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# PHILIPPINES: FINAL COUNTRY REPORT

**MARCH 2007**

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DELIVER
No Product? No Program. Logistics for Health

# PHILIPPINES: FINAL COUNTRY REPORT

The authors' views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

## DELIVER

DELIVER, a six-year worldwide technical assistance support contract, is funded by the U.S. Agency for International Development (USAID).

Implemented by John Snow, Inc. (JSI) (contract no. HRN-C-00-00-00010-00) and subcontractors (Manoff Group, Program for Appropriate Technology in Health [PATH], and Crown Agents Consultancy, Inc.), DELIVER strengthens the supply chains of health and family planning programs in developing countries to ensure the availability of critical health products for customers. DELIVER also provides technical management of USAID's central contraceptive management information system.

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## Abstract

The Philippines is working to sustain recent gains in access to and use of family planning services through a Contraceptive Self-Reliance (CSR) strategy that must adjust for the impending phaseout of USAID's contraceptive donations. DELIVER, working through the Local Enhancement and Development (LEAD) for Health project, has helped local government units (LGUs) at the provincial and city levels—where responsibility rests for providing health services—to prepare CSR plans that consider the growth in demand for contraceptives, the impact of donor phaseout, and the resources needed to meet demand. In addition, DELIVER has adapted the national Contraceptive Distribution and Logistics Management Information System (CDLMIS) to allow the Department of Health to allocate the remaining donated supplies based on new poverty criteria, and to monitor new LGU contraceptive procurements. DELIVER has also provided training to national and LGU staff in how to use the CDLMIS to manage, monitor, and procure contraceptive supplies.

Because the public sector provides more than two-thirds of the contraceptives used in the county, the sustainability of the family planning program in the Philippines will be heavily dependent on the success of the CSR strategy at the local level. The national government has decided not to procure contraceptives, so all financing and procurement decisions will be made by provincial, city, and municipal authorities, whose commitment to family planning services varies widely.

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# CONTENTS

## Figures



## Tables

# ACRONYMS

| | |
|---|---|
| AO | Administrative Order |
| ARMM | Autonomous Region in Muslim Mindanao |
| BHS | Barangay health station |
| CDLMIS | contraceptive distribution and logistics management information system |
| CHD | Centers for Health Development |
| CII | Contraceptive Independence Initiative |
| CO | Central Office |
| CPR | contraceptive prevalence rate |
| CSR | contraceptive self-reliance |
| CPTs | contraceptive procurement tables |
| DOH | Department of Health |
| FP | family planning |
| FPLM | Family Planning Logistics Management project |
| IUD | intrauterine device |
| LEAD | Local Enhancement and Development for Health project |
| LGU | local government unit |
| LMS | logistics management information system |
| GRP | Government of the Republic of the Philippines |
| MSH | Management Sciences for Health |
| PA | partner agency |
| PLS | Procurement Logistic Service |
| POPCOM | Population Commission |
| RHU | rural health unit |
| SDP | service delivery point |
| TFR | total fertility rate |
| TOT | training of trainers |
| TWG | Technical Working Group |
| UNFPA | United Nations Population Fund |
| USAID | U.S. Agency for International Development |
| WRA | women of reproductive age |

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Our special thanks go to the short-term consultants, Bernardo Bersola, Miriam Balahadia, and Mariano Padilla, for assisting DELIVER in providing training for the implementation of the contraceptive self-reliance (CSR) strategy in 51 local government units (LGUs), and to Don Bulaong and Oliver Margarejo, for ensuring the proper modifications of the contraceptive distribution and logistics management information system (CDLMIS) system at the central level.

Also, we would like to thank Mr. Ferdinand de la Cruz from the Department of Health/Procurement Logistic Service (DOH/PLS), for his support and involvement in managing the CDLMIS.

# EXECUTIVE SUMMARY

The Philippines has a population of 86 million people; and a total fertility rate (TFR) of 3.4 births per woman of reproductive age in 2006, down from 5.8 in 1970. TFR continues to be high among the poorest fifth of women (6.5), in contrast to the richest fifth (2.1). Contraceptive prevalence rates (CPR) for all methods have increased steadily since 1968, from 15 percent to 49 percent in 2003. Although CPR for all methods increased by only two percentage points between 1998 and 2003, use of modern methods increased from 28 percent to 33 percent during the same period, showing a significant improvement in contraceptive use, probably due to the availability of these supplies throughout the government facilities.

The public sector health system continues to be the major provider of family planning methods, with 67.2 percent of the share of CPR, compared to 29.3 percent from the private sector, including 17.2 percent covered by pharmacies. Since 1970, the U.S. Government has been a major donor by providing assistance to the family planning program of the Philippines, and for the last 12 years, USAID contraceptive donations (pills, injectables, intrauterine devices [IUDs], and condoms) accounted for 80 percent of the country's total requirements. However, in 2003 USAID began phasing out its donations as part of a broader effort to encourage local ownership of the family planning program.

In addition, since 1991, responsibility for providing health services has been devolved to local government units—provinces and cities—and in 1998, the family planning program was also devolved to LGUs. In 2003, the national Department of Health, with USAID and other donors, developed a contraceptive self-reliance (CSR) strategy that works to ensure that the gains in CPR over the last 40 years are sustained even as donor support to the family planning program decreases. The greatest challenge to this is mobilizing the commitment and resources of local government units (LGUs) to finance and procure contraceptive supplies for the population segments that depend on the public sector. The national government decided not to directly finance and procure contraceptives, leaving the decision to the LGUs about whether to do so and what resources to use. However, the LGUs were ill-prepared to take on the complex task of implementing the CSR strategy.

In response to USAID's support for the CSR strategy, the DELIVER project has assisted the government of the Philippines in strengthening the capacity of LGUs and LGU staff to manage the CSR strategy and to begin to assume greater responsibility for the procurement and distribution of contraceptive supplies. DELIVER worked closely with the USAID-funded Local Enhancement and Development (LEAD) for Health project to achieve the following three objectives:

- Develop a phase-down allocation schedule for each province based on poverty incidence, LGU capacity/readiness to adopt a reduction in contraceptive donations, CPR, and unmet need.
- Modify the CDLMIS software at the Department of Health/Central Office (DOH CO), to help DOH manage the reduced allocations of donated contraceptives to provinces based on LGU classification (by wealth), and to allow LGUs to monitor locally procured supplies.
- Train LGU, DOH/Centers for Health Development, and Population Commission (POPCOM) staff to address the contraceptive phaseout issues described under the CSR strategy, and the development and implementation of Policy Guidelines Formulation workshops for DOH, provincial, and LGU staff.

DELIVER achieved each objective, helping to allocate the remaining USAID donations based on poverty criteria as well as demand, adapting the contraceptive distribution and CDLMIS to manage and monitor LGU procurements, and building capacity in the DOH and in 51 LGUs to develop and implement CSR plans.

# PROGRAM BACKGROUND

In response to USAID's contraceptive self-reliance (CSR) strategy approved in 2003, the DELIVER project has assisted the government of the Philippines in strengthening the capacity of local government units (LGUs)—provincial and city governments—and LGU staff to manage the CSR strategy and begin to assume greater responsibility for the procurement and distribution of contraceptive supplies.

The U.S. Government has been a major donor, providing assistance to the family planning program of the Philippines since 1970. For the last 12 years, USAID contraceptive donations (pills, injectables, intrauterine devices [IUDs], and condoms) have accounted for 80 percent of the country's total requirements. According to USAID, the continued supply of free contraceptives to the Philippines was slowing down the country's ability to become self-reliant in providing much–needed, good-quality family planning services in the country. In 1999, the Government of the Republic of the Philippines (GRP) promulgated a Contraceptive Independence Initiative (CII) policy to move the country to more self-reliant provision of these commodities. The USAID commodity phaseout plan supports this initiative.

Along this line, USAID's overarching goal was to help create the conditions that will foster the country's ability to sustain good-quality and affordable family planning services and commodities within the context of an expanding population and continued efforts to increase the country's contraceptive prevalence rate (CPR).

The CSR strategy articulates the principles of the phaseout of the contraceptive commodity donations; describes the transition plan showing timeline and method mix; and outlines the implications of USAID's reduction in contraceptive procurement. It also discusses options for how the country could respond, including a mix of public and private partnership efforts, and clarifies USAID's concurrent support and shifting emphasis of assistance to the Philippines Family Planning Program.

## COUNTRY CONTEXT

The Philippines has a population of 86.3 million people, with a population density of 745 inhabitants per square mile. The rural population remains larger (52 percent) than the urban population (48 percent), and the total fertility rate (TFR) continues to be high among women in poorest fifth quintile (6.5), in contrast to the richest fifth quintile (2.1). See table 1.

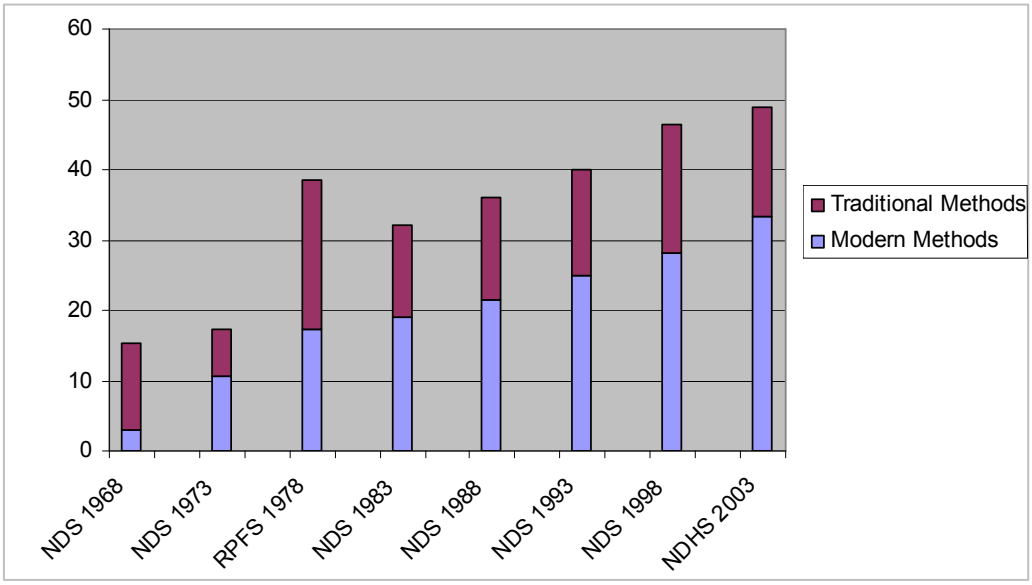
The public sector health system continues to be the major provider of family planning methods, with 67.2 percent of the share of CPR, in contrast with 29.3 percent from the private medical sector, including 17.2 percent covered by pharmacies. These proportions place a large burden on public health facilities to provide family planning services and bring into question whether the GRP will be able to continue providing the same level of family planning services in the future.

**Table 1. Country Population Data, Philippines**

| Demographic Variable | Data | Source/Notes |
|---|---|---|
| Population Mid-2006 | 86,300,000 | *PRB 2006 World Population Data Sheet* |
| Population 2025 (projected) | 115,700,000 | *PRB 2006 World Population Data Sheet* |
| Density (population/sq. mile) | 745 | *PRB 2006 World Population Data Sheet* |
| Lifetime Births per Woman (TFR) | 3.4 | *PRB 2006 World Population Data Sheet* |
| Rate of Natural Incr. (birth rate minus death rate, expressed as a %) | 2.1 | *PRB 2006 World Population Data Sheet* |
| Total Fertility Rate, Poorest Fifth (lifetime births per woman) | 6.5 | PRB *The Wealth Gap in Health Datasheet*<br>Notes: *DHS Survey Year 1998* |
| Total Fertility Rate, Middle Fifth (lifetime births per woman) | 3.6 | PRB *The Wealth Gap in Health Datasheet*<br>Notes: *DHS Survey Year 1998* |
| Total Fertility Rate, Richest Fifth (lifetime births per woman) | 2.1 | *PRB The Wealth Gap in Health Datasheet*<br>Notes: *DHS Survey Year 1998* |
| Urban Population (%) | 48 | *PRB 2006 World Population Data Sheet* |
| Women Ages 15–49, 2005 (%) | 52 | *PRB 2005 Women of Our World* |
| Contraceptive Use Among Married Women, All Methods, Ages 15–49 (%) | 49 | *PRB 2006 World Population Data Sheet* |
| Contraceptive Use Among Married Women, Modern Methods, Ages 15–49 (%) | 33 | *PRB 2006 World Population Data Sheet* |
| Source of Supply of Modern Contraceptive Methods, Public (%) | 67.2 | *DHS Philippines 2003* |
| Unmet Need for Family Planning (%) | 18.8 | *UNFPA Population and Reproductive Health Country Profiles, 2003*<br>Notes: Data for year 1998 |
| GNI PPP Per Capita, 2005 (U.S.$) | $5,300 | *PRB 2006 World Population Data Sheet* |

Prevalence rates for all methods increased from 47 percent to 49 percent between 1998 and 2003, barely two percentage points in five years. However, the use of modern methods increased from 28 percent to 33 percent in the same period, showing a significant improvement in the use of contraceptives, probably due to the availability of these supplies throughout government facilities (see figure 1).

**Figure 1. Trends in Contraceptive Use (Married Women 15–49), Philippines (1968–2003)**




## KEY PLAYERS AND ROLES

The Department of Health (DOH) has the mandate to implement the CSR strategy at the national level and ensure that there is a smooth transition between donated and locally procured contraceptives. Since the passage of the Local Government Code in 1991, the responsibility for providing basic services, including family planning, was devolved to local government units (LGUs). To manage donated products, the DOH played an important role in ensuring the availability of contraceptives through the LGUs and implemented the centralized Contraceptive Distribution and Logistics Management Information System (CDLMIS), which was designed to give primary responsibility for internal distribution of contraceptives to the provincial and city governments. In early 1999, the DOH made a decision to reengineer the DOH Central Office (CO), and reassigned the majority of the CO staff responsible for making the CDLMIS work at the central level to regional offices and hospitals. This put a lot of strain on the system and on the centralized management of the CDLMIS. This system worked smoothly for a whole decade (1991–2001), until full responsibility for its management was transferred to the DOH.

USAID has been the major provider of technical assistance and contraceptive donations over the past 30 years. To a lesser degree, The United National Population Fund (UNFPA) has also provided some assistance with contraceptive donations.

The Centers for Health Development (CHD)—the 17 regional offices of the DOH—have actively participated in the development of policies, plans, and guidelines for partner agencies (PAs) and LGUs in implementing the CSR strategy and in monitoring the progress of these activities.

The Management Sciences for Health/Local Enhancement and Development for Health (MSH/LEAD) project, in close collaboration with the DELIVER project, played an important role in providing technical assistance to LGUs (in LEAD project areas) and in developing CSR policy guidelines for implementing CSR. These activities included the design of planning tools and training curricula and conducting the trainings/workshops for trainers and LGU health personnel on the revised CDLMIS, specifically for the Family Planning and Health Systems and the Autonomous Region in Muslim Mindanao (ARMM) units.

Local government units are the main players in the CSR strategy and the main focus of technical assistance provided by DELIVER. LGUs were responsible for formulating provincial/city CSR Logistics

Policy Guidelines for their respective areas, allocating the needed funds and other resources required for the procurement of contraceptives, and undertaking specific activities to implement the CSR strategy.

## KEY CHALLENGES

As DELIVER worked closely with LGUs by providing training and technical support in the implementation of the CSR strategy, the project identified the following challenges, which may hinder the LGUs' ability to become fully self-sustainable:

### IMPROVE LGUs' ABILITY TO MANAGE AND IMPLEMENT THE CSR STRATEGY

One of the main limitations of LGUs in implementing the CSR strategy is their ability to allocate enough resources to procure contraceptives and to continue managing the system. In several LGUs, family planning has a low priority and is considered a controversial program. This has a direct impact on the LGUs' ability to advocate for resources and continue with services.

### CENTRAL GOVERNMENT'S POLITICAL WILL TO MAKE A FAMILY PLANNING A PRIORITY PROGRAM

With the devolution of responsibilities to the LGUs, the national government has shifted ownership of the program to the lower levels, and its involvement as a regulatory body has diminished significantly. The family planning program doesn't have the central-level support it needs to deploy the CSR strategy fully, and there doesn't seem to be any commitment to work with LGUs to promote allocation of enough resources to continue running the family planning program. An integrated approach to family planning, in which it is included as a standard health service, perhaps as a component of maternal and child health services, should be considered and promoted by the national government to ensure sustainability and ownership of the program.

### WEAK LEADERSHIP ROLE OF DOH CO AND CHD

In most of the activities that DELIVER and LEAD projects carried out to strengthen LGUs' policy formulation and advocacy for resources, the DOH CO and CHD have played a discreet role in the promotion of CSR strategy. A key factor in the success of the strategy is developing leadership to provide clear direction and adopting a proactive role that will result in strong leadership.

### TIMEFRAME OF PHASEOUT OF DONATED PRODUCTS VIS-À-VIS PACE OF CSR STRATEGY IMPLEMENTATION

Even though DELIVER and LEAD projects worked intensively with LGUs by training and guiding staff on policy formulation and CDLMIS modifications to ensure timely and gradual appropriation of resources, LGUs have had a difficult time implementing all of the strategies effectively. Two major constraints have been the timeframe for the phaseout of donated contraceptive supplies vis-à-vis the pace of CSR project implementation activities, and the ability of LGUs to assume full responsibility for CSR within the phaseout period.

# GOALS AND OBJECTIVES

In the face of implementation of the CSR strategy, the LGUs have experienced difficulties in meeting their procurement needs, especially within the established timeframe. USAID/Philippines has provided technical assistance and support to the DOH through the DELIVER project; the primary focus of this assistance has concentrated on the following areas:

- Development of a phasedown allocation schedule for each province, based on poverty incidence, LGU capacity/readiness to adopt a reduction in contraceptive donations, CPR, and unmet need.
- Modification of the CDLMIS software at DOH CO, to help DOH manage the reduced allocations of donated contraceptives to provinces, based on LGU classification (by wealth), and allow monitoring of locally procured supplies by LGUs.
- Training of LGU, DOH/CHD, and Population Commission (POPCOM) staff to address the contraceptive phaseout issues described under the CSR strategy, and the development and implementation of Policy Guidelines Formulation workshops for DOH, provincial, and LGU staff.

## DELIVER OBJECTIVES

Based on the objectives described above, DELIVER developed the following activities, as described in table 2.

**Table 2. Summary of Activities and Strategies Implemented by DELIVER**

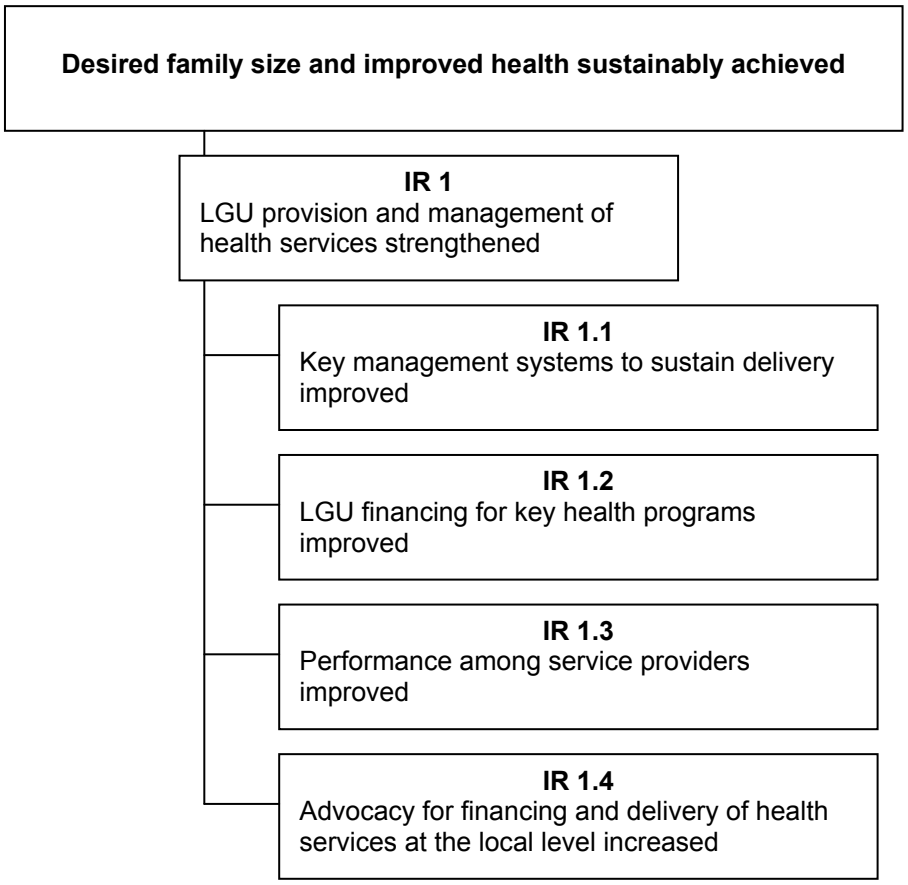
| Activity | Strategy |
|---|---|
| 1. Hired local consultants. | To implement the two-day CSR Logistics Policy Guidelines Formulation Workshops, the one-day follow-up workshops, and the training of LGU health personnel on the revised CDLMIS, JSI hired two additional consultants, and LEAD hired three consultants. |
| 2. Developed a *training of trainers* (TOT) core group. | Training teams composed of technical staff from the DOH CO/CHD, POPCOM, LEAD, and DELIVER were trained to implement the series of CSR logistics workshops for the LGUs. DELIVER and LEAD logistics consultants developed the training curriculum (didactic and practicum) and implemented two batches of five-day TOTs. |
| 3. Developed CSR Logistics Planning Tool and Facilitators Guide. | Developed a comprehensive Logistics Planning Tool that LGUs can use to address the contraceptive phaseout issues (phaseout schedule, shortfalls, LMIS, inventory levels, distribution, forecasting, and procurement), and to better manage contraceptive during the phaseout period. A companion facilitator's guide was also developed for the use of the facilitators in implementing the workshop. |

| Activity | Strategy |
|---|---|
| 4. Developed provincial/city CSR Logistics Planning and Policy Guidelines Formulation Workshops. | Implemented a series of CSR Logistics Policy Guidelines Formulation Workshops for the LGU provincial/city CSR Technical Working Groups (TWGs). Using the CSR Logistics Planning Tool, the TWGs formulated draft policy guidelines during the two-day workshops, which were later refined in a separate one-day follow-up workshop.<br><br>*(Sample CSR Logistics Policy Guidelines for the city of Davao and the province of Pangasinan are attached as appendices 3 and 4, respectively.)* |
| 5. Assisted USAID and DOH in preparing Phasedown Allocation Tables. | Using CDLMIS consumption data at the DOH CO, phasedown contraceptive allocation tables for the LGUs were prepared showing the phased-down quantities, gaps, and projected costs of donated contraceptives over the four- to five-year phaseout period. These helped LGUs quantify the costs and funds they needed to procure the shortfalls in their contraceptive requirement. |
| 6. Revised CDLMIS training. | Developed a training design on the revised CDLMIS, focusing on the revised CDLMIS forms and the other aspects of CDLMIS (distribution, inventory level, forecasting) that had to be modified and adapted to the CSR strategy. The provincial/city CSR policy guidelines were an important element in the design. Also developed a facilitators guide and Echo Training design for the Barangay health station (BHS) midwives training. A series of these trainings were conducted for provincial/city and municipal health personnel (family planning coordinators, supply officers, nurses, and midwives). |
| 7. Prepared Contraceptive Procurement Tables (CPTs). | Provided assistance to the DOH/Procurement Logistic Service (PLS) in preparation for the CPTs, more specifically on IUD shipment schedules, quantity, and justification for the requested quantities. |
| 8. Conducted ARMM CSR Logistics Policy Guidelines Formulation Workshops. | Working closely with the ARMM Unit of LEAD, adapted and expanded the two-day CSR Logistics Policy Guidelines Formulation Workshops for the ARMM. The workshops that were implemented resulted in an Executive Order on CSR+ Policy and Implementation Guidelines for the ARMM. |
| 9. Provided training on the revised CDLMIS for ARMM. | Designed a TOT curriculum and conducted TOT for provincial/city trainers in the ARMM. These trainers, with assistance from the DELIVER logistics consultants, were responsible for conducting the training on the revised CDLMIS of the rural health unit (RHU) nurses/main health center midwives in their areas. The trained RHU nurses/main health center midwives would then train their respective midwives using the Echo Training design provided. |
| 10. Developed CDLMIS Data Base software modification at DOH CO. | A JSI IT advisor and local IT consultants developed specifications for the DOH CO database software modifications. A local IT consultant, working closely with DOH/PLS, modified the DOH central database software to capture data on both donated and locally procured contraceptives, including a monitoring report on the progress of the LGUs' compliance with CSR. The modified software was tested before it was turned over to DOH CO. |

## RELATIONSHIP TO USAID AND CLIENT OBJECTIVES

The DELIVER interventions described in table 2 were implemented based on work plans discussed and approved with USAID/Philippines, and all activities were aimed at responding to the mission's Strategic Objective 3, as described in figure 2. DELIVER activities concentrated on strengthening LGUs' capacity to implement DOH Administrative Order (AO) 158, which shifted the responsibility for providing sufficient and continuous contraceptives supplies to the LGUs. Therefore, our efforts responded to the mission's Intermediate Results 1.1 and 1.3.

**Figure 2. Population, Health, and Nutrition Results Framework—USAID/Philippines**




## DELIVER'S ROLE IN RELATION TO OTHER ORGANIZATIONS

During implementation of the training strategies, DELIVER worked very closely with the LEAD project. Both projects coordinated efforts and trained staff in more than 51 LGUs throughout the country. To guarantee close communication at all times, LEAD designated office space for DELIVER consultants at its central office in Manila and facilitated access to their administrative staff as well as office equipment. Throughout the implementation of activities, DELIVER was recognized as the leading project in performance improvement and capacity building as well as in the design of the model to allocate donations based on poverty indices.

## SUMMARY OF INTERVENTIONS AND STRATAGIES

For a complete description of interventions and strategies, refer to the information described in table 2.

## SUMMARY OF DELIVER FUNDING AND STAFFING

For the period October 2000–September 2006, USAID/Philippines allocated a total of U.S.$1,332,000 to DELIVER, to carry out the activities described in this report.

| | |
|---|---|
| Family Planning Logistics Management project carry-over | $493,000 |
| Fiscal year 2004 | $539,000 |
| Fiscal year 2005 | $300,000 |
| **Total** | **$1,332,000** |

To accomplish the scope of work, a combination of external Washington-based advisors and locally hired consultants was assigned or hired to carry out the activities. These staff were hired according to skills and expertise needed to implement the work plan. Main technical assistance providers were Washington-based advisors Daniel Thompson and Nora Quesada, and Gualberto Amable, Bernardo Bersola, Miriam Balahadia, and Mariano Padilla, all local consultants who provided technical assistance and training on the CSR strategy in 51 LGUs. With regard to the technical work on the CDLMIS, DELIVER hired (at different stages) Don Bulaong and Oliver Margarejo to modify the software to respond to the changes required, based on the CSR strategy, and the DOH AO 158. These two consultants worked very closely with Mr. Ferdinand de La Cruz, from the DOH/PLS division, to ensure timely and proper implementation of these changes. Ashraf Islam from JSI/Washington provided technical oversight to ensure technical compliance with DELIVER standards and timely completion of the modifications.

# PROGRAM RESULTS

As a result of all interventions described in this report, the following results are highlighted.

## ELEMENT I: IMPROVED LOGISTICS SYSTEM

As mentioned before, DOH AO 158 shifted to the LGUs responsibility for providing an adequate and continuous supply of contraceptives, as a result of the phaseout of donated contraceptives. To ensure that the LGUs were able to address and manage the changes faced by the logistics system under this new environment, DELIVER developed the CSR Logistics Planning Tool. This tool was used during the CSR Logistics Guidelines Formulation Workshops where the LGU provincial/city CSR TWG participants formulated their provincial/city CSR Policy Guidelines to respond to the requirements of DOH AO 158. The tool identifies the logistics-related issues and the answers or options that LGUs can adopt, particularly for the expected contraceptive shortfalls/gaps, logistics management information system (LMIS) design-related issues, inventory level/control system, distribution, storage, forecasting, procurement, resource mobilization, funding sources, and modification of the existing CDLMIS for the LGUs to manage donated and locally procured contraceptives under the CSR strategy. A modified and expanded version of the tool was developed and adapted for the ARMM because of its unique governmental structure.

## ELEMENT II: IMPROVED HUMAN CAPACITY IN LOGISTICS

In addition to developing the CSR Logistics Planning Tool and implementing the CSR Logistics Policy Guidelines Formulation Workshops for the provincial/city CSR TWG, DELIVER developed a TOT curriculum and conducted two batches of TOT for DOH CO/CHD and for POPCOM central and regional technical staff. These trainers assisted the DELIVER and LEAD logistics consultants/trainers in the conduct of the two-day provincial/city CSR Logistics Policy Guidelines Formulation Workshops and one-day Follow-up Workshops for the LGUs. Staff from 51 LGUs participated in these workshops, and DELIVER strengthened the LGUs' technical and management skills to implement the CSR strategy, using the Policy Guidelines Formulation developed at each LGU.

In addition, training curricula was developed for TOT activities aimed at provincial/city LGU trainers. Because the CDLMIS was modified at the central level, a curriculum for roll-out trainings on the revised CDLMIS was developed, and was used by the municipal health trainers during their workshops for the BHS Midwives. These training curricula and designs were the ones used to conduct the revised CDLMIS TOT and roll-out trainings for provincial/city/municipal/Barangay health personnel. The training curricula/designs were also modified and adapted for trainings in the ARMM. All of the training curricula/designs had a companion guide for the facilitators. A summary of the various CSR Logistics Workshops and Revised CDLMIS Trainings is attached as appendix 1.

## ELEMENT III: IMPROVED ADOPTIONS OF ADVANCES IN LOGISTICS

To collect the additional data requirements of the logistics system (i.e., locally procured contraceptives), in response to the CSR strategy, DELIVER worked closely with the DOH/PLS division and developed specifications to modify and upgrade the CDLMIS software to capture the data and information on donated and locally procured contraceptives from the LGU quarterly reports. The modification and upgrade of the system also included the development of a monitoring system for the DOH, LGUs, and USAID to assess the performance and compliance of the LGUs in implementing the CSR strategy. Now,

the DOH has a software system that can process detailed data from lower levels and assist the DOH/PLS CDLMIS manager to make informed decisions on contraceptive resupply.

## ELEMENT IV: ESTIMATION OF USAID CONTRACEPTIVE NEEDS

As a result of the CSR strategy, and the phasedown plan that determined fixed contraceptive allocations to LGUs, USAID/Philippines established fixed contraceptive amounts to procure and donate to the DOH. DELIVER advisors and local logistics consultants assisted the DOH/PLS in preparing the CPTs, particularly for IUDs, as requested by USAID. Contraceptive requirements and shipping schedules were prepared for 2004, 2005, and 2006, and submitted to USAID for contraceptive procurement.

# LESSONS LEARNED AND FUTURE DIRECTIONS

One of the key factors that contributed to the relatively smooth implementation of the activities carried out by DELIVER was regular communication with USAID counterparts, which helped us focus on the priority issues and provided support throughout the process. However, certain issues beyond our control will influence the ability of the DOH to implement the CSR strategy successfully.

## NATIONAL GOVERNMENT AND THE DOH ROLE

The GRP and the DOH should lead the process of CSR implementation and play a more visible and leading role. They should provide support mechanisms to the LGUs and not just shift the burden of responsibility for implementing the health programs and services to the LGUs. More guidance and support is needed from the DOH to implement the CSR strategy fully and to reinforce the need to continue gathering complete and timely data on stock status and use.

## INVOLVE NATIONAL LEAGUE OF GOVERNORS, MAYORS, AND OTHER KEY ACTORS IN THE ADVOCACY EFFORT FOR CSR STRATEGY IMPLEMENTATION

Tapping these existing networks (League of Governors, City/Municipal Mayors, Sanggunian, and Barangays) for program advocacy and dissemination should be prioritized and strengthened. This approach will facilitate timely communication with LGUs and reduce the barriers identified in dealing with individual LGUs and obtaining their consensus on, acceptance of, and commitments to the CSR strategy and program policies. This is vital to ensure timely allocation of resources for contraceptive procurement before donations come to an end.

## CONSIDER INTEGRATING HEALTH PROGRAMS TO CONTRIBUTE TO SUSTAINABILITY

Given the limited financial and human resources and capabilities of the LGUs, an integrated health program and systems development approach is recommended. Health programs and systems should be packaged and not presented as separate programs with different and varying systems, thereby making them more difficult and cumbersome for LGUs to implement. This also scatters LGUs' already limited resources. Existing LGU systems should be enhanced rather than suppressed or replaced and should be driven by the particular needs of the LGU.

## COORDINATE PARTNER AGENCIES' ASSISTANCE TO LGUs, TO AVOID OVERLAP

A number of PAs are currently implementing various programs and projects for the LGUs. In many instances these programs and projects overlap or compete with one another for LGUs' counterpart resources (financial, technical, and human). Frequently the same LGU and their health/technical personnel are involved with different PAs, resulting in excessive workloads. It is in this area that donors and the DOH, together with the PAs, should develop and establish a mechanism for closer collaboration and coordination for programs and projects to be complementary rather than competitive and overlapping.

## CONSIDER DECENTRALIZING CDLMIS AND THE MONITORING TOOL

With decentralization and local autonomy, the CDLMIS software and the monitoring tool should be decentralized to the regional level and, if possible, to the provinces and LGUs, since the policy decision makers who really need and process the data are the chief executives and key officials at the LGU level. The central DOH and the CHDs should continue to strengthen their role in providing much-needed technical guidance and support, and they should continue monitoring the LGUs as they implement the CLDMIS at the local level, to ensure proper use of the modified system.

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APPENDIX 1

# STATUS OF CSR LOGISTICS TRAININGS/WORKSHOPS

| STATUS OF CSR LOGISTICS TRAININGS/WORKSHOPS | | | | | |
|---|---|---|---|---|---|
| CHD | LGU | LEAD PRIORITY SITES | ACTIVITIES | | |
| | | | Policy Form W'shop | Follow-up W'shop | TOT/Revised CDLMIS |
| I | Pangasinan | / | completed | completed | completed |
| III | Bulacan | / | completed | completed | completed |
| III | Angeles | / | completed | completed | completed |
| III | Nueva Ecija | | completed | No need | completed |
| V | Albay | | completed | completed | completed |
| V | Sorsogon | / | completed | completed | completed |
| V | Catanduanes | / | completed | completed | completed |
| VI | Iloilo | / | completed | completed | completed |
| VI | Negros Occ | / | completed | completed | completed |
| VI | Guimaras | | completed | completed | completed |
| VII | Negros Or | / | completed | completed | completed* |
| VIII | Leyte | | completed | completed | completed |
| VIII | So Leyte | / | completed | completed | completed |
| VIII | East Samar | | completed | completed | completed |
| VIII | Biliran | | completed | completed | completed |
| IX | Zambo City | | completed | No guidelines | |
| X | Bukidnon | / | completed | completed | completed |
| X | Misamis Orr | | completed | completed | completed |
| X | Misamis Occ | / | completed | completed | |
| XI | Davao City | | completed | completed | completed |
| XI | Davao Norte | / | completed | completed | completed |
| XI | Davao Sur | | completed | completed | completed |
| XI | Com. Valley | / | completed | completed | completed |
| XII | South Cot | / | completed | completed | completed |
| XII | Gen Santos | | completed | completed | completed |
| CARAGA | Agusan Sur | / | completed | completed | completed |
| CARAGA | Agusan Norte | / | completed | completed | |

| | | | | | |
|---|---|---|---|---|---|
| CAR | Benguet | / | completed | completed | completed |
| CAR | Baguio City | | completed | completed | completed* |
| ARMM | Basilan | | completed | completed | completed* |
| ARMM | Lanao Sur | | completed | completed | completed* |
| ARMM | Sulu | | completed | completed | completed* |
| ARMM | Maguindanao | | completed | completed | completed* |
| ARMM | Tawi-Tawi | | completed | completed | completed* |
| ARMM | Marawi | | completed | completed | completed* |
| NCR | Caloocan City | | completed | completed* | |
| NCR | Navotas | | completed | completed* | |
| NCR | Malabon | | completed | completed* | |
| NCR | Valenzuela | | completed | completed | |
| NCR | Taguig City | | completed | completed | completed |
| NCR | Quezon City | | completed | completed | |
| NCR | Pasay | | completed | completed | completed |
| NCR | Pasig | | completed | completed* | |
| NCR | Mandaluyong | | completed | no need | |
| NCR | Makati | | completed | completed | completed |
| NCR | San Juan | | completed | completed* | |
| NCR | Marikina | | completed | completed* | |
| NCR | Las Pinas | | completed | completed* | |
| NCR | Paranaque | | completed | completed | |
| NCR | Muntinlupa | | completed | completed | |
| NCR | Pateros | | completed | completed | |

* Conducted using JSI funds

# APPENDIX 2

# CS BRIEF

| **CS Brief** | |
|---|---|
| | |
| Population | 86 million |
| Population growth rate | 2.1% |
| Women of Reproductive Age (WRA) | |
| Fertility rate | 3.4 births per WRA (2006) |
| CPR (modern methods)<br>• Public sector<br>• Private sector<br>• Other | 33%<br>67.2% of the share of CPR<br>29.3% of the share of CPR |
| HIV/AIDS prevalence rate | <0.1% (UNAIDS, 2006) |
| Health regions, districts, and service delivery points (SDPs) providing rural health/family planning (RH/FP) services (their numbers) | 17 regional offices, 347 LGUs |
| **Forecasting** | |
| Current method mix and projected trend (2003 Demographic and Health Survey) | Oral contraceptives: 13%<br>Female sterilization: 11%<br>IUD: 4%<br>Injectables: 3% |
| Presentation and use of CPTs in management decision making | At the request of USAID/Manila, DELIVER provided assistance to the DOH/PLS in the preparation of the CPT for IUDs only, to schedule shipments, quantities, and justification for donations from USAID. |
| Assumptions related to data used in the CPTs *(approach used)* | Data from the computerized system (CDLMIS) is used for routine monitoring of the consumption data from LGUs. So, historic consumption data is used. |
| Sources and accuracy of data used in forecasting *(data quality)* | CDLMIS collects reliable consumption data from all provinces in the country, which consolidate the consumption data from LGUs, every month. |
| Role of technical assistance | 1. Assist LGUs in preparation of CSR plans.<br>2. Adapt CDLMIS to allow the DOH to allocate supplies and monitor procurements.<br>3. Provide training for national and LGU staff in use of CDLMIS to manage, monitor, and procure contraceptives. |

| | |
|---|---|
| **Procurement** | |
| Existence and role of the Procurement Unit | The DOH/PLS is in charge of forecasting, and monitoring the procurement and use of donated contraceptives. It also consolidates the stocks on hand and consumption data at the national level, using a computerized system, the contraceptive and distribution logistics management information system (CDLMIS), which provides information to allocate donated products to the LGUs, and monitors the locally procured supplies under the CSR implemented by USAID. |
| Stock status analysis over one-year period (overstocks, stockouts, and consistency of procurement plans) | As a result of the CSR, DELIVER concentrated on assisting LGUs with the development of CSR plans. CDLMIS data have shown an increase in stockouts at the LGU level, since some local governments haven't procured the contraceptive quantities needed. However, no stock status assessment has been performed in the past year, and the stock status situation is unknown. |
| Contraceptive supplier situation (percentage of commodities provided by supplier) | Nearly 80 percent of the country's total requirements were provided by USAID until recently. Donations of most products, except IUDs, will end by 2008. |
| Historical, current, and future role of USAID as a contraceptive donor | Since 1970, the U.S. Government has been a major donor, providing assistance to the family planning program of the Philippines, and for the last 12 years, USAID contraceptive donations (pills, injectables, IUDs, and condoms) accounted for 80% of the country's total requirements. However, USAID began phasing out its donations in 2003 as part of a broader effort to encourage local ownership of the family planning program. |
| **Financing** | |
| Commodity funding mechanism (i.e., basket funding, cost recovery, local public funds, etc.) | Under the CSR strategy, LGUs are supposed to allocate municipal funds to procure contraceptives. There are no established cost-recovery mechanisms in place. However, some LGUs (e.g., Pangasinan province), have conducted means testing at some health centers and posts to determine clients' ability to pay and establish cost-recovery fees. |
| Current and future donor contribution in commodity financing plan over the next 5 years | USAID does not plan to continue donating contraceptives to the DOH, except for IUDs, in the next 5 years. |

| | |
|---|---|
| USAID/Mission intervention strategies (strategic objectives and plan for contraceptive security) | DELIVER activities concentrated on strengthening LGUs' capacity to implement DOH AO 158, which shifted the responsibility for providing sufficient and continuous contraceptives supplies to the LGUs. Therefore, efforts responded to the Mission's Intermediate Results 1.1 (Key management systems to sustain delivery improved) and 1.3 (Performance among service providers improved) under Strategic Objective 3: Desired family size and improved health sustainability achieved. |

**Supply Systems**

| | |
|---|---|
| Length of the pipeline | DOH is a 3-tier supply system: central, provincial, and LGU level, where BHSs and RHUs are considered part of the LGU level. |
| Major institutions involved in RH/FP activities | DOH, POPCOM, and LGUs, USAID through MSH/LEAD and JSI/DELIVER. |
| LMIS status (level of efficiency) | CDLMIS was recently modified to help DOH/PLS monitor the LMIS throughout the system. For years, it was considered very efficient and provided key logistics information to monitor stocks on hand and consumption data at the national, provincial, and LGU levels. As of today, CDLMIS continues to provide key information to allocate the gradually reduced donated contraceptives and to monitor locally procured contraceptives by LGUs. |
| Commodity availability at SDPs | Unknown |

**Major Issues**

Stock status situation at the LGU level is not clearly known, because no major surveys/assessments have been conducted lately. Recent DELIVER visits to the LGUs, to help them prepare and implement their CSR plans, showed that many LGUs are not replacing donations with locally procured contraceptives, which could indicate that LGUs don't have sufficient contraceptives to cover increasing demand.

# APPENDIX 3

## DAVAO CITY: CONTRACEPTIVE SELF-RELIANCE STRATEGIES AND LOGISTICS MANAGEMENT GUIDELINES

### I. INTRODUCTION:

Consistent with the National Family Planning Program policy promulgated in 2001, on July 2004, Department of Health issued Administrative Order 158 otherwise known as the Contraceptive Self-Reliance Strategy.

Contraceptive Self-Reliance (CSR) is a set of measures to assure that supplies for family planning services will continue to be provided for increasing numbers of current and potential users to eventually eliminate unmet needs for Family Planning.

AO 158 therefore defines the national CSR Strategy which *"provides for the orderly transition from externally donated contraceptives to locally provided commodities for family planning", and further "provides that the LGU shall ensure that actual levels of contraceptive supplies in the locality are not disrupted during the phase-out period so that current CPR do not decline and future CPR continue to increase consistent with the goal of eventual elimination of unmet need for FP."*

In this manner, the LGU with support from DOH shall now perform the following roles:

1. Become local guarantor of overall contraceptive availability
2. Assure sufficient supply of free contraceptives for poorest users and
3. Promote expansion of commercial sources of contraceptive supply.

Thus, consistent with the Local Government Code of 1991 giving mandate to local government unit to provide family planning services and ensure availability of FP contraceptives in health facilities, and consistent with Section 8, Item A, Number 5 of DOH AO 158 which states " Provincial and city government shall be authorized to issue and adopt their own desired local policies consistent with national policies, for governing the financing, procurement, distribution and management of all sources of contraceptive in the localities", and consistent with the city's priority program on reproductive health, gender and development, Davao City hereby adopts and promulgates this City Contraceptive Self-Reliance (CSR) Strategies and Logistics Management Guideline

### A. GENERAL POLICY STATEMENT:

The poor shall be given priority to the donated and locally procured contraceptives based on household ranking from the Living Standards Survey (LSS).

### B. IMPLEMENTING DOH PHASE-OUT SCHEDULE

Since the city will be following the national phase-out schedule, we have formulated the following policy guidelines in the allocation and distribution of donated and locally procured contraceptives during the phase-out period.

1. The Paquibato and Marilog Districts will be given 100% of their contraceptive requirements based on their geographic location and socio economic factors.
2. Davao Medical Center (DMC) and NGOs providing FP services within the city shall no longer be given their share of donated and locally procured supplies beginning 3rd quarter of 2005 and onwards.
3. The rest of the districts in the city will receive their allocation based on the national phase down schedule. However, subdivisions within the district shall not be given allocation but advised to buy from private outlets. These provisions are subject to change after the Living Standards Index (LSI) shall have been generated and available.

## C. ADDRESSING THE EXPECTED SHORTFALLS:

Under the DOH AO 158, the phase-out of donated contraceptives is applied in percentages to particular quarters in a given year. It is spread out over a period of 4-5 years. The phase-out will commence in 2004 (3rd & 4th quarter) and end in 2007 for pills and 2005–2008 for injectables. Using the NSCB poverty index, Davao City belongs to the 1st batch of LGUs classified as the wealthier LGUs who will be affected first by this phase out schedule.

In the case of Davao City, shown below are the phase-out schedule and the expected shortfalls of contraceptives that the city will experience following the phase-out:

| Year | Quarters | Donated Pill Allocation | Shortfall | Donated Injectable Allocation | Shortfall |
|---|---|---|---|---|---|
| 2004 | Q 3 & 4 | 80% | 20% | 100% | - |
| 2005 | Q 1 & 2<br>Q 3 & 4 | 50%<br>30% | 50%<br>70% | 80%<br>70% | 20%<br>30% |
| 2006 | Q 1 & 2<br>Q 3 & 4 | 20%<br>0% | 80%<br>100% | 60%<br>40% | 40%<br>60% |
| 2007 | Q 1 & 2<br>Q 3 & 4 | 0%<br>0% | 100%<br>100% | 20%<br>0% | 80%<br>100% |

On an annual percentage average, the city's shortfall or reduction of donated contraceptives are as follows:

| Year | Donated Pill Allocation | Shortfall | Donated Injectable Allocation | Shortfall |
|---|---|---|---|---|
| 2005 | 40% | 60% | 75% | 25% |
| 2006 | 20% | 80% | 50% | 50% |
| 2007 | - | - | 20% | 80% |
| 2008 | - | - | - | - |

Based on the 2003 average quarterly pill consumption of 7,560 cycles, and an average quarterly consumption on injectable of 736 vials, the actual quantities to be received by Davao City under this phase-out schedule shall be as follows:

| Year | Quarters | Quarterly Donated Pill Allocation (in cycles) | Quarterly Shortfall (in cycles) | Quarterly Donated Injectable (in vials) | Quarterly Shortfall (in vials) |
|---|---|---|---|---|---|
| 2005 | Q 1 & 2<br>Q 3 & 4 | | | | |
| 2006 | Q 1 & 2 | | | | |
| | Q 3 & 4 | 0 | | | |
| 2007 | Q 1 & 2 | 0 | | | |

It is significant to note that the decreasing quantity and eventual phase-out of donated contraceptives from the DOH inversely increased the quantity of contraceptives that the LGU will have to procure to ensure continuous and adequate supply of the contraceptives not only for its current, but also future users. Covering for the shortfall generated by the reduced allocation during the phase-out period is indeed a big responsibility that the city has to address.

In addressing therefore for the expected contraceptive shortfalls, we have formulated the following guidelines:

a. The city government together with its barangays shall appropriate funds to cover the full cost of the contraceptives to be procured based on the computed forecast prepared by the City Health Office.

b. The Barangays shall appropriate funds annually under their health program for the purchase of contraceptives.

c. The city shall classify the barangays using the results from Living Standards Index (LSI).

d. The mayor will be requested to issue an Executive Order enjoining the barangays to a pooled procurement system.

e. Should the city fall short of the funds, the following are the options:

**1.** Donated and procured contraceptives shall be allocated to government facilities only.

**2.** adopt clients segmentation based on the Living Standard Index (LSI)

**3.** shift clients to permanent method

**4.** refer paying clients to private sector

**5.** create trust fund from the congressional funds of the three congressmen.

## D. CONTRACEPTIVE LOGISTICS POLICIES

### 1. LMIS REPORTING AND RECORDING

**1.1** In terms of reporting and recording, Davao City shall be using the modified **Contraceptive Delivery Logistics Management Information System (CDLMIS)** reporting and recording forms such as the following:

a. **Contraceptive Order Form** (COF) – This form is to be accomplished by the delivery team in four (4) copies during its quarterly delivery run. The modified COF already includes unmet demand which is not available in the old form.

b. **CDLMIS Inventory Report Form** – This form is to be accomplished by the Supply Officer in 4 copies. One copies each for the DOH Central Office, CHD, FP Coordinator and Supply Officer every end of the quarterly delivery run. This will provide us available stocks on hand of all contraceptives.

c. **BHS Monthly Worksheet Form** – This form is to be accomplished by the BHS Midwife for ordering contraceptives from the RHU, and by the RHU nurse for issuing contraceptives to the BHS midwives. Both the BHS midwife and the RHU nurse keeps a copy of the BHS worksheet.

d. **Dispensed to User Record (DTUR)** – This form is used to record all issuances of contraceptives made to FP clients the health facility every time a client gets his/her supply.

### 1.2 REPRODUCTION OF CDLMIS FORMS

The City Health Office will be responsible for the provision and printing of the revised forms to be distributed to all health facilities at the district and barangay level.

Relative to the use of this modified forms, midwives, nurses, designated supply officers will be oriented and trained on how to fill-up the said forms.

## 2. CONTRACEPTIVE DISTRIBUTION:

Davao City shall maintain and continue to use the existing Contraceptive Delivery Logistics Management Information System (CDLMIS) where delivery teams trained on CDLMIS deliver contraceptives from the city to the district, following a ***quarterly delivery schedule***.

The CDLMIS Team shall be responsible for the following:

### 2.1 Prior to the delivery

a. Prepares allocation list

b. Prepares COF

### 2.2 During the delivery

a. Count the stocks of the health facilities

b. Complete the CDLMIS reporting forms

c. Issues adequate contraceptive supplies

### 2.3 After the delivery

a. Do the inventory of the city stocks

b. Submits the required CDLMIS forms to DOH Central and Center for Health Development (CHD).

At the BHS level the midwife counts her stock on hand, complete the required forms, and goes to the RHU nurse to get her supplies ***monthly*** on the designated ordering date.

## 3. INVENTORY CONTROL

To maintain adequate supply at the city, district and barangay level, the Authorized Stock Level (ASL) under the CDLMIS, shall be maintained, following a new ASL requirement. Authorized Stock Level can be determined by multiplying the average monthly usage (AMU) with the preferred ASL. In Davao City, the new ASL requirement that shall be followed for each level is:

| Level | Authorized Stock Level (ASL) |
|---|---|
| City | 6 |
| District | 4 |
| Barangay | 2 |

This new ASL requirement shall only be applied to pill, condom and injectable. ASLs for IUD will be maintained at 6, 6, and 3 for each level.

**Likewise, a buffer or safety stock shall also be maintained at 1 month for each level to avoid under stocking and overstocking of supplies, excluding IUD which shall have a buffer stock of 3,3, 2 for each level.**

Training/orientation for the new ASLs shall be incorporated in the modified CDLMIS training.

## 4. CONTRACEPTIVE STORAGE

Davao City has only one (1) storage area for both the donated and locally procured contraceptives, however a distinction shall be made to identify the stocks which are donated and locally procured by the LGU. As of the present, the city has a storage area where conditions are adequate to ensure the quality of contraceptives while in storage. Designated staff at the city level, in-charge of the supply of contraceptives had already been trained on the proper storage of contraceptives. Likewise, at the district level, they have been provided steel cabinets, solely for FP contraceptives storage.

But since, we have designated supply officers in the district who were not yet trained on proper warehouse management; part of the CSR plan is to provide them with such kind of training to ensure quality of contraceptives while in storage at their level.

**E. OTHER LOGISTICS ISSUES**

## FORECASTING AND PROCUREMENT

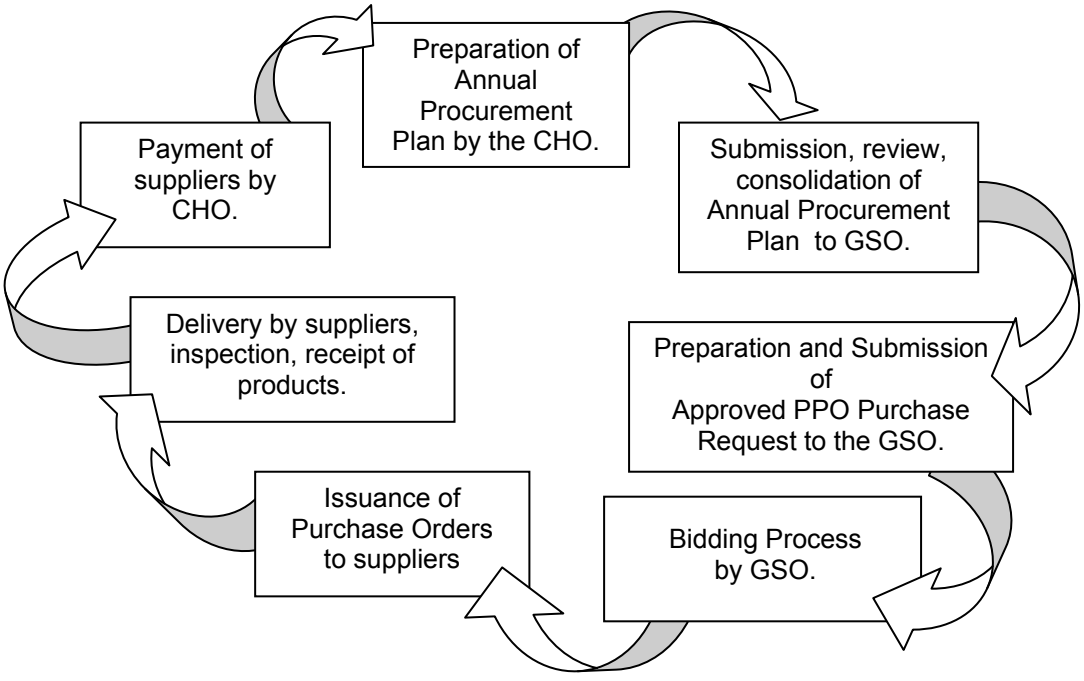
### FORECASTING:

1. The contraceptive requirements of the city during the phase-down has been determined by the DOH based on 2003 CDLMIS consumption data. Meanwhile, the city shall continue to use consumption-based method in determining the commodity requirement of the public sector.
2. Since the city has its on-going Community Based Monitoring Information System (CBMIS) and Living Standard Survey (LSS), as soon as the data will be available it will be utilized to forecasts the contraceptive requirement of the city.
3. Other variables shall also be considered in forecasting such as the number of women of reproductive age, contraceptive prevalence rate (CPR) and the population growth rate of the city.
4. The forecasts will be regularly reviewed based on the availability of data.

### PROCUREMENT:

1. In the procurement of drugs, medicines and contraceptives, the city shall follow the pooled procurement system as shown below:

**POOLED PROCUREMENT CYCLE**



2. Aside from the pooled procurement system that we have been using, we are also guided by the following guidelines:

    a. Purchases of drugs, medicines and contraceptive supplies shall be in accordance with the approved annual procurement program of the office;

    b. Procurement of drugs, medicines and contraceptive supplies shall be from the DMC Murang Gamot.

    c. Those not available shall require waiver from the DMC Murang Gamot authorized official.

    d. Competitive bidding shall be the primary mode of procurement for those items not available. However, other modes of procurement allowed under GPRA (RA 9184) maybe employed as determined by the BAC of the City Govt.

## RESOURCE MOBILIZATION

During the phase-out period, it is expected that Davao City will procure the contraceptives on a gradually increasing quantity (2005- 2007) until it will shoulder the full cost of the contraceptive requirements after the phase-out.

The following are the options of the LGU to fund the procurement of contraceptives:

1. It can be incorporated into the Annual Budget of City Health Office. For the 1st and 2nd quarter of 2005, we have already appropriated funds for the procurement of contraceptives, pills, condom and injectables.
2. The city government through its Local Finance Committee shall sourced out funds annually for the procurement of the contraceptives.
3. If funds are inadequate, the following financing strategies or schemes can also be adopted:

    a. Creation of a Trust Fund through Congressional Assistance.

    b. Donations and participation of NGOs and private sector such as the Health Plus, DKT, Well-Family Clinic and Friendly Care.

    c. The city government shall ensure the upgrading of health facilities to acquire SS Certification and Phil Health Accreditation.

# APPENDIX 4

## PANGASINAN: PROVINCIAL STRATEGIES AND GUIDELINES IN MANAGING FP LOGISTICS SUPPORT TO CITIES AND MUNICIPALITIES

### PROVINCE OF PANGASINAN

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### I. BACKGROUND AND RATIONALE

#### 1.1 THE PANGASINAN CONTRACEPTIVE SELF-RELIANCE (CSR) INITIATIVE

On the later part of 2002, Pangasinan province learned of the policy shift of US-AID on the country's family planning program from commodity procurement to other forms of technical assistance to local government units.

This critical shift in donor assistance will greatly impact on the FP program of Pangasinan that has (a) high unmet need for FP of 25%, (b) high dependence (87%) on public sector for provision of FP services, and (c) increasing number married women of reproductive age as potential FP users. Under this scenario, providing for the expected shortfalls from the local government units' own resources while reducing FP unmet need at the same time pose a major program challenge and create a logistics issue.

In January 2003, the provincial government started a contraceptive self-reliance initiative to prepare the province for the eventual phase-out of US-AID support for donated family planning contraceptives. It sought assistance from and entered into a partnership with US-AID for the provision of technical assistance through a project entitled "Pangasinan's Initiative to Address FP Unmet Need and Working Towards Contraceptive Self-Reliance" and eventually called the "Pangasinan CSR Initiative" (Attachment 1).

The CSR project selected eight municipalities and one city in the PALARIS Inter-Local Health Zone and Urdaneta City as advance implementation sites. At the end of almost a year of project intervention, the province and nine local government units have put in place policy and financial reforms that paved the way for the appropriation of local funds for procurement of contraceptives to replace the expected shortfall in 2004.

However, the ten CSR sites represent only one fourth of the 47 component cities and municipalities in the province and 17% of its total population. The phase down schedule, when implemented by US-AID through the Department of Health, will affect all the LGUs regardless of their readiness for CSR. During the phase out period, which is 2007 for pills and 2008 for injectables, all local government units will have increasing commodity requirement as their share of donated contraceptives from DOH will gradually diminish.

Pangasinan will start its contraceptive reduction in 2005. Palaris ILHZ and the rest of the component municipalities and cities will have to appropriate the needed local

funds and/or identify alternative financing sources to meet the increasing commodity shortfalls.

In order to caution the adverse effect of the phase down of donated commodities to LGUs, a provincial CSR Strategy and logistics management guidelines has to be formulated to effect an orderly transition from national allocation to local procurement and distribution.

Provincial CSR strategies and logistics management guidelines are intended to cover all the 47 municipalities and cities to assure that ***"supplies for family planning services will continue to be provided for increasing numbers of current and potential users and to eventually eliminate unmet needs for FP in the province".***

## 1. 2 The Department of Health Administrative Order (DOH-AO) 158 and Its Implications to Pangasinan Contraceptive Self-Reliance Initiative

From the lessons of the Pangasinan CSR Initiative, the Department of Health issued Administrative Order 158 in July 2004 which defines the national CSR Strategy which ***"provides for the orderly transition from externally donated contraceptives to domestically provided commodities for family planning."*** The AO further outlines the guidelines for the distribution of the remaining donated contraceptives during the phase down period (2004-2008). It also identifies several broad directions and strategies in order for local government units (LGUs) to attain CSR once contraceptive donations are no longer available.

### A. DOH Phase-Down Schedule

According to AO 158 (Attachment 2), pills and injectables are the FP commodities to be immediately affected by the phase-down. The DOH will continue to supply IUDs to the province based on consumption as this commodity is not readily available in the local market and pharmaceutical suppliers.

Under the DOH phase-down schedule, Pangasinan is classified as Batch 2 (middle poverty index) LGU and has the following schedule:

| Year | Quarters | Donated Pill Allocation | Shortfall | Donated Injectable Allocation | Shortfall |
|---|---|---|---|---|---|
| 2005 | Q 1,2 | 80% | 20% | 90% | 10% |
| | Q 3,4 | 60% | 40% | 80% | 20% |
| 2006 | Q 1,2 | 40% | 60% | 70% | 30% |
| | Q 3,4 | 20% | 80% | 60% | 40% |
| 2007 | Q 1,2 | 0% | 100% | 40% | 60% |
| | Q 3,4 | 0% | 100% | 20% | 80% |
| 2008 | Q 1,2 | | | 0% | 100% |

On an annual percentage average, the shortfall or reduction of donated contraceptives are as follows:

| Year | Donated Pill Allocation | Shortfall | Donated Injectable Reduction | Shortfall |
|---|---|---|---|---|
| 2005 | 70% | 30% | 85% | 15% |
| 2006 | 30% | 70% | 65% | 35% |
| 2007 | -- | -- | 30% | 70% |
| 2008 | -- | -- | -- | -- |

Based on the 2003 average quarterly pill consumption of 125,703 cycles and an average quarterly injectable consumption of 15,882 the actual quantities to be received by the province shall be as follows:

| Year | Quarters | (Quarterly) Donated Pill Allocation | (Quarterly) Shortfall | (Quarterly) Donated Injectable Allocation | (Quarterly) Shortfall |
|---|---|---|---|---|---|
| 2005 | Q 1,2 | 100,562 | 25,141 | 14,294 | 1,588 |
| | Q 3,4 | 75,422 | 50,261 | 12,706 | 3,176 |
| 2006 | Q 1,2 | 50,261 | 75,422 | 11,117 | 4,765 |
| | Q 3,4 | 25,141 | 100,562 | 9,529 | 6,353 |
| 2007 | Q 1,2 | 0 | 125,703 | 6,353 | 9,529 |
| | Q 3,4 | 0 | 125,703 | 3,176 | 12,706 |
| 2008 | Q 1,2 | 0 | 125,703 | 0 | 15,882 |

In the light of decreasing levels of donated contraceptives, LGUs (i.e. provinces, municipalities, and cities), as contained in Sec. C, item C, of DOH-AO 158, are expected to assume three new interrelated and mutually reinforcing roles, namely to:

1. Become local guarantor of overall contraceptive availability;
2. Assure sufficient supply of free contraceptives for poorest users; and
3. Promote expansion of other sources of contraceptive supply.

### B. DOH- AO 158 Coverage

Section III states that , *"Also within the scope of this Order are offices and other instrumentalities, which include: agency, entity,* ***local government,*** *or non-government or private organizations, that expect to continue obtaining access to donated contraceptives under the stewardship of the DOH"*.

### C. CSR AND LOCAL AUTONOMY

The contraceptive self-reliance initiative of the province is consistent with the Local Government Code of 1991 giving mandate to the local government unit to provide family planning services and ensure availability of FP commodities/contraceptives in health facilities.

In the same manner, the DOH-AO 158 is in accordance with the provision of the LGC by stating that "Local government units shall define their CSR strategies and policies responsive to their local situation and availability of resources".

Thus, the provincial CSR strategies and guidelines as formulated are in consonance with both the LGC and DOH-AO 158.

## II. PROVINCIAL CONTRACEPTIVE SELF-RELIANCE STRATEGIES AND LOGISTICS MANAGEMENT GUIDELINES

Consistent with Sec. VIII, item A, number 5 of DOH AO 158 which states *"Provincial and city governments shall be authorized to issue and adopt their own desired local policies consistent with national policies, for governing the financing, procurement, distribution and management of all sources of contraceptives in the localities….."*, and consistent with Pangasinan's reforms on its population and family planning programs, provincial government hereby adopts and promulgates its **PROVINCIAL CSR strategies and logistics management guidelines.**

### General Policy Statement

**The poor shall have priority access to donated and locally procured contraceptives.**

### 2.1 Policies in managing donated and LGU procured contraceptives

#### A. Distribution and Allocation of Donated Contraceptives During Phase-Down Period

##### A.1 Implementation of the phase-down schedule per DOH AO 158

a. The province shall allocate the donated contraceptives to cities and municipalities using across the board or straight allocation based on *the average quarterly consumption level for 2003. The province percentage reduction shall follow the DOH phase-down schedule.*

b. The province shall use the DOH CDLMIS consumption data in estimating the shortfall of municipalities and cities.

c. The contraceptive supplies of non-government organizations (NGOs) providing FP services within the province shall continue to receive their share of donated supplies during the phase-out period. After the phase-out period, its up for the NGO to make negotiation to LGU to continue the system.

d. Component cities and municipalities may adopt similar guidelines for allocation and distribution of donated contraceptives to their barangays.

##### A.2 Funding the gaps or providing for the shortfall of donated contraceptives during the phase down period

a. The province shall allocate in the annual budget appropriation for the procurement of contraceptives (pills, injectables and NFP cycle beads).

b. The province shall procure contraceptives to augment the requirement of the poor FP users of public facilities and accredited NGOs in cities and municipalities.

c. The province shall allocate its contraceptive counterpart to LGUs based on criteria such as poverty incidence, availability and sufficiency of budgetary allocations to provide for the requirements of the poor (Attachment 3).

d. As the phase down progresses, the provincial government may introduce additional criteria such as presence of active private sector providers and existence of client classification at the public facility level.

**B. Allocation and Distribution of LGU Procured Contraceptives**

a. The allocation of contraceptives procured by the province to municipalities and cities shall be guided by the DOH phase-down schedule.

b. The province shall classify its component cities and municipalities according to poverty index and readiness of the LGU in terms of fund allocation (Attachment 4), as follows:

**Priority 1:** ***Local government units without budget allocation to cover the cost of their shortfall and with high poverty incidence at 44% above.***

Under this category, the province shall follow the provincial level phase-down schedule shown in item B.1 to augment the shortfall of municipalities and cities, respectively. The remaining percent of the shortfall for municipalities and cities shall be covered by the LGUs own resources. In cases of insufficiency of contraceptive supplies, they shall prioritize the limited supplies or ensure sufficient supply to the poor.

**Priority 2:** *Local government units without budget allocations to cover the full cost of their shortfall and with moderate poverty incidence at 43 % below or LGUs with insufficient budget allocations, regardless of poverty incidence.*

Under this category, the province shall likewise follow the provincial level phase-dwon schedule shown in item B.1 to augment the shortfall for both cities and municipalities. The remaining percent shall be covered by the LGUs own resources. Incases of insufficiency of contraceptive supplies, they shall prioritize the limited supplies or ensure sufficient supply to the poor.

**Priority 3:** ***Cities and municipalities that have sufficient or more than enough fund allocation to cover the full cost of their shortfall.***

LGUs under this category shall procure contraceptives using their own appropriations to cover all their shortfall requirement. While these are considered full CSR LGUs, they may opt to avail of the

provincial government share of 10% for the next three years and 5% in 2008, to cover the gap in their shortfall, if any.

### B.1 Provincial Level Phase-Down Schedule (For Pills & Injectable)

| LGU CLASSIFICATION | Poverty Index &/or level of fund allocation | 2005 | | 2006 | | 2007 | | 2008 | |
|---|---|---|---|---|---|---|---|---|---|
| | | Prov | CMLGU | Prov | CMLGU | Prov | CMLGU | Prov | CMLGU |
| Priority 1 | 43 % & above; w/o budget | 70% | 30% | 40% | 60% | 20% | 80% | 15% | 85% |
| Priority 2 | Moderate poverty incidence>43% and w/o budget; insufficient fund regardless of poverty incidence | 50% | 50% | 35% | 65% | 25% | 75% | 10% | 90% |
| Priority 3 | Sufficient fund regardless of poverty incidence | 10% | 90% | 10% | 90% | 10% | 90% | 5% | 95% |

a. IUDs shall continue to be provided for free beyond 2008 to health facilities based on actual consumption report.

### B. 2 Allocation to Provincial Government Hospitals

a. Provincial government hospitals (i.e. provincial, district, medicare or community hospitals) are public health facilities owned and managed by the province and shall continue to receive their share of donated and provincially procured contraceptives.

b. The share of provincial government hospitals shall follow the straight or across the board allocation. The percentage reductions to be applied shall follow the DOH phase down schedule.

c. The distribution of free donated and provincially procured contraceptives shall be limited to the truly indigent patients, as determined by the hospitals' medical social worker or existing client classification system.

d. Only indigent patients residing within the hospital's catchment inter-local health zone shall be given free contraceptives. An inter-LGU referral system shall be set-up to ensure FP services to clients outside of the ILHZ:

i. If, despite adoption of strict client classification procedures and the remaining supply of free contraceptives would still be insufficient to meet the requirements of the poor, the provincial government shall cover the shortfall.

ii. To provide and ensure the availability of contraceptive supplies to its non-poor clients, provincial government hospitals shall set-up their own cost-recovery scheme. This scheme shall adopt the hospital's user fee schedule, subject to the provisions of the Provincial Tax Code of 2001, as amended. Collection of fees and fund management shall follow the existing hospital financial systems and procedures.

## C. ON RESOURCE MOBILIZATION

i. Each city and municipality shall allocate in their annual budget appropriations for procurement of their contraceptive requirement. They shall be encouraged to use alternative fund sourcing such as cost-recovery schemes, use of PHILHEALTH capitation and enrolment in the Indigent Program.

2. The province shall appropriate funds to support the commodity shortfall of cities and municipalities. The percentage share of the province shall gradually decline as LGUs assume greater responsibility for providing for their own requirement. The gradual decline shall allow the LGUs with greatest capability to achieve self-sufficiency sooner while giving LGUs with the least capability more time to do.

# III. GENERAL GUIDELINES ON LOGISTICS MANAGEMENT

## *A. ON FORECASTING*

1. The contraceptive requirements of the province during the phase-down has been determined by the DOH based on the 2003 CDLMIS consumption data. The province shall continue to use consumption data in determining the commodity requirement of the public sector.

2. Other modes of forecasting commodity requirement shall also be used. Particularly, the data from the community-based family planning management information system (CBFPMIS) shall be utilized for forecasting future needs of FP clients based on targeted program goals.

3. Contraceptive consumption data shall continue to be collected from the modified PLMIS records & reports (Attachment 5-8). The PLMIS shall be the primary source of data to be used by the province and its component cities and municipalities in preparing their quarterly or annual forecast of their contraceptive requirement.

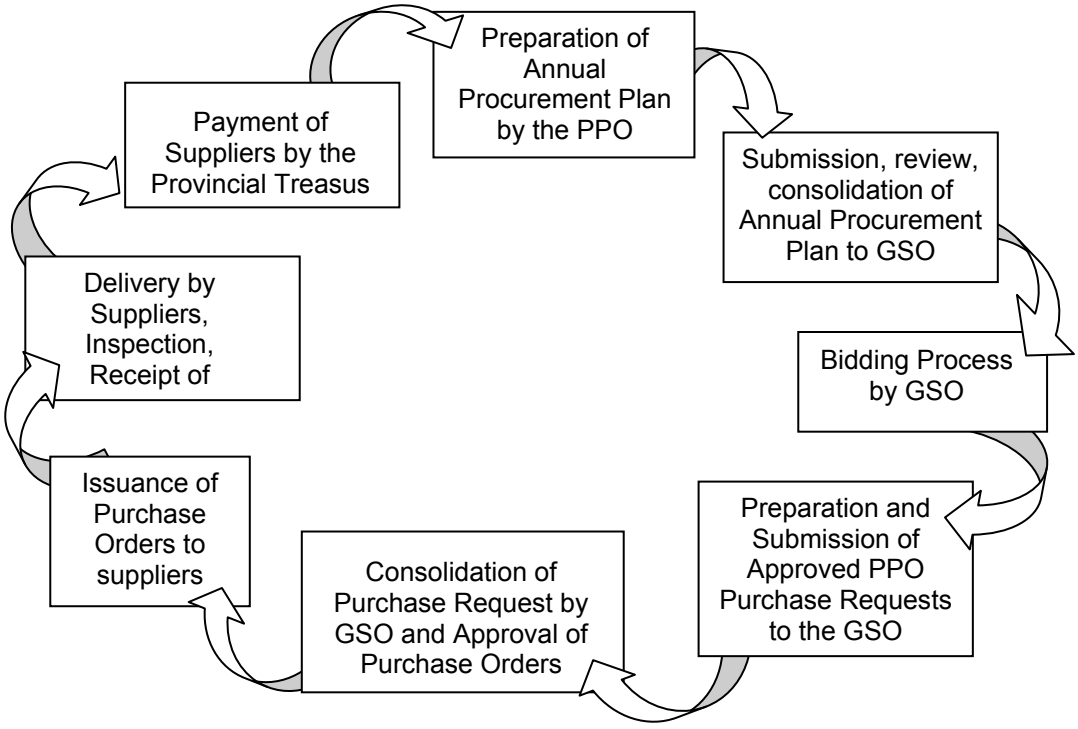
4. The province shall prepare the annual forecast of the total shortfall and determine its share vis-à-vis the component cities and municipalities. It shall provide these LGUs with

information on their requirement by end of June of each year as the local budget period starts in July of every year. Forecasts shall be re-adjusted at mid or end of each year.

## B. ON PROCUREMENT AND WAREHOUSING

1. The province shall follow the cycle of the pooled procurement system for drugs and medicines used by provincial government hospitals in the procurement of contraceptive supplies, shown below:

**POOLED PROCUREMENT CYCLE**




2. The contraceptive procurement shall follow the guidelines and procedures set by the **Republic Act No. 9184,** otherwise known as the **"Government Procurement Reform Act".**

3. The contraceptive supplies as delivered by the suppliers shall be stored in a designated warehouse maintained by the Provincial Population Office.

### TRANSITORY PROVISIONS

The following phases of the logistics management cycle or CSR process shall be considered as part of the transition period. The current systems shall be maintained until such time that the province shall have developed its own local contraceptive delivery system. The present DOH CDLMIS shall be reviewed every six months to determine whether it is able to respond to the LGU needs and situation.

### C. ON INVENTORY CONTROL

1. The province shall maintain at least one month buffer stock.

2. Cities/municipalities and barangays shall adopt recommended minimum-maximum stock level (3 months operating & 1 month buffer) based on their local ordering and procurement schedules.

### D. ON DISTRIBUTION

1. The province shall maintain the existing quarterly delivery schedules of the provincial logistics team to cities and municipalities.

### E. LOGISTICS MANAGEMENT INFORMATION SYSTEM, REPORTING AND RECORDING

1. The province shall continue to use the modified PLMIS for its reporting and recording of logistics data such as consumption, issuances and inventories.

## IV. STRATEGIES TO ENHANCE MUNICIPAL AND CITY GOVERNMENTS' CAPABILITIES TO ACHIEVE CSR

As the quantities of donated contraceptives decrease, the pressure for the municipalities and cities to allocate more resources for local procurement proportionately increases. Local government units with limited resources will have to prioritize the LGU procured contraceptives for the requirements of the poor.

With this prioritization, an estimated 32% of current FP users who get their FP supplies from the public sector may no longer be served by the free contraceptives. However, this un-served demand can be considered as capable of paying for their own supplies as the data from the 2003 Pangasinan Willingness to Pay Study which covered 8 municipalities and 1 city in the PALARIS Inter-Local Health Zone and Urdaneta City showed that 38% of public sector users claim to be actually paying for their contraceptive supplies. In the absence of a province-wide data, this figure is initially used as a baseline for estimating percentages of poor and non-poor clients. The results of the PALARIS socio-economic status survey which will be available in June 2005 will be used by the LGUs to determine the proportion of poor they can serve with their limited resources).

Cities/municipalities and their health facilities are encouraged to undertake the following strategies for FP service provision in order to enhance their contraceptive self-reliance:

a. Institute client classification approaches to segment its market or in the absence of a client classification system, the LGU may use self-

classification by clients and shift clients willing to pay and can pay for their contraceptive to the private sector;

b. Adopt targeting strategies to focus its limited resources to its primary/priority markets;

c. Develop complementary means of financing to enable all current and future users to sustain practice of their FP methods of choice through a variety of options (i.e. Phil-Health capitation or employer benefits, out-of-pocket financing of affordably-priced contraceptive supplies);

d. Encourage the development or expansion of complementary outlet sources of contraceptive supplies (i.e. pharmacies, private health providers, non-government organizations, industrial clinics)

e. All municipalities and cities shall appropriate adequate funds to cover their share of contraceptive requirement during the phase–out period and full cost of their contraceptive requirements after the phase-down period. These LGUs shall be encouraged to use alternative fund sourcing such as cost-recovery and use of PHILHEALTH capitation and Indigent Program enrollment.

## IV. SUPPORT MECHANISMS TO ENHANCE ACCEPTANCE OF CSR STRATEGIES AT THE LOCAL LEVEL

The province, in collaboration with US-AID cooperating agencies and key partners such as the Department of Health, Commission on Population, PHILHEALTH, others, shall assist and support cities and municipalities in strengthening the needed support systems towards the generation of positive response to CSR, specially in the following areas:

1. Advocacy

There shall be continuing advocacy efforts to local chief executives, local officials and policy makers and key stakeholders for institutionalization of funding and policy support.

2. Information, Education and Communication

Key messages and essential information about CSR and its implementation should be provided to stakeholders and the public through community information campaigns and interpersonal communications.

3. Technical Assistance

The technical assistance needs of LGUs and key stakeholders shall be identified and provided to enable them to implement and participate in CSR.

4. Trainings/Capability Building

Training needs of LGUs, partners and key stakeholders shall be defined and provided with appropriate programs.

## V. ROLES AND RESPONSIBILITIES

**The roles and responsibilities of the different provincial, municipal, and city local government offices relative to the contraceptive phase down are as follows:**

### 1. Provincial CSR Management Team (Population Office and Health Office)

a. Manage the distribution of donated contraceptives to the municipalities, cities, and provincial government health facilities;

b. Assist the provincial government in allocating resources for the province's counterpart share to the commodity requirements of the poor in the municipalities and cities;

c. Formulate and initiate campaigns to inform the public, municipalities, and cities of the contraceptive phase down plan;

d. Assist the municipal and city governments formulate their own contraceptive distribution guidelines for their catchment areas;

e. Monitor the FP and CSR strategy implementation in the province;

f. Provide technical assistance in the expansion and improvement of FP services towards eliminating unmet needs;

g. Provide technical assistance in setting up systems (e.g. inter-LGU cooperation, cost-sharing scheme, referral) to improve LGU and public health capabilities to attain full CSR;

h. Conduct a preliminary analysis of the gathered CDLMIS records and reports of the municipalities and cities; Province can develop tools and systems to assess procurement and consumption.

i. Consolidate the data / records (CDLMIS reports) submitted by the municipalities, cities, and public health facilities;

j. Submit a quarterly CDLMIS report to the CHD I and the DOH-PLS; and

k. Monitor the implementation of the CDLMIS and, if necessary, initiate revisions to formulate a Pangasinan Provincial Logistic Management Information System taking into consideration the unique conditions in the province.

l. The CSR PM Team shall maintain the present operations and structures of the provincial CDLMIS team

**2. General Services Office**

m. Prepare bid documents and identify qualified suppliers for the contraceptive requirements of the province; and

n. Procure contraceptives which shall be distributed as the provincial government's counterpart assistance to the municipalities, cities, and provincial health facilities

**3. Municipal / City Health and Population Offices**

o. Provide resources for the procurement and distribution of contraceptives in their catchment areas to ensure the continuous supply of FP commodities to the poor;

p. Undertake measures to guarantee local availability of contraceptives to include any or all of the following:

i. Make available contraceptives for sale at cost recovery basis or at margins above cost;

ii. Allow consigned supplies from social marketing sources or commercial sources to be made available to clients in LGU outlets;

iii. Initiate policies and activities to expand private sector participation in the provision of FP services and commodities to the non-poor;

q. Develop contraceptive distribution guidelines to cover their catchment areas and facilities;

r. Continue with the quarterly ordering and inventory of the contraceptive stocks at the municipal and city level; and

s. Maintain the modified CDLMIS records, now known as the Pangasinan Logistics Management Information System, attached as PART II.

## VI. Coordination and Implementation Arrangements

### A. Managing contraceptive supply between DOH and the province

a. That the province shall comply to the pertinent provisions of DOH AO 158 section VIII items A 1-5

**B. Managing contraceptive supplies between the province and the city/municipalities**

1. The province shall distribute the donated commodities and its counterpart to the shortfall to public health facilities and NGOs in that particular city/municipality.

2. The province shall require all component cities, municipalities, NGOs and private facilities availing of the free commodities to continue to maintain logistics and service delivery records.

3. NGOs or private facilities availing of free commodities from DOH and province shall be allowed charging of minimal service fees.

**RECOMMENDING APPROVAL:**

**FOR THE :**

**PROVINCIAL HEALTH OFFICE**

**EDWIN T. MURILLO, MD.**
**Provincial Health Officer**

**FOR THE:**

**PROVINCIAL POPULATION OFFICE**

**LUZVIMINDA N. MUEGO**
**Provincial Population Officer**

**APPROVED :**

**VICTOR E. AGBAYANI**
**GOVERNOR**

Provincial Contraceptives Logistics Management Information System

PANGASINAN PROVINCE

This guideline is intended to guide the province in the management of the logistics processes in the context of the eventual phase-out of donated FP commodities and in the context of utilizing combined resources of various local stakeholders.

Pangasinan is currently using the DOH Contraceptive Distribution and Logistics Management Information System (CDLMIS) as its tool for local distribution and logistics system for management of its contraceptive supplies. Presently, the CDLMIS responds to the needs of the province for efficient distribution and information management. ***(However, DOH encourages the adoption or modification of the system to function within the framework of the phase-out period and the LGU's future needs).***

After the commodity phase-out in 2007, the province and its component LGUs will assume full responsibility for logistics management and in ensuring continued availability of contraceptives for current and potential users. Towards this end, an assessment was done on the logistics components and operations of the CDLMIS in the areas of: 1) forecasting, 2) procurement, 3) distribution, 4) inventory control, 5) storage, and 6) logistics information system.

In this context, the province shall continue with the current Contraceptive Delivery and Logistics Management Information System (CDLMIS) with modifications to fit the LGU need during the transition period.

The current modified system shall be evaluated and may be further modified as the situation warrants.

ROLES & RESPONSIBILITIES OF MAJOR STAKEHOLDERS UNDER THE CONTRACEPTIVES LOGISTICS MANAGEMENT INFORMATION SYSTEM

**1. Provincial CDLMIS Team**

**i. Provincial Health Office**

1. Serves as the overall provincial delivery team leader
2. Supervises the timely & accurate distribution of commodities
3. Maintains storage & inventory control over the donated contraceptives
4. Undertakes joint forecasting, review and determination of provincial counterpart, and formulates recommendations
5. Serves as technical resource in the development of distribution guidelines
6. Conducts periodic monitoring & evaluation of local distribution system
7. Supervises collection and accomplishment of CDLMIS reports
8. Transmit reports to PPO LMIS Unit, CHD 1 and DOH
9. Undertakes review and formulate recommendations to maintain and improve Provincial Contraceptive Logistics Management Information System after the phase-out.

**ii. PPO**

1. Provides resource mobilization support to the provincial delivery team, i.e. shares area coverage, reproduction of CDLMIS forms
2. Maintains storage and inventory control over locally procured contraceptives
3. Consolidates overall inventory control for both the PHO & PPO warehouse/stockroom
4. Undertake joint forecasting, review and determination of provincial counterpart;
5. Generates consumption-based and/or population-based data as documents for forecasting;
6. Process ordering/re-ordering documents for provincial level procurement;
7. Forwards processed documents to GSO for procurement procedures.
8. Provides technical support to PHO in the evaluation of local system
9. Maintains the LMIS Unit for the province (refer to PPO LMIS Unit functions)
10. Organizes periodic review of the system by TWG
11. Undertakes review and formulate recommendations to maintain or improve PCLMIS after phase-out.

**2. General Services Office[1]**

a. Prepare bid documents and identify qualified suppliers to the contraceptive requirements of the province; and
b. Procure contraceptives which will be distributed as the provincial government's counterpart assistance to the municipalities, cities, and provincial health facilities

**3. Municipal / City Health and Population Offices[1]**

a. Provide resources for the procurement and delivery of contraceptives in their catchment areas to ensure the continuous supply of FP commodities to the poor;
b. Undertake measures to guarantee local availability of contraceptives to include any or all of the following:
   i. Make available contraceptives for sale at cost recovery basis or at margins above cost;
   ii. Allow consigned supplies from social marketing sources or commercial sources to be made available to clients in LGU outlets;
   iii. Initiate policies and activities to expand private sector participation in the provision of FP services and commodities to the non-poor;
c. Develop contraceptive distribution guidelines to cover their catchment areas and facilities;
d. Continue with the quarterly distribution and inventory of the contraceptive stocks at the municipal and city level; and
e. Maintain /accomplish quarterly CDLMIS records to the provincial CSR TWG (DT)

*[1] taken out of the TWG roles & responsibilities as defined under Section V items 1-3 of the Pangasinan Logistics Management Guidelines*

## LOGISTICS MANAGEMENT INFORMATION SYSTEM

### I. FORECASTING

The province, cities and municipalities may opt to use one or a combination of various indicators available at the locality in coming up with a forecast on requirements, i.e. consumption-based indicators, population –based indicators and program goals.

Consumption-based Forecast

1. PPO LMIS Unit generates 2 to3 -year period consumption-based reports;
2. Computes for annual forecast using prescribed computation

Population-based

1. PPO maintains and processes the CBFPMIS to generate data on MWRA coverage, CPR and method mix;
2. Computes for corresponding commodity requirement by multiplying method mix with estimated CYP.

Program Goals

1. PPO & PHO identifies program goals & targets in the context of increasing CPR and reducing unmet need;
2. Determines quantifiable indicators for increasing CPR & reducing unmet need to targeted level;
3. Computes for corresponding commodity requirement by multiplying method mix with estimated CYP.

Integrating multiple indicators

1. Compare multiple indicators and decide on necessary adjustments to integrate consumption – based, population-based and program goals into the forecast

Data sources:

| | |
|---|---|
| Contraceptive Order Form | BHS Worksheet |
| LPMP Plan | |
| Community-Based FP MIS | Dispense to User Record (DTUR) |

*A fix and reduced allocation of donated commodities had been pre-determined using the consumption-based data. On the other hand, the LGU may opt to employ favored orecasting method during the transition and apply the adjustments in the LGU share.*

## II. Contraceptive Ordering & Procurement System

While the province continually receives a gradually reduced donated commodity until 2007, it shall procure portion of the predetermined quantity of shortage based on the straight across the board allocation by DOH.

1. Donated Contraceptives

    a. DOH delivers pre-determined allocation to the province based on phase-down schedule.

    b. Province delivers pre-determined allocation to LGUs, NGO Clinics and to the provincial-owned hospitals.

2. Locally Procured Contraceptives

    *PROVINCE*

    The procurement of contraceptives shall follow the provincial pharmaceutical pooled procurement system.

    a. Ordering

        i. Preparation of Purchase Request (PR) based on

            1. Inventory

            2. Safety stock (buffer)

        ii. Purchase Request is submitted to General Services Office (GSO) for PR number. For fund control, PR goes to:

            1. Office of the Governor

            2. Budget Office, as to appropriation

            3. Accounting Office, as to fund allocation

        iii. PR goes to GSO for preparation of Purchase Order (P.O.)

            1. if bidded GSO prepares abstract

            2. if not, GSO prepares P.O.

        iv. Supplier picks-up P.O.

        v. Supplier delivers to Provincial Population Office

vi. PPO receives delivery

1. GSO inspection team inspects the commodities
2. PPO checks delivery receipts as to quantity and specification
3. PPO prepares voucher
4. Finance section for processing of payment
5. Supplier gets paid by the Provincial Treasurer

*CITY/MUNICIPALITY*

b. Ordering & Re-ordering

i. RHU Nurse refers to sharing scheme and phase down schedule to determine City/municipal share.
ii. Processes ordering/re-ordering documents
    1. Purchase Requests
iii. Forward to MHO the ordering document for his/her approval.
iv. MHO/CHO forwards processed documents to Municipal *General Services Officer or Supply Officer as the case maybe.*
    1. LGU requests for bidding
    2. Awards winning bidder
v. Receipt & endorsement of commodities
    1. RHU Nurse receives & inspects delivered commodities from supplier and safe-keep the delivered commodities

## III. Distribution

I. Inter-LGU Distribution & Allocation

Two alternative scheme for determining distribution shall be applied depending on the current level (scenario 1 & 2) of LGU counterpart. This shall minimize the incidence of stockouts at the dispensing facility at least until the last quarter, thus provide a lead time of more or less one month.

Buffer stock

If province can maintain a buffer stock of at least one month in addition to the annual allocation/share, the province can maintain an Authorized Stock Level (ASL) of more than 3 months every quarter at the facility. The computation of ASL shall be proportionate to the province's commodity share (10% -50%-70%) only.

Delivery run shall be done quarterly (every 3 months) except for special facilities which are done semi-annually or annually.

a. Prior to delivery schedule
    i. PHO/PPO prepares communication to RHUs for the schedule of delivery.
    ii. PHO/PPO Delivery Team (DT) estimates the contraceptives to be delivered based on the sharing scheme and phase-down schedule;
    iii. DT withdraws contraceptives from the PHO (donated) and PPO (local)*;*
    iv. DT delivers to facilities.
b. During Delivery
    i. DT conducts physical inventory in the presence of the PHN/supply custodian at the LGU facilities;
    ii. DT fills-up the COF and RIS and leave one copy to each of the facility. (Please see attached ____ for the form)
    iii. DT delivers required stock and/or removes excess stock from facility.
c. After Delivery (at the provincial warehouse)
    i. DT returns undelivered stocks to provincial warehouse & conducts inventory at provincial warehouse with supply officer;
    ii. DT fills-up the Inventory Form;
    iii. DT forwards accomplished COFs, RIVs and Inventory Forms to PPO MIS unit within 5 days after the last day of delivery; sends copy to CHD and DOH Central Office.

II. RHU to BHS

The Public Health Nurse (PHN) shall issue contraceptives to BHS Midwives every month [or every 3 months in special cases].

a. Prior to designated ordering date
    i. Conducts monthly inventory of donated & locally-procured commodities at the RHU level.
    ii. PHN identifies pre-determined ASL/requirements for each BHSs based on phase-down schedule and/or on the preferred LGU ASL.
b. During Issuance
    i. PHN reviews the midwives' BHS Contraceptive Order Worksheet data for accuracy;
    ii. PHN validates midwives' dispensed to user record;
    iii. PHN completes the BHS Contraceptive Order Worksheets columns 7-8;
    iv. PHN issues contraceptives to midwives and request midwife to sign in the BHS worksheet.

*The system shall take into consideration medical opinion on the mix use of two different brand of pills and injectables. Medical advice against mix use shall considerably affect the procedure for dispensing and tracking of client use per product type.*

III. BHS to Community Volunteer (BSPO/BHW)

a. Prior to issuance

i. Conducts monthly inventory of donated & locally-procured commodities;
*ii.* Midwife identifies resupply requirements for each volunteer based on *masterlist.(CBFPMIS)*

b. During Issuance

v. Midwife reviews the volunteer's DTUR for accuracy;
vi. Midwife issues contraceptives to volunteer.

PPO Logistics MIS

The PPO through its MIS unit shall maintain a computerized based system to monitor the status and stock level of contraceptives in every facilities.

Function of the PPO Logistics MIS Unit:

1. Monitors consumption and/or non-distribution of contraceptives;
2. Checks and counterchecks all stocks distributed and irregular consumptions of commodities;
3. Consolidates gathered data and generates various reports essential to the Logistics System.

Procedures

1. Receipt of delivery documents
    a. PHO sends copy of COF, RIS and Inventory Forms to CHD 1 and DOH;
    b. PHO forwards of COF, RIS and Inventory Forms to PPO MIS Unit.

2. Masterlisting Procedure
    a. Sorting and/or coding of COFs by facility, LGU and Inter-Local Health Zone, by commodity and by quarter;
    b. Check for completeness of the documents containing the COFs, RIVs and Inventory Form;
    c. Send feedback notes to DT Leader about incomplete and erroneous documents.

3. Data Entry/Updates
    a. Enter the data from COFs and RIVs using MS Excel or MS Access;
    b. Editing/proofreading/validation for **data errors** and/or **deleting** of facilities with irreconcilable data.
4. Data Processing
    a. Generate report essential in the monitoring and analysis of consumptions, status and stock level of contraceptives;
    b. Print Summary Report [matrix form and feedback narrative].

DATA SOURCES

| Form | Description | Sources |
|---|---|---|
| Inventory Form | One-page summary of commodity receipts from supplier/DOH, withdrawals & deliveries by DT | PHO/PPO Warehouse |
| Contraceptive Order Form | A form used to determine status, types and quantity commodities required | Delivery Team, Facility (Supply Custodian) |
| Requisition & Issue Slip | Acknowledgement receipt indicating the type and quantity of commodity issued | Delivery Team, Facility (Supply Custodian) |

**INVENTORY CONTROL**

The old system use an Authorized Stock Level (ASL) to maintain adequate supply at the province, city/municipality, and barangay levels. The ASL for each level would depend on the capacity of the province of city/municipality to finance the corresponding counterpart.

Maximum and Minimum ASL by Level

| Level | Maximum ASL | Minimum ASL |
|---|---|---|
| Province | 4 | 1 |
| City/Municipality | 4 | 1 |
| BHS | 2 | 1 |

**STORAGE OR WAREHOUSING**

Utilizing one inventory control (?) or warehouse management control for the province, two provincial storage facilities will be maintained separating the donated from the locally procured commodities due to the limitation in the present space. The PHO will serve as the consignee and maintain storage of the donated supplies. Whereas, the PPO shall maintain a stockroom for the locally procured commodities.

**Proper Storage of Contraceptives**

Province

1. *Keep warehouse clean and pest free*. Do not keep food or drinks near or inside shelves and cabinets. This is one of the best ways to keep pests and insects away.

   Disinfects and spray storage areas regularly. Rodents and some insects such as termites and roaches love to eat contraceptives and their packaging. Some pesticides are effective against termites, roaches and rodents.

2. *Maintain the roof, flooring and walls.* Water destroys the contraceptives and their packing. If the packaging is damaged or dirty, this makes the contraceptives unacceptable to the client even if the product is undamaged.

3. *Use platforms or pallets*. A preventive measure to avoid water penetration is to stack the contraceptive cartons on platforms or pallets which are at least 4 inches off the floor. Position pallets away from walls and far enough apart to promote air circulation and facilitate movement of stock, cleaning, inspection and doing inventory of stocks. Air circulation and facilitate movement of stock, cleaning, inspection and doing inventory of stocks.

4. *Provide adequate lighting*. Dark areas are good habitat for pests.

5. *Store supplies away from direct sunlight.* Direct exposure to sunlight can reduce the shelf life of contraceptives. Ultraviolet light from the sun can damage latex products like condoms and gloves. As much as possible, store the contraceptives in their original shipping cartons (big, brown and thick) or boxes (the smaller white box usually contains 100s) which are specially coated to protect the product.

6. *Store open cartons of condoms and rubber gloves away from electric motors and fluorescent lamps*. Ozone, which is a chemical created in the air when fluorescent lamps and electric motors operate, can seriously damage latex products like condoms and gloves.

7. *Store hazardous chemicals like insecticides away from contraceptive supplies*.

8. *Stack contraceptive cartons at least 4 inches, or 10 cms., off the floor; at least 1 foot (0.3m) away from the wall.* This will allow air to circulate and protect the contraceptives from being damaged due to water or other environmental conditions.

9. *Stack cartons of contraceptives not more than 8 ft. high* to avoid crushing the cartons at the bottom of a stack. Besides, the stocks might fall and injure the warehouse staff.

10. *Stack cartons in such a way that expiry dates are always visible.* Rewrite in large numbers the expiration dates if the original markings are in small print or are difficult to read.

11. *Distribute contraceptives stocks based on the "first expiry first out" principle.* It may happen that contraceptive supplies recently delivered may be older than the existing stock at the warehouse.

12. *Dispose of the expired and damaged contraceptives* following the commission on Audit (COA) rules and regulations on proper disposal of waste materials.

13. *Secure warehouse from flammable substances and from fire hazards.* Fire accidents happen anytime. A fire extinguisher should be procured and installed in a strategic location in the warehouse for easy retrieval and use in case of fire.

14. *Secure the warehouse from theft.* Only authorized personnel should be allowed to have access into the warehouse. It is important to have an alternate staff designated to whom the key to the storeroom or warehouse may be entrusted whenever the person in-charge is out of the office or leave.

15. *Maintain accurate and up-to-date stock cards and other records.*

RHUs, NGOs and Hospital

1. *Clean and disinfect the storage area regularly*
2. *Provide adequate lighting and ventilation.* Dark areas are good habitat for insects and pests. The shelf life of contraceptives is reduced if the storage is hot or moist.
3. *Store contraceptives away from direct sunlight and fluorescent lights and electric motors.*
4. *Keep the contraceptives in their original boxes which has a protective coating*
5. *Stack cartons at least four inches off the floor and at least one foot away from the outer wall* to allow some air to circulate freely and to protect the contraceptives from being damaged due to water and other environmental conditions.
6. *Write the expiration dates on the outside of the cartons and boxes* and arrange the cartons in such a way that supplies which will expire first are used first (FEFO: First Expiry First out)
7. *Secure storage areas from thieves and curious adults and children.* Use locks and limit entry or access to the storeroom or cabinets to authorize personnel only.
8. *Separate and return expired and damaged contraceptives to the delivery team.*
9. *Store all supplies of oral contraceptives, IUDs, condoms and injectables together in one place to make it easy for the delivery team to count the stocks*.

Barangay Health Station

The contraceptives the midwives get from the RHU are packed in white boxes which can be easily placed inside cabinets or shelves. The midwives are given the following reminders on storing contraceptives.

1. *Keep contraceptives away from direct sunlight, fluorescent lights and electric motors.* Ultraviolet light from the sun and ozone, a chemical created in the air when fluorescent lamps and electric motors operate, can damage latex products like condoms.
2. *Keep the storage area dry, clean and pest-free.* Termites and roaches eat oral contraceptives as well as the cartons and inner packaging.
3. *Make sure that the storage area is well-ventilated*. Condoms should be stored in areas where temperature is not more than 40 degrees centigrade for DMPA.
4. *Provide the storage area with adequate lighting.* Dark places are good habitat for insects and pests.
5. *Secure the storage area from curious children and adults and thieves.*
6. *Keep contraceptives in their original boxes which have a special protective coating.*
7. *Write the expiration date of the contraceptives on the outlet surface of the box.*
8. *Distribute the contraceptives according to expiry date- first expiry, first out (FEFO).* Note that new deliveries of contraceptives may have an earlier expiry date than your unit's existing stock.
9. *Remove expired, spoiled, or damaged contraceptives and return these to the RHU.*

**ROLES & RESPONSIBILITIES OF RHU/HOSPITAL/NGO STAFF & COMMUNITY VOLUNTEERS AT THE CITY/MUNICIPAL LEVEL**

MHO/CHO

a. Review record of contraceptive inventories prepared by the PHN.
b. Approve ordering documents for locally procured contraceptives.
c. Transmit ordering documents to the Municipal Supply Officer or General Services Officer

RHU Nurse

a. Serves as custodian for donated and locally procured contraceptives;
b. Ensures that all midwives order contraceptives every month at specified dates;
c. Reviews the midwives' BHS Contraceptive Order Worksheet data for accuracy;
d. Validates midwives' dispensed to user record;
e. Completes the BHS Contraceptive Order Worksheets columns 6-7;
f. Issues contraceptives to midwives;
g. Follows good storage practices;
h. Conducts regular inventory of supplies;
i. Prepares ordering a re-ordering documents for locally procured contraceptives.

MPO

The role of the Municipal Population Officer (MPO) id dependent on the Local Government Unit Contraceptive Self Reliant set-up.

BHS Midwife

a. Completes dispensed to user/volunteer record (DTUR);
b. Ensures that volunteers doing resupply order every month at specified dates;
c. Validates/crosschecks volunteers' dispensed to user record with masterlist.;
d. Counts stock on hand each month;
e. Completes column 1-5 on their BHS worksheet monthly;
f. Brings the completed BHS worksheet and DTUR to the RHU monthly;
g. Copies the data from their completed BHS worksheet onto the copy kept at the RHU;
h. Acknowledges receipt of contraceptives by signing (col. 8) in the RHU copy of the BHS worksheet.

Community Volunteer (BSPO/BHW)

a. Completes dispensed to user record (DTUR) for re-supply of pills and supply & re-supply of condoms;
b. Brings the completed DTUR to the BHS Midwife;
c. Acknowledges receipt of contraceptives by signing in the BHS Midwife's DTUR.

Hospital

NGO Clinic Staff

a. Completes dispensed to user/volunteer record (DTUR);
b. Counts stock on hand each month.

For more information, please visit www.deliver.jsi.com.

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