MNCHN Strategy

Localized Manual of Operations

Implementing Health Reforms towards
Rapid Reduction in Maternal and Neonatal Mortality

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Name of Health Facility

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The Cordillera Administrative Region's Localized MNCHN Manual of Operations 2012

Baguio City, Republic of the Philippines
Center for Health Development-Cordillera Administrative Region

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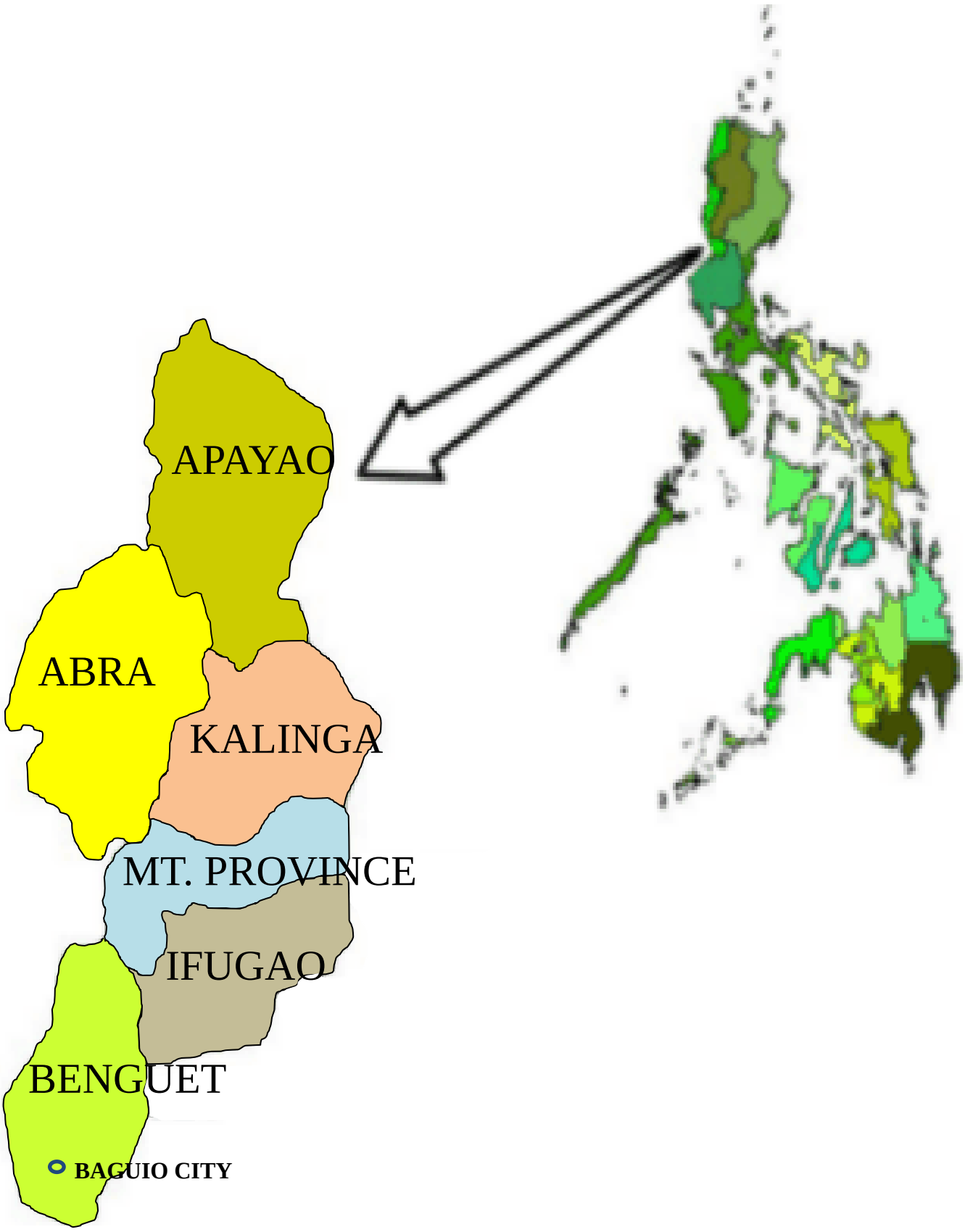
December 2012

Map of Cordillera Administrative Region



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CORDILLERA ADMINISTRATIVE REGION

FOREWORD

The National Demographic Health Survey results on Maternal Mortality Ratio from 1993 (209/100,000 live births), 1998 (172/100,000 LB), 2006 (162/100,000 LB), and 2008 (140/100,000 LB) show a declining trend at a very slow rate. These data indicate that the country has not yet achieved Millennium Development Goal 5 target which is 52/100,000 LB by 2015.

The MDG 5 target by 2015 is to reduce infant deaths by two thirds with an Infant Mortality Rate of 17/1,000 LB. Based on 2008 NDHS, the Philippines had 25/1,000 IMR. In the 2010 Field Health Service Information System, there were 21 maternal deaths in the region with uterine atony and pre-eclampsia as the leading causes of death.

While the data of Cordillera Administrative Region reflect with low maternal mortality ratio at 55/100,000 LB in 2010, doubling effort is still needed to save the lives of the mother and newborn towards better maternity, newborn and child care within the cultural practices and beliefs of the Indigenous Peoples.

The MNCHN policy was formulated by the Department of Health to rapidly reduce maternal and neonatal deaths. This addresses health risks that lead to maternal and especially neonatal deaths, which comprise half of the reported infant deaths. Supporting this public health problem will improve coverage of prenatal care, facility-based delivery, fully immunized child, and contraceptive prevalence rate.

This Localized MNCHN Strategy-Manual of Operations reflect the DOH policy and provides for the steps in identifying at risk 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, and the mechanisms by which to monitor and evaluate performance within the context of cultural integrity of the Cordillerans. It also defines the roles of the DOH central office units, the CHDs, LGUs, NCIP and other partners in implementing the strategy.

DR. VALERIANO JESUS V. LOPEZ, MHA, MPH, CESO IV
Director IV

MESSAGE

One of the three strategic thrusts of the Aquino Health Agenda: Achieving Universal Health Care for all Filipinos is to improve the provision of public health services to achieve health related Millennium Development Goals (MDGs). To achieve MDG 4 (reduce child mortality) and 5 (improve maternal health), the Center for Health Development – Cordillera Administrative Region has been scaling up the implementation of the MNCHN strategy.

Through the support of Japan International Cooperation Agency (JICA), scaling up the implementation of the MNCHN strategy will be facilitated by the dissemination of this Manual of Operations (MOP) – Cordillera Version to guide Local Government Units (LGUs) in implementing local MNCHN interventions. This Localized MNCHN MOP updates the protocols, standards, and recommended steps to guide local implementation of the MNCHN strategy within the framework of Indigenous People's Republic Act of 1997.

In recognition of the differences in local conditions and constraints in the region, this MOP was revised based on the local context—geographical condition and cultural beliefs and tradition of Indigenous People. 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.

This localized manual was identified to further move forward the regional initiatives in saving the lives of the mothers and children as reflected to the current JICA-supported project for "*Cordillera-wide Strengthening of the Local Health System for Effective and Efficient Delivery of Maternal and Child Health Services*"—a project formulated by CHD-CAR to expand the experiences and learning of the former JICA-supported projects in CAR to other provinces in the region: *Maternal and Child Health project* in Ifugao (2006-2010), which developed *Family Health Diary* (Cordillera version of *Mather and Child Book*) as well as strengthened *Women's Health Teams* activities; and *Local Health System Strengthening project* in Benguet Province (2006-2011), which enhanced inter LGU cooperation thru Inter Local Health Zone (ILHZ) system.

Basically, this manual highlights the four points in accordance to the need of CAR: (1) Harmonization of the Indigenous People's Republic Act of 1997 to the MNCHN Strategy; (2) Underlining the inter-LGU cooperation as one among the important support mechanisms in implementing the MNCHN; (3) Integration for the use of *Family Health Diary* and putting more emphasis on the role of Community Health Team; and (4) Strengthening the Barangay Health Station as service provider for birthing services at the community level.

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

MAKOTO TOBE, Ph.D, MPH
Chief Advisor of the Project

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	Center 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
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
IPRA	Indigenous People's Republic Act
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
MWR	Married Women of Reproductive Age
A NBS	Newborn Screening
NMR	Neonatal mortality rate
NSV	No-Scalpel Vasectomy
NCIP	National Commission for Indigenous Peoples
PhilHealth	Philippine Health Insurance Corporation
PHO	Provincial Health Officer
PIPH/CIPH	Province-Wide/City-Wide Investment Plan For Health
PPC	Post-partum care
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 (ANC) 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 using the Family Health Diary (FHD), 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 Newborn Care (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 (CPR) 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 month's 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 (IMR) 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.

Indigenous People's Republic Act (IPRA) of 1997 or RA 8371 – An act to recognize, protect and promote the rights of the indigenous community.

Maternal Mortality Ratio (MMR) 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.

Maternal, Newborn and Child Health and Nutrition (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 (MNCHN-SDN) 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 (NMR) refers to the number of deaths within the first 28 days of life per 1000 live births in a given period.

Post-partum Care (PPC) encompasses management of the mother, newborn, and infant during the postpartal period. This period usually is considered to be the first few days after delivery, but technically it includes the six-week period after childbirth up to the mother's post-partum checkup with her health care provider.

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, prenatal 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 (TBA) 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 (UFMR) 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.

PART I: *INTRODUCTION*

Chapter 1: *What is the MNCHN Localized Manual of Operation (MOP)*

Chapter 2: *MNCHN Strategy*

1. What is the MNCHN Localized 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. This situation has also been observed in the Cordillera Administrative Region (CAR) despite with intervention and effort made by the heath sector. The Field Health Service Information System (FHSIS) of the region shows with more than 20 mothers still died each year since 2007 and recorded with 21 maternal deaths in 2010. In response, the Center for Health Development-Cordillera Administrative Region (CHD-CAR) has issued this localized manual of operation in implementing the Maternal, Newborn and Child Health and Nutrition (MNCHN) in accordance to the Indigenous People's Republic Act of 1997 (or R.A. 8371) and the Administrative Order 2008-0029 of the Department of Health, otherwise known as "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 localized Manual of Operations (MOP) is a guidebook prepared by the CHD-CAR, with technical assistance of JICA Experts, based on the result of Consultative Workshops conducted by the Family Health Cluster of CHD-CAR in all six provinces in the region last August-September 2012 using the provisions of R.A. 8371, specifically on delivering basic social services, and most updated version of MOP issued by the DOH 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 AO2008-0029 also known as the MNCHN Strategy.

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

The Localized 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 in accord to the geographical situation as well as protection to the cultural integrity of the people in Cordillera Administrative Region. 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.

Moreover, this manual harmonizes the Republic Act No. 8371, otherwise known as *Indigenous People's Republic Act of 1997*, to protect the cultural integrity of indigenous community as well as provision of full access to maternal, newborn and child health care and nutrition.

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 Localized MOP structured?

The Localized MOP is organized into three major parts with integration of all points for localization as summarized below:

Table 1: Points of Localization

Areas for Integration	***Summary Points***
Harmonization with the Indigenous People's Republic Act 8371	To make the MNCHN strategy consistent with the Indigenous people's policy or IPRA 8371, the concepts and guiding rule on protecting the cultural integrity will be harmonized in the manual. This will ensure that all community shall access quality maternal and child health care from the professional health personnel in the

Areas for Integration	*Summary Points*
	facility. Specifically, it will be integrated in the following component: • Continual right of the indigenous people on their cultural practices, belief and tradition within the education, promotion and advocacy work of community health team and service delivery of MNCHN services at the health facility; • Involvement of community leaders and elders in the implementation process of MNCHN at the community level; and • Participation of National Commission of Indigenous People (NCIP), the sole government organization who oversee on carrying out the IPRA 8371, in the MNCHN Team.
Integration of the Family Health Diary	To fully maximize the use of Family Health Diary (Cordillera version of Mother and Child Book) at the local level, the material will be introduce in all aspect of Service Delivery Network component of the MNCHN manual of operation. Purposely, it will be highlighted in the following: • As one of the major reference on educating and informing the community on preventive, promotion and full access of MNCHN services from the professional health personnel at the facility; • Assisting the families on formulating their birth and emergency plan; • Assisting the professional health personnel and the community on developing interventions for the women's MNCHN need; • Assisting information sharing on mothers and children among health workers; and • Monitoring on the utilization of quality MNCHN services by the community at the health facility, especially the expectant mothers. The Family Health Diary was produced in CY2009 by the Center for Health Development-Cordillera Administrative Region, with technical and financial support of JICA, based on the content from DOH generated Mother and Child Book.
Strengthening Community Health Team	The roles and functions of the community-based volunteers as detailed at CHT Guidebook shall be captured in the MNCHN manual. The use of pregnancy and post-partum tracking reporting shall also be highlighted. CHT composition and sustainability mechanism are also detailed in the manual.
Inter-local Health Zone (ILHZ)	As part of the strengthening of MNCHN utilization, the proposed localized material will also include the ILHZ as one among the instruments in the local health system. It will highlight the role of the local level on policy development to support the use of the MNCHN MOP, presentation of the locally formulated mandates for possible replication, integration of MNCHN at ILHZ Plan and financial contribution to support the MNCHN implementation through Common Health Trust Fund.

Areas for Integration	*Summary Points*
	Basically, it will function as inter-LGU cooperation to provide continuous MNCHN services effectively an efficiently.
Strengthening Barangay Health Station as Birthing Centers	It will highlight the use of BHSs as Birthing Centers, manned by the midwives and trained on Harmonized BEmONC, which are strategically located in areas with pocket of identified priority population. Specifically, the role of the BHS and the midwife will be extensively described in the MNCHN Service Delivery Network.
Monitoring	This will include a suggestions on setting up of monitoring / spot map board for identified priority population and provided with close intervention as part of the monitoring management, inclusion of post-partum care in the service coverage indicators and monitoring arrangement between CHD, PHO and MHOs in the implementation of MNCHN Strategy at the local level.

This manual 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 and National Commission of Indigenous People (NCIP) are to be designed and channeled 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 which include the summary points of localization. Chapter 2 provides an overview of the situation of women's and children's health in both country-wide and Cordillera Administrative Region specific, 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) where the involvement of NCIP is highlighted, 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) which are still 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), National Commission of Indigenous People (NCIP) 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 Localized MOP is developed to guide local authorities (chief executives, health officers and staff) of Cordillera Administrative Region and other concerned stakeholders in implementing the MNCHN strategy. It aims to guide local officials, local health managers from both public and private sectors 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, PhilHealth and NCIP 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.

2. MNCHN Strategy

2.1. Maternal, Newborn, and Child Health and Nutrition Situation in the Cordillera Administrative Region and in the Philippines

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]

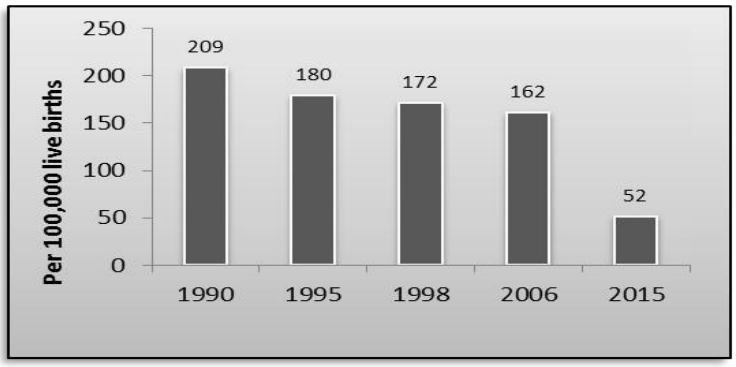


Figure 1: Maternal Mortality Ratio, Philippines, 1990-2015

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 42 percent in 1990 to 26 percent 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, 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.

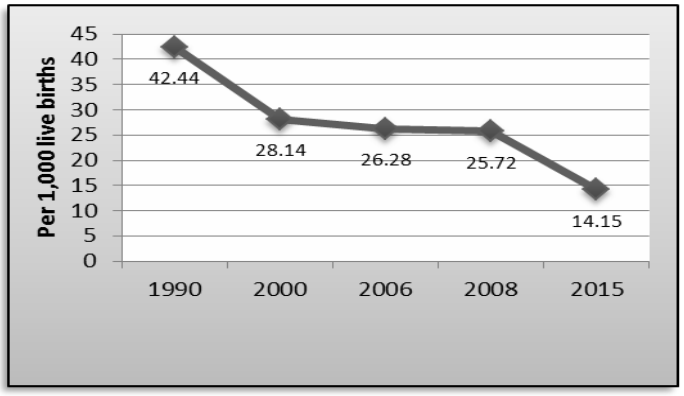


Figure 2: Infant Mortality Rate, Philippines, 1990-2015

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

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.

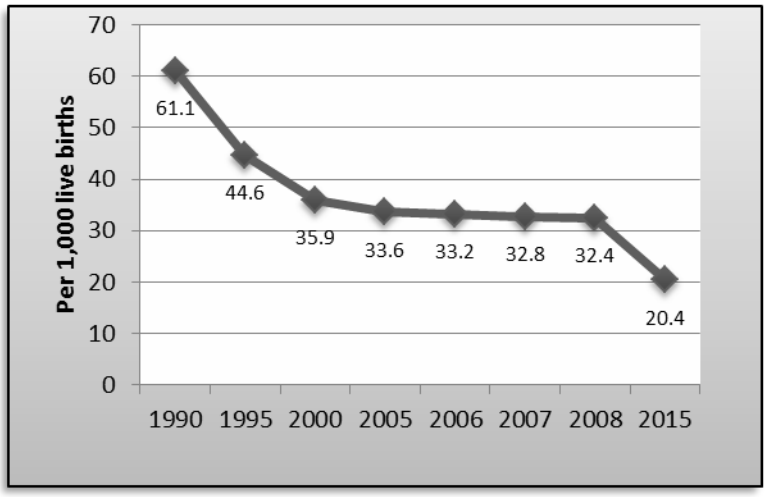


Figure 3: Under-five Mortality Rate, Philippines, 1990-2015

In CAR, the region have consistently recorded with 28 maternal deaths from 2008 to 2009 and it only reduces in 2010 to 21 maternal deaths or 65.41/100,000 live births as reflected at Figure 4 below and detailed for each province at footnote no. 6 (CHD-CAR FHSIS, 2010). It is most high in both provinces of Apayao and Mountain Province with 6 maternal deaths. The figures indicate that significant number of cordilleran women still suffering to life threatening events during the birth of their baby.

The report further shows that uterine atony and post-partum hemorrhage remain as the leading causes of maternal death. All other causes include eclampsia, placenta retention, placenta accreta and gestational hypertension or pregnancy-induced hypertension.

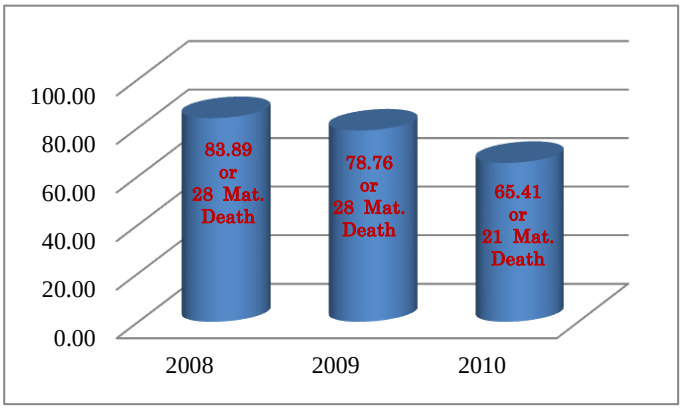


Figure 4: Maternal Mortality, CAR, 2008-2010[6]

On infant mortality, a fluctuating trend of death is observed in CAR from 2008 to 2010 and it is most high in 2009 with 391 infant deaths (or 11 deaths per 1,000 live births) as shown in Figure 5

[6] Detailed Maternal Mortality per Province, 2008-2010

	Abra		*Apayao*		*Benguet*		*Ifugao*		*Kalinga*		*Mt. Province*		*Baguio City*		*CAR*	
Year	Death	LB	Death	LB	Death	LB	Death	LB	Death	LB	Death	LB	Death	LB	Death	LB
2008	5	4816	3	2529	3	6567	3	3608	7	4621	3	3068	4	8168	28	33377
2009	2	4862	2	2195	1	6334	4	4191	8	4349	3	3506	8	10114	28	35551
2010	1	5033	6	2277	1	6817	1	4107	3	3592	6	3427	3	6851	21	32104

Source: CHD-CAR FHSIS, 2006-2010

below. However, the rate decreases with almost 2 deaths per 1,000 live births in 2010 making the region with total infant deaths of 290.

Accordingly, prematurity remains the prevailing top cause of death among the infant for over three years and followed with sepsis. All other causes of death are pneumonia, asphyxia, congenital anomaly and heart disease.

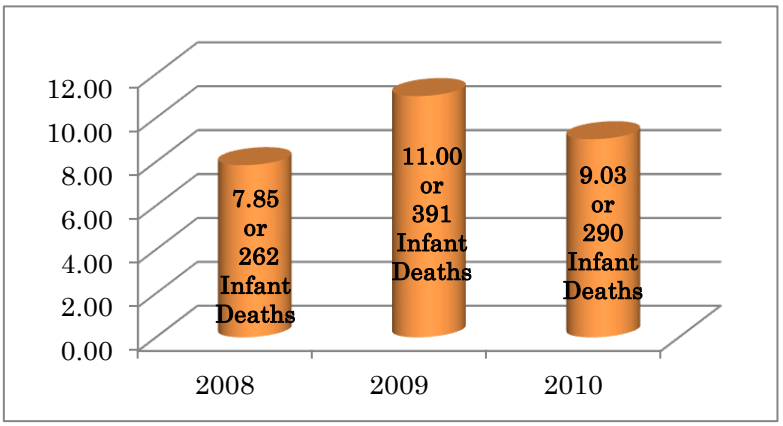


Figure 5: Infant Mortality, CAR, 2008-2010[7]

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.

Specific in CAR, these direct causes of maternal and neonatal deaths require care by skilled health professionals in well-equipped facilities. However, almost 32 percent of births are delivered at home, of which 13.4 percent are attended to by TBAs or hilots and others.[8] 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.

[7] Detailed Infant Mortality per Province, 2008-2010

	Abra		*Apayao*		*Benguet*		*Ifugao*		*Kalinga*		*Mt. Province*		*Baguio City*		*CAR*	
Year	Death	LB	Death	LB	Death	LB	Death	LB	Death	LB	Death	LB	Death	LB	Death	LB
2008	31	4816	35	2529	29	6567	40	3608	34	4621	56	3068	37	8168	262	33377
2009	53	4862	19	2195	63	6334	61	4191	27	4349	49	3506	119	10114	391	35551
2010	17	5033	20	2277	54	6817	45	4107	31	3592	42	3427	81	6851	290	32104

Source: CHD-CAR FHSIS, 2006-2010

[8] CHD-CAR FHSIS Annual Health Report, 2010

The likelihood of maternal and neonatal deaths is further magnified with the critical accumulation of four risks such as (1) mistimed, unplanned, unwanted and unsupported pregnancy[9]; (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 post-partum 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 within the cultural integrity of the region. 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 Geographically Isolated and Disadvantaged Areas (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 localized MOP is still within the interrelatedness of the direct threats to life that necessitate immediate DOH-standard 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 while protecting the cultural beliefs and tradition of the people.

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 reproductive age and newborns at different stages of the life cycle[10], but also to the community.

- Establishment of a Service Delivery Network at all levels of care to provide the package of services and interventions. This network shall include private hospitals and clinics.

[9] 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.

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

- 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.

  The role of the regional office and provincial offices of National Commission for Indigenous People shall be boosted to ensure the full implementation of MNCHN Strategy within the context of IPRA.

Given the limited resources, areas with poor MNCHN performance in terms of service coverage indicators such as contraceptive prevalence rate, prenatal 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 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[11]. This also encompasses deworming of women of reproductive age (to reduce other causes of iron deficiency anemia), nutritional counseling, and oral health.

[11] 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."

Specific to adolescent health services, the RHUs and BHSs should have the following as stipulated at the DOH-Administrative Order No. 34-A *(known as Adolescent and Youth Health Policy)* signed last April 10, 2000 as presented at *Annex Q:*

- Rural Health Midwives who shall screen and refer adolescents and youth in the proper level of care;
- Doctor and nurses who shall screen and provide basic intervention and refer client when necessary to higher level of care;
- Records that must be kept confidential; and
- Install the following features:
    - A counseling room/area where indigenous-friendly, privacy and confidentiality will be ensured. It must be free from physical barriers like office table, telephone, etc. to minimize and avoid distractions;
    - Attractive promotional IEC materials posted on the wall and take home reading materials;
    - Available trained professional health care providers;
    - Equipped with necessary logistics and supplies; and
    - Open from 9:00AM until 5:00PM from Monday to Friday.

2. **Pregnancy:** first antenatal visit at first trimester, at least 4 antenatal 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, counseling on healthy lifestyle and breastfeeding, prevention and management of infection, as well as oral health services. While the contribution of prenatal care in anticipating and preventing maternal and newborn emergencies is unclear, components of prenatal care remain effective in reducing perinatal deaths[12]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."*[13]

   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*

[12] 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.

[13] 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.

during pregnancy, child birth and the immediate post-partum period".[14]

4. **Post-Partum:** visit within 72 hours and on the 7th day post-partum to check for conditions such as bleeding or infections, Vitamin A supplements to the mother, and counseling on family planning and available services. It also includes maternal nutrition and lactation counseling and post-partum care 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."*

   Moreover, newborn screening should be done to all babies on day two after birth or no less than 78 hours in accordance to R.A. 9288 or the *"Newborn Screening Act in 2004"*. The service is intended to the baby with treatable conditions before they present clinically, or suffer irreversible damage. Basically, the following are the NBS panel of disorders including the latest updates as specified at DOH-Department Memorandum No. 2012-0154 dated May 15, 2012:
   - Congenital hypothyroidism (CH)
   - Congenital Adrenal Hyperplasia (CAH)
   - Galactosemia (GAL)
   - Phenlyketonuria (PKU)
   - Glocuse-6-Phosphate dehydrogenase (G6PD)
   - Maple Syrup Urine Disease (MSUD).

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.

   Specific to Child Injury Prevention, the tool at *Annex N* shall be accomplished by a Barangay Kagawad, appointed by the Barangay Captain. It shall be submitted to the Center for Health Development (CHD), through the Provincial Health Team Office, every first week of July and second week of January through the Provincial Health Office. The CHD shall capacitate the "kagawads" on the guidelines and process before it will be implemented.

2.3.2. MNCHN Service Delivery Network

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 an Inter-local Health Zone (ILHZ) or province or city-wide network of

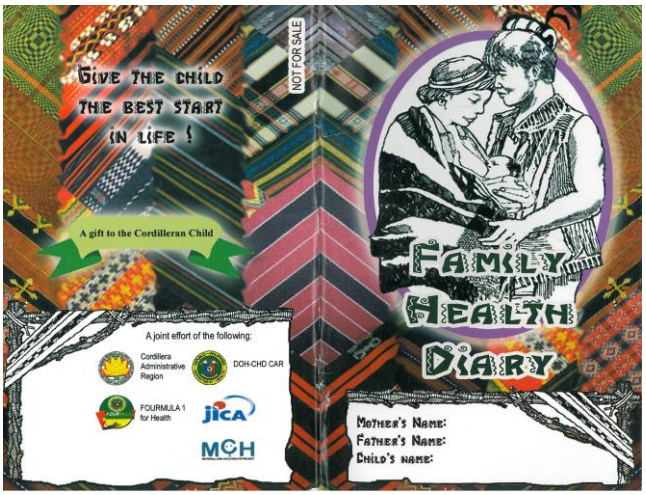
[14] Reducing maternal mortality, a joint statement by WHO, UNFPA, UNICEF, WB, Geneva, 1999.

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.

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. Using the **Family Health Diary**, the *navigation* function will include informing families of their health risks, assisting families in health risks and needs assessment; assisting families develop health use plans such as Birth and Emergency Plan and facilitating access by families to critical health services (e.g. emergency transport, carrying the patient by foot to nearest facilities and communication) and financing sources (e.g. PhilHealth). Their basic service delivery functions will involve on. advocating for birth spacing and counseling 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.

   Specific to areas where pocket of identified priority population located, a birthing center will be installed at the BHS to provide the normal deliveries including other functions as detailed at page 31.

2. **Basic Emergency Obstetric and Newborn Care (BEmONC)-capable** network of facilities and providers can be based in hospitals, RHUs, BHS or birthing centers. Blood transfusion services, which may or may not include blood collection and screening, can be provided by the hospital-based BEmONC facility if they have available required trained professional health professional health personnel, supplies and equipment. These

facilities operate on a 24-hour basis (either on-manned or on-call) with staff complement of skilled health professionals such as doctors, nurses, midwives and medical technologists.

A BEmONC based in RHUs, BHS, or birthing centers 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 centers operated by skilled health professionals (doctor, nurse and midwife) . 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.

Moreover, instruments developed and initiated by the LGUs will be highlighted for possible replication to other areas that are found effective and efficiently implemented at the local level. This include policy on Strengthening Facility-based delivery in the municipality of Pudtol (Apayao province), strengthening maternal and child health (MCH)-related activities in the province of Benguet, ensuring availability of MCH-related supplies and medicines in an ILHZ of Benguet province and policy on male involvement in the province of Ifugao.

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: Hospital 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

PART II: *LGU-wide Implementation of the MNCHN Strategy*

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.

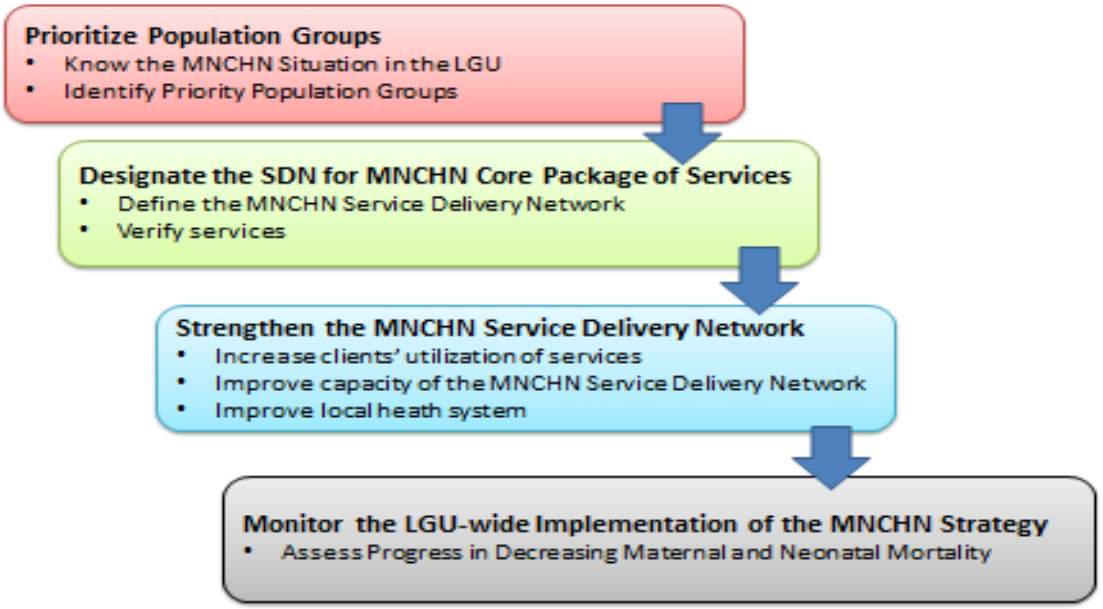


Figure 6: Flowchart of LGU-wide MNCHN Implementation

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, Center for Health Development-Cordillera Administrative Region as well as hospitals of both from 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 Inter-Local Health Zone or provincial hospitals or even private health facilities/hospitals for women, mothers and children to have access to a continuum of care.

Other member shall include:

1. Representatives from partners, non-government organizations (NGOs) and civil society may be invited to be part of the team; and
2. Representative from the Office of Education, Culture and Health of the National Commission of Indigenous People (NCIP)-Regional Office shall be involved to guarantee respect of the IPs' cultural integrity while providing full opportunities for health and nutrition as stipulated at

IPRA[15]. Specifically, NCIP will ensure the following in the implementation of MNCHN Strategy:

a. Integration of MNCHN services at the Indigenous People Development Plan as an immediate measure to all Indigenous women, children and their families for full access of maternal and child health and nutrition;
b. Mainstream the social and cultural spheres of life of the indigenous peoples in the MNCHN Strategy; and
c. Involvement of the Indigenous people in the implementation of the MNCHN strategy in their respective locality.

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.

[15] Chapter I, sec. 2.e – *"The State shall take measures, with the participation of the ICCs/IPs concerned, to protect their rights and guarantee respect for their cultural integrity, and to ensure that members of the ICCs/IPs benefit on an equal footing from the rights and opportunities which national laws and regulations grant to other members of the population"*

Chapter V, sec. 25 – *"The ICC/IP have the right to special measures for the immediate, effective and continuing improvement of their economic and social conditions, including in the areas of employment, vocational training and retraining, housing, sanitation, health and social security. Particular attention shall be paid to the rights and special needs of indigenous women, elderly, youth, children and differently-abled persons. Accordingly, the State shall guarantee the right of ICCs/IPs to government 's basic services which shall include, but not limited to water and electrical facilities, education, health and infrastructure."*

Chapter V, sec. 26 - *The State shall provide full access to education, maternal and child care, health and nutrition, and housing services to indigenous women. Vocational, technical, professional and other forms of training shall be provided to enable these women to fully participate in all aspects of social life. As far as possible, the State shall ensure that indigenous women have access to all services in their own languages.*

Chapter VII, sec. 39 - *The NCIP shall protect and promote the interest and well-being of the ICCs/IPs with due regard to their beliefs, customs, traditions and institutions.*

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:

1. *Maternal Mortality Ratio (MMR),*
2. *Newborn Mortality Rate (NMR),*
3. *Infant Mortality Rate (IMR),*
4. *Under-five Mortality Rate (UFMR); and*
5. *Proportion of underweight 6 to 59-month old children*

Service Coverage Indicators:

1. *Contraceptive Prevalence Rate (CPR),*
2. *Prenatal Care (ANC),*
3. *Facility- based Deliveries (FBD),*
4. *Post-partum Care (PPC),*
5. *Fully Immunized Children (FIC),*
6. *Early initiation of breastfeeding,*
7. *Exclusive breastfeeding from birth up to six (with sustained breastfeeding and complementary feeding); and*
8. *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[16]. *Annex C* is a set of instructions that the LGU can refer to validate data for MNCHN service coverage indicators.

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

Following are some indicators that data may NEED validation for its accuracy:

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

Follow these steps to assess local MNCHN situation:

1. Determine national targets and latest available national levels for MNCHN indicators. Table 2 shows MNCHN Service Coverage indicators while Table 3 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 checking. 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 prenatal 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.

In CAR, on-going consolidation of result is done in all provinces.

Table 2: Evaluation of LGU Performance Using MNCHN Service Coverage Indicators

Column 1	*Column 2*	*Column 3*	*Column 4*
Health Indicators	National Targets[17]	Provincial Target	Provincial Performance
CPR	65.0 (2016)		
ANC	77.8 (2016)		
FBD	90.0 (2016)		
PPC	90.4 (2016)[18]		
FIC	95.0 (2016)		

Table 3: Evaluation of LGU Performance Using MNCHN Health Outcome Indicators[19]

Column 1	*Column 2*	*Column 3*	*Column 4*
Health Indicators	National Targets *(2016)*	Provincial Target	Provincial Performance
MMR	50/100,000 LB		
UFMR	25.5/1,000 LB		
IMR	17/1,000 LB		
NMR	10/1,000 LB		

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

[17] National Objectives for Health 2011-2016, DOH, Manila, July 2012
[18] % of Women with at least 1 Post-partum care visit within 1 week of delivery up to 41 days. National Objectives for Health 2011-2016, DOH, Manila, July 2012
[19] National Objectives for Health 2011-2016, DOH, Manila, July 2012

Following the concept of the LGU scorecard, color codes maybe used to denote increase or decrease in performance or if targets are met or not. For service coverage indicators, put a *green* shade if the LGU performance is above the targets or current national levels, a *yellow* shade if equal and a *red* shade if below the national targets.

A *red* shade indicates that the LGU is performing poorly compared to national data and would need to improve its service provision to attain the desired health outcomes.

Information to assess performance should be obtained from the most updated source. 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

4.2.1. Priority Areas

The MNCHN Team should compare the performance of municipalities and cities with the province using the MNCHN Health Outcome Indicators and MNCHN Service Coverage Indicators as indicated in the Tables 2 and 3 above.

Moreover, MNCHN situation varies from one municipality to another or from one barangay to another. Assessing performance of each municipality or city will allow the LGU to prioritize areas for interventions to improve MNCHN Health Outcomes. This can be done through identifying areas with most number of maternal deaths.

4.2.2. Priority Population Groups

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

1. Women incurring the highest risks during pregnancy *(based on the result of the National Demographic health Survey of 2008):*
    - Pregnant women less than 18 years old
    - Pregnant women above 35 years old
    - Women who had received only up to elementary education
    - Women in the 20 percent poorest households
    - Women in areas of armed or tribal conflict
    - Women who are victims of domestic violence
    - Pregnant women with concurrent chronic illness (iron-deficiency, anemia, tuberculosis, cardio vascular disease, diabetes mellitus, etc)[20]

2. Communities with the following characteristics:
    - Indigenous people's groups (majority of population in Cordillera Administrative Region);
    - Geographically isolated and disadvantaged areas (GIDA) and areas in CAR belonging to the identified 609 municipalities[21] in the country by Department of

[20] National Statistics Office [NSO] & ORC Macro, *National Demographic and Health Survey 2008*.
[21] DBM-DILG-DSWD-NAPC Joint Memorandum Circular No. 1, series of 2012 signed March 8, 2012

Social Welfare and Development (DSWD) and National Anti-Poverty Commission (NAPC). Specifically, these are:

Abra:

- Boliney
- Bucay
- Bucloc
- Daguioman
- Dolores
- La Paz
- Lacub
- Lagangilang
- Licuan-Baay
- Luba
- Malibcong
- Pidigan
- Pilar
- Sallapadan
- San Juan
- Tayum
- Tubo

Apayao:

- Conner
- Luna
- Pudtol

Benguet:

- Bakun
- Kibungan

Ifugao:

- Aguinaldo
- Alfonso-Lista (Potia)
- Banaue
- Hingyon
- Hungduan

Kalinga:

- City of Tabuk
- Lubuagan
- Pasil
- Pinukpuk
- Tanudan
- Tinglayan

Mountain Province:

- Bontoc
- Paracelis
- Sadanga
- Sagada

- Areas at the border/s of LGU which are not usually reached by services;
- Female adolescents (high cases of pregnant women age 19 and below and with high cases of abortions among adolescents)[22];
- Highly urbanized and densely populated areas *(e.g. Baguio City, La Trinidad of Benguet, Tabuk City of Kalinga, Bontoc of Mountain Province, Lagawe of Ifugao and Bangued of Abra).*

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

[22] "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.

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 (SDN):

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.

Private and public health providers should be part of the SDN.

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, the following steps are suggested:

Step 1: It is 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.

Step 2: It 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, prenatal care as well as post-partum 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 communication systems.

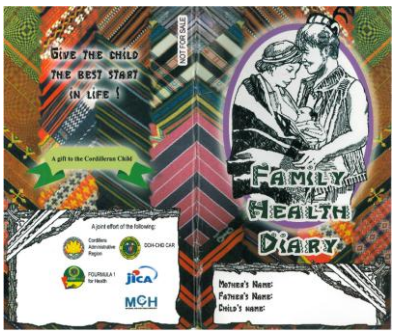
The MNCHN core package of services are to be made available through a network of BHS, RHUs, private clinics and Community Health Teams (CHT) organized in each barangay or *purok* of the locality. ***It is essential that every community identified as a priority group should have a CHT.***

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 or any barangay official identified 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), Barangay Nutrition Workers/Scholars and other volunteer workers including barangay officials and representatives from people's organizations or non-government organizations (NGOs).

   While there are areas defined as remote isolated and can be accessible only by foot before reaching either to the facility or vehicle passable areas, it is suggested that male population will form part of CHT. They can take and carry the pregnant women on foot to the nearest health facility or ambulance, where they can receive much needed maternal care. Example is presented in *Box 4*.

   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 for the 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.



   Specific on MNCHN services, **Family Health Diary** shall

be used by CHT as medium in informing and educating the community as well as monitoring the utilization of services by the mother and children. The diary consists of three parts: Mother's Record, Child's Record and Key Health Messages.

The Barangay Health Stations, manned by the midwife who serves as CHT leader, shall provide the following services:

- Prenatal care
- Post-partum care
- Vaccination and Immunization
- Child care
- Family planning
- Micronutrient supplementation

Moreover, in areas where the pocket of identified priority population is located, birthing service should be installed in nearby BHS making the facility as Birthing Center. The midwife should receive a skills- training on harmonized BEmONC and shall be assisted by her CHT member. Specifically, the BHS shall provide the following services[23] that do not necessarily require BEmONC or CEmONC referral:

- Provision of safe care to a woman in labor including the use of Partograph;
- Active management of the third stage of labor (oxytocin);
- Under the supervision of a Physician, magnesium sulfate be provided for prevention;
- Use of initial dose of antibiotics in prolonged labor, premature rupture of membranes;
- Repair of first and second degree perineal lacerations to control bleeding;
- Internal examination except when the woman has antepartum bleeding;
- Management of retained placenta and uterine atony;
- Intravenous fluid infusion during obstetric emergencies;
- Referral of emergencies that need management by the higher facilities (RHUs and BEmONC or CEmONC hospital);
- Prenatal steroids in preterm labor;
- Newborn care: newborn resuscitation, giving vitamin K and Hepatitis B, oxygen support

The skilled birth attendant *(Doctor, Nurse and Midwife)* may allow the mothers in their preferred position during labor but taking high consideration the safety of both women-in-labor and baby and provision of support system. Facility should be kept clean and sanitized.

Community leaders such as barangay leaders should also be given regular feedback on the 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.

[23] DOH, "Harmonized BEmONC Training for Midwives Trainor's Guide", October 2010.

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.

   It is essential that every community identified as a priority group should have a CHT and each member of CHT can handle at most 20 households.

   Herewith are the specific major functions of CHT as specified at the CHT Guidebook (DOH, 2011):

   a. ***Profiling***

      Basic information on each family member will be collected using the Form 1 from CHT Guidebook to identify which persons in the household are most in need of health care.

      Pregnancy tracking and post-partum tracking reports shall be attached to the consolidated family profile. This can be used in reconciling the entry of Target Client List (TCL) for updating and ensure that all pregnant women and new mothers are recorded and reported accordingly.

   b. ***Orient***

      As navigator, the catchment families will be oriented on the available sources of information that they can get and how they can directly benefit. This will include Family Health Guide and Family Health Diary.

   c. ***Assess***

      Guided with the CHT Manual and Family Health Diary, the navigators will make a health risk assessment of each member of the families in their respective catchment areas. Assessment shall be done specifically on:

      - Prenatal care;
      - Post-partum care;
      - Newborn, infant and child health;
      - Family planning; and
      - Chronic cough management.

   d. ***Inform***

      Using the Family Health Diary, CHT will share key health messages and helpful tips for the families that enable them make decisions about their health as well as accessing services in the health facilities from the professional health personnel. These messages shall include:

      - Development of the baby in mother's womb and reminders to the expectant woman;
      - Things to prepare for birth of the baby including the formulation of Birth and Emergency Plan;
      - Routine baby care;

- Newborn screening;
- Common problems when breastfeeding;
- Feeding recommendations especially to children with diarrhea;
- Vitamin A supplementation and deworming;
- Child developmental milestone;
- An early childhood screening tool;
- Oral health care of pregnant women and children and tooth eruption schedule
- Practical tips to ensure child's safety; and
- Rights of a child.

Moreover, CHT shall ensure that indigenous women have access the appropriate MNCHN Core Package of services in their own languages while protecting their cultural integrity.

e. ***Plan***

CHT shall assist their catchment families in planning their health goals and use of health services. Using the reference materials in the Family Heath Guide and Family Health Diary, CHT member will help choose health service providers in the health facilities and transport options

f. ***Monitor***

Regular monitoring to all catchment families shall be done to check if all identified member of the family have accessed appropriate services in accordance to their need. Specifically to: pregnant women for pre-natal care, new mother for post-partum care and newborn for vaccination, newborn screening and breastfeeding.

This can also help the CHT update the profiling and pregnancy / post-partum tracking.

g. ***Report***

CHT shall periodically accomplish and submit the summary forms in a monthly basis as specified at the CHT Guidebook including the pregnancy and post-partum tracking. The information is very essential in monitoring the overall health status of their communities and making decisions in improving the implementation of health programs.

Specifically, the CHT shall submit the accomplished CHD Mobilization Forms No. 1 to 5 as scheduled below, *regardless if it fall on Sundays, Saturdays and Holidays* :

- CHT to Midwife: every 26th of the month
- Midwife to PHN for validation: every 29th of the month
- PHN to MHO for approval: every 29th of the month
- MHO to PHO and PHTO for consolidation: every 30th of the month
- PHO and PHTO to CHD for consolidated report: every 3rd of succeeding month
- CHD to DOH Central Office: every 5th of succeeding month

It is suggested that community leaders or elders should be involve in organizing, identifying gaps and strengths among CHTs and planning process for specific activities affecting the developmental lives, beliefs, institutions and spiritual well-being of the indigenous community.

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 gives 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 and PhilHealth accreditation status.

   - 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 ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
What type of PhilHealth Accreditation does the facility have?	☐ NONE ☐ Center of Safety ☐ Center of Quality ☐ Center of Excellence ☐ Others: _____	☐ NONE ☐ Center of Safety ☐ Center of Quality ☐ Center of Excellence ☐ Others: _____	☐ NONE ☐ Center of Safety ☐ Center of Quality ☐ Center of Excellence ☐ Others: _____
Who owns the hospital?	☐ LGU ☐ DOH ☐ Private	☐ LGU ☐ DOH ☐ Private	☐ LGU ☐ DOH ☐ Private
Travel time from residence of priority population group?	☐ <30 mins. ☐ ≥30 mins. to 1hr ☐ 1 hr to 2 hrs	☐ <30 mins. ☐ ≥30 mins. to 1hr ☐ 1 hr to 2 hrs	☐ <30 mins. ☐ ≥30 mins. to 1hr ☐ 1 hr to 2 hrs
What is the mode of travel from residence of priority population group to the facility?	☐ Walking ☐ Tricycle ☐ Jeep ☐ Boat ☐ Others_____	☐ Walking ☐ Tricycle ☐ Jeep ☐ Boat ☐ Others_____	☐ Walking ☐ Tricycle ☐ Jeep ☐ Boat ☐ 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 existing capacity to provide for both caesarean operations and Blood Transfusion;

- 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.

Table 5: 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 ☐ NO		☐ YES ☐ NO		☐ YES ☐ NO	
At least 1 anaesthesiologist or GP trained in anesthesiology on call	☐ YES ☐ NO		☐ YES ☐ NO		☐ YES ☐ NO	
At least 1 pediatrician every 8 hours or on call	☐ YES ☐ NO		☐ YES ☐ NO		☐ YES ☐ NO	
1 OR nurse per 8- hour shift	☐ YES ☐ NO		☐ YES ☐ NO		☐ YES ☐ NO	
2 ward nurses per 8-hour shift	☐ YES ☐ NO		☐ YES ☐ NO		☐ YES ☐ NO	
1 medical technologist per 8- hour shift	☐ YES ☐ NO		☐ YES ☐ NO		☐ YES ☐ NO	
Can the hospital perform caesarean operations?	☐ YES ☐ NO		☐ YES ☐ NO		☐ YES ☐ NO	
Can the hospital attend to newborn emergencies?	☐ YES ☐ NO		☐ YES ☐ NO		☐ YES ☐ NO	
Does the hospital have safe blood supply?	☐ YES ☐ NO		☐ YES ☐ NO		☐ YES ☐ 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 (BEmONC) service package is the set of interventions that aim to treat/manage complications of pregnancy which are the major causes of maternal deaths namely haemorrhage, 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) prenatal steroids in preterm labor;

2. Provide newborn screening and emergency newborn services, which include at the minimum: (1) newborn resuscitation; (2) treatment of neonatal sepsis/infection; and (3) oxygen support. Except for RHU BEmONC-functional facilities, blood transfusion should be made available in all hospital-based BEmONC if the facility is found capable. Otherwise, an agreement should be enter with any nearby hospital (*public and private)* for referral to ensure the availability and accessibility of blood transfusion service in the locality.;

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 can follow the below steps to designate the BEmONC-capable network of facilities and providers to update the designation of facilities in the PIPH/Facility Rationalization/Facility Mapping. However, the Local Government Units still have an option to establish, make functional and sustained operation of their existing Rural Health Units, Hospitals and Lying-in Clinic / Barangay Health Units for BEmONC, regardless of distance, to ensure that all areas in the community especially for identified priority population have an access of available and equitable safe pregnancy, full facility-based delivery and post-partum care.

1. Identify priority areas for the designation and establishment 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:

      a. If CEmONC is more than 2 hours away, designate a hospital-based BEmONC with blood services;

      b. If CEmONC is 1-2 hours away, designate stand-alone BEmONC-capable facility or BEmONC with network arrangements; and

      c. 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.

4. Designate Health Facility As BEmONC Provider.

   Designate BEmONC facility/ies from among those that are considered capable. Take note of the following in designating: (a) level of priority according to the identified priority populations' access to the designated BEmONC facility; and (b) recommended type of BEmONC facility for the particular population group.

   If the Municipal LGU, with at most 5,000 populations, has identified two or more BEmONC facilities, the following steps are suggested to select with only ONE BEmONC facility:

   - 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:
   - IUD insertion and removal
   - No-scalpel vasectomy
   - Bilateral tubal ligation
   - 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:
   - Improve capacity of providers in the service delivery network
   - Collaborate with providers in another LGU that is accessible to the priority population group
   - 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.

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).

- *Peace and Order* – refers to aggression, ethnic and other types of conflicts that hinder the women and families to access a quality health care.

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 Municipality: Barangay: Purok:		Remarks
Information		
1. Is there a process to assess health needs of population groups?	☐ Yes ☐ No	
2. Are members of the population groups assisted in preparing health plans that are most appropriate for their health needs?	☐ Yes ☐ No	
3. Are population groups informed as to where to avail of services whether from private or public health providers?	☐ Yes ☐ No	
4. Is there a system that would provide population groups information on good health practices?	☐ Yes ☐ No	
5. Can clients send their feedback about the type and quality of service that they receive from providers?	☐ Yes ☐ No	
Cultural Preferences		
6. Are there any cultural/ethnic group beliefs that prevent the priority population from seeking care for health professionals?	☐ Yes ☐ No	
Time		
7. Can clients avail of services at a time that is most convenient for them?	☐ Yes ☐ 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 ☐ No	
Capacity to Pay		
9. Are members of the population groups able to pay for the cost of outpatient services from the BHS/RHU/ Hospital?	☐ Yes ☐ No	
10. Are members of the population groups able to pay for the cost of inpatient services from BEmONC or CEmONC-capable facilities?	☐ Yes ☐ 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 ☐ No	
Peace and Order		
12. Are there any plan of action to protect from coercion/conflict and assist the families to access quality health care from the professional health personnel in the facility?	☐ Yes ☐ 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.

While the Indigenous People's Republic Act clearly state that Indigenous community have the right to practice and revitalize their own cultural traditions and custom *(Chap. VI, sec. 31 of IPRA 8371)*, CHTs should intensified the information and education activities at the community level on the opportunities and benefits on accessing quality health care from the Professional Health Personnel within the appropriate standard of health service delivery towards saving their lives. Community leader or elders should be involved from planning phase of IEC activities to implementation to ensure that cultural integrity is well protected.

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.

On intervention for time of the client to access quality health care from the health service providers, the CHT can assist the concerned family on formulating and finalize the Emergency and Birth Plan (page 13 of Family Health Diary) where a line is clearly indicated on "person to care to look after the other children while the mother is in the health facility". This will also serve for other concerns of the clients such as livestock, farm and others.

Moreover, the Emergency and Birth Plan also outlined the preparation for mode of payment of the expectant mother. If the mother is identified as indigent but not enrolled to PhilHealth, the family concern shall be indorsed to the Municipal Social Welfare and Development Office (MSWDO) for possible inclusion to the PhilHealth Sponsorship Program. Other possibilities on financing preparation of the clients are daily savings, community-based cost sharing through PESO for Health, and other mechanism that identified by the local level.

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 suggested 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 systems in the area for:
   2.1 Transportation:
   - 2.1.1 Private transportation. These may include tractors with trailers, reconditioned vehicles and even farm carts. Private motorcycle can be mobilized if it has available platforms or trailers.
   - 2.1.2 Public transportation:
     - e) Jeepneys
     - f) Motorboats/ *Bancas*
     - g) Bicycles with trailers

h) tricycles with platform
i) Any other publicly operated vehicles.

2.2 Communication:

a) Mobile phone/Cellphone
b) 2-way radio; and
c) Other mode of communication identified by the locality.

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:
    - Provincial and/or Municipal IRA
    - 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 to 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. 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.

4. 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.

5. 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.

6. 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, prenatal 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, post-partum 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 if needed.

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.

7. Assess the sustaining functionality of the CHTs due to lack of incentives and disincentives. Considering the community-based health workers are volunteer-in-nature, a mechanism on taking their motivation to continue their work is robust support from the local government units, local health managers and the community. Example incentives for CHTs:
   a. Monetary
      - Honorarium from the Provincial Government Unit, Municipal Government Unit and Barangay;
      - Share from user's fee; and
      - Share from PhilHealth-capitation fund and MCP reimbursement.
   b. Free access of medical care from the government-owned health facilities;
   c. Attendance to training, seminars and workshops specifically designed for the CHT members.

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						
Training needed						
Equipment and Infrastructure Requirements						
Logistics and Supplies Requirements						

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, manual and guidebooks that can assist CHTs in performing their duties such as the Family Health Diary, 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.

    - List down appropriate interventions across gaps identified in Column 2 of Table 7 above.

    - Next, determine the target time frame for the start and completion of proposed interventions in Column 3 of Table 7 above.

    - 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 pediatrician (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						
Training needed						
Equipment and Infrastructure Requirements						
Logistics and Supplies Requirements						

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 facility and birthing Center 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 lying-in clinics should composed of 1 doctor, 1 nurse, 1 midwife, 1 medical technologist on call

    - BHS /birthing center 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 and Birthing Center

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

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						
Training needed						
Equipment and Infrastructure Requirements						
Logistics and Supplies Requirements						

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 Projected service loads and proportion of target population to general population in patient census
	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 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 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

7. Improve Local Health System

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) of Philippine Health Insurance Corporation (PhilHealth) especially the poor

4. Accreditation of hospitals and facilities such as RHUs, BHS, lying in clinics or birthing centers or other outpatient clinics and health providers by the PhilHealth;

5. Certification of health facilities (hospitals, RHUs and Lying-in clinics) for BEmONC by the Center of Health Development

6. Licensing of Birthing Facilities (Barangay Health Stations and Private Birthing Clinics) by the Center of Health Development;

7. Local budget for health

8. 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

9. Functional procurement and logistics management information system

10. Emergency transport and communication systems especially for priority populations

11. 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:

a) vision of what the LGU wants to achieve such as reducing maternal death;
b) involvement of all stakeholders in the locality and coordination mechanism to synchronize their actions;
c) monitoring system to assess progress;
d) health information system to gather necessary data;
e) system that would continuously improve capacity of health human resource;
f) functional procurement and logistics management system to ensure availability of supplies in health facilities;
g) health promotion and BCC to increase demand, improve feedback and sustain support for programs;
h) 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 Inter-local Health Zone Plan, Provincial-wide Investment Plan for Health Plan (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 such as BEmONC, 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 ILHZ-wide, 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; and
(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, prenatal 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:

a) Generate resources to fund critical investment requirements; and
b) 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
- ❖ Mobilization of external resources
- ❖ Cost recovery schemes
- ❖ 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.

Funds can also be pooled through Inter-local Heath Zone through their Common Health Trust Fund. It will serve as funding source to comply the requirements for MNCHN Strategy for the health facilities within the member LGUs of the zone such as purchase of equipment, infrastructure to meet the standard for BEmONC and

DOH Licensing for birthing centers and PhilHealth-MCP accreditation.

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:

i. The Municipal Development Fund Office (MDFO)

ii. 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
Telephone Nos.: (632) 525-9186 or 523-9936 to 37 or 5259186-87
email address: mdfo@dof.gov.ph .

Development banks such as the Development Bank of the Philippines and the Land Bank 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
- 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, PPC, 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
- Minimize cost

❖ *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. Enroll the indigent population to PhilHealth

LGUs should enroll 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 Maternity Care Package, PCB 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:
        (d) Health personnel;
        (e) Drugs, medicines, commodities and supplies; and
        (f) 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; and
    (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.

❖ *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:

i. 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;
ii. 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;
iii. 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

❖ *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:

i. 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.

ii. 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.

iii. 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.

iv. 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, 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; and
   (d) establish a reporting and monitoring system linked to the DOH which will provide the DOH the information for re-supply.

❖ *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.

i. 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.

ii. 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: Inter-local Cooperation

Inter-local 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 enroll 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 II

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), Prenatal Care (ANC), Facility Based Deliveries (FBD), Post-partum care (PPC), 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:
   (a) Improving capacity of personnel;
   (b) Enhancement of infrastructure and equipment of facilities; and
   (c) 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, PPC, early initiation of breastfeeding and FIC can be provided monthly by all public health facilities.

2. Maternal and Newborn Death Reviews (MNDR)

The Maternal and Newborn Death Review (MNDR) 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 MNDR in accordance to the protocol:

- Report as soon as the event occurs to the Municipal Health Office.
- Accomplished tools on maternal and neonatal deaths should be submitted to the Provincial Health Office (PHO) by the concerned Municipal Heath Office
- 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 gynecologist and pediatrician 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; and
   - Provide appropriate needed technical assistance to the MNCHN implementors.

   Ideally, the team from LGU shall compose with:

   a) Provincial Health Officer
   b) Provincial MNCHN Coordinator
   c) Municipal Health Officer
   d) Representative from the Center for Health Development
   e) Representative from the Public Hospital
   f) Representative from the Private Hospital, if available
   g) Representative from PhilHealth
   h) Representative from NCIP; and
   i) Representative from NGOs/POs

   In some areas, the Mayor leads the team at the municipal level while the Governor for the

provincial level.

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.

PART III: Support of National Agencies

Chapter 9: *Role of National Agencies*

Chapter 10: *Monitoring the Implementation of the MNCHN Strategy*

9. Role of National Agencies

There are at least three national agencies that directly provide LGUs support for the implementation of the Localized MNCHN Strategy, especially in areas with IPs community:

- Department of Health
- Philippine Health Insurance Corporation; and
- National Commission for Indigenous People.

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 and Newborn Death Review (MNDR);

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 Grant 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 centers 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 Regional 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. Assist and provide certification for identified BEmONC-functional facilities in the locality as guided in DOH-A.O.#2011-0014 (Guidelines on the Certification of Health Facilities with basic Emergency Obstetric and Newborn Care Capacity) as reflected at *Annex O* through:
    a. Promotion to apply certification for their BEmONC-functional facilities;
    b. Assess the identified BEmONC-functional facilities within the acceptable standard requirements of DOH;
    c. Coordinate with DOH-recognized BEmONC training centers for BEmONC Post-Training Evaluation;
    d. Provide technical assistance to LGUs to meet and comply the standard for BEmONC Certification in accordance with DOH requirements;
    e. Facilitate the approval of LGUs application to BEmONC Certification for their identified health facilities.

10. Assist and provide license to LGUs' identified Birthing Centers.

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/RHUs/Birthing Center clerks and 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. National Commission for Indigenous People

The National Commission for Indigenous People (NCIP) shall serve as liaison between the Department of Health, Center for Health Development and the indigenous community pertaining legal matters in the implementation of MNCHN Strategy to ensure the cultural rights, beliefs and tradition of the indigenous peoples.

9.4. Management Arrangements

Managing the implementation of the MNCHN Strategy can be divided into 4 components, 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.

All provinces are encouraged to develop their own management arrangement in reference to the above mechanism. It should be clearly reflected in their Provincial and Municipal MNCHN Executive Orders.

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:**
  - (a) Maternal Mortality Ratio
  - (b) Neonatal Mortality Rate
  - (c) Infant Mortality Rate
  - (d) Under Five Mortality Rate

- **Service Coverage Indicators:**
  - (a) Contraceptive Prevalence Rate
  - (b) Prenatal Care
  - (c) Facility-Based Deliveries
  - (d) Post-partum Care
  - (e) Early initiation of breastfeeding
  - (f) 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 and Newborn Death Tracking

Reduction of maternal mortality and Newborn Mortality are among the goals of the MNCHN Strategy. The DOH shall track maternal and newborn deaths by having CHDs report occurrence of deaths in their localities.

The CHDs should ensure that the province and involved providers conduct Maternal and Newborn Death Reviews (MDR) of all deaths occurring in the region in accordance to the DOH acceptable protocol. MNDR 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, deployed and functional.
2. Number of CEmONCs designated, capacitated, made functional and accredited
3. Number of BEmONCs- designated, capacitated, made functional and accredited
4. Number of BHS-Birthing Centers-designated, capacitated, made functional and licensed
5. Number of Facilities for Safe Blood Supply designated/established
6. 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									
BHS – Birthing Center									
Private Birthing Clinics									
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									
BHS-Birthing Center									
Private Birthing Clinics									
Transportation and Communication System									
Safe Blood Supply Network									
Blood Center									
Blood Collection Unit									
Blood Station									
Blood Bank									

Table 13: MNCHN Monitoring Tool for DOH-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									
BHS-Birthing Center									
Private Birthing Clinics									
Transportation and Communication System									
Safe Blood Supply Network									
Blood Center									
Blood Collection Unit									
Blood Station									
Blood Bank									

ANNEXES

Annex A: A.O.#2008-0029 (Implementing Health Reforms for Rapid Reduction of Maternal and Neonatal Mortality

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

Annex C: Data Validation of MNCHN Service Coverage Indicators

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

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Annex G: Sample on Current Status on MNCHN Provider Competencies Necessary for Adequate Delivery of MNCHN Core Package of Services (Selected Municipalities from the Province of Abra, Cordillera Administrative Region)

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Annex P: Micronutrients Supplementation – Highlights from the Manual of Operation

Annex Q: DOH-A.O. 34-A s. 2000 – Adolescent and Youth Policy

Annex A: A.O.#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: (i) safer sex and prevention of HIV/STIs (ii) smoking cessation (iii) healthy diet and nutrition (iv) physical activity; (v) Adolescent and youth health services including peer and professional counseling and	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 Prenatal 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	X	X	X
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
Prenatal administration of steroids in preterm labor		X	X
IEC/Counseling on FP methods especially LAM	X	X	X
IEC/Counseling on Healthy Lifestyle: (i) safer sex and HIV/STI prevention (ii) smoking cessation (iii) 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		
Prenatal 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
Clean and Safe Delivery		X	X
Monitoring progress of labor using		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

Delivery	Community - Level Provider	BEmONC- *capable* Facility	CEmONC - *Capable* Facility
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
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 capable hospital based BEmONC)	X
Care of the preterm babies and/or low birth weight babies			X
Counseling and Provision of BTL services		X	X
Removal of retained products of conception		X	X

Post-partum	Community - Level Provider	BEmONC- *capable* Facility	CEmONC - *Capable* Facility
Identification of early signs and symptoms of post-partum complications:			
Maternal problems: hemorrhage, infection and hypertension		X	X
Maternal Nutrition Iron/folate Vitamin Aiodine Deworming tablet: Mebendazole or Albendazole 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: (i) Safer sex and HIV/STI prevention (ii) smoking cessation; (iii) healthy diet and nutrition; and (iv) 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 Removal of retained products of conception 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) - Dry and provide warmth to the baby - Do skin to skin contact - Do delayed or non-immediate cord clamping - Provide support for initiation of breastfeeding - Provide additional care for small baby or twin - Reposition, suction and ventilate *(if after 30 secs of thorough drying, newborn is not breathing or is gasping)* - 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) - Vitamin K prophylaxis - Inject Hepatitis B and BCG vaccinations at birth - Examine the baby - Check for birth injuries, malformations, or defects - Properly timed cord clamping and cutting - Provide additional care for a small baby or twin		X	X
Care Prior to Discharge *(but after the first 90 mins)* - Support unrestricted, per demand breastfeeding, day and - Night - Ensure warmth of the baby - Washing and bathing (Hygiene) - Look for danger signs and start resuscitation, if necessary, keep warm, give first 2 doses of IM antibiotics, give oxygen - Look for signs of jaundice and local infection - Provide instructions on discharge - Perform newborn screening (blood spot) and newborn hearing screening (if available in the facility or known service delivery network)		X	X
Emergency Newborn Care - Ensure adequate oxygen supply - 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 Prenatal 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 the oldest data recorded on current users and do a recomputation if a different formula was applied.
Current Users (current month) =			
Current Users (as of end of previous month) + (plus) New Acceptors: (New user) of the Previous Month + (plus) Other Acceptors (Changed Method, Changed Clinic & Restart) of Current Month - (minus) Drop-Outs (Current Month)			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

ASSESSMENT QUESTIONS for FP Current Users	Yes	No	IF NO
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- inserted			
c.3 Client did not return on the scheduled date of follow-up visit 3-6			
d. **Condom** – client is considered a drop-out if she/he fails to return for resupply on			

ASSESSMENT QUESTIONS for FP Current Users	Yes	No	IF NO
e. **LAM** – client is considered a drop- out if any of the three (3) conditions are <u>not met</u>, as follows:			
e.1 Mother has no menstruation or is amenorrheic within six months. Spotting or bleeding during the last fifty-six (56) days post-partum 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			
NFP *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. *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 <u>NOTE:</u> • 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**. • An **'autonomous user'** can be considered a current user as these clients no longer need assistance in charting from the health workers. 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.

ASSESSMENT QUESTIONS for FP Current Users	Yes	No	IF NO
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? 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?			If column 6 (LMP/G-P) of TCL for prenatal care is not filled up, check if terms are understood LMP – last menstrual period which is important to compute for the expected date of confinement 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 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

Assessment Guide for 4 ANC	Yes	No	If No
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 □ 1st trimester – first 3 months (*up to 12 weeks or 0-84 days*) □ 2nd trimester – middle 3 months (*13-27 weeks or 85-189 days*)			*(Note: This is critical for midwives to review so that they can advise their client of the needed birth plan prior to the EDC)* If dates of visit do not correspond to the trimesters of pregnancy (i.e. if consultations were done beyond the period of the trimester), then take out this entry from the total number of women with 4ANC. 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. 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. Ensure that reporting of the pregnant woman with 4ANC is done on the month when the pregnant woman completed the "1-1-2 rule". 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")
□ 3rd trimester - last 3 months (28 wks& more or 190 days & more) For a pregnant woman to be counted as provided with 4 prenatal care, the schedule of prenatal care/visits should be at least: □ 1 during the 1st trimester □ 1 during the 2nd trimester □ 2 during the 3rd trimester			

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 Date Terminated – month, day and year current pregnancy is terminated Outcome – pregnancy outcome maybe, livebirth (LB) Stillbirth (SB) or Abortion (AB) (Note: It is possible to have more than 2 codes (Livebirth, Stillbirth or Abortion) appearing in the outcome due to multiple births.) *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 Codes: Types of Delivery - NSD – Normal spontaneous delivery - Others – Caesarian Section or forceps Place of Delivery - 1 = Home - 2 = Hospitals (hospitals, RHUs and birthing facilities both public and private) - 3 = Others Attended by - A = doctor - B = nurse - C = midwife - D = Hilot/TBA - E = Others

Assessment Guide for FDB and SBA	Yes	No	If No
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: -Doctor -Nurse -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. Identify and count births/deliveries that are registered but not recorded in the TCL 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. **Note:** 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. 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. 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 Check entry in column 12 (Date fully immunized) The date entered should be the same date with the date the last antigen (anti- measles) was given Check age of child when last dose of scheduled immunization (DPT 3, Polio3, Hepa B3 and

Assessment Guide for FIC	Yes	No	If No
For a child to be counted as fully immunized child, the child has received ALL of the following: *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* 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 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 (i.e. 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 baby

    b. Summary Table (**ST**)

    c. Monthly Form (**M1**)

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

    d. 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 1^{st}, 2^{nd}, 3^{rd}, 4^{th}, 5^{th}. The check mark indicates that the infant is exclusively breastfed for that period/age 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 Only when the infant reaches 6 months of age and has been exclusively breastfed from 1^{st} to the 6^{th} 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) 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 Check if date indicated is within the 6^{th} 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 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 seen8. Revise **Q1** report based on the results of the data cleaning and submit to PHO/CHD

<u>For Garantisadong Pambata Vitamin A Supplementation</u>

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

Assessment Guide for Vitamin A Supplementation	**Yes**	**No**	**If No**
Is the reported number of 6-59 months old children given GP Vitamin A consistent with the list of 6-59 months old children? **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 Check if the list of children given Vitamin A is within the target group of: A. 6-11 months B. 12-59 months 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. 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. 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. Formula: □ 6-11 months = total population x 1.35% □ 12-59 months = total population x 10.8%
Is the target group disaggregated by age: □ 6-11 months □ 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 Children who were missed should be followed up and given Vitamin A 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 RISK ASSESSMENT FORM

Name of Head of Family: *(Last name, First Name)*					Household No.		
Name of CHT Member: *(Last name, First Name)*					Date:		
A	**B**	**C**	**D**	**E**	**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							
	(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: - Diarrhea (watery/bloody) - Dehydration (sunken fontanelles, dry lips and mouth etc.) - Frequent cough and colds - Breathing fast (more than 50-60 breaths/minute) - Difficulty in feeding (less than 5x in 24 hours)_ - Pus in the eyes - Yellowing of the skin - Convulsion - Foul-smelling discharge from the cord - Fever - Body rashes	Early detection of childhood illnesses and early referral to a health service provider can help save your child's life. A sick child needs to be seen immediately by a health provider to prevent complications and even death. NOTE: Prepare a sick child plan and prioritize immediate referral to a health provider; Navigator may accompany the parents to the health provider. Give health messages on symptoms and simple home management of sick infants.

A	B	C	D	E	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. A sick newborn/infant needs to be seen immediately by a health provider to prevent complications and even
2	Is he/she being immunized?						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.

A	B	C	D	E	F	G	H
Q #	**Screening Questions**	**YES**	**NO**	**Don't Know**	**Follow-up Questions**	**Health Risks Identified**	**Health Messages to Emphasize**
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) 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: - High fever >2 days - Convulsion - Diarrhea (watery/bloody) - Frequent cough/colds - Malnutrition - Severe vomiting - Nose bleeding - Difficulty in breathing - Laceration/deep wounds - Falls/accidents - Snake bite/animal bite - Burn - Poisoning - Presence of parasites [ ] with sick child/children <5 years old who may have TB and needs immediate medical attention, as follows: - recurring fever - wound in the neck that does not heal -weight loss	Early detection of childhood illnesses and early referral to a health service provider can help save your child's life. A sick child needs to be seen immediately by a health provider to prevent complications and even death. NOTE: Prepare a sick child plan and prioritize immediate referral to a health provider; Navigator may accompany the parents to the health provider. Give health messages on symptoms and simple home management of sick infants.
8	Was your child weighed during the last OPT? List names:	═══	═══	═══	If YES, are any of your children underweight? _____ YES _____ NO	[ ] with a child who is not regularly weighed [ ] 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.					[ ] 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.					[ ] 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.** 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: Swelling of the legs, hands, and/or face Severe headache, dizziness, blurring of vision - Vaginal bleeding - Pale Skin - Vomiting - Convulsion - Difficulty in breathing - Fever and chills - Too weak to get out of bed - Severe abdominal pain - Foul-smelling/watery vaginal discharge - Painful urination - 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 1st trimester? _ 2nd trimester? _ 3rd trimester? _	[ ] 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? TT1 _____ TT2 _____ TT3 _____ TT4_____	[ ] no or incomplete tetanus toxoid in the past and/or present pregnancy	Receiving tetanus toxoid will prevent Neonatal tetanus. *(Recommended schedule of TT:* *TT1-as early as possible during pregnancy* *TT2- at least 4 weeks later* *TT3- at least 6 months later* *TT4- at least 1 year later)*
17	Do you plan to deliver your baby in a health facility?				If NO/DON'T KNOW, why? ( ) No money ( ) Safer/more convenient at home ( ) far from health facility ( )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? - painful /uncomfortable - formula milk will make my baby smarter - will destroy my breasts - 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. 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? ( ) No money ( ) far from health facility ( ) not a common practice	[ ] most likely will not have post-partum checkup 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? ( ) No money ( ) far from health facility ( ) fear of complications ( ) lack of awareness ( ) 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? ( ) No money ( ) far from health facility ( ) 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	E	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) NATURAL FP (_____Cervi Mucus; _____Basal Body Temp; _____Symptothermal; _____SDM; _____LAM) _____Condom; _____Injectable;_____				If NO, why? ( ) Afraid of side-effects ( )costly ( ) far from health provider ( )don't know where to avail ( ) religious beliefs ( ) lack of awareness	[ ] no modern method of family planning used	any myths and misconceptions on FP) Correct use of modern FP methods can help you space births properly.
28	Are you using the method regularly?				If NO, why? ( ) Stopped due side-effects ( )costly ( ) far from health provider ( ) 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 of CHT Member: *(Last name, First Name)*		Date:
Part 1:		
Health Risk / Consequence Identified	**Health Needs**	**Recommendations**
[ ] Mother is currently pregnant	[ ] Pre-natal check up	You need to develop a birth pan
[ ] 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 post-partum 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 misconception 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		
[ ] congenital anomalies that will lead to mental retardation may not be detected and corrected early	[ ] newborn screening for the baby	
REPRODUCTIVE HEALTH / FAMILY PLANNING		
[ ] mother has more than 4 pregnancies	[ ] appropriate FP counseling	You need to develop a reproductive health plan
[ ] family has no definite plan or had a mistimed or unplanned pregnancy	[ ] a appropriate FP method assed 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 birth	
[ ] 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 breastfeed	[ ] 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	
[ ] 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 for, 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.

	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*	*Brgy Multicab*
	R.Lopez	*0910xxxxxx*	*Single Motorcycle (private)*

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).

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 1: To be filled out by the couple with the assistance of the navigator			
A	Name of the Child *(Last name, First Name)* *Soriano, M.*		Date of Birth *(MM/DD/YY)* *Feb. 14, 2007*
	Name of the Mother *(Last name, First Name)* *Soriano, G.*		Age *(in years)* *23*
	Name of the Father *(Last name, First Name)* *Soriano, L.*		Age *(in years)* *25*
	Name of the Navigator *(Last name, First Name)* *Soriano, G.*		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
	[ ] 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***
F	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/follow 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)* *Solis, C.*			Date of Birth: *(MM/DD/YY)* *January 4, 2009*
	Name of Mother: *(Last name, First name)* *Solis, M.*			Age: *(in years)* *26*
	Name of Father: *(Last name, First name)*			Age: *(in years)* *28*
	Name of Navigator:*(Last name, First name)* *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 post-partum 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

<table>
<tr><td colspan="4">BIRTH PLAN</td></tr>
<tr><td colspan="4">Part I: To be filled out by the couple with the assistance of the navigator</td></tr>
<tr><td rowspan="4">A</td><td colspan="2">Name of Mother: (Last name, First name)
Rosario, G.</td><td>Age: (in years)
23</td></tr>
<tr><td colspan="2">Name of Husband: (Last name, First name)
Rosario, L.</td><td>Age: (in years)
25</td></tr>
<tr><td colspan="2">Name of Navigator:(Last name, First name)
Cruz, D.</td><td>GMP Family No.:
123</td></tr>
<tr><td>Referred to Health Provider (indicate name of Midwife, Nurse or Doctor)
Anita R.</td><td>Scheduled date of consult:

(MM/DD/YY) Feb 20, 2009</td><td>Reason for referral:
[x] For Pre-natal services
[ ] for post-partum care</td></tr>
<tr><td rowspan="3">B</td><td>Health goals: (pls. check)
[x] to have monthly pre-natal check up (at least 4 visits);
[x] at least 1 visit during the1st trimester;
[x] at least 1 visit during the 2nd trimester;
[x] at least 2 visits in the 3rd trimester</td><td>To have baby delivered by:
[ ] physician
[ ] nurse
[x] midwife</td><td>[x] to deliver in a health facility</td></tr>
<tr><td>[x] to receive post-partum care</td><td>[x] to have our baby receive newborn screening</td><td>[ ] others, pls. specify:</td></tr>
<tr><td>[ ] to receive FP Counseling / services</td><td></td><td></td></tr>
</table>

Part II: To be filled by health provider (midwife, nurse or doctor)			
C	Provider for Prenatal/Post-partum care: Anita Reyes		Date of 1st PPC visit: *(MM/DD/YY) Feb 19, 2009* Date of 2nd PPC visit: Date of 3rd PPC visit: Date of 4th PPC 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? Midwife	*Where will I deliver? HealthCenter	
	*How much should I prepare? 3,000.00	*Who will accompany me? Husband & Navigator Who will take care of the children? 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)* *Gomez, R.*		Age: *(in years)* *27*
	Name of Husband: *(Last name, First name)* *Gomez, R.*		Age: *(in years)* *30*
	Name of Navigator:*(Last name, First name)* *Montes, L.*		GMP Family No.: *456*
	Referred to: *(indicate name of Midwife, Nurse or Doctor) J. Martinez*	Scheduled Date of Consult: *(MM/DD/YY)* *February 6, 2009*	Reason for referral: [x] For FP counseling [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): *J. Martinez*		Date of Initial Visit: *(MM/DD/YY)* *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		
	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
8) Mother and Child Book in this format: MM/DD/YY
9) 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.
10) 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
11) 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
12) Column H- Indicate any event/factors relevant to the family/family's health use plans.
13) 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	PPC	PPC 1- 2/20/09 PPC 2- PPC 3- PPC 4- *(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: Sample on Current Status on MNCHN Provider Competencies Necessary for Adequate Delivery of MNCHN Core Package of Services (Selected Municipalities from the Province of Abra, Cordillera Administrative Region)

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.

Province of Abra (selected municipalities only)

A. PRE-PREGNANCY

Services	**COMPETENCIES**	**Community Level Provider (Manabo RHU)**	**Community Level Provider (San Quintin, BHS)**	**BEmONC-capable facilities (Sam Quintin, RHU)**	**Community Level Provider (Bangued, RHU)**	**Community Level Provider (Langiden, RHU)**	**Community Level Provider (Tayum, RHU)**
Assessment of health needs of women, mothers and children	Able to assess health needs and assist clients in filling up health plans	✓	✓	✓	✓	✓	✓
FP services: 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	✓	✓	✓	✓	✓	✓
	Basic and comprehensive Knowledge on modern methods of FP and managing side effects	✓					
	Able to encourage and empower patient to						

Services	COMPETENCIES	Community Level Provider (Manabo RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
	make an informed decision	✓					
2. Provision of FP services: Pills, DMPA, condom, NFP	Able to discuss with the patient the most appropriate FP method	✓	✓	✓	✓	✓	✓
○ IUD ○ BTL ○ NSV ○ Management of complications resulting from FP	Able to properly insert IUD	X ✓	✓	✓	x	x	✓
	Able to perform surgical sterilization (BTL,NSV)					x	x
	Management of complications resulting from FP	✓	✓	✓	✓	x	✓
Women's/maternal health, nutrition, and micronutrient supplementation	Knowledge on reproductive health	✓	✓	✓	✓	✓	✓
	Able to measure height and weight, and identify malnutrition or obesity (BMI)	✓	✓	✓	✓	✓	✓
	Knowledge and able to counsel on Basic Nutrition	✓	✓	✓	✓	✓	✓
	Familiarity with dosing, timing , and benefits of iron, folate, Vitamin A, calcium, and iodine supplementation	✓	✓	✓	✓	✓	✓
	Maternal Mortality tracking	✓	✓	✓	✓	✓	✓
Tetanus toxoid immunization	Knowledge on timing, dose, and method of vaccine administration	✓	✓	✓	✓	✓	✓
IEC/Counseling on health caring and seeking behavior	Able to counsel patients on when to consult provider	✓	✓	✓	✓	✓	✓
Updated master listing of women of reproductive age	Data collection, organization, consolidation	✓	✓	✓	✓	✓	✓

B. PREGNANCY/PRENATAL

Services	COMPETENCIES	Community Level Provider (Manabo RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
Maternal health, nutrition, and micronutrient supplementation	Prenatal maternal care	✓	✓	✓	✓	✓	✓
	Able to measure height and weight, and identify malnutrition or obesity (BMI)	✓	✓	✓	✓	✓	✓
	Able to counsel patient on proper nutrition	✓	✓	✓	✓	✓	✓
	Knowledge on maternal nutritional needs during the prenatal period	✓ ✓	✓	✓	✓	✓	✓
	Familiarity with dosing, timing , and benefits of iron/folate, therapeutic dose of Vitamin A (i.e. xerophthalmia), and iodine supplementation						
Tetanus toxoid immunization	Knowledge on timing, dose, and method of vaccine administration	✓	✓	✓	✓	✓	✓
Deworming	Healthy lifestyle promotion able to explain its importance to pregnant woman	✓	✓	✓	✓	✓	✓
Counseling on healthy lifestyle · Safer sex and STI/HIV prevention · smoking cessation · healthy diet and nutrition · physical activity · alcohol intake	Able to counsel patients on importance of healthy lifestyle for the pregnant woman	✓	✓	✓	✓	✓	✓
	Able to explain thoroughly the effects of poor nutrition, smoking, and alcohol on the development of the fetus	✓	✓	✓	✓	✓	✓
	Knowledge on prevention of STI/HIV/AIDS	✓	✓	✓	✓	✓	✓

Services	**COMPETENCIES**	**Community Level Provider (Manabo RHU)**	**Community Level Provider (San Quintin, BHS)**	**BEmONC-capable facilities (Sam Quintin, RHU)**	**Community Level Provider (Bangued, RHU)**	**Community Level Provider (Langiden, RHU)**	**Community Level Provider (Tayum, RHU)**
	Able to counsel patients on when to consult provider	✓	✓	✓	✓	✓	✓
Counseling on health caring and seeking behavior	Knowledge on modern methods of FP and managing side effects	✓	✓	✓	✓	✓	✓
Counseling on FP especially LAM; birth spacing, contraception, return to fertility	Able to discuss with the patient the most appropriate method for her	✓	✓	✓	✓	✓	✓
	Able to thoroughly discuss the benefits of LAM	✓	✓	✓	✓	✓	✓
	Gender sensitivity	✓	✓	✓	✓	✓	✓
	Knowledge of, recognition and identification of danger signs and complications of pregnancy	✓	✓	✓	✓	✓	✓
Early detection of danger signs and complication of pregnancy	Knowledge of, recognition and identification, and management of danger signs and complications of pregnancy	✓	✓	✓	✓	✓	✓
	Able to refer patients to the proper provider for management	✓	✓	✓	✓	✓	✓
Administration of steroids in preterm labor	Knowledge of the timing and dose of steroid administration in preterm labor	X	✓	✓	✓	✓	x
Support Services: 1. Prenatal registration with Mother-Child Book 2. Birth Plan 3. Home visit and follow-up	Able to track pregnancy and assist women with birth planning using MCB and able to collect necessary information	✓	✓	✓	✓		✓
	Familiarity with timing of prenatal visits and able to discuss follow-up schedule	✓	✓	✓	✓		✓
4. Safe blood supply 5. Support from community	Advising patient on importance of regular check-ups	✓	✓	✓	✓	✓	✓

Services	COMPETENCIES	Community Level Provider (Manabo RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
(e.g. pregnant women) 6. Birth registration/ registration of women in reproductive age	Ensure presence of social support for patient	✓	✓	✓	✓	✓	✓
	Civil registration of maternal death using the Maternal Death Reporting form	✓	✓	✓	✓	✓	✓
	Organizing outreach activities and community-based blood donation activities as necessary	x	✓	✓	x	✓	✓
	Make preparations for obtaining safe blood supply for patient	x	✓	✓	x	✓	x
Diagnostic/Screening Tests · CBC · Blood typing · Urinalysis · VDRL or RPR · HBsAg · OGCT · Pregnancy Test · Cervical cancer screening using VIA or pap smear · Oral health	Pap smear and visual inspection acetic acid (VIA) wash technique	x	x	x	x	x	x
	Knowledge of the essential diagnostic and screening tests	✓	✓	✓	✓	x	✓
	Able to request that the patient take these tests at the appropriate time (from outside laboratory if not available in their facility)	✓	✓	✓	✓	✓	✓
	Interpretation of laboratory results or refer to one able to do so		✓	✓	✓	✓	✓
1. Screening for adequacy of fetal growth 2. Assessment of fetal well-being and prediction of fetal compromise	Knowledge on normal progress of pregnancy and signs of maternal and/ fetal complications	✓	✓	✓	✓	✓	✓
	Able to examine all necessary parameters and record and monitor maternal and fetal well-being throughout pregnancy	✓	✓	✓	✓	✓	✓
	Performance of Leopold's maneuvers to estimate fetal growth and determine adequacy for gestational age	✓	✓	✓	✓	✓	✓

Services	COMPETENCIES	Community Level Provider (Manabo RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
	Knowledge of normal fetal parameters	✓	✓	✓	✓		✓
	Can auscultate fetal heart tones	✓	✓	✓	✓	✓	✓
	Referral to higher-level /specialty facility if complicated	✓	✓	✓	✓	✓	✓
3. Prenatal diagnosis of congenital anomalies	o Knowledge on ideal timing of prenatal ultrasound to detect congenital abnormalities o Able to perform congenital anomaly ultrasound scan and interpret it o Able to provide appropriate prenatal counselling	x	✓		X X ✓	X X	X

C. LABOR AND DELIVERY

INTERVENTIONS	COMPETENCIES	Community Level Provider (Manabo RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
Diagnosis of labor	Knowledge of criteria of diagnosis of labor	✓	✓	✓	✓	✓	✓
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	✓	✓	✓	✓	✓
Clean and Safe Delivery Monitoring progress of labor	o Knowledgeable about the use of the WHO partograph;	✓	✓	✓	✓	✓	✓

INTERVENTIONS	COMPETENCIES	Community Level Provider (Manabo RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
using partograph	○ knows when to refer based on the partograph recording						
1. Identification of early signs and symptoms and management of abnormalities ○ preterm labor ○ hypertension ○ bleeding; ○ infection ○ malpresentation; ○ prolonged labor;	○ Familiarity of signs and symptoms of abnormalities/ complications of labor; ○ Ability to refer complicated cases to appropriate provider	X ✓	✓	✓	✓	✓	✓
2. Monitoring maternal and fetal well-being during labor	Knowledgeable of normal parameters of fetal well-being	✓	✓	✓	✓	✓	✓
3. Continuous support during labor	Knowledgeable on counseling for both the Patient and companion in providing continuous support during labor	✓	✓	✓	✓	✓	✓
4. Induction and augmentation of labor	○ Knowledgeable on the indications of induction and augmentation of labor ○ Able to perform caesarean section if induction/ augmentation fails.	x		x	✓	X x	x
5. Controlled delivery of head and active management of third stage of labor	○ Knowledgeable on normal stages of labor ○ Skillful in controlled delivery of the fetal head	✓	✓	✓	✓	✓	✓
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	✓	✓	✓	✓	✓	✓
7. Episiotomy and repair - Controlled delivery of the head - Perineal support	Performance of restrictive episiotomies (when indicated) and episiorrhaphies	✓	✓	✓	✓	✓	✓

INTERVENTIONS	COMPETENCIES	Community Level Provider (Manabo RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
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	✓	✓	✓	✓	✓	✓
	Knowledge of methods of bleeding control and uterine contraction promotion after placental separation	✓	✓	✓	✓	✓	✓
	Use of uterotonics for active management of 3rd stage of labor	✓		✓	✓	x	✓
10. Pain relief	○ Knowledgeable on methods of providing analgesia and possible adverse effects. ○ Able to manage possible complications	✓		x	✓	✓	✓
Management of abnormalities 1. Prolonged labor	○ Familiarity with identifying prolonged labor or dystocia by interpreting the WHO partograph ○ Knowledgeable on indications for emergency caesarean section	✓	✓	✓	✓	x	✓
2. Hypertension · Gestational hypertension, chronic hypertension, mild preeclampsia	Familiarity with hypertensive disorders of pregnancy and able to classify as gestational hypertension, chronic hypertension, chronic hypertension with pre eclampsia, mild pre eclampsia, severe pre eclampsia and eclampsia	x	✓	✓	✓	✓	✓
	Familiarity of appropriate medications to manage hypertension Knowledgeable on anti-hypertensive medications to avoid and able to counsel patient on medications and diet	✓		✓	✓	x	✓
Severe pre eclampsia - 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	x	x

INTERVENTIONS	COMPETENCIES	Community Level Provider (Manabo RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
	○ Able to conduct emergent delivery if term ○ Able to prepare fetus for possible early delivery ○ Knowledgeable on the management of eclampsia: ○ Providing oxygen, anticonvulsants, control of blood pressure and emergent delivery	x		✓	x	x	x
Malpresentation - Performance of external cephalic version	Able to diagnose malpresentation	✓		✓	✓	x	✓
	Able to emergent breech deliveries and caesarean sections	x		x	x	x	✓
Bleeding	Diagnosis and differentiation of pathologic causes of bleeding: Placenta previa and abruption placenta	x	✓	✓	✓	x	✓
	Able to do blood transfusion	✓		x	x	x	✓
	Able to do caesarean section	x		x	x	x	✓
Preterm labor - Dexamethasone if preterm and at risk for delivery	Knowledgeable on signs of preterm labor	✓	✓	✓	✓	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	x	✓
	Able to manage premature neonates or refer to appropriate provider	✓		x	✓	x	✓
Infection	Knowledgeable on methods to prevent perinatal infections; Handwashing	✓	✓	✓	✓	✓	
	Able to diagnose infection or risk factors for infection (ex. Premature rupture of membranes)	✓	✓	✓	✓	✓	✓
	Familiarity with appropriate antibiotics	✓	✓	✓	✓	✓	✓

INTERVENTIONS	COMPETENCIES	Community Level Provider (Manabo RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
	to use during pregnancy and breastfeeding						
Basic Emergency obstetric care Parenteral Administration of oxytocin in the 3rd stage of labor	Knowledgeable on dose and timing of oxytocin or other uterotonic administration	✓		✓	✓	x	✓
Parenteral administration of loading dose of anticonvulsant for severe preeclampsia and eclampsia	Able to administer initial anticonvulsant dose then refer to CEmONC capable facility	✓		x	x	x	✓
	Ability to observe necessary precaution	✓		✓	✓	x	✓
	CEmONC capable facility: Able to perform emergent delivery, administer anticonvulsants, control blood pressure and diagnose and manage complications	✓		x		x	✓
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	✓
Performance of assisted delivery during imminent breech delivery	Able to recognize breech deliveries Knowledgeable on imminent vaginal breech delivery	✓		x	✓	✓	✓
Removal of retained products of conception	○ Able to identify retained products of conception ○ Able to remove retained products	✓	✓	✓	✓	✓	✓
Medical and Manual removal of retained placenta	○ Able to manually remove retained placenta without causing complications ○ Able to perform possible procedures necessary to manage complications	✓		✓	✓	✓ x	✓

INTERVENTIONS	COMPETENCIES	Community Level Provider (Manabo RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
	Knowledgeable on and with facilities for regional analgesia	✓		x	x	x	x
	Knowledgeable on general anaesthesia	✓		x	x	x	x
Safe blood supply and transfusion	○ Familiarity with indications for blood transfusion ○ Safe blood collection, testing, distribution ○ Recognition, management, reporting of blood transfusion reactions	✓		X (manual: by trained MD only in extreme emergencies and in areas difficult to access)	x	x x	✓
Comprehensive emergency obstetric care Caesarean section	Knowledgeable on indications for and on performing caesarean section	✓		x	x	x	x
Anaesthesia	Knowledgeable on and with facilities for general anaesthesia	x		x	x	x	x
Counselling and Provision of BTL services	Able to counsel patients on benefits and disadvantages of bilateral tubal ligation	✓	✓	✓	✓	✓	✓
	Able to perform procedure	✓			x	x	x

D. POST-PARTUM

INTERVENTIONS	COMPETENCIES	Community Level Provider (Manabo RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
Identification of early signs and symptoms of post-partum complications (haemorrhage,	Knowledgeable on the early signs and symptoms of post-partum haemorrhage and infection	✓	✓	✓	✓	✓	✓

INTERVENTIONS	COMPETENCIES	Community Level Provider (Manabo RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
infection)	Familiarity with management of infection and causes of post-partum hemorrhage or able to refer patient to appropriate provider	✓	✓	✓	✓	✓	✓
Latching on/early newborn contact	Knowledgeable on benefits of latching on and ability to facilitate it within the first hour	✓	✓	✓	✓	✓	✓
IEC counselling on breastfeeding	Knowledgeable on technique and benefits of breastfeeding	✓	✓	✓	x	✓	✓
Family Planning IEC Counselling on: o Responsible parenting o Informed choice and voluntarism o 4 pillars on FP o Fertility awareness o Birth spacing o All FP methods	Able to counsel patient on proper birth spacing, responsible parenting	✓	✓	✓	✓	✓	✓
	Knowledgeable on the expected return to fertility after a term pregnancy, preterm delivery or a miscarriage	✓	✓	✓	✓	✓	✓
	Able to encourage and empower patient to make an informed decision	✓	✓	✓	✓	✓	✓
Provision of FP Services/contraception o Pills o DMPA o Condoms o NFP	Familiarity with different methods of family planning Able to counsel patient on method best for her	✓	✓	✓	✓	✓	✓
o IUD	Able to proper IUD insertion	✓		x	x	x	✓
o BTL, NSV	Able to do NSV and BTL	✓		x		x	x
Encourage LAM exclusive breastfeeding up to 6 months	Familiarity with the benefits of lactational amenorrhea method	✓	✓	✓	✓	✓	✓
Prevention and management of abortion complications Removal of retained products of conception	Familiarity with different types of abortion, complications and appropriate management or able to refer patient to proper provider	✓	✓	✓	✓	✓	✓

INTERVENTIONS	COMPETENCIES	Community Level Provider (Manabo RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
Treatment of Infection		✓	✓	✓	x	✓	✓
Correction of anemia		✓	✓	✓		✓	✓
Tetanus toxoid		✓	✓	✓		✓	✓
Return to fertility and birth spacing counselling	Familiarity with different methods of family planning; able to counsel patient on method best for her	✓	✓	✓	✓	✓	✓
Diagnostic Test: Breast and cervical cancer screening (acetic acid wash)	Familiarity with breast examination and cervical cancer screening methods, timing and interpretation of result	✓	✓	✓	✓	x	✓
Maternal Nutrition o Iron/Folate o Vitamin A o Iodine	Knowledgeable on nutritional needs of mother post-partum, particularly while breastfeeding	✓	✓	✓	✓	✓	✓
IEC Counselling on Healthy Lifestyle: o Safer sex and HIV/STI prevention o Smoking cessation	Able to counsel patients on importance of healthy lifestyle for the mother during post-partum period and breastfeeding	✓	✓	✓	✓	✓	✓
Physical activity Moderate alcohol intake	Able to counsel on importance of smoking cessation and alcohol intake especially during breastfeeding and good physical activity	✓	✓	✓	✓	✓	✓
	Knowledge on prevention of STI/HIV/AIDS	✓	✓	✓	✓	✓	✓

E. NEWBORN AND EARLY CHILDHOOD

INTERVENTION	COMPETENCIES	Community Level Provider (Manabo RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
Identification of early signs and	Able to identify early signs and	✓	✓	✓	✓	✓	✓

INTERVENTION	COMPETENCIES	Community Level Provider (Manabo RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
symptoms of newborn problems (eg. Respiratory distress, change color, etc.)	symptoms of newborn problems and severe illness						
Basic Emergency Newborn Care Newborn Resuscitation	Assessment of neonatal status at birth and initiation of resuscitation within 1 minute if neonate is bot breathing or if gasping until with stable breathing	✓	✓	✓	✓		✓
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	✓
Oxygen support for neonates	Provision of oxygen support	✓		✓	✓	x	✓
Safe blood transfusion	○ Safe blood collection, distribution, transfusion ○ 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	x
Advance Newborn resuscitation	Detection of need for further resuscitation	✓		✓	✓	x	✓
	Skill on advance newborn resuscitation following guidelines recommended by the Essential Newborn Care Clinical Practice Pocket Guide	✓		x	x	x	x
Management of sick newborns with severe illness (prematurity, breathing difficulty, sepsis, severe birth trauma and asphyxia, severe jaundice, etc.)	Able to management infants with severe problems such as prematurity, breathing difficulty, sepsis, severe birth trauma and asphyxia and severe jaundice Skill in newborn resuscitation	✓		x	x	x	x
Routine newborn Care	Basic post-partum care	✓	✓	✓	✓	✓	✓
	Knowledge of benefits and techniques of	✓	✓	✓	✓	✓	✓

INTERVENTION	COMPETENCIES	Community Level Provider (Manabo RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
o Early latching on within the 1st hour o Weighing of infant o Eye care o Cord care o Thermoregulation o Vitamin K injection o Delayed bathing to 6 hours of life o Hepatitis B and BCG vaccination	proper breastfeeding						
	Properly weigh infant after delivery	✓	✓	✓	✓	✓	✓
	Knowledge of timing and method of application of erythromycin ointment on both eyes	✓	✓	✓	✓	✓	✓
	Perform proper cord care	✓	✓	✓	✓	✓	✓
	Knowledge of ways of thermoregulation and properly and adequately provide it	✓	✓	✓	x	✓	✓
	Knowledge on benefits, timing, dosing, method of administration of vitamin K	✓	✓	✓	✓	✓	✓
	Knowledge on benefits of Hepatitis B vaccine birth dose and BCG, the timing, dosing, method of administration and storage	✓	✓	✓	✓	✓	✓
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 Coordination with NIH for newborn screening	✓	x	✓	✓	x	✓
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	✓		✓	✓	✓	✓
Kangaroo Mother Care	Knowledge on the principles of Kangaroo Mother Care and its benefits	✓	✓	✓	✓	✓	✓
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 malformations	✓	✓	✓	✓	✓	✓

INTERVENTION	COMPETENCIES	Community Level Provider (Manabo RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
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 preterm, with very low birth weight, severe complications or malformations	✓		x	x	x	✓
Retinopathy of prematurity screening	Knowledge when ROP screening is indicated and skill on ROP screening	✓		✓	x	x	x
Support services (MCB and birth registration within 30 days)	Properly fill up information in Mother and Child book Properly and accurately fill up information needed in birth certificate	✓	✓	✓	x	✓	✓
Post-partum Care Package o Assessment of infant's wellbeing and breastfeeding	Newborn assessment Counselling on newborn care and nutrition Knowledge of proper breastfeeding, assessment of adequacy of breastfeeding, and management of problems	✓	✓	✓	✓	✓	✓
Information and counselling on home care and immunization	Knowledge on routine home care instructions, schedule of routine immunizations, importance of compliance.	✓	✓	✓	✓	✓	✓
Additional follow up visits for higher risk babies	Knowledge on the signs and symptoms that warrant further evaluation and management Counsel on importance of regular follow ups	✓	✓	✓	✓	✓	✓
Child protection and injury prevention	Knowledge on the management and prevention of childhood injury	✓	✓	✓	✓	✓	✓
Vision screening	Skill in vision screening	✓	✓	✓	x	x	x
Newborn hearing screening	Skill in hearing screening tests	✓	✓	✓	x	✓	x
Expanded Program on	Knowledge on the timing, dosing,	✓	✓	✓	✓	✓	✓

INTERVENTION	COMPETENCIES	Community Level Provider (Manabo RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
Immunization	method of administration and storage of vaccines						
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	✓	✓	✓	✓	✓	✓

Annex H: Sample Current Status of selected Target BEmONC-CEmONC Facilities on Standard Infrastructure Requirements (Province of Abra, Cordillera Administrative Region)

Province of Abra

RHU, BHS, birthing Centers, 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 Dressing room for the doctors and nurses Maternity ward with rooming – in feature for the newborn Nurse's station Toilet bath with appropriate fixtures Sleeping quarter for health staff Waste management system that includes a placenta pit Communication radio of telephone Emergency transport system

Annex I: Current status of selected BEmONC-CEmONC Facilities on Logistics and Supplies Necessary for Adequate Delivery of MNCHN Core Package of Services (Province of Abra, Cordillera Administrative Region)

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 capabilities of health providers in the service delivery network.

A checkmark is placed under a box of 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 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's not necessary to provide these equipment for a particular part 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 (Manabo RHU)**	**Community Level Provider (San Quintin, BHS)**	**BEmONC-capable facilities (Sam Quintin, RHU)**	**Community Level Provider (Bangued, RHU)**	**Community Level Provider (Langiden, RHU)**	**Community Level Provider (Tayum, RHU)**
Assessment of health needs of women, mother and children	☐ Health needs assessment forms ☐ Information materials on provider in the area, available services and cost of these services ☐ Forms for health plans	✓	✓	✓	✓		✓
FP services:		✓					
IEC/ Counselling on: Informed Choice and Voluntarism; Responsible Parenthood; Availability of a broad-range of family planning methods;	☐ IEC materials on FP ☐ Iron Supplementation ☐ Deworming ☐ Healthy life style ☐ Oral Health ☐ Folic Acid	✓	✓	✓	✓		✓

Service	EQUIPMENT/ SUPPLIES	Community Level Provider (Manabo RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
Provision of FP services Pills, DMPA, condom, NFP	☐ Adequate supply of pills, DMPA, condoms, NFP, IUD ☐ FP Form 1 ☐ TCL for FP	✓	✓	✓			✓
IUD	☐ IUD kit drape for the patient, clean cloth to place	x		x	X		x
BTL, NSV 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 guaze or cotton balls, dry guaze or cotton balls, narrow /alligator forceps (10”) for guaze removal]						
	☐ 5cc syringes ☐ Sterile Gloves ☐ Lubricating Jelly ☐ Face Mask ☐ Micropore tape ☐ Povidone Iodine ☐ Sterile Cotton ☐ Sterile gauze ☐ Lidocaine 2% 50 ml ☐ BTL Kit ☐ NSV Kit ☐ Cut down on minor set ☐ Scrub suit	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓			x		✓

Service	**EQUIPMENT/ SUPPLIES**	**Community Level Provider (Manabo RHU)**	**Community Level Provider (San Quintin, BHS)**	**BEmONC-capable facilities (Sam Quintin, RHU)**	**Community Level Provider (Bangued, RHU)**	**Community Level Provider (Langiden, RHU)**	**Community Level Provider (Tayum, RHU)**
Women's/ maternal health, nutrition and micronutrient supplementation	☐ IEC materials on ENC and Breastfeeding ☐ Therapeutic dose Vitamin A (for case of xerophthalmia) ☐ Iron / Folate 60 mg elemental iron / 400ug folic acid tabs ☐ Iodized salt ☐ Pregnancy tracking form ☐ Mother and Child Book ☐Maternal Death Report Form ☐ Stethoscope ☐ Sphygmomanometer ☐ Weighing Scale ☐ Measuring tape/ height chart ☐ Food table/ pyramid ☐ Patient Registry	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	X X X X X X X X X X X X X X X X X X		✓
Tetanus toxoid Immunization	☐ Tetanus toxoid ampoules ☐ Syringes with needles ☐ Patient registry ☐ Vaccine Carrier ☐ Vaccine refrigerator	✓ ✓ ✓ ✓ ✓	✓	✓	✓		✓
IEC/ Counselling on health caring and seeking behaviour	☐IEC materials	✓	✓	✓	✓		✓
Updated master listing of women of reproductive age	☐ Record book for master list (Target client List)	✓	✓	✓	✓		✓

B. PREGNANCY/ PRENATAL

Service	EQUIPMENT/ SUPPLIES	Community level Provider	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
Maternal health, nutrition, and micronutrient supplementation	☐ IEC materials for Unang Yakap/ ENC and Breastfeeding ☐ Weighing scale ☐ Measuring tape/ height chart ☐ Food table/pyramid ☐ Iron/ Folate 60 mg elemental iron/ 400 ug folic acid tablet ☐ Iodine 200 mg elemental iodine ☐ Iodized salt ☐ 5cc syringe with needle ☐ Patient registry ☐ Mother and Child Book	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	✓	✓	✓		✓
Tetanus toxoid immunization	☐ Tetanus toxoid ampoules ☐ Syringes with needles ☐ Patient registry ☐ Vaccine carrier ☐ Vaccine refrigerator	✓ ✓ ✓ ✓ ✓	✓	✓	✓		✓
Deworming	☐ Mebendazole or albendazole tablets	✓	✓	✓	✓		✓
Counselling on health caring and seeking behavior	☐ IEC materials	✓	✓	✓	✓		✓
Early detection and management of danger signs and complications of pregnancy	☐ Pen, patient record, possibly chart or checklist of danger signs ☐ BP apparatus ☐ Stethoscope ☐ Ambulance of transport facility	✓ ✓ ✓ ✓	✓	✓	✓		✓
Antenatal administration of steroids in preterm	☐ Syringes, dexamethasone 5 or 8 mg/ ampule or Betamethasone	✓		x	x		✓

Service	EQUIPMENT/ SUPPLIES	Community level Provider	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
labor							
Support Services: Prenatal registration with mother – child book Birth Plan Home visit and follow – up Safe blood supply Support from community (e.g pregnant women) Birth registration / registration of women in reproductive age	☐ Calendar ☐ Prenatal registration card ☐ Patient record ☐Pen ☐ Pregnancy tracking forms ☐ Mother and Child Book ☐ Community Health Team Maternal Death Tracking Reporting Form	✓ ✓ ✓ ✓ ✓ ✓ ✓	✓	✓	X X X X X X X		✓
	☐ Registry of Births and Women of reproductive age	✓	✓	✓	x		✓
	☐ Computer ☐ Blood testing and storage facility	✓ ✓		x (blood testing)	x		✓
Diagnostic/ Screening Test CBC Blood Typing Urinalysis VDRL or RPR HBsAg OGCT Pregnancy test	For VIA test: ☐ Light source ☐ Speculum ☐ Sterile cotton pledget ☐ Boiled water or normal saline solution ☐ Acetic acid 3-5 % ☐ Syringe without needle ☐ Patient registry	✓ ✓ ✓	x x x	x x x	x x x		✓ ✓ ✓
Cervical cancer screening using acetic acid wash and pap smear Oral health	☐ Microscope ☐ Slide, cover slip, stains ☐ Centrifuge ☐ Syringes with/without needle ☐ Tourniquet ☐ Sterile urine vials ☐ EDTA and plain test tubes ☐ Well – equipped laboratory that	✓ ✓ ✓ ✓ ✓ ✓ ✓ x	x	x	x		✓

Service	EQUIPMENT/ SUPPLIES	Community level Provider	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
	can run there tests						
Screening for adequacy of fetal growth Assessment of fetal well – being and prediction of fetal compromise	☐ Tape measure	✓	✓	✓	x		✓
	☐ Stethoscope ☐ Lubricating jelly ☐ Examining table ☐ Weighing scale ☐ Sphygmomanometer (non - mercurial) ☐ Thermometer (non - mercurial) ☐ Patient registry	✓	✓	✓	x		✓
Prenatal diagnosis of congenital anomalies	☐ Ultrasound machine	x		x	x		x

C. LABOR AND DELIVERY

Service	EQUIPMENT/ SUPPLIES	Community level Provider (Manabo, RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
Diagnosis of labor	☐Sterile gloves ☐ Lubricant	✓	✓	✓	✓		✓
General care during labor	☐ Sterile gloves ☐ povidone iodine solution ☐ clean linen ☐ sterile instruments ☐ Sterile OS/ sponges ☐ sink ☐ antiseptic soap ☐ alcohol	✓	✓	✓	✓		✓
Clean and Safe delivery	☐ Partograph form ☐ sterile gloves ☐ lubricant ☐ povidone iodine solution	✓	✓	✓	✓		✓

Service	EQUIPMENT/ SUPPLIES	Community level Provider (Manabo, RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
Monitoring progress of labor using partograph		✓		x	✓		✓
Identification of early signs and symptoms and management of abnormalities Preterm labor Hypertension Bleeding; Infection Malpresentation; Prolonged labor;	☐ Partograph form ☐ sterile gloves ☐ lubricant ☐ povidone iodine solution ☐ stethoscope ☐thermometer ☐ speculum ☐ Ambulance/ transport facilities	✓		✓	✓		✓
	☐ facilities for labs (e.g CBC)	✓	x	x	✓		✓
	☐ Ultrasound ☐ Tacometer (CEmONC)	x			x		x
Monitoring fetal well – being during labor	☐ Stethoscope ☐ Fetal Doppler (BEmONC, CEmONC) ☐ Tacometer (CEmONC)	✓ ✓	x	x	x		✓
Continuous support during labor	☐ Possibly instruction materials on the role of the companion during labor, maintaining asepsis	✓	x	x			✓
Introduction and augmentation of labor	☐ Oxytocin ☐ IV needs ☐ sterile gloves ☐ lubricant ☐ povidone iodine solution ☐ stethoscope	✓			x		✓
Controlled delivery of head and active management of third stage labor	☐ Sterile gloves ☐ Sterile gowns ☐ guaze	✓	✓	✓	x		✓
Properly timed cord clamping and cutting	☐ cord clamp ☐ scissors ☐ Kelly clamps	✓	✓	✓	✓		✓

Service	EQUIPMENT/ SUPPLIES	Community level Provider (Manabo, RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
Repair laceration	☐ local anaesthesia ☐ Sterile scissors ☐ sterile gloves ☐ sutures (absorbable); Chromic 2.0 ☐ suture needles ☐ needle holder	✓	✓	✓	x		✓
Expectant and active management of third stage of labor	☐ Kelly/cord clamps ☐ sterile gloves ☐ Uterotonics: oxytocin, ergotamine, oxytocin – ergotamine, methylergotamine , prostaglandin tabs (misoprosols)	✓		✓	x		✓
Pain relief	☐ IV needs, epidural set, analgesics, parenteral agents (e.g meperidine, promethazine)	✓			x		✓
Management of abnormalities Prolonged labor	☐ Partograph ☐ sterile gloves ☐ lubricant ☐ povidone iodine solution ☐ sphygmomanometer (non - mercurial) ☐ Stethoscope ☐ Thermometer (non - mercurial) ☐ Speculum ☐ Facilities for labs (e.g CBC)	✓			✓		✓
	☐Tacometer (CEmONC) ☐ Antibiotics ☐ IV needs	✓			x		✓
Hypertension Gestational hypertension, chronic hypertension, mild preeclampsia	☐ As in above (1), plus ☐ Ultra sound (CEmONC) ☐ Antihypertensive medications: nifedipine, hydralazine, methyldopa	✓	X	X	x		✓

Service	EQUIPMENT/ SUPPLIES	Community level Provider (Manabo, RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
Severe preeclampsia	☐ As in hypertension above, plus : ☐ Ultrasound ☐ Facilities for labs (e.g., CBC, urinalysis, blood chemistries) ☐ Magnesium sulphate ☐ Oxygen ☐ Face Mask and tubing	✓		X	x		✓
Malpresentation	☐ As in prolonged labor above (1), plus ☐ Ultrasound ☐ Piper forceps	✓ X X		X	x		✓ X x
Bleeding	☐ As in prolonged labor above (1), plus	x		X	x		x
	☐ Ultrasound	x	X	X	x		x
	☐ Blood transfusion set	✓		X	x		✓
Preterm labor	☐ As in prolonged labor above (1), plus:	x	X	X	x		x
	☐ Ultrasound	x	X	X	x		x
	☐ Tocolytics	x	X	X	x		x
	☐ Dexamethasone or Betamethasone	✓	X	X	x		✓
Infection	☐ As in prolonged labor above (1), plus ☐ Ultrasound	✓ x	X	X	x		x
	☐ Dexamethasone or Betamethasone	✓	X	X	x		✓
Essential Newborn Care	☐ 2 Linen ☐ Bonnet ☐ Glass room thermometer ☐ Vitamin K ☐ BCG ☐ Delivery bed	✓ ✓ ✓ ✓ ✓ ✓	 ✓ ✓	X	x		✓
Basic Emergency Obstetric care	☐ Oxytocin ☐ Needles and syringes	✓		✓	x		✓

Service	EQUIPMENT/ SUPPLIES	Community level Provider (Manabo, RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
Parenteral administration of oxytocin in the 3rd stage of labor	☐ Normal saline solution ☐ IV set, venocath						
Parenteral administration of initial dose of antibiotics as indicated or as needed	☐ Magnesium sulphate vials ☐ Syringes with needle, 30cc ☐ Diazepam ☐ Intravenous / intramuscular sedative ☐ IV needs	✓			x		✓
	☐ Intravenous antibiotics (ampicillin, gentamicin) ☐ Syringe with needle ☐ IV needs	✓			x		✓
Performance of assisted delivery during imminent breech delivery	☐ Piper forceps	✓			x		✓
Removal of retained products of conception	☐ Curettage sets	✓			x		✓
Medical and Manual removal of retained placenta	☐ Syringe ☐ Normal saline ☐ Oxytocin ☐ 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 ☐ Regional analgesia needs (BEmONC)	✓			x		✓
	☐ Anaesthesia machine (CEmONC) ☐ General anaesthesia needs (CEmONC) ☐ Sterile gowns	✓			x		✓
Safe blood supply and	☐ Blood donor and distribution	✓			x		✓

Service	EQUIPMENT/ SUPPLIES	Community level Provider (Manabo, RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
transfusion	registries ☐ Blood storage ☐ Lab facility for blood typing ☐ Blood transfusion sets						
Comprehensive emergency obstetric care Caesarean section	☐ Caesarean section kits including sutures ☐ Antibiotics ☐ Sterile gowns and gloves, masks ☐ IV needs ☐ Povidone iodine solution ☐ Sterile gauze	x			x		x
2. Anaesthesia2	☐ General anaesthesia needs (CEmONC)	x			x		x
Counselling and Provision of BTL services	☐Diagrams on BTL ☐ Tubal ligation sets including sutures ☐Sterile gown and gloves ☐Sterile gauze	✓			x		✓

D. POST-PARTUM

Service	EQUIPMENT/ SUPPLIES	Community level Provider (Manabo, RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
Identification of early signs and symptoms of post-partum complications (haemorrhage, infection)	☐Possibly charts or posters enumerating the early signs of hemorrhage and infection ☐ Stethoscope ☐Sphygmomanometer (non-mercurial) ☐Thermometer (non-mercurial) ☐Ambulance/transport facilities	✓		✓	✓		✓
Latching on/ early	☐ Educational materials on benefits	✓	✓	✓	✓		✓

Service	EQUIPMENT/ SUPPLIES	Community level Provider (Manabo, RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
newborn contact	of latching on						
IEC counselling on breastfeeding	☐Educational materials on breastfeeding	✓	✓	✓	✓		✓
Family Planning 1. IEC counselling on: · Responsible parenting · Informed choice and voluntarism · 4 pillars on FP · Fertility awareness · Birth spacing · All FP methods	☐Educational materials to aid in counselling patients on the importance of birth spacing and responsible parenting	✓	✓	✓	✓		✓
2. Provision of FP Services/contraception · Pills · DMPA · Condoms · NFP	☐ Educational materials on different family planning methods	✓	✓	✓	✓		✓
· IUD · BTL, NSV	☐ Intrauterine device (copper T) ☐ Lubricant	✓			x		✓
	☐ NSV and BTL sets ☐ Sterile gown and gloves ☐ Povidone iodine solution ☐ Lidocaine	✓			x		✓
3. Encourage LAM exclusive breastfeeding up to 6 months	☐Educational materials on lactational amenorrhea method	✓	✓	✓	✓		✓
Prevention and management of abortion complications Removal or retained products of conception	☐ Curettage kit	✓			x		✓

Service	EQUIPMENT/ SUPPLIES	Community level Provider (Manabo, RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
2. Treatment of infection	☐ Appropriate antibiotics preferably intravenous, syringes, IV access needs	✓			x		✓
3. Correction of anemia	☐ Iron supplements 60mg/tab ☐Facility for haemoglobin/ haematocrit determination in facility or in local area ☐Needs for blood transfusion	✓			x		✓
Anti-tetanus Serum (ATS) injection	☐ Anti-tetanus serum ☐ Syringe with needle ☐ Cotton ☐Alcohol 70% Isopropyl/Ethyl	✓	✓	✓	✓		✓
Return to fertility and interpregnancy interval counselling	☐ Educational materials on different family planning methods	✓	✓	✓	✓		✓
Diagnostic test: breast and cervical cancer screening (acetic acid wash)	☐ Light source ☐Examination table ☐Acetic acid 3-4% ☐ Vaginal speculum ☐Big cotton balls ☐Boiled water or normal saline solution ☐Syringe ☐Chlorine solution	✓			x		✓
	☐Colposcopy	x			✓		✓
Maternal Nutrition · Iron and folate · Vitamin A	☐IEC materials ☐ Iron/ folate 60mg elemental iron/400ug folic acid tablets ☐Vitamin A 200,000 IU capsules	✓	✓	✓	✓		✓
IEC/Counselling on Healthy Lifestyle · Safer sex and HIV/STI	☐IEC materials ☐Weighing scale (adult) ☐Height chart/tape measure	✓	✓	✓	✓		✓

Service	EQUIPMENT/ SUPPLIES	Community level Provider (Manabo, RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
prevention · smoking cessation · physical activity · moderate alcohol intake	☐ Patient registry						
	Maternal Death Reporting Form	✓			✓		✓

E. POST-PARTUM AND EARLY CHILDHOOD

INTERVENTION	EQUIPMENT/ SUPPLIES	Community level Provider (Manabo, RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
Essential Newborn Care 1. Immediate and thorough drying 2. Early skin-to-skin contact 3. Properly timed cord clamping and cutting 4. Nonseparation of newborn and mother for early breastfeeding 5. Vitamin K injection 6. Hepatitis B and BCG vaccination 7. Timely cord clamping and cutting	☐Stethoscope ☐Soap & Water ☐IEC materials on breastfeeding ☐Weighing scale (pedia) ☐Erythromycin ointment ☐Cord clamp, Cord tie and Sterile cord clips ☐Alcohol 70% Isopropyl/Ethyl solution ☐Sterile gauze ☐Povidone iodine solution ☐Any device for thermoregulation (incubator, radiant warmer, drop light, dry linen) ☐Vitamin K ampules ☐Tuberculin syringes and 3 cc syringe ☐Hepatitis B vaccine ☐BCG vaccine ☐Vaccine refrigerator ☐Thermometer	✓		✓	✓		✓
Basic Emergency Newborn	☐Neonatal ambubag and mask,				x		✓

INTERVENTION	EQUIPMENT/ SUPPLIES	Community level Provider (Manabo, RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
Care 1. Newborn resuscitation	laryngoscope ☐Sterile gloves ☐Stethoscope ☐Firm and padded resuscitation surface ☐Oxygen source ☐Oxygen tubing ☐Suction equipment ☐Aspiration bulb ☐Syringe ☐Mechanical suction and tubing ☐Suction catheters ☐Devices for thermoregulation (radiant warmer, droplight, warm blankets or linen, plastic wraps or zip lock bags) ☐Linen	✓					
2. Treatment of neonatal sepsis	☐Thermometer (non-mercurial) ☐IV antibiotics ☐IV needs ☐Instruments and supplies for umbilical cannulation	✓			x		✓
3. Oxygen support for neonates	☐Appropriate ambu bag for term and preterm neonates for positive pressure ventilation	✓			x		✓
4. Safe blood transfusion	☐ Blood transfusion set ☐ Blood donor and distribution registries ☐ Blood storage ☐ Lab facility for blood typing	✓			x		✓
5. Advance newborn resuscitation	☐ Stethoscope ☐ Oxygen source	✓			x		✓

INTERVENTION	EQUIPMENT/ SUPPLIES	Community level Provider (Manabo, RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
	☐ Bag and mask or equivalent equipment for positive pressure ventilation ☐ Intubation equipment ☐ Instruments and supplies for umbilical cannulation ☐ Devices for thermoregulation ☐ IV fluids ☐ Blood glucose monitor ☐ Resuscitation medications (Epinephrine, Sodium bicarbonate, volume expanders, D10W, Naloxone)						
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: ☐Parenteral drugs ☐ Inotropes ☐Blood products ☐ Chemical and microbiological laboratory ☐Radiography (x-ray, UTZ) ☐ Phototherapy ☐ Pulse oximeter ☐ Sphygmomanometer (paediatric set, non-mercurial) ☐ 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		✓
8. Newborn hearing Screening (in BEmONC	☐ Otoacoustic emission test machine (if available)	x			x		x

INTERVENTION	EQUIPMENT/ SUPPLIES	Community level Provider (Manabo, RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
CEmONC facilities)							
9. Eye examination of newborn (done in BEmONC/ CEmONC facilities)	☐Opthalmoscope	✓			x		✓
10. Advice on danger signs, emergency preparedness and follow up	☐ Checklist of danger signs ☐ Calendar ☐ Medical record ☐ Immunization card ☐Discharge slip	✓			x		✓
11. Kangaroo Mother Care	☐Information materials on KMC	✓					✓
Treatment of mild to moderate local infections and birth injuries	☐Topical or oral antibiotics ☐Pain relievers ☐Antiseptic solution ☐Sterile sutures and needles ☐Sterile gauze ☐Bandages ☐Splints	✓			x		✓
Post-resuscitation/Pre-transport stabilization (STABLE: blood sugar, temperature, airway, blood pressure, laboratory work up, emotional support)	☐Same as needs for advance newborn resuscitation, plus: ☐Pulse oximeter ☐ Sphygmomanometer (pediatric set, non-mercurial) ☐ Thermometer (non-mercurial) ☐Inotropes ☐Laboratory (ABGs, CBC, chest x-ray) ☐ Ambulance	✓ x x ✓ ✓ ✓ ✓			x		✓
Management of correctable malformations	☐Operating room ☐Surgical instruments needs for surgery ☐Same needs for newborn	X X X X			x		v

INTERVENTION	EQUIPMENT/ SUPPLIES	Community level Provider (Manabo, RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
	resuscitation ☐Anaesthesia ☐Anaesthesiologist	X					
Retinopathy of premature screening	☐ Indirect ophthalmoscope	x			✓		x
Support services (MCB and birth registration within 30 days)	☐ Mother and child book ☐Birth certificate	✓	✓	✓	✓		✓
Newborn Care Package 1. Assessment of newborn wellbeing and breastfeeding	☐Soap ☐Water ☐Information materials on breastfeeding and newborn care and nutrition	✓	✓	✓	✓		✓
2. Information and counselling on home care and immunizations	☐Immunization schedule ☐Immunization cards	✓	✓	✓	✓		✓
3. Additional follow-up visits for high-risk babies	☐Information materials	✓	✓	✓	✓		✓
4. Child protection and injury prevention	☐Information materials on Injury Prevention	✓	✓	✓	✓		✓
Expanded Program on Immunization	☐Vaccines ☐Vaccine refrigerator ☐Thermometer ☐3cc and tuberculin syringes ☐Cotton balls ☐Alcohol ☐Immunization schedule ☐Immunization cards ☐Patient registry	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	✓	✓	✓		✓
Integrated Management of Childhood Illnesses	☐Stethoscope ☐Thermometer (non-mercurial) ☐Sphygmomanometer (pediatric	✓ ✓ X	✓	✓	✓		✓

INTERVENTION	EQUIPMENT/ SUPPLIES	Community level Provider (Manabo, RHU)	Community Level Provider (San Quintin, BHS)	BEmONC-capable facilities (Sam Quintin, RHU)	Community Level Provider (Bangued, RHU)	Community Level Provider (Langiden, RHU)	Community Level Provider (Tayum, RHU)
	set, non-mercurial) ✓ ☐Oral antibiotics ✓ ☐Oral rehydration solution ✓ ☐Zinc supplements ✓ ☐Iron supplements ✓ ☐Vitamin A capsules ✓ ☐IMCI manual ✓ ☐Patient registry ✓						

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:

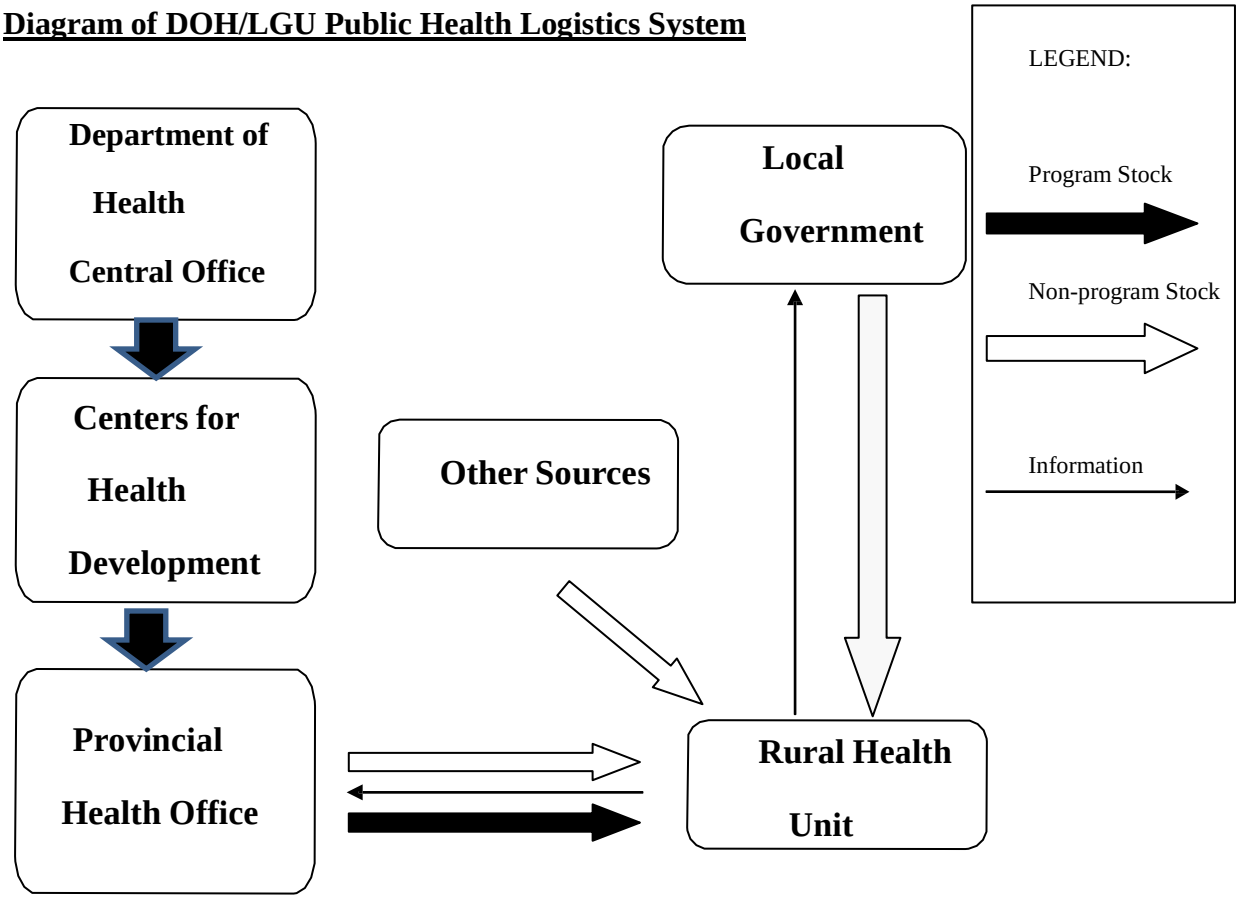
- Receiving drugs and medical supplies;
- Safe storage;
- Dispensing to patients;
- Issuing to midwives and BHSs;
- Carrying out physical inventories;
- Ordering new stock;
- Reporting on stock; and
- Keeping track of drug expiration dates.

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.

 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						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						
28						
29						
30						

Form B

Daily Dispensing Record Book																				
Program:_____																				
				Drug Names/Preparation																
Date	**Name of Client**	**Address**	**Age**	**Quantity Dispensed**															**Signature of Client**	**Remarks**

Form C

Daily Stock Issue Record																	
Name of Program: _____																	
	Drug Name/Preparation																
Date	**Quantity Issued (units)**															**Issued to (facility and name)**	**Signature**

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**

Form D-2

Monthly Physical Inventory and Drug Expiration Record									
Program:									
onnel 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**	**Balance of stocks based on the *Daily Stock Record*** **	**Losses**	**Remarks**
						(A)	(B)	(B-A)	

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**

Authorized Signature: _____

Form F

Stock Purchase Request Form				
Name of Facility:			**Personnel in charge:**	
Name of City/Municipality:			**Date:**	
A	**B**	**C**	**D**	**E**
ct name and preparation	**Stocks consumed since last request**	**te of last request**	**Current stock level**	**Quantity Requested**

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.

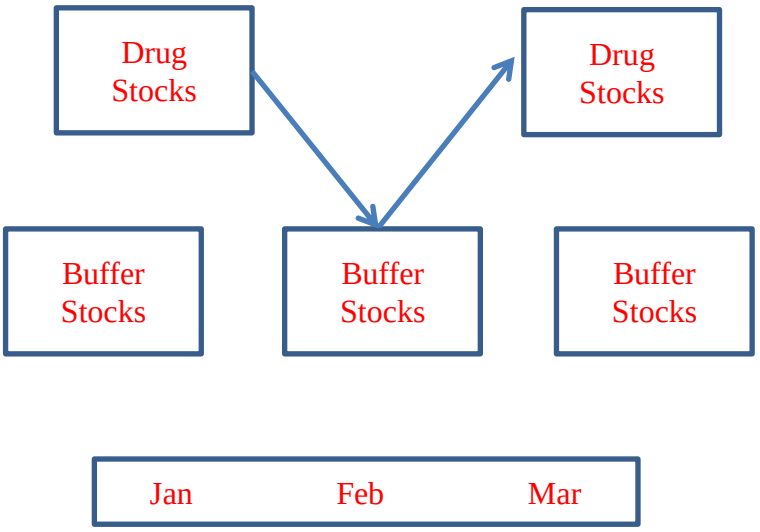
Attachment 3

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	PhilHealth	NCIP	Donors	Others	MFDO	Others

Guide in the Accomplishment of the Annual Operational Plan

Annual Operational Plan Matrix

i. Column 1 - Program/Project/Activities

This should contain the Priority Program, Project Activities arranged according to the six components *(Service Delivery, Regulation, Financing, Human Resource, Information System 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

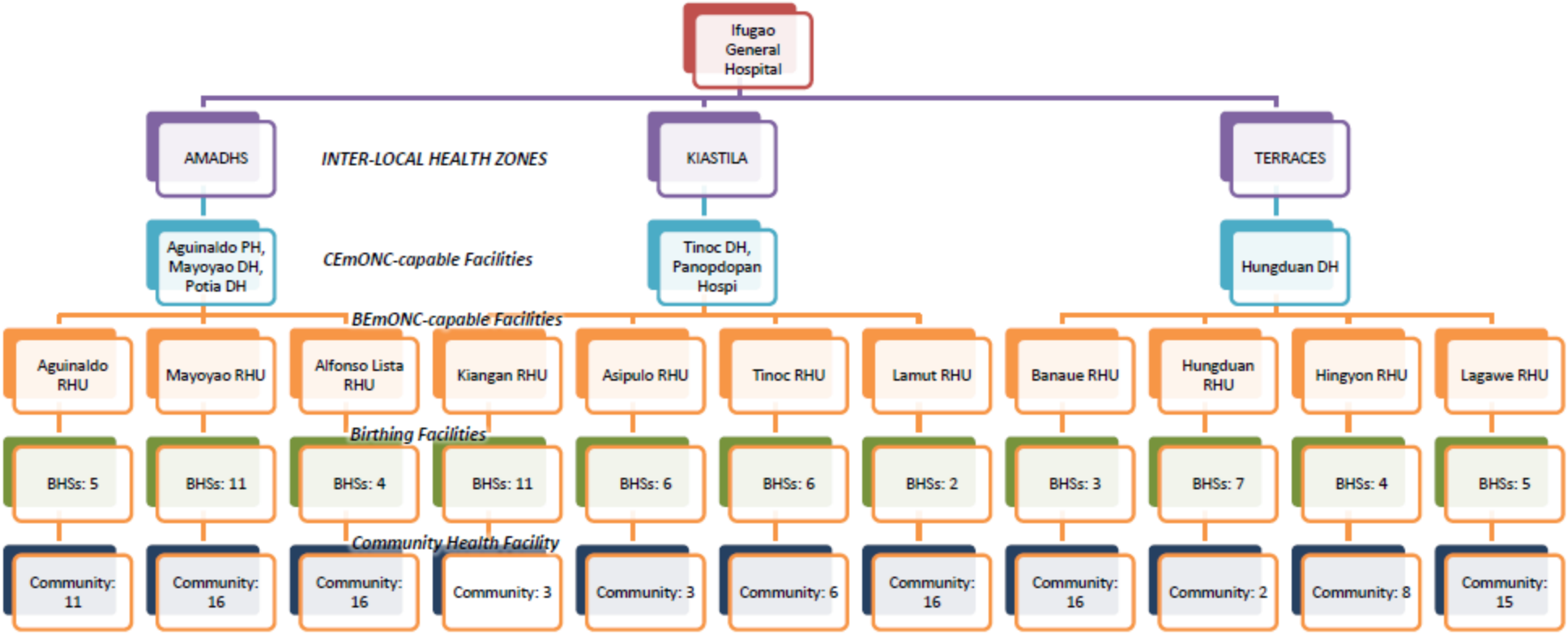
Include personnel technologies, training needs, medicines, supplies, etc. that are needed to be able to conduct a particular activity and produce a given output or outcome. It may also be useful to indicate those personnel, offices or entities that provide critical support in the conduct of the activity.

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 like DOH, PhilHealth and NCIP 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.

Annex M: Sample Current Status of MNCHN Service Delivery Network (Province of Ifugao, Cordillera Administrative Region, October 2012)



Annex N: Child Injury Assessment Policy and Tool

Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY
2/F Bldg. No. 1 San Lazaro Compound, Rizal Avenue, Sta. Cruz, 1003 Manila
Tel Nos. (632) 743-8301 locals 1125/1126, Telefax (632) 743 1829; Direct: 711-9502/711950
URL: http://www/doh.gov.ph

June 16, 2006

ADMINISTRATIVE ORDER
No. 2006 - 0016

SUBJECT: **National Policy and Strategic Framework on Child Injury Prevention**

I. BACKGROUND AND RATIONALE

The World Health Organization estimated that in the year 2002, about 875,000 children under the age of 18 years died as a result of injury. Moreover, injuries account for approximately 6% of the global burden of disease for children under the age of 15 years (WHO, 2002). Majority of these injuries resulted from falls, animal bites, violence and assaults, poisoning, drowning, burns and road traffic accidents. Poor children were disproportionately affected; more than 98% of these deaths occurred in low- and middle-income countries, particularly Africa, the Eastern Mediterranean Region, South Asia and the Western Pacific (WHO, 2005). These studies showed that injury now constituted a significant part of childhood mortality and morbidity.

In the Philippines, accidents and injuries are the 5th leading causes of morbidity with a rate of 308 per 100,000 population. Furthermore, it is the 6th leading cause of mortality with a rate of 42 deaths per 100,000 population (DOH, 2000). According to the Philippine National Injury Survey (Lim et al, 2003), vehicular accidents, falls, poisoning, violence and assaults, drowning, and animal bites account for injuries among children below 18 years of age. The impact of these injuries on society is appalling; families are deprived of their children and children who survived had to learn to cope with the consequences of their injury, which, in some cases, can be both long-lasting and profound. This situation is further compounded by the economic burden imposed on the affected families.

Several initiatives were undertaken by non-government and other government organizations, business sectors, professional societies and the academe to address the prevailing situation. However, there is a need to strengthen collaborative efforts to impact on child injury prevention. In response, the Department of Health with the support from the United Nations Children's Fund (UNICEF) convened all injury prevention stakeholders to a consultative forum held in January 2006. A consensus was reached, endorsing the recommendations contained in the ***National Strategic Framework on Injury Prevention and Safety Promotion among Children in the Philippines***, a paper prepared by the Technical Working Group on Child Injury Prevention (TWG-CAIP). The paper called for establishing an infrastructure to support an integrated strategy, evidenced-based programming, research and surveillance, safety promotion, and capability-building.

To guide stakeholders in planning interventions for injury prevention, **the *National Policy and Strategic Framework on Child Injury Prevention* is hereby formulated**. This shall serve as a sub-document to the overall framework of a national injury and violence prevention program under which a number of specific injury issues could be addressed.

II. DECLARATION OF POLICIES

The policy and strategic framework shall be guided by the following legal mandates:

A. *Article 24* of the *1989 United Nations Convention on the Rights of the Child* emphasized the social responsibility of the member States to protect children and to provide them with appropriate support and services, emphasizing their right to the highest attainable level of health and the right to safe environment, free from injury and violence.

B. The *1987 Philippine Constitution* mandates through Article 15, Section 3, that "The State shall defined the right of children to assistance including proper care and nutrition, special protection from all forms of neglect, abuse cruelty, exploitation, and other conditions prejudicial to their development."

C. *Article 13, Section 11* of the *1987 Philippine Constitution* adjured the State to protect and promote the right to health of every Filipino by making quality and adequate health care available and accessible, especially the underprivileged. This entails the adoption of an integrated and comprehensive approach to health development; implying a multi-sectoral partnership and multi-level health care delivery system.

D. *Administrative Order No. 2005-0023* of the Department of Health identified *Four*mula *One for Health* as the implementing mechanism for health sector reforms, thereby ensuring better health outcomes, a more responsive public health system, and a more equitable health care financing for all Filipinos. This involved critical reform initiatives in the areas of health financing, regulation, service delivery and governance.

E. *Executive Order No. 310* adopted the *Philippine National Strategic Framework for Plan Development for Children (Child 21)* as the national framework to promote and safeguard the rights of Filipino children. It aims to synchronize family, community, and national efforts toward the full realization of the rights of children (i.e. survival, development, protection, and participation); advocating not only for a more focused targeting for children but also for interfacing critical interventions as the various stages of child development.

F. *Chapter 3, Sections 18 to 20 of the Magna Carta for Disabled Persons (R.A. No. 7277)* required the Department of Health to institute a national health program which shall provide quality and affordable health services covering prevention of disability, early detection and timely intervention to arrest disabling conditions, and medical treatment and rehabilitation.

III. OBJECTIVES

This Administrative Order aims to:

A. Provide a strategic framework for child injury prevention implementation that is anchored on health sector reforms.

B. Provide policy directions for DOH offices, its attached agencies, LGU and other partners in terms of prioritizing activities related to child injury prevention.

C. Provide guidance to partners in the health sector identifying priority areas for support in the context of multi-sectoral collaboration/partnership to generate and mobilize resources.

D. Provide guidance to DOH concerned offices and other relevant agencies in facilitating implementation of child injury prevention in the DOH and at LGUs.

IV. COVERAGE AND SCOPE OF APPLICATION

This Order covers to DOH at the Central Office, CHD, Hospital and other attached agencies to provide supportive policy environmental and in prioritizing resources for strengthening collaborative efforts for promoting and preventing child injury in the country. It also applies to the entire health sector, as well as the public and private sectors, national agencies and local government units, external development agencies, academe, professional associations and civil society involved in injury prevention among children 0 to 17 years old.

It shall initially focus on the following priority injury causes:

1. Road traffic injuries
2. Burns and scalds
3. Drowning
4. Falls
5. Poisoning

V. DEFINITION OF TERMS

A. **Community Capacity** - the characteristics of communities that affect their ability to identify, mobilizes and addresses social and public health problems.

B. **Empowerment** – a process that enables people identify their own concerns and gain the skills and confidence to act upon them.

C. **Evidenced-based Medicine** – is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating clinical expertise with the best available external clinical evidence from systematic research.

D. **Evidenced-based Health Care** – is a discipline centered upon evidenced-based decision-making about groups of patients, or populations, which may be manifest as evidence-based policy-making, purchasing or management.

E. **Health and Public Policy** – is a characterized by an explicit concern for health and equity in all areas of policy, and by an accountability of health impact. The main aim of healthy public policy is to create a supportive environment to enable to people to lead healthy lives. Such a policy makes healthy choices possible or easier for citizens. It makes social and physical environments health enhancing.

F. **Injury** – refers to the physical damage that results when a human body is suddenly or briefly subjected to intolerable levels of energy. It can be a bodily lesion resulting from acute exposure to energy (mechanical, thermal, electrical or radiant) in amounts that exceed the threshold of physiological tolerance, or it can be an impairment of function resulting from lack of one or more vital elements (i.e. air, water, warmth), as in drowning, strangulation or freezing. The time between exposure to the energy and the appearance of an injury is short.

G. **Injury prevention** – means making positive choices about minimizing risk at all levels of society, while maintaining healthy, active and safe communities and lifestyles. These choices are strongly influenced by the social, economic and physical environments where one lives, works, learns and plays.

H. **Population Health** – is an approach to health that aims to improve the health status of the entire population or subpopulations and to reduce health inequities among population groups. It looks and acts upon the *determination of health* – i.e. income and social status, social support networks, education, employment and working conditions, physical and social environments, biology and genetic endowment, personal health practices and coping skills, healthy child development, health services, gender and culture.

I. **Safety** – a state in which hazards and conditions leading to physical injury, i.e. psychological or material harm, are controlled in order to preserve the health and well-being of individuals and the community.

J. **Safety Promotion** – a process that aims to provide populations with the means to ensure the presence of, and maintain the conditions necessary to reach and sustain, an optimal level of safety.

K. **Surveillance** – the process of systematic collection, orderly consolidation and evaluation of pertinent data with prompt dissemination of the results to those who need to know, particularly those who are in a position to take action.

VI. GENERAL GUIDELINES

A. The Department of Health cognizant of the public health significance of child injuries and its impact in society shall institutionalize a comprehensive Child Injury Prevention Program, guided by the principles of evidence-based practice, partnership and shared responsibility, and integration. This shall be operationalized by means of policy and legislative, enforcements, health sector reforms, public information, education and communication, surveillance systems and multi-sectoral collaboration in service provision.

B. The health program for child injury prevention shall be in accordance with the thrusts of the National Objectives for Health (2005-2010), Medium Term Development Plan of the "Department of Health (2002-2010), and Millennium Development Goals (2005-2015).

C. The Strategy will initially focus on areas where interventions are possible, effective, and able to be implemented with a clear and actionable role for the health sector. Five priority areas for immediate action by the health sector will be undertaken. These are prevention of road traffic injuries, falls, burns, poisoning, and drowning.

D. In line with the DOH mission to guarantee equitable, sustainable and quality *Health for All Filipinos*, especially the disadvantaged and vulnerable sectors, the Child Injury Prevention Strategy will be based on a *population health approach* that addresses the range of factors (i.e. social, economic, cultural, and political) that determine the health and well-being of the overall population.

E. Consistent with the World Health Organization definition of health, the approach views health as an asset and resource for everyday living, not simply the absence of disease. Health depends more than just health care. The population health approach concerns itself with the living, working and economic environments that effect people's health and safety, the conditions that enable and support people in making healthy choices, and the services that promote and maintain health.

F. Numerous determinants of health influence the health of individuals and communities: income and social status, social support networks, education, employment and working conditions, physical environments, genetics, personal health practices and coping skills, health services, gender and culture, and healthy services, gender and culture, and healthy child development. It is the complex interaction of these determinants that has an impact on the health of individuals and communities. These are all factors that make a difference on how long people live, the quality of their lives and their risk of injury.

G. In applying this approach to injury prevention, the burden and the solutions lie not just within the health sector, but evidently with many other sectors, e.g., transportation, public works and highways, labor and industry, education, local government, social welfare, and others.

VII. STRATEGIC FRAMEWORK ON CHILD INJURY PROGRAM

A. VISSION AND MISSION

Vision: *The Philippines has the lowest child injury rate in Asia.*

Mission: *Guarantee cost-effective injury prevention interventions to every Filipino child, and ensure sustainable and equitable multi-sectoral support.*

B. GOALS

Reduce health disparities that increase the risk of injury among children

and

Reduce societal burden of child injury, and improve the health of the Filipino child.

C. PROGRAM OBJECTIVES

Decrease the incidence, severity, morbidity and mortality associated with child injuries at home, in the community, schools, roadways and acute care settings.

The specific program objectives include the following:

1. To address the health gaps and needs pertaining to injury prevention.
2. To empower families and communities in ensuring safety mechanisms for children.
3. To expand/strengthen partnerships and multi-sectoral involvement at the national and local levels.
4. To increase access to quality care and rehabilitation services.
5. To develop a data base on child injury.

D. GUIDING PRINCIPLES

The Child Injury Prevention Strategy development is guided by the following principles:

1. *Evidence-based Practices*

Evidence-based practices can be positioned along a continuum from qualitative to quantitative evidence. Examples ranging from qualitative to quantitative include: opinion based on community experience or cultural knowledge, to descriptive studies, surveys, cohort studies, non-randomized trials, and finally, randomized control trials. Decision-making regarding interventions are to be based on a systematic appraisal of the best evidence available in the context of the prevailing values and resource available.

To prevent the continued waste of valuable resources on practices that may not be effective, practitioners, researchers and policy-makers need to work closely to develop and implement a national research agenda that supports the Strategy, this includes institutionalization of an injury surveillance system. Research has shown that injury prevention strategies that combine environmental design (e.g., road construction, product design), education and legislative and regulatory requirements that support environmental and behavioral change, are most effective.

2. *Partnership and Shared Responsibility*

A partnership is a voluntary agreement between two or more parties to work cooperatively toward a set of shared outcomes in injury prevention. Partnerships may form part of a multi-sectoral collaboration for Child Injury Prevention, or be based on alliances for specific injury issues. Partnerships may include the public sector, the non-government organizations and the private sector. They may also involve different levels of jurisdiction (e.g. municipal, city provincial, regional, national and international levels).

The principle of shared responsibility recognizes that injury prevention is not just the responsibility of individuals. Creating conditions conducive to injury prevention is the responsibility of all sectors (e.g. transportation, public works and highways, health, education, industry, and others) and is affected by governments at all levels, the private sector, the non-government organizations, families, schools, workplaces and communities.

Partnerships are an important mechanism for putting the idea of integration into practice. Effective partnerships have the potential to add value to work that is already being done to address issues in Child Injury Prevention.

3. *Integration*

Considerable work is already being done to address specific injury issues (e.g. motor vehicle safety, workplace safety, 'Petron-Road Traffic Accident Prevention', 'Safe Kids', 'Bantay Bata', 'Bisig Bayan') by community groups, governments, non-government organizations and the private sector, including media. Integration shall the major focus of the Strategy. It means working in a more coordinated way to address specific issues together, as much as possible.

E. STRATEGIC DIRECTIONS

The strategic directions have been set for a five year period, from 2006, up to 2010. To decrease the incidence, severity, morbidity and mortality associated with child and adolescent injuries is the principal objective of the Child Injury Prevention Strategy. Accordingly, the following strategic responses shall be adopted:

1. Enhanced capacity for data collection

Best evidenced for policy, decision making and tracking progress require good data source on interventions that work, surveillance and special surveys. The Child Injury Prevention Program shall make decisions based on evidence gathered routinely from regular monitoring and evaluation. Continuing improvement shall be targeted through research.

2. Legislations and Enforcement

Support from political leaders is not only necessary to ensure proper funding and effective legislation, but also to give injury prevention efforts increased legitimacy and a higher profile within the public consciousness. Commitment is as important at national level, where policy and legislative decisions are made, as at provincial district, city and municipal levels, where the day-to-day functioning of many interventions is controlled.

Because many of the determinants of health injury prevention are influenced by policies and legislations outside of the health sector, all sectors (e.g. health, transportation, public works and highways, labor, education and others) need to work together in the pursuit of win-win policies that create environments for child and adolescent injury prevention. Governments at all levels have an important role to play in developing healthy public policy. Several laws and ordinances were promulgated to provide safety on the road, at home, in school, workplace and recreational areas. There is a need to monitor adherence to existing laws on safety and injury prevention measures.

3. Transformation of Health Systems

The prevention of deaths and disability secondary to injury include assuring access to health facilities, improving quality of hospital care through upgraded hospital equipment and enhanced capacity of health personnel, strengthening emergency response mechanisms, and establishing rehabilitation services. In areas where it is not possible to provide tertiary health care and rehabilitation services, a referral system should be established.

Development of standards and regulations for product safety will complement the capacity of the health system to prevent injuries, particularly in poisoning, burns, and other unintentional external causes of injury. Moreover, the present systems for quality control implemented by different government agencies need to be strengthened. There is a need to focus on how standards and regulations, as well as existing laws on safety can be strictly implemented.

4. Resource Generation and Mobilization through Partnerships

The Child Injury Prevention Strategy encourages multi-sectoral collaboration to generate and mobilize resources. Resource sharing from an established network of stakeholders will increase the capacity to respond to child injuries and their determinants.

It must be emphasized that health inequalities must be addressed through the health financing system, especially the Philippine Health Insurance System (PHIC). A review of the present coverage for injuries should be undertaken to expand the PHIC benefit packages.

5. Health Workforce Development

Primary health care workers and secondary-care hospital workers should know how to manage injury cases. The hospitals should also be furnished with basic equipments and supplies in the diagnosis, management and treatment of injuries. Particular emphasis in primary prevention responses will be promoted during skills training.

6. Empowerment of parents, families and the community

Improvement of family and community practices shall be the core of safety promotion. Injury prevention entails information, education and communication campaign in all levels of societal structures, which include the home, community, school and workplace. Mass media can be used to intensify health promotion and injury prevention, including early interventions. Appropriate key messages should be developed to effect changes in attitude and behavior. This empowers the people to assume responsibility for their own safety and strengthens their capacity to respond to a range of public health issues on injuries for children and adolescents.

Health promotion approaches that are based on an assessment of community needs, engage and empower communities, and contribute to increased community capacity are most likely to achieve sustainable, long-term outcomes.

VIII. PROGRAM IMPLEMENTATION

A. PROGRAM COMPONENTS

In accordance with the *National Injury Prevention and Control Program* of the Department of Health, the following program components for *Child Injury Prevention* will be developed.

1. Health Promotion

This component shall include advocacy, information, education and communication activities addressed to policy makers, other government and non-government agencies, private sectors including media, the general public and other stakeholders concerning underlying socio-economic and environmental conditions, the individual risk factors, risk behaviors and the impact of child and adolescent injuries on society; to evoke positive socio-political response and changes in the public perceptions about the preventability of injury.

2. **Human Resource Development and Management**

This component shall focus on enhancing the capability of health and non-health service providers at all levels in injury prevention. It shall include developing mechanisms to guarantee availability and accessibility of accredited training institutions and service providers adept in rendering comprehensive injury prevention interventions for each key settings, which may include, but not limited to the community, schools, homes, leisure and sports areas.

3. **Surveillance System**

This component shall ensure that a system of date recording and reporting of child and adolescent injuries is established and institutionalized at the national, regional and local levels. A health information system shall be developed for this purpose. The system shall adopt the ICD-10 for the definitions and classification of injuries, and include other pertinent data for monitoring and evaluation of program effects. All injury stakeholders shall cooperate and coordinate with the Department of Health for information exchange which shall be made available and accessible to all end-users for evidence-based decision-making.

4. **Networking and Linkages**

This component shall establish multi-sectoral collaboration and partnerships with injury stakeholders at the national, regional and local levels. It shall take into account the mandates and activities of the various stakeholders involved in child injury prevention, and forge agreements and commitments in the following areas, but not limited to advocacy and awareness campaigns, research, information exchange, service provision and referrals, resource sharing, and regulatory enforcements.

5. **Equitable Health Financing Package**

In coordination with the Philippine Health Insurance Corporation (PHIC), this component shall formulate PHIC-indigent packages for injury-related sequelae. Compensations and other benefit packages for work-related injuries shall be addressed through existing programs for employees in the private sector (Social Security System) and public sector (Government Service Insurance System) in consonance with the guidelines developed by the employee's Compensation Commission.

6. **Research and Development**

This component shall establish a research agenda to build knowledge and evidences, and gain a better understanding of child injuries in relation to the determinants of health. Thus, appropriate responses can be developed and evaluated. It shall include, but not limited to the causes of injury, it consequences, costs and impact of interventions.

7. **Service Delivery**

This component shall establish a comprehensive and integrated package of service provisions in all levels of the health care delivery system, with emphasis on primary prevention. If necessary, cross-sectoral intervention management shall be instituted through appropriate referral mechanisms. The principle of evidence-based practice shall be applied to all interventions to ensure quality care and cost-effectiveness.

8. **Monitoring and Evaluation**

This component shall identify key indicators for the evaluation of program effects, which include, process (strategy objectives), impact (program objectives) and outcome (program goals) for each of the six priority area. The results of the evaluations shall be used in revising or formulating policies, guidelines, strategies and program plans for child adolescent injury prevention.

B. TYPES OF INJUTY

For analysis purposes and for identifying interventions opportunities, injuries are categorized according to whether or not they were deliberately inflicted and by whom. Based on the *International Statistical Classification of Diseases and Related Health Problems, 10th Revision* (ICD-10), the following categories will be adapted:

1. **Unintentional (i.e. accidental)**

   a. *Road traffic injuries* – any injury due to crashes originating, terminating or involving a vehicle partially or fully on a public highway or street.

   b. *Poisoning* – all unintentional poisoning-related deaths and non-fatal outcomes caused exposure to noxious substances. Those which are intentional or for which the intent is undetermined as well as those resulting from reactions to drugs are excluded from the definition used here.

   c. *Falls* – fall–related deaths and non-fatal injuries exclude those due to assault and intentional self-harm. Falls from animals, burning buildings and transport vehicles, and falls into fire, water and machinery are also excluded.

   d. *Burns* – occur when some or all the different layers of cells in the skin are destroyed by a hot liquid (scald), a hot solid (contact burns) or a flame (flame burns). Skin injuries due to ultraviolet radiation, radioactivity, electricity or chemicals, as well as respiratory damage resulting from smoke inhalation, are also considered to burns.

   e. *Drowning* – all unintentional drowning and submersions (with the exception of those which occur as a result of cataclysm, transport and water transport accidents) are classified as drowning deaths.

   f. *Other intentional injuries* – includes exposure to animate and inanimate mechanical forces

   (including firearms); exposure to extreme ambient temperature and pressure, and to forces of nature, contact with venomous plants and animals; and other external causes.

2. **Intentional (i.e. deliberate)**

   a. *Interpersonal violence*– the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results on or has a likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation. Interpersonal violence-related mortality includes death due to homicide, sexual assault, neglect and abandonment, and other form of maltreatment.

   b. *Self*-harm - includes self-inflicting poisoning or injury (e.g. abuse of drugs and alcohol, and self-mutilation).

c. *Suicide* – is defined as a death arising from an act inflicted upon oneself with the intent to kill oneself.

d. *Legal intervention* – includes action by police or other law enforcement personnel involving firearm discharge, explosives, gas, blunt/sharp objects, and other specified means.

e. *War, civil insurrection and disturbances* – includes injuries to military personnel and civilians caused by war and civil insurrection (e.g. demonstrations and riots).

f. *Undetermined intent* – events where available information is insufficient to enable a medical or legal authority to make a distinction between accident, self-harm and assault. It includes self-inflicted injuries, but not poisoning, when not specified whether accidental or with intent to harm.

IX. IMPLEMENTING GUIDELINES

A. ORGANIZATIONAL STRUCTURE

Based on the activities of the ***Five-Year Strategic Workplan***, the organizational structures shall be established, with delineation of roles and responsibilities, and identification of areas of coordination and collaboration among all child injury prevention stakeholders.

1. National Structure

a. ***A National Child Injury Prevention Partnership*** **(NCIPP)** shall be created by virtue of an Administrative Executive Order; designating the ***Department of Health***, represented by the Undersecretary of Health Program Development Cluster and the ***Council for the Welfare of Children***, represented by its Executive Director as co-chairs. The NCIPP meetings shall be alternately convened and presided by both agencies. Composed of core staff from both agencies, other government and non-government agencies, professional societies, academe, other public and private sectors, it shall be responsible for developing and implementing a national action plan for child prevention. It shall be responsible for developing and implementing a national action plan for child injury prevention. It shall call on the different agencies to do their part in preventing child injury.

a.1 **Sub-committees** shall be organized corresponding to the five priority areas as necessary. According to specific areas of involvement, the sub-committees shall comprise sector representatives and DOH program managers. In coordination with the regional and local implementing committees, it shall be responsible for program monitoring and evaluation based on their respective priority areas, and provide recommendations to the NCIPP.

a.2 There shall be a Secretariat responsible for coordinating the meetings, preparation of agenda and documenting the minutes of the meetings and shall come from the agency responsible for convening the NCIPP meetings.

2. Regional and Local Structures

b. Program strategies and activities undertaken at the local level shall be managed by the ***Regional Child Injury Prevention Partnership (RCIPP)*** or by existing committees than can absorb this function. The composition and organizational arrangements shall correspond to the NCIPP. For NCIPP without regional counterparts, other stakeholders shall be encouraged to be involved

c. Program implementation shall be carried out at the provincial, city, municipal and barangay levels. The composition and organizational arrangements shall relate to the RCIPP. Each corresponding level shall be under the leadership of the chief local executive. For RCIPP without local counterparts, other stakeholders shall be encouraged to be involved.

B. Roles and Responsibility

1. *Department of Health*

The Department of Health as the lead agency, undertook the initial assessment of the magnitude of the problem of child injury in the country. It shall continuously raise awareness among its partners in the government and private sectors, advocate for and create political commitment, and set up a multi-sectoral mechanism on child injury prevention.

The Department of Health, and for that matter the health sector, has the primary responsibility of providing care to the victims of violence and injury. Formulation of policies to prevent injury may be the scope of other agencies, but the health system may help shape these policies by providing data on health outcomes and effective intervention based on science-based approaches. Specifically, the health sector has the following core tasks:

- Develop a surveillance system to capture incidence and prevalence of injuries
- Collect, analyze and disseminate data on the magnitude and health consequences of injuries.
- Advocate for action to prevent and control injuries
- Make available preventive, emergency, curative and rehabilitation services
- Train public health and health-care providers in injury prevention and care
- Design and implement IEC activities
- Evaluate the intervention activities using a science-based approach

2. Role of Local Government Units (LGUs)

The LGUs should be able to translate the national policy on child injury into local policies or ordinances for implementation. The LGUs shall facilitate the allocation of funds and generate resources from its various partners in the field. They shall harness the involvement of government agencies, non-government agencies, families and communities and other stakeholders for a unified action towards child injury prevention.

3. Role of other government agencies, the nongovernment agencies, private sector, civil society and other partners

The wide range of causes of and solutions to injury problems entail stakeholders from various discipline and competencies. Each potential stakeholder shall pitch in their expertise and competence, resources and skills, adopting a multi-sectoral, joint action-oriented effort with no competition and conflict of interests. The problem of injuries cannot be solved by a single agency on its own.

C. FUNDING

The Department of Health and Centers for Health Development shall provide funds for technical assistance, monitoring and advocacy campaigns. The Council for the Welfare of Children, other national government and non-government agencies, local government units and other stakeholders shall contribute counterpart funds to ensure and sustain the implementation of the Child Injury Prevention Program.

X. REPEALING CLAUSE

The provision of previous Orders and other related issuances inconsistent or contrary with the provisions of this Administrative Order are hereby revised, modified, repealed or rescinded accordingly. All other provisions of existing issuances which are not affected by this Order shall remain valid and in effect.

XI. EFFECTIVITY

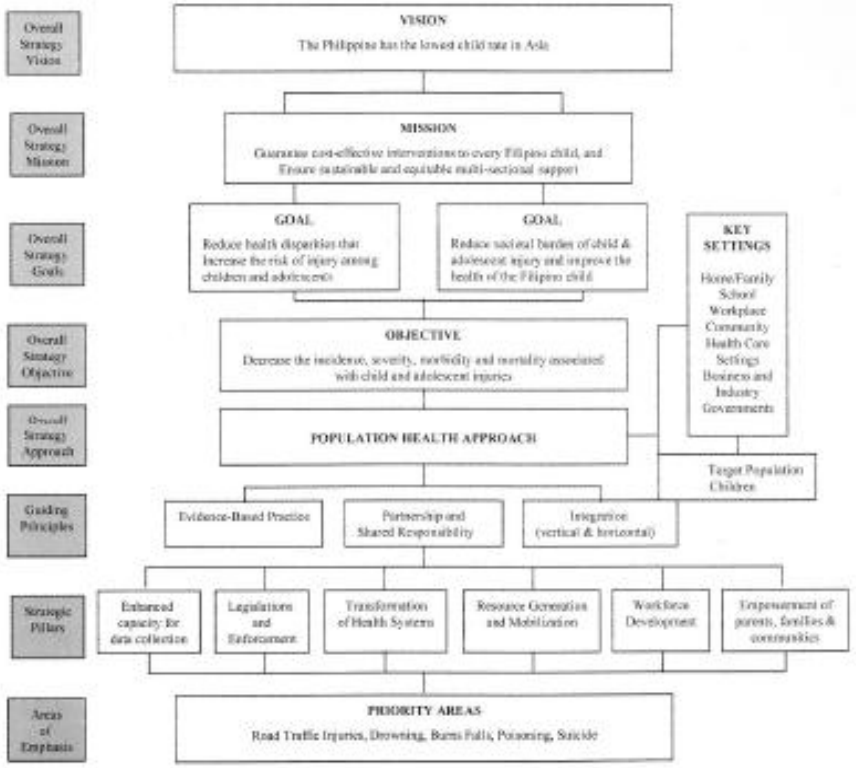
This Order shall take effect immediately.

FRANCISCO T. DUQUE III, MD, MSc.
Secretary of Health

ANNEX 1

STRATEGIC FRAMEWORK

Figure 1. Key Elements of the Child Injury Prevention Strategy



APPENDIX I

Child Injury Prevention and Control Program
SAFE COMMUNITY ASSESSMENT TOOL

Name of Community: _____
(Barangay) (Municipality) (District) (City/Province)

Location: From _____ **To** _____
Rural ☐ **Urban** ☐
Time of observation started: _____ **Time of observation ended:** _____

Instructions:
1. *Please observe the environment and risk-behaviors for a period of one (1) hour.*
2. *Under the ENVIRONMENT column, tick the appropriate box.*
3. *Under the BEHAVIOR column, observe AT LEAST TEN (10) INDIVIDUALS. Encircle the number observed for each item.*

	ENVIRONMENT	YES	NO	N/A	BEHAVIOR*	Number Observed
I. ROAD SAFETY						
1. Road	Free from obstructions (e.g. pelay, copra, barriers, basketball court, etc.)				a) Children playing/begging/ selling on the street	0 1 2 3 4 5 6 7 8 9 ≥10
	Covered manhole					
	No stray animals					
2. Pedestrian	Presence of sidewalk				b) Pedestrians using the sidewalk	0 1 2 3 4 5 6 7 8 9 ≥10
					c) Sidewalk/street vendors	0 1 2 3 4 5 6 7 8 9 ≥10
					d) Children texting/playing video games while walking	0 1 2 3 4 5 6 7 8 9 ≥10
	Visible pedestrian lane				e) Pedestrians using the pedestrian lane	0 1 2 3 4 5 6 7 8 9 ≥10
					f) Children crossing with guide/adult supervision	0 1 2 3 4 5 6 7 8 9 ≥10
	Presence of footbridge				g) Pedestrians using the footbridge	0 1 2 3 4 5 6 7 8 9 ≥10
	Presence of signage (ex. school zone, give way, no crossing)				h) Pedestrians following signage instructions	0 1 2 3 4 5 6 7 8 9 ≥10
	Presence of traffic enforcer/aid, crossing guard				i) Traffic enforcer/aid or crossing guard assisting children	0 1 2 3 4 5 6 7 8 9 ≥10
	Presence of pedestrian crossing signs/lights				j) Pedestrians obeying crossing signs/lights	0 1 2 3 4 5 6 7 8 9 ≥10
3. Passenger	With designated loading/unloading areas				k) Passengers embarking/ disembarking on loading/ unloading areas	0 1 2 3 4 5 6 7 8 9 ≥10
					l) Passengers wearing safety helmet while riding in tandem on a bicycle/motorbike	0 1 2 3 4 5 6 7 8 9 ≥10
					m) Passengers using seatbelt/child restraints	0 1 2 3 4 5 6 7 8 9 ≥10
4. Motorist	Visible road markings with reflectors				n) Motorists obeying loading/unloading sign	0 1 2 3 4 5 6 7 8 9 ≥10
	Presence of traffic/road signs (ex. no parking, pedestrian crossing, destination signs)				o) Motorists giving way to pedestrians crossing	0 1 2 3 4 5 6 7 8 9 ≥10
					p) Motorists complying with loading capacity	0 1 2 3 4 5 6 7 8 9 ≥10
	Presence of functional traffic lights				q) Motorists obeying traffic lights/signals	0 1 2 3 4 5 6 7 8 9 ≥10
					r) Motorists using mobile phones while driving	0 1 2 3 4 5 6 7 8 9 ≥10

	ENVIRONMENT	YES	NO	N/A	BEHAVIOR	Number Observed
II. OTHER PUBLIC PLACE/STRUCTURE						
1. Electrical Post	Secured electric post (non-leaning)					
	Power lines/cables free from obstructions or not entangled from tree branches/streamers					
2. Recreational Areas						
a. Playground	Visible warning/cautionary notices (ex. slippery, drinking liquor not allowed)				s) Children following safety tips/ warning/cautionary notice	0 1 2 3 4 5 6 7 8 9 ≥10
	Safety tips posted (ex. wear appropriate attire)				t) Children playing supervised by adults	0 1 2 3 4 5 6 7 8 9 ≥10
	Barrier fence/enclosure present				u) Children climbing fences/other high structures	0 1 2 3 4 5 6 7 8 9 ≥10
	Well-maintained & functional facilities (no broken parts)					
b. Swimming pool & other bodies of water, e.g. beach, rivers, lakes, ponds, streams, creeks, 'esteros'	Visible warning/cautionary notices (ex. no diving, depth level marks, drinking liquor not allowed)				v) Children following safety tips/ warning/cautionary notice	0 1 2 3 4 5 6 7 8 9 ≥10
	Safety tips posted (ex. wear appropriate attire, water safety instructions)				w) Children swimming supervised by adults	0 1 2 3 4 5 6 7 8 9 ≥10
	Barrier fence/enclosure present				x) Children climbing fences/other high structures	0 1 2 3 4 5 6 7 8 9 ≥10
	Presence of life guard				y) Children attending swimming lessons	0 1 2 3 4 5 6 7 8 9 ≥10
	Well-maintained & functional facilities (not rusty, no broken parts/ structures)					

COMMENTS/REMARKS:

Name of Assessor: _____ Designation: _____
Print name and signature
Date of Assessment: _____

APPENDIX C

Child Injury Prevention and Control Program

HOME SAFETY CHECKLIST

NAME: _____ **Father** ☐ **Mother** ☐ **Guardian** ☐ **AGE:** ____ owner/head of the house
ADDRESS: _____ **Rural** ☐ **Urban** ☑
Number of Children: _____ **Age of Children:** _____
HOME TYPE: Light ☐ Semi-concrete ☐ Concrete ☐

Instruction: Please observe the following structures and check the appropriate box for your answer.

HOUSE STRUCTURE/FACILITIES	Yes	No	Not Applicable
Outside the House (backyard, playground, etc)			
1. House pets caged/leashed/confined in a safe or secured place	✓		
2. Gate/doors always locked	✓		
3. No children climbing and playing on the trees or fences	✓		
4. Canals, creeks, rivers, fish ponds and the likes around the house, if any, are properly fenced	✓		
5. No harmful plants (e.g. *tuba-tuba*, mushroom, *bayati*)	~~✓~~		✓
6. Open well (balon) covered	~~✓~~		✓
7. Pesticides and fertilizers properly stored and kept out of children's reach	~~✓~~		✓
Living Room			
1. Sharp edges/corner of home furniture's/appliances with cover/protectors	✓		
2. Picture frames and other decorative objects hanged properly on the wall	✓		
3. Electrical outlets with cover (itaas mo ang saksakan)		✓	
4. Electric cords are properly fixed (not entangled)	✓		
5. No multiple electrical connections (octopus connection) from one electrical outlet	✓		
6. Large objects/equipment e.g. TV's, bookcases, entertainment units, secured/fixed properly	✓		
7. No scattered items on the floor, like toys, water or other things	✓		
8. Presence of handrails in the stairs	✓		
Kitchen			
1. Cooking stove out of children's reach*	✓		
2. Cooking stove located away from curtains and other combustible materials	✓		
3. Stove firmly fixed/stable (no gas leak, no loose/broken parts)	✓		
4. Presence of a functional fire extinguisher (OPTIONAL)		✓	
5. Kerosene, insecticides, paints, matches and chemicals used for cleaning such as liquid soaps are properly stored and kept out of children's reach*	✓		
6. Sharp utensils such as knives, can opener and others are well kept and out of children's reach*	✓		
7. Electrical cords and wirings of home appliances well fixed and out of children's reach*	✓		
8. Thermos bottle, air pot, kettle or any hot container placed out of children's reach*	✓		
9. Adequate ventilation (with open windows or exhaust fan)	✓		
Bathroom			
1. Bathroom floor well maintained and not slippery	✓		
2. Water containers with cover	✓		
3. Razors, hair dryers and other hazardous items stored out of children's reach*			✓
4. Medicine cupboard/cabinet locked secured from children's reach*	✓		
Bedroom			
1. Windows secured with grills	✓		
2. Child's/infant's bed safe (with railings, floor with matting, sharp edges with cover, etc)			
3. Toys kept in a proper place where the child can easily access/reach without climbing	✓		
4. Safe Toys (in good condition, suitable for child's age, no small detachable parts)	✓		
5. Presence of nightlight (OPTIONAL)	✓		
6. Electrical outlets with cover matataas about 7 feet	✓	~~✓~~	
7. Electric cords are properly fixed (not entangled)	✓		
8. No multiple electrical connections (octopus connection) from one electrical outlet	✓		
Laundry Area			
1. Laundry soap/powder and bottles of bleaching liquid are stored/secured away from children's reach*	✓		

* All or none law will apply

2. Water containers covered	/		

*out of children's reach refers to:
(a) distance of one (1) foot away from the potential source of injury to the outstretched arm of a child; or (b) secured/locked in a cabinet/cupboard

COMMENTS/REMARKS:

_____

_____

Name of Assessor: _____ Designation: _____
Print name and signature

Date of Assessment: _____

APPENDIX F

Child Injury Prevention and Control Program
SAFE SCHOOL ASSESSMENT TOOL

Name of School: _____ **Public** ☐ **Private** ☐

Category: **Pre-school** ☐ **Primary/Elementary** ☐ **Secondary/High School** ☐

Location: _____

Name of Respondent: _____ **Designation:**_____

Instructions: Please check appropriate box/es. Fill-up blank spaces if necessary.

I. SURROUNDINGS (inside & outside school premises)

A. Visible warning signage (ex. school zone, slow down, children crossing, Warning! High Voltage) Present ☐ Absent ☐

B. Crossing guard Present ☐ Absent ☐

C. No harmful plants (ex. mushroom,Tuba-tuba, bayati) Present ☐ Absent ☐

D. School perimeter fence/wall Present ☐ Absent ☐

II. PHYSICAL STRUCTURES

A. CLINIC Present ☐ Absent ☐

B. CLASSROOM has adequate:

1. Lighting YES ☐ NO ☐
2. Number of desks/chairs YES ☐ NO ☐
3. Space between seats YES ☐ NO ☐
4. Ventilation (ex. electric fan/exhaust fan) YES ☐ NO ☐
5. Electrical outlets with cover YES ☐ NO ☐

Absence of scattered objects/things on the floor? YES ☐ NO ☐

If no, check the appropriate box/es below:

Toys ☐ Food ☐ Scissors or other sharp objects ☐ Others ☐ _____

Good condition of facilities/structures within the classroom:

Doors YES ☐ NO ☐ Ceiling YES ☐ NO ☐

Walls YES ☐ NO ☐ Seats YES ☐ NO ☐

Floor YES ☐ NO ☐

C. TOILET

Toilet facilities/structures are in good condition: YES ☐ NO ☐

If no, check the appropriate box/es below:

Mirror ☐ Toilet bowl ☐ Floor ☐ Door ☐

Ceiling ☐ Wall ☐ Others ☐ _____

D. PLAYGROUND

1. Free of stray animals YES ☐ NO ☐ NA ☐
2. Clean (no scattered trash/rubbish) YES ☐ NO ☐ NA ☐
3. Proper fencing (no barbed wires/pointed/sharp objects) YES ☐ NO ☐ NA ☐
4. Flooring of play facilities: YES ☐ NO ☐ NA ☐

	SLIDE	SWING	MONKEY BAR	SEE-SAW
Sand				
Soil				
Cement				
Rubber Mat				

E. GYMNASIUM

Sport facilities/equipment are properly installed: YES ☐ NO ☐ NA ☐

If no, check the appropriate box/es below:

Basketball ring/board ☐ Ceiling ☐ Floor ☐ Door ☐

Volleyball net/posts ☐ Others ☐ _____

F. With SWIMMING POOL: YES ☐ NO ☐ NA ☐

If yes, check the appropriate box/es below:

1. Fenced YES ☐ NO ☐
2. With lifeguard YES ☐ NO ☐
3. Posted warning signs YES ☐ NO ☐

G. HALLWAY has the following:

1. Pathway free from obstructions/holes YES ☐ NO ☐
2. Non-slippery flooring YES ☐ NO ☐
3. Identified Emergency Exit/signage YES ☐ NO ☐
4. Adequate lighting YES ☐ NO ☐

H. STAIRWAY has the following:

1. Handrails on both sides YES ☐ NO ☐
2. Free from obstructions/holes YES ☐ NO ☐
3. Non-slippery flooring YES ☐ NO ☐
4. Adequate lighting YES ☐ NO ☐
5. With directional signage (ex. keep right, emergency exit) YES ☐ NO ☐

I. CANTEEN has the following:

1. Non-slippery flooring YES ☐ NO ☐
2. Regularly maintained fire extinguisher YES ☐ NO ☐
3. No leaking LPG (odorless) YES ☐ NO ☐

J. LABORATORY/TECHNOLOGY SHOP has the following:

1. Tidy tool-room/box/cabinet (proper labels/tools in place) YES ☐ NO ☐ NA ☐
2. Proper electrical connections (no octopus) YES ☐ NO ☐ NA ☐
3. Posters with Safety Tips YES ☐ NO ☐ NA ☐
4. Properly placed and secured chemicals YES ☐ NO ☐ NA ☐
5. Regularly maintained fire extinguisher YES ☐ NO ☐ NA ☐
6. Adequate safety equipments/gadgets YES ☐ NO ☐ NA ☐
7. Flooring has the following:
   a. Color coding for safety YES ☐ NO ☐ NA ☐
   b. Clean, non-slippery (ex. no oil spills) YES ☐ NO ☐ NA ☐
   c. Enough working space YES ☐ NO ☐ NA ☐

K. SAFETY MANUAL YES ☐ NO ☐
(integrated in student's handbook/subject)

L. SCHOOL SAFETY PROGRAM YES ☐ NO ☐

COMMENTS/REMARKS: _____

_____

Name of Assessor: _____ Designation: _____
Print name and signature

Date of Assessment: _____

Annex O: DOH-A.O.# 2011-0014 (Guidelines on the Certification of Health Facilities with basic Emergency Obstetric and Newborn Care (BEmONC) Capacity

Administration of Life-Saving Drugs and Medicines by Midwives to Rapidly Reduce Maternal and Neonatal Morbidity and Mortality.

III. OBJECTIVES

In general, this policy and guide aims to ensure the appropriate provision of quality care for emergency obstetrics and newborn care in the country. Specifically, it aims to:

(1) Ensure quality assurance, public protection and safety in the delivery of maternal and newborn health care services; and
(2) Guide health care providers on professional standards of care for emergency obstetrics and neonatal care to promote the compliance/adherence to facility-based deliveries

IV. SCOPE OF APPLICATION

This Order shall apply to all national, regional and local government public health facilities that are recipients of national government support with the Health Facilities Enhancement Program (HFEP) of the DOH linked to the Conditional Cash Transfer (CCT) convergence sites and all relevant stakeholders whose functions and activities contribute to the delivery and provision of Basic Emergency Obstetrics and Newborn Care (BEmONC) services nationwide.

V. DEFINITION OF TERMS

1. 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.
2. BEmONC Capable Facility- a health facility that can either be a primary/district hospital, RHU operating 24/7 or an RHU/BHS that operate on an on-call basis after regular office/ clinic hours. Such facilities can be certified by the DOH after meeting the standard requirements for certification.
3. CCT Convergence Site – cities or municipalities within a province that have been identified by the National Household Targeting System of the DSWD as recipients of the FOUR P's Program of the Department of Social Welfare and Development.
4. Certification- A process and procedure of external assessment or examination by which an individual or facility is determined to possess a minimally acceptable body of knowledge and/or skills with the capacity to provide the standards of care with adequate resources which includes drugs, supplies, standard equipment and physical infrastructure.

5. Skilled Health Professional- duly licensed practicing health care professionals which include doctors, nurses and midwives

VI. GENERAL GUIDELINES

1. Certification Process

Each health facility shall apply for certification with the Centers for Health Development of the DOH within their respective area or jurisdiction and ensure compliance to technical standard requirements upon application. A Certificate of Compliance shall be conferred by the CHD to a BEmONC capable facility that meets the following requirements:

1.1 Public health facilities shall operate 24/7 and have been upgraded under the Health Facilities Enhancement Program (HFEP) of the DOH with the provision of the standard equipment and health facility infrastructure to function as a BEmONC capable facility

1.2 Have a staff complement trained as BEmONC teams composed of a doctor, nurse and midwife that have undergone the competency based BEmONC training in a DOH designated training center and issued a Certificate of Attendance as skilled health professionals

A Certificate of Compliance issued by the Centers for Health Development shall be valid for one year.

2. Regional Team of Assessors

The Centers for Health Development shall establish an adequate number of staff to constitute the regional team of assessors who will validate the compliance of the health facility to BEMONC service standards applying for BEmONC Certification. The team of assessors shall submit their recommendation upon validation to the regional director who will approve the Certificate of Compliance for those health facilities that meet the certification standards.

3. Maternity Care Package (MCP)

The accreditation of BEmONC capable facilities shall be linked to the Maternity Care Package developed by the Philippine Health Insurance Corporation (PHIC) for District Hospitals (DH), Rural Health Units (RHUS) and Barangay Health Stations (BHS).

The Philippine Health Insurance Corporation (PHIC) shall grant accreditation upon application of the health facilities without the need for a pre-accreditation survey. It shall be subject to the health facility's compliance to requirements as prescribed jointly by the DOH and PHIC with the issuance of the following: (1) **Certificate of Attendance** to trainings conducted by the Department of Health for BEmONC skilled health professionals and (2) **Certificate of Compliance** by the DOH- Centers for Health Development (CHD) for complying with health facility standards for BEmONC.

Building 1, San Lazaro Compound, Rizal Avenue, Sta. Cruz, 1003 Manila • Trunk Line 743-83-01 Direct Line: 711-9501
Fax: 743-1828; 743-1786 • URL: http://www.doh.gov.ph; e-mail: osec@doh.gov.ph

VII. REPEALING CLAUSE

All other Orders and related issuances inconsistent with the provisions of this issuance is hereby repealed and rescinded.

VIII. EFFECTIVITY

This Order shall take effect immediately.

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

Annex P: Micronutrients Supplementation – Highlights from the Manual of Operation

Micronutrient Supplementation Package for 0-11 Month-Old Infants

Target Clients	Micronutrient	Preparation	Dosage/Frequency/ Duration
A. Routine Supplementation			
6-11 month-old	Iron Once the micronutrient powder (MNP) is locally available, iron requirement will be in the form of MNP instead of iron drops.	Drops, 15 mg elemental iron/ 0.6 ml MNP Single served sachet 15 micronutrient formulation	Give 0.6 ml once a day for 3 months. Give 60 sachets to consume in 6 months. (This maybe provided during the growth monitoring visits of children at the health center)
	Vitamin A	Capsule, 100,000 IU	Give 1 capsule once (single dose)
B. Therapeutic Supplementation			
Low Birth Weight Infants (< 2.5 kg)	Iron	Drops, 15 mg elemental iron/0.6 ml	Give 0.3 ml once a day starting at 2 months up to 6 months.
6-11 month-old clinically diagnosed with iron-deficiency anemia	Continue with the iron supplement, but infants need to be assessed for further management.	Drops, 15 mg elemental iron/0.6 ml	Give 3-6 mg/kg/d elemental iron in 3 divided doses a day for 3 months. *Note:* After completing 3 months therapeutic supplementation, infants should continue preventive supplementation regimen. *OR* Give approximately 0.6 ml two to three times a day for 3 months.

Target Clients	Micronutrient	Preparation	Dosage/Frequency/ Duration
B. Therapeutic Supplementation			
6-11 month-old clinically diagnosed with measles (based on IMCI protocol)	Vitamin A	Capsule, 100,000 IU	Give 1 capsule upon diagnosis regardless when the last dose of Vitamin A capsule (VAC) was given. Give another capsule after 24 hours.
6-11 month-old with persistent diarrhea	Vitamin A	Capsule, 100,000 IU	Give 1 capsule upon diagnosis except when child was given VAC less than 4 weeks before diagnosis.
6-11 month-old with severe pneumonia	Vitamin A	Capsule, 100,000 IU	Give 1 capsule upon diagnosis except when child was given VAC less than 4 weeks before diagnosis.
6-11 month-old severely underweight	Vitamin A	Capsule, 100,000 IU	Give 1 capsule upon diagnosis except when child was given VAC less than 4 weeks before diagnosis.
6-11 month-old clinically diagnosed with xerophthalmia	Vitamin A	Capsule, 100,000 IU	Give immediately 1 capsule upon diagnosis, 1 capsule the next day, and another capsule 2 weeks after.
< 6 month-old with diarrhea	Zinc	Drops 27.5 mg/ml (equivalent to 10 mg elemental zinc) 15 ml drops Tablet, 20 mg elemental zinc	Give 1 ml once a day for not less than 10 days; *OR* Give ½ tablet once a day for not less than 10 days
6-11 month-old with diarrhea	Zinc	Syrup, 55 mg/5 ml (equivalent to 20 mg elemental zinc) 60 ml syrup Tablet, 20 mg elemental zinc	Give 20 mg once a day for not less than 10 days. *OR* Give 1 tablet once a day for not less than 10 days.
12-59 month-old with diarrhea	Zinc	Syrup, 55 mg/5 ml (equivalent to 20 mg elemental zinc) 60 ml syrup Tablet, 20 mg elemental zinc	Give 1 teaspoon once a day for not less than 10 days. *OR* Give 1 tablet once a day for not less than 10 days.

Micronutrient Supplementation Package for 12-59 Month-Old Children

Target Clients	Micronutrient	Preparation	Dosage/Frequency/ Duration
A. Routine Supplementation			
12-23 month-old	Iron MNP Note: Once MNP becomes locally available, iron requirement will be in the form of MNP instead of iron syrup	Syrup containing 30 mg elemental iron/ 5 ml Single served sachet 15 micronutrient formulation	Give 1 tsp once a day for 3 months or 30 mg once a week for 6 months with supervised administration. Give 120 sachets in a year.
12-59 month-old	Vitamin A	Capsule, 200,000 IU	Give 1 capsule every 6 months
B. Therapeutic Supplementation			
12-23 month-old clinically diagnosed with iron deficiency anemia	Iron	Syrup, 30 mg elemental iron/5 ml	Give 3-6 mg/kg per day for 3 months. *OR* Give approximately 5 ml two to three times a day for 3 months. If available, continue MNP supplementation after 3 months.
24-59 month-old clinically diagnosed with iron-deficiency anemia	Iron	Syrup, 30 mg elemental iron/5 ml	Give 3-6 mg/kg per day for 3 months. *OR* Give approximately 5 ml two to three times a day for 3 months. Assess children after 3 months for further management.

Target Clients	Micronutrient	Preparation	Dosage/Frequency/ Duration
B. Therapeutic Supplementation			
12-59 month-old clinically diagnosed with measles (based on IMCI protocol)	Vitamin A	Capsule, 200,000 IU	Give 1 capsule upon diagnosis regardless of when the last dose of vitamin A was given. Give another capsule after 24 hours.
12-59 month-old with severe pneumonia	Vitamin A	Capsule, 200,000 IU	Give 1 capsule upon diagnosis, except when child was given VAC less than 4 weeks before diagnosis.
12-59 month-old with persistent diarrhea	Vitamin A	Capsule, 200,000 IU	Give 1 capsule upon diagnosis, except when child was given VAC less than 4 weeks before diagnosis
12-59 month-old who is severely underweight	Vitamin A	Capsule, 200,000 IU	Give 1 capsule upon diagnosis except when child was given VAC less than 4 weeks before diagnosis
12-59 month-old clinically diagnosed with xerophthalmia	Vitamin A	Capsule, 200,000 IU	Give immediately 1 capsule upon diagnosis, 1 capsule the next day and another capsule 2 weeks after.

Micronutrient Supplementation Package for Female Adolescents (10-14 years old) and Non-pregnant/ Non-lactating Women of Reproductive Age (15-49 years old)

Target Clients	Micronutrient	Preparation	Dosage/Frequency/ Duration
A. Routine Supplementation			
10-49 year-old women	Iron/Folic acid	Tablet, 60 mg elemental iron with 2.8 mg folic acid	Give 1 tablet once a week once menarche starts and until one gets pregnant.
B. Therapeutic Supplementation			
10-49 year-old women manifesting clinical signs/ symptoms of malaria.	Iron/Folic acid	Tablet, 60 mg elemental iron with 400 ug folic acid	Give 1 tablet once a day for 2 months.
	Note: Give malaria drugs first and after at least 24 hours, administer iron supplements. Treatment and control program for malaria should be in place in the community.		
10-49 year-old women who have moderate to severe schistosomiasis in endemic areas	Iron	Tablet, 60 mg elemental iron with 400 ug folic acid	Give 2 tablets once a day for 30 days.
	Note: In schistosomiasis-endemic areas, administer the Praziquantel 15-30 days after giving the iron supplement.		
10-49 year-old women clinically diagnosed with IDA	Therapeutic dose of iron/Folic acid	Tablet, 60 mg elemental iron with 400 ug folic acid	Give 2 tablets once a day until hemoglobin reaches normal level. Evaluate after 1 month. If there is adequate response to therapy (defined as an increase in hemoglobin by 1 to 2 g/dl), continue supplementation and re-evaluate after 2-3 months. If there is no adequate response to one month of oral iron therapy, evaluate for other possible causes of anemia.

Micronutrient Supplementation Package for 5-9 Year-Old Children

Target Clients	Micronutrient	Preparation	Dosage/Frequency/ Duration
Therapeutic Supplementation			
5-9 year-old clinically diagnosed with iron-deficiency anemia	Therapeutic dose of iron based on actual body weight	Syrup, 30 mg elemental iron/5 ml	Give 3-6 mg/kg per day for 3 months. *OR* Give approximately 5 ml (1 teaspoon) three to four times a day for 3 months.
5-9 year-old manifesting clinical signs/ symptoms of malaria	Iron	Syrup, 30 mg elemental iron/5 ml syrup	Give 10 ml (2 teaspoons) once a day for 2 months.
	Note: Give malaria drugs first and after at least 24 hours, administer iron supplements. Treatment and control program for malaria should be in place in the community.		
5-9 year-old who are infected with schistosomiasis	Iron	Syrup, 30 mg elemental iron/5 ml syrup	Give 10 ml (2 teaspoons) once a day for 2 months.
	Note: In schistosomiasis-endemic areas, administer the Praziquantel 15-30 days after giving the iron supplement.		
5-9 year-old with xerophthalmia	Vitamin A	Capsule, 200,000 IU	Give 1 capsule immediately upon diagnosis, another capsule the next day, and another capsule 2 weeks after.

Micronutrient Supplementation Package for Pregnant and Lactating Women

Target Clients	Micronutrient	Preparation	Dosage/Frequency/ Duration
A. Routine Supplementation			
Pregnant Women	Iron/Folic acid	Tablet, 60 mg elemental iron with 400 ug folic acid	Give 1 tablet once a day as soon as pregnancy is determined. Give at least a total of 180 tablets administered once a day to be taken for the whole duration of pregnancy.
Pregnant Women	Iodine	Capsule, 200 mg elemental iodine	Give 2 capsules single oral dose once a year, only in any of the following situations: i. IDD prevalence is classified as moderate or severe (UIE is <20ug/l – 49ug/l); ii. Cretinism and neonatal hypothyroidism are present; iii. Iodine supplementation may be given during pregnancy in areas where < 90% of households are using iodized salt and the median urinary iodine is 100 ug/l among school children. *Note:* Give iodine supplementation during the first trimester, but no later than the second trimester. This has been shown to prevent cretinism and other abnormalities.
Post-Partum or Lactating Women	Iron/Folic acid	Tablet, 60 mg elemental iron with folic acid 2.8 mg	Give 1 tablet once a week until one gets pregnant again.
	Vitamin A	Capsule, 200,000 IU	Give 1 capsule within 1 month after delivery.
Lactating Women	Iodine	Capsule, 200 mg elemental iodine	Give 2 capsules single oral dose if not given in the past 12 months.

Target Clients	Micronutrient	Preparation	Dosage/Frequency/ Duration
B. Therapeutic Supplementation			
Pregnant, Post-partum/ Lactating Women clinically diagnosed with iron-deficiency anemia	Iron	Tablet, 60 mg elemental iron with 400 ug folic acid	Give 2 tablets once a day for 3 months. Evaluate after 1 month. If there is adequate response to therapy (defined as an increase in hemoglobin by 1 to 2 g/dl), continue supplementation and re-evaluate after 2-3 months. If there is no adequate response to one month of oral iron therapy, evaluate for other possible causes of anemia. *Note:* After completing 3 months of therapeutic supplementation, pregnant women should continue preventive supplementation regimen.
Pregnant Women clinically diagnosed with xerophthalmia	Vitamin A	Capsule, 10,000 IU	Give 1 capsule of 10,000 IU once a day for four weeks upon diagnosis, regardless of age of gestation. However, if the pregnant woman is currently taking multivitamins with vitamin A, do not give the 10,000 IU VAC.
Post-partum/ Lactating Women clinically diagnosed with xerophthalmia	Vitamin A	Capsule, 200,000 IU	Give 1 capsule upon diagnosis, 1 capsule the next day, and another capsule 2 weeks after.

Annex Q: DOH-A.O. 34-A s. 2000 – Adolescent and Youth Policy

II. *Adolescent and Youth Health Framework:*

Vision: Well-informed, empowered, responsible and healthy adolescents & youth

Mission: Ensure that all adolescents & youth have access to quality comprehensive health care and services in an adolescent & youth -friendly environment.

Goals:

- Healthy development and reproduction maturation
- Healthy lifestyles to avoid illness / diseases / injuries / disabilities
- Information, education, counseling care, and rehabilitation for common health problems
- Healthy adolescents & youthfriendly settings

General Objectives:

To institutionalize a comprehensive program for the health of adolescents & youth.

Health Objectives:

- Reduce morbidity and mortality among adolescents and youth
- Eliminate unwanted pregnancy / abortion / STIs
- Eliminate disabilities and accidents → drug/substance abuse; abusive/destructive behaviors
- Promote general health and development
- Provide quality adolescent & youth -friendly health programs and services.

III. Guidelines and Procedures:

General:

1. The following WHO definition shall be adopted:

Adolescent:	10-19 years old
Youth:	15-24 years old
Young people:	10-24 years old

2. Adolescents and youth are the priority target group of the program.
   - This stage is a time of experimentation and uncertainty that may place them at risk of health related problems which may have lifelong effects.

3. The priority activity shall focused on the prevention of health risk and promotion of healthy activities.
   - This should include information and services that will improve their reproductive health, nutrition, immunity from common illnesses, psychosocial health, oral health, sexual health and environmental safety.

4. Provision of a safe environment

- Parents and adults should exert all efforts to create a safe environment and protect adolescents and youths from all type of exploitation such as exposure to cigarette smoke, unhealthy food (empty calorie-food), abuse by people with authority over them such as relatives, school personnel, media and advertising that emphasizes sex and violence.

5. The family shall be the most important source of basic knowledge, behavior, attitude and skills of adolescents & youth health.

6. The concerned sectors such as teachers, counselors, health providers, social workers, religious leaders, employers, the community and others should support the family in caring for adolescents & youth to prepare them in making good health decisions.

7. Health care services should be accessible and available at all times.
   - These should be in location where they can easily go to or in places where they are usually found such as the schools, shopping malls, teen-age "hang-outs", movie houses, sports centers and in hospitals where they can avail of higher level of care.

   - Selected RHUs with well-trained personnel on adolescent & youth health shall also provide adolescent services.

8. Health care services should be integrated at the client level and therefore must be multi-sectoral.
   - Most adolescent & youth concerns are interrelated in nature and must be responded within a comprehensive program. This should include intervention to address, social, cultural, spiritual and economic aspects of health care.

9. Special services for special health problems and conditions such as disability, rape and abuse victims should be also made available. This shall include medical, legal, & rehabilitation services as well as social, legal and support services.

10. Privacy and confidentiality should be preserved at all times when dealing with adolescent problems.
    - Confidentiality will build trust of the adolescents and will also protect them from the unnecessary peer pressure and embarassment.

11. The adolescents & youth should be actively involved in the planning and development and implementation of health programs and services in their respective area.
    - They should be given enough time to process and discuss the concepts among themselves so that they reach the proper decisions on the methods and approaches that would best suit their interest and frame of mind.

12. Monitoring and evaluation of the availability and effectivity of services shall be conducted regularly to further enhance the quality of programs and services.

13. Health Care Financing scheme shall be organized, developed and maintained to support the institutionalization of adolescent & youth health care and services.

14. The DOH-FHC should designate a Sub-Program-Coordinator for AYH.

Specific Guidelines:

1. Adolescents and youth shall be encouraged to promote the health of their peers, younger children and adults.

2. The promotion of mental health among adolescent and youth will be a _____ including the development of skills and competencies in stress management.

3. The DOH in close partnership with DECS organize a working group to update , review and evaluate the schools health program..

4. All DOH hospitals and facilities shall provide a adolescent and youth - friendly designated area for its program.

5. A comprehensive quality health care services should be provided to all adolescents & youth resources of ethnic, cultural, religious, social, political affiliation. Trained, health care providers such as doctors dentist, nurses, social workers, shall observe the principles of privacy and confidentiality. These services should also be gender sensitive.

Description of the Adolescent & Youth - Friendly Designated Area.

A. *All DOH facilities* should :

- Have a trained health care provider and access to on-call specialists for special needs
- Have comfortable room where privacy can be observed
- Have a small table and 2-3 chairs available
- Have a safety cabinet where records will be kept.
- Minimize unnecessary furnishings such as office table, telephone and other physical barriers and distractions especially during the counseling session.
- Have easy accessibility from outside the hospital or separate entrance and waiting areas from other patients/ clients. A separate room from the hospital building would be ideal..
- Be equipped with necessary logistics and supplies.
- Have alternative promotional IEC materials posted on the wall and take home reading materials
- open for 24 hours.

B. *One stop shop Adolescent & Youth Health Center shall be accredited by DOH* (Malls, Teen-age hangouts/ Tambayan, etc) based on fulfillment of the following basic requisites:

- supervised by a professional care giver (psychologist, psychiatrist, doctor, nurse, midwife or any professional trained in counseling)
- available trained peer counsellors and professionals or on call professional care giver
- available recreational activities like video equipment, computers, games, etc., and reading material
- equipped with necessary logistics and supplies
- comfortable room where privacy can be observed
- a small table and 2-3 chairs available
- unnecessary furnishing such as office table, telephone etc. must be avoided to minimize physical barriers and distractions especially during the counselling session.

- safety cabinet where records will be kept.
- open until 8:00 PM.

C. *RHU/ BHS* should :

- Rural health midwives who shall screen and refer adolescents in the proper level of care
- nurses & doctors who shall screen and provide basic intervention and refer client when necessary to higher level of care
- records that must be kept confidential.
- The following features:
  - a counselling room / area where privacy and confidentiality will be ensured. It must be free from physical barriers like office table, telephone, etc. to minimize and avoid distractions
  - attractive promotional IEC materials posted on the wall and take home reading materials
  - available trained professional health care providers
  - equipped with necessary logistics and supplies
  - open until 5 PM.

IV. Implementing Mechanism:

1. National Level

The DOH shall act as the lead agency in the promotion of Adolescent & Youth Health. Specifically, the Childrens Health Program will be the core health program structure that will undertake the development, monitoring & evaluation of the national AYHP strategy within the Family Health Cluster.

The PHC shall convene a Technical Working Group on AYHP to be composed of the following:

Chair:	Head, FHC
Members:	Focal Person, MCHS
	Focal Person, FPS
	Focal Person, Nutrition Service
	Focal Person, NASPCP
	Focal Person, NCDCS
	Focal Person, Dental Health Service
	Focal Person, WHDP
	Focal Person, PIHES
	Retained Hospital
	NGO
	Other GOs & partner agencies with Adolescent & Youth Concerns

The Technical Working Group will develop a technical framework for specific projects under the sub-program and will review and recommend priorities based on strategic opportunities.

2. Regional Health System:

The Centers for Health & Development (CHD) in various regions of the country will be the sub-national structures that will assist in the implementation of AH strategy & its operating policies. All DOH Retained Hospital shall make Adolescent & Youth Health care as an integral part of hospital services.

The CHD shall likewise organize a Regional TWG, the composition of which will be parallel to that of the national TWG.

3. Human Resource Development:

The following shall be trained / oriented in Adolescent & youth Health:

1. Designated DOH staff (National & Regional)
2. Designated staff of all retained DOH hospitals
3. Designated RHU / BHS staff
4. Other agencies (GOs, NGOs etc.) with adolescent & youth concerns
5. Parents, peers, community, etc.
6. Representative from Sangunian kabataan
7. School teachers & counsellors

4. Logistic support:

The DOH national & regional office shall include in their budget sufficient allocation for adolescent & youth health services & activities to ensure sustainability.
All DOH units shall encourage funding support from different agencies, organization both local and international agency.

5. Social Mobilization and IEC:

This shall be a responsibility of all DOH units. Participation of other agencies (GOs, NGOs and youth themselves) is encouraged.

6. Referral system:

A referral system should be established at all levels. This shall follow the District Health System model and shall conform with provisions of EO 205 on establishing inter-local health zones.

7. Networking:

The Center for Family Health is tasked to spearhead the operationalization of the AYH and establish the necessary linkages with other services, other GOs, NGOs, academe, media and other private institutions including local and foreign donor agencies.

8. Database

The Adolescent and Youth Health Sub-Program will ensure the generation and utilization of data on adolescent & youth for project development, program planning, monitoring and evaluation.

9. Quality Assurance Program:

The Adolescent & Youth Health Program (AYHP), in all aspects of implementation, shall apply the standards and concepts set by the Sentrong Sigla to ensure quality health services. The Adolescent & Youth Health (AYH) TWG, shall therefore coordinate closely with the Sentrong Sigla Steering Committee and its 4 pillars to ensure that quality standards are developed and updated to conform with program structures and directions.

V. Resource Mobilization / Institutionalization:

Multisectoral participation in resource mobilization and rational budget setting for adolescent health promotion are the key to institutionalization of Adolescent & Youth Health (AYH). Efforts must be directed to tapping both public & private sectors for investments.

The DOH-CFH shall allocate 10-20% of its funds to AYH annually.

Local Health Financing:

As stated in the HSRA, the Phil. Health Insurance Corporation will be the key partner to initiate efforts for investing in AYH. Tapping other sources for implementation of AYH shall be a major activity for the cluster particularly private sector or non-government sources.

VI. Effectivity:

This order shall take effect immediately upon its approval & signing by the Secretary of Health.

ALBERTO G. ROMUALDEZ JR., MD
Secretary of Health

Acknowledgement

This Localized Maternal, Newborn and Child Health and Nutrition (MNCHN) Manual of Operation was developed by the Center for Health Development – Cordillera Administrative Region (CHD-CAR) using the 2nd Edition of DOH-MNCHN MOP dated March 2011 and within the context of Indigenous People Republic Act of 1997 or R.A. 8371.

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DOH-CHD-CAR, Baguio City

A healthy mother begets a healthy child!

A joint effort of the following:

Cordillera Administrative Region

DOH CHD CAR

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