

Department of Health
Management Sciences for Health

YN-ADP-123

National FP Consultative and
Planning Workshop

PROCEEDINGS

May 22-24, 2002
Cebu City

A

Day 1

May 21, 2002

The National Consultative and Planning Workshop began with the singing of the National Anthem and a brief invocation.

Welcome Remarks

Dr. Rosario Buenabaye

The program accomplishments and initiatives of the Philippines in Family Planning (FP) as a health concern were previously discussed at the National Staff Meeting of the Department of Health (DOH) in Naga City and the last consultative planning session in 1995. Considering current trends and practices, those initiatives will have to be pursued and the key action points operationalized, in order to raise the level of FP acceptance (Contraceptive Prevalence Rate) and push program agenda forward.

Message

Dr. Milagros Fernandez

The Conference is a wake up call to program proponents and service providers. FP is a subject that should be discussed in the context of Reproductive Health (RH). As one of the component elements of RH, the objective would be to improve the health of women and children. **The Philippine leadership is determined to give a vigorous push to what is essentially no longer a policy – but an implementation issue – at the grassroots level. The government sees FP as an implementation issue because it works within the parameters of family size, couple prerogative, health, and the paradigm of church groups.**

The task confronting the group is to see that operational strategies translate into action. Regional Health Offices (RHOs) should provide technical assistance, hospitals appropriate services, and local government units (LGUs) the whole spectrum of FP methods. It would be the churches' role to push Natural Family Planning (NFP) initiatives with the corresponding shift from critical non-collaboration to principled collaboration.

The sphere of partnership should be broadened as a sustained long-term commitment among partners in the national and local governments, Non-Government Organizations (NGOs), church, international agencies, media and other sectors.

The DOH leadership anticipates outputs in the areas of regional directions, plans to operationalize mandates and recommendations of the Naga Staff Meeting. These will be presented to DOH Secretary Manuel Dayrit at the succeeding consultative workshop with the regions the following week.

There are adequate sources of funds for FP – the General Appropriations Act for commodities and training (Php76M), Php4M for policy formulation activities, congressional initiatives worth Php50M (Rep. de Venecia), about Php1M from each region, Php36M for oral contraceptives from Sen. Juan Flavio, and supply funds through 2004, ensuring an inventory level of 85 percent in health centers. Meanwhile, the United States Agency for International Development (USAID) and other agencies will continue to supply technical assistance.

Workshop Rationale and Mechanics

Carmen V. Auste, Process Consultant

The workshop will be action-focused, the objective of which is to develop a shared understanding on FP and build consensus on strategic options vis a vis operationalization of FP per Administrative Order 50, series of 2001. Five stages of action to be followed in the conference discussions are initiation, analysis, definition, transition, and continuous improvement. The following are expected:

Day 1 (Clarificatory) - FP Protocols and Clinical Standards Manual

Day 2 (Synergy for Action) - Implementing guidelines and Key Steps, Standard Days Method (SDM) and Action Plans/ Guidelines for Voluntary Surgical Sterilization Itinerant Teams

Output Day 3 (Mobilizing for Action) - Enhanced strategies for Family Planning in the context of Reproductive Health

The end desired is a doable action plan from 2002 - 2004.

PRESENTATION 1

National FP Policy: Strategic Thrusts and Policies

Dr. Loreto Roquero

(For comprehensive presentation, refer to attached document)

Gist of Presentation

FP planning directions seek to promote the health of Filipino women and children. The goal is to prioritize programs that prevent high risk pregnancies and abortions, promote safe motherhood and Responsible Parenthood, respond to unmet needs and demands of women and lead to the country's overall sustainable socio-economic development.

The general policies of government are guided by respect for the sanctity of family life, human rights, religious beliefs, freedom of choice and voluntary decision, respect for the rights of couples to determine their family size, and offer a range of method mix.

The FP Program aims to reduce maternal, infant and under-five mortality rates, and the total fertility rate from 3.7 in 1998 to 2.7 in 2004, on the basis of recent survey findings. By the end of 2004, the CPR should move up from 46.5 to 57, and the proportion of modern FP use from 28.2 to 50.54%.

The program will focus services on urban poor through IEC and aggressively promote permanent methods, considering that as much as 1.1 million Women of Reproductive Age (WRA) could not access services and that the demand for vasectomy was seen.

Home services will be delivered by Volunteer Health Workers (VHWs) drawn from within targeted depressed communities who will conduct active case finding and master listing. DOH hospitals will maintain itinerant teams and an efficient referral system as well as conduct surgical missions. There is adequate subsidy for indigent services, in partnership with LGU hospitals and NGOs. PhilHealth coverage of FP services will be expanded.

There is a need to strengthening FP in regions with lowest CPRs and operationalize strategies for mainstreaming Natural Family Planning (NFP) and support initiatives in counseling, men and adolescents' reproductive health.

Discussions

Clarificatory Questions/Remarks

Questions	Answers
What could be the possible reasons behind the indecision (<i>to subscribe to FP</i>) by 1.1 million of the Philippine population?	The NSO survey surfaced findings such as the lack of providers and commodities and the persistence of access problems, spousal objection, unfounded rumors and fears of side effects.
Can we achieve the targeted CPR?	We are encouraged by the continuing demand for reproductive health services.
Can we have CP ratings in relation to maternal-child mortality and health issues like malnutrition, etc.?	There is a corresponding rise in the number of indicators and we are probing mechanisms into how FP can contribute to the contributing factors.
Note: International proxy indicators can be accessed and revalidated over time. It should be noted that variables are extraneous and could not be controlled. A number of concerns have not yet been considered.	
A major issue is funding support for VSC itinerant teams. In the area of male RH, what are the present directions in funding on the part of LGUs?	This will be discussed in the presentations. On the national level, regions and hospitals are investing in the program.
Does the Php465 million allocation represent the entire program funding and is the Php165 a fraction of the overall health budget?	The fractional amount of Php165M will fund sterilization, training, FP and commodities but the agency is banking on the support of cooperating agencies.
Is the Autonomous Region of Muslim Mindanao (ARMM) entitled to this budget?	The flow will be made through RHOs on the strength of an agreement with DOH. A PMO manned by a career official is based in the region. But the ARMM initiatives must be supported by an operational plan.

<p>Notes, Dr. Rodriguez: What bears citing are not just vertical but horizontal resources as well, in terms of foreign assisted projects. In 2002, the Management Sciences for Health (MSH), under its Matching Grant Program (MGD), was able to allocate PPhp3 million for ARMM; in 2003 Region 4 will allocate PPhp3 million to the region as authorized by Health Undersecretary Milagros Fernandez.</p>	
<p>Tacloban, Leyte intended to organize itinerant teams but could not spare adequate personnel. What could be done?</p>	<p>The workshop will discuss ways of strengthening itinerant teams within doable parameters</p>
<p>Are hospital-based FP services free? Can hospitals avail of income from other sources and programs for hiring purposes for itinerant teams?</p>	<p>Government will subsidize the needs of the poor in line with its bias for this segment. Pay structures depend on hospital policy. It is true that hospitals cannot always dispense services for absolutely free.</p>
<p>We lack operating definitions of supply and under supply.</p>	<p>Under CDL-MIS, figures show that 85 percent of supply centers were adequate, maintaining a regular inventory of stocks.</p>
<p>If FP is an element of RH, how should reproductive rights be defined and is the department promoting all methods? NGOs need the collaboration with government but parameters of partnership should be laid.</p>	<p>There are various contexts in which FP is situated – adolescent and women's RH; as a matter of policy, DOH is promoting all methods. NGO participation and collaboration is encouraged until a coalition for FP is securely built. There is a need to move away from a monopoly of FP services. FP policies are moved and shifted on the local level.</p>

Observations

<ul style="list-style-type: none"> • Services can be accessed through PhilHealth.
<ul style="list-style-type: none"> • It takes time to look for internal funds due to DBM policy constraints.
<ul style="list-style-type: none"> • Income from services is normally remitted to the National Treasury according to standard government procedures.
<ul style="list-style-type: none"> • Other concerns are personnel, supplies and funding. Commitment minus resources is unacceptable. We must consider imperatives such as one, current and immediate resources, and two, actual resources. Foreign assistance may be accessed but ultimately, government will still have to fund the brunt of program requirements.
<ul style="list-style-type: none"> • There are two chief nurses doing FP rounds whose activities are supported by the LGU. Adjacent municipalities supply the requirements of their FP clients. Operating Room equipment have also been supported by LGU and NGO hospitals, while referred clients are supported by multi-sectors.
<ul style="list-style-type: none"> • (Esper Dowling) Two points to consider are that one, FP is Health and secondly, strategies continue to lean toward contraception. The policy should be to widen the range of stakeholders. But many of them could not come in due to the contraceptive thrust. We should mull ways of clarifying areas of collaboration. FP should operate within a wellness and preventive culture; otherwise, stakehold expansion is not possible.
<ul style="list-style-type: none"> • An area of synergy will be probed in terms of re-calibrating perception from one that was based on previous experiences in lieu of one situated on current realities.

PRESENTATION 2

Highlights and Implications of 2001 NSO FPS Findings

Lilia Tandoc, Regional Director, NSO VII

(Please refer to attached Comprehensive Presentation)

Gist of Presentation

The objectives of Family Planning Survey (FPS) were presented which were to provide information on contraceptive use to the DOH and development planners that will enable them to keep track of progress toward program goals. The FPS is a quarterly nationwide survey, respondents to which are female members of households 15 to 45 years old.

The 2001 FPS provided data on CPR and contraceptive method mix. In this survey, 20,036 households and 30,132 women were interviewed, with a response rate of 94.1 percent. Comparative findings are as follows:

	CPR	Modern	Traditional
2001 FPS	49.5	33.1	16.4
2000 FPS	47.0	32.3	14.7

Source: Presentation Paper, NSO

Discussions

Clarificatory Questions/Remarks

<ul style="list-style-type: none"> • The Presentation can be accessed on the Web. • Oral contraceptives, along with other methods, are delivered mainly through hospitals. Surgical methods availed exclusively from hospitals contributed significantly to the rise in CPR. 	
There may be no problems of physical accessibility, but there are more constraints in the area of awareness and education.	This should be viewed on a by method basis. There are serious access issues per method.
Public sector supply centers could stand a lot of improvement.	Roughly, NGOs account for 50 percent of service delivery in the provinces. This contribution appears small because of the common channel of distribution at the service delivery point, in the person of VHWs. There is no clear division between government and NGO supply chains.
There are other female household members who could qualify as respondents and count as WRAs.	Children will not admit their use of contraceptives in front of their parents. The surveys focus on the spouses. We have to perform a school-based survey to arrive at this information.
Contraceptive use peaked at ages 35 to 39. What is meant by peak age?	This refers to the age group wherein a particular method is most widely used. The reasons for the bias toward a

	particular method within a specified age range may be that there are more complications to be encountered in those groups.
We might need additional reports from the field for effective comparison with DOH data.	The NSO data is a rider survey. But field level approach is accomplished through the CDL-MIS. Their operational feasibility deserves further study.

Observations

<ul style="list-style-type: none"> • There is a 25-fold mark-up in the rate of NGO attribution. Services are usually accessed from centers and clinics while NGOs can be misconstrued as centers or clinics. NGOs operate only in specific places and there are figures that correspond to the quantity of their delivery.
<ul style="list-style-type: none"> • There has been a marked improvement in the role of education when one views the survey results. A specific program should cater to adolescent education and involve support agencies like the Department of Education (DepEd). There may be a need to conduct a survey on unmet needs to reflect the actual demand for FP services. There are women who want to limit or space births but who can't avail of commodities in time. The findings may provide significant inputs to the program.
<ul style="list-style-type: none"> • Dr. Infantado. A method mix survey should validate a nine-percent figure for each of the withdrawal and calendar methods. The reason why traditional methods predominate is that they represent scientific FP methods. If we want to transform such usage into modern methods, they should be acceptors of NFP.
<ul style="list-style-type: none"> • Industry based usage stands improvement. DOH regional offices can do much to increase industry-based FP clinics, i.e., Subic Freeport Zone employs thousands of potential users. <i>Senrong Sigla</i> and Hall of Fame programs could be located in these areas.
<ul style="list-style-type: none"> • Family planning is a positive way of addressing poverty issues

PRESENTATION 3

The 2002 National Multi-stakeholder FP Campaign Challenges and Opportunities

Jose Miguel de la Rosa

(Please refer to attached Comprehensive Presentation)

Gist of Presentation

The Johns Hopkins University (JHU) country office, since the 90s, was one of the technical agencies behind the national FP program. It used to promote products and services exclusively through the DOH in collaboration with other donors. The CPR behavior appears to be bogged down by problems relating to method mix, in spite of the passage of 30 years.

Hence, message strategies are now undertaken in collaboration with other sectors including private businesses, NGO and GO organizations, advocating that FP is a desirable end and an ingredient of a successful normative

lifestyle. The messages will be aired on television for a period of six months and will be anchored on family, social and health contexts.

The overall objective is to increase the use and social acceptance of FP. It will target Married Couples of Reproductive Age (MCRAs) with unmet needs but positive attitudes, those supportive of FP but are not practicing, the C & D class audiences, spacers, limiters and urban poor. At the same time, stakeholders will be made aware that the campaign will generate demand.

Proposed Messages

Media: Posters and 30-second T.V. Plugs
Sarap Mabuhay
Maliit na Pamilya

Campaign Components

Print Posters
National Media TV spots

Targeted Events

National Events
Father's Day
FP and Population Days

Local community programs will utilize key stakeholders and other synergy points, like advocacy drives and caravans.

End Note: There are two Chinese characters for crisis: one is danger but the other one is opportunity. Coping with both remains the challenge.

PRESENTATION 4.

The FP Communication Plan for DOH Key Elements and Features

Marietta Bernaje

(Please refer to attached Comprehensive Presentation)

Gist of Presentation

Simple messages are the desirable communication tools for promoting FP. The rationale of the plan is that government recognizes the population issue as a matter of priority, the national figure standing at 76 million. The steady increase in population has impacted on the Filipinos' quality of life. Important decisions have to be made to address focal issues.

The health promotion plan will use as its basis the Precede/Proceed Analysis. It should be noted that the program remains on an awareness level (90%), reflecting a practice value of only 45 percent. The informed choices of women will be needed, as well as the management of unfounded fears of side effects. The enabling personalities who will push the program forward are policy makers, program supervisors and regional health workers. Their efforts will be

reinforced by MIS instruments that include the Demographic and Health Survey, advocacy and IEC materials.

The objectives and strategies of the campaign are to increase social acceptance and practice of FP as a desirable and natural part of a successful Filipino lifestyle, and to generate a value-derived opinion and behavior that having a small family is beneficial to health and happiness.

Target Couples

MCRAs in the C and D classes

Thematic Message

Practicing FP ensures the family a better life.

Proposed Communication Handle

Family Planning: *GINHAWA SA BUHAY*

Activities of the National Campaign

Tri-Media campaign

Media relations

Improved FP standards and policies

Special events

Monitoring and evaluation

Suggested Regional and LGU Activities

Building health public policy for health workers and LGUs

Creating supportive environment by health workers and partners

Strengthening community action by health workers and partners

Developing personal skills of target audiences by providing IEC and counseling

Re-orienting health services by health workers and partners

Discussions

Clarificatory Questions/Remarks

Questions	Answers
There is no question as to what can be reached, i.e., the happy family. Before this, we have to look at the persistent reasons for non-use, namely health concerns, side effects, lack of knowledge, fatalistic attitudes, and people wanting large children, and others. Focus should start on the first two reasons. In the early 90s, this was done but a recall is in order.	JHU always based its messages on gathered information. We used to have method-specific materials. We can only do so much in terms of only two flagship messages.
We have to plug the general message that all FP methods are safe and effective.	The challenge is how to re-position FP as a happy and desirable experience. We must move this down to the level of inter-

	personal communications (IPC) through counseling as a preferred channel and not so much in the area of IEC.
Relevant to the communications handle, only one uniform message will be necessary. <i>Masarap Mabuhay</i> and <i>Ginhawa sa Buhay</i> messages should be consolidated.	We are working on one consistent high-impact message with photo action.
Among suggested activities on regional and LGU levels, part of strategic direction is for LGUs to ensure availability of all methods. But what was indicated was the mainstreaming of NFP. It is important to upgrade worker skills to provide the mechanics for this method.	The effort is to bring NFP to the level of other methods. There was no investment on the part of NFP in the past, hence the need for a catch-up mechanism.

Observations

- The role of the 30-seconder is to legitimize action but it cannot serve to change the person. About 34 years ago, the campaign was IEC but over time, IPC and massive counseling have become the preferred modes for pushing five-point thrust. Service plus communication and skills building will be a more effective combination. This is truly the time to assess the sustainability of information and education drives. We need leaders at the lowest levels.
- We are working toward integration.
- There will always be opposition to FP. We are working in a democracy and should allow for the non-use of FP. While it is expedient to create a positive image for FP, we have to introduce the dimension of reality.
- The opposition may not actually be that strong
- We have to change the equation of FP with methods.
- We have to review old materials that were effective in the 70s and 80s for possible adoption. For instance, the messages entitled *Masarap ang Mabuhay* is not applicable to the poor.
- We are looking at a CPR of 49, despite the odds or opposition, one out of every two women are practicing FP. We need to work closely within these parameters.
- We can make messages shorter to obtain simple perception.
- Stakeholder base should expand; if time has overtaken FP why should we be reactive to the views of the Catholic Church? We must concentrate on priority areas in the design of propaganda.

- In dealing with medical side effects, the campaign seems to focus on lifestyle; past promotional experiences should be able to provide insights.
- The coalition concept allows everybody to promote brands (Trust, etc.). We are building categories for FP in the campaign. Specific methods and approaches permit autonomy for as long as they conform to national policy.
- Health workers tend to advocate and campaign only for products that are supplied. This should not be delimiting. We have to provide guidelines on the use of other brands.
- In the choice of rider events, we must bring to the consciousness of people only one message. They tend to be overwhelmed by the number of messages reaching them. If we can focus on just one message within a given period, we may reach our targets.
- We are trying to segmentalize messages to appeal to a particular sector. We cannot deliver one sweeping message for all. One over-riding theme should predominate
- *"Kung silay mahal mo, magplano"* was cited globally for its impact and could still be modified for adoption.
- FP is a desired future state and the option to turn it into a norm is a strategic decision that has to be made. IPC communication is the best method to address FP objections. Communication campaigns should thus be carried on various levels, observing consistency in the types of messages to be plugged.
- Participating agencies are not properly directed. Why should the program limit its scope to C and D markets, leaving the E class behind? Why not utilize the powerful vehicle of soap operas? Local TV channels in the region could also be effective. Government has a role to fulfill in information and education, for instance in raising awareness of the law on family courts. At the local level, ordinances are anchored on the national law. The communication campaign should be able to address the problem of transitions. Coalition involves the fusion of cooperating agencies but the DOH should always remain the frontline lead agency.
- In order to de-politicize family planning, it should be eased out of the political and government system. It should be moved away from power blocs and pressures. What the DOH is doing is to allow other partners to take the lead in other program components.
- DOH should be pro-active in leading the coalition. NGOs have their own advocacy networks that could form the basis of a coalition. The driver of the campaign should not be the cooperating agencies. Maybe this is what the workshop should work on.

- The message on "small families" seems superfluous at the grassroots level whose members could not relate to the messages advocating *Sarap* and *Ginhawa sa buhay*. Churches are always against the prescription of small families. If our target is "small families", then this should not be explicitly stated on print. Instead, we must call for "planned families." To capture FP, only one word should be adopted. In carrying out the drive, we must strengthen the flow of information on field.
- There is a need to address adolescent health since this is the biggest most vulnerable group among WRAs. Most of IEC materials presented were contraceptive laden. FP is positioned in the field of contraceptives, and we are looking at young people – as to what strategy or focus could be more effective towards their sector. I have reservations against using the word "uso" because contraceptives are not as popular anymore.
- Approach toward this area could not be lumped along with other campaigns. One step to take in this direction is fertility awareness.

PRESENTATION 5

Updates on Checklists and Monitoring Tools for Enhancing Quality of Reproductive Health Services

Dr. Moises Serdoncillo

(Please refer to attached Comprehensive Presentation)

Gist of Presentation

The design of the checklists and monitoring tools adopted an approach and a logical framework that provided a hierarchy of inputs leading to the attainment of outputs. The focus was on results, with the goal of *improving quality of life*. The purpose is to contribute to the increased utilization of integrated quality RH services for men, women and adolescents, and gender-sensitive RH information and counseling services for behavioral changes related to health reproductive and sexual practices.

The results-based management approach (RBM) utilized objectively verifiable indicators and compared plans with actual outputs. It involved defining results expected for a specific period, identifying actual results achieved, analyzing and explaining differences, and identifying changes to be made to increase likelihood of achieving planned results.

Operationalizing output requires the provision of quality and gender sensitive core RH services to include Family Planning, Maternal Care, and RTI-STI-AIDS prevention under a climate that is holistic, empowering, accessible, efficient and comfortable. "Quality" refers to the respect given by providers to their individual clients, empowering women to participate in decision-making. The Indicators of quality RH services are: percentages of service providers (SPs) observing process standards; percentages of service delivery points (SDPs) providing the package of services, percent increase in FP male clients in all SDPs, and percentage of satisfied clients.

The framework for quality services consists of methods of assessment of RH services and means of verification to generate quantitative and qualitative data. The monitoring tools will use basic tabulations, reporting forms, and checklists. Observation checklists for health professionals focus less on professional competence and more on their attitudinal behavior, communication skills, interpersonal relations. Technical competence is assessed in terms of training effectiveness, extent of amorality, and state of facilities

Recommendations include the following: retrieval and analysis of quality indicators for services; direct observation using checklists based on standards; process measures and tools that focus only on relevant information.

Discussion

Clarificatory Questions/Remarks

Questions	Answers
If men can be made to participate in FP, this will effectively increase CPR.	
Checklists are comprehensive and ideal, but who will use them, the provinces or RHOs?	At the provincial level, personnel could hardly manage to fill in all the forms they are required to accomplish, and the new addition may just serve to saddle them all the more. We are introducing a system that can be adapted to local needs, leading to a set of standards where points of intervention can be identified in terms of technical backstopping and DOH interfacing.
In Nueva Vizcaya, a community based MIS was piloted to which BHWs were resistant. UNFPA provided a technician and computer base. In the end, what they were able to appreciate was ease of retrieval and reduced paperwork. This experience showed us that indicators can be adopted and modified to conform to local needs, given the chance to the used. The only requirement would be to train the workers.	
How did this come about?	In the nine pilot provinces, we are able to disaggregate data as to how many service providers were polite, etc. We are now in the process of encoding the data collected for retrieval and analysis.
The regional directors wish to be appraised of the actual state of facilities at the service delivery points (SDPs).	The only problem at the site of actual observation was observing the practitioner from the pre to post-natal periods. Otherwise, the monitoring checklist was comprehensive, user friendly, and even facilitated the actual competence of service providers.
Region 10 has conducted quality assurance training for hospital personnel. In that part of the checklist on obstetrical care, is the unit of analysis the client or personnel, since the end desired is the	In utilizing both existing and community based methods, we tried to be client centered and simple. In the exit interviews, client satisfaction will point toward institutional capability, efficiency

timely performance of medical procedures?	of records, etc. The technology can be improved according to the needs of the locale.
Since refinements are still forthcoming, may we suggest the inclusion of end-users? Please comment on the level of accuracy, completeness and conciseness of your data.	If the monitoring and checklists are intended for a survey, it will result in a different time frame. For monitoring purposes, supervisors can point out weaknesses and devise a plan for improvement. For the clients, a pre-testing was done at the community level to determine their concerns. Refinements are acceptable.
How many days will be consumed by the monitoring process?	At random and as the patients arrive, it could take as long as three weeks. Monitoring requires an assessment of areas; the minimum quality of standards are non-negotiable but can provide a guide to community targets. Frequency is dictated by need and the availability of resources. Scoring methods are included.
How was satisfaction gauged?	Depends on the knowledge, attitudes and perception of clientele in general. The exit interview, however, will only benefit actual users. Community focus group discussions, for instance, will yield the true picture.
Is the checklist being used?	Yes, in the nine (9) pilot provinces; inter-provincial monitoring was adopted.
<i>Senrong Sigla</i> indicators were reviewed periodically - were they included in the checklist?	We are considering the inclusion of some of the entries.
<ul style="list-style-type: none"> Engender Health also developed a tool and is conducting training in all regions focusing on VSC. Tools were developed for hospitals, training centers, and health units that include FP counseling methods. The objective is to strengthen the capability of RHOs, for to institutionalize the gains. This will be followed by capability building on facilitative supervision for regional health staff. While we encourage regional officers to bring gender monitoring to the provincial level, they should know how the process can be sustained. It is easy to see why the CDLMIS can function as a demand side measurement, which is to access resources successfully. This is a quality improvement tool used worldwide to improve the quality of health services. 	
Why should we focus on improving quality? If Philhealth itself has taken the view that quality improvement is optional, how can we expect the imperative to be taken up by regional staff? In the scheme of things, why should FP take precedence over the number of things that need to be done?	The program has focused on the perspective of making services available and accessible - with artificial FP on one end, natural FP on the other, and all the other methods in the middle. How do we ensure quality and maintain it? The nine provinces know the basic quality components and tools to be used to assess quality. This involves a critical look at current policies and procedures.

	against the framework of quality set by the department in RH core components.
What is the difference between the monitoring tools currently used by regional staff and this set?	The regions were seen as the best source points of technical monitoring. Thus, Engender Health undertook a training workshop on the how to's of monitoring for all regions. The UNFPA monitoring tools are therefore more comprehensive.
There are two view decks of quality intervention but there are common areas where two tracks converge.	
Our concern is that these monitoring issues are supposed to be utilized by regional coordinators already equipped with available monitoring tools, adding up to their paper load.	We can look at areas of interface. They may be integrated with the Regional Health Information System that serves as a tool to generate data.

Observations

In advancing women's health, the line followed is that health is a rights and policies-based issue. If this is integrated into the health system, the duty of health providers can be qualified. A demand-driven dimension is the focus. We involved organized women in the community. We had to initiate inter-action between the women, providers and LGUs. Feedback mechanisms were needed so we developed exit interviews. The women themselves used these as tools to monitor health services delivered at their level. This led to the identification of interventions.
Another model adopted by the Population Council focused on FP services. The <i>Sentrong Sigla</i> Certification Program is incorporating process indicators. The elements of assessment are similar.
NGOs rely on quality-of-care indicators. Whatever indicator may be adopted, it helps to know that these indicators exist. NGOs don't give services for free but deliver them in a socialized manner. If the tools will help us to become better, they should capture vital concerns, i.e. experiences with drugs like <i>Logentrol</i> . Tools enable providers to pinpoint affordability, accessibility and quality. As to reporting, it should be noted that NGOs do not submit reports because of their autonomy.

Synthesis

Quality has been de-mystified. Now, we know how to concretize and cut up dimensions of quantity and quality of care. The preponderance of many monitoring models should not lead to a confusion but to the realization that quality is a vital requirement of the service. The development of tools is process oriented. We have to emphasize the need for ownership. The main point is to synthesize and synchronize mechanisms to meet leadership directive to ensure continuity of service. Service providers, facilities and client puzzles can be made to fit. Tracking forms can be modified to monitor the quality of care.

PRESENTATION 6.

Assessment of Counseling Program for FP. A Review of the Program Framework and Project Milestones

Jose Miguel de la Rosa
(Please refer to attached Comprehensive Presentation)

Mr. De la Rosa explained why quality FP counseling is important. A unique approach was adopted in the project wherein partners were formed into a Technical Resource Working Group. Seven key areas were covered. The objective was to assess FP counseling program performance which was considered vital in improving CPR targets.

There is a trend to involve regional media groups in the program. A media network will be created at the local level where CHDs will serve as the focal points for FP promotion. Directories of media practitioners will be disseminated that can function as an effective resource base.

Observations

• Counseling is a power tool that can effectively change behavior.
• Counseling appears to be method-based, whereas it should lean more in the direction of the question, "why FP?" On the level of service providers, expectations are too big. Untrained professionals can be uncomfortable, considering the fact that they are the change agents.
• These concerns will be covered and clients will be given the prerogative to decide. Counseling will be viewed from a programmatic point of view.
• We should dig deeper into the types of information given because of the difference between informing and counseling.
• There are concrete simple models that could be regarded as counseling.
• FP requires a specific type of counseling.
• All counseling methods should be considered to encourage sustained FP practice
• The DOH Counseling Manual provides a source of reference.

Day 2
May 22, 2002

Workshop 1
Review and Targeted Assessment of FP Protocols and
Clinical Standards

(Refer to Annex I for Workshop Outputs)

The demand for Natural Family Planning (NFP) in the Philippines is among the highest in the world. Although various types of natural family planning methods have evolved over time, the demand for NFP services continues to be keenly felt. The policy of the Department was to imbibe new technologies in NFP, i.e., non-scalpel vasectomy, and bringing its practice to the level of other FP methods.

PRESENTATION 7

Policy, Principles, Processes, People and Enabling Mechanisms of NFP Mainstreaming

Dr. Rebecca Infantado

(Please refer to attached Comprehensive Presentation)

Gist of Proceedings

Health indices have remained high but the knowledge of fertile periods is low - only 14 percent of all women know that ovulation lies somewhere in the middle of the menstrual cycle.

Administrative issuances for NFP, particularly DOH Circular 130 dated 1997, define NFP in the context of World Health Organization (WHO) definitions and concepts. An educational process determining accurate fertile and infertile periods of women may be safely resorted to so that lovemaking may be timed accurately in order to avoid or achieve a pregnancy. Adherence equals rhythm. This order contains vital information on service delivery points offering NFP services.

Other issuances are the following: DC 101 1994 that provides information on the 1) cervical mucus method; 2) basal body temperature; and 3) symptothermal method; Executive Order 307 1996 that mandates local chief executives (LCEs) to include information on NFP; and 3) Administrative Order 50 dated 2002 that enunciates FP policy within context of Reproductive Health (RH).

"Mainstreaming NFP in the Philippine FP Program in NCR" (June 2001-June 2004) is a project of DOH in partnership with the Philippine Federation for NFP. The goal of this program is to provide universal access to NFP information and services in order to improve the health status of women and children and empower couples to make decisions. It aims to reduce MMR

and IMR, increase CPR and promote the use of modern methods. It also seeks to facilitate the shift from traditional NFP practices to modern or scientific NFP. One field experience is that organizing the users of NFP has proven to be an effective mechanism for expanding services in an area.

The NFP concept has been broadened to cover sectors like male involvement and domestic violence. Male acceptors eventually became advocates of the NFP method. NFP is also into achieving a pregnancy so infertility work-ups can be done.

The strategies employed in the promotion of NFP include consultation dialogues with stakeholders, advocacy and social mobilization, a functional inter-intra referral system, IEC campaign, technical assistance, documentation of good practices, institutional capability building and operations research.

Demonstration:

NFP scoring sets (abacus) were distributed to the participants and their use was explained by Ms. Dowling.

PRESENTATION 8

Standard Days Method Mainstreaming

Milagros Rivera

Studies show that new methods in FP serve to increase CPR because the number of choices have expanded. Under the Standard Days Method (SDM), a woman's fertile period is reckoned on the 8th to the 19th day after the first day of the menstrual cycle, during which abstinence should take place. This method is highly indicated for women with regular menstrual cycles.

The SDM bead set (or necklace) represents the cycle while the individual beads, the days. The non-fertile days are represented by the brown beads and the fertile days, the white beads. A chart may be drawn to indicate the probability of pregnancy from intercourse on days relative to ovulation. The three biological factors that determine a woman's fertile period are ovulation, the lifespan of sperm cells (5 days maximum) and the fertility span of the egg cell (24 hours maximum). The presence of all these factors equals the likelihood of pregnancy.

The eighth to 19th day span was set because of 1) ovulation moves, and 2) menstrual cycles vary from woman to woman. An eight-day fertility period is common to women with cycles of 18 to 22 days while average women have cycles of 26 to 32 days.

As an FP model, the SDM evolved over time. The WHO provided an institute with 7,000 cycles of women that were run through the computers. The 8th to 19th day stretch proved to be the best formula wherein zero pregnancies occurred. Pilot tests were made in three countries that included the Philippines (Benguet as the field test province). The Philippines provided about 50 percent of the population with 4, 035 cycles of method use. Efficacy and clinical trials were done on women who were closely monitored for a six

month-period. The multi-site prospective study was undertaken, and the services provided through existing programs. The correct use of the method yielded a failure rate of 4.8 percent, and an effectiveness rating of about 95 percent.

The findings culled from the pilot experience were that: there was a need to sensitize and train providers; SDM was easy to learn and use; many couples were willing to use the method correctly; male involvement led to successful use, the necklace was an effective communications tool; SDM can be used in combination with other methods; and correct use increases over time.

The method was picked up by 14 other countries. In the Philippines, the monitoring of client users continues. SDM has been introduced to agricultural workers cooperative in Bukidnon, in two clinics of Friendly Care, in Fabella Hospital. In these sites information and advocacy campaign by satisfied male client is carried out.

Demonstration:

Participants were given free sets of the SDM cycle beads and their use was explained.

Discussions

Clarificatory Questions/Remarks

Questions	Answers
In the tested population, how many cycles went beyond 32 days? Was the abstinence observed for the duration of the white beads? Were adjustments needed?	Cycles measuring beyond 32 days were excluded. Were lengthened to accommodate.
The use of other methods during the white bead days seemed to have negated the SDM method.	The other methods were resorted to only for purposes of accommodating husbands wishing to engage in intercourse during the white bead days.
<p>Notes: Studies revealed the use of condoms and withdrawal by partners who felt the need for barriers. The satisfaction lay in the knowledge that these barriers were not as frequently used as when other methods were employed. In the abacus method, what is adjusted is the pre-ovulation period and what remains stationary is the post ovulation period. 14 days after ovulation, the woman would menstruate leading to the fertility period of 14 days. It may be wiser to lengthen the post ovulatory case in SDM.</p>	
The use of barriers during the abstinence days seems to point to a combination type of method use.	The NFP component prevails because the couple reserves the right to use commodities or not. When an implementing agency is a multi-method agency that is open to the use of commodities, it becomes a reporting issue. We are trying to accommodate as many groups as possible willing to use a fertility based method.

<p>Note: SDM should go with abstinence. Basically, if this is violated, it is a choice of the client. It should accommodate abstinence because it is a method that is correctly NFP.</p>	
<p>There is silence on the use of other methods. What is being prescribed is an additional NFP method during fertile days. This is a point of reflection, but there are groups who teach NFP without mentioning the availability of other methods: these are the "pure NFPs."</p>	<p>What was recommended is a demonstrated and acceptable method mix. Other countries have accommodated implants. We are still looking at potential ways of expanding services through a consideration of new methods. There has been an expansion in other countries of various categories of NFP.</p>
<p>We wish to situate NFP because we teach the use of the method. We want to improve the approach and put together the requirements for NFP and SDM.</p>	<p>The minimum requirement is to make NFP appropriate and desirable for the couple. Fertility awareness is a requirement of all FP methods, and the point is to underscore male participation</p>
<p>In training for the use of the mucus method, for instance, we do not immediately introduce the method, we first explain the process involved.</p>	
<p>Is SDM, like NFP, ready for mainstreaming? What specific plans or testing has been done to "mainstream it"?</p>	<p>We must look at the study as a whole. The foremost question is effectivity. We need to look at acceptability. Based on these, mainstreaming is possible. Definitely, there are plans for the three NFP methods. DOH has the mandate to mainstream but detailed plans for the purpose will be drawn by the regions.</p>
<p>NFP has been sidetracked to 1.1 percent for the last three years. Very few have raised the banner for NFP because of the difficulty of process. Hence, the inclination to other methods "kills" NFP that cannot rise to the level of other methods. Majority still prefer the natural method. The future DOH strategy should appeal to the breastfeeding campaign. The best and natural FP is still breastfeeding. We must adopt the same attitude for NFP. Church organizations will be drawn to it because it is highly acceptable.</p>	<p>DOH looks at the preferences of clients. People have expressed the ir need by choosing permanent methods. It cannot prescribe particular method. The first line of the campaign is fertility awareness and the approach is to present the range of FP methods available.</p>
<p>A recent international study compared countries in terms of strategies adopted in FP programs, identifying factors that have contributed to success. Was the mix of methods available?</p>	<p>The mix was successful because of reduced pressure and conformity with the norms. Clients must be given a wide range of choices. We are removing the mix but what happened was that SDM was not given the importance it deserved, whereas there were incentives to the use of other methods. If attention is given, there will be a greater level of acceptance.</p>

Notes:

Increasing support for NFP should not be made at the expense of the other methods. If the government can spend Php30 million for NFP, what is given in terms of logistics is only for current users, not new acceptors. Government should address the gap and provide resources equitably.

NFP addresses the diverse needs of FP while addressing the needs of various religious congregations.

Dr. Roquero.

NFP should not lag behind other methods. Support from government and funding donors were minimal. The department has been given a budget for NFP but not many funding donors wanted to support it.

NFP is in a catch-up mode but this does not mean the exclusion of other methods. The framework is to make NFP services available, VSS on the other, and the rest in between. The government has allocated a yearly budget of Php250 million for commodities.

PRESENTATION 9

Highlights of the Action Plan and Proposed Operational Guidelines for VSS Itinerant Teams

Dr. Annabel Sumayo

(Refer to attached Comprehensive Presentation)

Gist of Presentation

The need for permanent methods is high: about 1.11 million women are potential clients of Voluntary Surgical Sterilization (VSS) services. They could not be reached because of the programmatic challenges of availability, accessibility, sustainability and quality.

Efforts were made by DOH, in cooperation with its partners, to address these issues by way of providing assistance to enable DOH, NGO and LGU sites to increase the number of service sites, renovate operating facilities and equipment, train providers and counselors, and improve referral systems. Engender Health assisted the program, in partnership with other NGOs, LGUs and private hospitals. The consultative workshop in 1999 discussed the training of Ob-Gyne residents. Assistance was also provided to make DOH retained hospitals become functional centers for Mini-Lap under local anesthesia per AO 2 - 2000, that requires physicians to be competent in the technique.

RHO capabilities were likewise enhanced in monitoring and technical assistance under the devolved set-up. Personnel training on facilitative supervision was conducted to enable the RHOs to lend assistance to VSS service sites. Augmentation funds were provided by the central DOH to make the procedure affordable.

However, the transfer of trained providers from the hospitals to other places of assignment has adversely affected the project. This situation was addressed by the formation of itinerant teams. The pilot centers for VSS Itinerant teams are Fabella and Rizal Meedical Center.

Details of Proposed Guidelines for VSS Itinerant Teams

Dr. Francis Floresca

Itinerant teams that used to form part of the FP program should be revived in order to bring services where the clients are. The sites for outreach services include communities with documented demands for VS services and places where trained providers are not available. DOH retained hospitals were mandated to organize the teams. According to the guidelines, each of the hospitals are authorized to form two teams. The role of counselors was emphasized.

The staff composition includes a surgeon, nurse, midwife assistant and circulating staff. Venues are hospitals with functional OR facilities complying with the requirements for minor surgery or Bilateral Tubal Ligation (BTL). In health centers, refurbishing will be necessary to allow for procedures. Vasectomy can be done in a non-hospital setting. Instruments available can be shared, along with sets for non-scalpel procedures.

Drugs and supplies will be supplied by DOH retained hospitals that should be able to target a specific number of potential clients. A target of 30 clients per team visit was set. The hospital should maintain a level of drugs to accommodate VSS clients. LGUs can help in providing drugs and supplies.

One of responsibilities of the team is screening, monitoring pre/post-operative follow-ups in the outreach areas. FP counseling and information activities were considered vital to the accomplishment of the Informed Consent Forms. Another concern of Itinerant Team service is financial resources. The Center for Health and Development coordinates these activities. The CHD assists the DOH retained hospitals while the regions allocate a budget.

Presentation.

A Video Presentation on Non-Scalpel Vasectomy was shown, followed by a testimony of image model for VSC, Dr. John Flavier.

Discussion

Clarificatory Statements/Remarks

Question	Answer
The requirements for the formation of Itinerant Teams should be more flexible. Chiefs of hospitals (CoH) may find difficulty in providing nursing components. The wordings of the EO should take this situation into account.	The proposed guidelines are being submitted to this Conference for additional recommendations.
VSS can be done but the problem of supplies arises. Hospitals need drugs and logistics because present stocks are not even enough for standard hospital procedures. When districts were not yet	We can identify areas for resource mobilization. A sub-allotment of Php500T was set for each of the retained hospitals. We are also looking at potential funding from PhilHealth that

devolved, VSS was commonly practiced.	subsidizes reimbursements for BTL operations provided that the procedures are done by PhilHealth-accredited hospitals.
What can be piloted in NCR?	VSS Itinerant Teams in <i>Kalahi</i> areas.
<p>Note: VHWs can identify potential clients in the community who can avail of services in family planning including BTL. Hospitals can find a way of scheduling staff, since it is done on a special basis. The services of VHWs are important but the point is to meet the backlog, so there is a need to allot Php4 million to fund the needs of VHWs. LGUs are the ones who compensate VHWs. Next year, urban poor communities in other sites can be identified.</p>	
<p>Note, Dr. Rodriguez. The MGD can provide resources to assist projects for the urban poor.</p>	
<p>There is no need to pilot VHW-aided project, for as long as good rapport is established with the LGUs.</p>	
<p>There are clear and explicit needs in specific areas of Mindanao that should be prioritized outside of Metro Manila.</p>	

Observations
<ul style="list-style-type: none"> • Priorities of the FP program should be clear with local governments, industries and political leaderships. Another thing to consider is that regional health nurses with OR skills can be mobilized for the program. • One major concern of hospitals is quality manpower and resources. We are in the process of upgrading manpower; in resources, Congressman Macias directed that tertiary hospitals should no longer subsidize secondary and primary care. The budgets of the retained hospitals were correspondingly reduced, with the consequence of becoming vulnerable to public censure. The additional responsibility of maintaining itinerant teams on top of TB and other programs will be a burden. Our frontline services will suffer as a result. • For the past years, we have been doing surgical missions with the exclusion of VSS. The average cost for BTL is Php483 vasectomy. This will be compounded by the insurance requirement of traveling teams. • Nueva Vizcaya carries out medical missions, but we have taken out the medical function to be able to include BTL and circumcision. We have six consultants, eight residents, and two anesthesiologists. In agreement with other LGUs we have sent teams to other places including Ifugao.

DOH - GOP Budget for FP

Dr. Loreto Roquero

(Please refer to the DOH GOP Fund Report)

Urban poor communities proliferate in the biggest urban districts like Metro Manila, Cebu and Davao. Prioritizing does not mean we do not support everyone. This can be tabled for future discussion.

The urban poor program came about as an initiative of cooperating agencies, when the President wanted a program for urban poor areas. It was not a case of prioritizing NCR. What happened in NCR was the demonstrated funding for VSS. LGUs are ideal sources of funding for VSC. Cases paid for by

LGUs and PhilHealth can be farmed out to other needy areas where ambulatory surgical outreach services could be offered. It remains to see whether the procedures can be performed by accredited or non-accredited providers.

Congress has been criticizing retained hospitals and medical centers for extending primary health services. The objective was to transfer public health roles to provincial health offices. There are immediate sources of funding in the GAA, Php50 Million from Congressman Rodolfo De Venecia for NFP, and Php50 Million from Senator Juan Flavier for contraceptives. Whether this will actually happen bears watching because of DBM memos that inhibit the purchase of commodities.

Finally, what was read in Congress is that ten percent of hospital budgets are supposed to support medical missions requested by politicians. Ten percent of Maintenance and Other Operating Expenses is presently followed. Maybe half of this can be diverted to health promotive activities like outreach surgical contraception. The disallowed funds for contraceptives and PhilHealth funds can augment funds for ambulatory VSS.

Hospitals as Centers of Wellness program funds amounting to Php100 million is small. We do not agree with the Php4 million allotment for NCR. The Php1.1 million unmet needs will amount to more than Php400 million in terms of BTL operations. More vasectomies are in order since one BTL is equivalent to the cost of three vasectomies. We have success stories of LGUs providing counterpart funds for health and PhilHealth funds. Congressional initiatives may contain a DBM *colatilla* that could be restrictive.

The congressional initiative of Php7.6 million originally intended for Region I from Cong. De Venecia was expanded to Php50 million. Urban poor communities in Manila include *homes along the riles* (railway track shanties), Pasig Riverbank communities, and *Kalahi* areas. Php4M will be allocated to VSS as well as information and itinerant teams; Php500T will go to each of the 30 DOH retained hospitals. Senator Flavier's Php50 million for commodities has been withheld by the DBM restriction. The Php36M allotment for hospitals will help us move ahead. All these however, will depend on the submission of plans.

Clarificatory Questions/Remarks

Question	Answer
Please provide a copy of the DBM directive not to release funds for	FP commodities, which is an urgent action matter for advocacy groups. There is an internal memo from Malacañang to DBM. It was relayed at the meeting of Popcom officials.

Congressional insertions started with the partnership between Gov. Viktor Agbayani and Speaker de Venecia. A work planning session was called and tabled with the Popcorn Board. Since it was a service delivery program, the DOH was tasked to lead the group. The funds will consist of a Php50 million CIA and Php50 million GOP. The initiative was taken up with two bishops from Region land Region IX for funding support of NFP programs. This is an open window for future joint proposals.

The expectation is a unified guideline for NFP. We must be aware that the positions of Bishop Cruz and Bishop Ledesma are individual and personal decisions on their part. We are hoping to open windows in NFP service delivery with the Catholic Bishops Conference of the Philippines (CBCP). We hope that this will become a model for others to follow in terms of an inter-faith collaboration among church groups.

There is nothing wrong with collaboration and coordination but these should be kept at the policy level. NFP deserves support as part of the overall FP methods. But we are involving the church, their areas and choices of clients. As a consequence, half of FP workers will be identified by the church. In Manila, it is an inter faith group. If were to avoid hegemonic designs and intentions, there should be an ecumenical approach

These are models that can be used to implement mainstreaming. Inter-faith, church, lay groups, and LGU initiatives comprise a multi-stakeholder approach.

The NFP found a niche in inter-faith partnering. The defining characteristic of NFP is people whose principles and values have a paradigm clash with other methods. It is not a matter of pleasing any type of church group.

Participants were clustered into six groups, three groups for NFP and three for VSS. The workshop will identify action points, potential constraints, and recommendations in terms of NFP, and mainstreaming and review of proposed guidelines for VSS.

Day 3
 May 24, 2002

**Workshop II Presentation and Discussion of Outputs:
 Natural Family Planning and VSS Itinerant Teams**
 (Refer to Annex 2 for Workshop Outputs)

TOPIC 1: VSS ITINERANT TEAMS

Discussion, Visayas-Mindanao Team

Clarificatory Questions/Remarks

Questions	Answers
Entry No. 3 on VSS Standards (Counseling the Client) should be removed. The client, in signing the consent form after counseling, assumes responsibility for his action, not the guardian. Only in instances when the client has to secure permission or consent from a 3 rd party (in cases of mental or physical incapacity is the legal guardian's signature required.	Previously, spousal consent was necessary but under the revised guidelines, only that of the client's is secured. He alone has the right to render decisions regarding his body. BTL and vasectomy clients are the signatories of the consent form, as it is presumed to be a shared decision.
A consensus was arrived at to dispense with the legal guardian's signature inasmuch as reproductive right is a legal right.	
NFP should be included as part of professional education.	Recommend the creation of a Department of Surgery. In the Ob-Gyne Department, most of the residents are female doctors who want to be trained in NFP.
Age is a serious concern in VSC. The standard should indicate at what age vasectomy can be performed. The free choice should be given to an individual male person regardless of his age or civil status. Are there guidelines that should limit his access to vasectomy? Children and minors are vulnerable to the manipulation of unscrupulous adults who may require them to undergo the procedure. This is a protective measure to safeguard male rights.	Consent presupposes legal age. No age, parity, civil status, religion or race. Informed consent presupposes the decision of the client and his partner to undergo the procedure.
No responsible surgeon will perform an operation on a minor. Eighteen years is the age of majority. VSS is a permanent procedure and subject to liability.	
Will we allow mentally disabled clients to be vasectomized?	Delete No. 1, Dots 3-4.
There are insane women we are trying to protect from rape and STD - who gives the consent for mentally deranged women in the streets? What policy	Dr. Roquero We must look at the purpose of VSS. We are putting too many requirements, there are more safeguards rather than

<p>guidelines should be followed when someone attempts to subject male prostitutes to the procedure?</p>	<p>guidelines. No surgeon will conduct random surgery on the mentally handicapped. Let us not burden ourselves with too many requirements. The objective is Responsible Parenthood. While it is an individual decision, it is also a shared responsibility. The decision of the individual client should prevail.</p>
<p>When a single person applies for VSS, will he or she be allowed to undergo the procedure?</p>	<p>Dr. Rodriguez. A word of caution in this regard, we propose that this be allowed on a case to case basis particularly with regard to VSS under spinal anesthesia. We must be aware that morbidity and risks are higher and resources are scarcer, since the patient will be an in-patient, not an out-patient.</p>
<p>Our concern is zero pain. If we do low spinal, in the hands of a good anesthesiologist, we can remove the pain. The patient can stay for a minimum period of 12 hours then leave, with minimal cost. No matter how skillfully a provider can perform a BTL, the risks of pain are great. Itinerant teams, 24 hours after post-partum, can perform the procedure but implications should be studied.</p>	<p>What is important is to screen patients at the site thoroughly before sending vulnerable patients to hospitals for longer and more expensive procedures.</p>

On the Use of Anesthesia

Let us leave the decision to the patient and the surgeon on the choice of spinal or local anesthesia.

We must remember that there should be a standard practice, if it is indicated that we have to adhere to the basic requirements of local anesthesia.

There are capabilities to explore in the provinces and districts. There should be uniform guidelines for the public and private health sectors.

Spinal anesthesia depends on the physical condition of the patient. We have an outreach team in the province performing local anesthesia in an OR setting. Situations vary from province to province.

Local anesthesia is a basic requirement but it is open to other options. Otherwise, why did we incorporate the services of an anesthesiologist?

Redirect the program through re-training for mini lap under local anesthesia.

Financial resources (page 4) should not delimit the service to internal financial centers; it should take into account cooperative arrangements with LGUs.

Discussion, Luzon Team A

On the phraseology for Background and Rationale, the FP positioning should be recalibrated – the rationale for program would be *to assist* (not “promote”) couples choices.

Team A Presentation. There were no clarificatory questions and comments on the presentation of Team A. The participants moved for an agreement with all the strategies outlined in the presentation.

Discussion, Luzon Team B

Clarificatory Questions, Remarks

Questions	Answers
With regard to possible conflicts with Pro-Life NGOs, NFP is even more conducive to the standards of Pro-Life hence the statement should either be removed or re-phrased.	The NGOs may appear to help NFP but once within the fold, they may question artificial methods that may lead to a conflict of issue. This can become an incomplete partnership.
One constraint is lack of a directive for organization of NFP Management Teams. From where will the directive be issued?	This may be concluded among stakeholders in the area, it is not a top-down not form of management.
The directive should be issued from a higher level where it would be easier to involve the multi-agencies.	
Dr. Serdencillo. Meetings have cost implications, if there is a basis for funding, it is possible to involve line agencies.	
In Davao, a fund of Php3 million was devoted to NFP.	If the action will be confined to the committee, costs are disallowed. But if it is a multi-agency initiative, we can have the basis for accessing funds.
<p>On Coalition Building</p> <p>Dr. Roquero. We need to build coalitions for FP and NFP – to be spearheaded by management teams at the national level and the regional levels. A team of multi stakeholders for all FP methods is preferable. There are matters that should concern the national office (legalization) and the local levels (implementation). The organization of VHWs in NCR may be similar or different from that encountered in Davao. We may not find the need to build coalitions with other agencies, most GOs have their own FP programs which do not need any national mandate. Dr. Castillo. Even in the absence of a higher directive, we can do it, but if we can have one, it can benefit the regions who expressed the need for it.</p>	
Ms. Dowling. We respect the autonomy of region and the higher office. Regional groups, however, are the critical setters. It is they who could positively influence the adversarial dynamics with Pro-Life and church-based NGOs. In the early days, there was openness to the use of condoms. If NFP is offered, should the other methods not be offered? The reality is that there are other groups who would not subscribe to methods other than NFP.	
The Pastoral Letter of Bishop Ledesma is a welcome development. It is not yet the position of CBCP. We must examine the structure of NFP to expand the base of stakeholders. The Catholic Church dimension may be softened by the inter faith approach.	
Ms. Auste said that in reality, bishops have their own right to take their own position. While the CBCP as a body has not issued an official statement on NFP, if one tries to look at the history of successful coalitions, programs succeeded because activities focused on local autonomous parish structures. The presentation of SDM did not express open acceptance of condom use. But they were open to the reality that there are couples who may opt to use it	

What are management teams for?	The recreation of NFP management teams at the regional level will facilitate the establishment of a coalition, which is an implementation partnership. They can consist of key players in the region. We should be clear because as a standard of managing NFP on ground, the project will be adequately guided.
What will be the composition of the management team?	Del Castillo. Representatives from line agencies like DOLE, DILG, DepEd, no clear nor the name it will be called. Coalition strategy can be done through the Regional Development Councils (RDCs). Other key players are FP Coordinators who attend the regular RDC meetings with task forces, and the regional Popcom that created task forces on NFP.

TOPIC 2: NFP MAINSTREAMING

Discussion, Team C

Clarificatory Questions and Remarks

Questions	Answers
The revised general guidelines on the utilization of the Php4-million for mainstreaming NFP are not limited to training alone but are likewise specified for mobilization, advocacy, IEC and other programmed activities.	There are specific issuances on RH but we are looking at specific components for individual areas. We are operating within the framework of RH.
We must be equipped and armed with legal orders and other documents that have not been received will be distributed next week. These are old laws issued from 1994-97.	Issuances
Dr. Moises Serdoncillo. In the approved protocol for services, there are annexes that cite the respective issuances that can be added on and enhanced. Relevant laws will be retrieved and disseminated.	
Dr. Roquero Incentives for high performers include one ICU and one OPD. For purposes of NFP, there are other sources for high performers. Every region will be given the minimum fund requirement, but regions needing catch-up programs will be given special funding.	
The reasons behind low performance is not only insufficient funding, but also wrong strategies and slow mobilization. We suggest the equitable distribution of funds rather than zero-budgeting or cutting down on low performers.	

PRESENTATION 10.

Strategies and Approaches to Respond to the RH Needs of Priority Regions and Communities

Dr. Jose Rodriguez

(Refer to attached Comprehensive Document)

Dr. Rodriguez expounded on the findings of the 1995 Survey on Unmet Needs. The Cordillera Administrative Region, Bicol, Eastern Visayas and ARMM manifested the lowest CPR. For year 2002, poor regions were given an augmentation fund of Php1 million to address service inequities in FP. Some of the strategies that were adopted were expansion of MGP coverage, increased funding support to poor communities, and skills training for BHWs and BSPOs that in effect brought VSC closer to the clients, the use of CDL-MIS for target clients, and strengthening social support.

Vital to consider are other options that improve access to VSC such as the NGOs, the Mary Stopes chain of clinics, private sector physicians, and other existing networks – the more creative, the more options. The appropriate private-public sector mix consists of a complementation of private sector providers who cover pay clients and public sector providers who take care of free clients.

As to whether interventions can be sustained; in the short term, support comes in through foreign grants; in the long term, from the regions. With the PhilHealth, partnership, FP VSS becomes an outpatient package. LGUs offer another option to make program sustainable.

Guidelines for Action Planning were given by the process Consultant, Ms. Auste. The participants from the regions were gathered into five cluster groups, two for Luzon, one for the Visayas and two for Mindanao. The break-out groups began discussions at 1:00 p.m. of Day 3.

ACTION PLANNING

(Refer to Annex III for Individual Regional Plans)

DOH Undersecretary Milagros Fernandez informed the participants of the importance of the Consultative and Strategic Planning Conference, which was the creation of **Individual Regional Action Plans on FP in the context of Reproductive Health** in 16 regions that would guide the thrusts of the Department of Health from 2002 - 2004.

Discussion, Visayas Group

Questions	Answers
<p>Usec Fernandez: Is this for the whole Visayas group, no individual work plans?</p>	<p>We combined all the plans.</p>
<p>Usec Fernandez. Your plan appears to include activities already onstream in many areas. You need a budget for that, you have to fine-tune plans based on the reactions of people here. Why are you are in a hurry to go home? You should go home tomorrow. I invite everyone to react if you can feel you can make a plan better, a hospital more effective, and produce results, hiring the necessary people in the process. Your vision is only on NFP and fertility awareness, how about other methods?</p>	<p>The training we aim to conduct are capability building training with NGO organizations, Training of Trainors on Fertility Awareness with participation regionwide (Php112,500); training of service providers and health educators (Php450,000); recruitment and capability building of new hirees on SDM (about PhpPhp112,500) including training and projected salaries of Php900,000; and participation of doctors (Php1.6M) for a Total Planned Budget of Php1.8 Million</p>
<p>Dr. Roquero. I noted that the focus is mostly on health workers. The regional and local levels are building coalitions. In initial training, bring in partners from multi sectors already. Identify potential trainors from those partners. I took note of your interest in SDM but you have to consider its limitations because it is indicated for women with regular cycles. How do we deal with other women who cannot qualify for SDM?</p>	<p>We have included this already so we can work with intervention plans (four batches within six months). We discussed the possibility of adopting the abacus if adequately tested.</p>

Usec. Fernandez

We are conducting operations research to challenge what has been declared as scientific methods in terms of recording and charting. We are **easing out the use of the charting which is the main reason for dropouts in NFP.**

Dr. Rodriguez

Will ultimate trainers be volunteers? There are SDM materials but we are in the process of developing a **training module for volunteers** that we included in the CDL-MIS. This was tested in NCR but will be made available to other regions.

Synchronize advocacy plans seriously and localize national campaigns.

In Negros Occidental, Mary Stopes Clinics are already providing a lot of services in eight cities and municipalities. The Family Planning Organization of the Philippines has formed a non-scalpel vasectomy team in Region 6.

We have to train additional staff who are presently not health workers.

One of the constraints was sustainability of the program but you also mentioned hiring - which is more cost-efficient, giving additional training and allowance to existing personnel or hiring additional staff?

We opt to hire personnel because of regular fund releases that assure the supply of trained people. The GOP can sustain the services of these employees. We have hired 12 casuals from MOOE that we can augment.

Usec. Fernandez

You will not be allowed to hire. **Analyze the strength of your own regional office.** How many FP plans are there in the region? If one, you want to strengthen, think of how to do it at your level by **putting in additional people sourced from related programs.** You can **reorganize the team.** You don't need to hire people anymore. You cannot hire and source money for training and logistics in general. There is a **limit to our budget,** we can only hire a certain no of people.

Your TNA plans are good. But we must train in a holistic way. Find the needs of BHWs on field and train them on FP, NFP or in other methods. **Schedule all trainings in one sitting. You have to have a certain design. Go back to basics and reflect it in the work plan.** Let us not be generalists. Who should be trained in what? How and who are the implementers to be trained first? What type of training must be done for BHWs? In motivation, counseling, recruitment, will they prescribe a method or will their work be limited to FP? You decide.

As for hospitals, we should create a VSS itinerant team for all the hospitals. How will you do this, who will compose it, will it be composed within the Ob-Gyn Department, from the Surgery Department, or from the districts? Put **doable plans** for the local level.

What will be the **role of NGOs in FP** in the regions, what are their **resources, and expertise?** Consider the Popcom. Bring them back into the program, include them in the plan. The church, how can they be **harnessed in NFP?** Coordinate with them. **We never succeeded in doing FP alone.** We have a low CPR, our people use traditional methods. So this is a renewed program that will enable us to survive opposition, criticism, and move forward.

If you have a good plan, the DOH and funding donors will assist. USAID wants to see political will, but we should be concerned with activities at grassroots.

PLENARY DISCUSSION

- *On Raising CPR thru NFP and VSS*

At start of workshop, there were two strategic areas to look at: low CPR with high unmet needs, and areas with high prevalence of traditional methods. The strategic activity to undertake is **building itinerant teams, training of BHWs in urban poor areas, and mainstreaming NFP**. What is the prioritization for NFP, VSS and health worker training, how can they be applied? We would like to see these in the **formulation of the budget**. We like to see more NFP in areas where the practice of traditional methods are more widespread, so these could be shifted to modern methods. We have seen that NFP can be mainstreamed.

One way to start will be to review strengths. Engender Health has already trained doctors in mini-lap under local anesthesia. The strength here is that the A.O. allows physicians to perform the procedure under local anesthesia. One of the steps to take is to formulate a regional order or hospital order creating teams with trainers. We want to know how funds for drugs and supplies can be used adequately for VSS. For instance, **put a mechanism in place so that these drugs can be monitored to balance supply with demand**.

- *On Partnering Potentials with Mary Stopes*

The issuances will add more teeth to the plans. Add columns on what we want to see after a timetable, i.e., two itinerant teams. Clarify the status of working with Mary Stopes.

At the Execom Meeting in DOH, Mary Stopes personnel were invited to discuss their activities in the country. The DOH Secretary wanted them to follow comply with accreditation requirements that is now lodged with the regional level. The organization is a potential partner in VSS and DOH can facilitate this process.

For as long as Mary Stopes performs the operation in a DOH-accredited institution, their procedures are considered legal. BTL requires a hospital setting. The provider should be trained in VSS, hence the need for the accreditation of training institutions.

USec. Fernandez

Accreditation is necessary to ensure they do not perform the illegal practice of abortion.

Dr. Rodriguez

Are we questioning their providers who perform BTL in hospitals?

Usec. Fernandez

The trouble is that not everyone knows much about the organization. The Secretary is intent on seeing some coordination but a representative is always unavailable. It would be better to link up with Engender Health.

Dr. Castillo.

The licensing staff has not yet acted on this to allow the VSS procedures to be done at the regional level.

Before devolution, the authorized accreditors were the regions. The difference with Mary Stopes is that it is not office-based but itinerant. They usually perform in aseptic places such as markets, schools, etc. DOH trained personnel can partner with them when the operation is offered in a facility. We accredit the person but not the facility. They have not shown up when they were invited. We left self-assessment forms at their clinics but they did not return them because they argued that the accreditation request was voluntary. I am disturbed by this because they go direct to the LGUs and manage to get a permit from the Mayor. In case of complications, the RHUs are tasked to solve the problem.

Question.

If such a group is not accredited, why are we allowing them to perform?

Answer.

Only the DOH has the power to stop them. We observe a DOH quality standard of performance and adopted the style of Mary Stopes using local anesthesia. If the patient is compromised, we are left to deal with the problem.

- ***On Professional/Facilities Accreditation***

The solution is for DOH to train its own health workers. In Amedeo, Cavite, patients were able to avail of quick ligation procedures. We have to **train a cadre of certified providers skilled in all the methods.** We have to make an inventory of trained people.

We would like to get in touch with the consultants, fellows and diplomates of the Philippine Obstetrical and Gynecological Society (POGS) who are competent in BTL in order to see whether they still need accreditation from the DOH. I suggest that if the doctor is a diplomate or fellow of POGs, there is no need for accreditation, since it is part of their training. Other district doctors should undergo accreditation.

Dr. Rodriguez.

There is an adequate supply of surgeons but they must be **skilled in non-scalpel vasectomy.** The issue is, what process is followed in accreditation? Physicians practicing at the Makati Medical Center would certainly not seek accreditation. If the program should accredit, it should go for BTL standard procedures.

- ***On-Site Competency/Residency Training in Local Anesthesia***

Question.

How do we define certification - who will certify?

Answer.

While we do not belittle the competency of fellows and graduates of big medical centers, we must come up with **anesthesiology cases**. They do it under spinal anesthesia wherein they have demonstrated competence.

Question.

What about local anesthesia which is the DOH standard?

Answer.

On-site competency training can be conducted by trainers with learning experiences in 23 medical centers on BTL under local anesthesia. Fellows and diplomates do not know how to use the uterine elevator and the "no hands technique"; they can see how it is done and echo it to their residents. Common cases are CS with BTL and post partum with BTL. We must **strengthen the referral system** to the Vicente Sotto Memorial Medical Center and other tertiary hospitals. **Non-scalpel vasectomy can be introduced alongside urology training in hospitals.**

Dr. Rodriguez.

While we may want to adopt intervention as ex post-facto, **we must get specialty groups to accept the methodology.** For those already trained in local anesthesia, they can function as training specialists.

Do not expect fellows and diplomates to undergo training again. One observation by a good surgeon can already be sufficient.

It takes longer for older surgeons to learn the technique. It is competency-based.

We must make the training program a requirement for exams and graduation. This will require modifications in the **Specialty Board Accreditation.**

Dr. Floresca.

The purpose of A.O.280 is to train residents. I appreciate the suggestion because if DOH is a signatory to the certificates of graduation and residency, it equips graduates for government service.

The FP policy signed by Secretary Dayrit contains provisions on training and on the certification of facilities and service providers. We will be coordinating with the Health Human Resource Development Bureau and the Center for Family and Environmental Health **to come up with standard guidelines regarding training.**

Synthesis.

The aim is to create a broad-based multi-sectoral partnership. We are looking forward to new non-traditional alliances. Look at what you are working on and working with it. Revitalized and renewed is to know what follows or what to

expect after forging the partnership. Coalitions do not exist for themselves. There are three types of objectives - routine, innovative and high impact, and problem-solving. In terms of advocacy and IEC, focus not just on orientation, but on whether it is going to make noise and have voice. Enabling mechanisms like guidelines and standards are things that enable you to do what you want to do.

Dr. Rodriguez.

There is a tendency to target 20 things across which you can spread yourselves too thinly. If results are desired, **make a flow chart** to assure that process will lead to realization. This is important to pinpoint the purpose of the funds and the budget.

It would help to **examine whether the plans are synergistic**. There may be activities that contradict or negate their mutuality. Synchronizing is important for time effectiveness. Sustainable does not mean you continue to exist. The essence of sustainability is getting better and better over time. Is the program better now than before?

Dr. Roquero.

It is high time to do **advocacy and back-up plans**. How are we going to handle the opposition?

Discussion, ARMM Group

USec. Fernandez.

Gather documents as inputs for a new consultative meeting involving religious leaders in Mindanao. Set a meeting with other regions in Mindanao, set training dates, make a course syllabus, and identify facilitators and resource speakers from among the people. The output of the experience (religious meeting) with the people of Maguindanao can be replicated. It is good to have gained access to Maguindanao and Basilan.

Discussion, Mindanao Group

Plans should be made to access geographically inaccessible and disadvantaged area. Large quantities of medicines for VSS can be sourced through MGD funds - non scalpel vasectomy entails minimal expense.

Discussion, Regions III, IV, NCR and Metro Manila

USec. Fernandez

We have problematic areas in Region 4, Puerto Princesa City and in Manila. We must devise strategies to address situations in these places.

Urban poor FP programs for Manila and *Kalahi* areas were identified. We have recruited VHWs who will identify clients for home service. Home service delivery will be coordinated with LGUs.

Puerto Princesa City, Palawan will be the site of an NFP pilot project to increase CPR, but services there will continue with advocacy programs for other methods. We received logistic support for FP that we brought to extension offices in other municipalities in need of supplies.

In Metro-Manila, surgical interventions remain problematic. The NFP circle is trying to get the support of Mrs. Atienza. Programs are carried out on demand basis. The anticipated Php4 million from DOH will fund the services of health workers.

Ms. Dowling

Mrs. Atienza assessed the service delivery situation at the LGU level in order to expand toward areas beyond NFP. NFP shall be used as the starting point in identified areas with guidelines from LGUs and the churches. The archdiocese in NCR has 280 parishes, only 46 parishes of which have NFP services. We cross our fingers that the inter-faith strategy will move the program. A referral system to access NFP will be drawn. Guidelines for CBCP, Methodist and inter-faith churches are being crafted, and this presents a challenge. Mini-consultations have cleared the air for FP. The good news is that the Cardinal is open to a meeting with inter-faith groups. The challenge is that the Catholic Church will not address the ecumenical effort.

Dr. Roquero

What is back up plan to crisis management and opposition? Puerto Princesa, in consultation in *Sangguniang Bayans*, declared the city as a Pro Life City, effectively disenfranchising the FP users. The contraceptives that were supposed to be publicly burned were retrieved from the city and sent to the province. This is the call of advocacy and service delivery.

USec. Fernandez

How will itinerant teams come in if the policy is a No-no to artificial methods except NFP?

Answer

The plan will be brought to the hospitals. In an area where there is strong opposition, services will be confined at the hospital. The solution would be to give a grant to service organizations through a Memorandum of Agreement that shall focus on population with unmet needs. The Secretary does not like to cross paths with church. Indirectly, the support will continue. The chance must be given to the private sector to come in strongly and provide artificial methods.

Ms. Dowling. A meeting shall be held on Friday with multi-method NGOs in Manila.

USec. Fernandez.

We cannot insist on carrying out programs in health centers under the Metro-Manila city government.

When I presented this problem to the MMDA, the chairperson of social services and Mayor Bobbit Carlos of Valenzuela City vowed to make use of a Memorandum of Agreement to solve the population problem.

Bicol has a low CPR because of religious action. Camarines Sur has the biggest population. Depo Provera and IUD methods were given to different municipalities and RHUs without the knowledge of the Governor. We tapped the Dorefs and maintained dialogues with provincial development officer who can delivery the contraceptive supply.

The challenge for DOH retained hospitals is to link up with LGUs like this to make surgical processes accessible. Work hard on itinerant outreach. In crafting the budget for FP program, we should try to look for strategies outside the box because there are agencies willing to help to augment GOP funds. We need more IEC on non-scalpel vasectomy. On the manner of handling opposition, FP is even Pro-Quality of Life. To read from the bible, we should come up with strategies for funding.

NCR should have a strong visibility. Work out a strategy for VSS with a Technical Working Group to build the image of those who perform ligation and vasectomy. They get lambasted from the pulpits. The strategy is to help service providers with the responsibility to deliver. Let us not be confined to numbers.

Maternal Child Health and Child Survival/Safe Motherhood, Malnutrition Program serve as areas of collaboration that the church is open to; just find a way of communicating with them.

Dr. Roquero

We tend to veer away from areas of the opposition. We try to engage sectors we can potentially work with. We should be ready to handle crisis and conflict.

Discussion, Northern Luzon

Create an internal FP Management Team composed of FPOP, Popcom, Dole, and other sectors. Based on an assessment of accomplishments, a mapping will be made through field analysis in order to surface restraining factors for the management of constraints. Popcom and FPOP are allies of the program who could be involved in the training of health providers on FP.

In Nueva Ecija, basic training was not undertaken. Paulino J. Garcia Medical Center adopted Nueva Ecija and Tarlac while the Jose P. Locsin took in Tarlac, Bulacan, Pampanga. A consultative meeting was organized to identify areas where itinerant teams can go.

In Region II, networking will be done with existing service providers of NFP. We will enjoin the academe to conduct training for NFP. We received a letter from St. Paul's University that offered assistance to NFP training. For

advocacy, we will be renting spaces in different provinces for advertisements on NFP.

Ms. Dowling.

If the institution is a religious organization, only the Billings Method would fit. If the initiative comes from within the College of Nursing, it would be easier to integrate plans with the DOH modules.

We are thinking of holding refresher courses on modern NFP methods.

Usec. Fernandez

St. Mary's and St. Paul's University are pilot institutions for RH and if they are into NFP, link up with them.

The *Kapihan sa Kumbento* for Region 1 is an in-place structure. Governor Agbayani and Archbishop Cruz set it up as a regular dialogue forum which came up with an **NFP Program for Pangasinan**. For VSS, two teams from a technical division will undergo training at the hospitals and the Center for Health and Development.

Adjournment of the Conference

Dr. Roquero

We hope that we do not stop with the plans. We tried to look at and confront the barriers of FP guided by the intent to *Bigay Todo sa Pagplano*.

Dr. Rodriguez

When we were asked to support FP, we knew the importance of policies, priorities, and gaps. We saw that issues were discussed but not addressed. We are happy and pleased to support the next workshop at the PHO level.

Closing Remarks

Usec. Fernandez

If we believe that Family Planning is a health intervention program leading to the health of women and children, **do something**. If it is a means to reduce poverty and lead to Responsible Parenthood which means to promote MCH and prevent abortion, **commit ourselves** so that it will be placed as the **main agenda of work in the regions and in the hospitals**.

FP is necessary because it is the only means to make women and children healthy. Exert effort to give FP a boost at the region and local LGU areas. With the PHOs talk about the plans to see how they can enrich and work out those plans that conform with the regional funds. Money matters can be taken up with the government.

I thank the cooperating agencies. Let us revive the working relationship in the 70s and 80s when we worked hand in hand with the regional offices through Popcom so that there will be two agencies working hand in hand.

With the private sector, we can succeed. We will mainstream NFP but it is not only NFP we are promoting but also all the methods. We will not be afraid to implement all the methods because the national policy is to provide people with all the information. We will not be criticized for masking methods the cafeteria way without saying anything. We are also going to strengthen the counseling skills of our service providers.

Chiefs of Hospitals will submit their individual plans alongside the regional offices and the hospitals. Dr. Dayrit at the Execom will ask for the output. If the plans fit in they can be considered for funding with various funding agencies.

* * * * *

Respectfully submitted:

Russel Fariñas

Lito Tenebre

Mary Anne Barcelona
Documentation Team

OPERATIONAL PLAN MATRIX
CHD/ Hospital/ Bureau/ Service/ Unit/ Office : CAR/BGHMC
Period Covered : CY 2002-2003

General Objective: Increase CPR from 46.8% to 50%

Specifics: 1. Mainstream NFP

2. Active VS Itinerant Teams

Strategies/ Activities	Time Frame	Targets	Resource Requirements			Responsible Office Staff	Expected Output
			Item	OC	Cost		
I. Coalition Building							
1. Revitalize/ expand the multi-sectoral groups working on FP (RPMC, RH task force) by calling a coordinative meeting	2 nd week, June, 2002	PAs, NGOs, church, academe, & media	Snacks/ meals Hand-outs		15,000	CHD-CAR	Plan formulated; commitments forged
2. Forging of commitments/ Agreements	- do -	- do -					
3. Planning	- do -	- do -					
4. Conduct of regular meetings	end of month	- do -	Snacks, handouts		10,000	CHD-CAR	
II. Resource Mobilization							
1. Mapping up of resources like manpower, logistics	1 st week of June, 2002	GOP, foreign funded	handouts		5,000		
2. Integration of funds/ resources available	- do -	- do -					
III. Capability Building							
1. Training Audit	1 st week of June, 2002	Field HWs, other stakeholders Provincial/ PA				CHD-CAR	List of untrained staff/HS

*National Family Planning Consultative and Planning Workshop
May 22-24, 2002, Cebu City*

2. TOT on SDM/ modern NFP	June to July, 2002	Provincial	Training expenses		CHD-CAR	Provincial Municipal/ Barangays and other stakeholders trained
3. Training on VS Monitoring for Service Providers	August, 2002	Provincial		150,000		- do -
4. On site NSV Training	September, 2002	Municipal/ Barangay HS		150,000		- do -
5. Training of service providers on modern NFP/SDM	August, 2002	Other stakeholders		2,000,000		- do -
IV. Advocacy/IEC						
1. Provincial orientations on NFP Mainstreaming	Aug.-Sept., 2002	LCE, other stakeholders	Training expenses	130,000	CHD-CAR	NFP Oriented to LCEs - commitments/ agreements forged
2. Tri-media Campaign	Year round with E on special events	WRA, adolescents, women	IEC materials/ Airtime	125,000		
3. Production and Distribution of IEC Materials	July-Dec., 2002		IEC materials reproduction	200,000	CHD-CAR	
V. Service Delivery						
1. Conduct of Outreach Mission through Itinerant Teams	Aug. - Dec. 2002	Low performance municipal hard to reach areas	Supplies/ DM	1,000,000		
2. Provide Regular VS Services	Ongoing	BGHMC	- do -	120,000		
3. Upgrade Facilities/ Equipments	July-Dec.	LGU Hospital	- do -	500,000		
VI. Program Management						
1. Procurement of equipment/ supplies	August	Regional office	Laptop, copier,	150,000 75,000		

*National Family Planning Consultative and Planning Workshop
May 22-24, 2002, Cebu City*

VII. Monitoring/ Evaluation			supplies		100,000	
1. Field Visits/ FS	Monthly	Prov./Mun./Bgy.	Traveling expenses		450,000	
2. Conduct of PIRs	Semi-annually		Meals and snacks, traveling expenses			
GRAND TOTAL:					5,480,000	

7

OPERATIONAL PLAN MATRIX
CHD/ Hospital/ Bureau/ Service/ Unit/ Office : CHD Ilocos
Period Covered : CY 2002-2003

Strategies/ Activities	Time Frame	Targets	Resource Requirements			Responsible Office Staff	Expected Output
			Item	CO	Cost		
1. Orientation/ Meeting of RDC for: a. Form NFP Task Force b. ID Stakeholders	June, 2002	DEPED, DOLE, NEDA, PopCom, DSWD, DILG, NSO, Academe, Church, Project Organization	Lunch		1,500.00	DOH	FP Formed Orientation Stakeholders Identified
	2. TOT Modern FP and NFP	August	40 pax, 4 CHD, 4 PopCom, 6 Hospitals, 12 Province, 7 CF IDO & 7 CFP	Board and Lodging, Training Materials, TEVs, gasoline for 7 days		250,000	CO
3. Training for Supervisors, L, U - 1 batch (40pax) I,S - 2 batches (70pax) IN - 1 batch (48 pax) Proj. - 3 Proj. (112pax)	Sept.-Oct. 2002	MHOs, PHNs (270)	Board and lodging, materials, supplies, TEVs for 5 days, gasoline		1,215,000	CHD/PopCom	Supervisors Trained
			4. Training for Midwives	Nov.-Dec. 2002	GOO	Board and lodging, materials	900
5. Reproduction and Training Modules	August, 2002	6075 MCR 121152 MCRA	X 5 days		400,000		Module Trained
6. Natural - abacus					-50,000		
- necklace					-50,000		
- Thermometer & BBT Chart					P50 each P750 each		303,750
7. IEC - Charts???			P10each		500,000		

*National Family Planning Consultative and Planning Workshop
May 22-24, 2002, Cebu City*

- Posters		1,170	P25 each		29,250		
8. Organization, Advocacy Committee	2002					Task force & HEPO's	Advocacy Committee Trained
1. Regional							
2. Provincial							
3. City advocacy orientation							Orientation done
9. Radio Spots frequency – 25 spots/day for 6 mos. production for 30 seconder radio spot	2002-2003	4 provinces	P250/50 sec.				
10. Billboard Production/Installation Rental of Space	2002-2003	12 pcs					
11. Monthly Monitoring	2002-2003		TEV, gas and ???				

OPERATIONAL PLAN MATRIX
 CHD/ Hospital/ Bureau/ Service/ Unit/ Office : CHD III
 Period Covered : CY _____

Strategies/ Activities	Time Frame	Targets	Resource Requirements			Responsible Office Staff	Expected Output
			Item	CO	Cost		
1. Create a FP Management Team	June,2002						
2. Conduct Meeting of FP Management Team	June,2002						
3. Conduct of FP Consultative Meeting	June 14, 2002	25pax x P300			7,500		
4. Conduct of TOT on NFP			-Board & lodging (21pax)		94,000		
			-3 facilitators (900 @ for 5 days)		13,000		
			-SDM (21 x 50)		1,050		
			-Abacus (21 x 50)		1,050		
			-Modules (21 x 400)		8,400		
			-Supplies (21 x 150)		3,150		
5. Training of Service Providers on NFP		122 Pop. & FPOP staff, DOLE, IMCCSDI	-Board & lodging (122 x 900 x 3days)		329,400		
			-SDM (122 x 50)		6,100		
			-Abacus (122 x 50)		6,100		
			-Modules (122 x 400)		48,800		
			-Supplies (122 x 150)		18,300		
		750 RHU &	-Board & lodging (750 x		2,025,000		

*National Family Planning Consultative and Planning Workshop
May 22-24, 2002, Cebu City*

6. Conduct Level I FP Training	Hospital Staff	900 x 3days)				
		-SDM (750 x 50)		37,500		
		-Abacus (750 x 50)		37,500		
		-Modules (750 x 400)		300,000		
	25 pax (1 st batch)	-Supplies (750 x 150)		112,500		
		-Board & lodging (25 x 900 x 10days)		225,000		
	25 pax (2 nd batch)	-Practicum (25 x 300 x 5days)		37,500		
		-Modules & Supplies (25 x 500)		12,500		
		-Board & lodging (25 x 900 x 10days)		225,000		
		-Practicum (25 x 300 x 5days)		37,500		
7. Reproduce IEC Materials - leaflets - posters	-Modules & Supplies (25 x 500)		12,500			
	5,000 x 10		50,000			
8. Procure the Following	5,000 x 25		125,000			
	-SDM (3000 x 50)		150,000			
	-BBT Thermometer 1000 X 50)		50,000			
	-Abacus (93 x 50)		4,600			

OPERATIONAL PLAN MATRIX

CHD/ Hospital/ Bureau/ Service/ Unit/ Office : CHD 3 – Paulino J. Garcia Memorial Research & Medical Center
 Period Covered : CY _____

Strategies/ Activities	Time Frame	Targets	Resource Requirements			Responsible Office Staff	Expected Output
			Item	CO	Cost		
1. Consultative Meeting with Stakeholders		20pax			3,000		
2. Creation of 2 Itinerants Teams Composed of ; 1 midwife, 1 nurse, & 2 doctors, to provide VS Services & Train District Hospital Staff on ML-LA							
3. Coordination with EH & Department of Surgery Regarding Schedule of NVS on Site Training							
4. Procure Drugs & Medicines					482,000		
5. Conduct Itinerant Team Sterilization					15,000		
GRAND TOTAL:					500,000		

✓ OPERATIONAL PLAN MATRIX
 CHD/ Hospital/ Bureau/ Service/ Unit/ Office : CHD IV
 Period Covered : CY 2002

Strategies/ Activities	Time Frame	Targets	Resource Requirements			Responsible Office Staff	Expected Output
			Item	CO	Cost		
I. A. Organize Regional FP Management Team	E.O. May	Regional FP Coord. In external office, retained hospital FP Coord.					FP formed, composition identified
B. Review and Compile DOH-FP Policies, issuances, guidelines	1 st wk. of June						
II. Consultative FP Planning WS - identify areas of collaboration - role clarification - training audit/ need assessment - formulation of regional plan, june-december,2002 & January-december,2003 - set priority areas - mainstream NFP activities	E.O June	Provincial FP coord., City FP coord., FP designate, Ext. office, HEPO, PopCom, other stakeholders	Board & lodging (900x50x2days) training kits, forms, gas		90,000 10,000		- Areas of collaboration identified -roles clarified -needs identified -plan made -priorities set
III. Capability Building							
1. TOT on FA & NFP	July- Nov.	FP coord., supervisors	Board & lodging (50pax x 900 x 5 days)		225,000		Increased manpower capability
2. Series of trainings on FA and NFP		Service providers	Board & lodging (250 pax x 900 x 3 days)		675,000		Increased acceptors Increased CPR
3. Revitalize, Organize VSS, NSV Itinerant Teams	June- July	Retained hospital,					

*National Family Planning Consultative and Planning Workshop
May 22-24, 2002, Cebu City*

4. Basic Compre FP Training	October	district hospital, provincial hospital	Board & lodging (900 x 100pax x 21 days)	1,890,000	
		New health personnel, untrained health personnel	Manuals (100 x 200)	20,000	
IV. Advocacy	June- July	-PHOs, CHOs			- ride on with regular meetings -increased awareness -increased NFP/FP acceptors
1. Orientation of PHOs, CHOs on NFP/FP New Thrusts & Directions		-Industrial clinics	Meals & snacks (500pax x 150 x 3 batches)	225,000	
2. Series of Lectures/ Symposium on WFB/ other FP methods			NFP Manuals (450 x 300)	135,000	
3. Reproduction of IEC materials, manuals					
4. Radio, TV plugs, Guestings		-All province	-Streamers	20,000	
5. FP Month Celebration "NFP Launching in Selected Areas"			-Meals & snacks	50,000	
			-Gas	2,000	
V. Procurement of Medicines, Supplies and other Logistics		Support to VSS itinerant teams	Medicines and supplies	300,000	
			Necklace (50 x 5,000)	250,000	
VI. Networking/ Linkaging	June- August	LCE, COH, PHOs	Gas, TEVs	10,000	-Increased accessibility of FP services -Increased VSS -Increased acceptors
- Integrate NFP/ FP in ILHZ					
- Activate/ Organize Itinerant Teams in District Hospitals					
- Strengthen Referral System					
VII. Monitoring & Evaluation of FP Implementation	June- Dec.		Gas, per diems, TEVs	150,000	Issuance/ concerns immediately addressed
- coaching and mentoring					
VIII. Year End Program Review	Dec.	FP Coordinator	Board & lodging (50 x 900 x2 days)	90,000	Issuance concerns

*National Family Planning Consultative and Planning Workshop
May 22-24, 2002, Cebu City*

			Forms, kits, gas		15,000		identified; recommendation made; plans revised
IX. Mainstreaming of NFP in Puerto Princesa	June- Nov.						
1. Dialogue/ Conference with LCE		FP Coordinator of City, LCE	Plane fare, TEVs,		30,000	FP teams	- identify areas of collaboration -relocation of FP supplies - Tap NGOs as FP outlets
2. Train Personnel on NFP			Plane fare, TEVs		40,000		
			(30pax x 900 x 3 days)		81,000		

OPERATIONAL PLAN MATRIX
CHD/ Hospital/ Bureau/ Service/ Unit/ Office : CHD V
 Period Covered : CY _____

Strategies/ Activities	Time Frame	Targets	Resource Requirements			Responsible Office Staff	Expected Output
			Item	OC	Cost		
1. Conduct Regional Meeting	2 nd wk. of June, 2002	NMMC, COH, CHD, MGT, Staff, FP Coordinator & Training nurse, MS IV RPD Coordinator	Meals & snacks		10,000	CHD-FP Coordinator	Regional Plan Completed
2. Creation of Regional Enhancement Team	2 nd wk. of June, 2002	RP Coordinator, GOs, NGOs	1 meal & 2 snacks		3,000	CHD FP Coordinator, RPO Coordinator	RE Team Created
3. Training Needs Assessment on FP	1 st wk. July, 2002	Service providers in RHUs, Hospitals/ CHDs	TED & gas for 5 days		5,000	CHD FP Coordinator & HRD Team, Nurse NMMC FP Coordinator	Training Needs Assessed
4. Conduct Training on Mucus Method & Necklace Method	3 rd wk. of July, 2002	CHD technical staff & training staff, 20 participants;	Meals & snacks for three days training period.		48,000		Training conducted for CHD staff and PHO staff
		1 st batch			10,000		
5. Conduct Training on Basic Comprehensive FP for Newly Appointed Health Personnel	2 nd wk. of Jan., 2003	PHO staff 20 participants	B/ Lady		48,000		Trainings Conducted
		PHN/RHM/ CHO/ Hospital staff 30 participants			270,000		
			Training Materials		6,000		

National Family Planning Consultative and Planning Workshop
May 22-24, 2002, Cebu City

6. Training of Physicians on Sterilization Training	November, 2002	2 batch - 5 LGU - Physicians	TEV for NMMC Team	20,000	NMMC Trainers or Engender Health	Number of MDS Certified
7. Advocacy/ IEC						
- Inter-Local Health Zone Meeting	As need arises	LGUs, NGOs	-TEO & gas for CHD	5,000	CHD-RD & Regional staff FP Coord.	Meeting Attended
- Inter-Agency Consultative Meeting	Nov., 2003 - June, 2003	GOs & NGOs (30 pax)	-1 meal & 2 snacks, training materials	45,000		Inter-Agency Meeting Done
- Tri-Media Campaign	June-Dec., 2002 - June 2003		-Radio, TV	7,500		
8. PIR for FP	November, 2002	PHO staff, CHD Staff, MS IV, DOH rep. (50 pax)	Meals and snacks for 2 days	65,000	CHD-FP Coordinator	PIR Conducted
9. Provision of Logistics for VS	June- Dec., 2002	13 LGU rep., 2 DOH rep., 1 CHO	Drugs/ Meds	150,000		Logistics Provided
			-Med supplies	145,000		
			-CDLMIS ??	200,000		
			-FP Form 1	100,000		
10. Monitoring/ Evaluation	July-Dec., 2002	Hospital/ RHs/BHS	TEV & gas	20,000		Monitoring and Evaluation done
11. Others	June 2002	3 contracted	200/day for 180 days	108,000		Contractual Recruited
Training of Contractuals - Nurses for MHARSTTH ??? City & NMMC			4 contracted			
GRAND TOTAL:				1,350,000		

OPERATIONAL PLAN MATRIX
CHD/ Hospital/ Bureau/ Service/ Unit/ Office : CHD V
 Period Covered : CY _____

Strategies/ Activities	Time Frame	Targets	Resource Requirements			Responsible Office Staff	Expected Output
			Item	OC	Cost		
I. Health Advocacy & Promotion Strategy a. Multi sectoral conference/ meeting in FP/RH task force to include FA/NFP b. Putting -up of Billboards in strategic places c. Radio plugging of FA/NFP VS d. Highlights advocacy and promotion in special events 1. celebration of FP day 2. Pop. dev. Celebration e. Reproduction of IEC Materials	June, 2002 December, 2002	LGUs, NGOs, Other GOs and religious organization 16 pcs.					
	August						
	July-December						
	August 1						
	November						
II. Capability Building a. Conduct training need assessment b. Training of trainers of FA/NFP c. Training of stakeholders on	June, 2002	PHO/CHO				DOH-CHD 6	
	1 st wk of July	Regional, provincial FP coordinator, HE-DOH dept.				IRH	
	July	DOLE, PopCom, FPOP, IMCH				IRH	

*National Family Planning Consultative and Planning Workshop
May 22-24, 2002, Cebu City*

FA/NFP						
d. Training of implementers on FA/NFP - 3 batches	August	PHO, CHO, MHO, nurses, RHM				DOH CHD 6 Provincial trainers
e. Training of BHW on FA/NFP - 4 batches	Sept. - Oct.	Volunteers				DOH CHD 6
f. Training of MD's on non-scalpel vasectomy	July	Retained hospital				Provincial trainers certified of hospital
III. Revitalize the Itinerant Team in Retain Hospital to be dispatched in different Areas if Needed	July - December					
IV. Implementation						
1. Organization regional FP team	July - December					
2. Purchase of medicines						
3. Purchase of SDM beads - 2,000 pcs	June-December					
V. Monitoring & Evaluation						
???? monitoring of FP/RH program	July - December					

OPERATIONAL PLAN MATRIX
CHD/ Hospital/ Bureau/ Service/ Unit/ Office : Cotabato Regional & Medical Center
 Period Covered : CY _____

Strategies/ Activities	Time Frame	Targets	Resource Requirements			Responsible Office Staff	Expected Output
			Item	OC	Cost		
I. Conduct TOT on VS		Consultants and Residents	Meals and snacks			Trainers from Engender Health	
II. Conduct Training on SDM, NFP		Service provider, new young					
1. Launching of SDM, NFP, VS		Nurses/ midwives from CRM & other district/ provincial hospital					
2. Create Itinerant VSS Team		Ask from district/ provincial hospital					
III. Provision of Logistics							
1. Medicines/ drugs			-BLR 500 cc -Lidocaine 2% (50 ml/vinyl) -Dinzifam 5mg/ml -Demeral 50/ml				
2. Med. Supplies/ instruments			-Chonic 2-0 -Gloves -Macroset -Scalp vein (619) -RID Book -Tenaculum -SDM 1,000 pcs -OR gowns -Computer 1 unit				

OPERATIONAL PLAN MATRIX
CHD/ Hospital/ Bureau/ Service/ Unit/ Office : RIMC & ITRMC
 Period Covered : CY 2002-2003

Strategies/ Activities	Time Frame	Targets	Resource Requirements			Responsible Office Staff	Expected Output
			Item	CO	Cost		
1. Presentation during Management Meeting	1 st wk. of June 2002	Department and section heads				HCWP	
2. Orientation of Hospital Staff	July 2002	Nurses, Admin., & 4 department staff				HCWP head/ FP coordinator/HEPO	
3. Training of 2-3 Staff on NSV	July 2002	Surgical Staff				Engender Health	
4. Organization of Hospital VS Itinerant Teams	June 2002	OB/ Surgical, dispersal resident, & nursing staff				HCWP Head, FP Coordinator, OB/Surgery Head, CN	
5. Procurement of Drugs, Medicines, & Supplies	June 2002					CHD FP Coordinator, Pharmacist/ SO	
6. Integration of VS Itinerant Team in the Regular Surgical Mission	Monthly starting July 2002					MCC, CDC, HCWP head, FP Coordinator, HEPO	
7. Reproduction of IEC Materials	July 2002					HEPO, HCWP Coordinator	
8. HE at the OPD & Wards	August onwards	Patients, watchers, public				HEPO, HCWP staff	
9. Advocacy to LGUs, NGOs, Professional Groups, Private Organization	3 rd & 4 th quarter	LGUs, NGOs, professional groups, private groups				HCWP head, FP coordinator	
10. Dialogue with Marie Stopes	3 rd quarter	Private organization				ECHD	
11. Strengthening/ Sustaining Support Groups	ongoing	"Tall Club"			500,000	HCWP Head, FP Coordinator	

OPERATIONAL PLAN MATRIX
CHD/ Hospital/ Bureau/ Service/ Unit/ Office : Zamboanga Peninsula
Period Covered : CY 2002

Strategies/ Activities	Time Frame	Targets	Resource Requirements			Responsible Office Staff	Expected Output
			Item	CO	Cost		
A. Improve Availability & Accessibility of FP Services							
1. Consultation/ Dialogue with NFP Stakeholder	June	30 pax Regional Pop. Div. Council			9,000 1,000		CHD
1.1 Orientation Planning		Regional Pop. Div. TWG					# of stakeholders oriented
1.2 Inventory of Personnel							
2. Advocacy/ Social Mobilization							
2.1 Assessment of Partners	June						Increased Acceptance and Advocates
2.2 Identification of Committees with low CPR	June						
2.3 Organization of Management Committee & Advocacy Group for NFP	June						
2.4 Inventory of Resources Clinic (private, government) Hospital (private, government)	June						
2.5 Celebration on NFP (tri-media, reproduction of streamers, IEC materials) FP Women's Health Month,	August				100,000		

*National Family Planning Consultative and Planning Workshop
May 22-24, 2002, Cebu City*

Candle Light Day, Natural FP Day, World Aids Day, POPDEV Week Celebration						
3. Institutional Capability Building					DOH-CHD	1. # of trained personnel 2. improved delivery of services
3.1 TOT for Fertility awareness of NFP (3 days)	1 st wk. of Aug.	30 pax	T.M. Transpo.	45,000 4,500 45,000		
3.2 FA & NFP courses for supervisors: Z. North, Z. Sur, Z. Sibungay, Dapitan City, Dipolod, Pagadian City, Isabela, Zamboanga City	2 nd wk. of Aug.	30 pax	T.M. Transpo.	45,000 4,500 45,000		
3.3 FA & NFP Courses for Frontliners HWs for 6 MGP Municipalities (2 courses)	Sept.	60 pax (physicians, nurses, midwives, BHWs)	T.M. Transpo.	90,000 9,000 90,000	CHD 9	
3.4 Basic Comprehensive Training on FP (45 days)	July		T.M. Transpo.	450,000 45,000 30,000		
3.5 TOT Training on Pre-Marriage Counselling	Sept.		T.M.	67,000 10,000		
3.6 Training for Pre-Marriage Counseling for Counselors	Sept.		T.M.	67,000 10,000		
4. IEC Campaign					DOH-CHD 9	
4.1 Production and Reproduction of Print Materials				50,000		

National Family Planning Consultative and Planning Workshop
May 22-24, 2002, Cebu City

4.2 Procurement of Abacus (50/pcs)	July	1,000 clients			50,000		
4.3 Procurement of SDM necklace	July	1,000 clients			50,000		
4.4 Information Campaign (tri-media like TV, radio, news publication)					30,000		
5. Assistance for Repair/ Construction of NFP Counseling Room of: Z. Norte Z. Sur Z. Sibugay Z. Cas C	July	4 municipalities 2 municipalities 2 municipalities 1 municipal			400,000 200,000 200,000 100,000		Improved facilities
6. Monitoring & Documentation of Good Practices	Nov.	3 pax			9,000		Documentation on good practices
7. Evaluation Consultative Workshop	Dec.	50 pax for 2 days		Transpo.	50,000		Gaps identified
8. Research					45,000		
- use of abacus - use of necklace	Oct. Oct.				200,000 200,000		# of research conducted
9. Organization of Itinerant Team	quarterly 2003	120- clients (10 client/mo.)			54,000	Surgeon, FP physician, OB Gyne Resident, midwives, dentist	# of patient ligated

OPERATIONAL PLAN MATRIX
CHD/ Hospital/ Bureau/ Service/ Unit/ Office : CARAGA
 Period Covered : CY _____

"Gender Health the Family Planning"

Major Strategies/ Activities	Capacity Building	Target/ Time Frame	Resource Requirements	Policy Management Decision	End Result	
I. Increase awareness/ Knowledge of Stakeholders & Provided on FP Services	- Orientation to CHD staff (Organizing and Planning	30 pax BO of June	Meals & snacks - 6,000	Regional order regarding attendance of pax for orientation	100% pax trained/ oriented	
	- Training of Trainers to all provinces and Cities	8 CHD staff	B&J – 21,000 Mats – 3,000			
	- Refresher Course among health personnel on NFP (MHOs, PHNs, RHM)		300,000			
	- Training of health personnel of NFP		1,000,000			
		Supervisors Frontline workers, BHWs				
	- Organization of inter-faith coalition (economical)		300pax – 54,000			-4 Provinces and 3 cities organized
	-Reorganization/ revitalization of RH - Regional Technical Working Group	50pax x 2 batches (quarterly)	meals & snacks – 10,000			-RHTWG organized
	-Orientation of BHWs	3000pax	meals & snacks- 600,000			90% of BHWs oriented
	- Training of CBT to newly appointed personnel	30pax	B&L- 500,000 Training modules –	# of personnel trained on CBT		

National Family Planning Consultative and Planning Workshop
May 22-24, 2002, Cebu City

<p>II. Service Delivery in the Implementation of FP Activities</p>	<ul style="list-style-type: none"> - Creation of Itinerant Teams; regional, hospital - Training of Members of IT - Functional Referral Mechanism to all Inter-local Health Zone 	<p>50,000</p>		
<p>III. Logistic Management. Provision & Augmentation of Logistics to Level off the "Unmet" needs</p>	<ul style="list-style-type: none"> - Purchase of drugs & medicines for IT - Augmentation of supplies and materials - Recruitment of volunteers for itinerant team. - Purchase of SDM beads 	<p>300,000 forms -5,000</p>	<p>RSO signed for the creation of reg. IT</p>	<p>Regional & hospital IT organized and functional</p>
<p>IV. Sustainability</p>	<ul style="list-style-type: none"> - Collaboration/ coordination with GOs & NGOs; DECS, PopCom, DILG, Academe - Inclusion of ordinary to provincial & municipal level - Functional local health boards, supportive for FD activities - Incentive for volunteer IT members - Availability of ??? room at the Women's Resource Center - Inclusion of FP in ongoing GAD activities 	<p>500,000</p> <p>200,000</p> <p>5,000</p> <p>25,000</p> <p>5,000</p>	<p>RSO signed for the creation of hosp. IT</p> <p>RIV signed/ approved</p> <p>Letters signed for recruitment of volunteers MDs</p> <p>MOA drafted done with GOs and NGOs</p> <p>Memo for incentives for volunteers</p>	<p>100% of IT member. Finished skills training</p> <p>Drugs/ supplies purchased and distributed to IT</p> <p>Volunteer ??? as member of IT</p> <p>Good relationship with GOs and NGOs observed</p> <p>Incentives awarded to volunteer</p>

*National Family Planning Consultative and Planning Workshop
May 22-24, 2002, Cebu City*

V. IEC/ Advocacy	- Incentives for high performing CPR (provincial, cities)		100,000	
	- Tri-media approach		26,250	IEC material development (culture friendly)
	-sales conference		1,000	
	-face the region			
	-radio plugging			
	-speaker bureau			
	-involvement of academe			
-reproduction of streamers		50,000		
- Consultative Workshop/ PIR		50,000		
- Dialogue with catholic churches and other religious groups		30,000		
- Quarterly assessment of Service Providers	300pax – Dec. 2002	20,000		
- Users Assembly (best practices showdown)		50,000		# of pax attended assembly meeting

OPERATIONAL PLAN MATRIX
CHD/ Hospital/ Bureau/ Service/ Unit/ Office : Region XI
Period Covered : CY _____

Strategy: I Improving Availability & Accessibility of NFP, VSS & Other FP Services

Strategies/ Activities

A. IEC/ Advocacy

1. Building coalition

1.1 Identify potential partners

1.2 Organization of FP coalition, Interfaith and other stakeholders

1.3 Planning workshop

- role clarification
- resource mobilization (including grant accessing)
- coverage/scope
- launching
- working agreements

2. Capability/ capacity after the conduct of TNA

2.1 TOT

2.2 on site training

2.3 training among health providers and volunteer workers

2.4 training among religious groups

3. Development/ reproduction of IEC Materials

4. Conduct of Information Campaign through Video in Target Areas

5. Plugging of FA, NFP, VS and Other FP in Special Body Meetings, Celebrations, tri-media

6. Establish Linkage with Academes

- mass communication for a/v production
- high school and medical allied colleges for curriculum inclusion

- B. Service Delivery**
1. Identification of priority areas
 - GIDA - high unmet needs
 - Fac. without capabilities - fac. with capabilities but lack of resources
 - Industrial plants - high demand of specific method like NFP
 2. Creation of itinerant teams – 2 hospitals, 1CHD (3)
 3. Provision of logistics
 4. Conduct outreach activities
 5. Sustain the “ADOPT AN AREA” concept

Strategy: II Improving the Quality of FP Services

1. Quality Improvement Initiative
 - 1.a Regular facility assessment based on QA standards
 - 1.b Focus group discussions
 - 1.c Client satisfaction
 - 1.d Regular information dissemination on standards and policies
2. Monitoring
 - 2.a Expansion of monitoring team (multi-sectoral)
 - 2.b Training on effective monitoring
 - CHD – new members
 - Hospitals
 - other team members
 - 2.c Integrate relevant info/data from proposed checklist in the existing
 - 2.d Regular conduct of multi sectoral monitoring

Strategy: III Improving Sustainability

1. Conduct program implementation review participated by all stakeholders (problem identification)
2. Regular consultation meeting (problem solving; redirection)

3. Put in place data gathering mechanism from all FP implementers
4. Continue resource/support generation
 - presentation of menu of packages for support to potential donors
e.g. Friendly Care @ DRH
5. Assist organizations of satisfied users
 - grants
 - recognition as member of local speakers bureau
6. Conduct operational research as needed. Review available research
7. Replication of best practices in better prepared target areas

OPERATIONAL PLAN MATRIX
CHD/ Hospital/ Bureau/ Service/ Unit/ Office : CHD V
Period Covered : CY _____

Strategies/ Activities	TimeFrame	Targets	Resource Requirements			Responsible Office Staff	Expected Output
			Item	OC	Cost		
I. Consultative Planning Workshop	June 2002 and Dec. 2002	LGU FP and Selected Regional Staff	Meals / Supplies		126,000	Thrust Cluster	Consultation meetings
1.1 Conduct series of consultative meetings and workshops		Representative if GOs/NGOs					Planning and workshops conducted as scheduled
1.2 Define roles and responsibilities		Other stakeholders					
1.3 Specify support and assistance		POPCOM					
1.4 Catch up planning							
1.5 TRG Audit							
II. Human Resource Development	July to Dec. 2002	HP (20)	Meals and accommodation		210,000	-do-	Improved KAS and training
2.1 Basic Comprehensive on FP		HOOP POPCOM	Modules		15,000		Capabilities of 40 HP/ hospital staff and POPCOM
			Trng. Mat'ls		3,000		
			TFV		9,000		
			Transpo		9,000		
			Meals and accommodation		75,000		
2.2 Fertility Awareness and NFP ToT (20 pax)	-do-	Academe FP and POPCOM NGOs	Modules		7,500		
			Trng. Mat'ls		1,500		
			Transpo		4,500		

Supervisors		RHN (225)	120 pcs necklace meals/ accommodation Modules Trng. Mat'ls 1350 necklace	7,200 618,750 56,250 22,520 81,000	Thrust Cluster
Partograph Trng- ToT	July - Dec.	Hospital Gov't/ Private	Meals/accommodation Modules Trng. Mat'ls 120 necklace	225,000 15,000 6,000 21,600	
• ToT					
• Frontliners		25 Provincial Coordinators Womens	Meals/accommodation Modules Trng. Mat'ls	93,750 4,000 4,000	Improved KAS and Trng. Capabilities of 25 provincial coordinators
		225 Frontliners	Meals/Accommodation Modules Trng. Mat'ls	843,750 45,000 45,000	
Frontliners		450 MD, RHW, Nurses	Meals/Accommodation Modules Trng. Mat'ls	742,500 112,500 45,000	Improved KAS of frontliners
Other Religious Affiliates		20	2,700 Necklace Meals/Accommodation Modules Trng. Mat'ls 120 Necklace	162,000 45,000 5,000 2,000 7,200	
Maternal Mortality	July-Dec.	CS		24,000	Maternal Mortality Review Conducted
Competency Based FP	July				Improved KAS of BHW
• Trng course for					

National Family Planning Consultative and Planning Workshop
May 22-24, 2002, Cebu City

BHW							
Organize VSC Itinerant Teams	June-July	Retained Hospital			C/o MSH		Itinerant Teams Organized
III. Works on inventory of FP supplies and equipment and existing FP Clinics	July		TEV		12,200	DOH Representative	
• Maintain Proper Logistics						Provincial FP Coordinator	
Mgt. Thru CDLMIS						Thrust Cluster	
Disseminate information on schedule and available FP service particularly in priority areas	Whole year round	Community Health Agencies Clinics	CDLMIS Forum		200,000		
IV. Intensify health Info and Advocacy							
• Conduct launching of NFP			IEC / Mat'ls		1,000,000	Advocacy Cluster/ Thrust Program	
• Observance of National Events	August 1						Immensed Awareness

FP Day POP ED Day Fora/ Assembly			Local				# of fora/ assembly
<ul style="list-style-type: none"> Multi-media Campaign – Radio, TV Reproduction of IEC Materials , forms, CDLMIS 	August Dec. August	100 laborers, fishermen, farmers	IEC Mat'ls Leaflets				
V. LGU Support		LGU Hospitals					
Provision of Logistics							Logistics to LGU funded
<ul style="list-style-type: none"> VSS Drugs and Supplies PAPS SMEAR Kit Forms CDLMIS Reporting Forms 							
Augmentation to Retained Hospital							
<ul style="list-style-type: none"> Training VSS Drugs & Supplies 					100,000 100,000 5,000		
VI. Regular Monitoring/ Supervision							# of monitoring visits done • visits

<p>Conduct regular monitoring ...areas</p> <ul style="list-style-type: none"> • Provide technical assistance <p>Conduct Regular Assesment Evaluation of Program Implementation</p> <ul style="list-style-type: none"> • Consultation Meeting <p>VSS Monitoring</p>		<p>LGU,NGOs and FP Clinics and hospitals</p> <p>6 provinces 3 cities</p> <p>Hospitals</p>	<p>TEV Forms</p> <p>TEV</p>		<p>18,000</p>	<p>DOH Representatives Thrust Program</p> <p>POP Officer CHD FP Coordinators</p>	<p>communities identified and acted upon</p> <ul style="list-style-type: none"> • updates provided
--	--	---	-----------------------------	--	---------------	--	---

OPERATIONAL PLAN MATRIX
CHD/ Hospital/ Bureau/ Service/ Unit/ Office : BMC - Bicol
 Period Covered : CY _____

Strategies/ Activities	TimeFrame	Targets	Resource Requirements			Responsible Office Staff	Expected Output
			Item	OC	Cost		
I. Creation of Itinerant Teams <ul style="list-style-type: none"> • Issuance of Hospital Orders • Orientation • Identification of DH 	July 2002	CS					Itinerant Team Organized
II. Capability Building <ul style="list-style-type: none"> • OB resident -BTL • Surgery - Vasectomy • Nurse Midwives • District Hospital Doctors/ Nurses 		10 courses/ mo	Drugs		60,000		Improved KAS of Personnel
		10 courses/ mo	Drugs		60,000		
III. Collaboration of LGU/NGOs <ul style="list-style-type: none"> • Coordinators Meetings • Linkings 							
IV. Service Delivery							

	<ul style="list-style-type: none"> • Instruments • Drugs and Supplies 				200,000	Engender Health	Acquired Instruments
V.	Surgical Mission						
	<ul style="list-style-type: none"> • BTL • Vasectomy 	30 courses/ mo	Drugs		180,000		
		30 courses/ mo	Drugs		180,000		
VI.	Monitoring and Evaluation						
VII.	Conduct Trng. On Natural FP			Meals	12,000		
	<ul style="list-style-type: none"> • Nurse 			Necklace	10,000		

OPERATIONAL PLAN MATRIX
CHD/ Hospital/ Bureau/ Service/ Unit/ Office : Region 8 –CHDO – Eastern Visayas
 Period Covered : CY 2002-2003

Strategies/ Activities	TimeFrame	Targets	Resource Requirements				Expected Output
			Item	Unit Cost	GOP	Other Sources	
I. Capability Building 1. ToT for FA and NFP Training	July 2002	<ul style="list-style-type: none"> • EVRMC OB Staff • District Hospital OB Personnel 	25 pax/course 2 Fac 1 sec	700/day	210,000		
			28 total pax/course				
	Sept. 2002	<ul style="list-style-type: none"> • Provincial FP City Coordinator • Provincial Hospital OB Personnel 	2 course	700/day	146,300		
			15 pax/ course 3 fac 1 sec				
July 2002 to Dec. 2002	MHO PHN RHM	19 total pax/course 1 course	700/day	1,960,000	MSH		
		25 pax/course 2 fac 1 sec					
August 2002	Rep. NGOs/ GOs/ Stakeholders	28 pax	700/day	196,000			
		2 courses					

National Family Planning Consultative and Planning Workshop
May 22-24, 2002, Cebu City

1.	FA and NFP Training for DOH Personnel (Inhouse Training)	Aug. 2002	DOH Personnel	28 pax 2 course	450/ day	126,000		
2.	BHW/VHW Training on FA and NFP	July – Dec. 2002	BHW/ VHW	28 pax 20 courses	450/day	1,260,000		
3.	Coaching/ Mentoring of facility based service provider	July Dec. 2002	SP	2pax 2 days/ month	300/day	1,800		
III.	Logistics and Materials							
1.	VSS drugs and medical supplies	3 rd Quarter 2002	14 hospital	Lidocaine 2%/ 50s 20 boxes	680/box	13,600		
				D5LR&L 100 bottles	150/bottle	150,000		
				Diazepan 5 mg 100 tablets	60/tablet	60,000		
2.	Necklace/ Abacus	July – Dec. 2002		Necklace/ Abacus	50 200pcs	100,000		
3.	FP Form 1	DUR	6 LGUs	Forms 5,000 pcs	5/pc	25,000		
4.	CDLMIS Forms	DUR	6 LGUs	Forms 5,000 CDLMIS pcs	5/pc	25,000		
5.	Training Modules/ Handouts	(to be used during training)				200,000		

III. IEC/ Advocacy/ Social Mobilization							
1. Development production/ re-production of print materials (streamers, tapes, flyers, posters) including use of collateral (T-shirts, billboards) and issuances	DUR	Regionwide			300,000		
2. Networking among stakeholders	July-Dec. 2002-03	Regionwide	Letters/Communication		100,000		
3. Plugging in video cassette tapes for land, air and inter-island vessels							
4. Aggressive information and marketing campaign	DUR	Workplaces, markets, churches other gatherings	TEV	300/day 3days/ week	900		
5. Creation of IEC/ Advocacy Task Force	DUR	HEPOS, Province/ cities/ NGOs/ Gos,	TEV/ Snacks/ Meals		10,000		

6. Conduct Focus Group Discussions	DUR	Informal Groups	TEV/ Snacks/ Meals		10,000		
7. Celebration of major events (Mother's/ Father's Day, POPDEV, Week, world Pop Day, FP Day)	DUR	Special Events	Streamers/ TEV/ Snacks/ Meals		15,000		
IV. Monitoring and Evaluation							
1. Visits VSS hospitals/ RHUs/ MGP areas	DUR	VSS Hospital, RHU/ MGP areas	TEV	300/ day 2x 3days	1,800		
2. Expansion of Monitoring Team (multi sectoral)	DUR	POPCOM, CHD, Province, cities	TEV	300/day 3days 1,800/person 4 persons	5,400		
3. Monitoring FP Promotion plan at all levels	DUR	-do- HEPO's	TEV		5,400		
4. Consultative Workshop	Semestral	Regionwide		50,000/workshop	100,000		
5. Program Implementation Review	Annual	Regionwide	Snacks/ Meals		75,000		

OPERATIONAL PLAN MATRIX
CHD/ Hospital/ Bureau/ Service/ Unit/ Office : XII
 Period Covered : CY 2002-2003

Strategies/ Activities	TimeFrame	Targets	Resource Requirements			Responsible Office Staff	Expected Output
			Item	OC	Cost		
Policy Making							
1. Attendance to zonal/ national meetings, workshops, conference	Quarterly	RD FP Med. Coordinator FP Nurse Coordinator	3 pax 6 times	10,000	180,000		
2. City and Provincial FP Coordinators meeting, planning, workshops, etc.,	Semi-Annual	25 pax	25 pax 2 days 3 meetings	800	120,000		
3. RH/ FP Multi-sectoral Coalition/ Task Force	Semi-Annual	POPCOM DECS NGO's Inter-Faith	20 pax 1 day 3 meetings	200	120,000		
4. Strengthening RIAT to be utilized as RH/FP Management Team	July 2002	RD Chief of Hospital RTAT Members ROA-RTA (UNFPA)					
Capability Building							

National Family Planning Consultative and Planning Workshop
May 22-24, 2002, Cebu City

Advocacy/ SOC-MOB						
1. Reproduction of existing Prototype IEC Materials	Q4 2003				100,000	
2. Distribution of Reproduced IEC Materials	Q1 2003	Health Fac. High School College				
3. Reproduction and Distribution of existing DOH FP Policies and Standard/ Guidelines	Q3 2002	All FP/VS Service Delivery Point				
4. Massive information on FP especially NF P down to the municipal level as needed or per request	Q4 2002- yr thereafter (per request)	Regionwide	TEV/ per diem: 3 pax x 50 12 months	300	54,000	
5. Creation of linkages with academe - Provide Fertility Awareness Education	Yr 2003 (per request)	NDU CCSPC Laboratory H-School Nat'l Hi-Sch. St. Benedict, etc.,				

34

National Family Planning Consultative and Planning Workshop
May 22-24, 2002, Cebu City

1.	Fertility Awareness (FA) and NFP	Aug. 2002	25 pax	B/L: 25 pax x5 days S/M: 25 pax	800 400	100,000 10,000		
2.	FA and NFP course for Supervisors	Q4 2002	25 pax	B/L: 25 pax x5 days S/M: 25 pax	800 400	100,000 10,000		
3.	FA and NFP for Frontline HWs	Q4 2003	180 pax	B/L: 30 pax x 30 days 6 batches 5 fax x 30 6 batches S/M: 30 pax 6 batches	800 800 400	432,000 72,000 72,000		
4.	FP Counseling Training using the Gather Approach	Sept. 2002-2003	180 pax	B/L: 30 pax x5 days 6 batches 4 fax x 50 6 batches S/M: 30 pax 6 batches	800 800 200	720,000 96,000 36,00		
5.	CBT-FP	2003	90 pax	D/L: 30 pax x 16 days 3 batches 5 fax x 16 days 3 batches S/M: 30 pax 3 batches	800 800	1,152,000 192,000		
6.	CBT-BHWs/VHWs	June 2002-2003	MGP Areas SK - 12 mun. CP- 12 mun.			27,000	C/o MGP Funds	
7.	Whole Site Training for NSV	Oct. 2002 - 2003		B/L: 25 pax x5 days S/M: 25 pax			C/o Engender Health	

	among high school students and college students					
6.	FP Day Celebration - Best Practices Showdown	Aug. 2003	Regionwide		200,000	
7.	Create Linkage with Tri-Media Practitioners -TV guesting -Radio guesting Topic: NFP		Ugnayan sa DA DXCM DXMY		Free	
	Research					
1.	Assesment of FP Programs in Region 12	2003			200,000	
	Service Delivery /					

LGU Assistance						
1.	Creation of Regional Based Itinerant team for NSV	Q4 2002	MLANG MHO CHD MDs PHO Surgeons			
2.	Conduct of NSV Outreach Activity	Q4 2002	MGP Areas	TEV/ Per Diems		C/o MGP Funds
3.	Provision of Logistics/ supplies/ Medicines/ supplies			FP Forms CDLMIS Forms Albaryl D5LR 500cc Lidocaine Diazepam Nalbuphine Chromic 2-0 Cut6ut Gloves Lubricating Gel SDM Necklace (NFP) Abacus (NFP)	50,000 50,000	
	Resource Management				200,000	
1.	Procurement of Computer Laptop (to be used in the advocacy)	Q4 2002	Laptop	1 computer laptop	100,000	
2.	Office supplies	Q4 2002		Office supplies and	50,000	

and Materials			materials				
Monitoring/ Evaluation							
1. Quarterly Monitoring	Quarterly		TEV/ per diems 3 pax x 5days 6 quarters x 4 sites	300	108,000		
2. Year end PIR	Q4 2002 Q4 2003		B/L: 25 pax x 2 days 2 meetings	800	80,00		

OPERATIONAL PLAN MATRIX
CHD/ Hospital/ Bureau/ Service/ Unit/ Office : CHD VII
 Period Covered : CY _____

Strategies/ Activities	TimeFrame	Targets	Resource Requirements			Responsible Office Staff	Expected Output
			Item	OC	Cost		
I. Capability Building							
A. Send Training Need Assessment to LGUs/ PHOs/CHOs	June 24, 2002	PHO CHO				DOH - 7	
B. Trng. Of Trainers in FP and NFP (one batch)	1 st week of July	RHO PHO CHO				IRH	
C. Trng. Of Stakeholders (one batch)	4 th week of July	Religious org. (interfaith) Kapwa Ko... POPOCOM DOLE FPOP ALU				DOH 7 PHO's	
D. Trng. Of Implementors (8 batches)	2 nd week of Aug.	MHO Nurses Midwives					
E. Trng. Of Volunteers (6 batches)	4 th week of Aug.	Volunteers					

<p>F. Training of BHW</p> <p>G. Production of Training Materials (SDM, Billings, Procure Necklace)</p>	<p>2nd week of Sept.</p>	<p>BHWs</p>			<p>PHO's RHO's</p>	
<p>II. Advocacy</p> <p>1. Launching Activities</p> <p>a. Press Conference</p> <p>b. Exhibit</p> <p>c. Motorcade</p> <p>d. Provincial Dissemination Forum</p>						
<p>III. IEC</p> <p>1. Production of IEC Materials (printers, flyers, IEC)</p>						

h8

<p>2. Production of Billboards</p> <ul style="list-style-type: none">- for cities of Bohol and Cebu- for RHU's in Bohol							
<p>3. Production of radio drama</p> <ul style="list-style-type: none">- development- airing							
<p>4. Production of reports</p> <ul style="list-style-type: none">- development- production- airing on NGO's Program							
<p>IV. Implementation</p> <p>1. Purchase of medicine, medical supply and necklace</p> <p>2. Conduct outreach mission together with cataract and</p>							

<p>LGUs activities</p> <ol style="list-style-type: none">3. Organize Provincial Itinerant Team4. Provide Logistic Support <p>V. Monitoring</p> <ol style="list-style-type: none">1. Monthly Monitoring Visits2. Monitoring forms3. Documentation - Purchase of camera						<table border="1"><tr><td data-bbox="1890 188 2184 379"></td></tr><tr><td data-bbox="1890 379 2184 638"></td></tr></table>		

OPERATIONAL PLAN MATRIX

CHD/ Hospital/ Bureau/ Service/ Unit/ Office : CHD - 02

Period Covered : CY June – Dec. 2002

Strategies/ Activities	TimeFrame	Targets	Resource Requirements			Responsible Office Staff	Expected Output
			Item	OC	Cost		
I. Management							
1. Multisectoral	3 rd week of June 2002	PA's, Media, NGOs, POs (50)	Meals, snacks, materials		12,500	Regional FP Tech/ trng. Coordinator	
2. Expansion of membership of RP&B	-do-	SPU, CSU, SMU	Letter of Invitation		-do-	-do-	
3. Identification and Networking with existing Service Provider	-do-	NGO FP Provider			-do-	-do-	

II. Capability Building							
1.	Attendance to ToT on FA & NFP	July 2002	3 FP Coordinator	TEV		10,000	Co
2.	Training of supervisors on FA & NFP and other methods	Aug. 02	20 pax	Training allowance Training materials		42,000	Regional Trainers
3.	Training of frontline Health Workers and CBHWs on FA & NFP & other methods	Aug. 02 onward to 2003	PHNs RHMs CBHWs	Training Allowance Training Materials Training Allowance Training Materials 1000 module		2.4 M 500,00 c/o MSH	Regional/ Provincial Trainers
4.	Institutionalization of academe and training institution for FA and NFP	As scheduled	SPU, CSU SMU				CHR 02
5.	Designing Training activities/ topic to dovetail other FP methods into FA * NFP						CHR 02
6.	Training of itinerant teams on VSS		2 Teams for CHD 1 surgeon VRH				CVMC
7.	On-site training on NSV					C/o VRH	Engender Health

III. Implementation							
1. Outreach on VSS		Prospective clients for VSS	VSS med/ supplies		500,000 per retained hospital CVMC, VRASIBH		
2. Provision on NFP, VSS and other methods in FP Service Outlet		-do	Contraceptives NFP paraphernalia			Service Provider	

IV.	IEC and Advocacy						
1.	Consultative dialogue ride on during provincial/municipal LHB meetings	As scheduled	LCEs, POs, Interfaith orgs., community	TEVS Materials		Regular costs of TEVs	DOH-Reps
2.	Celebrations activities for NFP to coincide with special events	May August November		IEC materials		100,000	FP Coordinator
3.	Putting up of signboards			Messages		130,500	
4.	TV guesting during local shows						
5.	Tipon-tipon						
6.	Press Release/cds in CHD local paper, school organs					10,000	
7.	Translation/Reproduction of IEC Materials					300,000	

V. Logistic Support						
1.	Inclusion of NFP/VSS paraphernalia into APP		CVMC, VRH SIGH	VSS drugs/ supplies Thermometer Necklace Focus		COH
2.	Reproduction of FP Focus			FP/ NFP forms	100,000	FP coordinator
3.	Provision of NFP paraphernalia		NFP client	Thermometer Necklace	100,000	-do-
4.	Augmentation of VS drugs/ supplies		8 VS LGU Hospital	Drugs/ supplies	100,000	-do-
VI. Monitoring/ Evaluation						
1.	Bi-annual Regional Project Review	Nov. 02 June- Nov. 2003	Coordinator DOH Reps.	Meals/ snacks Materials	75,000	-do-
2.	Monitoring NFP/VSS services	On-going		TEV	100,00	-do-
3.	Attendance to quarterly provincial program review	As scheduled		TEV		

Annex I

Bridging Session

Insights	Inquiries	Implications	Reactions	Recommendation
<ul style="list-style-type: none"> Revitalized and refreshed our mind about the program FP is not a separate program but it should be integrated with the health programs Inclusion of NOVs in the discussion will help to see and reach other better. 	<p>Do we have funds to do similar redirection/interaction at the lower level?</p>	<p>Need for funding</p>	<p>There are many reporting/monitoring tools which created confusion</p>	<ul style="list-style-type: none"> Treat these tools as reference methods Leave it to the end users to decide which tools to use
<ul style="list-style-type: none"> FP plays a big role in the health of its clients In 35 years stakeholders are increased but to date still fragmented strategies ... Policy direction not complementing operational activities because of high politization 	<ul style="list-style-type: none"> Will funding donors continue supporting FP? Until when? Are there inverse support for the different methods? 	<p>Highly politicized program cause the DOH to bend and follow popular demand.</p>		<p>DOH should be the convener in the coalition and taking leadership in convening council.</p>
<ul style="list-style-type: none"> There is still much room for improvement at all levels using different strategies Strong collaboration and networking with NGO, CAs will strengthen the FP program. 	<ul style="list-style-type: none"> Where hospital should come in? 	<p>Given the updates there is a focus of FP program and putting more emphasis on the weak activities/strategies.</p>	<ul style="list-style-type: none"> Hospital has different set up 	<p>Hospital FP coordinator or hospital public health unit representatives should be included in this workshop.</p>
<ul style="list-style-type: none"> Continuity of FP program direction to be implemented regardless of who is at the helm. Models for QA monitoring tools is integrated. 	<p>Why was the hospital FP coordinator not included in this workshop?</p>	<p>There are lots of things to do to make FP successful.</p>		<ul style="list-style-type: none"> Accessibility – should cover geographical, organizational, economic, cultural, linguistics. Time frame for activities.
<ul style="list-style-type: none"> So many concerns Unmet needs will take as a challenge Statistical survey 			<p>Adolescent RH should be given priority.</p>	<ul style="list-style-type: none"> Coalition team approach. IEC needs improvement.

*National Family Planning Consultative and Planning Workshop
May 22-24, 2002, Cebu City*

not reflective of true picture • Communication campaign (e.g. IEC) very vital.		
• One prototype of monitoring and assessment tool will provide a better quality service	Do we have an over-all regular monitoring updates of FP program?	Assessment period will be an opportunity for advocacy and counseling

Inquiries	Answers
Do we have funds to do similar redirection/interaction at the lower level?	
<ul style="list-style-type: none"> • Will funding donors continue supporting FP? • Until when? • Are there inverse supports for the different methods? 	
Where they should come in?	
Why was the hospital FP coordinator not included in this workshop?	
Do we have an over-all regular monitoring updates of FP program?	

OUTPUTS WORKSHOP I

GROUP I - FAMILY PLANNING MANUAL "Akala ko...Akala ninyo"

- A. Role of Counseling in Family Planning
 - *remove "also"*
- B. Essentials of Counseling
 - 1. Competent counselor
 - a. Knowledgeable – The counselor should had undergone training on Family Planning and basic counseling
 - b. Caring – the counselor should have:
 - 1. understanding ...
 - 2. respect...
 - 3. honesty...
- C. Skills – Ok
- D. Counseling Elements
 - 1. Greet – *add* – "If counseling is done at the client's home, introduce yourself and explain the reason for the visit" after "...why the client came to the clinic"
 - 2. Ask
 - a. name
 - b. age
 - ↓
 - g. LMP/PMP
 - 3. Tell
 - 4. Help
 - 5. Explain
 - remove "Encourage..."*
 - change to "Explain to the client the reasons for returning in case of side effects"*
 - 6. Return – *remove "Routine"*

- *should be like this* "RETURN for Follow-up..."
 - Tell the client ... Ok
 - *Add* "Encourage the client to come back if she/he experiences any side effects"
 - Refer the client... Ok
 - routine follow-up visit
 - outside of routine
- E. Counteracting
- *remove* "Find out where the rumor..."
- F. Key Messages...
1. Health Benefits. "FP...both mothers and children."
 - *remove* "as well as father"

II – Checklist (organize)

Page 1 and 2 – Ok

Page 3 – add – IV stand on equipment

Page 4 – 3.1.19.1. - instead of repeating "Dressing tray" 6 times
change to

3.1.19. Dressing tray containing
1. forceps



7. cotton
8. pick-up forceps

3.1.20.1 - instead of repeating "Delivery kit" 7 times
change to

3.1.20. Delivery Kit Containing
1. Mayo scissors
2. Pick-up forceps *
3. Big Kelly *
4. Needle holder
5. Uterine forceps
6. Cord clamps
7. Sterile Gauze
8. Sterile towel
9. Sutures chronic 2.0 *
10. Anaesthetic – xylocaine 2% *
11. Syringe & needle (5cc) *
12. Antiseptic *

(* to be included)

Page 5 – 3.2. Medicines/Drugs
1. Oxytocins amp.
2. Methergin tab./amp.
3. Amoxicillin 500 mg.
4. Mefenamic 500 mg.
5. Ferrous Sulfate
6. Vitamin A
7. Ophthalmic mg.
8. Vitamin K
9. IVF
10. Pills
11. DMPA

3.3. Medical Supplies

1. condom
2. IUD
3. IV set and Tourniquet (to be included)
4. Kelly Pad



12. plaster
13. slides *
14. cotton applicator *
15. fixative *

(* to be included for papsmear)

Page 6 – 3.4.

Other Materials

1.



- 11.
12. Apgar Scoring Chart *
13. Leopold's Maneuver Chart *

(* to be included)

Recommendations:

- **add definition for partial and fully met**

GROUPS 2 – 3 – 4 - REPRODUCTIVE HEALTH CLUSTER GROUP

Highlights of the Group Discussion

On General Physical Examination

- Q. How many health workers have undergone training in Bethesda examination and reporting techniques?
- A. No capability building activity has yet been done. Examinations and reporting methods still adhere to the standard Pap Smear Test. It is only the interpretative reading of the smear and classification of the report that were revised. Examination processes have not changed.

Note:

Bethesda is the new approach in pathology for cervical examination.

- Q. There is a need to inform service providers of the Pap-Bethesda transition and the Manual.
- A. Once the Manual is revised and distributed, refresher training will begin for all service providers.

Agreements/Action Points

Both the Pap Smear Technique and the Bethesda reporting and classification should be followed so that the transition to the new Bethesda technology will be smooth.

If the participation of the Pathological Society would be required, we must follow this protocol. It should be recalled that nurses and doctors do not interpret smear results.

On the RH Manual

- Will the manual cover only family planning or the whole spectrum of RH? If it is the range of RH and its components, it is an entirely new Manual.
- If there will be changes, what will be changed is not the FP Form 1-A but the Client Service Record.
- Family Planning Folders contain only the Patient Treatment Record for the individual member of the family, which does not contain much.
- One measure to address this is to attach additional sheets to include all family members so that it becomes the FAMILY FOLDER.

Q. Will the group choose an RH programmatic approach or FP?

A. It is possible to create an entirely new record and titled REPRODUCTIVE HEALTH RECORD, inclusive of the FP and other forms.

- Some regions have not received copies of the RH Modules, so that health providers can only carry out their tasks within the limits of their present resources.

Manual Development: History and Background

(Dr. Moi Serdencillo)

The RH Manual was conceived as a systems development project under a foreign grant. It views RH as a concept, a program, and thematic. It has taken for its inputs existing training modules on FP, women's health and MCH training modules, and others. It covers all the elements and clinical standards of RH. It differs from previous manuals in terms of this encompassing perspective.

Trainers on women's health on field were invited as facilitators and resource persons to the workshops organized for purposes of the design and development. No drastic changes in the area of substance to the integration of existing manuals were made – they were minimal.

In a sense, the RH Manual enhances the FP content but will take into consideration all the concerns of this Workshop. It is strong in gender sensitivity, it adopted the rights-based approach, and facilitates inter-active participatory training. The Manual was also designed to be policy dependent (awaits policy) and aims to be comprehensive and user friendly.

150 copies of the UNFPA Manual were given to the DOH

BASIC OVERALL RECOMMENDATIONS OF THE RH GROUP

1. **Review Reporting Forms and the UNFPA Manual.** All foregoing manuals will be regarded as thematic area concerns but there will be an integrated, consolidated Manual for RH that shall serve as the "Bible of Reproductive Health Care."

- Consolidation of all existing training manuals inclusive of experiences, initiatives, thrusts, RH service protocols
- Recall all points taken in previous training manuals on FP, MCH, VSS, Adolescent RH, Women's Health, etc.
- Focal group discussions with participation by category:
Service providers: doctors, nurses, midwives
Implementors: BHWs, RH personnel

2. **Organize a Writeshop.** All recommendations and proposed changes to the Manual will be studied for further refinements. These will then be given to a Technical Working Group for review and styling purposes. The Writeshop will involve regional health providers who will be given the chance to participate in the discussions. The Manual should take into account all the experiences and the cultural differences that were encountered in the pilot sites. Once finalized, the Manual will be pre-tested and piloted prior to adoption.

Response, DOH Central

Dr. Loreto Roquero

All the suggestions and recommendations discussed in this Consultative and Planning Workshop cannot be finalized in one sitting. A subsequent Writing Session will have to be organized that will discuss all commitments, perceptions, pledges, proposals in a scoping and table process session for subsequent consolidation. DOH will decide on the timetable for mainstreaming in the regions.

On the Checklist

- Items in the checklist should be viewed as a baseline of future agreements on thematic areas
- The first step is to review the service protocols
- Craft a Resolution/Agenda for Action for feedbacking to DOH in order to address identical needs of the program.
- If the Manual strives for convergence, then the checklist should also do the same.
- There are concomitant investments to consider in the design of future manuals, checklists. Insights should be borrowed from the UNFPA experience.
- People below must be comfortable with the system.
- What is the preference, the Women's Health Manual or UNFPA Manual since there is no convergence in the field in terms of protocols. There, the practice is "to each his own."
- What is the protocol from the perspective of the Central Office?
- The Checklist appears to consolidate all the manuals but based on our discussion, it is not so.
- Is the Checklist donor driven?

- The immediate review and finalization of the Manual is necessary because prior to implementation, we have to submit estimates to the region for budgetary allocations for training.

INDIVIDUAL GROUP OUTPUTS (GROUPS 2-4)

Workshop Output, Group 2

Client History

1. Demographic Information

Include I (page 22):

- a. Age / Date of Birth
- b. Civil Status

2. Reproductive Health Data, include

Other RH component data:

c.) FP Hx (page 23)

- change contraceptive into FP, in "contraceptive method previously used"
- change "cause of discontinuation" to "reason" and add "side-effects"

General PE:

2. "Timing" change to "schedule" (page 25)

- a. delete ideally
- b. & c. should be interchange

3. Steps (page 25)

Note: Ensure that all instruments/supplies needed during procedure (e.g. gloves, lubricant, vaginal speculum, pick-up forceps, cotton balls) are prepared and in places

- a. add "and confidentiality" after "privacy" (page 25)
- b. conduct complete physical examination
 - b.1. check the client's vital signs... (item c)
 - b.2. Head (page 26)
 - ii. delete the words "and consistency"
 - iii. add "hematoma, etc" after the word "discoloration"
 - iv. add the word "odor" after "missing teeth"
 - b.4. Heart (page 27)
 - i. insert "/shaded areas" after the word "site"
 - d.5. Lungs (page 27)
 - i. insert "/shaded areas" after the word sites
- c. add "conduct male physical examination"
 - c.1. General data
 - c.2. Uro-genital examination
 - i. Penile
 - ii. Scrotal
 - iii. Rectal

Chart II (page 44)

-to include in the proposed checklist"

8. change "Papanicolaou's smear" to "Bethesda classification (result classification, reporting form, interpretation)

- d. Follow up (page 57)
data sentence Class II to V -

Add another sentence. "Abnormal findings should be referred to physician.

CHART IV (Page 68) should be placed in the Appendix

Page 75: Family Planning Service Record should be changed to Reproductive Health Service Record

- CLIENT SERVICE RECORD

Must have and RH Service Record

Review Reporting Forms

1. Review the manual
 - small group
 - participatory
 - "pilot/initiations"

Workshop Output Group 3
(Checklist)

- To include waiting time, time spent by service provider for each client.

STRUCTURING

>Columns for rating

NA	/	YES	/	NO
----	---	-----	---	----

2

0

I.	Interpersonal Relations	}	Applies for all types of clients
II.	Technical Competence		

A & B

III. SERVICES

Family planning

- > Delete 1.1 (incorporate to A & B)
- > Activities should follow T-H-E-R tasks
- > For reports TCL/logbook

• MATERNAL CARE

- AP - include TT immunization and FeSO₄ supplementation
- specify counselling on
- a. Dental care
 - b. Breastfeeding
 - c. Nutrition and micronutrient supplementation
 - d. Info on FP

PP >counsel on:

BF, FP, nutrition, immunization, newborn care

General remarks/observations on the last page of the checklist.

RECOMENDATIONS:

1. Integrate all existing checklists
 - > ENGENDER
 - > Sentrong Sigla
 - > UNFPA
2. DOH/region may formulate/modify their checklist applicable to their setting.

PROCEDURES MANUAL

RH care

SCOPE - lacks 4 elements

- a. Men's RH
- b. VAW
- c. PMAC counseling
- d. Sexual Health

ARH – No specific health services

MOTHER/BABY CARE PACKAGE

- > No newborn care package
- > No nutrition info

SEQUENCING

- > Follow life cycle approach

ENHANCE the distribution and dissemination of RH modules and clinical standards

**Workshop output, Group 4
(Checklist)**

General Data

- To include
Pr/City
Mun/District
- Interlocal HZ Congr. District Marital Status

01

2.

2.2 Delete Beneficiary

ACTIVITY

- I. Delete #3, to incorporate, eg. Eye contact in #2
- II.B. #5 delete "includingnecessary"
#7 add external
7.1 & 7.2 delete "external exam of pelvis"
- C. 1.1 add and refers acc.
 - 1.6 → 1.5
 - 1.7 → 1.6
 - 1.5 → 1.7 & 1.8
- C2.
 - 2.1.1 after OB score, include G_P_(T-P-A-L)
 - 2.1.6 add after ff: & does immediate referral
Delete 2.1.8
 - 2.2 Labor and Delivery – delete instr. "To be ..."
 - 2.3.3.4 add immunization
rearrange
 - 2.3.6 → 2.3.4
 - 2.3.7 → 2.3.5
 - 2.3.4 → 2.3.6
 - 2.3.5 → 2.3.7

5.

- 5.1 add after violence, "accdg. to protocol"
- 5.2 after intervention, add "as necessary"

6.

- 6.1.5 separate the larche
- 6.4 add including availability of appropriate FP services

Add item 7. other RH services

7.1 conducts initial assessment and refers accordingly

- Delete instructions: "To be done...."
- Add scoring instructions
- Include definition of terms

Compare all existing manuals, checklists, tools, etc. and decide which is the best to be adopted.

"Comfortable"

"Retraining"

GROUP 5 - METHODS OF FAMILY PLANNING

Page 90 LAM Algorithm – Ok

- But should be presented in horizontal manner to see the events after delivery (*the commission will do it*)
 - o to effect three criteria of LAM
 - o to effect correct observation of events.

Page 93 – 109 – NFP Methods

- Need redrafting for there are simple ways of using the natural methods plus other FP methods
 - Fertility awareness or FOS
 - Methods Instruction
 - Initial Instructions for learning tools and follow-up sessions
 - Records keeping of continuing users, drop-outs and shifters

ON ALL METHODS

1. Uniformity in the presentation relating to method contraindication/precaution

Suggestion: **Adopt who medical eligibility criteria**

2. Review guidelines on the MGT of :
 - complications
 - instruments *used should conform with existing instruments available in the clinic.*

VSC

1. Tubal Ligation

- Nature should be redefined
- Minilap and Laparoscopy are not type but approaches to F.S.
- Timing of postpartum
Minilap not recommended after 48' after delivery

(refine Sentrong Sigla criteria)

HOW DO WE CATEGORIZE FP METHODS?

Natural:

1. Non menstrual cycle based
 - LAM
2. Menstrual cycle based

A. Mucus Method

- Ovulation method (OM)
- Billings ovulation (BOM) *
not in the clinical standard but will be requested
- SDM *
these protocol should be developed

B. Body Basal Temperature (BBT) *

C. Sympto Thermal Method (STM) *

(Integrate all department circular on NFP to the new thrust of the administration)

Artificial:

1. Pill
2. IUD
3. Condom
4. Depo

Permanent:

1. Vasectomy
2. Tubal Ligation

(organize scientific body to review/assess all FP methods)

INFECTION CONTROL

1. Hand-washing
 - b. ii. *Include "soup dispenser"*
 - c. i. *No jewelry should be worn. (delete the rest of the statement)*
2. Antisepsis of skin and mucus membrane
 - b. ii. *Before and after contact with a client*
 - d. *It is needed before an IUD procedure or any internal exams procedure except when you need to see grossly the mucus membranes and to draw specimen. Also, before certain treatment are applied to the mucus membrane.*

Comment on antiseptic solutions:

Chart XIV

- Hexachlorophene is no longer in the market and should be deleted.

(technical experts should review on infection control autoclave in the hospital)

RECOMMENDATION

- Simplify LAM Algorithm to be client friendly

**GROUP 6 – 7 - MANAGEMENT OF FP CLINIC SERVICES
 AND FACILITY OBSERVATION**

Introduction

XXX...

Chart XX. Minimum Standards for Family Planning Service Outlets

Chart XX. Minimum Standards for Family Planning Service Outlets				
Outlet/ Facility	Minimum Staffing Required	Minimum Set of FP Services Provided	Basic Training Required	Basic Resource Requirement
Barangay Health Station (BHS)	XXX	XXX Provision of Pills, Condom, DMPA and LAM/NFP (mens, thermal, SDM	XXX	XXX Weighing scale Examining materials Speculum Gloves Cutting blades Acetic Acid Paps smear kit Referral Forms
<p>Note:</p> <p>What about in areas without MW?</p> <p>Unresolved Issue:</p> <p>1. Inclusion of IUD Insertion in BHS</p>				
Rural Health Unit/Main Health Center	XXX Med Tech	XXX Infertility Counseling/ Referral	XXX	XXX PLUS: XXX Microscope (Binoculars) IUD Kit Fire Extinguisher
Hospitals/Referral Center	XXX Referral Network with	XXX	XXX	XXX

*National Family Planning Consultative and Planning Workshop
May 22-24, 2002, Cebu City*

	higher levels			
	Within scope of capability			
Note:				
Categorize hospital by level (1; 2; 3)				

A. Clinic Facilities	<p>XXX</p> <p>Some of the criteria of a good RH-FP clinic are:</p> <p>6. A clean and functional comfort room for staff and clients. Different Able-Friendly comfort room</p> <p>8. Ready and adequate clean water supply.</p> <p>11. An area for washing and sterilization of gloves and instruments; an area for lavatory.</p> <p>13. Availability of color-coded garbage receptacles. An area for group counseling.</p>
B. Clinic Staff	<p>Family Planning services must be provided by a physician, nurse or midwife who is trained in the full range of methods provided in FP service outlets.</p> <p>(delete temporary)</p> <p>XXX..</p>

<p>CHART XXI: FUNCTIONS AND TASKS OF THE NURSE AND MIDWIFE IN THE DELIVERY OF FP SERVICE</p> <p>Delineate task of Nurse and Midwife</p>	
1. Planning	<p>XXX...</p>
2. Implementation	<p>If both Nurse and Midwife are present:</p> <p>a. provide informational/educational talks to small groups of women in the clinic, on a daily basis preferably</p> <p>b. Collect specimen and perform the laboratory test when possible:</p> <ul style="list-style-type: none"> • Urinalysis for glucose and protein • Hemoglobin and Blood Typing • Pregnancy test

- Wet smear
 - Schiller's test
 - Maternity Index in cases of Infertility
- c. Manage common gynecological problems within scope of practice
 - d. Manage common side-effects of a method within scope of practice
 - e. Perform Basic Life Support for Emergencies
 - f. Refer clients with problems or needs outside scope of practice
 - g. Provide information, counseling and referral to couples complaining of infertility
 - h. Provide information and referral to clients desiring to:
 - Voluntary Surgical Contraception
 - i. Provide Natural Family Planning
 - j. Follow up and counsel drop outs
 - k. Keep accurate, complete and up-to-date client records
 - l. Maintain infection control and other clinic operation/activities

Nurse:

- a. Educate and counsel individual clients about their FP options and method choice(s)
- b. Conduct interviews and record the client's history
- c. Perform the physical assessment including the pelvic examination
- d. Collect Pa smear and send it for analysis
- e. Provide and dispense the temporary method of contraception to potential clients after counseling/education and thorough physical examination

Midwife:

- a. Prepare clinic equipment, supplies and records for the day's work
- b. Provide information/ educational talks on RH/FP to community groups at least monthly

3. Education

XXXX

4. Supervision

XXX

5. Monitoring and Evaluation

XXX

CHART XXII: FUNCTIONS AND TASKS OF THE PHYSICIAN
IN THE DELIVERY OF FP SERVICES

1. Planning

XXX...

b. Identify...

- Logistics
 -
-

3. Supervision & Monitoring XXX...
4. Education XXX...

C. CLINIC ACTIVITIES	xxx..
	3. XXX...
	a. The purpose...
	<ul style="list-style-type: none"> • To find out results of medical intervention
D. LOGISTICS MANAGEMENT	XXX...
	b. Medicines...
	<ul style="list-style-type: none"> • Delete Albothyl Concentrate • Delete Anti-rust tablets
	c. Contraceptives
	<ul style="list-style-type: none"> • Thermometer • "Necklace" beads
	XXX...

CHART XXIII: CLINIC REFERRAL SLIP						
Name					Date	
Address	Age		Family No.			
Referred from:	RHM	PHN	PHD	SI	MHO	Others:
Referred to:	RHM	PHN	PHD	SI	MHO	Others:
Pertinent Clinical Data/ findings by referring level:						

Reason for referral: _____						
Action taken by referring level: _____						

Signature						

Referring Level				Referred Level		

CHART XXIII: CLINIC REFERRAL SLIP			
Name	Date		
Address	Age	Family No.	
Referred from:	RHM PHN PHD SI MHO	Others:	
Referred to:	RHM PHN PHD SI MHO	Others:	
Pertinent Clinical Data/ findings by referring level:			

Reason for referral: _____			
Action taken by referring level: _____			
Instruction to referring level: _____			
_____ Signature			
_____		_____	
Referring Level		Referred Level	

Note:

- Return Slip to the Referring Unit
- Upper half to be filled up by the Referring Unit
Lower half to be filled up by Referred Level to be returned to Referring Unit

WORKSHOP I BREAK-OUT GROUP COMPOSITION

Group 1 Counseling Barangay Health Station

- | | |
|---------------------------|-----------------------|
| 1. Dr. David Lozada | 5. Dr. Glenda Subong |
| 2. Ms. Susan Juangco | 6. Dr. Firma Abarquez |
| 3. Ms. Tess dela Cruz | 7. Dr. Arthur Suyko |
| 4. Dr. Eusebio Alquizalas | 8. Dr. Amy Estrella |

Group 2 Basic Reproductive Health Care Visit Service Provider Observation Checklist Midwife/ Nurses

- | | |
|---------------------------|------------------------|
| 1. Dr. Marietta Fuentes | 5. Dr. Rogelio Chua |
| 2. Dr. Teresita Bonoan | 6. Dr. Domingo Vega |
| 3. Dr. Amelita Pangilinan | 7. Dr. Rey delos Reyes |
| 4. Ms. Fe Modesto | 8. Dr. Fatima Emban |

Group 3 Reproductive Health Care/ Service Provider Observation

- | | |
|------------------------|------------------------|
| 1. Dr. Lourdes Labiano | 5. Dr. Ruth Peralta |
| 2. Dr. Gerardo Bayugao | 6. Dr. Melody Mercado |
| 3. Ms. Nelia Gumela | 7. Dr. Joselita Cacdac |
| 4. Ms. Vicky Olivas | 8. Dr. Emily Reyes |

*National Family Planning Consultative and Planning Workshop
May 22-24, 2002, Cebu City*

Group 4

- | | |
|-----------------------------|-------------------------|
| 1. Dr. Dolores Castillo | 6. Dr. Evelyn Clarete |
| 2. Dr. Lourdes Naragdao | 7. Dr. Adelaida Anprinn |
| 3. Ms. Carmelita Tagaba | 8. Dr. Nenita Moraza-Po |
| 4. Dr. Annalyn Dimapanat | 9. Atty. Dory Rateria |
| 5. Dr. Anna Nerissa Sanchez | |

Group 5 Methods of FP – How do we categorize FP Methods – Infection Control

- | | |
|------------------------|------------------------|
| 1. Dr. Ethelyn Nieto | 5. Dr. Emily Bernardo |
| 2. Dr. Rosario Famaran | 6. Dr. Manny Factora |
| 3. Ms. Virgie Pagunsin | 7. Dr. Jose Man Fermin |
| 4. Dr. Cynthia Dionio | 8. Dr. Noel Pasion |

Group 6 Management of FP Clinic Services/ Facility Observation

- | | |
|-----------------------|--------------------------|
| 1. Dr. Charito Awiten | 5. Dr. Lydia Ramirez |
| 2. Dr. Tao Usman | 6. Emmanuel Achiba |
| 3. Dr. Edna Abcede | 7. Dr. Rosalinda Arandia |
| 4. Ms. Jasmin Sarce | 8. Gloria Balboa |

Group 7 Management of FP Clinic Services – Team

- | | |
|--------------------------|------------------------|
| 1. Dr. Lydia Depra-Ramos | 5. Dr. Edgardo Espiana |
| 2. Dr. Rosano Benabaye | 6. Dr. Napoleon Obana |
| 3. Dr. Mary Grace Alviar | 7. Dr. Gerardo Cunanan |
| 4. Dr. Laura Evangelio | 8. Dr. Ed Jamario |

ANNEX II

Workshop II Output

Group 1 - Visayas-Mindanao VSS Team

Recommendations for VSS

Standards: ** Delete please or review or re-craft appropriately.

1.3 & 4 *Rephrase* – VS client, natural or legal guardian to VS client, natural or legal guardian of clients below 18 years old

- instead of putting only 6 elements thereof it should be enumerated

II – DOH-CHD – Health development

III B to include anesthesiologist (PRN)

IV – 3a creation of CHD itinerant team wherever possible

3a.5 be provided with copies – to get a copy

3b.4 to add after performed ... status or condition on discharge and schedule of follow-up

4.3 after "NGO" add "specialty societies."

III A – The team could be incorporated with the hospital surgical outreach team.
 (for the hospitals with regular outreach program)

To maximize utilization of resources

Other Recommendations

1. Amendment of AO no.2 s2000
 - to include non-scalpel vasectomy requirement for surgical residency training
2. Option to use spinal/local anesthesia be based on the clinical assessment of the surgeon and anesthesiologist
3. Time spent by OB-Gyne and surgery dispersal who are member of itinerant team be accredited as community SVC.

Constraints	Recommendations
• Availability of equipment and instruments	• Provide ML-LA and VAS set – DOH/EH
• Availability of drugs and supplies	• Provide drugs and medicines to include emergency drugs – DOH
• Manpower – initial implementation	• Itinerant team to be provided by DOH

*National FP Consultative and Planning Workshop
May 22-24m 2002m Cebu City*

	<ul style="list-style-type: none">Retained regular and medical contains with augmentation for CHD office and LGU to include other members of medical and surgical mission teams
<ul style="list-style-type: none">Sustainability	<ul style="list-style-type: none">Retained Regional Hospitals and Medical Center as training venues of itinerant team and as supervision of ITTrained IT from OH and CHD personnel and LGU will compose the IT
<ul style="list-style-type: none">Equipment	<ul style="list-style-type: none">Include portable anesthetic machine

General Recommendation:

1. For consistency of nomenclature to use DOH retained Hospitals
2. Delete limiting of a couple's children (page 1)

ANNEX II

Workshop Group II on Family Planning

Goals:

1. Clients will have universal access to NFP information and services.
2. Increase CPR, particularly NFP.
3. Decrease IMR, MMR, and TFR

Actions Points:

1. Organization of NFP management team at regional and local levels.
2. Capability building for trainers and service providers at all levels.
3. IEC and advocacy campaign.
4. Revitalization of industrial clinic
5. Collaboration/partnership with NGAs, NGOs, LGUs and Pos

Constraints:

1. **Lack of directive to organize NFP management team.**
2. **Availability of NFP experts/trainers.**
3. **Availability of information materials about NFP**
4. **Personal biases of service providers and partners.**
5. **Possible conflict with PROLIFE NGOs.**
6. **Sustainability of funds for the conduct of activities.**
7. **Lack of support/interest of industrial leaders.**
8. **Availability of NFP paraphernalia.**

Recommendations:

1. **Issuance of official directive-(NFP Teams)**
2. **Identification and recruitment of NFP expert/trainers.**
3. **Provision of adequate communications materials and paraphernalia on NFP.**
4. **Massive information campaign using tri-media approach for the 4 methods of NFP.**
5. **Proactive participation at CHD level.**
6. **Lobby for the approval of line item in the GAA for FP**
7. **Include NFP as a licensing requirement of industrial clinics.**

National FP Consultative and Planning Workshop
 May 22-24m 2002m Cebu City
 2002 - 2003 PLAN ON FAMILY PLANNING PROGRAM
 CENTRE FOR HEALTH DEVELOPMENT - METRO MANILA

MAJOR GOAL	OBJECTIVES	STRATEGIES	ACTIVITIES	TARGET	TIME FRAME	LOCUS OF RESPONSIBILITY	RESOURCE MANAGEMENT	Budget	INDICATORS
I. To develop an integrated and strategic FP Plan aligned with DOH Thrusts and Directions in Zone B (NCR, Bicol, Region IV)	A. To determine the status of FP program implementation in LGU's	1. Policy / guidelines and program review	1.1 Review records, reports and plans, policies and guidelines	Regional/Prvt Records	June	FH Cluster Head	LGUs' records/H40 rep ofts Results of survey 2000 and 2001	300,000 00	Review and LGU assessment done Results available and copies provided to LGU's
			2. Assessment of LGU Performance	2. Conduct assessment of LGU performance and needs					
II. At least 50% of women who delivered their last child in 1999 and 2000 should space their next pregnancy by a minimum of 1 yrs through provision of quality FP services	B. To develop an integrative and strategic regional FP plan 2002	1. Consultative planning workshop	1.1 Conduct series of consultative meetings and workshops a. Feedback on assessment results b. Identify areas of collaboration / coordination c. Define roles of responsibilities d. Specify support and assistance	LGU FP coord Selected regional staff Representatives of GO's/NGO's Other stakeholders	June	FP Coordinator	FP Policies guidelines meals/supplies Results of prog review Meals/supplies	300,000 00	consultative meetings, planning & workshop conducted as scheduled
			2. Development of integrative and strategic FP plan aligned with the DOH Thrusts and Directions	2.1 Formulate 2002 reg'l FP Plan a. Set priority areas (urban sites) b. Identify priority and convergent activities c. Mainstream NFP activities					
	A. To develop/improve KAS on FP	Quality Assurance through 1. Human Resource Dev	1.1 Conduct courses on FP a. TOT on NFP for barangay volunteers b. FP on volunteers in 7 urban prov selected priority areas select 10 women and recruit 800 BHWs in priority urban areas c. VBS among selected hosp staff d. FP counseling e. Safe motherhood and Reproductive Health f. Family awareness and NFP Training of Trainers Course for Supervisors Course for Frontline Health Workers	selected reg'l & local health staff 1600 BHWs for NCR only hosp staff selected BHW and hosp staff 30 health workers selected cluster staff (NGO's/GO's) LGU's and workers	May 2002 May-Aug. 2002 3rd 4th qr of 2002 starting May 2002 3rd qr 3rd 4th qr onwards	Local FP coord Hosp Chief Dept Head (DR/Burg) FH Cluster FH Cluster FH Cluster	img materials lunch/dinngg modules img materials TFV allowance meals img materials / supplies / meals / accommodations no no	14M	Improved KAS A. img capabilities of selected staff 800 BHWs in selected priority areas Improved KAS on VBS among hosp staff Improved KAS in FP/NFP counseling Appropriate counseling on VBS (home care)

2002 - 2003 PLAN ON FAMILY PLANNING PROGRAM
CENTER FOR HEALTH DEVELOPMENT - METRO MANILA

MAJOR GOAL	OBJECTIVES	STRATEGIES	ACTIVITIES	TARGET	TIME FRAME	LOCUS OF RESPONSIBILITY	RESOURCE MANAGEMENT	Budget	INDICATORS	
III To improve knowledge and increase participation on SMFP/ RH Programs	B To provide technical assistance such as: - facility upgrading - logistic augmentation	2 Sustain technical support through timely provision of adequate resources	g Integrated Management of Pregnancy Associated Complications (IMPAC) (Obstetrical Emergencies)	- selected health staff Gov/NGOs - field implementors in LICs			FH Cluster		Improved KAS in FA Improved KAS on SM/IMPAC	
			h Mens RH/Adolescent Health	- selected RHU and hosp staff RHU's/ Hosp	3rd 4th qtr Of 2002 2nd qtr onwards	FP Coordinator DOH Reps/LHAD	- do -	1.5M	Improved KAS on MH / CH Assessment findings reviewed No stock out experienced Logistic Management in place	
			2.1 Review of assessment findings in health facilities based on SS criteria and CDLMIS reports						COLMIS and SS reports records Inventory reports	
			2.2 Make an inventory of FP supplies and equipments 2.3 Maintain proper logistic management thru CDLMIS		3rd qtr	Local FP coordinators	Contraceptives forms TEV/transport facilities medicines/drugs/ supplies			
	C To operationalize a 2 way referral system	3 Sustain efficient effective inter/intra referral flow	2.4 Upgrade VSS facilities in selected LGUs	FP health facilities, LGUs, NGO's, GO's VSS Clinics in district & other gov't hosp, priv Clinics VSS Clinics in other FP clinics, GO's, NGO's			Hosp Mgt FP Coordinator DOH Reps, DOH CO Itinerant Teams		VSS Clinics operational Regular VSS conducted by itinerant teams	
			3.1 Make a registry of key health facilities for referral of surgical and other FP services including NFP		May, 2002	FP Coordinator	reference materials addresses & services of FP facilities		key FP facilities identified	
	D To integrate FP/RM and RH in Health Facilities providing Family Health care services	4 Integrative & coordinative Family Health care	3.2 Establish referral system, prepare referral & reporting forms/feedbacks, hold regular meetings with stakeholders		starting 3rd qtr 2002			system flow, MOA, reports, records	established and functional issues concerned identified and acted upon	
			3.3 Disseminate information on schedule and available FP service particularly in priority areas	community health agencies/ clinics	whole year round	all FP clinics, FP Coordinator	info materials	regular schedule in FP planning areas maintained		
			4.1 Adopt the life cycle approach to include provision of FP services and counseling and other health programs (Search for Super Nanny and Star Kid) NCR only	health care providers including volunteers	whole year	MHO, CHO, coordinators, FP Coordinator	Essential logistics info of materials	complaints monitored life cycle approach implemented total care provided		
			A To raise social acceptance thru importance of FP in family life	1 Advocacy	1.1 Conduct advocacy on FP among various stake holders thru consultations with different groups, consultative workshops, fora assembly, meetings, LGU visits	NGOs, inter faith groups, professionals, academe, DDOs Private hospitals gov't clinic community	on going	FP coord, DOH Reps, Reps Of NGO's, DDO's	info materials media/speakers	170 000 00
1.2 Conduct launching of FP	community, gov, sub, health workers, gov't clinic, media				FP Coordinator DOH Rep, LGU Mgt	other IEC materials media, TV				
B To generate participation on FP of various agencies	2 Networking/Linking	2.1 Solicit support from various sources	community people other DDO's/NGO's multi sector					1.5M		
		2.2 Define areas of collaborative coordination								
		2.3 Formulate a registry of								

National FP Consultative and Planning Workshop
 May 22-24m 2002m Cebu City
 2002 - 2003 PLAN ON FAMILY PLANNING PROGRAM
 CENTER FOR HEALTH DEVELOPMENT - METRO MANILA

MAJOR GOAL	OBJECTIVES	STRATEGIES	ACTIVITIES	TARGET	TIME FRAME	LOCUS OF RESPONSIBILITY	RESOURCE MANAGEMENT	Budget	INDICATORS
IV. Evaluate progress in FP endeavor	C. To provide accurate and essential information on FP	1. IEC Campaign	partner agencies & org - holding Dialogue - Producers/Instituto IEC materials	Gen Pub, Specific group & agencies	3rd qtr onwards	HEPO, FH Cluster DOH Rep	IEC prototypes supplies/materials	3M	No. and appropriateness of IEC materials produced, distributed & utilized Improved knowledge on FP Increased no of NA and CU More suppl generated
			3.2 Disseminate info in FP utilizing various approach, - IPC - Multi-media Campaign - radio, TV, newspaper - Barangay Announcements - Lectures in Industries/Companies	Gen Pub specific groups and agencies	whole year round	- do -	IEC materials		
	A. To monitor the implementation of FP activities	Regular monitoring/supervision	1.1 Conduct regular monitoring visit in focus areas - provide tech assistance - to facilitate in actual transactions - to determine status of prog implementation thru CBMIS	LGU, NGO, and FP clinic and hosp BHV health worker	on-going	regional team, fam health cluster FP coord, selected NGO, DOH Reps	Checklist, forms, records, reports, TEV	750,000.00 at 250 per region	No. of monitoring visits done Issues concerns identified and acted upon updates provided CBMIS in place data assessed, analyzed good practices documented
			1.2 Conduct reg Assessment evaluation of prog implementation - table review of LGU accomp in FP - consultative meeting on status - consultative planning workshop survey / FGD	Local FP coord Reg'l staff other stake holders	monthly quarterly semi-annual annual	local/reg'l FP coordinators FH cluster Reg'l staff DOH staff DOH Reps NGO's/GO's	LGU reports, documents on good practices in FP forms, TEV, meals		
B. To assess status & progress of FP activities	Evaluation			BHW/com				2100000	survey done result feedback analyzed

ACTION PLAN
 Reproductive Health - Family Planning Program
 CHD - ARMM
 24-May-02

SRTRATEGIES ACTIVITIES	TARGET	TIME FRAME	RESOURCE REQUIREMENTS		RESPONSIBLE OFFICE/STAFF	EXPECTED OUTPUT
			ITEM	OC COST		
<ul style="list-style-type: none"> • Consultative & advocacy Meeting to come up with brochure on FP contraceptives in Islam 	<ul style="list-style-type: none"> • Darul Iftah (House of Islamic) Opinion 	<ul style="list-style-type: none"> • Upon availability of funds 	<ul style="list-style-type: none"> • Nourishment: 1st. Meeting 20 Paxx P20 = P 1,000.00 2nd. Meeting 20 Paxx P50 = P 1,000.00 		CHD-ARMM	FP Brochure in Islam
<ul style="list-style-type: none"> • FP Orientation & advocacy writeshop 	<ul style="list-style-type: none"> • Muslim clerics: - Tabligh - Maturat - Imam Association - Al-Ihsan Foundation - ISCAG - Sharia Lawyers - RCC 	<ul style="list-style-type: none"> • After coming up with FP Brochure by Darul Iftah 	<ul style="list-style-type: none"> • DSA 40 Pax X 5 Batches X P300.00 = P60,000.00 			

**Policy, Principles, Processes,
People and Enabling
Mechanisms of NFP
Mainstreaming**

DOH in partnership with PFNFP

Health Indices have remained high:

MMR 172/100,000 LB

IMR 35/1,000 LB

TFR 3.7 Children/woman

NDHS of 1998

CPR 46.1% ———— 28.2% Modern Methods
17.9% Traditional Method

Awareness:

9% Calendar/Rhythm 9% Withdrawal

Artificial ———— 95.9% Pill
93.4% Condom
87.8% Female Sterilization
86.7% IUD

NFP ———— 20.8% MCA
20.7% BBT
9.5% STM

KNOWLEDGE OF FERTILE PERIOD
Percent Distribution (NDHS 1998)

Perceived Fertile Period	Ever users of calendar-based FP	All women
During menstrual period	6.4	6.9
Days after period has ended	34.5	33.2
In the middle of the cycle	23.7	13.8
Just before period begins	3.8	5.4
Other	13.1	6.8
No particular day	15.7	29.6
Don't know	6.5	20.1
Missing	0.1	0.1
Total	100.0	100.0
Number of women	728	1,938

NFP - "an educational process of determining the accurate fertile and infertile periods of a woman, by observing physiologic signs and symptoms according to her menstrual cycle (average, short, long) so that lovemaking may be timed to avoid or achieve a pregnancy".

Rhythm - "Identification of fertile/infertile periods thru prescription of days of lovemaking or abstinence to avoid or achieve a pregnancy."

D.C. # 130 s. 1997 includes:

Availability of NFP information and services at appropriate levels, adhering to standards and quality care as promulgated by the National Program.

Basis:

- I. Proponent's participation in NFP Program with the following outcome:
 - Organizing NFP continuing users is an effective mechanism for service expansion in an area.
 - NFP continuing users demonstrated a practice of 42-45 months using colored accessories after learning phase instead of recording and charting.
 - Tested accessories of NFP continuing users can be standardized to effect a wider use of practice.

Administrative Issuances:

D.C. # 130 s. 1997

- NFP Implementing Rules and Guidelines
- Definition of NFP vis-a-vis Rhythms

Basis:

- Coaching/mentoring by facility based service providers re-inforced training
- Five elements of RH are tested and focused male involvement, prevention of domestic violence, early detection of early RTI, infertility intervention work-up and pregnancy counseling for prevention of abortion
- Satisfied users-husbands are potential facilitators for expanded NFP Service
- Installation of NFP services facilitated after consultation with different religious leaders

Source: UNFPA # CP PO: Final Report 1998

II. Study of NFP in the Philippines by an NGO-Health Action Information Network (HAIN) with the following recommendations:

- Dialogue consultation with NFP stakeholders
- Continuing education and research
- Advocacy and Social mobilization
- Documentation of good practices
- Integration of cultural and social values in the NFP practice

Strategies:

A. Consultation/Dialogue with NFP stakeholders

- Orientation/role clarification
- Strategic planning

B. Advocacy/Social Mobilization

- Rapid Assessment of partners (investments) and communities (KAP)
- Installation of Management Committee, Interfaith Alliance and the Advocacy Group for NFP
- Networking among stakeholders
- Creating a new image for NFP:
 - S- pacing
 - A-chieving
 - V-alue-based bonding
 - E-mpowerment
 - S-afe Motherhood

C. Review and strengthening of a functional Inter/intra-referral system

D. IEC campaign

- Development, production and re-production of print materials (handbook, flyers, posters) including use of collaterals
- Innovative use of "abacus", which can be used to facilitate NFP practice using color-coding for different phases of the cycle
- Use of video cassette tapes for land, air and inter-island vessels
- Aggressive information and marketing campaign

FAMILY PLANNING DIRECTIONS



LORETO B. ROQUERO JR., MD, MPH
Director III

PAMILYANG PINOY



Family Planning

- intervention to promote health of
 - ❖ filipinos
 - ❖ specially women and
 - ❖ children

SAFETY NI MOMMY AT BABY

Prevent high risk pregnancies

- 7 M WRA high risk for pregnancy
 - ❖ too young (less 18 y.o.)
 - or too old (over 34 y.o.)
 - ❖ have 4 or more pregnancies
 - ❖ closely spaced pregnancies (< 2 years)
 - ❖ concurrently ill
- 2.6 M expected to become pregnant each year



SAFE MOTHERHOOD

Reduce maternal deaths

- Leading cause of death WRA
 - ❖ related to pregnancy and child bearing
 - ❖ post partum hemorrhage



BUHAY AT DIGNIDAD

Prevent abortions

- 1 in 6 pregnancies ends up in abortion because they are unplanned or unwanted
 - ❖ in 1999 - estimated 365,655 abortions



KABABAIHAN AT KARAPATAN

Respond to unmet needs/demand of women

- 2 M MWRA have unmet needs for FP
 - ❖ 1.1 M want no more children
 - ❖ 0.9 M wanted to space pregnancy



FAMILYANG NAKAPLANO. . . PANALO!

Responsible Parenthood

- support family as basic unit of society
- promote welfare, values and unity



BAYAN AT KAUNLARAN

Sustainable development

- healthy and productive families
- population growth matching economic growth
- special focus on FP needs of urban & rural poor



ANO BA TALAGA KUYAI!

General policies

- respect for sanctity of family life
 - ◇ responsible parenthood
 - ◇ NO to abortion
- respect for human rights
 - ◇ religious beliefs
 - ◇ medically and legally permissible methods



ANO BA TALAGA ATE!

General policies

- freedom of choice and voluntary decision
 - ◇ non-coercion
- respect right of couples to determine desired family size
 - ◇ helping them achieve desired fertility



HIYANG KA DITO!

Method mix

- natural family planning (NFP)
- pills
- condoms
- hormonal injectables / DMPA
- intrauterine device (IUD)
- lactational amenorrhea method (LAM)
- voluntary surgical sterilization (VSS)
 - ◇ bilateral tubal ligation (BTL)
 - ◇ vasectomy



IBABA. . .

Specific objectives

By end of 2004, reduce:

- maternal mortality rate from 172 deaths/100,000 LB in 1998 to less than 100 deaths/100,000 LB
- infant mortality rate from 35.3 deaths/1000 LB in 1998 to 32 deaths/1000 LB
- under 5 mortality rate from 48 deaths/1000 LB in 1998 to 33.6 deaths/1000 LB
- total fertility rate from 3.7 children per woman in 1998 to 2.7 children per woman



ITAAS. . .

Specific objectives

By end of 2004, increase:

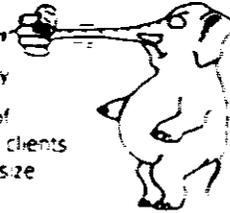
- contraceptive prevalence rate from 46.5% in 1998 to 57.04%
- proportion of modern family planning method use from 28.2% to 50.54%



WALA NANG PALIGOY-LIGOY PA!

FP for the Urban Poor

- urban poor IEC strategy
- aggressive promotion of permanent methods in clients with completed family size



HOME SERVICE!

Family Planning VHWs

- active case finding
- masterlisting of potential acceptors
- motivation of clients
- expanded role of volunteer health workers
 - ◇ initial supply of contraceptives



ISANG TALI KA LANG!

- high unmet needs for FP
 - ◇ 1.1 M WRA wanted permanent methods
 - ◇ don't access services due to varied reasons
- demand for vasectomy seen with
 - ◇ proper promotion
 - ◇ making services available and accessible



FAMILY PLANNING PATROL

Frontline participation of hospitals

- FP itinerant teams
- FP medical and surgical missions
- government subsidy for surgical methods for indigents
- partnership with LGU hospitals/NGOs
- expanded PhilHealth coverage of FP services



THE WEAKEST LINK!

Strengthening FP in Regions with lowest CPR

- CAR
- Region V
- Region VIII
- ARMM
 - ◇ focus on the most popular methods
 - ◇ LGU specific approaches



IBA ANG NATURAL!



- high unmet needs for FP
 - ❖ 0.9 M WRA wanted spacing
- unmet needs can be partially answered by expanding NFP services
- 18% of FP users use traditional methods
 - ❖ periodic abstinence, incorrect rhythm, withdrawal
 - ❖ based on incorrect understanding of when woman is likely to get pregnant
- NFP accounts for 0.2 % of total FP users

FIRST TIME MOI



Mainstreaming NFP

- fertility awareness
- adoption of Necklace Method (SDM) as additional NFP method for FP program
 - ❖ AO No. 49 s. 2003
- other NFP methods
 - ❖ mucus
 - ❖ basal body temperature
 - ❖ symptothermal

BITIN KA BAI



Support Initiatives

- assessment and strengthening of
 - ❖ FP counseling
 - ❖ CDLMIS
- prevention and management of abortion complications
- Men's reproductive health
- Adolescent reproductive health



THANK YOU!



Contraceptive use in the Philippines¹

Presented by

MR. PAUL ZAMONING, JR., CES-III

Statistician III

Health and Statistics Department

National Statistics Office



National Statistics Office



United States Agency for International Development

Objectives of FPS

General Objective:

- to provide information on contraceptive use in the Philippines to the Department of Health (DOH)
- to provide development planners with information to monitor changes in family planning practice and keep track of progress towards program goals

Source: National Statistics Office, 2001 Family Planning Survey



Objectives of FPS

Specific Objectives

- to determine the contraceptive prevalence rate in 2001
- to find out what contraceptive methods women use
- to monitor the source of modern contraceptives method
- to measure the percentage of births whose mothers are highly exposed to maternity-related risk
- to determine if there is a difference in contraceptive use between women in poor households and those in non-poor households. and

Source: National Statistics Office, 2001 Family Planning Survey



Background

- Nationwide survey
- Done together with April 2001 Labor Force Survey
- Female members 15-49 years old
- Sixth round (1995-2002)
- Resources from USAID

Source: National Statistics Office, 2001 Family Planning Survey



The Sample



No. of HHs Interviewed	20,036
Total Women Sampled	32,035
Total Women Interviewed	30,132
Response Rate	94.1

Source: National Statistics Office, 2001 Family Planning Survey



Background Characteristics of All Women

- 36.6 % below 24 years
- 10.4 % above 45 years
- 54.2 % married
- 16.0 % from National Capital Region
- 41.4 % from other Luzon
- 39.9 % currently married in their 30's
- 68.0 % currently married with at least high school education

Source: National Statistics Office, 2001 Family Planning Survey



Current Use of Family Planning Method

2001 FPS provides data on
contraceptive prevalence
rate (CPR) and contraceptive
method mix

Source: National Statistics Office, 2001 Family Planning Survey



Current Use of Family Planning Method

2001 FPS provides data on
contraceptive prevalence rate (CPR)
and contraceptive method mix

CPR -
proportion of all
currently married
women reporting
current use of any
contraceptive method

Method Mix -
percentage
distribution of
contraceptive users
by method

Source: National Statistics Office, 2001 Family Planning Survey



CPR increased in 2001, mainly due to traditional methods.
Modern methods increased by 0.8 %

Contraceptive Prevalence Rate

Survey Round	CPR (%)	Modern (%)	Traditional (%)
2001 Family Planning Survey	↑ 49.5	↑ 33.1	↑ 16.4
2000 Family Planning Survey	47.0	32.3	14.7

Source: National Statistics Office, 2001 Family Planning Survey



CPR for modern methods was twice the CPR for traditional methods

Contraceptive Prevalence Rate

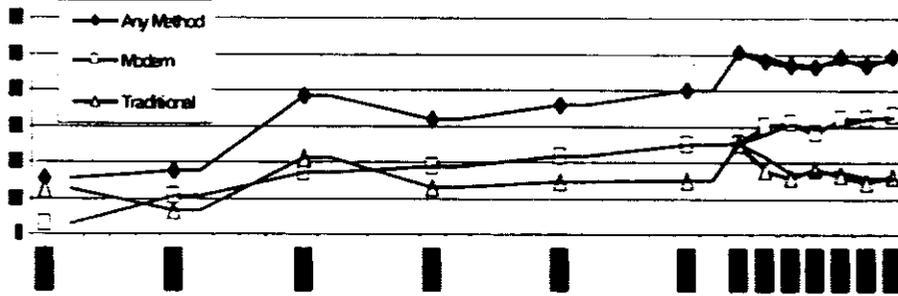
Survey Round	CPR (%)	Modern (%)	Traditional (%)
2001 Family Planning Survey	↑ 49.5	↑ 33.1	↑ 16.4
2000 Family Planning Survey	47.0	32.3	14.7

Source: National Statistics Office, 2001 Family Planning Survey



CPR exhibited generally increasing trend with slight fluctuations due to erratic trend of traditional methods.

Contraceptive Prevalence Rate, Philippines 1968-2001

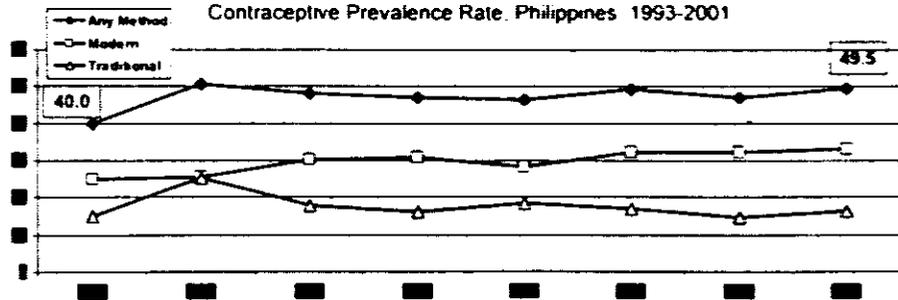


Source: National Statistics Office, 2001 Family Planning Survey



CPR for any method is 9.5 percentage points higher than 1993 figure

Contraceptive Prevalence Rate, Philippines 1993-2001



Source: National Statistics Office, 2001 Family Planning Survey

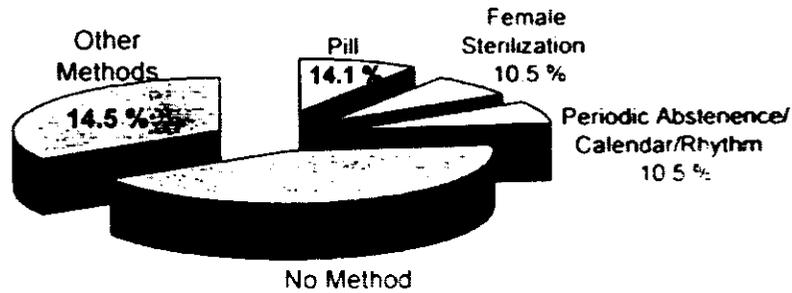


Pill was the leading contraceptive method currently used

Method Mix



Use of Contraception of CMW

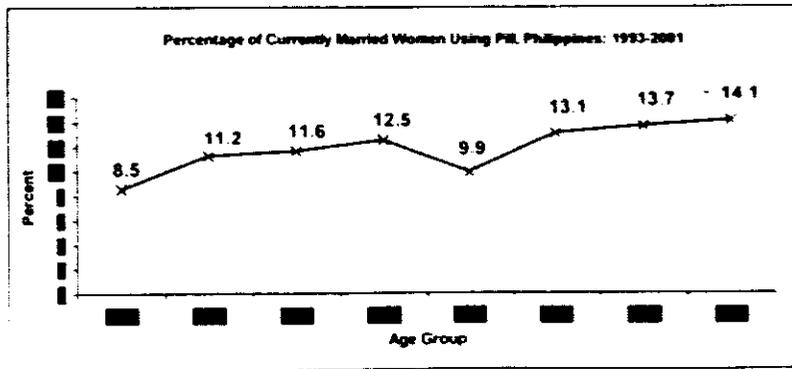


Source: National Statistics Office, 2001 Family Planning Survey



Pill continually increased over the last seven years (except in 1998)

Method Mix



Source: National Statistics Office, 2001 Family Planning Survey

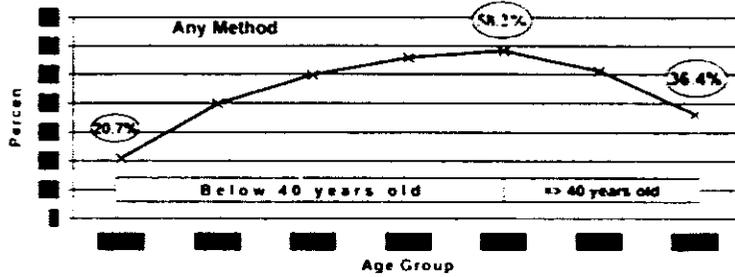


Contraceptive use peaked at ages 35 to 39

Method Mix



Percentage of Currently Married Women Using Any Method of Contraception by Age Group Philippines, 2001



Source: National Statistics Office, 2001 Family Planning Survey

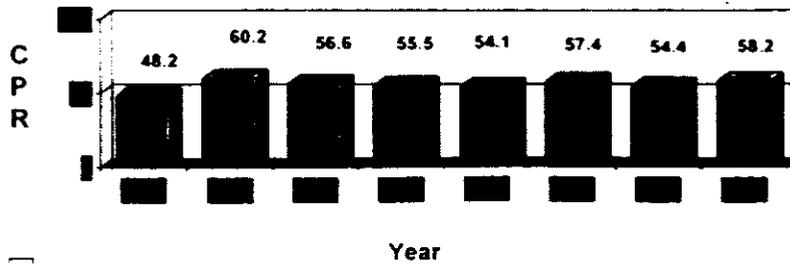


From 1993 to 2001, contraceptive use peaked also at ages 35 to 39

Method Mix



CPR at its Peak



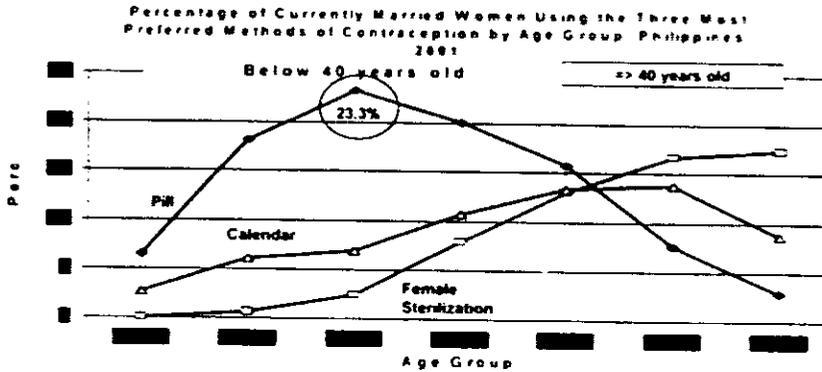
Legend:
Age Group 35-39

Source: National Statistics Office, 2001 Family Planning Survey



CMW using pill peaked at ages 25 to 29

CPR by Age



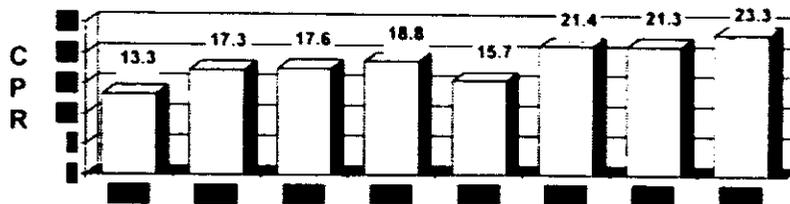
Source: National Statistics Office, 2001 Family Planning Survey



From 1993 to 2001, CMW using pill peaked also at ages 25 to 29

Method Mix

Pill at its Peak



Legend
Age Group 25-29

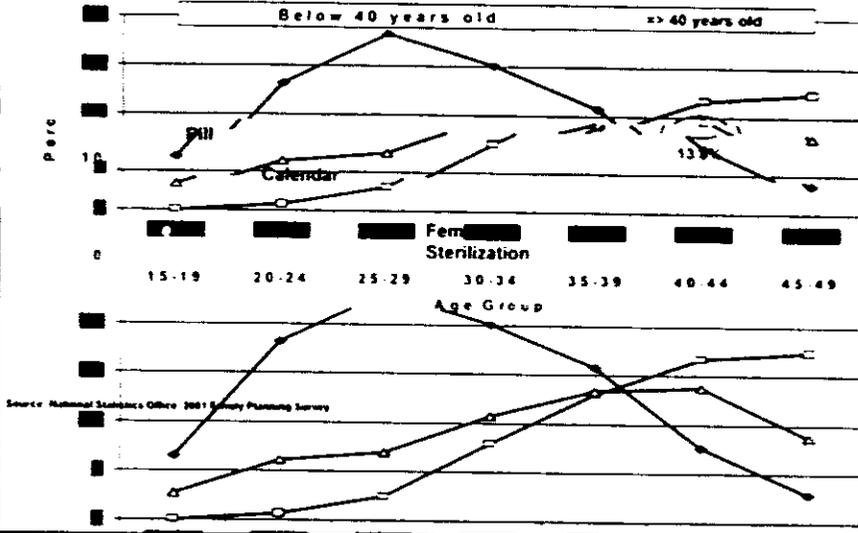
Source: National Statistics Office, 2001 Family Planning Survey



CMW using calendar method peaked at ages 40 to 44

CPR by Age

Percentage of Currently Married Women Using the Three Most Preferred Methods of Contraception by Age Group - Philippines 2001

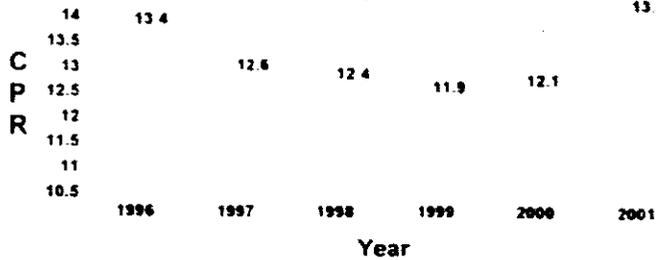


Source: National Statistics Office 2001 Family Planning Survey

From 1999 to 2001, CMW using calendar peaked at ages 40 to 44

Method Mix

Calendar Method at its Peak



Legend:
Age Group 35-39 40-44

Source: National Statistics Office 2001 Family Planning Survey

From 1995 to 1998, the CPR was highest
in Region 11 (Southern Mindanao)

CPR by Residence

Region	Survey Year						
	1995	1996	1997	1998	1999	2000	2001
1	41.6	45.4	43.3	43.2	51.0	41.0	43.6
2	54.2	51.8	50.3	48.3	63.2	61.2	61.7
3	56.2	54.8	52.0	54.8	53.1	54.9	54.7
4	53.1	50.3	49.5	45.0	48.0	48.7	50.6
5	41.1	40.5	37.1	36.3	43.5	31.7	42.0
6	49.3	46.8	44.4	45.0	47.8	47.6	45.5
7	46.9	48.9	51.3	51.5	48.1	47.0	49.0
8	45.6	37.8	33.8	37.5	42.0	37.2	44.9
9	54.1	41.7	36.3	43.8	45.8	49.1	49.9
10	54.8	57.6	59.8	54.0	57.0	57.3	54.6
11	59.1	59.0	59.9	55.2	55.8	55.4	60.5
12	56.2	44.7	43.9	45.2	49.4	50.8	52.1
NCR	53.3	49.4	51.1	49.4	53.0	45.7	51.3
CAR	46.8	43.4	46.3	42.0	47.9	50.6	46.8
ARMM	17.8	13.5	13.0	15.8	15.5	12.6	15.1
Caraga	-	52.9	51.5	48.8	52.6	47.3	51.5

Source: National Statistics Office, 2001 Family Planning Survey

From 1995 to 1998, the CPR was highest
in Region 11 (Southern Mindanao)

CPR by Residence

Region	Survey Year						
	1995	1996	1997	1998	1999	2000	2001
1	41.6	45.4	43.3	43.2	51.0	41.0	43.6
2	54.2	51.8	50.3	48.3	63.2	61.2	61.7
3	56.2	54.8	52.0	54.8	53.1	54.9	54.7
4	53.1	50.3	49.5	45.0	48.0	48.7	50.6
5	41.1	40.5	37.1	36.3	43.5	31.7	42.0
6	49.3	46.8	44.4	45.0	47.8	47.6	45.5
7	46.9	48.9	51.3	51.5	48.1	47.0	49.0
8	45.6	37.8	33.8	37.5	42.0	37.2	44.9

Source: National Statistics Office, 2001 Family Planning Survey



From 1995 to 1998, the CPR was highest in Region 11 (Southern Mindanao)



CPR by Residence

Region	Survey Year						
	1995	1996	1997	1998	1999	2000	2001
9	54.1	41.7	36.3	43.8	45.8	49.1	49.9
10	54.8	57.6	59.8	54.0	57.0	57.3	54.6
11	59.1	59.0	59.9	55.2	55.8	55.4	60.5
12	56.2	44.7	43.9	45.2	49.4	50.8	52.1
NCR	53.3	49.4	51.1	49.4	53.0	45.7	51.3
CAR	46.8	43.4	46.3	42.0	47.9	50.6	46.8
ARMM	17.8	13.5	13.0	15.8	15.5	12.6	15.1
Caraga	-	52.9	51.5	48.8	52.6	47.3	51.5

Source: National Statistics Office, 2001 Family Planning Survey



From 1999 to 2001, Cagayan Valley topped all regions on the use of family planning methods

CPR by Residence

Region	Survey Year						
	1995	1996	1997	1998	1999	2000	2001
1	41.6	45.4	43.3	43.2	51.0	41.8	43.8
2	54.2	51.8	50.3	48.3	53.2	61.2	61.7
3	56.2	54.8	52.0	54.8	53.1	54.1	54.7
4	53.1	50.3	49.5	45.0	48.0	48.7	50.6
5	41.1	40.5	37.1	36.3	43.5	31.7	42.0
6	49.3	46.8	44.4	45.0	47.8	47.6	45.5
7	46.9	48.9	51.2	51.5	48.1	47.0	49.0
8	45.6	37.8	33.4	37.5	42.0	37.2	44.9
9	54.1	41.7	36.3	43.8	45.8	49.1	49.9
10	54.8	57.6	59.8	54.0	57.0	57.3	54.6
11	59.1	59.0	59.9	55.2	55.8	55.4	60.5
12	56.2	44.7	43.9	45.2	49.4	50.8	52.1
NCR	53.3	49.4	51.1	49.4	53.0	45.7	51.3
CAR	46.8	43.4	46.3	42.0	47.9	50.6	46.8
ARMM	17.8	13.5	13.0	15.8	15.5	12.6	15.1
Caraga	-	52.9	51.5	48.8	52.6	47.3	51.5

Source: National Statistics Office, 2001 Family Planning Survey



From 1999 to 2001, Cagayan Valley topped all regions on the use of family planning methods

CPR by Residence



Region	Survey Year						
	1995	1996	1997	1998	1999	2000	
2001							
1	41.6	45.4	43.3	43.2	51.0	41.0	43.6
2	54.2	51.8	50.3	48.3	63.2	61.2	61.7
3	56.2	54.8	52.0	54.8	53.1	54.9	54.7
4	53.1	50.3	49.5	45.0	48.0	48.7	50.6
5	41.1	40.5	37.1	36.3	43.5	31.7	42.0
6	49.3	46.8	44.4	45.0	47.8	47.6	45.5
7	46.9	48.9	51.3	51.5	48.1	47.0	49.0
8	45.6	37.8	33.8	37.5	42.0	37.2	44.9

Source: National Statistics Office, 2001 Family Planning Survey



From 1999 to 2001, Cagayan Valley topped all regions on the use of family planning methods

CPR by Residence



Region	Survey Year						
	1995	1996	1997	1998	1999	2000	
2001							
9	54.1	41.7	36.3	43.8	45.8	49.1	49.9
10	54.8	57.6	59.8	54.0	57.0	57.3	54.6
11	59.1	59.0	59.9	55.2	55.8	55.4	60.5
12	56.2	44.7	43.9	45.2	49.4	50.8	52.1
NCR	53.3	49.4	51.1	49.4	53.0	45.7	51.3
CAR	46.8	43.4	46.3	42.0	47.9	50.6	46.8
ARMM	17.8	13.5	13.0	15.8	15.5	12.6	15.1
Caraga	-	52.9	51.5	48.8	52.6	47.3	51.5

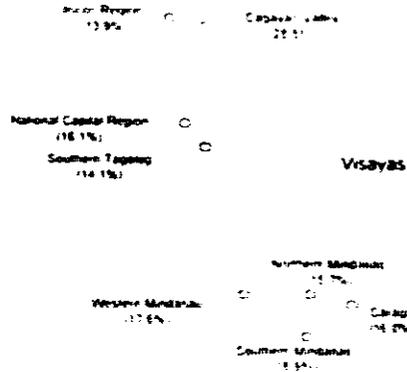
Source: National Statistics Office, 2001 Family Planning Survey



Pill commonly used in eight (8) regions

CPR by Residence

Pill commonly used in
 Ilocos Region
 Cagayan Valley
 Southern Tagalog
 Western Mindanao
 Northern Mindanao
 Southern Mindanao
 National Capital Region (NCR)
 Caraga

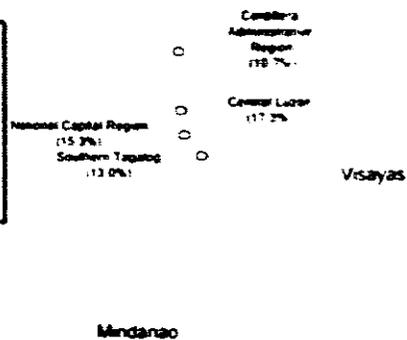


Source: National Statistics Office, 2011 Family Planning Survey

Female Sterilization frequently used in Central Luzon and other 3 Regions

CPR by Residence

Female Sterilization commonly used in:
 Cordillera Administrative Region
 Central Luzon
 National Capital Region (NCR)
 Southern Tagalog

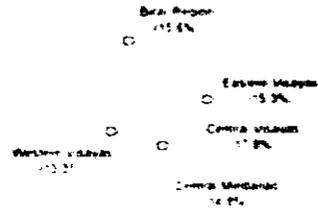


Source: National Statistics Office, 2011 Family Planning Survey

Calendar Rhythm mainly used in the Visayan Regions

CPR by Residence

Calendar and Rhythm commonly used in:
 Bicol Region
 All the Visayan Regions
 Central Mindanao

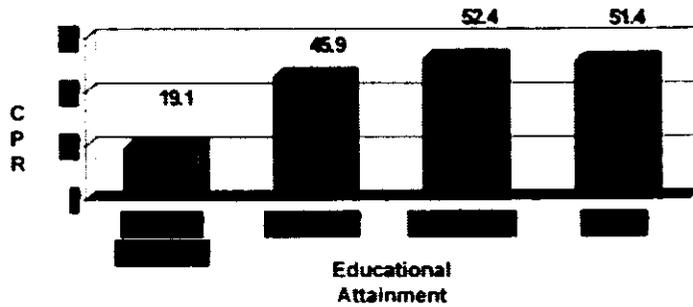


Source: National Statistics Office, 2001 Family Planning Survey



Women with at least an elementary education were more likely to use contraception

CPR by Education



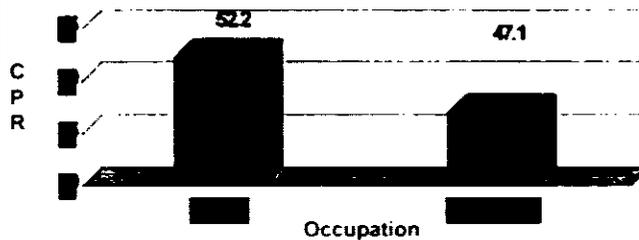
Source: National Statistics Office, 2001 Family Planning Survey



CPR among women engaged in gainful occupation was higher than those not engaged in any gainful occupation



CPR by Occupation



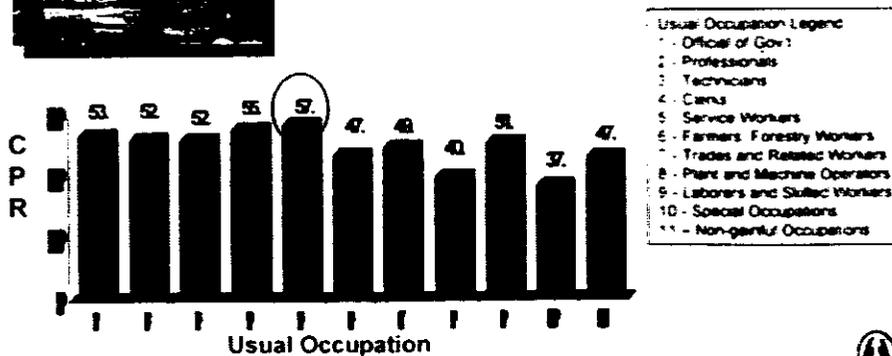
Source: National Statistics Office, 2011 Family Planning Survey



Among gainful workers, those in service- and sales-related jobs registered the highest CPR followed by clerical jobs



CPR by Occupation



Source: National Statistics Office, 2011 Family Planning Survey



Female Sterilization was preferred over any other method by women who were officials in the government, corporate executives and managers



CPR by Occupation

Occupation	Most preferred method
<input type="checkbox"/> gov't officials, corporate executives and managers	<input checked="" type="checkbox"/> <u>ligation</u> (17.1%)
<input type="checkbox"/> professionals	<input checked="" type="checkbox"/> <u>calendar/rhythm</u> (14.0%)
<input type="checkbox"/> technicians and associate profs	<input checked="" type="checkbox"/> <u>ligation</u> (15.5%)
<input type="checkbox"/> clerks	<input checked="" type="checkbox"/> <u>calendar/rhythm</u> (15.4%)
<input type="checkbox"/> service- and sales-related jobs	<input checked="" type="checkbox"/> <u>pill</u> (16.8%)

Source: National Statistics Office, 2001 Family Planning Survey



Pill was the most preferred method by women laborers and skilled workers



CPR by Occupation

Occupation	Most preferred method
<input type="checkbox"/> farmers, forestry workers and fishermen	<input checked="" type="checkbox"/> <u>pill</u> (12.5%)
<input type="checkbox"/> trades and related workers	<input checked="" type="checkbox"/> <u>calendar/rhythm</u> (12.7%)
<input type="checkbox"/> Plant and machine operators and assemblers	<input checked="" type="checkbox"/> <u>ligation</u> (10.6%)
<input type="checkbox"/> women laborers and skilled workers	<input checked="" type="checkbox"/> <u>pill</u> (16.0%)
<input type="checkbox"/> non-gainful occupation	<input checked="" type="checkbox"/> <u>pill</u> (14.5%)

Source: National Statistics Office, 2001 Family Planning Survey





CPR by Socio-economic Status

Based on presence of housing conveniences/durable goods, a household was assigned a score that will indicate its socio-economic standing. Then, the household was classified into either "poor" or "non-poor"

Source: National Statistics Office, 2001 Family Planning Survey



Overall CPR for non-poor, higher by 8.3% than belonging to poor households



CPR by Socio-economic Status

	"Poor"	"Non-poor"
any method	43.9 %	52.2 %
modern method	26.7	36.2
traditional method	17.3	16.0

Source: National Statistics Office, 2001 Family Planning Survey





CPR by Socio-economic Status

2001 FPS also provides information for estimating the CPR and method mix by socio-economic income

Source: National Statistics Office, 2001 Family Planning Survey



Modern methods were more popularly used than traditional methods regardless of socio-economic standing



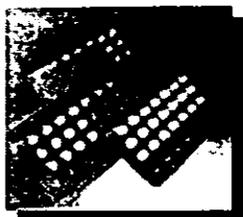
CPR by Socio-economic Status

	"Poor"	"Non-poor"
any method	43.9 %	52.2 %
modern method	26.7	36.2
traditional method	17.3	16.0

Source: National Statistics Office, 2001 Family Planning Survey



Pill was the most popular contraceptive method for poor and non-poor



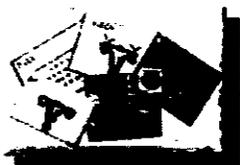
CPR by Socio-economic Status

	Preferred Methods	
	"Poor"	"Non-poor"
Pill	13.7 %	14.3 %
Female sterilization	5.0	13.2
Calendar/rhythm	11.6	9.9
Withdrawal	5.0	5.9



Source: National Statistics Office, 2001 Family Planning Survey

Public Sector provided supplies of modern contraceptives to about three out of four women



Public Sector

Source of Supply	Percentage
Public Sector	72.8 %
Government hospitals	23.4
Rural health unit/urban health center	24.8
Barangay health station	22.2
Barangay service point officer/health worker	2.4



Source: National Statistics Office, 2001 Family Planning Survey

One out of every four women had her supply of modern contraceptives from the Private Sector



Private Sector

Source of Supply	Percentage
Private Sector	26.1 %
Private hospital/clinic	10.6
Private doctor	1.2
Private midwife	0.2
Pharmacy	12.4
Store	1.1
NGO	0.5
Industry-based clinic	0.1

Source: National Statistics Office, 2001 Family Planning Survey



More than fifty percent of condom users had her supply of modern contraceptives from the private sector, mainly from pharmacies



Private Sector

Source of Supply	Percentage
Private Sector	26.1 %
Private hospital/clinic	10.6
Private doctor	1.2
Private midwife	0.2
Pharmacy	12.4
Store	1.1
NGO	0.5
Industry-based clinic	0.1

Source: National Statistics Office, 2001 Family Planning Survey



Wanting a child was the most frequently cited reason for non-use of contraception



Reasons for Not Using Contraception

✓	Wants child	21.6 %
✓	Reasons relating to exposure to contraception	40.5 %
	✗ difficult to get pregnant	12.5 %
	✗ menopausal/had hysterectomy	6.7 %
	✗ infrequent sex/husband away	5.8 %
	✗ amenorrhoeic	6.3 %
	✗ not sexually active	2.2 %
✓	Opposition to use	5.9 %
✓	Lack of knowledge	2.3 %
✓	Method-related reasons	20.9 %
✓	Others	8.9 %

Source: National Statistics Office, 2001 Family Planning Survey



Four out of ten are less exposed to contraception or not at all at risk of conceiving



Reasons for Not Using Contraception

✓	Wants child	21.6 %
✓	Reasons relating to exposure to contraception	40.5 %
	✗ difficult to get pregnant	12.5 %
	✗ menopausal/had hysterectomy	9.7 %
	✗ infrequent sex/husband away	9.8 %
	✗ amenorrhoeic	6.3 %
	✗ not sexually active	2.2 %
✓	Opposition to use	5.9 %
✓	Lack of knowledge	2.3 %
✓	Method-related reasons	20.9 %
✓	Others	8.9 %

Source: National Statistics Office, 2001 Family Planning Survey



*Project Budget
Chosen Topic*

**Family Planning:
GINHAWA SA
BUHAY**

(National Family Planning Campaign)

RATIONALE

- Government recognizes the population issue as a priority.
- The steady increase in population produced an equally adverse impact on the quality of life among the Filipino families.
- Important decisions have been made during the 47th Execom Meeting for the NFPP including the design of a national campaign to promote Family Planning.

**Basis for the Campaign
(Precede/Proceed Analysis)**

- Predisposing Factors
 - Awareness on FP is 90% but practice is low.
 - Contraceptive Prevalence Rate is only 49% as of 2001.
 - 19% or about 2M Women of Reproductive Age would like to practice FP but need to be given informed choices to finally decide to practice it.
 - Existing IEC on FP are not addressing the fears of side effects.

Precede/Proceed Analysis

● **Enabling Factors**

- Natural Family Planning (NFP) was not given much emphasis during FP training
- Few health workers are trained on NFP
- Inadequate, even erroneous training on FP for health workers
- Program supervision not being done or if done is inadequate after devolution

Precede/Proceed Analysis

● **Reinforcing Factors**

- National Demographic and Health Survey and FP surveys not well disseminated and thus not utilized for planning FP activities
- Advocacy not maximizing health benefits of Family Planning
- IEC materials are either absent or supply very limited
- IEC materials are contraceptives oriented.

Objectives/Strategies of the Campaign

- increase social acceptance and practice of Family Planning by positioning it as a desirable and natural part of a successful Filipino lifestyle.
- Generate a value-derived opinion and behavior that having a small family is beneficial to health and happiness.

Target Audience

- Primary - Married Couple of Reproductive Age (MCRA), C and D Class
- Secondary - Engaged couples/adults of reproductive age

Thematic Message

“Practicing Family Planning gives you and your family a better life.”

Proposed Communication Handle

**Family Planning:
GINHAWA SA BUHAY**

Activities for the National Campaign

- Tri-Media Campaign giving out thematic messages on FP
- Media Relations
- Improve standards and policies for FP campaign
- Special Events
- Monitoring and Evaluation

Suggested Regional and LGU Activities on HP Action Areas

- Building Healthy Public Policy by HW & LGUs
 - Dissemination of FP Policy (AO No. 50-A s. 2001)
 - Issue Local Ordinances to support FP
 - Consider Sec. Dayrit's policy directions
 - Before doing the campaign, appropriate preparatory work should be determined first and must be quickly addressed.
 - LGUs must ensure availability and quality of all kinds of FP methods at the facility level.
 - FP messages should support thematic messages at the National level.

Suggested...

- Creating Supportive Environment by HW & Partners
 - Ensure quality, availability and accessibility of FP information at all levels
 - Establish HP Structures at all levels
 - Conduct advocacy meetings with stakeholders
 - Establish Network and build alliances with:
 - League of Governors/Mayors/Boy Captains
 - Women's Groups
 - Academe
 - Business Sector
 - Professional, Religious & Civic Groups
 - Media, Other GOs and relevant organizations

Suggested...

- Strengthening Community Action by HW & Partners
 - Prepare, implement and monitor Health Promotion Plans at all levels
 - Organize communities thru DOH Reps and other NGOs
 - Conduct IEC campaign at all levels
 - Organize BHW brigade for FP
 - Establish support groups for couples practicing FP
 - Establish/strengthen existing referral system

Suggested...

- Develop Personal Skills of Target Audiences
 - Provide IEC addressing fears of side effects
 - Provide information on all available FP methods with special emphasis on NFP
 - Strengthen IPC to increase level of FP acceptance and practice
 - Conduct counseling at all health facilities using the GATHER process

● Develop Personal Skills

- Support thematic messages carried by tri-media produced at the national level
- Reproduce and/or distribute collaterals (streamers, T-Shirts and posters) based on the prototypes provided at the national level
- Document FP campaign activities

Suggested...

- Re-orienting Health Services by HW & Partners
 - Provide FP protocols and tools and ensure compliance
 - Integrate FP in other relevant campaign/ events
 - Deploy itinerant teams
 - Conduct FP trainings

THANK YOU!

Developing Checklists and Monitoring Tools for Enhancing Quality of RH Services: UNFPA Experience

Moses S. Serdoacillo, MD
NPO for RH, UNFPA

National FP Planning Workshop
Cebu City, May 22-25, 2002

Background:

The UNFPA 5th Country Programme
2000-2004

The RH Programme :
Use of the Logical Framework

Programme Tool: Use of the Logframe Matrix

GOAL: Contribution to the improvement of the quality of life of the population through better RH

PURPOSE: Contribution to increased utilization of RH services and improved quality of RH services

Activities:

- Enhanced technical capacity of service providers at all levels for RH services
- Strengthened professional quality & skills of staff RH services considering case scenarios
- Enhanced knowledge related to IEC
- Contribution of VAW services
- Enhanced institutional capacity to manage, plan, implement and monitor RH programs

DEMAND → **SUPPORT**

Planning, M&E, etc., Training, Services, Advocacy

Operationalize Output 1.

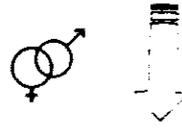
Provision of quality and gender-sensitive core RH services...



1. Family Planning
2. Maternal Care
3. RTI/STI/HIV/AIDS

Operationalize Output 1.

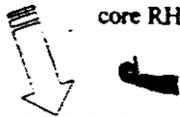
Provision of quality and gender-sensitive core RH services



- understanding and consideration of the different needs, identity and behavior of women and men arising from unequal relations and an awareness that a policy or program can benefit women and men differently

Operationalize Output 1.

Provision of quality and gender-sensitive core RH services...



1. Holistic
2. Empowering
3. Accessible
4. Efficient and comfortable

Holistic: One Stop Shop Concept

- Scope of services include a wide range of reproductive and other health concerns for women, men, children and adolescents
- Where services can be accessed by women and other members of the household
- It is client centered, not program focused

Empowering:

- Clients/beneficiaries especially women are likewise participants and not just recipients of services
- Clients are given dignity and respect as treated by the service providers
- Client education is an important element in the delivery of health care services
- Women are encouraged to participate in the decision making process

Accessible:

- Conveniently located
- Welcomes all clients regardless of social class, age and sexual orientation
- Clinic procedure offer ease and comfort for its client
- Clients are attended the soonest possible time

Basic Tabulations:

OV: 1a and 1b No. of BSA's and BSA's No. of BSA's and BSA's with a non-officer No. of BSA's No. of BSA's providing more services as a package No. of BSA's providing more services as a package based on BSA organizational structure	Other personnel using OVY to show on their own sheet as in OV: 1c
OV: 1c No. of BSA's in same area No. of BSA's No. of BSA's in same area providing services as a package No. of BSA's providing more services as a package No. of BSA's providing more services as a package based on BSA organizational structure	BSA's using of BSA's in same area and BSA's No. of BSA's providing more services as a package No. of BSA's providing more services as a package based on BSA organizational structure
OV: 1d No. of BSA's providing more services as a package No. of BSA's providing more services as a package based on BSA organizational structure No. of BSA's providing more services as a package based on BSA organizational structure No. of BSA's providing more services as a package based on BSA organizational structure	AAU's providing more services as a package No. of BSA's providing more services as a package No. of BSA's providing more services as a package based on BSA organizational structure No. of BSA's providing more services as a package based on BSA organizational structure
OV: 1e No. of BSA's providing more services as a package No. of BSA's providing more services as a package based on BSA organizational structure No. of BSA's providing more services as a package based on BSA organizational structure	Other personnel
OV: 1f No. of BSA's providing more services as a package No. of BSA's providing more services as a package based on BSA organizational structure No. of BSA's providing more services as a package based on BSA organizational structure	Other personnel Name, Address, Telephone

Provision

BSA Category

1	Total number of BSA's providing more services as a package								
2	Number of BSA's providing more services as a package based on BSA organizational structure								
3	Total number of BSA's								
4	Number of BSA's providing more services as a package								
5	Number of BSA's providing more services as a package based on BSA organizational structure								
6	Total number of BSA's								
7	Number of BSA's providing more services as a package								
8	Number of BSA's providing more services as a package based on BSA organizational structure								
9	Number of BSA's								
10	Number of BSA's providing more services as a package based on BSA organizational structure								

	Total
A Total number of BSA's (BSA's) = BSA1 + BSA2	
B Number of BSA's providing more services as a package	
C Total number of BSA's = BSA1 + sample BSA2	
D Number of BSA's = BSA1 + sample BSA2 providing more services as a package	

BSA Category

1	Number of BSA's providing more services as a package								
2	Number of BSA's providing more services as a package based on BSA organizational structure								
3	Number of BSA's providing more services as a package based on BSA organizational structure								
4	Number of BSA's providing more services as a package based on BSA organizational structure								
5	Number of BSA's providing more services as a package based on BSA organizational structure								
6	Number of BSA's providing more services as a package based on BSA organizational structure								

Provision

Type of BSA	Start	End/Specific Time Point		% Business Revenue
		Actual	Expected	
BSA No. of each BSA Provision and BSA's				
BSA No. of each BSA Provision				
BSA No. of each BSA Provision				

Provision

Type of BSA and Service	No. employees	No. units	% revenue
BSA 1. BSA 2. BSA 3. Provision and BSA's of BSA's 4. BSA's			
BSA 1. BSA 2. BSA 3. Provision and BSA's of BSA's 4. BSA's			
BSA 1. BSA 2. BSA 3. Provision and BSA's of BSA's 4. BSA's			
BSA 1. BSA 2. BSA 3. Provision and BSA's of BSA's 4. BSA's			



STANDARD DAYS METHOD

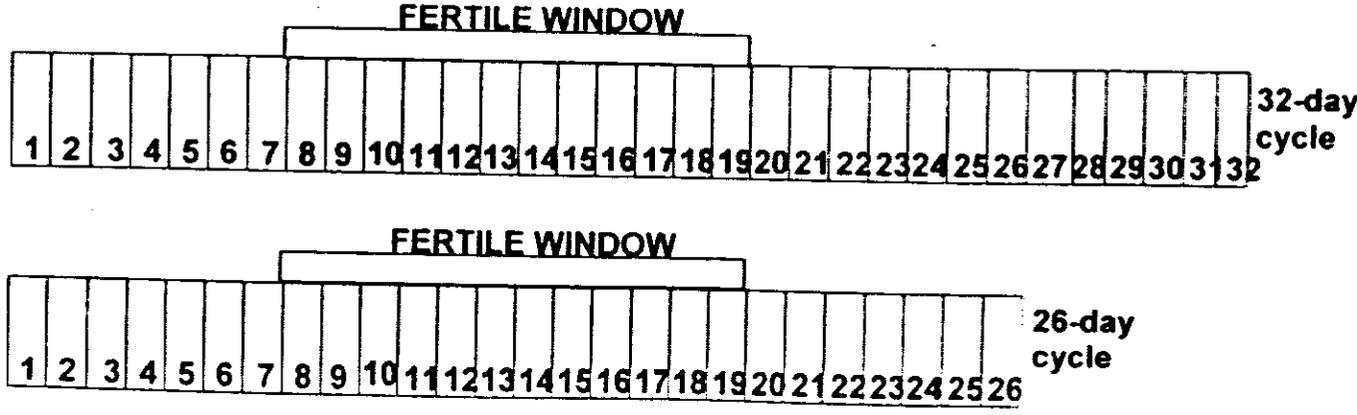
- The Standard Days Method (SDM), developed by the Institute for Reproductive Health at Georgetown University, is a modern scientific method of family planning based on the fact that a woman has a fixed fertile window within her menstrual cycle during which she can become pregnant from unprotected intercourse.
- The Institute has come up with the formula that Days 8-19 as the woman's fertile period based on theoretical studies done on a large set of data from the World Health Organization (WHO)

Why the 12-day fertile window?

The 12-day fertile window of SDM is based on the fact that the cycle length varies from time to time. Although studies suggest that women are most likely to ovulate close to the middle of their cycle, time of ovulation also varies from one cycle to the next. The "fertile window" accounts for the timing of ovulation, life span of the egg-cell (12 to 24 hours) and the life span of the sperm (3-5 days).

For women whose cycles are between 26 and 32 days long, this window is from day 8 through day 19 of their cycles. The rule is to abstain from intercourse or use an alternative method during the fertile days where the woman can most likely get pregnant.

As the figure below shows, this identified window is consistent regardless of cycle length when the cycle is within the 26-32 day range. The probability of this window covering all fertile days is highest for cycles within this range, however it also provides significant coverage for cycles that are somewhat longer or somewhat shorter."

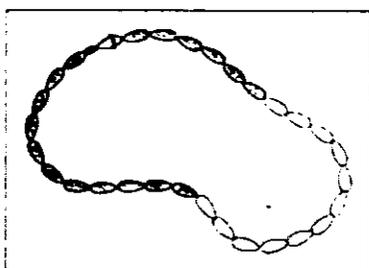


How effective is SDM?

The efficacy study of the Standard Days Method yielded good results. 478 women from Peru, Bolivia and the Philippines were followed up for 13 cycles. It was found out that women were able to successfully prevent pregnancy while using SDM.

With correct use of method by not having intercourse on days 8-19, the effectiveness rate is 95% or a pregnancy rate of 4.7%. With correct use with other methods like the use of condom or withdrawal, effectiveness is 94% or a pregnancy rate of 5.6%. Typical use of method where correct use of method is combined with non-compliance of method yielded an effectiveness rate of 88% or a pregnancy rate of 12%.¹¹¹

Use of CycleBeads



CycleBeads

The SDM makes use of a mnemonic device called CycleBeads, a string of beads, with each bead representing a day of the cycle (called the "collar" in Spanish and Portuguese), to be a helpful tracking tool. The CycleBeads consist of 32 beads. The bead representing the first day of menstruation is red, followed by 6 brown beads (indicating that the first 7 days of the cycle are not fertile). These are followed by 12 white beads, which represent the fertile window. The rest of the beads are brown, again indicating

infertile days. The woman moves a black rubber ring one bead per day so she can tell when she is in her fertile window.

What next?

Introduction studies are being conducted in different areas in different countries. These studies aim to find out the best ways of introducing SDM in various service delivery systems. In the Philippines, introduction studies or operations studies on SDM are being undertaken in hospital-based free of charge set up, in communities using male and couple motivators, and in fee for service set up in private clinics.

¹¹¹ Arevalo M, Sinai I, Jennings V.

¹¹² Arevalo M, Jennings V, Sinai I. Efficacy of the Standard Days Method of Family Planning. In press, August 2001.

Quotes from Participants
2nd National Dissemination Form on SDM of Family Planning (Vismin Launching)

1. *Hon. Milagros Fernandez, MD, MPH*
Undersecretary
Department of Health

"SDM complements the other existing natural family planning methods. SDM catalyst to convince the Catholic Church that the Population Program of the government gives equal importance to natural family planning methods. SDM can serve as the entry point for FP activities/services in areas with local Government Executives who are conservative and refuse artificial FP methods."

2. *Dr. Lydia S. Depra-Ramos*
Director IV
Region VI
Department of Health

"I would say that this is an effective method for as long as the wife is conscientious to use the necklace there is no reason for failure. It's simplicity made it more advantageous for the use of the less-educated wives or mothers as it very mechanical - no brainwork after the initial instruction."

3. *Dr. Lourdes C. Labiano*
Director IV
Center for Health Development - Zamboanga Peninsula
Department of Health

"SDM is simple method, easy to teach and learn, and easy to use. Practical way and make women understand their fertile window. SDM is acceptable to religious groups who are against family planning. Empowers women on how and plan for their family size."

4. *Dr. Milagros Bacho-Bacus*
Director IV
Region VIII
Department of Health

"I had been lecturing about NFP but this method makes it simpler for couples to follow; preferably for those couples who have no problems on being forgetful because this entails a conscious effort on the part of the couples to move the rubber band and a lot of discipline during the fertile period. Resources to manufacture the necklace - if none, probably sell the necklace at cost."

5. *Dr. Marilyn Benabaye*
Director II
Region VII
Department of Health

"SDM is an effective, safe, new choice of family planning method which could be acceptable to clients/couples whose conviction of religious denomination cannot accept the artificial contraceptive methods"

6. *Dr. Charito Awiten*
Director II
Center for Health Development - CARAGA
Department of Health

"Thanks for the opportunity. "The Power of Choice" is the best slogan for SDM. This will be a "springboard" for better and wider horizon which will be left as a legacy now and beyond!"

7. *Dr. Loreto B. Roquera*
Director III & OIC
Center for Family and Environmental Health
Department of Health

"Contribute to meeting unmet needs. Convert traditional FP users to modern, more scientific and reliable natural family planning."

8. *Mr. Nolito M. Quilang*
Director
POPCOM Reg. VII

"For SDM to succeed, it must be accompanied by values clarification sessions as well as orientation sessions that will re-enforce the will and ability of acceptors. This probably can open the line between Catholic church and government."

SDM Quotes:

National Dissemination Form on SDM of Family Planning (Luzon)

1. *Dr. Ethelyn P. Nieto*
Director II
Region III
Department of Health

"SDM makes it easier for Center for Health Development to implement. SDM is a tool to determine fertility period and couples to practice natural methods."

2. *Dr. Gerardo V. Bayugo*
Director II
Region I
Department of Health

"May konting information omission "no sex" during menstrual period. SDM is a brilliant strategy to push the natural family planning component of the RH Program. Acceptable and easy to disseminate or implement. Concretize a rather abstract concept that is natural family planning. May konting religious likewise because of the beads (just like a rosary)."

3. *Myrna R. Suratos, MD, MPH*
OIC
Region I
Department of Health

"Welcome treat to us, Bicol having high fertility rate, increasing trend of teenage pregnancy, high unmet needs for family planning, low CPR and strong opposition of the church and others. SDM may be an answer to all of these."

4. *Mr. Forter G. Puguon*
Director
Bureau of Working Conditions
Department of Labor and Employment

"Initially, my impression is that SDM is indeed simple and easier to understand and practice. However, I believe that for its effectiveness it requires the full participation of the husband. I also believe that SDM should be promoted on a multi-agency approach, considering that population is a key factor in most of the other services of the government, like employment, health education and social welfare services."

5. *Gerardito F. Cruz, MD*

FP RH Specialist
FAMUS

"It's a simple, practice method aside from the long abstinence period. I see the cost of the necklace could be a barrier and some innovations need to be done to reduce cost, use of other cheaper substitute device."

6. *Esperanza Dowling*
Executive Director
Phil. Federation for NFP

"12 days abstinence can still be challenged for regular cycle. Are acceptability studies lined up for other areas?"

Quotes from Participants



STANDARD DAYS METHOD

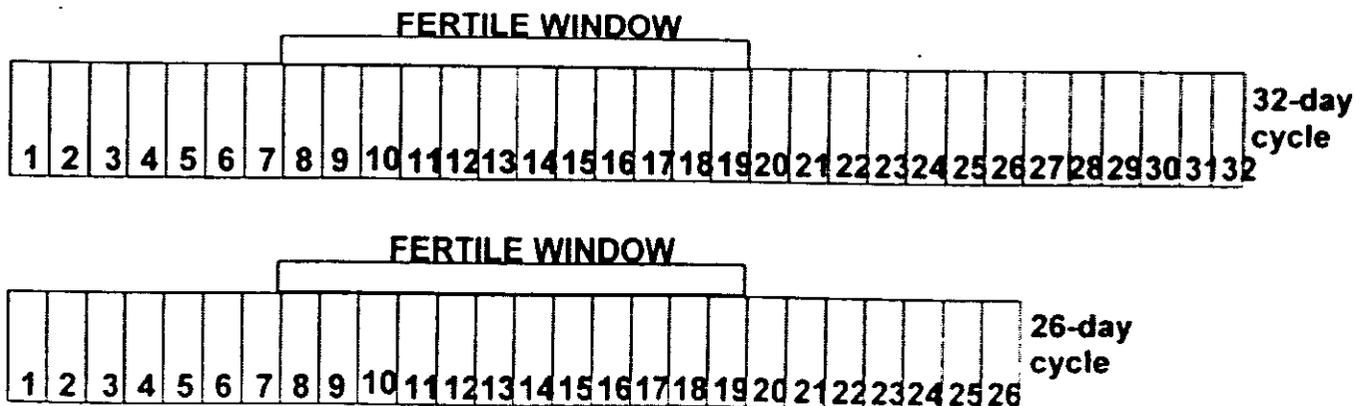
- The Standard Days Method (SDM), developed by the Institute for Reproductive Health at Georgetown University, is a modern scientific method of family planning based on the fact that a woman has a fixed fertile window within her menstrual cycle during which she can become pregnant from unprotected intercourse.
- The Institute has come up with the formula that Days 8-19 as the woman's fertile period based on theoretical studies done on a large set of data from the World Health Organization (WHO)

Why the 12-day fertile window?

The 12-day fertile window of SDM is based on the fact that the cycle length varies from time to time. Although studies suggest that women are most likely to ovulate close to the middle of their cycle, time of ovulation also varies from one cycle to the next. The "fertile window" accounts for the timing of ovulation, life span of the egg-cell (12 to 24 hours) and the life span of the sperm (3-5 days).

For women whose cycles are between 26 and 32 days long, this window is from day 8 through day 19 of their cycles. The rule is to abstain from intercourse or use an alternative method during the fertile days where the woman can most likely get pregnant.

As the figure below shows, this identified window is consistent regardless of cycle length when the cycle is within the 26-32 day range.¹ The probability of this window covering all fertile days is highest for cycles within this range, however it also provides significant coverage for cycles that are somewhat longer or somewhat shorter."



Quotes from Participants
2nd National Dissemination Form on SDM of Family Planning (Vismin Launching)

1. *Hon. Milagros Fernandez, MD, MPH*
Undersecretary
Department of Health

"SDM complements the other existing natural family planning methods. SDM catalyst to convince the Catholic Church that the Population Program of the government gives equal importance to natural family planning methods. SDM can serve as the entry point for FP activities/services in areas with local Government Executives who are conservative and refuse artificial FP methods."

2. *Dr. Lydia S. Depra-Ramos*
Director IV
Region VI
Department of Health

"I would say that this is an effective method for as long as the wife is conscientious to use the necklace there is no reason for failure. It's simplicity made it more advantageous for the use of the less-educated wives or mothers as it very mechanical - no brainwork after the initial instruction."

3. *Dr. Lourdes C. Labiano*
Director IV
Center for Health Development - Zamboanga Peninsula
Department of Health

"SDM is simple method, easy to teach and learn, and easy to use. Practical way and make women understand their fertile window. SDM is acceptable to religious groups who are against family planning. Empowers women on how and plan for their family size."

4. *Dr. Milagros Bacho-Bacus*
Director IV
Region VIII
Department of Health

"I had been lecturing about NFP but this method makes it simpler for couples to follow; preferably for those couples who have no problems on being forgetful because this entails a conscious effort on the part of the couples to move the rubber band and a lot of discipline during the fertile period. Resources to manufacture the necklace - if none, probably sell the necklace at cost."

5. *Dr. Marilyn Benabaye*
Director IV
Region VII
Department of Health

"SDM is an effective, safe, new choice of family planning method which could be acceptable to clients/couples whose conviction of religious denomination cannot accept the artificial contraceptive methods"

6. *Dr. Charito Awiten*
Director II
Center for Health Development - CARAGA
Department of Health

"Thanks for the opportunity. "The Power of Choice" is the best slogan for SDM. This will be a "springboard" for better and wider horizon which will be left as a legacy now and beyond!"

7. *Dr. Loreto B. Roquero*
Director III & OIC
Center for Family and Environmental Health
Department of Health

"Contribute to meeting unmet needs. Convert traditional FP users to modern, more scientific and reliable natural family planning."

8. *Mr. Nolito M. Quilang*
Director
POPCOM Reg. VII

"For SDM to succeed, it must be accompanied by values clarification sessions as well as orientation sessions that will re-enforce the will and ability of acceptors. This probably can open the line between Catholic church and government."

TO SUMMARIZE

The objective of the project is to assess FP counseling program performance

Assessment contributes to efforts to improve the quality of FP counseling

7 geographical sites --

Metro Manila (Nail Capital Region)

	100% FP	100% FP
Luzon	CAGAYAN VALLEY	BARAS
Visayas	C. VISAYAS	S. VISAYAS
Mindanao	S. MINDANAO	N. MINDANAO

Improved quality FP counseling is vital because it --

Contributes to overall client satisfaction

Helps ensure informed choice

Improves FP continuation rates

Promotes clients as decision-makers

Assessment teams will spend about 7 days in each site

Day 1: Entry, courtesy visits to local leaders, arrangements

Day 2: Stakeholder discussions

Day 3-6: Visit 5 clinics, spending half day per clinic

Day 6-7: Three community meetings (female users, female non-users, males)

Quality FP counseling leads to better ability to meet the country's Contraceptive Prevalence Rate (CPR) targets

Project timetable --

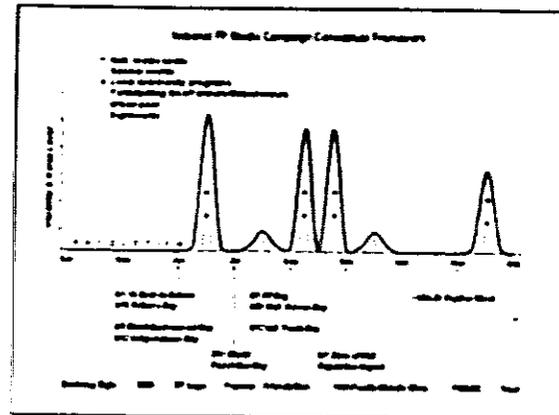
May: Finalize design, Pre-testing of assessment tools

June to August: Field work, data-gathering, data-analysis

August: Completion of data-analysis

September: Submission of topline report

October: Final report completed and submitted



Campaign Components

Natl. media TV spots --

- 3 spots to be produced (specars, Emilers, urban poor);
- 2 spots (specars, Emilers) to be aired w/ available resources
- Need to mobilize resources for airing urban poor spot
- Campaign resources limited to production of materials & limited placement -- How can the FP community support a larger campaign? Can the DON CHDs, through local structures, support the national campaign?

Targeted events --

- For major stakeholders: Father's Day, FP Day, Natl. Heroes Day
- For other stakeholders: Back-to-School, World Pop. Day, State of Phil. Pop. Rpt, PopDev Week, Festivals (e.g., Ad-Ashim)

Preliminary Calendar

Dev't, pre-testing of materials	June
Production	June
Ad Board approval	June
Campaign launch	1 July
Urban poor research initial findings	July
Completion of urban poor research	July
Dev't, approval of urban poor message concepts	August
Airing of urban poor spots	September
Dev't, prod., death of event materials	
- for July	Until end of June
- for August	Until end of July
- for November	Until end of Sept

Local Community Programs

- **Key stakeholders --**
 - Their names/logos will be included in natl. media ads
 - They will join in major FP Westyle campaign events at the community level
- **Other synergy points --**
 - Service provider promos/fairs
 - Advocacy promos/drives/caravans
 - Public sector initiatives
 - Multiple stakeholder activities

**PROPOSED IMPLEMENTING GUIDELINES IN THE
CREATION AND OPERATIONALIZATION OF ITINERANT
TEAMS FOR VOLUNTARY STERILIZATION (VS) SERVICES.**

I. Background and Rationale:

The ultimate goal of the activities undertaken by the Department of Health's Family Planning program has always been the improvement of the quality of life of the Filipino family. The efforts of the program to promote the spacing or limiting of a couple's children and planning the number of children according to the couple's desires, are done with the intended results of healthier families enjoying a good quality of life.

The provision for Voluntary Sterilization (VS) services – whether bilateral tubal ligation (BTL) or vasectomy is an important component of the Department of Health's Family Planning program. However, in the 1998 demographic survey there is a 51% unmet demand among women of reproductive age. Of these findings, it has been identified that there is a 20% unmet demand for contraception among couples who do not want to have additional children (or who would want to stop childbearing). When specifically translated to numbers, this includes approximately 1.1 million potential VS clients, who are unable to avail of these services. There is also an estimated 300,000 to 500,000 abortions per year indicating a huge number of unplanned, unintended or unwanted pregnancies.

The current use of surgical contraception documents a mere 10.3% use of bilateral tubal ligation (BTL), and 0.2% use of vasectomy clearly illustrating the unmet demand for permanent contraception, that requires an urgent and concerted action to reinforce the past and ongoing efforts in strengthening the VS program. Admittedly by its very nature, the provision of VS services had encountered bigger programmatic challenges compared with other FP methods. Precisely to respond to the unmet demand for permanent contraception, the DOH and other key stakeholders have been working to put together and implement a program to make quality VS services available to Filipino couples. Previous efforts undertaken under the VS program have included the following:

- 1) Improving availability and accessibility of services through assistance to upgrade DOH and LGU hospitals to become VS capable sites with appropriate equipment and trained VS providers.
- 2) Selected DOH-retained regional hospitals and medical centers had also been strengthened to become functional training centers for VS.
- 3) Strengthening the capability of key FP staff in the Regional Health Offices to become effective monitors of the VS program.
- 4) Improving referral mechanisms between the peripheral field health units and the VS service sites to strengthen dissemination of information on the availability of VS

services to the patients and clients inside hospitals as well as outside in the surrounding community.

- 5) Provision of augmentation funds/external resources through special projects to reduce costs of the procedure (including drugs and supplies) to make the procedure more affordable.

On top of these efforts, it was recognized that among the lingering causal factors that continue to hinder clients from availing of VS services include physical/geographic inaccessibility and the limited number of VS sites which have the capability to routinely offer VS services. Another persistent constraint involved the transportation costs that would have to be shouldered by the clients, his/her companion (usually a member of the family), and the Barangay health Worker, if the referral VS hospital is far from the client's residence.

All of the above constraints could be adequately addressed by the fielding of outreach VS teams and by bringing the services to the communities where the potential VS clients live.

The Department of Health Administrative Order No. 50-A s. 2001 specifically states, that "all DOH-retained hospitals shall create FP itinerant teams and make them available for dispatch to respond to the needs for surgical methods especially in urban and rural poor communities". Furthermore, "family planning shall form part of the standard services to be delivered by these hospitals in all its medical missions and outreach activities".

This Order is issued for compliance by DOH-retained regional hospitals and medical centers.

II. Coverage and Scope

The coverage and scope for the provision of itinerant VS services shall include areas in the country where there is a need to bring the VS services directly to communities where the clients live. The DOH Center for Health and Development in coordination with the concerned DOH-retained regional hospital or medical center and the LGU community shall identify these areas. These shall include the following:

- a) Communities where there is a documented demand for permanent contraception and where trained service providers are not available to provide VS services.
- b) Communities where the existing VS sites are inadequate to meet the demand for VS.

III. Creation of Itinerant Teams

A) Organizational Structure

The itinerant VS teams shall be organized in all DOH-retained regional hospitals and medical centers, which shall serve as the base of the team. There should be a minimum of two VS teams per hospital. The Chief of the respective regional hospital or medical center shall be responsible for the creation and organization of the teams. A hospital order shall be issued to create and operationalize the itinerant VS teams of the hospital/medical center.

B) Staff Composition

One itinerant VS team shall be composed of the following :

- a) A BTL surgeon who is proficient in the minilaparotomy under local anesthesia (MLLA) procedure
- b) A trained Vasectomy surgeon
- c) A surgical nurse or midwife
- d) A circulating staff

IV. Operationalization

A) Service Delivery

1) Facilities, Equipment and Instruments

- The venue or itinerant outreach VS sites shall be in a hospital (DOH or LGU managed) with operating room facility that complies with the minimum requirements for performing minor surgery, tubal ligation, and vasectomy procedures.
- For the health center or non-hospital venue as itinerant VS site, it shall be refurbished to comply with the minimum requirements for providing ML/LA and NSV.
 - For ML-LA, a space is identified that could be refurbished to simulate an operating room that is restricted and measuring 3m x 3m x 3m in size, and provision for a semi-restricted area.
 - For NSV, this procedure could be performed in a clinic that is enclosed, well ventilated and with fly-proof windows.
- The itinerant VS teams should be equipped with a minimum of five minilaparotomy sets and three no-scalpel vasectomy sets during each scheduled itinerant VS service. The team shall bring with them an OR table, OR light and a mini-sterilizer or boiler if necessary.

2) Drugs and Supplies

- The DOH-retained hospital or medical center shall maintain a minimum stock level of drugs and supplies adequate for a total of 30 clients for each scheduled itinerant VS service. The itinerant teams should bring to the site drugs and supplies that is equivalent to 30 clients per itinerant service.
- The Regional CHD shall ensure provision of augmentation support for drugs and supplies for use of the itinerant teams in the DOH-retained hospitals
- Alternatively and whenever appropriate, the outreach VS site or the LGU community may be tapped to provide VS drugs and supplies

3) Manpower requirement including duties and responsibilities

a. Itinerant team

- Two itinerant VS teams shall be dispatched during the scheduled itinerant services.
- The itinerant VS surgeons shall be responsible for screening and final selection of clients, verification of informed consent, assurance of quality of care, including proper infection prevention practices.
- The provision of voluntary sterilization shall be performed in accordance with the DOH approved minilaparotomy under local anesthesia for female clients, and no-scalpel vasectomy technique for male acceptors.

- Members of the itinerant VS team must ensure proper examination and monitoring of clients in the immediate post-operative period and upon discharge on the same day.
- The itinerant VS team shall be provided with copies of the records of all BTL and Vasectomy cases performed and shall be responsible for submitting reports of performance to the DOH- Center for Health and Development every month.

b. Staff of the outreach VS site

- FP counseling shall be provided by trained staff of the outreach VS site and shall be available to conduct counseling activities regularly and during the scheduled outreach VS services.
- There should be medical staff available at the outreach VS site who shall be responsible for follow up of post-BTL and post-Vasectomy clients during the scheduled follow up visit.
- Staff of the outreach VS sites shall be responsible of providing both verbal and written post-operative instructions and follow-up schedules to the client prior to discharge.
- The staff of the outreach VS site shall keep the charts/records of all BTL and Vasectomy clients, and these shall include complete name of client, age, address, number of children and date procedure and procedure performed.

4) FP Counseling and information dissemination activities

- All clients undergoing BTL or vasectomy shall undergo FP counseling prior to the procedure. The staff of the outreach VS site shall be trained to provide FP counseling.
- Informed consent shall be explained and signed by the VS clients during the counseling session.
- The Center for Health and Development shall be responsible for coordinating activities with the Local Government Unit in relation with strengthening referral activities, linkages with other NGOs, and information dissemination for outreach VS services.
- The barangay health workers shall be tasked to identify potential clients from the surrounding communities and refer them for appropriate screening and counseling to the outreach VS sites.
- Appropriate referral forms shall be utilized by the referring units, and adequately documented, both at the referring and referral units.

5) Schedules

- The DOH-retained regional hospital or medical center shall coordinate with the outreach VS site in arranging a 2-day schedule for itinerant VS services to be regularly conducted on a monthly basis.
- The CHD shall assist the DOH-retained hospital and the itinerant VS site in the appropriate scheduling of the itinerant VS services.

B) Financial Resources

- a) The DOH-retained regional hospitals and medical centers shall ensure that funds for itinerant VS teams including medical missions and outreach services are incorporated in their regular annual budget. This is to reiterate the same provision in the DOH A.O. No. 50 s. 2001.
- b) The DOH-Center for Family and Environmental Health and the DOH Center for Health and Development shall provide assistance to the DOH-retained regional hospitals and

medical centers by providing augmentation funds to support the VS program including the itinerant VS teams.

V. Supervision and Management

- a) The Chief of Hospital of the DOH-retained regional hospital and medical center or his designate shall be responsible of ensuring that the itinerant VS teams are operational and functional as provided for in the guidelines.
- b) The DOH Center for Health and Development in the concerned regions shall provide oversight to ensure that the regional hospitals and medical centers are delivering outreach VS services through the itinerant VS teams, as they had been mandated.

**Training of Trainers on Minilaparotomy under Local Anesthesia
in DOH-retained Medical Centers and Regional Hospitals**

<i>Region</i>	<i>Hospital</i>	<i>Date of TOT Training</i>	<i>Name of Trained Trainers</i>
I	1. Ilocos Training & Regional Medical Center, San Fdo, La Union	September 4-8 2000	Dr. Gerardo Garcia Dr. Aurora Valdez
II	2. Veterans Memorial RH Bayombong, Nueva Viscaya	August 21-25 2000	Dr. William Bhady Dr. Odette Tia-Valencia
III	3. JB Linggad Memorial RH San Fernando, Pampanga	Sept 18-22 2000	Dr. Agnes Gaddi
	4. Dr. Paulino J Garcia MMRC Cabanatuan City, Nueva Ecija	October 23-27 2000	Dr. Teodora Matias Dr. Kristine Estanol
IV	5. Batangas Regional Hospital Batangas City	October 2-6 2000	Dr. Angelina Villena Dr. Pedro Comia Jr
V	6. Bicol Medical Center Naga City, Camarines Sur	October 16-20 2000	Dr. Antonia Vilgeron Dr. Catherine Buban
	7. Bicol Regional Training & teaching Hospital, Legaspi City, Albay	October 2-6 2000	Dr. Amy Rivera Dr. Glenda Sugong
VI	8. Corazon Locsin Memorial Regional Hospital, Bacolod City	October 16-20 2000	Dr. Luz Altarejos Dr. Marlon Tabligan
	9. Western Visayas Medical Center Iloilo City	March 12-16 2001	Dr. Ma Te Maxbika Dr. Leticia S. Saucedo
VII	10. Vicente Sotto Memorial Medical Center, Cebu City	Nov 6-10 2000	Dr. Grace Abugan Dr. Florabeth Taguba
	11. Gov. Celestino Gallares Memorial Regional Hospital, Tagbilaran City, Bohol	Dec 11-15 2000	Dr. Maya Trinidad-Araneta Dr. Stella Maris Amora
VIII	12. Eastern Visayas Medical Center, Tacloban City, Leyte	Nov 6-10 2000	Dr. Emma Japlana
IX	13. Zamboanga City Medical Center, Zamboanga City	Dec 11-15 2000	Dr. Suzette Montuno Dr. Filma Abarquez
X	14. Northern Mindanao Medical Center, Cagayan de Oro City	January 8-12 2001	Dr. Caroline Orimaco Dr. Edna Palabrica
XI	15. Davao Medical Center Davao City	December 4-8 2000	Dr. Amelia Vega Dr. Alicia Layug
	16. Davao Regional Hospital, Tagum City, Davao Norte	December 4-8 2000	Dr. Agnes Resurreccion Dr. Amelia Ang
XII	17. Cotabato Regional Hospital Cotabato City	June 18-22, 2001	Dr. Gloria Redoble Dr. Nurlinda Arumpac
CAR	18. Baguio General Hospital & Medical Center, Baguio City	October 23-27 2000	Dr. Mildred Torres Dr. Jesse Diaz Dr. Ma Rosario Paggao
NCR	19. Rizal Medical Center Pasig City, Metro-Manila	January 8-12 2000	Dr. Carmencita Solidum Dr. Ma Carmen Quevedo
	20. Jose R Reyes Memorial Medical Center, Sta Cruz, Metro-Manila	November 20-25 2000	Dr. Marina Alcalde Dr. Benjamin Cuenca
	21. East Avenue Medical Center East Avenue, Quezon City	May 7-11 2001	Dr. Manuel Ramos Jr Dr. Elenita Mojica-Veloso
	22. Eulogio Rodriguez Memorial Medical Center, Marikina, Rizal	January 2002	Dr. Cristina Fabella Dr. Amy Estrella
• Caraga	23. Caraga Regional Hospital Surigao City, Surigao Norte	June 18-22, 2001	
Total	23 Hospitals		42

VOLUNTARY STERILIZATION (VS) STANDARDS

VS is a permanent FP method. It is an elective surgical procedure and one of the safest choice available for couples who wish to end their fertility. VS can be performed either on a woman (procedure is called bilateral tubal ligation) or on the man (the procedure is called vasectomy).

Guidelines

I. On informed Choice

1. VS shall be provided to any individual who has voluntarily decided to undergo the procedure regardless of his/her age, marital status, religious or cultural background, occupation, number of children, or age of the youngest child. FOR AS LONG AS informed choice is ensured and the informed consent is fully understood.
2. Informed choice shall be ensured for all VS clients especially those for whom the procedure is medically or surgically indicated.
3. Before the procedure is performed, the VS client, natural or legal guardian must sign the informed consent after fully understanding the six (6) elements thereof. The consent of and/or signature of the partner is not required.
4. Informed consent for mentally disabled VS clients who are not capable of understanding the six (6) elements of informed consent and decision making should be secured from the client's natural /legal guardian.

II. On the Procedures

1. For all VS clients, the standard procedure is minilaparotomy under local anesthesia (Pomeroy method) unless contraindication exists. The following conditions may require other surgical/ anesthesia techniques:
 - a) Extreme obesity (BMI = 30) $BMI = \left[\frac{\text{weight in Kg}}{(\text{height in meters})^2} \right]$
 - b) Previous history of abdominal or pelvic surgery
 - c) Previous history of pelvic inflammatory disease/s.

2. Female sterilization procedure should be performed in a hospital operating room and according to DOH standards; or in a "simulated" OR setting for non-hospital venues.
3. For male VS clients, the no-scalpel vasectomy technique should be the standard procedure.
4. Pre-operative evaluation of all VS clients should include complete medical history, physical and pelvic examination. Laboratory test such as CBC, urinalysis, pregnancy test and others are *not* necessary and *should not* be performed routinely unless clinically indicated.
5. The procedure should be performed by a duly certified VS provider.
6. All facilities providing VS services should have at least one trained FP counselor.
7. The standard drugs for female VS are:
 - Meperidine (Demerol) 50 mg by slow IV push for analgesia
 - Diazepam (e.g. Valium) 5 mg by slow IV for sedation
 - Lidocaine 2% or 1% for local anesthesia

If these are not available, the following alternative drugs may be used:

- Nalbuphine (Nubain) 10-mg slow IV or Butorphanol tartrate (Stadol) 1 mg slow IV or 2 mg IM for analgesia.
- Midazolam (Dormicum) 2.5 – 5 mg slow IV for sedation

If diazepam ampule is not available, the diazepam tablet (5-10 mg) maybe given orally 30 minutes prior to the procedure on an empty stomach.

Antibiotics are NOT routinely given or prescribed post-operatively.

8. The usual drugs used for no-scalpel vasectomy (NSV) are local anesthesia (Lidocaine 2%) and an oral analgesic that is prescribed post-operatively.
9. Clients for bilateral tubal ligation under local anesthesia must be placed on nothing per Orem (NPO), except medications, for at least four (4) hours prior to the procedure. Clients for vasectomy are not required to be placed on NPO.

10. When done under local anesthesia, post-BTL clients with uneventful post-operative course may be sent home once they are fully awake and can tolerate oral intake of food. Minilaparotomy under local anesthesia is considered an outpatient procedure and does not require admission for overnight stay at the hospital. Post-NSV clients can go home after thirty (30) minutes observation.

11. The following are NOT routine procedures for VS:

- Shaving the perineal area prior to the procedure
- Urethral catheterization for emptying the urinary bladder. Ask the client to void prior to the procedure.
- Bowel cleansing prior to the procedure such as as cleansing enemas, dulcolax oral or suppository.

WHO Medical Eligibility Criteria for Female Sterilization and Vasectomy:

- **ACCEPT:** No medical reason to prevent performing the procedure in a routine setting
- **CAUTION:** The procedure can be performed in a routine setting but with extra preparation and precautions.
- **DELAY:** Delay the procedure. condition must be treated and resolved before the procedure can be performed. Provide temporary methods.
- **REFER:** Refer client to a center where an experienced surgeon and staff can perform the procedure. setting should be equipped for general anesthesia and other medical support. Provide Temporary methods.



Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY
San Lazaro Compound, Sta. Cruz, Manila
Telephone No.: 743 8301 to Local 1125-1131

CERTIFIED TRUE COPY:

January 4, 2000

Administrative Order
No. 2 s. 2000

[Signature]
LAMBERTA G. MANUEL
CHIEF, RECORDS SECTION
DOH- *[Handwritten initials]*

SUBJECT: Implementing Guidelines for Strengthening the Training in Minilaparotomy Under Local Anesthesia for Resident Physicians in OB - Gyne in all DOH Retained Hospitals and Medical Centers.

I. **Background and Rationale:**

The goal of the Department of Health's Family Planning Program is to ensure the universal availability of all Family Planning (FP) methods to all Filipino men and women. Voluntary Sterilization (VS), which includes Bilateral Tubal Ligation (BTL) for women and Vasectomy for men are permanent FP methods that are recognized as highly effective FP methods.

The standard technique for Bilateral Tubal Ligation (BTL) that has been recognized by the DOH is Minilaparotomy under Local Anesthesia (MI-LA). This has been incorporated in the clinical standards for the Department of Health Family Planning Program. The use of local anesthesia makes the method more accessible and available to a greater number of potential BTL clients. The advantages of this technique include lesser risks and complications, lesser cost, lesser duration of hospitalization, procedure can be performed where there are no anesthesiologists, therefore enabling the procedure in the hospitals in rural and far flung areas.

A Consultative meeting convened in October 1999 attended by chief of hospitals and OB department heads resulted in an agreement to strengthen the training of resident physicians in Minilaparotomy under local anesthesia. The goal of such is to ensure that there would be a greater number of physicians who are able to provide quality BTL services using the standard technique.

This order provides guidelines that performance of BTL procedures using minilaparotomy under local anesthesia shall be incorporated in the residency training curriculum.

Signed: AD Received in
the Records Section on 1/21/2000

"Sa Sentrong Sigla, Kalusugan Mo at Ng'Yong Pamilya Laging Una"



Guidelines:

Minilap under local anesthesia shall be included in the residency training program

- a) First year residency:
 - 1. first six (6) months, OB Gyne residents shall *assist* in minilap under local anesthesia.
 - 2. last six (6) months of the year, shall *perform* minilap under supervision.
 - 3. should be able to perform *10 cases* of minilap *under supervision*.
- b) Second year residency:
 - 1. residents shall perform minilap *without* supervision
 - 2. residents shall be required to perform a minimum of 40 cases of BTL, using minilap under local anesthesia during the residency program

III. Conduct of training:

- 1. There are trained VS providers in all DOH retained hospitals and medical centers hence these VS providers (usually OB physicians) will be responsible in transferring the technology to the resident physicians in their respective hospitals.
- 2. All OB-Gyne residents will be trained on Minilap under local anesthesia
- 3. Each DOH-retained hospital/medical center shall ensure the availability of trainers for ML-LA in their institution
- 4. In cases where trainers are not available, the DOH in coordination with the accredited VS training centers and AVSC International shall train trainers from the OB-Gyne department to become certified trainers in ML-LA. This will be done through the conduct of on-site training of trainers at the requesting DOH-retained hospital/medical center.
- 5. There are three VS training centers in the Philippines:
 - a. Cagayan Valley Regional Hospital
 - b. Jose Fabella Memorial Hospital
 - c. Region I Medical Center
- 6. Conduct of refresher courses in ML-LA can be done in DOH VS training centers.

This order shall take effect immediately.

ALBERTO G. ROMUALDEZ, JR., MD.
Secretary of Health

CERTIFIED TRUE COPY:

LAMBERTA G. MANDEL
CHIEF, RECORDS SECTION
DOH- MANILA

181 -

RECOMMENDATIONS
of the NATIONAL TECHNICAL WORKING GROUP (TWG) ON
STRENGTHENING the VOLUNTARY STERILIZATION (VS) SERVICES
in the PHILIPPINES

OVERALL STRATEGY: ENSURING UNIVERSAL ACCESS TO QUALITY
VOLUNTARY STERILIZATION (VS) SERVICES FOR ALL FILIPINOS OF
REPRODUCTIVE AGE

MAJOR STRATEGIES	SERVICE DELIVERY	CAPABILITY BUILDING	IEC and ADVOCACY	POLICY and FINANCING
1. Improving availability and accessibility of VS services	<ul style="list-style-type: none"> >Determining status of existing facilities and capability of service providers to provide VS services. Increasing VS (BTL and Vasectomy) service delivery sites in government and private sectors >Bringing NSV services to commercial/ business /Industrial establishment and establishing a referral mechanism for BTL services. >Developing outreach VS teams (from VS capable sites) to render services in 	<ul style="list-style-type: none"> >Increasing the number of accredited VS (Vasectomy and BTL) training centers in government and private sectors >Strengthening existing government training centers in BTL >Establishment of training centers for Vasectomy (at least one per region) IN GOVERNMENT AND/OR PRIVATE SECTOR. >Strengthening and institutionalizing VS training in all DOH-retained training hospitals through 	<ul style="list-style-type: none"> >Identifying gaps in current IEC for VS through a nationwide Needs Assessment on VS-Knowledge, Attitudes and Practices/Skills of Service Providers and Potential clients/Public >Developing IEC materials for Service Providers & clients including materials in the local dialects >Coordination w/ LGUs & NGOs for the conduct of intensive community-based information drive, including tapping VS acceptors as VS "champions" or VS 	<ul style="list-style-type: none"> >Ensuring strict compliance of the existing DOH training policy on BTL (embodied in DOH A.O. no. 2 s. 2000 on BTL training on the ML-LA technique > Dev't of policy making DOH-RHO/HRRD as signatory to OB residents' certificates of completion of trng. >Formulation of training policy on Vasectomy (through a DOH Administrative Order) > FORMULATION OF

	<p>non-capable sites.</p> <ul style="list-style-type: none"> >Strengthening and institutionalization of community-based FP client identification systems and tools >Ensuring availability of drugs and supplies for VS 	<p>strict compliance to the DOH AO No. 2s.2000 (Strengthening Training in Minilap under LA in Ob-Gyne Residency)</p> <ul style="list-style-type: none"> > Establishing tie-ups with Academic institutions (PUA, PAFP, etc.) for the training of members in Vasectomy and BTL 	<p>advocates</p> <ul style="list-style-type: none"> >Enhancing the image of VS service providers >Strengthen networking among stakeholders through regular partnerships, meetings and unified workplans >Development /Expansion of models for local advocacy > Ensuring that hospitals conduct "inreach activities" or in-house information drives for FP and VS among inpatients and outpatients 	<p>IMPLEMENTING GUIDE-LINES ON NO-SCALPEL VASECTOMY (NSV)</p> <ul style="list-style-type: none"> >Formulation of policies on VS Outreach teams > Formul'n. of Impl. Guidelines For Outreach VS Services (Issuance of a Dept. Order) >Strengthening the implementation of FP/VS component of the medical/nursing/midwifery curricula
--	---	---	--	--

MAJOR STRATEGIES	SERVICE DELIVERY	CAPABILITY BUILDING	IEC and ADVOCACY	POLICY and FINANCING
<p>2. Improving the Quality of VS services</p>	<ul style="list-style-type: none"> >Adopting best practices in VS implementation as appropriate >Ensuring Informed Choice through provision of Family Planning Counseling for all clients >Implementation of Sentrong sigla and other quality assurance/quality improvement standards and tools in the provision of VS services 	<ul style="list-style-type: none"> >Ensure follow-up of VS trainees by the training institution through inclusion in the training plan >Strengthening the training and post-training follow-up of FP providers in FP counseling > Development of integrated monitoring tools FOR THE TOTAL FP PROGRAM for use in quality improvement > Ensure training and follow-up of VS service providers in quality improvement standards and tools 	<ul style="list-style-type: none"> >Ensuring information dissemination of VS standards and policies > Reproduction and distribution of VS standards and policies > Designation of FP corners in hospitals and field units for posting of FP policies and standards (including VS policies and standards) 	<ul style="list-style-type: none"> >Development of accreditation standards and policies for Service Providers and facilities jointly adopted by DOH/PHIC >Dev't of Standards and Policies Expanding PHIC Coverage For Procedures Currently Not Covered (including Outreach VS teams; outpatient services) >Compliance to Sentrong Sigla and other quality assurance stds and tools

MAJOR STRATEGIES	SERVICE DELIVERY	CAPABILITY BUILDING	IEC and ADVOCACY	POLICY and FINANCING
<p>3. Improving the Sustainability of VS services</p>	<ul style="list-style-type: none"> > Ensuring compliance of policies on incorporation of VS drugs and supplies in hospital budgets of government hospitals > Ensuring compliance to relevant policies for reduction of the cost of VS services, whether in government or private hospitals > Promotion of continuous linkages between VS service sites, VS outreach teams and the peripheral field units 	<ul style="list-style-type: none"> > Strengthening the capacity of Regional Health Office monitors to conduct effective monitoring and supervision of VS clinical and program activities appropriate under the decentralized set-up > Improving the capacity of LGU supervisors in the efficient management and supervision of the LGU's FP /VS Programs > Ensuring that training courses in VS and FP Counseling will include budget for follow-up of trainees > Inclusion of VS training as part of the residency programs in OB-Gyne for INTERESTED non-DOH hospitals > Inclusion of VS as part of the Required 	<ul style="list-style-type: none"> > Setting-up of nationwide Information system on VS through Information Technology > Dev't of VS website to include clinical and program updates, directory of stakeholders, available services, other key information. > Development and implementation of "Local Government Units (LGUs) Advocacy Strategy for VS) > Advocacy for LGU funding of continuous information-dissemination activities by community-based health workers > Documentation of best practices for replication in other areas 	<ul style="list-style-type: none"> > Universal coverage by PHIC to include VS clients from the indigent and informal sectors. > Policy Guideline on upgrading PHIC component package for VS coverage > Institutionalization of budget allocations for VS drugs and supplies > Policy development on financing by: <ul style="list-style-type: none"> a) Marketing segmentation b) non-donor dependent financing sources c) government grant mechanisms > Policy development on employment - related benefits: <ul style="list-style-type: none"> a) Liberal leaves/free services for NSV/BTL clients a) Increasing

		<p>Learning Experience for Nurses and Midwives</p> <ul style="list-style-type: none"> >Inclusion of FP (including VS) rotation in Post Graduate Internship and Clinical clerkship of medical students > Inclusion of FP questions in licensure exams in medicine, nursing and midwifery >Institutionalizing the transfer of VS skills to colleagues through on-the-job training with appropriate accreditation 	<p>PHIC/SSS benefits for families w/ 3 children or less</p> <ul style="list-style-type: none"> > Policy formulation for institutionalization of reward system for well-performing FP and VS service providers at all levels <ul style="list-style-type: none"> a)Review and improve higher PHIC reimbursements of professional fees b) Provide staff development and training updates for VS providers >Dev't of guidelines in the implementation of budget allocations for vs drugs and supplies >Policy Dev't by LGUs in support and promotion of Family Planning as stipulated in section 17 of the local gov't code
--	--	---	---