Competency Training on Adolescent Health for Health Service Workers

A REFERENCE MATERIAL
Greetings!

In recent years, there has been a steady increase in the number of teenage pregnancies, adolescent victims of violence and abuse, substance use and abuse and physical, emotional and psychosocial concerns among adolescents. Recognizing the need to address these concerns of our adolescents, the Department of Health (DOH) has taken to the forefront the Adolescent Health and Development Program (AHDP) specifically to assist and support clients in this age group.

Aside from coming up with activities to address their needs, encouraging health facilities to be adolescent-friendly and coordinating with concerned agencies, the DOH – Family Health Office has also embarked on improving the capability of health service providers to deal with adolescents. In addition to capability building activities for these adolescent health focal persons, a reference material on the Competency Training on Adolescent Health for Health Service Workers was formulated as their quick guide.

This Reference Material was formulated as an adjunct to the Adolescent Job Aid (AJA). It contains the most recent data and additional information on what is contained in the AJA. This will assist the health service workers better understand the concepts and relay more accurate information to their clients.

It is our hope that the Reference Material will satisfy the needs of both providers and clients to enable them to work together so that the adolescents will adhere to the recommended practices and behavior.

ENRIQUE T. ONA, MD, FPCS, FACS
Secretary of Health
MESSAGE

Adolescence is a period in life which encompasses puberty and marks a stage of rapid physical growth and development as well as changes in the emotional, psychosocial and intellectual aspects. Adolescents are in a stage of life wherein they are no longer a child and not yet an adult. They are in a phase where their adventurous spirit puts them at risk of adopting unhealthy behaviors and experience the consequences of such.

While health programs for infants, children, individuals of reproductive age as well as those in the post reproductive age have been established and are currently being improved, programs to address the special needs of adolescents also need to be looked into. The increasing number of teenage pregnancies, sexually transmitted infections (STI) and HIV, substance use and abuse, victims of violence of all forms and other health concerns signal that initiatives have to be taken to look after adolescents.

In recent years, the Department of Health has taken steps to address the health concerns of adolescents as well as implement preventive measures to encourage them to practice healthy behaviors. Standards for Adolescent Friendly Health Facilities and Services have been formulated to encourage them to consult local health facilities. Coordination with organizations and agencies with expertise on adolescent health are being done to ensure that we are on the right track. Public health workers are being trained to ensure that they are able to deal with the peculiar psyche and needs of clients in this age group.

Likewise, the 1st National Adolescent Immunization using Measles, Mumps and Rubella (MMR) and Tetanus and Diphtheria (Td) was initiated in selected provinces and cities nationwide. Public-public and public-private partnerships have been strengthened to orient and train health workers, teachers, and parents on the importance of catch up immunization program for adolescent to combat vaccine preventable diseases.

The Adolescent Job Aid (AJA) has been developed to assist workers on how to go about their tasks in dealing with special concerns of adolescents. It is presented in the simplest, yet comprehensive manner to make it as an easy reference guide for health workers. However, there arises the need to provide details and data on the information provided for in the AJA. This is how this Reference Material on the Competency Training on Adolescent Health for Health Service Workers has come into being. This material is envisioned to provide health service workers with the explanations and added information on what is in the AJA. By doing so, they can better guide their clients into making better and healthier choices.

JANETTE LORETO-GARIN, MD, MBA-H
Undersecretary of Health
Women, Children and Family Health Cluster
ACKNOWLEDGEMENT

The Family Health Office, National Center for Disease Prevention and Control (FHO-NCDPC) of the Department of Health (DOH) would like to express its sincerest gratitude to the following:

Dr. Irma Asuncion, Director of the National Center for Disease Prevention and Control, for her leadership and constant support in the capability building activities of our adolescent health focal personnel in the country;

Dr. Honorata Catibog (Former Director, Family Health Office) and Dr. Joyce Ducusin (Director, Family Health Office), for their invaluable inputs and guidance in the development of this resource material;

The Society of Adolescent Medicine of the Philippines, Inc. (SAMPI) in collaboration with the Department of Health (DOH), that developed the Adolescent Job Aid (AJA) which served as the basis in developing the content outline of this reference material; and

The participants during the pretesting, for their significant inputs, comments and suggestions that were used in finalizing this reference material.

DR. MINERVA VINLUAN
Program Manager for Adolescent Health
HOW TO USE THIS REFERENCE MATERIAL

The *Competency Training on Adolescent Health for Health Service Workers: A Reference Material* will serve as a resource material for adolescent health personnel and other personnel from government and non-government agencies nationwide involved in the delivery of adolescent health services.

This reference material is composed of six major parts:

- Part 1: The Adolescent-Friendly Health Services and the Risk Behaviors of Adolescents
- Part 2: General Health Concerns
- Part 3: Mental Health and Psychological Concerns
- Part 4: Sexual and Reproductive Health Concerns
- Part 5: Maintaining a Healthy Lifestyle
- Part 6: Adolescents in Emergencies

In addition to the above contents, this document also includes Annexes of Laws and Other Policies relevant to Adolescent Health: *Annexes 1 to 3 – International Policies* and *Annexes 4 to 18 – National Laws and Policies*.

When using this reference material, health service workers should always remember to use language and techniques that are appropriate to the feelings, beliefs, and cultural orientation of their audience and this material should be used judiciously. Use the contents which are applicable and relevant to your setting.

By no means is this document all-inclusive, however, as with every evolving text in the ever-changing science of adolescent health, it will always be subject to updating and further improvement.
# TABLE OF CONTENTS

List of Acronyms  
Introduction  

## Part 1: The Adolescent-Friendly Health Services and the Risk Behaviors of Adolescents
- A. The Adolescent-Friendly Health Services  
- B. Risk Behaviors of Adolescents in the Philippines  

## Part 2: General Health Concerns
- A. Male and Female Puberty-related Conditions  
- B. Breast Development  
- C. Menstrual Concerns  
- D. Nutritional Concerns  
- E. Oral Health  

## Part 3: Mental Health and Psychological Concerns
- A. Anxiety  
- B. Depression  
- C. Suicide  
- D. Physical and Sexual Abuse  

## Part 4: Sexual and Reproductive Health Concerns
- A. Genital Problems in Male Adolescents  
- B. Genital Problems in Female Adolescents  
- C. Sexually-Transmitted Infections including HIV and AIDS  
- D. Teen Pregnancy  
- E. Sex, Gender, Sexuality and LGBTs  

## Part 5. Maintaining a Healthy Lifestyle
- A. Use of Tobacco, Alcohol and Other Substances  
- B. Nutritional Status and Physical Activity  

## Part 6. Adolescents in Emergencies  

Part 5: Maintaining a Healthy Lifestyle  
- A. Use of Tobacco, Alcohol and Other Substances  
- B. Nutritional Status and Physical Activity  

Part 6. Adolescents in Emergencies  

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of Acronyms</td>
<td>i</td>
</tr>
<tr>
<td>Introduction</td>
<td>ii</td>
</tr>
<tr>
<td>Part 1: The Adolescent-Friendly Health Services and the Risk Behaviors of Adolescents</td>
<td></td>
</tr>
<tr>
<td>A. The Adolescent-Friendly Health Services</td>
<td>2</td>
</tr>
<tr>
<td>B. Risk Behaviors of Adolescents in the Philippines</td>
<td>30</td>
</tr>
<tr>
<td>Part 2: General Health Concerns</td>
<td></td>
</tr>
<tr>
<td>A. Male and Female Puberty-related Conditions</td>
<td>34</td>
</tr>
<tr>
<td>B. Breast Development</td>
<td>38</td>
</tr>
<tr>
<td>C. Menstrual Concerns</td>
<td>39</td>
</tr>
<tr>
<td>D. Nutritional Concerns</td>
<td>43</td>
</tr>
<tr>
<td>E. Oral Health</td>
<td>65</td>
</tr>
<tr>
<td>Part 3: Mental Health and Psychological Concerns</td>
<td></td>
</tr>
<tr>
<td>A. Anxiety</td>
<td>68</td>
</tr>
<tr>
<td>B. Depression</td>
<td>69</td>
</tr>
<tr>
<td>C. Suicide</td>
<td>72</td>
</tr>
<tr>
<td>D. Physical and Sexual Abuse</td>
<td>74</td>
</tr>
<tr>
<td>Part 4: Sexual and Reproductive Health Concerns</td>
<td></td>
</tr>
<tr>
<td>A. Genital Problems in Male Adolescents</td>
<td>78</td>
</tr>
<tr>
<td>B. Genital Problems in Female Adolescents</td>
<td>82</td>
</tr>
<tr>
<td>C. Sexually-Transmitted Infections including HIV and AIDS</td>
<td>85</td>
</tr>
<tr>
<td>D. Teen Pregnancy</td>
<td>94</td>
</tr>
<tr>
<td>E. Sex, Gender, Sexuality and LGBTs</td>
<td>97</td>
</tr>
<tr>
<td>Part 5. Maintaining a Healthy Lifestyle</td>
<td></td>
</tr>
<tr>
<td>A. Use of Tobacco, Alcohol and Other Substances</td>
<td>101</td>
</tr>
<tr>
<td>B. Nutritional Status and Physical Activity</td>
<td>105</td>
</tr>
<tr>
<td>Part 6. Adolescents in Emergencies</td>
<td>110</td>
</tr>
</tbody>
</table>
## ANNEXES

<table>
<thead>
<tr>
<th>No.</th>
<th>International Policies</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>General Comment No. 4. Adolescent Health and Development in the Context of the Convention on the Rights of the Child</td>
<td>116</td>
</tr>
<tr>
<td>3</td>
<td>United Nations Millennium Declaration (September, 2000)</td>
<td>135</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No.</th>
<th>National Laws and Policies</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>The 1987 Constitution of the Republic of the Philippines</td>
<td>144</td>
</tr>
<tr>
<td>6</td>
<td>Republic Act No. 7160. An Act Providing for Stronger Deterrence and Special Protection Against Child Abuse, Exploitation, and Discrimination, and for Other Purposes</td>
<td>171</td>
</tr>
<tr>
<td>7</td>
<td>Republic Act No. 9165. An Act Instituting the Dangerous Drugs Act of 2002, repealing Republic Act No. 4625, otherwise known as the Dangerous Drugs Act of 1972, as amended, Providing Funds Therefor, and for Other Purposes</td>
<td>182</td>
</tr>
<tr>
<td>8</td>
<td>Republic Act No. 9442. An Act Amending Republic Act No. 7277, otherwise known as the Magna Carta for Disabled Persons, and for Other Purposes</td>
<td>228</td>
</tr>
<tr>
<td>9</td>
<td>Republic Act No. 9523. An Act Requiring Certification of the Department of Social Welfare and Development (DSWD) to declare a “Child Legally Available for Adoption” as a Prerequisite for Adoption Proceedings, Amending for this Purpose certain provisions of Republic Act No. 8552, Otherwise known as the Domestic Adoption Act of 1998, Republic Act 8043, otherwise known as the Inter-Country Adoption Act of 1995, Presidential Decree No. 603, Otherwise known as the Child and Youth Welfare Code, and for Other Purposes</td>
<td>233</td>
</tr>
<tr>
<td>10</td>
<td>Republic Act No. 9344. An Act Establishing a Comprehensive Juvenile Justice and Welfare System, Creating the Juvenile Justice and Welfare System under the Department of Justice, Appropriating Funds Therefor, and for Other Purposes</td>
<td>239</td>
</tr>
<tr>
<td></td>
<td>Administrative Order No. 34-a, s 2000. Adolescent and Youth Health (AYH) Policy</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Republic Act No. 10354. An Act providing for a National Policy on Responsible Parenthood and Reproductive Health</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Department Memorandum No. 2013-0168. Guidelines in the implementation of School-Based Adolescent Immunization</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Republic Act No. 10627. An Act Requiring All Elementary and Secondary Schools to Adopt Policies to Prevent and Address the Acts of Bullying in their Institutions</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>AHDP</td>
<td>Adolescent Health and Development Program</td>
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<td>AFHF</td>
<td>Adolescent-Friendly Health Facility</td>
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<td>AFHS</td>
<td>Adolescent-Friendly Health Services</td>
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<td>AJA</td>
<td>Adolescent Job Aid</td>
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<td>AYHDP</td>
<td>Adolescent and Youth Health and Development Program</td>
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<td>BMI</td>
<td>Body Mass Index</td>
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<td>DMFT</td>
<td>Decayed, Missing and Filled Teeth</td>
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<td>DOH</td>
<td>Department of Health</td>
</tr>
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<td>ELISA</td>
<td>Enzyme-linked Immunosorbent Assay</td>
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<td>GO</td>
<td>Government Organizations</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HPV</td>
<td>Human Papilloma Virus</td>
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<tr>
<td>HSV</td>
<td>Herpes Simplex Virus</td>
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<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
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<td>ITR</td>
<td>Individual Treatment Record</td>
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<tr>
<td>LGBT</td>
<td>Lesbian, Gay, Bisexual and Transgender</td>
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<td>LGU</td>
<td>Local Government Unit</td>
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<td>NGO</td>
<td>Non-Government Organizations</td>
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<td>NSU</td>
<td>Non-Specific Urethritis</td>
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<td>SOP</td>
<td>Standard Operating Protocol</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>STD</td>
<td>Sexually Transmitted Disease</td>
</tr>
</tbody>
</table>
INTRODUCTION

Adolescence is one of the most rapid phases of human development. Adolescence is a period of life with specific health and developmental needs and rights. It is also a time to develop knowledge and skills, learn to manage emotions and relationships, and acquire attributes and abilities that will be important for enjoying the adolescent years and assuming adult roles.

The World Health Organization (WHO) defines adolescents as those people between 10 and 19 years of age. United Nations Children’s Fund (UNICEF) defines adolescence in three stages:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Age</th>
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</thead>
<tbody>
<tr>
<td>Early Adolescence</td>
<td>10-13 years of age</td>
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<tr>
<td>Middle Adolescence</td>
<td>14-16 years of age</td>
</tr>
<tr>
<td>Late Adolescence</td>
<td>17-19 years of age</td>
</tr>
</tbody>
</table>

Based on WHO data, around 1 in 6 persons in the world is an adolescent: that is 1.2 billion people aged 10 to 19. Most are healthy, but there is still significant death, illness and diseases among adolescents. Illnesses can hinder their ability to grow and develop to their full potential. Alcohol or tobacco use, lack of physical activity, unprotected sex and/or exposure to violence can jeopardize not only their current health, but often their health for years to come.

Promoting healthy practices during adolescence, and taking steps to better protect young people from health risks are critical for the prevention of health problems in adulthood, and for countries’ future health and social infrastructure.
PART 1

THE ADOLESCENT-FRIENDLY HEALTH SERVICES AND RISK BEHAVIORS OF ADOLESCENTS

At the end of Part 1, the health and non-health workers are expected to:

1. Define standards as used in the context of Adolescent-Friendly Health Services;
2. Outline the Philippines National Standards for Adolescent-Friendly Health Services;
3. Explain the implementation guide in operationalizing Adolescent-Friendly Health Services;
4. Cite the common risk behaviors in the Philippines.

This part contains information on two major topics, namely:

A. The Adolescent-Friendly Health Services
B. Risk Behaviors in the Philippines
A. ADOLESCENT-FRIENDLY HEALTH SERVICES

I. Standards for Adolescent-Friendly Health Services (AFHS)

The right to health, according to the UN Committee on Economic, Social and Cultural Rights, consists of six normative elements namely, health availability, health physical accessibility, health economic accessibility, health information accessibility, health acceptability and health quality. WHO’s criteria for adolescent-friendly health services include services being equitable, affordable, acceptable, adequate, comprehensive, effective, and efficient.

Cognizant of the right of the adolescent to the highest attainable standard of health through improved access and utilization of health services and the WHO criteria for provision of Adolescent Friendly Health Services, the Philippines adopts four national standards for the provision of Adolescent-Friendly Health Services.

Philippines National Standards for Adolescent-Friendly Health Services:

A standard is a statement of desired quality. The four quality standards for provision of Adolescent-Friendly Health Services (AFHS) were developed to ensure that adolescents will be able to enjoy a variety of facilities, goods, services and conditions necessary to realize the highest attainable standard of health. These standards are in line with the WHO’s criteria for Adolescent-Friendly Health Services and with the policy documents that exist in the country. These standards will also apply to health services that address the needs of youth.

| Standard 1 | "Adolescents in the catchment area of the facility are aware about the health services it provides and find the health facility easy to reach and obtain services from it". |
| Standard 2 | “The services provided by health facilities to adolescents are in line with the accepted package of health services and are provided on-site or through referral linkages by well-trained staff effectively”. |
| Standard 3 | “The health services are provided in ways that respect the rights of adolescents and their privacy and confidentiality. Adolescents find surroundings and procedures of the health facility appealing and acceptable”. |
| Standard 4 | “An enabling environment exists in the community for adolescents to seek and utilize the health services that they need and for the health care providers to provide the needed services”. |

The standards criteria were developed keeping in view the necessary resources, operational activities and the expected outcomes. The National standards will ensure that services being provided to the adolescents are uniform across all the service delivery points and are relevant to the present day needs of the adolescents. It is expected that adhering to the laid down standards would improve the utilization of such services.
II. Criteria of the Quality Standards of Adolescent-Friendly Health Services (AFHS) and Implementation Guide

**Standard 1**: "Adolescents in the catchment area of the facility are aware about the health services it provides and find the health facility easy to reach and obtain services from it."

**Rationale**: Adolescents are generally not aware about the availability of health services that cater to their needs. They either do not know about the location of the facility that provides health services in an adolescent-friendly manner or the type of services that are available from the facility. Thus, despite the availability of these services and competent personnel to provide such services, there is a low utilization rate of such services. Some of the reasons for low utilization could be the lack of informational activities to promote the adolescent services provided by these facilities; accessibility of the facility in terms of distance, cost and time; or the affordability of services. Actions are to be taken to ensure that adolescents are well-informed about the availability of health services.

<table>
<thead>
<tr>
<th>Input Criteria</th>
<th>Process Criteria</th>
<th>Output Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.1. There is a well-defined plan to inform adolescents in the community as to the availability of services from the facility.</td>
<td>P1.1. Activities to inform adolescents about the availability of services from the facility are carried out as per the existing plan.</td>
<td>Adolescents are aware about the type of services from the health facility, their working days and hours and know that they are welcome.</td>
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<tr>
<td>11.2. Health facility has a signboard which indicates - the type of health services that are provided - when they are provided - that adolescents are welcome.</td>
<td></td>
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<tr>
<td>11.3. Flexible time schedule for adolescent clients, if possible, is in place.</td>
<td>P1.3. Health services are provided as per the flexible time schedule.</td>
<td></td>
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<tr>
<td>11.4. Policies and procedures to provide health services to adolescents free of charge or at affordable prices are in place.</td>
<td>P1.4. Service providers provide adolescent with services free of charge or at affordable prices in line with the policies and procedures.</td>
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</tr>
<tr>
<td>11.5. A plan to provide outreach health services to adolescents, particularly those belonging to special groups in the catchment area of the health facility, is in place.</td>
<td>P1.5. Regular outreach services are being delivered to special groups of adolescents as per the plan.</td>
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</tbody>
</table>
Implementation Guide:

1.1 **Elements of a plan to inform adolescents.** The Information, Education and Communication (IEC) plan should contain the activities for information dissemination, place and time frame that they will be conducted, persons responsible, the resources needed, as well as the evaluation indicators and methods. In terms of activities, the facility may conduct periodic community sessions, information dissemination activities in schools especially during home room period, produce and post billboards in community areas being frequented by community residents especially the adolescents, and seminars in schools during special occasions. Posters containing the services in the facility may also be posted in strategic locations in the community. The information material, such as flyers, which can be distributed to adolescents during community festivities, after school hours, and in malls where adolescents usually go to, should contain the services available, time and place where these are available as well as the contact persons. Linkages with ongoing programs of various departments can be established and, if available, "peer group workers" and volunteers of various health programs should be informed about the services.

1.2 **Appropriate signboard.** The facility should have an appropriate signage in the health facility reflecting the services being provided and when they are provided. Tarpaulin, banners or posters stating that adolescents are welcome in the facility are posted/placed in an area in the facility that can easily be read by the adolescent clients.

1.3 **Use of a flexible time schedule.** In government-owned and operated facilities, services are offered on the usual schedule which is 8:00 AM to 5:00 PM. It is advisable to have facility schedule that suit the needs of the adolescents. To address this need, the facility personnel can either go on shifts making provision after office hours or weekend duties but still within the mandated minimum number of hours per week for government employees. If this is not possible, coordination with other facilities, organizations, agencies offering the same services even during weekends and after office hours should be made. Mechanisms to share the data with regards the clients served, services given and outcome should be put in place. A two-way functional referral system must be implemented. However, some private and non-government facilities are encouraged to have flexible time schedule so that they can cater to the needs of adolescents who may be engaged in other activities during the 8:00 AM to 5:00 PM schedule. The services could be offered from 7:00 AM to 10:00 PM, on a 24-hour basis, Saturdays and Sundays in these facilities.

1.4 **Provision of 'free' health services.** Government facilities offer health services to adolescents without any charges. As much as possible, services for adolescents should be given for free from other facilities, too. However, considering the expenses incurred for the maintenance and improvement of the facility vis-a-vis the budget given for the operation of these facilities, LGUs may resort to cost-sharing schemes. The amount to be paid should be by consensus and reached through consultations with different stakeholders including the clients, services providers, representatives from agencies concerned with adolescent care, community and even the government through the barangays. The cost of services and/or commodities will be posted in strategic places to inform the clients, general population and all stakeholders.
Private and non-government organizations may also institute schemes to sustain the operations of their facilities. Some of their services can be availed by adolescent clients at affordable prices or in a subsidized form.

1.5 **Elements of a plan to provide outreach services to adolescents.** Outreach services are needed to follow-up outcome of cases and / or defaulters, reach adolescents in hard-to-reach areas and/or clients with special needs, cater to special circumstances (i.e. victim of abuse/violence, etc.). These outreach activities should be planned. The plan should include the date and time, place, the personnel to be involved in the activity, the services to be given, resources needed, other agencies involved (if any) and the assistance that these agencies/organizations will provide. The outreach provider must have the necessary supplies.

Outreach activities may include periodic health check-ups, mobile clinics, community health camps, education sessions utilizing the available IEC materials, home visitation, and use of traditional media such as puppet shows and psychodrama. The provider should develop and maintain linkages with peer educators, volunteers, school teachers, school physicians and school nurses (where available), personnel from youth centers and other relevant agencies and develop joint activities to provide services. The provider should link up with schools to organize "question box" activities in the schools. The general questions could be taken up during the school health assembly.

| Standard 2: “The services provided by health facilities to adolescents are in line with the accepted package of health services and are provided on-site or through referral linkages by well-trained staff effectively”.

Rationale: Some of the health needs of adolescents may appear to be similar to those of adults yet the unique characteristics of this age group in terms of their physical, physiological, psycho-emotional, and even socio-cultural aspects necessitates that the needed services be provided in line with the required package effectively. In many cases the services that meet the adolescents' needs are either not fully provided from the health facilities or the services that are provided are not effective. This standard ensures that protocols, guidelines as well as services as per the accepted package that cater to the special needs of individuals in this age group are available from the designated health facilities.

This standard also ensures that the staff of adolescent-friendly health facilities possesses the necessary knowledge, attitude, skills and behavior to deal with their target clients.
<table>
<thead>
<tr>
<th><strong>Input Criteria</strong></th>
<th><strong>Process Criteria</strong></th>
<th><strong>Output Criteria</strong></th>
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<tbody>
<tr>
<td>I2.1. An agreed upon 'package' of services to be provided to adolescents is in place.</td>
<td>P2.1. Services provided / delivered on-site or through referrals are based on the agreed upon adolescent health package.</td>
<td>The services provided by the health facilities are effective and in line with the accepted package of services, and are provided on-site or through referral linkages by well-trained staff. The adolescents find the services to be in line with the defined package of services.</td>
</tr>
<tr>
<td>I2.2. An agreed upon list of essential commodities and supplies is in place.</td>
<td>P2.2. The essential commodities and supplies as per the agreed upon list are available and are provided to adolescents.</td>
<td></td>
</tr>
<tr>
<td>I2.3. A focal person has been designated for provision of adolescent-friendly health services.</td>
<td>P2.3. The focal person actually provides services to adolescents either at the facility or through referral and coordinates other activities.</td>
<td></td>
</tr>
<tr>
<td>I2.4. Service providers have been trained / oriented for the provision of AFHS and are competent in managing adolescent clients and providing guidance to their parents.</td>
<td>P2.4. The facility staff utilizes their competencies to provide health services effectively and competently.</td>
<td></td>
</tr>
<tr>
<td>I2.5 Protocols / guidelines to provide services competently in non-judgmental, caring, considerate, gender and culturally-sensitive attitude and manner are in place.</td>
<td>P2.5. The service providers follow the protocols /guidelines to provide services competently and in a non-judgmental, caring, considerate, gender and culturally-sensitive attitude and manner.</td>
<td></td>
</tr>
<tr>
<td>I2.6. Clinical management guidelines for the provision of the specified health services are in place.</td>
<td>P2.6. The service providers follow the clinical guidelines for the provision of services.</td>
<td></td>
</tr>
<tr>
<td>I2.7. A resource directory of organizations and referral networks providing health services that are not provided at the facility is available.</td>
<td>P2.7. The resource directory is utilized to refer the needy adolescents for the particular services that are not available at the facility.</td>
<td></td>
</tr>
<tr>
<td>I2.8. Appropriate forms for referral and feedback are available.</td>
<td>P2.8. The appropriate forms are utilized for referral and feedback.</td>
<td></td>
</tr>
</tbody>
</table>

**Implementation Guide:**

2.1 **The package of health services to be provided.** The list of essential health services to be provided to the adolescents as packages include basic essential health package, adolescent pregnancy package and STI/HIV package. The components of the package will be determined by the Department of Health.

2.2 **Essential medicines, equipment and supplies.** At the minimum, the basic medicines, equipment and supplies needed in the provision of services are present in the facility.
2.3 **Focal person/s in the health facility.** The facility must have a team of personnel (composed of the doctor, nurse and midwife) who will render services to adolescent clients and coordinate within and outside the facility. They should be oriented by attending orientation /training programs on dealing with adolescent clients such as the Orientation Program on Adolescent Health and Adolescent Job Aid (AJA). The focal person/s must provide the services to adolescents either at the facility or through appropriate referral institutions.

2.4 **Capability building for AFHS service providers.** It would be preferred that like the focal person/s in the facility, other service providers who are likely to deal with adolescents must have the competencies to deal with adolescents and their health needs effectively. They should attend capability building programs so that they can deal effectively with their adolescent clients. Programs include Orientation Program on Adolescent Health, Orientation on Standards and Implementation Guide for AFHS, and Adolescent Job Aid.

2.5 **Dealing in a non-judgmental and caring manner with adolescents.** The adolescent client should be dealt with respect and shown all courtesies that are due to a human being. Facility staff should be polite and considerate and avoid making any hurtful or damaging remarks for what so ever reason. Service providers must cultivate a non-judgmental attitude and not deprive adolescents from appropriate services on extraneous grounds including those on gender, education, social class, marital status, religious and political beliefs, and orientation. They should deal with adolescents sensitively and in a caring, considerate, gender and culturally-sensitive manner. Clinic rooms must have window curtains and a bed-screen surrounding the examination tables. Nobody else should be allowed to enter the room when the client is already there, in order to ensure privacy. Confidentiality policy of the clinic should be displayed and clearly expressed to the client and the individuals accompanying them in the first session.

2.6 **Clinical management of adolescents.** The Adolescent Job Aid (AJA) that was developed by a multi-sectoral group spearheaded by the DOH will be used for the common conditions of adolescents. The service provider should also refer to other relevant clinical guidelines (STI, management of specific conditions and other available guidelines) that are periodically issued / circulated by DOH.

2.7 **Resource directory of individuals/organizations and referral networks.** All facilities must develop a resource directory that should contain contact details of the relevant institutions and individuals. The resource directory should include the names of the organization/individual, address, contact person as well as contact details including the telephone numbers and websites (if available).
Resource Directory of Some Organizations

<table>
<thead>
<tr>
<th>#</th>
<th>Company/Organization/Complete Address</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Family Health Office, National Center for Disease Prevention and Control, Department of Health</td>
<td>ML: 6517800</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F:  7329956</td>
</tr>
<tr>
<td>2</td>
<td>United Nations’ Population Fund (UNFPA) 30/F Yuchengco Tower, RCBC Plaza 6819 Ayala Ave. corner Gil Puyat Ave., Makati City</td>
<td>DL: 9010328</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F:  9010348</td>
</tr>
<tr>
<td>3</td>
<td>Philippine Nurses Association (PNA) 1663 F.T. Benitez Street Malate, Manila</td>
<td>DL: 5361888</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F:  5251596</td>
</tr>
<tr>
<td>4</td>
<td>Integrated Midwives Association of the Philippines, Inc. (IMAP, Inc.) Pinaglabanan Street corner Ejercito Street San Juan City, Metro Manila</td>
<td>DL: 7244849</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F:  7244849</td>
</tr>
<tr>
<td>5</td>
<td>National Anti-Poverty Commission (NAPC) Youth &amp; Students MWSS-LWUA Complex Katipunan Ave. Balara, Quezon City</td>
<td>DL: 4265028</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F:  4265028 Local 107</td>
</tr>
<tr>
<td>6</td>
<td>Council for the Welfare of Children (CWC) 10 Apo Street, Sta. Mesa Heights Quezon City</td>
<td>DL: 7811039 Local 1005</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F:  7405490</td>
</tr>
<tr>
<td>7</td>
<td>Plan Philippines 4th Floor, Bloomingdale Building No. 205 Salcedo St., Legaspi Village Makati City</td>
<td>DL: 844-2175 to 78</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F:  8132033</td>
</tr>
<tr>
<td>8</td>
<td>Teen Republic Philippine Children’s Medical Center Quezon Ave., Quezon City</td>
<td>DL: 9246601 Local 234</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F:  9240840</td>
</tr>
<tr>
<td>9</td>
<td>Adolescent Wellness Center Teen Health Hub, The Medical City Ortigas Ave., Pasig City</td>
<td>DL: 6356789</td>
</tr>
<tr>
<td></td>
<td></td>
<td>By Appointment</td>
</tr>
</tbody>
</table>

2.8 Referral form. A referral form which contains the name of the referring facility and service provider, client’s details (name, age, address), history of present condition, physical/laboratory findings if appropriate, name and address of the facility where the client is to be referred, and reason for referral must be in place. A return referral form should be present and the client be instructed to bring this back to the referring facility. The referral form should be sealed in an envelope and addressed to the service provider of the facility to which the client is being referred to. All referrals made and their outcome should be listed in a referral logbook that should be maintained at the facility.
Sample Referral Form

### REFERRAL FORM

(To be left in the Referral Facility)

<table>
<thead>
<tr>
<th>Reference number ----</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Referring Facility:</td>
</tr>
<tr>
<td>Address: Tel No:</td>
</tr>
<tr>
<td>Name/Position of Service Provider Referring: Date of Referral:</td>
</tr>
<tr>
<td>Name of the facility to which the client is being referred:</td>
</tr>
<tr>
<td>Name of Client: Age:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Reason for Referral:</td>
</tr>
<tr>
<td>Brief History (Include pertinent PE and laboratory findings and actions taken, if any.)</td>
</tr>
<tr>
<td>Clinical Impression:</td>
</tr>
<tr>
<td>Signature of Person Referring Signature Over Printed Name of Client/Guardian:</td>
</tr>
</tbody>
</table>
REFERRAL RETURN SLIP

(Please cut and instruct patient/guardian to deliver back to Referring Facility)

Reference Number -----

<table>
<thead>
<tr>
<th>Name of Referral Facility:</th>
<th>Tel No:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name/Position of Person Who Attended to the Patient:</th>
<th>Date Seen:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Final Diagnosis:

Actions Taken (Include results of laboratory/ancillary procedures done and management)

Follow up advice:

<table>
<thead>
<tr>
<th>Signature of Person Who Attended to the Patient:</th>
<th>Signature Over Printed Name of Client/Guardian:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Standard 3** “The health services are provided in ways that respect the rights of adolescents and their privacy and confidentiality. Adolescents find surroundings and procedures of the health facility appealing and acceptable”.

**Rationale:** Adolescents will not seek services if the physical environment and procedures are not appealing to them. While ensuring the adolescents’ comfort and ease at the facility, it is crucial that the privacy and confidentiality of adolescents should be preserved and maintained throughout. Aside from the quality of services and attitude of personnel, the condition and features of the facility will also help contribute to client satisfaction and quality of care. It is important to get feedback, suggestions and recommendations from adolescents to be able to design facilities, procedures and protocols that will appeal to adolescents as well as suit their needs and taste.
### Implementation Guide:

3.1 **Ambiance of the facility.** The facility should:

- Provide comfortable seats with proper ventilation, fans, and good lighting.
- Provide access to clean drinking water and clean toilets. A separate toilet for female should be provided.
• Provide appealing reference materials (such as comics, brochures, services, survey results) for the adolescent to browse through while waiting.
• If possible, provide a computer/TV monitor and a player where a video material can be shown while client is waiting for his/her turn.

3.2 Confidentiality and privacy policy. The confidentiality and privacy should include provisions stating the mechanisms for registration, the filing and storage of records (records keeping), access to these records (specifying the personnel who can access these records as well as protocols to follow if people outside of the health facility would want to access records and information), general guidelines on non-disclosure of information regarding the patient, designated spaces for provider – client interaction to provide privacy, provision of barriers such as curtains, separate rooms, etc.

3.3 Ensuring confidentiality. Clients and their accompanying adults should be informed about the measures to maintain confidentiality. Each client should have an envelope or folder where their medical records or individual treatment records (ITRs), results of laboratory examinations or other special procedures done, referrals and other pertinent documents are filed. These are filed depending on a prescribed system (by numbers, family name, barangays, etc.). As much as possible, there should be a designated room with lock and key where these records should be filed. If this is not possible, these records should be kept in a filing cabinet with lock and key. There will be a designated personnel with access to these records. Records will only be pulled out only if a client – provider interaction will occur or in any situation as may be necessary. Personnel working outside the facility should have a written request if they want to access to the clients’ records for purposes of research, follow-up, etc. A verbal/written consent of the client should be obtained before information contained in their records will be disclosed to outside parties. The staff should not discuss the client’s situation with non-concerned parties.

3.4 Ensuring privacy. As much as possible, there should be a separate room where provider – client interaction should take place and where examinations such as pap smear, physical examination, etc. should be done. If it is not possible to provide a separate room, barriers such as curtains should be provided. The provider should only attend to one client at a time not unless the clients request that they be counseled together with other clients with similar problems or with friends/families/significant others. Specifically, the following must be observed:

• Ensure that the consultation and examination are done in a place where the interaction between the health worker and the adolescent cannot be heard or seen by anyone else;
• Ensure that no interruption occurs when a consultation or examination is in progress (like phone/text calls, signing papers, etc.)
• Ensure that no needless delays occur;
• Ensure that the adolescent is clear about on what to do (e.g. by labeling the different rooms such as pharmacy, and providing clear instructions as to where to go, have a laboratory test and when to come back for the results).
Examples: Privacy and Confidentiality

#1 – “We will be spending some time to talk about Maria’s history, especially her immunization, past illnesses and your concerns about her health. After that, I would like to spend some time alone with Maria. After I have examined her, I will ask you to come in again and we can discuss my assessment and our plans, any laboratory tests, treatments and follow-up plans. Is that all right with you?”

#2 – “First of all, I would like to say that whatever we talk about in this interview will be kept strictly confidential. Do you understand what is meant by confidential? Or would you want me to explain it further? However, there are certain situations when we may have to break this confidentiality – usually in the person's own interest. First is, if the person plans to hurt herself or hurt others, if she has been abused, if she has engaged in a serious crime or any activity that makes us believe that she could be in danger… in these situations, we will have to break confidentiality. So Mrs. X please be assured that I will notify you if I need to. Is that all right with you?”

3.5 Providing service in a friendly and appropriate manner. Service providers should view the adolescent as the primary patient. They should greet the adolescents and accompanying adult when they enter the clinic. Their behavior should inspire confidence in the adolescents. They should also offer a seat to the waiting clients if there are other clients seeking consultation and availing of the services. They must get the initial information from the client in an area designated for this purpose.

3.6 Adolescent involvement. As much as possible, adolescents should be involved in layout of the room and in putting up posters and IEC materials. The adolescents from the catchment area should be involved in making decisions about the type of IEC materials that should be kept in the facility. Once they are in the facility, they may be asked about the set-up of the facility, how equipment, materials and furniture can be arranged in such a way that they will not be hesitant to interact with the health personnel. A suggestion box on the manner by which services are provided can be placed in a conspicuous area in the facility.

3.7 Ensuring a smooth patient flow. A schematic diagram showing the flow of activities from admission to the different services provided, including the approximate time it would take to complete each transaction, should be posted in strategic areas. All efforts to reduce the waiting time to a minimum should be adopted.

Standard 4. “An enabling environment exists in the community for adolescents to seek and utilize the health services that they need and for the health care providers to provide the needed services”.

Rationale: In many situations, the community members are not aware of the importance of providing health services to adolescents. At times, there is reluctance, reservations and even opposition to ensuring access to such services. This deters not only adolescents from availing the services but also the service providers from delivering the needed health services to adolescents.
This standard encompasses community actions including educational campaigns that are aimed to increase the awareness of the community to the need and importance of providing health services to adolescents including those that aim to improve the sexual and reproductive health of adolescents. This standard seeks the assistance of individuals, agencies and organizations in the community in providing/delivering the services needed by the adolescents.

<table>
<thead>
<tr>
<th>Input Criteria</th>
<th>Process Criteria</th>
<th>Output Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>I4.1 A plan of activities (including community assemblies, meetings with parents, group meetings and school visits,) to be carried out in the community to inform community members about the benefits and availability of services to adolescents is in place.</td>
<td>P4.1 Activities as per the plan are carried out.</td>
<td>Community members are aware of provision of services and convinced about the benefits of providing adolescents with health information and services.</td>
</tr>
<tr>
<td>I4.2 Procedures to communicate with all adults visiting the health facility the benefits and availability of services to adolescents are in place.</td>
<td>P4.2 Service providers communicate effectively about the value of providing health services to adolescents and the type of services available in their interactions with adults.</td>
<td>Adolescents receive services from NGOs, selected community members, outreach workers and other adolescents.</td>
</tr>
<tr>
<td>I4.3 Plan to provide some health services and commodities to adolescents by selected community members, NGOs, outreach workers and adolescents themselves are in place.</td>
<td>P4.3 Activities as mentioned in the plan are carried out.</td>
<td></td>
</tr>
<tr>
<td>I4.4 A plan to carry out advocacy for support to provision of services for adolescents from the Local Development Plan (LDP) exists.</td>
<td>P4.4 Activities in the plan to seek support from the Local Development Plan (LDP) are carried out.</td>
<td></td>
</tr>
</tbody>
</table>

**Implementation Guide:**

4.1 **Activities to inform community members about the value of providing adolescents with services.** The community can be engaged in a variety of ways like seeking their views while informing them about the benefits and availability of services to adolescents and involving them in prioritizing the areas that need to be addressed. The energies of the community members should be utilized in a variety of ways to create an enabling environment. Community assemblies can be utilized to explain to the members of the community the benefits that adolescents can derive from seeking services from the facility. In schools, concerns of adolescents can be discussed during parent-teacher meetings and the service providers can discuss the services that adolescents can avail of depending on the issues and concerns that are presented in the meeting. Service providers may visit schools during health fairs and have a booth that displays their services. In these events, a health communication material developed by the facility and prepared in the vernacular can also be distributed. Short meetings can be organized with women's groups, self-help groups and other relevant sections and discussion about adolescent vulnerabilities and availability of services could be discussed.
Activities can also be planned during fairs and other festivities where adolescents are expected to gather in large numbers.

Folk media and mass media (TV, Radio, newspapers, magazines and web-based) should be effectively engaged in generating awareness about issues that impact the health of adolescents as well as for improving awareness regarding the availability of adolescent-friendly health services.

4.2 Communicating with other ADULTS visiting the facility about the value of providing adolescents with services. All adults visiting the facility should be informed of the current status of adolescent health in the community. IEC materials (such as comics, leaflets, flyers) with the adults/parents as target audience can be given so that they will be informed of the value of availing of the services of the facility whenever their adolescent sons and daughters are in need of these services. Sessions with adults can also be done in the health center/facility using a flipchart. Concerns of these adults/parents can also be addressed in the open forum/question and answer part right after the education session.

4.3 Involving selected community members in providing health services/commodities. It is necessary to identify different organizations, individuals, agencies in the community who have adolescent care as their main area of concern or interest. These different stakeholders should be involved in formulating plans for the provision or improvement of services. This will enable them to identify their roles and contributions to the overall plan for service provision to this special group. It is also an opportunity to forge partnerships and devise procedures and mechanisms to ensure the smooth flow of service delivery.

Community members and organizations may also be involved in other activities such as sports fest, clean and green campaigns, and tree planting. The elected officials of the community may also pass ordinances banning smoking and alcohol use among minors. In this way, adolescents can be productive and responsible members of the community. In the event that there are adolescents who need to be rehabilitated, elected officials may also be involved in community-based rehabilitation programs.

4.4 Advocating for support in the local development plan. A Task Force on adolescent health can be created/established. Members of the task force would be representatives from planning, budget, health, NGOs, social services, among others. Other approaches should also be explored. The facility manager or focal person may present the services being provided during meetings of the local health board. In this way, the representative of the local health unit, together with the elected officials in the community will be enlightened on the importance of providing services to adolescents. Meetings of the school board are also another venue for generating support to the provision of health services to adolescents. Local government units (LGUs) may develop resolution and pass ordinances in support of adolescent health activities and programs.

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Tips for Health Providers on How to Deal with Adolescents and their Accompanying Adult

General Guidelines for the Clinic Visit

1. Space
   - Adolescents prefer their own waiting area in a health facility. They do not want to be treated as young children, nor as adults.
   - It is helpful if the waiting area/room has materials such as magazines and other health education items appropriate for adolescents. Playing educational video programs and films will also be good, so that every opportunity is maximized to provide them with information. Likewise, it helps the adolescent to feel that it is “OK” to talk about the subjects.
   - At least one examination room should be set aside for use with teens. The examination table should be facing away from the door.
   - When interviewing an adolescent, avoid sitting behind a large desk or office table. The desk should be oriented in a way that you can sit beside the desk, not behind it. Placing a large desk between you and the adolescent can create an artificial barrier.

2. Liking the Adolescent
   - To provide effective care and establish rapport with the adolescent, the health-care provider must like adolescents. If the health-care provider dislikes or is extremely uncomfortable with teenagers, it is best to refer them to Health Service Providers who are comfortable with them.

3. Avoiding interruptions
   - Constant interruptions and phone calls during the interview as well as during the examination tend to decrease rapport.

4. Note-Taking
   - When note-taking, the health service provider should first request teen’s permission. During the interview, take note only of pertinent data.

5. Ensuring Privacy and Confidentiality
   - It is important to establish a sense of privacy and confidentiality with the adolescent.
   - Ensure a private place for the examination and counseling
   - Tell the client that all discussions and matters pertaining to the visit will not be transmitted to others.
   - Never discuss confidential information about the client with other people outside the facility.
   - Much of the history/information should be obtained directly from the teenager. If accompanied (by parents/guardian or a friend etc.) ask the companion to stay out of the room.
   - Organize the examination area so that, during the examination, the adolescent is protected from the view of other people (door, curtain, screen, wall).
- Keep all records in a safe place.
- Limit access to logbooks and registers to responsible providers only.
- A potential breaking of confidentiality can be done when:
  a. The situation has a grave threat to the adolescent’s own life; e.g. s/he plans to commit suicide; someone plans to kill or harm her/him; or to prevent the occurrence of further abuse.
  b. The matter has a grave threat to the life and health of others; e.g. such as to prevent spread of HIV/AIDS to other people; s/he is contemplating to kill other person, etc.

If in certain circumstances, you believe that it is necessary to share information with others, explain why it is important and explain to whom, when, and how the information will be shared. Be sure you have the adolescent’s consent before doing so. But, whether s/he agrees or not, you can report the matter to the right agency/person; and if it is with a clear intention of helping the concerned adolescent get out of the grave situation.

6. Establishing Rapport

Establishing rapport with an adolescent, especially with a non-verbal or hostile teenager, can be difficult. Helpful suggestions include:

- Greet the adolescent politely and make her/him feel comfortable.
- Begin the interview by introducing yourself to the teen and parents or guardian (if s/he comes with a companion). It is helpful to shake the hands of the adolescent.
- Be friendly, respectful and non-judgmental throughout your interaction with the client.
- Call the adolescent by his/her name during the session.
- Begin by chatting informally about friends, school or hobbies. This decreases tension, it also enables the service provider to gain important insights into the adolescent’s personality, mood and thought content.
- Allow the adolescent to talk freely.
- Treat the adolescents’ comments seriously. The adolescent should feel you are treating him/her as a person, not as a child or patient.
- Start with non-threatening health questions. At any medical examination or before any procedure, seek his/her permission; inform and explain to the adolescent what you are doing.
- Explore with the adolescent the issues that concern her/him. These issues may differ radically from concerns expressed by the parent or guardian.
- Along the course of interaction, summarize the most important information that the adolescent has to understand, medical findings, laboratory tests done and treatments.
- If a referral to other facility is necessary, provide a two-way referral slip and explain where, how and when the client can go to avail of the needed services.

- Schedule his/her return visit.

If in case you had a hard time getting the adolescent’s cooperation it would be better to schedule another clinic visit.

Aside from the guidelines mentioned above, the following are additional tips on how to establish rapport

Establishing rapport with your adolescent clients

What you should be aware of:
1. Some adolescents may come to you of their own accord, alone or with friends or relatives. Other adolescents may be brought to see you by a parent or another adult. Depending on the circumstances, the adolescent could be friendly or unfriendly with you. Also, depending on the nature of the problem or concern, the adolescent could be anxious or afraid.

2. Adolescents may be reluctant to disclose information on sensitive matters if their parents or guardians, or even spouses are also present.

What you should do:
1. Greet the adolescent in a cordial manner.
2. Explain to the adolescent that:
   - you are there to help them, and that you will do your best to understand and respond to their needs and problems;
   - you would like them to communicate with you freely and without hesitation;
   - they should feel at ease and not be afraid because you will not say or do anything that negatively affects them;
   - you want them to decide how much they would like to involve their parents or others;
   - you will not share with their parents or anyone else any information that they have entrusted you with, unless they give you the permission to do so.

3. If the adolescent is accompanied by an adult, in their presence, explain to the accompanying adult that you want to develop a good working relationship with the adolescent. At some stage you may need some time to speak to the adolescent alone.

III. Implementing Mechanisms at Various Levels

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Different sectors and facilities are involved in the provision of adolescent-friendly health services. Roles are outlined so that respective sectors and facilities are informed of what they should do in catering to the needs of adolescents.

National Level (Department of Health):
- Formulate standards/policies/guidelines
- Develop communication plan on adolescent health
- Develop training manual for personnel rendering health services to adolescents
- Conduct capability-building activities for personnel involved in the provision of services for the adolescents
- Coordinate with other agencies (GOs and NGOs) on the implementation of standards and guidelines for health facilities
- Develop guidelines which are in line with the implementation of AFHS
- Mobilize resources for the implementation of adolescent health activities
- Conduct monitoring and evaluation activities

Center for Health Development (CHD) Level:
- Provide technical assistance to LGUs (plan preparation, materials development etc.)
- Disseminate guidelines to LGUs and other directives that may be circulated by the Department of Health periodically
- Appoint focal person in the region who will be in-charge of the implementation of the standards and implementation guide
- Organize a multi-sectoral technical working group in the region
- Formulate a region-wide plan on the implementation of standards and implementation guide
- Establish a database of facilities in the region providing adolescent health services
- Monitor and evaluate the facilities providing services to adolescents in the provinces under its jurisdiction

LGU (Provincial/Municipality/City) Level:
- Develop ordinances, resolutions in support of adolescent health
- Disseminate guidelines, protocols, policies and procedures which may be circulated by the Department of Health in relation to the provision of health services to adolescents
- Provide support to adolescent health activities and advocacy efforts
- Network with various sectors
- Prepare report on the services utilized by the adolescents; commodities used and needed to be replaced; personnel who provided services; and attended capability building activities

Non-Government Organizations
- Utilize the standards and implementation guide in the provision of health services
- Provide services needed by adolescents within the capability of the organization
- Share good practices in the provision of services to adolescents

Professional Organizations
- Orient the members of the organization on the standards and implementation guide
- Disseminate the guidelines and other directives to its members that may be circulated by the Department of Health periodically
- Act as technical resource group on adolescent health
- Participate in the conduct of orientation programs related to adolescent health

Academic Institutions
- Promote adolescent-friendly institutions
- Act as technical resource persons on adolescent health
- Develop adolescent-oriented programs and activities
- Orient the teachers and other personnel of the standards and implementation guide
- Refer adolescents to facilities that provide services to adolescents
- Conduct orientation programs to adolescents regarding the services which they can avail from adolescent-friendly health facilities

IV. Monitoring and Evaluation of the AFHS Quality Standards

The AFHS quality standards will be monitored and evaluated in two ways:
1. Continuous monitoring of the AFHS package implementation
2. Periodic evaluation on compliance with the AFHS quality standards

The implementation of quality standards of AFHS will be monitored by the authorities. The initial activity will be spearheaded by the National Technical Working Group (TWG) and will be done six (6) months after the implementation of the standards and implementation guide. A bi-annual monitoring will be conducted by the regional technical working group among the facilities under its jurisdiction.

The evaluation on the compliance with the AFHS quality standards will be carried out in line with Department of Health (DOH) guidelines. Tools contained in this document may be utilized by various organizations and facilities in the monitoring and evaluation activities.

Note:
The following recording and reporting forms, developed by the Adolescent Health and Development Program (AHDP), Family Health Office, National Center for Disease Prevention and Control, should be used by adolescent health focal personnel in government facilities in the Philippines.

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### Adolescent Health and Development Program AHDP

**Reporting Form**

<table>
<thead>
<tr>
<th>Province</th>
<th>Number of Municipalities/cities</th>
<th># of Mun &amp; cities With Trained HW on AIA, Give #s</th>
<th># of Mun &amp; Cities with trained peer educators</th>
<th># of RHU/CHO with peer ed assisting</th>
<th>Total # of Peer Educators</th>
<th># of Adolescents seek consult</th>
<th>Top Ten Common Adolescent Health Issues and Numbers</th>
<th>Teen Pregnancy</th>
<th>Number of adolescents Referred</th>
<th>Number of Feedback received</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

**Reported by:**

Regional Adolescent Health and Development Program Coordinator

**Noted by:**

Cluster Head

**Approved by:**

Regional Director
### Adolescent Health and Development Program AHDP

**Reporting Form**

<table>
<thead>
<tr>
<th>Name of Municipality</th>
<th>Number of Health Workers oriented on AJA</th>
<th>Number of adolescents trained on peer education</th>
<th>Number of adolescents seeking consult</th>
<th>Top ten common issues of adolescents</th>
<th>Number referred</th>
<th>Number of Feedbacks</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

Reported by: ___________________________  
Noted By: ___________________________  
Approved by: ___________________________

AHDG coordinator  
Cluster Head  
Provincial Health Officer
<table>
<thead>
<tr>
<th>Name of RHU</th>
<th>Name of adolescent</th>
<th>Age</th>
<th>Sex</th>
<th>Birthday</th>
<th>Address</th>
<th>Chief Complaint</th>
<th>PE</th>
<th>Working Diagnosis</th>
<th>Final Diagnosis</th>
<th>Management</th>
<th>Remarks</th>
</tr>
</thead>
</table>

**PART 1: THE ADOLESCENT-FRIENDLY HEALTH SERVICES AND RISK BEHAVIORS OF ADOLESCENTS**
## ADOLESCENT HEALTH AND DEVELOPMENT PROGRAM (AHDP)

**Reporting Form**

| Region: __________________________ |
| Name of Province: __________________________ |
| Name of Municipality: __________________________ |

<table>
<thead>
<tr>
<th>Total Number of RHU Personnel</th>
<th>Number of Trained Health Worker on AIA</th>
<th>Number of Peer Education Sessions Conducted</th>
<th>Number of Trained Peer Educator Assisting in the RHU</th>
<th>Number of Adolescents Seeking Consult at RHU</th>
<th>Top 10 Common Issues Among Visiting Adolescents (Cases and Numbers)</th>
<th>Teen Pregnancy</th>
<th>Number of Referrals</th>
<th>Number of Feedbacks</th>
<th>Other Adolescent Activities as Community Outreach Conducted</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Reported by:** __________________________________________  
**Noted and approved By:** __________________________________________

---

**PHN/ AHDP Coordinator**  
**Municipal Health Officer**
Note:

The following monitoring and evaluation forms, developed by the Adolescent Health and Development Program (AHDP), Family Health Office, National Center for Disease Prevention and Control, should be used by adolescent health focal personnel in government facilities in the Philippines.

### Adolescent Health and Development Program Evaluation

**City/Province:** __________  **Region:** ______________________

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Bases for Computation</th>
<th>Accomplishment</th>
<th>Points</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Established Adolescent-Friendly Health Facility (AFHF)</td>
<td>No. of Mun/Cities with AFHF</td>
<td>100% = 10 pts</td>
<td>75% = 7.5 pts</td>
<td>50% = 5 pts</td>
</tr>
<tr>
<td></td>
<td>Total number of municipalities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LGU program support/allocated budget for Adolescent Program</td>
<td># of LGUS allocated specific budget for adolescent health program</td>
<td>100% = 10 pts</td>
<td>75% = 7.5 pts</td>
<td>50% = 5 pts</td>
</tr>
<tr>
<td></td>
<td>Total # of LGUs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social mobilization &amp; Program Implementation</td>
<td># of LGUs conducted AHDP activity</td>
<td>100% = 10 pts</td>
<td>75% = 7.5 pts</td>
<td>50% = 5 pts</td>
</tr>
<tr>
<td></td>
<td>Total # of LGUs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescent &amp; Youth Capability Building</td>
<td># of LGUs with organized AYHD training among youths</td>
<td>100% = 10 pts</td>
<td>75% = 7.5 pts</td>
<td>50% = 5 pts</td>
</tr>
<tr>
<td></td>
<td>Total # of LGUs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td># of L&amp;D institutions with organized AYHD training among in-school</td>
<td>100% = 10 pts</td>
<td>75% = 7.5 pts</td>
<td>50% = 5 pts</td>
</tr>
<tr>
<td></td>
<td>Total # of Learning &amp;Dev’t. Institutions in the Area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program Networking &amp; Partnership</td>
<td># of LGUs with organized partners supporting Adolescent Health and Development Programs</td>
<td>100% = 10 pts</td>
<td>75% = 7.5 pts</td>
<td>50% = 5 pts</td>
</tr>
<tr>
<td></td>
<td>Total # of LGUs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recording and referral</td>
<td># of LGUs with Adolescent recording and reporting system</td>
<td>100% = 10 pts</td>
<td>75% = 7.5 pts</td>
<td>50% = 5 pts</td>
</tr>
<tr>
<td></td>
<td>Total # of LGUs</td>
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</tbody>
</table>

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<table>
<thead>
<tr>
<th></th>
<th># of LGUs with Adolescent referrals system established</th>
<th>100% = 10 pts</th>
<th>75% = 7.5 pts</th>
<th>50% = 5 pts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total # of LGUs</td>
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</tbody>
</table>

|                               | # of LGUs with adoption of ordinance of AHDP         | 100% = 10 pts | 75% = 7.5 pts | 50% = 5 pts |
|                               | Total # of LGUs                                      |               |               |            |

|                               | # of LGUs with localized ordinance of AHDP           | 100% = 10 pts | 75% = 7.5 pts | 50% = 5 pts |
|                               | Total # of LGUs                                      |               |               |            |

Submitted by:

______________________________
AYHDP Coordinator

Approved by:

______________________________
Regional Director
## MONITORING CHECKLIST

ADOLESCENT AND YOUTH HEALTH DEVELOPMENT PROGRAM (AYHDP)

Municipality/City/Province: ______________________ Region: ______________________

<table>
<thead>
<tr>
<th>Program/Service</th>
<th>Regional Health Office</th>
<th>Provincial Health Office</th>
<th>City Health Office</th>
<th>Rural Health Unit</th>
<th>Barangay Health Station</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Provision</td>
<td></td>
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<td></td>
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<tr>
<td>• Immunization</td>
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<tr>
<td>• Deworming</td>
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<tr>
<td>• Dental</td>
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<tr>
<td>• Iron supplement</td>
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<tr>
<td>• Prenatal check up</td>
<td></td>
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<tr>
<td>• Post natal check up</td>
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<tr>
<td>• Health Education and Counselling</td>
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<tr>
<td>Surveillance</td>
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<tr>
<td>• Reporting system</td>
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<tr>
<td>• Referral/feedback</td>
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<tr>
<td>Capacity building</td>
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<tr>
<td>• Peer Education Training</td>
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<tr>
<td>• AJA Training /Equivalent</td>
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<tr>
<td>Social Mobilization</td>
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<tr>
<td>• Policy Dissemination/ Implemented</td>
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<tr>
<td>Advocacy</td>
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<tr>
<td>• Information Educ. Communications Sessions</td>
<td></td>
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<tr>
<td>• IEC Materials distributed</td>
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<td></td>
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<tr>
<td>• Information Educ. Communication Strategies</td>
<td></td>
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<tr>
<td>Networking and partnership</td>
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<tr>
<td>Monitoring and Evaluation</td>
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</table>

Monitoring Teams:

__________________________  Noted by  ______________________

__________________________  Designation  ______________________

__________________________
Protocols in the Conduct of Monitoring AHDP:

- Courtesy call to the Regional Director/LCEs
- Request for assistance from the AHDP
- Micro planning with the regional coordinator

Guide Questions:

I. Adolescent Friendly Health Facility

Manpower
- Who is the focal person managing adolescent client? ____________________________
- Are there trained personnel on AHDP using AJA? Yes _____ How many ____________ No Why?__________________________
- Who conducted the training? ____________when? ____________And where? ____________

Mansion
- Where will you conduct physical/psychosocial evaluation of adolescent client? ____________________________
- Is there room specific for adolescent?Yes ________ No ________

Methods/Management/procedure
- Do you practice confidentiality and privacy? Yes _______ How? ____________________________
- No _______ Why? ______________________________________________________________________

Money
- Is there specific budget for the program? Yes ________ No ________ Why ____________________________
- How much of the total health budget goes to AHDP? Specify percent.________________________

Materials
- What are your available services for adolescents(young people)? Pls mention all
  ____________________________ ____________________________ ____________________________
- Do you have FP commodities? Yes _____ No ________
- If yes, are you providing FP commodities? (mention all) ____________________________

II. Partnership:

- Are there organizations in the community that adolescents are involve? Yes _______ No ____________
- Can you name the organization and the involvement of the adult, young/adolescent people?
  ____________________________ ____________________________ ____________________________
- Was there peer education training conducted? Yes _____ No ________
- Who conducted it? ______________ Where? ____________________________
- ____________________________ When was this conducted? ____________________________
  ____________________________
- What do you think was the impact of that training to young people? To Adult?
III. Social Mobilization:
- Was there AHDP activity in the area? What ________________ when ________________ where ________________ and who initiated it ________________
- What are the roles of young people.
  (ex. Medical outreach, community activity like school to school disease prevention campaign etc)

IV. Recording and Reporting:
- Do you have a system of recording all the services for young people? Yes ______ No ______
- Where do you log adolescent clients name?
- Are there separate recording for adolescents? Yes ______ No ______ Are there segregated data for 10-14 and 15-19 years old? ________________
- Where do you report cases and how often.

V. Referrals:
- Do you refer adolescent clients? Yes _____ No _____ What particular case, where?
  ________________ ________________
- Are there feedback of your referred client?
- In a month how often do you/your office refer young people case? ________________ (what particular case)

VI. Policies/ Ordinances:
- Do you have policy on AHDP? Yes _____ No _____ Date issued ________________
- Are there ordinances pertaining to young people? Date? Ask one if possible ________________
- Was the ordinance implemented? ________________
- Impact to young people
  ________________ ________________

Thank you.
B. RISK BEHAVIORS IN THE PHILIPPINES

2013 Young Adult Fertility and Sexuality (YAFS) Study

The Young Adult Fertility and Sexuality (YAFS) Study is a series of national surveys on the Filipino youth, conducted since 1982 by the University of the Philippines Population Institute (UPPI) and the Demographic Research and Development Foundation. Gathering data from Filipino youth aged 15 to 24 year-olds, YAFS is one of the primary sources of information on sexual and non-sexual risk behaviors and its determinants in the Philippines, at the national and regional levels. Rapid technological change especially in communications technology, the changing landscape of Philippine labor, emergent issues in reproductive health such as the rising prevalence in HIV infection, premarital sex, teenage pregnancy and sexually transmitted infections (STIs) among today’s youth - all provided the impetus to collect new data on young people through a fourth YAFS round now called YAFS 4. Work on YAFS 4 commenced in September 2012 and is set to be completed by July 2014. The total number of respondents is 19,178. The profile of the respondents in the 2013 Young Adult Fertility and Sexuality (YAFS) Study (YAFS 4) is as follows:

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>48.80</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>51.20</td>
<td></td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-19</td>
<td>59.80</td>
<td></td>
</tr>
<tr>
<td>20-24</td>
<td>40.20</td>
<td></td>
</tr>
<tr>
<td><strong>Highest Education Completed</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elementary</td>
<td>15.00</td>
<td></td>
</tr>
<tr>
<td>High School Undergrad</td>
<td>37.90</td>
<td></td>
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<tr>
<td>High School/Vocational</td>
<td>26.80</td>
<td></td>
</tr>
<tr>
<td>College</td>
<td>20.20</td>
<td></td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never married</td>
<td>76.10</td>
<td></td>
</tr>
<tr>
<td>Formally married</td>
<td>9.30</td>
<td></td>
</tr>
<tr>
<td>Living-in</td>
<td>13.70</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>1.00</td>
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<tr>
<td><strong>Religion</strong></td>
<td></td>
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<tr>
<td>Catholic</td>
<td>74.20</td>
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<tr>
<td>Other Christian</td>
<td>18.40</td>
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<tr>
<td>Muslim</td>
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<tr>
<td><strong>Main Activity</strong></td>
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<tr>
<td>None</td>
<td>9.50</td>
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</tr>
<tr>
<td>Student</td>
<td>37.10</td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>6.80</td>
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<tr>
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<td>20.30</td>
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<tr>
<td>Unpaid family worker</td>
<td>3.30</td>
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<tr>
<td>Working</td>
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<td></td>
</tr>
</tbody>
</table>


A. Non-Sexual Risk Behaviors

Key Findings based on YAFS 4: Non-sexual risk behaviors\textsuperscript{9}

- Decreasing proportion of youth who are currently smoking
  a. YAFS 1994: 21.6
  b. YAFS 2002: 20.9
  c. YAFS 2013: 19.7

- Decrease in the proportion of youth who are currently drinking during the past decade
  a. YAFS 1994: 37.4
  b. YAFS 2002: 41.4
  c. YAFS 2013: 36.7

- Decrease in the proportion of youth who ever used drugs during the past decade
  a. YAFS 1994: 5.7
  b. YAFS 2002: 10.6
  c. YAFS 2013: 3.9

B. Sexual Risk Behaviors

Key Findings based on YAFS 4: Sexual risk behavior of Pinoy young adults\textsuperscript{10}

- 1 in 3 Pinoy Youth has engaged in premarital sex
- Increasing prevalence of premarital sex over the years
- Narrowing gap in levels of premarital sex between males and females
  o Percent of youth who have engaged in premarital sex
    ▪ Male: 35.5
    ▪ Female: 28.7
    ▪ Both Sexes: 32.0

- Higher levels of premarital sex among males, older youth and those who are living-in compared to their counterparts
  o Percent of youth who have engaged in premarital sex according to:

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
<th>Marital Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male:</td>
<td>35.5</td>
<td>15-19: 16.9</td>
</tr>
<tr>
<td>Female:</td>
<td>28.7</td>
<td>20-24: 54.3</td>
</tr>
</tbody>
</table>


- 78% of the 1st premarital sex was unprotected against the risk of pregnancy and/or STI
  - Percent of youth who did not use any form of protection during 1st premarital sex according to:

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
<th>Marital Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male:</td>
<td>73.4</td>
<td>Never married:</td>
</tr>
<tr>
<td>Female:</td>
<td>83.8</td>
<td>Formally married:</td>
</tr>
<tr>
<td></td>
<td>15-19:</td>
<td>72.8</td>
</tr>
<tr>
<td></td>
<td>20-24:</td>
<td>84.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Living-in:</td>
</tr>
<tr>
<td></td>
<td>79.0</td>
<td>83.5</td>
</tr>
</tbody>
</table>

- Pinoy youth have also engaged in other risky sexual behaviors
  a. 7.3% have engaged in casual sex
  b. 5.3% of male youth have MSM experience
  c. 3.1% of ever-married youth (including those living-in) have extramarital sex experience
  d. Most of these risky sexual activities are unprotected against the risk of pregnancy and/or STIs
At the end of Part 2, the health and non-health workers are expected to:

1. Differentiate the male and female puberty-related conditions
2. Outline the stages in breast development among female adolescents
3. Discuss the menstrual cycle as part of fertility awareness
4. Discuss the nutritional concerns of adolescents including sports nutrition
5. Explain the oral health concerns of adolescents

This part contains information on the following topics, namely:

A. Male and Female Puberty Related Conditions
B. Breast Development
C. Menstrual Cycle
D. Nutritional Concerns
   - Height, Weight and BMI Computation
   - Anemia
   - Sports Nutrition
E. Oral Health
A. MALE AND FEMALE PUBERTY RELATED CONDITIONS

Puberty is the developmental stage during which secondary sexual characteristics appear. This usually begins between ages 8 – 12 in girls and 9 – 14 in boys or Tanner Stage 2 breast development in girls and Tanner Stage 2 testicular enlargement in boys. This is due to the pulsatile secretion of the Gonadotropin releasing hormone (GnRH) and the activation of the hypothalamic – pituitary – gonadal axis.

Important related terms are:
- **Thelarche** is the onset of female breast development.
- **Pubarche** is the appearance of sexual hair.
- **Adrenarche** is the onset of androgen-dependent body changes such as growth of axillary and pubic hair.

In females, breast development earmarks the beginning of puberty with menarche (first menstruation) as its major landmark. In males, testicular enlargement earmarks the beginning of puberty with the first ejaculation as its major landmark. The most visible changes during puberty are growth in stature and development of secondary sexual characteristics.

Girls and boys undergo different physical changes and at different rates during puberty. The physical changes during the stages of puberty for girls and boys are presented in following table.

Changes that occur in girls and boys during puberty

<table>
<thead>
<tr>
<th>Stages</th>
<th>Boys</th>
<th>Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Stage</td>
<td>9 – 12 (average age: 10)</td>
<td>8 - 11</td>
</tr>
<tr>
<td>Age of Onset</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Changes</td>
<td>● Initial growth spurt (average of 2 inches a year)</td>
<td>● Changes are occurring inside the body as the ovaries react to LH and FSH and develop estrogen producing capabilities</td>
</tr>
<tr>
<td></td>
<td>● Growth of scrotum and testis but still unable to reproduce</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Appearance of very fine hair in the pubic area</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Occasionally experience erection</td>
<td></td>
</tr>
</tbody>
</table>

| Second Stage       | 12 – 13                   | 11 -12                     |
| Age of Onset       |                           |                            |
| Changes            | ● Continue to grow taller more rapidly at a rate of 2 – 3 inches per year | ● Budding of breasts (areola rises and darkens and some transitional breast tissue exists) |
|                    | ● Testis continue to grow |                                |
|                    | ● Pubic hair begin to gain some color |                                |
|                    | ● Erections become more frequent |                                |
|                    | ● Body begins to take a leaner, more adult and masculine shape |                                |
|                    | ● Growth spurt occurs |                                |

---


**Third Stage**

<table>
<thead>
<tr>
<th>Age of Onset</th>
<th>13 – 14 (as early 11 and as late as 16)</th>
<th>12 - 13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes</td>
<td>• Gains in height</td>
<td>• Growth of breasts and pubic hair continues</td>
</tr>
<tr>
<td></td>
<td>• Testicles continue to grow</td>
<td>• Hair may have begun to show in the armpits</td>
</tr>
<tr>
<td></td>
<td>• Penis begins to grow in length</td>
<td>• Vagina grows in size</td>
</tr>
<tr>
<td></td>
<td>• Pubic hair begins to grow darker and fuller</td>
<td>• Menarche will occur in 7 out of 10 girls</td>
</tr>
<tr>
<td></td>
<td>• Erections become common</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Voice suddenly and uncontrollably changes pitch mid-word or sentence</td>
<td></td>
</tr>
</tbody>
</table>

**Fourth Stage**

<table>
<thead>
<tr>
<th>Age of Onset</th>
<th>14 – 15</th>
<th>13 - 14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes</td>
<td>• Grows taller and faster at about 4 inches a year</td>
<td>• Accelerated growth in height slows down</td>
</tr>
<tr>
<td></td>
<td>• Pubic hair grows more coarse</td>
<td>• Level of body fat will reach higher adult levels</td>
</tr>
<tr>
<td></td>
<td>• Hair begins showing in the armpits and face</td>
<td>• Pubic and underarm hair will continue to grow fuller and coarser</td>
</tr>
<tr>
<td></td>
<td>• Penis grows thicker and continues to lengthen</td>
<td>• Ovulation may be irregular as it establishes its rhythm</td>
</tr>
<tr>
<td></td>
<td>• Voice becomes deeper</td>
<td></td>
</tr>
</tbody>
</table>

**Final Stage**

<table>
<thead>
<tr>
<th>Age of Onset</th>
<th>14 - 18</th>
<th>14 – 17 (for some it may be until 19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes</td>
<td>• Achieves most of his height</td>
<td>• Have reached their full adult height</td>
</tr>
<tr>
<td></td>
<td>• Pubic hair spreads out to inner thighs and lower stomach</td>
<td>• Breasts have reached their full size</td>
</tr>
<tr>
<td></td>
<td>• Body shape evolved to that of a man – broad shoulders; fully developed and formed muscles; proportioned arms, legs and chest for power and masculine appearance</td>
<td>• Pubic hair has fully developed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Period and ovulation occur regularly</td>
</tr>
</tbody>
</table>
Pubic Hair

Stage 1: Pre-adolescent

Male: Vellus hair appears over the pubes with a degree of development similar to that over the abdominal wall. There is no androgen-sensitive pubic hair.
Female: Vellus hair develops over the pubes in a manner not greater than that over the anterior wall. There is no sexual hair.

Stage II

Male: There is sparse development of long pigmented downy hair, which is only slightly curled or straight. The hair is seen chiefly at the base of penis. This stage may be difficult to evaluate on a photograph, especially if the subject has fair hair.
Female: Sparse, long, pigmented, downy hair, which is straight or only slightly curled, appears. These hairs are seen mainly along the labia. This stage is difficult to quantitate on black and white photographs, particularly when pictures are of fair-haired subjects.

Stage III

Male: The pubic hair is considerably darker, coarser, and curlier. The distribution is now spread over the junction of the pubes, and at this point that hair may be recognized easily on black and white photographs.
Female: Considerably darker, coarser, and curlier sexual hair appears. The hair has now spread sparsely over the junction of the pubes.

Stage IV

Male: The hair distribution is now adult in type but still is considerably less that seen in adults. There is no spread to the medial surface of the thighs.
Female: The hair distribution is adult in type but decreased in total quantity. There is no spread to the medial surface of the thighs.

Stage V:

Male: Hair distribution is adult in quantity and type and is described in the inverse triangle. There can be spread to the medial surface of the thighs.
Female: Hair is adult in quantity and type and appears to have an inverse triangle of the classically feminine type. There is spread to the medial surface of the thighs but not above the base of the inverse triangle.
Genital Development (Boys)

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
<th>Illustration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage I: Pre-adolescent.</strong></td>
<td>The testes, scrotal sac, and penis have a size and proportion similar to those seen in early childhood.</td>
<td>![Stage I Illustration]</td>
</tr>
<tr>
<td>Testicular Volume: &lt; 1.5 ml</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Penile Size: Small, 3 cms or less.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Stage II</strong></td>
<td>There is enlargement of the scrotum and testes and a change in the texture of the scrotal skin. The scrotal skin may also be reddened, a finding not obvious when viewed on a black and white photograph.</td>
<td>![Stage II Illustration]</td>
</tr>
<tr>
<td>Testicular Volume: 1.6 ml to 6 ml</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Penile Size: remains unchanged</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Stage III</strong></td>
<td>Further growth of the penis has occurred, initially in length, although with some increase in circumference. There also is increased growth of the testes and scrotum.</td>
<td>![Stage III Illustration]</td>
</tr>
<tr>
<td>Testicular Volume: 6 ml to 12 ml</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Penile Size: lengthens to about 6 cms</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Stage IV</strong></td>
<td>The penis is significantly enlarged in length and circumference, with further development of the glans penis. The testes and scrotum continue to enlarge, and there is distinct darkening of the scrotal skin. This is difficult to evaluate on a black-and-white photograph.</td>
<td>![Stage IV Illustration]</td>
</tr>
<tr>
<td>Testicular Volume: 12 ml to 20 ml</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Penile Size: Increases in length to about 10 cm; also increases in circumference</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Stage V</strong></td>
<td>The genitalia are adult with regard to size and shape.</td>
<td>![Stage V Illustration]</td>
</tr>
<tr>
<td>Testicular Volume: more than 30 ml</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Penile Size: Length is about 15 cms; adult scrotum</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## B. BREAST DEVELOPMENT

<table>
<thead>
<tr>
<th>Stage I (Preadolescent)</th>
<th><img src="image1" alt="Image" /></th>
</tr>
</thead>
<tbody>
<tr>
<td>Only the papilla is elevated above the level of the chest wall. No glandular tissue. The areola follows the contour of the chest.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage II (Breast Budding)</th>
<th><img src="image2" alt="Image" /></th>
</tr>
</thead>
<tbody>
<tr>
<td>Elevation of the breasts and papillae may occur as small mounds along with some increased diameter of the areolae. Elevation of the breasts and papillae may occur as small mounds along with some increased diameter of the areolae.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage III</th>
<th><img src="image3" alt="Image" /></th>
</tr>
</thead>
<tbody>
<tr>
<td>The breasts and areolae continue to enlarge, although they show no separation of contour. Breast begins to become more elevated, and extends beyond the borders of the areola, which continues to widen but remains in contour with surrounding breast.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage IV</th>
<th><img src="image4" alt="Image" /></th>
</tr>
</thead>
<tbody>
<tr>
<td>The areolae and papillae elevate above the level of the breasts and form secondary mounds with further development of the overall breast tissue. Increased breast size and elevation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage V</th>
<th><img src="image5" alt="Image" /></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mature female breasts have developed; breast reaches final adult size. The papillae may extend slightly above the contour of the breasts as the result of the recession of the areolae.</td>
<td></td>
</tr>
</tbody>
</table>
C. MENSTRUAL CONCERNS

Menstruation is a woman’s monthly bleeding. When a woman menstruates, she sheds the lining of her uterus. The menstrual blood flows from the uterus through the cervix and passes out of the body through the vagina. Most menstrual periods last from 3 to 5 days. The first menstruation of a woman is known as menarche, it usually occurs between 12 – 14 years of age.

The menstrual cycle is a series of changes that occurs in the ovaries and linings of uterus starting with preparation of an egg for fertilization. It is essential for the production, maturation and release of egg cells (ovulation) and preparation of the uterus for pregnancy. The length of the menstrual cycle in humans average 28 days (26 – 32 days). Each cycle can be divided into three phases based on the events in the ovary or in the uterus. The ovarian cycle consists of the follicular phase, ovulation and luteal phase. The uterine cycle consists of menstruation, proliferative phase and secretory phase. Generally, the menstrual cycle consists of the pre ovulatory, ovulatory and post ovulatory phase.

**Pre Ovulatory**

The menstrual cycle begins with the shedding of the endometrium due to low levels of estrogen and progesterone. The low level of estrogen sends signals to the brain to release follicle stimulating hormone (FSH). This hormone causes the follicles in the ovary to mature. The maturing follicles in turn cause a rise in the levels of estrogen which causes thickening of the endometrial lining. The cervix, during this phase remains closed and faces downwards; vaginal secretion is wet and dry.

**Ovulatory Phase**

When estrogen levels reach its peak, it will cause a sudden rise in luteinizing hormone (LH surge). This releases the matured egg from the ovary (ovulation). At this time, the vaginal secretion becomes wet and slippery; the cervix slightly rises and opens. The body temperature suddenly dips a few tenths of a degree from its average level during the first 10 days.

---

Post ovulatory Phase

The remnants of the released egg in the ovary becomes the corpus luteum. This releases progesterone, the hormone responsible for maintaining pregnancy in its initial stage. Since progesterone is thermogenic, this will cause an elevation of the body temperature. Progesterone will also maintain the thickened endometrial lining. The vaginal secretion is dry and a mucus plug is formed on the cervix. At this point, estrogen levels begin to fall. If the egg is not fertilized, the corpus luteum regresses and progesterone levels fall. This will cause the shedding of the endometrium marking the first day of the next menstrual cycle.

Common Menstrual Problems of Adolescents

*Pre Menstrual Syndrome (PMS)*

This condition includes physical and emotional symptoms that female gets right before their periods such as:

- acne
- bloating
- fatigue
- backaches
- sore breasts
- headaches
- constipation
- diarrhea
- food cravings
- depression or feeling blue
- irritability
- difficulty concentrating
- difficulty handling stress
- feeling tense or anxious

These symptoms appear several years after menstruation starts. It is usually at its worst during the 7 days prior to menstruation and disappears soon after it begins. PMS is hypothesized to be due to changing hormonal levels and chemicals in the brain. Some girls seem to be more sensitive to hormonal changes than others.

*Cramps*

Many girls experience abdominal cramps during the first few days of their periods. This is caused by prostaglandin, a chemical in the body that makes the smooth muscle in the uterus contract. These involuntary contractions can be either dull or sharp and intense.

Cramps usually only last a few days. Consultation with a health professional may be needed if severe cramps that keeps one at home, from school or from doing stuff with friends.

You can help an adolescent feel comfortable when she experiences PMS or menstrual cramps by counseling them to:

- eat a balanced diet with lots of fresh fruit and vegetables
- reduce her intake of salt (which can cause water retention) and caffeine (which can make her jumpy and anxious)
- include foods with calcium, which may reduce the severity of her PMS symptoms
- take a brisk walk or bike ride to relieve stress and aches
- soak in a warm bath or put a hot water bottle on her abdomen, which may help her relax
- talk to their parents so they can seek medical help

**Irregular Periods**

It can take 2 to 3 years from a girl's first period for her body to develop a regular cycle. During that time, the body is essentially adjusting to the influx of hormones unleashed by puberty. And what's "regular" varies from person to person. The typical cycle of an adult female is 28 days, although some are as short as 21 days and others are as long as 35.

Changing hormone levels might make a girl's period last a short time during one month (just a few days) and a long time the next (up to a week). She may skip months, get two periods almost right after each other, or alternate between heavy and light bleeding from one month to another.

However, any girl who is sexually active and misses a period should seek consult to rule out pregnancy. Other signs and symptoms that may warrant consultation are if a girl has not had a relatively predictable pattern after three (3) years; if she has four or five regular periods and then skips a period and becomes irregular; if she has a cycle of less than 21 days or more than 45 days; or if she does not have a period three months at any time after menarche.

**Delayed Menarche**

Girls go through puberty at different rates. Some reach menarche (the medical term for the first period or the beginning of menstruation) as early as 9 or 10 years old and others don't have their first periods until they're well into their teen years. So, if a girl is a "late bloomer," it doesn't necessarily mean there's something wrong with her.

The age of menarche may be influenced by genetics; ethnic groups and at times diet and / or the nutritional status. If a girl has not gotten her period by age 15, or by 3 years after starting puberty, consultation should be made.

**Menstrual Problems that May be a Cause for Concern**

Although there are period problems that are considered as “harmless” like the three previously mentioned, some menstrual conditions may warrant medical evaluation and management:

**Amenorrhea**

Amenorrhea is a term used to describe the absence of menstruation in:
- Young women who have not had their menarche by age 15 or three years after they had their menarche (primary amenorrhea). This is usually caused by a genetic abnormality, hormone imbalance; or a problem in the development of the reproductive organs.
Women and girls who have not had their periods for 90 days after they have been menstruating for so long (secondary amenorrhea). Hormonal imbalance has been implicated as a cause of secondary amenorrhea. Other conditions include:

- Stress
- Significant weight loss or gain
- Eating disorders (anorexia)
- Ovarian cysts (polycystic ovarian syndrome)
- Thyroid conditions
- Stopping birth control pills
- Other conditions that affect hormone level

**Menorrhagia**

It is normal for a girl to be heavier on some days than others. However, some girls suffer from excessive menstrual periods or prolonged periods. This is called menorrhagia. This is a condition which can include soaking through at least one sanitary napkin an hour for several hours in a row or periods that last longer than seven (7) days\(^\text{17}\). Objective menorrhagia is taken to be a blood loss of approximately 80 ml per day (normal menstrual blood loss is estimated to be between 20 – 35 ml per day)\(^\text{18}\). Some girls may not be able to attend school nor leave home because they are unable to control their menstrual flow.

Because many adolescents have slight hormone imbalances during puberty, menorrhagia is not uncommon in this age group. However, in some cases, heavy menstrual bleeding can be caused by problems such as:

- fibroids (benign growths) or polyps in the uterus
- thyroid conditions
- clotting disorders
- inflammation or infection in the vagina or cervix

**Dysmenorrhea (Painful Periods)**

There are two types of dysmenorrhea (painful menstruation) that can interfere with a girl's ability to attend school, study, or sleep:

1. **Primary dysmenorrhea** is very common in teens and is not caused by a disease or other condition. Instead, the culprit is prostaglandin, the chemical behind cramps. Some prostaglandin can lead to mild cramps. But large amounts of prostaglandin can lead to


nausea, vomiting, headaches, backaches, diarrhea, and severe cramps. Fortunately, these symptoms usually only last for a day or two.

2. **Secondary dysmenorrhea** is pain caused by some physical condition like polyps or fibroids in the uterus, endometriosis, pelvic inflammatory disease (PID), or adenomyosis (tissue that usually lines the uterus growing into the muscular wall of the uterus).

**When to consult your physician?**

For problems in menstrual cycle, the adolescent must know that she needs medical consult if:

- Her period hasn't started her period by the time she's 15 or her period hasn't become regular after 3 years of menstruating.
- She stops getting her period or it becomes irregular after it has been regular.
- She has heavy or long periods, especially if she gets her period frequently.
- She has very painful periods\(^\text{19}\).

**D. NUTRITIONAL CONCERNS**

Increased nutritional needs during adolescence are brought about by increased growth rate and physiological changes associated with puberty. The increase in energy and nutrient requirements are affected by food choices and nutrient intake and status. Factors that are common during adolescence such as desire for independence and acceptance, increased mobility, greater time spent at school and/or work activities also contribute to the unhealthy eating behaviors during adolescence\(^\text{20}\).

**National Prevalence**

Among children, 10-19 years old, 35.7\% were severely stunted to stunted based on Height-for-Age classification. On the other hand, 12.7\% prevalence of wasting was noted using BMI-for-Age classification (see Figure below)\(^\text{21}\).

---


Nutritional status of children, 10-19 years old (121-228 months), based on height-for-age and BMI-for-age classification using WHO-Growth Reference: Philippines, 2011

By age group, stunting was higher among the 16-19 years old. On the other hand, higher prevalence of wasting and overweight/obese was noted among the pre-adolescent group (10-12 years) compared to the other age groups. (see Figure below)
Prevalence of a.) stunting; b.) wasting; and c.) overweight/obese among children, 10-19 years old (121-228 months), by single age: Philippines, 2011

**Trends in Malnutrition Prevalence among Pre-Adolescents and Adolescents**

Comparing the prevalence of malnourished children in the four survey periods, 10-19 year old children showed an increasing trend in the prevalence of wasting and overweight/obese with an annual average increase of 0.25%-points and 0.225%-points, respectively. Stunting was noted to have an annual average decrease in prevalence by 0.38%-points (see Figure below) since 2003.

**Height, Weight and Body Mass Index of Adolescents**

It is between the ages of 10-14 comes the onset of growth spurt. Peak height velocity occurs about one to one and a half years before menarche. Additional height of 10.8 - 22.3 cm is gained after peak height velocity and about 7.4 - 10.6 cm after menarche.22

---

Weight gain during puberty accounts for about half of the ideal adult body weight of an individual. The period of onset, however, is highly variable. Peak health velocity occurs about 18-24 months earlier in the female than in the male. However, those of females average 2 cm/yr less than in males. In males, the peak weight and peak height velocity happens at the same time. However, for females it takes 6-9 months after the peak height velocity for the peak weight velocity to occur\textsuperscript{23}.

Body Mass Index (BMI) is a measure of relative weight based on an individual’s mass and height\textsuperscript{24}.

The 2007 WHO Child Growth Reference BMI tables for adolescents for boys and girls (using z scores) are shown in the next pages.

<table>
<thead>
<tr>
<th>Growth Reference for 5-19 years (according to z-scores)\textsuperscript{25}</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; + 2 SD</td>
</tr>
<tr>
<td>&gt; + 1 SD</td>
</tr>
<tr>
<td>&lt; - 2 SD</td>
</tr>
<tr>
<td>&lt; - 3 SD</td>
</tr>
</tbody>
</table>

The formula in computing the BMI is as follows:

\[
\text{BMI} = \frac{\text{mass (kg)}}{\text{height (m)}^2}
\]

\textsuperscript{23} Neinstein, Lawrence S. Puberty – Normal Growth and Development. Retrieved from: http://www.usc.edu/student-affairs/Health_Center/adolhealth/content/a1.html


## BMI-for-age BOYS

5 to 19 years (z-scores)

<table>
<thead>
<tr>
<th>Year: Month</th>
<th>Month</th>
<th>L</th>
<th>M</th>
<th>S</th>
<th>-3 SD</th>
<th>-2 SD</th>
<th>-1 SD</th>
<th>Median</th>
<th>1 SD</th>
<th>2 SD</th>
<th>3 SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>5: 1</td>
<td>61</td>
<td>-0.7387</td>
<td>15.2641</td>
<td>0.08390</td>
<td>12.1</td>
<td>13.0</td>
<td>14.1</td>
<td>15.3</td>
<td>16.6</td>
<td>18.3</td>
<td>20.2</td>
</tr>
<tr>
<td>5: 2</td>
<td>62</td>
<td>-0.7621</td>
<td>15.2616</td>
<td>0.08414</td>
<td>12.1</td>
<td>13.0</td>
<td>14.1</td>
<td>15.3</td>
<td>16.6</td>
<td>18.3</td>
<td>20.2</td>
</tr>
<tr>
<td>5: 3</td>
<td>63</td>
<td>-0.7856</td>
<td>15.2604</td>
<td>0.08439</td>
<td>12.1</td>
<td>13.0</td>
<td>14.1</td>
<td>15.3</td>
<td>16.6</td>
<td>18.3</td>
<td>20.2</td>
</tr>
<tr>
<td>5: 4</td>
<td>64</td>
<td>-0.8089</td>
<td>15.2605</td>
<td>0.08464</td>
<td>12.1</td>
<td>13.0</td>
<td>14.1</td>
<td>15.3</td>
<td>16.7</td>
<td>18.3</td>
<td>20.3</td>
</tr>
<tr>
<td>5: 5</td>
<td>65</td>
<td>-0.8322</td>
<td>15.2619</td>
<td>0.08490</td>
<td>12.1</td>
<td>13.0</td>
<td>14.1</td>
<td>15.3</td>
<td>16.7</td>
<td>18.3</td>
<td>20.3</td>
</tr>
<tr>
<td>5: 6</td>
<td>66</td>
<td>-0.8554</td>
<td>15.2645</td>
<td>0.08516</td>
<td>12.1</td>
<td>13.0</td>
<td>14.1</td>
<td>15.3</td>
<td>16.7</td>
<td>18.4</td>
<td>20.4</td>
</tr>
<tr>
<td>5: 7</td>
<td>67</td>
<td>-0.8785</td>
<td>15.2684</td>
<td>0.08543</td>
<td>12.1</td>
<td>13.0</td>
<td>14.1</td>
<td>15.3</td>
<td>16.7</td>
<td>18.4</td>
<td>20.4</td>
</tr>
<tr>
<td>5: 8</td>
<td>68</td>
<td>-0.9015</td>
<td>15.2737</td>
<td>0.08570</td>
<td>12.1</td>
<td>13.0</td>
<td>14.1</td>
<td>15.3</td>
<td>16.7</td>
<td>18.4</td>
<td>20.5</td>
</tr>
<tr>
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**2007 WHO Reference**

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**PART 2: GENERAL HEALTH CONCERNS**
### BMI-for-age BOYS

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**2007 WHO Reference**
### BMI-for-age BOYS

5 to 19 years (z-scores)

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## BMI-for-age BOYS

5 to 19 years (z-scores)

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2007 WHO Reference

**PART 2: GENERAL HEALTH CONCERNS**
## BMI-for-age GIRLS

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PART 2: GENERAL HEALTH CONCERNS
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#### 2007 WHO Reference
### BMI-for-age GIRLS

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### 2007 WHO Reference
### BMI-for-age GIRLS

#### 5 to 19 years (z-scores)

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**2007 WHO Reference**
# BMI-for-age GIRLS

5 to 19 years (z-scores)

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2007 WHO Reference
Anemia

Anemia is the condition when the body lacks ability to produce healthy red blood cells. This can be caused by deficiency of the mineral iron or by inherited defects in red blood cells production. Other causes are prolonged blood loss or parasitic infections (hookworm)\(^{26}\).

Currently, it is one of the most common nutritional problems globally. It is a global public health problem affecting both developing and developed countries also affecting social and economic development. Iron deficiency anaemia can occur at all stages of human growth and development. It is more prevalent in pregnant women and young children. Adolescents, particularly girls, are also vulnerable to iron deficiency as they have started menstruation. Interventions to address the problems brought by anemia are important during adolescence period. This should include measures of increasing iron intake such as food fortification with iron and also improved health services\(^{27}\).

The 7\(^{th}\) National Nutrition Survey done by Food and Nutrition Research Institute of the Department of Science and Technology (FNRI-DOST) in 2008 reported that the prevalence of anemia in the Philippines between ages of 13 and 19 (adolescence) was 18.2\% for the women. It is higher than those of males which is 10.4\%. However, this age bracket (13-19 years old) has the lowest prevalence among women as compared to other age groups. Below is the complete figure of the trends derived from the survey\(^{28}\).


BIOCHEMICAL SURVEY

Anemia

Prevalence of anemia by age, sex and physiologic state: Philippines, 2008

- The overall prevalence of anemia, from 6 mos to the elderly is 19.5%.
- The highest prevalence was observed among the infants 6 mos to <1 year at 55.7%, followed by the pregnant women at 42.5%.
- Based on the > 40% epidemiological criteria for assessing severity and magnitude of anemia, the prevalence among infants and pregnant women remains a significant public health problem.
- Males had significantly lower anemia prevalence compared to their female counterparts among the 13-19 year olds, 20-39 year olds and 40-59 year olds.
- Male and female prevalence rates were similar among the 6-12 year olds and among the elderly.
- Based on the 2008 Projected Population (using the 2000 Census), the estimated number of anemic children, 6 mos to <1 year is 0.74M, 1-5 years is 2.10 M and 6-12 years is 2.77 M.


- Anemia prevalence rates among children in the 2008 survey were generally lower than the previous year survey.


- There was no significant decrease in anemia prevalence rate from 43.9% in 2003 to 42.5% in 2008 among pregnant women.
- Prevalence rate for lactating women was significantly lower in 2008 at 31.4% compared to the 2003 anemia prevalence rate of 42.2%.
Sports Nutrition

Sports participation is a major type of activity in which youth are involved. Therefore, it can be considered a practical method of promoting good health.

Proper nutrition is one of many factors that can contribute into making sports a positive experience for adolescents. Being nutritionally prepared and well-hydrated will help adolescents to be adequately fueled for physical activities.

The following are important notes for a dietary assessment:

- **Enough fluid intake to prevent dehydration and promote optimal endurance.**

  Sweating helps the body avoid overheating during exercise. The water lost can be excessive and may lead to dehydration. Intensive workout and hot environment also increases the amount of water loss. Aside from water, electrolytes which are needed for health body functions, including potassium and sodium can also be lost after a physical workout.

  Water is recommended for shorter or less intense workouts when electrolyte losses are minimal. Longer workouts require higher intakes of fluid along with electrolytes. Sports drinks are also good choices during long or hard workouts as they contain fluids, electrolytes, and carbohydrates. The table below lists recommendations for fluid intake at every stage of activity. It is important to drink plenty of fluids before, during, and after exercise to stay hydrated and perform at an optimal level.

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<td>10–15 minutes before: drink 8–10 oz</td>
<td>After 90 minutes: drink 8-10 oz sports drink every 15–30 minutes</td>
<td>Continue drinking as needed</td>
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- **Sufficient carbohydrate intake to promote glycogen storage.**

  Carbohydrates provide energy to the body. Most (60-70%) of the calorie intake of active adolescents should be from carbohydrates even in ordinary days and without any sporting event. Eating carbohydrate-rich foods every day helps restore energy stores and be fueled up for the next event. The best sources of carbohydrates are fruits, vegetables, low-fat dairy foods, and grains, especially whole grains. Fruits and low-fat milk and milk products also supply the body with quick energy. Starchy vegetables, like corn, potatoes, and peas, as well as grains are used more slowly and help prevent hunger.

- **Adequate protein intake for growth, but not too much that it may increase the risk of dehydration or kidney problems.**
Protein helps the body to maintain and repair muscles. Adolescents involved in sports need protein to keep muscles healthy and to repair damage from training. Active or inactive teens need to eat to meet their caloric needs. The best protein choices are lean meats, fish, poultry, low-fat milk products, and beans (legumes).

- Adequate, but not excessive fat intake.

Fats provide essential fatty acids needed to absorb certain vitamins. Fat takes longer to digest than other foods, so eating a high-fat meal before practice or a sporting event can cause stomach pain. The recommended daily fat intake for adolescents is 25–35% of total calories. Examples of foods with healthy fats are avocado, nuts, seeds and olives.

- Variety of fruits and vegetables for sources of vitamin and minerals needed for growth and performance.

Vitamins and minerals are essential for body functioning. Girls have different nutritional needs compared to boys their age. Due to monthly menstrual cycle, girls have a higher need for iron which is needed so that red blood cells can carry oxygen to the muscles. Low iron levels, or anemia, can cause teens to feel tired and have poor performance. Athletes in general are more likely to have low iron levels, but teen boys are able to compensate as they tend to eat enough protein.

- Variety of calcium and vitamin D sources to promote peak bone mineralization

Calcium is another mineral that is important for all teens, especially athletes. It is important to the bones development as teenagers grow very quickly and getting plenty of calcium helps them build strong bones. Adolescents need 1,300 milligrams of calcium per day, more than any other age group.  

E. ORAL HEALTH

Oral health is a state of being free from chronic mouth and facial pain, oral and throat cancer, oral sores, birth defects such as cleft lip and palate, periodontal (gum) disease, tooth decay and tooth loss, and other diseases and disorders that affect the oral cavity. Risk factors for oral diseases include unhealthy diet, tobacco use, harmful alcohol use, and poor oral hygiene.31

In the Philippines, the 2005 – 2006 National Oral Health Survey showed that the prevalence of dental caries among 12 year old Filipinos was 82%. The mean number of teeth with caries experience was 2.9 DMFT. One out of three decayed teeth developed caries progression into the pulp with resulting difficulties. About 16% of the 12 year olds reported to have a problem in their mouth at the time of the survey.32

Oral Diseases and Conditions

Dental cavities
Worldwide, 60–90% of school children and nearly 100% of adults have dental cavities, often leading to pain and discomfort.

Periodontal disease
Severe periodontal (gum) disease, which may result in tooth loss, is found in 15–20% of middle-aged (35-44 years) adults.

Tooth loss
Dental cavities and periodontal disease are major causes of tooth loss. Complete loss of natural teeth is widespread and particularly affects older people. Globally, about 30% of people aged 65–74 have no natural teeth.

Oral cancer
The incidence of oral cancer ranges from one to 10 cases per 100 000 people in most countries. The prevalence of oral cancer is relatively higher in men, in older people, and among people of low education and low income. Tobacco and alcohol are major causal factors.

Fungal, bacterial or viral infections in HIV
Almost half (40–50%) of people who are HIV-positive have oral fungal, bacterial or viral infections. These often occur early in the course of HIV infection.

Oro-dental trauma
Across the world, 16–40% of children in the age range 6 to 12 years old are affected by dental trauma due to unsafe playgrounds, unsafe schools, road accidents, or violence.

Noma
Noma is a gangrenous lesion that affects young children living in extreme poverty primarily in Africa and Asia. Lesions are severe gingival disease followed by necrosis (premature death of cells in living tissue) of lips and chin. Many children affected by noma suffer from other infections such as measles and HIV. Without any treatment, about 90% of these children die.

Cleft lip and palate
Birth defects such as cleft lip and palate occur in about one per 500–700 of all births. This rate varies substantially across different ethnic groups and geographical areas.

Common Causes
Risk factors for oral diseases include an unhealthy diet, tobacco use and harmful alcohol use. Poor oral hygiene is also a risk factor for oral disease.

The prevalence of oral disease varies by geographical region, and availability and accessibility of oral health services. Social determinants in oral health are also very strong. The prevalence of oral diseases is increasing in low- and middle-income countries, and in all countries, the oral disease burden is significantly higher among poor and disadvantaged population groups.

Prevention and Treatment
The burden of oral diseases and other chronic diseases can be decreased simultaneously by addressing common risk factors. These include:

- decreasing sugar intake and maintaining a well-balanced nutritional intake to prevent tooth decay and premature tooth loss;
- consuming fruit and vegetables that can protect against oral cancer;
- stopping tobacco use and decreasing alcohol consumption to reduce the risk of oral cancers, periodontal disease and tooth loss;
- ensuring proper oral hygiene;
- using protective sports and motor vehicle equipment to reduce the risk of facial injuries; and
- safe physical environments.

Dental cavities can be prevented by maintaining a constant low level of fluoride in the oral cavity. Fluoride can be obtained from fluoridated drinking water, salt, milk and toothpaste, as well as from professionally-applied fluoride or mouth rinse. Long-term exposure to an optimal level of fluoride results in fewer dental cavities in both children and adults. Most oral diseases and conditions require professional dental care.\(^{33}\)

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PART 3
MENTAL HEALTH AND PSYCHOLOGICAL CONCERNS

At the end of Part 3, the health and non-health workers are expected to:

1. Discuss the different mental health and psychological concerns of adolescents;
2. List down the tips that the parents, health and non-health workers can do in responding to these adolescent concerns.

This part contains information on the following topics, namely:

A. Anxiety
B. Depression
C. Suicide
D. Physical and Sexual Abuse
A. ANXIETY

Anxiety is mainly characterized by worry or the excessive concern about situations with uncertain outcomes. According to the WHO, anxiety is very common among the Filipino youth. In a Global School-based Student Health Survey (GSHS) conducted in the Philippines in 2003-2004, it was found that 42% of Filipino students surveyed felt sad or hopeless for two weeks or more in the past year. Worrying too much is unhealthy as it may interfere with one’s ability to take action into solving a problem. Symptoms of anxiety may be shown in the person’s thinking, behavior, or physical reactions.

Parents dealing with Child’s Anxiety

Aside from the professional interventions that may be necessary for the child’s anxiety situation, it may be helpful to parents if they also deal with the child with anxiety at home. It is reminded that parents should be consistent in the ways of handling problems and administering discipline. It must be remembered that anxiety reflects an inability to control misbehavior and is not intentional. Therefore, parents must be patient and prepared to listen. Talking to a child with anxiety regularly also helps. Taking all discussion seriously, and avoid giving too much advice and instead be there to help and offer assistance as requested. Anxious children may also need consistent, but flexible routine for homework, chores, and activities from their parents.

Moreover, reasonable and achievable goals shall be maintained by the parents for the child with anxiety. Parents must not let the child view perfection as the one which is expected or acceptable. With this, anxious children will only try to be perfect and please the adults. They should also praise and reinforce effort, even if success is less than expected. As long as it does not create unrealistic expectations and result in unreasonable standards, reinforcing effort does nothing wrong to the child. Teaching the child with simple strategies to help with anxiety, such as learning how to relax under stressful conditions is important. It is suggested that parent will help a child prepare for event which he/she is being anxious about by practicing it often to increase the child’s confidence and decrease the discomfort.

Lastly, it must not be assumed by the parent that the child is being difficult or that the problem will go away. Seeking help is important if the problem continues to interfere with daily activities.

B. DEPRESSION

Depression is a common mental disorder that is characterized with depressed mood, loss of interest or pleasure, lack of energy, feelings of guilt or low self-worth, disturbed sleep or appetite, poor concentration, and oftentimes with the symptoms of anxiety. It is possible that these can become chronic or recurrent and therefore impair in an individual’s ability of handling his or her everyday responsibilities. For worst situations, depression can lead to suicide. Almost 1 million lives are lost yearly due to suicide or 3000 suicide deaths every day. For every person who completes a suicide, 20 or more may attempt to end his or her life.36

Adolescent depression can be defined as identification of an individual who experiences depressive characteristics for a 2-week or longer period.37

Usually, the period of adolescence is marked by significant changes in emotional, social and intellectual state of the individual. Therefore, symptoms are often difficult to determine in this stage. However, if an individual continue to experience certain symptoms for a 2 week period or longer, it is likely a diagnosis of depression. These symptoms associated with adolescent depression include poor performance in school, withdrawal from family and friends, feelings of hopelessness and sadness, anger, lack of enthusiasm and motivation. Also, changes in eating and/or sleeping patterns, substance abuse, suicidal thoughts or actions can be observed.

For adolescents suffering from depression, the issue needs to be addressed and given attention especially if the symptoms are noticeable in the behavior. Professional help should be sought immediately.

There are several means of treatment available for those individuals suffering from depression, and can be determined by a professional. Some of these include the psychotherapy which teaches coping skills and provides opportunity to discover the painful or troubling events and feelings. Another option is the cognitive-behavioral therapy which helps modify negative patterns of thinking and behaving. In addition to them, there is also the interpersonal therapy which focuses on developing healthier relationships at home and at school. Medication is also an aid to relieve some symptoms of depression and is often prescribed along with therapy.

Depression is a very serious issue among adolescents. If remains untreated, depression can change the life of an adolescent. Worst scenario is when some cases lead to suicide. With this, professional help is very much necessary.

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**Emotional Well-being of Adolescents**

**Messages for adolescents**


1. Adolescence is a time of enormous change in one’s life. These changes can be stressful.

2. Spending time every day doing things that you enjoy, being with people whom you like and doing some physical activity can help to prevent and reduce stress.

3. Feeling anxious, sad or angry from time to time is normal. Talking to friends, your parents or other trusted adults can be helpful. They can give you comfort and support, and help you to think things through clearly.

4. Do not use tobacco, alcohol or other substances as a way of coping when you are under pressure, or are feeling anxious, sad or angry. Alcohol and other substances can make feelings of depression and anxiety worse. You may become addicted to these substances.

5. Do not act hastily or impulsively when you are under pressure or are feeling anxious, sad or angry. You may be tempted to pick a fight or ride a motorcycle fast as a way to deal with these feelings. This will put you and others at great risk of injury.

6. If you have sad, anxious or angry thoughts and feelings every day for several days and especially if they affect you from doing your daily activities (for example, doing your school work), or if you have thoughts of harming yourself or others seek help from a health worker.

Messages for parents:

What you should know:

1. Adolescence is a time when young people acquire the skills they need to become independent adults. During this time, many adolescents appear to reject their parents’ guidance, and withdraw from the close attachment they had with them when they were younger. This can be difficult for parents to accept. However, all adolescents still need, and benefit greatly from, the support and guidance of parents. Feeling needed by and being valued by one’s family can give a young person a positive sense of well-being.

2. Adolescents need to develop the skills to cope with the stresses and strains of everyday life, as well as emotions such as sadness and anger in a healthy way. They also need to know that they can ask their parents for help when they find that they cannot cope by themselves.

3. With prompt diagnosis and effective treatment, adolescents with many mental health problems can get back to good health and to productive lives.

What you should do:
1. Make every effort to communicate with your son or daughter. Encourage them to share their hopes and expectations, fears and concerns with you. Show interest in their activities and viewpoints. Show that you care for them through your words and actions. Let them know that you will always be there to support them when needed. Encourage them to contribute to family and community activities.

2. Talk to your son or daughter about healthy ways of dealing with the stresses and strains of everyday life, such as doing activities that they find relaxing, being with people they like, and doing some physical activity.

3. Warn them of the dangers of using tobacco, alcohol or other substances as a means of dealing with negative thoughts and feelings. Also, warn them that when they are upset they could do things – such as picking a fight or driving dangerously – that could cause harm to themselves or others. Talk to them about the importance of asking for help when they feel that they cannot handle their problems by themselves.

4. Be watchful for changes in the mood or behavior of your son or daughter. Common signs of stress or mental illness include: changes in sleeping patterns; changes in eating patterns; decreased school attendance or performance; difficulties in concentration; a persistent lack of energy; frequent crying or persistent feelings of helplessness, hopelessness, sadness and anxiety; persistent irritability; frequent complaints of headache or stomach ache and the excessive use of alcohol or other substances. If any of these changes are marked or last for several days, seek help from a health worker.

5. Seek help from a health worker immediately, if your son or daughter has thoughts of harming or killing himself/herself or others.

C. SUICIDE

In the world, suicide is one of the three leading causes of death among those in the most economically productive age group (15-44 years). It is also considered the second leading cause of death in the 15-19 years age group.

Results from the 2013 Young Adult Fertility and Sexuality Study in the Philippines revealed: a decline in the proportion of youth who ever thought of committing suicide; a low level of suicide attempt among the youth (all youth). However, it was noted that there was an increase in the proportion of suicide attempts among those who ever thought of committing suicide during the past decade.39

Suicide Prevention Strategies

In its most recent publication (2012), the World Health Organization (WHO) recommends the use of the developed “Stepwise Approach in Developing a Suicide Prevention Strategy”. It consists of the following steps:

1. Identifying stakeholders
2. Undertaking a situational analysis
3. Assessing the requirement and availability of resources
4. Achieving political commitment
5. Addressing stigma
6. Increasing awareness

WHO identified three evidence-based population level strategies to prevent suicide:

1. Restrict access to means of self-harm/suicide
2. Develop policies to reduce harmful use of alcohol as a component of suicide prevention
3. Assist and encourage the media to follow responsible reporting practices of suicide

At the individual level, prevention strategies include:

1. Identification and treatment of mental disorders
2. Management of persons who attempted suicide or who are at risk.40

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Preventing Suicide in Schools

Suicidal students give people around them enough warnings and scope to intervene. In suicide prevention work, teachers and other school staff face a challenge of great strategic importance, in which it is fundamental:

- to identify students with personality disturbances and offer them psychological support;
- to forge closer bonds with young people by talking to them and trying to understand and help;
- to alleviate mental distress;
- to be observant of and trained in the early recognition of suicidal communication whether through verbal statements and/or behavioral changes;
- to help less skillful students with their school work;
- to be observant of truancy;
- to destigmatize mental illness and help to eliminate misuse of alcohol and drugs;
- to refer students for treatment of psychiatric disorders and alcohol and drug abuse;
- to restrict students’ access to means of suicide - toxic and lethal drugs, pesticides, firearms and other weapons, etc.;
D. PHYSICAL AND SEXUAL ABUSE

Results from the 2013 Young Adult Fertility and Sexuality Study in the Philippines showed that the proportion of the youth who experienced physical violence in the past 12 months was higher for the younger age cohort and males; and the respondents from the National Capital Region (NCR) had the largest proportion of the youth who experienced physical violence in the past 12 months. From 20.8% in 2002, the proportion of youth who had been physically threatened increased to 23.7% in 2013.\(^42\)

**Interventions for preventing child abuse**

Interventions to prevent child abuse include home visiting, parent education, child sex abuse prevention, abusive head trauma prevention, multi-component interventions, media-based interventions, and support and mutual aid groups.\(^43\)

In the Philippines, the Special Committee for the Protection of Children is the body responsible in the monitoring and implementation of Republic Act No. 7610, “The Special Protection for a Child Against Abuse, Exploitation, and Discrimination Act.”\(^44\)

**How can violence against children be prevented?**

There are two different types of violence that are experienced by children, one is the child maltreatment done by parents and caregivers in children aged 0-14, while the other one is the violence happening in community settings among adolescents aged 15-18 years. These different types of violence can be prevented if the underlying causes and risk factors specific to each type are properly addressed.

Prevention of child maltreatment by parents and caregivers from occurring is possible by reducing unintended pregnancies, harmful levels of alcohol and illicit drug use during pregnancy or by new parents. Another way of prevention is by providing home visitation services by professional health care providers to families whose children are at high-risk of maltreatment; and training for parents regarding child development, non-violent discipline and problem-solving skills. Also, improved access to high quality pre- and post-natal services can also avoid the incidences of child violence.

On the other hand, the violence involving children in community settings can also be prevented in many ways. It can be through providing pre-school enrichment programs to provide the young children an educational advance, life skills training or even by assisting high-risk adolescents to finish their schooling. Furthermore, it can also help if alcohol availability will be reduced through the enactment and enforcement of liquor licensing laws, taxation and pricing and restricting access to firearms.\(^45\)


Messages for adolescents

1. Talk to your parents or other responsible adults about what you could do to avoid experiencing violence.

2. As far as possible, avoid being in places where you may experience violence.

3. If you find yourself in a situation where you feel threatened, walk away as quickly as you can.

4. If someone is trying to force you to have sex, make it clear through your words and actions that you absolutely do not want it. Leave the place as quickly as you can and call for help if necessary.

5. Disagreements and disputes can occur from time to time. If they do occur, try to stay calm and deal with them in a non-violent manner. Do your best to avoid provoking violence or responding to provocation with violence.

6. If you have been physically or sexually assaulted or coerced into doing something you do not want to do, bring this to the attention of your friends, parents or other responsible adults. They could give you the care and support you need, help prevent this from happening again, and help bring the perpetrators to justice.

Messages for parents

What you should know:

1. Discussing the issue of violence with your son or daughter can help them to protect themselves. It may make them more likely to seek help if they have been the victim of violence.

2. Working with other parents and individuals to fight violence in your community could make a difference to the lives of your son or daughter and to many other children and adolescents.

What you should do:

1. Talk with your son or daughter about how to avoid violence, and what they could do if and when they experience violence. You could raise the following issues:
   a. the importance of dealing with disagreements and disputes (if and when they occur) in a peaceful manner;
   b. the dangers of carrying, threatening people with or using weapons;
   c. the importance of avoiding places where they could experience violence;
   d. the option of walking away if they find themselves in a threatening situation;
   e. how to clearly refuse unwanted sexual advances through words and actions, and to call for help if needed.
f. the importance of informing you or other responsible adults if and when they experience violence.

2. Be a good role model; do not use violence in dealing with issues with your son or daughter, or with others.

3. Work with members of your community to create awareness of the dangers of violence, to contribute to efforts to prevent it from occurring and to bringing perpetrators to justice.  

**4Rs of VAWC**

4Rs of Violence and Abuse of Women and Children refers to the “processes of recognition, recording, reporting and referral of violence against women and child abuse”.

In the women and children protection program of Department of Health, one of the minimum requirements of all hospitals is to require all hospital personnel to undergo training on the recognition, reporting, recording and referral (4R’s) of cases of violence against women and children.

In a 2011 report by Child Protection Network of the Philippines, the child abuse training program for pediatric residents uses the 4Rs of child abuse, namely recognizing, recording, reporting, and referring. During a four-week rotation at the Philippine General Hospital-Child protection Unit (PGH-CPU), pediatric residents are trained to be competent in recognizing the presenting signs, symptoms and objective findings of given cases. Also, they must be able to draw out a comprehensive pediatric history and conduct a complete physical examination in suspected cases of child abuse. They are also taught to carry out initial interventions. Lastly is the referral of victims to an interdisciplinary team for management and reporting the abuse to authorities and identifying community resources for supporting the child/family.

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PART 4

SEXUAL AND REPRODUCTIVE HEALTH CONCERNS

At the end of Part 4, the health and non-health workers are expected to:

1. Discuss the genital problems in male adolescents;
2. Explain the genital problems in female adolescents;
3. Explain the sexually-transmitted infections commonly afflicting the adolescents;
4. Describe the risk and protective factors in teen pregnancy
5. Discuss the concepts of sex, gender, sexuality and LGBTs.

This part contains information on the following topics, namely:

A. Genital Problems in Male Adolescents
B. Genital Problems in Female Adolescents
C. Sexually-Transmitted Infections including HIV and AIDS
D. Teen Pregnancy
E. Sex, Gender, Sexuality and LGBTs
A. GENITAL PROBLEMS IN MALE ADOLESCENTS

I. Penile Discharge

Penile discharge (see Figure) is the unusual loss of fluid which is not urine or semen from the urethra (urine tube) at the tip of the penis. The discharge can vary in amount from very little to plentiful while the color is from clear to yellow or green. The frequency can vary from loss in the morning only to throughout the day.

Other symptoms often observed are:

- burning on passing urine or dysuria
- rash in the genital area, which can be painful or itchy
- swollen lymph nodes in the groin
- frequent urination
- excessive need to urinate at night or nocturia

The common origin of penile discharge is having gonococcal urethritis or non gonococcal or non-specific urethritis (NSU). Urethritis is the inflammation of the urethra, the tube between the bladder and the tip of the penis. It is classified into gonococcal and non gonococcal. Infection or inflammation of the prostate or prostatitis may also present as penile discharge.

1.1 Gonorrhea

Gonorrhea is a sexually transmitted disease (STD) caused by the bacteria Neisseria gonorrhoeae. It can grow easily in warm, moist areas of the reproductive tract and the urethra. The bacterium can also grow in the mouth, throat, eyes and anus.

Gonorrhea is transmitted through sexual intercourse including oral sex. Anal infection is common in anal intercourse. The incubation period is two to five days.

Gonorrhea is not spread by kissing, hugging, sharing baths or towels, swimming pools, toilet seats, or sharing cups, or plates.

Signs and symptoms of Gonorrhea include:

- Thick green or yellow discharge from penis
- Pain when urinating

References:
If you present with any of the symptoms and are worried of having an STI, you should visit a sexual health clinic. Gonorrhea can be easily diagnosed by use of a swab.

Gonorrhea is treated usually with antibiotics. This treatment is very effective. A follow-up and abstinence from sex are highly recommended.

1.2 Non gonococcal or non-specific urethritis (NSU)\textsuperscript{54,55}

Nonspecific urethritis is the most common cause of urethral discharge. It is most common among males 20 – 35 years of age. The common causative organisms are:

1. \textit{Chlamydia trachomatis} is the most common cause of NSU. This is characterized by painful urination and watery discharge. The patient may be asymptomatic.
2. \textit{Mycoplasma genitalium}
3. \textit{Urea urealyticum}
4. \textit{Trichomonas vaginalis} is a parasite that may cause NSU. It is more common in women than in men. Common symptoms are discharge and painful urination.
5. \textit{Herpes simplex} should be considered especially in individuals with recurrent symptoms and inflammation of the meatus.
   - It can spread even with the use of condoms.
   - It is also possible to transmit it even when there are no visible lesions.
   - Since this is a viral infection, there is no cure but anti-viral drugs will reduce the number and severity of lesions and lessen the chances of viral shedding.

\textbf{Diagnosis}

A thorough review of history should be done for men presenting with urethral symptoms. Ask the client to milk his urethra by serial palpation down the shaft of the penis towards the urethra. Any discharge should be tested for gonorrhea and chlamydia. If no discharge is present, first void urine should be tested to document pyuria. Currently, urethritis can be diagnosed by at least one of the following:

- Presence of urethral discharge
- At least 10 WBC per high power field in the first void urine sediment

Palpation of the scrotum for evidence of orchitis or epididymitis is advised. Testing and examination of other sites of sexual exposure (oropharynx, anus) should be considered if signs of inflammation are present.

\textbf{Treatment}

Physicians usually prescribe antibiotics to treat conditions with penile discharge.

II. Painful Urination

Painful urination is also called dysuria. It is felt usually in the urethra or the tube that carries urine out of your bladder. It can also be felt on the area surrounding your genitals of the perineum. Painful urination in men is most commonly brought by urethritis and certain prostate conditions\(^{56}\).

Aside from Chlamydia and Gonorrhea, other causes of painful urination includes

- bladder and kidney stones/infection
- prostatitis (prostate inflammation)
- STI
- urethritis (infection of the urethra)
- urinary tract infection (UTI)
- cystitis (bladder infection).
- Use of drugs, such as those used in cancer treatment, in personal-care products, such as soaps or perfumes can also cause painful urination.

Other than gonococcal urethritis and NSUs, the most common cause of painful urination is urinary tract infection (UTI)\(^{57}\).

Urinary tract infections happen when bacteria get into the urethra and travel up into the bladder. There are three types of UTI: urethritis, cystitis and pyelonephritis. It is called urethritis if the bacteria affect only the urethra. If the infection is just in the bladder, it is called cystitis. Infection traveling into the kidneys is called a kidney infection or "pyelonephritis." See Figure for symptoms of UTI.

Some of the factors that increase the risk of developing a UTI include:

- having sex frequently and/or having multiple partners
- diabetes
- bladder or kidney infection in the past 12 months
- use of a spermicide for birth control.
- men who are not circumcised or had anal sex
- kidney stones
- genetics


Diagnosis

Urinary tract infection is diagnosed based on the patient’s symptoms and results of laboratory examinations. Initially, microscopic analysis of the urine will present white blood cells in the urine. For the urine culture, it usually takes 24 – 48 hours before the results. This aids in the identification of the causative organism of the infection.

Treatment and Prevention

Urinary tract infection is treated with complete antibiotic course after which symptoms will abate after 1-2 days. Drinking plenty of water will also be helpful.

III. Scrotal Swelling

Scrotal swelling is the enlargement of the scrotal sac which is caused by an accumulation of fluid, inflammation, or an abnormal growth within the scrotum (see Figure). The swelling may be painless or painful. Painful swelling requires emergency treatment and if left untreated may result in loss of testicles due to necrosis (death of tissue)\(^{58}\).

Scrotal swelling can occur slowly or rapidly. One of its most common causes is testicular torsion. This is an injury or event which causes the testicle in the scrotal sac to twist, cutting off the blood circulation.

Other conditions that may cause scrotal swelling are\(^{59}\):

- testicular cancer
- varicocele (abnormally enlarged veins in the scrotum)
- orchitis (acute inflammation of the testes)
- hydrocele (swelling due to increased fluid)
- hernia
- epididymitis (inflammation or infection in the epididymis, at the back of the testicle)
- congestive heart failure

B. GENITAL PROBLEMS IN FEMALE ADOLESCENTS

I. Vaginal Discharge

To keep the vagina free from infection women have healthy bacteria in their vaginal canal which inhibits the growth of pathogens coupled with vaginal discharges which regulate and cleanses the vagina and keeps the tract suitable for growth and survival of healthy bacteria.

A healthy vaginal discharge may appear clear, cloudy white and/or yellowish. Changes with the delicate balance of vaginal secretion can create an environment conducive for infection \(^60\).

The amount, odor, and hue of vaginal secretions may vary depending on the time in the menstrual cycle, fertility and hormone levels \(^61\). There is a noticeable increase in wetness in the middle of the menstrual cycle. It is more acidic on the days prior to and during menstruation.

Also the Figure illustrates the different vaginal discharges according to fertility and hormone levels.

Aside from the normal causes stated above, any changes in the texture, color and amount of the vaginal discharge maybe due to Sexually Transmitted Infection (STI). Table below gives an overview of the characteristics of vaginal discharges and their possible causes.

![Different vaginal discharges in different levels of fertility](image)

<table>
<thead>
<tr>
<th>Type of Discharge</th>
<th>What It Might Mean</th>
<th>Other Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bloody or brown</td>
<td>Irregular menstrual cycles, or less often, cervical or endometrial cancer</td>
<td>Abnormal vaginal bleeding, pelvic pain</td>
</tr>
<tr>
<td>Cloudy or yellow</td>
<td>Gonorrhea</td>
<td>Bleeding between periods, urinary incontinence</td>
</tr>
<tr>
<td>Frothy, yellow or greenish with a bad smell</td>
<td>Trichomoniasis</td>
<td>Pain and itching while urinating</td>
</tr>
<tr>
<td>Pink</td>
<td>Shedding of the uterine lining after childbirth (lochia)</td>
<td></td>
</tr>
<tr>
<td>Thick, white, Cheesy</td>
<td>Yeast infection</td>
<td>Swelling and pain around the vulva, itching, painful sexual intercourse</td>
</tr>
<tr>
<td>White, gray, or yellow with fishy odor</td>
<td>Bacterial vaginosis</td>
<td>Itching or burning, redness and swelling of the vagina or vulva</td>
</tr>
</tbody>
</table>

The following are the most common STIs/STDs in women in greater detail.


1.1 Bacterial Vaginosis

The exact cause of bacterial vaginosis is unknown. Nearly half of women with this condition remain asymptomatic. Recurrence is common and it can co-exist with other vaginal infections. Having multiple sexual partners or having sexual intercourse with a person with multiple sexual partners places a woman at risk for BV. This may present as: increased amount of discharge, grey / white, thin watery discharge, foul, fishy odor with discharge and increased odor to discharge immediately after intercourse. Physicians prescribe antibiotics to treat this condition.

1.2 Trichomoniasis

This is caused by a one celled organism, Trichomonas vaginalis and is almost always transmitted through sexual intercourse. However, the protozoan organism can survive for up to 24 hours in a moist environment making wet towels or bathing suits possible instruments of transmission from someone with an infection.63

Signs and symptoms include foul smelling yellow, green or grey vaginal discharge, painful urination, pain on intercourse, inflammation of the vulva and an itchy, irritated genital area. Trichomoniasis is treated with antibiotics. Treatment of sexual partner/s should be done.

1.3 Monilia (Yeast) Infection

This is caused by Candida albicans, which is normally present in the vaginal area. However, there may be conditions that can cause an overabundance of this microorganism such as stress, pregnancy, use of certain medicines (prolonged antibiotics use, oral contraceptives) and certain disease conditions most commonly diabetes.

The pathognomonic sign of candidiasis is a white, clumpy cottage-cheese like discharge. There may also be redness, itching and burning in the vaginal / vulvar area.

Treatment goal is to reduce the overgrowth of yeast and return the vagina to a healthy balance. The use of anti-fungal agents is useful. If the infection is a co-morbid condition, it is best to treat the cause (example: control blood sugar if it is due to diabetes).

1.4 Chlamydia

This is an STI caused by Chlamydia trachomatis. The disease is common in women aged 15 – 24 years. Mode of transmission is through unprotected sexual intercourse. Mother to baby transmission can occur. Though it is usually asymptomatic, those who manifest symptoms do so about one to three weeks after being infected. Signs and symptoms may include vaginal discharge, painful urination, lower abdominal pain, and spotting in between periods.

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Complications include chronic pelvic pain, difficulty in getting pregnant, ectopic pregnancy, other complications of pregnancy, infertility and pelvic inflammatory disease (PID).

Diagnosis is by testing vaginal, cervical or urethral swabs or urine specimen. Treatment is with a single dose of Azithromycin or a one week regimen with Doxycycline.

### 1.5 Gonorrhea

Gonorrhea is a sexually transmitted disease (STD) that can infect both men and women. It can cause infections in the genitals, rectum, and throat. It is a very common infection, especially among young people ages 15-24 years.

One can get gonorrhea by having anal, vaginal, or oral sex with someone who has gonorrhea. A pregnant woman with gonorrhea can give the infection to her baby during childbirth.

Most women with gonorrhea do not have any symptoms. Even when a woman has symptoms, they are often mild and can be mistaken for a bladder or vaginal infection. Women with gonorrhea are at risk of developing serious complications from the infection, even if they don’t have any symptoms.

Symptoms in women can include:

- Painful or burning sensation when urinating;
- Increased vaginal discharge;
- Vaginal bleeding between periods.

You can protect yourself from getting gonorrhea by:

- Not having sex;
- Being in a long-term mutually monogamous relationship with a partner who has been tested and has negative STD test results;
- Using latex condoms right way every time you have sex.

C. Sexually Transmitted Infections including HIV and AIDS

Sexually transmitted diseases (STD), also referred to as sexually transmitted infections (STI) and venereal diseases (VD), are illnesses that are transmitted between humans by means of sexual behavior, including vaginal intercourse, anal sex and oral sex. Other modes of transmission are through sharps (sharing of needles) after use of an infected person, childbirth or breastfeeding\(^65\).

The WHO estimates that there are 333 million curable sexually transmitted infections (STIs) that occur each year. More than two thirds of these are in the developing world. The large proportion of infections occur individuals less than 25 years of age, with the highest rates among the 20–24 year olds followed by those between 15 – 19\(^66\). About 13% of youths aged 13 – 19 contract STD each year\(^67\).

I. BACTERIAL

1.1 Chlamydia

This is the most common bacterial STD. Transmission is via genital, anal or oral sex. It can also be transmitted by the mother to her child during the birthing process wherein newborns develop chlamydia eye infection. Please see “Chlamydia” under vaginal discharge above for more information.

1.2 Gonorrhea

Gonorrhea, also called “clap” or “drip” is caused by the bacteria Neisseria gonorrhea. This bacteria easily grows in the warm moist areas of the reproductive tract including the cervix, uterus, fallopian tubes in women and urethra in men. It can also grow in the mouth, throat, eyes and anus\(^68\).

Men have a 20% risk of getting the infection from a single act of vaginal intercourse with an infected woman. This is higher for men who have sex with men. On the other hand, women have a 60–80% risk of getting the infection from a single act of vaginal intercourse with an infected man. It cannot be spread by toilets or bathrooms\(^69\). Please refer to “Gonorrhea” under vaginal discharge above for more information.

1.3 Syphilis


\(^{68}\) Gonorrhea – CDC Fact Sheet http://www.cdc.gov/std/gonorrhea/stdfact-gonorrhea.htm

Syphilis is caused by the spirochete Treponema pallidum. Its main route of transmission is through sexual contact. Mother to child transmission during pregnancy or at birth can cause a condition called congenital syphilis. Person to person transmission happens with contact with the syphilitic sore called chancre. The disease has been known as the “great imitator” due to its atypical presentations. It can present in one of four stages:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Clinical Presentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary syphilis</td>
<td>Single firm, round, small, and painless sore (chancre)</td>
</tr>
<tr>
<td>Secondary syphilis</td>
<td>Nonitchy, reddish-brown skin rash and mucous membrane lesions +/- systemic symptoms (fever, pharyngitis, headache, arthralgias)</td>
</tr>
<tr>
<td>Tertiary syphilis</td>
<td>Guma formation (nonspecific granulomatous lesion that may infiltrate the skin, bone, or any organ or tissue)</td>
</tr>
<tr>
<td>Latent syphilis</td>
<td>Positive serologic test, but no symptoms</td>
</tr>
</tbody>
</table>

Screening tests such as Venereal Disease Research Laboratory (VDRL) and Rapid Plasma Reagin (RPR) can be used. Screening should be done for pregnant mothers; those whose partners were diagnosed with syphilis; most at risk population; and those whose behavior puts them at risk for contracting syphilis. However, these tests are not definitive. Definitive diagnosis is the visualization of the spirochete via dark field microscopy. Treatment is with the use of Benzathine Penicillin.

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70 Syphilis. CDC Fact Sheet http://www.cdc.gov/std/syphilis/STDFact-Syphilis-detailed.htm
II. VIRAL

2.1 Human Papilloma Virus (HPV)

Human Papilloma Virus (HPV) are viruses that cause warts. Persistent infection with high risk HPV types may progress to pre-cancerous lesions or may result in cancer of the cervix, vulva, vagina and anus in women and anus and penis in men (see figure)\textsuperscript{72,73}. HPV may be transmitted from mother to newborn during birth, through the hands, shared objects and sexual contact.

Genital HPV usually presents as genital or anal warts. Although there are several HPV types that can cause genital warts, 90% are caused by Types 6 and 11. The HPV that cause genital warts are not the same types that cause cervical cancer nor warts on other parts of the body such as the hands or inner thighs.

Most HPV infections are temporary and have little long term significance. Sometimes HPV infection can persist and cause a variety of problems:

- Genital warts. They can appear as a small bump or group of bumps in the genital area. Warts can appear weeks or months after contact with an infected partner even if the partner has no overt lesions.
- Cervical cancer does not cause any symptoms until it is quite advanced.
- Recurrent respiratory papillomatosis is a rare condition in which warts grow in the throat.
- Other types of cancer – vulva, vagina, penis or anus

HPV is a self-limiting infection. Safer sexual practices and vaccination may help decrease the likelihood of developing signs and symptoms.

2.2 Herpes Simplex Virus

Genital Herpes is an infection caused by Herpes simplex virus (HSV). Following the HSV classification, there are two distinct categories – 1 and 2. It was established that HSV1 was above the waist and HSV 2 was below the waist. Genital herpes was thought to be caused only by HSV 2. However, there are increasing cases of genital herpes caused by HSV 1 identified\textsuperscript{74}.

Most individuals infected with HSV are asymptomatic or may have mild lesions that can go unnoticed or be mistaken for another skin condition. When symptoms do occur, they appear as clusters of papules or vesicles resembling “cold sores.” The incubation period is 2 to 12 days
(average 4 days). The vesicles break away and form painful ulcers that may take two to four weeks to heal. This is referred to as having an “outbreak” or episode.

Signs and symptoms differ between the first and recurrent outbreaks. The first outbreak is associated with longer duration of lesions. Increased viral shedding and systemic symptoms like fever, body malaise, swollen lymph nodes and headache. Recurrent outbreaks are common during the first year of infection. Half of patients will have prodromal symptoms of mild tingling or shooting pain in the legs, hips and buttocks before eruption of herpetic lesions. However, duration is shorter than the first outbreak.

Tests can detect viable virus, viral antigen or viral nucleic acid. Some of these tests are viral culture, nucleic acid amplification tests; and serologic tests (ELISA).

CDC does not recommend screening for the general population. Instead, HSV screening should be done in:

- Patients with recurrent genital symptoms or atypical symptoms and negative HSV cultures;
- Patients with a clinical diagnosis of genital herpes but no laboratory confirmation;
- Patients who report having a partner with genital herpes;
- Patients presenting for an STD evaluation (especially those with multiple partners);
- Persons with HIV infection; and
- MSM at increased risk for HIV acquisition.

Treatment is with the use of antiviral drugs such as Acyclovir, Valacyclovir and Famciclovir.

2.3 Human Immunodeficiency Virus (HIV) / Acquired Immune Deficiency Syndrome (AIDS).

Human Immunodeficiency Virus (HIV) is a lentivirus that causes Acquired Immune Deficiency Syndrome (AIDS). The latter is a condition in humans in which the progressive failure of the immune system allows life threatening opportunistic infections and cancer to thrive.

To become infected with HIV, infected blood, semen or vaginal secretions must enter your body. One cannot become infected by hugging, kissing, dancing or shaking hands with someone who has HIV or AIDS. Further, HIV cannot be transmitted through air, water or insect bites.

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Diagram of HIV
One can transmit HIV:

- During sex. You can become infected through vaginal, anal or oral sex with an infected partner. The virus can enter your body through mouth sores or small tears in the rectum or vaginal during sexual activity.
- Blood transfusions.
- Sharing needles. HIV can be transmitted through needles and syringes contaminated with infected blood. Sharing intravenous drug paraphernalia puts one at higher risk of HIV and other blood transmissible diseases like Hepatitis.
- From mother to child. Infected mothers can spread the virus to their babies during pregnancy, delivery or through breastfeeding. However, if pregnant mothers receive treatment for HIV during pregnancy, the risk is significantly reduced.

Rare ways the virus may be spread include:

- Accidental needle injury
- Artificial insemination with infected semen
- Organ transplantation with infected organs

While the prevalence of HIV in the Philippines remains low, the HIV AIDS registry revealed a 79% increase in the number of new cases for 2013 compared to the previous year. The Philippines is one of two Asian countries where the number of HIV cases from 2001 – 2009 increased by more than 25%. In fact, the Philippine Health Sector has expressed concerned over the new 498 HIV-AIDs cases in the country for the first quarter of 2014 alone, raising the total number of cases to 1,432 from January to March.

Sexual contact is still the main mode of transmission with men having sex with men (MSMs) showing a marked increase in cases.

HIV infects vital cells in the human immune system such as T helper cells, specifically macrophages, and dendritic cells. HIV lowers CD4 cell count through apoptosis of uninfected bystander cells and direct viral killing of infected cells. Cell mediated immunity is lost and the body becomes susceptible to opportunistic infections like:

- Pneumocystis pneumonia
- Cytomegalovirus
- Tuberculosis
- Toxoplasmosis
- Cryptosporidiosis

The symptoms of AIDS depend on the phase of infection.

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77 HIV / AIDS. Mayo Clinic Staff http://www.mayoclinic.com/health/hiv-aids/DS00005/DSECTION=causes
79 HIV AIDS Philippines UNICEF http://www.unicef.org/philippines/hivaids.html#.UnihGSz5dAg
80 HIV / AIDS. Mayo Clinic Staff http://www.mayoclinic.com/health/hiv-aids/DS00005/DSECTION=causes
Primary

Majority manifest with flu like symptoms within a month or two after the virus enters the body. The illness, known as primary or acute HIV infection may last for a few weeks. Possible symptoms include fever, muscle soreness, rash, headache, sore throat, mouth or genital ulcers, swollen lymph glands mainly on the neck, joint pain, night sweats, diarrhea. Although the symptoms are mild to go unnoticed, viral load at this time is high. It is during this phase that HIV spreads more efficiently.

Clinical Latent

Swelling of the lymph nodes may persist during this phase. Other than that, there may be no other signs and symptoms. At this phase, the virus remains in the body and in infected white blood cells. This stage lasts an average of 8 to 10 years depending on the person’s immune system.

Early Symptomatic HIV Infection

The virus continues to multiply and destroy immune cells. The deterioration in the immune system may manifest as fever, fatigue, swollen lymph nodes, diarrhea, weight loss, cough and shortness of breath.

Progression to AIDS

If the individual does not receive any treatment, the disease may progress to full blown AIDS in about 10 years. A diagnosis of AIDS signals that the person’s immune system has been severely damaged making them susceptible to opportunistic infections. This may manifest as soaking night sweats, chills and/or fever, cough and shortness of breath, chronic diarrhea, candidiasis, headaches, persistent unexplained fatigue, blurred or distanced vision, weight loss and skin rashes or bumps.

Diagnosis is made initially by testing by ELISA. A non-reactive result would mean the individual is HIV negative. A reactive result would warrant confirmatory testing Western blot and less commonly by immunofluorescence assay.

Currently, there is no known treatment for AIDS. Anti-retroviral drugs improve survival and are helpful in preventing mother to child transmission. Efforts are being done to reduce transmission. Information education campaigns focus on abstinence, mutual monogamy, condom use, discouraging the use of drugs and other prohibited substances and educating oneself. Advocating for sexual safer practices, in case one cannot practice abstinence is also being done. Those who are at risk are encouraged to undergo voluntary counseling and testing.

Syndromic Approach

In low resource places, and geographically isolated communities, definitive diagnosis with the use of the various laboratory examinations is close to impossibility. The most that can be done is microscopic diagnosis and health service providers have to rely on a thorough history and physical examination. This is the reason why the Syndromic approach was formulated.
In this strategy, the STIs are grouped according to signs and symptoms. Each syndrome is based on history and physical examination and takes into consideration the most common causative organism.

Principles of Syndromic Approach:
- Recognize the syndrome
- The syndrome can be caused by one or more organisms
- Treat with a combination of drugs
- Drugs should cover the common organisms potentially responsible for the syndrome
- Organisms must be sensitive to the drug

Advantages:
- No laboratory tests needed
  a. Reduce cost
  b. Patient does not have to wait for the results
- Works well for urethral discharge and genital ulcers
- Simple to use
- Can be used in all levels of the health system
- Promotes standardization
- Facilitates training

Challenges:
- Many STIs are asymptomatic
- Vaginal discharge is not necessarily the result of STI
- Vaginitis vs. cervicitis – under treatment vs. overtreatment
- Overuse of drugs; cost; side effects; resistance
- Lack of acceptance by clinicians

Although STIs are frequent among certain groups of adolescents, most of them lack access to STI treatment services. The barriers to access are:

- Nature of STIs and diagnostic methods
  a. Infection often asymptomatic
  b. Lack of affordable screening tests
  c. Inaccurate risk assessments

- Adolescents’ knowledge, attitudes and skills related to STI and health seeking
  a. Lack of knowledge of symptoms
  b. STI treatment a low priority
  c. So not know where to go for treatment
  d. Do not have skills needed to express a sexual problem
  e. Fear of examinations
  f. Fear of parents and adults finding out

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PART 4: SEXUAL AND REPRODUCTIVE HEALTH CONCERNS

- Access to services
  a. Long distance to clinics
  b. Lack of money for transport
  c. Inconvenient opening times for adolescents
  d. Legal / policy restrictions
  e. Unfriendly / judgmental providers
  f. High cost of treatment

- Poor case management
  a. Drug shortages
  b. Ineffective drugs or suboptimal doses
  c. Failure of informal providers to educate, promote, and offer condoms and to notify partners

It is important to address these barriers if one intends to improve the health seeking behavior of adolescents in terms of prevention and control of STIs in their age group.

III. FUNGAL

3.1 Candidiasis

Genital / Vulvovaginal Candidiasis sometimes called “yeast infection” is caused by an overgrowth of the normal vaginal yeast flora. This is caused by Candida albicans. Aside from transmission through sexual contact, candidiasis can also develop because of disruption of the normal vaginal flora due to douching; pregnancy; use of oral contraceptives; as co morbid condition in persons with diabetes, prolonged antibiotic use, those undergoing chemotherapy or any condition that would lower the immune system.

Infection of the genital area may cause severe itching, burning, soreness, irritation and a whitish or whitish gray cottage cheese like discharge. These symptoms may be present in women with bacterial vaginosis. In males, symptoms of candidiasis will include red skin around the end of the penis; swelling, irritation, itchiness, and soreness of the head of the penis; thick, lumpy discharge under the foreskin, unpleasant odor, difficulty in retracting the foreskin, and painful urination.

Diagnosis is done via microscopic examination with KOH or culture.

Candidiasis is treated with antimycotics, which include clotrimazole, topical nystatin, fluconazole, and topical ketoconazole.

IV.PROTOZOAN

4.1 Trichomoniasis
Trichomoniasis, sometimes referred to as “itch” is a sexually transmitted infection caused by the protozoan parasite *Trichomonas vaginalis*. Women are more commonly affected compared to their male counterpart\(^{82}\).

Unlike the previously mentioned STIs, women usually present signs and symptoms of this infection such as greenish – yellow frothy vaginal discharge with fishy odor; painful urination; vaginal itching and irritation; discomfort during intercourse; and rarely lower abdominal pain. These symptoms appear 5 to 28 days after exposure.

Men often do not have symptoms of trichomoniasis. When they do appear, symptoms in males include irritation inside the penis, mild discharge and slight burning after urination or ejaculation\(^{83}\).

Researches showed that trichomoniasis increases the risk of HIV transmission; cause a woman to delivery low birth weight or premature infants; and increases the risk of cervical cancer in women and prostate cancer in males due to the inflammatory process.

Trichomoniasis is diagnosed upon microscopic identification of the protozoan using vaginal discharge specimen. Identification of the causative organism is more difficult in males and a string index of suspicion is raised when their partners are diagnosed with trichomoniasis. Treatment is with the use of Metronidazole.

\(^{82}\) Trichominiasis. Sexual conditions health center http://www.webmd.com/sexual-conditions/guide/trichomoniasis

\(^{83}\) Ibid
D. TEENAGE PREGNANCY

According to the most recent Young Adult Fertility and Sexuality (YAFS 4) Study, teenage fertility in the Philippines increased in the past decade:

- Percent of females of 15-19 who are mothers
  - 2002: 4.4
  - 2013: 11.0

- Percent of females of 15-19 who are pregnant with 1st child
  - 2002: 1.9
  - 2013: 2.6

- Percent of females of 15-19 who have begun childbearing
  - 2002: 6.3
  - 2013: 13.6

It was also revealed in YAFS 4 that:

- The proportion of teenage females who have begun childbearing increases with age:
  - Age 15: 1.8
  - Age 16: 4.4
  - Age 17: 10.4
  - Age 18: 22.8
  - Age 19: 35.2
  - Age 15-19: 13.6

Risk and Protective Factors

A risk factor is anything that encourages behavior that could result in a pregnancy or sexually transmitted disease (STD) or that discourage behavior that could prevent them. On the other hand, protective factors are those that discourage behavior that could lead to a pregnancy or STD or that encourage behavior.

These risk and protective factors may be grouped into four:

1. Individual biological factors (e.g. age, physical maturity and gender)
2. Disadvantage, disorganization and dysfunction in the lives of the teens themselves and their environments (e.g. rates of substance abuse, violence, and divorce; also levels of education)
3. Sexual values, attitudes, and modeled behavior (e.g. teens’ own values about sexual behavior as well as those expressed by parents, peers, and romantic partners)

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4. Association to adults and organizations that discourage sex, unprotected sex, or early childbearing. (e.g. attachment to parents and other adults in their schools and places of worship)\(^{86}\)

**Myths and Misconceptions**

Some myths and misconceptions about pregnancy prevalent among the youth are summarized in the table below:\(^{87}^{88}\):

<table>
<thead>
<tr>
<th>MYTHS and MISCONCEPTIONS</th>
<th>FACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>“You can't get pregnant the first time you have sex.”</td>
<td>If you are ovulating it doesn’t matter if it's the first time or the hundredth time you’ve had sex, you can still get pregnant when the sperm fertilizes the egg.</td>
</tr>
<tr>
<td>“Girls can't get pregnant during their period.”</td>
<td>There is a chance that you can get pregnant if you have sex during your period. Once in the vagina, sperm can stay alive for several days so even if the last time you had sex was 3 days ago during your period, you could now be ovulating and therefore you could get pregnant.</td>
</tr>
<tr>
<td>“You can't get pregnant if you've never had a period.”</td>
<td>You may ovulate 14 days before your first period so it is possible to get pregnant even if you haven't had a period yet.</td>
</tr>
<tr>
<td>A girl can’t get pregnant/a guy can’t get a girl pregnant if:</td>
<td>Wrong. You can get pregnant anytime you have sex.</td>
</tr>
<tr>
<td>1. you have sex standing up;</td>
<td></td>
</tr>
<tr>
<td>2. the girl is on top;</td>
<td></td>
</tr>
<tr>
<td>3. you have sex in a hot tub or a swimming pool;</td>
<td></td>
</tr>
<tr>
<td>4. you jump up and down immediately after sex;</td>
<td></td>
</tr>
<tr>
<td>5. the girl douches, takes a bath, or urinates</td>
<td></td>
</tr>
<tr>
<td>immediately after sex;</td>
<td></td>
</tr>
<tr>
<td>6. it's your first time;</td>
<td></td>
</tr>
<tr>
<td>7. you're both virgins;</td>
<td></td>
</tr>
<tr>
<td>8. the guy pulls out before he ejaculates or if he</td>
<td></td>
</tr>
<tr>
<td>doesn't go all the way in;</td>
<td></td>
</tr>
<tr>
<td>9. the girl doesn't have an orgasm;</td>
<td></td>
</tr>
<tr>
<td>10. the guy and the girl don’t orgasm at the same</td>
<td></td>
</tr>
<tr>
<td>time;</td>
<td></td>
</tr>
<tr>
<td>11. the girl pushes really hard on her belly button</td>
<td></td>
</tr>
<tr>
<td>after sex; or</td>
<td></td>
</tr>
<tr>
<td>12. the girl makes herself sneeze for fifteen</td>
<td></td>
</tr>
<tr>
<td>minutes after sex.</td>
<td></td>
</tr>
<tr>
<td>“A girl can’t pregnant when having sex in the pool”</td>
<td>Wrong. You can get pregnant in any form of water – bath tub, shower, pool, as long as sex has taken place.</td>
</tr>
<tr>
<td>“Drinking and drugs make sex much more fun.”</td>
<td>If you're drunk or high, it's hard to make good decisions about sex. 20% of 15- to 17-year-olds say</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Statement</th>
<th>Evidence/Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;If you talk with or educate young people about sexual health, they will experiment with sex.&quot;</td>
<td>Research shows the opposite. If children know more about sexual health, they are more likely to postpone initiation or use contraceptives (Frost &amp; Darroch Forrest, 1995; Grunseit &amp; Kippax, 1993; Grunseit et al., 1997; Kirby, 2000).</td>
</tr>
<tr>
<td>&quot;If teachers or parents are not comfortable talking about sexual health, then it is better not to discuss it.&quot;</td>
<td>It is okay for adults to admit they are uncomfortable. By using techniques such as depersonalizing questions, protecting privacy and using the proper terms for anatomy and sexual practices, we de-stigmatize and normalize the discussion.</td>
</tr>
<tr>
<td>&quot;Making condoms available to young people will increase sexual activity.&quot;</td>
<td>Research has clearly documented that the promotion and distribution of condoms to adolescents does not increase rates of sexual activity, but significantly increases condom use among those adolescents who are sexually active (Guttmacher et al., 1997; Schuster, Bell).</td>
</tr>
<tr>
<td>&quot;Comprehensive” Sexual Health Education Programs don’t promote abstinence.”</td>
<td>Comprehensive or holistic programs usually have postponement of sexual activity as one of their primary messages. The secondary message usually is: if you are or considering being sexually active, then the use of condoms and contraception is suggested.</td>
</tr>
</tbody>
</table>

What parents can do to help prevent teen pregnancy:

1. Talk to your teenager about your own sexual values and attitudes.
2. Establish rules and behavioral standards.
3. Know your teen’s friends and their parents.
4. Discourage your teenager dating others with significant differences in age.
5. Show your teenager that there is more to life.
6. Be vocal about your value for education.
7. Know what your kids are doing.
8. Develop a close relationship[^9].

E. SEX, GENDER, SEXUALITY AND LGBT

Sex and gender are terms that are sometimes used interchangeably. There is, however, a great difference between the two. The following section presents the definition of terms commonly used in gender and sexuality\textsuperscript{90}.

On the one hand, sex refers to a person’s biological status and is typically categorized as male, female, or intersex (i.e., atypical combinations of features that usually distinguish male from female).

Gender, on the other hand, refers to the attitudes, feelings, and behaviors that a given culture associates with a person’s biological sex.

Gender identity refers to “one’s sense of oneself as male, female, or transgender.”

Gender expression refers to the “…way in which a person acts to communicate gender within a given culture; for example, in terms of clothing, communication patterns and interests. A person’s gender expression may or may not be consistent with socially prescribed gender roles, and may or may not reflect his or her gender identity.”

Sexual orientation refers to the sex of those to whom one is sexually and romantically attracted. Categories of sexual orientation typically have included attraction to members of one’s own sex (gay men or lesbians), attraction to members of the other sex (heterosexuals), attraction to members of both sexes (bisexuals), attraction to the same or both sexes or transgendered individuals (queer), and not experiencing sexual attractions (asexual).

Coming out refers to the process when one acknowledges and accepts one’s own sexual orientation. It also encompasses the process in which one discloses one’s sexual orientation to others. The term closeted refers to a state of secrecy or cautious privacy regarding one’s sexual orientation.

LGBT

LGBT stands for lesbian, gay, bisexual, and transgender. It has been used since 1990s as an adaptation of the initials LGB to replace the term gay in reference to the community beginning in the mid to late 1980s\textsuperscript{91}. Different cultures have different understanding of what being a lesbian, gay, bisexual or transgender is.

\textsuperscript{90} Definition of Terms: Sex, Gender, Gender Identity, Sexual Orientation. Retrieved from: http://www.apa.org/pi/lgbt/resources/sexuality-definitions.pdf

Western terminology which describes sexual orientation and gender identity include⁹²:

- **Straight** (heterosexual) - attraction to someone of the opposite sex
- **Gay** - attraction to someone of the same sex, such as a man to another man, or a woman to another woman. This term can be used by both men and women
- **Lesbian** - attraction of a woman to another woman
- **Bisexual** - attraction of a person to both men and women
- **Transed** - 'Trans' can be used by and to describe people who are transgendered, transsexual or cross-dressers (transvestites)
- **Transgendered** - Transgendered people feel that the sex they were assigned at birth does not fit easily with their own gender identity. For example, a boy with male genitals may feel emotionally and consciously like a girl, and a girl, with female genitals, may feel like a boy.
- **Transsexuals** - Transsexuals usually want to live full-time as the gender they identify with and may choose medical procedures such as hormone treatment or surgery to change their bodies appropriately.
- **Cross-dressers** (transvestites) are those who choose to wear clothes that are considered to be for the opposite gender but may not want to change their bodies. Cross-dressers like to wear clothing of the opposite gender but, generally, do not identify with that gender and do not want to change their body.
- **Homosexual** - this word is no longer encouraged because, historically, it has promoted negative stereotypes, and the preferred wording is gay, lesbian or bisexual.
- **Transvestite** - this word is also outdated - today 'cross-dresser' is commonly used
- **GLBT** is the short description for gay, lesbian, bisexual and transgendered. 'LGBT' is an alternative abbreviation to GLBT meaning lesbian, gay, bisexual and transgendered.
- **Questioning** - someone who is feeling unsure about their sexuality and has not identified

In general, LGBTs suffer from different types of discrimination which include homophobia, heterosexism and heterosexual privilege. Homophobia arises from making generalizations (stereotyping) and/or treating a person or a group unjustly (discrimination) thought of as gay, lesbian or bisexual. It is also an irrational fear, hatred or repulsion of this group. Heterosexism is the belief or assumption that everyone is heterosexual and that heterosexuality is the only “right” and “natural” sexual orientation thus considering it as superior to homosexuality. Heterosexual privilege pertains to individuals identifying themselves as heterosexual who automatically gain some rights and advantages simply because they are attracted to individuals of the opposite sex.

In the Philippines, LGBTs has a distinctive culture but limited legal rights.⁹³ They are at the very least, tolerated, if not accepted and still discriminated. The Philippines does not offer any legal recognition to same sex marriages, civil unions or domestic partnerships. Since 2006, three anti same sex marriage bills have been introduced and pending before the Senate and Congress. In addition to that, the Philippines did not sign the United Nations declaration on sexual orientation

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and gender identity which condemns violence, harassment, discrimination, exclusion, stigmatization, and prejudice based on sexual orientation and gender identity.

In the Philippine legislative branch, Akabayan Citizens’ action Party List was the first political party to integrate LGBT rights into its political platform in the 1990s. The Ang Ladlad is a new progressive political party, with a primary agenda of combating discrimination and harassment on the basis of sexual orientation or gender identity. In November 11, 2009, the Philippine Commission on Elections (COMELEC) denied Ang Ladlad’s petition to run in the May, 2010 elections on ground of immorality and for failing to prove they have nationwide membership. On April 8, 2010, the Supreme Court of the Philippines reversed the COMELEC ruling.

In their fight for their own rights, many Filipino LGBT organizations have been identified both inside and outside Philippines. Table below lists some Filipino LGBT organizations and their aim. Some organizations not included in the table are ProGay: a gay rights organization; Can’t Live in the Closet: lesbian activist group; and Society of Transsexual WOMEN of the Philippines (STRAP), all based in Metro Manila. There are also groups outside Metro Manila such as the Northern Samar LGBT Community (NSLGBT) in Northern Samar and AKOD, a gay support group in Davao Oriental State College of Science and Technology.

Some Filipino LGBT Organizations:

<table>
<thead>
<tr>
<th>Organization</th>
<th>Location</th>
<th>Background</th>
</tr>
</thead>
<tbody>
<tr>
<td>PUP Kabaro</td>
<td>Metro Manila</td>
<td>a gender equality activist organization at the Polytechnic University of the Philippines</td>
</tr>
<tr>
<td>UP Babaylan</td>
<td>Quezon City</td>
<td>the first LGBT student organization (based in University of the Philippines Diliman) in the Philippines</td>
</tr>
<tr>
<td>Doll House</td>
<td>Quezon City</td>
<td>group for open-minded individuals based in the Ateneo de Manila University</td>
</tr>
<tr>
<td>Lunduyan ng Sining (&quot;Sanctuary of Art&quot;)</td>
<td>Metro Manila</td>
<td>registered lesbian arts organization providing a venue for lesbians to showcase their art</td>
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<tr>
<td>IWAG</td>
<td>Davao City</td>
<td>gay social support group</td>
</tr>
<tr>
<td>GAHUM</td>
<td>Cebu City</td>
<td>gay support and advocacy</td>
</tr>
<tr>
<td>Rainbow Rights Project (R-Rights)</td>
<td>Philippines</td>
<td>an NGO that serves as a legal &amp; policy think tank dedicated to LGBT issues</td>
</tr>
<tr>
<td>PinoyFTM</td>
<td>Metro Manila</td>
<td>the first organization for transsexual and transgender men in the Philippines</td>
</tr>
<tr>
<td>LGBTS Christian Church</td>
<td>Quezon City</td>
<td>a family-oriented, progressive, ecumenical community of faith of the lesbian, gay, bisexual, transgender and straight people</td>
</tr>
<tr>
<td>Task Force Pride (TFP) Philippines</td>
<td>Philippines</td>
<td>seeks to promote positive visibility for the LGBT community</td>
</tr>
<tr>
<td>The Knightingales</td>
<td>Davao City</td>
<td>an awareness group, a non-profit organization that aims to uphold the LGBT rights especially the gay rights</td>
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</table>
At the end of Part 5, the health and non-health workers are expected to:

1. Discuss the different ways on how adolescents can maintain a healthy lifestyle.

This part contains information on the following topics, namely:

A. Use of Tobacco, Alcohol and Other Substances
B. Nutritional Status and Physical Activity
A. USE OF TOBACCO, ALCOHOL AND OTHER SUBSTANCES

First experiences with tobacco, alcohol and illicit drugs are usually taking place during adolescence. Adolescent finds this as time to explore their limitations and to be engaged into risky behaviors. These can have a negative impact on adolescent health and well-being.

Tobacco Use

Tobacco use - both smoked and smokeless - during adolescence increases the risk of persistent nicotine addiction, leading to regular and sustained tobacco use in adulthood. Tobacco use remains one of the largest contributors to non-communicable diseases and to early mortality among adults\(^94\).

In the Philippines, it was reported that there is a decreasing proportion of youth who are currently smoking according to the 2013 Young Adult Fertility and Sexuality Survey (YAFS 4)\(^95\):

- YAFS 1994: 21.6
- YAFS 2002: 20.9
- YAFS 2013: 19.7

Alcohol Use

Alcohol use contributes to risks during adolescence for injury, violence, unprotected sex and suicide attempts. In adulthood it plays a role in risk for non-communicable diseases\(^96\).

In the Philippines, there is a decrease in the proportion of youth who are currently drinking during the past decade according to the 2013 Young Adult Fertility and Sexuality (YAFS 4) Study\(^97\):

- YAFS 1994: 37.4
- YAFS 2002: 41.4
- YAFS 2013: 36.7

Other Substances

Many adolescents begin using drugs by experimenting with marijuana. In most of the countries, adolescent boys aged 13–15 were more likely in use of drugs than adolescent girls of the same age. Also, one of the consequences of drug use among adolescents is the increased risk of HIV infection\(^98\).


Comparative data from the Dangerous Drugs Board (DDB) of the Philippines regarding the profile of drug users in 2008 and 2012 showed:

<table>
<thead>
<tr>
<th></th>
<th>2008&lt;sup&gt;9&lt;/sup&gt;</th>
<th>2012&lt;sup&gt;10&lt;/sup&gt;</th>
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<tbody>
<tr>
<td>Mean Age</td>
<td>28</td>
<td>29</td>
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<tr>
<td>Male to Female Ratio</td>
<td>10:1</td>
<td>10:1</td>
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<td>Civil Status:</td>
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<td>Single</td>
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<tr>
<td>Employment Status</td>
<td>Unemployed</td>
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</tr>
<tr>
<td>Educational Attainment</td>
<td>High School Level</td>
<td>College Level</td>
</tr>
<tr>
<td>Average Monthly Income</td>
<td>Php 16,290.00</td>
<td>Php 15,789.00</td>
</tr>
<tr>
<td>Residence</td>
<td>Urban Area</td>
<td>Urban Area</td>
</tr>
<tr>
<td>Duration of Drug Use</td>
<td>More than 6 years</td>
<td>More than 6 years</td>
</tr>
<tr>
<td>Nature of Drug Use</td>
<td>Poly drug use</td>
<td>Poly drug use</td>
</tr>
<tr>
<td>Commonly Abused Substances</td>
<td>Methamphetamine Hydrochloride (Shabu)</td>
<td>Methamphetamine Hydrochloride (Shabu)</td>
</tr>
<tr>
<td></td>
<td>Cannabis (marijuana)</td>
<td>Cannabis (marijuana)</td>
</tr>
<tr>
<td></td>
<td>Inhalants (Contact Cement Adhesive)</td>
<td>Inhalants (Contact Cement Adhesive)</td>
</tr>
</tbody>
</table>

The following data are reported from the 2013 Young Adult Fertility and Sexuality (YAFS 4) Study among Filipino adolescents<sup>101</sup>:

- Decrease in the proportion of youth who ever used drugs during the past decade
  - YAFS 1994: 5.7
  - YAFS 2002: 10.6
  - YAFS 2013: 3.9

**Helping Your Child Avoid Tobacco, Drugs, and Alcohol**

It is the best thing for parents to help their children prevent drug and alcohol misuse before a drug problem starts. Talking with the child about these harmful substances at the age of 5 or 6 is important. Parents must be honest and serious in talking about all kinds of tobacco, drugs, and alcohol as well as other things kids for them to cope with stress in their lives.

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Focusing on the positive side is important. Parents talking to the child about the ways of making responsible choices will help. They must make sure that they praise their child to build self-worth. Parents should also set a positive example by not engaging in tobacco smoking, alcohol use, and substance abuse. Supporting the child to get involved in sports, clubs, hobbies, and other activities can help them think that there is fun without drugs and alcohol. Parents should also take part in the child's life, knowing the child's routines.

It is also role for the parents to explain the dangers and consequences of tobacco, drug, or alcohol use to their child. They should discuss everything about how the body gets addicted to nicotine and other drugs, the legal problems that can result from using drugs or alcohol, withdrawal symptoms that happen when a person tries to quit.

Peer pressure can contribute to a person’s decision of being engaged in tobacco, alcohol and drugs abuse. Many adolescents feel pressured to use alcohol or drugs because some of their friends are using them. That’s why it is important that parents will encourage their child into finding other hobbies or has friends who are not in alcohol, drugs or tobacco use.

Messages for adolescents:

1. Do not be pressured into using tobacco, alcohol or other substances by people around you, or by images on television etc.
2. Talk to your friends, parents or other trusted adults if someone offers you substances to use. They could help you avoid using them.
3. If you have started using alcohol or other substances, seek help from your friends, parents or other trusted adults. They could help you give up their use.
4. If you do use alcohol or other substance that impair judgment, do so with someone you trust and in a safe place. You are more likely to suffer an overdose if you consume substances on your own, and are more likely to be a victim of crime or violence if you are alone and in an unsafe place.
5. If you do use alcohol or other substances that can impair your judgment, avoid driving a car, motorcycle or bicycle while under their influence.

Messages for parents

What you should know:

1. Increasing the awareness of your son or daughter about the dangers of substance use, and helping them become aware of the influence that peers and the media can have, can help them avoid substance use.
2. Early detection of substance use, followed by counseling by health workers, has been shown to be effective in motivating adolescents to give up their use or to reduce the harm it could cause them.

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What should you do:

1. Talk to your son or daughter about the dangers of using tobacco, alcohol or other substances. Do this in early adolescence. Do not wait until their use has started.
2. Discuss with your son or daughter the influence that their peers and images in the media could have in persuading them to initiate substance use. Explain to them the importance of deciding what is best for themselves.
3. Make clear what your expectations regarding their behavior are. Provide a good role model through your own behavior.
4. Be watchful for signs of substance use by your son or daughter. If and when you notice them, discuss the matter, and together seek help from a health worker103.

B. NUTRITIONAL STATUS AND PHYSICAL ACTIVITY

Nutritional Status and Diet

According to the 2013 Young Adult Fertility and Sexuality (YAFS 4) Study, Filipino adolescents had: high consumption of unhealthy/junk food and carbonated drinks regularly: The following data shows the:

- Proportion of the survey respondents who consumed the following items at least once a week\textsuperscript{104}:
  - Softdrinks: 68.0%
  - Instant noodles: 63.0%
  - Chips: 62.5%
  - Grilled street food: 52.0%

### Healthy Eating During Adolescence

Healthy eating is important for adolescent as essential body changes on this stage of development bring effects on an individual’s nutritional and dietary needs. Many adolescents experience an increase in appetite and therefore need healthy foods to meet their growth needs. As adolescents become more independent, they make good decisions on their own. Adolescents tend to eat more meals away from home compared to younger children. They can also be influenced by their peers on their food choices. They prefer meal convenience is important to many adolescents such as eating too much of the wrong types of food (i.e., soft drinks, fast-food, processed foods).

A common concern of many adolescents especially girls is dieting. They usually feel pressure from peers to be thin thus limiting their food consumption. Also, both boys and girls can be involved in any particular sports or social event making them go into diet to "make weight". The following are some helpful considerations to help adolescents in managing their nutrition:

- Help teens find out about nutrition for themselves by providing them teen-oriented magazines or books with food articles. This will encourage them to have interest in health, cooking, or nutrition.
- Consider their suggestions when possible, about foods to prepare at home.
- Try out with foods outside your own culture.
- Make several nutritious snack foods readily available and can offer convenience to the adolescent.
- Avoid bringing home the foods that they usually don’t prefer\textsuperscript{105}.

### Messages for Adolescents

1. Eating a sufficient amount and a wide variety of health foods is important for you to grow and develop normally


2. While it important that you eat enough food for your body to grow and develop normally, it is important to remember that eating too much food can make you overweight; this is not good for your health.
3. Eating healthily means having regular meals and avoiding unhealthy snacks (especially those that contain a lot of fat or sugar).

Messages for Parents

**What you should know:**

1. Your child needs to eat a wide variety and sufficient amount of healthy foods to grow and develop normally.
2. If your child develops healthy eating habits during their adolescent years, these habits are likely to continue for the rest of their lives.

**What you should do:**

1. Talk to your child about health foods and healthy eating.
2. Support your child to develop healthy eating habits.
3. Provide your child with a good role model by eating healthy yourself.\textsuperscript{106}

**Physical Activity**

Regular physical activity has important physical, mental and social benefits both during adolescence and later in life. Physical activities include sports such as football and exercise such as jogging. They also include regular daily activities such as walking to school and work done at home (e.g. cleaning the floor) or at work (e.g. painting a room).\textsuperscript{107} In the Philippines, the 2013 Young Adult Fertility and Sexuality (YAFS 4) Study revealed that:\textsuperscript{108}

- The youth have enough sleep and engage in physical activities:
  - Sleep: 8 hours average hours of sleep with no significant difference across age and sex.
  - Physical Exercise
    - 2/3 engage in physical exercise
    - 67% exercise at least 2X a week
    - More males than females exercise regularly


\textsuperscript{108} Media and Lifestyle of the Pinoy Young Adults. Retrieved from: http://www.drdf.org.ph/sites/default/files/PinoyYouthToday%20%20%282%29%20Media%20and%20Lifestyle.pdf
Recommended levels of physical activity for children aged 5 - 17 years:

For children and young people, physical activity includes play, games, sports, transportation, chores, recreation, physical education, or planned exercise, in the context of family, school, and community activities.

In order to improve cardiorespiratory and muscular fitness, bone health, and cardiovascular and metabolic health biomarkers:

- Children and youth aged 5–17 should accumulate at least 60 minutes of moderate- to vigorous-intensity physical activity daily.
- Amounts of physical activity greater than 60 minutes provide additional health benefits.
- Most of the daily physical activity should be aerobic. Vigorous-intensity activities should be incorporated, including those that strengthen muscle and bone*, at least 3 times per week.

*For this age group, bone-loading activities can be performed as part of playing games, running, turning or jumping.

Messages for adolescents

Around sixty minutes of physical activity on most, if not all days, can provide you with the following benefits:

Physical benefits
- It will help your bones and muscles grow and develop.
- It will help you remain (or become) fit and trim.

Mental benefits
- It can help to build your self-confidence and self-esteem.
- It can help you study and work better.
- It can help you calm down when you are anxious, sad or angry.

Social benefits
- Participating in sports can help you meet people and develop a sense of camaraderie.
- It can also help you learn how to play by the rules, how to cooperate with members of your team, and how to deal with both victory and defeat.
Messages for parents

What you should know:
1. Many adolescents need to be encouraged to build in some regular physical activity in their daily lives.
2. Developing this habit in adolescence and maintaining it into adulthood will help them prevent health problems that inactivity contributes to such as high blood pressure and diabetes.

What you should do:
1. Encourage your son or daughter to engage in regular physical activity for around 60 minutes on most, if not all days. Encourage them to match their physical activity with an adequate diet.
2. Provide incentives and opportunities for your son or daughter to engage in regular physical activity.
3. Provide your son or daughter with a good role model, by engaging in regular physical activity yourself\(^\text{109}\).

PART 6

ADOLESCENTS IN EMERGENCIES

At the end of Part 6, the health and non-health workers are expected to:

1. Discuss the situation of adolescents in emergency situations.
2. Cite roles of adolescents during emergencies

This part contains information on the following topics, namely:

A. Losses and Impacts of Emergencies to Adolescents
B. Role of Adolescents during Emergencies
ADOLESCENTS IN EMERGENCIES

An emergency is an extraordinary situation that puts the health and survival of a population at risk. These are manmade or natural; unpredicted or occur regularly; or be short-term or long-running. Emergencies are characterized by turmoil, insecurity, poor sanitation, and short supplies of clean water, food, fuel, medical care and shelter.110

Types of Losses for Adolescents in Emergencies

The leading causes of death for adolescents during emergencies are diarrheal diseases, acute respiratory infection, measles, malaria, and severe malnutrition. If they survive the aftermath of the emergency, adolescents then suffer from a pervading loss of the following:

- Loss of the time for learning and opportunity to build a good future;
- Loss of place of home or places of belonging;
- Loss of family, friends and significant adult role models;
- Loss of order, routines and meaningful activities, and the onset of a time of waste and emptiness;
- Loss of health or capacity through injury, illness and poor; and
- Loss of trust in response to personal or witnessed experiences of harm or abuse

This feeling of loss comes at a time which is usually set aside for learning and development of livelihood skills. Most of these adolescents perceive these losses as something they may never recover.

Specific Impacts of Emergencies Relevant to Adolescents

A. Gender

Gender is perceived through a lens of vulnerability and cuts across survival, education, health, protection and participation. Gender issues are particularly important in emergencies because the disaster tends to exacerbate existing gender inequalities. Studies have shown that girls and women are more likely to die during disasters. The gender gap is weakened for women of higher socio economic status which indicates that it is the socially construed nature of gender roles rather than physiological differences that places women at risk.

During disasters, boys may be burdened to provide and protect; to adopt the peer group rather than the family as a point of reference with associated uptake of risky or violent behaviors. Boys become more vulnerable to masculinized pattern of externalized or aggressive survival; are more likely to be pushed to militia; and are at greater risk for mental problems associated with depression and drug use. They are also more likely to be pushed into physically risky work.

110 Cahill, Helen et al. Adolescent in Emergencies. University of Melbourne, 2010
Girls, on the other hand, assume a leadership role in the family as a systemic response to disasters. They can forgo meals, engage in unsafe livelihoods, assume disproportionate levels of domestic burden, or marry early to relieve financial responsibilities for their families. These circumstances isolate them from friends, school, community, and the networks of aid that might support them. Nevertheless, in the face of such obstacles, they show resilience. Girls face the following challenges during emergencies:

- Risk of personal and bodily safety. There is an increase in violence and bodily harm against girls and women due to the breakdown of community cohesion. Temporary housing makes adolescent girls vulnerable to perpetuators.
- Risk for humanitarian abuses including exploitation by aid workers. Adolescents are constrained to vocalize their concerns publicly and may be intimidated by formal and informal authority figures due to existing social norms.
- Take on disproportionate levels of household burdens which may include caring for other siblings. They experience isolation and disruption of social networks and a higher incidence of missing or discontinued education. The lack of access to social, financial, health and educational services often results from the adolescent girl’s limited mobility within communities and the typical dispersion of such services.
- Face greater malnourishment and lack of iron in their diet. Girls are not the priority for feeding. In some countries, priority is given to male siblings and even livestock.
- Lesser access to schooling especially of the caliber available to their male counterparts. There are a variety of reasons why adolescent girls are pulled out of school – high cost in relation to the benefits of educating a female child; security concerns; and the obligation to care for the family and other siblings.
- Engage in unsafe livelihoods on their own initiative or due to family pressure. In some settings, adolescent girls engage in transactional sex to augment family income or in exchange for goods and other favors.
- Families see the bride price of adolescent girls as a means of survival. Early marriages increase during disasters as a means of survival.
- Lack of access to quality, youth friendly reproductive health services, information and commodities. The emergency situation heightens this situation. Emergency situations foster an increase in early and unintended pregnancies, HIV and other STIs and unsafe abortions.

B. Sexual Violence

Women are more vulnerable to abuses in evacuation centers / camps due to:

- Lack of awareness on their rights
- Lack of information about resources and benefits available to them
- Illiteracy
- Male control of resources in camps

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Women resort to coping mechanisms such as exchange of sex for money, goods, and favors to overcome these inequalities.

**C. Mental Health**

There has been a significant concern about the potential for traumatic experiences to trigger the development of mental disorders, most commonly post-traumatic stress disorder (PTSD). Post-traumatic stress is defined as the normal response to trauma whereby people experience the intrusion of distressing memories of the experience. PTSD is the term used when the reaction has become a severe anxiety disorder which may include re-experiencing the original trauma through flashbacks, nightmares, avoidance of images, sounds or places associated with the trauma, increased arousal or vigilance, difficulty falling or staying asleep. Anger or numbing. These persist over time and are severe enough to disrupt social, occupational, or other areas of functioning.

Other mental disorders such as depression, anxiety, poor impulse control and high levels of reactive aggression may also occur as a result of the disaster experience.

**D. Sexual and Reproductive Health**

Under normal circumstances, adolescents have problems with access to sexual and reproductive health services because of individual, socio cultural and structural barriers. This situation is heightened during emergencies due to damage to infrastructure, pressure to the health provider. This occurs at a time when the risk for sexual violence, unwanted pregnancy, unsafe abortion and STIs and HIV are increased.

The UNFPA and Save the Children have identified the following populations as at heightened risk during disasters:\(^{112}\):

- Very young adolescents (10-14 years), especially girls: due to their dependence, lack of life experience, lack of power and lack of participation in decision making.
- Pregnant adolescent girls: due to an increased risk of pregnancy complications and reduced availability of emergency obstetric care services in emergency settings.
- Marginalized adolescents (e.g. HIV+, disability): due to stigma, culture, mental or physical limitations.
- Adolescents separated from their families (parents/ partner) and adolescent heads of household: due to lack of protection, access to livelihood.
- Adolescent survivors of sexual/gender based violence: due to a risk of unwanted pregnancy, unsafe abortion, STIs, mental health problems and social stigmatization.
- Adolescent girls selling sex: due to a risk of unwanted pregnancy, unsafe abortion, STIs, drug and alcohol problems and exploitation.
- Children associated with armed forces: usually sexually active at a younger age and risk of STIs and higher risk of HIV, sexual violence and abuse (especially for females), this leads

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\(^{112}\) Cahill, Helen et al. Adolescent in Emergencies. University of Melbourne, 2010
Failure to respond to the sexual and reproductive health needs of adolescents also contribute to their mental health status. Feelings of security and safety are compromised when adequate food, water, medicine and health care are unavailable. Feelings of dignity and self-respect are decreased when health services are withheld due to moral grounds or provided in a subjective manner; Feelings of shame, stigma and neglect are associated with higher levels of despair, alienation, aggression and depression.

**E. Trafficking**

Poverty, deteriorating living conditions, persistent unemployment, conflicts, human deprivation and feelings of hopelessness bring about problems in trafficking. These situations are exacerbated in disasters putting displaced populations as preys to traffickers. In the absence of alternative opportunities, desperate people will resort to low paid labor and exploitation. The absence of law and order with a large number of vulnerable populations make emergency situations a good source for human trafficking for sexual exploitation or forced labor. This has major health and wellbeing risks for the victims. Women and children suffer disproportionately from lack of access to resources and education and the lack of comprehensive information or access to legitimate migration programs.

**F. Child Soldiers**

Child soldiers include children up to 18 years of age, who have either been abducted to fight, or signed up voluntarily. Some perceive this as the best way to ensure the satisfaction of their survival. Adolescents are also vulnerable to ideological recruitment and education of religious organizations and families can play a role in socializing adolescents in pro conflict beliefs.

Adolescents returning from soldier experiences may suffer from PTSD or may suffer from stress, guilt and nightmares. Adolescents returning to the community face persecution, threats to life or stigmatization due to the acts they have committed or abuse and / or resentment from grieving families of unreturned child soldiers. An additional burden is the loss of opportunities brought about by lost education and employment skills due to the time spent in fighting.

**G. Loss of Access to Education**

Emergency situations deprive adolescents of the opportunities to attend school because they have to attend to family responsibilities; and lack of opportunities and environment fit for their age and circumstances. The lack of education is due to the priority given to primary education over and above adolescent education. This is due to the fact that adolescent education is seen as a part of development rather than a life saving measure. Without skill building opportunities, adolescents engage in risky behaviors and activities in order to survive. Adolescent girls are likely to miss out on education opportunities compared to the male counterparts because of security concerns, family responsibilities, unavailability of sanitary or hygiene facilities, pressure to marry, and the perpetuation of the belief that the needs of boys must be catered to first.
Role of Adolescents during Emergencies: The Active Participation of Adolescents

Ensuring adolescents’ meaningful participation can be difficult at the best of times. Adults often do not recognize the value of their views and they sometimes have restricted access to information and opportunities to participate. In times of emergency, practicing participatory approaches can be moved even further down the priority list, despite evidence of its positive impact on communities.

Recommendations for good practice are summarized below:

- Involve adolescents in all stages of program needs analysis, development, operation, monitoring and evaluation.
- Include adolescents from various backgrounds such as age, caste, class, religion, ethnicity, and give them equal possibility to have their voices heard.
- Encourage the wider community to unpack their assumptions about adolescents and acknowledge the benefits of adolescent participation.
- Be aware that while participatory processes can empower young people, they can also further manipulate them, depending on the level of consultation and the opportunity they are given to make choices. Full participation goes beyond consultation and should include opportunities for leadership and decision making.
## ANNEXES

### INTERNATIONAL POLICIES

<table>
<thead>
<tr>
<th></th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>General Comment No. 4. Adolescent Health and Development in the</td>
<td>116</td>
</tr>
<tr>
<td></td>
<td>Context of the Convention on the Rights of the Child</td>
<td></td>
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<tr>
<td></td>
<td>(Cairo, 1994)</td>
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<tr>
<td>3</td>
<td>United Nations Millennium Declaration (September, 2000)</td>
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ANNEX 1

UNITED NATIONS Convention on the Rights of the Child
COMMITTEE ON THE RIGHTS OF THE CHILD
Thirty-third session
19 May-6 June 2003

Adolescent health and development in the context of the
Convention on the Rights of the Child

Introduction
1. The Convention on the Rights of the Child defines a child as “every human being below the age of 18 years unless, under the law applicable, majority is attained earlier” (art. 1). Consequently, adolescents up to 18 years old are holders of all the rights enshrined in the Convention; they are entitled to special protection measures and, according to their evolving capacities, they can progressively exercise their rights (art. 5).

2. Adolescence is a period characterized by rapid physical, cognitive and social changes, including sexual and reproductive maturation; the gradual building up of the capacity to assume adult behaviors and roles involving new responsibilities requiring new knowledge and skills. While adolescents are in general a healthy population group, adolescence also poses new challenges to health and development owing to their relative vulnerability and pressure from society, including peers, to adopt risky health behavior. These challenges include developing an individual identity and dealing with one’s sexuality. The dynamic transition period to adulthood is also generally a period of positive changes, prompted by the significant capacity of adolescents to learn rapidly, to experience new and diverse situations, to develop and use critical thinking, to familiarize themselves with freedom, to be creative and to socialize.

3. The Committee on the Rights of the Child notes with concern that in implementing their obligations under the Convention, States parties have not given sufficient attention to the specific concerns of adolescents as rights holders and to promoting their health and development. This has motivated the Committee to adopt the present general comment in order to raise awareness and provide States parties with guidance and support in their efforts to guarantee the respect for, protection and fulfillment of the rights of adolescents, including through the formulation of specific strategies and policies.

4. The Committee understands the concepts of “health and development” more broadly than being strictly limited to the provisions defined in articles 6 (right to life, survival and development) and 24 (right to health) of the Convention. One of the aims of this general comment is precisely to identify the main human rights that need to be promoted and protected in order to ensure that adolescents do enjoy the highest attainable standard of health, develop in a well-balanced manner, and are adequately prepared to enter adulthood and assume a constructive role in their communities and in society at large. This general comment should be read in conjunction with the Convention and its two Optional Protocols on the sale of children, child prostitution and child pornography, and on the involvement of children in armed conflict, as well as other relevant international human rights norms and standards.
I. FUNDAMENTAL PRINCIPLES AND OTHER OBLIGATIONS OF STATES PARTIES

5. As recognized by the World Conference on Human Rights (1993) and repeatedly stated by the Committee, children’s rights too are indivisible and interrelated. In addition to articles 6 and 24, other provisions and principles of the Convention are crucial in guaranteeing that adolescents fully enjoy their right to health and development.

The right to non-discrimination

6. States parties have the obligation to ensure that all human beings below 18 enjoy all the rights set forth in the Convention without discrimination (art. 2), including with regard to “race, color, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status”. These grounds also cover adolescents’ sexual orientation and health status (including HIV/AIDS and mental health). Adolescents who are subject to discrimination are more vulnerable to abuse, other types of violence and exploitation, and their health and development are put at greater risk. They are therefore entitled to special attention and protection from all segments of society.

Appropriate guidance in the exercise of rights

7. The Convention acknowledges the responsibilities, rights and duties of parents (or other persons legally responsible for the child) “to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the Convention” (art. 5). The Committee believes that parents or other persons legally responsible for the child need to fulfill with care their right and responsibility to provide direction and guidance to their adolescent children in the exercise by the latter of their rights. They have an obligation to take into account the adolescents’ views, in accordance with their age and maturity, and to provide a safe and supportive environment in which the adolescent can develop. Adolescents need to be recognized by the members of their family environment as active rights holders who have the capacity to become full and responsible citizens, given the proper guidance and direction can develop. Adolescents need to be recognized by the members of their family environment as active rights holders who have the capacity to become full and responsible citizens, given the proper guidance and direction.

Respect for the views of the child

8. The right to express views freely and have them duly taken into account (art. 12) is also fundamental in realizing adolescents’ right to health and development. States parties need to ensure that adolescents are given a genuine chance to express their views freely on all matters affecting them, especially within the family, in school, and in their communities. In order for adolescents to be able safely and properly to exercise this right, public authorities, parents and other adults working with or for children need to create an environment based on trust, information-sharing, the capacity to listen and sound guidance that is conducive for adolescents’ participating equally including in decision-making processes.
Legal and judicial measures and processes

9. Under article 4 of the Convention, “States parties shall undertake all appropriate legislative, administrative and other measures for the implementation of the rights recognized” therein. In the context of the rights of adolescents to health and development, States parties need to ensure that specific legal provisions are guaranteed under domestic law, including with regard to setting a minimum age for sexual consent, marriage and the possibility of medical treatment without parental consent. These minimum ages should be the same for boys and girls (article 2 of the Convention) and closely reflect the recognition of the status of human beings under 18 years of age as rights holders, in accordance with their evolving capacity, age and maturity (arts. 5 and 12 to 17). Further, adolescents need to have easy access to individual complaint systems as well as judicial and appropriate non-judicial redress mechanisms that guarantee fair and due process, with special attention to the right to privacy (art. 16).

Civil rights and freedoms

10. The Convention defines the civil rights and freedoms of children and adolescents in its articles 13 to 17. These are fundamental in guaranteeing the right to health and development of adolescents. Article 17 states that the child has the right to “access information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health”. The right of adolescents to access appropriate information is crucial if States parties are to promote cost-effective measures, including through laws, policies and programs, with regard to numerous health-related situations, including those covered in articles 24 and 33 such as family planning, prevention of accidents, protection from harmful traditional practices, including early marriages and female genital mutilation, and the abuse of alcohol, tobacco and other harmful substances.

11. In order to promote the health and development of adolescents, States parties are also encouraged to respect strictly their right to privacy and confidentiality, including with respect to advice and counseling on health matters (art. 16). Health-care providers have an obligation to keep confidential medical information concerning adolescents, bearing in mind the basic principles of the Convention. Such information may only be disclosed with the consent of the adolescent, or in the same situations applying to the violation of an adult’s confidentiality.

Adolescents deemed mature enough to receive counseling without the presence of a parent or other person are entitled to privacy and may request confidential services, including treatment.

Protection from all forms of abuse, neglect, violence and exploitation

12. States parties must take effective measures to ensure that adolescents are protected from all forms of violence, abuse, neglect and exploitation (arts. 19, 32-36 and 38), paying increased attention to the specific forms of abuse, neglect, violence and exploitation that affects this

Age group. In particular, they should adopt special measures to ensure the physical, sexual and mental integrity of adolescents with disabilities, who are particularly vulnerable to abuse and neglect. States parties should also ensure that adolescents affected by poverty who are socially marginalized are not criminalized. In this regard, financial and human resources need to be allocated to promote research that would inform the adoption of effective local and national laws, policies and programs. Policies and strategies should be reviewed regularly and revised
accordingly. In taking these measures, States parties have to take into account the evolving capacities of adolescents and involve them in an appropriate manner in developing measures, including programs, designed to protect them. In this context, the Committee emphasizes the positive impact that peer education can have, and the positive influence of proper role models, especially those in the worlds of arts, entertainment and sports.

**Data collection**

13. Systematic data collection is necessary for States parties to be able to monitor the health and development of adolescents. States parties should adopt data-collection mechanisms that allow desegregation by sex, age, origin and socio-economic status so that the situation of different groups can be followed. Data should also be collected to study the situation of specific groups such as ethnic and/or indigenous minorities, migrant or refugee adolescents, adolescents with disabilities, working adolescents, etc. Where appropriate, adolescents should participate in the analysis to ensure that the information is understood and utilized in an adolescent-sensitive way.

**II. CREATING A SAFE AND SUPPORTIVE ENVIRONMENT**

14. The health and development of adolescents are strongly determined by the environments in which they live. Creating a safe and supportive environment entails addressing attitudes and actions of both the immediate environment of the adolescent - family, peers, schools and services - as well as the wider environment created by, inter alia, community and religious leaders, the media, national and local policies and legislation. The promotion and enforcement of the provisions and principles of the Convention, especially articles 2-6, 12-17, 24, 28, 29 and 31, are key to guaranteeing adolescents’ right to health and development. States parties should take measures to raise awareness and stimulate and/or regulate action through the formulation of policy or the adoption of legislation and the implementation of programs specifically for adolescents.

15. The Committee stresses the importance of the family environment, including the members of the extended family and community or other persons legally responsible for the child or adolescent (arts. 5 and 18). While most adolescents grow up in well-functioning family environments, for some the family does not constitute a safe and supportive milieu.

16. The Committee calls upon States parties to develop and implement, in a manner consistent with adolescents’ evolving capacities, legislation, policies and programs to promote the health and development of adolescents by

(a) providing parents (or legal guardians) with appropriate assistance through the development of institutions, facilities and services that adequately support the well-being of adolescents, including, when needed, the provision of material assistance and support with regard to nutrition, clothing and housing (art. 27 (3));

(b) providing adequate information and parental support to facilitate the development of a relationship of trust and confidence in which issues regarding, for example, sexuality and sexual behavior and risky lifestyles can be openly discussed and acceptable solutions found that respect the adolescent’s rights (art. 27 (3));
(c) providing adolescent mothers and fathers with support and guidance for both their own and their children’s well-being (art. 24 (f), 27 (2-3));

(d) giving, while respecting the values and norms of ethnic and other minorities, special attention, guidance and support to adolescents and parents (or legal guardians), whose traditions and norms may differ from those in the society where they live; and (e) ensuring that interventions in the family to protect the adolescent and, when necessary, separate her/him from the family, e.g. in case of abuse or neglect, are in accordance with applicable laws and procedures. Such laws and procedures should be reviewed to ensure that they conform to the principles of the Convention.

17. The school plays an important role in the life of many adolescents, as the venue for learning, development and socialization. Article 29 (1) states that education must be directed to “the development of the child’s personality, talents and mental and physical abilities to their fullest potential”. In addition, general comment No. 1 on the aims of education states that “Education must also be aimed at ensuring that … no child leaves school without being equipped to face the challenges that he or she can expect to be confronted with in life. Basic skills should include … the ability to make well-balanced decisions; to resolve conflicts in a non-violent manner; and to develop a healthy lifestyle [and] good social relationships …”. Considering the importance of appropriate education for the current and future health and development of adolescents, as well as for their children, the Committee urges States parties, in line with articles 28 and 29 of the Convention to (a) ensure that quality primary education is compulsory and available, accessible and free to all and that secondary and higher education are available and accessible to all adolescents; (b) provide well-functioning school and recreational facilities which do not pose health risks to students, including water and sanitation and safe journeys to school; (c) take the necessary actions to prevent and prohibit all forms of violence and abuse, including sexual abuse, corporal punishment and other inhuman, degrading or humiliating treatment or punishment in school, by school personnel as well as among students; (d) initiate and support measures, attitudes and activities that promote healthy behavior by including relevant topics in school curricula.

18. During adolescence, an increasing number of young people are leaving school to start working to help support their families or for wages in the formal or informal sector. Participation in work activities in accordance with international standards, as long as it does not jeopardize the enjoyment of any of the other rights of adolescents, including health and education, may be beneficial for the development of the adolescent. The Committee urges States parties to take all necessary measures to abolish all forms of child labor, starting with the worst forms, to continuously review national regulations on minimum ages for employment with a view to making them compatible with international standards, and to regulate the working environment and conditions for adolescents who are working (in accordance with article 32 of the Convention, as well as ILO Conventions Nos. 138 and 182), so as to ensure that they are fully protected and have access to legal redress mechanisms.

19. The Committee also stresses that in accordance with article 23 (3) of the Convention, the special rights of adolescents with disabilities should be taken into account and assistance provided to ensure that the disabled child/adolescent has effective access to and receives good
quality education. States should recognize the principle of equal primary, secondary and tertiary educational opportunities for disabled children/adolescents, where possible in regular schools.

20. The Committee is concerned that early marriage and pregnancy are significant factors in health problems related to sexual and reproductive health, including HIV/AIDS. Both the legal minimum age and actual age of marriage, particularly for girls, are still very low in several States parties. There are also non-health-related concerns: children who marry, especially girls, are often obliged to leave the education system and are marginalized from social activities.

Further, in some States parties married children are legally considered adults, even if they are under 18, depriving them of all the special protection measures they are entitled under the Convention. The Committee strongly recommends that States parties review and, where necessary, reform their legislation and practice to increase the minimum age for marriage with and without parental consent to 18 years, for both girls and boys. The Committee on the Elimination of Discrimination against Women has made a similar recommendation (general comment No. 21 of 1994).

21. In most countries accidental injuries or injuries due to violence are a leading cause of death or permanent disability among adolescents. In that respect, the Committee is concerned about the injuries and death resulting from road traffic accidents, which affect adolescents disproportionately. States parties should adopt and enforce legislation and programs to improve road safety, including driving education for and examination of adolescents and the adoption or strengthening of legislation known to be highly effective such as the obligations to have a valid driver’s license, wear seat belts and crash helmets, and the designation of pedestrian areas.

22. The Committee is also very concerned about the high rate of suicide among this age group. Mental disorders and psychosocial illness are relatively common among adolescents. In many countries symptoms such as depression, eating disorders and self-destructive behaviors, sometimes leading to self-inflicted injuries and suicide, are increasing. They may be related to, inter alia, violence, ill-treatment, abuse and neglect, including sexual abuse, unrealistically high expectations, and/or bullying or hazing in and outside school. States parties should provide these adolescents with all the necessary services.

23. Violence results from a complex interplay of individual, family, community and societal factors. Vulnerable adolescents such as those who are homeless or who have been recruited as child soldiers are especially exposed to both institutional and interpersonal violence. Under article 19 of the Convention, States parties must take all appropriate measures to prevent and eliminate: (a) institutional violence against adolescents, including through legislation and administrative measures in relation to public and private institutions for adolescents (schools, institutions for disabled adolescents, juvenile reformatories, etc.), and training and monitoring of personnel in charge of institutionalized children or who otherwise have contact with children through their work, including the police; and (b) interpersonal violence among adolescents, including by supporting adequate parenting and opportunities for social and educational development in early childhood, fostering non-violent cultural norms and values (as foreseen in article 29 of the Convention), strictly controlling firearms and restricting access to alcohol and drugs.
24. In light of articles 3, 6, 12, 19 and 24 (3) of the Convention, States parties should take all effective measures to eliminate all acts and activities which threaten the right to life of adolescents, including honor killings. The Committee strongly urges States parties to develop and implement awareness-raising campaigns, education programs and legislation aimed at changing prevailing attitudes, and address gender roles and stereotypes that contribute to harmful traditional practices. Further, States parties should facilitate the establishment of multidisciplinary information and advice centers regarding the harmful aspects of some traditional practices, including early marriage and female genital mutilation.

25. The Committee is concerned about the influence exerted on adolescent health behaviors by the marketing of unhealthy products and lifestyles. In line with article 17 of the Convention, States parties are urged to protect adolescents from information that is harmful to their health and development, while underscoring their right to information and material from diverse national and international sources. States parties are therefore urged to regulate or prohibit information on and marketing such as alcohol and tobacco, particularly when it targets children and adolescents.

III. INFORMATION, SKILLS DEVELOPMENT, COUNSELLING, AND HEALTH SERVICES

26. Adolescents have the right to access adequate information essential for their health and development and for their ability to participate meaningfully in society. It is the obligation of States parties to ensure that all adolescent girls and boys, both in and out of school, are provided with, and not denied, accurate and appropriate information on how to protect their health and development and practice healthy behaviors. This should include information on the use and abuse, of tobacco, alcohol and other substances, safe and respectful social and sexual behaviors, diet and physical activity.

27. In order to act adequately on the information, adolescents need to develop the skills necessary, including self-care skills, such as how to plan and prepare nutritionally balanced meals and proper personal hygiene habits, and skills for dealing with particular social situations such as interpersonal communication, decision-making, and coping with stress and conflict. States parties should stimulate and support opportunities to build such skills through, inter alia, formal and informal education and training programs, youth organizations and the media.

28. In light of articles 3, 17 and 24 of the Convention, States parties should provide adolescents with access to sexual and reproductive information, including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV/AIDS and the prevention and treatment of sexually transmitted diseases (STDs). In addition, States parties should ensure that they have access to appropriate information, regardless of their marital status and whether their parents or guardians consent. It is essential to find proper means and methods of providing information that is adequate and sensitive to the particularities and specific rights of adolescent girls and boys. To this end, States parties are encouraged to ensure that adolescents are actively involved in the design and dissemination of information through a variety of channels beyond the school, including youth organizations, religious, community and other groups and the media.
29. Under article 24 of the Convention, States parties are urged to provide adequate treatment and rehabilitation for adolescents with mental disorders, to make the community aware of the early signs and symptoms and the seriousness of these conditions, and to protect adolescents from undue pressures, including psychosocial stress. States parties are also urged to combat discrimination and stigma surrounding mental disorders, in line with their obligations under article 2. Every adolescent with a mental disorder has the right to be treated and cared for, as far as possible, in the community in which he or she lives. Where hospitalization or placement in a psychiatric institution is necessary, this decision should be made in accordance with the principle of the best interests of the child. In the event of hospitalization or institutionalization, the patient should be given the maximum possible opportunity to enjoy all his or her rights as recognized under the Convention, including the rights to education and to have access to recreational activities. Where appropriate, adolescents should be separated from adults. States parties must ensure that adolescents have access to a personal representative other than a family member to represent their interests, when necessary and appropriate. In accordance with article 25 of the Convention, States parties should undertake periodic review of the placement of adolescents in hospitals or psychiatric institutions.

30. Adolescents, both girls and boys, are at risk of being infected with and affected by STDs, including HIV/AIDS. States should ensure that appropriate goods, services and information for the prevention and treatment of STDs, including HIV/AIDS, are available and accessible. To this end, States parties are urged (a) to develop effective prevention programs, including measures aimed at changing cultural views about adolescents’ need for contraception and STD prevention and addressing cultural and other taboos surrounding adolescent sexuality; (b) to adopt legislation to combat practices that either increase adolescents’ risk of infection or contribute to the marginalization of adolescents who are already infected with STDs, including HIV; (c) to take measures to remove all barriers hindering the access of adolescents to information, preventive measures such as condoms, and care.

31. Adolescent girls should have access to information on the harm that early marriage and early pregnancy can cause, and those who become pregnant should have access to health services that are sensitive to their rights and particular needs. States parties should take measures to reduce maternal morbidity and mortality in adolescent girls, particularly caused by early pregnancy and unsafe abortion practices, and to support adolescent parents. Young mothers, especially where support is lacking, may be prone to depression and anxiety, compromising their ability to care for their child. The Committee urges States parties (a) to develop and implement programs that provide access to sexual and reproductive health services, including family planning, contraception and safe abortion services where abortion is not against the law, adequate and comprehensive obstetric care and counseling; (b) to foster positive and supportive attitudes towards adolescent parenthood for their mothers and fathers; and (c) to develop policies that will allow adolescent mothers to continue their education.

32. Before parents give their consent, adolescents need to have a chance to express their views freely and their views should be given due weight, in accordance with article 12 of the Convention. However, if the adolescent is of sufficient maturity, informed consent shall be obtained from the adolescent her/himself, while informing the parents if that is in the “best interest of the child” (art. 3).
33. With regard to privacy and confidentiality, and the related issue of informed consent to treatment, States parties should (a) enact laws or regulations to ensure that confidential advice concerning treatment is provided to adolescents so that they can give their informed consent. Such laws or regulations should stipulate an age for this process, or refer to the evolving capacity of the child; and (b) provide training for health personnel on the rights of adolescents to privacy and confidentiality, to be informed about planned treatment and to give their informed consent to treatment.

IV. VULNERABILITY AND RISK

34. In ensuring respect for the right of adolescents to health and development, both individual behaviors and environmental factors which increase their vulnerability and risk should be taken into consideration. Environmental factors, such as armed conflict or social exclusion, increase the vulnerability of adolescents to abuse, other forms of violence and exploitation, thereby severely limiting adolescents’ abilities to make individual, healthy behavior choices. For example, the decision to engage in unsafe sex increases adolescents’ risk of ill-health.

35. In accordance with article 23 of the Convention, adolescents with mental and/or physical disabilities have an equal right to the highest attainable standard of physical and mental health. States parties have an obligation to provide adolescents with disabilities with the means necessary to realize their rights. States parties should (a) ensure that health facilities, goods and services are available and accessible to all adolescents with disabilities and that these facilities and services promote their self-reliance and their active participation in the community; (b) ensure that the necessary equipment and personal support are available to enable them to move around, participate and communicate; (c) pay specific attention to the special needs relating to the sexuality of adolescents with disabilities; and (d) remove barriers that hinder adolescents with disabilities in realizing their rights.

36. States parties have to provide special protection to homeless adolescents, including those working in the informal sector. Homeless adolescents are particularly vulnerable to violence, abuse and sexual exploitation from others, self-destructive behavior, substance abuse and mental disorders. In this regard, States parties are required to (a) develop policies and enact and enforce legislation that protect such adolescents from violence, e.g. by law enforcement officials; (b) develop strategies for the provision of appropriate education and access to health care, and of opportunities for the development of livelihood skills.

37. Adolescents who are sexually exploited, including in prostitution and pornography, are exposed to significant health risks, including STDs, HIV/AIDS, unwanted pregnancies, unsafe abortions, violence and psychological distress. They have the right to physical and psychological recovery and social reintegration in an environment that fosters health, self-respect and dignity (art. 39). It is the obligation of States parties to enact and enforce laws to prohibit all forms of sexual exploitation and related trafficking; to collaborate with other States parties to eliminate intercountry trafficking; and to provide appropriate health and counseling services to adolescents who have been sexually exploited, making sure that they are treated as victims and not as offenders.
38. Additionally, adolescents experiencing poverty, armed conflicts, all forms of injustice, family breakdown, political, social and economic instability and all types of migration may be particularly vulnerable. These situations might seriously hamper their health and development. By investing heavily in preventive policies and measures States parties can drastically reduce levels of vulnerability and risk factors; they will also provide cost-effective ways for society to help adolescents develop harmoniously in a free society.

V. NATURE OF STATES’ OBLIGATIONS

39. In exercising their obligations in relation to the health and development of adolescents, States parties shall always take fully into account the four general principles of the Convention. It is the view of the Committee that States parties must take all appropriate legislative, administrative and other measures for the realization and monitoring of the rights of adolescents to health and development as recognized in the Convention. To this end, States parties must notably fulfill the following obligations:

(a) To create a safe and supportive environment for adolescents, including within their family, in schools, in all types of institutions in which they may live, within their workplace and/or in the society at large;

(b) To ensure that adolescents have access to the information that is essential for their health and development and that they have opportunities to participate in decisions affecting their health (notably through informed consent and the right of confidentiality), to acquire life skills, to obtain adequate and age-appropriate information, and to make appropriate health behavior choices;

(c) To ensure that health facilities, goods and services, including counseling and health services for mental and sexual and reproductive health, of appropriate quality and sensitive to adolescents’ concerns are available to all adolescents;

(d) To ensure that adolescent girls and boys have the opportunity to participate actively in planning and programming for their own health and development;

(e) To protect adolescents from all forms of labor which may jeopardize the enjoyment of their rights, notably by abolishing all forms of child labor and by regulating the working environment and conditions in accordance with international standards;

(f) To protect adolescents from all forms of intentional and unintentional injuries, including those resulting from violence and road traffic accidents;

(g) To protect adolescents from all harmful traditional practices, such as early marriages, honor killings and female genital mutilation;

(h) To ensure that adolescents belonging to especially vulnerable groups are fully taken into account in the fulfillment of all aforementioned obligations;

(i) To implement measures for the prevention of mental disorders and the promotion of mental health of adolescents.
40. The Committee draws the attention of States parties to the general comment No. 14 on the right to the highest attainable standard of health of the Committee on Economic, Social and Cultural Rights which states that, “States parties should provide a safe and supportive environment for adolescents that ensures the opportunity to participate in decisions affecting their health, to build life skills, to acquire appropriate information, to receive counseling and to negotiate the health-behavior choices they make. The realization of the right to health of adolescents is dependent on the development of youth-sensitive health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services.”

41. In accordance with articles 24, 39 and other related provisions of the Convention, States parties should provide health services that are sensitive to the particular needs and human rights of all adolescents, paying attention to the following characteristics:

(a) Availability. Primary health care should include services sensitive to the needs of adolescents, with special attention given to sexual and reproductive health and mental health;

(b) Accessibility. Health facilities, goods and services should be known and easily accessible (economically, physically and socially) to all adolescents, without discrimination. Confidentiality should be guaranteed, when necessary;

(c) Acceptability. While fully respecting the provisions and principles of the Convention, all health facilities, goods and services should respect cultural values, be gender sensitive, be respectful of medical ethics and be acceptable to both adolescents and the communities in which they live;

(d) Quality. Health services and goods should be scientifically and medically appropriate, which requires personnel trained to care for adolescents, adequate facilities and scientifically accepted methods.

42. States parties should, where feasible, adopt a multisectoral approach to the promotion and protection of adolescent health and development by facilitating effective and sustainable linkages and partnerships among all relevant actors. At the national level, such an approach calls for close and systematic collaboration and coordination within Government, so as to ensure the necessary involvement of all relevant government entities. Public health and other services utilized by adolescents should also be encouraged and assisted in seeking collaboration with, inter alia, private and/or traditional practitioners, professional associations, pharmacies and organizations that provide services to vulnerable groups of adolescents.

43. A multisectoral approach to the promotion and protection of adolescent health and development will not be effective without international cooperation. Therefore, States parties should, when appropriate, seek such cooperation with United Nations specialized agencies, programs and bodies, international NGOs and bilateral aid agencies, international professional associations and other non-State actors.¹

Chapter VI
POPULATION GROWTH AND STRUCTURE

A. Fertility, mortality and population growth rates

Basis for action

6.1. The growth of the world population is at an all-time high in absolute numbers, with current increments approaching 90 million persons annually. According to United Nations projections, annual population increments are likely to remain close to 90 million until the year 2015. While it had taken 123 years for world population to increase from 1 billion to 2 billion, succeeding increments of 1 billion took 33 years, 14 years and 13 years. The transition from the fifth to the sixth billion, currently underway, is expected to take only 11 years and to be completed by 1998. World population grew at the rate of 1.7 per cent per annum during the period 1985-1990, but is expected to decrease during the following decades and reach 1.0 per cent per annum by the period 2020-2025. Nevertheless, the attainment of population stabilization during the twenty-first century will require the implementation of all the policies and recommendations in the present Program of Action.

6.2. The majority of the world's countries are converging towards a pattern of low birth and death rates, but since those countries are proceeding at different speeds, the emerging picture is that of a world facing increasingly diverse demographic situations. In terms of national averages, during the period 1985-1990, fertility ranged from an estimated 8.5 children per woman in Rwanda to 1.3 children per woman in Italy, while expectation of life at birth, an indicator of mortality conditions, ranged from an estimated 41 years in Sierra Leone to 78.3 years in Japan. In many regions, including some countries with economies in transition, it is estimated that life expectancy at birth has decreased. During the period 1985-1990, 44 per cent of the world population were living in the 114 countries that had growth rates of more than 2 per cent per annum. These included nearly all the countries in Africa, whose population- doubling
time averages about 24 years, two thirds of those in Asia and one third of those in Latin America. On the other hand, 66 countries (the majority of them in Europe), representing 23 per cent of the world population, had growth rates of less than 1 per cent per annum. Europe's population would take more than 380 years to double at current rates. These disparate levels and differentials have implications for the ultimate size and regional distribution of the world population and for the prospects for sustainable development. It is projected that between 1995 and 2015 the population of the more developed regions will increase by some 120 million, while the population of the less developed regions will increase by 1,727 million.

Objective

6.3. Recognizing that the ultimate goal is the improvement of the quality of life of present and future generations, the objective is to facilitate the demographic transition as soon as possible in countries where there is an imbalance between demographic rates and social, economic and environmental goals, while fully respecting human rights. This process will contribute to the stabilization of the world population, and, together with changes in unsustainable patterns of production and consumption, to sustainable development and economic growth.

Actions

6.4. Countries should give greater attention to the importance of population trends for development. Countries that have not completed their demographic transition should take effective steps in this regard within the context of their social and economic development and with full respect of human rights. Countries that have concluded the demographic transition should take necessary steps to optimize their demographic trends within the context of their social and economic development. These steps include economic development and poverty alleviation, especially in rural areas, improvement of women's status, ensuring of universal access to quality primary education and primary health care, including reproductive health and family-planning services, and educational strategies regarding responsible parenthood and sexual education. Countries should mobilize all sectors of society in these efforts, including nongovernmental organizations, local community groups and the private sector.

6.5. In attempting to address population growth concerns, countries should recognize the interrelationships between fertility and mortality levels and aim to reduce high levels of infant, child and maternal mortality so as to lessen the need for high fertility and reduce the occurrence of high-risk births.
B. Children and youth

Basis for action

6.6. Owing to declining mortality levels and the persistence of high fertility levels, a large number of developing countries continue to have very large proportions of children and young people in their populations. For the less developed regions as a whole, 36 per cent of the population is under age 15, and even with projected fertility declines, that proportion will still be about 30 per cent by the year 2015. In Africa, the proportion of the population under age 15 is 45 per cent, a figure that is projected to decline only slightly, to 40 per cent, in the year 2015. Poverty has a devastating impact on children's health and welfare. Children in poverty are at high risk for malnutrition and disease and for falling prey to labor exploitation, trafficking, neglect, sexual abuse and drug addiction. The ongoing and future demands created by large young populations, particularly in terms of health, education and employment, represent major challenges and responsibilities for families, local communities, countries and the international community. First and foremost among these responsibilities is to ensure that every child is a wanted child. The second responsibility is to recognize that children are the most important resource for the future and that greater investments in them by parents and societies are essential to the achievement of sustained economic growth and development.

Objectives

6.7. The objectives are:

   (a) To promote to the fullest extent the health, well-being and potential of all children, adolescents and youth as representing the world's future human resources, in line with the commitments made in this respect at the World Summit for Children and in accordance with the Convention on the Rights of the Child;

   (b) To meet the special needs of adolescents and youth, especially young women, 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, counseling and high-quality reproductive health services;

   (c) To encourage children, adolescents and youth, particularly young women, to continue their education in order to equip them for a better life, to increase their human potential, to help prevent early marriages and high-risk child-bearing and to reduce associated mortality and morbidity.
Actions

6.8. Countries should give high priority and attention to all dimensions of the protection, survival and development of children and youth, particularly street children and youth, and should make every effort to eliminate the adverse effects of poverty on children and youth, including malnutrition and preventable diseases. Equal educational opportunities must be ensured for boys and girls at every level.

6.9. Countries should take effective steps to address the neglect, as well as all types of exploitation and abuse, of children, adolescents and youth, such as abduction, rape and incest, pornography, trafficking, abandonment and prostitution. In particular, countries should take appropriate action to eliminate sexual abuse of children both within and outside their borders.

6.10. All countries must enact and strictly enforce laws against economic exploitation, physical and mental abuse or neglect of children in keeping with commitments made under the Convention on the Rights of the Child and other relevant United Nations instruments. Countries should provide support and rehabilitation services to those who fall victims to such abuses.

6.11. Countries should create a socio-economic environment conducive to the elimination of all child marriages and other unions as a matter of urgency, and should discourage early marriage. The social responsibilities that marriage entails should be reinforced in countries' educational programs. Governments should take action to eliminate discrimination against young pregnant women.

6.12. All countries must adopt collective measures to alleviate the suffering of children in armed conflicts and other disasters, and provide assistance for the rehabilitation of children who become victims of those conflicts and disasters.

6.13. Countries should aim to meet the needs and aspirations of youth, particularly in the areas of formal and non-formal education, training, employment opportunities, housing and health, thereby ensuring their integration and participation in all spheres of society, including participation in the political process and preparation for leadership roles.

6.14. Governments should formulate, with the active support of non-governmental organizations and the private sector, training and employment programs. Primary importance should be given to meeting the basic needs of young people, improving their quality of life, and increasing their contribution to sustainable development.

6.15. Youth should be actively involved in the planning, implementation and evaluation of development activities that have a direct impact on their daily lives. This is especially important
with respect to information, education and communication activities and services concerning reproductive and sexual health, including the prevention of early pregnancies, sex education and the prevention of HIV/AIDS and other sexually transmitted diseases. Access to, as well as confidentiality and privacy of, these services must be ensured with the support and guidance of their parents and in line with the Convention on the Rights of the Child. In addition, there is a need for educational programs in favor of life planning skills, healthy lifestyles and the active discouragement of substance abuse.

C. Elderly people

Basis for action

6.16. The decline in fertility levels, reinforced by continued declines in mortality levels, is producing fundamental changes in the age structure of the population of most societies, most notably record increases in the proportion and number of elderly persons, including a growing number of very elderly persons. In the more developed regions, approximately one person in every six is at least 60 years old, and this proportion will be close to one person in every four by the year 2025. The situation of developing countries that have experienced very rapid declines in their levels of fertility deserves particular attention. In most societies, women, because they live longer than men, constitute the majority of the elderly population and, in many countries, elderly poor women are especially vulnerable. The steady increase of older age groups in national populations, both in absolute numbers and in relation to the working-age population, has significant implications for a majority of countries, particularly with regard to the future viability of existing formal and informal modalities for assistance to elderly people. The economic and social impact of this "ageing of populations" is both an opportunity and a challenge to all societies. Many countries are currently re-examining their policies in the light of the principle that elderly people constitute a valuable and important component of a society's human resources. They are also seeking to identify how best to assist elderly people with long-term support needs.

Objectives

6.17. The objectives are:

(a) To enhance, through appropriate mechanisms, the self-reliance of elderly people, and to create conditions that promote quality of life and enable them to work and live independently in their own communities as long as possible or as desired;

(b) To develop systems of health care as well as systems of economic and social security in old age, where appropriate, paying special attention to the needs of women;
(c) To develop a social support system, both formal and informal, with a view to enhancing the ability of families to take care of elderly people within the family.

Actions

6.18. All levels of government in medium- and long-term socio-economic planning should take into account the increasing numbers and proportions of elderly people in the population. Governments should develop social security systems that ensure greater intergenerational and intragenerational equity and solidarity and that provide support to elderly people through the encouragement of multigenerational families, and the provision of long-term support and services for growing numbers of frail older people.

6.19. Governments should seek to enhance the self-reliance of elderly people to facilitate their continued participation in society. In consultation with elderly people, Governments should ensure that the necessary conditions are developed to enable elderly people to lead self-determined, healthy and productive lives and to make full use of the skills and abilities they have acquired in their lives for the benefit of society. The valuable contribution that elderly people make to families and society, especially as volunteers and caregivers, should be given due recognition and encouragement.

6.20. Governments, in collaboration with non-governmental organizations and the private sector, should strengthen formal and informal support systems and safety nets for elderly people and eliminate all forms of violence and discrimination against elderly people in all countries, paying special attention to the needs of elderly women.
D. Indigenous people

Basis for action

6.21. Indigenous people have a distinct and important perspective on population and development relationships, frequently quite different from those of the populations with which they interrelate within national boundaries. In some regions of the world, indigenous people, after long periods of population loss, are experiencing steady and in some places rapid population growth resulting from declining mortality, although morbidity and mortality are generally still much higher than for other sections of the national population. In other regions, however, they are still experiencing a steady population decline as a result of contact with external diseases, loss of land and resources, ecological destruction, displacement, resettlement and disruption of their families, communities and social systems.

6.22. The situation of many indigenous groups is often characterized by discrimination and oppression, which are sometimes even institutionalized in national laws and structures of governance. In many cases, unsustainable patterns of production and consumption in the society at large are a key factor in the ongoing destruction of the ecological stability of their lands, as well as in an ongoing exertion of pressure to displace them from those lands. Indigenous people believe that recognition of their rights to their ancestral lands is inextricably linked to sustainable development. Indigenous people call for increased respect for indigenous culture, spirituality, lifestyles and sustainable development models, including traditional systems of land tenure, gender relations, use of resources and knowledge and practice of family planning. At national, regional and international levels, the perspectives of indigenous people have gained increasing recognition, as reflected, inter alia, in the presence of the Working Group on Indigenous Populations at the United Nations Conference on Environment and Development, and the proclamation by the General Assembly of the year 1993 as the International Year of the World's Indigenous People.

6.23. The decision of the international community to proclaim an International Decade of the World's Indigenous People, to commence on 10 December 1994, represents a further important step towards fulfillment of the aspirations of indigenous people. The goal of the Decade, which is the strengthening of international cooperation for the solution of problems faced by indigenous people in such areas as human rights, the environment, development, education and health, is acknowledged as directly related to the purpose of the International Conference on Population and Development and the present Program of Action. Accordingly, the distinct perspectives of indigenous people are incorporated throughout the present Program of Action within the context of its specific chapters.
Objectives

6.24. The objectives are:

(a) To incorporate the perspectives and needs of indigenous communities into the design, implementation, monitoring and evaluation of the population, development and environment programs that affect them;
(b) To ensure that indigenous people receive population- and development- related services that they deem socially, culturally and ecologically appropriate;
(c) To address social and economic factors that act to disadvantage indigenous people.

Actions

6.25. Governments and other important institutions in society should recognize the distinct perspective of indigenous people on aspects of population and development and, in consultation with indigenous people and in collaboration with concerned non-governmental and intergovernmental organizations, should address their specific needs, including needs for primary health care and reproductive health services. All human rights violations and discrimination, especially all forms of coercion, must be eliminated.

6.26. Within the context of the activities of the International Decade of the World's Indigenous People, the United Nations should, in full cooperation and collaboration with indigenous people and their relevant organizations, develop an enhanced understanding of indigenous people and compile data on their demographic characteristics, both current and historical, as a means of improving the understanding of the population status of indigenous people. Special efforts are necessary to integrate statistics pertaining to indigenous populations into the national data-collection system.

6.27. Governments should respect the cultures of indigenous people and enable them to have tenure and manage their lands, protect and restore the natural resources and ecosystems on which indigenous communities depend for their survival and well-being and, in consultation with indigenous people, take this into account in the formulation of national population and development policies.  

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Resolution adopted by the General Assembly
[without reference to a Main Committee (A/55/L.2)]

55/2. United Nations Millennium Declaration

The General Assembly adopts the following Declaration:

United Nations Millennium Declaration

I. Values and principles

1. We, heads of State and Government, have gathered at United Nations Headquarters in New York from 6 to 8 September 2000, at the dawn of a new millennium, to reaffirm our faith in the Organization and its Charter as indispensable foundations of a more peaceful, prosperous and just world.

2. We recognize that, in addition to our separate responsibilities to our individual societies, we have a collective responsibility to uphold the principles of human dignity, equality and equity at the global level. As leaders we have a duty therefore to all the world’s people, especially the most vulnerable and, in particular, the children of the world, to whom the future belongs.

3. We reaffirm our commitment to the purposes and principles of the Charter of the United Nations, which have proved timeless and universal. Indeed, their relevance and capacity to inspire have increased, as nations and peoples have become increasingly interconnected and interdependent.

4. We are determined to establish a just and lasting peace all over the world in accordance with the purposes and principles of the Charter. We rededicate ourselves to support all efforts to uphold the sovereign equality of all States, respect for their territorial integrity and political independence, resolution of disputes by peaceful means and in conformity with the principles of justice and international law, the right to self-determination of peoples which remain under colonial domination and foreign occupation, non-interference in the internal affairs of States, respect for human rights and fundamental freedoms, respect for the equal rights of all without distinction as to race, sex, language or religion and international cooperation in solving international problems of an economic, social, cultural or humanitarian character.

5. We believe that the central challenge we face today is to ensure that globalization becomes a positive force for all the world’s people. For while globalization offers great opportunities, at present its benefits are very unevenly shared, while its costs are unevenly distributed. We recognize that developing countries and countries with economies in transition face special difficulties in responding to this central challenge. Thus, only through broad and sustained efforts to create a shared future, based upon our common humanity in all its diversity,
globalization be made fully inclusive and equitable. These efforts must include policies and measures, at the global level, which correspond to the needs of developing countries and economies in transition and are formulated and implemented with their effective participation.

6. We consider certain fundamental values to be essential to international relations in the twenty-first century. These include:

- Freedom. Men and women have the right to live their lives and raise their children in dignity, free from hunger and from the fear of violence, oppression or injustice. Democratic and participatory governance based on the will of the people best assures these rights.
- Equality. No individual and no nation must be denied the opportunity to benefit from development. The equal rights and opportunities of women and men must be assured.
- Solidarity. Global challenges must be managed in a way that distributes the costs and burdens fairly in accordance with basic principles of equity and social justice. Those who suffer or who benefit least deserve help from those who benefit most.
- Tolerance. Human beings must respect one another, in all their diversity of belief, culture and language. Differences within and between societies should be neither feared nor repressed, but cherished as a precious asset of humanity. A culture of peace and dialogue among all civilizations should be actively promoted.
- Respect for nature. Prudence must be shown in the management of all living species and natural resources, in accordance with the precepts of sustainable development. Only in this way can the immeasurable riches provided to us by nature be preserved and passed on to our descendants. The current unsustainable patterns of production and consumption must be changed in the interest of our future welfare and that of our descendants.
- Shared responsibility. Responsibility for managing worldwide economic and social development, as well as threats to international peace and security, must be shared among the nations of the world and should be exercised multilaterally. As the most universal and most representative organization in the world, the United Nations must play the central role.

7. In order to translate these shared values into actions, we have identified key objectives to which we assign special significance.

II. Peace, security and disarmament

8. We will spare no effort to free our peoples from the scourge of war, whether within or between States, which has claimed more than 5 million lives in the past decade. We will also seek to eliminate the dangers posed by weapons of mass destruction.

9. We resolve therefore:

- To strengthen respect for the rule of law in international as in national affairs and, in particular, to ensure compliance by Member States with the decisions of the International Court of Justice, in compliance with the Charter of the United Nations, in cases to which they are parties.
- To make the United Nations more effective in maintaining peace and security by giving it the resources and tools it needs for conflict prevention, peaceful resolution of disputes, peacekeeping, post-conflict peace-building and reconstruction. In this context, we take note
of the report of the Panel on United Nations Peace Operations and request the General Assembly to consider its recommendations expeditiously.

• To strengthen cooperation between the United Nations and regional organizations, in accordance with the provisions of Chapter VIII of the Charter.

• To ensure the implementation, by States Parties, of treaties in areas such as arms control and disarmament and of international humanitarian law and human rights law, and call upon all States to consider signing and ratifying the Rome Statute of the International Criminal Court.

• To take concerted action against international terrorism, and to accede as soon as possible to all the relevant international conventions.

• To redouble our efforts to implement our commitment to counter the world drug problem.

• To intensify our efforts to fight transnational crime in all its dimensions, including trafficking as well as smuggling in human beings and money laundering.

• To minimize the adverse effects of United Nations economic sanctions on innocent populations, to subject such sanctions regimes to regular reviews and to eliminate the adverse effects of sanctions on third parties.

• To strive for the elimination of weapons of mass destruction, particularly nuclear weapons, and to keep all options open for achieving this aim, including the possibility of convening an international conference to identify ways of eliminating nuclear dangers.

• To take concerted action to end illicit traffic in small arms and light weapons, especially by making arms transfers more transparent and supporting regional disarmament measures, taking account of all the recommendations of the forthcoming United Nations Conference on Illicit Trade in Small Arms and Light Weapons.

• To call on all States to consider acceding to the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-personnel Mines and on Their Destruction, as well as the amended mines protocol to the Convention on conventional weapons.

10. We urge Member States to observe the Olympic Truce, individually and collectively, now and in the future, and to support the International Olympic Committee in its efforts to promote peace and human understanding through sport and the Olympic Ideal.

III. Development and poverty eradication

11. We will spare no effort to free our fellow men, women and children from the abject and dehumanizing conditions of extreme poverty, to which more than a billion of them are currently subjected. We are committed to making the right to development a reality for everyone and to freeing the entire human race from want.

12. We resolve therefore to create an environment – at the national and global levels alike – which is conducive to development and to the elimination of poverty.

13. Success in meeting these objectives depends, \textit{inter alia}, on good governance within each country. It also depends on good governance at the international level and on transparency in the financial, monetary and trading systems. We are committed to an open, equitable, rule-based, predictable and nondiscriminatory multilateral trading and financial system.

14. We are concerned about the obstacles developing countries face in mobilizing the resources needed to finance their sustained development. We will therefore make every effort to ensure the

15. We also undertake to address the special needs of the least developed countries. In this context, we welcome the Third United Nations Conference on the Least Developed Countries to be held in May 2001 and will endeavor to ensure its success. We call on the industrialized countries:

• To adopt, preferably by the time of that Conference, a policy of duty- and quota-free access for essentially all exports from the least developed countries;
• To implement the enhanced program of debt relief for the heavily indebted poor countries without further delay and to agree to cancel all official bilateral debts of those countries in return for their making demonstrable commitments to poverty reduction; and
• To grant more generous development assistance, especially to countries that are genuinely making an effort to apply their resources to poverty reduction.

16. We are also determined to deal comprehensively and effectively with the debt problems of low- and middle-income developing countries, through various national and international measures designed to make their debt sustainable in the long term.

17. We also resolve to address the special needs of small island developing States, by implementing the Barbados Program of Action and the outcome of the twenty-second special session of the General Assembly rapidly and in full. We urge the international community to ensure that, in the development of a vulnerability index, the special needs of small island developing States are taken into account.

18. We recognize the special needs and problems of the landlocked developing countries, and urge both bilateral and multilateral donors to increase financial and technical assistance to this group of countries to meet their special development needs and to help them overcome the impediments of geography by improving their transit transport systems.

19. We resolve further:

• To halve, by the year 2015, the proportion of the world’s people whose income is less than one dollar a day and the proportion of people who suffer from hunger and, by the same date, to halve the proportion of people who are unable to reach or to afford safe drinking water.
• To ensure that, by the same date, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling and that girls and boys will have equal access to all levels of education.
• By the same date, to have reduced maternal mortality by three quarters, and under-five child mortality by two thirds, of their current rates.
• To have, by then, halted, and begun to reverse, the spread of HIV/AIDS, the scourge of malaria and other major diseases that afflict humanity.
• To provide special assistance to children orphaned by HIV/AIDS.
• By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers as proposed in the “Cities Without Slums” initiative.
20. We also resolve:
• To promote gender equality and the empowerment of women as effective ways to combat poverty, hunger and disease and to stimulate development that is truly sustainable.
• To develop and implement strategies that give young people everywhere a real chance to find decent and productive work.
• To encourage the pharmaceutical industry to make essential drugs more widely available and affordable by all who need them in developing countries.
• To develop strong partnerships with the private sector and with civil society organizations in pursuit of development and poverty eradication.
• To ensure that the benefits of new technologies, especially information and communication technologies, in conformity with recommendations contained in the ECOSOC 2000 Ministerial Declaration, are available to all.

IV. Protecting our common environment
21. We must spare no effort to free all of humanity, and above all our children and grandchildren, from the threat of living on a planet irredeemably spoilt by human activities, and whose resources would no longer be sufficient for their needs.

22. We reaffirm our support for the principles of sustainable development, including those set out in Agenda 21, agreed upon at the United Nations Conference on Environment and Development.

23. We resolve therefore to adopt in all our environmental actions a new ethic of conservation and stewardship and, as first steps, we resolve:
• To make every effort to ensure the entry into force of the Kyoto Protocol, preferably by the tenth anniversary of the United Nations Conference on Environment and Development in 2002, and to embark on the required reduction in emissions of greenhouse gases.
• To intensify our collective efforts for the management, conservation and sustainable development of all types of forests.
• To press for the full implementation of the Convention on Biological Diversity and the Convention to Combat Desertification in those Countries Experiencing Serious Drought and/or Desertification, particularly in Africa.
• To stop the unsustainable exploitation of water resources by developing water management strategies at the regional, national and local levels, which promote both equitable access and adequate supplies.
• To intensify cooperation to reduce the number and effects of natural and manmade disasters.
• To ensure free access to information on the human genome sequence.

V. Human rights, democracy and good governance
24. We will spare no effort to promote democracy and strengthen the rule of law, as well as respect for all internationally recognized human rights and fundamental freedoms, including the right to development.

25. We resolve therefore:
• To respect fully and uphold the Universal Declaration of Human Rights.
• To strive for the full protection and promotion in all our countries of civil, political, economic, social and cultural rights for all.
• To strengthen the capacity of all our countries to implement the principles and practices of democracy and respect for human rights, including minority rights.
• To combat all forms of violence against women and to implement the Convention on the Elimination of All Forms of Discrimination against Women.
• To take measures to ensure respect for and protection of the human rights of migrants, migrant workers and their families, to eliminate the increasing acts of racism and xenophobia in many societies and to promote greater harmony and tolerance in all societies.
• To work collectively for more inclusive political processes, allowing genuine participation by all citizens in all our countries.
• To ensure the freedom of the media to perform their essential role and the right of the public to have access to information.

VI. Protecting the vulnerable

26. We will spare no effort to ensure that children and all civilian populations that suffer disproportionately the consequences of natural disasters, genocide, armed conflicts and other humanitarian emergencies are given every assistance and protection so that they can resume normal life as soon as possible.

We resolve therefore:
• To expand and strengthen the protection of civilians in complex emergencies, in conformity with international humanitarian law.
• To strengthen international cooperation, including burden sharing in, and the coordination of humanitarian assistance to, countries hosting refugees and to help all refugees and displaced persons to return voluntarily to their homes, in safety and dignity and to be smoothly reintegrated into their societies.
• To encourage the ratification and full implementation of the Convention on the Rights of the Child and its optional protocols on the involvement of children in armed conflict and on the sale of children, child prostitution and child pornography.

VII. Meeting the special needs of Africa

27. We will support the consolidation of democracy in Africa and assist Africans in their struggle for lasting peace, poverty eradication and sustainable development, thereby bringing Africa into the mainstream of the world economy.

28. We resolve therefore:
• To give full support to the political and institutional structures of emerging democracies in Africa.
• To encourage and sustain regional and sub-regional mechanisms for preventing conflict and promoting political stability, and to ensure a reliable flow of resources for peacekeeping operations on the continent.
• To take special measures to address the challenges of poverty eradication and sustainable development in Africa, including debt cancellation, improved market access, enhanced
Official Development Assistance and increased flows of Foreign Direct Investment, as well as transfers of technology.
• To help Africa build up its capacity to tackle the spread of the HIV/AIDS pandemic and other infectious diseases.

VIII. Strengthening the United Nations
29. We will spare no effort to make the United Nations a more effective instrument for pursuing all of these priorities: the fight for development for all the peoples of the world, the fight against poverty, ignorance and disease; the fight against injustice; the fight against violence, terror and crime; and the fight against the degradation and destruction of our common home.

30. We resolve therefore:
• To reaffirm the central position of the General Assembly as the chief deliberative, policy-making and representative organ of the United Nations, and to enable it to play that role effectively.
• To intensify our efforts to achieve a comprehensive reform of the Security Council in all its aspects.
• To strengthen further the Economic and Social Council, building on its recent achievements, to help it fulfill the role ascribed to it in the Charter.
• To strengthen the International Court of Justice, in order to ensure justice and the rule of law in international affairs.
• To encourage regular consultations and coordination among the principal organs of the United Nations in pursuit of their functions.
• To ensure that the Organization is provided on a timely and predictable basis with the resources it needs to carry out its mandates.
• To urge the Secretariat to make the best use of those resources, in accordance with clear rules and procedures agreed by the General Assembly, in the interests of all Member States, by adopting the best management practices and technologies available and by concentrating on those tasks that reflect the agreed priorities of Member States.
• To promote adherence to the Convention on the Safety of United Nations and Associated Personnel.
• To ensure greater policy coherence and better cooperation between the United Nations, its agencies, the Bretton Woods Institutions and the World Trade Organization, as well as other multilateral bodies, with a view to achieving a fully coordinated approach to the problems of peace and development.
• To strengthen further cooperation between the United Nations and national parliaments through their world organization, the Inter-Parliamentary Union, in various fields, including peace and security, economic and social development, international law and human rights and democracy and gender issues.
• To give greater opportunities to the private sector, non-governmental organizations and civil society, in general, to contribute to the realization of the Organization’s goals and programs.

31. We request the General Assembly to review on a regular basis the progress made in implementing the provisions of this Declaration, and ask the Secretary-General to issue periodic reports for consideration by the General Assembly and as a basis for further action.
32. We solemnly reaffirm, on this historic occasion, that the United Nations is the indispensable common house of the entire human family, through which we will seek to realize our universal aspirations for peace, cooperation and development. We therefore pledge our unstinting support for these common objectives and our determination to achieve them.\(^3\)

\textit{8th plenary meeting}

\textit{8 September 2000}

### ANNEXES

#### NATIONAL LAWS AND POLICIES

<table>
<thead>
<tr>
<th></th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>The 1987 Constitution of the Republic of the Philippines</td>
<td>144</td>
</tr>
<tr>
<td>5</td>
<td>Republic Act No. 8371. An Act to Recognize, Protect, Promote the</td>
<td>149</td>
</tr>
<tr>
<td></td>
<td>Rights of the Indigenous Cultural Communities/Indigenous Peoples,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Creating a National Commission on Indigenous Peoples,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>establishing Implementing Mechanisms,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Appropriating Funds Therefor, and for Other Purposes</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Republic Act No. 7160. An Act Providing for Stronger Deterrence and</td>
<td>171</td>
</tr>
<tr>
<td></td>
<td>Special Protection Against Child Abuse, Exploitation, and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discrimination, and for Other Purposes</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Republic Act No. 9165. An Act Instituting the Dangerous Drugs Act</td>
<td>182</td>
</tr>
<tr>
<td></td>
<td>of 2002, repealing Republic Act No. 4625, otherwise known as the</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dangerous Drugs Act of 1972, as amended, Providing Funds Therefor,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>and for Other Purposes</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Republic Act No. 9442. An Act Amending Republic Act No. 7277,</td>
<td>228</td>
</tr>
<tr>
<td></td>
<td>otherwise known as the Magna Carta for Disabled Persons, and for</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other Purposes</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Republic Act No. 9523. An Act Requiring Certification of the</td>
<td>233</td>
</tr>
<tr>
<td></td>
<td>Department of Social Welfare and Development (DSWD) to declare a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“Child Legally Available for Adoption” as a Prerequisite for</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adoption Proceedings, Amending for this Purpose certain</td>
<td></td>
</tr>
<tr>
<td></td>
<td>provisions of Republic Act No. 8552, Otherwise known as the</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Domestic Adoption Act of 1998, Republic Act 8043, otherwise known</td>
<td></td>
</tr>
<tr>
<td></td>
<td>as the Inter-Country Adoption Act of 1995, Presidential Decree No.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>603, Otherwise known as the Child and Youth Welfare Code, and for Other Purposes</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Republic Act No. 9344. An Act Establishing a Comprehensive Juvenile</td>
<td>239</td>
</tr>
<tr>
<td></td>
<td>Justice and Welfare System, Creating the Juvenile Justice</td>
<td></td>
</tr>
<tr>
<td></td>
<td>and Welfare System under the Department of Justice,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Appropriating Funds Therefor, and for Other Purposes</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Administrative Order No. 34-a, s 2000. Adolescent and Youth Health</td>
<td>261</td>
</tr>
<tr>
<td></td>
<td>(AYH) Policy</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Administrative Order No. 2006-0016. National Policy and Strategic</td>
<td>268</td>
</tr>
<tr>
<td></td>
<td>Framework on Child Injury Prevention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>and Injury Prevention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Private Partnership in Health</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Republic Act No. 10354. An Act providing for a National Policy on</td>
<td>298</td>
</tr>
<tr>
<td></td>
<td>Responsible Parenthood and Reproductive Health</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health and Development</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Department Memorandum No. 2013-0168. Guidelines in the implementation of School-Based Adolescent Immunization</td>
<td>324</td>
</tr>
<tr>
<td>18</td>
<td>Republic Act No. 10627. An Act Requiring All Elementary and</td>
<td>335</td>
</tr>
<tr>
<td></td>
<td>Secondary Schools to Adopt Policies to Prevent and Address the Acts of Bullying in their Institutions</td>
<td></td>
</tr>
</tbody>
</table>
ANNEX 4

THE 1987 CONSTITUTION
OF THE
REPUBLIC OF THE PHILIPPINES

PREAMBLE
We, the sovereign Filipino people, imploring the aid of Almighty God, in order to build a just and humane society, and establish a Government that shall embody our ideals and aspirations, promote the common good, conserve and develop our patrimony, and secure to ourselves and our posterity, the blessings of independence and democracy under the rule of law and a regime of truth, justice, freedom, love, equality, and peace, do ordain and promulgate this Constitution.

ARTICLE I
NATIONAL TERRITORY

The national territory comprises the Philippine archipelago, with all the islands and waters embraced therein, and all other territories over which the Philippines has sovereignty or jurisdiction, consisting of its terrestrial, fluvial and aerial domains, including its territorial sea, the seabed, the subsoil, the insular shelves, and other submarine areas. The waters around, between, and connecting the islands of the archipelago, regardless of their breadth and dimensions, form part of the internal waters of the Philippines.

ARTICLE II
DECLARATION OF PRINCIPLES AND STATE POLICIES

PRINCIPLES
Section 1. The Philippines is a democratic and republican State. Sovereignty resides in the people and all government authority emanates from them.

Section 2. The Philippines renounces war as an instrument of national policy, adopts the generally accepted principles of international law as part of the law of the land and adheres to the policy of peace, equality, justice, freedom, cooperation, and amity with all nations.

Section 3. Civilian authority is, at all times, supreme over the military. The Armed Forces of the Philippines is the protector of the people and the State. Its goal is to secure the sovereignty of the State and the integrity of the national territory.

Section 4. The prime duty of the Government is to serve and protect the people. The Government may call upon the people to defend the State and, in the fulfillment thereof, all citizens may be required, under conditions provided by law, to render personal, military or civil service.
Section 5. The maintenance of peace and order, the protection of life, liberty, and property, and promotion of the general welfare are essential for the enjoyment by all the people of the blessings of democracy.

Section 6. The separation of Church and State shall be inviolable.

**STATE POLICIES**

Section 7. The State shall pursue an independent foreign policy. In its relations with other states, the paramount consideration shall be national sovereignty, territorial integrity, national interest, and the right to self-determination.

Section 8. The Philippines, consistent with the national interest, adopts and pursues a policy of freedom from nuclear weapons in its territory.

Section 9. The State shall promote a just and dynamic social order that will ensure the prosperity and independence of the nation and free the people from poverty through policies that provide adequate social services, promote full employment, a rising standard of living, and an improved quality of life for all.

Section 10. The State shall promote social justice in all phases of national development.

Section 11. The State values the dignity of every human person and guarantees full respect for human rights.

Section 12. The State recognizes the sanctity of family life and shall protect and strengthen the family as a basic autonomous social institution. It shall equally protect the life of the mother and the life of the unborn from conception. The natural and primary right and duty of parents in the rearing of the youth for civic efficiency and the development of moral character shall receive the support of the Government.

Section 13. The State recognizes the vital role of the youth in nation-building and shall promote and protect their physical, moral, spiritual, intellectual, and social well-being. It shall inculcate in the youth patriotism and nationalism, and encourage their involvement in public and civic affairs.

Section 14. The State recognizes the role of women in nation-building, and shall ensure the fundamental equality before the law of women and men.

Section 15. The State shall protect and promote the right to health of the people and instill health consciousness among them.

Section 16. The State shall protect and advance the right of the people to a balanced and healthful ecology in accord with the rhythm and harmony of nature.
Section 17. The State shall give priority to education, science and technology, arts, culture, and sports to foster patriotism and nationalism, accelerate social progress, and promote total human liberation and development.

Section 18. The State affirms labor as a primary social economic force. It shall protect the rights of workers and promote their welfare.

Section 19. The State shall develop a self-reliant and independent national economy effectively controlled by Filipinos.

Section 20. The State recognizes the indispensable role of the private sector, encourages private enterprise, and provides incentives to needed investments.

Section 21. The State shall promote comprehensive rural development and agrarian reform.

Section 22. The State recognizes and promotes the rights of indigenous cultural communities within the framework of national unity and development.

Section 23. The State shall encourage non-governmental, community-based, or sectoral organizations that promote the welfare of the nation.

Section 24. The State recognizes the vital role of communication and information in nation building.

Section 25. The State shall ensure the autonomy of local governments.

Section 26. The State shall guarantee equal access to opportunities for public service and prohibit political dynasties as may be defined by law.

Section 27. The State shall maintain honesty and integrity in the public service and take positive and effective measures against graft and corruption.

Section 28. Subject to reasonable conditions prescribed by law, the State adopts and implements a policy of full public disclosure of all its transactions involving public interest.

**ARTICLE III**

**BILL OF RIGHTS**

Section 1. No person shall be deprived of life, liberty, or property without due process of law, nor shall any person be denied the equal protection of the laws.

Section 2. The right of the people to be secure in their persons, houses, papers, and effects against unreasonable searches and seizures of whatever nature and for any purpose shall be inviolable, and no search warrant or warrant of arrest shall issue except upon probable cause to be determined personally by the judge after examination under oath or affirmation of the complainant and the witnesses he may produce, and particularly describing the place to be searched and the persons or things to be seized.
Section 3. (1) The privacy of communication and correspondence shall be inviolable except upon lawful order of the court, or when public safety or order requires otherwise, as prescribed by law. (2) Any evidence obtained in violation of this or the preceding section shall be inadmissible for any purpose in any proceeding.

Section 4. No law shall be passed abridging the freedom of speech, of expression, or of the press, or the right of the people peaceably to assemble and petition the government for redress of grievances.

Section 5. No law shall be made respecting an establishment of religion, or prohibiting the free exercise thereof. The free exercise and enjoyment of religious profession and worship, without discrimination or preference, shall forever be allowed. No religious test shall be required for the exercise of civil or political rights.

Section 6. The liberty of abode and of changing the same within the limits prescribed by law shall not be impaired except upon lawful order of the court. Neither shall the right to travel be impaired except in the interest of national security, public safety, or public health, as may be provided by law.

Section 7. The right of the people to information on matters of public concern shall be recognized. Access to official records, and to documents and papers pertaining to official acts, transactions, or decisions, as well as to government research data used as basis for policy development, shall be afforded the citizen, subject to such limitations as may be provided by law.

Section 8. The right of the people, including those employed in the public and private sectors, to form unions, associations, or societies for purposes not contrary to law shall not be abridged.

Section 9. Private property shall not be taken for public use without just compensation.

Section 10. No law impairing the obligation of contracts shall be passed.

Section 11. Free access to the courts and quasi-judicial bodies and adequate legal assistance shall not be denied to any person by reason of poverty.

Section 12. (1) Any person under investigation for the commission of an offense shall have the right to be informed of his right to remain silent and to have competent and independent counsel preferably of his own choice. If the person cannot afford the services of counsel, he must be provided with one. These rights cannot be waived except in writing and in the presence of counsel. (2) No torture, force, violence, threat, intimidation, or any other means which vitiate the free will shall be used against him. Secret detention places, solitary, incommunicado, or other similar forms of detention are prohibited. (3) Any confession or admission obtained in violation of this or Section 17 hereof shall be inadmissible in evidence against him. (4) The law shall provide for penal and civil sanctions for violations of this section as well as compensation to the rehabilitation of victims of torture or similar practices, and their families.
Section 13. All persons, except those charged with offenses punishable by *reclusion perpetua* when evidence of guilt is strong, shall, before conviction, be bailable by sufficient sureties, or be released on recognizance as may be provided by law. The right to bail shall not be impaired even when the privilege of the writ of habeas corpus is suspended. Excessive bail shall not be required.

Section 14. (1) No person shall be held to answer for a criminal offense without due process of law. (2) In all criminal prosecutions, the accused shall be presumed innocent until the contrary is proved, and shall enjoy the right to be heard by himself and counsel, to be informed of the nature and cause of the accusation against him, to have a speedy, impartial, and public trial, to meet the witnesses face to face, and to have compulsory process to secure the attendance of witnesses and the production of evidence in his behalf. However, after arraignment, trial may proceed notwithstanding the absence of the accused: Provided, that he has been duly notified and his failure to appear is unjustifiable.

Section 15. The privilege of the writ of *habeas corpus* shall not be suspended except in cases of invasion or rebellion, when the public safety requires it.

Section 16. All persons shall have the right to a speedy disposition of their cases before all judicial, quasi-judicial, or administrative bodies.

Section 17. No person shall be compelled to be a witness against himself.

Section 18. (1) No person shall be detained solely by reason of his political beliefs and aspirations. (2) No involuntary servitude in any form shall exist except as a punishment for a crime whereof the party shall have been duly convicted.

Section 19. (1) Excessive fines shall not be imposed, nor cruel, degrading or inhuman punishment inflicted. Neither shall death penalty be imposed, unless, for compelling reasons involving heinous crimes, the Congress hereafter provides for it. Any death penalty already imposed shall be reduced to *reclusion perpetua*. (2) The employment of physical, psychological, or degrading punishment against any prisoner or detainee or the use of substandard or inadequate penal facilities under subhuman conditions shall be dealt with by law.

Section 20. No person shall be imprisoned for debt or non-payment of a poll tax.

Section 21. No person shall be twice put in jeopardy of punishment for the same offense. If an act is punished by a law and an ordinance, conviction or acquittal under either shall constitute a bar to another prosecution for the same act.

Section 22. No ex post facto law or bill of attainder shall be enacted.\(^4\)

ANNEX 5

Republic of the Philippines
Congress of the Philippines
Metro Manila
REPUBLIC ACT NO. 8371

AN ACT TO RECOGNIZE, PROTECT AND PROMOTE THE RIGHTS OF INDIGENOUS CULTURAL COMMUNITIES/INDIGENOUS PEOPLES, CREATING A NATIONAL COMMISSION ON INDIGENOUS PEOPLES, ESTABLISHING IMPLEMENTING MECHANISMS, APPROPRIATING FUNDS THEREFOR, AND FOR OTHER PURPOSES

CHAPTER I

General Provisions

SECTION 1. Short Title. — This Act shall be known as “The Indigenous Peoples’ Rights Act of 1997”.

SECTION 2. Declaration of State Policies. — The State shall recognize and promote all the rights of Indigenous Cultural Communities/Indigenous Peoples (ICCs/IPs) hereunder enumerated within the framework of the Constitution:

a) The State shall recognize and promote the rights of ICCs/IPs within the framework of national unity and development;

b) The State shall protect the rights of ICCs/IPs to their ancestral domains to ensure their economic, social and cultural wellbeing and shall recognize the applicability of customary laws governing property rights or relations in determining the ownership and extent of ancestral domain;

c) The State shall recognize, respect and protect the rights of ICCs/IPs to preserve and develop their cultures, traditions and institutions. It shall consider these rights in the formulation of national laws and policies;

d) The State shall guarantee that members of the ICCs/IPs regardless of sex shall equally enjoy the full measure of human rights and freedoms without distinction or discrimination;

e) The State shall take measures, with the participation of the ICCs/IPs concerned, to protect their rights and guarantee respect for their cultural integrity, and to ensure that members of the ICCs/IPs benefit on an equal footing from the rights and opportunities which national laws and regulations grant to other members of the population; and
f) The State recognizes its obligations to respond to the strong expression of the ICCs/IPs for cultural integrity by assuring maximum ICC/IP participation in the direction of education, health, as well as other services of ICCs/IPs, in order to render such services more responsive to the needs and desires of these communities.

Towards these ends, the State shall institute and establish the necessary mechanisms to enforce and guarantee the realization of these rights, taking into consideration their customs, traditions, values, beliefs, interests and institutions, and to adopt and implement measures to protect their rights to their ancestral domains.

CHAPTER II

Definition of Terms

SECTION 3. Definition of Terms. — For purposes of this Act, the following terms shall mean:

a) Ancestral Domains — Subject to Section 56 hereof, refer to all areas generally belonging to ICCs/IPs comprising lands, inland waters, coastal areas, and natural resources therein, held under a claim of ownership, occupied or possessed by ICCs/IPs, by themselves or through their ancestors, communally or individually since time immemorial, continuously to the present except when interrupted by war, force majeure or displacement by force, deceit, stealth or as a consequence of government projects or any other voluntary dealings entered into by government and private individuals/corporations, and which are necessary to ensure their economic, social and cultural welfare. It shall include ancestral lands, forests, pasture, residential, agricultural, and other lands individually owned whether alienable and disposable or otherwise, hunting grounds, burial grounds, worship areas, bodies of water, mineral and other natural resources, and lands which may no longer be exclusively occupied by ICCs/IPs but from which they traditionally had access to for their subsistence and traditional activities, particularly the home ranges of ICCs/IPs who are still nomadic and/or shifting cultivators;

b) Ancestral Lands — Subject to Section 56 hereof, refers to land occupied, possessed and utilized by individuals, families and clans who are members of the ICCs/IPs since time immemorial, by themselves or through their predecessors-in-interest, under claims of individual or traditional group ownership, continuously, to the present except when interrupted by war, force majeure or displacement by force, deceit, stealth, or as a consequence of government projects and other voluntary dealings entered into by government and private individuals/corporations, including, but not limited to, residential lots, rice terraces or paddies, private forests, hidden farms and tree lots;

c) Certificate of Ancestral Domain Title — refers to a title formally recognizing the rights of possession and ownership of ICCs/IPs over their ancestral domains identified and delineated in accordance with this law;

d) Certificate of Ancestral Lands Title — refers to a title formally recognizing the rights of ICCs/IPs over their ancestral lands;
e) Communal Claims — refer to claims on land, resources and rights thereon, belonging to the whole community within a defined territory;

f) Customary Laws — refer to a body of written and/or unwritten rules, usages, customs and practices traditionally and continually recognized, accepted and observed by respective ICCs/IPs;

g) Free and Prior Informed Consent — as used in this Act shall mean the consensus of all members of the ICCs/IPs to be determined in accordance with their respective customary laws and practices, free from any external manipulation, interference and coercion, and obtained after fully disclosing the intent and scope of the activity, in a language and process understandable to the community;

h) Indigenous Cultural Communities/Indigenous Peoples — refer to a group of people or homogenous societies identified by self-ascription and ascription by others, who have continuously lived as organized community on communally bounded and defined territory, and who have, under claims of ownership since time immemorial, occupied, possessed and utilized such territories, sharing common bonds of language, customs, traditions and other distinctive cultural traits, or who have, through resistance to political, social and cultural inroads of colonization, non-indigenous religions and cultures, became historically differentiated from the majority of Filipinos. ICCs/IPs shall likewise include peoples who are regarded as indigenous on account of their descent from the populations which inhabited the country, at the time of conquest or colonization, or at the time of inroads of non-indigenous religions and cultures, or the establishment of present state boundaries, who retain some or all of their own social, economic, cultural and political institutions, but who may have been displaced from their traditional domains or who may have resettled outside their ancestral domains;

i) Indigenous Political Structures — refer to organizational and cultural leadership systems, institutions, relationships, patterns and processes for decision-making and participation, identified by ICCs/IPs such as, but not limited to, Council of Elders, Council of Timuays, Bodong Holders, or any other tribunal or body of similar nature;

j) Individual Claims — refer to claims on land and rights thereon which have been devolved to individuals, families and clans including, but not limited to, residential lots, rice terraces or paddies and tree lots;

k) National Commission on Indigenous Peoples (NCIP) — refers to the office created under this Act, which shall be under the Office of the President, and which shall be the primary government agency responsible for the formulation and implementation of policies, plans and programs to recognize, protect and promote the rights of ICCs/IPs;

l) Native Title — refers to pre-conquest rights to lands and domains which, as far back as memory reaches, have been held under a claim of private ownership by ICCs/IPs, have never been public lands and are thus indisputably presumed to have been held that way since before the Spanish Conquest;
m) Nongovernment Organization — refers to a private, nonprofit voluntary organization that has been organized primarily for the delivery of various services to the ICCs/IPs and has an established track record for effectiveness and acceptability in the community where it serves;

n) People’s Organization — refers to a private, nonprofit voluntary organization of members of an ICC/IP which is accepted as representative of such ICCs/IPs;

o) Sustainable Traditional Resource Rights — refer to the rights of ICCs/IPs to sustainably use, manage, protect and conserve a) land, air, water, and minerals; b) plants, animals and other organisms; c) collecting, fishing and hunting grounds; d) sacred sites; and e) other areas of economic, ceremonial and aesthetic value in accordance with their indigenous knowledge, beliefs, systems and practices; and

p) Time Immemorial — refers to a period of time when as far back as memory can go, certain ICCs/IPs are known to have occupied, possessed in the concept of owner, and utilized a defined territory devolved to them, by operation of customary law or inherited from their ancestors, in accordance with their customs and traditions.

CHAPTER III

Rights to Ancestral Domains

SECTION 4. Concept of Ancestral Lands/Domains. — Ancestral lands/domains shall include such concepts of territories which cover not only the physical environment but the total environment including the spiritual and cultural bonds to the areas which the ICCs/IPs possess, occupy and use and to which they have claims of ownership.

SECTION 5. Indigenous Concept of Ownership. — Indigenous concept of ownership sustains the view that ancestral domains and all resources found therein shall serve as the material bases of their cultural integrity. The indigenous concept of ownership generally holds that ancestral domains are the ICC’s/IP’s private but community property which belongs to all generations and therefore cannot be sold, disposed or destroyed. It likewise covers sustainable traditional resource rights.

SECTION 6. Composition of Ancestral Lands/Domains. — Ancestral lands and domains shall consist of all areas generally belonging to ICCs/IPs as referred under Sec. 3, items (a) and (b) of this Act.

SECTION 7. Rights to Ancestral Domains. — The rights of ownership and possession of ICCs/IPs to their ancestral domains shall be recognized and protected. Such rights shall include:

a) Right of Ownership. — The right to claim ownership over lands, bodies of water traditionally and actually occupied by ICCs/IPs, sacred places, traditional hunting and fishing grounds, and all improvements made by them at any time within the domains;
b) Right to Develop Lands and Natural Resources. — Subject to Section 56 hereof, right to develop, control and use lands and territories traditionally occupied, owned, or used; to manage and conserve natural resources within the territories and uphold the responsibilities for future generations; to benefit and share the profits from allocation and utilization of the natural resources found therein; the right to negotiate the terms and conditions for the exploration of natural resources in the areas for the purpose of ensuring ecological, environmental protection and the conservation measures, pursuant to national and customary laws; the right to an informed and intelligent participation in the formulation and implementation of any project, government or private, that will affect or impact upon the ancestral domains and to receive just and fair compensation for any damages which they may sustain as a result of the project; and the right to effective measures by the government to prevent any interference with, alienation and encroachment upon these rights;

c) Right to Stay in the Territories. — The right to stay in the territory and not to be removed therefrom. No ICCs/IPs will be relocated without their free and prior informed consent, nor through any means other than eminent domain. Where relocation is considered necessary as an exceptional measure, such relocation shall take place only with the free and prior informed consent of the ICCs/IPs concerned and whenever possible, they shall be guaranteed the right to return to their ancestral domains, as soon as the grounds for relocation cease to exist. When such return is not possible, as determined by agreement or through appropriate procedures, ICCs/IPs shall be provided in all possible cases with lands of quality and legal status at least equal to that of the land previously occupied by them, suitable to provide for their present needs and future development. Persons thus relocated shall likewise be fully compensated for any resulting loss or injury;

d) Right in Case of Displacement. — In case displacement occurs as a result of natural catastrophes, the State shall endeavor to resettle the displaced ICCs/IPs in suitable areas where they can have temporary life support systems: Provided, That the displaced ICCs/IPs shall have the right to return to their abandoned lands until such time that the normalcy and safety of such lands shall be determined: Provided, further, That should their ancestral domain cease to exist and normalcy and safety of the previous settlements are not possible, displaced ICCs/IPs shall enjoy security of tenure over lands to which they have been resettled: Provided, furthermore, That basic services and livelihood shall be provided to them to ensure that their needs are adequately addressed;

e) Right to Regulate Entry of Migrants. — Right to regulate the entry of migrant settlers and organizations into the domains;

f) Right to Safe and Clean Air and Water. — For this purpose, the ICCs/IPs shall have access to integrated systems for the management of their inland waters and air space;

g) Right to Claim Parts of Reservations. — The right to claim parts of the ancestral domains which have been reserved for various purposes, except those reserved and intended for common public welfare and service; and
h) Right to Resolve Conflict. — Right to resolve land conflicts in accordance with customary laws of the area where the land is located, and only in default thereof shall the complaints be submitted to amicable settlement and to the Courts of Justice whenever necessary.

SECTION 8. Rights to Ancestral Lands. — The right of ownership and possession of the ICCs/IPs to their ancestral lands shall be recognized and protected.

a) Right to transfer land/property. — Such right shall include the right to transfer land or property rights to/among members of the same ICCs/IPs, subject to customary laws and traditions of the community concerned.

b) Right to Redemption. — In cases where it is shown that the transfer of land/property rights by virtue of any agreement or devise, to a non-member of the concerned ICCs/IPs is tainted by the vitiated consent of the ICCs/IPs, or is transferred for an unconscionable consideration or price, the transferor ICC/IP shall have the right to redeem the same within a period not exceeding fifteen (15) years from the date of transfer.

SECTION 9. Responsibilities of ICCs/IPs to their Ancestral Domains. — ICCs/IPs occupying a duly certified ancestral domain shall have the following responsibilities:

a) Maintain Ecological Balance. — To preserve, restore, and maintain a balanced ecology in the ancestral domain by protecting the flora and fauna, watershed areas, and other reserves;

b) Restore Denuded Areas. — To actively initiate, undertake and participate in the reforestation of denuded areas and other development programs and projects subject to just and reasonable remuneration; and

c) Observe Laws. — To observe and comply with the provisions of this Act and the rules and regulations for its effective implementation.

SECTION 10. Unauthorized and Unlawful Intrusion. — Unauthorized and unlawful intrusion upon, or use of any portion of the ancestral domain, or any violation of the rights hereinbefore enumerated, shall be punishable under this law. Furthermore, the Government shall take measures to prevent non-ICCs/IPs from taking advantage of the ICCs/IPs customs or lack of understanding of laws to secure ownership, possession of land belonging to said ICCs/IPs.

SECTION 11. Recognition of Ancestral Domain Rights. — The rights of ICCs/IPs to their ancestral domains by virtue of Native Title shall be recognized and respected. Formal recognition, when solicited by ICCs/IPs concerned, shall be embodied in a Certificate of Ancestral Domain Title (CADT), which shall recognize the title of the concerned ICCs/IPs over the territories identified and delineated.

SECTION 12. Option to Secure Certificate of Title Under Commonwealth Act 141, as amended, or the Land Registration Act 496. — Individual members of cultural communities, with respect to their individually-owned ancestral lands who, by themselves or through their predecessors-in-interest, have been in continuous possession and occupation of the same in the concept of owner
since time immemorial or for a period of not less than thirty (30) years immediately preceding the approval of this Act and uncontested by the members of the same ICCs/IPs shall have the option to secure title to their ancestral lands under the provisions of Commonwealth Act 141, as amended, or the Land Registration Act 496.

For this purpose, said individually-owned ancestral lands, which are agricultural in character and actually used for agricultural, residential, pasture, and tree farming purposes, including those with a slope of eighteen percent (18%) or more, are hereby classified as alienable and disposable agricultural lands.

The option granted under this section shall be exercised within twenty (20) years from the approval of this Act.

CHAPTER IV

Right to Self-Governance and Empowerment

SECTION 13. Self-Governance. — The State recognizes the inherent right of ICCs/IPs to self-governance and self-determination and respects the integrity of their values, practices and institutions. Consequently, the State shall guarantee the right of ICCs/IPs to freely pursue their economic, social and cultural development.

SECTION 14. Support for Autonomous Regions. — The State shall continue to strengthen and support the autonomous regions created under the Constitution as they may require or need. The State shall likewise encourage other ICCs/IPs not included or outside Muslim Mindanao and the Cordilleras to use the form and content of their ways of life as may be compatible with the fundamental rights defined in the Constitution of the Republic of the Philippines and other internationally recognized human rights.

SECTION 15. Justice System, Conflict Resolution Institutions, and Peace Building Processes. — The ICCs/IPs shall have the right to use their own commonly accepted justice systems, conflict resolution institutions, peace building processes or mechanisms and other customary laws and practices within their respective communities and as may be compatible with the national legal system and with internationally recognized human rights.

SECTION 16. Right to Participate in Decision-Making. — ICCs/IPs have the right to participate fully, if they so choose, at all levels of decision-making in matters which may affect their rights, lives and destinies through procedures determined by them as well as to maintain and develop their own indigenous political structures. Consequently, the State shall ensure that the ICCs/IPs shall be given mandatory representation in policy-making bodies and other local legislative councils.

SECTION 17. Right to Determine and Decide Priorities for Development. — The ICCs/IPs shall have the right to determine and decide their own priorities for development affecting their lives, beliefs, institutions, spiritual well-being, and the lands they own, occupy or use. They shall
participate in the formulation, implementation and evaluation of policies, plans and programs for national, regional and local development which may directly affect them.

SECTION 18. Tribal Barangays. — The ICCs/IPs living in contiguous areas or communities where they form the predominant population but which are located in municipalities, provinces or cities where they do not constitute the majority of the population, may form or constitute a separate barangay in accordance with the Local Government Code on the creation of tribal barangays.

SECTION 19. Role of Peoples Organizations. — The State shall recognize and respect the role of independent ICCs/IPs organizations to enable the ICCs/IPs to pursue and protect their legitimate and collective interests and aspirations through peaceful and lawful means.

SECTION 20. Means for Development/Empowerment of ICCs/IPs. — The Government shall establish the means for the full development/empowerment of the ICCs/IPs own institutions and initiatives and, where necessary, provide the resources needed therefor.

CHAPTER V

Social Justice and Human Rights

SECTION 21. Equal Protection and Non-discrimination of ICCs/IPs. — Consistent with the equal protection clause of the Constitution of the Republic of the Philippines, the Charter of the United Nations, the Universal Declaration of Human Rights including the Convention on the Elimination of Discrimination Against Women and International Human Rights Law, the State shall, with due recognition of their distinct characteristics and identity, accord to the members of the ICCs/IPs the rights, protections and privileges enjoyed by the rest of the citizenry. It shall extend to them the same employment rights, opportunities, basic services, educational and other rights and privileges available to every member of the society. Accordingly, the State shall likewise ensure that the employment of any form of force or coercion against ICCs/IPs shall be dealt with by law.

The State shall ensure that the fundamental human rights and freedoms as enshrined in the Constitution and relevant international instruments are guaranteed also to indigenous women. Towards this end, no provision in this Act shall be interpreted so as to result in the diminution of rights and privileges already recognized and accorded to women under existing laws of general application.

SECTION 22. Rights During Armed Conflict. — ICCs/IPs have the right to special protection and security in periods of armed conflict. The State shall observe international standards, in particular, the Fourth Geneva Convention of 1949, for the protection of civilian populations in circumstances of emergency and armed conflict, and shall not recruit members of the ICCs/IPs against their will into the armed forces, and in particular, for use against other ICCs/IPs; nor recruit children of ICCs/IPs into the armed forces under any circumstance; nor force indigenous
individuals to abandon their lands, territories and means of subsistence, or relocate them in special centers for military purposes under any discriminatory condition.

SECTION 23. Freedom from Discrimination and Right to Equal Opportunity and Treatment. — It shall be the right of the ICCs/IPs to be free from any form of discrimination, with respect to recruitment and conditions of employment, such that they may enjoy equal opportunities for admission to employment, medical and social assistance, safety as well as other occupationally-related benefits, informed of their rights under existing labor legislation and of means available to them for redress, not subject to any coercive recruitment systems, including bonded labor and other forms of debt servitude; and equal treatment in employment for men and women, including the protection from sexual harassment.

Towards this end, the State shall, within the framework of national laws and regulations, and in cooperation with the ICCs/IPs concerned, adopt special measures to ensure the effective protection with regard to the recruitment and conditions of employment of persons belonging to these communities, to the extent that they are not effectively protected by laws applicable to workers in general.

ICCs/IPs shall have the right to association and freedom for all trade union activities and the right to conclude collective bargaining agreements with employers’ organizations. They shall likewise have the right not to be subject to working conditions hazardous to their health, particularly through exposure to pesticides and other toxic substances.

SECTION 24. Unlawful Acts Pertaining to Employment. — It shall be unlawful for any person:

a) To discriminate against any ICC/IP with respect to the terms and conditions of employment on account of their descent. Equal remuneration shall be paid to ICC/IP and non-ICC/IP for work of equal value; and

b) To deny any ICC/IP employee any right or benefit herein provided for or to discharge them for the purpose of preventing them from enjoying any of the rights or benefits provided under this Act.

SECTION 25. Basic Services. — The ICCs/IPs have the right to special measures for the immediate, effective and continuing improvement of their economic and social conditions, including in the areas of employment, vocational training and retraining, housing, sanitation, health and social security. Particular attention shall be paid to the rights and special needs of indigenous women, elderly, youth, children and differently-abled persons. Accordingly, the State shall guarantee the right of ICCs/IPs to government’s basic services which shall include, but not limited to, water and electrical facilities, education, health, and infrastructure.

SECTION 26. Women. — ICC/IP women shall enjoy equal rights and opportunities with men, as regards the social, economic, political and cultural spheres of life. The participation of indigenous women in the decision-making process in all levels, as well as in the development of society, shall be given due respect and recognition.
The State shall provide full access to education, maternal and child care, health and nutrition, and housing services to indigenous women. Vocational, technical, professional and other forms of training shall be provided to enable these women to fully participate in all aspects of social life. As far as possible, the State shall ensure that indigenous women have access to all services in their own languages.

SECTION 27. Children and Youth. — The State shall recognize the vital role of the children and youth of ICCs/IPs in nation-building and shall promote and protect their physical, moral, spiritual, intellectual and social well-being. Towards this end, the State shall support all government programs intended for the development and rearing of the children and youth of ICCs/IPs for civic efficiency and establish such mechanisms as may be necessary for the protection of the rights of the indigenous children and youth.

SECTION 28. Integrated System of Education. — The State shall, through the NCIP, provide a complete, adequate and integrated system of education, relevant to the needs of the children and young people of ICCs/IPs.

CHAPTER VI
Cultural Integrity

SECTION 29. Protection of Indigenous Culture, Traditions and Institutions. — The State shall respect, recognize and protect the right of ICCs/IPs to preserve and protect their culture, traditions and institutions. It shall consider these rights in the formulation and application of national plans and policies.

SECTION 30. Educational Systems. — The State shall provide equal access to various cultural opportunities to the ICCs/IPs through the educational system, public or private cultural entities, scholarships, grants and other incentives without prejudice to their right to establish and control their educational systems and institutions by providing education in their own language, in a manner appropriate to their cultural methods of teaching and learning. Indigenous children/youth shall have the right to all levels and forms of education of the State.

SECTION 31. Recognition of Cultural Diversity. — The State shall endeavor to have the dignity and diversity of the cultures, traditions, histories and aspirations of the ICCs/IPs appropriately reflected in all forms of education, public information and cultural-educational exchange. Consequently, the State shall take effective measures, in consultation with ICCs/IPs concerned, to eliminate prejudice and discrimination and to promote tolerance, understanding and good relations among ICCs/IPs and all segments of society. Furthermore, the Government shall take effective measures to ensure that the State-owned media duly reflect indigenous cultural diversity. The State shall likewise ensure the participation of appropriate indigenous leaders in schools, communities and international cooperative undertakings like festivals, conferences, seminars and workshops to promote and enhance their distinctive heritage and values.

SECTION 32. Community Intellectual Rights. — ICCs/IPs have the right to practice and revitalize their own cultural traditions and customs. The State shall preserve, protect and develop
the past, present and future manifestations of their cultures as well as the right to the restitution of cultural, intellectual, religious, and spiritual property taken without their free and prior informed consent or in violation of their laws, traditions and customs.

SECTION 33. Rights to Religious, Cultural Sites and Ceremonies. — ICCs/IPs shall have the right to manifest, practice, develop, and teach their spiritual and religious traditions, customs and ceremonies; the right to maintain, protect and have access to their religious and cultural sites; the right to use and control of ceremonial objects; and, the right to the repatriation of human remains. Accordingly, the State shall take effective measures, in cooperation with the ICCs/IPs concerned, to ensure that indigenous sacred places, including burial sites, be preserved, respected and protected. To achieve this purpose, it shall be unlawful to:

a) Explore, excavate or make diggings on archeological sites of the ICCs/IPs for the purpose of obtaining materials of cultural values without the free and prior informed consent of the community concerned; and

b) Deface, remove or otherwise destroy artifacts which are of great importance to the ICCs/IPs for the preservation of their cultural heritage.

SECTION 34. Right to Indigenous Knowledge Systems and Practices and to Develop own Sciences and Technologies. — ICCs/IPs are entitled to the recognition of the full ownership and control and protection of their cultural and intellectual rights. They shall have the right to special measures to control, develop and protect their sciences, technologies and cultural manifestations, including human and other genetic resources, seeds, including derivatives of these resources, traditional medicines and health practices, vital medicinal plants, animals and minerals, indigenous knowledge systems and practices, knowledge of the properties of fauna and flora, oral traditions, literature, designs, and visual and performing arts.

SECTION 35. Access to Biological and Genetic Resources. — Access to biological and genetic resources and to indigenous knowledge related to the conservation, utilization and enhancement of these resources, shall be allowed within ancestral lands and domains of the ICCs/IPs only with a free and prior informed consent of such communities, obtained in accordance with customary laws of the concerned community.

SECTION 36. Sustainable Agro-Technical Development. — The State shall recognize the right of ICCs/IPs to a sustainable agro-technological development and shall formulate and implement programs of action for its effective implementation. The State shall likewise promote the biogenetic and resource management systems among the ICCs/IPs and shall encourage cooperation among government agencies to ensure the successful sustainable development of ICCs/IPs.

SECTION 37. Funds for Archeological and Historical Sites. — The ICCs/IPs shall have the right to receive from the national government all funds especially earmarked or allocated for the management and preservation of their archeological and historical sites and artifacts with the financial and technical support of the national government agencies.
CHAPTER VII

National Commission on Indigenous Peoples (NCIP)

SECTION 38. National Commission on Indigenous Cultural Communities/Indigenous Peoples (NCIP). — To carry out the policies herein set forth, there shall be created the National Commission on ICCs/IPs (NCIP), which shall be the primary government agency responsible for the formulation and implementation of policies, plans and programs to promote and protect the rights and well-being of the ICCs/IPs and the recognition of their ancestral domains as well as the rights thereto.

SECTION 39. Mandate. — The NCIP shall protect and promote the interest and well-being of the ICCs/IPs with due regard to their beliefs, customs, traditions and institutions.

SECTION 40. Composition. — The NCIP shall be an independent agency under the Office of the President and shall be composed of seven (7) Commissioners belonging to ICCs/IPs, one (1) of whom shall be the Chairperson. The Commissioners shall be appointed by the President of the Philippines from a list of recommendees submitted by authentic ICCs/IPs: Provided, That the seven (7) Commissioners shall be appointed specifically from each of the following ethnographic areas: Region I and the Cordilleras; Region II; the rest of Luzon; Island Groups including Mindoro, Palawan, Romblon, Panay and the rest of the Visayas; Northern and Western Mindanao; Southern and Eastern Mindanao; and Central Mindanao: Provided, That at least two (2) of the seven (7) Commissioners shall be women.

SECTION 41. Qualifications, Tenure, Compensation. — The Chairperson and the six (6) Commissioners must be natural born Filipino citizens, bona fide members of the ICCs/IPs as certified by his/her tribe, experienced in ethnic affairs and who have worked for at least ten (10) years with an ICC/IP community and/or any government agency involved in ICC/IP, at least 35 years of age at the time of appointment, and must be of proven honesty and integrity: Provided, That at least two (2) of the seven (7) Commissioners shall be members of the Philippine Bar: Provided, further, That the members of the NCIP shall hold office for a period of three (3) years, and may be subject to re-appointment for another term: Provided, furthermore, That no person shall serve for more than two (2) terms. Appointment to any vacancy shall only be for the unexpired term of the predecessor and in no case shall a member be appointed or designated in a temporary or acting capacity: Provided, finally, that the Chairperson and the Commissioners shall be entitled to compensation in accordance with the Salary Standardization Law.

SECTION 42. Removal from Office. — Any member of the NCIP may be removed from office by the President, on his own initiative or upon recommendation by any indigenous community, before the expiration of his term for cause and after complying with due process requirement of law.

SECTION 43. Appointment of Commissioners. — The President shall appoint the seven (7) Commissioners of the NCIP within ninety (90) days from the effectivity of this Act.
SECTION 44. Powers and Functions. — To accomplish its mandate, the NCIP shall have the following powers, jurisdiction and function:

a) To serve as the primary government agency through which ICCs/IPs can seek government assistance and as the medium, through which such assistance may be extended;

b) To review and assess the conditions of ICCs/IPs including existing laws and policies pertinent thereto and to propose relevant laws and policies to address their role in national development;

c) To formulate and implement policies, plans, programs and projects for the economic, social and cultural development of the ICCs/IPs and to monitor the implementation thereof;

d) To request and engage the services and support of experts from other agencies of government or employ private experts and consultants as may be required in the pursuit of its objectives;

e) To issue certificate of ancestral land/domain title;

f) Subject to existing laws, to enter into contracts, agreements, or arrangement, with government or private agencies or entities as may be necessary to attain the objectives of this Act, and subject to the approval of the President, to obtain loans from government lending institutions and other lending institutions to finance its programs;

g) To negotiate for funds and to accept grants, donations, gifts and/or properties in whatever form and from whatever source, local and international, subject to the approval of the President of the Philippines, for the benefit of ICCs/IPs and administer the same in accordance with the terms thereof; or in the absence of any condition, in such manner consistent with the interest of ICCs/IPs as well as existing laws;

h) To coordinate development programs and projects for the advancement of the ICCs/IPs and to oversee the proper implementation thereof;

i) To convene periodic conventions or assemblies of IPs to review, assess as well as propose policies or plans;

j) To advise the President of the Philippines on all matters relating to the ICCs/IPs and to submit within sixty (60) days after the close of each calendar year, a report of its operations and achievements;

k) To submit to Congress appropriate legislative proposals intended to carry out the policies under this Act;

l) To prepare and submit the appropriate budget to the Office of the President;

m) To issue appropriate certification as a pre-condition to the grant of permit, lease, grant, or any other similar authority for the disposition, utilization, management and appropriation by any
private individual, corporate entity or any government agency, corporation or subdivision thereof on any part or portion of the ancestral domain taking into consideration the consensus approval of the ICCs/IPs concerned;

n) To decide all appeals from the decisions and acts of all the various offices within the Commission;

o) To promulgate the necessary rules and regulations for the implementation of this Act;

p) To exercise such other powers and functions as may be directed by the President of the Republic of the Philippines; and

q) To represent the Philippine ICCs/IPs in all international conferences and conventions dealing with indigenous peoples and other related concerns.

SECTION 45. Accessibility and Transparency. — Subject to such limitations as may be provided by law or by rules and regulations promulgated pursuant thereto, all official records, documents and papers pertaining to official acts, transactions or decisions, as well as research data used as basis for policy development of the Commission shall be made accessible to the public.

SECTION 46. Offices within the NCIP. — The NCIP shall have the following offices which shall be responsible for the implementation of the policies hereinafter provided:

a) Ancestral Domains Office — The Ancestral Domain Office shall be responsible for the identification, delineation and recognition of ancestral lands/domains. It shall also be responsible for the management of ancestral lands/domains in accordance with a master plan as well as the implementation of the ancestral domain rights of the ICCs/IPs as provided in Chapter III of this Act. It shall also issue, upon the free and prior informed consent of the ICCs/IPs concerned, certification prior to the grant of any license, lease or permit for the exploitation of natural resources affecting the interests of ICCs/IPs or their ancestral domains and to assist the ICCs/IPs in protecting the territorial integrity of all ancestral domains. It shall likewise perform such other functions as the Commission may deem appropriate and necessary;

b) Office on Policy, Planning and Research — The Office on Policy, Planning and Research shall be responsible for the formulation of appropriate policies and programs for ICCs/IPs such as, but not limited to, the development of a Five-Year Master Plan for the ICCs/IPs. Such plan shall undergo a process such that every five years, the Commission shall endeavor to assess the plan and make ramifications in accordance with the changing situations. The Office shall also undertake the documentation of customary law and shall establish and maintain a Research Center that would serve as a depository of ethnographic information for monitoring, evaluation and policy formulation. It shall assist the legislative branch of the national government in the formulation of appropriate legislation benefiting ICCs/IPs;

c) Office of Education, Culture and Health — The Office on Culture, Education and Health shall be responsible for the effective implementation of the education, cultural and related rights as
provided in this Act. It shall assist, promote and support community schools, both formal and non-formal, for the benefit of the local indigenous community, especially in areas where existing educational facilities are not accessible to members of the indigenous group. It shall administer all scholarship programs and other educational rights intended for ICC/IP beneficiaries in coordination with the Department of Education, Culture and Sports and the Commission on Higher Education. It shall undertake, within the limits of available appropriation, a special program which includes language and vocational training, public health and family assistance program and related subjects.

It shall also identify ICCs/IPs with potential training in the health profession and encourage and assist them to enroll in schools of medicine, nursing, physical therapy and other allied courses pertaining to the health profession.

Towards this end, the NCIP shall deploy a representative in each of the said offices who shall personally perform the foregoing task and who shall receive complaints from the ICCs/IPs and compel action from appropriate agency. It shall also monitor the activities of the National Museum and other similar government agencies generally intended to manage and preserve historical and archeological artifacts of the ICCs/IPs and shall be responsible for the implementation of such other functions as the NCIP may deem appropriate and necessary;

d) Office on Socio-Economic Services and Special Concerns — The Office on Socio-Economic Services and Special Concerns shall serve as the Office through which the NCIP shall coordinate with pertinent government agencies specially charged with the implementation of various basic socio-economic services, policies, plans and programs affecting the ICCs/IPs to ensure that the same are properly and directly enjoyed by them. It shall also be responsible for such other functions as the NCIP may deem appropriate and necessary;

e) Office of Empowerment and Human Rights — The Office of Empowerment and Human Rights shall ensure that indigenous socio-political, cultural and economic rights are respected and recognized. It shall ensure that capacity building mechanisms are instituted and ICCs/IPs are afforded every opportunity, if they so choose, to participate in all levels of decision-making. It shall likewise ensure that the basic human rights, and such other rights as the NCIP may determine, subject to existing laws, rules and regulations, are protected and promoted;

f) Administrative Office — The Administrative Office shall provide the NCIP with economical, efficient and effective services pertaining to personnel, finance, records, equipment, security, supplies and related services. It shall also administer the Ancestral Domains Fund; and

g) Legal Affairs Office — There shall be a Legal Affairs Office which shall advice the NCIP on all legal matters concerning ICCs/IPs and which shall be responsible for providing ICCs/IPs with legal assistance in litigation involving community interest. It shall conduct preliminary investigation on the basis of complaints filed by the ICCs/IPs against a natural or juridical person believed to have violated ICCs/IPs rights. On the basis of its findings, it shall initiate the filing of appropriate legal or administrative action to the NCIP.
SECTION 47. Other Offices. — The NCIP shall have the power to create additional offices as it may deem necessary subject to existing rules and regulations.

SECTION 48. Regional and Field Offices. — Existing regional and field offices shall remain to function under the strengthened organizational structure of the NCIP. Other field offices shall be created wherever appropriate and the staffing pattern thereof shall be determined by the NCIP: Provided, that in provinces where there are ICCs/IPs but without field offices, the NCIP shall establish field offices in said provinces.

SECTION 49. Office of the Executive Director. — The NCIP shall create the Office of the Executive Director which shall serve as its secretariat. The Office shall be headed by an Executive Director who shall be appointed by the President of the Republic of the Philippines upon recommendation of the NCIP on a permanent basis. The staffing pattern of the office shall be determined by the NCIP subject to the existing rules and regulations.

SECTION 50. Consultative Body. — A body consisting of the traditional leaders, elders and representatives from the women and youth sectors of the different ICCs/IPs shall be constituted by the NCIP from time to time to advise it on matters relating to the problems, aspirations and interests of the ICCs/IPs.

CHAPTER VIII

Delineation and Recognition of Ancestral Domains

SECTION 51. Delineation and Recognition of Ancestral Domains. — Self-delineation shall be the guiding principle in the identification and delineation of ancestral domains. As such, the ICCs/IPs concerned shall have a decisive role in all the activities pertinent thereto. The Sworn Statement of the Elders as to the scope of the territories and agreements/pacts made with neighboring ICCs/IPs, if any, will be essential to the determination of these traditional territories. The Government shall take the necessary steps to identify lands which the ICCs/IPs concerned traditionally occupy and guarantee effective protection of their rights of ownership and possession thereto. Measures shall be taken in appropriate cases to safeguard the right of the ICCs/IPs concerned to land which may no longer be exclusively occupied by them, but to which they have traditionally had access for their subsistence and traditional activities, particularly of ICCs/IPs who are still nomadic and/or shifting cultivators.

SECTION 52. Delineation Process. — The identification and delineation of ancestral domains shall be done in accordance with the following procedures:

a) Ancestral Domains Delineated Prior to this Act. — The provisions hereunder shall not apply to ancestral domains/lands already delineated according to DENR Administrative Order No. 2, series of 1993, nor to ancestral lands and domains delineated under any other community/ancestral domain program prior to the enactment of this law. ICCs/IPs whose ancestral lands/domains were officially delineated prior to the enactment of this law shall have the right to apply for the issuance of a Certificate of Ancestral Domain Title (CADT) over the area without going through the process outlined hereunder;
b) Petition for Delineation. — The process of delineating a specific perimeter may be initiated by 
the NCIP with the consent of the ICC/IP concerned, or through a Petition for Delineation filed 
with the NCIP, by a majority of the members of the ICCs/IPs;

c) Delineation Proper. — The official delineation of ancestral domain boundaries including 
census of all community members therein, shall be immediately undertaken by the Ancestral 
Domains Office upon filing of the application by the ICCs/IPs concerned. Delineation will be 
done in coordination with the community concerned and shall at all times include genuine 
involvement and participation by the members of the communities concerned;

d) Proof Required. — Proof of Ancestral Domain Claims shall include the testimony of elders or 
community under oath, and other documents directly or indirectly attesting to the possession or 
occupation of the area since time immemorial by such ICCs/IPs in the concept of owners which 
shall be any one (1) of the following authentic documents:

1) Written accounts of the ICCs/IPs customs and traditions;

2) Written accounts of the ICCs/IPs political structure and institution;

3) Pictures showing long term occupation such as those of old improvements, burial grounds, 
sacred places and old villages;

4) Historical accounts, including pacts and agreements concerning boundaries entered into by the 
ICCs/IPs concerned with other ICCs/IPs;

5) Survey plans and sketch maps;

6) Anthropological data;

7) Genealogical surveys;

8) Pictures and descriptive histories of traditional communal forests and hunting grounds;

9) Pictures and descriptive histories of traditional landmarks such as mountains, rivers, creeks, 
ridges, hills, terraces and the like; and

10) Write-ups of names and places derived from the native dialect of the community.

e) Preparation of Maps. — On the basis of such investigation and the findings of fact based 
thereon, the Ancestral Domains Office of the NCIP shall prepare a perimeter map, complete with 
technical descriptions, and a description of the natural features and landmarks embraced therein;

f) Report of Investigation and Other Documents. — A complete copy of the preliminary census 
and a report of investigation, shall be prepared by the Ancestral Domains Office of the NCIP;
g) Notice and Publication. — A copy of each document, including a translation in the native language of the ICCs/IPs concerned shall be posted in a prominent place therein for at least fifteen (15) days. A copy of the document shall also be posted at the local, provincial and regional offices of the NCIP, and shall be published in a newspaper of general circulation once a week for two (2) consecutive weeks to allow other claimants to file opposition thereto within fifteen (15) days from date of such publication: Provided, That in areas where no such newspaper exists, broadcasting in a radio station will be a valid substitute: Provided, further, That mere posting shall be deemed sufficient if both newspaper and radio station are not available;

h) Endorsement to NCIP. — Within fifteen (15) days from publication, and of the inspection process, the Ancestral Domains Office shall prepare a report to the NCIP endorsing a favorable action upon a claim that is deemed to have sufficient proof. However, if the proof is deemed insufficient, the Ancestral Domains Office shall require the submission of additional evidence: Provided, That the Ancestral Domains Office shall reject any claim that is deemed patently false or fraudulent after inspection and verification: Provided, further, That in case of rejection, the Ancestral Domains Office shall give the applicant due notice, copy furnished all concerned, containing the grounds for denial. The denial shall be appealable to the NCIP: Provided, furthermore, That in cases where there are conflicting claims among ICCs/IPs on the boundaries of ancestral domain claims, the Ancestral Domains Office shall cause the contending parties to meet and assist them in coming up with a preliminary resolution of the conflict, without prejudice to its full adjudication according to the section below.

i) Turnover of Areas Within Ancestral Domains Managed by Other Government Agencies. — The Chairperson of the NCIP shall certify that the area covered is an ancestral domain. The secretaries of the Department of Agrarian Reform, Department of Environment and Natural Resources, Department of the Interior and Local Government, and Department of Justice, the Commissioner of the National Development Corporation, and any other government agency claiming jurisdiction over the area shall be notified thereof. Such notification shall terminate any legal basis for the jurisdiction previously claimed;

j) Issuance of CADT. — ICCs/IPs whose ancestral domains have been officially delineated and determined by the NCIP shall be issued a CADT in the name of the community concerned, containing a list of all those identified in the census; and

k) Registration of CADTs. — The NCIP shall register issued certificates of ancestral domain titles and certificates of ancestral lands titles before the Register of Deeds in the place where the property is situated.

SECTION 53. Identification, Delineation and Certification of Ancestral Lands. —

a) The allocation of lands within any ancestral domain to individual or indigenous corporate (family or clan) claimants shall be left to the ICCs/IPs concerned to decide in accordance with customs and traditions;

b) Individual and indigenous corporate claimants of ancestral lands which are not within ancestral domains, may have their claims officially established by filing applications for the
identification and delineation of their claims with the Ancestral Domains Office. An individual or recognized head of a family or clan may file such application in his behalf or in behalf of his family or clan, respectively;

c) Proofs of such claims shall accompany the application form which shall include the testimony under oath of elders of the community and other documents directly or indirectly attesting to the possession or occupation of the areas since time immemorial by the individual or corporate claimants in the concept of owners which shall be any of the authentic documents enumerated under Sec. 52 (d) of this Act, including tax declarations and proofs of payment of taxes;

d) The Ancestral Domains Office may require from each ancestral claimant the submission of such other documents, Sworn Statements and the like, which in its opinion, may shed light on the veracity of the contents of the application/claim;

e) Upon receipt of the applications for delineation and recognition of ancestral land claims, the Ancestral Domains Office shall cause the publication of the application and a copy of each document submitted including a translation in the native language of the ICCs/IPs concerned in a prominent place therein for at least fifteen (15) days. A copy of the document shall also be posted at the local, provincial, and regional offices of the NCIP and shall be published in a newspaper of general circulation once a week for two (2) consecutive weeks to allow other claimants to file opposition thereto within fifteen (15) days from the date of such publication: Provided, That in areas where no such newspaper exists, broadcasting in a radio station will be a valid substitute: Provided, further, That mere posting shall be deemed sufficient if both newspapers and radio station are not available;

f) Fifteen (15) days after such publication, the Ancestral Domains Office shall investigate and inspect each application, and if found to be meritorious, shall cause a parcellary survey of the area being claimed. The Ancestral Domains Office shall reject any claim that is deemed patently false or fraudulent after inspection and verification. In case of rejection, the Ancestral Domains Office shall give the applicant due notice, copy furnished all concerned, containing the grounds for denial. The denial shall be appealable to the NCIP. In case of conflicting claims among individuals or indigenous corporate claimants, the Ancestral Domains Office shall cause the contending parties to meet and assist them in coming up with a preliminary resolution of the conflict, without prejudice to its full adjudication according to Sec. 62 of this Act. In all proceedings for the identification or delineation of the ancestral domains as herein provided, the Director of Lands shall represent the interest of the Republic of the Philippines; and

g) The Ancestral Domains Office shall prepare and submit a report on each and every application surveyed and delineated to the NCIP, which shall, in turn, evaluate the report submitted. If the NCIP finds such claim meritorious, it shall issue a certificate of ancestral land, declaring and certifying the claim of each individual or corporate (family or clan) claimant over ancestral lands.

SECTION 54. Fraudulent Claims. — The Ancestral Domains Office may, upon written request from the ICCs/IPs, review existing claims which have been fraudulently acquired by any person
or community. Any claim found to be fraudulently acquired by, and issued to, any person or community may be cancelled by the NCIP after due notice and hearing of all parties concerned.

SECTION 55. Communal Rights. — Subject to Section 56 hereof, areas within the ancestral domains, whether delineated or not, shall be presumed to be communally held: Provided, That communal rights under this Act shall not be construed as co-ownership as provided in Republic Act No. 386, otherwise known as the New Civil Code.

SECTION 56. Existing Property Rights Regimes. — Property rights within the ancestral domains already existing and/or vested upon effectivity of this Act, shall be recognized and respected.

SECTION 57. Natural Resources within Ancestral Domains. — The ICCs/IPs shall have priority rights in the harvesting, extraction, development or exploitation of any natural resources within the ancestral domains. A non-member of the ICCs/IPs concerned may be allowed to take part in the development and utilization of the natural resources for a period of not exceeding twenty-five (25) years renewable for not more than twenty-five (25) years: Provided, That a formal and written agreement is entered into with the ICCs/IPs concerned or that the community, pursuant to its own decision making process, has agreed to allow such operation: Provided, finally, That the NCIP may exercise visitorial powers and take appropriate action to safeguard the rights of the ICCs/IPs under the same contract.

SECTION 58. Environmental Considerations. — Ancestral domains or portions thereof, which are found to be necessary for critical watersheds, mangroves, wildlife sanctuaries, wilderness, protected areas, forest cover, or reforestation as determined by appropriate agencies with the full participation of the ICCs/IPs concerned shall be maintained, managed and developed for such purposes. The ICCs/IPs concerned shall be given the responsibility to maintain, develop, protect and conserve such areas with the full and effective assistance of government agencies. Should the ICCs/IPs decide to transfer the responsibility over the areas, said decision must be made in writing. The consent of the ICCs/IPs should be arrived at in accordance with its customary laws without prejudice to the basic requirements of existing laws on free and prior informed consent: Provided, That the transfer shall be temporary and will ultimately revert to the ICCs/IPs in accordance with a program for technology transfer: Provided, further, That no ICCs/IPs shall be displaced or relocated for the purpose enumerated under this section without the written consent of the specific persons authorized to give consent.

SECTION 59. Certification Precondition. — All departments and other governmental agencies shall henceforth be strictly enjoined from issuing, renewing, or granting any concession, license or lease, or entering into any production-sharing agreement, without prior certification from the NCIP that the area affected does not overlap with any ancestral domain. Such certification shall only be issued after a field-based investigation is conducted by the Ancestral Domains Office of the area concerned: Provided, That no certification shall be issued by the NCIP without the free and prior informed and written consent of ICCs/IPs concerned: Provided, further, That no department, government agency or government-owned or -controlled corporation may issue new concession, license, lease, or production sharing agreement while there is a pending application for a CADT: Provided, finally, That the ICCs/IPs shall have the right to stop or suspend, in
accordance with this Act, any project that has not satisfied the requirement of this consultation process.

SECTION 60. Exemption from Taxes. — All lands certified to be ancestral domains shall be exempt from real property taxes, special levies, and other forms of exaction except such portion of the ancestral domains as are actually used for large-scale agriculture, commercial forest plantation and residential purposes or upon titling by private persons: Provided, That all exactions shall be used to facilitate the development and improvement of the ancestral domains.

SECTION 61. Temporary Requisition Powers. — Prior to the establishment of an institutional surveying capacity whereby it can effectively fulfill its mandate, but in no case beyond three (3) years after its creation, the NCIP is hereby authorized to request the Department of Environment and Natural Resources (DENR) survey teams as well as other equally capable private survey teams, through a Memorandum of Agreement (MOA), to delineate ancestral domain perimeters. The DENR Secretary shall accommodate any such request within one (1) month of its issuance: Provided, That the Memorandum of Agreement shall stipulate, among others, a provision for technology transfer to the NCIP.

SECTION 62. Resolution of Conflicts. — In cases of conflicting interest, where there are adverse claims within the ancestral domains as delineated in the survey plan, and which can not be resolved, the NCIP shall hear and decide, after notice to the proper parties, the disputes arising from the delineation of such ancestral domains: Provided, That if the dispute is between and/or among ICCs/IPs regarding the traditional boundaries of their respective ancestral domains, customary process shall be followed. The NCIP shall promulgate the necessary rules and regulations to carry out its adjudicatory functions: Provided, further, That any decision, order, award or ruling of the NCIP on any ancestral domain dispute or on any matter pertaining to the application, implementation, enforcement and interpretation of this Act may be brought for Petition for Review to the Court of Appeals within fifteen (15) days from receipt of a copy thereof.

SECTION 63. Applicable Laws. — Customary laws, traditions and practices of the ICCs/IPs of the land where the conflict arises shall be applied first with respect to property rights, claims and ownerships, hereditary succession and settlement of land disputes. Any doubt or ambiguity in the application and interpretation of laws shall be resolved in favor of the ICCs/IPs.

SECTION 64. Remedial Measures. — Expropriation may be resorted to in the resolution of conflicts of interest following the principle of the “common good”. The NCIP shall take appropriate legal action for the cancellation of officially documented titles which were acquired illegally: Provided, That such procedure shall ensure that the rights of possessors in good faith shall be respected: Provided, further, That the action for cancellation shall be initiated within two (2) years from the effectivity of this Act: Provided, finally, That the action for reconveyance shall be within a period of ten (10) years in accordance with existing laws.
CHAPTER XIII

Final Provisions

SECTION 78. Special Provision. — The City of Baguio shall remain to be governed by its Charter and all lands proclaimed as part of its townsite reservation shall remain as such until otherwise reclassified by appropriate legislation: Provided, That prior land rights and titles recognized and/or acquired through any judicial, administrative or other processes before the effectivity of this Act shall remain valid: Provided, further, That this provision shall not apply to any territory which becomes part of the City of Baguio after the effectivity of this Act.

SECTION 79. Appropriations. — The amount necessary to finance the initial implementation of this Act shall be charged against the current year’s appropriation of the ONCC and the OSCC. Thereafter, such sums as may be necessary for its continued implementation shall be included in the annual General Appropriations Act.

SECTION 80. Implementing Rules and Regulations. — Within sixty (60) days immediately after appointment, the NCIP shall issue the necessary rules and regulations, in consultation with the Committees on National Cultural Communities of the House of Representatives and the Senate, for the effective implementation of this Act.

SECTION 81. Saving Clause. — This Act will not in any manner adversely affect the rights and benefits of the ICCs/IPs under other conventions, recommendations, international treaties, national laws, awards, customs and agreements.

SECTION 82. Separability Clause. — In case any provision of this Act or any portion thereof is declared unconstitutional by a competent court, other provisions shall not be affected thereby.

SECTION 83. Repealing Clause. — Presidential Decree No. 410, Executive Order Nos. 122-B and 122-C, and all other laws, decrees, orders, rules and regulations or parts thereof inconsistent with this Act are hereby repealed or modified accordingly.

SECTION 84. Effectivity. — This Act shall take effect fifteen (15) days upon its publication in the Official Gazette or in any two (2) newspapers of general circulation.5

Approved: October 29, 1997

Republic of the Philippines

Congress of the Philippines

Metro Manila

Ninth Congress

ANNEX 6

REPUBLIC ACT NO. 7610

June 17, 1992

AN ACT PROVIDING FOR STRONGER DETERRENCE AND SPECIAL PROTECTION AGAINST CHILD ABUSE, EXPLOITATION AND DISCRIMINATION, AND FOR OTHER PURPOSES

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

ARTICLE I

Title, Policy, Principles and Definitions of Terms

Section 1. Title. – This Act shall be known as the "Special Protection of Children Against Abuse, Exploitation and Discrimination Act."

Sec. 2. Declaration of State Policy and Principles. – It is hereby declared to be 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. The State shall intervene on behalf of the child when the parent, guardian, teacher or person having care or custody of the child fails or is unable to protect the child against abuse, exploitation and discrimination or when such acts against the child are committed by the said parent, guardian, teacher or person having care and custody of the same.

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.

The best interests of children shall be the paramount consideration in all actions concerning them, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities, and legislative bodies, consistent with the principle of First Call for Children as enunciated in the United Nations Convention of the Rights of the Child. Every effort shall be exerted to promote the welfare of children and enhance their opportunities for a useful and happy life.

Section 3. Definition of Terms. –
(a) "Children" refers to person below eighteen (18) years of age or those over but are unable to fully take care of themselves or protect themselves from abuse, neglect, cruelty, exploitation or discrimination because of a physical or mental disability or condition;

(b) "Child abuse" refers to the maltreatment, whether habitual or not, of the child which includes any of the following:
(1) Psychological and physical abuse, neglect, cruelty, sexual abuse and emotional maltreatment;

(2) Any act by deeds or words which debases, degrades or demeans the intrinsic worth and dignity of a child as a human being;

(3) Unreasonable deprivation of his basic needs for survival, such as food and shelter; or

(4) Failure to immediately give medical treatment to an injured child resulting in serious impairment of his growth and development or in his permanent incapacity or death.

(c) "Circumstances which gravely threaten or endanger the survival and normal development of children" include, but are not limited to, the following;

(1) Being in a community where there is armed conflict or being affected by armed conflict-related activities;

(2) Working under conditions hazardous to life, safety and normal which unduly interfere with their normal development;

(3) Living in or fending for themselves in the streets of urban or rural areas without the care of parents or a guardian or basic services needed for a good quality of life;

(4) Being a member of a indigenous cultural community and/or living under conditions of extreme poverty or in an area which is underdeveloped and/or lacks or has inadequate access to basic services needed for a good quality of life;

(5) Being a victim of a man-made or natural disaster or calamity; or

(6) Circumstances analogous to those above stated which endanger the life, safety or normal development of children.

(d) "Comprehensive program against child abuse, exploitation and discrimination" refers to the coordinated program of services and facilities to protect children against:

(1) Child Prostitution and other sexual abuse;

(2) Child trafficking;

(3) Obscene publications and indecent shows;

(4) Other acts of abuses; and

(5) Circumstances which threaten or endanger the survival and normal development of children.

ARTICLE II

Program on Child Abuse, Exploitation and Discrimination

Sec. 4. Formulation of the Program. – There shall be a comprehensive program to be formulated, by the Department of Justice and the Department of Social Welfare and Development in coordination with other government agencies and private sector concerned, within one (1) year from the effectivity of this Act, to protect children against child prostitution
and other sexual abuse; child trafficking, obscene publications and indecent shows; other acts of abuse; and circumstances which endanger child survival and normal development.

ARTICLE III

Child Prostitution and Other Sexual Abuse

Sec. 5. Child Prostitution and Other Sexual Abuse. – Children, whether male or female, who for money, profit, or any other consideration or due to the coercion or influence of any adult, syndicate or group, indulge in sexual intercourse or lascivious conduct, are deemed to be children exploited in prostitution and other sexual abuse.

The penalty of reclusion temporal in its medium period to reclusion perpetua shall be imposed upon the following:

(a) Those who engage in or promote, facilitate or induce child prostitution which include, but are not limited to, the following:

(1) Acting as a procurer of a child prostitute;

(2) Inducing a person to be a client of a child prostitute by means of written or oral advertisements or other similar means;

(3) Taking advantage of influence or relationship to procure a child as prostitute;

(4) Threatening or using violence towards a child to engage him as a prostitute; or

(5) Giving monetary consideration goods or other pecuniary benefit to a child with intent to engage such child in prostitution.

(b) Those who commit the act of sexual intercourse of lascivious conduct with a child exploited in prostitution or subject to other sexual abuse; Provided, That when the victims is under twelve (12) years of age, the perpetrators shall be prosecuted under Article 335, paragraph 3, for rape and Article 336 of Act No. 3815, as amended, the Revised Penal Code, for rape or lascivious conduct, as the case may be: Provided, That the penalty for lascivious conduct when the victim is under twelve (12) years of age shall be reclusion temporal in its medium period; and

(c) Those who derive profit or advantage there from, whether as manager or owner of the establishment where the prostitution takes place, or of the sauna, disco, bar, resort, place of entertainment or establishment serving as a cover or which engages in prostitution in addition to the activity for which the license has been issued to said establishment.

Sec. 6. Attempt To Commit Child Prostitution. – There is an attempt to commit child prostitution under Sec. 5, paragraph (a) hereof when any person who, not being a relative of a child, is found alone with the said child inside the room or cubicle of a house, an inn, hotel, motel, pension house, apartelle or other similar establishments, vessel, vehicle or any other hidden or secluded area under circumstances which would lead a reasonable person to believe that the child is about to be exploited in prostitution and other sexual abuse.
There is also an attempt to commit child prostitution, under paragraph (b) of Sec. 5 hereof when any person is receiving services from a child in a sauna parlor or bath, massage clinic, health club and other similar establishments. A penalty lower by two (2) degrees than that prescribed for the consummated felony under Sec. 5 hereof shall be imposed upon the principals of the attempt to commit the crime of child prostitution under this Act, or, in the proper case, under the Revised Penal Code.

ARTICLE IV

Child Trafficking

Sec. 7. Child Trafficking. – Any person who shall engage in trading and dealing with children, including, but not limited to, the act of buying and selling of a child for money, or for any other consideration, or barter, shall suffer the penalty of reclusion temporal to reclusion perpetua. The penalty shall be imposed in its maximum period when the victim is under twelve (12) years of age.

Sec. 8. Attempt to Commit Child Trafficking. – There is an attempt to commit child trafficking under Sec. 7 of this Act:

(a) When a child travels alone to a foreign country without valid reason therefor and without clearance issued by the Department of Social Welfare and Development or written permit or justification from the child's parents or legal guardian;

(c) When a person, agency, establishment or child-caring institution recruits women or couples to bear children for the purpose of child trafficking; or

(d) When a doctor, hospital or clinic official or employee, nurse, midwife, local civil registrar or any other person simulates birth for the purpose of child trafficking; or

(e) When a person engages in the act of finding children among low-income families, hospitals, clinics, nurseries, day-care centers, or other child-during institutions who can be offered for the purpose of child trafficking.

A penalty lower two (2) degrees than that prescribed for the consummated felony under Sec. 7 hereof shall be imposed upon the principals of the attempt to commit child trafficking under this Act.

ARTICLE V

Obscene Publications and Indecent Shows

Section 9. Obscene Publications and Indecent Shows. – Any person who shall hire, employ, use, persuade, induce or coerce a child to perform in obscene exhibitions and indecent shows, whether live or in video, or model in obscene publications or pornographic materials or to sell or distribute the said materials shall suffer the penalty of prision mayor in its medium period.

If the child used as a performer, subject or seller/distributor is below twelve (12) years of age, the penalty shall be imposed in its maximum period.
Any ascendant, guardian, or person entrusted in any capacity with the care of a child who shall cause and/or allow such child to be employed or to participate in an obscene play, scene, act, movie or show or in any other acts covered by this section shall suffer the penalty of prision mayor in its medium period.

ARTICLE VI

Other Acts of Abuse

Sec. 10. Other Acts of Neglect, Abuse, Cruelty or Exploitation and Other Conditions Prejudicial to the Child's Development. –

(a) Any person who shall commit any other acts of child abuse, cruelty or exploitation or to be responsible for other conditions prejudicial to the child's development including those covered by Article 59 of Presidential Decree No. 603, as amended, but not covered by the Revised Penal Code, as amended, shall suffer the penalty of prision mayor in its minimum period.

(b) Any person who shall keep or have in his company a minor, twelve (12) years or under or who in ten (10) years or more his junior in any public or private place, hotel, motel, beer joint, discotheque, cabaret, pension house, sauna or massage parlor, beach and/or other tourist resort or similar places shall suffer the penalty of prision mayor in its maximum period and a fine of not less than Fifty thousand pesos (P50,000): Provided, That this provision shall not apply to any person who is related within the fourth degree of consanguinity or affinity or any bond recognized by law, local custom and tradition or acts in the performance of a social, moral or legal duty.

(c) Any person who shall induce, deliver or offer a minor to any one prohibited by this Act to keep or have in his company a minor as provided in the preceding paragraph shall suffer the penalty of prision mayor in its medium period and a fine of not less than Forty thousand pesos (P40,000); Provided, however, That should the perpetrator be an ascendant, stepparent or guardian of the minor, the penalty to be imposed shall be prision mayor in its maximum period, a fine of not less than Fifty thousand pesos (P50,000), and the loss of parental authority over the minor.

(d) Any person, owner, manager or one entrusted with the operation of any public or private place of accommodation, whether for occupancy, food, drink or otherwise, including residential places, who allows any person to take along with him to such place or places any minor herein described shall be imposed a penalty of prision mayor in its medium period and a fine of not less than Fifty thousand pesos (P50,000), and the loss of the license to operate such a place or establishment.

(e) Any person who shall use, coerce, force or intimidate a street child or any other child to;

(1) Beg or use begging as a means of living;

(2) Act as conduit or middlemen in drug trafficking or pushing; or

(3) Conduct any illegal activities, shall suffer the penalty of prision correccional in its medium period to reclusion perpetua.
For purposes of this Act, the penalty for the commission of acts punishable under Articles 248, 249, 262, paragraph 2, and 263, paragraph 1 of Act No. 3815, as amended, the Revised Penal Code, for the crimes of murder, homicide, other intentional mutilation, and serious physical injuries, respectively, shall be reclusion perpetua when the victim is under twelve (12) years of age. The penalty for the commission of acts punishable under Article 337, 339, 340 and 341 of Act No. 3815, as amended, the Revised Penal Code, for the crimes of qualified seduction, acts of lasciviousness with the consent of the offended party, corruption of minors, and white slave trade, respectively, shall be one (1) degree higher than that imposed by law when the victim is under twelve (12) years age.

The victim of the acts committed under this section shall be entrusted to the care of the Department of Social Welfare and Development.

**ARTICLE VII**

Sanctions for Establishments or Enterprises

Sec. 11. Sanctions of Establishments or Enterprises which Promote, Facilitate, or Conduct Activities Constituting Child Prostitution and Other Sexual Abuse, Child Trafficking, Obscene Publications and Indecent Shows, and Other Acts of Abuse. – All establishments and enterprises which promote or facilitate child prostitution and other sexual abuse, child trafficking, obscene publications and indecent shows, and other acts of abuse shall be immediately closed and their authority or license to operate cancelled, without prejudice to the owner or manager thereof being prosecuted under this Act and/or the Revised Penal Code, as amended, or special laws. A sign with the words "off limits" shall be conspicuously displayed outside the establishments or enterprises by the Department of Social Welfare and Development for such period which shall not be less than one (1) year, as the Department may determine. The unauthorized removal of such sign shall be punishable by prision correccional.

An establishment shall be deemed to promote or facilitate child prostitution and other sexual abuse, child trafficking, obscene publications and indecent shows, and other acts of abuse if the acts constituting the same occur in the premises of said establishment under this Act or in violation of the Revised Penal Code, as amended. An enterprise such as a sauna, travel agency, or recruitment agency which: promotes the aforementioned acts as part of a tour for foreign tourists; exhibits children in a lewd or indecent show; provides child masseurs for adults of the same or opposite sex and said services include any lascivious conduct with the customers; or solicits children or activities constituting the aforementioned acts shall be deemed to have committed the acts penalized herein.

**ARTICLE VIII**

Working Children

Sec. 12. Employment of Children. – Children below fifteen (15) years of age may be employed except:

(1) When a child works directly under the sole responsibility of his parents or legal guardian and where only members of the employer's family are employed: Provided, however, That his employment neither endangers his life, safety and health and morals, nor impairs his normal
development: Provided, further, That the parent or legal guardian shall provide the said minor child with the prescribed primary and/or secondary education; or
(2) When a child's employment or participation in public & entertainment or information through cinema, theater, radio or television is essential: Provided, The employment contract concluded by the child's parent or guardian, with the express agreement of the child concerned, if possible, and the approval of the Department of Labor and Employment: Provided, That the following requirements in all instances are strictly complied with:
(a) The employer shall ensure the protection, health, safety and morals of the child;
(b) the employer shall institute measures to prevent the child's exploitation or discrimination taking into account the system and level of remuneration, and the duration and arrangement of working time; and;
(c) The employer shall formulate and implement, subject to the approval and supervision of competent authorities, a continuing program for training and skill acquisition of the child. In the above exceptional cases where any such child may be employed, the employer shall first secure, before engaging such child, a work permit from the Department of Labor and Employment which shall ensure observance of the above requirement. The Department of Labor Employment shall promulgate rules and regulations necessary for the effective implementation of this Sec. .

Sec. 13. Non-formal Education for Working Children. – The Department of Education, Culture and Sports shall promulgate a course design under its non-formal education program aimed at promoting the intellectual, moral and vocational efficiency of working children who have not undergone or finished elementary or secondary education. Such course design shall integrate the learning process deemed most effective under given circumstances.

Sec. 14. Prohibition on the Employment of Children in Certain Advertisements. – No person shall employ child models in all commercials or advertisements promoting alcoholic beverages, intoxicating drinks, tobacco and its byproducts and violence.

Sec. 15. Duty of Employer. – Every employer shall comply with the duties provided for in Articles 108 and 109 of Presidential Decree No. 603.

Sec. 16. Penalties. – Any person who shall violate any provision of this Article shall suffer the penalty of a fine of not less than One thousand pesos (P1,000) but not more than Ten thousand pesos (P10,000) or imprisonment of not less than three (3) months but not more than three (3) years, or both at the discretion of the court; Provided, That, in case of repeated violations of the provisions of this Article, the offender's license to operate shall be revoked.

ARTICLE IX
Children of Indigenous Cultural Communities

Sec. 17. Survival, Protection and Development. – In addition to the rights guaranteed to children under this Act and other existing laws, children of indigenous cultural communities shall be entitled to protection, survival and development consistent with the customs and traditions of their respective communities.
Sec. 18. System of and Access to Education. – The Department of Education, Culture and Sports shall develop and institute an alternative system of education for children of indigenous cultural communities which culture-specific and relevant to the needs of and the existing situation in their communities. The Department of Education, Culture and Sports shall also accredit and support nonformal but functional indigenous educational programs conducted by non-government organizations in said communities.

Sec. 19. Health and Nutrition. – The delivery of basic social services in health and nutrition to children of indigenous cultural communities shall be given priority by all government agencies concerned. Hospitals and other health institution shall ensure that children of indigenous cultural communities are given equal attention. In the provision of health and nutrition services to children of indigenous cultural communities, indigenous health practices shall be respected and recognized.

Sec. 20. Discrimination. – Children of indigenous cultural communities shall not be subjected to any and all forms of discrimination.

Any person who discriminate against children of indigenous cultural communities shall suffer a penalty of arresto mayor in its maximum period and a fine of not less than Five thousand pesos (P5,000) more than Ten thousand pesos (P10,000).

Sec. 21. Participation. – Indigenous cultural communities, through their duly-designated or appointed representatives shall be involved in planning, decision-making implementation, and evaluation of all government programs affecting children of indigenous cultural communities. Indigenous institution shall also be recognized and respected.

ARTICLE X
Children in Situations of Armed Conflict

Sec. 22. Children as Zones of Peace. – Children are hereby declared as Zones of Peace. It shall be the responsibility of the State and all other sectors concerned to resolve armed conflicts in order to promote the goal of children as zones of peace. To attain this objective, the following policies shall be observed.
(a) Children shall not be the object of attack and shall be entitled to special respect. They shall be protected from any form of threat, assault, torture or other cruel, inhumane or degrading treatment;
(b) Children shall not be recruited to become members of the Armed Forces of the Philippines of its civilian units or other armed groups, nor be allowed to take part in the fighting, or used as guides, couriers, or spies;
(c) Delivery of basic social services such as education, primary health and emergency relief services shall be kept unhampered;
(d) The safety and protection of those who provide services including those involved in fact-finding missions from both government and non-government institutions shall be ensured. They shall not be subjected to undue harassment in the performance of their work;
(e) Public infrastructure such as schools, hospitals and rural health units shall not be utilized for military purposes such as command posts, barracks, detachments, and supply depots; and
(f) All appropriate steps shall be taken to facilitate the reunion of families temporarily separated due to armed conflict.

**Sec. 23. Evacuation of Children During Armed Conflict.** – Children shall be given priority during evacuation as a result of armed conflict. Existing community organizations shall be tapped to look after the safety and well-being of children during evacuation operations. Measures shall be taken to ensure that children evacuated are accompanied by persons responsible for their safety and well-being.

**Sec. 24. Family Life and Temporary Shelter.** – Whenever possible, members of the same family shall be housed in the same premises and given separate accommodation from other evacuees and provided with facilities to lead a normal family life. In places of temporary shelter, expectant and nursing mothers and children shall be given additional food in proportion to their physiological needs. Whenever feasible, children shall be given opportunities for physical exercise, sports and outdoor games.

**Section 25. Rights of Children Arrested for Reasons Related to Armed Conflict.** – Any child who has been arrested for reasons related to armed conflict, either as combatant, courier, guide or spy is entitled to the following rights;
(a) Separate detention from adults except where families are accommodated as family units;
(b) Immediate free legal assistance;
(c) Immediate notice of such arrest to the parents or guardians of the child; and
(d) Release of the child on recognizance within twenty-four (24) hours to the custody of the Department of Social Welfare and Development or any responsible member of the community as determined by the court. If after hearing the evidence in the proper proceedings the court should find that the aforesaid child committed the acts charged against him, the court shall determine the imposable penalty, including any civil liability chargeable against him. However, instead of pronouncing judgment of conviction, the court shall suspend all further proceedings and shall commit such child to the custody or care of the Department of Social Welfare and Development or to any training institution operated by the Government, or duly-licensed agencies or any other responsible person, until he has had reached eighteen (18) years of age or, for a shorter period as the court may deem proper, after considering the reports and recommendations of the Department of Social Welfare and Development or the agency or responsible individual under whose care he has been committed.

The aforesaid child shall subject to visitation and supervision by a representative of the Department of Social Welfare and Development or any duly-licensed agency or such other officer as the court may designate subject to such conditions as it may prescribe. The aforesaid child whose sentence is suspended can appeal from the order of the court in the same manner as appeals in criminal cases.

**Sec. 26. Monitoring and Reporting of Children in Situations of Armed Conflict.** – The chairman of the barangay affected by the armed conflict shall submit the names of children residing in said barangay to the municipal social welfare and development officer within twenty-four (24) hours from the occurrence of the armed conflict.
ARTICLE XI
Remedial Procedures

Sec. 27. Who May File a Complaint. – Complaints on cases of unlawful acts committed against the children as enumerated herein may be filed by the following:
(a) Offended party;
(b) Parents or guardians;
(c) Ascendant or collateral relative within the third degree of consanguinity;
(d) Officer, social worker or representative of a licensed child-caring institution;
(e) Officer or social worker of the Department of Social Welfare and Development;
(f) Barangay chairman; or
(g) At least three (3) concerned responsible citizens where the violation occurred.

Sec. 28. Protective Custody of the Child. – The offended party shall be immediately placed under the protective custody of the Department of Social Welfare and Development pursuant to Executive Order No. 56, series of 1986. In the regular performance of this function, the officer of the Department of Social Welfare and Development shall be free from any administrative, civil or criminal liability. Custody proceedings shall be in accordance with the provisions of Presidential Decree No. 603.

Sec. 29. Confidentiality. – At the instance of the offended party, his name may be withheld from the public until the court acquires jurisdiction over the case. It shall be unlawful for any editor, publisher, and reporter or columnist in case of printed materials, announcer or producer in case of television and radio broadcasting, producer and director of the film in case of the movie industry, to cause undue and sensationalized publicity of any case of violation of this Act which results in the moral degradation and suffering of the offended party.

Sec. 30. Special Court Proceedings. – Cases involving violations of this Act shall be heard in the chambers of the judge of the Regional Trial Court duly designated as Juvenile and Domestic Court.

Any provision of existing law to the contrary notwithstanding and with the exception of habeas corpus, election cases, and cases involving detention prisoners and persons covered by Republic Act No. 4908, all courts shall give preference to the hearing or disposition of cases involving violations of this Act.

ARTICLE XII
Common Penal Provisions

Sec. 31. Common Penal Provisions. –
(a) The penalty provided under this Act shall be imposed in its maximum period if the offender has been previously convicted under this Act;
(b) When the offender is a corporation, partnership or association, the officer or employee thereof who is responsible for the violation of this Act shall suffer the penalty imposed in its maximum period;
(c) The penalty provided herein shall be imposed in its maximum period when the perpetrator is an ascendant, parent guardian, stepparent or collateral relative within the second degree of consanguinity or affinity, or a manager or owner of an establishment which has no license to operate or its license has expired or has been revoked;
(d) When the offender is a foreigner, he shall be deported immediately after service of sentence and forever barred from entry to the country;
(e) The penalty provided for in this Act shall be imposed in its maximum period if the offender is a public officer or employee: Provided, however, That if the penalty imposed is reclusion perpetua or reclusion temporal, then the penalty of perpetual or temporary absolute disqualification shall also be imposed: Provided, finally, That if the penalty imposed is prision correccional or arresto mayor, the penalty of suspension shall also be imposed; and
(f) A fine to be determined by the court shall be imposed and administered as a cash fund by the Department of Social Welfare and Development and disbursed for the rehabilitation of each child victim, or any immediate member of his family if the latter is the perpetrator of the offense.

ARTICLE XIII
Final Provisions

Sec. 32. Rules and Regulations. – Unless otherwise provided in this Act, the Department of Justice, in coordination with the Department of Social Welfare and Development, shall promulgate rules and regulations of the effective implementation of this Act. Such rules and regulations shall take effect upon their publication in two (2) national newspapers of general circulation.

Sec. 33. Appropriations. – The amount necessary to carry out the provisions of this Act is hereby authorized to be appropriated in the General Appropriations Act of the year following its enactment into law and thereafter.

Sec. 34. Separability Clause. – If any provision of this Act is declared invalid or unconstitutional, the remaining provisions not affected thereby shall continue in full force and effect.

Sec. 35. Repealing Clause. – All laws, decrees, or rules inconsistent with the provisions of this Acts are hereby repealed or modified accordingly.

Sec. 36. Effectivity Clause. – This Act shall take effect upon completion of its publication in at least two (2) national newspapers of general circulation.6

Approved: June 17, 1992

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ANNEX 7
Congress of the Philippines
Twelfth Congress
First Regular Session

REPUBLIC ACT NO. 9165

June 7, 2002

AN ACT INSTITUTING THE COMPREHENSIVE DANGEROUS DRUGS ACT OF 2002, REPEALING REPUBLIC ACT NO. 6425, OTHERWISE KNOWN AS THE DANGEROUS DRUGS ACT OF 1972, AS AMENDED, PROVIDING FUNDS THEREFOR, AND FOR OTHER PURPOSES

Be it enacted by the Senate and House of Representatives of the Philippines in Congress

Section 1. Short Title. – This Act shall be known and cited as the "Comprehensive Dangerous Drugs Act of 2002".

Section 2. Declaration of Policy. – It is the policy of the State to safeguard the integrity of its territory and the well-being of its citizenry particularly the youth, from the harmful effects of dangerous drugs on their physical and mental well-being, and to defend the same against acts or omissions detrimental to their development and preservation. In view of the foregoing, the State needs to enhance further the efficacy of the law against dangerous drugs, it being one of today's more serious social ills.

Toward this end, the government shall pursue an intensive and unrelenting campaign against the trafficking and use of dangerous drugs and other similar substances through an integrated system of planning, implementation and enforcement of anti-drug abuse policies, programs, and projects. The government shall however aim to achieve a balance in the national drug control program so that people with legitimate medical needs are not prevented from being treated with adequate amounts of appropriate medications, which include the use of dangerous drugs.

It is further declared the policy of the State to provide effective mechanisms or measures to re-integrate into society individuals who have fallen victims to drug abuse or dangerous drug dependence through sustainable programs of treatment and rehabilitation.

ARTICLE I

Definition of terms

Section 3. Definitions. As used in this Act, the following terms shall mean:

(a) Administer. – Any act of introducing any dangerous drug into the body of any person, with or without his/her knowledge, by injection, inhalation, ingestion or other means, or of committing
any act of indispensable assistance to a person in administering a dangerous drug to himself/herself unless administered by a duly licensed practitioner for purposes of medication.

(b) Board. - Refers to the Dangerous Drugs Board under Section 77, Article IX of this Act.

(c) Centers. - Any of the treatment and rehabilitation centers for drug dependents referred to in Section 34, Article VIII of this Act.

(d) Chemical Diversion. – The sale, distribution, supply or transport of legitimately imported, in-transit, manufactured or procured controlled precursors and essential chemicals, in diluted, mixtures or in concentrated form, to any person or entity engaged in the manufacture of any dangerous drug, and shall include packaging, repackaging, labeling, relabeling or concealment of such transaction through fraud, destruction of documents, fraudulent use of permits, misdeclaration, use of front companies or mail fraud.

(e) Clandestine Laboratory. – Any facility used for the illegal manufacture of any dangerous drug and/or controlled precursor and essential chemical.

(f) Confirmatory Test. – An analytical test using a device, tool or equipment with a different chemical or physical principle that is more specific which will validate and confirm the result of the screening test.

(g) Controlled Delivery. – The investigative technique of allowing an unlawful or suspect consignment of any dangerous drug and/or controlled precursor and essential chemical, equipment or paraphernalia, or property believed to be derived directly or indirectly from any offense, to pass into, through or out of the country under the supervision of an authorized officer, with a view to gathering evidence to identify any person involved in any dangerous drugs related offense, or to facilitate prosecution of that offense.

(h) Controlled Precursors and Essential Chemicals. – Include those listed in Tables I and II of the 1988 UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances as enumerated in the attached annex, which is an integral part of this Act.

(i) Cultivate or Culture. – Any act of knowingly planting, growing, raising, or permitting the planting, growing or raising of any plant which is the source of a dangerous drug.

(j) Dangerous Drugs. – Include those listed in the Schedules annexed to the 1961 Single Convention on Narcotic Drugs, as amended by the 1972 Protocol, and in the Schedules annexed to the 1971 Single Convention on Psychotropic Substances as enumerated in the attached annex which is an integral part of this Act.

(k) Deliver. – Any act of knowingly passing a dangerous drug to another, personally or otherwise, and by any means, with or without consideration.
(l) Den, Dive or Resort. – A place where any dangerous drug and/or controlled precursor and essential chemical is administered, delivered, stored for illegal purposes, distributed, sold or used in any form.

(m) Dispense. – Any act of giving away, selling or distributing medicine or any dangerous drug with or without the use of prescription.

(n) Drug Dependence. – As based on the World Health Organization definition, it is a cluster of physiological, behavioral and cognitive phenomena of variable intensity, in which the use of psychoactive drug takes on a high priority thereby involving, among others, a strong desire or a sense of compulsion to take the substance and the difficulties in controlling substance-taking behavior in terms of its onset, termination, or levels of use.

(o) Drug Syndicate. – Any organized group of two (2) or more persons forming or joining together with the intention of committing any offense prescribed under this Act.

(p) Employee of Den, Dive or Resort. – The caretaker, helper, watchman, lookout, and other persons working in the den, dive or resort, employed by the maintainer, owner and/or operator where any dangerous drug and/or controlled precursor and essential chemical is administered, delivered, distributed, sold or used, with or without compensation, in connection with the operation thereof.

(q) Financier. – Any person who pays for, raises or supplies money for, or underwrites any of the illegal activities prescribed under this Act.

(r) Illegal Trafficking. – The illegal cultivation, culture, delivery, administration, dispensation, manufacture, sale, trading, transportation, distribution, importation, exportation and possession of any dangerous drug and/or controlled precursor and essential chemical.

(s) Instrument. – Any thing that is used in or intended to be used in any manner in the commission of illegal drug trafficking or related offenses.

(t) Laboratory Equipment. – The paraphernalia, apparatus, materials or appliances when used, intended for use or designed for use in the manufacture of any dangerous drug and/or controlled precursor and essential chemical, such as reaction vessel, preparative/purifying equipment, fermentors, separatory funnel, flask, heating mantle, gas generator, or their substitute.

(u) Manufacture. – The production, preparation, compounding or processing of any dangerous drug and/or controlled precursor and essential chemical, either directly or indirectly or by extraction from substances of natural origin, or independently by means of chemical synthesis or by a combination of extraction and chemical synthesis, and shall include any packaging or repackaging of such substances, design or configuration of its form, or labeling or relabeling of its container; except that such terms do not include the preparation, compounding, packaging or labeling of a drug or other substances by a duly authorized practitioner as an incident to his/her administration or dispensation of such drug or substance in the course of his/her professional
practice including research, teaching and chemical analysis of dangerous drugs or such substances that are not intended for sale or for any other purpose.

(v) Cannabis or commonly known as "Marijuana" or "Indian Hemp" or by its any other name. – Embraces every kind, class, genus, or specie of the plant Cannabis sativa L. including, but not limited to, Cannabis Americana, hashish, bhang, guaza, churrus and ganjab, and embraces every kind, class and character of marijuana, whether dried or fresh and flowering, flowering or fruiting tops, or any part or portion of the plant and seeds thereof, and all its geographic varieties, whether as a reefer, resin, extract, tincture or in any form whatsoever.

(w) Methylene dioxy methamphetamine (MDMA) or commonly known as "Ecstasy", or by its any other name. – Refers to the drug having such chemical composition, including any of its isomers or derivatives in any form.

(x) Methamphetamine Hydrochloride or commonly known as "Shabu", "Ice", "Meth", or by its any other name. – Refers to the drug having such chemical composition, including any of its isomers or derivatives in any form.

(y) Opium. – Refers to the coagulated juice of the opium poppy (Papaver somniferum L.) and embraces every kind, class and character of opium, whether crude or prepared; the ashes or refuse of the same; narcotic preparations thereof or therefrom; morphine or any alkaloid of opium; preparations in which opium, morphine or any alkaloid of opium enters as an ingredient; opium poppy; opium poppy straw; and leaves or wrappings of opium leaves, whether prepared for use or not.

(z) Opium Poppy. – Refers to any part of the plant of the species Papaver somniferum L., Papaver setigerum DC, Papaver orientale, Papaver bracteatum and Papaver rhoeas, which includes the seeds, straws, branches, leaves or any part thereof, or substances derived therefrom, even for floral, decorative and culinary purposes.

(aa) PDEA. – Refers to the Philippine Drug Enforcement Agency under Section 82, Article IX of this Act.

(bb) Person. – Any entity, natural or juridical, including among others, a corporation, partnership, trust or estate, joint stock company, association, syndicate, joint venture or other unincorporated organization or group capable of acquiring rights or entering into obligations.

(cc) Planting of Evidence. – The willful act by any person of maliciously and surreptitiously inserting, placing, adding or attaching directly or indirectly, through any overt or covert act, whatever quantity of any dangerous drug and/or controlled precursor and essential chemical in the person, house, effects or in the immediate vicinity of an innocent individual for the purpose of implicating, incriminating or imputing the commission of any violation of this Act.

(dd) Practitioner. – Any person who is a licensed physician, dentist, chemist, medical technologist, nurse, midwife, veterinarian or pharmacist in the Philippines.
(ee) Protector/Coddler. – Any person who knowingly and willfully consents to the unlawful acts provided for in this Act and uses his/her influence, power or position in shielding, harboring, screening or facilitating the escape of any person he/she knows, or has reasonable grounds to believe on or suspects, has violated the provisions of this Act in order to prevent the arrest, prosecution and conviction of the violator.

(ff) Pusher. – Any person who sells, trades, administers, dispenses, delivers or gives away to another, on any terms whatsoever, or distributes, dispatches in transit or transports dangerous drugs or who acts as a broker in any of such transactions, in violation of this Act.

(gg) School. – Any educational institution, private or public, undertaking educational operation for pupils/students pursuing certain studies at defined levels, receiving instructions from teachers, usually located in a building or a group of buildings in a particular physical or cyber site.

(hh) Screening Test. – A rapid test performed to establish potential/presumptive positive result.

(ii) Sell. – Any act of giving away any dangerous drug and/or controlled precursor and essential chemical whether for money or any other consideration.

(jj) Trading. – Transactions involving the illegal trafficking of dangerous drugs and/or controlled precursors and essential chemicals using electronic devices such as, but not limited to, text messages, email, mobile or landlines, two-way radios, internet, instant messengers and chat rooms or acting as a broker in any of such transactions whether for money or any other consideration in violation of this Act.

(kk) Use. – Any act of injecting, intravenously or intramuscularly, of consuming, either by chewing, smoking, sniffing, eating, swallowing, drinking or otherwise introducing into the physiological system of the body, and of the dangerous drugs.

**ARTICLE II**

**Unlawful Acts and Penalties**

**Section 4. Importation of Dangerous Drugs and/or Controlled Precursors and Essential Chemicals.** The penalty of life imprisonment to death and a ranging from Five hundred thousand pesos (P500,000.00) to Ten million pesos (P10,000,000.00) shall be imposed upon any person, who, unless authorized by law, shall import or bring into the Philippines any dangerous drug, regardless of the quantity and purity involved, including any and all species of opium poppy or any part thereof or substances derived therefrom even for floral, decorative and culinary purposes.

The penalty of imprisonment ranging from twelve (12) years and one (1) day to twenty (20) years and a fine ranging from One hundred thousand pesos (P100,000.00) to Five hundred thousand pesos (P500,000.00) shall be imposed upon any person, who, unless authorized by law, shall import any controlled precursor and essential chemical.
The maximum penalty provided for under this Section shall be imposed upon any person, who, unless authorized under this Act, shall import or bring into the Philippines any dangerous drug and/or controlled precursor and essential chemical through the use of a diplomatic passport, diplomatic facilities or any other means involving his/her official status intended to facilitate the unlawful entry of the same. In addition, the diplomatic passport shall be confiscated and canceled.

The maximum penalty provided for under this Section shall be imposed upon any person, who organizes, manages or acts as a "financier" of any of the illegal activities prescribed in this Section.

The penalty of twelve (12) years and one (1) day to twenty (20) years of imprisonment and a fine ranging from One hundred thousand pesos (P100,000.00) to Five hundred thousand pesos (P500,000.00) shall be imposed upon any person, who acts as a "protector/coddler" of any violator of the provisions under this Section.

Section 5. Sale, Trading, Administration, Dispensation, Delivery, Distribution and Transportation of Dangerous Drugs and/or Controlled Precursors and Essential Chemicals. - The penalty of life imprisonment to death and a fine ranging from Five hundred thousand pesos (P500,000.00) to Ten million pesos (P10,000,000.00) shall be imposed upon any person, who, unless authorized by law, shall sell, trade, administer, dispense, deliver, give away to another, distribute, dispatch in transit or transport any dangerous drug, including any and all species of opium poppy regardless of the quantity and purity involved, or shall act as a broker in any of such transactions.

The penalty of imprisonment ranging from twelve (12) years and one (1) day to twenty (20) years and a fine ranging from One hundred thousand pesos (P100,000.00) to Five hundred thousand pesos (P500,000.00) shall be imposed upon any person, who, unless authorized by law, shall sell, trade, administer, dispense, deliver, give away to another, distribute, dispatch in transit or transport any controlled precursor and essential chemical, or shall act as a broker in such transactions.

If the sale, trading, administration, dispersion, delivery, distribution or transportation of any dangerous drug and/or controlled precursor and essential chemical transpires within one hundred (100) meters from the school, the maximum penalty shall be imposed in every case.

For drug pushers who use minors or mentally incapacitated individuals as runners, couriers and messengers, or in any other capacity directly connected to the dangerous drugs and/or controlled precursors and essential chemical trade, the maximum penalty shall be imposed in every case.

If the victim of the offense is a minor or a mentally incapacitated individual, or should a dangerous drug and/or a controlled precursor and essential chemical involved in any offense herein provided be the proximate cause of death of a victim thereof, the maximum penalty provided for under this Section shall be imposed.
The maximum penalty provided for under this Section shall be imposed upon any person who organizes, manages or acts as a "financier" of any of the illegal activities prescribed in this Section.

The penalty of twelve (12) years and one (1) day to twenty (20) years of imprisonment and a fine ranging from One hundred thousand pesos (P100,000.00) to Five hundred thousand pesos (P500,000.00) shall be imposed upon any person, who acts as a "protector/coddler" of any violator of the provisions under this Section.

Section 6. Maintenance of a Den, Dive or Resort. - The penalty of life imprisonment to death and a fine ranging from Five hundred thousand pesos (P500,000.00) to Ten million pesos (P10,000,000.00) shall be imposed upon any person or group of persons who shall maintain a den, dive or resort where any dangerous drug is used or sold in any form.

The penalty of imprisonment ranging from twelve (12) years and one (1) day to twenty (20) years and a fine ranging from One hundred thousand pesos (P100,000.00) to Five hundred thousand pesos (P500,000.00) shall be imposed upon any person or group of persons who shall maintain a den, dive, or resort where any controlled precursor and essential chemical is used or sold in any form.

The maximum penalty provided for under this Section shall be imposed in every case where any dangerous drug is administered, delivered or sold to a minor who is allowed to use the same in such a place.

Should any dangerous drug be the proximate cause of the death of a person using the same in such den, dive or resort, the penalty of death and a fine ranging from One million (P1,000,000.00) to Fifteen million pesos (P500,000.00) shall be imposed on the maintainer, owner and/or operator.

If such den, dive or resort is owned by a third person, the same shall be confiscated and escheated in favor of the government: Provided, That the criminal complaint shall specifically allege that such place is intentionally used in the furtherance of the crime: Provided, further, That the prosecution shall prove such intent on the part of the owner to use the property for such purpose: Provided, finally, That the owner shall be included as an accused in the criminal complaint.

The maximum penalty provided for under this Section shall be imposed upon any person who organizes, manages or acts as a "financier" of any of the illegal activities prescribed in this Section.

The penalty twelve (12) years and one (1) day to twenty (20) years of imprisonment and a fine ranging from One hundred thousand pesos (P100,000.00) to Five hundred thousand pesos (P500,000.00) shall be imposed upon any person, who acts as a "protector/coddler" of any violator of the provisions under this Section.
Section 7. Employees and Visitors of a Den, Dive or Resort. - The penalty of imprisonment ranging from twelve (12) years and one (1) day to twenty (20) years and a fine ranging from One hundred thousand pesos (P100,000.00) to Five hundred thousand pesos (P500,000.00) shall be imposed upon:

(a) Any employee of a den, dive or resort, who is aware of the nature of the place as such; and

(b) Any person who, not being included in the provisions of the next preceding, paragraph, is aware of the nature of the place as such and shall knowingly visit the same

Section 8. Manufacture of Dangerous Drugs and/or Controlled Precursors and Essential Chemicals. - The penalty of life imprisonment to death and a fine ranging Five hundred thousand pesos (P500,000.00) to Ten million pesos (P10,000,000.00) shall be imposed upon any person, who, unless authorized by law, shall engage in the manufacture of any dangerous drug.

The penalty of imprisonment ranging from twelve (12) years and one (1) day to twenty (20) years and a fine ranging from One hundred thousand pesos (P100,000.00) to Five hundred thousand pesos (P500,000.00) shall be imposed upon any person, who, unless authorized by law, shall manufacture any controlled precursor and essential chemical.

The presence of any controlled precursor and essential chemical or laboratory equipment in the clandestine laboratory is a prima facie proof of manufacture of any dangerous drug. It shall be considered an aggravating circumstance if the clandestine laboratory is undertaken or established under the following circumstances:

(a) Any phase of the manufacturing process was conducted in the presence or with the help of minor/s:

(b) Any phase or manufacturing process was established or undertaken within one hundred (100) meters of a residential, business, church or school premises;

(c) Any clandestine laboratory was secured or protected with booby traps;

(d) Any clandestine laboratory was concealed with legitimate business operations; or

(e) Any employment of a practitioner, chemical engineer, public official or foreigner.

The maximum penalty provided for under this Section shall be imposed upon any person, who organizes, manages or acts as a "financier" of any of the illegal activities prescribed in this Section.

The penalty of twelve (12) years and one (1) day to twenty (20) years of imprisonment and a fine ranging from One hundred thousand pesos (P100,000.00) to Five hundred thousand pesos (P500,000.00) shall be imposed upon any person, who acts as a "protector/coddler" of any violator of the provisions under this Section.
Section 9. Illegal Chemical Diversion of Controlled Precursors and Essential Chemicals. - The penalty of imprisonment ranging from twelve (12) years and one (1) day to twenty (20) years and a fine ranging from One hundred thousand pesos (P100,000.00) to Five hundred thousand pesos (P500,000.00) shall be imposed upon any person, who, unless authorized by law, shall illegally divert any controlled precursor and essential chemical.

Section 10. Manufacture or Delivery of Equipment, Instrument, Apparatus, and Other Paraphernalia for Dangerous Drugs and/or Controlled Precursors and Essential Chemicals. - The penalty of imprisonment ranging from twelve (12) years and one (1) day to twenty (20) years and a fine ranging from One hundred thousand pesos (P100,000.00) to Five hundred thousand pesos (P500,000.00) shall be imposed upon any person who shall deliver, possess with intent to deliver, or manufacture with intent to deliver equipment, instrument, apparatus and other paraphernalia for dangerous drugs, knowing, or under circumstances where one reasonably should know, that it will be used to plant, propagate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain or conceal any dangerous drug and/or controlled precursor and essential chemical in violation of this Act.

The penalty of imprisonment ranging from six (6) months and one (1) day to four (4) years and a fine ranging from Ten thousand pesos (P10,000.00) to Fifty thousand pesos (P50,000.00) shall be imposed if it will be used to inject, ingest, inhale or otherwise introduce into the human body a dangerous drug in violation of this Act.

The maximum penalty provided for under this Section shall be imposed upon any person, who uses a minor or a mentally incapacitated individual to deliver such equipment, instrument, apparatus and other paraphernalia for dangerous drugs.

Section 11. Possession of Dangerous Drugs. - The penalty of life imprisonment to death and a fine ranging from Five hundred thousand pesos (P500,000.00) to Ten million pesos (P10,000,000.00) shall be imposed upon any person, who, unless authorized by law, shall possess any dangerous drug in the following quantities, regardless of the degree of purity thereof:

1. 10 grams or more of opium;
2. 10 grams or more of morphine;
3. 10 grams or more of heroin;
4. 10 grams or more of cocaine or cocaine hydrochloride;
5. 50 grams or more of methamphetamine hydrochloride or "shabu";
6. 10 grams or more of marijuana resin or marijuana resin oil;
7. 500 grams or more of marijuana; and
8. 10 grams or more of other dangerous drugs such as, but not limited to, methylenedioxymethamphetamine (MDA) or "ecstasy", paramethoxyamphetamine (PMA), trimethoxyamphetamine (TMA), lysergic acid diethylamine (LSD), gamma hydroxyamphetamine (GHB), and those similarly designed or newly introduced drugs and their derivatives, without having any therapeutic value or if the quantity possessed is far beyond
therapeutic requirements, as determined and promulgated by the Board in accordance to Section 93, Article XI of this Act.

Otherwise, if the quantity involved is less than the foregoing quantities, the penalties shall be graduated as follows:

(1) Life imprisonment and a fine ranging from Four hundred thousand pesos (P400,000.00) to Five hundred thousand pesos (P500,000.00), if the quantity of methamphetamine hydrochloride or "shabu" is ten (10) grams or more but less than fifty (50) grams;

(2) Imprisonment of twenty (20) years and one (1) day to life imprisonment and a fine ranging from Four hundred thousand pesos (P400,000.00) to Five hundred thousand pesos (P500,000.00), if the quantities of dangerous drugs are five (5) grams or more but less than ten (10) grams of opium, morphine, heroin, cocaine or cocaine hydrochloride, marijuana resin or marijuana resin oil, methamphetamine hydrochloride or "shabu", or other dangerous drugs such as, but not limited to, MDMA or "ecstasy", PMA, TMA, LSD, GHB, and those similarly designed or newly introduced drugs and their derivatives, without having any therapeutic value or if the quantity possessed is far beyond therapeutic requirements; or three hundred (300) grams or more but less than five (hundred) 500) grams of marijuana; and

(3) Imprisonment of twelve (12) years and one (1) day to twenty (20) years and a fine ranging from Three hundred thousand pesos (P300,000.00) to Four hundred thousand pesos (P400,000.00), if the quantities of dangerous drugs are less than five (5) grams of opium, morphine, heroin, cocaine or cocaine hydrochloride, marijuana resin or marijuana resin oil, methamphetamine hydrochloride or "shabu", or other dangerous drugs such as, but not limited to, MDMA or "ecstasy", PMA, TMA, LSD, GHB, and those similarly designed or newly introduced drugs and their derivatives, without having any therapeutic value or if the quantity possessed is far beyond therapeutic requirements; or less than three hundred (300) grams of marijuana.

Section 12. Possession of Equipment, Instrument, Apparatus and Other Paraphernalia for Dangerous Drugs. - The penalty of imprisonment ranging from six (6) months and one (1) day to four (4) years and a fine ranging from Ten thousand pesos (P10,000.00) to Fifty thousand pesos (P50,000.00) shall be imposed upon any person, who, unless authorized by law, shall possess or have under his/her control any equipment, instrument, apparatus and other paraphernalia fit or intended for smoking, consuming, administering, injecting, ingesting, or introducing any dangerous drug into the body: Provided, That in the case of medical practitioners and various professionals who are required to carry such equipment, instrument, apparatus and other paraphernalia in the practice of their profession, the Board shall prescribe the necessary implementing guidelines thereof.

The possession of such equipment, instrument, apparatus and other paraphernalia fit or intended for any of the purposes enumerated in the preceding paragraph shall be prima facie evidence that the possessor has smoked, consumed, administered to himself/herself, injected, ingested or used a dangerous drug and shall be presumed to have violated Section 15 of this Act.
Section 13. Possession of Dangerous Drugs During Parties, Social Gatherings or Meetings. – Any person found possessing any dangerous drug during a party, or at a social gathering or meeting, or in the proximate company of at least two (2) persons, shall suffer the maximum penalties provided for in Section 11 of this Act, regardless of the quantity and purity of such dangerous drugs.

Section 14. Possession of Equipment, Instrument, Apparatus and Other Paraphernalia for Dangerous Drugs During Parties, Social Gatherings or Meetings. - The maximum penalty provided for in Section 12 of this Act shall be imposed upon any person, who shall possess or have under his/her control any equipment, instrument, apparatus and other paraphernalia fit or intended for smoking, consuming, administering, injecting, ingesting, or introducing any dangerous drug into the body, during parties, social gatherings or meetings, or in the proximate company of at least two (2) persons.

Section 15. Use of Dangerous Drugs. – A person apprehended or arrested, who is found to be positive for use of any dangerous drug, after a confirmatory test, shall be imposed a penalty of a minimum of six (6) months rehabilitation in a government center for the first offense, subject to the provisions of Article VIII of this Act. If apprehended using any dangerous drug for the second time, he/she shall suffer the penalty of imprisonment ranging from six (6) years and one (1) day to twelve (12) years and a fine ranging from Fifty thousand pesos (P50,000.00) to Two hundred thousand pesos (P200,000.00): Provided, That this Section shall not be applicable where the person tested is also found to have in his/her possession such quantity of any dangerous drug provided for under Section 11 of this Act, in which case the provisions stated therein shall apply.

Section 16. Cultivation or Culture of Plants Classified as Dangerous Drugs or are Sources Thereof. - The penalty of life imprisonment to death and a fine ranging from Five hundred thousand pesos (P500,000.00) to Ten million pesos (P10,000,000.00) shall be imposed upon any person, who shall plant, cultivate or culture marijuana, opium poppy or any other plant regardless of quantity, which is or may hereafter be classified as a dangerous drug or as a source from which any dangerous drug may be manufactured or derived: Provided, That in the case of medical laboratories and medical research centers which cultivate or culture marijuana, opium poppy and other plants, or materials of such dangerous drugs for medical experiments and research purposes, or for the creation of new types of medicine, the Board shall prescribe the necessary implementing guidelines for the proper cultivation, culture, handling, experimentation and disposal of such plants and materials.

The land or portions thereof and/or greenhouses on which any of said plants is cultivated or cultured shall be confiscated and escheated in favor of the State, unless the owner thereof can prove lack of knowledge of such cultivation or culture despite the exercise of due diligence on his/her part. If the land involved is part of the public domain, the maximum penalty provided for under this Section shall be imposed upon the offender.

The maximum penalty provided for under this Section shall be imposed upon any person, who organizes, manages or acts as a "financier" of any of the illegal activities prescribed in this Section.
The penalty of twelve (12) years and one (1) day to twenty (20) years of imprisonment and a fine ranging from One hundred thousand pesos (P100,000.00) to Five hundred thousand pesos (P500,000.00) shall be imposed upon any person, who acts as a "protector/coddler" of any violator of the provisions under this Section.

Section 17. Maintenance and Keeping of Original Records of Transactions on Dangerous Drugs and/or Controlled Precursors and Essential Chemicals. - The penalty of imprisonment ranging from one (1) year and one (1) day to six (6) years and a fine ranging from Ten thousand pesos (P10,000.00) to Fifty thousand pesos (P50,000.00) shall be imposed upon any practitioner, manufacturer, wholesaler, importer, distributor, dealer or retailer who violates or fails to comply with the maintenance and keeping of the original records of transactions on any dangerous drug and/or controlled precursor and essential chemical in accordance with Section 40 of this Act.

An additional penalty shall be imposed through the revocation of the license to practice his/her profession, in case of a practitioner, or of the business, in case of a manufacturer, seller, importer, distributor, dealer or retailer.

Section 18. Unnecessary Prescription of Dangerous Drugs. – The penalty of imprisonment ranging from twelve (12) years and one (1) day to twenty (20) years and a fine ranging from One hundred thousand pesos (P100,000.00) to Five hundred thousand pesos (P500,000.00) and the additional penalty of the revocation of his/her license to practice shall be imposed upon the practitioner, who shall prescribe any dangerous drug to any person whose physical or physiological condition does not require the use or in the dosage prescribed therein, as determined by the Board in consultation with recognized competent experts who are authorized representatives of professional organizations of practitioners, particularly those who are involved in the care of persons with severe pain.

Section 19. Unlawful Prescription of Dangerous Drugs. – The penalty of life imprisonment to death and a fine ranging from Five hundred thousand pesos (P500,000.00) to Ten million pesos (P10,000,000.00) shall be imposed upon any person, who, unless authorized by law, shall make or issue a prescription or any other writing purporting to be a prescription for any dangerous drug.

Section 20. Confiscation and Forfeiture of the Proceeds or Instruments of the Unlawful Act, Including the Properties or Proceeds Derived from the Illegal Trafficking of Dangerous Drugs and/or Precursors and Essential Chemicals. – Every penalty imposed for the unlawful importation, sale, trading, administration, dispensation, delivery, distribution, transportation or manufacture of any dangerous drug and/or controlled precursor and essential chemical, the cultivation or culture of plants which are sources of dangerous drugs, and the possession of any equipment, instrument, apparatus and other paraphernalia for dangerous drugs including other laboratory equipment, shall carry with it the confiscation and forfeiture, in favor of the government, of all the proceeds and properties derived from the unlawful act, including, but not limited to, money and other assets obtained thereby, and the instruments or tools with which the particular unlawful act was committed, unless they are the property of a third person not liable for the unlawful act, but those which are not of lawful commerce shall be ordered destroyed without delay pursuant to the provisions of Section 21 of this Act.
After conviction in the Regional Trial Court in the appropriate criminal case filed, the Court shall immediately schedule a hearing for the confiscation and forfeiture of all the proceeds of the offense and all the assets and properties of the accused either owned or held by him or in the name of some other persons if the same shall be found to be manifestly out of proportion to his/her lawful income: Provided, however, That if the forfeited property is a vehicle, the same shall be auctioned off not later than five (5) days upon order of confiscation or forfeiture.

During the pendency of the case in the Regional Trial Court, no property, or income derived therefrom, which may be confiscated and forfeited, shall be disposed, alienated or transferred and the same shall be in custodia legis and no bond shall be admitted for the release of the same.

The proceeds of any sale or disposition of any property confiscated or forfeited under this Section shall be used to pay all proper expenses incurred in the proceedings for the confiscation, forfeiture, custody and maintenance of the property pending disposition, as well as expenses for publication and court costs. The proceeds in excess of the above expenses shall accrue to the Board to be used in its campaign against illegal drugs.

Section 21. Custody and Disposition of Confiscated, Seized, and/or Surrendered Dangerous Drugs, Plant Sources of Dangerous Drugs, Controlled Precursors and Essential Chemicals, Instruments/Paraphernalia and/or Laboratory Equipment. – The PDEA shall take charge and have custody of all dangerous drugs, plant sources of dangerous drugs, controlled precursors and essential chemicals, as well as instruments/paraphernalia and/or laboratory equipment so confiscated, seized and/or surrendered, for proper disposition in the following manner:

(1) The apprehending team having initial custody and control of the drugs shall, immediately after seizure and confiscation, physically inventory and photograph the same in the presence of the accused or the person/s from whom such items were confiscated and/or seized, or his/her representative or counsel, a representative from the media and the Department of Justice (DOJ), and any elected public official who shall be required to sign the copies of the inventory and be given a copy thereof;

(2) Within twenty-four (24) hours upon confiscation/seizure of dangerous drugs, plant sources of dangerous drugs, controlled precursors and essential chemicals, as well as instruments/paraphernalia and/or laboratory equipment, the same shall be submitted to the PDEA Forensic Laboratory for a qualitative and quantitative examination;

(3) A certification of the forensic laboratory examination results, which shall be done under oath by the forensic laboratory examiner, shall be issued within twenty-four (24) hours after the receipt of the subject item/s: Provided, That when the volume of the dangerous drugs, plant sources of dangerous drugs, and controlled precursors and essential chemicals does not allow the completion of testing within the time frame, a partial laboratory examination report shall be provisionally issued stating therein the quantities of dangerous drugs still to be examined by the forensic laboratory: Provided, however, That a final certification shall be issued on the completed forensic laboratory examination on the same within the next twenty-four (24) hours;
(4) After the filing of the criminal case, the Court shall, within seventy-two (72) hours, conduct an ocular inspection of the confiscated, seized and/or surrendered dangerous drugs, plant sources of dangerous drugs, and controlled precursors and essential chemicals, including the instruments/paraphernalia and/or laboratory equipment, and through the PDEA shall within twenty-four (24) hours thereafter proceed with the destruction or burning of the same, in the presence of the accused or the person/s from whom such items were confiscated and/or seized, or his/her representative or counsel, a representative from the media and the DOJ, civil society groups and any elected public official. The Board shall draw up the guidelines on the manner of proper disposition and destruction of such item/s which shall be borne by the offender: Provided, That those item/s of lawful commerce, as determined by the Board, shall be donated, used or recycled for legitimate purposes: Provided, further, That a representative sample, duly weighed and recorded is retained;

(5) The Board shall then issue a sworn certification as to the fact of destruction or burning of the subject item/s which, together with the representative sample/s in the custody of the PDEA, shall be submitted to the court having jurisdiction over the case. In all instances, the representative sample/s shall be kept to a minimum quantity as determined by the Board;

(6) The alleged offender or his/her representative or counsel shall be allowed to personally observe all of the above proceedings and his/her presence shall not constitute an admission of guilt. In case the said offender or accused refuses or fails to appoint a representative after due notice in writing to the accused or his/her counsel within seventy-two (72) hours before the actual burning or destruction of the evidence in question, the Secretary of Justice shall appoint a member of the public attorney’s office to represent the former;

(7) After the promulgation and judgment in the criminal case wherein the representative sample/s was presented as evidence in court, the trial prosecutor shall inform the Board of the final termination of the case and, in turn, shall request the court for leave to turn over the said representative sample/s to the PDEA for proper disposition and destruction within twenty-four (24) hours from receipt of the same; and

(8) Transitory Provision: a) Within twenty-four (24) hours from the effectivity of this Act, dangerous drugs defined herein which are presently in possession of law enforcement agencies shall, with leave of court, be burned or destroyed, in the presence of representatives of the Court, DOJ, Department of Health (DOH) and the accused/and or his/her counsel, and, b) Pending the organization of the PDEA, the custody, disposition, and burning or destruction of seized/surrendered dangerous drugs provided under this Section shall be implemented by the DOH.

Section 22. Grant of Compensation, Reward and Award. – The Board shall recommend to the concerned government agency the grant of compensation, reward and award to any person providing information and to law enforcers participating in the operation, which results in the successful confiscation, seizure or surrender of dangerous drugs, plant sources of dangerous drugs, and controlled precursors and essential chemicals.
Section 23. Plea-Bargaining Provision. – Any person charged under any provision of this Act regardless of the imposable penalty shall not be allowed to avail of the provision on plea-bargaining.

Section 24. Non-Applicability of the Probation Law for Drug Traffickers and Pushers. – Any person convicted for drug trafficking or pushing under this Act, regardless of the penalty imposed by the Court, cannot avail of the privilege granted by the Probation Law or Presidential Decree No. 968, as amended.

Section 25. Qualifying Aggravating Circumstances in the Commission of a Crime by an Offender Under the Influence of Dangerous Drugs. – Notwithstanding the provisions of any law to the contrary, a positive finding for the use of dangerous drugs shall be a qualifying aggravating circumstance in the commission of a crime by an offender, and the application of the penalty provided for in the Revised Penal Code shall be applicable.

Section 26. Attempt or Conspiracy. – Any attempt or conspiracy to commit the following unlawful acts shall be penalized by the same penalty prescribed for the commission of the same as provided under this Act:

(a) Importation of any dangerous drug and/or controlled precursor and essential chemical;

(b) Sale, trading, administration, dispensation, delivery, distribution and transportation of any dangerous drug and/or controlled precursor and essential chemical;

(c) Maintenance of a den, dive or resort where any dangerous drug is used in any form;

(d) Manufacture of any dangerous drug and/or controlled precursor and essential chemical; and

(e) Cultivation or culture of plants which are sources of dangerous drugs.

Section 27. Criminal Liability of a Public Officer or Employee for Misappropriation, Misapplication or Failure to Account for the Confiscated, Seized and/or Surrendered Dangerous Drugs, Plant Sources of Dangerous Drugs, Controlled Precursors and Essential Chemicals, Instruments/Paraphernalia and/or Laboratory Equipment Including the Proceeds or Properties Obtained from the Unlawful Act Committed. – The penalty of life imprisonment to death and a fine ranging from Five hundred thousand pesos (P500,000.00) to Ten million pesos (P10,000,000.00), in addition to absolute perpetual disqualification from any public office, shall be imposed upon any public officer or employee who misappropriates, misapplies or fails to account for confiscated, seized or surrendered dangerous drugs, plant sources of dangerous drugs, controlled precursors and essential chemicals, instruments/paraphernalia and/or laboratory equipment including the proceeds or properties obtained from the unlawful acts as provided for in this Act.

Any elective local or national official found to have benefited from the proceeds of the trafficking of dangerous drugs as prescribed in this Act, or have received any financial or material contributions or donations from natural or juridical persons found guilty of trafficking.
dangerous drugs as prescribed in this Act, shall be removed from office and perpetually disqualified from holding any elective or appointive positions in the government, its divisions, subdivisions, and intermediaries, including government-owned or –controlled corporations.

Section 28. Criminal Liability of Government Officials and Employees. – The maximum penalties of the unlawful acts provided for in this Act shall be imposed, in addition to absolute perpetual disqualification from any public office, if those found guilty of such unlawful acts are government officials and employees.

Section 29. Criminal Liability for Planting of Evidence. – Any person who is found guilty of “planting” any dangerous drug and/or controlled precursor and essential chemical, regardless of quantity and purity, shall suffer the penalty of death.

Section 30. Criminal Liability of Officers of Partnerships, Corporations, Associations or Other Juridical Entities. – In case any violation of this Act is committed by a partnership, corporation, association or any juridical entity, the partner, president, director, manager, trustee, estate administrator, or officer who consents to or knowingly tolerates such violation shall be held criminally liable as a co-principal.

The penalty provided for the offense under this Act shall be imposed upon the partner, president, director, manager, trustee, estate administrator, or officer who knowingly authorizes, tolerates or consents to the use of a vehicle, vessel, aircraft, equipment or other facility, as an instrument in the importation, sale, trading, administration, dispensation, delivery, distribution, transportation or manufacture of dangerous drugs, or chemical diversion, if such vehicle, vessel, aircraft, equipment or other instrument is owned by or under the control or supervision of the partnership, corporation, association or juridical entity to which they are affiliated.

Section 31. Additional Penalty if Offender is an Alien. – In addition to the penalties prescribed in the unlawful act committed, any alien who violates such provisions of this Act shall, after service of sentence, be deported immediately without further proceedings, unless the penalty is death.

Section 32. Liability to a Person Violating Any Regulation Issued by the Board. – The penalty of imprisonment ranging from six (6) months and one (1) day to four (4) years and a fine ranging from Ten thousand pesos (P10,000.00) to Fifty thousand pesos (P50,000.00) shall be imposed upon any person found violating any regulation duly issued by the Board pursuant to this Act, in addition to the administrative sanctions imposed by the Board.

Section 33. Immunity from Prosecution and Punishment. – Notwithstanding the provisions of Section 17, Rule 119 of the Revised Rules of Criminal Procedure and the provisions of Republic Act No. 6981 or the Witness Protection, Security and Benefit Act of 1991, any person who has violated Sections 7, 11, 12, 14, 15, and 19, Article II of this Act, who voluntarily gives information about any violation of Sections 4, 5, 6, 8, 10, 13, and 16, Article II of this Act as well as any violation of the offenses mentioned if committed by a drug syndicate, or any information leading to the whereabouts, identities and arrest of all or any of the members thereof; and who willingly testifies against such persons as described above, shall be exempted from prosecution or punishment for the offense with reference to which his/her information of
testimony were given, and may plead or prove the giving of such information and testimony in bar of such prosecution: Provided, That the following conditions concur:

(1) The information and testimony are necessary for the conviction of the persons described above;

(2) Such information and testimony are not yet in the possession of the State;

(3) Such information and testimony can be corroborated on its material points;

(4) the informant or witness has not been previously convicted of a crime involving moral turpitude, except when there is no other direct evidence available for the State other than the information and testimony of said informant or witness; and

(5) The informant or witness shall strictly and faithfully comply without delay, any condition or undertaking, reduced into writing, lawfully imposed by the State as further consideration for the grant of immunity from prosecution and punishment.

Provided, further, That this immunity may be enjoyed by such informant or witness who does not appear to be most guilty for the offense with reference to which his/her information or testimony were given: Provided, finally, That there is no direct evidence available for the State except for the information and testimony of the said informant or witness.

Section 34. Termination of the Grant of Immunity. – The immunity granted to the informant or witness, as prescribed in Section 33 of this Act, shall not attach should it turn out subsequently that the information and/or testimony is false, malicious or made only for the purpose of harassing, molesting or in any way prejudicing the persons described in the preceding Section against whom such information or testimony is directed against. In such case, the informant or witness shall be subject to prosecution and the enjoyment of all rights and benefits previously accorded him under this Act or any other law, decree or order shall be deemed terminated.

In case an informant or witness under this Act fails or refuses to testify without just cause, and when lawfully obliged to do so, or should he/she violate any condition accompanying such immunity as provided above, his/her immunity shall be removed and he/she shall likewise be subject to contempt and/or criminal prosecution, as the case may be, and the enjoyment of all rights and benefits previously accorded him under this Act or in any other law, decree or order shall be deemed terminated.

In case the informant or witness referred to under this Act falls under the applicability of this Section hereof, such individual cannot avail of the provisions under Article VIII of this Act.

Section 35. Accessory Penalties. – A person convicted under this Act shall be disqualified to exercise his/her civil rights such as but not limited to, the rights of parental authority or guardianship, either as to the person or property of any ward, the rights to dispose of such property by any act or any conveyance inter vivos, and political rights such as but not limited to,
the right to vote and be voted for. Such rights shall also be suspended during the pendency of an appeal from such conviction.

ARTICLE III

Dangerous Drugs Test and Record Requirements

Section 36. Authorized Drug Testing. – Authorized drug testing shall be done by any government forensic laboratories or by any of the drug testing laboratories accredited and monitored by the DOH to safeguard the quality of test results. The DOH shall take steps in setting the price of the drug test with DOH accredited drug testing centers to further reduce the cost of such drug test. The drug testing shall employ, among others, two (2) testing methods, the screening test which will determine the positive result as well as the type of the drug used and the confirmatory test which will confirm a positive screening test. Drug test certificates issued by accredited drug testing centers shall be valid for a one-year period from the date of issue which may be used for other purposes. The following shall be subjected to undergo drug testing:

(a) Applicants for driver's license. – No driver's license shall be issued or renewed to any person unless he/she presents a certification that he/she has undergone a mandatory drug test and indicating thereon that he/she is free from the use of dangerous drugs;

(b) Applicants for firearm's license and for permit to carry firearms outside of residence. – All applicants for firearm's license and permit to carry firearms outside of residence shall undergo a mandatory drug test to ensure that they are free from the use of dangerous drugs: Provided, That all persons who by the nature of their profession carry firearms shall undergo drug testing;

(c) Students of secondary and tertiary schools. – Students of secondary and tertiary schools shall, pursuant to the related rules and regulations as contained in the school's student handbook and with notice to the parents, undergo a random drug testing: Provided, That all drug testing expenses whether in public or private schools under this Section will be borne by the government;

(d) Officers and employees of public and private offices. – Officers and employees of public and private offices, whether domestic or overseas, shall be subjected to undergo a random drug test as contained in the company's work rules and regulations, which shall be borne by the employer, for purposes of reducing the risk in the workplace. Any officer or employee found positive for use of dangerous drugs shall be dealt with administratively which shall be a ground for suspension or termination, subject to the provisions of Article 282 of the Labor Code and pertinent provisions of the Civil Service Law;

(e) Officers and members of the military, police and other law enforcement agencies. – Officers and members of the military, police and other law enforcement agencies shall undergo an annual mandatory drug test;
(f) All persons charged before the prosecutor's office with a criminal offense having an imposable penalty of imprisonment of not less than six (6) years and one (1) day shall have to undergo a mandatory drug test; and

(g) All candidates for public office whether appointed or elected both in the national or local government shall undergo a mandatory drug test.

In addition to the above stated penalties in this Section, those found to be positive for dangerous drugs use shall be subject to the provisions of Section 15 of this Act.

Section 37. Issuance of False or Fraudulent Drug Test Results. – Any person authorized, licensed or accredited under this Act and its implementing rules to conduct drug examination or test, who issues false or fraudulent drug test results knowingly, willfully or through gross negligence, shall suffer the penalty of imprisonment ranging from six (6) years and one (1) day to twelve (12) years and a fine ranging from One hundred thousand pesos (P100,000.00) to Five hundred thousand pesos (P500,000.00).

An additional penalty shall be imposed through the revocation of the license to practice his/her profession in case of a practitioner, and the closure of the drug testing center.

Section 38. Laboratory Examination or Test on Apprehended/Arrested Offenders. – Subject to Section 15 of this Act, any person apprehended or arrested for violating the provisions of this Act shall be subjected to screening laboratory examination or test within twenty-four (24) hours, if the apprehending or arresting officer has reasonable ground to believe that the person apprehended or arrested, on account of physical signs or symptoms or other visible or outward manifestation, is under the influence of dangerous drugs. If found to be positive, the results of the screening laboratory examination or test shall be challenged within fifteen (15) days after receipt of the result through a confirmatory test conducted in any accredited analytical laboratory equipment with a gas chromatograph/mass spectrometry equipment or some such modern and accepted method, if confirmed the same shall be prima facie evidence that such person has used dangerous drugs, which is without prejudice for the prosecution for other violations of the provisions of this Act: Provided, That a positive screening laboratory test must be confirmed for it to be valid in a court of law.

Section 39. Accreditation of Drug Testing Centers and Physicians. – The DOH shall be tasked to license and accredit drug testing centers in each province and city in order to assure their capacity, competence, integrity and stability to conduct the laboratory examinations and tests provided in this Article, and appoint such technical and other personnel as may be necessary for the effective implementation of this provision. The DOH shall also accredit physicians who shall conduct the drug dependency examination of a drug dependent as well as the after-care and follow-up program for the said drug dependent. There shall be a control regulations, licensing and accreditation division under the supervision of the DOH for this purpose.

For this purpose, the DOH shall establish, operate and maintain drug testing centers in government hospitals, which must be provided at least with basic technologically advanced equipment and materials, in order to conduct the laboratory examination and tests herein
provided, and appoint such qualified and duly trained technical and other personnel as may be necessary for the effective implementation of this provision.

**Section 40. Records Required for Transactions on Dangerous Drug and Precursors and Essential Chemicals.** –

a) Every pharmacist dealing in dangerous drugs and/or controlled precursors and essential chemicals shall maintain and keep an original record of sales, purchases, acquisitions and deliveries of dangerous drugs, indicating therein the following information:

1. License number and address of the pharmacist;

2. Name, address and license of the manufacturer, importer or wholesaler from whom the dangerous drugs have been purchased;

3. Quantity and name of the dangerous drugs purchased or acquired;

4. Date of acquisition or purchase;

5. Name, address and community tax certificate number of the buyer;

6. Serial number of the prescription and the name of the physician, dentist, veterinarian or practitioner issuing the same;

7. Quantity and name of the dangerous drugs sold or delivered; and

8. Date of sale or delivery.

A certified true copy of such record covering a period of six (6) months, duly signed by the pharmacist or the owner of the drugstore, pharmacy or chemical establishment, shall be forwarded to the Board within fifteen (15) days following the last day of June and December of each year, with a copy thereof furnished the city or municipal health officer concerned.

(b) A physician, dentist, veterinarian or practitioner authorized to prescribe any dangerous drug shall issue the prescription therefor in one (1) original and two (2) duplicate copies. The original, after the prescription has been filled, shall be retained by the pharmacist for a period of one (1) year from the date of sale or delivery of such drug. One (1) copy shall be retained by the buyer or by the person to whom the drug is delivered until such drug is consumed, while the second copy shall be retained by the person issuing the prescription.

For purposes of this Act, all prescriptions issued by physicians, dentists, veterinarians or practitioners shall be written on forms exclusively issued by and obtainable from the DOH. Such forms shall be made of a special kind of paper and shall be distributed in such quantities and contain such information and other data as the DOH may, by rules and regulations, require. Such forms shall only be issued by the DOH through its authorized employees to licensed physicians, dentists, veterinarians and practitioners in such quantities as the Board may authorize. In
emergency cases, however, as the Board may specify in the public interest, a prescription need not be accomplished on such forms. The prescribing physician, dentist, veterinarian or practitioner shall, within three (3) days after issuing such prescription, inform the DOH of the same in writing. No prescription once served by the drugstore or pharmacy be reused nor any prescription once issued be refilled.

(c) All manufacturers, wholesalers, distributors, importers, dealers and retailers of dangerous drugs and/or controlled precursors and essential chemicals shall keep a record of all inventories, sales, purchases, acquisitions and deliveries of the same as well as the names, addresses and licenses of the persons from whom such items were purchased or acquired or to whom such items were sold or delivered, the name and quantity of the same and the date of the transactions. Such records may be subjected anytime for review by the Board.

**ARTICLE IV**

**Participation of the Family, Students, Teachers and School Authorities in the Enforcement of this Act**

**Section 41. Involvement of the Family.** – The family being the basic unit of the Filipino society shall be primarily responsible for the education and awareness of the members of the family on the ill effects of dangerous drugs and close monitoring of family members who may be susceptible to drug abuse.

**Section 42. Student Councils and Campus Organizations.** – All elementary, secondary and tertiary schools' student councils and campus organizations shall include in their activities a program for the prevention of and deterrence in the use of dangerous drugs, and referral for treatment and rehabilitation of students for drug dependence.

**Section 43. School Curricula.** – Instruction on drug abuse prevention and control shall be integrated in the elementary, secondary and tertiary curricula of all public and private schools, whether general, technical, vocational or agro-industrial as well as in non-formal, informal and indigenous learning systems. Such instructions shall include:

1. Adverse effects of the abuse and misuse of dangerous drugs on the person, the family, the school and the community;
2. Preventive measures against drug abuse;
3. Health, socio-cultural, psychological, legal and economic dimensions and implications of the drug problem;
4. Steps to take when intervention on behalf of a drug dependent is needed, as well as the services available for the treatment and rehabilitation of drug dependents; and
5. Misconceptions about the use of dangerous drugs such as, but not limited to, the importance and safety of dangerous drugs for medical and therapeutic use as well as the differentiation
between medical patients and drug dependents in order to avoid confusion and accidental stigmatization in the consciousness of the students.

Section 44. Heads, Supervisors, and Teachers of Schools. – For the purpose of enforcing the provisions of Article II of this Act, all school heads, supervisors and teachers shall be deemed persons in authority and, as such, are hereby empowered to apprehend, arrest or cause the apprehension or arrest of any person who shall violate any of the said provisions, pursuant to Section 5, Rule 113 of the Rules of Court. They shall be deemed persons in authority if they are in the school or within its immediate vicinity, or even beyond such immediate vicinity if they are in attendance at any school or class function in their official capacity as school heads, supervisors, and teachers.

Any teacher or school employee, who discovers or finds that any person in the school or within its immediate vicinity is liable for violating any of said provisions, shall have the duty to report the same to the school head or immediate superior who shall, in turn, report the matter to the proper authorities.

Failure to do so in either case, within a reasonable period from the time of discovery of the violation shall, after due hearing, constitute sufficient cause for disciplinary action by the school authorities.

Section 45. Publication and Distribution of Materials on Dangerous Drugs. – With the assistance of the Board, the Secretary of the Department of Education (DepEd), the Chairman of the Commission on Higher Education (CHED) and the Director-General of the Technical Education and Skills Development Authority (TESDA) shall cause the development, publication and distribution of information and support educational materials on dangerous drugs to the students, the faculty, the parents, and the community.

Section 46. Special Drug Education Center. – With the assistance of the Board, the Department of the Interior and Local Government (DILG), the National Youth Commission (NYC), and the Department of Social Welfare and Development (DSWD) shall establish in each of its provincial office a special education drug center for out-of-school youth and street children. Such Center which shall be headed by the Provincial Social Welfare Development Officer shall sponsor drug prevention programs and activities and information campaigns with the end in view of educating the out-of-school youth and street children regarding the pernicious effects of drug abuse. The programs initiated by the Center shall likewise be adopted in all public and private orphanage and existing special centers for street children.

ARTICLE V

Promotion of a National Drug-Free Workplace Program With the Participation of Private and Labor Sectors and the Department of Labor and Employment

Section 47. Drug-Free Workplace. – It is deemed a policy of the State to promote drug-free workplaces using a tripartite approach. With the assistance of the Board, the Department of Labor and Employment (DOLE) shall develop, promote and implement a national drug abuse
prevention program in the workplace to be adopted by private companies with ten (10) or more employees. Such program shall include the mandatory drafting and adoption of company policies against drug use in the workplace in close consultation and coordination with the DOLE, labor and employer organizations, human resource development managers and other such private sector organizations.

Section 48. Guidelines for the National Drug-Free Workplace Program. – The Board and the DOLE shall formulate the necessary guidelines for the implementation of the national drug-free workplace program. The amount necessary for the implementation of which shall be included in the annual General Appropriations Act.

ARTICLE VI

Participation of the Private and Labor Sectors in the Enforcement of this Act

Section 49. Labor Organizations and the Private Sector. – All labor unions, federations, associations, or organizations in cooperation with the respective private sector partners shall include in their collective bargaining or any similar agreements, joint continuing programs and information campaigns for the laborers similar to the programs provided under Section 47 of this Act with the end in view of achieving a drug free workplace.

Section 50. Government Assistance. – The labor sector and the respective partners may, in pursuit of the programs mentioned in the preceding Section, secure the technical assistance, such as but not limited to, seminars and information dissemination campaigns of the appropriate government and law enforcement agencies.

ARTICLE VII

Participation of Local Government Units

Section 51. Local Government Units’ Assistance. – Local government units shall appropriate a substantial portion of their respective annual budgets to assist in or enhance the enforcement of this Act giving priority to preventive or educational programs and the rehabilitation or treatment of drug dependents.

Section 52. Abatement of Drug Related Public Nuisances. – Any place or premises which have been used on two or more occasions as the site of the unlawful sale or delivery of dangerous drugs may be declared to be a public nuisance, and such nuisance may be abated, pursuant to the following procedures:

(1) Any city or municipality may, by ordinance, create an administrative board to hear complaints regarding the nuisances;

(2) any employee, officer, or resident of the city or municipality may bring a complaint before the Board after giving not less than three (3) days written notice of such complaint to the owner of the place or premises at his/her last known address; and
(3) After hearing in which the Board may consider any evidence, including evidence of the general reputation of the place or premises, and at which the owner of the premises shall have an opportunity to present evidence in his/her defense, the Board may declare the place or premises to be a public nuisance.

**Section 53. Effect of Board Declaration.** – If the Board declares a place or premises to be a public nuisance, it may declare an order immediately prohibiting the conduct, operation, or maintenance of any business or activity on the premises which is conducive to such nuisance.

An order entered under this Section shall expire after one (1) year or at such earlier time as stated in the order. The Board may bring a complaint seeking a permanent injunction against any nuisance described under this Section.

This Article does not restrict the right of any person to proceed under the Civil Code against any public nuisance.

**ARTICLE VIII**

**Program for Treatment and Rehabilitation of Drug Dependents**

**Section 54. Voluntary Submission of a Drug Dependent to Confinement, Treatment and Rehabilitation.** – A drug dependent or any person who violates Section 15 of this Act may, by himself/herself or through his/her parent, spouse, guardian or relative within the fourth degree of consanguinity or affinity, apply to the Board or its duly recognized representative, for treatment and rehabilitation of the drug dependency. Upon such application, the Board shall bring forth the matter to the Court which shall order that the applicant be examined for drug dependency. If the examination by a DOH-accredited physician results in the issuance of a certification that the applicant is a drug dependent, he/she shall be ordered by the Court to undergo treatment and rehabilitation in a Center designated by the Board for a period of not less than six (6) months: Provided, That a drug dependent may be placed under the care of a DOH-accredited physician where there is no Center near or accessible to the residence of the drug dependent or where said drug dependent is below eighteen (18) years of age and is a first-time offender and non-confinement in a Center will not pose a serious danger to his/her family or the community.

Confinement in a Center for treatment and rehabilitation shall not exceed one (1) year, after which time the Court, as well as the Board, shall be apprised by the head of the treatment and rehabilitation center of the status of said drug dependent and determine whether further confinement will be for the welfare of the drug dependent and his/her family or the community.

**Section 55. Exemption from the Criminal Liability Under the Voluntary Submission Program.** A drug dependent under the voluntary submission program, who is finally discharged from confinement, shall be exempt from the criminal liability under Section 15 of this act subject to the following conditions:

(1) He/she has complied with the rules and regulations of the center, the applicable rules and regulations of the Board, including the after-care and follow-up program for at least eighteen
(18) months following temporary discharge from confinement in the Center or, in the case of a dependent placed under the care of the DOH-accredited physician, the after-care program and follow-up schedule formulated by the DSWD and approved by the Board: Provided, That capability-building of local government social workers shall be undertaken by the DSWD;

(2) He/she has never been charged or convicted of any offense punishable under this Act, the Dangerous Drugs Act of 1972 or Republic Act No. 6425, as amended; the Revised Penal Code, as amended; or any special penal laws;

(3) He/she has no record of escape from a Center: Provided, That had he/she escaped, he/she surrendered by himself/herself or through his/her parent, spouse, guardian or relative within the fourth degree of consanguinity or affinity, within one (1) week from the date of the said escape; and

(4) He/she poses no serious danger to himself/herself, his/her family or the community by his/her exemption from criminal liability.

Section 56. Temporary Release From the Center; After-Care and Follow-Up Treatment Under the Voluntary Submission Program. – Upon certification of the Center that the drug dependent within the voluntary submission program may be temporarily released, the Court shall order his/her release on condition that said drug dependent shall report to the DOH for after-care and follow-up treatment, including urine testing, for a period not exceeding eighteen (18) months under such terms and conditions that the Court may impose.

If during the period of after-care and follow-up, the drug dependent is certified to be rehabilitated, he/she may be discharged by the Court, subject to the provisions of Section 55 of this Act, without prejudice to the outcome of any pending case filed in court.

However, should the DOH find that during the initial after-care and follow-up program of eighteen (18) months, the drug dependent requires further treatment and rehabilitation in the Center, he/she shall be recommitted to the Center for confinement. Thereafter, he/she may again be certified for temporary release and ordered released for another after-care and follow-up program pursuant to this Section.

Section 57. Probation and Community Service Under the Voluntary Submission Program. – A drug dependent who is discharged as rehabilitated by the DOH-accredited Center through the voluntary submission program, but does not qualify for exemption from criminal liability under Section 55 of this Act, may be charged under the provisions of this Act, but shall be placed on probation and undergo a community service in lieu of imprisonment and/or fine in the discretion of the court, without prejudice to the outcome of any pending case filed in court.

Such drug dependent shall undergo community service as part of his/her after-care and follow-up program, which may be done in coordination with nongovernmental civil organizations accredited by the DSWD, with the recommendation of the Board.
Section 58. Filing of Charges Against a Drug Dependent Who is Not Rehabilitated Under the Voluntary Submission Program. – A drug dependent, who is not rehabilitated after the second commitment to the Center under the voluntary submission program, shall, upon recommendation of the Board, be charged for violation of Section 15 of this Act and prosecuted like any other offender. If convicted, he/she shall be credited for the period of confinement and rehabilitation in the Center in the service of his/her sentence.

Section 59. Escape and Recommitment for Confinement and Rehabilitation Under the Voluntary Submission Program. – Should a drug dependent under the voluntary submission program escape from the Center, he/she may submit himself/herself for recommitment within one (1) week therefrom, or his/her parent, spouse, guardian or relative within the fourth degree of consanguinity or affinity may, within said period, surrender him for recommitment, in which case the corresponding order shall be issued by the Board.

Should the escapee fail to submit himself/herself or be surrendered after one (1) week, the Board shall apply to the court for a recommitment order upon proof of previous commitment or his/her voluntary submission by the Board, the court may issue an order for recommitment within one (1) week.

If, subsequent to a recommitment, the dependent once again escapes from confinement, he/she shall be charged for violation of Section 15 of this Act and he subjected under section 61 of this Act, either upon order of the Board or upon order of the court, as the case may be.

Section 60. Confidentiality of Records Under the Voluntary Submission Program. – Judicial and medical records of drug dependents under the voluntary submission program shall be confidential and shall not be used against him for any purpose, except to determine how many times, by himself/herself or through his/her parent, spouse, guardian or relative within the fourth degree of consanguinity or affinity, he/she voluntarily submitted himself/herself for confinement, treatment and rehabilitation or has been committed to a Center under this program.

Section 61. Compulsory Confinement of a Drug Dependent Who Refuses to Apply Under the Voluntary Submission Program. – Notwithstanding any law, rule and regulation to the contrary, any person determined and found to be dependent on dangerous drugs shall, upon petition by the Board or any of its authorized representative, be confined for treatment and rehabilitation in any Center duly designated or accredited for the purpose.

A petition for the confinement of a person alleged to be dependent on dangerous drugs to a Center may be filed by any person authorized by the Board with the Regional Trial Court of the province or city where such person is found.

After the petition is filed, the court, by an order, shall immediately fix a date for the hearing, and a copy of such order shall be served on the person alleged to be dependent on dangerous drugs, and to the one having charge of him.

If after such hearing and the facts so warrant, the court shall order the drug dependent to be examined by two (2) physicians accredited by the Board. If both physicians conclude that the
respondent is not a drug dependent, the court shall order his/her discharge. If either physician finds him to be a dependent, the court shall conduct a hearing and consider all relevant evidence which may be offered. If the court finds him a drug dependent, it shall issue an order for his/her commitment to a treatment and rehabilitation center under the supervision of the DOH. In any event, the order of discharge or order of confinement or commitment shall be issued not later than fifteen (15) days from the filing of the appropriate petition.

Section 62. Compulsory Submission of a Drug Dependent Charged with an Offense to Treatment and Rehabilitation. – If a person charged with an offense where the imposable penalty is imprisonment of less than six (6) years and one (1) day, and is found by the prosecutor or by the court, at any stage of the proceedings, to be a drug dependent, the prosecutor or the court as the case may be, shall suspend all further proceedings and transmit copies of the record of the case to the Board.

In the event he Board determines, after medical examination, that public interest requires that such drug dependent be committed to a center for treatment and rehabilitation, it shall file a petition for his/her commitment with the regional trial court of the province or city where he/she is being investigated or tried: Provided, That where a criminal case is pending in court, such petition shall be filed in the said court. The court shall take judicial notice of the prior proceedings in the case and shall proceed to hear the petition. If the court finds him to be a drug dependent, it shall order his/her commitment to a Center for treatment and rehabilitation. The head of said Center shall submit to the court every four (4) months, or as often as the court may require, a written report on the progress of the treatment. If the dependent is rehabilitated, as certified by the center and the Board, he/she shall be returned to the court, which committed him, for his/her discharge therefrom.

Thereafter, his/her prosecution for any offense punishable by law shall be instituted or shall continue, as the case may be. In case of conviction, the judgment shall, if the accused is certified by the treatment and rehabilitation center to have maintained good behavior, indicate that he/she shall be given full credit for the period he/she was confined in the Center: Provided, however, That when the offense is for violation of Section 15 of this Act and the accused is not a recidivist, the penalty thereof shall be deemed to have been served in the Center upon his/her release therefrom after certification by the Center and the Board that he/she is rehabilitated.

Section 63. Prescription of the Offense Charged Against a Drug Dependent Under the Compulsory Submission Program. – The period of prescription of the offense charged against a drug dependent under the compulsory submission program shall not run during the time that the drug dependent is under confinement in a Center or otherwise under the treatment and rehabilitation program approved by the Board.

Upon certification of the Center that he/she may temporarily be discharged from the said Center, the court shall order his/her release on condition that he/she shall report to the Board through the DOH for after-care and follow-up treatment for a period not exceeding eighteen (18) months under such terms and conditions as may be imposed by the Board.
If at anytime during the after-care and follow-up period, the Board certifies to his/her complete rehabilitation, the court shall order his/her final discharge from confinement and order for the immediate resumption of the trial of the case for which he/she is originally charged. Should the Board through the DOH find at anytime during the after-care and follow-up period that he/she requires further treatment and rehabilitation, it shall report to the court, which shall order his/her recommitment to the Center.

Should the drug dependent, having been committed to a Center upon petition by the Board escape therefrom, he/she may resubmit himself/herself for confinement within one (1) week from the date of his/her escape; or his/her parent, spouse, guardian or relative within the fourth degree of consanguinity or affinity may, within the same period, surrender him for recommitment. If, however, the drug dependent does not resubmit himself/herself for confinement or he/she is not surrendered for recommitment, the Board may apply with the court for the issuance of the recommitment order. Upon proof of previous commitment, the court shall issue an order for recommitment. If, subsequent to such recommitment, he/she should escape again, he/she shall no longer be exempt from criminal liability for use of any dangerous drug.

A drug dependent committed under this particular Section who is finally discharged from confinement shall be exempt from criminal liability under Section 15 of this Act, without prejudice to the outcome of any pending case filed in court. On the other hand, a drug dependent who is not rehabilitated after a second commitment to the Center shall, upon conviction by the appropriate court, suffer the same penalties provided for under Section 15 of this Act again without prejudice to the outcome of any pending case filed in court.

**Section 64. Confidentiality of Records Under the Compulsory Submission Program.** – The records of a drug dependent who was rehabilitated and discharged from the Center under the compulsory submission program, or who was charged for violation of Section 15 of this Act, shall be covered by Section 60 of this Act. However, the records of a drug dependent who was not rehabilitated, or who escaped but did not surrender himself/herself within the prescribed period, shall be forwarded to the court and their use shall be determined by the court, taking into consideration public interest and the welfare of the drug dependent.

**Section 65. Duty of the Prosecutor in the Proceedings.** – It shall be the duty of the provincial or the city prosecutor or their assistants or state prosecutors to prepare the appropriate petition in all proceedings arising from this Act.

**Section 66. Suspension of Sentence of a First-Time Minor Offender.** – An accused who is over fifteen (15) years of age at the time of the commission of the offense mentioned in Section 11 of this Act, but not more than eighteen (18) years of age at the time when judgment should have been promulgated after having been found guilty of said offense, may be given the benefits of a suspended sentence, subject to the following conditions:

(a) He/she has not been previously convicted of violating any provision of this Act, or of the Dangerous Drugs Act of 1972, as amended; or of the Revised Penal Code; or of any special penal laws;
(b) He/she has not been previously committed to a Center or to the care of a DOH-accredited physician; and

c) The Board favorably recommends that his/her sentence be suspended.

While under suspended sentence, he/she shall be under the supervision and rehabilitative surveillance of the Board, under such conditions that the court may impose for a period ranging from six (6) months to eighteen (18) months.

Upon recommendation of the Board, the court may commit the accused under suspended sentence to a Center, or to the care of a DOH-accredited physician for at least six (6) months, with after-care and follow-up program for not more than eighteen (18) months.

In the case of minors under fifteen (15) years of age at the time of the commission of any offense penalized under this Act, Article 192 of Presidential Decree No. 603, otherwise known as the Child and Youth Welfare Code, as amended by Presidential Decree No. 1179 shall apply, without prejudice to the application of the provisions of this Section.

Section 67. Discharge After Compliance with Conditions of Suspended Sentence of a First-Time Minor Offender. – If the accused first time minor offender under suspended sentence complies with the applicable rules and regulations of the Board, including confinement in a Center, the court, upon a favorable recommendation of the Board for the final discharge of the accused, shall discharge the accused and dismiss all proceedings.

Upon the dismissal of the proceedings against the accused, the court shall enter an order to expunge all official records, other than the confidential record to be retained by the DOJ relating to the case. Such an order, which shall be kept confidential, shall restore the accused to his/her status prior to the case. He/she shall not be held thereafter to be guilty of perjury or of concealment or misrepresentation by reason of his/her failure to acknowledge the case or recite any fact related thereto in response to any inquiry made of him for any purpose.

Section 68. Privilege of Suspended Sentence to be Availed of Only Once by a First-Time Minor Offender. – The privilege of suspended sentence shall be availed of only once by an accused drug dependent who is a first-time offender over fifteen (15) years of age at the time of the commission of the violation of Section 15 of this Act but not more than eighteen (18) years of age at the time when judgment should have been promulgated.

Section 69. Promulgation of Sentence for First-Time Minor Offender. – If the accused first-time minor offender violates any of the conditions of his/her suspended sentence, the applicable rules and regulations of the Board exercising supervision and rehabilitative surveillance over him, including the rules and regulations of the Center should confinement be required, the court shall pronounce judgment of conviction and he/she shall serve sentence as any other convicted person.

Section 70. Probation or Community Service for a First-Time Minor Offender in Lieu of Imprisonment. – Upon promulgation of the sentence, the court may, in its discretion, place the accused under probation, even if the sentence provided under this Act is higher than that
provided under existing law on probation, or impose community service in lieu of imprisonment. In case of probation, the supervision and rehabilitative surveillance shall be undertaken by the Board through the DOH in coordination with the Board of Pardons and Parole and the Probation Administration. Upon compliance with the conditions of the probation, the Board shall submit a written report to the court recommending termination of probation and a final discharge of the probationer, whereupon the court shall issue such an order.

The community service shall be complied with under conditions, time and place as may be determined by the court in its discretion and upon the recommendation of the Board and shall apply only to violators of Section 15 of this Act. The completion of the community service shall be under the supervision and rehabilitative surveillance of the Board during the period required by the court. Thereafter, the Board shall render a report on the manner of compliance of said community service. The court in its discretion may require extension of the community service or order a final discharge.

In both cases, the judicial records shall be covered by the provisions of Sections 60 and 64 of this Act. If the sentence promulgated by the court requires imprisonment, the period spent in the Center by the accused during the suspended sentence period shall be deducted from the sentence to be served.

Section 71. Records to be kept by the Department of Justice. – The DOJ shall keep a confidential record of the proceedings on suspension of sentence and shall not be used for any purpose other than to determine whether or not a person accused under this Act is a first-time minor offender.

Section 72. Liability of a Person Who Violates the Confidentiality of Records. – The penalty of imprisonment ranging from six (6) months and one (1) day to six (6) years and a fine ranging from One thousand pesos (P1,000.00) to Six thousand pesos (P6,000.00), shall be imposed upon any person who, having official custody of or access to the confidential records of any drug dependent under voluntary submission programs, or anyone who, having gained possession of said records, whether lawfully or not, reveals their content to any person other than those charged with the prosecution of the offenses under this Act and its implementation. The maximum penalty shall be imposed, in addition to absolute perpetual disqualification from any public office, when the offender is a government official or employee. Should the records be used for unlawful purposes, such as blackmail of the drug dependent or the members of his/her family, the penalty imposed for the crime of violation of confidentiality shall be in addition to whatever crime he/she may be convicted of.

Section 73. Liability of a Parent, Spouse or Guardian Who Refuses to Cooperate with the Board or any Concerned Agency. – Any parent, spouse or guardian who, without valid reason, refuses to cooperate with the Board or any concerned agency in the treatment and rehabilitation of a drug dependent who is a minor, or in any manner, prevents or delays the after-care, follow-up or other programs for the welfare of the accused drug dependent, whether under voluntary submission program or compulsory submission program, may be cited for contempt by the court.

Section 74. Cost-Sharing in the Treatment and Rehabilitation of a Drug Dependent. – The parent, spouse, guardian or any relative within the fourth degree of consanguinity of any person
who is confined under the voluntary submission program or compulsory submission program shall be charged a certain percentage of the cost of his/her treatment and rehabilitation, the guidelines of which shall be formulated by the DSWD taking into consideration the economic status of the family of the person confined. The guidelines therein formulated shall be implemented by a social worker of the local government unit.

Section 75. Treatment and Rehabilitation Centers. – The existing treatment and rehabilitation centers for drug dependents operated and maintained by the NBI and the PNP shall be operated, maintained and managed by the DOH in coordination with other concerned agencies. For the purpose of enlarging the network of centers, the Board through the DOH shall encourage, promote or whenever feasible, assist or support in the establishment, operations and maintenance of private centers which shall be eligible to receive grants, donations or subsidy from either government or private sources. It shall also support the establishment of government-operated regional treatment and rehabilitation centers depending upon the availability of funds. The national government, through its appropriate agencies shall give priority funding for the increase of subsidy to existing government drug rehabilitation centers, and shall establish at least one (1) drug rehabilitation center in each province, depending on the availability of funds.

Section 76. The Duties and Responsibilities of the Department of health (DOH) Under this Act. – The DOH shall:

1. Oversee the monitor the integration, coordination and supervision of all drug rehabilitation, intervention, after-care and follow-up programs, projects and activities as well as the establishment, operations, maintenance and management of privately-owned drug treatment rehabilitation centers and drug testing networks and laboratories throughout the country in coordination with the DSWD and other agencies;

2. License, accredit, establish and maintain drug test network and laboratory, initiate, conduct and support scientific research on drugs and drug control;

3. Encourage, assist and accredit private centers, promulgate rules and regulations setting minimum standards for their accreditation to assure their competence, integrity and stability;

4. Prescribe and promulgate rules and regulations governing the establishment of such Centers as it may deem necessary after conducting a feasibility study thereof;

5. The DOH shall, without prejudice to the criminal prosecution of those found guilty of violating this Act, order the closure of a Center for treatment and rehabilitation of drug dependency when, after investigation it is found guilty of violating the provisions of this Act or regulations issued by the Board; and

6. Charge reasonable fees for drug dependency examinations, other medical and legal services provided to the public, which shall accrue to the Board. All income derived from these sources shall be part of the funds constituted as special funds for the implementation of this Act under Section 87.
ARTICLE IX

Dangerous Drugs Board and Philippine Drug Enforcement Agency

Section 77. The Dangerous Drugs Board. – The Board shall be the policy-making and strategy-formulating body in the planning and formulation of policies and programs on drug prevention and control. It shall develop and adopt a comprehensive, integrated, unified and balanced national drug abuse prevention and control strategy. It shall be under the Office of the President.

Section 78. Composition of the Board. – The Board shall be composed of seventeen (17) members wherein three (3) of which are permanent members, the other twelve (12) members shall be in an ex officio capacity and the two (2) shall be regular members.

The three (3) permanent members, who shall possess at least seven-year training and experience in the field of dangerous drugs and in any of the following fields: in law, medicine, criminology, psychology or social work, shall be appointed by the President of the Philippines. The President shall designate a Chairman, who shall have the rank of a secretary from among the three (3) permanent members who shall serve for six (6) years. Of the two (2) other members, who shall both have the rank of undersecretary, one (1) shall serve for four (4) years and the other for two (2) years. Thereafter, the persons appointed to succeed such members shall hold office for a term of six (6) years and until their successors shall have been duly appointed and qualified.

The other twelve (12) members who shall be ex officio members of the Board are the following:

(1) Secretary of the Department of Justice or his/her representative;

(2) Secretary of the Department of Health or his/her representative;

(3) Secretary of the Department of National Defense or his/her representative;

(4) Secretary of the Department of Finance or his/her representative;

(5) Secretary of the Department of Labor and Employment or his/her representative;

(6) Secretary of the Department of the Interior and Local Government or his/her representative;

(7) Secretary of the Department of Social Welfare and Development or his/her representative;

(8) Secretary of the Department of Foreign Affairs or his/her representative;

(9) Secretary of the Department of Education or his/her representative;

(10) Chairman of the Commission on Higher Education or his/her representative;

(11) Chairman of the National Youth Commission;
(12) Director General of the Philippine Drug Enforcement Agency.

Cabinet secretaries who are members of the Board may designate their duly authorized and permanent representatives whose ranks shall in no case be lower than undersecretary.

The two (2) regular members shall be as follows:

(a) The president of the Integrated Bar of the Philippines; and

(b) The chairman or president of a non-government organization involved in dangerous drug campaign to be appointed by the President of the Philippines.

The Director of the NBI and the Chief of the PNP shall be the permanent consultants of the Board, and shall attend all the meetings of the Board.

All members of the Board as well as its permanent consultants shall receive a per diem for every meeting actually attended subject to the pertinent budgetary laws, rules and regulations on compensation, honoraria and allowances: Provided, That where the representative of an ex officio member or of the permanent consultant of the Board attends a meeting in behalf of the latter, such representative shall be entitled to receive the per diem.

Section 79. Meetings of the Board. – The Board shall meet once a week or as often as necessary at the discretion of the Chairman or at the call of any four (4) other members. The presence of nine (9) members shall constitute a quorum.

Section 80. Secretariat of the Board. – The Board shall recommend to the President of the Philippines the appointment of an Executive Director, with the rank of an undersecretary, who shall be the Secretary of the Board and administrative officer of its secretariat, and shall perform such other duties that may be assigned to him/her. He/she must possess adequate knowledge, training and experience in the field of dangerous drugs, and in any of the following fields: law enforcement, law, medicine, criminology, psychology or social work.

Two deputies executive director, for administration and operations, with the ranks of assistant secretary, shall be appointed by the President upon recommendation of the Board. They shall possess the same qualifications as those of the executive director. They shall receive a salary corresponding to their position as prescribed by the Salary Standardization Law as a Career Service Officer.

The existing secretariat of the Board shall be under the administrative control and supervision of the Executive Director. It shall be composed of the following divisions, namely: Policy Studies, Research and Statistics; Preventive Education, Training and Information; Legal Affairs; and the Administrative and Financial Management.

Section 81. Powers and Duties of the Board. – The Board shall:
(a) Formulate, develop and establish a comprehensive, integrated, unified and balanced national drug use prevention and control strategy;

(b) Promulgate such rules and regulations as may be necessary to carry out the purposes of this Act, including the manner of safekeeping, disposition, burning or condemnation of any dangerous drug and/or controlled precursor and essential chemical under its charge and custody, and prescribe administrative remedies or sanctions for the violations of such rules and regulations;

(c) Conduct policy studies, program monitoring and evaluations and other researches on drug prevention, control and enforcement;

(d) Initiate, conduct and support scientific, clinical, social, psychological, physical and biological researches on dangerous drugs and dangerous drugs prevention and control measures;

(e) Develop an educational program and information drive on the hazards and prevention of illegal use of any dangerous drug and/or controlled precursor and essential chemical based on factual data, and disseminate the same to the general public, for which purpose the Board shall endeavor to make the general public aware of the hazards of any dangerous drugs and/or controlled precursor and essential chemical by providing among others, literature, films, displays or advertisements and by coordinating with all institutions of learning as well as with all national and local enforcement agencies in planning and conducting its educational campaign programs to be implemented by the appropriate government agencies;

(f) Conduct continuing seminars for, and consultations with, and provide information materials to judges and prosecutors in coordination with the Office of the Court Administrator, in the case of judges, and the DOJ, in the case of prosecutors, which aim to provide them with the current developments and programs of the Board pertinent to its campaign against dangerous drugs and its scientific researches on dangerous drugs, its prevention and control measures;

(g) Design special trainings in order to provide law enforcement officers, members of the judiciary, and prosecutors, school authorities and personnel of centers with knowledge and know-how in dangerous drugs and/or controlled precursors and essential chemicals control in coordination with the Supreme Court to meet the objectives of the national drug control programs;

(h) Design and develop, in consultation and coordination with the DOH, DSWD and other agencies involved in drugs control, treatment and rehabilitation, both public and private, a national treatment and rehabilitation program for drug dependents including a standard aftercare and community service program for recovering drug dependents;

(i) Design and develop, jointly with the DOLE and in consultation with labor and employer groups as well as nongovernment organizations a drug abuse prevention program in the workplace that would include a provision for employee assistance programs for emotionally-stressed employees;
(j) Initiate and authorize closure proceedings against non-accredited and/or substandard rehabilitation centers based on verified reports of human rights violations, subhuman conditions, inadequate medical training and assistance and excessive fees for implementation by the PDEA;

(k) Prescribe and promulgate rules and regulations governing the establishment of such centers, networks and laboratories as deemed necessary after conducting a feasibility study in coordination with the DOH and other government agencies;

(l) Receive, gather, collect and evaluate all information on the importation, exportation, production, manufacture, sale, stocks, seizures of and the estimated need for any dangerous drug and/or controlled precursor and essential chemical, for which purpose the Board may require from any official, instrumentality or agency of the government or any private person or enterprise dealing in, or engaged in activities having to do with any dangerous drug and/or controlled precursors and essential chemicals such data or information as it may need to implement this Act;

(m) Gather and prepare detailed statistics on the importation, exportation, manufacture, stocks, seizures of and estimates need for any dangerous drug and/or controlled precursors and essential chemicals and such other statistical data on said drugs as may be periodically required by the United Nations Narcotics Drug Commission, the World Health Organization and other international organizations in consonance with the country's international commitments;

(n) Develop and maintain international networking coordination with international drug control agencies and organizations, and implement the provisions of international conventions and agreements thereon which have been adopted and approved by the Congress of the Philippines;

(o) Require all government and private hospitals, clinics, doctors, dentists and other practitioners to submit a report to it, in coordination with the PDEA, about all dangerous drugs and/or controlled precursors and essential chemicals-related cases to which they have attended for statistics and research purposes;

(p) Receive in trust legacies, gifts and donations of real and personal properties of all kinds, to administer and dispose the same when necessary for the benefit of government and private rehabilitation centers subject to limitations, directions and instructions from the donors, if any;

(q) Issue guidelines as to the approval or disapproval of applications for voluntary treatment, rehabilitation or confinement, wherein it shall issue the necessary guidelines, rules and regulations pertaining to the application and its enforcement;

(r) Formulate guidelines, in coordination with other government agencies, the importation, distribution, production, manufacture, compounding, prescription, dispensing and sale of, and other lawful acts in connection with any dangerous drug, controlled precursors and essential chemicals and other similar or analogous substances of such kind and in such quantity as it may deem necessary according to the medical and research needs or requirements of the country including diet pills containing ephedrine and other addictive chemicals and determine the quantity and/or quality of dangerous drugs and controlled precursors and essential chemicals to
be imported, manufactured and held in stock at any given time by authorized importer, manufacturer or distributor of such drugs;

(s) Develop the utilization of a controlled delivery scheme in addressing the transshipment of dangerous drugs into and out of the country to neutralize transnational crime syndicates involved in illegal trafficking of any dangerous drugs and/or controlled precursors and essential chemicals;

(t) Recommend the revocation of the professional license of any practitioner who is an owner, co-owner, lessee, or in the employ of the drug establishment, or manager of a partnership, corporation, association, or any juridical entity owning and/or controlling such drug establishment, and who knowingly participates in, or consents to, tolerates, or abets the commission of the act of violations as indicated in the preceding paragraph, all without prejudice to the criminal prosecution of the person responsible for the said violation;

(u) Appoint such technical, administrative and other personnel as may be necessary for the effective implementation of this Act, subject to the Civil Service Law and its rules and regulations;

(v) Establish a regular and continuing consultation with concerned government agencies and medical professional organizations to determine if balance exists in policies, procedures, rules and regulations on dangerous drugs and to provide recommendations on how the lawful use of dangerous drugs can be improved and facilitated; and

(w) Submit an annual and periodic reports to the President, the Congress of the Philippines and the Senate and House of Representatives committees concerned as may be required from time to time, and perform such other functions as may be authorized or required under existing laws and as directed by the President himself/herself or as recommended by the congressional committees concerned.

Section 82. Creation of the Philippine Drug Enforcement Agency (PDEA). – To carry out the provisions of this Act, the PDEA, which serves as the implementing arm of the Board, and shall be responsible for the efficient and effective law enforcement of all the provisions on any dangerous drug and/or controlled precursor and essential chemical as provided in this Act.

The PDEA shall be headed by a Director General with the rank of Undersecretary, who shall be responsible for the general administration and management of the Agency. The Director General of the PDEA shall be appointed by the President of the Philippines and shall perform such other duties that may be assigned to him/her. He/she must possess adequate knowledge, training and experience in the field of dangerous drugs, and in any of the following fields: law enforcement, law, medicine, criminology, psychology or social work.

The Director General of the PDEA shall be assisted in the performance of his/her duties and responsibilities by two (2) deputies director general with the rank of Assistant Secretary; one for Operations and the other one for Administration. The two (2) deputies director general shall likewise be appointed by the President of the Philippines upon recommendation of the Board.
The two (2) deputies director general shall possess the same qualifications as those of the Director General of the PDEA. The Director General and the two (2) deputies director general shall receive the compensation and salaries as prescribed by law.

Section 83. Organization of the PDEA. – The present Secretariat of the National Drug Law Enforcement and Prevention Coordinating Center as created by Executive Order No. 61 shall be accordingly modified and absorbed by the PDEA.

The Director General of the PDEA shall be responsible for the necessary changes in the organizational set-up which shall be submitted to the Board for approval.

For purposes of carrying out its duties and powers as provided for in the succeeding Section of this Act, the PDEA shall have the following Services, namely: Intelligence and Investigation; International Cooperation and Foreign Affairs; Preventive Education and Community Involvement; Plans and Operations; Compliance; Legal and Prosecution; Administrative and Human Resource; Financial Management; Logistics Management; and Internal Affairs.

The PDEA shall establish and maintain regional offices in the different regions of the country which shall be responsible for the implementation of this Act and the policies, programs, and projects of said agency in their respective regions.

Section 84. Powers and Duties of the PDEA. – The PDEA shall:

(a) Implement or cause the efficient and effective implementation of the national drug control strategy formulated by the Board thereby carrying out a national drug campaign program which shall include drug law enforcement, control and prevention campaign with the assistance of concerned government agencies;

(b) Undertake the enforcement of the provisions of Article II of this Act relative to the unlawful acts and penalties involving any dangerous drug and/or controlled precursor and essential chemical and investigate all violators and other matters involved in the commission of any crime relative to the use, abuse or trafficking of any dangerous drug and/or controlled precursor and essential chemical as provided for in this Act and the provisions of Presidential Decree No. 1619;

(c) Administer oath, issue subpoena and subpoena duces tecum relative to the conduct of investigation involving the violations of this Act;

(d) Arrest and apprehend as well as search all violators and seize or confiscate, the effects or proceeds of the crimes as provided by law and take custody thereof, for this purpose the prosecutors and enforcement agents are authorized to possess firearms, in accordance with existing laws;

(e) Take charge and have custody of all dangerous drugs and/or controlled precursors and essential chemicals seized, confiscated or surrendered to any national, provincial or local law enforcement agency, if no longer needed for purposes of evidence in court;
(f) Establish forensic laboratories in each PNP office in every province and city in order to facilitate action on seize or confiscated drugs, thereby hastening its destruction without delay;

(g) Recommend to the DOJ the forfeiture of properties and other assets of persons and/or corporations found to be violating the provisions of this Act and in accordance with the pertinent provisions of the Anti-Money-Laundering Act of 2001;

(h) Prepare for prosecution or cause the filing of appropriate criminal and civil cases for violation of all laws on dangerous drugs, controlled precursors and essential chemicals, and other similar controlled substances, and assist, support and coordinate with other government agencies for the proper and effective prosecution of the same;

(i) Monitor and if warranted by circumstances, in coordination with the Philippine Postal Office and the Bureau of Customs, inspect all air cargo packages, parcels and mails in the central post office, which appear from the package and address itself to be a possible importation of dangerous drugs and/or controlled precursors and essential chemicals, through on-line or cyber shops via the internet or cyberspace;

(j) Conduct eradication programs to destroy wild or illegal growth of plants from which dangerous drugs may be extracted;

(k) Initiate and undertake the formation of a nationwide organization which shall coordinate and supervise all activities against drug abuse in every province, city, municipality and barangay with the active and direct participation of all such local government units and nongovernmental organizations, including the citizenry, subject to the provisions of previously formulated programs of action against dangerous drugs;

(l) Establish and maintain a national drug intelligence system in cooperation with law enforcement agencies, other government agencies/offices and local government units that will assist in its apprehension of big-time drug lords;

(m) Establish and maintain close coordination, cooperation and linkages with international drug control and administration agencies and organizations, and implement the applicable provisions of international conventions and agreements related to dangerous drugs to which the Philippines is a signatory;

(n) Create and maintain an efficient special enforcement unit to conduct an investigation, file charges and transmit evidence to the proper court, wherein members of the said unit shall possess suitable and adequate firearms for their protection in connection with the performance of their duties: Provided, That no previous special permit for such possession shall be required;

(o) Require all government and private hospitals, clinics, doctors, dentists and other practitioners to submit a report to it, in coordination with the Board, about all dangerous drugs and/or controlled precursors and essential chemicals which they have attended to for data and information purposes;
(p) Coordinate with the Board for the facilitation of the issuance of necessary guidelines, rules and regulations for the proper implementation of this Act;

(q) Initiate and undertake a national campaign for drug prevention and drug control programs, where it may enlist the assistance of any department, bureau, office, agency or instrumentality of the government, including government-owned and or –controlled corporations, in the anti-illegal drugs drive, which may include the use of their respective personnel, facilities, and resources for a more resolute detection and investigation of drug-related crimes and prosecution of the drug traffickers; and

(r) Submit an annual and periodic reports to the Board as may be required from time to time, and perform such other functions as may be authorized or required under existing laws and as directed by the President himself/herself or as recommended by the congressional committees concerned.

Section 85. The PDEA Academy. – Upon the approval of the Board, the PDEA Academy shall be established either in Baguio or Tagaytay City, and in such other places as may be necessary. The PDEA Academy shall be responsible in the recruitment and training of all PDEA agents and personnel. The Board shall provide for the qualifications and requirements of its recruits who must be at least twenty-one (21) years old, of proven integrity and honesty and a Baccalaureate degree holder.

The graduates of the Academy shall later comprise the operating units of the PDEA after the termination of the transition period of five (5) years during which all the intelligence network and standard operating procedures of the PDEA has been set up and operationalized.

The Academy shall be headed by a Superintendent, with the rank of Director. He/she shall be appointed by the PDEA Director General.

Section 86. Transfer, Absorption, and Integration of All Operating Units on Illegal Drugs into the PDEA and Transitory Provisions. – The Narcotics Group of the PNP, the Narcotics Division of the NBI and the Customs Narcotics Interdiction Unit are hereby abolished; however they shall continue with the performance of their task as detail service with the PDEA, subject to screening, until such time that the organizational structure of the Agency is fully operational and the number of graduates of the PDEA Academy is sufficient to do the task themselves: Provided, That such personnel who are affected shall have the option of either being integrated into the PDEA or remain with their original mother agencies and shall, thereafter, be immediately reassigned to other units therein by the head of such agencies. Such personnel who are transferred, absorbed and integrated in the PDEA shall be extended appointments to positions similar in rank, salary, and other emoluments and privileges granted to their respective positions in their original mother agencies.

The transfer, absorption and integration of the different offices and units provided for in this Section shall take effect within eighteen (18) months from the effectivity of this Act: Provided, That personnel absorbed and on detail service shall be given until five (5) years to finally decide to join the PDEA.
Nothing in this Act shall mean a diminution of the investigative powers of the NBI and the PNP on all other crimes as provided for in their respective organic laws: Provided, however, That when the investigation being conducted by the NBI, PNP or any ad hoc anti-drug task force is found to be a violation of any of the provisions of this Act, the PDEA shall be the lead agency. The NBI, PNP or any of the task force shall immediately transfer the same to the PDEA: Provided, further, That the NBI, PNP and the Bureau of Customs shall maintain close coordination with the PDEA on all drug related matters.

ARTICLE X

Appropriations, Management of Funds and Annual Report

Section 87. Appropriations. – The amount necessary for the operation of the Board and the PDEA shall be charged against the current year's appropriations of the Board, the National Drug Law Enforcement and Prevention Coordinating Center, the Narcotics Group of the PNP, the Narcotics Division of the NBI and other drug abuse units of the different law enforcement agencies integrated into the PDEA in order to carry out the provisions of this Act. Thereafter, such sums as may be necessary for the continued implementation of this Act shall be included in the annual General Appropriations Act.

All receipts derived from fines, fees and other income authorized and imposed in this Act, including ten percent (10%) of all unclaimed and forfeited sweepstakes and lotto prizes but not less than twelve million pesos (P12,000,000.00) per year from the Philippine Charity Sweepstakes Office (PCSO), are hereby constituted as a special account in the general fund for the implementation of this Act: Provided, That no amount shall be disbursed to cover the operating expenses of the Board and other concerned agencies: Provided, further, That at least fifty percent (50%) of all the funds shall be reserved for assistance to government-owned and/or operated rehabilitation centers.

The fines shall be remitted to the Board by the court imposing such fines within thirty (30) days from the finality of its decisions or orders. The unclaimed and forfeited prizes shall be turned over to the Board by the PCSO within thirty (30) days after these are collected and declared forfeited.

A portion of the funds generated by the Philippine Amusement and Gaming Corporation (PAGCOR) in the amount of Five million pesos (P5,000,000.00) a month shall be set aside for the purpose of establishing adequate drug rehabilitation centers in the country and also for the maintenance and operations of such centers: Provided, That the said amount shall be taken from the fifty percent (50%) share of the National Government in the income of PAGCOR: Provided, further, That the said amount shall automatically be remitted by PAGCOR to the Board. The amount shall, in turn, be disbursed by the Dangerous Drugs Board, subject to the rules and regulations of the Commission on Audit (COA).

The fund may be augmented by grants, donations, and endowment from various sources, domestic or foreign, for purposes related to their functions, subject to the existing guidelines set by the government.
Section 88. Management of Funds Under this Act; Annual Report by the Board and the PDEA. – The Board shall manage the funds as it may deem proper for the attainment of the objectives of this Act. In addition to the periodic reports as may be required under this Act, the Chairman of the Board shall submit to the President of the Philippines and to the presiding officers of both houses of Congress, within fifteen (15) days from the opening of the regular session, an annual report on the dangerous drugs situation in the country which shall include detailed account of the programs and projects undertaken, statistics on crimes related to dangerous drugs, expenses incurred pursuant to the provisions of this Act, recommended remedial legislation, if needed, and such other relevant facts as it may deem proper to cite.

Section 89. Auditing the Accounts and Expenses of the Board and the PDEA. – All accounts and expenses of the Board and the PDEA shall be audited by the COA or its duly authorized representative.

ARTICLE XI

Jurisdiction Over Dangerous Drugs Cases

Section 90. Jurisdiction. – The Supreme Court shall designate special courts from among the existing Regional Trial Courts in each judicial region to exclusively try and hear cases involving violations of this Act. The number of courts designated in each judicial region shall be based on the population and the number of cases pending in their respective jurisdiction.

The DOJ shall designate special prosecutors to exclusively handle cases involving violations of this Act.

The preliminary investigation of cases filed under this Act shall be terminated within a period of thirty (30) days from the date of their filing.

When the preliminary investigation is conducted by a public prosecutor and a probable cause is established, the corresponding information shall be filed in court within twenty-four (24) hours from the termination of the investigation. If the preliminary investigation is conducted by a judge and a probable cause is found to exist, the corresponding information shall be filed by the proper prosecutor within forty-eight (48) hours from the date of receipt of the records of the case.

Trial of the case under this Section shall be finished by the court not later than sixty (60) days from the date of the filing of the information. Decision on said cases shall be rendered within a period of fifteen (15) days from the date of submission of the case for resolution.

Section 91. Responsibility and Liability of Law Enforcement Agencies and other Government Officials and Employees in Testifying as Prosecution Witnesses in Dangerous Drugs Cases. – Any member of law enforcement agencies or any other government official and employee who, after due notice, fails or refuses intentionally or negligently, to appear as a witness for the prosecution in any proceedings, involving violations of this Act, without any valid reason, shall be punished with imprisonment of not less than twelve (12) years and one (1) day to twenty (20) years and a fine of not less than Five hundred thousand pesos (P500,000.00), in addition to the
administrative liability he/she may be meted out by his/her immediate superior and/or appropriate body.

The immediate superior of the member of the law enforcement agency or any other government employee mentioned in the preceding paragraph shall be penalized with imprisonment of not less than two (2) months and one (1) day but not more than six (6) years and a fine of not less than Ten thousand pesos (P10,000.00) but not more than Fifty thousand pesos (P50,000.00) and in addition, perpetual absolute disqualification from public office if despite due notice to them and to the witness concerned, the former does not exert reasonable effort to present the latter to the court.

The member of the law enforcement agency or any other government employee mentioned in the preceding paragraphs shall not be transferred or re-assigned to any other government office located in another territorial jurisdiction during the pendency of the case in court. However, the concerned member of the law enforcement agency or government employee may be transferred or re-assigned for compelling reasons: Provided, That his/her immediate superior shall notify the court where the case is pending of the order to transfer or re-assign, within twenty-four (24) hours from its approval; Provided, further, That his/her immediate superior shall be penalized with imprisonment of not less than two (2) months and one (1) day but not more than six (6) years and a fine of not less than Ten thousand pesos (P10,000.00) but not more than Fifty thousand pesos (P50,000.00) and in addition, perpetual absolute disqualification from public office, should he/she fail to notify the court of such order to transfer or re-assign.

Prosecution and punishment under this Section shall be without prejudice to any liability for violation of any existing law.

Section 92. Delay and Bungling in the Prosecution of Drug Cases. – Any government officer or employee tasked with the prosecution of drug-related cases under this act, who, through patent laxity, inexcusable neglect, unreasonable delay or deliberately causes the unsuccessful prosecution and/or dismissal of the said drug cases, shall suffer the penalty of imprisonment ranging from twelve (12) years and one (1) day to twenty (20) years without prejudice to his/her prosecution under the pertinent provisions of the Revised Penal Code.

Section 93. Reclassification, Addition or Removal of Any Drug from the List of Dangerous Drugs. – The Board shall have the power to reclassify, add to or remove from the list of dangerous drugs. Proceedings to reclassify, add, or remove a drug or other substance may be initiated by the PDEA, the DOH, or by petition from any interested party, including the manufacturer of a drug, a medical society or association, a pharmacy association, a public interest group concerned with drug abuse, a national or local government agency, or an individual citizen. When a petition is received by the Board, it shall immediately begin its own investigation of the drug. The PDEA also may begin an investigation of a drug at any time based upon the information received from law enforcement laboratories, national and local law enforcement and regulatory agencies, or other sources of information.

The Board after notice and hearing shall consider the following factors with respect to each substance proposed to be reclassified, added or removed from control:
(a) Its actual or relative potential for abuse;
(b) Scientific evidence of its pharmacological effect if known;
(c) The state of current scientific knowledge regarding the drug or other substance;
(d) Its history and current pattern of abuse;
(e) The scope, duration, and significance of abuse;
(f) Risk to public health; and
(g) Whether the substance is an immediate precursor of a substance already controlled under this Act.

The Board shall also take into accord the obligations and commitments to international treaties, conventions and agreements to which the Philippines is a signatory.

The Dangerous Drugs Board shall give notice to the general public of the public hearing of the reclassification, addition to or removal from the list of any drug by publishing such notice in any newspaper of general circulation once a week for two (2) weeks.

The effect of such reclassification, addition or removal shall be as follows:

(a) In case a dangerous drug is reclassified as precursors and essential chemicals, the penalties for the violations of this Act involving the two latter categories of drugs shall, in case of conviction, be imposed in all pending criminal prosecutions;

(b) In case a precursors and essential chemicals is reclassified as dangerous drug, the penalties for violations of the Act involving precursors and essential chemicals shall, in case of conviction, be imposed in all pending criminal prosecutions;

(c) In case of the addition of a new drug to the list of dangerous drugs and precursors and essential chemicals, no criminal liability involving the same under this Act shall arise until after the lapse of fifteen (15) days from the last publication of such notice;

(d) In case of removal of a drug from the list of dangerous drugs and precursors and essential chemicals, all persons convicted and/or detained for the use and/or possession of such a drug shall be automatically released and all pending criminal prosecution involving such a drug under this Act shall forthwith be dismissed; and

(e) The Board shall, within five (5) days from the date of its promulgation submit to Congress a detailed reclassification, addition, or removal of any drug from the list of dangerous drugs.
ARTICLE XII

Implementing Rules and Regulations

Section 94. Implementing Rules and Regulations. – The present Board in consultation with the DOH, DILG, DOJ, DepEd, DSWD, DOLE, PNP, NBI, PAGCOR and the PCSO and all other concerned government agencies shall promulgate within sixty (60) days the Implementing Rules and Regulations that shall be necessary to implement the provisions of this Act.

ARTICLE XIII

Final Provisions

Section 95. Congressional Oversight Committee. – There is hereby created a Congressional Oversight Committee composed of seven (7) Members from the Senate and seven (7) Members from the House of Representatives. The Members from the Senate shall be appointed by the Senate President based on the proportional representation of the parties or coalitions therein with at least two (2) Senators representing the Minority. The Members from the House of Representatives shall be appointed by the Speaker, also based on proportional representation of the parties or coalitions therein with at least two (2) Members representing the Minority.

The Committee shall be headed by the respective Chairpersons of the Senate Committee on Public Order and Illegal Drugs and the House of Representatives Committee on Dangerous Drugs.

Section 96. Powers and Functions of the Oversight Committee. – The Oversight Committee on Dangerous Drugs shall, in aid of legislation, perform the following functions, among others:

(a) To set the guidelines and overall framework to monitor and ensure the proper implementation of this Act;

(b) To ensure transparency and require the submission of reports from government agencies concerned on the conduct of programs, projects and policies relating to the implementation of this act;

(c) To approve the budget for the programs of the Oversight Committee on Dangerous Drugs and all disbursements therefrom, including compensation of all personnel;

(d) To submit periodic reports to the President of the Philippines and Congress on the implementation of the provisions of this Act;

(e) To determine inherent weaknesses in the law and recommend the necessary remedial legislation or executive measures; and
(f) To perform such other duties, functions and responsibilities as may be necessary to effectively attain the objectives of this Act.

**Section 97. Adoption of Committee Rules and Regulations, and Funding.** – The Oversight Committee on Dangerous Drugs shall adopt its internal rules of procedure, conduct hearings and receive testimonies, reports, and technical advice, invite or summon by *subpoena ad testificandum* any public official, private citizen, or any other person to testify before it, or require any person by *subpoena duces tecum* documents or other materials as it may require consistent with the provisions of this Act.

The Oversight Committee on Dangerous Drugs shall be assisted by a secretariat to be composed by personnel who may be seconded from the Senate and the House of Representatives and may retain consultants.

To carry out the powers and functions of the Oversight Committee on Dangerous Drugs, the initial sum of Twenty-five million pesos (P25,000,000.00) shall be charged against the current appropriations of the Senate. Thereafter, such amount necessary for its continued operations shall be included in the annual General Appropriations Act.

The Oversight Committee on Dangerous Drugs shall exist for a period of ten (10) years from the effectivity of this Act and may be extended by a joint concurrent resolution.

**Section 98. Limited Applicability of the Revised Penal Code.** – Notwithstanding any law, rule or regulation to the contrary, the provisions of the Revised Penal Code (Act No. 3814), as amended, shall not apply to the provisions of this Act, except in the case of minor offenders. Where the offender is a minor, the penalty for acts punishable by life imprisonment to death provided herein shall be *reclusion perpetua* to death.

**Section 99. Separability Clause.** – If for any reason any section or provision of this Act, or any portion thereof, or the application of such section, provision or portion thereof to any person, group or circumstance is declared invalid or unconstitutional, the remainder of this Act shall not be affected by such declaration and shall remain in force and effect.

**Section 100. Repealing Clause.** – Republic Act No. 6425, as amended, is hereby repealed and all other laws, administrative orders, rules and regulations, or parts thereof inconsistent with the provisions of this Act, are hereby repealed or modified accordingly.

**Section 101. Amending Clause.** – Republic Act No. 7659 is hereby amended accordingly.

**Section 102. Effectivity.** – This Act shall take effect fifteen (15) days upon its publication in at least two (2) national newspapers of general circulation.\(^7\)

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Approved,

(Sgd) FRANKLIN M. DRILON
President of the Senate

(Sgd) JOSE DE VENECIA, JR.
Speaker of the House of Representatives

This Act which is a consolidation of Senate Bill No. 1858 and House Bill No. 4433 was finally passed by the Senate and the House of Representatives on May 30, 2002 and May 29, 2002, respectively.

(Sgd) OSCAR G. YABES
Secretary of the Senate

(Sgd) ROBERTO P. NAZARENO
Secretary
General
House of Representatives

Approved: January 23, 2002

(Sgd) GLORIA MACAPAGAL-ARROYO
President of the Philippines
ANNEX 8
Republic of the Philippines
Congress of the Philippines
Metro Manila
Thirteenth Congress
Third Regular Session

Begun and held in Metro Manila, on Monday, the twenty-fourth day of July, two thousand six.

REPUBLIC ACT NO. 9442 April 30, 2007

AN ACT AMENDING REPUBLIC ACT NO. 7277, OTHERWISE KNOWN AS THE "MAGNA CARTA FOR DISABLED PERSONS, AND FOR OTHER PURPOSES"

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

Section 1. A new chapter, to be denominated as "Chapter 8. Other Privileges and Incentives" is hereby added to Title Two of Republic Act No. 7277, otherwise known as the "Magna Carta for Disabled Persons", with new Sections 32 and 33, to read as follows:

"CHAPTER 8. Other Privileges and Incentives

"SEC. 32. Persons with disability shall be entitled to the following:

(a) At least twenty percent (20%) discount from all establishments relative to the utilization of all services in hotels and similar lodging establishments; restaurants and recreation centers for the exclusive use or enjoyment of persons with disability;

(b) A minimum of twenty percent (20%) discount on admission fees charged by the theaters, cinema houses, concert halls, circuses, carnivals and other similar places of culture, leisure and amusement for the exclusive use or enjoyment of persons with disability;

(c) At least twenty percent (20%) discount for the purchase of medicines in all drugstores for the exclusive use or enjoyment of persons with disability;

(d) At least twenty percent (20%) discount on medical and dental services including diagnostic and laboratory fees such as, but not limited to x-rays, computerized tomography scans and blood tests, in all government facilities, subject to guidelines to be issued by the Department of Health (DOH), in coordination with the Philippine Health Insurance Corporation (PHILHEALTH);

(e) At least twenty percent (20%) discount on medical and dental services including diagnostic and laboratory fees, and professional fees of attending doctors in all private hospitals and medical facilities, in accordance with the rules and regulations to be issued by the DOH, in coordination with the PHILHEALTH;
(f) At least twenty percent (20%) discount on fare for domestic air and sea travel for the exclusive use or enjoyment of persons with disability;

(g) At least twenty percent (20%) discount in public railways, skyways and bus fare for the exclusive use and enjoyment of persons with disability;

(h) Educational assistance to persons with disability, for them to pursue primary, secondary, tertiary, post tertiary, as well as vocational or technical education, in both public and private schools, through the provision of scholarships, grants, financial aids, subsidies and other incentives to qualified persons with disability, including support for books, learning materials, and uniform allowance to the extent feasible; provided, that persons with disability shall meet minimum admission requirements;

(i) To the extent practicable and feasible, the continuance of the same benefits and privileges given by the Government Service Insurance System (GSIS), Social Security System (SSS), and PAG-IBIG, as the case may be, as are enjoyed by those in actual service;

(j) To the extent possible, the government may grant special discounts in special programs for persons with disability on purchase of basic commodities, subject to guidelines to be issued for the purpose by the Department of Trade and Industry (DTI) and the Department of Agriculture (DA); and

(k) Provision of express lanes for persons with disability in all commercial and government establishments; in the absence thereof, priority shall be given to them.

The abovementioned privileges are available only to persons with disability who are Filipino citizens upon submission of any of the following as proof of his/her entitlement thereto:

(I) An identification card issued by the city or municipal mayor the barangay captain of the place where the person with disability resides;

(II) The passport of the persons with disability concerned; or

(III) Transportation discount fare Identification Card (ID) issued by the National Council for the Welfare of Disabled Persons (NCWDP).

The privileges may not be claimed if the persons with disability claims a higher discount as may be granted by the commercial establishment and/or under other existing laws or in combination with other discount program/s.

The establishments may claim the discounts granted in sub-sections (a), (b), (c), (e), (f) and (g) as tax deductions based on the net cost of the goods sold or services rendered: provided, however, That the cost of the discount shall be allowed as deduction from gross income for the same taxable year that the discount is granted: provided, further, That the total amount of the claimed tax deduction net of value-added tax if applicable, shall be included in their gross sales receipts for tax purposes and shall be subject to proper documentation and to the provisions of the National Internal Revenue Code (NIRC), as amended.

"SEC. 33. Incentives. - Those caring for and living with a person with disability shall be granted the following incentives;
(a) persons with disability shall be treated as dependents under Section 35(A) of the National Internal Revenue Code, as amended and as such, individual taxpayers caring for them shall be accorded the privileges granted by the code Insofar as having dependents under the same section are concerned; and

(b) Individuals or nongovernmental institutions establishing homes, residential communities or retirement villages solely to suit the needs and requirements of persons with disability shall be accorded the following:

(i) Realty tax holiday for the first five years of operation; and

(ii) Priority in the building and/or maintenance of provincial or municipal roads leading to the aforesaid home residential community or retirement village."

Sec. 2. Republic Act No. 7277 is hereby amended by inserting a new title, chapter and section after Section 38 to be denominated as Title 4, chapters 1 and 2 and Sections 39, 40, 41 and 42 to read as follows:

"Title Four

Prohibitions on Verbal, Non-verbal Ridicule and Vilification Against Persons with Disability

"CHAPTER 1. Deliverance from Public Ridicule.

"SEC. 39. Public Ridicule. - For purposes of this Chapter, public ridicule shall be defined as an act of making fun or contemptuous initiating or making mockery of persons with disability whether in writing or in words, or in action due to their impairment/s.

"SEC. 40. No individual, group or community shall execute any of these acts of ridicule against persons with disability in any time and place which could intimidate or result in loss of self-esteem of the latter.

"CHAPTER 2. Deliverance from Vilification

"SEC. 41. Vilification. - For purposes of this chapter, vilification shall be defined as:

(a) the utterance of slanderous and abusive statements against a person with disability; and/or

(b) An activity in public which incites hatred towards serious contempt for, or severe ridicule of persons with disability."

"SEC. 42. Any individual, group or community is hereby prohibited from vilifying any person with disability which could result into loss of self-esteem of the latter." 

Sec. 3. Section 46 of Republic Act No. 7277 is hereby amended to read as follows:

"SEC. 46. Penal Clause. -

(a) Any person who violates any provision of this Act shall suffer the following penalties:
(1) For the first violation, a fine of not less than Fifty thousand pesos (P50,000.00) but not exceeding One hundred thousand pesos (P100,000.00) or imprisonment of not less than six months but not more than two years, or both at the discretion of the court; and

(2) For any subsequent violation, a fine of not less than One hundred thousand pesos (P100,000.00) but not exceeding Two hundred thousand pesos (P200,000.00) or imprisonment for not less than two years but not more than six years, or both at the discretion of the court.

(b) Any person who abuses the privileges granted herein shall be punished with imprisonment of not less than six months or a fine of not less than Five thousand pesos (P5,000.00), but not more than Fifty thousand pesos (P50,000.00), or both, at the discretion of the court.

(c) If the violator is a corporation organization or any similar entity, the officials thereof directly involved shall be liable therefore.

(d) If the violator is an alien or a foreigner, he shall be deported immediately after service of sentence without further deportation proceedings.

Upon filing of an appropriate complaint, and after notice and hearing the proper authorities may also cause the cancellation or revocation of the business permit, permit to operate, franchise and other similar privileges granted to any business entity that fails to abide by the provisions of this Act.

Sec. 4. The title of Republic Act No. 7277 is hereby amended to read as the "Magna Carta for Persons with Disability", and all references on the said law to "disabled persons" shall likewise be amended to read as "persons with disability".

Sec. 5. The Department of Social Welfare and Development, the National Council for the Welfare of Disabled Persons, and the Bureau of Internal Revenue, in consultation with the concerned Senate and House committees and other agencies, organizations, establishments shall formulate an agencies, organizations, establishments shall formulate an implementing rules and regulations pertinent to the provisions of this Act within six months after the effectivity of this Act.

Sec. 6. This Act shall take effect fifteen (15) days after its publication in any two newspapers of general circulation.

Approved:

JOSE DE VENECIA JR.                     MANNY VILLAR
Speaker of the House                    President of the Senate
of Representatives
This Act which is a consolidation of Senate Bill No. 2580 and House Bill No. 1214 was finally passed by the Senate and the House of Representatives on February 8, 2007 and February 7, 2007, respectively.  

ROBERTO P. NAZARENO

Secretary General

House of Representatives

OSCAR G. YABES

Secretary of Senate

Approved: April 30, 2007

GLORIA MACAPAGAL-ARROYO

President of the Philippines

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ANNEX 9

Republic of the Philippines
Congress of the Philippines
Metro Manila

Fourteenth Congress
Second Regular Session

Begun and held in Metro Manila, on Monday, the twenty-eight day of July, two thousand eight.

Republic Act No. 9523    March 12, 2009


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

Section 1. Declaration of Policy. – It is hereby declared the policy of the State that alternative protection and assistance shall be afforded to every child who is abandoned, surrendered, or neglected. In this regard, the State shall extend such assistance in the most expeditious manner in the interest of full emotional and social development of the abandoned, surrendered, or neglected child.

It is hereby recognized that administrative processes under the jurisdiction of the Department of Social Welfare and Development for the declaration of a child legally available for adoption of abandoned, surrendered, or neglected children are the most expeditious proceedings for the best interest and welfare of the child.

Section 2. Definition of Terms. – As used in this Act, the following terms shall mean:

(1) Department of Social Welfare and Development (DSWD) is the agency charged to implement the provisions of this Act and shall have the sole authority to issue the certification declaring a child legally available for adoption.
(2) Child refers to a person below eighteen (18) years of age or a person over eighteen (18) years of age but is unable to fully take care of him/herself or protect him/herself from abuse, neglect, cruelty, exploitation, or discrimination because of physical or mental disability or condition.

(3) Abandoned Child refers to a child who has no proper parental care or guardianship, or whose parent(s) have deserted him/her for a period of at least three (3) continuous months, which includes a founding.

(4) Neglected Child refers to a child whose basic needs have been deliberately unattended or inadequately attended within a period of three (3) continuous months. Neglect may occur in two (2) ways:

(a) There is physical neglect when the child is malnourished, ill-clad, and without proper shelter. A child is unattended when left by himself/herself without proper provisions and/or without proper supervision.

(b) There is emotional neglect when the child is maltreated, raped, seduced, exploited, overworked, or made to work under conditions not conducive to good health; or is made to beg in the streets or public places; or when children are in moral danger, or exposed to gambling, prostitution, and other vices.

(5) Child Legally Available for Adoption refers to a child in whose favor a certification was issued by the DSWD that he/she is legally available for adoption after the fact of abandonment or neglect has been proven through the submission of pertinent documents, or one who was voluntarily committed by his/her parent(s) or legal guardian.

(6) Voluntarily Committed Child is one whose parent(s) or legal guardian knowingly and willingly relinquished parental authority to the DSWD or any duly accredited child-placement or child-caring agency or institution.

(7) Child-caring agency or institution refers to a private non-profit or government agency duly accredited by the DSWD that provides twenty-four (24) hour residential care services for abandoned, neglected, or voluntarily committed children.

(8) Child-placing agency or institution refers to a private non-profit institution or government agency duly accredited by the DWSW that receives and processes applicants to become foster or adoptive parents and facilitate placement of children eligible for foster care or adoption.

(9) Petitioner refers to the head or executive director of a licensed or accredited child-caring or child-placing agency or institution managed by the government, local government unit, non-governmental organization, or provincial, city, or municipal Social Welfare Development Officer who has actual custody of the minor and who files a certification to declare such child legally available for adoption, or, if the child is under the custody of any other individual, the agency or institution does so with the consent of the child’s custodian.
(10) Secretary refers to the Secretary of the DSWD or his duly authorized representative.

(11) Conspicuous Place shall refer to a place frequented by the public, where by notice of the petition shall be posted for information of any interested person.

(12) Social Case Study Report (SCSR) shall refer to a written report of the result of an assessment conducted by a licensed social worker as to the social-cultural economic condition, psychosocial background, current functioning and facts of abandonment or neglect of the child. The report shall also state the efforts of social worker to locate the child's biological parents/relatives.

Section 3. Petition. – The petition shall be in the form of an affidavit, subscribed and sworn to before any person authorized by law to administer oaths. It shall contain facts necessary to establish the merits of the petition and shall state the circumstances surrounding the abandonment or neglect of the child.

The petition shall be supported by the following documents:

(1) Social Case Study Report made by the DSWD, local government unit, licensed or accredited child-caring or child-placing agency or institution charged with the custody of the child;

(2) Proof that efforts were made to locate the parent(s) or any known relatives of the child. The following shall be considered sufficient:

(a) Written certification from a local or national radio or television station that the case was aired on three (3) different occasions;

(b) Publication in one (1) newspaper of general circulation;

(c) Police report or barangay certification from the locality where the child was found or a certified copy of a tracing report issued by the Philippine National Red Cross (PNRC), National Headquarters (NHQ), Social Service Division, which states that despite due diligence, the child's parents could not be found; and

(d) Returned registered mail to the last known address of the parent(s) or known relatives, if any.

(3) Birth certificate, if available; and

(4) Recent photograph of the child and photograph of the child upon abandonment or admission to the agency or institution.

Section 4. Procedure for the Filing of the Petition. – The petition shall be filed in the regional office of the DSWD where the child was found or abandoned.
The Regional Director shall examine the petition and its supporting documents, if sufficient in form and substance and shall authorize the posting of the notice of the petition conspicuous place for five (5) consecutive days in the locality where the child was found.

The Regional Director shall act on the same and shall render a recommendation not later than five (5) working days after the completion of its posting. He/she shall transmit a copy of his/her recommendation and records to the Office of the Secretary within forty-eight (48) hours from the date of the recommendation.

Section 5. Declaration of Availability for Adoption. – Upon finding merit in the petition, the Secretary shall issue a certification declaring the child legally available for adoption within seven (7) working days from receipt of the recommendation.

Said certification, by itself shall be the sole basis for the immediate issuance by the local civil registrar of a foundling certificate. Within seven (7) working days, the local civil registrar shall transmit the foundling certificate to the National Statistic Office (NSO).

Section 6. Appeal. – The decision of the Secretary shall be appealable to the Court of Appeals within five (5) days from receipt of the decision by the petitioner, otherwise the same shall be final and executory.

Section 7. Declaration of Availability for Adoption of Involuntarily Committed Child and Voluntarily Committed Child. – The certificate declaring a child legally available for adoption in case of an involuntarily committed child under Article 141, paragraph 4(a) and Article 142 of Presidential Decree No. 603 shall be issued by the DSWD within three (3) months following such involuntary commitment.

In case of voluntary commitment as contemplated in Article 154 of Presidential Decree No. 603, the certification declaring the child legally available for adoption shall be issued by the Secretary within three (3) months following the filing of the Deed of Voluntary Commitment, as signed by the parent(s) with the DSWD.

Upon petition filed with the DSWD, the parent(s) or legal guardian who voluntarily committed a child may recover legal custody and parental authority over him/her from the agency or institution to which such child was voluntarily committed when it is shown to the satisfaction of the DSWD that the parent(s) or legal guardian is in a position to adequately provide for the needs of the child: Provided, That, the petition for restoration is filed within (3) months after the signing of the Deed of Voluntary Commitment.

Section 8. Certification. – The certification that a child is legally available for adoption shall be issued by the DSWD in lieu of a judicial order, thus making the entire process administrative in nature.

The certification, shall be, for all intents and purposes, the primary evidence that the child is legally available in a domestic adoption proceeding, as provided in Republic Act No. 8552 and in an inter-country adoption proceeding, as provided in Republic Act No. 8043.
Section 9. Implementing Rules and Regulations. – The DSWD, together with the Council for Welfare of Children, Inter-Country Adoption Board, two (2) representatives from licensed or accredited child-placing and child-caring agencies or institution, National Statistics Office and Office of the Civil Registrar, is hereby tasked to draft the implementing rules and regulations of this Act within sixty (60) days following its complete publication.

Upon effectivity of this Act and pending the completion of the drafting of the implementing rules and regulations, petitions for the issuance of a certification declaring a child legally available for adoption may be filed with the regional office of the DSWD where the child was found or abandoned.

Section 10. Penalty. – The penalty of One hundred thousand pesos (P100,000.00) to Two hundred thousand pesos (P200,000.00) shall be imposed on any person, institution, or agency who shall place a child for adoption without the certification that the child is legally available for adoption issued by the DSWD. Any agency or institution found violating any provision of this Act shall have its license to operate revoked without prejudice to the criminal prosecution of its officers and employees.

Violation of any provision of this Act shall subject the government official or employee concerned to appropriate administrative, civil and/or criminal sanctions, including suspension and/or dismissal from the government service and forfeiture of benefits.

Section 11. Repealing Clause. – Sections 2(c)(iii), 3(b), (e) and 8(a) of Republic Act No. 8552, Section 3(f) of Republic Act No. 8043, Chapter 1 of Title VII, and VIII of Presidential Decree No. 603 and any law, presidential decree, executive order, letter of instruction, administrative order, rule, or regulation contrary to or inconsistent with the provisions of this Act are hereby repealed, modified or amended accordingly.

Section 12. Separability Clause. – If any provision of this Act is held invalid or unconstitutional, the other provisions not affected thereby shall remain valid and subsisting.

Section 13. Effectivity. – This Act shall take effect fifteen (15) days following its complete publication in two (2) newspapers of general circulation or in the Official Gazette.

Approved,

(Sgd.) PROSPERO C. NOGRALES
Speaker of the House of Representatives

(Sgd.) JUAN PONCE ENRILE
President of the Senate
This Act which is a consolidation of Senate Bill No. 2391 and House Bill No. 10 was finally passed by the Senate and the House of Representatives December 17, 2009.  

(Sgd.) MARILYN B. BARUA-YAP  
Secretary General  
House of Representatives

(Sgd.) EMMA LIRIO-REYES  
Secretary of Senate

Approved: MAR 12, 2009

(Sgd.) GLORIA MACAPAGAL-ARROYO

President of the Philippines

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AN ACT ESTABLISHING A COMPREHENSIVE JUVENILE JUSTICE AND WELFARE SYSTEM, CREATING THE JUVENILE JUSTICE AND WELFARE COUNCIL UNDER THE DEPARTMENT OF JUSTICE, APPROPRIATING FUNDS THEREFOR AND FOR OTHER PURPOSES

Be it enacted by the Senate and House of Representatives of the Philippines in Congress assembled.

TITLE I
GOVERNING PRINCIPLES

CHAPTER 1
TITLE, POLICY AND DEFINITION OF TERMS

SECTION 1. Short Title and Scope. - This Act shall be known as the "Juvenile Justice and Welfare Act of 2006." It shall cover the different stages involving children at risk and children in conflict with the law from prevention to rehabilitation and reintegration.

SEC. 2. Declaration of State Policy - The following State policies shall be observed at all times:

(a) The State recognizes the vital role of children and youth in nation building and shall promote and protect their physical, moral, spiritual, intellectual and social well-being. It shall inculcate in the youth patriotism and nationalism, and encourage their involvement in public and civic affairs.

(b) The State shall protect the best interests of the child through measures that will ensure the observance of international standards of child protection, especially those to which the
Philippines is a party. Proceedings before any authority shall be conducted in the best interest of the child and in a manner which allows the child to participate and to express himself/herself freely. The participation of children in the program and policy formulation and implementation related to juvenile justice and welfare shall be ensured by the concerned government agency.

(c) The State likewise recognizes the right of children to assistance, including proper care and nutrition, and special protection from all forms of neglect, abuse, cruelty and exploitation, and other conditions prejudicial to their development.

(d) Pursuant to Article 40 of the United Nations Convention on the Rights of the Child, the State recognizes the right of every child alleged as, accused of, adjudged, or recognized as, having infringed the penal law to be treated in a manner consistent with the promotion of the child's sense of dignity and worth, taking into account the child's age and desirability of promoting his/her reintegration. Whenever appropriate and desirable, the State shall adopt measures for dealing with such children without resorting to judicial proceedings, providing that human rights and legal safeguards are fully respected. It shall ensure that children are dealt with in a manner appropriate to their well-being by providing for, among others, a variety of disposition measures such as care, guidance and supervision orders, counseling, probation, foster care, education and vocational training programs and other alternatives to institutional care.

(e) The administration of the juvenile justice and welfare system shall take into consideration the cultural and religious perspectives of the Filipino people, particularly the indigenous peoples and the Muslims, consistent with the protection of the rights of children belonging to these communities.

(f) The State shall apply the principles of restorative justice in all its laws, policies and programs applicable to children in conflict with the law.

SEC.3. Liberal Construction of this Act. - In case of doubt, the interpretation of any of the provisions of this Act, including its implementing rules and regulations (IRRs), shall be construed liberally in favor of the child in conflict with the law.

SEC.4. Definition of Terms. - The following terms as used in this Act shall be defined as follows:

(a) "Bail" refers to the security given for the release of the person in custody of the law, furnished by him/her or a bondsman, to guarantee his/her appearance before any court. Bail may be given in the form of corporate security, property bond, cash deposit, or recognizance.

(b) "Best Interest of the Child" refers to the totality of the circumstances and conditions which are most congenial to the survival, protection and feelings of security of the child and most encouraging to the child's physical, psychological and emotional development. It also means the least detrimental available alternative for safeguarding the growth and development of the child.

(c) "Child" refers to a person under the age of eighteen (18) years.

(d) “Child at Risk” refers to a child who is vulnerable to and at the risk of committing criminal offenses because of personal, family and social circumstances, such as, but not limited to, the following:

1) being abused by any person through sexual, physical, psychological, mental, economic or any other means and the parents or guardian refuse, are unwilling, or unable to provide protection for the child;

2) being exploited including sexually or economically;
(3) being abandoned or neglected, and after diligent search and inquiry, the parent or guardian cannot be found;
(4) coming from a dysfunctional or broken family or without a parent or guardian;
(5) being out of school;
(6) being a street child;
(7) being a member of a gang;
(8) living in a community with a high level of criminality or drug abuse; and
(9) living in situations of armed conflict.

(e) “Child in Conflict with the Law” refers to a child who is alleged as, accused of, or adjudged as, having committed an offense under Philippine laws.
(f) “Community-based Programs” refers to the programs provided in a community setting developed for purposes of intervention and diversion, as well as rehabilitation of the child in conflict with the law, for reintegration into his/her family and/or community.
(g) “Court” refers to a family court or, in places where there are no family courts, any regional trial court.

h) “Deprivation of Liberty” refers to any form of detention or imprisonment, or to the placement of a child in conflict with the law in a public or private custodial setting, from which the child in conflict with the law is not permitted to leave at will by order of any judicial or administrative authority.

(i) “Diversion” refers to an alternative, child-appropriate process of determining the responsibility and treatment of a child in conflict with the law on the basis of his/her social, cultural, economic, psychological or educational background without resorting to formal court proceedings.

(j) “Diversion Program” refers to the program that the child in conflict with the law is required to undergo after he/she is found responsible for an offense without resorting to formal court proceedings.

(k) “Initial Contact With the Child” refers to the apprehension or taking into custody of a child in conflict with the law by law enforcement officers or private citizens. It includes the time when the child alleged to be in conflict with the law receives a subpoena under Section 3(b) of Rule 112 of the Revised Rules of Criminal Procedure or summons under Section 6(a) or Section 9(a) of the same Rule in cases that do not require preliminary investigation or where there is no necessity to place the child alleged to be in conflict with the law under immediate custody.

(l) “Intervention” refers to a series of activities which are designed to address issues that caused the child to commit an offense. It may take the form of an individualized treatment program which may include counseling, skills training, education, and other activities that will enhance his/her psychological, emotional and psycho-social well-being.

(m) “Juvenile Justice and Welfare System” refers to a system dealing with children at risk and children in conflict with the law, which provides child-appropriate proceedings, including programs and services for prevention, diversion, rehabilitation, re-integration and aftercare to ensure their normal growth and development.

(n) “Law Enforcement Officer” refers to the person in authority or his/her agent as defined in Article 152 of the Revised Penal Code, including a barangay tanod.

(o) “Offense” refers to any act or omission whether punishable under special laws or the Revised Penal Code, as amended.
(p) “Recognizance” refers to an undertaking in lieu of a bond assumed by a parent or custodian who shall be responsible for the appearance in court of the child in conflict with the law, when required.

(q) “Restorative Justice” refers to a principle which requires a process of resolving conflicts with the maximum involvement of the victim, the offender and the community. It seeks to obtain reparation for the victim; reconciliation of the offender, the offended and the community; and reassurance to the offender that he/she can be reintegrated into society. It also enhances public safety by activating the offender, the victim and the community in prevention strategies.

(r) “Status Offenses” refers to offenses which discriminate only against a child, while an adult does not suffer any penalty for committing similar acts. These shall include curfew violations; truancy, parental disobedience and the like.

(s) ‘Youth Detention Home” refers to a 24-hour child caring institution managed by accredited local government units (LGUs) and licensed and/or accredited nongovernment organizations (NGOs) providing short-term residential care for children in conflict with the law who are awaiting court disposition of their cases or transfer to other agencies or jurisdiction.

(t) ‘Youth Rehabilitation Center” refers to a 24-hour residential care facility managed by the Department of Social Welfare and Development (DSWD), LGUs, licensed and/or accredited NGOs monitored by the DSWD, which provides care, treatment and rehabilitation services for children in conflict with the law. Rehabilitation services are provided under the guidance of a trained staff where residents are cared for under a structured therapeutic environment with the end view of reintegrating them into their families and communities as socially functioning individuals. Physical mobility of residents of said centers may be restricted pending court disposition of the charges against them.

(u) ‘Victimless Crimes” refers to offenses where there is no private offended party.

CHAPTER 2
PRINCIPLES IN THE ADMINISTRATION OF JUVENILE JUSTICE AND WELFARE

SEC 5. Rights of the Child in Conflict with the Law
- Every child in conflict with the law shall have the following rights, including but not limited to:

(a) the right not to be subjected to torture or other cruel, inhuman or degrading treatment or punishment;
(b) the right not to be imposed a sentence of capital punishment or life imprisonment, without the possibility of release;
(c) the right not to be deprived, unlawfully or arbitrary, of his/her liberty; detention or imprisonment being a disposition of last resort, and which shall be for the shortest appropriate period of time;
(d) the right to be treated with humanity and respect, for the inherent dignity of the person, and in a manner which takes into account the needs of a person of his/her age. In particular, a child deprived of liberty shall be separated from adult offenders at, all times. No child shall be detained together with adult offenders. He/She shall be conveyed separately to or from court. He/She shall await hearing of his/her own case in a separate holding area. A child in conflict
with the law shall have the right to maintain contact with his/her family through correspondence and visits, save in exceptional circumstances;
(e) the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his/her liberty before a court or other competent, independent and impartial authority, and to a prompt decision on such action;
(f) the right to bail and recognizance, in appropriate cases;
(g) the right to testify as a witness in his/her own behalf under the rule on examination of a child witness;
(h) the right to have his/her privacy respected fully at all stages of the proceedings;
(i) the right to diversion if he/she is qualified and voluntarily avails of the same;
(i) the right to be imposed a judgment in proportion to the gravity of the offense where his/her best interest, the rights of the victim and the needs of society are all taken into consideration by the court, under the principle of restorative justice;
(k) the right to have restrictions on his/her personal liberty limited to the minimum, and where discretion is given by law to the judge to determine whether to impose fine or imprisonment, the imposition of fine being preferred as the more appropriate penalty;
(l) in general, the right to automatic suspension of sentence;
(m) the right to probation as an alternative to imprisonment, if qualified under the Probation Law;
(n) the right to be free from liability for perjury, concealment or misrepresentation; and
(o) other rights as provided for under existing laws, rules and regulations.


SEC. 6. Minimum Age of Criminal Responsibility. – A child fifteen (15) years of age or under at the time of the commission of the offense shall be exempt from criminal liability. However, the child shall be subjected to an intervention program pursuant to Section 20 of this Act.

A child above fifteen (15) years but below eighteen (18) years of age shall likewise be exempt from criminal liability and be subjected to an intervention program, unless he/she has acted with discernment, in which case, such child shall be subjected to the appropriate proceedings in accordance with this Act. The exemption from criminal liability herein established does not include exemption from civil liability, which shall be enforced in accordance with existing laws.

SEC. 7. Determination of Age. - The child in conflict with the law shall enjoy the presumption of minority. He/She shall enjoy all the rights of a child in conflict with the law until he/she is proven to be eighteen (18) years old or older. The age of a child may be determined from the child’s birth certificate, baptismal certificate or any other pertinent documents. In the absence of these documents, age may be based on information from the child himself/herself, testimonies of other persons, the physical appearance of the child and other relevant evidence. In case of doubt as to the age of the child, it shall be resolved in his/her favor.
Any person contesting the age of the child in conflict with the law prior to the filing of the information in any appropriate court may file a case in a summary proceeding for the determination of age before the Family Court which shall decide the case within twenty-four (24) hours from receipt of the appropriate pleadings of all interested parties.

If a case has been filed against the child in conflict with the law and is pending in the appropriate court, the person shall file a motion to determine the age of the child in the same court where the case is pending. Pending hearing on the said motion, proceedings on the main case shall be suspended. In all proceedings, law enforcement officers, prosecutors, judges and other government officials concerned shall exert all efforts at determining the age of the child in conflict with the law.

**TITLE II**

**STRUCTURES IN THE ADMINISTRATION OF JUVENILE JUSTICE AND WELFARE**

**SEC. 8. Juvenile Justice and Welfare Council (JJWC)** - A Juvenile Justice and Welfare Council (JJWC) is hereby created and attached to the Department of Justice and placed under its administrative supervision. The JJWC shall be chaired by an undersecretary of the Department of Social Welfare and Development. It shall ensure the effective implementation of this Act and coordination among the following agencies:

(a) Council for the Welfare of Children (CWC);
(b) Department of Education (DepEd);
(c) Department of the Interior and Local Government (DILG);
(d) Public Attorney's Office (PAO);
(e) Bureau of Corrections (BUCOR);
(f) Parole and Probation Administration (PPA);
(g) National Bureau of Investigation (NBI);
(h) Philippine National Police (PNP);
(i) Bureau of Jail Management and Penology (BJMP);
(j) Commission on Human Rights (CHR);
(k) Technical Education and Skills Development Authority (TESDA);
(l) National Youth Commission (NYC); and
(m) Other institutions focused on juvenile justice and intervention programs.

The JJWC shall be composed of representatives, whose ranks shall not be lower than director, to be designated by the concerned heads of the following departments or agencies:

(a) Department of Justice (DOJ);
(b) Department of Social Welfare and Development (DSWD);
(c) Council for the Welfare of Children (CWC);
(d) Department of Education (DepEd);
(e) Department of the Interior and Local Government (DILG);
(f) Commission on Human Rights (CHR);
(g) National Youth Commission (NYC); and
(h) Two (2) representatives from NGOs, one to be designated by the Secretary of Justice and the other to be designated by the Secretary of Social Welfare and Development.
The JJWC shall convene within fifteen (15) days from the effectivity of this Act. The Secretary of Justice and the Secretary of Social Welfare and Development shall determine the organizational structure and staffing pattern of the JJWC. The JJWC shall coordinate with the Office of the Court Administrator and the Philippine Judicial Academy to ensure the realization of its mandate and the proper discharge of its duties and functions, as herein provided.

SEC. 9. Duties and Functions of the JJWC - The JJWC shall have the following duties and functions:
(a) To oversee the implementation of this Act;
(b) To advise the President on all matters and policies relating to juvenile justice and welfare;
(c) To assist the concerned agencies in the review and redrafting of existing policies/regulations or in the formulation of new ones in line with the provisions of this Act;
(d) To periodically develop a comprehensive 3 to 5-year national juvenile intervention program, with the participation of government agencies concerned, NGOs and youth organizations;
(e) To coordinate the implementation of the juvenile intervention programs and activities by national government agencies and other activities which may have an important bearing on the success of the entire national juvenile intervention program. All programs relating to juvenile justice and welfare shall be adopted in consultation with the JJWC;
(f) To formulate and recommend policies and strategies in consultation with children for the prevention of juvenile delinquency and the administration of justice, as well as for the treatment and rehabilitation of the children in conflict with the law;
(g) To collect relevant information and conduct continuing research and support evaluations and studies on all matters relating to juvenile justice and welfare, such as, but not limited to:
   (1) the performance and results achieved by juvenile intervention programs and by activities of the local government units and other government agencies;
   (2) the periodic trends, problems and causes of juvenile delinquency and crimes; and
   (3) the particular needs of children in conflict with the law in custody.

The data gathered shall be used by the JJWC in the improvement of the administration of juvenile justice and welfare system. The JJWC shall set up a mechanism to ensure that children are involved in research and policy development.

(h) Through duly designated persons and with the assistance of the agencies provided in the preceding section, to conduct regular inspections in detention and rehabilitation facilities and to undertake spot inspections on their own initiative in order to check compliance with the standards provided herein and to make the necessary recommendations to appropriate agencies;
(i) To initiate and coordinate the conduct of trainings for the personnel of the agencies involved in the administration of the juvenile justice and welfare system and the juvenile intervention program;
(j) To submit an annual report to the President on the implementation of this Act; and
(k) To perform such other functions as may be necessary to implement the provisions of this Act.

SEC. 10. Policies and Procedures on Juvenile Justice and Welfare - All government agencies enumerated in Section 8 shall, with the assistance of the JJWC and within one (1) year from the effectivity of this Act, draft policies and procedures consistent with the standards set in the law.
These policies and procedures shall be modified accordingly in consultation with the JJWC upon the completion of the national juvenile intervention program as provided under Section 9 (d).

SEC. 11. Child Rights Center (CRC) - The existing Child Rights Center of the Commission on Human Rights shall ensure that the status, rights and interests of children are upheld in accordance with the Constitution and international instruments on human rights. The CHR shall strengthen the monitoring of government compliance of all treaty obligations, including the timely and regular submission of reports before the treaty bodies, as well as the implementation and dissemination of recommendations and conclusions by government agencies as well as NGOs and civil society.

TITLE III
PREVENTION OF JUVENILE DELINQUENCY
CHAPTER 1
THE ROLE OF THE DIFFERENT SECTORS

SEC. 12. The Family. - The family shall be responsible for the primary nurturing and rearing of children which is critical in delinquency prevention. As far as practicable and in accordance with the procedures of this Act, a child in conflict with the law shall be maintained in his/her family.

SEC. 13. The Educational System – Educational institutions shall work together with families, community organizations and agencies in the prevention of juvenile delinquency and in the rehabilitation and reintegration of child in conflict with the law. Schools shall provide adequate, necessary and individualized educational schemes for children manifesting difficult behavior and children in conflict with the law. In cases where children in conflict with the law are taken into custody or detained in rehabilitation centers, they should be provided the opportunity to continue learning under an alternative learning system with basic literacy program or non-formal education accreditation equivalency system.

SEC. 14. The Role of the Mass Media - The mass media shall play an active role in the promotion of child rights, and delinquency prevention by relaying consistent messages through a balanced approach. Media practitioners shall, therefore, have the duty to maintain the highest critical and professional standards in reporting and covering cases of children in conflict with the law. In all publicity concerning children, the best interest of the child should be the primordial and paramount concern. Any undue, inappropriate and sensationalized publicity of any case involving a child in conflict with the law is hereby declared a violation of the child’s rights.

SEC. 15. Establishment and Strengthening of Local Councils for the Protection of Children - Local Councils for the Protection of Children (LCPC) shall be established in all levels of local government, and where they have already been established, they shall be strengthened within one (1) year from the effectivity of this Act. Membership in the LCPC shall be chosen from among the responsible members of the community, including a representative from the youth sector, as well as representatives from government and private agencies concerned with the welfare of children. The local council shall serve as the primary agency to coordinate with and assist the LGU concerned for the adoption of a comprehensive plan on delinquency prevention, and to oversee its proper implementation.
One percent (1%) of the internal revenue allotment of barangays, municipalities and cities shall be allocated for the strengthening and implementation of the programs of the LCPC: Provided, That the disbursement of the fund shall be made by the LGU concerned.

SEC. 16. Appointment of Local Social Welfare and Development Officer - All LGUs shall appoint a duly licensed social worker as its local social welfare and development officer tasked to assist children in conflict with the law.

SEC. 17. The Sangguniang Kabataan - The Sangguniang Kabataan (SK) shall coordinate with the LCPC in the formulation and implementation of juvenile intervention and diversion programs in the community.

CHAPTER 2
COMPREHENSIVE JUVENILE INTERVENTION PROGRAM

SEC. 18. Development of a Comprehensive Juvenile Intervention Program - A Comprehensive juvenile intervention program covering at least a 3-year period shall be instituted in LGUs from the barangay to the provincial level.

The LGUs shall set aside an amount necessary to implement their respective juvenile intervention programs in their annual budget. The LGUs, in coordination with the LCPC, shall call on all sectors concerned, particularly the child-focused institutions, NGOs, people's organizations, educational institutions and government agencies involved in delinquency prevention to participate in the planning process and implementation of juvenile intervention programs. Such programs shall be implemented consistent with the national program formulated and designed by the JJWC.

The implementation of the comprehensive juvenile intervention program shall be reviewed and assessed annually by the LGUs in coordination with the LCPC. Results of the assessment shall be submitted by the provincial and city governments to the JJWC not later than March 30 of every year.

SEC. 19. Community-based Programs on Juvenile Justice and Welfare - Community-based programs on juvenile justice and welfare shall be instituted by the LGUs through the LCPC, school, youth organizations and other concerned agencies. The LGUs shall provide community-based services which respond to the special needs, problems, interests and concerns of children and which offer appropriate counseling and guidance to them and their families. These programs shall consist of three levels:
(a) Primary intervention includes general measures to promote social justice and equal opportunity, which tackle perceived root causes of offending;
(b) Secondary intervention includes measures to assist children at risk; and
(c) Tertiary intervention includes measures to avoid unnecessary contact with the formal justice system and other measures to prevent re-offending.
TITLE IV
TREATMENT OF CHILDREN BELOW THE AGE OF CRIMINAL RESPONSIBILITY

SEC. 20. Children Below the Age of Criminal Responsibility- If it has been determined that the child taken into custody is fifteen (15) years old or below, the authority which will have an initial contact with the child has the duty to immediately release the child to the custody of his/her parents or guardian, or in the absence thereof, the child's nearest relative. Said authority shall give notice to the local social welfare and development officer who will determine the appropriate programs in consultation with the child and to the person having custody over the child. If the parents, guardians or nearest relatives cannot be located, or if they refuse to take custody, the child may be released to any of the following: a duly registered nongovernmental or religious organization; a barangay official or a member of the Barangay Council for the Protection of Children PCPC); a local social welfare and development officer; or, when and where appropriate, the DSWD. If the child referred to herein has been found by the Local Social Welfare and Development Office to be abandoned, neglected or abused by his parents, or in the event that the parents will not comply with the prevention program, the proper petition for involuntary commitment shall be filed by the DSWD or the Local Social Welfare and Development Office pursuant to Presidential Decree No. 603, otherwise known as “The Child and Youth Welfare Code”.

TITLE V
JUVENILE JUSTICE AND WELFARE SYSTEM
CHAPTER 1
INITIAL CONTACT WITH THE CHILD

SEC. 21. Procedure for Taking the Child into Custody - From the moment a child is taken into custody, the law enforcement officer shall:
(a) Explain to the child in simple language and in a dialect that he/she can understand why he/she is being placed under custody and the offense that he/she allegedly committed;
(b) Inform the child of the reason for such custody and advise the child of his/her constitutional rights in a language or dialect understood by him/her;
(c) Properly identify himself/herself and present proper identification to the child;
(d) Refrain from using vulgar or profane words and from sexually harassing or abusing, or making sexual advances on the child in conflict with the law;
(e) Avoid displaying or using any firearm, weapon, handcuffs or other instruments of force or restraint, unless absolutely necessary and only after all other methods of control have been exhausted and have failed;
(f) Refrain from subjecting the child in conflict with the law to greater restraint than is necessary for his/her apprehension;
(g) Avoid violence or unnecessary force;
(h) Determine the age of the child pursuant to Section 7 of this Act;
(i) Immediately but not later than eight (8) hours after apprehension, turn over custody, of, the child to the Social Welfare and Development Office or other accredited NGOs, and notify the child's parents/guardians and Public Attorney's Office of the child's apprehension. The social welfare and development officer shall explain to the child and the child's parents/guardians the consequences of the child's act with a view towards counseling and rehabilitation, diversion from the criminal justice system, and, reparation, appropriate;
j) Take the child immediately to the proper medical and health officer for a thorough physical and mental examination. The examination results shall be kept confidential unless otherwise ordered by the Family Court. Whenever the medical treatment is required, steps shall be immediately undertaken to provide the same;

(k) Ensure that should detention of the child in conflict with the law be necessary, the child shall be secured in quarters separate from that of the opposite sex and adult offenders;

(l) Record the following in the initial investigation:

1. Whether handcuffs or other instruments of restraint were used, and if so, the reason for such;

2. That the parents or guardian of a child, the DSWD, and the PAO have been duly informed of the apprehension and the details thereof; and

3. The exhaustion of measures to determine the age of a child and the precise details of the physical and medical examination or the failure to submit a child to such examination; and

(m) Ensure that all statements signed by the child during investigation shall be witnessed by the child's parents or guardian, social worker, or legal counsel in attendance who shall affix his/her signature to the said statement.

A child in conflict with the law shall only be searched by a law enforcement officer of the same gender and shall not be locked up in a detention cell.

SEC. 22. Duties During Initial Investigation - The law enforcement officer shall, in his/her investigation, determine where the case involving the child in conflict with the law should be referred.

The taking of the statement of the child shall be conducted in the presence of the following:

1. The child's counsel of choice or in the absence thereof, a lawyer from the Public Attorney's Office;
2. The child's parents, guardian, or nearest relative, as the case may be; and
3. The local social welfare and development officer. In the absence of the child's parents, guardian, or nearest relative, and the local social welfare and development officer, the investigation shall be conducted in the presence of a representative of an NGO, religious group, or member of the BCPC.

After the initial investigation, the local social worker conducting the same may do either of the following:

a. Proceed in accordance with Section 20 if the child is fifteen (15) years or below or above fifteen (15) but below eighteen (18) years old, who acted without discernment; and

b. If the child is above fifteen (16) years old but below eighteen (18) and who acted with discernment, proceed to diversion under the following chapter.

CHAPTER 2
DIVERSION

SEC 23. System of Diversion - Children in conflict with the law shall undergo diversion programs without undergoing court proceedings subject to the conditions herein provided:

a. Where the imposable penalty for the crime committed & is not more than six (6) years imprisonment, the law enforcement officer or Punong Barangay with the assistance of the local social welfare and development officer or other members of the LCPC shall conduct mediation, family conferencing and conciliation and, where appropriate, adopt indigenous modes of conflict resolution in accordance with the best interest of the child with a view to accomplishing the
objectives of restorative justice and the formulation of a diversion program. The child and his/her family shall be present in these activities.

(b) In victimless crimes where the imposable penalty is not more than six (6) years imprisonment, the local social welfare and development officer shall meet with the child and his/her parents or guardians for the development of the appropriate diversion and rehabilitation program, in coordination with the BCPC;

(c) Where the imposable penalty for the crime committed exceeds six (6) years imprisonment, diversion measures may be resorted to only by the court.

SEC 24. Stages Were Diversion May be Conducted - Diversion may be conducted at the Katarungang Pambarangay, the police investigation or the inquest or preliminary investigation stage and at all levels and phases of the proceedings including judicial level.

SEC 26. Confidentiality, Mediation and Conciliation. – A child, in conflict with law may undergo conferencing, mediation or conciliation outside the criminal justice system or prior to his entry into said system. A contract of diversion may be entered into during such conferencing, mediation or conciliation proceedings.

SEC. 26. Contract of Diversion - If during the conferencing, mediation or conciliation, the child voluntarily admits the commission of the act, a diversion program shall be developed when appropriate and desirable as determined under Section 30. Such admission shall not be used against the child in any subsequent judicial, quasi-judicial or administrative proceedings. The diversion program shall be effective and binding if accepted by the parties concerned. The acceptance shall be in written and signed by the parties concerned and the appropriate authorities. The local social welfare and development officer shall supervise the implementation of the diversion program. The diversion proceedings shall be completed within forty-five (45) days. The period of prescription of the offense shall be suspended until the completion of the diversion proceedings but not to exceed forty-five (45) days. The child shall present himself/herself to the competent authorities that imposed the diversion program at least once a month for reporting and evaluation of the effectiveness of the program. Failure to comply with the terms and conditions of the contract of diversion, as certified by the local social welfare and development officer, shall give the offended party the option to institute the appropriate legal action. The period of prescription of the offense shall be suspended during the effectivity of the diversion program, but not exceeding a period of two (2) years.

SEC. 27. Duty of the Punong Barangay When There is No Diversion. - If the offense does not fall under Section 23(a) and (b), or if the child, his/her parents or guardian does not consent to a diversion, the Punong Barangay handling the case shall, within three (3) days from determination of the absence of jurisdiction over the case or termination of the diversion proceedings, as the case may be, forward the records of the case of the child to the law enforcement officer, prosecutor or the appropriate court, as the case may be. Upon the issuance of the corresponding document, certifying to the fact that no agreement has been reached by the parties, the case shall be filed according to the regular process.
SEC. 28. Duty of the Law Enforcement Officer When There is No Diversion. - If the offense does not fall under Section 23(a) and (b), or if the child, his/her parents or guardian does not consent to a diversion, the Women and Children Protection Desk of the PNP, or other law enforcement officer handling the case shall, within three (3) days from determination of the absence of jurisdiction over the case or termination of diversion proceedings, forward the records of the case of the child under custody, to the prosecutor or judge concerned for the conduct of inquest and/or preliminary investigation to determine whether or not the child should remain under custody and correspondingly charged in court. The document transmitting said records shall display the word “CHILD” in bold letters.

SEC. 29. Factors in Determining Diversion Program - In determining whether diversion is appropriate and desirable, the following factors shall be taken into consideration:
(a) The nature and circumstances of the offense charged;
(b) The frequency and the severity of the act;
(c) The circumstances of the child (e.g. age, maturity, intelligence, etc.);
(d) The influence of the family and environment on the growth of the child;
(e) The reparation of injury to the victim;
(f) The weight of the evidence against the child;
(g) The safety of the community; and
(h) The best interest of the child.

SEC. 30. Formulation of the Diversion Program. – In formulating a diversion program, the individual characteristics and the peculiar circumstances of the child in conflict with the law shall be used to formulate an individualized treatment. The following factors shall be considered in formulating a diversion program for the child:
(a) The child's feelings of remorse for the offense he/she committed;
(b) The parents' or legal guardians' ability to guide and supervise the child;
(c) The victim's view about the propriety of the measures to be imposed; and
(d) The availability of community-based programs for rehabilitation and reintegration of the child.

SEC. 31. Kinds of Diversion Programs. - The diversion program shall include adequate socio-cultural and psychological responses and services for the child. At the different stages where diversion may be resorted to, the following diversion programs may be agreed upon, such as, but not limited to:
(a) At the level of the Punong Barangay:
(1) Restitution of property;
(2) Reparation of the damage caused;
(3) Indemnification for consequential damages;
(4) Written or oral apology;
(5) Care, guidance and supervision orders;
(6) Counseling for the child in conflict with the law and the child's family;
(7) Attendance in trainings, seminars and lectures on:
   (i) anger management skills;
   (ii) problem solving and/or conflict resolution skills;
   (iii) values formation; and

...
(iv) other skills which will aid the child in dealing with situations which can lead to repetition of the offense;

(8) Participation in available community-based programs, including community service; or (9) Participation in education, vocation and life skills programs.

(b) At the level of the law enforcement officer and the prosecutor:
(1) Diversion programs specified under paragraphs (a) (l) to (a) (9) herein; and
(2) Confiscation and forfeiture of the proceeds or instruments of the crime;
(c) At the level of the appropriate court
(1) Diversion programs specified under paragraphs (a) and (b) abuse
(2) Written or oral reprimand or citation;
(3) Fine;
(4) Payment of the cost of the proceedings; or
(5) Institutional care and custody.

CHAPTER 3
PROSECUTION
SEC. 32. Duty of the Prosecutor's Office - There shall be a specially trained prosecutor to conduct inquest, preliminary investigation and prosecution of cases involving a child in conflict with the law. If there is an allegation of torture or ill-treatment of a child in conflict with the law during arrest or detention, it shall be the duty of the prosecutor to investigate the same.

SEC. 33. Preliminary Investigation and Filing of Information - The prosecutor shall conduct a preliminary investigation in the following instances: (a) when the child in conflict with the law does not qualify for diversion; b) when the child, his/her parents or guardian does not agree to diversion as specified in Sections 27 and 28; and (c) when considering the assessment and recommendation of the social worker, the prosecutor determines that diversion is not appropriate for the child in conflict with the law.
Upon serving the subpoena and the &davit of complaint, the prosecutor shall notify the Public Attorney's Office of such service, as well as the personal information, and place of detention of the child in conflict with the law.
Upon determination of probable cause by the prosecutor, the information against the child shall be filed before the Family Court within forty-five (45) days from the start of the preliminary investigation.

CHAPTER 4
COURT PROCEEDINGS
SEC. 34. Bail - For purposes of recommending the amount of bail, the privileged mitigating circumstance of minority shall be considered.

SEC. 35. Release on Recognizance. - Where a child is detained, the court shall order:
(a) the release of the minor on recognizance to his/her parents and other suitable persons;
(b) the release of the child in conflict with the law on bail; or
(c) the transfer of the minor to a youth detention home/ youth rehabilitation center.

The court shall not order the detention of a child in a jail pending trial or hearing of his/her case.
SEC. 36. Detention of the Child Pending Trial – Children detained pending trial may be released on bail or recognizance as provided for under Sections 34 and 35 under this Act. In all other cases and whenever possible, detention pending trial may be replaced by alternative measures, such as close supervision, intensive care or placement with a family or in an educational setting or home. Institutionalization or detention of the child pending trial shall be used only as a measure of last resort and for the shortest possible period of time.

Whenever detention is necessary, a child will always be detained in youth detention homes established by local governments, pursuant to Section 8 of the Family Courts Act, in the city or municipality where the child resides.

In the absence of a youth detention home, the child in conflict with the law may be committed to the care of the DSWD or a local rehabilitation center recognized by the government in the province, city or municipality within the jurisdiction of the court. The center or agency concerned shall be responsible for the child's appearance in court whenever required.

SEC. 37. Diversion Measures - Where the maximum penalty imposed by law for the offense with which the child in conflict with the law is charged is imprisonment of not more than twelve (12) years, regardless of the fine or fine alone regardless of the amount, and before arraignment of the child in conflict with the law, the court shall determine whether or not diversion is appropriate.

SEC. 38. Automatic Suspension of Sentence - Once the child who is under eighteen (18) years of age at the time of the commission of the offense is found guilty of the offense charged, the court shall determine and ascertain any civil liability which may have resulted from the offense committed. However, instead of pronouncing the judgment of conviction, the court shall place the child in conflict with the law under suspended sentence, without need of application: Provided, however, That suspension of sentence shall still be applied even if the juvenile is already eighteen years (18) of age or more at the time of the pronouncement of his/her guilt. Upon suspension of sentence and after considering the various circumstances of the child, the court shall impose the appropriate disposition measures as provided in the Supreme Court Rule on Juveniles in Conflict with the Law.

SEC. 39. Discharge of the Child in Conflict with the Law - Upon the recommendation of the social worker who has custody of the child, the court shall dismiss the case against the child whose sentence has been suspended and against whom disposition measures have been issued, and shall order the final discharge of the child if it finds that the objective of the disposition measures have been fulfilled. The discharge of the child in conflict with the law shall not affect the civil liability resulting from the commission of the offense, which shall be enforced in accordance with law.

SEC. 40. Return of the Child in Conflict with the Law to Court - If the court finds that the objective of the disposition measures imposed upon the child in conflict with the law have not been fulfilled, or if the child in conflict with the law has willfully failed to comply with the conditions of his/her disposition or rehabilitation program; the child in conflict with the law shall be brought before the court for execution of judgment.
If said child in conflict with the law has reached eighteen (18) years of age while under suspended sentence, the court shall determine whether to discharge the child in accordance with this Act, to order execution of sentence, or to extend the suspended sentence for a certain specified period or until the child reaches the maximum age of twenty-one (21) years.

SEC. 41. Credit in Service of Sentence - The child in conflict with the law shall be credited in the services of his/her sentence with the full time spent in actual commitment and detention under this Act.

SEC. 42. Probation as an Alternative to Imprisonment - The court may, after it shall have convicted and sentenced a child in conflict with the law, and upon application at any time, place the child on probation in lieu of service of his/her sentence taking into account the best interest of the child. For this purpose, Section 4 of Presidential Decree No. 968, otherwise known as the “Probation Law of 1976”, is hereby amended accordingly.

CHAPTER 5
CONFIDENTIALITY OF RECORDS AND PROCEEDINGS

SEC. 43. Confidentiality of Records and Proceedings – All records and proceedings involving children in conflict with the law from initial contact until final disposition of the case shall be considered privileged and confidential. The public shall be excluded during the proceedings and the records shall not be disclosed directly or indirectly to anyone by any of the parties or the participants in the proceeding for any purpose whatsoever, except to determine if the child in conflict with the law may have his/her sentence suspended or if he/she may be granted probation under the Probation Law, or to enforce the civil liability imposed in the criminal action.

The component authorities shall undertake all measures to protect this confidentiality of proceedings, including not disclosure of records to the media, maintaining a separate police blotter for cases involving children in conflict with the law and adopting a system of coding to conceal material information which will lead to the child's identity. Records of a child in conflict with the law shall not be used in subsequent proceedings for cases involving the same offender as an adult, except when beneficial for the offender and upon his/her written consent.

A person who has been in conflict with the law as a child shall not be held under any provision of law, to be guilty of perjury or of concealment or misrepresentation by reason of his/her failure to acknowledge the case or recite any fact related thereto in response to any inquiry made to him/her for any purpose.

TITLE VI
REHABILITATION AND REINTEGRATION

SEC. 44. Objective of Rehabilitation and Reintegration - The objective of rehabilitation and reintegration of children in conflict with the law is to provide them with interventions, approaches and strategies that will enable them to improve their social functioning with the end goal of reintegration to their families and as productive members of their communities.

SEC. 45. Court Order Required - No child shall be received in any rehabilitation or training facility without a valid order issued by the court after a hearing for the purpose. The details of
this order shall be immediately entered in a register exclusively for children in conflict with the law. No child shall be admitted in any facility where there is no such register.

SEC. 46. Separate Facilities from Adults - In all rehabilitation or training facilities, it shall be mandatory that children shall be separated from adults unless they are members of the same family. Under no other circumstance shall a child in conflict with the law be placed in the same confinement as adults.

The rehabilitation, training or confinement area of children in conflict with the law shall provide a home environment where children in conflict with the law can be provided with quality counseling and treatment.

SEC. 41. Female Children - Female children in conflict with the law placed in an institution shall be given special attention as to their personal needs and problems. They shall be handled by female doctors, correction officers and social workers, and shall be accommodated separately from male children in conflict with the law.

SEC. 48. Gender-Sensitivity Training - No personnel of rehabilitation and training facilities shall handle children in conflict with the law without having undergone gender sensitivity training.

SEC. 49. Establishment of Youth Detention Homes – The LGUs shall set aside an amount to build youth detention homes as mandated by the Family Courts Act. Youth detention homes may also be established by private and NGOs licensed and accredited by the DSWD, in consultation with the JJWC.

SEC. 50. Care and Maintenance of the Child in Conflict with the Law - The expenses for the care and maintenance of a child in conflict with the law under institutional care shall be borne by his/her parents or those persons liable to support him/her: Provided, That in case hi/her parents or those persons liable to support him/her cannot pay all or part of said expenses, the municipality where the offense was committed shall pay one-third (1/3) of said expenses or part thereof; the province to which the municipality belongs shall pay one-third (1/3) and the remaining one-third (1/3) shall be borne by the national government. Chartered cities shall pay two-thirds (2/3) of said expenses; and in case a chartered city cannot pay said expenses, part of the internal revenue allotments applicable to the unpaid portion shall be withheld and applied to the settlement of said obligations: Provided further, That in the event that the child in conflict with the law is not a resident of the municipality/city where the offense was committed, the court, upon its determination, may require the city/municipality where the child in conflict with the law resides to shoulder the cost.

All city and provincial governments must exert effort for the immediate establishment of local detention homes for children in conflict with the law.

SEC. 51. Confinement of Convicted Children in Agricultural Camps and other Training Facilities - A child in conflict with the law may, after conviction and upon order of the court, be made to serve his/her sentence, in lieu of confinement in a regular penal institution, in an agricultural camp and other training facilities that may be established, maintained, supervised and controlled by the BUCOR, in coordination with the DSWD.
SEC. 52. Rehabilitation of Children in Conflict with the Law - Children in conflict with the law, whose sentences are suspended may, upon order of the court, undergo any or a combination of disposition measures best suited to the rehabilitation and welfare of the child as provided in the Supreme Court Rule on Juveniles in Conflict with the Law.

If the community-based rehabilitation is availed of by a child in conflict with the law, he/she shall be released to parents, guardians, relatives or any other responsible persons in the community. Under the supervision and guidance of the local social welfare and development officer, and in coordination with his/her parents/guardian, the child in conflict with the law shall participate in community-based programs, which shall include, but not limited to:
(1) Competency and life skills development;
(2) Socio-cultural and recreational activities;
(3) Community volunteer projects;
(4) Leadership training;
(5) Social services;
(6) Hornelife services;
(7) Health services;
(8) Spiritual enrichment; and
(9) Community and family welfare services.

In accordance therewith, the family of the child in conflict with the law shall endeavor to actively participate in the community-based rehabilitation.

Based on the progress of the youth in the community, a final report will be forwarded by the local social welfare and development officer to the court for final disposition of the case. If the community-based programs are provided as diversion measures under Chapter 11, Title V, the programs enumerated above shall be made available to the child in conflict with the law.

SEC. 53. Youth Rehabilitation Center - The youth rehabilitation center shall provide 24-hour group care, treatment and rehabilitation services under the guidance of a trained staff where residents are cared for under a structured therapeutic environment with the end view of reintegrating them in their families and communities as socially functioning individuals. A quarterly report shall be submitted by the center to the proper court on the progress of the children in conflict with the law. Based on the progress of the youth in the center, a final report will be forwarded to the court for final disposition of the case. The DSWD shall establish youth rehabilitation centers in each region of the country.

SEC. 54. Objectives of Community-Based Programs – The objectives of community-based programs are as follows:

(a) Prevent disruption in the education or means of livelihood of the child in conflict with the law in case he/she is studying, working or attending vocational learning institutions;
(b) Prevent separation of the child in conflict with the law from his/her parents/guardians to maintain the support system fostered by their relationship and to create greater awareness of their mutual and reciprocal responsibilities;
(c) Facilitate the rehabilitation and mainstreaming of the child in conflict with the law and encourage community support and involvement; and
(d) Minimize the stigma that attaches to the child in conflict with the law by preventing jail detention.

SEC. 55. Criteria of Community-Based Programs - Every LGU shall establish community-based programs that will focus on the rehabilitation and reintegration of the child. All programs shall meet the criteria to be established by the JJWC which shall take into account the purpose of the program, the need for the consent of the child and his/her parents or legal guardians, and the participation of the child-centered agencies whether public or private.

SEC. 56. After-Care support Services for Children in Conflict with the Law - Children in conflict with the law whose cases have been dismissed by the proper court because of good behavior as per recommendation of the DSWD social worker and/or any accredited NGO youth rehabilitation center shall be provided after-care services by the local social welfare and development officer for a period of at least six (6) months. The service includes counseling and other community-based services designed to facilitate social reintegration, prevent reoffending and make the children productive members of the community.

TITLE VII
GENERAL PROVISIONS
CHAPTER 1
EXEMPTING PROVISIONS

SEC. 57. Statue Offenses - Any conduct not considered an offense or not penalized if committed by an adult shall not be considered an offense and shall not be punished if committed by a child.

SEC. 58. Offenses Not Applicable to Children – Persons below eighteen (18) years of age shall be exempt from prosecution for the crime of vagrancy and prostitution under Section 202 of the Revised Penal Code, of mendicancy under Presidential Decree No. 1563, and sniffing of rugby under Presidential Decree No. 1619, such prosecution being inconsistent with the United Nations Convention on the Rights of the Child: Provided, That said persons shall undergo appropriate counseling and treatment program.

SEC. 59. Exemption from the Application of Death Penalty - The provisions of the Revised Penal Code, as amended, Republic Act No. 9165, otherwise known as the Comprehensive Dangerous Drugs Act of 2002, and other special laws notwithstanding, no death penalty shall be imposed upon children in conflict with the law.

CHAPTER 2
PROHIBITED ACTS

SEC. 60. Prohibition Against Labeling and Shaming - In the conduct of the proceedings beginning from the initial contact with the child, the competent authorities must refrain from branding or labeling children as young criminals, juvenile delinquents, prostitutes or attaching to them in any manner any other derogatory names. Likewise, no discriminatory remarks and practices shall be allowed particularly with respect to the child's class or ethnic origin.

SEC. 61. Other Prohibited Acts. - The following and any other similar acts shall be considered prejudicial and detrimental to the psychological, emotional, social, spiritual, moral and physical health and well-being of the child in conflict with the law and therefore, prohibited:
(a) Employment of threats of whatever kind and nature;
(b) Employment of abusive, coercive and punitive measures such as cursing, beating, stripping, and solitary confinement;
(c) Employment of degrading, inhuman and cruel forms of punishment such as shaving the heads, pouring irritating, corrosive or harmful substances over the body of the child in conflict with the law, or forcing him/her to walk around the community wearing signs which embarrass, humiliate, and degrade his/her personality and dignity; and
(d) Compelling the child to perform involuntary servitude in any and all forms under any and all instances.

CHAPTER 3
PENAL PROVISION

SEC. 62. Violation of the Provisions of this Act or Rules or Regulations in General - Any person who violates any provision of this Act or any rule or regulation promulgated in accordance thereof shall, upon conviction for each act or omission, be punished by a fine of not less than Twenty thousand pesos (P20,000.00) but not more than Fifty thousand pesos (P50,000.00) or suffer imprisonment of not less than eight (8) years but not more than ten (10) years, or both such fine and imprisonment at the discretion of the court, unless a higher penalty is provided for in the Revised Penal Code or special laws. If the offender is a public officer or employee, he/she shall, in addition to such fine and imprisonment, be held administratively liable and shall suffer the penalty of perpetual absolute disqualification.

CHAPTER 4
APPROPRIATION PROVISION

SEC. 63. Appropriations. - The amount necessary to carry out the initial implementation of this Act shall be charged to the Office of the President. Thereafter, such sums as may be necessary for the continued implementation of this Act shall be included in the succeeding General Appropriations Act.
An initial amount of Fifty million pesos (P50,000,000.00) for the purpose of setting up the JJWC shall be taken from the proceeds of the Philippine Charity Sweepstakes Office.

TITLE VIII
TRANSITORY PROVISIONS

SEC. 64. Children in Conflict with the Law Fifteen (15) Years Old and Below. - Upon effectivity of this Act, cases of children fifteen (15) years old and below at the time of the commission of, the crime shall immediately be dismissed and the child shall be referred to the appropriate local social welfare and development officer. Such officer, upon thorough assessment of the child, shall determine whether to release the child to the custody of his/her parents, or refer the child to prevention programs as provided under this Act. Those with suspended sentences and undergoing rehabilitation at the youth rehabilitation center shall likewise be released, unless it is contrary to the best interest of the child.

SEC. 65. Children Detained Pending Dial. - If the child is detained pending trial, the Family Court shall also determine whether or not continued detention is necessary and, if not, determine appropriate alternatives for detention. If detention is necessary and he/she is detained with adults, the court shall immediately order the transfer of the child to a youth detention home.
SEC. 66. Inventory of "Locked-up" and Detained Children in Conflict with the Law. - The PNP, the BJMP and the BUCOR are hereby directed to submit to the JJWC, within ninety (90) days from the effectivity of this Act, an inventory of all children in conflict with the law under their custody.

SEC. 67. Children Who Reach the Age of Eighteen (18) Years Pending Diversion and Court Proceedings. - If a child reaches the age of eighteen (18) years pending diversion and court proceedings, the appropriate diversion authority in consultation with the local social welfare and development officer or the Family Court in consultation with the Social Services and Counseling Division (SSCD) of the Supreme Court, as the case may be, shall determine the appropriate disposition. In case the appropriate court executes the judgment of conviction, and unless the child in conflict the law has already availed of probation under Presidential Decree No. 603 or other similar laws, the child may apply for probation if qualified under the provisions of the Probation Law.

SEC. 68. Children Who Have Been Convicted and are Serving Sentence - Persons who have been convicted and are serving sentence at the time of the effectivity of this Act, and who were below the age of eighteen (18) years at the time of the commission of the offense for which they were convicted and are serving sentence, shall likewise benefit from the retroactive application of this Act. They shall be entitled to appropriate dispositions provided under this Act and their sentences shall be adjusted accordingly. They shall be immediately released if they are so qualified under this Act or other applicable law.

TITLE IX
FINAL PROVISIONS

SEC. 69. Rule Making Power - The JJWC shall issue the IRRs for the implementation of the provisions of this Act within ninety (90) days from the effectivity thereof.
SEC. 70. Separability Clause - If, for any reason, any section or provision of this Act is declared unconstitutional or invalid by the Supreme Court, the other sections or provisions hereof not affected by such declaration shall remain in full force and effect.
SEC. 71. Repealing Clause - All existing laws, orders, decrees, rules and regulations or parts thereof inconsistent with the provisions of this Act are hereby repealed or modified accordingly.
SEC. 72. Effectivity - This Act shall take effect after fifteen (15) days from its publication in at least two (2) national newspapers of general circulation.

Approved,

JOSE DE VENECIA JR.  FRANKLIN M. DRILON
Speaker of the House of Representatives  President of the Senate
This Act which is a consolidation of Senate Bill NO. 1402 and House Bill No. 5065 was finally passed by the Senate and the House of Representatives on March 22, 2006.  

ROBERTO P. NAZARENO  
Secretary General  
House of Representatives  

OSCAR G. YABES  
Secretary of the Senate  

Approved April 28, 2006  

GLORIA MACAPAGAL-ARROYO  
President of the Philippines  

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April 10, 2000

ADMINISTRATIVE ORDER
No 34-a s,2000

SUBJECT: Adolescent & Youth Health (AYH) Policy

I. Background / Rationale

Currently, health programs for young children (0-5) have been developed and are being implemented successfully throughout the country. In 1998, the Health Department identified the need to develop a health program to address the needs of the adolescents & youth who currently constitute 40% of the entire population. The challenges in this age group are numerous since this is the stage where experimentation and unhealthy behaviors & habits start eventually leading to chronic illnesses and disability. There is therefore an urgent need, to develop a comprehensive program to meet the need of this special population group.

Adolescence and youth is not just a transitional stage of life between childhood and adulthood. These are biological, social physical and emotional milestone specific to the age groups that are critical to maturation. The World Health Organization defines, an adolescent as one belonging to ages 10-19 while youth covers the period 15-24 years old. The definition of the parameters of adolescence is problematic, since children are introduced early to adult social and economic responsibilities, with little transition between childhood and adulthood.

The stage 'of adolescence & youth is marked by rapid changes - in the physical, physiological, emotional and social development of the individual. Physically, there is a spurt of growth marked by changes in size and shape of the body. Psychosocially, the individual acquires a sense of identity, drawing apart from the elders with the developing intense relationship with peers and interest in major life decisions (eg. search for a mate or job). An important feature of this stage is curiosity and the initiation of risk behavior.
During this stage of life, confusion, conflicts and disagreements with parents usually occur and if not properly handled may lead to maladaptation and anti-social behavior. Likewise, due to accessibility of transport, the migration of rural youth to highly urbanized areas has become common. The cultural shock encountered by these youth and the lack of necessary skills and experience to cope with complex situations may result in further isolation.

To address these emerging concerns, the Department of Health is creating the Adolescent & Youth Health Sub-Program under the Program for Children’s Health Cluster for Family Health.

II. Adolescent and Youth Health Framework:

Vision: Well-informed, empowered, responsible and healthy adolescents & youth

Mission: Ensure that all adolescents & youth have access to quality comprehensive health care and services in an adolescent & youth-friendly environment.

Goals:

- Healthy development and reproduction maturation
- Healthy lifestyles to avoid illness / diseases / injuries / disabilities
- Information, education, counseling care, and rehabilitation for common health problems
- Healthy adolescents & youth friendly settings

General Objectives:
To institutionalize a comprehensive program for the health of adolescents & youth.

Health Objectives:
- Reduce morbidity and mortality among adolescents and youth
- Eliminate unwanted pregnancy / abortion / STIs
- Eliminate disabilities and accidents - drug/substance abuse; abusive/destructive behaviors
- Promote general health and development
- Provide quality adolescent & youth-friendly health programs and services.

III. Guidelines and Procedures:

General:

1. The following WHO definition shall be adopted:

Adolescent: 10-19 years old Youth: 15-24 years old Young people: 10-24 years old
2. Adolescents and youth are the priority target group of the program. This stage is a time of experimentation and uncertainty that may place them at risk of health related problems which may have lifelong effects.

3. The priority activity shall focus on the prevention of health risk and promotion of healthy activities. This should include information and services that will improve their reproductive health, nutrition, immunity from common illnesses, psychosocial health, oral health, sexual health and environmental safety.

4. Provision of a safe environment. Parents and adults should exert all efforts to create a safe environment and protect adolescents and youths from all type of exploitation such as exposure to cigarette smoke, unhealthy food (empty calorie-food), abuse by people with authority over them such as relatives, school personnel, media and advertising that emphasizes sex and violence.

5. The family shall be the most important source of basic knowledge, behavior, attitude and skills of adolescents & youth health.

6. The concerned sectors such as teachers, counselors, health providers, social workers, religious leaders, employers, the community and others should support the family in caring for adolescents & youth to prepare them in making good health decisions.

7. Health care services should be accessible and available at all times. These should be in location where they can easily go to or in places where they are usually found such as the schools, shopping malls, teen-age "hang-outs", movie houses, sports centers and in hospitals where they can avail of higher level of care. Selected RHUs with well-trained personnel on adolescent & youth health shall also provide adolescent services.

8. Health care services should be integrated at the client level and therefore must be multisectoral. Most adolescent & youth concerns are interrelated in nature and must be responded within a comprehensive program. This should include intervention to address, social, cultural, spiritual and economic aspects of health care.

9. Special services for special health problems and conditions such as disability, rape and abuse victims should be also made available. This shall include medical, legal, & rehabilitation services as well as social, legal and support services.

10. Privacy and confidentiality should be preserved at all times when dealing with adolescent problems.

   ▪ Confidentiality will build trust of the adolescents and will also protect them from the unnecessary peer pressure and embarrassment.

11. The adolescents & youth should be actively involved in the planning and development and implementation of health programs and services in their respective area.
- They should be given enough time to process and discuss the concepts among themselves so that they reach the proper decisions on the methods and approaches that would best suit their interest and frame of mind.

12. Monitoring and evaluation of the availability and effectivity of services shall be conducted regularly to further enhance the quality of programs and services.

13. Health Care Financing scheme shall be organized, developed and maintained to support the institutionalization of adolescent & youth health care and services.

14. The DOH-FHC should designate a Sub-Program-Coordinator for AYH.

**Specific Guidelines:**

1. Adolescents and youth shall be encouraged to promote the health of their peers, younger children and adults.

2. The promotion of mental health among adolescent and youth including the development of skills and competencies in stress management.

3. The DOH in close partnership with DECS organizes a working group to update, review and evaluate the schools health program.

4. All DOH hospitals and facilities shall provide adolescent and youth - friendly designated area for its program.

5. A comprehensive quality health care services should be provided to all adolescents & youth resources of ethnic, cultural, religious, social, political affiliation. Trained, health care providers such as doctors dentist, nurses, social workers, shall observe the principles of privacy and confidentiality. These services should also be gender sensitive.

**Description of the Adolescent & Youth - Friendly Designated Area.**

*A. All DOH facilities should*

- Have a trained health care provider and access to on-call specialists for special needs
- Have comfortable room where privacy can be observed
- Have a small table and 2-3 chairs available
- Have a safety cabinet where records will be kept.
- Minimize unnecessary furnishings such as office table, telephone and other physical barriers and distractions especially during the counseling session.
- Have easy accessibility from outside the hospital or separate entrance and waiting areas from other patients/ clients. A separate room from the hospital building would be ideal.
- Be equipped with necessary logistics and supplies.
- Have alternative promotional IEC materials posted on the wall and take home reading materials
- Open for 24 hours.
B. **One stop shop Adolescent & Youth Health Center shall be accredited by DOH** (Malls, Teen-age hangouts/ Tambayan, etc) based on fulfillment of the following basic requisites:

- supervised by a professional care giver (psychologist, psychiatrist, doctor, nurse, midwife or any professional trained in counseling)
- available trained peer counselors and professionals or on call professional care giver
- available recreational activities like video equipment, computers, games, etc., and reading material
- equipped with necessary logistics and supplies
- comfortable room where privacy can be observed
- a small table and 2-3 chairs available
- unnecessary furnishing such as office table, telephone etc. must be avoided to minimize physical barriers and distractions especially during the counseling session.
- safety cabinet records will be kept
- open until 8:00 PM.

C. **RHU/ BHS should**

- Rural health midwives who shall screen and refer adolescents in the proper level of care
- nurses & doctors who shall screen and provide basic intervention and refer client when necessary to higher level of care
- records that must be kept confidential.

The following features:
- a counseling room / area where privacy and confidentiality will be ensured. It must be free from physical barriers like office table, telephone, etc. to minimize and avoid distractions
- attractive promotional IEC materials posted on the wall and take home reading materials
- available trained professional health care providers
- equipped with necessary logistics and supplies
- open until 5 PM.

IV. **Implementing Mechanism:**

1. **National Level**

The DOH shall act as the lead agency in the promotion of Adolescent & Youth Health. Specifically, the Children’s Health Program will be the core health program structure that will undertake the development, monitoring & evaluation of the national AYHP strategy within the Family Health Cluster.

The FHC shall convene a Technical Working Group on AYHP to be composed of the following:

Chair: Head, FHC
Members:  Focal Person, MCHS
Focal Person, FPS
Focal Person, Nutrition Service Focal Person, NASPCP Focal Person, NCDCS
Focal Person, Dental Health Service Focal Person, WHDP Focal Person, PIHES Retained Hospital NGO
Other GOs & partner agencies with Adolescent & Youth Concerns

The Technical Working Group will develop a technical framework for specific projects under the sub-program and will review and recommend priorities based on strategic opportunities.

2. **Regional Health System:**

The Centers for Health & Development (CHD) in various regions of the country will be the sub-national structures that will assist in the implementation of AH strategy & its operating policies. All DOH Retained Hospital shall make Adolescent & Youth Health care as an integral part of hospital services. The CHD shall likewise organize a Regional TWG, the composition of which will be parallel to that of the national TWG.

3. **Human Resource Development:**

The following shall be trained / oriented in Adolescent & youth Health:
   1. Designated DOH staff (National & Regional)
   2. Designated staff of all retained DOH hospitals
   3. Designated RHU / BHS staff
   4. Other agencies (GOs, NGOs etc.) with adolescent & youth concerns
   5. Parents, peers, community, etc.
   6. Representative from Sangunian kabataan
   7. School teachers & counselors

4. **Logistics Support**

The DOH national & regional office shall include in their budget sufficient allocation for adolescent & youth health services & activities to ensure sustainability. All DOH units shall encourage funding support from different agencies, organization both local and international agency.

5. **Social Mobilization and IEC:**

This shall be a responsibility of all DOH units. Participation of other agencies (GOs, NGOs and youth themselves) is encouraged.

6. **Referral system:**
A referral system should be established at all levels. This shall follow the District Health System model and shall conform with provisions of EO 205 on establishing inter-local health zones.

7. **Networking:**

The Center for Family Health is tasked to spearhead the operationalization of the AYH and establish the necessary linkages with other services, other GOs, NGOs, academe, media and other private institutions including local and foreign donor agencies.

8. **Database**

The Adolescent and Youth Health Sub-Program will ensure the generation and utilization of data on adolescent & youth for project development, program planning, monitoring and evaluation.

9. **Quality Assurance Program:**

The Adolescent & Youth Health Program (AYHP), in all aspects of implementation, shall apply the standards and concepts set by the Sentrong Sigla to ensure quality health services. The Adolescent & Youth Health (AYH) TWG, shall therefore coordinate closely with the Sentrong Sigla Steering Committee and its 4 pillars to ensure that quality standards are developed and updated to conform with program structures and directions.

V. **Resource Mobilization / Institutionalization:**

Multisectoral participation in resource mobilization and rational budget setting for adolescent health promotion are the key to institutionalization of Adolescent & Youth Health (AYH). Efforts must be directed to tapping both public & private sectors for investments.

The DOH-CFH shall allocate 10-20% of its funds to AYH annually.

**Local Health Financing:**

As stated in the HSRA, the Phil. Health Insurance Corporation will be the key partner to initiate efforts for investing in AYH. Tapping other sources for implementation of AYH shall be a major activity for the cluster particularly private sector or non-government sources.

VI. **Effectivity:**

This order shall take effect immediately upon its approval & signing by the Secretary of Health.11

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ADMINISTRATIVE ORDER

No. 2006-0016

Subject: National Policy and Strategic Framework on Child Injury Prevention

I. BACKGROUND AND RATIONALE

The World Health Organization estimated that in the year 2002, about 875,000 children under the age of 18 years died as a result of the injury. Moreover, injuries account for approximately 6% of the global burden of disease of children under the age of 15 years (WHO, 2002). Majority of these injuries resulted from falls, animal bites, violence and assaults, poisoning, drowning, burns and road traffic accidents. Poor children were disproportionately affected; more than 98% of these deaths occurred in low and middle income countries, particularly Africa, the Eastern Mediterranean Region, South Asia and the Western Pacific (WHO, 2005). These studies showed that injury now constituted a significant part of childhood mortality and morbidity.

In the Philippines, accidents and injuries are the 5th leading causes of morbidity with a rate of 308 per 100,000 populations. Furthermore, it is the 6th leading cause of mortality with a rate of 42 deaths per 100,000 population (DOH, 2000). According to the Philippine National Injury Survey (Lim et al, 2003), vehicular accidents, falls, poisoning, violence and assaults, drowning and animal bites account for injuries among children below 18 years of age. The impact of these injuries on the society is appalling; families are deprived of their children and children who survived had to learn to cope with the consequences of their injury, which in some cases can be long lasting and profound. This situation is further compounded by the economic burden imposed to the affected families.

Several initiatives were undertaken by non-government and other government organizations, business sectors, professional societies and the academe to address the prevailing situation. However, there is a need to strengthen collaborative efforts to impact on child injury prevention. In response, the Department of Health with the support from the United Children’s Fund (UNICEF) convened all injury prevention stakeholders to a consultative forum held in January 2006. A consensus was reached, endorsing the recommendations contained in the National Strategic Framework on Injury Prevention and Safety Promotion among Children in the Philippines, a paper prepared by the Technical Working Group on Child Injury Prevention (TWG-CAIP). The paper called for establishing an infrastructure to support an integrated strategy, evidence-based programming, research and surveillance, safety promotion, and capacity-building.
To guide stakeholders in planning interventions for injury prevention, the National Policy and Strategic Framework on Child Injury Prevention is hereby formulated. This shall serve as a sub-document to the overall framework of a national injury and violence prevention program under which a number of specific injury issues could be addressed.

II. DECLARATION OF POLICIES
The policy and strategic framework shall be guided by the following legal mandates:

A. Article 24 of the 1989 United Nations Convention on the Rights of the Child emphasized the social responsibility of the member States to protect children and to provide them with appropriate support and services, emphasizing their right to the highest sustainable level of health and the right to safe environment, free from injury and violence.

B. The 1987 Philippine Constitution mandates through Article 15, Section 3 that “The State shall defend the right of the children to assistance including proper care and nutrition, special protection from all forms of neglect, abuse, cruelty, exploitation, and other conditions prejudicial to their development.”

C. Article 13, Section 11 of the 1987 Philippine Constitution adjured the State to protect and promote the right to health of every Filipino by making quality and adequate health care available and accessible, especially the underprivileged. This entails the adoption of an integrated and comprehensive approach to health development; implying a multi-sectoral partnership and multi-level health care delivery system.

D. Administrative Order 2005-0023 of the Department of Health identified Formula One for Health as an implementing mechanism for health sector reforms, thereby ensuring better health outcomes, a more responsive public health system, and a more equitable health care financing for all Filipinos. This involved critical reform initiatives in the areas of health financing, regulation, service delivery and governance.

E. Executive Order No. 310 adopted the Philippine National Strategic Framework for Plan Development for Children (Child 21) as the national framework to promote and safeguard the rights of Filipino children. It aims to synchronize family, community and national efforts toward the full realization of the rights of the children (i.e. survival, development, protection, and participation); advocating not only for a more focused targeting for children but also for interfacing critical interventions at the various stages of child development.

F. Chapter 3, Section 18 to 20 of the Magna Carta for Disabled Persons (R.A. No. 7277) required the Department of Health to institute a national health program which shall provide quality and affordable health services covering prevention of disability, early detection and timely interventions to arrest disabling conditions, and medical treatment and rehabilitation.

III. OBJECTIVE
This Administrative Order aims to:

A. Provide a strategic framework for child injury prevention implementation that is anchored on health sector reforms.

B. Provide policy direction for DOH offices, its attached agencies, LGU and other partners in terms of prioritizing activities related to child injury prevention.

C. Provide guidance to partners in the health sector identifying priority areas for support in the context of multi-sectoral collaboration/partnership to generate and mobilize resources.
D. Provide guidance to DOH concerned offices and other relevant agencies in facilitating implementation of child injury prevention in the DOH and at LGUs.

IV. Coverage and Scope of Application
This Order covers the DOH at the Central office, CHD, Hospital and other attached agencies to provide supportive policy environment and in prioritizing resources for strengthening collaborative efforts for promoting and preventing child injury in the country. It also applies to the entire health sector, as well as the public and private sectors, national agencies, and local government units, external development agencies, academe, professional associations and civil society involved in injury prevention among children 0 to 17 years old.

It shall initially focus on the following priority injury causes:
1. Road traffic injuries
2. Burns and scalds
3. Drowning
4. Falls
5. Poisoning

V. Definition of Terms
A. Community capacity – the characteristics of communities that affect their ability to identify, mobilizes and addresses social and public health problems.
B. Empowerment - a process that enables people identify their own concerns and gain the skills and confidence to act upon them.
C. Evidence-based Medicine – is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating clinical expertise with the best available external clinical evidence from systematic research.
D. Evidence-based Health Care – is a discipline centered upon evidence-based decision making about groups of patients, or populations, which may be manifest as evidence-based policy-making, purchasing or management.
E. Health Public Policy – is characterized by an explicit concern for health and equity in all areas of policy and by an accountability of health impact. The main aim of healthy public policy is to create a supportive environment to enable people to lead healthy lives. Such a policy makes healthy choices possible or easier for citizens. It makes social and physical environments health enhancing.
F. Injury – refers to the physical damage that results when a human body is suddenly or briefly subjected to intolerable levels of energy. It can be a bodily lesion resulting from acute exposure to energy (mechanical, thermal, electrical or radiant) in amounts that exceed the threshold of physiological tolerance, or it can be an impairment of function resulting from lack of one or more vital elements (i.e. air, water, warmth), as in drowning, strangulation or freezing. The time between exposure to the energy and the appearance of an injury is short.
G. Injury Prevention – means making positive choices about minimizing risks at all levels of society, while maintaining healthy, active and safe communities and lifestyles. These choices are strongly influenced by the social, economic and physical environments where one lives, works, learns and plays.
H. **Population Health** – is an approach to health that aims to improve the health status of the entire population or subpopulation and to reduce health inequities among population groups. It looks and acts upon the determinants of health - i.e. income and social status, social support networks, education, employment and working conditions, physical and social environments, biology and genetic endowment, personal health practices and coping skills, healthy child development, health services, gender and culture.

I. **Safety** – a state in which hazard and conditions leading to physical injury, i.e. psychological or material harm, are controlled in order to preserve the health and well-being of individuals and the community.

J. **Safety Promotion** – a process that aims to provide populations with the means to ensure the presence of, and maintain the conditions necessary to reach and sustain, an optimal level of safety.

K. **Surveillance** – the process of systematic collection, orderly consolidation and evaluation of pertinent data with prompt dissemination of the results to those who need to know, particularly those who are in a position to take action.

VI. **GENERAL GUIDELINES**

A. The Department of Health cognizant of the public health significance of child injuries and its impact in society shall institutionalize a comprehensive Child Injury Prevention Program, guided by the principles of evidence-based practice, partnership and shared responsibility, and integration. This shall be operationalized by means of policy and legislative enforcements, health sector reforms, public information, education and communication, surveillance systems and multi-sectoral collaboration in service provision.

B. The health program for child injury prevention shall be in accordance with the thrusts of the National Objectives for Health (2005-2010), Medium Term Development Plan of the Department of Health (2002-2010), and Millennium Development Goals (2005-2015).

C. The Strategy will initially focus on areas where the intentions are possible, effective and able to be implemented with a clear and actionable role for the health sector. Five priority areas for immediate action by the health sector will be undertaken. These are prevention of road traffic injuries, falls, burns, poisoning and drowning.

D. In line with the DOH mission to guarantee equitable, sustainable and quality *Health For All Filipinos*, especially the disadvantaged and vulnerable sectors, the Child Injury Prevention Strategy will be based on a population health approach that addresses the range of factors (i.e. social, economic, cultural and political) that determine the health and well-being of the overall population.

E. Consistent with the World Health Organization definition of health, the approach views health as an asset and resource for everyday living, not simply the absence of disease. Health depends more than just health care. The population health approach concerns itself with the living, working and economic environments that affect people’s health and safety, the conditions that enable and support people in making healthy choices, and the services that promote and maintain health.

F. Numerous determinants of health influence the health of individuals and communities: income and social status, social support networks, education, employment and working conditions, physical environments, genetics, personal health practices and coping skills, health services, gender and culture, and healthy child development. It is the complex interaction of these determinants that has impact on the health of individuals and communities. These are all factors that make a difference on how long people live, the quality of their lives and their risk of injury.
G. In applying this approach to injury prevention, the burden and the solutions lie not just within the health sector, but evidently with many other sectors, e.g. transportation, public works and highways, labor and industry, education, local government, social welfare and others.

VII. STRATEGIC FRAMEWORK ON CHILD INJURY PROGRAM

A. VISION AND MISSION

Vision: The Philippines has the lowest child injury rate in Asia.

Mission: Guarantee cost-effective injury prevention interventions to every Filipino child, and ensure sustainable and equitable multi-sectoral support.

B. GOALS:

Reduce health disparities that increase the risk of injury among children and
Reduce societal burden of child injury, and improve the health of the Filipino child.

C. PROGRAM OBJECTIVES

Decrease the incidence, severity morbidity and mortality associated with child injuries at home, in the community, schools, roadways and acute care settings.

The specific program objectives include the following:
1. To address the health gaps and needs pertaining to injury prevention
2. To empower families and communities in ensuring safety mechanisms for children
3. To expand/strengthen partnerships and multi-sectoral involvement at the national and local levels
4. To increase access to quality health care and rehabilitation services
5. To develop a database on child injury

D. GUIDING PRINCIPLES

The Child Injury Prevention Strategy development is guided by the following principles:

1. Evidence-based Practices

   Evidence-based practices can be positioned along a continuum from qualitative to quantitative evidence. Examples ranging from qualitative to quantitative include: opinion based on community experience or cultural knowledge, to descriptive studies, survey, cohort studies, non-randomized trials, and finally, randomized control trials. Decision-making regarding interventions are to be based on systematic appraisal of the best evidence available in the context of the prevailing values and resource available.

   To prevent the continued waste of valuable resources on practices that may not be effective, practitioners, researchers and policy makers need to work closely to develop and implement a national research agenda that supports the strategy, this includes institutionalization of an injury surveillance system. Research has shown that injury prevention strategies that combine environmental design (e.g. road construction, product design), education and legislative and regulatory requirements that support environmental and behavioral change, are most effective.
2. Partnership and Shared Responsibility

A partnership is a voluntary agreement between two or more parties to work cooperatively toward a set of shared outcomes in injury prevention. Partnership may form part of a multi-sectoral collaboration for Child Injury Prevention, or be based on alliances for specific injury issues. Partnerships may include the public sector, the non-government organizations and the private sector. They may also involve the different levels of jurisdiction (e.g. municipal, city, provincial, regional, national and international levels).

The principle of shared responsibility recognizes that injury prevention is not just the responsibility of individuals. Creating conditions conducive to injury prevention is not just the responsibility of individuals. Creating conditions conducive to injury prevention is the responsibility of all sectors (e.g. transportation, public works and highways, health, education, industry, and others) and is affected by governments at all levels, the private sector, the non-government organizations, families, schools, workplaces and communities.

Partnerships are an important mechanism for putting the idea of integration into practice. Effective partnerships have the potential to add value to work that is already being done to address issues in Child Injury Prevention.

3. Integration

Considerable work is already being done to address specific injury issues (e.g. motor vehicle safety, workplace safety, ‘Petron-Road Traffic Accident Prevention’, ‘Safe Kids’, ‘Bantay Bata’, ‘Bisig Bayan’) by community groups, governments, non-government organizations and the private sector, including media. Integration shall be the major focus of the Strategy. It means working in a more coordinated way to address specific issues together, as much as possible.

E. STRATEGIC DIRECTIONS

The strategic directions have been set for a five-year period, from 2006 up to 2010. To decrease the incidence, severity, morbidity and mortality associated with child and adolescent injuries is the principal objective of the Child Injury Prevention Strategy. Accordingly, the following strategic responses shall be adopted:

1. Enhanced capacity for data collection

Best evidence for policy, decision making and tracking progress require good data source on interventions that work, surveillance and special surveys. The Child Injury Prevention Program shall make decisions based on evidence gathered routinely from regular monitoring and evaluation. Continuing improvement shall be targeted through research.

2. Legislations and Enforcements

Support from political leaders is not only necessary to ensure proper funding and effective legislation, but also to give injury prevention efforts increased legitimacy and a higher profile within the public consciousness. Commitment is as important at national level, where
policy and legislative decisions are made, as at provincial, district, city and municipal levels, where the day-to-day functioning of many interventions is controlled.

Because many of the determinants of health and injury prevention are influenced by policies and legislations outside of the health sector, all sectors (e.g. health, transportation, public works and highways, labor, education, and others) need to work together in the pursuit of win-win policies that create environments for child and adolescent injury prevention. Governments at all levels have an important role to play in developing health public policy. Several laws and ordinances are promulgated to provide safety on the road, at home, in school, workplace and recreational areas. There is a need to monitor adherence to existing laws on safety and injury prevention measures.

3. Transformation of Health Systems

The prevention of deaths and disability secondary to injury include assuring access to health facilities, improving quality of hospital care through upgraded hospital equipment and enhanced capacity of health personnel, strengthening emergency response mechanisms, and establishing rehabilitation services. In areas where it is not possible to provide tertiary health care and rehabilitation services, a referral should be established.

Development of standards and regulations for product safety will complement the capacity of the health system to prevent injuries, particularly in poisoning, burns and other unintentional external causes of injury. Moreover, the present systems for quality control implemented by different government agencies need to be strengthened. There is a need to focus on how standards and regulations, as well as existing laws on safety can be strictly implemented.

4. Resource Generation and Mobilization through Partnerships

The Child Injury Prevention Strategy encourages multi-sectoral collaboration to generate and mobilize resources. Resources sharing from an established network of stakeholders will increase the capacity to respond to child injuries and their determinants.

It must be emphasized that health inequalities must be addressed through the health financing system, especially the Philippine health Insurance System (PHIC). A review of the present coverage for injuries should be undertaken to expand the PHIC benefit packages.

5. Health Workforce Development

Primary health care workers and secondary-care hospital workers should know how to manage injury cases. The hospitals should also be furnished with basic equipment and supplies in the diagnosis, management and treatment of injuries. Particular emphasis in primary prevention responses will be promoted during skills training.

6. Empowerment of parents, families, and the community

Improvement of family and community practices shall be the core of safety promotion. Injury prevention entails information, education and communication campaigns in all levels of societal structures, which include the home, community, school and workplace. Mass media can
be used to intensify health promotion and injury prevention, including early interventions. Appropriate key messages should be developed to effect changes in attitude and behavior. This empowers the people to assume responsibility for their own safety and strengthens their capacity to respond to a range of public health issues on injuries for children and adolescents.

Health promotion approaches that are based on an assessment of community needs, engage and empower communities, and contribute to increased community capacity are most likely to achieve sustainable, long-term outcomes.

VIII. PROGRAM IMPLEMENTATION
A. PROGRAM COMPONENTS
In accordance with the National Injury Prevention and Control Program of the Department of Health, the following program components for Child Injury Prevention will be developed.

1. Health Promotion
   This component shall include advocacy, information, education and communication activities addressed to policy makers, other government and non-government agencies, private sectors including media, the general public and other stakeholders concerning the underlying socio-economic and environmental conditions, the individual risk factors, risk behaviors and the impact of child and adolescent injuries on society; to evoke positive socio-political response and changes in the public perceptions of the preventability of injury.

2. Human Resource Development and Management
   This component shall focus on enhancing the capability of health and non-health providers at all levels in injury prevention. It shall include developing mechanisms to guarantee availability and accessibility of accredited training institutions and service providers adept in rendering comprehensive injury prevention interventions for each key setting, which may include, but not limited to the community, schools, homes, leisure and sports areas.

3. Surveillance System
   This component shall ensure that a system of data recording and reporting of child and adolescent injuries is established and institutionalized at the national, regional and local levels. A health information system shall be developed for this purpose. The system shall adopt the ICD-10 for the definition and classification of injuries, and include other pertinent data for monitoring and evaluation of program effects. All injury stakeholders shall cooperate and coordinate with the Department of Health for information exchange which shall be made available and accessible to all end-users for evidence-based decision making.

4. Networking and Linkages
   This component shall establish multi-sectoral collaboration and partnerships with injury stakeholders at the national, regional and local levels. It shall take into account the mandates and activities of the various stakeholders involved in child injury prevention, and forge agreements and commitments in the following areas, but not limited to advocacy and awareness campaigns, research, information exchange, service provision and referrals, resource sharing, and regulatory enforcements.
5. Equitable Health Financing Package
   In coordination with the Philippine Health Insurance Corporation (PHIC), this component shall formulate PHIC-indigent packages for injury-related sequelae. Compensations and other benefit packages for work-related injuries shall be addressed through existing programs for employees in the private sector (Social Security System) and public sector (Government Service Insurance System) in consonance with the guidelines developed by the Employee’s Compensation Commission.

6. Research and Development
   This component shall establish a research agenda to build knowledge and evidences, and gain a better understanding of child injuries in relation to the determinants of health. Thus, appropriate responses can be developed and evaluated. It shall include, but not limited to the causes of injury, its consequences, costs and impact of interventions.

7. Service Delivery
   This component shall establish a comprehensive and integrated package of service provisions in all levels of the health care delivery system, with emphasis on primary prevention. If necessary, cross-sectoral intervention management shall be instituted through appropriate referral mechanisms. The principle of evidence-based practice shall be applied to all interventions to ensure quality care and cost-effectiveness.

8. Monitoring and Evaluation
   This component shall identify key indicators for the evaluation of program effects, which include process (strategy objectives), impact (program objectives) and outcome (program goals) for each of the six priority areas. The results of the evaluations shall be used in revising or formulating policies, guidelines, strategies, and program plans for child and adolescent injury prevention.

B. TYPES OF INJURY

For analysis purposes and for identifying intervention opportunities, injuries are categorized according to whether or not they were deliberately inflicted and by whom. Based on the International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10), the following categories will be adapted:

1. Unintentional (i.e. accidental)
   a. Road traffic injuries – any injury due to crashes originating, terminating or involving a vehicle partially or fully on a public highway or street.
   b. Poisoning – all unintentional poisoning-related deaths and non-fatal outcomes caused by exposure to noxious substances. Those which are intentional of for which the intent is undetermined as well as those resulting from reactions to drugs are excluded from the definition used here.
c. Falls – fall-related deaths and non-fatal injuries exclude those due to assault and intentional self-harm. Falls from animals, burning buildings and transport vehicles, and falls into fire, water and machinery are also excluded.

d. Burns – occur when some or all of the different layers of the cells in the skin are destroyed by a hot liquid (scald), a hot solid (contact burns), or a flame (flame burns). Skin injuries due to ultraviolet radiation, radioactivity, electricity or chemicals, as well as respiratory damage resulting from smoke inhalation, are also considered to burns.

e. Drowning – all unintentional drowning and submersion (with the exception of those which occur as a result of cataclysm, transport and water transport accidents) are classified as drowning deaths.

f. Other intentional injuries – includes exposure to animate and inanimate mechanical forces (including firearms); exposure to extreme ambient temperature and pressure, and to forces of nature; contact with venomous plants and animals; and other external causes.

2. Intentional (i.e. deliberate)

a. Interpersonal violence – the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation.

b. Self-harm – includes self-inflicting poisoning or injury (e.g. abuse of drugs and alcohol, and self-mutilation)

c. Suicide - is defined as a death arising from an act inflicted upon oneself with the intent to kill oneself.

d. Legal interventions – includes actions by police or other law enforcement personnel involving firearm discharge, explosives, gas, blunt/sharp objects and other specified means.

e. War, civil insurrection and disturbances – includes injuries to military personnel and civilians caused by war and civil insurrection (e.g. demonstrations and riots).

f. Undetermined intent – events where available information is insufficient to enable a medical or legal authority to make a distinction between accident, self-harm and assault. It includes self-inflicted injuries, but not poisoning, when not specified whether accidental or with intent to harm.

IX. IMPLEMENTING GUIDELINES

A. ORGANIZATIONAL STRUCTURE

Based on the activities of the Five-Year Strategic Workplan, the organizational structures shall be established, with delineation of roles and responsibilities, and identification of areas of coordination and collaboration among child injury prevention stakeholders.

1. National Structure

a. A National Child Injury Prevention Partnership (NCIPP) shall be created by virtue of an Administrative Executive Order designating the Department of Health represented by the Undersecretary of Health Program Development Cluster and the Council for the Welfare of Children, represented by its Executive Director as co-chairs. The NCIPP meetings shall be alternately convened and preside by both agencies. Composed of core staff from both agencies, other government and non-government agencies, professional societies, academe, other public and private sectors, it shall be responsible for developing and
implementing a national action plan for child injury prevention. It shall call on the
different agencies to do their part in preventing child injury.
a.1 Sub-committees shall be organized corresponding to the five priority areas as
necessary. According to specific areas of involvement, the sub-committee shall
comprise sector representatives and DOH program managers. In coordination with
the regional and local implementing committees, it shall be responsible for program
monitoring and evaluation based on their respective priority areas, and provide
recommendations to the NCIPP.
a.2 There shall be a Secretariat responsible for coordinating the meetings, preparation of
agenda and documenting the minutes of the meeting and shall come from the agency
responsible for convening the NCIPP meetings.

2. Regional and Local Structures
b. Program strategies and activities undertaken at the local level shall be managed by the
Regional Child Injury Prevention Partnership (RCIPP) or by existing committee that can
absorb this function. The composition and organizational arrangements shall correspond
to the NCIPP. For NCIPP without regional counterparts, other stakeholders shall be
encouraged to be involved.
c. Program implementation shall be carried out at the provincial, city, municipal and
barangay levels. The composition and organizational arrangements shall relate to the
RCIPP. Each corresponding level shall be under the leadership of the chief local
executive. For RCIPP without local counterparts, other stakeholders shall be encouraged
to be involved.

B. Roles and Responsibilities
1. Department of Health
The Department of Health as the lead agency, undertook the initial assessment of the
magnitude of the problem of child injury in the country. It shall continuously raise awareness
among its partners in the government and private sectors, advocate for and create political
commitment, and set up a multi-sectoral mechanism on child injury prevention.

The Department of Health, and for that matter the health sector, has the primary
responsibility of providing care to the victims of violence and injury. Formulation of policies
to prevent injury may be the scope of other agencies, but the health system may help shape
these policies by providing data on health outcomes and effective intervention based on
science-based approaches. Specifically, the health sector has the following core tasks:

- Develop a surveillance system to capture incidence and prevalence of injuries
- Collect, analyze and disseminate data on the magnitude and health consequences of
  injuries.
- Advocate for action to prevent and control injuries
- Make available preventive, emergency, curative and rehabilitative services
- Train public health and health care providers in injury prevention and care
- Design and implement IEC activities
- Evaluate the intervention activities using a science-based approach
2. **Role of the Local Government Units (LGUs)**
   The LGUs should be able to translate the national policy on child injury into local policies or ordinances for implementation. The LGUs shall facilitate the allocation of funds and generate resources from its various partners in the field. They shall harness the involvement of government agencies, non-government agencies, families and communities and other stakeholders for a unified action towards child injury prevention.

3. **Role of other government agencies, the non-government agencies, private sector, civil society and other partners**
   The wide range of causes and solutions to injury problems entail stakeholders from various disciplines and competencies. Each potential stakeholder shall pitch in their expertise and competence, resources and skills, adopting a multi-sectoral, joint action-oriented effort with no competition and conflict of interests. The problem of injuries cannot be solved by a single agency on its own.

C. **FUNDING**
   The Department of Health and Centers for Health Development shall provide funds for technical assistance, monitoring and advocacy campaigns. The Council for the Welfare of Children, other national government and non-government agencies, local government units and other stakeholders shall contribute counterpart funds to ensure and sustain the implementation of the Child Injury Prevention Program.

X. **REPEALING CLAUSE**
   The provisions of previous Orders and other related issuances inconsistent or contrary with the provisions of this Administrative Order are hereby revised, modified, repealed or rescinded accordingly. All other provisions of existing issuances which are not affected by this Order shall remain valid and in effect.

XI. **EFFECTIVITY**
   This Order shall take effect immediately.12

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STRATEGIC FRAMEWORK

Figure 1. Key Elements of the Child Injury Prevention Strategy

VISION
The Philippines has the lowest child rate in Asia

MISSION
Guarantee cost-effective interventions to every Filipino child, and
Ensure sustainable and equitable multi-sectoral support

GOAL
Reduce health disparities that
increase the risk of injury among
children and adolescents

GOAL
Reduce societal burden of child &
adolescent injury and improve the
health of the Filipino child

OBJECTIVE
Decrease the incidence, severity, morbidity and mortality associated with
child and adolescent injuries

POPULATION HEALTH APPROACH

Evidence-Based Practice
Partnership and
Shared Responsibility
Integration
(vertical & horizontal)

Enhanced capacity for
data collection
Legislations and
Enforcement
Transformation of Health Systems
Resource Generation and Mobilization
Workforce Development
Empowerment of parents, families &
communities

Target Population
Children

PRIORITY AREAS
Road Traffic Injuries, Drowning, Burns, Falls, Poisoning, Suicide
ADMINISTRATIVE ORDER

No, 2007 – 0010

SUBJECT: National Policy on Violence and Injury Prevention

I. BACKGROUND AND RATIONALE

The World Health Organization reported that injuries have become a major public health problem throughout the world. Injuries accounted for 9% of the world’s death in 2000. (World Health Report) In industrialized countries, intentional and unintentional injuries have become the 3rd most important cause of overall mortality and main cause of death among 1-40 year old age group. (World Health Report 2000) There is evidence moreover that the incidence of injuries is growing.

The multi-factorial causes give injuries a prominent position among health problems. It represents 12% of the global burden of diseases. (WHO 2000) The WHO estimated that 5.1 million people worldwide died from injuries in 2000, which corresponds to a rate of 87.3/100,000 populations, 112/100,000 male population and 54.9/100,000 female populations. By the year 2020 it is expected that road traffic crashes will account for the 3rd highest cause of the global burden of disease, jumping from its current ranking of ninth. (World Health Report 2000) Others like the interpersonal violence, self-inflicted injuries and wars are expected to rise also (WHO 2000) Developing countries will be largely responsible for this predicted sharp rise, having already experienced a significant increase in road deaths throughout the last decade while high-income countries have sustained a steady decrease. (WHO 2000) Within the Western Pacific Region, consisting of 20 member states that are considered middle to low income countries, the leading injury-related causes of death are road traffic injuries (1st among 15-29 years old), interpersonal violence (2nd among 15-29 years old) and drowning (4th among 5-14 years old) (Global Burden of Diseases Project 2002)
Injury is a major contributor of ill health and disability. It can occur everywhere, at home, at work, in public places, during recreational and leisure activities or even in the conduct of legal activities or interventions. Injuries are not accidents or acts of fate, and these are preventable and predictable. By investing in injury prevention can save money and save lives. Injuries have substantial impact on the lives of every Filipinos.

Accidents consistently remain one of the leading causes of morbidity and mortality in the country. The Philippine Health Statistics from 1975 to 2002 revealed that there has been an increasing trend of mortality due to accidents per 100,000 populations. Mortality rate increased from 19.1/ 100,000 population in 1975 to 42.3 in 2002 corresponding to 33,617 deaths, majority of which is caused by assaults (13,276); transport accidents (6,131); accidental drowning and submersion (2,871); and accidental falls (1,536). Accidents ranked 8th in 1975, 7th in 1985 and 6th in 1995 and 5th in 2002 among the 10 leading causes of death.

Reports from the Traffic Management Group, showed that road accidents went down. This figure is contradictory to the reports from the Philippine General Hospital, that there is an increasing number of serious vehicle-related injuries wherein as much as 50 percent of emergency serious injuries admitted are vehicle related (Road Crash: Of Numbers and Other Problems by Emerson Sanchez). Road safety problem shall pose a big problem if we do not know the real data. There shall be a good registry of road traffic accidents to identify and implement effective solutions to reduce traffic accidents.

Several actions were taken by individual government agency pertaining to road traffic accidents prevention, for instance Land Transportation and Traffic Code, Seat Belt Law which was amended to include provision for child safety; helmet use, pedestrian lanes and Barangay Tanod assistance for crossing school children. Despite these laws and initiatives, the expected outcomes or impact are yet to be realized due to some pressing priorities. Another issue is the presence of different organizations involved in the prevention of accident and injuries. They seemingly adhere to unclear levels and elements of integration. In parallel, they even lack clear direction for local implementation. Undoubtedly, the general public and the government should give importance to road safety and other causes of injuries. Government, in particular, should take the initiative in preventing, if not lessening, its negative effects through its various agencies such as the DOH, DOTC, PNP-TMG, DILG, DPWH, DepEd, MMDA and others.

With the Fourmula One for Health as the current framework for health reforms, and the National Objectives for Health 2006-2010, as its actualization, the DOH sets out government’s vision for an injury-free Philippines. The Department would be better focused on equitably allocating efforts and resources to injury prevention by providing a clear direction to necessary stakeholders, such as, other government agencies, organizations, local government units, and individuals.
II. DECLARATION OF POLICIES

The program shall be guided by the following basic policies:

1. The 1987 Philippine Constitution mandates the following: (1) Article II Section 15 for the protection and promotion of the right to health of the people and instills health consciousness among them; and (2) Article 13 Section 11, which specifies that the State shall adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services available to all the people at affordable cost. There shall be priority for the needs of the under-privileged, sick, elderly, disabled, women, and children. The State shall endeavor to provide free medical care to paupers.

2. Administrative Order No. 2005-0023 of the Department of Health identified Formula One for Health as the implementing mechanism for health sector reforms, thereby ensuring better health outcomes, a more responsive public health system, and a more equitable health care financing for all Filipinos. This involved critical reform initiatives in the areas of health financing, regulation, service delivery and governance.

3. Chapter 3, Section 18 to 20 of the Magna Carta for Disabled Persons (R.A. No. 7277) required the Department of Health to institute a national health program which shall provide quality and affordable health services covering prevention of disability, early detection and timely intervention to arrest disabling conditions, and medical treatment and rehabilitation.


III. OBJECTIVES

To establish a national policy and strategic framework for injury prevention activities for DOH and other government agencies, local government units (LGUs), non-government organizations (NGOs), community and individuals.

IV. SCOPE

This Order shall apply to all bureaus, national centers, centers for health development, and DOH retained hospitals. Active advocacy shall also be undertaken in order to inculcate the principles and activities set by this Order to other agencies, local government units, non-government organizations (NGOs), civil societies, communities and individuals.

V. DEFINITION OF TERMS

For purposes of this Order, the following terms shall be defined as follows:

1. Accidents – refers to unexpected occurrence, which happens by “chance” or “acts of fate”. It is an event that is not amenable by planning or prediction. They result from risks that are poorly managed.
2. DepEd – refers to the Department of Education
3. DILG – refers to the Department of Interior and Local Government
4. DOTC – refers to the Department of Transportation and Communication
5. DPWH – refers to the Department of Public Works and Highways
6. DSWD – refers to the Department of Social Welfare and Development
7. Injury – refers to a bodily lesion at the organic level resulting from acute exposure or by the transfer of energy, such as kinetic, thermal, chemical, electrical or radiant interacting with the body in amounts or rates that exceed the threshold of physiological tolerance. It can also be due to the absence of oxygen or heat.
8. Injury Prevention – refers to efforts that prevent agents of injury from reaching people in amounts or rates that exceed human injury tolerance. This may include components of primary, secondary and tertiary prevention (e.g. increasing resistance to injury by increasing human injury threshold).
9. Injury Surveillance – refers to the ongoing systematic collection, analysis and interpretation of injury-related data that are essential for planning, implementation and evaluation of policy makers. The application of gathered data to prevention and control constitutes the final link of the surveillance chain.
10. Intentional Injury – refers to injury resulting from interpersonal or self-inflicted violence. It includes Homicide, assault, suicide and suicide attempt, sexual assault and violence among family members and intimate partners or injury resulting from deliberate violence inflicted by oneself or another person.
11. MMDA – refers to the Metro Manila Development Authority
12. PNP – refers to the Philippine National Police
13. Road Traffic Injury – refers to injuries involving at least one moving vehicle that occurs or originates on a way or street that is open to public traffic.
14. Unintentional Injury – refers to injury that is not inflicted by deliberate means. It also refers to death or disability resulting from “accidental” circumstances, such as: Falls, Drowning, Road Traffic Injuries, Asphyxiation, and Burns.
15. Violence – refers to intentional use of physical force or power, whether threatened or actual, against oneself, another person, a group or community that either results in or has a high likelihood of resulting to injury, death, psychological harm, maldevelopment or deprivation.

VI. GENERAL GUIDELINES
The National Policy on Violence and Injury Prevention shall be guided by the following principles:
1. Evidence-based practices. Interventions shall be developed through a clear and careful identification of the issues that need to be addressed based on best and applicable research evidences.
2. **Partnership and shared-responsibility.** Violence and injury prevention requires collaboration of all sectors and partners, including public and private agencies, individuals, communities, and other stakeholders.

3. **Integration.** This means that all involved sectors shall be working in a coordinated way to address specific issues together. Integration in three areas of public policy, research and intervention can also add value to what is currently being done for greater impact and more efficient and effective use of resources.

4. **The 4 E’s.** Strategies shall utilize the concept of the 4 “E’s”, Education, Enforcement (in addition to Enactment), Engineering, and Economic incentives, in the prevention and control of injuries.
   - **Education** entails dissemination of information related to injury prevention. Strategies and programs can be targeted at the risk group identified in the populations.
   - **Enforcement and enactment** strategies identify opportunities for injury prevention policy development and implementation.
   - **Engineering** provides an effective way of reducing the impact of injury causes through the application of energy transmission designs.
   - **Economic incentives** can be instrumental in pursuing injury prevention policies. An example is when it is utilized to provide access to injury prevention devices such as child restraint seats.

VII. **SPECIFIC GUIDELINES**

The program and action plans that are to be developed for each classification of injuries shall consider the following principles:

1. **Health Promotion.** DOH, in collaboration with other stakeholders, shall undertake advocacy, information and education, political support, and inter-sectoral collaboration on accidents/injury prevention and patterns and factors associated with incidence of accidents/injury to policy makers, government agencies, civil societies, people’s organizations, the general public and other stakeholders.

2. **Developing Institutional Arrangement and Capacity.** DOH, in partnership with other stakeholders shall develop and enhance the violence and injury prevention capabilities of a wide range of sectors and stakeholders at the local and national levels. Training programs shall be made available and accessible to policy implementers at the national, regional and local levels.

3. **Injury Surveillance System.** DOH shall establish and institutionalize a system of data recording, reporting and analysis at the national, regional and local levels. An information
system (e.g. National Injury Surveillance System) shall be developed for this purpose. The system shall record injuries, patterns and factors that may have caused the injury as well as the available services, health status needs and circumstances of injured person. DOH shall advocate to various stakeholders involved in the management of the different types of injuries through cooperated reporting, archiving and linking of new and existing databases for a more comprehensive picture.

4. **Networking and Resource Mobilization.** DOH shall promote partnerships with and among various stakeholders to build coalitions and networks and generate resources for activities related to violence and injury prevention. In the process, the Department shall initiate coalition building through formal and informal instruments (e.g. M.O.A., M.O.U. etc.) with stakeholders in order to ascertain their commitment in implementing defined action plans and programs, and in mobilizing all available resources. Sharing of responsibilities and allocation of resources to address the problem to achieve a maximum result shall be explored.

5. **Monitoring and Evaluation.** DOH, in consultation with various stakeholders, shall identify indicators and targets for program monitoring and evaluation purposes.

6. **Equitable Health Financing Package.** DOH in collaboration with various stakeholders, shall advocate to health financing institutions and financial intermediaries, i.e. PHIC, insurance companies, the development and implementation of policies that would be beneficial to victims of violence and injury.

7. **Research and Development.** DOH shall promote the conduct of multi-disciplinary and multi-sectoral solutions and researches for purposes of developing national and local competence in injury prevention, health care services and for other purposes that may be necessary.

8. **Service delivery.** In collaboration with stakeholders, DOH shall institutionalize systems and procedures for the integration and provision of services at the community level. Information shall be utilized for continued public health information and education, planning and implementation, and policy revision. Appropriate primary prevention, care and rehabilitation of injured people shall also be crucially provided.

9. **Community Participation.** DOH shall aim for a successful community-based violence and injury prevention to anchor upon a community-wide sense of ownership and empowerment to accomplish tasks. This is to ensure that all patients receive quality services at the appropriate levels of health care delivery system. Successful community-based programs also revolve around the formation of new partnerships between a diverse group of constituents who have vested interest in violence and injury control, including representatives of public safety, law enforcement, fire, local governments, school, businesses community groups, and
health care providers. All rural health units should be linked to a referral center specific to and appropriate to the type of injury sustained.

10. **Policy Advocacy.** DOH shall advocate for the necessary policy instruments, such as laws, executive orders, administrative orders and ordinances to the Congress, other national agencies and LGUs respectively. This approach shall ensure sectoral and community-based interventions to propel action on violence and injury prevention.

**VIII. IMPLEMENTING MECHANISM**

A. **The Injury Prevention Program**

The DOH shall serve as the focal agency with respect to violence and injury prevention. As such, it shall design, coordinate and integrate activities, plans and programs of various stakeholders into an effective and efficient system. The Violence and Injury Prevention Program is hereby institutionalized as one of the programs of the National Center for Disease Prevention and Control.

To ensure coordination and sustainability of the Program, a Program Management Committee (PMC) shall be organized. The Committee shall then be subdivided into Sub-Committees according to the following areas of concern, namely: a.) Road Traffic Injuries; b) Thermal Injuries (burns and scalds); c) Drowning; d) Physical Injuries (falls, violence); e) Chemical Injuries (Poisoning, etc.). For a comprehensive approach, the program shall coordinate with other programs like the Maternal and Child Health and other DOH offices such as the National Center for Health Facility Development, Health Emergency and Management Services, among others, solicit active representation from public and private stakeholders that are involved in violence and injury prevention.

The Undersecretary for Policy and Standards Development-Health Service Delivery Team shall exercise overall supervision on the program. The Degenerative Disease office Staff shall provide secretariat support.

A National Program Coordinator shall be designated from the Degenerative Disease Office.

B. **The Program Management Committee (PMC)**

1. **Composition**

The PMC shall be chaired by the Director IV of the National Center for Disease Prevention and Control with the following as members: Division Chief of the Degenerative Disease Program; National focal person (Program Manager) for violence and injury prevention program; and Representatives from DOTC, DPWH, DILG / League of municipalities, Specialty Societies, and other agencies/organizations, which are to be identified by the Committee itself. Experts in the
various aspects of violence and injury prevention shall also be involved to ensure a comprehensive program approach.

The PMC members shall be nominated by the agency/organization that they represent. Their membership to the PMC shall be on an annual basis. Renewal or replacement of membership shall be the exclusive prerogative of the represented agency/organization.

The PMC shall be subdivided into Sub-Committee to undertake more specific policy interventions and activities in relation to each area of concern. Each Sub-Committee shall have an interdisciplinary composition.

The composition the PMC shall be provided for in pertinent Department issuances in relation to written agreements such as M.O.A. or M.O.U. with necessary agencies and stakeholders.

2. Functions and Responsibilities
The Project Management Committee (PMC) shall have the following responsibilities:

a.) Recommend to the Secretary of Health activities and plans
b.) Monitor the implementation of program activities
c.) Initiate and undertake inter-agency collaboration through and informal modes.
d.) Endorse the support of researchers in the clinical, epidemiological, public health and knowledge management areas.
e.) Others that may be identified and approved by the Secretary of Health

Each Sub-Committee shall have the following responsibilities:

a) Agree upon an annual research agenda for injury prevention
b) Incorporate creativity enhancement strategies in their program plans to increase innovative potentials, and;
c) Issue periodically clinical practice guidelines, which will be developed in consultation with various stakeholders.

IX. FUNDING
The Department of Health and Centers for Health Development shall provide funds for technical assistance, monitoring and advocacy campaign (IEC materials). Furthermore, the local government units, DOTC, DepEd, DILG, DSWD, DPWH, PNP, MMDA, NGOs and other stakeholders are encouraged to allocate/contribute counterpart funds to ensure the implementation of the National Injury Prevention Program.

X. REPEALING CLAUSE
consistent with the provisions of this order are hereby revised, modified or rescinded accordingly.

XI. SEPARABILITY CLAUSE
In the event that any provision of this Order is held invalid, the validity of the remaining provisions shall not be affected.

XII. EFFECTIVITY
This order shall take effect immediately.\(^{13}\)

FRANCISCO T. DUQUE III, MD, MSc
Secretary of Health

Strategic Framework
ANNEX 14

Republic of the Philippines
Department of Health
Office of the Secretary

Administrative Order
No. 2012-0004

SUBJECT: Policy Framework for Public-Private Partnerships in Health

I. Background and Rationale

In pursuit of the objectives of Universal Health Care or “Kalusugang Pangkalahatan (KP)”, as defined in Administrative Order No. 2010-0036 (The Aquino Health Agenda: Achieving Universal Health Care for All Filipinos), the Department has committed to engage in more Public-Private Partnerships (PPPs) specifically to enable physical improvements in government health facilities. PPPs have been also looked upon by no less than the President of the Republic as a key national development instrument, the furtherance of which is therefore a priority of all government agencies, including the Department of Health.

The private sector is deemed to have intrinsically better capabilities in some areas, such as more timely financing, operational efficiency, highly-responsive services and even dominant market presence. If optimally harnessed, more cooperative undertakings with the private sector may help significantly address some of the constraints and inefficiencies inherent in public-only provision of health services.

The Philippine government has long recognized the advantage of adopting PPPs in public sector undertakings, especially for large-scale priority infrastructure developments. The mechanisms for the latter had been laid out in the Republic Act 771, otherwise known as the Amended BOT Law. While the latter account for several possible variants of PPPs, the included listing is still not exhaustive. Separate guidelines for Joint Ventures, another PPP modality, have been drawn up by the National Economic and Development Authority (NEDA).

The local PPP experiences in the health sector have thus far been varied. While many such endeavors have been documented, most of these have been found to be non-contractual in nature (with consequent minimal accountabilities and performance references), and many have been unsustainable. It also remains to be determined if existing and upcoming PPPs in health
substantially address the fundamental UHC goal of enhanced access to health care for the country’s poor. All these assume greater significance in the light of the reported United Nation’s consideration of the Philippines as the Center of Excellence for PPPs in Health.
It is apparent from the foregoing that while the national policy on PPPs has been set, much remains to be clearly delineated and effectively adapted for health services. This Administrative Order has therefore been crafted in order to better define the applicability and prioritization of the relevant policies, streamline their implementation, and enable the continuing evaluation of PPPs in the health sector.

II. SCOPE AND COVERAGE
This issuance shall apply to the entire health sector, from both the public and private sectors, the DOH bureaus, national centers, hospitals, and attached agencies especially Philippine Health Insurance Corporation (PhilHealth), which are involved in the support for and provision of health services.

III. GOAL AND OBJECTIVES
A. Goal
The establishment of Public Private Partnerships is to be encouraged and sustained in the areas of health care where these most contribute to the achievement of “Kalusugan Pangkalahatan”, and thereby ensure equitable access and better outcomes for disadvantaged Filipinos.

B. Objectives
The DOH aims to:
1. prioritize PPPs that meet national and local government objectives of addressing adequately the health service needs of the poor;
2. promote and provide a focused approach that harmonizes the existing PPP-applicable legal and administrative mandates as well as internal strategies and procedures;
3. foster a culture that endangers transparency, fairness, and robust competition;
4. develop and integrate in the overall PPP efforts, incentives, which are aligned with both departmental goals and expected health outcomes; and
5. continually assess the collective experiences on PPPs in the health sector so as to be able to adapt public policies and approaches to new developments and needs to sustain accessibility to quality healthcare.

IV. DEFINITION OF TERMS
A. Health sector – refers to health systems, including all institutions, organizations, enterprises and entities, involved in actions that protect, promote or advance the health status of individuals or populations; conceptually includes all aspects of society that influence health
status but operationally focuses on those entities specifically organized to provide or govern the provision of health services and goods.

B. **Public sector** – refers to health providers (individual practitioners, health centres, hospitals, organizational units, agencies) within the rules and regulations of the government and all providers under the administration and control of the DOH, other national agencies (DepED, DOLE, DND, etc) or local governments (provincial, city or municipal governments)

C. **Private Sector** – refers to health providers and facilities individual practitioners, clinics, hospitals, facilities, drug outlets) licensed and regulated under existing laws but otherwise operating outside the ownership or management of the government; includes the drug and pharmaceutical industry, non-government organizations, as well as propriety enterprises providing health services as part of their activities.

D. **Public-Private Partnership (PPP)** – a cooperative venture between the public and private sectors, built on the expertise of each partner, that best meet clearly defined public needs through the appropriate allocation of resources, risks and rewards.

E. **“Kalusugan Pangkalahatan” (KP)** – a focused approach to health reform implementation, ensuring that all Filipinos especially the poor receive the benefits of health reform; intended to ensure that the poor are given financial risk protection through enrolment in PhilHealth and that they are able to access affordable and quality health care and services in times of need.

V. GENERAL GUIDELINES

Cognizant of the still under-tapped potential offered by PPPs in expanding the provision, particularly in capital-intensive areas, of health services, the DOH will adhere to the following guiding principles to both facilitate and regulate these engagements:

A. **Consistency of Priorities**: PPPs in the health sector which are in line with key national, DOH, and even LGU developmental priorities will be favored, in terms of the administrative, technical and operational support that may be provided by the DOH.

B. **Synergized Strategies**: All the relevant KP-related strategies, the implementation of which will cultivate an environment which is supportive of PPPs, are to be given more emphasis by the DOH.

C. **Comparative Advantage**: The DOH will actively promote the adoption of PPPs in health in areas where these are deemed to be the most meritorious option for the implementation of specific health programs or services.

D. **Sector Coordination**: The DOH will coordinate with the other concerned national government offices and agencies, LGUs and private institutions and organizations so as to expedite the processing and functioning of priority PPPs in health.

E. **Fair Competition**: To ensure a level playing field, as well as to be aligned with the nationally-defined strategy, contractual PPPs, entered into following a competitive bidding process, will be preferentially encouraged.
F. **Transparent Processes**: An informational and procedural clearing system will be established, which will be made accessible to all health-related PPP stakeholders.

G. **Conditional Incentives**: Technical, material, or financial incentives are to be developed and provided which are in concordance with both KP objectives and strategies as well as actual PPP performance vis-à-vis intended population health outcomes.

H. **Continuing Appraisal**: The DOH shall establish a repository of Health PPP performance and experiences, and utilize the data so collated to effectively fine-tune the relevant policies and procedures.

**VI. SPECIFIC GUIDELINES**

A. The determination of health programs or services which are to be given precedence, in terms of DOH-provided support, for PPP establishment shall be based on:
   1. KP goals and strategies
   2. Other DOH-set priority areas

B. The Department shall comply with the following legal and administrative instruments and frameworks in the promotion, implementation, and evaluation of PPPs:
   1. RA 6957, as amended by RA 7718 (BOT Law) and its Implementing Rules and Regulations
   2. RA 9184 (Government Procurement Reform Act)
   3. Batas Pambansa Blg 68 (Corporation Code of the Philippines)
   4. RA 7160 (Local Government Code)
   5. EO 292 (Administrative Code of the Philippines)
   6. EO 226 (Omnibus Investment Code of 1987)
   7. NEDA Joint Venture Guidelines and Procedures
   8. NEDA Investment Coordination Committee (ICC) Guidelines
   9. Commission on Audit (COA) Guidelines
   10. Other related legal and administrative issuances

C. Even as the DOH assumes the lead in the establishment of strategic PPPs in the health sector, it shall coordinate with, as well as provide any necessary assistance, to the following entities:
   1. Public-Private Partnership Center of the Philippines, NEDA for medium to large-scale health PPPs
   2. LGUs and Local Development Boards for LGU-initiated PPP endeavors
   3. Development partners, financial institutions, NGOs and other parties interested in PPPs

D. The DOH shall endeavor to ensure that the financial environment for health-related activities is conducive to private sector participation by:
1. Progressively increasing, in coordination with PhilHealth, membership in the social health insurance system, with particular emphasis on attaining universal coverage of the poor
2. Putting in place more adequate and timely reimbursement mechanisms, also in coordination with PhilHealth
3. Streamlining the PhilHealth accreditation of qualified health service facilities and providers
4. Promoting efficiency and responsiveness among public providers of health services by encouraging their assumption of greater administrative and fiscal autonomy

E. Suitability, transparency and fair competition in the establishment of PPPs in health are to be advanced by the adoption of the following:
   1. Determination of the applicable and clinical, administrative, and economic norms for PPP undertakings
   2. Publication of user-friendly procedural guides
   3. Declared partiality for solicited bids in the setting up of PPPs
   4. Development and dissemination of performance standards
   5. Endorsing the inclusion of public disclosure clauses in PPP contracts

F. Assessment as well as incentives schemes are to be developed and are to be premised on:
   1. The commitment by the Department to provide substantial technical, material, and financial support (through conditional grants or soft loans) as additional incentive mechanisms
   2. The actual incentive mix to be pre-determined for targeted types of or desired outcomes for PPPs.
   3. A system for periodic monitoring and evaluation is to be set-up purposely for both exclusive as well as comparative appraisal of PPPs in health
   4. Regular publication of the performance assessments of initiated PPPs

VII. ROLES AND RESPONSIBILITIES
A. **DOH**, through the following offices, shall:
   1. Office of the Secretary
      a. Provide policy directions for and ensure the Department’s sustained commitment to PPPs for the health sector
      b. Commit resources to support the PPP undertakings of the Department
      c. Develop and implement the corresponding organizational framework, inclusive of lines of accountability, in support of the PPPs for health effort

   2. PPP Task Force
      a. Serve as the point group for PPPs in the DOH
b. Assume all the responsibilities for PPPs as listed in Department Personnel Order No. 2010-5150

c. Support the establishment of the DOH Center for Excellence on Public-Private Partnerships in Health (DOH-CEP3H), which will eventually take over the Task Force’s responsibilities as well as become the primary office concerned with the PPP-related initiatives and activities of the DOH

d. Provide the primary link to the external network of government agencies and private entities which are involved or interested in PPP undertakings in health

e. Recommend to the Secretary appropriate PPP measures for the furtherance of the UHC/KP goals and strategies.

3. DOH Bureaus, Agencies, Hospitals, and other subsumed offices, particularly Center for Health Development (CHD)
   a. Identify and develop priority areas in their corresponding fields of operations where PPP arrangements will be appropriate
   b. Collaborate with the pertinent DOH offices, government agencies as well as private entities in the planning, implementation, and monitoring of PPPs in health.

B. Philippine Health Insurance Corporation (PhilHealth) shall:
   a. Ensure effective coverage of social health insurance through expanded enrollment of the sponsored and informal sector, widely accessible accredited facilities and better support value
   b. Develop the contracting modality, case-based payments and other measures for timely and efficient payments of providers.

C. Local Government Units (LGUs) are encouraged to:
   a. Consider the option of PPP whenever appropriate for the implementation of their Province-wide Investment Plan for Health (PIPHs)
   b. Transfer more governance and fiscal responsibilities and capacities to their health facilities to enable these specifically to retain and appropriately utilize generated revenues
   c. Adopt the appropriate incentive systems for developing and sustaining local PPPs in health
   d. Coordinate with DOH agencies in the development, implementation, and monitoring of local PPPs in health
   e. Utilize the guidelines and other instruments provided by DOH for the local development of PPPs in health.

D. Other Government Agencies, Development Partners, and Private Sector Organizations are advised to:
a. Align their objectives and PPP-related activities so as to be consistent with KP goals and strategies
b. Coordinate with the DOH and concerned government agencies in the development, implementation, and monitoring of PPPs in health

VIII. REPEALING CAUSE
The provisions of previous Orders and other related issuances inconsistent with or contrary to the provisions of this Administrative Order are hereby revised, modified, repealed or rescinded accordingly. All provisions of existing issuances which are not affected by this Order shall remain valid and in effect.

IX. IMPLEMENTATION
The Implementing Rules or equivalent guidelines in line with this order shall be developed within three months.

X. EFFECTIVITY
This Order shall take effect immediately.  

ANNEX 15

Fifteenth Congress
Third Regular Session

Begun and held in Metro Manila, on Monday, the twenty-third day of July, two thousand twelve.

[ REPUBLIC ACT NO. 10354 ]

AN ACT PROVIDING FOR A NATIONAL POLICY ON RESPONSIBLE PARENTHOOD AND REPRODUCTIVE HEALTH

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

SECTION 1. Title. – This Act shall be known as “The Responsible Parenthood and Reproductive Health Act of 2012”.

SEC. 2. Declaration of Policy. – The State recognizes and guarantees the human rights of all persons including their right to equality and nondiscrimination of these rights, the right to sustainable human development, the right to health which includes reproductive health, the right to education and information, and the right to choose and make decisions for themselves in accordance with their religious convictions, ethics, cultural beliefs, and the demands of responsible parenthood.

Pursuant to the declaration of State policies under Section 12, Article II of the 1987 Philippine Constitution, it is the duty of the State to protect and strengthen the family as a basic autonomous social institution and equally protect the life of the mother and the life of the unborn from conception. The State shall protect and promote the right to health of women especially mothers in particular and of the people in general and instil health consciousness among them. The family is the natural and fundamental unit of society. 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 State also recognizes and guarantees the promotion and equal protection of the welfare and rights of children, the youth, and the unborn.

Moreover, the State 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. The advancement and protection of women’s human rights shall be central to the efforts of the State to address reproductive health care.

The State recognizes marriage as an inviolable social institution and the foundation of the family which in turn is the foundation of the nation. Pursuant thereto, the State shall defend:
(a) The right of spouses to found a family in accordance with their religious convictions and the demands of responsible parenthood;

(b) 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;

(c) The right of the family to a family living wage and income; and

(d) The right of families or family associations to participate in the planning and implementation of policies and programs that affect them

The State likewise guarantees universal access to medically-safe, non-abortifacient, effective, legal, affordable, and quality reproductive health care services, methods, devices, supplies which do not prevent the implantation of a fertilized ovum as determined by the Food and Drug Administration (FDA) and relevant information and education thereon according to the priority needs of women, children and other underprivileged sectors, giving preferential access to those identified through the National Household Targeting System for Poverty Reduction (NHTS-PR) and other government measures of identifying marginalization, who shall be voluntary beneficiaries of reproductive health care, services and supplies for free.

The State shall eradicate discriminatory practices, laws and policies that infringe on a person’s exercise of reproductive health rights.

The State shall also promote openness to life; Provided, That parents bring forth to the world only those children whom they can raise in a truly humane way.

SEC. 3. Guiding Principles for Implementation. – This Act declares the following as guiding principles:

(a) The right to make free and informed decisions, which is central to the exercise of any right, shall not be subjected to any form of coercion and must be fully guaranteed by the State, like the right itself;

(b) Respect for protection and fulfilment of reproductive health and rights which seek to promote the rights and welfare of every person particularly couples, adult individuals, women and adolescents;

(c) Since human resource is among the principal assets of the country, effective and quality reproductive health care services must be given primacy to ensure maternal and child health, the health of the unborn, safe delivery and birth of healthy children, and sound replacement rate, in line with the State’s duty to promote the right to health, responsible parenthood, social justice and full human development;

(d) The provision of ethical and medically safe, legal, accessible, affordable, non-abortifacient, effective and quality reproductive health care services and supplies is essential in the promotion
of people’s right to health, especially those of women, the poor, and the marginalized, and shall
be incorporated as a component of basic health care;

(e) The State shall promote and provide information and access, without bias, to all methods of
family planning, including effective natural and modern methods which have been proven
medically safe, legal, non-abortifacient, and effective in accordance with scientific and evidence-
based medical research standards such as those registered and approved by the FDA for the poor
and marginalized as identified through the NHTS-PR and other government measures of
identifying marginalization: Provided, That the State shall also provide funding support to
promote modern natural methods of family planning, especially the Billings Ovulation Method,
consistent with the needs of acceptors and their religious convictions;

(f) The State shall promote programs that: (1) enable individuals and couples to have the number
of children they desire with due consideration to the health, particularly of women, and the
resources available and affordable to them and in accordance with existing laws, public morals
and their religious convictions: Provided, That no one shall be deprived, for economic reasons,
of the rights to have children; (2) achieve equitable allocation and utilization of resources; (3)
ensure effective partnership among national government, local government units (LGUs) and the
private sector in the design, implementation, coordination, integration, monitoring and evaluation
of people-centered programs to enhance the quality of life and environmental protection; (4)
conduct studies to analyze demographic trends including demographic dividends from sound
population policies towards sustainable human development in keeping with the principles of
gender equality, protection of mothers and children, born and unborn and the promotion and
protection of women’s reproductive rights and health; and (5) conduct scientific studies to
determine the safety and efficacy of alternative medicines and methods for reproductive health
care development;

(g) The provision of reproductive health care, information and supplies giving priority to poor
beneficiaries as identified through the NHTS-PR and other government measures of identifying
marginalization must be the primary responsibility of the national government consistent with its
obligation to respect, protect and promote the right to health and the right to life;

(h) The State shall respect individuals’ preferences and choice of family planning methods that
are in accordance with their religious convictions and cultural beliefs, taking into consideration
the State’s obligations under various human rights instruments;

(i) Active participation by nongovernment organizations (NGOs), women’s and people’s
organizations, civil society, faith-based organizations, the religious sector and communities is
crucial to ensure that reproductive health and population and development policies, plans, and
programs will address the priority needs of women, the poor, and the marginalized;

(j) While this Act recognizes that abortion is illegal and punishable by law, the government shall
ensure that all women needing care for post-abortive complications and all other complications
arising from pregnancy, labor and delivery and related issues shall be treated and counselled in a
humane, non-judgmental and compassionate manner in accordance with law and medical ethics;
(k) Each family shall have the right to determine its ideal family size: Provided, however, That the State shall equip each parent with the necessary information on all aspects of family life, including reproductive health and responsible parenthood, in order to make that determination;

(l) There shall be no demographic or population targets and the mitigation, promotion and/or stabilization of the population growth rate is incidental to the advancement of reproductive health;

(m) Gender equality and women empowerment are central elements of reproductive health and population and development;

(n) The resources of the country must be made to serve the entire population, especially the poor, and allocations thereof must be adequate and effective: Provided, That the life of the unborn is protected;

(o) Development is a multi-faceted process that calls for the harmonization and integration of policies, plans, programs and projects that seek to uplift the quality of life of the people, more particularly the poor, the needy and the marginalized; and

(p) That a comprehensive reproductive health program addresses the needs of people throughout their life cycle.

SEC. 4. Definition of Terms. – For the purpose of this Act, the following terms shall be defined as follows:

(a) Abortifacient refers to any drug or device that induces abortion or the destruction of a fetus inside the mother’s womb or the prevention of the fertilized ovum to reach and be implanted in the mother’s womb upon determination of the FDA.

(b) Adolescent refers to young people between the ages of ten (10) to nineteen (19) years who are in transition from childhood to adulthood.

(c) Basic Emergency Obstetric and Newborn Care (BEMONC) refers to lifesaving services for emergency maternal and newborn conditions/complications being provided by a health facility or professional to include the following services: administration of parenteral oxytocic drugs, administration of dose of parenteral anticonvulsants, administration of parenteral antibiotics, administration of maternal steroids for preterm labor, performance of assisted vaginal deliveries, removal of retained placental products, and manual removal of retained placenta. It also includes neonatal interventions which include at the minimum: newborn resuscitation, provision of warmth, and referral, blood transfusion where possible.

(d) Comprehensive Emergency Obstetric and Newborn Care (CEMONC) refers to lifesaving services for emergency maternal and newborn conditions/complications as in Basic Emergency Obstetric and Newborn Care plus the provision of surgical delivery (caesarian section) and blood bank services, and other highly specialized obstetric interventions. It also includes emergency neonatal care which includes at the minimum: newborn resuscitation, treatment of neonatal
sepsis infection, oxygen support, and antenatal administration of (maternal) steroids for threatened premature delivery.

(e) Family planning refers to a program which enables couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so, and to have access to a full range of safe, affordable, effective, non-abortifacient modem natural and artificial methods of planning pregnancy.

(f) Fetal and infant death review refers to a qualitative and in-depth study of the causes of fetal and infant death with the primary purpose of preventing future deaths through changes or additions to programs, plans and policies.

(g) Gender equality refers to the principle of equality between women and men and equal rights to enjoy conditions in realizing their full human potentials to contribute to, and benefit from, the results of development, with the State recognizing that all human beings are free and equal in dignity and rights. It entails equality in opportunities, in the allocation of resources or benefits, or in access to services in furtherance of the rights to health and sustainable human development among others, without discrimination.

(h) Gender equity refers to the policies, instruments, programs and actions that address the disadvantaged position of women in society by providing preferential treatment and affirmative action. It entails fairness and justice in the distribution of benefits and responsibilities between women and men, and often requires women-specific projects and programs to end existing inequalities. This concept recognizes that while reproductive health involves women and men, it is more critical for women’s health.

(i) Male responsibility refers to the involvement, commitment, accountability and responsibility of males in all areas of sexual health and reproductive health, as well as the care of reproductive health concerns specific to men.

(j) Maternal death review refers to a qualitative and in-depth study of the causes of maternal death with the primary purpose of preventing future deaths through changes or additions to programs, plans and policies.

(k) Maternal health refers to the health of a woman of reproductive age including, but not limited to, during pregnancy, childbirth and the postpartum period.

(l) Modern methods of family planning refers to safe, effective, non-abortifacient and legal methods, whether natural or artificial, that are registered with the FDA, to plan pregnancy.

(m) Natural family planning refers to a variety of methods used to plan or prevent pregnancy based on identifying the woman’s fertile days.

(n) Public health care service provider refers to: (1) public health care institution, which is duly licensed and accredited and devoted primarily to the maintenance and operation of facilities for health promotion, disease prevention, diagnosis, treatment and care of individuals suffering from
illness, disease, injury, disability or deformity, or in need of obstetrical or other medical and nursing care; (2) public health care professional, who is a doctor of medicine, a nurse or a midwife; (3) public health worker engaged in the delivery of health care services; or (4) barangay health worker who has undergone training programs under any accredited government and NGO and who voluntarily renders primarily health care services in the community after having been accredited to function as such by the local health board in accordance with the guideline’s promulgated by the Department of Health (DOH).

(o) Poor refers to members of households identified as poor through the NHTS-PR by the Department of Social Welfare and Development (DSWD) or any subsequent system used by the national government in identifying the poor.

(p) Reproductive Health (RH) refers to the 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. This implies that people are able to have a responsible, safe, consensual and satisfying sex life, that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. This further implies that women and men attain equal relationships in matters related to sexual relations and reproduction.

(q) Reproductive health care refers to the access to a full range of methods, facilities, services and supplies that contribute to reproductive health and well-being by addressing reproductive health-related problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations. The elements of reproductive health care include the following:

1. Family planning information and services which shall include as a first priority making women of reproductive age fully aware of their respective cycles to make them aware of when fertilization is highly probable, as well as highly improbable;

2. Maternal, infant and child health and nutrition, including breastfeeding;

3. Proscription of abortion and management of abortion complications;

4. Adolescent and youth reproductive health guidance and counseling;

5. Prevention, treatment and management of reproductive tract infections (RTIs), HIV and AIDS and other sexually transmittable infections (STIs);

6. Elimination of violence against women and children and other forms of sexual and gender-based violence;

7. Education and counseling on sexuality and reproductive health;

8. Treatment of breast and reproductive tract cancers and other gynecological conditions and disorders;
(9) Male responsibility and involvement and men’s reproductive health;

(10) Prevention, treatment and management of infertility and sexual dysfunction;

(11) Reproductive health education for the adolescents; and

(12) Mental health aspect of reproductive health care.

(r) Reproductive health care program refers to the systematic and integrated provision of reproductive health care to all citizens prioritizing women, the poor, marginalized and those invulnerable or crisis situations.

(s) Reproductive health rights refers to the rights of individuals and couples, to decide freely and responsibly whether or not to have children; the number, spacing and timing of their children; to make other decisions concerning reproduction, free of discrimination, coercion and violence; to have the information and means to do so; and to attain the highest standard of sexual health and reproductive health: Provided, however, That reproductive health rights do not include abortion, and access to abortifacients.

(t) Reproductive health and sexuality education refers to a lifelong learning process of providing and acquiring complete, accurate and relevant age- and development-appropriate information and education on reproductive health and sexuality through life skills education and other approaches.

(u) Reproductive Tract Infection (RTI) refers to sexually transmitted infections (STIs), and other types of infections affecting the reproductive system.

(v) Responsible parenthood refers to the will and ability of a parent to respond to the needs and aspirations of the family and children. It is likewise a shared responsibility between parents to determine and achieve the desired number of children, spacing and timing of their children according to their own family life aspirations, taking into account psychological preparedness, health status, sociocultural and economic concerns consistent with their religious convictions.

(w) Sexual health refers to a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free from coercion, discrimination and violence.

(x) Sexually Transmitted Infection (STI) refers to any infection that may be acquired or passed on through sexual contact, use of IV, intravenous drug needles, childbirth and breastfeeding.

(y) Skilled birth attendance refers to childbirth managed by a skilled health professional including the enabling conditions of necessary equipment and support of a functioning health system, including transport and referral faculties for emergency obstetric care.
(z) Skilled health professional refers to a midwife, doctor or nurse, who has been educated and trained in the skills needed to manage normal and complicated pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns.

(aa) Sustainable human development refers to bringing people, particularly the poor and vulnerable, to the center of development process, the central purpose of which is the creation of an enabling environment in which all can enjoy long, healthy and productive lives, done in the manner that promotes their rights and protects the life opportunities of future generations and the natural ecosystem on which all life depends.

SEC. 5. Hiring of Skilled Health Professionals for Maternal Health Care and Skilled Birth Attendance. – The LGUs shall endeavor to hire an adequate number of nurses, midwives and other skilled health professionals for maternal health care and skilled birth attendance to achieve an ideal skilled health professional-to-patient ratio taking into consideration DOH targets: Provided, That people in geographically isolated or highly populated and depressed areas shall be provided the same level of access to health care: Provided, further, That the national government shall provide additional and necessary funding and other necessary assistance for the effective implementation of this provision.

For the purposes of this Act, midwives and nurses shall be allowed to administer lifesaving drugs such as, but not limited to, oxytocin and magnesium sulfate, in accordance with the guidelines set by the DOH, under emergency conditions and when there are no physicians available: Provided, That they are properly trained and certified to administer these lifesaving drugs.

SEC. 6. Health Care Facilities. – Each LGU, upon its determination of the necessity based on well-supported data provided by its local health office shall endeavor to establish or upgrade hospitals and facilities with adequate and qualified personnel, equipment and supplies to be able to provide emergency obstetric and newborn care: Provided, That people in geographically isolated or highly populated and depressed areas shall have the same level of access and shall not be neglected by providing other means such as home visits or mobile health care clinics as needed: Provided, further, That the national government shall provide additional and necessary funding and other necessary assistance for the effective implementation of this provision.

SEC. 7. Access to Family Planning. – All accredited public health facilities shall provide a full range of modern family planning methods, which shall also include medical consultations, supplies and necessary and reasonable procedures for poor and marginalized couples having infertility issues who desire to have children: Provided, That family planning services shall likewise be extended by private health facilities to paying patients with the option to grant free care and services to indigents, except in the case of non-maternity specialty hospitals and hospitals owned and operated by a religious group, but they have the option to provide such full range of modern family planning methods: Provided, further, That these hospitals shall immediately refer the person seeking such care and services to another health facility which is conveniently accessible: Provided, finally, That the person is not in an emergency condition or serious case as defined in Republic Act No. 8344.
No person shall be denied information and access to family planning services, whether natural or artificial: *Provided*, That minors will not be allowed access to modern methods of family planning without written consent from their parents or guardian/s except when the minor is already a parent or has had a miscarriage.

SEC. 8. *Maternal Death Review and Fetal and Infant Death Review.* – All LGUs, national and local government hospitals, and other public health units shall conduct an annual Maternal Death Review and Fetal and Infant Death Review in accordance with the guidelines set by the DOH. Such review should result in an evidence-based programming and budgeting process that would contribute to the development of more responsive reproductive health services to promote women’s health and safe motherhood.

SEC. 9. *The Philippine National Drug Formulary System and Family Planning Supplies.* – The National Drug Formulary shall include hormonal contraceptives, intrauterine devices, injectables and other safe, legal, non-abortifacient and effective family planning products and supplies. The Philippine National Drug Formulary System (PNDFS) shall be observed in selecting drugs including family planning supplies that will be included or removed from the Essential Drugs List (EDL) in accordance with existing practice and in consultation with reputable medical associations in the Philippines. For the purpose of this Act, any product or supply included or to be included in the EDL must have a certification from the FDA that said product and supply is made available on the condition that it is not to be used as an abortifacient.

These products and supplies shall also be included in the regular purchase of essential medicines and supplies of all national hospitals: *Provided, further*, That the foregoing offices shall not purchase or acquire by any means emergency contraceptive pills, postcoital pills, abortifacients that will be used for such purpose and their other forms or equivalent.

SEC. 10. *Procurement and Distribution of Family Planning Supplies.* – The DOH shall procure, distribute to LGUs and monitor the usage of family planning supplies for the whole country. The DOH shall coordinate with all appropriate local government bodies to plan and implement this procurement and distribution program. The supply and budget allotments shall be based on, among others, the current levels and projections of the following:

(a) Number of women of reproductive age and couples who want to space or limit their children;

(b) Contraceptive prevalence rate, by type of method used; and

(c) Cost of family planning supplies.

*Provided*, That LGUs may implement its own procurement, distribution and monitoring program consistent with the overall provisions of this Act and the guidelines of the DOH.

SEC. 11. *Integration of Responsible Parenthood and Family Planning Component in Anti-Poverty Programs.* – A multidimensional approach shall be adopted in the implementation of policies and programs to fight poverty. Towards this end, the DOH shall implement programs prioritizing full access of poor and marginalized women as identified through the NHTS-PR and
other government measures of identifying marginalization to reproductive health care, services, products and programs. The DOH shall provide such programs, technical support, including capacity building and monitoring.

SEC. 12. PhilHealth Benefits for Serious and Life-Threatening Reproductive Health Conditions. – All serious and life-threatening reproductive health conditions such as HIV and AIDS, breast and reproductive tract cancers, and obstetric complications, and menopausal and post-menopausal-related conditions shall be given the maximum benefits, including the provision of Anti-Retroviral Medicines (ARVs), as provided in the guidelines set by the Philippine Health Insurance Corporation (PHIC).

SEC. 13. Mobile Health Care Service. – The national or the local government may provide each provincial, city, municipal and district hospital with a Mobile Health Care Service (MHCS) in the form of a van or other means of transportation appropriate to its terrain, taking into consideration the health care needs of each LGU. The MHCS shall deliver health care goods and services to its constituents, more particularly to the poor and needy, as well as disseminate knowledge and information on reproductive health. The MHCS shall be operated by skilled health providers and adequately equipped with a wide range of health care materials and information dissemination devices and equipment, the latter including, but not limited to, a television set for audio-visual presentations. All MHCS shall be operated by LGUs of provinces and highly urbanized cities.

SEC. 14. Age- and Development-Appropriate Reproductive Health Education. – The State shall provide age- and development-appropriate reproductive health education to adolescents which shall be taught by adequately trained teachers informal and nonformal educational system and integrated in relevant subjects such as, but not limited to, values formation; knowledge and skills in self-protection against discrimination; sexual abuse and violence against women and children and other forms of gender based violence and teen pregnancy; physical, social and emotional changes in adolescents; women’s rights and children’s rights; responsible teenage behavior; gender and development; and responsible parenthood: Provided, That flexibility in the formulation and adoption of appropriate course content, scope and methodology in each educational level or group shall be allowed only after consultations with parents-teachers-community associations, school officials and other interest groups. The Department of Education (DepED) shall formulate a curriculum which shall be used by public schools and may be adopted by private schools.

SEC. 15. Certificate of Compliance. – No marriage license shall be issued by the Local Civil Registrar unless the applicants present a Certificate of Compliance issued for free by the local Family Planning Office certifying that they had duly received adequate instructions and information on responsible parenthood, family planning, breastfeeding and infant nutrition.

SEC. 16. Capacity Building of Barangay Health Workers (BHWs). – The DOH shall be responsible for disseminating information and providing training programs to the LGUs. The LGUs, with the technical assistance of the DOH, shall be responsible for the training of BHWs and other barangay volunteers on the promotion of reproductive health. The DOH shall provide the LGUs with medical supplies and equipment needed by BHWs to carry out their functions
effectively. Provided, further, That the national government shall provide additional and necessary funding and other necessary assistance for the effective implementation of this provision including the possible provision of additional honoraria for BHWs.

SEC. 17. Pro Bono Services for Indigent Women. – Private and nongovernment reproductive healthcare service providers including, but not limited to, gynecologists and obstetricians, are encouraged to provide at least forty-eight (48) hours annually of reproductive health services, ranging from providing information and education to rendering medical services, free of charge to indigent and low-income patients as identified through the NHTS-PR and other government measures of identifying marginalization, especially to pregnant adolescents. The forty-eight (48) hours annual pro bono services shall be included as a prerequisite in the accreditation under the PhilHealth.

SEC. 18. Sexual and Reproductive Health Programs for Persons with Disabilities (PWDs). – The cities and municipalities shall endeavor that barriers to reproductive health services for PWDs are obliterated by the following:

(a) Providing physical access, and resolving transportation and proximity issues to clinics, hospitals and places where public health education is provided, contraceptives are sold or distributed or other places where reproductive health services are provided;

(b) Adapting examination tables and other laboratory procedures to the needs and conditions of PWDs;

(c) Increasing access to information and communication materials on sexual and reproductive health in braille, large print, simple language, sign language and pictures;

(d) Providing continuing education and inclusion of rights of PWDs among health care providers; and

(e) Undertaking activities to raise awareness and address misconceptions among the general public on the stigma and their lack of knowledge on the sexual and reproductive health needs and rights of PWDs.

SEC. 19. Duties and Responsibilities. –

(a) Pursuant to the herein declared policy, the DOH shall serve as the lead agency for the implementation of this Act and shall integrate in their regular operations the following functions:

(1) Fully and efficiently implement the reproductive health care program;

(2) Ensure people’s access to medically safe, non-abortifacient, legal, quality and affordable reproductive health goods and services; and

(3) Perform such other functions necessary to attain the purposes of this Act.
(b) The DOH, in coordination with the PHIC, as may be applicable, shall:

1. Strengthen the capacities of health regulatory agencies to ensure safe, high quality, accessible and affordable reproductive health services and commodities with the concurrent strengthening and enforcement of regulatory mandates and mechanisms;

2. Facilitate the involvement and participation of NGOs and the private sector in reproductive health care service delivery and in the production, distribution and delivery of quality reproductive health and family planning supplies and commodities to make them accessible and affordable to ordinary citizens;

3. Engage the services, skills and proficiencies of experts in natural family planning who shall provide the necessary training for all BHWs;

4. Supervise and provide assistance to LGUs in the delivery of reproductive health care services and in the purchase of family planning goods and supplies; and

5. Furnish LGUs, through their respective local health offices, appropriate information and resources to keep the latter updated on current studies and researches relating to family planning, responsible parenthood, breastfeeding and infant nutrition.

c) The FDA shall issue strict guidelines with respect to the use of contraceptives, taking into consideration the side effects or other harmful effects of their use.

d) Corporate citizens shall exercise prudence in advertising its products or services through all forms of media, especially on matters relating to sexuality, further taking into consideration its influence on children and the youth.

SEC. 20. Public Awareness. – The DOH and the LGUs shall initiate and sustain a heightened nationwide multimedia-campaign to raise the level of public awareness on the protection and promotion of reproductive health and rights including, but not limited to, maternal health and nutrition, family planning and responsible parenthood information and services, adolescent and youth reproductive health, guidance and counseling and other elements of reproductive health care under Section 4(q).

Education and information materials to be developed and disseminated for this purpose shall be reviewed regularly to ensure their effectiveness and relevance.

SEC. 21. Reporting Requirements. – Before the end of April each year, the DOH shall submit to the President of the Philippines and Congress an annual consolidated report, which shall provide a definitive and comprehensive assessment of the implementation of its programs and those of other government agencies and instrumentalities and recommend priorities for executive and legislative actions. The report shall be printed and distributed to all national agencies, the LGUs, NGOs and private sector organizations involved in said programs.
The annual report shall evaluate the content, implementation, and impact of all policies related to reproductive health and family planning to ensure that such policies promote, protect and fulfill women’s reproductive health and rights.

SEC. 22. Congressional Oversight Committee on Reproductive Health Act. – There is hereby created a Congressional Oversight Committee (COC) composed of five (5) members each from the Senate and the House of Representatives. The members from the Senate and the House of Representatives shall be appointed by the Senate President and the Speaker, respectively, with at least one (1) member representing the Minority.

The COC shall be headed by the respective Chairs of the Committee on Health and Demography of the Senate and the Committee on Population and Family Relations of the House of Representatives. The Secretariat of the COC shall come from the existing Secretariat personnel of the Senate and the House of Representatives committees concerned.

The COC shall monitor and ensure the effective implementation of this Act, recommend the necessary remedial legislation or administrative measures, and shall conduct a review of this Act every five (5) years from its effectivity. The COC shall perform such other duties and functions as may be necessary to attain the objectives of this Act.

SEC. 23. Prohibited Acts. – The following acts are prohibited:

(a) Any health care service provider, whether public or private, who shall:

(1) Knowingly withhold information or restrict the dissemination thereof, and/or intentionally provide incorrect information regarding programs and services on reproductive health including the right to informed choice and access to a full range of legal, medically-safe, non-abortifacient and effective family planning methods;

(2) Refuse to perform legal and medically-safe reproductive health procedures on any person of legal age on the ground of lack of consent or authorization of the following persons in the following instances:

(i) Spousal consent in case of married persons: Provided, That in case of disagreement, the decision of the one undergoing the procedure shall prevail; and

(ii) Parental consent or that of the person exercising parental authority in the case of abused minors, where the parent or the person exercising parental authority is the respondent, accused or convicted perpetrator as certified by the proper prosecutorial office of the court. In the case of minors, the written consent of parents or legal guardian or, in their absence, persons exercising parental authority or next-of-kin shall be required only in elective surgical procedures and in no case shall consent be required in emergency or serious cases as defined in Republic Act No. 8344; and

(3) Refuse to extend quality health care services and information on account of the person’s marital status, gender, age, religious convictions, personal circumstances, or nature of
work: Provided, That the conscientious objection of a health care service provider based on his/her ethical or religious beliefs shall be respected; however, the conscientious objector shall immediately refer the person seeking such care and services to another health care service provider within the same facility or one which is conveniently accessible: Provided, further, That the person is not in an emergency condition or serious case as defined in Republic Act No. 8344, which penalizes the refusal of hospitals and medical clinics to administer appropriate initial medical treatment and support in emergency and serious cases;

(b) Any public officer, elected or appointed, specifically charged with the duty to implement the provisions hereof, who, personally or through a subordinate, prohibits or restricts the delivery of legal and medically-safe reproductive health care services, including family planning; or forces, coerces or induces any person to use such services; or refuses to allocate, approve or release any budget for reproductive health care services, or to support reproductive health programs; or shall do any act that hinders the full implementation of a reproductive health program as mandated by this Act;

(c) Any employer who shall suggest, require, unduly influence or cause any applicant for employment or an employee to submit himself/herself to sterilization, use any modern methods of family planning, or not use such methods as a condition for employment, continued employment, promotion or the provision of employment benefits. Further, pregnancy or the number of children shall not be a ground for non-hiring or termination from employment;

(d) Any person who shall falsify a Certificate of Compliance as required in Section 15 of this Act; and

(e) Any pharmaceutical company, whether domestic or multinational, or its agents or distributors, which directly or indirectly colludes with government officials, whether appointed or elected, in the distribution, procurement and/or sale by the national government and LGUs of modern family planning supplies, products and devices.

SEC. 24. Penalties. – Any violation of this Act or commission of the foregoing prohibited acts shall be penalized by imprisonment ranging from one (1) month to six (6) months or a fine of Ten thousand pesos (P10,000.00) to One hundred thousand pesos (P100,000.00), or both such fine and imprisonment at the discretion of the competent court: Provided, That, if the offender is a public officer, elected or appointed, he/she shall also suffer the penalty of suspension not exceeding one (1) year or removal and forfeiture of retirement benefits depending on the gravity of the offense after due notice and hearing by the appropriate body or agency.

If the offender is a juridical person, the penalty shall be imposed upon the president or any responsible officer. An offender who is an alien shall, after service of sentence, be deported immediately without further proceedings by the Bureau of Immigration. If the offender is a pharmaceutical company, its agent and/or distributor, their license or permit to operate or conduct business in the Philippines shall be perpetually revoked, and a fine triple the amount involved in the violation shall be imposed.
SEC. 25. Appropriations. – The amounts appropriated in the current annual General Appropriations Act (GAA) for reproductive health and natural and artificial family planning and responsible parenthood under the DOH and other concerned agencies shall be allocated and utilized for the implementation of this Act. Such additional sums necessary to provide for the upgrading of faculties necessary to meet BEMONC and CEMONC standards; the training and deployment of skilled health providers; natural and artificial family planning commodity requirements as outlined in Section 10, and for other reproductive health and responsible parenthood services, shall be included in the subsequent years’ general appropriations. The Gender and Development (GAD) funds of LGUs and national agencies may be a source of funding for the implementation of this Act.

SEC. 26. Implementing Rules and Regulations (IRR). – Within sixty (60) days from the effectivity of this Act, the DOH Secretary or his/her designated representative as Chairperson, the authorized representative/s of DepED, DSWD, Philippine Commission on Women, PHIC, Department of the Interior and Local Government, National Economic and Development Authority, League of Provinces, League of Cities, and League of Municipalities, together with NGOs, faith-based organizations, people’s, women’s and young people’s organizations, shall jointly promulgate the rules and regulations for the effective implementation of this Act. At least four (4) members of the IRR drafting committee, to be selected by the DOH Secretary, shall come from NGOs.

SEC. 27. Interpretation Clause. – This Act shall be liberally construed to ensure the provision, delivery and access to reproductive health care services, and to promote, protect and fulfil women’s reproductive health and rights.

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

SEC. 29. Repealing Clause. – Except for prevailing laws against abortion, any law, presidential decree or issuance, executive order, letter of instruction, administrative order, rule or regulation contrary to or is inconsistent with the provisions of this Act including Republic Act No. 7392, otherwise known as the Midwifery Act, is hereby repealed, modified or amended accordingly.

SEC 30. Effectivity. – This Act shall take effect fifteen (15) days after its publication in at least two (2) newspapers of general circulation.

This Act which is a consolidation of Senate Bill No. 2865 and House Bill No. 4244 was finally passed by the Senate and the House of Representatives on December 19, 2012.  

Republic of the Philippines

NOTE:

The high court declared unconstitutional these provisions of the law:

- Section 7 and the corresponding provisions in the Implementing Rules and Regulations, insofar as (a) they require private health facilities and non-maternity hospitals owned and operated by a religious group to refer patients, not in an emergency of life-threatening cases, as defined under RA 8544, to another health facility which is conveniently accessible, and (b) allow minor patients or minors who have suffered miscarriage access to modern methods of family planning without written consent from their parents or guardian;

- Section 23 (a)(1) and the corresponding provision in the IRR, particularly Section 5.24 insofar as it punishes a health provider who fails or refuses to disseminate information regarding programs and services on reproductive health, regardless of his or her religious beliefs;

- Section 23(a)(2)(1) insofar as they allow a married individual not in an emergency or life-threatening situation, as defined under RA 8544, to undergo reproductive health procedures without the consent of the spouse;

- Section 23(a)(3) and the corresponding provisions in the IRR, particularly Section 5.24 insofar as they allow any health care provider who fails and or refuses to refer a patient not in an emergency or life-threatening case as defined under RA 8544 to another health care service provider within the same facility or one which is conveniently accessible, regardless of his or her belief;

- Section 23 (b) and the corresponding provision in the IRR, particularly Section 5.24 insofar as they punish any public officer who refuses to support reproductive health programs or shall do any act that hinders the full implementation of a reproductive health program, regardless of his or her religious beliefs;

- Section 17 and the corresponding provision in the IRR regarding the rendering pro bono reproductive health service insofar as they affect the conscientious objector in securing Philhealth accreditation;

- Section 3.01(a) and (11) insofar as it penalizes a health service provider who will require parental consent from the minor in not emergency or serious situations.\(^{16}\)

Department of Health

ADMINISTRATIVE ORDER

No. 2013 – 0013

SUBJECT: National Policy and Strategic Framework on Adolescent Health and Development

I. BACKGROUND AND RATIONALE

The twenty million (19,844,578) adolescents age 10-19 years comprise 21.5% of the country’s population (NSO, 2010). Thus, they are essential to achieve the Millennium Development Goals and should be part of the national strategy to reduce poverty.

Adolescents face many threats to their health and well-being. While mortality rate in this age group are low, they are susceptible to conditions that are related to their increased mobility, socialization (Valenzuela-Teoxon, 2007), and risk-taking behavior. One in every 10 young women ages 15-19 is already a mother, doubling the likelihood of maternal death compared to those over 20 years (DOH, UNFPA, WHO, 2002) and increasing the risk of dropping out of school and facing limited economic opportunities. Sixteen (16) percent of abortion attempts occur among teenagers (Singh, 2006). Sexually Transmitted Infections, HIV and AIDS, drugs, alcohol, and smoking are also on the rise among adolescents. Drowning and transport accidents are among the top five causes of death among the 10-14 and 15-19 age group (DOH, 2005). Three percent of young people ages 15-27 have attempted to commit suicide (UPPI/DRDF, 2002). Issues of assault and bullying are also causing increasing concern among parents, educators, and adolescents themselves.

Administrative Order 34-A, s 2000, the Adolescent and Youth Health (AYH) Policy was issued in April 2000, creating the Adolescent and Youth Health Sub-program under the Program for Children’s Health Cluster of Family Health. It envisions “well-informed, empowered, responsible and health adolescents & youth” and had a mission to “ensure that all adolescents & youth have access to quality comprehensive health care and services in an adolescent & youth-friendly environment”.

In 2006, the Department of Health (DOH) created the Technical Committee for Adolescent and Youth Health Program (AYHP), composed of both government and non-government organizations dedicated to uplifting the welfare of adolescents and tasked to revitalize the AYHP. The committee embarked on a Strategic Plan for Accelerated Action on Adolescent Health. In 2010, the National Center for Disease Prevention and Control (NCDPC) drafted a National Standards and Implementing Guide for Adolescent Friendly Health Facility and an Adolescent Job Aid manual and a Primer on Legal Bases for Adolescent Health Services in the Philippines.
Due to an increasing health risky behavior among our Filipino adolescents, the DOH embark on revising the current policy and address the major adolescent health problems, marginalized groups and humanitarian emergency settings and to provide clear understanding among implementers and to guarantee program sustainability thus this Order is developed.

II. DECLARATION OF POLICIES

1. The 1987 Philippine Constitution charges the State to promote and protect the youth’s physical, moral, spiritual, intellectual, and social well-being and prioritizes the health of children.

2. The Convention on the Rights of the Child, which the Philippines ratified with the force of law in 1990, defines a child as “every human being below the age of 18 years unless, under the law applicable, majority is attained earlier” and directs States to “strive to ensure that no child is deprived of his or her right of access to such health care services.” The Committee on the Rights of the Child, in its General Comment No. 4 (2003) emphasized Adolescent Health and Development in the context of the CRC (CRC/GC/2003/4)

3. The Report of the International Conference on Population and Development (ICPD, 1994), Chapter VI, B. 6.15, states that “Youth should be actively involved in the planning, implementation and evaluation of development activities that have a direct impact on their daily lives. This is especially important with respect to information, education and communication activities and services concerning reproductive and sexual health, including the prevention of early pregnancies, sex education and the prevention of HIV and other sexually transmitted diseases.”

4. In September 2000, the Philippines and other member nations ratified and signed the Millennium Declaration which embodies global and country commitments, specific targets and milestones for 2015, including the Eradication of extreme poverty and hunger (MDG 1), Promotion of gender equality and empowerment of women (MDG 3), Reduction of Child Mortality (MDG 4), Improvement of Maternal Health (MDG 5), and Combating HIV and AIDS, malaria, and other diseases (MDG 6).

5. Republic Act No. 10354, signed into law on December 21, 2012, provided for a National Policy on Responsible Parenthood and Reproductive Health.


7. AO 2008-0029 was enacted for Implementing Health Reforms for Rapid Reduction of Maternal and Neonatal Mortality.
8. AO 2006-0016 provided a National Policy and Strategic Framework on Child Injury Prevention

9. AO 2007-0010 provided a National Policy on Violence and Injury Prevention

10. AO 2011-0003 enacted the National Policy on Strengthening the Prevention and Control of Chronic Lifestyle Related Non-Communicable Diseases

11. RA 8371 promotes the Rights of Indigenous Cultural Communities/ Indigenous Peoples

III. OBJECTIVES

This Order aims to:

1. Provide a strategic framework for the Adolescent Health Program that is anchored on Universal Health Care

2. Provide policy direction and guidance for DOH offices, its attached agencies, and LGUs and development partners in prioritizing interventions for adolescent health

IV. COVERAGE AND SCOPE OF APPLICATION

This Order shall apply to the entire public health system, to include DOH bureaus, Centers for Health Development (CHDs), hospitals and other health facilities, attached agencies, local government facilities, external development partners and other stakeholders implementing health programs for and with adolescents.

V. DEFINITION OF TERMS

1. Adolescent: refers to young people between the ages of 10 and 19 years who are in transition from childhood to adulthood (RA10354) and are the primary targets of this Order, differentiated from “youth” and “young people”.

2. Early adolescence is from 10-13 years old. Middle adolescence 14-16 years. Late adolescence 17-19 years. (Philippine Pediatric Society)

3. Children refers to person below eighteen (18) years of age or those over but are unable to fully take care of themselves or protect themselves from abuse, neglect, cruelty, exploitation or discrimination because of a physical or mental disability or condition (RA 7610).

4. Adolescent Health is a state of complete physical, mental and social well-being of persons aged 10-19 years.
5. Reproductive Health Rights of Adolescents and Youth refer to their human right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health (CPD, 2012)

6. Early pregnancy: refers to pregnancy in women less than 20 years old.

7. Bullying or Peer Abuse: refers to willful aggressive behavior that is directed towards a particular victim who may be out-numbered, younger, weak, with disability, less confident, or otherwise vulnerable (DepEd)

8. Empowerment: refers to having a sense of self-worth; to have and to determine choices, access to opportunities and resources, the power to control their own lives; and the ability to influence the direction of social change to create a more just social and economic order, nationally and internationally. (UN, 2001)

9. Adolescent Participation: refers to public processes in which adolescents are involved in decision making, either directly or through representatives. Adolescent participation recognizes adolescents as citizens and stakeholders in the present – not just in the future. (IAWGCP, 2007)

10. Evolving Capacities: The UNCRC recognizes that children in different environments and cultures, with different life experiences, will acquire competencies at different ages, and this process will vary according to circumstances. Children do not acquire competencies merely as a consequence of age, but rather through experience, culture, and levels of parental support and expectation. Evolving capacities is central to the balance between empowerment and protection. (Save the Children, 2007)

11. Life skills are abilities for adaptive and positive behavior that enable individuals to deal effectively with the demands and challenges of everyday life (WHO definition)

12. The Private Sector refers to health providers and facilities (individual practitioner, clinics, hospitals, facilities, drug outlets) licensed and regulated under existing laws but otherwise operating outside the ownership or management of the government. (DOH AO 2012-0004).

VI. GENERAL GUIDELINES

1. The Adolescent Health and Development Program (AHDP) shall be in accordance with the thrusts of the National Objectives for Health, the Philippine Development Plan, the AIDS Medium Term Plan, the Millennium Development Goals, and the Philippine Youth Development Plan of the National Youth Commission.

2. The AHDP shall target primarily adolescents age 10-19 years. This will complement the roles of the Council for the Welfare of Children, which serves to protect the rights of children under 18 years old, and the National Youth Commission, which is mandated to provide leadership in the formulation of policies for youth ages 15-30. Few programs address the unique health needs of very young adolescents ages 10-14. Thus resources need to be directed to this age group while also preventing pregnancies before the age of 20, when there is an increased risk of maternal (DOH, UNFPA, WHO, 2002) and infant (Phipps, 2002).
mortality, low birth weight babies (NSO), and limiting of the woman’s education and livelihood opportunities.

3. The AHDP shall aim to achieve the following health outcomes: (1) Healthy Development; (2) Healthy Nutrition; (3) Sexual and Reproductive Health; (4) reduction of substance use; (5) reduction of injuries and mortality, morbidity and psychosocial consequences of injuries; (6) reduction of all forms of violence and mortality, morbidity and psychosocial consequences of violence; and (7) Mental health. (National Standards and Implementation Guide for the Provision of Adolescent-Friendly Health Services, DOH, 2010)

4. The AHDP recognizes the risks inherent to early sexual initiation or having one’s first sexual intercourse occurring before the adolescent is physically and psychosocially capable of dealing with the consequences of sexual intercourse and shall aim to delay sexual initiation among adolescents.

5. The AHDP shall respect the rights of all adolescents. Specific strategies for marginalized and vulnerable groups need to be put in place to promote equity and inclusion. Marginalized groups include, but are not limited to, the following: Adolescents in Indigenous Communities as defined in RA 8371, Adolescents (Persons) with Disability (RA 9442), Adolescents (Children) in Conflict with the Law (RA 9344), Drug-dependent Adolescents (RA 9165), Abandoned and Neglected Adolescents (RA 9523), Adolescents on the Streets, Adolescents in Commercial Sexual Exploitation, Adolescent Survivors of Calamity, Adolescents in Situations of Armed Conflict, Adolescent Key Affected Populations, Adolescent Survivors of Abuse and Exploitation (RA 7610).

6. Program strategies shall include:

   a. Health Promotion and Behavior Change for adolescents to utilize health services, practice healthy behaviors, avoid risks, and participate in governance and policy decisions affecting their health and development

   b. Improving access to quality and adolescent-friendly health care services and information for adolescents, including access to quality hospitals and health care facilities following the National Standards and Implementation Guide for Adolescent-friendly Health Services and utilizing various settings outside the health system, such as schools, cruising sites, and social media, to promote adolescent health.

   c. Expanding Health Insurance. The DOH shall design a proposal for an Adolescent Health Package with PhilHealth while mobilizing other sources of financing such as local government and the private sector.

   d. Enhancing skills of service providers, families, and adolescents to protect their health and development

   e. Strengthening partnerships among adolescent groups, government agencies, civil society, the private sector, families and communities to make them accountable for the achievement of MDGs
f. Strengthening policy at all levels to ensure that all adolescents have access to information and services

g. Ensuring sufficient resources to implement a sustainable adolescent health program

h. Resource Mobilization. The Department of Health and Centers for Health Development shall provide funds for technical assistance, monitoring, and advocacy. The Council for the Welfare of Children, National Youth Commission, Department of Education, and Department of Social Welfare and Development shall provide counterpart funds to implement the Adolescent Health and Development Program within the scope of their responsibility. The Philippine Health Insurance Corporation shall develop benefits coverage for adolescent members and beneficiaries. Local government units shall provide funding for the implementation of the AHDP in their area, mobilizing external resources and internal funding such as SK funds and the GAD budget.

7. Monitoring and Evaluation systems shall be strengthened to improve access to strategic information to effectively assess the attainment of goals and utilize data in developing programs to forward adolescent health. To this end, the DOH shall develop a Five-year Strategic Plan for the AHDP with Goals, Objectives, Indicators, and Targets, including a monitoring and evaluation plan to measure attainment of the goals and objectives. The DOH and the National Statistics Office shall provide the necessary data, including baseline data disaggregated for the 10-19 age groups.

VII. STRATEGIC FRAMEWORK

Strategies of the AHDP shall be designed in accordance with the Program’s Vision, Mission, and Goals. Health status outcomes and adolescents’ rights shall be enjoyed through positive behavior change, which are achieved by a variety of strategies. In turn, these strategies will be built upon actionable program components. These elements are non-linear as multiple health and development goals call for a range of interventions delivered in an integrated manner.

1. VISION AND MISSION

Vision: Well-informed, empowered, responsible and healthy adolescents who are leaders in society

Mission: Ensure that all adolescents have access to quality comprehensive health care and services in an adolescent-friendly environment

2. The AHDP’s OVERALL GOALS are to improve the health status of adolescents and to enable them to fully enjoy their right to health.

3. GUIDING PRINCIPLES

The Adolescent Health Program is guided by the Convention on the Rights of Children which states that it should be of the Best interests of the child; the adolescent’s rights are indivisible and interrelated; Non-discrimination; have Access to accurate information, have access to life-saving interventions as long as he/she is mature enough to face the consequences; contain a meaningful adolescent participation; recognize adolescent as a
whole person needing a supportive environment; sustainable Life skills to help him/her cope with and manage their lives in a healthy and productive manner; capacitate the family as a primary source of basic knowledge, behavior, attitudes, and skills necessary for his/her well-being; a Life Cycle Approach where it continue to affect health and development of an adolescent from infancy to parenthood; Respect the adolescent’s right to privacy and confidentiality, including with respect to advice and counseling on health matters; Recognize the involvement, commitment, accountability, and responsibility in all areas of sexual and reproductive health as well as the protection and promotion of reproductive health concerns specific to men and boys (UNFPA); Recognize the positive impact of peer education, and the positive influence of proper role models, especially those in the worlds of arts, entertainment and sports (CRC/GC/2003/4).

VIII. IMPLEMENTING MECHANISMS

ORGANIZATIONAL STRUCTURE

The DOH shall act as the lead agency, along with the LGUs, for the implementation of this Order. The National Center for Disease Prevention and Control - Family Health Office shall designate a Sub-program Manager for Adolescent Health and Development. The DOH shall convene a Technical Working Group on Adolescent Health and Development whose primary role is to oversee the implementation of the Program and monitor progress based on the M&E Framework.

IX. ROLES AND RESPONSIBILITIES

1. DOH - National Center for Disease Prevention and Control (NCDPC), National Center for Health Promotion (NCHP), National Epidemiology Center (NEC), Philippine National AIDS Council (PNAC)
   - Serve as the focal point for overall planning, management, monitoring, and evaluation of the AHDP
   - Provide technical leadership in all matters pertaining the AHD
   - Advocate for adolescent health and development in national and local public forums
   - Ensure meaningful participation of adolescents at all stages of the program cycle
   - Create, strengthen, and maintain inter-agency links and public-private partnerships
   - Formulate an age- and development-appropriate Reproductive Health and Sexuality Education curriculum in coordination with the DSWD, DepEd, CHED, and TESDA
   - Provide parents with adequate and relevant scientific materials on the age-appropriate topics and manner of teaching Reproductive Health and Sexuality Education to their children
   - Development, implementation, and monitoring of a Health Promotion, Communications and Advocacy Plan for Adolescent Health and Development
   - Provide age-disaggregated data necessary for monitoring and evaluation of results of AHDP
   - Provide technical assistance and guideline in matters pertaining to STI and HIV and AIDS and services for Young Key Affected Populations

2. Center for Health Development
The Centers for Health Development are responsible for

- Localization and dissemination of this Order
- Providing technical assistance to local government units in implementation
- Monitoring results and reporting these to the DOH Central Office
- Creating inter-agency links to support local government units in implementation of the AHDP
- Advocating for policies and resources at the local level
- Ensuring that hospitals and health care facilities under CHD management meet the National Standards for the Provision of Adolescent-Friendly Health Services

3. Department of Education (DepEd), Commission on Higher Education (CHED), and Technical Education and Skills Development Authority (TESDA)

- With the DOH and DSWD, formulate an age- and development-appropriate Reproductive Health and Sexuality Education curriculum
- Provide parents with adequate and relevant scientific materials on the age-appropriate topics and manner of teaching Reproductive Health and Sexuality Education to their children
- Integrate other adolescent health concerns in school curriculum
- Mobilize teachers, guidance counselors, and parents to implement the AHDP


- With the DOH, DepEd, CHED, and TESDA, formulate an age- and development-appropriate Reproductive Health and Sexuality Education curriculum
- Provide parents with adequate and relevant scientific materials on the age-appropriate topics and manner of teaching Reproductive Health and Sexuality Education to their children
- Provide adolescent-friendly health services and protection to adolescents who are out of school, with disabilities, in conflict with the law, drug dependent, on the streets, in prostitution, survivors of calamity, in situations of armed conflict, and survivors of abuse and exploitation
- Train multi-disciplinary teams for Women and Child Protection Units and sustain 24/7 Crisis Interventions Units in every region
- Formulate policies, programs and measures on adolescent participation
- Assist in monitoring and evaluation of results of the AHDP
- Create inter-agency links to build support of local government units for the implementation of the AHDP
- Advocate, mobilize, and generate resources for adolescent development

5. Council for the Welfare of Children (CWC)

- Integrate adolescent health and development in national and local development plans
- Advocate for adolescent rights as enshrined in the CRC
- Include adolescent health and development issues in the Country Report to the CRC

6. Commission on Human Rights (CHR)
• Integrate the rights of adolescents in information and public advocacy, research, and training
• Investigate violations of adolescents’ rights and provide legal aid

7. National Statistics Office (NSO)
• Provide age-disaggregated data necessary for monitoring and evaluation of results of the AHDP

8. Philippine Health Insurance Corporation (PhilHealth)
• Provide benefits coverage for adolescents, particularly marginalized sub-sectors

9. Professional Medical and Allied Medical Associations, Academic Institutions, Adolescent and Youth Organization
• Develop members’ capacity to provide adolescent-friendly health services
• Provide technical assistance in the formulation of policies, guidelines, and tools for adolescent health and development
• Contribute to research on adolescent health and development
• Participate in monitoring and evaluation of results of the AHDP
• Advocate for adolescent rights as enshrined in the CRC
• Participate in the design and implementation of adolescent health and development programs
• Participate in the monitoring and evaluation of results of the AHDP

10. Non-Government, Faith-based, Civil Society Organizations, the United Nations and other development partners working with and for adolescents
• Implement adolescent-centered programs and outreach services in priority communities that are consistent with the AHDP in coordination with government agencies
• Provide technical assistance in the formulation of policies, guidelines, and tools for adolescent health and development
• Contribute to research on adolescent health and development
• Advocate, mobilize and generate resources for adolescent health and development

11. Private Sector
• Enforce policies for the protection of adolescent employees
• Implement workplace programs for parents of adolescents
• Support adolescent health and development activities in communities, schools, and other settings

12. Local Government Units
• The provision of reproductive health information, care and supplies shall be the joint responsibility of the National Government and Local Government Units (LGUs)
• LGUs must ensure provision of basic adolescent health care services including, but not limited to, the operation and maintenance of facilities and equipment necessary for the delivery of full range of reproductive health care services and the purchase and
distribution of family planning goods and supplies as part of the essential information and service delivery package defined by the DOH

- LGUs, specifically the Rural Health Units, City Health Offices, and Provincial Health Offices, are responsible for designing, funding, implementing, and monitoring local Adolescent Health and Development programs suited for adolescents in their area, in partnership with youth, government agencies, civil society, and the private sector, under the technical guidance of the CHD and this Order. LGUs should design specific strategies to reach marginalized and vulnerable adolescent sub-sectors. They should ensure meaningful participation of adolescents and communities in this process. Hospitals and health care facilities under LGU management must meet the National Standards for the Provision of Adolescent-Friendly Health Services.

X. REPEALING CLAUSE

The provisions of previous Orders and other related issuances inconsistent or contrary with the provisions of this Administrative Order, including AO 34-A s, 2000, are hereby revised, modified, repealed or rescinded accordingly. All other provisions of existing issuances which are not affected by this Order shall remain valid and in effect.

XI. SEPARABILITY CLAUSE

If any provision of this Order is declared unauthorized or rendered invalid by any court of law or competent authority, those provisions not affected thereby shall remain valid and effective.

XII. EFFECTIVITY

This Order shall take effect immediately.¹⁷

[Signed]

ENRIQUE T. ONA, M.D.

Secretary of Health

DEPARTMENT MEMORANDUM

No. 2013-0168

FOR : ALL UNDERSECRETARIES, ASSISTANT SECRETARIES, DIRECTORS OF BUREAUS, CENTER FOR HEALTH DEVELOPMENT, SERVICES, CHIEFS OF MEDICAL CENTERS, SPECIALTY HOSPITALS AND OTHER CONCERNED

SUBJECT : Guidelines in the Implementation of School-Based Adolescent Immunization

A. Rationale

Immunization is essential for adults as well as children. They protect against diseases like measles, mumps, rubella, hepatitis B, polio, diphtheria, tetanus, and pertussis (whooping cough). Some vaccines like tetanus toxoid when given in complete dose (until TT5 orTd) to women of childbearing age, does not only protect women against tetanus, but also prevent neonatal tetanus in their newborn infants. Immunization program in the Philippines has been started in July 1979 and in 1986, the country made a response to the Universal Child Immunization goal with four major strategies such as: sustaining high routine Full Immunized Child (FIC) coverage of at least 90% in all provinces and cities, sustaining the polio-free country for global certification; eliminating measles by 2008 and eliminating neonatal tetanus by 2008. (Wikipedia, June 2012)

In June 2000, the 57 countries that have not yet achieved elimination of neonatal tetanus were ranked. The Philippines together with 22 other countries was listed in Class A, a classification for countries close to maternal and neonatal tetanus elimination (Wikipedia, June 2012).

In 2007, an Executive Order No. 633 was signed to implement the National Commitment for “Bakuna ang Una sa Sanggol at Ina”. The goal is to eliminate measles and neonatal tetanus, eradicate polio, control Hepatitis B and other vaccine preventable diseases. Likewise, a Republic Act 10152, an Immunization Act of 2011 is to adapt a comprehensive and sustainable immunization program against vaccine preventable diseases. In addition, the National Youth Commission issued a Resolution Supporting the Expanded Immunization Program – Free Adolescent Vaccination – of the Department of Health.
Adolescents (10-19 years old) make up a significant proportion of each country’s population. They comprise about 21.5 percent or almost 20 million of the 92 million Filipinos counted in the 2010 census (NSO, 2010) as cited by the University of the Philippines Population Institute (UPPI). They contributed significantly to the labor force of the country. Considering that they represent as the most active group, they are the most vulnerable to vaccine preventable diseases due to their risky behaviors and are potential for outbreaks in schools and community especially for measles, diphtheria and pertussis.

Based on the National Epidemiology Center surveillance reports, an increasing confirmed cases of measles in 2010-2011 (1,157 and 1,562 respectively) and the probable diphtheria cases in 2010-2011 (24-31 cases respectively) among adolescents. Likewise, reports on suspected pertussis cases 2011 and 2012 (1 and 6 cases respectively).

B. Coverage

The vaccination shall prioritize ALL 1st year to fourth year high school students (Grade 7-10) in public school of the priority provinces and cities (ANNEX 1). This shall also serve as a guide to all partners (DOH, DepEd, CHED, TESDA, DSWD, LGUs, NGOs and other GOs) that has been selected to introduce vaccination in adolescent.

C. Recommended Schedule of Adolescent Immunization

1. All first year to fourth year high school students in the selected province/city shall receive a booster dose of Measles-Mumps-Rubella (MMR) and Tetanus-diphtheria (Td) Vaccine.
2. MMR vaccine shall not be given to pregnant female eligible target. The DOH and DepEd shall conduct screening of all female students before immunization.
3. The recommended schedule is as follows:

<table>
<thead>
<tr>
<th>Name of Vaccine</th>
<th>Number of Doses</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1st Dose</td>
<td>2nd Dose</td>
</tr>
<tr>
<td>Tetanus-diphtheria</td>
<td>√</td>
<td>NA</td>
</tr>
<tr>
<td>(Td)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR</td>
<td>√</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Dosage, Route of Administration and Site of Vaccine Administration

<table>
<thead>
<tr>
<th>Name of the Vaccine</th>
<th>Dosage</th>
<th>Route of the Administration</th>
<th>Site of the Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR</td>
<td>0.5 ml</td>
<td>Subcutaneous (SC)</td>
<td>Deltoid, Right Arm</td>
</tr>
<tr>
<td>Td</td>
<td>0.5 ml</td>
<td>Intramuscular (IM)</td>
<td>Deltoid, Left Arm</td>
</tr>
</tbody>
</table>
D. Vaccination Procedures

D1 Before the Immunization Days

- Organize the vaccination teams
- Orient the vaccination teams
- Coordinate with the focal person from school
  - Orientation of the Teachers and students
  - Identify the immunization sites
  - Distribute the notification letter
  - Retrieve the signed notification letter
  - Screen all women for presence or absence of pregnancy

D2 During the Immunization Days

- Set-up the immunization posts
- Prepare the immunization logistics
- Line the students with parental consent for immunization
- Inform the other students of the risk for non-vaccination

D3 After the Immunization Days

- Consolidate the reports
- Submits the reports to the next administrative level
- Follow-up the students missed and vaccinate
- Report AEFI

E. Recording and Reporting

Recording Forms: The main recording and reporting tools are the following (ANNEX 2)

Form 1: Parental Notification and Consent

This serves as a note to the parents/guardians of the students for approval of the students to be vaccinated. Such form shall be collected by the teacher a day prior to the immunization.

Form 2: Masterlist of Students

This form lists the names of the students per section by year level. Same list shall be used to record the vaccines administered. This shall be kept by the school clinic or health center catchment.

Form 3: Immunization Card for Adolescent
Record the date the MMR and Td vaccines were administered. Give to the vaccinated students and advise to keep the card.

**Form 4: School Consolidated Accomplishment**

This record the # of students vaccinated against MMR and Td per classroom including those students missed for vaccinations and reasons why missed. The focal immunization person in the school shall submit this report to the province or city where the school is located. This shall be accompanied by the Line List of Adverse Events Following Immunization (AEFI).

**Form 5: Provincial/City Consolidated Accomplishment**

This record the # of students vaccinated against MMR and Td school per school. The basis of the data shall be the School Consolidated Accomplishment Report submitted to them by the school’s focal immunization person. This shall be reported to the Center for Health Development (CHD). This shall be accompanied by the Line List of Adverse Events Following Immunization (AEFI).

**Form 6: Regional Consolidated Accomplishment**

This record the # of students vaccinated against MMR and Td per province/city. The basis of the data shall be the Provincial/City Consolidated Accomplishment Report submitted to them by the Adolescent Health Coordinator. This shall be reported to the Adolescent Health Coordinator at the National Center for Disease Prevention and Control (NCDPC). This shall be accompanied by the Line List of Adverse Events Following Immunization (AEFI).

**F. Vaccine Storage, Handling and Transport of Vaccines**

1. DOH shall provide the MMR and Td vaccines to all schools providing the immunization following the proper storage of the vaccines.
2. MMR and Td vaccines shall be stored at +2°C to +8°C during immunization session.
3. MMR vaccine shall be discarded after 6 hours of reconstitution.
4. Td vaccine follows the multi-dose vial policy. Open vials of Td vaccine may be used in subsequent sessions (28 days) provided the following conditions are met.
   a. Expiry date has not passed
   b. Vaccines are stored under appropriate cold chain conditions
   c. Vaccine vial septum has not been submerged in water.
   d. Aseptic technique has been used to withdraw all doses,
   e. Vaccine Vial Monitor (VVM) is intact and has not reached the discard point
   f. Date is indicated when the vial was open.
G. Immunization Safety

Special precautions must be instituted to ensure that blood-borne diseases are not transferred to other persons. This shall include:

- Always use the auto-disable syringe (AD)
- Do not pre-fill syringes.
- Do not recap needles.
- Dispose used syringes and needles into the safety collector box with used immunization wastes through the recommended appropriate final disposal for hazardous wastes.

Auto-disabled syringes shall be used in all immunization sessions. Use of aspirating needles and pre-filling of syringes are strictly prohibited.

Used needles and syringes, empty vaccine vials, used cotton balls are considered infectious and shall be disposed in the recommended appropriate disposal of infectious/biological wastes.

H. Contraindication

Some of the local reactions are pain, swelling and/or redness at the injection site. Symptomatic local reactions can be expected in about 10% of vaccine recipients.\(^{18}\)

By Authority of Secretary of Health:

[Signed]

ENRIQUE A. TAYAG, MD, PHSAE, FPSMID, CESO III
Assistant Secretary of Health
Support to Service Delivery Technical Cluster II

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\(^{18}\) Department of Health, Department Memorandum No. 2013-0168. Guidelines in the Implementation of School-Based Adolescent Immunization
<table>
<thead>
<tr>
<th>REGION</th>
<th>PROVINCE/CITY</th>
<th>Target (Grade 7-10)</th>
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<tbody>
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<td>NCR</td>
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<td>Paranaque</td>
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<td>Apayao</td>
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<td>I</td>
<td>La Union</td>
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<tr>
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<td>Name of School</td>
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(Grade 7 to Fourth Year)

Adolescent Health and Development Program
Immunization for Adolescents

Reporting Form 2: Masterlist of Students
<table>
<thead>
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<th>Grade</th>
<th>Year</th>
<th>Level</th>
<th>Number</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
<th>%</th>
<th>Year</th>
<th>Level</th>
<th>Number</th>
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<th>Female</th>
<th>Total</th>
<th>%</th>
<th>Year</th>
<th>Level</th>
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<th>Male</th>
<th>Female</th>
<th>Total</th>
<th>%</th>
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</tr>
</tbody>
</table>

Province/City: ____________________________  Region: ____________________________

Name of School: ____________________________  Division: ____________________________

GRADE 7 TO FOURTH YEAR

ADOLESCENT HEALTH AND DEVELOPMENT PROGRAM

IMMUNIZATION FOR ADOLESCENTS

Reporting Form 4: School Consolidated Accomplishment
<table>
<thead>
<tr>
<th>Province/City:</th>
<th>Region:</th>
</tr>
</thead>
</table>

GRADE 7 TO FOURTH YEAR

ADOLESCENT HEALTH AND DEVELOPMENT PROGRAM

IMMUNIZATION FOR ADOLESCENTS

Reporting Form: Province/City Consolidated Accomplishment
ANNEX 18

H. No. 5496

Republic of the Philippines
Congress of the Philippines
Metro Manila
Fifteenth Congress
Third Regular Session

Begun and held in Metro Manila, on Monday, the twenty-third day of July, two thousand twelve.

[REPUBLIC ACT NO. 10627]

AN ACT REQUIRING ALL ELEMENTARY AND SECONDARY SCHOOLS TO ADOPT POLICIES TO PREVENT AND ADDRESS THE ACTS OF BULLYING IN THEIR INSTITUTIONS

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

SECTION 1. Short Title. – This Act shall be known as the “Anti-Bullying Act of 2013”.

SEC. 2. Acts of Bullying. – For purposes of this Act, “bullying” shall refer to any severe or repeated use by one or more students of a written, verbal or electronic expression, or a physical act or gesture, or any combination thereof, directed at another student that has the effect of actually causing or placing the latter in reasonable fear of physical or emotional harm or damage to his property; creating a hostile environment at school for the other student; infringing on the rights of the other student at school; or materially and substantially disrupting the education process or the orderly operation of a school; such as, but not limited to, the following:

a. Any unwanted physical contact between the bully and the victim like punching, pushing, shoving, kicking, slapping, tickling, headlocks, inflicting school pranks, teasing, fighting and the use of available objects as weapons;

b. Any act that causes damage to a victim’s psyche and/or emotional well-being;

c. Any slanderous statement or accusation that causes the victim undue emotional distress like directing foul language or profanity at the target, name-calling, tormenting and commenting negatively on victim’s looks, clothes and body; and

d. Cyber-bullying or any bullying done through the use of technology or any electronic means.

SEC. 3. Adoption of Anti-Bullying Policies. – All elementary and secondary schools are hereby directed to adopt policies to address the existence of bullying in their respective institutions. Such policies shall be regularly updated and, at a minimum, shall include provisions which:
a. Prohibit the following acts:

(1) Bullying on school grounds; property immediately adjacent to school grounds; at school-sponsored or school-related activities, functions or programs whether on or off school grounds; at school bus stops; on school buses or other vehicles owned, leased or used by a school; or through the use of technology or an electronic device owned, leased or used by a school;

(2) Bullying at a location, activity, function or program that is not school-related and through the use of technology or an electronic device that is not owned, leased or used by a school if the act or acts in question create a hostile environment at school for the victim, infringe on the rights of the victim at school, or materially and substantially disrupt the education process or the orderly operation of a school; and

(3) Retaliation against a person who reports bullying, who provides information during an investigation of bullying, or who is a witness to or has reliable information about bullying;

b. Identify the range of disciplinary administrative actions that may be taken against a perpetrator for bullying or retaliation which shall be commensurate with the nature and gravity of the offense: Provided, That, in addition to the disciplinary sanctions imposed upon a perpetrator of bullying or retaliation, he/she shall also be required to undergo a rehabilitation program which shall be administered by the institution concerned. The parents of the said perpetrator shall be encouraged by the said institution to join the rehabilitation program;

c. Establish clear procedures and strategies for:

(1) Reporting acts of bullying or retaliation;

(2) Responding promptly to and investigating reports of bullying or retaliation;

(3) Restoring a sense of safety for a victim and assessing the student’s need for protection;

(4) Protecting from bullying or retaliation of a person who reports acts of bullying, provides information during an investigation of bullying, or is witness to or has reliable information about an act of bullying; and

(5) Providing counseling or referral to appropriate services for perpetrators, victims and appropriate family members of said students;

(a) Enable students to anonymously report bullying or retaliation: Provided, however, That no disciplinary administrative action shall be taken against a perpetrator solely on the basis of an anonymous report;

(b) Subject a student who knowingly makes a false accusation of bullying to disciplinary administrative action;
(c) Educate students on the dynamics of bullying, the anti-bullying policies of the school as well as the mechanisms of such school for the anonymous reporting of acts of bullying or retaliation;

(d) Educate parents and guardians about the dynamics of bullying, the anti-bullying policies of the school and how parents and guardians can provide support and reinforce such policies at home; and

(e) Maintain a public record of relevant information and statistics on acts of bullying or retaliation in school: Provided, That the names of students who committed acts of bullying or retaliation shall be strictly confidential and only made available to the school administration, teachers directly responsible for the said students and parents or guardians of students who are or have been victims of acts of bullying or retaliation.

All elementary and secondary schools shall provide students and their parents or guardians a copy of the anti-bullying policies being adopted by the school. Such policies shall likewise be included in the school’s student and/or employee handbook and shall be conspicuously posted on the school walls and website, if there is any.

The Department of Education (DepED) shall include in its training programs, courses or activities which shall provide opportunities for school administrators, teachers and other employees to develop their knowledge and skills in preventing or responding to any bullying act.

SEC. 4. Mechanisms to Address Bullying. – The school principal or any person who holds a comparable role shall be responsible for the implementation and oversight of policies intended to address bullying.

Any member of the school administration, student, parent or volunteer shall immediately report any instance of bullying or act of retaliation witnessed, or that has come to one’s attention, to the school principal or school officer or person so designated by the principal to handle such issues, or both. Upon receipt of such a report, the school principal or the designated school officer or person shall promptly investigate. If it is determined that bullying or retaliation has occurred, the school principal or the designated school officer or person shall:

(a) Notify the law enforcement agency if the school principal or designee believes that criminal charges under the Revised Penal Code may be pursued against the perpetrator;

(b) Take appropriate disciplinary administrative action;

(c) Notify the parents or guardians of the perpetrator; and

(d) Notify the parents or guardians of the victim regarding the action taken to prevent any further acts of bullying or retaliation.
If an incident of bullying or retaliation involves students from more than one school, the school first informed of the bullying or retaliation shall promptly notify the appropriate administrator of the other school so that both may take appropriate action.

SEC. 5. Reporting Requirement. – All schools shall inform their respective schools division superintendents in writing about the anti-bullying policies formulated within six (6) months from the effectivity of this Act. Such notification shall likewise be an administrative requirement prior to the operation of new schools.

Beginning with the school year after the effectivity of this Act, and every first week of the start of the school year thereafter, schools shall submit a report to their respective schools division superintendents all relevant information and statistics on acts of bullying or retaliation. The schools division superintendents shall compile these data and report the same to the Secretary of the DepED who shall likewise formally transmit a comprehensive report to the Committee on Basic Education of both the House of Representatives and the Senate.

SEC. 6. Sanction for Noncompliance. – In the rules and regulations to be implemented pursuant to this Act, the Secretary of the DepED shall prescribe the appropriate administrative sanctions on school administrators who shall fail to comply with the requirements under this Act. In addition thereto, erring private schools shall likewise suffer the penalty of suspension of their permits to operate.

SEC. 7. Implementing Rules and Regulations. – Within ninety (90) days from the effectivity of this Act, the DepED shall promulgate the necessary rules and regulations to implement the provisions of this Act.

SEC. 8. Separability Clause. – If, for any reason, any provision of this Act is declared to be unconstitutional or invalid, the other sections or provisions hereof which are not affected thereby shall continue to be in full force or effect.

SEC. 9. Repealing Clause. – All laws, decrees, orders, rules and regulations or parts thereof which are inconsistent with or contrary to the provisions of this Act are hereby repealed, amended or modified accordingly.

SEC. 10. Effectivity. – This Act shall take effect fifteen (15) days after its publication in at least two (2) national newspapers of general circulation.

Approved,

(Sgd.) JINGGOY EJERCITO ESTRADA (Sgd.) FELICIANO BELMONTE JR.
Acting Senate President Speaker of the House of Representatives
This Act which originated in the House of Representatives was finally passed by the House of Representatives and the Senate on June 5, 2013.

(Sgd.) EMMA LIRIO-REYES    (Sgd.) MARILYN B. BARUA-YAP
Secretary of the Senate    Secretary General
House of Representatives

Approved: SEP 12 2013\(^\text{19}\)

(Sgd.) BENIGNO S. AQUINO III
President of the Philippines