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Original Article

National multisectoral governance challenges of implementing the Philippines' Reproductive Health Law

Vanessa T Siy Van[1,*,†], Jhanna Uy[1,2,†], Joy Bagas[2] and Valerie Gilbert T Ulep[2,3]

[1]Health Sciences Program, School of Science and Engineering, Ateneo de Manila University, Katipunan Avenue, Loyola Heights, Quezon City, Metro Manila 1108, Philippines
[2]Philippine Institute for Development Studies, Research Department, 18th Floor Three Cyberpod Centris-North Tower, Quezon Avenue, Diliman Quezon City, Metro Manila 1100, Philippines
[3]Ateneo Policy Center, School of Government, Ateneo de Manila University, Katipunan Avenue, Loyola Heights, Quezon City, Metro Manila 1108, Philippines

[†]Co-first authors who contributed equally to the writing of this manuscript.
*Corresponding author. Health Sciences Program, School of Science and Engineering, Ateneo de Manila University, Room 401 PLDT-CTC Building, Katipunan Avenue, Loyola Heights, Quezon City, Metro Manila 1108, Philippines. E-mail: vsiyvan@ateneo.edu

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Abstract

In recognition of the role of reproductive health in individual and national development, the Responsible Parenthood and Reproductive Health (RPRH) Law of 2012 was passed in the Philippines after 30 years of opposition and debate. Seven years later, this article examined the cohesiveness of national multi-sectoral governance among state and non-state actors and identified challenges in coordination as part of the first comprehensive evaluation of the landmark policy. Using a qualitative intrinsic case study design and guided by the World Health Organization's systems checklist for governing health equity as our theoretical perspective, we conducted 20 semi-structured interviews with national implementers from health agencies ($n = 11$), non-health agencies ($n = 6$) and non-state actors ($n = 3$) that included civil society organizations (CSOs). Key themes identified through thematic analysis were supported with document reviews of policy issuances, accomplishment reports and meeting transcripts of the RPRH National Implementation Team (NIT). The study found that despite aspirations for vibrant multi-sectoral coordination, the implementation of the RPRH Law in the Philippines was incohesive. National leaders, particularly the health sector, were neither able to rally non-health sector actors around RPRH nor strategically harness the power of CSOs. Local resource limitations associated with decentralization were exacerbated by paternalistic financing, coordination, and monitoring. The absence of multi-agency plans fostered a culture of siloed opportunism, without consideration to integrated implementation. This case study shows that for neutral policies without conflicts in sector objectives, the interest and buy-in of non-health state actors, even with a national law, cannot be assumed. Moreover, possible conflicts in interests and perspectives between state and civil society actors must be managed in national governance bodies. Overall, there is need for participatory policymaking and health-sector advocacy to set health equity as an intersectoral goal, involving subnational leaders in developing concrete action plans, and strengthening NIT's formal accountability systems.

Keywords: Philippines, Responsible Parenthood and Reproductive Health Law, multi-sectoral governance, decentralization, civil society organizations

Introduction

Sustainable Development Goals (SDG) (Transforming Our World: The 2030 Agenda for Sustainable Development, 2015) target 3.7 enjoins countries to integrate reproductive health (RH) into their national strategies and ensure universal access to RH and information services by 2030. RH covers the biological aspects of human reproduction across life stages and their outcomes. It is directly linked to several other SDG targets like maternal mortality, child mortality and human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS). Beyond physiology, RH is also a crucial facet of human and social development. Access to RH-related information and social services can empower individuals, especially women and adolescents, to make choices for the wellbeing of the self and the family (Tsui *et al.*, 1997). Comprehensive RH policies are vital to the sustainable growth of populations, human capital and economies (Kanem, 2020; Pillai and Maleku, 2015; Williams *et al.*, 2008).

In recognition of the importance of RH, the Philippines passed Republic Act (RA) 10354 or the Responsible Parenthood and Reproductive Health (RPRH) Law in 2012 (An Act Providing for a National Policy on Responsible Parenthood and Reproductive Health, 2012). The law's history in Philippine legislature started in the 1970s where several precursor bills faced vehement opposition from conservative groups (Dañguilan, 2018). It was only in 2011 with explicit support from incumbent president and amidst fierce national debate among academe, religious and civil society organizations (CSOs) that House Bill 4244 or the 'Reproductive Health Bill' gained bicameral approval and was signed into law on the 21st of December 2012 (Cabral, 2014). Thereafter, the enactment of the RPRH law was delayed twice as the Supreme Court (SC) passed a status quo ante order in March 2013 and a temporary restraining order (TRO) on the procurement of contraceptives in June 2015. Through the concerted effort of CSOs and national government agencies (NGAs), particularly the Department of Health (DOH)

Key messages

- The Philippines' Responsible Parenthood and Reproductive Health Law of 2012 highlighted the need for multi-sectoral, integrated, and holistic reproductive healthcare and information services for the population.
- Seven years after implementation began, national leaders failed to rally non-health sector actors around RPRH or strategically harness the power of civil-society organizations. Paternalistic directives from national agencies proved ineffective in engaging with local government units in the country's decentralized government.
- Multi-sectoral leadership requires concrete operational frameworks reflecting the interests of partners and their roles in improving health outcomes. Possible conflicts in interests and perspectives between state and civil society actors must be managed in national governance bodies.
- Strategic leadership is necessary to avoid common pitfalls of multi-sectoral coordination such as siloed working, funding and staffing shortages, and lack of accountability, all of which threaten implementation sustainability.

and the Commission on Population and Development (POPCOM), the RPRH law was declared constitutional in April 2014 and the restraining order lifted in November 2017.

The RPRH law represented an important shift in how the Philippine state viewed the role of women, the family and RH, in the socio-economic development of the nation. It declared access to RH services as an instrumental right integral to the rights to life and health, as well as the achievement of the wider national development agenda (National Economic and Development Authority, 2017). To this end, the law took a comprehensive approach and specified 12 elements to RPRH that cover four broad areas.

Enhancement of health system capacity to deliver essential health services for mothers and their children, including family planning (FP):

1. RH and sexuality information and education, with special attention to the needs of adolescents and their guardians;
2. access to quality and affordable health care for the prevention and treatment for reproductive tract disorders and infections such as HIV/AIDS, sexually transmitted diseases, sexual dysfunction and cancers; and
3. gender equality that affirms men's participation in RH, the mental health in RH and protections for women and children against violence.

The Philippines is a lower-middle-income country (LMIC) (GDP: 2019 USD3485 per capita) (The World Bank, 2021) of 110 million people spread out across an archipelago of 7641 islands (Philippine Statistics Authority, 2019). Health expenditures total to USD133 per capita with 48% sourced from out-of-pocket expenditures (Philippine Statistics Authority, 2020). The RPRH law was passed and is implemented in the context of a unitary democratic government with decentralized social services. Legislation and country priority-setting are done at the central level and 21 executive departments craft national policies and programs to execute laws and other directives. National plans are conveyed to regional offices who liaise instructions to local government units (LGUs) and monitor compliance and progress. By the Local Government Code of 1991 (RA 7160) (Local Government Code, 1991), the delivery of social services is primarily the responsibility of LGUs (Liwanag *et al.*, 2018; Liwanag and Wyss, 2019). LGUs refer to the political and administrative units of the country that is divided into 81 provinces covering 146 cities and 1488 municipalities. Ultimately, policies designed at the national level are executed by LGUs and locally elected officials who have final discretion over resource allocation and prioritization of programs.

Considering the complex structure of Philippine government and its vibrant civil society, strong multi-sectoral governance for health (Bennett *et al.*, 2018) at the national level is necessary to guide LGUs and coordinate country-wide execution of comprehensive laws like RPRH. RH outcomes are also driven by determinants outside the health sector (Fawcett *et al.*, 2010; Rasanathan *et al.*, 2017; Sathyanarayana Rao *et al.*, 2012) that affect socioeconomic status and gender relations. Accordingly, an interagency National Implementation Team (NIT) was created in 2015 to facilitate governance and coordination in policies and plans at the central level (Department of Health, 2015). The NIT is chaired by a DOH undersecretary and its members include non-health NGAs, CSOs, academe and multilateral organizations.

These findings on national governance are a part of a wider comprehensive evaluation of the implementation of the RPRH law. The evaluation was commissioned by the Philippine DOH in compliance with the law (An Act Providing for a National Policy on Responsible Parenthood and Reproductive Health, 2012) that stipulates an independent third party present an evaluation every 5 years to a special Congressional Committee for accountability purposes. We had two main aims: (1) to assess whether national multi-sectoral governance for RPRH was executed cohesively, paying attention to the roles and relationships among national and local and public and CSO implementers and (2) to identify gaps in governance and challenges in coordination among NGAs, CSOs and LGUs. Cohesiveness referred to whole-of-government-and-society coordination and integration of responsibilities to improve health outcomes, including policies, expenditure and decision-making (Brown *et al.*, 2014). Thus, cohesive governance involves the non-health sectors that play an essential role in action on the social determinants of health. Taken together, answers to these objectives may provide the international community a look into the current status of a landmark law considered one of the most divisive bills (Dañguilan, 2018) in Philippine history. While adding to the empirical literature on the national RH policies in Southeast Asia (Glandon *et al.*, 2018; McGregor *et al.*, 2014), our findings may contribute to a better understanding of the complexity of multi-sectoral governance for health in LMICs for a neutral policy (Kanchanachitra *et al.*, 2018) where there are no clear conflicting interests among sectors and many opportunities for synergy. In particular, our paper may provide lessons on pitfalls to avoid and the challenges to anticipate in mustering a common vision for collaboration among many state and non-state actors outside within and outside the health sector.

Materials and methods

Study design and theoretical perspective

We employed a qualitative intrinsic case study design (Crowe *et al.*, 2011) with semi-structured interviews and document review. Our case focused on multi-sectoral governance for the RPRH law in the Philippines from 2012 to 2019 based on the activities, experiences, and perspectives of its national-level implementers. Supplementary File S1 contains an accomplished Consolidated Criteria for Reporting Qualitative (COREQ) research checklist (Tong *et al.*, 2007) for transparent reporting.

A review of literature informed the theoretical underpinnings for this study, guiding our aims, interview guide and interpretations of the data. Operationally, we defined governance as formal and informal structures and processes to manage operations such that organizational activities can be coordinated strategically to respond to constituents needs (Brown *et al.*, 2014; UNESCO International Bureau of Education, 2020). Governance includes decision and power dynamics that facilitate multi-sectoral coordination and enable effective delivery of social services (Buse *et al.*, 2012). We synthesized eight areas from the literature (Bennett *et al.*, 2018; Brown *et al.*, 2014; Rasanathan *et al.*, 2017) for a more focused inquiry: central to governance is (1) stewardship or leadership's ability to direct implementation strategically and influence how (2) organizational structure, (3) financial resources, (4) human resources and (5) policy infrastructure are (6) coordinated within and across collaborating agencies to carry out RPRH mandates. (7) Monitoring and evaluation and (8) accountability then serve as feedback mechanisms to improve operations and hold implementers answerable for progress. To systematically assess challenges and reasons for gaps in governance, we adapted the WHO systems checklist (Brown *et al.*, 2014) for governing health equity through action on social determinants of health that lists the characteristics (Table 1) and steps (Table 2) necessary to muster successful intersectoral collaboration and possible reasons for failures.

From the 10 characteristics, eight governance areas guided the study. Since results from the study were a component of the first national evaluation of the law, implementers' commitment to modernization and learning could not be determined as revisions to policy and implementations based on research recommendations were yet to be implemented at the time of writing. The governance areas are inputs to the 11 steps for implementing multisectoral action, which framed the Discussion section. The same WHO document also outlines possible governance failures tied to an inability to accomplish the checklist.

Table 1. WHO systems functions and characteristics for governing health equity through multi-sectoral action

Governance domain[a]	Systems characteristics
Political commitment:	
(1) Stewardship	Political commitment to multisectoral action for health
(2) Organizational structure	Presence of an intersectoral committee
(3) Financial resources	Explicit budget
(4) Institutional and human resource capacity	Capacity development and training of adequate staff for multisectoral action on the social determinants of health
(5) Policy coherence across government sectors and levels	Formal and explicit frameworks for all stakeholders, linking activities and budgets nationally and locally. Policy instruments which institutionalize collaborations across sectors and levels of government
(6) Coordinating and involving local people	Participation of local people and subnational authorities in policy design, monitoring progress and identifying solutions
(7) Intelligence (monitoring and evaluation)	Evidence and information to inform policy and investment decisions, monitor progress and hold stakeholders to account
(8) Accountability structures and systems	Legislative frameworks, structures, and systems to enable multisectoral action; governance boards to review progress on duties and hold stakeholders to account
Modernized public health	Review and modernization of public health training and practice
Learning and innovation systems	Commitment to continuous improvement and ongoing performance reviews in governance for equity in health through multisectoral action

[a]Governance areas of the study indicated by numbers in parentheses.
Source: (Brown *et al.*, 2014).

Interviews

Our semi-structured interview schedule (Supplementary file S3) asked about the leadership for RPRH within organizations, how this translated to changes in the eight governance areas and major challenges and their causes. We purposively sampled from three groups of national implementers (Table 3) with differing perspectives:

Table 2. WHO systems checklist for successful implementation of intersectoral action

Step	Description
1	Create a policy framework and an approach to health that are conducive to intersectoral action
2	Emphasize shared values, interests and objectives among partners and potential partners
3	Ensure political support; build on positive factors in the policy environment
4	Engage key partners at the very beginning, be inclusive
5	Ensure appropriate horizontal linking across sectors as well as vertical linking of levels within sectors
6	Invest in the alliance-building process by working towards consensus at the planning stage
7	Focus on concrete objectives and visible results
8	Ensure that leadership, accountability and rewards are shared among partners
9	Build stable teams of people who work well together, with appropriate support system
10	Develop practical methods, tools and mechanisms to support the implementation of intersectoral action
11	Ensure public participation; educate the public and raise awareness about health determinants and intersectoral action

Source: (Brown *et al.*, 2014).

Table 3. Organizations and number of respondents interviews

Organization	Roles in RPRH Implementation[a]	Number
A. Health sector agencies		
DOH	Lead agency for nationwide implementation of the law. Technical lead for various RPRH-related health programs such as maternal and child health, adolescent health and HIV/AIDS.	6
POPCOM	Co-manager with the DOH for the National Family Planning program. Lead secretariat for the NIT.	4
Philippine Health Insurance Company (PhilHealth)	Insurance coverage for RPRH services to improve their affordability.	1
B. Support agencies involved in social determinants		
Department of Social Welfare and Development (DSWD)	Integrate RPRH services into poverty alleviation and social welfare programs	2
Philippine Commission on Women (PCW)	Integrate RPRH, gender concerns, and women's empowerment into laws, policies and plans of government agencies.	2
Department of Interior and Local Government (DILG)	Coordinate with and monitor LGU implementation of the RPRH law.	1
DepEd	Integrated RPRH information into basic education curriculums	1
C. Non-government stakeholders		
Independent advisor to the NIT	Special external advisor and health sector governance expert.	1
CSO	Voluntarily collaborate with the public sector in areas such as monitoring government programs, policy discussions and service delivery.	1
Multilateral Organization	Technical and financial aid to public sector actors and CSOs.	1

[a]Organization roles synthesized from RPRH Law Revised Internal Rules and Regulations (2017).

1. Health sector agencies with leading roles in RPRH (health sector);
2. supporting agencies whose core mandates influence social determinants of RH (Non-health sector); and
3. non-government stakeholders who work extensively with government agencies (non-government).

To identify potential participants from agencies with explicit mandates, we started with a review of the RPRH law and its implementing rules. We consulted DOH and POPCOM, the lead implementer and NIT secretariat, for a list of regular representatives to the NIT. Introductory meetings between the co-investigators and potential participants were conducted to explain the study's purpose as a commissioned review required by law, scope out agency activities for RPRH and request for documents and interviews. Given the use of Philippine-specific acronyms in this paper, a full table of acronyms is found in Supplementary file S4.

Twenty (20) interviews were conducted from February to June 2020. All invited respondents agreed to participate. Interviews were planned for three other NGAs, but they were not pursued because saturation (Matthes *et al.*, 2017), where no new information emerged with additional interviews, was reached. Thirteen respondents were female and seven were male. Among the 17 respondents encompassing seven NGAs, there was one executive director, three division chiefs, one assistant division chief, ten national program managers and two coordinators from health agency regional offices. Most participants from government were career bureaucrats with a median of four (range:1–15) years of experience. Three respondents were non-government stakeholders who regularly attended the NIT as designated representatives and who have over 15 years of experience in the Philippine health sector. They included an independent advisor, the executive director of a CSO, and a chief technical officer from a multilateral agency.

One co-investigator and one research assistant were present in each interview. One co-investigator has a PhD in health policy, while the other has a Master of Science in epidemiology. Both are health systems researchers from the Philippine government's primary socio-economic think tank and are experienced in interviewing government stakeholders. Prior to interviews, participants were informed about the study objectives and procedures, their right to refuse to participate or withdraw at any time and that their anonymity would be ensured in publications. Interviews lasted between one to two hours and were conducted in a mix of English and Tagalog. Quotes presented in the results section were translated into English. Thirteen interviews were conducted face-to-face in a private room at the participant's workplace, while seven were via videoconferencing. Audio-recordings, anonymized transcripts and field notes were kept in password-protected computers with access limited to the research team.

Document review

Parallel to the interviews, a document review was used to corroborate statements from the interviews to validate their facticity or to glean details about a cited issue. The key documents reviewed were the RPRH Law, the law's Implementing Rules and Regulations (IRR) (2017 revision), national policy issuances, annual accomplishment reports and 79 NIT meeting transcripts from 2014 to 2019. See Supplementary File S2 for the full list.

Data analysis

Qualitative analysis aimed to identify common themes, contrasting perspectives and gaps in national governance across the three respondent groups. The analytic strategy followed a five-cycle process as described by Yin (2015). We aimed to guard against subjectivity in interpretation and confirmation bias.

First, transcripts and field notes were organized and compiled. Three researchers independently read each transcript to familiarize themselves with the data. Second, the researchers disassembled the transcripts using codes that represented

concepts, summaries or observations. Initial deductive coding used the eight governance areas as a priori codes. Researchers independently created codes inductively upon further re-reading of transcripts. Third, codes were reassembled into preliminary themes for each governance area and organized in Excel for comparison and linkage. At this stage, the researchers reviewed the documents separately, created notes and linked this to their initial themes. Fourth, a three-day workshop was held between the researchers to discuss and achieve consensus on themes per governance area and their interpretations. The researchers maintained an attitude of reflexivity (Dev *et al.*, 2009), during interpretation of results, bracketing (Tufford and Newman, 2012) preconceived assumptions and subjective biases that may have influenced the research themes. Last, we collaboratively drew conclusions and synthesized the main findings across the eight governance areas to answer our research questions and produce the themes presented in this paper. These findings were also submitted and presented to the DOH for comments and validation.

Results

Our analysis found three main themes in answer to our research aims.

1. National leaders, particularly the health sector, were unable to rally non-health sector actors around RPRH, leading to a lack of operational vision for cohesive implementation

Interviews inquired about multi-agency vision and plans, comparing NGA activities with their assigned mandates. Interviews repeatedly found that while there was agreement that the country's vision for a rights-based RPRH was anchored in the law, there were no concrete strategies and operational plans for integrated RPRH service delivery across sectors. Without agreed upon interagency strategies or explicit communication of benefits outside of health, the NIT struggled to onboard non-health NGAs to invest in intra-agency systems and comprehensive plans for RPRH.

> *The vision is still anchored on the IRR and the law. But as to the plans, schedules, timelines, there is nothing like that.* (Respondent 8, Health sector)

Most NGAs interviewed did not make formal changes to their organizational structures for their RPRH mandates. Rather, they 'folded-in' RPRH in units with similar responsibilities. Without additional dedicated staff, these units reported juggling RPRH with their original responsibilities. The absence of focal units hampered intersectoral coordination where program managers noted bureaucratic difficulties such as requiring approval up the chain of command before engaging in joint operations with RPRH programs of another agency.

A lack of dedicated funds for RPRH activities caused delays in program implementation (Respondent 5, Non-health sector). The Department of Education (DepEd) respondent cites this reason for rating the completion of comprehensive sexuality education roll-out in basic education curriculums with a score of four out of 10, with 10 being full implementation. For the DOH, channeling scarce funds into FP commodities limited investment in support systems such as capacity building, hiring and information technology (Respondent 7, Health sector) needed for program strengthening and sustainability.

Overall, meeting RPRH mandates was left to the discretion of individual organizations, leading to a fragmented approach. For instance, the NIT's Planning, Monitoring and Evaluation Guide was a tool to 'carefully evaluate the different programs and projects of various implementing partners in the country (Commission on Population and Development & Department of Health, 2015, p. 1).' However, it was developed by DOH and POPCOM in 2015, after implementation had already begun in several agencies. The guide does not present concrete targets. Instead, agencies report a list of RPRH activities that are compiled in the annual Accomplishment Reports without evaluating their contribution to improving RPRH outcomes. Although these should be submitted to a Congressional Oversight Committee (COC) for evaluation and recommendations (IRR Drafting Committee for Republic Act No. 10354 & Commission on Population and Development, 2017), only DOH has formal accountability to the COC.

> *It's very difficult for them [agencies] to interact with each other. It's like they are there only when we put together the Accomplishments [Report]. But working together, that is really very seldom- that the commitment of 'okay, let's find time so that your efforts and my efforts can be seen in one program implementation,' is very seldom.* (Respondent 11, Health sector)

Agencies' lack of organizational, financial and regulatory commitments to RPRH was reflected in their formal policy infrastructure. Over the five annual ARs, the NIT listed 104 policies and guidelines. Most were developed after the SC TRO was lifted in 2014 (26; 25%) and 2015 (37; 36%), with few issuances prior (4, 4%) and a decreasing number in 2016 (10; 10%), 2017 (13; 13%) and 2018 (14, 13%). The majority of policies were implementing guidelines and national strategies for specific programs (Table 4). Following its duties in the IRR to provide technical guidance and standards for RPRH implementation, DOH issued most of both.

Only eight policies directed RPRH operations within NGAs; most did not pertain to RPRH as a whole, instead focusing on specific programs Within DOH, the two internal policies that addressed RPRH were regarding the SC TRO (Department Circular 2015–0199 and Memorandum Circular 2015–0195). After the TRO was lifted, health-sector leadership turned back towards health agenda. Of the 104 policies, only 10 (10%) addressed RPRH across elements and sectors to cover service delivery networks, gender mainstreaming and RH in disaster situations.

Consequently, the lack of formal operational plans and monitoring and evaluation framework limited implementers' accountability for fulfilling their RPRH mandates that are only vaguely defined in the law. POPCOM, for example, committed to fund RPRH activities of other NGAs such as DepEd and became the co-manager for the National FP program with DOH. Although other NGA respondents expressed gratitude for POPCOM's commitment, some remarked that acting on an ad-hoc basis, without a formal mandate, has created confusion for direction-setting and accountability (Respondent 3, Non-government; Respondent 11, Health sector).

Table 4. Reported RPRH-related policies per agency by type of document, 2012 to 2018

Type of Document	Agency							
	DOH	POPCOM	PhilHealth	PCW	DepEd	DSWD	DILG	Total
Implementing guidelines	46	3	0	0	1	8	1	59 (57%)
National strategies and frameworks	11	0	0	1	0	0	0	12 (11%)
Internal policy within NGA to direct implementation	3	2	0	0	3	0	0	8 (8%)
PhilHealth benefits	–	–	12	–	–	–	–	12 (11%)
PhilHealth accreditation	–	–	3	–	–	–	–	3 (3%)
LGU directives for implementation	0	0	0	0	0	0	5	5 (5%)
Announcements for events (e.g. National FP conference)	1	0	0	0	0	0	2	3 (3%)
Joint agency policies[a,b]	XX	X	0	X	X	XX	XX	2 (2%)

Source: RPRH Accomplishment Reports 2014–2018, KIIs with NGA respondents.
[a]The two joint agency policies are (a) DILG-DOH-DSWD-POPCOM-PSA JMC No. 01 'Revised Pre-Marriage Orientation and Counseling Program Implementing Guidelines of 2018' and (b) IAC-VAWC resolution 2018–02 where all council members commit to fund contents of the Inter-agency Council on Violence Against Women and their Children (IAC-VAWC) strategic plan for 2017–2022.
[b]Indicates which NGAs participated in the joint policy. 'X' is participation in one, while 'XX' is participation in both.

Another operational challenge was the lack of open discussion among NIT members about the actual progress of RPRH implementation. Representatives felt pressured to preserve their agencies' good image (Respondent 6, Non-health sector) and withhold reporting issues in implementation, hindering collaborative multisectoral problem-solving.

> *We report what we have but don't present out of how many [i.e., the denominator]. Because they will get back to us [to ask], but we are the ones reporting. Would we report something that may throw ourselves under the bus? We report what has been done, but we indicate the set of challenges where we have fallen short in implementation in the report.* (Respondent 9, Health sector)

When respondents were asked about possible reasons for failure to develop an operational vision, they posited that frequent changes in the upper and middle management of the lead implementer DOH may be associated with gaps in RPRH priority and continuity. Within DOH, RPRH is left to the discretion of department secretaries, undersecretaries and assistant secretaries, each with their own priorities and expertise (Respondent 13, Health sector). In the eight years since RPRH was passed, DOH has had four secretaries of health and six undersecretaries for the DOH unit in charge of RPRH.

> *But of course, we cannot say that RPRH services that we support or advocate stopped. I cannot say that. It's just that there are really priorities per administration.* (Respondent 15, Health sector).

2. NGAs channel multiple paternalistic directives for RPRH down to smaller subnational units with larger burden for implementation but limited human resources

National implementers cited challenges associated with decentralized government: At the level of NGAs, a single program from a one NGA may seem easy to manage, since the program managers at the central offices (COs) delegate to the 17 regional offices (ROs), which in turn delegate it to 5 to 7 provinces each that then manage 10 to 20 cities or municipalities (Figure 1). CO program managers, however, described their regional counterparts as handling multiple programs despite having leaner staff and more responsibilities. ROs not only guide multiple LGUs in technical implementation but also collate data and feedback from LGUs to COs. Moreover, LGUs have the most disproportionate staff-to-responsibilities ratio, as one LGU is expected to implement multiple programs from over a dozen NGAs from parallel lines of reporting.

Devolution envisioned LGUs autonomously determining the most appropriate local policy solutions. The current national governance approach makes LGUs reliant on paternalistic directives that, by design, do not commonly account for local priorities. Moreover, information lags may be such that new national guidelines are issued before earlier policies are even understood by LGUs.

> *The NGAs want the LGUs to implement and prioritize the programs all at once. It is deafening for LGUs. They do not know what to do first. Once, they [NIT] liked updates on a monthly basis..That's why LGUs are saying the heaviest burden for implementing laws was on them. They have too many reports to accomplish.. We have so many policies. LGUs are yet to internalize the latest policy which requires a report, and then a new one will be issued. To think, LGU officials are not permanent staff.* (Respondent 6, Non-health sector)

LGUs, especially poorer ones with low tax revenues and limited capacity to hire staff, must prioritize some programs over others. They forgo responsibilities like quarterly accomplishment reports and resort to requesting assistance from the national government. Although several respondents voiced concern over LGU reliance on NGA resources, a universal shift to empower LGUs has not begun. For instance, DOH attempted to foster contraceptive self-reliance among LGUs in 2004. However, due to the provision in Section 9 of the RPRH law that 'DOH shall procure, distribute to LGUs and monitor the usage of FP supplies for the whole country (An Act Providing for a National Policy on Responsible Parenthood and Reproductive Health, 2012),' national respondents perceived that LGUs defaulted to relying on national government for these commodities.

> *They [LGUs] started buying [contraceptives] then suddenly the RPRH Law came, they went back to the past practice, wasting the behavior change. Although not all LGUs*

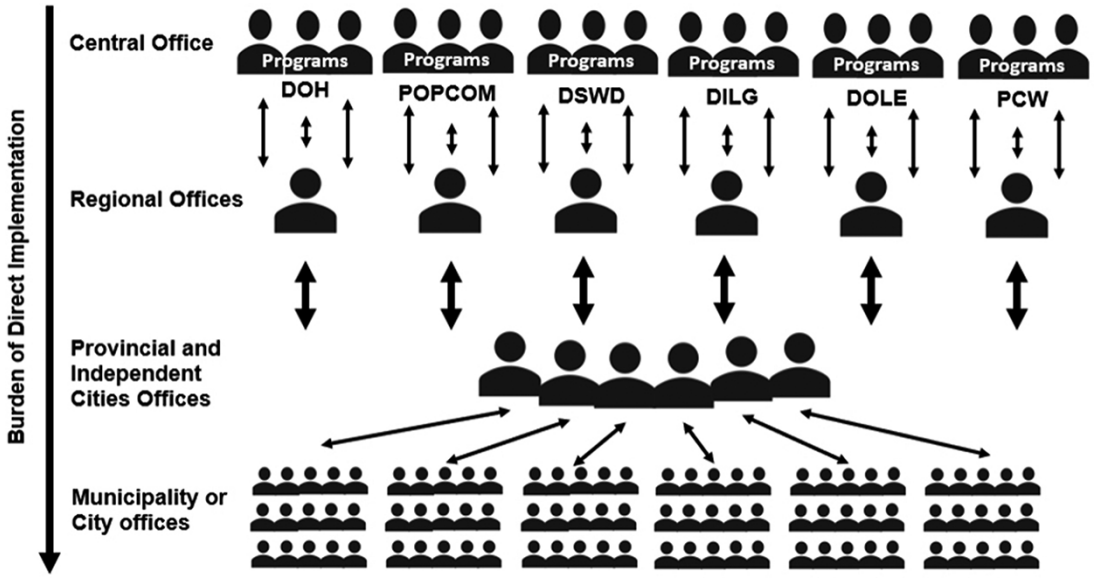

Figure 1. Representation of Philippine decentralized government from central-to LGU-level

had started buying, I feel like they were getting there. We were teaching them and training them to be self-reliant. (Respondent 10, Health sector).

A respondent noted that the national government may not be a stable source of funding, since at that time, 'DOH also has difficulty because their budget was being slashed by the policymakers (Respondent 11, Health sector).' Given the lack of institutionalization at the national level and its high-profile nature, RPRH was vulnerable to political interference: in 2016, DOH's FP funds amounting USD 3.7-million (Cruz, 2016) were deleted from its annual budget in the bicameral conference. The SC also prevented DOH from allocating and disbursing funding for contraceptives for 2 years. In 2017, no allocation for implants was given and the USD 5.0-million allocation for pills and injectables was not expended. With another USD 3.7-million budget cut in 2020 (Yee, 2019), DOH projected it would not have implants stocked for 2021.

Finally, respondents noted that CO and RO staff have weak means to communicate with LGUs and monitor policy execution. For LGUs, the section for penalties in the IRR (Section 17.03) lacks operational criteria for compliance and violations. NGAs rely on incentives and awards to spur LGUs. From the other end, LGUs are not represented in the NIT and cannot directly dialogue with NGAs.

Interviewer: *What if the LGU does not take your recommendation or comply?*

Respondent 6, Non-health sector: *We just remind them. Because - there is nothing in the RH law that is saying we will punish the LGU. Usually, we do not sanction the LGU. We have a program..it's like we just reward them, give LGUs incentives.*

3. CSOs were undoubtedly important macro-level partners in implementation, but failure to manage their expectations and conflicts of interest decreased the effectiveness of the NIT as a platform for multi-sectoral governance

NIT respondents lauded CSO's as local partners in advocacy (Respondent 1, Non-health sector), grassroots link to communities (Respondent 7, Health sector), service delivery where government reach is limited (Respondent 16, Health sector), technical assistance (Respondent 5, Non-health sector), and watchdogs for public accountability (Respondent 17, Non-government). Concurrently, the same respondents pointed out that CSOs had private interests, differing perspectives on policy that occasionally put them at odds with national priorities and imposed expectations on NGAs that contributed to making the NIT an unconducive environment for coordination.

The NIT has pros and cons. The pros are the engagement with CSOs, so the needs of CSOs are discussed..It's a powerful engagement tool for them and at the same time they can raise their concerns. They also get immediately informed about the available budget and services. The cons are the warring perspectives, it is different for CSOs and it is different [for government agencies]. (Respondent 1, Non-health sector)

CSO representatives have been reported to steer the NIT agenda towards relatively micro-operational concerns. Of the 71 NIT meeting transcripts, 25 (35%) included discussions on CSOs inquiring about accreditation and grants, while 21 (30%) involved CSOs clarifying claims and reimbursements policies. Moreover, 48 (67%) NIT minutes documented discussions about CSO objections to DOH-proposed maternal health and FP policies. In one case, CSOs criticized DOH for requiring that septic-abortion cases be managed only in secondary and tertiary hospitals, which may be inaccessible to poor women (42nd, 62nd and 66th NIT meetings). While both DOH and CSOs aimed to protect mothers, DOH took a broad perspective of regulating national healthcare safety: appropriate staff and equipment could only be guaranteed in higher level hospitals and, by this directive, LGUs should then make these facilities available to the poor [DOH AO 2018–003].

For civil society there is a difference because, for example, they cater to a small village. Of course, they can do

what is very ideal because it is only one village..We manage for the whole Philippines. There are differing personalities, we talk to different stakeholders. (Respondent 10, Health sector)

On the other hand, CSOs emphasized the need to represent the interests of often-neglected sectors in society, such as the poor, women youth, elderly, and persons-with-disabilities. They envision their role as partners to formal governance, by promoting citizen participation in the 'social movement (Respondent 3, Non-government)' of bringing RPRH to all Filipinos. With fewer layers of bureaucracy, they quickly identified community needs for RPRH and raised these to national implementers.

Because RH is very contested, right? It's really so controversial. You really need CSOs, because CSOs don't really have bureaucracy. And CSOs are the ones that push the ceiling. (Respondent 3, Non-government)

As NGA representatives work within large bureaucracies, CSOs strong presence in the NIT and insistence for immediacy inadvertently created an uncomfortable environment for state actors. Several NIT respondents expressed disappointment that the NIT had turned into a place for complaints and non-constructive criticism. Some have stopped attending NIT meetings as a result.

The goal of the NIT was really good, it was to be a coordinating body because all the agencies are there. But what happened eventually to the NIT was it became a place for complaints and grievances. No, it's true. It's a place for CSOs to question or rant about why regulations are like [this]… it's a very big group and each and every meeting issues are brought up over and over again, but we haven't been able to talk about strategies. (Respondent 7, Health sector)

I don't like to attend NIT meetings.. It stresses me out every time I attend. If the indicators are not good, it seems like it's my fault. They [CSOs] will tell you, 'you are incompetent, you are inefficient.' Do you want to hear those?…There's no problem with criticizing if you say it constructively… How do we make so that we jive?…I have many colleagues; we do not want to attend. We do not want to sit there because it's like a revalida*—one where they shame you. Why am I being scolded by them when they are supposedly my partners*? (Respondent 10, Health sector)

The culture of non-constructive criticism was acknowledged by CSOs, but it was emphasized that the behavior was characteristic of only some CSOs (Respondent 3, Non-government), while most earnestly saw NGAs as partners for RPRH implementation.

Discussion

Universal access to RH services is an instrumental human right and well executed national RH policies are fundamental to the sustainable development of nations. Our study examined multi-sectoral cohesion in national governance for the RPRH law of 2012, identifying gaps in intersectoral coordination and reasons for failures. Despite the initial fervor and momentum from the successful passage of the law, the absence of buy-in from non-health sectors, the lack of national strategic and operational plans and the country's complex decentralized government hampered the law's execution. Paternalistic directives from national agencies did not engage LGUs who were unequipped for the volume of programs. Weak national governance was augmented by CSOs. While CSOs were undoubtedly important partners, failure to manage their expectations and conflicts of interest decreased the effectiveness of the national interagency body created for RPRH governance.

Nonetheless, the multi-sectoral vision of the law still shows great promise. Since 2012, unmet need for FP methods shrunk from 30% in 1993 to 17% in 2017 (Philippine Statistics Authority & ICF, 2018), closing the gap with the country's goal of zero unmet need. In the years following the passage of the law, the adolescent fertility rate decreased from 5.7% in 2012, the highest it has been since 1971, to 4.7% in 2017 (World Bank, 2021). Despite these accomplishments, other RH outcomes stagnated or fell behind: in 2015, the country failed to meet its Millennium Development Goals for maternal mortality, HIV/AIDS and child health. Given the maternal mortality ratio of 121 maternal deaths per 100 000 live births (World Bank Group, 2021), the country stands to once again fail to meet its SDG target of nearly half this number. Between 2010 and 2017, HIV/AIDS incidence increased 174% (Gangcuangco, 2019), one of the fastest-growing in the region. As recent as 2020, a third of Filipino children were stunted (UNICEF, 2020), putting the Philippines among the top 10 countries with the highest rates of stunting in the world. While much research on multi-sectoral coordination in LMICs covers the need for financing (McGuire *et al.*, 2019), human resources (Roder-Dewan *et al.*, 2019) and monitoring systems (National Academy of Engineering (US) and Institute of Medicine (US) Committee on Engineering and the Health Care System, 2005) for successful policy implementation, the study emphasizes the need to strengthen governance, highlighting stewardship as the driver of intersectoral action for health, economy and development. A fully-realized RPRH Law could bridge the country's shortcomings RH outcomes and bridge socioeconomic inequities that disadvantage the poor and uneducated (Philippine Statistics Authority, & ICF, 2018).

Drawing on the WHO's systems checklist for governing health equity through intersectoral action, the Philippine case demonstrates the four main types of reasons for failures in governance and delivery despite existing efforts. The first three failures are exemplified by the three themes of the Results section, while the fourth failure is a possible implication of the governance shortcomings among national actors, between national and local implementers and between public and private stakeholders.

First, without a cohesive interagency vision, a conceptual failure occurred due to the lack of a unifying theory of change or logic model that shows how each RPRH stakeholder benefits and links together to contribute to RPRH outcomes and impacts. Implementers were unable to accomplish the first three steps for successful multisectoral action: creating a common policy framework, emphasizing shared interests and garnering intersectoral political support. This made it difficult to engage key partners, gain consensus on how to integrate interventions and coordinate the public sector and

civil society. Assessments (Brown *et al.*, 2014) by the WHO-Europe found that while many countries referenced frameworks highlighting the complex causal pathways contributing to health, connections between social determinants were not clearly articulated in operational strategies. Siloed working among government agencies led to sector-specific achievements that focused on intermediate or proximal determinants such as healthcare services.

Such findings were corroborated by a multi-country study in LMICs (Glandon *et al.*, 2018) that found that while multisectoral coordination was an uncontested goal among policymakers, one major barrier was creating systems to obtain the strong commitment of non-health sector stakeholders. A recent review (Rasanathan *et al.*, 2018) recommended mapping sector incentives and approaches to the policy problem, followed by strategically framing the public health issue to encompass those interests. In a district-level case-study (Billings and Wullingdool, 2019), the Ghanian multi-sectoral nutrition movement was able to successfully garner both national and subnational intersectoral commitment from key officials, as advocacy and intersectoral discourse bridged understanding of the scope and depth of the problem. This in line with WHO's recommendation to make health equity a government-wide indicator for national development, since its determinants, such as poverty reduction and social cohesion, are priorities of other sectors (Brown *et al.*, 2014). The Philippines' long-term development agenda, Ambisyon Natin 2040 (National Economic and Development Authority, 2017), identified health equity as a priority, although the agenda has yet to be formally operationalized within non-health sector NGAs. Health-sector agencies can leverage the RPRH Law and related policies like Ambisyon Natin as an advocacy tool during NIT meetings to deepen intersectoral commitment to RPRH as well as institutionalize RPRH activities within their own agencies.

A dissociation between national and local government action for RPRH in the Philippines demonstrates a delivery chain failure caused by the inability to level-off expectations about stakeholder contribution to solving the policy problem. Without engaging subnational authorities and consolidating horizontal national directives, national implementers were unable to accomplish the fourth to sixth steps of the WHO implementation checklist. A wide body of public administration research (Atun *et al.*, 2006; Barnes-Dabban *et al.*, 2017; Healey *et al.*, 2008; McIlrath and MacLabhrainn, 2007; Zaidi *et al.*, 2018) has underscored the importance of institutionalizing multi-sectoral reforms after the policy window sets it into motion. Rigid hierarchies, however, that characterize LMIC public administration (Bennett *et al.*, 2018) have promoted a paternalistic approach to policy making.

The emphasis on traditional authority is further complicated in devolved health systems (Abimbola *et al.*, 2019), which carry over geographical inequities in financial, technical and human resources. This limits LGU capacity to implement holistic policies such as RPRH that require multiple concurrent investments. An assessment (McCollum *et al.*, 2018) of health system governance in other devolved LMICs found similar challenges, with LGUs ill-equipped to handle their heavier responsibilities, including priority-setting. Like LGUs in the Philippines, local governments in Kenya and Indonesia tended to replicate norms and practices of the central government, including negative organizational cultures. Nonetheless, LGUs show great potential for intersectoral action (Rantala *et al.*, 2014), given their proximity and influence over social determinants. This way, different levels of government can act independently but coherently to achieve public health goals. WHO recommends a mix of instruments to ensure shared accountability across sectors and different levels of government (Brown *et al.*, 2014). First, expectation-setting among stakeholders is formalized through a cross-government framework. Existing policy guidelines must then be reviewed and revised in accordance with the framework, including joint accounting and incentives for meeting shared targets. Currently, LGUs play a vital role in RPRH service delivery but are not present in the NIT. Including representatives from the League of Cities and League of Municipalities can engage local government officials as well as raise their concerns to national policymakers. LGU involvement in operationalizing RPRH can promote participatory as opposed to paternalistic policymaking, shifting NGAs' role to capacitating and training LGUs.

A government control strategy failure occurs when political will is institutionalized in organizational agenda, but there are no formal systems to hold state actors accountable. This refers to the seventh, eighth and ninth steps of the systems checklist for multisectoral implementation. In the RPRH case, NGAs only had informal or courtesy accountability to one another, soft power over LGUs, and difficulty managing the private interests of CSOs. Without formal investigation mechanisms or concrete links to sanctions or incentives, data collected from NGAs and LGUs were primarily for reporting purposes and not utilized.

WHO recommends (Brown *et al.*, 2014) creating a formal agency to ensure accountability among implementers and generate evidence to inform decisions. The NIT was envisioned to fulfill this role, although its lack of capacity and resources hindered regular assessments of RPRH implementation and subsequent reporting to its congressional oversight committee. That even countries in the European region (Brown *et al.*, 2014) have yet to establish agencies with the necessary civic or legislative capacity for similar purposes speaks to the complexity of creating a governing body for governing bodies. Although the NIT shows potential as a multisectoral coordinating body, implementation progress was hampered by a lack of open discussion about agency shortcomings. Creating a formal impartial committee within the NIT to track implementation progress and hold members accountable can lessen the pressure of maintaining their image. The committee can also report annual progress to the COC and alleviate the burden of sole accountability for RPRH from the DOH.

Consequently, a public health system failure may result: when poor governance relegates health to the health sector as opposed to a whole-of-society approach (Brown *et al.*, 2014), a failure to carry out the last two steps of the systems checklist. In many LMICs (Bennett *et al.*, 2018), the private sector supplements the state in public–private partnerships. This approach, however, often does not address the underlying administrative weaknesses in state actors that necessitate them. Given NGAs' difficulty coordinating with LGUs, CSOs have become a valuable link to the public. While there is no question of the importance of civil society as watchdogs for state actors and grass-roots links to communities, CSO focus on service delivery and advocacy may encourage a myopic view of technical interventions, steering them away from a

more integrative role that bridges local and national strategies (Banks *et al.*, 2015). This was exemplified by the dynamic between CSOs and NGAs in NIT meetings: both actors have the same underlying interest in advancing RPRH, but frequent CSO criticism on details of proposed policies consumed a large portion of the NIT's limited time. Balancing the interests of multiple sectors and levels of government will necessitate securing stakeholder interest in health equity, clear operational frameworks developed with input from all actors, and equipping the NIT to hold all implementers accountable as the national leader of RPRH implementation.

Future policy responses built on these system failures, as opposed to first seriously addressing them, will have diminished impact on and further contribute to inconsiderable gains in RH outcomes in the past decade.

Limitations

Our focus on national governance concentrated data collection at the central level of Philippine government. However, the NIT does not have LGU members and national documents did not cover the perspective of LGUs. Given the lack of respondents and data from LGUs, the study's findings do not fully capture the experiences of subnational government units with the RPRH Law and mentions of LGUs were framed only as the perspectives of national implementers. Since the study was a commissioned review required by Congress, NGAs interviews may have carried the risk of social desirability bias (Krumpal, 2013) in which respondents provide answers associated with favorable presentation of themselves and their organizations. However, we believe that the majority of the respondents candidly represented national issues in multi-sectoral governance as they listed negative experiences, challenges and weaknesses about their own agencies. Nevertheless, respondent statements were cross-checked with data from respondents of other sectors and official documents. Further studies on the governance and operations of lagging programs like adolescent RH and development are recommended to provide more concrete solutions to existing issues in interagency coordination. Future studies that focus on the implementation experiences of LGUs and CSOs can identify governance gaps hindering the translation of national agenda into local action.

Conclusion

Despite aspirations for vibrant multi-sectoral coordination, the implementation of the RPRH Law in the Philippines was incohesive. Health sector leaders were neither able to rally non-health sector actors around RH nor strategically harness civil society. Local resource limitations associated with decentralization were exacerbated by paternalistic financing, coordination and monitoring. The absence of multi-agency plans, targets and accountability systems fostered a culture of siloed opportunism, without consideration to integrated implementation. Similar to challenges observed in other LMICs and HICs, this case study shows that for neutral policies without conflicts in sector objectives, the interest and buy-in of non-health state actors, even with a national law, cannot be assumed. Moreover, possible conflicts in interests and perspectives between state and civil society actors must be managed in national governance bodies. Overall, there is a need for more participatory policymaking and systematic advocacy by the health sector to set health equity as an intersectoral goal, involving subnational leaders developing concrete action plans, and strengthening NIT's formal accountability systems.

Supplementary data

Supplementary data are available at *Health Policy and Planning* online.

Data availability

Interview and NIT meeting transcripts cannot be shared publicly to protect the privacy of the respondents. Data requests and inquiries may be directed to the DOH– Disease Prevention and Control Bureau or POPCOM. A list of official documents analyzed were derived from sources in the public domain (Supplementary File S2).

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