Accelerating Access to Postpartum Family Planning (PPFP) in Sub-Saharan Africa and Asia

PPFP Country Programming Strategies Worksheet

Country:	Philippines	Country Coordinator:	

III. Existing PPFP Programs

Consider the figures above and review chapter 3 in Programming Strategies for PPFP to determine which PPFP programs already exist in your country. Discuss as many programs as possible with your country team but list the most promising three programs in the table below and explain the specific activities that have been undertaken to implement each one. Note the key stakeholders (policymakers, program managers, providers, nongovernment organizations, beneficiaires) who have supported each activity and the organizations that have been involved in the implementation. Identify any indicators being used to evaluate whether the program's goals are being achieved.

Existing PPFP Program 1:	**Establishment and Strengthening Centers of Excellence (COEs) for Postpartum Family Planning (PPFP)**
Activity 1:	**Establishment and Strengthening of Centers of Excellence (COEs), both public and privately-owned, on Postpartum Family Planning (PPFP) Service Provision**
Timeframe	**2013 to present**
Evidence of success	**Functioning national and regional COEs (9 as of) May 2015 have been established across the country to actively lead in the capability building of health service providers**
Total cost over timeframe	
Has this activity been scaled? Why or why not?	**Yes, additional DOH retained hospitals will be established as COE at least one per region.**
Key stakeholders	**Central/Regional Department of Health, Provincial/City and Municipal Government, Public and Private health facilities**
Implementing agency(ies)	**Central/ Regional and Local health facilities, public and private.** **Training of Health Service Providers in DOH-retained and Candidate COEs on PPFP/PPIUD services (COEs as PPFP service providers)** **Conduct training of HSPs Utilizing the DOH-retained COEs on LARC-PSI services for PPFP Integration**
Activity 2:	**Developing pool of trainers to expand PPIUD service provision from hospitals to peripheral public and private birthing facilities**
Timeframe	**2013 to present**
Evidence of success	**Training of trainers from Baguio General Hospital and Medical Center (5), Quirino Memorial Medical Center (1) and Quezon City Birthing Facilicities (8) were conducted to increase access to training providers for health service providers.**
Total cost over timeframe	
Has this activity been scaled? Why or why not?	**Yes. Regional and provincial and city trained trainers, public and private are providing training of health service providers for PPFP/PPIUD**

Key stakeholders	**DOHRO-CAR, DOH-NCRO, Quezon City Health Department, BGHMC and QMMC**
Implementing agency(ies)	**DOH RO, DOH retained hospitals**
Activity 3:	**Facilitate the provision of PPFP/PPIUD services in privately-owned health facilitiies as Clinical Practice Sites**
Timeframe	**2013-2015**
Evidence of success	**Since April 2014, more than 8 batches of HSPs trained on PPFP/PPIUD with the COE-SPMC underwent actual case application in privately-owned clinics of Berato. With strong partnership, the SPMC and the DRH (in Davao Reg 11) collaborated with private clinics, on PPFP/PPIUD, as Clinical Practice Sites. Furthermore, a total of 15 privately-owned health facilities have joined Berato Clinic on PPFP/PPIUD service provision.**
Total cost over timeframe	
Has this activity been scaled? Why or why not?	**Yes. The first Training of Trainers (TOT) in Davao Region was followed-up with additional batches of TOTs that involved the private sector providers. Other than Berato Clinic, more privately-owned health facilities are now able to co-share as Clinical Practice Sites (CPS) on PPFP/PPIUD for the trainees from both public and private sectors. To date, 21 private providers have contributed to 491 client-aceptors on PPFP/PPIUD. Yes. The capacity enhancement that was strengthened in Sept. 2013 through a Training of Trainers (TOT) in Davao Region, could now be seen in other Mindanao regions. Privately-owned health facilities are now able to provide access to more women delivering in privately-owned health facilities (from Berato Midwifery Clinic to Well Family Midwife Clinic, Friendly Care Clinics, etc).**
Key stakeholders	**Program Managers of DOH-Regional Offices 10, 11 and 12 and the managers of private clinics departments contributed to the success of promoting wider acccess in Mindanao.**
Implementing agency(ies)	**Private owners, managers and providers have contributed to the success in providing PPFP/PPIUD services as a continuum to potential clients. Private owners, managers and providers have contributed to the success in providing PPFP services as a continuum the moment the woman visited and registered in private health faciilties (e.g., Berato Midwifery Clinic, Well Family Midwives Clinic, etc.) as potential clients from the communities**
Indicator(s) (Data Source):	**No. of Health Service Providers (HSPs) trained on PPFP/PPIUD; No. of HSP-trainees underwent supportive supervision; No. of Service Delivery Points (SDPs) with fixed PPFP/PPIUD providers; No. of women provided with PPFP Counseling and PPIUD Services from MindanaoHealth database**
Activity 4:	**Training of Providers in DOH-retained and Candidate COEs on PPFP/PPIUD, PSI services (COEs as service providers)**
Timeframe	**2012-2015**
Evidence of success (PPIUD)	**> In Mindanao, the DOH-retained facilities of Zamboanga City Medical Center (Region 9), the Northern Mindanao Medical Center (Reg 10), the Southern Philippines Medical Center and the Davao Regional Hospital (Reg 11) have been conferred as COEs on PPFP/PPIUD by the DOH-National Office upon recommendation by the USAID-Project MCHIP. in additon, around 159 service delivery points (SDPs) have been assisted by the COEs and registered in the MindanaoHealth database as PPFP/PPIUD providers since 2012 up to March 31,2015.**

Evidence of success (PSI)	> Master Trainers from the COEs of SPMC and DRH jointly conducted the Training of Trainers on LARC-PSI in Davao City for the trainers from Regions 10, 11, 12, Caraga and the Autonomous Region of Muslim Mindanao. To date, one (1) batch of training was conducted for participants from Regions 11, 12 and ARMM by the new set of trainers.
Total cost over timeframe	
Has this activity (PPIUD) been scaled? Why or why not?	Yes. This capacity enhancement that started in 2012, followed by a Training of Trainers (TOT) in Sept 2013, has been introduced to the Northern Mindanao Medical Center, then South Cotabato Provincial Hospital (SCPH) and the General Santos City Medical Center (GSCMC) providing access to more women who have been delivering in health facilities.
Has this activity (PSI) been scaled? Why or why not?	Yes, while anticipating the WHO-MEC re-categorization of the LARC/PSI, one (1) batch of training for the Health Service Providers was conducted by new set of trainers. However, additional batch of a TOT on LARC-PSI and additional batches of Training for the Health Service Providers are now on the pipeline for Lanao del Sur, Basilan, Sulu and Tawi-tawi providers and trainers for BASULTA and Zamboanga Peninsula.
Key stakeholders (PPIUD)	With Dr. Romulo Busuego as the former Head of the DOH satelite office for Mindanao and the top leaders of DOH-Regional Offices of Zamboanga Peninsula, Northern Mindanao, Davao Region, SOCCSKSARGEN region and later, the Caraga Region. All the above-mentioned Chief of Hospitals and their respective Obstetrics and Gynecology departments and the clients, as stakeholders, have contributed to the success in Mindanao.
Key Stakeholders (PSI)	Top leaders of DOH and the Directors the Regional Offices of 9, 10, 11, 12, Caraga and ARMM, the IPHOs of Maguindanao and Lanao del Sur. The Chief(s) of Hospitals and their respective Ob-Gyne departments, and the clients, as stakeholders.
Implementing agency(ies) (PPIUD)	The DOH-Regional Offices, the DOH-retained facilities and privately-owned Brokenshire Hospital with respective Obstetrics and Gynecology departments, the health personnel within the health facilities, MCHIP and MindanaoHealth/Jhpiego have jointly contributed to the success as a continuum the moment a woman visited and registered in these health facilties as potential client from the community.
Implementing agency(ies) (PSI)	The DOH, privately-owned hospital with respective Ob-Gyne departments, health personnel, UNFPA, FP Consortium with UP-PCH, Fabella, MCHIP and MindanaoHealth/Jhpiego have jointly contributed to the success the skills of the HSPs and trainers on LARC-PSI.
Existing PPFP Program 2:	Delivery of PPFP Services Postpartum Female Voluntary Surgical Sterilization-Bilateral Tubal Ligation Under Local Anesthesia (BTL-MLLA) Enhancing PPFP Services Availability and Utilization
Activity 1:	Revitalizing FP services in hospitals including Fixed and Ambulatory BTL-MLLA services
Timeframe	current
Evidence of success	Post-partum BTL MLLA availability and accessability in regional, provincial/city, municpal and district hospitals across the country
Total cost over timeframe	

Has this activity been scaled? Why or why not?	**Yes through conduct of BTL-MLLA training for service providers from provincial and district hospitals and by the inclusion of the PPFP/PPBTL coverage in the National Health Insurance Program accreditation of PPIUD services to subsidise service provision**
Key stakeholders	**DOH regional and local facilities**
Implementing agency(ies)	**DOH retained hospitals,provincial, municipal and dictrict hospitals with trained BTL MLLA providers , LuzonHealth**
Activity 2:	**Provision of PPFP/PPIUD Services in DOH-retained health facilities, LGU and private health facilities**
Timeframe	**2012-2015 MH; June 2013 - March 2015 VH**
Evidence of success	**As of April 2015 report, a partial total of 2,510 women have been served for PPFP/PPIUD in DOH retained and LGU -facilities in Mindanao, and a total of 4,052 clients served in the Visayas**
Total cost over timeframe	
Has this activity been scaled? Why or why not?	**Yes. The PPFP/PPIUD and the LARC/PSI capacity enhancement that started in 2012 and in Oct 2013, respectively for the two methods, has been introduced to the other regions of Zamboanga, Northern Mindanao, SOCCSKSARGEN, Caraga and ARMM in providing access and menu of options to more women who have been visiting and delivering in these health facilities.** **Partly, because more clients have been benefitted but the health care providers need to reach out to more interested women.** **Yes. From the 2 clients recorded in Sept 2013, the TOT and introduction to SCPH, the GSCH and 60 other LGU-owned SDPs that have been providing access to more than 1,554 client-women who have been delivering in LGU-owned health facilities.**
Key stakeholders	**The DOH top leaders and DOH-Regional Offices of Zamboanga Peninsula (9), Northern Mindanao (10), Davao Region (11), SOCCSKSARGEN region (12) and later, the CARAGA Region (13), ARMM. All the above-mentioned Chief of Hospitals and their respective Obstetrics and Gynecology departments and the clients, as stakeholders, have contributed to the success in Mindanao.** **VisayasHealth, DOH RO 6, 7, 8- Local governments in 8 Provinces (Region 6-Iloilo and Negros Occ; Region 7- Cbu, Bohol and Tri-Cities; Region 8- Northern Samar, Samar, Leyte and South Leyte)** **DOH statelite office for Mindanao and the DOH-Regional Offices 9,10, 11, 12 and 13, Hospital Chiefs and respective Ob-Gyne departments, as stakeholders, have contributed to the success in Mindanao.**
Implementing agency(ies)	**The DOH-Regional Offices and retained facilities and private-owners, managers, health personnel, MCHIP and MindanaoHealth/Jhpiego.** **VisayasHealth, DOH RO 6, 7, 8- Local governments in 8 Provinces (Region 6-Iloilo and Negros Occ; Region 7- Cbu, Bohol and Tri-Cities; Region 8- Northern Samar, Samar, Leyte and South Leyte)** **The DOH-Regional Offices and retained facilities, the Provincial/City/Municipal Officials and private-owners, managers, health personnel, MCHIP and MindanaoHealth/Jhpiego.**

Indicator(s):	No. of Health Service Providers (HSPs) trained on PPFP/PPIUD; No. of HSP-trainees underwent supportive supervision; No. of Service Delivery Points (SDPs) with fixed PPFP/PPIUD providers; No. of women provided with PPFP Counseling and PPIUD Services from MindanaoHealth database # of DOH RO certified proficient midwives No. of Health Service Providers (HSPs) trained on PPFP/PPIUD; No. of HSP-trainees underwent supportive supervision; No. of Service Delivery Points (SDPs) with fixed PPFP/PPIUD providers; No. of women provided with PPFP Counseling and PPIUD Services from MindanaoHealth database
(Data Source):	DOH RO records/IMAP records (copy)
Activity 3:	Mentoring and Monitoring for Midwives - Post Partum Care (with provision of FP Info) / IUD Insertion and Removal
Timeframe	2012-2015
Evidence of success	ongoing
Total cost over timeframe	
Has this activity been scaled? Why or why not?	no
Key stakeholders	DOH, LGUs, local midwives association, APSOM Association of Philippine schools of Midwifery
Implementing agency(ies)	IMAP, DOH national and regional Strengthening the Local Government Unit (LGU)-owned Facilities on PPFP Service Provision Facilitate the provision of PPFP/PPIUD services in the DOH-retained Health Faciltiies Facilitate the provision of PPFP/PPIUD services in LGU-owned health faciltiies Conduct training of health service providers in privately-owned clinics and health facilities Strengthening Selected Privately-owned Facilities on PPFP/PPIUD Service Provision Facilitate the provision of PPFP/PPIUD services in privately-owned health faciltiies as Clinical Practice Sites
Indicator(s) (Data Source):	
Existing PPFP Program 3:	Systems/policies/enabling environment for PPFP
Activity 1:	National Health Insurance Program in the accreditation of PPIUD services to subsidise service provision
Timeframe	There is a current national initiative to include PPIUD in the Philhealth reimbursement scheme.

Evidence of success	**On going initiatives at the national levels**
Total cost over timeframe	
Has this activity been scaled? Why or why not?	
Key stakeholders	**DOH**
Implementing agency(ies)	**DOH, NHIP**
Indicator(s):	**# of COEs?**
(Data Source):	**what will certify a COE?**
Activity 2:	**Issuance of the Family Planning in Hospitals (Administrative order)**
Timeframe	
Evidence of success	**A number of hospitals are being prepared to be able to promote and provide PPFP services**
Total cost over timeframe	
Has this activity been scaled? Why or why not?	**Not yet since this is still at the stage of dissemination to field partners and preparation of hospitals**
Key stakeholders	**All health service providers of Family Planning**
Implementing agency(ies)	**Department of Health National and Regional levels**
Activity 3:	**Development of Guidelines on FP Outreach Services**
Timeframe	
Evidence of success	
Total cost over timeframe	
Has this activity been scaled? Why or why not?	**The itinerant team were organized by the Department of Health to support outreach services reaching hard to reach and geographically isolated and disadvantaged areas**
Key stakeholders	**Regional Hospitals, Local Government Units, Community based service providers**

Implementing agency(ies)	**Regional Hospitals (Government)**
Indicator(s) (Data Source):	
Activity 4:	**Developing implementing guidelines for selected alternative BTL MLLA birthing facility sites (e.g. birthing facilities or lying-in)**
Timeframe	**2016**
Evidence of success	**None yet since the current initiative is still at the planning stage**
Total cost over timeframe	
Has this activity been scaled? Why or why not?	**N/A**
Key stakeholders	**regional and local birthing facilities**
Implementing agency(ies)	**DOH Regional and local facilites**
Indicator(s) (Data Source):	
Activity 5:	**Development of the 2014 Updated Family Planning Clinical Standards Manual and the PPFP Manuals**
Timeframe	
Evidence of success	
Total cost over timeframe	
Has this activity been scaled? Why or why not?	
Key stakeholders	
Implementing agency(ies)	
Indicator(s) (Data Source):	

USAID FROM THE AMERICAN PEOPLE — Maternal and Child Survival Program

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PPFP Country Programming Strategies Worksheet

Country:	Philippines	Country Coordinator:	

V. Health Systems "SWOT" Analysis

The structure of a country's health system greatly affects whether PPFP programs succeed, particularly as implementation moves to scale. Use the table below to conduct a Strengths, Weaknesses, Opportunities, Threats (SWOT) analysis of each of the existing PPFP programs in sheet III. Existing PPFP Programs. List the internal strengths and weaknesses and the external opportunities and threats of each program from each health system dimension. For guiding questions, consult Section 2.2 in Chapter 2 of *Programming Strategies for Postpartum Family Planning* .

Existing PPFP Program 1:	**Existing PPFP Program 1 Establishing and Strengthening Institutions for PPFP services including COEs (Centers of Excellence), public and private providers and facilities**

	Health System Dimension	**Strenths**	**Weaknesses**	**Opportunities**	**Threats**
1	Health Services				
	a. Public sector	Strong cooperation among COE providers and managers on PPFP/PPIUD; Several DOH-retained health facilities (4) and at least one privately-owned HFs developed into COEs PPFP/PPIUD	Need for broader and pro-active participation among few COEs (e.g., CRMC, CRH); Need to develop more localized policies in some COEs to sustain interventions	Still high unmet need--women, couples who visit and for women/young girls who deliver in COEs;	Recent termporary restraining order (TRO) prohibits DOH and agents from administering Implanon/NXT. Some are overinterpreting the TRO and stopping provision of other FP methods
				The RPRH Law still has to be fully implemented	
		Financial and other resources (including teaching materials, aids and anatomical models for COEs) to implement activities to impact public health outcomes; Wide coverage for service provision	Administrative processes may hamper activities	Available government (DOH) resources esp. for COE operations.	
		Sets policies and gives strategic direction of the program; regulates private sector; stewards of public health		Public-private partnerships wherein public sector drives and leads the collaboration while the private responds to opportunities for collaboration	
	b. Faith-based/non-governmental organization (NGO)	Efforts are ongoing to engage NGOs in FP programs; NGOs (e.g. IMAP) exist that are (a) ensuring that providers (e.g. midwives) are capable of providing quality FP/ MNCHN services to clients; (b) developing good working relationship with public partners both at the national and local levels; (c) working to improve the capacities of their local chapters e.g. IMAP, FPOP, Likhaan	Need for earlier LTAP engagement	Government and donor policies and priorities on CSO/NGO involvement	Reluctance of NGOs to improve recording and reporting of high "drop-outs" on LAM and other methods;
			Limited resources	Provides technical assistance in improving the collaboration between public and private sector	Presence of anti-RH NGOs in key cities of Davao, CDO City

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
1	c. Private sector	With convergence on AY-Friendly Providers, a model private (Brokenshire) facility has been slowly emerging as good practice	Few candidates of privately-owned COEs or Clinical Practice Sites were tapped	Growing appreciation with a working knowledge on PPFP with BTL procedures and post-CS services with FP integration.	Acceptability among (by and of) potential privately-owned-COEs or Clinical Practice Sites
		Private sector midwives can easily respond, adapt and implement activities without any administrative impediment	Need process documentation (or Operations Research) for sharing	Brokenshire Hospital is taking concrete steps on COE pathway	
		Private sector midwives have a good relationship with the public sector in many places	Mostly situated at the urban areas and limited presence in GIDA areas	Public-private partnership wherein private sector can complement public sector efforts	
2	Health management information system (HMIS)	Ongoing efforts to develop a tracking tool and enhance the database	Not all data entries are entered on agreed timelines. Not all staff have the working knowledge of developing a database with partners	HIS Opportunities: acceptance to the efforts to develop a tracking tool and enhance the database with corresponding requests for its installation; HIS Threats: Not all DOH-Regional Offices have accepted the proposal. Some program managers feel threatened of "possible revision/ modification" of their existing database.	
3	Health workforce	Readiness to be DOH licensed or PhilHealth certified as PPFP/PPIUD providers	Non-availability of COE or facility-based trainers or mentors to do supportive supervision to address those who have not performed yet	Development of PPP approaches in a service delivery network (SDN)	Addressing those who have not performed and their willingness to do more
4	Medicines and technology	Available LARC-PPIUD, PSI units, long/short-acting methods for PPFP	Fragmented approaches on FP/RH programming	WHO-MEC re-classification of LARC/PSI	Difficulties of IUD and other methods to be certifiied by FDA as "non-abortifacient"
5	Health financing	Increasing number of PhilHealth accredited facilities	Not all facilities have experienced setting up a Trust Fund	Clearer coverage for PhilHealth reimbursement of PPFP/PPIUD services and soon on LARC/PSI, etc.	Not all facilities have existing separate Trust Fund for FP/RH or MNCHN

#	Health System Dimension	Strenths	Weaknesses	Opportunities	Threats
6	Leadership and governance			The presence of incumbent SOH and RIT members	Continuity or prioritization of FP/RH by the next set of leadership?
7	Community and sociocultural				
	a. Community-based	Presence of Usapan series modules and technology	Need to strengthen tracking of pregnant women/young girls or couples from ANC to IP and PP period	DOH promotion to broaden community-to-house approaches on RPRH Law	Difficulties for the IUD method to be accepted among Muslim Women.
	b. Mobile outreach	Ongoing effort to introduce mMentoring on PPFP/PPIUD	Few areas on mMentoring have been covered so far	DOH resources to scale up innovations	Changes in priorities
	b. Mobile outreach				
	c. Social marketing			DOH, with its resources, will soon launch series of advocacy campaign	Prevailing myths and misconceptions and reinforced by the anti-RH group

Existing PPFP Program 2:	Existing PPFP Program 2 Expanding availability and access (in public and private facilities and in communities) to PPFP services (IUD, PSI, BTL)

Health System Dimension	Strenths	Weaknesses	Opportunities	Threats

Health System Dimension			Strenths	Weaknesses	Opportunities	Threats
I	Health Services					
	a. Public sector		Strong cooperation among COE, DOH, LGU, private sector on PPFP; (a) LGU providers on PPFP thru PPIUD and LARC-PSI integration; more than 64 LGU-owned facilities tapped as providers or PPFP/PPIUD	Need to develop more appropriate localized policies to sustain interventions; Need for broader and pro-active participation among LGU-owned as well as privately-owned facilities as Clinical Practice Sites;	Still high unmet need among women, couples who visit and for women/young girls who deliver in COEs; Current/exisiting issues and concerns to be resolved on low CPR and high maternal mortality The RPRH Law has still to be fully implemented	2016 Elections may see new local chief executives who are not only unsupportive but oppose FP/PPFP
			Standardize training modules and materials and integration of FP during ANC visits; Available teaching materials, aids and anatomical models in COEs	Limited capacity for demand generation in medical centers and regional hospitals; Weak post training monitoring and evaluation;	Streamlined/simplified DOH certification process for health service providers; Available government (DOH and PhilHealth), LGU and private sector resources to leverage for PPFP operations; Improving remuneration for providing training (e.g., tuition fee, honoraria)s	Funding for service provision is dependent on LCEs priorities and interest; uneven political support, unstable interest to improving maternal health including PPFP services
	a. Public sector		Presence of high volume accredited facilities in terms of deliveries; DOH retained hospitals scaled up as training institutions for BTL; Trainers and training center on PPIUD are in-place in each province	Logistics is dependent on government fund availability; Health human resource is limited; Skills on Counseling and Advocacy need to be improved; Physicians not fully motivated	strong influences on policies; National and Regional DOH policy support;	varying local government policies on dual practice, `double compensation' etc.
	b. Faith-based/NGO		Efforts to engage CSOs/NGOs and academe as local technical assistance providers are ongoing	Need to earlier engage or fast-track andscale-up engagement of NGOs/CSOs	DOH and donor thrust to tap CSOs/ NGOs for MNCHN/FP, esp. for interpersonal counseling and communication/demand generation;	Willingness of NGOs to report on high "drop-outs" on LAM and other methods.
			Can form as a large group of people that can serve as influence/advocacy	persistent misconceptions on FP (e.g. IUD as an abortifacient; side effects of other methods)	Willingness of CSOs, NGOs or privately-owned facilities to report "drop-outs" on LAM and other methods;	Presence of anti-RH NGOs in key cities of Davao, CDO City
			community based with skills in community organization	Limited resources to carry out advocacy and demand generation activities	NGOs interest for recognition and ROI	Leadership ?

	Health System Dimension	Strenths	Weaknesses	Opportunities	Threats
1	c. Private sector	With convergent approaches on AY-Friendly Providers, a model private (Brokenshire) facliity has been slowly emerging as good practice	Few candidates for COEs or Clinical Practice Sites were tapped; DOH does not consider private sector a high priority for training; Entrepreneurship/Profit sometimes prioritized over service orientation	Growing appreciation, knowledge and interest on PPFP (e.g. from bilateral tubal ligation procedures, post-CS services) among private partners with FP integration. Private hospital (Brokenshire) taking concrete steps on taking COE pathway	Acceptability among potential privately-owned-COEs or Clinical Practice Sites
		Strong interest, organized and structured system, and entrepreneurship of private sector providers; There are many accredited birthing centers with high volume of deliveries; More than 15 private providers were tapped for PPFP/PPIUD	Need process documentation (or Operations Research) for sharing; Undeveloped mechanism for public private partnership on PPFP	Simplification of certification for health service providers by DOH; Inclusion of PPIUD in PhilHealth benefits; NGO/ private sector interest for recognition and ROI (return on investment)	Public sector dominance in capability building and government funding; Imposition of public regulation and control on privte sector processes- recording and reporting, NBB
		Accreditation as a training institution	No other accredited training institution on PPIUD	Develop appropriate approaches and mechanism to strengthen PPP; Existing established organizations with strong collaboration with government;	2016 Elections
2	HMIS	Some DOH and donor project staff with knowledge and skills on Data Quality Checking (DQC)	Not all LGUs have been infuenced on good data tracking	Change leadership in DOH with Data Quality Checking (DQC) priorities;	Change leadership in DOH with Data Quality Checking (DQC) priorities;
		Ongoing efforts to develop a tracking tool and enhance the database	Not all data entries are entered on agreed timelines. Or staff have the working knowledge on database with partners	Models on HMIS reporting from private sector	Models on HMIS reporting from private sector
		Availability of present HMIS (i.e. FHSIS)	FHSIS is often incomplete, delayed in submission, and does not capture the private sector information	Introduction of electronic medical records for reporting (e.g., wireless access for health, e-clinicsys)	Introduction of electronic medical records for reporting (e.g., wireless access for health, e-clinicsys)
3	Health workforce	Readiness to be DOH licensed or PhilHealth certified as PPFP/PPIUD providers	Non-availability of COE or facility-based trainers or mentors to do supportive supervision to assist those who have not performed PPFP yet	Development of PPP approaches in a service delivery network (SDN), province-wide w/ DOH resources	Addressing local trained providers who have not performed and their willingness to do more
		Can form as a large group of people that can serve in service delivery and advocacy	Rapid turnover and delayed filling-up of vacant positions; lack of institutional memory at DOH-CO level due to streamlining and rationalization; No permanent staff- contractual and OJT position		Addressing local trained providers who have not performed and their willingness to do more

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
3	Health workforce	Presence of workforce interested in PPFP		Commitment of health personnel; Build their capacity to provide quality services	Political influence of the LCEs to shuffle positions of health workers
4	Medicines and technology	Increasing availability and acceptance on LARC such as PSI and other permanent methods		WHO-MEC re-classification of LARC/PSI; FDA approval on LARC/PSI	Difficulties of IUD and other methods to be certifiied by FDA as "non-abortifacient"
		Increased DOH budget for procurement of medicines and commodities	Inefficient logistics management system	Strengthening of existing systems that have been deployed (NOSIRS, SMRS); DOH formed TWG to resolve issues related to Logistics management	DOH Central has no specific office to manage logistics issues and concerns
		DOH retained hospitals scaled up as training institutions for BTL	Difficulty in procurement of narcotic analgesics used for procedures	Development of a system in working with related government agancies for availabiltiy of narcotics	Present government policies
5	Health financing	Increasing number of PhilHealth accredited facilities	Not all facilities have experienced setting up a Trust Fund	Clearer coverage for PhilHealth reimbursement of PPFP/PPIUD services and soon on LARC/PSI, etc.	Not all facilities have existing separate Trust Fund for FP/RH or MNCHN
		Exisitng policy/program on NHIP (Philhealth) Universal Health Coverage	Need to model a privately-owned "Trust Fund"	Clearer coverage for PhilHealth reimbursement of PPFP/PPIUD services and soon on LARC/PSI, etc.	Unclear guidelines on use of "Trust Fund" among private providers for FP/RH or MNCHN
		NHIP (Philhealth) Universal Health Coverage	The system for processing in accreditation, utilization, reimbursement are inefficient	Advocacy for reimbursement of services included in PPFP program	Lack of guidelines in distribution of reimbursement (LCEs take full reimbursements)
6	Leadership and governance	Supportive local chief executives	Lacking knowledge on PPFP among LCEs Provision on spousal consent	The presence of LGU Champions (identified thru HLGP) and support of incumbent SOH and RIT members	Continuity or prioritization of FP/RH by the next set of leadership?

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
6	Leadership and governance	The inclusion of PPFP Program supported by the national leadership of DOH in RPRH Law		Support of incumbent SOH and RIT members and ongoing cooperation with LGUs	Continuity or prioritization of FP/RH by the next set of leadership?
		Determine/formulate policies and regulations	Lacking knowledge on PPFP among LCEs	National support to RPRH Law and IRR	Misinterpretation of the law
7	Community and Sociocultural				
	a. Community-based	Presence of Usapan series modules and technology	Need to strengthen tracking of pregnant womed/young girls or couples from ANC to IP and PP period	Adoption of Usapan Series as LGU-owned and privately-owned technology	Modification of tracking tools (incl for private sector) leading to more confusion;
		Usapan series modules and technology that could be shared to private providers	Need to track and counsel PPFP women who chose on LAM	Mobilzation in providing information, referrals, profiling of clients Identification of unmet needs	Difficulties for the IUD method to be accepted among Muslim Women.
		Extensive network of CHTs/BHWs for community mobilization Presence of community-based organization	Voluntary nature of CHTs services without compensation		Requires lot of resources - training, transpo, others
	b. Mobile outreach	Ongoing effort to introduce mMentoring on PPFP/PPIUD could also be used by private sector	Variance in local support of LCEs Limited capacity to provide outreach services	There is existing unmet demand for services for LAPM (outreach)	Absence of local policy to sustain outreach services Varying degree of local support for outreach services
		Realization of local health managers on the importance of outreach services thorugh the evidences of success	Few areas on mMentoring have been covered	Providing TAs in developing itinerant teams for outreach activities	Faith-based group against FP service provision
				DOH and LGU resources to scale up innovations	Changes in priorities
	c. Social marketing	Existing NGOs/Foundations providing/conducting social marketing activities for FP (Zuellig Foundation)	Limited activities for social awareness and recognition	DOH, combined with LGU and private counterpart resources could strengthen series of pro-RH advocacy campaign	Although minimal impact locally, the prevailing myths and misconceptions need to be addressed with appropriate interpersonal communication (IPC)
		NGOs/Foundations providing/conducting social marketing activities for FP (Zuellig Foundation)	Limited activities for social awareness and recognition	Operational research	Faith-based group against FP service provision

Existing PPFP Program 3:	Strengthening enabling environment for PPFP service provision

Health System Dimension	Strenths	Weaknesses	Opportunities	Threats

	Health System Dimension	Strenths	Weaknesses	Opportunities	Threats
1	Health Services				
	a. Public sector	Health services in the public sector are being run by Local government units in a devolved setting	Inadequacies in the availability of trained and certified health service providers due to weakness in the training system	opportunities to build partnerships with potential private sector institutions as training partners	Slow certification of trained providers may lead to furthr lack of interest among newly trained providers
		Issuance of AO on installing FP in hospitals	Slow implementation of this AO due to lack of appropriate dissemination and advocacy	Assistance of development partners in training and setting up of FP proframs in hospitals	
		Provision of PHIC of professional fees to providers as second case	Mechanism of payment for providers are unclear	Plan to include hospitals in providing FP commodities by DOH	Requirement of new RPRH Law for written consent of spouse
	b. Faith-based/NGO	There are existing NGOs that offer direct services	Faith based groups are yet to be explored in this area	partnership between government and faith based organizations/ NGOs can be explored to expand availability of PPFP services	
	c. Private sector	there are quite a number of private sector groups offering PPFP services	There is a need to tap their participation through engagement with the public sector		
		The Department of Health has issued administrative order to support public and private sector partnership in the provision of FP services	The order has yet to be strengthened in the implementation field		
2	HMIS	There is an existing Field Health Service Information System that integrates the Family Planning Program in general	Given the current health system which is working in a devolved setting, getting information from the field remains to be a very big challenge	Perhaps the current system should explore the possibility of setting up the system at the regional level (Regional Health Offices) which is more closer to the service delivery points	
3	Health workforce	inadequacies in the availability of trained service providers	there is no registry of accredited providers who can be tapped to provide service		

	Health System Dimension	Strenths	Weaknesses	Opportunities	Threats
4	Medicines and technology	technology has been set and standardized	controversy on the use and avaiability of sedatives for use in outreach or hospital settings without anesthesioloogists	Some teaching//training hospitals include PPFP in the residency programs	Guidelines on PPFP in training hospitals should be standardized as training centers use different procedures like regional or GA which is different from PH practice
5	Health financing	There is an existing National Health Insurance Program thru PhilHealth that provides financial protection to clients for FP service utilization		Provision oof PPFP methods are considered second cases pf PHIC hence entitled to compensation apart from delivery	
6	Leadership and governance	The Philippine government has recently passed the RPRH Law which supports FP Program implemnentation nationwide	The law has just recently been passed an would need to be disseminated to the field implementers		Some provisions of the law may not be favorable and therefore need to be clarified to providers and clients
7	Community and Sociocultural				
	a. Community-based	There are existing community based activities that assists families who have unmet MFP needs thru community health volunteers	There is a need to strenthen support for the community volunteers who will be tapped in the program to continue their work with families and referring them to appropriate health service providers	Currently the CHTs assist in encouraging clients to seek FP services in health facilities	Talks of impending plans to take out CHTs in the FP program
	b. Mobile outreach	Itinerant teams have been organized in the Dept of Health Retained Hospitals and Medical centers		Outreach services are performed in hospitals which may provide opportunities for hospital staff to learn the procedures	Instead of upgrading services whereby surgical procedures are only done in accredited health facilities, there are moves to do BTL in RHUs which may not have the dedicated space and facilities needed
	c. Social marketing	With the benefit packages newly introduced by PHIC, social marketing may be possible since out of pocket expense may be almost nil			