PWDs. The NMMC adds that health providers lack confidence to apply the lessons that they have learned.

There are also cases of inadequate provision of supplies such as the limited supply of Lysol for the health center. ICCW's account that BHWs do not receive their allowance or salary on time and no hazard pay is given to them since it is dependent on the availability of funds from the city.

Nurses and doctors in hospitals, clinics and health center also suffer from chronic fatigue due to the nature of their work. Consequently, some LGUs have not fully implemented the Magna Carta for health providers which have led to health providers feeling demoralized. Incentives for health providers are also not fully given. The NMMC also highlights that doctors, nurses and medical staff suffer from patient cyber bullying especially when there are unmet needs

and expectations from patients. Among nurses themselves there is prohibition against getting pregnant.

A family planning coordinator also mentioned that there is no compliance among health service providers because no quota or incentive is given to them. ICCW cites that some Barangay Health Councils are also not functional. All barangays have a budget but there is a problem on implementation of RH services.

3. PRESENCE OF CULTURAL AND RELIGIOUS RESISTANCE

The NMMC also cites religion and external influence from in-laws as barriers to RH.

ZAMBOANGA

Fact-finding for Zamboanga City was done on April 13-14, 2016 and April 19-20, 2016.

Five barangays were identified for the mission. They are Brgys. Masepla, Taluksangay, Ayala, Sangali, Tulungatung and Mangusu.

The fact-finding team was divided into three. On April 13, Teams 1 and 2 covered Brgy. Masepla 1, 2, and 3; Team 3 covered Brgy. Taluksangay. On April 14, Team 1 covered Brgy. Ayala and Tulungatung; Team 2 covered Brgy. Sangali; and Team 3 covered Brgy. Mangusu. Validation and additional gathering was conducted on April 19-20, 2016 by members of the GFPS together with the HR management office personnel, CEWHRC OIC, and UNFPA representatives.

During the fact-finding, the teams observed the following procedure: 1) conduct of an overview of RA 10354; 2) interview with participants about the RH concerns; 3) conduct of ocular in health centers in the identified barangays; 4) interview with BHWs, midwives and other related personnel; 5) validation of gathered information and additional data from institutions; and 6) charting of issues under identified categories.

The public hearing was conducted after the fact-finding, on April 21, 2016. Its participants included various NGOs; IDPs of Brgys. Taluksangay and Masepla 3; personnel from CHO, POPCOM, Zamboanga City Medical Center, NCIP, DSWD, Brent Hospital and other LGU units. A total of 96 participants were present at the hearing.

The fact-finding and public hearing took off from the results of the regional consultation in March 17, 2016, which surfaced the following RH issues on lack of awareness, inadequate information dissemination, inaccessibility due to distance, insufficient number of health workers, unsupportive spouse, unsupportive LGUs to health workers, insufficient contraceptive supply, cultural barriers, and financial constraints.

Three key features of Zamboanga City reveal to be significant to the implementation of RH Law. First is the strong religiosity in the city, which has translated to resistance to the RH Law as it can be interpreted to conflict with the locals' beliefs and practices. Second is the presence of armed conflict in the area which has resulted to the security concerns in some of its areas that discourages health workers from providing much needed services. Third is poverty in the area, which hinders people's ability to access to RH goods and services.

Based on the data from both the fact-finding mission and the public hearing, the following concerns are identified under the four RH issues:

EFFECTIVENESS AND LEVELS OF IMPLEMENTATION OF RH SERVICES AND INFORMATION

1. NATIONAL POLICY AS BARRIER TO LOCAL IMPLEMENTATION

Cases include the TRO in Implanon, which according to the CHO happened to be preferred even by Muslim women. This was affirmed during the Public Hearing.

2. INCONSISTENT AVAILABILITY, ACCESSIBILITY, SUFFICIENCY AND ADEQUACY OF RH GOODS AND SERVICES

RH goods and services can be unavailable in the area. Cases include a woman in Brgy. Masepla who had to go to another barangay to give birth; the barangay center in Brgy. Masepla to be always closed; a woman in Brgy. Talusangay unable to avail of information services on birth control; the lack of medical staff in Brgy. Ayala; the lack of facilities and equipment for delivery, breastfeeding and isolation within the city jail; and the lack of medicines in health center in Brgy. Masepla. Cases include charging patients P800 in Brgy. Mangusu and Brgy. Sangalo the gasoline consumption for ambulance services; a woman from Brgy. Mangusu whose birthing was delayed because the ZCMC did not have the transport service required to transfer her to another center; and a woman in Brgy. Ayala, suffering from bleeding because of a breast tumor rupture, whose transfer from one center to another was delayed because there was no ambulance available.

While RH goods and services may be available, they can be inaccessible. Cases include a woman in Brgy. Masepla who had to buy needed medicines from another barangay or city. This was affirmed in the Public Hearing, with the addition that this is a particular problem for those living in far-flung areas. Cases include a charge of P800 in Brgy. Mangusu and Brgy. Sangalo the gasoline consumption for ambulance services; a woman from Brgy. Mangusu whose birthing was delayed because the ZCMC did not have the transport service required to transfer her to another center; and a woman in Brgy. Ayala, suffering from bleeding because of a breast tumor rupture, whose transfer from one center to another was delayed because there was no ambulance available.

While RH goods and services may be both available and accessible, they can be inadequate. Cases include delayed attention to pregnant women who were about to give birth in ZCMC; a woman in Brgy. Masepla who had availed of pills without receiving explanation about its use; delayed arrival of ambulance resulted to the death of a newborn in Brgy. Masepla; an inmate in the city jail who suffered bleedings, for which her mattress was taken out although she was taken care of by the Bureau; an inmate from the city jail who had to avail of private hospital services amounting to P3,500 for her myoma operation because ZCMC was already full; an inmate in the city jail who was pregnant upon coming in and since the delivery of her baby has not received updates of the latter from her in-laws; a women preferring to have homebirths because of experiences of discomfort in birthing clinics and hospitals; and a woman in Brgy. Masepla who did not receive enough of needed medicines.

2. IMPROVABLE PUBLIC USE OF RH GOODS AND SERVICES

Among couples who practice FP, almost half use modern FP methods. The government project4Ps proved to be a mechanism for raising awareness on RH.

THE DENIAL AND/OR BARRIERS IN ACCESSING RH

1. UNPROFESSIONAL/UNETHICAL HEALTH WORKER PRACTICES

There are reported cases of the denial of service to patients, which include a hospital's refusal to admit a pregnant woman despite proper referral; the non-admission of another who was about to give birth; while cases of conditional services include the collection of fees without issuance of receipt. Cases of uncaring attitude include a woman from Brgy. Sangali who had to insist to the doctor that she already had to give birth before she was attended to; health workers who according to a woman from Brgy. Ayala mistreat patients; and a woman in Brgy. Masepla who was not immediately attended to after delivering her baby.

Similar cases include a woman in Brgy.Masepla who had to pay P80 before her child who had measles could be examined by the doctor; women from Brgy. Mangusu, Brgy. Ayala, and Brgy. Tulungatung who were required to give "donations" for some vaccines and medicine, pills (P20), and depo (P100), immunization (P60), and syringe (P10); a woman in Brgy. Ayala who was denied service because she had no money for "donation"; health workers in Brgy. Tulungatung who provide goods and services only for those they personally know; violent reactions in Brgy. Sangali upon knowledge of the gathering of testimonies from service recipients. This was affirmed during the public hearing.

2. PRESENCE OF CULTURAL AND RELIGIOUS RESISTANCE

On top of these are cultural factors such as how condoms are not very welcome among Muslim communities, according to a BHW in Brgy. Taluksangay, and the continued homebirthing in Brgy. Taluksangay.

AVAILABILITY, ACCESSIBILITY, ADEQUACY AND AFFORDABILITY OF RH SERVICES FOR VULNERABLE/MARGINALIZED WOMEN

1. UNEVEN POLICY RESPONSE TO VULNERABLE/MARGINALIZED SECTORS

There is a lack of awareness about RH among parents as well as the youth. People's financial capacity to avail themselves of RH goods and services was also cited as a general issue.

There is also particular lack of access to information on RH by IDPs. Cases include IDPs being unaware about the RH Law and RH goods and services in Brgy. Taluksangay.

There is, on the other hand, the availability of some RH goods and services for jail inmates. Particular services such as STI and HIV screening and pap smear for inmates are cited as available in the city.

2. LACK OF ADEQUATE RESPONSE TO INTERSECTING VULNERABILITIES

RH goods and services remain inaccessible to various marginalized sectors. Cases include a woman from Brgy. Tulungatung whose 'special child' did not receive needed medicine; the unavailability of vitamins for children especially for the malnourished in Brgy. Tulungatung; the unavailability of contraceptives in Brgy. Tulungatung; the lack of a lying-in center or ambulance in Brgy. Tulungatung; a woman whose child died for lack of medical attention in the Grand Stand Evacuation Center in Brgy. Masepla; a 6-month pregnant woman who has not had any prenatal checkup yet because the health center is always closed.

Discriminatory practices are also evident towards various marginalized sectors. Cases include discrimination against IDPs and the distribution of expired medicines in Brgy. Tulungatung; requiring donations from IDPs before needed medicine is released in Brgy. Tulungatung; the lack of dedication and work ethic of health workers in Brgy. Tulungatung; charging recipients for contraceptives, and syringes for immunization in Brgy. Tulungatung; IDPs in Brgy. Taluksangay made to pay membership fee of (P70) before receiving services.

BARRIERS/CHALLENGES ENCOUNTERED BY STATE AND OTHER HEALTH SERVICE PROVIDERS

1. UNSUPPORTIVE POLICY ENVIRONMENT

The TRO in Implanon also directly hinders them from distributing the already available 21,000 pieces of Implanon packs. Cultural resistance is also considered a hindrance with 42% of eligible users employing FP.

2. LACK OF SUPPORT FOR HEALTH WORKERS

Cases include one health worker in Brgy. Taluksangay who chose to work abroad for better pay. Related to this is the lack of human resources for service providing institutions. Limited resources curtail their implementation of the RH Law. This entails the insufficient number of health workers, and the insufficient budget and supply for medication. Interviewees shared that there is only one midwife and one nurse in main health center, and there is one city health center covering 6-7 barangays. Also in the Zamboanga City Medical Center, which caters not only to Zamboanga City but Basulta as well, the FP program has 5 consultants while there are 400 hospital beds catering to 600 patients. They also report insufficient number of health workers.

Security issues are also prevalent in the area. Cases include the testimony from Pinay Kilos on security issues as barrier to RH Law implementation. This was affirmed during the public hearing, with the explanation that health workers get discouraged to go on duty in areas of high security risk.

RECOMMENDATIONS

Found below are the recommendations that followed from the fact finding and public hearing:

To Policymakers:

- Continue monitoring the compliance of government agencies with the Magna Carta of Women (NCR)
- Intensify the monitoring of the RH Law with the engagement of CHR (Zamboanga)
- Enhance and update the CHR's Regional Women's Human Rights Profile (NCR)
- Integration of institutional efforts such the DepEd and DOH for RH education (CDO)
- Review policies on abortion in light of international policy trends on abortion, obligations under CEDAW, and the effect of its decriminalization on women's right to PAC under the MCW and RH Law (NCR)
- Augment funds for the RH Law (Legazpi-Sorsogon)
- Ensure funding for RH through national government agencies rather than LGUs (Legazpi-Sorsogon)

To Implementing Agencies/ Service Providers

- Strengthen advocacy for RH, emphasizing the moral rather than just legal obligations of service providers and communities towards RH (Leyte-Samar)
- Implementers should go to the ground to see what is happening (Leyte-Samar)
- Increased information dissemination on RH, including exhausting venues for educating women and men such as the 4Ps (Legazpi-Sorsogon) and for educating the youth such as schools (CDO)
- The government should also educate the women on their right to their own bodies, the control to their own bodies, their right to say NO, on their right to assert their needs. Those are things that should be part in the family planning and reproductive health implementations. (Leyte-Samar)
- Increase effort at motivating couples to undergo FP and RH training (Zamboanga)
- Identify and capacitate a focal person for the RH Law (Zamboanga)
- Promote CSO engagement including for capacity-building (Zamboanga)
- Engage religious leaders in the promotion of RH (Zamboanga)
- Ensure the full provision and delivery of RH goods and services especially to those living in far flung areas (Legazpi-Sorsogon)
- Strengthen the provision of balanced and accurate information drive on natural and modern FP methods, (Legazpi-Sorsogon)
- Ensure the availability of different FP methods so people can have their choice on what to use (Legazpi-Sorsogon)

For Specific Sectors:

- Ensure the availability of RH goods and services especially for marginalized sectors (Legazpi-Sorsogon)
- The needs of IPs (marginalized sectors) must be better recognized (Leyte-Samar)
- The involvement of men in FP and in promoting RH must be increased; they should be actively engaged in the RH agenda (Leyte-Samar, CDO, Zamboanga)
- Train nurses/Barangay Health Workers in sign language (CDO)
- Screen adolescents in transitory sites for HIV/AIDS
- Work with IP leaders better to promote RH (Zamboanga)
- Establish IP desks in every barangay (Zamboanga)
- Educate parents and youth on teenage pregnancy issues (Zamboanga)
- Educate adolescents though integration of Sexual and Reproductive Health and Rights in the curriculum (Zamboanga)
- Increase materials for RH education for students (Zamboanga)
- Indigenize materials on RH for local use (Zamboanga)

As part of the Commission on Human Rights' National Inquiry on Reproductive Health, the Commission conducted fifteen (15) Regional Consultations on CEDAW and Magna Carta of Women with special focus on Reproductive Health, this report presents the consolidated result of the 15 Regions bring the voices of women on VAW, Access to Justice and Reproductive Health and Rights

Regional Consultations on CEDAW, Magna Carta of Women with special focus on RH : Consolidated Report

Part of the Commission's National Inquiry on RH

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EXECUTIVE SUMMARY

For the whole month of March 2016, the Commission on Human Rights conducted Regional Consultations on the implementation of CEDAW and Magna Carta of Women, with particular focus on Reproductive Health Rights. This activity is a part of the Commission's **National Inquiry on Reproductive Health Rights,** which is being undertaken in accordance with its mandate as a National Human Rights Institution (NHRI) to monitor the compliance of the State with its treaty obligations, including CEDAW. As Gender Ombud under the Magna Carta of Women (MCW), the Commission likewise monitors the implementation of the MCW and other related laws on women like the Responsible Parenthood and Reproductive Health Law (RPRH). The results of the Consultations will form part of the Commission's independent report to the CEDAW Committee this July.

The Consultations were conducted through the Commission's fifteen (15) regional field offices.

The key issues that emerged during the consultations on CEDAW and MCW and on Reproductive Health are:

- **Community members' lack of awareness of the remedies and services available for them**. Lack of information on the laws that seek to protect women and children against violence; the remedies to access justice and services to help VAW victims-survivors; the available RH goods and services within the communities; and any programs for marginalized women, including those victims of displacement and other natural disasters and development aggression; is a major hindrance for women's access to these goods, services and programs. This is especially true for people in hinterland and far-flung communities.

- **Uneven implementation of the laws and programs on VAW and RH**. In many areas, legal provisions and programs on VAW and RH are not implemented effectively, which limit access to services. Among the factors are: (i) lack of training of service providers; (ii) insensitive and discriminatory attitudes of

service providers towards clients, especially IPs and LGBTs; (iii) "*palakasan*" system or selective provision of goods and services based on kinship, friendship, or political affiliation; (iv) unavailability of RH goods ("out of stock"), and/or even if these are supposed to be free, demand of donations or payment in exchange for these.

- **Intersectionality of issues for marginalized women.** Women in marginalized sectors face worse challenges, exacerbated by different factors including discrimination mediated by their own specific vulnerabilities. IPs, rural women, and those in far-flung areas have the least access to information and services related to VAW and RH. IPs, LGBTs and women in prostitution face discrimination when trying to access RH and VAW-related services. This is compounded when women belong to different vulnerable groups at the same time (i.e. PWDs who are also IPs, etc.)

- **Women's needs in times of displacement are not adequately met**. RH goods and services are not a priority in times of displacement caused by natural disasters and development aggression. Supplies for sanitary napkins and women's hygienic needs are not always available. Evacuation centers do not have separate spaces and sanitation facilities for women and girls, making them vulnerable to harassment and abuse.

RESULTS OF THE REGIONAL CONSULTATIONS ON CEDAW AND MCW

Women's Access to Justice and Violence Against Women

Most of the participants in the various regions are not aware of the laws protecting women and children and the services available within their communities to address cases of violence against women (VAW). A major reason for this is the lack of information dissemination, especially in rural and far-flung areas. In addition, while there are claims that cases of VAW are rampant and are increasing, many of these are unreported and/or undocumented. Women hesitate or refuse to report cases of abuse due to the following reasons:

- **Desire to keep the family intact**: Women tend to keep their sufferings to themselves particularly if the abuser is the husband in order to keep their families intact and for fear of ridicule.
- **Wariness of the response of service providers**. Women hesitate to report abuses against them because the authorities are not accommodating, aven treating their report as a mockery.
- **Low level of awareness of available remedies**.
- **Lack of financial resources**. Many women are discouraged from reporting cases because of limited financial resources which they will need in processing and filing cases.

With respect to the sufficiency of responses to VAW victim-survivors' issues / claims, many of the Regions reported that when cases are properly reported, the claims of the victim/survivors are addressed sufficiently. However, issues have been raised on the accessibility of protective services for the victim-survivors.

- Newly elected officials are unaware of the procedures due to lack of information. Capacity building for government officials in handling VAWC cases should be given due attention.
- There are no free interpreters that can assist PWDs whenever cases are filed at the PNP or barangay level. It is only the court that provides interpreter. This problem affects the ability of the child/PWD in expressing themselves.
- Delays in the resolution of the case cause victims to lose interest. Long process of case hearings, postponements of hearing sometimes trigger clients to enter into settlements because of loss of interest on the case.
- Lack of sensitivity of the police and others personnel handling the cases; treating the case as a mockery; Lack of qualified and trained personnel to handle the case.
- Financial constraints, lack of financial support for the victims during the pendency of the case – e.g. for transportation, food.

Specifically for marginalized women, the following issues have been raised

- **PWDs** - There are no free interpreters that can assist PWD whenever cases are filed at the PNP or barangay level.
- **LGBTs** - Most of the gender-related services are concentrated on VAWC and put little emphasis on LGBT issues.
- **OFWs** - Lack information on how or where to access financial assistance.
- **Women in rural areas and in upland barangays** - The victims do not have sufficient access to protection and support services from the communities because they are unaware of what to do in cases of violence committed against them.
- Many women victims-survivors in upland and hinterland barangays could not access justice and other services because of lack of financial support for transportation.

In terms of access to quality services, many VAW victims-survivors do not have access to services that would enhance their chances of surviving and rebuilding their lives.

- There is no available "crisis center" for abandoned and abused women.
- Even where there are crisis centers, there are no diversion programs for VAW victim-survivors to prepare them for their livelihood independence from their abusers.
- There is a dearth of employment opportunities offered to women who VAW victim-survivors.
- Lack of counselors and psychologists to help victims cope up with what they've gone through.

Issues of Marginalized Women

Indigenous Women

- Indigenous women cannot easily access basic social services such as health, education, employment and vocational opportunities due to their isolated location.

- As in the case of IPs in Libacao, Aklan, majority of the members and their children are not registered in the civil registry. This makes it difficult for the government or concerned agencies to cater to their needs or monitor whether services are being provided to them.
- They encounter difficulties in finding employment. The Aetas, for example find it hard to get a job because "they are pre-judged or stereotyped that they know little about new technologies".
- Some offices also implement programs that are not appropriate to the needs of the IPs. As pointed out by participants from Region 9, "*why would Badjaos be taught of carpentry when they excel in fishing*?" Job opportunities should be given to them depending on their adapted skill.
- Badjaos are observed to be begging off the streets. They require financial assistance as well as improved livelihood. (Region 7) .
- IPs do not have access to information regarding laws and services that they can help them.

Moro Women

- Moro women face various forms of discrimination even within their own communities and families, but many of them do not complain because they have been brought up believing that they are "lower than men" or *"ubos sa laki".*
- Lack of education and livelihood opportunities for Moro women and the younger members of the workforce have been noted. Most teenagers in the Muslim community are out of school and would rather work to earn money for their family than go to school.
- Discrimination and stereotypes, including labelling them as terrorists. For example, in Region 9, some employers in malls and stores refuse to hire Muslim women wearing Hijab because they fear that customers will be discouraged from buying in their shops.
- Moro women cannot easily access business permits (*so sometimes, they ask help from Christian friends to process business permits*)
- Insensitivity to their culture and practices. Some establishments require Moro women to wear short skirts as uniform, which is contrary to their traditional attire. Women who wear *niqab* and *hijab* are discriminated.

- PhilHealth benefits on pregnancy and childbirth is inadequate because it covers only up to four childbirths per woman. Moro women are not allowed to discontinue having children by using contraceptives, hence, many of them can go beyond four childbirths, and will no longer have any benefits.

Persons with Disabilities

- Authorities lack data management regarding population of PWDs which makes it very difficult for them to respond to their problems, issues, and necessities.
- PWDs have difficulty in accessing social, health and education services, as well as information about the availability of such. Most of the PWDs families do not have easy access to information that will help this group of people to avail free services from the government.
- Lack of employment and livelihood opportunities for PWDs despite having finished college, and even if they are employed, they are subjected to discrimination. For deaf people, employers immediately think communication will be impossible. The employers tend to be doubtful of their capabilities regardless of educational achievements.
- Difficulty in accessing education. Schools lack interpreters for deaf students which hampers the provision of inclusive education. Many schools do not have PWD friendly facilities such as ramps or hand rails. Some PWDs who are enrolled in school become victims of discrimination and bullying.
- In Region 2, participants lamented the absence of higher education institutions for the Deaf.
- Specifically to women who are mentally ill, it was noted in Region 6 that there is not enough shelter for women who are mentally ill and street children, thus, they are easily subjected to sexual abuse. Some of them even get pregnant.
- In Region 3, non-issuance of Philhealth cards to PWDs has been noted. In Region 9, it was noted that PWDs need to renew their PhilHealth, membership every after one or two years, unlike the lifetime membership of the Senior Citizens.

Women sex workers / Women in prostitution

- Some of these women are victims of human trafficking. Women who are mired in poverty and come from remote areas are targeted for recruitment supposedly for

work in the cities only to be trafficked or forced into prostitution. Because of lack of other options, they stay in prostitution and suffer all kinds of abuse and discrimination.

- They are vulnerable to physical and other kinds of abuses.
- They have limited access to health and social services, including free medicines, ST/HIV testing, general check-ups.
- When they complain about abuse and assault by their clients, police do not entertain them.
- They have high risk of acquiring sexually transmitted diseases and infections, HIV, and AIDS due to the nature of their work.
- They vulnerable to exploitation - they are underpaid or not paid at all, only their handlers benefit from them.
- Women who wish to get out of prostitution lack employment opportunities or face employment discrimination.
- The women working in night clubs are immediately stereotyped as prostitutes.

Lesbians, Gays, Bisexuals, and Transgenders (LGBTs)

- LGBT issues are not prioritized in many LGU programs on gender, resulting in failure to address their specific issues.
- Service providers often do not address their concerns appropriately. For instance, they encounter discrimination in filing complaints.
- LGBTS are bullied and discriminated against solely because of their gender. Regardless of whether they dress appropriately or not or act appropriately or not, people still disrespect them.
- Various cases of discrimination have been noted in Region 10: A public school elementary student who self-identified as a boy and dressed as such - was humiliated by the school principal by forcing the student to parade around the campus wearing a window curtain as a skirt, stressing that the student was born female and thus must dress as a girl; A transwoman who was told to cut her hair short so she could get a job; A security agency which tried to layoff all its lesbian security guards/employees.
- Lack of family acceptance, and discrimination even from family members.

- Street bullying against LGBTs (name-calling, throwing rocks at them, hate crimes).
- LGBTs have no concrete livelihood program which sometimes causes them to engage in prostitution.
- Need for protection for the "joint" properties of LGBT couples.
- Lack of information / awareness on HIV/AIDS.

Senior Citizens / The Elderly

- Senior Citizens are confronted with issues concerning their health, and the need for a comprehensive health care, facilities for geriatric care, and other necessities. There is also lack of education on management of menopause and andropause.
- Lack of awareness on the benefits they are entitled to. For the Moro community in particular, some Senior Citizens are holders of IDs but they lack knowledge on the extent of their benefits.
- There are issues concerning the use of their Senior Citizens ID cards. In buying medicines, for instance, some of them wonder why drugstores still ask to see their papers despite being on their second purchase of certain medicines. Others also experience getting turned down by drugstores and are immediately told that the medicines they need are not available. (Region 2)
- Their 20% discount is not strictly implemented. Some Senior Citizens even experience discrimination – for instance, tricycle drivers refuse them because of their fare discounts.
- It has been suggested that health cards for Senior Citizens and PWDs should be free.
- Social pension is not properly implemented. Some of those entitled to it do not receive the benefits de them.
- Senior citizens need financial assistance as well. They also have difficulty acquiring a job because of age discrimination.

Youth / Teenage Mothers

- Lack of access to information and guidance make the youth vulnerable to early pregnancies. Fertility management and family planning are not openly discussed in school or in their own homes. The implementation of adolescent reproductive

health is limited. Some teenagers hesitate to open up to their parents regarding this issue.

- For the teenage mothers, they lack support system which makes it difficult for them to go back to school and take care of their child at the same time.
- Young women who are out of school youth are vulnerable to drug addiction and prostitution.
- Children are deterred from expressing their gender/ identities even in schools due to restrictions imposed through school policies.
- There is a clamor for the youth sector to be represented in development or government planning councils so that their voices and opinions will be heard.

Solo Mothers

The issue raised with respect to solo parents is that the Solo Parent Act is limited in that it only caters to solo parents who are employed. The law is also silent when it comes to solo mothers with incapacitated children who are 18 years old and above.

Migrant Workers and their families

- The children are mostly affected when mothers are away from them. They are often neglected and are vulnerable to sexual, physical, and mental abuse by their guardians. Some become pregnant in their teenage years.
- Migrant workers and their children are vulnerable to high risk of sexually transmitted diseases and infections.

Women in the Informal Economy

Participants from Region 5 enumerated the issues being faced by women in the informal economy:

- Greater/heavier bulk of work yet low income
- No social services/ benefits
- Low RH information
- No additional benefits
- Non-members of SSS, Philhealth, etc.
- Lack of education

- Discrimination/
- Low productivity
- Prejudices on reproductive health concerns
- Vulnerable to abuse and exploitation

In addition, Region 11 participants noted that most of these women are not aware if their benefits. Most house helpers for instance are underpaid and do not know the remuneration and benefits they are legally entitled to.

Rural women

- Most marginalized group lack access to social, health, education, employment services.
- Fisher folks lack livelihood during typhoons – it is recommended that they be given alternative livelihood when they are unable to fish due to typhoons.
- The beneficiaries of 4Ps do not fully enjoy the benefits because there are reports that some barangay officials claimed shares from the government's cash support.

Issues in Relation to Displacement and/or Development Aggression

Based on experiences of the participants (including during Typhoons Yolanda and Pablo, Zamboanga Siege, armed conflicts), women suffer from specific vulnerabilities in times of displacement.

- In times of disaster women are the last persons to vacate from natural disasters/conflict area and they are usually burdened with taking care of the entire family. During floods and storms, women are faced with the problem of securing the safety of their family because there are no proper evacuation centers.
- During displacement security is the top issue for women because of unsafe environment. In evacuation centers, there is no proper classification between men and women. Families staying in evacuation centers are mixed - sometimes, several families are staying in a classroom where males and females are mixed. There is only one comfort room for men and women. Some comfort rooms have no locks and divided only with curtains. Hence, safety and security of women are compromised. Women and girls are vulnerable to sexual abuse.

- Disintegration of marital relationships because of lack of intimacy and increased sexual frustration at the evacuation center, even resulting to domestic violence including sexual abuse and marital rape.
- In times of war, women and children are harassed and sexually abused in the evacuation areas.
- The immediate help that is provided is food, and the specific needs of women (sanitary napkins, other necessities for personal hygiene) are not addressed. There are no health care kits or dignity kits distributed to them.
- Lack of proper hygiene in evacuation centers makes it dangerous for pregnant women.
- During disasters such as typhoon, there is no food, shelter, water. Women and their families succumb to hunger because there is no immediate response on the part of the Government as to relief operations, especially in isolated areas. Poverty arises because of lack of livelihood. If there is no food, women would do anything for survival. There will be recruitment, trafficking, and women would enter into illegal situations just to have food.
- During the onslaught of typhoon Yolanda, aside from loss of livelihood and access to health services, some women became vulnerable subjects for human trafficking and prostitution. Participants shared that some of the women who were victims of typhoon Yolanda are currently working as entertainers in Angeles City.
- Yolanda devastation caused women to be subjected to severe trauma and poverty. There were no services for psycho-social interventions.
- Women, children, sick people and the elderly lack medical attention. It has been observed that the government does not know how to treat bedridden women in evacuation centers.
- It has been noted that IPs are being discriminated in evacuation centers.

The children also suffer from specific vulnerabilities. Among those pointed out are:

- Disruption in education
- Children are exposed to trafficking, child labor and prostitution
- Depression, trauma, self-pity and sickness. Children are more prone to diseases in the evacuation centers. Psycho-social debriefing or rehabilitation is sorely lacking.

- Some cases where children commit crimes, turn to drugs, are noted.
- In areas of armed conflict, children are recruited as soldiers/combatant

Although the groups could not pinpoint specific documented cases of VAW during these times, they shared that there is high incidence of trafficking and prostitution of women and girls after the occurrence of a disaster or armed conflict. Participants shared that accounts of violence have been observed towards victims of calamities and displacements but many of these are usually unreported and undocumented. Consequently, these are not addressed. Prostitution, labor exploitation and early marriages occur. Reports of extrajudicial killings have also been observed in Region 7. Cases of drug abuse also become widespread.

In Region 5, the following have been noted:

- High incidence of trafficking and prostitution of women and girls after the occurrence of a disaster or armed conflict
- Wives/partners of suspected rebels are also accused
- Presence of military detachments near schools has spawned violations of IHL (schools as zones of peace)
- Harassment of organized women's group
- Increase in robbery incidents

Many of the Regions affirmed that the government provides support during times of displacement/disaster. However, they are also consistent in saying that the support is inadequate, especially in addressing women's needs. Among the interventions needed which are highlighted by various participants are:

- Psychosocial services and support system for women and children who are traumatized by the situation.
- Separate evacuation centers for women and children.

Recommendations

During the consultations on CEDAW and MCW, a few recommendations emerged:

- Training and information dissemination on VAW. Training should be provided for authorities tasked to respond to VAW, and continuous information dissemination should be done to raise peoples' awareness on VAWC.
- Support groups should be formed to help VAW victims.
- VAW desk should be established in every Barangay (CAR).
- Awareness raising on the services available for marginalized women.
- Livelihood programs for marginalized women.
- LGBT concerns should be incorporated in every LGU GAD plan.
- Comprehensive rehabilitation services to enable PWDs to achieve social functionality and economic sufficiency, through the DSWD's Area Vocational Rehabilitation Center,
- Proper consultations before enacting laws so that the people are aware of its provisions.
- During times of disaster, training on disaster preparedness to help people become ready and equipped in times of emergencies and calamities, especially those in far-flung areas. More exhaustive training for women who are more vulnerable than men.
- Support system and psychosocial services for women and children who are traumatized because of the calamity suffered.
- Safe and secure evacuation centers/ transitory sites, with women given more privacy.
- Prenatal services for pregnant women (e.g. Tetanus Toxoid injection).
- Proper consultations before the introduction of development projects, to obtain free and informed consent especially from the indigenous peoples, and women in the rural areas.
- Information dissemination before commencing development projects to avoid misunderstandings.

RESULTS OF THE REGIONAL CONSULTATION ON REPRODUCTIVE HEALTH

The Regions have available commodities and services for reproductive health. However, while these goods and services are ideally available for free, issues have been raised regarding their actual availability and accessibility.

- The supplies are limited and do not suffice to provide for all community women who need these. Many of the health centers claim that the commodities are "out of stock".
- There is a practice in some areas of asking "donations" in exchange for the commodities, which is tantamount to asking payments for the goods.
- There is also lack of information dissemination and encouragement for the community members to enjoy or maximize health services like pills and other family planning commodities.

Many choose not to access RH goods and services, i.e. lesbians who become pregnant are too ashamed to avail of RH services:

- Moros say that it is forbidden by culture.
- Badjaos are ashamed of accessing healthcare since healthcare providers belittle them due to their lack of hygiene.
- The youth are also ashamed of approaching the barangay for RH services.

Generally, women, youth, and LGBTs, know where to go whenever they need RH goods and services. Health centers in every barangay are accessible to everyone. The community members are aware that health centers in their communities provide reproductive health goods and services including family planning services.

Most women are also able to access family planning services, including traditional and modern forms of contraception. Among the services available to women are natural and artificial family planning and counselling for married couples, ante-natal care, immunization for pregnant women, post-natal care.

Again, women in the hinterlands do not have access to information regarding family planning and maternal health services. In these areas even when they want to practice family planning, the only method available to them is traditional/natural method. In some cultures the preference is for natural family planning methods as it is not part of their

culture to use artificial contraceptives. They have traditional knowledge and use herbs and plants for contraception.

The youth also generally do not have access to family planning services without the consent of their parents. No adolescent, and youth medical services including sex education are available for teenagers in many communities.

Post abortion services. Women in majority of the Regions do not have access to post-abortion services in health facilities. This is not included in the range of RH services that the health centers provide. The exceptions are in Region 4 where health facilities, especially in San Pablo City, are clean and accredited to conduct services in post-abortion care; and in Region and 8 where to some extent, post abortion services are offered in hospitals.

Policies and practices on RH. Majority of the LGUs are deemed to be supportive of RH, in varying degrees, and with certain limitations. However, there are common issues that repeatedly come out with respect to implementation of LGU's programs on RH.

- It is a recurring issue that marginalized groups, especially women in hinterlands and IPs, are not able to access the programs of the LGUs, mainly because of the distance and the lack of information available to them.
- Even where there are available RH good, services, and programs by the LGUs, many people do not avail of these because they are not aware of their availability. For instance, IUDs or contraceptive pills are available in health centers but some community members think these are not free hence they do not avail of these.
- In Region 12, there is a problem on the continuity of RH programs and projects for basic services due to the changes in the political landscape. Some local leaders do not continue previous programs of their predecessors especially when they belong to opposite political parties. In addition, allocation of budgets for RH is inconsistent, depending on the political will and position of the local leaders.

With respect to policies and/or practices by LGUs and/ or Healthcare providers that prevent access of women and girls to RH, the following were mentioned:

- In Sorsogon City (Region 5), the City Mayor issued in February of 2015 a "pro-life" resolution prohibiting the distribution of contraceptives. An Ordinance criminalizing the dispensation of family planning commodities is pending in the City Council of Sorsogon.
- In Iligan City (Region 10), a City Ordinance was passed asking women for donations before they can avail of RH products and services. As this donation has fixed amount, this is tantamount to rendering these products and services as for sale. There is also a TRO on subdermal implant.

The groups noted that women do not willingly seek services in the community. As mentioned above, many of them lack awareness of the services available. When they do visit health centers, there are no staff available to conduct family planning services, or commodities are unavailable or "out of the stock".

Specifically, the participants listed the following factors that hinder women in accessing RH services in their communities.

- Lack of information on the services and good available, who to approach, how to avail, etc.
- Geographical location of healthcare services. The father the location is, the more difficult for healthcare clients to access these goods and services.
- Negative experience due to unfriendly, insensitive, and discriminatory attitudes of service providers
- Religion and cultural beliefs - traditional women opt to resort to culturally-based beliefs and practices.
- Women are discouraged because of the prevailing "*palakasan* system" wherein goods and services are extended only to those clients they know or favor.
- The fear of spending too much on RH goods and services and the fear of generally submitting themselves for medical care also overpower the desire of these women to access RH services
- Fear of the perceived side effects of contraceptives
- Uncooperative male spouses / Partners are not supportive
- Stigma against persons with sexually transmitted diseases /HIV.

Behavior and outlook of health service providers. Although not generalizing, almost all the Regions cited examples of negative attitudes from some health personnel / service providers. Among the behaviors noted were:

- Some health workers in barangays do not explain very well the things that need to be explained regarding RH.
- Insensitivity of some Barangay Health Workers to the PWDs and elderly has been noted.
- Some health workers have attitude problems, sanitary issues, and gender sensitivity issues. Some women patients would sometimes hear negative comments coming from the health workers.
- There are instances of dealing with insensitive health workers, giving them "cold treatment", particularly for example towards women in prostitution. This discourages them from going back for health services.
- Quality of counseling is low due to bulk of patients, when it should be one at a time. Sometimes in the barangay there are only BHWs who are not trained to do family planning counseling. Many go to big hospitals, but the rural people could not because of distance.
- Some volunteer health workers still need to be educated on proper implementation of medical procedures.
- The local language terms used in sexuality/RH education come out as vulgar-sounding, which is a factor that hampers the learning of community members.

- Doctors are only scheduled in the centers once a month.
- Mindset of medical practitioners that pregnancy and delivery is no one else's responsibility but the mother alone.
- Some health workers are also hesitant to deal with HIV patients because of scarcity of supplies

Availability of RH Goods and Services for Marginalized Women. Where there are available RH goods and services, these are also available to marginalized women, except, in some cases, for the youth. The barangay health centers are open to all stakeholders in

the communities. Contraceptives are distributed to those who need these regardless of gender, marital status, cultural affiliation, etc.

Some of the issues noted are:

- As has been repeatedly mentioned, women in rural, far-flung areas have the least access to RH goods and services.
- "*Palakasan*" or "*padrino*" system - Participants relayed that only those who know someone in the health center, office or facility will be able to access services. Connections or political affiliations serve as crucial factors in terms of who will be assisted by LGUs and offices.
- PWDs have difficulty accessing RH services since some services are offered in facilities or sites far from their residences, there are no ramps or hand rails, and there are no interpreters. Several PWDs do not possess vehicles to access assistance from RH service providers.
- Youth – in some areas, contraceptives are not made available to the youth. There are no adolescent, and youth medical services including sex education for teenagers. As a result, early pregnancy often happens.

Due to the issues and barriers to accessing RH services mentioned in previous paragraphs, many women in the marginalized sectors often hesitate to seek services in their communities.

Availability of RH Goods and Services during Displacement and Development Aggression. For many of the Regions, while RH goods and services are available during times of displacement / calamity/ development aggression, these are not sufficient. They are consistent in saying that these are not prioritized during times of crisis.

In Region 11, during the typhoon Pablo, some of the experiences were detailed as follows:

- There were pregnant women who got sick, and some suffered from TB because the response arrived late. It took a long time for the goods and services to arrive because there were debris everywhere.

- There was discrimination in giving supplies – those who are nearest of kin or family were prioritized. Others received expired goods and medicines. Delivery of goods and services was political and followed color coding, e.g. if your color was yellow and not pink, you cannot receive supplies. There were patients who were denied immediate care. The victims who were wounded were told to list their names to receive payments, but when the money was released it did not reach the victims.
- During the typhoon Pablo there were politicians who hid the supplies (medicines, etc.), and gave these to private persons for selling, and they would tell the people there are no more supplies but that they could but from this specific person.
- For the health workers, lack of concern was noted. They only catered to the ones they wanted to serve. They would not go to rural areas because it is muddy, or the people have no "proper hygiene", and smell bad.

Challenges and barriers in accessing RH goods and services

- Lack of awareness on the available RH goods and services during times of calamities, crisis and displacement.
- Discrimination in providing services and supplies. In some cases, the granting of these goods and services are based on kinship and political affiliations. "Palakasan" system, or "kila-kilala" system is very prevalent.
- Non-availability of on-call health workers. Sometimes there are no personnel in health centers.
- Lack of medicines and other medical supplies.
- Attitude problems of some heath workers at the LGU level. Some are not approachable/ accommodating, and do not use simple, layman's terms that can be easily understood by the community members.
- Lack of technical training of health workers. There are instances where the health workers are not well-equipped with knowledge on the RH goods and services.
- Absence of midwives. Midwives hesitate to go to the community of participants because of fear of huge waves (Sicogon).
- Anxiety over family planning procedures; side effects of contraceptives.
- Discrimination against IPs.

With all the issues surrounding the availability and accessibility of RH goods and services during times of crisis, it is not surprising that the participants remark that the State does not provide enough RH goods and services during times of displacement / crisis / calamity / development aggression.

Recommendations

- Information dissemination should be conducted to increase awareness of the community people on women's reproductive health and the RH goods and services available in Barangay Health Centers, as well as services available during displacement and development aggression.

- More training should be conducted for health providers to enable them to explain very well the family planning options. Instructions on how to use RH should also be explained clearly in layman's language to ensure that the users understand. More importantly, these should be given by the health providers with a smile and respect for human dignity. (Region 4)
- There is a need to reconcile cultural practices to the reproductive health laws (Region 12).
- Involvement of male partners as equal partners in RH matters should ne ensured.
- In cases of marginalized women, more efforts should be made in explaining RH goods and services to women with disabilities, such as entertaining their questions. (Region 10)
- For LGBTs, it is recommended that the health provider also belongs to the LGBT group to be able to provide better support system to the client. (Region 4)
- Sex education for the youth. In CAR, methods such as conduct of film showing for the youth and children on RH, teenage pregnancies, etc. are suggested.
- In times of calamities and displacement: it is recommended that doctors and nurses be deployed after calamities to provide RH services (Reg 7)
- "*Kubo-kubo*" houses (huts) should be made available whenever displacement occurs for couples to "exercise sexual rights" while recovering from calamities (Reg 7).

Rationale and Background

As a National Human Rights Institution (NHRI), the Commission on Human Rights Philippines (Commission) monitors the compliance of the State with its treaty obligations, including the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW). As Gender Ombud under Republic Act 9710 or the Magna Carta of Women (MCW), the Commission likewise monitors the implementation of the MCW and other related laws on women like Republic Act 10353 or the Responsible Parenthood and Reproductive Health (RPRH) law.

Role of NHRIs

In the 2012 Amman Declaration and Programme of Action, NHRIs committed to 1) protect and promote reproductive rights without any discrimination; 2) encourage and aid the compilation of an evidence base (e.g., data, inquiries, research) concerning the exercise of reproductive rights and the right to sexual and reproductive health, including but not limited to cases of de jure and de facto discrimination in access to sexual and reproductive health care information and services; 3) encourage and aid the compilation of an evidence base (e.g., data, inquiries, research) concerning the exercise of reproductive rights and the right to sexual and reproductive health, including but not limited to cases of de jure and de facto discrimination in access to sexual and reproductive health care information and services; and 4) promote measures to ensure access to comprehensive sexual and reproductive health information and services and to remove barriers which hinder such access, and support the establishment of accountability mechanisms for the effective application of the laws and the provision of remedies when obligations have been breached.

The second quarter of 2016, the Commission on Human Rights of the Philippines, through its Focal Commissioners on Women, Commissioner Karen Gomez- Dumpit and Commissioner Gwendolyn Gana-Pimentel decided to undertake a national inquiry on reproductive health and reproductive rights. The conduct of the inquiry was timely and strategic considering the incoming review of the Philippines' by the CEDAW Committee and in view of the continuing challenges in the implementation of the RPRH law.

Reproductive Health and Rights Challenges

The CEDAW Committee in its 36th session in 2006 expressed its concern about the inadequate recognition and protection of the reproductive health and rights of women in the Philippines. The Committee is concerned at the high maternal mortality rates, particularly the number of deaths resulting from induced abortions, high fertility rates, inadequate family planning services, the low rates of contraceptive use and the difficulties of obtaining contraceptives. It is also concerned about the lack of sex education, especially in rural areas. It is concerned at the high rate of teenage pregnancies, which present a significant obstacle to girls' educational opportunities and economic empowerment.

The Philippines enacted two ground-breaking laws that recognize women's rights: Republic Act 9710 or the Magna Carta of Women (MCW) in 2009 and Republic Act 10354 or the Responsible Parenthood and Reproductive Health Act (RPRH Law) in 2012. The MCW mandates the State to provide "comprehensive, culture-sensitive, and gender-responsive health services and programs covering all stages of a women's life cycle and which address the major causes of women's mortality and morbidity . . . .[i]" It also provides for women's access to family planning and post-abortion care[ii]. The RPRH Law mandates "universal access to contraception, reproductive and sexuality education, post-abortion care, and maternity care, and requires the Department of Health (DOH) to procure and distribute a wide range of modern forms of contraception.[iii]" While the constitutionality of the RPRH Law was immediately challenged upon its passage, the Supreme Court finally upheld its constitutionality last 8 April 2014 and DOH proceeded with the issuance of guidelines for its implementation[iv]. On the other hand, in 2015, the CEDAW Committee released its key findings and recommendations of its Special Inquiry on Reproductive Health, particularly on the issue of the Manila Pro-Life EO 003. The findings held the Philippine government accountable for grave and systematic reproductive rights violations.

Even with these progressive laws, women in the Philippines continue to face significant inequality and discrimination in accessing reproductive health information and services. The Philippines has one of the highest rates of maternal mortality in the Asia and the

Pacific region and is off-track to achieve the Millennium Development Goal 5. The high level of maternal mortality and the slow progress in reducing it implies that on average about 4,288 women die every year from pregnancy and child birth. The unmet need for family planning[v] has also has increased from 15.7 percent (2006) to 19.3 percent (Family Health Survey 2011).

The implementation of the RPRH Law continues to face challenges. At the national level, despite the Supreme Court victory of the RPRH Law, a Temporary Restraining Order was issued last June of 2015 on the procurement of contraceptives and on the dispensation and administration of implants and implant NXT. This prompted the DOH to issue guidance on the observance of the TRO to its regional and other line offices. To date, the TRO has not yet been lifted by the SC. In addition, the 2016 budget amounting to P1 billion for contraceptives was removed during the deliberations of the Senate and House bicameral conference committee. At the local government unit level, in the City of Sorsogon, the mayor issued in February 2015 a "pro-life" resolution and contraceptives were pulled out from health centers depriving women of reproductive health services. A City Ordinance criminalizing the dispensation of family planning commodities is pending in the City Council of Sorsogon.

It is highly understandable then that the CEDAW Committee, in its list of issues has dedicated a substantial portion on health, particularly on how the State has taken adequate measures to "ensure access to health services for all women, in particular rural women, women with disabilities, indigenous women and Muslim women."

With the foregoing, the Commission as National Human Rights Institution and as the Gender Ombud embarked on the National Inquiry process with technical and financial assistance from the United Nations Populations Fund (UNFPA) and in coordination with its fifteen (15) Regional Offices and in coordination with civil society organizations focusing on reproductive health and women's rights.

Terms of Reference of the National Inquiry

For the July 2016 review of the CEDAW Committee, the Commission intends to submit its independent report. The report will focus on the issues as identified by the CEDAW

Committee in the List of Issues Prior to Reporting (LOIPR) and it will highlight access to reproductive health particularly of marginalized groups. For the former, the Commission will be conducting consultations, for the latter, the Commission will be conducting a national inquiry.

A national inquiry process is a strategy adopted by National Human Rights Institutions (NHRIs) whereby a large number of individual complaints can be dealt with in a pro-active and cost effective way[1]. A national inquiry is an effective strategy in addressing systemic violations of human rights – based on evidence from individual cases, but also embracing an examination of the laws, policies, and programs (or lack of them) which have given rise to violations in question.

Objectives:

The National Inquiry on Reproductive Health and Reproductive Rights, through written submissions, fact finding missions and public hearings, aims to:

1. Examine the effectiveness and implementation of laws (MCW and the RPRH Law), and related issuances by the DOH on Reproductive Health;
2. Document individual and/or systemic accounts of acts or omissions, structures, policies or practices which result to denial of access to reproductive health services or which hinder and serve as barriers in accessing reproductive health services;
3. To focus on the denial of and barriers to reproductive health services as experienced by the most vulnerable and marginalised, particularly the poorest of the poor, rural women, indigenous women, women with disabilities, Lesbian, Bisexual and Transwomen, women in the informal economy, elderly women, girl children and women who are internally displaced and/or those who are not beneficiaries of the Department of Health's 2015 Family Planning Funds;

[1] Asia Pacific Forum. National Human Rights Institutions and National Inquiries.

4. To document the barriers and problems experienced by service providers, both state and non-state, in providing reproductive health services, particularly to those most vulnerable and marginalized;
5. To provide an analysis and to report on women's access to reproductive health in the light of the State's obligations under CEDAW and the provisions of the MCW and the RH Law;
6. To relate women's right to reproductive health to other rights under CEDAW and to highlight the intersectionality of women's discrimination through the accounts provided by the written submissions, the fact finding, and the public hearings;
7. To provide concrete recommendations to the State and the concerned agencies to address individual and systemic/structural barriers to women's access to reproductive health services;

Strategies and Methodology

In order to ensure an inclusive and participatory approach in the preparation of the Commission's report to the CEDAW Committee on the implementation of CEDAW and other laws on women, and in order to gather grounded experiences of women and RH advocates, the Commission, with technical and financial assistance from the United Nations Population Fund (UNFPA) and in coordination with Likhaan Center for Womens Health and other CSOs focusing on RH will be conducting a National Inquiry on Reproductive Health and Reproductive Rights from 1 March to 15 May 2016.

The National Inquiry will consist of three interrelated parts:

1. Launch of the National Inquiry on 1 March 2015 at the Commission on Human Rights and the official call for submissions from individuals and/or organizations documenting their experiences with respect to denial of/discrimination and barriers in accessing reproductive health services. This may be in the form of acts or omissions resulting to denial and/or discrimination in accessing reproductive health services and information. These may be policies, practices which deny, hinder of prevent access to reproductive health, single and isolated incidents or systemic acts of violations and discrimination.

2. Conduct of Regional Consultations through its fifteen (15) regional field offices on CEDAW and Magna Carta of Women with particular focus on Reproductive Health and Reproductive Rights in March and in time for the celebration of women's month. The Regional Consultations will be conducted by the Commission's Regional Offices with guidance from GEWHRC and the UNFPA;

3. Conduct of Fact Finding Missions and Public Hearings in five select areas in the country during the month of April. The select areas are: Metro Manila, Legazpi City (Albay, Region 5), Tacloban City (Leyte, Region 8), Zamboanga City (Zamboanga Del Sur, Region 9), and Cagayan de Oro City (Misamis Oriental, Region 10), and. Two days will be devoted to fact finding and one day for the public hearing. The Public Hearing for Metro Manila will be on 4th of April; in Legaspi, April 14; in Zamboanga, April 21; in Tacloban, April 25 and in Cagayan de Oro, April 29. Individuals, organizations with specific concerns on RH and particularly falling within the scope of the Inquiry are encourage to participate and attend.

The Philippines signed and ratified in 1981 the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW). Since then, various legislations recognizing, affirming and promoting women's human rights were enacted. Recently, two ground-breaking laws were passed, the Magna Carta of Women (MCW) and the Responsible Parenthood and Reproductive Health Law (RPRH).

Despite the various progressive laws, women in the Philippines continue to face significant challenges and discrimination. In the area of reproductive health, the Philippines has one of the highest rates of maternal mortality in the Asia and the Pacific Region at 120 deaths per 100,000 live births[2], and is off-track to achieve the Millennium Development Goal 5. The CEDAW Committee, in its 36th session in 2006, expressed concern over this, noting the number of deaths resulting from induced abortion, high fertility rates, inadequate family planning services, low rates of contraceptive use, and the difficulties of obtaining contraceptives. It also noted the lack of sex education

[2] UNDP. 2015. *Human Development Report*. Comparative data shows an average of 72 deaths per 100,000 live births for East Asia and the Pacific Region.

especially in rural areas, and expressed concern over the high rate of teenage pregnancies. Hence, in its list of issues, the CEDAW Committee has dedicated a substantial portion on health, particularly on how the State has taken adequate measures to "ensure access to health services for all women, in particular rural women, women with disabilities, indigenous women and Muslim women".

While the passage of the RPRH law was a significant step towards the promotion of reproductive health rights, its implementation continues to face obstacles. The constitutionality of the law was immediately challenged upon its passage, and while the Supreme Court upheld its constitutionality, a Temporary Restraining Order (TRO) was issued in June 2015 on the procurement of contraceptives and on the dispensation and administration of implants and implant NXT. To date, the TRO has not been lifted. In addition, the 2016 DOH budget amounting to one billion pesos for contraceptives was removed during the deliberations of the Senate and House of Representatives bicameral conference committee. In the local government, an Ordinance criminalizing the dispensation of family planning commodities is pending in the City Council of Sorsogon. The City Mayor issued in February of 2015 a "pro-life" resolution and contraceptives were pulled out from health centers depriving women of reproductive health services.

This July, the Philippines will once again be under review by the CEDAW Committee for its sixth and seventh consolidated report. For this July 2016 review, the Commission on Human Rights intends to submit its independent report. As a National Human Rights Institution (NHRI), the Commission monitors the compliance of the State with its treaty obligations, including CEDAW. As Gender Ombud under the Magna Carta of Women, the Commission likewise monitors the implementation of the MCW and other related laws on women like the RPRH Law.

For this report, the Commission conducted a **National Inquiry on Reproductive Health Rights,** focusing on the issues as identified by the CEDAW Committee in the List of Issues Prior to Reporting (LOIPR), and with a special focus on reproductive health rights particularly of marginalized groups. The activity was with funding support from the United Nations Populations Fund (UNFPA), and in coordination with civil society

organizations (CSOs) such as Likhaan Center for Reproductive Health Rights and other CSOs focusing on Reproductive Health Rights.

The objectives of the National Inquiry on Reproductive Health included:

- Examine the effectiveness and implementation of laws (MCW and the RH Law), and related issuances by the DOH on Reproductive Health;
- Document individual and/or systemic accounts of acts or omissions, structures, policies or practices which result to denial of access to reproductive health services or which hinder and serve as barriers in accessing reproductive health services;
- To focus on the denial of and barriers to reproductive health services as experienced by the most vulnerable and marginalized, particularly the poorest of the poor, rural women, indigenous women, women with disabilities, Lesbian, Bisexual and Transwomen, women in the informal economy, elderly women, girl children and women who are internally displaced and/or those who are not beneficiaries of the Department of Health's 2015 Family Planning Funds;
- To document the barriers and problems experienced by service providers, both state and non-state, in providing reproductive health services, particularly to those most vulnerable and marginalized;

- To provide an analysis and to report on women's access to reproductive health in the light of the State's obligations under CEDAW and the provisions of the MCW and the RH Law;
- To relate women's right to reproductive health to other rights under CEDAW and to highlight the intersectionality of women's discrimination through the accounts provided by the written submissions, the fact finding, and the public hearings;
- To provide concrete recommendations to the State and the concerned agencies to address individual and systemic/structural barriers to women's access to reproductive health services;

Regional Consultation on CEDAW and Magna Carta of Women
With Special Focus on Reproductive Health Law

In order to ensure an inclusive and participatory approach in the preparation of the Commission's report to the CEDAW Committee, and in order to gather grounded experiences of women and RH advocates, the Commission conducted Regional Consultations through its fifteen (15) regional field offices. The Regional Consultation forms part of the consultation for the Commission's CEDAW independent report and of the Commission's National Inquiry on Reproductive Health Rights[3].

A. OBJECTIVES:

1. To gather women's rights and reproductive health advocates from the Regional Office's areas of responsibilities for a consultation/participatory process towards CEDAW reporting;
2. To document issues on the implementation of CEDAW and the Magna Carta of Women particularly on the following select key issues: (1) Access to Justice including violence against women; (2) Issues and effective access to services for Marginalized Women: Women in the 'informal sector,' rural women, Indigenous Women, Moro women, women with disabilities and Lesbian, Bisexual and transgender; (3) Women's issues in the context of displacement and development aggression.
3. To document issues on the implementation of the Reproductive Health Law (RA 10354) including the scanning of discriminatory policies and practices in relation to accessing reproductive health services. Particular attention shall be directed to the access of marginalized sectors (IPs, Moro Women, PWDs and LGBTIs) to reproductive health services.

[3] Funded by the UNFPA, the Commission is undertaking a National Inquiry on Reproductive rights from the months of March-April-May 2016.

B. SCHEDULE

The Regional Consultations were undertaken during the whole month of March. The consultations formed part of the respective Regions' Women's month celebration. The regions were free to choose a date within the month of March for the conduct of its consultation.

Table 1 – Schedule of Consultation Meetings

REGIONAL OFFICE	DATE	VENUE
National Capital Region (NCR)	30 March 2016	UP Complex, Diliman, Quezon City
Cordillera Administrative Region (CAR)	21 March 2016	Hotel Veniz, Baguio City
Region 1	31 March 2016	Hotel Ariana, Bauang, la Union
Region 2	10 March 2016	CHR Regional Office, Tuguegarao, Cagayan
Region 3	21 March 2016	Epatha Development Training Center, San Fernando, Pampanga
Region 4	17 March 2016	Human Resource Training Center, San Pablo City, Laguna
Region 5	30 March 2016	La Roca Veranda Suites, Gogon, Legazpi City
Region 6	31 March 2016	The Grand Tower Suites, Iloilo City
Region 7	30 March 2016	Ecotech Center, Sudlon, Lahug, Cebu City
Region 8	18 March 2016	Asian Development Foundation, Tacloban City
Region 9	17 March 2016	Don Toribio, Tetuan, Zamboanga City
Region 10	15 March 2016	Grand Caprice, Cagayan de Oro City
Region 11	31 March 2016	Felis Beach Resort Complex, Davao City
Region 12	22 March 2016	D& M Resto, Cotabato City
CARAGA	29 March 2016	Ericka's Pasta Story, Butuan City

C. METHODOLOGY

The Regional Offices of the Commission, through the Gender Focal Persons led by the Regional Director, oversaw the conduct of the Consultation including the sending of invites to participants, the selection of venue, and holding of the consultation proper.

Each Region was provided funds through the CHR-UNFPA. The Gender Equality and Women's Human Rights Center (GEWGRC) provided the Concept Note and the Consultation Guide. GEWHRC likewise worked closely with the Regional GFPs in the preparation, conduct of the consultation and in the liquidation and accounting of CHR-UNFPA funds.

GUIDE QUESTIONS

Three break-out groups for the focus group discussions were formed, to discuss one topic each from the CEDAW List of Issues:

(1) Access to Justice and Violence Against Women;
(2) Issues affecting marginalized women; and
(3) Issues related to displacement and/ or development aggression.

Members of the group were requested to fill out the group profile sheet. The profile sheet generally seeks information on the participants' address, age, civil status, gender, educational background, work, ethnicity, and protected status.

FGDs were limited to one hour with responses of the group reflected in visual aids, and a rapporteur for the group duly designated to report for 10 minutes.

The guide questions are as follows:

FGD Group I. Access to Justice and VAW protective services

Are women aware of the legal aid and other support services in cases of violence against women?

a. Are you aware of laws/provisions that protect women and children (Anti-rape, Anti-VAWC, MCW, Anti-trafficking, etc.)?
b. Are you aware of any services in the community to address or respond to VAW and discrimination?

c. If you have experienced some form of gender-based violation/discrimination, do you know where to go to seek protection if you need it?
d. What do you do if you have witnessed some form of gender-based violation/discrimination?

What is the prevalence of VAW and accessibility of services?

e. Would you have an idea on the number of reported cases of VAW in your community? Are they sufficiently addressed by (a) the barangay; (b) the police; (c) the prosecutors' (d) the courts; (e) social welfare officers; (f) health officer?
f. Do you feel that issues/claims of survivors are properly managed/heard by protective services providers (barangay, police, MSWDO, etc.)?

Are marginalized women able to access justice and quality services?

g. Are you aware if victims-survivors of violence (i.e rape, intimate partner violence, sexual harassment), including women with disabilities, are able to access high quality protection and support services (shelter/rehabilitation) in your community?
h. Do you think the survivors get the proper and adequate help that they need (Health services from health center, psychosocial support from social welfare, protection from barangay or the police)?
i. Do you think your rights, or women's rights, are sufficiently protected?
j. In cases of violation, what hinders you from seeking justice or protective services?
k. Do you believe the legal system provides proper justice/protection regardless of gender, social status, financial capacity, education, etc?

FGD Group II. Issues of Marginalized Women

Who are the marginalized women and what are their issues?

a. Are you aware of women in your community that are marginalized or are at a disadvantage?
b. Are there any other group of people who are marginalized in your community (street children, LGBT groups, etc.)?
c. Are you aware of the issues facing these women? What about issues facing IP and Moro women?
d. Are you aware of the issues facing the other marginalized groups such as the LGBT community?

Are marginalized women able to access social, health and other services?

e. Do you think the marginalized women have equal access to social and health benefits from the community? How about the other disadvantaged groups?
f. Do the vulnerable groups have access to (a) inclusive education; (b) employment; and (c) vocational opportunities; and (d) social services?
g. Do you think the state or the community provide adequate support these vulnerable groups?

FGD Group III. Issues in relation to displacement and/or development aggression

How are women affected by natural disasters, climate change and/ or development aggression?

a. How does natural disasters, conflict or development aggression affect your community?
b. Are there any vulnerable groups in your community that is more affected by disasters, conflict or development aggression (ie. IPs, LGBT, pregnant women, etc.)?
c. How are the women in your community affected by disasters, conflict or development aggression?
d. How are the women in your community affected by displacement?

e. How are the children and other vulnerable groups affected by displacement?

Are there documented accounts of violence during armed conflict or during disasters in your areas?

f. Are there documented accounts of violence during armed conflict or during disasters in your areas? Are they sufficiently addressed?
g. Do think the state provide adequate support to the community in times of displacement/disaster?
h. Do you think the vulnerable groups, especially the women, have adequate protection in times of displacement/disaster?

<u>FGD Group I. Levels of RH Implementation</u>

What RH goods and services are available in your areas?

a. Are there available RH goods in your community? If so where? And how much does it cost? Can you name a few?
b. Are there available RH services in your community? If so where? How much and can you name a few?

Are RH goods and services accessible to women, youth and LGBTs?

c. Do you think people (women, youth, LGBT) know where to go if they need access to RH goods and services?
d. Are women able to access both traditional and modern forms of contraceptives in your community?
e. Are women able to access Family Planning services (counseling, ante-, post-natal care, etc.)
f. Are women able to access post-abortion care in health facilities?
g. Are your RH needs being met timely and appropriately (i.e. Health facilities provide both traditional and modern contraceptive options, health service provider is always available for counseling, etc.)?

FGD Group II. Policies and practices on RH

Are LGUs supportive of RH?

a. Are you aware if the LGU provide enough support for RH goods and services in your community?
b. If women need any RH services, do they willingly seek services in your own community?
c. What are the hindering factors for women in accessing RH services in your community?
d. Are there policies and/or practices by LGUs, healthcare providers that prevent access of women and girls to RH?

What are the challenges?

e. What can you say about the behavior and outlook of health service providers (i.e. openly and clearly explains health issues, not reliable, not welcoming and friendly, etc.)
f. Do you think the LGUs provide enough RH services in your community?
g. Will it be better if funds and policies on RH came from National Agencies like DOH instead of LGUs?

FGD Group III. Availability of RH goods and services for marginalized women

Are health services available for marginalized women?

a. Are there available RH goods and services in your community for women in the informal sector? For people with disability? For the youth? For IP? For Moro? For the LGBT community?
b. If these groups need any RH services, do they willingly seek services in your own community?

What are the experiences of these women in accessing RH?

c. What can you say about the behavior and outlook of health service providers? (i.e. openly and clearly explains health issues, biased and not welcoming, etc.)

d. What are the hindering factors for these groups to access RH goods and services in the community?
e. Do you think these groups' needs are being addressed timely and appropriately?
f. Does the State provide enough RH goods and services for these groups?

FGD Group IV. Availability of RH goods and services during displacement and development aggression

Are RH services available during displacement and other crisis situations?

a. During times of displacement / crisis / calamity / development aggression, are there RH goods and services that are available?
b. What was your experience in accessing RH goods and services during times of displacement / crisis / calamity / development aggression?
c. Were you able to access RH goods and services in a timely and appropriate manner?

What are the challenges and barriers in accessing RH goods and services?

d. What are factors that hinder you from accessing RH goods and services during times of displacement / crisis / calamity / development aggression?
e. Do you think the state provide enough RH goods and services during times of displacement / crisis / calamity / development aggression?

C. PARTICIPANTS / ORGANIZATIONS CONSULTED

The consultations targeted a maximum of fifty (50) participants. To make the consultation as inclusive as possible, each Region was encouraged to ensure the participation of at least:

- 2 IP Organizations/Individuals;
- 2 PWD Organizations/Individuals;
- 2 Women's Organizations/Individual Advocates;
- 2 Men's Organization/ Elderly or individuals;

- 2 Youth Organizations or Individuals;
- 2 LGBTI organizations or individuals.

Considering that the consultation covered issues of women in the 'informal sector', rural women, Moro women and LBTs, efforts were made by the Regions to invite these sectors. Women with experiences on displacement and development aggression were also invited.

To keep the discussion open and to encourage stakeholders to speak their minds freely, the consultation solely focused on COs, CSOs, RH advocates and the Regional Offices were instructed not to invite government health providers. However, some volunteer health workers and service providers like CSOs working on RH were invited.

All in all, a total of **551** participants attended the consultations:

Table 2. Number of Participants per Region

REGION	NO. OF PARTICIPANTS
NCR	46
CAR	41
Region 1	40
Region 2	22
Region 3	45
Region 4	42
Region 5	30
Region 6	28
Region 7	22
Region 8	33

REGION	NO. OF PARTICIPANTS
Region 9	42
Region 10	40
Region 11	22
Region 12	49
CARAGA	49
TOTAL:	**551**

While the reports of the respective Regional Offices noted the participation of representatives from women's and men's organizations and individual advocates, IPs, PWDs, LGBTs, Senior Citizens, and Youth Organizations or Individuals, only a few provided a detailed breakdown of the participants, hence, information is very limited. A summary of the breakdown of participants for Regions I, II, IV, and CARAGA are in Table 3.

Table 3 – Breakdown of Participants

Indigenous Peoples	Moro Women	LGBTI	PWDs	Elderly	Men/ Men's Orgs	Youth	Total No. of Participants	REGION
		2	2	1	2	3	40 (10 BHWs, 10 from CSOs; 9 are government workers)	I
5 (2 are also youth)	3		4 (2 deaf)	1		3	22 (19 females; 3 males; 3 government workers; 2 from the rural sector, 1 from academe)	II

Indigenous Peoples	Moro Women	LGBTI	PWDs	Elderly	Men/ Men's Orgs	Youth	Total No. of Participants	REGION
4		5		5	2		27 (respective sectors were not identified for some)	IV
4	2	8	2		2	4	34 (others are NGO members, IDPs)	CARAGA

For the others Regions, there is limited information regarding the participants, with some even failing to indicate the number of individuals and organizations participating in the consultations.

- **National Capital Region (NCR)** - 33 participants, representing the IPs, PWD, Women, Men, Elderly, Youth, and LGBTIs.
- **Cordillera Administrative Region (CAR)** - 41 participants representing the abovementioned sectors. In addition, representatives from the informal women's sector; health workers of Pacdal, Irisan and City Camp Proper; and personnel from the Department of Health (DOH) and Population Commission (POPCOM) were also present.
- **Region 2** - Aside from those indicated in Table 2, the following also participated in the consultations: 5 women from the rural sector who are also among the persons affected by displacements; representatives from Regional PWD Federation; PWD and Women With Disability – Solana Chapter; members of the indigenous groups Bannag Tribe, Gaddang Tribe from Paracelis, Mountain Province, and Agta Association in Agugaddan, Peñablanca.
- **Region 4** - 27 participants; 4 identified themselves as members of the indigenous groups; 5 as belonging to the LGBT community; 2 are men; and 5 are from ages 60 onwards.

- **Region 5** - 29 participants from the women's sector, including women's rights and RH advocates, women in the informal economy, urban poor, PWD, migrant women, youth, women affected by disaster and/or development aggression, and representatives from non-government organizations and academe.
- **Region 6** - participants from LGBT community, IPs, particularly from the A*ti* tribe (5), and *Aklanon Bukidnon* (3), women's rights advocates, PWDs, religious sector, youth sector, minority groups (specifically from Sicogon Island, Carles and Libacao and Madalag, Aklan), and senior citizens.
- **Region 7** – among the participants are representatives from BISDAK Pride, Lihok Filipina Foundation, LGUs, Bantay Banay, LAW Inc, and 2 PWDs.
- **Region 9** – the participants included members of the LGBT community and IDPs Silsilah, Moro women, PWDs, senior citizens and the Head of the Office for Senior Citizens Affairs, IPs, youth including representative from Boses ng Kabataan, Barangay Health Workers, men's representative and a Department of Health personnel.
- **Region 10** – representatives from various organizations (indicated in Table 2) and representatives from regional offices of DOH, DILG, DSWD, PCW, National Youth Commission, City Health Office, and Population Commission.
- **Region 12** – representatives from various organizations (see table 2).

LIST OF ORGANIZATIONS CONSULTED

Among the organizations listed by some of the Regional Offices are:

Table 2. List of Organizations Consulted

ORGANIZATION	REGION
• Igorota Foundation, representing indigenous peoples groups • Tebtebba, representing indigenous peoples groups • Indigenous People's Movement • BUMTOVI, representing People with Disabilities (PWDs) • KALIPI • Save our Women • Pilot Barangay Women's Organization • Episcopal Women's Association, all representing • Women's Group of Gibraltar, Baguio City representing the Informal Women's Sector. ERPAT and Post Phil, representing the Men's Organization • BARP-Benguet representing Senior Citizen's Group • FBASECA representing Senior Citizen's Group • Baguio City Center for Young Adults (BCYA) • National Youth Commission (NYC) • Department of Health (DOH) and Population Commission (POPCOM) representing the Regional Line Agencies.	IV
Some of the organizations mentioned in Regions II & VII (the list is not exhaustive as a complete list was not included in the reports) • PWD and Women With Disability – Solana Chapter • Regional PWD Federation • Agta Association in Agugaddan, Peñablanca • BISDAK Pride, Lihok Filipina Foundation, LGUs, Bantay Banay, • LAW Inc,	II & VII
• TISAKA (TINGOG SA KASANAG, Indigenous Peoples - Mandatory Representative, • Persons with Disability Affairs Office(PDAO), • DAMOR (Deaf Association of Misamis Oriental, Inc) • Federation of Cagayan de Oro Urban Poor Organization,	X

ORGANIZATION	REGION
• Oro Youth Development Council (OYDC) • People Like US – PLUS CDO, • Kagay-an PLUS Inc. • Calamities and Disaster Sector (IDP) • Misamis Oriental Cagayan de Oro Aids Network, • BALAOD MINDANAW • AMNESTY INTERNATIONAL – CDO, • YouRHealth • PILIPINA • THE SAMDHANA INSTITUTE • National Service Training Program (NSTP), Xavier University- Ateneo de Cagayan • University	X
• Health Organization for Mindanao (provides medical and psychological assistance to the vulnerable population of Mindanao especially in ARMM region during emergencies) • Kalipunan ng Liping Pilipina (Kalipi) • KAAGAPAY OFWRSC Inc. (servicing the needs of OFWs abroad and returnees including its families, relatives and friends) • Kagkalimwa – federation of OFW Organizations • United Youth for Peace and Development (UNYPAD) • United Youth of the Philippines-Women, Inc. (provides assistance to women who are subjected to violence, sexual and physical abuses, trafficking and other forms of discrimination) • Men Opposed to VAW Everywhere (MOVE) • Mindanao Tri-People Women Resource Center (MTWRC) • Kadtabanga Foundation for Peace and Development Advocates Inc. • Office for Senior Citizens Affairs	XII

II. LEGAL FRAMEWORKS

A. CEDAW

The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) was adopted by the United Nations General Assembly in 1979. Described as the International Bill of Rights for Women, CEDAW contextualizes the neutral human rights standards found in previous instruments such as the Universal Declaration of Human Rights (UDHR), to the situation of women. The general premise of eliminating discrimination is stated in its preamble. It then highlights the different areas that specifically affect women.

CEDAW specifies 12 sites of gender discrimination and the state obligations to address these. Among the common areas of discrimination are education, employment, health, and political participation. Article 12 of the Convention, for instance, seeks to eliminate discrimination in the access to health care for women, and underscores the necessity for appropriate, gender-specific healthcare services such as those related to pregnancy, and post-natal period.

For the purpose of monitoring the progress made in the implementation of CEDAW, a Committee on the Elimination of Women was established. States-Parties to the Convention undertook to submit to the UN Secretary-General, for consideration by the Committee, a report on the measures adopted to give effect to the provisions of CEDAW.

The Philippines signed the CEDAW in 1980 and was the first ASEAN country to ratify it in 1981. Since then, it has submitted reports to the CEDAW Committee and has been subject to periodic reviews.

For the next reporting, the report will focus on the issues as identified by the CEDAW Committee in the List of Issues Prior to Reporting (LOIPR), summarized below as follows (The complete LOIPR is in Annex "A").

- Access to justice and legal complaint mechanisms

- National Machinery for the advancement of women
- Temporary special measures
- Gender stereotypes
- Violence against women
- Trafficking and exploitation of prostitution
- Participation in political and public life
- Education
- Employment
- Health
- Women with disabilities
- Indigenous and Muslim women
- Rural women
- Natural disasters and climate change
- Marriage and family relations

The report will likewise have a special focus on reproductive health rights particularly of marginalized groups.

B. MAGNA CARTA OF WOMEN

The Magna Carta of Women (Republic Act 9710) is the most comprehensive Philippine legislation upholding women's rights. It provides legal basis for the enforcement of specific civil, political, economic, social and cultural rights of women. Enacted in 2009, it is described as the Filipino women's bill of rights.

As the fulfillment of the Philippines' commitment to CEDAW, the MCW prohibits discrimination against women by recognizing, protecting, fulfilling and promoting all human rights and fundamental freedoms of Filipino women. It reiterates the duty of the State, as the primary duty-bearer, to protect women against discrimination and violation of their rights, and to promote and fulfill their rights in all spheres.

Among the provisions of the law are: protection of women from all forms of violence; provision of humanitarian assistance to women affected by disasters, calamities, and other crisis situations; affirmative actions to accelerate women's participation in all spheres of society; elimination of discrimination in education, scholarships, training, sports, military, and media. It also enumerates the rights and empowerment of women in marginalized sectors, defined as those disadvantaged, or vulnerable persons or groups. This includes small farmers and rural workers, fisherfolk, urban poor, workers in the informal economy, migrant workers, indigenous peoples, Moro women, children, senior citizens, persons with disabilities, and solo parents. Provisions are also included for women in especially difficult circumstances (WEDC), including victims and survivors of sexual and physical abuse, illegal recruitment, prostitution, trafficking, armed conflict, women in detention, victims and survivors of rape and incest, and other related circumstances.

With respect to health, the law highlights the state's obligation to provide for a comprehensive, culture-sensitive, and gender-responsive health services and programs covering all stages of a woman's life cycle, and which addresses the major causes of women's mortality and morbidity. Section 17 of the law enumerates the services that need to be provided: maternal care; family planning; youth sexuality education; prevention and management of reproductive tract infections; infertility and sexual dysfunction; services for women and children victims of violence; and care of the elderly women.

The law underscores the obligations of the State, its agencies and instrumentalities, and local government units, to implement its provisions. The Commission on Human Rights, as the Gender and Development Ombud, is mandated to, among others, monitor the development of indicators and guidelines to comply with the duties related to the human rights of women, establish guidelines and mechanisms to facilitate access of women to legal remedies under the law, and enhance the protection and promotion of the right of women, especially marginalized women.

C. THE RESPONSIBLE PARENTHOOD AND REPRODUCTIVE HEALTH ACT

The Responsible Parenthood and Reproductive Health Act of 2012 (Republic Act 10354) or RPRH Law gives a special focus on the reproductive health rights of women. It underscores the state's obligation to provide universal access to medically-safe, non-abortifacient, effective, legal, affordable, and quality reproductive health care services, methods, and commodities; and to eradicate discriminatory practices, laws and policies that infringe on a person's exercise of reproductive health rights.

The law enumerates the elements of reproductive health care, as follows:

1) Family planning information and services which shall include as a first priority making women of reproductive age fully aware of their respective cycles to make them aware of when fertilization is highly probable, as well as highly improbable;
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 (RTIs), HIV and AIDS and other sexually transmittable infections (STIs);
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) Reproductive health education for the adolescents; and
12) Mental health aspect of reproductive health care.

The law highlights the need to ensure effective partnership among national government, local government units (LGUs) and the private sector in the design, implementation, coordination, integration, monitoring and evaluation of programs that enhance the reproductive health of the people. It also stresses the obligations of the DOH and the LGUs to give effect to its provisions.

III. RESULTS OF THE REGIONAL CONSULTATIONS ON CEDAW AND MCW

A. Women's Access to Justice and Violence Against Women

1. Awareness of the laws protecting women and children

Most of the participants in the various regions are not aware of the laws on women and children such as MCW, Anti-VAWC, Anti-rape, and Anti-trafficking laws. Group discussions in NCR, CAR, Regions 6, 7, 9, 11, 12, and CARAGA (53.33% of the regional FGD's) yielded the observation that women are not fully aware of the laws or provisions that protect them and their children. In Region 7, for instance, it was estimated that only 10% of the Cebu population are aware of women's laws.

Some of the responses in the different Regions are as follows:

- **CAR** – Women are not fully aware of the laws or provisions that protect them and their children unless an incident happened. They do not know where to go and where to seek help or assistance about their condition. Some local government employees are aware of the existence of the law but they lack orientation.
- **Region 6** - There is lack of awareness because there is lack of information dissemination. VAW is not given emphasis in the local level.
- **Region 9** - Services and Laws in cases of women's discrimination and violence against women are not well-known to the group.
- **Region 11** - Not all the people of the community are fully aware of laws/provisions that protect women, especially the participants from Davao del Norte and Davao del Sur.
- **Region 12** - Women, especially IPs and those living in the far-flung areas are not fully aware of laws such as anti-VAWC and MCW.
- **CARAGA** - No, they are not aware.
- **NCR** – Not aware.

Lack of information dissemination. The groups cited lack of information dissemination as a major cause for the limited awareness of the communities on the relevant laws. In CAR, it was observed that despite the clarity of the law, problem arises because of the ineffective and inefficient information dissemination. Even local government employees, who are aware of the existence of the laws, lack orientation, important updates, and knowledge of implementing rules.

Lack of awareness is more severe in remote areas. Participants from Regions 10 and 12 point out that women, especially IPs and those living in the far-flung areas, are not fully aware of laws such as anti-VAWC and MCW. As observed by a participant from CAR, even NGOs and other independent advocates against VAW rarely go to remote rural areas to conduct awareness-raising activities.

In Region 7, it was recommended that barangay legal clinics and paralegal trainings be undertaken to improve community members' awareness of relevant laws. This was also suggested in NCR, where participants claimed that any awareness they have on VAW and discrimination was obtained through internet and television, and seminars are necessary to enhance their knowledge.

On the other hand, participants from Regions 1, 4, 8, and 10 representing 26.66% of the regional FGDs, claimed that in general, they are aware of the relevant laws in cases of VAW, enumerating laws such as Anti-Violence against Women and Their Children Act of 2004 (RA 9262); (2) Anti-Trafficking in Persons Act of 2003 (RA 9208); (3) Special Protection of Children against Abuse, Exploitation and Discrimination Act of 1992 (RA 7610); (4) Magna Carta of Women (RA 9710); (5) Anti-Sexual Harassment Act of 1995 (RA 7877); (6) Anti-Child Pornography Act of 2009 (RA 9775); (7) Anti-Rape Law of 1997 (RA 8353); and (8) the proposed House Bill "An Act Penalizing Discrimination on the Basis of Sexual Orientation or Gender Identity".

They cited attending seminars, barangay forums, radio and TV programs, as the means by which they acquired information, specifically in Region 8. Still, it was stressed that while they have general knowledge about the laws, they need more detailed information regarding the provisions of the laws.

2. Awareness of community services to address/respond to VAW and discrimination

Participants in many of the Regions claim that people know or at least have an idea of the services available within their communities in cases of VAW. Group discussions in NCR, Regions 1, 5, 8, 9, 10, and 11 or 46.66% of the FGDs, showed that people, in varying degrees, know what to do or where to go if they experience or witness cases of violence and discrimination.

However, even within regions, the levels of awareness vary across different municipalities or cities. In Region 11, residents from Davao City are aware of services in the community to address or respond to VAW and discrimination, although some challenges remain, such as the continuing discrimination against prostituted women/children. However, in other municipalities, they do not know where to access services in terms of VAWC and discrimination against women. The data from NCR is limited to the experience of Quezon City residents, who are aware that they can go to Quezon City Protection Center located in Quezon City General Hospital, and Quezon City VAW desk. In case they witness an incident, they also know how to assist the victim at the barangay level. For the other Regions, generally they know that there are women's desks in the barangays and police stations, and are aware of the availability of Protection Orders under RA 9262:

- **Region 1** cited the availability of Women and Children's Protection Desk (WCPD) in every Police Station; and the HRAO Desk. Victims may be referred to the Barangay - VAW Desk, PNP (WCPD), DOH, DSWD, the Courts, and CHR.
- **Region 4** - Initial actions for rape cases include the reporting to the Barangay for 15 days protection order and to the Public Attorney's Office (PAO) for the temporary protection order for 30 days. The same will apply to women and children who are victims of violence. As an initiative to inform the community on VAWC, 4Ps parent leaders conducts VAWC trainings while LGUs provides Information, Education, and Communication (IEC) materials.

- **Region 5 -** Among the services cited are: At the Barangay - Issuance of BPO, women's desk; PNP: Women's Desk, investigation; CHR: investigation & legal assistance; DSWD: shelter; rehabilitation; livelihood; CSO: microfinance; shelter; livelihood; literacy.
- **Region 8** - In general, they are aware of the laws, provisions, legal aid and other support services in VAW cases. These were obtained through attending seminars, barangay forums, radio and TV programs. However, they need more detailed information regarding the provisions of the law in relation to VAW

- **Region 9** - The group is also aware that in VAW cases, women's desks are open for the victims especially Police Offices, Barangay Halls and other offices. These cases shall be dealt in accordance with the mechanisms per office. For example, in the Department of Education, concerns and issues can be reported through Grievance Machinery. Alternative Dispute Resolutions are also taken into consideration if the issues can still be resolved thru the Mediation Committee.
- **Region 10** - Generally, participants are aware of services in the communities to address VAW and discrimination. They know where to seek protection but this is hampered by the lack of financial support for indigenous peoples and also urban and rural poor for case build up in gender based violence cases (particularly in Cagayan de Oro City).

On the other hand, in a significant number of areas, the people are not aware of the services and do not know what to do in cases of VAWC. This is especially true for women in hinterlands or far-flung areas, as noted in Region 12. For IPs and PWDs, they encounter difficulties in accessing services due to the absence of interpreters. Some of the VAW desks have been characterized as not functioning, specifically in Regions 6 and 12. As mentioned above, in many areas in Region 11 except Davao City, they do not know where to access services in terms of VAWC and discrimination against women. In CAR, it was categorically stated that women do not know where to go and where to seek help or assistance in VAW cases, and that information dissemination is not effective and efficient. In CARAGA only an estimated 25% are able to access legal aid and other support services.

3. Prevalence of VAW

While there are claims that cases of VAW are rampant and are increasing, the participants could not provide an estimate of the number of VAW cases within their areas. This is either because they do not keep track of the number of incidents, or there are no deliberate efforts to keep records of the cases in their barangay, or most of the cases are unreported or undocumented. With the exception of Regions 1, 7, and 11, the Regions reported that they cannot ascertain the number of VAW cases within their communities.

Failure / Refusal to report abuse. Aside from the limited awareness of VAWC laws, remedies, and services available to women as mentioned above, one reason cited for the lack of information on the prevalence of VAW is women's hesitance or refusal to report abuse. In CAR for instance, it was shared that women victims of abuse tend to keep their sufferings to themselves for the following reasons:

- **Desire to keep the family intact**: Women want to keep the family intact notwithstanding the fact that they suffer violence or abuse inside their homes. These abuses may be physical, psychological, emotional, or economic. The main perpetrator of these abuses is their husband or partner. With this kind of culture, women tend to keep their sufferings to themselves and pretend that it will not happen again. Moreover, these abused women let the abuse pass and get used to it. They always thought that it was their fault why they are abused. This is evident on the perception of men seeing women as naggers. Also, women are fearful of how powerful or dominant their perpetrators are and how such experience affects their children emotionally and psychologically.

In Region 8, some VAW cases are undocumented due to the fact that victims refuse to report the incident for various reasons like fear, anxiety, but mostly due to the high regard for the family and its unity. In addition, it was observed that victims hesitate to report cases due to lack of witnesses and evidence to support the complaint. Similarly, in **Regions 5 and 9**, among the factors that hinder women from reporting the cases include fear of family ridicule or the shame of bringing scandal to the family.

In Islam areas in **Region 11**, women reportedly do not file cases against their husbands because "God that does not want that". Also, for IPs, the "Tribu has a customary law where such cases are settled within the Tribu".

- **Wariness of the response of service providers**. Also as observed in CAR, women tend to be shy to report abuses or violence against them because the authorities are not accommodating. The personnel would sometimes treat the report or the incident as a mockery, and claim that the incident is temporary and the couple will eventually resolve their issues, which is a common occurrence as they want to preserve the family's image and reputation.

Groups from **Regions 5 and 6** also cited the insensitivity of personnel handling cases of VAW, and discrimination towards marginalized sector such as PWDs and IPs. Another specific example is cited in **Region 9**, wherein reportedly, when persons are not politically affiliated/aligned with the Barangay Captain, they will be wary of seeking help from the barangay because they know that the opposing party will be favoured. This is also echoed in **Region 5**.

- **Low level of awareness of remedies**. In **CAR**, there is a low level of awareness of services in the community to address or respond to VAW and discrimination. One of the reasons cited is the insufficiency of funds to provide the services. Among the recommendations to remedy these are: to have VAW desk in every Barangay, and training for authorities and local government officials tasked to handle VAW cases. In **Region 9**, women, especially those in rural areas, are unaware of the things they need to do after VAW is committed against them. Lack of awareness to services and laws protecting women still prevails, hence, the poorly reported cases of VAW.

- **Lack of financial resources**. Many women are discouraged from reporting cases because of limited financial resources which they will need in processing and filing cases. As mentioned in **Region 9**, although there are lawyers who handle pro bono cases, they are worried that their case will not be given enough attention because of the volume of pro bono cases being handled. In **Regions 10 and 11**, participants

lamented that while there are laws to protect women, they have no budget to support the victims, for instance for transportation and food.

"*Our government is always making laws but does not give budget. We tell our sentiments on these laws, we support these laws, we practice them, we are obedient to these laws. The problem is financial. It should not only be in writing, we should be provided financially*." – a participant in Region 11.

In Regions 1, 7, and 11, the data on the prevalence of VAW is as follows:

- **Region 1** - As of CY 2015, there are 589 cases of VAW broken down into different cases particularly Rape cases. (Based on the data received by WCPD).
- **Region 7** - An average of 48 VAW cases were observed per month (it is not clear if this is an average per barangay/municipality/city).
- **Region 11** - There are about 50 reported cases of VAW in Brgy. Limbaan (since early 200)s) and these cases are not sufficiently addressed to the court, only to the police (not all) and to the barangay council/purok. There is a high rate of VAWC but they do not file it in court.

In 7 barangays of Davao City, there are 105 reported rape cases (vulnerable children), 20 cases of sexual abuse in prostituted women and children (VAWC, trafficking)

In Brgy. Matiao there are 20 reported cases that are sufficiently addressed in barangay but not in national agencies. Rape cases cannot be addressed in barangay and should be reported to the police.

4. Sufficiency of responses to VAW victim-survivors' issues / claims

When cases are properly reported, seven of the fifteen Regions or 46.66% (NCR, Regions 1, 5, 7, 9, 10, 11) asserted that the claims of the victim/survivors are addressed sufficiently: in NCR, through Barangay and Social Welfare workers; in Region 5 through the barangay and Courts, and partially by the Police; in Region 7, through NGOs; and in Region 9, by the Police, Barangay Government Units, and Social Welfare and Development

Offices. In **Region 11** particularly in Davao City, there are institutions such as Sidlakan where VAWC victims can go, and Balay Dangupan in Cabantian for children victims of rape.

In **Region 11**, it was claimed that the Barangays assist by issuing Barangay Protection Orders (BPO). The problem is the victims, especially those belonging to low-income families, would often go back to their spouses due to economic reasons. Because they are worried of how to feed their families, they are forced to go back to their spouses, and the abuse then continues.

For other Regions, responses to VAW cases have been insufficient. Several issues on the accessibility of protective services were cited. For **Region 4**:

- Newly elected officials are unaware of the procedures due to lack of information. Capacity building for government officials in handling VAWC cases should be given due attention.
- There are no free interpreters that can assist PWDs whenever cases are filed at the PNP or barangay level. It is only the court that provides interpreter. This problem affects the ability of the child/PWD in expressing themselves.
- Issues of LGBTs are not addressed appropriately; services are concentrated on VAWC.
- Delays in the resolution of the case cause victims to lose interest. Long process of case hearings, postponements of hearing sometimes trigger clients to enter into settlements because of loss of interest on the case.

The other concerns raised were:

- Lack of sensitivity of the police and others personnel handling the cases; treating the case as a mockery; Lack of qualified and trained personnel to handle the case. (CAR, Regions 5 and 6).

- Financial constraints, lack of financial support for the victims during the pendency of the case – e.g. for transportation, food. (Regions 9 and 11)

5. Marginalized women's access to justice and quality services

In the various Regions, there are many instances in which marginalized women are denied equal access to justice and quality services. The following are among the issues raised:

- **PWDs** - There are no free interpreters that can assist PWD whenever cases are filed at the PNP or barangay level. It is only the court that provides interpreter. (Region 4)
- **LGBTs** - Most of the gender-related services are concentrated on VAWC and put little emphasis on LGBT issues. Some of the municipalities have not yet incorporated the LGBT concerns in their respective GAD plans. It was suggested to pattern the municipal GAD plan of other localities with that of the Laguna GAD Plan. (Region 4)
- **OFWs** - Lack information on how or where to access financial assistance (Region 7)
- **Women in rural areas and in upland barangays** - The victims, especially those in rural areas, do not have sufficient access to protection and support services from the communities because they are unaware of what to do in cases of violence committed against them (Region 9)
- Many women victims-survivors in upland and hinterland barangays could not access justice and other services because of lack of financial support for transportation. Services such as psycho-social services for indigenous women are lacking. (Region 10)

It is to be noted that participants belonging to the Manobo indigenous group in Region 8 asserted that they do not consider themselves disadvantaged because they feel equally treated by other people.

Access to services and programs for rehabilitation. In terms of access to quality services, many VAW victims-survivors do not have access to services that would enhance their chances of surviving and rebuilding their lives. Participants from **Region 7,** for instance, pointed out that marginalized women lack support services such as the

provision of shelter and programs for women's rehabilitation, as well as financial assistance for their livelihood and economic empowerment. An example of support needed cited in **CAR** is the provision of loans without collateral to assist women in their livelihood.

Similarly, in Region 6, the following concerns were raised:

- There is no available "crisis center" for abandoned and abused women.
- Even where there are crisis centers, there are no diversion programs for VAW victim-survivors to prepare them for their livelihood independence from their abusers.
- There is a dearth of employment opportunities offered to women VAW victim-survivors.
- Lack of counselors and psychologists to help victims cope with what they've gone through.

An important issue raised in **Region 10** is that even where there are shelters, victims-survivors are not willing to stay long because they have to attend to their families. There needs to be an adequate support system for these women.

Although they did not specify the particular issues faced by marginalized women in terms of accessing justice and quality service, participants from **CAR** and **Region 8** also asserted that marginalized women do not have equal access to services. In Region 8 specifically, it was observed that some women are denied access to services based on their socio-economic status, physical appearance, and "networks".

The "padrino system" / political affiliation factor. One of the most cited issues that hinder women from seeking justice or protective services is the "*kilala-kilala*" system or "*padrino*" system, specifically in NCR, Regions 5, 8, and 9, and CARAGA. Participants relayed that only those who know someone in the health center, office or facility will be able to access services. Connections or political affiliations serve as crucial factors in terms of who will be assisted by LGUs and offices. In NCR, many hesitate to file cases even in the barangay level because only a selected few are extended help ("*kadalasan sa*

barangay ay namimili ng tinutulungan"). In Region 8, it was alleged that even in cases of distribution of Philhealth cards, only selected beneficiaries were able to avail of the card, chosen based on their political affiliations.

Thus, it is not surprising that many of the participants do not believe that the legal system provides proper justice/protection for all regardless of gender, social status, financial capacity, education, among other factors. In NCR, it was asserted that not all who seek assistance are helped by the authorities. In other areas:

- **CAR** - The legal system does not provide proper justice or protection regardless of gender, social status, financial capacity, education, and others. There are certain complainants who are not immediately informed about the outcome of the case. There is a low level of persuasion to the victims to fight for their rights because they lack faith to the justice system and other personal reasons.
- **Region 10** - The legal system does not provide proper justice given the lack of coordination between the agencies. In a rape case, the victim-survivor first went to the barangay hall where she was told to go to the police women's desk and from there was told to go to the hospital where there was no doctor do medical examination or assistance.

B. <u>Issues of Marginalized Women</u>

The marginalized women enumerated by the groups are:

- Indigenous Peoples (IPs)
- Moro women
- Persons with disabilities (PWDs)
- Victims-survivors of VAWC,
- Women who are engaged in commercial sex work / Women in prostitution / Women working in night clubs
- Lesbians, Bisexuals, Transgenders (LBTs)
- Senior citizens / the Elderly
- Youth sector / Young or teenage mothers,
- Solo mothers or parent

- Migrant workers and their children
- Street Children
- Women in the informal economy (e.g. house helpers, market vendors)

ISSUES OF MARGINALIZED WOMEN

Indigenous Women

The Regional FGDs highlighted the different forms of discrimination experienced by Indigenous women in the country. Issues faced by indigenous women were discussed and covered by 11 out of the 15 regions, or 73% of the FGDs.

- As commonly observed in most of the Regions, indigenous women cannot easily access basic social services such as health, education, employment and vocational opportunities due to their isolated location (i.e. specifically mentioned in CAR, Regions 3, 5, 6, 9, 11, 12, CARAGA, or 53.33%).

    - Women from the Aeta communities in Region 3 live in the mountains, and usually do not have access to health and social services. A pregnant woman living in the mountains is deprived of the basic services needed for her to give birth safely to a healthy child because of the distance. In CAR, although there is an ordinance in some areas prohibiting pregnant women from giving birth at home and seeking the services of traditional "hilot" because the State provides for healthcare and labor facilities, women still resort to giving birth at home with the help of "hilot" due to distance to the facilities.
    - The Agtas in Peñablanca (Region 2) and most of the IPs in the others regions do not have access to schools. Hence, instead of going to school, many children are working at an early age, and only using skills passed on to them by their parents.
    - Before they reach the barangay hall, government agencies or NGOs that can provide the services they need, they have to travel several mountains and rivers (Region 11)

- As in the case of IPs in Libacao, Aklan, majority of the members and their children are not registered in the civil registry. This makes it difficult for the government or concerned agencies to cater to their needs or monitor whether services are being provided to them.
- They encounter difficulties in finding employment. The Aetas, for example find it hard to get a job because "they are pre-judged or stereotyped that they know little about new technologies".
- Some offices also implement programs that are not appropriate to the needs of the IPs. As pointed out by participants from Region 9, "*why would Badjaos be taught of carpentry when they excel in fishing*?" Job opportunities should be given to them depending on their adapted skill.
- Badjaos are observed to be begging off the streets. They require financial assistance as well as improved livelihood. (Region 7).

- IPs do not have access to information regarding laws and services that can help them.

Moro Women

In 7 of the 15 regions, or 46.66% of the regional FGDs (CARAGA, Regions 2, 3, 7, 9, 11, and 12), issues faced by Moro women within their homes, in their communities, workplace, and other institutions, were highlighted.

- Moro women face various forms of discrimination even within their own communities and families, but many of them do not complain because they have been brought up believing that they are "lower than men" or *"ubos sa laki"* (Region 7)
- Lack of education and livelihood opportunities for Moro women and the younger members of the workforce have been noted. Most teenagers in the Muslim community are out of school and would rather work to earn money for their family than go to school. (Region 2)
- Discrimination and stereotypes, including labelling them as terrorists (Regions 3, 9). For example, in Region 9, some employers in malls and stores refuse to hire

Muslim women wearing Hijab because they fear that customers will be discouraged from buying in their shops. Fortunately, the newly-opened mall, KCC, is now hiring Muslim women wearing Hijabs.. In addition, a teacher questioned the help given to the Muslim victims of the Zamboanga Siege, saying that the Muslims are behind the attack.

- Moro women cannot easily access business permits (*so sometimes, they ask help from Christian friends to process business permits*) (CARAGA)
- Insensitivity to their culture and practices. Some establishments require Moro women to wear short skirts as uniform, which is contrary to their traditional attire. Women who wear *niqab* and *hijab* are discriminated. (Region 12)
- PhilHealth benefits on pregnancy and childbirth is inadequate because it covers only up to four childbirths per woman. Moro women are not allowed to discontinue having children by using contraceptives, hence, many of them can go beyond four childbirths, and will no longer have any benefits. (Region 2)

Persons with Disabilities

In 11 of the 15 Regional FGDs (73.33%), the plight of women with disabilities have been subject to discussion, all highlighting the serious issues of accessibility, neglect and other forms of discrimination.

- Authorities lack data management regarding population of PWDs which makes it very difficult for them to respond to their problems, issues, and necessities. (CAR)
- PWDs have difficulty in accessing social, health and education services, as well as information about the availability of such. Most of the PWDs families do not have easy access to information that will help this group of people to avail free services from the government. (Region 3)
    - Difficulties in communication and lack of interpreters are hindrances to reporting in cases and accessing justice for sexual abuse and discrimination. Some deaf women hesitate to report rape. (Region 10).

    - There is lack of sign language interpreters and facilities (i.e. ramps) for PWDs in Women's Desks, hospitals, court rooms, etc. (Region 2)

- In relation to reproductive health, there is a lack of PWD-sensitive health facilities and service providers. (CAR)
- Interpreters are also needed in visiting health centers. Deaf women lack access to information on HIV, which is why many engage in unsafe sex. Because audio announcements are used for making barangay services known in the communities, many deaf persons miss out on information and access to reproductive health services. The same radio announcements are used for information about calamities. (Region 10)

- Lack of employment and livelihood opportunities for PWDs despite having finished college, and even if they are employed, they are subjected to discrimination. For deaf people, employers immediately think communication will be impossible. A participant in Region 11 noted that 85% of deaf mutes are unemployed. In Region 9, a woman with crutches was questioned not just about her performance but also her ability to handle unavoidable emergency cases like fire since she was with crutches. The employers tend to be doubtful of their capabilities regardless of educational achievements. (Also highlighted in Regions 2, 3, 6,9, 10, 11).
- Difficulty in accessing education. Schools lack interpreters for deaf students which hampers the provision of inclusive education. Many schools do not have PWD friendly facilities such as ramps or hand rails. Some PWDs who are enrolled in school become victims of discrimination and bullying (Region 3, 10, 11)
- In Region 2, participants lamented the absence of higher education institutions for the Deaf. In Cagayan Province, there is no school offering college degrees for the Deaf. The nearest is in Isabela, but not all Deaf can afford to go there. This explains the large number of Deaf who are not in school.
- Specifically to women who are mentally ill, it was noted in Region 6 that there is not enough shelter for women who are mentally ill and street children, thus, they are easily subjected to sexual abuse. Some of them even get pregnant.
- In Region 3, non-issuance of Philhealth cards to PWDs has been noted. In Region 9, it was noted that PWDs need to renew their PhilHealth, membership every after one or two years, unlike the lifetime membership of the Senior Citizens.

- A participant from Region 10 also expressed disagreement on the practice of certain European countries sterilizing women with disabilities to prevent them from being pregnant, saying that this is a violation to the right to self-determination and the right to life.

VAW victims-survivors

The issues faced by women victims-survivors of violence are all enumerated in part I.

Prostituted Women

Five of the 15 regional FGDs (33.33%) covered discrimination experienced by prostituted women. The five regions discussed the vulnerability of women engaged in sex work and connect their situations to trafficking and to development aggression.

- Some of these women are victims of human trafficking. Women who are mired in poverty and come from remote areas are targeted for recruitment supposedly for work in the cities only to be trafficked or forced into prostitution. Because of lack of other options, they stay in prostitution and suffer all kinds of abuse and discrimination. (Region 10)
- In Region 12 / CARAGA, mining is a crucial factor leading women into prostitution.
- They are vulnerable to physical and other kinds of abuses. (CAR)
- They have limited access to health and social services, including free medicines, STD/HIV testing, general check-ups.
- When they complain about abuse and assault by their clients, police do not entertain them (Region 10)
- They have high risk of acquiring sexually transmitted diseases and infections, HIV, and AIDS due to the nature of their work. (CAR)
- They are vulnerable to exploitation - they are underpaid or not paid at all, only their handlers benefit from them. (CAR)
- Women who wish to get out of prostitution lack employment opportunities or face employment discrimination (Region 10)

- The women working in night clubs are immediately stereotyped as prostitutes. (Region 6)

Lesbians, Gays, Bisexuals, and Transgenders (LGBTs)

Various forms of discrimination against LGBTs have been noted in 10 out of the 15 Regional Consultations (66.66%), including discrimination within their homes, schools, and government facilities, as well as ridicule and lack of prioritization in accessing government services.

- LGBT issues are not prioritized in many LGU programs on gender, resulting in failure to address their specific issues. For instance, LGBT concerns are not yet incorporated in the GAD plan of the Municipality of Nagcarlan (Region 4).
- There are no specific programs for VAW for LGBTs who are victims of violence. Furthermore, there are no programs at all for transgender women and men, and for lesbians who are not victims of violence.
- Service providers often do not address their concerns appropriately. For instance, they encounter discrimination in filing complaints. In one case (Region 10), the police berated a victim-complainant of a mauling incident who is gay, telling the victim that he deserved what happened to him because he is gay.
- LGBTS are bullied and discriminated against solely because of their gender. Regardless of whether they dress appropriately or not or act appropriately or not, people still disrespect them (Region 8).
- Various cases of discrimination have been noted in Region 10: A public school elementary student who self-identified as a boy and dressed as such - was humiliated by the school principal by forcing the student to parade around the campus wearing a window curtain as a skirt, stressing that the student was born female and thus must dress as a girl; A transwoman who was told to cut her hair short so she could get a job; A security agency which tried to layoff all its lesbian security guards/employees.
- Lack of family acceptance, and discrimination even from family members.
- Street bullying against LGBTs (name-calling, throwing rocks at them, hate crimes).

- LGBTs have no concrete livelihood program which sometimes causes them to engage in prostitution. (Region 7)
- Need for protection for the "joint" properties of LGBT couples (Region 10)
- Lack of information / awareness on HIV/AIDS.

Senior Citizens / The Elderly

The key issues that senior citizens are facing were underscored in 7 of the 15 regions (NCR, CAR, Regions 1, 2, 6, 7, and 9), comprising 46.66% of the regional FGDs. Most of the issues are related to their health needs, problems in accessing the benefits they are legally entitled to, and in using their Senior Citizen cards.

- Senior Citizens are confronted with issues concerning their health, and the need for a comprehensive health care, facilities for geriatric care, and other necessities. There is also lack of education on management of menopause and andropause. (CAR)
- Lack of awareness on the benefits they are entitled to. For the Moro community in particular, some Senior Citizens are holders of IDs but they lack knowledge on the extent of their benefits.
- There are issues concerning the use of their Senior Citizens ID cards. In buying medicines, for instance, some of them wonder why drugstores still ask to see their papers despite being on their second purchase of certain medicines. Others also experience getting turned down by drugstores and are immediately told that the medicines they need are not available. (Region 2)
- Their 20% discount is not strictly implemented. Some Senior Citizens even experience discrimination – for instance, tricycle drivers refuse them because of their fare discounts. (Region 2)
- It has been suggested that health cards for Senior Citizens and PWDs should be free. (Region 2)
- Social pension is not properly implemented. Some of those entitled to it do not receive the benefits de them. (Region 6)
- Senior citizens need financial assistance as well. They also have difficulty acquiring a job because of age discrimination. (Region 7)

Youth / Teenage Mothers

Participants in 6 of the 15 regions (40% of the regional FGDs) raised issues specifically confronting the youth. Teenage pregnancy is a key problem, which is related to the lack of information on sexuality and reproductive health.

- Lack of access to information and guidance make the youth vulnerable to early pregnancies. Fertility management and family planning are not openly discussed in school or in their own homes. The implementation of adolescent reproductive health is limited. Some teenagers hesitate to open up to their parents regarding this issue. (NCR, CAR, Region 3)
- For the teenage mothers, they lack support system which makes it difficult for them to go back to school and take care of their child at the same time (CAR)
- Young women who are out of school are vulnerable to drug addiction and prostitution. (Region 6)
- Children are deterred from expressing their gender/ identities even in schools due to restrictions imposed through school policies. (Region 8)
- There is a clamor for the youth sector to be represented in development or government planning councils so that their voices and opinions will be heard. (Region 2)

Solo Mothers

The issue raised with respect to solo parents is that the Solo Parent Act is limited in that it only caters to solo parents who are employed. The law is also silent when it comes to solo mothers with incapacitated children who are 18 years old and above.

Migrant Workers and their families

Specifically in CAR and Region 6, challenges faced by migrant women and their families have been highlighted.

- The children are mostly affected when mothers are away from them. They are often neglected and are vulnerable to sexual, physical, and mental abuse by their guardians. Some become pregnant in their teenage years. (CAR, Region 6)
- Migrant workers and their children are vulnerable to high risk of sexually transmitted diseases and infections.

Women in the Informal Economy

Participants from Region 5 enumerated the issues being faced by women in the informal economy:

- Greater/heavier bulk of work yet low income
- No social services/ benefits
- Low RH information
- No additional benefits
- Non-members of SSS, Philhealth, etc.
- Lack of education
- Discrimination/
- Low productivity
- Prejudices on reproductive health concerns
- Vulnerable to abuse and exploitation

In addition, Region 11 participants noted that most of these women are not aware of their benefits. Most house helpers for instance are underpaid and do not know the remuneration and benefits they are legally entitled to.

Rural women

- Most marginalized group lack access to social, health, education, employment services.
- Fisher folks lack livelihood during typhoons – it is recommended that they be given alternative livelihood when they are unable to fish due to typhoons. (Region 7)

- The beneficiaries of 4Ps do not fully enjoy the benefits because there are reports that some barangay officials claimed shares from the government's cash support. (Region 12)

Access to social, health and other services. Participants in most of the Regions claimed that it is more difficult for marginalized women to access adequate social, health and other services. There are even mentally ill women who are roaming in the streets and are often subjected to sexual abuse, sometimes even getting pregnant. Women in prostitution are refused services and are not entertained when filing complaints of abuse and assault by their clients.

Commendable Practices. Despite different barriers and issues faced by women from marginalized sectors, there are positive reports from some of the regional FGDs. In Region 2, it is reported that marginalized women and other disadvantaged groups have equal access to social and health benefits. At the PNU North Luzon for example, all their IP students are scholars of the school, some are even scholars of their own communities or groups. Vulnerable groups have access to inclusive education, employment, vocational opportunities, and social services. The Alternative Learning System (ALS) is implemented by higher institutions such as the PNU among Agtas who have no access to schools, bringing the modules to them. PNU also partners with Bombo Radyo for an educational radio program and distributes transistor radios to the Agtas so that they can tune in during the scheduled timeslot. In addition, the university provides training to IPs who are working as tour guides to improve their skills. TESDA visits the Moro community to offer training courses and vocational opportunities.

In Region 9, it was reported that Senior Citizens are now thankful for having pension under the SSS. People are also grateful for the ALS being implemented in some evacuation / transitory sites.

C. <u>Issues in Relation to Displacement and/or Development Aggression</u>

In times of natural disasters, climate change and/ or development aggression, men women, and children are all severely affected. When people are evacuated or are forced

to flee because of development projects, or during armed conflict, cessation of government services results, and thus, access to basic necessities. Families are separated, there is difficulty providing food for family members, there is loss of source of income and access to livelihood opportunities. The participants related some of their experiences related to this.

The groups identified the following as the most vulnerable during times of disasters and displacement: women, especially pregnant women, sick persons, children, senior citizens, PWDs, IPs, and members of the LGBT community.

1. Effect of natural disasters, climate change and/ or development aggression on women

Based on experiences of the participants (including during Typhoons Yolanda and Pablo, Zamboanga Siege, armed conflicts), women suffer from specific vulnerabilities in times of displacement.

Issues in Relation to Protection, Security and Gender Based Violence

- In times of disaster, women are the last persons to vacate from natural disasters/conflict area and they are usually burdened with taking care of the entire family. During floods and storms, women are faced with the problem of securing the safety of their family because there are no proper evacuation centers.
- During displacement security is the top issue for women because of unsafe environment. In evacuation centers, there is no proper classification between men and women. There is only one comfort room for men and women. Some comfort rooms have no locks and divided only with curtains. Hence, safety and security of women are compromised. Women and girls are vulnerable to sexual abuse.
- Lack of intimacy between spouses and increased sexual frustration at the evacuation center sometimes results to domestic violence including sexual abuse and marital rape.
- In times of war, women and children are harassed and sexually abused in the evacuation areas.

- During the onslaught of typhoon Yolanda, because of loss of livelihood some women became vulnerable to human trafficking and prostitution. Participants shared that some of the women who were victims of typhoon Yolanda are currently working as entertainers in Angeles City.

Food security

- During disasters such as typhoon, there is no food, shelter, water. Women and their families succumb to hunger because there is no immediate response on the part of the Government as to relief operations, especially in isolated areas. Poverty arises because of lack of livelihood. If there is no food, women would do anything for survival. There will be recruitment, trafficking, and women would enter into illegal situations just to have food.
- Specifically in Regions 10 and 4, lack of access to food and/or unequal food distribution has been noted.
- It was also noted that IPs are being discriminated in evacuation centers.

Health

- Women, children, sick people and the elderly lack medical attention. It has been observed that the government does not know how to treat bedridden women in evacuation centers.
- Yolanda devastation caused women to be subjected to severe trauma and poverty. There were no services for psycho-social interventions.

Issues in Relation to Shelter

- The need for shelter is not adequately addressed. Displaced families often find themselves in school classrooms along with many other families, where males and females are mixed. There are no adequate facilities for sanitation and other necessities for living.
- Situation in the evacuation centers does not allow for intimacy between spouses, leading to increased sexual frustration and disintegration of marital relationships.

Water, Sanitation, and Hygiene

- Even when relief goods arrive, the immediate help that is provided is food. The specific needs of women (sanitary napkins, other necessities for personal hygiene) are not addressed. There are no health care kits or dignity kits distributed to them.
- Lack of proper hygiene in evacuation centers makes it dangerous for pregnant women.
- During disasters such as typhoon, there is no food, shelter, water.

2. Effect of natural disasters, climate change and/ or development aggression on children

The children also suffer from specific vulnerabilities. Among those pointed out are:

- Disruption in education
- Children are exposed to trafficking, child labor and prostitution
- Depression, trauma, self-pity and sickness. Children are more prone to diseases in the evacuation centers. Psycho-social debriefing or rehabilitation is sorely lacking.
- Some cases where children commit crimes, turn to drugs, are noted.
- In areas of armed conflict, children are recruited as soldiers/combatant

3. VAW during armed conflict or during disasters

Although the groups could not pinpoint specific documented cases of VAW during these times, they shared that there is high incidence of trafficking and prostitution of women and girls after the occurrence of a disaster or armed conflict. In Regions 1, 4, 5, and 7, (26.66% of the regional FGDs) the participants shared that accounts of violence have been observed towards victims of calamities and displacements but many of these are usually unreported and undocumented. Consequently, these are not addressed. Prostitution, labor exploitation and early marriages occur. Reports of extrajudicial killings have been observed in Region 7. Cases of drug abuse also become widespread. In

Region 8, a participant shared that her husband became a drug user and he frequently beat her.

In Region 5, the following have been noted:

- High incidence of trafficking and prostitution of women and girls after the occurrence of a disaster or armed conflict
- Wives/partners of suspected rebels are also accused
- Presence of military detachments near schools has spawned violations of IHL (schools as zones of peace)
- Harassment of organized women's group
- Increase in robbery incidents

In certain cases of development aggression, such as the incident in Sicogon Island (Region 6), women and their families were forced to abandon their homes and livelihood. They were given options to demolish their house in exchange for a meager sum of money. If they refuse to leave their homes and heed the demands of the aggressors, they are harassed by armed men. The opposition of the community against the development aggressors would sometimes result to death. In fact, a woman was found dead and her body was mutilated. Because of the fear that the men in their family might die in the hands of their aggressors, the women would be the one to face the armed men.

In Davao City (Region 11), it is claimed that cases of violence are usually addressed, but this cannot be said of other provinces and municipalities.

4. State response and support to the communities in times of displacement/ disaster

Many of the Regions affirmed that the government provides support during times of displacement/disaster. Specifically, participants from CAR, Regions 2, 4, 5, 11, and CARAGA (40% of the regional FGDs) answered in the affirmative with respect to the question on the availability of government support. CAR, for instance, reports that LGUs are prepared for these kinds of problem because of awareness and facilities. They have

hazard maps and data base to prevent high casualties during calamities. Calamity funds are available on purchases of reliefs and other necessities of their constituents during disasters.

However, they are also consistent in saying that the support is inadequate, especially in addressing women's needs. Among the interventions needed which are highlighted by various participants are:

- Psychosocial services and support system for women and children who are traumatized by the situation.
- Separate evacuation centers for women and children.

Specifically, among the responses of the Regions are:

- **NCR** - Kulang ang suporta ng state.
- **Region 12** - During displacement, evacuation centers have limited sanitation facilities and privacy.
  - The evacuation centers have no identified women and children friendly spaces.
  - The relief assistance is not human rights responsive since relief goods do not include necessaries for women.
  - During relief distributions, there is no priority lane for pregnant, elders and persons with disabilities.
  - During displacement, women especially IPs, do not have equal access to micro-financing. This may result to illegal recruitment, human trafficking and forced labor among minors.
  - Displaced women do not have enough access to psycho-social interventions.

- **Region 10** - Psycho-social debriefing or rehabilitation is sorely lacking. Based on experience of a victim during typhoon Sendong, there was adequate provision of non-food items such as pails, dippers, etc. but in terms of food and shelter, it was inadequate. Shelters lack provision for sanitation and hygiene, conjugal spaces. There were cases where funds for rehabilitation were lost through corruption, and there were stories of "lost donations".

- **CAR** - It is a good proposal to the authorities to have separate evacuation centers for PWDs, pregnant women, men, and women with their children to have an organized and specific catering of their necessities. Since they are more vulnerable than men, women should be trained exhaustively for disaster-preparedness thru trainings form Disaster Risk Reduction Management Council (DRRMC). The LGUs should also provide support system for women and children who are traumatized because of the calamity suffered. Psychosocial services are greatly needed during these times thus government should always give such access of services to those greatly affected.
- **Region 6** - The issues as to development aggression are not properly given attention by their LGUs, thus, the people in the community would travel for long hours and spend a lot of money to ask the help of the Commission on Human Rights.
- **Region 5** - Most of the issues are addressed but the measures taken are not sufficient
- **Region 9** - For the victims of unfortunate events, such as the Zamboanga Siege and Fire, tagging is done with those in the sites but when missed and not tagged, no share of the donations is given, even if the people are also victims of crises. Though there are situations like this, those in the transitory sites are more privileged of information as compared to those in the grassroots

In Region 7, participants were firm in asserting that vulnerable groups, especially the women, have no adequate protection in times of displacement/disaster. These vulnerable groups are usually found with limited resources (e.g., food, shelter, and finances) and medical attention is few and far between.

Participants from Region 2 also lamented the lack of rubber boats and other equipment during rescue operations, and unavailability of medicines and contraceptives. In Region 4, they noted that the government provides adequate support but there are variations in the implementation of programs depending on the LGUs.

In Davao City, adequate support is provided but in other provinces, these are insufficient.

D. RECOMMENDATIONS

During the consultations on CEDAW and MCW, a few recommendations emerged:

Recommended interventions on VAW:

- **Training and information dissemination on VAW** - There should be continuous education regarding violence against women and children.

    - Authorities and local government officials particularly those designated to handle violence against women cases should be trained, and they should also be in the frontline to monitor proper implementation of Anti-VAWC law. (CAR)
    - Budget should be allocated for information dissemination and proper coordination and implementation among government agencies down to barangay level. Concerned agencies and instrumentalities should oversee the implementation of GAD funding. (CAR)
    - Monitoring is a must and there should be strong lobbying for survivors and against violators. Citizens in all communities should advocate for the promotion against violence and protection for victim-survivors. (CAR)

- **Strengthened support services for victim-survivors of VAW.** There is a need to address the absence of/or inadequacy of support services for women victims-survivors of VAW. This include not only the provision of legal, shelter, psychosocial support, but also livelihood and financial. Many VAW cases do not prosper for lack of financial, transportation support. (Region 10)
- **Monitoring of LGU compliance with the law.** There should be a VAW desk in every Barangay (CAR), and monitoring of the functionality of the VAW desks should be undertaken (Region 6). In view of the reported absence, lack of services like shelter, psychosocial and other services, monitoring of the availability, accessibility and functionality of these services, especially for the marginalized, should be undertaken.

- **Support groups.** A support group should be formed to help the victims of VAW. Moreover, there should be activities or livelihood available to them to help them move forward from the traumatic experience. It should give women just loans without collateral.

Recommended interventions for marginalized groups:

- **Awareness raising on the services available for marginalized women** (Regions 9, 2). For the IP sector who are scattered (geographically), the government or the concerned sector should bring the services to them and should provide support in the form of scholarships, health benefits, representation, employment, and equal protection.
- **Address issues of accessibility of information, processes, and mechanisms for PWDs, IPs, Moro Women and other marginalized groups.** In Region 10, for instance, interpreters for deaf women have been recommended to facilitate their access to health centers, barangay and police women's desks, and to help them access information on HIV, reproductive health, etc. LGBT desks should be provided in police stations to discrimination, which they are often faced with when filing complaints.
- **Livelihood programs for marginalized women** (Regions 1, 7). As pointed out in Region 7, LGBTs have no concrete livelihood program which sometimes causes them to engage in prostitution. It was suggested that a national program be made to address their lack of livelihood needs.
- LGBT concerns should be incorporated in every LGU GAD plan. In Region 4, these GAD plans may be patterned after the Laguna GAD Plan. Further, it was suggested that July 26 be declared as "Araw ng Kalalakihan" in the municipal GAD plans, and October 11 as Laguna Gay Day.
- There is a need to educate and empower the youth insofar as the law and prevalence of violence against women is concerned. (CAR)
- Specific intervention for PWDs were recommended in Region 9: the Department of Social Welfare and Development, through the Area Vocational Rehabilitation Center, should cater to social work intervention through comprehensive

rehabilitation services that enable the PWDs to achieve social functionality and economic sufficiency.

- **Proper consultations**. In drafting laws, proper consultation should be made so that the people will be well-aware of their rights and the provisions of the law prior to its passing. (Region 9)

Recommended interventions in times of natural disasters / development aggression

Protection and Security

- Upon the onslaught of an emergency or disaster, the most vulnerable should be protected and secured. Women and children, the elderly, and women with disabilities should be accorded due protection and priority. Disaster response and humanitarian response should be human rights based and gender responsive.
- To prepare and equip the communities and ensure their protection and security in times of emergencies and calamities, training on disaster preparedness procedures should be conducted, with focus on families in the communities especially those in far-flung areas (Region 9).
- Since they are more vulnerable than men, women should be trained exhaustively for disaster-preparedness thru trainings form Disaster Risk Reduction Management Council (DRRMC) (CAR).
- Strengthening of training for members of the City/Municipal Disaster Risk Reduction and Management Council (C/MDRRMC) in rescuing the disadvantaged groups is highly recommended. (Region 2)

Preventing and Addressing GBV in Emergency and Humanitarian Situations

- Acknowledging the vulnerability to gender based violence and to trafficking of women, particularly marginalized women during disaster and emergency situations, LGUs should strengthen measures to prevent and address GBV and trafficking. This includes addressing the need for safe and secure evacuation centers, putting in place facilities to report and address GBV and trafficking.

- This also includes provision by LGUs of support system and psychosocial services for women and children who are traumatized because of the calamity suffered. Psychosocial services are greatly needed during these times. (CAR)

Food Security

- Accounts have been documented that specific needs of women are often not addressed during emergency situations. It is recommended that LGUs ensure gender responsive delivery of services. This should include provisions of prenatal services for pregnant women like Tetanus Toxoid injection, breastfeeding and/or supplemental feeding. (Region 9).

Health

- It has been noted that women, children, sick people and the elderly lack medical attention. Hence, LGUs should ensure that health personnel and services are available in transitory sites to cater to the needs of sick people especially pregnant and lactating women, the elderly, and sick children.
- Interventions for victims of displacement and calamities should include provisions for psycho-social services especially for women and children who were subjected to severe trauma.

Shelter: Safe and secure evacuation centers/ transitory sites

- Women should be given more privacy, also taking into consideration the families with daughters. (Region 9). In CAR, it was recommended that there should be separate evacuation centers for PWDs, pregnant women, men, and women with their children to have an organized and specific catering of their needs.

Water, Sanitation, and Hygiene

- In the provision of relief goods, attention should be given to the specific needs of women such as sanitary napkins and hygiene kits. LGUs should also ensure that separate sanitation facilities form women and girls, which are safe and secure, be provided in evacuation centers.

Proper consultations. Before the introduction of development projects, proper consultation should be done. There should be free and informed consent from the indigenous peoples especially women in the rural areas. (CAR)

There should be an over sighting committee to supervise the rights of women whether marginalized or not. There should also be effective information dissemination to avoid misunderstanding that will result to aggression. The national government through the LGUs should also strengthen the mainstreaming of gender development. (CAR)

IV. RESULTS OF THE REGIONAL CONSULTATION ON REPRODUCTIVE HEALTH

A. Levels of Implementation

1. Availability of RH goods and services in the community

The Regions have available commodities and services for reproductive health.

Table 3. RH Goods and Services in the Communities

REGION	RH GOODS AVAILABLE	RH SERVICES AVAILABLE
NCR	In the Barangay Health Center: • Papsmear – P350.00 • Injectable – P100.00 • Pills – P20.00 • Condom, These payments are reportedly for donation.	Papsmear, family planning

REGION	RH GOODS AVAILABLE	RH SERVICES AVAILABLE
I	• Pills- P50.00 • Condom- P25.00 • Injectables- /3 months • Vasectomy for the men	Marriage counseling
II	Condoms, pills, and DMPA (Depo) Accessible for free in the barangay health centers.	Immunizations and Vitamin A supplementation for children, deworming, and anti-flu vaccine for Senior Citizens. Accessible for free in the barangay health centers.
III	• pills/ depo provera • anti- flu vaccine • anti- tetanus for pregnant women • anti -polio for children • Emergency medicines such as paracetamol and amoxicillin although not on a regular basis • nebulizer apparatus RH goods and services are available in the communities (Angeles City, Dau, Mabalacat and Capas, Tarlac). Barangay centers in the offer these goods and services for free. However, the staff usually asks for voluntary donations from the patients.	• New born screening, usually at public hospitals • Birthing centers (at o' Donell Capas, Tarlac, Barangays Balibago, EPZA and Cutud, Angeles City ant at Dau, Mabalacat • in Angeles City, various barangays provide "Barangay Day" two times a week wherein medical mission is conducted to provide medical services • dental," tuli" and minor operations. • pre and post-natal check-ups and pneumonia care for senior citizens

REGION	RH GOODS AVAILABLE	RH SERVICES AVAILABLE
IV	Pills and condoms are available for free in the community health centers. During times that there are no available supplies in the health centers, clients are given referral on where to buy RH goods. Among the available RH goods are the following: • Pills (Diane-Php 600; Lady-Php 165; Altea-Php 360; and Micropills (generic)-P2.00) that are good for one month; • Condom (Trust-Php 5.00); • Injectable worth Php 250. However, concerns are raised over the low quality of supplies that are sometimes available in Brgy. health centers.	• Pre-natal check-up (Free service from the government; Php 500 for the private hospital); • Anti-tetanus toxoid (free from the government); • Delivery (Government-Php 2,000; Lying in- Php 7,500 or less than Php 6,000-with Philhealth); • CS (Government-Php 12,000 without medicine; Private-around Php 50,000); • Ligation (Government-Php300 for transportation and service is free); • Newly Born Screening (Php 600); • Vaccination/Immunization (Penta and measles vaccine are provided free but costs Php 4,800 and Php 900, respectively, for private health providers); • Pre marriage counseling and family planning seminars. Health cards or blue cards are also provided to beneficiaries and monthly visitation is being conducted to pregnant women.

REGION	RH GOODS AVAILABLE	RH SERVICES AVAILABLE
V		• Pre-natal check-up/services conducted by the BHW/BHS • Reproductive health education in the barangays
VI	(Free medicines for the people are always out of stock. However, if you have money or a family, or friend of the health worker, the medicine is available)	• Family planning services • Maternal health care • Neonatal, infant, child health and nutrition services • RTI, HIV/ AIDS, STI prevention, treatment and management • Services for reproductive tract cancers • Service for victims of VAW is available but it lacks proper information dissemination. As a result, victims would hide because of shame.
VII	• Free condoms, contraceptive pills, anti-tetanus shots, • However, barangays run out of contraceptives	• Prenatal and postnatal services • Establishment of birth centers
VIII	There are available goods such as pills, depo, pap smear, vitamins and other medicines which are offered for free.	• Birthing clinics. • Immunization • Family planning • Pre-natal care for pregnant women, • Counseling for married couples

REGION	RH GOODS AVAILABLE	RH SERVICES AVAILABLE
		• To some extent, post abortion services are offered in hospitals.
IX	Barangay Health Stations offer family planning commodities but the supplies are limited. For instance, pills are given for free in the health center but the supplies are not enough to be given to all women under family planning. Donations are given in exchange of the pills	• Prenatal care • Immunization • Natural and artificial family planning and counselling • BHWs visit areas of their communities once in a while to do regular check-up on the families' health but because of lack of health workers in the community, some services are not well-implemented.
X	RH commodities are not readily available in community health centers and clinics ("out of stock").	• LGUs provide enough RH services but there are instances for example in Iligan City where women are asked for donations for RH products and services before they can avail of such services.
XI	• In urban areas, RH goods and services are available. Davao City, for instance, is very supportive of RH programs and there are available goods in the community, mostly in health centers, public clinics, hospitals, health facilities.	• prenatal, neonatal, post delivery services. • management of sexually transmitted infections; HIV counseling and testing; • pap smear; management of gynecological conditions on women; gram straining for STI; etc.

REGION	RH GOODS AVAILABLE	RH SERVICES AVAILABLE
	• The cost depends on where they are getting the goods & services. In health centers, these are free. There are some which only ask for donations, sometimes fixed donations which have no receipts. In the private sector, consultation ranges from P250 – P500.	• There are also referral mechanisms in place, but no feedback mechanism to check whether the referral really reaches the facility referred to.
XI	Reproductive health goods are available but inaccessible especially to women in rural areas.	Limited manpower to provide basic health services to women in remote barangays.
CARAGA	At the barangay health centers, gov't hospitals and private hospitals. Barangay Health Center - free Gov't hospital - donation Birthing clinic- (Gov't) P200.00 Private hospital - w/pay Birthing clinic - (private) P290.00	• family planning services • maternal health services • neonatal, infant, child and nutrition services • advocacy in the barangay level on HIV, AIDS and RTI Available at barangay health center, Regional Health Unit, Municipal Health Office, City Health Office, Public and Private Hospitals.

However, while these goods and services are ideally available for free, issues have been raised regarding their actual availability and accessibility.

- The supplies are limited and do not suffice to provide for all community women who need these. Many of the health centers claim that the commodities are "out of stock".

- There is a practice in some areas of asking "donations" in exchange for the commodities, which is tantamount to asking payments for the goods.
- There is also lack of information dissemination and encouragement for the community members to enjoy or maximize health services like pills and other family planning commodities.

Many choose not to access RH goods and services, i.e. lesbians who become pregnant are too ashamed to avail of RH services;

- Moros say that it is forbidden by culture.

- Badjaos are ashamed of accessing healthcare since healthcare providers belittle them due to their lack of hygiene.
- The youth are also ashamed of approaching the barangay for RH services.

2. Accessibility of RH goods and services to women, youth and LGBTs

Generally, women, youth, and LGBTs, know where to go whenever they need RH goods and services. Health centers in every barangay are accessible to everyone. The community members are aware that health centers in their communities provide reproductive health goods and services including family planning services.

The exceptions are in Region 6, 9, and CARAGA, where participants claimed that there are only a few who know where to go to access RH goods and services because of lack of information. In Region 6, the following issues were raised:

- Lack of knowledge about maternal health services.
- There are no health centers in remote areas (e.g. Libacao and Sicogon). Because of this, people are not properly informed of the health services available to them.
- No adolescent, and youth medical services including sex education for teenagers. As a result, early pregnancy often happens.
- No seminars are being conducted about RTI, HIV, etc.

- Service for victims of VAW is available but it lacks proper information dissemination. As a result, victims would hide because of shame.
- Lack of information of treatment of STDs.
- The community is not informed about tract cancer.

Access to Family Planning Services

Traditional and Modern Forms of Contraception

In all the Regions, most women are able to access family planning services, including traditional and modern forms of contraception. Among the services available to women are natural and artificial family planning and counselling for married couples, ante-natal care, immunization for pregnant women, post-natal care. In many areas such as in Region 4, during pre-marital counseling which all couples are required to undergo before marriage, family planning is the first topic discussed.

The exceptions are for women in the hinterlands who do not have access to information regarding family planning and maternal health services. In these areas (i.e. in Regions 5 and 6), even when they want to practice family planning, the only method available to them is traditional/natural method. In some cultures especially among the IPs, the preference is for natural family planning methods. For some IPs in Region 9, for example, it is not part of their culture to use artificial contraceptives. They have traditional knowledge and use herbs and plants for contraception.

Others simply choose not to access RH goods and services: lesbians who become pregnant are too ashamed to avail of RH services; Moros say that it is forbidden by culture; Badjaos are ashamed of accessing healthcare since healthcare providers belittle them due to their lack of hygiene; the youth are also ashamed of approaching the barangay for RH services (Region 7).

The youth also generally do not have access to family planning services without the consent of their parents. No adolescent, and youth medical services including sex

education are available for teenagers in many communities (i.e. in Region 6). As a result, early pregnancy often happens.

Post abortion services

Women in majority of the Regions do not have access to post-abortion services in health facilities. This is not included in the range of RH services that the health centers provide. A reason cited is that abortion is taboo in Philippine culture and is, therefore not tolerated or talked about (Region 2). These kinds of services are accessed in private institutions. For instance:

- In CAR, abortionists can be easily contacted through the vendors of herbal medicines. Abortifacient drugs are very accessible in drugstores because some are not prohibited or banned. For example, the Lifeline Counselling Center (ProLife Baguio) provides counselling on post-abortion syndrome for free. There are incidents that the OB-Gyne department of Baguio General Hospital (BGH) will call their attention to follow-up an abortion patient, who is usually a student

The exceptions are in Region 4 where health facilities, especially in San Pablo City, are clean and accredited to conduct services in post-abortion care; and in Region and 8 where to some extent, post abortion services are offered in hospitals.

B. <u>Policies and practices on RH</u>

Majority of the LGUs are deemed to be supportive of RH, in varying degrees, and with certain limitations. In Region 1, local Ordinances have been passed supporting RH provision of services in the communities. In Region 2, LGU's commitment to implement RH services and to ensure that there is constant supply of RH goods in the community has been noted. Relevant trainings and seminars have been conducted in Region 4.

However, there are common issues that repeatedly come out with respect to implementation of LGU's programs on RH.

- It is a recurring issue that marginalized groups, especially women in hinterlands and IPs, are not able to access the programs of the LGUs, mainly because of the distance and the lack of information available to them.
- Even where there are available RH good, services, and programs by the LGUs, many people do not avail of these because they are not aware of their availability. Participants from Region 10 share that LGUs provide RH goods and services in the communities but there are gaps in educating and encouraging community members to avail of these. For instance, IUDs or contraceptive pills are available in health centers but some community members think these are not free and they don't have any funds for these. In Region 4, it was recommended that IEC or Information, Education and Communication, Home Visitations, Mothers' Classes, meetings with married couple of reproductive age and dialogue with target clients be undertaken to promote the programs.
- In Region 12, there is a problem on the continuity of RH programs and projects for basic services due to the changes in the political landscape. Some local leaders do not continue previous programs of their predecessors especially when they belong to opposite political parties. In addition, allocation of budgets for RH is inconsistent, depending on the political will and position of the local leaders.

With respect to policies and/or practices by LGUs and/ or Healthcare providers that prevent access of women and girls to RH, the following were mentioned:

- In Sorsogon City (Region 5), the City Mayor issued in February of 2015 a "pro-life" resolution prohibiting the distribution of contraceptives. An Ordinance criminalizing the dispensation of family planning commodities is pending in the City Council of Sorsogon.
- In Iligan City (Region 10), a City Ordinance was passed asking women for donations before they can avail of RH products and services. As this donation has fixed amount, this is tantamount to rendering these products and services as for sale. There is also a TRO on subdermal implant.

Willingness to seek services. The groups noted that women do not willingly seek services in the community. As mentioned above, many of them lack awareness of the

services available. When they do visit health centers, there are no staff available to conduct family planning services, or commodities are unavailable or "out of the stock".

Specifically, the groups listed the following factors that hinder women in accessing RH services in their communities.

- Lack of information on the services and good available, who to approach, how to avail, etc. (cited by almost all the Regions)
- Geographical location of healthcare services. The farther the location is, the more difficult for healthcare clients to access these goods and services. (CAR, Regions 1,6, 9)
- Negative experience due to unfriendly, insensitive, and discriminatory attitudes of service providers (CAR, Regions 1, 9)
- Religion and cultural beliefs - traditional women opt to resort to culturally-based beliefs and practices. (CAR, Regions 1, 3, 4, 5, 10, 11, 12)
- Women are discouraged because of the prevailing "*palakasan* system" wherein goods and services are extended only to those clients they know or favor.
- The fear of spending too much on RH goods and services and the fear of generally submitting themselves for medical care also overpower the desire of these women to access RH services (Region 2).
- Fear of the perceived side effects of contraceptives (Regions 4, 5).
- Uncooperative male spouses / Partners are not supportive (Regions 5, 9, 10, 12)
- Stigma against persons with sexually transmitted diseases /HIV. (Region 6)

Behavior and outlook of health service providers

Although not generalizing, almost all the Regions cited examples of negative attitudes from some health personnel / service providers. Among the behaviors noted were:

- Some health workers in barangays do not explain very well the things that need to be explained regarding RH.
- Insensitivity of some Barangay Health Workers to the PWDs and elderly has been noted.

- Some health workers have attitude problems, sanitary issues, and gender sensitivity issues. Some women patients would sometimes hear negative comments coming from the health workers.
- There are instances of dealing with insensitive health workers, giving them "cold treatment", particularly for example towards women in prostitution. This discourages them from going back for health services.
- Quality of counseling is low due to bulk of patients, when it should be one at a time. Sometimes in the barangay there are only BHWs who are not trained to do family planning counseling. Many go to big hospitals, but the rural people could not because of distance.
- Some volunteer health workers still need to be educated on proper implementation of medical procedures.
- The local language terms used in sexuality/RH education come out as vulgar-sounding, which is a factor that hampers the learning of community members.
- Doctors are only scheduled in the centers once a month.
- Mindset of medical practitioners that pregnancy and delivery is no one else's responsibility but the mother alone.
- Some health workers are also hesitant to deal with HIV patients because of scarcity of supplies

On the other hand, some of the participants explained that health workers may be overworked and stressed, and even underpaid. They may also be in need of training.

In Regions 2 and 4, the participants highlighted the positive attitude of service providers, who are "approachable, nice and cool and have a sense of humor, and exhibit proper behavior in communicating to patients", as well as "reliable, welcoming, friendly, respectful, and helpful, and patient enough to explain health issues to their clients".

Will it be better if funds and policies on RH came from National Agencies like DOH instead of LGUs?

Groups from NCR, Regions 4, 6, and 10 express agreement that funds and policies on RH come from National Agencies. One of the justifications for this is supposedly to avoid

biases and so that the services will not be politicized. It was also noted that DOH personnel are very approachable.

On the other hand, participants from Regions 8 and 9 maintain that funds and policies should be from the local agencies because they are more knowledgeable of the current situation and needs of the constituents.

For Region 2 participants, they stress that whether the funds and policies come from the LGUs or the national government, the government should make sure that these assets reach their intended beneficiaries.

C. <u>Availability of RH Goods and Services for Marginalized Women</u>

Where there are available RH goods and services, these are also available to marginalized women, except, in some cases, for the youth. The barangay health centers are open to all stakeholders in the communities. Contraceptives are distributed to those who need these regardless of gender, marital status, cultural affiliation, etc., (and in Region 2, even to minors like 16-year old girls who engage in premarital sex) without any requirements. The establishment and operation of birthing centers cater to the needs of poor women in remote areas. The birthing centers in Region 2 were observed to be well-equipped to address the needs of pregnant women.

Some of the issues noted are:

- As has been repeatedly mentioned, women in rural, far-flung areas have the least access to RH goods and services. In region 4, there is an advocacy for mobile health care facilities for IPs in hinterland communities in Mindoro.
- PWDs have difficulty accessing RH services since some services are offered in facilities or sites far from their residences, there are no ramps or hand rails, and there are no interpreters. Several PWDs do not possess vehicles to access assistance from RH service providers.

- Youth – in some areas, contraceptives are not made available to the youth. There are no adolescent, and youth medical services including sex education for teenagers. As a result, early pregnancy often happens.

Due to the issues and barriers to accessing RH services mentioned in previous paragraphs, many women in the marginalized sectors often hesitate to seek services in their communities. In Region 3, particularly, IPs or Aetas in Capas, Tarlac and the Bajaos in Pampanga do not willingly seek RH services and simply wait for the government to reach out to them. The government, on the other hand, does not prioritize their needs.

For NCR, CAR, Regions 2, 4, 8, and 9, they remark that marginalized women willingly seek RH services in the community whenever they need these.

The experiences and factors that hinder marginalized women from accessing RH services are similar to those already discussed in parts III-B and IV B (on hindering factors; behavior of service providers.

D. Availability of RH Goods and Services during Displacement and Development Aggression

For many of the Regions, while RH goods and services are available, to some extent, during times of displacement/crisis/calamity/development aggression, these are not sufficient. They are consistent in saying that these are not prioritized during times of crisis.

- **Region 2** - During times of displacement/ crisis/ calamity/ development aggression, RH goods and services are available but not in adequate supply. Some evacuation centers do not have enough facilities like clean comfort rooms. In some barangays, there are no designated evacuation centers.
- **Region 3** - During the time of displacement or crisis situation, the local government or the community tends to forget the reproductive health services because they focused on providing for the more basic needs of the people such as food, water and clothing.

- **Region 4** - There are RH services during disasters but this is the least priority as main concern is to meet the primary needs particularly food.
- **Region 6** - During calamities, there is lack of health center and birthing centers; the doctors or nurses only visit the remote areas once a month; pre-natal services are availed only after 6 month or never at all; the ratio of midwives to barangays is 1: 5 barangays. Because of the inability to access proper health services during calamities, women would resort to traditional methods of delivery. Medical missions for victims of displacement are only conducted during election period. Expired medicines are still given. They are told that the expired medicines are still good because of the so called "3 month extended expiration."
- **Region 7** - RH services during displacement are deemed available but not prioritized over food and shelter. When fires take place, condoms and napkins are not distributed.

- **Region 12** - Reproductive health goods are not emphasized during displacement. Women have no access to RH goods and services. There are no stay-in health professionals in evacuation centers.
- **Region 11** - 11 There are RH goods and services but insufficient. In Cateel, Davao Oriental, victims of typhoon Pablo in 2012 experienced inaccessibility of RH goods and inadequate services. The hospitals and health centers were damaged. The government was not prepared and the response did not arrive immediately.

Consequently, the experiences of those who have been victims of displacement in these Regions were not very positive in terms of accessing RH goods and services. In Region 2, they experienced delays in accessing the needed goods, as it usually took two to three days after a calamity before the displaced communities are able to access the needed RH goods and services. In remote areas in Region 3, because RH services are not readily available due to the distance, pregnant women rely on traditional health care like "hilot", "albularyo" and herbal medicine. In Region 4, there were problems on the continuity of the supply of RH goods. For instance, medical supplies like Ferrous Sulfate and other supplies needed by newborn and pregnant women are inadequate. In Region 10, in the aftermath of Typhoon Sendong, natural family planning counseling and pre-and post-natal services were available, but not artificial birth control commodities.

In Region 11, during the typhoon Pablo, some of the experiences were detailed as follows:

- There were pregnant women who got sick, and some suffered from TB because the response arrived late. It took a long time for the goods and services to arrive because there were debris everywhere.
- There was discrimination in giving supplies – those who are nearest of kin or family were prioritized. Others received expired goods and medicines. Delivery of goods and services was political and followed color coding, e.g. if your color was yellow and not pink, you cannot receive supplies. There were patients who were denied immediate care. The victims who were wounded were told to list their names to receive payments, but when the money was released it did not reach the victims.

- During the typhoon Pablo there were politicians who hid the supplies (medicines, etc.), and gave these to private persons for selling, and they would tell the people there are no more supplies but that they could but from this specific person.
- For the health workers, lack of concern was noted. They only catered to the ones they wanted to serve. They would not go to rural areas because it is muddy, or the people have no "proper hygiene", and smell bad.

In **Region 8,** RH goods and services are available during displacement, but these mostly come from NGOs and not the government.

For the other Regions, RH goods and services are available during times of displacement / crisis / calamity/ development aggression. In CAR, for instance, RH goods and services are always available, and there is an active Barangay DRRMC that provides for the necessities of the victims. The DOH also provides for goods and services during these crises. In Albay, these are available, but in other areas in Region 5 such as in Sorsogon City, the supplies and services are not sufficient. In the aftermath of Typhoon Sendong in Region 10, it was noted that there was a health center in one of the evacuation areas, although they are not sure as to the extent of the RH products and services available.

The constituents also experienced easy access to RH goods and services in these Regions.

Challenges and barriers in accessing RH goods and services

- Lack of awareness on the available RH goods and services during times of calamities, crisis and displacement.
- Discrimination in providing services and supplies. In some cases, the granting of these goods and services are based on kinship and political affiliations. "Palakasan" system, or "kila-kilala" system is very prevalent.

- Non-availability of on-call health workers. Sometimes there are no personnel in health centers.
- Lack of medicines and other medical supplies.
- Attitude problems of some heath workers at the LGU level. Some are not approachable/ accommodating, and do not use simple, layman's terms that can be easily understood by the community members.
- Lack of technical training of health workers. There are instances where the health workers are not well-equipped with knowledge on the RH goods and services.
- Absence of midwives. Midwives hesitate to go to the community of participants because of fear of huge waves (Sicogon).
- Anxiety over family planning procedures; side effects of contraceptives.
- Discrimination against IPs.

With all the issues surrounding the availability and accessibility of RH goods and services during times of crisis, it is not surprising that the participants remark that the State does not provide enough RH goods and services during times of displacement / crisis / calamity / development aggression.

E. <u>Recommendations</u>

- **Information dissemination.** Education campaigns should be conducted to increase awareness of the community people on women's reproductive health and the RH goods and services available in Barangay Health Centers, as well as services available during displacement and development aggression. These activities will

not only inform community members about these goods and services but encourage them to avail these, especially those in the far-flung areas. Among the methods suggested in Region 9 are IEC, home visitations, mothers' classes, meetings with married couple of reproductive age and dialogue with target clients. (Emphasized in most regions especially in Regions 9, 10, and 12).

- **Training**. More training should be conducted for health providers to enable them to explain very well the family planning options. The proper approach on these RH services is to lay out the choices and let the person choose, the health center employee should not impose or dictate to the patient what to use. Information about family planning should be disseminated properly to all concerned. (Region 3)
- Instructions on how to use RH should also be explained clearly in layman's language to ensure that the users understand. More importantly, these should be given by the health providers with a smile and respect for human dignity. (Region 4)
- Addressing attitude of health services providers. (NCR, CAR, Regions 3, 5, 9, 10, and 11).
- **Increasing the number and pay for health human resource**. In CAR and Region 3, participants surmised that the reason some of the health workers are not very accommodating might be because they are too overworked and stressed, hence increasing manpower may be able to remedy the situation. In Regions 2, 11, and 12, participants lamented the limited manpower to provide health services for the communities. Further, more counsellors should be hired, as the limited number of RH/family planning counselors was noted to affect the quality of counseling services due to bulk of patients.
- **Ensuring accessibility of reproductive health services.** This requires making health services accessible to PWDs by providing interpreters and necessary facilities. This includes addressing the needs of Indigenous women and those who are living in geographically isolated and inaccessible areas.
- **Engaging with Cultural Practices and Beliefs**. There is a need to reconcile cultural practices to the reproductive health laws (Region 12).

- **Involvement of male partners**. Information dissemination should also target males. The burden of the RH should be shared by partners, and males should be included in the discussions on RH. (Region 3)
- **Bring health center to women in far-flung areas (*"ilapit ang health center sa kababaihan")***. Health centers should be established in hinterlands and far-flung areas so that women can have access to health services. In Tuguegarao, one reason why women are discriminated against is their supposed "lack of hygiene". This was explained as due to the distance and length of time they have to travel, wherein they will be very sweaty (including in their private parts) when they reach the health centers.
- In cases of marginalized women, more efforts should be made in explaining RH goods and services to women with disabilities, such as entertaining their questions. (Region 10)
- For LGBTs, it is recommended that the health provider also belongs to the LGBT group to be able to provide better support system to the client. (Region 4)
- **Sex education for the youth**. In CAR, methods such as conduct of film showing for the youth and children on RH, teenage pregnancies, etc. are suggested.
- In times of calamities and displacement: it is recommended that doctors and nurses be deployed after calamities to provide RH services (Reg 7)
- "*Kubo-kubo*" houses (huts) should be made available whenever displacement occurs for couples to "exercise sexual rights" while recovering from calamities (Reg 7).
- **Ensuring Reproductive Health Services in emergency situations, particularly addressing the needs of the most vulnerable.** Absence of RH goods and services, lack of accessible health facilities, and/or unavailability of health professionals such as doctors, nurses, and midwives during disaster and emergency situations was highlighted in Regions 2, 3, 6, and 12.

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[i] Magna Carta of Women (RA 9710) Chapter IV, sec. 17. Id. ch. IV, secs. 17(3) & 17(7).
[ii] Magna Carta of Women (RA 9710) Ch. IV, secs. 17(3) & 17(7).
[iii] Center for Reproductive Rights. CEDAW Inquiry Fact Sheet
[iv] Department Circular 2015-0195, Department of Health
[v] The unmet need for family planning refers to the proportion of married women who are not using any method of family planning but do not desire any more children or would prefer to space births.

Republika ng Pilipinas
Komisyon ng Karapatang Pantao ng Pilipinas
(Commission on Human Rights of the Philippines)

RESOLUTION
CHR (V) No. AM2016-146

The Commission **RESOLVES** to **ADOPT** the Reproductive Health (RH) Inquiry report, as submitted by the Gender Equality and Women's Human Rights Center (GEWHRC).

SO RESOLVED.

Done this 31st day of August 2016, Quezon City, Philippines.

JOSE LUIS MARTIN C. GASCON
Chairperson

KAREN S. GOMEZ-DUMPIT
Commissioner

GWENDOLYN L.L. PIMENTEL-GANA
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