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Strengthening Public-Private Partnership in Expanding Hospital-based Provision of Maternal, Newborn, Child Health and Nutrition (MNCHN) Services



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ACRONYMS & ABBREVIATIONS

ANC	Antenatal Care
BEmONC	Basic Emergency Obstetric and Newborn Care
BTL-MLLA	Bilateral Tubal Ligation – Mini-Laparotomy through Local Anaesthesia
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHO	City Health Office
DOH-RO	Department of Health Regional Office
EINC	Essential Intra-partum and Newborn Care
EPI	Expanded Program of Immunization
FBD	Facility-Based Delivery
FHSIS	Field Health Services Information System
FP-CBT	Family Planning Competency-Based Training
FP-MCH	Family Planning Maternal and Child Health
ICV	Informed Choice and Voluntarism
ILHZ	Inter-Local Health Zones
IUD	Intra-uterine Device
LA/PM	Long Acting and Permanent Methods
LGU	Local Government Unit
MDG	Millennium Development Goals
MHO	Municipal Health Office
MNCHN	Maternal, Neonatal, Child Health & Nutrition
MOOE	Maintenance and Other Operating Expenses
MOP	Manual of Operations
NHIP	National Health Insurance Program
NSV	No-Scalpel Vasectomy
PHIC	Philippine Health Insurance Corporation
PHO	Provincial Health Office
PIPH	Province-wide Investment Plan for Health
RTTH	Regional Technical Team for Hospital
RHU	Rural Health Unit
SDN	Service Delivery Network
TCL	Target Client List
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VS	Voluntary Sterilization

PURPOSE OF THIS DOCUMENT

This document serves as a guide for technical assistance providers from both public and private sectors in informing, recruiting, and building the capacities of public or private hospitals in maternal, newborn, child health and nutrition (MNCHN) strategy implementation. This is intended for use by management, staff and field officers of technical assistance providers, such as the regional offices of the Department of Health (DOH), and development partners, such as USAID and UNFPA, as these institutions assist individual public and private hospitals expand their family planning and maternal and child health (FP-MCH) information, products and services provision. This also serves as a guide for replicating expansion of MNCHN provision and use in a hospital setting.

In summary, this guide contains the following:

- Process of engaging, developing and expanding MNCHN operations in public and private hospitals
- Sample key operational directions across the local health system in a province or city
- Operationalizing MNCHN provision and use within public and private hospitals
- Sample activity and training designs
- Reporting flows
- Sample referral flow showcasing the hospital's role in the referral network
- Quality assessment tools

RATIONALE

Large number of hospitals in the country

In 2009, the DOH reported a total of 1,795 licensed hospitals in the country. Of this number, 721 were government hospitals, and 1,074 were private hospitals. A basic element of hospital service is the provision of FP-MCH information, products and services. The large number and wide geographic range of hospitals throughout the country presents a great potential for increasing use of FP-MCH products and services among men and women of reproductive age. For example, a large government medical center in the Visayas recorded a total of 4,060 deliveries in 2007. The hospital could have used these deliveries as opportunities for mothers to use family planning, had services, e.g., counseling, and products been available. This same hospital had 16,420 admissions, provided 93,675 out-patient services and 26,640 emergency consultations for a total of 136,735 patient contacts. Hospitals, therefore, are a natural venue to drive demand for, and supply of FP-MCH information, products and services.

Limited, sporadic and unorganized hospital participation and involvement in FP-MCH activities

Current provision of family planning services, information and products in public and private hospitals has not been fully optimized, nor have the community fully utilized hospitals for the benefits of family planning. This is reflected by the high unmet need for family planning services nationwide, (22.3%, NDHS 2008) and the gap between desired (2.4) and actual (3.3, NDHS 2008) number of children in Filipino families.

Not all hospitals provide the full range of FP-MCH information, products and services on a regular basis. Such hospital-based services are usually provided on an individual basis to walk-in patients/clients seeking consultation on family planning. The service is akin to one given during a consultation for an illness or disease, rather than as part of a public health program. Most hospitals regard family planning, as low priority because it is considered elective and non-life-threatening, and therefore does not require treatment or curative care. In fact, FP-MCH products and services are usually relegated to rural health units, or health stations/centers. This has resulted in hospitals reducing services to family planning. Some public and private hospitals provide more consistent maternal and child health-related services rather than family planning services because these cases present an urgent need for medical treatment and are regarded as more economically beneficial to both the health provider and the hospital.

Positive experiences in hospitals' response to FP-MCH

It has been proven, that with the appropriate technical, logistic and financial support, hospitals can, and do play an active role in positively influencing public health outcomes, particularly in increasing contraceptive prevalence rate. For example, 32 DOH-retained, 156 public hospitals in 72 local government units, and eight private hospitals participated in the Integrated Family Planning and Maternal Health Program funded by USAID from 1995 to 1999. Over a five-year period, project assistance resulted in 42 trained trainers on the DOH-recognized standard technique for female sterilization, and a total of 48,033 informed choice-compliant voluntary sterilization cases.

Availability of PhilHealth financing for hospital-based FP-MCH

Improvements of benefits in the coverage of FP-MCH conditions under PhilHealth offer a viable argument that addresses the hospitals' concern regarding the non-profitability of offering FP-MCH services. Experience with private midwives and their clinics which were assisted in acquiring PhilHealth accreditation for maternity and newborn care packages have shown that income from PhilHealth reimbursements can be significant enough for economic viability and sustainability. With the Philippine government's commitment to provide universal healthcare coverage within the next three years and

considering that almost all hospitals and their physicians are already PhilHealth-accredited, incentives such as payments for deliveries (up to four), PhP4,000 per voluntary surgical sterilization case, IUDs, as well as case payments for various MCH conditions show the potential income from PhilHealth that may interest and sustain hospitals' participation in FP-MCH local service delivery networks. The current rate at which PhilHealth pays for family planning reimbursements does not even comprise one percent of its total payments for all cases in a year. Maximizing utilization of PhilHealth benefits for voluntary surgical sterilization will likewise address the issue of motivating voluntary surgical sterilization case surgeons to actively perform the procedure.

Goal

The goal of engaging hospitals to expand hospital-based MNCHN provision and use is to improve constant and consistent availability of, and access to safe, effective, efficient, youth-oriented, and gender-transformative MNCHN information, services and products across provinces, cities and regions.

With this goal, the hospitals are able to contribute to the government's efforts towards universal health access, specifically to MNCHN services, products and information.

Specific objectives

Implementing the MNCHN strategy in hospitals should result in:

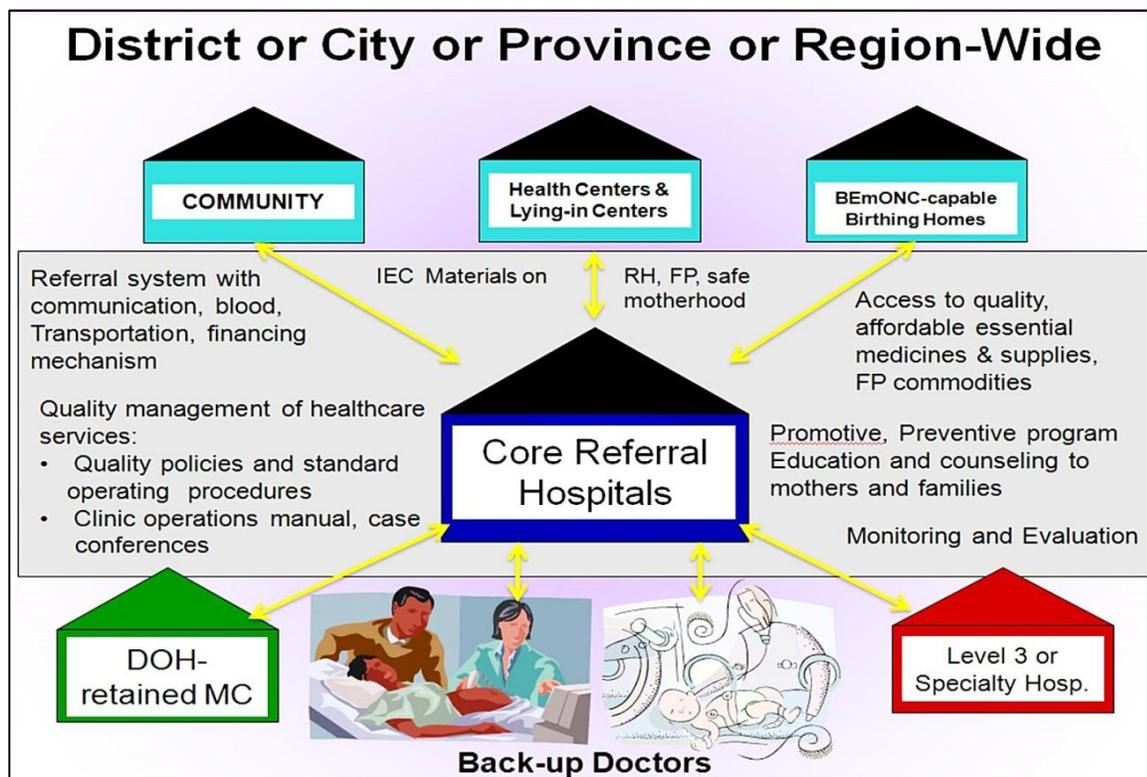
- Understandable, evidence-based information that enables clients to freely decide and act on their MNCHN needs
- MNCHN services that respond to the unmet need of women, men, couples and families
- Quality and affordable MNCHN products

KEY ROLES OF HOSPITALS IN THE MNCHN STRATEGY IMPLEMENTATION

Enabled hospitals can perform multiple tasks that will contribute to the SDN's functionality and sustainability. Depending on the capability of the hospitals, entrepreneurial direction, management decisions, and the demand by fellow service delivery network (SDN) members, hospitals can perform different key roles, as required by the SDN and the locality's health needs.

Hospitals assume critical roles in hastening the decline in maternal and neonatal morbidity and mortality. The following figure shows that the natural relationship of different SDN members and hospitals are central to local health systems and to the eventual provision and use of health care services and products.

Figure 1. Relationship of hospitals with other health facilities within the SDN in a locality



Role #1: Exemplar or model provider

Hospitals are most often viewed as providing the highest level of care, offering services other health providers cannot. Specifically, hospitals are expected to provide quality MNCHN information, services, and products, using the right tools, at the right time, at the right place, and provided at the right cost.

Once the hospital becomes a model MNCHN provider, it can proactively perform its other roles—as referral hub, trainer, advisor, efficient manager, etc.—contributing further to the SDN's systematic, programmatic response to unmet needs for family health.

Further, as hospitals become model MNCHN providers, other SDN members are inspired to follow. The hospitals' relevance in the SDN becomes more pronounced as they match their services to the demand generated from communities.

For hospitals to fully assume this role, their competencies have to be developed and their services monitored and well-supervised. The key MNCHN services and competencies expected from hospitals are given in [Annex A](#).

Role #2: Referral hub within the area-wide network

Hospitals support the day-to-day operation of SDNs and allow the two-way referral system to function, ensuring a continuum of care across the local health system. Hospitals receive referrals from lower level health care facilities. These clients are in need of comprehensive management for complicated pregnancies or labor, those who have voluntarily decided to undergo surgical contraception, or newborns in need of specialty care.

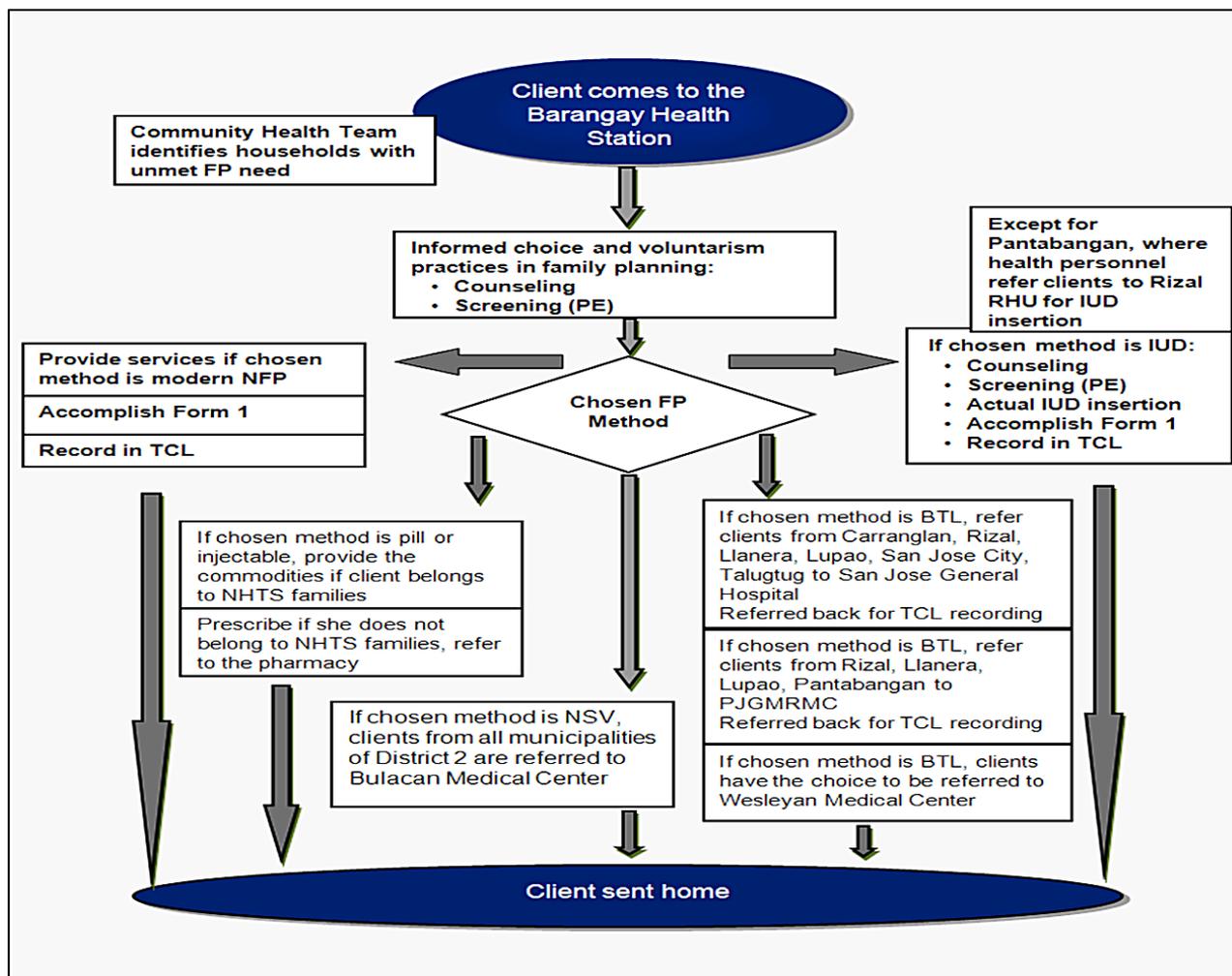
Hospitals also refer patients whose circumstances are beyond the hospital's capability to address. With two-way referrals, hospitals can refer patients – such as women with pregnancies assessed as healthy – to non-hospitals like birthing homes that are SDN members. Such referrals will free up beds, allowing hospitals to cater to patients with complicated cases that cannot be addressed by primary health care facilities.

To ensure quality care provided by primary healthcare providers at the birthing homes, the hospital can widen the coverage of its continuing quality improvement initiatives to include public and private birthing homes. This improves the confidence of hospital medical and nursing staff that refer clients back to primary healthcare providers, and provides assurances that clients who have uncomplicated pregnancies are appropriately taken care of by primary healthcare providers but will be immediately referred to the hospital should the need arise.

For hospitals to fully assume this role there have to be clear agreements between partners, standard operating procedures, and implementation of a continuing quality improvement plan.

The diagram below is an example of a referral flow for family planning involving different SDN members in Nueva Ecija.

Figure 2. Health referral flow for family planning involving hospitals in District 2, Nueva Ecija



Role #3: Adviser to network providers and stakeholders

Hospitals generate a wealth of data and information on health outcomes, the effectiveness of individual providers, and SDNs. SDNs can use these data to continually improve provision and use. Since obstetric and gynecology experts are practicing in hospitals, these hospitals naturally facilitate and provide avenues for maternal and neonatal death reviews, clinical case conferences for midwives, nurses and doctors and other allied health professions. Further, as hospital-based providers are clinical specialists, they can contribute to the continuing health education of primary healthcare providers. For hospitals to assume this role there has to be continuous data quality check, systematic data management, translation of data into usable information and regular avenues for interaction among different stakeholders.

Role #4: Trainer of service providers or trainers

Hospitals are likewise natural avenues for training and should work to become DOH-recognized training institutions or specialty boards, not only for doctors but also for teams of midwives, nurses and doctors. Soon after hospitals become certified service providers on MNCHN, key hospital staff can be trained as trainers for BTL-MLLA (Bilateral Tubal Ligation – Mini-Laparotomy through Local Anaesthesia), basic emergency obstetric and newborn care (BEmONC), family planning competency-based training (FP-CBT) for level I or IUD, essential intrapartum and newborn care (EINC) and other trainings required for

PhilHealth accreditation and DOH Licensing. The DOH-retained, and private hospitals can be developed as training facilities on the different technical areas under MNCHN, training both public and private providers. In the long term, the national or regional DOH can contract out different MNCHN trainings to these hospitals within the context of the training system.

For the hospitals to assume this role, the DOH has to recognize them as a qualified partner training facility.

Role #5: Efficient managers of health care financing

Hospitals need to ensure that PhilHealth members and beneficiaries fully utilize their benefits. Private hospitals, after having been briefed on the relevance of the no balance billing policy can be convinced to apply the risk-protection initiative, primarily for the poorest individuals who cannot afford to pay out-of-pocket, supporting the government's Millennium Development Goal to lower maternal and child mortality.

Implementing the No Balance Billing (NBB) Policy is not a money-losing venture. It makes the services equitable and financially accessible for the poor. On the other hand, it is profitable for hospitals, as PhilHealth will reimburse for the services and products provided for. Hospitals can then use the income from PhilHealth to improve FP-MCH services and as additional incentives for their workforce.

For hospitals to assume this role, they have to be PhilHealth-accredited and DOH-licensed at the minimum, have linkages with institutions that do demand generation, a functional local public-private referral mechanism, guidance from SDN management, public health tools that can be the basis for investment and income projections.

PREPARING THE REGIONS FOR EXPANDING HOSPITAL-BASED MNCHN PROVISION

Formation of the Regional Technical Team for Hospitals

The DOH-Regional Offices (DOH-ROs) should establish the stewardship machinery, cementing its technical leadership on expanding hospital-based MNCHN provision and use.

After identifying a DOH-retained hospital that will serve as a technical partner in moving this initiative forward, the DOH-RO can form the Regional Technical Team for Hospital (RTTH) by issuing a policy. The RTTH shall serve as the administrative and technical mechanism through which individual hospitals in the region will be developed into exemplar providers of FP-MCH information, products and services. The DOH-RO becomes the lead agency, its DOH-retained hospital in the region, will become the main technical backstop for the development program, and other senior DOH-RO and hospital personnel who shall contribute significantly to the program as policy and decision makers. The issuance will contain, but is not necessarily limited to: the composition of the team, roles/responsibilities/functions/authority of the team, organizational set-up, and working relationships.

There is a need for continuous stewardship of the RTTH for policy directions, financing, scheduling of resource mobilization, synchronization of demand generation with service provision, among other things. A clear example of this is the policy issuance of DOH-RO VII on long acting and permanent methods of contraception, which resulted in an increased number of public and private hospitals engaging in itinerant missions in Cebu.

[Annex B](#) provides the actual Personnel Order issued by the DOH-RO VI (Western Visayas) creating the RTTH in the region.

Capability-Building for Hospital-Based FP-MCH services in the DOH-retained hospitals

Under the management of the RTTH, the chosen DOH-retained hospital, upon concurrence of its medical director, shall be the first to be assisted to become the model FP-MCH service provider. The technical interventions needed to build the capability of the selected DOH-retained hospital shall be provided as soon as possible. Once the model DOH-retained hospital is ready, it shall provide technical assistance to public and private hospitals participating in the SDN.

Described below is the process of how the DOH-RO, with its development partner, determines which DOH-retained hospital will serve as its technical partner in the RTTH:

- I. DOH-RO makes an assessment site visit to the candidate DOH-retained hospital
 - a. Pay a courtesy visit to the Medical Director/Hospital Chief
 - Present the objectives of the site visit
 - Describe what activities will happen
 - Share what the expected outputs are
 - Inform of exit feedback at end of visit
 - b. Conduct assessment of the hospital using any one of the below tools:
 - i. If time is limited, use the Rapid Assessment Tool ([Annex C-1](#))
 - ii. If there is time for a more comprehensive assessment, use the Assessment Form for MNCHN Operations ([Annex C-2](#))

- c. Post-assessment Team conference – DOH-RO will collate findings and assess the hospital's capacity to serve as the RTTH technical backstop.
- d. Feedback conference. The DOH-RO will conduct a feedback conference with the management of the DOH-retained hospital to:
 - i. Share positive assessment findings
 - ii. Share findings regarding FP-MCH service provision that needs improvement
 - iii. Share information regarding DOH-RO's program to develop, improve, and expand hospital-based FP-MCH Services
 - iv. Challenge the hospital to become:
 - The DOH-RO technical resource partner **only if** the post-assessment conference shows that the DOH-retained hospital is qualified, **OR**:
 - A participant in the program (the hospital will be invited to a future launching event) – **if** the post-assessment conference reveals the hospital is NOT the one the DOH-Regional Office wants as a technical partner

At this point the DOH-retained hospital must make its own decision: whether to accept or to decline the offer to work in tandem with the DOH-RO to implement the technical initiative for improving hospital-based FP-MCH services. If the DOH-retained hospital **accepts**, then its **first action** is to become part of the Regional Technical Team for Hospitals. The Chief of Hospital can commit to the partnership.

If the DOH-retained hospital decides **not to accept** the role of DOH-RO technical backstop for the program, the DOH-Regional Office will explore other possibilities, such as:

- If available, assess and challenge other qualified DOH-retained hospitals that are willing to accept the role.
- Work with the DOH central office to engage the DOH-retained hospital, especially if there are no other DOH-retained hospitals in the region.
- In extreme cases, working with a cooperative LGU hospital with an equally cooperative local chief executive may be explored.
- As a last resort, a private hospital may be tapped.

Once the RTTH has been formed, the first task is to ensure the DOH-retained hospital is actually an FP-MCH information, products and services provider. The capacity of the DOH-retained hospital must first be developed before it can serve as a technical assistance provider who will in turn, develop the capacity of public and private hospitals.

The end result of the capability building activities is for this DOH-retained hospital, and eventually all public and private hospitals that will be developed under this program, and which will become part of the Service Delivery Network for MNCHN, to provide/conduct the following:

1. Regular BTL-MLLA (and/or NSV) services
2. Regular interval and post-partum IUD services
3. Regular family planning counselling services
4. No Balance Billing policy implementation for all 4Ps beneficiaries
5. Regular information provided for FP-MCH through *Usapan* (see box) or other approaches
6. Consistent and available supply of contraceptives and maternal health products at the hospital pharmacy
7. Funds for FP-MCH information, products and services provision are available and budgeted for annually
8. Regular coordination with community health partners and other information providers in the MNCHN SDN
9. If qualified, turning the DOH-retained hospital into a training center for BTL-MLLA and/or NSV, and other FP-MCH related training courses for other hospital staff
10. Where applicable, regularly conduct itinerant services for permanent family planning methods in areas where these are not available.

What is Usapan?

Usapan is a structured process for a facilitated group discussion on family planning or maternal and child health. Through conversation, the participants are able to identify a particular method or service as being responsive to their needs. The Usapan series is additionally characterized by the immediate, on-site, availability of one-on-one counseling, service provision, FP-MCH products and referrals.

Depending on the results of the assessment, the DOH hospital, and eventually other hospitals that will be developed in this program, will undergo the following capacity building activities under this initiative:

1. Training on informed choice and voluntarism and environmental compliance
2. Orientation on PhilHealth – benefits, claims, enrolment, 4Ps, no balance billing policy, etc.
3. Policy development to support the expansion of FP-MCH services provided in hospitals
4. Training courses on:
 - a. Family Planning Competency-Based Level I (Family Planning Contraceptive Technology and Counselling)
 - b. Family Planning Competency-Based Training Level 2:
 - i. Interval IUD
 - ii. Post-Partum IUD
 - iii. Bilateral Tubal Ligation – Minilaparotomy under Local Anaesthesia
 - iv. No-Scalpel Vasectomy
 - c. BEmONC, including Active Management of the Third Stage of Labor and Essential Newborn Care
 - d. Orientation on Field Health Services Information System (FHSIS)

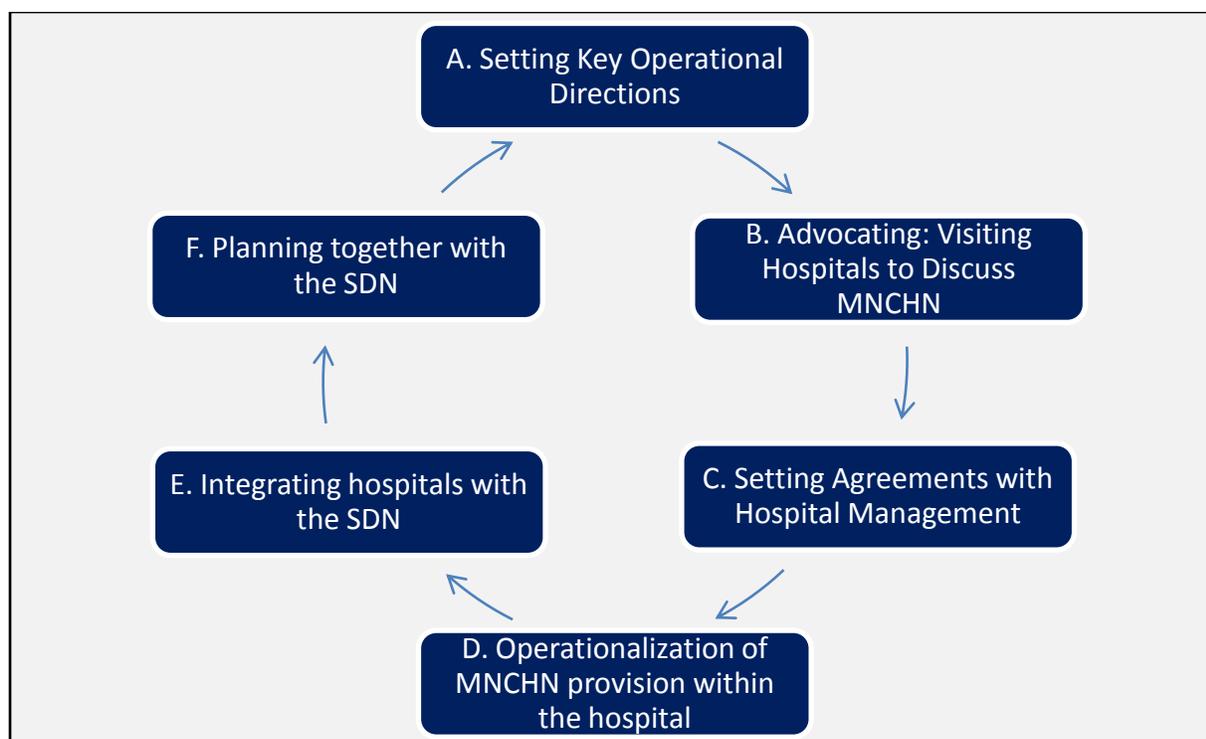
When the DOH-retained hospital, designated as the DOH- RO's technical backstop for this technical initiative, has been developed – or even while in the process of being developed – the next step would be to engage other public and private hospitals in the region to likewise expand and maximize their potential for FP-MCH information, products and services provision.

The key implementing steps for this initiative are described in the next section.

KEY IMPLEMENTING STEPS

The key implementing steps outlined in this section have been culled from the experiences of PRISM2 project sites. Figure 3 is a simplified illustration of the process of engaging, building capacities of hospitals on MNCHN provision and use, integrating them into the local service delivery network, and making them active partners in Public-Private Partnerships (PPPs).

Figure 3. Process of expanding MNCHN provision and use in public and private hospitals



A. Setting Key Operational Directions under the leadership of the DOH-RO, which together with the LGU is the steward for the local public-private partnership for FP-MCH.

Facilitated by local stewards, this step entails seeking agreement with public and private MNCHN providers regarding short- and long-term objectives, processes, and activities for the overall MNCHN strategy implementation across the local health care system. The process of seeking agreement can be done in a participative workshop, or it could be pre-programmed as mandated by an existing policy. The Key Operational Directions conforms with the government’s mandate on Universal Access to Health and Meeting the Unmet FP Needs for implementing MNCHN strategy in the local setting.

The box below shows, as an example, Cavite’s key operational directions which became the basis for establishing the roadmap towards building the public-private partnership for MNCHN in the province.

Sample Key Operational Directions in Cavite, drawn and agreed upon by the Health Offices of the Provincial, Municipal and City LGUs as well as workplaces, Southern Tagalog regional offices of the Department of Labor and Employment and Department of Health in 2010:

- ❑ Establishment of a functional public-private Referral System at the ILHZ and provincial levels
 - Crucial role of Service Delivery Network in the attainment of Millennium Development Goals to:
 - ✓ Decrease Maternal Mortality
 - ✓ Reduce Child Mortality
 - ✓ Establishment of Coordinating Mechanisms with Private-Public Partnership

- ❑ Key Building Blocks towards Public-Private Partnership for FPMCH provision and use, focusing on developing:
 - A network of workplaces working with each other, with government partners and with other private sector partners to improve and sustain provisions of FP/MCH
 - An organized effort to improve availability of correct information, essential products and quality services necessary for informed voluntary choice in FP and universal access to safe delivery
 - An agreed system of mutually supporting and assisting participating workplaces and organizations using resources of partners

B. Advocating: Visiting Hospitals to Discuss MNCHN. This is facilitated by the local stewards, specifically the health offices of the provincial, municipal, and city LGUs where these hospitals are located.

This entails discussing and seeking agreement with hospital management on:

- a. The role of hospitals in attaining Millennium Development Goals for maternal and child health and their role in the local MNCHN strategy implementation
- b. The short- and long-term availability of quality MNCHN information, services and products in hospitals
- c. Assessing the readiness of hospitals to provide quality MNCHN services

The DOH-RO and its LGU counterparts can organize a Hospital Forum with all interested public and private hospitals to a) present the program to participants, and b) get their commitment for engagement. Ideally, key decision-makers, such as hospital owners, the board chair, the Medical Director or Chief of the Hospital of interested DOH, LGU and private hospitals in the LGU, should be invited to this forum.

C. Setting agreements with hospital management on key implementation of the MNCHN strategy. This entails a series of workshops to identify, and agree on the following:

- a. Key basic principles that hospitals have to adopt or enhance, if these already exist. The box below provides the quality elements and the corresponding definitions that may be translated into the hospital's basic operational principles
- b. Gaps in competencies and capability building activities required to develop or enhance competencies of MNCHN providers in the hospitals

- c. Integration of the hospitals and their active participation with the local service delivery network
- d. Accepting and making referrals to ensure continuum of care for MNCHN
- e. Policies that the hospitals may need to develop and implement within their structure
- f. Enhancement of the hospital system or processes to ensure that MNCHN services, products, and information are accessed, understood, and used by clients

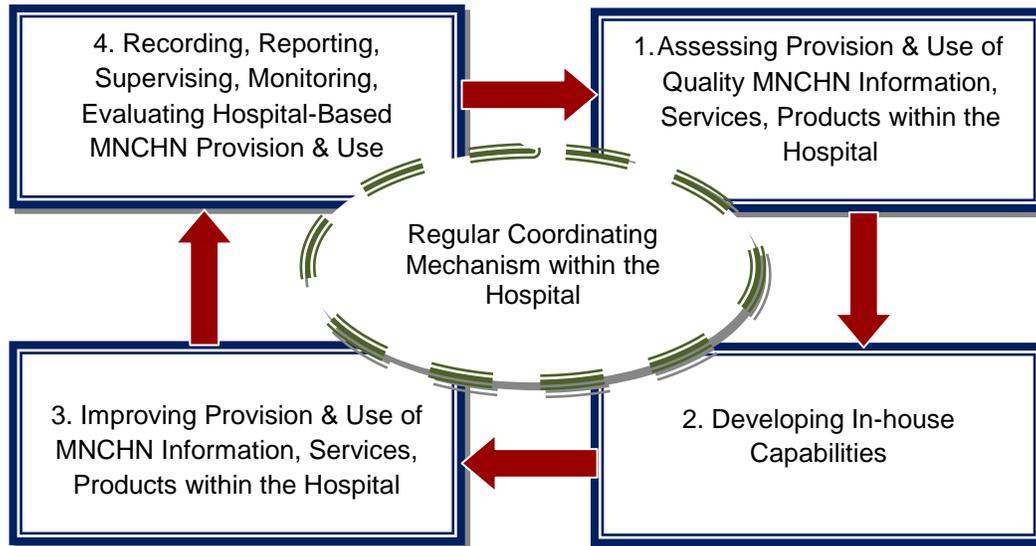
Key Principles

In general, hospitals should be able to exhibit quality elements in their provision of MNCHN information, services and products. These quality elements are defined as follows:

1. **Safety** – degree to which risks of injury, infection and other adverse effect on both staff and clients are minimized
2. **Accessibility** – degree to which health care information, products and services are rationally available and accessible in a manner that is sensitive to ethno-linguistic and socio-cultural milieu to be able to reach the concerned/targeted population, thereby eliminating financial, socio-cultural and physical barriers to access
3. **Equity** – degree to which resources are properly organized and distributed so that those who are unable to pay and underserved are prioritized for subsidies, out-of-pocket payments are minimized, and PhilHealth benefits are increasingly utilized
4. **Continuum of Care** – degree to which appropriate information, products and services are provided to the right people at the right place at the right time from the community to the different levels of health care and vice versa
5. **Effectiveness of Care** – degree to which the desired/expected results or outcomes are attained. At the micro-perspective, this is also the degree to which health workers and facilities perform their functions in accordance with the technical quality or universally accepted, safe, effective standards
6. **Efficiency** – degree to which resources are properly organized, invested on information, practices, products and services with value for money upheld, and associated costs are held in check in relation to the resulting output/outcome
7. **Client-centeredness** – degree to which information, practices, products and services are geared towards enhancing client’s empowerment to make informed choices at the right time that they are needed to act on their choices. This also refers to the degree to which trust, respect, confidentiality, courtesy, responsiveness, effective listening and communication between providers and clients are developed

D. Operationalization of MNCHN Provision Within the Hospital

Once hospital management has decided to commit to the MNCHN provision and implement it in their facility, the following steps can be initiated and institutionalized:

Figure 4. Key Steps in Operationalizing MNCHN in Individual Hospitals

I. Assessing Provision and Use of Quality MNCHN Information, Products and Services within the Hospital

This entails reviewing facility-based data, observing and conducting key-informant interviews, self-assessment on MNCHN provision and use. This step can be completed on a regular basis or at any given time as the need arises, and as agreed upon by both hospital management and local stewards. (Refer to [Annex C-1](#) and [C-2](#) for the assessment tools. This assessment can serve to supplement assistance to the facility in getting ready for inspection leading to DOH Licensing and PhilHealth Accreditation.

- a. Facility-based data that can be reviewed include:
 - Annual Statistical Reports;
 - Consolidated data at the out-patient department/emergency rooms for referrals, provision of MNCHN services, products;
 - Records at the Operating Rooms for Voluntary Surgical Contraception and deliveries;
 - PhilHealth submissions, claims and return-to-hospital forms;
 - Logbooks of minutes of committee/section/service area/staff meetings
 - Policies related to MNCHN as indicated in the hospital's Manual of Operation, Memoranda, Special Orders, etc.
- b. The actual provision of FP-MCH information, products and services by hospital staff can be observed
- c. Key informant interview can be done to assess Informed Choice and Voluntarism and environmental compliance

The assessment results should be consolidated, shared with the hospital management and implementers for validation and response, and presented to the stewards and public-private partners for appropriate programmatic planning, capability development, resource mobilization and policy development, if need be.

2. Developing In-house Capabilities

The line-up of training courses is based on DOH policies on Universal Health Care, Meeting the Unmet Needs for MNCHN, quality and safety. The hospital staff shall be provided with the appropriate

capability building opportunities, depending on the results of the assessment, that are intended to fill the gaps in the competencies of hospital staff as specified in the MNCHN Manual of Operations of the DOH.

Developing in-house capabilities entails:

- a. building the competencies of the hospital staff in providing MNCHN information, services and products (DOH training courses);
- b. developing appropriate policies, where applicable;
- c. improving hospital linkages with PhilHealth, DOH-ROs and LGUs;
- d. facilitating the integration of hospitals into the local SDN and, therefore, the local PPPs for MNCHN;
- e. enabling the hospitals to better record, report their accomplishments to the local stewards

The trainings follow the DOH-approved curriculum, and can only be obtained from DOH-certified trainers and training institutions. The participants are given Certificates of Competency once all requirements are fulfilled.

There are provinces which launch their trainings in accordance to their needs and as indicated in their annual work plans. There are ROs, such as DOH-RO Western Visayas based in Iloilo, which finance training for both public and private hospitals to enhance their competencies on MNCHN. *(For more details about trainings and the training system, please refer to the reference document on Training and Training System.)*

There should also be a regular update on PhilHealth and DOH policies to continually inform hospitals of developments from these two national agencies related to MNCHN Strategy implementation. Apart from the regular updates, there should also be a facilitator to mediate between and among the hospitals and the PhilHealth accreditation/quality assurance teams and the DOH licensing division.

The main objective of providing PhilHealth and DOH updates to hospital management and health service providers is to inform them about PhilHealth members' benefits associated with MNCHN provision and use, the requirements for providers and facilities, and the process of claiming the reimbursements. Such reimbursements will augment hospital incomes and serve to sustain the provision of quality FP-MCH information, products and services in the hospital.

It is envisaged that all trainings undertaken by the hospital staff shall be included in a training database lodged at the DHO-RO or a partner private training facility. This is within the context of the training system.

3. Improving Provision and Use of MNCHN Information, Services, Products within the Hospital

This entails actual implementation and regular provision of MNCHN information, services and products. Specifically, the hospital can regularize its family planning services especially for permanent methods which are not usually available in all hospitals. Regular BTL services must be scheduled by the hospital and provided by its own trained providers. Alternatively, if the hospital does not yet have its own trained BTL and NSV surgeons, it can host itinerant teams that provide these services. Hospitals that have trained surgeons can join these itinerant teams in areas where such services are not available. The hospital, together with the rest of health care facilities, is mandated by the DOH Administrative Order

201 I-0005 on Informed Choice and Voluntarism to provide a broad range of family planning services and products.

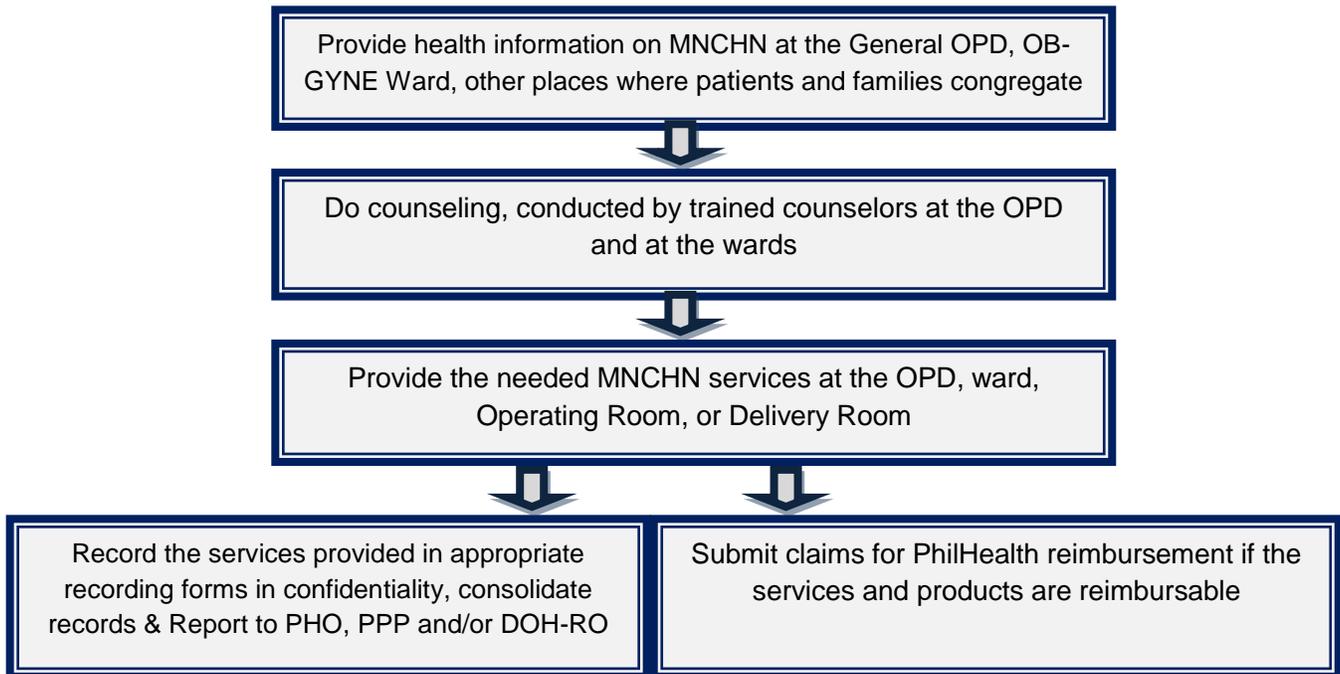
The hospital can also implement a Behavioral Change Communication (BCC) strategy to increase utilization of its MNCHN services and products. They can do this within the hospitals at the out-patient department or at the in-patient OBGYNE ward, similar to the activities done by the DOH-retained St. Anthony Mother and Child Hospital in Cebu. *(Please refer to the resource document on Usapan for details on how this activity is carried out.)* Or, the hospital can do the BCC activities outside the facility in a community setting as done by some private hospitals in Pangasinan.

The hospital can also include a broad range of family planning products as well as essential MCH products in its pharmacy and thus become an alternative distribution point.

A PhilHealth-accredited private hospital has the option to implement the NBB policy for indigent families enrolled by the government. Preferably, private hospitals recruited and included as private partners in the MNCHN SDN of a local community should implement the NBB policy for 4Ps clients, or the poorest of the poor as identified through the National Household Target System for Poverty Reduction program and PhilHealth indigent ID cards. This will encourage this segment of society that is most vulnerable to maternal deaths to access birthing facilities/hospitals for deliveries, as well as for BTL services for those who no longer want to have children. Several private hospitals in Nueva Ecija, Pampanga, Cavite, Iloilo, Cebu, Davao are already implementing the No Balance Billing policy for these clients/patients.

The hospital can develop a process flow for MNCHN service provision, integrated into the hospital's standard operating procedure or its manual of operations. Figure 5 illustrates a generic approach to MNCHN service provision within the hospital. The boxed text describes the standard operating procedure that the St. Therese Hospital in Iloilo province is implementing.

Figure 5. Process flow of MNCHN provision in hospitals



The provision of regular voluntary surgical contraceptive services and a broad range of family planning services, practice of EINC, improving PhilHealth claims for MNCHN services, products provided for are one of the key indicators if indeed the hospital is already implementing or expanding MNCHN provision. Overseeing this process is the RTTH, the SDN management team and the hospital-based managers. It has been shown that there has been an increasing number of private, DOH-retained and LGU hospitals that have been mobilized to provide MNCHN information, services and information from 2011-2014.

Protocol for BTL-MLLA Missions at the St. Therese-Maritime Training Center Colleges Hospital in Iloilo

1. FPOP personnel screens and submits all the requirements to the hospital at least two days prior to the scheduled operation. This includes the names and PhilHealth membership of the patients subject for BTL;
2. Hospital PhilHealth personnel reviews and checks the validity of the patient's PhilHealth membership as well as the PhilHealth accreditation of the Attending Physician;
3. Once all documents are complete and verified by the hospital, Family Planning Organization of the Philippines (FPOP) personnel can schedule their patients for BTL in the hospital, based on the availability of its Operating Room;
4. On the day of the scheduled operation, patients will be ushered to the out-patient department to fill up the operative data (consent for operation and operating room schedule), and sign the consent for BTL. The forms will be provided by the hospital. Each patient will be assigned a number in order to facilitate the smooth flow of the operation. All documentation regarding the operative procedures and patient's recovery phase will be noted by the FPOP Team in the patient's chart;
5. The patient's vital signs will be taken and recorded by the FPOP nurse, and a one-on-one counseling will be done by the FPOP Attending Physician before the patient is brought to the operating room. Only two patients at a time with one companion each will be allowed to go up to the operating room. This is to avoid congestion and noise in the hospital lobby;
6. All documents and patients' records are endorsed to the operating room head nurse or the senior nurse for easy access while the procedure is ongoing;
7. FPOP will provide at least two Attending Physicians and five nurses to perform the procedure. The hospital staff nurses' role is to facilitate any assistance needed by FPOP personnel during the operation;
8. Sterile packs and instruments needed during the operation will be provided by FPOP, including the pre-anesthetic drugs, solutions and medications;
9. Other medical supplies not included in the FPOP packs will be provided by the hospital. Those not covered by PhilHealth shall be charged to FPOP;
10. The minor room within the operating room will be used by FPOP on the day of the operation. The FPOP schedule for BTL is every 2nd or 4th Thursday of the month. Post-Anesthesia Care Unit will be occupied for post-operative patients;
11. Census for these scheduled patients will be included in the out-patient department and operating room records;
12. Food, transport, and take-home medication of the patients will be covered by FPOP.

Prepared (and signed) by:

RUTH P. BARBASA, RN., M.A.N.

Chief Nurse – QAR

Noted by:

JIMMY JAY BULLO, MD, DFM, FPAFP

Chief of Clinics

4. Recording, Reporting, Supervising, Monitoring, Evaluating Hospital-Based MNCHN Provision and Use

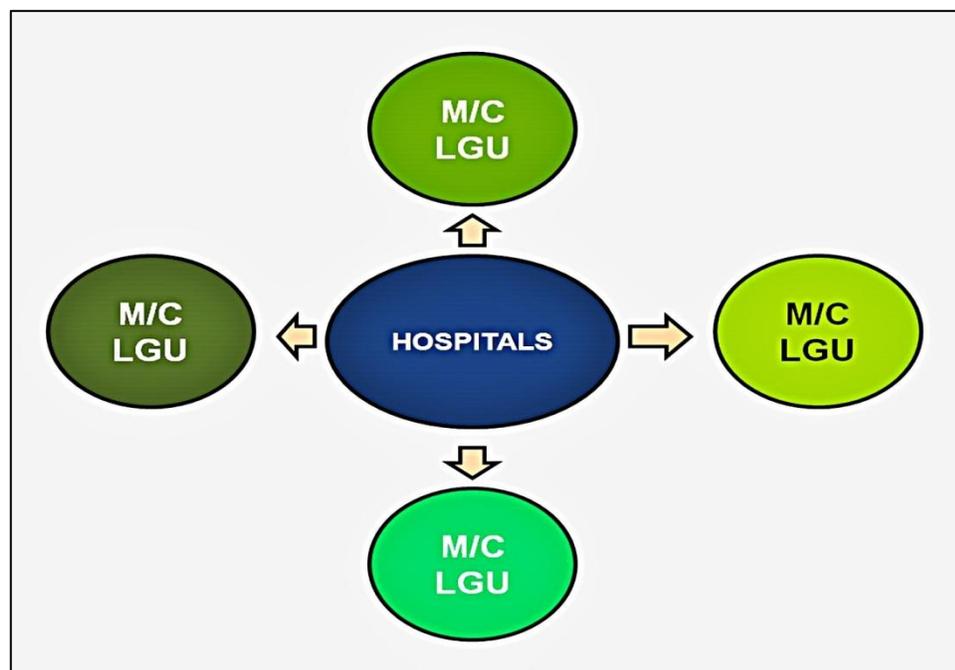
In order for public health managers to have a full picture of the entire locality, hospitals need to report their accomplishments to LGUs. Hospitals need to be trained on FHSIS to fully understand the public health system of recording and reporting processes and the indicators involved. There are many LGUs across the country which now gets reports from private hospitals. Stewards must decide on the reporting arrangements with hospitals to ensure that utilization of MNCHN services is captured by the regular information system.

Figure 6. Reporting flow in La Union



The next valuable step is a regular validation process where hospitals participate together with other stakeholders such as the private practicing midwives, public health providers and the stewards as facilitators. This is to ensure that there is no double reporting, and that the numbers reflect the true MNCHN status of the locality. The Provincial Health Office and/or Interlocal Health Zone (ILHZ) leadership can take the lead in the data validation across the province or the ILHZ. The City Health Office can take the lead in chartered cities.

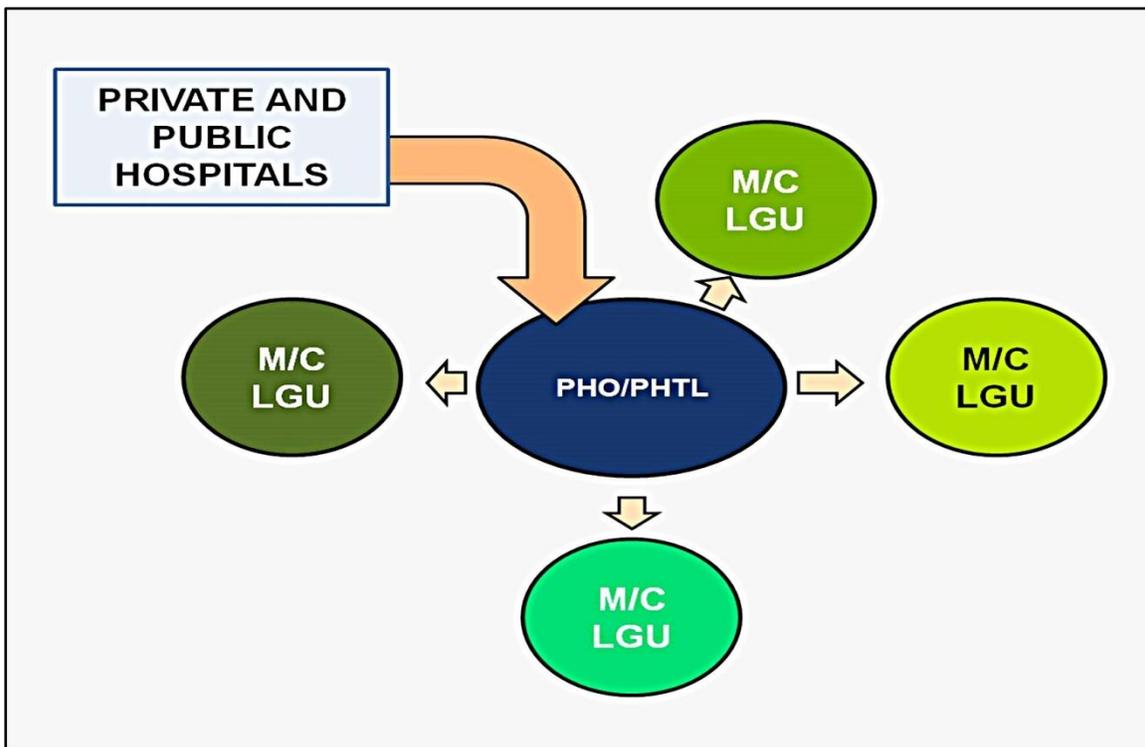
Figure 7. Reporting arrangement among hospitals and municipal/city LGUs



Figures 7 and 8 exemplify possible reporting mechanisms. Figure 7 shows the hospital disaggregating its data and reporting them to the LGUs. Hospitals located in Highly-Urbanized Cities which report directly to the DOH-Regional Offices without going through their Provincial Health Office, usually give their MNCHN accomplishments to the City Health Office. This is the arrangement between the private-owned St. Therese Hospital and the City Health Office of Iloilo City, and the Sacred Heart Hospital and City Health Office of Cebu City.

Figure 8 shows the hospitals reporting their data to the Provincial Health Officer or the Provincial Health Team Leader of the DOH Representatives, who will integrate them into the province-wide performance on MNCHN provision and use. It will be the Provincial Health Officer or his/her designated officer who shall inform the different municipalities and cities within their jurisdiction about the contribution of the hospitals regarding MNCHN provision and use.

Figure 8. Reporting arrangement between hospitals and Provincial Health Officer/ Provincial Health Team Leader

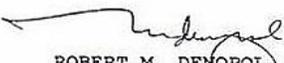


In Nueva Ecija, the PHO, CHO of Cabanatuan City, the DOH Representatives and the local chapter of the Philippine Hospital Association agreed to install an information system. This requires all 12 private, seven public and one DOH-retained hospitals to consolidate the number of clients they served for MNCHN, validate and submit these regularly to the PHO, CHO and DOH.

With the hospitals contributing to the local public health performance, they become natural participants in the management processes such as Program Implementation Reviews, investment planning (such as on MNCHN and Province-wide or City-wide Investment for Health)

Establishing a regular coordinating mechanism within the hospital

This entails having an organizational structure with a designated personnel or team within the hospital that discusses, updates, implements continuing quality improvement initiative on MNCHN. The hospital has the option to link this structure under the overall Quality Circle of the hospital. At the DOH-retained St. Anthony Mother and Child Hospital in Cebu City, this responsibility lies with the Chief Nurse and the head of the OB-GYNE Department. Both are part of the hospital's Quality Circle. The Quality Circle is a structure that is mandated by both PhilHealth Accreditation and DOH Licensing. The boxed text is a sample hospital order mandating the Chief Nurse to head the Continuing Quality Improvement committee with the OB-GYNE Department Head as the vice-chair.

	Republic of the Philippines Department of Health Saint Anthony Mother & Child Hospital Basak, San Nicolas, Cebu City ☎ (032) 261-9989/418-9477 "PHIC Accredited Health Care Provider"
January 1, 2012	
Hospital Order No. <u>014</u> .s2012	
Subject: "POINT PERSON/CHAIRMAN AND MEMBERS OF THE CQI COMMITTEE COMPOSITION OF THIS HOSPITAL".	
On top of their duties and responsibilities, the following personnel are hereby designated as point person/chairman and members of the CQI Committee Composition in this hospital.	
Chairman	: Dr. Rosenie A. Coronado (Chief Nurse)
Vice-Chairman	: Dr. Distancy B. Montejo (Medical Specialist I)
Members:	
Mrs. Blanquita D. Babon	(Administrative Officer IV)
Mrs. Annabelle A. Villaver	(Pharmacist II)
Mrs. Herminia P. Balbuena	(Nurse Supervisor)
Mr. Leonides C. Zafra	(Radiologic Technologist)
Mr. Simplicio H. Tadios III	(Medical Technologist)
Mrs. Elinor S. Ramirez	(Medical Records)
Mr. Lopesino A. Lauron	(Engineering & Hospital Maintenance)
Mr. Mario R. Semblante	(Pollution Officer)
Dr. Ma. Theresa C. Tipgos	(Therapeutic Committee)
Dr. Orlando N. Osorio	(EMS Coordinator)
Mrs. Luz E. Gebilaguin	(Social Welfare Officer I)
With these following functions:	
<ul style="list-style-type: none"> > Review scope and appropriateness of Quality assurance activities including finding the solutions to conclusions, recommendations and actions. > Acts upon the recommendation from incident, reporting and observation as needed. > Conduct or request additional information and/or department activities through a monthly meetings. > Recommend policies and/or procedures to the Chief of Hospital/CQI Committee for approval and implementation. > Keep records and minutes of all committee meetings and its activities for proper documentation. 	
This order being for the good of the service is declared official and made of record.	
 ROBERT M. DENOPOL, M.D., M.H.A. Chief of Hospital	

E. Integrating the hospitals with the Service Delivery Network

Integration of the trained or assisted hospital, after assessment, may take many forms, as follows:

1. It is included in the DOH-Regional Office advisory to the LGU as a recommended SDN partner, providing services as a CEmONC-capable facility;
2. The LGU confirms such recommendation and includes it as a potential SDN partner;
3. The hospital, together with other potential SDN partners, is invited to a workshop to discuss the draft Partnership Agreement among the SDN partners, and reviews, revises and finalizes the document;
4. The hospital and all the invited designated SDN partners sign the Partnership Agreement that spells out the roles, responsibilities and expectations among the SDN partners;
5. An official LGU issuance may follow recognizing the SDN and its members in the form of an Executive Order, an LGU resolution or Ordinance. Please refer to the resource document on policies;
6. The hospital-partners in the SDN will then be represented in the SDN management team or technical working group, or local PPP body that is tasked to oversee and manage the SDN. This team will ensure that there will be a continuing quality improvement in FP-MCH provision of information, products and services among all the hospitals in the SDN. Foremost among quality issues in the SDN will be ensuring that the referral systems for FP-MCH are functional as this will be key to the SDN's major contribution in reducing maternal and newborn deaths. The referral mechanisms contribute in eliminating or reducing the three delays leading to maternal and newborn deaths.

Hospitals are initially handheld as they are roped into the SDN and the local health referral mechanisms through regular meetings, workshops, planning processes, participation in program implementation reviews (PIRs).

This entails regular and continuous communication and engagement with hospitals. The SDN's local coordinating mechanism and regular feedbacking will ensure that quality services are provided. As they then become part of the PPPs by virtue of partnership agreements and other policy instruments and referral mechanisms, they become natural partners in improving FP-MCH provision and use.

Hospitals should be regularly informed of the unmet needs of the communities and the current capabilities of the SDN members. To ensure that this happens, the hospital should be part of the PPPs or local coordinating mechanisms, progress implementation reviews (PIR), maternal and neonatal death review.

A sample activity design for a hospital forum is given in [Annex D](#) aimed at initiating hospitals into the SDN. [Annex E](#) provides an activity design for integrating hospitals into the SDN.

F. Planning Together with the SDN

Once hospitals are part of the SDN, either on the basis of the collective memorandum of agreement or partnership agreement signed by the stakeholders or based on commitment shown by hospital management, they can take part of the planning sessions on MNCHN. They can conduct a joint planning with stewards, public and private partners in primary/secondary/tertiary health care. [Annex F](#) contains a sample activity design of a planning session attended by the local stewards, private practicing midwives, public and private hospitals. The objective of this planning session is to come up with a MNHCHN plan, involving PPP.

The SDN stewards should ensure that this MNCHN plan is to be integrated into the Province-wide or City-wide Investment Plan for Health (PIPH or CIPH). This MNCHN plan will ensure financing of program activities determined based on health needs and the involvement of PPPs across time.

Financing MNCHN strategy implementation in hospitals

Not one funding mechanism will be enough to fund the over-all implementation of the MNCHN strategy in hospitals. Several funding mechanisms need to be mobilized. These are as follows:

1. The DOH-Regional Offices can fund capability building initiatives in hospitals. But this has to be explicitly written in their annual or strategic plans. Private hospitals can finance their own training.
2. Hospitals can provide the counterparts for the operationalization.
 - a. Hospitals can shoulder supplies and medicines for clients and for which they can claim PhilHealth reimbursements. PhilHealth reimbursements are a major source of hospital income.
 - b. LGUs can finance logistics (for transportation, communication) or supplies and medicines for indigent couples in need of FP-MCH services
 - c. DOH-Regional Offices can partly finance supplies and medicines and logistical requirements of FP-MCH service providers during itinerant missions
3. Inter-Local Health Zones, DOH-Regional Offices or the Provincial Health Office can mobilize resources for coordinative meetings and other functions.
4. Both public and private hospitals can utilize public health tools to determine the amount of investment needed to provide the necessary services and products to reduce unmet need for family health. In turn, these public health tools can be used to determine prospective income for services or products provided. These public health tools may come in the form of percentage of Philhealth enrolled women and families, client identification tools from community-based health information, or health use plans.

Over-all, the SDN can lead in the discussion, mobilizing financial resources, seeking agreements on sustainable healthcare financing models, and ensuring returns of investments to its member facilities. For further information, please refer to the resource document on health care financing.

MANAGING THE HOSPITAL-BASED MNCHN PROVISION AND USE

Management at the DOH-Regional Office level will be the main task of the Regional Technical Team for Hospitals (RTTH). After completing the technical interventions needed to develop its technical backstop, the partner DOH-retained hospital, the RTTH will continue to ensure that the public and private hospitals it helped developed are providing good quality hospital-based FP-MCH information, products and services. This can be accomplished by regularly coordinating with the local PPP body or SDN management team that oversees the SDN.

The RTTH will likewise play a key role in providing resources beyond the SDN's reach that are needed by hospitals but are within the reach of the DOH-Regional Office or the DOH-retained hospital. This may include DOH supplies and products, DOH information and other materials, DOH sponsored training courses, dissemination of updates from the DOH, and links to other vital government line agencies. Such collaboration is the key to ensuring Regional Office support to the local SDN that, in turn, ensures its continuing functionality.

Management at the SDN level is led by the LGU, supported by the DOH-Regional Office, and assisted by a development partner (e.g., USAID). As mentioned above, such management lies with the SDN management team, or technical working group, or the public-private partnership body. Both public stewards, primarily the LGU health offices, and private partners in the SDN are represented in this group that regularly meets to discuss the various technical aspects of ensuring good quality FP-MCH information, products and services provision in the SDN. These aspects include functioning referral systems, compliance with DOH standards of clinical practice and others (e.g., ICV, environment), sustainable recording and reporting systems that capture hospital contribution to vital health statistics, sustainable health financing schemes that likewise considers the plight of the private sector, and monitoring and evaluation. All of this accounts for, and contributes to continuing quality improvement when adequately addressed.

PRISM2 EXPERIENCES

Nueva Ecija: To support the key operational directions of Nueva Ecija and DOH-RO III (Central Luzon), PRISM2 began assisting the province in 2011 to enhance FP-MCH provision and use at the DOH-retained hospital, Paulino J. Garcia Regional Memorial Medical Center. The hospital was developed as a technical backstop for the provision of FP-MCH services, information and products. After being trained by PRISM2 on BTL-MLLA, the Paulino J. Garcia Regional Memorial Medical Center trainers then trained physicians working with Wesleyan University Hospital, a private hospital in Cabanatuan, Nueva Ecija.

Both hospitals established regular BTL-MLLA services. They also formed an itinerant team of BTL-MLLA providers in 2012 who provided services in host facilities owned by the provincial government of Nueva Ecija. Meanwhile, PRISM2 assisted the Inter-Local Health Zone in 2013 with planning and synchronizing demand generation, scheduling, resource mobilization and PhilHealth claims in support of the provision of BTL-MLLA services.

To prepare the private and public hospitals to take on their tasks within the SDN, the local stewards (PHO and DOH-RO III) engaged these hospitals in a FP-MCH planning workshop focused on health referral strengthening, resource-sharing, supporting LAPM itinerant services and reporting mechanisms. On the latter, a systematic recording and reporting system was established connecting all seven LGU-owned hospitals, 12 private hospitals and the DOH-retained hospital.

Davao Region: In Region II, PRISM2 trained doctors practicing at the private hospitals (Rivera Medical Center, Inc. and Somoso General Hospital) and two public district hospitals in Davao del Norte in BTL-MLLA. After having been certified, they provided regular BTL-MLLA services and prioritized the indigent population through implementation of PhilHealth's no balance billing policy. The physician at the Rivera Medical Center joined two newly trained government physicians as an itinerant team, providing BTL-MLLA service in other district hospitals in Davao del Norte.

Located in different geographical clusters, the private and district hospitals became the new referral hubs for LAPM. Clients who chose LAPM after participating *Usapan* sessions conducted by PPMs or those listed by the community health teams based on health use plans were referred to the DOH-retained Southern Philippines Medical Center in Davao City, the private Rivera Medical Center in Panabo City or the two district hospitals with specific BTL-MLLA schedules.

PRISM2 assisted local stewards and service providers to synchronize demand generation activities with service provision for LAPM, linking the hospitals to PPMs, LGU health offices and SDNs for better coordination. PRISM2 also supported the coordination between Davao's City Health Office, the DOH-retained Southern Philippines Medical Center and project-assisted itinerant teams in the regular conduct of BTL-MLLA. Active linkages and referrals among the different levels of care in a functional SDN guarantee continuity of care, information and service provision, and subsequent reduction of unmet needs.

Cebu Region: PRISM2 assisted in expanding the FP-MCH competencies of the DOH-retained St. Anthony Mother and Child Hospital to provide information and services and support other hospitals

expand their FP-MCH programs. The project implemented continuous quality improvement initiatives based on the principles of ICV, gender and environmental mitigation. Afterwards, public and private physicians from Cebu, Bohol, and Negros Oriental in Region VII were trained on BTL-MLLA. In Cebu, St. Anthony's partnered with and trained the private Sacred Heart Hospital. This partnership also benefitted another LGU-owned hospital, Cebu City Medical Center, which has a decade-long consortium agreement with Sacred Heart. Sacred Heart and Cebu City Medical Center conducted organizational decision meetings and underwent several orientation sessions on PhilHealth, ICV and gender, as well as trainings on FP-CBT and FHSIS. Subsequently, they became the referral hubs for LAPM in Cebu. Aimed at helping DOH reduce unmet need for family planning methods for limiting, DOH-RO VII sub-allotted PhP400,000 to Sacred Heart to enable the hospital to provide free voluntary surgical contraception to clients in need of these services. A memorandum of agreement was executed for this sub-allotment. Already equipped with rich experience, St. Anthony's and Sacred Heart led seven public and three private hospitals in an effort to strengthen the SDN by expanding FP-MCH provision and use in hospitals, and increase itinerant missions for voluntary surgical contraceptive.

ANNEXES

Annex A: Key MNCHN Services

The following table shows the capabilities and inputs related to MNCHN implementation expected in all hospitals as mandated by the DOH AO-2012-0012, Rules and Regulations Governing the New Classification of Hospitals and Other Health Facilities.

Table 1: MNCHN-related items culled out from the minimum licensing requirements for hospitals of the DOH

	Level 1 Hospitals	Level 2 Hospitals	Level 3 Hospitals
Staffing	Qualified medical, allied medical & administrative personnel headed by a PRC-licensed physician	Qualified & competent personnel with Chief of Hospital/Medical Director and appropriate board certified Clinical Department Heads Departmentalized and equipped with service capabilities needed to support board certified/eligible medical specialists & other licensed physicians rendering services in the specialties of Obstetrics & Gynecology, Pediatrics, Medicine, Surgery & their subspecialties	Teaching and/or training hospital with accredited residency training program for physicians in the four major specialties: Obstetrics and Gynecology, Pediatrics, Medicine, Surgery
Bed space	Based on authorized bed capacity in accordance with DOH Guidelines in Planning and Design of Hospitals		
Operating room	OR with standard equipment and provision for sterilization of equipment and supplies in accordance with DOH policies on Planning and Design of an Operating Room/Theater & Guidelines on Cleaning, Disinfection & Sterilization of Reusable Medical Devices in Hospital Facilities in the Philippines		
Post-operative recovery room	With post-operative recovery room		
Maternity facilities	Maternity ward, room, delivery room exclusively for maternity patients and newborns		
Blood services	Provision for blood station		Provision for blood bank

These minimum requirements for DOH –licensing of hospitals mandate hospitals to provide the bundle of MNCHN services and be competent in doing such, based on the DOH MNCHN Manual of Operations.

Based on the DOH MNCHN MOP, hospitals must be competent to provide the following services:

Table 2: Packages of services and competencies of hospitals

Type of facilities	Services provider	Competencies and capabilities	Package of services being provided
Public & Private Hospital capable of providing Basic Emergency Obstetric and Newborn Care (BEmONC)	<p>With staff complement of skilled health professionals capable of providing MNCHN services</p> <ul style="list-style-type: none"> • Doctor • Dentist • Midwives • Nurse • Sanitary Engineer • Medical technologists • Ambulance driver 	<p>Should be able to perform the six obstetrical functions:</p> <ul style="list-style-type: none"> • Parenteral administration of oxytocin in the third stage of labor • Parenteral administration of loading dose of anti-convulsants • Parenteral administration of initial dose of antibiotics • Performance of assisted deliveries (imminent breech delivery) • Removal of retained products of conception • Manual removal of retained placenta <p>Knowledge and skills on:</p> <ul style="list-style-type: none"> • EPI • FP-CBT Level 1, 2 for LA/PM • IMCI • Newborn Screening • EINC • EPP including Voluntary Surgical • Procedure-IMCI • Provision of blood transfusion services • recording & reporting, FHSIS • oral health 	<ul style="list-style-type: none"> • EINC • FP, modern methods including LA/PM • Women and Child immunization • IEC/Counseling on health caring and seeking behavior • Under Five Care consultation (MNCHN) • Laboratory & diagnostic services • Dental Services • Environmental Sanitation Services • Hospital waste management, • Surveillance system (PIDSR, HEMS) • Infectious Disease control • Proper 2- way Referral System Transport System for referral • Health Promotion and Advocacy • Admission

Type of facilities	Services provider	Competencies and capabilities	Package of services being provided
<p>Public & Private Hospital capable of providing Comprehensive Emergency Obstetric and Newborn Care (CEmONC)</p>	<p>A typical CEmONC-capable facility has the following health human with health human resource complement:</p> <ul style="list-style-type: none"> • 3 doctors preferably obstetrician/surgeon or General Practitioner (GP) trained in CEmONC (1 per shift), • at least 1 anesthesiologist or GP trained in CEmONC (on call), • at least 1 pediatrician (on call), • 3 Operating Room nurses (1 per shift), • maternity ward nurses (2 per shift), and • 1 medical technologist per shift. 	<p>End referral facility or network of facilities capable of managing complicated deliveries and newborn emergencies.</p> <p>Should be able to perform:</p> <ul style="list-style-type: none"> • six signal obstetric functions, • caesarean delivery services, • blood banking and transfusion services, • other highly specialized obstetric interventions • newborn emergency interventions, which include, at the minimum, the following: <ul style="list-style-type: none"> (a) newborn resuscitation; (b) treatment of neonatal sepsis/infection; (c) oxygen support for neonates; (d) management of low birth weight or preterm newborn; and (e) Other specialized newborn services. • Regular or high volume case loads for IUD and VSC services, especially tubal ligations and NSV. 	

Annex B: DOH-Regional Office VI Issuance on RTTH Creation



Republic of the Philippines
Department of Health
**CENTER FOR HEALTH DEVELOPMENT
WESTERN VISAYAS**



September 30, 2011

CHD WV PERSONNEL ORDER
No. 1566 s. 2011

SUBJECT: Creation of the Regional Technical Team for Expanding Hospital-Based FP-MCH Information, Products and Services Provision.

To ensure that the Millennium Development Goals to reduce maternal and child mortalities will be attained by the country by year 2015, the Department of Health issued Administrative Order 2008-0029 entitled: Implementing Health Reforms for the Rapid Reduction of Maternal and Neonatal Mortality. The Maternal-Neonatal-Child Health and Nutrition (MNCHN) STRATEGY'S Manual of Operations outlined (page 16) the roles that hospitals shall take in implementing the strategy.

Additional, to further enhance the implementation, success and sustainability of the MNCHN strategy, the National Government and the Department of Health have begun harnessing Public Private Partnerships (PPPs). Such partnerships are expected to become a regular feature of the country's health care delivery system.

In order to ensure the active, significant and important contribution and roles of hospitals in the MNCHN strategy, using the PPP approach, as 1) exemplar providers of Family Planning-Maternal-Neonatal Child Health (FP-MNCH) information, products and services, 2) as advocates for area-wide local service delivery networking, and, 3) as advisers to network stakeholders, CHD is hereby creating the Regional Technical Team for Hospitals with the following features:

A. The Regional Technical Team for Hospitals

The Regional Technical Team for Hospitals (RTT for Hospitals) is the administrative vehicle or structure through which the CHD will develop individual hospitals in the region into exemplar providers of FP-MNCH information, products and services contributing actively, significantly and importantly in the context of the local market area's service delivery network (SDN) for FP-MNCH.

B. RTT for Hospitals Composition

The RTT for Hospitals shall be composed of senior representatives from the CHD and the designated DOH hospital. PRISM2 shall sit as ad hoc member and technical resource.

1. Organization:		
Chair:	Dir. Ariel I. Valencia	-Regional Director
Vice-Chair:	Dr. Jose Mari Fermin	-Medical Center Chief, WVMC
	Dr. Marilyn W. Convocar	-Assistant Regional Director
Finance Mgt.:	Ms. Mae P. Jondonero	-Accountant III
Liaison Officer:	Dr. Ma. Meila C. Bernabe	-Regional FP Coordinator
	Dr. May Ann S. Sta Lucia	-MCH Coordinator
M&E Officer:	Dr. Salvador Dela-Cruz	-MS IV
Secretariat:	Ms. Perla Gasalao	-Nurse
2. Members from the CHD:		
	Dr. Cornelio Tiple	-MO III, LRED
	Dr. Emilia Monicampo	-PHTL
	Ms. Maria Clarissa Juanico	-Planning Officer III
	Ms. Wilma Tasin	-Nurse II, Hospital Cluster



Republic of the Philippines
Department of Health
**CENTER FOR HEALTH DEVELOPMENT
WESTERN VISAYAS**

3. Member from the selected DOH Hospital
- | | |
|------------------------|-------------------------------------|
| Dr. Ma Cecilia Maclang | - Head, OB Department |
| Dr. Glenn Maclang | - Surgery |
| Dr. Patricia Tobias | - OB Training Officer, FP in Charge |
| Ms. Sandra Gonzales | - OB-OR Nurse |
4. Ad Hoc member
- | | |
|------------------------|----------|
| Ms. Lucina T. Esguerra | - PRISM2 |
|------------------------|----------|

C. Roles and Responsibilities of the CHD, DOH hospital and the RTT for Hospitals:

CHD:

1. Lead agency in the region-wide hospital development program for expanding and improving hospital-based FP-MNCH information, products and services provision
2. Creator of the RTT for Hospitals
3. In the context of the RTT for Hospitals, works closely with the selected technical backstop DOH hospital in ensuring provision of technical assistance to participating hospitals as part of the development program
4. Supporter of the selected DOH hospital and all participating hospitals in terms of
 - a. Provision of available FP and MNCH products and supplies
 - b. Access to capability-building resources – training events, training venues, training funds
 - c. Provision of available IEC materials
 - d. Policy issuances that improve policy environment for hospital-based FP-MNCH services
 - e. Recognition/certification issuances for qualified institutions, persons, etc.

Partner DOH hospital

1. Model for health care practice: the full range of FP-MNCH information, products and services shall be provided in demonstrably good quality, consistently and proficiently in the selected DOH hospital
2. Technical backstop for the CHD
 - a. Trainers and training venue for training of trainers in voluntary sterilization
 - b. Trainers and training venue for training of VS surgeons, IUD providers
 - c. Demonstration site for model FP-MNCH practices
3. Advocate for area-wide networking, active, significant and important central hub of the local SDN for FP-MNCH not just as a referral receiver but as a source of important data that will influence SDN partners for better health outcomes
4. Adviser to network stakeholders in terms of continuing quality improvement in the network; collaboration for FP-MNCH outcomes, initiator of activities that will enhance greater cooperation, collaboration, more open communication and therefore closer coordination among SDN partners

RTT for Hospitals:

1. Overall in-charge of managing, overseeing, directing, supervising, monitoring and evaluating the development process for improving and expanding hospital-based FP-MNCH in the region
2. Calls for regular meetings for addressing emerging issues and concerns during the course of the development process for hospitals, for periodic program assessment, evaluation of participating hospitals and to gather feedback/comments from participating hospitals
3. Calls for PPP meetings, dialogues, consultations in order to establish networking with public-private stakeholders and widen its pool of potential technical resources that can meet the needs of hospitals
4. Conducts regular M&E of participating hospitals



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5. Provides direction in systematizing hospital-based recording, reporting and documentation requirements for better data capture, processing and utilization
6. Crafts ideas for creating incentives or benefits to attract interested hospitals to participate in the development program
7. Ensures such incentives and benefits are actually implemented or provided to the participating hospitals
8. Crafts binding requirements that participating hospitals must comply with and sign to as its "Return Services Agreement" or counterpart in the program
9. Ensures that participating hospitals comply with the return services agreement
10. Crafts and finalizes policy issuances that enhance hospital-based FP-MNCH services provision that the CHO can sign off on and become a prototype policy that other DOH, LGU and private hospitals can adopt and adapt as their own. These may include the following:
 - a. Incentives for participating hospitals
 - b. Return services agreements with participating hospitals
 - c. Compliance with PhilHealth 2008 circular on VSC Case payments - ensuring that VS surgeons receive the P 1,000.00 designated for them for each VS case performed
 - d. Informational posters prominently displayed in all offices, wards and out-patient clinics of the hospitals that announce the full range of FP-MCH information, products and services available in the hospital including where to go for the services, who to contact, what number to call for details, etc.

D. The Authority of the RTT for Hospitals:

1. To choose which hospital to accept into the program
2. To reject hospitals not complying with agreements
3. To extend full support to participating hospitals as incentives for joining the program
4. To withdraw support from participating hospitals that do not comply with agreements
5. To explore public-private partnerships that will enhance the pool of technical resources that will be available to further improve the development program
6. To recognize, certify, endorse and emulate graduating hospitals that comply with the quality standards of the program
7. To recommend graduating hospitals as active, significant and important partners in their catchment area's local SDN for FP-MNCH

E. MEETINGS:

1. The RTT for Hospitals will have regular meetings every 1st month of the quarter or as necessary
2. The RTT for Hospitals can request any member of the RTT for Hospitals to participate in its meeting as necessary
3. Simple majority (50% plus one) will constitute a quorum

For compliance

ARIEL J. VALENCIA, M.D., MPH, CESO III
 Director IV, DOH-CHO WV

Office	Origin					Recommending Approval				
	ENSO		PHOC	IAZO	MSO	MSO		MSO		MSO
Signature										
Name of Office Chief	MA. SOPHIA A. LUMINIS, MD, MPH		SOPHIA A. LUMINIS, MD, MPH	MA. CELIA P. FRANCIA, MD, MPH	MONA B. MANCON, BA, MPA	MONA B. MANCON, BA, MPA		MONA B. MANCON, BA, MPA		MARTIN W. CORDERO, MD, MPH, CESO IV

Annex C-I: Rapid Assessment of FP-MCH Technical Needs of DOH-Retained Hospital to become DOH-Regional Office Technical Partner for the Hospital Development Program

A Guide Checklist

Name of DOH Hospital: _____ **Date:** _____

Accomplished by: _____

COMPONENTS	✓ or X	Findings/Comments
I. Management		
• Full management support to FP-MCH		
• 5% MOOE funds utilized for FP or VS itinerant team		
• Hospital has budget allocation for FP supplies		
• Hospital income derived from NHIP benefits for FP-MCH		
• FP-MCH related policies available (cite examples)		
• Open to expanded role of hospital in the local Service Delivery Network for FP-MCH		
• Open to helping other hospitals develop and improve their FP-MCH services		
• This hospital has a good communication and working relationship with the DOH-Regional Office		
• FP-MCH supplies sources other than hospital?		
2. Service Delivery		
• Human Resources		
– Permanent staff (nurse or midwife) trained in basic FP or in FP-CBT level I or higher		
– Permanent staff (nurse or midwife) trained in basic FP or in FP-CBT level I or higher and currently providing FP services regularly		
– Trained VS surgeons available and currently performing (BTL using MLLA or vasectomy using NSV technique)?		
– Trained trainers in VS – available and currently training others on VS?		
– Hospital staff trained or oriented on MCH protocols such as Essential Newborn Care (ENC), Newborn Screening (NBS), exclusive breastfeeding, EPI, etc.		
• Available FP services		
– FP counseling using the GATHER approach		
– Temporary methods available		
➤ Condoms dispensing		
➤ pills dispensing		
➤ Provision of injectables		

➤ NFP information giving/counseling		
• Long-Acting or Permanent Methods		
– IUD insertion and removal		
– Female sterilization using minilaparotomy under local anesthesia (ML/LA)		
– Male sterilization using no-scalpel vasectomy (NSV)		
• Available MCH services		
– Ante-natal care		
– Intra-partum care		
– Post-partum care		
– ENC protocol institutionalized		
– NBS routinely performed		
– Exclusive breastfeeding strictly followed		
3. Facility		
• With functional designated FP clinic or a consultation room with audio and visual privacy for counseling		
• IEC materials available & are being used		
• IEC activities regularly conducted		
• Information on FP services prominently announced through posters, etc.		
• Has Operating Room, restricted areas of which are observed, strict infection prevention practices		
• Voluntary Surgical Contraception services provided regularly (cite days offered)		
• Regular continuing quality improvement activities – maternal death reviews, medical audits, etc.		
• Available in-hospital FP-MCH recording and reporting forms or monitoring/evaluation/tracking system		
4. Voluntarism		
• Trained FP counselors are available		
• Regular counseling activities conducted with privacy and confidentiality		
• Informed choice verified prior to surgery		
• Informed consent form is used (secure copy)		
• Temporary methods are available, what methods?		
5. Review of Records (using the Voluntary Sterilization Record Review Checklist)		
• Refer to accomplished checklist for findings and recommendations		
6. Equipment, Supplies and Drugs		
• Clinic & OR equipment is adequate & functional		
• Basic instruments and expendable supplies for no-scalpel		

vasectomy and minilaparotomy under local anesthesia are regularly available		
<ul style="list-style-type: none"> • Supplies & drugs are adequate <ul style="list-style-type: none"> – Condoms – contraceptive pills – injectables – SDM beads – IUD – Oxytocin – vitamin A – zinc supplements – iron supplements – Pethidine (Demerol) or Nalbuphin (Nubain) – drugs of choice – Diazepam (Valium) or Midazolam (Dormicum) – alternative drugs • Functional system of maintaining adequacy of supplies and drugs 		
7. Client Satisfaction Feedback (using Client Interview Forms)		
<ul style="list-style-type: none"> • Refer to accomplished Client Interview Forms for results 		

Other comments:

Summary of findings:

Good points:

Points to improve (FP-MCH technical areas needing improvement)

Annex C-2: A Quick Guide on Documents Review

The following table denotes a quick guide on documents review – what documents to look for and possible sources of information:

Section	Methodology	Documents
A.1	KII, document review, Observations, photography	Census, CBMS, CBMIS, projected population with disaggregation
Info on hospital		Annual statistical report
PHIC accreditation		Accreditation papers posted in strategic areas such as the entrance, office of the AO or chief of hospital
PHIC reimbursement or claims		Logbook or consolidated reports of the designated PhilHealth desk officer
Annual budget for government facilities		AOP or Annual work and financial plan, or annual statement of obligation (ALOBS or SAOB)
Disaggregated list of FP clients		TCL for FP for RHU or logbook for private/public birthing homes and hospitals
Disaggregated list of clients for ANC, SBA, FBD		TCL for RHU or logbook for private/public birthing homes and hospitals
A.3		List of clients from logbooks or TCL
A.4	PHN or training unit or available list from the AO of the hospital, organizational structure posted in the wall, certificate of trainings,	
A.7	Memorandum or any letter of designation, accomplishment reports, minutes of meetings, waste management plans, facility-based facility.	

MNCHN Operations in Health Care Facilities

Name of Respondent: _____ **Date:** _____

Sex of Respondent: Male Female

Position: _____ **Contact details:** _____

Section A.I: Basic Information on FP-MCH Operations		
Name of health care facility:	Address:	
Population served (estimated):	Male	Female
50 years old and above 25-49 years old 19-24 years old 15 – 18 years old 14 years old and below		
Ownership: Government <input type="checkbox"/> Private: <input type="checkbox"/>		
If private, owned by: Midwife <input type="checkbox"/> Doctors <input type="checkbox"/> Others <input type="checkbox"/> _____		
If privately owned: Single Proprietorship <input type="checkbox"/> Corporation <input type="checkbox"/> Cooperative <input type="checkbox"/> Non-profit organization <input type="checkbox"/>		
For Hospital:		
Number of Authorized Bed Capacity: _____ Annual percent occupancy rate: _____		
Number of beds dedicated to OB: _____ Annual Percent occupancy rate: _____		
Number of beds dedicated to Pedia: _____ Annual Percent occupancy rate: _____		
For Government Hospital Categories:		
Municipal <input type="checkbox"/> District <input type="checkbox"/> Provincial <input type="checkbox"/> DOH Retained <input type="checkbox"/>		
PhilHealth Accreditation:	Level of DOH Licensing for Hospitals:	
Yes <input type="checkbox"/> No <input type="checkbox"/>	Level 1 <input type="checkbox"/> Level 2 <input type="checkbox"/>	
If yes, are you a :	Level 3 <input type="checkbox"/> Level 4 <input type="checkbox"/>	
Center of Quality ___ Center of Safety ___ Center of Excellence ___		
If PhilHealth accredited, does the health care facility get revenues from PhilHealth?		
Yes <input type="checkbox"/> No <input type="checkbox"/> Since when? _____		
If not yet PhilHealth accredited, what are the reasons for non-accreditation?		
If not yet PhilHealth accredited, any plans of applying? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, when _____		
Or is there an on-going accreditation process: Yes <input type="checkbox"/> No <input type="checkbox"/>		
If PhilHealth accredited, what is the no. of PhilHealth claims for Normal Spontaneous Deliveries: ___ Year _____		

Age bracket	No. of claims for NSD
50 years old and above	
25-49 years old	
19-24 years old	
15 – 18 years old	
14 years old and below	

No. of PhilHealth claims for FP: Year _____

Age bracket	No. of claims for IUD	No. of claims for BTL	No. of claims for NSV
50 years old and above			
25-49 years old			
19-24 years old			
15 – 18 years old			
14 years old and below			

Do you keep age-disaggregated list of your MCH Clients?

Yes No

If yes, how many clients in the recent past year: Year _____

Age bracket	Female
50 years old and above	
25-49 years old	
19-24 years old	
15 – 18 years old	
14 years old and below	

Do you keep a sex-disaggregated list of your FP clients? Yes No

If yes, how many total clients in the recent past year disaggregated in the following: Year _____

Age bracket	Male	Female
50 years old and above		
25-49 years old		
19-24 years old		
15 – 18 years old		
14 years old and below		

Total clients per method: Year _____

Age bracket	NSV	BTL	Pills	Injectables	IUD	NFP	Condom
50 years old and above							
25-49 years old							
19-24 years old							
15 – 18 years old							
14 years old and below							

If above data are available, do you include a gender analysis of these data in your accomplishment report? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Where do you get your supplies for your FP-MCH/MNCHN operations? Please specify _____		
Do you get funds from the government? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what are the sources of this Fund: Barangay: PhP _____ Municipal PhP _____ Provincial PhP _____ Congressional Fund PhP _____ Others _____ Please specify _____		
How often do you submit your accomplishment report? To what office do you submit it? Weekly <input type="checkbox"/> On What? _____ MHO <input type="checkbox"/> PHO <input type="checkbox"/> DOH-RO <input type="checkbox"/> ILHZ office <input type="checkbox"/> Others _____ Monthly <input type="checkbox"/> On What? _____ MHO <input type="checkbox"/> PHO <input type="checkbox"/> DOH-RO <input type="checkbox"/> ILHZ office <input type="checkbox"/> Others _____ Quarterly <input type="checkbox"/> On What? _____ MHO <input type="checkbox"/> PHO <input type="checkbox"/> DOH-RO <input type="checkbox"/> ILHZ office <input type="checkbox"/> Others _____ Yearly <input type="checkbox"/> On What? _____ MHO <input type="checkbox"/> PHO <input type="checkbox"/> DOH-RO <input type="checkbox"/> ILHZ office <input type="checkbox"/> Others _____		
Do you participate in the PIR of the government health facilities? Yes <input type="checkbox"/> No <input type="checkbox"/> If No, why?	Do you participate in the MDR? Yes <input type="checkbox"/> No <input type="checkbox"/> If No, why?	Do you participate in the Clinical Case Conference? Yes <input type="checkbox"/> No <input type="checkbox"/> If No, why?
Do you organize the PIR? Yes <input type="checkbox"/> No <input type="checkbox"/> If No, why?	Do you organize the MDR? Yes <input type="checkbox"/> No <input type="checkbox"/> If No, why?	Do you organize the Clinical Case Conference? Yes <input type="checkbox"/> No <input type="checkbox"/> If No, why?

Name of Respondent: _____ Date: _____

Sex of Respondent: Male Female

Position: _____ Contact details: _____

Section A.2. MNCHN Services				
Services	Availability (Check available services)	Name of Provider	Gender of Provider	Reason for non-availability (Refer to the choices below)
Counseling				
Pills Dispensing				
Injectables				
IUD Insertion				
Condom Dispensing				
Bilateral Tubal Ligation				
No Scalpel Vasectomy				
NFP				
Pre-natal services: <ul style="list-style-type: none"> • Weighing • BP taking • Routine Laboratory • Nutrition counseling • Iron & folate supplementation • Tetanus toxoid immunization • Assessment and treatment of other illnesses (TB, diabetes, etc) • Birth planning • FP counseling 				
Deliveries: <ul style="list-style-type: none"> • Normal spontaneous • Caesarian section 				
Newborn screening				
Post natal services				
Services related to nutrition				
If not available, what are the reasons for non-availability of services: <ol style="list-style-type: none"> 1. No trained staff 2. No resources (ex. physical infrastructure, budget for such services), please specify 3. No demand 4. No commodities 5. Specific beliefs, attitudes, conviction, commitment of health care provider 6. Others, please specify: _____ 				
If the services are not available, to what facility or to whom do you refer your clients? Please name the facility and health service providers: <ol style="list-style-type: none"> 1. Within catchment area: _____ 2. Outside catchment area: _____ 				

What is the core referral hospital of the ILHZ or district? _____ Where does the core referral hospital usually refer to next? _____ Reasons for referral	
Do you get referrals from BHWs?	Yes <input type="checkbox"/> No <input type="checkbox"/> With referral slip Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you get referrals from CHTs?	Yes <input type="checkbox"/> No <input type="checkbox"/> With referral slip Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you get referrals from private practicing midwives?	Yes <input type="checkbox"/> No <input type="checkbox"/> With referral slip Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you get referrals from public midwives?	Yes <input type="checkbox"/> No <input type="checkbox"/> With referral slip Yes <input type="checkbox"/> No <input type="checkbox"/>
What are the common feedbacks from clients/families that have been referred and attended to? 1. 2. 3. 4.	
Section A.3. MNCHN Services for young people	
a. Travel time from schools or communities where the youth population groups are to the health care facility?	<input type="checkbox"/> < than 30 minutes <input type="checkbox"/> > than 30minutes to 1 hour <input type="checkbox"/> 1 hour to 2 hours <input type="checkbox"/> > than 2 hours
b. What is the mode of transportation from the schools or communities where the young people are to the health care facility?	<input type="checkbox"/> walking <input type="checkbox"/> tricycle <input type="checkbox"/> jeep <input type="checkbox"/> boat <input type="checkbox"/> others, please specify
c. Is the health facility providing FP-MCH counseling and services to married and unmarried male and female young people (15-24 y/o)?	<input type="checkbox"/> Yes, (if the answer is yes, go directly to questions d - f <input type="checkbox"/> No; reason why not, if the answer is no, go directly to question l.
d. If yes, how many unmarried male and female young people (15-24 y/o) were counseled on FP-MCH in the preceding year?	___ number of unmarried male (15-24 y/o) counseled on FP/year ___ total number of male (all ages) counseled on FP, same time period ___ number of unmarried female (15-24 y/o) counseled on FP/year ___ total number of female (of reproductive age) counseled on FP, same time period

e. If yes, how many pregnant young people (15-24 y/o) were given pre-natal services in the preceding year?	<p>___ number of pregnant young women (15-24 y/o) given pre-natal services/year</p> <p>___ total number of pregnant women given pre-natal services, same time period</p>
f. If yes, how many pregnant young people (15-24 y/o) delivered in your facility?	<p>___ number of pregnant young women (15-24 y/o) who delivered in the facility/year</p> <p>___ total number of pregnant women who delivered in the facility, same time period</p>
g. Does the health facility have trained personnel (MDs, nurses, MWs) on adolescent reproductive health or DOH adolescent job aid	<input type="checkbox"/> Yes, If yes specify training program received and when
	<input type="checkbox"/> No; reason/s why not
h. Names, sex and occupation / designation of health professionals in-charge of providing FP-MCH services in the health facility	Number of Females: _____ Number of Males: _____
i. Does the health facility have a separate room assigned for FP – MCH services for married or unmarried young people (15-24y/o)?	<input type="checkbox"/> Yes
	<input type="checkbox"/> No; reason/s why not
j. Does the health facility conduct outreach activities to inform young people in their catchment areas about the FP-MCH and other reproductive health services in the health facility?	<input type="checkbox"/> Yes
	<input type="checkbox"/> No; reason/s why not
k. What are the programmatic areas to further improve / strengthen FP-MCH services towards meeting the FP-MCH needs of young people on preventing too early pregnancy, ensure ANC, SBA and FBD	<input type="checkbox"/> relevant training of providers, pls. Specify <input type="checkbox"/> management system, pls. specify <input type="checkbox"/> policy (facility or local policy) , pls. specify <input type="checkbox"/> referral network <input type="checkbox"/> others, please specify
l. What are the programmatic areas needed to establish FP-MCH services towards meeting the FP-MCH needs of young people on preventing too early pregnancy, ensure ANC, SBA and FBD.	<input type="checkbox"/> relevant training of providers, pls. Specify <input type="checkbox"/> management system, pls. specify <input type="checkbox"/> policy (facility or local policy) , pls. specify <input type="checkbox"/> referral network <input type="checkbox"/> others, please specify

Name of Respondent: _____

Date: _____

Position: _____

Contact details: _____

A4. Tool to assess capability building needs of health facility on MNCHN service provision

A.4. Staff Involved in FP-MCH service delivery and their training needs															
Name	Sex	Position or designation	PhilHealth accredited		Training (include year of last training) Check trainings for all individual staff										
			Y	N	Basic FP-CBT	Compre FP-CBT	Newborn Screening	Essential intra-partum & Newborn Care	Immunization	BEMO NC	Blood bank management & related training	Adolescent reproductive health	FHSIS	Gender sensitivity	Others, Specify

Note: Use extra sheets if necessary

Name of Respondent: _____

Date: _____

Position: _____

Contact details: _____

A.5. Available MNCHN InformationDo you provide information on client's rights to your clients? Yes No

What information on Maternal and Child Health are available in the facility?

Literatures <input type="checkbox"/> Language _____	Source of material _____
Posters <input type="checkbox"/> Language _____	Source of material _____
Flip chart <input type="checkbox"/> Language _____	Source of material _____
Brochures <input type="checkbox"/> Language _____	Source of material _____
Flyers <input type="checkbox"/> Language _____	Source of material _____
Leaflets <input type="checkbox"/> Language _____	Source of material _____

What information on Family Planning is available in the facility?

Literatures <input type="checkbox"/> Language _____	Source of material _____
Posters <input type="checkbox"/> Language _____	Source of material _____
Flip chart <input type="checkbox"/> Language _____	Source of material _____
Brochures <input type="checkbox"/> Language _____	Source of material _____
Flyers <input type="checkbox"/> Language _____	Source of material _____
Leaflets <input type="checkbox"/> Language _____	Source of material _____

If the facility provides counseling, what does it include:

Inform clients about FP method	Yes <input type="checkbox"/> No <input type="checkbox"/>
Inform about side effects	Yes <input type="checkbox"/> No <input type="checkbox"/>
Inform clients on what to do	Yes <input type="checkbox"/> No <input type="checkbox"/>
Inform other FP methods available	Yes <input type="checkbox"/> No <input type="checkbox"/>
Inform clients where to go for preferred methods and products	Yes <input type="checkbox"/> No <input type="checkbox"/>
Inform clients on available benefits from PHIC and other available financing modalities for FP-MCH	Yes <input type="checkbox"/> No <input type="checkbox"/>

Who are the main MNCHN information providers in the facility?

What is the key MNCHN information are they providing?

A.6. Available MNCHN products available in the facility

FP Product available	NO	YES	If yes, what type/brand	If yes, until when will the supply last
- Pills				
- Injectables				
- Beads				
- Condoms				
- IUD				
MCH Product available				
- Vit. A				

- Folic Acid&Ferrous Sulfate				
- Zinc				
- Tetanus toxoids				
- Vitamin K				
- Oxytocin				
- Supplies for safe delivery and care of newborn – cord clamp, clean/sterile gloves, non-mercuric thermometer, etc.				
- NSD kit				
- Essential antibiotics				
- Pain relievers				
- Vaccines				
- Others				
Tools used for monitoring of utilization				
Reordering level				

This tool does not replace the stock management system tools that are in place at the facility level.

Management tool(s) used to track availability: _____

Management tool(s) used to track utilization: _____

Management tool(s) used to track pricing: (optional) _____

A.7 Environmental Compliance Assessment Tool

As part of the baseline quality assessment and monitoring on environmental compliance, the team or the assessor can look at the following documents at the facilities:

1. At the hospital level:

- a. Memorandum or order designating certain staff as the environmental compliance officer or members of the waste management committee and their functions
- b. Staff development or capability building on waste management
- c. Waste management plan, monitoring results of the plan's implementation
- d. Minutes of meetings conducted by the waste management committee and results of the agreement in the meetings if there are
- e. Hospital policies on environmental protection, waste management, etc.
- f. Evidences of compliance with sanitation (sanitation permit) , Department of Environment and Natural Resources if so warranted, (Environmental Compliance Certificate), with fire and safety
- g. Benchbook checklist and look for the score (self-administered and the score by PhilHealth) in each indicator on safe practice and environment

These documents can be found in the facility's manual of operations if it has.

2. At the birthing home level:

- a. Evidences of compliance with sanitation (sanitation permit) , Department of Environment and Natural Resources if so warranted, (Environmental Compliance Certificate), with fire and safety
- b. Policies on environmental protection, waste management, etc.

These documents can be found in the facility's manual of operations if it has.

3. At the DOH-RO level:

- a. Results and recommendations of the licensing division regarding environmental protection in general and waste management in particular

All these documents are pertinent and have to be available if the facilities are licensed by the DOH& the LGU or accredited by PhilHealth. Further, to verify what is written in their documents, the team can inspect on-site and look at the following in the facilities:

1. If the facility is generally clean
2. Waste segregation scheme
 - a. How does the facility do its waste segregation scheme
 - b. What kind of waste does it segregate
 - c. Presence of sharps' container
3. Disinfection of waste prior to disposal
4. Manner of disposal for
 - a. Sharps (presence of separate vault for sharps)
 - b. Placenta (presence of separate septic tank for placenta or does the facility allow family to bring it home)

- c. Used supplies, commodities, etc. (ex. IUD, used supplies generated from the conduct of BTL/NSV)
 - d. Waste products from the laboratory, regular human waste from kitchen, wards, etc.
5. If the segregated waste is collected by the LGU's garbage collector
- a. What are the waste products that the LGU's garbage collector collects (sharps, placenta, commodities, etc.)?
 - b. How are they collected (dumped together with the other regular household waste)
 - c. Where are they disposed of
 - d. Distance of septic tank/vault from source of water in meters

Checklist of Environment Compliance Practices & Measures	
Facility has policies on environmental mitigation	Yes <input type="checkbox"/> No <input type="checkbox"/>
Facility is generally clean	Yes <input type="checkbox"/> No <input type="checkbox"/>
Waste segregation scheme	Yes <input type="checkbox"/> No <input type="checkbox"/>
What kind of waste is segregated in the facility	
Sharps' container	Yes <input type="checkbox"/> No <input type="checkbox"/>
Disinfection of sharps	Yes <input type="checkbox"/> No <input type="checkbox"/>
If disinfection is done, how is this done?	
Separate septic tank for general waste	Yes <input type="checkbox"/> No <input type="checkbox"/>
Separate vault for sharps	Yes <input type="checkbox"/> No <input type="checkbox"/>
Separate vault for placenta	Yes <input type="checkbox"/> No <input type="checkbox"/>
Allow family to bring placenta home	Yes <input type="checkbox"/> No <input type="checkbox"/>
Manner of disposal for used supplies, commodities, pharma products	
Separate washing place for instruments, equipment, etc.	Yes <input type="checkbox"/> No <input type="checkbox"/>
Distance of septic tank/vault from source of water in meters	
What are the waste products collected by the LGU garbage collector:	
Sharps Yes <input type="checkbox"/> No <input type="checkbox"/> Kitchen waste Yes <input type="checkbox"/> No <input type="checkbox"/> Anatomical waste Yes <input type="checkbox"/> No <input type="checkbox"/>	
Placenta Yes <input type="checkbox"/> No <input type="checkbox"/> Chemical waste Yes <input type="checkbox"/> No <input type="checkbox"/> Others _____	
Are they dumped together with other regular household waste?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Where are they disposed?	

Rapid assessment for ICV Compliance among FP-MCH providers Questions for Facility Managers/Supervisors/Providers

Name of Health Facility & Address:

Date of Site Visit:

Person Contacted and Title: _____

Gender of Person Contacted: __ Male __ Female

1. Can you tell me a bit more about your family planning program and the type of family planning services you provide? Which FP methods are currently available for clients?

- Pills
- Injectables
- IUD
- Condoms
- BTL
- Vasectomy
- Others (please specify) _____

If services are not provided at the facility, do you refer clients to another provider/facility? If so, what is your relationship with that provider/facility? Do you have an existing referral agreement? Is the referring provider given compensation for making referrals?

2. Clinic Level: For FP, how is your clinic performance evaluated? Do you have planned FP targets/goals? If yes, what kind of targets do you have for this facility?

Provider Level: Are you required to achieve any assigned specific targets/goals for family planning? If so, what are these targets? What happens if you meet/fail your targets?

3. Benefits and Incentives:

- How do you encourage female clients to avail of the clinic's FP program?
- How do you encourage male clients to avail of the clinic's FP program?
- Do clients receive any benefits for participating in the FP program (e.g. food, money)?
- Are any benefits denied if female clients choose not to participate?
- Are any benefits denied if male clients choose not to participate?

4. Comprehensive Information:

- What information do you provide to male and female clients interested in FP? Do you provide specific information for FP methods chosen? If so, what?
- Do you have materials (wall chart, brochure, flipchart etc.) that explain the various FP methods and their risks and benefits?

5. Have clients ever asked you advice about abortion? If so, what do you do?

6. Have clients ever asked you about regulation of menstruation? If so, what do you do?

7. BTL/VS Services

- What kind of information do you provide to clients interested in BTL/Vasectomy?
- Do you ask the client to sign an informed consent form before any VS procedure? If so, do you keep client record of informed consent?

- Are any benefits (food, money etc.) provided to clients who choose to undergo VS?

Closing Remarks: Thank you very much for your participation in this interview. We really appreciate your feedback and please do not hesitate to contact us if you have any questions or additional information you would like to share.

[Provide interviewee contact information]

Questions for Clients

Name of Health Facility & Address:

Date of Site Visit:

Person Interviewed: _____

Sex of Person Interviewed: _____

1. Are you currently using any FP method?
 - If so, which one? Why did you choose that method?
 - If not, please proceed to question 5.
2. Family Planning Counseling:
 - Who provided counseling on the FP methods?
 - What kind of information did the nurse/midwife/doctor provide?
 - Do you feel you received all the information necessary to make a decision about your FP needs?
3. Did you feel any pressure from anyone to use FP? If yes, from whom?
4. Did someone give you anything in exchange for using a FP method (e.g., food, money, gift)? If yes, what did they give you and how much?
5. Was there a time that you preferred not to use a FP method? Why?
 - If so, were you denied any benefits or access to any programs at this facility?
 - Do you know someone whose benefits are denied because of not accepting FP?
6. BTL/VS Clients:
 - Before you had the procedure, did you sign a form saying you understand what the procedure is about? Did someone explain the form to you?
 - Did you receive anything after the procedure? If so, what and how much?

Closing Remarks:

Thank you very much for your participation in this interview. We really appreciate your feedback and please do not hesitate to contact us if you have any questions or additional information you would like to share.

[Provide interviewee contact information]

Observation Checklist

When conducting site visits for interviews, Implementing Partner staff should also briefly take the time to make some observations at the facility. The following checklist can guide in this effort.

Family Planning Wall Chart Displayed	<input type="checkbox"/> Yes If Yes, language used _____ If yes, does it contain information for both males and females? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No
Other FP IEC materials available	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, what are these? <input type="checkbox"/> Flip Chart Language _____ For females? ____ For males? ____ <input type="checkbox"/> Brochure Language _____ For females? ____ For males? ____ <input type="checkbox"/> Leaflet Language _____ For females? ____ For males? ____ <input type="checkbox"/> Flyer Language _____ For females? ____ For males? ____ <input type="checkbox"/> Poster Language _____ For females? ____ For males? ____ <input type="checkbox"/> Other, Please Specify _____ Language _____ For females? ____ For males? ____
FP Record Review: Sharp increases in number of FP acceptors	<input type="checkbox"/> Yes If Yes, how much _____ <input type="checkbox"/> No
FP Record Review: Inconsistencies in FP data	<input type="checkbox"/> Yes If Yes, what is it _____ <input type="checkbox"/> No

Annex D: Activity Design for Hospital Forum

Hospital Forum Cabanatuan, Nueva Ecija March 5, 2013

Rationale:

On February 14-15, 2013 PRISM2 supported the Provincial Health Office of Nueva Ecija, DOH-RO III representatives, and the city/municipal health units, hospitals of District 2 ILHZ conducted a workshop to improve provision of FP-MCH services, products and information.

The workshop output was a referral flow for clients in need of Family Planning, ante-natal care, post-natal care and bundled with neonatal care. The referral flow showed that primary care providers coming from contiguous areas in District 2 of Nueva Ecija are more likely to engage with private and public hospitals in Cabanatuan City rather than refer their clients to their public core referral hospital, San Jose District Hospital. This hospital forum is proposed to strengthen the relationship of public and private primary health care providers with the public and private hospitals to improve the service delivery in the province.

Objectives:

At the end of the sessions, the PHO shall be able to:

- Identify concerns, barriers and solutions to enhancing participation of hospitals in the MNCHN service delivery network
- Get the commitment of participating hospitals for MNCHN service delivery network
- Schedule meeting for strengthening relationship among primary service providers with the participating hospitals towards launching the SDN.

Schedule of topics:

Time	Topic	Facilitator	Requirements
9:00 AM	Morning Prayers		
	Introduction		
	Welcome Address	PHO	
9:30 AM	Objective of the hospital forum	PHO	
9:45 AM	Expected core packages of FP-MCH services, products and information in the hospitals	DOH-RO	MNHCHN MOP
11:00 AM	Presentation of the referral flow as agreed on Feb. 14-15	PHO	Flow chart, as agreed
1:00 PM	Round-table discussions	PHO	Process documentor
3:00 PM	Agreements and Next steps	PHO	Process documentor

Participants: Private and public hospitals; Officers and members of the local chapter of the Philippine Hospital Association,

Facilitators: PHO and DOH Representatives

Annex E: Activity Design for Integration of Hospitals into the SDN

Integration of Hospitals into the Service Delivery Network (SDN) Cavite

Background

Maternal and mortality situation

The past decade has seen a worsening of the maternal mortality situation in the country. From 162 maternal deaths per 100,000 live births a decade before, it has worsened to a ratio of 227/100,000 (FHS, 2011). Such figure is surpassed only by the least developed countries in Asia and Africa. Sadly, most of these deaths are preventable and can be addressed through family planning services and skilled birth attendance.

The most common direct causes of maternal deaths are hypertension (28.4%), post-partum hemorrhage (17.2%), and pregnancy with abortive outcomes (8.3%). Most maternal deaths occur during delivery and during the postpartum period because of the following: (a) lack of provider skills on basic/comprehensive emergency obstetric care, with more than half (56%) of births taking place at home and around 26% percent of births being assisted by or traditional birth attendants or TBAs (NDHS 2008) who lack the necessary skills for safe and quality delivery; and (b) the absence of transportation and communication facilities for timely referral and management when pregnancy complications occur. Neonatal mortality which comprises almost half of the under-five deaths has remained constant in the past 15 years. Both the infant and under-five mortality rate went down from the 1993 figures of 38 and 64 deaths per 1,000 live births to 22 and 30 deaths, respectively, per 1,000 live births.

All of these data endangers the achievement of the country's Millennium Development Goals (MDGs) and nothing short of a dramatic push to reverse the trend is in order.

The Aquino Health Agenda (AHA) and Universal Health Care Under the new political administration, the Department of Health (DOH) has issued the Kalusugan Pangkalahatan (KP) Program as rationalized in AO No. 2010-0036, "The Aquino Health Agenda: Achieving Universal Health Care for all Filipinos". Its goal is to implement universal health care among Filipinos.

The three strategic thrusts of KP are: (a) increased risk protection especially among poor households in quintiles 1 and 2 through premium subsidy in the PhilHealth social health insurance program, greater availment of benefits, and increased support value; (b) provision of greater investments in the hospital system by rationalizing the Service Delivery Networks (SDNs) and public/private partnerships (PPP) in health; and (c) strengthening the public health system for the achievement of the health MDGs, mainly through invigorated Community Health Teams (CHTs) and refurbishing of rural health units (RHUs) and other public health infrastructure.

SDNs and PPPs

The concept of SDNs and PPPs is more explicitly articulated in the MNCHN Strategy Manual of Operations. It defines an SDN, on the one hand, as "the network of facilities and providers within the province-wide or city-wide health system offering the MNCHN core package of services in an integrated and coordinated manner. It includes the communication and transportation system supporting this network. The following health providers are part of the MNCHN Service Delivery Network: community

level providers, BEmONC-capable network of facilities and providers and CEmONC-capable facilities or network of facilities.

On the other hand, PPP is defined as that which is used “to characterize the sharing of common objectives, as well as risks and rewards, as might be defined in a contract or manifested through a different arrangement, so as to effectively deliver a service or facility to the public”.

In order to complete the loop for an effective and efficient public health system insofar as MNCHN interventions are concerned, it is necessary that the private sector be integrated into the network of public facilities and providers in order that real, unified and sustained results are realized that benefit the whole population.

Cavite Province’s SDN and PPP Initiatives

The Province of Cavite has been in the forefront of efforts to implement the MNCHN strategy in a most comprehensive manner. First, in compliance with the KP program it sought to determine the number, scope and coverage of MNCHN health facilities and providers, both public and private, and conducted an assessment of their service capabilities. This is particularly important, because being a rapidly industrializing economy; the Province has an accelerated expansion of the private sector. In the realm of health, it is expressed in the expanding number of private hospitals, private birthing homes and workplace health programs.

Second, the Provincial Government has conducted a thoughtful, systematic and participatory process for the crafting of a MNCHN referral system that is district based using the Inter-local Health Zones of the province. During the last consultative review, three different referral networks, corresponding to three SDNs have been formalized with the ratification of the various referral manuals with both the public and private health sector representatives participating, most of whom are hospital and workplace-based.

Through these achievements, the Province of Cavite has already virtually created its SDNs and PPPs less the formalization and compliance requirements. According to the MNCHN MOP, there are certain explicit and implicit requirements that have to be fulfilled, notably the following: a) the DOH (DOH-RO IV-A in this case) makes the facility assessments (and, therefore, the recommendatory authority since it is the agency that certifies BEmONC- and CEmONC-facility capability), b) a referral system has to be in place, c) the LGU designates the SDN and d) there has to be a public-private partnership (which has to be organized with a partnership agreement being signed by contracting parties so it can function normally as a legitimate body); and e) other requirements that can fall as assumed functions of the SDN and the PPP when their designation and organization have been formalized.

This activity being envisioned proposes to fulfil a key portion of the last two major tasks stated above. It is intended to formalize the integration of private and public hospital facilities and providers into the FP/MNCHN service delivery network of facilities and providers that is presently dominated by public health facilities and providers, private birthing homes in the second and first tier of the SDN. This will be capped by agreeing on the parameters, key elements of a quadripartite partnership agreement between and among the DOH-REGIONAL OFFICE IV-A, the Provincial Government and the other Cavite LGUs, representatives of public health facilities and representatives of private sector hospitals health facilities. The activity will also discuss through a workshop important next steps to strengthen the SDN through the formal integration of other important stakeholders who have already been engaged such as the workplaces and those that have yet to be engaged such as (they have been engaged already) professional

associations in the health profession, transportation and communication support groups, civil society organizations, etc.

The title that may be apt to this activity is “Strengthening the Delivery of FP/MNCHN Services in the Province of Cavite through the Formal Integration of Public and Private Hospitals and Providers into the Service Delivery Networks (SDNs)”.

Objectives:

General:

To officially integrate capacitated public and private hospital facilities and providers into the local service network for FP-MCH service delivery strengthening and provide PPP support.

Specific Objectives:

- To contextualize public and private sector hospital facilities and providers’ contribution towards strengthening the FP-MCH SDN in the light of current DOH thrusts and priorities;
- To formalize the integration of capacitated private hospital facilities and providers as SDN partners;
- To formalize private hospital partners’ integration into the local SDNs through a MOU/MOA signing ceremony that exemplifies a key component of PPP.
- To forge a quadripartite partnership agreement between and among the DOH-RO, LGUs (provincial Government/PHO, municipal governments), representatives of public facilities and providers and representatives of private hospitals and providers.

Suggested Participants

- From **DOH-RO**: Regional Director, Asst. Regional Director, MNCHN/FP/MCH Team Members or Coordinator, PPP Team Members or Point person
- From **DOH-retained hospital (CEmONC)**: Chief of Hospital, Chief Nurse, FP nurse or midwife, VS surgeon or Head of Department of OB/Gyne,
- From **LGUs**: Provincial Governor or representatives, City or Municipal Mayors or representatives, Provincial Health Officers, City or Municipal Health Officers, Chiefs of Hospitals of Provincial or District Hospitals (**BEmONC**), FP nurses or midwives of BEmONC hospitals
- From **Private Hospital Partners**: Private hospitals to be integrated, Medical Director and/or Owner, Trained BTL surgeon, trained nurse or midwife (FP-CBT level I)

Activity Flow:

Session Title, Process and Content	Main Product of Session	Tools/Design Needed
Opening Program Invocation National anthem Welcome Remarks (Governor)		
Purpose of the Activity	<p>Understanding of the objective of the activity. Presentation of workshop flow:</p> <ul style="list-style-type: none"> a) formal introduction of the private and public facilities and providers to each other; b) summary presentation of the map and flow of referral and related requirements (focus on where we left off on Sept. 9; c) workshop of proposed common and distinct roles of key partners; d) ratification and signing of referral system (3 sets) forging of agreement as SDN partners; and e) next steps in the formal integration of other SDN and PPP stakeholders and f) planning for the formal launch of the SDNs and signing of the multi-sectoral PPP agreement. 	<p>Powerpoint:</p> <p>Title</p> <p>Objectives</p>
Introduction of Participants	<p>Participants introduced as those who are part of the SDN, public facilities and providers and private hospitals and providers to be integrated into SDN as well as stewards and governance representatives.</p>	<p>MC calls on participants for self-introduction.</p>
Inspirational Message (by DOH-Regional Office Director)		

Session Title, Process and Content	Main Product of Session	Tools/Design Needed
<p>Sharing the Big Picture - National and Regional FP-MNCHN Situation and Current Initiatives of the Government that Affect Private Hospitals and Providers' Contribution to Improving Public Health and FP/MNCHN Outcomes</p> <p>By DOH-Regional Office FP-MCH Coordinator</p>	<p>Participants understand the context of MNCHN from a national and regional perspective; are able to situate the contribution of private hospitals and providers in improving public health outcomes</p>	<p>Powerpoint:</p> <p>National and regional stats from latest – 2011 FPS</p> <p>MMR, IMR, MDG</p> <p>Pertinent AOs, strategies, etc. to address MDGs</p> <p>UHC/KP, MNCHN Strategy, FP Command Call, PhilHealth's new directions, changes in licensing rules and procedures</p> <p>Current data on private hospitals and providers contribution to overall health and public health</p>
<p>The MNCHN Strategy Manual of Operations: Discussing its Finer Aspects and Establishing the Unique Roles of the Public, Private and Other Sectors within the SDN and in a PPP Arrangement</p> <p>By Cavite PHO</p>	<p>Participants understand the MOP's detailed operational elements and are able to situate their unique roles in improving MNCHN outcomes</p> <p>Participants understand what SDN and PPP are and their differentiation and complementation</p>	<p>Powerpoint</p> <p>MOP highlighting its key components</p> <p>Provide ideas on how the private and public sectors may contribute to the MOP's operationalization starting from the just finished drafts of the SDN referral systems</p>
<p>Summary Presentation of the 3 SDNs' Referral System and Move for Ratification</p> <p>By the DOH-Regional Office PPP or MNCHN Point Person and the point persons of the ILHZ</p>	<p>Participants are able to affirm the process, map and flow of the SDNs' respective referral systems and reach final decision for their ratification</p>	<p>Final printed copies of the SDNs' referral systems; map, summary copies and flow of the same</p>
<p>The Organizing Elements of SDN Strengthening Support: Proposed Quadripartite Partnership Agreement</p>	<p>Participants are able to provide their own inputs by way of a workshop on the draft quadripartite partnership agreement.</p>	<p>Powerpoint</p> <p>Draft of the main quadripartite</p>

Session Title, Process and Content	Main Product of Session	Tools/Design Needed
	Participants are able to agree on the final form of the partnership in plenary and make a decision on signing it.	partnership agreement Separate copies of common and specific roles and functions of each party to the agreement arranged in a matrix 4 workshop groupings: DOH-REGIONAL OFFICE Provincial Government/PHO Public hospital reps and providers Private hospital reps and providers
Private Sector Response By a representative of one of the private hospitals and providers to be integrated	Private sector shares reasons for their positive response to the challenge of strengthening the SDN; may also be good to publicly declare their commitment to helping improve overall MNCHN outcomes	Testimonial from private partners to be integrated
Next Steps: Towards the Convening of Multipartite SDNs and PPP and their Formal launch Benefits about completing the SDN integration process Benefits about having a sustainable mechanism to move the SDNs and PPP forward Initial planning for the launch	Participants arranged by “sectoral” groupings in workshops are able to provide their collective inputs into the planning of the next steps in integrating other sectors into the SDNs and PPP and the formal launch of the SDNs and PPP	Powerpoint Workshop Planning matrix

Annex F: Planning of Public-Private Partnership for MNCHN

Planning of PPP for MNCHN

San Jose ILHZ, Nueva Ecija and Pangasinan

September 17-18; 18-19, 2013

Rationale:

The provinces of Nueva Ecija and Pangasinan have already crafted their Province – Wide Investment Plan for Health (PIPH). However, the plan is still weak on public – private partnership for MNCHN. The local stewards and private partners have already formed the PPP for MNCHN via the Service Delivery Network. Short-term plans have been implemented, jointly financed by the project with leveraged funds from the DOH-RO and the LGUs.

Further, as PRISM2 is winding off its operations after 5 years, this planning process will ensure financing of activities that were previously financed by the project, adoption and ownership of the local stewards and PPPs of the project's technical initiatives.

Objectives:

This planning session is aimed at crafting a three-year plan for MNCHN agreed by the local PPP that can be integrated into the Province-wide Investment Plan for Health for 2014-2017.

Output:

- PPP MNCHN Three - Year Plan

Activity Flow

Day	Topic	Output	Facilitators or resource persons
Day 1: Sept. 17, 2013	Input: Presentation of LGU scorecard and MNCHN status	Consolidated status of accomplishment	Dr. Josie Garcia PHO
	Input: Presentation of contribution of private hospitals and private midwives and birthing homes on MNCHN		PHO or San Jose ILHZ
	Input: Presentation of identified problems per KP area	Root causes of the challenges are identified and appreciated or internalized	San Jose ILHZ
	Workshop I: Deepening of the identified problems (based on the workshop on July 9): <ul style="list-style-type: none"> • Sift through the issues previously identified and put them in the SWOT matrix • Identify the major challenges that impact on most or all of the issues identified in the SWOT • Among these major challenges, which can be addressed by the ILHZ, by the PHO, LGUs, 		PRISM2

Day	Topic	Output	Facilitators or resource persons
	private sector, PPP <ul style="list-style-type: none"> Identify root causes of these identified problems, using problem tree 		
	Workshop 2: Seeking Solutions: <ul style="list-style-type: none"> Crafting vision, mission Using the problem tree, convert these into objective tree Craft the objectives that can be accomplished in 2014, 2015, 2016 Using the SWOT, craft the strategies that can address the objective tree 	Solutions are identified	
	Input: current actions done by the PHO, ILHZ, city and municipality LGUs		
	Workshop: <ul style="list-style-type: none"> Internalize the current programs and actions if these can address the objectives identified in the previous sessions 		
	Interactive discussions among public stewards and private providers of San Jose ILHZ and Pangasinan: <ul style="list-style-type: none"> Nueva Ecija to present its (ex.) practice on itinerant missions for BTL Pangasinan to present its (ex.) practice on utilization of CBFPMIS <p><i>Note: These are just examples. The PPPs can decide what to present and cull lessons from</i></p>	Lessons learned extracted and appreciated by the PPPs as doable and can be implemented in their specific sites	
Day 2: September 18, 2013	Input: Planning matrix as used in the PIPH/CIPH		
	Workshop: Programming <ul style="list-style-type: none"> Based on the identified and agreed upon objectives, strategies extracted from the SWOT workshop, identify the programs and activities, financing, time frame and responsible unit, person, partner for each activity 	Initial draft of the workplan: Plan for each KP area is clearly identified	PRISM2, DOH-RO, PHO,

Day	Topic	Output	Facilitators or resource persons															
	<i>Mechanics: the organizers and participants can decide as to the grouping</i>																	
	Plenary: Interactive discussions on the reported workshop outputs		PRISM2, DOH-RO, PHO															
	<p>Plenary: what do we want to do with these plans:</p> <table border="1" data-bbox="344 840 1013 1575"> <thead> <tr> <th data-bbox="344 840 669 909">Activity</th> <th data-bbox="669 840 850 909">Timeline</th> <th data-bbox="850 840 1013 909">Facilitator</th> </tr> </thead> <tbody> <tr> <td data-bbox="344 909 669 1014">Finalizing the PPP MNCHN plan</td> <td data-bbox="669 909 850 1014"></td> <td data-bbox="850 909 1013 1014"></td> </tr> <tr> <td data-bbox="344 1014 669 1182">Communicating the PPP MNCHN plan to LCEs, heads of private facilities, PHO, DOH-RO</td> <td data-bbox="669 1014 850 1182"></td> <td data-bbox="850 1014 1013 1182"></td> </tr> <tr> <td data-bbox="344 1182 669 1413">Integration process of the PPP MNCHN plan to the PIPH Monitoring the implementation of the plan</td> <td data-bbox="669 1182 850 1413"></td> <td data-bbox="850 1182 1013 1413"></td> </tr> <tr> <td data-bbox="344 1413 669 1575">Management structure taking the lead in the implementation of the PPP MNCHN plan</td> <td data-bbox="669 1413 850 1575"></td> <td data-bbox="850 1413 1013 1575"></td> </tr> </tbody> </table>	Activity	Timeline	Facilitator	Finalizing the PPP MNCHN plan			Communicating the PPP MNCHN plan to LCEs, heads of private facilities, PHO, DOH-RO			Integration process of the PPP MNCHN plan to the PIPH Monitoring the implementation of the plan			Management structure taking the lead in the implementation of the PPP MNCHN plan			Clear next steps	
Activity	Timeline	Facilitator																
Finalizing the PPP MNCHN plan																		
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Integration process of the PPP MNCHN plan to the PIPH Monitoring the implementation of the plan																		
Management structure taking the lead in the implementation of the PPP MNCHN plan																		

Participants:

- Public stewards, supervisors
 - MHO/PHN, planning officers, SP/SB for health
- Private providers

Facilitators:

- PRISM2
- PHO
- DOH-RO