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## Engaging Cooperatives for Delivering Family Planning and Maternal and Child Health Services and Products



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July 2014

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## Acronyms

BEmONC	Basic Emergency Obstetric and Newborn Care
CDA	Cooperative Development Authority
CHO	City Health Office
DOH-RO	Department of Health-Regional Office
FP-CBT	Family Planning Competency-Based Training
FP-MCH	Family Planning and Maternal and Child Health
IMAP	Integrated Midwives Association of the Philippines
IWG	informal Workforce Group
MHO	Municipal Health Office
PHO	Provincial Health Office
PPM	Private Practicing Midwife
PRISM2	Private Sector Mobilization for Family Health-Phase 2

## Introduction

Achieving the Millennium Development Goals, particularly the reduction of maternal and infant deaths, requires coordinated action to improve intermediate health services, such as family planning, antenatal care, facility-based delivery, and child immunizations. Coordinated action means families receive assistance in assessing their health risks, information of where they can receive services and products, information of their benefits from the national health insurance program, and are made aware of the network of public and private health providers capable of delivering core family planning and maternal and child health (FP-MCH) services. Coordinated action also refers to public and private partnerships at both the national and local levels working to create demand for such services.

The private sector can add value to a health partnership program in many ways: identify funding sources; provide structure and manpower to manage a program; access communities; integrate health programs into their existing programs; and, lastly, fulfil their social responsibility to their constituents.

While the formal workforce sector has been engaged through the Department of Labor and Employment's Family Welfare Program, informal workforce groups have not been tapped to reach out to their own members.

Informal workforce groups (IWGs) are organized groups from the informal sector. The informal sector is made up of units engaged in the production of goods and services with the primary objective of generating employment and income among members in order to earn a living. The IWGs could also be organized groups of workers engaged in a common livelihood for profit or income, or whose employment and service rendered is either temporary or seasonal.<sup>1</sup> Examples of these are cooperatives, unions, transport groups, and vendors associations. The increasing emergence of the informal workforce in the Philippines equates to more involvement of men and women of reproductive age in the labor force.

A large number of IWGs are cooperatives. There are more than 23,355 registered cooperatives with more than 12 million members nationwide, of which 62% are multi-purpose cooperatives, and 23% of members are age 20 and above.<sup>2</sup> Their members are usually elementary and high school graduates looking for economic opportunities to support the needs of their families. Members of these cooperatives are often female (70%) and often do not have access to accurate information and quality FP-MCH services considering their level of education and socio-economic status.

By reaching out to IWGs, specifically cooperatives, public health institutions and other partners can leverage these institutions to reach members, providing the information and access to services that contribute to the millennium development goals.

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<sup>1</sup> National Statistical Coordination Board Resolution No. 15, Series of 2002

<sup>2</sup> CDA Statistics as of 31 December 2013

## The Challenge

The Cooperative Development Authority (CDA) recently issued “Guidelines on Social Audit of Cooperatives” (Annex I- Memorandum Circular no. 2013-16). The Social Audit, as defined in the memorandum circular, is a “procedure where the cooperative assesses its social impact and ethical performance vis-a-vis its mission, vision, goals and code of social responsibility. It is a process to assess the cooperative’s contribution for the upliftment of the status not only of its members’ economic needs but also of their social needs, and that of the community where it operates.” Included in the checklist are FP-MCH programs and networking with partners that can help them in their social programs. (Refer to CD for the Social Audit Tool of Cooperatives.)

Implementation of FP-MCH programs can prove challenging even to large- or medium-sized cooperatives. While associations and cooperatives usually have an interest in providing health programs to their members, they are often unable to deliver such programs because they do not have the necessary skills and experience. However, given proper training and guidance, cooperatives can perform their stewardship role through education on FP-MCH, broadening access to family planning programs through referrals to service delivery networks, and expand provision of FP-MCH services through cooperative-initiated activities in the community.

Recognizing that cooperatives are viable partners for health, even more so now because of Memorandum Circular 2013-16 and the challenges associated with the capacity of IWGs, the USAID Private Sector Mobilization for Family Health-Phase 2 (PRISM2) project developed a program that can be used as a support mechanism to ensure that cooperatives are addressing the social needs of its members and the community in which they operate. The program involves developing public-private partnerships to facilitate the roll-out of a unique behavior change strategy, the *Usapan* Series. (Refer to the technical document on “*Usapan* as a Behavior Change Communication Strategy to Improve Utilization of FP-MCH Products and Services in the Private Sector” for more information on the strategy.)

### Public-Private Partnership for Health

The Department of Health Regional Offices (DOH-ROs), Provincial Health Offices (PHOs) and City Health Offices (CHOs) will welcome the partnership with CDA as it will expand their reach to include those in organized private sector organizations, such as cooperatives, which their traditional partners may not be able to access. By partnering with the municipal, city or provincial health offices, local agency of the CDA receive support for the implementation of CDA Memorandum Circular 2013-16. Engaged providers (both public and private) will benefit from the partnership as it will enable them to reach more potential clients. As such, this is a win-win solution for all partners.

At the highest level, the partnership between local chapters of the CDA and networks of service providers can be formalized through a memorandum of understanding. These service provider networks could be purely public (through the Municipal Health Offices (MHOs), CHOs or PHOs) or may include the private sector (through local chapters of professional organizations such as the Integrated Midwives Association of the Philippines or IMAP). Through this partnership, the CDA Extension Office will endorse to cooperatives the adoption of the *Usapan* Series as a strategy to address health programs required by the social audit program, and provide the MHO with an updated directory of cooperatives in good standing.

Likewise, the MHO should endorse the program to their staff, particularly those trained in the implementation of *Usapan* and family planning-competency-based training level I (FP-CBT I), and the professional organizations will endorse the program to their members.

The second level of partnership is between the cooperatives and service providers for the implementation of the program. These service providers could be private practicing midwives (for cooperatives with capacity to pay; (2) cooperatives and the rural health unit as its service providers in cases when there are no available private birthing clinics or if the cooperative is not yet willing to pay for private services; or (3) cooperatives and a pharmaceutical company who will provide for the FP-MCH commodities as part of the livelihood program of the cooperative. Other types of partnerships can be arranged later based on the need of the cooperative members as they implement the program.

## Preparation

As part of the orientation process, the CDA will integrate the *Usapan Series Overview* during their social audit orientations or other activities with member cooperatives (refer to “Introduction to *Usapan*: Trainer’s Guide - Session I: Orientation on the *Usapan Series*”). During these orientations, the CDA may invite other cooperatives with on-going FP-MCH programs using the *Usapan Series* to present the overview, or the MHO may do the overview.

As a follow-up to the orientation session, a mini-workshop should be conducted to organize the core teams in each cooperative that is interested in conducting the *Usapan series* (refer to Annex 2 for a sample activity design). The core team is tasked to oversee the implementation of the FP-MCH program of the cooperative. Each cooperative will have its own structure depending on the number of branches or operational sites. At a minimum, there should be at least three core team members, with one member assigned to facilitate each of the major functions of the team. These major functions include: (1) event organizer; (2) host and co-facilitator; and, (3) document processor (refer to Annex 3 for the roles and qualification of these core team members).

This workshop will also help a) determine how the cooperative will be structured to support the FP-MCH program, b) organize upcoming activities, and, c) suggest linkages with the health service providers. For cooperatives with health service providers, such linkages may not be required, but for the majority of cooperatives, linkages with service providers serve as a core facilitator in the roll-out of the FP-MCH program through *Usapan*. Formal arrangements should be made between the cooperative and either the private practicing midwives (for cooperatives with capacity to pay) or rural health units (for cooperatives that are initially unwilling to pay or when there are no private midwives in the areas). To assist in developing these linkages, the CDA, MHO and IMAP or other provider organization should provide information regarding PhilHealth-accredited public and private practicing midwives (PPMs) and interested cooperatives, which would then be disseminated to their members and staff.

The core team members, together with health service providers, will develop a simple plan (see Annex 4 for the IWG planning worksheet) to execute the FP-MCH program and demand generation activities. A copy of this plan shall be submitted to the PHO/CHO/MHO and the CDA to let them know which cooperatives in their areas are interested in joining the FP-MCH program and what support can be facilitated through the *barangay* health stations or partner PPMs.

## Capacity building

The primary role of the core team is to create demand for and increase access to and utilization of FP-MCH services and products among members of participating cooperatives and their communities. The main strategy for demand generation is the *Usapan Series*, a communication tool for FP-MCH information-providers developed by the PRISM2 project. *Usapan* is easy to use, even for those with no medical background, and includes the following modules: (1) *Usapang Pwede Pa* (for spacers); (2) *Usapang Buntis* (for pregnant women and their spouses); (3) *Usapang Kuntento Na* (for limiters); and (4) *Usapang Bagong Maginoo* (for male involvement).

MHO staff and other *Usapan*-trained facilitators may be asked to provide the four-day ***Usapan training for facilitators***. Should the core team not be interested in becoming *Usapan* facilitators, they should still familiarize themselves with the entire *Usapan* process to be effective in their role in the core team.

For cooperatives with health service providers, their medical team should undergo ***FP-CBT I training***, a course on contraceptive technology and counselling. Only trained family planning counsellors should counsel potential family planning clients. The CDA can, on behalf of the cooperatives, request this training from the PHO/CHO/MHO. Private organizations, such as IMAP or Conrado and Ladislawa Foundation, Inc. (CLAFI) can also help to facilitate the FP-CBT I training.

## Demand-generation

The core team member assigned as event organizer will regularly schedule demand generation activities. These activities may take the form of health events or conducting *Usapan* and can either be integrated into the regular meetings of the cooperatives or done as a stand-alone activity, but should not last longer than two hours. The *Usapan Series* strictly adheres to the following protocols: Secure the *Usapan Series* job aids from the PHO/CHO/MHO like the family planning tarpaulin flipchart, flyers, action cards.

- Secure the *Usapan Series* job aids from the PHO/CHO/MHO like the family planning tarpaulin flipchart, flyers, action cards.
- Reproduce the *Usapan Action Cards*.
- Invite 10-15 IWG members per *Usapan* based on their specific health needs—for limiters (*Usapang Kuntento Na*), for spacers (*Usapang Pwede Pa*), and for pregnant women (*Usapang Buntis*). It is important to maintain this number since this is considered group counselling. For health events, however, there is no limit to the number of participants.
- Arrange the schedule in advance with the *Usapan*-trained facilitators, i.e., private/public health providers. All *Usapan* rollout trainings should be conducted with the presence of service health providers.
- Make sure that FP-MCH products are available at every *Usapan* venue so the clients can request the products after counselling. You may invite pharmaceutical companies carrying FP-MCH commodities to display their products.
- Ensure that there is enough room for privacy to do one-on-one counselling after the *Usapan* session.
- Record the attendance and counselling sessions using the *Usapan Attendance Sheet* and *Usapan Session Recording Form* and, if needed, the Referral Form (two copies).
- The core team will follow-up the clients' needs based on their action cards.

- The document processor will validate and update the masterlist of clients and update the referral logbook. Ensure that the partner service provider includes the output of the cooperatives in their Field Health Services Information System (FHSIS) report.

## Making supplies available

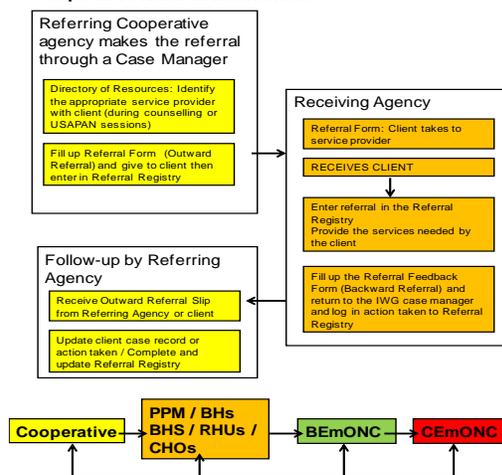
When the cooperatives are interested in providing continuing supplies of FP-MCH products to their members, the CDA can link the cooperatives with partner pharmaceutical companies and other suppliers such as the *Botika ng Bayan*, HealthPlus and J-Health Marketing. Making arrangements with these institutions facilitates turning the cooperatives into alternative distribution points, making supplies and commodities more accessible, available and affordable to their members and the communities where they operate.

## Integration into the Referral System and Private Public Partnership Network

The referral mechanism is crucial to ensure delivery of the clients' desired services. Below is the suggested referral mechanism for the FP-MCH program of cooperatives:

Figure 1

### Cooperative Referral Mechanism



\* PPM – Private Practicing Midwife; BHs – Birthing Homes; BHS – Barangay Health Station; RHUs – Rural Health Units; CHOs – City Health Offices; BEmONC – Basic Emergency Obstetric and Newborn Care; CEmONC - Comprehensive Emergency Obstetric and Newborn Care

Once the cooperative's FP-MCH program is considered functional and they have maintained a partnership agreement with a health service provider who submits their report to the barangay health station or MHO, the MHO should recommend formal recognition of the cooperative as a part of the public-private partnership through a memorandum issued by the mayor. (See Annex 5 for a sample memorandum.) This will formally link the cooperatives to the local service delivery network. Once formally recognized, the PHO/CHO/MHO and local government unit will provide continuing technical supervision, support and assistance to these cooperatives, and the cooperatives will be contributing to the local government unit's public health goals.

## **Sustainability**

The CDA through its Memorandum Circular 2013-16 helps pave the way for cooperatives to move towards providing health programs to its members and their communities, including an FP-MCH program. Furthermore, the cooperatives can mainstream the information and education program on FP-MCH as part of the regular membership welfare (medical health service) program. The strong partnership developed between the private and public health providers who will regularly conduct *Usapan* among new members of the organization and cooperatives will further ensure sustainability of the FP-MCH program. It is also highly recommended that the status of the FP-MCH program be discussed during the monthly CDA meetings and general assemblies to continuously advocate for the implementation of their health programs and PhilHealth.

## Examples of PRISM2 Experiences

**Negros Occidental:** The Malaga Cuenca Agrarian Reform Beneficiaries Multi- Purpose Cooperative, with approximately 200 households from Hacienda Malaga in Negros Occidental, realized the importance of PhilHealth insurance for its members, particularly those of childbearing age. They therefore partnered with the local office of PhilHealth to facilitating an orientation for their members. Following the orientation sessions, a total of 117 previously non-PhilHealth members were enrolled allowing them to receive affordable services from the Family Planning Organization of the Philippines midwife birthing clinic near the hacienda.

**Central Visayas:** The IMAP Cebu Midwife Clinics, Inc. has made arrangements with various cooperatives all over Cebu to deploy the member-midwife nearest the cooperative to provide FP-MCH services and run *Usapan* sessions as scheduled by the cooperatives. They have even organized an “*Usapan* Mobile Team” that can conduct *Usapan* sessions upon request, anywhere in Cebu, as long as there are potential new acceptors able to attend the session. A similar arrangement has been established in Bohol, through the support of the IMAP-Bohol chapter. The IMAP members trained on *Usapan* and FP-CBT I have each been assigned a cooperative that is interested in running a health program using the *Usapan* series. With the proper endorsement from the CDA officer during the IWG Orientation, IMAP offers their services to cooperatives in good standing. As a result of the active collaboration between IMAP and CDA, one of the cooperatives, Panabo Multi-Purpose Cooperative in Panglao, has even started to operate its own birthing clinic as one of its business ventures. The birthing clinic is being managed and supervised by IMAP-Bohol.

**Davao del Norte:** The cooperative cluster in Samal City receives support from a local PPM who manages two birthing clinics on the island. The PPM supports the cooperatives by conducting the *Usapan* sessions, providing FP-MCH services and managing the supply of FP-MCH products.

**Cebu:** The Cordova Multi-Purpose Cooperative has a core FP-MCH team composed of a nurse and two former human resources supervisors and members of the board. In the process of conducting regular *Usapan* series, the cooperative has been able to generate new members from the community where they conduct *Usapan*. Community members were impressed with the way the cooperative reached out to the community, saying that they felt the sincerity of the cooperative to help and they now understand the advantages of being a cooperative member. The cooperative’s general manager was very happy with the increasing membership as a result of the conduct of *Usapan*, and the core team receives the full support of top management and is encouraged to reach out to neighboring towns and underserved communities.

# Annexes

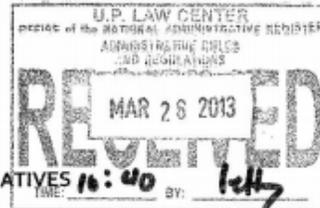
## Annex I: CDA Memorandum Circular No. 2013-16



March 1, 2013

MEMORANDUM CIRCULAR NO. 2013-16  
Series of 2013

SUBJECT: GUIDELINES ON SOCIAL AUDIT OF COOPERATIVES



Pursuant to the pertinent provisions of Article 80, Chapter IX and Article 53, Chapter V of RA 9520 and Rule 11 of its Implementing Rules and Regulations, the following guidelines is hereby issued.

### Section 1. Legal Bases

The legal bases for this guidelines are as follows:

*"Art.80. Annual Audit. – Cooperatives registered under this Code shall be subject to an annual financial, performance and social audit."*

*"The social audit shall be conducted by an independent social auditor accredited by the Authority."*

*"The Authority, in consultation with the cooperative sector, shall promulgate the rules and standards for the social audit of cooperatives."*

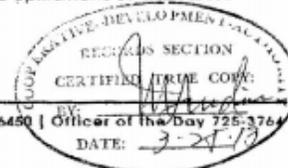
*"Art. 53. Reports. (1) Every cooperative shall draw up regular reports of its program of activities, including those in pursuance of their socio-civic undertakings, showing their progress and achievements at the end of every fiscal year."*

### Section 2. Coverage

All registered cooperatives regardless of types and categories shall be subject to social audit and shall submit the Social Audit Report.

### Section 3. Social Audit

It is a procedure where the cooperative assesses its social impact and ethical performance vis-à-vis its stated mission, vision, goals and code of social responsibility. It is a process to assess the cooperative's contribution for the upliftment of the status



not only to its members' economic needs but also social needs and the community where it operates. The cooperative's actual performance and accomplishment are compared to its vision, goals, and social responsibility as it relates to the impact not only to the community but to its regular members as the immediate beneficiary of the decisions and actions it promulgated, passed and implemented. Social Audit will serve as control mechanism to account for its social performance and evaluate its impact in the community taking into account the community development fund which shall be used for projects or activities that will benefit the community where the cooperative operates.

#### **Section 4. Objectives/Uses of Social Audit**

Social Audit validates the support of the cooperative to the seventh cooperative principles on the "Concern for Community" and determines whether the cooperative work for the community's sustainable development through policies approved by their members.

The audit focuses not only to the economic side of the cooperative but also the social aspect of the organization and appraises the cooperative performance as value based organization usually participative, user and community oriented and non-profit but service organization and how its social responsibility for its members and the community as a whole was fulfilled.

Social Auditing is the systematic review of the attitudes, values, behavior, and degree of interaction of people within the cooperative as well as the policies, programs and activities being implemented by the cooperative.

#### **Section 5. Social Audit Report**

The attached Social Audit Tool which was approved by the Board of Administrators per Resolution No. 58 – 5-2013, shall be used by the cooperatives as basis in reporting its annual socio-civic undertakings to be submitted to the Authority yearly. The Report shall be typewritten or printed in a form prescribed by the Authority. The Chairperson and the General Manager shall certify to the truthfulness of the statement contained in the report while the Chairperson shall finally approve the same.

#### **Section 7. Preparation and Submission of the Required Report**

The Social Audit Report shall be submitted by the cooperative to the CDA not later than 120 days from the end of each Calendar Year. Failure to file the report on time shall subject the accountable officers to a fine/penalty of one hundred pesos (Php 100.00)

per day of delay pursuant to Rule 8, Section 7 of the Implementing Rules and Regulations of Republic Act 9520.

The cooperative who failed to submit the report may also be subjected to a procedural process of cancellation or may be demanded to merge or consolidate with another cooperative operating in the same area of operation.

**Section 8. Transitory Provision**

The Social Audit Report shall be conducted by an Independent Social Auditor accredited by the Authority. In the initial year of submission of the Social Audit Report, the cooperative's Internal Auditor or Audit Committee shall conduct the Social Audit and shall prepare the report thereof. Thereafter, it shall be audited by an Accredited Cooperative Social Auditor.

**Section 9. Effectivity**

This Circular shall take effect fifteen (15) days after publication with the Office of the National Administrative Registry (ONAR).

  
EMMANUEL M. SANTIAGUEL, Ph.D.  
Chairperson

## Annex 2: Sample Activity Design for a Mini-workshop to Organize the Core Teams

### IWG FP-MCH Program Planning

Duration: 1 Day

Target Participants: IWG core team (3-5 participants per IWG depending on membership)

At the end of the session, participants are expected to:

Objectives:

1. Appreciate the PRISM 2 project, goals and benefits
2. Appreciate their role as IWG in contributing to the attainment of the country's FP-MCH program
3. Gain knowledge on key concepts on FP-MCH program and Informed Choice and Volunteerism
4. Craft/design an FP-MCH program for their organization

Expected Output:

1. Finalized IWG core team structure
2. IWGs oriented on ICV and FP-MCH services/program
3. IWG FP-MCH program plan formulated

Session Flow

Time	Activities	Methodology	Materials Needed	Person Responsible
8:30-9:00	Registration		Attendance sheet/IDs/ Pentel pens	
9:00- 10:30	<ul style="list-style-type: none"> <li>• Preliminaries (introductions, expectation setting)</li> <li>• PRISM 2 Project Orientation</li> <li>• Role Clarification</li> </ul>	Lecture/ Discussion  Workshop	Powerpoint presentation  Manila paper	
10:30-12:00	<ul style="list-style-type: none"> <li>• Context Setting IWG profile, structure, services vs. PRISM2 project technical assistance package</li> <li>• Informed Choice and Voluntarism</li> </ul>	Workshop  Lecture	paper  PPT presentation	
1:00- 2:00	<ul style="list-style-type: none"> <li>• FP-MCH Services</li> </ul>	Lecture	PPT presentation	
2:00-2:30	<ul style="list-style-type: none"> <li>• Information and Provision of FP-MCH counselling, services</li> </ul>	Lecture	PPT presentation	

	and products, and recording and reporting (IP/RR)			
2:30-3:30	<ul style="list-style-type: none"> <li>Action Planning of IWGs</li> </ul>	Workshop	Planning Sheet	
3:30-4:30	<ul style="list-style-type: none"> <li>Plenary Session (presentation of Action Plans of selected IWGs)</li> </ul>			
4:30-5:30	<ul style="list-style-type: none"> <li>Closing/Signing of Letter of Commitment of IWGs</li> </ul>			

## **Annex 3: Roles and Qualifications of IWG Core Team Members**

### **Roles**

#### ***Event organizer***

- Schedule the *Usapan* sessions through regular (at least a monthly) meeting with the partner service provider from the private or public sector;
- Ensure that the specific target groups attend the *Usapan* session;
- Ensure that the flipcharts, information materials and venue are available and that there are enough FP-MCH supplies available for sale or for free for potential users.

#### ***Host and Co-facilitator***

- Prepare the ice-breaker or energizer and makes the participants at ease during the *Usapan* Session;
- Ensure that the participants will have time for individual counselling after the discussions;

Ensures that the attendance sheet, *Usapan* forms and referral forms (Annex 6) are properly completed (Refer to the *Usapan* Trainer's Guide) **Document Processor**

- Meets with the partner midwives once a month to validate if there were effective referrals made;
- Maintains and updates the master-list of clients and the referral logbook;
- Follows-up interested clients for final acceptance or decisions and schedules;
- Prepares updated reports for management on the status of the FP-MCH program.

### **Qualifications**

The core team members should have the following qualifications:

- Member of any of the following: (a) education or health committee; (b) *barangay* health worker; (c) academe or health professional; or (d) cluster officers.
- Committed to devote time to organize and conduct a demand generation activity at least once a month.
- Demonstrates leadership qualities.
- Have experience in public speaking.
- With good communication and interpersonal skills.

The core team members should also demonstrate the following characteristics:

- Approachable and pleasant
- Non-judgmental
- Credible
- Caring

## Annex 4: IWG Planning Worksheet

### PRISM2 IWG PLANNING WORKSHEET/page 1

#### FP-MCH PROGRAM

Name of Organization: \_\_\_\_\_

Duration: \_\_\_\_\_

#### A. STRUCTURE ( *identify the persons responsible*)

1. Core Team:

2. *Usapan Training Facilitators: (if different from the core team)*

#### B. PROGRAM COVERAGE

1. Area of coverage (*Where will the program be implemented?*)

2. Beneficiaries (*Who will be the beneficiaries of the program?*)

#### C. SERVICE PROVISION FORM (IWG to decide which service provision from will they employ)

1. **I-P-R-R** ( Information and provision of FP-MCH counselling, services and products (as applicable), record and report)

**PRISM2 IWG PLANNING WORKSHEET/page 2**

I. Choose which FP-MCH services and products will be offered:

<b>FP services and products</b>		<b>MCH services and Products</b>	
Pills			
Condoms			
Injectables			
Fertility Awareness-based Methods - SDM			
NSV ( non scalpel vasectomy)			
BTL (Bilateral Tubal Ligation)			

2. **I – R – R –R** ( *Information, counselling and referral (of clients/patients to referral partners), record and report*)

List of potential referral agencies/Contact Person:

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## Annex 5: Sample Memorandum Recognizing the Cooperatives as Part of a Public Private Partnership

WAO Rural Health Unit  
Wao, Lanao del Sur

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July 3, 2014

### WAO RHU MEMORANDUM

No. 2014 –

**FOR:** DOH-Retained Hospitals, Provincial/City/Municipal Health Offices, MNCHN Service Delivery Networks, Barangay Health Offices, and other Partners Involved in Maternal, Neonatal, Child Health and Nutrition (MNCHN) Services

**FROM:**

  
**Dra. Emelyn L. Alvarez**  
Municipal Health Officer

**SUBJECT: Recognizing and Formalizing the Participation of Private Sector Organizations in the Effective and Comprehensive Delivery of (MNCHN) Information, Products and Services in the Rural Health Unit – Wao, Lanao del Sur**

### I. INTRODUCTION

For several decades now, private-sector organizations, more popularly known in the Philippines as Civil Society Organizations (CSOs) or Nongovernment Organizations (NGOs), have been contributing in shaping the country's socioeconomic policies and practices towards a more inclusive realization of the people's aspirations of peace, wellbeing, prosperity and progress.

Rooted in the Filipino principles of *Bayanihan* and *Pakikipagkapwa-tao*, these private sector organizations (PSOs) consist of a broad array of nongovernmental and not-for-profit organizations, such as barangay-level groups, labor/trade unions, primary cooperatives, indigenous groups, charitable organizations, faithbased organizations, youth organizations, transport groups, professional associations, local chambers of commerce, academic organizations, and foundations. Through an assortment of methods, like policy advocacy, information and mobilization as well as project implementation, these PSOs promote and protect the interests and ideals of their members and other similarly placed individuals, based on ethical, cultural, political, scientific, religious or humanitarian considerations.

In the healthcare sector, the role of the PSOs for improving and widening access to health services and information has long been recognized. Of note, PSOs play a significant part in strengthening primary and community-based health care services particularly among marginalized individuals and households and especially at a time marked by a shortage of trained health workers, increasing health inequalities, and a change in the nature of health concerns due to factors such as urbanization, migration, globalization, and climate change.

In a decisive solution to improve Maternal and Infant Mortality Rates in the country, the Aquino Administration has been implementing since 2010, a novel and comprehensive FP-MNCHN strategy. A vital component of this strategy is the mobilization and collective deployment of health facilities, providers and practitioners from the public and private sectors. Crucial, too, to implementation is the formal integration and involvement of PSOs to assist in bringing about much needed vitality and energy to FB-MNCHN networks and partnerships as well as sustaining future efforts. As preliminary studies indicate encouraging results from implementing this public-private FP-MNCHN strategy, the vital augmentative role of PSOs in hastening and sustaining the delivery of quality FP-MNCHN services throughout the country is all the more highlighted

## II. GENERAL GUIDELINES

The significant role that PSOs play in the overall delivery of healthcare information and services in *Wao, Lanao del Sur* is hereby affirmed and acknowledged. In particular, they are recognized as key partners of the various Health Service Delivery in the *Wao, Lanao del sur* jointly working towards the effective and comprehensive delivery of FP-MNCHN information, product and services in the area.

The list of these PSOs is found in Annex A of this memorandum.

The exceptional and historical positions, functions, and responsibilities of these PSOs as community-based workers and advocates committed to dialogue and mutual learning, to working and learning together, and to achieving maximum benefit, make them worthy partners and companions in ensuring that no more shall die in the process of giving life.

Therefore, in conformity with the FP-MNCHN goals and plans of their localities, all concerned are hereby enjoined to collaboratively design, initiate and implement appropriate mechanisms and procedures to ensure the effective and sustainable recognition and integration of the PSOs into present as well as future FP-MNCHN implementation structures, plans and actions.

This memorandum is consistent with the salient provisions of the following laws and policies:

1. RA 10354, otherwise known as the Responsible Parenthood and Reproductive Health Act of 2012
2. DOH Memorandum Circular No. 2103-0011, Implementing Rules and Regulations of Republic Act No. 10354 (The Responsible Parenthood and Reproductive Health Act of 2012), March 21, 2013

3. DOH National Objectives for Health: 2011-2016.
4. DOH AO No. 2010-0036 The Aquino Health Agenda: Achieving Universal Health Care for All Filipinos
5. DOH AO 2008-0029 entitled Implementing Health Reforms for the Rapid Reduction of Maternal and Neonatal Mortality

### **III. ROLES AND RESPONSIBILITIES**

The following entities will be playing key roles in this initiative:

#### **A. The *Wao* Government including its health-related instrumentalities, together with Barangay government units within its jurisdiction:**

1. Take the lead in identifying the priority population groups and areas within the *Wao*, Lanao del Sur for FP/MNCHN interventions;
2. Take the lead in the development of the *Wao, Lanao del Sur* MNCHN strategy and the corresponding the Annual Operational Plan (AOP);
3. Take the lead in establishing a coordination mechanism among and between health facilities and providers, including the PSOs, under the leadership of the *Wao* Rural Health Unit, towards the effective and comprehensive implementation of the FP-MNCHN plans and strategies in the locality; and
4. Take the lead in the enactment of supportive polices for FP/MNCHN.

#### **B. The Private Sector Organizations:**

1. Take the lead in harnessing the PSOs' moral support and material contribution in implementing the FP-MNCHN plans and strategy for the *Wao, Lanao del Sur*;
2. Take an active role in the expansion and or replication of this type of partnerships to other priority populations and areas within the province *Wao, Lanao del Sur*;
3. Harness the involvement of PSOs in the organization and delivery of outreach services to remote population groups and/or areas;
4. Take the leadership role in providing inputs and oversight to mission-critical provision of services to young people; observance of gender-sensitive approaches; and compliance to quality-assurance standards.

#### **C. DOH Regional Office ARMM**

1. Provide policy direction, supervision, guidance and technical assistance to all concerned to ensure the successful implementation of this initiative; and

2. Act as the main steward for increasing collaboration and cooperation between the public and private sectors involved in the delivery of services for the priority population groups and areas, in a way that is also beneficial to all parties.

#### **IV. EFFECTIVITY**

This memorandum shall take effect immediately.

## Annex 6: Sample Referral Form

### RETURN REFERRAL FORM

1. Time and Date Received: \_\_\_\_\_

2. Name of Patient: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Contact No.: \_\_\_\_\_

Address: \_\_\_\_\_

3. Evaluation/Diagnosis:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Management:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Name of Facility: \_\_\_\_\_

\_\_\_\_\_  
Receiving Health Provider  
Signature over Printed Name

\_\_\_\_\_  
Patient's Signature over Printed Name

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Date of USAPAN Series: \_\_\_\_\_

Title of USAPAN Series: \_\_\_\_\_

Name of IWG : \_\_\_\_\_

Address: \_\_\_\_\_