Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

JUN 27 2012

**ADMINISTRATIVE ORDER**
**No. 2012 - 0009**

**Subject: National Strategy Towards Reducing Unmet Need for Modern Family Planning as a means to Achieving MDGs on Maternal Health**

## I. BACKGROUND AND RATIONALE

Today, around six million Filipino women are estimated to have unmet need for modern Family Planning (FP), either for *limiting* (women who want no more children) or for *spacing* (women who want a child after three or more years). About half a million of these women have unplanned, unwanted, or mistimed pregnancies, that have 20 percent higher likelihood of complications during pregnancy and childbirth, including untimely deaths. This is because women with unplanned pregnancies are less likely to avail of adequate maternal care *(NDHS, 2008)*. Unplanned pregnancies also affect the health conditions of mothers, which can lead to poor maternal and fetal outcomes. Demand and supply side factors alter rates of unmet need.

Demand side factors that influence the level of unmet need for modern FP include: (1) lack of correct information on FP methods which result in fear of side effects, myths and misconceptions, and partner's refusal to any FP method or non-participation in decision-making process; (2) lack of information on what, how and where FP goods or services can be accessed; (3) lack of financial capacity to pay for FP goods and services; and (4) poor health-seeking behavior of clients. While the NDHS 2008 reported high level of awareness on FP (98 percent), this has not been translated into practice, in that only 34 percent reported use of any modern FP method.

On the other hand, supply side factors include: (1) inadequate availability of FP goods owing to irregular or maldistributed supply, poor logistics management; (2) inadequate number and capacity of both facilities/equipment and service providers (specially for long-acting and permanent methods or LAPM services); (3) missed opportunities during point of contact between client and information/service provider; (4) inadequate or nonsustainable budget allocation (i.e., financial and/or policy support) for FP at all levels; and (5) limited PhilHealth FP coverage and benefits.

Government-led intervention to address unmet need for modern FP is therefore necessary due to (1) inadequate and inappropriate information on FP and means to address unmet needs; (2) the serious and long-term health effects of having unplanned pregnancies; and (3) the need to minimize the costs of reducing unmet need.

In addition, the use of unmet need as the basis for developing programs and assessing progress in FP is consistent with the policy that focuses to meet needs rather than trying to change people's preferences on FP.

However, current efforts to address unmet need for FP remain inadequate and fall below desired targets. The 2008 NDHS reported that there were an estimated 900,000 new FP acceptors from 2003 to 2008, or an average of only about 180,000 new FP acceptors per year. At this rate, it would take the country 30 years to address the problem of unmet need in the country.

Reducing unmet need for modern FP is a critical element in attaining the MDG goal of reducing by two-thirds the maternal mortality. Attaining MDGs is part of the third strategic thrust of *Kalusugan Pangkalahatan* (KP), which is the administration's execution plan meant to achieve Universal Health Care. KP provides that public health effort and resources will be focused towards areas with high concentrations of poor families listed in the NHTS-PR, where access to health services remains low. *(AO No. 2010-0036 and DO No. 2011-0188).*

## II. OBJECTIVE

This Order provides for an updated and comprehensive approach to reduce unmet need for modern FP services in support of the strategic thrust to attain health-related MDGs by the year 2015, and is part and parcel of the implementation of the Aquino Health Agenda to achieve Universal Health Care as described in the *Kalusugan Pangkalahatan* Execution Plan.

## III. SCOPE AND COVERAGE

This Order shall apply to the health sector, from both the public and private sectors: DOH Central Office, Centers for Health Development (CHDs), and DOH-retained hospitals; Central offices and regional units of the Commission on Population (POPCOM), Philippine Health Insurance Corporation (PhilHealth), and other DOH attached agencies; LGUs as provided for in their agreements with the DOH that involve resource transfers, and DOH-ARMM as provided for in the Memorandum of Agreement between DOH and ARMM dated 23 April 2009; Development Partners, in the context of their strategic agreements for health with the Government of the Philippines; private health care providers; and all others concerned.

## IV. DEFINITION OF TERMS

1. **Community Health Team (CHT)** – a group of health volunteers having a critical role in increasing awareness on and recognition of health risks among families, promoting healthy behaviors, and prompting individuals to seek and utilize affordable and accessible health care services, particularly among poor families. DOH, DepEd, DSWD, and DILG JMC No. 2011-0073 provides for the creation of a TWG on CHTs, while DOH DM No. 2011-0286 provides for guidelines on the mobilization of CHTs.

2. **Cross-docking** – a practice in logistics management of unloading materials from the incoming bulk supplier and then loading these materials directly into outbound carriers/forwarders for direct delivery to the end distribution points, with little or no storage in between except for the time needed to obtain samples for quality control.

3. **Family Development Sessions (FDS)** – an integral activity of 4Ps that seeks to expand the knowledge and enhance the skills of beneficiary parents, in order to help them appreciate and comply with the health and education conditionalities of the program. *(DSWD Manual of Operations)*

4. **FP Competency-based Training (FP CBT)** – training for FP on infection prevention, client assessment, provision of certain FP methods (i.e., standard days method, hormonal contraceptives, and condoms), counseling, and FP clinic management that uses a laddered approach, exposing participants to levels of training based on developed knowledge, skills, and behavior. The modified training system, which is performance-based, develops the knowledge, attitudes, and skills of participants on the requirements of quality family planning (FP) service provision. FP CBT 1 covers knowledge on the different modern methods and skills on counseling, pills dispensing, injectable, condom insertion, and cycle beads FP methods, while CBT 2 covers IUD insertions. Specialized course on FP includes Natural Family Planning Methods, Minilaparotomy under local anesthesia (BTL), and No-scalpel vasectomy (NSV)

5. **Informed Choice and Voluntarism (ICV)** – a standard in the delivery of FP services, ensuring that clients freely make their own decision based on accurate and complete information on a broad range of available modern FP methods, and not by any special inducements or forms of coercion or misrepresentation. Guidelines on ensuring compliance to ICV in the delivery of FP services are contained in DOH AO No. 2011-0005.

6. **Interpersonal Communication and Counseling (IPCC)** – a face-to-face, verbal and non-verbal exchange of information. Effective IPCC between health care provider and client is one of the most important elements for improving client satisfaction, compliance and health outcomes.

7. ***Kalusugan Pangkalahatan* (KP)** – also known as the Aquino Health Agenda to achieve Universal Health Care (AHA-UHC), KP is a focused approach to health reform implementation, ensuring that all Filipinos especially the poor receive the benefits of health reform. KP's three strategic thrusts are i) rapid expansion in NHIP enrollment and benefit delivery using national subsidies for the poorest families; ii) improved access to quality hospitals and health care facilities through accelerated upgrading of public health facilities; and iii) attainment of the health-related MDGs by applying additional effort and resources in localities with high concentration of families who are unable to receive critical public health services. DOH AO No. 2010-0036 and DO No. 2011-0188 provide for the agenda and the execution plan to achieve UHC/KP, respectively.

8. **MDG 12 Areas** – these are sub-national areas of NHTS-PR poor households that have also been determined to have high concentrations of unmet need for public health services (including modern family planning), in accordance with DO No. 2011-0188 or the KP Execution Plan. These areas are: Metropolitan Manila, Negros Occidental, Quezon Province, Cebu Province, Pangasinan, Iloilo, Cavite, Maguindanao, Zamboanga del Sur, Leyte, Davao del Sur, and Pampanga.

9. **Municipal/City Links (MLs/CLs)** – serve as the link between the DSWD and LGUs in the over-all supervision of 4Ps implementation in municipalities/cities, in coordination with the Municipal Social Welfare and Development Office (MSWDO), and community facilities, like schools and health centers. They monitor compliance and grievances of all stakeholders in the program. Similarly, they provide training and capability building activities to beneficiaries.

10. **National Household Targeting System for Poverty Reduction (NHTS-PR)** – an information management system that identifies who and where the poor are, with its implementation being spearheaded by the DSWD. In compliance with EO No. 867, s. 2010, the DOH as a national government agency has adopted the NHTS-PR as a mechanism in prioritizing the beneficiaries of its programs and projects.

11. **National Online Stock Inventory Reporting System (NOSIRS)** – a logistics management initiative with standard and formal reporting systems that can generate logistics information at all levels of the health care system. NOSIRS utilizes Supply Management Recording (SMR) as the recording tool to efficiently track the status of commodities at health facilities and hospitals nationwide.

12. ***Pantawid Pamilyang Pilipino* Program (4Ps)** – a poverty reduction strategy that provides cash grants to extremely poor households to allow their family members to meet certain human development goals. The focus is on building human capital in the poorest families (through investments in their health/nutrition and education) because low schooling, ill health and high malnutrition are strongly associated with the poverty cycle in the Philippines. The 4Ps conditionalities for beneficiaries to remain in the program include the requirement for pregnant household members to attend at least one family planning counseling session prior to delivery, and another one within the first six weeks after childbirth. DSWD AO No. 16, s. 2008 provides for guidelines on the implementation of 4Ps.

13. **Parent Leaders (PLs)** – a beneficiary parent of 4Ps who has been determined by consensus of his/her peers to be the point person between the DSWD/4Ps, the LGU link, and the household grantees at the barangay level. The tasks of a PL include the follow-up and monitoring of attendance of household grantees in community assemblies and family development education sessions, as well as the conduct of home visits to household grantees who have not been attending the community assembly. *(DSWD 4Ps Manual of Operations)*

14. **Priority Municipalities for Poverty Reduction (Priority 609)** – these are municipalities tagged as the Aquino Government's priority areas for poverty reduction, pursuant to NAPC MC No. 2011-001.

15. **Private Sector Providers (PSPs)** – are health care providers (both for-profit and not-for-profit) that are not directly operated or controlled by the state or any of its instrumentalities. PSPs may be natural or juridical persons, and they may either provide health care services or goods.

16. **Service Delivery Network (SDN)** – refers to the network of facilities and providers within the province-wide or city-wide health system offering a core package of services (which includes modern family planning) in an integrated and coordinated

manner, pursuant to the MNCHN Strategy Manual of Operations (DOH DM No. 2011-0117).

17. **Social and Behavioral Change Communication (SBCC)** – an approach that looks at the role of communication in bringing about social change, including individual behaviors and social norms. SBCC utilizes a strategic mix of communication interventions using audience-appropriate interpersonal and mass media communication channels to engage individuals, families and communities to promote, stimulate and sustain behavior change.

18. **Unmet Need for Modern Family Planning (UMFP)** – the number of women who are fecund and sexually active but are not using any modern method of contraception, and report not wanting any more children (limiting) or wanting to delay the birth of their next child (spacing).

## V. STATEMENT OF POLICY

A. Filipino families have fundamental, constitutional human rights to determine the number of children they want to have. Given their preferences and understanding of the health risks involved in pregnancy and delivery, Filipino families shall have access to all modern FP methods in order to allow them to determine when to have children and meet their desired family size.

B. The reduction of unmet need for modern FP shall respect the personal preferences of individuals involved. It shall be contextualized as a human rights-based intervention guided and anchored on the following principles: respect for the sanctity of life, respect for human rights, informed choice and voluntarism *(AO No. 2011-0005)*, and respect for the rights of clients to determine their desired family size.

C. Modern FP shall include among its methods the following: pills; injectables/DMPA; condoms; IUDs; natural family planning/NFP *(AO No. 132 s. 2004)* including lactational amenorrhea method (LAM); bilateral tubal ligation (BTL); vasectomy *(AO No. 50-A s. 2001)*; and any other method deemed to be safe and effective by the DOH.

D. The demand for modern FP methods among the priority beneficiaries shall be accelerated alongside the enhanced and expanded equitable provision of FP goods and services at all levels of the health care system. A whole-of-society, client-centered and social determinants approach shall be adopted.

## VI. GENERAL GUIDELINES

A. FP as a program shall be implemented at the national and local levels with the active involvement of both public and private sectors. It shall have the following key elements *(RA No. 6365, Sec. 2 as amended by PD No. 79)*:
    1. Quantitative estimates centered on the elimination of unmet need for modern FP, used for determining logistics and budget requirements for planning purposes *(AO No. 2011-0005, provision VI.1.f)*;

2. Information and education campaigns targeted to priority beneficiaries and delivered mainly at the interpersonal level; and
3. Provision of affordable and accessible counseling, supplies, commodities, and services of all safe and effective methods to couples desiring to space or limit family size.

B. The implementation of the FP program shall be *integrated and synchronized* with other public health programs/campaigns (e.g., Maternal, Neonatal, and Child Health and Nutrition or MNCHN programs, *Garantisadong Pambata*, etc.) in the broader context of the KP Execution Plan. It is expected that resources shall be optimized for joint use where applicable with other health priorities. A client-centered, life cycle approach on delivering FP services at any point of contact shall be adopted.

In particular, the following shall be accomplished:

1. Expansion of the enrollment of poor families into the NHIP. This shall include information and guidance on use of PhilHealth benefits for FP through organized Community Health Teams or by some other means that is practicable and sustainable;
2. Enhancement of the service delivery network (SDN) capacity of providers for FP, especially for LAPM, by upgrading public facilities and to consider contracting private service providers where there are gaps for implementation; and
3. Fast tracking of procurement and streamlining of distribution and replenishment of goods such as pills, injectables, condoms and IUDs according to the estimates and preferences of beneficiaries in priority areas.

C. Informed choice and voluntarism (ICV) shall be promoted by all public or private health care providers rendering FP services. Clients shall not be denied any right or benefit including the right to avail of any program of general welfare or health care, as a consequence of any decision regarding FP services; neither shall they be coerced to use any particular FP method.

D. Priority shall be given to delivering additional/enhanced FP services in localities that have the highest estimated unmet need for modern FP methods. Nevertheless, the delivery of additional/enhanced FP services shall be carried out such that current levels of modern FP use in priority and other areas are equitably maintained.

E. Contraceptive self-reliance shall be encouraged. Resources such as grants, supplies and commodities, and training/capacity building may be provided to the priority LGUs as lead implementers, in order to leverage for good FP program performance. LGUs that receive such support or assistance are expected to provide complementary allocations to implement health programs.

F. Interventions to reduce unmet need for modern FP shall be tailor-fitted to prevailing local conditions and needs of province- or city-wide health systems, in close consultation with LGUs.

G. In highly populated or urbanized areas and where there are gaps in LGU services, private sector providers (e.g., private practice health professionals, lying-in clinics/birthing facilities, non-government organization clinics, etc.) of FP goods and/or services shall be engaged through the provision of grants, commodities, and technical assistance or any other acceptable mechanism.

H. Monitoring and evaluation of progress in reducing unmet need for modern FP shall focus on indicators based on factors that influence demand and supply, and the resulting outcomes from these interventions.

I. All Social and Behavioral Change Communication (SBCC) activities for FP shall be not be independent of the overall unifying communication strategy for *KP* that addresses individual knowledge and behavior, collective attitudes or norms, and societal level policies and regulations.

## VII. SPECIFIC GUIDELINES

A. The delivery of additional/enhanced FP services shall be executed according to the estimates of unmet need for FP in the following beneficiaries, in order of descending priority:
    1. NHTS-PR poor households living in MDG 12 areas;
    2. NHTS-PR poor households living in the Priority 609 municipalities;
    3. All other NHTS-PR poor households not included in items 1 and 2 above; and
    4. Other poor households that may be identified, as a result of need or availability of resources.

B. The procurement and distribution of commodities shall be streamlined according to the following:
    1. Commodities shall be procured according to the estimated needs of priority populations based on the preferred method mix per age group, as determined by data on observed health-seeking behaviors using the most recent demographic health survey or its equivalent, or by some other comparable scientific method as deemed appropriate by the DOH..
    2. Commodity grants to be provided to LGUs shall take into consideration the local availability of FP commodity stock supply, strength of the private sector market, LGU commodity self-reliance activities, and the commodity assistance of development partners.
    3. Supply chain management shall promote efficiency with the end goal of the expedited distribution of quality-checked commodities to beneficiary families. Towards this end, innovations such as but not limited to cross-docking of commodities shall be adopted.
    4. A unified information and communication technology (ICT) solution (e.g., NOSIRS/SMR) shall be used to track commodity flows in real time, from the point of initial procurement to the point of receipt by beneficiary families.
    5. Commodity assistance or donations for FP from Development Partners shall be coordinated with DOH, who will allocate the said commodities according to the prioritization of beneficiaries in this

Order. Donated commodities shall be reserved for distribution to LGUs with supply gaps.

C. LGUs shall take the lead in implementing FP programs and services. Consistent with applicable provisions of AO No. 2008-0020, DOH shall provide assistance through grants, commodities, facility enhancement, technical assistance, and/or training/capacity building in the context of other assistance packages under KP. Assistance shall be delivered through grant mechanisms that shall promote collaboration and innovation among local partners such as the private sector, labor associations, NGOs, or civil society.

D. The training/capacity building of FP providers shall proceed according to the following:
    1. Standardized training for the provision of all modern FP services shall be offered to all government/public and private sector providers at a reasonable cost (e.g., meals and accommodation, among others). Once trainees complete the prescribed courses/activities, they shall be included in the SDN of their respective areas;
    2. All DOH regional medical centers are hereby designated as training centers for permanent methods of FP, such as BTL via mini-laparotomy under local anesthesia (MLLA) and no scalpel vasectomy, provided that they shall also be training centers for IUD insertion in areas where there are no preceptor sites for FP CBT Level 2;
    3. CHDs and LGU health offices shall organize and conduct FP CBT Level 1 and natural FP training courses; and
    4. Where there are gaps in public sector trainers, private sector partner training institutions/training centers shall be contracted to provide capacity building.

E. FP services are to be provided to poor families with zero co-payment on their part, consistent with KP policy on No Balance Billing (NBB). PhilHealth shall be the main source of financing to pay for FP services, according to the terms and conditions of its benefit packages for FP.

F. The upgrading of public hospitals and other health facilities shall ensure the availability of appropriate FP services according to their respective service delivery mandates, and shall be part of the hospital development plan.

G. Social and behavioral change communication (SBCC) activities shall be customized and targeted for direct delivery to beneficiary families at the *interpersonal* level, according to the following, among others:
    1. Community health teams (CHTs) and other community based volunteers shall be mobilized to conduct household visits to inform families, assist in health use planning, as well as follow-up and refer couples to appropriate health facilities/providers;
    2. Parent Leaders (PL), in coordination with the DSWD and LGUs, shall be integrated into or shall work with CHTs for mobilization to 4Ps families, including the conduct of Family Development Sessions (FDS) on responsible parenthood and family planning. Municipal

Links (ML) shall be tapped to assist in organization of FDS centered on modern FP; and

3. The conduct of outreach activities to the poor shall generate supportive social norms for family planning, stimulate behavior change for the utilization of modern FP methods, and provide opportunities to serve clients (e.g., provision of mobile clinics)..

H. In areas where there is significant presence and activity of private sector providers and other stakeholders (e.g., urban areas), they may be contracted to provide and/or support FP services so that DOH, LGU, and other public sector effort and resources can be focused on isolated and hard-to reach areas (e.g., GIDAs).

I. Each province- or city-wide health system shall carry out measures to reduce unmet need for modern FP, which includes the following major steps:
    1. Using the latest data on the identities and locations of the priority beneficiary families (i.e., lists of 4Ps families and NHTS-PR families), estimate the magnitude of unmet need for modern FP as well as the magnitude of current modern FP use.
        a. The overall approach to reducing unmet need among the poor is conceptually illustrated in Annex A.
        b. Annex B provides the detailed estimates of unmet need for modern FP for CY 2012, subject to validation with actual households.
    2. Using the latest data on modern FP service and commodity preferences/method mix of the population, estimate the volume and cost of required commodities and services needed by the beneficiary families.
    3. Determine and document the inventory of available resources and capacities (budget, infrastructure, and trained personnel) for modern FP commodities and services from the central, regional, and local level, coming from the LGU, DOH, Development Partners, and private sector providers.
    4. Match/assign available resources and capacities for modern FP to the beneficiary families' requirements for commodities and services with the use of a geographic information system (GIS) such as Google Earth/Google Maps, or some other similar platform.
    5. Determine commodity and service gaps, if any, and propose solutions by which these gaps can be filled.
    6. Designate/contract at the level of municipalities/barangays public or private providers that can provide FP goods and services to the beneficiary families at no balance billing (NBB).
    7. Specify mechanisms for the delivery of FP services to families at the points of use, given local conditions and preferences, in consideration of both estimated unmet need and current use.
    8. Coordinate the timeline of activities to meet specific targets for reduction in unmet need and maintenance of current use with timelines at the regional and national levels.

J. The planned outcome of families using safe, affordable, and high quality FP commodities and services according to their preferences shall be achieved by ensuring that inputs (e.g., budgets, commodities, and other resources) shall lead to the necessary outputs (e.g., health use plans for FP) within a specific timeframe. An operational monitoring and evaluation system for FP services shall be integrated with its overall counterpart for KP, with data quality checking and adequate information systems management. In particular, CHTs shall validate the estimates of unmet need for modern FP with the expressed need of clients.

## VIII. ROLES AND RESPONSIBILITIES

A. A Technical Steering Committee (TSC) shall lead the implementation of this Order.
    1. The TSC shall be co-Chaired by the heads of the DOH CO Technical Clusters supervising POPCOM and NCDPC. The Executive Director of POPCOM shall be the Vice Chair of the TSC.
    2. TSC members shall include the Directors IV of NCDPC and NEC; a representative of PhilHealth; and one Regional Director for each Operations Cluster, to be designated by the respective Operations Cluster heads.
    3. The TSC shall take the lead in terms of policy development, standard setting, advocacy, resource mobilization, capacity building, networking and coordination, and monitoring and evaluation, according to the provisions of this Order.
    4. The TSC shall report directly to the Secretary of Health and the DOH Executive Committee on the organizational, programmatic, and communication arrangements to implement this Order.

B. The Department of Health (DOH) shall coordinate and work closely with their respective national and local counterparts of the DSWD, DILG, NAPC, other national government agencies including Civil Society Organizations (CSO), so that the national strategy for reducing unmet need for FP services is shared and implemented synchronously at all levels.
    1. The National Center for Disease Prevention and Control (NCDPC) through the Family Health Office shall assume technical leadership over the FP program while providing logistic supplies and arrangements, as well as developing policies and plans for establishing, developing, and sustaining FP services at all levels in high priority areas. Specifically, NCDPC shall:
        a. Identify the medium- and long-term quantifiable estimates to reduce unmet need for modern family planning;
        b. Prepare and oversee centralized procurement requests for FP commodities based on the forecast demand;
        c. Develop standards and protocols for the delivery of FP services (e.g., screening of women with unmet need for modern FP; participation of the private sector), for reference and use by LGUs in their service delivery activities and PhilHealth in their accreditation of FP providers;

d. Develop a monitoring and reporting mechanism to track progress in the implementation of this Order;
e. Coordinate with the following: the Health Policy Finance and Research Development Technical Cluster in developing principles of FP grants; the NCHFD for the upgrading of DOH and LGU hospitals and facilities; the NCHP for the development and implementation of an FP communication plan; and CHDs to provide technical support; and

2. Centers for Health Development (CHDs) of their respective Operations Clusters shall identify approaches and interventions that are most appropriate for the LGUs within their respective regions, and provide technical support to LGUs in the following areas:
   a. Development of the FP service delivery network and capacity building for FP CBT 1 and 2 and Natural Family Planning;
   b. Demand generation from women and couples with unmet need;
   c. Sustaining the current use rate for modern family planning;
   d. Design and implementation of FP grant mechanisms by consolidating available resources from the central office, regional funds, retained hospitals, and development assistance; and
   e. Monitoring and reporting of progress in reducing unmet need for modern FP.
3. DOH-retained hospitals, including among others the Fabella Memorial Hospital, shall influence local performance by:
   a. Creating FP itinerant teams and making them available for dispatch to respond to the needs for surgical methods especially in urban and rural poor communities *(AO No. 50-A, s. 2001)*;
   b. Being resource centers for technical assistance, training and research including logistics;
   c. Being local benchmarks for clinical practice and procedures, following the Philippine Clinical Standards Manual on Family Planning 2006;
   d. Being sources of competitive pressure so that local private and public facilities are influenced to deliver quality and affordable care; and
   e. Being end referral facilities that will complement services provided by LGU hospitals and facilities.
4. The Health Policy Finance and Research Development Technical Cluster, through the HPDPB and the BIHC, shall:
   a. Ensure that programs of units in the sector support the implementation of this Order by integrating programs, projects, and activities for FP into existing plans of KP;
   b. Integrate the monitoring and reporting mechanism to track progress in the implementation of this Order into the overall monitoring and evaluation frame for KP;
   c. Coordinate with Development Partners to ensure that their operations for FP are consistent with this Order.

5. The National Center for Health Facilities Development (NCHFD) shall:
    a. Provide standards for health facility enhancement related to FP services;
    b. Coordinate with Operations Clusters and CHDs so that the upgrading goals for DOH and LGU hospitals and facilities shall include the capability to provide FP services; and
    c. Work with NCDPC to coordinate, consolidate, and maximize interventions for FP services.
6. The Central Office Bids and Awards Committee (COBAC) shall, in coordination with the NCDPC, undertake necessary measures to facilitate timely and appropriate procurement of FP supplies and commodities, according to the provisions of this Order and in coordination with the TSC.
7. The Materials Management Division (MMD) shall, in coordination with the NCDPC, undertake necessary measures to strengthen logistics management to ensure, among others, the prompt delivery, tracking (e.g. use of NOSIRS) and distribution of FP supplies and commodities according to the provisions of this Order and in coordination with the TSC.
8. The Food and Drug Administration (FDA) shall facilitate the availability of safe, good quality, efficacious and cost-effective FP goods, including devices, by undertaking measures which include but are not limited to the release of necessary documents (e.g. CPR) for government procured or donated FP goods.
9. The National Center for Pharmaceutical Access and Management (NCPAM), in coordination with the FDA and NCDPC, shall ensure that FP goods are included in the Philippine National Drug Formulary, based on acceptable scientific standards, such as the WHO recommendations on Essential Medicines List.
10. The National Center for Health Promotion (NCHP) shall develop and implement an FP communication plan at the national, regional, and local levels, with focus on interpersonal communication and counseling (IPCC) to families through CHTs or any other mechanism, in tandem with the POPCOM, in order to generate increased demand for FP goods and services.
11. The National Epidemiology Center (NEC) shall provide technical assistance and operational support such as, among others, FP studies and surveys including the Field Health Surveillance and Information System (FHSIS), data quality assurance, and analysis of data related to FP indicators, in coordination with the TSC.
12. The Information Management Service (IMS) shall explore and implement options for developing and sustaining information systems for the FP program.

C. The Commission on Population (POPCOM) shall have a pivotal role of ensuring increased demand for FP goods and services, while assuming technical leadership over policies on human population and development, ensuring effective collaboration with major stakeholders, and lastly, providing an enabling environment for capacity building on advocacy.

Specifically, POPCOM shall:

1. Be the lead technical resource for FP advocacy particularly for LGU officials and in developing LGU capacity for demand generation;
2. Take the lead in assisting in the design and conduct of demand-generation activities based on the communication plan of LGUs and other stakeholders, such as private sector FP providers;
3. In coordination with the DOH-NCHP, launch advocacy/information and education campaigns on FP, with emphasis on interpersonal communication to families through mechanisms like the CHTs; and
4. In coordination with DOH-NCDPC, DOH-CHDs and DOH-ARMM, provide technical assistance and operations support in the monitoring and reporting of progress in reducing unmet need for modern FP.

D. PhilHealth shall exercise leadership in ensuring financial risk protection by providing options for optimal enrolment of recipients of FP services, and expanding benefits to its members to achieve goals of reducing unmet need for modern FP services.

Among others, it shall review its standards for accrediting and contracting health professionals (e.g., midwives, nurses, and physicians) and facilities (e.g., BHS, RHUs, private clinics, ambulatory surgical clinics, birthing centers, hospitals, etc.) alongside with the Bureau of Health Facilities and Services, in order to expand benefits and develop packages for FP services.

PhilHealth shall give due consideration to developing mechanisms to finance FP services delivered through alternative service delivery mechanisms such as outreach programs or by itinerant teams.

E. Local Government Units (LGUs) are encouraged and shall be assisted to:
   1. Execute and implement the major steps needed to reduce unmet need for modern FP, as enumerated in item VII. I. of this Order;
   2. Ensure that demand generation initiatives are implemented in the locality by providing local policy support, as well as budget allocation for all identified activities;
   3. Support the institutionalization of the participation of community-based volunteers in the locality for demand generation by providing incentives for their follow-ups/household visits;
   4. Participate in the SBCC campaigns by way of budget allocation for translation to local dialects and reproduction of SBCC materials;
   5. Mobilize and support local population officers/workers and barangay service point officers (BSPOs) or their designates to be the focal/resource persons in the conduct of the RP/FP module of the 4Ps FDS, as well as to be in-charge of overall reporting and monitoring of all RP/FP classes;
   6. Ensure that the FP service facilities are adequately accessible with trained service providers, appropriate equipment and commodities;

7. Ensure contraceptive self-reliance particularly to meet the FP unmet needs of their poor constituents;
8. Provide assistance in capacity building of MLs/PLs and community-based volunteers through the use of local facilities, equipment and vehicles and provision of budget for meals and snacks and materials for training; and
9. Monitor, submit and disseminate performance indicators on a regular basis through the CHDs, in coordination with the TSC.

F. Development Partners, within the context of the Sector-wide Development Approach for Health and subject to agreements with the DOH, shall ensure that their assistance to FP (commodities or otherwise) shall be consistent with the provisions of this Order. All FP-related projects shall be coordinated with the TSC, through the Bureau of International Health Cooperation (BIHC).

## IX. ANNEXES

The following Annexes are an integral part of this Order:

**Annex A** – Illustration of the overall approach to reducing unmet need among the poor, for planning and budgeting purposes
**Annex B** – Estimates of unmet need for modern FP for CY 2012, subject to validation with actual households

## X. REPEALING AND SEPARABILITY CLAUSE

All orders, rules, regulations, and other related issuances inconsistent with or contrary to this Order are hereby repealed, amended, or modified accordingly. All provisions of existing issuances which are not affected by this Order shall remain valid and in effect.

In the event that any provision or part of this Order is declared unauthorized or rendered invalid by any Court of law or competent authority, those provisions not affected by such declaration shall remain valid and effective.

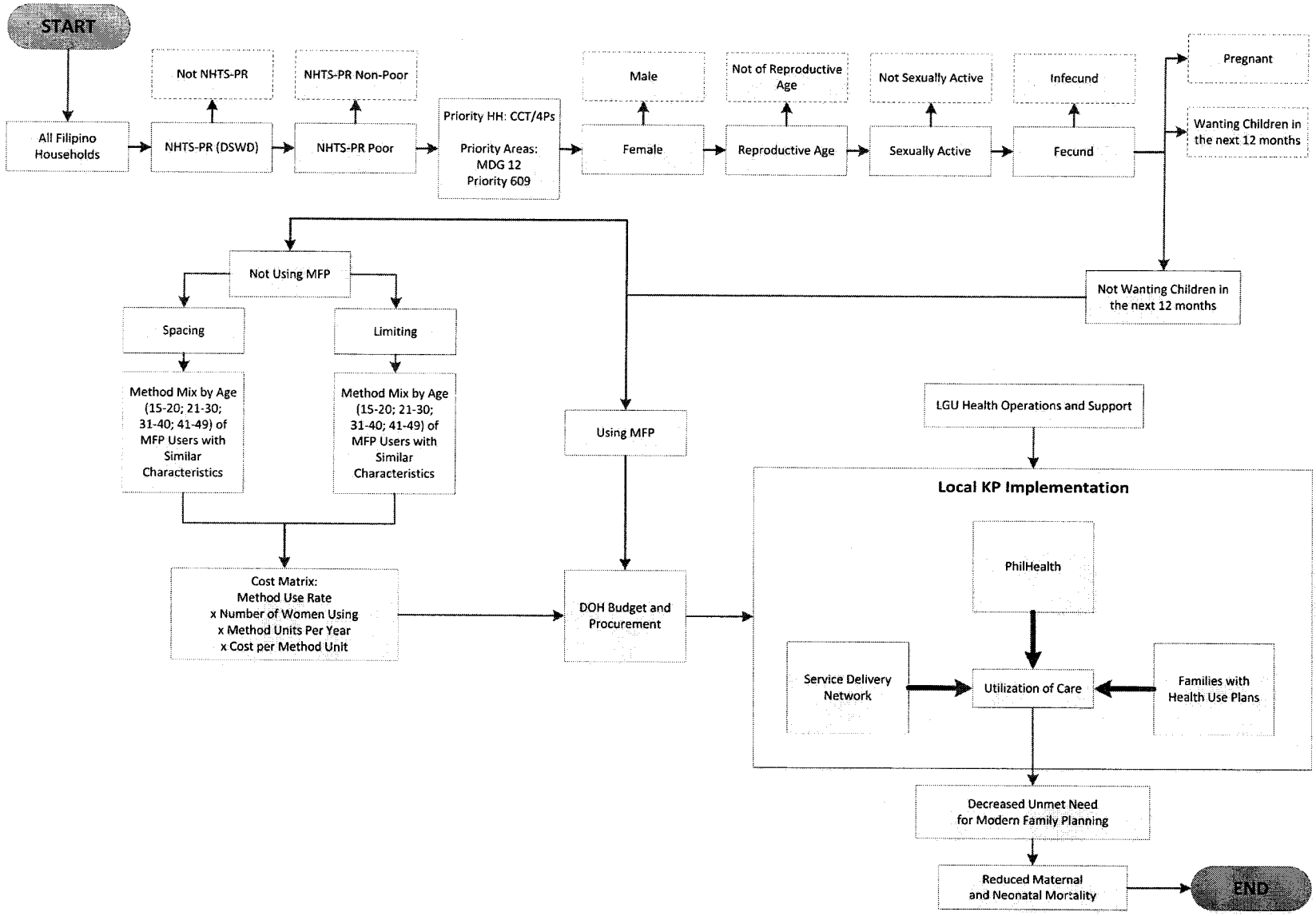
## XI. EFFECTIVITY

This Order shall take effect immediately.

**ENRIQUE T. ONA, MD**
**Secretary of Health**

Annex A – AO No. 2012-_____

Illustration of the overall approach to reducing unmet need among the poor, for planning and budgeting purposes



Annex B – AO No. 2012-0009
Estimates of unmet need for modern FP for CY 2012, subject to validation with actual households

**Estimates of Unmet Need for Modern FP for CY 2012**

| Area | Number of NHTS-PR poor households* | Number of CCT/4Ps households* | Estimated UMFP of NHTS-PR poor households | Estimated UMFP of CCT/4Ps households |
|---|---|---|---|---|
| **Philippines** | **5,255,094** | **2,991,466** | **2,232,963** | **1,316,838** |
| | | | | |
| **Northern and Central Luzon Operations Cluster** | **768,438** | **331,640** | **768,438** | **147,584** |
| **CAR** | **79,816** | **55,570** | **41,187** | **29,086** |
| ABRA | 17,544 | 12,422 | 8,966 | 6,586 |
| APAYAO | 10,838 | 7,413 | 4,473 | 3,160 |
| BENGUET | 17,947 | 11,195 | 11,685 | 7,340 |
| IFUGAO | 12,229 | 9,270 | 6,772 | 5,202 |
| KALINGA | 13,605 | 9,818 | 6,980 | 5,135 |
| MOUNTAIN PROVINCE | 7,653 | 5,452 | 2,310 | 1,662 |
| **CHD I** | **247,882** | **116,296** | **107,457** | **51,636** |
| ILOCOS NORTE | 24,890 | 14,785 | 8,240 | 5,816 |
| ILOCOS SUR | 34,213 | 13,219 | 3,517 | 6,605 |
| LA UNION | 40,178 | 16,114 | 17,255 | 6,959 |
| PANGASINAN | 148,601 | 72,178 | 41,135 | 32,255 |
| **CHD II** | **118,118** | **80,315** | **45,353** | **31,171** |
| BATANES | 178 | 0 | 66 | 0 |
| CAGAYAN | 38,270 | 28,413 | 15,536 | 10,039 |
| ISABELA | 54,678 | 35,330 | 25,566 | 12,867 |
| NUEVA VIZCAYA | 16,500 | 10,289 | 4,722 | 5,072 |
| QUIRINO | 8,492 | 6,283 | 1,416 | 3,193 |
| **CHD III** | **322,622** | **79,459** | **136,876** | **35,692** |
| AURORA | 9,333 | 6,516 | 3,864 | 5,788 |
| BATAAN | 16,655 | 3,049 | 5,475 | 1,468 |
| BULACAN | 73,683 | 10,141 | 19,504 | 5,336 |
| NUEVA ECIJA | 96,863 | 31,226 | 36,147 | 11,021 |
| PAMPANGA | 55,328 | 9,258 | 21,273 | 2,852 |
| TARLAC | 46,956 | 12,279 | 15,519 | 5,422 |
| ZAMBALES | 23,804 | 6,990 | 5,056 | 3,805 |
| | | | | |
| **Southern Luzon and NCR Operations Cluster** | **1,410,509** | **691,167** | **687,302** | **355,598** |
| **CHD IV-A** | **389,811** | **156,346** | **181,470** | **78,774** |
| BATANGAS | 105,359 | 49,597 | 36,189 | 17,637 |
| CAVITE | 58,536 | 11,019 | 25,612 | 4,986 |
| LAGUNA | 55,417 | 11,877 | 32,267 | 7,197 |
| QUEZON | 122,139 | 81,625 | 68,726 | 48,085 |
| RIZAL | 48,360 | 2,228 | 18,677 | 869 |

Annex B – AO No. 2012-_____
Estimates of unmet need for modern FP for CY 2012, subject to validation with actual households

| Area | Number of NHTS-PR poor households* | Number of CCT/4Ps households* | Estimated UMFP of NHTS-PR poor households | Estimated UMFP of CCT/4Ps households |
|---|---|---|---|---|
| **CHD IV-B** | **242,633** | **159,441** | **104,468** | **71,219** |
| MARINDUQUE | 14,152 | 7,315 | 6,512 | 3,411 |
| OCCIDENTAL MINDORO | 37,421 | 24,045 | 22,735 | 15,031 |
| ORIENTAL MINDORO | 73,878 | 52,272 | 30,731 | 22,491 |
| PALAWAN | 95,952 | 60,551 | 36,260 | 24,103 |
| ROMBLON | 21,230 | 15,258 | 8,230 | 6,183 |
| **CHD V** | **461,242** | **307,665** | **245,583** | **172,110** |
| ALBAY | 88,242 | 31,544 | 48,471 | 18,287 |
| CAMARINES NORTE | 40,802 | 28,546 | 25,517 | 18,872 |
| CAMARINES SUR | 136,208 | 98,721 | 70,763 | 53,198 |
| CATANDUANES | 16,743 | 13,724 | 9,372 | 7,939 |
| MASBATE | 103,478 | 77,645 | 56,843 | 45,797 |
| SORSOGON | 75,769 | 57,485 | 34,617 | 28,018 |
| **NCR** | **316,823** | **67,715** | **155,780** | **33,495** |
| Manila | 58,329 | 17,515 | 19,894 | 6,162 |
| Mandaluyong | 5,445 | 1,465 | 2,895 | 795 |
| Marikina | 11,997 | 1,750 | 6,164 | 903 |
| San Juan | 2,166 | 338 | 1,170 | 182 |
| Navotas | 20,633 | 4,639 | 12,714 | 3,018 |
| Las Pinas | 11,185 | 2,206 | 4,763 | 1,017 |
| Makati | 7,552 | 909 | 3,145 | 386 |
| Paranaque | 12,705 | 1,280 | 5,076 | 541 |
| Muntinlupa | 10,213 | 2,307 | 4,147 | 947 |
| Pateros | 2,436 | 317 | 1,015 | 131 |
| Quezon City | 51,445 | 9,416 | 25,739 | 4,784 |
| Pasay | 9,430 | 2,727 | 3,904 | 1,539 |
| Valenzuela | 18,615 | 3,051 | 11,339 | 1,941 |
| Malabon | 21,563 | 4,256 | 13,291 | 2,726 |
| Caloocan | 40,160 | 8,418 | 24,705 | 5,499 |
| Pasig | 19,131 | 3,781 | 10,373 | 1,596 |
| Taguig | 13,818 | 3,340 | 5,447 | 1,327 |
| | | | | |
| **Visayas Operations Cluster** | **1,035,376** | **683,684** | **464,239** | **318,921** |
| **CHD VI** | **385,516** | **253,171** | **173,669** | **116,298** |
| AKLAN | 34,924 | 23,207 | 14,425 | 9,858 |
| ANTIQUE | 38,155 | 27,103 | 18,217 | 13,409 |
| CAPIZ | 39,855 | 33,446 | 12,947 | 11,058 |
| GUIMARAS | 11,148 | 6,574 | 10,079 | 6,166 |
| ILOILO | 122,770 | 76,187 | 61,745 | 39,434 |
| NEGROS OCCIDENTAL | 138,664 | 86,654 | 56,256 | 36,374 |
| **CHD VII** | **314,652** | **205,925** | **126,512** | **86,183** |

Annex B – AO No. 2012-_____
Estimates of unmet need for modern FP for CY 2012, subject to validation with actual households

| Area | Number of NHTS-PR poor households* | Number of CCT/4Ps households* | Estimated UMFP of NHTS-PR poor households | Estimated UMFP of CCT/4Ps households |
|---|---|---|---|---|
| BOHOL | 70,028 | 45,996 | 37,939 | 25,681 |
| CEBU | 151,425 | 94,498 | 50,872 | 33,181 |
| NEGROS ORIENTAL | 88,548 | 62,937 | 34,769 | 25,663 |
| SIQUIJOR | 4,651 | 2,494 | 2,932 | 1,657 |
| **CHD VIII** | **335,208** | **224,588** | **164,058** | **116,440** |
| BILIRAN | 8,070 | 6,386 | 5,574 | 4,539 |
| EASTERN SAMAR | 38,487 | 22,118 | 16,723 | 10,106 |
| LEYTE | 132,377 | 88,549 | 52,422 | 37,162 |
| NORTHERN SAMAR | 59,262 | 44,255 | 24,975 | 19,758 |
| SAMAR (WESTERN SAMAR) | 73,827 | 46,437 | 44,759 | 30,527 |
| SOUTHERN LEYTE | 23,185 | 16,843 | 19,605 | 14,349 |
| | | | | |
| **Mindanao Operations Cluster** | **1,509,245** | **971,194** | **379,451** | **380,620** |
| **CHD IX** | **369,236** | **227,352** | **144,689** | **95,304** |
| CITY OF ISABELA | 10,596 | 5,029 | 6,039 | 3,168 |
| ZAMBOANGA DEL NORTE | 113,816 | 73,749 | 40,221 | 28,264 |
| ZAMBOANGA DEL SUR | 170,181 | 98,555 | 69,172 | 42,884 |
| ZAMBOANGA SIBUGAY | 74,643 | 50,019 | 29,257 | 20,988 |
| **CHD X** | **338,749** | **233,083** | **122,277** | **88,493** |
| BUKIDNON | 98,107 | 71,037 | 25,435 | 19,282 |
| CAMIGUIN | 7,470 | 4,889 | 3,869 | 2,752 |
| LANAO DEL NORTE | 94,007 | 63,471 | 37,825 | 26,868 |
| MISAMIS OCCIDENTAL | 46,061 | 34,191 | 17,364 | 13,818 |
| MISAMIS ORIENTAL | 93,104 | 59,495 | 37,784 | 25,773 |
| **CHD XI** | **272,932** | **172,182** | **83,949** | **56,061** |
| COMPOSTELA VALLEY | 58,148 | 38,283 | 16,795 | 11,946 |
| DAVAO DEL NORTE | 58,934 | 33,261 | 18,738 | 11,304 |
| DAVAO DEL SUR | 111,655 | 67,558 | 36,126 | 23,214 |
| DAVAO ORIENTAL | 44,195 | 33,080 | 12,290 | 9,598 |
| **CHD XII** | **296,043** | **185,645** | **112,486** | **72,090** |
| COTABATO (NORTH COTABATO) | 99,021 | 65,779 | 38,259 | 26,081 |
| COTABATO CITY | 19,434 | 10,992 | 12,184 | 6,975 |
| SARANGANI | 44,469 | 28,844 | 16,258 | 11,017 |
| SOUTH COTABATO | 70,771 | 40,552 | 26,849 | 16,047 |
| SULTAN KUDARAT | 62,348 | 39,478 | 18,936 | 11,971 |
| **CARAGA** | **232,285** | **152,932** | **96,738** | **68,671** |
| AGUSAN DEL NORTE | 49,437 | 28,412 | 22,896 | 13,989 |
| AGUSAN DEL SUR | 65,473 | 45,441 | 33,650 | 25,347 |

Annex B -- AO No. 2012-_____
Estimates of unmet need for modern FP for CY 2012, subject to validation with actual households

| Area | Number of NHTS-PR poor households* | Number of CCT/4Ps households* | Estimated UMFP of NHTS-PR poor households | Estimated UMFP of CCT/4Ps households |
|---|---|---|---|---|
| SURIGAO DEL NORTE | 58,209 | 39,635 | 26,260 | 19,257 |
| SURIGAO DEL SUR | 59,166 | 39,444 | 13,932 | 10,079 |
| | | | | |
| **ARMM** | **531,526** | **313,781** | **190,410** | **114,115** |
| BASILAN | 41,142 | 26,514 | 16,482 | 10,595 |
| LANAO DEL SUR | 109,725 | 82,024 | 52,578 | 38,760 |
| MAGUINDANAO | 227,599 | 111,343 | 69,991 | 34,219 |
| SULU | 122,218 | 77,663 | 39,521 | 24,235 |
| TAWI-TAWI | 30,842 | 16,237 | 11,838 | 6,306 |

*Data as of April 2012 update from DSWD CO NHTS-PR and 4Ps Offices