



Republic of the Philippines
DEPARTMENT OF HEALTH
Office of the Secretary



ADMINISTRATIVE ORDER
No. 2025 - **0028**

DEC 22 2025

SUBJECT: National Policy Framework on Community-Based Mental Health

I. RATIONALE

Mental, neurological, and substance use (MNS) conditions account for 10% of the global burden of disease [Institute of Health Metrics and Evaluation (IHME), 2021]. In the Philippines, an estimated 13.8% of the population, or 1 in 7 Filipinos, has experienced the onset of at least one mental health condition throughout their lives, most commonly panic attacks, dementia, and depression (De Guzman et al., 2024). Despite this burden, mental health services remain limited, hospital-based, and unevenly distributed across the country, particularly at the community level [World Health Organization (WHO) & Department of Health (DOH), 2006a]. Gaps in the workforce, financing, and service integration continue to hinder access to quality care.

Republic Act (RA) No. 11036, or the Mental Health Act, mandates the integration of mental health services into primary care at the city, municipal, and barangay levels. In alignment with RA 11223, or the UHC Act and the DOH's 8-Point Action Agenda, particularly Agenda 6: Ginhawa ng Isip at Damdamin, the Department commits to enhancing mental health and well-being by ensuring the availability and accessibility of services in communities, learning institutions, and workplaces (DOH, 2023a).

The successful implementation of the pilot community-based mental health (CBMH) programs in Lemery, Batangas, and subsequent expansion sites in Muntinlupa, Aklan, Leyte, Iloilo, and BARMM demonstrated that capacitating community members, particularly Barangay Health Workers (BHWs), significantly improves capacity to identify, manage, and refer mental health cases.

Building on these lessons, this Order institutionalizes the National Policy Framework on CBMH to guide the systematic and coordinated scale-up of integrated community-based and person-centered mental and neurologic health care services in communities.

II. OBJECTIVES

This Order shall establish the DOH's policy direction and implementation framework for CBMH. Specifically, it aims to:

1. Define the DOH's strategic shift towards integrated, community-based delivery of mental and neurological health services; and,
2. Delineate the functional roles and responsibilities of DOH bureaus, services, offices, and Centers for Health Development (CHDs), the Philippine Council for Mental Health (PCMH), local government units (LGUs), and other stakeholders implementing CBMH.

III. SCOPE OF APPLICATION

This Order shall apply to all DOH bureaus, services, offices, and CHDs, DOH hospitals, Drug Abuse Treatment and Rehabilitation Centers (DATRCs), LGUs, partners from national government agencies (NGAs), non-governmental organizations (NGOs) or civil society organizations (CSOs), international health partners (IHPs), faith-based organizations, people with disabilities (PWD) organizations, and learning institutions.

Likewise, this Order shall apply to the Ministry of Health - Bangsamoro Autonomous Region in Muslim Mindanao (MOH-BARMM), subject to the applicable provisions of RA 11054 or the "Bangsamoro Organic Act" and subsequent rules and policies issued by the Bangsamoro Government.

IV. DEFINITION OF TERMS

For the purpose of this Order:

- A. **Advanced comprehensive specialty center (ACSC)** refers to a specialty center that serves a full range of specialty and subspecialty clinical services at the subnational level, and has the capacity to conduct and provide specialty and subspecialty clinical, public health, and operations research, and training (RA 11959, 2023).
- B. **Basic comprehensive specialty center (BCSC)** refers to a specialty center that serves a full range of specialty clinical services at the regional level, and has the capacity to conduct and provide specialty clinical, operational, and public health research, and training (RA 11959, 2023).
- C. **Basic mental and neurological health services** refer to a range of services designed to promote mental well-being (WHO, n.d.), prevent mental and neurological conditions, provide care and treatment for those experiencing such conditions (WHO, n.d; RA 11036), and support recovery from mental health problems (Mental Health Foundation, 2016). These services aim to address the diverse needs of individuals across the lifespan, from early childhood to older age.
- D. **Biopsychosocial Spiritual (BPSS) Framework** refers to the reorientation of mental health in the country and is multidimensional in its view of the individual as interconnected to the external environment and a spirit within:
 - 1. The **biological (physical) dimension** focuses on the brain, which serves as the system that integrates an individual's bodily functions and his/her ability to interact with the environment to maintain life. This basically addresses the perspective of the brain and the self.
 - 2. The **psychological dimension** addresses the individual's personality, which is the combination of his instinctual urges, limits of control, thought processes, emotional expressions, actions, and behaviors.
 - 3. The **social dimension** articulates the fact that the external environment of the individual, the societal system (society), is to be understood as distinct from him/her. Although interconnected with the individual, it has characteristics that are distinct from the individual. Society is not just the sum total of individual

characteristics.

4. The **spiritual dimension** addresses the recognition of a feeling, an experience, a belief of something greater than the self, something more to being human, but to which is experienced a connection that becomes a source of inner strength, guidance, and meaning in life (DOST-PCHRD, 2021).
- E. **Community-Based Mental Health (CBMH)** refers to the delivery of mental and neurological health services within a geographically defined community (DOH & WHO, 2021b).
- F. **Community health worker** refers to a person in the community equipped and trained to deliver mental and neurological health services such as but not limited to, teachers, parents and surrogate parents (i.e., mothers, fathers, caregivers in households), human resource managers, staff in workplaces, non-government staff running daycare centers for children and adults, volunteers, barangay health workers (BHWs), champions from self-help groups, faith-based leaders, and CSOs (DOH & WHO, 2021b).
- G. **Deinstitutionalization** refers to the process of transitioning service users, including persons with mental health conditions and psychosocial disabilities, from institutional and other segregated settings to community-based settings that enable social participation, recovery-based approaches to mental health, and individualized care in accordance with service users' will and preference (RA 11036, 2018).
- H. **Health Care Provider Network (HCPN)** refers to a group of primary to tertiary care providers, whether public or private, offering people-centered and comprehensive care in an integrated and coordinated manner, with the primary care provider acting as the navigator and coordinator of healthcare within the network (RA 11223, 2019).
- I. **Health literacy** refers to the personal knowledge and competencies that accumulate through daily activities, social interactions, and across generations. Personal knowledge and competencies are mediated by the organizational structures and availability of resources that enable people to access, understand, appraise, and use information and services in ways that promote and maintain good health and well-being for themselves and those around them (Geneva: World Health Organization, 2021a). The DOH (Department of Health - Health Promotion Bureau, 2022) further identifies two types of health literacy:
 1. **Comprehensive health literacy** entails people's knowledge, motivation, and competencies to access, understand, appraise and apply health information in order to make judgments and take decisions in everyday life concerning healthcare, disease prevention, and health promotion to maintain or improve quality of life during the life course (Sorensen, et al, 2012).
 2. **Functional health literacy** refers to taking basic skills in reading and writing that are necessary to function effectively in everyday situations (Nutbeam, 2000).
- J. **Mental health** refers to a state of well-being, in which the individual realizes one's own abilities and potentials, copes adequately with normal stresses, displays resilience in the face of extreme life events, works productively and fruitfully, and can make a positive contribution to the community (RA 11036, 2018). For the purpose of this

policy, mental health also captures neurological conditions as used in the respective definitions of Mental Health Conditions and Mental Health Services.

- K. **Mental health conditions** refers to a neurological or psychiatric condition characterized by the existence of a recognizable, clinically significant disturbance in an individual's cognition, emotional regulation, or behavior that reflects a genetic or acquired dysfunction in the neurobiological, psychosocial, or developmental processes underlying mental functioning (RA 11036, 2018).
- L. **Mental health services** refers to psychosocial, psychiatric, or neurological activities and programs along the whole range of mental health support services, including promotion, prevention, treatment, and aftercare, which are provided by mental health facilities and mental health professionals (RA 11036, 2018).
- M. **Mental health service provider** refers to an entity or individual providing mental health services, whether public or private, including, but not limited to, mental health professionals and workers, social workers and counselors, informal community caregivers, mental health advocates and their organizations, personal ombudsmen, and persons or entities offering non-medical alternative therapies (RA 11036, 2018).
- N. **Service user** - refers to a person with lived experience (PWLE) of any mental health condition, including persons who require or are undergoing psychiatric, neurological, or psychosocial care (RA 11036, 2018).
- O. **Task sharing** - refers to capacitating non-specialist healthcare service providers in the community to provide mental healthcare services, especially in areas lacking resources (DOH & WHO, 2021b).

V. GUIDING PRINCIPLES

The implementation of this Order shall be guided by the following principles:

- A. **Person-Centered, Human Rights-Based Approach.** Emphasizes individuals' dignity, autonomy, and participation in their care, ensuring that mental and neurological health services are accessible, equitable, and respectful of human rights. See Annex B for the Rights of Service Users and Other Stakeholders under RA 11036.
- B. **Holistic Mental and Neurological Health Care.** A holistic approach to mental and neurological health care, considering factors contributing to mental well-being and cultural, gender, and age sensitivity, integrating multiple dimensions of human experience to effectively understand, promote, and address mental health and mental and neurological conditions. Using the BPSS framework, a broader approach focuses on the interconnections of the individual with their environment.
- C. **Life Course and Settings-Based Approach.** CBMH strategies focus on the specific environments and contexts in which individuals learn, work, and live to provide more effective and tailored mental and neurological health services across different life stages. This approach recognizes that mental and neurological health is influenced by

various factors beyond individual symptoms, including community dynamics, cultural norms, and socioeconomic conditions. It emphasizes that health is shaped by these various factors from conception to old age.

- D. **Diversity, Equity, and Inclusion (DEI).** CBMH shall uphold diversity, equity, and inclusion by ensuring that services are culturally sensitive, gender-responsive, and accessible to marginalized and vulnerable populations. DEI refers to creating a workforce that is diverse across various dimensions (like geography, gender, and culture), ensuring equity through fair processes that address historical inequality to work towards equality in outcomes, and fostering an inclusive learning institution, workplace, and community where diversity is valued, and all individuals feel a sense of belonging, safety, and respect.

VI. GENERAL GUIDELINES

- A. The DOH shall promote the CBMH Program as a key strategy to ensure the delivery of accessible, integrated, and people-centered mental and neurological health services at the primary care level, consistent with the Mental Health Act and the UHC Act.
- B. The **CBMH framework** (see Annex C) shall serve as the overall guide for implementing mental and neurological health services at the community level. It shall inform the planning, delivery, and monitoring of primary care-based mental health programs.
- C. The implementation of CBMH shall adhere to the following key elements:
1. Community engagement;
 2. Capacity building of community health workers and community members;
 3. Service user empowerment;
 4. Strengthening of family and support systems; and,
 5. Continuity of care.
- D. Implementation of CBMH shall be participatory and collaborative, engaging LGUs, BHWs, community volunteers, local health providers, faith-based organizations, civil society organizations (CSOs), and other community-based stakeholders.

VII. SPECIFIC GUIDELINES

A. Governance and Support Structure

1. The DOH, through the PCMH, relevant bureaus and services, and CHDs, shall exercise overall leadership and coordination in the implementation of the CBMH.
2. The DOH shall lead the strategic rollout of the CBMH and shall provide technical assistance to LGUs and other implementing stakeholders, including support in planning, strategy development, and aligning local CBMH activities with this framework and other service delivery standards.
3. All stakeholders and implementing partners, shall adopt and implement CBMH strategies in line with the provisions of this AO and other related mandates stipulated in the Mental Health Act.
4. All LGUs, through their local mental health council or their local health boards

shall develop and implement their respective CBMH strategies, consistent with their mandates and guided by the CBMH Framework. These strategies shall take into account local epidemiological profiles, available resources, and sociocultural contexts, and be integrated into local health systems through the Local Investment Plan for Health and Annual Operation Plan.

5. An Operational Guidelines for the implementation of the CBMH program shall be developed to properly guide program managers, regional coordinators, service providers, LGUs, partners from NGAs, NGOs or CSOs, IHPs, faith-based organizations, PWD organizations, learning institutions, and other relevant stakeholders.

B. Community Engagement

1. The LGUs, with support from the CHDs, shall engage community actors, including local officials, local government agencies, health workers, service users, carers, CSOs, and faith-based or civic groups, throughout the development of CBMH programs, from planning to evaluation.
2. Community engagement must prioritize and emphasize the inclusion of vulnerable populations, such as individuals living in geographically isolated and disadvantaged areas (GIDAs) and rural areas, women, children, the elderly, indigenous peoples and other marginalized groups, to ensure equitable access and tailored support.
3. Service users and support groups, such as faith-based, peer support groups or civic organizations, shall actively contribute in designing and mobilizing resources for mental and neurological health initiatives.
4. LGUs shall conduct situational analyses and resource mapping to determine community needs and assets, followed by the preparation of a CBMH Action Plan integrated into the LIPH (Annex D).
5. CBMH services may be delivered through learning institutions, workplaces, and other community settings. Alternative delivery modes such as mobile clinics, digital platforms, and telemental health shall be encouraged to expand reach.

C. Building the Capacity of Community Health Workers and Community Members

1. CBMH implementers shall capacitate community health workers and members of the community based on the DOH MNS Competency Framework. The proposed minimum service requirements can be seen in Annex E.
2. The DOH, National Center for Mental Health (NCMH), and PCMH shall provide guidelines on identifying competencies, developing the training design, conducting actual training, and monitoring and evaluation. These can also be provided by other entities/stakeholders, such as, but not limited to, CHDs, MOH-BARMM, and other partners, with due approval from the DOH, NCMH, and PCMH.
3. The DOH, through the Disease Prevention and Control Bureau-Mental Health Division (DPCB-MHD), shall guide the CBMH programs in identifying available capacity-building activities for managers and implementers of the program. A critical focus of these capacity-building initiatives must be the empowerment and skill enhancement of vulnerable populations, including individuals living in GIDAs and rural areas, women, children, and the elderly. This includes tailored training and resources to address the unique mental health challenges faced by these groups, ensuring they can actively participate in and benefit from CBMH programs.
4. The competencies shall include knowledge, skills, judgment, interpersonal skills,

referral to a higher level of care, and alternative modes of care, among others.

D. Service User Empowerment

1. Service users shall be informed of their rights and health benefits provided by law and be allowed to participate in developing policies, programs, and treatment plans for service users to promote independence and well-being.
2. CBMH implementers shall enable community health workers to help service users understand and accept their mental and neurological conditions. They shall assist service users and their families throughout their journey to improve mental well-being and overall quality of life.
3. Support systems and mechanisms shall be established to assist the reintegration of service users in the community, guided by the Peer Support Group Playbook (<https://bit.ly/PlaybookforPeerSupport>).

E. Strengthen the Family and Support Groups

1. CBMH implementers shall encourage, educate, and provide support to families of service users as they play a central role in making mental and neurological health-related decisions.
2. CBMH implementers shall mobilize community institutions such as, but not limited to, neighborhood groups, faith-based organizations, civic or business groups, and NGOs to support the mental and neurological health of service users and the communities.
3. Family and support groups shall establish support systems and mechanisms to support service users and assist them in reintegration into the community.
4. Family and support groups shall provide support for carers of service users, including, but not limited to, family members, peers, and service providers. These include self-care seminars and activities, strengthened support groups, awareness and education programs on mental and neurological health, capacity building and continuing education, financial assistance for medication, and health services.

F. Continuity of Care

1. CBMH implementers shall include recovery assistance to support service users in maintaining positive lives post-treatment and reintegrating into their community.
2. CBMH implementers shall develop recovery and support programs in coordination with stakeholders. These include health management, stable and safe housing arrangements, job placement, recreational opportunities, involvement in meaningful daily activities, supportive and meaningful relationships, work accommodation, flexible leave arrangements, medical confidentiality, and other social support that service users may need.
3. CBMH implementers, in coordination with local health offices and local government agencies, shall establish referral mechanisms with social support services to ensure that service users and their carers are referred accordingly.
4. CBMH implementers shall coordinate referrals for cases requiring specialized or acute care to higher-level mental health services.

G. Minimum Community-Based Mental and Neurological Health Services

1. CBMH implementers shall promote mental and neurological health promotion and awareness:

- a. Promote mental and neurological health literacy and positive attitudes through education, advocacy, and supportive environments by enhancing resilience, teaching coping skills, and fostering social support networks.
 - b. Conduct culturally sensitive outreach and educational campaigns to raise awareness, reduce stigma, encourage help-seeking, and promote community dialogue.
 - c. Support the establishment of peer support groups and self-help networks to empower individuals with mental and neurological conditions, their families, and carers, building a sense of belonging.
 - d. Health promotion, in general, should be a central and foundational part of the broader health landscape, extending beyond the scope of minimum community-based mental health services.
2. CBMH implementers shall provide the following minimum community-based mental and neurological health services:
 - a. Basic mental and neurological health services, including screening, assessment, and management of common conditions, delivered by Mental Health Gap Action Program (mhGAP)-trained primary care providers in primary care facilities encompassing psychoeducation and information, advocacy and training, day care services, counseling and talk therapies, telemedicine, wellness programs, and medication provision.
 - b. Comprehensive mental and neurological health care services using telecommunications technology (e.g., video conferencing, phone calls, or mobile applications) to provide basic services to service users who cannot leave their homes, who work unconventional hours, or who live in remote or GIDAs.
 - c. Psychosocial support and counseling services to individuals with mental and neurological health concerns in the community through a network of trained mental and neurological health professionals and psychosocial responders.
 - d. Facilitate access to specialized mental and neurological health services for individuals requiring referral to higher-level facilities and those needing referral back to the community for continuity of care utilizing the existing HCPN.
 - e. Provide essential mental and neurological medications for individuals requiring pharmacological treatment, with appropriate monitoring and supervision by trained healthcare providers through the Medicine Access Program for Mental Health.
 - f. Accessible crisis intervention services such as Mental Health and Psychosocial Support (MHPSS), crisis hotlines and centers, and mobile health teams, to provide immediate support and assistance to individuals experiencing acute mental and neurological health crises or suicidal ideation.
3. CBMH implementers shall integrate mental health services into other primary care programs to ensure a holistic approach to health. Mental and neurological health screening, support, and interventions may be embedded in the following, but not limited to, programs addressing adolescent health, non-communicable diseases (NCDs), HIV, TB, healthy ageing, and general wellness checkups.

4. CBMH implementers and stakeholders shall conduct research studies to strengthen implementation strategies and ensure better health outcomes.

H. Monitoring and Evaluation

1. The DOH, through its CHDs and MOH-BARMM, shall lead the monitoring and evaluation, collecting data and sharing its reports and findings with local decision-makers quarterly.
2. The CBMH Program shall be monitored and evaluated using the CBMH indicators (Annex F).
3. CHDs and MOH-BARMM shall submit regular quarterly reports and data (in the succeeding month after the end of each quarter, i.e., April, July, October, and January) following the prescribed template specified in this policy (Monitoring Tool: <https://bit.ly/CBMHMonitoringTools>).
4. The recording of patient data shall be integrated into the Mental Health Information System (MHIS) of the provincial/city/municipal health facilities or barangay health centers.
5. Proper documentation, sharing, and safekeeping of health records shall be ensured by health facilities with due consideration to medical confidentiality pursuant to DOH, Department of Science and Technology (DOST), and PhilHealth JAO 2016-0002 or the Implementation of the Philippine Health Information Exchange and DOH Administrative Order (AO) No. 2020-0030 or the Data Privacy Guidelines on the Processing Health Information. See Annex G for the Data Management Plan for the National Policy Framework on Community-Based Mental Health.
6. In any instance where program data is to be shared with a third party, a Data Sharing Agreement (DSA) is mandatory. This agreement must be formally drafted and signed by all parties involved. The DSA must contain provisions that guarantee the recipient of the data will provide a comparable level of protection to that required by the Data Privacy Act Implementing Rules and Regulations. This ensures that the data remains secure and private even after it has been transferred (See Annex H. Data Sharing Agreement Template).

VIII. ROLES AND RESPONSIBILITIES

A. The Philippine Council for Mental Health (PCMH) shall:

1. Lead the biennial, multi-sectoral review of CBMH implementation and promote the multi-sectoral policy coordination and partnerships with various member agencies, organizations, and institutions;
2. Provide technical guidance to NGAs and local implementers as to the establishment of their respective CBMH programs; and,
3. Cascade and coordinate the roles and responsibilities of member agencies as to the adoption and implementation of the framework.

B. Department of Health

1. The Disease Prevention and Control Bureau (DPCB) shall:

- a. Lead the implementation of CBMH programs and serve as the central body for monitoring and evaluation (M&E), ensuring data consistency;
- b. Lead the capacity-building of the CHDs and other operating units, in

coordination with the PCMH and the NCMH. This includes disseminating the CBMH framework to stakeholders and implementers through orientations, forums, and various communication channels;

- c. Develop supportive policies and tools for effective implementation and operationalization of the CBMH framework, including updating the Omnibus Health Guidelines and creating or revising clinical practice guidelines
- d. Provide training and support to community-based mental health centers on providing service delivery and implementing a surveillance systems; and,
- e. Develop or update mental and neurological health training modules/designs for health care workers and community health workers.

2. The Health Promotion Bureau (HPB) shall:

- a. Lead the development of health promotion strategies, policies, research, and social and behavioral interventions directed to address behavioral risk factors and increase protective factors for mental and neurological health conditions in community settings in collaboration with NCMH, DPCB, and other stakeholders;
- b. Coordinate and cascade CBMH promotion interventions to CHDs and MOH-BARMM for local implementation; and,
- c. Facilitate research and development to mental and neurological health literacy.

3. The National Center for Mental Health (NCMH) shall:

- a. Provide technical leadership in developing, updating, and disseminating clinical and psychosocial care protocols for CBMH;
- b. Coordinate with CHDs and LGUs on the surveillance, analysis, and use of mental health data;
- c. Serve as the lead agency for the orientation and technical monitoring of specialty mental health centers on CBMH implementation; and,
- d. Assist in the development of digital and technology-based solutions to improve access and service delivery.

4. The Health Emergency and Management Bureau (HEMB) shall:

- a. Manage the mobilization of Health Emergency Response Teams, including MHPSS Service Providers, to deliver timely MHPSS support during emergencies and disasters;
- b. Establish and enhance coordination mechanisms for intersectoral mental health and psychosocial support during crisis situations, per NDRRMC Memo 62. S. 2017 or the National Guidelines on Mental Health and Psychosocial Support in Emergencies and Disaster Situations;
- c. Provide technical assistance to key stakeholders to strengthen their capacity to implement effective MHPSS interventions;
- d. Develop and regularly update MHPSS Training modules and program designs tailored to the specific needs and roles of healthcare workers and non-healthcare workers; and,
- e. Consult with the Department of Labor and Employment (DOLE), CHDs to determine their existing initiatives and capacities.



5. The Centers for Health Development (CHD) shall:

- a. Disseminate and reiterate, if needed, the CBMH framework and policy to local stakeholders;
- b. Provide technical assistance, to LGUs and other stakeholders on the implementation of this policy;
- c. Ensure that local efforts are in line with the CBMH framework;
- d. Monitor and evaluate the implementation of CBMH in coordination with LGUs, consolidate LGU reports, and submit regional summaries to the DOH Central Office quarterly; and,
- e. Provide training to local stakeholders on specific capacity-building programs as needed, in collaboration with training providers, such as, but not limited to, NCMH.

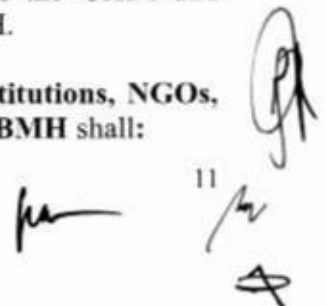
C. The LGUs shall:

1. Conduct resource mapping, identifying and documenting the various resources for mental and neurological health promotion, prevention, treatment, and support services available within the community, and allocate funds for the CBMH program;
2. Include the strategies, activities, and needed resources on mental and neurological health in the LIPH to ensure the involvement of all levels in the locality (province/city/municipal, barangay, NGOs/CSOs, private health stakeholders) in planning procedures;
3. Provide or facilitate mental and neurological health services directly within the community, such as schools, workplaces, and other facilities;
4. Ensure/coordinate with the Persons with Disability Affairs Office (PDAO) for data profiling, provision of Persons with Disability (PWD) ID to eligible service users, and link to membership of the city/municipal/barangay federation of PWDs;
5. Assess mental and neurological health needs in their area of responsibility. This includes collecting data on the frequency of mental and neurological health concerns, available services, and areas needing improvement in service provision;
6. Ensure/coordinate capacity building of health care workers and community health workers on mental and neurological health services;
7. In coordination with CHDs and MOH-BARMM, execute strategies to increase awareness of mental and neurological health and enhance mental wellness in the community; and,
8. Oversee the implementation and effectiveness of CBMH services and coordinate with CHDs and MOH-BARMM for data gathering and reporting.

D. Development partners are encouraged to:

1. Align their respective plans and activities with the CBMH Framework Policy;
2. Collaborate with the DOH, through the CHDs, MOH-BARMM, and NCMH, as to the implementation of community-based mental and neurological health initiatives; and,
3. Provide technical assistance and support to the DOH through the CHDs and MOH-BARMM in implementing the Policy Framework on CBMH.

E. Learning institutions, professional organizations, faith-based institutions, NGOs, CSOs, and other organizations with capacity and experience on CBMH shall:



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1. Cascade the Policy Framework on CBMH to their respective organizations and align their plans and activities to the CBMH Framework;
2. Establish mechanisms for data sharing with NCMH on mental and neurological health conditions and private crisis hotlines;
3. Assist in the implementation of community-level activities for mental and neurological health and well-being promotion, and suicide prevention and response, including but not limited to youth-led initiatives, peer support groups, self-help groups, interest groups, etc.; and,
4. Conduct and implement research on mental and neurological health and well-being and other related topics.

IX. TRANSITORY CLAUSE

During the period before the full integration of patient data into the Mental Health Information System (MHIS), all patient data shall be recorded in the following:

1. Existing Field Health Service Information System (FHSIS) of the provincial/city/municipal health facilities or barangay health centers: All relevant patient information shall be accurately and completely recorded in the existing information systems utilized by the respective health facilities or barangay health centers.
2. National Mental Health Program reporting mechanisms: Concurrent with the entries in the existing information systems, all required data shall be recorded and reported according to the reporting mechanisms prescribed by the National Mental Health Program.

X. SEPARABILITY CLAUSE

Should any provision of this Order or any part thereof be declared invalid, the other provisions shall remain in full force and effect insofar as they are separable from the invalid ones.

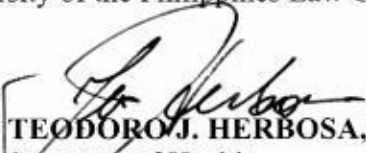
XI. FUNDING

All agencies shall allocate necessary funding for the implementation of this policy consistent with their mandate, subject to the usual accounting and auditing rules of the government.

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EFFECTIVITY

This Order shall take effect fifteen (15) days after publication in the Official Gazette or a newspaper of general circulation, with three (3) certified copies to be filed with the Office of the National Administrative Registrar of the University of the Philippines Law Center.


TEODORO J. HERBOSA, MD
Secretary of Health

Annex A. References (APA 7th Edition)

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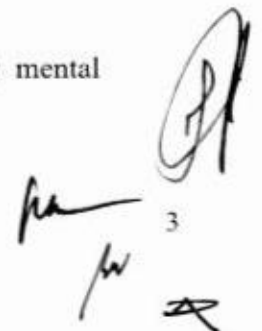
Annex B. Rights of Service Users and Other Stakeholders (RA 11036)

CHAPTER II

RIGHTS OF SERVICE USERS AND OTHER STAKEHOLDERS

Section 5. *Rights of Service Users.* - Service users shall enjoy, on an equal and nondiscriminatory basis, all rights guaranteed by the Constitution as well as those recognizes under the United Nations Universal Declaration of Human Rights and the Convention on the Rights of Persons with Disabilities and all other relevant international and regional human rights conventions and declarations, including the right to:

- (a) Freedom from social, economic, and political discrimination and stigmatization, whether committed by public or private actors;
- (b) Exercise all their inherent civil, political, economic, social, religious, educational, and cultural rights respecting individual qualities, abilities, and diversity of background, without discrimination on the basis of physical disability, age, gender, sexual orientation, race, color, language, religion or nationality, ethnic, or social origin;
- (c) Access to evidence-based treatment of the same standard and quality, regardless of age, sex, socioeconomic status, race, ethnicity, or sexual orientation;
- (d) Access to affordable essential health and social services for the purpose of achieving the highest attainable standard of mental health;
- (e) Access to mental health services at all levels of the national health care system;
- (f) Access to comprehensive and coordinated treatment integrating holistic prevention, promotion, rehabilitation, care and support, aimed at addressing mental health care needs through a multidisciplinary, user-driven treatment and recovery plan;
- (g) Access to psychosocial care and clinical treatment in the least restrictive environment and manner;
- (h) Humane treatment free from solitary confinement, torture, and other forms of cruel, inhumane, harmful, or degrading treatment and invasive procedures not backed by scientific evidence;
- (i) Access to aftercare and rehabilitation when possible in the community for the purpose of social reintegration and inclusion;
- (j) Access to adequate information regarding available multidisciplinary mental health services;



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(k) Participate in mental health advocacy, policy planning, legislation, service provision, monitoring, research, and evaluation;

(l) Confidentiality of all information, communications, and records, in whatever form or medium stored, regarding the service user, any aspect of the service user's mental health, or any treatment or care received by the service user, which information, communications, and records shall not be disclosed to third parties without the written consent of the service user concerned or the service user's legal representative, except in the following circumstances:

(1) Disclose is required by law or pursuant to an order issued by a court of competent jurisdiction;

(2) The service user has expressed consent to the disclosure;

(3) A life-threatening emergency exists and such disclosure is necessary to prevent harm or injury to the service user or other persons;

(4) The service user is a minor and the attending mental health professional reasonably believes that the service user is a victim of child abuse; or

(5) Disclosure is required in connection with an administrative, civil, or criminal case against a mental health professional, to the extent necessary to completely adjudicate, settle, or resolve any issue or controversy involved therein;

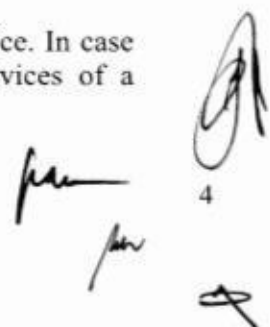
(m) Give informed consent before receiving treatment or care, including the right to withdraw such consent. Such consent shall be recorded in the service user's clinical record;

(n) Participate in the development and formulation of the psychosocial care or clinical treatment plan to be implemented;

(o) Designate or appoint a person of legal age to act as his or her legal representative in accordance with this Act, except in cases of impairment or temporary loss of decision-making capacity;

(p) Send or receive uncensored private communication which may include communication by letter, telephone, or electronic means, and receive visitors at reasonable times, including the service user's legal representative and representatives from the Commission on Human Rights (CHR);

(q) Legal services, through competent counsel of the service user's choice. In case the service user cannot afford the service user cannot afford the services of a

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counsel, the Public Attorney's Office, or a legal aid institution of the service user or representative's choice, shall assist the service user;

(r) Access to their clinical records unless, in the opinion of the attending mental health professional, revealing such information would cause harm to the service user's health or put the safety of others at risk. When any such clinical records are withheld, the service user or his or her legal representative may contest such decision with the internal review board created pursuant to this Act, authorized to investigate and resolve disputes, or with the CHR;

(s) Information, within the twenty-four (24) hours of admission to a mental health facility, of the rights enumerated in this section in a form and language understood by the service user; and

(t) By oneself or through a legal representative, to file with the appropriate agency, complaints of improprieties, abuses in mental health care, violations of rights of persons with mental health needs, and seek to initiate appropriate investigation and action against those who authorized illegal or unlawful involuntary treatment or confinement, and other violations.

Section 6. *Rights of Family Members, Carers and Legal Representatives.*- Family members, carers and duly designated or appointed legal representative of the service user shall have the right to:

(a) Receive appropriate psychosocial support from the relevant government agencies.;

(b) With the consent of the concerned service user, participate in the formulation, development and implementation of the service user's individual treatment plan;

(c) Apply for release and transfer of the service user to an appropriate mental health facility;

(d) Participate in mental health advocacy, policy planning, legislation, service provision, monitoring, research and evaluation.

Section 7. *Rights of Mental Health Professionals.* Mental health professional shall have the right to:

(a) A safe and supportive work environment;

(b) Participate in a continuous professional development program;

(c) Participate in the planning, development, and management of mental health services;

(d) Contribute to the development and regular review of standards for evaluating mental health services provided to service users;

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(e) Participate in the development of mental and health policy and service delivery guidelines;

(f) Except in emergency situations, manage and control all aspects of his or her practice, including whether or not to accept or decline a service user for treatment; and,

(g) Advocate for the rights of a service user, in cases where the service user's wishes are at odds with those of his or her family or legal representatives.


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Annex C. CBMH Framework

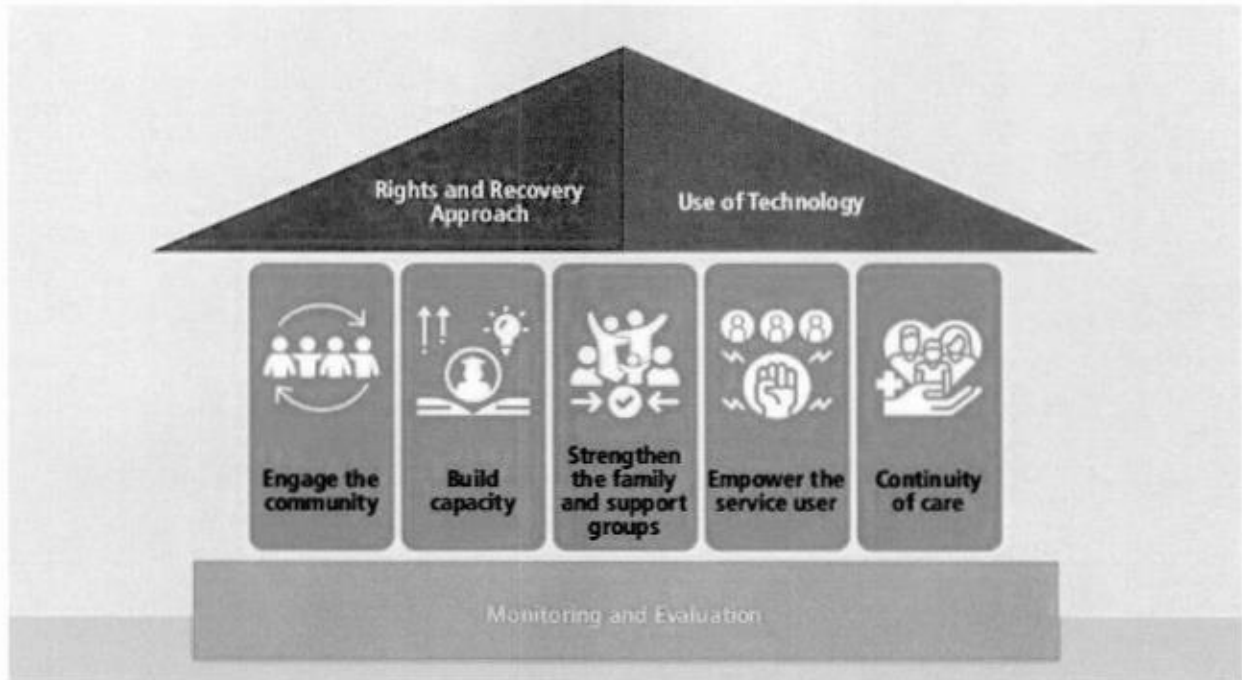


Figure 1. Components of the Community-Based Mental Health Framework (DOH & WHO, 2021b)

There are six key elements in the CBMH Program Framework (Figure 1):

1. Harnessing the community as a setting, a resource, a target and agent of change;
2. Building institutional and individual capacity among non-specialists in the community;
3. Empowering the service users;
4. Strengthening the family and support groups in the community;
5. Providing post recovery assistance and transition/reintegration to the community; and
6. Monitoring and evaluating the outcomes of CBMH.

Five complementary perspectives guide this Program Framework. Two of these are overarching viewpoints: 1) the rights and recovery approach; and 2) harnessing technology for the digitalization of mental health services. The rest are strong advocacies articulated in the literature, namely: 3) the integration of mental health care in the general health system, particularly in primary health care; 4) the consideration of social determinants of mental health as articulated in the social ecology approach; and 5) a balanced care approach to rehabilitation and recovery.

The Monitoring and Evaluation framework is meant to guide incremental long-term progress to ensure the scaling up of mental health services in Philippine communities. However, the journey towards having fully operational CBMH programs may take some time. It will vary from barangay to barangay and will depend on the “baseline health situation” upon the introduction of community mental health programs.

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Annex D. Action Plan Template

I. Situational Analysis

A. Executive Summary

1. Brief overview of the community and the current mental health program initiatives in the community
2. Key findings and recommendations

B. Introduction

1. Mandate and Purpose
2. Scope and methodology (e.g., data sources, tools used, stakeholder interviews)

C. Community Profile

1. Demographics (population size, age distribution, gender, ethnicity, socioeconomic status, etc.)
2. Geographic Information (location, urban/rural classification, infrastructure, etc.)
3. Cultural Context (language, tradition, beliefs, and norms related to mental health)
4. Economic overview (employment rates, income levels, major industries, and economic challenges)

D. Health and Mental Health Status

1. General Health (common physical health issues, healthcare access, and utilization, etc.)
2. Mental Health (prevalence of MH conditions, common conditions, specific community challenges, etc.)
3. Risk Factors (e.g., substance use, domestic violence, trauma, poverty, etc.)
4. Protective Factors (community strengths, social support networks, existing health programs)

E. Existing Mental Health Services and Resources

1. Healthcare Facilities (hospitals, clinics, MH centers, and other relevant institutions)
2. Mental Health Professionals (availability and distribution of MH service providers, e.g., psychologists, psychiatrists, counselors, social workers, etc.)
3. Community Resources (support groups, NGOs, community leaders, volunteers, CSOs, faith-based organizations, peer support groups, etc.)
4. Gaps and Barriers (accessibility issues, stigma, lack of funding, policy gaps, etc.)

F. Stakeholder Analysis

1. Key Stakeholders (e.g., local government, healthcare providers, community leaders, educational institutions, faith-based organizations, and other relevant organizations)
2. Stakeholder Roles and Interests (contributions, influence, and interest in the MH program)
3. Engagement Strategies (how to involve stakeholders in planning and implementation)



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G. Policy and Legal Environment

1. Relevant Policies (national and local MH policies, regulations, and programs)
2. Legal Framework (laws impacting MH services and patient rights)
3. Funding and Support (government funding opportunities, grants, partnerships)

H. SWOT Analysis (Strengths, Weaknesses, Opportunities, Threats)

1. Strengths (internal factors that will support the program)
2. Weaknesses (internal challenges or limitations)
3. Opportunities (external factors that can be leveraged for the program's success)
4. Threats (External challenges or risks to the program)

I. Needs Assessment

1. Community Needs (MH service needs, education, awareness, and intervention priorities)
2. Service Gaps (unmet needs and areas requiring immediate attention)
3. Priority Areas (key focus areas based on the community's specific context)

II. Program Plan

- A. Program Goals and Objects (specific, measurable, achievable, relevant, and time-bound (SMART) objectives)
- B. Project Scope (Description of what the project will include and exclude)
- C. Resources Required (Human, financial, and material resources needed)
- D. Timeline (Overview of the project duration and key milestones -Gantt Chart)

Key activities/milestones									
Key Activities	2024				2025	2026	2027	2028	
	Q1	Q2	Q3	Q4					

III. Implementation Plan

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- A. Detailed Activities (Specific activities and tasks to be completed)
- B. Responsibilities (assignment of roles and responsibilities)
- C. Budget (detailed budget plan, including costs for each activity, if any)
- D. Risk Management (identification of potential risks and mitigation strategies)

IV. Monitoring Plan

GOALS	ACTIVITIES	END-USER	INDICATORS FOR MONITORING	MEANS OF VERIFICATION	FREQUENCY OF MONITORING	ASSUMPTIONS	COMMENTS
ENGAGING THE COMMUNITY	<i>Example:</i> Recruitment of MH volunteers	LGU, Service users	No. of volunteers recruited	Census/logbook	Quarterly		
CAPACITY BUILDING OF COMMUNITY HEALTH WORKERS AND MEMBERS OF THE COMMUNITY							
SERVICE USER EMPOWERMENT							
STRENGTHENING SUPPORT GROUPS							
CONTINUITY OF CARE							

V. Evaluation Plan

PURPOSE OF EVALUATION	OBJECTIVES OF THE EVALUATION	PROGRAM COMPONENTS	INDICATORS	MOV	HOW DO YOU INTEND TO ANALYZE THE DATA

VI. Recommendation and Next Steps

- A. Strategic Actions (recommended strategies and actions to achieve program goals)
- B. Sustainability Plan (strategies for the long-term sustainability of the program)

VII. References

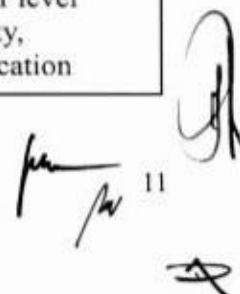


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Annex E. Proposed Minimum Service Requirements for CBMH

Competency	Description	HR	Service
Basic	Demonstrates foundational awareness of MNS conditions, engages in community-based advocacy, and upholds respect for client dignity and confidentiality.	Barangay Health Worker (BHW), Midwife, Nurse, Physician Other MNS stakeholders such as but not limited to: NGAs, CSOs, NGOs, professional organizations, learning institutions, social workers, allied health professionals, uniformed personnel, etc., mandated to provide and or support service delivery shall provide related services on MNS at the community based on mandates and capacities as mandated by the MH Act (RA 11036).	Health Education and Advocacy, Identification of red flags, screening, referral to primary care facility
Intermediate	Delivers entry-level support, performs structured assessment and basic care, and appropriate referrals with minimal supervision.	Nurse	Basic services PLUS Assessment, psychoeducation and information, Referral to higher level facility, Medication

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			provision
Advanced	Performs structured assessment and treatment planning, engages in community-based advocacy and interventions, and contributes to program implementation with minimal supervision.	Physician	Basic and intermediate level services PLUS Management, Treatment, Referral to higher level facility,




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Annex F. CBMH Indicators for Monitoring and Evaluation

INPUT INDICATOR/S	OUTPUT INDICATOR/S	OUTCOME INDICATOR/S	IMPACT INDICATORS
1. Leadership and Governance: a. Localization of Mental Health Act (Sec 38 of IRR MHA) - LGU Level and Presence of LGUs with localized MH Program - Provincial and Municipal Level b. A coordinating body (e.g., through Local Health Boards or the Regional Council for Mental Health or a Mental Health Working Group, as applicable) c. Promotion and awareness campaign plans 2. Health Financing: Budget allocation for the implementation of the MH Program (Mental Health Plan with budget allocation for MH) 3. Health Workforce: Complementary Personnel - at least (one) technical staff, coordinator, admin 4. Access to Essential Medicines: Mental, Neurologic, and Substance-Use related commodities	1. RHU Staff trained on contextualized mhGAP-IG 2. RHU staff trained in conducting SBIRT 3. Presence of LGUs (city and municipality level) with DOH-Accredited CBDRP 4. No. of RHUs providing MNS services, such as, but not limited to (at least 1): a. Assessment b. Psychosocial support services c. Medication (if applicable) d. Referral and reporting mechanism for MH	1. Proportion of individuals assessed using mhGAP-IG	1. Reduced the mortality of preventable deaths related to MNS Conditions 2. Improved Access to Mental, Neurological, and Substance Use (MNS) Services




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Annex G. Data Management Plan for the National Policy Framework on Community-Based Mental Health

This Data Management Plan (DMP) outlines the protocols for handling all personal and sensitive personal information collected under the National Policy Framework on Community-Based Mental Health. It ensures compliance with **Republic Act No. 11223 (The Universal Health Care Act)** and **Republic Act No. 10173 (The Data Privacy Act of 2012)** by establishing clear procedures for data collection, storage, security, sharing, and disposal.

I. Governance and Accountability

- A. The Data Protection Officer (DPO)** shall be responsible for overseeing the implementation and enforcement of this DMP. A **Data Privacy Committee** will be established to provide strategic guidance, review data-related policies, and address compliance issues.
- B. Roles & Responsibilities:**
 - 1. **DPO:** Manages compliance efforts, handles data subject requests, and serves as the primary point of contact with the National Privacy Commission (NPC).
 - 2. **Data Handlers:** All personnel involved in collecting, processing, and storing mental health data are required to undergo mandatory data privacy and security training.

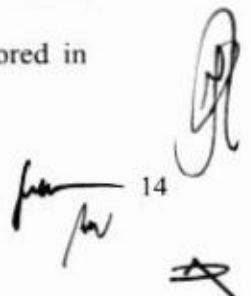
II. Data Collection and Usage

- A. Data Types:** The data to be collected includes, but is not limited to:
 - 1. **Demographic Information:** Age, gender, location, socioeconomic status.
 - 2. **Clinical Information:** Diagnosis, treatment plan, progress notes, and service utilization records.
 - 3. **Outcome Data:** Patient-reported outcomes, recovery metrics, and functional status.
- B. Purpose:** Data is collected for the legitimate purpose of monitoring and evaluating the effectiveness of community-based mental health programs, informing policy decisions, and conducting epidemiological research.
- C. Consent:** Informed consent will be obtained from all data subjects or their legal guardians before any personal or sensitive personal information is collected. The consent form will explicitly state the purpose of data collection, how the data will be used, and the data subject's rights.

III. Data Storage and Security

- A. The following measures will be implemented to protect the confidentiality, integrity, and availability of all data:**
 - 1. **Organizational Security:** A privacy manual will be distributed to all personnel. Access to personal data will be limited to authorized personnel with a legitimate need-to-know.
 - 2. **Physical Security:** All physical copies of data will be stored in locked cabinets within secure, access-controlled rooms.

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3. **Technical Security:** All electronic data will be stored on secure, password-protected systems. Data will be encrypted both at rest and in transit. A multi-factor authentication protocol will be required for access to databases.
4. **Access Control:** Access to electronic data will be governed by a **principle of least privilege**, with role-based access controls to prevent unauthorized viewing or modification.

IV. Data Retention and Disposal

- A. **Retention Period:** Personal and sensitive personal data will be retained for a period of **ten (10) years** from the last recorded service date to ensure continuity of care, legal compliance, and long-term program evaluation.
- B. **Secure Disposal:** After the retention period, all data will be securely disposed of.
 1. **Electronic Data:** Permanent deletion from all servers, backups, and storage devices.
 2. **Physical Data:** Shredding or incineration of all hard-copy documents.

V. Data Sharing and Disclosure

- A. Data sharing will be conducted in full compliance with the UHC Act and the Data Privacy Act.
 1. **Purpose:** Data will be submitted to the Department of Health (DOH) and the Philippine Health Insurance Corporation (PhilHealth) for monitoring, evaluation, and policy research purposes.
 2. **Data De-identification:** Before submission to the DOH or PhilHealth, all personally identifiable information (e.g., names, addresses) will be **de-identified** to protect patient privacy. The de-identified data will be used to generate aggregate statistics and policy reports.
 3. **Data Sharing Agreements (DSAs):** Formal agreements will be established with all third-party entities, including government agencies, to ensure they adhere to the same privacy and security standards outlined in this DMP.

VI. Data Subject Rights

- A. The following rights of data subjects will be protected:
 1. **Right to be Informed:** Data subjects have the right to be informed of the collection and processing of their data.
 2. **Right to Access:** Data subjects have the right to request and obtain a copy of their personal data.
 3. **Right to Correction:** Data subjects have the right to request the correction of any inaccurate or outdated information.
 4. **Right to Erasure or Blocking:** Data subjects have the right to request the removal or destruction of their personal data, subject to

legal and ethical limitations.

VII. Data Breach and Incident Response

- A. **Incident Detection:** All personnel are required to report any suspected or confirmed data security incidents immediately to the DPO.
- B. **Response Plan:** The DPO will initiate the Data Breach Response Plan to contain the breach, assess the impact, and mitigate further damage.
- C. **Notification:** In the event of a breach, the DPO will notify both the affected data subjects and the National Privacy Commission in accordance with the DPA's notification requirements.

VIII. Data Privacy Notice

Privacy Notice

The National Mental Health Program of the Disease Prevention and Control Bureau is committed to protecting your personal and sensitive personal information in accordance with the Republic Act No. 10173, also known as the Data Privacy Act of 2012 (DPA). This notice explains how we collect, use, and protect your data.

1. What Information We Collect

We collect and process personal and sensitive personal information that you provide to us, which is necessary for your participation in the program. This may include, but is not limited to:

- a. **Personal Details:** Your name, address, contact information, date of birth, and other demographic data.
- b. **Health Information:** Diagnoses, treatment records, test results, medication history, and other health-related data.
- c. **Psychosocial Information:** Data related to your mental health, social circumstances, or behavioral patterns relevant to the program.

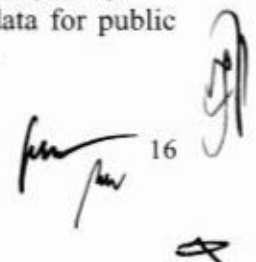
All health information collected is classified as "Sensitive Personal Information" under the DPA.

2. Why We Collect Your Information (Purpose and Legal Basis)

We collect your information for the following specific and legitimate purposes:

- a. **To provide care and services:** To effectively deliver the services and support outlined in the program, including treatment planning and coordination of care.
- b. **For monitoring and evaluation:** To assess the program's effectiveness, track participant progress, and ensure quality of care.
- c. **For compliance:** To meet the mandatory data submission requirements of the **Universal Health Care Act (Republic Act No. 11223)**, which mandates that we submit health-related data to PhilHealth and the Department of Health (DOH).
- d. **For policy and research:** To generate de-identified, aggregated data for public health research, policy development, and improving health services.

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Our legal basis for processing your sensitive personal information includes:

- a. Your **consent**, as freely given and informed.
- b. The necessity of processing your data to **protect your life and health** or the life and health of another person in an emergency, as permitted by the DPA.
- c. The necessity of processing your data to comply with our **legal obligations** under laws like the UHC Act.

3. How We Protect Your Information

We implement reasonable and appropriate physical, technical, and organizational measures to safeguard your data against accidental or unlawful destruction, alteration, and unauthorized access or disclosure. Only authorized personnel, who have signed confidentiality agreements, can access your information.

4. How We Share Your Information

Your sensitive personal information will not be shared with any third party without your consent, except in the following cases:

- a. **With regulatory bodies:** We are required to submit health and health-related data to PhilHealth and the DOH as mandated by the UHC Act. Before submission, we implement a strict protocol to **de-identify** your data, ensuring that your personal identity is protected.
- b. **With partner organizations:** If we need to share your data with a partner organization to facilitate your care, we will do so only after entering into a formal **Data Sharing Agreement (DSA)**. This agreement ensures that the recipient has comparable data protection measures in place.
- c. When required by law or a valid court order.

5. How Long We Keep Your Information

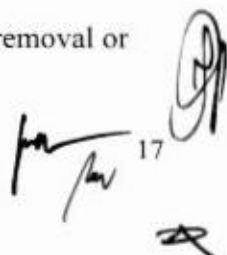
We will only retain your personal and sensitive personal information for as long as necessary to fulfill the purposes for which it was collected and to comply with legal requirements for data retention.

6. Your Data Privacy Rights

Under the DPA, you have the following rights as a data subject:

- a. **The right to be informed:** You have the right to be informed about how your data is being processed.
- b. **The right to access:** You have the right to access and obtain a copy of your personal data.
- c. **The right to object:** You have the right to object to the processing of your data.
- d. **The right to rectification:** You have the right to request the correction of any inaccurate or outdated data.
- e. **The right to erasure or blocking:** You have the right to request the removal or

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destruction of your personal data.

- f. **The right to data portability:** You have the right to obtain your data in an electronic or structured format.
- g. **The right to file a complaint:** If you feel your rights have been violated, you have the right to file a complaint with the National Privacy Commission (NPC).

7. Contact Us

If you have any questions, concerns, or requests regarding this Privacy Notice or the processing of your personal information, please contact us at: dpcbmhd@doh.gov.ph.



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Annex H. Data Sharing Agreement Template

This **Data Sharing Agreement** (the "Agreement") is made and entered into this **[Date]**, by and between:

[Name of Party A], a **[legal entity type, e.g., corporation, organization]**, with its principal place of business at **[Address of Party A]**, represented herein by its **[Title of Representative]**, **[Name of Representative A]** (hereinafter referred to as the "Disclosing Party");

-and-

[Name of Party B], a **[legal entity type, e.g., corporation, organization]**, with its principal place of business at **[Address of Party B]**, represented herein by its **[Title of Representative]**, **[Name of Representative B]** (hereinafter referred to as the "Receiving Party").

(Hereinafter, Party A and Party B shall be collectively referred to as the "Parties").

WHEREAS, the Parties wish to share certain data for a specific, legitimate purpose;

WHEREAS, the Parties are committed to ensuring the protection and security of any shared data in accordance with all applicable laws and regulations;

NOW, THEREFORE, in consideration of the mutual covenants contained herein, the Parties agree as follows:

Article I: Definitions

- **Personal Data:** Any information that relates to an identified or identifiable natural person.
- **Data Subject:** The individual to whom the Personal Data relates.
- **Purpose:** The specific, legitimate reason for which the data is being shared, as detailed in Article II.

Article II: Purpose of Data Sharing

The Parties agree that the data will be shared for the sole and exclusive purpose of **[State the legitimate purpose, e.g., research, service delivery, operational monitoring]**. The Receiving Party shall not process or use the data for any other purpose without the prior written consent of the Disclosing Party and the Data Subject.

Article III: Data Specification

The Parties agree to share the following types of data, which are limited to what is necessary for the stated Purpose:

- **[List specific data fields, e.g., Name, Email Address, Demographic Information]**
- **[List specific data fields, e.g., Service History, Usage Data, Financial Information]**

Article IV: Obligations of the Parties

4.1. Disclosing Party:

- Ensure a valid legal basis exists for sharing the data.
- Provide data that is accurate and up-to-date to the best of its knowledge.

4.2. Receiving Party:

- Process the shared data only for the Purpose specified in this Agreement.
- Ensure that all personnel with access to the data are aware of their confidentiality obligations.

- Not disclose, sell, or rent the shared data to any third party without the Disclosing Party's prior written consent.

Article V: Data Security and Confidentiality

Both Parties shall implement and maintain appropriate **technical, organizational, and physical security measures** to protect the shared data from unauthorized access, loss, destruction, alteration, or disclosure. These measures shall include, but are not limited to, data encryption, access controls, and secure data storage.

Article VI: Data Retention and Disposal

The Receiving Party shall retain the shared data only for the duration necessary to fulfill the Purpose, or as required by law. Upon the expiration of this period, the Receiving Party shall **securely dispose of all shared data**, including all copies and backups, using methods that prevent its recovery.

Article VII: Data Subject Rights

The Parties shall cooperate to facilitate the exercise of data subjects' rights, including the right to access, correct, or request the erasure of their personal data, in accordance with applicable laws.

Article VIII: Data Breach and Incident Response

In the event of a data breach, the Party that suffers the breach shall immediately notify the other Party. The breaching Party shall be responsible for its own containment, investigation, and mitigation, and shall provide timely notification to affected data subjects and relevant authorities as required by law.

Article IX: Term and Termination

This Agreement shall be effective upon the date first written above and shall remain in effect until the completion of the Purpose, or for a period of **[e.g., one year]**, unless terminated earlier by either Party upon a material breach of its provisions.

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the date first written above.

[Name of Party A] By: _____ [Name of Representative A] [Title of Representative A]

[Name of Party B] By: _____ [Name of Representative B] [Title of Representative B]


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