

ASSESSMENT OF ADOLESCENT AND YOUTH REPRODUCTIVE HEALTH (AYRH) IN THE PHILIPPINES

**Laws, policies and programs for the prevention of adolescent pregnancy
and provision of friendly-health services for young parents**

Final report submitted to

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Acronym

AFHS	Adolescent-Friendly Health Services
AFR	Adolescent fertility rate
AHD	Adolescent Health and Development
AHYDP	Adolescent Health and Youth Development Program
AJA	Adolescent Job Aide
AO	Administrative Order
ARMM	Autonomous Region in Muslim Mindanao
ASRH	Adolescent Sexual and Reproductive Health
AYHD	Adolescent and Youth Health Development
AYRH	Adolescent and Youth Reproductive Health
CA	Cooperating Agency
CALABARZON	Cavite, Laguna, Batangas, Rizal, Quezon
CEMONC	Comprehensive Emergency Obstetric and Newborn Care
CHCC	Community Health Care Clinics
CHED	Commission on Higher Education
CHO	City Health Office
CHP	Community Health Promoters
CHSI	Centre for Health Solutions and Innovations Philippines, Inc.
CLGP	City Leadership and Governance Program
COA	Counseling on Air
CPC	Church-Policymaker's Conference
CPO	City Population Office
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organization
CWC	Council for the Welfare of Children
DepEd	Department of Education
DHS	Demographic and Health Survey
DILG	Department of Interior and Local Government
DO	Department Order
DOH	Department of Health
DOLE	Department of Labor and Employment
DRDF	Demographic Research and Development Foundation
DSWD	Department of Social Welfare and Development
EO	Executive Order
ERPAT	Empowerment and Re-affirmation of Paternal Abilities
FAD	Foundation for Adolescent Development
FBO	Faith-based Organization
FP	Family Planning
GBV	Gender-based Violence
GDP	Gross Domestic Product
GEAMH	General Emilio Aguinaldo Memorial Hospital
HARP	HIV/AIDS Registry of the Philippines
HDI	Human Development Index

HEEADDSS	H- Home, E- Education, Employment, Eating, Exercise, A- Activities, Hobbies & Peer Relationships, D- Drug Use, D-Drinking, S - Sexual Activity and Sexuality, S - Suicide, Depression and Mental Health, Safety/Risk
HP	Health Providers
HIV/AIDS	Human Immunodeficiency Virus infection and Acquired Immune Deficiency Syndrome
HPDP	Health Policy Development Program
IHRDPY	Integrated Human Resource Development Program for Youth
ILHZ	Inter Local Health Zone
IPPF	International Planned Parenthood Federation
IPPRP	Interfaith Partnership for the Promotion of Responsible Parenthood, Inc.
IYCF	Infant and Young Child Feeding
JRGH	Jorge Royeca Genera Hospital
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
LAM	Lactation amenorrhea
LGU	Local Government Unit
LH	Luzon Health
LPPED	Learning Package of Parent Education on Adolescent Health and Development
MAPEH	Music, Arts, Physical Education and Health
MCP	Maternal Care Package
MCYA	Manila Centre for Young Adults
MH	Mindanao Health
MHWC	Marikina Youth Health and Adolescent Wellness Center
MNCHN	Maternal Newborn, Child Health and Nutrition
MICS	Multiple Indicator Cluster Survey
MOO	Manual of Operations
MOA	Memorandum of Agreement
MRL	Muslim Religious Leader
MSM	Men who have Sex with Men
NBB	No Balance Billing
NCDPC	National Centre for Disease Prevention and Control
NCR	National Capital Region
NEDA	<i>National Economic and Development Authority</i>
NHA	National Housing Authority
NHDS	<i>National Hospital Discharge Survey</i>
NHIC	National Health Insurance Company
NHTS-PR	National Household Targeting System for Poverty Reduction
NYC	National Youth Commission
OPS	Outpatient Services
OSY	Out-of-School Youth
PAFLO	Population Awareness and Family Life Orientation
PCaSo	Point of Care Solution
PES	Parent Effectiveness Services

PFT	Program for Teens
PHO	Provincial Health Office
PNAC	Philippine National AIDS Council
POC	Point of Care
PopCom	Commission on Population
PPM	Private Practicing Midwives
PPMP DP	Philippine Population Management Program Directional Plan
PRSP	Public Relations Society of the Philippines
PSA	Philippine Statistics Authority
PYAP	Pag-asa Youth Association of the Philippines
PYP	Program for Young Parents
QCGH	Quezon City General Hospital
RHU	Rural Health Unit
RPO	Regional Population Offices
RTI	Research Triangle Institute
SAMPI	Society of Adolescent Medicine of the Philippines, Inc.
SEXTER	Socially, Emotionally, Sexually Responsible Teeners
SHAPE	Sexually Healthy and Personally Effective
SPMC	Southern Philippines Medical Center
SSC	South-South Cooperation
SRHR	Sexual Reproductive Health and Rights
STI	Sexually Transmitted Infection
TA	Technical Assistance
TC	Teen center
TESDA	Technical Education and Skills Development Authority
THK	Teen Health Kiosk
THQ	Teen Health Quarter
TWG	Technical Working Group
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Emergency Fund
UPPI	University of the Philippines Population Institute
USAID CAs	United States Agency for International Development Cooperating Agencies
VH	Visayas Health
WHO	World Health Organization
YAFS	Young Adults Fertility Survey
YAFSS	Young Adults Fertility and Sexuality Study
YAPE	Young Adult Peer Educators
YDS	Youth Development Session
ZFF	Zuellig Family Foundation

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SUMMARY

This qualitative study has three main objectives, 1/To describe the magnitude and nature of the teen pregnancy problem and AYRH in general, 2/ To assess the various laws, policies, programs, and initiatives which are implemented by DOH, other government agencies, development partners and CSOs and 3/ To document good practices in the prevention and management of teen pregnancies and provision of AYRH services. This study was conducted for less than three months from May to July 2016.

Particular attention is given by this assessment to the link between demand generation and service delivery in the management and prevention of teenage pregnancies and motherhood. Desk review of research studies, laws, policies and programs and field study of seven USAID-Cooperating Agencies (CAs)- assisted tertiary hospitals (two DOH-retained, a private and four provincial hospitals), seven teen center (three CA assisted and four LGU assisted) were covered in the study. Visit to selected RHUs were conducted to determine their referral procedures to hospitals.

A total of 100 key informants, 20 FGDs and 17 group interviews were conducted. The key informants included hospital and teen center administrators and health/service providers, pregnant teenagers and teenage moms, partners and mothers of teenage moms, peer educators other government agency representatives and stakeholders.

Nature and magnitude of teenage pregnancy and AYRH in general

Different international and national agencies have varying terms and age ranges for young people. The Department of Health (DOH) and World Health Organization's (WHO) age range for adolescents is from 15 to 19. Three national agencies, the Department of Social Welfare and Development (DSWD), Technical Education and Skills Development Authority (TESDA) and Department of Labor and Employment (DOLE) refer to the 15 to 24-year- old as youth. DILG, on the other hand, states that the youth should be between 15 to 21 years old. The UP Population Institute (UPPI) refers to the 15 to 24-year old as young adults.

Two government agencies have larger age ranges for what they term as the youth. The Department of Education (DepEd) states that the youth falls between the ages of 7 to 30 while the National Youth Commission's (NYC) age range is between 15 to 30 years old.

The Philippines has the second highest adolescent fertility rate (AFR) in Southeast Asia. It is the only country in the region where the AFR is increasing. In 2011 the country's AFR was 56 births per 1,000 women ages 15-19. In 2014 this number rose to 61. The Young Adult and Fertility Surveys (YAFS) reinforce the foregoing trend.

The high AFR in the country is associated with a number of factors particularly a/ younger age at menarche, b/ early premarital sexual initiation, c/ unplanned sexual encounters d/ high unmet need for FP, e/ peer pressure, e//inadequate ASRH information, f/ changing family dynamics, g/

absence of accessible, adolescent-friendly clinics, and h/ the growing acceptance of out-of-wedlock pregnancy and living-in arrangements.

Teenage pregnancy perpetuates the cycle of poverty and inequality because most pregnant teenagers have no source of income and face greater financial difficulties later in life. This is because they drop out of school and are less likely to pursue further education or skills training

Giving birth in a medical facility is becoming more common in the Philippines. In 2013, 70 per cent of adolescent mothers had their most recent delivery at a health facility, compared with only 38 per cent in 2008. Despite this development, maternal deaths among teenage women (19 years old and below) have increased from 130 in 2005 to 168 in 2010.

On the first week of life, there is a 50 per cent chance of stillbirth and death among infants of adolescent mothers compared to those babies born to mothers aged 20 to 29. On the first month of life, mortality among babies of teenage mothers is high by 50 to 100 per cent. Preterm births, low birth weight and suffocation among infants born to adolescents are higher which raises the likelihood of poor health and even death for the child.

Adolescents with little or no education from poorest rural families are more likely to have started childbearing. It is, however, noted that better educated young people from non-poor families are starting to bear children. The foregoing factors and growing acceptance of out-of-wedlock pregnancy and living-in arrangement of couples contribute to the foregoing changing behavior.

Although the trend has been rising for males and females, studies have shown that more male adolescents are engaged in risky sexual behaviors which could predispose them to unwanted pregnancy and STIs. In recent years, the HIV and AIDS incidence has risen and there are more males than females who have acquired this disease. Multiple sexual partners and unprotected sex are among the major causes of this trend. Younger and older adolescents from rural and urban areas have experienced bullying, verbal and physical abuse in- and out-of the school settings.

The YAFS surveys have found that alcohol intake and drug abuse among the youth declined while smoking increased. There are more males than females who are engaged in these behaviors. Smoking and alcohol intake among females, however, have increased over the years.

Laws and national policies

The country has a number of laws in social protection/welfare and health which are supportive of adolescents including pregnant teenagers and young mothers.

Social Protection. The Magna Charta of Women 2010 is considered as the great charter because it guarantees all women including adolescents, their rights and social protection. A specific IRR provision of this law is helpful to pregnant female students because it prohibits expulsion and non-readmission to schools due to their having “contracted pregnancy outside of marriage.”

This Magna Carta of Women provision is supported by DepEd's RA 10533 known as the Enhanced Basic Education Act of 2013 which stipulates that all Filipinos are entitled to have access to free K to 12 education. This is further reinforced by the policy directive called "Education for All" 2015 which offers Alternative delivery models (ALM) especially for those who are in socially-difficult circumstances like pregnant adolescents and teen moms. The ALMs include Project EASE (Effective Alternative Secondary Education) which is concerned about students who are unable to attend classes because of personal and financial reasons.

An EASE student can make an arrangement with the school to study at home until she or he is ready to join the formal school system. Students who are unable to go to school due to work, physical disability, poverty or are situated in conflict areas could join the Open High School Program, a learner-centered system which utilizes several teaching-learning approaches by using print and non-print tools. This strategy is complemented by the *Balik Paaralan* Program or the Home Study Program.

The project team's interviews with guidance counsellors and school teachers validated the foregoing DepEd's policy because their institutions are implementing the ALMS for all their students including pregnant adolescents. There is, however, a need to systematically examine the effects of these models especially in supporting teen moms.

The Magna Carta also has a provision that women have rights to "culture-sensitive, and gender-responsive health services and programs covering all stages of a woman's life cycle which address the major causes of women's mortality and morbidity." It has specified the major RH elements and these are all applicable to female adolescents.

The 16-year old law, the Solo Parents' Welfare Act of 2000, provides a comprehensive package of services for solo parents and their children especially among those who fall below the poverty threshold. This would include livelihood, counseling and effective parenting. Several agencies are enjoined to implement the law, viz., DSWD, DOH DepEd, DILG, CHED, TESDA, NHA DOLE and others. This law is particularly useful for many poor and single teen moms because it provides protection to her and her child. Although a number of poor teen moms are currently living in with their partners (often in their parents' homes), the likelihood that they would become single mothers is high. This law could be utilized to seek support from the foregoing agencies.

The increasing physical, verbal and sexual abuse among students that would likely include pregnant adolescents are being addressed with the passage of Republic Act 10627 Anti-Bullying Act of 2013. Approved by the Senate and House of Representatives on June 7, 2013, this law empowers the DepED to penalize schools that do not stop bullying or sanction bullies. It authorizes schools to impose sanctions on student bullies. All elementary and secondary schools would be required to adopt anti-bullying policies and sanctions, which would cover prohibited acts committed within their campuses, school sponsored activities whether conducted in or outside school grounds, school bus stops, school buses, or other properties owned or leased by schools. This legislation, however, has to be systematically studied to determine whether it has indeed reduced violence among young people.

Health legislation. The passage of the long-awaited contentious Responsible Parenthood and Reproductive Health (RP & RH) Act of 2012 mandates the government to respond adequately to the RP and RH needs of the people. This legislation intends to empower Filipinos particularly women, adolescents and youth, to make informed choices through age and development-appropriate education. This legislation guarantees that all Filipinos especially the poor and those in socially-difficult circumstances, can access information, facilities and services by making sure that available and sustainable RH programs are provided. This could be attained through the collaboration between the national and local government units in partnership with CSOs, the academe, the private and the basic sectors.

In its IRR, the foregoing law specifically states that a/ AYRH guidance and counselling must be provided at the point of care; b/ the provision of age and development-appropriate education and counselling; and c/ age-and development appropriate RH education for adolescents in formal and non-formal educational settings.

The law's IRR's Section 4.07 specifies that public health care facilities can “dispense health products and perform procedures for family planning” provided that “the minor presents written consent from a parent or guardian.” The minor who has had previous pregnancy or who is already a parent must have written documentation from one of the following: skilled health providers, from ancillary examinations, a guardian, from local SWD officer, LGU official or health volunteer. Her parent, grandparent or guardian can also accompany her.

An important directive of the RP & RH Act of 2012 to DepEd is the provision of comprehensive sexuality education (CSE). With the implementation of the RP& RH Act of 2012, the DepEd is mandated to provide age and development-appropriate sexuality education in schools. To comply with this, DepEd has already included CSE in its K-12 curriculum. It has not yet adopted the CSE standards which were developed by a panel of experts in consultation with teachers, parents, RH providers and the adolescents. Teachers have yet to be trained of how best to deliver age-specific CSE within the K-12 curriculum.

There are, however, initiatives from various CSOs (e.g., FPOP, Likhaan, IMAP) and support from development partners (e.g., UNFPA) to develop CSE tools and standards which are being tested in selected institutions and locale.

The enactment of RP & RH Act of 2012 is a boon to the implementation of the AYRH program in the country. It is noted that a decade and- half-ago, the DOH issued its first AO 34-A s 2000 Adolescent and Youth Health Policy on AYHD which created a Youth Health Subgroup under the Health Cluster. This AO intended to ensure that all AY would obtain good quality and wide-ranging health services in a friendly setting. It took a decade before the National Centre for Disease Prevention and Control (NCDPC) drafted the national standards and implementing guide for adolescent-friendly facility and the Adolescent Job Aid (AJA) for health providers. The AJA is the DOH's main training tool for health workers in hospitals and RHUs in the provision of AFHS.

A year after the passage of the RP & RH Act of 2012, the DOH issued Administrative Order 2013-0013—National Policy and Strategic Framework on Adolescent Health and Development

(AHD). This AO is anchored on Universal Health Care (UHC) and the provision of policy directions and guidance for DOH and its attached agencies, the LGUs, development partners and NGOs in ranking health interventions. It rescinded or modified previous orders including AO34-As, 2000. This policy framework has provided a strong basis for the foregoing agencies to engage in AYRH activities at the national and LGU levels.

A law on socialized health insurance program which prioritizes the needs of the poor, sick, elderly, people with disability, women and children is RA No. 10606 An Act Amending Republic Act No. 7875 Otherwise known as the “National Insurance Act of 1995,” As Amended, And For Other Purposes (2013). In support of this amended legislation, PhilHealth has a policy instructing that no other fee shall be charged or paid by the PhilHealth patient on any of the identified medical and surgical cases under the case rates package payment scheme. Three beneficial circulars were further issued because these ensure that those who are below 21 and those who are about to deliver must be enrolled at the point of care.

There are other policies and programs from POPCOM, DSWD, DepEd, NYC and other government agencies and CSOs which are supportive of teen moms. The defunct Foundation for Adolescent Development (FAD) in particular, has pioneered a number of initiatives and projects to raise the awareness, knowledge and empowerment of young people. Some of these initiatives like the Teen Health Quarters (THQ) are still being pursued in cities of Marikina and Quezon.

It is observed, however, that there are more ARH advocacy and information -giving initiatives from the foregoing agencies.

Since 2014 new AYRH programs were initiated by the USAID-CAs particularly Luzon, Visayas and Mindanao Health, to provide technical support to LGUs, regional and provincial health offices to enable some CEMONC-capable tertiary health facilities to establish AFHS for pregnant teenagers and teen moms. Luzon Health has also provided technical support for school and community-based teen health kiosks or quarters. These innovative efforts are attempts to link demand generation with service delivery through policy formulation, governance, monitoring and evaluation (M & E), financing, service delivery and capacity- building strategies.

Lessons learned from the assessment of hospitals and teen centers

The lessons derived from the assessment in hospitals and teen centers are focused on the six strategies in providing AFHS in tertiary hospitals and teen centers.

DOH-retained and provincial hospitals

A. Policy

1/With technical support from the CAs, the selected seven tertiary hospitals formulated their respective program manuals of operations (MOO) or protocols. It is noted that facilities which fully implemented their MOO have met most of the DOH’s AFHS Standards.

For example, the Brokenshire Hospital’s PYT has a comprehensive 50-page MOO which provides a program description of this private facility including the endorsement from key

officials and different department heads. It has specific guidelines for service delivery and referral, recording, reporting and monitoring, supervision and assessment. A list of all the medical consultants and residents, other health providers and staff who went through the Adolescent Job Aid (AJA) training formulated this guide with MH, the CHO and other partners. The multi-disciplinary team of health personnel are observing the guidelines and are fully implementing the PFT in the hospital.

Both the Eastern Visayas Regional Medical Center (EVRMC) and the Iloilo Provincial Hospital's (IPH) Program for Young Parents (PYP) have similar protocols which describe the enrolment and service delivery of pregnant teenagers and teen moms, including the education sessions and other related activities.

B. Governance

2/ The buy-in of the hospitals' top-echelon officials and department heads is a key ingredient of the full implementation of the teen program. This is reflected in the top officials' statements in the MOO and in the active participation of the various departments in the program's activities.

For example, at IPH's PYP, the chief of hospital does not only support the PYP in his facility but he also chairs the pilot Central Iloilo Health Zone Alliance (CIHZA)-Service Development Network (SDN) of seven municipalities which are the hospital's demand-generation external partners.

C. Monitoring and evaluation

3/ Hospitals with a systematic recording system is able to track the progress of their teen mom clients and the performance of their programs.

The EVRMC and IPH have individual records of their PYP clients and they are able to follow them up for prenatal consultation and the *usapan* or education sessions through the RHU midwives and the mobile phone messaging. They even color-coded the pregnant teenagers' files to identify which *usapan* or education sessions they have attended. They are able to report regularly about a/ the number of clients who enrolled and delivered at the hospital, b/ who accepted a birth-spacing method, and c/ who returned for pre and postnatal care.

These hospitals have yet to fully computerize their clients' records. They are, however, in the process of installing the Point of Care Solution (PCaSo) in their computer system.

D. Financing

4/ PhilHealth's no-balance billing (NBB), care package and point-of-care enrolment appear to be practiced widely in the hospitals.

At EVRMC and IPH PYP's *usapan* sessions, the teen moms and their families are assisted by the social workers to comply with the social insurance's requirements. The clients seem satisfied with the PhilHealth benefits.

However, the teen moms and their families had out-of-pocket expenses for their transportation, food and miscellaneous expenses. The transportation costs can be prohibitive for teen moms who hail from distant provinces and municipalities.

5/ An important lesson the project team learned from the foregoing hospitals is that they have yet to prepare a business plan for the sustainability of their programs. At present, they rely on their current hospital budget and some CA technical support to operate their PYP. The hospital administrators and HPs are, however, in the process of developing their business plans for the possible expansion of their initiatives.

E. Demand Generation

6/ A successful AFHS program will require demand-generation activities within the hospital and in the community.

For example, the EVRMC and IPH's PYP have regular (every Wednesday) *usapan* sessions for the pregnant adolescents. They show films about FP and pregnancy and provide some reading materials during the *usapan*. To ensure that the pregnant teenagers will return to the PYP education sessions, the health provider/focal person usually follows them up through their mobile phones and the RHU midwives. First-time participants of the *usapan* sessions are asked to fill out a consent form indicating that they are willing to be contacted through their mobile phones. Permission is also sought from their parents or guardians.

The IPH has actively engaged the CIHZA expanded SDN to raise the demand for its PYP services. The expanded SDN is comprised of seven municipalities' mayors and MHOs, MPOs, representatives from DepEd, TESDA, MSWD, DOLE, Philhealth and private practising midwives (PPM). The IPH is the SDN's referral hospital and the Chief of Clinics chairs this group.

This cluster of municipal RHUs is largely responsible for the referral of pregnant teenagers to IPH's PYP and in providing information to their communities regarding the program. The IPH also endorses to the RHUs all the teen moms who enrolled in its PYP for postnatal care and for regular follow up in their respective barangays through their BHWs and NDPs.

The presence of the DepEd ensures that the teen moms are continually provided with assistance for their education while TESDA gives priority to the teen moms with PYP certificates for admission into its vocational training program. The MSWD also provides psycho-social support if the teen moms suffer from violence or are in need of other support. The PPM usually refers their pregnant teen clients to the hospital and provide them with postnatal care when these teen moms returned to their facilities.

7/ Another important lesson is that the pregnant teenagers' male partners hardly participate in EVRMC and IPH's *usapan* sessions because they are either busy working or have already broken up with the clients. However, it was reported that when a TESDA representative would serve as a resource person about vocational training and livelihood opportunities, the male

partners would attend the *usapan*. It was suggested that ARH matters should be included during the TESDA session.

8/ Tapping teen moms to become peer educators for other pregnant teenage appears to be an effective strategy to raise the demand for PYP services including birth-spacing.

AT EVRMC and IPH PYP, pregnant adolescents who have completed the program requirements, i.e., four *usapan* sessions, prenatal care, hospital delivery, acceptance of a birth-spacing method, were selected and trained to become “teen mom PYP champions.” They provide testimonies about their own journeys as teen moms and about their acceptance of birth-spacing methods. Their transportation and food expenses during the Wednesday *usapan* sessions are provided by the CA. The PYP champions are now either back in school or have enrolled in some TESDA training programs but they continue to help in the PYP during teen moms’ day. Many are unmarried or are living in with their partners mostly at the homes of their parents.

9/Engaging a mother of a teen mom champion to become a peer educator for other mothers seems to be a promising strategy because she has successfully convinced several; mothers to allow their daughters to use a birth-spacing method.

This strategy is currently being practiced at IPH PYP. The mother peer educator expressed satisfaction that she is able to encourage other mothers to help their daughters decide to accept birth-spacing methods and to return to school or enroll at TESDA’s training program.

10/Although it is a private hospital, Brokenshire’s medical consultants and residents actively promote the PFT to young people in the city by giving out information and flyers to secondary schools and colleges. It also has a 24/7 mobile phone hotline so that teenagers can call them anytime about ARH issues. They have enrolled over 300 young people from a barangay to enable them to participate in the PYT’s forums and to avail of the hospital’s services. They also partner with the CHO, CPO and other government agencies and NGOs to promote their program and to seek support especially for disadvantaged adolescents and youth.

F. Service Delivery

11/An important element in the AFHS provision is the availability of dedicated contiguous spaces for prenatal consultation, counseling and *usapan* sessions. There should also be clear signages about the program’s services and schedules.

The EVRMC, IPH and Brokenshire Hospital have rooms for prenatal and counseling rooms which ensure privacy and confidentiality to their clients. The EVRMC has a unique six-bed maternity ward which is solely for teen moms. This facility is in the same wing as the prenatal, *usapan* and counseling rooms.

12/Having a well-functioning AFHS program result in increased enrolment of pregnant adolescents in the hospital’s program and uptake of birth-spacing methods.

For example, at EVRMC, it has been documented that since the PYP launch in September 2014 until May 2016, a total of 1,311 teenagers from different provinces of the region delivered in the hospital. This represents 15 per cent of all the deliveries for that period. Two hundred eighty three (283) have accepted a birth-spacing method. Four fifths of the teen mom acceptors are PPIUD users. The others who did not accept a birth-spacing method at the hospital were advised to go to the RHUs in their respective municipalities. The EVRMC, however, has no jurisdiction to follow up the teen moms in their provinces because this is supposed to be the task of the LGUs.

A similar pattern was observed at the IPH's PYP. The midwife coordinator is better able to follow up the FP uptake of the teen moms by directly following up the RHU midwives.

The feedback obtained from the KII and FGDs with pregnant adolescents and teenage mothers as well as the mothers of the foregoing indicate satisfaction over the services obtained from the PYP. They felt that the HPs are approachable, helpful and are concerned about the teen moms' plight and future.

13/The presence of a dedicated or fulltime AJA-trained health provider is crucial for the continued operations of the hospital's program for teens or young parents.

The IPH has a fulltime midwife who is supervised by a part-time medical doctor and a team of health providers who have other responsibilities in the hospital. The fulltime midwife does a good job of coordinating the program activities and in linking with the CIHZA SDN e the RHUs particularly in tracking the teen moms before and after their deliveries. She, however, needs a part-time staff to help her record regularly all the clients' activities and to upload the data into the computer.

Brokenshire's PFT, on the other hand, has a resident doctor-coordinator and a large pool of AJA-trained multi-disciplinary team of medical residents and other HPs who are providing services to the teen clients.

G. Capacity building

14/ The DOH AJA has been used by the CAs and the participating hospitals as the main training tool to enable HPs to extend AFHS. However, there are varying usage of the HEEADSS form among the AJA-trained health personnel.

At Brokenshire Hospital, for example, the HPs use the HEEADSS form by interviewing prospective clients at any point of care for around 20 to 30 minutes and does the appropriate referral afterwards.

It was observed that some HPs of other hospitals had either reduced the number of questions or had only a one-page form or did not use the HEEADSS form at all. A midwife said that when she would interview teenagers, she did not use the HEEADSS form because she apparently memorized the questions and interviewing approach. Another midwife said that she used the form to interview pregnant teenagers but she did not utilize the results and just left the filled-out

forms under the table. There is, therefore, a need to further assess the AJA-trained HPs of how they are utilizing the HEEADSS form and applying what they have learned from the training.

15/The *usapan* or education sessions which are facilitated by the HPs and the teen mom champions are generally well received by the EVRMC clients. However, it was observed that facilitators and teen champions needed more substantive inputs for some topics like gender relations and FP. The curriculum and learning guide for these education sessions must be assessed and enhanced.

School and Community-based Teen Centers (TCs)

A. Policy

1/A vital lesson learned when establishing a teen center is the need to obtain a DepEd national or regional department order (DO) or an LGU legislation or Executive Order (EO) to ensure the full buy-in of TCs by the school authorities.

For example, in Iloilo Province, an ordinance was passed by the province regarding the establishment of multi-purpose TCs in all secondary schools. The provincial governor allocated a considerable amount of money for these facilities and their activities. The participating school counterpart is to allocate a classroom near a guidance counsellor's office and to assign faculty members who will serve as student advisers. The DepEd and the PPO were involved in the installation of these facilities. The ordinance and support from the foregoing legitimized the participation of the teachers and peer educators/helpers in this facility.

The LGUs of Marikina and QC had passed local legislations or ordinances supporting AYHD and the establishment of the community-based THQs. As a result, the needed human resources and funding are allocated to operate these facilities. They have, however, some difficulty in extending their activities to schools because of the absence of a DepEd directive.

B. Governance

2/Unlike the hospitals' PFT or PYP, it was noted that school and community-based TCs have no standards and written manual of operations or framework describing goals and objectives, the leadership structure, the roles and responsibilities of the HPs or teacher adviser and peer educators/helpers, the services and referral guidelines, recording, reporting and M & E. National standards and MOO are important for the TCs' smooth operation and to ensure accountability in the TCs.

C. Monitoring and Evaluation

3/To determine the effects of the school and community-based TCs on the intended clients, it is a good practice to conduct periodic assessments.

The Iloilo PPO, for example, conducted a baseline study in 2012 about the reported smoking, alcohol intake, drug use and premarital sex behaviors of the students where the multi-purpose

TCs are installed. Two years later, the same survey was conducted in the schools and found that the non-sexual and sexual behaviors dropped considerably. This systematic approach to monitoring the TCs' effects on the users' behavior should be a standard practice of school and community-based TCs to justify these facilities' presence. The survey can be further expanded to include suggestions for improvement of services and future directions.

Because the HPs of QC's Teen Health Quarters are also affiliated with the health center, the THQ's male and female client health data are submitted to the City Health Office (CHO) and are integrated into the computerized health data system. This practice provides the city with updated data about the health care services obtained by male and female adolescents and young adults.

In Davao City's Barangay 21-C TC, a facility which is located beside the barangay's health center, data about the teen mom clients are manually recorded by two assigned BHWs. Individual clients' records for prenatal consultation, delivery at the referral hospital and acceptance of birth-spacing methods are properly recorded, filed, and locked in a cabinet. The information about the teen clients' delivery at the referral hospital are obtained by the midwife by personally picking this up from the referral hospital every Friday. The teen moms are provided postnatal care and FP services at the health center and are followed up by the BHWs in their homes. Monthly and annual reports about teen pregnancy, deliveries and FP uptake are submitted to the district clinic.

D. Financing

4/ Most school and community-based TCs are sustainable because they are supported regularly by the LGUs.

In QC, Marikina, Iloilo and Davao, the teen centers are funded annually by their LGUs. Usage of their facilities and equipment are generally for free.

In Marikina's THQ, peer educators receive an allowance of P500/month to assist the health provider at the CHO where the THQ is located. They also serve as the contact persons of the barangays on AHD matters. The city provides them with scholarships at the LGU-supported college. Like the other THQ members, their membership card allows them to have access to the CHO's services and the city's sports facilities. The budget of the THQ in recent years, however, have been reduced, which limit the activities of the THQ in the community.

Young people who become members of the QC THQ are allowed the use of its facilities and health services for free. Funds from the CHO are for the upkeep of the THQ and for some activities of the peer educators. The THQ peer educators are also allowed to raise funds for their expenses in their other community outreach activities like organizing and charging P10 from the participants for each zumba dance/exercise lesson.

The QC CHO intends to establish similar THQs in other districts. These facilities must also be contiguous to health centers and schools and must be located in heavily-populated community. The mobile QC, ZFF and Philhealth's registration outreach for teen moms in barangays called

Gabayan ang batang ina will be continually undertaken to hasten their enrolment and delivery at the QC General Hospital.

In the TC of Davao City's Barangay 21-C, a facility next to the health center, the barangay officials, CHO and SK provided support to renovate the small building. Its facilities and training for the peer educators are supported by the LGU.

E. Demand Generation

5/To be able to attract young people to its services and activities, the TC should be a safe, fun place where the adolescents and youth can freely express themselves. It should have a variety of activities and recreational equipment as well as updated IEC materials on issues which are important to teenagers. Community outreach, sports and external learning activities (workshops, seminars, conferences) and exchange visit with other TCs can further harness the energies of young people.

Iloilo's multi-purpose TCs, for example, the peer educators and students are reportedly engaged in the foregoing activities. The newly-opened QC THQ has a large space with recreational equipment and several rooms for different purposes (counseling, meetings, medical consultation) which are currently attracting in and out-of-school young people.

F. Service delivery

6/The presence of adolescent-friendly health providers and peer educators in a teen center encourages young people to access their services.

In QC's THQ, for example, the facility is headed by a medical doctor who is at the same time the barangay health center's medical officer. She is assisted by a nurse, midwife and two health educators. The adolescents and youth who are utilizing the THQ's recreational activities and other facilities could easily obtain health care services including counseling for a variety of health needs. Pregnant adolescents are reportedly counseled and referred to the city's CEMONC-capable hospital for delivery. Prior to their enrolment at the hospital, the pregnant teenager is reportedly already enrolled by PhilHealth's *Gabayan ng batang ina* project.

Davao City's Barangay 21-C TC has a regular consultation day for prenatal consultation services by the midwife for pregnant teenagers of varying ethnicities (Muslims, migrants and settlers) from the large urban poor community. All pregnant teenagers are referred by the midwife to the District Clinic for simple laboratory tests and for referral to the regional hospital. The midwife goes to the regional hospital every Friday to pick up all the records of the women who delivered in the regional hospital including those of the teenage mothers. The mothers are provided with postnatal care at the barangay health center. They are regularly followed up in their homes by a group of BHWs.

G. Capacity building

7/TCs which provide longer duration of substantive, participative and adolescent friendly capacity-building activities tend to have well-trained peer educators.

Iloilo's multi-purpose TC peer educators and helpers have initially received a five-day training from the PPO and POPCOM about adolescent development, values, RH and non-RH matters. The training design provides a space for the young people to share and interact. This initial training is reportedly followed up by other short-term training and participation in external activities organized by the PPO like workshops, seminars and exchange visit to other TCs.

In QC THQ, several peer educators receive twice-a-week training for two months during school break by using FAD's 16 modules about ARH and life skills. The training is provided by a THQ staff who had received training from the defunct FAD's social franchise program for THQ.

In Marikina's THQ, the peer educators who have had training about FAD's ARH modules are reportedly provided with ARH updates by the health provider.

In Davao City, Barangay 21-C peer educators who are mostly OSY have had training about ARH and advocacy from the CPO. The records showed that they had attended several city-wide sponsored seminars and workshops. The number of peer educators, however, had gone down from over 20 to 8 because of employment, education and movement to other places. The operation of the TC, however, is maintained by two BHW and the midwife.

8/ The health providers particularly doctors, nurses and midwives who are providing AFHS have had AJA training. They, however, do not utilize the HEEADSS form in interviewing the teen clients.

Short-term recommendations to the CAs

Recommendations about what the CAs can do for the hospitals and teen centers which they are assisting in the remaining nine or more months of their USAID grant, are presented for their consideration.

Hospital-based program for teens and young parents

1/For those hospitals which have not fully implemented their MOO it is recommended that they do the following (GEAMH, SPMC, JRGH, SCPH)

- Review and fully implement the MOO.
- Enhance their demand generation activities within and outside the health facility.

2/For those hospitals which have fully implemented the MOO, the recommendations are as follows (EVMC, IPH):

- Hone the HPs and teen mom champions' communication and facilitation skills, and their knowledge about AYRH, FP, gender relations and other pertinent topics.
- Develop a business plan for sustainability (this is crucial for the possibility of scaling up the PYP in other hospitals).

- Formalize relationship with the Expanded CIHZA/SDN (have a MOA which specifies the roles, duties and responsibilities of the members in assisting pregnant teenagers and teen moms.)
- Include specific PYP guidelines in the CIHZA's SDN MNCHN document.
- Update the DOH RO (this is especially true for the regional hospital in order to obtain technical and financial support for scaling up the program).
- Review and develop the curricula for *usapan* or education sessions (this is vital for a more systematic training of the HP facilitators and teen mom champions and in scaling up the PYP).

3/For all hospital PYPs, the recommendations are:

- Review the use of the AJA-HEEADSS form and come up with a harmonized hospital-appropriate standard form and approach.
- Provide follow-up training for HPs and monitor how the AFHS standards are observed by them and the hospitals.
- Develop a computerized M & E system for the teen mom clients' records and synchronize these with the hospital's recording system.
- Maximize the use of mobile phone SMS and social media for demand generation.
- Enhance the organizational development (OD) and program management (PM) skills of the hospital senior staff and HPs to enable them to develop a business plan for program sustainability.

Recommendations for TCs: 9 months

1/School based TCs (Iloilo, Cavite)

- Conduct additional training on AYRH and communication skills. Iloilo's multi-purpose TC's peer educators need AYRH training curriculum and this can be designed in partnership with the PPO and PHO as well as RHU's MHOs who are serving as resource persons for the TCs. A systematic capacity-building training should follow.

Cavite's THK peer educators had only one 3-day training. A possibility of providing another follow up training is suggested.

b/Community based TC (QC, Marikina, Davao)

- Revitalize and assist the TC in its program directions. Marikina THQ, for example, used to be a popular facility in the city. It had all the elements of a good THQ but when it moved to the CHO, its appeal to young people dwindled. It has only one HP who is multi-tasking and its budget has been reduced.
- Assess the applicability of AJA-HEEADSS. The TCs' HPs are reportedly trained in AJA. There is a need to follow up and assess how the HEEADSS interview form is implemented in these facilities.

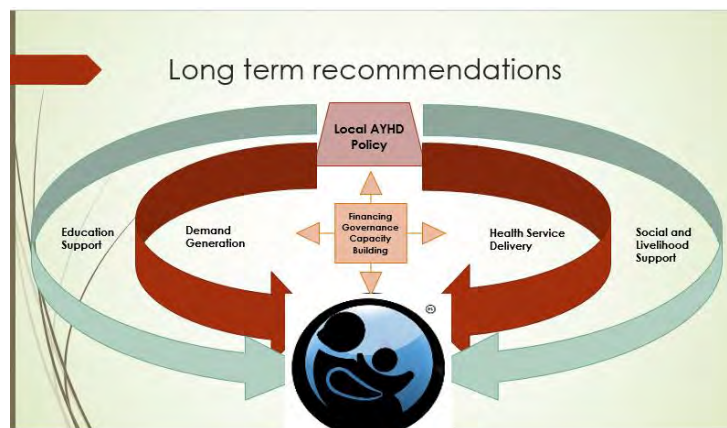
- Study the potential of having a PYP in QC’s General hospital. The current QC THQ is situated beside a health center and a secondary school in a heavily-populated district. The health center attends to the health needs of teenage clients in the facility and in the community. The CHO intends to have THQs beside health centers in all districts. Pregnant teenagers are referred by the health center to the city’s General Hospital but it has no PYP.

c/ For all TCs

- Advocate for issuance of: a/ DepEd DO re: School-based TC, and b/ LGU ordinance/EO. This should be a joint effort between the CA and the schools with TCs.
- Develop standards and MOO for adolescent-friendly school and community-based TCs to serve as guides in establishing and maintaining these facilities.
- Maximize the use of the social media and SMS to provide young people with appropriate and reliable AYRH messages.
- Assess the TCs to determine their program effects on teenage clients as well as their challenges and future directions especially in the prevention of risky behaviors and teenage pregnancies.

Long-term recommendations

This assessment is recommending the IPH’s PYP for the CAs’ long-term program because it meets most of the DOH AFHS standards. The PYP provides a clear link between demand generation strategies and service delivery. It supports teenage mothers before, during and after delivery at different levels of the health system. The hospital where the pregnant adolescent is compelled to deliver provides AYRH education, prenatal, natal and postnatal care including birth-spacing and opportunities for a better future. It also collaborates with an Inter-local Health Zone-SDN for demand generation and care for the teenage mothers.



The business and sustainability plan that will be developed by VH and IPH can also serve as a guide to start the PYP in other provinces.

This study also recommends that the EVRMC's PYP should be continued so that it can be emulated by other regional hospitals to facilitate the scaling up of the program in other provincial hospitals.

CHAPTER ONE

I. Introduction

From 2011 to 2014, the Philippines has ranked second among the Southeast Asian countries' Adolescent Fertility Rates (AFR) or births per 1,000 women ages 15-19. Instead of declining, the country's AFR increased from 56 to 61 births during these years. It is the only country in the region with a rising AFR. Countries with low GDP and HDI particularly those from the Greater Mekong Region (Myanmar, Vietnam and Cambodia except Laos) have lower AFR than the Philippines (UNPD, WPP, data.worldbank.org/indicator/SP.ADO.TFRT).

The foregoing statistics are supported by UPPI-DRDF's two rounds of the Young Adult Fertility Surveys (YAFS) which noted that teenage pregnancy has increased remarkably in the past decade from 6.3 per cent in 2002 to 13.6 per cent in 2013. Eleven per cent of the 2013 young women already had children while 2.6 per cent were pregnant at the time of the study.

The 2013 NDHS also found that 10 per cent of the 15 to 19 year-old women have started their childbearing. Eight per cent were already mothers while two percent were pregnant during the interviews. Young women from rural areas, with no education and from the poorest households were more likely to have started their childbearing. It also noted that there is a high unmet need for FP among young women who already have children. Biological, psycho-social and economic factors predispose these young women to greater health risks and death.

In recent years, it has been observed that teenagers who are not poor, who are living in urban areas and are better educated, have started childbearing. Younger age at menarche, premarital sexual activity at a young age, the rise in cohabiting unions in this age group and the possible decrease in the stigma of out-of-wedlock pregnancy are some of the factors that could explain this observation (Natividad, 2013).

Several programs and projects (largely on the demand side) have been developed in the past two decades by the Commission on Population (PopCom) and other government agencies, development partners, local government units and CSOs mainly to raise the awareness and knowledge of young people about sexuality, RH including HIV & AIDS, gender-relations and gender-based violence.

Up until the passage of the Responsible Parenthood and Reproductive Health Law (RA 10354), the Department of Education (DepEd) was reluctant to provide a comprehensive sexuality education (CSE) to young people. At present, however, DepEd in partnership with PopCom and other agencies are developing CSE teaching and learning tools but it has yet to institutionalize the use of these materials.

Concern for increasing HIV cases, drugs and other substance abuse, gender-based violence and adolescent pregnancies provided an impetus for DOH to issue AO 35A, s. 2000 on Adolescent and Youth Health Development (AYHD) to specify the roles of various stakeholders in the

provision of AYHD services. This was subsequently amended (AO 138 s. 2000) to ensure that health services for adolescents and the youth are sensitive to gender, culture, ethnicity and religious differences.

A decade later particularly in September 2010, DOH released the National Standards and Implementation Guide for the Provision of Adolescent-Friendly Health Services (AFHS) for public health institutions and providers. To further support the government's program for young people, the DOH Secretary issued AO 2013-0013 entitled "National Policy and Strategic Framework on Adolescent Health and Development (AHD)." This policy framework stated the urgency of addressing the rising AFR and other related risky behavior of Filipino adolescents with the following major strategies: 1/ advocacy, 2/ health information management, 3/ new and stronger partnerships, 4/ skilled service providers, families and adolescents, 5/ health insurance for adolescents, and 6/ access to quality services.

Programs were identified to correspond with the foregoing strategies including the provision of adolescent-friendly health services. A reference material for the Competency Training on Adolescent Health for health providers was also developed. It enjoined the responsible DOH units and other pertinent government agencies (DSWD, DepEd, CHED, TESDA) to partner with the LGUs, the UN and other development partners, the civil society, faith-based organizations and the private sector to help implement the foregoing strategies.

In the September Inter-CA meeting, USAID's OH Director specified that the Philippine Mission has committed to assist DOH in 1/ reducing first births to under 18, 2/ reducing subsequent births within less than 36 months from the last, 3/ reducing unplanned or mistimed pregnancies among young adults or the 20-24 age group, 4/ developing an AYRH strategy and documenting and disseminating best practices related to interventions which are currently implemented in the country. The following needs were discussed during the meeting:

A review of the AYRH situation in the country, to appreciate the magnitude and nature of the problem on teen pregnancies and AYRH;

The DOH, LGUs, CSOs, and development partners, including USAID CAs are implementing a variety of programs which are directed at preventing teen pregnancies and promoting ARH. There is need to clarify how these various programs and activities contribute to addressing the problem of teen pregnancies and AYRH; and

Clarification of the magnitude and nature of the teen pregnancy and AYRH problem, as well as the contribution of various initiatives will help guide USAID in programming its support to AYRH programs in the short and medium term. This includes possible modification and adjustments to existing AYRH programs implemented by CAs.

This assessment study was proposed by HPDP, a USAID CA, to address the foregoing needs.

II. Research objectives

The research objectives are as follows:

1/ To describe the magnitude and nature of the teen pregnancy problem and AYRH in general, using best available evidence (i.e. survey, program and project data, other available references both local and international) for young women and girls aged 10-24 years old.

2/ To assess the various policies, programs, and initiatives implemented by DOH and other government agencies (i.e. POPCOM, DepEd, DSWD, LGUs), CSOs, NGOs, DA, USAID CAs and other relevant partners, including faith- based groups, as well other agencies in terms of:

- a. Responsiveness to the need for preventing and managing teen pregnancies and promoting AYRH given the magnitude and nature of the problem. A proposed framework in assessing the responsiveness of programs is the health value chain that traces the link of various interventions concerning policy, budgets, demand generation and service delivery in the use of services and its ultimate impact on teen pregnancies.
- b. Addressing age-specific reproductive health needs of adolescents and youths such as:
 1. Preventing and managing teen pregnancies to those below the age of 19 years
 2. Reducing subsequent pregnancies (no less than 36 months) to those who got pregnant
- c. Reducing pregnancies (no less than 36 months) to those 19 -24 years; Use of known and effective interventions given best available evidence from scientific literature and field findings.

3/ To document good practices in the prevention and management of teen pregnancies and provision of AYRH services.

4/ To provide recommendations which may impact on national policy, USAID support and specific CA interventions given findings from the assessment.

III. Scope of the study

The study covers the following:

1/ Policies, programs and initiatives that target young people aged 10-24 years in the country;

2/ Programs/ projects including, but not limited to the following topics/ items for consideration:

- a. Interventions addressing issues on: 1) postponing early initiation of sexual activity; prevention of pregnancies, 2) taking care of young moms, 3) prevention of subsequent

pregnancies; determining factors which resulted to teenage pregnancies (i.e. coerced sex, role of male partner, parents/guardians, etc.);

- b. Interventions addressing other adolescent issues related to adolescent pregnancies (i.e. psychosocial issues, depression, substance abuse, gender-based health issues);
- c. DOH and relevant government agencies, USAID Cooperating Agencies, selected development partners working on AYRH, NGOs, LGUs, and CSOs in Luzon, Visayas and Mindanao.

IV. Methodology

Qualitative methods particularly desk review, key informant interview, observation and focus group discussion (FGD) are the main methods of this study.

- A. **The desk review.** Information about the magnitude and nature of the teenage pregnancy and motherhood and AYRH in general was collected particularly about a/ differences in the age definition of adolescents and youth by international and national agencies, adolescent fertility rate (AFR), consequences and factors related to AFR, unmet need for FP, STI and HIV, and smoking, alcohol intake and drug use. The desk review also examined laws and policies which are protective of adolescents particularly pregnant adolescents and teenage mothers.
- B. **The field study.** The pregnant adolescent is the fieldwork's main focus. It is particularly concerned about presence of a supportive AYHD policy and the link between demand generation activities and service delivery as well as the contribution of financing, governance and capacity-building strategies in ensuring her safe delivery and acceptance of a birth-spacing method.

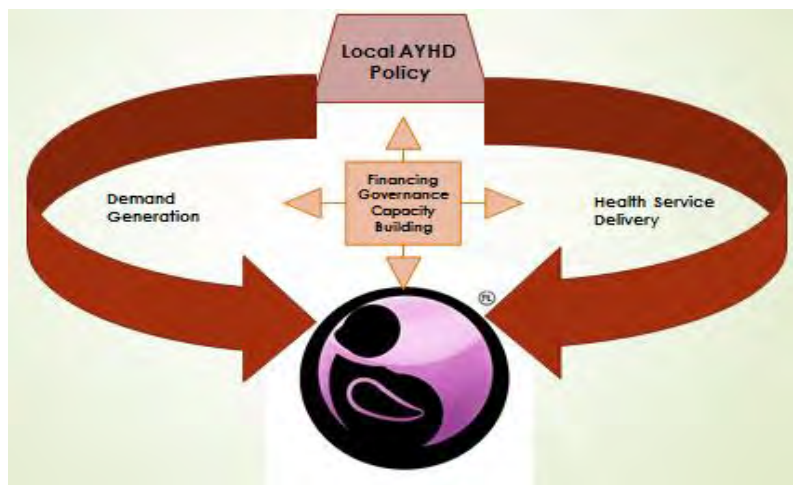


Figure 1. Field study framework

The study is also concerned about the levels of care and support for the pregnant adolescent— from the family, community and different agencies, the primary and tertiary-level health care facilities. She is expected to be referred by the RHU or health center (primary health care) to a CEMONC-capable hospital for prenatal, natal and postnatal care. The hospital in turn refers her back to the RHU for postpartum and other health care services. Social support from different government agencies to the teenage mother after delivery is vital for her future and her child.



Figure 2. Levels of care of teenage pregnancy and motherhood

C. **Location of the field study.** Because of time constraints (this entire study was undertaken for three months from May to July 2016), rapid assessment was conducted in selected CA and non-CA health facilities, school and community-based teen centers in Luzon, Visayas and Mindanao.

The CA facilities and teen centers were chosen after consultation with the key officials of Luzon, Visayas and Mindanao Health. The selection was also discussed during the presentation of the inception report during the CA-TWG meeting which was convened by HPDP in May 2016.



Figure 3. Location of the research sites

D. **The health facilities studied.** Six public and one private tertiary hospitals were the main facilities the project team studied because pregnant adolescents are compelled by the state to deliver there due to their high-risk health status. Technical assistance was extended by the CAs in their respective areas to establish their programs for teens especially the training of hospital staff on the use of the DOH Adolescent Job Aide (AJA), formulation of a manual or protocol of operations, development of local AYRH ordinances and other related support. The programs for teens in these hospitals are new--five were launched in 2015 and two in 2014. After administering the DOH AFHS standards facility assessment guide not all of them at this stage of their respective development, could be considered as good practices for further documentation.

The clients' perspectives' particularly the pregnant adolescents and teenage moms, their partners/husbands and mothers were included in the study to determine their perceptions and experiences in obtaining services from the tertiary hospitals.

Student and community-based-based teen centers were visited to determine their AYRH programs and activities as well as their link to the public health system and young people in their communities.

Some RHUs were visited mainly to learn whether the health providers are referring pregnant teenagers to the tertiary facilities and are followed up for postpartum care

including their uptake of birth-spacing methods not only at their health facilities but also in their communities.

Selected NGOs were studied to determine their current AYRH programs and how they are linked to the public health system and their communities. One NGO no longer provides AYRH services and two have just recently engaged in this field. They still have to demonstrate a good practice which other similar groups could emulate. Our project team, however, collected data about them.

Table 1. Selected government and non-government institutions of the study

Facility/institution/organization	Number
DOH-retained hospital	2
Provincial/city hospitals	4
Private hospital	1
Rural health unit/barangay health centres	4
Public school-based teen centres	4
Government community-based teen centres	2
NGO with AY program	3

E. **Methods, key informants and respondents.** This qualitative study utilized varied methods particularly desk review of documents, reports and research studies, key informant interview (KII), observation, focus group discussion (FGD), and group interview.

The fieldwork was conducted from May 31, 2016 to July 6, 2016. Prior to the fieldwork, the project leader and a consultant presented the inception report during a CA TWG meeting to clarify the design of the study and to discuss the selected health facilities and institutions.

A total of 100 key informants were interviewed in the research sites. Seventeen FGDs and 20 group interviews were conducted. The pregnant adolescents and pregnant teenagers who were included in the study were mostly single and who were either living in with partners and with their parents. Refer to Table 2 for the distribution of the key informants, FGDs and group interviews.

Table 2. Number of KIs, FGDs and group interviews conducted in Luzon, Visayas and Mindanao

Research area	Key informant	FGD	Group interview
Luzon	58	8	9
Visayas	16	3	6
Mindanao	26	6	5
Grand Total	100	17	20

F. Research instruments. KI and FGD interview and observation guides were the main instruments of the study. Four research instruments were developed as follows.

- An interview guide for focal persons to draw out information about their AYRH policies and strategies;
- A facility assessment guide which was drawn mainly from the monitoring tools of the DOH *National Standards and Implementation Guide 2010*. This instrument was utilized to assess which among the hospital-based programs for teens especially for pregnant adolescents and teen moms could be considered a good practice for further documentation;
- A interview guide for two types of school and community-based teen center personnel—the coordinator/adviser and the peer educator/teen volunteer; and
- The fourth set of instruments focused on a/ pregnant adolescent and teenage mom, b/ their guardians, mothers, and c/ partners. These instruments are intended to draw out the foregoing individuals’ perceptions and experiences about the services from the hospital-based programs for teens.

An informed consent form is on the first page of each research instrument. To ensure confidentiality of the interviews, the researcher was the one who signed the informed consent form after the approval from the KI or respondent was obtained.

Table 3. Research instruments and their contents

Interview guide	Method/and informant respondent	General contents
A.AYHD focal persons from selected agencies	Key informant interview(KII)	<i>AYRH Policies, Demand Generation activities, Health Service Delivery, Capacity Building, Governance, Financing</i>
B .Facility Assessment 1/ Facility observation checklist 2/ Facility manager table 3/ Service provider 4/ Health facility	Observation KII	1/ AFHS Standards Standard 1 Adolescents in the catchment area of the facility are aware about the health services it provides and find the health facility easy to reach and to obtain services from it. Standard 2 The services provided by health facilities to adolescents are in line with the accepted package of health services and are provided on site or through referral linkages by well-trained staff effectively. Standard 3 The health services are provided in ways that respect the rights of adolescents and their privacy and confidentiality. Adolescents find surroundings and procedures of the health facility appealing and acceptable. Standard 4 An enabling environment exists in the community for adolescents to seek and utilize the health services that they need and for the health care providers to provide the needed services <i>2/ Classification of facility staff, their status of tenure and training received</i> <i>3/ Service delivery, Financing, Regulation, Governance, Recommendation</i> <i>4/ General profile of pregnant adolescents' their access to services, Initial experience of consultation, prenatal care, delivery, post-partum care, FP services, recommendations</i>
C. Teen health centre coordinator and teen volunteers/peer educators 1/ School/ community-based teen centres coordinators/principal 2/ Teen health centres /kiosks/quarters' peer educators/ teen volunteers	1/ KII 2/ FGD	<i>1/ Background information, Teen centre basic information, Perceptions about adolescent pregnancy</i> <i>2/Background information, general information about teen centre and its activities, AYHD information dissemination, views about teen pregnancy</i>

Interview guide	Method/and informant respondent	General contents
<p>D. Pregnant teens, teen moms and their guardians</p> <p>1/ Pregnant teens and teenage mothers 2/ Mother or guardian of pregnant adolescent and teenage mothers 3/ Pregnant teens and teen mothers 4/ Interview guide for partners/husbands</p>	<p>1/KII 2/KII 3/FGD 4/ KII</p>	<p><i>1/Personal background information, perceptions and experience on using the health facility, Personal experience on pregnancy</i></p> <p><i>2/Background information, Daughter's pregnancy history, experience in using the health facility</i></p> <p><i>3/Background information, experience in using the health facility, personal experience about pregnancy,</i></p> <p><i>4/ Personal background, pregnancy experience of partner and his response</i></p>

The research tools, however, were modified in the course of the fieldwork because of varying contexts and circumstances in the research sites. In the original research design, it was perceived that the one-on-one personal interview would be appropriate for pregnant teenagers and teen moms because of the notion that they would not talk about their personal experiences in a group activity. However, FGDs or group interviews were conducted in some places where pregnant teenagers and teen moms were gathered together for the teen centres' education sessions and for postnatal care. It appeared that these young women were generally comfortable in sharing their stories in a group because of the similarities in their experiences and for the support extended to them by the health facilities' health providers.

In some places, the FGD was also deemed appropriate for teen moms who were asked by the health center to come for the study. For example, in one urban Mindanao barangay, it was difficult to ask a large group of teen moms with infants or toddlers to wait for their turn to be interviewed. Because there were only four project team interviewers who were conducting the field study, it was best to conduct a FGD.

G. Data analysis. Qualitative content analysis was utilized in processing the desk review and field data.

H. Limitations of the study

In this study's TOR, it was specified that the project team should include 20 to 24 year-old mothers (young adults) to determine their birth-spacing practices. During the fieldwork, however, the hospitals' programs for teens cater mainly to below 19 year-old pregnant adolescents. Thus only few 20-24 year old key informants were included in the study because most mothers of this age category are included in the mainstream clientele of the hospitals. Those who served as the KIs were teen moms who became champions or peer educators of the hospital teen centers.

Few male partners came to the hospitals and RHUs to accompany the pregnant adolescents so this study was only able to interview few men. Most of them were reportedly working or have parted ways with the women whom they impregnated.

The hospital facility interview guide simply asked for the presence and absence of a facility indicator like signage, schedule and flow of service, duration of service, and did not assess the quality of the facilities and activities.

Because the field study in some teen centers was conducted during summer break or before classes started, the project team was unable to interview several peer educators in these facilities. We only interviewed those who came to school for other purposes.

CHAPTER TWO

Results of the Desk Review

The desk review results are presented in two main parts. Part I describes the magnitude and nature of teen pregnancy in the country and AYRH in general. Part II presents the laws and policies which are supportive of adolescents and teen mothers as well as the AYRH programs, and initiatives of government agencies, development partners and civil society organizations. A summary caps this chapter.

I. Magnitude and nature of teen pregnancy and AYRH

This section describes the a/ varied classification and age ranges of adolescent and youth by different international and national agencies, b/ adolescent fertility rate (AFR), c/ factors associated with AFR, d/ consequences of high AFR, e/ contraceptive use among adolescents, f/ violence against young people, g/ HIV and AIDS, h/ ASRH knowledge and h/ substance abuse (smoking, alcohol intake and drug use).

Adolescent and youth (AY) age definition. Table 4 shows that different international and national organizations have varying age ranges for adolescents and youth, depending on their institutional thrusts, roles, responsibilities and services (POPCOM, PPMP Directional Plan 2011-2016, 2012).

Table 4. Definition of AY by different government and development agencies

Institution	Category	Age Range
World Health Organization (WHO)	Adolescents	10-19
Department of Health (DOH)	Adolescents	10-19
Department of Social Welfare and Development (DSWD)	Youth	15-24
Department of Labor and Employment (DOLE)	Youth	15-24
Technical Education and Skills Development Authority (TESDA)	Youth	15-24
Department of Interior and Local Government (DILG)	Youth	15-21
UP Population Institute (UPPI)	Young adult	15-24
Department of Education (DepEd)	Youth	7-30
National Youth Commission (NYC) (based on Republic Act 8044)	Youth	15-30

In the 2010 census, there were 92,097,978 Filipinos. Close to one third (30.6%) of the population were young people aged 10 to 24. Almost 20 million (70.3%) were adolescents 19 years old and

below. Close to one half (49.1%) of all young people were females. Among all females, 70 per cent were 19 years old and below. (See Table 5.)

Table 5. Adolescent Population in the Philippines, Census 2010*

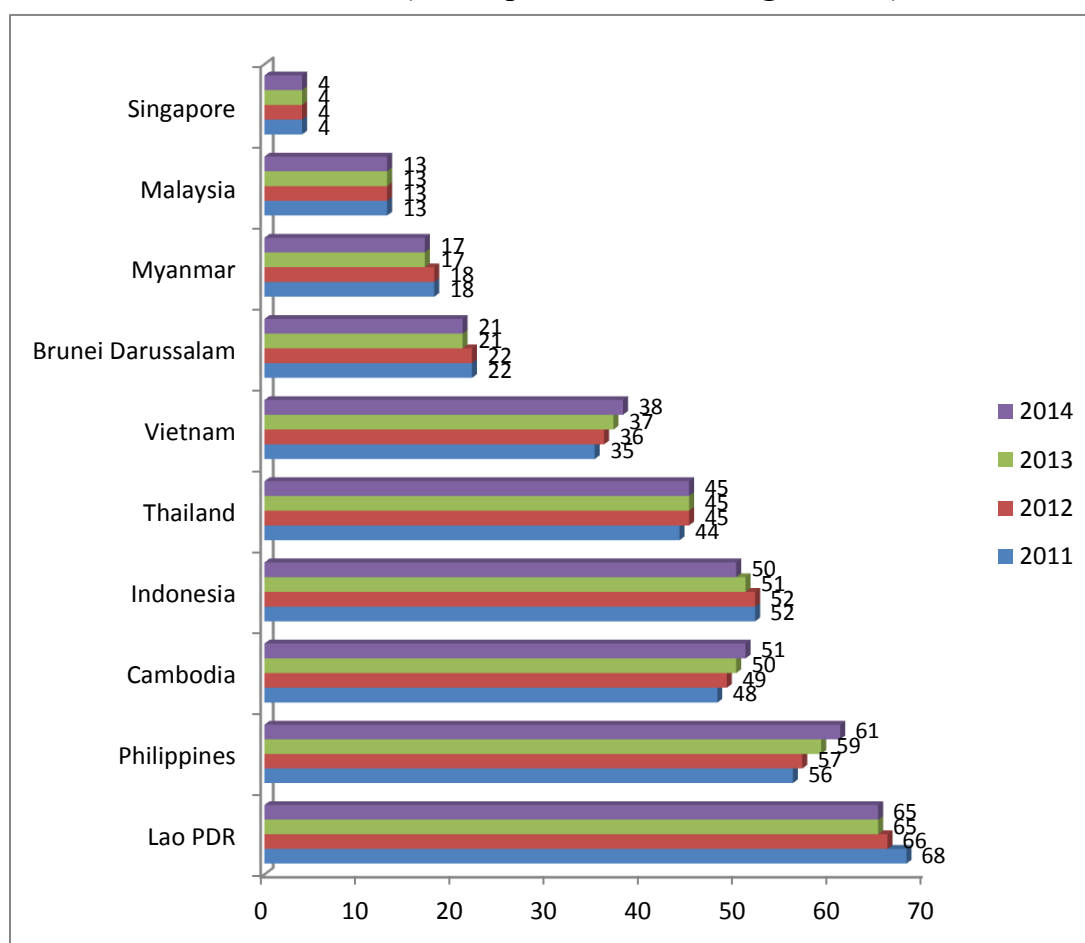
Age	Both Sexes	Female	%
20-24	8,369,801	4,140,276	49.5
15-19	9,676,094	4,761,845	49.2
10-14	10,168,546	4,937,613	48.6
Total	28,214,441	13,839,734	49.1

Source: https://psa.gov.ph/sites/default/files/attachments/hsd/pressrelease/Philippines_0.pdf

*Total population: 92,097,978.

Adolescent fertility rate (AFR). From years 2011 to 2016, the Philippine AFR ranked second among the 10 Southeast Asian countries. It was the only country with a rising AFR from 56 in 2011 to 61 in 2014.

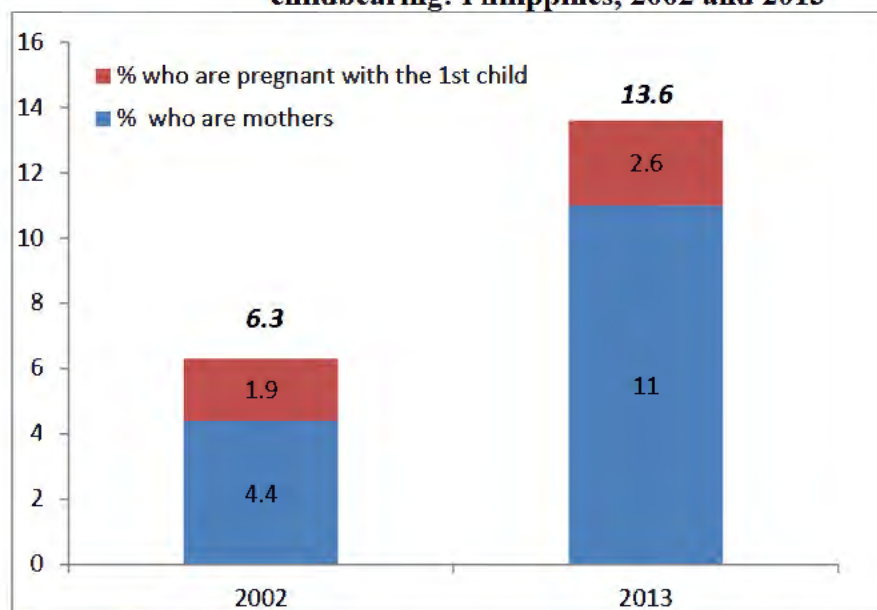
**Figure 4. Adolescent Fertility Rates, Southeast Asia 2011 to 2014
(Births per 1,000 women aged 15-19)**



Source: United Nations Population Division, World Population Prospects
data.worldbank.org/indicator/SP.ADO.TFRT

The 2013 YAFS findings supported the foregoing trend because the proportion of females aged 15-19 who had begun childbearing increased from 6.3 per cent in 2002 to 13.6 per cent in 2013. At the time of the study, 11 per cent already had children while 2.6 per cent were pregnant (DRDF, 2014).

Figure 5. Proportion of women, aged 15-19 who have begun childbearing: Philippines, 2002 and 2013



Source: DRDF, 2014

The rise of the Philippine AFR masks diverging trends by area of residence. While the AFR in rural areas declined from 74 in 2003 to 63 in 2013 the rate went up from 40 to 52 in the urban areas. The high and increasing trend of AFR in these areas suggests that greater efforts are needed to ensure the young people's access to birth-spacing and adolescent-friendly services (Guttmacher, 2015).

Early pregnancy and motherhood varies by education, wealth quintile, and region. It is more common among women aged 15 to 24 with less education than among those with higher education (44 % for women with elementary education versus 21 % for women with college education).

Early childbearing is highest in the regions of Caraga (38%) and Cagayan Valley (37%). The region with the lowest figure is the CALABARZON (24.2%) followed by the NCR (24.3%). The proportion of young adult women who have begun childbearing is higher among those who belong to poor households than those who come from wealthier households (37% for young women in the lowest wealth quintile vs. 13% for women in the highest wealth quintile) (PSA & ICF International, 2014).

With regards to male fertility (although this measure might be prone to bias because a male may not always know whether he has impregnated a woman), it was reported that among 15-19 year-old males, 2.4 per cent got someone pregnant. There is no difference among those with high or

low educational attainment. In terms of regional performance, the figures varied from a low of 0.9 per cent in Cagayan Valley and Zamboanga Peninsula to a high of 4.7 per cent in NCR and in CARAGA (DRDF, 2014).

Consequences of early childbearing. Teenagers from poor socioeconomic backgrounds are disproportionately represented among pregnant teenagers. However, experts have argued that teenage pregnancy should be understood as a symptom of dire economic conditions. Teenage pregnancy perpetuates the cycle of poverty and inequality because most pregnant teenagers have no source of income and face greater financial difficulties later in life. This is because they drop out of school and are less likely to pursue further education or skills training (Van der Hor, 2014).

Giving birth in a medical facility is becoming more common in the Philippines: As of 2013, 70 per cent of adolescent mothers had their most recent delivery at a health facility, compared with only 38 per cent in 2008. Despite this development, maternal deaths among teenage women (19 years old and below) have increased from 130 in 2005 to 168 in 2010 (Guttmacher, 2015).

On the first week of life, there is a 50 per cent chance of stillbirth and death among infants of adolescent mothers compared to those babies born to mothers aged 20 to 29. On the first month of life, mortality among babies of teenage mothers is high by 50 to 100 per cent. Preterm births, low birth weight and suffocation among infants born to adolescents are higher which raises the likelihood of poor health and even death for the child (WHO, 2016).

Many researches have shown that postponing childbirth could significantly improve the health of adolescents, reduce population growth rates and potentially creating wide-ranging socioeconomic advantages (WHO, 2016).

A recent study in the Philippines which was funded by UNFPA estimated that PhP33 billion in potential lifetime income for teenage girls is lost due to early pregnancy. Using 2012 and 2013 data from the Philippine Statistics Office's surveys, health economist Alejandro Herrin predicted that pregnancy or childbirth during a girl's teen years reduces the probability of high school completion. He calculated that a teenage girl who gets pregnant and does not finish high school may potentially lose earnings up to P83, 000 a year when she would get paid for work at age 20. This is about 87 per cent of the potential annual income of a 20-year-old woman who completed her high school education and did not get pregnant in her teen years. He added that there is a wide gap in the estimated daily wage rate between a girl who gets pregnant early and a girl who finishes her secondary education (Mocon-Ciriaco, 2016; UNFPA, n.d.).

Factors associated with AFR. A number of factors are linked with increasing AFR particularly younger age at menarche, sexual initiation and activities, HIV and AIDS incidence and contraceptive use.

Younger age at menarche

A contributory factor to the increasing prevalence of early childbearing is that adolescents are menstruating at younger age. The table below presents the reported age at menarche by women in the various reproductive age categories.

Table 6. Percent distribution of women by age at menarche according to age during the survey, 2008 NDHS

Current Age	Per cent reporting menarche at given age						Mean age at menarche
	≤ 10	11	12	13	14	15+	
15-19	2.5	9	31.3	29	19.1	9.2	12.8
20-24	2.9	8.9	28.2	27.3	17.9	14.9	13
25-29	2.4	8.6	26	26.5	19.1	17.5	13.2
30-34	3	7.5	23	24.5	22.4	19.6	13.3
35-39	2	7.6	22.1	22.5	22.4	23.2	13.4
40-44	2.5	6.2	24.8	21.1	19.1	26.3	13.5
45-49	1.4	6	20.9	20.6	20.4	30.7	13.7
Total	2.4	7.9	25.8	25.1	19.9	18.8	13.2

Source: NSO (Philippines) and ICF Macro, 2009

Table 6 indicates that the reported age at menarche has been declining across successive cohorts of women, e.g., among 15-19 year old girls the reported age at menarche peaks at age 12 (31%) while among the 41-49 year old women, the peak is at 15 and above (30%).

Sexual initiation and activities

Sexual initiation signals the start of exposure to the risk of reproduction and childbearing as well of STIs (DRDF, 2014). While the 2013 NDHS reported a decline in the percentage of women aged 20-49 years old who had sexual initiation by age 15 (from 2.7 % in 2003 to 2.4 % in 2013), the percentage of those who had first sexual encounter by age 18 increased from 17.6 per cent to 18 per cent. The nationwide survey also shows that in 2013, one in three youth aged 15 to 24 are engaged in sexual intercourse before marriage, compared to 23 per cent a decade ago (NSO (Philippines) and ORC Macro, 2004; PSA and ICF International, 2014).

The 2013 NDHS found that two percent of women aged 15 to 24 had their sexual debut before they turned 15. Close to one fifth of the 18 to 24 year women had their sexual initiation before the age of 18. However, women from better off families, urban areas and with higher education tend to have lower proportion of sexual initiation before they turn 18. (PSA and ICF International, 2014).

Only seven per cent of young adult women who had some college education had their sexual debut at 18 compared to over 40 per cent of those who had some elementary schooling. Over one third (36%) of the young adult women from the lowest wealth quintile had sex at 18 compared to only one tenth among those from the highest quintile. More rural than urban young adult women (22 vs. 17%) reported that they had sex before they reached the age of 18 (PSA, 2014).

The YAFS4 results, on the other hand, show an increasing trend in premarital sex among adolescent males and females. Among males, the proportion of those who engaged in premarital sex was 26 per cent in 1994 but in 2013, this rose to 35.8 per cent. A similar pattern was noted among the female respondents. The proportion of those who engaged in premarital sex was 10 per cent in 1994. Two decades later this proportion almost tripled (28.7%). A large majority (78 %) of the youth who engaged in premarital sex for the first time did not use any form of contraception or protection against STIs, HIV and AIDS (DRDF, 2014)

In the past 10 years, the YAFS 4 found that more Filipino adolescents are utilizing the internet and smart phones. Around a quarter have uploaded or downloaded pornographic videos through their cellular phones and from the internet. A small number (4%) have personally met their sexual partners through the internet and mobile phone text messaging (DRDF, 2014)

What is alarming is the non-use of any protection or contraception against pregnancy or sexually-transmitted diseases when they are having sex for the first time. For example, YAFS4 data reveal that among the youth who have premarital sexual experience, 12.9 per cent used condom during their first sexual encounter while 9.2 percent reportedly resorted to withdrawal. Over three fourths (78%) were all unprotected (DRDF, 2014).

YAFS 4 further found that some young people are engaged in commercial sex (paying for or getting paid for sex), casual sex, non-romantic regular sexual activities and extramarital sex. Among adolescents who reported to have ever paid for sex, only a little over a quarter (27.3%) used condom in the last 12 months prior to the survey. Among those with casual sex experience, only 18 per cent used condoms the last time they had sex (DRDF, 2014).

Moreover, YAFS4 documented an emerging new type of non-romantic relationship among young people called “FUBU” (or fucking buddies or friends with benefits)-- 6.6 percent among the adolescent males and 0.7 females are engaged in this type of sexual relationship.

Knowledge about ASRH

In 2013, adolescent Filipino women had heard of an average number of 4 to 5 modern contraceptive methods. Two-thirds of the women aged 15–24 reported that they knew where to get condoms. Over one-third (35%) reported that they could obtain condoms on their own (Guttmacher, 2015).

Although it is important to know when in the menstrual cycle a woman is most likely to conceive to be able to successfully use an array of contraceptive methods, only around a quarter (23%) of Filipino adolescent women correctly identified a woman’s fertile period (Guttmacher, 2015).

Despite the increasing level of sexual activities among the youth, YAFS4 found that only over a quarter (27.4%) reported that they have sufficient knowledge about sex (31% among males vs. 24% among females). Only over one third (36%) of those who have college education claimed that they have adequate knowledge about sex. The proportion of the YAFS4 respondents who

gave correct responses about a woman's fertile period increased with education level. However, the percentages are low—11.1 per cent among those with elementary education and 18.9 per cent among those with some college education (DRDF, 2014).

Adolescent and youth HIV/AIDS incidence

In 2009, the Philippines had 4,424 HIV cases and this number was predicted to rise up to 45,000 in 2015 unless proper interventions are installed (UNESCO, 2012). Most of those who have HIV are males, aged 15-24. The mode of transmission for HIV in the country is through sexual intercourse mostly among MSM and injecting drug users and through mother-to-child transmission. Metro Manila, Cebu and Davao have the highest number of HIV cases. People who are at greater risk of acquiring the disease are those a/ with STIs, b/ who are sexually active, c/ sex workers and their clients, d/ MSM, e/ injecting drug users, f/ who have no knowledge or information about HIV and AIDS (UNESCO, 2012).

The HIV/AIDS Registry of the Philippines (HARP) reported that from January 1984 to April 2016, the Philippines a total of 33,419 HIV Ab-seropositive cases. A large majority (91% or 30,455 people) of the total reported cases were asymptomatic at the time of the report. Ninety-two per cent (30,865) were males and 2,543 were females. The median age was 28 (range, 1 year [most likely from vertical transmission] to 82 years old). More than one half (17,096 cases or 51%) were from the 25 to 34 year-old category while over a quarter (8,965 or 27%) were the youth aged 15 to 24 (DOH- HARP, 2016).

For the same period, the regions with the most number of reported HIV/AIDS cases were from the NCR (a total of 14,415 cases or 43%), followed by (in this order) Region 4-A (with 4,610 cases or 14%). Region 7 (2,958 cases or 9%), Region 3 (2,772 cases or 8%) and Region 11 (1,979 cases). Seventeen per cent (5,539) of the cases came from the rest of the country (DOH, HARP, 2016).

Moreover, as regards mode of transmission, MSM transmission was predominant (25,068 or 81%) among males, followed by male-female sex (4,067 or 13%), and sharing of infected needles (1,388 or 4%). More than half (13,455 or 54%) of cases among MSM belong to the 25-34 year age group while 7,401 (30%) were youth 15- 24 years old. Meanwhile, among females, HIV-AIDS transmission was largely accounted to male-female sex (2,320 or 91%) followed by sharing of infected needles (89 or 4%). A total of 82 children (less than 10 years old) and 7 adolescents were reported to have acquired HIV through mother-to-child transmission. It is worth noting that from 1984 to 2009, in general, the predominant mode of transmission was male-female sex. Starting in 2010, the trend shifted to male to male sex and continually increased since then. For instance, from January 2011 to April 2016, 81% (22,140) of new infections through sexual contact were among MSM (DOH, HARP, 2016)

Notably, individuals infected with HIV are getting younger. Within the 2006-2010 period, the youth accounted for 25 per cent of HIV case in the Philippines. This figure went up to 28 per cent within the period of 2011-2016 period (DOH, HARP, 2016).

The 2013 NDHS showed that only one per cent of the sexually-active young women aged 15-24 were tested for HIV in the 12 months preceding the survey. The 2015 Philippine HIV/AIDS Registry showed that two fifths (43%) of the estimated 18,983 adolescents and young people with HIV infection were diagnosed. It was observed that only a few adolescents showed up in the HIV-testing centres. Those who were interested to get tested were constrained by the required parental consent (for under 18 years old) for HIV as mandated by RA 8504 or the Philippine AIDS Prevention and Control Act of 1998 (PSA, 2014).

Contraceptive use among adolescents and youth

Table 7 shows that from 2003 to 2013, the use of contraceptive method among 15-19 year old Filipino women was very low with small increment of 2.4 in 2003 to 4.4 in 2013. The same pattern is shown for the use of any modern and traditional methods.

Table 7. Proportion of women aged 15-19 by contraceptive method currently used: Philippines, 2003, 2008 and 2013

Year	Any Method	Any Modern Method	Any Traditional Method
2003	2.4	1.3	1.1
2008	3.1	1.6	1.5
2013	4.4	2.4	2.1

Sources: NSO (Philippines) and ORC Macro, 2004; NSO (Philippines) and ICF Macro, 2009; PSA and ICF International, 2014

The DOH noted that non-desire for pregnancy and high awareness of contraceptive methods were not enough to encourage adolescents to use contraceptives. Among the reasons cited for the low contraceptive use among adolescents are the perceptions that: 1/ contraceptives are for married individuals of reproductive age only; 2/ contraceptive use is taboo for young unmarried individuals; and 3/condoms are mainly for protection from STIs and HIV & AIDS rather than as contraceptives (DOH, DOH website, n.d.).

Over a quarter (29%) of married adolescents had an unmet need for FP, they do not want to get pregnant but they are not using any contraceptive method. This proportion is much higher than

the unmet need of married women of any other reproductive age (range, 15-22%) (Guttmacher, 2015).

The level of unmet need for FP among adolescents has very little change since 2003 (34%) until 2013 (32%). In 2013, the proportion of unmet need for FP among urban adolescents was higher than those of the rural adolescents (36 vs. 27%). Although the overall unmet need for FP among all married women of reproductive age has declined, the proportion is still much higher among married adolescents (Guttmacher, 2015).

While the RP and RH Act of 2012 guarantees universal access to FP, the Philippine Supreme Court did not allow the provision of FP and RH services to minors without parental consent. Those who have been pregnant or had a miscarriage will need to present supporting documents from legitimate authorities before they are allowed to access FP and RH services (Guttmacher, 2015).

Violence (physical, verbal and sexual abuse) against adolescents and youth

In a 2009 study of Plan International-Philippines entitled, “Towards a Child-Friendly Education Environment: A Baseline Study on Violence Against Children in Public Schools,” it was found that a majority of primary school children (73.6 %) and high school students (78.4%) from urban areas have suffered from their peers’ verbal abuse. Close to one third (30.2%) of the children in primary schools and a higher proportion (37.6%) of high school students from rural areas have experienced physical violence from other young people.

Urban primary and high school students have suffered from verbal sexual abuse from their peers (26.7% and 43.7% respectively). Some rural primary (9.6%) and high school students (17.7%) reported that they had experienced inappropriate touching from their peers and other people. Physical and sexual violence among all adolescents who were studied in 2008 was reportedly high at 17.2 per cent (Plan International-Phils, 2009).

The 2013 NDHS reported that the percentage of women who experienced violence during pregnancy was 13.6 per cent for women aged 15-19 and 6.2 per cent for women aged 20-24. These rates are higher than the 2008 levels which showed that 5.8 per cent of women aged 15-19 and 4.4 per cent of women aged 20-24 suffered from violence during pregnancy (NSO and ICF Macro, 2009; PSA and ICF International, 2014).

Smoking, Drinking and Drug Use

The YAFS4 data show that the prevalence of non-sexual risk behaviors particularly drinking and drug use has declined from years 2002 to 2014 (see Table 8 below). However, the adolescents and youth who were smoking at the time of the interview doubled (21 % in 2002 to 41.6% in 2013).

Table 8. Trends in non-sexual risk behaviors of Filipino youth: 1994, 2002 and 2013

Year	Currently smoking	Currently drinking alcohol	Ever used drugs
1994	21.6	37.4	5.7
2002	21.0	41.6	11.0
2013	41.6	36.7	4.0

Source: DRDF, 2014

There were more males than females who have ever smoked (56% vs. 22%). At the time of the interview, about one fifth (19.7%) of all the youth were smoking. More than one third (35.4%) of males were smoking and a much smaller proportion (4.7%) of females were smoking. The males started smoking at an earlier age (mean, 15.7 years old) compared to females who started smoking at a mean age of 16.3 (DRDF, 2014).

The YAFS 4 found that more than one half (53.2%) of its male respondents were drinking alcohol at the time of the survey. Around one fifth (21%) of its female respondents were alcohol drinkers. Alcohol intake is higher among college-level youth than high school undergraduates (43% vs. 29%). (DRDF, 2014).

Drug use is less common compared to smoking and drinking with only four per cent reporting that they ever used drugs. Only 7.1 per cent of male respondents have ever used drugs while only 0.8 per cent disclosed as every users of drugs. The mean age for first drug use is 17.3 years for both males and females (DRDF, 2014).

II. AYRH legislations, policies and program

The Philippines has a number of national laws which are supportive of AYRH and they can be classified into social protection and health legislations. The following are the major social protection laws:

- RA 9710 Magna Carta of Women of 2010
- RA 10533 Enhanced Basic Education Act of 2013
- Anti-Bullying Act of 2013
- Republic Act No. 8972 An Act providing for benefits and privileges to solo parents and their children (2000)

There are two significant legislations in health which are helpful to adolescents:

- Responsible Parenthood and Reproductive Health Act of 2012
- Republic Act No. 10606 An Act Amending Republic Act No. 7875 Otherwise known as the “National Insurance Act of 1995” As Amended, And For Other Purposes (2013)

Policies which are reinforcing the foregoing laws and programs of national government agencies, development partners and CSOs are briefly described in this section.

Social Protection laws. The major social protection legislations which are supportive of young people including pregnant teenagers and teen mothers are as follows.

Republic Act 9710 Magna Carta of Women of 2000

This wide-ranging 2010 women's human rights legislation seeks to remove discrimination against women by knowing, safeguarding, realizing and upholding the rights of Filipino women particularly the vulnerable, marginalized and those in socially-difficult circumstances.

This law's provisions would apply to all women. However, specific provisions are relevant to female adolescent and youth's SRH and these are quoted verbatim as follows:

- **SEC13. *Equal Access and Elimination of Discrimination in Education, Scholarships, and Training* (c)** Expulsion and non-readmission of women faculty due to pregnancy outside of marriage shall be outlawed. No school shall turn out or refuse admission to a female student solely on the account of her having contracted pregnancy outside of marriage during her term in school.
- **SEC 17. *Women's Right to Health— (a) Comprehensive Health Services.*** – The State shall, at all times, 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.

The Magna Carta of Women also specifies that women are entitled to comprehensive RH services particularly:

- Maternal care to include pre-and post-natal services to address pregnancy and infant health and nutrition;
- Promotion of breastfeeding;
- Responsible, ethical, legal, safe, and effective methods of family planning;
- Family and State collaboration in youth sexuality education and health services without prejudice to the primary right and duty of parents to educate their children;
- Prevention and management of reproductive tract infections, including sexually transmitted diseases, HIV, and AIDS;
- Prevention and management of reproductive tract cancers like breast and cervical cancers, and other gynecological conditions and disorders;
- Prevention of abortion and management of pregnancy-related complications;
- In cases of violence against women and children, women and children victims and survivors shall be provided with comprehensive health services that include psycho-social, therapeutic, medical, and legal interventions and assistance towards healing, recovery, and empowerment;
- Management, treatment, and intervention of mental health problems of woman and girls. In addition, healthy lifestyle activities are encouraged and promoted through

programs and projects as strategies in the prevention of diseases.

- **SEC. 30. *Women in Especially Difficult Circumstances.*** – For purposes of this Act, Women in Especially Difficult Circumstances” (WEDC) shall refer to 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 such other related circumstances which have incapacitated them functionally. Local government units are therefore mandated to deliver the necessary services and interventions to WEDC under their respective jurisdictions.

RA 10533 Enhanced Basic Education Act of 2013. This legislation stipulates that all Filipinos are entitled to have access to free K to 12 education. This is further supported by the policy directive called “Education for All” 2015 which offers “Alternative delivery models” especially among those who are in socially-difficult circumstances like pregnant adolescents and teen moms. These models include Project EASE (Effective Alternative Secondary Education) which is concerned about students who are unable to attend classes because of personal and financial reasons.

A, number of young people cannot complete their basic education due to several factors particularly poverty, work, health, physical distance and other personal reasons. In the past, the policy emphasis of basic education focused mainly on formal or classroom-type of education for children. EFA 2015 added a new dimension by stressing the value of providing basic education to all through a feasible alternative learning system. This would help the illiterate or the out-of-school students obtain some education or would return to school to enable them to develop some competencies for gainful occupations.

An important scheme which is applicable to those who are caught in socially-difficult circumstances like the pregnant adolescents and teen moms, is the Alternative delivery models which promote access and holding power of schools. Project EASE (Effective Alternative Secondary Education) was implemented for students who are unable to attend classes because of personal and financial reasons. An EASE student can make an arrangement with the school to study at home until she is ready to join the formal school system.

Students who are unable to go to school due to work, physical disability, poverty or are situated in conflict areas could join the Open High School Program, a learner-centered system which utilizes several teaching-learning approaches by using print and non-print tools. This strategy is complemented by the *Balik Paaralan* Program or the Home Study Program. At the elementary level, Project IMPACT, a combination of self-learning tools and an in-school, off-school mode, is implemented in the regions to reach out to students who live in distant places.

Republic Act 10627 Anti-Bullying Act of 2013. . Approved by the Senate and House of Representatives on June 7, 2013, this law empowers the DepEd to penalize schools which do not stop bullying or sanction bullies. It authorizes schools to impose sanctions on student bullies. All elementary and secondary schools would be required to adopt anti-bullying policies and sanctions, which would cover prohibited acts committed within their campuses, school-

sponsored activities whether conducted in or outside the school grounds, school bus stops, school buses, or other properties owned or leased by schools.

Republic Act No. 8972 or the “**Solo Parents’ Welfare Act of 2000.**” This 16-year old legislation was enacted on November 7, 2000 to provide a comprehensive package of services for solo parents and their children especially among those who fall below the poverty threshold. This package would include livelihood, counseling and effective parenting.

Several agencies are enjoined to implement this law, particularly the Department of Social Welfare and Development (DSWD), the Department of Health (DOH), the Department of Education, Culture and Sports (DepEd), the Department of the Interior and Local Government (DILG), the Commission on Higher Education (CHED), the Technical Education and Skills Development Authority (TESDA), the National Housing Authority (NHA), the Department of Labor and Employment (DOLE) and other related government and non-government agencies. (Sec.2, RA 8972).

There are several instances when this legislation is applicable to solo teen mothers or fathers.

- Delivery resulting from rape and other crimes against chastity;
- Spouse is imprisoned for a criminal conviction for at least a year;
- Physical and/or mental incapacity of spouse as certified by a public medical practitioner;
- 4/ Legal separation or de facto separation from spouse for at least one (1) year as long as she/he is entrusted to have custody of the children;
- 5/ Annulment of marriage as decided by a court or by a church as long as she/he is entrusted with the custody of the children;
- 6/ Abandonment of spouse for at least one year;
- 7 Single father/mother who prefers to keep and raise his/her child/children;
- 8/ Any other person who solely provides parental care and support to a child or children: As long as he/she is duly appointed as a foster parent by (DSWD) or as a legal guardian by the court; and
- 9/ Any family member who assumes the responsibility of head of family as a result of the death, abandonment, disappearance, or prolonged absence of the parents or solo parent for at least one year.

Health legislations. There are two major health laws which are supportive of AYRH especially teenage pregnancy and motherhood.

Responsible Parenthood and Reproductive Health (RP & RH) Act of 2012. The outcome of the persistent advocacy by varied stakeholders for more than a decade, the RP & RH Act of 2012 enjoins the government to adequately respond to the RP and RH needs of the people. This legislation intends to empower Filipinos particularly women, adolescents and youth to make informed choices through age and development-appropriate education. The law assures Filipinos especially the poor and those in socially-difficult circumstances, access to information, facilities and services by guaranteeing available and sustainable RH programs. This could be

attained through the collaboration between the national and local governments and in partnership with CSOs, the academe, the private and the basic sectors.

In this RP & RH Law's Implementing Rules and Regulations (IRR) there are provisions which are pertinent to AYRH and these are cited in the following chapters and sections.

(N.B. The provisions below are quoted verbatim.)

Chapter 1—General Provisions—Rule 3, Definition of Terms

Three of the 12 RH elements refer to adolescents and youth.

- **Element 4-** Adolescent and youth reproductive health guidance and counseling at the point of care
- **Element 7-**Age-and-development-appropriate education and counseling on sexuality and reproductive health
- **Element 11-** Age-and development- appropriate reproductive health education for adolescents in formal and non-formal educational settings

The next provision, Chapter 2 Section 4.07, which focuses on minors, has been contentious because of its implications to adolescent and youth's autonomy and decision making.

Chapter 2—Provision and Financing of Care Rule 4—Service Delivery Standards

- **Section 4.07 . Access of Minors to Family Planning Services.** Any minor who consults at health care facilities shall be given age-appropriate counseling on responsible parenthood and reproductive health. Health care facilities shall dispense health products and perform procedures for family planning: *Provided, That* in public health facilities, any of the following conditions are met :
 - a/ The minor presents written consent from a parent or guardian; or
 - b/ The minor has had a previous pregnancy or is already a parent as proven by any one of the following circumstances, among others: 1/ Written documentation from skilled health professional; 2/ Documentation through ancillary examinations such as ultrasound; 3/ Written manifestation from a guardian, local social welfare and development officer, local government official or local health volunteer; or 4/Accompanied personally by a parent, grandparent, or guardian.
- **Section 5.29 Training for Counseling and Referral of Adolescents.** The DOH shall develop a curriculum to train skilled health professionals in counseling about adolescents reproductive health, determining age- and development-appropriate methods or services, and referring adolescents to the appropriate facilities within the reproductive health care,

Republic Act No. 10606 An Act Amending Republic Act No. 7875 Otherwise known as the “National Insurance Act of 1995,” As Amended, And For Other Purposes (2013). This legislation declares that “the state shall provide comprehensive health services to all Filipinos through a socialized health insurance program that will prioritize the health care needs

of the underprivileged, sick, elderly, persons with disability, women and children and provide free health care services to indigents.”

In support of this amended legislation, PhilHealth has a policy instructing that no other fee shall be charged or paid by the PhilHealth patient on any of the identified medical and surgical cases under the case rates package payment scheme.

Two years after the passage of the amended NHIC, three circulars which are beneficial to women who are about to give birth, were released by PhilHealth. These were either revisions or expansion of benefits from the NHIC. These were circulated to all accredited health care institutions and professionals, PhilHealth members, PhilHealth regional offices and branches, local health insurance offices and central office and all others concerns. The circulars are as follows.

- **Circular No. 025-2015:** Social Health Insurance coverage and benefits to women about to give birth revision 1. This circular specifies that those women who are about to deliver and are not yet enrolled shall be covered. This would enable these women and their infants to “have financial access to essential health services that will ensure their survival and well-being.”
- **Circular No 0232-2015.** Enrolment and Coverage of Emancipated Individuals and/or Single Parents below 21 years old from the NHTSPR-identified Poor Families as Indigent Members. This revision states that “Any person below 21 years of age, married or unmarried but with a child, shall be enrolled as a member.”
- **Circular No. 038-2015.** Implementation of the Point of Care (POC) Enrolment Program (Revision 1). This document specifies that all indigents who are not enrolled in PhilHealth shall be a “priority in the use and availment of the services and facilities of government hospitals, health care personnel and other health organizations.” Government health care providers shall ensure that the poor are enrolled in the Program.

All three circulars are most beneficial to poor teenage mothers especially Circular No. 0232-2015 because it compels the public health hospitals to enroll them to PhilHealth.

A. DOH policies

- **DOH AO 34-A s, 2000 Adolescent and Youth Health Policy on AYHD of April 2000.** The DOH expressed its concern about the increasing risky behaviors of adolescents and youth 1.5 decades ago by issuing this first DOH AYHD policy. This served as a basis for creating a Youth Health Subgroup under the Health Cluster Program. This Subgroup envisioned “well-informed, empowered, responsible and healthy adolescents and youth.” Its mission was to ensure that all AY would obtain good quality and wide-ranging health services in a friendly setting. But this structure did not progress until six later when a Technical Committee comprising of members from DOH, other government agencies and NGOs was created to revitalize the AYHD.

Four years later or in 2010, the National Centre For Disease Prevention And Control (NCDPC) drafted the national standards & implementing guide for adolescent-friendly facility, and the primer on the legal bases for providing adolescent health services in the Philippines. It also developed with the Society of Adolescent Medicine of the Philippines, Inc. (SAMPI) the Adolescent Job Aide (AJA), an important training tool for health workers particularly trained and registered doctors, nurses and other health workers who provide services to young people.

The AJA provides a step-by-step guidance to health providers to enable them to attend to adolescent clients more effectively and with greater sensitivity. This tool has three main parts: 1/ Clinical contact between adolescent and providers, 2/ Tips for effective communication and 25 frequently-asked questions (FAQ) regarding health facets about developmental aspects, pregnancy, STI, HIV and others and 3/ Information for adolescents, parents and guardians about AYHD and other developmental aspects. The AJA has become a useful guide in the public health system.

- **DOH Administrative Order 2013-0013—National Policy and Strategic Framework on Adolescent Health and Development (AHD).** This DOH AO is intended to “provide a strategic framework for the Adolescent Health Program that is anchored on Universal Health Care” and to “provide policy directions and guidance for DOH offices, its attached agencies, LGUs and development partners in prioritizing interventions for adolescent health”. It rescinded or modified previous orders including AO34-A s, 2000.

The vision of the strategic framework is to have “well-informed, empowered, responsible and healthy adolescents who are leaders in society.” The goals are to improve the health status of adolescents and that they are able to enjoy their right to health. There four behavioral objectives: 1/ Increased service utilization, 2/ Adoption of health behaviors, 3/ Avoidance of risky behaviors, and 4/ participation in community development.

Six strategies are included: 1/ access to quality services, 2/ Health insurance for adolescents, 3/ Skilled service providers, families and adolescents, 4/ New and stronger partnerships. 5/ Information management, and 6/ Policy support.

DOH is the lead agency and within the department, the NCDPC-FHO shall designate a Sub-Program for AHD. There will be a TWG on AHD to oversee the implementation and monitor the progress of the program. The roles and responsibilities of the different partners are defined in this AO.

This AO has provided the impetus for some tertiary and lower-tier health facilities to offer adolescent-friendly services, receive AJA training and utilize the DOH Competency Training on Adolescent Health for Health Service Workers Reference Material.

- **DOH DO No. 2016-0133. Guidelines on the Implementation of the Project to Establish Barangay Health Stations in Public Schools** under the Health Facilities Enhancement Program (May 13, 2016). After the signing of the MOA by DOH, DepEd and DILG on January 26, 2016, DOH issued a DO No. 2016-0133 enjoining the three

agencies to establish barangay health stations (BHS) in public elementary school grounds by initially utilizing the Health Facilities Enhancement Program (HFEP) FY 2015 allocation and with the DepEd and DILG providing the local human resources and maintenance and operations requirements. This new DO is expected to improve the health-seeking behaviour and health status of elementary (K to Grade 8) children which include younger adolescents (ages 10 to 14)

- **DOH AO No. 2009-0006 - Guidelines on Antiretroviral Therapy (ART) among Adults and Adolescents with Human Immunodeficiency Virus (HIV) Infection.** This AO aims to provide standards for the use of antiretroviral (ARV) drugs among adults and adolescents living with HIV in the country.
- **The DOH likewise launched its human papillomavirus (HPV) vaccination campaign** to save young girls from cervical cancer, the second leading cause of cancer deaths among women in the country. It is estimated that 12 Filipino women die of cervical cancer every day even though it can be prevented through early screening and treatment.

B. DepEd policies

- **DepEd Order No. 10, s.2016 - Policy and Guidelines for Comprehensive Water, Sanitation and Hygiene in Schools (WINS).** In 2016, DepEd issued this order to all private and public elementary and secondary schools including learning centers. It aims to improve health outcomes among students through scalable school-based water, hygiene, sanitation and deworming program. It directs all the schools to have clean water as well as support mechanisms for hand-washing and effective menstrual hygiene management.
- **DepEd's Comprehensive Sexuality Education (CSE).** With the implementation of RP & RH Law (RA10354), the DepEd is mandated to provide age- and development-appropriate sexuality education in schools. To comply with this, DepEd has already included CSE in its K-12 curriculum. It has not, however, adopted the CSE standards developed by a panel of experts in consultation with teachers, parents, RH providers and the adolescents. Teachers have yet to be trained of how best to deliver age-specific CSE within the K-12 curriculum.

There are, however, initiatives from various CSOs and development partners to develop CSE tools and standards. Likhaan has just completed the module entitled "Comprehensive Sexuality Standards for the Philippines," a joint undertaking with PCPD and UNFPA for DepEd's K to 12 curriculum .

In some areas, FPOP clinic personnel have already developed CSE education manuals which are now being utilized by schools in their respective regions. For example, FPOP Iloilo has produced a CSE manual for Grades 7 to 10 in partnership with DOH Region 6. These are reportedly utilized by secondary schools in this region. FPOP General

Santos City signed a MOA with DepEd in Region 12 to enable some elementary and secondary schools to utilize its recently developed CSE K to 12 manual.

A related initiative at the local level is the five-year module on sexuality education developed by the Cavite Provincial Health Office (PHO) and IMAP based on K-12 health competency requirements. Private midwives were tapped to demonstrate the use of the module during the Music, Arts, Physical Education and Health (MAPEH) subject in five public high schools. Panel survey results that the intervention significantly increased adolescents' willingness to talk about sex-related matters with responsible adults.

- **DepEd Integration of PopEd in Basic Curriculum.** The DepEd continues to implement the integration of population education (PopEd) policy into the basic curricula of elementary, secondary and tertiary education levels and in non-formal education. This was further strengthened by Department Order No. 62, s. 1994 or the National Population Education Program.
- **DepEd has various interventions to contribute to the AYHD program** particularly Integration of ARH, Sexuality Education, HIV/AIDS and GAD in the K to 12 Basic Education Curriculum; The Child Protection Policy; Implementation of the DepEd's HIV/AIDS Prevention and Control Policy Program in Workplace; and Guidelines on the *Abot-Alam* Program (A convergence program which envisions a Zero Out-of-School Youth (OSY) Philippines (DepEd programs and projects for the AHYD program, 2016).
- **DO 17, series of 2015 *Abot Alam* Program of DepEd.** It is a national strategy to locate OSY nationwide who are 15-30 years old who have not completed basic education and who are unemployed to provide them with appropriate intervention on education, entrepreneurship and employment.
- **DepEd's PopEd Program.** The DepED implements the PopEd Program in all public and private schools at the elementary and high school levels. PopEd is an old program and it was strengthened in the mid-1990s and was further enriched by enlisting the participation of CHED and TESDA. The PopEd curriculum also includes an orientation regarding the implementation of HIV/AIDS education in the workplace.

C. DSWD/other social protection policies and programs

- **AO No.48 issued in 1974. The Integrated Human Resource Development Program for Youth (IHRDPY).** Although this is a four-decade policy, it has served as the framework of the current DSWD *Unlad Kabataan* Program. It provides “developmental, remedial and preventive services” to the OSYs through its three major areas: Self-employment Assistance Program, Social Awareness and Community Responsibility and Special Services. This policy has been enhanced to suit the present OSY and other disadvantaged young people situation as well as the youth program trends and development,

The Unlad Kabataan Program has not deviated from AO No. 48 because its program goals substantially the same: “To promote the development of the OSYs and other disadvantaged youth to become self-reliant, economically productive, and socially-responsible citizens able to contribute to the development of their family and community.” This program has two basic strategies: The organization of Pag-asa Youth Association (PYAP) and development of peer support system.

The PYAP is organized nationwide and is federated from the municipal, city/provincial, regional and national levels. Its federation at the different levels served as venues for young people, particularly the OSY, to build their capacity in basic social, moral and cultural values and to be self-reliant, productive and socially responsible.

The assistance provided by this program could also be extended to a number of OSY pregnant adolescents and teen moms, aged 15 to 24 by involving them in the program.

- **DSWD’s Manual on “Population Awareness and Family Life Orientation (PAFLO)” for the *Unlad Kabataan* Program.** DSWD also enhanced its Population Awareness and Family Life Orientation (PAFLO) Manual for the *Unlad Kabataan* Program, which aims to help out-of-school youth and other disadvantaged youth to become self-reliant, economically productive and socially responsible. The manual covers youth activities and discussion topics about the RPRH law as well as teenage pregnancy prevention.
- **DSWD’s Youth Development Session (YDS) for children of 4Ps beneficiaries.** To expand the delivery of ASRH services, the DSWD developed its Youth Development Session (YDS) module which is a parallel intervention to DSWD’s *Pantawid Pamilyang Pilipino Program* (4Ps) Family Development Session (FDS). It aims to empower the youth, especially high school student beneficiaries by educating them on topics concerning self-esteem, personality, skills and responsible parenting. Pilot modules on teenage pregnancy, substance abuse and changing bodies form part of the 11 modules which will be undertaken in the nationwide YDS program. YDS is conducted once a month and will be used as a program conditionality.
- **DSWD’s ERPAT.** The Empowerment and Reaffirmation of Paternal Abilities (ERPAT) Program strengthens the parenting skills of Filipino fathers and helps them achieve an active and equal role with their spouses in parenting their adolescent children.
- **DSWD’s Parent Effectiveness Services (PES).** The DSWD also initiated and institutionalized Parent Effectiveness Services (PES) which is aimed at addressing parent-child relationships and family stability. It equips parents with skills in dealing with the challenges of parental duties and responsibilities.

D. Other government programs

- **Commission on Population (POPCOM) Philippine Population Management Program.** As the overall coordinating agency for the Philippine Population Management Program, POPCOM, aims to: (a) lower incidence of pregnancy among the 15-19 age category, (b) lower incidence of early sexual involvement and unplanned marriage, (c) address RH problems such as STI, including HIV&AIDS especially among young males, and (d) reduce incidence of physical and sexual violence and other forms of violence against young people, particularly married young females aged 15-24. To achieve these objectives, POPCOM has been implementing various programs and initiatives, namely (POPCOM, 2016):

- **U4U.** POPCOM in partnership and support from UNFPA and Centre for Health Solutions and Innovations Philippines, Inc. (CHSI), initiated the U4U (You-for-You) which is Youth Hub Initiative. U4U aims to deliver critical information to Filipino teenagers aged 10-19, to prevent teen pregnancy and to reduce the prevalence of sexually transmitted infections through online and mobile platforms. One of its platforms is the Teen trail which is an educational and entertaining teen caravan. It is managed by teenagers who can easily set this up in schools and communities.

The U4U Trail Initiative has won the Grand Anvil at the 51st Anvil Award which was held on February 26, 2016. Organized by the Public Relations Society of the Philippines (PRSP), the Anvil Award is considered as the PR industry's version of the Oscars. POPCOM, UNFPA and CHSI shared the recognition with Page One, a media agency that has helped popularize U4U's social media platforms. It was the first time that the U4U participated in an award-giving competition.

- **Counselling on Air (COA).** The provision of ARH information and counselling services over radio programs is a strategic initiative especially in the regions. There are two radio counselling on-air (COA) programs in Regions 6 which are hosted by former peer educators for a number of years: a/ *Tingog Sang Pamatan-on Sa Hutik Sa Kagab-ihon* over Bombo Radyo-Iloilo which is aired every 4th and 5th Sundays of the month and b/ *Lamharon* over DYLL Radyo Ng Bayan which is aired every week.

- **Teen centres.** With technical assistance from POPCOM and its regional offices, several teen centres have been launched in secondary schools as a place for young people to hang out and an avenue to provide ARH information to them. In Iloilo Province, for example, the Governor provided substantial funds to launch teen centres in 43 secondary schools with the technical support from the Provincial Population Office and training tools from the regional and Central POPCOM. Peer educators were trained by the PPO and its municipal population officers about ARH and life skills.

- **POPCOM's Parent Education Program.** In 2006, POPCOM initiated the Parent Education Program to highlight the roles and strengthen the skills of parents as the

primary source of reliable information about adolescent health and development. Parents are often expected to prepare their children to become responsible adults and well-rounded citizens. This program developed the Learning Package of Parent Education on Adolescent Health and Development (LPPED). This tool aims to equip parents with the essential knowledge about ASRH and with skills to communicate with their adolescent children. Officers and staff from the regional population offices (RPOs) and provincial/city population offices (P/CPOs) were trained to conduct the classes on parenting adolescents in selected municipalities across the country.

- **POPCOM's SHAPE Adolescent Training Package.** POPCOM through its RPOs has continually utilized the Sexually Healthy and Personally Effective (SHAPE) Adolescents Training Package in building the capacity of adolescents and youth, in cooperation with partner agencies and LGUs. The SHAPE modules which were developed two decades ago, are revised recently to incorporate new developments and issues confronting adolescents today.
- **The POPCOM-Regional Population Offices** reported the following **capability building initiatives** for the adolescents and youth in their respective regions: a/ Training of young people as peer educators and teen leaders, b/ adolescent-led groups in schools and communities as peer educators and campaign managers, c/ training of community mobilizers and peer counselors for community support on the IYCF program, d/ Life skills among adolescents such as Teen Chat, e/Basic Adolescent and RH training, e/ Gender-sensitivity training for youth, and f/training of the youth for peace.
- **National/Regional Adolescent Health and Youth Development Film Festival.** POPCOM has organized a film festival for and by the Filipino youth. The theme for the AHYD Film fest for this year is *Ang pag-aaral ay para sa hinaharap, huwag ilpagpalit sa sandaling sarap* (education is for the future, do not exchange this for short-lived pleasure).
- POPCOM and its partner agencies and the RPOs have conducted, assisted and supported research studies about adolescents and youth. Noteworthy of these researches is YAFS 4 which was conducted in 2013. Further analysis and dissemination of 17 regional YAFS 4 data was conducted in 2015 to 2016.
- **South-South Cooperation Initiative (SSC) for FP, Gender and ARH between POPCOM and BKKBN (Indonesian Population and FP Board) with support from UNFPA Indonesia and Philippine Country Offices.** In August 2012, POPCOM signed an MOU with BKKBN to exchange good practices from years 2012-2017 through training, study visit, and internship on FP, gender and ARH programs. The activities are focused on ARMM Muslim religious leaders (MRL), health providers and LGU officials. They have visited Indonesia to participate in leadership training workshops on FP in Islam and were exposed to good practices and partnership between MRL and the government. The Indonesian partners came to the Philippines to attend training on ARH in normal times and during disaster, on decentralization & FP and the appreciation course

of the ZFF HLGP training. The MRLs are receiving technical support from POPCOM and other partners to become effective advocates of FP in their respective communities.

A recent development in the SSC initiative which has implications for Muslim young people is the issuance of the April 2015 religious edict entitled “Fatwa (Islamic rulings) issued by Dar-al Ifta on early and forced marriage, pre-marriage counseling, comprehensive gender and health education for youth, and gender-based violence.” The recommended ages at marriage for males and females are 24 and 22, respectively.

- The **National Youth Commission (NYC)**. The NYC, an entity under the Office of the Philippine President, formulated and monitored the Philippine Youth Development Plan for 2012-2016. Its objectives responded to various areas of interest to the youth such as increasing participation and promotion of adolescent health and youth development. Some NYC resolutions are as follows (NYC Programs and Projects for AHYDP, 2016):
 - Support of a National Policy on Reproductive Health
 - Inclusion of the ASRH module in the Youth Leadership Summit
 - Support for the Expanded Immunization Program particularly the free adolescent vaccination
 - Formation of city and municipal task forces for young adult SRH, and
 - Screening and testing for STI Including HIV of persons aged 15-17 without written parental Consent

With support from the Department of Health and the World Health Organization, the NYC convened the 2014 National Summit on Teen Pregnancy. This summit, which saw the active participation of adolescents and youth, delivered a clear message that ASRH is fast becoming the defining issue of this generation of Filipinos. Without a robust response from all stakeholders, the Philippines is on track towards a full-blown, national teenage pregnancy crisis.

At the end of the teenage pregnancy summit, the participants strongly endorsed the following: a/ a comprehensive sexual education curriculum, b/ a *Batang Ina* social movement, and c/ the establishment of adolescent-friendly spaces. The passage of the Responsible Parenthood and Reproductive Health Act 2012 was also recognized as an important step to make ASRH services more accessible to young people.

- **The Council for the Welfare of Children (CWC)** commissioned a study about adolescent pregnancy in the Philippines. It resulted in the development of a policy brief and a policy forum and round-table discussion about the research results concerning adolescent pregnancy (CWC Programs and Projects for AHYDP, 2016).
- **NEDA’s resolution in support of M&E on ASRH.** A notable policy at the regional level to improve monitoring and evaluation of ASRH program is the National Economic and Development Authority’s (NEDA) resolution requesting PSA to direct its provincial offices to support POPCOM IX in building its database on teenage pregnancies. This is important given the lack of regular and reliable data on ASRH.

- **The Trade Union Congress of the Philippines (TUCP).** This NGO has institutionalized the Young Adult Peer Educators (YAPE) Program in various workplaces. The participants of this program were trained to become important advocates of accurate information about SRH among young workers.
- **Gabayan ang Batang Ina project.** This undertaking is a new model that pro-actively recruits and enrolls teenage mothers to avail of PhilHealth’s Maternity Care Package(MCP). The pilot project is launched in Quezon City through the City Leadership and Governance Program (CLGP) which is supported by Zuellig Family Foundation (ZFF). It enrolls teenage mothers in QC who will eventually benefit from PhilHealth’s MCP. This benefit covers the complete essential health care services for women throughout their pregnancy and normal delivery (during antenatal, intra-partum and immediate postpartum periods) regardless of the type of health care institution where the services are rendered. The services shall include antenatal care, intra-partum monitoring, assistance in normal delivery and post-partum care within 72 hours and 7 days after delivery.

All Phil Health enrolled teen moms are eventually referred on their 3rd trimester of pregnancy for delivery at Quezon City General Hospital (QCGH), as teen moms are considered as “high risk” pregnancies that required hospital delivery. To further intensify coverage and reach, there is a counterpart “GBI on wheels,” where a roving team goes around QC, whose job is to search for all teen moms to enrol in PhilHealth before their delivery.

E. Development Partners and AYRH

- **USAID Cooperating Agencies--Luzon, Visayas and Mindanao Health.** Since 2014 three USAID Cooperating Agencies—Luzon Health (RTI), Visayas Health (Engender Health) and Mindanao Health (JHPIEGO) have engaged in a new initiative which is intended to deliver MNCHN and FP services to pregnant teenagers, teenage mothers and their partners. They collaborate with DOH, LGUs, provincial, municipal and city health offices in providing technical support to CEMONC-capable hospitals, health providers, RHUs/city health centres and other pertinent partners.

Aside from technical assistance to a provincial hospital’s Centre for Teen Parents, Luzon Health assists selected secondary schools to establish Teen Health Kiosks and train peer educators. Situated next to school clinics and guidance counselors’ offices, these facilities and the peer educators provide ARH information to other students. Selected RHUs are establishing their own teen centers to provide services to teenage mothers in their catchment areas and to refer them to the provincial hospital teen centers for delivery.

The Visayas Health’s Program for Young Parents, on the other hand, assists DOH-retained, provincial and city hospitals to provide comprehensive health services to pregnant teenagers and teen moms. The program also holds education sessions regularly

for pregnant teens on such topics as gender and FP, pregnancy danger signs and symptoms, life skills, PhilHealth requirements, breastfeeding, maternal and child care. It trains teen mom champions as PYP advocates and FP motivators. It collaborates with other supportive government and non-government agencies and with ILHZs for demand generation and better coordination and referrals from lower-tiered health facilities. It partners with DepED for the teen moms' continued education, with TESDA for livelihood skills, DSWD for psycho-social support, and DOLE for work referrals.

Mindanao Health provides technical support to a private hospital and government regional, provincial and city hospitals to establish their respective teen centres. It also extends technical support to eight pilot RHUs in Davao City and in Upi, Maguindanao Province to promote youth-friendly services and to utilize the HEADDSS risk-assessment for the early detection of psychosocial risks among the youth in communities and to provide health counselling and services. It collaborates with the LGU, CHOs and MHOs to implement this undertaking.

- **UNFPA Philippines.** The empowerment and improvement of the lives particularly the sexual reproductive health and rights (SRHR) of underserved women and young people are the foci of UNFPA work in the Philippines. To achieve this goal, its 7th Country Program of Assistance (2012 to 2016) focuses its “support for upstream policy engagement and catalytic support in selected geographic areas based on local development context, political commitment, as well as the availability of relevant and strategic opportunities to deliver integrated support to partners.”

To empower young people, UNFPA has adopted a multi-sectoral agenda and five global strategic thrusts. It supports AYRH research studies, a number of initiatives for young people in the area of research, CSE (it is reviving its support to DepEd to develop a CSE curriculum in previous country programs), service delivery, support for the marginalized including ARH in emergencies, and youth leadership.(UNFPA Strategy Adolescents and Youth, ppt. presentation, 2016).

- **Save the Children** has implemented several programs in the Philippines since 1982. These include the: a/ Metro Manila Adolescent Development Program covering the Cities of Caloocan, Malabon and Navotas and the b/ South Central Mindanao Adolescent Development Program covering Sultan Kudarat, South Cotabato and Sarangani (Save the Children Programs and Projects for AHYDP, 2016).

From 2003 to 2008, It had a ARSH program in West Visayas with the aim to improve the RH of 9,000 adolescents aged 13-18 years. Its intermediate results were to 1) increase the quality, accessibility and availability of ARSH services in government health centres, 2/ improve the socio-political and institutional environment to support ARSH, and 3/ increase the adolescents' level of knowledge, attitude and skills to apply what they learned about healthy and safe behaviour. It supported adolescent-friendly health services which respected adolescent clients, maintained privacy and confidentiality and engaged

the participation of adolescents in planning, implementation, monitoring and program evaluation.

An end line evaluation and use of secondary data showed that the program attained its objectives and learned the following major lessons: 1/ The involvement of policy makers and local government officials, parents, school principals was vital in creating an enabling environment, 2/ school-based teen centres are excellent areas for ARSH information exchange, networking and group discussions, 3/ disaggregating the rural population by age and sex was crucial in program work and 4/ using newsletters and other communications system were vital for partnership with policy makers.

F. Civil society organizations

Few CSOs are engaged in the provision of AYRH information and services. This section presents selected CSO that have developed programs and projects about AYRH particularly the recently defunct FAD, FPOP, Interfaith Partnership for the Promotion of Responsible Parenthood, Inc. (IPPRP) and Likhaan Centre for Women's Health..

Although it recently stopped operations, it is worthwhile to describe the pioneering efforts in extending SRH information and services to young people of the Foundation for Adolescent Development (FAD), Inc.

- **Foundation for Adolescent and Development, Inc.(1988 to 2016).** FAD was founded in 1988 as a non-stock, non-profit, NGO with a vision that it would become a reliable friend of young adults and a major ASRH resource center in the country. Its mission was to assist the youth to develop proper values, become self-reliant, confident and sexually-responsible people through its innovative strategies and program models which could be expanded and emulated by other groups. FAD's ground-breaking projects as follows:

1/ The Manila Centre for Young Adults (MCYA) was the first FAD project which was launched in 1990. It was designed as a drop-in centre in Manila's university belt where 40 colleges and universities are concentrated. The students were welcomed to hang around to discuss growing up issues and other related topics in a non-threatening milieu. Their usual topics were about boy-girl relationship, peer pressure, parent-child relationship, self-esteem, intimacy, teen pregnancy, STIs and other matters. Trained youth educators and counsellors conducted small group discussions and referrals. This project lasted for a decade.

2/ Dial-a-friend was the other undertaking which was started almost at the same time as the MCYA. It was the first a telephone hotline SRH counselling for young people in the country. Professional counselling was given to young people to provide them with options to make informed decisions. This hotline operated from Monday to Friday from 9 A.M. to 6 P.M. The non-directive approach to counselling integrated HIV and AIDS. From 1990 till 2000, it has assisted 122,465 callers who were mostly females and between the ages of 13 to 24.

3/The two foregoing projects ended in 2000 to give way to a new communication technology, the **Integrated web portal for teens** (www.teenfad.ph), an online interactive platform to connect and serve the youth beyond Metro Manila. It also held an online SRH library.

4/ The school/campus off-classroom program which nurtured **socially, emotionally, sexually responsible teeners (SEXTER)** is led by peer educators who provided students with AYSH information, counselling and referrals. This program received support from school administrators who believed that this was beneficial for students. A trainer's guide was developed for the training of peer educators.

5/ **The life planning, education and vocational skills community-based training program** was intended for disadvantaged adolescents. They were provided with life planning education, vocational skills training, and on-the-job training and job referral. This program's training session also provided answers to the following basic philosophical questions: Who am I?, Where am I going? How do I get there? A trainer's guide was developed for the facilitators and youth educators.

6/**The Entertainment for education program (Enter-Educate) focused on producing videos** which provided young people with relevant sexuality and RH messages. These videos had famous young actors as narrator about young people's issues like HIV & AIDS, adolescent pregnancy and other risky behaviours.

7/ **The Teen Health Quarters (THQ)** was a social franchise model which enabled adolescents and young adults aged 13 to 24 to obtain AYRH information on sexuality and RH and selected medical services. The THQs were managed by youth-friendly competent professionals. This was a social franchise model because it was inspired by a business franchising philosophy. It has a brand with standardized physical structure and layout, staff and volunteers' training, young people's general health and SRH services, training materials and a management information system.

LGUs from the NCR and from other provinces partnered with FAD to install the THQ on an agreed amount of franchise fee. Marikina City, Valenzuela and other LGUs installed the THQ in their communities. Some LGUs like Marikina City have sustained their THQ facilities in their health facilities.

FAD had built alliances with DOH, other NGOs and development partners. In the first two decades of operation, it received substantive support from various donors—USAID, UNFPA, UNICEF, AUSAID, Packard Foundation, Levis International Youth Foundation, Consuelo Foundation, Canada Fund for local initiatives, Johns Hopkins and Johns Hopkins. Towards the third decade, funding had dwindled and the founder became seriously ill. The programs and human resources could no longer be sustained so in early 2016, FAD closed down.

- **Family Planning of the Philippines (FPOP).** Founded 47 years ago, FPOP is a leading non-government organization which advocates for SRHR and provides SRH services especially for the poor, marginalized socially-excluded and underserved population in 25 provinces in the country. At present, it operates 30 Community Health Care Clinics (CHCCs) that provide a range of reproductive health care services and information. It is affiliated with the International Planned Parenthood Federation (IPPF).

FPOP has a two-year AYRH project called YES4YES which intends to enhance the Youth-Friendly Service (YFS) delivery of the CHCCs. It also aims to contribute to the development of a comprehensive sexuality education (CSE) manual and peer education modules for the organization. This project's emphasis is to provide "youth-friendly, gender-sensitive ASRH services" to a variety of out-of-school (OSY) young people. Aside from services, this project intends to do two more activities: a/ provide reliable and accurate ASRH information to young people and b/ develop their life skills and nurture them to develop positive attitudes and values.

The project is piloted in four cities and it involves at least 500 OSYs (half females and half males, aged 15-24 in each area). The project is funded by the Government of Netherlands through IPPF.

FPOP collaborates with development partners, DOH, LGUs and other NGOs. In some areas, FPOP clinic personnel have already developed CSE education manuals which are now being utilized by schools in their respective regions. For example, FPOP Iloilo has produced a CSE manual for Grades 7 to 10 in partnership with DOH Region 6. FPOP General Santos City is currently testing its CSE K to 12 manual in elementary and secondary schools in the city in partnership with DepEd in the region.

- **Interfaith Partnership for the Promotion of Responsible Parenthood, Inc. (IPPRP).** IPPRP is a gathering of various faith-based groups and other stakeholders who are committed to promote and advocate for RP, RH, population and development through information, education and partnerships among various faith-based organizations, government agencies and CSO. It envisions an "abundant and healthy life for each Filipino family."

The IPPRP was formally established in 2002 during the Church-Policymaker's conference (CPC) on the promotion and advocacy for Responsible Parenthood in Tagaytay city. Around 120 leaders from different faiths, national and local legislators, government officials, civil society representatives proclaimed their united commitment "to advance responsible parenthood within the milieu of our beliefs and practices as leaders and constituents of churches and religious groups in the country." It was registered at SEC four years later.

This faith-based multi-sectoral organization had a PCPD and other donors-supported project called Youth Venture from 2012 to 2015. This was integrated in a local church with a pastoral ministry in Barangay Cupang, Antipolo City. The activities focused mainly on training young people in the area of ARH including sexuality, personality development, drugs and vices, healthy lifestyle and teenage pregnancy. Small group

discussions were facilitated by adolescent and youth leaders with young people who were church members. Training modules were developed for these activities. Resource persons from PopCom, UNFPA and other sectors were invited to the training and advocacy activities.

- **Likhaan Centre for Women’s Health, Likhaan Centre for Women’s Health.** Founded in 1995, Likhaan is a NGO that provides Information and FP services in poor and marginalized communities especially to women of all ages including adolescents and youth.. It serves as a Centre for Women’s Health where issues related to women’s empowerment, universal access to good quality health care services, primary health care, maternal health and mortality, FP, unsafe abortion and patients’ rights are discussed.

Likhaan is a recipient of many international grants for its advocacy and community-based projects on maternal health and FP for poor women and their families. In 2015, it began to promote a separate AYRH program.

At present, it has three on-going RH projects. The first two projects are focused on delivering FP services and commodities in FP clinics to selected impoverished and marginalized communities in the country. The third is a UNICEF-supported 9-month pilot project which is aimed at improving AYSRH including teenage pregnancy, STIs including HIV through community mobilization by community health promoters (CHP) who were trained about SRH and child’s rights. The training topics include a/ contraceptives, b/ talking to rape victims, c/ LGBT and gender sensitivity, d/ Women’s rights, e/ Rights of the child, and f/ team building. The pilot project ended in April 2016 and there is a possibility that this viable project would be extended for a few years.

Likhaan has just completed the module entitled “ Comprehensive Sexuality Standards for the Philippines,” a joint undertaking with PCPD and UNFPA for DepEd’s K to 12 curriculum .The joint venture proposed seven core topics which are integrated in every grade level starting Grade 3 to Grade 12. These topics include (a) Human body and development, (b) Personhood, (c) Healthy relationships, (d) Sexuality and sexual behaviours, (e) SRH, (f) Personal safety and (g) Gender, media and human rights.

Summary

The Philippines has the second highest AFR in Southeast Asia. It is the only country in the region where the AFR is increasing. The YAFS, a large-scale survey of young adults reinforce the foregoing trend.

The high AFR in the Philippines is associated with a number of factors particularly a/ younger age at menarche, b/ early premarital sexual initiation, c/ unplanned sexual encounters d/ high unmet need for FP, e/ peer pressure, e//inadequate ASRH information f/breakdown of family life, e/ absence of accessible, adolescent-friendly clinics, and g/ growing acceptance of out-of-wedlock pregnancy and living-in arrangements (which appears to be the “new normal” behavior of family formation among young couples).

Adolescents with little or no education from poorest rural families are more likely to have started childbearing. It is., however, noted that better educated young people from non-poor families are starting to bear children. The foregoing factors and the reduction of stigma and growing acceptance of out-of-wedlock pregnancy and living-in arrangement of couples are observed to contribute to the foregoing changing behavior.

Although the trend has been rising for males and females, studies have shown that more male adolescents are engaged in risky sexual behaviours which could predispose them to unwanted pregnancy and STIs. In recent years, the HIV and AIDS incidence has risen and there are more males than females who have acquired this disease. Multiple sexual partners and unprotected sex are among the major causes of this trend.

Younger and older adolescents from rural and urban areas have experienced bullying, verbal and physical abuse in- and out-of the school settings.

Laws, policies and programs

The country has a number of laws for social protection/welfare, education and health which are supportive of adolescents including pregnant and young mothers.

Social Protection. The Magna Charta of Women 2010 is considered as the great charter because it guarantees all women including adolescents, their rights and social protection. A specific provision in this law is helpful to pregnant female students because it prohibits expulsion and non-readmission due to their having “contracted pregnancy outside of marriage.”

This Magna Carta of Women provision is reinforced by DepEd’s RA 10533 Enhanced Basic Education Act of 2013 which stipulates that all Filipinos are entitled to have access to free K to 12 education. . This is further supported by the policy directive called “Education for All” 2015 which offers Alternative delivery models especially among those who are in socially-difficult circumstances like the pregnant adolescents and teen moms. These models include Project EASE (Effective Alternative Secondary Education) which is concerned about students who are unable to attend classes because of personal and financial reasons.

An EASE student can make an arrangement with the school to study at home until she or he is ready to join the formal school system. Students who are unable to go to school due to work, physical disability, poverty or are situated in conflict areas could join the Open High School Program, a learner-centered system which utilizes several teaching-learning approaches by using print and non-print tools. This strategy is complemented by the Balik Paaralan Program or the Home Study Program.

The project team's interviews with guidance counsellors and school teachers validated that the foregoing DepEd's policy is being implemented because their institutions are engaged in the foregoing schemes for all their students including pregnant adolescents. There is, however, a need to systematically examine the effects of the alternative delivery models in the country especially for teen moms

The Magna Carta also has a provision that women have rights to “ 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.” It has specified the major RH elements and these are all applicable to female adolescents .

The 16-year old law, the **Solo Parents' Welfare Act of 2000**, provides a comprehensive package of services for solo parents and their children especially among those who fall below the poverty threshold. This would include livelihood, counseling and effective parenting. Many teen moms are poor. Several agencies are enjoined to implement law, viz DSWD, DOH DepEd, DILG, CHED, TESDA, NHA DOLE and others.

This law is particularly useful for many poor and single teen moms because it provides protection to her and her child. Although a number of poor teen moms are currently living in with their partners (often in their parents' homes), the likelihood that they would become single mothers is high. This law could be utilized to seek support from the foregoing agencies.

The increasing physical, verbal and sexual abuse among students which would likely include pregnant adolescents are being addressed with the passage of Republic Act 10627 Anti-Bullying Act of 2013. . Approved by the Senate and House of Representatives on June 7, 2013, this law empowers the DepED to penalize schools that do not stop bullying or sanction bullies. It authorizes schools to impose sanctions on student bullies. All elementary and secondary schools would be required to adopt anti-bullying policies and sanctions, which would cover prohibited acts committed within their campuses, school- sponsored activities whether conducted in or outside school grounds, school bus stops, school buses, or other properties owned or leased by schools. This legislation, however, has to be systematically studied to determine whether it has indeed reduced violence among young people.

Health legislation. The passage of the long-awaited contentious Responsible Parenthood and Reproductive Health (RP & RH) Act of 2012 mandates the government to adequately respond to the RP and RH needs of the people. This legislation intends to empower Filipinos particularly women, adolescents and youth to make informed choices through age and development-appropriate education. This legislation guarantees that all Filipinos especially the

poor and those in socially-difficult circumstances, can access information, facilities and services by making sure that available and sustainable RH programs are provided. This could be attained through the collaboration between the national and local government units in partnership with CSOs, the academe, the private and the basic sectors.

In its IRR, it specifically states that a/ AYRH guidance and counselling must be provided at the point of care; b/ the provision of age and development-appropriate education and counselling; and c/ age-and development appropriate RH education for adolescents in formal and non-formal educational settings.

An important directive of the RP & RH Act of 2012 to DepEd is the provision of comprehensive sexuality education (CSE). With the implementation of the RP& RH Act of 2012, the DepEd is mandated to provide age- and development-appropriate sexuality education in schools. To comply with this, DepEd has already included CSE in its K-12 curriculum. It not yet adopted the CSE standards which were developed by a panel of experts in consultation with teachers, parents, RH providers and the adolescents. Teachers have yet to be trained of how best to deliver age-specific CSE within the K-12 curriculum.

There are, however, initiatives from various CSOs (e.g., FPOP, Likhaan, IMAP) and development partners (e.g., UNFPA) to develop CSE tools and standards which are being tested in selected institutions and locale.

The enactment of Responsible Parenthood and Reproductive Health (RP & RH) Act of 2012 is a boon to the implementation of the AYRH program in the country. It is noted that a decade and-half-ago, the DOH issued its first AO 34-A s 2000 Adolescent and Youth Health Policy on AYHD which created a Youth Health Subgroup under the Health Cluster. This AO intended to ensure that all AY would obtain good quality and wide-ranging health services in a friendly setting. It took a decade before the NCDC drafted the national standards and implementing guide for adolescent-friendly facility and the AJA for health providers.

The passage of the RP & RH Act of 2012 provided further support for the issuance of DOH Administrative Order 2013-0013—National Policy and Strategic Framework on Adolescent Health and Development (AHD). This is anchored on UHC and the provision of policy directions and guidance for DOH and its attached agencies, the LGUs, development partners and NGOs in ranking health interventions. It rescinded or modified previous orders including AO34-A s, 2000. This policy framework has provided a strong basis for the foregoing agencies to engage in AYRH activities at the national and LGU levels.

A law that provides socialized health insurance program which prioritizes the needs of the poor, sick, elderly, people with disability, women and children is RA No. 10606 An Act Amending Republic Act No. 7875 Otherwise known as the “National Insurance Act of 1995,” As Amended, And For Other Purposes (2013). In support of this amended legislation, PhilHealth has a policy instructing that no other fee shall be charged or paid by the PhilHealth patient on any of the identified medical and surgical cases under the case rates package payment scheme. Three beneficial circulars were further issued because they ensure that those who are below 21 who are about to deliver must be enrolled in the point of care.

In the public health facilities which were studied, the health providers know about the Social Insurance benefits, However, many poor pregnant teenagers were not well informed about them. The strategy to include information while conducting the PYP usapan or education session at EVRMC and IPH, as well as the QC- ZFF initiative to enrol pregnant teenagers in PhilHealth under the *Gabayan ang batang ina* project are good approaches to provide information to young women.

There are other policies and programs from POPCOM, DSWD, DepEd, NYC and other government agencies and CSOs which are supportive of teen moms. The defunct FAD, in particular, has pioneered a number of initiatives and projects to raise the awareness, knowledge and empowerment of young people. Some of these initiatives like the THQ is still being pursued in the cities of Marikina and Quezon.

It is observed, however, that there are more ARH advocacy and information giving endeavors from the foregoing agencies and less in the provision of adolescent-friendly services.

In recent years, there are new initiatives from USAID CA-Luzon, Visayas and Mindanao Health, to provide technical support to regional and provincial health offices as well as LGUs to enable some CEMONC-capable tertiary health facilities to establish AFHS for teenage pregnancies and motherhood.

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CHAPTER THREE

Program for pregnant adolescents and teenage mothers: Good Practices in Tertiary Hospitals

Three tertiary hospitals may be considered as models in providing gender-responsive and rights-based ARH services for pregnant adolescents and teenage mothers because they have met most of the 2010 National Standards for Adolescent-Friendly Health Services. These facilities, however, have different characteristics and mandates in the health system. Brokenshire Woman Centre is a private hospital in Davao City with a Program for Teens. It receives technical assistance from Mindanao Health. EVRMC is a DOH-retained regional hospital while IPH is a LGU-supported provincial referral hospital of the nearest ILHZ. EVRMC and IPH have Programs for Young Parents and these institutions obtain technical support from Visayas Health.

I. Brokenshire Program for Teens

Brokenshire Hospital is a century-old private facility which is owned by the United Church of Christ of the Philippines (UCCP). It was founded as a mission hospital in 1908 and it evolved into a tertiary facility with a 240-bed capacity. It attends to around 12,000 patients annually. Around three to four per cent of the total number of pregnant women who were admitted to the hospital for childbirth are adolescents (Bonguyan and SanJose-Stuart, 2016).



Picture 1. Brokenshire Program for Teens Counselling Room (left) and its Logo (right)

With support from The Ford Foundation in the nineties, Brokenshire Hospital opened a Woman Centre to enable the Department of Obstetrics and Gynecology Department and the other concerned units to extend gender-responsive health services to women of reproductive age.

The rising premarital sexual practices, adolescent pregnancy and drug use in Region 11 where Davao City is located, provided an impetus for the Brokenshire Woman Centre to integrate adolescent health in its services and training. It sought technical support from CA-Mindanao Health (MH) to build the capacity of its staff in using the DOH Adolescent Job Aide (AJA).

The Centre for Teens concept evolved as the Program for Teens (PFT) because all departments and units, residency training programs, nursing services, chaplaincy and social services are involved in this undertaking. The facility does not only cover the OB-Gyne needs of female adolescents but it also includes the health issues and needs of adolescent males such as RTI and risky sexual and other behaviors.

The heads of the Departments of Family Medicine and Pediatrics pledged to extend their services to adolescent males. The PFT was formally launched on 2 September 2015.

Governance. The PFT has a steering committee which is comprised of high-level decision makers of the hospital such as the CEO, hospital administrator and medical directors and a technical committee which is chaired by the BWC Coordinator with the different departments' unit heads as members.

The day-to-day operations are managed by a core group comprised mostly of doctors in residency and other providers such as nurses and midwives. They conduct meetings when needed and minutes are recorded and kept.

No accomplishment report is submitted but data for the served client is included in the monthly audit of services provided by the hospital. Individual records for clients are maintained and are kept in a locked cabinet. There is also a computerized registry for serviced clients.

Capacity Building. Prior to the PFT's official launch, the PFT core group comprising of 18 doctors, five post graduate interns, five nurses and two midwives attended the Mindanao Health's organized AJA training. The core group disseminated what they learned from the training to other service providers in the hospital.

The MH also facilitated the write shop of the formulation of the Operational Guide of the Centre for Teens. The PFT AJA-trained core group, the CPO and other partners were involved in this activity

PFT policy. The management and procedures of the Program for Teens are anchored and guided by the Operational Guide. This describes 1/ the framework of operations, program components and key services; 2/ the management structure and their respective roles and functions; 3/ service delivery, referral guidelines and the step-by-step process in handling adolescent patient; 4/recording and reporting; and 5/ monitoring, supervision and assessment.

The Operational Guide was formulated through a consultative process which was participated by the heads, unit managers, consultants and frontline service providers of the different departments and units of the hospital to include the Department of OB-Gynecology and the Brokenshire Women Centre (BWC), Department of Pediatrics, Department of Family Medicine, Surgery, Labor and Delivery Room and the Emergency Room. MH provided technical assistance and facilitated the write shop in drafting this document.

Demand generation. The PFT demand generation activities are undertaken within and outside the hospital. Internal demand generation includes the provision of leaflets and reading materials to the clients about pregnancy, FP, maternal and childcare and the other PFT services. There are also promotional posters which highlight the PFT's services and related activities. These materials are provided by DOH, MH and the hospital.

The PFT staff have three major activities to reach out to young people in the community. They did outreach work and enrolled 384 young people in the program. More than 200 of these enrollees were able to join the first forum at Brokenshire Hospital entitled "All You Need is Pag-ibig" (All you need is love) where ARH, gender and sexuality issues are discussed. Young people were clustered by age category for age-appropriate discussions.

At the start of this school year, the Brokenshire PFT medical residents and program staff visited secondary schools and colleges to talk about their program to students. Flyers are distributed in this promotion.

The PFT also launched its 24/7 mobile phone hotline and an AJA-trained resident doctor on duty usually answers queries and provides counseling services on line. Some callers would eventually visit the hospital for PFT services.

Aside from the foregoing activities, the private hospital program staff collaborates with the City Health Office (CHO), DOH and the LGU for activities which are related to AYRH. Davao City program and activities are being coordinated by the City Population Office (CPO), a unit which falls under the CHO.



Picture 2. PFT promotional poster

The DOH AO 2013-0013 AHD policy and the RP & RH Act of 2012 serve as the framework in extending information and services to young people. The City also has enabling AYHD policies such as the decade-old Local Development Plan for Children (which also covers adolescents), the Women's Code and the DILG–Utilization of *Sangguniang Kabataan* (SK) funds for youth programs.

The need to update or amend the Local Development Plan for Children to specifically address adolescent and youth needs led to the drafting of a document for legislation. In partnership with MH, the CPO and other stakeholders, a city policy was drafted for the mayor's office entitled "An Executive Order Creating the City Health Office and District Health Offices, Public-Private High Schools and Colleges, Youth-Focused Community Facilities Youth-Friendly in Davao City."

An operational guide which supports the EO was also drafted. This is aimed to serve as the basis for implementing youth-friendly health and RH services and programs for adolescents aged 10 to 24 years old at all Davao City District Health Offices and other primary level facilities. This document was submitted during the term of former City Mayor Rodrigo Roa Duterte. Because of the recent presidential campaign and the subsequent election to the presidency of Mayor Duterte this EO was not signed. It will have to be re-submitted to the newly-elected mayor.

Health-service delivery. The PFT is open from Monday to Friday, at 8:00 A.M.to 4:00 P.M. and on Saturday morning.

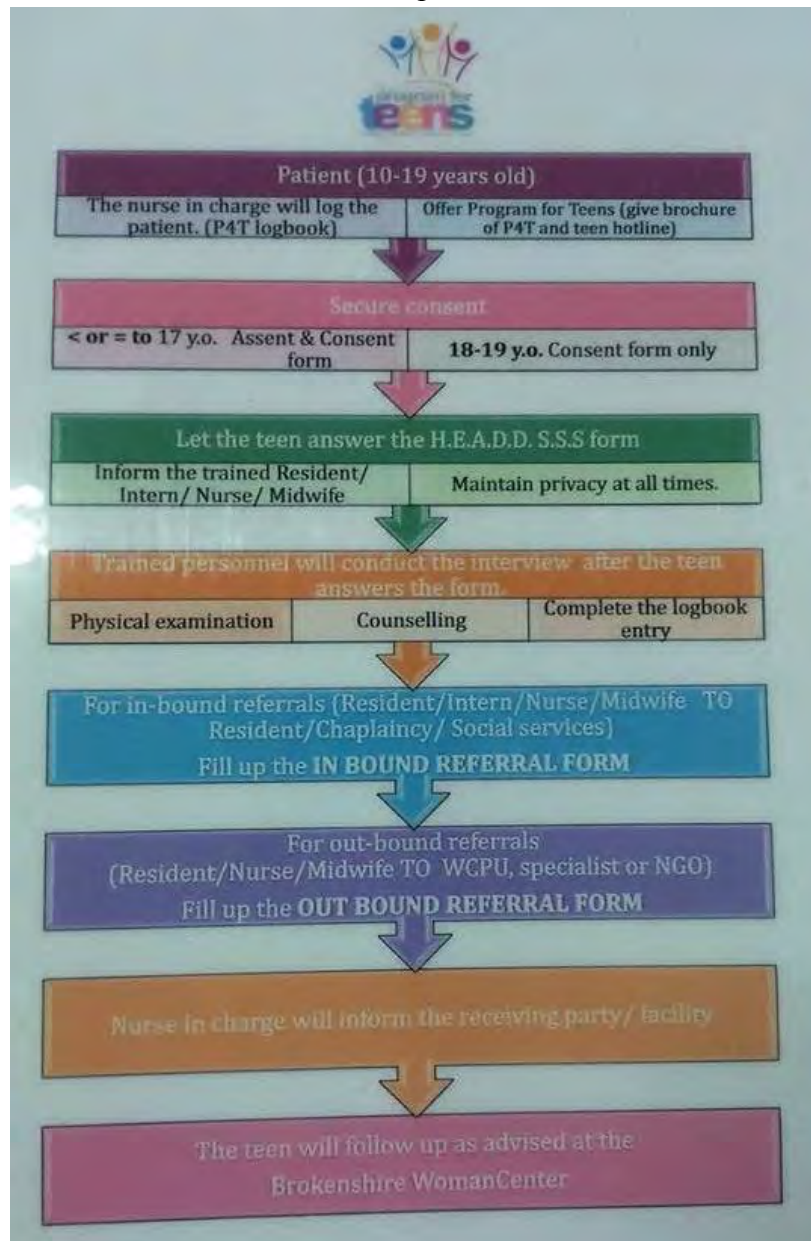
Procedures of admitting a teenage client

The hospital has the following protocol in accepting a teenage client. When an adolescent (17 years old and below) is admitted at any point of entry in the hospital (outpatient or emergency room) she or he is required to fill out an assent form. A parent or a guardian must accompany the adolescent and must fill out and sign a consent form. When the teenager is 18 years and older, she or he must fill out and sign the consent form.

After this, the AJA-trained health provider utilizes the HEADDSS form which is administered through a face-to-face interview for around 15 to 20 minutes. After this activity, the health provider refers the adolescent client to the appropriate department (e.g. the OB-Gyn Department for pregnant adolescents). The teen client may be referred to other facilities outside the hospital when the service is not available at Brokenshire Hospital or when the client could not afford the hospital's services.. Poor pregnant teen moms are at times referred to the Southern Philippines Medical Centre (SPMC), the government referral and regional hospital.

An in-bound referral form is utilized within the hospital. An out-bound form is given to the client who is referred to another health facility. The client, however, is not required to give a

feedback to Brokenshire Hospital about the referral result.



Picture 3. PFT flowchart

PFT has already enrolled 384 adolescents aged 15 to 19 from January to May 2016. They came to the facility for various services particularly maternal medical and dermatologic concerns, Tetanus Toxoid Vaccination, birth spacing and counseling services. They are mostly unmarried and those who are in a relationship are living-in with their partners. Most of them are not in school or are working.

Services

The PFTs provides the following services are available in the hospital.

- Counseling; Nutritional Assessment, Maternal Care Services (Prenatal, Natal, Post natal);
- Family planning
- STIs including HIV &AIDS
- RH assessment and counselling such as fertility awareness, menstrual health issues counseling, Pap Smear and pelvic exam
- Dental assessment
- Micronutrient supplementation (iron supplements are given for free to clients when there are available samples)
- Social and legal services (the hospital refers clients in need to LINGAP(financial and other assistance from the city government)
- Clients with substance abuse problems are referred to other facilities (e.g. the PSYCHIA Centre, a government facility)

To ensure confidentiality and privacy, PFT has a designated consultation and counseling room. Records are kept in a secure place and could only be accessed by authorized personnel.

Prenatal care

During the first prenatal consultation, the pregnant adolescent's vital signs are taken including her OB history and other possible risks. The young mother is also asked to have some laboratory tests. The succeeding visits are usually follow up of what were prescribed by the medical doctor from previous consultations. The laboratory test results are reviewed and referred to other specialists if necessary.

When samples are available, iron supplements are given for free to clients. Most pregnant teenagers have at least three prenatal consultation prior to delivery. Mothers of the pregnant teenagers usually accompany them during prenatal check-up. Some are accompanied by both parents or by their partners.

Pregnant teens who are enrolled at PFT are required to attend a "Parent's Class" which is scheduled on Saturdays, 32-35 weeks of gestation. The topics include breastfeeding, STIs, FP, childbirth and delivery, danger signs of pregnancy and the process of admission.

Delivery

Pregnant teen clients are encouraged by the service providers to deliver in the hospital. Since the PFT launch, 22 out of 28 of those who had their prenatal consultation at PFT delivered at Brokenshire Hospital. Four delivered at SPMC and two were planning to deliver at another government hospital. The client is usually given a choice to stay at the hospital's air conditioned lying-in-wards or at the hospital's private rooms. Whatever room is chosen, the client still

delivers at the same delivery room. The lying in-ward, however, is cheaper than the hospital rooms.

Postpartum Care

After delivery, the resident gives postpartum counseling to the teenage mother. The counseling topics include: a/reproductive anatomy (lochia, expected body changes); b/ breastfeeding; and c/ FP. The teen age mothers are usually advised to return to the hospital for postpartum care.

All the clients who availed of the lying-in package of the hospital usually returns for postpartum check-up. Complete post-delivery physical examination is conducted which includes pelvic examination for those who delivered by Normal Spontaneous Vaginal Delivery (NSVD), pelvic examination and wound dressing for those who delivered by Caesarian Section (CS). Postpartum counseling is also given about breastfeeding, bodily changes and FP.



Picture 4. PFT FP Counselling Room

Family Planning

Birth spacing methods are available in the hospital like oral contraceptives, injectables, IUD, SDI, male condom, bilateral tubal ligation, and standard days method.

The service providers conduct FP comprehensive counselling. They recommend that the teenage mothers should wait at least 12 months for those who delivered normally before they could get pregnant again. Those who gave birth by CS are advised to postpone their pregnancy for 24 to 36 months. The commonly accepted methods by the teenage mothers are progestin-only pills, subdermal implant, condoms and IUD.

According to the PFT staff, mothers of teenage mothers are influential in helping the teenage mothers decide what birth-

spacing method to use. Few are influenced by their partners or the resident doctors.

Most of the teenage mothers would like to go back to school. They would like to have another child when they would finish schooling and have stable occupation.

A 22-year old mother of two who obtained an implant from a public health center decided to go to PFT to have this removed because she had experienced some unpleasant side effects. She did not go back to the health centre because the providers are not allowed to remove it due to a recent Supreme Court TRO about

this method. She gave a score of 10 for the services received from PFT because *maka- entertain ng maayos, mabilis ang serbisyo*. (they can entertain me well, service is fast). She opted to use the pills *dahil P45 lang ang gastos ko sa isang buwan* (because it I only spend P45 a month).

Financing

As a private facility, the services obtained by teenage clients in the hospital are not for free. Pregnant adolescents who choose to give birth in this facility could avail of their benefits from PhilHealth. However, they still need to allocate around Php 8,500 for normal delivery and around Php13,500 for Caesarian Section on top of what they can obtain from PhilHealth. Those who could not afford to pay these additional costs are referred to “Lingap Para sa Mahirap Program” of the City Mayor’s Office and to the Philippine Charity Sweepstakes (PCSO).

A pregnant adolescent who had her prenatal care in a government health Center intended to deliver at Brokenshire Hospital. She said that *pinaghahandaan ng ama [her live-in partner] ang P15,000 para sa aking normal delivery*. She gave a rating of 8 (in a scale of 1-10) to the Program for Teens because she has yet to deliver in this health facility. She, however, felt that everything will be fine *naramdaman ko na dahil maalaga*. She has been counseled about FP and MCH. She appreciated that the doctor, nurses and midwife could speak Cebuano because she fully understood what was explained to her. She thought that all the information are important especially about pregnancy, sexuality and gender--*ano ang babae? Ano ang lalaki?* (What is a woman? What is a man?)

Strengths and Challenges

The Brokenshire PFT appears to have met most of the DOH standards for an adolescent- friendly facility. The facility’s well-designed infrastructure and the measures to ensure confidentiality and privacy are satisfactory. There appears to be no problem with the current clinical procedures and the corresponding waiting time and their referral system. The PFT evolved into a program because of the quick buy-in from the hospital authorities, the clinical departments and other pertinent units of the institution. It is coordinated by experienced OB-Gynecologists of the Brokenshire Woman’s Centre in partnership with AJA-trained residents, medical doctors, nurses and midwives and other groups in the hospital system.

Integrating the AFHS in the hospital, changing the attitudes and honing the skills of the health providers in the whole hospital, however, is a “constant challenge because of time and logistics demands of training” (Bonguyan and SanJose-Stuart 2016). It is suggested by some PFT core

team members that the AJA should be continually conducted until all the hospital personnel are able to attend this training. Adding adolescent gynecology in the training will also be most useful.

The hospital's demand generation activities need to be strengthened to reach out to many adolescents in the city who could benefit from the PFT services. "Parental resistance" is also seen as a major obstacle to the young people's enrolment at the PFT.

Because the PFT is a private hospital, it could not offer its services for free to adolescents. Partnership with the LGU, national and international development partners should be intensified to avail of opportunities for more funding for needy pregnant adolescents and other young people.

II. Eastern Visayas Medical Centre (EVRMC) Program for Young Parents (PYP)

Eastern Visayas Regional Medical Center (EVRMC) is a 500-bed tertiary level 4 teaching and



training hospital in Tacloban City, the regional capital. It is also the end-referral hospital of all government hospitals in the region. It was first known as the Leyte Provincial Hospital when it started its operation in 1916 with a 14-bed capacity. A legislation was passed in 1972 renaming the facility to Speaker Daniel Z. Romualdez Memorial Hospital

Picture 5. EVRMC Façade; Source: EVRMC PYP Team

(SDZRMH) with an increased bed capacity of 250. It was designated by DOH as a regional training hospital shortly after. After the EDSA upheaval in 1986, the hospital's name was changed by the Office of the Philippine President to Tacloban City Medical Centre. In March 1992 by virtue of R.A. 7879, the hospital was further renamed as EVRMC.

Although the hospital was severely damaged in 2013 during the onslaught of the world's strongest typhoon and storm surge, Haiyan, it never closed down its operations. It partnered with Visayas Health (VH) on 11 September 2014 to launch the "Program for Young Parents", (PYP) to respond to the high AFR in the region.

The PYP is patterned after the Teen Moms Program that was initially implemented at the Philippine General Hospital (UP-PGH) in 2000. The PYP does not only provide RH services to pregnant adolescents but it also involves their partners or husbands. The PYP intends to a/ assist

teenage mothers to postpone their childbearing for at least two years, b/ promote facility-based delivery, c/ reduce the number of births to women below age 19, d/ promote exclusive breastfeeding for at least six months. It also aims to increase the acceptance of birth-spacing methods particularly long-acting methods to avert subsequent unplanned pregnancies. Furthermore, the PYP assists teenage mothers and their partners to pursue other life goals by tapping the assistance of the government agencies to help them continue their education (through DepEd's ALS) and build their skills by training with TESDA and to find gainful occupations through DOLE.

The PYP is located on the ground floor of the hospital. The *usapan* or education session room is beside the prenatal room. There is a space for counseling to ensure privacy and confidentiality of the conversation between the health provider and client. A six-bed exclusive ward for teenage mothers is on the same side of the hospital.

Governance. The PYP is a multi-disciplinary program because a core team comprising of representatives from the Departments of Obstetrics and Gynecology, Pediatrics, Nursing, Family Medicine, Psychiatry, Social Work and Social Services was formed to oversee the program.

The PYP is managed by an OB Gynecologist. Other core team members who are directly involved in the daily operations are five resident doctors, three nurses, a midwife and a social worker. They are assisted by teen mom volunteers or PYP “champions” (those who went through the education sessions and who gave birth at the hospital and are birth-spacing acceptors). These volunteers share their pregnancy experiences and motivate the pregnant adolescents to use birth-spacing methods.

Capacity Building. Prior to the PYP's formal launch, VH conducted an AJA training and a PYP orientation to members of the core team. Not all service providers who are PYP team members are AJA trained because of the hospital policy that those who are on job order status cannot avail of this training. They were, however, given an orientation about the PYP.

PYP Champions training

The VH also extended technical assistance in training selected peer educators or champions about how they could effectively give their testimonies and conduct the gender sensitivity and life skills training.

The PYP champions were chosen based on the following criteria:

- a/ They must have enrolled in and graduated from the PYP by completing all the *usapan* or discussion / education sessions;
- b/ They have at least four prenatal check-up in the facility;
- c/ They must have given birth in the hospital;,
- d/ They must be a satisfied FP users,

- e/ They are willing to share experiences as teen mothers, their use of FP and PYP benefits;
- f/ They are willing to be trained and to handle parts of the PYP educational sessions; and
- 5/ They should have good communication skills.

Four teenage mothers were chosen as PYP Champions. Their ages range from 15 to 20 years old. Two are PPIUD acceptors while the other two are DMPA users. After the training which was conducted by VH, the PYP champions said that they have gained more confidence in speaking before a group and in relating to other people. One PYP champion said:

Hadto kasi aworon talaga ako. Ginkukurian ngani ak pagyakan ha atobangan hit mga tawo. Yana diri na.

(I used to be shy before. I even find it difficult to speak before a group unlike now.)

The PYP Champions are issued an EVRMC ID, uniforms and are formally introduced to the hospital staff. They are given Php200 every Wednesday (PYP education session and prenatal consultation) as reimbursement for their transportation. They are also provided with free meals.

Policy. The implementation and management of the PYP is guided by a Protocol which presents the objectives and the guidelines for the different program components including the service providers and teenage clients. This document also describes the step-by-step procedures in handling and managing teenage clients from the initial point of contact to service provision and client's exit from the facility and/or PYP.

Wednesday is declared as the PYP Day or Teen Mom's Day where pregnant teenagers participate in the *usapan* sessions. They are given priority to access prenatal and FP services.

Demand Generation. Within the hospital, demand generation activities include the provision of flyers, reading materials about pregnancy, FP and MCH. Audiovisual clips are also shown while clients are waiting for the education session to start and for their prenatal consultation. These materials and tools were obtained from DOH and VH.

PYP champions are designated to also motivate teen moms, their partners or their mothers who have not made up their minds about what birth-spacing methods to accept. They expressed their enthusiasm and pride in doing this task. A teen champion said:

Maupay man ha feeling nga nakakabulig kami labi na ha mga nagin parehas ha amon.

(It brings us a good feeling that we are able to help particularly those who have been in the same situation like us.)

Health-Service Delivery

The initial contact of the pregnant teenage client

The pregnant adolescent is initially referred to the Outpatient Services or at the OB-DR Triage Complex. The process to obtain PYP support is a bit different for a pregnant adolescent who is on labor and for someone who is still seeking prenatal care.

A teenager who is on labor will be referred by OB-DR for enrolment by PYP. A PYP card will be issued to her and she will be admitted to the hospital. If she has no PhilHealth membership yet, she would be assisted by the hospital's social worker for the point of care enrolment. She would be further assessed after delivery and if she needs need psycho-social support, she would be referred to the appropriate department. She would also be motivated to accept FP and be counseled about maternal health, nutrition, breastfeeding and child care.

If the initial contact of the client is at the OPS, she would be asked to comply with the requirements in seeking a hospital record for first-time clients. Then she will be referred to the PYP clinic for enrolment. If she comes on a Wednesday which is the designated PYP Day, she would be asked to attend the *usapan* session which is conducted before prenatal check-up. The resident doctor conducts an assessment which is guided by the HEADSS during prenatal consultations.

Patients who come on other days for their first consultation will be entertained by the OB resident and will be instructed that subsequent consultations will be done on Wednesdays at the PYP Clinic. To ensure that the pregnant teenage will attend the *usapan* sessions, the PYP staff will monitor her by using the mobile phone.

Referrals are made within the hospital as needed but no referral form is used. Clients who have been referred by other facilities have referral forms. No feedback mechanism or return referrals is practiced by the hospital. Notification of referring parties is left to the concerned client or the referring facility.

During the first consultation in the facility, the teen clients are usually accompanied by their mothers. Few partners or husbands join them for consultation.

Services

The PYP is open from Monday to Friday, at 8:00 A.M. to 4:00 P.M. and on Saturday morning. It provides the following services:

- Nutrition and RH assessment as well as counseling about fertility awareness, menstrual health issues
- Maternal care (prenatal, natal, post natal)
- STIs including HIV and AIDS
- Pap Smear and Pelvic Exam

- Family planning
- Dental care
- Social and legal services (social services department)
- Psychological counselling and substance abuse problems (referred to the Psychiatric Department of the hospital)
- Social and legal services (the hospital has social workers)

The WCPU is actively involved in the implementation of PYP. Pregnant adolescents aged 17 and below are automatically referred to the WCPU for assessment and provision of legal and social services when necessary.

Prenatal care

During the first consultation for prenatal care, the vital signs are taken including the OB history and other possible risks. The young mom is also asked to undergo laboratory exams. Depending on the volume of clients, the teen moms usually wait one hour or more before they are checked. The succeeding visits are usually a follow up from previous consultations. The results of laboratory exams are reviewed and referred to specialists when needed. Most (around 70%) of the teen clients have at least five prenatal consultations before they deliver in the hospital.

The hospital is not giving free iron supplements and Vitamin A or any other supplements.

Around half of the adolescents who came for prenatal care are on their second trimester (4th or 5th month). Some even came on the third trimester. A KI opined that among the reasons for the delayed hospital prenatal consultation are: 1/ poverty or no money for transportation, 2/ EVRMC's is far some clients' municipalities (some come as far as Samar or Southern Leyte), and; 3/feeling of shame to leave their homes because of the stigma attached to adolescent pregnancy.

An adolescent who was on her fourth month of pregnancy said that her boyfriend is supportive of her pregnancy but her parents were unaware about her condition.

Nag-uraw ako han kahibaro ko nga burod ako kay diri pa ako handa.
Nahadlok ako hit magigin reaksiyon hit ak pamilya.

(I cried when I found out that I'm pregnant because I'm not yet ready.
I'm afraid about the possible reaction of my family.)

Usapan or education sessions

Prior to the prenatal consultation, pregnant adolescents are enjoined to attend three *usapan* or education sessions by the PYP team. The three session topics are as follows: Session1: Gender

and FP; Session 2: Danger Signs of Pregnancy and Birth planning; and Session 3: Life skills (decision making, support from PhilHealth, DepEd, DSWD, TESDA, POPCOM).



Picture 6. EVRMC PYP Usapan Session

The first session is facilitated by a PYP champion in partnership with the health providers. The nurse and midwife facilitate the second session. A representative from the regional partners like POPCOM helps in facilitating Session 3. The pregnant adolescents are encouraged to participate actively during these sessions. They are followed up by the PYP team through SMS messaging to ensure that they will attend the sessions. There are usually very few partners or husbands who join these sessions.

The pregnant adolescent who goes through the three sessions receives a certificate of completion. She can present this when she would like to apply to TESDA for training or to continue her education and to avail of livelihood opportunities from DOLE.

Delivery

Pregnant teens are encouraged by the service providers and the PYP Team to deliver in the hospital and are made aware of their elevated risks. Nine out of 10 pregnant adolescents who came to EVRMC for prenatal consultation, delivered in this facility. The others may have delivered in private hospitals or in other public facilities which are closer to their areas.



Picture 7. Six-beds PYP Maternity Ward, EVRMC

The following table shows that from September 2014 to May 2016, there were 8,093 women who delivered at EVRMC. Of this number, 1,311 (15%) were adolescents. The highest proportion of adolescent births was from January to May 2016 (21%).

Table 9. Proportion of births to women, 19 years old and below at EVRMC, September 2014 to May 2016

Year	Total no. of women who gave birth at EVRMC	Total no. of adolescents (10-19 years old) who gave birth at EVRMC	Per cent (%)
2014 (Sep to Dec only)	2, 094	256	12.2
2015 (Jan- Dec)	5, 426	809	14.9
2016 (Jan - May)	1, 173	246	21.0
Total	8, 693	1, 311	15.0

Source: EVRMC PYP Registry, June 2016

Postpartum Care

After delivery, teenage mothers are advised to return to the facility after one week for their postpartum care and for their babies' checkup. The PYP team keeps track of the teenage mothers return because this is an opportunity to follow them up about their chosen birth-spacing method. Most of the PYP teenage mothers returned to the hospital for postpartum care.

Family Planning

EVRMC provides FP counseling, services and supplies for an array of methods such as oral contraceptives, male condoms, injectables, bilateral tubal ligation and IUD. It also teaches LAM. It has also offered implants prior to the Supreme Court's TRO.

Table 10. FP acceptors at EVRMC, September 2014 to May 2016

Year	No. of FP acceptors (excluding LAM) (All women)	No. of FP acceptors (excluding LAM) (19 years old and below)	Per cent %
2014 (Sep to Dec)	136	24	16.2
2015 (Jan to Dec)	1158	192	16.5
2016 (Jan to May)	356	67	18.8
Total	1,650	283	17.1

Source: EVRMC PYP Registry, June 2016

Table 10 shows that from September 2014 to May 2016, EVRMC had a grand total of 1,650 FP acceptors. Seventeen per cent (281) were adolescents. The highest period of FP uptake among adolescents was from January to May 2016 (18.8%).

The specific birth-spacing methods which were accepted by teenage mothers are shown on Table 11. Four fifths (224 out of 283 acceptors) of the teenage mothers utilized IUD/PPIUD. This may be attributed to the promotion of this method by the PYP particularly the health providers and PYP champions.

Table 11. FP uptake by type of method among adolescents (19 and below), EVRMC, September 2014 to May 2016

	2014 (Sep to Dec)	2015 (Jan to Dec)	2016 (Jan to May)	No.	Per cent %
IUD/PPIUD	16	145	63	224	79.2
Sub-dermal Implant	6	33	0	39	13.8
Oral Contraceptives	0	12	3	15	5.8
DMPA	0	2	1	3	1.0
Total	24	192	67	283	99.3

Source: EVRMC PYP Registry, June 2016

The teen mothers are advised that it is better for them to wait for three to five years or longer before they would have another child so that they could pursue their goals. A PYP service provider opined that teenage mothers should think about their future and their children before they would consider giving birth to another baby.

Ini nga kabataan dapat hunahunaan nira it pagpaningkamot anay nga magmaupay it ira kabuwason san-o nira sundan an ira panganak diri la para ha ira kalugaringon, pero para gihap han ira anak.

(Young women should first think about securing a better future before having another child, not only for themselves, but for their baby as well.)

General profile of PYP clients/enrollees

A total of 473 teenage mothers were already enrolled in the PYP since its launch in September 2014. Pregnant adolescents and teenage mothers are between the ages of 15 to 19. Most of them are living in with their partners and a few have separated. One tenth are younger than 15. The youngest PYP client is 12years old.

Table 12 shows that since the launch of the PYP, over one tenth (13.8% or 1,311) of all the deliveries at EVRMC were adolescents. However, not all the teenage clients who delivered at this facility enrolled in the PYP. Only over one third (36.1% or 473/1,311) were PYP enrollees.

This implies that there is a need to strengthen the promotion and coordination of the PYP within the hospital system.

Table 12. Proportion of Teenage Mothers enrolled to EVRMC-PYP, September 2014 to May 2016

	2014 (Sep to Dec)	2015 (Jan to Dec)	2016 (Jan to May)	Total
Total number of deliveries (All women)	2, 904	5, 426	1, 173	9,503
Total number of deliveries to women 19 years old and below	256	809	246	1,311
Women enrolled to PYP	71 (27.7%)	354 (43.8%)	48 (19.5%)	473 (36.1%)

Source: EVRMC PYP Registry, June 2016

Data Management/Monitoring and Evaluation

Individual records of PYP clients are in separate folders and these are maintained in the PYP Clinic but these are not placed in a locked cabinet. A bulletin board is also provided in the counseling room and services extended by the PYP are summarized here including the FP uptake among the adolescents. Logbook for the served client and related information is maintained and kept but there is no computerized database. The EVRMC is still awaiting for the installation of the software called PCaSo (Point of Care Solution) to ensure that their data recording and management are more efficient.



Picture 8. Bulletin board and record's corner, EVRMC PYP

The PYP submits reports and updates on the statistics of served clients to Visayas Health. A rapid assessment of the implementation of PYP was conducted by VH which resulted in some adjustments and improvement in the way the educational sessions are conducted including the recruitment and mobilization of the teen mom champions.

Aside from the above, no other monitoring and supervision scheme is in place. No regular meetings are set by the PYP team but the members are closely coordinating their activities

Financing

The PYP was launched with technical support from VH particularly in training health providers, development of the protocol of operations and the provision of some amenities like TV, DVD player and audiovisual materials. The space and the personnel in the operation and oversight in running and sustaining the program are the hospital's counterpart.

Services (assessment, counselling, facilitation, referral, Usapan Sessions) at the PYP are free. Maternal care package and FP services are covered by Philhealth.

Extending support to other facilities

The EVRMC PYP and VH staff are jointly providing technical assistance to Abuyog District Hospital in Abuyog Leyte and Salvacion Oppus Yniguez Memorial Provincial Hospital (SOYMPH) in Maasin City. The training needs of these facilities were assessed. A training task force was organized with members composed of the PYP focal person and two nursing assistants.

The training task force and VH provided technical assistance as follows:

1/ Observation and return demonstration by the facilitator of the PYP sessions; 2/ how to recruit, coach and mobilize PYP graduates to become PYP Champions, 3/ sharing of experiences and open forum, and; 4/ facilitating the drafting of the action plan and evaluation sessions.

Being a teaching and training hospital in the region, EVRMC is being primed to be the PYP demonstration site and training center where teams from other facilities can learn how to start and/or strengthen the PYP implementation.

Strengths and Challenges

The EVRMC's PYP is close to meeting all the DOH Standards of an Adolescent-Friendly facility. It probably has the best physical layout among the hospitals that the project team has visited. It has provided health education to pregnant teenagers to ensure safe delivery and post-natal care. It continually hones the skills of its champions, a new group of advocates among teen moms. The PYP has also forged alliances with other agencies like TESDA, DepEd, DSWD and POPCOM among others to open new windows of opportunities for the teen moms to continue their education and develop their competencies for a better quality of life.

However, the EVRMC's PYP needs to address the following challenges:

1/ As the PYP expands its services and training activities within the hospital and in other districts and provinces, it would need a fulltime coordinator and additional staff to manage the program. At present, the PYP's daily operation is handled by a VH staff with support from multi-tasking permanent staff and a JO personnel. This arrangement is not going to be sustainable in the long run because VH's term of providing technical support in the Visayas would end next year.

2/ Tapping teen mom champions to partner with health providers is an innovative approach in raising the demand for the PYP service including FP. It was observed that their knowledge about gender and RH and facilitation skills were still inadequate. There is therefore a need to enhance their capacity in these areas.

3/ It is noted that only over one third of all the adolescents who delivered in the hospital were enrolled in the PYP. This means that the majority of the teenagers who gave birth in the hospitals were not covered by the PYP. This might be the walk-in clients of the hospital. There is therefore a need to review the entry procedures for soon-to-deliver pregnant teenagers and to build the system and capacity of the OPS and other entry points to refer these clients to PYP.

4/ Male partners are often unable to join the education sessions of the pregnant adolescents. Those who were interviewed by the research project staff noted that some of them have multiple partners and are engaged in risky sexual behavior. This might be the situation for other men who were not covered by this study. Other strategies should be developed to encourage the male partners to learn about their own sexual health and about the situations of their pregnant partners e.g., holding TESDA supported sessions or DOLE job fairs which would include some sessions about ASRH and related topics.

III. Iloilo Provincial Hospital (IPH) Program for Young Parents(PYP)

Iloilo Provincial Hospital (IPH) is a 100-bed Level 1 government hospital which was established in 1947. It is located at Barangay Rumbang, Pototan Iloilo, a municipality which is 30 minutes away from the capital city.

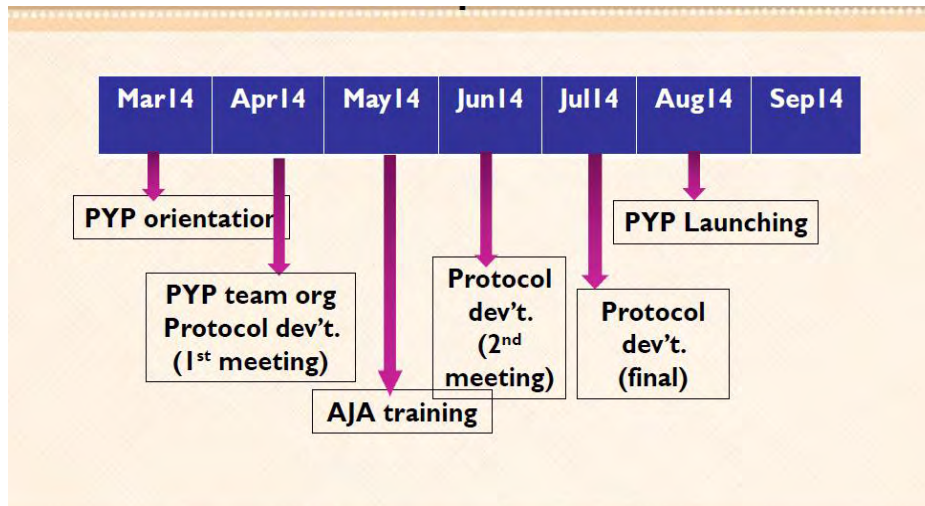
IPH is under the management and control of the Provincial Government of Iloilo and the core referral hospital of the Central Iloilo Health Zone Alliance (CIHZA). It is also the referral hospital of the province. Thus, it receives patients from other nearby towns and even patients from the nearby province of Capiz because of its accessibility. The major departments of the hospital include Pediatrics, OB-Gynecology, Surgery, Medicine including Anesthesia. It has an active Diabetic Clinic and Club headed by a Diabetologist. The hospital is undergoing a major renovation and it is adding a new wing to be able to meet the requirements of a Level 2 Hospital.

In early 2014, IPH partnered with Visayas Health (VH) and the Provincial Health Office (PHO) in conceptualizing a program that would address the growing number of pregnant adolescents in the province. A situational analysis was conducted to determine the resources of IPH to be able to implement the PYP. These include the hospital space and the personnel from the different

departments of the hospital who would be willing to join the PYP team. The composition of the PYP team and the program's key stakeholders were then identified and given an orientation about PYP. The PYP team members were subsequently trained about the AJA with technical support from VH.

After a series of consultation meetings with the departments' representatives, the PYP was launched at IPH on 20 August 2014. The graph below shows the sequence of activities prior to the PYP launch.

Figure 6. Sequence of IPH PYP Preparatory Activities and Launching



Source: IPH PYP

The PYP is aimed at providing adolescent-friendly, comprehensive health care and education for young mothers, their partners, and other significant adult.

Specifically the PYP intends to attain the following:

- A comprehensive pre-natal, intra-partum (EINC) and post-natal care including immunization to the pregnant adolescent.
- Provision of ENC and post-natal care, including immunization to the baby.
- Exclusive breastfeeding up to 6 months to women 19 years old and below.
- Reduction of pregnancy among women aged 19 and below.
- Increase FP acceptance to prevent subsequent unplanned pregnancies
- Active participation of patient's support group (i.e. husbands/partners/significant others/peers) during pregnancy, care of the new born and children and FP
- Provision of psycho-social counseling among teen moms with VAWC concerns
- Prevention of STI and HIV among pregnant adolescents



Picture 9. IPH PYP waiting area (left) and welcome signage (right)

Governance

IPH PYP has an Executive Committee that is chaired by the chief of hospital and co-chaired by the Head of the OB-Gynecology Department.

The daily PYP operation is managed by a fulltime midwife who also serves as the program's focal person. Other members of the team who are directly involved in the program are five doctors, three nurses, a midwife and a social worker. They assist in the service delivery and in other related activities concerning teen moms.

There are five volunteers comprising of four peer educators called PYP "champions" and a mother of a PYP champion. The PYP champions assist the focal person in the *usapan* session for the pregnant adolescents particularly in the Gender and FP session. They share their personal experiences about their pregnancy and their acceptance of birth-spacing methods as well as their future plans. The mother of the PYP Champion motivates other mothers of the teen moms about the benefits of FP.

Capacity Building

As stated earlier, the PYP team which is comprised of members from the different hospital departments had an orientation about PYP and a training about AJA with technical support from VH.

The VH also extended technical assistance in selecting the PYP champions and in training them on how they could render effective testimonials during health education sessions. The focal person also gave feedback to the PYP champions about their performance after the *usapan* sessions. They were also asked to observe how the educational sessions are conducted by the focal person and other resource persons.

The PYP champions were identified based on the following minimum qualifications: 1/must have completed the three *usapan* sessions; 2/ must have at least four prenatal visits at IPH; 3/ must have given birth in the hospital; and 4/ must be an acceptor of a birth spacing method.

The peer educators must be willing to share their personal experiences as a young mother and that of their adoption of FP method. The PYP focal person also scouts for potential peer educators during *usapan* sessions based on how they are able to interact and effectively express themselves in discussions.

The PYP Champions are issued ID, T-shirts and are introduced to the staffs of IPH so that they can freely move around IPH to do their functions. They report to PYP on Teen Mom's Day which is every Wednesday. They are given free meals and PhP250.00 as reimbursements of their fare.

The PYP also tapped the mother of a PYP Champion to be a volunteer who would talk to the mothers of the teen clients especially about FP acceptance.

Policy

The implementation and management of PYP is guided by a protocol which stipulates the objectives of the program, components, procedures and guidelines of interaction of the different components of the program to include the service providers and teenage clients. This document outlines the step-by-step procedures in handling and managing teenage clients from the initial point of contact to service provision and client's exit from the facility and/or PYP.

Wednesday is declared as the PYP Day or Teen Mom's Day where teen clients are prioritised in service provision like prenatal and FP services. Educational sessions are also conducted on this day.

Demand Generation

Demand generation within the hospital includes provision of leaflets and reading materials to the clients about pregnancy, FP, maternal and child care which are provided by DOH, VH and the hospital. Audiovisual clips which were given by VH are also shown before *usapan* sessions. The PYP champions are important advocates within the hospital and they also function as motivators for teen moms in the maternity ward to accept birth-spacing methods.

An important component to raise the demand for PYP services is the Central Iloilo Health Zone Alliance (CIHZA), one of the 10 Inter-local Health Zones (ILHZ) of the province. The creation of ILHZs in all provinces was mandated by an Executive Order 205 in January 2000. It is a form of inter-LGU cooperation and this is done by forming contiguous LGUs into clusters to provide better delivery of public health services through the efficient utilization and sharing of resources. The ILHZ also assures the LGU constituents that they have access to a range of essential health services from a Service Delivery Network (SDN).

As defined in the RP& RH Act of 2012, the SDN refers to a network of health facilities and service providers within the province- or city-wide health system and it offers a package of health care services in an integrated and coordinated manner. Like other ILHZs, the creation of CIHZA in 2004 was aimed at providing effective delivery of integrated care through a smooth coordination between and among LGUs.

It is worthwhile to note that through the initiative of the Provincial Health Office (PHO), the CIHZA MNCHN SDN Referral System Manual was formulated (it was in press at the time of the field study). This vital document is a useful guide to strengthen service delivery at different levels of MNCHN care, including the support for young mothers.

The MNCHN SDN refers to the network of province and city-wide facilities and providers which are offering the MNCHN core package of services in an integrated and coordinated manner. The network of facilities are community-level service providers, BEmONCs and CEMONC-capable facilities or networks of public and private facilities.

CIHZA-SDN is composed of seven contiguous RHUs and LGUs of the municipalities of Dingle, Duenas, Leganes, Mina, New Lucena, Pototan and Zarraga. The IPH is its referral hospital and the chair is the Chief of Hospital. When PYP was launched, the CIHZA-SDN became an important component of the program because it facilitated the identification and referral of pregnant adolescent clients to access PYP services (Parcon et al., 2016).

An orientation about the PYP was conducted by the IPH for the LGU members of CIHZA to define the roles and responsibilities of their referring facilities. A two-way referral system and forms between the RHU and IPH's PYP were developed. BHWs, school teen enters, youth organizations and other municipal agencies were also enjoined to disseminate information about PYP and to refer pregnant adolescents to IPH through the RHUs. To further expand the network, private practicing midwives and other government agencies (municipal population officer, DepEd, MSWD, PhilHealth and TESDA) were included in the SDN. These partners are deemed essential in helping teenage mothers obtain important support in education, livelihood and other psycho-social needs.

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Central Iloilo Health Zone Alliance (CIHZA)
INTER HEALTH FACILITY REFERRAL SLIP

Facility: BHS Dept OPD Cases: OB/GYNE Infant Medical/Surgical
 RHU ER Neonatal Under 5 Medical Others

REFERRED TO (Facility/Provider): _____ Date: _____
 ADDRESS: _____

PATIENT'S NAME: _____ AGE: _____ SEX: _____ CS: _____
 ADDRESS: _____

PHIC: YES (Indigent Employed Individually Paying No

CHIEF COMPLAINT: _____
 VITAL SIGNS: BP _____ RR _____ HR _____ Weight _____ Temp _____

BRIEF CLINICAL HISTORY AND PHYSICAL EXAM (including PAST AND PRESENT history):

IMPRESSION: _____
 MANAGEMENT GIVEN/ACTION TAKEN: _____

REASON FOR REFERRAL: _____
 Further evaluation & management Per patient's request Others: _____

FROM: (Name and Signature of Provider) _____ Designation: _____
 Contact No. _____

Central Iloilo Health Zone Alliance (CIHZA)
INTER HEALTH FACILITY RETURN REFERRAL SLIP

Name of Facility: _____ Address: _____
 TO: (Health Facility) _____ Address: _____
 Patient's Name: _____ Sex: _____ Age: _____ CS: _____
 (Surname) (First Name) (Middle Name)

Address: _____
 Final Diagnosis/ Impression: _____
 Management (including medication): _____
 Instructions/ Recommendations (including follow-up, preventive actions to be undertaken):

FROM: (Name and signature of Provider) _____ Designation: _____
 Contact No. _____

Picture 10. CIHZA Referral Form, Iloilo

Recent IPH data suggest that after formally establishing the ILHZ-SDN, the number of teenage prenatal visit and deliveries in the hospital went up. Postpartum visit at the hospital and RHUs and acceptance of FP methods by teen moms also increased. It is envisioned that in the long run, the PYP and its ILHZ- SDN will significantly contribute to reducing rapid repeat pregnancies among adolescents.

Health-Service Delivery. The IPH-PYP has the same CA technical consultants as the EVRMC. Therefore, there are similarities in their procedures of extending health services. The following flow chart shows the steps from the initial access to the facility, prenatal care, education sessions, delivery and postpartum care.

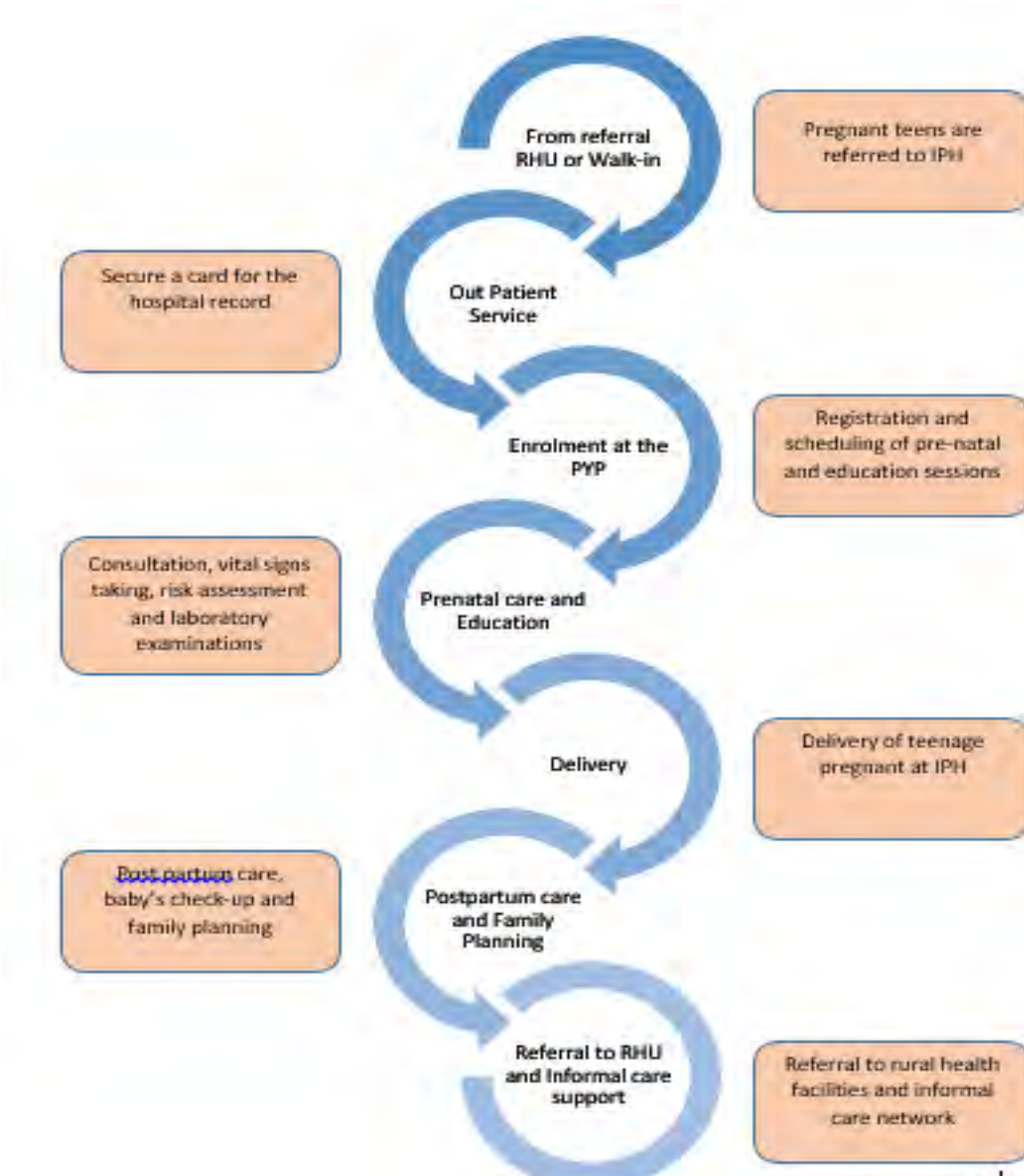


Figure 7. IPH PYP Service Delivery Flowchart

Initial Access to the Facility and Enrolment to PYP. The patient’s initial contact in the hospital is usually the Outpatient Services (OPS) to secure a card for the hospital record. When the patient is pregnant and she is 19 or younger, the OPD personnel refers her to the PYP.

When the PYP staff would accept her, her record is stamped as “PYP” and “high risk.” This is done so that when the pregnant adolescent would be referred to other departments, the staff will know that she is from PYP.

The PYP focal person/midwife would then assess the client and would refer her for initial prenatal care. The midwife would schedule her subsequent prenatal consultation on Wednesday, the PYP day dedicated to teen moms and her attendance in the *usapan* sessions. If the pregnant adolescent first came to the hospital on another day, she would still be attended by the hospital but she would be advised that Wednesday is the prenatal day for teenagers. She will be monitored via SMS messaging by the midwife to ensure that she returns on the scheduled prenatal consultation and the *usapan* session.

Republic of the Philippines
Province of Iloilo
Provincial Health Office
ILOILO PROVINCIAL HOSPITAL
Pototan, Iloilo
Contact No. (033) 822-999 / 822-998 • Telefax No. (033) 829-7491 • e-mail: iph_iloilo@pho.gov.ph

HOSPITAL CASE NO.: 25-12-98

Date Consulted: 03/11/14
Time Consulted: 9:00 am/pm

NAME: Ms. Hannah G. Gato Albalde **AGE:** 18 **SEX:** F **CIVIL STATUS:** Single
ADDRESS: Purok 1, Bantayan, Pototan **DATE OF BIRTH:** 9-28-1996
GUARDIAN: Melanie **RELATIONSHIP:** Aunt

CONTACT NUMBERS: 0917 698 9450

CLASSIFICATION: PHIC PAY SERVICE OTHERS
DEPARTMENT: MEDICAL PEDIATRIC SURGICAL OB/GYN

DATE	DIAGNOSIS	TREATMENT	REMARKS
9-8-14	G, B	PREST FEELING	
10-11-14	1st visit		
11-11-14			G, B NIC Douch 12, 14
12-11-14			NIC
1-11-15			(analysis)
2-11-15			RPR
3-11-15			HPV Ag
4-11-15			Multivitamin

Picture 11. Sample IPH PYP Individual Treatment Record

The midwife said that no HEADDSS Form is used in assessing the pregnant teenager but she assures that she is guided by what she learned from the AJA Training.

Referrals are made within the hospital as needed but no form is used. Marginal notes for referral are written on the Individual Client Record. Some clients who are referred by other health facilities would submit referral forms to the midwife but others do not. At present, most of the RHUs who refer pregnant teenagers to the PYP would send SMS messages to the PYP midwife to check whether their referred clients went to PYP.

During first consultation at the PYP, the pregnant teenagers are usually accompanied by their mothers. Few partners or husbands would join the prenatal consultation.

Services. The PYP is open from Monday to Friday, 8:00 A.M. to 4:00 P.M. The PYP midwife assesses the pregnant teenage client and facilitates the provision of the needed maternal care services. She also links her to the social worker for PhilHealth enrolment and other psycho-social needs.

The following services are available at IPH:

- Counselling, nutrition and RH assessment
- Maternal Care Services (prenatal, natal, postpartum)
- Services for STIs including HIV/AIDS
- Pap smear and pelvic exam
- Dental Assessment
- Micronutrient supplementation (iron supplements and Vitamin A are given for free as long as supplies are available)
- Social and legal services (through the social workers)
- Patients with substance abuse problem are referred to the Iloilo Rehabilitation Centre



Picture 12. IPH PYP prenatal facility

Prenatal and delivery. Pregnant teenagers usually come to PYP for prenatal care on the second trimester of their pregnancy. Transportation cost, shame and stigma are the common reasons for coming at this stage of their pregnancy.

Ninety per cent of those who consulted the PYP delivered at IPH. Apparently, the remaining number delivered in other health facilities. Table 12 shows the number of women including adolescents who have delivered at IPH in the last five years. As shown, the proportion of teenagers giving birth at IPH has increased in the last five years, from 10.6 per cent in 2011 to 19.1 per cent in 2015. In 2015, IPH had 10 deliveries in a day; two of these were teenagers.

Table 13. Number of deliveries at IPH from years 2011 to 2015

Year	No. of women who gave birth at IPH	No. of adolescents (10-19 years old) who gave birth at IPH	Per cent %
2011	1, 316	139	10.6
2012	1, 541	186	12.1
2013	2, 283	248	10.9
2014	2, 583	324	12.5
2015	3, 347	640	19.1
Total	11,070	1, 537	13.9

Source: IPH Log Book of Delivery, 2011-2015

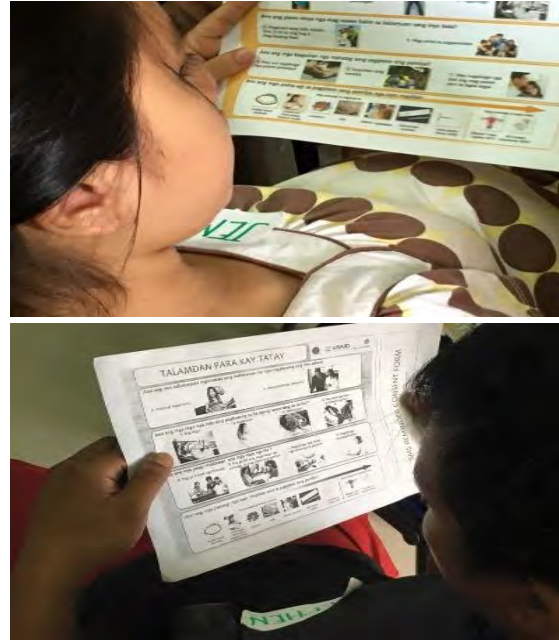
The IPH has no dedicated maternity ward for teenage mothers. The hospital is in the process of adding a new wing and it intends to have this facility in the new structure

Postpartum Care. Teenage mothers are advised to return to the facility after one week for postpartum and infant care. The PYP focal person /midwife and champions follow up the teenage mothers through SMS messaging to ensure that they return to the PYP. Almost all teen moms come back to the PYP for postpartum care which include a check-up for possible complications and for acceptance of FP services.

Family Planning. The hospital is offering FP counseling for all methods. It provides services and supplies for methods such as oral contraceptives, male condom, injectables, bilateral tubal ligation and IUD. It has also offered implants prior to imposition of TRO. Since the PYP launch in August 2014 until May 2016, 103 adolescents have accepted birth-spacing methods-- 92 of these are PPIUD users while the rest accepted implants.

The available birth-spacing methods at IPH are: oral contraceptives, injectable, implants, male condom and bilateral tubal ligation. It was noted during the education sessions that the providers and champions that the PPIUD is their highly recommended method.

During Gender and FP session, different methods of FP are discussed by the PYP focal person/midwife by showing the different methods and by distributing a one-page paper called “Guide for Mothers,” which has information about the different methods. The Guide for Mothers contains reminders for pregnant mothers and a perforated portion to be filled out with name, address and contact number of the client. The perforated portion which is given back to PYP focal person also serves as a consent form to receive SMS from PYP. A complimentary set of this material called “Guide for Fathers” is also given to the partner of the pregnant teen when present. Testimonials are given by the PYP champions. Teen moms are encouraged to choose a method that will suit them. Through the testimonies, the benefits of birth spacing are discussed and emphasized.



Picture 13. Teen Clients using Guide for Young Parents during Usapan

Teen moms are advised by the PYP focal person that it is better to wait for 24 months or longer before having another child. Among the benefits of adopting a birth spacing method is that the pregnancy of having another child too soon will be prevented, allowing the mother to pursue other endeavors such as schooling. KI opines that the teen mother has a bigger chance of fulfilling her dreams and having a better future if she will not have another child shortly after giving birth with her first.

Mas better ang ilang future ug mafulfill ilang dreams if dili magbata dayon.

(Their future would be better and their dreams will be fulfilled if they will not have another baby right away.)

The PYP Focal person noted that it is the mother of the teen mom who influences her over her decision on what birth-spacing method to use.

Usapan sessions. PYP is also giving three *usapan* sessions which run from 30 minutes to almost one hour for the following: 1/Gender sensitisation and FP Session; 2/ Birth planning and danger signs of pregnancy; and 3/Life skills.

The Gender sensitisation and FP session is facilitated by the PYP focal person with the help of the PYP Champions. The birth planning and danger signs of pregnancy session is facilitated by a nurse and at times a doctor who are members of the PYP Team. Life skills session is facilitated by the hospital’s social worker who is also a member of PYP Team. Representatives from either

DepEd - ALS, DOLE, DSWD, TESDA are invited in this session. Pregnant teen clients and their partners are enjoined to attend the three sessions within the duration of their pregnancy.

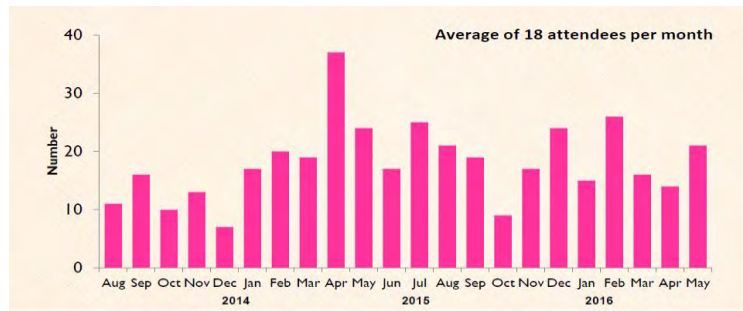


Picture 14. IPH PYP focal person and peer educator during Usapan Session

Those who have attended the three sessions will receive a certificate of completion which they can present in applying for further schooling and/ or livelihood opportunities. A local church-based organization in Pototan, the Daughters of Mary Immaculate, recently expressed interest to partner with PYP in the life skills session and for possible collaboration to involve teen mothers and/or their partners in livelihood programs.

Figure 8 shows the number of attendees of Usapan Sessions since PYP was launched in August 2014 up. On the average, there are 18 attendees per month.

Figure 8. Number of Young Parents Attending Usapan Sessions, Aug 2014 to May 2016



Source: PYP Team, IPH

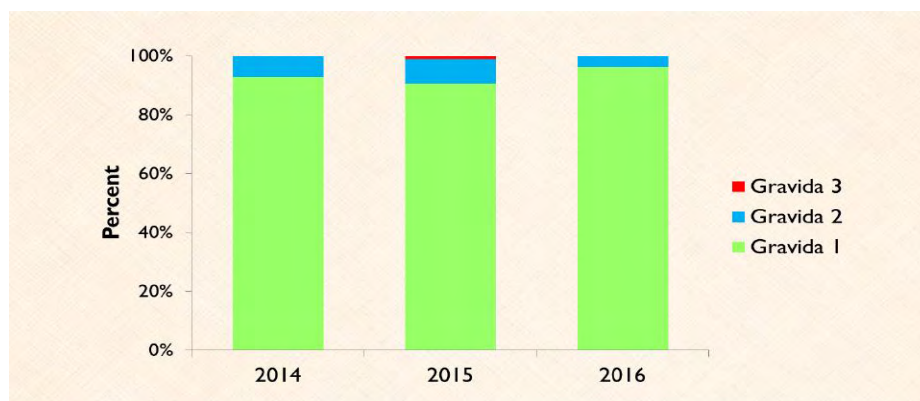
Mobile technology is used in following-up the pregnant adolescents for the Usapan Session, prenatal check-up, FP acceptance and/attendance in other health education session.

To ensure confidentiality and privacy, PYP clients counseled individually. The PYP has a prenatal room and the adjoining room for counselling and Usapan Sessions. The prenatal space is separated by curtain partitions.

PYP Clients. The PYP registry shows that from Aug 2014 to May 2016, the PYP has an average of 22 pregnant teenage mother-enrollees every month.

The registry further shows that most PYP enrollees are pregnant for the first time. There were few Gravida 2 and 3 enrollees. Please see Figure 9.

Figure 9. Number of Pregnancies of IPH PYP Enrollees, Aug 2014 to May 2016



Source: IPH PYP Team

In an FGD conducted among PYP clients, teenagers expressed their satisfaction on the manner they were attended by the PYP staff. “Everyone in the hospital makes us feel important.”

During a group interview with their partners, the following reaction was articulated by a pregnant teenager:

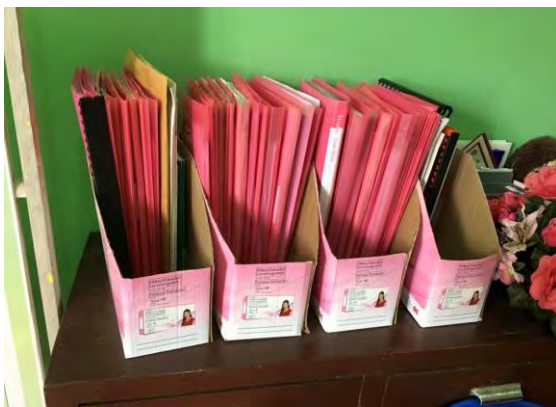
Mayad man, friendly man sila Mam. Wa'ay man mi kabudlayi.

Friendly man sila Mam, wa'ay buangit.

Tzytel, a PYP champion, was impregnated while she was 18 years and was studying in college. Her life has changed after she enrolled in the PYP. She inspires others by sharing her struggles and how she has overcome them with the support of her mother and PYP.

Tzytel is now 19 years old and she married the father of her baby who is now 8 months old. She is currently pursuing a caregiver vocational course at TESDA through the PYP's recommendation. Below is an excerpt of her testimony during the Adolescent and Youth Reproductive Health Technical Conference which was held in Iloilo City on 28-29 June 2016.

My moment at PYP has helped me to have an opportunity to meet different people. Doctors, nurses, midwives, teens like me who become good friends, and people from other organizations. My involvement in PYP has helped me gain my maturity and take responsibility for my actions, because I have completed all the educational sessions, delivered in the hospital, and now I'm using a family planning method I was qualified for the IPH PYP endorsement at the TESDA. I was accepted to pursue a caregiving course. Even with my classes, I have committed to continue serving as a PYP champion at the IPH Teen Moms Day. I realized that it is the least I can do for the program that helped me so much.



Picture 15. IPH PYP Files

Data management/monitoring and evaluation.

A logbook about the clients and other related information is maintained by PYP. It does not have computerised database. PCaSo (Point of Care Solution) at IPH is available but there is no computer which is compatible to this software. It also does not have and competent staff to manage this software. PYP does not maintain the Individual Treatment Records for its clients. A client folder is returned to the hospital's record section but it is readily available when requested.

The focal person submits a Monthly Statistics Report (MSR) of clients to IPH and VH. Aside from the above, no other monitoring and supervision scheme is in place. No regular meetings are set by the PYP team but they closely coordinate with each other.

Financing. The PYP was provided with technical assistance by VH akin to the support given to EVRMC (training, advice, protocol development). The program was also provided with chairs, TV, DVD player and some audiovisual materials. The space, the personnel, and oversight in running and sustaining the program is the hospital's counterpart.

Like EVRMC, PYP services are free. Maternal care package and FP services are available through Philhealth.

Cost of Putting up a PYP in a Hospital Setting. VH provided cost estimates in establishing a PYP. These cover preparation, launching and operations costs. Around PhP288,750 is needed for the preparatory phase. This includes the a/conduct of a situational analysis, b/ advocacy to the management of hospital for the eventual buy-in of the program, c/ organization of the hospital's PYP Team, d/initial capacity building of the PYP Team which include protocol development, e/ orientation of the Team about the PYP and protocol, f/ AJA Training for six staffers and g/ refurbishment of PYP area in compliance with DOH AFHS Standards.

The program launch is optional but it is useful for raising awareness and advocacy. This is estimated at PhP45,000. The operating cost is estimated at PhP55,000 per month and it involves part-time personnel which include the chief of hospital, OB-Gyne, pediatrician, nurse, midwife, medical social worker and four volunteers.

The PYP total estimated start-up cost is PhP388,750.00 (see budget estimates in the Appendix).

Strengths

One of the major strengths of PYP-IPH is the presence of an enabling network called CIHZA for demand generation and service delivery. Strengthening linkages with ILHZs like the CIHZA is essential in ensuring that teen mothers are able to access the services needed through the program.

The IPH's PYP is close to meeting the DOH standards for an adolescent friendly facility. It has a dedicated room for Usapan Sessions counseling, and a curtained cubicle for prenatal consultation. It also plans to have a PYP Ward upon the completion of the IPH renovation.. Although delivery services for teen moms are still integrated in the hospital system, the services extended by the health providers from the different departments are reportedly adolescent-friendly.

The PYP has built alliances with other institutions like TESDA, DepEd, DSWD to open opportunities for the teenage mothers to continue their education and build new competencies and skills for gainful occupations.

It has also identified and developed PYP champions to help motivate other pregnant teenagers to utilize FP methods after they deliver.

PYP has started involving the mother of a teen client as volunteer who talks with other mothers who accompany their pregnant teenagers. The focal person expressed that the mothers of the teens are the ones who exert strong influence on their choice of birth-spacing methods.

Ang ilang nanay man ang maghambal. Hipos nalang ang anak.

(Their mothers do all the talking. The daughters remain quiet.)

This scenario is a drawback in providing birth spacing method when the mother is against it, It can also be an opportunity if she would be supportive of birth spacing methods. To address this situation, the PYP has one mother champion to play this role.

The PYP is fully supported by the chief of hospital who has been very active since the preparatory phase of the program. Thus, the buy-in of the program is also from the different hospital department heads and assistant heads who have been working in the hospital for more than 18 years. However, three of the team members are retiring soon while the others are already in their late 50s. Some of those who are about to retire are the facilitators in Usapan Sessions. Thus, there is a need to train younger members

Challenges

The IPH PYP Team needs training on program management for the sustainability of the program when VH support is no longer present. The PYP expenses such as utilities, salaries of the focal person and other persons who are directly involved in running the PYP and other “hidden” costs are integrated in the hospital’s regular operating expenses. This makes it difficult for PYP to come up with disaggregated costs and a financial report. IPH plans to include in the annual hospital budget, a separate line item for the operations of the PYP. The PYP Team also plans to tap part of the Philhealth capitation fund to sustain the program.

Monitoring and Evaluation of PYP needs to be strengthened especially data recording and management. Referrals from other facilities and return referrals should be recorded. The current systems operate based on good relationships with the providers.

There is also a need for the PYP to formalize its work arrangements with the staff to ensure that the roles are defined and the tasks will not be affected when someone would resign or retire from the service (it was noted during the field study that a number of the staff were about to retire).

Moreover, while the Point of Care Solution (PCaSO) software is available at IPH, there is no available computer unit and a competent staff who would utilize this technology.

The *usapan* sessions are good venues for educating young women. However, the focal person expressed that pregnant teenagers preferred to go home immediately after the prenatal checkup without attending the health education. She recognized that there is a need to popularize *usapan* sessions and its benefits.

Just like the EVRMC, partners of pregnant adolescents are enjoined to attend *usapan* sessions. A group discussion among partners of these teens also revealed that the young males have been engaging in sex with multiple partners while in a relationship without the use of any protection. They also have low awareness about STIs. Conducting a separate session for the partners of teen clients may be considered through a TESDA job fair.

Summary

The tertiary hospitals

Three tertiary hospitals may be considered as models in providing gender-responsive and rights-based ARH services for pregnant adolescents and teenage mothers because they have met most of the 2010 National Standards for Adolescent-Friendly Health Services. These facilities, however, have different characteristics and mandates in the health system. Brokenshire Woman Centre is a private hospital in Davao City with a Program for Teens. It receives technical assistance from Mindanao Health. EVRMC is a DOH-retained regional hospital while IPH is a LGU-supported provincial referral hospital of the nearest ILHZ. EVRMC and IPH have Programs for Young Parents and these institutions obtain technical support from Visayas Health.

The private hospital. Brokenshire Hospital, a century- old private facility, is owned by the United Church of Christ of the Philippines (UCCP). It was founded as a mission hospital in 1908 and it evolved into a tertiary facility with a 240-bed capacity. It attends to around 12,000 patients annually. Around three to four per cent of the total number of pregnant women who were admitted to the hospital for childbirth are adolescents. It has a Program for Teens (PYT) which include services for pregnant adolescents and teenage mothers.

PFT appears to have met most of the DOH standards for an adolescent- friendly facility. The facility's well-designed infrastructure and the measures to ensure confidentiality and privacy are satisfactory. There appears to be no problem with the current clinical procedures and the corresponding waiting time and their referral system. The PFT evolved into a program because of the quick buy-in from the hospital authorities, the clinical departments and other pertinent units of the institution. It is coordinated by experienced OB-Gynecologists of the Brokenshire Woman's Centre in partnership with AJA-trained residents, medical doctors, nurses and midwives and other groups in the hospital system. The PFT also partners with the LGU health system in adolescent-related activities.

Integrating the AFHS in the hospital, changing the attitudes and honing the skills of the health providers in the whole hospital appear to be the PFT's major challenge. The hospital's demand generation activities also need to be strengthened to reach out to many adolescents in the city

who could benefit from the PFT services. “Parental resistance” is also seen as a major obstacle to the young people’s enrolment at the PFT.

Because the PFT is in a private hospital, it could not offer its services for free to adolescents. Partnership with the LGU, national and international development partners should be intensified to avail of opportunities for more funding for needy pregnant adolescents and other young people.

The public tertiary hospitals. The Eastern Visayas Regional Medical Centre (EVRMC) and the Iloilo Provincial Hospital (IPH) Program for Young Parents were assessed as having met most of the DOH AFHS standards in providing adolescent-friendly services to pregnant adolescents and teenage mothers.

Similarities of the two facilities. The EVRMC and IPH have similar PYP strategies in their hospitals. The buy-in of the hospital administrators is reflected in the establishment of multi-disciplinary teams comprising of health providers from different departments who are working together to provide an integrated program for young parents.. The health providers have had AJA training and PYP orientation. They have similar protocols which provide guidelines of how the services are extended to pregnant adolescents and teenage mothers.

The clients are enjoined to enrol in the PYP for prenatal care and to participate in the Usapan or education sessions about gender and FP, danger signs and symptoms of pregnancy and life skills. They help enrol the adolescents in PhilHealth’s point of care support to finance their delivery and access to birth-spacing methods. They also have PYP champions who assist the Usapan health providers by sharing their life experiences to other pregnant adolescents during the Usapan. The two hospital’s M & E is done manually because they are waiting for the installation of the PCaSo software.

The two institutions also partner with DSWD, DepEd, TESDA and DOLE to ensure that the teen moms who receive their PYP certificates are able to obtain support from the foregoing.

Differences between the two hospitals. The EVRMC facilities in extending PYP services are found in one location (the ground floor of the hospital). The counselling and prenatal rooms are next to each other. .Nearby is the six--bed ward exclusively for teenage mothers (this is the only tertiary facility with a dedicated ward).

The IPH counseling and prenatal consultation spaces are found in one room. It intends to open an exclusive ward for teenage mothers in the hospital’s new wing which is still under construction. For the meantime, teen moms share the maternity ward with older women.

As a training regional hospital, the EVRMC has started to train other district and city hospitals in the region about PYP. It will soon move to a newly-constructed regional hospital. As EVRMC expands its PYP activities, there is a need for the institution to review its human resources, the capacity of their PYP champions and the referral system within and outside the hospital.

As the LGU-supported hospital, the IPH's PYP is directly related with the lower-tiered facilities to provide AFHS to pregnant adolescents and teenage mothers. To raise the demand for its PYP services, it coordinates with its nearest ILHZ's SDN. The PYP and the concerned RHUs are collaborating closely to follow up and provide the needed services for the teenage mothers.

It is worthwhile to note that aside from the PYP champions, IPH has started to involve teen moms as a FP motivator. This appears to be a promising approach to encourage mothers of teen moms to hasten the acceptance of FP by their daughters.

There is also closer contact with DepEd, MSWD, TESDA and DOLE in the SDN to ensure that the teen moms would obtain the needed support from these institutions. The RHUs are also linking with the LGU-supported teen centres. Having PYP champions who are now accessing the support of these agencies is a demonstration that the partnership with the foregoing institutions is viable.

How much does it cost to establish a PYP in the IPH? The estimates provided by VH Health of less than P400,000 appears to be affordable as startup costs for this facility. There is a however, a need for a through financial analysis and projection for this program. It is recommended that support for EVRMC and IPH be continued because their PYP strategies are indeed friendly and supportive of pregnant adolescents and teenage mothers.

CHAPTER FOUR

Field Study Findings: School and community-based teen centres

This chapter describes the programs and activities of school and community-based teen centres and their link to the public health system in two provinces and three cities. There are, however, no national standards for teen centres because their establishment and maintenance are dependent on the support given to them by their institutions and the LGUs.

The project team visited six school and community-based teen centres to find out how their programs and activities are related to the prevention of risky behaviours and to know whether they are collaborating with their local health system particularly with their barangay health centres, rural health units and hospitals.

I. School based teen centres

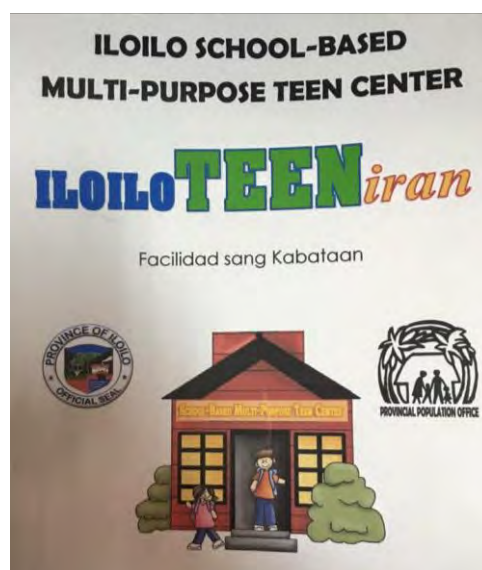
School-based teen centres are adolescent- friendly spaces in secondary schools where teenagers can freely express themselves and can access information and psycho-social support. Their location, sizes and facilities vary, depending on the availability of school space and support from their institutions and from their LGUs. The facilities which were seen by the project team were varied. Some were stand-alone multi-purpose centres while others are placed beside school clinics or guidance counselling office or near both facilities so that young people could be easily referred to the pertinent personnel for their health and psycho-social needs.

The project team has seen two types of school-based teen centres: a/ the multi-purpose facilities, and b/ teen health kiosks which are intended to relate directly to the ARH needs of young people. The multipurpose teen centres are located in Iloilo while the teen health kiosks are found in Cavite.

Iloilo Province's multi-purpose teen centres.

Alarmed by the increasing rate of pregnancy, smoking and alcoholism among young people, Iloilo Provincial Governor Arthur Defensor Sr., approved a Provincial Resolution in 2011 of a project entitled "Establishing Multi-purpose Teen Centres in all Public High Schools in Iloilo." This resulted in the establishment of teen centres in 37 (out of 43) national secondary schools in the province. Six teen centres are in the process of construction.

Each teen centre has a budget of Php 300,000 for the procurement of recreational materials, educational table games, and training of peer helpers and teen centre coordinators. The floor area of a teen centre is equivalent to that of a classroom. The Provincial Population Office (PPO) assisted the province in the establishment of the teen centres.



Picture 16. Cover, Documentation of Iloilo School-Based Teen Centers

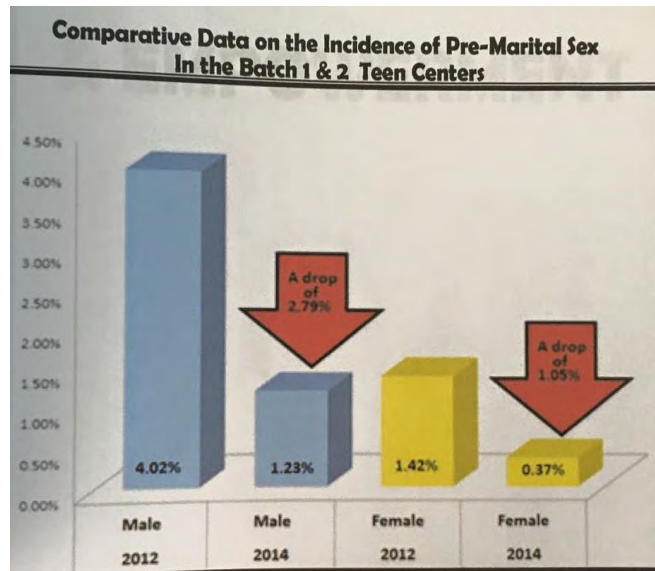
The teen centres are intended to provide a venue to empower and build the capacity of young people to enable them to become productive and competitive. These facilities have trained peer helpers who provide information and advice to other students regarding the dangers of unsafe sex, smoking, drugs, and alcoholism. POPCOM and the PPO provided training on adolescent reproductive health (excluding family planning) to peer helpers and counsellors.

The multi-purpose teen centres gave different interesting names for their facilities. e.g., Very Friendly Teen Centre of Oton National High School, Teens Nook Teen Centre of Pavia National High School, and Young Saver Teen Centre of Igaras National High School.

A teen centre usually has a receiving area, a separate space for counselling, reading and playing. It also has wall posters with messages about values, board games, computers, TV, musical instruments, physical fitness facilities and study tables. Moreover, the teen centre often serves as “Tambayan” where students hang around during their free time.

Iloilo Province through its Population Office established a monitoring system to determine the effects of these facilities. In 2012, they conducted a baseline survey about premarital sex, smoking and alcohol intake and use of illegal drugs. Then in 2014, they made an assessment to determine if the students’ behaviour changed. The findings showed that substance abuse (cigarette smoking, alcohol and drug use) and premarital sex went down.

In **Mina National High School**, for example, the Teen Centre guidance counselor said that the school offered *Dropout Reduction Program* (DORP) as an alternative mode of education for pregnant students who stop attending school.



The three major components of DORP are: 1/ Open High School Program or distance study learning program; 2/ Project EASE, a program for regular high school students who intermittently miss classes due to various reasons; and 3/ School-initiated Interventions (SII) which is often an informal arrangement like tutorial.

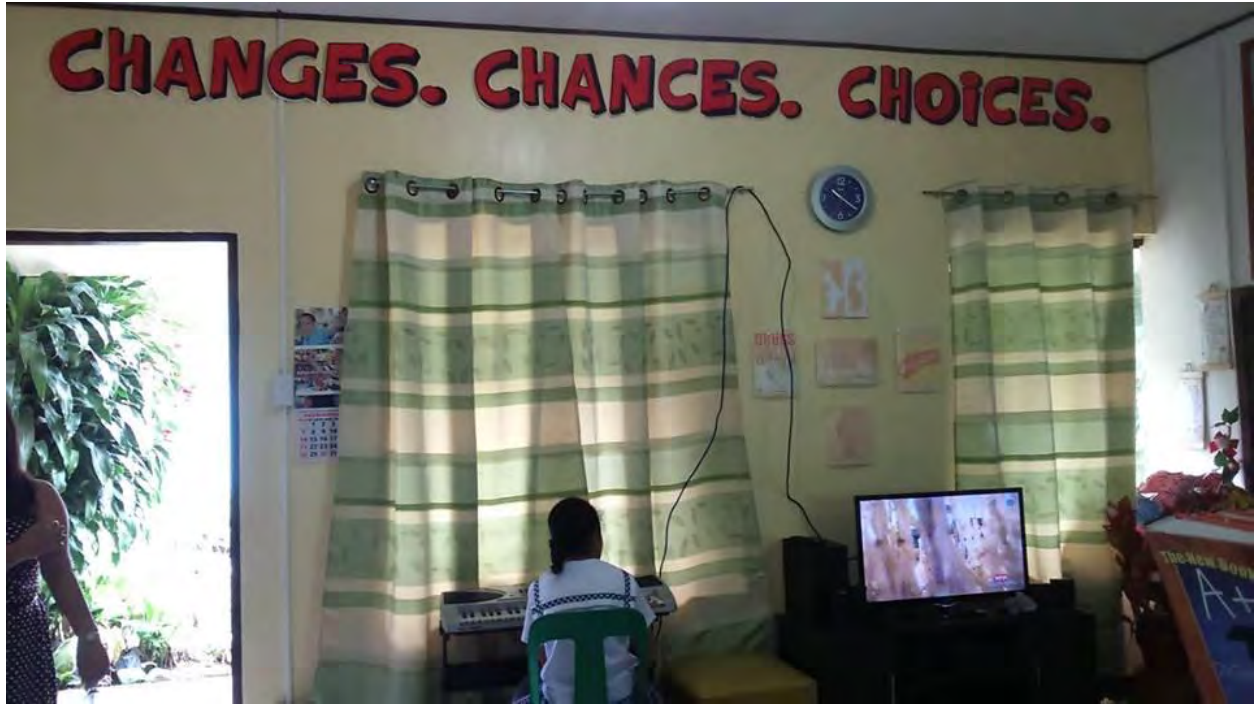
Figure 10. 2012 and 2014 Survey results of the Reported premarital sexual behavior of students in the Province of Iloilo



Picture 17. Facade of Mina Hillside Haven Teen center, Mina National High School, Mina, Iloilo

The Teen Centre coordinator said that this facility has five trained peer helpers but he said that most of them were not available at the time because schools were not officially opened yet. He added that the Mina MHO regularly served as a resource person on ARH topics during the school-wide symposia and other out-of-classroom programs. The interview with the MHO of Mina's RHU confirmed this relationship. The Mina RHU also has well-designed PYP services especially for the prenatal and postnatal care of teenage mothers.

Duenas Organization of Motivational Initiatives in Nurturing Adolescents or better known as DOMINA is a multi-purpose teen centre of Duenas National Comprehensive High School. Like any other school-based teen center in Iloilo, it serves as a “tambayan” for students where they can play board games, be with friends and discuss teen issues or talk with peer helpers. There are four peer helpers who were trained for five days by the Provincial Population office and POPCOM. The peer helpers, through the teen centre guidance counsellor, refer pregnant teen moms to the MHO. It is interesting to note that the municipal mayor and the barangay council contribute to the maintenance of DOMINA.



Picture 18. Recreation area of Domina Teen Center, Duenas Comprehensive National Highschool, Duenas, Iloilo

Pregnant teens are reportedly referred by the guidance counsellor to the RHU for prenatal check-up. Prenatal services are given by the RHU doctor and midwife. They later refer them to the Iloilo Provincial Hospital for enrolment in the PYP for care and support during their pregnancy.

A major challenge faced by DOMINA is that it only has four remaining trained peer educators because the others have graduated from the school. There are, however, 15 untrained peer volunteers who assist in operating the teen centre. There is a plan to have them trained by POPCOM and the PPO.

Cavite Province's Teen Health Kiosks (THK). A consultative meeting was held between Luzon Health and DepEd at the Cavite Collaboration Centre for Public Health on October 10, 2013 to identify national secondary schools which are willing to establish THKs. These teen centres were expected to serve as information and referral hubs to health facilities. Eleven National High School were identified in January 2014. Peer educators were subsequently chosen to attend a series of training conducted by Luzon Health from September 2014 to January 2015. In March 2015, 11 school-based teen health kiosks (THK) were formally launched. It was agreed that these facilities will be next to the school clinic and guidance counsellors' office.

School based THKs are a part of Cavite Province's three-pronged AYHD program which aims to assist in the prevention of risky behaviour and in raising the demand among young people for

the RHU's health services. The RHU in turn conducts screening services for the referred student including pregnant adolescents. It will also refer pregnant adolescents to the referral provincial hospital.

The THK program envisions to have "well-informed, empowered, responsible, and healthy adolescents who are leaders in society". The mission is "to ensure that all adolescents have access to quality comprehensive health care and services in an adolescent-friendly environment". Its main goal is to "improve the health status of adolescents and to enable them to fully enjoy their right to health." The THKs are also expected to network with other agencies such as DSWD, PNP, TESDA.

In 2015, the THK program reported that it had a/ trained 105 peer educators, b/ tapped 55 THK advisers, c/ 20, 357 high school students received information about AYHD and d/ 29 cases of teen pregnancy were referred to RHUs and the Teens Program Centre.

Tanza National Comprehensive High School (TNCHS) THK. The TNCHS was launched over a year ago in March 2015 through the technical support of the PHO and Luzon Health. The TNCHS is in a small air conditioned room with a TV, a wooden cabinet, a large table, a sala set, some reading materials, and a poster with the photos of the peer educators. It is a place where young people hang around during their break period and when they want to obtain some advice from the assigned peer educator.

It has five advisers: two guidance counsellors, one MAPEH teacher (main adviser), one AP teacher and the clinic nurse. The main adviser provides guidance, support and instructions in developing the peer educators program of activities and their learning materials. The nurse refers students with health problems especially pregnant adolescents to the RHU.

In May 2016, the TNCHS had 25 peer educators who were selected through the recommendation of another peer educator or the adviser because of their personal abilities. In October 2014, they went through a three-day training workshop about ARH which was organized by Luzon Health. It was a live-in activity and the peer educators stayed at H20 Hotel in Manila. After this capacity-building activity, only one official training activity was conducted by DOH entitled "enhancement training" regarding understanding and improving one self.

After the three-day training, the peer educators shared what they learned to other students during school assembly and in MAPEH classes. They developed their own power point presentations and utilized the video clips and movies which were provided by Likhaan. Through the help of the school's Special Course in Journalism students, the THK developed comics-like brochures which provide basic information about FP, HIV AIDS, drug addiction, relationships, sex and gender and teenage pregnancy.

The peer educators do not only provide ARH information in school but they are also invited as resource persons outside Tanza Municipality. Together with the main adviser, they were invited by DepEd Rizal Province to go to Cainta to talk to young people and teachers in some schools. This effort led to the establishment of many teen centres in a number of Cainta high schools.

Some of the TNHS-TK's challenges are the reduced number of peer educators because several have graduated already. Only 7 peer educators were left at the time of the study. There were plans to recruit more.

The main adviser and peer educators felt that there is a need for more training about ARH because they thought that the three-day training received from Luzon Health was not sufficient. It was also perceived as too cramped and not learner friendly (there was too much information over a short period of time that the peer educators could not absorb them anymore). The main adviser and the peer educators wanted more updates and training because they have been downloading materials from the internet to supplement whatever they have learned. They were not certain that these are reliable.

It was also disclosed that the DepEd regional office has not issued a directive to recognize the status of the THKs so that students could receive extra points for their involvement. At present, THK is an extra-curricular activity and no points could be gained by the students in their involvement in this facility. It was learned that in Cainta, such a DepEd regional office directive was reportedly issued which resulted in the establishment of several national high school THKs in Rizal Province.

B/ Community based teen centres

Community-based teen centres are adolescent-friendly spaces that provide health service to adolescents and a place where they can hang out. These are located inside or near health centres, which was said as *“advantageous in addressing health issues of adolescents because of its proximity to the referral facility”*. These centres are staffed by health workers like nurses, midwives and barangay health workers.

Presented here are three models of teen centre in the communities. These centres operate in different levels of the health system.

Barangay level Teen Center of Davao City. This community-based teen centre was established in 2012 with support from the barangay leaders and Barangay 21 Health Centre, the Mini-forest District Clinic, the City Population and Health Office. The Teen Center was renovated in 2015 with support from the Barangay 21-C Council and Samahang Kabataan (SK).

Facilities of the teen center

The Teen Centre is a small bungalow with two rooms—a receiving room with a table and chairs, TV, ARH posters and other, IEC materials and another room for consultation and counselling.

The documents about teen center clients, peer educators and their activities and other related documents are systematically filed and kept in a cabinet. It is located on the right side of the barangay health centre.

Program for adolescent

The vision of Brangay 21-C is to have a “well-informed, empowered, responsible and healthy adolescents who are leaders in society.” Its mission is to “ensure that all adolescents have access to quality comprehensive health care and services in an adolescent-friendly environment.”



Picture 19. Posters and bulletin board inside Brgy 21 Teen Center in Davao City

The Teen Centre is open every Wednesday and Thursday afternoon for counselling by the midwife. Other afternoons are slated for discussion sessions about FP and ARH matters. Thursdays are also devoted to report writing.

It is operated by two committed BHWs (one is unmarried who has served the community for over 30 years and the other has been there for 6 years).

The BHWs who are assigned to the teen centre have the following functions:

- Assist in pre- and post-natal basic services
- Conduct risk assessment and mapping of pregnant teens and adults
- Maintain master list of clients including adolescents
- Conduct house- to- house follow-up visits to clients
- Report to Midwife cases of complications due to pregnancy for referral to SPMC
- Provide FP information and counselling

Since 2012, the Barangay Council has had many training activities and seminars about ARH in partnership with the health centre's midwife, the peer educators, the district clinic, CPO, resource persons from many groups. These are

- Peer educators and health providers' ARH training,
- Workshop on ARH advocacy involving barangay,
- Livelihood training for teenage mothers,
- M & E for ARH intervention,
- Orientation about ARH for barangay functionaries,
- Development of ARH training manual and facilitators' guide.

Teen volunteers

BHWs are assisted by 8 peer educators from the barangay. The peer educators (mostly OSY girls) were not available during the visit to the facility because some were working while others were on vacation. There used to be more peer educators but others resigned because they have found work or have moved elsewhere. They have had numerous capacity-building activities about ARH and other group activities in Davao City

Link with the health system

For complicated cases, the BHWs report these to the barangay centre's midwife who in turn refers these to the District Clinic, and eventually to the referral hospital. Pregnant teenagers are among these cases. They are referred to SPMC and their records are picked up by the midwife every Friday from the said facility. The BHWs follow them up for their postnatal care and the immunization of their babies.

Youth and Adolescent for Health and Wellness of Marikina City. Marikina City is an international and national awardee for its many exemplary health programs. It collaborates with partner LGUs and NGOs in initiating novelty programs and projects in the Philippines. It is one of the first LGUs which opened an adolescent health program.

Origin

The Teen Health Quarters (THQ) is a part of the *Healthy City initiative* of Marikina City. The THQ technology and brand was obtained in 2005 through a social franchise arrangement with the Foundation for Adolescent Development (FAD). The social franchise fee of P450,000 was obtained from the Sanggunian Kabataan Fund. After the social franchise ended in 2014, the THQ became a city-run program. The THQ is now called "*Marikana Youth*



Picture 20. Marikina Teen Centre's Tarpaulin

and Adolescent Health and Wellness Center” or MYHAWC (pronounced as MY House). For over a decade, this facility went through several changes in policies, operational procedures, location and implementing partners.

Facilities of the teen center

The original THQ is strategically-located in Sta Elena, Marikina City which has now been converted into Sta. Elena Health Center. In 2014, with the dissolution of Sanguniaang Kabataan (SK), Marikina THQ has been transferred to the 3rd floor of the Marikina City Health Office.

A tarpaulin with a list of services offered to adolescents is at the entrance of the MYHAWC. This facility occupies one fourth of the entire third floor of the CHO building. It has two main rooms.

The first room is an office with two desks (one for the midwife and one desk for the doctor), a reception area which has a sofa and various ARH IEC materials are placed on the tables. The walls also have various adolescent health-related and FP poster. In a curtained corner, an examination bed is placed.



Picture 21. Audiovisual and IEC room, Marikina Teen Centre

The second room is a training venue and it lies across the THQ office. This is where most of the adolescent and youth activities are conducted. This area is not exclusive for THQ use because other government offices can use it for lectures or /workshops.

On the further end, is the Marikina HIV treatment hub office where the HIV counsellors are

conducting their counseling activities.



Picture 22. Medical and counseling room, MYHAWC

Program for adolescents

The MYHAWC has a full time midwife who also serves as the youth coordinator. During Mondays, there is a visiting doctor in the centre and he provides medical consultation services to the adolescent and youth. Tuesday is dedicated for dental services. The remaining days of the week are spent for outreach activities in schools and communities.

Basically, the MYHAWC provides comprehensive services to the youth. These are pregnancy test and counselling, pre- and postnatal care, FP and counselling, pap smear examination, breast examination, STI management, HIV testing and counselling, dental services and information and education drives. These services are being provided in partnership with other health offices like the dental clinic, social hygiene clinic, population office and health centres.

In 2014, a Youth Privilege Card (ATM type) was introduced in Marikina through the city Ordinance No. 039 Series of 2014. The idea is to encourage young people to seek health services at Marikina health facilities. It also provides discounts to other establishments such as free entrance to Marikina sports centre, free CHO services and the like.

Teen Volunteers

The MYHAWC has peer educators who are trained by the center provider. They provide school-to-school education drives, community outreach and other IEC activities. These teens are

required to finish FAD's 18-module training they can be considered as peer educator. At present, there are seven peer educators. In the past, however, the MYHAWC had 16 peer educators. Each barangay then had one peer educator. The ideal ratio is one peer educator per barangay.

They are assigned to serve at the MYHAWC for at least four hours a day for five days. In return, they receive 500 pesos per month as their allowance plus transportation money for their outreach activities. They are also provided with scholarships to study at the University of Marikina.

MYHAWC's peer educators have no officers. They said that "we are all equal on footing." They are directly under the coordinator who also serves as their adviser. They expressed that their adviser should receive an award because she performs more than what is expected of her. She even spends her own money for their activities.

These peer educators have several activities in Marikina City. They are being tapped by different schools, communities, agencies and organizations to serve as resource persons for adolescents and youth.

The MYHAWC health providers have attended capacity building activities under the guidance on Adolescent Job Aid. The peer educators had TOT.

The AJA training was a three-day workshop and it was provided by Luzon Health and PopCom NCR in 2014 and 2015. The peer educators received training from the Marikina City Health personnel to develop their skills on how to provide adolescent-friendly health services and to promote a pleasant environment in their respective facilities.

Link with the health system

There are several entry points for the city's young people to access the MYAHWC. This could be through the health centres, the dental clinic and the social hygiene and population offices. After initial contact, they are referred to MYAHWC for registration and possible additional support. After registration they can receive the following services: pregnancy test, pap smear examination, breast examination, screening and management of STIs, HIV testing and counselling and dental care.

For pregnant adolescents, the MYAHWC advise them to visit the nearest health centre for prenatal care and for referral to a CEMONC-capable hospital.

Challenges

The MYAHWC is an established THQ which is located at the City Health Office. It is supported by the LGU with ordinances and policies. The THQs are linked to the barangays through the peer educators and the health centres. It has served as a model in the country of what a LGU-supported teen centre should be.

In recent years, however, it is noted that the demand for the THQ services has gone down because young people do not find the location conducive to their modes of expression and activities. The policy of bringing the facility to the CHO in order to have more accessible health care services appears to be a good strategy. However, the CHO also serves many clients including the elderly and it was felt by the young people who were interviewed that their actions are constrained in this environment. Young people do not find the THQ's location accessible unlike the time when it was closer to the communities and schools.

The low annual THQ budget has also limited the centre from updating and upgrading its technology and facilities. In addition, it only has one health provider who performs a number of responsibilities the focal person/coordinator. MYAHWC needs technical support to formulate new directions and strategies to make this a dynamic facility that it once was.

National Government Center Teen Health Quarters (THQ) of Quezon City

The Teen Health Quarters (THQ) has various adolescent-friendly health services and activities for young people in Quezon City.

Origin

In 2008, Quezon City passed an ordinance on reproductive health which is known as Quezon City Population and Reproductive Health Management Policy. Two years later, Quezon City partnered with FAD through a social franchise model, and established a THQ in Cubao. Although this Cubao THQ is still existing, it is no longer providing services to adolescents.



Picture 23. NGC Teen Health Quarter Facade, Quezon City

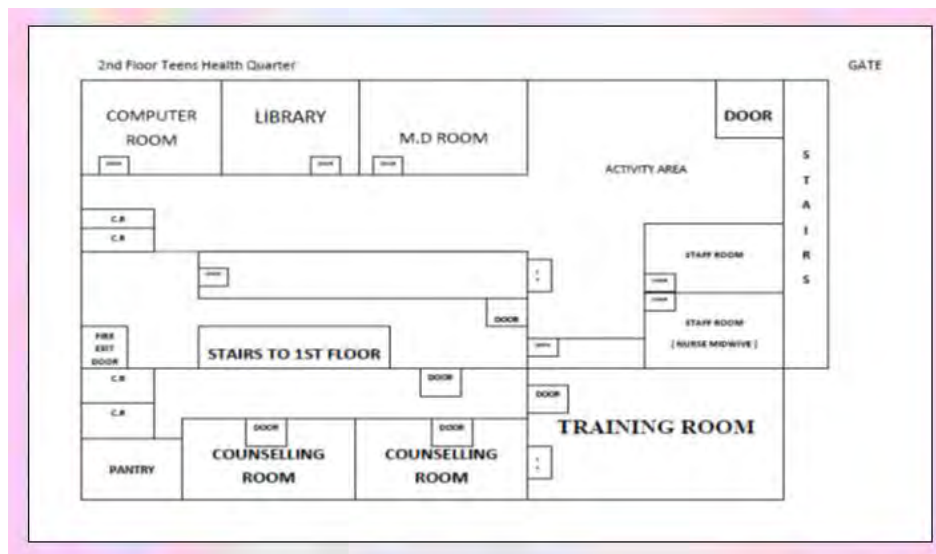
District 2 Quezon City Commonwealth which is identified as the most populous district in Metro Manila, became the new site of the National Government Center (NGC) THQ. Launched in February 2016, this facility became a part of the health facility complex which includes a lying-in health centre.

Facilities of the teen center

The NGC-THQ is located at the 2nd Floor of a new two-storey building. The lying in clinic is on the ground floor. Behind this newly-built structure is the Barangay Health Centre of Commonwealth, District 2.

The main entrance has a receptionist. It has several rooms for the doctor, consultation, library, computer, health educator, midwife, counselling and training. Because it just opened in February 2016, it is evident that there is still enough space for new equipment. On the third quarter, new supplies and computers will be delivered. The THQ is painted white and it is very clean.

Figure 9. NGC THQ Floor Plan



The THQ is headed by the RHU doctor and she is assisted by nurse, midwife and two health educators. The THQ is open every day from 800 A.M. to 500 P.M. Wednesdays afternoon is reserved for teen medical consultations.

Program for adolescent

The QC Adolescent Health and Development Program (AHDP) is supervised by a coordinator. It has an Adolescent Health Team (QCAHT) which is comprised of seven members: the AHDP coordinator, doctor, dentist, nurse, PPO, midwife and a nutritionist.

The NGC THQ aims a/ to protect young people against risky behaviour, b/ to assist them develop life skills and c/to empower them to build confidence to be able to face challenges. The THQ services include the following: a/ medical and dental consultation, d/ ARH services c/ life skills development, d/ discovering and enhancing talents, e/ leadership training.

Various information and educational activities are conducted at the THQ such as: 1/ learning group sessions/activities; 2/ educational video/film shows 3/ library services, 4/ production and acting workshops 5/ zumba and 6/counseling services. Also available is the CHSI's rubix-cube designed interactive table on various adolescent health issues. Furthermore, outreach activities such as volleyball and basketball are part of their monthly program.

Wednesday afternoon is scheduled for teen health consultation by the health centre's medical doctor. Teenagers who are pregnant, or who need contraceptives (at least 18 years old) are referred to the health centre. The THQ staff were trained by the FAD THQ Cubao focal person on FP competency level 1 and on the application of AJA. The THQ Cubao focal coordinator has provided technical assistance to the team.

FADs THQ had 16 training modules on several RH and related topics: STI, HIV, teen pregnancy, sexual abuse, gender, boy/girl relationships, fertility, substance abuse, dating, adolescence and sexuality. These topics are relevant teenagers as they face various life challenges.

Since it opened its services four months ago, a total of 1,163 THQ clients came to the facility for different services. The profiles of 90 young people were collected and a total of 19 medical consultations were delivered. Most of the THQ Commonwealth clients are students from nearby secondary public schools. THQ serves as a place to hang out after their classes. They play board games with other young people while waiting to be picked up by their parents. They can also consult with a THQ staff on some personal issues.

Teen volunteers

NGC-THQ has 21 teen volunteers aged 13 to 19 years old. They were recruited through a public announcement in the barangay. Most of them who responded are the community health workers' children and grandchildren or their friends.

The teen volunteers do not have a formal organization and officers. They expressed that they prefer to be treated equally, "pantay pantay." All of them are leaders from their own personal networks such as schools, churches and civic societies.

In April and May 2016, THQ Cubao staff conducted a training for the peer volunteers by using the FAD's 16 modules. The training was done every afternoon of Thursday and Friday. Those 16 year old and above who completed the training are called "peer educators" while the younger teenagers are called "assistant peer educators." They all felt that the training was good. It was suggested by some peer educators that the participants who disclosed previous experiences like suicide and abortion would need psycho-social support from the organizers during the training.



Picture 24. Activities for Teen Volunteers, NGC-THQ

Link with the health system

The THQ staff and peer educators do not have a referral form for clients who are referred to the health center because the medical doctor also heads this facility. There is no formal follow up after the referral. “Kusang bumabalik sila.” (They just return to the THQ.) The THQ, however, has an intake-client form. The health centre in turn provides prenatal services and refers the pregnant adolescents to the city hospital. The teenage mothers are reportedly advised to seek postpartum care after delivery.

Future plans

Quezon City plans to replicate the THQ in all the districts. It might be doubled in some districts depending on the population and adolescent pregnancies in these areas. The THQ AYHD opined that aside from the THQ at the districts, there should be a THQ which is managed by the Barangay Health Management Council. She added that there is a need for a Teen Educator (community level) who will take charge of youth at the community level. They can be counterparts of the Barangay health workers (BHW) and the Community health workers (CHWS)

There are also plans to make the city hospital to be adolescent friendly. There is a current project in the city called Gabayan ang batang ina, an undertaking with ZFF and PhilHealth. A mobile group is enlisting all pregnant adolescents in the various districts to become PhilHealth members so that they and their babies would obtain benefits from the national insurance.

Challenges of the teen centres

The NGC THQ is a new facility and it needs to come up with a protocol or manual of operations defining the objectives, roles and procedures for the health providers, peer educators and clients to provide and access its services. It specifically needs to define the meaning of peer educators, junior peer educators and community volunteers, expectations from their involvement and the benefits which are given to them.

The provision of psycho-social services must be installed in training peer educators because the young people who volunteer to serve as peer educators may have unpleasant experiences which must be addressed while on training and serving the THQ.

There is a need to install an efficient M & E system to systematically track the performance of the THQ and the status of the teen clients. Referral and back referral forms to the health facility is vital in tracking and assisting the teenage clients, especially the teenage mothers.

Summary

The assessment has covered varying teen centre models using different entry points: the school the community and LGU.

School-based teen centres. Two types of school-based teen centres were identified from the field study: the multi-purpose school teen centre of Iloilo Province and the Teen Health Kiosks of Cavite Province.

Iloilo's multi-purpose centres were established in almost all the national secondary schools in Iloilo through a 2012 ordinance and the financial support from the provincial governor's office. These facilities were established with the concurrence DepEd and with the

PPO's assistance. They serve as venues to empower and build the capacity of young people to enable them to become productive and competitive. These facilities have trained peer helpers who provide information and advice to other students regarding the dangers of unsafe sex, smoking, drugs, and alcoholism. POPCOM and the PPO provided training on adolescent reproductive health (excluding family planning) to peer helpers and counsellors.

The multi-purpose teen centres serve as "tambayan" or places where young people hang out to engage in activities which are of interest to them (social media, sports, arts and music).. Because of the alliance forged in the ILHZ's SDN some MHOs and other health providers are now serving as resource persons about ARH and the RHU services in multi—purpose teen centers..

In Cavite, 11 national high schools which were selected from the 11 ILHZs established teen health kiosks (THK) in March 2015.. It was agreed that these facilities will be next to the school clinics and guidance counselors' offices. THKs are a part of Cavite Province's three-pronged AYHD program which aims to assist in the prevention of risky behavior and in raising the demand among young people for the RHU's health services.. The RHU in turn conducts screening and ARH services for the referred student including pregnant adolescents. It will also refer pregnant adolescents to the referral provincial hospital.

As a program, the THK is envisioned to have knowledgeable, empowered, reliable and healthy adolescents who would become future leaders. Its mission is that adolescents will be able to access quality comprehensive health care services in an environment that is adolescent friendly. The program is also expected to align with other government agencies. It was reported that 105 peer educators were trained, that there are over 50 THK advisors, and over 20 thousand had received information about AYHD and 29 cases of adolescent pregnancy were reported to the RHUs by the THQ.

A dilemma raised by one Cavite THK is the fact that the regional DepEd has not issued a policy directive recognizing the status of the THKs to enable students to receive extra points for their involvement in this teen centers.. At present, the THK is an extra-curricular activity and no points could be gained by the students in their involvement in this facility. This has constrained the THK in recruiting more peer educators because the school principal has not received any mandate from the regional DepEd. It was learned that in another municipality of a nearby province where the Cavite THK peer educators served as resource persons for a training of secondary school youth leaders, a DepEd regional office directive was reportedly issued and this resulted in the establishment of some national high school teen centres..

A policy directive from DepEd is most urgent to address the foregoing difficulty faced by Cavite THs.. Apparently, the DepEd regional office is also waiting for a national policy directive on health centres.

Community-based teen centers. Two types of community-based centres were covered in this field study. One is barangay based and it is being administered by a midwife and BHWs who are also operating the barangay health centre which is located next to the barangay teen centre. The midwife has scheduled consultation hours in a week. Referrals are made for difficult

cases to the district clinics. Pregnant adolescents are referred by the midwife to the referral hospital.

The teen moms who delivered in the referral hospital are followed up for their postnatal and child care including FP uptake. This teen centre receives support from the barangay and the SK for renovation and related activities. It has a good manual recording system of all the teenage clients. It used to have several peer educators who are mostly OSY and who were able to attend several activities which were organized by the CHO and other groups. During the year, only a few peer educators are volunteering in the teen centre.

Marikina City and Quezon City have similar facility-based teen centres. Both are FAD's social franchising clients prior to the LH technical assistance. Both have peer educators, ordinances and policies which are supportive of their programs. They offer similar health services. Their peer educators were trained with the use of FAD's training modules. They are operated by health providers who have had AJA training. MHAWC provides scholarships to peer educators and youth members' privilege cards for access to health and recreational facilities.

Although much more established than QC THQ, the MHAWC does not seem to have the same dynamism as the QC THQ. One major difference is the location of their facility. The MHAWC is based in the CHO and it is not reportedly accessible to young people who are in school and from the barangays. Several programs and services are present in this facility but the time of operation is not convenient for in-school adolescents. There are other programs (the elderly, the offices) at the CHO which reportedly inhibit young people from expressing their interests and creativity. It only has one midwife who serves as the coordinator and a visiting doctor. Its budget is low to enable the staff to engage in innovative activities. It has no LGU-supported CEMONC-capable hospital in the city where pregnant teens could be referred. They instead send them to regional facilities.

The MHAWC needs TA and LGU support if it were to resume its old stature. The LGU may consider moving out the MHAWC from its current location, add more human resources and increase its budget.

The QC THQ, on the other hand, has a building solely for the adolescents and the structure is near a school, a health centre and the community. It has sufficient space for varied activities—counselling, consultation by the health providers (it has five including the M.D. who heads the health centre as well), game boards and others. They are able to undertake activities in nearby communities where the peer educators and other young people come from. The time of operations is flexible and the budget is reportedly bigger than MHAWC's.

The THQ has supportive AYHD policies, efficient system in collecting adolescent data for use in monitoring and evaluation program, health financing for teen moms and vibrant civil society (QC has the most number of NGOs) which can be tapped for various activities.

There are plans to establish similar structures in other districts of Quezon City. The city has an LGU-supported CEMONC-capable tertiary hospital. It also plans to improve the city hospital's services for teen moms and other adolescents

CHAPTER FIVE

Lessons learned and recommendations

This chapter presents the lessons learned from the assessment of selected AYRH programs of hospitals and teen centers. Recommendations for action in the remaining months of the CAs' USAID grant and in the long-term conclude this study.

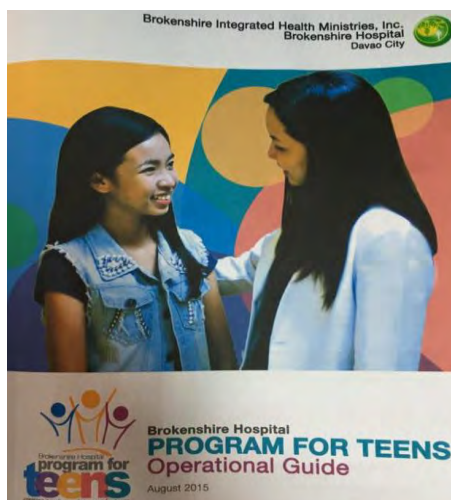
The Tertiary Hospitals

The lessons derived from the assessment are focused on the six strategies in providing AFHS, to wit: policy, governance, monitoring and evaluation, financing, service delivery and capacity building.

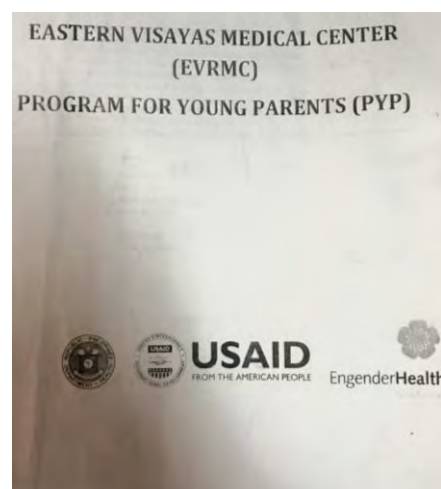
Policy

1/ With technical support from the CAs, the selected seven tertiary hospitals formulated their respective program manual of operations (MOO) or protocols. It is noted that facilities which fully implemented their MOO have met most of the DOH AFHS Standards.

For example, the Brokenshire Hospital's PFT has a comprehensive 50-page MOO which provides a program description of this private facility including the endorsement from key officials and different department heads. It has specific guidelines for service delivery and referral, recording, reporting and monitoring, supervision and assessment. A list of all the medical consultants and residents, other health providers and staff who went through the Adolescent Job Aid (AJA) training formulated this guide with MH, the CHO and other partners. The multi-disciplinary team of health personnel are observing the guidelines and are fully implementing the PFT in the hospital



Picture 25. Brokenshire PFT Operational Guide



Picture 26. EVRMC PYP Protocol

Both the Eastern Visayas Regional Medical Center (EVRMC) and the Iloilo Provincial Hospital's (IPH) Program for Young Parents (PYP) have similar protocols which describe the enrolment and service delivery of pregnant teenagers and teen moms, including the education sessions and other related activities.

H. Governance

2/ The buy-in of the hospitals' top-echelon officials and department heads is a key ingredient of the full implementation of the teen program. This is reflected in the top officials' statements in the MOO and in the active participation of the various departments in the program's activities.

For example, at IPH's PYP, the chief of hospital does not only support the PYP in his facility but he also chairs the pilot Central Iloilo Health Zone Alliance (CIHZA)-Service Development Network (SDN) of seven municipalities which are the hospital's demand-generation external partners.

I. Monitoring and evaluation

3/ Hospitals with a systematic recording system is able to track the progress of their teen mom clients and the performance of their programs.

The EVRMC and IPH have individual records of their PYP clients and they are able to follow them up for prenatal consultation and the *usapan* or education sessions through the RHU midwives and the mobile phone messaging. They even color-coded the pregnant teenagers' files to identify which *usapan* or education sessions they have attended. They are able to report regularly about a/ the number of clients who enrolled and delivered at the hospital, b/ who accepted a birth-spacing method, and c/ who returned for pre and postnatal care.

These hospitals have yet to fully computerize their clients' records. They are, however, in the process of installing the Point of Care Solution (PCaSo) in their computer system.

J. Financing

4/ PhilHealth's no-balance billing (NBB), care package and point-of-care enrolment appear to be practiced widely in the hospitals.

At EVRMC and IPH PYP's *usapan* sessions, the teen moms and their families are assisted by the social workers to comply with the social insurance's requirements. The clients seem satisfied with the PhilHealth benefits.

However, the teen moms and their families have to shoulder out-of-pocket expenses for their transportation, food and miscellaneous expenses. The transportation costs can be prohibitive for teen moms who hail from distant provinces and municipalities.

5/ An important lesson the project team learned from the foregoing hospitals is that they have yet to prepare a business plan for the sustainability of their programs. At present, they rely on their current hospital budget and some CA technical support to operate their PYP. The hospital administrators and HPs are, however, in the process of developing their business plans for the possible expansion of their initiatives.

K. Demand Generation

6/ A successful AFHS program will require demand-generation activities within the hospital and in the community.

For example, the EVRMC and IPH's PYP have regular (every Wednesday) *usapan* sessions for the pregnant adolescents. They show films about FP and pregnancy and provide some reading materials during the *usapan*. To ensure that the pregnant teenagers will return to the PYP education sessions, the health provider/focal person usually follows them up through their mobile phones and the RHU midwives. First-time participants of the *usapan* sessions are asked to fill out a consent form indicating that they are willing to be contacted through their mobile phones. Permission is also sought from their parents or guardians.

The IPH has actively engaged the CIHZA expanded SDN to raise the demand for its PYP services. The expanded SDN is comprised of seven municipalities' mayors and MHOs, MPOs, representatives from DepEd, TESDA, MSWD, DOLE, Philhealth and private practising midwives (PPM). The IPH is the SDN's referral hospital and the Chief of Clinics chairs this group.

This cluster of municipal RHUs is largely responsible for the referral of pregnant teenagers to IPH's PYP and in providing information to their communities regarding the program. The IPH also endorses to the RHUs all the teen moms who enrolled in its PYP for postnatal care and for regular follow up in their respective barangays through their BHWs and NDPs.

The presence of the DepEd ensures that the teen moms are continually provided with assistance for their education while TESDA gives priority to the teen moms with PYP certificates for admission into its vocational training program. The MSWD also provides psycho-social support if the teen moms suffer from violence or are in need of other support. The PPM usually refers their pregnant teen clients to the hospital and provide them with postnatal care when these teen moms returned to their facilities.

7/ Another important lesson is that the pregnant teenagers' male partners hardly participate in EVRMC and IPH's *usapan* sessions because they are either busy working or have already broken up with the clients. However, it was reported that when a TESDA representative would serve as a resource person about vocational training and livelihood opportunities, the male partners would attend the *usapan*. It was suggested that ARH matters should be included during the TESDA session.

8/ Tapping teen moms to become peer educators for other pregnant teenage appears to be an effective strategy to raise the demand for PYP services including birth-spacing.

AT EVRMC and IPH PYP, pregnant adolescents who have completed the program requirements, i.e., four *usapan* sessions, prenatal care, hospital delivery, acceptance of a birth-spacing method, were selected and trained to become “teen mom PYP champions.” They provide testimonies about their own journeys as teen moms and about their acceptance of birth-spacing methods. Their transportation and food expenses during the Wednesday *usapan* sessions are provided by the CA. The PYP champions are now either back in school or have enrolled in some TESDA training programs but they continue to help in the PYP during teen moms’ day. Many are unmarried or are living in with their partners mostly at the homes of their parents.

9/Engaging a mother of a teen mom champion to become a peer educator for other mothers seems to be a promising strategy because she has successfully convinced several mothers to allow their daughters to use a birth-spacing method.

This strategy is currently being practiced at IPH PYP. The mother peer educator expressed satisfaction that she is able to encourage other mothers to help their daughters decide to accept birth-spacing methods and to return to school or enroll at TESDA’s training program.

10/Although it is a private hospital, Brokenshire’s medical consultants and residents actively promote the PFT to young people in the city by giving out information and flyers to secondary schools and colleges. It also has a 24/7 mobile phone hotline so that teenagers can call them anytime about ARH issues. They have enrolled over 300 young people from a barangay to enable them to participate in the PFT’s forums and to avail of the hospital’s services. They also partner with the CHO, CPO and other government agencies and NGOs to promote their program and to seek support especially for disadvantaged adolescents and youth.

L. Service Delivery

11/ An important element in the AFHS provision is the availability of dedicated contiguous spaces for prenatal consultation, counseling and *usapan* sessions. There should also be clear signages about the program’s services and schedules.

The EVRMC, IPH and Brokenshire Hospital have rooms for prenatal and counseling rooms which ensure privacy and confidentiality to their clients. The EVRMC has a unique six-bed maternity ward which is solely for teen moms. This facility is in the same wing as the prenatal, *usapan* and counseling rooms.

12/ Having a well-functioning AFHS program result in increased enrolment of pregnant adolescents in the hospital’s program and uptake of birth-spacing methods.

For example, at EVRMC, it has been documented that since the PYP launch in September 2014 until May 2016, a total of 1,311 teenagers from different provinces of the region delivered in the hospital. This represents 15 per cent of all the deliveries for that period. Two hundred eighty three (283) have accepted a birth-spacing method. Four fifths of the teen mom acceptors are PPIUD users. The others who did not accept a birth-spacing method at the hospital

were advised to go to the RHUs in their respective municipalities. The EVRMC, however, has no jurisdiction to follow up the teen moms in their provinces because this is supposed to be the task of the LGUs.

A similar pattern was observed at the IPH's PYP. The midwife coordinator is better able to follow up the FP uptake of the teen moms by directly following up the RHU midwives.

The feedback obtained from the KII and FGDs with pregnant adolescents and teenage mothers as well as the mothers of the foregoing indicate satisfaction over the services obtained from the PYP. They felt that the HPs are approachable, helpful and are concerned about the teen moms' plight and future.

13/ The presence of a dedicated or fulltime AJA-trained health provider is crucial for the continued operations of the hospital's program for teens or young parents.

The IPH has a fulltime midwife who is supervised by a part-time medical doctor and a team of health providers who have other responsibilities in the hospital. The fulltime midwife does a good job of coordinating the program activities and in linking with the CIHZA SDN and the RHUs particularly in tracking the teen moms before and after their deliveries. She, however, needs a part-time staff to help her record regularly all the clients' activities and to maintain a computerized database.

Brokenshire's PFT, on the other hand, has a resident doctor-coordinator and a large pool of AJA-trained multi-disciplinary team of medical residents and other HPs who are providing services to the teen clients.

M. Capacity building

14/ The DOH AJA has been used by the CAs and the participating hospitals as the main training tool to enable HPs to extend AFHS. However, there are varying usage of the HEEADSS form among the AJA-trained health personnel.

At Brokenshire Hospital, for example, the HPs use the HEEADSS form by interviewing prospective clients at any point of care for around 20 to 30 minutes and does the appropriate referral afterwards.

It was observed that some HPs of other hospitals had either reduced the number of questions or had only a one-page form or did not use the HEEADSS form at all. A midwife claimed that when she would interview teenagers, she did not use the HEEADSS form because she apparently memorized the questions and interviewing approach. Another midwife said that she used the form to interview pregnant teenagers but she did not utilize the results and just left the filled-out forms under the table. There is, therefore, a need to further assess the AJA-trained HPs of how they are utilizing the HEEADSS form and applying what they have learned from the training.

15/The *usapan* or education sessions which are facilitated by the HPs and the teen mom champions are generally well received by the EVRMC clients. However, it was observed that

facilitators and teen champions needed more substantive inputs for some topics like gender relations and FP. The curriculum and learning guide for these education sessions must be assessed and enhanced.

School and Community-based Teen Centers (TCs)

H. Policy

1/ A vital lesson learned when establishing a teen center is the need to obtain a DepEd national or regional department order (DO) or an LGU legislation or Executive Order (EO) to ensure the full buy-in of TCs by the school authorities.

For example, in Iloilo Province, an ordinance was passed by the province regarding the establishment of multi-purpose TCs in all secondary schools. The provincial governor allocated a considerable amount of money for these facilities and their activities. The participating school counterpart is to allocate a classroom near a guidance counsellor's office and to assign faculty members who will serve as student advisers. The DepEd and the PPO were involved in the installation of these facilities. The ordinance and support from the foregoing legitimized the participation of the teachers and peer educators/helpers in this facility.

The LGUs of Marikina and Quezon City had passed local legislations or ordinances supporting AYHD and the establishment of the community-based THQs. As a result, the needed human resources and funding are allocated to operate these facilities. They have, however, some difficulty in extending their activities to schools because of the absence of a DepEd directive.

I. Governance

2/Unlike the hospitals' PFT or PYP, it was noted that school and community-based TCs have no standards and written manual of operations or framework describing goals and objectives, the leadership structure, the roles and responsibilities of the HPs or teacher adviser and peer educators/helpers, the services and referral guidelines, recording, reporting and M & E. National standards and MOO are important for the TCs' smooth operation and to ensure accountability in the TCs.

J. Monitoring and Evaluation

3/ To determine the effects of the school and community-based TCs on the intended clients, it is a good practice to conduct periodic assessments.

The Iloilo PPO, for example, conducted a baseline study in 2012 about the reported smoking, alcohol intake, drug use and premarital sex behaviors of the students where the multi-purpose TCs are installed. Two years later, the same survey was conducted in the schools and found that the non-sexual and sexual behaviors dropped considerably. This systematic approach to monitoring the TCs' effects on the users' behavior should be a standard practice of school and

community-based TCs to justify these facilities' presence. The survey can be further expanded to include suggestions for improvement of services and future directions.

Because the HPs of QC's Teen Health Quarters are also affiliated with the health center, the THQ's male and female client health data are submitted to the City Health Office (CHO) and are integrated into the computerized health data system. This practice provides the city with updated data about the health care services obtained by male and female adolescents and young adults.

In Davao City's Barangay 21-C TC, a facility which is located beside the barangay's health center, data about the teen mom clients are manually recorded by two assigned BHWs. Individual clients' records for prenatal consultation, delivery at the referral hospital and acceptance of birth-spacing methods are properly recorded, filed, and locked in a cabinet. The information about the teen clients' delivery at the referral hospital are obtained by the midwife by personally picking this up from the referral hospital every Friday. The teen moms are provided postnatal care and FP services at the health center and are followed up by the BHWs in their homes. Monthly and annual reports about teen pregnancy, deliveries and FP uptake are submitted to the district clinic.

K. Financing

4/ Most school and community-based TCs are sustainable because they are supported regularly by the LGUs.

In QC, Marikina, Iloilo and Davao, the teen centers are funded annually by their LGUs. Usage of their facilities and equipment are generally for free.

In Marikina's THQ, peer educators receive an allowance of P500/month to assist the health provider at the CHO where the THQ is located. They also serve as the contact persons of the barangays on AHD matters. The city provides them with scholarships at the LGU-supported college. Like the other THQ members, their membership card allows them to have access to the CHO's services and the city's sports facilities. The budget of the THQ in recent years, however, have been reduced, which limit the activities of the THQ in the community.

Young people who become members of the QC THQ are allowed the use of its facilities and health services for free. Funds from the CHO are for the upkeep of the THQ and for some activities of the peer educators. The THQ peer educators are also allowed to raise funds for their expenses in their other community outreach activities like organizing and charging P10 from the participants for each zumba dance/exercise lesson.

The QC CHO intends to establish similar THQs in other districts. These facilities must also be contiguous to health centers and schools and must be located in heavily-populated community. The mobile QC, ZFF and Philhealth's registration outreach for teen moms in barangays called *Gabayan ang batang ina* will be continually undertaken to hasten their enrolment and delivery at the QC General Hospital.

In the TC of Davao City's Barangay 21-C, a facility next to the health center, the barangay officials, CHO and SK provided support to renovate the small building. Its facilities and training for the peer educators are supported by the LGU.

L. Demand Generation

5/ To be able to attract young people to its services and activities, the TC should be a safe, fun place where the adolescents and youth can freely express themselves. It should have a variety of activities and recreational equipment as well as updated IEC materials on issues which are important to teenagers. Community outreach, sports and external learning activities (workshops, seminars, conferences) and exchange visit with other TCs can further harness the energies of young people.

Iloilo's multi-purpose TCs, for example, the peer educators and students are reportedly engaged in the foregoing activities. The newly-opened QC THQ has a large space with recreational equipment and several rooms for different purposes (counseling, meetings, medical consultation) which are currently attracting in and out-of-school young people.

M. Service delivery

6/ The presence of adolescent-friendly health providers and peer educators in a teen center encourages young people to access their services.

In QC's THQ, for example, the facility is headed by a medical doctor who is at the same time the barangay health center's medical officer. She is assisted by a nurse, midwife and two health educators. The adolescents and youth who are utilizing the THQ's recreational activities and other facilities could easily obtain health care services including counseling for a variety of health needs. Pregnant adolescents are reportedly counseled and referred to the city's CEMONC-capable hospital for delivery. Prior to their enrolment at the hospital, the pregnant teenager is reportedly already enrolled by PhilHealth's *Gabayan ng batang ina* project.

Davao City's Barangay 21-C TC has a regular consultation day for prenatal consultation services by the midwife for pregnant teenagers of varying ethnicities (Muslims, migrants and settlers) from the large urban poor community. All pregnant teenagers are referred by the midwife to the District Clinic for simple laboratory tests and for referral to the regional hospital. The midwife goes to the regional hospital every Friday to pick up all the records of the women who delivered in the regional hospital including those of the teenage mothers. The mothers are provided with postnatal care at the barangay health center. They are regularly followed up in their homes by a group of BHWs.

N. Capacity building

7/TCs which provide longer duration of substantive, participative and adolescent friendly capacity-building activities tend to have well-trained peer educators.

Iloilo's multi-purpose TC peer educators and helpers have initially received a five-day training from the PPO and POPCOM about adolescent development, values, RH and non-RH matters. The training design provides a space for the young people to share and interact. This initial training is reportedly followed up by other short-term training and participation in external activities organized by the PPO like workshops, seminars and exchange visit to other TCs.

In QC THQ, several peer educators receive twice-a-week training for two months during school break by using FAD's 16 modules about ARH and life skills. The training is provided by a THQ staff who had received training from the defunct FAD's social franchise program for THQ.

In Marikina's THQ, the peer educators who have had training about FAD's ARH modules are reportedly provided with ARH updates by the health provider.

In Davao City, Barangay 21-C peer educators who are mostly OSY have had training about ARH and advocacy from the CPO. The records showed that they had attended several city-wide sponsored seminars and workshops. The number of peer educators, however, had gone down from over 20 to 8 because of employment, education and movement to other places. The operation of the TC is maintained by two BHW and the midwife.

8/ The health providers particularly doctors, nurses and midwives who are providing AFHS have had AJA training. They, however, do not utilize the HEEADSS form in interviewing the teen clients.

Short-term recommendations to the CAs

Recommendations about what the CAs can do for the hospitals and teen centers which they are assisting in the remaining nine or more months of their USAID grant are presented for their consideration.

Hospital-based program for teens and young parents

1/ For those hospitals which have not fully implemented their MOO it is recommended that they do the following (GEAMH, SPMC, JRGH, SCPH)

- Review and fully implement the MOO.
- Enhance their demand generation activities within and outside the health facility.

2/ For those hospitals which have fully implemented the MOO), the recommendations are as follows (EVMC, IPH):

- Hone the HPs and teen mom champions' communication and facilitation skills, and their knowledge about AYRH, FP, gender relations and other pertinent topics.
- Develop a business plan for sustainability (this is crucial for the possibility of scaling up the PYP in other hospitals).

- Formalize relationship with the Expanded CIHZA/SDN (have a MOA which specifies the roles, duties and responsibilities of the members in assisting pregnant teenagers and teen moms.)
- Include specific PYP guidelines in the CIHZA's SDN MNCHN document.
- Update the DOH RO (this is especially true for the regional hospital in order to obtain technical and financial support for scaling up the program).
- Review and develop the curricula for *usapan* or education sessions (this is vital for a more systematic training of the HP facilitators and teen mom champions and in scaling up the PYP).

3/ For all hospital PYPs, the recommendations are:

- Review the use of the AJA-HEEADSS form and come up with a harmonized hospital-appropriate standard form and approach.
- Provide follow-up training for HPs and monitor how the AFHS standards are observed by them and the hospitals.
- Develop a computerized M & E system for the teen mom clients' records and synchronize these with the hospital's recording system.
- Maximize the use of mobile phone SMS and social media for demand generation.
- Enhance the organizational development (OD) and program management (PM) skills of the hospital senior staff and HPs to enable them to develop a business plan for program sustainability.

Recommendations for TCs: 9 months

1/ School based TCs (Iloilo, Cavite)

- Conduct additional training on AYRH and communication skills. Iloilo's multi-purpose TC's peer educators need AYRH training curriculum and this can be designed in partnership with the PPO and PHO as well as RHU's MHOs who are serving as resource persons for the TCs. A systematic capacity-building training should follow.

Cavite's THK peer educators had only one 3-day training. A possibility of providing another follow up training is suggested.

b/ Community based TC (QC, Marikina, Davao)

- Revitalize and assist the TC in its program directions. Marikina THQ, for example, used to be a popular facility in the city. It had all the elements of a good THQ but when it moved to the CHO, its appeal to young people dwindled. It has only one HP who is multi-tasking and its budget has been reduced.
- Assess the applicability of AJA-HEEADSS. The TCs' HPs are reportedly trained in AJA. There is a need to follow up and assess how the HEEADSS interview form is implemented in these facilities.

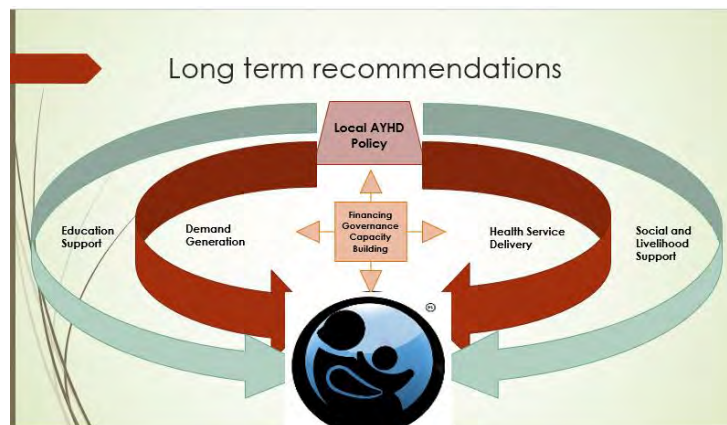
- Study the potential of having a PYP in QC's General hospital. The current QC THQ is situated beside a health center and a secondary school in a heavily-populated district. The health center attends to the health needs of teenage clients in the facility and in the community. The CHO intends to have THQs beside health centers in all districts. Pregnant teenagers are referred by the health center to the city's General Hospital but it has no PYP.

c/ For all TCs

- Advocate for issuance of: a/ DepEd DO re: School-based TC, and b/ LGU ordinance/EO. This should be a joint effort between the CA and the schools with TCs.
- Develop standards and MOO for adolescent-friendly school and community-based TCs to serve as guides in establishing and maintaining these facilities.
- Maximize the use of the social media and SMS to provide young people with appropriate and reliable AYRH messages.
- Assess the TCs to determine their program effects on teenage clients as well as their challenges and future directions especially in the prevention of risky behaviors and teenage pregnancies.

Long-term recommendations

This assessment is recommending the IPH's PYP for the CAs' long-term program because it meets most of the DOH AFHS standards. The PYP provides a clear link between demand generation strategies and service delivery. It supports teenage mothers before, during and after delivery at different levels of the health system. The hospital where the pregnant adolescent is compelled to deliver provides AYRH education, prenatal, natal and postnatal care including birth-spacing and opportunities for a better future. It also collaborates with an Inter-local Health Zone-SDN for demand generation and care for the teenage mothers.



The business and sustainability plan which will be developed by VH and IPH can also serve as a guide to start the PYP in other provinces.

This study also recommends that the EVRMC's PYP should be continued so that it can be emulated by other regional hospitals to facilitate the scaling up of the program in other provincial hospitals.

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Appendix B. Cost Estimate from Visayas Health for Setting Up PYP

Activity/Milestones	Cost Estimate		
	Item	Cost	Total
<u>Situational Analysis</u> (est. 3 visits to the facility)	Project Staff Time	1,500.00/day x 3 days	4,500.00
	Transportation Expense	1,000/day x 3 days	3,000.00
	Meeting Expense	500/day x 3 days	1,500.00
			9,000.00
<u>Advocacy to Hospital Management</u>	Project Staff Time:		
	Report Preparation	1,500.00/day x 2 days	3,000.00
	Organization of Orientation Meeting	1,500.00/day x 2 days	3,000.00
	Conduct of Orientation Meeting	1,500.00 x 1 day	1,500.00
	Transportation Expense	1,000.00/day x 5 days	5,000.00
	Refreshments	300.00/pax x 30 pax	9,000.00
	Venue; sound system; lcd projector	5,000.00	5,000.00
	Consultant	5,000.00/day x 3 days	15,000.00
	Materials	500.00	500.00
	Hospital Staff Time	12,000.00	12,000.00
		54,000.00	
<u>Organization of Hospital PYP Team</u>	Project Staff Time	1,500.00/day x 1 day	1,500.00
	Transportation Expense	1,000.00/day x 1 day	1,000.00
	Hospital Staff Time	12,000.00	12,000.00
	Refreshments	1,000.00	1,000.00
			15,500.00
<u>Formulation of Hospital</u>	Project Staff Time	1,500.00/day x 2 days	3,000.00

<u>Protocol for the PYP</u>	Transportation Expense	1,000.00/day x 2 days	2,000.00
	Consultant	5,000.00/day x 3 days	15,000.00
	Refreshments	5,000.00	5,000.00
	Venue; sound system; lcd projector	5,000.00	5,000.00
	Hospital Staff Time	12,000.00	12,000.00
			42,000.00
<u>Orientation of Hospital Staff on PYP Protocol</u>	Project Staff Time	1,500.00/day x 1 day	1,500.00
	Transportation Expense	1,000.00/day x 1 day	1,000.00
	Refreshments	50.00/pax x 50 pax	2,500.00
	Venue; sound system; lcd projector	5,000.00	5,000.00
	Hospital Staff Time	25,000.00	25,000.00
			35,000.00
<u>Training on <i>Dealing with Adolescent Clients</i></u>	Project Staff Time	1,500.00/day x 4 days	6,000.00
	Transportation Expense	1,000.00/day x 4 days	4,000.00
	Meals	1,200.00/day x 2.5 days x 6 pax/facility	18,000.00
	Accommodations	1,150.00/day x 2.5 days x 6 pax/facility	17,250.00
	Materials	500.00/pax x 6 pax/facility	3,000.00
	Consultants	30,000.00/consultant x 2 consultants	60,000.00
			108,250.00
<u>Refurbishment of PYP Area (in compliance with DOH AFHS Standards)</u>	Project Staff Time	1,500.00/day x 2 days	3,000.00
	Transportation Expense	1,000.00/day x 2 days	2,000.00
	Materials & Labor	10,000.00	10,000.00
	IEC Materials & Signages	10,000.00	10,000.00

			25,000.00
			337,000.00
<u>Program Launch</u> (Optional, but useful for raising awareness & advocacy)	Project Staff Time	1,500.00/day x 1 day	1,500.00
	Transportation Expense	1,000.00/day x 1 day	1,000.00
	Materials	2,500.00	2,500.00
	Refreshments	100.00/pax x 100 pax	10,000.00
	Venue; sound system; lcd projector	5,000.00	5,000.00
	Hospital Staff Time	25,000.00	25,000.00
			45,000.00
<u>Cost of Operating PYP/month</u>	Chief of Hospital	60,000.00/month 20 days/month x 4 weeks	12,000.00
	Ob-Gyne	55,000.00/ month 20 days/month x 4 weeks	11,000.00
	Pediatrician	55,000.00 /month 20 days/month X 4 weeks	11,000.00
	Nurse	40,000.00 /month 20 days/month x 4 weeks	8,000.00
	Midwife	20,000.00/month 20 days/month x 4 weeks	4,000.00
	Medical Social Worker	25,000/month 20 days/month x 4 weeks	5,000.00
	Volunteers	250.00/week x 4 weeks x 4 volunteers	4,000.00
			55,000.00