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Postpartum Family Planning, Prevention of Postpartum Hemorrhage and Management of Pre-Eclampsia/Eclampsia:

MCHIP Assessment Report on Current Practices in the Philippines

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ABBREVIATIONS AND ACRONYMS

AMTSL	Active management of third stage of labor
ANC	Antenatal care
AO	Administrative Order
APSOM	Association of Philippine Schools of Midwifery
ARMM	Autonomous Region in Muslim Mindinao
BEmONC	Basic emergency obstetric and newborn care
BP/CR	Birth preparedness/complication readiness
CHAT	Community health action team
CHC	City Health Center
CHD	Center for Health Development
CHT	Community Health Team
CPR	Contraceptive prevalence rate
DOH	Department of Health
DSWD	Department of Social Welfare and Development
EINC	Essential intrapartum and newborn care
EmONC	Emergency obstetric and newborn care
FHS	Family Health Survey
FP	Family planning
IMAP	Integrated Midwifery Association of the Philippines
IMR	Infant mortality rate
LAM	Lactational amenorrhea method
LB	Live births
L&D	Labor & Delivery
LGU	Local Government Unit
LSS	Life-Saving Skills
MDG	Millennium Development Goal
MgSO4	Magnesium sulfate
MMR	Maternal mortality ratio
NDHS	National Demographic and Health Survey
NMR	Neonatal mortality rate
PE/E	Pre-eclampsia/eclampsia
PHIC	Philippine Health Insurance Corporation
POGS	Philippine Obstetrical and Gynecological Society
PPC	Postpartum care
PPFP	Postpartum family planning
PPH	Postpartum hemorrhage
PPIUD	Postpartum IUD
PPTL	Postpartum tubal ligation
RHU	Rural Health Unit
SBA	Skilled birth attendant
TBA	Traditional birth attendant
TFR	Total fertility rate
UFMR	Under-five mortality rate
WHO	World Health Organization

BACKGROUND

MCHIP was asked to conduct an assessment in the Philippines in order to develop a program to strengthen capacity-building for long-acting and permanent family planning (FP) methods in the postpartum period, scale up interventions for postpartum hemorrhage (PPH) and pre-eclampsia and eclampsia (PE/E), and strengthen FP and child health integration. The program description from the Philippines Mission is attached in Annex 1. MCHIP has received $1,000,000 for this activity, and the assigned period of performance (pending MCHIP extension) is July 2012–March 2014.

MCHIP's assessment team included Ricky Lu, Team Leader for FP, Jhpiego; Barbara Deller, Senior Maternal Newborn Health Advisor, Jhpiego; and Koki Agarwal, Director, MCHIP. The assessment team visited the Philippines from July 28–August 10, 2012. The approach of the assessment team included the following:

1. Review various project and policy documents
2. Conduct key informant interviews with stakeholders in various provinces (see Annex 2)
3. Conduct focus group discussions with frontline providers
4. Conduct rapid facility assessments and observe the delivery of high-impact interventions for PPH, PE/E, and postpartum family planning (PPFP)
5. Observe in-service training, as possible
6. Visit the schools of midwifery, as possible

POLICY ENVIRONMENT

The Philippines is a signatory to the United Nations Millennium Development Goals (MDGs) and has undertaken several steps to demonstrate its commitment to reach the designated targets. Order No. 79, s 2000 on Safe Motherhood Policy focuses on ensuring safe motherhood and healthy newborns. In addition, Administrative Order (AO) 2008–2009 issued in 2008 on Implementation of Health Reforms for Rapid Reduction of Maternal and Newborn Mortality (MNCHN policy) and Administrative Order 2009-0025—Adopting Policies and Guidelines on Essential Newborn Care (ENC)—are examples of steps taken by the country to accelerate progress toward MDGs 4 and 5. In 2010, the Department of Health (DOH) issued Administrative Order 2010-0014: "Administration of Life-Saving Drugs and Medicines by Midwives to Rapidly Reduce Maternal and Neonatal Morbidity and Mortality." This Administrative Order recognized that the midwives who are conducting births, often without a physician, in the facility, or in a home, must have the authority to provide emergency, lifesaving drugs, including oxytocin for the prevention and treatment of PPH, magnesium sulfate (MgSO4) for the management of PE/E, prenatal steroids in the case of preterm labor, and antibiotics for infection. This AO also states that "midwives shall be provided with legal assistance, if this becomes necessary in relation to their performance as EmONC providers such as in administering life-saving drugs."

The current Administration's emphasis is on reducing poverty and enabling those in the lowest income quintile to avail of health services free of cost. The National Health Insurance Program (NHIP) implemented by the Philippine Health Insurance Corporation (PHIC or PhilHealth) is the mandatory social health insurance program. Current NHIP coverage nationwide is 53%. The maternity care package and FP (bilateral tubal ligation, vasectomy, and IUD insertion) are covered. Reforms in NHIP in recent years have focused on providing premium subsidy for poor households. Under the current Aquino Administration, this has been expanded to the poorest

two quintiles of the population in a nationwide, universal health care program called KP (Kalusugan Pangkalahatan). There are current efforts to increase the coverage of PhilHealth with door-to-door campaigns on health messages, identification of health facilities, PhilHealth membership, and enrollment. In addition, there is an effort to revitalize the Community Health Team headed by a public health midwife—with a membership of RN HEALS, barangay nutrition scholars, barangay health workers, barangay service point officers, women's groups, and traditional birth attendants (TBAs) as "trackers" in some CHTs.

Table 1. Basic Statistics

	2008 (NDHS)	2011 (FHS)
Maternal mortality ratio	N/A	221
Infant mortality rate	25	22
Newborn mortality rate	16	14
Under-five mortality rate	34	30
Total fertility rate	3.3%	2.95
Contraceptive prevalence rate	34%	37%
Unmet need	22%	23%
Unmet need postpartum	51%	N/A

The DOH of the Government of the Philippines is committed to achieving the MDGs of reducing child mortality and improving maternal health by 2015. Although significant gains in maternal and child mortality have been realized in the past four decades, pregnancy and childbirth still pose the greatest risk to Filipino women of reproductive age, who have a 1:120 lifetime risk of dying from maternal causes.[1] Maternal deaths account for 14% of deaths among women of reproductive age. The maternal mortality ratio (MMR) in the country remains high and has increased from 162/100,000 live births (LB) in 2006[2] to 221/100,000 LB (based on survivorship of sisters) in 2011.[3]

Although the under-five mortality rate (UFMR) and infant mortality rate (IMR) have considerably declined (UFMR from 61/1,000 LB in 1990 to 32/1,000 LB in 2008; IMR 42% in 1990 to 26% in 2006),[3] the rates of decline have decelerated over the last 10 years. The deceleration is driven largely by the high neonatal deaths and slow decline of infant deaths.[4] The neonatal mortality rate (NMR) is still high, with 17 infants dying per 1,000 LB within the first 28 days of life. In 2000–2003, newborn deaths accounted for 37% of all under-five mortalities. Most neonatal deaths occur within the first week after birth—half of which occur in the first two days of life. With the slow decline in MMR for the past two decades and the loss of momentum in rate of decrease in newborn, infant, and child deaths, the Philippines is at risk of not attaining its MDG targets of lowering maternal deaths to 52/100,000 LB and child deaths to 20/1,000 LB by 2015.

The majority of pregnant women have contact with the health care system during pregnancy and childbirth, with 78% of pregnant women attending four or more antenatal care (ANC) visits. Also, 78% of women are attended by a Skilled Birth Attendant (SBA (doctor, nurse, or midwife) at birth, although this ranges from 16% in the Autonomous Region in Muslim Mindinao (ARMM) to 71% in Luzon. However, not all of the deliveries are at a facility. These multiple contacts provide an opportunity for PPFP counseling and immediate PPFP service

[1] National Statistics Office, Department of Health, Republic of the Philippines. 2006. Family Health Survey.

[2] UNICEF. 2010 Philippines Annual Country Report 2010.

[3] National Statistics Office, Department of Health, Republic of the Philippines. 2006. Family Health Survey.

provision (postpartum IUD [PPIUD], postpartum tubal ligation [PPTL], lactational amenorrhea method [LAM]). Sixty-six percent of women, ranging from 42.9% in ARMM to 75.5% in Davao, attending ANC clinics were counseled on FP, although the quality and content of this "counseling" is unknown. In addition, 84% of women receive at least one postpartum care (PPC) visit during the first week postpartum representing more opportunity for PPFP counseling and services.[4]

Fifty five percent of women, ranging from 19.2% in ARMM to 77.4% in the National Capital Region, delivered in a health facility, providing them the opportunity to receive immediate PPFP methods such as PPIUD, PPTL, and LAM.[5]

The infant mortality rate is 33/1,000 for infants born less than two years after the birth of a sibling, 16/1,000 for those born three years after a previous sibling, and 17/1,000 for those born four or more years after a previous sibling. These statistics highlight the importance of waiting at least two years after a previous pregnancy before becoming pregnant again.

> One doctor in a clinic in Davao complained that she was basically short of a midwife because the one on her staff did not want to provide family planning even if the clients requested a method.

The majority of maternal deaths directly result from pregnancy complications occurring during labor, delivery, and the postpartum period. These complications include hypertension, postpartum hemorrhage, and other medical problems arising from poor birth spacing and various chronic and infectious diseases. And a significant number of neonatal deaths are the result of newborn asphyxia.[6]

The fertility levels are much higher in the Philippines, concomitant with lower modern contraceptive use (37%) as compared to the 50–70% range in neighboring Asian counterparts. The method mix is dominated by oral contraceptive pills. A very small percentage of women in the Philippines rely on long-acting and permanent methods.

A distinct policy environment exists in the ARMM region of Mindanao that covers five provinces: Lanao del Sur, Maguindanao, Sulu, Tawi-Tawi, and Basilan. ARMM's population is primarily Muslim. Also within ARMM—and indeed, within Mindanao as a whole—are a number of indigenous people still living in traditional villages, often in geographically isolated and disadvantaged areas (GIDA). As an autonomous region, ARMM has its own Department of Health, and does not have a Center for Health Development (CHD). (See Community-Based Partnerships section below.)

Policy and Operational Barriers

Lack of Commitment to Family Planning

There exists strong religious opposition to family planning because it is viewed as a measure of population control. Some providers are unwilling to provide modern contraception because they consider it equivalent to committing a sin. Rumors about methods still exist amongst the general population. And many see FP as "population control" rather than a lifesaving intervention to reduce maternal and newborn mortality.

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[4] Family Health Survey 2011.
[5] Family Health Survey 2011.
[6] Department of Health, National Center for Disease Prevention and Control. Government of the Philippines. 2011. MNCHN Strategy Manual of Operations.

The Philippine Government's current Reproductive Bill, which emphasizes "responsible parenthood," was rejected by the Church even before it moved to the floor for discussion. The Church's disapproval of FP continues to constrain the health sector's ability to provide services to fulfill the unmet need for family planning. Devolution brings with it yet another challenge. And in areas where a local governor or mayor does not approve of family planning, financial support for the purchase of commodities may be curtailed. Efforts to create a favorable environment for FP depend on finding champions and supporters within every Local Government Unit (LGU).

Despite many of the challenges, the team noted a strong demand for family planning among postpartum women. Several of the providers who were interviewed expressed strong support for family planning.

Meetings with UNFPA and other members of the Family Planning Consortium demonstrated the continued need to advocate for family planning based on health and survival reasons. The Advocacy efforts need to be strengthened at the national and regional levels. There is a lack of effective tools and advocacy documents, and using tools that demonstrate the gains in health from including family planning would be very useful.

Lack of Commitment to the Midwife as a Skilled Birth Attendant

Although the World Health Organization (WHO) and other global leaders in the field of maternal and newborn survival strongly advocate for the midwife as a skilled birth attendant (SBA), the midwife in the Philippines is not being recognized or supported in this function. While global SBA competencies include the seven basic emergency obstetric and newborn care (BEmONC) signal functions[7] as essential, lifesaving skills for anyone attending a birth, the Midwifery Law in the Philippines does not support the midwife in giving injections or in performing such skills as manual removal of placenta. In 2010, the DOH issued an Administrative Order (2010-0014) supporting the midwife to administer oxytocin, MgSO4, antenatal steroids (for women in premature labor), and antibiotics. Many in the health care community, including midwives, are still concerned that they are not legally covered for administration of these functions and so will not perform the related functions. There is inconsistent support for the Administrative Order that approves strengthening midwives as SBAs. While efforts of the DOH are directed to promote deliveries within facilities, having women deliver with a midwife who is not trained to provide the full range of SBA functions will compromise maternal survival.

On the flip side, there are reports of some midwives in private practice who manage cases more aggressively than their competencies allow. In addition, several hospital-level providers claim that women are referred too late to higher-level facilities. They attribute this delay to PhilHealth reimbursements that are higher for delivery and not distributed to facilities that provide care received along the way. In areas where a midwife is the only health care provider, such as in a barangay health post, a woman delivering at a facility still may not have access to lifesaving care because of the limitations in the range of competencies that midwives are allowed to acquire and practice.

[7] BEmONC signal functions: Administration of an antibiotic, administration of a parenteral oxytocin, manual removal of placenta, administration of MgSO4, manual vacuum aspiration, assisted vaginal delivery (vacuum or forceps), and newborn resuscitation.

Recommendations

- Use the revised Lives Saved Tool to calculate national-level gains in maternal and infant mortality and to highlight the health impacts of family planning in the Philippines. Combine this information with the cost-benefit analysis for family planning that has already been done for the Philippines to support the national efforts to advocate with various stakeholders.
- Work with UNFPA and the Family Planning Consortium to write a paper on repositioning the IUD and other long-acting and permanent methods in the Philippines.
- Identify champions among politicians, the DOH, professional associations, religious groups, and pre-service institutions who advocate among colleagues and communities for PPFP and SBA-attended births.
  - Advocate among men's and women's groups in local parishes/churches with targeted messages that emphasize birth spacing as key to healthier mothers and babies (reduction of maternal and neonatal mortality).
  - Approach the advocacy efforts through the lens of healthy spacing and timing of pregnancy for preventing the death of the mother and the newborn.

> **Much training is done in the Philippines but practice of those skills is lacking.**
>
> ~CHD, Zamboanga, Cebu and Davao

- Provide appropriate technical assistance in the development of the training policy and strategy to include PPFP training for all SBAs, rather than only for FP providers.
- Support ongoing efforts to revise the Midwifery Law and develop an Executive Order. Provide examples of expanded midwifery roles in other neighboring countries.
- Work with the Integrated Midwifery Association of the Philippines (IMAP) and other agencies to strengthen the leadership and capacity of such organizations to bring about change and advocate for the potential role of midwives in saving lives.
- Support the administrators of government-retained hospitals to hire (as allowed despite the moratorium on hiring) maternal and newborn health (MNH) staff, especially contract workers as employees.
- Conduct a study tour for key stakeholders to countries with a mature PPFP/PPIUD program. A learning opportunities study tour for key stakeholders, including government officials, policymakers, senior medical and midwifery faculty, and those tasked with implementation of policy, would provide an opportunity for the participants to learn from and initiate similar changes in the Philippines.

HUMAN RESOURCES

Issues related to human resource management, deployment, training (both in-service and pre-service), and performance were highlighted by almost all stakeholders interviewed by the MCHIP assessment team.

Training

Much effort has gone into standardizing competency-based training for various technical areas. Numerous in-service education programs have been conducted and are being conducted that include active management of third stage of labor (AMTSL) for the prevention of PPH, as well as MgSO4 for the management of severe pre-eclampsia and eclampsia. Names of courses have

historically changed with the replacement of the President of the Philippine Obstetrical and Gynecological Society (POGS) annually. Courses include:

- Enhanced midwifery skills training in the 1990s – By POGS to expand the midwifery function to internal exams, IVs, suturing.
- Life-Saving Skills (LSS) – New POGS leadership changed in-service midwifery training to Life-Saving Skills (LSS), which added a few BEmONC skills.
- MDG Skills Enhancement – New POGS leadership changed LSS to MDG training, which added AMTSL, MgSO4, antenatal steroids, and antibiotics with AO2010-0014. MDG training targeted public and private sector midwives, was funded by UNFPA, and stopped when funding ceased and the DOH introduced BEmONC and essential intrapartum and newborn care (EINC) trainings for public sector staff.
- BEmONC – This is an 11-day training, conducted by the DOH to train teams of a doctor, nurse, and midwife from a facility, but has no provision for training the individual midwife who may be the sole care provider in a barangay health post. Private midwives are not included in this training.
  - Content includes the BEmONC functions as well as AMTSL. While the administration of MgSO4 for PE/E as well as manual removal of placenta for the treatment of postpartum hemorrhage is taught, many reported that only the physicians are given practical skills because midwives are not allowed to perform these functions. The BEmONC course is required for PhilHealth accreditation.
  - Some report that FP was included in BEmONC, others that it is not.
- EINC conducted by DOH for doctor-nurse-midwife teams in government facilities includes basic preventive care for the newborn as well as AMTSL. Newborn resuscitation is not included in this course because it is preventive care of the newborn.
- Community Management of Maternal and Newborn Care (CMMNC) conducted by Shield for midwives in ARMM. This course reportedly includes AMTSL, but not newborn resuscitation or MgSO4 administration.

Most midwives and other providers from peripheral health units mentioned that they refer a baby that is not breathing. They do not have proper equipment to resuscitate.

All the stakeholders interviewed universally identified a gap in follow-up post-training to observe competency and mentor frontline workers who were trained.

While BEmONC and MDG training is reportedly a competency-based training that allows clinical practice, preferably in hospitals with large numbers of births, EINC training includes demonstration of AMTSL, but apparently does not provide for clinical skills development.

According to health care workers interviewed, while many SBAs have been trained, not all of the training included the same content, and much of the content that has been taught has not been translated into practice in the workplace. Although an action plan for implementation of the BEmONC practices is developed during the BEmONC training, BEmONC trainers who have followed up learners in the field generally report that only 10% of the action plan is implemented. All of the stakeholders interviewed universally identified a gap in follow-up post-training to observe competency and mentor frontline workers who were trained. The follow-up is supposed to occur six months post-training and sometimes is delayed for reasons related to availability of staff or transport. A six-month time frame before any supportive supervision occurs is likely to lead to

inconsistent performance. Some midwives reported that they were confident and able to follow up on the new skills they acquired, while others felt they did not have confidence to perform those tasks.

Also, private midwives who often operate lying-in/birthing homes are rarely included in basic or emergency maternal or newborn care training. And contractual workers are rarely included in training.

While the content of these training may not be very different, it creates confusion, especially when accreditation for PhilHealth is sought. And there is inconsistent plotting of who has received the training, although there is a desire to map this information as part of the Service Delivery Network.

Senior managers, for example, the Chief Physician of the hospital, complained that they did not have enough staff to deliver services and also send them to provide extensive training and follow-up. This dilemma is further amplified because of the DOH moratorium on hiring staff. However, exemptions can be justified for clinical staff, but the CHDs do not make that effort to hire trainers. Several of the staff are hired on contracts that need to be renewed every six months, thereby creating further uncertainty and bureaucratic hurdles.

Family Planning Training

There was an opportunity to observe the conduct of an FP CBT2 training (Family Planning Competency-Based Training 2) on the third day of a five-day course. Four trainers and one DOH representative were the facilitators for a group of 22 midwives from Region 9 who were in attendance. The materials included the FP CBT manual and PowerPoint presentations. Additionally, two gynecologic pelvic simulators were available but critical parts were missing or detached. The session consisted of a combination of presentations, questions and answers, and small group work. The facilitators are cognizant of the desired ratio of participants to caseload and mentors such that there are plans to send the participants to designated preceptors and practice sites. The training does not provide a starter kit for IUD insertion. The trainers indicated that supplying starter kits and training preceptors are critical.

Pre-Service Midwifery Education

Five years ago, midwifery education, which was previously a two-year course with the prerequisite of completion of Grade 10, became a four-year course. There is now some discussion of instituting a three-year program after completion of grades K+12. Most midwifery schools are private. While tuition for midwifery education in private colleges is often more expensive (approximately 22,000 PHP per semester during the first year and increasing each year) than tuition for nursing education, the pay grade for midwives is that of an orderly rather than that of a nurse. Without a parallel increase in the salary at the end of four years, the price for midwifery education has become quite prohibitive, and enrollment is threatened. In addition, although years three and four were supposed to focus on management of obstetric complications, pre-service midwifery education does not include skill development for several lifesaving skills such as manual removal of placenta, $MgSO_4$ for PE/E, or evidence-based newborn resuscitation. Many pre-service midwifery programs do, however, include AMTSL and EINC skills. The Diploma in Midwifery (two-year course) consists of 118 units, including 1,275 hours of clinical practicum, while the Bachelor of Science in Midwifery program consists of 188 units, including 2,346 hours of clinical practicum. The Association of Philippine Schools of Midwifery (APSOM), which developed the national curriculum, has also developed checklists for key skills as well as some other training materials.

Midwifery schools are regulated by the Commission on Higher Education, which makes an assessment visit annually. For accreditation, each school is required to use the national curriculum and to have at least one lying-in/birthing home where students may get practical experience. Not all schools can afford to send their students to the regional medical center for clinical rotation. Skills labs have not been updated in years and are often poorly developed. In Zamboanga, which has two schools of midwifery, the skills lab in the Brent College of Midwifery has only two anatomic models, a ZOE for FP, and a breast model, both provided by Jhpiego more than 15 years ago.

The ability of midwives to function as frontline SBAs is constrained by the Midwifery Law that prohibits midwives from giving injections. While Administrative Order 2010-0014 has been issued by the DOH, and we were told that it was at least being implemented in ARMM, a focus group discussion with midwives in ARMM indicated that, even in ARMM, midwives are not giving a loading dose of MgSO4, although they are giving oxytocin for AMTSL. In other parts of the Philippines visited by the team, the reports were very inconsistent. (See more details in the Service Delivery: PPH/PE/E and Newborn Care section.)

> **We are using the models donated by Jhpiego 15 years ago. They are not in good shape but we do not have resources to get new ones.**
>
> ~Dean of a Midwifery School

Recommendations

- Support the ongoing effort to revise the Midwifery Law by inviting International Confederation of Midwives experts (Survive and Thrive Global Development Alliance) to work with IMAP, UNFPA, and other stakeholders. While the law is addressed, collaborate with IMAP, APSOM, POGS, and donors working in maternal survival to ensure wider dissemination and interpretation of the AO so that midwives can practice as true frontline SBAs, able to prevent and manage life-threatening complications of pregnancy, and also to perform newborn resuscitation.
  - In the short term, work with professional organizations and LGUs for liberal interpretation of AO 210-0014.
- Develop Centers of Excellence at Fabella and Philippine General Hospital, and extend them to other regions in a phased manner. These centers will also be training sites for in-service and pre-service training for the region.
  - Advocate with the DOH for designated technical experts who will conduct training and follow-up.
  - Enhance improvement collaboratives by introducing quality improvement standards through a process that is "owned" by the health care workers and managers, and rewarded through DOH recognition. Centers of Excellence will model this system, and support institutions in all DOH and private facilities providing MNH care.
    - Provide skill development support when necessary.
    - Provide job aids.
  - Incorporate a supportive supervision system that uses checklists, rewards successes, and supports performance as needed.
- Strengthen the BEmONC and EINC curricula and trainers/follow-up in:
  - AMSTL – Include proper storage of oxytocin and "safe injection practices."
  - MgSO4 – Include competency-based skills development.

- Neonatal resuscitation skills development using bag and mask.
- Include PPFP counseling and method provision, PPIUD, PPTL, and accurate LAM counseling that emphasizes LAM as a gateway to other methods.

- Support the training follow-up system to ensure that trainers can follow up training participants within two months of training to mentor/strengthen skills as needed and to assist in problem-solving for barriers to implementation of skills learned.
- Work with IMAP to develop midwife trainers to roll out BEmONC training among private sector midwives as well.
- Harmonize AMTSL being taught to ob/gyn residents with AMSTL being taught to SBAs in DOH in-service training.
- Explore opportunities to send selected faculty, policymakers, and representatives of professional associations for global or regional learning opportunities and the sharing of global best practices.
- Support strengthening of skills labs and faculty skills at midwifery schools.

SERVICE DELIVERY: POSTPARTUM FAMILY PLANNING

Hospital Family Planning Clinics

- Of the eight hospitals visited in this activity (seven medical centers and one district hospital), half have dedicated space and staff dedicated for outpatient FP services. The other half task-shares the room and the staff with ambulatory ob-gyn services, which are run concurrently.
- The majority of the clients at these facilities are internal referrals as well as referrals from other facilities, especially for tubal ligation. The provision of tubal ligation includes both postpartum and interval methods although the majority of the procedures are in the postpartum period, including its provision concurrent with cesarean section.
- The technique for bilateral tubal ligation outside of abdominal delivery utilizes the minilap technique but pain management is variable, with some clinics utilizing regional spinal block and some a combination of intravenous sedation (analgesic + anxiolytic) and local anesthesia using 2 % lidocaine.

Table 2: Sample Caseload for Tubal Ligation

Hospital	PPTL	Interval TL
Zamboanga City Medical Center (January–July 2012)	30	-
Davao Medical Center (January–June 2012)	41	-
Davao Regional Hospital (January–July 2012)	274	14
R1 Medical Center (2011)	692	376
Urdaneta District Hospital (2011)	445	90

- Providers have been variably been updated through FPCBT1 (Family Planning Contraceptive Technology Update 1). Some of the bilateral tubal ligation providers received their training through PRISM2. At one site, the current providers are aging and are soon to retire.
- Except for Zamboanga City and Fabella, most of the hospitals assessed do not offer PPIUD. Fabella has been providing PPIUD services for women who are within eight to 72 hours

after delivered their baby. The technique involves using the inserter tube to place the IUD. Zamboanga City MC has a nurse who underwent training in Fabella in May 2012. Since June, she has inserted a total of 36 IUDs in the postpartum period. She was able to counsel additional women who accepted the procedure at the newly opened birthing center on the hospital grounds. In both instances, the women are usually moved to the FP outpatient clinic for the procedure.

- All of the hospitals have FP commodities in their cupboards. However, the oft-repeated request was for new set of minilap instruments, particularly the apelo retractors and the Kelly's for grasping the tube.

Rural Health Unit (RHU)/City Health Center (CHC)

- Five facilities classified as RHU or City Health Centers were reached during this assessment visit. All of the facilities have a complement of physician, nurse and midwives. All facilities have stocks of oral contraceptives, DMPA, and IUDs. Condoms were not available.
- All sites were providing IUDs; however, infection prevention, particularly instrument processing, needs standardization and updating. Only one RHU was providing PPIUD services, and this was made possible through a training activity in March in Fabella.
- Various staff underwent training in FPCBT1 and 2.
- An instrument, such as an alligator forceps, was frequently requested as a requirement for managing removal of an embedded IUD.
- Record keeping ranged from regular to one instance of a seven-month delay in recording FP use.

Antenatal Care

ANC services were assessed primarily for the provision of PPFP messages, especially for immediate PP methods (PPIUD, PPTL, and LAM). Although service providers reported that PPFP messages were given during ANC, none of the women interviewed reported receiving FP messages during ANC. Also, in the one ANC clinic visited, the topics for all health education messages were listed, but FP was not included among them. In some facilities, there was some possibility for private counseling of clients, but many of the ANC spaces lacked accommodation for client privacy. Several times we were told that the women are shy to discuss issues of FP in front of others or even with health care providers. In several health centers, as well as in a barangay health post, one midwife would conduct 60–80 ANC visits per day, indicating that little time is available for counseling. One midwife who provides ANC and PPC to women in a barangay health post reports that she also provides FP counseling at these times. She seemed to have accurate knowledge about PPFP, including LAM, according to the few questions that we asked. When asked, a provider of ANC, PNC, and FP at a health center said that if a five-month postpartum woman who is exclusively breastfeeding asks for an IUD, she would require her to return when she is having her menses. This woman may think she is protected, but can become pregnant before her menses returns and she can obtain an IUD.

Other Findings

- Correct LAM messaging is rarely heard.
- FP remains free except for the cost of supplies, particularly in surgical procedures.

- Support from LGUs, especially the Local Chief Executive (LCE), is variable, but most sites do not interfere actively, with only one site hesitant to do active community mobilization.
- Care is overwhelmingly focused on permanent methods.
- There are variable standards in client selection, and in techniques for both the procedure and pain management.
- Post-procedure instructions and materials are of variable availability.
- There are issue with:
  - Dedicated space both for consultation and procedures (i.e., the operating room is shared)
  - The quantity and quality of instruments (e.g., lack of apelo, the Kelly old and barely grasping, lack of alligator forceps for IUD removal)
  - A problem with IUD string prematurely breaking when grasped for removal (described at one site)
  - Access to reference materials
  - Poor quality of counseling

SERVICE DELIVERY: PPH/PE/E AND NEWBORN CARE

Facilities varied in the state of the infrastructure, but most were quite clean, and many were expanding the MNH facilities and services. Most regional medical centers are large, with up to 1,200 beds and 1,300 deliveries per month (in Southern Philippine Medical Center).

Labor and Delivery (L&D)

Labor, delivery, and postpartum areas, except in one regional hospital, were very crowded.

Unnecessary practices:

- **Expenditures on routine prescriptions upon discharge**
- **Overuse of episiotomy**

- Lack of respectful maternity care was obvious in most sites visited. Only one facility had curtains separating delivery tables. Women were not allowed a companion during birth at any facility visited, and although some facilities said they allowed a woman to choose her labor position, in all deliveries observed the woman was in the lithotomy position. Besides the emotional comfort of a companion and position of choice, current global evidence shows that these two practices reduce length of labor and the necessity of medical intervention. During most deliveries observed, women had IVs and most primiparas received routine episiotomy, although when asked about them, managers and service providers denied these practices.
- While each L&D provider interviewed said that a partograph was used during labor, no completed partographs were observed in charts reviewed in any of the facilities. In some facilities, charts included a modified partograph with only cervical dilatation, but no recording of maternal or fetal condition. However, none of these charts was filled in.

Almost all providers interviewed could correctly describe the steps in AMTSL. In observation of actual and simulated deliveries, with a couple of exceptions in health centers, most providers performed AMTSL correctly. By report, stock-outs of oxytocin are rare, although two facilities report that the patient must purchase it prior to, or at, admission to the L&D ward. In one large birthing center, AMTSL was not performed at an observed delivery because oxytocin was not available, although it was available in a different part of the hospital. In one facility, we were

told that the family needs a prescription to obtain oxytocin, but that it is less expensive in a private pharmacy than in the hospital. Philippine General Hospital was the only facility where we saw the administration of oxytocin being recorded in the registry. In other sites, we were told that since it is given routinely, it does not need to be recorded.

In several facilities, providers were using Carboprost (tromethamine salts, also called Hemabate, Tham) for prevention and management of PPH. Carboprost is a synthetic prostaglandin analogue of PGF2α (specifically, it is 15-methyl-PGF2α) with oxytocic properties. It is available as an injectable at the cost of approximately 200–300 PHP per injection. Although misoprostol, at a fraction of the cost, is heat- and light-stable and does not require an injection, it is not included in the Clinical Practice Guidelines of POGS, while Carboprost is included. Most providers noted that they do an episiotomy only when needed for primiparas. However, even in the few deliveries that were observed by the assessment team, we noted inconsistent practices, with an over-reliance on episiotomies.

Most facilities also routinely gave methergine (an oral uterotonic) to prevent PPH as well as amoxicillin for three days postpartum after discharge. These drugs are not only unnecessary, they are costly and the consequences of routine use of antibiotics may create other public health and clinical problems. If proper infection prevention practices are used, the woman who has had a normal labor and birth would need neither amoxicillin nor methergine.

While much emphasis was noted on immediate newborn care, practices were inconsistent. Several facilities where EINC training had been conducted displayed large wall posters describing the steps in EINC, yet these practices were not always followed. Although almost every facility reported the use of Kangaroo Mother Care (KMC) for preemies and/or skin-to-skin care in the immediate postpartum, this practice was not evident in most of the services observed. In Southern Philippines Medical Center in Davao, after delivery, mothers are kept on gurneys/stretchers in the hall for observation for two hours while infants are kept in another part of the postpartum area. This is the time when thermo-regulation and initiation of breastfeeding are crucial for the newborn.

While emphasis is being given to essential newborn care, little attention was given to resuscitation of the asphyxiated newborn. Since more than 20% of newborn mortality is due to asphyxia, and more than 5% of child mortality in Southeast Asia is due to newborn mortality,[8] little progress can be made toward achieving MDG 4 without national attention to newborn asphyxia. None of the regional hospitals, and only one of the birthing centers, had a functional newborn Ambu bag and mask. When asked how they managed an asphyxiated newborn, all but one of the midwives or nurses said that they refer, while several mentioned cardiac compression. Of course, a newborn who is not breathing is not likely to survive even a short time, and global standards require that each skilled birth attendant be skilled in newborn resuscitation, because this is a complication that is often not predictable, even in a "low-risk" mother. While the Society of Newborn Medicine in the Philippines teaches cardiac compression as part of newborn resuscitation, the American Academy of Pediatrics and USAID are part of a global consortium promoting a simplified newborn resuscitation program, Helping Babies Breathe (HBB), which has been proven to allow rapid scale-up of newborn resuscitation skills among frontline health care providers. In an attempt to manage cardiac compression, instead of immediately using ventilation with a simple bag and mask, vital minutes of oxygen deprivation are lost. The bag and mask gets air into the baby's lungs even before spontaneous breathing occurs.

[8] Black RE, et al. 2010. Global, regional, and national causes of child mortality in 2008: A systematic review. *The Lancet* 375: 1969–1987.

Postpartum/Pre-Discharge

All but one of the postpartum wards were extremely crowded, often with two or more women in a bed. Bed-sharing can be detrimental to mother and baby because of possible cross-contamination of infected women, possible transmission of infection to the newborn baby, lack of rest for the mother, and difficulty for the nurses or midwives in caring for the women. The worst situations were in Zamboanga Medical Center and in a district hospital in Region I, where women are kept until they can pay their bill, which is 8,000 pesos for a normal delivery, or as much as 21,000 pesos for surgery for an ectopic pregnancy. Poor women are often kept days or weeks and sometimes months, resulting in extreme crowding. Women who are treated disrespectfully may not return for services and may communicate with sisters and neighbors that they will risk being held "captive" if they deliver in this facility. However, in Vincente Soto Regional Medical Center in Cebu, staff from the Department of Social Welfare and Development (DSWD) sat inside the hospital, where they provided funding for those who were not able to pay their bills, so women could leave the hospital with their babies the day after giving birth.

Although all facilities visited reported that mothers are kept with their babies after birth, this was not the practice always observed. In Davao Medical Center, women are kept 12 hours postpartum and babies are kept for 24 hours to facilitate screening. Although women can return to breastfeed their infants, this practice is also not conducive to early bonding between a baby and its parents. Furthermore, men are not allowed in the postpartum ward at all.

Most nurses and midwives working in the postpartum ward say they are talking to women about FP; however, we were told that women who inquire about FP are referred to the outpatient clinic. None receive a contraceptive method before discharge unless they want a PPTL. Several regional hospitals had TL rooms near the labor and delivery area, and several reported performing a small number each month. Much attention is given to breastfeeding, and most staff interviewed seemed to believe that women would not need a contraceptive for some period of time because they are all breastfeeding. This contradicts FHS data showing that only 27% of women exclusively breastfeed. Only one or two health care workers interviewed could mention the three criteria for LAM or seemed to understand that a woman could become pregnant while breastfeeding if her menses returns, if the baby is more than six months old, or if she is supplementing the breastfeeds. One nurse was heard to tell a patient, who said she did not want to become pregnant for four or five years, that she could breastfeed for three or four years and thereby not become pregnant. Informal questioning of staff about postpartum return to fertility and other basic PPFP questions showed that they have unreliable knowledge and are likely passing this on to clients, who then falsely believe they are protected from pregnancy.

Commodities and Supplies

Several relevant problems with commodities also seem to influence service delivery. We found MgSO4 only in regional medical centers. We were told that MgSO4 is not present in health centers or barangay health posts even if deliveries are conducted there because women with eclampsia or severe pre-eclampsia are referred to the hospital. Yet transfer to a hospital can take from 15 minutes to several hours. The fetus, as well as the mother, may not survive continuing eclamptic seizures for this length of time. Because lifesaving care requires immediate management of severe pre-eclampsia or eclampsia, global standards require that each SBA be able to manage PE/E.

Consistently, oxytocin was found in facilities accessible to the delivery rooms. Unfortunately, only in Davao Medical Center and in Fabella Hospital was it refrigerated. Consistently, providers did not know that oxytocin loses potency when stored outside of refrigerators. So, although AMTSL is being provided in the facilities visited, it is likely limited in its effectiveness

because of oxytocin's loss of potency. It was also reported that midwives who conduct deliveries in homes use oxytocin that is kept in their bags and carried from home to home.

Infection Prevention

While many health care providers interviewed said that they were using "safe injection practices," in only one site did we see safe sharps disposal. Most used an open cardboard box or basket. Most sites had running water in or near the service delivery areas, and may have been using appropriate handwashing practices, although none were observed.

Maternal Death Reviews

A number of clinical and non-clinical factors apparently contribute to maternal deaths—lack of understanding of danger signs or the need to access care; lack of access to, or use of, a skilled birth attendant; lack of transportation to a facility; lack of finances; poor or unskilled treatment after reaching a facility; and perhaps other factors. At least some within the health care system are making efforts to conduct maternal death reviews to sort out and identify and address the apparent and underlying factors. A Director III official at a Regional Office of the DOH told us that he routinely joins in regular maternal death reviews that are conducted in his region. Although we did not get to participate in or learn details about these reviews, it is promising that an attempt is being made to analyze the pertinent factors. Technical support in the implementation of these reviews and the follow-through to address delays or gaps identified may help key stakeholders actually to take action to save lives.

PhilHealth

Reference to PhilHealth was frequent during our visits. Facilities at various levels referred to training or facilities improvements that were being made in order to ensure PhilHealth accreditation. Many highlighted the 8,000 PHP reimbursement for deliveries as a key source of income. The medical chief of one health center told us that she submits invoices to the local government authority, which reimburses the amount. She said that she uses a major portion of these funds to supplement the income of midwives and other staff who were involved in the delivery. Staff often work overtime to complete a delivery but have no other way to be compensated for their time. She also mentioned that her facility had received more than 102,000 PHPs since becoming affiliated with PhilHealth less than a year ago.

However, in several sites we heard that the PhilHealth incentives for deliveries result in delayed referral and so women arrive at referral facilities in very poor condition. Reportedly, private midwives as well as doctors in health centers often delay referral because they want to complete the delivery and get the full reimbursement. In several facilities, health care providers spoke of competition between local private midwives and the DOH facility because both want the PhilHealth reimbursement.

Recommendations

- The recommendations listed above for the development of Centers of Excellence—with the enhancement of improvement collaboratives with the introduction of quality improvement standards—would also address the findings in this section concerning care provided in L&D and the postpartum ward, including infection prevention in these areas.
- Investigate the possibility of including newborn resuscitation as part of EINC orientation rollout.

- Provide technical support to maternal death review committees connected to Centers of Excellence to ensure that actions taken address identified gaps and delays.

COMMUNITY-BASED PARTNERSHIPS

The DOH, together with the DSWD, PhilHealth, Department of Education, and DILG (Department of Interior and Local Government), is mandated under an Administrative Order of the DOH to organize into CHTs to work together for the health and welfare of communities. According to interviews, the head midwife, the TBAs, and others have varying levels of skills development, although the community health action team (CHAT) model of Shield in ARMM seems to be having some positive effect.

Recommendations

- Strengthen the performance of CHTs in counseling and in referring to health care facilities when needed, with special attention to ARMM.
- Develop skills of CHT members, including TBAs, in recognition of danger signs and birth preparedness and complication readiness (BP/CR), using adult, competency-based training methodologies.
- Develop simple job aids for CHT midwives and TBAs to use in recognition of danger signs, BP/CR, and PPFP counseling.
- Support City Health Offices and DOH facilities to disseminate the model in which TBAs are incentivized to bring women to facilities for delivery and are included in labor and postpartum care.
- Link FP counselors (who use screening checklists) in immunization clinics to barangay midwives for home follow-up of women who are interested in FP, but have not yet received a method (based on the HealthGov model).

PUBLIC-PRIVATE PARTNERSHIPS

The Integrated Midwifery Association of the Philippines (IMAP), the professional association for midwives, is reportedly an active association that conducts regular training for their members. We were told that the Association of Philippine Schools of Midwifery (APSOM) develops national curricula and teaching aids for use in schools of midwifery across the nation. According to midwives interviewed, private midwives are currently not usually included in DOH training. The City Health Officer of Zamboanga, who is also the head of a nongovernmental organization that operates a private hospital, expressed interest in developing a public-private partnership to benefit and improve the practices of both public and private providers.

Recommendations

Support public-private partnerships that strengthen the practice of evidence-based skilled birth attendance and PPFP care:

- Solidify the DOH's relationship with IMAP, including the development of trainers within IMAP, and the improvement of services of private midwives according to DOH standards that are developed, as mentioned above.
- Develop formal relationships for training and quality improvement between City Health Offices and private facilities in cities such as Zamboanga, where the City Health Officer is enthusiastic about this relationship.

Pilot a community-based postpartum hemorrhage prevention program that includes the distribution of misoprostol for the prevention of postpartum hemorrhage:

- The Director of Health in Davao is supportive of innovative approaches to meet public health needs, including the use of misoprostol in the community.
- Keep the pilot low-profile, but solicit advocacy by Champions when the results are released.

Annex 1: Program Description

USAID/Philippines Program Description
Maternal and Child Health Integrated Program
Field Support for the Maternal and Child Health Integrated Program
(GHS-A-00-08-00002)
June 2012

PURPOSE

This activity shall aims to strengthen long acting and permanent method capacity-building, scale-up post-partum hemorrhage and pre-eclampsia and eclampsia interventions, and strengthen family planning and child health integration. It will be implemented through USAID/Philippines' provision of Field Support to a central mechanism, the Maternal and Child Health Integrated Program (MCHIP).

BACKGROUND

The 2011 Family Health Survey (FHS) showed that maternal mortality increased from 162 to 221 between 2006 and 2011 and it is projected that the Philippines' MDG target for maternal mortality would not be achieved. Although antenatal care, facility-based delivery, and skilled-birth attendance is increasing, the FHS data showed that there is still a high preference for traditional birth attendants (TBA) particularly in poor regions; in Mindanao region alone, 37 to 67% of women prefer TBAs. For place of delivery, four out of five women deliver at home; however, in ARMM, the poorest region, eight out of ten women deliver at home.

Post-partum hemorrhage and severe pre-eclampsia are the leading cause of maternal mortality and women who deliver at home are the most vulnerable to succumb to these preventable conditions. Although there are policies on PPH and PE/E policies, there is a need to assess the quality and extent of implementation of PPH and PE/E prevention program. Currently there are initiatives implemented such as Essential Intrapartum Newborn Care Training and Basic Emergency Obstetric and Neonatal Care conducted by the Department of Health in partnership with donor agencies and the Philippine Obstetric and Gynecological Society. USAID's project in the Autonomous Region of Muslim Mindanao has also trained more than 600 midwives on active management of third stage of labor with oxytocin as the main uterotonic used. While there are best practices, there is a gap in documenting, monitoring, systematizing (e.g., level of implementation; availability of oxytocin; etc.) and scaling-up.

Another factor which has contributed to the high maternal mortality is the lack of a good family planning program. The Philippines has lagged behind the rest of Southeast Asia mainly because of challenges in national policy and support to service delivery for FP and reproductive health services. Based on the 2011 FHS, the unmet need for FP in the Philippines is at 20 percent (10 percent for spacing and 8 percent for limiting); contraceptive prevalence rate has barely moved from 36 to 36.9 between 2006 and 2011. It is estimated that as many as 5.3 million Filipino women of reproductive age (WRA) or women within the 15-49 years age range have an unmet need for FP. One of the gaps identified is the lack of long-acting permanent methods provision including immediate post-partum IUD, which is not yet available in the country.

There is also a need to improve the integration of FP and child health services, which is a proven best practice in maternal health programs.

PROGRAM OBJECTIVES AND ACTIVITIES

MCHIP assistance will contribute to the overall measurable goal of the existing USG-assisted FP/MCH portfolio and help demonstrate the improvement of current practices through high-impact and evidence-based interventions. The following are the expected activities:

- **Family planning:**
  - Develop and strengthen training site/s for immediate post-partum intra-uterine contraceptive device method.
  - Rapid assessment of long-acting permanent method program implementation at public health facilities and provide concrete recommendations on how best to scale it up.
  - Develop technical notes on scaling-up LAPM best practices.
  - Develop training modules (including materials) for long acting and permanent methods.
- **Post-partum hemorrhage and pre-eclampsia and eclampsia (PPH and PE/E):**
  - Assessment of the level of PPH and PE/E Prevention and Management implementation, identify gaps (e.g., using the Dhaka Conference Pathways), and recommend ways to achieve institutionalization and sustainability.
  - Document best practices in PPH prevention and management and provide advice on how best to scale up implementation.
  - Assessment of the viability of introducing Misoprostol for PPH prevention in the Philippines and recommend how best to implement this intervention, which has been proven globally as a life-saving intervention for mothers.
- **Family planning and maternal and child health integration:** Rapid assessment of family planning and maternal and child health integration in USAID sites and provide recommendations on how to scale this up.

IMPLEMENTATION PERIOD AND ESTIMATED COST

The total estimated cost planned for obligation for MCHIP is $1,000,000.00 for the period August 2012 to March 2014 (pending MCHIP extension). With the FP/MCH projects ending in December 2012, it is envisioned that the MCHIP activities will provide continuity of USAID support to the Department of Health. With new projects coming in, additional or revised activities may be added in this Program Description.

Annex 2: Key Informants during the Assessment Visit

Name	Facility	Position	Contact Details
Zamboanga			
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Lolot Yap	Cebu City Health Office	FP Coordinator	
Dr. Alan Bongo	Carreta CHC	Internist	
Jenneifa	Carreta CHC	Midwife	
Emmy Cusing	Carrete CHC	Midwife	
Dr. Daisy Villa	Mabolo CHC	Medical Officer	
Lakshmi Legaspi	Department of Health	Director III	
Marcia Sokoro	Department of Health	Acting FP Coordinator	

Name	Facility	Position	Contact Details
Davao			
Dr. Abdullah Dumama	Department of Health	Regional Director for Davao Region	081-226 4826; 081-227 9362
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Dr. Leopold Vega	Southern Philippines Medical Center	Chief of Hospital	
Dr. Assuncion Layug	Southern Philippines Medical Center	OB Department Head	
Mina Rico	Southern Philippines Medical Center	OPCC Nurse	
Dr. Evelyn Baňo	Agdao Health Center	Medical Officer	
Ms. Rosana Muňoz	Agdao Health Center	FP Coordinator	
Ms. Carmencita Sumuyang	San Antonio Barangay Health Station	Midwife	
Dr. Amelia Ang	Davao Regional Health Hospital	OB Chief Consultant	
Dr. Zenaida Baňez	Davao Regional Health Hospital	Training Coordinator	
Dr. Arturo Zuico	Davao Regional Health Hospital	Chief of Clinics	
Dr. Marivic Dublas	Davao Regional Health Hospital	OB Resident	
Dr. Arnel Florendo	Tagum City Health Office	City Health Officer	
Dr. Romela Busuego	Davao Regional Health Hospital	Chief of hospital	
San Fernando			
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Aurora Doria	Pangasinan PHO	FP/PHO	
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Manila			
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Name	Facility	Position	Contact Details
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