Appendix A
CURRENT THRUSTS OF THE NATIONAL FAMILY PLANNING PROGRAM

This section describes the current family planning (FP) program implemented by the Department of Health (DOH). It focuses on meeting the unmet FP needs of women of reproductive age, especially those in the National Household Targeting System for Poverty Reduction (NHTS-PR). It also summarizes the implementing rules and regulations of the newly approved Responsible Parenthood and Reproductive Health (RPRH) Act of 2012.

Situation

The Philippines has substantially reduced the mortality rate of under-five children from 54 per 1,000 live births in 1993 to 30 in 2011 (Family Health Survey [FHS]) as well as infant mortality from 34 to 22. However, the 2013 survey of the NDHS showed that the under-five and infant mortality rates have increased again (Figure 1).

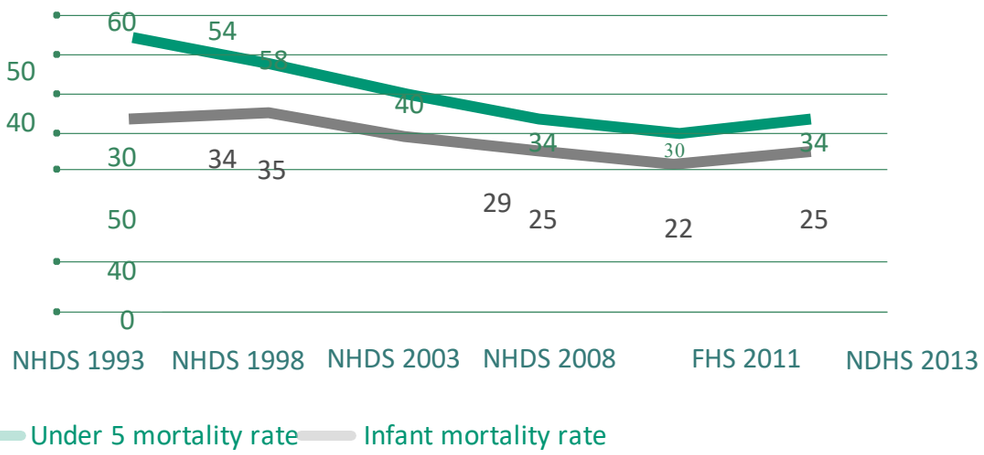

Figure 1. Infant and under-five mortality rates per 1,000 live births.
Source: NDHS and FHS, Philippines, 1993-2013.

The FHS survey showed that the maternal mortality rate decreased from 213 per 100,000 live births in 1988 to 162 in 2008 but sharply increased in 2011 (221 per 100,000 live births) (Figure 2). Despite the increased availability of antenatal care, facility-based delivery, and skilled birth attendance, traditional birth attendants continue to be preferred in poor regions (FHS, 2011).

Figure 2. Maternal mortality ratio.

Source: NDHS and FHS, Philippines, 1988-2011.

The Philippine population stood at 96 million in 2012 and is expected to grow by more than 30 percent by 2025 (120.2 million). The total fertility rate (TFR) in the country remains at 3.1 children per woman (2011), which is considerably higher than the desired fertility rate of 2.5 children per woman. The 2013 NDHS showed a slight decrease in the TFR of 3.0 children per woman (Figure 3).

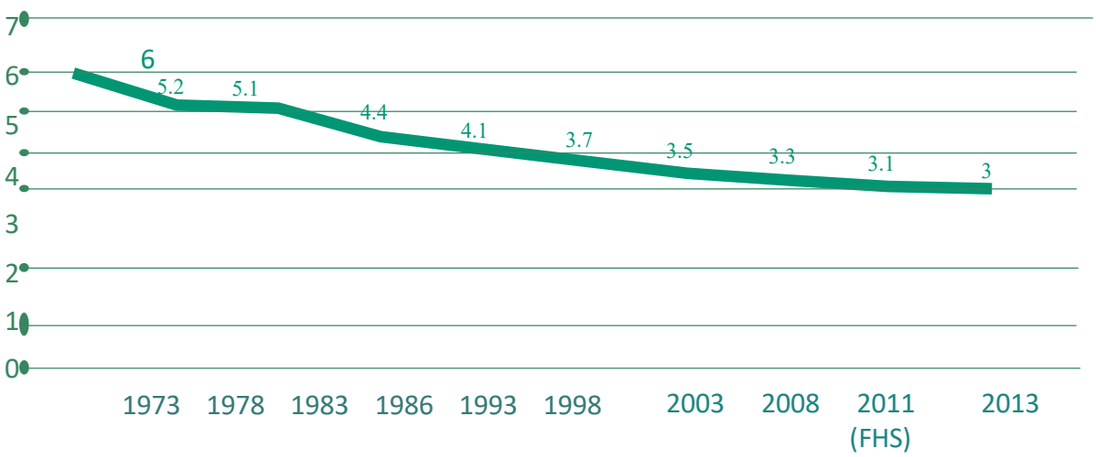

Figure 3. Total fertility rate.

Source: NDS, RFPS, CPS, FHS and NDHS, Philippines, 1973-2013.

The contraceptive prevalence rate gradually increased from 15.4 percent (1968) to 56 percent (NDHS, 2013) in 45 years (Figure 4).

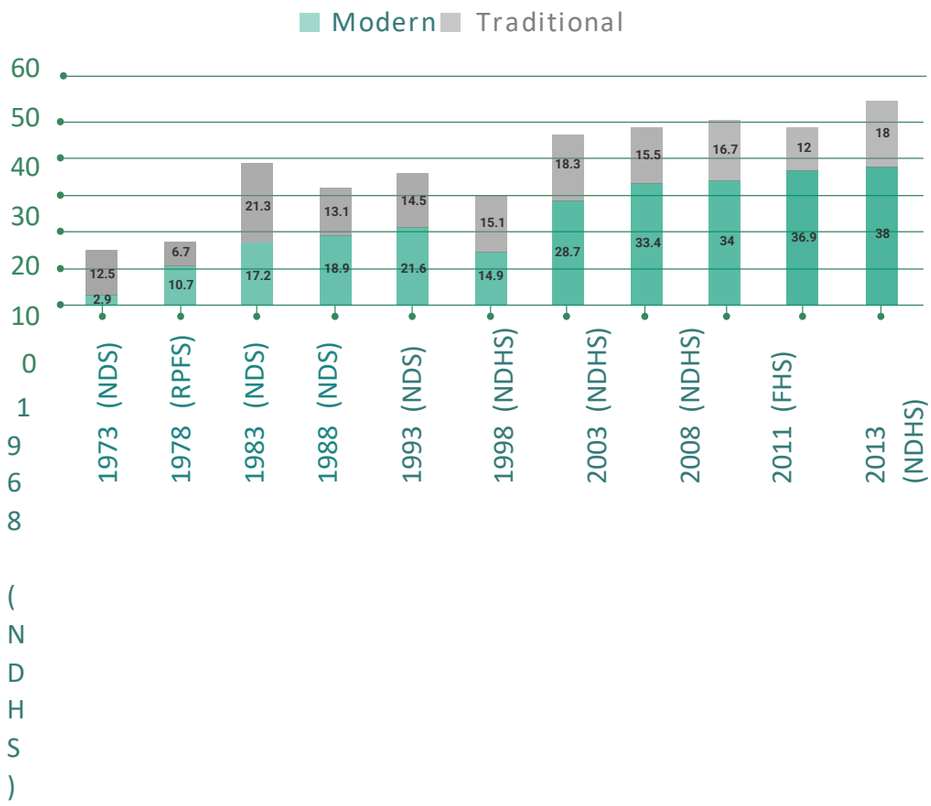

Figure 4. Contraceptive prevalence rate.

Source: NDS, RPFS, FHS and NDHS, Philippines, 1968-2013.

In 2011, the contraceptive prevalence rate (CPR) was 48.9 percent; however, this value significantly varied from one region to another. The 2011 FHS data recorded ARMM as the region with the lowest CPR and Davao as the region with the most number of FP users (Figure 5). The unmet FP needs also slightly declined from 26.2 percent in 1993 to 19.3 percent in 2011 (Figure 6). However, the unmet FP needs increased from 2003 to 2011 by 2 percent.

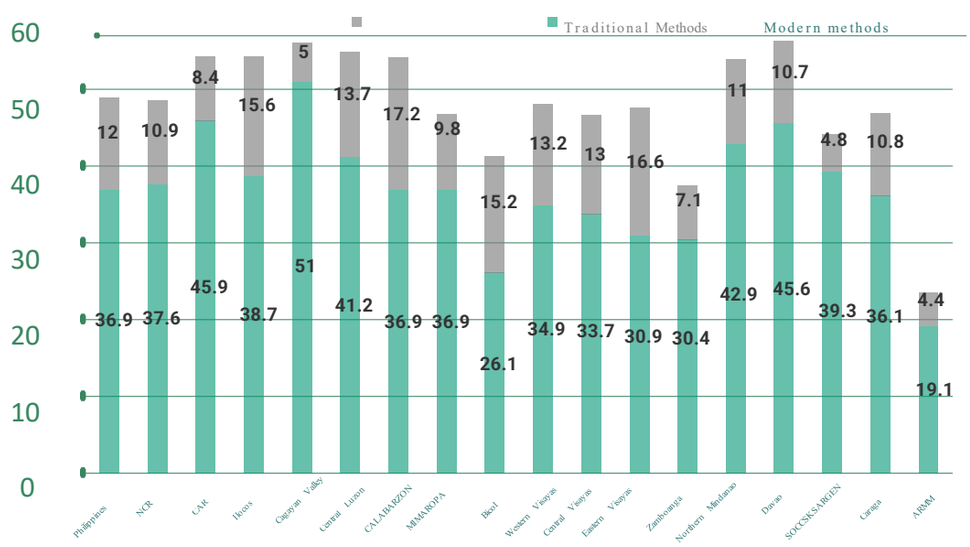

Figure 5. Contraceptive prevalence rate by region.

Source: FHS, Philippines, 2011.

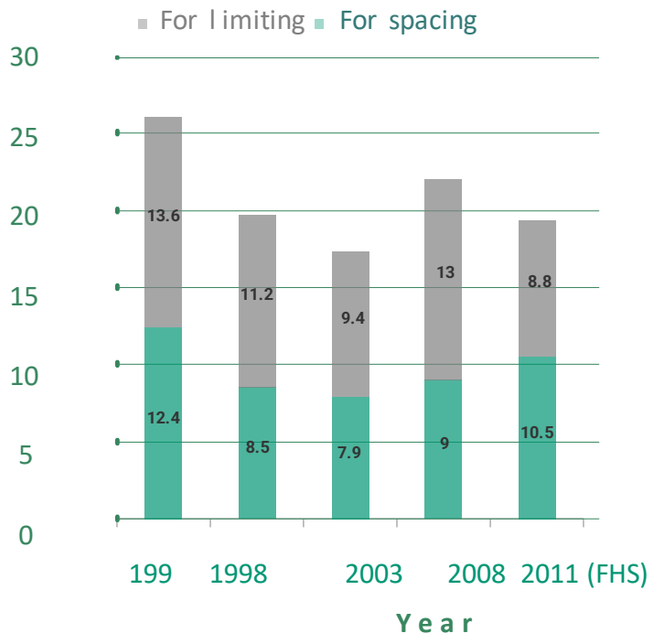

Figure 6. Unmet family planning needs.

Source: NDHS and FHS, Philippines, 1993-2011.

In 2011, the unmet FP needs was 19.3 percent, of which 10.5 percent wanted to space and the other 8.8 percent wanted to limit. These data varied across regions, with ARMM and Zamboanga showing the two highest unmet FP needs (Figure 7).

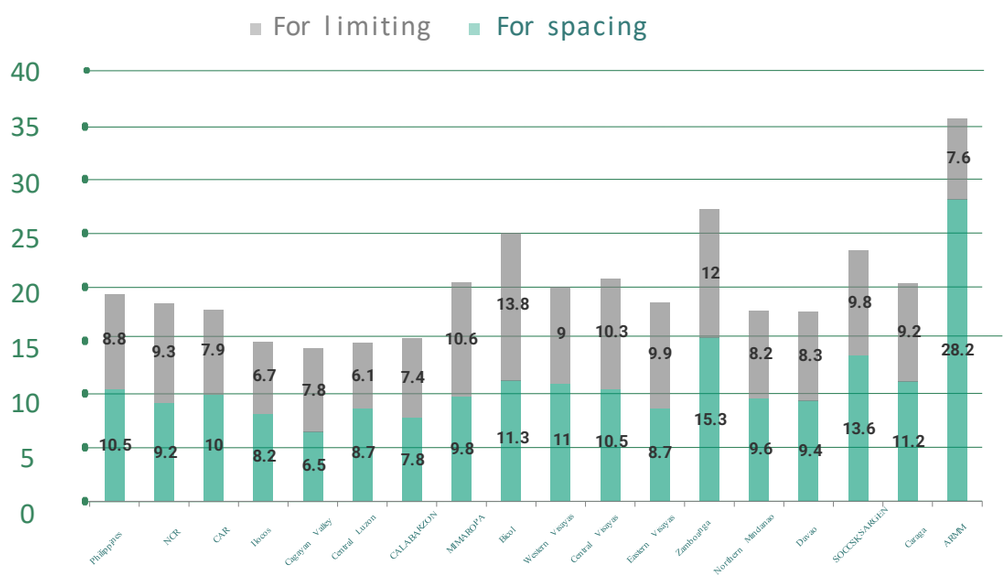

Figure 7. FP unmet needs by region.

Source: FHS, Philippines, 2011.

Philippine FP Program

The Philippine FP Program aims to promote the overall health of all Filipinos by preventing high-risk pregnancies, reducing maternal deaths, and responding to the unmet needs of women. In 2008, the Maternal, Neonatal, and Child Health Nutrition (MNCHN) strategy was established through AO 29 s. 2008. Its goal is to rapidly address the needs of women and reduce maternal and child mortality rates at the local and national levels.

In 2010, the Aquino administration through the Aquino Health Agenda launched Kalusugan Pangkalahatan (KP). Its objectives are to achieve universal healthcare focused on health reform implementation and to ensure that the poorest of the poor receives its benefits.

Vision, Mission, Goal, and Objectives

The National Objectives for Health (NOH) for 2011 to 2016 specifies a clear and concrete way of achieving the targets set in the MDGs. In consonance with the NOH, the FP Program aims to reduce the following:

- Infant deaths from 25 per 1,000 live births (2008) to 17 per 1,000 live births (2016)
- Neonatal mortality from 16 per 1,000 live births (2008) to 10 per 1,000 live births (2016)
- Under-five deaths from 34 per 1,000 live births (2008) to 25.5 per 1,000 live births (2016)
- Maternal mortality ratio from 163 per 100,000 live births (2010) to 50 per 100,000 live births (2016)

Vision

To empower women and men to live healthy, productive, and fulfilling lives with the right to achieve their desired family size through quality, medically sound, and legally permissible FP methods.

Mission

The DOH, in partnership with local government units (LGUs), non-government organizations (NGOs), private sector, and communities, shall ensure the availability of FP information and services to men and women who need them.

Goal

To provide universal access to FP information and services whenever and wherever needed.

Objectives

1. The FP Program addresses the need to help couples and individuals achieve their desired family size within the context of responsible parenthood and improve their reproductive health to attain sustainable development.
2. This program aims to ensure the availability of quality FP services in DOH- retained hospitals, LGU-managed health facilities, NGOs, and the private sector.

Benchmarks

The progress of the FP Program is measured based on the benchmarks listed in Table 1

Table 1. Benchmarks for measuring the adoption of family planning practices, 2011–2016

Benchmark	From 2011	To 2016
Reduced population growth rate (%)	2.12	1.9
Reduced total fertility rate (No. of children that a woman could have during her reproductive period)	3.1	2.1
Increased contraceptive prevalence rate (%)	48.9	6.5
Increased use of modern FP (%)	36.9	60.0
Reduced unmet FP needs (%)	19.3	8.6

Source: NOH, DOH, 2011–2016

Family Planning Guiding Principles

The design, management, and implementation of the FP Program abide with the following principles, which are referred to as the Four Pillars of the FP Program:

Responsible Parenthood: It is the will and ability to respond to the needs and aspirations of the family. It promotes the freedom of responsible parents to decide on the timing and size of their families in pursuit of a better life.

Respect for Life: The 1987 Constitution protects the life of the unborn from the moment of conception. Abortion is not a method of FP. Pursuant to this principle, the current administration endorses the term "reproductive health" on the condition that it explicitly excludes abortion.

Birth Spacing: Proper spacing of three to five years from recent pregnancy enables women to recover from pregnancy and to improve their well-being, the health of the child, and husband–wife and parent–children relationships.

Informed Choice: Couples and individuals may choose the methods that they will use to exercise responsible parenthood in accordance with their religious and ethical values and cultural background and subject to conformity with universally recognized international human rights.

Program Components

Under the devolved setup, LGUs are primarily responsible for implementing the program components. The DOH continues to provide policy directions and technical guidelines, set standards, conduct monitoring and evaluation, and perform regulatory functions.

The FP Program has seven components:

1. ***Service Delivery***

   Quality FP information and services will be made available and accessible to all clients by

   - Making the FP Method Mix available in appropriate health service facilities in both public and private sectors: pills, condom, injectables, intrauterine devices, subdermal implants, NFP, lactational amenorrhea method, voluntary surgical contraception services (i.e., bilateral tubal ligation thru minilaparotomy under local anesthesia and vasectomy), and Standard Days Method;
   - Ensuring client access and utilization of FP services in the service delivery network
   - Establishing a referral mechanism;
   - Providing FP services through trained and accredited service providers;
   - Recruiting and mobilizing trained FP volunteer health workers/ community health teams (CHTs) to support FP home service delivery with proper and regular supervision and monitoring by LGU health personnel;
   - Organizing and deploying itinerant teams; and
   - Developing the capacity of hospitals to provide LAPM and all other services for FP.

2. ***Training***

   Delivery of quality FP information and services is possible only through competent service providers. Competency-based training is the main vehicle for developing the skills of service providers:

   - Training of all categories of FP service providers (doctors, nurses, and midwives) in both public and private sectors on relevant courses using DOH-prescribed/accredited curricula to ensure and maintain the quality of FP service provision;

- Conduct of training only by accredited training institutions with certified and competent training staff;
- Attendance of trained FP service providers in refresher courses at least every five years for updates on recent, evidence-based developments and trends; and
- Follow-up and evaluation of trained service providers by the responsible regional office/NGO/LGU trainers after three to six months.

3. ***Logistics Management***

The delivery of quality FP services is centered on the continuous and sufficient supply of FP commodities in health facilities. It also requires the installation and maintenance of equipment. This goal can be realized through the following:

- Procurement and allocation of commodities at the national level and direct delivery/ distribution to public health facilities (e.g., rural health units [RHUs] and hospitals) based on reports on consumption
- Use of available contraceptive distribution logistics management information system in terms of storage, distribution, inventory control, authorized stock level, recording, and reporting using the appropriate modified forms
- Local forecasting of contraceptive requirements and procurement
- Installation of equipment with regular inventory and maintenance

4. ***Health Promotion and Advocacy***

Information, education, and communication (IEC) are important to generate demands for FP services. Current program thrusts highlight the roles of CHTs and other community-based health volunteers to reach out and provide key messages and adequate information on where to access available services for priority population groups (e.g., NHTS-PR poor households).

Strong advocacy is essential in mobilizing the commitment and support of stakeholders at various levels of administration. Advocacy and IEC need to be intensified by

- Developing a local health promotion plan, particularly on FP;
- Adopting/translating and reproducing prototype IEC materials on FP;
- Institutionalizing local campaigns or similar local endeavors as part of the annual FP Month Celebration and other health events;
- Orienting/educating and counseling women and men of reproductive age on FP (individually or in groups) in appropriate settings (e.g., clinic- based, community-based, and hospital-based);
- Community organization and social mobilization for FP;
- Organizing and deploying CHTs to reach out and identify household members with unmet modern FP needs;
- Networking with various groups of stakeholders at the national, regional, and local levels and with international entities;
- Empowering local officials to ensure the availability and sustainability of FP commodities and other requirements for FP service delivery;
- Creating an enabling environment supportive to FP (i.e., ordinances and resolutions); and
- Monitoring and evaluating IEC and advocacy-related activities on FP.

5. *Monitoring and Evaluation*

Delivery of quality FP information services largely depends on the results of regular monitoring and evaluation by

- Developing a monitoring and evaluation plan to monitor the quality of FP services and to keep track of the progress of FP-related initiatives;
- Allocating funds for regular monitoring and evaluation at various levels of operations;
- Regularly conducting consultative meetings to review and assess program accomplishments at inter- and intra-levels of administration;
- Establishing a feedback mechanism for monitoring and evaluating results for appropriate and immediate action by concerned agencies and authorities; and
- Documenting and disseminating good practices.

6. ***Research and Development***

Evidence-based policies, standards, and guidelines are powerful tools that increase the use of quality FP services. Evidence-based IEC and advocacy materials are effective in improving the acceptance of the FP program and in generating support from stakeholders.

- Development of capacities of national- and local-level entities on research and development
- Establishment of collaborative linkages with the academe and research institutions
- Allocation of resources for research and development

7. ***Management Information System***

Quality, timely, and accurate information is vital for strategic planning and decision making. This can be ensured by

- Maintaining regular FP client recording and reporting of service statistics for planning purposes;
- Mainstreaming the updated data collection and reporting system including FP services in hospitals;
- Establishing and continuously updating the database on FP service providers and facilities, including accredited training institutions and training providers/trainers;
- Tracking clients with unmet needs through CHT reporting (e.g., CHT forms)
- Adopting and installing the community-based monitoring information system; and
- Analyzing and disseminating relevant information to local officials, FP program managers, and other stakeholders.

Identified Strategies to Reduce Unmet Needs for Modern FP

In 2012, the DOH issued AO 2012-0009 and launched a national strategy to reduce the unmet FP needs of women to achieve the MDGs in 2015. These strategies aim to avert maternal deaths by improving access to FP. The strategies include the following:

1. FP as a program should be implemented at the national and local levels with the active involvement of both public and private sectors. Quantitative estimates should be used to determine the extent of FP services needed and how they can be delivered. Information and education campaign should reach target beneficiaries. Affordable services should be within reach by these target beneficiaries.
2. Implementation of the FP program should be integrated and synchronized with other public health campaigns. Resources should be maximized, and a client-centered approach on delivering FP services should be adopted.
3. Informed choice and voluntarism should be promoted.
4. Areas with the highest unmet needs will be prioritized in delivering additional or enhanced FP services.
5. Contraceptive self-reliance should be encouraged.
6. Interventions to reduce unmet needs should be catered to the conditions of localities in close consultation with LGUs.
7. In urban areas, gaps in LGU services and private sector providers will be bridged through the provision of grants, commodities, and technical assistance.
8. Monitoring and evaluation of the progress in reducing the unmet modern FP needs should be focused on factors that affect the demand and supply of commodities and the resulting outcomes from these interventions.
9. All social and behavioral change communication activities for FP should be in line with the KP thrust.

Responsible Parenthood and Reproductive Health Act of 2012

The Responsible Parenthood and Reproductive Health Act of 2012 or Republic Act No. 10534 was signed into law in December 2012. The law is aimed at addressing the reproductive health issues of Filipinos and averting maternal and child deaths through contraceptive use. Furthermore, the law promotes responsible parenthood by encouraging Filipinos to determine and achieve the number, spacing, and timing of their children according to their own family life aspirations.

The RPRH law mandates the national government to guarantee universal access to medically safe, non-abortifacient, effective, legal, affordable, and quality reproductive healthcare services, methods, devices, and supplies. These services should be provided according to the priority needs of women, children, and other underprivileged sectors, especially those identified through the NHTS-PR (and other identification measures). The families identified in the database may be voluntary beneficiaries of free reproductive healthcare, services, and supplies. This list can be further used as a basis in identifying households who have unmet modern FP needs.

Guiding Principles for Implementation

The DOH reviews and revises existing policies and materials to which the provision of the new law will be incorporated. The guiding principles and rules relevant to FP in the RPRH's IRR are briefly enumerated below.

Section 2 of the RPRH IRR states that

- *Informed choice and voluntarism shall be promoted by all public and private health care providers rendering reproductive health care. Clients shall not be denied any right or benefit (including the right to avail of any program of general welfare or health care) as a consequence of any decision regarding reproductive health care; neither shall they be coerced nor induced to avail of any particular service or health product;*
- *The provision of reproductive health care shall not discriminate between married or unmarried individuals, for all individuals regardless of their civil status have reproductive health concerns;*
- *Since human resource is among the principal assets of the country, effective and quality reproductive health care services must be given primacy to ensure maternal and child health, the health of the unborn, safe delivery and birth of healthy children, and sound replacement rate, in line with the State's duty to promote the right to health, responsible parenthood, social justice and full human development;*
- *The provision of ethical and medically safe, legal, accessible, affordable, non-abortifacient, effective and quality reproductive health care services and supplies is essential in the promotion of people's right to health, especially those of women, the poor, and the marginalized, and shall be incorporated as a component of basic health care;*

- *The State shall promote and provide information and access, without bias, to all modern methods of family planning, whether natural or artificial, which have been proven medically safe, legal, non-abortifacient, and effective in accordance with scientific and evidence-based medical research standards such as those registered and approved by the FDA for the poor and marginalized as identified through the NHTS-PR and other government measures of identifying marginalization: Provided, That the State shall also provide funding support to promote all modern natural methods of family planning, especially the Billings Ovulation Method, consistent with the needs of acceptors and their religious convictions;*
- *Each family shall have the right to determine its ideal family size: Provided, however, That the State shall equip each parent with the necessary information on all aspects of family life, including reproductive health and responsible parenthood, in order to make that determination;*
- *There shall be no demographic or population targets and the mitigation, promotion and/or stabilization of the population growth rate is incidental to the advancement of reproductive health;*

In Section 4 of the law, the service delivery standards include the following:

- *Section 4.03 Availability of Information and Services in General. All public health facilities shall provide full, age- and development-appropriate information on responsible parenthood and reproductive health care to all clients, regardless of age, sex, disability, marital status, or background.*

  Within six (6) months from the effectivity of these Rules, the DOH shall review existing and/or develop introductory materials (e.g., primers and/ or pamphlets, health use plans, key messages for Community Health Teams, among others) on responsible parenthood and reproductive health care. These introductory materials shall be made available in major local languages, including but not limited to Tagalog, Cebuano, Ilokano, Hiligaynon, Bikol, and Waray. Furthermore, these introductory materials shall include scientifically correct, evidence-based and comprehensible information on mechanisms of action and benefits, including effectiveness, contraindications, possible side effects, correct usage, availability at health care facilities and providers, and other information as determined necessary by the DOH. The DOH shall ensure that all public facilities have copies of these introductory materials freely available to all clients seeking information for reproductive health.

- *Section 4.04 Informed Choice and Voluntarism. To ensure adherence to the principles of the RPRH Act and the delivery of quality reproductive health care services to voluntary recipients, the applicable provisions of DOH guidelines on Informed Choice and Voluntarism shall form part of these Rules.*

- *Section 4.05 Access to Family Planning. All accredited public health facilities shall provide a full range of modern family planning methods, which shall also include medical consultations, supplies and necessary and reasonable procedures for poor and marginalized couples having infertility issues who desire to have children.*

  The LGUs, with assistance of the DOH, shall ensure that all public health facilities within the Service Delivery Network shall provide full, age-, capacity-, and development-appropriate information and services on all methods of modern family planning to all clients, regardless of age, sex, gender, disability, marital status, or background.

  These services include, but are not limited to the following:

  1. *Fertility awareness and family planning information and education;*
  2. *Interpersonal communication and counseling (IPCC) services to the client to allow him or her to make a free and informed choice regarding his or her intention/plan;*
  3. *Provision of modern family planning methods which shall include dispensing of medically safe, legal, and non-abortifacient health products and procedures, among others;*
  4. *Infertility services;*
  5. *Referral services where necessary; and*
  6. *Other family planning information and services as deemed relevant by the DOH.*

- *Section 4.06 Access to Family Planning Information and Services. No person shall be denied information and access to family planning services, whether natural or artificial: Provided, That minors will not be allowed access to modern methods of family planning without written consent from their parents or guardian/s.*

- *Section 4.07 Access of Minors to Family Planning Services. Any minor who consults at health care facilities shall be given age-appropriate counseling on responsible parenthood and reproductive health. Health care facilities shall dispense health products and perform procedures for family planning: Provided, That in public health facilities the minor presents written consent from a parent or guardian;*

  Provided further, That a consent shall not be required in the case of abused or exploited minors, where the parent or the person exercising parental authority is the respondent, accused, or convicted perpetrator as certified by the proper prosecutorial office or the court.

  Provided further, That in the absence of any parent or legal guardian, written consent shall be obtained only for elective surgical procedures from the grandparents, and in their default, the oldest brother or sister who is at least 18 years of age or the relative who has the actual custody of the child, or authorized representatives of children's homes, orphanages, and similar institutions duly accredited by the proper government agency, among others. In no case shall consent be required in emergency or serious cases as defined in RA 8344.

  Provided finally, That in case a minor satisfies any of the above conditions but is still refused access to information and/or services, the minor may direct complaints to the designated Reproductive Health Officer (RHO) of the facility. Complaints shall be acted upon immediately

In Section 8, rules on drugs, supplies, and health product procurement are stated as follows:

- *Section 8.02 Supply and Budget Allotments. The supply and budget allotments for family planning supplies shall be based on the current levels and projections of the following:*
  1. *Number of women of reproductive age and couples who want to space or limit their children;*
  2. *Contraceptive prevalence rate, by type of method used;*
  3. *Cost of family planning supplies; and*
  4. *Other relevant, objective, and needs-based criteria as determined by the DOH.*

The DOH shall develop a methodology to determine the number of women with unmet need for modern family planning, prioritizing the poor as identified by the NHTS-PR or other government procedures of identifying marginalization, which shall be consistent with the above-set criteria.

Health products shall be procured according to the estimated needs of identified populations based on the preferred method mix per age group, as determined by data on observed health-seeking behaviors using the most recent demographic health survey or its equivalent, or by comparable scientific methods as deemed appropriate by the DOH.

The DOH, for planning and budgeting purposes, shall also take into account the procurement of drugs, supplies, and health products at the LGU level. The local availability of reproductive health product stocks, strength of the private sector market, LGU commodity self-reliance activities, and the health product assistance of development partners, shall be considered as factors in the procurement of supplies for that locality.

In Section 12, the duties and responsibilities of the DOH and the national government include the following:

- *Ensure that all skilled health professionals assigned to public health facilities have appropriate training to provide the full range of reproductive health services; Provided, That cities and municipalities shall endeavor that all nurses and midwives assigned to public primary care facilities such as RHUs are given training and certification to administer life-saving drugs within one (1) year from the effectivity of these Rules;*
- *Respond to unmet needs and/or gaps as enshrined in these Rules.*