

Maternal and Child Health Project



TEAMING UP for Safe Motherhood



The Biliran and Ifugao Experience



TEAMING UP for Safe Motherhood:

The Biliran and Ifugao Experience

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Maternal and Child Health Project



Acronyms

AMADHS	Aguinaldo -Mayoyao- Alfonso Lista District Health System
BEmONC	Basic Emergency Obstetric and Newborn Care
BHS	Barangay Health Station
BHW	Barangay Health Worker
BNS	Barangay Nutrition Scholar
BPH	Biliran Provincial Hospital
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CMMNC	Community Managed Maternal and Newborn Care
CHD	Center for Health Development
DH	District Hospital
DOH	Department of Health
EmONC	Emergency Obstetric and Newborn Care
LSS	Life Saving Skills
MCH	Maternal and Child Health
MCP	Maternal Care Package
MHO	Municipal Health Office
MDR	Maternal Death Review
MMR	Maternal Mortality Ratio
NCDPC	National Center for Disease Prevention and Control
NMR	Neonatal Mortality Rate
PhilHealth	Philippine Health Insurance Corporation
PHO	Rural Health Midwife
RHM	Rural Health Unit
RHU	Skilled Birth Attendant
SBA	Traditional Birth Attendant
TBA	Technical Working Group
TWG	

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Foreword



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MESSAGE

As a major advocate of the rights of women and children, the Department of Health has developed programs geared toward safe motherhood and child health and survival.

The Maternal and Child Health (MCH) Project continues to be one of the priority programs of the DOH. This partnership between the Japan International Cooperation Agency (JICA) and the DOH, through the local government units (LGUs) of Biliran and Ifugao provide a holistic approach toward improving the health status of the community and ensuring the quality of healthcare of the whole population, with preferential attention to the needs of women and children.

The year 2008 saw the blossoming of the initial efforts of this partnership. The MCH Project generated enormous community support. In acceptance at the provincial, municipal and barangay levels has been the catalyst behind the tremendous gains of the project.

In less than three years of implementation the essential activities of the project have already been laid out such as facilities upgrading, human resource development, capacity building, information management and monitoring systems. The strengthening of these systems is the next step to follow during the remaining life of the project.

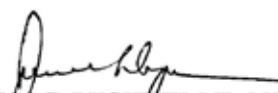
It is heartening to note that our efforts over the last two years have begun to bear fruit. The documentation of this collaboration including project gains and good practices was necessary so these may be replicated in other areas and initiatives.

This publication, *"Teaming up to Lower Maternal and Infant Deaths: the Biliran and Ifugao Experience,"* is aimed at sharing these outputs and inspiring other LGUs to follow suit. It also offers valuable inputs based on actual experiences for those who intend to implement or are currently in the process of conducting MCH projects/programs to lower maternal and infant/neonatal mortality rates.

At present, it is encouraging to note that other stakeholders and partners, inspired by the success of our collective efforts, have started to take actions toward mainstreaming the project's initiatives and approaches to women empowerment and community participation towards maternal and child health. We hear about local chief executives allocating funds for health services for mothers and children, legislative bodies enacting gender-responsive ordinances in support of safe pregnancy and childbirth and the increasing number of gender-sensitive health providers, among others.

We, at the DOH believe that more than being a key component in the achievement of the Millennium Development Goals (specifically MDGs 4,5 and 6), the MCH project through its humble efforts, has shown that organizing for health and development as well as harnessing community involvement through partnerships is an effective way of addressing the problem.

Let us continue to nourish this partnership as we concertedly move towards our goal of attaining and sustaining improvements in the health and well-being of our women and children. It is my fervent hope that this document shall serve as a guide for everyone in the right direction of ensuring maternal and child health in the country.


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



Message

As the deadline for the achievement of the Millennium Development Goals (MDG) nears, the Japan International Cooperation Agency (JICA) is unwavering in its support to assist developing countries like the Philippines in achieving their MDG targets.

Our support to the Maternal and Child Health (MCH) Project is part of our commitment to assist the Philippine Government in improving maternal and newborn services, particularly in the provinces of Ifugao and Biliran.

As the project will be embarking on its third year of implementation, I am proud to note that for the past two years, the project continuously show active cooperation between the government, the communities, development agencies, non-government organizations, and other key stakeholders. The project has proven that effective partnership and strong commitment among the different stakeholders are key elements in efficient service delivery to vulnerable groups, particularly for mothers and newborn children who need timely interventions.

The project's achievements are also proofs of the hard work and thorough consultations with local government officials, Department of Health (DOH), JICA, and other community stakeholders. The challenges that the project faces and the efforts made into addressing them are testaments that improving maternal and child health is a priority issue for the country.

I am confident that in the next two years of program implementation, the project will continue to lay down the groundwork for sustainable maternal and child health initiatives for the Philippines. I hope that the project will be an inspiration for MCH advocates and service implementers, and that the efforts presented here will be replicated in the other provinces.

Maraming Salamat at Mabuhay Kayong Lahat!

Norio Matsuda

JICA Resident Representative

Introduction

This book, *Teaming-Up for Safe Motherhood: The Biliran and Ifugao Experience*, is a compilation of experiences culled from the first two years of implementing the Maternal and Child Health (MCH) Project in Biliran and Ifugao provinces.

A partnership among the Department of Health (DOH), the provincial and municipal governments of Biliran and Ifugao provinces, and the Japan International Cooperation Agency (JICA), the MCH Project aims to lower maternal and neonatal deaths by involving communities – from the provincial down to the barangay level – in implementing safe motherhood programs.

The project works on the premise that maternal and neonatal deaths occur due to the three delays: (1) delay in deciding to seek medical care; (2) delay in reaching appropriate care; and (3) delay in receiving care at health facilities.

Thus, the MCH Project attacks the issue of maternal and newborn deaths in a holistic fashion: educating mothers and community health workers on the risks involved during pregnancy, providing appropriate referral mechanisms to ensure that trained health workers perform deliveries, and improving capability of health facilities to enable them to strengthen emergency obstetric and newborn care.

While the Project is still halfway through, significant gains have already been made towards lowering maternal and infant deaths in the two project areas: Biliran province and the Aguineldo-Mayoyao-Alfonso Lista Inter Local Health Zone (AMADHS-ILHZ) in Ifugao province.

This positive impact has made the program implementors confident that, if properly replicated, the MCH program can significantly reduce maternal and neonatal deaths in other provinces and, ultimately, at the national level.

This book is designed to inspire other local government units (LGUs), health districts/ inter-local health zones (ILHZs), and community health workers to replicate this Program in their localities. It includes detailed activities undertaken, challenges that implementors have faced and the road towards successful implementation of Safe Motherhood Programs.

The first steps have been taken. The way has been shown. It is now time to take the safe motherhood challenge head on and tackle it the practical way.

Country Situationer

The Philippines has been experiencing high maternal mortality ratio (MMR) for several decades. Data from a United Nations MDG regional review (2005) revealed that the country has an MMR of 200 per 100,000 live births (or 2/1,000 live births) and infant mortality rate (IMR) of 27 per 1,000 live births – one of the highest among ASEAN nations.

As per MDGs, the Philippines might be able to achieve its IMR commitments. But MMR is quite a different matter.

The country's high MMR may be attributed to the fact that Filipinos traditionally view pregnancy as a natural occurrence and not as a risky medical condition. Furthermore, the death of a pregnant woman or new mother was traditionally viewed by the community to be due to fate rather than to lack of adequate medical care.

Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR) of selected ASEAN countries

Country	IMR (per 1,000 live births)	MDG at 2015	MMR (per 100,000 live births)	MDG at 2015
Philippines	27	19	200	52
Vietnam	19	12	130	33
Thailand	23	16	44	11
Malaysia	7	0	41	10

Also, while the country's primary health service delivery facilities are far better than other third world countries of the same demographic characteristics – most have at least a rudimentary access to primary health care – the lack of equipment, facilities and know-how also contributes to the high incidence of maternal and newborn deaths.

Referral procedures are hampered by the long distance to the nearest emergency obstetric care facility, lack of transportation, poor road conditions, and poverty (no money for transportation, for food to bring to the medical facility, to pay hospital bills, medicines and supplies; no one to stay with children left at home) This has led to a situation wherein most people in the rural areas would rather give birth at home than in Barangay Health Stations (BHS), Rural Health Units (RHU), or district hospitals, or even in bigger hospitals, thus increasing the risk of pregnancy-related deaths.

While a number of project and program interventions have been implemented to improve maternal and child health services in the Philippines, these efforts treated maternal and child health services as separate issues – requiring separate inputs and delivery mechanisms. It is only now that the country's health managers recognize that integration of maternal and child health services is the way to go for the Philippines to lower MMR, IMR, and NMR and thus improve maternal and child health.

With these in mind, The Maternal and Child Health (MCH) Project – a joint technical cooperation project between the Department of Health and the local government units in Biliran and Ifugao (3 municipalities) provinces – was formed.



Provincial Executive Committees (Provincial Execom) and Technical Working Groups (TWG) oversee the MCH Project's implementation.

The Provincial Execom is composed of the Provincial Governor as chairperson, mayors, Provincial Health Officer, Municipal Health Officers, the chairperson of the Inter Local Health Zones, representatives from the Regional Health Office, other supporting government agencies (PhilHealth, etc.) and NGOs and funding agencies.



Provincial Execoms and TWGs of Ifugao (top) and Biliran (left) in action.

The Maternal and Child Health Project

The Maternal and Child Health Project (MCH) aims to improve the health and safety of mothers and newborns by ensuring the availability of quality health care and increasing the utilization of health facilities specially Emergency Obstetric and Newborn Care services.

A joint effort among the Department of Health (DOH), provincial and municipal stakeholders in the provinces of Biliran and Ifugao (initially covering the AMADHS ILHZ), and the Japan International Cooperation Agency (JICA), the MCH Project is a four year (2006 to 10) project with a holistic approach towards safe motherhood.

Recognizing that maternal and newborn deaths occur due to the three delays: (1) delay in deciding to seek medical care; (2) delay in reaching appropriate care; and (3) delay in receiving care at health facilities, the project's activities were focused on:

1. Strengthen implementation mechanisms and capacity of the central level to enhance Emergency Obstetric and Newborn Care (EmONC) in all levels;
2. Strengthen MCH services and EmONC in the project target areas;
3. Strengthen supporting mechanism for mothers and babies at the primary health level;
4. Put in place management and supportive mechanisms for Women's Health Teams (WHT) and midwives to improve quality of service at the primary health level; and
5. Lessons from the project's implementation contribute to MCH policy formulation at the municipal, provincial, regional and national levels.

PROJECT SITES

The two project sites targeted for implementation, although having considerably high maternal and newborn death rates, differ in degree. Biliran province in Eastern Visayas has the highest MMR and IMR in the whole of Region 8 (even higher than the national levels). While Ifugao province (specifically the AMADHS ILHZ) in the Cordillera Autonomous Region (CAR) has somewhat lower rates, the situation is still alarming because MMR and IMR in the province do not show signs of decreasing. This may be due to the province's mountainous terrain and indigenous beliefs which make formal health services difficult to access and accept.

Biliran province

Biliran is an island province located in the Eastern Visayas region, between Samar and Leyte Islands. It is a fourth class province with a total land area of 55,550 hectares. The smallest among six Eastern Visayas (Region 8) provinces, Biliran has eight (8) municipalities: Naval (the capital), Almeria, Culaba, Kawayan, Cabugcayan, Biliran, Caibiran and Maripipi (an island municipality).

Ifugao province

Home to the spectacular hand-carved rice terraces, Ifugao is located in the north of Luzon, 384 kilometers away from Manila. This third class province lies deep in the Cordillera mountain range. Landlocked, it is bounded on the west by Benguet, on the north by Mountain Province, on the east by Isabela and on the south by Nueva Vizcaya. Ifugao has 11 municipalities, namely: Lagawe (the capital), Banaue, Kiangan, Lamut, Asipulo, Hungduan, Hingyon, Tinoc, Alfonso Lista, Aguineldo and Mayoyao.

BILIRAN province



Coverage: 8/8 municipalities

Population: 160,000

CEmONC: 1

BEmONC: 8 RHU (8 MCP)

BHS: 35 (15 birthing stations)

IFUGAO province

Coverage: 3/11 municipalities

Population: 52,000 (3 municipalities covered)

CEmONC: 0 (Provincial Hospital not in area; 3 hrs. away by car)

BEmONC: 6 (3 district hospital, 3 MCP RHU)

BHS: 34 (8 to be birthing stations)



ACTIVITIES COMPLETED

The following activities were undertaken in the first two years of program implementation (March 2006 to March 2008):

NARRATIVE SUMMARY	ACTIVITIES
OUTPUT 1 <i>Strengthen implementation mechanisms and capacity of the central level to enhance Emergency Obstetric and Newborn Care (EmONC) in all levels.</i>	Developed and printed training manuals which were made available to training institutions and collaborating partners nationwide (500 for BEmONC, 32,000 for CMMNC)
	184 trainers nationwide received 4-day training
OUTPUT 2 <i>Strengthen MCH services and EmONC in the project target areas.</i>	27 from Ifugao and 26 from Biliran participated in 11-day BEmONC training (coverage: 100%)
	73 from Ifugao and 70 from Biliran received 4-day CMMNC training (coverage: 100%)
	40 from Ifugao (coverage: 100%); 42 from Biliran (coverage: 85%) attended 6-day Life Saving Skills (LSS) Training
	8 out of 8 RHUs received PhilHealth Maternity Care Package (MCP) accreditation in Biliran (coverage: 100%); 2 out of 3 RHUs have received accreditation in Ifugao
	BEmONC Facilities: 8 RHUs and 1 Provincial Hospital in Biliran; 3 District Hospitals and 3 RHUs in Ifugao
	BHS as Birthing Station: Biliran: 15 of 15 Ifugao: 0 of 8
OUTPUT 3 <i>Strengthen supporting mechanism for mothers and babies at the primary health level.</i>	WHT: 96 teams with 321 members in Ifugao, 221 teams with 700 members in Biliran
	Orientations took place twice in 63 Barangays in Ifugao and once in 132 Barangays in Biliran. Community plans formulated
OUTPUT 4 <i>Put in place management and supportive mechanisms for Women's Health Teams (WHT) and midwives to improve quality of service at the primary health level.</i>	Monthly meetings have taken place in both sites and case conferences also carried out once in the meetings

NARRATIVE SUMMARY	ACTIVITIES
<p>OUTPUT 5</p> <p><i>Lessons from the project's implementation contribute to MCH policy formulation at the municipal, provincial, regional and national levels.</i></p>	<p>Three-hundred (300) sets of CMMNC Trainers Guide and Training Kit were given to 19 FOURmula One target provinces and 17 Centre for Health Development Regions; CD versions given to the Philippine Midwife Association and USAID-affiliated NGOs</p>
	<p>WHT Guide: 600 copies (Ayangano & English version, Ilocano & English version) to Ifugao Province; 700 copies (Waray & English version, Cebuano & English version) to Biliran</p>
	<p>Project stakeholders have been invited to the following meetings to talk about their experiences:</p> <ul style="list-style-type: none"> ● DOH-organized First Health Sector Conference held in Palawan on May 31, 2007; ● Annual Health Decision-Makers' Forum organized by CHD in the Cordillera Administrative Region (CHD-CAR); and, ● Annual Mindanao Safe Motherhood Summit organized by CHD in the Southern Mindanao Region (November 28-29, 2007).

Project Achievements

CENTRAL LEVEL

The following are the MCH Project's achievements at the national (central) level:

- Active involvement in policy development (assist DOH in formulating policies on Safe Motherhood)
- Development of materials (CMMNC Facilitators Guide, Training Kit, WHT guides, Mother and Child Book)
- Donor coordination (above activities were joint activities with cost sharing among donors)



DOH Undersecretary Mario Villaverde (leftmost) addresses the National Project Management Committee during the MCH project's Mid-Term Evaluation.

PROVINCIAL LEVEL

Both target provinces showed a decrease in the number of maternal and neonatal deaths. However, Ifugao showed a slight increase in IMR. A more detailed description of achievements, as well as the reasons behind these, are shown below.

Ifugao

Achievement in IFUGAO AMADHS

Indicators	2005	2007	MDG Target
% of SBA-attended deliveries	54%	57%	-
Facility-based deliveries (hospitals, RHUs, BHS)	19%	25%	-
% of pregnant women who get antenatal care more than 4 times	88%	90%	-
Maternal Mortality Ratio	85.2 (1/1,173)	0 (0/1,392)	52
Infant Mortality Rate	8.5 (1/1,173)	10 (14/1,392)	19
Neonatal Death Rate	5.1 (6/1,173)	5.0 (7/1,392)	-

Facility-based delivery increased only slightly from 19 to 25% in Ifugao AMADHS. The slight increase, despite the upgrading of facilities and capability of RHUs and massive information campaign, is due to the area's mountainous terrain which makes accessibility to health facilities extremely difficult. Oftentimes, a woman due for delivery has to be carried on a hammock over several kilometers on rough terrain, thus the preference to deliver at home.

This situation prompted a paradigm shift within the program – from strictly enforcing facility-based delivery to allowing home deliveries by skilled birth attendants (SBAs). However, data show that people are now preferring to give birth in health facilities.

Biliran

Achievement in BILIRAN

Indicators	2005	2007	MDG Target
% of SBA-attended deliveries	30%	79%	-
Facility-based deliveries (hospitals, RHUs, BHS)	30%	79%	-
% of pregnant women who get antenatal care more than 4 times	67%	64%	-
Maternal Mortality Ratio	289.2 (10/3,458)	115.6 (4/3,461)	52
Infant Mortality Rate	16.8 (58/3,458)	13.3 (46/3,458)	19
Neonatal Death Rate	4.3 (15/3,458)	3.8 (13/3,458)	-

Related to the increase in facility-based delivery is a drastic decrease in home deliveries – from 84% before the program started to 25% by the end of 2007.

Deliveries at RHUs increased 10 times, while BHS deliveries also posted significant increase due to upgrading of facilities and provision of Life Saving Skills (LSS) training to midwives, making them birthing centers. To date, Biliran has 15 BHS birthing centers. These BHS cum birthing centers serve the more far-flung barangays, including two in the island municipality of Maripipi.

The significant impact of the MCH Project in Biliran province is not only due to its terrain. It is also largely due to the immense support provided by the provincial and municipal governments to the project – not only in the form of financial, manpower and logistical support but more so in terms of political will.

A baby named JICA

Bry. Butac is one of the far-flung villages in Aguinaldo, Ifugao where poor road conditions and lack of access to transportation prevent people from reaching health facilities in times of emergency. These conditions could prove fatal for pregnant women who suffer complications. This was nearly the case for Cely Blanza.

On July 10, 2007, the 36 year-old Cely was in labor for hours for her 2nd child. As part of the WHT protocol, she was set to travel to Aguinaldo People's Hospital, at least two hours by bus, for her delivery. Since the village had no available emergency vehicle, Cely's husband waited patiently for the arrival of the only public bus for them to hire, but to no avail.

Since Cely was already in severe pain, her relatives decided to bring her to the hospital on a hammock, known in these parts as "ayod". Along the way, they happened to come across a JICA-MCH vehicle, which was on the way to a meeting with WHT members for an upcoming barangay health orientation.

After almost two hours of travel over rough roads, Cely was finally admitted to the hospital, where she gave birth. The baby boy was named Jay JICA.



Cord around baby Jay Jica's neck was the reason for his delayed delivery.



Cely being transported on the "Ayod" or hammock. Notice how her belly is protected.



Cely and her handlers after an hour of travelling by hammock (right).

Project Framework

The MCH Project has three components in order for it to holistically tackle the problem of high maternal and newborn deaths.

These components are:

1. Project Management
2. Project Supply Side
3. Project Demand Side

Notice that the terms used for the components all coincide with the project's major stakeholders: the management side composed of the DOH office and the Provincial governments; the demand side composed of the women's health teams (the communities) and the local government units (province, municipality, and barangay); and the supply side composed of training institutions, provincial and district hospitals, rural health units and barangay health stations (in essence, the health service providers).

The management side ensures the creation of policies and strategies that guide the implementation of the program at all levels. It also provides training programs and manuals for the development of the implementors. At the provincial level, the management side comes up with facility-mapping and generates health data, as well as supervises and monitors WHTs.

The supply side ensures that training and equipment are adequately provided to the implementors.

The demand side ensures that community involvement is fully harnessed, via the formation and continued strengthening of WHTs as well as provision of the necessary legislative and monitoring needs of the program (e.g. ordinances, resolutions).

These three components, working harmoniously, all contribute to the project's ultimate goal – lowering maternal, infant and newborn deaths in the target areas.

MANAGEMENT SIDE

1. Department of Health

- Safe Motherhood Policy and Strategy
- Development of Emergency Obstetric and Newborn Care (EmONC) training manuals

2. Province

- PHO ⇔ Facility Mapping of EmONC service
- Supervision and monitoring of MCH Program
- MHO ⇔ FHIS data collection, supervision and monitoring of WHT

- Pregnancy tracking ↑
- Delivery at facility ↑

- Upgraded facilities/ equipment and provided training to SBAs
- RHU/BHS ⇔ BEmONC and MCP accredited for financial stability
- BHS ⇔ Birthing Station and MCP accredited for financial stability
- District Hospital ⇔ BEmONC

IMR ↓
MMR ↓

DEMAND SIDE

1. Formation of Women's Health Team (*more than 1 per Barangay; members are midwife as leader, barangay health and nutrition volunteer, TBA etc.*)

- WHT Textbook
- WHT TOT for SBAs
- Barangay Orientation
- Training for WHT members

2. Political commitment

- Provincial Executive Order on formation of WHT (IFUGAO)
- Provincial Ordinance on limiting functions of TBA (BILIRAN)
- Municipal Resolutions for RHU users fee, utilization of PhilHealth capitation fund, additional manpower for RHUs to support 24-hour service, upgrading of BHS to Birthing Stations

SUPPLY SIDE

1. Human resource (*Training to EmONC service provider*)

- DOH ⇔ selection of training institute
 - ⇔ TOT for Basic EmONC
 - ⇔ TOT for Community Managed Maternal and Newborn Care (CMMNC)
- Province ⇔ BEmONC Training to SBAs
 - ⇔ CMMNC Training for SBAs
 - ⇔ Life Saving Skills Training for midwives

2. Equipment support to facilities

- District Hospitals and RHU ⇔ for BEmONC-capable and to be accredited in PhilHealth's Maternal Care Package of (i.e. delivery beds, delivery tables, etc.)
- Barangay Health Station ⇔ To be upgraded to Birthing Stations and to be PhilHealth-MCP accredited (i.e. delivery beds)

- Facility delivery ↑
- Home delivery with TBA ↓

CRITICAL FACTORS FOR SUCCESS

The first two years have shown that implementing the Maternal and Child Health project entails FIVE factors to ensure success, to wit:

1. Pooling of resources
2. Political commitment/Governance
3. Financial stability
4. Capacity-building/Service delivery
5. Community involvement

1. Pooling of resources

Realizing that this type of endeavor would entail resources at a scale that cannot be funded by a single entity, all stakeholders – the DOH, LGUs, JICA, other NGOs/Funding Agencies, and the community – contributed whatever resources they have to the project.

The DOH made available its policies and experts, LGUs strengthened their provincial and district hospitals and training facilities, hired more people, enacted laws, lent their time and resources for information campaigns, allocated funds for improvement of existing facilities or erection of new facilities and enrolled more people to PhilHealth.

Aside from opening their hearts and minds to the program, the communities lent their funds, manpower, facilities and time to trainings, pooled together resources for referral, and allocated funds for the improvement of existing health facilities.

These contributions augmented JICA/MCH Project's and other funding agencies' resources, ensuring the project's success and giving all stakeholders confidence in its sustainability.

2. Political commitment/Governance

Resolutions were passed in both provinces to give stronger enforcement to the program.

In 2006, Biliran enacted Provincial Resolution No. 166 limiting traditional birth attendants from delivering babies. However, they were integrated as members of the WHT and thus given

the key task of identifying pregnant mothers, conducting information dissemination activities about maternal and child health and health care and serve as advocates for facility-based delivery. Furthermore, they are still allowed to go about their usual “traditional caring” activities (*see Annex 1*).

Believing that facility-based delivery is the way to go and recognizing that people will not go to health facilities even if these are safely and conveniently located, the provincial government enacted a resolution encouraging the use of health facilities. This was made more stronger at the municipal level through a Municipal Ordinance, which imposes stiff penalties (like fines and imprisonment) for both TBA and mother who perform birth at home.

In Ifugao, an Executive Order mandating the formation of “Ifugao AYOD Community Health Teams” was promulgated and signed by the governor (*see Annex 2*).

Role of TBAs under Provincial Resolution No. 166 (Full text of Resolution in Annex)

1. Serve as member of Woman’s Health Team (WHT) – with midwife as team leader and barangay health volunteers and TBA as members – to support tasks of skilled birth attendants and maternal and newborn needs;
2. Advocate for health facility-based birth delivery;
3. Encourage women to enrol for essential pre-and post-natal care and to obtain care from a skilled attendant during childbirth;
4. Help women and families to follow-up on self-care advice and other recommendations from skilled birth attendants (nutrition, treatment, dietary supplementation, immunization, scheduled appointments, plan for births and emergencies, etc.);
5. Encourage the involvement of the male partner in the care of the woman and their newborn;
6. Disseminate health information through the community and families;
7. Give social support during and after delivery, possibly as a birth companion;
8. Inform the skilled birth attendant about women in early pregnancy so that the SBA can make contact with them;
9. Serve as a link between families, communities and local authorities and the reproductive health services; and
10. Encourage community involvement in the development and maintenance of the continuum of care.

Along with enacting laws, other initiatives such as MCP accreditation by PhilHealth for all RHUs (which is also now being done with BHSs); hiring more midwives (even on a contractual basis); enrolling more indigents to PhilHealth; and, giving free service to WHT members and their families at the provincial hospital and RHU, contributed to the success of MCH implementation in the province of Biliran.

3. Financial sustainability

While LGUs (provincial, municipal, even barangay levels) have allocated funds in the course of the program’s implementation, the stakeholders all realized early on that LGU-allocated funds – given the limited budgets – cannot sustain the program in the long-run.

Ifugao AYOD Community Health Teams: Health in the Hands of the community

Ifugao's mountainous terrain and bad roads make access to health facilities extremely difficult. More often than not, vehicles cannot get to the "sitios" (settlements) deep in the mountains. Thus, those in need of medical attention, including mothers about to give birth, are brought to the nearest BHS or RHU on a hammock or *Ayod* which is carried by male community members over several kilometers of rough terrain. *Ayod* is the Ifugao term for "hammock", which is used to carry sick people and women about to give birth to the nearest facility.

The MCH Project has adopted the WHT initiative to promote facility-based delivery. Upon closer observation of WHTs in AMADHS, Ifugao governor Teodoro Baguilat Jr. enacted Provincial Executive Order (E.O.) Nos. 19 and 22 to rename WHT as "Ifugao *Ayod* Community Health Teams". Essentially, the EO expanded the membership of WHTs to include the barangay captain and 2 male volunteers. The inclusion of males in the WHT is an ingenious adaptation to the local situation. Ifugao being predominantly mountainous, it would need men to carry *Ayods* over long distances and difficult terrain. Thus, a group that is composed purely of women (such as WHT) is not logical.

The province also provided for rewards and incentives to outstanding or high performing *Ayod* Teams. It also provides for Technical Assistance (training and monitoring) from the provincial and municipal health offices.

Ifugao currently has 219 *Ayod* teams with 2,169 members.



Gov. Baguilat with Ayod promotional bag



Promotion drama during barangay orientations in Aguinaldo, Ifugao

Thus, they turned to a source that has long been in existence but has not been fully utilized at the local levels – the Philippine Health Insurance Corporation (PhilHealth).

The strategy was simple: enrol as many indigents as possible to the PhilHealth and give the poor members of the community free access to RHU care, specifically free deliveries.

However, implementing this “simple” strategy is quite tricky. Given the limited budgets of most LGUs, finding the money needed to enrol indigents is quite difficult. This is where creativity comes in.

Some LGUs in the project areas rely heavily on the provincial government and the congressman for their PhilHealth enrolment. Others apply more creative approaches such as asking for help from town mates who have migrated overseas.

After enrolling the indigents, the LGU can get the RHUs and even BHSs accredited to the PhilHealth MCP program and gain access to PhilHealth’s capitation fund. Simply put, the capitation fund is a refund given by PhilHealth to members who availed themselves of medical services in accredited medical facilities.

Since RHUs and BHSs normally provide free delivery services for non-PhilHealth or non-Maternity Care package qualified indigent members, the capitation fund is shared by the LGU with the facility to augment the free provision of medicines. This is instant income for the LGU, which can be used in sustaining the program.

Almeria RHU trust fund

Almeria, about 15 minutes drive from the capital town of Naval, was the first municipality in Biliran to fully implement the provincial resolution banning home deliveries.

It was also the first in the province to charge fees for delivery in health facilities (RHU and BHS).

A huge chunk of fees that the RHU is divided equally among the staff. A portion goes to augment the LGU’s budget for health (for the purchase of medicines and supplies), while the rest goes into a trust fund – under the name of Almeria municipality – to sustain the project even without funding agency and LGU support.

The amount needed to enrol an indigent community member in PhilHealth is just PhP 1,200 a year. This may be a small sum for “rich” LGUs, but for LGUs with fewer resources this can be a challenge. However, LGUs in the project sites combined their own resources with creative funds sourcing activities to enrol as many indigents as possible.

In Biliran Province, each RHU and BHS has secured funds allocation from the respective LGU through the Municipal MCH Ordinance. Community members who are capable of paying share the costs via the facility-based user’s fee.

The challenge now is how to ensure continuous enrolment since membership is renewed on an annual basis. Continuous monitoring to ensure that only indigents are enrolled using LGU funds is also critical.

4. Capacity-building

Project implementors realized early on that providing equipment and facilities without the community knowing how to maximize these resources is futile. Thus, training has been one of the project's major components.

Core professional technical skills trainings were conducted on the following topics:

- **Community Managed Maternal and Newborn Care (CMMNC) Training of Trainers** (conducted for 184 trainers in 19 provinces)
- **Basic Emergency Obstetric Care (BeMOC) Training** given to 36 Skilled Birth Attendants (SBAs): doctors, nurses and midwives
- **CMMNC Training** for 90 SBAs
- **Life Saving Skills (LSS) Training** for 82 rural health midwives
- **Barangay Orientation on Safe Motherhood Programs** by WHT for 200 barangays

In addition, several regional, provincial and municipal health practitioners also benefited from international trainings in Japan.

5. Community involvement

Perhaps the best evidence of community involvement in the MCH project is the formation of WHTs (called Ifugao Ayod Community Health Teams in Ifugao and Barangay Quick Response Team or BQRT in Naval municipality in Biliran).

The WHT is not an MCH project invention. It was adopted from the “Women’s Health and Safe Motherhood Project 2” of the DOH (supported by the World Bank), which is being implemented from 2005 to 2011.



The project did not experience difficulties in organizing WHTs because the communities welcomed them with open arms. Although rural health workers such as midwives and barangay health workers have been coordinating for many years now, the WHT formalized this coordination mechanism and even added traditional birth attendants (TBAs) as members. The addition of TBAs strengthened the link between the formal health service delivery system and the community and built a level of trust not seen before in any previous health programs.

Community involvement in the project also manifested itself during many safe motherhood orientation activities conducted in the first two years of the program's implementation.

While DOH, the LGUs and JICA/MCH Project provided the experts, and to some extent the logistics, the communities themselves chipped in whatever they can to help make these orientations successful.

Aside from ensuring maximum attendance and participation, some barangays even provided food. Those who really cannot afford provided the manpower to cook the food. These orientation sessions really brought out the Filipino spirit of “bayanihan” and made the program's implementors truly believe that the MCH program is here to stay.

Scenes from barangay orientations in Ifugao show how the community bands together for MCH



Health education for children is an essential part of barangay orientations.



Demonstrations on Ifugao traditional delivery methods, where the husband usually assists, are conducted.



The entire community is involved during barangay orientations on safe motherhood. The men initiate the cooking.

AREAS FOR IMPROVEMENT

During the first two years of the MCH project's implementation, the following issues surfaced. These are challenges that stakeholders (the DOH, LGUs and communities) will be working on, with support of the MCH project, in the next two years:

NEWBORN DEATH

- Set-up and make functional a Newborn Intensive Care Unit at the Provincial Hospitals (handled by well-trained personnel)
- Continuous implementation of Newborn Death Review
- Promote breastfeeding
- Ensure access to facility-based postpartum and newborn care

HOME DELIVERIES

- Develop the necessary number of BHSs into Birthing Centers to make facility-based delivery accessible to far-flung and mountainous areas
- Closely monitor and supervise WHTs to gather data and provide support to all pregnant women in their areas
- Assist the barangay in developing, implementing and monitoring the Barangay Health Emergency Preparedness Plan
- Disseminate holistically for strict compliance the MCH Ordinance on full facility-based delivery and partnering with barangay leaders (Biliran)

SUSTAINABILITY

- Support LGUs to enable them to fully comply with the regulations on providing Hazard Pay and Subsistence Allowance to Public Health Workers (as motivator for continuous 24-hour operations in Biliran, for instance)
- Ensure full compliance to Ordinance on User's Fee (for those with capacity to pay)
- Enrollment of more indigent community-members to PhilHealth to ensure provision of basic health care for the poor and underserved

PROVINCIAL HOSPITALS

While all RHUs already have BEmONC in-place, which is a primary target of the project, district and provincial hospitals are not yet fully equipped to handle CEmONC functions. While the project is not necessarily targetting hospitals to strengthening EmONC, it is encouraging the Provincial Health Office to allocate more funds to strengthening services, such as:

- Adopt a CPG (Clinical Practice Guideline) for maternity care (since this is still non-existent)
- Make medicines available at all times especially in the Delivery Rooms
- Provide capability-building to Delivery Room staff to effectively monitor pregnant women in labor
- Make fetal monitoring apparatus available in the Delivery Room, Emergency Room and OPD
- Continuous and regular implementation of Maternal Death Review

IMPLEMENTATION STEPS

Just like in any program, there is no cookie-cutter way, no real formula, in instantly implementing the Maternal and Child Health (MCH) Program.

What is clear is that strengthening obstetric and newborn care services – whether improving health facilities so that pregnant women deliver their babies in these facilities, or widening the reach of quality obstetric and newborn care so that it can easily be accessed even by those from far-flung areas – can indeed lower maternal and infant (particularly newborn) mortality rates.

There is, however, a prerequisite – something that needs to be present – for the program to succeed or even take off: COMMITMENT. Commitment from all stakeholders – LGUs, rural health workers, even the community members themselves – to providing, on the part of Rural Health Workers (RHWs) and LGUs and wanting, on the part of community members, quality obstetric and newborn care. This is non-negotiable.

The activities described in detail in the following pages, though not set in stone, is a good guide for those who have made the commitment to safe motherhood.

It is the hope of those who blazed the trail – the communities in Biliran and Ifugao – that these steps, these activities, will help other communities as much as these have helped them.

Given the scope of the program, it is imperative that proper management systems are in place – from the provincial down to the community-level.

Matrix of the key Implementation Steps

KEY STEPS	MAIN OUTPUT	PERSONS INVOLVED	ESTIMATED TIME FRAME	RESOURCES REQUIRED
1. Recognizing the problem and identifying options given available resources	Prioritized gaps/issues on maternal and child health care Identified options to address gaps/issues	Provincial Health Board, ILHZ Board, Provincial, Municipal Government Units	6-12 months	Time and budget for meetings
2. Implementing strategies that are doable and realistic				
2.1. Formulating policies to improve MCH implementation	<ul style="list-style-type: none"> ● Provincial Resolution issued to regulate the practice of TBAs and to encourage facility-based delivery ● Municipal Ordinance issued prescribing the rate of service charges rendered by the MHO; providing incentives to WHT 	Same as above plus community for needs assessment	3-5 months	Time and budget for meetings, drafting and issuance of board resolutions and
2.2. Organizing Women's Health Team (WHT) as advocates for MCH Program	<ul style="list-style-type: none"> ● WHTs organized 	MHO personnel	1-2 months	Time and budget for meetings
Defining WHT roles and functions	<ul style="list-style-type: none"> ● WHT roles clarified 	MHO personnel		
Building capacities of WHT members	<ul style="list-style-type: none"> ● WHT Training as advocates of MCH Program conducted 	MHO personnel		
Mobilizing WHT	<ul style="list-style-type: none"> ● Clustering of WHT and master listing of households done 	MHO personnel		

Matrix of the key Implementation Steps

KEY STEPS	MAIN OUTPUT	PERSONS INVOLVED	ESTIMATED TIME FRAME	RESOURCES REQUIRED
2.3. Improving the capacities of health personnel	● Trained hospital staff (doctors, nurses and midwives) on CEmONC	● PHO, DOH, LGU	1 month	Time and budget for trainings
	● Trained MHO staff (doctors, nurses and midwives) on BEmONC		2 weeks	
	● Trained RHMs on Life Saving Skills		1 week	
2.4. Ensuring the availability of medicines, equipment and supplies for facility-based delivery	● Equipment, medicines and medical supplies provided	● LGU, DOH	3 months	Budget for medicines, equipment and supplies
3. Sustaining quality maternal and child care by increasing financial resources and providing incentives	● Financing scheme developed	● LGU, DOH, PhilHealth		Time and budget for complying with PhilHealth standards and accreditation fees
3.1. Acquiring Maternity Care Package (MCP) Accreditation			3-6 months	
3.2. Increasing the number of PhilHealth indigent enrollees	● 100% PhilHealth indigent coverage		3 months	
3.3. Implementing user's fee for facility-based deliveries	● All municipalities are collecting user's fees.			
3.4. Imposing penalties and utilizing fines collected for MCH activities and incentives for health personnel	● Disincentives for TBAs handling deliveries implemented ● Incentives provided to WHT and health personnel			

Matrix of the key Implementation Steps

KEY STEPS	MAIN OUTPUT	PERSONS INVOLVED	ESTIMATED TIME FRAME	RESOURCES REQUIRED
4. Monitoring and evaluation	<ul style="list-style-type: none"> ● Pregnancy tracking system in place. ● Regular meeting of RHU staff ● Regular WHT meeting ● Maternal Death Review ● Under Five Mortality Review ● Program Implementation Review ● Various health related meetings ● Regular field visits of Provincial MCH Coordinator to all Municipal Health Units 	CHD, PHO, ILHZ, MHO	Monthly Monthly Monthly As needed Quarterly Annual Monthly Monthly	Time and budget for meetings, forms, mother and child book, WHT manual

Key Implementation Steps

Step 1: Recognizing the Problem and identifying options given available resources

The need to enhance the quality of health care should be discussed from two angles – the supply side and the demand side. Various strategies were formulated to respond to the identified needs and concerns, as well as the implementation gaps.

It should be recognized that mobilization of support from the community is needed to fully utilize existing health services at the local health facility.

A valuable realization is the need to organize a functional WHT in every barangay to serve as prime MCH advocate at the grassroots level.

Step 2: Implementing strategies that are doable and realistic

To realize the recommended strategy, the following sub-steps are needed:

2.1. Formulation of policies to improve MCH implementation

The DOH, in its Safe Motherhood Policy, clearly states that the role of TBAs – that of an advocate for facility-based delivery. Thus, TBA practices should be regulated, while capacities and capabilities of skilled birth attendants should be improved at all levels.

The Provincial and Municipal Health Offices should take the lead in these matters.

In Biliran, a municipal resolution was adopted to govern the responsibilities of clients in relation to facility-based delivery. Essentially, the resolution covers the following:

- Penalty of couple who allow home-based delivery;
- Penalty of TBAs who provide service for home-based delivery;
- Facility-based services user's fee for those who can afford to pay that would help augment the operational expenses of the health facility; and
- Incentives for WHT members.

Consultative meetings with the technical management committee and community/barangay members were done before these mandates were implemented.

Involvement of Mayors, Barangay Captains in Information Dissemination

Aside from spearheading the program and allocating funds and other resources, LGU officials must take an active role in information-dissemination campaigns. People, especially in the rural areas, usually regard their officials with the highest esteem and it would immensely help the program if the officials themselves go to the communities and talk about safe motherhood.

Instances where local officials are involved in info campaigns

Mayor Rolando Ty of Almeria, Biliran does not only rely on his barangay captains to spread the word about the safety of facility-based delivery, he himself also goes around telling everybody about it. As a result, facility-based delivery in Almeria increased from 70 in 2005 to 270 in 2007.

Mayor Delfin Bullan of Aguinaldo, Ifugao, has included orientation on safe motherhood in the town's regular "pulong-pulong" (barangay town meetings). As a result, there have now been 15 deliveries in the RHU so far this year, compared to three last year. This figure may be low compared to other areas but is quite promising for Aguinaldo given its mountainous terrain.



Aguinaldo RHU staff (top left) and the only baby born so far in the RHU (top right)

Community involvement

Involving the community from the very start of the program's implementation is crucial to its success. It makes the program easier to implement because the people themselves have a sense of ownership for the program.

The baseline data sharing (discussed previously) is the first step. The community should be involved during the data analyzing phase.

Dissemination of the analysis is also crucial in getting the community's involvement in the program. It makes them aware of the health situation in their community and thus gives them impetus to act on it.

But perhaps the best way to get community involvement in the MCH program, as shown

by the experience in Biliran and Ifugao, is if they themselves are deeply involved in its implementation.

Thus, critical to the success of the MCH program is the formation of Community Health Teams. These teams may go by different names. Women's Health Team is the generic term but in Ifugao they call it AYOD Community Health Team (AYOD being the hammock used to transport the sick) and Naval, Biliran chose to call it the Barangay Quick Response Team or BQRT.

It is easy to form WHTs because the target members have been working together for several decades – they just don't know that they're in fact a team.

Community involvement in the program also manifested itself during the many safe motherhood orientation activities conducted in the first years of the program's implementation.

While the DOH, PHO, and LGUs provide technical assistance, and to some extent, logistics, the communities themselves chipped in whatever they can to help make these orientations a success – either by providing food or the labor to cook the food and serve it.

2.2. Organizing Community/Women's Health Team (WHT) as advocates for MCH

The first step in organizing Community/Women's Health Teams is to identify the existing barangay-based health volunteers as a crucial support group at the community level. It involves the barangay health workers and barangay nutrition scholars and the traditional birth attendants. Each member was identified according to their function as health service advocates in the barangay.

Consultative meetings with TBAs in each municipality should also be held to fully gain their support. Discussions should focus on the targets of the national health sector and World Health Organization (WHO) for access to facility-based services especially for deliveries.

Technical assistance should be provided by the PHO, and training of the Municipal Health Officers should be given to make Women's Health Teams fully functional at the barangay level.

Building Capacities of WHT Members

Training should be provided to all members of the organized WHTs in each barangay, which include the following inputs (guide books are available):

- Overview of Women's Health Team Strategy;
- Overview of the DOH's Concept and Strategy of Safe Motherhood and Newborn Care;
- DOH Strategy on Making Pregnancy and Childbirth Safer;
- World Health Organization's 1999 Statement on Reducing Maternal Mortality;

- Roles and functions of WHT Members; and
- Birth Planning.

Mobilizing Women's Health Teams

To make the WHT fully functional, each member should be given a geographical area of responsibility and tasked to do the following:

WHT composition, roles and functions

In its most basic form, the WHT is composed of the Rural Health Midwife (as chairperson/head), Barangay Health Workers (BHWs), Barangay Nutrition Scholars (BNSs), and traditional birth attendants (TBAs: healers/"hilots"). Other areas include the Barangay Captain and male members, for the simple reason that males are needed to transport pregnant women to the nearest facility.

Formalization is the key to forming WHTs. This means that provinces and municipalities, even barangays, should enact resolutions to formalize the teams' composition, duties and responsibilities, support mechanisms, even incentives.

Functions:

1. Conduct health promotion activities within the barangay (IEC, Advocacy on FOURmula One (F1) flagship programs);
2. Ensure that F1 Program projects and activities (PPAs) are integrated into the Barangay Development Plan;
3. Conduct parents' classes;
4. Conduct active listing and tracking of pregnant women in the barangay;
5. Assist couples in the preparation of birth plans using the Mother and Child Book or Pink Card;
6. Advise pregnant women to deliver in health facilities;
7. Report maternal and under-five deaths to the Municipal Health Office (MHO);
8. Make referrals to health facility or appropriate agency; and
9. Assist in malaria, dengue, TB, rabies and environmental sanitation activities.

- Conduct pregnancy tracking/ master listing;
- Advocate facility-based delivery;
- Advocate access to facility-based health services;
- Conduct one-on-one orientation sessions to all pregnant women and new mothers;
- Conduct mother's class;
- Assist during the conduct of general assembly on health; and
- Assist during the provision of health services at the barangay level such as EPI, prenatal and weighing of babies.

Monitoring and Supervision by Team Leaders

- Regular monthly meetings should be conducted by Rural Health Midwives (RHMs) in each of their respective catchment areas to determine the status of implementation and concerns of the WHTs. RHMs should also ensure that technical assistance is readily provided to answer their identified implementation gaps and concerns.

- Regular follow-up should be done by the Municipal Health Officer and Public Health Nurse through the Rural Health Midwives on the functions of the WHT.

2.3. Improving the capacities of Health Personnel

To better respond to the need for quality provision of care to the community, the following basic capacity building trainings are necessary for skilled birth attendants:

Training on Basic Emergency Obstetric and Newborn Care (BEmONC)

Technical skills received by the Skilled Birth Attendants include:

- Principles of Good Care;
- Quick Check;
- Antenatal Care;
- Labor, delivery and post-partum;
- Perineal Anatomy, Lacerations, and Repair;
- Suturing of Perineal Lacerations;
- Exam of Newborn at Delivery;
- Postpartum Care;
- Neonatal Resuscitation; and Use of Partograph

This training is required by the PhilHealth for MCP accreditation.

Training on Life Savings Skills Training for Midwives

This training is facilitated by the Philippine Obstetric and Gynecological Society (POGS) and the Fabella Hospital and held in Manila. The six-day training is given to Rural Health Midwives. Skills acquired from the training are: IV Insertion, Internal Examination, Laceration Repair (1st and 2nd degree) and Labor Management and Monitoring using Partograph.

WHT conventions

WHT conventions – a cornerstone of the reward and recognition system for the WHT program – gather all members of the Women's Health Team for them to bond and share experiences and best practices. Activities held during the WHT convention are awarding of outstanding WHTs, games, short training/orientation sessions, and inspirational messages by provincial and municipal officials.

Some conventions were even more creative. Mayoyao held a “battle of the bands”, and another town in Ifugao conducted a “Miss WHT pageant”



Community-based orientation on MCH service of RHUs

Community orientation is essential to make people at the barangay level aware about safe pregnancy, safe delivery, newborn care and responsible parenthood. Usually spearheaded by the RHUs, with invaluable help from WHTs, this half-day activity should cover each and every barangay.

Provincial health officials, as well as provincial and local officials, can help a lot by being present in these orientation programs.

Training on Community-Managed Maternal and Newborn Care

This four-day training for all skilled birth attendants is necessary to give the community's women and their families greater awareness and knowledge on safe pregnancy and safe delivery. It aims to strengthen the capacity of the Municipal Health facilities in managing and improving health service delivery to pregnant women and newborns.

The training covers essential information needed by the skilled birth attendants to sustain the “Safe Motherhood Programs” in their locality.

2.4. Ensuring the availability of medicines, equipment and supplies for facility-based delivery

For medicines and supplies to be available anytime, the following strategy should be undertaken:

- Ensure continuity of funds for the Provincial Hospital and all Municipal Health facilities, through PhilHealth's capitation mechanism;
- Ensure continuous budget allocation for health from the municipal government;
- Ensure continuous availment of reimbursement claims from PhilHealth; and



Inspection of JICA-donated equipment at one of target areas' district hospitals

- Strictly implement the charging of the “user's fee” for non-members of PhilHealth MCP who give birth in RHUs and BHSs.

Equipment needed by birthing facilities also need to meet the same standards used for Rural Health Units seeking accreditation with PhilHealth's MCP (**See Annexes 3 and 4**).

Step 3: Sustaining Quality Maternal and Child Care by Increasing Financial Resources and Providing Incentives

3.1. Providing incentives to personnel

As a measure of sustainability, the LGU should consider providing honoraria and incentive to all personnel. In Biliran, TBAs received transportation allowance from the user's fee collected by the RHU. In addition, all members of WHT received a 30% share from the user's fee of their handled and monitored pregnant women. This was done to continually mobilize the TBAs since they are no longer allowed to perform home deliveries based on the provincial and municipal ordinances.

3.2. Acquiring PhilHealth Maternity Care Package (MCP) Accreditation

LGUs can think of a lot of creative ways to raise funds for the sustainability of the program. But perhaps the most important source identified so far is PhilHealth. The capitation fund, amounting to P4,500 for every delivery in an accredited facility, can be used to provide incentives for health workers and WHT members, and built up as trust fund for the program's long-term sustainability.

LGUs provide funds for improvement of facilities

Almeria, Biliran LGU allocated Php 300,000.00 to build an additional delivery room, labour room and recovery room. The decision to provide funds was largely due to the increased demand for facility-based delivery as manifested by a tremendous increase (from zero in 2005 to 172 in 2007). Mayor Rolando Ty, an entrepreneur by heart, saw that the RHU was earning from deliveries and increasing its capability would greatly increase its income. As a portion of what the RHU collects goes to a trust fund, increasing its income would eventually lead to sustainability of the program.

Aguinaldo, Ifugao is also building an extension to its RHU. Initially planned as a geriatric ward and retirement house, the demand for facility-based delivery has made officials allocate a portion of it to house an additional labour, delivery and recovery room.

LGUs (like Naval, Maripipi, and Alfonso Lista) also mobilized their funds to build or repair 10 BHS to make them birthing stations.

However, an RHU as well as other health facilities should be PhilHealth MCP accredited to access this fund. Thus, a Workshop for Accreditation, conducted by a PhilHealth representative and PHO technical personnel, is a crucial activity towards financial sustainability (**See Annexes 3 and 4**).

3.3. Increasing the Number of PhilHealth Indigent Enrollees

Poverty mapping should always be done at the barangay level – through the Community-Based Management Information System – to identify non-enrolled indigents and for them to be subsequently included in the LGU's annual target for PhilHealth beneficiaries.

3.4. Implementing User's Fees and imposing penalties and incentives

To fully implement the Maternal and Child Health Program and make facility-based delivery functional and available anytime, cost-sharing with the patients should be done via a “user's fee scheme”.

Penalties should also be imposed for both pregnant women and health workers/TBAs who deliver at home.

Capitation Fund

Almeria and Naval, both in Biliran, have effectively seen how PhilHealth's capitation fund can make their MCH programs self-sustaining.

Since these two towns have the highest increase in RHU-based deliveries, both their RHUs have benefited from the fund.

However, it is only Almeria that has so far established a trust fund – now close to Php 100,000 – which it hopes will grow further and be able to sustain its MCH program even without external and LGU funding in the future.



Top: Mother who gave birth at Almeria RHU proudly shows off her new baby.



Left: RHMs pose with one-day old baby and his mother (Almeria RHU, Biliran)

Likewise, incentives should be given to WHT members who referred pregnant women to health facilities for delivery as well as SBAs who conducted the actual delivery at the facility (as stated in 3.1 above).

These fees, penalties and incentives should be given legal imprimatur via a Municipal Ordinance for these to be implementable.

Step 4: Monitoring and Evaluation

The following tools are used to determine the status of the Women's Health Team's functionality:

4.1. Pregnancy Tracking Reporting

All members of the Women's Health Team are given a specific area of assignment to include in the master list. They track expectant mothers and ensure that they are provided the needed facility-based health services. The list is submitted to the Rural Health Midwives every 1st week of the month.

The Pregnancy tracking report is consolidated at the municipal level.

4.2. Monthly Meetings

Regularly done in each catchment area by the Rural Health Midwives, these monthly meetings aim to identify and provide appropriate action on issues and concerns of the barangay women's health team, which affect their task as community-based health volunteers and advocates.

Sharing of MCH Experiences



Above: Dr. Virginia Dulnuan of Mayoyao RHU shares their WHT experience during the Dissemination Workshop at the Regional Health Meeting held in Baguio.

Left: Ifugao implementors' visit to Biliran (with Biliran Gov. Espina and Ifugao Gov. Baguilat in the middle).

Contact Details

If you think you are ready to strengthen the MCH program, in your locality, or have further questions, you may get in touch with:

Biliran Provincial Health Office

Castin St., Naval, Biliran

Telefax: (053) 500-9918

Ifugao Provincial Health Office

Natuwolan, Cudog

Lagawe, Ifugao

Telefax: (074) 382-2108 (c/o Provincial Governor's Office)

MCH Project Office

Building 3, Department of Health (DOH)

San Lazaro Compound

Rizal Avenue, Sta. Cruz, Manila.

Office number: (632) 7438301 loc 1345

Almeria, Biliran Resolution on Rate of Service Charges for Facility-Based Delivery, Creation of Trust Fund, and WHT Incentives

Republic of the Philippines
PROVINCE OF BILIRAN
MUNICIPALITY OF ALMERIA
-6544-

OFFICE OF THE SANGGUNIANG BAYAN

EXCERPT FROM THE MINUTES OF THE 7TH REGULAR SESSION OF THE HONORABLE SANGGUNIANG BAYAN OF THE MUNICIPALITY OF ALMERIA PROVINCE OF BILIRAN HELD ON FEBRUARY 12, 2007 AT THE SB SESSION HALL.

PRESENT:	Hon. Richard D. Jaguros	Vice-Mayor/ Presiding Officer
	Hon. Dominador O. Agajan	SB Member
	Hon Henry O. Quijano	SB Member
	Hon. Domingo A. Barrina	SB Member
	Hon. Dioscoro S. Mecaydor	SB Member
	Hon. Ricky A. Morillo	SB Member
	Hon. Zaldy P. Salloman	SB Member
	Hon. Jasmine T. Jaguros	SB Member
	Hon. Orion B. dela Peña	SB Member
	Hon Hilarion C. Lanugan	SB Member
ABSENT:	Hon. Ma. Luz Rosario Jaguros	SB Member

RESOLUTION NO. 15, S-2007

A RESOLUTION TO APPROVE AND ENACT AN ORDINANCE PRESCRIBING THE RATE ON SERVICE CHARGES RENDERED BY THE RURAL HEALTH UNIT OF ALMERIA MATERNITY CARE AND CHILD HEALTH CLINIC AND MANDATING FURTHER THAT THE INCOME GENERATED BY ITS SERVICE CHARGE SHALL ACCRUE TO A TRUST FUND TO BE DEVOTED SOLELY TO THE MATERNITY CLINIC OPERATIONS AND INCENTIVES TO WOMEN'S HEALTH TEAM OF THIS MUNICIPALITY.

WHEREAS, the Sangguniang Bayan of the Municipality of Almeria, pursuant to its powers and functions, deemed its best to enact an ordinance for the establishment and implementation of the maternity care package in our Municipality, so as to provide and give our expectant mothers and newborn babies quality health care they rightfully deserve;

NOW THEREFORE, on motion of Hon Henry O. Quijano, as chairman on Committee on Health and Sanitation, duly seconded by Hon. Dominador O. Agajan, Hon. Domingo A. Barrina and Hon. Dioscoro S. Mecaydor, be it;

RESOLVED AS IT IS HEREBY RESOLVED, to ordain as it s hereby ordained, the following ordinance to wit;

ORDINANCE NO. 01, SERIES OF 2007

"AN ORDINANCE PRESCRIBING THE RATE ON SERVICE CHARGES RENDERED BY THE RURAL HEALTH UNIT OF ALMERIA MATERNITY CARE AND CHILD HEALTH CLINIC AND MANDATING FURTHER THAT THE INCOME GENERATED BY ITS SERVICE CHARGE SHALL ACCRUE TO

A TRUST FUND TO BE DEVOTED SOLELY TO THE MATERNITY CLINIC OPERATIONS AND INCENTIVES TO WOMEN'S HEALTH TEAM OF THIS MUNICIPALITY”.

BE IT ORDAINED by the Sangguniang Bayan of Almeria, Biliran in session assembled that:

ARTICLE I GENERAL PROVISIONS

Section 1-Title

This ordinance shall be known and referred as “An ordinance prescribing the rate on service charges rendered by the Rural Health Unit of Almeria Maternity Care and Child Health Clinic and mandating further that the income generated by its service charge shall accrue to a trust fund to be devoted solely to the Maternity Clinic Operations and incentives to Women's Health Team of this Municipality”.

Section 2- DECLARATION OF POLICIES

It is hereby declared to be the policy of the Municipality of Almeria in partnership with the Provincial Government of Biliran as provided under their Memorandum of Agreement to implement a comprehensive and integrated maternity care and child health clinic in our municipality to:

- 1) Provide high quality delivery care for pregnant women and newborn babies.
- 2) Help reduce maternal and newborn morbidity and mortality rate.
- 3) Give moral, social and technical support services during and after delivery as well as to the family of the pregnant mother.
- 4) Encourage community involvement in the development and maintenance of our maternity clinic.

ARTICLE II DEFINITIONS

Section 3

- A) Almeria Rural Health Unit Maternity and Child Health Clinic- shall refer to an establishment under the control and supervision of the municipality of Almeria that provides health services catering most especially to pregnant women and newborn babies.
- B) MSWD Officer – Refers to an officer of the Department of Social Welfare of our Local Government Unit, whose task mandated by the ordinance is to identify marginalized and indigent maternal patients.
- C) BARANGAY CAPTAIN – shall refer to the chief executive of the lowest level of a governmental unit whose duty under this ordinance is to work in tandem with the DSWD officer in selecting and identifying marginalized and indigent maternal clients.
- D) BeMONC Facilities- shall refer to the equipment and services provided by a team of trained health personnel of the Rural Health Unit Maternity and Child Care.
- E) LOCAL TREASURER- shall refer to the departmental entity of a local government unit who is mandated by this ordinance to collect the income generated by the service charges of the maternal and child health clinic.
- F) Skilled Birth Attendants- consist of a trained Doctor, Nurse and Midwife on basic emergency obstetric care.
- G) WOMEN'S HEALTH TEAM (WHT) – shall refer to a group of community health volunteers such as BHWs, BNS, and TBA.

ARTICLE III SCOPE/COVERAGE

Section 4

The Rural Health Unit of Almeria Maternity and Child Health Care Clinic is committed to provide quality maternal and child care by providing them with the basic package of needed services and skilled birth attendants through the implementation of the BeMONC facility.

Section 5

The above mentioned health facility is a PhilHealth OPB and Maternity Care package accredited unit providing basic health services to indigent and non-indigent clients.

Section 6

Indigent clients with or without PhilHealth cards are exempted from payment of service charge of Rural Health Unit, provided said obstetric patient is duly certified by the MSWD officer or his authorized representative or by the Barangay Captain. Service charges shall be collected by the Local Treasurer as follows;

1. A service charge of P1,000.00 shall be collected for the first delivery.
2. For the next succeeding deliveries an amount of P500.00 shall be collected.

Section 7

Provided that the income generated by its service charges shall accrue to a trust fund to be devoted solely to the Maternity Clinic Operations and incentives to Women's Health Team (WHT).

Section 8

The WHT organized per Barangay is composed of volunteer health workers such as BHWs, BNS, and TBA with the Rural Health Midwife as the team leader. These volunteer health workers are responsible for tracking all pregnant and post-partum mothers in their respective areas and reporting the same to the health facility for prenatal, natal, and post-partum care.

Section 9

Provided that the percentage of service charges is allotted to the clinic operation and WHT incentives as follows: 70% of the proceeds for the clinic operations, while 30% be distributed among the WHT members responsible for the reporting and referral of obstetric patients in their area.

Section 10

Provided further, that other service fees for health examinations provided under the 2006 Revised Revenue Code of the Municipality of Almeria is inapplicable to the enactment of this ordinance.

ARTICLE IV PENALTIES

Section 11-A

Hilots whether trained or untrained are hereby prohibited from performing live birth deliveries at home. Failure to follow will be meted the following penalties:

1. First offense –reprimand
2. 2nd offense – fine of P500.00 or rendition of community work for 8 hours a day for 2 days at the discretion of the court.
3. 3rd offense – fine of P1,000.00 or an imprisonment for 3 days at court discretion.



Republic of the Philippines
Province of Ifugao



Office of the Provincial Governor

EXECUTIVE ORDER NO. 22
Series of 2008

AMENDING EXECUTIVE ORDER NO. 19 ON ORGANIZATION OF COMMUNITY HEALTH TEAMS TO BE KNOWN AS IFUGAO AYOD COMMUNITY HEALTH TEAM AND INSTITUTIONALIZING THE SAME ALL OVER THE PROVINCE.

Whereas, Millennium Development Goals 4, 5 & 6 are related to health improvement and promotion towards attaining better health outcomes;

Whereas, the Province of Ifugao is one of the convergence sites identified for the implementation of the Health Sector Policy Support Programme with FOURMULA ONE (F1) as the over-all framework;

Whereas, FOURMULA ONE is aligned to the National Objectives of Health, Medium Term Philippine Development Plan and ultimately to the Millennium Development Goals;

Whereas, the attainment of better health outcomes requires the active participation of all sectors of society in partnership with the direct providers of health services;

Whereas, the organization of Community Health Teams to be known as Ifugao AYOD Community Health Team is necessary to attain better health outcomes;

NOW, THEREFORE I, TEODORO B. BAGUILAT, JR., Provincial Governor of Ifugao by virtue of the powers vested in me by law do hereby order the organization of atleast one (1) Ifugao Ayod Community Health Team per barangay level with the following composition and functions:

Section 1. COMPOSITION OF AYOD COMMUNITY HEALTH TEAM:

Chairperson:	Barangay Captain
Co-chairperson:	Rural Health Midwife
Members :	Barangay Health Workers
	Barangay Nutrition Scholar
	Kagawad on Health
	2 male volunteers
	2 female volunteers
	Traditional Birth Attendants and
	trained hilots.

Provincial Capitol Compound, Lagawe, Ifugao
E-mail : ifugaoprovince@yahoo.com / ifugaoprovince@gmail.com
Telephone/Fax : (074) 382-2108
Hotlines CP Nos : +639214153982 / +639179690516

Section 2. FUNCTIONS AND RESPONSIBILITIES OF AYOD COMMUNITY HEALTH TEAM:

1. Conduct health promotion activities within the barangay. (IEC, Advocacy on F1 flagship programs)
2. Ensuring that F1 PPAs are integrated into the Barangay Development Plan.
3. Conduct Parents Classes.
4. Active listing and tracking and listing of pregnant women in the barangay.
5. Assist couples in the preparation of birth plan.
6. Advice pregnant women to deliver in health facilities.
7. Report maternal and under five deaths to the Municipal Health Office.
8. Make referrals to health facility or appropriate agency.
9. Assist in malaria, dengue, rabies and environmental sanitation activities.

Section 3. TECHNICAL ASSISTANCE:

The Provincial Health Office in coordination with the Municipal Health Offices and other health partners shall:

1. Train the officers and members of the Ifugao Ayod Community Health Teams to perform their functions.
2. Devise a monitoring and evaluation system to track the impact of the Ifugao Ayod Community Health Teams in improving the health status of their respective barangays.
3. Document the good practices of Ifugao Ayod Community Health Teams which can be replicated in other areas.
4. Devise a reward system to recognize outstanding/performing Ifugao Ayod Community Health Teams during appropriate ceremonies.

Section 4. The Ayod CHT shall subsume the functions of the GFMC initiated Barangay Action Team (Malaria and Dengue), UNFPA-initiated Barangay Health Committees, and the JICA-MCH initiated Womens Health Teams.

This ORDER shall take effect immediately.

DONE this 22nd day of APRIL 2008 at the Provincial Capitol, Lagawe, Ifugao.


TEODORO B. BAGULAT, JR.
Provincial Governor

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
 City State 709 Shaw Blvd., Pasig City
 Health line 637-9999, www.philhealth.gov.ph

PHIC Form MCPC-AF-2
 2/13/03

**APPLICATION FOR ACCREDITATION
 NON-HOSPITAL HEALTH FACILITY FOR THE MATERNITY CARE PACKAGE**

(Date)
THE PRESIDENT
 Philippine Health Insurance Corporation
 Pasig City, Philippines

SIR:

I, _____, Filipino, of legal age, _____ with address at _____
 (Position/Designation)
 and the duly authorized representative to act for and in behalf of _____
 (Health Care Institution), hereby applies for accreditation under Sec. 16 L of R.A. 7875 and its Implementing Rules and Regulations thereto. For this purpose, I hereby submit the following pertinent information and documentary requirements.

Name of Health Facility: _____		Type of Health Facility: _____	
Complete Address: _____			
Telephone No. _____		Fax No. _____	
Date Established: _____		Director/Owner _____	
Nature of Ownership: <input type="checkbox"/> Government <input type="checkbox"/> Private		E-mail Address: _____	
Type of Application: <input type="checkbox"/> Initial <input type="checkbox"/> Renewal <input type="checkbox"/> Re-accreditation		Zip Code: _____	
I. CLINIC FACILITIES			
1. General Infrastructure			
<input type="checkbox"/> Space for large and clear sign bearing name of the Health Facility <input type="checkbox"/> Additional sign indicating it is a PhilHealth provider <input type="checkbox"/> Space for large sign enumerating the service components of the Maternity Care Package <input type="checkbox"/> Generally clean environment <input type="checkbox"/> Fire safety provision <input type="checkbox"/> Sufficient seats for patients in a well ventilated area <input type="checkbox"/> Adequate lighting/electric supply <input type="checkbox"/> Adequate clean water supply <input type="checkbox"/> Covered garbage containers with color-coded segregation		<input type="checkbox"/> Separate receptacle for disposing pointed/sharp objects <input type="checkbox"/> Private consultation/examination room or cubicle <input type="checkbox"/> Examination table with clean linen <input type="checkbox"/> Delivery room with delivery table <input type="checkbox"/> Recovery area with bed/s <input type="checkbox"/> Area for cleaning/resuscitation of newborn <input type="checkbox"/> Toilet facility <input type="checkbox"/> Area for cleaning of instruments <input type="checkbox"/> Cleaning supplies for the facility and clinical instruments	
2. Basic Consultation and Delivery Room Equipment:			
<input type="checkbox"/> Alligator forceps 10" <input type="checkbox"/> Ambu bag (adult) <input type="checkbox"/> Ambu bag (pedia) <input type="checkbox"/> Bassinet/newborn carrier <input type="checkbox"/> BP Apparatus <input type="checkbox"/> Delivery table <input type="checkbox"/> Electric Stove <input type="checkbox"/> Foot stool <input type="checkbox"/> Gooseneck lamp (2) <input type="checkbox"/> Haemostatic straight forceps <input type="checkbox"/> Instrument cabinet <input type="checkbox"/> Instrument table	<input type="checkbox"/> IV Stand <input type="checkbox"/> Jar with stainless cover <input type="checkbox"/> Jar without cover <input type="checkbox"/> Kelly pad <input type="checkbox"/> Needle holder <input type="checkbox"/> Ovum forceps <input type="checkbox"/> Oxygen gauge/regulator <input type="checkbox"/> Oxygen tank (5 lbs. minimum) <input type="checkbox"/> Pail <input type="checkbox"/> Pick up forceps <input type="checkbox"/> Portable emergency light or flashlight	<input type="checkbox"/> Rubber suction bulb syringe <input type="checkbox"/> Sponge holding forceps <input type="checkbox"/> Stainless bowl (kidney shape) <input type="checkbox"/> Stainless bowl (round shape) <input type="checkbox"/> Stainless iodine cup <input type="checkbox"/> Stainless steel instrument tray with cover <input type="checkbox"/> Stainless steel instrument tray without cover <input type="checkbox"/> Stethoscope <input type="checkbox"/> Stool <input type="checkbox"/> Straight forceps 10"	<input type="checkbox"/> Suction apparatus <input type="checkbox"/> Surgical scissors (straight) <input type="checkbox"/> Tenaculum forceps <input type="checkbox"/> Tissue forceps 6" (regular) <input type="checkbox"/> Uterine forceps 10" <input type="checkbox"/> Uterine sound 12" <input type="checkbox"/> Vaginal speculum <input type="checkbox"/> Wall clock with second hand <input type="checkbox"/> Weighing scale (adult) <input type="checkbox"/> Weighing scale (infant)
3. Standard Supplies:			
<input type="checkbox"/> 70 % Isopropyl Alcohol <input type="checkbox"/> Bed sheets <input type="checkbox"/> Butterfly set (G19) <input type="checkbox"/> DSLR <input type="checkbox"/> Disposable syringes w/ needles <input type="checkbox"/> DR Gown/scrub suit <input type="checkbox"/> IV Tubing <input type="checkbox"/> Linen for bassinet/newborn carrier <input type="checkbox"/> Nasal Cannula	<input type="checkbox"/> Plaster <input type="checkbox"/> Plastic apron <input type="checkbox"/> Povidone iodine <input type="checkbox"/> Soaking/sterilizing solution <input type="checkbox"/> Sterile absorbable suture with/without needle <input type="checkbox"/> Sterile cord clips/ties for baby <input type="checkbox"/> Sterile cotton balls <input type="checkbox"/> Sterile cotton pledgets	<input type="checkbox"/> Sterile cutting needle <input type="checkbox"/> Sterile drapes <input type="checkbox"/> Sterile gauze <input type="checkbox"/> Sterile gloves <input type="checkbox"/> Sterile round needle <input type="checkbox"/> Surgical cap <input type="checkbox"/> Surgical masks <input type="checkbox"/> Tape measure <input type="checkbox"/> Thermometer (oral)	<input type="checkbox"/> Thermometer (rectal) <input type="checkbox"/> Xylocaine/Lidocaine <input type="checkbox"/> Methergin <input type="checkbox"/> Tetanus toxoid <input type="checkbox"/> Erythromycin ophthalmic ointment (0.5%) <input type="checkbox"/> Vitamin K Ampule <input type="checkbox"/> Progesterone only pills <input type="checkbox"/> D-Medroxyprogesterone acetate(DMPA) <input type="checkbox"/> Intrauterine Device (copper T)
4. Means of Transport for Conduction of Patients:			
<input type="checkbox"/> Transport vehicle for patient's use		<input type="checkbox"/> Contract with providers of such ambulance services	

5. Standard FP-MCH Records/Reports/Materials:						
<input type="checkbox"/> Consultations/Admissions logbook		<input type="checkbox"/> Patient's Clinical Record	<input type="checkbox"/> Printed materials/posters for patient education			
		<input type="checkbox"/> Referral Forms				
II. CLINIC STAFF						
	Name	PRC No.	Validity	Signature		
	Provider (Midwife/Physician)					
	Provider (Midwife/Physician)					
	Provider (Midwife/Physician)					
	Partner OB Physician					
	Partner Pedia Physician					
	Clinic Aide					
III. SERVICE CAPABILITY						
<input type="checkbox"/> Prenatal Consultation		<input type="checkbox"/> Delivery	<input type="checkbox"/> Postnatal including FP			
IV. QUALITY ASSURANCE ACTIVITIES (optional for initial accreditation)						
<input type="checkbox"/> Mission/Vision		<input type="checkbox"/> Human resource development				
<input type="checkbox"/> Clinical standard operating procedures (SOP) of performance and referral		<input type="checkbox"/> Satisfaction surveys for employees and patients				
<input type="checkbox"/> Records Management		<input type="checkbox"/> Compliance to monitoring and evaluation activities of PHIC				
<p>I hereby declare under penalties of perjury that the answers given are true and correct to the best of my knowledge and belief.</p> <div style="display: flex; justify-content: space-around; margin-top: 20px;"> <div style="text-align: center;"> <p>_____</p> <p>Date Accomplished</p> </div> <div style="text-align: center;"> <p>_____</p> <p>Owner</p> </div> </div> <div style="margin-top: 20px;"> <p>Res. Cert. No. _____</p> <p>Issued at: _____</p> <p>Issued on: _____</p> </div>						
<p>Status of Application:</p> <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <div style="text-align: center;"> <input type="checkbox"/> Approved Date: _____ </div> <div style="text-align: center;"> <input type="checkbox"/> Deferred Date: _____ </div> <div style="text-align: center;"> <input type="checkbox"/> Denied Date: _____ </div> </div> <div style="margin-top: 20px;"> <p>Date Received at CO: _____</p> <p style="margin-left: 200px;">Date Received at PRO: _____</p> </div>						
<p>Checklist of Requirements for Non-Hospital Health Facility for Maternity Care Package</p> <table style="width: 100%; border: none;"> <tr> <td style="vertical-align: top; width: 50%;"> <input type="checkbox"/> PhilHealth application form properly accomplished and notarized <input type="checkbox"/> Mayor's permits and Proofs of operation for a minimum period of three (3) years <input type="checkbox"/> Patients' records <input type="checkbox"/> Sworn testimonies from the parish priest, other religious or community leaders <input type="checkbox"/> Tax returns of the facility for the past three (3) years <input type="checkbox"/> Identification of precursor health facility <input type="checkbox"/> Accreditation Fee (refer to PhilHealth Circular 29, s. 2004) by postal money order payable only to Philippine Health Insurance Corporation or cash paid directly to the cashier. The accreditation fee is non-refundable. </td> <td style="vertical-align: top; width: 50%;"> <input type="checkbox"/> MOA with hospital of higher category to admit referred cases <input type="checkbox"/> MOA with a physician <input type="checkbox"/> Transport vehicle or MOA with a vehicle owner <input type="checkbox"/> Current photographs of clinic facade and other facilities <input type="checkbox"/> Current photographs of complete Clinic Staff <input type="checkbox"/> Complete list of staff with respective designations <input type="checkbox"/> List of equipment and supplies <input type="checkbox"/> List of available drugs in the clinic <input type="checkbox"/> Current standard operating procedure <input type="checkbox"/> PhilHealth RF1 <input type="checkbox"/> Quality Assurance activities </td> </tr> </table>					<input type="checkbox"/> PhilHealth application form properly accomplished and notarized <input type="checkbox"/> Mayor's permits and Proofs of operation for a minimum period of three (3) years <input type="checkbox"/> Patients' records <input type="checkbox"/> Sworn testimonies from the parish priest, other religious or community leaders <input type="checkbox"/> Tax returns of the facility for the past three (3) years <input type="checkbox"/> Identification of precursor health facility <input type="checkbox"/> Accreditation Fee (refer to PhilHealth Circular 29, s. 2004) by postal money order payable only to Philippine Health Insurance Corporation or cash paid directly to the cashier. The accreditation fee is non-refundable.	<input type="checkbox"/> MOA with hospital of higher category to admit referred cases <input type="checkbox"/> MOA with a physician <input type="checkbox"/> Transport vehicle or MOA with a vehicle owner <input type="checkbox"/> Current photographs of clinic facade and other facilities <input type="checkbox"/> Current photographs of complete Clinic Staff <input type="checkbox"/> Complete list of staff with respective designations <input type="checkbox"/> List of equipment and supplies <input type="checkbox"/> List of available drugs in the clinic <input type="checkbox"/> Current standard operating procedure <input type="checkbox"/> PhilHealth RF1 <input type="checkbox"/> Quality Assurance activities
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WARRANTIES OF ACCREDITATION FOR OUT PATIENT CLINICS FOR THE MATERNITY CARE PACKAGE

1. ELIGIBILITY

- 1.1 That it is in operation for at least three (3) years.
- 1.2 That it is affiliated with a PHIC accredited secondary hospital;
- 1.3 That it has the human resources, equipment, physical structure and other requirements in conformity with standards established by the Corporation;
- 1.4 That it has an ongoing quality assurance activity;
- 1.5 That it has at most three (3) accredited midwives.

2. COMPLIANCE TO PERTINENT LAWS

- 2.1 That the aforementioned health care institution shall in the course of its participation with the NHI Program by virtue of its accreditation comply with the provisions of the National Health Insurance Law (RA 7875), its Implementing Rules and Regulations, and all administrative orders of the corporation;
- 2.2 That it shall accept the formal program of quality assurance, payment mechanism and utilization review of the NHI Program;
- 2.3 That its personnel shall strictly adhere and comply at all times with the Codes of Ethics of their respective professions and other medical related professions of the Philippines.

3. CLINICAL SERVICES

- 3.1 That the aforementioned health care institution shall guarantee safe, adequate and standard maternal care for all patients seeking maternal care; and shall exercise observance of public health measures in case of communicable disease;
- 3.2 That it shall adopt referral protocols, strictly follow guidelines and health resource sharing arrangements of the Program;
- 3.3 That it shall extend without delay chargeable benefits due qualified members and beneficiaries;
- 3.4 That it shall not engage in unethical and illegal solicitation of patients for purposes of compensability under the NHI program;
- 3.5 That it shall maintain serviceable equipment and facilities and required personnel.

4. CLINICAL RECORDS AND PREPARATION OF CLAIMS

- 4.1 That the aforementioned health care institution shall maintain and accomplish at all times accurate chronological records of all patients, services rendered, health outcomes resulting from such services and health expenditures on patient care;
- 4.2 That it shall keep neat and systematic records file in a safe but accessible place for easy retrieval;
- 4.3 That it shall undertake measures to enter only true and correct data in all patients' records and in the preparation of claims and ensure the filing of legitimate claims within the sixty (60) calendar days after the patient's discharge;
- 4.4 That I, acting on behalf of this institution, together with the concerned personnel, shall take full responsibility for any omission or commission in the preparation of claims and in the entry of clinical records.

5. MANAGEMENT INFORMATION SYSTEM

- 5.1 That the aforementioned health care institution shall give proper information of its accreditation status by posting the PhilHealth certificate of accreditation in a very conspicuous place in the said institution;
- 5.2 That it shall post at its billing section updated information of the Program's benefits and procedural requirements and make available the necessary forms for patient's use;
- 5.3 That it shall inform the Department of Health all reportable cases confined in the aforementioned institution;
- 5.4 That it shall immediately inform the PhilHealth in writing of any of the following changes in the institution's 1) location, 2) ownership or management, or 3) closure or temporary cessation of the outpatient clinic for the MC Package operation.

6. OUTPATIENT CLINIC INSPECTION / VISITATION / INVESTIGATION

- 6.1 That the aforementioned health care institution recognizes the authority of the PhilHealth and its duly authorized representative or agents deputized by PhilHealth to conduct inspection, visitation or investigation of the institution at anytime;
- 6.2 That it shall cooperate in the inspection / visitation / investigation by making ready and available all clinic records (medical & financial) and other pertinent documents;
- 6.3 That it shall obey without delay summon, subpoena or subpoena duces tecum from the Corporation or Local Health Insurance Office.

Finally, the undersigned hereby affirms that the PhilHealth, by virtue of its power under RA 7875 may suspend or revoke the accreditation of this institution if found to have violated any of the provisions of the National Health Insurance Act, or its Implementing Rules and Regulations and any of these Warranties of Accreditation.

WITNESS MY HAND AND SEAL, this _____ day of _____, 200_ at _____.

Administrator/Provider
(Signature over printed name)

Doc. No. _____
Book No. _____
Page No. _____
Series of 200_

Notary Public
Until _____
PTR No. _____
Issued at _____
Issued on _____

Contents of Safe Motherhood Assessment Tool for RHUs and BHSs
(Requirement for PhilHealth MCP accreditation)

**Safe Motherhood Needs Assessment Tool-
 Rural Health Units/Barangay Health Stations**

Contents

Form 1:	Facility Management Tool (All Facility Levels)
Form 2:	Facility Function Assessment Form (All Facility Levels)
Form 3:	Facility Case Summary Form (All Facility Levels)
Form 4-B:	Health Facility – Infrastructure (RHU/BHS)
Form 5-B:	Health Facility – Furniture and Linen (RHU/BHS)
Form 6-B:	Health Facility – Equipment (RHU/BHS)
Form 7-B:	Needs Assessment – Drug List (RHU/BHS)
Form 8:	Health Management Information System Questionnaire (All Facility Levels)

**SAFE MOTHERHOOD/EMERGENCY
 OBSTETRICS CARE
 NEEDS ASSESSMENT TOOL**

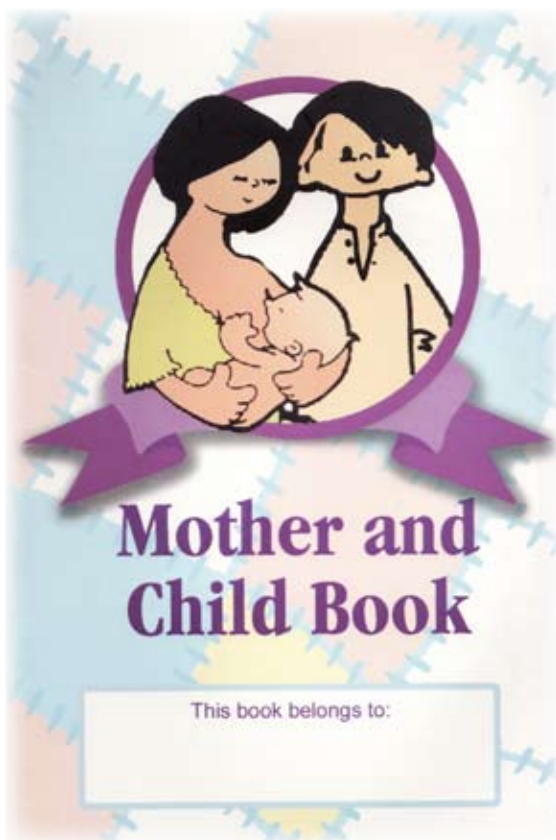
**RURAL HEALTH UNITS/
 BARANGAY HEALTH STATIONS**



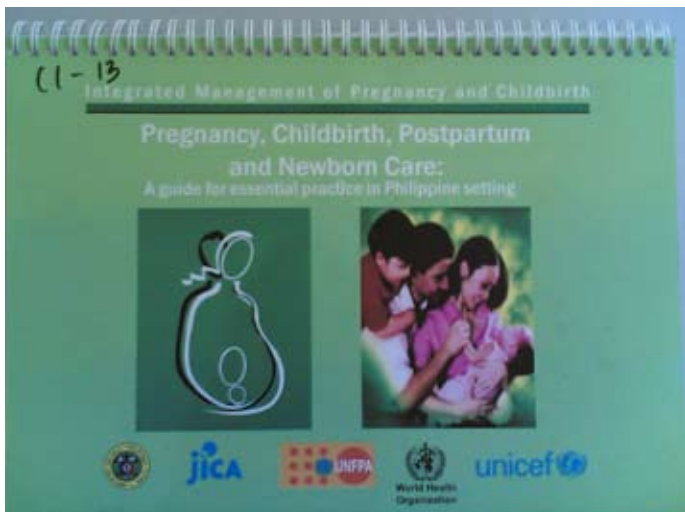
Annex 5

Publications that can be used as references in implementing the MCH program (available at the Department of Health)

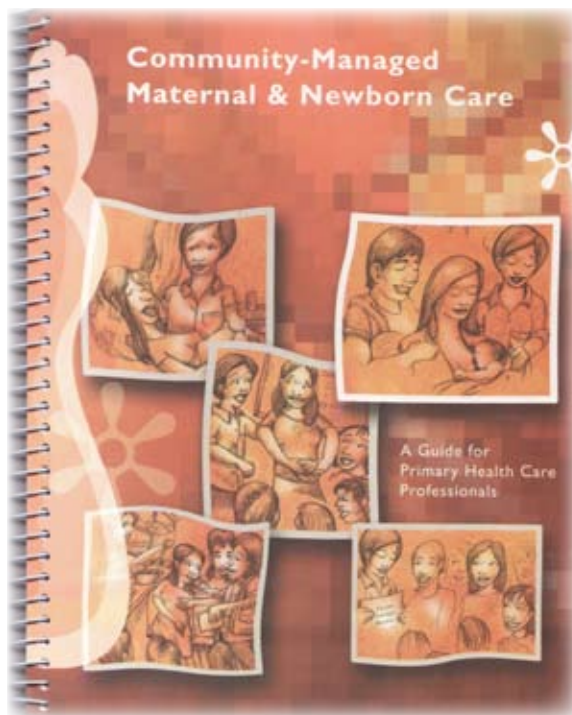
Mother and Child Book



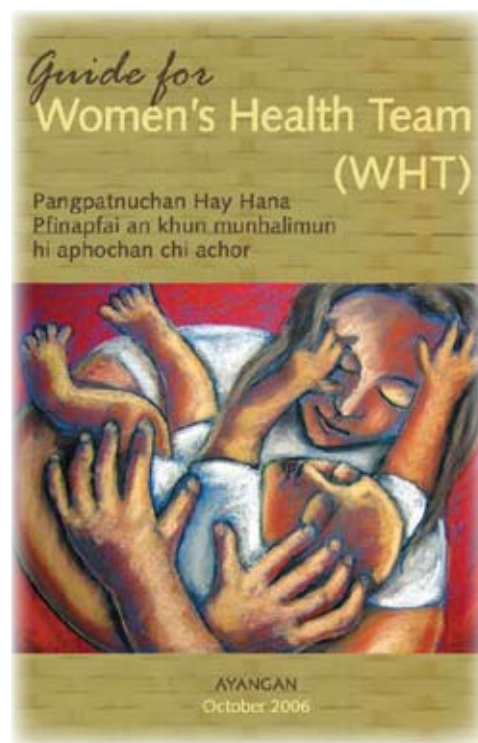
BEmONC Textbook

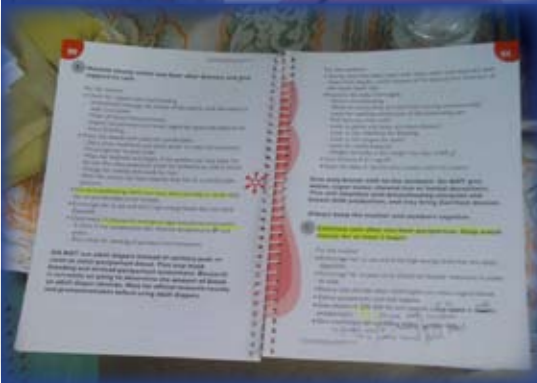


CMMNC Guidebook



WHT Guidebook





Department of Health (DOH)
 Japan International Cooperation Agency (JICA)
 Biliran Provincial Government
 Ifugao Provincial Government