Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

September 7, 2004

ADMINISTRATIVE ORDER
No. 158 s. 2004

SUBJECT: Guidelines on the Management of Donated Commodities under the Contraceptive Self-Reliance Strategy

I Background and Rationale

In keeping with the constitutional mandate that the state shall protect and promote the people's right to health, the country's national family planning program is an essential health program of the Government of the Philippines. Its basic policy centers on the constitutional premise that couples have the responsibility to decide how many children to have, in accordance with their religious beliefs, preferences and needs the laws of the country and the demands of responsible parenthood for sustainable development.

In 1991, with the passage of the Local Government Code, the responsibility for the provision of basic services including family planning services was devolved to local government units. This is specifically provided for in Section 17 of Republic Act 7160, otherwise known as the Local Government Code of 1991. Thus, family planning services form part of the basic health services that local government units now provide.

For more than thirty years, external donors have supported this important health program through, among others, the donation of various types and necessary quantities of contraceptives used by couples, choosing among different methods of family planning delivered by Philippine health care providers. These contraceptive donations were never intended to go on indefinitely and the country seeks to assume, as soon as possible, the full responsibility for providing its own citizens' needs in this vital health services. External donors, with the concurrence of the Philippine government have decided to begin in 2004, a gradual phase-down of foreign donations of contraceptive commodities, which will end in 2008 with the complete phase-out of all donated supplies of condoms, pills and injectables. There are still no plans at present to phase-out donations of IUDs. The Philippine Government intends to build this action by the donors through formulation and implementation by the Department of Health of a Contraceptive Self-Reliance (CSR) Strategy, which among others, provides for the orderly transition from externally donated contraceptives to domestically provided commodities for family planning.

The 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 FP. This objective is consistent with the National Family Planning Program policy promulgated in 2001. in order to provide substantive direction to the implementation of the CSR, a technical Working group on Contraceptive Self Reliance (TWG - CSR) was created in 2003. Consistent with its mandated function, the TWG-CSR has recommended plans, policies, systems and guidelines on the attainment of contraceptive self reliance in the country. The guidelines contained in this order are among these recommendations of the TWG-CSR, which have been adopted and issued by the Department of Health as government policy.

This Administrative Order provides for guidelines regarding the orderly, fair and beneficial disposition of declining quantities of donated contraceptives in a manner that maximizes the opportunities for all domestic stakeholders of the national family planning program to take appropriate pro-active steps to protect and assure continued access to contraceptives of all Filipinos who need these vital health enhancing commodities.

II Goals and Objectives

Goal: The Philippines shall arrange for the gradual replacement of externally donated supplies with domestically provided supplies, and expand further the domestic supplies of contraceptives to meet the needs of future additional new users who may want to practice modern FP methods but are not yet doing so at present.

A. General Objective

To formulate and implement critical policies and plans, complementary actions and supportive measures that are necessary to prevent any possible disruption in the delivery of PP services with the phase-out of donated contraceptives and sustain continued increase in FF use to eventually eliminate unmet needs.

B. Specific Objectives

1. To establish criteria-based allocation and distribution to Philippine beneficiaries of the diminishing quantity of supplies of donated contraceptives during the phase-out period 2004 to 2008;

2. To revise existing guidelines and procedures concerning the distribution, documentation, and utilization of donated contraceptives as appropriate under the situation;

3. To advocate to all concerned about the factual circumstances and reasonable expectations concerning the immediate phase-down and eventual phase-out of contraceptive donations

III Coverage

This Administrative Order shall apply to all DOH offices within the DOH system, including all of its attached agencies. 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.

IV Definition of Terms

A. Contraceptive self Reliance - A multi-sectoral effort which seeks to ensure the country's self-sufficiency in Family Planning services and commodities in its ability to sustain the provisions of affordable quality Family Planning services to eliminate unmet needs in the context of increasing contraceptive use. It requires the capacity to forecast, finance, procure and deliver Family Planning services and contraceptives to all men and women who need them, when they need them.

B. Contraceptive Prevalence rate (CPR) - A measure of the extent of contraceptive practice among defined population group at a time. The numerator and denominator generally come from the household surveys with numerator consisting of the number of defined women estimated to be practicing contraception, including male-partner oriented methods. The total number of married women of reproductive age is used as denominator. The CPR, as used in this order, was based on the 2000 Family Planning Survey published by the National Statistics Office (NSC).

C. Local Government Units (LGUs) - LGUs are defined, for this purpose, as provincial and city government contained in the DOH Contraceptive Distribution and Logistics Management information System (CDLMIS) list, and are therefore directly receiving their contraceptive supplies from the Department of Health Central Office.

D. Poverty Incidence Index - percentage of the population that falls below the poverty threshold, the minimum amount required by a family to meet their food and non-food basic needs. The Poverty incidence Index, as used in this order, was based on the 2000 Philippine Provincial Poverty Statistics published by the National Statistical Coordination Board.

E. Contraceptive Distribution and Logistics Management information System (CDLMIS) - is a nationwide contraceptive delivery system that is operated and maintained by the Department of Health (DOH). The system ensures adequate and continuous flow of supply of contraceptives to all the delivery sites and service facilities covered by CDLMIS, which includes Provincial/City Health Offices (P/CHOs), Rural Health Units (RHUs), Hospitals, other Government Offices (GOs), Non-Government Organizations (NGOs), and affiliated industry-based clinics.

V. Policy Goals/Statements

A. The attainment of the desired family size through elimination of unmet need for family planning under the CSR strategy shall be ensured.

B. The Government remains committed in assuring that all Filipino couples attain their desired family size according to their respective beliefs, preferences and needs in accordance with Philippine laws. Fulfilling this commitment is consistent with, among others, the elimination of unmet need for family planning as, on average, current levels of actual fertility are significantly

higher than the desired fertility.

C. The Government's commitment to supporting couples' attainment of their desired family size is therefore consistent with increasing the overall contraceptive prevalence rate (CPR). This includes increased prevalence of FF practice using modern methods, several of which depend on the availability, access and use of contraceptives. In short, attainment of the Government's policy goal is consistent with, among other indicators, a rising CPR for modern methods.

D. As the donated contraceptives are phased-out, potential users of FP who are poor shall have, within the means available to LGUs, priority access to free or subsidized contraceptives through donated supplies while these last, and eventually through government provided supplies. in addition, potential users who are not poor should also have ready sources to affordably and conveniently obtain their contraceptive supplies through their own purchases or through subsidized provisions by better-off local governments that can afford to do so.

VI. The Contraceptive Self-Reliance (CSR) Framework

A. Contraceptive Self-Reliance Strategy

1. The Contraceptive Self Reliance Strategy shall create twin supply conditions necessary to eliminate unmet needs for PP under current conditions, namely: (a) the phasing up of domestically provided supplies to replace these quantities of contraceptives used by current users that are being met by externally donated supplies being phased out ("serving the replacement market of current users"); (b) the increase in levels of domestic supplies of contraceptives made available to meet the needs of additional future users of contraceptives ("sewing the larger market of future new users").

2. The CSR strategy shall exercise a systematic influence to induce the overall pattern of responses of key players along (as far as possible the following) three broad directions:

2.1 National government shall work with local governments to assure that no disruption occurs in contraceptives supplies to current users during the period that external donations are being phased out. Government, to include national and local levels, shall set as "guarantor of last resort" assuring that contraceptives remain available for those current users who depend on donated supplies, with local governments assuming a primary front-line responsibility for assuring sufficient quantities of contraceptives for free distribution to those users without means to pay for their contraceptives.

2.2 Developing complementary means of financing contraceptives shall be initiated (in addition to donor and government financing supporting free distribution of contraceptives which remains the most appropriate mechanism for meeting the needs of poorest users with no means to pay) that can enable all current and future users to sustain practice of their FP methods of choice through a variety of options such as PhilHealth or employer benefits, and out of pocket financing of affordably priced contraceptive supplies.

2.3 Expansion of complementary outlet sources of contraceptive supplies shall be instituted (in

addition to subsidized distribution by government outlets which remains the most appropriate source for serving disadvantaged communities) to routinely access private sources of services that can assure universal coverage of the population through such options as self help community based distribution, NGO outlets, private and commercial providers and workplace-based outlets.

Policies and guidelines shall be developed and issued to implement the country's movement towards these three broadCSR directions. The focus will be to define the allocation, distribution and use of the declining quantities of donated contraceptives, in ways to maximize concerted movement towards-the three broad CSR directions.

B. Support Mechanisms to Enhance Widespread positive Responses to CSR Strategy

1. Information, communications and public education

Key messages and essential knowledge about CSR and its implementation should be provided to all stakeholders through EC and Behavior Communication Change.

2. Technical assistance

Technical assistance needs of stakeholders to enable them to participate in CSR implementation shall be identified and provided.

3. Training

Training needs of stakeholders in CSR shall be defined and provided with appropriate programs.

4. Support with other health commodities

A mechanism, to support LGUs embarking on CSR with provision of its health commodities will be established and maintained.

5. Localities included as project sites of foreign assisted projects

To the extent that is possible, localities identified as project sites of FAPS shall include CSR as part of their project activities.

VII. General Guidelines (for the Phasing-Out of Contraceptive Donations under the CSR strategy)

A. Prior to agreed phase-out of contraceptive donations, contraceptives provided by external donors and distributed by DOH, were estimated on the basis, of actual consumption patterns of Filipino couples, practicing modern FP methods. With the declining quantities of donated contraceptives expected to be received by the DOH in the next four years, the basis, terms and conditions for receiving supplies shall be redefined.

B. The phase-out of contraceptive donations shall begin in 2004, as agreed between the Government and the external donors. As such, in 2004, there will be a complete cessation of condom donations and an initially slight reduction in the quantity of pill donations with progressive reductions annually, and full support in the quantity of injectables with progressive reduction annually. Based on the currently agreed schedule, the phase-out for the whole country will mean the following expected quantities of donated pills and injectables:

Country-Level Schedule of Phase-out of **Pill** Donations

Year	Donated Quantity	Basis for Quantity	% of Poor Users' Needs Met
2004	10,552,188 cycles	93% of consumption	More than 100%
2005	6,631,626 cycles	59% of consumption	More than 100%
2006	2,608,765 cycles	23% of consumption	44%
2007	688,871 cycles	6% of consumption	11%
2008	0	0	0

Country-Level Schedule of Phase-out of **Injectables** Donations

Year	Donated Quantity	Basis for Quantity	% of Poor Users' Needs Met
2004	Full support	100% of consumption	More than 100%
2005	1,169,061	82% of consumption	More than 100%
2006	844,945	59% of consumption	More than 75%
2007	329,953	23% of consumption	28% of poor users' needs
2008	67,205	5% of consumption	7% of poor users' needs
2009	0	0	0

C. The phase-out schedule for the whole country shall be translated into a corresponding phase-out for each locality receiving supplies of donated contraceptives. The reduced quantities of donated contraceptives shall be distributed among localities in the country in ways that would encourage all LGUs, With the support of the DOH, to eventually become fully responsive to the FP needs of their constituents. Consistent with the three broad directions of the CSR strategy, an LGU that is fully responsive to the FP needs of its constituents should, among others, move towards creating the following three inter- related and mutually reinforcing directions in contraceptive supplies:

1. Become Local Guarantor of Overall Contraceptive Availability: Regardless of quantity of donated contraceptives received by the locality, 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. Operationally, this means that the LGU, with support from DOH, performs the role of the local "guarantor of last resort" that supplies of contraceptives in the locality will always be sufficient to meet the needs of all current users. This is consistent with the Local Government Code of 1991, which mandates LGUs to provide family planning services and ensure contraceptive availability in the community.

2. Assure Sufficient Supply of Free Contraceptives for Poorest Users: As quantities of donated contraceptives received by the locality fall below levels of actual current consumption, the LGU shall make sure that the available supply of contraceptives for free distribution are always sufficient

to meet the needs of poorest users. In the beginning, this might mean simply reserving the increasingly scarce supplies of donated contraceptives exclusively for poorest users. Eventually, it will mean using public funds to procure contraceptives to support free distribution to poorest users even when donated supplies are short or no longer available.

3. Promote Expansion of Other Sources of Contraceptive Supply: As quantities of donated contraceptives received by the loCality fall below levels of actual consumption, LGU shall encourage current users of donated contraceptives but with means to pay, to shift their source of supply to commercial and NGO sources, while making sure that such shifts will not lead to interruptions in their FP practice. In the beginning, this might initially require transitional public support for non-poor users not yet ready to shift to commercial sources. Eventually, it will mean more vigorous support for local expansion of affordable supplies from commercial sources.

4. The nationwide allocation scheme for the reduced contraceptive donations shall be designed to enable different LGUs with different local conditions, to become equally fully responsive to their constituents needs for modern FP methods. The whole country has, on average, four years for donated pills and five years for donated injectables to run out. LGUs with highest shares of their population who have the means to pay and lowest shares who are poor are scheduled to run out of donated pills within two to three years, while LGUs with lowest shares of population who have means to pay and largest shares who are poor would be given more time, with donated pills running out within four to five years.

Thus, the scheme for allocating declining donations of contraceptives is designed to induce LGUs with greatest capabilities to be locally self-reliant to act sooner, while allowing LGUs with the least capabilities to be similarly locally self-reliant to have more time to do so. The terms and conditions for accessing the remaining quantities of contraceptive donations have been revised to provide the greatest opportunity for LGUs to assume full responsibility for the adequacy and sufficiency of contraceptives supplies in their respective localities.

E. Distribution of supplies shall begin by the third quarter of 2004. Only the provincial and city governments shall be considered eligible to receive donated contraceptives from DOH. During the third quarter, arrangements shall be made for all municipal governments and component cities to routinely access donated contraceptives through their respective provincial/city governments. Similar arrangements shall also be made for NGOs and private providers to continue accessing donated contraceptives through the provincial, city or municipal governments of the localities served by their service outlets.

F. In circumstances where an LGU is not able to receive and distribute donated contraceptives, the DOH shall establish alternative temporary mechanisms for assuring adequate supplies of contraceptives in that LGU coverage area, which might include deputizing NGOs, private providers or retained DOH facilities to make donated contraceptives available to local providers and users.

G. All the 77 provinces and 34 cities (as indicated in Annex A) covered in the CDLMIS have been classified into five groups according to their respective rates of poverty incidence in 2000. The first

group, consisting of cities and provinces with lowest poverty incidence, shall comprise the first batch of LGUs to have the most accelerated pace of contraceptive donation phase-out. The second and third groups, with next higher rates of poverty incidence, shall comprise the second batch of LGUs with a longer phase-out period. The fourth and fifth groups of LGUs, with the highest rates of poverty incidence, shall comprise the last batch with the longest phase-out period.

H. Since the operation of the existing Contraceptive Distribution and Logistics Management Information System (CDLMIS) is based on forecasts and provisions for actual consumption of contraceptives, the distribution of donated, contraceptives during the phase-out period will continue to be based on similar forecasts and estimates of actual consumption. The actual year-by-year reductions in quantities of donated contraceptives to be distributed to each group of LGUs are summarized as follows and expressed in terms of declining percentages of estimated consumption that will be covered by donated supplies.

Quantity of Donated **Pills** to be Distributed to LGUs During the Phase-out Period
(Based on % of Estimated Annual Consumption)

Year	Batch 1 LGUs (Richest)	Batch 2 LGUs (Middle)	Batch 3 LGUs (Poorest)
2004/Q3-4	80	100	100
2005/Q1-2	50	80	90
2005/Q3-4	30	60	70
2006/Q1-2	20	40	50
2006/Q3-4	0	20	30
2007/Q1-2	0	0	30
2007/Q3-4	0	0	30

Quantity of Donated **Injectables** to be Distributed to LGUs During the Phase-out Period
(Based on % of Estimated Annual Consumption)

Year	Batch 1 LGUs (Richest)	Batch 2 LGUs (Middle)	Batch 3 LGUs (Poorest)
2005/Q1-2	80	90	100
2005/Q3-4	70	80	90
2006/Q1-2	60	70	80
2006/Q3-4	40	60	70
2007/Q1-2	20	40	60
2007/Q3-4	0	20	40
2008/Q1-2	0	0	30
2008/Q3-4	0	0	30

I. Provincial and city governments receiving contraceptive donations shall be authorized to manage the internal allocation and distribution of these donated supplies according to the provisions contained in this order.

VIII. Coordination and implementation Arrangements

A. Managing Contraceptive Supplies between DOH and Provincial/City Governments

1. The provincial and city governments shall be encouraged and assisted by the DOH to adopt the CDLMIS as the basic recommended local distribution and logistics system for comprehensive management of all sources of contraceptive Supplies in the whole province or city. This implies that provincial and city governments should routinely develop sound forecasts, estimates and plans for meeting the total consumption needs for contraceptives by all FP users in the whole province or city. The DOH shall require the provincial and city governments provide prompt, complete and accurate reports of actual consumption and forecasts of needs to enable it to allocate and distribute donated contraceptives. Failure to provide such information may compromise access to the declining quantity of donated contraceptives.

2. Annual forecasts of estimated total consumption needs of pills and injectables shall be generated by each province and city starting 2005 and onwards. For planning management purposes, future supplies of donated pills and injectables flowing to the localities starting 2005 shall be treated by both DOH and provincial/city governments as a temporary and declining external input for meeting part of the total needs of localities.

3. Provincial and city governments, with assistance from DOH and the participation of other local stakeholders, shall adopt a framework for planning a local CSR strategy which consists of the following key operational elements:

Year's forecast of consumption of pills and injectables for whole province or city (with estimates for segments of total population of potential users) to be met by:

a. The years share of total consumption to be supported by donated supplies balance of year's total consumption to be met by local means, divided into:

• Portion met by LGU financing, procurement and distribution
• Portion met by users obtaining supply from commercial sources
• Portion met by current users of contraceptives shifting to non-contraceptive modern methods in support of clients' needs.

4. As far as the contraceptive supplies dispensed by various local FP service cutlets are concerned, the above local CSR strategy framework implies that the stocks of pills and injectables in the locality will eventually consist of four potential sources with corresponding uses as follows:

a. Donated supplies exclusively for free distribution.
b. LGU-finance/procured supplies either for free distribution; for sale at cost-recovery basis; or for sale at margins above costs.
c. Commercially consigned supplies either for free distribution (with payment by LGU) or for sale with payment by clients.

d. Socially marketed supplies for sale at cost recovery basis.

5. 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, provided that as far as use of donated contraceptives in public health facility is concerned, such supplies shall be dispensed only for the actual voluntary and informed use by FP clients and without charge (free to clients), with priority for meeting needs of clients without means to pay.

B. Contraceptive Supply Management between Provincial/City Governments and Service Outlets in the Locality Providing FP.

1. Provincial and city governments shall assume the role of local guarantors of adequate availability of contraceptive supplies in the whole province or city. During the phase-out period, supplies of donated contraceptives shall be allocated to the whole province or city according to the batching of LGUs scheduled for reductions contained in Section VI above. These donated supplies shall be subject to the disposition of the provincial or city government in accordance with the provisions of this order.

2. Provincial governments shall establish appropriate arrangements for component city and municipal governments to participate and contribute to the attainment of the CSR in the whole province. Each provincial government is authorized to set reasonable conditions on component city and municipal governments' access to donated contraceptives that can encourage component city and municipal governments to contribute to overall movement towards the three key directions of CSR described in Section V and towards their pursuing the three directions for becoming fully responsive to the FP needs of their constituents described in Section VII.

3. Within the context of a local CSR framework described in Section VII above, provincial, city or municipal governments obtaining supplies of donated contraceptives may, at their discretion, make portions of such donated contraceptives available not only to their own service outlets but also NGOs and private providers serving their localities. Local policies may allow charging of fees for services rendered in connection with the dispensing of donated contraceptives which is given for free.

4. DOH, in consultation with concerned local stakeholders, shall develop a variety of model agreements between provincial governments and component city/municipal governments, and between LGUs and NGOs or private provider, that incorporates the basic principles and provisions contained in this Order.

IX. Roles and Responsibilities

The responsibilities of the different DOH offices, local government units, and other partners relative to the contraceptive phase down plan as follows:

A. Offices/Units at DOH Central office

1. The CSR Technical Working Group (CSR-TWG)

Continue developing plans, systems, policies and guidelines to assist LGUs achieve contraceptive self - reliance. This shall include:

a. Identifying appropriate FP. service delivery schemes;
b. Defining market segmentation methodologies;
c. Developing targeting approaches;
d. Enhancing PhilHealth and private sector participation; and
e. Strengthening cost-recovery and referral systems.

To support this function, the TWG is authorized to establish secretariat to be staffed by seconded government personnel and other staff provided by partners in the CSR strategy.

2. The National Center for Disease Prevention and Control - Family Health Office (NCDPC-FHO)

a. Provide technical assistance to CHDsi LGUs relative to the implementation of the contraceptive phase down plan;
b. Review and approve summary delivery reports to be sent to the different provinces and cities and provide CHDs with a copy of the approved summary delivery reports; and
c. Monitor, evaluate and submit periodic reports on the progress of the contraceptive phase down implementation to the CSR-TWG and to the Secretary of Health.

3. The Procurement and Logistic Service (PLS)

a. Receive, encode, analyze, and consolidate the distribution and consumption report submitted by the LGUs;
b. Submit a copy of the consolidated LGU distribution and consumption report to the NCDPC;
c. Manage the distribution of commodities to the LGUs, consistent with the phase down plan;
d. Recommend modification(s) to the CDLMIS, consistent with the guidelines in this order;
e. Continue conducting periodic table/ field monitoring in accordance to CDLMIS procedures; and,
f. Provide technical assistance to LGUs with regards to distribution of contraceptives.

4. The Bureau of Food and Drugs (including National Drug Policy Unit)

Formulates essential drug policy to support contraceptive self-reliance strategy

5. The Health Policy Development and Planning Bureau (HPDPB)

As the secretariat of the National Health Planning Committee (NHPC), help LGUs achieve contraceptive security by proposing strategies to allocate resources for FP commodities in the local budget.

6. The Bureau of Local Health Development (BLHD)

a. Provide technical assistance in setting up systems for inter-LGU cooperation, cost-sharing schemes and referral; and
b. Support CHDs and LGUs in the formulation of contraceptive phase down plan and in the identification of technical inputs and packages to implement the plan.

7. Bureau of International Health Cooperation (BIHC)

Ensure that the concerned foreign funded projects shall provide financial and technical support in the implementation of the contraceptive phase down plan such as contraceptive management training for national, CHD, provincial, city, and municipal offices.

B. The Centers for Health Development (CHDs) of the DOH and Regional ARMM

1. Formulate and initiate campaigns to inform the LGUs, NGOs, and industrial clinics of the contraceptive phase down plan;
2. Assist the provincial/city governments formulate their own contraceptive distribution guidelines for the catchment cities and municipalities;
3. Assist the provinces in informing the catchment cities and municipalities about the provincial contraceptive distribution guidelines;
4. Collect and conduct a preliminary analysis of the CDLMIS reports of the provinces and cities;
5. Monitor the FP and CSR strategy implementation in their respective regions; and
6. Provide technical assistance in the expansion and improvement of FP services towards eliminating unmet needs.

C. Agencies Attached to the DOH

Agencies attached to the DOH, specifically PhilHealth and POPCOM, are enjoined to formulate complementary policies in support of the CSR strategy in coordination with the TWG-CSR.

D. Local Government Units (Province and City) and ARMM

To ensure provision of direct family planning services in their respective areas, LGUs and ARMM are expected, under this AO, to undertake the following role and responsibilities:

1. Develop contraceptive distribution guidelines to cover their catchment cities, municipalities, and devolved health facilities;

2. Conduct campaigns to inform their catchment cities, municipalities and devolved health facilities, of the LGU's contraceptive distribution guidelines;

3. Provide resources for the delivery of contraceptives to their catchment cities, municipalities, and

devolved health facilities;

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

a. Allocate budget to procure contraceptives for free distribution;
b. Make available contraceptives for sale at cost recovery basis or at margins above cost; and/or
c. Allow consigned supplies from social marketing sources or commercial sources to be made available to clients in LGU outlets.

5. Continue with the quarterly distribution and inventory of the contraceptive stocks at the public health and NGO facilities;

6. Consolidate the CDLMIS reports; and

7. Ensure the prompt, quarterly submission of CDLMIS reports to PLS copy furnished the CHD.

X. Repealing Clause

All Administrative Orders and other issuances inconsistent with this Order are hereby repealed or modified accordingly.

XI. Effectivity Clause

This Order shall take effect immediately.

MANUEL M. DAYRIT, MD, MSc
Secretary of Health

08 June 2004

Annex A. List of LGUs Per Batch

Batch	Province (including independent cities in the CDLMIS)