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MCHIP Philippines End-of-Project Report

July 2012 – June 2014



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Submitted by:

Dr. Bernabe Marinduque

The Maternal and Child Health Integrated Program (MCHIP) is the USAID Bureau for Global Health's flagship maternal, neonatal and child health (MNCH) program. MCHIP supports programming in maternal, newborn and child health, immunization, family planning, malaria, nutrition, and HIV/AIDS, and strongly encourages opportunities for integration. Cross-cutting technical areas include water, sanitation, hygiene, urban health and health systems strengthening.

MCHIP brought together a partnership of organizations with demonstrated success in reducing maternal, newborn and child mortality rates and malnutrition. Each partner took a lead in developing programs around specific technical areas:

Jhpiego, as the Prime, led maternal health, family planning/reproductive health, and prevention of mother-to-child transmission of HIV (PMTCT);

JSI—child health, immunization, and pediatric AIDS;

Save the Children—newborn health, community interventions for MNCH, and community mobilization;

PATH—nutrition and health technology;

JHU/IIP—research and evaluation;

Broad Branch—health financing;

PSI—social marketing; and

ICF International—continued support for the Child Survival and Health Grants Program (CSHGP) and the Malaria Communities Program (MCP).

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Country Summary Report



Selected Health and Demographic Data for Philippines	
GDP per capita (USD)	\$4,400
Total population	96.2 million
Maternal Mortality Ratio (deaths/100,000 live births)	162 / 100,000 live births
Skilled birth attendant coverage	62%
Antenatal care, 4+ visits	75%
Neonatal mortality rate (deaths/1,000 live births)	14 / 1,000 live births
Infant mortality rate (deaths/1,000 live births)	22 / 1,000 live births
Under-five mortality (deaths/1,000 live births)	29 / 1,000 live births
Unmet need for family planning	22%
Modern contraceptive prevalence rate	34%
Total fertility rate	3.2
Total health expenditure per capita (USD)	\$97

Sources: Population Reference Bureau, 2012 World Population Data Sheet, WHO Global Health Observatory Data Repository, Philippines



Program Dates	July 1, 2012 – June 30, 2014					
Overall Mission Funding to date by Area	\$1,500,000					
Geographic Coverage	No. (%) of provinces	47%	No. of districts	31	No. of facilities	10
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Table of Contents

Tables and Graphs.....	5
Acronyms and Abbreviations.....	6
Acknowledgments.....	7
Executive Summary	8
Introduction	12
Major Accomplishments	17
Recommendations and Way Forward.....	33
Annex 1: Indicator Matrix.....	36
Annex 2: Success Stories	39
Annex 3: List of Presentations at International Conferences and Publications	41
Annex 4: List of Materials and Tools Developed or Adapted	42
Annex 5: July 2012 – June 2014 Total PPIUD and Counseling Stats	43
Annex 6: KMC in Facilities: A Process Documentation.....	45

List of Figures

1) PPIUD Insertions by Facility, July 2012 – June 2014	10
2) Number of women counseled on PPFP/PPIUD by type of visit, July 2012 – June 2014.....	25

Acronyms and Abbreviations

ANC	Antenatal Care
BCC	Behavior Change Communication
COE	Center(s) of Excellence
CPG	Clinical Practice Guidelines
DHS	Demographic and Health Survey
DOH	Department of Health
EINC	Essential Intrapartum and Newborn Care
FHS	Family Health Survey
FP	Family Planning
FPCBT2	Family Planning Competency-Based Training
ICV	Informed Consent and Voluntarism
KMC	Kangaroo Mother Care
LAM	Lactation Amenorrhea Method
LAPM	Long-Acting and Permanent Methods
LBW	Low Birth Weight
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MCHIP	Maternal and Child Health Integrated Program
MDG	Millennium Development Goals
MNCH	Maternal, Newborn, Child Health
MNH	Maternal and Newborn Health
MOU	Memorandum of Understanding
PP	Postpartum
PPFP	Postpartum Family Planning
PPIUD	Postpartum Intrauterine Device
RHO	Regional Health Office
SBA	Skilled Birth Attendant
SS	Supportive Supervision
TOT	Training of Trainers

Acknowledgments

MCHIP’s approach is to leverage support from existing organizations, programs and agencies to increase the visibility and integration of PPFPP/PPIUD. To this end, MCHIP built upon existing partnerships with—among others—the DOH, the Regional Health Offices, the United Nations Population Fund, Health Policy and Development Program, Basic Emergency Obstetric Care Training, Essential Intrapartum and Newborn Care Training, Integrated Midwifery Association Program, Philippines Obstetrics and Gynecology Society, KMU Foundation, the Family Planning Consortium, and the upcoming Behavior Change Communication Program, as well as USAID’s three regional bilateral programs in Luzon, Visayas and Mindanao.

This program would not have been possible without MCHIP’s dedicated and talented team in the Philippines, comprised of:

- Dr. Bernabe Marinduque, *Senior Technical Advisor, Jhpiego*
- Grace Mateo, *Senior Program Manager / Study Manager, Jhpiego*
- Venus Mendoza, *Finance and Administrative Officer, Jhpiego*
- Donna Miranda, *Documentation Officer, Jhpiego*
- Aimee Liz Malingan, *Monitoring and Evaluation Officer, Jhpiego*
- Dr. Amado Parawan, *Health and Nutrition Advisor, Save the Children*
- Conie Pamposa, *Awards Manager, Save the Children*

Executive Summary

The Philippines National Demographic and Health Survey (DHS) reported that in 2008, 40 percent of postpartum (PP) women who wanted to space or limit their pregnancy for the next 2 years were not using any family planning (FP) method. One of the gaps identified is the lack of access to long-acting or permanent methods (LAPM), including immediate placement of PP intrauterine devices (PPIUD), during the PP period. Improving access to LAPM by integrating PFP services into established maternal and child health programs has been proven as a viable approach in reducing unmet need for FP and promoting healthy birth spacing among women living in low-resource settings. Lessons learned from other Maternal and Child Health Integrated Program (MCHIP) sites demonstrate the feasibility of this approach.

Global research has shown that birth-to-pregnancy intervals in developing countries are too short. An analysis of DHS data from 52 developing countries, including the Philippines, found that short birth-to-pregnancy intervals are associated with adverse pregnancy outcomes, increased morbidity in pregnancy, and increased infant and child mortality. Specifically, the 2008 Philippines DHS reports that the mortality rates for Filipino infants and children decrease by almost half with longer birth-to-pregnancy spacing, from 35 infant deaths and 54 under-five child deaths for every 1,000 live births at shorter birth-to-pregnancy intervals of 15 months to just 18 infant deaths and 26 child deaths for every 1,000 live births at longer birth-to-pregnancy intervals of 27 to 38 months.

Because of the clear evidence of the benefits of spacing from countries like the Philippines, the World Health Organization has recommended that women wait at least 24 months after giving birth before attempting to become pregnant again to reduce maternal, perinatal, and infant health risks. In the Philippines, 50 percent of all non-first pregnancies occur within 24 months of a previous birth, putting both mother and child at unnecessarily high risk.



PPIUD insertion demonstration during Family Planning: State of the Art event in March 2014

Pregnancies that occur too soon after a previous birth (during the “postpartum” period) can present serious health risks to mothers and children. Most Filipino couples want to delay or limit future pregnancies after giving birth, but many do not use modern methods of family planning and are unaware of the potential for future pregnancy when they are sexually active following a birth. Postpartum family planning (PFP) for healthy timing and spacing of births addresses women’s need for family planning and saves countless lives by preventing high-risk pregnancies. PPIUDs are presently the only PFP method for couples requesting a highly effective and reversible, yet long-acting, family

planning method that can be initiated during the immediate postpartum in lactating women. Postpartum intrauterine contraceptive devices (PPIUDs) can be placed within 10 minutes to 48 hours of the delivery of the placenta or during cesarean section. PPIUDs are cost-effective and can be inserted by a trained, mid-level skilled birth attendant.

In addition to the challenges presented by short birth intervals, the Philippines also has the highest burden of low birth weight (LBW) newborns in the region. About 15% of all births in the

Philippines are preterm, making this condition a significant contributor to newborn deaths in the country. Kangaroo Mother Care (KMC) is a low-cost intervention that helps regulate the body temperature of a LBW newborn and facilitates early initiation of breastfeeding. Although the Philippines was one of the pioneer countries in Asia to implement KMC, it is not practiced regularly in every facility. To address this issue, MCHIP in the Philippines worked to promote and integrate KMC services in facilities.



Instructions on proper PPIUD insertion given during MCHIP training in Manila

In early 2012 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, and strengthen FP and child health integration. MCHIP received \$1,000,000 for this activity, and the assigned period of performance was July 2012–March 2014. The USAID mission in the Philippines approved an additional \$500,000 for MCHIP in July 2013, and the period of performance was extended through June 2014. MCHIP's visibility and support to the regional projects and the newborn scope was increased with this new funding.

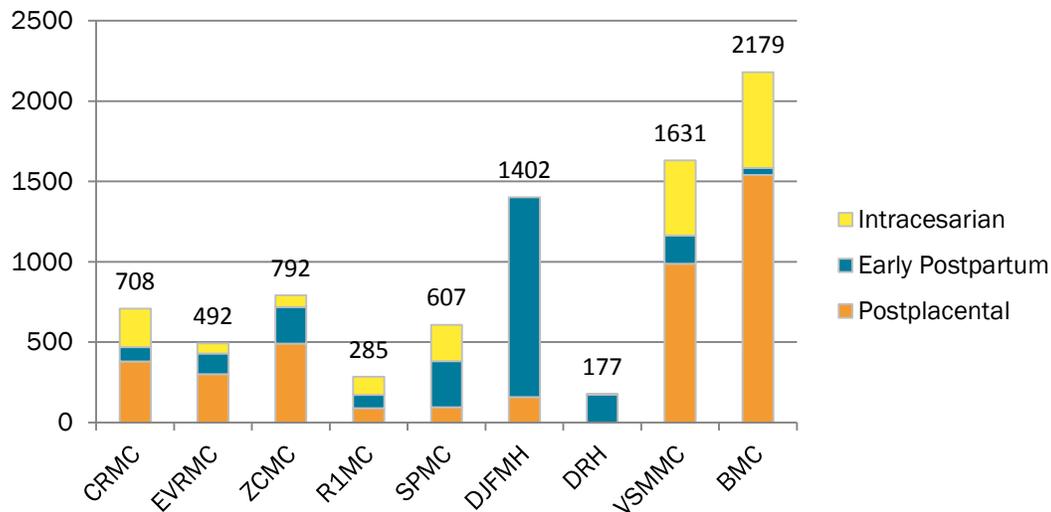
MCHIP in the Philippines works with the Philippines Department of Health (DOH) to create an enabling policy environment for PPF/PPIUD, and to establish resources and capacity for service delivery and training for PPF/PPIUD adoption and scale-up.

Summary of Major Accomplishments

- **MCHIP established nine Centers of Excellence (COE) for PPF/PPIUD across Philippines.** Through a comprehensive development process, out of the ten facilities provided with MCHIP technical assistance, nine COE for PPF/PPIUD were established and strengthened. The COE are located in Luzon, Visayas, and Mindanao, and the catchment area of these nine sites covers 31 provinces. These COEs are envisioned to serve as model delivery sites that: (1) provide quality PPF-PPIUD services to postpartum women, (2) train PPF-PPIUD service providers and clinical trainers, and (3) serve as a technical resource to initiate adoption and scale-up of PPF-PPIUD services in their respective regions or localities. From July 2012 to June 2014, a total of 6.7% (n=8,273) of all women who delivered at these COEs received PPIUD insertions. Within the same time frame, the project capacitated 23 PPF-PPIUD service providers and 20 PPF-PPIUD trainers at these sites. An additional 43 PPF-PPIUD service providers from other facilities outside these sites were also trained.
- **69 trainers for PPF/PPIUD were developed.** These trainers have the capacity and certification to provide PPF/PPIUD training for providers, thus building the available pool of qualified PPF/PPIUD service providers and improving women's access to quality PPF counseling and services when needed. The training of 38 trainers was funded by MCHIP Philippines while the rest were financed by other USAID health projects with technical assistance of MCHIP Philippines. Fifty-three of these trainers are from the COE while the others are from partner organizations, e.g. private facilities, regional health offices, and other USAID health projects.

- **Over 200,000 clients accessing essential MNCH services at MCHIP-supported facilities received FP counseling**, either during the antenatal period, early labor period, or postpartum period. Access to FP counseling during these periods has historically been very limited. Through MCHIP’s efforts, postpartum women who want to space or limit their pregnancies for the next two years have increased access to information about the FP options available to them.

Figure 1: PPIUD Insertions by Facility, July 2012 - August 2014



- **MCHIP’s efforts to train and build capacity of regional projects are beginning to catalyze the implementation of PPFPP/PPIUD in some areas.** For example, the Cebu DOH Regional Office has already conducted training on PPFPP/PPIUD with the technical assistance of Visayas Health.
- **MCHIP facilitated the inclusion of PPIUD in the Clinical Practice Guidelines on Family Planning and the Philippines Clinical Standards Manual on Family Planning.** MCHIP worked with the DOH to include information on the PPIUD in the first edition of the Clinical Practice Guidelines on Family Planning published by the Philippine Family Planning Society, Inc. and the Philippine Obstetrical and Gynecological Society (Foundation), Inc. The section recommends proper IUD insertion during the postpartum period as a safe and effective contraceptive method. Inclusion of PPIUD in the Clinical Practice Guidelines has the imprimatur of the DOH, making the method official in a sense. It allays the fears of some obstetrician-gynecologists that this method is not acceptable in the Philippines, which may increase the likelihood that providers will counsel patients on their FP options leading up to and during the postpartum period. MCHIP also finalized a service



Postpartum Family Planning supplement to the Philippines Clinical Standards Manual on Family Planning

delivery manual for PPFPP/PPIUD to supplement the current Philippine Clinical Standards Manual on Family Planning, which was approved and endorsed by the DOH. The supplement is expected to aid FP service providers with updated information on PPFPP technologies, strengthen the adaptation and scale-up of PPFPP-PPIUD services in health facilities, and increase stake holder buy-in among the cadre of FP service providers.

- **KMC implementation at two tertiary hospitals and inclusion of KMC and EINC indicators in accreditation checklists.** A Memorandum of Understanding (MOU) was signed between the two hospitals and the KMC Philippines Foundation for duration of three years. The KMC programs will be managed by a KMC committee composed of trained KMC core staff authorized by the hospital administrations. Due to MCHIP's advocacy efforts the Department of Health also expressed that KMC and EINC indicators will be included in the Mother-Baby Friendly Hospital accreditation checklist which is currently being revised.

In family planning, the success of adoption and implementation of the program is due to the effective competency-based training given to highly motivated providers who can echo their learning and skills to equally motivated and supported FP providers in their respective hospitals. Integration of the program in MCH services, specifically in antenatal, intrapartum, and postpartum care, has been key in driving and sustaining the demand for PPFPP-PPIUD services and strengthening the capacity of both hospitals and their FP providers. The administrative support of hospital leadership, assistance of the three USAID regional projects, and diligent supportive supervision from MCHIP staff has also been critical in achieving the objectives of the program. Nevertheless, consideration for diligent and consistent FP data reporting and recording needs to be further enforced and addressed both by the COE and through the assistance of MCHIP staff. Similarly, MCHIP is also encouraging COE to seek and advocate for the support of their local health offices to ensure that a supportive policy environment for PPFPP-PPIUD services is put in place.

Introduction

Every year, 5,000 women in the Philippines die from complications associated with pregnancy and childbirth. Most of these deaths directly result from complications that could be prevented through healthy spacing of pregnancies. These complications—which occur during labor, delivery and the postpartum (PP) period—include hypertension, PP hemorrhage and other medical problems arising from poor birth spacing and various chronic and infectious diseases. Some improvement in maternal and newborn outcomes has been reported in the past few years: a considerable decline in the under-five mortality rate and infant mortality over the past decade as well as increases in antenatal care (ANC) visits and skilled birth attendance. However, maternal mortality rates remain high, with a reported increase from 162 to 221 per 100,000 between 2006 and 2011 (Family Health Survey [FHS], 2011).

Across the range of maternal and child health services, uptake of family planning (FP) services in Philippines remains markedly low. Data from FHS 2011 indicate that the contraceptive prevalence rate has barely moved from 36 percent to 36.9 percent between 2006 and 2011, in contrast to the increase in ANC visits, facility-based delivery and skilled birth attendance. FHS estimates that as many as 5.3 million Filipinas of reproductive age have unmet need for FP. Gaps in delivery of essential maternal health services, lack of access to effective FP methods and challenges in national health policy remain the major obstacles to improving maternal health outcomes in the country. The lack of a consistent, effective and enabling policy environment for FP services, in particular, is critical, and will have to be addressed to improve access to FP services and—ultimately—maternal mortality in the Philippines.

For most Filipinas, pregnancy and childbirth may be the only opportunity to access formal health services. In the Philippines, 78 percent of pregnant women receive care from skilled birth attendants during the antenatal period and 55 percent of births are delivered at a health facility. In addition, 84 percent of women receive at least one PP care visit during the first week PP. These data indicate there are multiple “touch points” and opportunities to introduce the benefits of safe birth spacing; yet only a fraction of women receive FP assistance during ANC, prior to discharge and during PP care. An assessment activity conducted by MCHIP in 2012 reports that while service providers claimed that PPF messages were given during ANC, none of the women interviewed at the site reported receiving FP messages during ANC. Postpartum women in the Philippines, including those in the extended postpartum period, represent an underserved segment among women of reproductive age needing FP. Reaching out to this segment of the population will not only contribute to achieving the contraceptive prevalence rate target for the Philippines, but will also be instrumental in fulfilling the Millennium Development Goals of reducing child mortality and improving maternal health by 2015.

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, and strengthen FP and child health integration. MCHIP received \$1,000,000 for this activity, and the assigned period of performance was 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. In addition, the assessment team also conducted the first PPF/PIUD training for service providers in July 2012 in Manila laying the foundation for PPF/PIUD follow-up work in the Philippines. In July 2013, The USAID mission in the Philippines approved an additional \$500,000 for MCHIP in July 2013, and the period of performance was extended through June 2014. MCHIP’s

visibility and support to the regional projects and the newborn scope was increased with this new funding.

The goal of MCHIP in the Philippines is to support the Department of Health (DOH) to improve family health in the Philippines by reducing the unmet need for FP. The objectives of MCHIP in the Philippines are as follows:

Objective 1: To increase access to long-acting and permanent methods (LAPM) of family planning in the postpartum period through advocacy. In the Philippines, there exists strong religious opposition to FP because it is viewed as a measure of population control. Some providers are unwilling to provide modern contraception as they consider it equivalent to committing a sin. Rumors about methods still exist among the general population. And many see FP as “population control” rather than a lifesaving intervention to improve MNH and decrease mortality. The Philippine Government’s 2012 Reproductive Health Law that emphasizes “Responsible Parenthood” was decried by the Catholic 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 FP. Decentralization brings with it yet another challenge. And in areas where a local governor or mayor does not approve of FP, financial support for the purchase of commodities may be curtailed. MCHIP’s approach is to work with the DOH to create a favorable environment for FP by creating resources for advocacy based on evidences and best practices. The passing of the Reproductive Health Law, formally known as the Responsible Parenthood and Reproductive Health Act of 2012, provides a strong opportunity to increase access to FP and reproductive health education.

Objective 2: To develop comprehensive resources for the service delivery and training of PPFPP/PPIUD services through development of training sites and increased integration of PPFPP with relevant MNCH services. In the Philippines, the majority of pregnant women have contact with the health care system during pregnancy and childbirth, with 78 percent of pregnant women attending four or more antenatal care (ANC) visits. Also, 73 percent of women are attended by a skilled birth attendant (SBA) (doctor, nurse or midwife) during childbirth—and 60 percent of women deliver at a health facility—providing opportunity for provision of immediate PPFPP methods such as PPIUD, postpartum tubal ligation, and Lactational Amenorrhea Method (LAM) counseling. IUDs are ideal for the postpartum period, since PPIUDs are the only long-acting, reversible method that does not interfere with breastfeeding, and that can be provided before the woman leaves the birthing facility. PPIUDs can be provided post-placentally (within 10 minutes after expulsion of the placenta), immediately postpartum (< 48 hours after delivery), during cesarean section, or four or more weeks postpartum.

From discussions with key stakeholders, the best complement for their ongoing work is to focus on building national capacity and technical leadership (champions) for PPFPP/PPIUD services, as well as training capacity, so these services can then be expanded. To address this need, MCHIP supported the DOH in working with training hospitals, service delivery sites, FP consortia, MNCH stakeholders and professional associations to develop service delivery and training sites and in strengthening commitment among providers for PPFPP integration with MNCH services.

Objective 3: To increase access to lifesaving maternal and newborn care interventions, especially Kangaroo Mother Care for the management of low birth weight newborns. The Kangaroo Mother Care (KMC) intervention has been scientifically proven through systematic researches and evaluation to be a life-saving technique of care for

preterm and/or low birth weight newborns in the Philippines and in many parts of the world. It is presently an intervention of choice in select health facilities through the collaborative efforts of non-government organizations. The recently-completed USAID/Maternal and Newborn Health Integrated Program (MCHIP) and WHO Multi-country Assessment of KMC in Asia, categorized the Philippines to be in the early stage of KMC implementation. In pursuit of the KMC advocacy agenda, further steps need to be taken to scale-up the country's KMC implementation in order to facilitate the achievement of MDG 4 (decreasing under-five mortality) in the Philippines.

In August 2013, a consultative workshop was held at the national level to develop action plans to implement the interventions for improving newborn survival. In addition to basic newborn care, life-saving interventions such as KMC and resuscitation were prioritized for implementation at scale. Although the initiation of KMC and appropriate neonatal resuscitation are included in the Essential Intrapartum and Newborn Care (EINC) protocol and guidelines, training for KMC implementation and program management is not included. The KMC Philippines Foundation, based in Manila, has the expertise to provide technical support to roll out KMC with support from the DOH and other key stakeholders. MCHIP collaborated with the DOH, KMC Philippines Foundation and WHO in order to advocate for KMC and plan for KMC roll out in the country.

The interventions and coverage by objectives are listed below:

Objective 1: To increase access to long-acting and permanent methods (LAPM) of family planning in the postpartum period through advocacy. The major intervention under this objective is to develop an advocacy toolkit for PPFPP/PPIUD that repositions the IUD and other LAPM as part of the range of PPFPP options that can be offered to women during the continuum of antenatal, labor & delivery, and postnatal care. Because of the decentralized nature of the Philippines health system, as well as renewed momentum for family planning with the passage into law (and expected implementation) of the Responsible Parenthood and Reproductive Health Act of 2012, dedicated advocacy materials are needed to encourage nationwide PPFPP scale-up, explaining the evidence in favor of PPIUDs and other LAPM to multiple audiences and describing effective and integrated PPFPP programming strategies for local health officials to adopt.

Objective 2: To develop comprehensive resources for the service delivery and training of PPFPP/PPIUD services. The major interventions of national scope under this objective are as follows:

- Develop Centers of Excellence (COE) for PPFPP/PPIUD. The PPFPP/PPIUD COE are defined as DOH retained hospitals that can serve as service delivery sites as well as training sites for PPFPP/PPIUD. For the COE 10 target hospitals were selected from across the Philippines representing the three regions of Visayas, Luzon, and Mindanao. To support the COE structure MCHIP also planned to facilitate the development of PPFPP/PPIUD job aids for providers and supportive supervision guidelines for supervisors such as trainers or regional health office (RHO) personnel to supervise PPFPP/PPIUD clinical skills and services.
- Provide technical assistance and resources for the expansion of PPFPP/PPIUD. In addition to the development of COE, MCHIP intends to support scale up of PPFPP/PPIUD in the Philippines by: 1) providing technical assistance to the regional projects on PPFPP/PPIUD training and capacity building in their respective regions of Luzon, Visayas, and Mindanao; 2) developing a replication 'how to' guideline to document the best practices on becoming a PPFPP/PPIUD COE; and 3) leading a

contraceptive technology update roadshow to bring awareness on the latest FP methods in the Philippines targeting service providers, government officials, program managers, and other stakeholders.

- Collect evidence for supporting PPFPP/PPIUD in the Philippines. MCHIP intends to collect evidence for supporting PPFPP/PPIUD in the Philippines through: 1) assessment of clients' satisfaction with PPIUD as their chosen FP method just after insertion and 6 weeks after insertion through a PPFPP/PPIUD assessment study; 2) review the documentation of the IUD services at Dr. Jose Fabella Memorial Hospital over the past 20 years; and 3) review the service delivery data to compare the PPFPP uptake in the MCHIP-nominated COE to understand if the introduction of PPFPP/PPIUD services in these sites has changed the PPFPP uptake beyond PPIUD.

Objective 3: To increase access to lifesaving maternal and newborn care interventions, especially Kangaroo Mother Care for the management of low birth weight newborns. MCHIP is promoting Kangaroo Mother Care (KMC) for low birth weight (LBW) newborns. The Philippines has the highest burden of LBW in the region. However, it has also pioneered KMC, an intervention that has been proven to save newborn lives as well as improve the quality of life of surviving premature, LBW infants. MCHIP has been working with the KMC Philippines Foundation to adopt KMC in two tertiary care health facilities as well as conduct the first national forum on KMC to mobilize commitments from stakeholders.

The major implementation strategies and interventions under this objective are as follows:

- Increase advocacy and raise awareness on the importance of Kangaroo Mother Care (KMC) in the Philippines. MCHIP, in coordination with the KMC Philippines Foundation, the DOH, and other development partners, will hold a National KMC Forum to advocate and engage regional projects on KMC and develop an action plan for implementation at the national and regional levels. Additionally, MCHIP, the KMC Philippines Foundation and the DOH will collaborate on the development of a KMC advocacy briefer and national action plan to prioritize and integrate KMC into health facilities within the Philippines.
- Provide technical support to establish KMC in two tertiary hospitals. MCHIP will work with the University of the Philippines, Philippine General Hospital in Manila and St. Luke's Medical Center in Quezon City to adopt KMC services. This will include training on KMC for relevant staff at each facility as well as basic refurbishment of supplies and equipment for implementing KMC. Lessons learned from the trainings and implementation will be documented and shared with other partners and the DOH for institutionalization and scaling up.

The National Demographic Health Survey (NDHS) reports that as of 2008, 40 percent of postpartum women who wanted to space or limit their pregnancy for the next two years were not using any FP method. The major reason for this was the lack of access to long-acting or permanent methods, including immediate post-partum IUD, during the postpartum period. MCHIP's major strategy in the Philippines is to generate awareness on the postpartum period as an important opportunity to introduce life-saving FP services to women and families, as well as a viable strategy to reduce the unmet need for FP services through the introduction of PPFPP/PPIUD services.

MCHIP's major intervention to achieve this strategy is to develop 10 COE for PFP/PPIUD. These COE are envisioned to serve as model delivery sites that: (1) provide quality PFP-PPIUD services to postpartum women, (2) train PFP-PPIUD service providers and clinical trainers, and (3) initiate adoption and scale-up of PFP-PPIUD services in their respective regions or localities. As of June 2014, PFP-PPIUD services have been integrated into relevant MCH services of 8 of these 10 hospitals, with one additional hospital that has fulfilled most COE criteria but that experienced a setback of services after Typhoon Yolanda struck in November 2013. From July 2012 to June 2014, a total of 8,273 women received PPIUD insertions at one of the Centers of Excellence. In addition to the development of COE, MCHIP is also providing technical assistance to regional projects and other stakeholders to expand PFP/PPIUD awareness and services, as well as establishing evidence for best practices.

Major Accomplishments

Major accomplishments by objectives are listed below:

Objective 1: To increase access to long-acting and permanent methods (LAPM) of family planning in the postpartum period through advocacy.

1. *Advocacy toolkit package.* MCHIP developed an advocacy toolkit package comprised of a Philippines 2008 DHS reanalysis for PPFPP in brief and presentation formats. The DHS reanalysis, entitled “FP needs during the first two years postpartum in the Philippines,” summarizes key findings related to birth and pregnancy spacing, fertility return, unmet need for and use of FP, and contact with key services for women during the period from the last birth through two years postpartum. The presentation includes facilitator notes. The purpose of this advocacy toolkit is to serve as a job aid for PPFPP/PPIUD advocacy with political leaders, clinical providers, and program managers to reposition the IUD and other LAPM as part of the range of PPFPP options that can be offered to women during the continuum of antenatal, labor & delivery, and postnatal care. The toolkit’s key messages highlight the appropriateness of PPFPP/PPIUD for postpartum mothers; with increased use of PPFPP/PPIUD, new mothers are more likely to achieve healthy birth intervals.

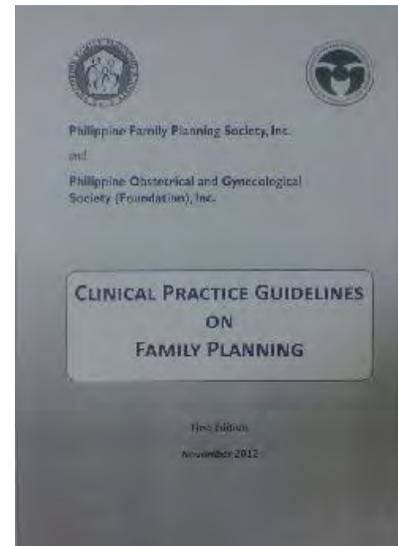
The first two components of the toolkit were developed using the data from the 2008 Philippines DHS with funding and technical assistance from MCHIP core funds. The extended PP here was defined as 0-23 months post-delivery. Hence, the analysis is based on the sub-sample of ever-married women aged 15-49 who gave birth in the last 23 months. The sample size (weighted) was total women 15-49 = 13,671 and Postpartum women (0-23 months) = 2,423.

Key messages from the toolkit are as follows:

- Half (50%) of all non-first births in the Philippines are spaced at less than the recommended 24-month birth-to-pregnancy interval, putting women and their infants at increased risk for poor maternal and perinatal outcomes. This analysis demonstrates that women in the Philippines have a significant unmet need for FP during the two years after a birth. Even though total unmet need decreases during this period (from 72% to 40%), the overall unmet need is still high.
- In the Philippines, risk of pregnancy peaks in the second half of the first year postpartum. While only 41 percent of sexually active women are at risk of pregnancy during the first six months postpartum, this risk increases to 65 percent among women 6–11 months postpartum, and then decreases slightly to 61 percent among women 12–23 months postpartum. Method mix in the Philippines relies heavily on traditional and short-term methods, with the majority of women relying on the pill (32%) and only 13 percent using long-acting or permanent methods (IUDs and female sterilization). However, the need to limit births is still high for postpartum women (42% among women 0–5 months postpartum and 25% among women 12–23 months postpartum), demonstrating the need for increased access to long-acting and permanent methods of FP, which are highly effective methods for women to achieve their desired pregnancy spacing/limiting needs.

- Perhaps reflective of access to services, women who deliver at home are much less likely to use a modern FP method than those who deliver in a health facility (25% and 36% respectively). With over half (56%) of all births in the Philippines occurring at home, these findings demonstrate the need for increased community-based services in rural settings. Program evidence indicates that offering postpartum family planning (PPFP) counseling during antenatal care and offering PPFP services during all maternal and child health contacts, can be effective for increasing awareness of, demand for and use of FP in this critical period.

2. *Clinical Practice Guidelines on Family Planning.* MCHIP facilitated the inclusion of PPIUD in the Clinical Practice Guidelines on Family Planning allowing providers to add another choice in the FP method mix. MCHIP worked with the DOH to include information on the PPIUD in the first edition of the Clinical Practice Guidelines on Family Planning published by the Philippine Family Planning Society, Inc. and the Philippine Obstetrical and Gynecological Society (Foundation), Inc. In Section 5 of said publication, proper IUD insertion during the postpartum period is recommended as a safe and effective contraceptive method. In addition, PPIUD is now included in the CPG on Cesarean Section, which was drafted by Dr. Marinduque in the section on Contraception. The technique of Transcesarean IUD insertion was included in the article. Inclusion of PPIUD in the CPG has the imprimatur of the DOH, making the method official in a sense. It allays the fears of some obstetrician-gynecologists that this method is not acceptable in the Philippines, which may increase the likelihood that providers will counsel patients on their FP options leading up to and during the postpartum period. The inclusion of PPIUD in the Clinical Practice Guidelines on Family Planning will allow for the integration of PPFP/PPIUD within all DOH-supported MNH/FP programs.



3. *PPFP supplement to the Philippines clinical standard manual on FP.* MCHIP finalized a service delivery manual for PPFP/PPIUD to supplement the current Philippine Clinical Standards Manual on Family Planning. The supplement was written by Dr. Marinduque and submitted to a Technical Working Group convened by the DOH, in order to encourage DOH ownership of the supplement. It was approved and endorsed by the DOH. The supplement is expected to aide FP service providers with updated information on PPFP technologies, strengthen the adaptation and scale-up of PPFP-PPIUD services in health facilities, and increase stake holder buy-in among the cadre of FP service providers.



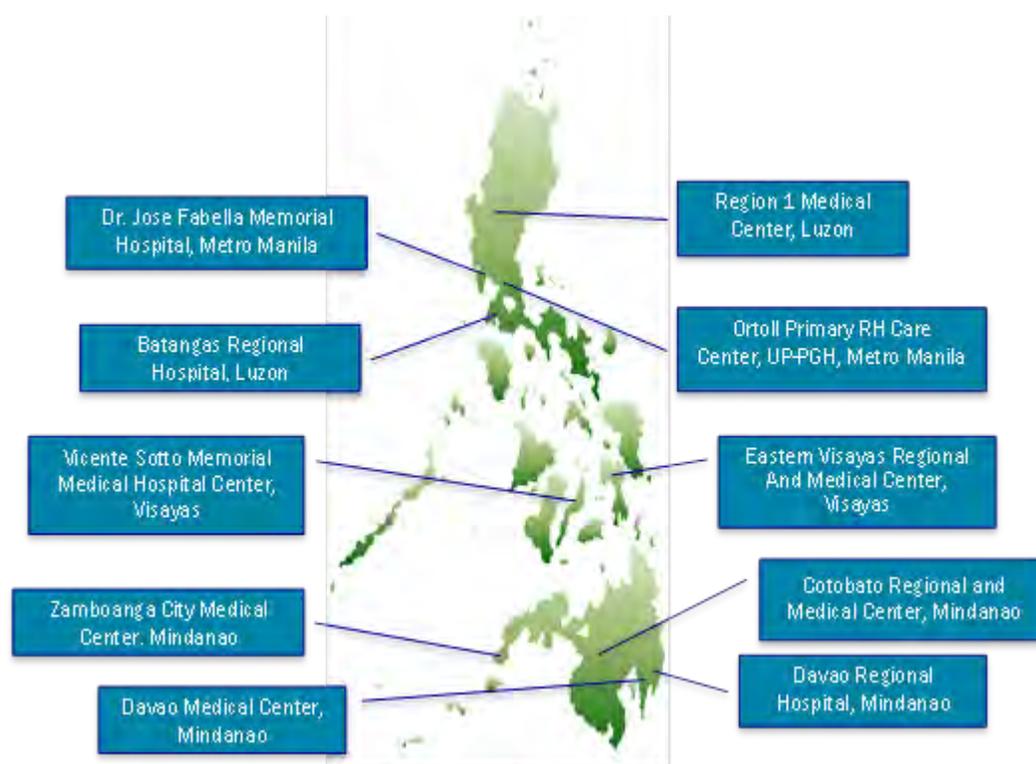
Objective 2: To develop comprehensive resources for the service delivery and training of PFP/PPIUD services.

Major accomplishments by interventions are as follows:

A. Develop COE for PFP/PPIUD.

MCHIP defines a center of excellence as a facility that:

- Has the training capacity or team of trainers for PFP/PPIUD and ability to conduct Supportive Supervision in collaboration with the RHO.
- Has all the components for PFP/PPIUD service delivery in place, including policy, counseling, services, support and follow-up.
- When feasible, the site is attached to a birthing unit that allows the trainees to get hands-on practicum experience.



Ten facilities were selected as the candidates for PFP/PPIUD COE (see figure above). Eight of the 10 pre-selected facilities are level 3 and 4 regional facilities, otherwise known as DOH-retained. For these DOH-retained hospitals, major funding comes from DOH Central Office, with the regional office providing technical monitoring, support and supervision. With the exception of Fabella and Ortol, the catchment areas of the 8 facilities cover the provinces within the regions where these facilities are providing coverage to a total of 31 provinces. The steps for the development of COE are as follows:

1. *Clinical skills training for PPFPP/PPIUD.* The goals of the clinical skills training are to: i) support the development of a core team of subject matter experts in PPFPP/PPIUD; ii) standardize the knowledge, skills, and attitudes of participants in the provision of safe and effective postpartum IUD services; and iii) prepare participants to start and sustain PPFPP/PPIUD at their workplaces.

Key areas covered during the training include: i) counseling women/ couples about PPFPP and PPIUD as a contraceptive method; ii) screening women to ensure that they do not have any characteristics or conditions that would make IUD an unsuitable option for them; iii) inserting the IUD in different postpartum scenarios, while incorporating appropriate infection prevention practices; iv) managing side effects and other potential problems associated with the use of IUDs; v) developing champions for PPFPP/PPIUD; and vi) facilitating start-up and sustaining PPFPP/PPIUD services at the participants' workplaces.



The training course is a competency-based course using various participatory training methodologies, such as illustrated lecture and group discussion, group exercises, role plays, case studies, demonstrations, practice on models, games, quizzes, and question and answer sessions. MCHIP developed the training capacity of the facilities to initiate PPIUD services and to eventually be developed as training resource centers.

DATES	NUMBER OF ATTENDEES	VENUE
August 6-9, 2012	18 (doctors, nurses, and midwives) representing all of MCHIP nominated sites.	Manila
January 28-31, 2013	33 (doctors, nurses, and midwives), non-MCHIP sites	Manila/Davao
May 21-23, 2014	15 (doctors and nurses) no MCHIP site	Manila

2. *Set up PPFPP/PPIUD services.* Immediately upon returning to their facilities the providers were engaged in initiating services at their respective sites with support from MCHIP and their hospital administration and management. Once the providers have attended the clinical skills course, if not certified during the clinical skills course, their first priority is to practice and get certified as a clinical provider. The certification was done during supportive supervision visits from MCHIP.

To set up services, the providers, in collaboration with the hospital management, were tasked with facilitating: i) awareness of PPFPP/PPIUD by organizing whole site orientation; ii) availability of instruments and supplies for PPFPP; iii) organization of integrated services throughout the continuum of care including adherence to infection prevention protocols; iv) the establishment of a reporting and recording system for

PPFP/PPIUD; and v) scheduling and arranging supportive supervision sessions to monitor the PPFP-PPIUD program using a performance indicator checklist.

3. *Supportive Supervision visits to the sites.* All sites received supportive supervision visits from MCHIP. The supportive supervision visits focused on evaluation of: i) health worker competence in PPFP counseling and service provision; ii) provider competence in PPIUD insertion; iii) adherence to infection prevention protocols; iv) adherence to principles of ICV; v) adherence to recording and reporting guidelines; and vi) use of FP Form 1. The supportive supervision visits also reviewed M&E data to set goals and objectives. MCHIP conducted the following supportive supervision visits:

DATES	SITES	MAJOR FINDINGS
October 18-20, 2012	Zamboanga City Medical Center	Need to build capacity of ZCMC so that they can be resource for training in the region.
October 23-25, 2012	Cotabato Regional and Medical Center	Need to build capacity of CRMC so that they can be resource for training in the region.
November 16, 2012	Dr. J. Fabella Hospital	Observed that PPIUD services integration in Fabella was not being pushed at that time.
November 19-20, 2012	Region 1 Medical Center	In this case, a major finding was the need to get buy-in from the Department of Ob-Gyn for full implementation of PPFP/PPIUD.
November 21, 2012	Batangas Medical Center	In this case, a major finding was the need to get buy in from the Department of Ob-Gyn for full implementation of PPFP/PPIUD.
December 3-5, 2012	Zamboanga City Medical Center	Supervisors need to spend more time observing trained providers do the insertion. PPIUD insertion using the kelly placental forceps is nil.
January 27-31, 2013	Davao Medical Center	The SS visit looked into preparedness of the SPMC as a training center and to serve as the practicum site for the PPIUD training. Previously trained providers were qualified as PPIUD providers during the visit and additional providers were identified for PPIUD training to expand the pool of service providers in SPMC.
January 28-31, 2013	Region 1 Medical Center	Basically, the visit allowed the team to see how R1MC has integrated the service in the facility. The medical residents were able to participate in the training and eventually become service providers for

		PPIUD as well.
February 1, 2013	Davao Regional Hospital	For this visit, Dr. Kusum observed actual PPIUD insertion of the trained providers for qualification purposes.
February 11, 2013	Dr. J. Fabella Hospital	This visit is made to observe PPIUD skills provision of the trained providers and found the provider satisfactory in terms of service provision.
February 25-27, 2013	Zamboanga City Medical Center	Confidence level of trained providers was low until the MCHIP conducted the SS visit. MCHIP was able to qualify the trained providers in PPFPP/PPIUD services. They also received a Zoe anatomical model, which they and their residents can use for PPIUD insertion practice.
March 11-12, 2013	Cotabato Regional and Medical Center	MCHIP visit supported CRMC in their launching of PPFPP/PPIUD during Buntis Day.
April 8, 2013	Batangas Medical Center	MCHIP, led by Dr. Marinduque, observed BatMC trained providers as to how they mentor residents and consultants in completing PPIUD-based clinical checklists
May 6, 2013	Vicente Sotto Memorial Medical Center	Dr. Marinduque advocated among Department of Ob-Gyn consultants and residents for PPIUD inclusion. Also made observation on the clinical skills of residents to perform PPIUD insertion.
June 18-19, 2013	Eastern Visayas Memorial Medical Center	Dr. Marinduque observed trained providers' compliance to clinical standards and deemed them compliant. They also shared their past challenges as to why they were not able to fully implement PPFPP/PPIUD services, particularly before the RH Bill passed. Dr. Marinduque oriented the Ob-Gyn Department and encouraged them to undergo the training on PPFPP/PPIUD. This is also where VisayasHealth and MCHIP started collaborating in assistance to EVRMC.
July 30-31, 2013	Region 1 Medical Center	The challenge for R1MC is to generate more clients. Ward nurses were asked to participate as Dr. Marinduque gave an orientation on PPFPP/PPIUD. The nurses were encouraged to do counselling during antenatal visits, early labor and during the postpartum period. MCHIP also assisted DOH in

		bringing in donated equipment such as kelly placental forceps and Zoe models. However, it was discovered that the four Zoe models were without postpartum uterus. This message was relayed to DOH. Currently, R1MC has one Zoe model with postpartum uterus and MCHIP can provide the additional to ensure that during trainings R1MC will have ample models to be used for practice.
Aug 28-29, 2013	Vicente Sotto Memorial Medical Center	This visit was mainly supportive supervision to observe the training capacity of Dr. Marybeth Delos Santos and Dr. Cherry Pangilinan in conducting a Training of Trainers on PPFPP/PPIUD.
Sep 19, 2013	Batangas Medical Center	This SS visit was focused on ICV compliance monitoring, due to high numbers of PPIUD insertions being asserted as potential vulnerability in ICV. During the visit, MCHIP team explained the importance of compliance to ICV principles. The next step for the team is to conduct an ICV orientation for the service providers for them to be aware of the principles and comply with them.

All the SS visits have benefited the COE and the program. Two cases in point: Zamboanga began to have an output of PPIUD service only after the first SS visit was completed. Prior to the SS, the two trained service providers did not have the confidence to offer the PPIUD. After the SS, when providers had a chance to perform insertions on actual clients supervised by the SS team and a department wide orientation was completed, the Zamboanga team started to report significant increases in the number of serviced clients. The boosted confidence of the Zamboanga team was likely facilitated by the extra practicum offered during the SS visit. The same happened with the EVRMC team.

4. *Training of Trainers.* The Training of Trainers prepares competent clinical trainers to conduct competency based clinical skills courses for service providers of PPFPP/PPIUD. The Training of Trainers for PPFPP/PPIUD was delivered in three phases: i) Jhpiego's ModCal for training skills, delivered through self-paced computer course; ii) a four-day group based session; and iii) a mentored practicum at one of the hospitals or facilities where the participants are trained to manage a clinical skills training course for service providers. The selected candidates for training of trainers were competent PPFPP/PPIUD service providers from MCHIP COE and had at least completed the Family Planning Competency Based Training series, a standard comprehensive family planning course for providers in the Philippines. MCHIP developed 69 trainers for PPFPP/PPIUD through Training of Trainers.

5. *Supportive Supervision Workshop.* The purpose of the Supportive Supervision (SS) workshop was to provide the supervisors guidelines and tools for conducting post-training and on-going supportive supervision visits to PFP/PPIUD facilities. The workshop had two equally important components: i) training in supportive supervision; and ii) exposure to PFP/PPIUD. The challenge to overcome was how to integrate these two components such that the supervisors are able to conduct SS competently and with authority. The supervisors' workshop was targeted mainly for the DOH regional office personnel, who are ultimately responsible for providing supervision and oversight to the hospitals.

SS guidelines developed by MCHIP were also introduced through this supportive supervision workshop. The guidelines encourage supervisors to observe and assess counseling, infection prevention practices, provider competency and motivation, and record keeping. Guidance on logistical pieces such as timing, personnel responsible, preparation, and organization of the visit is also included. The tools available in the guidelines are as follows: i) Outline, agenda, and schedule for supportive supervision workshop; ii) Steps on processing instruments and other items used in PFP/PPIUD services; iii) Action plan template for strengthening PFP/PPIUD services; iv) Certification sample; v) Course evaluation sample for supportive supervision; vi) Supportive supervision checklist for PFP/PPIUD service provision; vii) Supportive supervision tracking sheet; and viii) Supportive Supervision activity checklist.

6. *Assessments.* The PFP/PPIUD standard for service provision was introduced to the MCHIP COE during the first clinical service training for PFP/PPIUD in Manila. The sites scored themselves based on their performance relative to the standard, which was considered the baseline. A midline assessment was conducted in August 2013 with broad objectives of: i) sharing experiences, learning, challenges and best practices of the different sites; ii) validating data and accomplishments; iii) linking up sites to the USAID regional projects; and iv) identifying the next steps that will ensure the PFP/PPIUD program is sustained for the longer term.

Each of the COE has developed best practices in setting up PFP/PPIUD services based on counseling and service provision, organization/management, training, and advocacy. Some examples of these best practices are:

- *Region 1 Medical Center* has two trained providers available 24/7. PFP/PPIUD services are services made available at several client touch points: ANC at OB OPD and FP Unit, ER and Admitting section, delivery room complex: labor room and delivery ward, and in the obstetric care ward
- *Batangas Medical Center* is the first team to have established a supportive relationship with hospital administration early on. Now, the hospital administration encourages the team to hold trainings and to open its doors to individuals and organizations interested in training.
- *Dr. Jose Fabella Memorial Hospital* has integrated PPIUD in the FPCBT2 training. This is more of an orientation to PFP/PPIUD than a complete training but it serves to generate interest in the method.
- *Vicente Sotto Memorial Medical Center* has formed a strong partnership with DOH regional office and is already conducting independent PFP/PPIUD trainings.

- *Eastern Visayas Medical Center* has begun engaging the residency program in training for PPFPP/PPIUD.
- *Southern Philippines Medical Center* established a FP Unit Clinic within the medical center.
- *Davao Regional Hospital* has included post-PPIUD care instructions on their patients' discharge forms.
- *Cotabato Regional Medical Center* has developed a close relationship with the DOH who help support their training needs.
- *Zamboanga City Medical Center* providers are taking advantage of the ultrasound procedure as another opportunity to counsel patients in PPFPP.

Common challenges faced by 10 COE candidates are: (1) improving the number post-insertion follow-up visits, (2) improving counseling in ANC; and (3) enforcing consistent and accurate documentation and recording of information on counseling and PPIUD insertions. Action plans were developed for the identified gaps with support from MCHIP, DOH, CHD, and others. Another common challenge that COE are dealing with is a high number of requests from regional projects for trainings. The trainers from the COE are government employees and many are also in private practice. The added burden of training takes times from their practices and may weaken their motivation to continue to support the program.

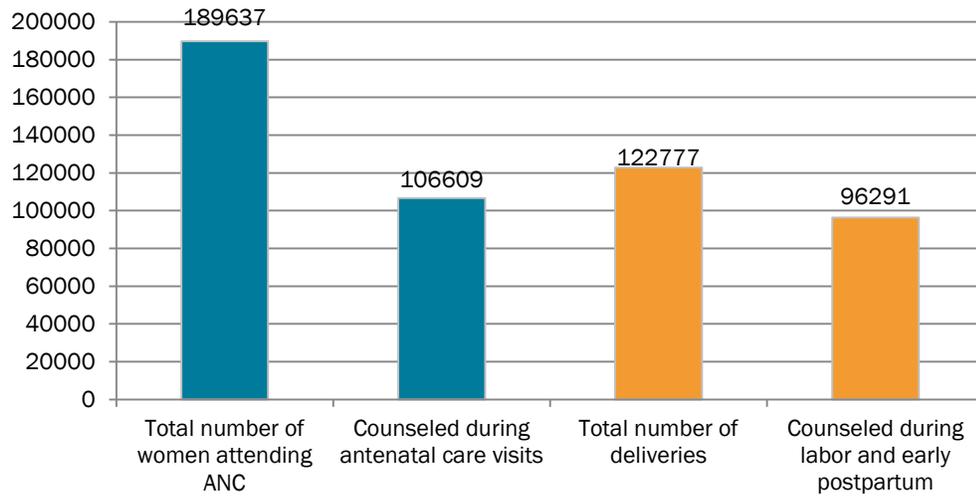
Recommendations for USAID and regional projects to address challenges:

- Strengthen SDN by making the COE the focal point of reference so that facilities at the health center level can easily retrieve patient information from and communicate with COE
- Improve quality of counseling- review and update content and method of counseling; assign a dedicated counselor for PPFPP
- Introduced Balanced Counseling
- Advocate for the consistent use of new FP form 1 (that includes PPFPP), not just for FP acceptors but also for those counseled on FP
- Tap the existing COE for PPFPP/PPIUD trainers, not just the regional project trainers
- If possible, scale up replication of COE in other regions

7. Results

- Opportunities for PPFPP Counseling
 - A total of 189,637 pregnant women visited for antenatal services in these 10 facilities (*please refer to Annex 5 for the complete summary data table presented during the endline assessment workshop*).
 - A total of 112,777 deliveries were reported for the period of July 2012 – June 2014.

Figure 2: Number of women counseled on PPF/PPIUD by type of visit, July 2012 - June 2014



- More than half (56%) of women visiting for ANC services have been counseled.
- Nearly eighty percent (78.4%) of those in early labor and postpartum women were counseled on PPF.
- This shows that ideally integration of PPF counseling is done at all points of contact with the client. There appears to be quite a number of women who have not been counseled

B. Provide technical assistance and resources for the expansion of PPF/PPIUD.

1. *Technical assistance to the regional projects.* MCHIP is the lead agency in-country providing technical assistance for the expansion of PPF/PPIUD to regional projects, DOH, professional organizations, and other stakeholders. In this capacity MCHIP provides technical oversight during training of clinical providers, training of trainers, and conducts joint supportive supervision in collaboration with the regional projects. The regional projects still seek MCHIP assistance in initiating and conducting training for service delivery and TOTs. Although the regional projects already have conducted clinical skills training for service providers on their own, they are still not confident in mounting TOTs and SS is still not routinely performed. For LuzonHealth, the project still needed to have MCHIP directly participate in the clinical skills training they initiated because there is a gap in follow-up SS due to them not having an in-house trainer. All regional projects will still have to better integrate SS into their training and do this on a regular basis.
2. *Replication 'how to' guidelines to document the best practices towards establishing a service delivery program.* MCHIP developed 'how to' replication guidelines that will give institutions a roadmap to establish a service delivery program. These guidelines outline the processes, best practices and challenges in setting up a PPF/PPIUD program in health facilities. The guidelines also outline the rationale and need for PPF/PPIUD in

the Philippines and policy considerations for a successful PFP/PPIUD national program. Steps to complete a needs assessment on local capacity are also outlined in the guidelines.

The COE model is targeted for expansion to other regions of the Philippines through USAID's regional projects. The guidelines will provide a pathway for other programs, agencies, and DOH to facilitate the expansion of the COE model.

Family Planning: State of the Art (FP SOTA) forum. With the Responsible Parenthood and Reproductive Health Act of 2012 in place, which greatly expands access to contraceptive methods and sexual education, this is the opportune time to bring practitioners up to speed with updates in contraceptive technology and hone their skills in contraceptive procedures. The goal of the FP SOTA forum, held in March 2014, was to highlight practical approaches to maximize effectiveness and satisfaction of contraceptive use, generate interest in PPIUD and other LAPM, and to underscore the importance of integrating FP into MNCH care. The forum, which brought together nearly 600 FP service providers from across the Philippines, kicked off at the Hyatt Regency Hotel in Manila. MCHIP organized the event in cooperation with the country's Department of Health (DOH), and USAID's Luzon, Visayas and Mindanao Health Projects. The forum was a timely response to the escalating demand for visibility and integration of FP services in primary and reproductive health care in the country, as corroborated by the high turnout and keen feedback of attendees in all three legs.

These three one-day knowledge sharing and discussion events—mounted consecutively over the period of one week in Manila, Cebu and Davao—were eagerly received both by service providers and program managers who generously lent their time, participation and valuable inputs during the sessions. The forums provided a much needed platform for international and local FP experts and advocates to discuss the most urgent FP issues facing the country. With special focus on high impact practices and FP solutions, the forum testifies to MCHIP's objective of creating an enabling environment for adoption and integration of FP in national health programs. This event catalyzed the desire of many health care providers, program managers, and advocates to improve the quality of services they offer by empowering themselves with updated knowledge and approaches in FP.

C. Collect evidence for PFP/PPIUD practice in the Philippines.

1. *PFP/PPIUD Assessment.* MCHIP Philippines has facilitated the development of PFP/PPIUD service delivery model at the nominated hospitals. While intervention facilities have tracked the number of PPIUD insertions, information related to follow-up findings by providers, provider experience, and client experience are not available. Therefore, a follow-up study of PPIUD acceptors is needed to study their satisfaction levels and problems using the method. The results of this study will inform the Government of Philippines about the experience of the project in the country and provide guidance for further scaling up of the PPIUD program in the Philippines. The findings of the study will also be useful to generate recommendations to improve the quality of services as well as to help develop feasible PPIUD strategies for service delivery in similar settings as the availability of this service expands. In addition, results from this study may also potentially be used to better define appropriate behavior change communication (BCC) strategies for demand generation for this type of intervention. The

PPFP/PPIUD Assessment study was initiated in April 2014 and will end in September 2014.

Study Objectives

The main evaluation question is to explore and describe PPIUD client and provider experiences across multiple study sites. More specifically, the objectives of this study are:

- To assess the clients' satisfaction with PPIUD as an FP method just after insertion and after 6 weeks of insertion. This is the primary objective of the study.
- To understand the demographic profile of clients accepting PPIUD
- To measure the incidence of problems/complications among clients who received a PPIUD (infection, heavy and/or irregular bleeding, missing strings, expulsion; reasons and rates of removal and other problems, if any) at 6 weeks (or later).
- To understand the role of counseling for PPFP/PPIUD services

Methods

This is primarily an observational follow-up study of PPIUD acceptors, with data being collected after PPIUD insertion (but before the acceptor leaves the health facility) and then again at 6 weeks of follow-up. In addition, a subset of women will be asked to participate in focus group discussions after 6 months of completion of PPIUD. Data will also be collected through a semi-structured interview with providers who have been trained in PPIUD and have had experience in conducting insertions.

Findings will be disseminated to USAID upon completion of the study.

2. *Descriptive Analysis of PPIUD Insertions at Fabella Maternity Hospital in Manila, Philippines.* Dr. Jose Fabella Memorial Hospital's (DJFMH) has been a nationally and internationally recognized training service and research facility providing experience, expertise and technical assistance to health workers and institutions involved in family planning. Fabella's Family Planning Unit has been providing IUD services since 1970 and postpartum IUD (PP IUD) insertions for the past 20 years. Since inception of Fabella's IUD program, over 360,000 interval and postpartum IUDs have been inserted at DJFMH's Family Planning Unit. This occurs within 48 hours of delivery and services are provided by doctors, residents, nurses and midwives.

DJFMH provides a potentially rich data source for describing and gaining a better understanding of PPIUD user characteristics and outcomes. MCHIP therefore conducted data abstraction and analysis of retrospective data using individual client records from 1990 – 2012 for all women who received PPIUD insertions.

The overall objectives of this study are to:

- Describe user characteristics for women obtaining PPIUD services including age, parity, and follow up visits
- Describe characteristics of insertion and outcomes such as method of insertion, perforations, expulsions, removals, infections, pregnancies with IUD, and visible threads.

Data was abstracted from historical individual client records maintained in the Family Planning Unit of Dr. Jose Fabella Memorial Hospital. This data is not available to the public but is owned by the hospital. Dr. Jose Fabella Memorial Hospital has given

Jhpiego/MCHIP permission to access and analyze the data. All analyses were done on the aggregate level using the outputs of the data abstraction tool. Frequencies and rates were calculated for the variables under investigation.

Findings

Profile of the Sampled PPIUD Clients from 1990-2012 in DJFMH:

- Majority (99.2%) had postpartum instrumental IUD insertion while the remaining proportion is post abortion.
- Seventy-eight percent of these women are between ages 20-35, within the peak of their reproductive years. Those who opted to plan their next pregnancy using PPIUD are those women with 2 to 4 children. Most of these women delivered their last child in full term prior IUD insertion.

Follow-up visits

Six out of ten women return for their follow up visit after PPIUD insertion. 82.5% returned to the facility within six weeks after the insertion.

Outcomes after insertion

- No perforation and pregnancy after PPIUD insertion were reported.
- Expulsion rate is at 6.2% amongst those who had reported expulsion of their IUD. For four out of 10 of these women, IUD expulsion is reported less than six weeks after insertion.
- Removal rate of IUDs is at 11.7%. Reasons for removals are partial expulsion and wanting to have another child. For those with partial expulsion, a little over three fourth have their IUD reinserted. As for those who decided to have their IUD removed, the computed average years of IUD used is 7.2 years. This is even longer than the WHO recommended period for healthy spacing of pregnancies.
- Infection rate is at 5.1% for clients who returned for follow up visit. Infection is reported more than 20 days after insertion.
- For those clients who went for follow up, majority (93.8%) had visible threads. Among those with visible strings, these were seen when they came back before the sixth week.

Objective 3: Increase access to lifesaving maternal and newborn care interventions, especially Kangaroo Mother Care for the management of low birth weight newborns

A. Increase advocacy and raise awareness on the importance of KMC

1. *Conduct KMC Coordinators' Meeting with key stakeholders.* The KMC Philippines Foundation, on behalf of MCHIP and in collaboration with the DOH and other development partners, conducted the First KMC Coordinators' Meeting on January 28, 2014 in Quezon City. The meeting served as a discussion of the experiences from KMC implementation (success and challenges) in the two newly-engaged KMC facilities,

Philippine General Hospital and St. Luke's Hospital, together with representatives from seven existing KMC facilities in the country.

2. *Develop KMC Advocacy Paper.* MCHIP, in collaboration with the KMC Philippines Foundation, developed an advocacy paper entitled, "Kangaroo Mother Care Saves Newborns", to advocate for the benefits of KMC as an intervention in preventing newborn deaths in the Philippines as well as promote the scale up of KMC implementation across all health facilities. The paper was disseminated at the "A Promise Renewed" meeting in Manila in April 2014 and is also available on the mchip.net website here:
http://www.mchip.net/sites/default/files/KMC%20advocacy%20paper_Philippines_0.pdf
3. *Conduct National KMC Forum.* In order to have a broader reach, the originally proposed National KMC Forum, was held in conjunction with the "A Promise Renewed" meeting organized by the DOH in collaboration with other development partners in April 2014 in Quezon City. Approximately 340 people attended the two-day meeting. Dr. Socorro De Leon-Mendoza, President of the KMC Philippines Foundation, gave a presentation on the second day of the meeting providing an overview of current KMC implementation in the Philippines as well as calling policy makers to action in promoting the scale up of KMC within the country. Additionally, a KMC consultative workshop was hosted by Dr. De Leon-Mendoza and Dr. Anthony Calibo of the DOH in order to outline specific recommendations for addressing the challenges of KMC implementation in the Philippines as well as receive commitments from policy makers outlining specific actions and milestones for each year. Stakeholders discussed the gaps and recommendations to advance KMC as a priority intervention. Some of the decisions are highlighted below.
 - Infrastructure and financing to support training, implementation, and monitoring and evaluation for sustainability of KMC programs in all health facilities
 - Incorporation of KMC into the "prematurity package" of PhilHealth, which should include support for follow-up visits until the newborn reaches 2500 grams
 - Incorporating the KMC protocol in the routine care of all premature/low birth weight newborns provided by all health care professionals
 - Inclusion of implementing guidelines on the full and standard adoption of Kangaroo Mother Care (KMC) for all low-birth-weight newborns in all facilities in the country in the Policy on Essential Newborn Care (AO 2009-0025)
4. *Inclusion of KMC in the Mother-Baby Friendly Accreditation of facilities.* The Department of Health expressed that KMC and EINC indicators will be included in the Mother-baby Friendly Hospital accreditation checklist which is currently being revised.

B. KMC implementation at two tertiary hospitals

MCHIP identified two health facilities in the metro Manila area to partner with on implementing KMC services; the University of Philippines, Philippine General Hospital (UP-PGH) in Manila and St. Luke's Medical Center in Quezon City.

1. *Selection criteria:*

UP-PGH is the national university hospital and operates the top medical school in the Philippines. The hospital includes an accredited residency program in Pediatrics as well as a fellowship in Neonatology. UP-PGH neonatology fellows oriented in KMC became some of the principal investigators to generate local evidence for the benefits of practicing KMC in the Philippines and their research has gained both national and international recognition. Despite this, the hospital had yet to implement KMC as a standard of care for low birth weight newborns.

St. Luke's Medical Center is a private medical facility that has distinguished itself as a premier health center not only in the Philippines, but in the entire Asian region. Like UP-PGH, they also operate a medical school with a fully-accredited residency program in Pediatrics. Given the status of the medical center, adoption of KMC was thought to be critical in improving the general impression of KMC being a low-income alternative to preventing newborn mortality and morbidity.

2. *Implementation:*

A Memorandum of Understanding (MOU) was signed between the two hospitals and the KMC Philippines Foundation for duration of three years. The KMC programs will be managed by a KMC committee composed of trained KMC core staff authorized by the hospital administrations.

In December 2013, a 5-day training of trainers' workshop was conducted for the core KMC teams of each health facility. A total of 30 medical staff composed of physicians, nurses, midwives and social workers, KMC service providers and program managers were trained on KMC service provision. At the end of the training, each team was provided with a KMC start-up kit that included: one soft, small baby doll, two breast models, two KMC tube blouses, a CD containing all training PowerPoint presentations, KMC documentation forms and a copy of the Clinical Practice Guidelines on KMC. Each hospital team was also tasked with creating an action plan for KMC service and program implementation within their facility, which will serve as a method for evaluating performance during follow up visits conducted by the KMC Philippines Foundation.

3. *Monitoring, evaluation and documentation:*

A thorough process documentation plan was developed to capture the steps for establishing KMC in a facility as well as the opportunities and challenges for sustaining and institutionalizing the practice. The detailed documentation will be available by the close-out of MCHIP. Monitoring and evaluation of the program implementation will be carried out by the KMC Philippines Foundation until the facilities become accredited KMC training centers of excellence. Thereafter, it is expected that the programs will scale up to other facilities within Manila and surrounding districts.

Additionally, the establishment of the KMC program at UP-PGH enabled a research study, conducted by one of the university students on the impacts of KMC in reducing newborn deaths. The key results of the research were presented as a poster at the APR Stakeholders' Forum and a complete manuscript of the research should be available by the end of the program.

Recommendations and Way Forward

One of the major challenges that the MCHIP Philippines team encountered was ensuring that the COE sites were established according to and continuing to meet COE criteria for PPFPP/PPIUD. A COE for PPFPP/PPIUD is clearly defined as a facility endorsed/ pre-selected by DOH that (1) has capacity to provide quality PPFPP/PPIUD service delivery; (2) has capacity to train for PPFPP/PPIUD – minimum requirement of training equipment, training site and trainers; (3) follows guidelines and protocols for PPFPP/PPIUD training, supportive supervision and M&E, in line with DOH standards; (4) can serve as technical resource for PPFPP/PPIUD. In addition to above criteria, a COE has an established link with the regional office of health in terms of the technical component of PPFPP/PPIUD along the line of DOH guidelines and protocols. Ensuring that the sites were following these criteria took a substantial amount of supportive supervision. MCHIP worked to verify the compliance of the sites against COE standards and provided necessary technical assistance during supportive supervision visits.

Two of the COE candidate sites experienced challenges specific to their own facilities. Ortoll Primary Reproductive Health Center decided to shut down due to the administrative issues they were experiencing. Their PPFPP/PPIUD program was therefore transitioned to Philippines General Hospital. A clinical skills training for obstetric residents at Philippines General Hospital was held in May 2014. Eastern Visayas Regional Medical Center in Tacloban was among the facilities hit hard by Typhoon Yolanda in November 2013. Supportive supervision and other planned activities to this site were postponed due to directives from the DOH to temporarily delay all but emergency services. However, despite the devastation caused by the typhoon, the dedicated team at this facility was able to continue the PPFPP/PPIUD service provision component after a brief delay. Even though the typhoon caused a setback in EVRMC's full development as a COE for PPFPP/PPIUD, MCHIP was able to complete an assessment to determine which criteria the facility has met and to what capacity the facility can be utilized and/or further developed. Further development of EVRMC will be completed in close coordination with the Western Visayas Regional Health Office and Visayas Health, for continuity purposes of technical support.

Due to time limitations and the small number of MCHIP staff, it was challenging to provide PPFPP/PPIUD technical assistance to the regional projects as much as it was requested. However, MCHIP worked to ensure that technical assistance was provided equally among the three regional projects and helped the regional projects tap local clinical trainers and expand the available pool of trainers.

Finally, KMC is yet to be routinely practiced in hospital obstetric care units. Orientation on KMC needs to be conducted with the obstetric units (obstetric department chairs, officers, consultants, doctors, and nurses) and KMC needs to be more vigorously promoted in the post-delivery wards. This continues to be an ongoing challenge but can be overcome if hospital leadership and KMC champions continually promote KMC messages and reinforce KMC practices in routine training and supervision.

A MCHIP Close-Out Consultation was held August 7-8, 2014, attended by MCHIP staff, USAID's regional MNCHN/FP projects, and USAID. MCHIP presented on the program's challenges and recommendations for the regional MNCHN/FP projects to pick up activities and move them forward. Documentation of these recommendations can be found in the chart below.

Closeout Consultation

Note: Challenges cannot be disaggregated per facility as the discussion was national in scope.

CHALLENGES	RECOMMENDATIONS
<p>TRAINING</p> <ul style="list-style-type: none"> • Certification of Competency for clinical trainers and master trainers • No Philippine Curriculum on PFP/PPIUD training • Conduct of Supportive Supervision after training • Instruments, materials, training site and equipment dedicated specifically for training 	<ul style="list-style-type: none"> • Conduct more trainings (PPIUD, BTL-MLA, PSI) • Include Supportive Supervision in the program of PPIUD Training for service providers—budget and curriculum • Creation of the manual mandated to the regional project namely MindanaoHealth under the direction of the DOH • Wait for the issuance of the Administrative Order on Training from DOH for the certification
<p>SERVICE DELIVERY</p> <ul style="list-style-type: none"> • Reassignment of trained providers to other units • Lack of PFP Counselors • Lack of appropriate area for counseling • Supply of FP logistics 	<ul style="list-style-type: none"> • Staff augmentation/addition • Whole department training on PFP e.g. Ob-Gyn Department • Maintain/sustain FP commodities • Utilization of the training budget from DOH • Tap the DOH human resource deployment initiative
<p>ADVOCACY AND POLICY</p> <ul style="list-style-type: none"> • No hospital initiated written protocol for PFP training and service delivery in the Centers of Excellence for PFP • Need guidelines for Supportive Supervision 	<ul style="list-style-type: none"> • Strengthen information dissemination activities to increase awareness on PFP • Coordinate with hospital administration to make a standard protocol for FP services • Work closely with DOH-Regional Offices and other development partners to strengthen the PFP-PPIUD program • Dissemination of approved guideline on Supportive Supervision from DOH (awaiting printing)
<p>MONITORING AND EVALUATION</p> <ul style="list-style-type: none"> • No dedicated person for record keeping • Lack of guidelines for the recording and reporting of PFP 	<ul style="list-style-type: none"> • Integrate family planning data with the records section of the hospital
<p>FINANCING</p> <p>PhilHealth to cover PPIUD</p>	<ul style="list-style-type: none"> • Awaiting endorsement from DOH • Advocacy for policy change to expand the coverage for FP in the postpartum period
<p>COLLABORATION WITH STAKEHOLDERS (development partners)</p>	<ul style="list-style-type: none"> • Conduct regular inter agency communication • Maintain an open network among

Lack of coordination between DOH and development partners with regard to implementation of project activities initiated to achieve deliverables	development partners
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Annex 1: Indicator Matrix

PROJECT COMPONENT/ PERFORMANCE INDICATOR	BASELINE VALUE (SOURCE, YEAR)*	END-OF- PROJECT TARGET	TARGET FOR FY 2014	FY 2014 ACCOMPLISHMENT			CUMULATIVE PERFORMANCE	MEANS OF VERIFICATION	REMARKS
				Q1 OCT-DEC 2013	Q2 JAN-MAR 2014	Q3 APR-JUN 2014			
2.1.1: COEs for PFPF/PPIUD established									
Number of COEs for PFPF/PPIUD services	0 (2012)	10	0	8	1	0	9	DOH certification	Of the 10 facilities, PFPF service at Ortoll is no longer feasible due to administrative conflict on its operations during the project implementation.
Number of health facilities/locations/service delivery points/sites that offer integrated PFPF as part of MNCH services†	0	10	0	8	1	0	9	Program reports Accomplished PFPF logbooks at FP clinic (OPD), Delivery Room/ Birthing Clinic at sites	Ortoll is no longer fully operational as a birthing facility. No new service delivery points have been added since MCHIP was geared towards strengthening existing MCHIP supported sites
Number of MCHIP-supported health facilities demonstrating increased compliance with clinical standards over baseline†	0	10	NA	NA	NA	NA	NA	Accomplished self-assessment forms at project midlife and validated by technical advisor using the COE Performance Checklist	Increased compliance will be measured through the end of project review.
Number of trainers developed for PFPF/PPIUD	0	20	10	0	23	46	69	Attendance sheets Program report/ training report	Training of 38 trainers funded by MCHIP, while the rest were financed by other USAID health projects with technical assistance from MCHIP.
Number of supportive supervision visits conducted	0	20	10	0	7	3	28	Program report	
Number of clients accessing essential MNCH services with integrated FP at MCHIP-supported facilities who received FP counseling†	0	120,000	48,000	<ul style="list-style-type: none"> ▪ 12,316 antenatal FP counseling ▪ 9,764 early labor 	<ul style="list-style-type: none"> ▪ 4,395 antenatal FP counseling ▪ 5,934 early labor 	<ul style="list-style-type: none"> ▪ 6,619 ANC ▪ 8,878 EL and PP ▪ 15,497 total accepting FP counseling 	<ul style="list-style-type: none"> ▪ 106,609 antenatal FP counseling ▪ 96,291 early labor and postpartum ▪ 202,900 total accepting 	PFPF logbooks Accomplished MCHIP PFPF monthly reporting forms Program reports	

PROJECT COMPONENT/ PERFORMANCE INDICATOR	BASELINE VALUE (SOURCE, YEAR)*	END-OF- PROJECT TARGET	TARGET FOR FY 2014	FY 2014 ACCOMPLISHMENT			CUMULATIVE PERFORMANCE	MEANS OF VERIFICATION	REMARKS
				Q1 OCT-DEC 2013	Q2 JAN-MAR 2014	Q3 APR-JUN 2014			
				and postpartum ▪ 22,080 total accepting counseling	and postpartum ▪ 10,329 total accepting FP counseling		counseling		
Number (and percentage) of women delivering at the health facility who accept a PPF method prior to discharge	0	Not applicable	Not applicable	<ul style="list-style-type: none"> ▪ 1,096 PPIUD insertions ▪ 15,282 deliveries ▪ 7% PPIUD acceptor 	<ul style="list-style-type: none"> ▪ 472 PPIUD insertions ▪ 8,226 deliveries ▪ 6% PPIUD acceptor 	<ul style="list-style-type: none"> ▪ 678 PPIUD insertions ▪ 2761 deliveries ▪ 5% PPIUD acceptor 	<ul style="list-style-type: none"> ▪ 8,273 PPIUD insertions ▪ 122,777 deliveries ▪ 6.7% PPIUD acceptors 	PPFP logbooks Monthly reporting forms Program reports	
2.1.2: Best practices documented and "how to" operational manual prepared for COE replication									
Number of documents developed and disseminated	0	7	7	0	0	0	5	Copy of pertinent document	Documents in final form and in the process of review and approval of DOH: <ul style="list-style-type: none"> ▪ Advocacy toolkit— Tool kit and document brief in approval stage. ▪ PPF job aids—approval stage (5 pieces) ▪ Implementation guideline (1 piece) ▪ Supportive supervision guideline (1 piece) ▪ Advocacy paper on KMC (1 piece)
2.1.3: TA to other agencies for PPF/PPIUD expansion									
Number of TA visits for PPF/PPIUD expansion		10	6	2	2		12	Project records	
2.1.4: FP service providers trained									
Number of people trained on PPF-PPIUD through USG-supported programs†		120	40	0	23	15	120	Attendance sheets Project records	

PROJECT COMPONENT/ PERFORMANCE INDICATOR	BASELINE VALUE (SOURCE, YEAR)*	END-OF- PROJECT TARGET	TARGET FOR FY 2014	FY 2014 ACCOMPLISHMENT			CUMULATIVE PERFORMANCE	MEANS OF VERIFICATION	REMARKS
				Q1 OCT-DEC 2013	Q2 JAN-MAR 2014	Q3 APR-JUN 2014			
2.1.6: FP service delivery guideline updated									
Number of national policies drafted with USG support†		1	1	1	0	0	1	Copy of DOH-endorsed document	PPFP Supplement to the Philippines Clinical Standards Manual on Family Planning
2.1.7: PPFP/PPIUD follow-up assessment conducted									
Number of studies†		2	2	0	0	1	2	Copy of pertinent report	Fabella Study completed, PPIUD Assessment Study will be completed by September 2014.

*Collection of baseline FP data (July 2011–August 2012) from 10 COE sites has not yet been completed.

†MCHIP Global Indicator.

Abbreviations: COE, Center of Excellence; EVRMC: Eastern Visayas Regional Medical Center; FP, Family Planning; KMC, Kangaroo Mother Care; MCHIP, Maternal and Child Health Integrated Program; MNCH, Maternal, Neonatal and Child Health; PPFP, Postpartum Family Planning; PPIUD, Postpartum Intrauterine Device; TA, Technical Assistance; USG, US Government.

Annex 2: Success Stories

National Family Planning “Roadshow” Improves Knowledge of Filipino Service Providers

"Family planning is not about population control, but more importantly an effective intervention that significantly contributes to reducing maternal death and other prenatal complications experienced by many poor Filipino mothers," said Dr. Esperanza Arias, Quezon City Health Officer, at the closing of the Manila leg of Family Planning: State of the Art (FP SOTA) forum.

The forum, which brought together nearly 600 FP service providers from across the Philippines, kicked off at the Hyatt Regency Hotel in Manila. The highly anticipated national roadshow on contraceptive updates was organized by MCHIP in cooperation with the country's Department of Health (DOH), and USAID's Luzon, Visayas and Mindanao Health Projects. The forum was a timely response to the escalating demand for visibility and integration of FP services in primary and reproductive health care in the country, as corroborated by the high turnout and keen feedback of attendees in all three legs.

These one-day knowledge sharing and discussion events in late March—mounted consecutively over the period of one week in Manila, Cebu and Davao—were eagerly received both by service providers and program managers who generously lent their time, participation and valuable inputs during the sessions. The forums provided a much needed platform for international and local FP experts and advocates to discuss the most urgent FP issues facing the country.

The attendance of the DOH cluster heads—Usec Teodoro Herbosa (Luzon) in Manila, Asec Romulo Busuego (Mindanao) in Davao and Asec Jean Paulyn Rosell-Ubial (Visayas) in Cebu—underscored the government's commitment to closing the gaps in the delivery of essential maternal and child health services. This is a principal strategy in averting the needless deaths of Filipino mothers and children.

In his speech, Usec Herbosa stressed the government's efforts to ensure equal access to high-quality primary and reproductive health services for all Filipinos—poor and paying clients alike. Similarly, Busuego underscored the importance of improving the capacity of healthcare facilities to address the growing reproductive health needs of mothers and families living in Mindanao. Alluding to the plight of many young mothers in Visayas, some of whom she has met during her visits to typhoon stricken Tacloban, Ubial highlighted the urgency of meeting the increasing reproductive health and FP needs of adolescent mothers.

“A lot of work remains to be done, and that work entails all of you in this room today. You are the people who touch the lives of everyone else on an everyday basis,” said USAID Mission Director Gloria Steele, who delivered the Agency's message of support.

This call to action reverberated among the attendees, who expressed their commitment to put into practice what they have learned. Dr. Florencia Miel, Chapter President of Philippine Obstetrics and Gynecology Society, said: “We need to educate ourselves with newer, innovative FP solutions and technologies that we can apply in our practice.”

With special focus on high impact practices and FP solutions, the forum testifies to MCHIP’s objective of creating an enabling environment for adoption and integration of FP in national health programs. This event catalyzed the desire of many health care providers, program managers, and advocates to improve the quality of services they offer by empowering themselves with updated knowledge and approaches in FP.

ACTIVITY/PRODUCT	DESCRIPTION	MULTIPLIER EFFECT/ESTIMATED REACH
Success story	“Mothers in the Philippines Space their Births to Address Unacceptably High Maternal Mortality”	Posted on MCHIP Global website November 2013 (http://www.mchip.net/node/2054)
Success story	“Providers in Philippines Persuade Hospital Leadership of Importance of Postpartum IUD”	Posted in MCHIP Global website, 31 August 2013
Success story	Filipino Women Celebrate “Buntis Day,” Attend Postpartum Family Planning Launch Ceremony	Posted in MCHIP Global website, 18 April 2013
Success story	“Expanding Essential Care for Newborn and their Mothers - Philippines”	Posted on Health Newborn Network, 10 March 2014 (http://www.healthynewbornnetwork.org/blog/expanding-essential-care-newborn-and-their-mothers-philippines)

Annex 3: List of Presentations at International Conferences and Publications

- “*Kangaroo Mother Care for Low Birth Weight Newborns: A Call to Action.*” Presented by Dr. Socorro De Leon-Mendoza, President of the KMC Philippines Foundation, at the APR Stakeholders Forum in Manila on 24 April 2014.

Annex 4: List of Materials or Tools Developed or Adapted

- **Advocacy toolkit package** that consists of 1) Philippines 2008 DHS reanalysis for PPFPP brief; 2) PowerPoint with facilitator's guideline on the 2008 DHS reanalysis. The advocacy toolkit package is intended for use by professional organizations, government and non-government agencies, and other stakeholders for advocacy of PPFPP/PPIUD in the Philippines
- **PPFP/PPIUD Follow-Up Assessment Study-** research plan. The research plan outlines the objectives of the study to understand the demographic profile of clients accepting PPIUD; to measure the incidence of problems/complications among clients who received a PPIUD (infection, heavy and/or irregular bleeding, missing strings, expulsion; reasons and rates of removal and other problems, if any) at 6 weeks (or later); to understand the role of counseling for PPFPP/PPIUD services; and to learn about service providers' perspectives, practice and experience with PPIUD services. The assessment study also includes an outline for the review of the documentation services at Dr. Jose Fabella Memorial Hospital (DJFMH) to extract lessons learned.
- **Supportive Supervision Guideline for PPFPP/PPIUD.** The support supervision guideline is targeted for the supervisors or personnel conducting supervision visits to the PPFPP/PPIUD trained providers or facilities. The guideline provides timeline, scope of work or responsibility, and follows up items for that the supervisors will need to follow.
- **Replication guideline for PPFPP/PPIUD COE.** The replication guideline for PPFPP/PPIUD COE provides best practices, implementation process, and challenges in developing or becoming a COE. MCHIP used its program experience to develop this guideline and is targeted toward facilities and stakeholders that are interested in becoming a COE.
- **Postpartum Family Planning Supplement to the Philippine Clinical Standards on Family Planning.** Approved and endorsed by the Department of Health, this supplement augments the existing clinical standards manual on FP. It is expected to aide providers and managers with updates on family planning technology that can be offered to women in the postpartum period (time immediately after birth until 6 weeks). This is envisioned as an indispensable reference for PPFPP-PPIUD service providers, giving them valuable information on timing of initiation, attributes, risks and benefits of different PPFPP methods. Most of all, this guideline is pivotal in mobilizing awareness for the postpartum as an important, and yet missed, opportunity to introduce life-saving family planning methods to women.
- **KMC start-up kit.** The kit was introduced after the KMC training in each facility that includes KMC brochure, forms, tube-blouse, register, demo doll, breast model etc.
- **KMC Monitoring/documentation Forms.** The forms were adapted to collect data on KMC newborns in the two implementation hospitals.
- Documentation of the KMC start-up activities in two hospitals.
- **KMC Advocacy Paper.** This paper was developed in order to advocate for KMC as an intervention and promote scale up of implementation in health facilities across the Philippines. Posted on mchip.net:
http://www.mchip.net/sites/default/files/KMC%20advocacy%20paper_Philippines_0.pdf

Annex 5: July 2012 – June 2014 Total PPIUD and Counseling Stats

	CRMC	EVRMC	ZCMC	R1MC	SPMC	DJFMH	DRH	VSMCMC	BMC	TOTAL
PPFP/PPIUD Services										
1. Total Number of PPIUD Insertion	708	492	792	285	607	1,402	177	1631	2179	8,273
• Postplacental	379	300	490	88	95	158	0	987	1539	4,036
• Postpartum (Early)	90	129	228	84	286	1,244	173	176	44	2,454
• Intracesarian	239	63	74	113	226	0	4	468	596	1,783
2. Number of Deliveries	3440	9,127	11,943	7,877	18,827	37,203	14,169	12,099	8,092	122,777
Counseling										
3. Total No of clients counseled for PPFP/PPIUD during early labor & postpartum	599		3,700	3,429		30,914	1,297	11,200	8,064	59,203
• Total No. of counseled during early labor	171	9,127	1,500	265	1,733	158		9,800		22,754
• Total No. of counseled during postpartum	428	9,127	2,200	3,164	17,101	30,756		1,400		64,176
4. Total no. of clients counseled for PPFP/PPIUD during ANC	11,824	6,728	2,000	1,618	5,587	58,236	1,394	12,368	6,854	106,609

5. Number of women attending antenatal care (ANC)	11,824	6,729	7,576	4,183	50,154	72,888	17,061	12,368	6,854	189,637
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Annex 6: KMC in Facilities: A Process Documentation

Introduction

Adopting KMC as a standard program of care for LBW newborns in health facilities entails a process in which many stakeholders and partners play different but equally important roles. Documenting this process can be beneficial for future replication and expansion of KMC in the country. This report intends to document the processes and strategies that could help mobilize commitment from the government, partner organizations and other stakeholders; to learn how KMC was initiated and modelled in two (2) health facilities; and, to outline the best practices and lessons learned on the approaches taken by each facility, and the challenges they have encountered.

Adoption of KMC

The Kangaroo Mother Care Foundation Phil., Inc. began engaging with health facilities to adopt KMC in 2010. Initially, a personal invitation and/or exploratory meeting with a colleague in Neonatology known to the Foundation President is made to unravel and generate interest in the intervention and also assess the need for such a program in the hospital. If a positive response is received, the Foundation writes a formal letter of invitation to the Hospital Director to adopt KMC as a program, coupled with the offer to support planning, training, implementation, monitoring and evaluation activities until accreditation status as a KMC Center of Excellence is achieved. Support for clinical or operations research is likewise offered and encouraged. If there is acceptance, a Memorandum of Agreement (MOA) is drawn between the Foundation and the hospital outlining the activities and expectations from each side. The signing the MOA marks the beginning of a 3-year engagement and partnership between the facility and the Foundation, subject to renewal of the terms of reference between both parties based on the needs of the facility to move KMC forward in the region. The Foundation continues to offer quality technical support for scaling up of the program in the area where the KMC Center of Excellence is located. The choice of health facilities to train and partner with is based on the regional burden of neonatal morbidity and mortality. Over a period of three years, the Foundation has trained and accredited six (6) other regional facilities in KMC and maintained collaborative efforts with the pioneer institutions - the Dr. Fabella Memorial Hospital and the Manila Health Department.

On the establishment of KMC, the choice of the two (2) facilities in the National Capital Region (Metro Manila) was based on the following factors:

1. In order to complete the project within the short time frame (six months), project sites needed to be only within the metropolis;
2. The Philippine General Hospital of the University of the Philippines, Manila (PGH-UPM) has been the site of KMC researches for the past three years and has generated most of the local evidences to support the KMC intervention. The engagement of the state university training hospital to actually adopt and implement the intervention as their standard of care for LBWs will provide impetus for the government and other hospitals to follow suit; and,
3. The St. Luke's Medical Center in Quezon City (SLMC-QC) is the premier, high end private-run tertiary care hospital in the National Capital Region (Metro Manila), sought

after by many top government officials and prominent personalities of the country for their health care needs, not only for medical expertise but more importantly for availability of state-of-the-art equipment and technology. Its engagement in KMC implementation can be the model for other private-run health institutions to recognize the value of KMC in newborn health, regardless of technological advances and economic status.

The administrators of both hospitals accepted the proposal and agreed to adopt the KMC program, as evidenced by the signed MOUs (Annex 1). Besides meeting and discussions with the head neonatologists of both facilities, factors that facilitated this agreement include:

1. The local research evidences that have been generated in the PGH-UPM (one of the project sites) made the uptake of the KMC intervention easier;
2. The Medical Director of SLMC-QC is an Obstetrician-Gynecologist by profession and fully appreciates KMC;
3. The two hospitals' Pediatric Department Chairpersons were included in the first KMC Coordinator's Meeting held in January 2014 (Annex 2). Herein, they met and appreciated the discussions with other KMC Coordinators from the regions of the country on their respective experiences on the implementation of KMC.
4. KMC will be included as a requirement in the new Mother and Baby Friendly Hospital Initiative (MBFHI) accreditation guidelines of the Department of Health, based on the Administrative Order 2009-0025 issued in December 2009 (Annex 3) which included KMC; and,
5. Follow-up meetings, updates and discussions between key department heads of the hospitals and the Foundation's KMC team including the technical staff from Save the Children (Annex 4)

Furthermore, as the Foundation engaged each health facility adopting KMC, a "Champion" was identified among the members of the designated core team who underwent the initial intensive KMC training. Much of subsequent implementation and sustainability was strongly related to the identified KMC Champion who had a good grasp of the technology, demonstrated strong leadership qualities as well as possessed good team-player characteristics, and competent trainer skills. A KMC Champion was identified in each hospital. Dr. Esterlita V. Uy, Training Officer of the Section of Neonatology at PGH-UPM and Dr. Ma. Luisa Manlapaz together with Ms. Riza Dumapay, Chair and member of the Mother-Baby Friendly Care group respectively at SLMC-QC.

Implementation of KMC in the Two Partner Health Facilities

FACTORS		PGH-UPM	SLMC-QC
LOGISTICS SYSTEM	Allocation and provision of hospital beds / lounging and rocking chairs in KMC Units	5 rocking chairs in the NICU for intermittent KMC use were augmented with 5 additional lounging chairs to accommodate more mothers to do KMC. Identification and refurbishment of the "Kiko's Room" at the Pedia Ward into	All areas in the NICU, IMCU and Isolation Rooms within the NICU complex have space for bedside KMC. Identification of area in the NICU complex where collective and intermittent KMC

		<p>a KMC Unit for continuous KMC, with 5 hospital beds and 5 lounging chairs.</p> <p>Identification of available space for 3-4 beds in the OB Ward (approval of the OB Department Chair still pending)</p> <p>Provision of 5 KMC lounging chairs in the PICU where outborn (born outside the facility), sick LBW neonates are also admitted and enrolled to KMC as well</p>	<p>practice can be done.</p> <p>Provision of 5 KMC lounging chairs (Lazy Boy) approved and will be provided by hospital administration. (Delivery still pending)</p> <p>Continuous KMC will be implemented in the individual private rooms upon order of the attending physicians.</p>
	Job aids	<p>Included in the start-up KMC package for first 50 enrollees were:</p> <ul style="list-style-type: none"> - 50 sets of KMC charts and baby booklets for recording and reporting - 50 KMC flyers for mothers and family members to read in the hospital and at home - 7 KMC log books for daily recording - 2 plastic drawers for KMC supplies - 2 KMC tarpaulins as signages - 6 Practice Dolls - 5 copies of KMC Clinical Practice Guidelines as reference material <p>- Provision of 3 breast pumps to facilitate breast milk expression by visiting KMC mothers and assure their own baby's milk supply for the time when they are away.</p>	<p>Included in the start-up KMC package for first 50 enrollees were:</p> <ul style="list-style-type: none"> -50 sets of KMC charts and baby booklets for recording and reporting - 50 KMC flyers for mothers and family members to read in the hospital and at home - 3 log books for daily recording - 2 KMC tarpaulins as signages - 6 Practice dolls - 5 copies of KMC Clinical Practice Guidelines as reference material - Provision of 3 breast pumps to facilitate breast milk expression by visiting KMC mothers and assure their own baby's milk supply for the time when they are away.
	Supplies	<p>Start-up KMC package for first 50 enrollees included:</p> <ul style="list-style-type: none"> -60 tube blouses - 50 baby bonnets 	<p>Start-up KMC package for first 50 enrollees included:</p> <ul style="list-style-type: none"> - 50 tube blouses - 50 baby bonnets
	Necessary Inputs from the Project	<p>Additional KMC-related supplies provided after one month due to large numbers of enrollees.</p> <p>Funding to support sewing of</p>	<p>Administration committed to take-over procurement of KMC-related supplies once consumed and will be supplied to the mothers</p>

		<p>tube blouses for mothers (e.g., clothing, materials, thread, and sewer). KMC unit has contracted a mother, previously practicing KMC, to make the blouses for a small fee – a small amount of which they charge to mothers interested in buying.</p> <p>Funding support for photocopying and/or printing of additional KMC forms</p> <p>Funding support for job aids such as KMC flip charts and video</p>	in accordance with hospital policies
	Areas for improvement	<p>Systems of procurement and financing of essential KMC supplies need to be outlined to sustain practice</p> <p>Inclusion of a “legend” of the terminologies used in the KMC forms</p> <p>KMC forms can be color-coded for the hospital nurses and doctors to fill out</p>	<p>A functional procurement system (which is in place) should include KMC</p> <p>Some words or phrases in the KMC forms need to be more explicit or simplified for the documenters to understand</p>
TRAINING (Annex 5)	Training of Trainers	20 trained trainers included Neonatology consultants and fellows, Pediatric residents, charge clinical nurses, training office nurses, and midwives	10 trained trainers included Neonatologists, Pediatric residents, and nurses from the training office, NICU, and OPD
	Curricula	5-day Trainers’ and Implementers’ Seminar-Workshop that included didactics, hands-on skills workshop, facility visits to the Dr. Jose Fabella Memorial Hospital and SLMC-QC, enhancement of trainer knowledge, skills and values in health care, and planning of program implementation for each hospital	
	Areas for Improvement	Neuro-developmental follow-up using the Infant Neurological International Battery Test (INFANIB), a 20-item test that grades the infants’ neurologic integrity, can be enhanced by a video presentation and practiced	

		<p>during the ambulatory KMC workshop session. A Trainers' Toolkit can include a standard video on positioning, preferred breastfeeding position for LBW's, supplementary breast milk feeding techniques, exercise for LBW's and infant massage in KMC.</p> <p>The Obstetrical Departments of both health facilities need to be engaged in the KMC advocacy and implementation, not only for prenatal information dissemination but also because mothers will need to stay longer in the OB ward/rooming-in facility, to provide KMC to their babies, in particular for PGH. In SLMC-QC, the LBW may be transferred to a private room once ready for continuous KMC and will not require obstetrical physician's consent.</p> <p>What about refresher sessions? Mentoring and coaching for new staff?</p>	
ENROLLMENT & TRAINING OF KMC DYADS	Enrollment	<p>After the orientation of the NICU staff, enrolment of LBW babies started on March 11, 2014 and logged accordingly. Except for those LBWs participating in the randomized controlled trial RCT on KMC, all other eligible babies were enrolled.</p> <p>Mothers' acceptance was universal & encouraging and resulted in lack of chairs for visiting mothers providing intermittent KMC</p> <p>Documentation and filling-up of KMC charts required repeated orientation during morning endorsements for both doctors and nurses</p>	<p>After the orientation of NICU staff and kick-off meeting, enrolment of LBW babies started on Feb 18, 2014. At present, 25% of eligible LBWs are being enrolled to the program.</p> <p>Only one mother (out of 17 enrollees) expressed reluctance in doing KMC for personal reasons.</p> <p>Documentation of enrolment was readily feasible for nurses. Pediatric residents required more orientation than nurses</p>
	Supervision and monitoring	Monitoring of the KMC dyads was done once a shift by the	Monitoring of the KMC dyads that were doing it

		NICU nurses and documented accordingly in the adaptation sheets	at bedside was achieved by the doctors and nurses.
	Follow-up after discharge	Organized system of follow-up under discussion with the High Risk Clinic of the Pediatric outpatient department.	Follow-up and tracking system with private attending physicians under study by the department of Pediatrics.
	Challenges/areas for improvement	<p>Space limitations in the NICU allows only chairs for intermittent KMC at the moment and the KMC unit in the Pedia Ward for continuous KMC can accommodate only 5 KMC dyads at a time. The floor plans for the NICU renovation will include a larger area for KMC but still cannot accommodate adult patient beds for mothers to stay for continuous KMC.</p> <p>Integration of KMC “routines” by all concerned staff (from enrollment, monitoring, discharge, follow-up and documentation) in their daily work</p>	<p>Cannot compel private paediatricians to enroll their LBW patients.</p> <p>More attending private paediatricians need to be oriented and engaged into the KMC practice.</p>
SUSTAINING QUALITY OF CARE	Best Practices	Organized KMC Core Committee under the Section of Neonatology of the Department of Pediatrics, was recognized and approved by Hospital Administration	Organized KMC Core Committee to be within the Mother-Baby Friendly Care Group (who also oversees the Essential Intrapartum and Newborn Care and the Infant and Young child Feeding programs) under the supervision of the Medical Director of the hospital.
	Areas for Improvement	<p>KMC Policy and Standard Operating Procedures need to be outlined and approved for incorporation in the hospital’s Manual of Operations. This will also serve as the basis for the provision of personnel, infrastructure, and supplies, and the necessary budgetary allocation for sustained practice and eventual accreditation as a KMC Center of Excellence and Training.</p> <p>Use of data from documentation/monitoring to continuously improve quality of care</p> <p>Ambulatory KMC and networking with the community will need to be defined, discussed with relevant services and</p>	

		partners in the city health departments of Manila and Quezon city	
HUMAN RESOURCES FOR KMC	Service providers	Medical, nursing and midwifery staff (approximately 50% oriented to date) provided KMC orientation and training to all eligible mothers with LBW babies	All oriented nurses (60% to date) and pediatric residents (60% to date) provided KMC training and orientation to mothers with LBW babies upon doctor's orders
	Support staff	No additional support staff available for KMC.	No additional support staff for KMC.
	Challenges	Inclusion of KMC into the hospital system for consistent provision of service providers and integration into the management Information System of the hospital	Inclusion of KMC in the hospital's Management Information System recognizing that the KMC data is more detailed compared to the general hospital data.
ROLES OF MOTHER/FAMILY		Highlighted in the KMC program through a signed commitment from the mother or guardian to practice KMC	Mother's willingness assured through a signed commitment which was translated to English
INSTITUTIONALIZATION OF KMC		KMC Policy and Standard Operating Procedures to be formulated, deliberated upon, and approved as part of the hospital's Manual of Operations.	

KMC practice in the two adopted health facilities

1) University of the Philippines – Philippine General Hospital



- *NICU – KMC AREA with rocking and stackable plastic chairs*



- *KMC Unit signage located at the Pediatrics Ward 9 and mother s with their babies inside the unit.*

2) St. Luke's Medical Center – Quezon City



- *First Monitoring visit by KMC Team with Save the Children International staff. Bedside KMC at Intermediate care unit (IMCU)*



- *NICU Area (formerly viewing room for normal babies) identified for continuous KMC awaiting lounging chairs to be delivered within the year*

Recommendations and Future Implications

Challenges:

Adoption of KMC by health facilities in both the public and the private sector is feasible. The initiation process can be similar in both facilities, but the challenges are different in the following areas:

- 1) Logistics, infrastructure and service provision can be more challenging in the public hospital pending the issuance of the KMC operational guidelines from the DOH, in accordance with the AO2009-25 on essential newborn care
- 2) Engaging private paediatricians to practice KMC on their patients is more difficult, realizing that quality of surviving preterm newborns is not readily obvious during hospital confinement;
- 3) Engagement of the obstetric unit or OB-GYN Department is more difficult in the public hospital given the space limitations and bed capacity for postpartum mothers;
- 4) Follow-up ambulatory KMC is unified and can be monitored in the public hospital, whereas that in the private setting, which will be done by individual attending physicians, can be challenging in terms of tracking of outcomes;
- 5) Long term impact assessment may not be easy in the private hospital due to challenges in data collection, post-discharge or during follow-up care provided by individual private Pediatricians. Unless an institutional formative research is done in this aspect of KMC, one may not have easy access to all the data needed; and
- 6) Continuous KMC is more challenging in the public hospital mainly due to space limitations in the rooming-in obstetric unit as well as the establishment of a KMC Unit in the paediatrics ward.

Recommendations:

- A. Steps towards sustainability of KMC program
 - 1) Follow-up monitoring and evaluation of program implementation is necessary for at least one year to assure sustained KMC practice in both hospitals (the challenges notwithstanding) until accreditation status is achieved.
 - 2) On-going challenges at the time of project completion need to be addressed to further improve implementation in accordance with the action plan submitted and approved by both hospitals' administration.
 - a. Development of standard protocols in KMC including ambulatory KMC
 - b. Inclusion of KMC as a hospital policy of care for all low birth weight neonates
 - c. Engagement of the Obstetrics department in the implementation of KMC
 - d. Assurance of supplies and staffing requirements to sustain the program
 - e. Defining the networking process with the Manila Health Department
 - 3) Explicit and clear Operational Guidelines on KMC, from the Department of Health need to be available soon, to help facilitate the implementation of KMC in both public and private health facilities
- B. "Ripple effect" of modelling KMC in health facilities
 - 1) The two adopted KMC health facilities, chosen for specific reasons outlined previously, are expected to draw more attention to KMC, since both are reputable hospitals in the country. National media coverage and scientific journal publications coming from these facilities can potentially attract other regional facilities to adopt KMC.

- 2) The conduct of an annual KMC Forum, whether as stand-alone or in conjunction with national perinatal conferences, DOH activities or pediatric conventions, will be valuable in gaining more attention from the professional health care practitioners and groups, development partners and other stakeholders.

C. Role of Stakeholders and Partners

- 1) Policy makers must collaborate with the Department of Health on the KMC strategy to help achieve the MDG-4 2015 targets and beyond. Much still needs to be done soon to address the policy gaps on KMC identified during the forum.
- 2) Pending the approval of the National Guidelines on KMC, support for continued work on KMC by civil society organizations such as the KMC Foundation and other NGOs is needed to sustain the momentum of accelerated scale-up of KMC in the country. Herein, the role of development partners cannot be over emphasized.
- 3) Professional societies and groups in the fields of Perinatology, Pediatrics, Family Medicine, Nursing, Midwifery, Nutrition and Social work, must be alerted and engaged to contribute to the pool of KMC trainers and implementers in the country.
- 4) The Commission on Higher Education (CHED) should integrate KMC in the curriculum of all health care professions involved in perinatal care and also included in the board exams.
- 5) Women's groups supporting mothers and babies can be induced to become KMC stalwarts in the communities which they serve
- 6) Development partners can support an operations research of the on-going LGU-managed city-wide KMC program in Manila and assess the possibility of creating a model for replication in other parts of the country

Annexes:

- | | |
|----------|---|
| Annex 1. | Summary of KMC meetings between hospital and KMC team |
| Annex 2. | KMC training report |
| Annex 3. | KMC forms |
| Annex 4. | KMC Agreement – English translation |

Philippine General Hospital
 Department of Pediatrics – Section of Neonatology
 Kangaroo Mother Care Committee
 May 7, 2014, NICU Call room

Attendance:

Dr. Esterlita V. Uy,
 Dr. Catherine Luistro
 Dr. Jesiica Anne Dumalag
 Dr. Paulene Derna
 Dr. Aimee Tan
 Dr. Ardee Lugo
 Ms. Daphne

Minutes:

DETAIL	PARTICULARS	ACTION PLAN
1. Review of mission vision and objectives	<u>Training</u> MOU approved – April 2014 Need to talk to OB 100% trained HCPs	1. KMC module from SEA Urchin – NICU nurses And PICU Nurses 2. 2 hour orientation – Ward 9 and 11 -Need to know % nurses trained pay ward, PICU, Ward 9 and 11 % residents trained
	All mothers knowledgeable on KMC	Flip chart - need to revise some slides -Monthly audit – all eligible, all enrolled -High risk census- Less than 2.5 kg
	Inclusion in training - EINC – okay -STABLE program – add slides on KMC transport in the themoregulation part -NRP – one slide -lactation – included Inclusion in basic sciences	-Need one slide in EINC after non separation slide to emphasize that KMC is started during this time period if dealing with LBW infant -Need to add slides to STABLE - need to add one slide in NRP -already have lecture on KMC in last lactation management course - still for discussion- will talk to BJ Sablan
	<u>Service</u>	KMC policy – need to finish KMC as a hospital committee –

		talked with Asst. Director for Nursing
	Infrastructure	KMC room - 5 beds -screen divider - freezer -Breastmilk containers 100 cc -Breastpumps
	KMC room policy for admission	Asked chief resident regarding existing policy – none She sent a draft but needs more improvement
	OPD follow up	Problem with follow up of patients - revise logbook so that columns will have name, birthday, date enrolled, contact numbers, address, date of discharge and date of follow up Daphne need to text every Sunday for the Monday High Risk Clinic
	Research – KMC 3 ongoing	Need to post in website -not sure about funds
Orientation Training	Ward 9 – May 15 Ward 11 – May 16 NICU – May 28 NICU seminar – First week JUNE	Need to ask additional budget since Ward 9 and 11 orientation are separate.
Problems:	Some resistance with nurses Dr. Sookee and Dr Tita have talked with head nurse, Mam Fe who said that they have lots of work. Explained that KMC will actually decrease their work	Talked to AND regarding KMC program - With NICU nurses initiated KMC orientation this month -Food care of USAID/MCHIP project grant
	Documentation	Currently we have Daphne (clerk) who helps with documentation and checking of completeness of forms
	Orientation of NICU nurses - Head nurse went on leave so that the program orientation did not materialize	Orientation will be provided using the Sea Urchin as well as the Nurse initiated seminar
	Space - Due to large number of LBW, not enough chairs	Lounging chairs will be provided by USAID/MCHIP project

KANGAROO MOTHER CARE PROGRAM – MONITORING VISIT 1
Philippine General Hospital – UP Manila
11Mar 2014, 10-12nn

Attendance:

1. Ms. Fe Basinag – NICU- KMC head nurse
2. Dr. Cathy Luistro – Fellow in Neonatology and KMC Researcher
3. Dr. Jessica Anne Dumalag – Fellow in Neonatology
4. Dr. Esterlita V. Uy – KMC Consultant Coordinator

Minutes of the Meeting/Visit

1. Dr. Mendoza (project leader) was met at the breastfeeding room of the NICU by the above personnel together with two (2) other NICU nurses who are in charge of the breastfeeding program and recently oriented to the KMC program.
2. Ms. Fe Basinag informed Dr. Mendoza that after the kick-off meeting (11 Feb 2014) they started to hold “pocket” orientation meetings with the NICU nurses, on the KMC implementation procedures and began to enrol low-birth weight (LBW) babies to the program. Similarly, an orientation of Pediatric resident physicians is scheduled on 24 March 2014. Furthermore, Dra. Uy plans to bring the KMC orientation to the Division of Nursing Education & Training (DNET) office of the hospital.
3. Dr Luistro and Dr. Dumalag, in relation to the KMC researches they are conducting, have been enrolling babies to the program (n=34).The enrolment however, was stopped temporarily in the first week of March (1-7 March) due to closure of the NICU for general cleaning.
4. Dr. Mendoza visualized the charts/records of babies enrolled to the program, but noted that the log books did not contain the names of the KMC enrolees. The personnel were reminded to log-in all the KMC enrolees together with their clinical data.
5. Tracking and securing the KMC charts of enrolees and discharges was discussed and planning for outpatient follow-up visits was clarified.
6. Potential expansion of KMC area within the NICU to a room near the NICU entrance was explored.
7. Follow-up of the KMC unit to be refurbished in the Pediatrics Ward was done, as well as the MOU which was still at the Legal Office at the time of the visit.
8. Suggestions for improvement of implementation were given, in particular on documentation and completion of orientation for all NICU and Pedia personnel.

Prepared & Submitted by:

SOCORRO DE LEON-MENDOZA, M.D.
Project Leader

TRAINING REPORT

Preparatory Activities for this review period is centered on the following:

1. Communication and coordination of Project sites for adoption of KMC started Nov 4th. The sites identified were the Philippine General Hospital (PGH), and the other, St. Luke's Medical Center in Quezon City. The adoption of both hospitals to KMC is significant in that the PGH is the country's leading university-affiliated public hospital while St. Luke's is the first private hospital to adopt KMC for its patients.
2. Consultation meetings and appointment of KMC coordinators that will be responsible for the implementation of the project were appointed on Nov 15th. They are:
 - Project Team Leader – Dr. Socorro Mendoza
 - Field Consultant Coordinators – Dr. Esterlita Uy, Dr. Ma. Luisa Manlapaz
 - Field Assistant – Ms. Ericka Abu
 - Finance and Admin Assistant – Annabella Guerrero
3. Preparation of training logistics started in November and continued up to Dec 1st
 - Updating and printing of the training manual,
 - Sourcing of venue, food caterer, and materials and supplies
 - Enrollment of participants from the 2 sites. The original quota of 10 participants per site was exceeded due to demand and interest. Total participating medical staffs reached 30.
4. Trainors with different areas of expertise were sourced as lecturers.
 - Dr. Socorro Mendoza – KMC Foundation President and pioneer of KMC implementation in the Philippines, Neonatologist
 - Dr. Mary Anne Ilaog – Head of the KMC program at Fabella Hospital, Neonatologist
 - Merle Pimentel – Values in Healthcare Trainor
 - Charlita Pepino – Community KMC coordinator of Manila's Lying-In clinics and health centers
 - Annabella Guerrero – KMC Foundation Board Secretary and marketing research consultant.
5. Coordination with Fabella Hospital for permission to tour their KMC facility as part of the training workshop to familiarize participants with the KMC program.

Training Course Outline

1. Course Objectives – At the end of the course, the trainees shall have:
 - Acquired sufficient knowledge, avowed the right attitude and demonstrated the skills to be able to implement the KMC program in his/her home institution.
 - Demonstrated the capability to train and facilitate a KMC seminar/workshop.

- Formulated a strategic plan of action for the full implementation of the KMC program in his/her home institution.
2. **Course Outline**
 - Day 1 – History, Concept and Process of KMC
 - Day 2 – Inpatient and Outpatient KMC
 - Day 3 – Facility Visit (Fabella and St. Luke's)
 - Day 4 – Training the Trainor
 - Day 5 – Planning and implementation of a KMC Program
 3. **Each day's training is composed of:**
 - A recap of the previous day's learnings
 - Lectures
 - On site workshops
 - Focused group discussions
 - Values in healthcare training
 - Evaluation of the training process and learnings

Training Results and Output

1. A total of 30 medical practitioners finished the KMC workshop. They were composed of neonatologist and pediatricians, nurses, and some hospital training specialists. The list of attendees and signatures are attached.
2. Results of the pre-test and post-test evaluation of the degree of knowledge of participants of the KMC program improved.
3. Evaluation of each day's learning and lecturers were done.
4. Output of the 5th day was a strategic action plan by each of the sites 'KMC team. These action plans shall be finalized over the next month by each team and presented to their respective heads of hospitals for approval and implementation.
5. The Foundation has committed to monitor each site's KMC implementation over of the next 6 months to ensure that KMC standards are adhered to. Initial monitoring visits shall be in January 2014 and monthly thereafter up to May, then quarterly until accreditation status is achieved, based on the monitoring checklist.



K A S U N D U A N

UKOL SA

“KANGAROO MOTHER CARE PROGRAM”

AKO, si _____, _____ taong gulang, ina/ama/kamag-anak ni _____ ay sumasang-ayon sa mga alituntunin ng “Kangaroo Mother Care Program” ng _____, tulad ng mga sumusunod:

1. Itutuloy ko ang pangangalaga sa aking sanggol sa bahay sa pamamaraan na itinuro sa akin habang ako ay nasa ospital pa, araw-araw, 24 oras sa bawat araw, hanggang sa siya na mismo ang umayaw sa posisyon na ito (pangkaraniwan kung 4-5 libra na ang sanggol).
2. Kung sakali man at ako ay may kailangan gawin ukol sa pansariling pangangailangan, hindi ko maaaring iwanan ang aking sanggol na mag-isa at nakahiga sa kuna; bagkus ang aking asawa o kaya’y kamaganak o kasambahay ay aking kasalit sa paghawak sa aking sanggol sa “kangaroo position”.
3. Ako ay mamamahinga sa gabi kasiping ang aking sanggol sa “kangaroo position” tulad ng kinasanayan ko sa loob ng ospital.
4. Ibabalik ko ang aking sanggol sa “OPD Clinic” dalawang beses sa bawat linggo at tutupad ako sa bawat appointment na itatakda ng aking manggagamot at sa mga sumusunod na araw.
5. Kung ako ay may kailangan o pagaalinlangan sa aking sanggol maaari akong tumawag sa NICU ng ospital para malinawan at mapagpayuhan.
6. Tutupad ako sa lahat ng tungkuling ito hanggang maging isang taong gulang ang aking sanggol.
7. Naipaliwanag ng malinaw ang lahat ng alituntunin ng “Kangaroo Mother Care Program” sa akin, naintindihan ko ito ng lubos at maluwag sa aking kalooban, ang paglagda sa kasunduang ito.

LAGDA:

INA

AMA/KAMAG-ANAK

SAKSI



**Department of Pediatrics
KANGAROO MOTHER CARE PROGRAM**

PATIENT RECORD

Hospital Reg no (Birth) _____

KMC Patient No. _____

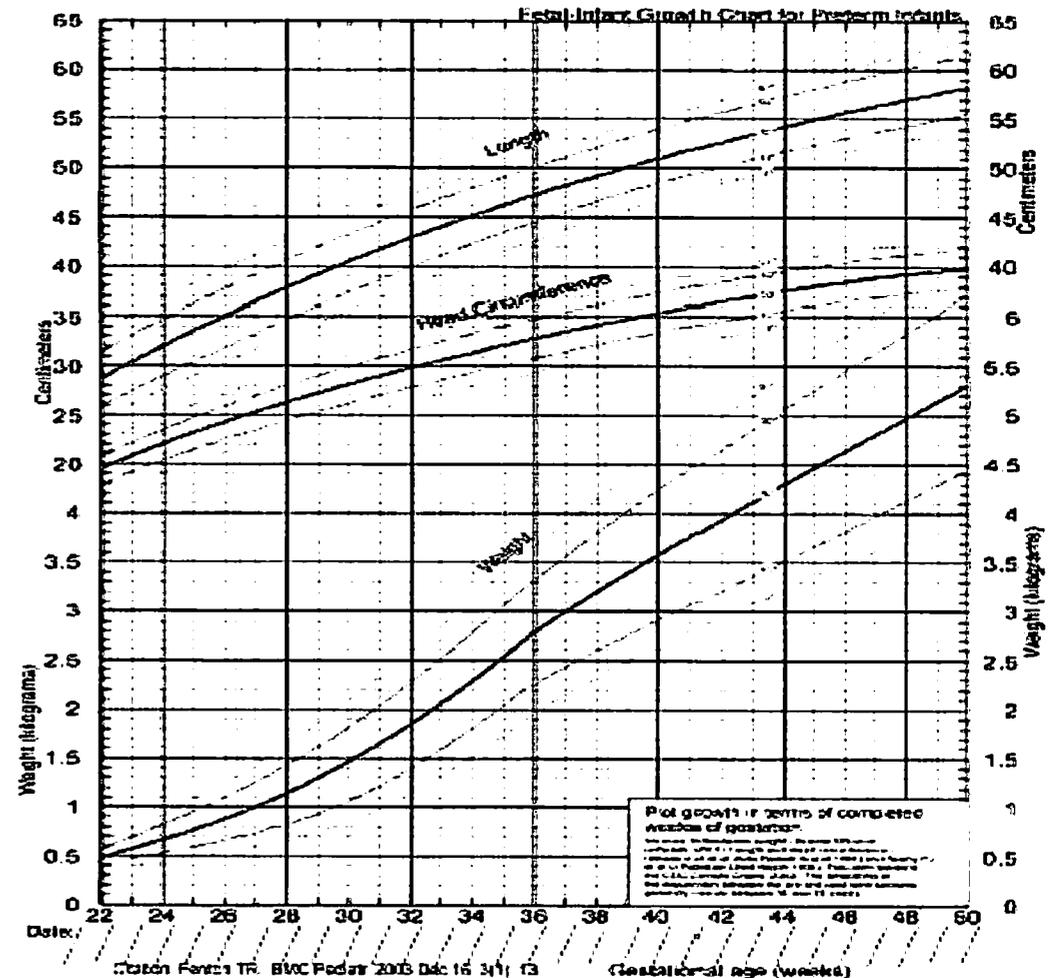
Name of Mother _____ Name of Baby _____ DOB _____ AOG _____ Bwt _____ DATE DISCHARGED _____

IMMUNIZATION RECORD

Vaccine	Date Given	Lot #/Exp.	Signature	Prof.
BCG				
DPT	1			
	2			
	3			
OPV/IPV	B1			
	B2			
	B3			
	1			
	2			
	3			
HIB	B1			
	2			
	3			
	B1			
Hepa B	1			
	2			
	3			
Measles				
MMR				
Chickenpox				

Vital Status: Alive / Died _____ Date of Death _____

KMC Discontinuation: Date: _____ Weight: _____



KMC PATIENT RECORD

FAMILY CHARACTERISTICS <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td></td> <td>Reader</td> <td>Working</td> <td>House</td> </tr> <tr> <td></td> <td>Age</td> <td>Y es No</td> <td>Wife Studying</td> </tr> <tr> <td>Mother</td> <td>1 2</td> <td>1 2</td> <td>3 4</td> </tr> <tr> <td>Father</td> <td>1 2</td> <td>1 2</td> <td>3 4</td> </tr> </table> <p>Civil Status 1 Alone w / Support 2 Alone No Support 3 Stable Couple Number of meals per day 1 2 3 4 5 ___ Access to Water 1 No 2 Yes, with treatment 3 Yes without treatment</p> <p>Family Income per month PHP _____ Number of family members living with income 1 2 3 4 5 ___ Home location 1 -In the city 2 -1 hr. Away 3 -2hrs away 4 -Outside the City Help at home during first month 1 Yes 2 No</p>		Reader	Working	House		Age	Y es No	Wife Studying	Mother	1 2	1 2	3 4	Father	1 2	1 2	3 4	SUBSTANCE ABUSE Cigarette 1 Never 2 Moderate 3 Often Alcohol 1 Never 2 Moderate 3 Often TREATMENTS Antenatal corticoids # of doses 1 2 3 4 5 ___ Iron 1 Yes 2 No Malaria 1 Yes 2 No HIV 1 Yes 2 No Folic Acid 1 Yes 2 No Multivitamins 1 Yes 2 No Other maternal treatments _____ Pregnancy Desired 1 Yes 2 No Planned Pregnancy 1 Yes 2 No Family Planning 1 Yes 2 No Method 1 Hormonal 2 IUD 3 Barrier 4 Rhythm Others _____ # of months worked during pregnancy _____ DELIVERY AND BIRTH Fetal Distress Abnormal fetal heart rate 1 Yes 2 No Abnormal monitoring 1 Yes 2 No Meconium Liquid 1 Yes 2 No PRCD 1 Yes 2 No Manner of delivery 1 NSD 2 EES 3 CS APGAR 1' _____ 5' _____ 10' _____ Resuscitation 1 Yes 2 No Gender 1 Female 2 Male 3 A Rank in birth 1 2 3 4 5 6 6 ___ Place of birth 1 Born 2 Out born Where _____ Attendance 1 Prof 2 TBA Others _____ Weight _____ gms Length _____ cm HC _____ cm AOG _____ wks 1 LMP 2 LH 3 SG 4 Ballard Lubchenko 1 PTAGA 2 PTSGA 3 PTLGA 4 TSGA Prophylaxis of HIV 1 Yes 2 No 3 NA Navirapine 1 Yes 2 No 3 NA AZT 1 Yes 2 No 3 NA Place of Admission 1 NICU I 2 R 3 NICU II 4 KMC Others _____	NEONATAL COURSE Total hospital stay in days NICU I _____ days NICU II _____ days KMC Ward _____ days OB Ward _____ days Days of SSMV 0 1 2 3 4 5 ___ Days of CPAP 0 1 2 3 4 5 ___ Days on Oxygen 0 1 2 3 4 5 ___ Days on ext of TPN 0 1 2 3 4 5 ___ 1st Gen 2nd Gen 3rd Gen Days on antibiotics _____ # doses of surfactant 1 2 3 4 5 ___ Received EPO _____ 1 Yes 2 No Cerebral ECG/Cranial IUTZ 1 Yes 2 No CT Scan 1 Yes 2 No Cardiac Echography / ZD Echo 1 Yes 2 No Age of first enteral feed _____ days or date Selected Discharge Diagnosis Resp Distress Syndrome RDS 1 Yes 2 No Pathologic Jaundice 1 Yes 2 No Intra-ventricular Hemorrhage 1 Yes 2 No How diagnosis was made 0 Not investigated 1 Clinical diagnosis 3 Ultrasound Degree of IVH 0 G1 G2 G3 G4 5 Not evaluated Symptomatic Hypoglycemia 1 Yes 2 No INFECTIONS Suspected Infections 1 Yes 2 No Early Neonatal Infection (<7 days) Sepsis 1 Yes 2 No Meningitis 1 Yes 2 No Omphalitis 1 Yes 2 No Arthritis 1 Yes 2 No Necrotizing Enterocolitis 1 Yes 2 No Pneumonia 1 Yes 2 No Anemia 1 Yes 2 No Coagulopathy 1 Yes 2 No Intra-ventricular Hemorrhage 1 Yes 2 No Others _____	Late Neonatal Infections (>7 days) Sepsis 1 Yes 2 No Meningitis 1 Yes 2 No Omphalitis 1 Yes 2 No Arthritis 1 Yes 2 No Necrotizing Enterocolitis 1 Yes 2 No Others _____ Neurological Dysfunction 1 Yes 2 No Abnormal Tonus 1 Hypotonia 2 Hypertonia 3 None Seizures 1 Yes 2 No Apneas 1 Yes 2 No Oxygen dependency (>28 days or beyond 36 weeks of PCA) 1 Yes 2 No ROP 1 Yes, Regressive 2 No 3 Yes with treatment 4 Yes, degree Right Eye 1 0 1+ 0 IV-Bnd Left Eye 1 0 1+ 0 IV-Bnd Mother Status 1 Adult intensive care 2 Recovering 3 Well 4 Dead 5 Disappeared	INTRAHOSPITAL KMC PROGRAM KMC Enrollment 0 Enrolled with KMC Date _____ Age in days _____ Reason for no KMC enrollment 1 Mother not willing 2 Staff not willing 3 Not authorized by Healthcare 4 Others _____ Place 1 NICU I 3 KMC ward 2 NICU II 4 PCU Weight _____ gm Length _____ cm HC _____ cm Breastfeeding 1 Possible 2 No Permanent 3 No Temporary 4 Supply by others, not pasteurized 5 Supply by others, pasteurized Alimentation 1 Mom EBM 2 EBM + MF 3 Milk Formula 4 EBM + IMF Way of Administration 1 Yes 2 No Breast 1 Yes 2 No Continuous Gavage 1 Yes 2 No Discontinuous Gavage 1 Yes 2 No Bottle 1 Yes 2 No Parenteral nutrition 1 Yes 2 No Use of fortifiers 1 Yes 2 No Persistence of Neonatal Pathology Respiratory 1 Yes 2 No Infectious 1 Yes 2 No Neurologic 1 Yes 2 No KMC Providers Mother 1 Yes 2 No Others _____	KMC Adaptation Total days _____ Max hours/day _____ Weight gain/kg/day _____ Aminophylline 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No Multivitamins 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No Antireflux drugs 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No Alimentation Human Milk 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No HM & MF 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No Milk Formula 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No Parenteral nutrition 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No Way of Administration Breast 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No Continuous Gavage 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No Discontinuous Gavage 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No Bottle 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No Training of Others 1 Yes 2 No Number of blood transfusion 0 1 2 3 4 5 ___ # days after enrollment mother is confident with KMC ___ AMBULATORY KMC PROGRAM Home discharge Date _____ Age _____ Entry in ambulatory KMC Date _____ Age _____ Weight _____ gm Length _____ cm HC _____ cm Eligibility criteria completed Alimentation Human Milk 1 Yes 2 No HM & MF 1 Yes 2 No Milk Formula 1 Yes 2 No Way of Administration Breast 1 Yes 2 No Bottle 1 Yes 2 No Tube 1 Yes 2 No Dropper 1 Yes 2 No Oxygen dependency 1 Yes 2 No Neurological dysfunction 1 Normal 2 Abnormal Aminophylline 1 Yes 2 No Multivitamins 1 Yes 2 No Anti-reflux drugs 1 Yes 2 No Commitment of family 1 Yes 2 Yes
	Reader	Working	House																		
	Age	Y es No	Wife Studying																		
Mother	1 2	1 2	3 4																		
Father	1 2	1 2	3 4																		

KMC OUTPATIENT RECORD

Mother's Name _____		Address _____	
Baby's Name _____			
DATE _____	Clinical Dx	Rx	Immunization
Age ___mo. ___wk. ___day Corrected Age _____ Weight _____gm. Length _____cm Head Cir _____cm Temperature _____C KMC Provider 1M 2F 3O Accompanied 1Yes 2No Alimentation: 1 Human Milk 2 HM & MF 3 Milk Formula Way of Administration 1 Breast 2 Bottle 3 Tube 4 _____ Kangaroo Position Status () Baby still in kangaroo position () Left kangaroo position Date Left _____ Weight _____gms Age ___mos. ___wks.	() Well baby () Not Well DX if not well: Infectious Diseases 1Yes 2No Aspirative Pneumonia 1Yes 2No Anemia 1Yes 2No Hypoglycemia 1Yes 2No Failure to thrive 1Yes 2No Hemorrhagic illness 1Yes 2No Others _____ Neurological Status 1Yes 2No Abnormal tone 1Yes 2No 1 Hypertonia 1Yes 2No 2 Hypotonia 1Yes 2No 3 Dystonia 1Yes 2No 4 Normal 1Yes 2No Abnormal primitive reflexes 1Yes 2No ROP 1Yes 2No Degree ___Right Eye ___Left Eye On-going Chronic Pathology Respiratory 1Yes 2No Neurological 1Yes 2No Others _____	Rx Medicines () Multivitamins () Anti-reflux () Theophylline () Iron Others _____ # Consultation outside KMC _____	() DPT Poto () Hib () Hepatitis B () BCG () Measles Others: _____ # Readmission 0 1 2 3 ___ Total stay ___ days

DATE _____	Clinical Dx	Rx	Immunization
Age ___mo. ___wk. ___day Corrected Age _____ Weight _____gm. Length _____cm Head Cir _____cm Temperature _____C KMC Provider 1M 2F 3O Accompanied 1Yes 2No Alimentation: 1 Human Milk 2 HM & MF 3 Milk Formula Way of Administration 1 Breast 2 Bottle 3 Tube 4 _____ Kangaroo Position Status () Baby still in kangaroo position () Left kangaroo position Date Left _____ Weight _____gms Age ___mos. ___wks.	() Well baby () Not Well DX if not well: Infectious Diseases 1Yes 2No Aspirative Pneumonia 1Yes 2No Anemia 1Yes 2No Hypoglycemia 1Yes 2No Failure to thrive 1Yes 2No Hemorrhagic illness 1Yes 2No Others _____ Neurological Status 1Yes 2No Abnormal tone 1Yes 2No 1 Hypertonia 1Yes 2No 2 Hypotonia 1Yes 2No 3 Dystonia 1Yes 2No 4 Normal 1Yes 2No Abnormal primitive reflexes 1Yes 2No ROP 1Yes 2No Degree ___Right Eye ___Left Eye On-going Chronic Pathology Respiratory 1Yes 2No Neurological 1Yes 2No Others _____	Rx Medicines () Multivitamins () Anti-reflux () Theophylline () Iron Others _____ Rx # Consultation outside KMC _____	() DPT Poto () Hib () Hepatitis B () BCG () Measles Others: _____ # Readmission 0 1 2 3 ___ Total stay ___ days

DATE _____	Clinical Dx	Rx	Immunization
Age ___mo. ___wk. ___day Corrected Age _____ Weight _____gm. Length _____cm Head Cir _____cm Temperature _____C KMC Provider 1M 2F 3O Accompanied 1Yes 2No Alimentation: 1 Human Milk 2 HM & MF 3 Milk Formula Way of Administration 1 Breast 2 Bottle 3 Tube 4 _____ Kangaroo Position Status () Baby still in kangaroo position () Left kangaroo position Date Left _____ Weight _____gms Age ___mos. ___wks.	() Well baby () Not Well DX if not well: Infectious Diseases 1Yes 2No Aspirative Pneumonia 1Yes 2No Anemia 1Yes 2No Hypoglycemia 1Yes 2No Failure to thrive 1Yes 2No Hemorrhagic illness 1Yes 2No Others _____ Neurological Status 1Yes 2No Abnormal tone 1Yes 2No 1 Hypertonia 1Yes 2No 2 Hypotonia 1Yes 2No 3 Dystonia 1Yes 2No 4 Normal 1Yes 2No Abnormal primitive reflexes 1Yes 2No ROP 1Yes 2No Degree ___Right Eye ___Left Eye On-going Chronic Pathology Respiratory 1Yes 2No Neurological 1Yes 2No Others _____	Rx Medicines () Multivitamins () Anti-reflux () Theophylline () Iron Others _____ Rx # Consultation outside KMC _____	() DPT Poto () Hib () Hepatitis B () BCG () Measles Others: _____ # Readmission 0 1 2 3 ___ Total stay ___ days

DATE _____	Clinical Dx	Rx	Immunization
Age ___mo. ___wk. ___day Corrected Age _____ Weight _____gm. Length _____cm Head Cir _____cm Temperature _____C KMC Provider 1M 2F 3O Accompanied 1Yes 2No Alimentation: 1 Human Milk 2 HM & MF 3 Milk Formula Way of Administration 1 Breast 2 Bottle 3 Tube 4 _____ Kangaroo Position Status () Baby still in kangaroo position () Left kangaroo position Date Left _____ Weight _____gms Age ___mos. ___wks.	() Well baby () Not Well DX if not well: Infectious Diseases 1Yes 2No Aspirative Pneumonia 1Yes 2No Anemia 1Yes 2No Hypoglycemia 1Yes 2No Failure to thrive 1Yes 2No Hemorrhagic illness 1Yes 2No Others _____ Neurological Status 1Yes 2No Abnormal tone 1Yes 2No 1 Hypertonia 1Yes 2No 2 Hypotonia 1Yes 2No 3 Dystonia 1Yes 2No 4 Normal 1Yes 2No Abnormal primitive reflexes 1Yes 2No ROP 1Yes 2No Degree ___Right Eye ___Left Eye On-going Chronic Pathology Respiratory 1Yes 2No Neurological 1Yes 2No Others _____	Rx Medicines () Multivitamins () Anti-reflux () Theophylline () Iron Others _____ Rx # Consultation outside KMC _____	() DPT Poto () Hib () Hepatitis B () BCG () Measles Others: _____ # Readmission 0 1 2 3 ___ Total stay ___ days

KMC OUTPATIENT RECORD

Mother's Name _____		Address _____	
Baby's Name _____			
DATE	Clinical Dx	Rx	Immunization
Age ___mo. ___wk. ___day Corrected Age _____ Weight _____gm Length _____cm Head Cir _____cm Temperature _____C KMC Provider 1M 2F 3O Accompanied 1Yes 2No Alimentation: 1 Human Milk 2 HM & MF 3 Milk Formula Way of Administration 1 Breast 2 Bottle 3 Tube 4 _____ Kangaroo Position Status () Baby still in kangaroo position () Left kangaroo position Date Left _____ Weight _____gms Age ___mos. ___wks.	() Well baby () Not Well DX if not well: Infectious Diseases 1Yes 2No Aspirative Pneumonia 1Yes 2No Anemia 1Yes 2No Hypoglycemia 1Yes 2No Failure to thrive 1Yes 2No Hemorrhagic illness 1Yes 2No Others _____ Neurological Status 1Yes 2No Abnormal tone 1Yes 2No 1 Hypertonia 1Yes 2No 2 Hypotonia 1Yes 2No 3 Dystonia 1Yes 2No 4 Normal 1Yes 2No Abnormal primitive reflexes 1Yes 2No ROP 1Yes 2No Degree ___Right Eye ___Left Eye On-going Chronic Pathology Respiratory 1Yes 2No Neurological 1Yes 2No Others _____ # Consultation outside KMC _____	Rx Medicines () Multivitamins () Anti-reflux () Theophylline () Iron Others _____ Feelings of Mother with KMC (1- negative, 5- positive, MI- missing info) Period after discharge was stressful 1 2 3 4 5 MI Feel safe at time of visit 1 2 3 4 5 MI Staff support appreciated 1 2 3 4 5 MI Comfortable being close to each other 1 2 3 4 5 MI Feel support of family members 1 2 3 4 5 MI Others _____ # Readmission 0 1 2 3 ___ Total stay ___ days	() DPT Pctio () Hib () Hepatitis B () BCG () Measles Others: _____ # Readmission 0 1 2 3 ___ Total stay ___ days

DATE	Clinical Dx	Rx	Immunization
Age ___mo. ___wk. ___day Corrected Age _____ Weight _____gm Length _____cm Head Cir _____cm Temperature _____C KMC Provider 1M 2F 3O Accompanied 1Yes 2No Alimentation: 1 Human Milk 2 HM & MF 3 Milk Formula Way of Administration 1 Breast 2 Bottle 3 Tube 4 _____ Kangaroo Position Status () Baby still in kangaroo position () Left kangaroo position Date Left _____ Weight _____gms Age ___mos. ___wks.	() Well baby () Not Well DX if not well: Infectious Diseases 1Yes 2No Aspirative Pneumonia 1Yes 2No Anemia 1Yes 2No Hypoglycemia 1Yes 2No Failure to thrive 1Yes 2No Hemorrhagic illness 1Yes 2No Others _____ Neurological Status 1Yes 2No Abnormal tone 1Yes 2No 1 Hypertonia 1Yes 2No 2 Hypotonia 1Yes 2No 3 Dystonia 1Yes 2No 4 Normal 1Yes 2No Abnormal primitive reflexes 1Yes 2No ROP 1Yes 2No Degree ___Right Eye ___Left Eye On-going Chronic Pathology Respiratory 1Yes 2No Neurological 1Yes 2No Others _____ # Consultation outside KMC _____	Rx Medicines () Multivitamins () Anti-reflux () Theophylline () Iron Others _____ Feelings of Mother with KMC (1- negative, 5- positive, MI- missing info) Period after discharge was stressful 1 2 3 4 5 MI Feel safe at time of visit 1 2 3 4 5 MI Staff support appreciated 1 2 3 4 5 MI Comfortable being close to each other 1 2 3 4 5 MI Feel support of family members 1 2 3 4 5 MI Others _____ # Readmission 0 1 2 3 ___ Total stay ___ days	() DPT Pctio () Hib () Hepatitis B () BCG () Measles Others: _____ # Readmission 0 1 2 3 ___ Total stay ___ days

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Age ___mo. ___wk. ___day Corrected Age _____ Weight _____gm Length _____cm Head Cir _____cm Temperature _____C KMC Provider 1M 2F 3O Accompanied 1Yes 2No Alimentation: 1 Human Milk 2 HM & MF 3 Milk Formula Way of Administration 1 Breast 2 Bottle 3 Tube 4 _____ Kangaroo Position Status () Baby still in kangaroo position () Left kangaroo position Date Left _____ Weight _____gms Age ___mos. ___wks.	() Well baby () Not Well DX if not well: Infectious Diseases 1Yes 2No Aspirative Pneumonia 1Yes 2No Anemia 1Yes 2No Hypoglycemia 1Yes 2No Failure to thrive 1Yes 2No Hemorrhagic illness 1Yes 2No Others _____ Neurological Status 1Yes 2No Abnormal tone 1Yes 2No 1 Hypertonia 1Yes 2No 2 Hypotonia 1Yes 2No 3 Dystonia 1Yes 2No 4 Normal 1Yes 2No Abnormal primitive reflexes 1Yes 2No ROP 1Yes 2No Degree ___Right Eye ___Left Eye On-going Chronic Pathology Respiratory 1Yes 2No Neurological 1Yes 2No Others _____ # Consultation outside KMC _____	Rx Medicines () Multivitamins () Anti-reflux () Theophylline () Iron Others _____ Feelings of Mother with KMC (1- negative, 5- positive, MI- missing info) Period after discharge was stressful 1 2 3 4 5 MI Feel safe at time of visit 1 2 3 4 5 MI Staff support appreciated 1 2 3 4 5 MI Comfortable being close to each other 1 2 3 4 5 MI Feel support of family members 1 2 3 4 5 MI Others _____ # Readmission 0 1 2 3 ___ Total stay ___ days	() DPT Pctio () Hib () Hepatitis B () BCG () Measles Others: _____ # Readmission 0 1 2 3 ___ Total stay ___ days

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Age ___mo. ___wk. ___day Corrected Age _____ Weight _____gm Length _____cm Head Cir _____cm Temperature _____C KMC Provider 1M 2F 3O Accompanied 1Yes 2No Alimentation: 1 Human Milk 2 HM & MF 3 Milk Formula Way of Administration 1 Breast 2 Bottle 3 Tube 4 _____ Kangaroo Position Status () Baby still in kangaroo position () Left kangaroo position Date Left _____ Weight _____gms Age ___mos. ___wks.	() Well baby () Not Well DX if not well: Infectious Diseases 1Yes 2No Aspirative Pneumonia 1Yes 2No Anemia 1Yes 2No Hypoglycemia 1Yes 2No Failure to thrive 1Yes 2No Hemorrhagic illness 1Yes 2No Others _____ Neurological Status 1Yes 2No Abnormal tone 1Yes 2No 1 Hypertonia 1Yes 2No 2 Hypotonia 1Yes 2No 3 Dystonia 1Yes 2No 4 Normal 1Yes 2No Abnormal primitive reflexes 1Yes 2No ROP 1Yes 2No Degree ___Right Eye ___Left Eye On-going Chronic Pathology Respiratory 1Yes 2No Neurological 1Yes 2No Others _____ # Consultation outside KMC _____	Rx Medicines () Multivitamins () Anti-reflux () Theophylline () Iron Others _____ Feelings of Mother with KMC (1- negative, 5- positive, MI- missing info) Period after discharge was stressful 1 2 3 4 5 MI Feel safe at time of visit 1 2 3 4 5 MI Staff support appreciated 1 2 3 4 5 MI Comfortable being close to each other 1 2 3 4 5 MI Feel support of family members 1 2 3 4 5 MI Others _____ # Readmission 0 1 2 3 ___ Total stay ___ days	() DPT Pctio () Hib () Hepatitis B () BCG () Measles Others: _____ # Readmission 0 1 2 3 ___ Total stay ___ days

KMC OUTPATIENT RECORD

Mother's Name _____		Address _____	
Baby's Name _____			
DATE _____	Clinical Dx	Rx	Immunization
Age <u> </u> mo. <u> </u> wk. <u> </u> day	() Well baby () Not Well	Rx Medicines	() DPT Polio
Corrected Age _____	DX if not well:	() Multivitamins	() Hib
Weight _____ gm	Infectious Diseases 1 Yes 2 No	() Anti-reflux	() Hepatitis B
Length _____ cm	Aspirative Pneumonia 1 Yes 2 No	() Theophylline	() BCG
Head Cir _____ cm	Anemia 1 Yes 2 No	() Iron	() Measles
Temperature _____ C	Hypoglycemia 1 Yes 2 No	Others _____	Others: _____
KMC Provider 1 M 2 F 3 O	Failure to thrive 1 Yes 2 No		
Accompanied 1 Yes 2 No	Hemorrhagic Illness 1 Yes 2 No		
Alimentation:	Others _____		
1 Human Milk	Neurological Status 1 Yes 2 No		
2 HM & MF	Abnormal tone 1 Yes 2 No		
3 Milk Formula	1 Hypertonia 1 Yes 2 No		
Way of Administration	2 Hypotonia 1 Yes 2 No		
1 Breast	3 Dystonia 1 Yes 2 No		
2 Bottle	4 Normal 1 Yes 2 No		
3 Tube	Abnormal primitive reflexes 1 Yes 2 No		
4 _____	ROP 1 Yes 2 No		
Kangaroo Position Status	Degree <u> </u> Right Eye <u> </u> Left Eye		
() Baby still in kangaroo position	On-going Chronic Pathology		
() Left kangaroo position	Respiratory 1 Yes 2 No		
Date Left _____	Neurological 1 Yes 2 No		
Weight _____ gms	Others _____		
Age _____ mos. _____ wks.	# Consultation outside KMC _____		
		Feelings of Mother with KMC (1- negative, 5- positive, MI- missing info)	
		Period after discharge was stressful 1 2 3 4 5 MI	
		Feel safe at time of visit 1 2 3 4 5 MI	
		Staff support appreciated 1 2 3 4 5 MI	
		Comfortable being close to each other 1 2 3 4 5 MI	
		Feel support of family members 1 2 3 4 5 MI	
		Others _____ 1 2 3 4 5 MI	
		# Readmission 0 1 2 3 _____ Total stay _____ days	

DATE _____	Clinical Dx	Rx	Immunization
Age <u> </u> mo. <u> </u> wk. <u> </u> day	() Well baby () Not Well	Rx Medicines	() DPT Polio
Corrected Age _____	DX if not well:	() Multivitamins	() Hib
Weight _____ gm	Infectious Diseases 1 Yes 2 No	() Anti-reflux	() Hepatitis B
Length _____ cm	Aspirative Pneumonia 1 Yes 2 No	() Theophylline	() BCG
Head Cir _____ cm	Anemia 1 Yes 2 No	() Iron	() Measles
Temperature _____ C	Hypoglycemia 1 Yes 2 No	Others _____	Others: _____
KMC Provider 1 M 2 F 3 O	Failure to thrive 1 Yes 2 No		
Accompanied 1 Yes 2 No	Hemorrhagic Illness 1 Yes 2 No		
Alimentation:	Others _____		
1 Human Milk	Neurological Status 1 Yes 2 No		
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1 Breast	3 Dystonia 1 Yes 2 No		
2 Bottle	4 Normal 1 Yes 2 No		
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Kangaroo Position Status	Degree <u> </u> Right Eye <u> </u> Left Eye		
() Baby still in kangaroo position	On-going Chronic Pathology		
() Left kangaroo position	Respiratory 1 Yes 2 No		
Date Left _____	Neurological 1 Yes 2 No		
Weight _____ gms	Others _____		
Age _____ mos. _____ wks.	# Consultation outside KMC _____		
		Feelings of Mother with KMC (1- negative, 5- positive, MI- missing info)	
		Period after discharge was stressful 1 2 3 4 5 MI	
		Feel safe at time of visit 1 2 3 4 5 MI	
		Staff support appreciated 1 2 3 4 5 MI	
		Comfortable being close to each other 1 2 3 4 5 MI	
		Feel support of family members 1 2 3 4 5 MI	
		Others _____ 1 2 3 4 5 MI	
		# Readmission 0 1 2 3 _____ Total stay _____ days	

DATE _____	Clinical Dx	Rx	Immunization
Age <u> </u> mo. <u> </u> wk. <u> </u> day	() Well baby () Not Well	Rx Medicines	() DPT Polio
Corrected Age _____	DX if not well:	() Multivitamins	() Hib
Weight _____ gm	Infectious Diseases 1 Yes 2 No	() Anti-reflux	() Hepatitis B
Length _____ cm	Aspirative Pneumonia 1 Yes 2 No	() Theophylline	() BCG
Head Cir _____ cm	Anemia 1 Yes 2 No	() Iron	() Measles
Temperature _____ C	Hypoglycemia 1 Yes 2 No	Others _____	Others: _____
KMC Provider 1 M 2 F 3 O	Failure to thrive 1 Yes 2 No		
Accompanied 1 Yes 2 No	Hemorrhagic Illness 1 Yes 2 No		
Alimentation:	Others _____		
1 Human Milk	Neurological Status 1 Yes 2 No		
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Kangaroo Position Status	Degree <u> </u> Right Eye <u> </u> Left Eye		
() Baby still in kangaroo position	On-going Chronic Pathology		
() Left kangaroo position	Respiratory 1 Yes 2 No		
Date Left _____	Neurological 1 Yes 2 No		
Weight _____ gms	Others _____		
Age _____ mos. _____ wks.	# Consultation outside KMC _____		
		Feelings of Mother with KMC (1- negative, 5- positive, MI- missing info)	
		Period after discharge was stressful 1 2 3 4 5 MI	
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		Staff support appreciated 1 2 3 4 5 MI	
		Comfortable being close to each other 1 2 3 4 5 MI	
		Feel support of family members 1 2 3 4 5 MI	
		Others _____ 1 2 3 4 5 MI	
		# Readmission 0 1 2 3 _____ Total stay _____ days	

DATE _____	Clinical Dx	Rx	Immunization
Age <u> </u> mo. <u> </u> wk. <u> </u> day	() Well baby () Not Well	Rx Medicines	() DPT Polio
Corrected Age _____	DX if not well:	() Multivitamins	() Hib
Weight _____ gm	Infectious Diseases 1 Yes 2 No	() Anti-reflux	() Hepatitis B
Length _____ cm	Aspirative Pneumonia 1 Yes 2 No	() Theophylline	() BCG
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Temperature _____ C	Hypoglycemia 1 Yes 2 No	Others _____	Others: _____
KMC Provider 1 M 2 F 3 O	Failure to thrive 1 Yes 2 No		
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1 Human Milk	Neurological Status 1 Yes 2 No		
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Kangaroo Position Status	Degree <u> </u> Right Eye <u> </u> Left Eye		
() Baby still in kangaroo position	On-going Chronic Pathology		
() Left kangaroo position	Respiratory 1 Yes 2 No		
Date Left _____	Neurological 1 Yes 2 No		
Weight _____ gms	Others _____		
Age _____ mos. _____ wks.	# Consultation outside KMC _____		
		Feelings of Mother with KMC (1- negative, 5- positive, MI- missing info)	
		Period after discharge was stressful 1 2 3 4 5 MI	
		Feel safe at time of visit 1 2 3 4 5 MI	
		Staff support appreciated 1 2 3 4 5 MI	
		Comfortable being close to each other 1 2 3 4 5 MI	
		Feel support of family members 1 2 3 4 5 MI	
		Others _____ 1 2 3 4 5 MI	
		# Readmission 0 1 2 3 _____ Total stay _____ days	



Department of Pediatrics
KANGAROO MOTHER CARE PROGRAM

INFANIB SCORING SHEET

INFANIB Name _____ NIC # _____
 Mother _____
 Date of exam _____ Chronologic age _____ Corrected age _____

#	ITEM											Factors									
		0 to 1	1 to 2	2 to 3	3 to 4	4 to 5	5 to 6	6 to 7	7 to 8	8 to 9	9-18 mos.	1	2	3	4	5					
1	Hands closed/open	Closed	Sometimes closed	Open																	
2	Scarf sign	0-15°	15-45°	45-60°	60-85°																
3	Heel to ear	90-100°	60-90°	40-60°	10-40°																
4	Popliteal angle	80-90°	90-100°	100-150°	50-170°																
5	Leg abduction	40-70°	70-100°	100-130°	130-180°																
6	Dorsiflexion of foot	0-10°	10-40°	40-70°	70-80°	80-90°															
7	Foot grasp	PRESENT ++		AVERAGE+			NONE-			4=2, 1=3, 0=5											
8	Tonic (s)	Shoulder retract, arms flexed		+ some			Absent (-)			+1, 1=3, (-)=5											
	Labyrinthine	Legs flex/extend		+ some			Absent (-)			+1, 1=3, (-)=5											
9	Tonic (s) neck reflex	Spontaneous persistent		Postures in move out			Absent (-)			+1, 1=3, (-)=5											
10	Pull to sitting	Head extend Arm extend		Head up arm ext.		Head flex Arm ext.		Head flexed Arms flexed													
11	Body Rotative											present =5 asym=3 absent=1									
13	Prone all fours	Lifts head	Head up 45	Forearms only	Head up 90	Bears wt. on ext. arms	assumes all 4's unsteadily	assumes all 4 well	stands up thru craniograde												
14	Tonic (P)	Shoulder protraction & some flexion of legs, arms, hips.																			
	Labyrinthine																				
15	Sitting Position																				
16	Sideways Parachute											Present =5 Slow or sl. asym=3 abst. or asym=1									
17	Backwards Parachute											same as # 16									
18	Weight bearing	no weight bearing		poor wt. bearing breaks at knee		unequal wt. bearing		feet flat													
19	Positive support	no.		> 30 sec. on toes =1		5-30 sec. on toes then drop to feet flat =3		feet flat =5													
20	Forward parachute											present =5 slow or sl. asym=3 absent or marked asym=1									
Degree of AbN based on Total Score		< 4 mos < 48 = abnormal 40 to 65 = transient > 65 = normal			4 to 8 mos. < 54 = abnormal 55 to 71 = transient > 72 = normal			> 8 mos. < 68 = abnormal 69 to 82 = transient > 83 = normal			TOTAL										
Category of Abnormality		<input type="checkbox"/> Spastic Tetraparesis or Dyskinesia		<input type="checkbox"/> Spastic Hemiparesis		<input type="checkbox"/> Spastic Diplegia		<input type="checkbox"/> Hypotonia		Score: 5= Normal 3= one stage 1=2 stage											



**AGREEMENT
KASUNDUAN
ON THE
UKOL SA
"KANGAROO MOTHER CARE PROGRAM"**

I, _____, _____ years old, Mother/Father/Relative of _____ agree to perform all the duties and responsibilities of the "Kangaroo Mother Care Program" of St. Luke's Medical Center as follows:

AKO, si _____, _____ taong gulang, ina/ama/kamag-anak ni _____ ay sumasang-ayon sa mga alituntunin ng "Kangaroo Mother Care Program" ng St. Luke's Medical Center, tulad ng mga sumusunod:

1. I will continue caring for my child/baby at home using the techniques taught to me while in the hospital, ideally 20 hours a day, until my baby attained a weight of 5lbs 8oz or 2500gms.

Itutuloy ko ang pangangalaga sa aking sanggol sa bahay sa pamamaraan na itinuro sa akin habang ako ay nasa ospital pa, araw-araw, 20 oras sa bawat araw, hanggang sa siya ay umabot sa timbang na 5lbs 8oz or 2500gms.

2. If I need to attend to my personal needs, I will never leave my baby alone lying down in the crib: instead, my husband, relative or my baby's caregiver will take my place in holding him/her in the "Kangaroo Position".

Kung sakali man at ako ay may kailangan gawin ukol sa pansariling pangangailangan, hindi ko maaaring iwanan ang aking sanggol na mag-isa at nakahiga sa kina; bagkus ang aking asawa o kaya'y kamaganak o kasambahay ay aking kasalit sa paghawak sa aking sanggol sa "kangaroo position".

3. I shall take my rest at night together with my baby in the "Kangaroo Position" as I have Practiced during my stay in the hospital.

Ako ay mamamahinga sa gabi kasiping ang aking sanggol sa "kangaroo position" tulad ng kinasanayan ko sa loob ng ospital.

4. I will bring my baby back to the OPD or his/her Pediatrician's Clinic, two (2) times a week and conform with every appointment/schedule given by my doctor in the succeeding days.

Ibabalik ko ang aking sanggol sa "OPD Clinic" o sa aking pribadong doktor, dalawang beses sa bawat linggo at tutupad ako sa bawat appointment na itatakda ng aking manggagamot at sa mga sumusunod na araw.

5. If ever I need to make an inquiry or I am in doubt about my baby's condition, I will call the NCU (Neonatal Care Unit) of the hospital for information and advice.

Kung ako ay may kailangan o pagaalinlangan sa aking sanggol maaari akong tumawag sa NCU ng ospital para malinawan at mapagpayuhan.

6. I will return for Neuro-Developmental follow-up up to one (1) year.

Tutupad ako sa lahat ng tungkuling ito hanggang maging isang taong gulang ang aking sanggol.

7. All the precepts and principles of the "Kangaroo Mother Care Program" were clearly explained to me and I understand it fully, I will sign this agreement freely and without reservations.

Naipaliwanag ng malinaw ang lahat ng alituntunin ng "Kangaroo Mother Care Program" sa akin, naintindihan ko ito ng lubos at maluwag sa aking kalooban, ang paglagda sa kasunduang ito.

Print name & signature:

Mother

Father/Relative

Witness