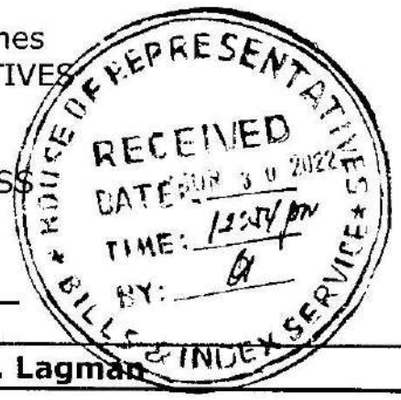
Republic of the Philippines
HOUSE OF REPRESENTATIVES
Quezon City

NINETEENTH CONGRESS
First Regular Session

House Bill No. 79



Introduced by Rep. Edcel C. Lagman

EXPLANATORY NOTE

Adolescent mothers should be relics of the past when early childbearing was the norm. But child mothers are still ubiquitous in the modern setting, not only in underdeveloped and developing countries but also in developed nations.

The UNFPA (United Nations Population Fund) in 2020 reported that the "Philippines has one of the highest teenage pregnancy rates among the ASEAN member states." It documented that "more than 500 Filipino adolescent girls are getting pregnant and giving birth everyday" or in excess of 182,500 births annually.

The Commission on Population and Development (PopCom) said that "the number of children below 15 years old who had gotten pregnant has doubled in ten years". The pandemic has aggravated the incidence of adolescent pregnancy in the Philippines where lockdowns have induced consensual intimacy and even more coerced sex involving minors. This is compounded by the difficulty of obtaining reproductive health (RH) services during the pandemic.

In 2020, a Social Welfare Stations survey revealed that Filipinos consider teenage pregnancy the "most important problem of women today". The National Economic Development Authority and PopCom have described the teenage pregnancy situation as a "national social emergency". Perforce, policymakers and implementers must solve this alarming emergency.

On 25 June 2021, Executive Order No. 142 was issued (Adopting as a National Priority the Implementation of Measures to Address the Root Causes of the Rising Number of Teenage Pregnancies and Mobilizing Government Agencies for This Purpose).

The major deleterious consequences of adolescent pregnancies impact adversely on both adolescents and the economy. Complications during pregnancy and childbirth are the leading cause of deaths for teenagers worldwide because young girls' bodies are not ready for pregnancy and childbirth. Moreover, babies born to teenage mothers face greater health risks.

Due to early pregnancy, young girls fail to finish basic education, lack adequate skills for remunerative work, and are economically vulnerable, thus perpetuating inter-generational poverty.

Adolescent pregnancies negatively affect the economy with a yearly average of P33-B forfeited revenues due to "lost opportunities and forgone savings" consequent to early childbearing. Most adolescent mothers remain unemployed and unproductive. The government also spends billions of pesos annually for the health care of pregnant teenagers, adolescent mothers, and their infants. Consequently, the country fails to reap the benefits of a demographic dividend from the potential of a huge young population.

The major programs and strategies to prevent adolescent pregnancies are: (1) age and development-appropriate reproductive health and sexuality education; (2) access to contraceptives by adolescents; and (3) comprehensive legislation.

Countries providing RH education clearly show that accurate information on health and sexuality at the right time and appropriate age encourages responsible behavior and delays the onset of sexual activity. What is important is that information and services are accessible, accurate, and appropriate.

The beneficent outcomes of RH education are: (a) instilling correct and relevant sexual values, discarding preconceived myths on sex, and addressing young people's curiosity, thus foreclosing risky behavior and experimentation; (b) initiation into sexual activity is delayed; (c) abstinence before marriage is encouraged; (d) life skills to counter peer pressure and resist coerced sex are acquired; (e) for the sexually active, safe sex and prevention of unintended pregnancy are achieved; (f) multiple sexual partners is avoided; and (g) transmission of HIV-AIDS and sexually transmitted diseases is prevented.

Mandatory RH education assumes more importance in the Philippines where majority of Filipino parents default in teaching their children proper sexual values because conversation about sex in most Filipino homes is taboo or the parents themselves are uninformed.

It is lamentable that almost ten years after the enactment of the RH Law, the Department of Education (DepEd) has not fully completed the mandated curriculum on RH education which has yet to be implemented nationwide. DepEd appears to be the graveyard of RH education.

Adolescents' access to contraception complements RH sexuality education. Increased use of contraceptives accounts for an 86% decline in teenage pregnancy in the United States. Contraceptive use is also cost-effective. It is a small portion of the total expenditure for overall RH care and services. Contraceptive availment likewise reduces abortion rates.

Unfortunately, in the Philippines there is a stringent legal barrier to adolescents accessing modern contraceptives. The diluted compromise provision in the RH law requiring written parental consent for minors to access modern contraception, "*except when the minor is already a parent or has had a miscarriage*", was further diluted by the Supreme Court in *Spouses Imbong vs. Ochoa* where the majority struck down the two aforesaid exceptions for purportedly eroding parental authority in the rearing of children. Consequently, without a written parental consent, no minor can access modern contraception.

In stark contrast, the US Federal Supreme Court as early as four decades ago in *Carey vs. Population Services, Int'l.* ruled that a 16-year-old minor's constitutional right to privacy includes the right to freely avail of contraceptives. It also debunked for want of proof the pretension that access to contraception increases minors' sexual indulgence.

Since there should be no idolatrous adherence to precedents, it stands to reason that Congress can depart from the aforesaid pronouncement in *Imbong* by legislating that parental consent is not necessary for adolescents, particularly those who are 16 years old and above, to access contraceptives because the State policy upholding the constitutional right to privacy of minors is superior to parental authority, which needs government support and intervention like in the case of defaulting parents.

Legislating a comprehensive law on preventing adolescent pregnancy is imperative to institutionalize policies and strategies on eliminating or mitigating adolescent pregnancy, and extend social protection to adolescent mothers and their infants.

Verily, enacting a law preventing adolescent pregnancy will save young girls from the clutches of maternal death, unemployment, and poverty, and improve their future and reinforce their self-esteem.

Immediate approval of this bill is earnestly sought.

EDCEL C. LAGMAN

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NINETEENTH CONGRESS
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House Bill No. 79

Introduced by: Rep. Edcel C. Lagman

AN ACT PROVIDING FOR A NATIONAL POLICY PREVENTING ADOLESCENT PREGNANCIES, INSTITUTIONALIZING SOCIAL PROTECTION FOR ADOLESCENT PARENTS, AND PROVIDING FUNDS THEREFOR

Be it enacted by the Senate and House of Representative of the Philippines in Congress assembled:

Section 1. ***Short Title***. This Act shall be known as the "*Adolescent Pregnancy Prevention Act.*"

Section 2. ***Declaration of Policy***. It shall be the policy of the State to:

(a) Recognize, promote and strengthen the role of adolescents and young people in the overall human socio-economic development of the country;
(b) Recognize and promote the responsibility of the State to create and sustain an enabling environment for adolescents to enable them to achieve their development aspirations and potentials as well as mobilize them to positively contribute to the development of the nation;
(c) Pursue sustainable and genuine human development that values the dignity of the human person and affords full protection to people's rights, especially of adolescents and their families;
(d) Promote and protect the human rights of adolescents particularly in their exercise of their rights to sexual and reproductive health, equality and equity before the law, including freedom of expression, the right to development, the right to education, the right to participate in decision-making, and the right to choose and make responsible decisions for themselves;
(e) Pursue an adolescent pregnancy reduction strategy that is anchored on the empowerment of adolescents and their right to health and development; that is cognizant of the structural barriers, including but not limited to gender, poverty, age, ethnicity, and disability that lead to adolescent pregnancy; and that is based on adolescents' needs and preferences;
(f) Provide full and comprehensive information to adolescents to help them prevent early and unintended pregnancies and their life-long consequences;
(g) Provide safe, quality and respectful maternal health care, including antenatal, delivery, and postnatal care to adolescent girls and enable their access to these services;

(h) Ensure corresponding interventions that could respond to the socioeconomic, health and emotional needs of adolescents and youth, especially young girls, with due regard for their own creative capabilities, for social, family, and community support, employment opportunities, participation in the political process, and access to education, health, counselling, and high-quality reproductive health services;
(i) Guarantee universal access to medically-safe, legal and affordable reproductive health care services, methods and devices, and information that prioritize the needs of the underprivileged, especially adolescent girls, and adolescent parents;
(j) Encourage adolescent mothers and fathers to continue and finish their education or acquire functional and technical skills in order to equip them for a better life, improve their income, increase their human potential to help prevent early marriages, high-risk child-bearing and repeated pregnancy, and reduce mortality and morbidity resulting from adolescent pregnancy through comprehensive social protection interventions;
(k) Create enabling mechanisms and opportunities for adolescent parents especially those who are minors to achieve their aspirations and potentials through a comprehensive and integrated social protection measures;
(l) Recognize and promote the rights, duties and responsibilities of parents, teachers, and other persons legally responsible for the growth of adolescents to provide them, consistent with their evolving capacities, appropriate direction and guidance in sexual and reproductive matters in a manner.

Section 3. ***Definition of Terms***. – For purposes of this Act, the following terms shall be defined as follows:

(a) *Adolescents* – refers to the population aged 10 to 19 years, as defined by the World Health Organization (WHO).
(b) Adolescent Health and Development Advisory Committee – hereafter referred to as the Committee, is an interagency and intersectoral committee that shall be formed through this Act and serve as the policy-making body of the social protection program for adolescent mothers and their children.
(c) Adolescent male involvement and participation – refers to the active involvement, participation, commitment of adolescent males and their joint responsibility with adolescent females in all areas of adolescent sexual and reproductive health, as well as reproductive health concerns specific to males.
(d) *Adolescent Sexual and Reproductive Health (ASRH) Care* – refers to the access to a full range of methods, techniques and services that contribute to the reproductive health and well-being of young people by preventing and solving reproductive health-related problems. Following the WHO's definition of reproductive health, ASRH is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, in all matters relating to the sexual and reproductive system and to its functions and processes in individuals aged 10 to 19.
(e) Adolescent Sexuality – as defined by the WHO, it is a central aspect of being human throughout life, which encompasses sex, gender

identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction of individuals aged 10 to 19. It is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships; and is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical. religious, and spiritual factors.

(f) Comprehensive Adolescent Sexuality Education (CASE) – refers to the process of acquiring complete, accurate, relevant, and age-appropriate information and skills on all matters relating to the reproductive system, its functions and processes, human sexuality and forming attitudes and beliefs about sex, sexual identity, interpersonal relationship, affection, intimacy, and gender roles of adolescents. It shall develop the skills of adolescents for them to make informed decisions such as the capacity to distinguish between facts and myths on sex and sexuality; critically evaluate and discuss the moral, religious, social, and cultural dimensions of related sensitive issues such as contraception and abortion; and the prevention of risky behaviors that can undermine the realization of their aspirations and potentials. It is a rights-based and gender-focused approach to adolescent health education taught over several years with progressive age-appropriate information consistent with the evolving capacities of young people and adolescents. CASE is implemented in schools, alternative learning systems, communities and other venues which the government may identify and utilize, taking into consideration its appropriateness and the protection of its beneficiaries' privacy.

(g) *Information and Service Delivery Network for Adolescent Health and Development (ISDN for AHD)* – refers to the network of facilities, institutions, and providers within the province, district, municipality/city-wide health and social system offering information, training, and core packages of health and social care services in an integrated and coordinated manner.

(h) Local Council for the Protection of Children (LCPC) – for the purposes of this Act, the LCPC shall coordinate with the ISDN for AHD in the implementation of programs, support social protection of adolescent mothers and their children.

(i) *Normal Schools or Colleges for Teachers* – learning institutions training or educating teachers whether in the primary, secondary, technical or vocational, college and others which may be applicable.

(j) *Public-Private Partnership (PPP)* – contractual agreement between the Government and a private firm in financing, designing, implementing and operating infrastructure facilities and services intended for various development projects and programs.

(k) *Reproductive Health* – refers to state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes.

(l) *Risky Behaviors* – refer to ill-advised practices and actions both sexual and non-sexual that are potentially detrimental to a person's health or general well-being.

(m) *Social Protection* – policies and programs that seek to reduce poverty and vulnerability to risks and enhance the social status and

rights of the marginalized by promoting and protecting livelihood and employment, protecting against hazards and sudden loss of income, and improving people's capacity to manage risks.

Section 4. ***Development and Implementation of the National Program of Action and Investment Plan for the Prevention of Adolescent Pregnancy.*** – The Committee, in collaboration with the Department of Education (DepEd), Department of Health (DOH), Department of Social Welfare and Development (DSWD), Commission on Population and Development (POPCOM), and other relevant national agencies and civil society organizations (CSOs) shall develop an evidence-based *National Program of Action and Investment Plan.* This program of action shall provide for comprehensive and sustained cost-effective strategies to reduce and prevent pregnancies among adolescents and serve as the national framework for interagency and inter-sectoral collaboration and resource allocation at all levels to address the various health, cultural, socio-economic, and institutional determinants of adolescent pregnancy.

The development of the national program of action shall be coordinated and provided with a secretariat and continuing support for its implementation by the POPCOM and the Council for the Welfare of Children (CWC).

Section 5. *Information and Service Delivery Network for Adolescent Health and Development or ISDN for AHD.* – All provinces and chartered cities shall organize and operationalize an ISDN for AHD consisting of different government and non-government organizations, institutions, and facilities to provide a referral mechanism for AHD-related information and services to adolescents within their locality. In cases of provinces and cities with existing ISDNs for AHD, the network shall harmonize new and existing efforts and programs for AHD particularly the services responding to the socioeconomic dimensions of adolescent pregnancy.

The organization and mobilization of ISDN for AHD shall support the program through the following tasks and functions:

(a) Mapping and analysis of the various factors contributing to pregnancies among adolescents at the regional and local levels;
(b) Support the LCPC, in identifying, harmonizing, coordinating, and implementing interagency interventions to address the various issues related to adolescent pregnancies in the region and at the local level;
(c) Capacity-building of institutions involved in the ISDN for AHD in collaboration with relevant regional government agencies to ensure accurate and quality information and services to adolescents;
(d) Providing, in collaboration with concerned LGUs, needed information and services for adolescent development;
(e) Generating or sharing of resources among involved institutions and facilities in the implementation of the joint strategic plan of the ISDN for AHD; and
(f) Monitoring and evaluating the effectiveness of coordinative and referral systems and other interagency interventions jointly implemented by the ISDN for AHD.

The local ISDN for AHD shall be organized and coordinated by the Office of the Provincial/City/Municipal Population Officer in collaboration with the LCPC and Sangguniang Kabataan (SK) Federation in the concerned localities with technical assistance from the Committee and other relevant national government agencies. In Metro Manila, the ISDN for AHD shall be organized and coordinated with the Metro Manila Development Authority, while in the Bangsamoro Autonomous Region in Muslim Mindanao, it shall be organized and coordinated with its population office. The local ISDN for AHD must be established within one (1) year after the promulgation of the Implementing Rules and Regulations of this Act.

Section 6. ***Mandatory Establishment of Functional Local "Teen Centers" for Adolescent Health and Development.*** – A school- or community-based Teen Center for AHD shall be established and operationalized in all municipalities and cities in the country. These youth-led Centers shall serve as facilities where adolescents and youth can access accurate and appropriate information and services on ASRH and other concerns relevant to their holistic development. The Teen Centers shall be the convergence or catchment facilities or hubs for the services under the ISDN for AHD. The Center may also serve as a peer-helping, counseling and treatment center for adolescents in crisis or victims of abuse and violence as well as a venue for the implementation of programs and strategies under the Social Protection Program for Adolescent Mothers and Their Children (SPPAMC).

The Center shall be mainly coordinated, managed, operated and maintained by the by the LGU through Sangguniang Kabataan (SK) in collaboration with the local office designated to organize and coordinate the ISDN for AHD; other youth volunteers and workers; and other organized adolescents and youth groups recognized by the LGU with the assistance of various adult service providers and youth-service professionals including civil society organizations (CSOs). The establishment and operation of the Teen Centers shall be funded in the Annual General Appropriations Act (GAA) and other relevant local sources.

The POPCOM in collaboration with DepEd, Commission on Higher Education (CHED), DOH, Department of the Interior and Local Government (DILG), and CSOs shall formulate the guidelines and standards in setting-up of Teen Centers in schools and communities. National government agencies shall provide assistance to LGUs and schools in setting-up the Teen Centers.

Section 7. ***Adolescent and Youth-Friendly Facilities and LGUs.*** – The DOH-approved standards for adolescent-friendly health facilities and hospitals shall be institutionalized and made a requirement for the licensing and relevant accreditation of public and private health facilities. The DOH shall likewise identify specific AHD-related health services that should be made available in public health facilities and hospitals under the operational framework and mechanisms for the Universal Health Care Act.

The Committee shall likewise facilitate the development and adoption of standards for the establishment and maintenance of adolescent and youth-friendly public facilities providing information and services for adolescents.

Section 8. ***Community-Based and Culturally-Sensitive Comprehensive Adolescent Sexuality Education (CASE).*** – To complement and support age- and development-appropriate reproductive health education mandated for implementation in all public and private schools by Republic Act No. 10354 or the Responsible Parenthood and Reproductive Health Act of 2012 and to ensure inclusive promotion of CASE, culturally-sensitive and appropriate modules shall also be developed and adopted through community-based information, education and communication (IEC) programs for adolescents belonging to indigenous people, persons with disabilities, out-of-school youth, children in conflict with the law, beneficiaries of residential social welfare services, and other marginalized groups. Reinforcing the relevant provisions of the Republic Act 10354, public and private educational and technical skills development institutions and facilities, with support from the Committee and in collaboration with relevant national government agencies and civil society organizations, shall adopt a government-approved age- and development-appropriate CASE module in relevant educational and technical skills development curricula and training programs. Relevant CASE modules shall also be adopted in relevant higher educational curriculum and vocational institution. The Secretariat shall coordinate with concerned agencies in the development of appropriate modules and IEC programs.

Delivery of CASE in a non-formal education setting shall be ensured by DepEd through their Alternative Learning System. Community youth leaders, through the SK and LCPC shall invest in a concentrated effort in reaching these groups and encourage peer-to-peer counseling. Volunteer groups and interested civil society organizations and non-government organizations shall be recognized for supplemental support to the local ISDNs for AHD.

DepEd, along with other relevant government agencies, shall be tasked to integrate CASE syllabus that is culturally sensitive into the existing Madrasah curriculum.

The CASE curriculum shall be compulsory part of education, integrated at all levels of learning with the end of goal of normalizing discussion of sex and gender, adolescent sexuality, reproductive health, and to remove stigma on the discussion of these topics. The materials and modules developed must be evidence-based, medically accurate, rights-based, culturally-sensitive and non-discriminatory towards adolescents of different sexual orientation, gender identity, and gender expression.

The current curricula should be regularly reviewed, updated and broadened with a view of ensuring adequate coverage of concerns such as gender sensitivity, reproductive health choices, and responsibilities and sexually transmitted diseases and infections, including HIV-AIDS.

This curriculum shall be designed to strengthen respect for human rights and fundamental freedoms, including those related to reproductive health, sexuality, population and development. The materials shall be complementary to the Responsible Parenthood and Reproductive Law, and should be based on the need for responsible human sexuality and must reflect the realities of current sexual behavior.

Section 9. ***Training of Teachers, Guidance Counselors, and School Nurses on CASE.*** – The DepEd, Technical Education and Skills Development Authority (TESDA), and CHED, with support and technical assistance from the DOH, POPCOM, NYC, and relevant CSOs for technical assistance shall ensure that all teachers, guidance counselors, instructors, school nurses, and other school officials are properly trained on adolescent health and development to effectively educate and guide pupils and students in dealing with sexuality-related concerns. Agencies concerned must allot annual allocations for the program training to be included in their annual allocation to be approved by the Congress.

The CHED shall ensure that CASE standards are guided by principles of gender equality and equity and women's human rights and must be integrated in the curriculum and across specializations in the professional preparation and training for would-be teachers in normal schools or teacher education institutions in the country.

The training must introduce and improve the delivery of the current service so as to promote greater responsibility and awareness on the interrelationships between adolescent health issues, sexual and reproductive health, and gender equality and equity.

Section 10. ***ASRH Training for Policy-makers and Implementers.*** – The DOH and POPCOM shall be responsible for disseminating guidelines and providing training programs for policy-makers and implementers in both the executive and legislative branches of government at all levels to enable a better understanding of ASRH as well as policies and practices to promote it.

The guidelines crafted for the purpose of this section shall be framed from a lens of gender equality and equity and women's rights and shall be made in consultation with academic institutions and civil society organizations focused on gender and women's rights.

Section 11. ***CASE for Parents and Guardians as well as those with Special Concerns***. – The DSWD, DOH, POPCOM, and local government units shall collaborate to intensify and institutionalize interactive learning methodologies for CASE among parents and guardians to effectively guide adolescents in their growth and development. A Parent Effectiveness Program shall be formulated by the above-mentioned agencies and implemented by local government units with the objective of enhancing the child-rearing skills of parents, guardians, relatives and other significant adults who care for and have influence over adolescents.

Section 12. ***Sustained National Campaign on the Prevention of Adolescent Pregnancy.*** – The Committee shall develop and implement a nationwide communication campaign through various types of media, including online platforms, to reach adolescents in the most wide-ranging way. POPCOM, in collaboration with the Committee members and other agencies shall develop, maintain and regularly update a web portal for all AHD communication information, referrals, materials. Relevant services shall be developed and promoted by the Committee to harmonize and link various government websites and online services for ASRH including the networked operationalization of ISDN for AHD.

The Philippine Information Agency (PIA), as the official public information arm of the government, will take the lead in promoting ASRH and in advocating for adolescent pregnancy prevention in media. It will be tasked to provide regular reports on the trend and incidence rates of adolescent pregnancies in the country and to provide the public with information on resources and health practices for ASRH, among others, in collaboration with relevant Committee member agencies. Private broadcast networks news channels or news programs will also be encouraged and mobilized for the national campaign as part of their corporate social responsibility initiatives.

Section 13. ***Participation of the Private Sector in CASE Promotion***. – The government may enter into Public-Private Partnership (PPP) agreements in mobilizing private communication networks and companies in promoting CASE through text or short message service (SMS) or media messages. An incentive mechanism for telecommunications companies shall be developed and implemented by concerned agencies to recognize private participation in promoting CASE and adolescent youth health-seeking behavior, positive attitude towards sex, sexual relations and sexuality, among others. It will be recognized as part of the companies' corporate social responsibility programs.

Section 14. ***Access to Reproductive Health Information and Services***. – Access to information and services on modern family planning methods with proper counselling by trained service providers shall be provided to adolescents following a rights-based approach in public and private health facilities, including Teen Centers. Priority shall be given to adolescents who are already sexually active or have previously engaged in sexual activities. The aforementioned counseling is carried out with the end in view of ensuring healthy practices through the promotion of optimal health outcomes and protecting minors, especially those in vulnerable circumstances, from possible predatory and sexually exploitative practices.

For this purpose, all health service providers in all health facilities shall be trained on providing adolescent-friendly and responsive information and services. It is the duty of health service providers to provide complete and medically-correct information on reproductive health services, including the right to informed choice and access to legal, medically-safe, and effective contraception and other family planning methods.

Provided, that all, health facilities shall be enhanced to become an adolescent- friendly facility by ensuring confidentiality; exclusive schedules for adolescents; and non-judgmental, stigma-free, and gender responsive health service providers. Provided, further, that adolescents shall not be denied access to clinical services and modern methods of contraceptives if and when they seek to avail of the aforementioned healthcare services.

The Committee shall ensure that ASRH training is integrated in the pre-service curriculum training of Barangay Health Workers (BHWs), front-line health care providers, and social workers. The said training shall include topics such as, but not limited to: consent, adolescent sexual and reproductive health, effective contraception use, disease prevention, HIV and AIDS, STIs, hygiene, healthy lifestyle, and prevention of gender and sexual violence. Linkages and referral systems shall be established in educational institutions in order to bridge gaps between CASE and access to SRH services for in-school adolescents out-of-school youths (OSYs) and other groups. A community peer

educator could be chosen to advocate accessing SRH services and distribution of commodities.

In cases of pregnant adolescents, or adolescents who have already begun childbearing, or adolescents who have experienced sexual abuse, or adolescents who have had a miscarriage, a wider spectrum of SRH services shall be made available to them spanning the antenatal and postnatal stages of pregnancy and its respective health care requirements. Provision of reproductive health services to adolescents shall be based on the principles of non-discrimination and confidentiality, the rights of adolescents, their evolving capacities and as a life-saving intervention. Further, it shall be ensured that adolescents are not denied the information and services needed to prevent future unintended adolescent pregnancies and are able to access treatment and care services without fear of stigmatization, discrimination and violence.

Section 15. ***Social Protection Program for Adolescent Mothers and Their Children (SPPAMC)***. – A comprehensive and integrated social protection program for adolescent mothers, adolescents who are currently pregnant, and their partners and parents shall be developed by DSWD and POPCOM to prevent unplanned repeat pregnancies and to ensure the wellbeing of both the children and their adolescent parents, especially the mother, while assuming the responsibilities of being young parents. This social protection program is to be implemented by LGUs, anchored on the approved Philippine Social Protection Operational Framework and Strategies. Such program aims to create a more enabling environment and support or a protective system for adolescent parents who are exposed to various risks and vulnerabilities of being young mothers and fathers.

The SPPAMC shall include information and services that address the risks, vulnerabilities and needs attendant to being a young parent, to include, but not be limited to:

(a) Maternal health services including antenatal check-ups and facility-based delivery;
(b) Post-natal family planning counseling and services for either or both adolescent parents;
(c) Personal PhilHealth coverage, making mandatory enrollment and membership of indigent and indigenous adolescent mothers;
(d) Both home- and school-based education, training, skills development, and livelihood support programs for the household of the adolescent parents, especially for those belonging to low-income families;
(e) Continuing CASE for teenage parents;
(f) Workshops on couples counseling, parenting and positive discipline for the parents-to-be;
(g) Protective and support services for adolescents who are victims or are exposed to gender-based violence, abuse and exploitation;
(h) Safety net measures for adolescent parents during emergency and crisis situations; and
(i) Psycho-social support and mental health services for adolescent mothers.

Beneficiaries of the program who are 18 years old and above shall be entitled to maternal and paternal leave, especially if both are employed.

Suspension, forced resignation and other discriminatory acts in the workplace against pregnant girls shall be prohibited. The local councils through the Local Social Welfare and Development (LSWD) and/or the Population Office shall implement a continuing CASE program for teenage mothers and fathers with technical assistance from the Committee.

The services must safeguard the rights of the adolescents to privacy, confidentiality, respect and informed consent, respecting cultural values and beliefs.

The National Government shall provide funding for the SPPAMC in the annual General Appropriations Acts as a priority poverty reduction program. The National Government shall provide additional and necessary funding and other essential assistance for the effective implementation of this provision.

Section 16. ***Care and Management for First-Time Parents.*** – All pregnant adolescents, especially those in poor and hard-to-reach groups, shall have access to skilled care throughout their pregnancy, delivery, and post-natal period. SRH providers shall strive to provide as many adolescent mothers with their birth plans that detail their intended place of childbirth delivery, availability of transport to these health care institutions, and respective costs. Special attention shall be given to younger pregnant mothers during obstetric care.

Workshops, classes and seminars for first-time parents shall be provided with ante- and post-natal care education. These classes shall include topics such as, but not limited to, infant feeding and care, positive discipline, responsible parenthood, and safe sex practices. The classes shall be made available free of charge and at times most convenient for adolescent parents.

Educational institutions shall be encouraged to develop and establish support mechanisms that will encourage the return of adolescent mothers and parents including, but not limited to, in-school day-care and breastfeeding stations.

LGUs may request the national government through the Committee to provide additional and necessary funding and other necessary funding and other necessary assistance for the effective implementation of these provisions.

Section 17. ***Promotion of Adolescent Male Involvement in the Prevention of Early and Unintended pregnancies.*** – The Committee shall develop programs to be implemented by LGUs that will promote male involvement in the prevention of early and unintended pregnancies. These programs shall include the topics such as, but not limited to, responsible fatherhood, male responsibility in family planning, couples counseling, avoiding gender violence, life-skills, and co-parenting strategies. These programs shall emphasize the roles and responsibilities of being a father and promote the active involvement of the partners of the beneficiaries of the SPPAMC. These programs shall also serve as an avenue to encourage the uptake of SRH services and information for boys and young men.

Section 18. ***Integration of Local Program for the Prevention of Adolescent Pregnancy in LCPC Programs.*** – Strategies and programs

which aim to prevent incidence of adolescent pregnancies shall be integrated in the LCPC programs at the local and community level.

The LCPC shall likewise implement programs and activities that aim to develop the potentials and skills of adolescents to make them more productive members of the society. The topics of the said programs and activities shall include, among others, leadership training, classes on maintaining a healthy lifestyle, seminars on active citizenship, improving critical thinking and decision-making, and building other crucial life skills that can be done together by adolescents and their families. LCPC shall encourage youth participation in these activities as means of focusing the potentials and capabilities of adolescents into more meaningful and productive endeavors.

The LCPC at the barangay level shall enlist the support of the local barangay council, SK council, and barangay health center to be able to provide a more complete array of services, activities and programs.

Section 19. ***Residential Care Facilities for Disadvantaged Women.*** – The existing residential care facilities for disadvantaged women of the DSWD shall be capacitated to accommodate the needs of pregnant adolescent girls. The management of the said facilities shall coordinate with their respective locality's ISDN to provide SRH information and services to their residents. In order to effectively serve their pregnant adolescent residents, these centers shall employ the following personnel: a healthcare worker, an on-call obstetrician-gynecologist, a full-time midwife or nurse, and a psychologist.

If there is an identified demand and need for a residential care facility to be built and established, the local ISDN shall prioritize the city or municipality with the highest rate of adolescent pregnancy.

Section 20. ***Creation of a National Monitoring and Evaluation System on the Prevention of Adolescent Pregnancy.*** – The Committee shall create a monitoring and evaluation system that will comprehensively assess and effectively monitor and evaluate the status, success, and efficacy of the National Program of Action for the Prevention of Adolescent Pregnancy.

An Adolescent Health and Development Survey shall be carried out every four (4) years to conduct surveys and collect age- and gender-disaggregated data. It shall cover a wide range of topics and indicators extending beyond adolescent sexuality and reproductive health. Its coverage shall include topics such as, but not limited to, education, adolescent health, and labor. Existing surveys such as the National Demographic and Health Survey, Family Health Survey, Family Planning Survey, and Maternal and Child Health Survey shall begin the collection of data disaggregated at age 10-14 and include never-married women in the data collection in order to have a more accurate picture. Research and data from the assessment and evaluation shall be stored in a public database.

LGUs are required to conduct safety audits every three (3) years to assess the efficacy and effectiveness of the implementation of this Act within their jurisdiction. Such audits shall be multisectoral and participatory, with consultations undertaken with population officers, social workers, health workers, schools, and civil society organizations.

Section 21. ***Implementation Structure.*** – An Adolescent Health and Development Advisory Committee shall be established and composed of the following:

(a) The POPCOM Executive Director as the Chairperson;
(b) The CWC Executive Director as Co-Chairperson;
(c) Senior officials (at least Undersecretary level) of the DOH, NYC, DepEd, DSWD, DILG, CHED, and TESDA as ex-officio members;
(d) Five members appointed by the Chairperson who are persons with knowledge, expertise, accomplishment, and with no less than five years' experience in the fields of public health, adolescent rights and social protection, education, psychology, and social welfare, provided that one qualified member is appointed in each field; and
(e) Two youth representatives appointed by the Committee Chairperson from various nationally-represented youth organizations, provided that one is male and one is female.

The POPCOM and CWC shall serve as the secretariat of the Committee.

The Committee shall perform the following tasks and functions:

(a) Facilitate the development, implementation and assessment of the comprehensive and integrated National Plan of Action and Investment Plan for the Prevention of Adolescent Pregnancy;
(b) Propose legislative and administrative policies on the prevention of adolescent pregnancy based on emerging trends, needs and preferences of adolescents;
(c) Develop operational guidelines for government agencies and private organizations in the development and implementation of comprehensive strategies and programs for prevention of adolescent pregnancy;
(d) Facilitate the conduct of research and generation of evidence and knowledge on the drivers of adolescent pregnancy to guide the development of programs and policies;
(e) Address and resolve emerging institutional barriers in the implementation of this law;
(f) Provide relevant agencies and private organizations with recommendations and solutions to challenges and gaps in the course of implementing the program; and
(g) Engage the private sector and the citizenry to ensure active partnership in looking for solutions to address the problems of adolescent pregnancy.

At the national level, the Adolescent Health and Development Advisory Committee agency members shall have the following duties and functions in accordance to their mandates and in relation to the Implementation of this Act.

The POPCOM shall:

(a) Develop and coordinate with relevant agencies the National Program for the Prevention of Adolescent Pregnancy (NPPAP) as part of the National Population Management Program;

(b) Implement a program for the training of parents and guardians in effectively guiding adolescents on ASRH issues;
(c) Set-up a National Information System Database on the prevention of adolescent pregnancy that shall be used for planning and programming, monitoring, and evaluation of indicators at all levels;
(d) Create an enabling environment for adolescents to make informed decisions on their sexual and reproductive health that best suited to their personal needs;
(e) Spearhead efforts to harmonize information within the network. The POPCOM may invest on platform or information portal that would allow linking the data between members of the network;
(f) Serve as overall coordinator for the nationwide and community-based campaign for the prevention of teenage pregnancy including the development and maintenance of a web portal for relevant online information and services;
(g) Serve as the Secretariat of the Adolescent Health and Development Advisory Committee.

The DOH shall:

(a) Ensure the availability and provision of ASRH information, services and commodities in all public and private health facilities;
(b) Ensure the training of health service providers in providing adolescent-friendly and responsive health service;
(c) Support and provide technical assistance in the capacity building to existing ISDNs and establishment of new ISDNs at the local level;
(d) Establish Teen Mom Clinics in all hospitals to provide adolescent mothers with access to post-natal services and counselling as well as reproductive commodities to avoid successive and/or unintended pregnancies;
(e) Coordinate with the POPCOM on the establishment of a monitoring and evaluation system to ensure the responsiveness, coverage, and delivery of this Act;

The DepEd and CHED shall:

(a) Ensure the development and promotion of CASE standards and its corresponding learning modules for teachers and students;
(b) Ensure the comprehensive training of all teachers in CASE;
(c) Lead the delivery and implementation of CASE in all public and private basic education and tertiary educational institutions as well as in non-formal educational settings;
(d) Ensure the incorporation of CASE in the modules of future educators; and
(e) Guarantee quality assurance of educational institutions in terms of CASE delivery compliance through the Philippine Accreditation System for Basic Education.

The TESDA shall:

(a) Provide social protection to adolescent parents by providing skills training and livelihood support; and

(b) Encourage enrollment in technical-vocational courses for adolescent parents who are not fully equipped to return to in-school education.

The DSWD shall:

(a) Take the lead in providing social protection for adolescent parents especially in cases of sexual violence, abuse, and exploitation;
(b) Ensure the provision of social protection for adolescents in humanitarian and/or emergency situations;
(c) Equip their existing Distressed Centers for Disadvantaged Women with increased capacity to accommodate more residents, particularly adolescent girls;
(d) Incorporate ASRH and adolescent pregnancy prevention modules for both parents and adolescents in existing Family Development Sessions and Youth Development Sessions under the Pantawid Pamilyang Pilipino program with modules for adolescents emphasizing peer-to-peer discussions;
(e) Promote CASE for adolescents with special needs and in difficult circumstances.

The NYC shall:

(a) Ensure the integration of ASRH and CASE promotion in the SK or TFYD and LYCDC programs and projects;
(b) Capacitate the SK or TFYD and LYDC in the implementation of this Act at the local level; and
(c) Conduct workshops, classes and seminars for first-time parents in partnership with DOH, DSWD, and other concerned Council members and relevant agencies.

The CWC shall:

(a) Integrate in its development and strategic frameworks children-specific issues and concerns, particularly the prevention of adolescent pregnancy, and ensure the adoption of such frameworks by LGUs and other stakeholders;
(b) Vigorously advocate for the awareness and prevention of adolescent pregnancy; and
(c) Develop, adopt, and implement in a manner consistent with adolescents' evolving capacities, legislation, policies, and programs that will promote child and adolescent health and development. At the local level, the provincial population office and the provincial health office shall organize and lead the coordination of local ISDNs. The two offices shall headline the implementation of the NPPAP at the local level. The LGU's City or Municipal Population Health officers shall become the local ISDN's point person. With assistance from the provincial coordinators, the local SK/LYDC, and the Council, they shall adopt the NPPAP in their localities and be responsible for its implementation, monitoring, and evaluation. The local development councils shall enlist the participation of children, adolescents, and youth-oriented groups, as well as CSOs and NGOs as much as possible. Specific strategies

shall be design to reach marginalized and vulnerable adolescent sub-sectors; and

(d) Serve as the secretariat of the Adolescent Health and Development Advisory Committee.

The DILG shall:

a) Ensure the compliance of local development councils in the implementation of this Act by including the implementation of ASRH programs as a qualifying requirement of the Seal of Good Local Governance; and
b) Assist the local ISDNs through their League of Provinces, League of Cities, League of Municipalities, and League of Barangays.

At the local level, the LCPC shall act as the coordinating body that will manage and ensure the implementation of this law within their respective jurisdictions.

All LGUs shall:

a) Ensure the development of local strategies for the prevention of adolescent pregnancy in their localities;
b) Ensure the promotion of CASE in schools and communities;
c) Mobilize the SK for key strategies in the prevention of adolescent pregnancy in their localities;
d) Facilitate the organization and mobilization of ISDN for AHD;
e) Ensure the availability and provision of appropriate health and social services for adolescents;
f) Set-up a data base on adolescent pregnancy for programming and planning;
g) Implement a program for the training of parents and guardians in effectively guiding adolescents on ASRH issues; and
h) Allocate funds necessary for strategies in preventing adolescent pregnancy.

Section 22. ***Designating February of Every Year as the Month for Raising Public Awareness on Preventing Adolescent Pregnancy and the Conduct of Nationwide Communication Campaigns***. – To raise public consciousness on the issues on teenage pregnancy and generate support from various stakeholders, the entire month of February shall be designated as *Month for Public Awareness on Preventing Adolescent Pregnancy* which shall be observed nationwide. Schools and other stakeholders shall hold activities with the objective of raising awareness and generate crucial actions to address the issues of increasing adolescent pregnancy.

Section 23. ***Annual Allocations***. – All concerned government agencies including the LGUs shall include in their annual budget the necessary funds for strategies and activities within mandates that are contributory to the implementation of this Act.

National government agencies or instrumentalities implementing or supporting the implementation of this Act shall include in their annual budget the necessary funds for activities and strategies, in which case, the allocation shall not be less than five percent (5%) of their total budget.

Section 24. ***Joint Congressional Oversight Committee.*** – There is hereby created a Joint Congressional Oversight Committee to monitor the implementation of this Act and to review the Implementing Rules and Regulations promulgated. The committee shall be composed of five (5) Senators and five (5) Representatives to be appointed by the Senate President and Speaker of the House of Representatives, respectively. The Oversight Committee shall be co-chaired by the Chairpersons of the Senate Committee on Women, Children, Family Relations and Gender Equality, and the House Committee on Population and Family Relations. At least one (1) Senator and one (1) Representative from the opposition shall be a member of the Joint Congressional Oversight Committee.

Section 25. ***Declaration of National Social Emergency.*** – A National Social Emergency is a condition where the state is facing a persisting problem that poses an intergenerational peril and stumbling blocks to the development of human capital and attainment and sustenance of socioeconomic growth due to the rise in the rate of adolescent pregnancies for a continuous period of at least ten (10) years. It shall direct the POPCOM Board of Commissioners to convene as an interagency task force under the Office of the President and produce, within seven (7) days from the release of the order declaring a national social emergency a national plan of action requiring a whole-of-government approach, the purpose of which is to address the high rate of adolescent pregnancies and prevent a crisis for the protection of current and future generation's interests towards their right to health, socioeconomic development, and the national patrimony.

Section 26. ***Timeline for Adoption, Monitoring and Evaluation of this Act.*** – Networks and services included in this Act shall be established within three (3) years upon effectivity of this Act. Periodic monitoring and evaluation of coverage and delivery of RH services for pregnant adolescents shall also be conducted every three (3) years.

Section 27. ***Implementing Rules and Regulations.*** – Within 60 days upon the effectivity of this Act, the Adolescent Health and Development Advisory Committee composed of the POPCOM Executive Director as Chairperson and the CWC Executive Director as Co-Chairperson; senior officials of the DOH, NYC, CWC, DepEd, DSWD, DILG, CHED, and TESDA as ex-officio members shall convene to appoint representatives as identified in Section 20 of this Act. Such appointments shall require the concurrence of a simple majority of the government agencies represented in the same Committee. Subsequent appointments shall requirement a simple majority of all members.

Immediately upon the appointment of the representatives in Section 20 paragraphs (d) and (e), regardless of whether the seats in the Committee have been filled, the Committee shall begin drafting the Implementing Rules and Regulations of this Act which shall be promulgated within sixty (60) days after the appointment of the first representative.

Section 28. *Separability Clause.* – If any part, section, or provisions of this Act is held invalid or unconstitutional, other provisions not affected thereby shall remain in full force and effect.

Section 29. *Repealing Clause.* – All other statutes, executive orders, and administrative issuance or rules and regulations contrary to or inconsistent with the provisions of this Act are hereby repealed, amended or modified accordingly.

Section 30. *Effectivity Clause.* – This Act shall take effect fifteen (15) days after publication in the *Official Gazette* or at least two (2) newspapers of general circulation.

Approved,