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Private Sector-Strengthened
Service Delivery Networks for
Family Planning-Maternal and Child Health:
An Approach to Reducing Maternal and Newborn
Deaths



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Table of Contents

Acronyms.....	ii
Introduction	1
PRISM2 Technical Initiatives and the SDNs.....	4
Guidelines for Establishing SDNs.....	6
PRISM2 Experiences in Establishing SDNs.....	10
Guidelines for Sustaining the SDNs	11
PRISM2 Experiences in Sustaining SDNs	16
Lessons Learned.....	17
Annexes	18
Annex A: Sample Technical Advisory.....	19
Annex B: Assessment of Facilities for MNCHN Core Package of Services for SDN Categorization	21
Annex C: Advocacy Briefer for Private Hospitals.....	26
Annex D: Powerpoint Presentation on MNCHN Core Services and SDN	29
Annex E: Prototype SDN Agreements	32
Annex F: Sample Executive Order Designating the LGU’s SDN	45
Annex G: Developing the SDN’s local MNCHN referral system.....	52
Annex H: SDN Management Team SOW/TOR.....	55
Annex I: Sample Self-Assessment Guide Questions:.....	58

Acronyms

AO	Administrative Order
BEmONC	Basic Emergency Obstetric and Newborn Care
BTL	Bilateral Tubal Ligation
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHT	Community Health Team
CQI	Continuing Quality Education
DOH	Department of Health
DOH-RO	Department of Health – Regional Office
FHSIS	Field Health Service Information System
FP-MCH	Family Planning, Maternal and Child Health
IUD	Intrauterine Device
LGU	Local Government Unit
LMRS	Local MNCHN Referral System
MDG	Millennium Development Goal
MNCHN	Maternal, Neonatal and Child Health and Nutrition
MOp	Manual of Operations
NSV	No-Scalpel Vasectomy
NHIP	National Health Insurance Program
PPP	Public-Private Partnership
PRISM2	Private Sector Mobilization for Family Health-Phase 2
RHU	Rural Health Unit
SDN	Service Delivery Network
TWG	Technical Working Group

Introduction

From 2009 to 2014, the Private Sector Mobilization for Family Health Phase 2 (PRISM2) Project implemented activities that ultimately led to the establishment of private sector-strengthened service delivery networks (SDNs) of family planning and maternal and child health (FP-MCH) information, products and service providers and facilities in its 36 project sites. As the PRISM2 project closes, it is envisioned that development partners should be able to utilize the established SDNs as vehicles for ongoing implementation of public private partnerships (PPPs) in FP-MCH. For the purpose of this document, SDNs are categorized as those composed mostly of public sector facilities and providers, while “strengthened SDNs” are those strengthened by the private sector facilities and providers.

There is likewise similar benefit from working with the established SDN management teams. There is no need to form new technical working groups or committees or the like, although existing teams should be continually strengthened or empowered to ensure continuing quality improvement in FP-MCH information, products and services provision. These teams must be actively involved in addressing the various technical issues and concerns affecting the provision of quality FP-MCH in the localities.

This documentation serves as a tool that can be used to replicate PRISM2 experiences in 36 project sites that will scale-up the process of establishing and strengthening SDNs in non-PRISM2 areas using PRISM2 models, processes, tools, templates, champions, etc. With strong relationships established with the different Department of Health Regional Offices (DOH-ROs) over the years, Department of Health (DOH) support can be relied upon in this scaling up of private sector-strengthened SDNs in all local government units (LGUs) in the country.

Background

The infant mortality rate of 23 per 1000 live births that the 2013 Philippine National Demographic and Health Survey reported seems to confirm what has been known for some time now—that the country may be on track to meet Millennium Development Goal (MDG) 4 for infant deaths (from 25 per 1,000 live births in 2008 to 19 in 2015).¹ However, the maternal mortality ratio target of 52 per 100,000 live births for MDG 5 is not likely to be achieved—the country remains a long way off at 162 maternal deaths per 100,000 live births in the 2006 Family Planning Survey.²

Filipinas continue to die from mostly preventable causes primarily due to problems of access to needed maternal care throughout the maternal continuum—from pre-pregnancy to pregnancy to labor to delivery and the post-partum period. Postpartum hemorrhage, preeclampsia and unsafe abortions remain among the top major causes of maternal death that currently result in an estimated 11 mothers dying daily.³ These are preventable problems that can be addressed through access to contraceptives during pre-pregnancy and to basic or comprehensive emergency obstetric care during the rest of the

¹National Demographic and Health Survey

²http://www.who.int/gho/maternal_health/countries/phl.pdf?ua=1

continuum. Inadequate access to contraceptives and delays in access to emergency obstetric care services result in unplanned pregnancies and inadequate management of complicated pregnancies and deliveries.

In 2008, the DOH, in recognition of the urgent need to address maternal and neonatal deaths in the country, issued DOH Administrative Order (AO) No. 2008-0029 entitled “Implementing Health Reforms for the Rapid Reduction of Maternal and Neonatal Mortality”. This AO requires all public and private health stakeholders to take collective action to rapidly decrease maternal and newborn deaths throughout the country. The AO acknowledges that the public sector cannot lower maternal mortality by itself and therefore recognizes the potential significant impact that the private sector can contribute towards this common goal through PPPs. Commonly referred to as the Maternal, Newborn and Child Health and Nutrition (MNCHN) Strategy, the AO was designed to ensure that the country will catch up with its commitment to the MDGs on maternal and child health. It was not until three years later, however, on 27 March 2011, that the final version of the Manual of Operations (MOp) for this AO was issued.

The centerpiece of this strategy is the establishment of functional MNCHN SDNs designed to minimize or eliminate the various delays that result in mothers and newborns dying from complicated pregnancies and deliveries. By definition, the MNCHN SDN refers to a network of facilities and providers offering the MNCHN core package of services in an integrated and coordinated manner. It includes the communication and transportation system supporting this network, and is composed of the following tiers or levels of service providers and facilities:

- community level providers;
- basic emergency obstetric and neonatal care (BEmONC)-capable facilities or network of facilities and providers; and
- comprehensive emergency obstetric and neonatal care (CEmONC)-capable facilities or network of facilities and providers.

These three tiers of public and private facilities and providers operating together as SDN members are required to coordinate, cooperate and work in partnership to address the problems of inadequate access to contraceptives and emergency maternal care thereby eliminating unplanned pregnancies and the delays that often lead to deaths.

Although the private sector was mentioned in the AO, at the time of its conceptualization, the reality was that, usually, government and private health sectors engaged in FP-MCH were working independently of each other without any significant coordination, much less partnership. At the community level, where actual service provision occurs, there was often distrust between the two sectors. Private looks at public as corrupt, of poor quality, being poorly managed and maintained, not accommodating, etc., while the public sector looks at private providers as competitors, money-focused and profit-driven, greedy and somewhat arrogant. There was little coordination as nobody was prepared to make the first move to reach out and establish a relationship. The private was waiting for the public sector to ask for their FP-MCH records of accomplishments, for example, whereas the public was not even interested in getting these reports—indicated by the fact that the private sector was not included in the DOH’s Field Health Services Information System (FHSIS). The private sector did not want to participate in local procurement of contraceptives, for example, because of perceived corruption in the

bidding and procurement processes, for fear of delays in payment, or worse, not being paid at all. Additionally, by way of example, the public sector does not include private health providers in orientations or training courses that would have updated their knowledge and skills in FP-MCH (and thus standardize clinical practices among private and public) perhaps thinking that since private practitioners are moneyed anyway, they do not deserve such updates from government. Another glaring example of such disconnect between public and private providers is the fact that in the past, and even during the early days of the PRISM2 project, public health midwives in rural health units refused to provide immunizations to infants who were delivered at private birthing homes, claiming that since their parents had money to deliver there, they probably do not deserve free vaccines and were advised to go back to these private clinics for immunizations. This was eventually corrected through the project's various PPP initiatives.

This perception and practice of independence instead of interdependence, of competition instead of collaboration and partnership, further denied women of meeting their needs and contributed to the inadequacy of access to contraceptives and emergency care that lead to preventable deaths among mothers. Implementation of the AO, and the engagement of the private sector, therefore required a significant paradigm shift by public and private partners if any significant impact on maternal and neonatal survival was to be made.

Furthermore, the public sector did not see itself as overseers or stewards of the private sector's health efforts, although, to a certain extent, the private sector did look to the government for technical directions and policy guidance. Although the government already implements regulatory oversight through regular licensing and accreditation activities, other than this once a year or less frequent interaction, the private sector did not feel that the government exercised any technical oversight over private practice. The private sector often knew little about the government's FP-MCH programs and had no clue as to how they could contribute. The reality is that the public health sector at national, regional and local government levels had, at the time of the release of the AO, very limited experience in engaging and mobilizing the private sector, particularly in the field of FP-MCH. Technical assistance for capacity building was crucially needed at all levels before AO implementation could be realized: for the public sector, its exercise of stewardship over the private sector; and, for the private sector, its mobilization and eventual engagement as FP-MCH partners in the local SDNs. The PRISM2 project provided this crucial technical assistance to both public and private partners.

PRISM2 Technical Initiatives and the SDNs

The PRISM2 project is a five-year (2009-2014) USAID-funded project mandated to work with government in mobilizing the private sector for greater involvement in FP-MCH information, products and services provision in support of the DOH commitment to attaining the MDGs. Project focus was towards supporting the DOH MNCHN strategy through strengthening SDNs by increasing the number of private sector health providers and facilities that are part of the SDNs nationwide.

While the MOp for the DOH-AO 2008-0029 was being developed, the PRISM2 project had been consulting with public and private stakeholders in FP-MCH in its project areas. These consultations led to the identification of the following nine specific FP-MCH technical improvements needed and for which technical interventions using PPPs can be directed towards:

- A. **Information provision on FP-MCH** that would guide local providers of FP-MCH information to propagate correct, credible, coherent, compelling and relevant FP-MCH messages;
- B. **Contraceptive availability** that would expand access beyond the few currently available traditional outlets for contraceptives;
- C. **Providers' competencies in family planning** to address the limited number of competently trained family planning service providers that serve men and women of reproductive age;
- D. **Providers of long acting and permanent methods of contraception** that would expand the limited sources of quality long acting and permanent methods of contraception (intra-uterine devices or IUDs, bilateral tubal ligation or BTL and no-scalpel vasectomy or NSV);
- E. **Hospital-based FP-MCH services** improving from none or limited family planning services at some hospitals to most hospitals having a wide range of family planning methods available and increasing caseloads of family planning clients;
- F. **Providers' competencies in MCH** that would address the wide variations in scope and quality of maternal care being provided, thus leading to standardization of quality practices;
- G. **Utilization of FP-MCH benefits of the National Health Insurance Program (NHIP)** from very low utilization to more FP-MCH benefits utilized by enrolled members with increasing and faster PhilHealth payments to accredited FP-MCH public and private providers and facilities;
- H. **Professional midwife practice** expanding from limited coverage to increasing numbers of midwives in professional practices in the public and private sectors providing quality FP-MCH services;
- I. **Monitoring and evaluation on FP-MCH** improving local capacities for securing reliable, updated and complete information about current use and future demand for FP-MCH services

Implementation of these technical initiatives for PPPs required capacity building of public and private partners to achieve or implement these key operational directions. Success and sustainability also required local stewardship of the total FP-MCH market that would see regional and local public health authorities taking overall responsibility for managing, sustaining and further improving FP-MCH through a PPP approach. Encouraging local stewardship and building the capacities of public and private partners were prerequisites for the integration of the private sector as official partners in the local SDNs for FP-MCH.

The centerpiece for the PRISM2 project, the value that this project adds to the DOH MNCHN strategy, was to increase in the number of participating private health providers and facilities in the FP-MCH or MNCHN SDN. As DOH itself recognizes, government alone cannot accomplish the huge task of achieving the desired decrease in maternal and newborn deaths. The fact is that there are simply insufficient government resources to meet the FP-MCH needs of the entire country. These include insufficiency in health human resources (health manpower) and health facilities, especially in the rural and hard-to-reach areas, not to mention financial resources, of course.

Mobilizing the private sector health providers and facilities for FP-MCH helps address over-congestion in public hospitals usually overloaded with normal deliveries; increase the number of facilities and providers ready to attend to patients thereby increasing the possibility of eliminating the deadly delays in recognition, referral and reception of complicated pregnancies; increase the facility-based deliveries especially as the campaign for universal PhilHealth coverage assures no out-of-pocket expenses especially for the poor; increase health manpower that will implement the various health programs of government (and without the added burden of salaries and benefits falling on government shoulders); and, among others, provide a more accurate picture of the FP-MCH accomplishments (both public and private health efforts) in the country.

Aside from the benefits to FP-MCH service delivery, mobilizing and engaging private sector likewise benefits the country in terms of capacity/capability-building for FP-MCH. It was estimated by the DOH that, if only DOH will conduct all the training needed to train government workers alone on BEmONC, it would take seven years. This is where the private sector can make a significant contribution since there are a lot of academic institutions nationwide that can be developed and then contracted as trainers to conduct the various training courses for the DOH. Training of private service providers, a neglected need for the past four decades, will likewise be better addressed when private trainers and training institutions are available.

In terms of financial resources, the private sector is known to be the moneyed sector of society. Most private companies have Corporate Social Responsibility funds that could be tapped for FP-MCH service delivery or capacity building. The private sector is also open to various co-financing or other schemes, for as long as they are economically feasible and sustainable. It views most expenses as investments that will, in the long run, turn into profit to sustain their businesses, thus there is more willingness to engage. Most importantly, there is much value for the private sector in having a good public image and social repute, something that is provided by being involved in public health programs that lower the numbers of mothers and children dying.

The private sector-strengthened local SDNs that PRISM2 facilitated establishing are LGU-led, DOH-RO-supported and development partner-assisted networks composed of public and private facilities and providers that provide high quality FP-MCH information, products and services.

As of 2011, however, none of the 36 PRISM2 project sites had any established SDNs. Instead, therefore, of merely strengthening what would have been already established SDNs by integrating more private sector partners whose capabilities have been built through technical assistance, the project took the responsibility of initiating the process of establishing these SDNs. In many areas, this process started with orienting public sector partners on AO 2008-0029 and the MNCHN MOp.

Guidelines for Establishing SDNs

There are many different variations on how SDNs can be established. Generally, however, establishing SDNs involved the following steps, although not necessarily sequential:

A. Provider and Facility Mapping

By definition, the SDN is a network of providers and facilities. It is therefore imperative that these be identified within a given locality or area. In many previous undertakings, the government, through the DOH-ROs and LGUs, has had efforts aimed at making an inventory of, or mapping out, the different public and private health providers that are located in their areas of responsibility. One such effort conducted several years ago was previously called the “rationalization plan” for facilities. One of the first steps, therefore, is for DOH-ROs to review and update these plans or mappings or inventories and determine the list of public and private facilities and providers which may be recommended to form part of the SDN– who they are, what they are capable of providing, where they are located, if they are still functioning and if new providers or facilities have set up practice.

B. Categorizing Potential Providers and Facilities for the SDN

Since the SDN is also defined in terms of the three tiers or levels of care or provision of the MNCHN core service packages, simultaneous with the above step will be matching the providers and facilities identified with these tiers. This will help facilitate the designation of the SDN.

C. DOH-RO Recommendatory Technical Advisory on SDNs

Once the providers and facilities have been categorized into the three MNCHN tiers, the DOH-RO can issue a technical advisory ([Annex A](#)) addressed to the LGUs under its jurisdiction. This advisory will recommend the composition of the MNCHN SDN in the different LGUs, specifically naming the providers and facilities to make up the community level providers, the BEmONC and CEmONC facilities. Being recommendatory in nature, final designation therefore rests with the LGUs under the DOH-RO. The DOH-RO will continue to provide technical assistance to the LGUs for the finalization efforts.

D. LGU Rapid Assessment of Potential Providers and Facilities for the SDN

Upon receipt of the DOH-RO recommendations, the LGU sets out to conduct a rapid assessment of the recommended providers and facilities as a screening or verifying procedure designed to facilitate finalization of SDN designation. Identifying community level providers is quite straight forward, as these are mostly community-based, first-contact health care providers and facilities, such as rural health units (RHUs), *barangay* health stations (BHS), private outpatient clinics (including private, non-NHIP accredited lying-ins or birthing homes) and their health staff, and volunteer health workers (such as *barangay* health workers and traditional birth attendants) that may comprise the community health team (CHT).

BEmONC-capable facilities and providers provide the following six signal obstetric functions: (1) parenteral administration of oxytocin in the third stage of labor; (2) parenteral administration of loading dose of anti-convulsants; (3) parenteral administration of initial dose of antibiotics; (4) performance of assisted deliveries (imminent breech delivery); (5) removal of retained products of

conception; and (6) manual removal of retained placenta. These facilities are also able to provide emergency newborn interventions, which include the minimum: (1) newborn resuscitation; (2) treatment of neonatal sepsis/infection; and (3) oxygen support. It shall also be capable of providing blood transfusion services on top of its standard functions.

PhilHealth Maternity Care Package-accredited lying-in clinics and birthing homes, since they have formal linkages with PhilHealth-accredited obstetricians-gynecologists, pediatricians and hospitals who can attend to deliveries that may become complicated, are included in this tier as part of a BEmONC-network of facilities and providers.

BEmONC-capable facilities may therefore be stand-alone facilities capable of providing all the signal functions (such as hospitals) or may be a network of facilities working together to ensure that all signal functions are provided in a well coordinated manner.

CEMONC-capable facilities or network of facilities can perform the six signal obstetric functions for BEmONC, as well as provide caesarean delivery services, blood banking and transfusion services, and other highly specialized obstetric interventions. They are also capable of providing neonatal emergency interventions, which include, at a minimum: (1) newborn resuscitation; (2) treatment of neonatal sepsis/infection; (3) oxygen support for neonates; (4) management of low birth weight or preterm newborn; and (5) other specialized newborn services. Under this tier are the tertiary care hospitals such as large government medical centers and regional hospitals, as well as private medical centers designated as CEmONC-capable facilities by government.

Since these are well defined expected MCNHN service capabilities and capacities, assessing the presence or absence of these signal functions, together with their accompanying facility or clinic or hospital equipment, instruments and staff, can be done with a simple rapid assessment guide ([Annex B](#)) that LGUs can use to confirm or verify the DOH-RO recommendations for the LGUs' SDNs designations.

E. LGU-led DOH-RO-supported “Operational Decision-Making” meetings

LGUs' final list of potential SDN partners will depend on the rapid assessment conducted by health personnel and other decision makers. These potential partners, however, particularly the private sector, have to be oriented on the MNCHN strategy and the SDN as an initial step before they are able to make a commitment or operational decision on whether to join the SDN or not.

All public and private health providers and facilities in the locality that are assessed to be qualified to be categorized in any of the three tiers of the MNCHN SDN, based on the rapid assessment conducted, may potentially become part of the SDN. However, while public sector providers and facilities are expected by the DOH to automatically be part of the SDN as mandated by the government-issued MNCHN AO, the potential private sector SDN partners will have to make crucial operational decisions on whether to be part of the SDN or not. Since it is voluntary for private providers and facilities to become integral to the SDN, it is important that there should be a meeting to identify expectations and to present the SDN as not just a life-saving, socially responsive, vehicle for achieving MNCHN goals but, primarily for the private sector health providers, as a potentially economically sustainable effort as well. This is not a hard case to make, since with the

universal PhilHealth coverage thrust of the government, even indigents who have no capacity to pay will be a potential source of revenue for the private sector because of the *Kalusugang Pangkalahatan* and the Conditional Cash Transfer program of the government for the poorest of the poor ([Annex C](#)).

While it is the LGU that has the ultimate responsibility to meet with potential SDN partners, the DOH-RO, being the architect of the MNCHN strategy and overall steward for FP-MCH quality of care, information and products provision, likewise has to be sure that the potential public and private providers and facilities are amenable and committed to being named or counted as part of the SDN. DOH-RO therefore provides technical assistance and support to the LGU in providing potential SDN partners with orientation to the SDN, the MNCHN strategy and its MOp, what the expectations are of the SDN members, their privileges or “what’s in it for them”, PhilHealth potential income, possible donations from government, and other information. An example of a presentation covering these topics, developed by the Department of Health, is attached in [Annex D](#).

F. Local Policy Issuance Formalizing Creation of the SDN

Public and private health providers assessed to be qualified to be part of the SDN and who, upon complete understanding of what partnership in the SDN entails, agree to commit themselves to the SDN and MNCHN strategy will then be involved in finalizing a SDN partnership agreement. A series of meetings among the various stakeholders and potential SDN partners, organized by the LGU with DOH-RO support, will discuss a template or prototype public-private partnership SDN agreement ([Annex E](#)). They will discuss, revise, edit and come to agreements on the proposed roles, responsibilities, scope of responsibility, requirements for SDN involvement, expectations, and other details of the SDN partnership as embodied in the prototype document. This series of discussions and consultations will result in a final PPP-SDN Partnership Agreement to which the SDN partners must agree, will sign on and abide by.

As a policy issuance, this may take the form of a simple partnership agreement without any legal formality with just the SDN partners signing. Some LGUs however prefer more legal instruments such as a Memorandum of Agreement or an Executive Order ([Annex F](#)) which are signed by the Local Chief Executives. Others may prefer an LGU resolution. This formal and legal policy instrument issuance is based on the PPP SDN agreement and serves not just to supplement such agreements but to make it officially binding on all parties signing.

Whichever form of legal or other document is used to designate the SDN should be considered a working, dynamic, document, open to changes as the situation on the ground evolves, new agreements are reached, and new potential partners emerge. It is urgent, however, that the partners immediately agree to some common grounds in order to formally establish the SDN so that delays in attending to pregnant mothers will immediately be reduced or removed.

G. Formal SDN Launching

While not required, many SDNs are formally launched through a public event at which the final agreement among PPP and SDN partners is signed. This is a kickoff event organized by the LGU with support from the DOH-RO that publicly officially declares the establishment of the SDN,

announces who the SDN partners are, and promotes these partners as quality FP-MCH information, products and services providers committed to working together to reduce or eliminate preventable maternal and newborn deaths in their locality.

The local chief executive shall be the last signatory to sign the local policy issuance referred to above. All SDN partners shall have signed the document prior to the event. Additionally, a ceremonial signing on a large tarpaulin seals the pledge of commitment among the SDN partners. A directory of the SDN partners should be ready for distribution during this event. This will include information such as the providers' and facilities' contact details, address, clinic hours, services being offered, etc., and are distributed among the SDN members to facilitate their referrals to one another. The directories may be distributed to the participants of the signing event as a form of information dissemination.

H. Developing the SDN's Local MNCHN Referral System (LMRS)

With or without a formal policy issuance or SDN launch, it is important that a SDN is developed into a functional referral network. This means that there is a smoothly-running system wherein, depending on a client's or patient's particular health condition, the SDN partners freely refer and accept these clients or patients to one another, unhindered by unnecessary "red tapes" or misunderstandings usually result in delays to the provision needed emergency care. It implies that SDN partners are all (1) well-trained in recognizing early enough the signs and symptoms of a non-normal pregnancy and its potential complication, (2) well-oriented on the agreed protocols for referring patients to co-partners in the SDN, and, (3) well-prepared to immediately accept patients referred by co-partners providing the appropriate quality care to address the patient's condition. Such a working referral system when consistently implemented by all the SDN partners reduces or totally eliminates the common delays to maternal and newborn emergency care that directly result in maternal and newborn deaths. Establishing and organizing the SDN must ultimately lead to such smoothly working referral relationship that is the essence of the SDN's very being.

Two key activities are needed to formalize the creation of a referral system among the SDN partners. These activities are described more in [Annex G](#). While these activities will formalize the system, focused efforts will be required to ensure implementation of the Local MNCHN Referral System (LMRS). SDN partners will also need to seek to continually improve the quality of the LMRS, and may therefore require regular consultations, coordination and collaboration.

PRISM2 Experiences in Establishing SDNs

As noted, these steps did not necessarily occur sequentially. Since PRISM2 started ahead of the release of the MNCHN MOp, many activities were already being conducted in the context of the project that eventually supported the establishment of the SDN partnerships.

Quezon City: The Quirino Memorial Medical Center (QMMC) initiated an innovative “variant” of the SDN. PRISM2 assisted this tertiary DOH hospital in establishing the QMMC Recognized Partnership (QRP) program to help reduce maternal and neonatal deaths in surrounding communities by ensuring that all pregnant women receive an appropriate package of services, information and products for their continuum of care. QMMC established partnerships with 14 PhilHealth-accredited privately practicing midwives and their respective birthing homes, two public birthing homes and one private hospital all of which are within a seven km. radius of QMMC, limiting referral time to 30 minutes to one hour from partner facilities to QMMC and vice versa. Referrals are not just from lower to higher levels of care but vice versa. This resulted in a referral average rate of 10 to higher and 20 to lower levels of care per month among the partners during the project last four months.

Visayas: Active involvement of DOH-ROs was a significant contributing factor in the facilitation of SDN formation in a number of sites. In the Visayas, for instance, all three DOH-ROs had formed their DOH-RO level PPP technical working groups or focal groups early in the PRISM2 project. Despite this, however, SDN formation actually originated from bottom to top—with the LGUs likewise actively involved in formalizing PPPs among health providers at the local level—such that it was straight forward to formalize SDN formation on paper. In most cases in the Visayas, there was no explicit need for a DOH-RO advisory on SDN formation. The DOH-ROs, nonetheless, had a major and significant contribution to the formation and strengthening of the SDNs by actively assuming their stewardship roles in the implementation of the MNCHN strategy and PPPs for FP-MCH.

Caloocan City: In the National Capital Region, the independent cities were guided by the DOH-RO technical advisory on LGU SDN formation. In Caloocan City, for example, the DOH-RO issued an advisory letter to the local chief executive requesting him to designate the SDN for the city. The letter included a list of potential public and private partners which then served as basis for the executive order designating the SDN that was signed and issued by the city mayor two months later. The SDN management team and subcommittees were then formed within the same month.

Guidelines for Sustaining the SDNs

It is one thing to establish the SDNs and quite another to keep it going.

Once established, the SDN is then managed by a PPP management team (or local PPP body) selected from among the SDN partners and other members of the larger public-private partnership in the area who may not necessarily be FP-MCH providers or facilities but are key program managers or decision-makers. Its composition may vary but usually includes LGU officials, hospital representatives, private providers and facility representatives and other public and private representatives from the different tiers of the SDN. This management team oversees the SDN operations ensuring continuing SDN functionality and quality improvement, including smooth referrals and working relationships among the public and private SDN partners ([Annex H](#)). Wherever appropriate and applicable, this local PPP body – the SDN management team – should be LGU-led, CHD-supported, and development partner-assisted.

The SDN should be viewed as the vehicle for continuing various technical initiatives that will ensure continuing quality improvement (CQI) in the delivery of FP-MCH information, products and services in the LGU. To make this happen, the following steps were instituted:

A. Creation of the SDN management team

Immediately after the launching or signing event, the LGU health official calls for a the SDN meeting in order to agree on assigning a smaller body, if not yet formed, that will be tasked to oversee or manage the SDN. This body will have both public and private partners represented by program managers, information, products and service providers, and other stakeholders. This should ideally be a group of no more than ten, tasked with initiating a systematic CQI process and talking about each technical issue affecting the delivery of FP-MCH information, products and services.

This body is likewise tasked to ensure that all SDN members are satisfied with how the system is working, fulfilled in the performance of their core competencies and roles, and happy in terms of getting what they need out of the partnership. For the public sector, the increase in accomplishments that result from the additional manpower and resources (from the private sector) as well as the additional reports they receive, will contribute to overall LGU and DOH-RO performance and thus keep them happy. For the private sector, the SDN provides a structure through which they can gain revenue while caring for indigents PhilHealth members and gives the added benefit of having a good public image and public demonstration of the performance of its corporate social responsibility. This has proved to be highly valued by the private partners, and keeps them interested, involved and happy to remain as SDN partners.

This body took on several names in the different areas in the course of the PRISM2 project. These names included PPP-MNCHN Technical Working Group (TWG), MNCHN/Contraceptive Self-Reliance (CSR) Task Force, Coordinating Council for Family Health, MNCHN Coordinating and MNCHN SDN Partnership Coordination Committee.

Additionally, some LGUs saw the need for their SDN management teams to have sub-committees to focus on specific technical areas of the MNCHN strategy. These sub-committees report to the SDN management team and oversee their specific area of concern. Examples of these sub-

committees are those for adolescents and youth, recording and reporting, quality assurance, monitoring and evaluation, referral system, etc.

B. SDN sustainability through CQI processes

Once formed, the SDN management team or body, of whatever name, convenes regularly (as determined by the team) in order to address the different technical areas affecting effective delivery of FP-MCH information, products and services in the LGU through the SDN. This regular meeting is a problem-oriented analysis approach that aims to ensure good quality of FP-MCH information, products and services among the SDN partners.

The following illustrates this process:

- I. The team tackles the different technical areas necessary to improve FP-MCH in a locality according to their perceived priority. These can be discussed one or two technical areas at a time depending on the time available to the management team. These technical areas include:
 - a. Referral systems – ensuring effective and efficient systems that ensure all referrals are received, attended to, documented and discharged. This is the top priority of the SDN management team and the entire SDN and should be addressed first and foremost. A smoothly functioning referral system will most likely prevent all the delays leading to preventable maternal and newborn deaths in the area, which is the very reason for the creation of the SDN;
 - b. Recording and reporting systems – ensuring comprehensive data capture that includes accomplishments from both public and private health efforts in providing quality FP-MCH information, products and services;
 - c. Clinical standards – ensuring that all SDN partners, particularly public and private midwives and the hospitals and staff (which are the main service providers in the SDNs), are well-oriented on, updated with, and compliant to, DOH clinical standards in FP-MCH service provision. Under this technical area is the need to ensure an efficient training system that allows public and private providers access to DOH-compliant training opportunities such as the basic family planning competency training, BTL, IUD, BEmONC, BEmONC for midwives, etc.;
 - d. Financing – ensuring that, in addition to PhilHealth, various financing sources and schemes are made available to, and easily accessed by, all SDN partners in order to sustain both public and private practices making them economically sustainable;
 - e. Local access to FP-MCH products – ensuring that there is a continuing supply, with no stock-outs, of these products in the LGU through the SDN partners – both public and private;
 - f. Demand generation – ensuring increasing client and patient utilization of the available FP-MCH information, products and services within and among the different SDN partner providers and facilities. To support this, the project successfully developed and implemented the *Usapan Series*;
 - g. Others – including working with young people and informal workforce groups as special sources of potential clients and patients; compliance with informed choice and voluntarism, environmental compliance, etc.

Since the SDNs are established to ensure smoothly functioning referral system that prevents delays in maternal and newborn emergency care, the technical area of referral systems should be prioritized by the SDN management team. A possible second priority technical area is the aspect of ensuring that the LGU's FHSIS report accurately captures the private sector FP-MCH accomplishments in order to reflect the true, more complete picture of the LGU's accomplishments.

2. Using self-assessment guide questions, members of the SDN management team assess the SDN's good points and as well as the gaps in the specific technical area chosen for SDN management team discussions.

The questions are statements that reflect the ideal situations or events occurring when good quality FP-MCH services, information and products are being provided. All questions answered affirmatively therefore are considered good points, while those answered negatively are points that need improvement for which the management team develops a simple action plan to address the root cause of the negative point.

The SDN management team should take leadership in developing the specific questions relevant to their on-the-ground situation, based on known quality standards. A selection of sample questions for each of the technical areas is presented in [Annex I](#).

3. The points that need improvement – those questions that were answered “no” – (also referred to as the gaps) that were identified through these questions are further discussed through a problem analysis exercise. Such exercise seeks to answer a series of “why?” questions to arrive at a general consensus as to the probable root cause of the gap or points that needs improvement. Generally speaking, the last answer to the last “why?” question may be the root cause of the problem and, as such, it is of utmost importance that this root cause be addressed for a long-lasting resolution of such problem or gap identified.
4. Once root causes are identified, the members of the SDN management team then agree on possible recommendations to specifically address the root causes (the more specific the action to address the specific root cause, the more definitive the solution will be). These recommendations are then assigned to specific persons in the management team who will be responsible for implementing, or facilitating the implementation, of the recommendations. The team then agrees on specific deadlines by when the recommended actions addressing the root causes needs to be carried out. For the good points identified – those questions answered with “yes” – policy or funding support should be identified and documented to further scale up or enhance these points. A simple matrix, such as the one below, may be used to document these recommendations and commitments to action:

ISSUES (Root Causes of Problem/s identified)	RECOMMENDATIONS	BY WHOM (Specific Name)	BY WHEN (Specific Date)

This action plan forms the basis for follow up meetings, to be held after two to three months, to determining the status or progress made on each recommendation.

C. SDN management team continues the CQI approach

Since there are a number of technical areas significantly contributing to the SDN’s good quality FP-MCH information, products and services provision in the community, it is not practical to expect that the management team can tackle all these technical areas at one meeting. During each regular meeting of the SDN management team, the CQI process described above is applied to one or two technical areas at a time.

Thus, with each SDN management meeting, these technical areas may be tackled one issue at a time. Subsequent follow-up meetings, given the agreed time for the recommendations to be carried out on the initial technical areas tackled will determine the status of the recommendations made during the first meeting, specifically noting whether these recommendations were carried out or not, and, if they were effective in addressing the root causes and the gaps identified in the initial meeting.

At the end of this follow-up meeting, another simple action plan will be developed for problems that were not adequately addressed in the initial meeting and for which other recommended actions need to be formulated if the problem still exists. This follow-up action plan of the initial technical area (for example, referral system) will again be the basis for another follow-up meeting to determine the progress or status of the recommended steps in the follow up action plan.

The simple follow-up matrix below may be used for the follow up meeting action plan:

ISSUES (Root Causes of Problem/s identified)	RECOMMENDATIONS	BY WHOM (Specific Name)	BY WHEN (Specific Date)	STATUS

The approach should be repeated every few months until all the different technical areas are assessed, discussed, root causes pinpointed and recommendations developed for which a simple action plan is drawn.

D. SDN management team dissemination to the SDN members

After the management team goes through the CQI process for the technical areas as discussed above, a less frequent meeting of the entire SDN partnership is usually called by the management team. Final and agreed upon action plans to address specific problems in the assessed and discussed technical area are disseminated or shared with the SDN partners during these general sessions of SDN partners for their information and cooperation. Additionally, some SDN partners may contribute other actions that will help address the problems identified.

As the above mechanism shows, regularly coming together as a management team immediately after formation of the SDN to address barriers to quality FP-MCH information, products and service provision in the SDN is key to sustaining its functionality and relevance. Likewise, regularly meeting as an entire assembly of SDN partners, albeit less frequently than the management team meetings, is crucial to ensuring that all partners are provided opportunities to give feedback to the management team and other SDN members. Such meetings are key to having the SDN partners staying actively involved, relevant, connected, informed, fulfilled and happy.

PRISM2 Experiences in Sustaining SDNs

The SDN is a sustainability vehicle for various FP-MCH technical initiatives. Sustaining the SDNs refers to empowering the SDN management teams in order to develop the SDNs as functioning catalysts for CQI of FP-MCH technical areas leading to decreased maternal and newborn deaths. Regular meetings that tackle these different technical areas are essential in ensuring that the SDN sustains its role as guardians of the quality MNCHN information, products and services provision in their localities. By virtue of having regular SDN management team meetings, for the PRISM2 project, the region that had the most experiences in sustaining SDNs is the Visayas. All three DOH-ROs in the region have been actively involved in PPP formation and SDN support from the early days of the project. All project sites in the Visayas have DOH-RO level, LGU-level and local level PPP TWGs that oversee coordination and address their SDNs' FP-MCH issues and concerns. The following are snapshots of the results of private sector strengthening of the SDNs in the region:

Lapu-Lapu City: Quoted from a message to partners by City Health Officer Dr. Rodolfo Berame in September 2012 – *“Forty mobilized private hospitals, birthing homes, private/company clinics, and info and product providers have been engaged by the City Health Office. This group allows the City to establish presence and deploy services to its constituents in 40 new sites. This approximately doubles the number of service delivery sites in the city. Executive order EO 2010-54 issued by Mayor Paz Radaza adopting the PPP approach as a means to expand MNCHN service coverage in the city has helped catalyze and solidify the city’s partnership with the private sector for MNCHN.”*

Bohol: The public-private humanitarian response for FP-MCH has served 190 earthquake-displaced pregnant women from the municipality of Catigbian, Bohol during the period February 2014 to July 2014 through the referral arrangements instituted between the municipality and the Integrated Midwives Association of the Philippines Lying-in Clinics, Inc, with the assistance of PRISM2. This scheme has made possible the release of PhilHealth financing for maternity care to the amount of Php 1,852,500 (US\$41,160) in spite of the complete damage of the municipality’s RHU as a result of the earthquake.

Davao del Norte: After the launching of the SDN, the SDN management team facilitated activities that resulted in the development and dissemination of the health referral system manual. This manual included specifically the MNCHN strategy, MNCHN SDN description and MNCHN service protocols. Different batches of orientations were conducted for the different key stakeholders including LGU officials, *barangay* officials, rural health midwives, PPMs, *barangay* health workers and other agencies such as the police and officials from the department of social work. As a result, there was an improved referral working relationship between and among the partners. A verification of the results in one cluster – the SIKAT cluster with four municipalities – showed that 17 of the 18 facilities were using the standard color-coded referral forms and the referral registry logbooks; 17 facilities had copies of referral manuals, standard color-coded referral forms and referral registry logbooks; and 90-95% of referrals received return referrals to the referring facilities following treatment. Other government agencies, such as the local police and the Department of Social Welfare and Development, were noted to also be using the SDN referral forms.

Lessons Learned

- A. DOH-ROs need technical assistance in helping the LGUs establish their SDNs. The attached sample technical advisory ([Annex A](#)) may be used as a prototype in facilitating the LGU's SDN designation. DOH-ROs can also facilitate finalization of the SDN partnership agreements or Executive Orders or resolutions.
- B. Many private sector health providers are very willing to collaborate with government to contribute to improvements in public health outcomes. More often than not, they were just not aware of how they could be involved. Once informed and, with proper policy support from government and for as long as it is not detrimental to their businesses, most private providers gradually and gladly increased their participation in the health programs including submission of accomplishments and other reports.
- C. Politics is a constant factor – either positive or negative – influencing program implementation, especially at the LGU level. At the DOH-RO level, developing champions or advocates has worked, to some degree, to neutralize the impact of regular changes in DOH-RO leadership. At the LGU level, however, even such advocates or champions are themselves subject to being re-assigned somewhere else, or being moved to a “floating” or “frozen” status or outright removal from office when there are changes in local leadership.

Annexes

Annex A: Sample Technical Advisory



Republic of the Philippines
Department of Health
CENTER FOR HEALTH DEVELOPMENT – METRO MANILA
Acacia Lane, Block 6 Barangay Road, Welfareville Compound
Barangay Addison Hills, Mandaluyong City 1550
website: <http://www.chdmm.doh.gov.ph>

September 30, 2013

**The Honorable
DEL R. DE GUZMAN**
Mayor
MARIKINA CITY

Re: RECOMMENDATION TO DESIGNATE THE FP/MNCHN SERVICE DELIVERY NETWORK (SDN) IN MARIKINA CITY

Dear Mayor,

Under the Aquino Health Agenda for Universal Health Care and related administrative orders and memoranda issued by the Department of Health (DOH), the government is addressing seriously the implementation of the maternal, neonatal, child health and nutrition (MNCHN) strategy to reduce the maternal, neonatal and child mortality and morbidity rates to a level that would help the country achieve its Millennium Development Goals (MDGs).

In order to achieve this in the National Capital Region and in the City of Marikina, the DOH Center for Health Development (CHD NCR) has been pursuing the implementation of the DOH MNCHN Strategy Manual of Operations (MOP) anchored on the following key elements:

1. Identification and assessment of capacities of different health facilities and providers, whether public or private, to determine their classification as to: a) being able to perform the whole range of functions in connection with pregnancy and pregnancy-related complications, also called Comprehensive Emergency Obstetric Care (CEmONC), Level 3, or end-referral unit; b) being able to perform the basic functions in connection with pregnancy and pregnancy-related complications, also called Basic Emergency Obstetric Care (BEmONC), Level 2, or intermediate referral unit; and d) community level facilities (Rural Health Units, Barangay Health Stations, Birthing Homes and local health centers) and providers, or primary level;
2. Crafting of a two-way referral system that binds MNCHN service delivery under an effective and efficient network of health care;
3. Organization of Community Health Teams (CHTs) led by a midwife consisting of independent midwives, concerned barangay officials and health staff, members of Barangay Health Workers (BHWs) and other organizations, women leaders and professionals, and community-based volunteers;
4. Provision and designation of a transportation and communication system to provide immediate response to MNCHN emergencies;

5. Provision of an enabling environment through the formulation of various types of policies such as the establishment of MNCHN programs, encouragement of the practice of mid-wifery and operation of birthing homes and resource mobilization for FP/MNCHN; and
6. Involvement of the private sector through the forging of public-private partnerships for FP and MNCHN.

Through your leadership and the collaboration between our respective offices, we have now laid down the foundation towards the realization of effective, efficient and functioning FP/MNCHN Service Delivery Networks (SDN) weaved together by a strong two-way referral system whose proposed composition in terms of health facilities and providers is listed under **Annex A**.

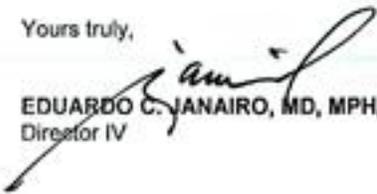
The list that we have prepared has been selected using strict criteria that went through a highly consultative process with different provincial, district and city stakeholders co-led by us and your good office. Under the MNCHN MOP, however, it is the LGU that **officially designates** the MNCHN SDN/s for the following reasons:

1. The SDN-designee, including its component facilities and providers, falls within the territorial and political jurisdiction of the Marikina City and promises to positively impact its governance and public health system;
2. It is envisioned to focus and enhance the provision of services mostly to the province's population, especially women and children, who are poor, marginalized, socially excluded and underserved; and
3. It expects to benefit from the support and resources of the City Government;

In this regard, we are recommending that the FP/MNCH SDN/s be officially recognized and designated through the issuance of an Executive Order from your good office a draft of which is attached for your review and approval, at your most convenient time.

Thank you and kind regards.

Yours truly,


EDUARDO C. JANAIRÓ, MD, MPH, CESO III
Director IV

Annex B: Assessment of Facilities for MNCHN Core Package of Services for SDN Categorization

MNCHN Core Package of Services and the Service Delivery Network

Pre-Pregnancy	Community-Level Provider	BEmONC-capable Facility	CEmON C-Capable
Maternal Nutrition: Micronutrient supplementation such as Iron/folate tabs	X	X	
Oral Health	X	X	
FP Services			
IEC/Counseling on: (i) Responsible Parenting; (ii) Informed Choice and Voluntarism; (iii) Four Pillars on FP; (iv) All FP Methods; (v) Fertility Awareness	X	X	
Provision of FP services			
Pills	X	X	
DMPA	X	X	
IUD	X(BHS/RHU)	X	
Condom	X	X	
NFP	X	X	
NSV	X(If RHU has trained provider for NSV)	X	
BTL(Mini-lap under Local Anesthesia)			X
Deworming or anti-helminthic intake	X	X	
IEC/Counseling on Healthy Lifestyle I): safer sex and prevention of HIV/STIs (i) smoking cessation, (ii) healthy diet and nutrition; and (iii) physical activity; (iv) Adolescent and youth health services including peer and professional counseling and RH education;	X	X	
Information on health caring and seeking behavior	X	X	
Prevention and Management of Other Diseases as indicated			
STI/HIV/AIDS	prevention	X	
Anemia	X	X	
Update master listing of women of reproductive age	X		
Assessment of health risks	X		
Assistance in filling up health need plans	X		
Organize outreach services	X	X(MDs, midwives, nurses as part of outreach or itinerant team)	X(MDs, midwives, nurses as part of outreach or itinerant team)

Pregnancy	Community - Level Provider	BEmONC-capable Facility	CEmONC-Capable Facility
Provision of essential antenatal care services:	X	X	X
Monitoring of height and weight	X	X	X
Taking blood pressure	X	X	X
Maternal Nutrition	X	X	X
Iodine caps	X	X	X
Iron/Folate tabs	X	X	X
Vitamin A for clinically diagnosed with xerophthalmia	X	X	X

Pregnancy	Community - Level Provider	BEmONC-capable Facility	CEmONC-Capable Facility
Deworming: mebendazole or albendazole	X	X	X
Promotion of iodized salt	X	X	X
Early detection and management of danger signs and complications of pregnancy (e.g. prevention and management of early bleeding in pregnancy)	X	X	X
TT Immunization	X	X	X
Ante-natal administration of steroids in preterm labor		X	X
IEC/Counseling on FP methods especially LAM	X	X	X
IEC/Counseling on Healthy Lifestyle: I) safer sex and HIV/STI prevention (ii) smoking cessation; (ii) healthy diet and nutrition; and (iii) physical activity	X	X	X
IEC/Counseling on health caring and seeking behavior	X	X	X
Support Services:	X	X	X
Support from community (e.g., pregnant women)	X		
Antenatal registration with Mother-Child Book	X	X	X
Assist client in filling-up birth plan	X	X	X
Home visit and follow-up	X	X	X
Safe blood supply	advocacy	X	X
Transportation and communication support services	X	X	X
Diagnostic/Screening Tests			
CBC		X	X
Bloodtyping		X	X
Urinalysis		X	X
VDRL or RPR		X	X
HbSAg		X	X
Oral Glucose Challenge test (OGCT)		X	X
Prevention and Management of Other Diseases as indicated:			
STI/HIV/AIDS	prevention	X	X
Anemia	X	X	X

Delivery	Community - Level Provider	BEmONC-capable Facility	CEmONC-Capable Facility
Clean and Safe Delivery		X	X
Monitoring progress of labor using partograph		X	X
Identification of early signs and symptoms and management of abnormalities: prolonged labor; hypertension, mal-presentation; bleeding; pre term labor; and infection	Identification of early signs and symptoms	Management	Management
Controlled delivery of head and active management of third stage of labor		X	X
Basic Emergency Obstetric and newborn care			
Parenteral administration of oxytocin		X	X
Parenteral administration of loading dose of anticonvulsants		X	X
Parenteral administration of initial dose of antibiotics		X	X
Performance of assisted delivery		X	X

Delivery	Community - Level Provider	BEmONC-capable Facility	CEmONC-Capable Facility
Removal of retained products of conception		X	X
Manual removal of retained placenta		X	X
Initial dose parenteral administration of Dexamethasone		X	
Comprehensive Emergency Obstetric Care			
Caesarean section		X	X
Blood transfusion		X(for hospital-based BEmONC)	X
Care of the preterm babies and/or low birth weight babies			X
Counseling and Provision of BTL services		X	X

Post-partum	Community - Level Provider	BEmONC-capable Facility	CEmONC-Capable Facility
Identification of early signs and symptoms of postpartum complications:			
Maternal problems: hemorrhage, infection and hypertension		X	X
Maternal Nutrition Iron/folate Vitamin A Iodine Deworming tablet: Mebendazole or Albendazole Promotion of iodized salt	X	X	X
Family Planning			
IEC/counseling on: (i) birth spacing; (ii) return to fertility; (iii) all FP methods including LAM	X	X	X
Provision of all Modern Family Planning Methods including LAM: pills, condom, DMPA, IUD, LAM, Bilateral Tubal Ligation, No-scalpel Vasectomy	X	X	X
IEC/Counseling on Healthy Lifestyle: I) Safer sex and HIV/STI prevention (i) smoking cessation; (ii) healthy diet and nutrition; and (iii) physical activity	X	X	X
Prevention and Management of Other Diseases as indicated:			
STI/HIV/AIDS	prevention	X	X
Anemia	X	X	X
Prevention and Management of Abortion Complications Removal of retained products of conception Treatment of infection		X	X
Correction of anemia	X	X	X
Anti-tetanus serum (ATS) Injection	X	X	X
Diagnostic and Screening Test	X	X	X

Newborn	Community - Level Provider	BEmONC-capable Facility	CEmONC-Capable Facility
<p>Immediate Newborn Care (the first 90 mins) - (please refer to ENC Clinical Practice Pocket Guide)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dry and provide warmth to the baby <input type="checkbox"/> Do skin to skin contact <input type="checkbox"/> Do delayed or non-immediate cord clamping <input type="checkbox"/> Provide support for initiation of breastfeeding <input type="checkbox"/> Provide additional care for small baby or twin <input type="checkbox"/> Reposition, suction and ventilate (if after 30 secs of thorough drying, newborn is not breathing or is gasping) <input type="checkbox"/> Maintain non-separation of the newborn for early initiation of breastfeeding 		X	X
<p>Essential Newborn Care (from 90 mins to 6 hours)- (please refer to ENC Clinical Practice Pocket Guide)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Vitamin K prophylaxis <input type="checkbox"/> Inject Hepatitis B and BCG vaccinations at birth <input type="checkbox"/> Examine the baby <input type="checkbox"/> Check for birth injuries, malformations, or defects <input type="checkbox"/> Properly timed cord clamping and cutting <input type="checkbox"/> Provide additional care for a small baby or twin 		X	X
<p>Care Prior to Discharge (but after the first 90 mins)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Support unrestricted, per demand breastfeeding, day and Night <input type="checkbox"/> Ensure warmth of the baby <input type="checkbox"/> Washing and bathing (Hygiene) <input type="checkbox"/> Look for danger signs and start resuscitation, if necessary, keep warm, give first 2 doses of IM antibiotics, give oxygen <input type="checkbox"/> Look for signs of jaundice and local infection <input type="checkbox"/> Provide instructions on discharge <input type="checkbox"/> Perform newborn screening (bloodspot) and newborn hearing screening (if available in the facility or known service delivery network) 		X	X
<p>Emergency Newborn Care</p> <ul style="list-style-type: none"> <input type="checkbox"/> Ensure adequate oxygen supply <input type="checkbox"/> Resuscitation and stabilization 		X	X
Treatment of neonatal sepsis/infection		X	X
Intensive newborn care for low birth weight(LBW), preterm, IUGR, babies born with congenital anomalies, and sick neonates		X	X
Kangaroo Care		X	X
BCG Immunization		X	X
Early and Exclusive BF to 6 months	X	X	X
Newborn Screening or referral		X	X
Support Services			
Birth Registration	X	X	X
Follow-up visit and care	X	X	X

Annex C: Advocacy Briefer for Private Hospitals

Private Hospitals Supporting the MNCHN Strategy: Why It Makes Sense... and More Cents!

June 2012

By participating in the Department of Health's Maternal, Newborn and Child Health and Nutrition (MNCHN) Strategy, private hospitals will not only help improve the health of mothers and their children, and therefore, public health outcomes such as Maternal Mortality Ratio and Infant Mortality Rate, but also move forward the respective hospital's mission and goal. This is a practical application of the government's Public-Private Partnerships for Health, i.e., increasing Private Sector Solutions to Public Health Problems.

Making Sense...

Improving health outcomes

The country's health status is best summarized in the progress towards the Millennium Development Goals (MDG). While the Philippines is on target for most of its MDGs, it lags behind in terms of reducing the maternal mortality ratio (MMR). The decline in neonatal mortality has also been very slow, as neonatal deaths comprise the majority of infant deaths. The MMR and infant mortality rate (IMR) were still at 95 to 163 per 100,000 live births in 2010, and 25 per 1,000 live births in 2008 respectively (National Statistics Office, 2008), as against the MDG targets of 52 and 19, respectively.

Maternal deaths account for 14% of deaths among women of reproductive age. More than 10 Filipino women die daily due to pregnancy, and childbirth related complications and unsafe abortion (UNFPA, 2007) and over half (56%) of yearly maternal deaths are unreported. About 17 infants die per 1,000 live births.

Unmet need for contraceptives is 23.15% for poor vs. 13.6% for non-marginalized women. (NDHS 2003). One in four pregnancies is mistimed; one in five is unwanted or unplanned. Only 38% of deliveries is attended to by skilled health care professionals (doctors, nurses and midwives).

To address these alarming conditions, the Aquino administration has embarked on a Universal Health Care (UHC) program which aims to ensure universal access to and utilization of MNCHN Core Package of services and interventions directed to women and newborns at different stages of the life cycle, from womb to tomb. One of the key strategic actions of the UHC is the establishment of local service delivery networks (SDNs) at all levels of care to provide the package of services and interventions. Private hospitals have an important role as part of these SDNs.

Private Hospitals Participating

The local SDNs comprise of a network of public and private providers and facilities that together deliver the whole MNCHN core package at three levels: community providers, facilities with Basic Emergency Obstetric and Newborn Care (BEmONC) and Comprehensive EmONC (CEmONC) services. Hospitals play a key role in the success of the SDN and therefore the entire strategy. Most BEmONC and CEmONC facilities are hospitals which act as hubs of the networks.

Private hospitals may voluntarily, actively participate as either BEmONC or CEmONC facilities in the SDNs. They will be recognized and officially accepted by the local government and the DOH CHDs as partners in the SDN under agreed terms.

The DOH Centers for Health Development (CHDs), with assistance from the USAID project PRISM2, provides technical assistance to private hospitals that are willing and interested to expand their MNCHN capabilities. The program enhances the hospitals' capability to provide specific hospital-based FP-MNCH information, products and services; increases the demand (and therefore clientele base) for such information, products and services from within the hospital premises and from the community; and formally integrates these private hospitals into the DOH/LGU-recognized SDN as official partners.

... and Making More than Mere Cents... of it

Untapped Potential from the NHIP

This program provides an opportunity for private hospitals not only to respond to major public health gaps but also, by virtue of the availability of government funds through the National Health Insurance Program (NHIP), to realize acceptable margins of profit by providing good quality FP-MNCH information, products and services.

Over and beyond fulfilling important gaps in the supply of high-quality FP-MCH information, products and services, private hospitals can benefit financially by getting involved in the MNCHN program. Although the public sector still remains as the major source of FP methods, a substantial percentage of 27.8% of modern method users still go to the private sector.

The NHIP currently provides the following case payments for NHIP members availing of these services performed by NHIP-accredited service providers in NHIP-accredited private hospitals:

CASES	RATES
Newborn Care Package (NCP) in Hospitals and Lying-in Clinics	P 1,750.00
Maternity Care Package (MCP)	P 8,000.00
Normal Spontaneous Delivery (NSD) Package in Level I Hospitals	P 8,000.00
NSD Package in Levels 2 to 4 Hospitals	P 6,500.00
Bilateral tubal ligation using Mini-laparotomy under Local Anaesthesia	P 4,000.00
No-Scalpel Vasectomy	P 4,000.00
IUD insertion	P 300.00

(PHIC Circular No. 0011-2011 and PHIC Circular No. 16 series 2008)

Statistics show that these NHIP benefits for FP-MCH services are largely untapped. By way of example, in 2010, PhilHealth statistics show that out of a potential claim of NHIP benefits for FP-MCH worth PhP 685,986,665.00, the corporation actually paid only P 64,160,221.00 for Region 4A CALABARZON PhilHealth members or a measly 9.35% utilization or payment rate.

For the Private Hospital, Being Part of the Service Delivery Network Means...

- Contributing to saving the lives of women and children from avoidable pregnancy-related deaths
- Becoming a Public-Private Partner for Health
- Access to available government-organized capability-building opportunities: training in Family Planning Competency-Based Training Levels 1 and 2; Bilateral Tubal Ligation using local anaesthesia; No-Scalpel Vasectomy
- Access to available government supplies such as vaccines for which services can be charged
- Access to available government information-education-communication materials on FP and MCH (e-copies and start-up copies)
- Access to government agencies such as the DOH, PhilHealth, DOLE, DILG, DSWD, the LGUs

- Free marketing and promotions for the hospital in the context of the SDN partners
- Link to other possible business partners such as pharmaceutical suppliers of FP-MCH products
- Possible “Seal of Recognition for Exemplar FP-MCH Services” from the Department of Health
- Point of Care Solution software (PCaSo) to facilitate recording and reporting integration into public health accomplishments reports

For the Local Service Delivery Network, Having the Private Hospital as a Partner Means...

- Possible socialized billing or, if management agrees, No-Balance Billing policy for FP-MCH services rendered to PhilHealth-sponsored members (indigent program cardholders)
- Having private hospital partners thus ensuring self-sustainable provision of good quality DOH-recognized FP-MCH services in the local area
- Access to alternative hospital care for PhilHealth members in case of overcrowding at the government hospitals
- A more complete referral system that includes both public and private partners for health

Challenge:

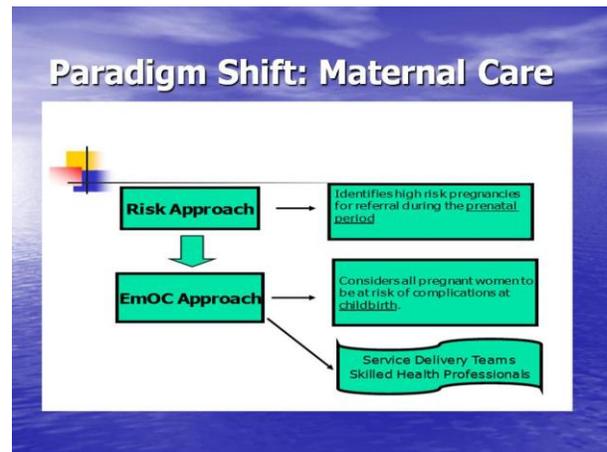
***BE A MNCHN Service Delivery Network PARTNER and
Together with Government
HELP SAVE WOMEN’S AND CHILDREN’S LIVES!***

Annex D: Powerpoint Presentation on MNCHN Core Services and SDN



The MNCHN Core Service Package for the Rapid Reduction of Maternal and Newborn Mortality

Diego C. Danila Jr, MD, MPH
MNCHN Task Force



Implication of the "Shift"

- More emergency referrals to higher facilities or CEmONC
- Fewer childbirth at home and CEmONC

Core Service Package (Life Cycle Approach)



- Pre-pregnancy package of services
- Complete pre-natal package
- Complete care during delivery
- Immediate postpartum and neonatal
- Emergency maternal and newborn service package

Pre-pregnancy package



- Micro-nutrients (Iron w/ folic acid)
- Tetanus-toxoid immunizations
- Fertility awareness, birth spacing and FP counselling
- Nutrition and healthy lifestyle
- Oral health
- Counselling and services on STD/HIV/AIDS
- Management of lifestyle related diseases

Pre-Natal package



- Monitoring of height and weight
- Blood pressure determination and monitoring
- Pregnancy test, urinalysis, CBC, blood typing, STI screening
- Pap smear and acetic acid wash, blood sugar determination
- Micro-nutrient supplementation
- Tetanus toxoid
- Malaria prophylaxis
- Birthplanning

Pre-Natal package



- Counselling on FP methods (LAM, BMF contraceptives)
- Counselling on healthy lifestyle
- Prevention and management of bleeding in early pregnancy
- Early detection and management of danger signs and complications of pregnancy
- Assessment of fetal growth and well being
- Prevention and management of other diseases
- Provision of other support services

Childbirth Service Package



- Monitoring progress of labor using the partograph
- Identification of early signs/symptoms and appropriate management
- The 3 Cs of childbirth.
- No episiotomy and no fundal pressure
- Active management of the third stage of labor
- *Essential Newborn Care Package*

Obstructed labor

Post-partum service package

- Physical Exam (BP monitoring, pelvic exam)
- Identification of early signs and symptoms of postpartum complications like hemorrhage, infection and hypertension
- Micronutrient supplementation
- Provision of FP services
- Counselling on
 - Nutrition
 - Exclusive breastfeeding up to six months
 - neonatal care



Neonatal Care

(w/in 24 hours postpartum routine care)

- Cord care
- Vitamin K injection
- Eye prophylaxis
- Delayed bathing to 6 hours of life
- BCG and Hepatitis B Immunization
- Newborn screening
- Birth registration
- Counselling on post-partum/post-natal check-up home care and immunization




Basic Emergency Obstetrics and Newborn Care (BE mONC)

- Parenteral administration of oxytocin in the third stage of labor
- Parenteral administration of loading dose of anti-convulsant
- Parenteral administration of initial dose of antibiotics
- Assisted delivery during imminent breech presentation

Bleeding

Pre-eclampsia

Infection



BEmONC (continuation)

Bleeding

Bleeding & Infection

Neonatal death

- Manual removal of placenta
- Removal of retained placental products
- Administration of loading dose of corticosteroids for threatened pre-mature delivery
- Newborn resuscitation w/ oxygen support
- Essential Newborn Care



Comprehensive Emergency Obstetrics and Newborn Care (CEmONC)



BEmONC

- Parenteral administration of oxytocin in the third stage of labor
- Parenteral administration of loading doses of anti-convulsant
- Parenteral administration of initial dose of antibiotics
- Assisted delivery during imminent breech delivery
- Manual removal of placenta (active management of 3rd stage of labor)
- Removal of retained placental products
- Administration of corticosteroids for threatened pre-mature delivery
- Newborn resuscitation
- Essential Newborn Care
- *Operative delivery (C. Section)*
- *Blood transfusion services*
- *Advanced life support management for low birth weight, premature and sick newborn like sepsis, asphyxia, severe birth trauma, severe jaundice, etc.*



Annex E: Prototype SDN Agreements

PROTOTYPE
PARTNERSHIP AGREEMENT
 TO STRENGTHEN THE SERVICE DELIVERY NETWORK (SDN)
 ON FP/MNCHN THROUGH PUBLIC-PRIVATE PARTNERSHIPS
 IN THE PROVINCE [CITY] OF [NAME]

THIS PARTNERSHIP AGREEMENT is made

BETWEEN AND AMONG:

THE FOLLOWING PERSONS, in representation of their respective organizations, or of themselves as independent entities, whose respective organizations and affiliations, business addresses and contact numbers are set out opposite their names:

NAME	ORGANIZATION/HEALTH FACILITY/AFFILIATION	ADDRESS	CONTACT NUMBER
A. Representatives of Provincial/City/Municipal Government Units and other LGU Offices			
1)			
2)			
3)			
4)			
5) [INSERT MORE LINES OR DELETE]			
B. Representatives of National Government Agencies (e.g., DOH, PhilHealth, DSWD)			
6)			
7)			
8)			
9)			
10) [INSERT MORE LINES OR DELETE]			
C. Managers and/or Representatives of Public Hospitals and Other Health Facilities and Providers			
11)			

12)			
13)			
14)			
15)			
16)			
17)			
18)	[INSERT MORE LINES OR DELETE]		
D. Owners and/or Managers of Private Hospitals and Other Health Facilities and Providers			
19)			
20)			
21)			
22)			
23)			
24)			
25)	[INSERT MORE LINES OR DELETE]		
E. Representatives of Associations of Midwives and/or Owners or Managers of Birthing Homes and Independent Midwife Practitioners			
26)			
27)			
28)			
29)			
30)	[INSERT MORE LINES OR DELETE]		
F. Owners/Managers of Pharma Companies, Drugstores, Logistics & Distribution Companies, ADPs; and Transpo/Com Companies			
31)			
32)			

33)			
34)[INSERT MORE LINES OR DELETE]			
G. CHT Representatives			
35)			
36)			
37)			
38)[INSERT MORE LINES OR DELETE]			
H. Representatives of Civil Society Organizations (CSOs)			
39)			
40)			
41)			
42)[INSERT MORE LINES OR DELETE]			

I. DEFINITION OF TERMS

For purposes of this Agreement, certain terms are defined in a separate document (herein identified as Annex A) to ensure commonality in understanding of these terms. Such attachment is deemed part of this document.

2. FORMATION AND NAME

The persons herein assembled hereby commit their respective organizations, units and/or themselves as independent entities to formally belong to, and actively participate in, the Public-Private Partnership to Strengthen the Service Delivery Network (SDN) for Family Planning (FP) and Maternal, Neonatal and Child Health and Nutrition (MNCHN), hereinafter Partnership or PPP, in the Province [CITY] of [NAME].

3. PURPOSE

The overall objective for the establishment of the Partnership is to contribute to the reduction of maternal, neonatal and child mortalities by improving the provision of FP/MNCHN core package of services to benefit the priority population groups and areas in the Province [CITY] of [NAME].

[ADD SPECIFICS, IF NECESSARY]

4. FUNCTIONS OF THE PARTNERSHIP IN [PROVINCE/CITY]

The following have been agreed upon to be the strategic and specific functions for which the Partnership has been established.

- (a) Help organize, coordinate and manage a multi-level, multi-facility and multi-provider two-way referral system within and among the designated CEmONC/s, BEmONC/s, Community-Level Health Providers and Community Health Teams (CHTs);
- (b) Service delivery: Help determine the scope and coverage of the priority population groups and the FP/MNCHN core service package, mechanism of access, and types and coverage of capacity building activities for service providers within the SDN;
- (c) Financing: Help determine the appropriate financing terms for the SDN as well as this PPP including standard fees and charges and their disposition; subsidies; facility development plans including investment requirements; financing sources and uses; sharing arrangements for joint costs; and PhilHealth enrolment targets, licensing and accreditation investments, claims facilitation and sharing of revenues from claims, capitation, grants and other revenues;
- (d) Regulation and compliance to standards: Help in the adoption of FP/MNCHN practices and standards including the conduct of compliance monitoring activities and provision of incentives to quality care;
- (e) Act as a venue 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.
- (f) Help in the organization, expansion and development, including capacity building, of midwife-led Community Health Teams (CHTs) across the province of Cavite, including its component city/ies municipalities, *barangays* and *sitios*.
- (g) Conduct a PPP and SDN resource mapping, especially with regard to the type and level of care of each of the health facilities, organization and structure, health human resources, logistics and finance systems, strategic and action plans, transportation and communication resources, and funding to support their use; and provide the means for their use 24/7 during emergencies and whenever needed by the SDN;
- (h) Provide leadership in the conduct of regular FP/MNCH outreach services, including the provision of services for long-acting and permanent methods of family planning under a regime of informed consent and voluntarism (ICV) to remote population groups and geographically isolated and depressed areas (GIDAs);
- (i) Provide leadership in the conceptualization, development, and advocacy of enabling policies, including budget support, among all local government units (LGUs), national government unit counterparts in the locality, and across all levels of care within the SDN;

- (j) Help in the continuous improvement of the capacities of the designated SDN or SDNs, including the certified CEmONC AND BEmONC facilities and providers, the CEmONC- and BEmONC-capable facilities and providers, as well as the other community-level facilities and providers and the Community Health Teams (CHTs), in terms of staffing, training, construction and/or renovation, equipment upgrading and logistics and supplies procurement within and among the SDNs; such will include the integration of young people's FP/MNCHN concerns, and the provision of gender-sensitive and gender-appropriate interventions and quality assurance measures;
- (k) Establish appropriate management arrangements including those of reporting and communication protocols, decision making and representation in policy making and related bodies, reporting arrangements with FHSIS and other government-mandated databases; and the practice of financial accountability;
- (l) **[OTHERS]**

5. ROLES AND RESPONSIBILITIES OF PARTIES

Each of the parties to this agreement hereby commits to perform the following roles and responsibilities:

- (a) ***Provincial Government including its health-related instrumentalities, together with other LGUs within the Province of Cavite.***
 - (1) Take the lead in identifying the priority population groups and areas within the Province of Cavite for FP/MNCHN interventions;
 - (2) Take the lead in the development of the provincial MNCHN strategy and plan within the Province-wide Investment Plan for Health and the Annual Operational Plan (AOP);
 - (3) Designate the initial composition of the SDN **[or each of the SDNs, whichever is applicable]** in terms of the certified CEmONCS and BEmONCS and/or designated CEmONC- and BEmONC-capable facilities and providers and and/or network of facilities and providers, community-level primary health facilities, CHTs and support organizations and individuals from the public and private sectors for delivery of the core package of FP/MNCHN services;
 - (4) Within the framework of the SDN, take the lead in establishing public-private partnerships for FP/MNCHN within the Province of Cavite by establishing a coordination mechanism among local government leaders and the private sector as a venue for the provision of support for the functioning, strengthening and financing of the SDN/s;
 - (5) Within the framework of the SDN, take the lead in establishing a coordination mechanism for health facilities and providers, including the CHTs, under the leadership of the Provincial Health Office [or the Inter-Local Health Zone, as the case maybe], as venue for consensus-making on clinical guidelines for the management of cases such as AMTSL,

EINC, CEmONC and BEmONC services, BTL, NSV, IUD, micronutrient supplementation, and others;

- (6) Take the lead in assessing and building the capacity of health providers, public and private;
- (7) Take the lead in developing a logistics management and information system for FP/MNCHN services;
- (8) Take the lead in the enactment of supportive policies for FP/MNCHN; and
- (9) Take the lead in earmarking and mobilizing funds and other resources for use in employing and contracting service providers, increasing NHIP enrolment, upgrading facilities and procuring logistics, drugs and supplies.

(10) [OTHERS]

(b) Representatives of Relevant National Agencies in the Province [CITY] Led by the DOH Center for Health Development (CHD) and PhilHealth

- (1) Provide technical assistance and support to the PPP and SDN and their individual components, organizations, and entities in the identification of appropriate interventions and in planning for the implementation of the FP/MNCHN strategy;
- (2) Assess the capacities of health facilities and providers, issue CEmONC and BEmONC certifications and/or CEMONC- and/or BEMONC-capable designations as well as confirmations to primary health and/or community health facilities and providers as being fit to belong to an SDN;
- (3) Recommend to the Governor and/or City Mayor which grouping of health facilities and providers within the province, district and or city/cities are to be designated as belonging to an SDN;
- (4) Facilitate the linking of DOH-retained hospitals, other public sector hospitals and other health facilities and providers, and private sector hospitals and facilities and providers to the SDN/s;
- (5) Mobilize logistics and financial assistance in favor of the SDN/s;
- (6) Assist the SDN/s and its/their component facilities and entities in the management of claims, payments, reimbursements, capitation grants and other financial assistance;
- (7) Lead in the conduct of information campaigns to increase NHIP enrolment and utilization of PhilHealth benefits by priority groups;
- (8) Provide oversight in the implementation of the MNCHN strategy by the SDN;
- (9) [OTHERS]

(c) *Managers and/or Representatives of Public Sector Health Facilities*

- (1) Take the lead in preparing, enhancing and upgrading the public sector's facilities and providers to be designated as full-fledged CEmONC and/or BEmONC or CEmONC- and/or BEmONC-capable facilities and providers;
- (2) Take the lead in the development of a multi-level, multi-facility and multi-level provider two-way referral system within the SDN;
- (3) Take the lead in the provision of CEmONC- or BEmONC-defined and related services, as the case may be, and accept and provide referrals from and to allied facilities and providers within the SDN;

(4) [OTHERS]

(d) *Owners and/or Managers of Private Hospitals and Representatives of Medical Associations*

- (1) Take the lead in offering the PPP as a venue for other private sector hospital owners and providers to join the SDN and support the FP/MNCHN strategy;
- (2) Take the lead in preparing, enhancing and upgrading the private sector's facilities and providers to be designated as full-fledged CEmONC and/or BEmONC or CEmONC- and/or BEmONC-capable facilities and providers;
- (3) Assist in the development of a multi-level, multi-facility and multi-provider two-way referral system within the SDN;
- (4) Enhance the provision of CEmONC- or BEmONC-defined and related services, as the case may be, and accept and provide referrals from and to allied facilities and providers within the SDN.

(5) [OTHERS]

(e) *Owners and/or Managers of Pharmaceutical Companies, Drugstores, Pharmacies; Logistics and Distribution Companies, Alternative Distribution Points and Outlets; and Transportation and Communication Companies and/or Outlets*

- (1) Take the lead in offering the Partnership as a venue for other private sector hospital owners and providers to join the SDN and support the MNCHN strategy
- (2) Take the lead in preparing, enhancing and upgrading the private sector's facilities and providers to become CEmONC and BEmONC-capable;
- (3) Assist in the development of a multi-level, multi-facility and -provider cross-referral system within the SDN;

- (4) Enhance the provision of CEmONC- or BEmONC-defined and related services, as the case may be, and accept and provide referrals from and to allied facilities and providers within the SDN

(5) [OTHERS]

(f) Representatives of Employers' Organizations, Workplaces, and Chambers and Academic Organizations, Universities, Colleges and High Schools

- (1) Take the lead in offering the Partnership with like organizations as a venue for them to join the SDN and support the MNCHN strategy;
- (2) Facilitate the linking of workplace and school programs to the SDN;
- (3) Take the lead in preparing, enhancing and upgrading the sectors' facilities, if any, and providers' skills to become CEmONC or BEmONC-capable;
- (4) Assist in the development of a multi-level, multi-facility and -provider cross-referral system within the SDN;
- (5) Enhance the provision of CEmONC- or BEmONC-defined and related services, as the case may be, and accept and provide referrals from and to allied facilities and providers within the SDN

(6) [OTHERS]

(g) Representatives of Associations of Midwives and/or Owners or Managers of Birthing Homes and Independent Midwife Practitioners

- (1) Take the lead in offering the Partnership as a venue for association members, birthing home owners and operators, and Independent Midwife Practitioners to join the SDN and support the MNCHN strategy
- (2) Take the lead in preparing, enhancing and upgrading birthing homes and providers to the SDN standards;
- (3) Take the lead in the development of a multi-level, multi-facility and -provider cross-referral system within the SDN;
- (4) Enhance the provision of CEmONC- or BEmONC-defined and related services, as the case may be, and accept and provide referrals from and to allied facilities and providers within the SDN

(5) [OTHERS]

(h) Representatives of CHTs

- (1) Take the lead in ensuring that CHTs are able to do the following:

- i. Assess health needs of families especially women, mothers and children and assist mothers fill-up health plans to respond to families' health needs;
 - ii. Keep an updated master list women of reproductive age especially those with unmet need for family planning, women who are pregnant or post-partum, and children 0 to 11 months old and those 6 to 59 months old;
 - iii. Inform families and other community members of available services and the corresponding fees of the different health providers within the SDN;
 - iv. Inform families of the need to know their registration status with PhilHealth and the benefits of being covered by the National Health Insurance Program;
 - v. Advocate for prenatal care, facility-based deliveries, postpartum and newborn care as well as provide health information such as self-care to address common health problems during pregnancy;
 - vi. Guide women in choosing the appropriate providers of the MNCHN Core Package of Services;
 - vii. Report maternal and neonatal deaths to RHU and participate in maternal death reviews;
 - viii. Track and follow-up clients such as those that were already given initial service;
- (2) Take the lead in engaging CHTs to undertake a continuing upgrade of skills of skilled health professionals who are members of CHTs;
 - (3) Take the lead in engaging CHTs to conduct a continuing upgrade of primary care facilities (RHUs, BHS, private clinics) that are within their area/s of responsibility;
 - (4) Take the lead in engaging young people who are in-school and out-of-school and those who are from the workplaces who live within the CHT's area of responsibility to utilize the services available within the SDN and to actually participate in the CHT's activities;
 - (5) Take the lead in institutionalizing the conduct of regular assessments, planning and monitoring and evaluation activities among the CHTs.

(6) [OTHERS]

(i) Representatives of Civil Society Organizations (CSOs), including non-government organizations, people's organizations, faith-based organizations, civic organizations

- (1) Take the lead in harnessing the moral support and material contribution of CSOs in implementing the MNCHN strategy and the SDN for the province [CITY];
- (2) Whenever possible, and in case there is a lack of facilities and providers that hampers the designation of a CemONC and BEmONC-capable facility and providers, take active role in the mobilization of investments to be able to designate an SDN;

- (3) Take an active role in the expansion and or replication of SDNs to other priority populations and areas within the province [CITY] if warranted by the situation;
- (4) Harness the involvement of CSOs in the organization and delivery of outreach services to remote population groups and/or areas;
- (5) 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.

(6) [OTHERS]

6. INSTITUTIONALIZING THE PARTNERSHIP

It is hereby agreed under this Agreement to confer this Partnership the power and task to formally organize itself and foster its institutionalization. As such, it is agreed that it shall formulate its vision, mission, goals and strategies, develop action plans, structures and systems, provide a coordination mechanism and staff support, engage in resource generation and access funds, whenever possible, in support of the Partnership and the SDN.

7. COORDINATION MECHANISM AND SECRETARIAT SUPPORT

There is hereby organized a Partnership Coordination Committee and Secretariat to be headed by the Provincial Health Officer [**CITY HEALTH OFFICER**] and composed of one representative each from the major sectoral groupings identified in this Agreement. Fulltime Secretariat staff support shall be provided by the PHO [**CITY HEALTH OFFICER**].

The Partnership Coordination Committee and Secretariat for this Partnership shall have the following functions:

- (a) Conduct a resource mapping of each of the stakeholder groups, organizations and individuals in this Partnership;
- (b) Secure commitments and forge individual partnership agreements for the sharing of resources to the Partnership and the SDN;
- (c) Facilitate the formal organization and development of the organizing elements of the Partnership (vision, mission, goals, strategies, structures, systems and procedures, action plans, elections of officers, etc.);
- (d) Develop plans for resource mobilization;
- (e) Provide communication and liaison support to the Partnership;
- (f) Act and make executive decisions on behalf of the Partnership when the latter is not able to convene;
- (g) [OTHERS]

8. REPEALING CLAUSE

(Optional at this time)

9. EFFECTIVITY

This Agreement takes effect on [DATE]

IN WITNESS WHEREOF, ALL PARTIES HEREIN REPRESENTED undertake to affix their signatures:

NAME	SIGNATURE
A. Representatives of Provincial/Municipal Government Units and other LGU Offices	
1)	
2)	
3)	
4) [INSERT MORE LINES OR DELETE]	
B. Representatives of National Government Agencies	
5)	
6)	
7)	
8)	
7) [INSERT MORE LINES OR DELETE]	
C. Managers and/or Representatives of Public Sector Health Facilities	
9)	
10)	
11)	
12)	
13)	
14) [INSERT MORE LINES OR DELETE]	
D. Owners and/or Managers of Private Sector Hospitals	
15)	

16)	
17)	
18)	
19)	
20)	
21)	
22)	
23) [INSERT MORE LINES OR DELETE]	
E. Representatives of Associations of Midwives and/or Owners or Managers of Birthing Homes and Independent Midwife Practitioners	
24)	
25)	
26)	
27)	
28) [INSERT MORE LINES OR DELETE]	
F. Owners/Managers of Pharma Companies, Drugstores, Logistics & Distribution Companies, ADPs; and Transpo/Com Companies	
29)	
30)	
31) [INSERT MORE LINES OR DELETE]	
G. CHT Representatives	
32)	
33)	
34)	
35)	
36)	
37)	
38)	

39)	
40)	
41) [INSERT MORE LINES OR DELETE]	
H. Representatives of Civil Society Organizations (CSOs)	
42)	
43)	
44)	
45)	
46)	
47) [INSERT MORE LINES OR DELETE]	

Annex F: Sample Executive Order Designating the LGU's SDN



Republic of the Philippines
Autonomous Region in Muslim Mindanao
Province of Maguindanao
Municipality of Parang



OFFICE OF THE MAYOR
Poblacion I, Parang, Maguindanao
-000-

EXECUTIVE ORDER No. _____
Series of 2014

**AN EXECUTIVE ORDER DESIGNATING THE SERVICE DELIVERY NETWORK (SDN)
TO IMPROVE THE PROVISION OF FAMILY PLANNING (FP)
AND MATERNAL, NEONATAL AND CHILD HEALTH AND NUTRITION (MNCHN)
SERVICES IN THE MUNICIPALITY OF PARANG, MAGUINDANAO**

Pursuant to existing Laws, Policies and Orders most particularly a) **AO 2008-2009** – Maternal, Neonatal Child Health and Nutrition Strategy; b) **AO 2010-0014**: Administration of Life-saving Drugs and Medicines by Midwives to Rapidly Reduce Maternal and Neonatal Morbidity and Mortality; c) **AO 2010-0036** - Aquino Health Agenda and Kalusugan Pangkalahatan Execution Plan; d) **the MNCHN Strategy Manual of Operations, 2011 (2nd Edition)**; e) **AO 2012-0009** National Strategy Towards Reducing Unmet Need for Modern Family Planning as a Means to Achieving MDGs for Maternal Health; f) **AO 2012-0012** Rules and Regulations Governing the new Classification of Hospitals and Other Health Facilities in the Philippines; and g) **Department Order 2012-0120**: Guidelines on the Execution of the 2012 Family Health and Responsible Parenting Budget for Maternal, Neonatal and Child Health and Nutrition Grants to LGUs

NOW THEREFORE

I IBRAHIM P. IBAY, duly elected Mayor of the Municipality of Parang, Maguindanao, by virtue of the power vested in me by law, do hereby mandate the strict compliance and implementation of this order:

1. RATIONALE

In the past decade, the family planning (FP) and maternal, neonatal and child health and nutrition (MNCHN) situation in the country has worsened. The National Government, through the Department of Health has come up with various measures to address the issues and concern of FP/MNCHN in the Region. Such policies and programmes include the following: a) **AO 2008-2009** – Maternal, Neonatal Child Health and Nutrition Strategy; b) **AO 2010-0014**: Administration of Life-saving Drugs and Medicines by Midwives to Rapidly Reduce Maternal and Neonatal Morbidity and Mortality; c) **AO 2010-0036** - Aquino Health Agenda and Kalusugan Pangkalahatan Execution Plan; d) **the MNCHN Strategy Manual of Operations, 2011 (2nd Edition)**; e) **AO 2012-0009** National Strategy Towards Reducing Unmet Need for Modern Family Planning as a Means to Achieving MDGs for Maternal Health; f) **AO 2012-0012** Rules and Regulations Governing the new Classification of Hospitals and Other Health Facilities in the Philippines; and g) **Department Order 2012-0120**: Guidelines on the Execution of the 2012 Family Health and Responsible Parenting Budget for Maternal, Neonatal and Child Health and Nutrition Grants to LGUs.

It is the position of the Local Government to support national government efforts and comprehensively address the FP/MNCHN situation in this Municipality. Foremost among these efforts is the identification and strengthening of service delivery network (SDN) of health facilities and providers throughout the Municipality in the context of a broader public-private partnership (PPP) that is able to respond to the FP/MNCHN needs of the population especially the poor, marginalized, socially excluded and underserved populations.



Republic of the Philippines
Autonomous Region in Muslim Mindanao
Province of Maguindanao
Municipality of Parang



OFFICE OF THE MAYOR
Poblacion 1, Parang, Maguindanao
-00-

For this Municipality, the Rural Health Unit under the Municipal Health Officer Dr. Abdul Rahman T. Biruar has identified the public and private facilities as well as the health providers that should initially compose the FP/MNCHN SDN and has submitted its recommendations. This Order formalizes the designation of the FP/MNCHN SDN in this Municipality of Parang, Maguindanao.

II. PURPOSE

The overall objective for the designation of the FP/MNCHN SDN within a broader public private partnership is to reduce the maternal, neonatal and child mortality situation in the Municipality of Parang, Maguindanao

III. DESIGNATION OF THE FP/MNCHN SDN

The following are hereby designated to become part of the FP/MNCHN SDN within the Municipality of Parang, Maguindanao

CEMONC-LEVEL FACILITIES AND PROVIDERS

[PUBLIC]

COTABATO REGIONAL & MEDICAL CENTER
Sinsuat Ave., Rosary Heights 10, Cotabato City
Tel # 084-421-2192
DRA. HELEN P. YAMBAO, FPOGS
DRA. GLORIA REDOBLE, FPOGS
DRA. RUTH PERALTA, FPOGS
DRA. NURLINDA P. ARUMPAC, FPOGS
DRA. LOIDA M. MANGELE, FPOGS
DRA. SWEET ALI- AMIL, FPOGS
DRA. NELLY REDOBLE, FPOGS
DRA. LOVE DEVILLES- AGTARAP, FPOGS

BEMONC-LEVEL FACILITY/IES AND PROVIDERS

[PUBLIC]

PARANG RURAL HEALTH UNIT
Poblacion 1, Parang, Maguindanao
Contact No. 09176220778
DR. ABDUL RAHMAN T. BIRUAR

CAMP. SALIPADA K. PENDATUN HOSPITAL
Making, Parang, Maguindanao
Contact No. 09153955001
Maj. FRANKLY JOHN E. DEDEL, MD
Chief of Hospital



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Province of Maguindanao
Municipality of Parang



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Poblacion 1, Parang, Maguindanao
-oOo-

COMMUNITY-LEVEL FACILITY/IES AND PROVIDERS
[PUBLIC]

Barangay Health Station in Parang, Maguindanao

Zuellig Family Foundation Birthing Center (Barangay Sarmiento Birthing Center)

Brgy. Sarmiento, Landasan, Parang, Maguindanao

Contact No. 09159131009

Merlyn Asuncion, RM

Margie Sulco, RM

T.G. Guingona Birthing Center (Barangay Making Birthing Center)

Brgy. Making, Parang, Maguindanao

Contact No. 09261429633

Jonalyn Endonilla, RM

Zuellig Family Foundation Birthing Center (Barangay Litayen Birthing Center)

Brgy. Litayen, Bongo Island, Parang, Maguindanao

Contact No.

ZURINA NAKAN, RM

[PRIVATE]

MONIB WELL FAMILY MIDWIFE CLINIC

Crossing Barira, Parang, Maguindanao

Contact No. 09053524727

ANGKO MONIB, RM

CAMARUDIN MEDICAL & LYING-IN CLINIC

Alfonso St., Poblacion 1, Parang, Maguindanao

Contact No. 09276313272

DRA. GUIARIA S. CAMARUDIN

DAVILLES-AGTARAP MATERNAL HEALTH CARE & LYING IN CLINIC

TLA Bldg. Marang St., Pob.1, Parang, Maguindanao

Contact No. 09177226570

DRA. LOVE DEVILLES-AGTARAP

ORBINA- RAMOS MEDICAL CLINIC

Town Site, infront Parang Central School

Contact No. 09273763698

DRA. IMELDA ORBINA-RAMOS



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Province of Maguindanao
Municipality of Parang



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Poblacion 1, Parang, Maguindanao
-oOo-

[OTHER SERVICES]

(DENTAL)

RAI DENTAL CLINIC

Near Easter Joy School, Pob. Parang, Maguindanao

Contact No. 09273547599

DRA. SORAIDA LUMAMBAS- UMPA, DMD

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MR. USMAN R. IBAY

IV. FUNCTIONS OF THE FP/MNCHN SDN

The functions of the FP/MNCHN SDN are the following:

Core Package of Services. Deliver a Core Package of Services consisting of interventions that will be delivered for each life stage: pre-pregnancy, pregnancy, delivery, and the post-partum and neonatal periods. These consist of the following:

Pre-pregnancy. Provision of iron and folate supplementation, advice on family planning and healthy lifestyle, provision of family planning services, prevention and management of infection and lifestyle-related diseases.

Pregnancy. First prenatal visit at first trimester, at least 4 prenatal visits throughout the course of pregnancy to detect and manage danger signs and complications of pregnancy, provision of iron and folate supplementation for 3 months, iodine supplementation and 2 tetanus toxoid immunization, counselling on healthy lifestyle and breastfeeding, prevention and management of infection.

Delivery. Skilled birth attendance/skilled health professional-assisted delivery and facility-based deliveries including the use of partograph, proper management of pregnancy and delivery complications and newborn complications, and access to BEmONC or CEmONC.



Republic of the Philippines
 Autonomous Region in Muslim Mindanao
 Province of Maguindanao
 Municipality of Parang



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 Poblacion I, Parang, Maguindanao
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A Comprehensive Emergency Obstetric and Newborn Care (CEmONC)-Capable Facility (or Network of Facilities) and providers consist of health facility/ies and providers that can perform the six signal obstetric functions for BEmONC, as well as provide caesarean delivery services, blood banking and transfusion services, and other highly specialized obstetric interventions. It is also capable of providing neonatal emergency interventions, which include at the minimum, the following: (1) newborn resuscitation; (2) treatment of neonatal sepsis/infection; (3) oxygen support for neonates; (4) management of low birth weight or preterm newborn; and (5) other specialized newborn services. These facilities can also serve as high volume providers for IUD and VSC services, especially tubal ligations. It should also provide an itinerant team that will conduct out-reach services to remote communities. The itinerant team is typically composed of 1 physician (surgeon), 1 nurse and 1 midwife.

A Basic Emergency Obstetric and Newborn Care (BEmONC)-Capable Facility (or Network of Facilities and Providers) consist of health facilities and providers that can perform the following six signal obstetric functions: (1) parenteral administration of oxytocin in the third stage of labor; (2) parenteral administration of loading dose of anti-convulsants; (3) parenteral administration of initial dose of antibiotics; (4) performance of assisted deliveries (Imminent Breech Delivery); (5) removal of retained products of conception; and (6) manual removal of retained placenta. These facilities are also able to provide emergency newborn interventions, which include the minimum: (1) newborn resuscitation; (2) treatment of neonatal sepsis/infection; and (3) oxygen support. It shall also be capable of providing blood transfusion services on top of its standard functions.

Post-Partum. Visit within 72 hours and on the 7th day postpartum to check for conditions such as bleeding or infections, Vitamin A supplements to the mother, and counselling on family planning and available services.

Newborn Care Until the First Week of Life. Interventions within the first 90 minutes such as immediate drying, skin to skin contact between mother and newborn, cord clamping after 1 to 3 minutes, non-separation of baby from the mother, early initiation of breastfeeding, as well as essential newborn care after 90 minutes to 6 hours, newborn care prior to discharge, after discharge as well as additional care thereafter as provided for in the "Clinical Practice Pocket Guide, Newborn Care Until the First Week of Life."

Child Care: Immunization, micronutrient supplementation (Vitamin A, iron); exclusive breastfeeding up to 6 months, sustained breastfeeding up to 24 months with complementary feeding, integrated management of childhood illnesses, injury prevention and insecticide-treated nets for mothers and children in malaria endemic areas.

Referral System: Participate in a multi-level, multi-facility and multi-provider referral system within and among the designated CEMONC/s, BEMONC/s and Community Health Providers;

Service Delivery: Participate in determining the scope and coverage of MWRAs and neonates, mechanism of access, and types and coverage of capacity building activities for service providers within the SDN;

Financing: Participate in determining the appropriate financing terms within the SDN, and the network of facilities and providers, including standard fees and charges and their disposition; subsidies; individual facility development plans including investment requirements; financing



Republic of the Philippines
Autonomous Region in Muslim Mindanao
Province of Maguindanao
Municipality of Parang



OFFICE OF THE MAYOR

Poblacion I, Parang, Maguindanao

-00-

sources and uses; sharing arrangements for joint costs; and Philhealth enrolment targets, licensing and accreditation investments, claims facilitation and sharing of revenues from claims, capitation, grants and other revenues;

Regulation and Compliance to Standards: Participate in the adoption of FP/MNCHN practices and standards including the conduct of compliance monitoring activities and provision of incentives to quality care;

Outreach Services. Act as a venue and/or staging point for outreach services on FP/MNCHN, including the provision of services for Long-Acting and Permanent Methods (LA/PM) of family planning under a regime of Informed Consent and Voluntarism (ICV) to remote population groups and geographically isolated and depressed areas (GIDAs);

Technical Assistance. Act as the principal source of technical expertise in building the capacity of community level providers and the Community Health Teams (CHTs) in the Municipality of Parang, Maguindanao including its barangays and sitios;

Resource Mapping. Lead in the conduct of resource mapping within the SDN, especially with regard to the type and level of care Of each of the health facilities, organization and structure, health human resources, logistics and finance systems, strategic and action plans, transportation and communication resources, and funding to support their use;

Policy Advocacy. Participate in the conceptualization, development, and advocacy of enabling policies, including budget support, among all local government units (LGUs), national government unit counterparts in the locality, and across all levels of care within the SDN;

Capacity Building. Act as the venue for the continuous improvement of the capacities of the SDN, including the CEmONC- and BEmONC-capable facilities and providers, as well as the other community-level facilities and providers and the Community Health Teams (CHTs), in terms of staffing, training, construction and/or renovation, equipment upgrading and logistics and supplies procurement within and among the SDNs; such will include the integration of young people's FP/MNCHN concerns, and the provision of gender-sensitive and gender-appropriate interventions and quality assurance measures; and

V. PRIVATE SECTOR INVOLVEMENT

In the spirit of this Order, the private sector is deemed to be a vital partner in the coordination, implementation and delivery of services, maintenance of quality-assured products and services, as well as in resource mobilization, monitoring and evaluation and pursuing sustainability of the FP/MNCHN SDN. As such, a public-private partnership shall be organized consisting of the following: a) the Municipal Government, other LGUs, and their relevant offices; b) officials of



Republic of the Philippines
Autonomous Region in Muslim Mindanao
Province of Maguindanao
Municipality of Parang



OFFICE OF THE MAYOR
Poblacion 1, Parang, Maguindanao
-000-

relevant national government agencies (NGAs) such as the DOH, PHIC, DSWD and DILG; c) managers and representatives of public sector health facilities; d) managers and/or representatives of private sector health facilities and medical associations; e) owners/managers of pharmaceutical companies, drugstores, logistics and distribution companies, alternate distribution points; transportation and communication companies and related workplaces; f) representatives of midwife/nurses associations, birthing homes and independent midwives; g) CHT representatives; and h) representatives of civil society organizations.

VI. GENDER SENSITIVITY AND RESPONSIVENESS

The provision of services will be made gender sensitive and responsive by: (i) ensuring that FP/MNCHN services are intended to respond to the needs of both men and women of reproductive age; (ii) respecting and responding to the choice of client for male or female skilled health professional to administer the service; (iii) designing information, education, and communication materials and activities in a way that will invite the attention and respond to FP needs of both men and women of reproductive age; (iii) urging prospective clients to jointly decide with their spouses/partners on the availment of this service, but, in times of disagreement between spouses/partners, to respect the decision of the one who will undergo the procedure; (iv) providing assistance (e.g., counseling or referral to proper agencies) to prospective clients whose reasons for not availing the services are related to gender issues (e.g., fear of disapproval of spouse or other relatives, dependence on spouse/partner, experience of physical battering or other forms of gender-based violence); and (v) keeping sex-disaggregated data on clients to track the availment of services by both men and women of reproductive age.

VII. DELEGATED AUTHORITY

The Rural Health Unit (RHU) led by the Municipal Health Officer is hereby tasked to oversee the implementation of this Order. He is also tasked to report once every month to the undersigned on his accomplishments with respect to this Order.

VII. EFFECTIVITY

This Order takes effect immediately.

Signed this 30th day of April 2014 in the office of the Municipal Mayor, Municipal Hall, Poblacion 1, Parang, Maguindanao, Philippines.

MAYOR IBRAHIM P. IBAY, DND
Municipal Mayor

Annex G: Developing the SDN's local MNCHN referral system

Once the SDN has been officially designated and the members/officers of the SDN management team have been officially identified and likewise designated, it is of critical importance that the local referral system for MNCHN care and services is officially set up. Ensuring a smooth referral flow among members of the SDN is top priority for the SDN management team.

Critical Assumptions

Official designation of the SDN members pre-supposes that the LGU, with technical assistance from the DOH-RO, has already assessed and properly categorized each of these members into one of the three tiers of the SDN – either as (1) community level providers/facilities, or, as (2) BEmONC providers/facilities, or, finally, as (3) CEmONC providers/facilities. This means that verification and/or validation of the qualifications or competence of these providers and facilities to determine their suitability for their particular tier in the SDN has already been done. The appropriate technical experts from the LGU and DOH should regularly conduct periodic evaluation of SDN facilities and providers to ensure that best quality services are provided by all SDN members and that all referrals are adequately and appropriately attended to. The focus of this annex shall only be on the official formation of the SDN's actual referral flows and system.

Staff of the designated SDN partners are all trained to recognize maternal and newborn cases that cannot be handled at their facilities' level of care capacity. This critical assumption is the basis for the expectation that no mother or newborn shall die due to delayed access to immediate emergency care in a functional SDN because cases too complicated for a lower level of care facility are recognized early and immediately referred, and attended to, by a higher level of care SDN partner. CEmONC facilities are expected to be able to handle all maternal and newborn emergency cases. The referral system is not always simply from lower to higher level of care, however, but CEmONC and BEmONC providers/facilities are expected to refer normal pregnancies and deliveries to lower level partners in order to help decongest these higher level care facilities to be able to accommodate the more complicated cases.

Objective

The objective of the LMRS is to ensure immediate quality emergency care for mothers and newborns, particularly in cases of non-normal pregnancies and deliveries. Additionally, for non-emergency cases, the SDN's LMRS facilitates meeting the LGUs' unmet need for pre-pregnancy services, such as and most notably, for BTLs and other family planning methods not readily available in all facilities.

Pre-existing Referral "System"

Wherever health facilities are located, some form of a referral "system" most probably already exists whether such a system has been formally developed or just came into being on its own. By

virtue of the nature of health services, it is inevitable that health facilities do relate in some way to each other regardless of whether these relationships are viewed positively or negatively.

When a SDN is created however, it is always desirable that a referral system among its members be deliberately formed with all members formulating and, ideally, agreeing with the terms and conditions for such a system. All members must view the SDN's referral arrangements as positive and beneficial to each one with, of course, the patient's or client's wellbeing, health and safety taken into foremost consideration.

Two-Step Approach to Formalizing SDN-LMRS

Two key activities are needed to formalize the creation of a referral system among the SDN partners. These activities are described below. While these activities will formalize the system, focused efforts will be required to ensure implementation of the LMRS. SDN partners will also need to seek to continually improve the quality of the LMRS, and may therefore require regular consultations, coordination and collaboration.

The first major activity is the conduct of a workshop with, as much as possible, all SDN partners to (1) determine the current state of how referrals are being conducted; and, (2) draft agreements among partners that will improve the referral arrangements in the SDN.

While the workshop is designed to surface current referral practices, the second objective seeks to draw from the SDN partners their own recommendations on how to further improve their working and referral relationships. The following four aspects of a referral system will further guide the discussions leading to the attainment of these two workshop objectives:

- a) Reasons for referrals – the conditions that warrant referrals. This leads to a discussion about the appropriateness and timeliness of referrals. All the SDN partners must agree to abide by the clinical standards or clinical practice guidelines for each and every possible MNCHN case. These guidelines set the boundaries for when referrals to higher levels of care must be made.
- b) Requirements for referrals – enumerating the necessary documents, procedures and referral flow expected by the referral (or receiving) facility from the referring facility (duly accomplished referral slip, for example) and vice versa (properly filled out return portion of the referral slip from receiving facility to referring facility).
- c) Roster of referral partners – the updated directory of all SDN partners. Each member of the SDN must have a copy of this directory which must contain updated information about all the SDN partners including the contact person(s), contact details, schedules and types of services available. During the workshop, having the SDN partners complete a directory form, can facilitate this updating of all the partners' information.
- d) Recording and reporting of referrals will provide much-needed feedback that will enable the SDN management team to continue quality improvement on the LMRS. This is accomplished through the return referral slip and the referral registry log(book) that all SDN partners should

be mandated to maintain. The documentation will help assess the effectiveness of the referral agreements and allow room for recommendations for further improvements.

At the end of this workshop, the SDN partners will have a draft set of agreements for each of the four aspects of their referral/working relationships within the SDN. These agreements are actually recommendations for improvement based on the workshop's initial output (from the first objective) that surfaced the current referral practices that need improvement.

The SDN management team, or a smaller sub-committee assigned by it, should work on finalizing the draft agreements. This will include updated the directory of SDN partners, diagrammatic representations of the various referral flows, detailed instructions on referral procedures and requirements, as well as recording/reporting arrangements. All these are needed prior to the conduct of the second activity.

The second major activity is the dissemination of the "final" initial referral agreements to all SDN partners. One option is to have a high-profile activity that will invite the community, LGU officials and key stakeholders (such as PhilHealth, health NGOs, etc.) to witness the dissemination as well as to inform the community about the SDN-LMRS. This serves as a marketing and promotional activity for all the SDN partners. It will also inform the community about the referral system so that there will be clear expectations from both the general public and the SDN partners, thus minimizing frustrations and complaints and facilitating cooperation and coordination.

The other option, especially when resources are inadequate, is for the SDN management team to call for a second meeting with all SDN partners to simply announce the referral agreements, distribute the partners' updated directories, and the written referral guidelines, and agree to abide by these guidelines and implement the agreements for a certain period of time, say six months, and to come together again for a re-assessment of the referral system.

A third option may be for the SDN management team to issue a memorandum to all SDN partners informing them of the "final" referral guidelines. Attached to this memo will be the forms required, the diagram of the referral flows, directories of the partners and other pertinent documents. The memo will enjoin all SDN partners to implement the agreements for the next three to six months after which a follow up assessment or meeting will be called.

Regardless of the chosen option for the second major activity, note that during the follow up meeting after the trial or implementation period, the sustainability questions that will be used will come from the annexed guide questions as referred to in the section "Guidelines for Sustaining the SDNs" on page 10.

Annex H: SDN Management Team SOW/TOR

Executive Order Creating the TWG for the Efficient and Effective Implementation of the MNCHN Strategy Including Family Planning in the City of General Santos and other Purposes



Republic of the Philippines
General Santos City
OFFICE OF THE CITY MAYOR

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EXECUTIVE ORDER NO.26 Series of 2013

AN EXECUTIVE ORDER CREATING THE TECHNICAL WORKING GROUP (TWG) FOR THE EFFICIENT AND EFFECTIVE IMPLEMENTATION OF THE MATERNAL, NEONATAL AND CHILD HEALTH AND NUTRITION STRATEGY (MNCHN), INCLUDING FAMILY PLANNING (FP), IN THE CITY OF GENERAL SANTOS AND OTHER PURPOSES.

WHEREAS, DOH AO 2010-0036 strongly advocates the need to implement the Universal Health Care Program (UHC) that is directed towards achieving better health outcomes, sustained health financing and more responsive health system while ensuring that all Filipinos, especially the disadvantaged groups, have equitable access to affordable health care;

WHEREAS, DOH AO 2010-0036 recognizes the National Health Insurance Program (NHIP) as the prime mover for improving financial risk protection (particularly for the poor), generating resources to modernize and sustain health facilities and improve the provision of public health services to achieve the Millennium Development Goals (MDGs) of reducing infant/child mortality and improving maternal health, among others;

WHEREAS, the City of General Santos fully supports and ensures the effective implementation of the MNCHN/FP strategy as part of its strong commitment to local health sector reform implementation. Also, it supports the engagement of all concerned health care facilities and providers to form a coordinated MNCHN/FP Service Delivery Network (SDN), the mobilization and involvement of the communities to be covered and served, and the strengthening of collaboration between and among the public and private stakeholders under a public-private partnership within and outside the health sector;

WHEREAS, the City of General Santos recognizes that reforms in service delivery, governance, regulation and financing are needed for the sustained improvement of the health status of mothers and children and such can only be achieved if an appropriate mechanism, such as a MNCHN/FP Technical Working Group (TWG) is created to undertake and manage the implementation of MNCHN/FP strategy for a more efficient and effective health service delivery.

NOW THEREFORE, I **RONNEL C. RIVERA**, City mayor of General Santos, by virtue of the power vested in me by the law, do hereby Order:

SECTION 1. Creation of the MNCHN/FP Technical Working Group (TWG) and composition – The General Santos City MNCHN-FP TWG is hereby created to be composed of the following members:

Honorary Chairperson	:	CITY MAYOR
Chairperson	:	CITY HEALTH OFFICER

C0-Chairperson	:	POGS SARGEN CHAPTER
Secretariat	:	PRISM2
	:	MAHINTANA FOUNDATION
Members	:	Executive Secretary on Health
	:	FP-MNCHN Coordinator
	:	SP Chair on Health
	:	DOH Representative
	:	IMAP President
	:	Mindanao Health

SECTION 2. Functions of TWG – The following are the functions of the MNCHN/FP TWG:

(2.1) Ensure effective coordination of the Service Delivery Network (SDN) for MNCHN/FP, especially in the matter of rationalization and strengthening of the two-way referral system between and among the public and private health facilities and providers;

(2.2) Under the leadership of the City Mayor and the City Health Officer (CHO), orchestrate the conduct of assessment, planning, implementation coordination, and monitoring and evaluation of all MNCHN/FP program, projects and activities of the City Government;

(2.3) Lead in the mobilization of resources such as technical assistance packages and financial resources from the national government and its regional offices especially the center for Health Development (CHD), development partners, local government budget allocations, local organizations and other such resources that have similar programs, projects and activities;

(2.4) Ensure the effective integration of the PPP approach in the MNCHN/FP-related programs, projects and activities of the City Government;

(2.5) Develop a training system and capacity building plan to ensure that the knowledge, attitude, skills and practice (KASP) of both public and private partners are evenly distributed so that MNCHN and FP services to the communities, especially the poor, are optimized;

SECTION 3. Committees and their composition – The following organizations/department/office/institution/agencies, are appointed to the following committees that are hereby created under the MNCHN/FP TWG:

(3.1) Resource Mobilization	:	CLAFI
	:	FPOP
	:	PRISM2
	:	COMDEV
	:	PMA
	:	Pharmaceutical Companies
(3.2) Monitoring and Evaluation	:	Medical Health Officers
	:	MNCHN Team
	:	PHIC
	:	DOH-CHD 12 Rep
	:	IMAP

	:	Medical Health Officers
(3.3) Policy and Advocacy	:	SP Chair on Health
	:	Executive Assistant on Health
	:	SP Chair on Budget/Finance
	:	PRISM2
	:	Mindanao Health Project
(3.4) Education	:	Academe, School Organizations
	:	Dept. of Education
	:	Faith-based Organizations
	:	Public and Private Hospitals
	:	City Population Office
	:	PMA, PNA, Specialty Organizations
(3.5) Service Delivery	:	Public and Private Hospitals
	:	Private Lying-Ins
	:	Health Centers/Unit Stations
	:	IMAP
	:	PLGPMI
	:	Mother and Child Center
	:	Civic Organization

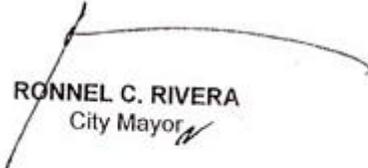
SECTION 4. Definition of the roles and functions of the various committees- The various committees created under this Order are hereby mandated to define their roles and functions subject to the general functions enunciated under Section 2 of this Order and the approval of the City Mayor upon recommendation by the CHO.

SECTION 5. Repealing Clause.- All orders, circulars, or memoranda not consistent herewith are either repealed or modified accordingly by this order.

SECTION 6. Separability Clause. – If any section or provision of this order is held invalid, other parts or provisions which are not affected thereby shall continue to be in full force and effect.

SECTION 7. Effectivity Clause. - This Executive Order shall take effect immediately.

Signed this 8 day of October 2013 in General Santos City, Philippines.


RONNEL C. RIVERA
City Mayor

Annex I: Sample Self-Assessment Guide Questions:

a. Referral systems

- 1) Are all members of the SDN aware of the terms of agreement for the referral system?
- 2) Do all SDN partners have the agreed referral and return referral forms?
- 3) Do all SDN partners have their co-partners' contact details – copies of the updated SDN directory?
- 4) Are all complicated pregnancies and deliveries or newborns referred to BEmONC or CEmONC facilities appropriately and immediately without delays?
- 5) Are all referrals accepted by the facility and providers to which the patient was referred?
- 6) Are all referred and accepted patients/clients attended to, cared for and clinically managed immediately and without delays?

b. Recording and reporting systems

- 1) Are all SDN partners oriented or trained in FHSIS?
- 2) Is there a clear recording and reporting flow or system:
 - a. Between service providers within the same facility?
 - b. Between the facility (or provider, if lone practitioner) and the LGU reporting unit?
- 3) Are all members or partners in the SDN aware of this recording and reporting system?
- 4) Do all members or partners in the SDN follow the agreed steps of this recording and reporting system?
- 5) Is the private sector accomplishment in FP-MCH information, services and products provision consistently included in the overall accomplishment of the SDN or LGU as reflected in the FHSIS reports?

c. Clinical standards

- 1) Do all partners in the SDN have their own copies of reference materials for FP-MCH issued by the DOH such as the:
 - a. FP Clinical Standards Manual;
 - b. Quality Assurance Package for Midwives
 - c. Others....?
- 2) Has an assessment of the training needs of the SDN partners been conducted recently (within 2 years)?
- 3) Are all member or partners in the SDN oriented or trained or updated on the DOH standards of FP-MCH service provision in the following areas, as appropriate:
 - a. FP-Competency Based Training Level I (family planning counseling, oral contraceptives, injectable contraceptives, condoms, standard days method, natural family planning)
 - b. Contraceptive technology updates for physicians
 - c. Interval IUD insertion and removal
 - d. Post-partum IUD insertion
 - e. Bilateral tubal ligation using minilaparotomy under local anesthesia – interval and post-partum
 - f. No-scalpel vasectomy
 - g. Contraceptive implants

- h. BEmONC for Midwives
 - i. BEmONC (for teams)
 - j. Newborn screening
 - k. Newborn hearing
- 4) Is there a system for regular technical supportive or facilitative supervision of all service providers and facilities in the SDN using tools such as the Quality Assurance Package for Midwives or supportive supervision, etc.?
 - 5) Are there venues for learning for SDN partners such as maternal mortality audits, clinical case conferences for midwives, morbidity reviews, etc.?
 - 6) Are all partners in the SDN – public as well as private practitioners – regularly provided with equal opportunities to access available training courses in FP-MCH?
 - 7) Are all SDN partners compliant with the DOH standards of quality of care in FP-MCH information, products and service provision?
 - 8) Is the SDN management team coordinating with the DOH-RO so that the SDN partners' training needs could be met through the DOH RO-based training system for FP-MCH?
 - 9) Are some members of the SDN partnership already part of the FP-MCH training system in the region?

d. Financing

- 1) Is the PhilHealth coverage of all deserving indigents in the catchment area of the SDN sufficient enough to make private sector involvement in the SDN sustainable?
- 2) Are majority of the SDN partners already employing or complying with the no-balance billing Policy for PhilHealth-enrolled indigents?
- 3) Are all SDN partners (facilities and providers) already DOH-licensed and PhilHealth-accredited?
- 4) Aside from PhilHealth, are there other funding sources outside the SDN that are being tapped to sustain private sector active involvement as SDN partners?
- 5) Are there current and successful financing arrangements between and among the SDN partners to secure economic sustainability of both public and private partners?
- 6) Are there clear guidelines or mechanisms or precedents on using government funds to pay the private sector for some FP-MCH services provision, as necessary?
- 7) Are there clear guidelines or mechanisms or precedents on using government funds to pay the private sector for some FP-MCH training activities as may be needed?

e. Local access to FP-MCH products

- 1) Do all partners in the SDN carry FP-MCH products in their clinics or hospitals or lying-in clinics or traditional and non-traditional supplies outlets?
- 2) Do SDN partners coordinate regularly with each other ensuring that the potential FP-MCH clients and patients in the community will have a continuing supply of their needed FP-MCH products from either public or private partners?
- 3) Are all partners in the SDN aware of the suppliers who may be tapped for needed FP-MCH products in case these are needed... ensuring no stock-outs occur in the SDN?
- 4) Is there adequate policy support from the LGU that will ensure the SDN's continuing supply of FP-MCH products in its partners' facilities?

- 5) Are private suppliers of FP-MCH products actively involving themselves in the LGU's procurement of its supplies for the poorest of the poor segment of society?

f. Demand generation

- 1) Is the entire community of potential clients and patients in the SDN's catchment area aware of the SDN?
- 2) Is the entire community of potential clients and patients in the SDN's catchment area aware of the SDN's individual partner providers and facilities?
- 3) Are there informational campaigns or activities or materials that serve to inform potential clients and patients in the entire SDN catchment area promoting the SDN as a network of good quality FP-MCH information, products and services providers and facilities?
- 4) Are SDN partners regularly promoting their co-partners practices?
- 5) Are SDN partners regularly actively referring clients and patients to their SDN partners for information, products and services that may not available in their facilities instead of referring them to other facilities and providers that are not part of the SDN?
- 6) Are there regular behavior change communication activities happening throughout the SDN, such as the USAPAN sessions, in order to increase utilization of FP-MCH services from SDN partners?

g. Others

- 1) Are all SDN partners oriented and compliant with the DOH's informed choice and voluntarism policy and administrative order?
 - a. Do all partners offer a broad range of family planning methods or refer to other SDN partners for methods not available in their facility?
 - b. Do all facilities of SDN partners display the "all method poster" to inform all potential clients that there are several family planning choices?
 - c. Is there a regular monitoring and reporting for ICV compliance among SDN partners?
- 2) Do all SDN partners practice gender equality and sensitivity in their practices, facilities, materials and dealings with all contacts?
- 3) Are all SDN facilities and providers compliant with existing environmental compliance rules and regulations?
- 4) Have informal workforce groups such as cooperatives, peoples' organizations, associations and others been reached for potential partnership in increasing utilization of SDN services, products and information?
- 5) Is the SDN making efforts to competently address the special reproductive health needs of young people?