

**IMPLEMENTING HEALTH REFORMS  
TOWARDS RAPID REDUCTION IN  
MATERNAL AND NEONATAL MORTALITY**

**MANUAL OF OPERATIONS**



**Department of Health  
2009**

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### LIST OF ATTACHMENTS:

1. PREGNANCY TRACKING FORM
2. WHT MATERNAL DEATH REPORTING FORM
3. FACILITY MATERNAL DEATH REPORTING FORM
4. MNCHN MONITORING FORM
5. AO 2008-0029

## DEFINITION OF TERMS

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

**Basic Emergency Obstetrics and Newborn Care (BEmONC) Provider** is a capable private health facility or an appropriately upgraded public health facility that is either a Rural Health Unit (RHU) and/or its satellite Barangay Health Station (BHS) or Hospital capable of performing the following emergency obstetric functions: (1) parenteral administration of oxytocin in the third stage of labor; (2) parenteral administration of loading dose of anti-convulsants; (3) parenteral administration of initial dose of antibiotics; (4) performance of assisted deliveries in imminent breech; (5) removal of retained placental products ; and (6) manual removal of retained placenta. It is also capable of providing neonatal emergency interventions, which include at the minimum, newborn resuscitation, provision of warmth, and referral. The hospital BEmONC shall also be capable of providing blood transfusion services. These facilities can likewise serve as high volume providers for IUD (intra-uterine device) and VSC (voluntary surgical contraception) services. It can also be a single or stand alone facility or part of a network of facilities in an inter-local health zone.

**Comprehensive Emergency Obstetrics and Newborn Care (CEmONC) Provider** is a tertiary level regional hospital or medical center, provincial hospital or an appropriately upgraded district hospital. It can also be a capable privately operated medical center. It is capable of performing emergency obstetric functions as in BEmONC provider facilities, as well as provides surgical delivery (caesarean section) and blood bank transfusion services, and other highly specialized obstetric interventions. It is also able to provide emergency neonatal care, which include the minimum: (1) newborn resuscitation; (2) treatment of neonatal sepsis/infection; (3) oxygen support; and, (4) antenatal administration of (maternal) steroids for threatened premature delivery. It can also serve as high volume providers for intra-uterine device (IUD) and voluntary surgical contraception (VSC) services.

**Contraceptive Prevalence Rate (CPR)** is the proportion of women age 15-49 years reporting current use of a modern method of family planning, i.e. pill, IUD, injectables, condom, mucus method, basal body temperature method, standard days method (SDM), and lactational amenorrhea method (LAM).

**High volume providers for IUD and VSC** are RHUs (for IUDs) and hospitals (for IUDs and VSCs) and accredited private clinics having sufficient case load to maintain a certain level of proficiency, about 1-2 per day or more so that the service is part of a sustainable practice and receive appropriate support from the LGUs.

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

**Integrated MNCHN Service** is a package of services for women and children covering a spectrum of known cost-effective public health and clinical management measures capable of reducing exposure to and the severity of risks for maternal and neonatal deaths, as well as preventing their direct causes, that are within the capacity of the health system to routinely provide.

**Maternal Mortality Ratio (MMR)** refers to the number of women who die from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, per 100,000 live births.

**Maternal, Neonatal and Child Health and Nutrition (MNCHN) Service Delivery Network** refers to the network of facilities and providers within a province and (chartered) city health system offering integrated MNCHN services in a coordinated manner, including the supporting financing, communication and transportation systems. Such network includes the BEmONC-CEmONC network (a network of facilities providing emergency obstetric and newborn care) and matches the Inter-Local Health Zone (ILHZ) arrangement.

**Neonatal Mortality Rate** refers to the number of deaths within the first 28 days of life per 1000 live births in a given period. It serves as an indicator of maternal and neonatal health care.

**Province and City Health Systems** refer to an organized scheme for delivering health services including the integrated MNCHN service package in a contained geographic area covering an entire province and city. It is divided into small sub-systems consisting of public and private providers organized into Inter-Local Health Zones (ILHZ).

**Service Delivery Gap** refers to the “weak links” in the MNCHN service delivery chain that significantly contribute to the maternal and neonatal mortalities in an identified area.

**Service Utilization Gap** refers to barriers to consumption of health services that significantly contribute to poor health outcomes.

**Skilled Health Professional** refers to a doctor, nurse, or midwife with proficiency in managing pregnancy and childbirth including the appropriate management of complications that might occur. These professionals have complimentary proficiencies and should work as a team towards a coordinated effort in the initiative of saving lives of women and newborns.

**Traditional Birth Attendants (TBAs)** are independent, non-formally trained community-based providers of care during pregnancy, childbirth, and postpartum period using conventional method. Under the MNCHN strategy, they are made part of the formal health system as members of the community-based Women’s Health Teams and serve as advocates for skilled professional care.

## **FOREWORD**

The magnitude of influence of the health status of women and children to global development cannot be overemphasized, with two of the eight Millennium Development Goals (MDGs) calling for the reduction of child mortality and the improvement of maternal health by reducing maternal deaths. Along with 189 nations and 147 heads of state, the Philippines committed to the Millennium Development Declaration in 2000 and pledged to fulfil its goals of reducing disease and poverty by 2015.

In pursuit of this global commitment, the Department of Health (DOH) in partnership with Local Government Units is implementing health reforms to rapidly reduce maternal and newborn death through the Integrated Maternal, Newborn and Child Health and Nutrition (MNCHN) strategy.

This strategy addresses the risks that continuously threaten the lives of underprivileged Filipino women of reproductive age and their children. The approach highlights the importance of having committed skilled health professionals in appropriate health facilities to support the elements of reproductive health, particularly maternal and child health towards improving access and utilization of quality health interventions that are responsive to the urgent needs of women and newborns. The approach likewise defines in operational terms a well-coordinated referral system and requires strong support from the national and local stakeholders, to effect a rapid reduction in the maternal and neonatal mortality in the country.

This Manual of Operations (MOP) defines the mechanism critical to the operation of the MNCHN network throughout the country. In line with the FOURmula ONE for Health framework, standards for MNCHN implementation are appropriately detailed in the accompanying protocols that partner LGUs may use as guide.

The task to reduce maternal and newborn deaths entail collective hard work and struggle to win over all obstacles to attain the vision of giving mothers and children a better lease in life. It is a difficult challenge that DOH is committed to face. I express my sincerest gratitude to our partner LGUs, partners in government and non-government organizations and to everyone supporting the cause of championing the health of women and children. Let us work together to save their lives.

**FRANCISCO T DUQUE III MD MSc**  
Secretary of Health



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May 10, 2009

**DEPARTMENT MEMORANDUM**

**No. 2009-0110**

**TO: ALL UNDERSECRETARIES, ASSISTANT SECRETARIES,  
BUREAU/SERVICE/ CENTER FOR HEALTH DEVELOPMENT  
DIRECTORS, CHIEFS OF HOSPITAL/MEDICAL CENTER  
CHIEFS, EXECUTIVE DIRECTORS OF SPECIALTY  
HOSPITALS, ATTACHED AGENCIES AND LOCAL  
GOVERNMENT UNITS**

**SUBJECT: Adoption of the Manual of Operation on Maternal, Newborn, and  
Child Health and Nutrition (MNCHN) in the Implementation of  
Programs, Projects and other Initiatives for Women and Children.**

Millennium Development Goal 5 (MDG5) calls for the reduction of maternal mortality ratio by three-quarters and the promotion of universal access to reproductive health services by 2015. The attainment of this MDG has posed a challenge and has become the focus of investments by the Department of Health (DOH) and its partners. The Philippines has committed to reduce MMR from 209 (1993 NDHS) to 52 deaths per 100,000 live births in 2015. While this target is ambitious, the goal is attainable. There are inspiring examples of success from countries that experienced remarkable drops in the maternal mortality ratio, an indicator of the safety of pregnancy and childbirth and an inspiring reminder that with the right policies and conditions in place, dramatic and rapid progress is possible.

The DOH, in coordination with other partners, commits to reduce maternal and newborn mortality to support the government's dedication to achieve the MDGs and save the lives of women and newborns.

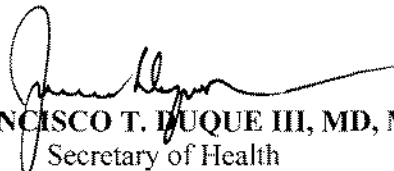
It is in this light that everyone is enjoined to support women's health, safe motherhood and child survival initiatives at all levels particularly at the local government units.

To guide implementers in enhancing implementation of women's health and child health initiatives, a Manual of Operations (MOP) for Implementing Health Reforms to Rapidly Reduce Maternal and Newborn Mortality is hereby issued. Specifically, the MOP aims to:

- (1) Guide officials, health managers and other groups and professionals concerned to establish, put into operation and sustain a responsive MNCHN service delivery network nationwide. In some sites, this is more popularly known as the Basic Emergency Obstetric and Newborn Care (BEmONC)-Comprehensive Emergency Obstetric and Newborn Care (CEmONC) network.
- (2) Guide the Department of Health, its attached agencies and other agencies within the bureaucracy in providing LGUs the necessary support as they adopt and implement health programs within the MNCHN framework;
- (3) Define the management structures among and between concerned stakeholders as each implement and supports the MNCHN Framework and the recommended intervention models and strategies.

The implementers may also refer to other documents developed by DOH relative to implementation of health sector reforms such as the Manual of Operations for Local Governance, and the Operations Guidelines for Women's Health and Safe Motherhood. These documents can be downloaded from the DOH website ([www.doh.gov.ph](http://www.doh.gov.ph)) and/or coordinate with the Task Force for the Rapid Reduction of Maternal Mortality.

Let us use this MOP as our common guide at the national, sub-national and local levels to improve women and children's health and survival.

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

## SCOPE AND COVERAGE

This Manual of Operations (MOP) is developed to assist the national and LGU health program implementers towards achieving the goal of rapid reduction in maternal and neonatal mortality and consequently cause an improvement in women and children's health. The aim is to guide local stakeholders in putting into operation the Maternal Newborn Child Health and Nutrition (MNCHN) strategy towards enhancing implementation of program activities that influence the achievement of MDG 4 and 5 targets. But while the current focus is limited to mothers and newborns, by 2011 this will transcend towards an improved operation of the broader women's health and child survival programs nationwide. This MOP is a work in progress - field experiences and implementation reviews will lead to its improvement over time.

This MOP is organized into 6 chapters:

Chapter 1: **Introduction** provides a backdrop for the basis of the Department of Health's (DOH) commitment to push for the implementation of reforms to allow the country to achieve the millennium development goals particularly the targets for mortality reductions among mothers, newborns and children below 5 years old. This chapter provides a comprehensive appraisal of the health status of Filipino mothers and newborns, the Philippine maternal and child health service delivery system, and an analysis of the health systems past policies and interventions that did not work in saving mother's and newborn's lives. A glimpse on what works in maternal mortality reduction is made to provide better understanding of the current DOH policy direction: facility based deliveries.

Chapter 2: **MNCHN Strategy: Overview** orients health system stakeholders particularly the implementers on the local operation of the MNCHN strategy, the basic guiding principles from which the strategy was derived, what the strategy intends to accomplish over the short and medium term, and the key interventions that it hope to efficiently implement to achieve its expected outcome of rapid reductions in maternal and newborn death.

Chapter 3: **Delivering MNCHN Services** aimed its focus on the package of MNCHN services and the manner of delivering them in an integrated fashion.

Chapter 4: **Regulating MNCHN Services** provides the standards for service delivery in terms of requirements relative to organization of the MNCHN network (BEmONC-CEmONC provincial configuration) and physical infrastructure, equipment, human resource, and the requirement for safe blood.

Chapter 5: **Financing MNCHN Services** presents a discussion on the financing options available for LGUs and offers ways to improve financial sustainability and better health facility operation.

Chapter 6: **Governance Mechanism for MNCHN** offers practical but technically sound ways to set the MNCHN strategy into operation. This chapter also provides a discussion on the paradigm shift in maternal and child health service delivery and the local health systems requirements to allow them to deliver the services efficiently and effectively to targeted clients and to substantially contribute to the attainment of the national goal of reducing maternal and newborn death. Overall, its aim is to improve stakeholders' accountability in MNCHN because every stakeholder action leads to an outcome.



## Chapter I

### INTRODUCTION

The Philippines has committed to the United Nations millennium declaration that translated into a roadmap a set of goals that targets reduction of poverty, hunger and ill health. In the light of this government commitment, the Department of Health is faced with a challenge: to champion the cause of women and children towards achieving MDGs 4 (reduce child mortality), 5 (improve maternal health) and 6 (combat HIV/AIDS, malaria and other diseases). Pregnancy and childbirth are among the leading causes of death, disease and disability in women of reproductive age in developing countries. A commitment to the MDGs is, among others, a commitment to work towards the reduction of maternal mortality ratio by three-quarters and under-five mortality by two-thirds by 2015 at all cost.

For the Philippines, the targets are to reduce MMR (maternal mortality ratio) from 209 (1993NDHS) to 52 deaths per 100,000 live births and NMR (newborn mortality rate) from 13 deaths (2006 FPS, NSO) to 10 per 1000 live births by 2015. While these targets are ambitious, the goal is attainable. There are inspiring examples of success from countries that experienced remarkable drops in the maternal mortality ratio, an indicator of the safety of pregnancy and childbirth and an inspiring reminder that with the right policies and conditions in place, dramatic and rapid progress is possible.

The MDG challenge provides DOH an excellent opportunity to improve the lives of many by adopting practical approaches to meeting the Millennium Development Health Goals. As DOH took the challenge towards the achievement of each of the health goals, it has taken bold steps to reform the health system via the FOURmula ONE for Health Program. These reforms focus on service delivery, regulation, financing, and governance and pursue concrete strategies to improve health by scaling up investments in infrastructure and human resource while ensuring equity and sustainability in the provision of various health goods. These strategies are described in the National Objectives for Health (NOH). The NOH identifies interventions and policy measures needed for the DOH Public Health Programs to achieve each of their health goals. Confronted with the challenge of MDG 5 and the multi-faceted challenges of high maternal mortality ratio, increasing neonatal deaths particularly on the first week after birth, unmet need for reproductive health services, weak maternal care delivery system, and identifying the technical interventions to address these problems, has led the DOH to focus on making pregnancy and childbirth safer and sought to change fundamental societal dynamics that influence decision making on matters related to pregnancy and childbirth while it tries to bring quality emergency obstetric and newborn care to facilities nearest to homes. This move ensures that those most in need of quality health care by competent doctors, nurses and midwives have easy access to such care.

Newborn survival is inextricably linked to the health of the mother. This is evidenced by the high risk of death for newborns and infants whose mothers die in childbirth for various complications. For both newborns and mothers, the highest risk of death occurs at childbirth and the critical period after birth, which is up to 7 days for the newborn and 42 days for the mother. The postpartum and postnatal period is therefore, especially critical for newborns and mothers and supports the call on the importance of postpartum and postnatal follow-ups as equally important as prenatal and childbirth care. This critical time for health center visits, has not been given equal importance in past advocacies.

The maternal newborn child health and nutrition (MNCHN) strategy is aimed at achieving the twin goals of **maternal mortality reduction** and **neonatal mortality reduction**, with emphasis on the biological link of mother and child. It intends to bridge

the gap between the existing Safe Motherhood Program and Child Survival Program. It fosters integration into other existing programs addressing reproductive health issues among them family planning, prevention of sexually transmitted infections and control of HIV and AIDS, as well as adolescent and youth health. It proposes a continuum of care that begins before pregnancy and continues throughout pregnancy, childbirth and after delivery, and ensures care for children and adolescents.

The approach endorsed by DOH to reduce maternal and newborn death calls for a paradigm shift that is simple, inexpensive and requires a technology that is relatively “low tech”. However, recognizing the current health system set-up, it also acknowledges the fact that achieving the health goals entails extraordinary effort. Thus, while the initiative focuses on women and children, it is guaranteed to benefit from the on-going health sector reforms.

### ***The Philippine Situation***

The Maternal Mortality Ratio (MMR) in the country is considered moderately high at 162/100,000 live births,<sup>1</sup> far from the MDG target reduction of 75 percent which is 52/100,000 by 2015. With a 1:120 lifetime risk of dying due to maternal causes,<sup>2</sup> pregnancy and childbirth pose the greatest risk to Filipino women of reproductive age. Childhood death rates on the other hand, showed a downward trend from 1993 to 2003 with the decline slowing down in the last 10 years (*Making the Philippine Child Survival Strategy Work, 2006*). Of the total under-five deaths, (42/1000 live births), more than two-thirds (30/1000 live births) occur before the child’s first birthday. Moreover, the neonatal mortality rate remains high at 17 per 1000 live births in 2003 (*NDHS 2003*) and 13 in 2006 (*FPS 2006, NSO*). This figure is a challenge to the NOH target of 10 (neonatal deaths per 1000 live births) by 2010 (*NOH, 2005*). The combined number of neonatal and post neonatal deaths is almost thrice the number of deaths among 1-4 years old (12/1000 live births). Further breakdown by day of life shows that half of neonatal deaths occur during the first two days of life.

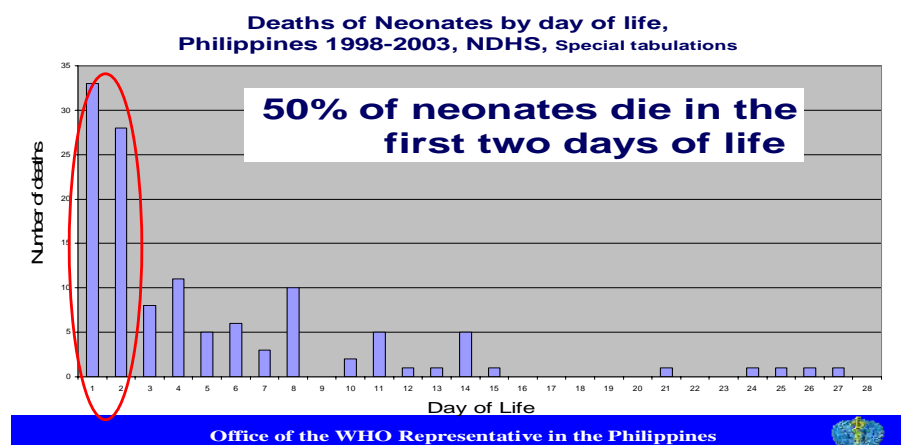
The current level of maternal mortality in the Philippines is mostly attributed to the predominance of home births (61% per the 2003 National Demographic and Health Survey (NDHS)) and the relatively high proportion (37%) of these births assisted by traditional birth attendants (TBAs) or “hilots”. TBA practice is usually handed down from one generation to the next. This makes their knowledge and skills highly uneven. Thus, efforts to train them on safe birthing practices have been largely unsuccessful, as the review of literature on international experiences reveals.

The NDHS further shows that 88% of women who had a live birth during the survey period saw a health professional for antenatal care. Yet, a significant number eventually ended up giving birth at home, attended by a TBA. This indicates that women are generally aware of the importance of skilled care by a health professional during pregnancy. However, when it comes to childbirth, a significant number are either unwilling to seek the same level of care or are unable to overcome obstacles to accessing such care. Thus, any intervention that seeks to address the maternal mortality situation would need to find ways to help women overcome these obstacles.

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<sup>1</sup> 2006 Family Planning Survey

<sup>2</sup> NSO, 2004; UNFPA



### *Gaps in MNCHN Service Delivery and Utilization*

Despite the focus on Maternal and Child Health in the past, gaps in health service delivery continue to challenge the system. These gaps result to poor access and utilization of childbirth services that consequently contribute to the slow decline of maternal and neonatal mortality. Among the gaps noted are: 1) emergency obstetrics and newborn care services are available only in secondary and tertiary level health facilities such as big district hospitals, provincial hospitals and medical centers, facilities that are not geographically accessible to majority of women, 2) past policy on maternal care accommodated TBA training and home deliveries assisted by TBAs, 3) failure to link TBAs to the formal health system, 4) failure of the health system to address women's issues that result to their deciding to give birth at home rather than in hospitals or health centers, 5) poor access to family planning commodities.

3.1 million pregnancies occur each year. Of these, 39% are planned, 31% are unplanned, 15% result in induced abortions and 15% in spontaneous abortions. (*NDHS 2003, Sighn S, et al., Unintended Pregnancy and Induced Abortion in the Philippines: Causes and Consequences, New York: Guttmacher Institute, 2006.*). Despite an increasing contraceptive prevalence rate in the last three decades, 51% currently married women are not using any family planning method and the unmet need for family planning is 17% in 2003. This poor access to poor family planning contributes to 20% of maternal mortality in the country. (*NSO, FPS 2006*).

In 2005, DOH noted a flux in the percentage of women with at least 4 prenatal visits: 77% in 1998 to 70% in 2003 and 88% in 2005 (NOH 2005). Although current consensus states antenatal screening has low predictive value because of its low sensitivity (30%) and relatively low specificity (90%) (*Chang et al. 1980; Hall et al. 1980; Koblinsky et al. 1994; Walsh et al. 1994; Acharya 1995; Rohde 1995; Yuster 1995; Dujardin et al. 1996; McDonagh 1996*)" (*quote from V. De Brouwere et al. 199*) antenatal visits are always a good opportunity for the health worker to interact with the woman and provide health advice. Moreover, evidence shows that antenatal care is beneficial for the survival of the newborn, reducing as much as 55% of neonatal deaths.

### *The Failure of Past Interventions*

The bane of high maternal and neonatal deaths is shared by many developing countries. A number of strategies to reduce maternal deaths have been tried over the years to address it. Results have been uneven across countries but the general view is that the strategies that have been popular since the 1970s have barely made a dent in worldwide

maternal mortality rates. Thus, there needs to be a strategic shift if the international community is to achieve the mortality declines envisioned by the MDGs. A review of the literature that surveys and analyzes international experience in addressing maternal mortality over the past decade provides insights on how to shape such a new strategy to tailor it to fit the Philippine situation.

Two basic strategies have underpinned past efforts to address high maternal mortality ratios:

(1) Applying the risk approach through antenatal clinics and 2) TBA training. (*De Brouwere, et al.* 1998)

The risk approach takes the view that a sufficient number of antenatal visits would allow the attending health provider to identify at-risk pregnancies and anticipate complications. (*Tucker J, Florey CdV, Howie P, Mellwaine G and Hall MH. 1994, in De Brouwere, et al. 1998*).<sup>1</sup> Thus the focus during the 1970s and 80s was to promote the development of antenatal clinics and to encourage mothers to make the necessary number of antenatal visits (*V. De Brouwere et al. 1998*).

TBA training was the other strategic axis. The health system's reliance on TBAs as childbirth attendants was justified as follows:

- There were not enough professional health providers to attend to mothers in need of maternal care;
- TBAs were highly accessible, especially in the rural areas;
- TBAs were also culturally acceptable and were usually able to influence a mother's health-seeking behavior.

Training the TBAs on modern methods of delivery was therefore widely seen as a logical solution to the health provider gap. Moreover, community empowerment was at the core of the primary health care strategy in the seventies and training them was fully consistent with this overarching objective.

The mid eighties saw the emergence of studies evaluating TBA performance and voicing skepticism about the strategy (Namboze 1985, Ross 1986). This gradually led De Brouwere and others (1998) to a shared conclusion that the training of **TBAs has had little impact on maternal mortality and that the most effective measures were those that which make it possible to reach a well-equipped hospital**. (Greenwood et al. 1990; Maine et al. 1991; Fauveau & Chakraborty 1994; Koblinsky et al. 1994; Turmen & AbouZahr 1994).

### ***Maternal Mortality Reduction: What Works***

There is a global consensus on what works to address maternal death. This is embodied in a joint statement by WHO, UNFPA, UNICEF and the World Bank in 1999, calling on countries to: **“Ensure that all women and newborns have skilled care during pregnancy, childbirth and the immediate postnatal period.”** (*Reducing maternal mortality*. A joint statement by WHO/UNFPA/UNICEF/World Bank. Geneva, World Health Organization, 1999).

Such care is to be provided by a skilled birth attendant: an accredited health professional who has been educated and trained in the skills needed to manage the critical stages in pregnancy and childbirth as well as in the identification, management and referral of complications: **Midwife, Nurse, or Doctor**.

In 2006, the Lancet came out with a 5-article series on maternal survival called The Lancet Maternal Survival Series. In the 2<sup>nd</sup> article, the authors contend that while “**the**

concept of knowing what works in terms of reducing maternal mortality is complicated by a huge diversity of country contexts and of determinants of maternal health, only a few strategic choices need to be made” to attain the objective. They go on to make a compelling case for focusing on just “one strategy based on delivery in primary-level institutions (health centers), backed up by access to referral-level facilities”, labelling it their “best bet to bring down high rates of maternal mortality” (Campbell et al 2006).

They argue on the basis of the observation that “most maternal deaths occur during labor, delivery or the first 24 hours postpartum, and most complications cannot be predicted or prevented” (this quote from Campbell et al. is based on the results of the first report in the series: Ronsmans C, Graham WJ. 2006). They further argue that while the necessary level of skilled care could very well be delivered at home for mothers who prefer to give birth there, a strategy encouraging home deliveries has distinct disadvantages:

- For one, home conditions can be very basic and could limit the ability of the skilled attendant to deal with emergencies, especially since the attendant has only the family to rely on to assist rather than other providers such as doctors or nurses in health centers or hospitals.
- Moreover, home-based deliveries are inefficient in terms of not only the skilled attendant’s time but also that of the supervisor (who is most likely the already overburdened rural health physician).

Therefore, based on the evidence that they present, the authors conclude:

**“The best intrapartum-care strategy is likely to be one in which women routinely choose to deliver in a health centre, with midwives as the main providers, but with other attendants working with them in a team” (Campbell et al. 2006)**

## Chapter II

### THE MNCHN STRATEGY: AN OVERVIEW

The Maternal Newborn Child Health and Nutrition (MNCHN) Strategy calls for coordinated actions with the end goal of improving women and children's health and consequently effecting a rapid reduction in the maternal, newborn and child mortalities towards attaining MDGs 4 and 5 within the set time frame. With this call to act, the Department of Health commits to assist LGUs upgrade their proposed health facilities to EmONC (Emergency Obstetric and Newborn Care) standard, a major MNCHN initiative. The LGU proposal was the result of a Facility Mapping and Needs Assessment Exercise conducted as part of the over-all initiative to rationalize investments in health. The map identified strategically located health facilities to deliver an integrated package of services that are critical to improving women's and children's health and preventing maternal, neonatal and child deaths.

The package of services provided to mothers, newborn and children follows an integrated approach to service delivery that seeks to maximize client visits, avoid missed opportunities, and ensure cost-effectiveness in the delivery of critical interventions.

### **Guiding Principles**

The MNCHN strategy is based on the following guiding principles:

1. In line with the agenda for health sector reform, the province-wide or city-wide health system is recognized as the unit for planning, organizing and implementing the MNCHN strategy.

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

2. Local stakeholders shall be engaged and public-private partnerships shall be strengthened to support the goal of rapidly reducing maternal and neonatal mortality.

Local stakeholders should be engaged to review the current functionality of their respective local service delivery network. Functionality includes, among others, the level and quality of coordination across the various activities and functions of public and private providers. Based on this assessment, all local stakeholders shall be enjoined to take part in activities that address maternal and newborn health.

3. LGU capacity to deliver the integrated MNCHN services shall be assured and the service delivery network shall be mobilized to provide the continuum of MNCHN services.

Universal access to and utilization of the integrated MNCHN services in its full continuum spanning the pre-pregnancy, pregnancy, delivery, post-partum/ post-natal care phases shall be ensured in all localities, and shall be backed-up by pertinent laws and accessible operational resources. A core list of MNCHN services include those from the women's health and child survival package developed by the DOH.

4. Improvements in the delivery of various component services in the maternal and neonatal service package shall be continuously pursued.

In order to mount rapid response capacity in local health systems, the MNCHN strategy shall build on existing service capacities and utilization patterns. Targeted quality improvements in facilities and human resources, together with measures to

facilitate utilization by clients shall be carried out to achieve rapid mortality reduction with minimal efforts and investments in the immediate and medium term. Over time, improvements in the current delivery system configuration and services shall be introduced as standards improve, as demand increases, as local health systems acquire additional capacities, as legal and resource constraints are addressed and as the nature of the maternal and neonatal mortality evolves.

5. The implementation of appropriate demand-side interventions shall be developed and supported.

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

6. A monitoring, evaluation and dissemination system for the MNCHN strategy shall be established and operated at local and national health systems.

The DOH shall develop and support the establishment, operations and maintenance of monitoring and evaluation mechanisms for local implementations of the MNCHN strategy. Appropriate methodologies (e.g. maternal and neonatal death reviews), shall be employed to establish baseline, track progress and assess the impact of various interventions towards improving health service delivery. The monitoring and evaluation system shall be developed incrementally and shall begin with a set of readily available and verifiable indicators. These monitoring and evaluation mechanisms shall be transparent, have established dissemination channels that feed into a formal feedback mechanisms to policy makers and health program managers at CHD (Center for Health Development) and national levels.

7. National support to local planning and development for the MNCHN strategy shall be provided.

DOH shall develop and apply various instruments to help localities develop customized MNCHN strategies, strengthen their service delivery network, secure critical goods and commodities, and improve monitoring, evaluation and dissemination. These instruments shall include a mixed of grant assistance schemes, policy issuances, technical assistance, institutionalized trainings, research and development, development of new standards, provision of specialized services, financing mechanisms through PhilHealth and other regulatory measures.

## **Goals and Expected Outcomes**

The following are key indicators to the achievement of the MNCHN goals:

- (1) 60% modern contraceptive prevalence rate (CPR) by 2010; 80% by 2015 (*baseline, 2006 FPS, NSO: 35.9%*).
- (2) 80% of pregnant women with at least 4 antenatal visits by 2010; 100% by 2015 (*baseline, 2003 NDHS: 70%*).
- (3) 80% facility-based deliveries by 2012; 90% by 2015 (*baseline, 2003 NDHS: 39%*).
- (4) 50% of infants 4-5 months old are exclusively breastfed by 2010 (*baseline, 2003 NDHS: 16%*).
- (5) 85% of newborns are screened for metabolic disorders by 2010 and 100% by 2015.

- (6) 80% postpartum and postnatal visits done within the first week of delivery by 2015(*baseline, 2003 NDHS: 51%*).
- (7) 95% fully immunized children by 2010; 100% by 2015 (*baseline, 2003 NDHS: 70%*).

The implementation of the MNCHN strategy shall lead the country to its most desired outcome: **no woman dies giving birth; no newborn dies at birth.**

Thus, for DOH, all efforts shall be geared towards achieving this desired outcome by assisting LGUs in their efforts to improve the health status of their constituents particularly women and children: (1) upgrade health facilities towards MNCHN service delivery both in terms of infrastructure and equipment requirements, (2) train health workers to deliver quality MNCHN services particularly emergency obstetric and newborn care; (3) monitor, evaluate and disseminate compliance to standards and target accomplishments.

### **MNCHN Key Interventions**

The risks to maternal and newborn health can be addressed through key interventions tailored to the various stages of the life cycle from pre-pregnancy, antepartum, intrapartum, postpartum, neonatal and post-neonatal. The effective implementation of these interventions is expected to reduce the burden of maternal and neonatal deaths, especially among the underserved population of Filipino women and children.

Thus the country strategy to rapidly reduce maternal and neonatal mortality in the context of FOURmula One (F1) for Health adapts a model that calls for a sustainable delivery of an integrated package of maternal newborn child health and nutrition services in strategically located health facilities aptly upgraded to allow them to provide appropriate emergency obstetric and newborn care. It focuses its intervention in areas that have the greatest impact on reproductive health:

- (i) Provision of Family Planning and other pre-pregnancy services including adolescent health and control of sexually transmitted infections and HIV prevention services.
- (ii) Access to comprehensive antenatal care services.
- (iii) Facility-based births attended by skilled health professionals.<sup>3</sup>
- (iv) Immediate postpartum and postnatal care by skilled health professionals to include initiation of breastfeeding and immunization among others.

While the focus of the intervention package appears to be limited to those that influence maternal and newborn death reduction, a smooth transition of this initiative to a more comprehensive women's health and child survival packages shall be ensured.

The MNCHN framework therefore seeks to put in place effective interventions to address the main causes of maternal and newborn death in the short term (2008-2015) while trying out **innovative ways to deliver them in a cost-effective and sustainable manner** and transit to a more comprehensive child survival and women's health framework in the medium term with focus on assuring access to complete child care and reproductive health packages

## **Chapter III**

### **MNCHN SERVICE DELIVERY**

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<sup>3</sup> WHO/UNFPA/UNICEF/World Bank, 1999



The maternal and newborn care package is characterized by a paradigm shift from the risk approach that focuses on identifying pregnant women at risk of complications to one that considers **all pregnant women at risk** of such complications. This is mainly in response to the previously mentioned findings that reveal the inability of antenatal protocols to accurately predict the onset of complications during childbirth. The new strategy therefore seeks to –

- (1) Encourage women to give birth in conveniently located health facilities that are suitably equipped to render **basic emergency obstetric and newborn care**. Complicated pregnancies and those needing caesarian sections and blood transfusions are referred to higher level facilities rendering **comprehensive emergency obstetric and newborn care**. This network of basic and comprehensive emergency obstetric and newborn care provider facilities is deployed in such a manner as to allow women to access the services they need within a timeframe that ensures a safe outcome; and
- (2) Manage the new MNCHN service delivery which involves shifting from centrally controlled national programs operating separately and governed independently at various levels of the health system, to an LGU-governed health system that delivers the integrated maternal newborn child health and nutrition service package. Such a devolved approach is envisioned to make delivery of the integrated model more responsive to the local situation.

### **The MNCHN Core Service Package**

The MNCHN core service package consists of health services that are both preventive and curative established to lower the risk and respond to the direct causes of maternal and neonatal deaths and consequently improve women's and children's health. The interventions cater to the spectrum of needs of women and children. For the women, this consist of services that span the period before pregnancy to post childbirth services that include essential newborn care during the first week of life. For the children, the service package covers essential health care of the newborn after the first week to adolescent stage. These service packages must be made available and easily accessible to targeted population.

To assure the safety of mothers and newborns, the following standards of care must be delivered in all facilities within the MNCHN service delivery Network.

#### **A. BASIC EMERGENCY OBSTETRIC AND NEWBORN CARE (BEmONC)**

**PROVIDER FACILITIES:** These facilities are upgraded or enhanced Barangay Health Station (BHS), Rural Health Unit (RHU), District and Community Hospitals that are required to provide the following services:

##### **1.) Pre-pregnancy package of services include the following provisions:**

- a. Micronutrient supplementation consisting of important minerals and vitamins such as zinc, iodine, calcium, vitamin A capsules and iron tablets-
  - o Iron folate 60 mg tablets 1 tablet daily
  - o Vitamin A at least 5000 IU every week (a daily multivitamin supplement maybe taken as option when the required vitamin A is not available)
  - o Promotion of use of iodized salt
- b. Tetanus toxoid immunization following the recommended schedule
- c. Family Planning

- IEC and FP counseling with focus on modern methods and fertility awareness and observing the principles of informed choice, birth spacing, responsible parenthood and respect for life; and
- Contraceptive provision as appropriate.
- d. Provision of oral health services
- e. Counselling on STI/HIV/AIDS, nutrition, personal hygiene, and the consequences of abortion
- f. STI screening using syndromic approach
- g. Adolescent and youth health services including peer and professional counselling and RH education
- h. Promotion of healthy lifestyle including advice relative to smoking cessation, healthy diet, regular exercise and moderate alcohol intake.
- i. Management of lifestyle-related diseases like diabetes, cardiovascular disease (CVD), etc.
- j. Prevention and Management of other diseases including tuberculosis, malaria (e.g. provision of insecticide treated bed nets for malaria-infested areas), schistosomiasis, and anemia.

## 2.) Complete **Pre-Natal** Package

- a. Provision of eight essential antenatal care services
  - Monitoring of height and weight
  - Taking the blood pressure
  - Screening and blood testing including Complete Blood Count, blood Typing, urinalysis, VDRL or RPR, HbSAg, blood sugar screening, pregnancy test, cervical cancer screening using acetic acid wash and papanicolau smear.
  - Micronutrient supplementation (iron, folate and Vitamin A supplementation)
  - Malaria prophylaxis where appropriate
  - Deworming
  - Birth planning
- b. Promotion of exclusive breastfeeding, newborn screening, BCG and Hepatitis B birth dose immunization.
- c. Counselling on –
  - use of modern FP methods especially lactation amenorrhea (LAM), with focus on health caring and health seeking behaviors; and
  - contraception including surgical procedures where appropriate: bilateral tubal ligation (BTL), no-scalpel vasectomy (NSV) and management of complications resulting from contraception.
- d. Laboratory screening and medical management of STI-HIV cases and their complications.
- e. Counselling on Healthy Lifestyle with focus on smoking cessation, healthy diet and nutrition, regular exercise, STI control HIV prevention and oral health.
- f. Prevention and management of early bleeding in pregnancy.
- g. Administration of antenatal loading dose of steroids for threatened premature delivery.
- h. Early detection and management of signs of complications of pregnancy.

- i. Measurement of fundic height against the age of gestation, fetal heart beat and fetal movement count to assess the adequacy of fetal growth and well-being.
- j. Prevention and management of other conditions as indicated:
  - Hypertension
  - Anemia
  - Diabetes
  - Tuberculosis
  - Malaria
  - Schistosomiasis
  - STI/HIV/AIDS
- k. Provision of other support services
  - Antenatal registration through active tracking by the WHTs
  - Birth Planning
  - Home visits and follow up
  - Safe blood supply
  - Transportation and communication support services

### 3.) Complete **Childbirth** Package

For the mother:

- a. Monitoring vital signs and the progress of labor using the partograph.
- b. Identification of early signs and symptoms and administration of appropriate management of prolonged labor, hypertension, abnormal presentation, bleeding.
- c. Active management of the third stage of labor.
- d. Provision of immediate post-partum nursing care (prior to discharge from the delivery room)
  - Perineal washing
  - Changing of hospital gown
  - Checking vital signs
  - Rooming-in

For the newborn:

- a. Drying to keep the baby warm
- b. Provision of appropriate thermal care through mother and newborn skin-to-skin contact, maintaining a delivery room temperature of 25-28 degrees centigrade and wrapping the newborn with clean, dry cloth.
- c. Immediate latching on and initiation of breastfeeding within first hour after birth.
- d. Non-immediate cord clamping (1-3 minutes or until cord pulsation stops)

Should complications occur, a BEmONC provider facility must be able to administer the following emergency care services:

- Parenteral administration of oxytocin in the third stage of labor.
- Parenteral administration of loading doses of anti-convulsant.
- Parenteral administration of initial dose of antibiotics.

- Assisted vaginal delivery during imminent breech delivery.
- Manual removal of placenta.
- Removal of retained placental products.
- Administration of loading dose of steroids for premature labor.
- Administration of intravenous fluid, blood volume expander and/or blood transfusion.
- Newborn resuscitation.
- Treatment of neonatal sepsis as necessary.
- Oxygen support for newborns.

#### 4.) Complete **Post-Partum and Post-Natal** Package

For the mother:

- Post-partum check up including identification of early signs and symptoms of postpartum complications like hemorrhage, infection and hypertension.
- Micronutrient supplementation, including iron and folate.
- Counselling on
  - Proper Nutrition.
  - Benefits of exclusive breastfeeding up to six months.
  - Benefits of skin to skin contact especially among preterm babies.
  - Essential neonatal care
- Laboratory screening and medical management of STI-HIV cases and their complications
- Provision of FP services and contraception including surgical procedures where appropriate: bilateral tubal ligation (BTL), no-scalpel vasectomy (NSV) and management of complications resulting from contraception.
- Prevention and management of other diseases as indicated:
  - Hypertension
  - Diabetes
  - Anemia
  - Tuberculosis
  - Malaria
  - Schistosomiasis
  - STI/HIV/AIDS

For the baby:

- Post-natal care required within 24 hours after birth includes
  - Cord care
  - Breastfeeding
  - Vitamin K injection
  - Eye prophylaxis
  - Delayed bathing until 6 hours of life
  - BCG and first dose of Hepatitis B Immunization
  - Newborn screening
- Counselling on post-partum/post-natal check-up, home care and immunization

#### 5.) Provision of other support services

- Birth registration

- Safe blood
- Transportation and communication

**B. COMPREHENSIVE EMERGENCY OBSTETRIC AND NEWBORN CARE (CEmONC) PROVIDER FACILITIES** are departmentalized district, provincial and regional hospitals. These hospitals shall provide the following services:

**1. Pre-pregnancy care**

- Micronutrient supplementation consisting of important minerals and vitamins such as zinc, iodine, calcium, vitamin A capsules and iron tablets-
  - Iron folate 60 mg tablets 1 tablet daily for 3-6 months.
  - Vitamin A at least 5000 IU every week (a daily multivitamin supplement maybe taken as option when the required vitamin A is not available).
  - Promotion of use of iodized salt.
- Tetanus toxoid immunization following the recommended schedule.
- Family Planning
  - IEC and FP counseling with focus on modern methods and fertility awareness and observing the principles of informed choice, birth spacing, responsible parenthood and respect for life; and
  - Contraceptive provision as appropriate.
- Provision of oral health services
- Counseling on STI/HIV/AIDS, nutrition, personal hygiene, and the consequences of abortion
- Laboratory screening for STIs
- Adolescent and youth health services including peer and professional counselling and RH education
- Promotion of healthy lifestyle including advice relative to smoking cessation, healthy diet, regular exercise and moderate alcohol intake.
- Management of lifestyle-related diseases like diabetes, CVD, etc.
- Prevention and Management of Other Diseases including tuberculosis, malaria (e.g. provision of insecticide treated bed nets for malaria-infested areas), schistosomiasis, and anemia.

**2. Prenatal care package**

The following antenatal services provided at the BEmONC provider facilities shall likewise be provided in a CEmONC facility:

- Provision of eight essential antenatal care services
  - 1) Monitoring of height and weight
  - 2) Taking the blood pressure
  - 3) Screening and blood testing including Complete Blood Count, blood Typing, urinalysis, VDRL or RPR, HbSAg, blood sugar screening, pregnancy test, cervical cancer screening using papanicolau smear
  - 4) Micronutrient supplementation (iron, folate and Vitamin A supplementation)
  - 5) Tetanus toxoid immunization
  - 6) Malaria prophylaxis where appropriate
  - 7) Deworming

8) Birth planning

- b. Promotion of exclusive breastfeeding, newborn screening, BCG and Hepatitis B birth dose immunization.
- c. Counselling on –
  - use of modern FP methods especially lactation amenorrhea (LAM), with focus on health caring and health seeking behaviours; and
  - contraception including surgical procedures where appropriate: bilateral tubal ligation (BTL), no-scalpel vasectomy (NSV) and management of complications resulting from contraception.
- d. Counselling on Healthy Lifestyle with focus on smoking cessation, healthy diet and nutrition, regular exercise, STI control HIV prevention and oral health.
- e. Prevention and Management of early bleeding in pregnancy and its complications.
- f. Administration of antenatal loading dose of steroids for threatened premature delivery.
- g. Early detection and management of danger signs and complications of pregnancy.
- h. Measurement of fundic height against the age of gestation, fetal heart beat and fetal movement count to assess the adequacy of fetal growth and well-being.
- i. Prevention and management of other diseases as indicated:
  - Hypertension
  - Anemia
  - Diabetes
  - Tuberculosis
  - Malaria
  - Schistosomiasis
  - STI/HIV/AIDS
- j. Provision of other support services
  - Antenatal registration by active tracking by WHTs
  - Assistance in birth planning
  - Safe blood supply
  - Transportation and communication support services

3. Complete **childbirth** package

For the mother:

- a. Monitoring vital signs and the progress of labor using the partograph.
- b. Identification of early signs and symptoms and administration of appropriate management of prolonged labor, hypertension, abnormal presentation, bleeding.
- c. Active management of the third stage of labor.
- d. Provision of immediate post-partum nursing care (prior to discharge from the delivery room)
  - Perineal washing
  - Change hospital gown

- Check vital signs
- Rooming-in in the case of non-problematic cases.
- Return to ward if baby is preterm and needs to be confined at the Newborn Intensive Care Unit (NICU). Advice should be given relative to breastfeeding schedules at the NICU.

For the newborn:

- Drying to keep the baby warm
- Non-immediate cord clamping
- Provision of warmth through skin-to-skin contact with mother, immediate latching on and initiate breastfeeding within first hour after birth.
- Provision of appropriate thermal care through mother and newborn skin-to-skin contact, maintaining a delivery room temperature of 25-28 degrees centigrade and wrapping the newborn with clean, dry cloth.

#### ***Basic Emergency Obstetric and Newborn Care***

- Parenteral administration of oxytocin in the third stage of labor.
- Parenteral administration of initial dose of antibiotics.
- Assisted vaginal delivery during imminent breech delivery.
- Manual removal of placenta.
- Removal of retained placental products.
- Administration of loading dose of steroids for premature labor.
- Intravenous fluid administration, blood volume expander and/or blood transfusion.
- Newborn resuscitation.
- Treatment of neonatal sepsis.
- Oxygen support for the newborn.

#### ***Comprehensive Emergency Obstetric and Newborn Care***

- Caesarian section
- Blood transfusion
- Management of newborn complications

#### **4. Postpartum/ postnatal care**

Postpartum care package

- Post-partum check up including identification of early signs and symptoms of postpartum complications such as hemorrhage, infection and hypertension.
- Micronutrient supplementation, including iron and folate
- Counselling on:
  - Nutrition
  - Exclusive breastfeeding up to six months
  - Essential neonatal care
  - Special neonatal care for preterm and “problematic” babies
- Laboratory screening and medical management of STI-HIV cases and their complications

- e. Provision of FP services including contraception: bilateral tubal ligation (BTL), no-scalpel vasectomy (NSV) and management of complications resulting from contraception.
- f. Prevention and management of other diseases as indicated:
  - Hypertension
  - Diabetes
  - Anemia
  - Tuberculosis
  - Malaria
  - Schistosomiasis
  - STI/HIV/AIDS
- g. Counselling on post-partum/post-natal check-up, home care and immunization

***Immediate postnatal care package*** (required within 24 hours after birth)

- a. Cord care
- b. Initiation of Breastfeeding within the first hour of life
- c. Vitamin K injection
- d. Eye prophylaxis
- e. Delayed bathing to 6 hours of life
- f. BCG and first dose of Hepatitis B Immunization
- g. Newborn screening

Other services:

- h. Birth registration

In addition, the CEmONC provider facilities shall provide **comprehensive emergency postnatal** care that include life support management for -

- 1. low birth weight newborns
- 2. premature newborns
- 3. sick newborns
  - sepsis
  - fetal alcohol syndrome
  - asphyxia
  - severe birth trauma
  - severe jaundice
  - others

## **Chapter IV**

### **REGULATION**

#### **Ensuring MNCHN Standards**

The local health system with technical guidance from the Department of Health shall enforce regulatory measures and guidelines related to the establishment and operation of health facilities within the MNCHN network. The measures shall be complemented by capacity building of adequate health staff tasked to provide specific MNCHN service



through competency-based standards that are linked with suitable performance-based incentives.

To assure the safety of mothers and newborns, as a standard, all BEmONC and CEmONC provider facilities shall have the infrastructure features, equipment, and human resource configuration and are part of a systematic safe blood supply network required by the MNCHN strategy:

#### **A. Facility Infrastructure Requirements**

The following technical considerations are important in the infrastructure design of MNCHN facilities:

##### **1. Basic Emergency Obstetric and Newborn Care (BEmONC) provider Facilities**

A BEmONC provider facility is a primary level health facility tasked to provide the integrated MNCHN service package that include basic emergency obstetric and newborn care (BEmONC) and is either a –

- a. Barangay health station (BHS),
- b. Rural health unit (RHU),
- c. Lying-in clinic,
- d. Birthing home,
- e. District hospital, or
- f. Any other similar structure.

These facilities are duly identified and designated by the local health officers by virtue of its strategic location and on the basis of the selection criteria set by DOH in consultation with LGUs and receives referral from the community-based Community or Women's Health Teams (C/WHTs). C/WHTs refer cases considered not having difficult pregnancy to these facilities. Facilities of this type should be appropriately constructed in locations most accessible to women.

##### *BHS and RHU BEmONCs*

**BHSs and RHUs are facilities that are nearest to homes and are therefore significant structure in the MNCHN network.** The following access factors are considered in identifying a BHS or RHU as BEmONC provider:

- 1) **Geographic access** - women and clients in general are discouraged to access health services if the travel time to reach a health facility is more than 30 minutes (*CEPR Baseline Study commissioned by WHSMP2, 2007*). This finding validated the observation that the BHS is the only facility that is most accessible to at least 60% of the population in any given locality. Thus the call for women to give birth in a facility with capability to provide basic emergency obstetric and newborn care considers the BHS as most rationale for upgrading.
- 2) **Gender and culture sensitivity** –Women have various reasons why they opt to deliver at home rather than at a health facility. One such reason is: “*There is no one to be left at home to take care of my other small children*”. This reason is in addition to the cost of medical care and transportation (*BCC study for WHSMP2, 2004*).

To enable the BHS and RHU BEmONC providers to respond to the access factors and function effectively, the following amenities should be considered in its **structural design**:

- a. Delivery room
- b. At least a 2-bed capacity Ward: 1 bed for the mother and newborn and another bed with a “pull-a-bed” feature for the birth companion and small children. The ward also doubles as a labor room.
- c. A small kitchen appropriately furnished.
- d. A toilet and bath with appropriate fixtures.
- e. A sleeping quarter for health staff.
- f. A waste management facility that includes a placenta pit.

#### *Hospital BEmONCs*

Hospital BEmONC providers shall offer the same amenities except for the structural design which should include:

- a. Labor room appropriately furnished
- b. Delivery room
- c. A scrub room for the doctors and nurses
- d. A maternity ward with rooming-in feature for the newborn
- e. A toilet and bath with appropriate fixtures
- f. A sleeping quarter for health staff
- g. A waste management system that includes a placenta pit

BEmONC provider facilities are made attractive and comfortable with privacy and space for an accompanying “birth companion” (family member, friend, TBA or BHW) as well as for minor children in cases where leaving them at home is not possible.

## **2. Comprehensive Emergency Obstetric and Newborn Care (CEmONC) Provider Facilities**

CEmONC provider facilities are departmentalized according to medical specialties and are usually large, adequately and appropriately equipped and staffed by competent CEmONC Teams (CTs). Clients referred from BEmONC facilities can reach these facilities within 1-hour travel time.

The CEmONC Teams and the Itinerant Teams (ITs) are based in these facilities. Its structural design features the following amenities:

- a. Emergency Room
- b. Admission Room
- c. Pharmacy
- d. Well equipped laboratory
- e. Blood station appropriately equipped and furnished
- f. Labor room
- g. Delivery room
- h. An obstetric operating room
- i. Sterilization or autoclave room
- j. A recovery room
- k. A Newborn Intensive Care Unit
- l. A breastfeeding lounge
- m. A scrub room for the doctors and nurses

- n. A dressing (change) room for the doctors and nurses
- o. A maternity ward with rooming-in feature for the newborn
- p. A nurses station
- q. A toilet and bath with appropriate fixtures
- r. A sleeping quarter for health staff
- s. Waste management system that includes a placenta pit.

All health facilities providing emergency obstetric and newborn care (BEmONC and CEmONC) should be equipped with:

- a. **Radio or telephone** for easy contact with a designated higher-level facility should advice or referral be needed
- b. An **emergency transport system** that is based at the facility or community for a reasonable fee.

Since **CEmONC and hospital BEmONC** providers also caters to other cases, **small children are not allowed to accompany their mothers to the hospital**. This is to protect them from hospital- acquired infections. In this regard, an arrangement should be made with the concerned C/WHTs for either a TBA or BHW to take care of the small children at home while their mother is giving birth in the hospital.

## **B. Equipment Requirements**

Emergency Obstetric and Newborn Care (EmONC) provider facilities should have the required **vital equipment** to enable them to deliver quality WHSM services to clients. Vital equipment are the most basic equipment needed to operate BEmONC and CEmONC provider facilities in accordance with the standards of the service delivery model and are considered “first priority” in judging the operational capability of the facility.

### **1. Basic Emergency Obstetric and Newborn Care Equipment**

#### **a. Vital Equipment**

- 1) Vaginal speculum set of 6
- 2) NSD Kit (that contains: artery forceps or clamp, dissecting forceps, needle holder, scissors, sterile disposable gloves, urinary catheter, sponge forceps, vaginal speculum, sterile blade, absorbable sutures, sterile cord clamp, plastic sterile disposable sheet for the mother)
- 3) Adult ambubag
- 4) Pediatric ambubag + mask
- 5) Simpson’s forceps (optional)
- 6) Suction machine portable 2 L capacity
- 7) Oxygen tank with regulator/gauge
- 8) Spare oxygen gauge
- 9) Kelly pad
- 10) Bassinet
- 11) Cervical inspection set
- 12) NSV (no scalpel vasectomy) set
- 13) IUD (intra-uterine device) kit
- 14) Cut down or minor surgical set
- 15) Microscope
- 16) Nebulizer
- 17) Pediatric stethoscope
- 18) Doppler
- 19) Baby weighing scale

- 20) Non-mercury pediatric sphygmomanometer
- 21) Non- mercury body thermometer
- 22) Mucus extractor (bulb suction apparatus)

**b. Furniture and Fixtures**

- 1) Delivery bed with stirrups
- 2) Bassinet
- 3) Revolving stool
- 4) Droplight
- 5) Emergency light
- 6) Ward beds with side railings
- 7) IV stand

**2. Comprehensive Emergency Obstetric and Newborn Care Equipment**

**1.) Vital Equipment**

- 1.) Vaginal speculum set of 6
- 2.) Laparotomy pack (caesarian section kit)
- 3.) Portable anesthesia machine
- 4.) Incubator
- 5.) Transport incubator (optional)
- 6.) Curettage set
- 7.) NSD kit (that contains: artery forceps or clamp, dissecting forceps, needle holder, scissors, sterile disposable gloves, urinary catheter, sponge forceps, vaginal speculum, sterile blade, absorbable sutures, sterile cord clamp, plastic sterile disposable sheet for the mother)
- 8.) Adult ambubag
- 9.) Suction machine (portable 2 L capacity)
- 10.) Pediatric ambubag + mask
- 11.) Simpsons forceps
- 12.) Suction machine (mobile 6 L capacity)
- 13.) Oxygen tank with regulator /gauge
- 14.) Nitrous oxide with regulator/gauge
- 15.) Cervical inspection set
- 16.) BTL (bilateral tubal ligation) set
- 17.) IUD (intra-uterine device) kit
- 18.) Microscope

**2.) Standard Equipment**

- 1) Ultrasound machine
- 2) Anesthesia machine upright model
- 3) Vacuum extraction set
- 4) Pediatric stethoscope
- 5) Adult laryngoscope
- 6) Pediatric laryngoscope
- 7) EKG machine
- 8) Cut down minor set

**3.) Special Equipment**

- 1) Cardiac monitor
- 2) Cardiac defibrillator

- 3) Pulse oximeter
- 4) Glucometer
- 5) Automated blood chemistry analyzer
- 6) Water bath
- 7) Coulter blood counter
- 8) Spectrophotometer
- 9) Incubator

#### 4.) Basic Furniture and Fixtures

- 1.) Delivery bed with stirrups
- 2.) Operating room table
- 3.) Revolving stool
- 4.) Operating room light
- 5.) Drop light
- 6.) Emergency light
- 7.) Ward beds with side railings
- 8.) IV stand
- 9.) Bassinet

### C. Blood Supply

Hospital BEmONC and CEmONC provider facilities are required to have **easy access to safe blood** supply at all times. This requires the local blood services network to establish a network that assures availability of this vital commodity whenever it is needed in selected hospital BEmONC and in all CEmONC provider facilities. The standard defines the local blood services network as comprising the following organizational classification:

1. Blood Center
2. Blood Banks
3. Blood Stations
4. Blood Collection Units
5. Local Blood Council

Current evidence in maternal mortality points to hemorrhage as the main cause of maternal death in the country, accounting to 26% of total maternal deaths in 1998 (*NDHS*). Thus, the setting up of a **Safe Blood Supply Network** is seen as an important condition in the establishment of a Provincial MNCHN Facility Network. *Please see Chapter VI for a more detailed discussion on Organizing a Safe Blood Supply Network.*

### D. Human Resource

**Adequate and appropriate Human Resource shall be assured at all levels.** This shall consist of Community/Women's Health Teams at community level and competent professionals at health facility level.

The current public health service delivery model designates a BHS as satellite facility of the RHU. The objective of this arrangement is to enable the health system to reach out to clients in remote barangays. **A BHS BEmONC therefore requires that the MHO and PHN, who are based at the RHU make regular supervisory visit and be available "on call" to assist the midwife in BEmOC provision.**

#### 1. Conditions to Ensure the Effectiveness of the MNCHN Strategy

Conditions	Requirements
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1) Organization of Service Delivery Teams	<ul style="list-style-type: none"> <li>• <b>1 Women's Health Team per barangay</b></li> <li>• 3 BEmONC Teams per Hospital BEmONC facility</li> <li>• 1 BEmONC Team per RHU/BHS BEmONC Facility</li> <li>• 3 CEmONC Teams per CEmONC facility</li> <li>• 1 Itinerant Team per CEmONC facility</li> <li>• 1 SHC Team- Social Hygiene Clinic or RHU-based</li> </ul>
2) Assignment of Health Staff	1 midwife per BHS
3) EmONC facilities sufficiently staffed for a 24-hour operation	

## 2. MNCHN Staffing Requirement

<b>Community Level: BHS and RHU</b>	<b>BEmONC Provider Facility</b>
1 Midwife per Barangay Health Station (BHS)	3 BEmONC Teams per hospital BEmONC provider (1 Team per 8-hour shift)  1 BEmONC Team per RHU/BHS:
1 Community/Women's Health Team (WHT) per barangay.  Composition of the C/WHT: <ul style="list-style-type: none"> <li>• Midwife</li> <li>• Barangay Health Workers (BHWs)</li> <li>• Traditional Birth Attendants (TBAs)</li> </ul>	Composition of the BEmONC Team: Hospital: <ul style="list-style-type: none"> <li>• 3 doctors (1 per shift)</li> <li>• 3 nurses (1 per shift)</li> <li>• 3 midwives (C/WHT) (1 per shift)</li> <li>• 1 medical technologist on call per ILHZ or CEmONC-BEmONC Cluster</li> </ul> For RHU: 1 doctor, 1 nurse, 3 midwives (1 per 8-hour shift). For BHS: 1 RHU doctor and 1 PHN "on call," 1 midwife with WHT members as assistants (TBAs and BHWs)

CEmONC provider facilities staffing requirement.

<b>CEmONC Provider Facility</b>
3 CEmOC Teams (1 Team per 8-hour shift)
Composition of the CEmONC Team: <ul style="list-style-type: none"> <li>• 3 doctors preferably obstetric – gynecology specialist or GP trained in CEmONC (1 per shift)</li> <li>• 1 anesthesiologist or GP trained in anesthesiology (on call)</li> </ul>

<ul style="list-style-type: none"> <li>• 1 pediatrician (on call)</li> <li>• 3 OR nurses (1 per shift)</li> <li>• Maternity ward nurses (2 per shift)</li> <li>• 3 Medical technologists (1 per shift)</li> </ul>
<p>Composition of the Itinerant Team</p> <ul style="list-style-type: none"> <li>• 1 doctor (surgeon)</li> <li>• 2 nurses (or 1 nurse 1 midwife)</li> </ul>

**3. Women's Health Safe Motherhood Teams required competencies are as follows:**

- 1) Barangay – based Community or Women's Health Teams should be guaranteed to be competent in the conduct of their assigned tasks that include among others:
  - a. Pregnancy tracking using the recommended tool (*Please see Attachment 1*).
  - b. Assisting pregnant women in Birth Planning using the Mother and Child Book as guide.
  - c. Reporting maternal deaths occurring in the assigned community using the form designed for WHTs. (*Please see Attachment 2*).
  - d. Organizing outreach activities as necessary.

*Please refer to the WHT Module or the WHSMP2 Operations Guidelines for a more detailed discussion on the functions of the WHTs at women's health publications at [www.doh.gov.ph](http://www.doh.gov.ph).*

- 2) The BEmONC Teams should be competent in the provision of the following services:
  - a) Basic maternal care to include prenatal and postnatal care
  - b) Basic emergency obstetric and newborn care services as defined to include newborn resuscitation
  - c) Newborn screening
  - d) Family planning services
  - e) Breast and cervical cancer screening
  - f) Risk assessment and clinical screening and diagnosis of STI and HIV
  - g) Laboratory screening
  - h) Syndromic case management of STIs
  - i) Counseling
  - j) Monitoring, evaluation, research and dissemination
  - k) Referral
  - l) Recording and reporting
  - m) Maternal death reporting using the recommended facility reporting form
  - n) Civil registration of births and deaths
- 3) The CEmONC Teams should be competent in the delivery of the following services:
  - a) BEmONC services as defined
  - b) Surgical childbirth (caesarian section)
  - c) Safe blood transfusion
  - d) Management of newborn complications
  - e) Surgical family planning methods in addition to basic FP methods
  - f) Breast and Cervical screening including interpretation of laboratory results
  - g) Management of breast and cervical cancers
  - h) STI risk assessment and screening
  - i) Management of STIs and its complications

- j) Counseling
- k) Referral
- l) Recording and reporting
- m) Maternal death reporting using the recommended facility reporting form
- n) Civil registration of births and deaths

*Chapter 3 provides a detailed discussion of the BEmONC services. A separate manual on Managing Pregnancy and Childbirth is provided to BEmONC Skills Training participants.*

- 4) The Itinerant Teams are competent in the conduct of:
  - a) Surgical sterilization upon client request
  - b) Gender sensitive Counselling
  - c) Coordination for related outreach activities
- 5) The Social Hygiene Clinic Teams are competent in:
  - a) Laboratory screening and diagnosis of STIs
  - b) Syndromic and etiologic management of cases
  - c) Gender sensitive counselling

## **Chapter V**

### **FINANCING THE MNCHN SERVICES**

Combined financing strategies using instruments available through DOH and LGU budgets, PhilHealth payments and other funding sources will be used to finance the MNCHN services. These funding sources shall finance the acquisition of additional capacities and maximize utilization of services particularly in areas or population groups where maternal and neonatal mortality is most severe.

A major objective of implementing health reforms to rapidly reduce maternal and



newborn mortality is to enable MNCHN facilities particularly the BEmONC and CEmONC provider facilities deliver the maternal and newborn care package in a sustainable manner. This is best achieved if these facilities are financially sustainable and are not solely reliant on budgetary outlays to fund their operational needs. Such a goal is attainable especially if advocacy efforts succeed in convincing women who presently prefer to give birth at home to shift preferences in favor of facility birth.

The basic strategy that the LGUs can do is to pursue to attain the above goal through:

1. Making MNCHN facilities financially sustainable by broadening their fund sources beyond the traditional budgetary allocation from the LGU. This could be done by
  - a. Enhancing PhilHealth reimbursements;
  - b. Allowing the facilities to collect user fees from the non-poor; and
  - c. Allowing the facilities to retain their revenues from these sources to augment operational funds and health worker compensation.
2. Ensuring the sustainability of MNCHN facilities in providing essential life-saving drugs and contraceptives by establishing revolving fund schemes:
  - a. Through the P100 program of DOH for the essential medicines; and,
  - b. Through the Pop Shop scheme developed by DKT for FP commodities.

### **Sources of Funds for MNCHN Strategy**

The financial sustainability of facilities tasked to deliver the MNCHN service package require a scheme that broadens the sources of financing to set up and maintain the network of facilities that deliver the MNCHN services without compromising the access of the poor and the vulnerable population to the same services. The sources of funds include LGU funding, DOH support to capital outlay and performance-based grants, PhilHealth reimbursements and user fees.

#### **I. LGU funding**

The LGU budget for health remains to be the primary source of financing to fund the operations of the MNCHN provider facilities. The LGU budget covers the salaries and other benefits of the local health human resource, including the incentives for Barangay Health Workers, Community/Women's Health Teams, and other community volunteer workers, depending on the availability of LGU funds. Moreover, the LGU budget also finances the maintenance and other operating costs of all health facilities under the LGU's management, including the designated BEmONC and CEmONC provider facilities. Depending on the financial capacity and priority of the LGU, investments in terms of capital outlay for MNCHN facilities are likewise funded locally. The operating costs also cover other support activities like maintenance of infrastructure and equipment of MNCHN facilities and enrollment of indigents to social health insurance.

The LGUs who belong to an ILHZ and agree to co-finance the maintenance and operations of MNCHN provider facilities may opt to create a trust fund that will be managed by the MNCHN Management Team. The LGU budget for MNCHN shall be reflected in the Provincial Investment Plan for Maternal Newborn Child Health and Nutrition and the Province-wide/ City-wide Investment Plan for Health (PIPH/CIPH).

#### **II. DOH support through Performance-Based Budget(PBB)or Performance-Based Grant (PBG) for Public Health**

DOH Administrative Order 2006-0022 provides the guidelines for prioritizing public health programs and for the adoption of a performance-based allocation and execution for priority public health programs like the MNCHN. One of the goals of implementing the performance-based budgeting includes the improvement of reproductive health outcomes through the maternal and child health programs. Specifically, the PBB supports investments critical to reduce the MMR, IMR, U5MR and TFR and increase the CPR.

There are three categories of PBB schemes, namely,

- a) **Baseline Public Health Commodity Fund (BPHCF)** which funds the procurement of public health commodities that will be allocated and distributed to the LGUs in order to achieve national public health targets and health outcomes;
- b) **Public Health Programs Funds (PHPF)** that supports the policy and systems development and provision of technical assistance by DOH to LGUs and funds fixed administrative and utility costs for sustaining operations; and,
- c) **Public Health Development Program Fund (PHDPF)** which comes from the savings generated, unallocated budget from the PHPF, and grants and loan inputs from the ODAs and used for MOOE and capital outlay activities.

The BPHCF covers the purchase of commodities to meet current need of the population and ensure its protection from public health problems. These commodities include vaccines, syringes, treatment of diseases that will require mass treatment (e.g. malaria, filariasis) and management of programs that will require selective treatment (e.g. leprosy, tuberculosis). Considerations in allocating public health commodities will take the following factors into consideration: population growth, epidemiology or disease burden, ideal target versus minimum target to prevent an outbreak, poverty rate, public sector and private market share, public sector performance and level of buffer stock required.

In contrast the PHDPF is used as an incentive for achieving the LGU capacity to fulfil higher levels of performance and these funds can be used for MOOE and capital outlay. For the MNCHN facilities, these funds are allocated for the upgrading of identified RHUs, BHS, hospitals and health centers to BEmOnC providers and other LGU hospitals to become CEmONC providers. Moreover, necessary equipment and furniture to operate the MNCHN facilities are likewise financed.

#### **MNCHN Performance-Based Grant**

A specific DOH Performance-Based Grant (PBG) facility has been earmarked, as a Special Provision No. 10 of the DOH General Appropriations Act for 2008, to improve the MNCHN services and to achieve the NOH targets on the following:

- 60% Contraceptive Prevalence Rate for Modern Family Planning Methods,
- 95% Fully Immunized Children,
- 80% Facility-based deliveries, and
- 80% Ante-natal care coverage.

This performance-based grant is being offered to LGUs that have sufficiently showed performance in terms of (1) achieving key MNCHN targets, (2) having sufficient capacity to provide MNCHN services and (3) committing to continue improving services for their constituents. The grant awards that LGUs are entitled to are based on scores gathered upon assessment of their performance using the above criteria as bases.

The MNCHN PBG uses three performance domains with a corresponding scoring system. The grants distributed to the provinces are referred to as ceilings because they

represent the maximum amount that LGUs in a cluster or district health zone can access. LGUs are entitled to receive an equivalent amount based on their performance against the following domains:

- Performance Domain 1 - Achievement of key MNCHN outcomes in Year 2009 (40%)
- Performance Domain 2 - Capacity to deliver MNCHN services in Year 2009 (40%)
- Performance Domain 3 - Commitment to pursue improvement in the delivery of MNCHN services for Year 2010 (20%)

The basic process of applying for the MNCHN PBG is as follows. After the announcement of the availability of the grants facility by the DOH and the distribution of application materials to CHDs and LGUs, the whole process of LGU application requires the following 4 major steps:

#### **1. Submission of application forms and other supporting documents to the CHD.**

Based on the forms and the list of required documents included in this application guide, LGUs prepare application package for submission to the CHD. Note that CHD only requires minimum document requirements prior to validation as specified in this guideline. For appropriate guidance, it is always best to get in touch with your CHD. For any queries regarding the application process, please contact the FP coordinator or point person at the CHD.

LGUs must submit a complete application package which shall include the following items:

- Duly accomplished application form
- Supporting documentary requirements
- Signed Letter of Intent by the Local Chief Executive

##### **1) Completion of submission of required documents**

As soon as LGU has submitted the accomplished application form and other supporting documents, CHD duly acknowledges the receipt of and process the application package. Processing of application also includes validation of the indicated LGU performance and determining the adequacy of the submitted supporting documents.

Based on the assessment of the CHD, additional supporting documents may be required or appropriate validation procedure (e.g. actual inspection) may be employed to determine the accuracy of entries in the submitted LGU application package. The CHD specifies additional requirements or documents in a letter to the proponent LGU. The LGU responds by sending the additional validation documents to the CHD Director to allow the CHDs to perform appropriate validation procedure.

##### **2) Signing of MOA**

After completing the documentary requirements together with the LGU application package, the CHDs determines the level of LGU performance (based on the performance domains) and allocates the equivalent amount of grant award. Awarding of the grant proceeds to the LGU shall be formalized by the CHD through a MOA formally signed between the Sponsor LGU and the CHD.

##### **3) Receipt of the grant award**

The signing of MOA in Step 3 triggers the release of the allocated grant proceeds to the recipient LGU. Transfer of the LGU grant award requires coordination between the CHD and the Regional DBM which then releases the amount specified by the CHD. The LGU facilitates fund transfer from CHD by creating a new Trust Account or a separate Ledger in an existing Trust Account for health specific for this purpose.

*For more details, please refer to MNCHN LGU Application guide.*

### **III. PhilHealth Reimbursements**

PhilHealth reimbursements would be forthcoming only if the client is a PhilHealth member and the facility is PhilHealth accredited. The investments in MNCHN facilities are designed to ensure that these facilities have the necessary infrastructure and equipment to comply with DOH licensing standards and PhilHealth accreditation. This initiative is envisioned to eventually make PhilHealth reimbursements a dominant source of financing for facility operations and the enhancement of provider compensation.

Aside from ensuring that critical upgrading is done for DOH licensing and PhilHealth accreditation, measures should be in place to enrol the poor and vulnerable families, i.e. the low income households identified as informal sector. Identification of Clients for Subsidized Service (*identification of the poor survey*) adopts the Proxy Means Test (PMT) designed by the Department of Social Welfare and Development (DSWD). The PMT is also being adopted by PhilHealth as their official means of identifying the households for sponsored membership.

In anticipation of the increase in facility births as result of the behavior change initiatives and the advocacy work of the WHTs, the PHO should initiate a meeting with the MHOs, and key staff of the MNCHN Service Delivery Teams (nurses and midwives) to decide on a reimbursement-sharing scheme among the members of the teams that would include the WHT. Such a sharing scheme would apply to the portion of the reimbursement allotted for providers.

The foci of the sharing scheme are:

- The Maternal Care Package (MCP) and Neonatal Care Package (NCP) of PhilHealth.
- The user fee for services provided.

The MCP sets the following conditions for normal spontaneous deliveries (NSDs):

1. NSD (normal spontaneous delivery) covers normal, uncomplicated vaginal deliveries, only for the first four deliveries; all other types of deliveries are covered regardless of order of birth. The NSD is compensable both in hospitals and in non-hospital facilities at a case rate of P 4,500 for NSDs. For hospitals, this is paid after delivery and covers the following:

- P2,500 for the hospital and
- P2, 000 for professional fees.

For non-hospitals, reimbursement is made in two tranches:

- First payment of P3,650 for prenatal care, normal delivery, and newborn care; and
- Second payment of P850 for postnatal care` and family planning counselling.

The non-hospital facilities are obliged to give not less than 40 percent of the case payment to the health care professionals who provided the service. Newborn care package (NCP) of P1,000 is filed as a separate claim for hospital births but is included in the NSD package for births in non-hospital facilities.

2. The NCP package covers the first dose of hepatitis B vaccination, routine newborn care and newborn screening of all qualified respondents for the case payment of 1,000.

DOH Department Order No. 20007-0098 provides a reference for the LGUs in determining a sharing scheme that is most equitable and acceptable to health workers. The following sharing guidelines recommended by DOH maybe modified to suit local situations:

- 1) For services rendered to indigent and non-indigent PhilHealth members, the guidelines issued by PhilHealth on MCP reimbursement apply.
- 2) To ensure sustainability of providing incentives to C/WHTs, the professional fees (PF) provided by the MCP shall be shared among doctors and members of C/WHTs as follows:
  - Fifty percent (50 %) of the total MCP PF shall be the share of the MHO.
  - Forty percent (40%) of the total MCP PF shall be the share of the concerned WHT.
  - Ten percent (10%) of the total MCP PF shall be the share of the RHU staff which should not include the MHO and the midwife.
  - The WHT share shall be determined by the MHOs with technical assistance from the CHD if necessary.
- 3) For services rendered to clients in a hospital BEmONC, the sharing shall be as follows:
  - Eighty percent (80%) of the total MCP PF shall be the share of the facility and shall follow the usual sharing observed in hospitals for PhilHealth members. This shall be subject to the agreement made by the Chief of Hospital (COH).
  - Twenty percent (20%) of the total MCP PF shall be the share of the WHT. The share of each member shall be determined by the MHO with technical assistance from the CHD if necessary.
  - Private health professionals who opt to use the facilities of an RHU or hospital BEmONC, regardless of whether their patients are PhilHealth members or not, should pay the equivalent twenty percent 20% of their PF as service fee.
  - The twenty percent (20%) service fee paid by the private health professional shall be further subdivided among the health personnel upon approval by the COH.

#### **IV. User Fees**

Another viable source of facility financing is the collection of user fees. Such fees are usually collected from non-poor clients using a socialized pricing scheme. However, facilities need to be authorized to collect such fees by the LGU, preferably through an ordinance passed by the *Sanggunian* to help ensure continuity over time across political

administrations. Such an ordinance should also empower the facility to use the funds generated from such user fees to finance operations and to augment provider compensation (in instances where the allocation of Philhealth reimbursements to facilities and providers is not clearly laid out either in policy or in practice, the said ordinance may have to cover such allocation issues with regards to Philhealth reimbursements as well).

Pricing schemes are ideally socialized, taking into account the client's capacity to pay (a recommended strategy for determining such capacity is discussed below). Price levels should not be pegged in an ordinance to allow facility managers to respond to changes in the local situation. Thus, in an economic downturn, facilities may opt to reduce prices or forego user fees altogether for a larger segment of the population so as not to make affordability an obstacle to access.

Charging user fees do not end up as obstacles to access since it requires a pricing scheme that is sensitive to people's ability to pay as well as a reliable system for identifying segments of the population that would need either full or partial subsidies. To arrive at such a pricing scheme, one has to take into account the difference in financing objectives between a public health facility and a private facility. While the private health system has an underlying profit motive in the delivery of health services, the public health system is established for the primary purpose of providing health services to the community (in most cases this is its sole purpose). Generating revenue to either recover cost or to make a profit is hardly in the equation, if at all. The cost of delivering a service need not be recovered since such costs are supposed to be financed out of the budget that the facility receives from the LGU. However, budget constraints can be quite severe for some LGUs especially small, remote municipalities with a miniscule tax base. In such cases, service delivery may suffer severely unless their sources of financing are broadened. Thus, the need to sustainably deliver health services of acceptable quality drives the effort to recover at least some of the cost of delivering these services. How much can be recovered would depend on –

- The budget constraint that the facility faces and
- The ability of its client to shoulder some of these costs.

The objective of **formulating a pricing scheme** that allows the facility to effectively deliver health services to a wide sector of the population, particularly the poor and marginalized, while recovering enough of its costs to enable it to deliver such services in a sustainable manner may be pursued by taking either of **two strategies**.

**First is to use as benchmarks prices charged for the same services** by private or NGO facilities operating at the same level in health care hierarchy (e.g., health center; primary, secondary or tertiary facility). **Apply a discount, taking into account the fact that some of the fixed costs** (and maybe even some of the variable costs) **of delivering the service are unchanging items in the facility budget and will not be affected by the level of facility operation.** Examples of these items are the cost of the building (although one may have to factor into the fee the cost of building maintenance) and the salaries of support personnel. Although the salary budget for permanent item holders is fixed and will always be forthcoming from the LGU, one may want to factor in an incentive scheme for those directly providing the service and include its cost in the fee calculations. An amount to provide for the hiring of contractual staff when the load becomes heavy or when specialized skills need to be sourced from the private sector may also be factored into the cost calculus.

**A second possible strategy is to follow a cost plus pricing scheme.** This involves a tally of the major cost items involved in the delivery of the service. As in the first strategy above, one has to take the perspective of a public facility that is seeking to recover those

costs that may not be supported by the budget. Thus, cost items in the said tally may include mostly such variable costs as the cost of drugs, medicines and supplies, utility costs, incentives for direct providers, depreciation cost of specialized equipment used, etc.

After baseline prices have been determined for each of the services rendered by the facility, a **socialized factor may be applied** to adjust these prices to account for the client's capacity to pay. Thus, those clients in the highest income levels may be made to pay the full cost while those at the lowest income levels may avail of the services for free. Prices may be graduated for those clients belonging to income levels in between.

## **V. Other financing mechanisms to ensure sustainability of essential drugs and contraceptives**

Drugs and medicines usually constitute a major cost item in most health interventions. Their cost can significantly affect health seeking behavior and may even serve as an access barrier to those who are too poor to afford them. The public health budgets of most LGUs are usually too meager to support the provision of free or subsidized drugs to the poor. Thus, public health facilities usually provide not much beyond their supply of donated drugs and supplies.

The sustainability strategy should therefore include helping facilities to become sustainable in the supply of drugs and to enable them to provide their poor clients with free or subsidized drugs. The strategy involves building a large enough revolving fund to allow the sustainable procurement of needed essential drugs, contraceptives and medical supplies. **This strategy shall be pursued by collaborating with two existing DOH programs with similar objectives:**

- The P100 program on essential drugs and
- The Pop Shop initiative of the DOH Social Marketing Project for contraceptives which is managed by DKT.

The collaborative approach is envisioned to generate synergies between the MNCHN framework and the above programs leading to a strengthened effort towards drug sustainability for LGU health facilities. A brief description of each of these projects and the MNCHN strategy for collaborating with them are discussed below.

### **The P100 Program**

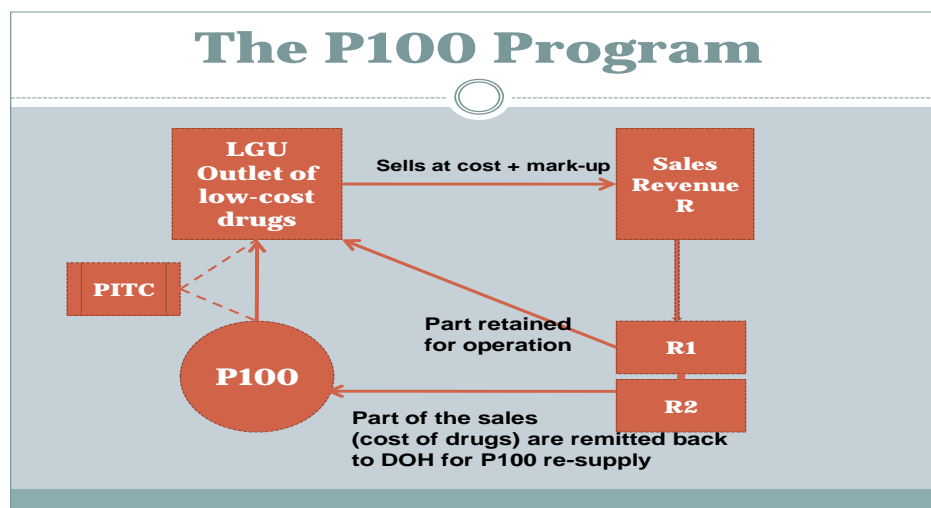
The program is an initiative of the Secretary of Health and is funded out of the government budget. The program seeks to increase access to low cost quality drugs, taking into consideration -

- rational drug use,
- economies of scale in procurement and
- a unified pricing scheme (the targeted ceiling for a complete regimen is one hundred pesos).

DOH and LGU hospitals with functioning Therapeutic Committees and are accredited by PHIC may participate. LGU participants are encouraged to work for the passage of an LGU ordinance authorizing them to establish a revolving fund for drugs and medicines.

Participants are required to submit Requisition and Issue Slips (RIS) to DOH to determine the quantities to be procured by PITA Pharma, the partner procurement agency. Participants may retail the drugs with a mark-up so long as the price does not

exceed 100 pesos per package. From the sales revenue, participants are required to remit back to DOH an amount equivalent to the wholesale cost of the drug. The profit is retained by the facility.



#### Funds and Process Flow

1. The LGU through its Provincial Health Officer submits the RIS for its share of P100 drugs to the P100 Program Management Team (PMT is based at the National Drug Policy, Office of the Secretary) after verifying the accuracy of the request.
2. The P100 PMT submits the RIS for the P100 drugs to PITC Pharma and transfers funds for their purchase.
3. PITC Pharma delivers the requested P100 drugs to the LGU.
4. The LGU retails the P100 drugs at prices equivalent to cost plus mark-up. The LGU remits back to the P100 PMT part of the sales revenue equivalent to the cost of the P100 drugs. The LGU retains the sales revenue.

#### The DOH Contraceptive Self Reliance and Social Marketing Programs

The Family Planning Policy issued by DOH in 2000 recognizes and affirms the need for Contraceptive Self Reliance (CSR) in response to the phase down and eventual phase out of donated contraceptives. CSR as a national strategy is further defined in Administrative Order Number 58 series of 2004, which provides guidelines on the management of donated commodities as supply levels are phased down. (*A.O. # 58 s.2004 Guidelines on the Management of Donated Commodities under the Contraceptive Self-Reliance Strategy*). The CSR Strategy provides for the transition from externally donated to domestically provided commodities for family planning. CSR has two broad goals:

- (1) To effect a gradual replacement of externally donated supplies with domestically provided supplies, and
- (2) To expand further the domestic supplies of contraceptives.



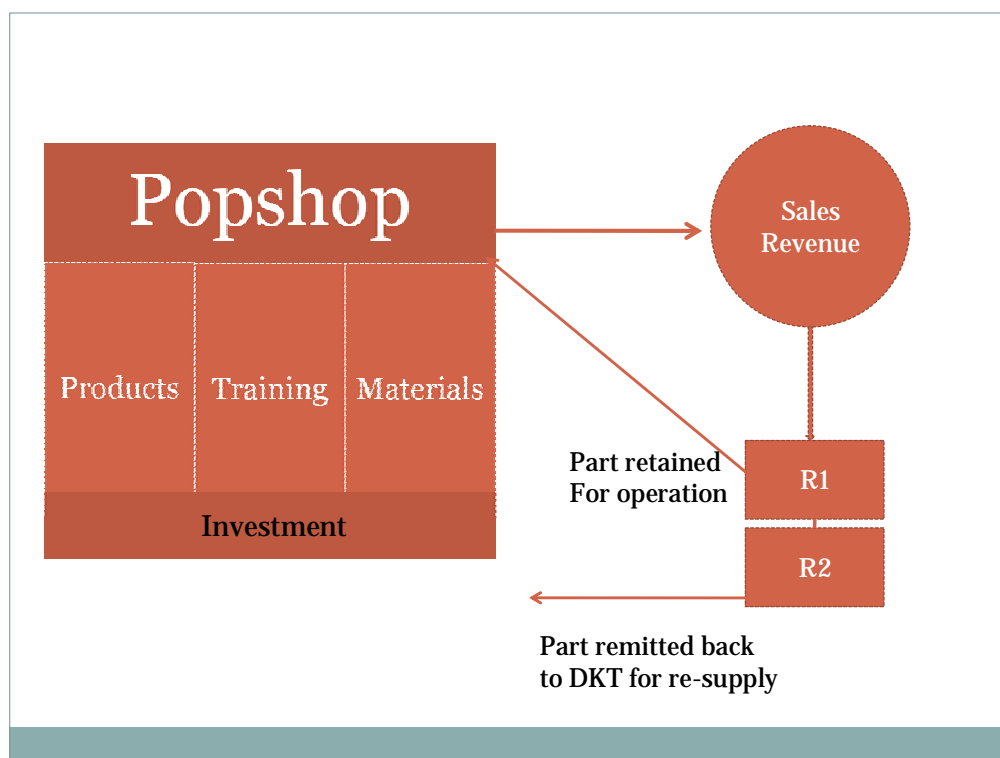
The **first goal** seeks to minimize supply disruptions in the public sector as donations decline, while the **second** seeks to encourage a wider private sector role in the contraceptive market. Attainment of these twin goals will not only help ensure that present contraceptive prevalence rate (CPR) levels are not adversely affected by the withdrawal of contraceptive donations, but will hopefully also lead to finally ending the country's reliance on donor support in the provision of family planning services and commodities.

To effectively pursue the twin CSR objectives above, DOH further strengthened its Social Marketing Program which for years has been successfully managed by DKT, Philippines. Under a renewed mandate, DKT focused on helping attain the CSR objectives by launching the POPSHOP Franchise System. Designed especially to support LGUs maintain a sustainable supply of contraceptives at the community level, the POPSHOP package offers products, training and materials needed to help LGUs promote and operate their Family Planning Programs. Under the system, **affordable contraceptives are provided on a modified consignment arrangement allowing franchisees to recover the initial cost while they continue to generate funds to sustain their programs.** The acceptability of the scheme to even the poorest remote communities is manifested by the over 200 POPSHOPS that have been established nationwide from as far north as Luna, Apayao to Bongao, Tawi-Tawi which is at the southernmost tip of Mindanao, just a few nautical miles from Sabah in Malaysia (*PULSE, November 2007*).

The franchise is open to both public and private entities. Its target groups are LGUs, NGOs, midwives, industrial clinics and cooperatives. Investment costs range from-

- 25,000 pesos for the New Mini-POPSHOP Package which is offered to LGUs wishing to expand coverage, to
- 92,500 pesos for the Standard Full Package.

The amount covers enrolment and franchise fees and the seed stock. Franchisees are provided operations training, technical and management assistance, signages, IEC and promotional materials and client monitoring tools (*POPSHOP Briefing Paper*).

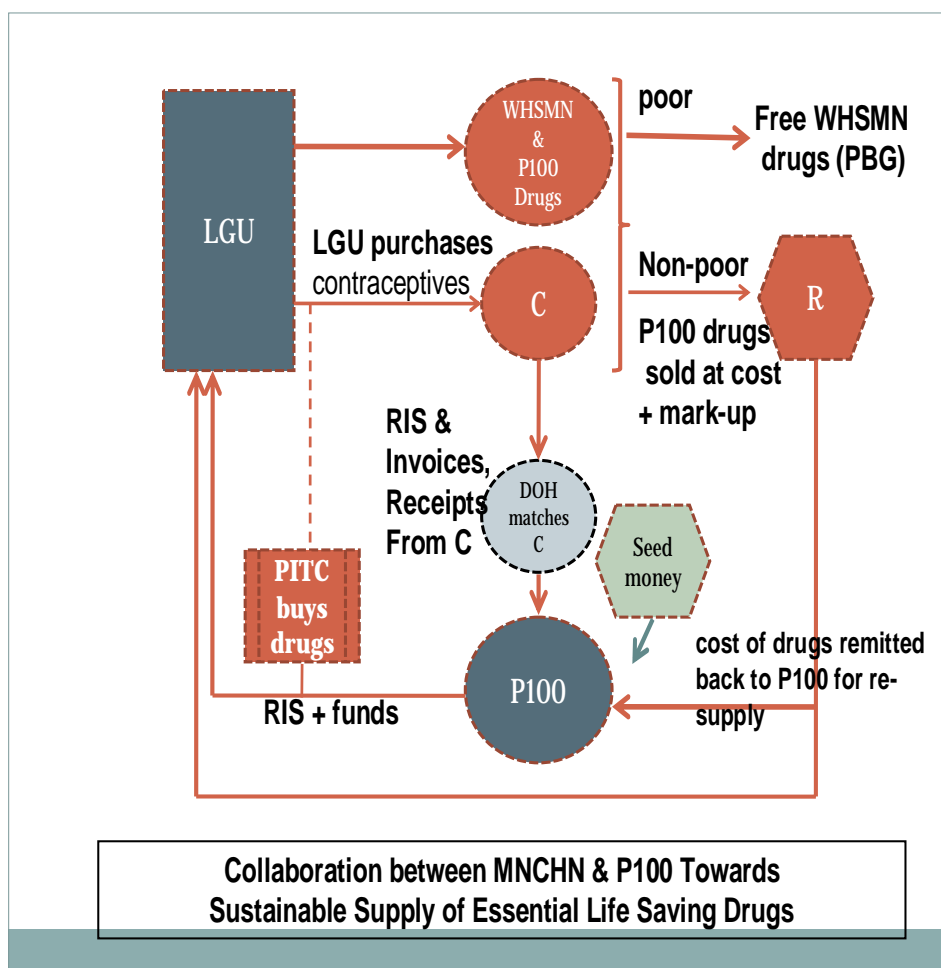


### Performance-Based Grant towards Self-Reliance in Essential Life-Saving Drugs and Contraceptives

A performance-based grant may be offered to encourage LGUs to participate in the above programs so that they may avail of the offered MNCHN grant and the technical assistance that they need to establish and effectively operate revolving fund schemes that would lead them to sustainable self-reliance in the supply of essential drugs, emergency obstetrics and newborn drugs and contraceptives.

The scheme initially requires –

- LGUs to purchase contraceptives to meet the needs of the poor. These contraceptives are to be given free to poor clients (those in the list of poor clients per the Client Classification Survey).
- DOH, on the other hand, commits to supply the LGU with an equivalent amount of emergency obstetrics and newborn drugs, mainly to help ensure that BEmONC and CEmONC clients have an adequate and consistent supply of these drugs. These drugs will be supplied through the P100 program and will be in addition to the essential drugs supplied by the program in the form of seed stock.
- As the revolving fund grows, outlets shall be increasingly capable of providing a steady supply of socially-priced drugs to those who are able to pay and free drugs to the poor without having to rely on budgetary outlays from the LGU. The process flow is shown below.



To help ease the budgetary burden of providing contraceptives to the poor, PBGs will also be made available to help LGUs defray the initial cost of setting up POPSHOPS, provided that they commit to allocate part of the POPSHOP profit to help defray the cost of supplying free contraceptives to the poor. As the POPSHOP revolving fund grows, it is envisioned to increasingly assume the financial burden of providing free contraceptives for the poor until eventually a budgetary outlay will no longer be necessary. At this point, the LGU shall have become self-reliant in maintaining a steady supply of socially-priced contraceptives to all segments of the population.

*A Special P100 Program that features the P100 essential drugs, emergency obstetrics and newborn drugs and supplies and Pop Shop franchise, is set for pilot testing in Womens' Health and Safe Motherhood Project 2 sites.*

## Chapter VI

### GOVERNANCE

#### Setting the MNCHN Network into Operation

Mechanisms that secure the political commitment of local stakeholders and exact accountability for results shall be established for good governance. These mechanisms shall have broad-based participation, non-partisan leadership and sustained popular support to assure continued local effort regardless of different political, economic and socio-cultural conditions.

#### I. Organization of the Maternal Newborn Child Health and Nutrition (MNCHN) Facility Network

The MNCHN Facility Network is a systematic arrangement of strategically-located basic and comprehensive emergency obstetric and newborn care provider facilities as well as non-EmONC facilities providing non-emergency public health services such as immunization, family planning, pre and postpartum/natal care, and the like. The choice of public and private health facilities that form the network is guided by the following considerations:

- Network coverage should be comprehensive enough as to encompass the whole province,
- Facilities should be within easy reach of each community in the catchment area,
- Facilities should be sufficiently dispersed as to allow each an unhampered pursuit of sustainability objectives, and
- Facilities should be cost-effectively deployed.

To be able to establish such a network, a **Facility Mapping and Needs Assessment Exercise** is first carried out. The exercise consists of two inter-related and highly participatory activities involving stakeholders of the provincial health system. **Facility Mapping** is a well-defined process for choosing strategically-located health facilities to form the Provincial MNCHN Network. It seeks to identify and select strategically located health facilities to be designated as either a “basic” or a “comprehensive” emergency obstetric and newborn care provider facility. The **Needs Assessment Exercise**, on the other hand, is designed to assist LGUs determine the investment needs of each facility chosen to be part of the MNCHN Network. The exercise **is part of the social preparation phase and is an important activity to undertake prior to drafting the Provincial Investment Plan for Health (PIPH)**. In particular, the Facility Mapping and Needs Assessment Exercise are able to:

1. Systematically determine the size and location of risk groups,
2. Spot the public and private health provider network,
3. Define service delivery gaps,
4. Identify potential MNCHN facilities to address the gaps, and
5. Develop customized facility maps showing the MNCHN referral network.

*Each of these activities is described in detail in the Facility Mapping and Needs Assessment Manual which can be accessed at women’s health publications at [www.doh.gov.ph](http://www.doh.gov.ph).*

#### II. Organization the Service Delivery Teams

The LGU capacity is envisioned to be operational with the organization of a network of **Service Delivery Teams** at various level of the Health Service Delivery System. The network shall consist of:

**At the community level:**

- Community/Women's Health Teams (C/WHT)

**At the facility level:**

- BEmONC and CEmONC Teams
- Itinerant Teams
- Social Hygiene Clinic Teams

The Teams are strategically dispersed throughout the Province to ensure timely access to obstetric and newborn emergency care by mothers. The Teams shall provide the full maternal and newborn care, family planning, adolescent reproductive health and STI and HIV service packages to the general population as well child survival packages: Infant and Young Child Feeding (IYCF), Integrated Management of Childhood Illnesses (IMCI), Expanded Program on Immunization (EPI), etc.

**Rationale for Organizing the Service Delivery Teams**

At the implementation level, the Service Delivery Teams are the only qualified health workers with responsibility for the care of women during pregnancy, childbirth, and the immediate postpartum and postnatal period. The Teams possess wide-range of competence for the tasks they are required to perform and contribute significantly to saving the lives of mothers and newborns and consequently improves health of women and children. Their organization guarantees the availability of an efficient support system in the implementation of the MNCHN interventions.

**The Organization Process**

**A. The Community/Women's Health Teams (C/WHTs)**

C/WHTs are organized and established in every barangay. The Team is composed of:

A Rural Health Midwife as Team Leader of all C/WHTs organized in her catchments. Her Members include:

Barangay Health Worker(s) and  
Traditional Birth Attendant(s)

The Municipal Health Officer acts as the RHU catchments Teams' supervisor.

*TBAs as C/WHT Members*

TBAs are important partner in the delivery of MNCHN services. It is now generally accepted that one of the main reasons why many TBA-based maternity care program of the past did not work was that the programs failed to link TBAs to a functioning health care system – one in which health care providers at all levels of the health system function as a team.

As member of the Community/Women's Health Team (C/WHT), the best role of the TBA is to serve as an advocate for skilled professional care – encouraging women to give birth in facilities providing basic emergency obstetric and newborn care. TBAs will be able to perform this role effectively when they are made part of team.

Thus, since the “risk approach” paradigm is no longer acceptable in maternal and newborn mortality reduction the standard shifted to the “EmONC approach” (emergency obstetric care and newborn care) with its set of services that cannot be delegated to the TBA. The paradigm shift in maternal and newborn care necessitates a modification of the TBA functions from assisting women deliver to midwife assistants. **The shift also required that TBAs be made part of the Community or Women's Health Team (C/WHT) so that they become part of the formal health system and do not compete with the skilled health professionals in providing childbirth services.**

The Municipal Health Officer and the Public Health Nurse with assistance from the Rural Health Midwives organizes the Teams for the municipality:

**Step 1:** Inventory of Midwives, BHWs and TBAs.

It is important for the Municipal Health Officers and the Public Health Nurses to have an inventory of the Barangay Health Workers (BHWs) and traditional birth attendants (TBAs) within their catchments with the help of the midwives. The objectives of this step are:

1. To determine the adequacy of members versus the number of teams that need to be organized, and
2. To define geographic dispersion of the teams.

**Step 2:** Determine the Criteria for Selection of C/WHT Members

Brainstorm on the qualification criteria that the municipal health system may want to consider in the selection of WHT members. The MHO may decide to have all TBAs and BHWs part of the WHT, this option is acceptable. However, knowing that most TBAs are old and under- schooled, it might be prudent to have a combination of ages (younger and older) in a team so that in carrying out certain activities, a younger member is on hand to accompany and assist an older member.

For team efficiency, certain qualifications are recommended but not required:

1. Ability to read and write,
2. With good vision and hearing,
3. Ability to walk without assistance, and
4. Not more than 65 years old.

**Step 3:** Determine the Number of Teams that needs to be organized.

The minimum requirement is for one barangay to have at least 1 team. Some municipalities may opt to have a team in every district, street or “purok” and to have as many members as possible.

If the finding of the inventory in step 1 point to an inadequacy of WHT members, then recruitment of members should be done before organizing the teams.

#### **Step 4:** Call for an Orientation Meeting

Organize a forum to orient the midwives and their members: TBAs and BHWs and to get their willingness to be part of the C/WHT.

Because of the number of participants involved, the midwives may need to be oriented first on the rationale of organizing the team and their functions. The TBAs and BHWs may need to be organized in batches of not more than 50 participants per batch. This is to allow for better interaction between the MHO and the PHN and the WHT members and maximize their understanding of the tasks at hand.

This meeting could be a venue of getting the recruits' decision to join the team. Should some recruits decide not to join the team, then the recruitment process should continue.

As much as possible, the MHO should get the TBAs to be part of the team. This is to make sure that they will not continue with their practice of assisting in childbirth at home.

#### **Step 5:** Enlist the members and meet the team regularly.

List down the members of the C/WHT per barangay, labeling them as Team 1, Team 2, etc. and their area of assignment. For example, Team 1: Purok 1, and so on.

Ensure that the teams are appropriately deployed in a manner that all women in the community are assured of access to a WHT member.

In an IP (indigenous people's) community, it is best to have IPs as members of the Team. This assures IP women's access to MNCHN services.

If the barangay is large, it may need to be divided into clusters or *puroks* and several C/WHTs may need to be organized with a team assigned in each cluster, *purok*, or street. Furthermore, if a barangay is in a mountainous area and is hard to reach, recruiting men members of the WHT should be considered. In communities where hiking the trail is the only means of mobility, men would make good assistants during referral. In this case, the name "Women's Health Team" may be changed to "Community Health Team", or whatever local name maybe desired.

#### **Step 6:** Train the Teams on their functions.

#### **Step 7:** Orient the Teams on their incentives.

*(A Module for training the WHTs has been developed. This can be accessed at women's health publications at [www.doh.gov.ph](http://www.doh.gov.ph)).*

### **B. The Facility-Based Teams**

Aside from the community-based C/WHTs, networks of facility-based public and private health providers should be mobilized to help efficiently deliver the MNCHN service package. The facility-based teams are:

- **BEmONC Teams** in every facility designated to provide basic emergency obstetric and newborn care,

- **CEmONC Teams** in every facility designated to provide comprehensive emergency obstetric and newborn care as well as surgical contraception and IUD insertion.
- **Itinerant Teams** in every CEmONC provider facility to deliver outreach FP services.
- **Social Hygiene Clinic Team** in a Social Hygiene Clinic, BEmONC provider facility or RHU where STIs are prevalent.

Organizing the Facility-Based Teams is not difficult since the members of the Teams are the staff of the Facility itself. However, problem may arise when the facility staffing requirement is not complied with. In this case, there is need to recruit members from the private sector or from other public health facilities such as the RHU or the Community Hospital.

#### 1. The BEmONC Teams

**BEmONC Teams** as the name implies are set up in every BEmONC provider facility, whether Hospital, RHU or BHS. **Its Team Leader** is a Doctor who may be the Chief of Hospital, Chief of Clinics, Head of the Obstetrics and Gynecology Department, or a General Practitioner trained in BEmONC service provision, and the Municipal Health Officer in the case of an RHU and BHS.

#### **At RHU and BHS BEmONCs, the Members are:**

- 1.) The Public Health Nurse,
- 2.) All Midwives as head of the WHT, and
- 3.) All members of the WHT

In a BHS BEmONC, the MHO or the RHU doctor heads the team with the RHU nurse, BHS midwife and the WHTs assigned in the catchment barangays as members.

#### **At Hospital BEmONCs, the Members are:**

- 1.) All staff nurses of a non-departmentalized hospital,
- 2.) All staff nurses of the OB ward and delivery room nurses of a departmentalized hospital
- 3.) The medical technologist whether in-house or visiting status under the inter-LGU or ILHZ staffing arrangement or private practicing Medical Technologist invited to work on call in the public health facility.

Optional members BHS and RHU-based WHTs – the midwife and her members

WHTs may be tapped to help in a hospital BEmONC specially when there is a serious staffing shortage. The midwives who head WHTs should undergo a BEmONC training course. The members on the other hand can be tapped to lend extra hand in the ward with supervision from the staff nurse.

The MHO and the Chief of Hospital organizes the BEmONC Team. The following are important considerations in the organization:

- 1.) **Hospital BEmONCs** should have 3 teams so that there is 1 team per 8-hour shift. This arrangement assures mothers and their families of quality care. Duty time per Team are as follows:

First shift:	7 AM – 3 PM
Second shift:	3 PM – 11 PM
Third shift:	11 PM – 7 AM



- a. For District Hospitals with an inadequate staff complement, the following scheme should be done:

- a) Invite the RHU doctor from a non-BEmONC facility to provide duty time just like a visiting consultant in the hospital and be a BEmONC service provider. Invite as well the RHU doctor from a neighboring municipality. This completes the required number of BEmONC teams.

Please note, that if the MHOs agree to the proposal, inform the Health Human Resource Development Bureau or National Center for Disease Prevention and Control of the Department of Health, for the training needs of the doctors.

- b) Encourage private providers (doctors, nurses, midwives) to apply as BEmONC service providers in the hospital and provide service to public health and their private clients.

- 2.) **RHU BEmONCs** may have only one (1) team but their working scheme may be modified as follows:

- a. 2 midwives or 1 midwife and 1 WHT members should be assigned to go on duty per shift. The duty time is the same as that of a hospital BEmONC provider:

First shift:	7 AM - 3 PM
Second shift:	3 PM - 11 AM
Third shift:	11AM - 7 PM

The RHU doctor and PHN are BEmONC providers on call.

- b. Since the RHU is not a 24-hour facility, those going on “shift” are required to be physically present at the RHU but should be allowed to sleep at night when there is no patient but with instruction that the RHU’s light should be left “on”. This assures the clients of service any time.

### 3. ) **BHS BEmONCs**

BHSs are satellite facilities of RHUs regardless as to whether it is a BEmONC provider or not. The work scheme at the BHS BEmONCs can be modified as follows:

- a. The BHS may not have a structured three 8-hour shift, but maternal and newborn health services should be made available anytime. This means that the midwife is on “on call” status after the usual 8-hour clinic time.
- b. The community should be kept informed on the availability of services after the 8-hour work schedule (8:00AM – 5:00 PM) and the midwife and members of the WHT assigned in their *purok* or street or cluster, can be called from their homes to the BHS. This can be done by posting a “Notice” on the bulletin board of the BHS or the Barangay Hall.
- c. The BHS may have the option to follow the three 8-hour shift with the WHT members assigned to go on shift, and observing the same rule as that of the RHU BEmONC. The midwife is called from her home whenever there is a woman who will give birth.

For **BHS BEmONC facility**, a **midwife** should be assigned to the BHS **full time** with the **municipal health officer and public health nurse available “on call” and alternately making supervisory visits**. Thus, the number of BHS BEmONCs is constrained by the ability of the doctor or the nurse to supervise them, especially if the BHSs are in remote barangays.

Organizing work is a challenge to health officers. Putting the Teams into operation is demanding. **To make the organization work and service schemes operational, the following should be done:**

- 1). The PHO and MHO should advocate for the passage of a local policy that provides for –
  - a) The official working arrangements of the various teams:
    - Community or Women’s Health Teams
    - BEmONC Teams at Hospitals, RHUs and BHSs
  - b) A defined staffing scheme for the BEmONC providers
  - c) A defined incentive scheme for the Teams:
    - Ensure appropriate fund source for additional financial incentives to the teams:
      - All BEmONC provider facilities should work for the accreditation to Maternity Care Package (MCP) by PhilHealth to ensure fund source.
      - Work towards a policy that will allow the facility to collect user fees for services rendered and for the revenues generated to be managed by the facility for its operation. Revenues generated by a BHS maybe managed by the RHU.
    - Provide reasonable additional financial incentives to the teams through a share in the hospital revenues: PhilHealth MCP reimbursements, user fees, and others.
      - Define amount or % share of professional directly assisting in childbirth and those of the WHTs that referred clients to give birth in the facility.

*(The WHSMP2 Operations Guidelines maybe referred to for a detailed discussion on the sharing scheme done by Project LGUs. This can be accessed at women’s health publications at [www.doh.gov.ph](http://www.doh.gov.ph)).*

## 2. The CEmONC Teams

Most CEmONC provider facilities are departmentalized, with medical specialties properly identified and segmented. In this setting, the Teams are configured as follows:

**Team Leader** can be the Chief of Clinics or head of the Obstetrics-Gynecology Department or an Obstetrics-Gynecology Specialist or a General Practitioner (GP) trained on basic and comprehensive emergency obstetric and newborn care.

### **The Members are:**

- Anesthesiologist or GP trained in anesthesiology whether in-house or visiting

- consultant
- Pediatrician or neonatologist whether in-house or visiting consultant
- All operating room nurses or only those assigned in the OB OR.
- Medical Technologists

A CEmONC provider hospital is usually the DOH operated tertiary hospital and Provincial Hospital – these are facilities that are better staffed, equipped and with the required amenities of a departmentalized facility. **Organization of CEmONC teams in these facilities may not be necessary because of the departmental arrangement:** obstetrics and gynecology department, department of pediatrics and a newborn intensive care unit (NICU), all operating on three 8-hour shifts.

However, the travel time criterion in saving mothers and newborns' lives necessitates the upgrading of some District Hospitals to CEmONC standard. Thus there are **three (3) types of CEmONC provider facilities:**

- DOH operated tertiary hospital
- Provincial Hospital
- District Hospital

The organization of CEmONC Teams in a District Hospital requires the following:

- 1) Hospital CEmONCs should have 3 teams, 1 team per 8-hour shift:

First shift:	7 AM – 3 PM
Second shift:	3 PM – 11 PM
Third shift:	11 PM – 7 AM

- 2) For District Hospitals with an inadequate staff complement, the following schemes should be done:

- a) Invite private practicing doctors with the following specialties to act as consultants:

- Obstetrics-gynecology
- Anesthesiology
- Pediatrics or neonatology

- b) Provide reasonable incentives to consultants providing service to poor public health clients:

- PhilHealth MCP reimbursement of professional fee amounting to PhP 2,000.00.
- Collection of professional fees from non-poor clients.

- 3) Train general practitioners on CEmONC skills.

3. **The Itinerant Teams (ITs)** are organized to encourage older couples of reproductive age who have attained their desired family size, to shift to more cost effective, permanent family planning methods. These teams are based in CEmONC facilities. **The team is composed of:**

- 1) A doctor trained to perform non-scalpel vasectomy (NSV), bilateral tubal ligation (BTL) and IUD insertion and
- 2) Two operating room nurses or an operating room nurse and a surgical midwife.

The main function of the team is to perform outreach activities on regular basis in communities within the CEmONC catchment area, in coordination with local C/WHTs. The outreach activity is meant to enhance reproductive health services particularly family planning.

4. **STI or SHC Teams (STs)** are organized in Social Hygiene Clinics or Rural Health Units with STI control services. The team is tasked to address the health needs of high-risk groups and to protect the general population from infection. **The STs are composed of:**

- 1) A physician,
- 2) A nurse,
- 3) Medical technologist and
- 4) Midwife

### **III. Training the Service Delivery Teams**

#### **THE STRATEGY**

Alongside the organization of service delivery teams is the effort to train its members on the required MNCHN competence. A strategy that is envisioned to enhance the capacity of the health system to train and develop its human resource to the optimum level of competence shall be implemented in consideration of the following:

1. A policy that calls on health and local government leaders to ensure skilled professional assisted childbirth within the health system, for all women.
2. A change from separate delivery of key women's health/reproductive health services towards an integrated service package – the maternal newborn child health and nutrition service package.
3. Strengthened client focus and social support for families and women in the reproductive age group.

Current training programs provided by the Dr Jose Fabella Memorial Hospital (DJFMH) and its network of training institutions focus primarily on upgrading and refreshing skills of staff (doctors, nurses and midwives) who have completed primary professional training and who are already working. In the next 3-5 years, the experience will be distilled for dissemination, including pre-service training content and procedures where appropriate. DOH-Health Human Resource Development Bureau (HHRDB) supports pre-service training for members of indigenous communities, through the stepladder-training program leading to midwifery qualification. This human resource training and development system being developed at the Dr Jose Fabella Memorial Hospital will be adopted for pre-service training programs in the health system, to minimize the need for continuous in-service training for newly graduated health professionals.

In the light of the new policy and service paradigm the human resource training and development strategy's objective is to be able to respond to the challenges of the MNCHN service delivery model through the following actions:

1. Upgrading of competence required of the following MNCHN teams to enable them to effectively perform their assigned tasks:
  - 1.) Community or Women's Health Teams at the village level,

- 2.) BEmONC Teams in basic emergency obstetric and newborn care provider facilities,
  - 3.) CEmONC Teams in comprehensive emergency obstetric and newborn care provider facilities,
  - 4.) Itinerant Teams for outreach services on family planning, and
  - 5.) STI control and HIV prevention Teams.
2. Making skills available through innovative and pragmatic action in the light of an ongoing brain drain of skilled health workers (nurses and doctors) from rural and underserved areas – The Doctors to the Barrios Program and the Volunteer Midwives Program are among the current initiatives that respond to the challenge.
  3. Re-orienting, upgrading and re-training of key public health providers to enable them to competently deliver the integrated package, work effectively as part of a team, and interact in an acceptable manner with clients, families and the community.
  4. Ensuring competence in the specific skill mix required to effectively render emergency obstetric and newborn care needed to deliver the services. The focus of the strategy is on practical primary level service delivery not on academic or high level specialties.
  5. Introduction and dissemination of competency based, practical learning, with a high level of responsibility taken on by the learner, and with mentoring and guidance from effective training providers.
  6. Linking training more closely with placement and staffing with the aim of producing and maintaining functioning service teams and adequate support services.

The strategy discourages past dependence on public sector health workers as trainers. Training of Trainers (TOT) formats have been shown to limit the availability, motivation, and effectiveness of the trainers, and have resulted in missed opportunities to make use of other training resources.

#### THE HRTD MECHANISM

To boost the health system's capacity, the Department of Health has established a more responsive and effective system for training health providers and support staff. The HRTD system utilizes a Training Consortium that is headed by the Dr. Jose Fabella Memorial Hospital (DJFMH) with qualified training institutions strategically located all over the country as members. Currently, the following training providers are recognized as part of DJFMH network of training institutions:

1. Quirino Memorial Medical Center, J.P.Rizal St, Project 4, Quezon City
2. Veterans Regional Hospital, Bambang, Nueva Vizcaya
3. St Anthony Hospital in cooperation with Vicente Sotto Memorial Medical Center, Cebu City
4. Davao Medical Center, Bajada St, Davao City

As head of the consortium, DJFMH is also the lead institution for the network of training providers, with the following responsibilities:

- Managing the training programs,
- Ensuring training quality,

- Periodically supervising, monitoring and evaluating the training institutions within the network.
- Periodically updating the faculty members

## THE TRAINING PACKAGES

Training the MNCHN Teams is focused on providing each member the skills needed to enable them to function effectively. Special training courses are designed for each category of health professional working within a team. These training packages will be continuously developed and updated:

The barangay – based **Women’s Health Teams**, are required to undergo an **Orientation and Skills Development Course** that is focused on their functions and includes among others, topics on:

1. Pregnancy Tracking
2. Birth Planning
3. Organizing Outreach Activities
4. Maternal Death Reporting

Likewise, as frontline health workers, they will be the main driving force in the Interpersonal Communication (IPC) strategy to effect positive behavior change among the women and men of reproductive age in communities. Thus, in addition to their main functions as WHTs, they will be trained on IPC (inter-personal communication).

Training courses for the **Facility-Based Teams** are specially designed for the expertise they are expected to develop in the course of their professional practice. The training packages guarantees the Teams’ competence in the delivery of services

1. Basic Emergency Obstetric and Newborn Care for BEmONC and CEmONC Teams

This is a 14-day course where a full team complement is required to attend on the same schedule. This is to ensure team work, complementation of functions, and camaraderie. Thus, included in the packages are modules on:

- 1) Medical management of basic obstetric and newborn emergencies for doctors,
- 2) Nursing management of basic obstetric and newborn emergencies for nurses,
- 3) Life saving skills with focus on early identification of signs and symptoms of basic obstetric and newborn emergencies for midwives,
- 4) Newborn screening,
- 5) Updates on prenatal and postnatal protocols,
- 6) Updates on the maternal and newborn death reporting protocol, and
- 7) Group dynamics session.

In the case of a hospital BEmONC provider, where there are no midwives, the midwives of the RHU nearest to the hospital should be made part of the team and should be trained one at a time. And where doctors are not enough to comply with the required 1 doctor per shift, the doctors of the RHUs nearest to the hospital should also be made part of the team and trained.

This course is open to general practitioners in BEmONC and CEmONC provider facilities only. Since nurses in CEmONC provider facilities are expected to be better skilled, the course maybe taken by this group of professionals assigned in the delivery and operating room as necessary

2. Family Planning courses for BEmONC and Itinerant Teams:

- 1) Level 1: Basic Knowledge on FP is an orientation course on modern FP methods and management of side effects. The whole team attends the orientation on FP methods together, and then will be re-grouped according to profession (e.g., doctors, nurses, midwives) during the discussion on the management of side effects:
  - a. Medical management will be for doctors,
  - b. Nursing management, counseling and referral for nurses, and
  - c. Giving practical advice and replenishment of supplies for midwives.
- 2) Level 2: Comprehensive FP including IUD insertion is open to doctors and nurses.
- 3) Breast and Cervical Cancer Screening is a training course open to doctors, nurses and medical technologists.
  - a. The doctors' training focuses on:
    - a) Physical examination of the breast and cervix
    - b) Medical interpretation of laboratory results: acetic acid wash, papanicolau smear
    - c) Making the appropriate diagnosis.
  - b. The medical technologists will be given updates on cervical cancer screening.
  - c. The nurses will be re-oriented on taking patients' medical history and gender sensitive counseling.

Staff of non-BEmONC provider facilities are also required to attend the FP courses as appropriate.

Special FP Course for CEmONC provider facility-based Itinerant Teams:

- 1) Voluntary Surgical Sterilization as necessary since a surgeon is usually assigned to head the team along with 2 operating room nurses.
3. Courses related to STI Control and HIV Prevention are offered to BEmONC Teams as well as Social Hygiene Clinic Teams (SHC) and RHU based STI Teams:

- 1) For Doctors:
  - a. Risk assessment: interpretation of laboratory results
  - b. Clinical screening and diagnosis
  - c. Syndromic and clinical management
- 2) For Nurses:
  - a. Risk assessment and counseling
  - b. Syndromic management
- 3) For Medical Technologists (as needed):
  - a. Laboratory STI tests

For CEmONC provider facility-based General Practitioner the following special courses are required:

- 1) Syndromic and etiologic management of STIs
- 2) Medical management of complications of STI

Other special training courses are designed to further enhance the quality of the Teams' ability to provide quality service:

1. Gender and Health
2. Leadership Training and Group Dynamics
3. Counseling for Nurses and Social Workers as necessary
4. Monitoring, Evaluation and Dissemination for Doctors and Nurses.

#### THE RECOMMENDED TEACHING AND LEARNING PROCESS FOR COMMUNITY OR WOMEN'S HEALTH TEAMS

As a teaching and learning methodology, the midwives are trained first. This training is not only aimed at **providing the midwives knowledge on the new protocols developed** but also provides them with the **skills that will enable them to transfer these skills to members of their Team** on a more personalized mode.

Adult learners require a different teaching-learning methodology. A classroom type of instruction does not appeal to the experienced adults. Given their vast life experience and household duties to think of, **a small group, interactive type of learning spanning short time periods** is more effective. If it is necessary to divide the modules into several sub-modules, this should be done to allow for ease in understanding and mastery. For instance, each C/WHT function may need to be taught singly in a day for 30 minutes with plenty of "on the job" reinforcements.

For example:

First lesson: **Pregnancy Tracking.**

Methodology: Discussion and individual instruction on:

- What is Pregnancy Tracking
- Why is Pregnancy Tracking necessary
- What is the Pregnancy Tracking Form
- How is the form filled up

Duration: 1 week

- 30 minutes -1 hour is for interactive instruction
- The rest of the week is for the members to develop their skills on pregnancy tracking

Evaluation: The midwife as team leader should check on the WHTs task (in this case, pregnancy tracking) and see if the form is properly filled-up.

A member should not be allowed to advance to the next lesson until the first lesson is mastered.

The midwife as the teacher can schedule the activity for her Teams at her own pace, e.g. whenever she visits her catchment barangays. The lesson topics should be guided by the "Functions of the WHT" as discussed in the WHT Module developed ([www.doh.gov.ph](http://www.doh.gov.ph)).



## ACCESSING TRAINING PROGRAMS

At the national level, the training program is managed by the following offices:

1. The Health Human Resource and Development Bureau (HHRDB) is in-charge of human resource management and development. This includes–
  - 1) Recruitment,
  - 2) Deployment,
  - 3) Career development, and
  - 4) Training.
2. The National Center for Disease Prevention and Control (NCDPC) as the technical arm for all public health programs, is responsible for providing assistance to the HHRDB in the –
  - 1) Assessment of training needs
  - 2) Over-all design of the training packages, and
  - 3) Maintenance of a data base that provides real time inventory of Teams trained on a particular course per facility. This is to ensure comprehensive training coverage across the country.
3. The DJFMH as the premier maternity hospital in the country is the main training arm for women's health and safe motherhood. With assistance from NCDPC, its training team is tasked to:
  - 1) Draft training curricula for the various training packages,
  - 2) Draft and produce training manuals,
  - 3) Conduct or supervise the actual conduct of the training,
  - 4) Conduct post-training evaluation of trainees,
  - 5) Establish networks of training providers across the country,
  - 6) Take charge of training quality assurance, and
  - 7) Monitor the performance of the training providers within the network.

In addition, training centers are charged to do administrative functions relative to managing the training program to include such tasks as:

- 1) Finalizing training schedules on yearly basis and informing stakeholders about the course offerings,
- 2) Determining the number of Teams that it can accommodate for a particular course per batch,
- 3) Costing the training package: tuition fee and miscellaneous expenses,
- 4) Negotiating for the Team's accommodation while on training,
- 5) Preparing the training kits, and
- 6) Assigning faculties for the course.

At the provincial level, the task of making sure that the teams are competent lies with the Health Human Resource Management Office (HHRMO) of the Provincial Health Office (PHO). Organizing the training of the Teams will involve the following steps:

**Step 1:** Assess the Team's capability to deliver the MNCHN – Service Package, particularly EmONC.

**Step 2:** Determine the number of Teams that needs to be trained.

**Step 3:** Make a schedule to train the Teams but have a contingency plan to make sure that enough number of health staff is left in the facility to continue to provide health services while a Team is undergoing training.

**Step 4:** Inform DOH-HHRDB of your request for training. Be clear on the training package and number of Teams that you want trained. It would help if you can provide HHRDB with your preferred schedule.

**Step 5:** Wait for a response from HHRDB which could normally take 2 weeks. As soon as HHRDB approves of your request, you will be endorsed to an appropriate training center and you will be sent a notice with the following information:

- 1.) Confirmation of the training schedule,
- 2.) Number of Teams allowed to train for the batch,
- 3.) Cost of training that includes tuition fee, accommodation and other miscellaneous expenses,
- 4.) Accommodation provision, and
- 5.) Contact person at DJFMH for other administrative details which may include-
  - a. The training institution where you can send your Teams and
  - b. Things that your Team is required to bring, e.g, clinical gowns and masks, etc.

**Step 6:** Inform the Teams and finalize schedule: What Teams will be enrolled in the first batch, and so on.

**Step 7:** Prepare your training fund. If your Team is being sponsored, by a donor, inform the donor about the cost and secure the timely release of funds. If the LGU is funding the training, inform the chief executive of the schedule and cost.

**Step 8:** Enroll your Teams.

**Step 9:** Send them to training.

#### *Post-training Activities*

The Teams are usually required to submit a post training plan. It would be wise for the PHO to require the Teams to present their plans and to discuss its implementation. The post training plan is among those evaluated by the DJFMH and the training centers within the consortium in their post-training evaluation where they do actual visit of their trainees in their posts and observe how well they practice the skills they have learned. A re-training maybe required if on evaluation the Evaluation Team finds a trainee still lacking the competence and/or confidence required.

## **IV. Assuring the Adequacy of Health Human Resource**

The shift in paradigm in maternal care resulted to changes in duties of critical health staff and in their relationships with each other. Among the changes are:

1. Selected Barangay Health Stations and Rural Health Units are upgraded to a standard that allows its staff to deliver basic emergency obstetric and newborn care. This change requires these facilities to make BEmONC service available for 24 hours and

its staff readily available on call beyond the usual 8 hours work.

2. The MHOs and PHNs of BEmONC provider facilities are required to adapt to the new role of their RHUs and BHSs by providing duty time as necessary and to be readily available at all times should there be a call for assistance by the BHS midwife.
3. The role of the Traditional Birth Attendant (TBA) changes to that of a midwife assistant. Under the new model, TBAs cease to be direct providers of childbirth services but will continue to provide supportive care to the mother and the newborn as a member of the Women's Health Team.

#### **A. Human Resource Deployment in BEmONC and CEmONC Provider Facilities**

##### **1. LGU Health Human Resource Profile**

The Needs assessment of facilities proposed to be BEmONC and CEmONC providers noted that at the LGU level, gaps of varying degrees are currently experienced in the deployment of health staff. The most common concerns are:

- a. The lack of such special skills as: obstetrics, anesthesiology, surgical nursing, and medical technology in proposed CEmONC provider facilities.
- b. Compliance with the human resource standards is a challenge, particularly in areas where geographic location and terrain serve as serious obstacles to access. Such situations mandated the designation of a number of BHS BEmONCs in an effort to make services available in these far flung and isolated areas.
- c. The LGU staffing patterns reveal an increase in the hiring of contractuales to provide nursing and medical technology services, mainly as a result of a mismatch between existing government plantilla positions and the demand for these services.
- d. The human resource standard for hospital BEmONC providers also pose a serious challenge as it require 3 doctors per facility to allow it to operate for 24 hours.
- e. In like manner, BHS BEmONC providers require that the RHU doctor and nurse are available on call to provide assistance to the BHS midwife when the need arises. This requirement would entail a strong commitment from the MHOs and the Public Health Nurses.

The concern therefore relates not just to competence but to adequacy in numbers as well.

##### *Short Term Solutions Employed by the LGUs*

Among the short term solutions employed by the LGUs to ease the human resource lack are:

- a. Hiring of staff on "job order" basis to serve contractually as staff nurses, midwives and medical technologists.

- b. Engaging private visiting consultants in the fields of obstetrics – gynecology and anesthesiology to fill the gaps in these areas in CEmONC provider facilities.

While the current remedy seems to work, it does not give assurance of quality care in the long term. Furthermore, such short term, temporary solutions may seriously disrupt health service provision especially in relation to staff with special skills since these arrangements do not require permanent and long-term commitments from the staff concerned.

## 2. Recommended LGU Options for Addressing the Human Resource Gaps

### 1) Inter-LGU Human Resource Sharing Arrangements

The cost-effectiveness objective of the facility mapping criteria implies that not all municipalities will house a BEmONC provider facility. Furthermore, all BEmONC and CEmONC providers are to render 24-hour service. Although RHU and BHS BEmONCs may not be open 24 hours, their staff are required to be available on call. The fact that most MNCHN facilities are to serve not only women from the municipality but from neighboring municipalities as well, coupled with the need for facility staff to render extended duty, could very well lead to patient loads that would be difficult for existing staff to handle, especially if those currently giving birth at home shift to facility birth. This gives rise to a need to consider resource sharing options across municipalities.

The conditions imposed by the MNCHN service delivery strategy give rise to two instances that may require resource sharing across municipalities:

- a) When a WHT from a non-BEmONC municipality refers a patient to a BEmONC in a neighboring municipality.
- b) When the patient load of a BEmONC is such that augmentation is needed in the form of provider (doctor, nurses, midwives) duty time to be rendered by providers from neighboring non-BEmONC municipalities. This is most likely to be the case for RHU and BHS BEmONCs where the lone RHU doctor can be easily overwhelmed by an upsurge of client referrals.

### Memorandum of Agreement

Such human resource sharing arrangements need to be covered by a Memorandum of Agreement (MOA) between the municipalities concerned. The MOA should authorize the following:

- o Allow WHTs from non-BEmONC municipalities to refer patients to a BEmONC and to assist in their deliveries,
- o Allow the visiting WHT to receive its share of the agreed incentive scheme provided when it refers poor clients and PhilHealth reimbursements when referring PhilHealth members. User fee sharing should follow the sharing scheme for PhilHealth reimbursements.
- o Allow non-BEmONC doctors to render duty time in BEmONC provider facilities and availing of their share in the above incentives. The conditions for rendering such duty time should be spelled out.

### 2) Hire and Deploy New Staff

The LGU staffing pattern has shown the hiring of more contractuels for nursing and medical technology, a reflection of a mismatch of the plantilla position and the service demand. Moreover, the shortage of such special skills as: obstetrics, anesthesiology, surgical nursing, and medical technology in proposed CEmONC provider facilities is an area of urgent concern that needs to be addressed by local governments by considering the option of **creating more plantilla positions for-**

- a) **The special skills** for their CEmONC provider facilities to function more effectively over the long term.
- b) **General Service skills** such as those of general practitioners (GPs), nurses assigned to provide bedside nursing in the wards and medical technologist should be considered. **GPs are an important part of the team as they could be trained to take on the role of a specialist should the need arise.** A general practitioner is also tasked to medically manage uncomplicated cases brought to the facility.

While hiring new staff is complicated, it can be done with swift action by the Local Boards (*Sangguniang Panlalawigan* and *Sangguninag Pambayan*).

### 3) Invite Private Practitioners

#### a) Visiting midwives in BEmONC provider facilities

Where the number of public midwives is insufficient to meet the midwife-to-population ratio requirements for C/WHTs and BEmONC Teams, private midwives may be invited to join the teams. The process of engaging them is similar to the current practice of inviting private doctors as visiting consultants in public and private hospitals.

- o Midwives are invited to apply to the MHO or Chief of a BEmONC Hospital to allow them to practice midwifery in the facility.
- o Under this arrangement, the private midwife accesses public health facilities and essential supplies to enable her to carry out maternal care, family planning and STI services for her private clients while providing services to public health clients when the need arises.
- o The private clients that the midwife brings in to the facility pay for the use of the facility (e.g. board and lodging, fees for delivery and labor room use, etc.) and the professional fees for services rendered. This way the BEmONC provider facility provides the midwife better amenities to practice and earn professional fees while at the same time earning from the user fees paid by non-poor clients for the facility's upkeep.

As added incentive, private midwives under this arrangement shall be invited to participate in DOH-sponsored training activities for free.

#### b) Visiting medical specialists in CEmONC provider facilities

The lack of doctors, particularly in the specialized fields of obstetrics-gynecology, pediatrics and anesthesiology, severely constrain the delivery of the MNCH service package. Under this scheme private

doctors shall be invited and given the privilege to practice in a public health facility as visiting consultants. The terms of their agreement with the facility shall follow existing arrangements for consultants in big government and private tertiary hospitals.

MHOs assigned in non-BEmONC provider facility with specialty training in anesthesiology, obstetrics and pediatrics may enter into such arrangements but should take into account his or her main role as MHO. A special arrangement could be devised for this purpose.

#### 4) Organize a Network of Community Based Service Delivery Teams

##### a) Organize and train members of the Women's Health Team

- Key to addressing the high maternal mortality ratio is the reduction of the incidence of home birth, especially those attended by TBAs. Estimates cited indicate that more than half of current deliveries are at home, mostly attended by TBAs - a situation that is seen to have led to the current high mortality ratio. The TBA is usually seen as the neighborhood healer, consulted for various illnesses as well as for childbirth. The TBA's childbirth services usually go beyond assisting in the delivery. Massaging the mother, helping in household chores and minding the children are often part of the package.
- The effort to encourage the mother to deliver in health facilities instead of at home should therefore include measures to address the TBA's influence on the mother's choice on where to deliver. The strategy is to make the TBA an ally in pursuing the above advocacy objective. **It is vital to recognize that the shift from home to facility birth would deprive the TBA of an important source of livelihood** since she attends to the majority of home deliveries in the community. Thus, the goal should be not to remove the TBA from the scene but instead make her an important part of it by designating her as member of the community-level Community or Women's Health Team (C/WHT) led by the rural health midwife.
- By assigning the TBA to assist the midwife in carrying out the functions of the WHT, one therefore merely changes the TBA's job description and opens the door for her to still look to deliveries as an important source of job satisfaction and livelihood (although facility births will be attended by a skilled professionals, the TBA can still be tasked to perform auxiliary functions such as comforting the mother during labor, looking after the children and the household, etc.).

The Provincial and Municipal Health Offices are encouraged to organize a network of community health workers composed of **BHWs** (barangay health workers) and **TBAs** (traditional birth attendants), and with **midwives as team leaders** to provide assistance in implementing ground level activities. *(Please refer the Women's Health and Safe Motherhood Project 2 Operations Guidelines for a more detailed discussion on how to organize WHTs).*

#### 5) Sustain Health Human Resource through Incentives

- I. LGU to Establish Incentive Packages to Attract New Personnel and Minimize Turn-over. Health workers incentives could be monetary and non-monetary.

#### *Monetary incentives*

There is no doubt that financial incentives are key motivating factors for hard work. This has been proven by the exodus of nurses that include former doctors who lately opted to become nurses to work abroad. The LGUs can reduce losing out their competent health workers to foreign employers **by assuring the provision of additional incentives**. This can be done by **generating revenues** out of facility services through such activities as –

- User fee collection from non-poor clients
- LGU enrolment of poor families to PhilHealth Sponsored Program and PhilHealth accreditation of facilities. This allows LGUs to make full and effective use of insurance reimbursements.
- Social marketing of drugs and commodities for modest mark ups.
- Implementation of grant mechanisms as a reward for good performance.

#### *Non-monetary incentives*

While money seems to be a major motivation, health workers need non-monetary rewards that acknowledge their competence and accomplishments:

- Scholarship grants,
- Sponsored travels to represent the LGU in an important meeting or conference,
- Sponsorship to short training courses,
- Recognition of an award giving body for outstanding performance, and
- Simple praise from superiors.

## **V. Reliable Support Mechanisms for Service Delivery**

The Task Force created by DOH to implement reforms to rapidly reduce maternal and newborn mortality oversees the implementation of the MNCHN initiatives until its turn-over to the National Center for Disease Prevention and Control. The Task Force, with support from the DOH management shall ensure that reliable sustainable support systems to support efficient delivery of services are in place. The support systems guarantee continuous service delivery even beyond the life of the Task Force.

### **A. Drug and Contraceptive Security**

The local government code required the LGUs to secure health logistics including drugs and contraceptives for their constituents. However, with three decades of USAID donations, the idea of having to buy contraceptives challenged the LGUs with health centers experiencing stock outs.

The MNCHN strategy shall seek to pursue an initiative on “Assuring Drugs and Contraceptive Security through the Special P 100 Program”. The program features essential drugs, emergency obstetric and newborn drugs and the Pop Shop. The Pop Shop is a DOH-LGU-DKT Partnership. This initiative shall not only provide drugs and

contraceptives security but also generate revenues for the LGU health system by selling these commodities to non-poor clients.

The objective of the MNCHN and P100 Program collaboration shall be to help LGUs establish a sustainable supply of reasonably-priced essential drugs while making sure that the poor has a safety net.

The Pop Shop on the other hand is a social franchise initiative of DKT aimed at making contraceptive products available, accessible and affordable to women and men of reproductive age. This private sector initiative is being tapped by DOH through the MNCHN initiative in response to helping LGUs cope with the provisions of the Contraceptive Self Reliance Strategy policy. The Pop Shops are viewed to enhance the P100 Program's objective of making available essential drugs along with emergency obstetric and newborn drugs.

*The National Drug Policy Program Management Unit is tasked to operate the P100 Program in the country. They can be contacted for inquiries regarding the program. Meanwhile, the Special P100 that features emergency obstetrics and newborn drugs and a Pop Shop Franchise is a proposal for pilot test in Women's Health Safe Motherhood Project 2 sites under its performance-based grant scheme. This PBG mechanism is described in the Project Operations Guidelines which can be accessed at women's health publications at [www.doh.gov.ph](http://www.doh.gov.ph).*

## **B. Safe Blood Supply**

At the central level, the National Council for Blood Services manages the National Voluntary Blood Program (NVBP) and supervises the operation of the Philippine National Blood Services composed of the Philippine Blood Center (PBC), Philippine National Red Cross, Sub-national Blood Centers and Regional Blood Centers. The Philippine National Blood Services takes care of all blood needs of the country, including ensuring adequacy of supply.

In addition a limited number of separately organized, and strategically located blood centers to serve the blood transfusion needs of all hospitals within a given but wide catchment area has been developed and established by the National Voluntary Blood Program, which is configured as follows:

- Blood Center is non-hospital based and is stationed at the regional level.
- Blood bank is hospital-based and could be based in a tertiary level facility or the provincial hospital. CEmONC providers shall have a blood bank in the network.
- Blood Collection Unit (BCU) could be hospital or non-hospital based. This takes charge of Community-Based Blood Collection activities. RHU BEmONC providers are considered BCUs in the MNCHN facility network.
- Blood Station could be hospital or non-hospital based. This dispenses blood units coming from the Blood Centers. Hospital BEmONC providers are Blood Stations or with an accessible blood station nearby.

### *Establishment of Blood Services Network to Ensure Safe Blood Supply*

The Blood Services Network is an informal organization composed of the designated blood centers and hospital blood banks, blood collection units, blood stations and end-user hospitals and institutions established to provide for the blood needs of a specific geographic area. The objective of the blood services network is the efficient distribution of the voluntarily donated blood to the different blood service facilities including BEmONC, CEmONC provider facilities and other end users to make blood available to all patients and



avoid wastage. It has the following advantages.

1. It builds and sustains true voluntary non-remunerated blood donation programs by reaching low risk donors at the community and convince them to be regular blood donor for altruistic reasons;
2. It develops and sustains high levels of technical proficiency in blood collection, testing and processing by handling a high volume of blood unit throughput at the blood center level which ensures quality blood and blood components; and
3. It achieves economies of scale in the procurement of the main material inputs for blood processing such as reagents, blood bags and other supplies.

#### Operational Features

BLOOD CENTER is a non-hospital based blood service facility licensed by the DOH Bureau of Health Facilities and Services (BHFS) with the following service capabilities:

1. Advocacy and promotion of voluntary non-remunerated blood donation including healthy lifestyle.
2. Recruitment, retention and care of voluntary non-remunerated blood donors.
3. Collection of blood (mobile or facility-based) from qualified voluntary non-remunerated blood donors.
4. For National, Sub-national and selected Regional Blood Centers only: testing of units of blood for five (5) infectious disease markers (Anti-HIV 1/2, Anti-HCV, HBsAg, Syphilis, Malaria).
5. Processing and provision of blood components.
6. Storage, issuance, transport and distribution of whole blood and/or blood components to hospitals and other blood service facilities.

The Blood Centers shall be classified into Regional, Sub-national and National whose service capabilities will be determined by the National Council for Blood Services (NCBS).

BLOOD COLLECTION UNIT (BCU) is a blood service facility, duly authorized by the DOH-CHD with the following service capabilities:

1. Advocacy and promotion of voluntary non-remunerated blood donation including healthy lifestyle.
2. Recruitment, retention and care of voluntary non-remunerated blood donors.
3. Screening and selection of qualified voluntary non-remunerated blood donors.
4. Conduct of health education and counselling services.
5. Collection of blood, either mobile or facility-based, from qualified voluntary non-remunerated blood donors.
6. Transport of blood units collected to blood center for testing, processing and distribution to hospitals and other health facilities.
7. Compatibility testing of red cell units, if hospital-based.

BLOOD STATION (BS) is a blood service facility, duly authorized by the DOH-CHD with the following service capabilities:

1. Advocacy and promotion of voluntary non-remunerated blood donation including healthy lifestyle.
2. Provision of whole blood and packed red cells.
3. Storage, issuance, transport and distribution of whole blood and packed red cells.

4. Compatibility testing of red cell units, if hospital-based.

HOSPITAL BLOOD BANK – a blood service facility in a hospital, duly licensed by the DOH –BHFS (Bureau of Health Facilities Services) and CHD (Center for Health Development), with the following service capabilities:

1. Advocacy and promotion of voluntary non-remunerated blood donation including healthy lifestyle.
2. Storage of whole blood & blood components obtained from a blood center or another blood service facility.
3. Compatibility testing of red cell units.
4. Direct Coombs Test.
5. Red cell antibody screening.
6. Investigation of blood transfusion reactions.
7. Assist the Hospital Blood Transfusion Committee (HBTC) in the conduct of post-transfusion surveillance (hemovigilance).

For adequate supply of blood, Blood Centers require blood service facilities in its network to submit an inventory of blood in their facilities that contains information on the number of blood units used for a certain period according to blood type.

All CEmONC provider facilities shall have a licensed **Blood Bank (BB)** while selected hospital BEmONC providers shall have an authorized **Blood Station (BS)**.

All Rural Health Unit (RHU) BEmONC providers function as Blood Collection Units (BCU). A BCU recruits volunteer donors and organizes a “community-based blood donation” activity (CBBD) with the assistance of the barangay-based Community or Women’s Health Teams (WHTs). On blood collection day, a team from the Regional Blood Center comes to screen donors and collect blood.

#### *The Community – Based Blood Donation (CBBD) Activity*

The Community – Based Blood Donation activity is a collaboration between the Blood Collection Units and the Blood Centers (BC). While the RHU is the main organizer of the CBBD, the BC provides all the needed supplies for blood collection and storage. The CBBD systematizes blood donation and triggers the operation of the Network tasked to assure safe blood availability at all times.

1. LGUs shall organize **Local Blood Councils (LBC)** composed of Local Chief Executives, NGOs and Hospital administrators to ensure the continuous supply of safe blood and safeguard the integrity of the Safe Blood Supply Network LBCs are required to conduct CBBDs regularly.
2. For MNCHN, the Community or Women’s Health Teams (C/WHTs) under the supervision of the MHO will be tasked to organize community blood donation activities in coordination with the Local Blood Council (LBC) who in turn will coordinate with the Blood Center (BC).
3. As a matter of policy, the BC requires all municipalities in a province to undertake CBBD. The blood collected is used to supply the blood needs of the province. This manner of blood collection is seen to:
  - a) Systematize the process of blood collection and distribution,
  - b) Assure availability of safe blood,
  - c) Improve access,

- d) Assure equity in blood distribution as blood use is rationalized, and
- e) Be widely acceptable to clients as it eliminates the inconvenience of the previous “blood replacement scheme” where a patient is required to have at least 2 blood donors.

4. The transfusing blood service facilities including BEmONC and CEmONC providers shall charge fees for blood screening which the PhilHealth, LGU or patient pays. But while there is a fee involved, this is also socialized. Likewise, every BC has a way of rewarding their donors or LGUs. Here are some examples of financing schemes for the blood program:

- a) The Bicol BC, which charges PhP 1,500.00 as screening fee per bag of 450 ml of whole blood, waives the fee for the Province of Sorsogon if the volume of blood collected in its community blood donation activities is more than the amount required by the Province and actually use.
- b) In the case of Surigao del Sur, the Blood Bank at Adela Serra Ty Memorial Medical Center (ASTMMC) screens all blood collected from the different LHADZs. While blood is made available to anyone in need, those patients from the donating LHADZ are given priority. Patients for surgery are no longer required to bring along 2 blood donors but are charged PhP 1,100.00 per pack as screening fee. Poor patients are charged according to the socialized scheme below, which is based on income class categories:
  - Class D: 2 units FREE; but if they need more than 2 units –
    - 3<sup>rd</sup> unit is charged to LGU
    - 4<sup>th</sup> unit is charged to congressman/congresswoman
  - Class C1: 75% of PhP 1,100.00
  - Class C2: 50% of PhP 1,100.00
  - Class C3: 25% of PhP 1,100.00
- c) ASTMMC Blood Bank maintains a Blood Donor Registry (per blood type). Blood Donors are entitled to free annual workup. In addition, they are entitled to the following privileges that are awarded according to their status as donor:
  - Regular donor – donates 3x a year. They are allocated 2 units of blood for free, which is consumable for one year.
  - Irregular donor – donates less than 3x a year. They are allocated 1 unit of blood for free, which is consumable within the year.
  - All donors are asked to undergo FBS (fasting blood sugar) and cholesterol determination every time they donate blood. These tests are free of charge.

Facility upgrading to ensure safe blood provision follow these guidelines:

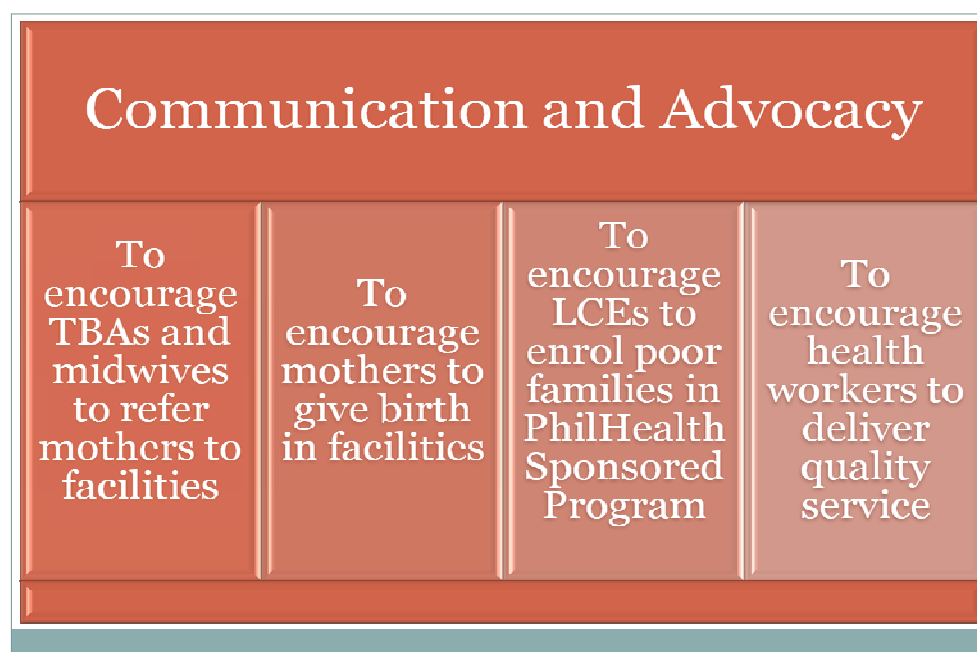
- Civil works for blood services in facilities designated to provide CEmONC services are included in the civil works requirement of these facilities. The requirement is modest as CEmONC provider facilities are expected to perform only storage, cross matching and transfusion functions.

- Equipment for storing and transfusing blood is included in the equipment list for CEmONC and selected BEmONC hospital provider facilities.

### C. Behavior Change Interventions

The shift in paradigm in maternal care and its consequent call for drastic reforms in health service delivery entails behavior change among critical stakeholders. To effect the desired behavior, LGU health officers and implementers are required to **focus their actions on issues that matters only in improving women's and children's health and consequently save lives of mothers and newborns**. This should include:

1. Promoting knowledge, attitude and behavior of disadvantaged women relative to the goal of making pregnancy and motherhood safer **by giving birth only in facilities assisted by professionals with competence to provide basic emergency obstetric and newborn care**.
2. Increase popular understanding by women and men particularly the adolescents and youth of the barriers and risks to better reproductive health, including a **greater appreciation of the risk of STI and HIV infection through irresponsible sexual practices**.
3. Reduce stigma and exclusion of disadvantaged and risk groups such as men and women in commercial sex work and indigenous people to **high quality reproductive health services** being offered in MNCHN facilities.
4. Engage LGU leadership support and create broad constituencies for vigorous, enlightened and forward-looking local government responses to delivering MNCHN services, including **increased public support for the full menu of family planning methods**.



The behaviour change intervention is supported by the FOURmula ONE for Health framework and under the MNCHN initiative it shall utilize 2 approaches:

- 1.) Communications and Advocacy and
- 2.) Awards for Good Performance

***Communication for Behavioral Impact*** shall be an integral element MNCHN and shall aim to promote better knowledge, positive attitude and behavior of the primary beneficiaries consistent with attaining program outcomes, including increased demand for and use of appropriate services; while aggressively soliciting for LGU and community support to the cause of women and children particularly the mothers and their newborns. To effect these positive changes in behavior among the critical stakeholders, the Task Force for the MNCHN initiative shall work in cooperation with the National Center for Health Promotion and provide the necessary assistance to local health systems.

At the community level, **communication for behavioral impact (COMBI)** shall be the core strategy with **interpersonal communication (IPC)** as its key media carrier with the Women's Health Teams as the main channel for communication. A program to enhance the WHT's capacity to bring the message across the community shall be implemented.

The WHTs' influence in decision making is viewed as effective since their experiences as women and mothers would make a good material for the "First Person Approach" in dealing with women of reproductive age particularly the pregnant women. COMBI through IPC plays a pivotal role in influencing individual decision-making and behavior change because it allows a very high level of interaction. IPC is also the media channel of choice for Advocacy, which entails selection of advocates or spokespersons among clients and community leaders and identification of champions within each government system or community location. **Community participation** shall continue to be the main COMBI channel for social support.

Radio and Print channels shall be used to support messages and reinforce information exchange and agreements reached during interpersonal and group communication. The project shall make use of TV reporting of local advocacy events, and shall coordinate with relevant national mass communication campaigns to allow it to participate in such campaigns to advocate for the cause of mothers and newborns and consequently women and children.

***Performance-Based Grants (PBGs) for MNCHN*** shall be formatted to effect a major behavior change among Local Chief Executives (LCEs) including the Health Officers, health staff, and clients particularly the disadvantaged women of reproductive age. The granting of awards shall take a more "universal" approach, focusing on the attainment of yearly targets by the LGUs.

The PBGs thus becomes a powerful strategy to improve local government and its health system performance and consequently service utilization. For DOH, the PBG shall be a means of holding local government officials and its entire health system accountable for achieving explicitly defined results that also influences local government organizational culture. Any reward provided to LGUs are expected to directly benefit the poor and the disadvantaged as well as other members of the local health system

The PBG shall be designed such that over time, the LGU has a reliable sustainable support (to service delivery) system in place:

- 1) Financial sustainability through maximum access to PhilHealth financing by

increased enrolment in the Sponsored Program, accreditation of health facilities and expanded accreditation of health providers,

- 2) A self-sustaining public health pharmacy.
- 3) Revenue –retention mechanism
- 4) Revenue sharing scheme.

*For the operating guidelines, please refer to the MNCHN Grants Operations Manual developed. Chapter V of this manual offers a more detailed discussion on the Financing schemes.*

#### **D. Efficient Referral System**

The facility map that identified the BEmONC – CEmONC provincial configuration also featured the network of referral facilities within an inter-local health zone and a system that allows inter-LGU referral arrangements. Under the MNCHN strategy, special referral arrangements shall be designed so as to allow a non-doctor e.g. any member of the Women's Health Team, to refer to a higher level facility (e.g. CEmONC provider) within the province catchment or outside such as an adjacent province or municipality because of boundary access considerations. This measure is in harmony with the 3-tier policy of emergency obstetric and newborn care service delivery that directs a client needing the service to appropriately consult a BEmONC provider facility or a CEmONC provider facility directly. Requiring a client to consult a non- EmONC provider at community level before being referred to a BEmONC or CEmONC is not necessary. This is to avoid unnecessary delays since time is a significant factor in saving lives of mothers and newborns.

To make the system of referral efficient, the MNCHN strategy also requires its network of facilities to be equipped with –

- a. Radio or telephone for easy contact with a designated higher-level facility should advice or referral be needed
- b. An emergency transport system based at the community for a reasonable fee.

An efficient communication and transport system has the following features:

- a) It is efficiently managed by the local government or private entity.
- b) A vehicle is well maintained and made available at all times.
- c) It has an established fee considered reasonable and socially accepted.
- d) The BEmONC provider facility contributes to its efficiency by:
  - (i) Having its WHTs making sure that transport provision is planned by the family by having them part of the Birth Plan. If a client does not have the means to pay for transport, the WHTs will provide assistance in negotiating with the local chief executive for a subsidized use of the ambulance or LGU managed emergency transport system early on during her pregnancy.
  - (ii) Posting a public notice of the availability of vehicles for hire at the admission area of all Barangay Health Stations, Rural Health Units and Hospitals with the following information:
    - o Contact person's name and number
    - o Rental fee

This measure of making the referral system more efficient is aligned with the current health reforms as it improves stakeholder's accountability while education and providing clients' comfort at a time of stress.

## **E. Managing Health Facility Finance to Improve Health Service Delivery Operation**

### **Estimating BEmONC and CEmONC Related Incremental Changes in Operating Costs**

It is important to have a fairly robust estimate of the MNCHN framework-induced incremental increase in facility operating costs since these costs are to be funded by the LGUs. The LGU budgets, especially at the municipal level, are usually quite tight and could therefore not accommodate too much variance. Thus, “The Provincial Investment Plan for Maternal Newborn Child Health and Nutrition” need only to focus on 2 categories of operating costs:

1. Operating costs for service delivery of MNCHN services and
2. Other operating costs

Operating costs for BEmONC and CEmONCs:

1. Costs for “normal spontaneous deliveries and newborn care”
2. Costs for caesarian section
3. Family planning commodities for the poor
4. Supplies for permanent FP methods: BTL, NSV
5. Cost for operating the STI control and HIV prevention program

Operating costs for support activities:

- 1) Maintenance of infrastructure and equipment
- 2) Enrollment of indigents to social insurance
- 3) Operating costs for ensuring safe blood supply

Estimates of operating costs are based on the assumptions described below, most of which are driven by the targets to rapidly reduce maternal and newborn mortality. The estimation process is as follows:

#### **Step 1: Determine the demand for services.**

The demand for services in the CEmONC and BEmONC provider facilities is premised on two factors:

1. The increase in total number of deliveries which is assumed to be the same as the population growth rate of the province or city.
2. The projected target of a 100 percent increase in deliveries performed in BEmONC or CEmONC provider facilities and 50% reduction of NSDs in CEmONC provider facilities.

The demand for Family Planning services is determined from:

1. The projections on contraceptive prevalence rate (CPR).
2. The projected targets of :
  - 1.) Increase in CPR by 10 percentage points
  - 2.) Increase to 16% the total proportion of women and their partners using permanent methods.

#### **Step 2: Estimate the cost of delivering WHSM and Newborn services**

For **normal spontaneous deliveries** (NSDs), consider 5 types of NSD-related costs:

1. Professional fees pegged at PhP 2,000.00 by the PhilHealth Maternal Care Benefit Package.
2. Newborn screening at the current PhilHealth-pegged cost of PhP 650.00.
3. Delivery room supplies and medicines estimated to be within the range of PhP 500.00 to 700.00. (The LGU should be able to determine the cost of these provisions according to local rates).
4. Facility operating costs (MOOE): room, electricity, water, and other costs that may be incurred by the facility estimated to be about PhP 1,500.00.
5. Incentive for WHSM Teams equivalent to at least 80-20 share of the revenues generated by the facility from PhilHealth reimbursements and user fees. (Facility-based teams shall get 80% share while the community-based WHTs gets 20% from the revenues).

*A sharing scheme policy has been approved by DOH in September 2007(department order at [www.doh.gov.ph](http://www.doh.gov.ph)).*

For **caesarian section**, the cost is estimated to be around PhP 5,000.00-10,000.00.

For **cost of FP commodities**, use the current price prevailing in the province.

### **Step 3: Identify financing sources**

There are four possible fund sources for the MNCHN operation:

1. LGU budget
2. DOH grants
3. User fees
4. PhilHealth reimbursements

Thus,

1. All PhilHealth-covered cases will be financed through PhilHealth reimbursements.
2. All non-PhilHealth-covered non-poor cases will be charged user fees.
3. All non-PhilHealth-covered poor cases will be subsidized by the municipal LGU.
4. All other operating costs will be covered by LGU budget, PhilHealth claims, user fees and grants from DOH if any.

A major objective of the MNCHN strategy is to enable health facilities particularly the BEmONCs and CEmONCs deliver MNCHN services in a sustainable manner. This is **best achieved if these facilities are financially sustainable and are not solely reliant on budgetary outlays** to fund their operational needs. Such a goal is attainable especially if advocacy efforts succeed in convincing women who presently prefer to give birth at home to shift preferences in favor of facility birth.

The basic strategy that is sought to pursue to attain the above goal can be summed up as follows:

1. Make MNCHN facilities financially sustainable by broadening their fund sources beyond the traditional budget allocation from the LGU. This could be done by –



- a. Enhancing Philhealth reimbursements
  - b. Allowing facilities to collect user fees from the non-poor, and
  - c. Allowing the use of the revenue from these sources to augment operational funds and health worker compensation.
2. Make MNCHN facilities sustainable in essential life-saving drugs and contraceptives by establishing revolving fund schemes:
  - a. For essential drugs, through the P100 program of DOH and
  - b. For contraceptives, through the Pop Shop scheme of DKT.

*(Please refer to Chapter V for a more detailed discussion of this financing schemes. The WHSMP2 Operations Guidelines may also be used as added reference).*

#### **F. Organization of MNCHN Management Team**

The implementation of the MNCHN Strategy requires a provincial/city coordinating body to oversee the direction, progress, adherence and sustainability of local MNCHN efforts towards the attainment of rapid reduction in maternal and neonatal deaths in their area. With the PHO taking the lead, the following steps must be undertaken:

1. Establish a province/city MNCHN Management Team
  - (a) Explore the possibility of using existing provincial/city bodies/entities to serve as the MNCHN Management Team: (i) existing Local Health Board (LHB) may be considered as a default team; (ii) functional committees (e.g. nutrition and health committee, reproductive health team, etc.), currently dealing with maternal-child health issues and concerns may also be tapped;
  - (b) If there is no functional body, the PHO in consultation with the heads of member facilities in the MNCHN service delivery network shall organize a Management Team for this purpose;
2. The MNCHN Management Team shall be headed by the PHO/CHO with the recommended but not limited to the following members:
  - (a) Chiefs/Heads of Hospitals designated as BEmONC/CEmONC;
  - (b) Representative from ILHZs;
  - (c) Designated MNCHN program coordinators from the PHO/CHO or district levels; and
  - (d) Representatives from other offices or institutions with vital functions and inputs to achieving the goals of the MNCHN Strategy. These may include development partners in the province/city, local chapters of relevant professional societies or groups, non-government organizations, private practitioners.
3. The MNCHN Management Team shall ensure the effective and efficient implementation of the MNCHN strategy at the local level:
  - a. Review regularly the adequacy and functionality of the service network and ensure that each facility in the network comply with the standard requirements to operate: staffing complement, equipments and infrastructure;
  - b. Coordinate the planning of MNCHN efforts and align investments with the priorities identified;

- c. Ensure that financing schemes are in place to support the priority activities;
  - d. Implement a local BCC strategy and ensure that results lead to increase in the utilization of MNCHN services;
  - e. Ensure that a continuous quality assurance (CQI) program is being implemented;
  - f. Ensure that an effective emergency transport and communication system is in place at BEmONC and CEmONC provider facilities;
  - g. Coordinate with DOH in the provision of technical assistance available to support activities and sourcing of funds and grants available for LGUs;
  - h. Conduct regular monitoring and evaluation and provides timely interventions;
4. Define the coordination arrangements for the MNCHN Management Team to function in a well-coordinated manner.
    - a) Designate a secretariat for the MNCHN Management Team. Secretariat staff can be mobilized from the PHO, hospitals or other member health facilities;
    - b) Agree on the frequency of coordination meetings;
    - c) Clarify and outline the communications flow from among member health facilities and to the Team;
    - d) Define reporting requirements, frequency and timeline for submission;
    - e) Identify sources of funds for the functions of the MNCHN Management Team;
  5. Come up with a plan to upgrade the capabilities of the members of the MNCHN Management team. Activities may include orientations on the current MNCHN status of the province/city, familiarity with the MNCHN service interventions and approaches; training on negotiations, advocacy and resource mobilization.
  6. Secure the mandate/authority of the MNCHN Management Team to perform its functions through the issuance of an Executive Order from the governor/mayor. The EO must contain the above details summarized as follows:
    - (a) Expand the composition of the LHB or organize a Technical Working Group;
    - (b) Define the duties and responsibilities of the TWG;
    - (c) Determine the lines of interaction with BEmONC, CEmONC, and community teams of the designated facilities;
    - (d) Designate a MNCHN Quality Assurance team which may be a sub-committee of the LHB or a sub-group of the TWG; and
    - (e) Designate a coordinator for each level of care (community, BEmONC, CEmONC).
    - (f) Define the lines of authority and accountability (e.g. it is recommended that the MNCHN Management team be answerable to the LCE, etc.)
  7. The LCE shall advocate to the Sanggunian the passage of necessary legislation based on the advisories of the MNCHN Management Team;

#### **G. Local Issuances and Legislation**

The adoption of the MNCHN Strategy requires a number of executive issuances and/or legislations to facilitate and sustain its implementation. The following areas are identified to be of special concern that requires policy issuance support and/or legislation:

- (a) Adoption of the MNCHN package of interventions to be made available to clients at appropriate levels of care with adherence to standards of quality;

- (b) Engagements of different health facilities as members of the MNCHN service delivery network from the community up to the province/city levels, and across private and public domains;
- (c) Engagements of the local health offices and other local government entities in establishing financing schemes in support to delivery of MNCHN services; and
- (d) Institutionalization of *Sentrong Sigla* as a continuing quality assurance initiative and participation to other quality assurance efforts (accreditation and certification programs).

H. **Monitoring, Evaluation, and Dissemination System for MNCHN** shall be set up as a special concern at the National Epidemiology Center to track the progress of the implementation of the MNCHN strategy through the use of selected output and outcome indicators.

**Monitoring** is a critical management tool to ensure that activities necessary to deliver desired outputs to accomplish MNCHN short term as well as long term objectives are implemented as planned and on time.

**Evaluation** activities are essential to measure the desired MNCHN outcomes and impact (e.g. increase in facility deliveries, reduction in maternal and newborn death) and be able to attribute such changes to MNCHN efforts.

The **dissemination** of results will ensure that the monitoring and evaluation subcomponent complements management functions by regularly providing information for evidence-based decision making. It will also substantially strengthen capacity for the reporting of information.

Data on inputs and processes will be collected by the various component projects, which will be accomplished and submitted monthly, to the PHO (where the MNCHN Management Team is housed).

Monitoring, Evaluation and Dissemination has four (4) major functions:

1. Monitoring the progress of MNCHN implementation
2. Evaluating the impact of the MNCHN strategy towards rapidly reducing maternal and newborn death
3. Evaluating the effectiveness of MNCHN strategy
4. Disseminating the results to support evidence-based decision-making processes

## THE MONITORING SYSTEM

The National Epidemiology Center as the main repository of health data shall continue to collect and process data relative to the MNCHN indicators using its Field Health Service Information System. However, because of the country's special concern on maternal and newborn health, it shall enhance its reporting system so that data are processed on time and provided to the Task Force in a timely manner.

In addition, a special reporting and monitoring form shall be devised to generate information that may not be available in the current FHSIS reporting form but are relevant in making the MNCHN strategy work to the advantage of women and children. These data relates to:

- Status of BEmONC/CEmONC provider facility with regards to PhilHealth accreditation for maternity package

- Number of clients availing of prenatal, birthing (intra-partum) postpartum and postnatal services
- Number of births registered in the facility admission record
- Number of births per type of delivery
- Patient classification
  - Referred by C/WHT (with birth plan)
  - Beneficiaries of PhilHealth –SP
  - Member of an indigenous population
- Number of fully immunized children
- Availability of FP commodities in the facility
- Number of FP acceptors by method
- Number of FP acceptors screened for STI
- Number of maternal deaths by cause
- Number of newborn death by cause

## EVALUATING THE IMPACT OF THE MNCHN STRATEGY

The purpose of evaluating the strategy is to be able to measure changes (desired and unintended) that occurred after activity implementation and to be able to attribute these changes to the implementation of the MNCHN strategy. Impact evaluation shall be done by 2010, 2012 and 2015 and it shall focus on the progress made towards achieving MDG 4 and 5 targets.

## DISSEMINATION OF RESULTS

The dissemination of results will be done at local and central level and will ensure that the monitoring and evaluation subcomponent complements management functions by regularly providing information for evidence-based decision making. It will also substantially strengthen capacity for the reporting of information.

At national level, the Task Force shall prepare semi-annual MNCHN strategy monitoring reviews in coordination with the DOH National Epidemiology Center and other national and local health system stakeholders through a semi-annual consultation meetings facilitated by CHD and PHO counterparts.

At the province level, the monitoring reviews shall focus on the local health systems' contribution to the national goal of improving women's and children's health: reduction in maternal and newborn mortality.

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# **ATTACHMENTS**

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## MATERNAL MORTALITY REVIEW

### WHT Reporting Form

Barangay \_\_\_\_\_  
Municipality \_\_\_\_\_  
Province \_\_\_\_\_  
Date \_\_\_\_\_

=====

Name of the Deceased \_\_\_\_\_  
Age (*at the time of death*) \_\_\_\_\_  
Address \_\_\_\_\_  
Name of Contact Persons: Husband \_\_\_\_\_  
Nearest Relative \_\_\_\_\_  
Address \_\_\_\_\_

Place of Death: Home \_\_\_\_\_  
BEmOC Facility \_\_\_\_\_  
CEmOC Facility \_\_\_\_\_  
Private Hospital \_\_\_\_\_  
Others (*please specify*) \_\_\_\_\_

Woman died: \_\_\_\_\_ during pregnancy  
\_\_\_\_\_ during childbirth  
\_\_\_\_\_ after childbirth; how many days? \_\_\_\_\_ (specify number of days)  
more than one month? \_\_\_\_\_ (please check)

Cause of Death: (*please check as appropriate*) \_\_\_\_\_ bleeding  
\_\_\_\_\_ infection  
\_\_\_\_\_ hypertension  
\_\_\_\_\_ prolonged labor  
\_\_\_\_\_ others (*please specify*) \_\_\_\_\_

=====

Submitted by:

Name of WHT Midwife \_\_\_\_\_  
Station \_\_\_\_\_

Submitted to and Validated by:

Name & Signature of RHU Physician \_\_\_\_\_  
Station \_\_\_\_\_  
Date of Validation \_\_\_\_\_  
Death Certificate Number \_\_\_\_\_

# MATERNAL MORTALITY REVIEW

## Facility Reporting Form

Name of Health Facility \_\_\_\_\_  
 Address \_\_\_\_\_  
 Date \_\_\_\_\_

Essential Data Items	Details
Name of the Deceased	
Age (at the time of death)	
Address	
Number of Pregnancies	
Name of Contact Person	Husband _____ Nearest Relative _____
Address	
Date & Time First Seen at Health Facility	Date: _____ Time: _____
Referral from (Please check as appropriate)	WHT _____ RHU _____ Lying in clinic _____ District Hospital _____ Others _____ ( Please specify)
Hospital Admission Details	Date: _____ Time: _____
Place of Death	Health Facility: _____ Address _____
Date and Time of Death	Date: _____ Time: _____
1. Cause of Death	
Condition at the Time of Death (Please check as appropriate)	Pregnant _____ Post-partum _____ In labor _____
If post-partum: Place of Delivery	
Attendant at Delivery (Please check as appropriate)	Doctor _____ Midwife _____ Nurse _____ TBA (Hilot) _____
Condition of the Baby at the Time of Mother's Death	Born alive? ( ) Yes ( ) No
Medical Management Received	Surgery (CS) done _____ Manual removal of placenta _____ Blood transfusion _____ Vaginal Assisted (forceps) _____ Administration of: _____ Removal of retained Anticonvulsant _____ placental products _____ Oxytocic _____ Others (specify) _____ Antibiotic _____ Oxygen inhalation _____ Fluids & Electrolytes _____

Submitted by: \_\_\_\_\_

Name of Doctor/Position

Submitted to: \_\_\_\_\_

Name of Provincial Health Officer

## PREGNANCY TRACKING FORM

Year \_\_\_\_\_

Barangay/Catchment _____ Municipality _____ Province _____	<b>WHT In-Charge:</b> Name of Midwife _____ Duty Station _____ Address _____
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**Referral Unit:**

\_\_\_\_\_  
 Name of Facility with **Basic Emergency Obstetric Care** (BEmOC )  
 Address \_\_\_\_\_

\_\_\_\_\_  
 Name of Facility with **Comprehensive Emergency Obstetric Care** (CEmOC)  
 Address \_\_\_\_\_

Name of Pregnant Woman	Age	Address	LMP	EDC	Prenatal Care Done (Please Check)				Pregnancy Outcome (If the Outcome is death, accomplish MMR WHT Report Form and submit to MHO immediately)
					1	2	3	4	

Name of WHT Member Accomplishing the Form (Please indicate whether TBA or BHW)

\_\_\_\_\_

CENTER FOR HEALTH DEVELOPMENT -

TOTAL	
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\*\* Outside of health facility

\*\*\* TBA, unlicensed MD, RN,

\_\_\_\_\_