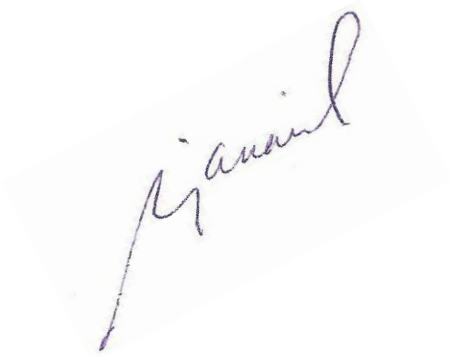
Department of Health

# MNCHN Strategy

# Manual of Operations



**The MNCHN Manual of Operations 2011**

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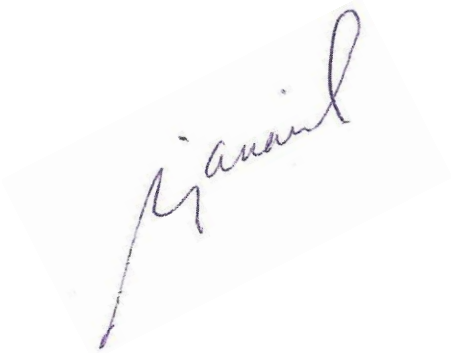

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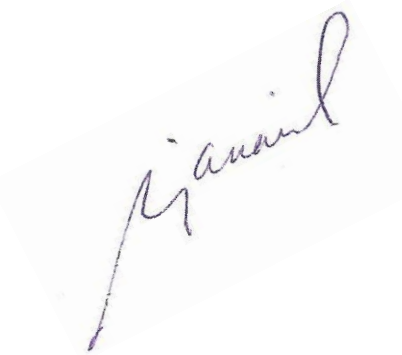

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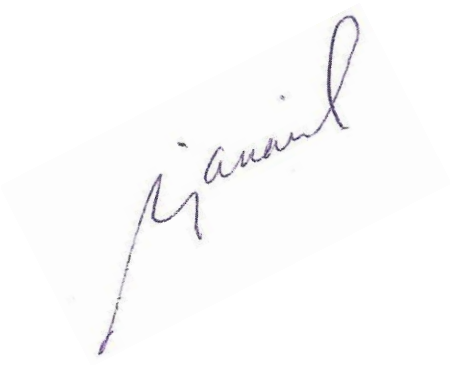


# Foreword

The slowing down of the rate of decline in maternal and child mortality in the Philippines places the country at risk of missing its Millennium Development Goal targets of reducing maternal and child mortality. To ensure rapid reduction of maternal and child mortality, the Department of Health (DOH) issued Administrative Order 2008-0029 entitled: "Implementing Health Reforms for the Rapid Reduction of Maternal and Neonatal Mortality".

This Manual of Operations (MOP) for the MNCHN strategy is intended to guide Local Government Units (LGUs) in designing approaches to deliver MNCHN services especially to populations that are most at risk from maternal and child deaths. In recognition of the differences in local conditions and constraints, the LGU should design the implementation of the MNCHN strategy based on their local context.

The MOP provides for the steps in identifying at risk and priority populations in a given locality, the service packages essential to addressing the MNCHN needs of the target population, the steps in establishing a functional MNCHN service delivery network, the steps to ensure quality of care in delivering MNCHN services, the various financing options to sustain implementation of the strategy, the mechanisms by which to monitor and evaluate performance and the roles of the DOH central office units, the CHDs, LGUs and other partners in implementing the strategy.

Being addressed to provincial, municipal and city health officers, program managers and other implementers of the MNCHN program, the MOP also serves as a roadmap in navigating through the various technical guidelines and tools produced by the DOH and its partners for the implementation of the MNCHN strategy.

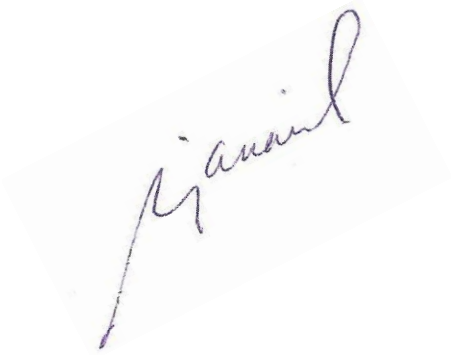
The DOH commits to supporting the implementation of the MNCHN strategy in various local government units in the country by providing the technical standards and guidelines for its implementation. The DOH, through its CHDs will also provide technical assistance to LGUs and other partners in adopting the MNCHN strategy in the context of local health systems development. Lastly, the DOH will also mobilize and coordinate resources to help LGUs and partners to finance the implementation of the strategy and linking this with the implementation of local investment plans for health.

Together let us save the lives of Filipino mothers and children.

**ENRIQUE T. ONA, MD, FPCS, FACS**
Secretary of Health

# List of Acronyms

| | |
|---|---|
| ANC | Antenatal care |
| AOP | Annual Operations Plan |
| ARMM | Autonomous Region for Muslim Mindanao |
| BCC | Behavioural Change Communications |
| BEmONC | Basic Emergency Obstetric and Newborn Care |
| BHS | Barangay Health Station |
| BTL | Bilateral tubal ligation |
| CEmONC | Comprehensive Emergency Obstetric and Newborn Care |
| CHD | Centers for Health Development |
| CHO | City Health Officer |
| CHT | Community Health Team |
| CPR | Contraceptive prevalence rate |
| CIPH | City-wide Investment Plan for Health |
| CSR | Contraceptive Self-Reliance Plan |
| EPI | Expanded program on immunization |
| ENC | Essential Newborn Care |
| FBD | Facility-Based Delivery |
| FIC | Fully-Immunized Children |
| FP | Family Planning |
| GIDA | Geographically Isolated and Disadvantaged Areas |
| IEC | Information, education, communication |
| ILHZ | Inter-local health zones |
| IMCI | Integrated Management of Childhood Illnesses |
| IMR | Infant Mortality Rate |
| IUD | Intrauterine device |
| LAM | Lactation Amenorrhea Method |
| LGU | Local Government Unit |
| MMR | Maternal Mortality Ratio |
| MDFO | Municipal Development Fund Office |
| MNCHN | Maternal, Newborn and Child Health and Nutrition |
| MOA | Memorandum of Agreement |
| MWRA | Married Women of Reproductive Age |
| NBS | Newborn Screening |
| NMR | Neonatal mortality rate |
| NSV | No-Scalpel Vasectomy |
| PhilHealth | Philippine Health Insurance Corporation |
| PHO | Provincial Health Officer |
| PIPH/CIPH | Province-Wide/City-Wide Investment Plan For Health |
| RHU | Rural Health Unit |
| SBA | Skilled Birth Attendants |
| SDM | Standard Days Method |
| TBA | Traditional Birth Attendants |
| UFMR | Under-Five Mortality Rate |
| VSC | Voluntary Surgical Contraception |



# Definition of Terms

**Antenatal care** coverage is an indicator of access and use of health care during pregnancy. It constitutes screening for health and socioeconomic conditions likely to increase the possibility of specific adverse pregnancy outcomes, providing therapeutic interventions known to be effective; and educating pregnant women about planning for safe birth, emergencies during pregnancy and how to deal with them (WHO; Indicator definitions and metadata 2008).

**Basic Emergency Obstetric and Newborn Care (BEmONC)-Capable** network of facilities and providers that can perform the following six signal obstetric functions: (1) parenteral administration of oxytocin in the third stage of labor; (2) parenteral administration of loading dose of anti-convulsants; (3) parenteral administration of initial dose of antibiotics; (4) performance of assisted deliveries (Imminent Breech Delivery); (5) removal of retained products of conception; and (6) manual removal of retained placenta. These facilities are also able to provide emergency newborn interventions, which include the minimum: (1) newborn resuscitation; (2) treatment of neonatal sepsis/infection; and (3) oxygen support. It shall also be capable of providing blood transfusion services on top of its standard functions.

**Community Health Team (CHT)** is composed of community health volunteers (e.g. Barangay Health Teams, Women's Health Teams and the like) led by a midwife that can provide community level care and services during the pre-pregnancy, pregnancy, delivery and post-partum period. One of the functions of CHTs is to improve utilization of services by women and their families by master listing pregnant women and women of reproductive age, assessing health risks of women and their families, assisting families in the preparation of health plans, provide information on available services, good health practices including financing options. Members of the CHT organize outreach services especially for remote areas and organize transportation and communication systems within the community. The CHTs shall also refer high risk pregnancies to appropriate providers, report maternal and neonatal deaths, follow-up of clients for family planning, nutrition and maternal and child care. The team shall also facilitate discussions of relevant community health issues, like those affecting women and children.

**Community level providers** refer primarily to Rural Health Units (RHUs), Barangay Health Stations (BHS), private outpatient clinics and its health staff (e.g. midwife) and volunteer health workers (e.g. barangay health workers, traditional birth attendants) that typically comprise the Community Health Team (CHT). This team implements the MNCHN Core Package of Services identified for the community level.

**Comprehensive Emergency Obstetric and NewbornCare (CEmONC)-Capable facility** or network of facilities that can perform the six signal obstetric functions for BEmONC, as well as provide caesarean delivery services, blood

banking and transfusion services, and other highly specialized obstetric interventions. It is also capable of providing neonatal emergency interventions, which include at the minimum, the following: (1) newborn resuscitation; (2) treatment of neonatal sepsis/infection; (3) oxygen support for neonates; (4) management of low birth weight or preterm newborn; and (5) other specialized newborn services. These facilities can also serve as high volume providers for IUD and VSC services, especially tubal ligations. It should also provide an itinerant team that will conduct out-reach services to remote communities. The itinerant team is typically composed of 1 physician (surgeon), 1 nurse and 1 midwife.

**Contraceptive Prevalence Rate** is the proportion of married women aged 15-49 reporting current use of a modern method of family planning, i.e. pill, IUD, injectables, bilateral tubal ligation, no scalpel vasectomy, male condom, mucus/Billings/ovulation, Standard Days Method (SDM), and Lactational Amenorrhea Method (LAM).

**Early initiation of breastfeeding** refers to initiating breastfeeding of the newborn after birth within 90 minutes of life in accordance to the essential newborn care protocol

**Facility-Based Deliveries (FBD)** is the proportion of deliveries in a health facility to the total number of deliveries.

**Fully Immunized Children (FIC)** is the ratio of children under 1 year of age who have been given BCG, 3 doses of DPT, 3 doses of Hepa B, 3 doses of OPV and measles vaccine to the total number of 0-11 months old children.

**Health Outcome Indicators** are parameters which reflect impact or outcomes. For MNCHN Strategy, the following health outcome indicators are monitored: maternal mortality ratio, neonatal mortality rate, infant mortality rate, and under-five mortality rate.

**Health systems gaps** refer to the absence or lack of instruments needed to support and sustain the provision and utilization of core MNCHN services. These instruments may include accreditation of health facilities and enrolment of population groups to PhilHealth, local budget for health, private and public partnership for health, procurement and logistics management system, inter-LGU arrangements, functional referral and feedback system.

**High volume providers** for IUD and VSC are RHUs (for IUDs) and hospitals (for IUDs and VSCs) and private clinics that have a sufficient case load to maintain a certain level of proficiency.

**Infant Mortality Rate** refers to the number of infants dying before reaching the age of one year per 1,000 live births in a given year. It represents an important component of under-five mortality rate.

**Maternal Mortality Ratio** refers to the number of women who die from any

cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, per 100,000 live births.

**MNCHN Core Package of Services** refer to a package of services for women, mothers and children covering the spectrum of (1) known appropriate clinical case management services including emergency obstetric and newborn care in preventing direct causes of maternal and neonatal deaths which are or will be within the capacity of the health system to routinely provide; and (2) known cost-effective public health measures capable of reducing exposure to and the severity of risks for maternal and newborn deaths that are routinely being provided by LGUs.

**MNCHN Service Delivery Network** refers to the network of facilities and providers within the province-wide or city-wide health system offering the MNCHN core package of services in an integrated and coordinated manner. It includes the communication and transportation system supporting this network. The following health providers are part of the MNCHN Service Delivery Network: community level providers, BEmONC-capable network of facilities and providers and CEmONC-capable facilities or network of facilities.

**Neonatal Mortality Rate** refers to the number of deaths within the first 28 days of life per 1000 live births in a given period.

**Province-wide or city-wide health system** refers to the default catchment area for delivering integrated MNCHN services. It is composed of public and private providers organized into systems such as inter-local health zones (ILHZ) or health districts for provinces and integrated urban health systems for highly-urbanized cities. Service arrangements with other LGUs may be considered if provision and use of MNCHN core package of services across provinces, municipalities and cities become necessary. Unless otherwise specified, LGUs refer to provinces or independent cities.

**Service Coverage Indicators** are parameters which reflect coverage or utilization of services. For MNCHN Strategy, the following indicators are monitored: contraceptive prevalence rate, antenatal care, facility-based deliveries, early initiation of breastfeeding, fully immunized children, and skilled-birth attendant / skilled health professional deliveries.

**Service utilization gaps** refer to the factors that prevent population groups from accessing and utilizing the MNCHN core package of services such as capacity to pay, availability of information, cultural preferences and distance from health facilities.

**Skilled health professionals** are providers such as midwives, doctors or nurses who were educated, licensed, and trained to proficiency in the skills needed to manage pregnancies, childbirth and the immediate newborn period, and in the identification, management and referral of complications in mothers

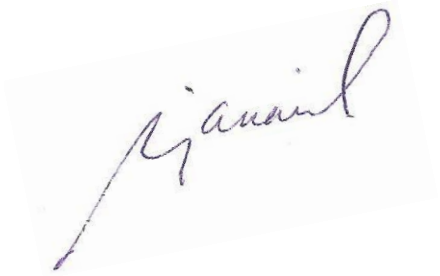
and newborns.

**Skilled-Birth Attendant (SBA)/ Skilled Health Professional Attended Deliveries** is the proportion of deliveries attended by skilled health professionals to the total number of deliveries.

**Traditional birth attendants** are independent, non-formally trained and community-based providers of care during pregnancy, childbirth, and neonatal period. Under the MNCHN Strategy, they are made part of the formal health system as members of the Community Health Teams and serve as advocates of skilled health professional care.

**Under-five Mortality Rate** is the probability (expressed as a rate per 1,000 live births) of a child born in a specified year dying before reaching the age of five if subject to current age-specific mortality rate.

**Unmet need for modern family planning** is the number or rate of all women of reproductive age who want to stop having children or to postpone the next pregnancy for at least three years but are not using modern contraceptive methods.



# Introduction

## Part I

# Chapter 1. What is the MNCHN MOP?

The rate of decline in maternal and newborn mortality has decelerated in the past decades to a point where Philippine commitments to the Millennium Development Goals (MDGs) may not be achieved. In response, the Department of Health (DOH) issued Administrative Order 2008-0029 "Implementing Health Reforms for Rapid Reduction of Maternal and Neonatal Mortality". This policy issuance provides the strategy for rapidly reducing maternal and neonatal deaths through the provision of a package of maternal, newborn, child health and nutrition (MNCHN) services. The goal of rapidly reducing maternal and neonatal mortality shall be achieved through effective population-wide provision and use of integrated MNCHN services as appropriate to any locality in the country. The strategy aims to achieve the following intermediate results:

1. Every pregnancy is wanted, planned and supported;
2. Every pregnancy is adequately managed throughout its course;
3. Every delivery is facility-based and managed by skilled birth attendants/skilled health professionals; and
4. Every mother and newborn pair secures proper post-partum and newborn care with smooth transitions to the women's health care package for the mother and child survival package for the newborn.

This Manual of Operations (MOP) is an updated version of the MOP issued through Department Memorandum 2009-0110 dated May 10, 2009 "Implementing Health Reforms towards Rapid Reduction in Maternal and Neonatal Mortality". This is also in accordance with Administrative Order 2009-0025 known as Adopting New Policies and Protocol on Essential Newborn Care, Administrative Order 2010-0001 known as Policies and Guidelines for the Philippine National Blood Services (PNBS) and the Philippine Blood Services Network (PBSN), Administrative Order 2010-0010, and Administrative Order 2010-0014 known as Administration of Life Saving Drugs and Medicines by Midwives to Rapidly Reduce Maternal and Neonatal Morbidity and Mortality. It aims to guide LGUs as well as national agencies in the implementation of AO 2008-0029 also known as the MNCHN Strategy.

## 1.1. What are the objectives and scope of the MOP?

The Manual of Operations (MOP) for the Rapid Reduction of Maternal and Neonatal Mortality aims to guide and support efforts for an LGU-wide implementation of the MNCHN Strategy. The MOP provides a set of instructions for ensuring the provision of the core package of MNCHN services being provided by a service delivery network and supported by appropriate health systems

instruments. It defines the standard package of services that should be delivered for each life event as well as the standards for each type of facility such as appropriate infrastructure and equipment, adequate and capable staff, adequate logistics and supplies, available source of safe blood supply as well as available transportation and communication systems. These standards shall be the bases of interventions that LGUs can propose and implement to improve delivery of MNCHN services in the localities.

While the MOP describes the standard package of services for each level of care, it does not contain specific clinical and treatment standards and procedures for services such as Family Planning, Essential Newborn Care (ENC), Active Management of the Third Stage of Labor (AMTSL), Micronutrient Supplementation, Expanded Program for Immunization (EPI) and other MNCHN services. The MOP also does not provide the specific steps to continuously improve the quality of care being delivered. The MOP does not also discuss the step by step process in logistics management, implementing a contraceptive self-reliance (CSR) strategy, PhilHealth enrolment for members of the community and accreditation of facilities, financial systems and the like. The MOP refers the reader to the specific guidelines, protocols and issuances pertaining to the preceding subjects whenever necessary. Some of these protocols, guidelines and issuances include the Clinical Practice Pocket Guide on Newborn Care until the First Week of Life, Manual of Operations for Micronutrient Supplementation, and the Philippine Clinical Standards Manual on Family Planning.

## 1.2. How is the MOP structured?

The MOP is organized into three major parts. It begins with the description of the overall process in implementing the integrated MNCHN Strategy. The second part deals with the detailed steps how the MNCHN strategy is to be implemented in each province or city. The last part deals with how the assistance and support from the DOH, its attached agencies and development partners are to be designed and channelled to support local implementation. If needed, checklists, worksheets and guidelines are annexed at the end of the MOP.

Part I. Introduction

This chapter describes the objectives and structure of the Manual of Operations. Chapter 2 provides an overview of the situation of women's and children's health, the past strategies implemented to improve their health outcomes and the MNCHN Strategy, goals, desired outcomes, approaches and guidelines as stipulated in Administrative Order 2008-0029.

Part II. LGU-Wide Implementation of the MNCHN Strategy

Part II guides the LGU in the process of establishing or reviewing the capability of health providers in the Service Delivery Network to provide the Core Package

of MNCHN Services as well as identifying the proper health systems instruments that would sustain provision of services. It is divided into 5 chapters which correspond to the different steps that LGUs have to go through to set-up or review delivery of MNCHN services. A chapter is devoted for the following topics: overview and preliminary activities (Chapter 3), identifying priority population groups (Chapter 4), determining the service delivery network and core package of services that should be provided (Chapter 5), strengthening the MNCHN service delivery network (Chapter 6), improving local health systems (Chapter 7) and implementation and monitoring of the MNCHN Strategy (Chapter 8). Whenever applicable implementing the MNCHN Strategy in special areas like Geographically Isolated and Disadvantaged Areas (GIDA), conflict affected areas and areas with unique cultural attributes like indigenous people's communities and the Autonomous Region in Muslim Mindanao (ARMM) shall be mentioned.

When possible, examples of interventions done by other LGUs on MNCHN are included in the text.

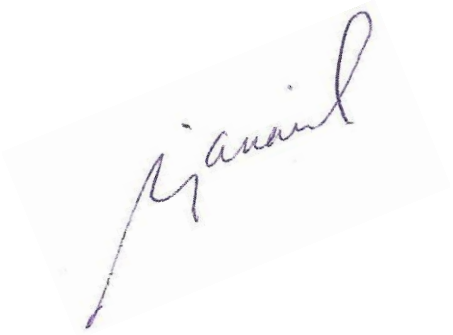
Part III. Implementation Arrangements for National Agencies

To show support of national agencies in the implementation of the MNCHN Strategy, this part outlines the roles of the Department of Health (DOH) and the Philippine Health Insurance Corporation (PhilHealth) to support LGUs in implementing the MNCHN Strategy (Chapter 9). The last chapter (Chapter 10) discusses the monitoring framework and process for DOH.

## 1.3. Who are the primary users of the MOP?

This MOP is developed to guide local authorities (chief executives, health officers and staff) and other concerned stakeholders in implementing the MNCHN strategy. It aims to guide local officials, local health managers and other concerned groups and professionals to establish, implement and sustain a responsive MNCHN service delivery network in identified priority areas and population groups needing most assistance.

Although the DOH and PhilHealth are not the primary target users, the MOP shall be their guide in extending technical assistance and other support to LGUs in the implementation of the MNCHN Strategy.



# Chapter 2. MNCHN Strategy

## 2.1. Maternal, Newborn, and Child Health and Nutrition Situation in the Country

The Department of Health (DOH) is committed to achieve the Millennium Development Goals (MDGs) of reducing child mortality and improving maternal health by 2015. Although significant gains in maternal and child mortality have been realized in the past four decades, pregnancy and childbirth still pose the greatest risk to Filipino women of reproductive age, with 1:120 lifetime risk of dying from maternal causes.1 Maternal deaths account for 14percent of deaths among women of reproductive age. The Maternal Mortality Ratio (MMR) in the country remains high and decreased very slowly at 162/100,000 live births (LB) in 2006 from 209/100,000 LB in 1990.[2]

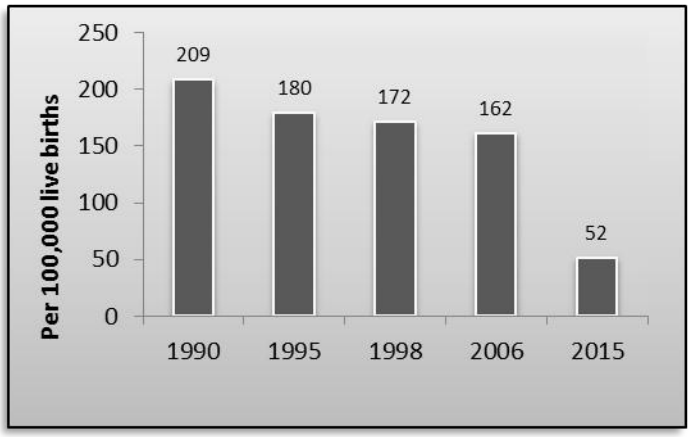



**Figure 1: Maternal Mortality Ratio, 1990-2015**

Although the Under-Five Mortality Rate (UFMR) and Infant Mortality Rate (IMR) have considerably declined (UFMR from 61/1,000 LB in 1990 to 32/1,000 LB in 2008; IMR 42percent in 1990 to 26percent in 2006)[3], the rates of decline have decelerated over the last ten years. The deceleration is driven largely by the high neonatal deaths and slow decline of infant deaths.[4] Neonatal Mortality Rate (NMR) is still high, with 17 infants dying per 1,000 LB within the first 28 days of life. In 2000-2003,

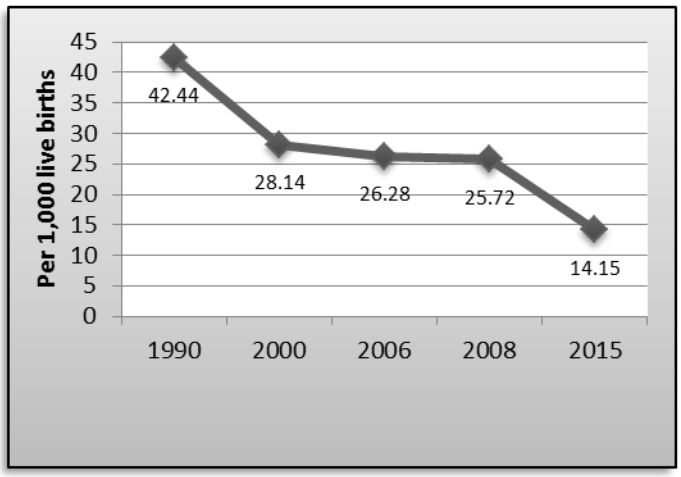



**Figure 2: Infant Mortality Rate 1990-2015**

[1]National Statistics Office, 2006 Family Planning Survey

[2]United Nations Development Program (UNDP) Philippines, Report on the Millennium Development Goals, 2007-2011

[3]UNICEF, WHO, World Bank, 2010, Level and Trends in Child Mortality Report

[4] WHO, 2006, Newborn and Perinatal Mortality: Country, Regional and Global Estimates

newborn deaths accounted for 37 percent of all Under-5 mortalities.[5]Most neonatal deaths occur within the first week after birth, half of which occur in the first two days of life.

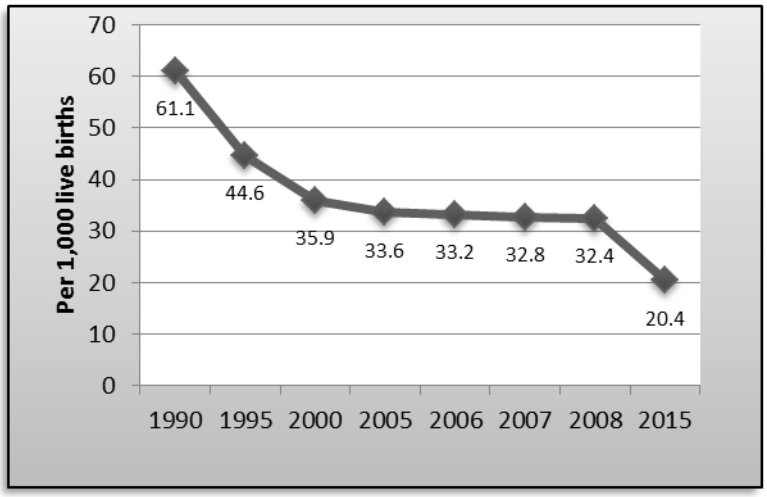



**Figure 3: Under-five Mortality Rate, 1990-2015**

With the slow decline in MMR for the past two decades and the loss of momentum in rate of decrease in newborn, infant, and child deaths, the Philippines is at risk of not attaining its MDG targets of lowering maternal deaths to 52/100,000 LB and child deaths to 20/1,000 LB in the next five years.

## 2.2. Factors Contributing to Maternal and Neonatal Deaths

Majority of maternal deaths directly result from pregnancy complications occurring during labor, delivery and the post-partum period. These complications include hypertension, post-partum hemorrhage, severe infections, and other medical problems arising from poor birth spacing, maternal malnutrition, unsafe abortions and presence of concurrent infections like TB, malaria and sexually transmitted infections as well as lifestyle diseases like diabetes and hypertension.

Neonatal deaths within the first week of life are often due to asphyxia, prematurity, severe infections, congenital anomalies, newborn tetanus, and other causes.

These direct causes of maternal and neonatal deaths require care by skilled health professionals in well-equipped facilities. However, 55 percent of births are delivered at home, of which 36 percent are attended to by TBAs or hilots.[6] This contributes to the three delays that lead to maternal and neonatal deaths such as delay in identification of complications, delay in referral, and delay in the management of complications. This could explain why TBAs, even if trained, has had little impact on reducing maternal and neonatal mortality.

The likelihood of maternal and neonatal deaths is further magnified with the critical accumulation of four risks such as (1) mistimed, unplanned, unwanted

[5] WHO, 2006, Newborn and Perinatal Mortality: Country, Regional and Global Estimates

[6]Health Policy Development Program (November 2010). *An Evaluation of Factors Affecting the Use of Modern Family Planning and Maternal Care Services.* Quezon City.

and unsupported pregnancy[7]; (2) not securing adequate care during the course of pregnancy; (3) delivering without being attended to by skilled health professionals (i.e. midwives, nurses and doctors) and lack of access to emergency obstetric and newborn services; and (4) not securing proper postpartum and newborn care for the mother and her newborn, respectively.

Prevention of maternal and neonatal morbidity and mortality entails the provision and use of the MNCHN core package of services. This will require informed decisions by mothers and their families and a health system that is responsive to their needs. However, informed decisions on utilization are prevented by low awareness and poor recognition of health risks, lack of information on available services and providers in the area, lack of options to finance health services due to poverty, lack of education, and staying in GIDA. On the other hand, responsiveness of the health system is limited by the insufficiency in scope, scale and quality of delivered health services; disparity between provided interventions and allocated budget; lack of harmony and coordination between public and private service providers; and financial support that is unresponsive to the needs of patients and their families.

Women and their newborns who may survive the threats posed by abnormalities during the course of pregnancy and delivery could still suffer from long standing adverse consequences if appropriate health services and care are not received. Furthermore, maternal deaths have detrimental health and socio-economic effects on the family and orphaned child.

## 2.3. Strategic Response to the MNCHN Situation

The MOP is anchored on the interrelatedness of the direct threats to life that necessitate immediate medical care, including basic and comprehensive emergency obstetric and newborn care, managing risks that increase likelihood of maternal and neonatal deaths, and the underlying socioeconomic conditions that hinder the provision and utilization of MNCHN core package of services.

As support, policy and strategic responses have been geared toward a range of strategies involving the entire health system – from individuals and households, communities, frontline health service providers, local governments, regional agencies, up to national agencies and other stakeholders.

The following key strategies employed reflect this continuum:

- Ensuring universal access to and utilization of an MNCHN Core Package of services and interventions directed not only to individual women of

[7]Analysis of the NDHS 2008 by Health Policy Development Program"*An Evaluation of Factors Affecting the Use of Modern Family Planning and Maternal Care Services"* place the estimate of unplanned, mistimed and unwanted pregnancies at 500,000 as a result of the unmet need for modern FP services that affect six million women.

reproductive age and newborns at different stages of the life cycle[8], but also to the community.

- Establishment of a Service Delivery Network at all levels of care to provide the package of services and interventions.
- Organized use of instruments for health systems development to bring all localities to create and sustain their service delivery networks, which are crucial for the provision of health services to all.
- Rapid build-up of institutional capacities of DOH and PhilHealth, being the lead national agencies that will provide support to local planning and development through appropriate standards, capacity build-up of implementers, and financing mechanisms.

Given the limited resources, areas with poor MNCHN performance in terms of service coverage indicators such as contraceptive prevalence rate, antenatal care, skilled-birth attendant / skilled health professional deliveries and facility-based deliveries, early initiation of breastfeeding, fully immunized children, and, and those areas that have large populations with poor and less educated mothers, and GIDAs will be prioritized. These areas are at higher risk from adverse maternal and neonatal outcomes.

A desired outcome for the integrated MNCHN Strategy is to make the least progressive and most vulnerable areas to move more rapidly and catch-up with the rest of the localities in the country. It is critical for DOH to always be reminded and for localities to understand that as the local conditions differ, the approach, pathway, and pace towards reaching this goal also vary. However, any action towards this desired endpoint is a step to the right direction even if it is short of the ideal and should be encouraged.

### 2.3.1. MNCHN Core Package of Services

The MNCHN Core Package of Services consists of interventions that will be delivered for each life stage: pre-pregnancy, pregnancy, delivery, and the post-partum and newborn periods. Most of these services require minimal cost and can be delivered by health workers as part of their routine functions with some that may require additional training and minimal investments in facilities.

The intervention in the MNCHN core package of services that were found effective in preventing deaths and in improving the health of mothers and children include the following:

1. Pre-pregnancy: provision of iron and folate supplementation, advice on family planning and healthy lifestyle, provision of family planning services, prevention and management of infection and lifestyle-related diseases. In

[8] Stages of life cycle refer to events during pre-pregnancy, pregnancy, birth and delivery, post-delivery, and newborn periods.

particular, modern family planning reduces unmet need and unwanted pregnancies that expose mothers to unnecessary risk from pregnancy and childbirth. Unwanted pregnancies are also associated with poorer health outcomes for both mother and her newborn. Effective provision of FP services can potentially reduce maternal deaths by around 20 percent[9]. This alsoencompass adolescent health services, deworming of women of reproductive age (to reduce other causes of iron deficiency anemia), nutritional counseling, oral health.

2. Pregnancy: first prenatal visit at first trimester, at least 4 prenatal visits throughout the course of pregnancy to detect and manage danger signs and complications of pregnancy, provision of iron and folate supplementation for 3 months, iodine supplementation and 2 tetanus toxoid immunization, counselling on healthy lifestyle and breastfeeding, prevention and management of infection, as well as oral health services. While the contribution of antenatal care in anticipating and preventing maternal and newborn emergencies is unclear, components of prenatal care remain effective in reducing perinatal deaths[10] and serves as a venue for birth planning and promotion of facility based deliveries.

3. Delivery: skilled birth attendance/skilled health professional-assisted delivery and facility-based deliveries including the use of partograph, proper management of pregnancy and delivery complications and newborn complications, and access to BEmONC or CEmONC services. The recent emphasis on the importance of access to emergency obstetrics and newborn care (EmONC) services is due to the shift from the risk approach to pregnancy management to that which considers all pregnancies to be at risk. Under the risk approach pregnant women are screened for risk factors and only those diagnosed with pregnancy complications are referred to facilities capable of providing EmONC services. The approach that considers all pregnancies to be at risk recommends that all pregnant women should deliver with assistance from skilled health professionals and have access to EmONC services since most maternal deaths occur during labor, delivery or the first 24 hours post-partum and most complications cannot be predicted or prevented. "The best intra-partum care strategy is likely to be one in which women routinely choose to deliver in health centers with midwives as the main providers but with other attendants working with them in a team."[11]

[9]Donnay, F. 2000. "Maternal Survival in Developing Countries: What HasBeen Done; What Can Be Achieved in the Next Decade." *International Journal of Gynecology and Obstetrics* 70 (1): 89–97; Kurjak, A., and I. Bekavac. 2001. "Perinatal Problems in Developing Countries: Lessons Learned and Future Challenges." *Journal of Perinatal Medicine* 29 (3): 179–87; UNICEF (United Nations Children's Fund). 1999. "World Summit for Children Goals: End of Decade Indicators for Monitoring Progress." Executive Directive EXD/1999-03, New York; Guttmacher Institute Report, 2009. "Meeting Women's Contraceptive Needs in the Philippines."

[10] Bale, J., B. Stoll, A. Mack, and A. Lucas, eds. 2003. Improving Birth Outcomes: Meeting the Challenges in the Developing World. Washington, DC: National Academy of Sciences and Institute of Medicine.

[11]Campbell O, Graham W and the Lancet Maternal Survival Series Steering Group, 2006 Strategies for reducing maternal mortality: getting on with what works, Lancet, 368:1284-1299.

This recommendation is in line with the global consensus that the best way to address high levels of MMR and NMR is to "ensure that all women and newborns have skilled care during pregnancy, child birth and the immediate post-partum period".[12]

4. Post-Partum: visit within 72 hours and on the 7th day postpartum to check for conditions such as bleeding or infections, Vitamin A supplements to the mother, and counselling on family planning and available services. It also includes maternal nutrition and lactation counseling and postnatal visit of the newborn together with her visit.

5. Newborn care until the first week of life: Interventions within the first 90 minutes such as immediate drying, skin to skin contact between mother and newborn, cord clamping after 1 to 3 minutes, non-separation of baby from the mother, early initiation of breastfeeding, as well as essential newborn care after 90 minutes to 6 hours, newborn care prior to discharge, after discharge as well as additional care thereafter as provided for in the "Clinical Practice Pocket Guide, Newborn Care Until the First Week of Life."

6. Child Care: immunization, micronutrient supplementation (Vitamin A, iron); exclusive breastfeeding up to 6 months, sustained breastfeeding up to 24 months with complementary feeding, integrated management of childhood illnesses, injury prevention, oral health and insecticide-treated nets for mothers and children in malaria endemic areas

### 2.3.2. MNCHN Service Delivery Network (SDN)

No single facility or unit can provide the entire MNCHN Core Package of Services. It is important that different health care providers within the locality are organized into a well-coordinated MNCHN service delivery network to meet the varying needs of populations and ensure the continuum of care. This is the reason for establishing the province as the basic unit for planning and implementation of the MNCHN Strategy.

The MNCHN SDN can be a province or city-wide network of public and private health care facilities and providers capable of giving MNCHN services, including basic and comprehensive emergency obstetric and essential newborn care. It also includes the communication and transportation system supporting this network.

There are three levels of care in the MNCHN SDN: (1) Community level service providers; (2) Basic Emergency Obstetrics and Newborn Care (BEmONC)-capable network of facilities and providers; and (3) Comprehensive Emergency Obstetrics and Newborn Care (CEmONC) - capable facility or network of facilities.

[12]Reducing maternal mortality, a joint statement by WHO, UNFPA, UNICEF, WB, Geneva, 1999.

1. **Community level providers** give primary health care services. These may include outpatient clinics such as Rural Health Units (RHUs), Barangay Health Stations (BHS), and private clinics as well as their health staff (*i.e.,* doctor, nurse and midwife) and volunteer health workers (*i.e.,* barangay health workers, traditional birth attendants).

   For the MNCHN Strategy, the **Community Health Team** (CHT) shall be organized and deployed to implement the MNCHN Core Package of Services identified for the community level. The CHTs provide both navigation and basic service delivery functions. Navigation functions include informing families of their health risks, assisting families in health risks and needs assessment; assisting families develop health use plans such as birthing plans and facilitating access by families to critical health services (e.g. emergency transport and communication as well as outreach) and financing sources (e.g. PhilHealth). Their basic service delivery functions include advocating for birth spacing and counselling on family planning services; tracking and master listing of pregnant women, women of reproductive age, children below 1 year of age; early detection and referral of high-risk pregnancies; and reporting maternal and neonatal deaths. The team shall also facilitate discussions of relevant community health issues especially those affecting women and children.

   CHTs should be present in each priority population area to improve utilization of services, ensure provision of services as well as follow-up care for post-partum mothers and their newborn.

2. **Basic Emergency Obstetric and Newborn Care (BEmONC)-capable** network of facilities and providers can be based in hospitals, RHUs, BHS, lying-in clinics or birthing homes. If the BEmONC is hospital based, blood transfusion services which may or may not include blood collection and screening will be provided. These facilities operate on a 24-hour basis with staff complement of skilled health professionals such as doctors, nurses, midwives and medical technologists.

   A BEmONC based in RHUs, BHS, lying-in clinics, or birthing homes can either be a stand-alone facility or composed of a network of facilities and skilled health professionals capable of delivering the six signal functions. A stand-alone BEmONC-capable facility is typically an RHU which has the complement of skilled health professionals such as doctors, nurses, midwives and medical technologists. BEmONCs operating as a network of facilities and providers can consist of RHUs, BHS, lying-in clinics, or birthing homes operated by skilled health professionals. At the minimum, this can be operated by a midwife who is either under supervision by the rural health physician or has referral arrangements with a hospital or doctor trained in the management of maternal and newborn emergencies. Under this arrangement, a midwife can provide lifesaving interventions within the intent of A. O. 2010-0014.

BEmONCs shall be supported by emergency transport and communication facilities. The provision of blood transfusion services in non-hospital BEmONCs shall be dependent on presence of qualified personnel and required equipment and supplies.

3. **Comprehensive Emergency Obstetric and Newborn Care (CEmONC)-capable facility or network of facilities** are end-referral facilities capable of managing complicated deliveries and newborn emergencies. It should be able to perform the six signal obstetric functions, as well as provide caesarean delivery services, blood banking and transfusion services, and other highly specialized obstetric interventions. It is also capable of providing newborn emergency interventions, which include, at the minimum, the following: (a) newborn resuscitation; (b) treatment of neonatal sepsis/infection; (c) oxygen support for neonates; (d) management of low birth weight or preterm newborn; and (e) other specialized newborn services.

   The CEmONC-capable facility or network of facilities can be private or public secondary or tertiary hospital/s capable of performing caesarean operations and emergency newborn care. Ideally, a CEmONC-capable facility is less than 2 hours from the residence of priority populations or the referring facility.

   These facilities can also serve as high volume providers for IUD and VSC services, especially tubal ligations and no-scalpel vasectomy.

   A typical CEmONC-capable facility has the following health human resource complement: 3 doctors preferably obstetrician/surgeon or General Practitioner (GP) trained in CEmONC (1 per shift), at least 1 anaesthesiologist or GP trained in CEmONC (on call), at least 1 pediatrician (on call), 3 Operating Room nurses (1 per shift), maternity ward nurses (2 per shift), and 1 medical technologist per shift.

   Alternatively, the SDN can also designate a CEMONC-capable network of facilities that has the necessary staff, equipment and resources coming from a network in order to provide the full range of CEmONC services. For example, a designated facility capable of doing caesarean sections may not have incubators within its physical facility but can secure this equipment either from other providers or assign care of premature neonates to another facility within the network.

   The CEmONC capable facility or network of facilities should organize an itinerant team that will conduct out-reach services to remote communities. A typical itinerant team is composed of at least 1 doctor (surgeon), 1 nurse and 1 midwife.

### 2.3.3. Health Systems Instruments

These consist of technical, organizational and human resource, regulatory, monitoring and reporting, financing, and governance mechanisms necessary to

effectively implement and sustain the MNCHN strategy. These instruments are developed to enable localities to set up and sustain the delivery of core package of MNCHN services through the network of service providers in the community. These include coordination mechanisms among LGUs and health providers, human resource management, logistics management, policies affecting utilization and provision of services, among others.

## 2.4. Policies Related to the Implementation of the MNCHN Strategy

The Department of Health has issued other policies to support the implementation of the MNCHN Strategy.

1. Administrative Order 2009-0025 known as Adopting New Policies and Protocol on Essential Newborn Care, issued on 01 December 2009.

2. Administrative Order 2010-0001 known as Policies and Guidelines for the Philippine National Blood Services (PNBS) and the Philippine Blood Services Network (PBSN), issued on 06 January 2010.

3. Administrative Order 2010-0010 known as Revised Policy on Micronutrient Supplementation to Support the Achievement of 2015 MDG Targets to Reduce Under-Five and Maternal Deaths and Address Micronutrient Needs of Other Population Groups, issued on 19 April 2010.

4. Administrative Order 2010-0014 known as Administration of Life Saving Drugs and Medicines by Midwives to Rapidly Reduce Maternal and Neonatal Morbidity and Mortality, issued on 14 May 2010. These lifesaving interventions (i.e. administration of Magnesium Sulfate, oxytocin, steroids and antibiotics) may be carried out by midwives who have undergone training and certification and while under the supervision of a physician trained on the emergency management of maternal and newborn complications.

Annex A is a copy of the Administrative Order 2008-0029 for the Implementation of Health Reforms to Rapidly Reduce Maternal and Neonatal Mortality. For copies of Administrative Orders on MNCHN and other issuances, please refer to www.doh.gov.ph or contact the nearest CHD.

Annex B shows the list of services that should be given for each life event by providers in the service delivery network.

**Box 1: Hospitals in the MNCHN Service Delivery Network**

## What is the role of hospitals in MNCHN Strategy?

*Hospitals are among the key players in operationalizing the MNCHN Strategy. The role they assume is mostly clinical in nature, with tertiary hospitals serving as end-referral facilities for cases that cannot be adequately managed by other facilities. However, with numerous other obligations and concerns, their operations tend to overlook the setting, demands, and limitations of the community. Being experts in maintaining health, looking at hospitals as mainly referral facilities is a great loss to the community.*

*To maximize the gains from participation of hospitals, the following are the roles that they can take on in the implementation of MNCHN Strategy:*

*(1) Model of health care practice. They can exemplify and influence other providers regarding correct, recommended, and good MNCHN practices in caring for patients. Hospitals, especially government facilities, could serve as training centers for new treatment protocols and guidelines.*

*(2) Advocate of area-wide networking. They can provide support in the operation of service delivery network. For example, they can assist in facilitating referrals to and from facilities within the network, as well as in providing referring facilities or concerned localities data regarding reportable cases (e.g., number of maternal and child deaths, infectious diseases, etc.)*

*(3) Adviser to network stakeholders. Having better facilities and more resources, hospitals can generate data and information regarding the effectiveness of the network to help enhance it.*

*Hospitals will respond to calls for their involvement because the MNCHN strategy provides for effective and beneficial services and interventions that a good hospital performs. These practices are also well within their capacities and resources. The costs are reasonable and affordable. With full implementation, their participation may even be financially rewarding (e.g., increased PhilHealth reimbursements, income from training other facilities/providers). Most importantly, being part of the health system and community that they serve, hospitals have a social obligation to provide clinical care that has impact on public health.*

## How can hospitals start participating?

*Illustrated below is a general process by which hospitals can initiate moving into their roles:*


## How can DOH support hospital response?

- *Provision of incentives for responding and moving towards the direction of improving maternal and child health in the country*
- *Ensure availability of technical resources that hospitals may need and access on demand as they assume their role in the MNCHN strategy*
- *Establishment of central and regional focal points to guide and monitor hospitals*

# LGU-wide Implementation of the MNCHN Strategy

## Part II

# Chapter 3. Overview

## 3.1. Introduction

The reduction of maternal-neonatal-child deaths in the country demands that comprehensive reforms be undertaken at the LGU level toward enhancing the provision of the MNCHN core package of services. Effective interventions are already known, available and have been proven effective to address the identified gaps and needs. However, LGU effort is required to ensure that all concerned health care providers are engaged to form a coordinated MNCHN SDN. The resources and participation of the entire community to be covered and served also needs to be harnessed and mobilized. Lastly, the collaboration with other groups of stakeholders within and outside the health sector should also be strengthened.

The LGU has to take note of the following in addressing MNCHN gaps and issues:

1. MNCHN gaps and problems vary from one area to another, from one municipality to another municipality, from one barangay to another barangay. There is a need to customize interventions according to the peculiarities and needs of the different communities or areas;

2. Not all the gaps and issues can be addressed all at the same time given limited resources. Interventions should be guided by the results of the assessment of the health situation of mothers and children. Evidence should guide the LGU in identifying gaps that need to be prioritized, population areas that would merit focused attention and interventions that are most appropriate to the situation;

3. Reforms in service delivery, governance, regulation, and financing are needed for the sustained improvement of the health status of mothers and children.

In the implementation of an LGU-wide MNCHN strategy, the LGU should have a team that will oversee the activities for the province and component municipalities. Building the MNCHN SDN and ensuring its sustainability would entail analysis of the existing situation in the locality and assessment of gaps in service delivery, utilization and health systems in general as well as identifying and planning appropriate interventions to address these gaps.

To begin this process, the LGU can organize a team coming from the Provincial Health Office, different Municipal Health Offices and other relevant members of the locality like DOH Center for Health Development, development partners, donors, non-government organizations (NGOs), civil society groups and the like. From this team, the LGU can assign a coordinating body to oversee the direction and progress of implementation of the MNCHN Strategy after assessment and

initial planning. Existing committees or task groups from the LGU may perform these tasks to avoid creation of too many groups within the province.

The LGU would have to take the following steps to implement the MNCHN Strategy:

1. Prioritize Population Groups and Areas
2. Designate the SDN for the MNCHN Core Package of Services
3. Strengthen the MNCHN SDN and improve local health systems
4. Monitor the progress of an LGU-wide Implementation of the MNCHN Strategy

The flowchart below describes tasks in each step in implementing the MNCHN Strategy.

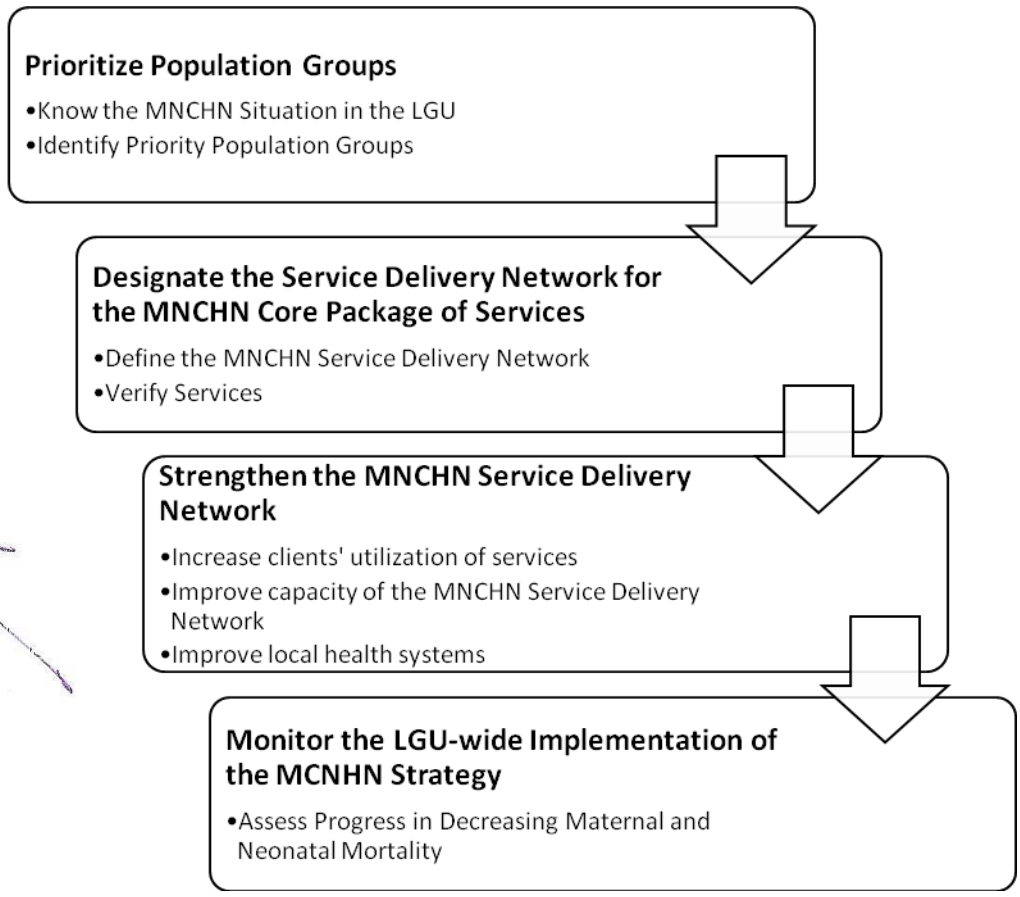



**Figure 4: Flowchart of LGU-wide MNCHN Implementation**

## 3.2. MNCHN Team

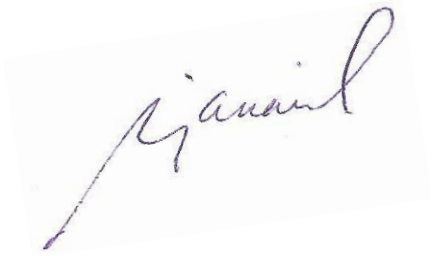
To begin the process of implementing an LGU-wide MNCHN Strategy, the province and its component municipalities and cities can organize a team coming from the Provincial Health Office, different Municipal Health Offices, DOH Center for Health Development as well as hospitals both from the public and private

sectors to assess and define interventions needed to improve the delivery of MNCHN services. It is important for provinces and cities to guarantee the participation of practitioners from the Rural Health Units (RHU) or City Health Units (CHO) to district or provincial hospitals or even private health facilities/hospitals for women, mothers and children to have access to a continuum of care.

Members from partners, non-government organizations (NGOs) and civil society may be invited to be part of the team.

Existing committees in the province and its component municipalities and cities may be tapped to lead the assessment of the MNCHN situation and strengthening the service delivery network. The province does not have to organize a new team for MCNHN but ensure that issues and concerns of women, mothers and children are tackled by the existing body.

From this team, the province and its component municipalities and cities and independent component cities can assign a coordinating body to oversee the direction and progress of implementation of the MNCHN Strategy.



# Chapter 4. Prioritize Population Groups

## 4.1. Know the MNCHN Situation in the LGU

The MNCHN Team's initial work would be to assess the MNCHN situation in the LGU. Assessing the LGUs' current level of performance against national or regional data would provide the province and component LGUs an idea of their performance in reducing maternal and neonatal deaths. The MNCHN Management Team can use Health Outcome Indicators or Health Service Coverage Indicators to assess the LGUs' situation.

**Box 2: MNCHN Health Indicators**

***MNCHN Health Indicators***

*Health indicators are used to monitor the health status of a population. These health indicators either (1) reflect impact or outcomes or (2) coverage or utilization of services. For MNCHN, health outcome indicators are Maternal Mortality Ratio (MMR), Newborn Mortality Rate (NMR), Infant Mortality Rate (IMR), Under-five Mortality Rate (UFMR) and proportion of underweight 6 to 59-month old children while Service Coverage indicators are Contraceptive Prevalence Rate (CPR), Antenatal Care (ANC), Facility-based Deliveries (FBD), Fully Immunized Children (FIC), Early initiation of breastfeeding, Exclusive breastfeeding from birth up to six (with sustained breastfeeding and complementary feeding). and early initiation of breastfeeding.*

*Since health outcome indicators are consolidated yearly, it might be difficult to get an accurate picture of the situation especially if data is collected midyear. Service coverage indicators are used to determine the reach of health services in a given population.*

As a reminder, LGUs should validate the data or report received from local health sources. If the health information system has not been revisited or revised to comply with standards, available data may not reflect an accurate health situation of the locality[13]. Annex C is a set of instructions that the LGU can refer to validate data for MNCHN service coverage indicators.

Following are some indicators that data may not be accurate:

- Zero or low maternal death reports
- More than 100 percent service coverage

Follow these steps to assess local MNCHN situation:

[13]The DOH recommends standards, procedures and protocols to ensure validity of data through the Field Health Surveillance and Information System (FHSIS).

1. Determine national targets and latest available national levels for MNCHN indicators. Table 1 shows MNCHN Service Coverage indicators while Table 2 shows MNCHN Health Outcome indicators.

2. Determine the latest MNCHN indicators of the province and fill up Column 3 of any of the tables below.

**Box 3: Data Quality Check**

*Ensuring the validity and reliability of data generated through the FHSIS is highly recognized as critical in ensuring that LGU planning and decision-making are evidence-based. If sound and reliable data are used, more focused and appropriate interventions and policies will be formulated and implemented as part of the local health sector reform.*

*A Self-Assessment Tool (SAT) developed by the Strengthening Local Governance for Health (HealthGov) project assisted by USAID was used to address critical points regarding data management (generation, recording, maintenance and reporting of) FP data. Using the presentation of the Health Information Systems (HIS) Framework as the starting point, rural health midwives (RHMs) and their supervising public health nurses (PHNs) are provided with the overall context of data quality chekcing. By systematically reviewing the various definitions and guidelines, and comparing these with the actual FHSIS records and reports of the participants, updated/corrected figures are arrived at for FP current users, 4 antenatal care, skilled birth attendant, facility based delivery, fully immunized children, exclusive breastfeeding, Garantisadong Pambata Vitamin A Supplementation.*

*The following provinces have already completed data quality check on FP current users and have consolidated the results for all of its municipalities: Tarlac, South Cotabato, Misamis Oriental, Zamboanga del Norte, Zamboanga Sibugay, Nueva Ecija, Bukidnon*

*Results of the data quality check for FP current users revealed that provincial CPR, as well as for most of the municipalities/cities, decreased. The extent of decrease varies across the municipalities, approximately ranging from 20% to 60% difference. Over-reporting was mainly due to lost to follow-up of clients, not following the drop-out criteria and counting of new acceptor numbers without names.*

| *Province* | *CPR before Validation* | *CPR after Validation* |
|---|---|---|
| *Nueva Ecija* | *34%* | *22%* |
| *Tarlac* | *38%* | *15%* |
| *Zamboanga del Norte* | *42%* | *33%* |
| *Zamboanga Sibugay* | *13%* | *8%* |
| *Bukidnon* | *60%* | *45%* |
| *Misamis Oriental* | *45%* | *24%* |
| *South Cotabato* | *74%* | *56%* |

*Results of data quality check show that ANC4 has the most significant change (decrease). Over-reporting for ANC4 was mainly due to the health staff's inability to follow the "1-1-2 rule" (i.e. at least one pre-natal visit of the pregnant woman during the 1st and 2nd trimester and at least 2 during the third trimester). For SBA and FBD, aside from manual computational errors in addition, the decrease was also due to confusion of midwives on the definition of the indicators. For FIC and EBF, among the reasons for the decrease are manual computational errors, confusion on the operational definition of the indicator and lack of dates of immunization/visits.*

**Table 1: Evaluation of LGU Performance Using MNCHN Service Coverage Indicators**

| Column 1 | Column 2 | Column 3 | Column 4 |
|---|---|---|---|
| Health Indicators | National Targets | Provincial Target | Provincial Performance |
| CPR | 60.0 (2010) | | |
| ANC | 80.0 (2010) | | |
| SBA/FBD | 80.0 (2010) | | |
| FIC | 95.0 (2010) | | |

**Table 2: Evaluation of LGU Performance Using MNCHN Health Outcome Indicators**

| Column 1 | Column 2 | Column 3 | Column 4 |
|---|---|---|---|
| Health Indicators | National Targets (2015) | Provincial Target | Provincial Performance |
| MMR | 52/100,000 LB | | |
| UFMR | 27/1,000 LB | | |
| IMR | 19/1,000 LB | | |
| NMR | 6/1,000 LB | | |

3. Assess performance of the LGU by comparing its current MNCHN indicators with national data. Use Table 1if the MNCHN Management Team is using Service Coverage Indicators and Table 2 if Health Outcome Indicators are used.

4. In indicating performance, the team may use appropriate symbols to denote increase or decrease in performance or if targets are met. For example, if Service Coverage Indicators are used, put a green shade if the LGU performance is equal to or above national targets or current national levels and a red shade if otherwise. A red shade indicates that the LGU is not providing adequate services to a majority of its population and the LGU would need to improve its service provision.

   If Health Outcomes Indicators are used, put a red shade if the LGU's performance is equal to or above the national targets or current national levels and a green shade if otherwise. A red shade indicates that the LGU is performing poorly compared to national data and would need to improve its service provision to improve health outcomes.

   In succeeding years, performance can be indicated by arrows pointing up or down depending on the level of performance relative to baseline.

   Information to assess performance should be obtained from the most updated source. For example, LGUs may use the performance indicators cited in their Province-wide Investment Plan for Health or in the Annual Operational Plans.

## 4.2. Identify Priority Population Groups and Areas

As mentioned, MNCHN situation varies from one municipality to another or from one barangay to another. So even if LGUs are performing better than the national level, it should look at pockets of population in the locality that have high or existing maternal and neonatal deaths.

The MNCHN Team should now compare performance of municipalities or cities with the province. Assessing performance of each municipality or city will allow the LGU to prioritize interventions to improve MNCHN Health Outcomes on the most affected population groups. The MNCHN Management Team may use any of the following processes in identifying priority population groups:

- Compare performance of municipalities and cities with the province using MNCHN Health Outcome or Service Coverage Indicators
- Identifying municipalities or cities with the most number of maternal and neonatal deaths

Follow the procedure below in identifying priority population groups in the province:

1. Compare performance of municipalities and cities with the province using MNCHN Health Outcome or Service Coverage Indicators

   The MNCHN Management Team can follow the same process in determining performance of the LGU compared with national targets or levels. Instead of having national targets or levels, data for the province should be placed under Column 2 and additional columns would have to be made for each municipality or city. The MNCHN Management Team can use Table 3 below as a sample.

**Table 3: Evaluation of Municipal Performance Using MNCHN Service Coverage Indicators**

| Column 1 | Column 2 | Column 3 | Column 4 | Column 5 | Column 6 |
|---|---|---|---|---|---|
| Health Indicators | Provincial Targets | Municipal 1 Targets | Municipal 1 Performance | Municipal...n Targets | Municipal...n Performance |
| CPR | 60.0 (2010) | | | | |
| ANC | 80.0 (2010) | | | | |
| FBD | 80.0 (2010) | | | | |
| FIC | 95.0 (2010) | | | | |

2. Identifying municipalities or cities with the most number of maternal and neonatal deaths

   Collecting MNCHN Indicators at the municipal or city level may be difficult because data are consolidated at the provincial level. The actual number of maternal and neonatal deaths for each municipality or city can be used to assess performance. Municipalities with the most number of maternal deaths should be prioritized.

After identifying priority municipalities and cities, identify population groups that are most vulnerable to or at risk for maternal and neonatal deaths. Based on the results of the National Demographic Health Survey of 2008, Filipino women incurring the highest risks during pregnancy are: (1) pregnant women less than 18 years old and those more than 35 years old; (2) women who had received only up to elementary education; (3) women in the 20 percent poorest households; (4) women in areas of armed conflict; (5) women victims of domestic violence; and (6) pregnant women with concurrent chronic illness (iron-deficiency anemia, tuberculosis, cardiovascular disease, diabetes mellitus, etc.)."[14]

Priority should also be given to communities with the following characteristics: indigenous peoples' groups, GIDA, highly urbanized and densely populated areas, areas at the borders of LGUs which are not usually reached by services, female adolescents.[15]

3. Take note of the area where population groups reside such as name of purok, barangay and municipality. It is advisable as well to identify their location on a map of the province which will assist the MNCHN Team in identifying the most appropriate health facilities that they could be referred or linked to.

Some reminders in prioritizing population groups:

- Prioritize population groups with the highest volume of women and children needing assistance. Geographic areas with very low population may yield lower number of mothers and children reached in contrast to areas with high population;
- Population groups or areas with highest prevalence of diseases necessitate priority attention. For example, municipalities with high incidence of maternal or infant or child deaths must be given due attention than areas without reported death, or those with least service coverage than those with rather better coverage;
- If there are areas where outbreaks occur that will compromise the health of other nearby areas, then these must be prioritized for action; (e.g.

[14]National Statistics Office [NSO] & ORC Macro, *National Demographic and Health Survey 2008*.

[15] "Of the reported 473,000 abortions per year, 36% of these involve young women, making the female adolescents at greatest risk to maternal deaths and complications", Juarez et al The incidence of induced abortion in the Philippines: Current level and recent trends. Int Fam Plan Perspect, 31(2005): 140:9.

# Chapter 5. Determine the MNCHN Service Delivery Network

This chapter complements the existing plans for the service delivery networks of province- and city-wide health systems as reflected in their PIPH, rationalization plans and facility mapping by allowing the LGUs to go through the process of updating the matching of existing public and private capacities with demand for the MNCHN Core Package of Services by their constituents.

After the LGU has identified the priority populations in the province and municipalities, it will now have to define the network of facilities and/or providers that shall deliver the MNCHN Core Package of Services. The following principles shall guide LGUs in identifying providers in the service delivery network:

1. Health providers, professionals and facilities that already exist in the area shall be designated as part of the network. As much as possible, LGUs are advised against developing or establishing new facilities to provide MNCHN services.
2. Private and public health providers should be part of the SDN.
3. Defining the SDN shall not be restricted within political boundaries of the province. Collaboration across provinces is considered in order to serve priority populations better.

To ensure that priority populations shall have access to all MNCHN services, it is first necessary to identify and designate facilities and providers that will deliver services during pre-pregnancy, pregnancy, delivery, post-partum and newborn periods. This step will be followed by verifying if those identified in the network can provide services such as family planning, micronutrient supplementation, and newborn care. The second step is important to ensure that mothers and their children would have access to the complete package of services for MNCHN from the community level, BEmONC–capable network of facilities and providers, up to the end referral facility which is the CEmONC-capable facility or network of facilities. Note that at this stage, the MNCHN Team shall not assess gaps and strengths of designated providers in the service delivery network. At this point, the goal of the MNCHN Team will only be identifying health providers that can give MNCHN core package of services especially to the priority population group.

Similar to the section "Know the MNCHN Situation in the LGU" in Chapter 4, some LGUs, with assistance from the DOH, may already have a facility mapping or Rationalization Plan that identified facilities to be designated, developed or upgraded to provide particular services. For LGUs with existing facility mapping or Rationalization Plan, the following sections can be useful in (1) showing

access of priority populations to facilities that are being upgraded or developed, (2) updating the matching of facilities with demand for services, and (3) facilitating a review of current capacities of these facilities especially if the facility mapping or Rationalization Plan was done some years ago.

## 5.1. Define the MNCHN Service Delivery Network

Defining the MNCHN SDN would involve organizing the Community Health Team (CHT) as part of the Community-Level Health Providers, designating the CEmONC-capable facility or network of facilities, and designating the BEmONC-capable network of facilities and providers.

### 5.1.1. Determine Presence of Community Level Providers

Under the MNCHN Strategy, the first level of service delivery occurs at the household or community level. This involves largely the delivery of public health services across the various life stages including outpatient clinical services such as family planning, antenatal care as well as postpartum and newborn care and nutrition. This also includes sharing of information to empower clients and assisting in the setting up of support systems such as transport and communications systems.

The MNCHN core package of services are to be made available through a network of BHS, RHUs, private clinics and Community Health Teams (CHT) organized in each barangay or purok of the locality. ***It is essential that every community identified as a priority group should have a CHT.***

The community-level MNCHN providers as part of the overall MNCHN SDN are comprised of the following:

1. At the barangay level, a Community Health Team (CHT) led by the midwife carries out the task of providing information and basic health services to households. The team maybe composed of Barangay Health Workers (BHWs), Traditional Birth Attendants (TBAs), and other volunteer workers including barangay officials and representatives from people's organizations or non-government organizations (NGOs).

   Community Health Teams provide preventive, promotive and clinical MNCHN services to community members. The navigation role of CHTs is critical in improving utilization of services by families. Navigation functions include assessment of health risks, assistance in developing health plans of families, informing families of available services and where they could access these services, giving appropriate health messages depending on families' needs and discussing financing options for health services. Primary care services such as micronutrient supplementation, family planning counselling and resupply of commodities, antenatal care visits, postpartum follow-up, and newborn care are provided by the CHTs as

well. MNCHN services that cannot be delivered by the CHT are to be provided by the RHUs, BHS or private clinics.

Community leaders such as barangay leaders should also be given regular feedback on implementation of health services by CHTs to ensure access of families to resources for transportation and communication, outreach services, health information campaigns and the like. Barangay officials should be involved in securing local funding for CHT-related activities.

2. At the clinic, BHS or RHU level, the doctor acts as head of the health facility and is supported by a team composed of nurses, medical technologists, midwives, sanitary officers and other types of health staff. While provision of services usually occurs in the fixed facility (e.g. clinics, RHUs, BHS) and during regular office hours, these providers also do outreach services especially in remote areas where a number of indigent families do not have access to health care.

The MNCHN Team shall determine the presence of a CHT working with priority populations. Organizing and identifying gaps and strengths among CHTs are discussed in the next chapter. For now, it is enough to know if there are any CHTs operating in priority areas.

**Box 4: Community Health Team (Ayod) in Ifugao**

*The Community Health Teams (Ayod) in Ifugao*

*Guided by the DOH overall direction to organize community based teams to provide primary level preventive and promotive care for mothers and children, and with support from the Council for the Welfare of Children and various development partners* the Province of Ifugao organized community health teams called AYOD . The use of the term AYOD which means hammock in English and the was derived from the customary practice in remote isolated areas like Ifugao to make use of the hammock (being held by about 4 men) in transporting sick members to the nearest health facility. Thus, the AYOD Team is seen as mainly responsible for bringing women who are about to deliver to the nearest birthing clinic or area. More than just a personification as a 'transport system,' the PHO of the province also expands its meaning to a 'bayanihan', proactive, and holistic approach in reducing maternal,-neonatal and child deaths in the province.*

*The AYOD Teams have no fixed honorarium/incentives. Their honoraria can range from as low as PhP50 to PhP200/month. However, as an additional incentive, the provincial government give them Php1,000.00 once a year. They are also entitled to free health services at the provincial hospital and RHU including their immediate family members.Outstanding or high performing teams are given awards and incentives.*

*To continuously provide support to AYOD Teams, weekly meetings are conducted by the BHS midwife and a monthly conference is held by RHU to share experiences and discuss issues and concerns. According to the AYOD Satisfaction Survey done in 2009, the AYOD members are highly satisfied with their involvement and their greatest motivation was to be able to save lives of their loved ones and community members.*

*JICA, UNFPA, EC, GFATM*

### 5.1.2. Designate the CEmONC-Capable Facility or Network of Facilities

A CEmONC-capable facility provides the highest level of care to women, mothers and children especially during labor and delivery, post-partum and newborn stages. A CEmONC-capable facility must have the following characteristics: (a) capable of managing maternal emergencies, including caesarean sections, as well as handling basic and emergency newborn care and providing blood transfusion and storage services; (b) has a set of sophisticated equipment, special infrastructure and highly skilled health staff to deliver said services; (c) strategically located to ensure wide accessibility to clients, substantial caseloads to maintain skill proficiency and adequate financing for operational viability; and (d) has the responsibility to serve its target population, provide quality care and reduce financing barriers to access. By default, the provincial hospital can be the designated CEmONC-capable facility.

To guarantee that mothers have a facility that can provide the highest level of care in case of emergencies, the MNCHN Team shall first identify a CEmONC-capable facility that would cater to the needs of identified priority population groups.

Follow these steps in designating the CEmONC-capable facility in order to update the designation of facilities in the PIPH/Facility Rationalization/Facility Mapping:

1. Identify and list all hospitals, both private and public, located near target populations within and outside the jurisdiction of the LGU.

The list shall include the following information:

- Hospital Information: names of hospitals, addresses, public or private facility, licensing status, PhilHealth accreditation status (Level 2 accreditation indicates that the facility has the capacity to perform caesarean operations)
- Average travel time using the most common form of travel from the residence of population groups to the facility using the farthest household as reference. The MNCHN Team can perform key informant interviews to determine travel time.
- Inpatient case load can be obtained from the annual hospital report submitted to the PHO. Case load can also be verified through key informant interviews.
- The MNCHN Team would have to repeat this process for every priority population identified.

Table 4 below can be used in the assessment:

**Table 4: Shortlist of CEmONC-capable Facilities**

| Priority Population 1 | Hospital 1 | Hospital 2 | Hospital 3 |
|---|---|---|---|
| Name of Hospital | | | |
| Address of Hospital | | | |
| Is facility licensed by DOH? | ☐ YES<br>☐ NO | ☐ YES<br>☐ NO | ☐ YES<br>☐ NO |
| What type of PhilHealth Accreditation does the facility have? | ☐ NONE<br>☐ LEVEL 1<br>☐ LEVEL 2<br>☐ LEVEL 3<br>☐ LEVEL 4<br>☐ ASC | ☐ NONE<br>☐ LEVEL 1<br>☐ LEVEL 2<br>☐ LEVEL 3<br>☐ LEVEL 4<br>☐ ASC | ☐ NONE<br>☐ LEVEL 1<br>☐ LEVEL 2<br>☐ LEVEL 3<br>☐ LEVEL 4<br>☐ ASC |
| Who owns the hospital? | ☐ LGU<br>☐ DOH<br>☐ Private | ☐ LGU<br>☐ DOH<br>☐ Private | ☐ LGU<br>☐ DOH<br>☐ Private |
| Travel time from residence of priority population group? | ☐ <30 mins.<br>☐ ≥30 mins. to 1 hr<br>☐ 1 hr to 2 hrs | ☐ <30 mins.<br>☐ ≥30 mins. to 1 hr<br>☐ 1 hr to 2 hrs | ☐ <30 mins.<br>☐ ≥30 mins. to 1 hr<br>☐ 1 hr to 2 hrs |
| What is the mode of travel from residence of priority population group to the facility? | ☐ Walking<br>☐ Tricycle<br>☐ Jeep<br>☐ Boat<br>☐ Others_____ | ☐ Walking<br>☐ Tricycle<br>☐ Jeep<br>☐ Boat<br>☐ Others_____ | ☐ Walking<br>☐ Tricycle<br>☐ Jeep<br>☐ Boat<br>☐ Others_____ |
| What is the average bed occupancy rate per month? | | | |

2. Based on the list of facilities, come up with a short list of hospitals to be designated as CEmONC provider by applying the following criteria:

   - Select only licensed facilities;
   - Select those with Level 2 PhilHealth Accreditation;
   - Determine which of these licensed hospitals are within one hour travel time from the residence of the targeted population using the most common mode of transportation. Specify the modes of transportation;
   - Next, rank hospitals which are within 2 hours from the residence of the identified priority population groups; and
   - Identify which of these are accessed by clients the most.

3. Assess if the hospitals in the short list meet the CEmONC core services. Core services refer to services that only a CEmONC-capable facility can provide. The Management Team can use the Table 5 below as guide.

**Table5: Checklist of Core Services for CEmONC-capable Providers**

| Priority Population 1 | Hospital 1 | | Hospital 2 | | Hospital 3 | |
|---|---|---|---|---|---|---|
| Does the facility have adequate staff requirement of a CEmONC facility? Indicate deficiency under remarks column. | | Remarks | | Remarks | | Remarks |
| At least 1 OB/Surgeon/MD trained in CEmONC every 8 hours | ☐ YES<br>☐ NO | | ☐ YES<br>☐ NO | | ☐ YES<br>☐ NO | |
| At least 1 anaesthesiologist or GP trained in anesthesiology on call | ☐ YES<br>☐ NO | | ☐ YES<br>☐ NO | | ☐ YES<br>☐ NO | |
| At least 1 paediatrician every 8 hours or on call | ☐ YES<br>☐ NO | | ☐ YES<br>☐ NO | | ☐ YES<br>☐ NO | |
| 1 OR nurse per 8-hour shift | ☐ YES<br>☐ NO | | ☐ YES<br>☐ NO | | ☐ YES<br>☐ NO | |
| 2 ward nurses per 8-hour shift | ☐ YES<br>☐ NO | | ☐ YES<br>☐ NO | | ☐ YES<br>☐ NO | |
| 1 medical technologist per 8-hour shift | ☐ YES<br>☐ NO | | ☐ YES<br>☐ NO | | ☐ YES<br>☐ NO | |
| Can the hospital perform caesarean operations? | ☐ YES<br>☐ NO | | ☐ YES<br>☐ NO | | ☐ YES<br>☐ NO | |
| Can the hospital attend to newborn emergencies? | ☐ YES<br>☐ NO | | ☐ YES<br>☐ NO | | ☐ YES<br>☐ NO | |
| Does the hospital have safe blood supply? | ☐ YES<br>☐ NO | | ☐ YES<br>☐ NO | | ☐ YES<br>☐ NO | |

4. Designate the most capable facility as the CEmONC-capable facility.

- Based on the results of the capacity assessment for core services, designate the hospital most capable in providing CEmONC services which is within 1 hour of travel accessible to most of the priority population and preferably government-owned facilities.

- If there is no CEmONC-capable or network of facilities located within one hour of travel time of the priority population, designate the next closest CEmONC-capable or network of facilities to the area which is within 1 to 2 hours travel time. Efforts though must be exerted to ensure that only skilled birth attendants/skilled health professionals manage all births and that emergency transport and communications services are available to facilitate referral.

- If only private facilities can be designated as providers, the LGU would have to enter into a Memorandum of Agreement with the facility. There is also a possibility that the nearest and most appropriate CEmONC-capable facility is in another LGU or a DOH-retained hospital. The LGU would have to enter into an agreement similar to that of the private sector.

- There is also a possibility that a facility may lack a doctor who can perform caesarean operations. The LGU can also negotiate with a private practitioner to provide CEmONC services to their clients as needed.

### 5.1.3. Designate BEmONC-Capable Network of Facilities and Providers

Basic emergency obstetric and newborn care service package (BEmONC) is the set of interventions that aim to treat/manage complications of pregnancy which are the major causes of maternal deaths namely hemorrhage, severe infection, hypertension and complications of abortions including septic abortion and dystocia. The MNCHN Strategy calls for the designation/establishment and/or upgrading of facilities in order to provide BEmONC services to all clients in addition to the MNCHN and other service package that they currently deliver.

BEmONCs serve three purposes in the MNCHN Strategy:

1. Provide maternal services including management of specific emergencies that do not necessarily require CEmONC referral, such as: (a) active management of the third stage of labor (oxytocin); (b) use of the anticonvulsants; (c) use of initial dose of antibiotics in prolonged labor, premature rupture of membranes; (d) Magnesium Sulfate for prevention and management of eclampsia; (e) assisted breech vaginal delivery; (f) management of retained placenta and uterine atony; and (g) antenatal steroids in preterm labor;

2. Provide emergency newborn services, which include at the minimum: (1) newborn resuscitation; (2) treatment of neonatal sepsis/infection; and (3) oxygen support. It shall also be capable of providing blood transfusion services on top of its standard functions;

3. Act as bridge facilities that allow immediate clinical interventions and stabilization of maternal and newborn emergency cases for referral to CEmONC-capable facilities; and

4. Provide screening/diagnostic services for mothers and newborns and referral to CEmONC providers of cases needing higher level of care.

5. Provide population based maternal and child health services to priority populations.

The MNCHN Team shall follow these steps to designate the BEmONC-capable network of facilities and providers to update the designation of facilities in the PIPH/Facility Rationalization/Facility Mapping:

1. Identify priority areas for the establishment or designation of BEmONCs. Based on the results of the assessment done on the access to CEmONC services by the priority population groups, classify the population groups that have high, good or poor access to CEmONC services.

    - *High Access to CEmONC*: populations with access to the designated CEmONC facility in less than an hour;
    - *Good Access to CEmONC*: populations with access to the designated CEmONC facility within 1-2 hours with dedicated transportation and communication systems for emergencies;
    - *Poor Access to CEmONC*: populations with access to the designated CEmONC facility within 1-2 hours or more but without ready transport and communication system.

    Match the Type of Health Facility as BEmONC Provider and Access to CEmONC Services. The following types of BEmONC are recommended to be designated depending on their distance from a CEmONC:

    - If CEmONC is more than 2 hours away, designate a hospital-based BEmONC with blood services;
    - If CEmONC is 1-2 hours away, designate stand-alone BEmONC-capable facility or BEmONC with network arrangements; and
    - If CEmONC is less than 1 hour away, designate at least a BEmONC with network arrangements or if a CEmONC is closer, refer directly to CEmONC.

2. Identify and select facilities to provide BEmONC services.

    - List all the hospitals identified in designating a CEmONC as well possible BEmONC facilities to constitute the pool for potential BEmONC-capable facilities;
    - Confirm the distances of each health facility from the identified population groups;
    - Categorize these health facilities according to type of BEmONC;
    - Complete their characteristics and features such as addresses, licensing and accreditation status, ownership, modes of transportation, client volume, etc. Refer to list in shortlisting CEmONC-capable facilities.

3. Assess Suitability of Potential Health Facilities as BEmONC Providers.

    Among the pool of potential facilities as BEmONC service providers, assess their suitability in terms of using core BEmONC capacities as basis. Consider

the recommended type of BEmONC facility that can be established based on the priority level for BEmONC services.

4. Designate Health Facility As BEmONC Provider.

   Designate BEmONC facilities from among those that are considered BEmONC capable. Take note of the following in designating BEmONC: (a) level of priority according to the priority populations' access to the designated BEmONC facility; (b) recommended type of BEmONC facility for the particular population group; and (c) if there is more than 1 BEmONC-capable facility, consider these steps in selecting one:

   - If there is a public owned BEmONC facility with blood services, designate the facility; OR
   - If the public owned facility is not capable of providing BEmONC plus blood services, but a private facility can, designate the private facility; OR
   - If there is a public owned fixed facility BEmONC, designate the facility; OR
   - If the public owned facility cannot provide all BEmONC services, but a private facility can, designate the private facility; OR
   - If the public owned facility can provide BEmONC services through a network arrangement, designate the facility; OR
   - If the public owned facility cannot provide BEmONC services even in a network arrangement, but a private facility can, designate the private facility.

**Box 5: Special Considerations in BEmONC Designation**

*Special Considerations in BEmONC Designation*

1. *If there is need for additional designated BEmONCs as in the case of densely populated urban areas, review the list of facilities that meet the standards and then choose from the list to designate the additional BEmONC.*
2. *If there is no qualified BEmONC within half an hour of travel time from the priority population to the facility, relax the rule to include facilities within a one hour radius and then assess for suitability and designate if qualified.*
3. *If there is no qualified BEmONC or CEmONC within an hour of travel time, the LGU is advised to undertake any if not all of the following in order of priority:*
   - *3.1 Review list of facilities that did not meet the suitability factors. If no facility meets the minimum criteria, a BEmONC or CEMONC from outside the 2-hour radius will have to be identified as referral facility.*
   - *3.2 Set up emergency transport and communication system to serve priority populations by facilitating referral to BEmONCs and CEmONC facilities;*
   - *3.3 Develop alternative transport and accommodation arrangements for mothers about to deliver (e.g. set up dormitories or lodging facilities for expectant mothers and their care providers close to BEmONCs or CEmONCs where they can be accommodated while waiting for delivery)*

*For those areas that have already undergone the facility mapping and needs assessment exercise and/or the facility rationalization planning, it is suggested that the LGU reviews its findings to update the said plans given the current demand for the MNCHN Core Package of Services.*

## 5.2. Verify Services by the Designated MNCHN Service Delivery Network

Capacities of health providers for maternal care services are usually used in designating the service delivery network for MNCHN. This process however presents a risk of omitting other services in the package of services for MNCHN like IUD insertion, bilateral tubal ligation or no-scalpel vasectomy. Similar to maternal care services, these services would require special skills from the provider and adequacy of equipment and infrastructure of a facility.

There is a need to verify services that can be delivered by the service delivery network since these services will also require a certain level of competency by providers. Follow these steps in verifying capacity to deliver other services in the MNCHN package:

1. Check which of the health providers identified as part of the service delivery network can perform the following services:
   a. IUD insertion and removal
   b. No-scalpel vasectomy

c. Bilateral tubal ligation

d. Management of complications due to defective insertion of IUD or abortion

2. If any of the services above cannot be provided, consider the following options:

   a. Improve capacity of providers in the service delivery network

   b. Collaborate with providers in another LGU that is accessible to the priority population group

   c. Negotiate with a private provider such as a physician, non-government organization that can provide any of these services

Annex K is a short discussion on contracting private providers to render services for MNCHN.

# Chapter 6. Strengthen the MNCHN Service Delivery Network

After the SDN has been designated, there is need to assess gaps and strengths in the utilization of services by clients, in the delivery of services by providers as well as in the availability of health systems instruments to sustain delivery of services. This will be the basis of interventions to improve services for priority population groups.

LGUs can use this chapter to review their progress towards improving delivery of services.

## 6.1. Improve Clients' Utilization of Services

The following steps will be followed to improve client's utilization of services:

1. Assess gaps
2. Interventions to improve clients' utilization of services

### 6.1.1. Assess Gaps

Gaps in clients' utilization of services are factors that prevent priority population groups from accessing the core package of MNCHN services. The following factors shall be assessed:

- Information - refers to the lack of awareness/information or misconceptions on the risks and consequences related to providers and services (e.g., pregnant women are not aware of the benefits of at least 4 prenatal visits)
- Cultural Preferences - refers to barriers influenced by beliefs, traditions, and prevailing health practices in the area, as well as personal preference for certain types of providers over another (e.g., women do not like to deliver in the hospitals because nobody could take care of their other children)
- Time - refers to lack of time of clients including their companions to avail of existing services (e.g., spare time of clients do not match operating hours of facilities)
- Distance - refers to conditions where distance and/or rugged terrain or topography that make it difficult for families to access care.
- Capacity to Pay - refers to ability to pay for user fees, including the cost of transportation and costs of other related goods and services (e.g., WRA unable to pay for transportation).

Use Table 6 in assessing clients' utilization of services. Assess utilization of services for each priority population group.

**Table 6: Assessment of Clients' Utilization of Services**

| **Population Group**<br>Municipality:<br>Barangay:<br>Purok: | | Remarks |
|---|---|---|
| **Information** | | |
| 1. Is there a process to assess health needs of population groups? | ☐ Yes<br>☐ No | |
| 2. Are members of the population groups assisted in preparing health plans that are most appropriate for their health needs? | ☐ Yes<br>☐ No | |
| 3. Are population groups informed as to where to avail of services whether from private or public health providers? | ☐ Yes<br>☐ No | |
| 4. Is there a system that would provide population groups information on good health practices? | ☐ Yes<br>☐ No | |
| 5. Can clients send their feedback about the type and quality of service that they receive from providers? | ☐ Yes<br>☐ No | |
| **Cultural Preferences** | | |
| 6. Are there any cultural/ethnic group beliefs that prevent the priority population from seeking care for health professionals? | ☐ Yes<br>☐ No | |
| **Time** | | |
| 7. Can clients avail of services at a time that is most convenient for them? | ☐ Yes<br>☐ No | |
| **Distance** | | |
| 8. Is the distance or terrain from place of residence of priority population to the nearest health facility a barrier to seeking care? | ☐ Yes<br>☐ No | |
| **Capacity to Pay** | | |
| 9. Are members of the population groups able to pay for the cost of outpatient services from the CHT or RHU? | ☐ Yes<br>☐ No | |
| 10. Are members of the population groups able to pay for the cost of inpatient services from BEmONC or CEmONC-capable facilities? | ☐ Yes<br>☐ No | |
| 11. Are members of the priority population capable of paying for other expenses related to seeking care such as transportation cost, food during confinement and the like? | ☐ Yes<br>☐ No | |

### 6.1.2. Interventions to Increase Client's Utilization of Services

Determine interventions that are most appropriate to improve utilization of services. The MNCHN Team should note practices or systems that already exist to ensure that clients utilize services. Assess how these practices can be improved. It is necessary to note these practices to ensure that funding for these activities by the LGUs, either by municipality or by the province, are continued and sustained.

**Community Health Team for Identified Priority Population Groups**

Community Health Teams (CHTs) are instrumental in assisting priority population groups in assessing health risk and needs, preparing health plans such as reproductive health plan, birth plan, well-baby or sick-baby plan, providing information on available services including the cost of these services and information on available support from the community like transportation and communications systems.

The CHT could also facilitate the conduct of regular outreach services for remote areas and organize the emergency transportation and communication systems in a community.

CHTs are part of the MNCHN Service Delivery Network and the process of organizing, improving capacity and delivering services is discussed in succeeding sections of the manual.

**Transportation and Communication Systems**

The availability of transportation and communications system to support the functionality of the MNCHN SDN especially in remote areas is critical considering the terrain and distance to facilities. The following is a set of procedures that communities can follow to provide transportation and communication services for priority population groups.

1. Difficulty in reaching health facilities can be identified using the form to assess the utilization of services by clients. Solutions to the problem shall be discussed by the CHT together with community leaders or barangay officials who have the capacity to mobilize resources in the area.

2. Identify available transportation and communication systems in the area. These may include public transportation like jeepneys, motorboats, bancas, bicycles with trailers, tricycles with platform, tractors with trailers, reconditioned vehicles and even farm carts. For communications, these may include (i) landlines, (ii) 2-way radio; and (iii) dedicated mobile line for official use by the facility.

3. Map out the availability of the different transportation and communication systems for the following:

    - From households to the primary level of care such as BHS, RHU, outpatient clinics

    - From BEmONC capable facility to CEmONC capable facility

4. Negotiate with owners of vehicles for the use of the vehicle by members of the community especially during emergencies, and other arrangements that need to be made to ensure safety during travel.

**Box 6: Patient Navigation**

*The Family Health Book Pilot in Compostela Valley*

*Barriers to utilization of health services by families significantly contribute to poor health outcomes. At times, even if health facilities, services and supplies are available, many families are unable to use appropriate services because they cannot recognize health risks, nor determine the services needed, locate where these services are available and know how to finance the use of these services.*

*In Compostela Valley, only 30 percent of women of reproductive age practice family planning. Among women who do not practice family planning, 53 percent attribute it to fear of side effects while 7 percent claim that they do not know about family planning. Among those who are pregnant, 41 percent of those that did not avail of prenatal care find it inconvenient due to distance and cost, while another 16 percent believed it was not necessary. In terms of delivery, close to 80 percent of births are delivered at home under the care of traditional birth attendants (TBA). Of these mothers, 24 percent believe that delivering with TBAs is safe.*

*The low utilization rates of critical MNCHN services have also been attributed to the distance and cost of traveling to facilities, the lack of information on health risks and needs as well as on financing options such as PhilHealth coverage and their entitlements as members. Utilization is further hampered by the lack of available providers and services in the area, including information on their capabilities and quality of care provided. Distance is particularly critical during emergencies considering that only three out of 11 hospitals had functional ambulances and only two have working telephone lines. Interestingly though 30 percent of households have cellular phones.*

*To improve health utilization patterns and address the identified barriers at the level of the families and the delivery system, the Province of Compostela Valley in cooperation with the CHD Davao Region and the Health Policy Development Program(a USAID supported project) implemented the Family Health Book (FHB) pilot.*

*Locally known as "Giya sa Maayong Panglawas", a book containing critical health information (e.g. health messages, list of providers with their address, operating hours and fees) was distributed to 4,735 randomly identified mothers in 47 barangays in four municipalities. The information provided was reinforced through family orientations and was acted on through the process of health risk assessment, health use planning for specific services and facilitated availment of services with the help of volunteer health navigators. The use of health navigators was adopted from the experience in developed countries like the US (i.e. cancer and HIV treatment navigators) and UK (care navigators) in helping patients choose treatment options, providers and financing sources as well as promote compliance to treatment. A total of 441 volunteer health navigators (mostly BHWs) were recruited, trained and deployed to groups of families. Navigators also assisted in organizing MNCHN focused outreach activities as well as in linking families with an emergency transport and communication system that utilized existing community resources (e.g. available ambulances, private and public vehicles, mobile phones).*

*Results from the FHB Operations Research showed that the combination of the book (information) and navigator-assisted-health use planning by mothers and families increased utilization of critical MNCHN services. Modern FP use increased by 23 percentage points. The timing of prenatal care visits by the first trimester improved by five percent while the likelihood of completing 4 prenatal visits increased by 11 percentage points. Moreover, full immunization of children increased by 10 percentage points. More importantly, deliveries with skilled attendance and facility based births increased by 25 percentage points. Modern FP use also improved by an additional 10 percentage points from those that availed of MNCHN outreach services.*

5. Determine how the community or barangay can provide resources to support the transportation and communication systems. Some possible sources are as follows:

- Barangay IRA – the barangay council can allocate funds for transportation cost health emergencies
- Companies with Corporate Social Responsibility (CSR) Programs – some telecommunications companies offer this assistance to remote communities
- Contributions from the community through a local financing system

**Outreach Services**

Outreach services should be regular and targeted towards hard-to-reach communities. Since these areas are not frequently visited by health providers and health facilities are not available, outreach activities can bring the needed services closer priority population groups, ensuring their accessibility to health services and adherence of the families to their health use plans. The following steps may be followed in conducting outreach services:

1. Organize a team that will plan, prepare, conduct and monitor outreach activities: a) **the planning team** to be headed by the MHO, with MLGU budget officer, procurement officer, PHO representative and the concerned barangay captains; b) the **medical team** composed of the PHO, MHO and health workers of participating NGOs; c) the **support team** composed of the CHT and barangay officials/volunteers, and NGOs; and d) the **monitoring team** from PHO.

2. Select barangays for outreach services using the following criteria: a) with areas/sitios where the travel time to the nearest RHU or government hospital is more than 2 hours using the common modes of transportation; b) with considerable number of families part of the priority population groups; c) the areas should be accessible by a motorcycle or "habal-habal" or boat; and d) the sitios/areas should be safe for the medical team. Other factors to consider in determining the number of barangays for outreach is the budget of the municipality, capacity and willingness of the medical team and the barangay officials.

3. Schedule outreach activities regularly to remote priority population groups. If possible conduct outreach activities every quarter. The schedule of the outreach should not interfere with the major activities of the residents during planting, harvesting and fiesta seasons, and important weekday or weekend activities.

4. Provide services based on health needs identified in the health plans of families. Health plans should be consolidated and request for appropriate services will be relayed to the municipal health office by the midwife in-charge of the barangay assisted by the CHT. Services may include prenatal/neonatal care (tetanus immunization, iron-folate supplementation, hypertension screening, etc.), child care services (immunization, nutrition counselling) and reproductive health services (counselling and provision of

FP commodities). Birth registration and PhilHealth orientation can also be provided.

5. The Municipal Health Officer (who heads the planning and medical team) will schedule, identify the venue and the participants, and prepare the logistical requirements for the outreach. Depending on the availability of budget, the MHO could procure and/or request the assistance of other agencies (Provincial Health Office/Department of Health/ other GO's and NGO's) to ensure that services and commodities will be available during the outreach.

6. The support team headed by the barangay captain prepares the venue and conducts promotional activities to ensure that families will attend and avail of the health services offered during the outreach.

7. On the day of the outreach, the medical team with the assistance of the support team shall provide the different health services. A suggested patient flow shall be followed to ensure that services will be provided adequately and in an orderly manner. Aside from the core MNCHN services and ancillary services, information support to families can also be provided (e.g. updating of health plans, health education, and referrals to appropriate providers). Patient and provider feedbacks should be gathered to improve subsequent outreach activities.

## 6.2. Improve Capacity of Health Providers to Deliver Services

The capacity to provide services by each health provider in the network shall be assessed by looking at a) adequacy and capacity of health personnel, b) appropriateness of equipment and infrastructure, and c) adequacy of logistics and supplies. Appropriate interventions based on these gaps can be implemented by the province and its component municipalities and cities or by independent cities.

### 6.2.1. Organize the Community Health Team

A critical component of the MNCHN Service Delivery Network is the Community Health Teams (CHTs). The LGU should therefore ensure that each priority population group has access to a CHT that provide women, mothers and children the right information on health including where and when they could avail of services and how much are they supposed to pay for services that they receive; provide basic services in nutrition, family planning, antenatal care and follow-up care; facilitate access to services through outreach services; ensure availability of emergency transportation and communication systems; guide and assist families in preparing birth plans and other health plans such as well-baby and

sick-baby plans, limiting or spacing children and the like; and tracking and active master listing of women, mothers and children in the community.

**Functions of the CHT**

1. Assess health needs of families especially women, mothers and children and assist mothers fill-up health plans to respond to families' health needs. These health plans include the following: reproductive health plan, birth plan, well-baby and sick-child plans.

   Annex D is a set of instructions on how to conduct a health risk assessment using the health risk assessment tool. Annex E contains samples of health plans and instructions on how to assist mothers and families in preparing or developing their health plans. Annex F is a tool that CHTs could use to monitor adherence to the different health plans and follow-up families as needed.

2. Actively master list women of reproductive age especially those with unmet need for family planning, women who are pregnant or post-partum, and children 0 to 11 months old and those 6 to 59 months old.

3. Inform families and other community members of available services and the corresponding fees of the different health providers in the area.

4. Inform families of the need to know their registration status with PhilHealth and the benefits of being covered by the National Health Insurance Program.

5. Advocate for prenatal care, facility-based deliveries, postpartum and newborn care as well as provide health information such as self-care to address common health problems during pregnancy.

6. Guide women in choosing the appropriate providers of the MNCHN Core Package of Services.

7. Reports maternal and neonatal deaths to RHU and participate in maternal death reviews.

8. Track and follow-up clients such as those that were already given initial service. For example, FP users who need replenishment and follow-up check-up must be encouraged to consult the facility. Pregnant women who have had their initial consults should be followed up at home to ensure that they follow advice given by the health staff and to continue seeking consults up to their third trimester of pregnancy. Children that need follow up immunization services should also be reminded to go back to the health facility. Post-partum women must also be followed up to avail of services and have follow-up check-up after delivering their babies. In some areas, follow-up and tracking is systematically done by the BHWs or other volunteer workers. In other areas, notes reminding them of their follow-up visits are sent by health staff to other community members.

9. Facilitate the conduct of outreach activities by organizing regular, comprehensive and systematic outreach services to remote barangays or difficult to reach areas.

10. Facilitate access of families to transportation and communication systems especially during emergencies.

11. Serve as link between families, communities and local authorities and providers of MNCHN health services.

**Assess Gaps**

Follow these steps in assessing gaps of CHTs:

1. Assess adequacy of staff using the following human resource standards:

The following service ratios shall be followed in assessing adequacy of health volunteers, midwives and RHU in the community:

- Ratio of BHWs to Households: 1:20 households. BHWs and other health volunteers shall be organized into Community Health Teams capable of performing services mentioned above.
- Ratio of BHS/MW to Population: 1 midwife to 5,000 populations
- Ratio of RHU to Population: 1 RHU to 20,000 populations

2. Using Annex G, assess competency of health personnel and other members of the CHT
3. Using Annex H, assess suitability of equipment and infrastructure for CHTs
4. Using Annex I, asses adequacy of logistics and supplies
5. Using Table 7 worksheet below, fill up the gaps that were identified in terms of adequacy of staff, competencies not met, equipment needed, infrastructure that need to be improved or developed, equipment for repair and for procurement, needed logistics and supplies under Column 1.
6. If there are several CHTs in the municipality, the municipality/city or province may consolidate and cluster similar gaps identified.

**Table 7: Service Delivery Gaps and Proposed Interventions for CHT**

| Gaps | Proposed Intervention e.g. training, renovation, procurement of drugs | Time Frame | Resource Requirements | | | |
|---|---|---|---|---|---|---|
| | | | Description of Needed Resources | Quantity | Unit Cost | Cost |
| Column 1 | Column 2 | Column 3 | Column 4 | Column 5 | Column 6 | Column 7 |
| Adequacy of Human Resource Complement | | | | | | |
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| Training needed | | | | | | |
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| Equipment and Infrastructure Requirements | | | | | | |
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| Logistics and Supplies Requirements | | | | | | |
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**Interventions**

Based on the above assessment, identify key interventions that need to be done in order to establish the community-level MNCHN service delivery network. The following measures are recommended:

- Organize CHT in each of the barangays/puroks/sites where majority of the priority population groups reside
- Expand the base of BHWs or other similar community volunteer workers to provide promotive and preventive MNCHN services at the household level
- Recruit and deploy or reassign health staff (e.g. midwife) to adequately cover the priority population groups
- Increase capacity to render services. The DOH has developed several training packages and manual that can assist CHTs in performing their duties such as the CHT Manual, Caring for Mothers and Newborn. Training on Family Planning such as Family Planning Competency-Based Training Level 1 and Level 2, NSV and BTL can also be availed from accredited

DOH training facilities. Training is also available concerning the navigation functions of the CHTs.

- Undertake regular outreach activities to meet the MNCHN needs of those in isolated/hard to reach areas
- Expand the coordination of MNCHN service provision with the private health care providers
- Establish new BHS/clinics/RHUs to adequately meet the MNCHN needs of the population
- Equip community-based health facilities with transportation and communication system
- Establish and strengthen linkage with other health care facilities for the provision of MNCHN core package of services. The process for referral to other facilities in the service delivery network and back should be clearly mapped out. A two-way referral system is needed to ensure continuity of service and follow-up of clients in the community.

1. List down appropriate interventions across gaps identified in Column 2 of Table 7 above.
2. Next determine the target time frame for the start and completion of proposed interventions in Column 3 of Table 7 above.
3. Identify resources needed for proposed interventions (Column 4), including the number of resource needed (Column 5), unit cost (Column 6) and total financial requirements (Column 7).

### 6.2.2. Improve the Designated CEmONC-Capable Facility

The highest level of care in the MNCHN core package of services should be available to priority population groups and the public in general. Follow these steps to assess gaps and propose interventions in the delivery of CEmONC services.

#### Assess Gaps

Follow these steps in assessing gaps of CEmONC-capable facilities:

1. Assess adequacy of staff using the following human resource standards

   A typical CEmONC-capable facility should have the following human resource complement:

   - 3 CEmONC Teams (1 team per 8 hour shift) composed of 1 doctor preferably obstetrics-gynaecology specialist or surgeon or GP trained in CEmONC; 1 anaesthesiologist or GP trained in anaesthesiology (on call); 1 paediatrician (on call); 3 operating room nurses (1 per shift); maternity ward nurses (2 per shift); 3 medical technologists (1 per shift)

- Itinerant team composed of 1 doctor (surgeon), 2 nurses (or 1 nurse &1 midwife)

2. Using Annex G, assess competency of health personnel of the CEmONC
3. Using Annex H, assess suitability of equipment and infrastructure for CEmONC
4. Using Annex I, asses adequacy of logistics and supplies
5. Using the Table 8, fill up the gaps that were identified in terms of adequacy of staff, competencies not met, equipment needed, infrastructure that need to be improved or developed, needed logistics and supplies under Column 1.

**Table 8: Service Delivery Gaps, Proposed Interventions for CEmONC-capable facility or network of facilities**

| Gaps | Proposed Intervention e.g. training, renovation, procurement of drugs | Time Frame | Resource Requirements | | | |
|---|---|---|---|---|---|---|
| | | | Description of Needed Resources | Quantity | Unit Cost | Cost |
| Column 1 | Column 2 | Column 3 | Column 4 | Column 5 | Column 6 | Column 7 |
| Adequacy of Human Resource Complement | | | | | | |
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| Training needed | | | | | | |
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| Equipment and Infrastructure Requirements | | | | | | |
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| Logistics and Supplies Requirements | | | | | | |
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**Interventions**

1. After assessing gaps in terms of adequacy and capacity of personnel, functional equipment and infrastructure, and adequacy of logistics and supplies, identify appropriate interventions to address these gaps and fill up Column 2 of Table 8 above.

2. Next determine the target time frame for the start and completion of proposed interventions in Column 3 of Table 8 above.

3. Identify resources needed for proposed interventions (Column 4), including the number of resource needed (Column 5), unit cost (Column 6) and total financial requirements (Column 7).

4. Consult and negotiate the terms of use of the CEmONC facility with the head of the designated CEmONC hospital and agree on the following:

   - Propose an arrangement for service use to govern the terms of accessing the CEmONC services. This may include the definition of a special service package for the target population, provision for subsidized or discounted user fees, compliance to minimum quality of care levels, referral arrangements and in the social marketing and promotion of the facility as the designated CEmONC;

   - Negotiate the terms of service use with the head of the CEmONC facility, and formalize these agreements and arrangements through an Executive order (if owned by LGU within the province) or a Memorandum of Agreement (if private or owned by adjacent LGU);

   - Use these agreements and arrangements as basis for estimating investments and in the allocation of resources. Compliance to the terms of service use will form part of these formal agreements as basis for mobilizing resources by the province and component LGUs or independent cities in support of the CEmONC.

### 6.2.3. Improve the Designated BEmONC-Capable Network of Facilities and Providers

Follow these steps to assess gaps and propose interventions in the delivery of BEmONC services.

#### Assess Gaps

Follow these steps in assessing gaps of BEmONC-capable facilities:

1. Assess adequacy of staff using the following human resource standards

   A typical BEmONC-capable hospital has the following human resource complement:

   - 3 BEmONC teams per hospital (1 team per 8 hour shift) composed of 1 doctor, 1 nurse, 1 midwife, 1 medical technologist on call

   - A BEmONC-capable RHU or BHS or lying-in clinics/birthing homes should at least have 1 midwife or nurse with a physician on call.

2. Using Annex G, assess competency of health personnel of the BEmONC

3. Using Annex H, assess suitability of equipment and infrastructure for BEmONC

4. Using Annex I, asses adequacy of logistics and supplies

5. Using the Table 9, fill up the gaps that were identified in terms of adequacy of staff, competencies not met, equipment needed, infrastructure that need to be improved or developed, needed logistics and supplies under Column 1.

**Table 9: Service Delivery Gaps, Proposed Interventions for BEmONC-capable network of facilities and providers**

| Gaps | Proposed Intervention e.g. training, renovation, procurement of drugs | Time Frame | Resource Requirements | | | |
|---|---|---|---|---|---|---|
| | | | Description of Needed Resources | Quantity | Unit Cost | Cost |
| Column 1 | Column 2 | Column 3 | Column 4 | Column 5 | Column 6 | Column 7 |
| Adequacy of Human Resource Complement | | | | | | |
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| Training needed | | | | | | |
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| Equipment and Infrastructure Requirements | | | | | | |
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| Logistics and Supplies Requirements | | | | | | |
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**Interventions**

1. After assessing gaps in terms of adequacy and capacity of personnel, functional equipment and infrastructure, and adequacy of logistics and supplies, identify appropriate interventions to address these gaps and fill up Column 2 of Table 9 above.

The Department of Health has developed and made available training packages to improve capacity of designated BEmONCs such as training of midwives in the active management of the third stage of labor and essential newborn care. The DOH also provides BEmONC Training for a team composed of physicians, nurses and midwives. To avail of these training packages and materials, the LGU is advised to contact the CHD.

2. Next, determine the target time frame for the start and completion of proposed interventions in Column 3 of Table 9 above.

3. Identify resources needed for proposed interventions (Column 4), including the number of resource needed (Column 5), unit cost (Column 6) and total financial requirements (Column 7).

4. Consult and negotiate the terms of use of the designated BEmONC with the head of the facility and agree on the following:

- Propose an arrangement for service use to govern the terms of accessing the BEmONC services. This may include the definition of a special service package for the target population, provision for subsidized or discounted user fees, compliance to minimum quality of care levels, referral arrangements and in the social marketing and promotion of the facility as the designated BEmONC;

- Negotiate the terms of service use with the head of the BEmONC facility, and formalize these agreements and arrangements through an Executive order (if owned by LGU within the province) or a Memorandum of Agreement (if private or owned by adjacent LGU);

- Use these agreements and arrangements as basis for estimating investments and in the allocation of resources. Compliance to the terms of service use will form part of these formal agreements as basis for mobilizing resources by the province and component LGUs or independent cities in support of the BEmONC.

Table 10 shows a summary of areas that should be negotiated for the service delivery network by provinces and its component LGUs and independent cities.

**Table 10: Areas for Negotiations for the Service Delivery Network**

| Negotiation Area | Negotiation Terms | Negotiation Outputs |
|---|---|---|
| Service delivery | Scope and coverage of priority population | Estimated number and location of the assigned priority population |
| | Service package | Facility-specific service package consistent with core MNCHN package for BEmONCs<br>Projected service loads and proportion of target population to general population in patient census |

| Negotiation Area | Negotiation Terms | Negotiation Outputs |
|---|---|---|
| | Mechanisms of access | Operating hours, transportation and communication arrangements for routine and emergency referrals, basic documents to bring on consult and admission, designation of action officer/helpdesk in facility |
| | Staff development | Types of training, names of staff to be sent to training, return service agreements |
| Financing | Fees and charges | Service fees for specific services, client segmentation categories and criteria, fee discounts, payment terms by clients |
| | Subsidy | Annual budget allocations from LGU, share from donated commodities, mode and timing of releases |
| | Upgrading of facilities and equipment | Facility development plan, list of proposed infrastructure and equipment investments, projected investment requirements, sources of financing, arrangements for paying for joint costs, mode and timing of releases |
| | PhilHealth | Enrolment targets among priority population, accreditation investments, facilitation of claims processing, sharing of revenues from capitation and claims |
| Regulation | Compliance to standards | Adoption of MNCHN practice and facility standards, conduct of compliance monitoring activities, incentives for quality care |
| Governance | Mandate and joint liabilities | Defined mandates, LGU obligations and joint liability definitions<br>Crafting of appropriate legal instruments to formalize agreements |
| | Enabling policies | List of orders, ordinances and other types of policies for development and enactment to facilitate implementation of the MNCHN strategy by the BEmONC |
| | Management arrangements | Reporting and communication protocols, decision making and representation in joint policy making and management bodies<br>Reporting arrangements with FHSIS and other government-prescribed databases for notifiable diseases and conditions related to maternal health Financial accountability |
| | Information, promotion and advocacy | Promotion of the facility as preferred provider for BEmONC/CEmONC services; advocacy with other LCEs in catchment area to support designated BEmONC/CEmONC |

# Chapter 7. Improve Local Health Systems

The MNCHN Strategy should be supported by health system instruments to sustain its implementation. These instruments may fall under governance and regulatory measures which should be put in place by the province and all its component municipalities and cities.

## 7.1. Assess Presence of Local Health Systems Instruments

The following instruments or mechanisms should be present in the local health systems to support and sustain the provision of MNCHN core package of services.

1. Inter-LGU arrangement in health service delivery which are collaborative arrangements or partnerships with other contiguous LGUs and the province
2. Functional Referral System which is indicated by the presence of a written manual or procedures in referring clients, service providers are oriented on the referral guidelines; referrals are acted upon by the referring units; and feedback on care provided is working
3. Enrolment of constituents to the National Health Insurance Program (NHIP) especially the poor
4. Accreditation of hospitals and facilities such as RHUs, BHS, lying in clinics or birthing homes or other outpatient clinics and health providers by the NHIP
5. Local budget for health
6. Public-Private partnership exists when a collaboration between the public health facility and the private sector which may include service delivery, monitoring and evaluation, health promotion, technical support and the like
7. Functional procurement and logistics management information system
8. Emergency transport and communication systems especially for priority populations
9. Plan which will indicate vision, target priority population and medium-term performance indicators for the MNCHN Strategy

## 7.2. Local Health Systems Instruments

After assessing the presence of local health systems instruments, determine the mechanisms that need to be enhanced or improved to sustain delivery of MNCHN

services. Health systems instruments can be classified into governance, regulations and financing.

### 7.2.1. Governance Measures

Broadly defined, health governance concerns the actions and measures adopted by the government, health providers and the community to organize itself in the promotion and the protection of the health of its population. For the implementation of the MNCHN Strategy, in particular, or health, in general, governance is translated to having a (1) vision of what the LGU wants to achieve such as reducing maternal death, (2) involvement of all stakeholders in the locality and coordination mechanism to synchronize their actions, (3) monitoring system to assess progress, (4) health information system to gather necessary data, (5) system that would continuously improve capacity of health human resource, (6) functional procurement and logistics management system to ensure availability of supplies in health facilities, (7) health promotion and BCC to increase demand, improve feedback and sustain support for programs, (8) support for the MNCHN strategy as shown by commitments to use local funds interventions for services such as contracting or hiring personnel, enrolling members to NHIP, upgrading facilities for accreditation and procurement of logistics, drugs and supplies.

1. MNCHN Plans

   LGU shall develop the MNCHN plan within the Province-wide Investment Plan for Health (PIPH) and their corresponding Annual Operational Plan (AOP). The MNCHN Plan should be incorporated into the PIPH which is the medium plan for health of the LGU. The MNCHN Plan should clearly identify its goals of reducing maternal and neonatal deaths, interventions to achieve this goals, indicators of performance to let LGUs appreciate their progress and financial requirements to sustain operations and generate resources for new investments.

   The plan should at least ensure the development and implementation of the MNCHN Service Delivery Network particularly CHTs as well as its support services such as safe blood supply, transportation and communication services, and demand generation activities.

2. Coordination mechanism

   The MNCHN Strategy cannot be implemented by a single entity alone. Its implementation requires the participation of all component LGUs in the locality, health providers, community members as well as civil society groups. Coordination mechanism across LGUs and other stakeholders should be defined to harmonize and maximize available resources. There are two levels of coordination for MNCHN Strategy; one is among local chief executives and health managers and second is among health providers.

a. Coordination Mechanism among Local Leaders

The coordination mechanism among local chief executives, health managers and representatives of health providers should be the venue share resources, decide on issues for the province and all component LGUs, define responsibilities of LGUs for the implementation of the MNCHN Strategy, and define protocols for referrals, among others. Below is a list of concerns that can be tackled:

- Describe the referral system from the community up to the CEmONC facility and back;
- Define responsibilities of each LGU in the implementation of the strategy, i.e. Municipal LGUs shall ensure that there is a transportation system coming from communities to facilities in the service delivery network to transport women, mothers and children; Provincial LGUs shall ensure that all health providers within the service delivery network have access to training, sources of financing, and the like, MLGUs and other members of the community shall be in-charge of communication and health promotion campaigns; PhilHealth shall conduct regular information campaigns to members and beneficiaries of the program;
- Define roles and participation of the private sector in the implementation of the MNCHN Strategy i.e. participation of local transport groups particularly in transporting clients from residences to health facilities, health volunteers to give information, follow-up clients, guide clients in birth planning and the like, participation of local media in promoting services and benefits of getting health services; and
- Develop a unified recording system which should include reporting system of the private health providers in the MNCHN Service Delivery Network.

b. Coordination among Health Providers

The coordination mechanism of health providers should be among providers in the MNCHN Service Delivery Network to be led by the CEmONC being the end-referral facility. It shall provide regular feedback to other members of the network especially on maternal and neonatal deaths, facilitate and participate in maternal death reviews and the like. This would be the venue for providers to report or discuss clinical guidelines for management of MNCHN cases such as AMTSL, ENC, BEmONC and CEmONC services, BTL, NSV, IUD, micronutrient supplementation, among others. This can also be used to discuss needs of the service delivery network or ways to improve current systems or challenges being encountered by providers.

It is important to note that coordination activities among health providers should be elevated to the group of local chief executives and health managers for concerns and problems to be acted upon.

As mentioned in previous chapters, the MNCHN Strategy cannot be implemented by a municipality or city alone. It has to share resources, services and expertise with other municipalities or the province. As such, there should be a coordination mechanism between health providers.

3. Capacity Building Program for Health Providers

   LGUs shall conduct a regular assessment of the capacity of MNCHN providers such as adequacy of staff with appropriate training, upgrading health facilities to provide a safe environment for service delivery and care, procurement of equipment and logistics and supplies like delivery kits, drugs and medicines, FP commodities, vaccines, etc., and adoption of standards and protocols in service delivery. The checklist of standards for human health resource, equipment and infrastructure, basic supplies, drugs, and FP commodities in the previous chapter can be used by the LGU to regularly check capacity of health providers.

4. Logistics Management and Information System

Adequacy and appropriateness of drugs, supplies including FP commodities, micronutrient, vaccines and the like is critical in the provision of services. Set-up and maintain a logistics management and information system that would:

a. Forecast requirement of all LGUs in the locality;

b. Facilitate procurement from reliable suppliers;

c. Distribute drugs, commodities and supplies to all LGUs following standards in cold chain maintenance, and the like;

d. Maintain an inventory management to monitor availability of drugs, commodities and supplies;

e. Develop a logistics management information system that would guide LGUs in planning for next cycle of procurement.

The DOH has been providing and can provide drugs, commodities and other supplies to the LGUs. It is therefore important to coordinate with DOH on the availability of stocks and provide feedback on the distribution of goods to clients to allow DOH to plan its support to LGUs.

Annex J is a guide for stock and inventory management that municipalities could use to manage logistics and supplies. The DOH has issued guidelines on reporting and recording of FP commodity stock at the provincial level. The "Philippine Clinical Standards Manual on Family Planning" has included these forms as well as instructions on filling them up. These reports can be used by the province to determine any commodity support that municipalities/cities may need.

5. Monitoring System

Track progress of implementation of the MNCHN Strategy by (a) developing the MNCHN Results Framework integrating the province-wide or city-wide strategies and key interventions, (b) identify members of the local M & E team and link them with DOH-CHDs as well as key stakeholders like hospitals, private sector, academe, NGOs, (c) design and implement the monitoring plan which should include frequency of visits to facilities and communities, reporting mechanisms to local officials and community members, (d) conduct review and planning to assess progress yearly or semi-annually, (e) prepare and implement revisions in the MNCHN plans depending on current situations in the locality.

A discussion devoted on monitoring progress in implementing the MNCHN Strategy is in Chapter 8.

6. Strengthen Health Information System

Working with several health providers coming from both the public and private sector requires the following:

a. Identify information that should be collected from the community up to hospitals. The LGU can follow outcome indicators as defined in the LGU scorecard. This will avoid collection of too many indicators from the field.

b. Validate information being collected by health providers in the field and put-up or enhance existing data collection system to ensure that valid and accurate data are reported by health providers.

c. Develop a unified reporting form and system within the service delivery network.

d. Set-up an entity that would serve as the repository and processing unit of all data collected from the different providers. Regularly review data being collected and validate information if necessary. This information can be used in planning activities yearly or in procurement of goods and supplies.

7. Strengthen Public-Private-Partnership

   Strengthen public and private collaboration particularly for MNCHN service delivery, logistics and equipment sharing, reporting and recording of service coverage or reports on maternal and neonatal deaths. LGUs shall enter into a MOA with private providers that are capable of delivering MNCHN services such as BEmONC or CEmONC for hospital providers.

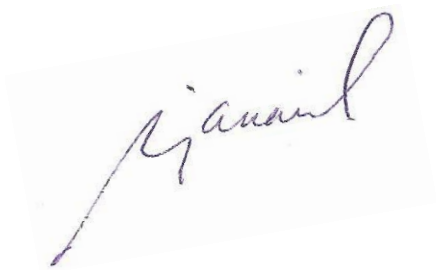
   LGUs may have to initially assist private midwife practitioners in their locality to improve their facilities, increase their capacity to provide services and meet service standards to qualify as an accredited provider of PhilHealth and as part of the BEmONC network. LGUs should also develop mechanisms to

allow private midwife practitioners to receive goods such as drugs, supplies and commodities from public sources.

The LGU and private health providers should agree on the following:

- Services to be provided
- Communities that should be provided services
- Financing arrangements – cost of services, reimbursements from PhilHealth, and the like
- Recording and reporting of cases including frequency of reporting to the LGU
- Compliance to PhilHealth accreditation and other service standards as part of the BEmONC network

Annex K is a set of instructions that LGUs may use in contracting private practicing midwives in their locality for the provision of MNCHN core package of services.



**Box 7: Public Private Partnership**

***The IMAP Lying in Clinics in Bohol***

*In 2007, the contraceptive prevalence rate in Bohol was below the national average at 27 percent. More importantly, 74 percent of births were delivered at home although 85 percent were attended to by skilled birth attendants. In order to expand access to MNCHN services, particularly facility based deliveries, the Integrated Midwives Association of the Philippines (IMAP) in the Province of Bohol established a network of lying in clinics under the IMAP Lying In Clinic, Inc. (ILC).*

*The ILC started operating its first lying in clinic in 1997 with just two beds. It has now expanded into an 8 bed facility, handling 55 deliveries a month and operates on 24 hour basis. In partnership with the Province of Bohol and its component municipalities with support from the Private Sector Mobilization for Family Health Project supported by USAID, the ILC now operates a network of nine lying in clinics strategically-located to serve the 30 municipalities of Bohol. Eight of these clinics are already accredited for the Maternal Care and Newborn Packages.*

*The ILC Lying In clinics provide services such as family planning, antenatal care and attend to uncomplicated (normal) deliveries. In the event of maternal or newborn emergencies, midwives refer cases to their partner physicians for co-management. Patients needing CEMONC level care are referred usually to the Gov. Celestino Gallares Memorial Hospital, a DOH-retained tertiary facility. To establish a working relationship with this hospital, IMAP Bohol and the hospital entered into a Memorandum of Understanding (MOU). IMAP has already referred about 695 cases to the Gallares Hospital since 2006.*

*To market their services, midwives conduct regular visits to partner companies for free seminars on FP and MCH, FP counseling, and pre-natal check-ups. This was pioneered by the Calceta branch of the ILC that has provided reproductive health services to the employees of the Bohol Quality Corporation and the Alturas Group of Companies since 2008. As a result, more than 20 deliveries from 2008-2009 were from employees of these companies.*

*The ILC also entered into joint ventures with the local governments in Bohol. This is the case of the ILC Lying In clinic in Barangay Tinago Health Station in the Municipality of Dauis, where the Barangay LGU and the Tinago Multipurpose Cooperative entered into a joint partnership with ILC to transform a previously non-functional BHS into a PhilHealth accredited birthing home operating on a 24-hour basis.*

*In addition, the ILC also provides additional employment opportunities for government midwives, with the Mayor allowing private practice after office hours in the ILC Lying In clinic in Barangay Katagbacan in the Municipality of Loon.*

*The ILC also provides business opportunities to midwives and their families such as the Calape branch of the ILC Lying In clinic which is owned by an IMAP member who turned the clinic operation into a family business.*

*As the lying in clinics are commercial operations, IMAP sustains service provision by charging minimal user fees and offer package rates for its services. Since the ILC Lying In clinics are also PhilHealth accredited, those covered do not have to pay out of pocket for delivery services.*

*To maintain quality, the ILC Lying In clinics institute a quality assurance system for its services (including conduct of public-private case conferences). The ILC also contributes to health system strengthening by regularly submitting service statistics to the government health information system and by actively participating in the development of LGU contraceptive self-reliance plans as well as the Bohol Province Wide Investment Plan for Health (PIPH).*

*Source: Private Sector Mobilization for Family Health (PRISM) 2, a USAID-supported project.*

### 7.2.2. Regulatory Measures

The adoption of the MNCHN Strategy in each identified priority province or city requires a number of executive issuances and/or legislations to facilitate and sustain its implementation. The following areas are identified as areas that require policy issuance support and/or legislation:

1. Issuance of a Policy Directive on the Adoption of the MNCHN package of interventions to be made available to clients at appropriate levels of care with adherence to standards of quality

   An advisory either through an executive order or a local legislation must be issued to concerned health facilities and other institutions in the locality to promote the adoption of the Core MNCHN Package of Services that must be made available to clients and to inform communities of the services that can be availed of at each level of care.

   The policy directive will promote and enforce regulations supportive of MNCHN goals and objectives, such as: (a) promotion of facility-based deliveries, and prohibition of TBA-assisted deliveries; (b) promotion and adoption of FP services as part of the package of interventions, which would result to adoption of the CSR policies and guidelines; and (c) reiteration of existing laws/legislation to promote MNCHN interventions such as exclusive breastfeeding, and adherence to Milk Code provisions; immunization of children, use of fortified foods, micronutrient supplementation and the like.

2. Engagement of different health facilities as members of the MNCHN service delivery network from the community level up to the province/city level, and across private and public facilities

   There is a need for the PHO/CHO to come up with an official issuance (Memorandum, Executive Order) regarding the establishment of the MNCHN Service Delivery Network that would cater to the needs of the identified priority population groups. The PHO/CHO also needs to enter into Memorandum of Agreement (MOA) with health facilities and providers that have been selected and designated as providers of CEmONC and BEmONC services particularly those that are privately owned or retained hospitals of the DOH or owned by another LGU.

3. Organization of community-based MNCHN team in every community, and formally engage their services

   LCE shall enter into a Memorandum of Agreement with the local League of Barangays and the LCEs of component LGUs, if applicable, to designate Community Health Teams. LCEs should likewise issue a Memorandum directing the Local Health Office to conduct orientation seminars for component LGUs and/or barangays on the steps in establishing Community Health Teams, their roles and responsibilities and financing CHTs.

### 7.2.3. Financing Measures

Financing measures are critical for the continuous and sustained operations of the network of MNCHN health care facilities in the LGU. After identifying MNCHN interventions appropriate to the needs of the target population groups in Chapter 6, the LGU should (1) generate resources to fund critical investment requirements and (2) develop schemes that would minimize cost of implementation.

This section discusses options that LGUs can consider to generate resources for new investments as well as operational costs and minimize expenses in the delivery of the core MNCHN package of services.

1. Generate Resources for One-time Investments

LGUs must assess the applicability of the following options in mobilizing additional resources: Increase in LGU budget allocation, PhilHealth reimbursements, and mobilization of external resources, cost recovery schemes and local financing schemes.

Resources are needed to fund one-time investment requirements such as infrastructure repairs or construction, purchase or repair of equipment, vehicle or start-up fund for revolving drugs mechanisms and the like. The following sources may be considered by the LGU: special loans offered by banks, grants from DOH and development partners or local budget itself.

a. Local Budget

The LGU can put up funds using local budget of the province and component municipalities and cities, to fund one-time investment requirements for delivery of MNCHN services.

b. Special Loans for Health from the MDFO and Development Banks

At least two types of loan facilities are available to LGUs that desire to borrow money to finance investments for MNCHN. These loans can be obtained from the following:

(1) The Municipal Development Fund Office or MDFO

(2) Development Banks

The MDFO was created by virtue of Executive Order no. 41 to assist LGUs in financing development projects (including health infrastructure), help establish LGUs credit worthiness, and promote fiscal discipline. Interested LGUs can inquire directly with MDFO through this address: Podium Level, DOF Bldg., BSP Complex, Roxas Boulevard, Manila with telephone numbers (632) 525-9186 or 523-9936 to 37 or 5259186-87 or email mdfo@dof.gov.ph .

Development banks such as the Development Bank of the Philippines and the LandBank of the Philippines also provide loans to LGUs that wish to invest in upgrading their MNCHN capacity. Interested LGUs may get in touch directly with the local branches of these banks for specific loan instructions and conditions.

If the LGU decides to acquire a loan from lending institutions, it may have to prepare detailed architecture and engineering design, and a feasibility study indicating projected income and expenses of planned development to allow the bank to assess the LGUs capacity to repay the loan being acquired. The DOH-CHD can also assist the LGU in complying with these requirements.

If the loan is approved, the LGU needs to ensure revenue inflow by:

- Promoting available services to constituents;
- Enrolling members to PhilHealth;
- Accrediting facilities with PhilHealth;
- Establishing a socialized user fee system.

c. Mobilizing External Resources

LGUs can access available grants from the Department of Health and development partners. The following is a description of available external resources:

MNCHN Grants from the Department of Health

The MNCHN Grants Facility is a fund allocated by the DOH to support LGUs implementing the MNCHN Strategy. The grants are distributed to all LGUs, provinces and independent or highly urbanized cities, based on the ratio of poor women of reproductive age in the locality. In order to access the grants, LGUs have to show proof of the following:

1. Achievement of target national MNCHN outcomes specifically CPR, ANC, FBD, early initiation of breastfeeding and FIC
2. Counterpart investments by the LGU particularly enrolment of members or at least of the priority population groups to PhilHealth, accreditation of facilities by PhilHealth, a functional coordination mechanism for the MNCHN Service Delivery Network

Based on the above requirements, the LGU should develop a reliable health information system which should have been identified as one of the interventions that have to be undertaken in the implementation of the MNCHN Strategy.

The DOH will issue guidelines every year to identify requirements for LGUs to access the MNCHN Grants.

Health Facility Grants from the Department of Health

DOH also provides Health Facility Grants for LGUs to upgrade rural health units, barangay health stations and hospitals to become BEmONC or CEmONC capable network.

Health Facility Grants from Development Partners

Development partners like the World Bank (WB), European Union (EU), Japan International Cooperation Agency (JICA), and United Nations (UN) agencies are assisting several provinces nationwide. These development partners provide several forms of assistance that LGUs can access to fund or support investment requirements for MNCHN implementation. LGUs should: (1) determine if the LGU is a recipient of grants from development partners; (2) study available grants of development partners for the LGU; and (3) comply with conditions set by development partners to access grants.

Grants from the Philippine Charity Sweepstakes Office (PCSO)

Access grants from the PCSO by identifying investments that the organization can fund such as transportation or communication equipment, equipment that could be used for the prevention of death from complicated cases. As a rule, the PCSO would fund interventions that can respond to or minimize catastrophic cases. Prepare a proposal for the PCSO identifying recipients of the grants, how the grants will be used and its impact to the target population.

2. Generate Resources for Operational Expenses

The following financing mechanisms can be considered by the LGU to fund operational expenses of health facilities and providers: PhilHealth reimbursements, cost-recovery mechanisms, revolving funds and the like to sustain supply of drugs and commodities.

a. PhilHealth Reimbursements

The Philippine Health Insurance Corporation (PhilHealth) is the national agency mandated to manage the National Health Insurance Program (NHIP). Through an insurance system, health providers are reimbursed expenses, up to a certain limit, for services rendered to a PhilHealth member or beneficiary. LGUs can receive reimbursements provided that they undergo the following process:

1. Enrol the indigent population to PhilHealth

LGUs should enrol indigent population to PhilHealth Sponsored Program. The National Household Targeting System (NHTS) of the Department of Social

Welfare and Development (DSWD) shall be the basis for identifying indigent populations. The LGUs can secure funding to pay for PhilHealth premiums through:

- sharing of premium payments between the municipal and provincial governments;
- sponsorship from private organizations;
- sponsorship from the PCSO;

2. Promote and facilitate the enrolment of the informal sector

LGUs need to promote and facilitate the enrolment of informal sector to PhilHealth through the following:

- Identify workers in the informal sector through their place of work or through their organizations or associations like tricycle drivers' groups, vendors' association, home-based workers' groups;
- Legislate mandatory enrolment by making enrolment of members or workers in a community organization, association, small to medium-sized enterprises and the like as a requirement for the acquisition of business permits and accreditation by the LGU;
- Establish PhilHealth payment centers within the locality or arrange a regular schedule with PhilHealth Service Office to collect payments from community organizations or groups;

3. Apply for accreditation of health facilities in the catchment areas

- Upgrade existing public health facilities to comply with PhilHealth accreditation standards for Maternal Care Package, Out-patient Benefit Package, Newborn Package and the inpatient package for hospital providers;
- Apply for accreditation of selected facilities with PhilHealth;
- All accredited facilities should establish information and education campaigns or strategies to inform members of available services in the facility.
- Allow health facilities to retain reimbursements from PhilHealth. Unless otherwise provided by specific guidelines from PhilHealth, LGUs can set the distribution of shares from reimbursements to the following items: (a) health personnel; (b) drugs, medicines, commodities and supplies; and (c) other operational expenses such as utilities, IEC campaigns.

4. Conduct an information campaign to PhilHealth members and beneficiaries

   LGUs should conduct regular information campaigns particularly to priority areas to inform members of the following: (a) a member of PhilHealth has several beneficiaries such as spouse, children, and parents, (b) available services, type, schedule, and location of providers, to members; (c) inform members of procedures and documents that should be prepared in order to avail of benefits;

5. Conduct orientation seminars for health providers

   Health providers should understand the process of filing claims to minimize errors and maximize reimbursements from PhilHealth. Health providers do not usually maximize reimbursements from PhilHealth due to poor pricing policies. The LGU should facilitate technical assistance to hospitals and other health facilities to update their pricing policies.

b. Cost Recovery Schemes – User Fee

LGUs can impose a user fee mechanism as a cost recovery measure to ensure continuous funding source for recurring expenses. Caution must always be observed in designing and implementing user fees to ensure that the poor are not deprived of services if they are unable to pay the cost. Alternative mechanisms must be ready to fully subsidize the poor.

For LGUs that have not set-up or would want to enhance an existing socialized user fee mechanism, the following steps may be considered:

1. Conduct a survey in the locality to segment the market according to income class. LGUs can use the means testing tool of PhilHealth for market segmentation;

2. Develop a tool to screen clients at the points of service like RHUs, BHS, or hospitals. Health facilities can utilize the means testing tool as well for screening clients;

3. Establish the fees to be charged to clients. As a rule, indigent clients should not pay any fees for using available services or be charged a minimal fee for drugs and medicines.

   LGUs can use any of the following in establishing fees:

   - Use prices charged for the same services by private facilities as benchmarks. The LGUs may apply a discount taking into account some of the fixed costs of delivering the service such as cost of the building, salaries of support personnel.

- Use a cost plus pricing scheme. This involves a tally of the major cost items involved in the delivery of the service. Cost items in the said tally may include mostly such variable costs as the cost of drugs, medicines and supplies, utility costs, incentives for direct providers, depreciation cost of specialized equipment used and the like.

- Disseminate guidelines and operating procedures on the implementation of user fees to members of the community and to all concerned health providers.

- LGUs should allow health facilities to retain user fees collected from clients and shall determine proportion of distribution of fees collected to the following items: (a) health personnel; (b) drugs, medicines, commodities and supplies; and (c) other operational expenses such as utilities, IEC campaigns

c. Revolving drug fund/Botika ng Barangay/P100 Program.

Drugs and medicines usually constitute a major cost item in most health interventions. LGUs can consider the following programs to ensure continuous supply of drugs and medicines within the catchment area of target populations:

1. Establish a Revolving Drug Fund in the LGU. These steps shall be taken by the LGU:

   - Identify needed supplies, drugs, medicines and commodities for delivery of MNCHN services to target populations.

   - Determine investments needed to fund initial requirements;

   - Establish price of supplies, drugs, medicines and commodities taking into consideration the baseline cost, and additional cost of personnel, operation of pharmacy.

   - Install an inventory and financial system to monitor stocks, revenues generated and expenses incurred.

2. Establish the P100 Program on Essential Drugs. LGUs can access low cost quality drugs through the P100 program of the DOH. Hospitals of LGUs with a functioning Therapeutics Committee and are accredited by PhilHealth can participate in the P100 program.

3. Establish Pop Shops in the LGU. Coordinate with the CHD-Family Planning Coordinator regarding the installation of Pop Shops in your LGU. LGUs can also contact directly the office and sales representatives of DKT for this purpose.

4. Assistance from DOH for drugs, commodities, logistics and supplies

DOH provides assistance to LGUs in the form of EPI vaccines, micronutrient supplements such as Vitamin A, iron, folate and zinc, MNCHN emergency drugs such as antibiotics, steroids and oxytocin or FP commodities, drugs and supplies. Although these drugs and supplies are transferred to the LGU regularly, it is good practice to (a) determine requirements of the LGU based on needs, (b) inquire from DOH through the CHD the volume or quantities that will be transferred, (c) develop a system to manage logistics such as warehousing and inventory management, distribution to component LGUs and service points, reporting of utilization of these drugs, commodities and supplies, (d) establish a reporting and monitoring system linked to the DOH which will provide the DOH the information for re-supply.

d. Minimize Cost

LGUs must explore strategies that would minimize cost in provision of services. Possible options are (1) cost sharing among LGUs in the locality or even with those outside its jurisdiction, (2) pooled procurement for drugs, commodities and supplies, (3) rational drug use and (4) installation of a functional logistics management system.

1. Cost Sharing Among Clusters of LGUs

Resource-sharing can work well through an LGU cooperation scheme. One example of an LGU cooperation scheme is the inter-local health zone (ILHZ) where LGUs share resources such as equipment, personnel, transportation and communication system. A common fund can be set up by the ILHZ which they can draw from for joint activities or common concerns. Aside from the ILHZ set-up, LGUs may collaborate with neighboring LGUs to share facilities and services. Cost sharing schemes allow the maximum use of resources which make services more affordable in the long run.

2. Cost Containment Measures

A way to improve financing of MNCHN services is by implementing cost-containment measures as pooled procurement which can considerably lower the cost of drugs, commodities and supplies, rational drug use to avoid purchase and use of expensive drugs, management of logistics and commodities to prevent wastage and spoilage.

After identifying interventions that are needed to increase utilization of services by clients, improve capacity of providers in the service delivery network, improve local health systems to support the implementation of the MNCHN Strategy, the LGU shall determine which of the proposed interventions will be funded by the province, municipalities, DOH, donors and other partners. The

province may use the format of the AOP to complete information for the MNCHN Plan.

Sections of Table 7, 8 and 9 are supposed to be used as part of the AOP. LGUs do not have to create a different document to finalize the MNCHN Plan for an LGU-wide implementation of the MNCHN Strategy.

**Box 8: Interlocal Cooperation**

***Interlocal Cooperation to Improve Maternal Health in Surigao del Sur***

*In 2005, Surigao del Sur* reported around 3 maternal deaths per 1,000 live births. This high rate of maternal mortality was due to the lack of skilled attendance during delivery with 80% of mothers delivering at home. More than half of these births were handled by traditional birth attendants (TBAs). To improve maternal health outcomes, the LGU improved access to skilled attendance in health facilities by mobilizing resources from its Local Area Health Development Zones (LAHDZ).*

*The LAHDZ which are composed of clusters of municipalities facilitated the sharing of funds, equipment and personnel to upgrade facilities and improve delivery of health services. Through the LAHDZ, the eight LGU hospitals were able to acquire ambulances, provide incentives to on-call midwives, train health staff on emergency obstetric and neonatal care and capacitate women's health teams working with families and communities. The province also passed ordinances prohibiting deliveries by TBAs and promoting facility-based deliveries. To finance health services, the LGUs increased budget allocations to health particularly for premiums to enrol indigent families to PhilHealth. The hospitals also allowed in kind payments for their services. In 2008, the province took out a P32M loan from LOGOFIND for the upgrading of hospitals and birthing facilities and the construction of half-way houses for expectant mothers and their families who come from far flung areas.*

*In 2009, the province reported 204% increase in facility-based deliveries. Maternal mortality was also reduced to 1 per 1,000 live births. By attaining "good health through good governance", the Province of Surigao del Sur received the Galing Pook Award for 2010.*

*Source: Galing Pook Outstanding Local Governance Programs for 2010*
*Surigao del Sur is one of the project sites of the World Bank-supported Women's Health and Safe Motherhood Project*

# Chapter 8. Monitoring Progress

Part of planning for the implementation of the MNCHN Strategy is defining the monitoring and reporting process to assess the LGUs' progress in achieving its target outputs and health indicators. The following questions shall guide LGUs to define the monitoring and reporting system for the implementation of the MNCHN Strategy:

1. What items or information will the LGUs track to assess progress?
2. How will this information be collected?
3. Who shall be in charge in monitoring progress of implementation in the LGU?

## 8.1. Identify Needed Information to Track Progress

LGUs should at least track the following to assess their progress in reducing maternal and neonatal deaths in the locality:

1. Service Coverage Indicators for MNCHN

Service Coverage Indicators such as Contraceptive Prevalence Rate (CPR), Antenatal Care (ANC), Facility Based Deliveries (FBD), early initiation of breastfeeding and Fully Immunized Children (FIC) reflect utilization of services by populations in the locality. In Chapter 3, LGUs are instructed to look at these indicators to assess situation in the locality and population groups that are most at risk of maternal and newborn mortalities. LGUs shall use this information as basis to set their yearly targets per municipality. The progress of each municipality in reaching that target should be assessed at least on a quarterly basis.

2. Number of maternal, neonatal and infant deaths

Maternal Mortality Ratio (MMR) measures the ratio of the number of pregnancy related maternal deaths in 100,000 populations. Since MMR, NMR, and IMR are consolidated yearly, it might be difficult to get an accurate picture of the situation especially if data is collected midyear. LGUs should then use the actual number of maternal, neonatal and infant deaths to monitor its progress. As a goal, each LGU should have zero maternal, neonatal, and infant deaths.

3. Process Indicators Based on the MNCHN Plan

In the development of the MNCHN Service Delivery Network and development of health systems instruments, LGUs are asked to develop a plan that would identify interventions needed for improving capacity of personnel, enhancement of infrastructure and equipment of facilities, and develop health systems

instruments that will sustain provision of MNCHN services. Progress should be assessed in terms of accomplishment against target outputs and actual expenses against projected financial requirements.

## 8.2. Determine activities that could be done to collect Information

1. Field Health Service Information System (FHSIS)

All public health facilities collect health data regularly and it is submitted to the Provincial Health Office (PHO) on a quarterly basis which is consolidated and submitted to the DOH Center for Health Development (CHD). Information on CPR, ANC, FBD, early initiation of breastfeeding and FIC can be provided monthly by all public health facilities.

2. Maternal Death Reviews (MDR)

The Maternal Death Review (MDR) is a process that will identify the causes of maternal and neonatal deaths. Investigation of the causes of deaths aims to identify interventions that can be done to prevent or reduce occurrence of a similar situation. The following processes can be followed in the conduct of MDR:

- Reports on maternal and neonatal deaths should be submitted to the Provincial Health Office (PHO)
- The PHO shall call a meeting of the attending physician, the Municipal Health Officer (MHO) where the mother used to reside, and members of the community health team in charge of the mother. Ideally, specialists such as obstetrician and gynaecologist and paediatrician should be part of the meeting to provide expertise on case management.
- Investigate the events leading to death from the time of pregnancy to delivery until death. The discussion of events does not intend to castigate health personnel involved but aims to understand what happened and be able to recommend interventions that can be done if and when a similar situation arise in the future.
- Ensure that discussion is documented.
- Circulate findings and recommendations to other health providers in the LGU including offices of Local Chief Executives (LCEs).

3. Client Feedback

Establish a client feedback mechanism where the opinions and reactions of the beneficiaries to services provided and on how they were managed and treated by health providers can be obtained. Client feedbacks could assist LGUs in

identifying improvements in service which could encompass training of health providers, enhancement of health facilities and the like.

Strategies to gather feedback from clients:

a. Administer a questionnaire to clients after services are provided in a health facility. The LGU may opt to allow a client to fill up the questionnaire independently or have an interviewer guide the client while answering.

b. Conduct focused group discussions in communities composed of community members that availed and did not avail of any health service. The Community Health Team (CHT) may lead the Focus Group Discussion (FGD) in its own community or a CHT from another community may conduct the FGD.

4. Progress Review

The LGU should conduct a monthly review to assess progress against target outputs specified in the MNCHN plan. Since the implementation of the MNCHN Strategy would need coordination across several LGUs and health providers, the monthly progress review can regularly inform implementers on what is being done in the LGU. Results or findings in the progress review will allow managers and implementers to modify their plans, interventions or processes according to the actual situation of the locality.

5. Program Implementation Review (PIR)

Aside from the regular progress review, the LGU should conduct Program Implementation Review (PIR) where the MNCHN program achievements are comprehensively reviewed and assessed by the health staff and other stakeholders providing support to the program. The PIR is usually undertaken on a semi-annual or annual basis, using data routinely collected and validated with those involved in the implementation and the beneficiaries of the interventions. Coverage of the PIRs include the MNCHN status based on agreed-upon set indicators, the extent of service coverage as well as the list of factors that influenced the program achievements. Results of the PIRs are used by health managers and heads of health offices in redesigning interventions, and developing plan anew.

## 8.3. Define the Roles of the MNCHN Team in Monitoring

The MNCHN Management Team shall lead in tracking the progress of the LGU in implementing the MNCHN Strategy. The following procedures should be followed by the MNCHN Management Team:

1. Select an individual in the team who will:

- Ensure availability of information from all component LGUs and health providers in the province
- Consolidate reports of all component LGUs and health providers

2. Determine information that should be collected and frequency of reporting
3. Determine activities that shall be conducted to collect relevant information
4. Decide on the frequency of monitoring meetings or progress reviews

Define reporting structure. Updates on progress and decisions taken during MNCHN Management Team meetings should be submitted to the local chief executives for appropriate action.

5. The LGU should issue an Executive Order authorizing the MNCHN Management Team to oversee implementation of the MNCHN Strategy which should contain the following information:
   - Roles and functions of the MNCHN Management Team
   - Composition of the MNCHN Management Team
   - Management arrangement describing the lines of authority and accountability
   - Reporting and monitoring framework

For an LGU that has an existing or functional Local Health Board or Committee on Health, the existing group may be assigned to perform the above functions. The LGU may also opt to assign a team that would do initial assessment and propose plans to Local Health Boards or Health Committees.

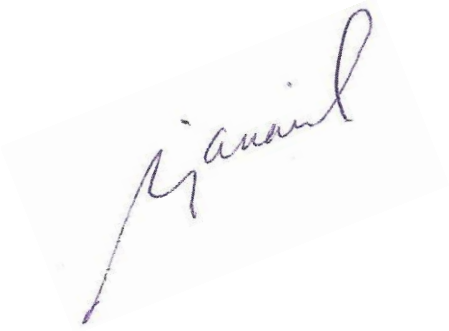
**Box 9: MDR Reporting in Capiz**

***Maternal Death Reporting in Capiz***

*In 2006, maternal mortality ratio of Capiz was 119/100,000 live births. Alarmed by the high MMR in the province, the PHO redesigned the Maternal Death Review (MDR) process. Compared to previous years when MDRs were conducted by health personnel in the RHU where the mother used to reside, the PHO convened MDRs involving providers from hospitals where the deaths occurred, and health providers assigned to where the mother lived. The PHO agreed on the following: (i) public hospitals will notify the PHO at once of any maternal death, (ii) to allow the PHO to look into their hospital records relative to the deaths, (iii) the PHO will inform the MHO of the area where the mother lived, and (iv) for the concerned midwives/municipality to undertake the investigation.*

*The PHO expanded the reporting of maternal deaths to the private health facilities by inviting them to participate in one of the maternal death review meetings to learn the process. These include members of the Capiz Medical Society, the practicing OB Gyne in the locality and all chiefs of hospitals from the private sector. That started the comprehensive reporting of maternal deaths in the whole province, which became an essential process in the regular MDRs province-wide.*

*Because of more reports coming from the public and private facilities, MMR increased to 155/100,000 in 2007. This improved reporting system enabled Capiz to come up with several interventions to address maternal deaths. At present, the Province of Capiz boasts of being able to present the true status of maternal health in the province. They also take pride in being able to show that despite the increasing number of maternal deaths after institutionalizing the reporting system, they became more focused and were able to address the different concerns that have caused these deaths among mothers. As a result, the LGU is now more confident that the number of maternal deaths and its subsequent decline in succeeding years provided a more accurate picture of the maternal death situation in the province.*



# Support of National Agencies

## Part III

# Chapter 9. Role of National Agencies

There are at least two national agencies that directly provide LGUs support for the implementation of the MNCHN Strategy: the Department of Health and the Philippine Health Insurance Corporation.

## 9.1. Department of Health

The Department of Health (DOH) shall provide leadership in the implementation of the MNCHN Strategy by (1) promoting the MNCHN Strategy for nationwide adoption and building coalitions of several stakeholders, (2) provision of technical support, logistics and financial assistance to LGUs and (3) monitoring progress of nationwide implementation.

### 9.1.1. National Centers and Bureaus at the Central Office

The **National Center for Disease Prevention and Control (NCDPC)** shall be the overall coordinator for the implementation of the MNCHN Strategy. It shall:

1. Re-organize its systems and processes to ably support the delivery of an integrated core package of MNCHN services;

2. Mount a well-concerted campaign to ensure the adoption of the MNCHN Strategy nationwide. The campaign, which shall aim to build a coalition of supporters, will be directed at the LGUs, development partners, professional societies and other concerned agencies such as the Department of Social Welfare and Development (DSWD), Department of Education (DepEd), Philippine Health Insurance Corporation (PhilHealth), Commission on Population (POPCOM), National Nutrition Council (NNC), Department of Interior and Local Government (DILG) among others. Public and private health facilities and their practitioners alike will be enjoined to support the strategy as well;

3. Provide policy directions for the implementation of the MNCHN Strategy as well as develop implementation guides for LGUs and health providers; develop MNCHN service protocols and standards based on evidence such as active management of the third stage of labor (AMTSL), essential newborn care (ENC), child health and nutrition, micronutrient supplementation, family planning service standards, emergency obstetrics and newborn care; and develop and promote strategies, interventions and approaches such as Reaching Every Barangay (REB) Strategy, Maternal Death Review (MDR);

4. Provide technical support to the CHDs in extending assistance to LGUs;

5. With inputs from the CHDs, provide logistics and financial assistance to LGUs and national health facilities. Assistance may be in the form of logistics support such as EPI vaccines, micronutrient supplements such as Vit. A, iron,

folate, and zinc, MNCHN emergency drugs and supplies such as antibiotics, steroids, oxytocin, FP commodities, drugs and supplies; financial support through the MNCHN Grants provided for LGUs implementing the MNCHN Strategy and for upgrading of facilities to become BEmONC-capable;

6. Develop a reporting and monitoring framework and system from points of service to LGUs to CHDs and to the central office;

**Box 10: MNCHN Grants Facility**

*MNCHN Grants Facility*

*The MNCHN Grants Facility is a fund allocated by the DOH to support LGU implementation of the MNCHN Strategy. Designed as a performance-based grant (PBG), LGUs can access the grants by showing performance in terms of achieving MNCHN outcome indicators such as CPR, ANC, FBD and FIC as well as process and operational indicators such as the presence of a MNCHN plan, coordination mechanism among LGUs and ensuring financial sustainability of the initiative through PhilHealth enrolment of members and accreditation of facilities. LGUs may use the grants to develop the service delivery network of providers which can include training of health personnel, improvement of facilities and repair/maintenance of equipment; partnership with private providers for services; information, education and communication campaigns to increase demand and utilization of services by clients, improve services of providers and sustain support of local legislators and managers; development of a reliable health information system; installation of a functional logistics management system and the like.*

*The DOH shall issue grants guidelines yearly that shall describe allocation of each LGU (province and independent component/highly urbanized city), conditions for access, guide for LGUs in utilization of grants and reporting and monitoring arrangements.*

7. Coordinate with other national centers and bureaus in the central office for the implementation of the MNCHN Strategy such as

   - Develop training designs and programs which shall be conducted through accredited training institutions by the Health Human Resource Development Bureau (HHRDB);

   - Develop IEC plans and materials together with the National Center for Health Promotion (NCHP);

   - Identify health facilities for upgrading with the National Center for Health Facilities Development (NCHFD);

   - Revisit data collection standards together with the National Epidemiology Center (NEC) to provide LGUs with accurate and reliable information necessary for planning and implementation of health services; and

- Pool resources from other national centers and bureaus for the MNCHN Grants Facility.

### 9.1.2. Health Human Resource and Development Bureau

HHRDB shall develop the strategy and program to retool national and regional DOH personnel in order to perform functions in the MNCHN Strategy, explore contracting-out of training functions to qualified training institutions, and design accreditation standards.

### 9.1.3. National Center for Health Promotion

NCHP shall advocate the availability and delivery of the MNCHN core package of services as well as design Behavioral Change Communication schemes addressing various groups of stakeholders such as hospitals, LGUs, service providers and communities, considering both the supply and demand sides of the MNCHN Services to ensure increased access and utilization of said services.

### 9.1.4. National Center for Health Facilities Development

The NCHFD shall identify, assess and capacitate BHS, RHUs, lying in clinics, birthing homes and other facilities as well as hospitals to become community level service providers as well as BEmONC/CEmONC service providers. It will also enhance the public health functions of hospitals such as the Mother-Baby Friendly Health Initiative criteria, use of the Mother and Child Book, promote compliance of hospital staff to public health program protocols and the like.

### 9.1.5. National Epidemiology Center

The NEC shall require accurate, timely and complete data as basis for policy decisions, strategic actions and prioritization of resources and efforts to enhance the FHSIS as a reliable source for tracking maternal mortality and other childhood health outcomes and design tools to improve data analysis skills for regional and local health managers and staff.

### 9.1.6. Centers for Health Development

The DOH Centers for Health Development serve as the local coordinator of the MNCHN Strategy. The roles of the CHDs are summarized as follows:

1. Build local coalitions composed of hospital practitioners, civil society, education and training institutions, local government and the like that would support implementation of the MNCHN strategy at the local level and reduce maternal and neonatal deaths;

2. Promote the adoption of the MNCHN Strategy to LGUs in the region and establishment of a province-wide or city-wide health systems in the region;

3. Link hospitals, DOH-retained, public and private hospitals, to LGUs for the provision of MNCHN services as well as technical expertise to local health providers;

4. Provide technical support to LGUs in identifying appropriate interventions and planning for the implementation of the MNCHN Strategy, developing systems that would support provision of MNCHN services such as logistics management, availability of safe blood supply, enhancement of current health information system, and the like;

5. Identify and develop local technical assistance providers that would serve as extensions of CHD services to LGUs;

6. Identify and develop local training institutions to facilitate capacity building of health providers in the region;

7. Assist LGUs in accessing available financial grants and support of the DOH, development partners and donors;

8. Assist LGUs in the procurement of FP commodities, drugs and supplies and MNCHN emergency drugs and commodities; including purchase FP commodities, drugs and supplies for and in behalf of LGUs as provided for in the MNCHN grants guidelines.

## 9.2. Philippine Health Insurance Corporation (PhilHealth)

In order to ensure the smooth and effective operation of the MNCHN service delivery network, the following support shall be provided by PhilHealth:

- Intensify enrolment campaigns in localities implementing the MNCHN Strategy;
- Facilitate the accreditation of facilities involved in the MNCHN service delivery network;
- Assist facilities in improving the management of claims, payments and reimbursement; and
- Adopt a Benefit Delivery Approach

1. Intensify information campaigns in localities implementing the MNCHN Strategy

   PhilHealth shall advocate for the enrolment of indigents especially target population groups to the Sponsored Program of the National Health Insurance Program (NHIP). It shall provide the proper information on enrolment and discuss benefits for LGUs and target population to ensure "buy in" of Local Chief Executives.

   PhilHealth shall assist LGUs to promote enrolment of the informal sector by conducting activities that will be able reach them where they are. These include orientation in the workplace/community, posting and distribution of appropriate IEC materials in the workplace/community, and tapping

community volunteers to promote PhilHealth enrolment. PhilHealth shall develop alternative mechanisms to ensure easier payment scheme particularly for the informal sector.

PhilHealth shall assist LGUs to involve as many stakeholders to contribute to the pool of resources to finance the enrolment of poor families. This shall include the province/city down to the barangay levels and the participation of other government/non-government groups which may have the capacity and interest to share resources for the payment of premiums.

It will also facilitate the enrolment process by coordinating with and assisting local social welfare and development offices in the identification of true indigents. It shall also ensure that the national counterpart for the premium for the Sponsored program can match the demand for enrolment at the local level. Commitments made by the priority LGUs must be realized through adequate allocation from the national government.

2. Facilitate the accreditation of facilities involved in the MNCHN service delivery network

   PhilHealth shall encourage all health facilities that provide MNCHN services to apply for accreditation to ensure greater access of services of the target population groups. It shall conduct orientation on the different PhilHealth benefits for facilities including the quality assurance program offered by PhilHealth.

   To facilitate compliance of facilities for accreditation, PhilHealth shall assist LGUs and health facilities to assess their compliance to accreditation standards, provide technical advice on how to comply with deficiencies, assist in the preparation of necessary documents and expedite review and accreditation approval of critical facilities.

   In addition, physicians and midwives should be assisted to comply with accreditation as PhilHealth Professional Health Providers.

3. Assist facilities in improving the management of claims, payments and reimbursement; and

   PhilHealth shall assist beneficiaries in availing covered services from accredited facilities by providing IEC materials, requiring identified indigent families to submit supporting documents for dependents and disseminate PhilHealth hotline for client inquiries.

   PhilHealth shall train designated hospital clerks on management of claims and provide technical support to hospitals found to have many return-to-hospitals claims. It shall also provide LGUs and RHUs the guidelines on the utilization of the capitation fund.

4. Adopt a Benefit Delivery Approach

PhilHealth shall adopt a benefit delivery approach that considers the whole cycle of PhilHealth operations and continuously assess the delivery of benefits to its beneficiaries. PhilHealth shall develop and implement this approach by ensuring that Filipinos are enrolled, eligible to claim benefits, avail of services covered in accredited facilities, and whose health care bills are fully reimbursed, particularly for indigents, mothers and children.

PhilHealth shall mobilize its regional offices to adopt the same approach and diagnose local variations in PhilHealth benefit delivery, as well as determine approaches to reduce the gaps by improving enrolment, accreditation, availment and support value.

PhilHealth shall prioritize the improvement of package for MNCHN services (e.g. higher reimbursement fees for BEmONC/CEmONC services).

## 9.3. Management Arrangements

Managing the implementation of the MNCHN Strategy can be divided into 4components, namely: 1) Oversight; 2) Technical supervision and resource mobilization; 3) Technical assistance and resource allocation; and 4) Field implementation.

Oversight functions shall be performed by the DOH EXECOM which shall also be the overall implementer of the MNCHN strategy.

The technical supervision and resource mobilization functions shall be executed by the various offices of the DOH with the Office of the Undersecretary for Health Sector Financing and Policy, Standards Development and Regulation (HSF-PSDR) Clusters taking the lead. The Office of the Undersecretary shall be supported by the MNCHN Technical Secretariat coming from the Family Health Office (FHO) of NCDPC.

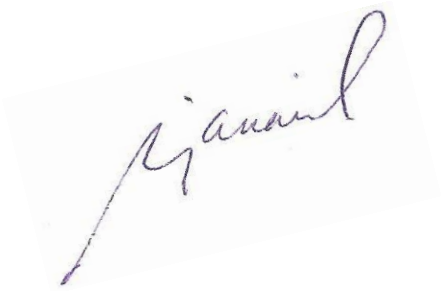
Technical assistance and resource allocation functions shall be executed by the Health Service Delivery (HSD) Cluster that will supervise all aspects of technical assistance provision by CHDs to LGUs and other partners as well as in resource allocation. Also included here are CHDs which serve as primary technical assistance providers to LGUs and other partners as well as managers for the MNCHN grants.

Lastly, field implementation is the primary function of LGUs that operate the MNCHN service delivery networks and link with other partners like the private sector, donor agencies, and civic groups.

A Department Personnel Order will be issued by the Department of Health containing the management structure, arrangements and roles and responsibilities of various DOH units and stakeholders in implementing the strategy.

The Technical Secretariat shall take the lead in convening orientation seminars on the MOP for other DOH units, the CHDs, development partners and national level stakeholders. CHDs in turn will hold their own orientation seminars on the MOP involving LGUs and other local partners.

The Technical Secretariat will convene technical working groups to draft the supporting manuals of procedures/guidelines/protocols to facilitate the implementation of the various MNCHN strategies and interventions.



# Chapter 10. Monitoring the Implementation of the MNCHN Strategy

The DOH shall establish a monitoring and evaluation system to be able to keep track of the progress and status of the MNCHN Strategy implementation in the country. This monitoring and evaluation system defines the overall set of indicators that need to be monitored and also specify those that will be tracked at each level of operations.

To monitor progress in the implementation of MNCHN Strategy by LGUs, the DOH shall monitor the achievement of health indicators and progress in establishment of the MNCHN Service Delivery Network.

## 10.1.Health Outcomes and Service Coverage Indicators

DOH shall use the following indicators to monitor progress in achieving target health indicators:

- Health Outcome Indicators: Maternal Mortality Ratio, Neonatal Mortality Rate, Infant Mortality Rate, Under Five Mortality Rate
- Service Coverage Indicators: Contraceptive Prevalence Rate, Antenatal Care, Facility-Based Deliveries, early initiation of breastfeeding, Fully Immunized Children

At the national level, NCDPC shall determine target health indicators using the latest National Objectives for Health as basis. Yearly progress of the regions and provinces shall be compared to the national targets.

At the regional level, CHDs shall use the target health indicators for the country using the latest National Objectives for Health as basis. Yearly progress of the provinces in the region shall be compared to the national targets. The CHDs shall consolidate data coming from the provinces and cities in the region and submit the report to NCDPC within the first month of the following year.

## 10.2.Maternal Death Tracking

Reduction of maternal mortality is one of the goals of the MNCHN Strategy. The DOH shall track maternal deaths by having CHDs report occurrence of deaths in their localities.

The CHDs should ensure that the province and involved providers conduct Maternal Death Reviews (MDR) of all deaths occurring in the region. MDR shall be the venue for providers and managers find local solutions and share resources for the reduction of maternal mortalities.

## 10.3.Process Indicators

The DOH supports LGUs in establishing capable MNCHN service delivery networks. Progress in the implementation of the MNCHN Strategy shall use the following indicators:

1. Number of Community Health Teams organized, trained and deployed
2. Number of CEmONCs designated, capacitated, made functional and accredited
3. Number of BEmONCs- designated, capacitated, made functional and accredited
4. Number of Facilities for Safe Blood Supply designated/established
5. Number of Transportation and Communication Systems established

At the provincial level, critical inputs to each of the above components shall be monitored by the CHD to assess how provinces are progressing in providing the service delivery network for MNCHN. Table 11 in the following page shall be used by CHD's Provincial Health Teams. The PHT shall submit the monitoring tool to the CHD on the first week of the succeeding quarter.

At the regional level, the CHD shall monitor the progress of implementation of the MNCHN Strategy using Table 12. This shall be the basis of the CHD in identifying any technical assistance requirement by the PHT as well as LGUs in the implementation of the MNCHN Strategy. The CHD shall submit the monitoring form to NCDPC on the second week of the succeeding quarter.

At the national level, NCDPC shall monitor the progress of implementation of the MNCHN Strategy using Table 13. NCDPC FHO shall consolidate all information from the different CHDs. A unit shall be responsible in following progress in the development of MNCHN Service Delivery in the regions. The collected data shall be the basis of NCDPC FHO in identifying technical support needed by the CHDs in guiding LGUs in the implementation of the MNCHN Strategy. It shall also be the basis of the NCDPC FHO in identifying support needed from other national centers and bureaus in the central office of the DOH.

**Table 11: MNCHN Monitoring Tool for CHD Provincial Health Team**

Instructions: This monitoring tool should assist the Provincial Health Team to monitor progress in the implementation of the MNCHN Strategy in the province. It will monitor process indicators of the MNCHN Strategy.

Indicate the number of priority populations for each municipality. Add columns as needed to accommodate municipalities in the province.

For each item, please fill-up by indicating the target number for the municipality and province as the denominator and the actual number as the numerator. Some items though may not be applicable to the province such as priority populations, CHTs.

For the column called "Total", add all numerators and denominators of all municipalities and cities and province.

For the column called "Percentage", divide the numerator by the denominator from the column called "Total".

| | Province | Mun. 1 | Mun. 2 | Mun. 3 | Mun. 4 | Mun. 5 | Mun. 6 | Total | % |
|---|---|---|---|---|---|---|---|---|---|
| Priority Populations | | | | | | | | | |
| Community Health Teams | | | | | | | | | |
| Organized community health volunteers | | | | | | | | | |
| Community Level Providers | | | | | | | | | |
| Updated target client list | | | | | | | | | |
| Mapping of priority populations | | | | | | | | | |
| CEmONC-capable Facility | | | | | | | | | |
| BEmONC-capable Facility | | | | | | | | | |
| Transportation and Communication System | | | | | | | | | |
| Safe Blood Supply Network | | | | | | | | | |
| Blood Center | | | | | | | | | |
| Blood Collection Unit | | | | | | | | | |
| Blood Station | | | | | | | | | |
| Blood Bank | | | | | | | | | |

**Table 12: MNCHN Monitoring Tool for CHD**

Instructions: This monitoring tool should assist the Center for Health Development to monitor progress in the implementation of the MNCHN Strategy in the region. It will monitor process indicators of the MNCHN Strategy.

Indicate the number of priority populations for each province or independent or highly urbanized city. Add columns as needed to accommodate provinces or cities in the region

For each item, please fill-up by indicating the target number for the province and independent or highly urbanized city as the denominator and the actual number as the numerator.

For the column called "Total", add all numerators and denominators of all municipalities and cities and province.

For the column called "Percentage", divide the numerator by the denominator from the column called "Total".

| | Prov 1 | Prov 2 | Prov 3 | Prov 4 | Prov 5 | City 1 | City 2 | Total | % |
|---|---|---|---|---|---|---|---|---|---|
| Community Health Teams | | | | | | | | | |
| Organized community health volunteers | | | | | | | | | |
| Community Level Providers | | | | | | | | | |
| Updated target client list | | | | | | | | | |
| Mapping of priority populations | | | | | | | | | |
| CEmONC-capable Facility | | | | | | | | | |
| BEmONC-capable Facility | | | | | | | | | |
| Transportation and Communication System | | | | | | | | | |
| Safe Blood Supply Network | | | | | | | | | |
| Blood Center | | | | | | | | | |
| Blood Collection Unit | | | | | | | | | |
| Blood Station | | | | | | | | | |
| Blood Bank | | | | | | | | | |

**Table 13: MNCHN Monitoring Tool for NCDPC**

Instructions: This monitoring tool should assist the NCDPC to monitor progress in the implementation of the MNCHN Strategy in the region. It will monitor process indicators of the MNCHN Strategy.

Indicate the number of priority populations for each province or independent or highly urbanized city. Add columns as needed to accommodate provinces or cities in the region

For each item, please fill-up by indicating the target number for the province and independent or highly urbanized city as the denominator and the actual number as the numerator.

For the column called "Total", add all numerators and denominators of all municipalities and cities and province.

For the column called "Percentage", divide the numerator by the denominator from the column called "Total".

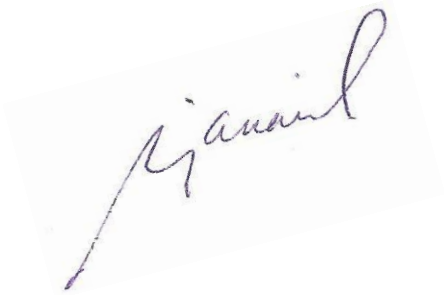
| | CHD 1 | CHD 2 | CHD 3 | CHD 4 | CHD 5 | CHD 6 | CHD 7 | CHD..n | Total |
|---|---|---|---|---|---|---|---|---|---|
| Community Health Teams | | | | | | | | | |
| Organized community health volunteers | | | | | | | | | |
| Community Level Providers | | | | | | | | | |
| Updated target client list | | | | | | | | | |
| Mapping of priority populations | | | | | | | | | |
| CEmONC-capable Facility | | | | | | | | | |
| BEmONC-capable Facility | | | | | | | | | |
| Transportation and Communication System | | | | | | | | | |
| Safe Blood Supply Network | | | | | | | | | |
| Blood Center | | | | | | | | | |
| Blood Collection Unit | | | | | | | | | |
| Blood Station | | | | | | | | | |
| Blood Bank | | | | | | | | | |

# Annexes

Annex J. Stock and Inventory Management System at the Municipal Level

Annex K. Contracting Private Providers

Annex L. Annual Operational Plan Matrix



**Annex A. AO 2008-0029 – Implementing Health Reforms for Rapid Reduction of Maternal and Neonatal Mortality**

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September 09, 2008

**ADMINISTRATIVE ORDER**
**No. 2008 - 0029**

**SUBJECT : Implementing Health Reforms for Rapid Reduction of Maternal and Neonatal Mortality**

## I. BACKGROUND AND RATIONALE

Despite previous efforts and improvement in general health status indicators, the rates of decline in maternal and neonatal mortality have decelerated in the past decade to a point where Philippine commitments to the Millennium Development Goals (MDGs) of lowering maternal mortality ratio (MMR) and infant mortality rate (IMR) may not be achieved.

However, with pregnancy and childbirth continuing to pose risks to Filipino mothers and their newborn, rapid reduction in these risks must be realized as quickly as possible while considering that variations in health outcomes and program performance across localities and population groups warrant targeted and locally-customized interventions in order to meet the rapid reduction goal.

The risk of maternal and neonatal deaths for a given population group is magnified with critical accumulation of the following four risks. First, is the risk of having mistimed, unplanned, unwanted and unsupported pregnancy. Secondly, having become pregnant exposes the mother and the fetus to the risk of not securing adequate care during the course of the pregnancy. Third, is the risk of delivering without being attended to by skilled birth attendants, namely: skilled midwives, nurses and physicians, and of not having access to emergency obstetric and neonatal care services. Lastly, there is the risk of not securing proper postpartum and postnatal care for the mother and neonate, respectively.

Long term control of mortality and morbidity and improvement in the equality of life require provision and use of a continuum of health services spanning each of the life cycle stages. Provision and use of these services would require informed decisions by mothers and their families (demand side), as well as a health system (supply side) that is responsive to their needs.

This Order applies the *Four*mula One for Health (F1) approach for the local implementation of an integrated Maternal, Neonatal and Child Health and Nutrition (MNCHN) Strategy. It outlines specific policies and actions for local health systems to systematically address health risks that lead to maternal and, especially neonatal deaths, which comprise half of reported infant mortalities.

## II. STATEMENT OF POLICY

An integrated MNCHN Strategy is hereby formulated and implemented pursuant to the priorities of F1 or Administrative Order No. 0023 series of 2005; the National Objectives for Health (NOH) 2005-2010; the Philippine commitments to the Millennium Development Goals (MDG) for 2015; the lessons obtained from various maternal and child health projects; National Health Sector Meeting Resolution No. 2008-01-02; DOH Executive Committee (Execom) resolution dated February 4, 2008 with a subsequent reiteration in DOH Execom resolution dated June 10, 2008 which was supplemented by DOH Execom resolutions dated July 21 and 30, 2008; as well as in compliance with the 1992 Philippine Midwifery Act or Republic Act (RA) 7392; the Early Childhood Development Act (RA 8980) of year 2000; the Newborn Screening Law (RA 9288) of 2004; Executive Order 286 on the Bright Child Program, 2004; Executive Order 51 on the Milk Code, 1986; the Rooming-In and Breastfeeding Act (RA 7600) of 1992; and, other related laws.

This strategy shall guide the development, implementation and evaluation of various programs aimed at women, mothers and children, with the ultimate goal of rapidly reducing maternal and neonatal mortality in the country. It shall also serve as guide in the engagement, assistance and empowerment of local government units (LGUs) and other partners in rapidly achieving the maternal and neonatal mortality reduction goal.

## III. GENERAL PRINCIPLES

The goal of rapidly reducing maternal and neonatal mortality shall be achieved through effective population-wide provision and use of integrated MNCHN services as appropriate to any locality in the country.

Reforms, improvements and changes in local health systems shall, among other results, create the following *intermediate results* that can significantly lower the risk of dying secondary to pregnancy and childbirth:

1. Every pregnancy is wanted, planned and supported;
2. Every pregnancy is adequately managed throughout its course;
3. Every delivery is facility-based and managed by skilled birth attendants; and
4. Every mother-and-newborn pair secures proper postpartum and postnatal care with smooth transitions to the women's health care package for the mother and child survival package for the newborn.

The above four intermediate results shall be achieved by:

1. *Health Service Delivery*—Addressing the direct causes of mortality during childbirth by managing deliveries in either a basic emergency obstetric and newborn care (BEmONC) or comprehensive emergency obstetric and newborn care (CEmONC) facility. Moreover, public health services that reduce the risk of dying and improve the well-being of women, mothers and their children shall be made available. A core list of high priority interventions shall be promoted and supported by DOH for implementation by province-wide or city-wide health systems.
2. *Health Regulation*—Enforcement of regulatory measures and guidelines related to the establishment and operations of health facilities, as well as the capacity building of an

adequate health staff through competency-based standards that are linked with suitable performance-based incentive mechanisms;

3. *Health Financing*—Application of combined financing strategies using instruments available through DOH and LGU budgets, PhilHealth payments and other funding sources. These sources shall finance the acquisition of additional capacities and maximize utilization of services particularly in areas or population groups where maternal and neonatal mortality is most severe; and
4. *Governance for Health*—Establishment of governance mechanisms that secure the political commitment of local stakeholders and exact accountability for results. These mechanisms shall have broad-based participation, non-partisan leadership and sustained popular support to assure continued local effort regardless of different political, economic and socio-cultural conditions.

## IV. GOAL AND OBJECTIVES

**Goal**

Rapidly reduce maternal and neonatal mortality through local implementation of an integrated MNCHN strategy.

**Objectives**

1. Develop, adopt, promote, implement and evaluate an integrated MNCHN strategy for the rapid reduction of maternal and neonatal mortality;
2. Engage all province-wide or city-wide health systems to adopt and implement the integrated MNCHN strategy;
3. Provide targeted support to province-wide or city-wide health systems and specific population groups where the maternal and neonatal mortality problem is most severe; and
4. Achieve national MNCHN program targets for the following key indicators by 2010:
    a. Increase modern contraceptive prevalence rate from 35.9% (Family Planning Survey, 2006) to 60%;
    b. Increase percentage of pregnant women having at least four antenatal care visits from 70% (National Demographic and Health Survey [NDHS], 2003) to 80%;
    c. Increase percentage of skilled birth attendance and facility-based births from 40% (NDHS, 2003) to 80%; and
    d. Increase percentage of fully immunized children from 70% (NDHS, 2003) to 95 percent.

## V. DEFINITION OF TERMS

**1. Basic Emergency Obstetric and Newborn Care (BEmONC) facilities** are capable of performing six signal obstetric functions, which include: (i) parenteral administration of oxytocin in the third stage of labor; (ii) parenteral administration of loading dose of anti-convulsants; (iii) parenteral administration of initial dose of antibiotics; (iv) performance of assisted deliveries; (v) removal of retained products of conception, and (vi) manual removal of retained placenta. BEmONC facilities are also capable of providing neonatal emergency interventions which include at the minimum: (i) newborn resuscitation, (ii) treatment of

neonatal sepsis/infection; and (iii) oxygen support. It shall also be capable of providing blood transfusion services on top of its standard functions.

2. **Community level providers** refer primarily to Barangay Health Stations (BHS) and its health staff (e.g. midwife) and volunteer health workers (e.g. barangay health workers, traditional birth attendants) that typically comprise the Women's Health Team (or Barangay Health Team). These teams implement integrated MNCHN services identified for the community level. Their functions include advocating for birth spacing and counseling on family planning services; the tracking and master listing of pregnant women; assisting pregnant women and their families in formulating a birthing plan; early detection and referral of high-risk pregnancies; and reporting maternal and infant deaths. The teams shall also facilitate discussions of relevant community health issues, particularly those affecting women and children.

3. **Comprehensive Emergency Obstetric and Newborn Care (CEmONC) facilities** can perform the six signal obstetric functions of a BEmONC and in addition, perform cesarean section and provide blood banking and transfusion services along with other highly specialized obstetric services. It is also capable of providing the following neonatal emergency interventions, which include at the minimum: (i) newborn resuscitation, (ii) treatment of neonatal sepsis/infection, (iii) oxygen support for neonates, and (iv) management of low birth weight or premature newborn, along with other specialized neonatal services.

4. **MNCHN service delivery network** refers to the network of facilities and providers within the province-wide or city-wide health system offering integrated MNCHN services in a coordinated manner. It also includes the communication and transportation system supporting this network. The facility, provider type and service standards for the network shall be described in the MNCHN Operations Manual.

5. **Integrated MNCHN services** refer to a package of services for women, mothers and children that cover the continuum of the following:
    1. Known appropriate clinical case management services in preventing direct causes of maternal and neonatal deaths, and which are within the capacity of the health system to routinely provide, and;
    2. Known cost-effective public health measures capable of reducing exposure to and the severity of risks for maternal and neonatal deaths, that are within the capacity of the health system to routinely provide.

6. **Province-wide or city-wide health system** refers to the default catchment area for delivering integrated MNCHN services. It consists of public and private providers organized into configurations such as interlocal health zones (ILHZ) or health districts for provinces and integrated urban health systems for highly-urbanized cities. Service arrangements with other LGUs may be considered if provision and use of integrated MNCHN services across provinces, municipalities and cities become necessary.

## VI. SCOPE AND COVERAGE

This Order shall apply to the whole hierarchy of the DOH and its attached agencies, as well as LGUs, other public and private providers of health care and development partners implementing the MNCHN strategy.

## VII. GENERAL GUIDELINES

**1. Recognize the province-wide or city-wide health system as the unit for planning, organizing and implementing the MNCHN strategy.** The province-wide or city-wide health system shall be the basic unit for planning, organizing and implementing MNCHN activities. The DOH shall advocate and promote the standards of a stable and mature service delivery network to local stakeholders. It shall also ensure that the standards are flexible enough to adapt to local conditions, and are appropriate to the local area and population.

**2. Engage local stakeholders and strengthen public-private partnerships to support the goal of rapidly reducing maternal and neonatal mortality.** Local stakeholders shall be engaged to review the current functionality of their respective local service delivery network. Functionality includes, among other things, the level and quality of coordination across the various activities and functions of public and private providers. Based on this assessment, all local stakeholders shall be enjoined to take part in activities that address maternal and newborn health.

**3. Mobilize the service delivery network to deliver the integrated MNCHN services as a continuum.** Universal access to and utilization of integrated MNCHN services in its full continuum spanning the pre-pregnancy, pregnancy, delivery and postpartum/postnatal care phases shall be ensured in all localities, and shall be backed-up by pertinent laws and accessible operational resources. A core list of MNCHN services include those from the women's health and child survival packages developed by the DOH.

**4. Pursue improvements in the delivery of various component services in the maternal and neonatal service package.** In order to mount rapid response capacity in local health systems, the MNCHN strategy shall build on existing service capacities and utilization patterns. Targeted quality improvements in facilities and human resources, together with measures to facilitate utilization by clients, shall be carried out to achieve rapid mortality reduction with minimal effort and investment in the immediate and medium term. Over time, improvements in the current delivery system configuration and services shall be introduced as standards improve, as demand increases, as local health systems acquire additional capacity, as legal and resource constraints are addressed and as the nature of the maternal and neonatal mortality problem evolves.

**5. Develop and support implementation of appropriate demand-side interventions.**

The DOH shall develop schemes to support local health systems in designing, implementing and evaluating appropriate demand-side interventions to improve health seeking behavior and service utilization patterns in localities. Demand-side measures shall be given due emphasis in local applications of the MNCHN strategy as life saving and cost saving interventions. These measures shall also be crafted and directed at specific target areas and populations (e.g. mothers, poor households) whichever is most appropriate and effective in a given locality.

**6. Develop monitoring and evaluation systems for the MNCHN strategy.** The DOH shall develop and support the establishment, operation and maintenance of monitoring and evaluation mechanisms for local implementation of the MNCHN strategy. Appropriate methodologies (e.g. maternal and perinatal death reviews) shall be employed to establish baseline, track progress and assess the impact of various interventions to improve the delivery of services in a local health system. The monitoring and evaluation system shall be developed incrementally and may begin with a limited set of readily available and verifiable indicators. It is also desired that these monitoring and evaluation mechanisms are transparent, have established dissemination channels that feed into formal feedback mechanisms to policy and management that is sustainable given local constraints and conditions.

**7. Provide national support to local planning and development in support of the MNCHN strategy.** The DOH shall develop and apply various instruments to help localities develop customized MNCHN strategies, strengthen their service delivery networks, secure critical goods and commodities and improve monitoring and evaluation. These instruments shall include a mix of grant assistance schemes, policy issuances, technical assistance, institutionalized training, research and development, development of new standards, provision of specialized services, financing mechanisms through PhilHealth, and regulatory measures.

## VIII. SPECIFIC GUIDELINES

The following are specific guidelines for implementing the general guidelines mentioned above:

1. The province-wide or city-wide health system shall be delineated by the politico-geographic jurisdictions of its component LGUs. Other providers and LGUs outside the catchment area may also be engaged within this health system should it be necessary for the effective provision and use of integrated MNCHN services. This may be recommended if the required service capacities are not accessible within the catchment area and/or if utilization patterns by constituents and neighboring populations overlap in these jurisdictions. To sustain operations, DOH shall also facilitate compliance of these facilities with DOH licensing and PhilHealth accreditation requirements.

2. The operations of the MNCHN service delivery network shall be organized as follows:

    a. **Third Tier**—CEmONCs are public or private facilities designated as the end-referral facility for integrated MNCHN services. The default CEmONC in a given locality shall be the provincial hospital or similarly capable DOH/LGU hospital or private hospital. ***Designation of the CEmONC facility shall be based primarily on its service capacity.*** However, other criteria such as pricing, service load, quality of care, location, topography, transport system, utilization patterns and other similar parameters may be used to determine the designation of a CEmONC facility. In case of multiple CEmONC facilities (as in large or highly-populated provinces or cities), the catchment area may be divided further into specific areas of responsibility for each facility, based on criteria mentioned above.

    Ideally, the CEmONC facility shall be accessible within two hours travel from any residence/referring facility within the province/city. However, in anticipation of possible delays during referral, CEmONC facilities are recommended to be accessible within one-hour travel time. A CEmONC facility shall operate on a 24-hour basis with emergency standby capacity. At least one obstetrician/surgeon, a pediatrician, an anesthesiologist, six nurses, a medical technologist and six midwives staff the typical CEmONC.

    b. **Second Tier**—The default BEmONC facility shall consist of the core district hospital or similarly capable public or private facility assigned to serve an ILHZ or health district. In certain cases, such as in geographically isolated and disadvantaged areas or in densely-populated areas, rural health units (RHUs), health centers, BHS, lying-in clinics or birthing homes capable of performing the six signal obstetric functions and neonatal emergency care may also be designated as BEmONC facilties.

***Designation of the BEmONC facility shall be based primarily on service capacity***. However, other criteria such as pricing, service load, quality of care, location, topography, transport system, utilization patterns and other similar parameters may be used to determine to upgrade and designate a facility as a BEmONC facility. In case of multiple BEmONC facilities serving a particular ILHZ or health district the catchment area may be divided further into specific areas of responsibility for each facility, based on criteria mentioned earlier.

Ideally, the BEmONC facility shall be accessible within one-hour travel from any residence/referring facility within the ILHZ, health district or city. However, in anticipation of possible delays during referral, BEmONC facilities are recommended to be accessible within 30 minutes of travel time. A BEmONC facility may have a minimum staff complement of at least one physician, a nurse and a midwife. The BEmONC facility shall operate on a 24-hour basis and shall have access to communication and transportation facilities to facilitate referrals.

Public and private clinics, lying-in clinics, birthing homes and other similar facilities currently managing deliveries but have no capacity to provide the six signal obstetric functions and neonatal emergency services may acquire new capacities to qualify and be designated as BEmONCs. Acquisition of these additional capacities shall be supported by DOH in terms of addressing legal and resource constraints, with resources focused mainly in areas where the maternal and neonatal mortality problems are most severe.

c. **First Tier**—Community level service providers such as RHUs, health centers, BHS or similar private facilities shall have Women's Health Teams or Barangay Health Teams led by a nurse or a midwife organized to provide the identified MNCHN services along with other functions deemed necessary in their communities. These teams shall vigorously campaign for proper birth spacing, complete required antenatal care visits, facilitate the shift from home deliveries to facility-based births attended by skilled professionals, provide postpartum and postnatal care, and ensure smooth transitions to other health care packages for women and children.

   The RHUs, health centers and private outpatient clinics in the network shall provide MNCHN services other than managing deliveries. These services shall include family planning, prenatal services and postpartum and postnatal care aside from other public health and clinical services deemed necessary in their localities, including organizing of outreach activities;

3. The province-wide or city-wide health system shall be supported by an adequate emergency communication and transportation system. This communication system shall facilitate consultation, referral and coordination from and by peripheral facilities all the way up to the end referral facility level. LGUs are encouraged to invest in modern communication systems available in and suitable to their localities. The transportation system is intended to bring patients to and from facilities during referrals and transfers. This may be done through an organized ambulance network that services the whole breadth of the province-wide or city-wide health system or a mix of facility-based ambulances and locally available transportation with explicit arrangements for use and financing during referrals and transfers.

Appropriate measures shall be taken to facilitate the shift from home-based deliveries to facility-based births attended by skilled birth attendants. In order to facilitate the shift, schemes can be developed to provide traditional, non-skilled attendants with incentives to refer deliveries to appropriate facilities. Aside from enjoining them to join barangay health teams, qualified TBAs may be provided educational assistance to become midwives.

4. The integrated MNCHN services shall consist of clinical and public health interventions for women and children that shall be delivered through a seamless continuum of care that shall include pre-pregnancy care, antenatal care, care during delivery and postpartum and postnatal care. The minimum standard services are:
    a. Pre-Pregnancy Services
        i. Provision of correct information and responsive counseling for fertility awareness, maternal nutrition, birth spacing and adolescent reproductive health;
        ii. Active identification and servicing of population segments with unmet needs for family planning and referral to alternative sources of services and supplies when these are not available in one's service outlet or facility;
        iii. Assurance of a safety net of free family planning services and supplies for indigent potential users; and
        iv. Provision of other basic and essential services for young females and women in the reproductive age.
    b. Antenatal Care
        i. Consistent coverage of all eight essential antenatal care functions (monitoring height and weight, taking blood pressure, blood testing, urine testing, iron and folate supplementation, tetanus toxoid immunization, malaria prophylaxis where appropriate and birth planning);
        ii. Focused attention to individualized birth preparedness counseling about the place of delivery and transport arrangements to increase the mother's readiness to deliver in health facilities; and
        iii. Discussion with household member/s and preparation for childbirth with partner support and involvement in care-seeking decisions.
    c. Care during Delivery
        i. Proper channeling of patient workloads with aggressive promotion of shifting from home-based deliveries to delivery in either a BEmONC or a CEmONC, especially for women with medical conditions and other special needs by classifying them as priority for transport and servicing by the appropriate delivery/birthing facility;
        ii. Deliberate planning and special provisions for hard-to-reach segments of the population within the province-wide or city-wide system to promote facility-based deliveries;
        iii. Active conversion and mobilization of traditional birth attendants into advocates and agents of facility-based deliveries; and
        iv. Correct and updated monitoring and reporting of the number and proportion of facility-based births.
    d. Postpartum and Postnatal Care
        i. Provision of proper postpartum/postnatal care for mothers and neonates; and
        ii. Provision of the whole range of women's health care services for mothers and of the child survival package for children.

5. The DOH shall support universal local implementation of the MNCHN strategy. However, local conditions and capacities shall be considered in the adoption of MNCHN services in the different LGUs. The DOH shall periodically determine the appropriateness and responsiveness of the comprehensive and core components of the integrated MNCHN package in order to adapt to the evolving nature of the maternal and neonatal mortality problem.

6. The assessment of coordination across the various MNCHN-related activities and functions within and outside the health service system shall be in accordance with specific criteria, and made part of a local monitoring and evaluation system. The assessment shall cover coordination within the province-wide or city-wide system, between public and private service providers, and between each tier of the 3-tier service delivery network.

## IX. ROLES AND RESPONSIBILITIES

For purposes of this Order, the various DOH instrumentalities, partners and other stakeholders shall have the following roles and functions:

1. **Office of the Undersecretary for Policy Standards and Development Team-Service Delivery**
   a. Provide overall leadership in the implementation of the MNCHN strategy;
   b. Mobilize and coordinate resources for implementation of the MNCHN strategy;
   c. Monitor overall progress of implementing the MNCHN strategy; and
   d. Regularly report progress of implementing the MNCHN strategy to the Secretary of Health, Execom and similar oversight bodies.

2. **National Centers for Disease Prevention and Control (NCDPC)**
   a. Reorganize its systems and processes to ably support the delivery of the integrated MNCHN services;
   b. Re-align relevant programs and services into the MNCHN framework and strategy;
   c. Provide technical leadership and assistance in the delivery of integrated MNCHN services to CHDs, LGUs and other stakeholders;
   d. Identify resources necessary to efficiently assist partners in their implementation of MNCHN;
   e. Develop service standards for MNCHN interventions; and,
   f. Coordinate monitoring and evaluation of the implementation of the MNCHN strategy.

3. **National Center for Health Facilities Development (NCHFD)**
   a. Assist designated facilities to comply with technical standards and requirements for providers in the service delivery network;
   b. Develop facility standards for MNCHN providers and other facilities within the service delivery network;
   c. Strengthen the MNCHN functions of hospitals and other facilities, including public health services; and,
   d. Assist in monitoring the progress of implementation of the MNCHN strategy.

4. **National Center for Health Promotion (NCHP)**
   a. Develop effective mechanisms to promote the MNCHN goals and strategies;
   b. Design and assess communication and health promotion schemes addressing various groups of stakeholders involved in MNCHN; and
   c. Provide technical assistance to CHDs, LGUs and other stakeholders in developing locally-specific communication and heath promotion packages.

5. **Health Human Resources Development Bureau (HHRDB)**
   a. Identify mechanisms to meet human resource requirements to operate province-wide or city- wide health systems;
   b. Develop strategy and program to retool national and local personnel in order to facilitate delivery of integrated MNCHN services;
   c. Facilitate integration and updating of existing training modules on maternal-neonatal health and other related programs;
   d. Develop training standards as part of civil service deployment and promotion criteria for local health officials.

6. **Bureau of Local Health Development (BLHD)**
   a. Develop guide/criteria for designing the province/-wide or city -wide health system providing integrated MNCHN services;
   b. Assist CHDs in the engagement of LGUs;
   c. Facilitate mainstreaming of the MNCHN strategy into the PIPH and AOPs of the F1 sites; and,
   d. Assist in monitoring local implementation of the MNCHN strategy.

7. **Health Policy Development and Planning Bureau (HPDPB)**
   a. Link MNCHN strategy implementation with DOH budget
   b. Facilitate the review and updating of policies and plans for consistency with the MNCHN strategy;
   c. Provide support in the enhancement of laws/IRRs in support of the MNCHN strategy; and
   e. Institutionalize mechanisms for the use of accurate, timely and reliable evidence for policy decisions, strategic actions and prioritization of resources and efforts.

8. **Bureau of International Health Cooperation (BIHC)**
   a. Manage external resources to support implementation of the MNCHN strategy;
   b. Influence the formulation by development partners of their country assistance package or assistance framework so that these are harmonized with the Philippine Health Sector Reform Program, in general, and the MNCHN strategy in particular; and
   c. Facilitate access to information on international experience and best practices to enhance MNCHN as necessary.

9. **National Epidemiology Center (NEC)**
   a. Provide accurate, timely and complete data as basis for policy decisions, strategic actions and prioritization of resources and efforts;
   b. Enhance FHSIS as source for tracking maternal mortality and the other childhood health outcomes;

c. Design tools to improve data collection and skills of regional/local health managers/staff, including development of compliance monitoring mechanisms; and,
d. Coordinate overall measurement of MDG-related goals on maternal-neonatal health including the conduct of national surveys and special studies.

**10. Finance, Procurement and Materials Management Services**

a. Assist in the development of guidelines for granting assistance to groups of stakeholders involved in the implementation of the strategy;
b. Facilitate process in transferring financial resources to the regions and LGUs as part of the overall grants approach to local health system development; and
c. Enhancing procurement and supply chain management system of essential MNCHN logistics.

**11. Office of Special Concerns, Field Implementation and Management Office and Centers for Health and Development**

a. Reorganize/staff to support the delivery of the integrated MNCHN services, in the context of the health sector reform elements and goals;
b. Promote the adoption of the MNCHN Policy Framework and Strategy to their catchment LGUs;
c. Advocate for the participation of muiti-sectoral partners and work for the establishment of a coalition of advocates to reduce maternal and neonatal deaths in the region;
d. Promote the establishment of province-wide or city- wide health systems in the region;
e. Assist DOH-retained hospitals to qualify to serve as CEmONC facilities in their respective networks;
f. Assist LGUs in applying and qualifying for MNCHN and related grants;
g. Manage regional implementation of MNCHN and related grants facilities; and
h. Provide technical assistance to LGUs and providers implementing the MNCHN strategy.

**12. Local Government Units**

a. Adopt and implement the MNCHN strategy;
b. Reorganize staff to deliver the integrated MNCHN services, in the context of the health sector reform elements and goals;
c. Invest in the development of facilities and staff to improve implementation of MNCHN services;
d. Ensure adequate financing of MNCHN service inputs by allocating budgets and actively sourcing alternative financing sources such as grants;
e. Monitor and supervise local implementation of the MNCHN; and
f. Ensure sustainability of quality MCNHN services in the locality.

**13. Philippine Health Insurance Corporation (PhilHealth)**

a. Intensify enrollment campaigns in localities implementing the MNCHN strategy;
b. Facilitate the accreditation of facilities involved in the MNCHN service delivery network;
c. Assist facilities in improving the management of claims, payments and reimbursements; and
d. Strengthen existing benefit packages in support of the MNCHN strategy.

14. **Commission on Population (PopCom)**
    a. Reorganize staff to support the delivery of the integrated MNCHN services, in the context of the health sector reform elements and goals;
    b. Coordinate and intensify efforts at promoting family planning, especially natural family planning methods in localities implementing the MNCHN strategy; and
    c. Mobilize local population workers including barangay population workers/volunteers (Barnagay Service Point Officers) and other community-based volunteers to support the MNCHN strategy in the localities.

15. **National Nutrition Council (NNC)**
    a. Reorganize staff to support the delivery of the integrated MNCHN services, in the context of the health sector reform elements and goals;
    b. Coordinate multisectoral efforts on nutrition in support of the MNCHN strategy (i.e. consolidating efforts targeted to mothers and children below two years old); and
    c. Mobilize Barangay Nutrition Scholars to support MNCHN strategy in their localities

16. **Philippine National AIDS Council (PNAC)**
    a. Coordinate multisectoral efforts on HIV/AIDS and STI prevention in support of the MNCHN strategy; and
    b. Mobilize Local HIV/AIDS Councils (LACs) to support MNCHN strategy in their localities.

17. **Development Partners**
    a. Align country programs and support to facilitate the adoption and implementation of the MNCHN strategy, in the context of the health sector reform elements and goals; and
    b. Provide technical assistance and other forms of support to LGUs in implementing the MNCHN strategy.

18. **Professional Societies/Groups**
    a. Support the implementation and continuing development of the MNCHN strategy;
    b. Assist in the review and updating of MNCHN facility and practice standards;
    c. Assist in the development and implementation of compliance monitoring strategies for the MNCHN strategy; and
    d. Promote the adoption of the MNCHN strategy among members and component societies.

## X. MANUAL OF OPERATIONS

The Undersecretary for Policy Standards and Development Team-Service Delivery shall organize and oversee the technical working group that shall draw up the Manual of Operations for the MNCHN Strategy, in consultation with maternal and child health experts and other sectoral and development partners. The Manual shall contain, among other necessary details, the following components of the MNCHN strategy:

a. Key indicators to measure progress in intermediate results
b. Integrated list of MNCHN services

c. Core list of MNCHN interventions
d. Budget execution guidelines for the MNCHN grants facility
e. Facility and service standards for the MNCHN network
f. Capacity building requirements for the MNCHN strategy
g. Coordination mechanisms within and with other province-wide or city-wide health systems
h. Monitoring and evaluation systems and implementation guide
i. Reporting and documentation

## XI. REPEALING CLAUSE

Provisions from previous issuances that are inconsistent or contrary to the provisions of this Order are hereby rescinded and modified accordingly.

## XII. SEPARABILITY CLAUSE

In the event that any provision or part of this Administrative Order be declared unauthorized or rendered invalid by any court of law or competent authority, those provisions not affected by such declaration shall remain valid and effective.

## XIII. EFFECTIVITY

This Order shall take effect immediately.

**FRANCISCO T. DUQUE III, M.D., MSc.**
Secretary of Health

## Annex B. MNCHN Core Package of Services and the Service Delivery Network

| Pre-Pregnancy | Community-Level Provider | BEmONC-*capable* Facility | CEmONC-*Capable* Facility |
|---|---|---|---|
| **Maternal Nutrition**: Micronutrient supplementation such as, , , Iron/folate tabs | X | X | |
| **Oral Health** | X | X | |
| **FP Services** | | | |
| IEC/Counseling on: (i) Responsible Parenting; (ii) Informed Choice and Voluntarism; (iii) Four Pillars on FP; (iv) All FP Methods; (v) Fertility Awareness | X | X | |
| Provision of FP services | | | |
| Pills | X | X | |
| DMPA | X | X | |
| IUD | X (BHS/RHU) | X | |
| Condom | X | X | |
| NFP | X | X | |
| NSV | X (If RHU has trained provider for NSV) | X | |
| BTL (Mini-lap under Local Anesthesia) | | | X |
| **Deworming or antihelminthic intake** | X | X | |
| **IEC/Counseling on Healthy Lifestyle:**1) safer sex and prevention of HIV/STIs (i) smoking cessation, (ii) healthy diet and nutrition; and (iii) physical activity; (iv) Adolescent and youth health services including peer and professional counseling and RH education; | X | X | |
| **Information on health caring and seeking behavior** | X | X | |
| Prevention and Management of Other Diseases as indicated | | | |
| STI/HIV/AIDS | prevention | X | |
| Anemia | X | X | |
| Update master listing of women of reproductive age | X | | |
| Assessment of health risks | X | | |
| Assistance in filling up health need plans | X | | |
| Organize out-reach services | X | X (MDs, midwives, nurses as part of outreach or itinerant team) | X (MDs, midwives, nurses as part of outreach or itinerant team) |

| Pregnancy | Community - Level Provider | BEmONC-*capable* Facility | CEmONC-*Capable* Facility |
|---|---|---|---|
| Provision of essential antenatal care services: | X | X | X |
| Monitoring of height and weight | X | X | X |
| Taking blood pressure | X | X | X |
| Maternal Nutrition | X | X | X |
| Iodine caps | X | X | X |
| Iron/Folate tabs | X | X | X |
| Vitamin A for clinically diagnosed with xerophthalmia | X | X | X |

| Pregnancy | Community - Level Provider | BEmONC-*capable* Facility | CEmONC-*Capable* Facility |
|---|---|---|---|
| Deworming: mebendazole or albendazole | X | X | X |
| Promotion of iodized salt | X | X | X |
| Early detection and management of danger signs and complications of pregnancy (e.g. prevention and management of early bleeding in pregnancy) | X | X | X |
| TT Immunization | X | X | X |
| Antenatal administration of steroids in preterm labor | | X | X |
| IEC/Counseling on FP methods especially LAM | X | X | X |
| **IEC/Counseling on Healthy Lifestyle1**) safer sex and HIV/STI prevention(i) smoking cessation; (ii) healthy diet and nutrition; and (iii) physical activity | X | X | X |
| IEC/Counseling on health caring and seeking behavior | X | X | X |
| Support Services: | X | X | X |
| Support from community (e.g. pregnant women) | X | | |
| Antenatal registration with Mother-Child Book | X | X | X |
| Assist client in filling-up birth plan | X | X | X |
| Home visit and follow-up | X | X | X |
| Safe blood supply | advocacy | X | X |
| Transportation and communication support services | X | X | X |
| Diagnostic/Screening Tests | | | |
| CBC | | X | X |
| Blood typing | | X | X |
| Urinalysis | | X | X |
| VDRL or RPR | | X | X |
| HbSAg | | X | X |
| Oral Glucose Challenge test (OGCT) | | X | X |
| Prevention and Management of Other Diseases as indicated: | | | |
| STI/HIV/AIDS | prevention | X | X |
| Anemia | X | X | X |

| Delivery | Community - Level Provider | BEmONC-*capable* Facility | CEmONC-*Capable* Facility |
|---|---|---|---|
| Clean and Safe Delivery | | X | X |
| Monitoring progress of labor using partograph | | X | X |
| Identification of early signs and symptoms and management of abnormalities: prolonged labor; hypertension, mal-presentation; bleeding; preterm labor; and infection | Identification of early signs and symptoms | Management | Management |
| Controlled delivery of head and active management of third stage of labor | | X | X |
| Basic Emergency Obstetric and newborn care | | | |
| Parenteral administration of oxytocin | | X | X |
| Parenteral administration of loading dose of anticonvulsants | | X | X |
| Parenteral administration of initial dose of antibiotics | | X | X |
| Performance of assisted delivery | | X | X |

| Delivery | Community - Level Provider | BEmONC- *capable* Facility | CEmONC- *Capable* Facility |
|---|---|---|---|
| Removal of retained products of conception | | X | X |
| Manual removal of retained placenta | | X | X |
| Initial dose parenteral administration of Dexamethasone | | X | |
| Comprehensive Emergency Obstetric Care | | | |
| Caesarean section | | X | X |
| Blood transfusion | | X (for hospital-based BEmONC) | X |
| Care of the preterm babies and/or low birth weight babies | | | X |
| Counseling and Provision of BTL services | | X | X |

| Post-partum | Community - Level Provider | BEmONC- *capable* Facility | CEmONC- *Capable* Facility |
|---|---|---|---|
| Identification of early signs and symptoms of postpartum complications: | | | |
| Maternal problems: hemorrhage, infection and hypertension | | X | X |
| Maternal Nutrition<br>Iron/folate<br>Vitamin AIodine<br>Deworming tablet: Mebendazole or Albendazole<br>Promotion of iodized salt | X | X | X |
| Family Planning | | | |
| IEC/counseling on: (i) birth spacing; (ii) return to fertility; (iii) all FP methods including LAM | X | X | X |
| Provision of all Modern Family Planning Methods including LAM: pills, condom, DMPA, IUD, LAM, Bilateral Tubal Ligation, No-scalpel Vasectomy | X | X | X |
| IEC/Counseling on Healthy Lifestyle: 1) Safer sex and HIV/STI prevention(i) smoking cessation; (ii) healthy diet and nutrition; and (iii) physical activity | X | X | X |
| Prevention and Management of Other Diseases as indicated: | | | |
| STI/HIV/AIDS | prevention | X | X |
| Anemia | X | X | X |
| Prevention and Management of Abortion Complications<br>Removal of retained products of conception<br>Treatment of infection | | X | X |
| Correction of anemia | X | X | X |
| Anti-tetanus serum (ATS) Injection | X | X | X |
| Diagnostic and Screening Test | X | X | X |

| Newborn | Community - Level Provider | BEmONC-*capable* Facility | CEmONC-*Capable* Facility |
|---|---|---|---|
| Immediate Newborn Care (the first 90 mins) - (please refer to ENC Clinical practice Pocket Guide)<br>• Dry and provide warmth to the baby<br>• Do skin to skin contact<br>• Do delayed or non-immediate cord clamping<br>• Provide support for initiation of breastfeeding<br>• Provide additional care for small baby or twin<br>• Reposition, suction and ventilate (if after 30 secs of thorough drying, newborn is not breathing or is gasping)<br>• Maintain non-separation of the newborn for early initiation of breastfeeding | | X | X |
| Essential Newborn Care (from 90 mins to 6 hours)- (please refer to ENC Clinical practice Pocket Guide)<br>• Vitamin K prophylaxis<br>• Inject Hepatitis B and BCG vaccinations at birth<br>• Examine the baby<br>• Check for birth injuries, malformations, or defects<br>• Properly timed cord clamping and cutting<br>• Provide additional care for a small baby or twin | | X | X |
| Care Prior to Discharge (but after the first 90 mins)<br>• Support unrestricted, per demand breastfeeding, day and<br>• Night<br>• Ensure warmth of the baby<br>• Washing and bathing (Hygiene)<br>• Look for danger signs and start resuscitation, if necessary, keep warm, give first 2 doses of IM antibiotics, give oxygen<br>• Look for signs of jaundice and local infection<br>• Provide instructions on discharge<br>• Perform newborn screening (blood spot) and newborn hearing screening (if available in the facility or known service delivery network) | | X | X |
| Emergency Newborn Care<br>• Ensure adequate oxygen supply<br>• Resuscitation and stabilization | | X | X |
| Treatment of neonatal sepsis/infection | | X | X |
| Intensive newborn care for low birth weight (LBW), preterm, IUGR, babies born with congenital anomalies, and sick neonates | | X | X |
| Kangaroo Care | | X | X |
| BCG Immunization | | X | X |
| Early and Exclusive BF to 6 months | X | X | X |
| Newborn Screening or referral | | X | X |
| Support Services | | | |
| Birth Registration | X | X | X |
| Follow-up visit and care | X | X | X |

## Annex C. Data Validation of MNCHN Service Coverage Indicators

FHSIS or the Field Health Service Information System (FHSIS) is designed to provide the basic service data needed to monitor activities of each health program, which includes MNCHN health coverage indicators. It is the only information system that is implemented down to the barangay level. It is expected to serve as a powerful instrument with respect to establishing sound data as bases for the implementation of health sector intervention and responding to different health sector challenges

However, significant concerns were raised with respect to the full and efficient implementation of the FHSIS. Devolution has redefined the roles and responsibilities of both the LGU and the DOH with respect to health service provision and management. New staff assumed positions without a complete and full knowledge of the FHSIS, including that of the provincial health staff, MHO, nurse, midwife and barangay health workers. Recording, validation and reporting of data, therefore, was not exactly synchronized or harmonized among different LGUs, particularly at the municipal level.

The validity of data is important in planning, monitoring and evaluating program performance. This tool to validate FHSIS data for MNCHN Service Coverage Indicators such as FP Current Users, 4 Antenatal Care, Facility Based Deliveries, Skilled Birth Attendants, breastfeeding and Fully Immunized Children is developed to ensure the quality of data produced and utilized by health officials at all levels.

### Steps in conducting data quality check:

### For FP Current Users

| ASSESSMENT QUESTIONS for FP Current Users | Yes | No | IF NO |
|---|---|---|---|
| 1. Are data on current users updated in the last month prior to the assessment? | | | Need to update data to reflect most recent month's entries. |
| Is a comprehensive database with details (e.g., name, age, address, type of client) of all the target clients available at the Municipal RHU? | | | If not, need to collect and get a copy of all the target client lists (TCLs) of the midwives; then assess whether consistent with the reported total data. |
| 2. Is the FHSIS formula below followed with respect to computing the number of current users: | | | If not, what formula was used? Data needs to be corrected using the FHSIS formula. The LGU needs to go back to |

| ASSESSMENT QUESTIONS for FP Current Users | Yes | No | IF NO |
|---|---|---|---|
| **Current Users (current month) =**<br>Current Users (as of end of previous month)<br>+ (plus) New Acceptors: (New user) of the Previous Month<br>+ (plus) Other Acceptors (Changed Method, Changed Clinic & Restart) of Current Month<br>- (minus) Drop-Outs (Current Month) | | | the oldest data recorded on current users and do a recomputation if a different formula was applied.<br>Or if time will allow and personnel are available, an actual recount of existing current users can be made by reviewing all the TCLs of the midwives or the individual treatment record (ITR) at the facility. Such recounted data can be used as the initial database for which to apply the defined formula |
| 3. Are users of pill, DMPA, IUD, condom, LAM, and NFP being dropped out based on the following definition? | | | If not, then the client is technically considered a drop-outs (and should be deducted from the current users), unless a special arrangement with respect to the next visit was made between the midwife and the client (In some cases, for instance, clients are provided a 2-month or 3-month supply of pills given the distance of the client's house and difficulty in traveling). |
| a. **Pill** - a client is considered a drop-out from the method if she: | | | |
| a.1. fails to get her re-supply from the last 21 white pill up to the last brown pill (if the pills have a set of brown tablets/iron); or within 7 days from the 21st pill/ last pill (if the pills contain only a set of white tablets) | | | |
| a.2. gets supply or transfers to another provider or clinic: in this case, the client is listed under the other acceptor ("changed clinic") in the clinic where she transferred and a drop-out in her former clinic | | | |
| a.3 decided to stop the use of pills for any reason | | | This may require the nurse and the midwife to review the individual treatment record (ITR) or the target client list (TCL), or wherever the follow-up visits of client are recorded. Any client that falls within the "drop-out definition list" should be considered a drop out and deducted from the current users list. |
| Note: The client should normally take the 1st pill on the very first day of her menstruation, expected to occur with that period. | | | |
| Note: The service provider should undertake a follow-up visit of the client within this period before dropping her from the method | | | |
| b. **Injectibles** – a client is considered a drop out if she: | | | |
| b.1 fails to visit the clinic on the scheduled date of visit up to the last day of 2 weeks after the scheduled date of visit for DMPA and up to the last day of 1 week after scheduled date of visit for NET-EN. The follow up of DMPA is every 3 months and every 2 months for NET-EN. | | | |
| b.2. gets supply or transfers to another provider; the client is listed under the other acceptor ("changed clinic") in the clinic where she transferred and a drop-out in her former clinic | | | |
| b.3. stops receiving injection for any reason | | | |
| Note: The service provider should undertake a follow-up visit during the above period prior to dropping her out of the method | | | |
| c. **IUD** – client is considered a drop-out if: | | | |
| c.1 Client decided to have the IUD removed | | | |
| c.2 Had expelled IUD that was not re- | | | |

| ASSESSMENT QUESTIONS for FP Current Users | Yes | No | IF NO |
|---|---|---|---|
| inserted | | | |
| c.3 Client did not return on the scheduled date of follow-up visit 3-6 weeks from when the procedure was done. It is best medical practice to follow up on the client yearly, but the client is dropped out if she does not return for 2 years. | | | |
| d. **Condom** – client is considered a drop-out if she/he fails to return for resupply on scheduled visit; or decides not to use condom for any reason | | | |
| e. **LAM** – client is considered a drop-out if any of the three (3) conditions are not met, as follows: | | | |
| e.1 Mother has no menstruation or is amenorrheic within six months. Spotting or bleeding during the last fifty-six (56) days postpartum is not considered return of menses. | | | |
| e.2 Fully/exclusive breastfeeding means no other liquid or solid except breastmilk is given to the infant, and intervals should not exceed four hours during the day and six hours at night | | | |
| e.3 Baby is less than 6 months old | | | |
| f. **Voluntary Surgical Contraception (for BTL)** – drop out when client reaches age beyond 49 years or experience others conditions as indicated in (g) | | | |
| g. **Other Conditions** - client is considered a drop-out if she reaches menopause; and other conditions that the client underwent such as hysterectomy or bilateral salpingo oophorectomy | | | |

| ASSESSMENT QUESTIONS for FP Current Users | Yes | No | IF NO |
|---|---|---|---|
| . **NFP**<br>*For Standard Days Method* - A client is considered a drop-out if she fails to return on the follow up date to identify her own fertile and infertile periods, has no indication of SDM use through beads or no knowledge of first day of menstruation or cycle length, or decides to stop the use of the method. The service provider should undertake a follow-up visit during the above period prior to dropping her out.<br>*For BBT/ Billing's/ Symptothermal Method* - A client is considered a drop-out if client fails to return on the follow up date to check on the correct charting and/or the proper use of the method, fails to identify her own fertile and infertile periods, decides to stop the use of the method<br>NOTE:<br>● Client is given a period of time as a **'learning' user** to practice correct charting with assistance before recording the client as a **new acceptor**.<br>● An **'autonomous user'** can be considered a current user as these clients no longer need assistance in charting from the health workers.<br>The service provider should undertake a follow-up visit during the above period prior to dropping her out. | | | |
| Are drop outs being recorded every month? (others are reportedly submitting drop-out reports at the end of the year) | | | If no, a monthly update on the number of drop-outs needs to be done, to reflect most recent monthly data. |
| 4. Are clients who have *changed method, changed clinic (from other clinics to the RHU) and restarted using a method* listed as among the new acceptor and added to the current users list? | | | If not, they need to be added to the current users list. |
| 5. Are clients' years of age being reviewed every year to check whether they still belong to MWRA age group (15-49)? Or are still reproductive (based on assessment of the RHU) | | | If not, a review will have to be done and those clients whose age is above 49 should be taken out of the current users' list. |
| 6. Is the MCT or Monthly Consolidation Table being reviewed and validated by at least two RHU staff (nurse and another staff) to ensure accuracy of data? Do they conduct cross-checking of possible double/triple counting of same client who accessed 2/3 different service delivery points? | | | If not, a review of computations will have to be done; and a validation of data vis-a-vis the reports (monthly forms – M1) submitted by the midwife or BHS will have to be conducted to ensure accuracy. |
| 7. Is a computer available at the RHU?<br>If yes, it would be best for the RHU to have an electronic copy of all TCLs of the midwife to have a consolidated client list that can be validated and reviewed regularly | | | If no, another hard copy of the TCL can be produced to ensure that data on both ends (those being held by the nurse and that of the midwife) are consistent and are updated accordingly before submitting the Quarterly Report (QF) to the FHSIS coordinator of the province |

**For 4 ANC:**

1. Secure copies of the following:
    a. Target Client List (**TCL**) for prenatal care/visit
    b. Summary Table (**ST**)
    c. Monthly Form (**M1**)
    d. Monthly Consolidation Table (**MCT**)
    e. Quarterly Form (**Q1**)
2. Using the assessment guide below, review the entries in the **TCL**

| Assessment Guide for 4 ANC | Yes | No | If No |
|---|---|---|---|
| Is the target client list for prenatal care updated? | | | Get copies of the individual treatment record or masterlist of pregnant women if available and update TCL |
| Is the target client list completely and correctly filled-up?<br><br>Check if dates of visits are listed appropriately under column 8 or the prenatal visit dates. Dates of visits should correspond to trimesters of pregnancy<br>• 1st trimester – first 3 months (*up to 12 weeks or 0-84 days*)<br>• 2nd trimester – middle 3 months (*13-27 weeks or 85-189 days*) | | | If column 6 (LMP/G-P) of TCL for prenatal care is not filled up, check if terms are understood<br><br>LMP – last menstrual period which is important to compute for the expected date of confinement<br>G/P – G is for gravida or number of pregnancies including current pregnancy and P is for parity number of births. G/P is important to know if pregnancy is of risk<br><br>If column 7 (EDC) is not filled up, check if difficulty is in the computation. EDC is important for follow-up visits to prevent post maturity<br><br>EDC – expected date of confinement computation:<br>• LMP Jan-Mar = +9 months + 7 days + 0<br>• LMP Apr-Dec = -3 months + 7 days + 1 year<br><br>e.g. LMP is April 14, 2007 to compute for EDC<br>4 14 2007<br>- 3 + 7 + 1<br>1 21 2008 or an EDC of Jan. 21, 2008<br><br>*(Note: This is critical for midwives to review so that they can advise their client of the needed birth plan prior to the EDC)*<br>If dates of visit do not correspond to the trimesters of pregnancy (i.e. if consultations were done beyond the |

| Assessment Guide for 4 ANC | Yes | No | If No |
|---|---|---|---|
| • 3rd trimester - last 3 months (*28 wks& more or 190 days & more*)<br><br>For a pregnant woman to be counted as provided with 4 prenatal care, the schedule of prenatal care/visits should be at least:<br><br>• *1 during the 1st trimester*<br>• *1 during the 2nd trimester*<br>• *2 during the 3rd trimester* | | | period of the trimester), then take out this entry from the total number of women with 4ANC.<br>If the required number of visits for each of the trimesters does not follow the "at least 1-1-2" rule, then take out this entry from the total number of women with 4ANC.<br>In cases that the client claims to have gone through pre-natal visit in a private facility/provider, get a copy of the record and determine the date of visits, then apply the rule above. Put under REMARKS column other necessary information to support this claim.<br>Ensure that reporting of the pregnant woman with 4ANC is done on the *month when the pregnant woman completed the "1-1-2 rule"*.<br>In other words, if the pregnant woman made additional visits, e.g. 1-1-5, she should no longer be counted again under 4ANC on the month of the additional visits since this woman should have been reported already on the month that she completed "1-1-2") |

3. Check and count the listed number of clients provided with at least 4 prenatal visits (1 in the 1st trimester of pregnancy, 1 in the 2nd trimester, and 2 in the 3rd trimester). Compare the count from the TCL with entries in ST of each RHM.

4. If discrepancies are noted (*Reminder: Only women who have completed the minimum required 4 prenatal visits, following the schedule above, by the end of the reporting month, shall be reported.),* reconcile the entries in ST with that of the actual number provided the service as listed in the updated TCL. If the number indicated in ST does not match (ie. higher than the number in TCL), follow the number based on TCL. Update M1 accordingly.

5. Review entries in the M1 against the MCT for correctness. Update if necessary.

6. Review actual number of accomplishment entered in the MCT and reconcile with that of the Q1

7. Review computation of eligible population for pregnant women (total population x 3.5%) entered in the Q1

8. Review computation of percentage accomplishment entered in **Q1:**

   Numerator = is number of pregnant women with 4 or more prenatal visits/care

Denominator = is eligible population (total population x **3.5%**)

9. Revise **Q1** report based on the results of the data cleaning and submit to PHO/CHD

**For Facility Based Deliveries and Skilled Birth Attendants**

1. Secure copies of the following:
    a. Target Client List (**TCL**) for prenatal care/visit
    b. Summary Table (**ST**)
    c. Monthly Form (**M1**)
    d. Annual-BHS (**A-BHS)**
    e. Annual 1-RHU (**A1-RHU**)
    f. Local Civil Registrar Records (**LCR**)
2. Using the assessment guide review the entries in the **TCL**

| Assessment Guide for FDB and SBA | Yes | No | If No |
|---|---|---|---|
| Is the target client list for prenatal care updated? | | | Get copies of the individual treatment record or masterlist of pregnant women if available and update TCL |
| Is the target client list completely and correctly filled-up? | | | If column 13 (Pregnancy Date Terminated and Outcome) of TCL for prenatal care is not filled up, check if terms are understood<br><br>Date Terminated – month, day and year current pregnancy is terminated<br>Outcome – pregnancy outcome maybe, livebirth (LB) Stillbirth (SB) or Abortion (AB)<br>(Note: It is possible to have more than 2 codes (Livebirth, Stillbirth or Abortion) appearing in the outcome due to multiple births.)<br>*If column 14 (Livebirths) is not filled up*, ensure that all information (Sex, Birth Weight in grams, Type of Delivery, Place of Delivery and Attended by) required for all livebirths are listed<br>Codes:<br>Types of Delivery<br>• NSD – Normal spontaneous delivery<br>• Others – Caesarian Section or forceps<br>Place of Delivery<br>• 1 = Home<br>• 2 = Hospitals (hospitals, RHUs and birthing facilities both public and private)<br>• 3 = Others |

| Assessment Guide for FDB and SBA | Yes | No | If No |
|---|---|---|---|
| | | | Attended by<br>• A = doctor<br>• B = nurse<br>• C = midwife<br>• D = Hilot/TBA<br>• E = Others |
| For a live birth to be counted as facility-based delivery, place of delivery should be in hospitals (which includes health facilities such as hospitals, RHUs and birthing facilities both public and private) | | | If live birth was not delivered in the health facility (*coded as HOSPITAL in the TCL*), then deduct the entry from the number of deliveries in health facilities |
| For a live birth to be counted as attended by a skilled health personnel, delivery should have been attended by any of the following:<br><br>-Doctor<br>-Nurse<br>-Midwife | | | If live birth was not delivered by DOCTOR, NURSE or MIDWIFE, then deduct the entry from the total number of births attended by skilled health personnel |

3. Check and count the number of facility-based deliveries and live births delivered by skilled health personnel (**Reminder:** Only those live births delivered in health facilities and delivered by skilled health personnel by the end of the reporting month.). Compare the count from the TCL with entries in **ST** under **Natality**.
4. If discrepancies are noted, reconcile the entries in **ST** with that of the actual count listed in the updated **TCL. If the number indicated in ST does not match (ie. lower/higher than the number in TCL), follow the number based on TCL.**
5. Update **M1** accordingly**.**
6. Review **A-BHS** of each RHM and compare entries in the **ST** and **M1** for correctness, completeness and/or discrepancies
7. Review entries in the **A-BHS** of each RHM against the **A1-RHU** for correctness
8. Using the additional assessment guide below, determine if number of live births reported in A1-RHU were included in the number of live births reported in **LCR**

| Assessment Guide for FBD and SBA | Yes | No | If No |
|---|---|---|---|
| Are copies of certificate of live births/deliveries registered in the municipality available? | | | Secure copies (photocopy if possible) of all certificate of live births/deliveries from the municipal/city local civil registrar's office |
| Is LCR report on the number of live births consistent with the number of live births in A1-RHU? | | | Check if births/deliveries recorded in the TCL are already registered. If not, then the LGU should establish mechanism to ensure that these births are registered.<br><br>Identify and count births/deliveries that are registered but not recorded in the TCL<br><br>Establish a mechanism on how to reconcile live births to be reported in A1-RHU with that of registered births/deliveries based on LCR report.<br><br>**Note:**<br><br>Registration of births/deliveries is by place of occurrence. Hence those delivered in hospitals or facilities outside of residence of pregnant woman will be registered in the place where the hospital or facility is located.<br><br>It is important that a mechanism is established by the PHO relative to natality recording and reporting) |

9. Review computation of accomplishment:

    a. % of births attended by skilled health personnel

        Numerator = total number of births attended by skilled health personnel

        Denominator= total number of livebirths

    b. % facility based deliveries

        Numerator = number of deliveries in health facilities (RHUs, hospitals and other birthing facilities)

        Denominator= total number of deliveries

10. Revise **A1-RHU** report based on the results of the data cleaning and submit to PHO/CHD

**For Fully Immunized Child (FIC)**

1. Secure copies of the following:

    a. Target Client List (**TCL**) for children under 1 year old

b. Summary Table (**ST**)

c. Monthly Form (**M1**)

d. Monthly Consolidation Table (**MCT**)

e. Quarterly Form (**Q1**)

2. Using the assessment guide below review the entries in the **TCL**

| Assessment Guide for FIC | Yes | No | If No |
|---|---|---|---|
| Is the target client list for children under 1 year old updated? | | | Get copies of the individual treatment record or masterlist of children under 1 year old if available and update TCL |
| Is the target client list completely and correctly filled-up? | | | Check entries in Column 11 (Date Immunization Received) of TCL for children under 1 year old.<br><br>Check if dates of immunization are entered in each column of the antigen (BCG, DPT1, DPT2, DPT3, Polio1, Polio2, Polio3, Hepatitis B1 {within 24 hours of birth or after 24 hours of birth}, Hepatitis B2, Hepatitis B3 and Anti-Measles Vaccine) following the ROUTINE IMMUNIZATION SCHEDULE for infants<br><br>Check entry in column 12 (Date fully immunized)<br>The date entered should be the same date with the date the last antigen (anti-measles) was given<br><br>Check age of child when last dose of scheduled immunization (DPT 3, Polio3, Hepa B3 and anti-measles vaccine) were received relative to the birthdate. |
| For a child to be counted as fully immunized child, the child has received ALL of the following:<br><br>*BCG, DPT1, DPT2, DPT3, Polio1, Polio2, Polio3, Hepatitis B1 {within 24 hours of birth or after 24 hours of birth}, Hepatitis B2, Hepatitis B3 and Anti-Measles Vaccine*<br><br>Only children who received the above antigens before the age of 12 months should be recorded as FIC | | | If one or more of these antigens *(BCG, DPT1, DPT2, DPT3, Polio1, Polio2, Polio3, Hepatitis B1 {within 24 hours of birth or after 24 hours of birth}, Hepatitis B2, Hepatitis B3 and Anti-Measles Vaccine)* were <u>not</u> administered to the child (before the first birth date), then drop the entry from the count of the total number of FIC<br><br>If age of child (at the time he/she received the last dose of vaccine) falls above 12 months, then drop the entry from the count of the total number of fully immunized children |

3. Check and count the listed number of infants fully immunized for the month. Compare the count from the TCL with entries in ST of each RHM.

4. If discrepancies are noted *(Reminder: Only infants who have received 1 dose of BCG at birth or anytime before reaching 12 months, 3 doses each of DPT, OPV and hepatitis B as long as the 3rd dose is given before the child reaches 12 months old and 1 dose of measles vaccine before reaching 12 months old*

*should be reported for the reporting month.),* reconcile the number reported in **ST** with that of the actual number of infants who received the last dose of the scheduled immunization as listed in the updated **TCL. If the number indicated in ST does not match (ie. lower/higher than the number in TCL), follow the number based on TCL.** Update **M1** accordingly**.**

5. Review entries in the **M1** against the **MCT** for correctness. Update if necessary.
6. Review actual number of accomplishment entered in the **MCT** and reconcile with that of the **Q1**
7. Review computation of eligible population (total population x 2.7%) entered in the **Q1**
8. Review computation of percentage accomplishment entered in **Q1**

   Numerator = total number of fully immunized children

   Denominator = total population x 2.7%
9. Revise **Q1** report based on the results of the data cleaning and submit to PHO/CHD

**For Exclusive Breastfeeding**

1. Secure copies of the following:
   a. Target Client List (**TCL**) for children under 1 year old
   b. Summary Table (**ST**)
   c. Monthly Form (**M1**)
   d. Monthly Consolidation Table (**MCT**)
   e. Quarterly Form (**Q1**)
2. Using the assessment guide below review the entries in the **TCL**

| Assessment Guide for Exclusive Breastfeeding | Yes | No | If No |
|---|---|---|---|
| Is the target client list for children under 1 year old updated? | | | Get copies of the individual treatment record or masterlist of children under 1 year old if available and update TCL |
| Is the target client list completely and correctly filled-up? | | | Check entries in column 13 (Child was exclusively breastfed) of TCL for children under 1 year old, note if a check is placed under the columns 1st, 2nd, 3rd, 4th, 5th. The check mark indicates that the infant is exclusively breastfed for that period/age.<br><br>Check entry on the last column (6th |

| Assessment Guide for Exclusive Breastfeeding | Yes | No | If No |
|---|---|---|---|
| | | | month) if date of visit was indicated. |
| For an infant to be counted as Exclusively breastfed infants mean that only breastmilk and no other food (including water) is given. However, drops of vitamins and prescribed medications given while breastfeeding is still considered exclusive breastfeeding<br><br>Only when the infant reaches 6 months of age and has been exclusively breastfed from 1st to the 6th month of age shall he/she be reported as exclusively breastfed | | | Review the definition of EBF – if entries were made but not really following definition of EBF, then take out the entry for the total number of infants exclusively breastfed until 6 months (important to remind the midwives to ask follow up questions to validate entries in the future)<br><br>Check ( / ) marks indicate that "mother was seen and asked if child is exclusively breastfed", if not, then take out the entry from the total number of infants exclusively breastfed until 6 months<br><br>Check if date indicated is within the 6th month age of the child (by reviewing date of birth), if visit is beyond 6 month, take out the entry from the total number of EBF<br><br>If no entry on the date of visit (implies that the mother did not visit, and thus no confirmation was made to check if mother followed the EBF rule), then take out entry from the total number of EBF |

3. Check and count the listed number of infants exclusively breastfed for the month. Compare the count from the **TCL** with entries in **ST** of each RHM.

4. If discrepancies are noted (**Reminder:** Only when infants have reached 6 months of age and are still exclusively breastfed shall they be recorded as exclusively breastfed for 6 months and reported for the reporting month.), reconcile the number reported in **ST** with that of the actual number of infants who were exclusively breastfed for 6 months listed in the updated **TCL. If the number indicated in ST does not match (ie. lower/higher than the number in TCL), follow the number based on TCL.** Update **M1** accordingly**.**

5. Review entries in the **M1** against the **MCT** for correctness. Update if necessary.

6. Review actual number of accomplishment entered in the **MCT** and reconcile with that of the **Q1**

7. Review computation of percentage accomplishment entered in **Q1**

   Numerator = total number of infants exclusively breastfed until 6 months

   Denominator = total number of infants 6 months of age seen

8. Revise **Q1** report based on the results of the data cleaning and submit to PHO/CHD

**For Garantisadong Pambata Vitamin A Supplementation**

1. Secure copies of the GP report

2. Using the assessment guide below, review the entries in the GP report

| Assessment Guide for Vitamin A Supplementation | Yes | No | If No |
|---|---|---|---|
| Is there an updated GP Vitamin A Supplementation Coverage masterlist? | | | Update the masterlist or any document listing children 6-59 months old children given Vitamin A supplementation |
| Is the GP report the latest version to date during the assessment? | | | Secure a copy of the latest report |
| Is the latest version the final report? | | | Ask when will the final report be available |
| Is the final report complete? | | | Ask the barangays that have not submitted their final report and assist in facilitating submission of the final report of these barangays |
| Is the reported number of 6-59 months old children given GP Vitamin A consistent with the list of 6-59 months old children?<br><br>**Note: Part of the DOH DM 2010-0052 (February 26, 2010), (Guidelines for the Conduct of GP Activities) 3 states that *"All well children given Vitamin A prior to GP and was reported in the FHSIS Report form shall be added to the GP accomplishment report and not to be included in the report of high risk cases as indicated in the FHSIS"*. | | | Check the GP masterlist of the health worker and check if all children listed were given Vitamin A; if not, then correct the number of children given Vit A<br><br>Check if the list of children given Vitamin A is within the target group of:<br>A. 6-11 months<br>B. 12-59 months<br><br>If age of children given Vit A does not belong to the age group (cases where elementary students are given Vit A and reported), then take out the entry from the number of children given Vit A.<br><br>Review the TCL for Under 1 year old and check if the recorded 6-11 months old children from January-April and May to October are included in the GP masterlist of 6-11 months old children for April and October GP campaign. If not, include these children in the GP report for the total number of 6-11 months old given Vitamin A. |
| Was the projected population based on 2000 census used as the reference population for the GP report? | | | Show the DOH DC 2009-0129 as reference document for the use of 2000 census in the computation of the 2010 projected population.<br><br>Assist in the re-computation of targets based on the 2010 projected population based on 2000 census. |
| Is the computation of target correct? | | | Assist the health personnel in re-computing the target population. |

| Assessment Guide for Vitamin A Supplementation | Yes | No | If No |
|---|---|---|---|
| | | | Formula:<br>• 6-11 months = total population x 1.35%<br>• 12-59 months = total population x 10.8% |
| Is the target group disaggregated by age:<br>• 6-11 months<br>• 12-59 months | | | Assist in disaggregating GP report by age |
| Are there barangays which reported less than 100% accomplishment? | | | Conduct rapid coverage assessment of a cluster of families with children 6-59 months old children in the barangay and check if there are missed children<br><br>Children who were missed should be followed up and given Vitamin A<br><br>A mop-up operation should be done in other areas of the barangay where children are missed in the giving of Vitamin A during GP week |

3. Review computation of percentage accomplishment

   **For infants 6-11 months old:**

   Numerator = total number of infants 6-11 month old given Vitamin A

   Denominator = total population x 1.35%

   **For children 12-59 months old:**

   Numerator = total number of 12-59 months old children given Vitamin A

   Denominator = total population x 10.8%

4. Revise **GP** report based on the results of the data cleaning and submit to PHO/CHD

## Annex D. Assessment of Health Risks and Needs of the Family by CHTs

Assessment of health risks and identifying needs of families are primary functions of members of the Community Health Team (CHT). Following are instructions on how to conduct the health risk assessment and the necessary forms to record responses and assess needs of families.

1. Explain to the family that you will assist them in determining their health risks and needs so that they can be properly guided in developing their health plan. Explain to the family the link between the health risk assessment and the health use plans that will be developed after the assessment. This is to further involve the family into the discussion of their health risks, as the family members present what their concepts of "health risks" are. Explore on their understanding of health risks and how they cope with risks. Whenever necessary, provide examples that the family can easily relate with. For example, experiences by neighbors and/or well known cases in the community.

2. After making them at ease with the "risk" concepts, point them to forms that you will help them with in filling up. Allay their possible apprehensions (if there are any) on the forms reiterating the benefits of assessing health risks in the family.

3. Two forms will be used here:

**a. Family Health Risks Assessment Form**

- This is divided into 3 major sections:
  i. Maternal and Newborn Health (Questions 1-8)
  ii. Reproductive Health/Family Planning (Questions 9-15)
  iii. Child Health (Questions 16-26)
- The screening and follow-up questions will identify the health risks based on awareness and health practices of the family. Reminder: Prioritize immediate health concerns of pregnant mother and/or sick child.
- Read each question and record the response of the family in the appropriate space. Whenever necessary, repeat the question and clarify concepts that are not readily understood by the family. Please refrain from arguing with the responses of the family. Let the family give details of their responses while noting the most appropriate response relative to the forms.

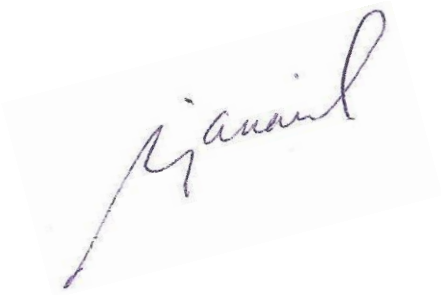
- Allow them to tell stories and examples. Story-telling is the best way to get appropriate responses. Whenever necessary do not interrupt as this may be taken as rudeness.

- At the end of the discussion, determine the risk areas to be addressed. Show to the family their risk profile. Explain to them that based on their responses, there are a number of risk areas that the family needs to give extra attention. Ask the family their reactions on the result of the assessment. Listen carefully on their responses and ask for suggestions. Continue these post-assessment discussions until the family agrees to the risk profile. The family's "thumbs-up" is a necessary ingredient for your healthy relationship with the family.

**b. Summary Assessment Form**

- The first part of the form identifies the family's health risks and needs (based on the assessment), as well as the recommended health use plans that need to be developed.

- The second part shows the commitment of the family as they agree to develop and follow the health use plans.



| FAMILY HEALTH RISKS ASSESSMENT FORM | | |
|---|---|---|
| Name of Head of Family: *(Last name, First name)* _____ | Household No.: _____ | |
| Name CHT Member: *(Last name, First name)* _____ | Date: _____ | |

| A | B | C | D | | F | G | H |
|---|---|---|---|---|---|---|---|
| **Q #** | **Screening Questions** | **YES** | **NO** | **Don't Know** | **Follow-up Questions** | **Health Risks Identified** | **Health Messages to Emphasize** |
| **CHILD HEALTH: NEWBORN/INFANT** | | | | | | | |
| 1 | (NOTE: If the family profile shows that there's an infant in the family, ask this question) Is your baby sick? | | If NO, proceed to Q2 | | If YES, what happened? What is your baby sick of? | [ ] with sick infant (<1 year old) who needs immediate medical attention, as follows:<br>- Diarrhea (watery/bloody)<br>- Dehydration (sunken fontanelles, dry lips and mouth etc.)<br>- Frequent cough and colds<br>- Breathing fast (more than 50-60 breaths/minute)<br>- Difficulty in feeding (less than 5x in 24 hours)_<br>- Pus in the eyes<br>- Yellowing of the skin<br>- Convulsion<br>- Foul-smelling discharge from the cord<br>- Fever<br>- Body rashes | Early detection of childhood illnesses and early referral to a health service provider can help save your child's life.<br>A sick child needs to be seen immediately by a health provider to prevent complications and even death.<br>NOTE: Prepare a sick child plan and prioritize immediate referral to a health provider; Navigator may accompany the parents to the health provider.<br>Give health messages on symptoms and simple home management of sick infants. |

| A | B | C | D | | F | G | H |
|---|---|---|---|---|---|---|---|
| **Q #** | **Screening Questions** | **YES** | **NO** | **Don't Know** | **Follow-up Questions** | **Health Risks Identified** | **Health Messages to Emphasize** |
| **2** | Is he/she being immunized? | | | | If YES, what kind? ___BCG; ___OPV1; ___OPV2; ___OPV3; ___DPT1; ___DPT2; ___DPT3; ___HEP-B1; ___HEP-B2; ___HEP-B3; ___Measles | [ ] with an infant who is not immunized or have irregular immunization | A child who is not immunized, not breastfed and underweight is prone to diseases which may cause death. Give information on child immunization, exclusive breast feeding and proper nutrition which can be found in the Mother and Baby Book. |
| **3** | Is he/she being breast fed? | | | | For infant <6 months, is he/she exclusively breastfed? ___YES ___NO | [ ] with an infant who may not be receiving adequate nutrition | |
| **4** | Was your infant weighed during the last OPT? | | | | If YES, was your infant found to be underweight? ____ YES ____NO | [ ] with an infant who was found to be underweight and may require closer monitoring | |
| **5** | Did your infant receive Vitamin A supplementation last GP? | | | | | [ ] with an infant who needs Vitamin A supplementation | |
| **6** | Do you bring your infant to a health provider when sick? | | | | | [ ] with an infant who may not be managed/seen early by the health service provider when sick | Early detection of childhood illnesses and early referral to a health service provider can help save your newborn's/child's life.<br><br>A sick newborn/infant needs to be seen immediately by a health provider to prevent complications and even |

| A | B | C | D | | F | G | H |
|---|---|---|---|---|---|---|---|
| **Q #** | **Screening Questions** | **YES** | **NO** | **Don't Know** | **Follow-up Questions** | **Health Risks Identified** | **Health Messages to Emphasize** |
| | | | | | | | death. |
| **CHILD HEALTH: BELOW FIVE YEARS OLD** | | | | | | | |
| **7** | (NOTE: If the family profile shows that there is/are a child/ren in the family below five years old, ask this question)<br><br>Is your child (below five years old) sick? | | | | If yes, what happened? What is the child sick of? | [ ] with sick child/children <5 years old who needs immediate medical attention, as follows:<br>- High fever >2 days<br>- Convulsion<br>- Diarrhea (watery/bloody)<br>- Frequent cough/colds<br>- Malnutrition<br>- Severe vomiting<br>- Nose bleeding<br>- Difficulty in breathing<br>- Laceration/deep wounds<br>- Falls/accidents<br>- Snake bite/animal bite<br>- Burn<br>- Poisoning<br>- Presence of parasites<br><br>[ ] with sick child/children <5 years old who may have TB and needs immediate medical attention, as follows:<br>- recurring fever<br>- wound in the neck that does not heal<br>-weight loss | Early detection of childhood illnesses and early referral to a health service provider can help save your child's life.<br><br>A sick child needs to be seen immediately by a health provider to prevent complications and even death.<br><br>NOTE: Prepare a sick child plan and prioritize immediate referral to a health provider; Navigator may accompany the parents to the health provider.<br><br>Give health messages on symptoms and simple home management of sick infants. |
| **8** | Was your child weighed during the last OPT? List names:<br>_____<br>_____<br>_____ | ____<br>____<br>____ | ____<br>____<br>____ | ____<br>____<br>____ | If YES, are any of your children underweight?<br>____ YES<br>____ NO | [ ] with a child who is not regularly weighed<br>[ ] with a child who was found to be underweight | |

| A | B | C | D | | F | G | H |
|---|---|---|---|---|---|---|---|
| **Q #** | **Screening Questions** | **YES** | **NO** | **Don't Know** | **Follow-up Questions** | **Health Risks Identified** | **Health Messages to Emphasize** |
| **9** | Did your child receive Vitamin A supplementation last GP? List name & indicate status. _____ _____ _____ | ____<br>____<br>____ | ____<br>____<br>____ | | | [ ] with a child who needs Vitamin A supplementation | Vitamin A supplementation every six months prevents illnesses and deaths. |
| **10** | Was your child dewormed last GP? List name & indicate status. _____ _____ _____ | ____<br>____<br>____ | ____<br>____<br>____ | | | [ ] with a child (1-<5 years old) who needs regular deworming | Parasites such as intestinal worms may lead to malnutrition. |
| **11** | Do you bring your child/children 1 to <5 years old to a health provider when sick? | | | | | [ ] with a child who may not be managed/seen early by the health service provider when sick | A sick child needs to be seen by a health provider to prevent complications and even death. Give health messages on symptoms and simple home management of sick infants. |
| **MATERNAL HEALTH** | | | | | | | |
| 12 | Are you Pregnant? | | | | If YES, when was your last menstrual period? _____ If NO, **proceed to Q # 21.** (If Don't know, refer to provider for confirmation of pregnancy, proceed to Q # 9) | [ ] is currently pregnant | **All pregnancies are risky. Mothers should be seen and attended to by SBA from pregnancy to delivery.**<br><br>Recommended schedule for prenatal check-up: 1 for 1st trimester; 1 for 2nd trimester; 2 for 3rd trimester. |

| A | B | C | D | | F | G | H |
|---|---|---|---|---|---|---|---|
| **Q #** | **Screening Questions** | **YES** | **NO** | **Don't Know** | **Follow-up Questions** | **Health Risks Identified** | **Health Messages to Emphasize** |
| 13 | Do you feel sick; or are there times when you feel sick? | | | | If yes, what are your symptoms? | [ ] Is currently experiencing the following:<br>- Swelling of the legs, hands, and/or face<br>- Severe headache, dizziness, blurring of vision<br>- Vaginal bleeding<br>- Pale Skin<br>- Vomiting<br>- Convulsion<br>- Difficulty in breathing<br>- Fever and chills<br>- Too weak to get out of bed<br>- Severe abdominal pain<br>- Foul-smelling/watery vaginal discharge<br>- Painful urination<br>- Absence of or decrease in baby's movement inside the womb | Provide health messages on identifying danger signs of pregnancy and health professional-assisted deliveries. See Mother & Child book for the proper care of pregnant mothers. |
| 14 | Is the current pregnancy planned? | | | | | [ ] unplanned pregnancy | |
| 15 | Have you consulted for pre-natal check-up? | | | | If yes, how many during<br>1st trimester? ___<br>_ 2nd trimester? ___<br>_ 3rd trimester? ___<br>_ | [ ] no pre-natal or irregular check up | |

| A | B | C | D | | F | G | H |
|---|---|---|---|---|---|---|---|
| **Q #** | **Screening Questions** | **YES** | **NO** | **Don't Know** | **Follow-up Questions** | **Health Risks Identified** | **Health Messages to Emphasize** |
| 16 | Have you received more than 2 doses of Tetanus Toxoid? | | | | If yes, when?<br>TT1 _____<br>TT2 _____<br>TT3 _____<br>TT4_____ | [ ] no or incomplete tetanus toxoid in the past and/or present pregnancy | Receiving tetanus toxoid will prevent Neonatal tetanus.<br>*(Recommended schedule of TT:*<br>*TT1-as early as possible during pregnancy*<br>*TT2- at least 4 weeks later*<br>*TT3- at least 6 months later*<br>*TT4- at least 1 year later)* |
| 17 | Do you plan to deliver your baby in a health facility? | | | | If NO/DON'T KNOW, why?<br>( ) No money<br>( ) Safer/more convenient at home<br>( ) far from health facility<br>( )prefers delivery by hilot | [ ] prefers to be delivered at home by hilot only | Complications may arise anytime during delivery. To ensure safe delivery, mothers should deliver in a health facility and/or should be assisted by an SBA. |
| 18 | Do you plan to breastfeed? | | | | IF NO, DON'T KNOW, why?<br>- painful /uncomfortable<br>- formula milk will make my baby smarter<br>- will destroy my breasts<br>- others | [ ] prefers not to breastfeed | One way to prevent common child illnesses is through breastfeeding. It increases your baby's defense against infection. Breastfeed your baby for the first six months of life, without water, milk formula, juice, other liquid, and food.<br><br>Colostrum is the |

| A | B | C | D | | F | G | H |
|---|---|---|---|---|---|---|---|
| **Q #** | **Screening Questions** | **YES** | **NO** | **Don't Know** | **Follow-up Questions** | **Health Risks Identified** | **Health Messages to Emphasize** |
| | | | | | | | yellowish substance that comes out of your breasts 30 minutes to 1 hour after you give birth. It is high in antibodies that will increase your baby's resistance against infection. It is important that your baby is latched on your breasts as soon as you give birth so that s/he could get the colostrum. |
| 19 | Do you plan to have post-partum check-up? | | | | If NO/DON'T KNOW, why?<br>( ) No money<br>( ) far from health facility<br>( ) not a common practice | [ ] most likely will not have post-partum check up for current pregnancy | Complications may arise during the post-partum period when mother can be put at risk. Emphasize importance of having Post-partum check-up. |
| 20 | Do you want your baby to have immunization? | | | | If NO/DON'T KNOW, why?<br>( ) No money<br>( ) far from health facility<br>( ) fear of complications<br>( ) lack of awareness<br>( ) religious beliefs | [ ] most likely will not have immunization for the baby | Full/complete immunization prevents serious childhood diseases. Have your child immunized fully before he reaches one year old. |

| A | B | C | D | | F | G | H |
|---|---|---|---|---|---|---|---|
| **Q #** | **Screening Questions** | **YES** | **NO** | **Don't Know** | **Follow-up Questions** | **Health Risks Identified** | **Health Messages to Emphasize** |
| 21 | Do you want your baby to be screened for congenital problems? | | | | If NO/DON'T KNOW, why?<br>( ) No money<br>( ) far from health facility<br>( ) lack of awareness | [ ] most likely will not have newborn screening | Newborn screening can detect certain congenital conditions and allows you to prevent its complications at minimal cost. |
| **REPRODUCTIVE HEALTH/FAMILY PLANNING** | | | | | | | |
| 22 | How many pregnancies did you have? _____ | | | | | [ ] mother has more than 4 pregnancies | A planned family is a healthy family. Mothers are in greater risk if: (a) they get pregnant too young – less than 18 years old; (b) they get pregnant too old - when they are above 35 years old; (c) the timing of their pregnancy is too close – less than 3 years apart; and (d) they have too many children already - more than four. (Introduce the different modern methods of FP or correct |
| 23 | Do you want to have more children? | | | | | [ ] family has no definite plan | |
| 24 | How old are you? _____ | | | | | [ ] mother is less than 18 or more than 35 years old | |
| 25 | How old is your youngest child? _____ | | | | | [ ] youngest child is less than 2 years old | |
| 26 | Do you want to plan your next pregnancy? | | | | | [ ] don't agree/don't know that pregnancy can be planned | |

| A | B | C | D | | F | G | H |
|---|---|---|---|---|---|---|---|
| **Q #** | **Screening Questions** | **YES** | **NO** | **Don't Know** | **Follow-up Questions** | **Health Risks Identified** | **Health Messages to Emphasize** |
| 27 | Do you practice "Modern" Family Planning? If yes, what method did you use in the last 3 months? (Check)<br>NATURAL FP ( ___Cervical Mucus; ___Basal Body Temp; _____Symptothermal; _____SDM; _____LAM)<br>ARTIFICIAL FP ( ___Pills ; _____Condom; _____Injectable;_____ IUD ) | | | | If NO, why?<br>( ) Afraid of side-effects<br>( )costly<br>( ) far from health provider<br>( )don't know where to avail<br>( ) religious beliefs<br>( ) lack of awareness | [ ] no modern method of family planning used | any myths and misconceptions on FP)<br><br>Correct use of modern FP methods can help you space births properly. |
| 28 | Are you using the method regularly? | | | | If NO, why?<br>( ) Stopped due side-effects<br>( )costly<br>( ) far from health provider<br>( ) missed the schedule | [ ] uses family planning method but not regularly or has defaulted | |

How to complete the family health risks assessment form

1) Write the name of the family and navigator in this format: Last name, First name (ex. Santos, Maria).

2) Copy GMP Family no. from the family ID.

3) Check for health concerns needing immediate referral to health facilities, and prioritize these in the assessment.

4) Begin by answering the screening questions on maternal and newborn health in column B.

5) Check the appropriate response (either YES/NO/Don't Know) in Column C to E or fill in the blanks.

6) Answer the follow-up questions accordingly.

7) If mother is not pregnant, skip Questions 1 to 8 and proceed to the section on reproductive health starting with Question 9.

8) Finish answering the screening questions (Q1-26) as appropriate.

9) Identify the health risks of the family by ticking the items in Column G.

***NOTE:****If the response to the screening question fall into a partly shaded area (either in Column C, D, or E), it means that there is a health risk. Tick the corresponding health risks in Column G.*

10) Explain to the family the consequences for every health risk identified and what should be done to avoid the identified risks.

11) Use the health messages in the GMP, and the Mother & Child Book, to emphasize key health information and necessary actions.

    a. The husband should become an active partner in choosing an FP method; during pregnancy, delivery, breastfeeding, immunization of children and emergencies;

    b. The couple may go to midwife, nurse or doctor if they want to time and space pregnancies through family planning;

    c. They may choose among FP methods that are modern natural (breastfeeding, thermometer, cervical mucus, symptom-thermal, standard days); other modern (contraceptive pills, condom, injectable hormones, IUD); or permanent (bilateral tubal ligation for women, non-scalpel vasectomy for men).

    d. The mother should have at least four (4) pre-natal check-ups during pregnancy;

e. The mother should go to the nearest hospital if she experiences danger signs during pregnancy (swelling of the legs, hands or face; severe headache, dizziness, blurring of vision etc.) and after delivery (severe headache, pale skin, fever etc.);

f. During delivery, the mother should be assisted by a midwife, nurse or doctor who can readily manage possible complications;

g. The parents should bring their neonate to the nearest facility if they notice danger signs such as difficulty in feeding, convulsion, foul smelling discharge from the cord etc.;

h. The parents should prevent their child from getting sick through breastfeeding, proper hygiene, giving Vitamin A and zinc, vaccine against TB, diphtheria, whooping cough, tetanus, measles and hepatitis B;

i. If the child has diarrhea, the child should be given plenty of fluids; and the parents should ask the midwife, nurse or doctor about giving zinc supplements;

j. The child should be brought to the health facility immediately if s/he shows signs of severe dehydration in diarrhea such as sunken fontanelles, dry lips and mouth etc.; and

k. To prevent pneumonia, the child should be brought immediately to a health facility for early treatment if his cough and colds worsen.

12) Make sure that the family fully understands their health risks. Such awareness prompts them to plan for their health and utilize health services.

13) Make sure that this form is accomplished with the family during the initial visit. Write the date when the form is accomplished.

| SUMMARY ASSESSMENT FORM | | |
|---|---|---|
| | | |
| Name of Head of Family: *(Last name, First name)* _____ | | Household No.: _____ |
| Name CHT Member: *(Last name, First name)* _____ | | Date: _____ |
| **Part 1** | | |
| **Health Risks/Consequence identified** | **Health Needs** | **Recommendations** |
| **MATERNAL & NEWBORN HEALTH** | | |
| [ ] Mother is currently pregnant | [ ] pre-natal check-up | You need to develop a birth plan |
| [ ] Mother and baby are not protected against tetanus | [ ] tetanus toxoid immunization | |
| [ ] home delivery by hilot may result to improper management of complications during and immediately after childbirth | [ ] need to identify skilled birth attendant/ health facility | |
| [ ] may not identify postpartum and newborn danger signs that will endanger both the life of the mother and the newborn | [ ] post-partum check up for current pregnancy | |
| [ ] Not breastfeeding the baby due to some misconceptions and fears will not give the baby the protection s/he needs to fight diseases | [ ] Counseling on exclusive breastfeeding | |
| [ ] newborn care | [ ] immunization for the baby | |
| [ ] not bringing the baby to the health facility for immunization will make him/her at risk of catching life-threatening diseases | [ ] newborn screening for the baby | |
| [ ] congenital anomalies that will lead to mental retardation may not be detected and corrected early | | |
| **REPRODUCTIVE HEALTH/FAMILY PLANNING** | | |
| [ ] mother has more than 4 pregnancies | [ ] appropriate FP counselling | You need to develop a reproductive health plan |
| [ ] family has no definite plan or had a mistimed or unplanned pregnancy | [ ] an appropriate FP method based on informed choice | |
| [ ] mother is less than 18 or more than 35 years old | [ ] couple uses modern family planning method but not regularly or has defaulted | |

| | | |
|---|---|---|
| [ ] may become pregnant again within 2 years from the last pregnancy | [ ] couple is not using any modern method of family planning and wants to space births | |
| [ ] don't agree/don't know that pregnancy can be planned | [ ] couple is not using any modern method of family planning | |

**CHILD HEALTH**

| | | |
|---|---|---|
| [ ] proper care for the infant | | You need to develop a well-baby plan |
| [ ] with an infant who is not immunized or have irregular immunization | [ ] immunization for the infant | |
| [ ] infant (<6 months old) is not exclusively breastfed | [ ] Vitamin A supplementation for the infant | |
| [ ] infant is underweight | [ ] counseling on nutrition | You need to develop a sick-child plan (1 sick child plan for every child who is <5 years old) |
| [ ] with a child/ children below 5 years old | [ ] early and proper treatment of the children < 5 years old when sick | |
| [ ] with a child who is underweight | [ ] counseling on nutrition and referral to a feeding program | |
| [ ] Vitamin A supplementation for the children 1 to <5 years old | [ ] regular deworming for the child (1 to <5 years old) | |

**Part 2**

**AGREEMENT**

I/We understand the health risks and needs of our family and I/we have decided to develop the following health use plans:

| | | |
|---|---|---|
| _____ Birth plan | | |
| _____ Reproductive Health Plan | | |
| _____ Well-baby Plan | | |
| _____ Sick Child Plan | | |
| _____ Emergency Plan | | |
| | | |
| | | |
| _____ _____ | _____ _____ | _____ _____ |
| Name/Signature of Mother | Name/Signature of Father | Name/Signature of Navigator |

How to complete the summary assessment form

1) Write the name of the family and navigator in this format: Last name, First name (ex. Santos, Maria).

2) Copy GMP Family no. from the family ID.

3) Try to accomplish this form with the family during the initial visit. However, if the family needs more time for orientation and health risk assessment, schedule a follow-up visit. Write the dates of visits.

4) Based on the completed Health Risks Assessment form, tick the appropriate health risks and needs of the family in Part 1 of the Summary Assessment form.

5) For every risk and need identified, tick the appropriate health use plans in the recommendation column.

6) Ask the family if they understand their health risks and needs.

   - ✓ If yes, ask if they are willing to develop the recommended health use plans.
   - ✓ If not, determine which part they don't understand. Re-emphasize key messages and help family realize the importance of understanding their risks.

7) Once the family had decided which health use plans to develop, formalize the agreement between you and the family.

8) Tick the appropriate health use plans in Part 2 which the family agrees to develop.

9) You and the family (mother or father or both) need to sign the agreement to show you and the family's commitment to one another.

## Annex E. Health Plans

Once the health needs are identified by the CHT and agreements made between the CHT and families, families should be assisted in developing appropriate health plans. Explain the importance of health plans and discuss each section with the family.

Guide the family in filling out Part I of the health plans. Part ll will have to be done by health service providers. Members of the CHT should be able to provide families details on available services and providers in the area including emergency contact numbers.

There are different types of health plans:

1. Family Emergency Plan
2. Sick Child Plan
3. Well Baby Plan Birth Plan
4. Birth Plan
5. Reproductive Health Plan

Following is a set of instructions for the CHT and the forms for each type of health plans.

### 1. Family Emergency Plan

Explain to the family what a Family Emergency Plan is. It is crucial that you make the family understand the link between the forms you are asking them to fill up with their goal to properly plan health emergencies that may happen in the family.

You have to explain the need to identify who will take care of the family members during emergencies or during consultation periods (Section B). At the same time, emphasize the importance of listing down persons who can easily be reached in times of emergencies (Section C).

| FAMILY EMERGENCY PLAN | | | |
|---|---|---|---|
| **Part I: To be filled out by the couple with the assistance of the navigator** | | | |
| **A** | Preferred Provider for Emergency care: *A. Dela Cruz* | | Minimum Consultation Fee:*50.00* |
| | | | |
| **B** | Caring for the Family during consults/emergency: | | |
| | Caregiver:*D.Cruz* | Relationship: *BHW/CHT* | |
| C | IN CASE OF EMERGENCY | | |
| | **Contact Person/s:** | **Contact Nos.:** | **Vehicle for Transport:** |
| | *Capt. MTorres* | *091xxxxxxx* | *BrgyMulticab* |
| | *R.Lopez* | *0910xxxxxx* | *Single Motorcycle (private)* |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## 2. Sick Child Plan

You have to explain to the family what a Sick Child Plan is. It is important to make the family understand the link between the forms you are asking them to fill in with their goal to properly attending to sick children in the family.

Guide the family in filling up the name, name of husband, their ages and your name as member of the CHT.

The most crucial information that the family needs to understand are the health goals found in Section B.

Before you ask them to fill up the form, explain the goals listed. You also have to explain each of the common illnesses/accidents listed in Section C. While sections C, D, E, F, & G will be filled up by a health provider, it would be good to explain these information to the family as well. This is your way of keeping the family more aware of the significance of having a Sick Child Plan.

How to develop the sick child plan

Note: Accomplish 1 form for every child<5 years old.

Part I – to be filled up by the family assisted by the Navigator

Write the name of child in this format: Last name, First name (ex. Santos, Jose) in Box A and her/his age in years.

Write the name of mother, father and navigator in this format: Last name, First name (ex. Santos, Jose) in Box A and her/his age in years.

Check the appropriate health goals identified by the family.

Show the list of illnesses/conditions (in Box C) that needs immediate medical attention. Instruct the family the need to bring the child to a health provider should the need arises.

Part II – to be filled up by health provider (midwife, nurse or doctor).

Sample filled-out Sick Child Plan

| | | | |
|---|---|---|---|
| **SICK CHILD PLAN** | | | |
| **Part I: To be filled out by the couple with the assistance of the navigator** | | | |
| **A** | Name of Child: *(Last name, First name)*<br>*Soriano, M.* | | Date of Birth *(MM/DD/YY)*<br>*Feb 14, 2007* |
| | Name of Mother: *(Last name, First name)*<br>*Soriano, G.* | | Age: *(in years)*<br>*23* |
| | Name of Father: *(Last name, First name)*<br>*Soriano, L.* | | Age: *(in years)*<br>*25* |
| | Name of Navigator:*(Last name, First name)*<br>*Cruz, D.* | | GMP Family No.: |
| **B** | Health goals: | [ x ] to bring child for early treatment of illnesses needing medical attention | |
| | | [ ] child to have nutritional assessment | |
| | | [ ] family to have nutritional counseling | |
| | | [ ] to receive Vitamin A supplementation/deworming every 6 months | |
| **C** | Common illnesses/accidents that needs immediate medical attention: | | |
| | [ ] high fever > 2 days | [ ] malnutrition | [ ] fall/accidents |
| | [ ] convulsion | [ ] severe vomiting | [ ] snakebite/animal bite |
| | [ ] watery diarrhea | [ ] nose bleeding | [ ] burn |
| | [ ] bloody diarrhea | [ ] difficulty in breathing | [ ] poisoning |
| | [ x ] frequent cough/colds | [ ] laceration/deep wounds | [ ] presence of parasites |
| | [ ] others _____ | | |
| **Part II: To be filled by health provider (midwife, nurse or doctor)** | | | |
| **D** | Health Provider (Indicate Name of Midwife, Nurse or Doctor):*Dr. J.Solis* | | Date of Consult:*Feb 16, 2009* |
| **E** | DIAGNOSIS/FINDINGS: | PLAN | Date of follow-up |
| | ***Pneumonia*** | ***Antibiotic treatment for 7 days*** | ***Feb. 24, 2009*** |
| | | | |
| | | | |
| | | | |
| **E** | **SCHEDULE OF VITAMIN A SUPPLEMENTATION** | | |
| | Due Date | Dose | Date Given |
| | | | |
| | | | |
| | | | |
| | | | |

| | | | |
|---|---|---|---|
| | | | |
| **F** | **SCHEDULE OF DEWORMING** | | |
| | Due Date | Drug/ Dose | Date Given |
| | *April 2009* | *Albendazole 400 mg, 1 tab, single dose* | |
| | *October 2009* | *Albendazole 400 mg, 1 tab, single dose* | |
| | | | |
| | | | |
| | | | |
| **G** | **Philhealth Claims, if applicable** | | |
| | Documents needed | Submit to | When to submit/ff up |
| | **For automatic deduction:** | | |
| | ☐ Duly accomplished PhilHealth Claim Form 1 (original) | Billing section | Prior to discharge from hospital/clinic |
| | ☐ Clear copy of Member Data Record (MDR). | | |
| | ☐ If dependent - patient is not listed yet in the MDR, submit applicable proof of dependency. | | |
| | **For Direct Filing/Reimbursement:** | | |
| | ☐ PhilHealth Claim Form 2 (to be filled up by the hospital and attending physicians) | nearest PhilHealth Office | within 60 days after discharged from hospital |
| | ☐ Official receipts or hospital and doctor's waiver | | |
| | ☐ Operative record for surgical procedures performed | | |
| **EXPECTED DATE OF COMPLETION OF THIS PLAN : *October 2009*** | | | |

## 3. Well Baby Plan

Explain to the family what a Well Baby Plan is. It is important to make the family understand the links between the forms you are asking them to fill up with their goal to properly taking care of the health of their babies.

Guide the family in filling up the name, name of husband, their ages and your name as the navigator. The most crucial information that the family needs to understand are the health goals stated in Section B.

Before you ask them to fill up, explain the goals listed. Sections C, D & E will be filled up by the health provider. However, you may still explain to the family the rationale for these sections and how these will help the family.

Sample filled-out Well Baby Plan

| WELL BABY PLAN | | | | |
|---|---|---|---|---|
| **Part I: To be filled out by the couple with the assistance of the navigator** | | | | |
| **A** | Name of Child: *(Last name, First name)*<br>*Solis, C.* | | | Date of Birth: *(MM/DD/YY)*<br>*January 4, 2009* |
| | Name of Mother: *(Last name, First name)*<br>*Solis, M.* | | | Age: *(in years)*<br>*26* |
| | Name of Father: *(Last name, First name)*<br>*Solis, D.* | | | Age: *(in years)*<br>*28* |
| | Name of Navigator:*(Last name, First name)*<br>*Alejo, T.* | | | GMP Family No.: |
| | | | | |
| **B** | Health goals: | [ x ] to receive BCG, 3 doses OPV, 3 doses DPT, 3 doses Hepa B, measles before reaching the age of 1 year | | |
| | | [ x ] to receive Vitamin A supplementation every 6 months | | |
| | | | | |
| **Part II: To be filled by health provider (midwife, nurse or doctor)** | | | | |
| **C** | Health Provider (midwife, nurse or doctor): | | | |
| **D** | **SCHEDULE OF IMMUNIZATION** | | | |
| | **Vaccine** | **Recommended Age of Vaccination** | **Due Date** | **Actual Date Vaccinated** |
| | BCG | Within 24 hours of birth *January 5, 2009* | | *January 4, 2009* |
| | DPT 1 | At six weeks | *February 18, 2009* | |
| | DPT 2 | At 10 weeks | *March 18, 2009* | |
| | DPT 3 | At 14 weeks | *April 15, 2009* | |
| | OPV 1 | At six weeks | *February 18, 2009* | |
| | OPV 2 | At 10 weeks | *March 18, 2009* | |
| | OPV 3 | At 14 weeks | *April 15, 2009* | |
| | Hepa B-1 | Within 24 hours of birth | *February 5, 2009* | |
| | Hepa B-2 | At six weeks of age | *February 18, 2009* | |

| | | | | |
|---|---|---|---|---|
| | Hepa B-3 | At 10 weeks or at 9 months | *March 18, 2009 or October 7, 2009* | |
| | Measles | At 9 months | *October 7, 2009* | |
| | | | | |
| | | | | |
| | | | | |
| **E** | **VITAMIN A SUPPLEMENTATION** | | | |
| | **Due Date** | **Dose Given** | **Actual Date Given** | **Remarks** |
| | April 2009 | 100,000iu | | |
| | October 2009 | 100,000iu | | |
| | | | | |
| | | | | |
| | | | | |

**EXPECTED DATE OF COMPLETION OF THIS PLAN:** ***October 2009***

## 4. Birth Plan

Explain to the family what a birth plan is. It is important to make the family understand the link between the forms you are asking them to fill up with the mother's well-being during pregnancy.

Guide the family in filling out the name, name of husband, their ages and your name as the navigator.

In Section A, the most crucial information that the family needs to supply are the names of their health providers (midwife, nurse or doctor; schedule of consultation and the reason (s) for referral.

Before you ask them to fill out, explain the purpose of this information. In filling out Section B, you have to explain all the goals listed.

You have to explain why at least four pre-natal check-ups are needed including the benefits the mother and the unborn will get if the mother completes at least four pre-natal check-ups. Explain also the suggested schedule of the check-ups and why this schedules need to be observed.

You have to probe as well on who will perform the delivery and where they intend to deliver. The role of the father, if present, needs to be emphasized. Ask the mother her preferences and immediately consult the father. Do not

leave the topic until a commitment/agreement is firmed up on who will deliver and where the delivery will take place.

To assist the family in their decision, you have to explain the benefits of delivery via skilled birth attendants (SBAs) which include doctors, nurses and midwives. Explain that the all pregnancies and deliveries are risky; hence they should be attended by skilled health attendants and in the health facilities. You may want to explain as well that although their costs are higher compared with "OTHER MEANS" (we need not mention hilot/TBAs) but deliveries are a lot safer. You can emphasize the thought that delivery via SBAs and health facilities is the best protection for the mother and the child.

You have to explain to the family as well what postpartum care, newborn screening and FP counseling/services mean.

By explaining all of these, more than just asking them to so you could fill up the form, you educate the family about the value of Birth Plan and make the family learn about proper maternal care.

Sections C, D & E will be filled up by the health provider. However, you may still explain to the family the rationale for these sections and how these will help the family.

Sample filled-out Birth Plan

| **BIRTH PLAN** | | | |
|---|---|---|---|
| **Part I: To be filled out by the couple with the assistance of the navigator** | | | |
| **A** | Name of Mother: *(Last name, First name)*<br>*Rosario, G.* | | Age: *(in years)*<br>*23* |
| | Name of Husband: *(Last name, First name)*<br>*Rosario, L.* | | Age: *(in years)*<br>*25* |
| | Name of Navigator:*(Last name, First name)*<br>*Cruz, D.* | | GMP Family No.:<br>*123* |
| | Referred to Health Provider: *(indicate name of Midwife, Nurse or Doctor)*<br>*Anita R.* | Scheduled date of consult: *(MM/DD/YY)*<br>*Feb 20, 2009* | Reason for referral:<br>[ x ] For Pre-natal services<br>[ ] for postpartum care<br>[ ] for newborn care |
| **B** | Health goals: *(pls. check)*<br>[ x] to have monthly pre-natal check up ( at least 4 visits);<br>[x ] at least 1 visit during the1st trimester;<br>[x ]at least 1 visit during the 2nd trimester;<br>[ x]at least 2 visits in the 3rd trimester | To have baby delivered by:<br>[ ] physician<br>[ ] nurse<br>[x ] midwife | [ x ] to deliver in a health facility |
| | [ x ] to receive postpartum care | [ x] to have our baby receive newborn screening | [ ] others, pls. specify: |

| | | | |
|---|---|---|---|
| | [ ] to receive FP counselling/services | | |
| **Part II: To be filled by health provider (midwife, nurse or doctor)** | | | |
| **C** | Provider for Prenatal/Post-partum care: Anita Reyes | | Date of 1st PNC visit: *(MM/DD/YY) Feb 19, 2009*<br>Date of 2nd PNC visit:<br>Date of 3rd PNC visit:<br>Date of 4th PNC visit: |
| **D** | **PLEASE FILL OUT ALL SECTIONS OF THE MOTHER & CHILD BOOK, to include:** | | |
| | ***Birth Plan (page 13 in the Mother & Child Book)** | | |
| | * Who will deliver my baby?<br>Midwife | *Where will I deliver?<br>HealthCenter | |
| | *How much should I prepare?<br>3,000.00 | *Who will accompany me?<br>Husband & Navigator<br>Who will take care of the children?<br>Mother in-law | |
| | *** other relevant information about pregnancy preparation and special concerns** | | |
| | * preparation for giving birth | | |
| | * warning signs during pregnancy | | |
| **E** | Philhealth Claims, if applicable | | |
| | Documents needed | Submit to | When to submit/ff up |
| | **For automatic deduction:** | | |
| | ☐ Duly accomplished PhilHealth Claim Form 1 (original) | Billing section | Prior to discharge from hospital/lying-in clinic |
| | ☐ Clear copy of Member Data Record (MDR). | | |
| | **For Direct Filing/Reimbursement:** | | |
| | ☐ PhilHealth Claim Form 2 (to be filled up by the hospital and attending physicians) | nearest PhilHealth Office | within 60 days after delivery |
| | ☐ Official receipts or hospital and doctor's waiver | | |
| | ☐ Operative record for surgical procedures performed | | |
| | ☐ Baby's birth certificate (LCR authenticated) | | |
| **EXPECTED DATE OF COMPLETION OF THIS PLAN: September 2009** | | | |

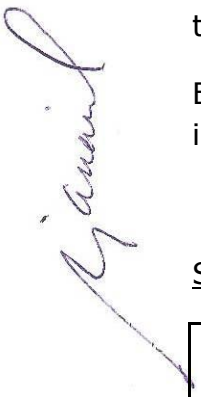
## 5. Reproductive Health Plan

Explain to the family what a Reproductive Health Plan is. Help them understand how the form can serve as an instrument for reaching their RH goal

Guide the family in filling out the name, name of husband, their ages and your name as the navigator. Copy GMP Family number from the family ID.

In Section A, assist the couple in from among the list of health providers where they can get FP counseling on the FP methods, the schedule of consultation and the reason for referral. Refer to Part 3 Section C of this kit.

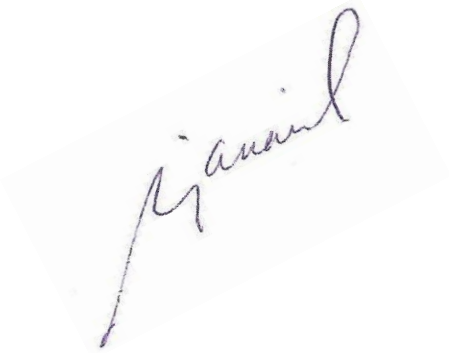
Explain the goals listed as you fill out Section B. Discuss with the family the importance of spacing pregnancies.



Sample filled-out Reproductive Health Plan

| | | | |
|---|---|---|---|
| **REPRODUCTIVE HEALTH PLAN** | | | |
| **Part I: To be filled out by the couple with the assistance of the navigator** | | | |
| **A** | Name of Mother: *(Last name, First name)*<br>*Gomez, R.* | | Age: *(in years)*<br>*27* |
| | Name of Husband: *(Last name, First name)*<br>*Gomez, R.* | | Age: *(in years)*<br>*30* |
| | Name of Navigator:*(Last name, First name)*<br>*Montes, L.* | | GMP Family No.:<br>*456* |
| | Referred to: *(indicate name of Midwife, Nurse or Doctor)*<br>*J. Martinez* | Scheduled Date of Consult: *(MM/DD/YY)*<br>*February 6, 2009* | Reason for referral:<br>[ x ] For FP counseling<br>[ x ] for FP services |
| **B** | Health goals: *(pls. check)* | | |
| | [ x ] to space pregnancy every ___3__ years | | [ x ] to limit the number of our children to __3__ |
| **Part II: To be filled by health provider (midwife, nurse or doctor)** | | | |
| | | | |
| **C** | Health provider (midwife, nurse or doctor):<br>*J. Martinez* | | Date of Initial Visit: *(MM/DD/YY)*<br>*February 6, 2009* |
| **D** | **Modern Family Planning Method of Choice** (*pls. check)* | | |
| | **Natural Methods** | | **Other Modern Methods** |
| | ___Basal Body Temperature | | __x_Pills |
| | ___Cervical Mucus | | ___DMPA |
| | ___Symptothermal | | ___Condom |
| | ___LAM | | ___IUD |
| | ___Standard Days | | ___Ligation |
| | | | ___Vasectomy |

| | | | |
|---|---|---|---|
| **E** | **SCHEDULE OF FP services/ resupply of commodities** | | |
| | **Date of Follow-up** | **Commodities/Services Needed** | **Date Provided/Purchased** |
| | ***March 4, 2009*** | ***Pills*** | |
| | | | |
| | | | |
| | | | |
| | | | |
| **F** | Philhealth Claims, if applicable | | |
| | Documents needed | Submit to | When to submit/ff up |
| | **For automatic deduction:** | | |
| | ☐ Duly accomplished PhilHealth Claim Form 1 (original) | Billing section | Prior to discharge from hospital/ clinic |
| | ☐ Clear copy of Member Data Record (MDR). | | |
| | **For Direct Filing/Reimbursement:** | | |
| | ☐ PhilHealth Claim Form 2 (to be filled up by the hospital and attending physicians) | Nearest PhilHealth Office | within 60 days after discharged from hospital |
| | ☐ Official receipts or hospital and doctor's waiver | | |
| | ☐ Operative record for surgical procedures performed | | |
| **EXPECTED DATE OF COMPLETION OF THIS PLAN:** ***February 2010*** | | | |



## Annex F. Monitoring Adherence to Health Plans

### The Family Call Sheet

The CHTs could use the Family Call Sheet as a tool to monitor adherence of families with their health plans and schedule visits to households. The family call sheet summarizes reproductive, maternal and child care needs of the family and the schedule of follow-up visits for each area of need. It should be filled up for every family beneficiary and kept by the navigator for easy monitoring of the family's schedules, which are based on the schedule indicated by the provider. The Health Use Plans developed with the family will be used as basis in filling-up this form. This form should be regularly updated as this would serve as a reminder for the navigator and would be helpful in monitoring the completion of health use plans made by the family.

*How to complete the family call sheet*

*one call sheet for every family

1) Write the name of the navigator in this format: Last name, First name (ex. De Leon, Linda)
2) Write the name of the Father (or Mother if single parent) in this format: Last name, First name (ex. Santos, Juan)
3) Copy GMP Family No. from family ID
4) Column A – write the month starting from the earliest schedule
5) Column B – write the first name of the family member needing the service
6) Column C – indicate health service is required
7) Column D - copy the due dates of health services from the health use plans and Mother and Child Book in this format: MM/DD/YY
8) Column E – indicate the date when the service was actually availed. Confirm this by checking the health use plans/Mother & Child Book or by checking the records of the health provider.
9) Column F – identify issues and problems if service is not availed. Response maybe:
   - no time
   - no money
   - no one will take care of the children
   - family member is sick
   - uninterested/refused
   - inconvenient
   - others
10) Column G – indicate action taken to address the issues/problems identified was not availed.
   - re-oriented the family/emphasized the importance of the service
   - accompanied family to health provider
   - sought assistance of community/neighbor/bgy
   - others
   - none
11) Column H- Indicate any event/factors relevant to the family/family's health use plans. May include death, major illnesses/accident, transfer of residence, etc.

Note: Columns D-H may be filled out after follow-up visits to families.

*Below is a sample of a filled-up Family Call Sheet based on the Health Use Plans of the family.*

Name of Head of the Family: *(Last name, First Name)* __Soriano, L._____

Name of GMP Navigator: *(Last Name, First Name)*_____Divina C._____

**FAMILY CALL SHEET**

| A | B | C | D | E | F | G | H |
|---|---|---|---|---|---|---|---|
| Month | Family Member who needs services | **Health Needs** | **Due Date *(MM/DD/YY)*** | **Date Done *(MM/DD/YY)*** | **Problems/ issues Identified** | **Action Taken** | **Remarks** |
| February | Grace | PNC | PNC 1- 2/20/09<br>PNC 2-<br>PNC 3-<br>PNC 4-<br>*(for dates of visit refer to page 3 of Mother and Child Book)* | | | | |
| | | During delivery | August 3rd wk | *(for date refer to page 15 of the Mother and Child Book)* | | | |
| | | Post natal care | *(dates reflected on page 17 of the Mother and Child Book)* | *(dates reflected on page 17 of the Mother and Child Book)* | | | |
| | Marie | Medical check-up :frequent cough & colds*(this info is reflected on PartC of the Sick Child Plan – the one being marked)* | Feb 16, 2009 *(date is reflected on Part B of the Sick Child Plan)* | Feb 16,2009 *(date reflected on Part C the Sick Child Plan)* | No available medicines in the RHU and the family cannot afford to buy the prescribed medicines | Navigator helped the family asked assistance from the Brgy Captain | The Brgy captain helped the family get assistance from the MSWDO |

Name of Head of the Family: *(Last name, First Name)* __Soriano, L._____

Name of GMP Navigator: *(Last Name, First Name)*_____Divina C._____

**FAMILY CALL SHEET**

| A | B | C | D | E | F | G | H |
|---|---|---|---|---|---|---|---|
| March | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| April | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| **NOTE:** | | | | | | | |
| ***PROBLEMS/ISSUES may include the following but not limited to:*** | | | | | ***REMARKS may include:*** | | |
| | No time | | a family member is sick | | | death of a family member (indicate date) | |
| | no money | | uninterested/refuses | | | major illness/accidents | |
| | No one will take care of the children | | inconvenient | | | transferred residence | |
| ***ACTION TAKEN may include the following but not limited to:*** | | | | | | | |
| | re-orient/emphasized importance of health service | | | | | | |
| | accompanied family to provider | | | | | | |
| | sought assistance of community/neighbor/bgy | | | | | | |
| | No action | | | | | | |

## Annex G. MNCHN Provider Competencies Necessary for Adequate Delivery of MNCHN Core Package of Services

This table is a checklist of services that each health provider should deliver for each life stage. Competency of health providers and equipment/supplies needed to provide each service are included. LGUs shall use this checklist to assess capacities of health providers in the service delivery network.

A checkmark is placed under a box of a health provider if it is expected to provide that service. Unless specified as otherwise, shaded boxes mean that the provider is not expected to give the service.

Some equipment may appear repeatedly for each service. It is understood that a facility should at least have the equipment and it is not necessary to provide these equipment for a particular type of service.

For the CHT, it is understood that it is composed of the midwife and health volunteers as well as the RHU which will provide services at the community level. An explanation will accompany entries that would refer to RHUs or BHs alone.

### A. PRE-PREGNANCY

| Services | COMPETENCIES | Community Level Provider | BEmONC-capable Facilities | CEmONC-capable Facilities |
|---|---|---|---|---|
| Assessment of health needs of women, mothers and children | Able to assess health needs and assist clients in filling up health plans | X | | |
| FP services:<br>1. IEC/Counselling on: Informed Choice and Voluntarism; Responsible Parenthood; Availability of a broad-range of family planning methods; | Knowledge on reproductive health and peer counselling | X | X | |
| | Basic and comprehensive Knowledge on modern methods of FP and managing side effects | X | X | |
| | Able to encourage and empower patient to make an informed decision | X | X | |
| 2. Provision of FP services: Pills, DMPA, condom, NFP | Able to discuss with the patient the most appropriate FP method | X | X | |
| • IUD<br>• BTL, NSV<br>• Management of complications resulting | Able to properly insert IUD | | X | |
| | Able to perform surgical sterilization (BTL, NSV) | | X | |

| Services | COMPETENCIES | Community Level Provider | BEmONC-capable Facilities | CEmONC-capable Facilities |
|---|---|---|---|---|
| from FP | Management of complications resulting from FP | | X | |
| Women's/maternal health, nutrition, and micronutrient supplementation | Knowledge on reproductive health | X | X | |
| | Able to measure height and weight, and identify malnutrition or obesity (BMI) | X | X | |
| | Knowledge and able to counsel on basic nutrition | X | X | |
| | Familiarity with dosing, timing , and benefits of iron, folate, Vitamin A, calcium, and iodine supplementation | X | X | |
| | Maternal Mortality tracking | X | X | |
| Tetanus toxoid immunization | Knowledge on timing, dose, and method of vaccine administration | X | X | |
| IEC/Counseling on health caring and seeking behavior | Able to counsel patients on when to consult provider | X | X | |
| Updated master listing of women of reproductive age | Data collection, organization, consolidation | X | | |

## B. PREGNANCY/ANTENATAL

| SERVICES | COMPETENCIES | Community Level Provider | BEmONC-capable Facilities | CEmONC-capable Facilities |
|---|---|---|---|---|
| Maternal health, nutrition, and micronutrient supplementation | Prenatal maternal care | X | X | X |
| | Able to measure height and weight, and identify malnutrition or obesity (BMI) | X | X | X |
| | Able to counsel patient on proper nutrition | X | X | X |
| | Knowledge on maternal nutritional needs during the prenatal period | X | X | X |
| | Familiarity with dosing, timing , and benefits of iron/folate, therapeutic dose of Vitamin A (i.e. xerophthalmia), , and iodine supplementation | X | X | X |

| SERVICES | COMPETENCIES | Community Level Provider | BEmONC-capable Facilities | CEmONC-capable Facilities |
|---|---|---|---|---|
| Tetanus toxoid immunization | Knowledge on timing, dose, and method of vaccine administration | X | X | X |
| Deworming | Healthy lifestyle promotion able to explain its importance to pregnant woman | X | X | X |
| Counseling on healthy lifestyle<br>• Safer sex and STI/HIV prevention<br>• smoking cessation<br>• healthy diet and nutrition<br>• physical activity<br>• alcohol intake | Able to counsel patients on importance of healthy lifestyle for the pregnant woman | X | X | X |
| | Able to explain thoroughly the effects of poor nutrition, smoking, and alcohol on the development of the fetus | X | X | X |
| | Knowledge on prevention of STI/HIV/AIDS | X | X | X |
| | Able to counsel patients on when to consult provider | X | X | X |
| Counseling on health caring and seeking behavior | Knowledge on modern methods of FP and managing side effects | X | X | X |
| Counseling on FP especially LAM; birth spacing, contraception, return to fertility | Able to discuss with the patient the most appropriate method for her | X | X | X |
| | Able to thoroughly discuss the benefits of LAM | X | X | X |
| | Gender sensitivity | X | X | X |
| | Knowledge of, recognition and identification of danger signs and complications of pregnancy | X | X | X |
| Early detection of danger signs and complications of pregnancy | Knowledge of, recognition and identification, and management of danger signs and complications of pregnancy | X | X | X |
| | Able to refer patients to the proper provider for management | X | X | X |
| Administration of steroids in preterm labor | Knowledge of the timing and dose of steroid administration in preterm labor | | A physician and trained nurse. | X |
| Support Services:<br>1. Antenatal registration with Mother-Child Book<br>2. Birth Plan<br>3. Home visit and follow-up | Able to track pregnancy and assist women with birth planning using MCB and able to collect necessary information | X | X | X |
| | Familiarity with timing of prenatal visits and able to discuss follow-up schedule | X | X | X |

| SERVICES | COMPETENCIES | Community Level Provider | BEmONC-capable Facilities | CEmONC-capable Facilities |
|---|---|---|---|---|
| 4. Safe blood supply<br>5. Support from community (e.g. pregnant women)<br>6. Birth registration/ registration of women in reproductive age | Advising patient on importance of regular check-ups | X | X | X |
| | Ensure presence of social support for patient | X | X | X |
| | Civil registration of maternal death using the Maternal Death Reporting form | X | X | X |
| | Organizing outreach activities and community-based blood donation activities as necessary | X | | |
| | Make preparations for obtaining safe blood supply for patient | | X (blood testing) | X (blood testing) |
| Diagnostic/Screening Tests<br>• CBC<br>• Blood typing<br>• Urinalysis<br>• VDRL or RPR<br>• HBsAg<br>• OGCT<br>• Pregnancy Test<br>• Cervical cancer screening using VIA or pap smear<br>• Oral health | Pap smear and visual inspection acetic acid (VIA) wash technique | X | X | X |
| | Knowledge of the essential diagnostic and screening tests | | X | X |
| | Able to request that the patient take these tests at the appropriate time (from outside laboratory if not available in their facility) | | X | X |
| | Interpretation of laboratory results or refer to one able to do so | | X | X |
| 1. Screening for adequacy of fetal growth<br>2. Assessment of fetal well-being and prediction of fetal compromise | Knowledge on normal progress of pregnancy and signs of maternal and/or fetal complications | X | X | X |
| | Able to examine all necessary parameters and record and monitor maternal and fetal well-being throughout pregnancy | X | X | X |
| | Performance of Leopold's maneuvers to estimate fetal growth and determine adequacy for gestational age | X | X | X |
| | Knowledge of normal fetal parameters | X | X | X |
| | Can auscultate fetal heart tones | X | X | X |
| | Referral to higher-level /specialty facility if complicated | X | X | X |

| SERVICES | COMPETENCIES | Community Level Provider | BEmONC-capable Facilities | CEmONC-capable Facilities |
|---|---|---|---|---|
| 3. Antenatal diagnosis of congenital anomalies | Knowledge on ideal timing of prenatal ultrasound to detect congenital abnormalities<br>Able to perform congenital anomaly ultrasound scan and interpret it<br>Able to provide appropriate antenatal counselling | | X | X |

## C. LABOR AND DELIVERY

| INTERVENTION | COMPETENCIES | Community Level Provider | BEmONC-capable Facilities | CEmONC-capable Facilities |
|---|---|---|---|---|
| Diagnosis of labor | Knowledge of criteria of diagnosis of labor | X | X | X |
| General care during labor | Knowledge of recommended practices of general care during labor, particularly preventing perinatal infections and encouraging the mother to choose her preferred position during labor | X | X | X |
| Clean and Safe Delivery<br>Monitoring progress of labor using partograph | Knowledgeable about the use of the WHO partograph; knows when to refer based on the partograph recording | X | X | X |
| 1. Identification of early signs and symptoms and management of abnormalities<br>• preterm labor<br>• hypertension<br>• bleeding;<br>• infection<br>• malpresentation;<br>• prolonged labor; | Familiarity with signs and symptoms of abnormalities/ complications of labor; Ability to refer complicated cases to appropriate provider | X<br><br><br><br><br><br> | X<br>X<br>X | X<br>X<br>X |
| 2. Monitoring maternal and fetal well-being during labor | Knowledgeable of normal parameters of fetal well-being | X | X | X |
| 3. Continuous support during labor | Knowledgeable on counseling for both the patient and companion on providing continuous support during labor | X | X | X |

| INTERVENTION | COMPETENCIES | Community Level Provider | BEmONC-capable Facilities | CEmONC-capable Facilities |
|---|---|---|---|---|
| 4. Induction and augmentation of labor | Knowledgeable on the indications of induction and augmentation of labor<br>Able to perform caesarean section if induction/ augmentation fails. | | X | X |
| 5. Controlled delivery of head and active management of third stage of labor | Knowledgeable on normal stages of labor<br>Skilful in controlled delivery of the fetal head | | X | X |
| 6. Delayed cord clamping | Clamping and cutting the umbilical cord and knowledge of benefits of delayed cord clamping for 1-3 minutes or until cord pulsation stops | | X | X |
| 7. Episiotomy and repair<br>- Controlled delivery of the head<br>- Perineal support | Performance of restrictive episiotomies (when indicated) and episiorrhaphies | | X | X |
| 8. Expectant and active management of third stage of labor | Familiarity with stages of placental separation and performing controlled cord traction while preventing uterine inversion and retention of products of conception | | X | X |
| | Knowledge of methods of bleeding control and uterine contraction promotion after placental separation | | X | X |
| | Use of uterotonics for active management of 3rd stage of labor | | X | X |
| 10. Pain relief | Knowledgeable on methods of providing analgesia and possible adverse effects.<br>Able to manage possible complications | | X | X |
| Management of abnormalities<br>1. Prolonged labor | Familiarity with identifying prolonged labor or dystocia by interpreting the WHO partograph<br>Knowledgeable on indications for emergency caesarean section | | X | X |
| 2. Hypertension<br>• Gestational hypertension, chronic hypertension, mild preeclampsia | Familiarity with hypertensive disorders of pregnancy and able to classify as gestational hypertension, chronic hypertension, chronic hypertension with preeclampsia, mild preeclampsia, severe preeclampsia and eclampsia | | X | X |

| INTERVENTION | COMPETENCIES | Community Level Provider | BEmONC-capable Facilities | CEmONC-capable Facilities |
|---|---|---|---|---|
| | Familiarity with appropriate medications to manage hypertension Knowledgeable on anti-hypertensive medications to avoid and able to counsel patient on medications and diet | | X | X |
| • Severe preeclampsia<br>- Administering corticosteroids in preterm at risk for delivery. | Familiarity with management of preeclampsia: medications to control hypertension, prevention of convulsions, identification of end-organ damage, diagnosis and management of HELLP syndrome | | X | X |
| | Able to conduct emergent delivery if term<br>Able to prepare fetus for possible early delivery<br>Knowledgeable on the management of eclampsia: providing oxygen, anticonvulsants, control of blood pressure and emergent delivery | | X | |
| • Malpresentation<br>- Performance of external cephalic version | Able to diagnose malpresentation | | X | X |
| | Able to do emergent breech deliveries and caesarean sections | | X | X |
| • Bleeding | Diagnosis and differentiation of pathologic causes of bleeding: placenta previa and abruptio placenta | | X | X |
| | Able to do blood transfusions | | X | X |
| | Able to do caesarean section | | X | X |
| • Preterm labor<br>Dexamethasone if preterm and at risk for delivery | Knowledgeable on signs of preterm labor | | X | X |
| | Familiarity with the use of tocolytics to control preterm labor (dose and timing) | | X | X |
| | Familiarity with administration of steroids to promote fetal lung maturity | | X | X |
| | Able to manage premature neonates or refer to appropriate provider | | X | X |
| • Infection | Knowledgeable on methods to prevent perinatal infections; Handwashing | | X | X |

| INTERVENTION | COMPETENCIES | Community Level Provider | BEmONC-capable Facilities | CEmONC-capable Facilities |
|---|---|---|---|---|
| | Able to diagnose infection or risk factors for infection (ex. Premature rupture of membranes) | | X | X |
| | Familiarity with appropriate antibiotics to use during pregnancy and breastfeeding | | X | X |
| Basic emergency obstetric care<br>1. Parenteral administration of oxytocin in the 3rd stage of labor | Knowledgeable on dose and timing of oxytocin or other uterotonic administration | | X | X |
| 2. Parenteral administration of loading dose of anticonvulsants for severe preeclampsia and eclampsia | Able to administer initial anticonvulsant dose then refer to CEmONC-capable facility | | X | X |
| | Ability to observe necessary precaution | | X | X |
| | CEmONC-capable facility: Able to perform emergent delivery, administer anticonvulsants, control blood pressure and diagnose and manage complications | | X | X |
| 3. Parenteral administration of initial dose of antibiotics as indicated or as needed | Knowledgeable on indications of parenteral antibiotics | | X | |
| | Familiarity with appropriate antibiotics, contraindicated antibiotics, and dose and timing of antibiotics | | X | |
| 4. Performance of assisted delivery during imminent breech delivery | Able to recognize breech deliveries<br>Knowledgeable on imminent vaginal breech delivery | | X | |
| 5. Removal of retained products of conception | Able to identify retained products of conception<br>Able to remove retained products | | X | |
| 6. Medical and Manual removal of retained placenta | Able to manually remove retained placenta without causing complications<br>Able to perform possible procedures necessary to manage complications | | X (manual: by trained MD, only in extreme emergencies and in areas difficult to access) | X |

| INTERVENTION | COMPETENCIES | Community Level Provider | BEmONC-capable Facilities | CEmONC-capable Facilities |
|---|---|---|---|---|
| | Knowledgeable on and with facilities for regional analgesia | | X | |
| | Knowledgeable on general anaesthesia | | X | |
| Safe blood supply and transfusion | Familiarity with indications for blood transfusion<br>Safe blood collection, testing, distribution<br>Recognition, management, reporting of blood transfusion reactions | | X (manual: by trained MD, only in extreme emergencies and in areas difficult to access) | X |
| Comprehensive emergency obstetric care<br>1. Caesarean section | Knowledgeable on indications for and on performing caesarean section | | X | |
| 2. Anaesthesia2. Anaesthesia | Knowledgeable on and with facilities for general anaesthesia | | X | |
| Counseling and Provision of BTL services | Able to counsel patients on benefits and disadvantages of bilateral tubal ligation | | X | |
| | Able to perform procedure | | X | |

## D. POST-PARTUM

| | COMPETENCIES | Community Level Provider | BEmONC-capable Facilities | CEmONC-capable Facilities |
|---|---|---|---|---|
| Identification of early signs and symptoms of postpartum complications (hemorrhage, infection) | Knowledgeable on the early signs and symptoms of postpartum hemorrhage and infection | | X | X |
| | Familiarity with management of infection and causes of postpartum hemorrhage or able to refer patient to appropriate provider | | X | X |
| Latching on/ early newborn contact | Knowledgeable on benefits of latching on and ability to facilitate it within the first hour | | X | X |
| IEC counseling on breastfeeding | Knowledge on technique and benefits of breastfeeding | X | X | X |

| | COMPETENCIES | Community Level Provider | BEmONC-capable Facilities | CEmONC-capable Facilities |
|---|---|---|---|---|
| Family Planning<br>IEC counseling on:<br>• Responsible parenting<br>• Informed choice and voluntarism<br>• 4 pillars on FP<br>• Fertility awareness<br>• Birth spacing<br>• All FP methods | Able to counsel patient on proper birth spacing, responsible parenting | X | X | X |
| | Knowledgeable on the expected return to fertility after a term pregnancy, preterm delivery or a miscarriage | X | X | X |
| | Able to encourage and empower patient to make an informed decision | X | X | X |
| 1. Provision of FP Services/contraception<br>• Pills<br>• DMPA<br>• Condoms<br>• NFP | Familiarity with different methods of family planning<br>Able to counsel patient on method best for her | X | X | X |
| • IUD<br>• BTL, NSV | Able to do proper IUD insertion | | X | X |
| | Able to do NSV and BTL | | X | X |
| 3. Encourage LAM exclusive breastfeeding up to 6 months | Familiarity with the benefits of lactational amenorrhea method | X | X | X |
| Prevention and management of abortion complications<br>1. Removal or retained products of conception | Familiarity with different types of abortion, complications and appropriate management or able to refer patient to proper provider | | X | X |
| 2. Treatment of infection | | | X | X |
| 3. Correction of anemia | | X | X | X |
| 4. Tetanus toxoid | | X | X | X |
| 5. Return to fertility and birth spacing counseling | Familiarity with different methods of family planning; able to counsel patient on method best for her | X | X | X |
| Diagnostic Test: breast and cervical cancer screening, (acetic acid wash) | Familiarity with breast examination and cervical cancer screening methods, timing and interpretation of results | X | X | X |
| Maternal Nutrition<br>• Iron/folate<br>• Vitamin A<br>• Iodine | Knowledgeable on nutritional needs of mother postpartum, particularly while breastfeeding | X | X | X |
| IEC/Counseling on Healthy Lifestyle:<br>• Safer sex and HIV/STI prevention<br>• smoking cessation | Able to counsel patients on importance of healthy lifestyle for the mother during postpartum period and breastfeeding | X | X | X |

| | COMPETENCIES | Community Level Provider | BEmONC-capable Facilities | CEmONC-capable Facilities |
|---|---|---|---|---|
| • physical activity<br>• moderate alcohol intake | Able to counsel on importance of smoking cessation and alcohol intake especially during breastfeeding, and good physical activity | X | X | X |
| | Knowledge on prevention of STI/HIV/AIDS | X | X | X |

## E. NEWBORN AND EARLY CHILDHOOD

| INTERVENTION | COMPETENCIES | Community Level Service Provider | BEmONC-capable Facilities | CEmONC-capable Facilities |
|---|---|---|---|---|
| Identification of early signs and symptoms of newborn problems (e.g. respiratory distress, change color, etc.) | Able to identify early signs and symptoms of newborn problems and severe illness | | X | X |
| Basic Emergency Newborn Care<br><br>1.Newborn resuscitation | Assessment of neonatal status at birth and initiation of resuscitation within 1 minute if neonate is not breathing or if gasping until with stable breathing | | X | X |
| 2.Treatment of neonatal sepsis | Able to choose and load appropriate initial antibiotics for suspected cases of neonatal sepsis then promptly refer to CEmONC or higher level facility | | X | X |
| 3. Oxygen support for neonates | Provision of oxygen support | | X | X |
| 4. safe blood transfusion | Safe blood collection, distribution, transfusion<br>Recognition and management of blood transfusion reactions | | X | X |
| Administration of steroids during preterm labor | Knowledge of the timing and dose of steroid administration in preterm labor | physician) | X | X |

| INTERVENTION | COMPETENCIES | Community Level Service Provider | BEmONC-capable Facilities | CEmONC-capable Facilities |
|---|---|---|---|---|
| Advance newborn resuscitation | Detection of need for further resuscitation | | X | X |
| | Skill on advance newborn resuscitation following guidelines recommended by the Essential Newborn Care Clinical Practice Pocket Guide | | X | X |
| Management of sick newborns with severe illness (prematurity, breathing difficulty, sepsis, severe birth trauma and asphyxia, severe jaundice, etc.) | Able to manage infants with severe problems such as prematurity, breathing difficulty, sepsis, severe birth trauma and asphyxia and severe jaundice<br>Skill in newborn resuscitation | | X | X |
| Routine newborn care<br><br>1. Early latching on within the 1st hour<br>2. Weighing of infant<br>3. Eye care<br>4. Cord care<br>5. Thermoregulation<br>6. Vitamin K injection<br>7. Delayed bathing to 6 hours of life<br>8. Hepatitis B and BCG vaccination | Basic postnatal care | | X | X |
| | Knowledge of benefits and techniques of proper breastfeeding | | X | X |
| | Properly weigh infant after delivery | | X | X |
| | Knowledge of timing and method of application of erythromycin ointment on both eyes | | X | X |
| | Perform proper cord care | | X | X |
| | Knowledge of ways of thermoregulation and properly and adequately provide it | | X | X |
| | Knowledge on benefits, timing, dosing, method of administration of Vitamin K | | X | X |
| | Knowledge on benefits of Hepatitis B vaccine birth dose and BCG, the timing, dosing, method of administration, and storage | X | X | X |
| 9. Newborn Screening within 48-72 hours | Knowledge of importance and timing of, method of sample collection and submission of blood samples for newborn screening<br>Coordination with NIH for newborn screening | X | X | X |

| INTERVENTION | COMPETENCIES | Community Level Service Provider | BEmONC-capable Facilities | CEmONC-capable Facilities |
|---|---|---|---|---|
| Advice on danger signs, emergency preparedness and follow-up | Knowledge on signs and symptoms to watch out for to prompt consult and of discharge instructions; Able to advice parents regarding these and the importance of follow-up | | X | X |
| Kangaroo Mother Care | Knowledge on the principles of Kangaroo Mother Care and its benefits | | X | X |
| Treatment of mild to moderate local infections and birth injuries | Knowledge on the management of local infections of the skin, cord and eyes and of birth injuries such as lacerations and fractures | | X | X |
| Post-resuscitation/Pre-transport stabilization (STABLE: sugar, temperature, airway, blood pressure, laboratory work-up, emotional support | Skill in pre-transport stabilization following the guidelines of the STABLE program of infants who are very pre-term, with very low birth weight, severe complications or malformations | | X | X |
| Management of correctable malformations | Able to correct malformations by paediatric surgery<br>Skill in newborn resuscitation in case the need arises | | X | X |
| Retinopathy of prematurity screening | Knowledge when ROP screening is indicated and skill on ROP screening | | X | X |
| Support services (MCB and birth registration within 30 days) | Properly fill-up information in Mother and child book<br>Properly and accurately fill-up information needed in birth certificate | X | X | X |
| Postnatal Care Package | Newborn assessment<br>Counseling on newborn care and nutrition | X | X | X |
| 1. Assessment of infant's wellbeing and breastfeeding | Knowledge of proper breastfeeding, assessment of adequacy of breastfeeding, and management of problems | X | X | X |
| 2. Information and counseling on home care and immunizations | Knowledge on routine home care instructions, schedule of routine immunizations, importance of compliance | X | X | X |

| INTERVENTION | COMPETENCIES | Community Level Service Provider | BEmONC-capable Facilities | CEmONC-capable Facilities |
|---|---|---|---|---|
| 3. Additional follow-up visits for high-risk babies | Knowledge on the signs and symptoms that warrant further evaluation and management<br>Counsel on importance of regular follow-ups | | X | X |
| 4. Child protection and injury prevention | Knowledge on the management and prevention of childhood injury | X | X | X |
| 5. Vision screening | Skill in vision screening | X | X | X |
| 6. Newborn hearing screening | Skill in hearing screening tests | | X | X |
| Expanded Program on Immunization | Knowledge on the timing, dosing, method of administration and storage of vaccines | X | X | X |
| Integrated Management of Childhood Illnesses | Able to manage mild to moderate illness such as acute respiratory illness, diarrhea and malaria using the guidelines under IMCI | X | X | X |

## Annex H. Standard Infrastructure Requirements for BEmONC and CEmONC-capable Facilities

| RHU, BHS, birthing homes, lying-in clinics BEmONC | HOSPITAL BEmONCS | CEmONCS |
|---|---|---|
| Delivery room | Labor room appropriately furnished | Emergency Room |
| At least a 2 bed capacity ward: 1 bed for the mother and newborn and another bed with a "pull-a-bed" feature for the birth companion and small children. The ward also doubles as a labor room | Delivery room | Admission Room |
| A small kitchen appropriately furnished | Scrub room for the doctors and nurses | Pharmacy |
| A toilet and bath with appropriate fixtures | Maternity ward with rooming in feature for the newborn | Well equipped laboratory |
| A sleeping quarter for health staff | Toilet and bath with appropriate fixtures | Blood station appropriately equipped and furnished |
| A waste management facility that includes a placenta pit | Sleeping quarter for health staff | Labor room |
| Communication radio or telephone | Waste management system that includes a placenta pit | Delivery room |
| Emergency transport system | Communication radio or telephone | Obstetric operating room |
| | Emergency transport system | Sterilization or autoclave room |
| | | Recovery room |
| | | Newborn intensive care unit |
| | | Breastfeeding lounge |
| | | Scrub room for the doctors and nurses<br>Dressing room for the doctors and nurses<br>Maternity ward with rooming-in feature for the newborn<br>Nurses' station<br>Toilet and bath with appropriate fixtures<br>Sleeping quarter for health staff<br>Waste management system that includes a placenta pit<br>Communication radio or telephone<br>Emergency transport system |

## Annex I. Logistics and Supplies Necessary for Adequate Delivery of MNCHN Core Package of Services

This table is a checklist of services that each health provider should deliver for each life stage. Competency of health providers and equipment/supplies needed to provide each service are included. LGUs shall use this checklist to assess capacities of health providers in the service delivery network.

A checkmark is placed under a box of a health provider if it is expected to provide that service. Unless specified as otherwise, shaded boxes mean that the provider is not expected to give the service.

Some equipment may appear repeatedly for each service. It is understood that a facility should at least have the equipment and it is not necessary to provide these equipment for a particular type of service.

For the CHT, it is understood that it is composed of the midwife and health volunteers as well as the RHU which will provide services at the community level. An explanation will accompany entries that would refer to RHUs or BHs alone.

### A. PRE-PREGNANCY

| Service | EQUIPMENT/SUPPLIES | Community Level Provider | BEmONC-capable Facilities | CEmONC-capable Facilities |
|---|---|---|---|---|
| Assessment of health needs of women, mothers and children | ☐ Health needs assessment forms<br>☐ Information materials on providers in the area, available services and cost of these services<br>☐ Forms for health plans | X | | |
| FP services: | | | | |
| 1. IEC/Counseling on: Informed Choice and Voluntarism; Responsible Parenthood; Availability of a broad-range of family planning methods; | ☐ IEC materials on FP<br>☐ Iron supplements<br>☐ Deworming<br>☐ Healthy lifestyle<br>☐ Oral Health<br>☐ Folic Acid | X | X | X |
| 2. Provision of FP services Pills, DMPA, condom, NFP | ☐ Adequate supply of pills, DMPA, condoms, NFP IUD<br>☐ FP Form 1<br>☐ TCL for FP | X | X | X |
| • IUD | ☐ IUD kit [drape for the patient, clean cloth to place | | X | X |

| Service | EQUIPMENT/SUPPLIES | Community Level Provider | BEmONC-capable Facilities | CEmONC-capable Facilities |
|---|---|---|---|---|
| • BTL, NSV<br>• Management of complications resulting from FP | between client and exam table, gloves, light source (droplight or flashlight), bivalve speculum, uterine tenaculum (12"), uterine sound (12"), IUD, sharp Mayo scissors, sponge forceps (12"), bowl containing antiseptic solution for cleansing cervix (chlorhexidine or povidone iodine) and gauze or cotton balls, dry gauze or cotton balls, narrow/alligator forceps (10") for IUD removal]<br>☐ 5 cc syringes<br>☐ Sterile gloves<br>☐ Lubricating jelly<br>☐ Face mask<br>☐ Micropore tape<br>☐ Povidone iodine<br>☐ Sterile cotton<br>☐ Sterile gauze<br>☐ Lidocaine 2% 50 mL<br>☐ BTL kit<br>☐ NSV kit<br>☐ Cut down on minor set<br>☐ Scrub suit | | X | X |
| | | X | X | X |
| Women's/maternal health, nutrition, and micronutrient supplementation | ☐ IEC materials on ENC and Breastfeeding<br>☐ Therapeutic dose Vitamin A (for cases of xerophthalmia)<br>☐ Iron/Folate 60mg elemental iron/400ug folic acid tabs<br>☐ Iodized salt<br>☐ Pregnancy tracking form<br>☐ Mother and Child Book<br>☐ Maternal Death Reporting Form<br>☐ Stethoscope<br>☐ Sphygmomanometer<br>☐ Weighing scale<br>☐ Measuring tape/height chart<br>☐ Food table/pyramid<br>☐ Patient registry | X | X | X |

| Service | EQUIPMENT/SUPPLIES | Community Level Provider | BEmONC-capable Facilities | CEmONC-capable Facilities |
|---|---|---|---|---|
| Tetanus toxoid immunization | ☐ Tetanus toxoid ampules<br>☐ Syringes with needles<br>☐ Patient registry<br>☐ Vaccine carrier<br>☐ Vaccine refrigerator | X | X | X |
| IEC/Counseling on health caring and seeking behavior | ☐ IEC materials | X | X | X |
| Updated master listing of women of reproductive age | ☐ Record book for master list (Target Client List) | X | | |

## B. PREGNANCY/ANTENATAL

| SERVICES | EQUIPMENT/SUPPLIES | Community Level Provider | BEmONC-capable Facilities | CEmONC-capable Facilities |
|---|---|---|---|---|
| Maternal health, nutrition, and micronutrient supplementation | ☐ IEC materials for Unang Yakap/ ENC and Breastfeeding<br>☐ Weighing scale<br>☐ Measuring tape/height chart<br>☐ Food table/pyramid<br>☐ Iron/ folate 60 mg elemental iron/400 ug folic acid tablet<br>☐ Iodine 200mg elemental iodine<br>☐ Iodized salt<br>☐ 5cc syringe with needle<br>☐ Patient registry<br>☐ Mother and Child Book | X | X | X |
| Tetanus toxoid immunization | ☐ Tetanus toxoid ampules<br>☐ Syringes with needles<br>☐ Patient registry<br>☐ Vaccine carrier<br>☐ Vaccine refrigerator | X | X | X |
| Deworming | ☐ Mebendazole or albendazole tablets | X | X | X |

| SERVICES | EQUIPMENT/SUPPLIES | Community Level Provider | BEmONC-capable Facilities | CEmONC-capable Facilities |
|---|---|---|---|---|
| Counseling on health caring and seeking behavior | ☐ IEC materials | X | X | X |
| Early detection and management of danger signs and complications of pregnancy | ☐ Pen, patient record, possibly chart or checklist of danger signs<br>☐ BP apparatus<br>☐ Stethoscope<br>☐ Ambulance or transport facility | X | X | X |
| Antenal administration of steroids in preterm labor | ☐ Syringes, dexamethasone 5 or 8 mg/ ampule or Betamethasone | | X | X |
| Support Services:<br>1. Antenatal registration with Mother-Child Book<br>2. Birth Plan<br>3. Home visit and follow-up<br>4. Safe blood supply<br>5. Support from community (e.g. pregnant women)<br>6. Birth registration/ registration of women in reproductive age | ☐ Calendar<br>☐ Antenatal registration card<br>☐ Patient record | X | X | X |
| | ☐ Pen<br>☐ Pregnancy Tracking Forms<br>☐ Mother and Child Book<br>☐ Community Health Team Maternal Death Reporting Form | X | X | X |
| | ☐ Registry for Births and Women of reproductive age | X | | |
| | ☐ Computer<br>☐ Blood testing and storage facility | | | X<br>(blood testing) |
| Diagnostic/Screening Tests<br>• CBC<br>• Blood typing<br>• Urinalysis<br>• VDRL or RPR<br>• HBsAg<br>• OGCT<br>• Pregnancy Test | For VIA test:<br>☐ Light source<br>☐ Speculum<br>☐ Sterile cotton pledget<br>☐ Boiled water or normal saline solution<br>☐ Acetic acid 3-5%<br>☐ Syringe without needle<br>☐ Patient registry | | X | X |
| | | | X | X |
| | | | X | X |

| SERVICES | EQUIPMENT/SUPPLIES | Community Level Provider | BEmONC-capable Facilities | CEmONC-capable Facilities |
|---|---|---|---|---|
| • Cervical cancer screening using acetic acid wash and pap smear<br>• Oral health | ☐ Microscope<br>☐ Slides, cover slips, stains<br>☐ Centrifuge<br>☐ Syringes with/without needle<br>☐ Tourniquet<br>☐ Sterile urine vials<br>☐ EDTA and plain test tubes<br>☐ Well-equipped laboratory that can run these tests | X | X | X |
| 1. Screening for adequacy of fetal growth | ☐ Tape measure<br>☐ Stethoscope<br>☐ Lubricating jelly<br>☐ Examining table<br>☐ Weighing scale<br>☐ Sphygmomanometer (non-mercurial)<br>☐ Thermometer (non-mercurial)<br>☐ Patient registry | X | X | X |
| 2. Assessment of fetal well-being and prediction of fetal compromise | | X | X | X |
| 3. Antenatal diagnosis of congenital anomalies | ☐ Ultrasound machine | | | X |

## C. LABOR AND DELIVERY

| SERVICES | EQUIPMENT/SUPPLIES | Community Level Provider | BEmONC-Facilities | CEmONC-Facilities |
|---|---|---|---|---|
| Diagnosis of labor | ☐ Sterile gloves<br>☐ Lubricant | | X | X |
| General care during labor | ☐ Sterile gloves<br>☐ povidone iodine solution<br>☐ clean linen<br>☐ sterile instruments<br>☐ sterile OS/ sponges<br>☐ sink<br>☐ antiseptic soap<br>☐ alcohol | | X | X |
| Clean and Safe Delivery | ☐ Partograph form<br>☐ sterile gloves<br>☐ lubricant<br>☐ povidone iodine solution | | | |
| Monitoring progress of labor using partograph | | | X | X |
| 1. Identification of early signs and symptoms and management of abnormalities<br>• preterm labor<br>• hypertension<br>• bleeding;<br>• infection<br>• malpresentation;<br>• prolonged labor; | ☐ Partograph form<br>☐ sterile gloves<br>☐ lubricant<br>☐ povidone iodine solution<br>☐ stethoscope<br>☐ thermometer<br>☐ speculum<br>☐ Ambulance/transport facilities | | X | X |
| | ☐ facilities for labs (e.g. CBC) | | X | X |
| | ☐ Ultrasound<br>☐ Tocometer (CEmONC) | | | X |
| 2. Monitoring fetal well-being during labor | ☐ Stethoscope<br>☐ Fetal Doppler (BEmONC, CEmONC)<br>☐ Tocometer (CEmONC) | | X | X |
| 3. Continuous support during labor | ☐ Possibly instruction materials on the role of the companion during labor, maintaining asepsis | | X | X |

| SERVICES | EQUIPMENT/SUPPLIES | Community Level Provider | BEmONC-Facilities | CEmONC-Facilities |
|---|---|---|---|---|
| 4. Induction and augmentation of labor | ☐ Oxytocin<br>☐ IV needs<br>☐ sterile gloves<br>☐ lubricant<br>☐ povidone iodine solution<br>☐ stethoscope | | | X |
| 6. Controlled delivery of head and active management of third stage of labor | ☐ Sterile gloves<br>☐ sterile gowns<br>☐ gauze | | X | X |
| 7. Properly timed cord clamping and cutting | ☐ cord clamp<br>☐ scissors<br>☐ Kelly clamps | | X | X |
| 8. Repair of laceration | ☐ Local anaesthesia<br>☐ sterile scissors<br>☐ sterile gloves<br>☐ sutures (absorbable); Chromic 2.0<br>☐ suture needles<br>☐ needle holder | | X | X |
| 9. Expectant and active management of third stage of labor | ☐ Kelly/cord clamps<br>☐ sterile gloves<br>☐ Uterotonics: oxytocin, ergotamine, oxytocin-ergotamine, methylergotamine, prostaglandin tabs (misoprostol)<br>☐ Intravenous infusion needs (D5LR, Venosect, Venocath G19)<br>☐ Syringes | | X | X |
| 10. Pain relief | ☐ IV needs, epidural set, analgesics, parenteral agents (e.g. meperidine, promethazine) | | | X |
| Management of abnormalities<br>1. Prolonged labor | ☐ Partograph<br>☐ sterile gloves<br>☐ lubricant<br>☐ povidone iodine solution<br>☐ sphygmomanometer (non-mercurial)<br>☐ stethoscope<br>☐ thermometer (non-mercurial)<br>☐ Speculum<br>☐ Facilities for labs (e.g. CBC), | | | X |

| SERVICES | EQUIPMENT/SUPPLIES | Community Level Provider | BEmONC-Facilities | CEmONC-Facilities |
|---|---|---|---|---|
| | ☐ Tocometer (CEmONC)<br>☐ Antibiotics<br>☐ IV needs | | | |
| 2. Hypertension<br>• Gestational hypertension, chronic hypertension, mild preeclampsia | ☐ As in above (1), plus<br>☐ Ultrasound (CEmONC)<br>☐ Antihypertensive medications: nifedipine, hydralazine, methyldopa | | X | X |
| • Severe preeclampsia | ☐ As in hypertension above, plus:<br>☐ Ultrasound<br>☐ Facilities for labs (e.g., CBC, urinalysis, blood chemistries)<br>☐ Magnesium Sulfate<br>☐ Oxygen<br>☐ Face mask and tubing | | | X |
| • Malpresentation | ☐ As in prolonged labor above (1), plus<br>☐ Ultrasound<br>☐ piper forceps | | | X |
| • Bleeding | ☐ As in prolonged labor above (1), plus | | | X |
| | ☐ Ultrasound | | X | X |
| | ☐ Blood transfusion set | | | X |
| • Preterm labor | ☐ As in prolonged labor above (1), plus: | | X | X |
| | ☐ Ultrasound | | X | X |
| | ☐ Tocolytics | | X | X |
| | ☐ Dexamethasone or Betamethasone | | X | X |
| • infection | ☐ As in prolonged labor above (1), plus:<br>☐ Ultrasound | | X | X |
| | ☐ Tocolytics | | X | X |
| | ☐ Dexamethasone or Betamethasone | | X | X |
| Essential Newborn Care | ☐ 2 linen<br>☐ Bonnet<br>☐ Glass room thermometer<br>☐ Vitamin K<br>☐ BCG<br>☐ Delivery bed | | X | X |

| SERVICES | EQUIPMENT/SUPPLIES | Community Level Provider | BEmONC-Facilities | CEmONC-Facilities |
|---|---|---|---|---|
| Basic emergency obstetric care<br>1. Parenteral administration of oxytocin in the 3rd stage of labor | ☐ Oxytocin<br>☐ Needles and syringe<br>☐ Normal saline solution<br>☐ IV set, venocath | | X | X |
| 2. Parenteral administration of loading dose of anticonvulsants for preeclampsia and eclampsia | ☐ Magnesium sulfate vials<br>☐ Syringes with needle, 30 cc<br>☐ Diazepam<br>☐ Intravenous/intramuscular sedatives<br>☐ IV needs | | X | X |
| 3. Parenteral administration of initial dose of antibiotics as indicated or as needed | ☐ Intravenous antibiotics (ampicillin, gentamicin)<br>☐ Syringe with needle<br>☐ IV needs | | X | X |
| 4. Performance of assisted delivery during imminent breech delivery | ☐ Piper forceps | | X | X |
| 5. Removal of retained products of conception | ☐ Curettage sets | | X | X |
| . Medical and Manual removal of retained placenta | ☐ Syringe<br>☐ Normal saline<br>☐ Oxytocin<br>☐ IV infusion needs | | X (manual: by trained MD, only in extreme emergencies and in areas with difficult to access) | X |
| | ☐ Must have means of transporting patient to a CEmONC facility<br>☐ Regional analgesia needs (BEmONC) | | X | |
| | ☐ Anaesthesia machine (CEmONC)<br>☐ General anaesthesia needs (CEmONC)<br>☐ sterile gowns | | | X |
| Safe blood supply and transfusion | ☐ Blood donor and distribution registries<br>☐ Blood storage<br>☐ Lab facility for blood typing<br>☐ Blood transfusion sets | | | |

| SERVICES | EQUIPMENT/SUPPLIES | Community Level Provider | BEmONC-Facilities | CEmONC-Facilities |
|---|---|---|---|---|
| Comprehensive emergency obstetric care<br><br>1. Caesarean section | ☐ Caesarean section kits including sutures<br>☐ Antibiotics<br>☐ Sterile gowns and gloves, masks<br>☐ IV needs<br>☐ Povidone iodine solution<br>☐ Sterile gauze | | | X |
| 2. Anaesthesia2. Anaesthesia | ☐ General anaesthesia needs (CEmONC) | | | X |
| Counseling and Provision of BTL services | ☐ Diagrams on BTL<br>☐ Tubal ligation sets including sutures<br>☐ Sterile gown and gloves<br>☐ Sterile gauze | | X<br><br>X | X<br><br>X |

## D. POST-PARTUM

| SERVICES | EQUIPMENT/SUPPLIES | Community Level Provider | BEmONC-Facilities | CEmONC-Facilities |
|---|---|---|---|---|
| Identification of early signs and symptoms of postpartum complications (hemorrhage, infection) | ☐ Possibly charts or posters enumerating the early signs of hemorrhage and infection<br>☐ Stethoscope<br>☐ Sphygmomanometer (non-mercurial)<br>☐ Thermometer (non-mercurial)<br>☐ Ambulance/transport facilities | | X<br><br>X | X<br><br>X |
| Latching on/ early newborn contact | ☐ Educational materials on benefits of latching on | | X | X |
| IEC counseling on breastfeeding | ☐ Educational materials on breastfeeding | X | X | X |
| Family Planning<br>1. IEC counseling on:<br>• Responsible parenting<br>• Informed choice and voluntarism<br>• 4 pillars on FP<br>• Fertility awareness<br>• Birth spacing<br>• All FP methods | ☐ Educational materials to aid in counseling patients on the importance of birth spacing and responsible parenting | X | X | X |

| SERVICES | EQUIPMENT/SUPPLIES | Community Level Provider | BEmONC-Facilities | CEmONC-Facilities |
|---|---|---|---|---|
| 2. Provision of FP Services/contraception<br>• Pills<br>• DMPA<br>• Condoms<br>• NFP | ☐ Educational materials on different family planning methods | X | X | X |
| • IUD<br>• BTL, NSV | ☐ Intrauterine device (copper T)<br>☐ Lubricant | | X | X |
| | ☐ NSV and BTL sets<br>☐ Sterile gown and gloves<br>☐ Povidone iodine solution<br>☐ Lidocaine | | X | X |
| 3. Encourage LAM exclusive breastfeeding up to 6 months | ☐ Educational materials on lactational amenorrhea method | X | X | X |
| Prevention and management of abortion complications<br>1. Removal or retained products of conception | ☐ Curettage kits | | X | X |
| 2. Treatment of infection | ☐ Appropriate antibiotics preferably intravenous, syringes, IV access needs | | X | X |
| 3. Correction of anemia | ☐ Iron supplements 60mg/tab<br>☐ Facility for hemoglobin/ hematocrit determination in facility or in local area<br>☐ Needs for blood transfusion | X | X | X |
| 4. Anti-tetanus serum (ATS) injection | ☐ Anti-tetanus serum<br>☐ Syringe with needle<br>☐ Cotton<br>☐ Alcohol 70% Isopropyl/Ethyl | X | X | X |
| 5. Return to fertility and interpregnancy interval counseling | ☐ Educational materials on different family planning methods | X | X | X |

| SERVICES | EQUIPMENT/SUPPLIES | Community Level Provider | BEmONC-Facilities | CEmONC-Facilities |
|---|---|---|---|---|
| Diagnostic Test: breast and cervical cancer screening, (acetic acid wash) | ☐ Light source<br>☐ Examination table<br>☐ Acetic acid 3-4%<br>☐ Vaginal speculum<br>☐ Big cotton balls<br>☐ Boiled water or normal saline solution<br>☐ Syringe<br>☐ Chlorine solution | X | X | X |
| | ☐ Colposcopy | | X | X |
| Maternal Nutrition<br>• Iron and folate<br>• Vitamin A | ☐ IEC materials<br>☐ Iron/ folate 60mg elemental iron/400ug folic acid tablets<br>☐ Vitamin A 200,000 IU capsules | X | X | X |
| IEC/Counseling on Healthy Lifestyle:<br>• Safer sex and HIV/STI prevention<br>• smoking cessation<br>• physical activity<br>• moderate alcohol intake | ☐ IEC materials<br>☐ Weighing scale (adult)<br>☐ Height chart/tape measure<br>☐ Patient registry | X<br>X<br>X | X<br>X<br>X | X<br>X<br>X |
| | Maternal Death Reporting Form | X | X | X |

## E. POSTNATAL AND EARLY CHILDHOOD

| INTERVENTION | EQUIPMENT/SUPPLIES | Community Level Provider | BEmONC-Facilities | CEmONC-Facilities |
|---|---|---|---|---|
| Essential Newborn Care<br>1. Immediate and thorough drying<br>2. Early skin-to-skin contact<br>3. Properly timed cord clamping and cutting<br>4. Nonseparation of newborn and mother for early breastfeeding<br>5. Vitamin K injection<br>6. Hepatitis B and BCG vaccination<br>7. Timely cord clamping and cutting | ☐ Stethoscope<br>☐ Soap & Water<br>☐ IEC materials on breastfeeding<br>☐ Weighing scale (pedia)<br>☐ Erythromycin ointment<br>☐ Cord clamp, Cord tie and Sterile cord clips<br>☐ Alcohol 70% Isopropyl/Ethyl solution<br>☐ Sterile gauze<br>☐ Povidone iodine solution<br>☐ Any device for thermoregulation (incubator, radiant warmer, drop light, dry linen)<br>☐ Vitamin K ampules<br>☐ Tuberculin syringes and 3 cc syringe<br>☐ Hepatitis B vaccine<br>☐ BCG vaccine<br>☐ Vaccine refrigerator<br>☐ Thermometer | | X | X |
| Basic Emergency Newborn Care<br>1. Newborn resuscitation | ☐ Neonatal ambubag and mask, laryngoscope<br>☐ Sterile gloves<br>☐ Stethoscope<br>☐ Firm and padded resuscitation surface<br>☐ Oxygen source<br>☐ Oxygen tubing<br>☐ Suction equipment<br>☐ Aspiration bulb<br>☐ Syringe<br>☐ Mechanical suction and tubing<br>☐ Suction catheters<br>☐ Devices for thermoregulation (radiant warmer, droplight, warm blankets or linen, plastic wraps or zip lock bags)<br>☐ Linen | | X | X |

| INTERVENTION | EQUIPMENT/SUPPLIES | Community Level Provider | BEmONC-Facilities | CEmONC-Facilities |
|---|---|---|---|---|
| 2. Treatment of neonatal sepsis | ☐ Thermometer (non-mercurial)<br>☐ IV antibiotics<br>☐ IV needs<br>☐ Instruments and supplies for umbilical cannulation | | X | X |
| 3. Oxygen support for neonates | ☐ Appropriate ambubag for term and preterm neonates for positive pressure ventilation | | X | X |
| 4. Safe blood transfusion | ☐ Blood transfusion set<br>☐ Blood donor and distribution registries<br>☐ Blood storage<br>☐ Lab facility for blood typing | | X | X |
| 5. Advance newborn resuscitation | ☐ Stethoscope<br>☐ Oxygen source | | X | X |
| | ☐ Bag and mask or equivalent equipment for positive pressure ventilation<br>☐ Intubation equipment<br>☐ Instruments and supplies for umbilical cannulation<br>☐ Devices for thermoregulation<br>☐ IV fluids<br>☐ Blood glucose monitor<br>☐ Resuscitation medications (Epinephrine, Sodium bicarbonate, volume expanders, D10W, Naloxone) | | X | X |
| 6. Management of sick newborns with severe illness (prematurity, breathing difficulty, sepsis, severe birth trauma and asphyxia, severe jaundice, etc.) | Same as needs for advance newborn resuscitation, plus:<br>☐ Parenteral drugs<br>☐ Inotropes<br>☐ Blood products<br>☐ Chemical and microbiological laboratory<br>☐ Radiography (x-ray, UTZ)<br>☐ Phototherapy<br>☐ Pulse oximeter<br>☐ Sphygmomanometer (paediatric set, non-mercurial)<br>☐ Blood glucose monitor | | | X |
| 7. Newborn Screening within 48-72 hours | ☐ Needles, newborn screening kit, cotton balls, micropore tape, correspondence to a facility who does newborn screening | | X | X |
| 8. Newborn hearing Screening (in BEmONC/ CEmONC facilities) | ☐ Otoacoustic emission test machine (if available) | | X | X |

| INTERVENTION | EQUIPMENT/SUPPLIES | Community Level Provider | BEmONC-Facilities | CEmONC-Facilities |
|---|---|---|---|---|
| 9. Eye examination of newborn (done in BEmONC/ CEmONC facilities) | ☐ Opthalmoscope | | X | X |
| 10. Advice on danger signs, emergency preparedness and follow-up | ☐ Checklist of danger signs<br>☐ Calendar<br>☐ Medical record<br>☐ Immunization card<br>☐ Discharge slip | | X | X |
| 11. Kangaroo Mother Care | ☐ Information materials on KMC | | X | X |
| Treatment of mild to moderate local infections and birth injuries | ☐ Topical or oral antibiotics<br>☐ Pain relievers<br>☐ Antiseptic solution<br>☐ Sterile sutures and needles<br>☐ Sterile gauze<br>☐ Bandages<br>☐ Splints | | X | X |
| Post-resuscitation/Pre-transport stabilization<br>(STABLE: blood sugar, temperature, airway, blood pressure, laboratory work-up, emotional support | ☐ Same as needs for advance newborn resuscitation, plus:<br>☐ Pulse oximeter<br>☐ Sphygmomanometer (pediatric set, non-mercurial)<br>☐ Thermometer (non-mercurial)<br>☐ Inotropes<br>☐ Laboratory (ABGs, CBC, chest x-ray)<br>☐ Ambulance | | X | X |
| Management of correctable malformations | ☐ Operating room<br>☐ Surgical instruments needs for surgery<br>☐ Same needs for newborn resuscitation<br>☐ Anaesthesia<br>☐ Anaesthesiologist | | | X |
| Retinopathy of prematurity screening | ☐ Indirect ophthalmoscope | | | X |
| Support services (MCB and birth registration within 30 days) | ☐ Mother and child book<br>☐ Birth certificate | X | X | X |
| Newborn Care Package<br>1. Assessment of newborn wellbeing and breastfeeding | ☐ Soap<br>☐ Water | X | X | X |
| | ☐ Information materials on breastfeeding and newborn care and nutrition | X | X | X |

| INTERVENTION | EQUIPMENT/SUPPLIES | Community Level Provider | BEmONC-Facilities | CEmONC-Facilities |
|---|---|---|---|---|
| 2. Information and counseling on home care and immunizations | ☐ Immunization schedule<br>☐ Immunization cards | X | X | X |
| 3. Additional follow-up visits for high-risk babies | ☐ Information materials | | X | X |
| 4. Child protection and injury prevention | ☐ Information materials on Injury Prevention | X | X | X |
| Expanded Program on Immunization | ☐ Vaccines<br>☐ Vaccine refrigerator<br>☐ Thermometer<br>☐ 3cc and tuberculin syringes<br>☐ Cotton balls<br>☐ Alcohol<br>☐ Immunization schedule<br>☐ Immunization cards<br>☐ Patient registry | X | X | X |
| Integrated Management of Childhood Illnesses | ☐ Stethoscope<br>☐ Thermometer (non-mercurial)<br>☐ Sphygmomanometer (pediatric set, non-mercurial)<br>☐ Oral antibiotics<br>☐ Oral rehydration solution<br>☐ Zinc supplements<br>☐ Iron supplements<br>☐ Vitamin A capsules<br>☐ IMCI manual<br>☐ Patient registry | X | X | X |

## Annex J. Stock and Inventory Management System at the Municipal Level

In March 2001, DOH commissioned the conduct of an inventory of contraceptive supplies among LGUs. Results of the inventory showed that many LGUs experienced significant levels of stock-outs and serious shortages in contraceptive supplies, particularly oral contraceptive pills. The stock-outs were not due to supply problems but rather, to weak distribution and forecasting system.

In 2009, a survey was done to assess the current status of logistics management, and procurement and distribution systems in the 23 provinces to make an objective evaluation of the gaps and deficiencies. The Stock and Inventory Management System (SIMS) was developed based on findings of this survey. It addresses gaps and deficiencies in the areas of logistics management

SIMS will help LGUs track expendable commodities in health facilities, especially drugs and medical supplies. It will help organize and update records for quantities received; quantities dispensed to clients; quantities issued to midwives or Barangay Health Stations (BHSs); and quantities in stock.

This system operates only within the health units and does not require any new reports. It may be thought of as a good housekeeping tool. For units that are already making logistics reports to specific programs such as TB or EPI, this system will facilitate the generation of information necessary for filling out their forms.

The tool includes instructions and forms for undertaking the following tasks:

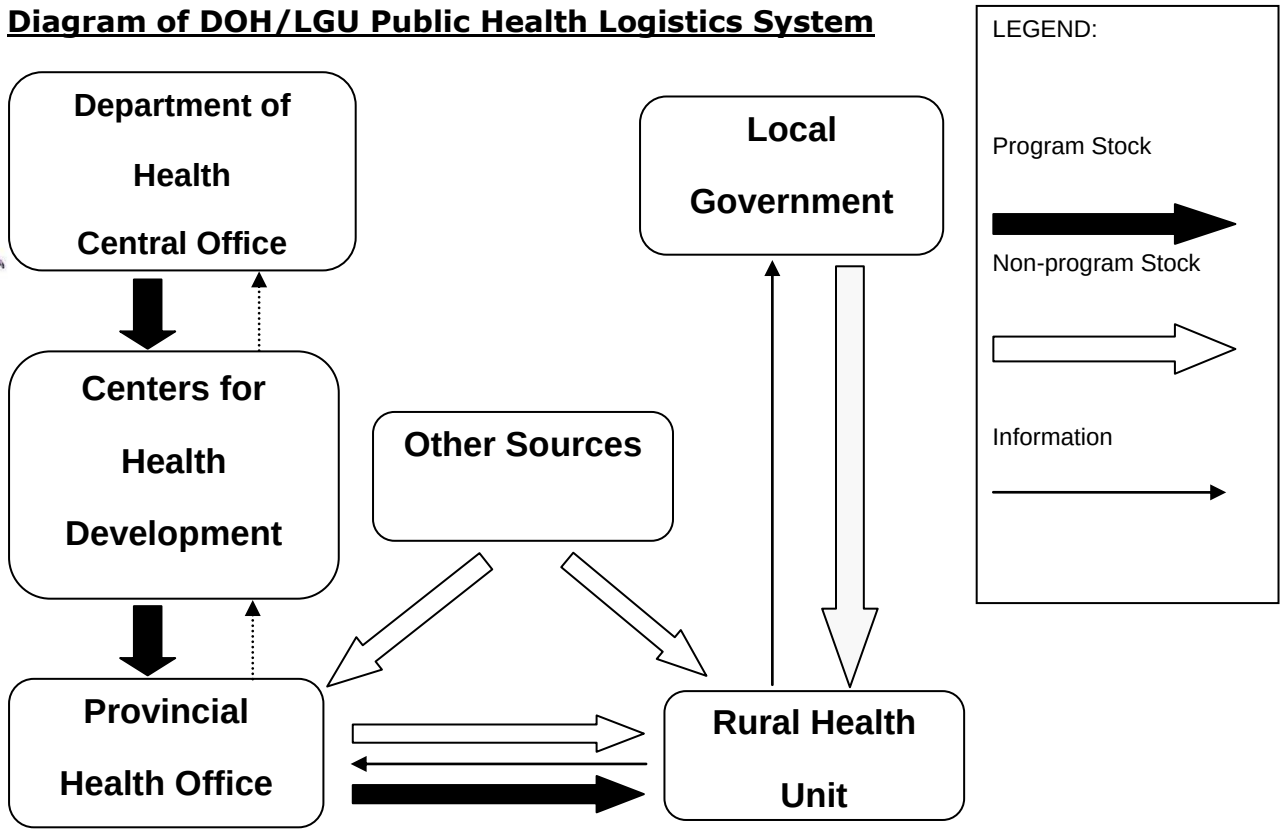
- Receiving drugs and medical supplies;
- Safe storage;
- Dispensing to patients;
- Issuing to midwives and BHSs;
- Carrying out physical inventories;
- Ordering new stock;
- Reporting on stock; and
- Keeping track of drug expiration dates.

Several forms are required in carrying out all of the above tasks. Some forms, like the Daily Stock Record Book or the Daily Dispensing Record Book, need daily monitoring to keep them up-to-date. Others, like the Monthly Physical Inventory Record, are used only once a month.

**Overview of DOH/LGU Logistics System**

The DOH/LGU logistics has four levels, as shown in the diagram below. The system operates through a cycle of product selection, financing, procurement, storage and transport. The levels are DOH central, CHD, Province and Municipality. In some countries, logistics systems are very centralized with product selection, financing and procurement taking place almost exclusively the central level. In these countries, the lower levels handle only transport and storage. The Republic of the Philippines is different. The public health logistics system is highly decentralized and all functions including financing and procurement are performed at all levels.

**Diagram of DOH/LGU Public Health Logistics System**




As the diagram shows, the logistics system produces a downward flow of stock that is ultimately headed to the health services delivery points, such as hospitals, RHUs and Barangay Health Stations. The system is also designed to produce an upward flow of information on stock levels and consumption for all products. It is the availability of this information that enables decision makers at each level to decide what to buy and how much. The upward flow of information originates in the health facilities. If the data at this level are inaccurate or non-existent, it makes it difficult to order or purchase the correct quantities of new stock. The purpose of this manual is to help assure that stock coming into health facilities is handled properly and that the facilities are able to provide accurate data about that stock at all times.

## 1. Receiving Drugs and Medical Supplies

**Responsible:** RHU Public Health Nurse or assigned Midwife

**When:** Whenever new stock arrive at the facility

**Steps:**

- Receives stock and verifies the condition of all products in the shipment.
- Counts incoming stock against the invoice and notes any discrepancies. The facility keeps one copy of the invoice and gives a second copy to the Municipal Health Officer.
- Places new stock in cabinet or store room
- Enters the amounts received for each drug in the appropriate Daily Stock Record Book (Attachment 1, Form A). Each program that provides drugs will have its own book. Drugs and other products that are purchased by the LGU, that are not part of a DOH program, are stored together as "Other Essential Drugs." Below is a list of well-known programs operated by Department of Health (DOH).

  DOH Programs: TB, EPI, Malaria, Nutrition, Family Planning

  Purchased by LGUs: Other Essential Drugs, Medical Supplies

## 2. Storing Drugs and Medical Supplies Safely

**Responsible:** Public Health Nurse or assigned Midwife

**When:** At all times

**Steps:**

- Assures that all drugs are placed in a secure, clean and dry place that is free of rodents and insects.
- Places drugs and supplies on shelves or in cabinets and groups them according to program or other source
- When placing drugs make sure that:
  - To the extent possible, drugs are placed in the same order that they are listed in the Daily Stock Record Book.
  - Expiration dates are facing outward and clearly visible.
  - All containers of liquids, such as bottles, vials or ampoules, are placed upright.

A list of these and other points for good storage practices is provided in Attachment 2.

### 3. Dispensing Drugs to Patients

**Responsible:** Municipal Health Officer, Public Health Nurse or assigned Midwife

**When:** Daily

**Steps:**

- The word "dispensing" refers only to the act of giving drugs to patients. When stock is given to Midwives or BHS, this is called "issuing."
- The MHO records the products to be dispensed to each patient in the patient chart/record, including the generic name of the drug, dosage and number of units to be dispensed.
- Next, the prescriber writes out a prescription slip, that shows the patient's name and all of the information listed above.
- The dispenser uses the prescription slip to determine the type of product and number of units to dispense.
- When more than one lot of any drug is in stock, always dispense first the drugs with the soonest expiration date.
- At the time drugs are dispensed, record the quantities dispensed to each patient in the Daily Dispensing Record Book. This is Annex 1 Form B.
- At the end of each day, using data from the Daily Dispensing Record Book, update for each drug, the stock balance in the Daily Stock Record Book. (The Invoices and Issue slips are also used for this step) There will be one book for each program, plus a book for LGU purchased supplies, as noted in Section 2, above.

### 4. Issuing Drugs to Midwives and Barangay Health Stations

**Responsible:** Public Health Nurse or assigned Midwife

**When:** Normally during the first week of each month

- Determine the number of units of each product to issue to Midwives or BHS.
- When more than one lot of any drug is in stock, always issue first the drugs with the soonest expiration date.
- At the time drugs or medical supplies are issued, fill out the Stock Issue Record (Attachment 1, Form C) including the date, name of product

dispensed, quantity issued, name of receiving facility and the signature of the recipient.

- Also at the time drugs are issued, record the quantities issued to each midwife or Barangay Health Station in the appropriate Daily Stock Record Book.

- It is already stated above, under "Dispensing Drugs to Patients" that the Daily Stock Record Books will be updated at the end of each day. Because the quantities issued are recorded in the book at the time they are handed over, these data will be automatically included in the daily update.

**5. Monthly Physical Inventory and Drug Expiration Records**

**Responsible:** RHU Nurse, Midwife, or RHU staff member designated as in-charge of drugs and medical supplies

**When:** Last working day of each month

**Steps:**

- The monthly physical count verifies the numbers of units of each drug or medical supply. It provides an opportunity to verify that the data in the Daily Stock Record Books are correct.

- Physically count the number of units of each drug and medical supply and record the results on the Monthly Physical Inventory and Drug Expiration Record (Attachment 1, Form D).

- In cases where there are differences between the physical count and the Daily Stock Record, inform the MHO of the losses in order to address the reason/s behind it.

- Expiration dates of drugs are also checked and recorded during this same activity.

- For newly received stocks, check each product's expiration date and record it on the same form.

- Whenever any lot reaches six months until the expiration date, take note of this fact and make a decision about whether or not it will be used before it expires.

- If any lot of any product cannot be used before expiration, it should be sent back to the PHO so that it can be sent to other units that can use it immediately. In the case of drugs that are purchased by the LGU, notify the Municipal Health Officer for appropriate action.

- If drugs do expire, the following steps are taken:

- Remove them from the shelves and place them in closed carton.
- Notify the Municipal Health Officer.
- Deduct them from the balance shown in the Daily Stock Record Book under "Losses" Column, with the annotation "expired". Stock quantity should also be noted in the Monthly Physical Inventory and Drug Expiration Record with "expired" written on the Remarks column.
- Assist the MHO in the correct disposal of the expired stocks according to Commission on Audit regulations.

- Any other "Losses" noted indicating either expiration or other conditions that render the stock unusable such as damage (sun exposure, discoloration, infestation, etc.) or are missing (unaccounted losses, pilferage, etc.) are noted and carried over to the Daily Stock Record to update the current balance at the column of "Losses" and the row indicating the date the inventory was done.

**6. Requesting New Stock**

**Responsible:** RHU Nurse

**When:** During the first week of January, April, July and October

**Steps:**

- Before ordering new stock from any source, make sure to bring the Daily Stock Record Books up to date and complete the monthly physical inventory.
- There are two basic sources of drugs and medical supplies. One is the program stock provided by the DOH via the PHO and the other is purchases executed by the LGU.
- For requesting program drugs and other supplies from PHO, use the Stock Replenishment Request Form. This is Annex 1 Form E.
- For requesting that the LGU purchase drugs, the Purchase Request Form is used. This is Annex 1 Form F.
- Determine for each product the amount needed for the coming quarter. This task is often easier said than done. It can be complicated by absence of key information about consumption and stock levels. (Implementation of this storage and record keeping system is intended to fix this problem.) It is also complicated by the fact that some stock is often stocked out, making it very difficult to estimate monthly consumption. Annex 3 provides information on how to deal with these problems.
- Enter the quantities requested on the appropriate request form.

- Submit the appropriate form to the either Provincial Health Office or person's in charge of procurement in the Municipal Hall.

## 7. Reporting to DOH Program

**Responsible:** Public Health Nurse or assigned Midwife prepares, HMO submits

**When:** At the end of March, June, September or December

**Steps:**

- There are already in place forms for reporting to DOH programs concerning the stock that they distribute. Officially, the reports should be quarterly, though this may vary in practice. Programs requiring reports include: TB, EPI, Malaria and Nutrition. Many LGUs' Family Planning Program discontinued reporting several years ago, but DOH is starting this practice again.
- While the different program reports have different formats, they all require about the same information. This manual accepts whatever reports are already being submitted. In the case of Family Planning, the new report is provided in Annex 1 Form G.
- The main types of information required are balances and consumption. At reporting time these items can be taken directly from the Daily Stock Record Book, if it is up to date.
- For all reports, prepare in the same way:
    - Make sure that the Daily Stock Record up to date.
    - Take the physical inventory and make any required adjustments in the Daily Stock Record.
    - Consumption for each product is calculated by adding up all of the quantities dispensed to patients or issues to midwives BHS during the reporting period.
    - Balances for each product will be found in the balance column.

## 8. Summary of the Files Kept at the Facility

A. Daily Stock Record Book

B. Daily Dispensing Record Book

C. Stock Issue Record

D-1. Baseline Physical Inventory and Drug Expiration Record

D-2. Monthly Physical Inventory and Drug Expiration Record

E. Stock Replenishment Request Form

F. Stock Purchase Request Form

G. Family Planning Program Reporting Form

***Monitoring and Evaluation***

Monitoring visits of Rural Health Units should be headed by the technical staff of the Provincial Health Offices (PHO). A SIMS assessment team may be organized by the PHO for this purpose.

Visits should be conducted at least once a month during the pilot-testing phase, starting a month after its commencement. If feasible, especially during the first year of implementation, regular monthly monitoring visits should be conducted by the PHO. This activity can be incorporated into the regular monitoring visits that various program coordinators conduct at the RHU.

These visits will not only be for data gathering. Feedback should be given to RHU staff on the visit's findings and recommendations. These same feedbacks should be documented and checked if acted upon on the following month's visit.

***Monitoring Tool***

I. Initial Implementation

1. Forms - *check for evidence of regular updating of records*
   - Are they being filled up?
     - daily for daily records
       1. Daily Stock Record Book (Yes/No)
       2. Daily Dispensing Record Book (Yes/No)
       3. Daily Stock Issue Record (Yes/No)
     - monthly for monthly records
       1. Monthly Physical Inventory and Drug Expiration Record (Yes/No)
   - What are the hindering factors in filling up these records?
   - What are the suggested improvements, if any, on the forms?

2. Using the SIMS – *at any time during the pilot phase*

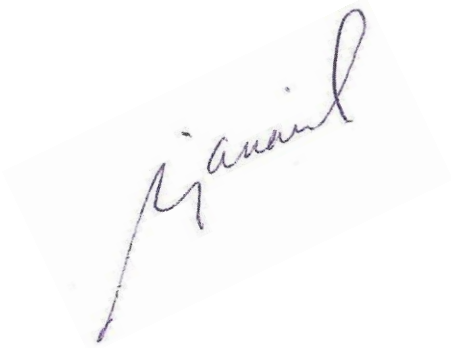
- Has the MHO ever used SIMS for decision making?
    - Checked stock balances using the SIMS? (Yes/No)
    - Used data for estimating quantities of commodities needed by the RHU? (Yes/No)
    - Used SIMS data for advocating for budget for commodity procurement? (Yes/No)
        - If yes, was budget provided? What was procured?
- Has SIMS data been used for preparing requests for replenishment of stocks?
    - For stock replenishment from PHO? (Yes/No)
    - For stock procurement by LGU? (Yes/No)
    - Can RHU tell you their average monthly consumption for EPI and NTP commodities? (Yes/No)
- Has the RHU experienced a stock-out or an emergency order for EPI and NTP logistics since SIMS started? (Yes/No)
- Are there visible efforts to improve storage standards? (Yes/No)
- Is the RHU using SIMS for other activities (aside from FP, NTP, EPI)? (Yes/No)
- Is the PHO, CHD using SIMS? (Yes/No)
    - If yes, how?

II. Sustainability - *can be done a quarter after commencement of SIMS*

- Has RHU reproduced forms on its own? (Yes/No)
- Are RHU stock replenishment requests to PHO based on SIMS data? (Yes/No)
- Has PHO reproduced forms to support RHUs? (Yes/No)
- Has PHO incorporated SIMS monitoring in its regular monitoring activities?
    - Check for documentation of SIMS monitoring (Present/Absent)
    - Has PHO observed SIMS use by RHUs in their preparation of commodity requests? (Yes/No)

During the visit, it would be likely to encounter personnel who have completed a form incorrectly or incompletely or who do not understand a specific procedure for its completion. Although this may be the perfect teaching moment, you should not interrupt your assessment to provide training. You probably will not have time to provide extensive training. Additionally, you want to encourage local staff to provide open, honest answers to your questions; correcting their work may make them less willing to share their insights with you.

At the end of the visit, you may take some time to explain or correct mistakes. Feedback should ideally be given in the presence of the head of the office. All negative responses to any of the guide questions should be probed further to seek an explanation for it. The question may need to be restated or clarified in case it was misunderstood. Negative responses may point to potential problems that would affect SIMS implementation. A course of action to solve this problem may be suggested including the person/s responsible and the time frame for this activity.



Attachment 1

Form A

| Daily Stock Record Book | | | | | | |
|---|---|---|---|---|---|---|
| Program: | | | | | | |
| Stock name and preparation: | | | | | | |
| Units of Stock: | | | | | | |
| Year: | | | | | | |
| Month: | | | | | | |
| Day | Stocks Received | Quantity Received | Quantity Dispensed to Patients in RHUs | Quantity Issued to Midwives | Losses | Balance |
| 1 | | | | | | |
| 2 | | | | | | |
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Form B

**Daily Dispensing Record Book**

**Program:_____**

| Date | Name of Client | Address | Age | Drug Names/Preparation — Quantity Dispensed | Signature of Client | Remarks |
|---|---|---|---|---|---|---|
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**Form C**

| **Daily Stock Issue Record** | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Name of Program:_____** | | | | | | | | | | | | | | | | | |
| | **Drug Name/Preparation** | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| **Date** | **Quantity Issued (units)** | | | | | | | | | | | | | | | **Issued to (facility and name)** | **Signature** |
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**Form D-1**

| **Baseline Physical Inventory and Drug Expiration Record** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Program:** | | | | | | | | |
| **Personnel in charge:** | | | | | | | | |
| **Date accomplished:** | | | | | | | | |
| **No.** | **Product and preparation** | **Manufacturer** | **Lot Number** | **Expiration Date** | **Check (√) if stocks expire within the next 6 months** | **Physical count of *usable** stocks** | **Losses** | **Remarks** |
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**Form D-2**

| **Monthly Physical Inventory and Drug Expiration Record** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Program:** | | | | | | | | | |
| **Personnel in charge:** | | | | | | | | | |
| **Date accomplished:** | | | | | | | | | |
| **No** | **Product and preparation** | **Manufacturer** | **Lot Number** | **Expiration Date** | **Check (√) if stocks expire within the next 6 months** | **Physical count of *usable** stocks** (A) | **Balance of stocks based on the *Daily Stock Record*** ** (B) | **Losses** (B-A) | **Remarks** |
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Form E

| **Stock Replenishment Request Form** | | | | |
|---|---|---|---|---|
| **Name of Facility:** | | **Personnel in charge:** | | |
| **Name of City/Municipality** | | **Date:** | | |
| A | B | C | D | E |
| **Product name and preparation** | **Stocks consumed since last request** | **Date of last request** | **Current stock level** | **Quantity Requested** |
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Authorized Signature: _____

Form F

| **Stock Purchase Request Form** | | | | |
|---|---|---|---|---|
| **Name of Facility:** | | | **Personnel in charge:** | |
| **Name of City/Municipality:** | | | **Date:** | |
| **A** | **B** | **C** | **D** | **E** |
| **Product name and preparation** | **Stocks consumed since last request** | **Date of last request** | **Current stock level** | **Quantity Requested** |
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Authorized Signature: _____

Forms G

| Family Planning Program Reporting Form | | | | |
|---|---|---|---|---|
| Facility type: | | Province: | | |
| Facility name: | | Local government unit | | |
| **Products** | **Opening balance** | **Received** | **Total dispensed and Issued** | **Closing balance** |
| **Free** | | | | |
| Condoms (pieces) | | | | |
| Oral contraceptives (cycles) | | | | |
| Progestin only orals (cycles) | | | | |
| IUD (pieces) | | | | |
| Injectable/DMPA Vials | | | | |
| **For Sale** | **Opening balance** | **Received** | **Total sold** | **Closing balance** |
| Condoms (pieces) | | | | |
| Oral contraceptives (cycles) | | | | |
| Progestin only orals (cycles) | | | | |
| IUD (pieces) | | | | |
| Injectable/DMPA Vials | | | | |

Authorized Signature: _____

Date:_____

Attachment 2

## Storage Conditions Guidelines

| No. | Description |
|---|---|
| 1. | Medicines and supplies that are ready for distribution are arranged so that identification labels and expiry dates and/or manufacturing dates are visible. |
| 2. | Medicines and supplies are stored and organized according to first-to-expire, first-out (FEFO) counting and general management. |
| 3. | Cartons and boxes are in good condition, not crushed due to mishandling or wet or cracked due to heat/radiation. |
| 4. | The facility makes it a practice to separate damaged and/or expired medicines and supplies from usable medicines and supplies and removes them from inventory. |
| 5. | Medicines and supplies are protected from direct sunlight on the day of the visit. |
| 6. | Cartons and boxes are protected from water and humidity on the day of the visit. |
| 7. | Storage area is visually free from harmful insects and rodents. (Check the storage area for traces of rodents [droppings], insects and bats.) |
| 8. | Storage area is secured with a lock and key, but is accessible during normal working hours. Access is limited to authorized personnel. |
| 9. | Medicines and supplies are stored at the appropriate temperature on the day of the visit, according to product temperature specifications. |
| 10. | The roof is maintained in good condition. |
| 11. | Storeroom is maintained in good condition (clean, all trash removed, sturdy shelves, organized boxes) |
| 12. | The current space and organization is sufficient for existing medicines and supplies including room for reasonable expansion. |
| 13. | Products are stacked at least 10 cm off the floor. |
| 14. | Products are stacked at least 30 cm away from the walls and other stacks. |
| 15. | Products are stacked no more than 2.5 meters high. |
| 16. | Fire safety equipment is available and accessible (any item identified as being used to promote fire safety should be considered (e.g. water bucket, sand). Do not consider empty and/or expired fire extinguishers as valid fire safety equipment). |
| 17. | Products are stored separately from insecticides and chemicals. |

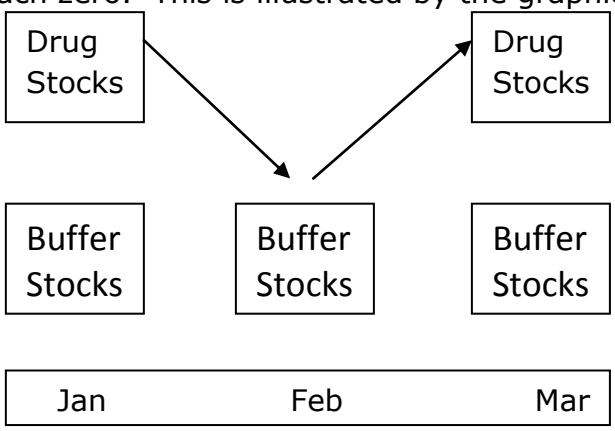
**Attachment 3**

## Options for Determining Stock Re-order Quantities

*Options for determining stock re-order quantities*

### Calculating Re-order Quantities using Average Monthly Consumption

- Basing reorder quantities on consumption can only be done for products that are in *full supply*. Currently this can be done for logistics like EPI vaccines and TB drugs.
- If the RHU is receiving DOH commodities or LGU purchased products that frequently are out of stock, it will not be possible to calculate average monthly consumption.
- It is not difficult to calculate average monthly consumption. When the program (EPI, NTP) has data for *at least* 3 full months, carry out the following steps for each product in full supply:
    - For a 3 month period from the Daily Stock Record Book, add up the numbers of all units of the product (1) dispensed to patients; and (2) issued to midwives and BHSs. This gives the "total quarterly consumption." To get the average monthly consumption, divide this number by 3.
    - Determine the total number of months for which you wish to order and multiply the average monthly consumption by that number to get the order quantity.
    - If replenishment is done every 3 months, the objective is to maintain a buffer stock that is equal the full supply of commodities for another 3 months.
    - Consumption and reordering continues from quarter to quarter and the cycle will repeat itself. Replenishment of stocks should not wait until stocks reach zero. This is illustrated by the graphic below.



- Below are some illustrative calculations:
    - Assume for NTP that the consumption for Cat 1 medicines is calculated at 8 boxes for January, 9 boxes for February, 8 boxes for March, 7 boxes for April, 7 boxes for May, and 5 boxes for June. The RHU gets replenishment stocks from the PHO every 3 months.
        - Total consumption for 6 months is calculated as 8+9+8+7+7+5 = 44
        - Average monthly consumption can be calculated as 44/6 = 7.33 or 7
        - Minimum stock to be requisitioned from PHO: 7 x 3 (months until the next requisition) = 21 boxes of Cat 1 drugs
        - Buffer stock should be another 21 boxes or equal to another 3 months of supply of commodities.

**When stock is not in full supply**

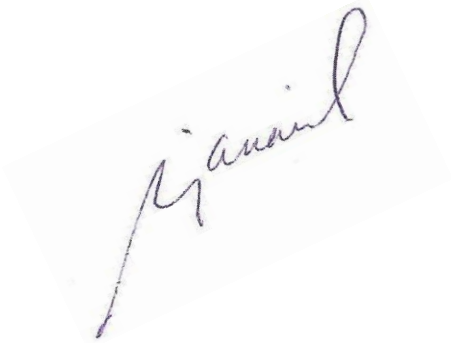
- When stock items are not in full supply, it is not possible to usefully calculate average monthly consumption. This is because during periods of stock out no units are dispensed and just calculating the totals actually dispensed during the month will underestimate needs.
- One simple method for estimating needs in these cases is to ask yourself, "What are the serious health problems that we must always be prepared to treat, NO MATTER WHAT. Examples of conditions that would be on such a list are:
    - Diarrhea induced dehydration in children
    - ARI in children
    - Severe attacks of asthma
- Next pair these conditions with the drugs of choice as defined by DOH treatment guidelines. For the conditions listed above, the pairing will be:
    - Dehydration/ORS
    - ARI/Cotrimoxizole
    - Asthma/Salbutamol
- The next step is to make an estimate of how many cases of each of these conditions are seen monthly, by age group. The most efficient way to do this would be to consult the morbidity and mortality data summarized in the Field Health Services Information System (FHSIS)
- Finally, by age group, the numbers of units of each paired drug are multiplied the numbers of cases to get an overall estimate of the amounts of each product required. If the numbers of cases are aggregated for the year, then

the product of this multiplication will be divided by 12 to get an "estimated monthly consumption".

- Below is an illustrative calculation for ORS for children 5 years and under:

  Recommended course of therapy of ORS = 3 ORS packets
  Total cases for this age group recorded in the FHSIS for the most recent year = 1200
  Ave. monthly consumption = 1200/12 months = 100 ORS packets/month
  Order for 3 month delivery interval = 300 ORS packets

- Real consumption should then be monitored using the information in the Daily Stock Record Book for 3 to 6 months. More accurate average monthly consumption can be estimated based on the data gathered.



## Annex K. Contracting Private Providers

LGUs may expand delivery of MNCHN services in areas underserved by the public health facilities by tapping private practice midwives (or private facilities) that are already providing or can provide MNCHN services. LGUs could hire a private practice midwife (or a health facility) to provide MNCHN services in remote areas or those not covered by existing public facilities. This could be done through public bidding as the general mode of procurement or through alternative methods such as negotiated bidding.

Planning for procurement of consultancy services of private midwives involves the following steps:

- Determine services that should be provided by private midwives or other health providers.

Based on the assessment of clients' utilization of services and health providers' capacity to render services, determine services that can be given by private practitioners especially for priority population groups.

Midwives could be tasked to provide basic health services in the community such as provision of family planning services, micronutrient supplementation, pre-natal care and follow-up services in the community for mothers and their newborns. If the LGU would need CHTs for priority population groups, contracting midwives and health volunteers to provide services in the community which will include masterlisting of eligible clients in the community, assisting families to prepare their health plans, following up of mothers and children and providing information on available services.

Please note that if services of midwives are going to be tapped to provide maternal care during childbirth that their facilities should be accredited by PhilHealth. Accreditation by PhilHealth would serve at least two things: (1) ensure that midwives give quality care and (2) presence of a mechanism for financial sustainability.

- Define parameters by which private midwives could receive locally or centrally procured commodities.

The decision to allow private practitioners to receive locally or centrally procured commodities should be legislated by the province or its component LGUs and independent cities. Parameters for commodity transfers should also be clearly defined such as:

  - Clients who should receive commodities
  - Reports to be submitted by private practitioners
  - Agreement on cost of services of private midwives or practitioners

- Preparation of the draft Terms of Reference

The health officer will need to specify the terms of reference or scope of work expected for the private practice midwives that will contracted. General guidelines in preparing the Terms of Reference (TOR)shall include the following: specific services that should be provided to identified priority population groups, roles of the LGU and private midwife practitioners such as initial support to improve facilities, improve capacities of midwives, installation of a support system for LGUs and provision of services, participation in training activities, participation in a monitoring and reporting system in LGUs, application for accreditation to PhilHealth for private midwife practitioners.

Ensure that arrangements for the following are also put in place to assist private midwife practitioners: allow private practitioners to receive publicly procured commodities, drugs and supplies for distribution to poor clients, continuous provision of quality services by having a (1) feedback mechanisms from clients and (2) ensuring compliance to standards by private midwife practitioners.

- Determination of the mode of procurement,

LGUs could go through a public bidding or through negotiated bidding to contract services of private midwife practitioners.

- Identification of candidate private practice midwives as consultants,

  Qualified candidates are the following: Midwives who are engaged in private practice and who have been trained to provide MNCHN services or has been providing MNCHN services for at least 1 year, private practice midwives who are willing to be trained and become part of the MNCHN network in the area.

- Determination of the Approved Budget for the Contract (ABC)

  The cost of consultancy shall be computed on the cost of actual services to be rendered by the consultant plus reasonable expenses associated to the delivery of MNCHN services.

**Annex L. Annual Operational Plan Matrix**

Annual Operational Plan

Province: _____

No. of ILHZ: _____

No. of Municipalities: _____

| PROGRAM/PROJECT/ ACTIVITIES | Activity/Target | Time Frame | Resource Requirements | | | LGU | | | National Government | | Grants | | Loans | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Quantity | Unit Cost | Cost | PLGU | MLGU | ILHZ | DOH | PHIC | Donor | Others | MFDO | Others |
| | | | | | | | | | | | | | | |
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**Guide in the Accomplishment of the Annual Operational Plan**

**Annual Operational Plan Matrix**

i. Column 1 - Program/Project/Activities

This should contain the F1 Priority Program, Project Activities arranged according to the four components (Service Delivery, Regulation, Financing and Governance). Included in this column are the specific objectives by program and the corresponding performance indicators.

- Specific Objectives are essentially subsets of F1 goal. Each goal usually consists of several quantifiable objectives indicating exactly what the health facility/service level wants to achieve. It is useful to consider the SMART criteria when formulating objectives Sound objectives are made specific, measurable, attainable, realistic and time-bound.
- Performance Indicators are measurement of Program output and are directly linked to the attainment of the program objectives.

ii. Column 2 – Activity/Target

This column includes the activities and targets. These are the objectives translated into action and results.

- Activities are the actual tasks undertaken to carry out each objective. It may be necessary to ask the questions: Are the activities the right ones to carry out the objective? Are the results that they produce enough to meet the desired objective?
- Each activity would have a specific target output. The identification of corresponding outputs leads to the quantifiability of the objective and is useful in monitoring accomplishment.

iii. Column 3 – Time Frames

Timeframes for each activity, the duration of action at which end the desired output or outcome should be realized. Indicating the time frame for an activity is useful in providing a good sense of sequencing and distribution of action over the implementation year. It is also needed for monitoring purposes. A detailed action or implementation plan for each activity will specify the actual month or quarter of the year when the activity is to be conducted.

iv. Columns 4 – 6 - Resource Requirements

Include personnel technologies, training needs, medicines, supplies, etc. that are needed to be able to conduct a particular activity and produce a given output or outcome. It may also be useful to indicate those personnel, offices or entities that provide critical support in the conduct of the activity.

The cost for each resource that is required for the conduct of an activity may have to be estimated considering the following: target population for the activity, the task itself, the duration or frequency of conduct. Total cost of all activities in the annual operational plan will be reflected in the total cost for health for the year.

v. Columns 7-16 Sources of Funds

Sources of Fund should reflect all financial sources such as those coming from local sources like PLGU and MLGU; national sources DOH and PhilHealth and donor/development partners such as: European Commission, ADB, USAID, Global fund, JICA, WB, etc. This is to show the extent of financial resources that each of these partners/donors have contributed in terms of interventions/activities in the implementation of the PIPH.