NATIONAL STRATEGIC AND COSTED IMPLEMENTATION PLAN FOR THE WOMEN AND CHILDREN PROTECTION PROGRAM (2021-2025)

DEPARTMENT OF HEALTH, PHILIPPINES

Child Protection Network

UNFPA

Foreword

The World Health Assembly declared prevention of violence a public health concern in 1996 (WHA49.25). In 2104, the World Health Assembly came up with a resolution strengthening the role of the health system in addressing violence in particular against women and girls and against children (EHA67.15). SDG 5 and SDG 16 both aim to eliminate violence against women and children by 2030. The Philippines has a long way to go before 2030. Data shows that one in four Filipino women age 15-49 has experienced physical, emotional, or sexual violence by an intimate partner. Likewise, three out of five children are being physically and psychologically abused and bullied, and almost one in five children being sexually violated. The alarming figures are expected to increase by 16% as a result of the COVID 19 pandemic quarantine and lockdowns as reported by a research study of the University of the Philippines Population Institute in 2020.

The government face major challenges in ensuring that services for survivors/ victims are in place and continues to deliver integrated and comprehensive VAWC services in government facilities during the pandemic. Gaps prior to Covid-19 are even more apparent and deepened during this time.

The Child Protection Network Foundation, Inc. [CPN] is pleased to have worked closely with the Department of Health Women and Child Protection Program [WCPP] in the development of the WCPP Strategic and Costed Implementation Plan 2021-2025. The multi-year investment plan was conceived to set the directional and investment plan that describes the strategic interventions that guide program implementation in the next five years. The investment plan focuses on efforts to guarantee that Women and Child Protection Units in government facilities are in place and operational.

Over the years, the Child Protection Unit of the UP PGH and the PGH Women's Desk have provided comprehensive and integrated services for women and children survivors of VAWC. Through the Child Protection Network Foundation, it has contributed to establishing and building the capacities of WCPUs nationwide both in DOH-retained hospitals as well as facilities being support by Local Government Units.

The Child Protection Network commits to work in collaboration with the Department of Health and other key stakeholders in ensuring that the WCPP Strategic and Costed Implementation Plan will be realized and to contribute to the achievement of the objectives and goal of the program.

I congratulate the Department of Health's Women and Child Protection Program for setting the governance and roadmap to ensure that VAWC clients would have access and are managed with the appropriate WCPU services nationwide. Let us all work together for the successful implementation of this plan.

Dr. Bernadette Madrid
Executive Director
Child Protection Network, Inc.

About the Women and Children Protection Program [WCPP]- Costed Implementation Plan 2021-2025

This technical document is all about a multi-year development plan of the Women and Children Protection Program of the Department of Health. It covers both the Strategic Framework as well as the Costing of identified interventions

Costed Implementation Planning is an important process that provides program management a tool to determine investments on focused and evidence- based interventions. It helps in mobilizing limited resources to targeted and strategic interventions that can produce the results. The CIP process enables the key stakeholders to discuss and set the priorities and targets to achieve the goals and objectives.

The costed implementation planning process was carried out over a period of 8 months to complete and finalize. A more detailed description of the CIP process can be found in Section III of this paper.

The Women and Children Costed Implementation Plan was developed through a series of consultative webinars that was participated in by the key players and stakeholders involved in the implementation of the Women and Child Protection Program.

This report was prepared by the Department of Health with technical assistance from the United Nations Population Fund [UNFPA] thru the Child Protection Network Foundation, Inc. [CPN] headed by Dr. Bernadette Madrid, Dr Jocelyn Ilagan (CIP Consultant), and Ms. Anna Teresa Clemente.

The DOH extends its appreciation to the valuable contributions of the WCPP Technical Working Group members:

Dr. Cherylle Gavino - Department of Health
Ms. Arlene Rivera - Department of Health
Ms. Mica Porcioncula – Department of Health
Dr. Bernadette Madrid – Child Protection Network Foundation, Inc.
Dr. Jocelyn Ilagan - Child Protection Network Foundation, Inc.
Ms. Anna Teresa Clemente – Child Protection Network Foundation, Inc.
Mr. Jose Juan dela Rosa – Reach Health
Ms. Faye Alma Balanon - UNICEF
Ms. Sittie Rajabia Monato - UNICEF
Ms. Maria Aimee Santos – UNFPA
Ms. Jocelyn Bellin - UNFPA
Mr. Rene Raya - Social Watch Philippines
Ms. Luz Anigan - Social Watch Philippines
Mr. Alce Quitalig – Social Watch Philippines

The DOH also acknowledges the participation of the WCPP Focal Persons as well as the Women and Children Protection Unit (WCPU) Coordinators who shared their experiences and ideas that aided in the formulation of the WCPP Technical Strategy and the Costed Implementation Plan.

Executive Summary

The Philippine Statistics Authority [NDHS, 2017] reported that one in four Filipino women age 15-49 has experienced physical, emotional, or sexual violence by the husband, or partner. Likewise, the National Baseline Study on Violence Against Children conducted by UNICEF in 2016, shows a high overall prevalence of violence against Filipino children with three out of five children being physically and psychologically abused, and bullied, and almost one in five children being sexually violated. Violence against women and children continues to be a social concern in the Filipino community with increasing prevalence as a result of the COVID 19 lockdowns.

According to the United Nations Population Fund (UNFPA, 2020) it was estimated that there had been a 20 percent increase in domestic violence globally. A study commissioned by UNFPA approximates that intimate partner violence will increase by 16 percent in the country. By the end of the year, there will be an estimated 839,000 women who are married or who has been married at least once in their lives who would experience GBV during this pandemic [UPPI, 2020].

The Department of Health is mandated under Section 40 of Republic Act 9262 [*AN ACT DEFINING VIOLENCE AGAINST WOMEN AND THEIR CHILDREN, PROVIDING FOR PROTECTIVE MEASURES FOR VICTIMS, PRESCRIBING PENALTIES THEREFORE, AND FOR OTHER PURPOSES]* to provide medical assistance to VAWC survivors that covers health programs and services that shall immediately be provided through a socialized scheme by the ***Women and Child Protection Units (WCPU)*** in DOH-retained hospitals or in coordination with Local Government Units or other government health facilities. The Women and Children Protection Program under the Disease Prevention and Control Bureau provides technical and management support to ensure that WCPUs are established and operational.

The Costed Implementation Plan for the Women and Children Protection Program has been developed from May 2020 to February 2021. Through the leadership of the WCPP Program Manager under the WMHDD, and DPCB, series of consultation and workshop were conducted to (a) determine the status of implementation of the WCPP with focus on the Women and Child Protection Unit operations, (b) define strategic direction and its results framework, and (c) define the cost of implementation including corresponding activities.

The goal of the WCPP is to increase the number of VAWC cases appropriately managed in health facilities. To achieve the goal, five outcomes had been determined that focuses on: (a) functionality of WCPUs; (b) primary VAWC prevention thru health promotion and advocacy; (c) strengthening of management structures at various levels; (d) an enabling environment; (e) adequate and sustainable financial resource. These outcomes will be supported by strategic objectives and interventions defined under seven Key Result Areas (KRAs). The Strategic and Results Framework of the CIP was the basis in formulating the costed implementation plan for the years 2021-2025

The overall projected cost for the WCPP implementation is PHP 507,960,919 with a large chunk of budgetary requirement (46%) or PHP 235,346,919 that covers investment on Service Delivery; PHP 221,723,000.00 (43.65%) Health Promotion and Advocacy and PHP 26,821,000 (5%) budgeted for Evidence based data management. The first two years of the implementation plan has placed a lot of investments on ensuring that WCPUs in government facilities especially the DOH-retained hospitals have been given priorities to ensure service functionality. An intensive social and behavioral communication and advocacy campaigns would follow (in the next year) to ensure that VAWC survivors are made aware of the availability of WCPU services in their localities.

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I. Background

The 2017 National Demographic Health Survey in 2017 by the Philippine Statistics Authority reported that one in four Filipino women age 15-49 has experienced physical, emotional, or sexual violence by the husband, or partner. Likewise, the National Baseline Study on Violence Against Children conducted by UNICEF in 2016, shows a high overall prevalence of violence against Filipino children with three out of five children being physically and psychologically abused, and bullied, and almost one in five children being sexually violated. Violence against women and children continues to become a social concern in the Filipino community.

"Violence against women and their children" refers to any act or a series of acts committed by any person against a woman who is his wife, former wife, or against a woman with whom the person has or had a sexual or dating relationship, or with whom he has a common child, or against her child whether legitimate or illegitimate, within or without the family abode, which result in or is likely to result in physical, sexual, psychological harm or suffering, or economic abuse including threats of such acts, battery, assault, coercion, harassment or arbitrary deprivation of liberty" [RA, 9262][1].

Section 40 of RA 9262, mandates the Department of Health to provide medical assistance to VAWC survivors that covers health programs and services that shall immediately be provided through a socialized scheme by the Women and Child Protection Units (WCPU) in DOH-retained hospitals or in coordination with Local Government Units or other government health facilities. This is also reiterated in the Implementing Rules and Regulations of the Magna Carta for Women (RA 9710) and the Responsible Parenthood and Reproductive Health Act of 2012 (RA 10354).

To ensure that health programs and services to VAWC survivors will be fully implemented, the Department of Health under the Women and Children Protection Program (WCPP) developed the WCPP Strategic and Costed Implementation Plan 2021-2025.

The Costed Implementation Plan is a multi-year directional plan that recognizes evidence-based strategies and approaches to enhance the implementation of the Women and Children Protection Program with focus on the functionality of Women and Children Protection Units and estimates the costs of implementing identified strategies. Originally, the CIP is a strategy design in building the costing requirements to implement strategies for Family Planning. With global evidences that CIP works for program implementation, the process and steps in the CIP are applied in the WCPP.

[1] RA 9262. *AN ACT DEFINING VIOLENCE AGAINST WOMEN AND THEIR CHILDREN, PROVIDING FOR PROTECTIVE MEASURES FOR VICTIMS, PRESCRIBING PENALTIES THEREFORE, AND FOR OTHER PURPOSES.*

II. The Costed Implementation Plan (CIP) as a tool in the Formulation of the Strategic Plan of National Women and Children Protection Program

A CIP is a multi-year roadmap that identifies evidence-based strategies and approaches to improve programs and estimates the costs of implementing these strategies. The CIP design originated from building the costing requirements to implement strategies for Family Planning. However, it will be noted that the process and steps in the CIP can be applied in other programs including the Women and Children Protection Program of the Department of Health

The CIP process provides a venue where all components of a program including its services are addressed and budgeted for. Components such as policy development and review, service delivery including commodity security, staffing and capacity building requirements, monitoring and information systems, financing scheme and performance accountability.

Process of CIP Development[2]

There are ten steps that are being followed in preparing the Costed Implementation Plan. The activities are grouped in 3 phases: 1) Plan; 2) Develop; and 3) Execute. The phases are further subdivided into 10 specific steps.

Phase 1: Planning

The government and key stakeholder buy-in is cultivated and secured in the planning phase. It is also in this phase that identification and engagement of key stakeholders is initiated; the approach, tools, and techniques to be used are developed (i.e., the how, by whom, and when); and resources for the development of the CIP are secured.

Phase 2: Development

The CIP is developed and planning begins for the transition into execution or actual implementation in Phase 3. The development process is iterative and cyclical and involves identifying key issues (Situational Analysis), defining the results, identifying intervention activities to achieve the results (Development of the Technical Strategy), and generating budgetary costs (Estimating the Resource Requirements and Costs including the Identification of Financing Gaps). It also includes outlining institutional arrangements for implementation (Setting up and Managing the Institutional Arrangements), developing a performance monitoring mechanism (Monitoring Performance), and conducting advocacy.

Phase 3: Execute/ Implementation

In the final phase, the CIP is executed, monitored, and managed. Execution involves three steps that occur in tandem to ensure a sustained commitment from leaders and stakeholders (at all levels) responsible for leading and managing plan implementation, resource mobilization, and advocacy and monitoring progress

[2] Guidance for Developing a Technical Strategy for Family Planning Costed Implementation Plans, Costed Implementation Plan Resource Kit, FP2020, UNFPA, USAID. familyplanning2020.org/cip

toward goals. Because the CIP is a living document, CIP execution should be dynamic and include periodic review and revision based on results and changes in the internal and external environment.

A CIP can also address equity issues—helping to ensure that marginalized and underserved populations such as those who are living in rural areas are included when there is a need for information and services to be scaled up. A CIP can outline the roles and responsibilities of all stakeholders involved in a program to eliminate duplicative efforts and increase accountability.

III. Developing the Women and Children Protection Program CIP

The components of the WCPP represent critical, preventive and responsive health actions that must be implemented simultaneously with other protective measures to support a VAWC survivor as a life-saving intervention mandated by numerous laws and policies, it is crucial to have a strategic direction in the implementation of the WCPP most particularly in establishing a functioning WCPU that should be given priority as a public health investment plan. This can be carried through the CIOP process of the WCPP. This is essential to reducing gender-based violence particularly among women and girls.

This CIP for WCPP had undergone the following processes:

- Planning on the CIP Process with key stakeholders particularly the Department of Health under the Women and Men's Health Development Division of the Disease Prevention and Control Bureau; A Technical Working Group that was convened and regularly meets to discuss and level of the understanding on each phase of the CIP process and the importance of having these validated at the field implementation level
- Determining the Situational Analysis on the implementation of WCPP with reference to the implementation of the Administrative Order that was issued in 2013. The findings were validated in a webinar meeting with Regional Coordinators and WCPU Focal Persons in the different regions and provinces.
- Setting the Strategic Directions and Results Framework (Technical Strategy) on WCPP in alignment with the overall thrusts of the Department of Health National Objectives for Health and other national level Inter-Agency commitments.
- A workshop was organized through a webinar in September 2020 together with the Regional Health Offices and WCPU both at the Regional and Provincial levels. The activity provided an opportunity for a core group of DOH participants from the national, regional as well as NGOS and hospital staff to analyze the current situation and formulate specific objectives/ results that needs to be achieved. (See Figure 2)
- Development of the Detailed Implementation Plan including specific timelines.
- Participatory Resource Mapping with Civil Society Organization Partners to identify the areas of complementation towards achieving the Goals and Objectives of the WCPP
- Costing of the Implementation Plan to determine resource requirements and costs of implementing WCPP Strategic and Costed Implementation Plan

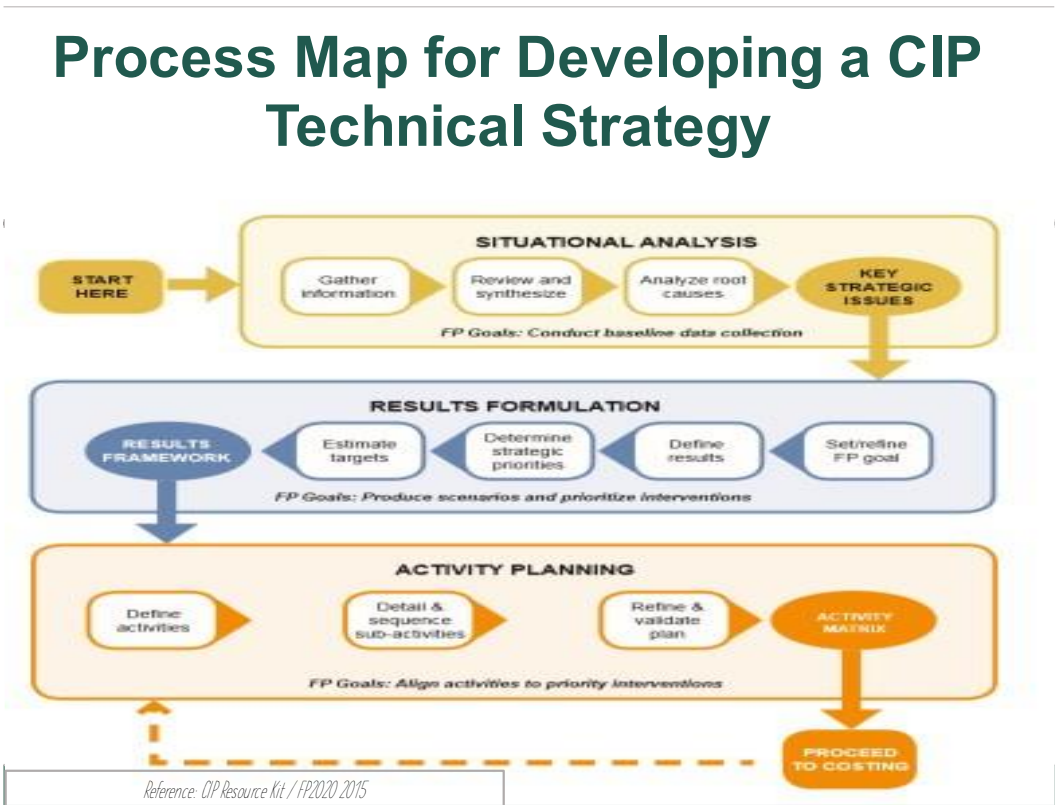


Figure 2. Steps in the development of the Technical Strategy

Figure 2 is an illustration on the various steps that are being carried out in the development of a Costed Implementation Plan. The illustration used the development of the Family Planning Program CIP process as an example. The same process/ steps were used in the development of the Women and Children Protection Program.

To support the CIP process, below are the assumptions set and estimation parameters:

(a) Covers five years from 2021 to 2025.
(b) Considered as a Health Sector Plan, which includes CSOs, private sector and international organizations.
(c) Costing of WCPUs were based from references being used by Implementing Partners, i.e., Child Protection Network Foundation, Inc. based at the UP-PGH; other relevant DOH costing templates; previous CIP documents developed at the DOH (i.e., FP, MISP)

II. The WCPP Legal Mandates

Several laws had been passed to support and institute the necessary protective measures to address gender-based violence in the Philippines.

1. The Philippine Constitution defined in Article II Section 12 under the Declaration of State Policies that the State shall protect and promote the right to health of women especially mothers in particular and of the people in general and instill health consciousness among them. The State shall likewise protect and advance the right of families in particular and the people in general to a balanced and healthful environment in accord with the rhythm and harmony of nature. The advancement and protection of women's human rights shall be central to the efforts of the State to address reproductive health care. It also recognizes and guarantees the promotion and equal protection of the welfare and rights of children, the youth, and the unborn. The State shall The State shall defend the right of children to assistance, including proper care and nutrition, and special protection from all forms of neglect, abuse, cruelty, exploitation, and other conditions prejudicial to their development; Moreover, the State further recognizes and guarantees the promotion of gender equality, gender equity, women empowerment and dignity as a health and human rights concern and as a social responsibility.

2. Republic Act (RA) 9710, otherwise known as the Magna Carta of Women, is a comprehensive women's human rights law that seeks to eliminate discrimination against women by recognizing, protecting, fulfilling and promoting the rights of Filipino women, especially those in the marginalized sectors. Section 12 D, Rule IV of the Rules and Regulations Implementing the Magna Carta of Women provides for the establishment of a VAW desk in every barangay to ensure that violence against women cases is fully addressed in a gender-responsive manner. A Memorandum Circular was jointly issued by the Department of the Interior and Local Government (DILG), the Department of Social Welfare and Development (DSWD), the Department of Health (DOH), the Department of Education (DepEd) and the Philippine Commission on Women (PCW), pursuant to Section 12 D.2 of the Implementing Rules and Regulations of RA 9710 to ensure its implementation.

3. Under the Magna Carta for Women Act [RA 9710], Women in especially difficult circumstances [WEDC] refers to a victim of trafficking, survivors of sexual and physical abuse, illegal recruitment, prostitution, armed conflict, women detention; b) temporary and protective custody; c) Medical and dental services; d) Psychiatric evaluation; e) Productivity skills capability building; e) Legal services; f) Livelihood assistance; g) Job placement; h) Financial assistance; i) transportation assistance.

4. RA 7610 entitled Special Protection of Children Against Child Abuse, Exploitation, and Discrimination Act as amended by RA 7658 and RA 9231 declares that it is the policy of the State to provide special protection to children from all forms of abuse, neglect, cruelty, exploitation, and discrimination, and other conditions prejudicial to their development; provide sanctions for their commission and carry out a program for prevention and deterrence of and crisis intervention in situations of child abuse, exploitation and discrimination. Section 2 further stipulates that it shall be the policy of the State to protect and rehabilitate children gravely threatened or endangered by circumstances which affect or will affect their survival and normal development and over which they have no control.

5. *According to the Responsible Parenthood and Reproductive Health (RPRH) Law (RA 10354) and its Implementing Rules and Regulation (IRR), Violence Against Women (VAW) or Gender-Based Violence (GBV)* refers to all forms of violence inflicted on women on account of their gender. In the broadest sense, it is a violation of a woman's personhood, mental or physical integrity or freedom of movement. More specifically, it refers to any act of gender-based violence that results, or is likely to result, in physical, sexual, or psychological harm or suffering to women including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or private life. **Section 4.08** specifically identified the development of guidelines and standards in implementing *Care for Victim-Survivors of Gender-Based Violence. The IRR also defined the Women and Children Protection Unit (WCPU)* as a unit composed of multi-disciplinary team of trained physicians, social workers, mental health professionals, and police providing comprehensive medical and psychological services to women and children who are victims of violence.

6. **RA 9262 under Section 13 described the Healthcare Provider Response to Abuse of Women and their Children**– Any healthcare provider, including, but not limited to, an attending physician, nurse, clinician, barangay health worker, therapist or counselor who suspects abuse or has been informed by

the victim of violence shall: (a) properly document any of the victim's physical, emotional or psychological injuries;(b) properly record any of victim's suspicions, observations and circumstances of the examination or visit; (c) automatically provide the victim free of charge a medical certificate concerning the examination or visit;(d) safeguard the records and make them available to the victim upon request at actual cost; and (e) provide the victim immediate and adequate notice of rights and remedies provided under this Act, and services available to them.

DOH Mandates

1. Section 40 of RA 9262 mandates the Department of Health to provide medical assistance to VAWC survivors. Under the Implementing Rules and Regulation of RA 9262, Medical assistance covers the following health programs and services that shall immediately be provided through a socialized scheme by the **Women and Children Protection Unit (WCPU)** in DOH-retained hospitals or in coordination with LGUs or other government health facilities: a) Complete physical and mental examinations; b) Medical/Surgical treatment; c) Psychological and psychiatric evaluation and treatment; 53 d) Hospital confinement when necessary; e) Referral to specialty hospital and other concerned agency as needed; f) Manage the reproductive health concerns of victim survivors of VAWC; and g) If necessary, contact the DSWD or social worker of the LGU for emergency assistance to the woman and her child/children, or the police women and children concerns protection desk officer.

2. The DOH issued Administrative Order 2013-0011 Entitled: Revised Policy on the Establishment of Women and Their Children Protection Units in All Government Hospitals.

3. DOH Department Circular 2017-0301 defined the various Reproductive Health programs and services of the Department of Health under RA10354 [RPRH Law] which includes Elimination of Violence Against Women and Children and other forms of sexual and gender-based violence [RH Element #5]. The administrative issuance specifically defined the following services under the DOH-Women and Child Protection Program:
    a. Provision of appropriate medical and psychosocial treatment for victims of VAWC thru the Women's and Children Protection Unit (WCPU) in hospitals;
    b. Medico-legal examination;

c. Forensic examination;

d. Gender-sensitive counseling;

e. Expert testimony in court

Other Laws in Support of Elimination of Gender based Violence in Women and Children

- Republic Act 7610: Anti-Child Abuse Law
- Republic Act 9262: Anti-Violence Against Women and their Children Act
- Republic Act No. 8353: Anti-Rape Law
- Republic Act 10364: Expanded Anti-Trafficking in Persons (RA 9208: Anti-Trafficking in Persons Act of 2003)
- Republic Act No. 8505: Rape Victim Assistance & Protect Act
- Republic Act 9710: Magna Carta of Women
- RA 7877: Anti-Sexual Harassment Act
- Republic Act 10354 (The Responsible and Reproductive Health Act of 2012)
- Administrative Order 1-B s. 1997: DOH Policy on the establishment of Women & Children's Protection Units (WCPU)
- Administrative Order 2013-0011: Revised guidelines on the establishment of WCPUs in all hospitals
- Administrative Order 2014-0002: Violence and Injury Prevention

III. VAWC Situation and Status of WCPUs in the country

a. Data shows that 80% of children and young people (age 13-24 years old) experience any form of violence in any setting. 3 in 5 (64.2%) children experienced any form of physical violence in various settings; Females (62.1%), Males (66.2%), 4 in 5 LGBT children; 3 in 5 ((61.9%) children have experienced any form of psychological violence in any setting; Females (59.7%), Males (64.1%), 4 in 5 LGBT children. 1 in 5 (22.4%) children experienced any form of sexual violence in any setting. Males (26.4%), Females (18.2 %), 3 in 10 LGBT children. [3]

b. In 2018, based on available data from the Philippine National Police (PNP) Women and Children Protection Center (WCPC) and DOH Violence Against Women and Children (VAWC) Registry System showed a declining trend in the reported cases of violence against women and children over the past three years. PNP reported a 19.5% decrease in VAW cases from 2016 (32,073) to 2017 (25,805); and another 26% decrease from 2017 to 2018 (18,947). A similar decline in the trend of cases on violence against children (VAC) was reported by the PNP over the last three years. There was a 9% reduction of cases from 2016 (28,686) to 2017 (26,143) and a decrease of 21% (20, 728) in 2018. The DOH VAWC Registry System also reports a substantial decreasing trend in reported cases from the hospitals. A 50% decrease in the VAWC cases was noted from 2016 (3,167 cases) to 2017 (1,574 cases). This further went down by 49% in 2018 (800 cases). The decline may be due to unreported cases especially from far-flung and isolated areas and less reporting compliance from participating hospitals.[4]

c. In 2018, there were a total of 108 Women and Child Protection Units (WCPU) nationwide. These are composed of the following:

Hospitals with WCPU	Number
At the Provincial level	55
At the City level	10
DOH retained Hospitals	39

[3] National Baseline Study on VAC, 2015
[4] 5th RPRH Annual Report, 2018

LGU operated hospitals	68
Private hospital	1
Total	108
Note: Provincial Hospitals without WCPU	*26*

Source: CPN Database, 2018

d. In the same year, these Women and Child Protection Units served a total of 15,260 cases of VAWC, 10,444 cases (68%) were violence against children and 4,816 (32%) were cases of violence against women. These reports were higher than those reported in 2017 which had a total of 13,475; the incidence from violence against children was 9192 (68%) while violence against women was reported at 4283 (32%). Also, in 2018, the reported cases of VAC incidence at the UP PGH Child Protection Unit: 69% of VAC were Sexual Abuse, 14% were Physical Abuse accounted, while there were around 4% of reported cases experiencing Sexual and Physical Abuse.[5] The same report presented that women who are aged 25-44 years old experienced physical violence while those who are aged 18-24 years old suffered from sexual assault.

Current Status of Women and Child Protection Units (Prior to the COVID 19 Pandemic)

On the status of WCPU implementation, the items below highlight the results of an evaluation study that was commissioned by the Child Protection Network. (November 2019). The study covered a total of 51 WCPUs (69%) of the total number of CPUs in the entire country. There were 236 respondents to the evaluation study, 141(60%) were WCPU staff, 53 (22.8%) were from referring agencies (PNP, DSWD, NGO), and 26 (11%) were from hospital staff (administrators and medical staff); and finally, 16 (7%) were from the local government units.

The Required Minimum Standard Criteria. This was used as the parameter to determine the functionality (in terms of the WCPUs at each level. It includes the minimum standards for staffing, programs and services provided by the unit. There are four Levels in the delivery of VAWC services: a) Multi-Disciplinary Team (MDT); b) Level 1 (Trained physician and the trained registered social worker); c) Level II (Level 1

[5] Annual Report of the Child Protection Network, 2018

plus Trained police investigator and/or Mental Health Professional; d) Level III (All Level II trained personnel plus additional trained physician and social worker.

General Findings:

1. **For Level 1 WCPU:**
    a. Sixty nine percent (11/16) of Level 1 WCPU are functioning based on the criteria that was set based on the specific level;
    b. However, there were four WCPUs who are only able to reach 50-69 required L1 service components; Also, it was noted that there was one WCPU who was unable to cater to a client from the beginning.
    c. There was one L1 WCPU who was unable to fulfill the 50% cut-off set by the evaluation team for being designated as a functional unit under this level due to changes in the local political landscape. Nevertheless, despite the situation the WCPU has been very active and was able to serve a total of 656 client survivors.
2. **Level 2 WCPU**
    a. Forty one percent (14/34) among the Level II WCPUs was reported to have reached 70% of the minimum standard criterion for both the staffing and required services for this level.
    b. Fifty percent (17/34) have reached 50-60% of the minimum standard requirements for both staffing and services. Majority of these WCPU are being supported under the Local Government Units (usually the Provincial Health Office and the Provincial Social Welfare Office)
    c. Nine percent (3/34) Level II WCPUs had scores below 50% of the minimum standard requirements for service component and all of them are operating under the Local Government Units.
3. **Level III WCPU**

    It was noted that there was only one Level III WCPU included in the evaluation study. Upon the application of the minimum standard criteria and required services for a Level III, the facility was observed to have reached all the minimum standard criteria and service requirements for a Level III Women and Child Protection Unit.

Specific Issues affecting WCPU operations and functionality

1) Human resource:
    i. Lack of personnel had resulted in additional workload to staff;
    ii. Multi-tasking
2) Facilities
    i. No permanent physical/ designated workspace that ensures maintaining confidentiality and safety of both the VAWC clients, their relatives, and staff of the WCPU; note however that majority of the respondent WCPUs minimum standards for materials and equipment were being satisfied.
    ii. Lack of /inadequacies in the supply of rape kits, HIV rapid screen test, access to HIV post-exposure prophylaxis, and access to contraceptives on the prevention of post rape pregnancies
3) Referrals
    i. On Client load
        1. For the WCPUs with high volume of clients, concerns for the provider-client ratio remains to be a challenge as these facilities could hardly cope with the demand for services. It was being advocated that the lower-level facilities (LGU based units) be equipped to ease the burden at the higher-level facilities.
        2. For the WCPUs with low volume of clients, there is a lack of information dissemination or raising of awareness on the availability of services at the WCPUs in the locality.
    ii. Another major concern, is the lack of mental health professionals to address the psycho-social services of the clients
4) Concerns during attendance to court hearings.
    i. Lack of financial support for attendance to court hearings. At times, even the reimbursement of staff remains to be difficult.
    ii. Out of town attendance to hearings increases the risk to WCPU staff including their safety.
5) Pressure from stakeholders including clients' relatives as a result of absence of temporary shelters for the VAWC clients. Sometimes, WCPU staff would give protective custody (allowing the clients to stay in their homes) which poses a high risk to safety.

6) Additional Observations:
    i. There is a steady number of increases coming from referrals, majority from the PNP covering 56% of the total number of referrals; Next is the DSWD with 7.5% of client referral.
    ii. At the Philippine General Hospital, there were 30% of clients who were "walk-ins".
    iii. Educational institutions (i.e., schools) had very low to almost negligible number of cases being referred where these places are considered to be second home to the children
    iv. Multi-disciplinary trainings were much appreciated by those who completed the training programs. They gave a rating/ score of 10 or excellent in terms of the training received.

4. Summary of findings and conclusion of the baseline report:
    1) WCPUs remain active and visible in the provision of VAWC services to women and children;
    2) While commitment from the WCPU staff has been very strong, however, they still need support to keep pace with the workload so that they are not overburdened;
    3) There is high post-training retention rate among the MDTs who were trained by CPN showing that there is value in putting investments to training programs;
    4) There is a need to balance between the demand side and capacities of the service providers, hence care and caution in creating demand generation activities
    5) There is a need to decongest some of the higher level by building the capacities at Level 1 (i.e., municipal, district, and provincial level facilities).
    6) MDTs can be tapped to link to communities needing their capacities (e.g., those who have not established a WCPU in their localities).

VAWC during the COVID 19 Pandemic[6]

Globally, violence against women (VAWC) remains a major threat to global public health and women's health during emergencies. Violence against women is highly prevalent. The most common form of violence is intimate partner violence. Globally, 1 in 3 women worldwide have experienced physical and/or sexual violence by an intimate partner or sexual violence by any perpetrator in their lifetime. Most of this is intimate partner violence. Globally, it is also estimated that up to 1 billion

[6] WHO/SRH/20.04 © World Health Organization 2020. https://www.who.int/reproductivehealth/topics/violence/en/

children aged 2–17 years, have experienced physical, sexual, or emotional violence or neglect in the past year. [7]

VAWC tends to increase during every type of emergency, including epidemics. Older women and women with disabilities are likely to have additional risks and needs. Women who are displaced, refugees, and living in conflict-affected areas are particularly vulnerable.

Although data are scarce, reports from China, the United Kingdom, the United States, and other countries suggest an increase in domestic violence cases since the COVID 19 outbreak began. The number of domestic violence cases reported to a police station in Jinzhou, a city in Hubei Province, tripled in February 2020, compared with the same period the previous year. In the Philippines, reports have decreased which may be due to difficulty in reporting during the quarantine period and the fact that the usual helping professionals are busy with COVID 19 response. Schools were also closed and there was no transportation.

The health impacts of violence, particularly intimate partner/domestic violence, on women and their children, are significant. Violence against women can result in injuries and serious physical, mental, sexual and reproductive health problems, including sexually transmitted infections, HIV, and unplanned pregnancies. According to the Commission on Population at least 40 to 50 Filipino teens aged 10-14 years give birth each week. With regards to teen pregnancy 500 youths give birth every week (PNA, 2020). A study done at the Child Protection Unit of the Philippine General Hospital revealed that 36.3% of those who have been sexually abused became teen-age mothers (Lorenzana, 2019).

Rapid Assessment & Monitoring of the Women and Child Protection Units (WCPUs) during the COVID 19 Pandemic

A Rapid Assessment and Monitoring Activity was conducted by the Department of Health under the WMHDD-Women and Children Protection Program in May 2020. The monitoring and rapid assessment tools were

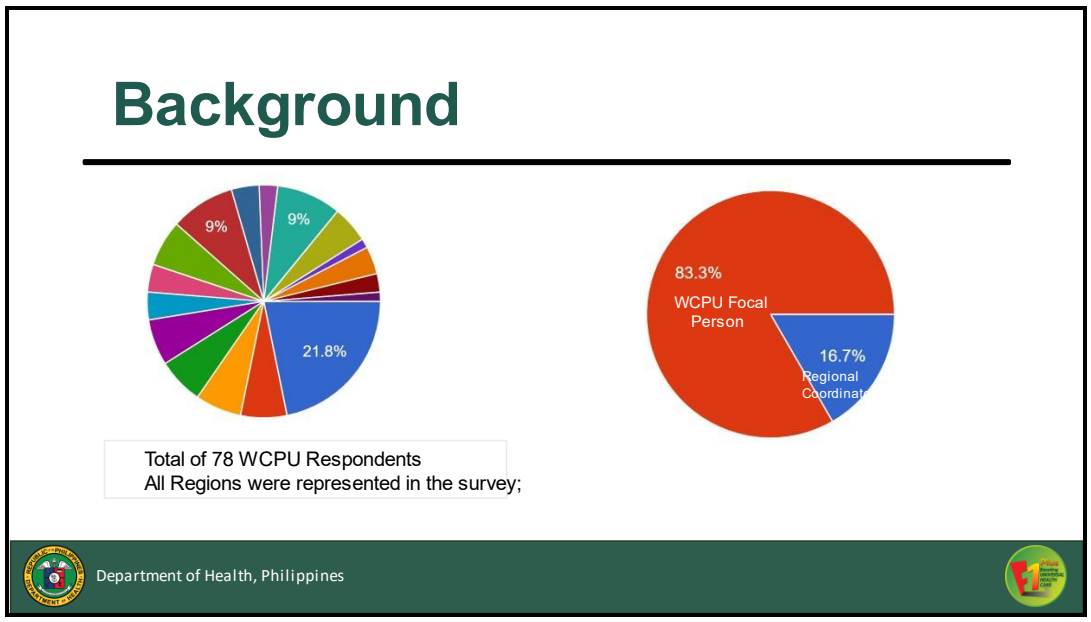
[7] WHO, Fact sheet, June 8, 2020. https://www.who.int/news-room/fact-sheets/detail/violence-against-children

developed and disseminated to the Regional WCPP program staff and WCPU focal persons. The participants were then requested to submit their responses on a specific deadline. The questionnaire focused on the following questions in terms of how the COVID 19 Pandemic affected WCPUs:

- Available Service hours
- Number of personnel on duty
- Number of available services/ those no longer offered
- Number of clients seen over the last 30 days
- Stock outs
- Challenges & Resolutions

The following were the results of the rapid assessment and monitoring exercise.

Figure 1. Profile of Respondents



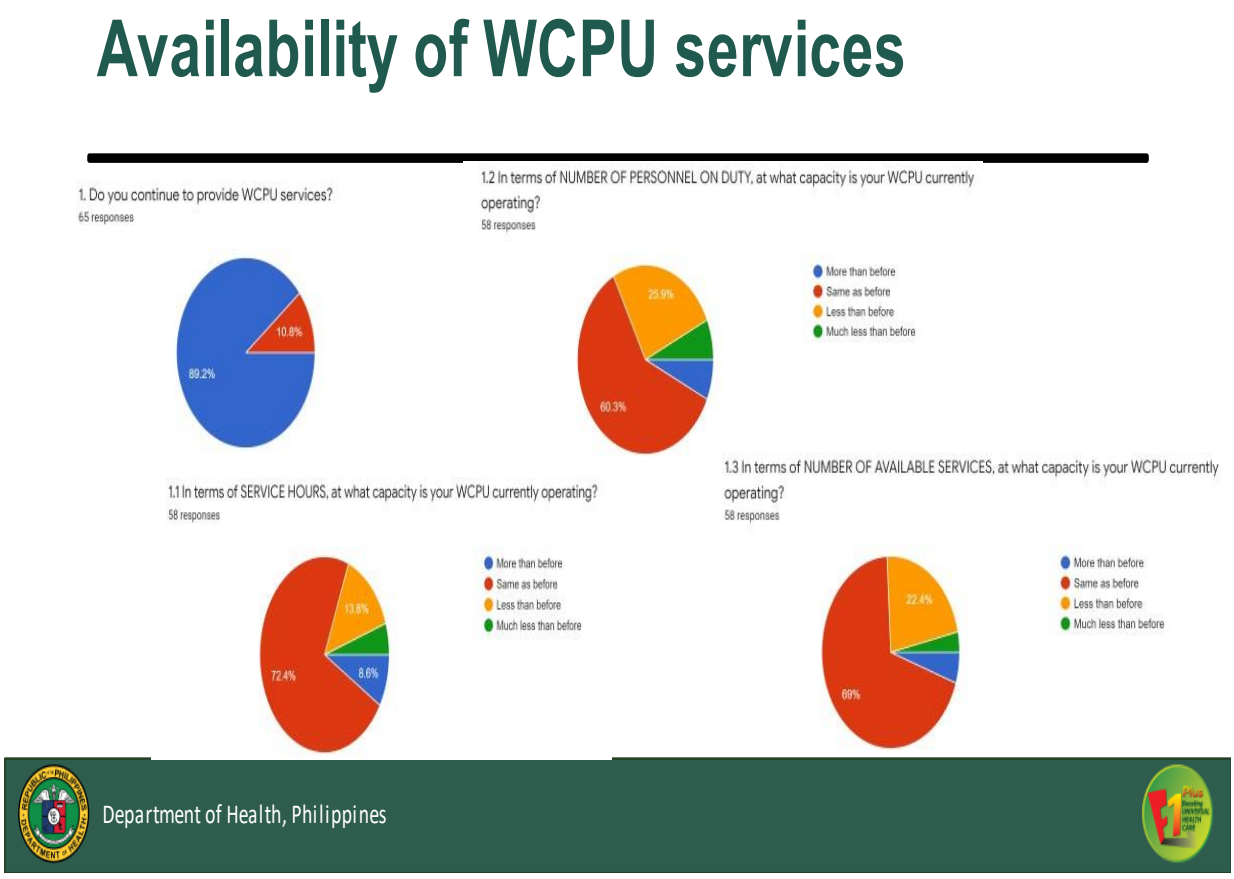
There was a total of 78 WCPU respondents in the survey conducted; all regions were represented. NCR had posted with the highest number of respondents at 18.

There were 16 respondents (83%) representing WCPUs while 13 respondents were WCPP Regional Coordinators

There were 58 out of the 65 responses who reported that they continue to provide WCPU during the COVID 19 period; while 7 respondents stated that they were unable to provide WCPU services. However, there were only 58 respondents who reported on the number of service hours they are operational which showed that 72% (42) were operational on the same number of hours as before.

There were 8 WCPUs who reported operating a lesser number of service hours compared to pre-covid. It was also noted that there were 5 WCPUs reporting that they are having increased operating hours during the COVID 19 period. In terms of the number of services available, there were 40 WCPUs who reported having the same number of available WCPU services at this time while 13 reported offering a smaller number of WCPU services.

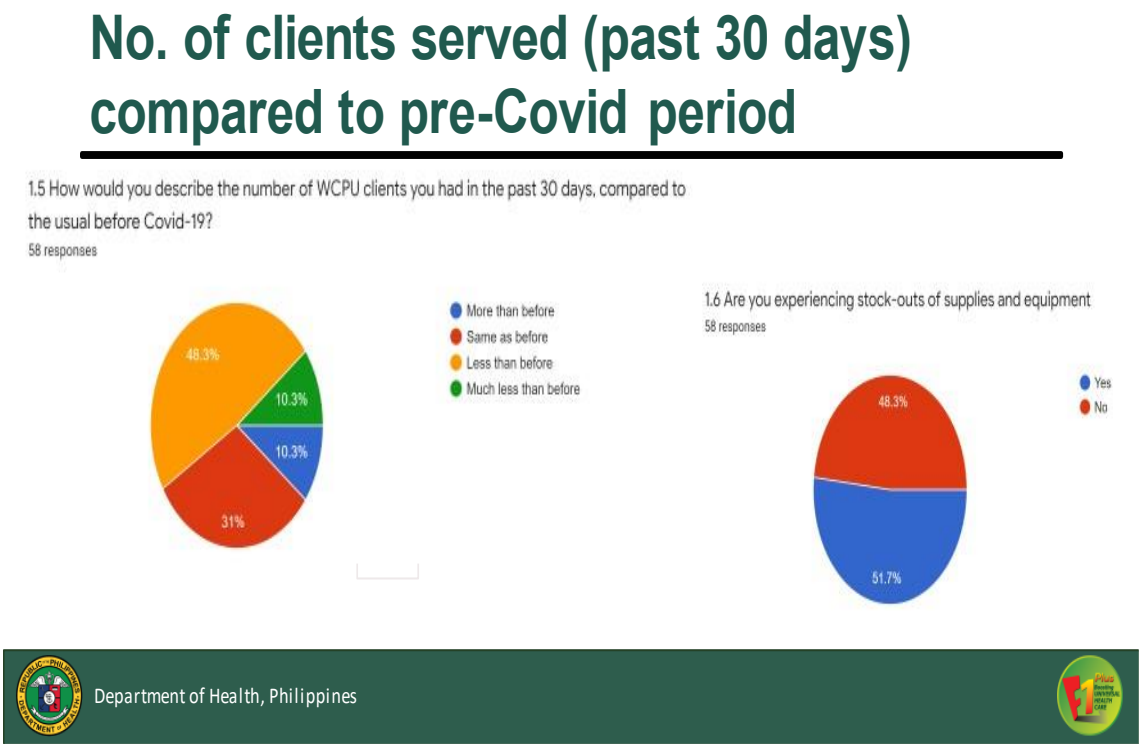
Figure 2. Availability of WCPU Services, DOH-WCPP, 2020



In terms of the number of personnel there were 35 respondents out of the 58 (60%) reported having the same number of personnel offering WCPU services at this time while 15 WCPUs reported having

less number of personnel on duty at this time. We also noted 4 respondents reporting having much less number of personnel on duty while 4 WCPUs also reported having an increased number of personnel on duty at this time.

Figure 3, Clients served



There were 28 WCPUs who reported having lesser number of clients reporting during the COVID 19 period. Furthermore, there were 30 WCPUs (31%) who reported having ran out of supplies and equipment during the period

The analysis on the reported status of WCPP Program and WCPU Services identified some of the key challenges and operational bottlenecks which were experienced by the service providers. Apparently, some of these issues were intensified during the pandemic period. The following Table shows us the list of these issues which were clustered and organized into thematic areas:

Table 1. Summary of Issues and Challenges per cluster

Thematic Areas	ISSUES/ CHALLENGES
Facility	• NO AVAILABLE ROOM; LIMITED SPACE • LACK OF PRIVACY & CONFIDENTIALITY • DIFFICULTY IN ESTABLISHING WCPU DUE TO COVID 19 PANDEMIC
Human Resource	• LACK OF NURSES; LACK OF DESIGNATED SOCIAL WORKERS EXCLUSIVELY FOR WCPUs • LESS NUMBER OF STAFF DUE TO SKELETAL DUTIES • NEED FOR FULL TIME STAFF • AVAILBAILITY OF WCPU SPECIALIST
Capacity Building	• NO TRAINED DOCTORS AND SOCIAL WORKERS • FEW SERVICE PROVIDERS TRAINED • UNABLE TO SEND TRAINEES FOR 4R'S
Support System	• WCPUs NOT BEING GIVEN PRIORITY AT THIS TIME • NEED FOR TRANSPORTATION SERVICES FOR STAFF • POOR ACCESS OF CLIENTS TO VAWC SERVICES DUE TO LACK OF TRANSPORT SERVICES • INADEQUATE PROTECTION OF PATIENTS AND HEALTH WORKERS AGAINST COVID 19 • INADEQUATE FUNDS TO SUPPORT OPERATIONS
Monitoring & Evaluation	• DELAYED REPORTING DUE TO LIMITED TRANSPORT • DIFFICULTY IN REGIONAL MONITORING OF WCPU TO INCLUDE DATA GATHERING • DECREASE IN THE NUMBER OF REPORTED VAWC CASES DUE TO POOR REPORTING OF CASES • POOR FOLLOW UP OF VAWC CLIENTS • VAWC REGISTRY PROBLEMS (e.g., internet connectivity)
Access to VAWC Services	• FEAR OF EXPOSURE TO COVID 19 HINDERING ACCESS TO HOSPITAL FACILITIES • REQUEST FOR HOME VISITS ARE NOT DONE • COORDINATION & TRANSFER TO TEMPORARY SHELTERS ALMOST IMPOSSIBLE • NEED CLOSE COORDINATION WITH BARANGAY (I.E. WCP DESKS, BCPCs)
Referrals	• INCOMPLETE INFORMATION OF REFERRED CASES • POOR INTER-AGENCY REFERRAL AND FOLLOW UP • RISKS POSED BY CPU REFERRALS WHO ARE COVID 19 SUSPECTS OR NON-COVID 19 CLIENTS WHO ARE POSITIVE
Program concerns	• NO ESTABLISHED PROGRAM DIRECTION • NEED TO DEVELOP A STRATEIC PLAN • NEED TO ORGANIZE WCPU TEAMS

In summary the following were the major areas of concern that needs to be addressed by the WCPP:

- Strategic Directions and Program Plans need to be formulated
- Availability of funds to support WCPU operations
- Setting up of WCPUs in some areas

- Requirement for additional Human Resource Requirements (preferably plantilla position) & capacity building of the WCPU team (under the new norm)
- Support Systems to improve access to integrated and comprehensive VAWC services
- Strengthening of the Community based response (Barangay level) & Referral System pathways/ protocol
- Improving the WCPU Monitoring and Database registry (specifically on reporting systems and the VAWC registry)
- Ensuring protection and safety nets for both the clients and WCPU providers
- Strengthening of Inter-Agency and Non-Government sector collaboration/ partnership

Addressing violence against women during the COVID 19 response [8]

The WHO recommends the following actions in terms of addressing VAWC during the COVID 19 Pandemic:

1. That Governments and policy makers must include essential services to address violence against women and children in preparedness and response plans for COVID 19, fund them, and identify ways to make them accessible and safe in the context of physical distancing measures, use of PPEs, etc.
2. Health facilities should identify and provide information about services available locally (e.g., hotlines, shelters, rape crisis centers, counselling) for survivors, including opening hours, contact details, and whether services can be offered remotely, and establish referral linkages.
3. Health providers need to be aware of the risks and health consequences of violence against women and children. They can help women and children who disclose by offering first-line support and medical treatment. First-line support includes: listening empathetically and without judgment, inquiring about needs and concerns, validating survivors' experiences and feelings, enhancing safety, and connecting survivors to support services. The use of mHealth and telemedicine in safely addressing violence against women and children must urgently be explored.
4. Humanitarian response organizations need to include services for women and children subjected to violence in their COVID 19 response plans and gather data on reported cases of violence against women.

[8] WHO/SRH/20.04 © World Health Organization 2020. https://www.who.int/reproductivehealth/topics/violence/en/. These recommendations were considered in the course of identifying the strategies/ interventions for the Women and Children Protection Program CIP.

IV. The Strategic and Results Framework for the Women and Children Protection Program

The Women and Children Protection Program [WCPP] - Costed Implementation Plan identified its Goals and Objectives to be met within the years 2021-2025. A Strategic Framework was initially formulated seen in Figure 4 which then evolved to the formulation of the Key Result Areas as seen in Figure 5.

The WCPP envisions a gender-fair and violence-free community where women and children are empowered with a mission to improve strategies towards a violence-free community through more systematic primary prevention, accessible and effective response system and strengthened functional mechanisms for coordination, planning, implementation, monitoring, evaluation and reporting.

The goal of the WCPP is: To increase the number of VAWC cases appropriately managed in health facilities

The identified WCPP Outcome at the end of five years are as follows

- Outcome1: Functional WCPUs providing a comprehensive and integrated VAWC services scaled-up and expanded
- Outcome2: Systematic primary VAWC prevention thru health promotion and advocacy strategies established
- Outcome3: Strengthened management structures and systems on WCPP for coordination, planning, implementation, monitoring, evaluation and reporting
- Outcome4: An enabling environment established that supports equitable access to an adaptive and resilient VAWC services among gender-based violence victims and survivors
- Outcome 5: Mobilize adequate and sustainable financial resource to support program and services for VAWC victims/ survivors

To reach the outcomes, the following strategic objectives had been identified:

1) Increase the number of functional WCPUs offering a comprehensive VAWC services nationwide consistent with the "new norm";
2) Ensure availability of the required WCPU human resource and multi-discipline team;
3) Design a Social and Behavior Change Communication Strategy for primary VAWC prevention
4) Create an enabling system to provide a supportive environment
5) Establish a robust VAWC management information system
6) Explore and tap available funding source to finance WCPP programs and services;

The following Key Results Areas (KRA) were identified to achieve the goals and objectives of the WCPP program

KRA 1: Increased availability of functional WCPUs and VAWC Desks in all levels adapting to the “new norm”

KRA 2: Intensified Social & Behavior Change Communication Strategies implemented

KRA 3: Improved Access to integrated and comprehensive VAWC services through appropriate referral networks

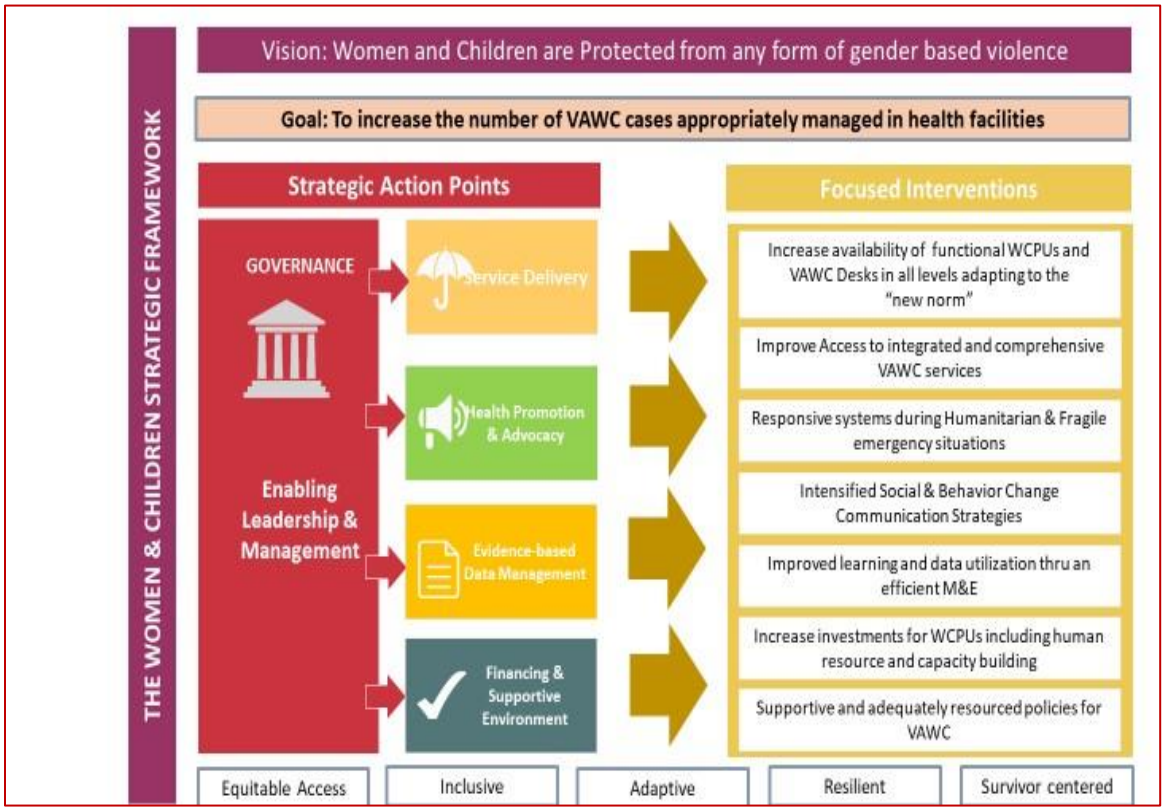
KRA 4: Responsive systems during Humanitarian & Fragile emergency situations

KRA 5: Improved learning and data utilization thru an efficient M&E

KRA 6: Increase investments for WCPUs including human resource and capacity building

KRA 7: Supportive and adequately resourced policies for VAWC

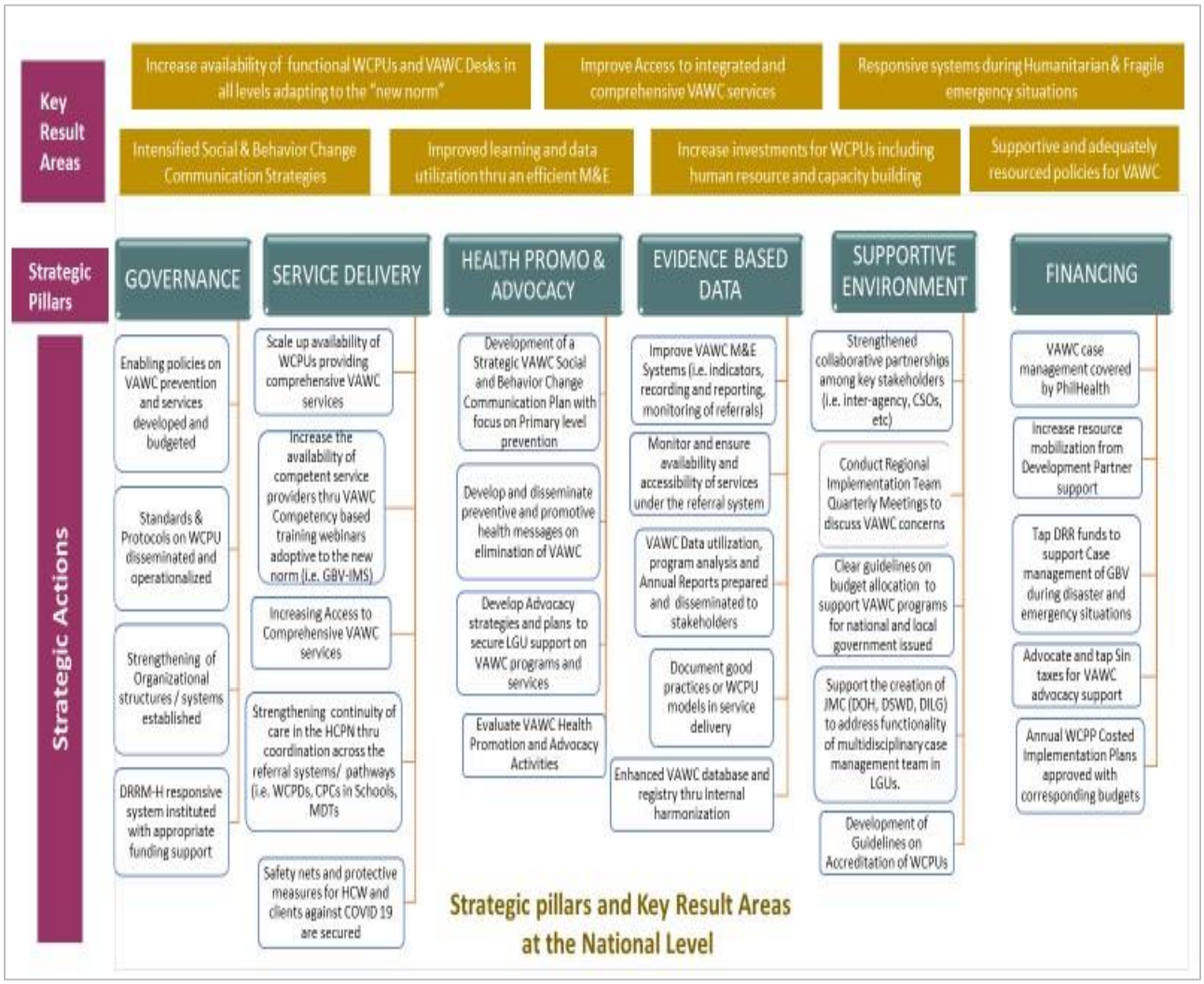
Figure 4. The WCPP Strategic Framework



There are six strategic pillars (SP) identified which are consistent with the existing policies and guidance governing the overall health strategy of the DOH. These strategic pillars are the provided with strategic actions (SA) which are sets of activities contributing to the achievement of the results.

Pillar	Strategic Pillar	Number of Strategic Actions
I	Leadership and Governance	Four strategic actions
II	Service Delivery	Five strategic Actions
III	Health Promotion and Advocacy	Four strategic actions
VI	Evidence based Data	Five strategic actions
V	Supportive Environment	Five strategic actions
VI	Financing	Five strategic actions

Figure 5. The Results Framework



V. Major Activities and Costing per Strategic Pillar

The section provides the detailed description and costing of the major strategies per strategic pillar. There are six strategic pillars with very specific actions that were identified. These intervention areas were agreed upon through participative discussions with the Regional and local partners. Further refinements were inputted by the WCPP TWG and further reviewed by the Program Manager at the Central DOH.

The Table below presents the major activities per Strategic Action, the expected outputs and corresponding costing. Timelines were also reflected in terms of prioritization.

The costing templates used to project/ calculate the required budgets are in the Annex section

1. Leadership and Governance Pillar

The leadership and governance pillar are critical in ensuring that the WCPP focuses its attention in ensuring that Women and Child Protection Units are established in government facilities both in DOH retained hospitals as well as LGU funded hospital facilities. Policies, standards and protocols need to be in place to support WCPU functionality in these facilities.

Strat Action	Major activities	Expected Output	Budget Summary	Timeframe					Responsible Agency
				2021	2022	2023	2024	2025	
1.1. Enabling policies on VAWC prevention and services developed and budgeted	Development of a New Administrative Issuance on the WCPP Strategic Framework and Implementation Plan (including description of the roles and responsibilities of the DOH, TWG, and Key Stakeholders	New Administrative Issuance on WCPP and the Estrablishment of Women and Child Protection Unit in Hospitals	1,200,000.00						DOH Central
1.2. Standards & Protocols on WCPU disseminated and operationalized	Review and Standardization of Clinical Practice Guidelines for WCPU (as an ANNEX to the revised AO)	Standards and CPGs developed and disseminated							
1.3. Strengthening of Organizational structures / systems established	Revision of the Manual of Procedures on the Women and Children Protection Program and Services	MOP Reviewed, Revised and disseminated							
	Dissemination activities								
1.5. DRRM-H responsive system instituted with appropriate funding support	Review/ Enhance the MISP guidelines on coordination and integration of VAWC response in HEMB-DRRMC-H MISP program plans.	Internal coordination with HEMB DRRMC-H MISP program established							
	GRAND TOTAL		**1,200,000.00**						

2. Service Delivery Pillar

The Service Delivery Pillar identified focuses on the scale up and expansion of WCPUs providing an integrated and comprehensive VAWC services. It covers human resource requirements, competency-based training, improving access to VAWC services through Telemedicine and Helplines in strategic areas. It also includes the strengthening of referral pathways across the health care provider network within the province-wide/ city-wide health delivery system of the Universal Health Care.

Strat Action	Major activities	Expected Output	Budget Summary	Timeframe					Responsible Agency
				2021	2022	2023	2024	2025	
2.1. Scale up/ expand availability of WCPUs providing integrated and comprehensive VAWC services	Formulation of Guidelines to expedite technical assistance and transfer of funds in support to setting up and operations of WCPU in all DOH Retained Hospitals and LGU operated hospital facilities	Guidelines disseminated on fund transfers to support setting up and operations of WCPUs							DOH Central
	Staffing of Multidisciplinary team to work on fulltime/ per WCPU (for DOH retained hospitals):	WCPUs staff with plantilla positions for Multidisciplinary teams	120,805,644.96						Lobby to DBM
	1.Provide Augmentation Funds to ensure that all hospitals (DOH-retained and LGU based) have operational WCPU (Issuance of DOH Guidelines to tap GAD funds) 2. Continue to lobby for establishment of WCPU in Government-retained and LGU-based hospitals (provincial level)	Augmentation funds are allocated to support WCPUs in DOH Retained Hospitals	50,350,000.00						DOH Retained Hospitals/ LGU operated WCPUs (with fund augmentation from DOH Central
	Equipping WCPU (Capital Outlay)	WCPUs capacitated to provide VAWC services	7,584,800.00						
	Sub-total		**178,740,444.96**						

Strat Action	Major activities	Expected Output	Budget Summary	Timeframe					Responsible Agency
				2021	2022	2023	2024	2025	
2.2,Capability building to Increase availability of competent VAWC service provider through competency based training	Development of the Training Plan on the WCPU Competency building for healthcare providers	Training Plan developed	165,000.00						DOH Central with Technical and Funding Assistance from Child Protection Network/ UNFPA
	Development of Online Training Modules on various modalities (e.g. face to face, online with practicum, etc.) and to include Trauma Informed Psychosocial Processing as well as development of Psycho-education Modules	Training Modules developed and implemented	4,646,000.00						
	Conduct of Online Training Courses	24 WCPUs trained on online courses	254,000.00						
	Conduct Practicum Phase of Training	MDTs in 24 WCPUs completed practicum phase of training	3,600,000.00						
	Build capacities of DOH Retained Hospitals as VAWC Certified Training Institutions	DOH Retained Hospitals capacited as VAWC Certified Training Institutions	4,000,000.00						
	Guidelines developed on the Transfer of Technical and Funding Support to National and Regional Training Institutions for conduct of training activities nationwide	Transfer of Technical and Funding Support to National and Regional Training Institutions for conduct of training activities completed	2,500,000.00						
	Develop and implement a supervision and mentoring strategy and guide to support WCPU staff and other healthcare providers in the HCPN	Supervision and Mentoring Strategies developed and implemented at the various WCPU implementing levels	4,110,000.00						
	Subtotal		**19,275,000.00**						

Strat Action	Major activities	Expected Output	Budget Summary	Timeframe					Responsible Agency
				2021	2022	2023	2024	2025	
2.3. Increasing Access to Comprehensive VAWC services	Development of guidelines for the establishment of WCPU helpline and telemedicine	Functional helpline and telemedicine	700,000.00						DOH Central with Technical and funding assistance from CPN /UNICEF
	Establish and set up operations for WCPU telemedicine and helpline	to support WCPU facilities are	3,724,000.00						
	Subtotal/year		4,424,000.00						
	Total for 5 years		**36,461,475.00**						
2.4. Strengthening continuity of care in the HCPN thru coordination across the referral systems/ pathways (i.e. WCPDs, CPCs in Schools, Multi-Disciplinary Teams)	Review and Enhancement of the Referral System/ Pathway on VAWC	Referral Systems/ Pathways on VAWC management established in the health care delivery network	870,000.00						DOH Central/ Regional Offices
	Identify available HCPN and coordinate all service providers, stakeholders and keyplayers like the WCPD, CPCs & MDT to establish a referral system								
	Subtotal		**870,000.00**						
2.5. Safety nets and protective measures for HCW and clients against COVID 19 are secured		Healthcare providers are provided with safety nets and protective euipment							DOH Retained and LGU operated WCPUs
	GRAND TOTAL		**235,346,919.96**						

3. Health Promotion and Advocacy Pillar

The Health Promotion and Advocacy Pillar provides the clients with critical information on VAWC prevention as well as informing them what are the available VAWC services in established WCPUs and how to access them. These are anchored on a clearly defined Social and Behavior Change Communication and Advocacy Plans to reach and disseminate VAWC information among the vulnerable groups in the communities.

Strat Action	Major activities	Expected Output	Budget Summary	Timeframe					Responsible Agency
				2021	2022	2023	2024	2025	
3.1. Develop Advocacy strategies and plans to secure LGU support on VAWC programs and services	Development of VAWC Social and Behavior Change Communication and Advocacy Strategic Plan	VAWC SBCC Strateic Plan Developed and Implemented	500,000.00						DOH Central (DPCB/Health Promo Bureau)
3.2. Preventive and promotive health messages and services on VAWC enhanced in all health care delivery system	Development of Key Messages on preventive and promotive health to eliminate VAWC including advocacy messages for LGU support	Development of Key messages and dissemination through various media platforms conducted	820,000.00						
	VAWC Elimination Campaign	Documentation of VAWC Elimination Campaign	45,000,000.00						
	Media Placement for TV and Radio Ads	Air time on various media placement	45,000,000.00						
	Billboard Ads Placement (Buses/ Train wraps)	Documentation of Billboard Ads Placement	129,000,000.00						
3.3. Evaluate VAWC Health Promotion & Advocacy Strategies	Conduct of Evaluation on the VAWC SBCC Strategies	Evaluation of VAWC SBCC Strategy conducted	1,403,000.00						
	GRAND TOTAL		**221,723,000.00**						

4. Pillar on Evidenced based Data

This pillar on Evidenced based Data identifies strategies to address information gaps and harmonization concerns among the various key stakeholders of the VAWC program. The process would enable the institutionalization of a robust, real time and relevant information that serves as basis or reference in the program analysis and planning purpose.

Strat Action	Major activities	Expected Output	Budget Summary	Timeframe					Responsible Agency
				2021	2022	2023	2024	2025	
4.1. Improve VAWC M&E Systems (i.e. indicators, recording and reporting, monitoring of referrals) for monitoring the WCPP Implementation including WCPU operations	Develop and implement the overall WCPP M&E Framework and Plan using the WCPP Strategic Plan as reference	WCPP M&E Framework developed and disseminated to regionl and local partners	1,070,000.00						DOH Central
	Train and capacitate WCPP Regional Coordinators and WCPU Focal persons on the use of WCPP monitoring tools								
	Develop and implement an online VAWC database to ensure timely and accurate reporting mechanisms on VAWC cases	Online VAWC database operational	7,411,000.00						DOH Central with Technical suppot and funding from CPN/UNFPA
4.2. VAWC Learning and Data analysis and utilization thru conduct of program implementation review and planning	Conduct of WCPP Program Performance Review (Online)	Regular conduct of WCPU Program Performance Review	810,000.00						DOH Central
4.3. Development of Annual WCPP Progress Reports completed and disseminated			4,870,000.00						DOH Central/ Regional Coordinators
4.4. Document good practices or WCPU models in service delivery	Documentation of Best Practices and Good Models (third year)	Documentation of Best Practices and Good Models (third year)	3,900,000.00						DOH Central
	-Ensure that best practices/ documenting changes in behavior and good models in relation to the SBCC strategy are documented -Document the linkage of the WCPU work at the work at the LGU level								
4.5. Enhanced VAWC database and registry thru Internal harmonization (i.e. DOH, CPN) towards assured participation in the interface of VAWC data with other agencies (DOH, DSWD, PCW, PNP, etc.)	Continue ongoing work on internal harmonization (CPN and DOH-KMITS)	Report on progress of VAWC database and VAWC registry harmonization	8,760,000.00						DOH Central with Technical Assistance and Funding Support from CPN/UNFPA
	Close Coordination with other National Agencies to ensure interface of VAWC Data	Progress report on discussions and agreements between agencies on the interface of VAWC data							
	Grand Total		**26,821,000.00**						

5 Supportive Environment Pillar

The Supportive Environment Pillar is anchored on the collaborative work and partnership building among the key stakeholders to ensure that efforts and funding will be focused on project initiatives that supports the achievement of the WCPP Goals and Objectives. The partnership and collaborative effort can work at various levels from the national, regional, and local levels.

Strat Action	Major activities	Expected Output	Budget Summary	Timeframe					Responsible Agency
				2021	2022	2023	2024	2025	
5.1. Strengthened collaborative partnerships among key stakeholders (i.e. inter-agency, CSOs, CSWD, LSWD, etc)	Meetings (thru Webinars)	Minutes of Meetings and Agreements	500,000.00						DOH Central
5.2. Conduct Regional implementation team quarterly meetings where WCPP activities are discussed. Point persons in the provincial hospitals are identified,									DOH Regional
5.3. Development of guidelines on budget allocation to support VAWC programs for national and local government issued (i.e. tapping of GAD funds)	Development of Budget Allocation Guidelines to support VAWC programs and services (i.e. national and llocal government units) to incude tapping of GAD funds for operational support	Budget Guidelines using GAD Funds to support VAWC programs and services developed and disseminated	1,050,000.00						DOH Central
	Conduct research studies to map existing budgets related to VAWC (basis if it will be expanded/ adjusted) and...	Research studies to map existing budgets related to VAWC executed	1,400,000.00						DOH Central
	A study to earmark for budget allocation on VAWC-related programs in LGU level (Mandanas ruling)								
5.4. Support the creation of JMC specifying delineation of roles and coordinative function (DOH, DSWD, DILG) to address functionality of multidisciplinary case management team in LGUs	Formulation of the Joint Memorandum Circular (to include PCW, CHR, CWC, DepEd, PNP,)	Joint Memorandum Circular Formulated	350,000.00						Inter-Agency Task Forces on VAW and VAC
	Conduct of annual conferences including case management (year 3-5)	Case Management Conference among WCPU practitioners conducted annually	12,500,000.00						DOH with Technical support from CPN
5.5. Guidelines on the accreditation of WCPUs	Development of Accreditation Guidelines	Accreditation Guidelines on WCPUs issued	500,000.00						DOH Central / PhilHealth
	GRAND TOTAL		**16,300,000.00**						

6. Sustainable Financing Pillar

The Sustainable Financing Pillar focused on strategies and activities that explores mechanisms on how the WCPP programs including the WCPU operations will be sustained. A critical step in this pillar is the inclusion of VAWC case management as part of PhilHealth coverage.

Strat Action	Major activities	Expected Ouput	Budget Summary	Timeframe					Responsible Agency
				2021	2022	2023	2024	2025	
6.1. VAWC case management covered by PhilHealth	Develop costing study on VAWC case management	Costing Study on VAWC Case Management carried out in support to PhilHealth coverage	3,300,000.00						DOH -Central/ PhilHealth
6.2. Increase resource mobilization from Development Partner support	**Convene round table discussion** --- present strat. plan of WCPP and budget requirements; pledging session --- secure specific budget allocation	Round table convened to present WCPP Plans and generate support from partner institutions; Partnership Agreements established	500,000.00						DOH Central/ DOH Regional Offices/ Dev Partners/ CSOs/ NGOs
	Request for possible Technical Assistance/ Collaborative areas to support WCPP Programs and services among the different Development Partners thru a partnership agreement describing the scope of TA Plan								Dev Partners
6.3. Tap DRR funds to support Case management of GBV during disaster and emergency situations	Collaboration with the DRR council --- orientation on how to access DRRM fund --- secure fund (on prevention) >Collaboration with HEMB and WCPP	Collaboration with HEMB established with agreements on ensuring case management of VAWC survivors during disasters and emergenciy situation	300,000.00						DOH Central
6.4. Advocate and tap Sin taxes for VAWC advocacy support	Non-government Stakeholders to convince Legislators to earmark WCP advocacy and services --- proposal to congress for special provision for the prevention of WCPP (e.g. rationalization: alcohol results to VAWC) --- tap committee/ person in the congress --- present utilization of GAD and its plan --- present costing study as evidence-based --- collborate with CSOs and other agencies for advocacy and lobbying (e.g. SWP, Action for Economic Reforms, Sin Tax Coalition)	Advocacy plan developed to to tap and use SIN Taxes in suppot to VAWC advocacy group	500,000.00						CSOs/ Dev Partners
6.5. Annual WCPP Costed Implementation Plans approved with corresponding budgets	Annual Review of the WCPP Strategic and Costed Implementation Plan [include PS, MOOE (operational requirements, activities[health promo], logistics[highlight commodities like rape kits]), capital outlay [lobby in DBM]; lobby WCP budget line item in DOH	Annual Review of the WCPP Strategic Plan conducted and used as reference in preparation of Annual Work and financial Plans	1,970,000.00						DOH Central
	GRAND TOTAL		**6,570,000.00**						

Summary of WCPP 2021-2025 Projected Budgetary Costs

Summary of WCPP Budgetary Costs 2021-2025

Strategic Pillar	Total Budget per Pillar	%
Leadership & Governance	1,200,000.00	0.24
Service Delivery	235,346,919.96	46.33
Health Promotion & Advocacy	221,723,000.00	43.65
Evidence based Data Management	26,821,000.00	5.28
Supportive/Enabling Environment	16,300,000.00	3.21
Sustainable Financing	6,570,000.00	1.29
Total CIP Budget for 5 years	**507,960,919.96**	**100**

Based on the Summary of WCPP projected budgetary costs, 46 percent was prioritized for ensuring the establishment of WCPUs in the hospitals to deliver VAWC services. 44 percent was budgetted ro ensure that health promotion and advocacy activities are in place to inform the VAWC clients on available services at all points of contact. 5 percent was invested for ensuring evidence-based data management.

VI. Indicative Directional Plan for 2021

For the year 2021, the priority activities and investments were on focused on the integration of the WCPUs in the Health Facility Development Plan for 2020-2040; lobbying of DOH Central Office and Regional WCPP Coordinators with the Local Government Units for establishing WCPUs in the remaining 24 LGU operated hospitals; and the conduct of Online Training Activities to capacitate Multi-disciplinary Teams in the WCPUs.

	GAPS	ACTIONS TO BE UNDERTAKEN	TIMELINE											
			JAN	FEB	MAR	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
Governance	WCPP CIP/ Strategic Plan	For presentation, finalization, approval and endorsement												
	Need to integrate WCPU operations in the Philippine Health Facilities Development Plan 2020-2040	-Draft D.O. on Creation of Ad hoc Technical Working Group (Adhoc TWG) for WCPP												
		- Notice of Meeting- TWG members												
		- Review membership, functions, reconstitution												
		- Prepare working documents												
		Coordination with Health Facilities Bureau to include/integrate WCPUs in the PHFDP (2020-2040)												
		- Review Manual of Operations for the establishment of WCPU												
	Standardized protocol in medical assistance /response	Review published WHO and other agency Standards, Protocols on Clinical Practice Guidelines for WCPUs / Issuance of Policy on adoption of CPGs												
		Review and enhancement of the Referral System / Pathway on VAWC Identify available HCPN and coordinated all service providers, stakeholders, and keyplayers like WCPD, CPCs and MDT to establish a referral system												
Human Resource for Health	No. of Training Center not enough to cover capacity building and practicum	Draft DM for the Secondary Training Centers												
	4Rs/ENTHAWC training modules needs improvement/ updating	Development of Training Plan with CPN and partners concerns for the competency of health care providers (online course)												
		Review of training modules on 4Rs with Reach Health (USAID), HHRDB and CPN												
	No. of trained health personnel are few	Mapping and inventory of HRH (CHDs and Hosp.)												
	Staff of Multidisciplinary Team (MDT) to work on fulltime per WCPU (for DOH-Retained Hospitals)	Identify plantilla positions of MDT for WCPU in DOH Retained Hospitals												
		- Meetings with Social Watch Philippines and other partners on Lobbying Plan for Plantilla Positions for WCPU												
		Conduct of WCPP Program Performance Review (online)												
		Virtual Meeting the Reg'l WCPP on Lobbying and getting the commitment of Local Chief Executives (Provincial/ City) for the establishment of WCPUs												
Service Delivery	Scale -up availability of WCPUs providing comprehensive VAWC services	Drafting of sub-allotment Guidelines in support to setting up and operations of WCPU in all DOH Retained Hospitals and LGU operated hospital facilities												
		Establishment of WCPUs in remaining LGUs & DOH Retained Hospitals												
		Regional Coordinators to lobby with LGUs in establishing WCPUs begin												
		Provide augmentation funds to ensure that all hospitals (DOH-Retained and LGU-managed) have operational WCPU (issuance of DOH Guidelines to tap GAD funds)												
		Online training of Multi-disciplinary Teams for the establishment of WCPUs in 24 provinces												
Health Info System	Irregular use of VAWC Registry System for reporting	Enhanced VAW /VAC Registry System												
		- Send Draft of VAWC Registry form for enhancement to KMITS												
		- Meetings with KMITS												
	Inaccurate and possible double reporting of cases	Data harmonization systems (VAWCRS and CPMIS of CPN)												
		Monitoring and Evaluation Framework and Plan, Tool												
Financing	Philhealth package	Advocate / discuss with Philhealth	To begin in 2022											

[BM3][JI4]

Source: DOH WCPP Program Manager, 2021

VII. CIP Implementation Mechanism

To ensure efficient and clear execution of this Costed Implementation Plan of the WCPP, it is necessary to define implementation mechanisms as per existing guidelines and structure of the Department of Health.

Institutional Arrangements

The Women and Men's Health Development Division of the Disease Prevention and Control Bureau particularly under the Women and Children Protection Program is currently providing technical oversight in establishing the Women and Children Protection Units in DOH Retained hospitals and in close collaboration with Local Government Units for the LGU operated hospital facilities.

Within the DOH, the WCPP-WMHDD shall ensure that program components responsible to support the implementation of the WCPP will have appropriate funds for activities and program commodities. Likewise, this arrangement will be mirrored by regional DOH offices and respective program managers/coordinators at the implementing levels. However, mirroring is subject to the integration in the existing structures at the regional and local levels.

Likewise, WMHDD-WCPP are responsible for ensuring that programmatic coordination with other DOH Bureaus and Offices as deemed appropriate. Likewise, close coordination and engagement of other national agencies of concern such as CWC, PNP, PWC, NGOs (i.e., CPN, Social Watch, etc.) and development organizations (USAID, UNFPA) shall be maintained

Annual Budget Allocation and Resource Mobilization

At the National Level, WCPP-WMHDD under the DPCB are mandated to appropriate budget for the implementation of the CIP for WCPP specifically in ensuring the operation of a functional Women and Children Protection Units in the public setting. It shall also advocate to other key stakeholders to support the other areas reflected in the CIP to complement and contribute to the achievement of the goals and objectives. This shall include close coordination and engagement with the other national agencies to advocate for budgetary inclusion of identified activities in their respective Agencies.

Monitoring of the WCPP CIP Implementation

Primarily, the WCPP is tasked to monitor the implementation of the Costed Implementation Plan and its compliance to the internationally recognized standard particularly in the establishment of functional women and child protection units in the different service delivery level. The monitoring shall include institutional and operational components of the WCPP with specific emphasis on WCPU functionality in all level of governance and service delivery.

For this CIP, this is the operational tool of the WCPP which will serve as an investment monitoring embedded in the key strategies for the program. This will be monitored by the WCPP Technical Working Group, but with leadership from DOH WCPP-WMHDD.

Evaluation and Reprogramming of CIP

Annually, there will be an Annual Investment Plan (AIP) for the Program, as an operational tool for the CIP on WCPP. The Annual Investment Plan will be collaboratively developed by concerned offices, and will serve as the reference for the Annual Work Plan of each programme. Thru this, investments will be tracked systematically for the WCPP CIP.

The WCPP shall be reviewed and updated as deemed appropriate by the Program Manager. The CIP serves as the reference document of the program to ensure that all strategies and interventions as set in the CIP will have been adequately budgeted and implemented at the operational levels.

ANNEXES

Annex. 1 Annual WCPP Cost of Implementation by Annual Level of Effort (indicative) – Part 1

Summary of WCPP Annual Cost of Implementation (2021-2025)

Strategic Pillar	Projected Cost	Annual Level of Effort					Annual Cost of Implementation				
		2021	2022	2023	2024	2025	2021	2022	2023	2024	2025
Strategic Pillar I: Leadership & Governance	1,200,000.00						480,000.00	540,000.00	180,000.00		
Enabling policies on VAWC prevention and services developed and budgeted	600,000.00	30%	40%	30%			180,000.00	240,000.00	180,000.00		
Standards & Protocols on WCPU disseminated and operationalized											
Strengthening of Organizational structures / systems established	400,000.00	50%	50%				200,000.00	200,000.00			
Performance accountability measures are adopted											
DRRM-H responsive system instituted with appropriate funding support	200,000.00	50%	50%				100,000.00	100,000.00			
		2021	2022	2023	2024	2025	2021	2022	2023	2024	2025
Strategic Pillar II: Service Delivery	235,346,919.96						13,457,647.50	13,248,795.00	14,967,442.50	14,758,590.00	174,000.00
Scale up availability of WCPUs providing comprehensive VAWC services thru											
a. WCPU Multidisciplinary team plantilla positions	120,805,644.96		25%	25%	25%	25%		31,790,959.20	63,581,918.40	95,372,877.60	120,805,644.96
b. Provide Augmentation Funds to ensure that all hospitals (DOH-retained) have operational WCPU [MOOE + Cap Outlay]	57,934,800.00	20%	20%	20%	20%	20%	11,586,960.00	11,586,960.00	11,586,960.00	11,586,960.00	11,586,960.00
Capability building to increase availability of competent VAWC service providers thru competency based training	**19,275,000.00**	50%	30%	20%			9,637,500.00	5,782,500.00	3,855,000.00	-	-
Increasing access to comprehensive VAWC services	**36,461,475.00**	10%	20%	30%	40%		3,646,147.50	7,292,295.00	10,938,442.50	14,584,590.00	
Strengthening continuity of care in the HCPN thru coordination across the referral systems/ pathways (i.e. WCPDs, CPCs in school, MDTs)	870,000.00	20%	20%	20%	20%	20%	174,000.00	174,000.00	174,000.00	174,000.00	174,000.00
		2021	2022	2023	2024	2025	2021	2022	2023	2024	2025
Strategic Pillar III: Health Promotion & Advocacy	221,723,000.00							1,070,000.00	109,750,000.00	66,541,800.00	44,361,200.00
Development of a Strategic VAWC Social and Behavior Change Communication and Advocacy Plan	500,000.00		50%	50%				250,000.00	250,000.00		
Development of Key Messages on preventive and promotive health to eliminate VAWC including advocacy messages for	820,000.00		100%				-	820,000.00	-	-	-
Media Ads Placement and Campaigns	219,000,000.00			50%	30%	20%			109,500,000.00	65,700,000.00	43,800,000.00
Evaluate VAWC Health Promotion & Advocacy Strategies	1,403,000.00				60%	40%				841,800.00	561,200.00

Annex A.2. Part 2

Summary of WCPP Annual Cost of Implementation (2021-2025)

Strategic Pillar	Projected Cost	Annual Level of Effort					Annual Cost of Implementation				
		2021	2022	2023	2024	2025	2021	2022	2023	2024	2025
Strategic Pillar IV: Evidence-based Data Management	31,101,000.00						5,440,200.00	5,440,200.00	7,000,200.00	6,610,200.00	4,058,000.00
Improve VAWC M&E Systems (i.e. indicators, recording and reporting, monitoring of referrals) for monitoring the WCPP Implementation including WCPU operations	12,761,000.00	20%	20%	20%	20%	20%	2,552,200.00	2,552,200.00	2,552,200.00	2,552,200.00	2,552,200.00
VAWC Learning and Data analysis and utilization thru conduct of program implementation review	810,000.00	20%	20%	20%	20%	20%	162,000.00	162,000.00	162,000.00	162,000.00	162,000.00
Development of Annual WCPP Progress Report completed and disseminated	4,870,000.00	20%	20%	20%	20%	20%	974,000.00	974,000.00	974,000.00	974,000.00	974,000.00
Document Good practices on WCPU Models in Service Delivery	3,900,000.00			40%	30%	30%			1,560,000.00	1,170,000.00	1,170,000.00
Enhanced VAWC database and registry thru Internal harmonization (i.e. DOH, CPN) towards ensured participation in the interface of VAWC data with other agencies (DOH, DSWD, PCW, PNP, etc.)	8,760,000.00	20%	20%	20%	20%	20%	1,752,000.00	1,752,000.00	1,752,000.00	1,752,000.00	1,752,000.00
		2021	2022	2023	2024	2025	2021	2022	2023	2024	2025
Strategic Pillar V: Supportive Environment	16,300,000.00						3,210,000.00	4,000,000.00	3,260,000.00	3,160,000.00	2,670,000.00
Strengthened collaborative partnerships among key stakeholders (i.e. inter-agency, CSOs, etc) Conduct Regional Implementation Team Meetings where WCPP activities are discussed. Engage provincial point persons in the hospital	500,000.00	20%	20%	20%	20%	20%	100,000.00	100,000.00	100,000.00	100,000.00	100,000.00
Develop clear guidelines on budget allocations to support VAWC programs issued at the national and local governments units based on research to map budget allocation/ expenditures on VAWC programs in all levels	2,450,000.00	20%	40%	20%	20%		490,000.00	980,000.00	490,000.00	490000	
Support the creation of JMC specifying delineation of roles and coordinative functions of DOH, DILG, DSWD to address functionality of the multidisciplinary case management team in LGUs	350,000.00	20%	20%	20%	20%	20%	70,000.00	70,000.00	70,000.00	70,000.00	70,000.00
Conduct of annual conferences on case management	12,500,000.00	20%	20%	20%	20%	20%	2,500,000.00	2,500,000.00	2,500,000.00	2,500,000.00	2,500,000.00
Develop guidelines for accreditation of WCPUs to PhilHealth	500,000.00	10%	70%	20%			50,000.00	350,000.00	100,000.00		
		2021	2022	2023	2024	2025	2021	2022	2023	2024	2025
Strategic Pillar VI: Sustainable Financing	6,570,000.00						1,154,000.00	3,434,000.00	704,000.00	734,000.00	544,000.00
VAWC Case Management covered by PhilHealth based from a Costing Study on VAWC case management	3,300,000.00	20%	80%				660,000.00	2,640,000.00			
Increase resource mobilization from development partners for support thru partnerhip agreements	500,000.00	20%	20%	20%	20%	20%	100,000.00	100,000.00	100,000.00	100,000.00	100,000.00
Tap DRRM funds to support GBV case management during disasters and emergency situations	300,000.00		50%	20%	30%			150,000.00	60,000.00	90,000.00	
Advocate and tap SIN Taxes for VAWC advocacy support	500,000.00		30%	30%	30%	10%		150,000.00	150,000.00	150,000.00	50,000.00
Annual VAWC CIP approved with budgetary support	1,970,000.00	20%	20%	20%	20%	20%	394,000.00	394,000.00	394,000.00	394,000.00	394,000.00

Annex B. Costing Template for WCPP Multidiscipline Team Plantilla Position and assumptions

Costing of Plantilla Position for DOH Retained Hospitals

POSITION TITLE	SALARY GRADE	BASIC SALARY	5% PREMIUM	TOTAL SALARY BASIC + 5%)	ANNUAL SALARY	Plus Calculated Benefits @ 30% of Annual	Total
WCPU MEDICAL OFFICER III	21	59,353.00	2,967.65	62,320.65	747,847.80	224,354.34	1,096,843.44
WCPU PSYCHOLOGIST III *	18	42,159.00	2,107.95	44,266.95	531,203.40	159,361.02	779,098.32
WCPU NURSE III *	17	38,464.00	1,923.20	40,387.20	484,646.40	145,393.92	710,814.72
WCPU MEDICAL SOCIAL WORKER	15	32,053.00	1,602.65	33,655.65	403,867.80	121,160.34	592,339.44
					Total Cost per Hospital Facility for 1 team per year		**3,179,095.92**

Assumptions:

The Costing of Plantilla Position included the minimum requirement for DOH personnel (Police officer will be handled under PNP; administrative officer can be assigned by Hospital)

The 30% benefit is calculated based from recommendations by Social Watch during the TWG

Plantilla items were recommended by DOH Program Manager with recommendation from the WCPP TWG (costs were based on standard government rates)

Annex C.1. Ranking of DOH Retained Hospitals per number of cases handled in the last 5 years

WCPUs	2015		2016		2017		2018		2019		Total # Cases	Prioritization for plantilla position)
Hospitals/ LGUs	Children	Women	Children	Women	Children	Women	Children	Women	Children	Women		
Vicente Sotto Memorial Medical Center	996	725	758	626	1024	612	981	658	745	5	7130	1
Southern Philippines Medical Center	660	459	643	413	353	213	784	476	609	563	5173	2
Zamboanga City Medical Center	317	355	390	342	565	368	687	362	728	356	4470	3
Baguio General Hospital and Medical Center	257	316	368	480	398	482	353	495	307	489	3945	4
Region I Medical Center	438	280	460	252	354	211	540	190	161	68	2954	5
Western Visayas Medical Center	376	79	299	64	380	103	486	123	512	165	2587	6
Eastern Visayas Regional Medical Center	343	0	110	64	499	231	216	109	389	216	2177	7
Davao Regional Medical Center	288	49	0	0	325	75	418	277	411	161	2004	8
Batangas Medical Center					438	318	340	217	372	208	1893	9
Dr. Paulino J. Garcia Memorial Medical Center	300	64	325	75	71	20	287	104	222	61	1529	10
Gov. Celestino Gallares Memorial Hospital	127	154	150	121	140	121	138	108	176	133	1368	11
Northern Mindanao Medical Center					371	52	320	78	259	55	1135	12
Cotabato Regional Medical Center	91	167	98	188	75	107	113	107	66	122	1134	13
Bataan General Hospital	107	22	131	44	176	37	179	82	221	93	1092	14
Veterans Regional Hospital	198	147	109	61	113	17	104	19	116	32	916	15
Bicol Medical Center	112	0	82	114	81	87	60	48	226	61	871	16
Philippine Children's Medical Center	142	0	168	0	148	2	156	1	98	0	715	17
Mariano Marcos Memorial Hospital & Medical Center	121	38	95	35	102	44	77	38	89	47	686	18
Mayor Hilarion A. Ramiro, Sr. Regional Training and Teaching Hospital	69	65	91	83	81	37	100	37	50	17	630	19
Bicol Regional Training and Teaching Hospital	5	4	86	56	63	42	86	67	71	44	524	20
Jose Lingad Memorial General Hospital	0	0	0	0	179	5	118	5	66	0	373	21
Ilocos Training and Regional Medical Center							113	31	139	61	344	22
Rizal Medical Center	0	0	0	0	33	6	100	23	0	0	162	23
Corazon Locsin Montelibano Memorial Regional Hospital	0	0	0	0	20	6	29	18	41	0	114	24
Margosatubig Regional Hospital					9	17	18	3	27	25	99	25
National Children's Hospital									41	4	45	26
San Lazaro Hospital							27	2	0	0	29	27
Cagayan Valley Medical Center									20	4	24	28

Note: This was used as reference in the prioritization of the proposed plantilla position for the WCPU staffing in the next 5 years

Annex C.2. Prioritizing 10 DOH Retained Hospitals (for MDT plantilla positioning)

WCPUs	Cost of Proposed Plantilla Position per year (Option 1:10 Hosp/Year)				
DOH Retained Hospitals	**2022**	**2023**	**2024**	**2025**	**2026**
Vicente Sotto Memorial Medical Center	**3,179,095.92**				
Southern Philippines Medical Center	**3,179,095.92**				
Zamboanga City Medical Center	**3,179,095.92**				
Baguio General Hospital and Medical Center	**3,179,095.92**				
Region I Medical Center	**3,179,095.92**				
Western Visayas Medical Center	**3,179,095.92**				
Eastern Visayas Regional Medical Center	**3,179,095.92**				
Davao Regional Medical Center	**3,179,095.92**				
Batangas Medical Center	**3,179,095.92**				
Dr. Paulino J. Garcia Memorial Medical Center	**3,179,095.92**				
Gov. Celestino Gallares Memorial Hospital		**3,179,095.92**			
Northern Mindanao Medical Center		**3,179,095.92**			
Cotabato Regional Medical Center		**3,179,095.92**			
Bataan General Hospital		**3,179,095.92**			
Veterans Regional Hospital		**3,179,095.92**			
Bicol Medical Center		**3,179,095.92**			
Philippine Children's Medical Center		**3,179,095.92**			
Mariano Marcos Memorial Hospital & Medical Center		**3,179,095.92**			
Mayor Hilarion A. Ramiro, Sr. Regional Training and Teaching Hospital		**3,179,095.92**			
Bicol Regional Training and Teaching Hospital		**3,179,095.92**			
Jose Lingad Memorial General Hospital			**3,179,095.92**		
Ilocos Training and Regional Medical Center			**3,179,095.92**		
Rizal Medical Center			**3,179,095.92**		
Corazon Locsin Montelibano Memorial Regional Hospital			**3,179,095.92**		
Margosatubig Regional Hospital			**3,179,095.92**		
National Children's Hospital			**3,179,095.92**		
San Lazaro Hospital			**3,179,095.92**		
Cagayan Valley Medical Center			**3,179,095.92**		
Quirino Memorial Med Center			**3,179,095.92**		
Far North Luzon General Hospital and Training Center			**3,179,095.92**		
Amang Rodriguez Memorial Medical Center				**3,179,095.92**	
Don Jose Monfort Medical Center Extension				**3,179,095.92**	
St Anthony Mother and Child Hospital				**3,179,095.92**	
Zamboanga del Sur Medical Center				**3,179,095.92**	
Tondo Medical Center				**3,179,095.92**	
Jose Reyes Memorial Medical Center				**3,179,095.92**	
San Lorenzo Ruiz Women's Hospital				**3,179,095.92**	
Las Pinas General Hospital and Satellite Trauma Hospital				**3,179,095.92**	
Yearly Total	**31,790,959.20**	**31,790,959.20**	**31,790,959.20**	**25,432,767.36**	

Annex C.3. Option 2 (Prioritizing 7 hospitals per year)

WCPUs	Cost of Proposed Plantilla Position per year (Option 2: 7 Hospitals per year)				
DOH Retained Hospitals	**2022**	**2023**	**2024**	**2025**	**2026**
Vicente Sotto Memorial Medical Center	**3,179,095.92**				
Southern Philippines Medical Center	**3,179,095.92**				
Zamboanga City Medical Center	**3,179,095.92**				
Baguio General Hospital and Medical Center	**3,179,095.92**				
Region I Medical Center	**3,179,095.92**				
Western Visayas Medical Center	**3,179,095.92**				
Eastern Visayas Regional Medical Center	**3,179,095.92**				
Davao Regional Medical Center		**3,179,095.92**			
Batangas Medical Center		**3,179,095.92**			
Dr. Paulino J. Garcia Memorial Medical Center		**3,179,095.92**			
Gov. Celestino Gallares Memorial Hospital		**3,179,095.92**			
Northern Mindanao Medical Center		**3,179,095.92**			
Cotabato Regional Medical Center		**3,179,095.92**			
Bataan General Hospital		**3,179,095.92**			
Veterans Regional Hospital			**3,179,095.92**		
Bicol Medical Center			**3,179,095.92**		
Philippine Children's Medical Center			**3,179,095.92**		
Mariano Marcos Memorial Hospital & Medical Center			**3,179,095.92**		
Mayor Hilarion A. Ramiro, Sr. Regional Training and Teaching Hospital			**3,179,095.92**		
Bicol Regional Training and Teaching Hospital			**3,179,095.92**		
Jose Lingad Memorial General Hospital			**3,179,095.92**		
Ilocos Training and Regional Medical Center				**3,179,095.92**	
Rizal Medical Center				**3,179,095.92**	
Corazon Locsin Montelibano Memorial Regional Hospital				**3,179,095.92**	
Margosatubig Regional Hospital				**3,179,095.92**	
National Children's Hospital				**3,179,095.92**	
San Lazaro Hospital				**3,179,095.92**	
Cagayan Valley Medical Center				**3,179,095.92**	
Quirino Memorial Med Center					**3,179,095.92**
Far North Luzon General Hospital and Training Center					**3,179,095.92**
Amang Rodriguez Memorial Medical Center					**3,179,095.92**
Don Jose Monfort Medical Center Extension					**3,179,095.92**
St Anthony Mother and Child Hospital					**3,179,095.92**
Zamboanga del Sur Medical Center					**3,179,095.92**
Tondo Medical Center					**3,179,095.92**
Jose Reyes Memorial Medical Center					**3,179,095.92**
San Lorenzo Ruiz Women's Hospital					**3,179,095.92**
Las Pinas General Hospital and Satellite Trauma Hospital					**3,179,095.92**
Yearly Total	**22,253,671.44**	**22,253,671.44**	**22,253,671.44**	**22,253,671.44**	**31,790,959.20**

Annex D. Phased Costing of Plantilla Positions in the next 5 years

PHASED COSTING OF PLANTILLA POSITIONS IN THE NEXT 5 YEARS					
Phasing Options	**CIP Yearly Budget for WCPU Plantilla Positions**				
	2022	**2023**	**2024**	**2025**	**Total**
Phasing Option1: (10 new plantilla position for priority hosp/ year)	31,790,959.20	63,581,918.40	95,372,877.60	120,805,644.96	120,805,644.96
Phasing Option 2: (7 new plantilla position for priority hosp/ year)	22,253,671.44	44,507,342.88	66,761,014.32	89,014,685.76	120,805,644.96
Notes: 1. Ranking of DOH Retained Hospital were based on number of cases received in the past 5 years (2015-2019)					
Assumptions: For DOH Retained Hospital WCPU Basic Plantilla position includes a team of:					
MEDICAL OFFICER III (1)					
PSYCHOLOGIST III (1)					
NURSE III (1)					
MEDICAL SOCIAL WORKER II (1)					
2. DOH Retained Hospital/ Sanitaria have not been prioritized but should include a Women and Protection Desk.					

Source: DOH, 2021

Annex E. Cost of initial Capital Outlay in establishing WCPUs

Initial Capital Assets (ICA)						
Furniture	10,000.00	2	units	1	Purchase	20,000.00
Examining Table	8,000.00	2	units	1	Purchase	16,000.00
Medicine Cart	7,500.00	2	units	1	Purchase	15,000.00
Droplight	2,000.00	2	units	1	Purchase	4,000.00
Filing cabinet	9,500.00	2	units	1	Purchase	19,000.00
Vaginal Speculum	2,800.00	2	units	1	Purchase	5,600.00
Desktop Computer	35,000.00	2	units	1	Purchase	70,000.00
Printer	5,000.00	2	units	1	Purchase	10,000.00
DSLR Camera	20,000.00	2	units	1	Purchase	40,000.00
TOTAL FOR ICA						**199,600.00**

Source: Child Protection Network Foundation, UP-PGH, Manila 2021

Annex F. List of Provinces without WCPUS

LUZON

1. Abra
2. Aurora
3. Apayao
4. Catanduanes
5. Ifugao
6. Ilocos Sur
7. Kalinga
8. Quirino
9. Rizal
10. Tarlac
11. Marinduque
12. Oriental Mindoro
13. Romblon

VISAYAS

14. Biliran
15. Camiguin
16. Siquijor

MINDANAO

17. Agusan del Sur
18. Compostela Valley
19. Cotabato
20. Davao del Sur
21. Dinagat Islands
22. Lanao del Norte
23. Sulu
24. Zamboanga Sibugay

Annex G. List of Participants during the WCPP CIP Webinar Workshop [October 7, 2020]

Women and Children Protection Unit (WCPU) Participants during the 4th Brown bag session on CIP Package for WCPU

Elizabeth J. Batino, MD	Baguio General Hospital and Medical Center, Baguio City
April Lippi Sudango, RSW	Baguio General Hospital and Medical Center, Baguio City
Louella S. Young, RSW	Southern Philippines Medical Center, Davao City
Bernadeth L. Gerodias	Southern Philippines Medical Center, Davao City
Marianne Naomi N. Poca, MD	Vicente Sotto Memorial Medical Center, Cebu City

Department of Health – CHD participants during the 4th Brown bag session on CIP Package for WCPU

Dave Isidore Plopinio	DOH Bicol - CHD
Margarita Santos-Natividad	DOH Central Luzon – CHD
Jamaica P. Escalera	DOH Central Luzon – CHD
Celestine Joy L. Membrebe	DOH Central Luzon – CHD
Amiellen P. Cutig	DOH Cordillera Autonomous Region – CHD
Delia A. Ligligen	DOH Cordillera Administrative Region - CHD
Veronica G. De Guzman	DOH – Ilocos Region - CHD
Emma Pilar Imperio	DOH Northern Mindanao – CHD
Dr. Anabelle S. Paguirigan	
Mary Agnes Panton	DOH SOCCSKSARGEN – CHD
Maria Lizandra Sante	DOH Western Visayas – CHD
Camille Arianne Masculino	DOH Western Visayas – CHD
Maria Lizandra Sante	DOH Western Visayas – CHD
Suzette G. Gonzales	DOH Zamboanga Peninsula - CHD
Catherine Rose DG Dela Rosa	DOH Region 4B - CHD
Mary Joy M. Chiu	DOH Region 12 - CHD
Jhoanna Katrina A. Luna	DOH National Capital Region
Jeanette Pauline Arellano-Cortes	DOH Central Visayas
Elma Mae Ordoña	DOH Central Visayas
Raquel D Montejo, MD	DOH DCHD
Denverlyn Jill C Ferolin	DOH DCHD

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GOOD PRACTICES IN NATIONAL ACTION PLANS ON VIOLENCE AGAINST WOMEN Expert group meeting organized by United Nations Entity for Gender Equality and Empowerment of Women (UN Women), 2010

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WHO/SRH/20.04 © World Health Organization 2020. https://www.who.int/reproductivehealth/topics/violence/en/

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