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Ensuring Quality in Family Planning Service Delivery: Toolkit for Monitoring Compliance on Informed Choice and Voluntarism and Environmental Mitigation



Ensuring Quality in Family Planning Service Delivery: Toolkit for Monitoring Compliance on Informed Choice and Voluntarism and Environmental Mitigation

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ACRONYMS

AO	Administrative order
DENR	Department of Environment and Natural Resources
DOH	Department of Health
DOH-RO	Department of Health Regional Office
FP-MCH	Family planning and maternal and child health services
ICV	Informed consent and voluntarism
LGU	Local government unit
PhilHealth	Philippine Health Insurance Corporation
USAID	United States Agencies for International Development

BACKGROUND

USAID places a high priority on ensuring that family planning activities supported by the agency adhere to the mandates of the Philippine government on the principles and practices of *voluntarism* and *informed choice* and environmental mitigation. These policies are very important in ensuring quality of care in family planning service provision. Given these requirements, it is incumbent upon all USAID projects to develop plans of action for ensuring the project's and its partners' implementation of these commitments.

This document describes strategies to ensure compliance with these requirements. The focus of the document is primarily informed choice and voluntarism (ICV) compliance and monitoring, but in the latter sections of the document there is discussion of specific activities and tools related to environmental compliance. Integration of environmental compliance initiatives with those related to ICV is an efficient and effective way to work with project teams and partners to address these two important issues. The document focusses on effort that can be implemented by USAID projects to strengthen their own teams' efforts in these areas and to build the capacity of their partners to ensure ICV and environmental mitigation compliance.

INTRODUCTION

An individual's decision to use a specific method of family planning or to use any method of family planning is considered *voluntary* if it is based upon correct information and the exercise of free choice, and is not influenced by any constraints, special inducements or any element of force, fraud, deceit, duress, or other forms of coercion or misrepresentation.

Clients have to be provided with adequate service options such as broad range of family planning services, appropriate information, counseling, privacy and confidentiality as regular features of quality client-provider interaction. These are mandated in the Philippine laws and Department of Health (DOH) Family Planning Program policies and principles. Informed and voluntary decision-making in family planning is one of the four pillars of the national family planning program as embodied in DOH Administrative Order (AO) 50-A series of 2001. In June 2011, the DOH issued, an improved policy, AO 2011-0005 providing Guidelines on Ensuring Quality Standards in the Delivery of Family Program and Services through Compliance to Informed Choice and Voluntarism. The Magna Carta of Women also provides for ensuring Filipino women's right to information, choice, family planning and maternal health services. Above all, the Philippine laws prohibit abortion and classify it as a criminal offense.

Projects funded by USAID have to comply with several U.S. legislative and statutory policy requirements relating to informed choice and voluntarism in the provision of family planning services.

The United States legislative and statutory requirements are as follows:

- A. Tiahrt amendment mandates that:
 1. Service providers or referral agents in the project shall not implement or be subject to quotas, or other numerical targets, of total number of births, number of family planning acceptors, or acceptors of a particular family planning method; although quantitative estimates or indicators used for budgeting or planning purposes are permissible;
 2. The project shall not include payment of incentives, bribes gratuities or financial reward to
 - a. an individual in exchange for accepting family planning, or

- b. program personnel for achieving a numerical target or quota of total number of births, number of family planning acceptors, or acceptors of a particular method of family planning;
 3. The project shall not deny right or benefit, including the right of access to participate in any program of general welfare or the right to access to health care, as a consequence of any individual's decision not to accept family planning services;
 4. The project shall provide family planning acceptors comprehensible information on the health benefits and risks of the method chosen, including those conditions that might render the method inadvisable and those adverse side effects known to be consequent to the use of the method; and,
 5. The project shall ensure that experimental contraceptive drugs and devices and medical procedures are provided only in the context of a scientific study in which participants are advised of potential risks and benefits.
- B. The Population Policy of 1982, provides for specific requirements for USAID-supported programs that include voluntary sterilization. These requirements include informed consent, ready access to other methods, and guidelines on incentive payments, which define payments to acceptors, providers and referral agents. This is referred to as the PD-3 provision.
- C. USAID strongly restricts the use of its resources for activities that directly or indirectly help promote abortion as a family planning method. These principles are embodied in the provisions of the different US Government family planning statutory and policy requirements. Although, the Mexico City Policy was rescinded in January 2009 and is no longer relevant, all other abortion-related legislative and statutory requirements remain intact and shall be enforced:
 1. The Helms amendment prohibits the use of funds for the performance of abortion as a family planning method or to motivate or coerce any person to practice abortions.
 2. The Leahy amendment clarifies the term "motivate" as it relates to family planning assistance saying it shall not be construed to prohibit the provision, consistent with local law, of information or counseling about all pregnancy options.
 3. The Siljander amendment prohibits US government funds from being used to lobby for or against abortions.
 4. The Biden amendment restricts the use of funds for biomedical research that relates to performance of abortions or involuntary sterilization.
 5. The Kemp-Kasten amendment guards against using US funds for involuntary sterilization or coercive abortions.
 6. The DeConcini amendment provision limits the use of funds only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services.
 7. Livingston-Obey amendment requires that in awarding grants for natural family planning, no applicant shall be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning; and, additionally, all such applicants shall comply with the requirements of the DeConcini Amendment.

PLANNING FOR ICV COMPLIANCE MONITORING

USAID-funded projects are required to develop ICV compliance monitoring plans. These plans contain recommended plans of actions that continually improve quality of care by ensuring ICV is protected and upheld at all times and that would prevent the commission of violations and reduce vulnerabilities against ICV principles.

There are three levels in which projects can develop plans of action to avoid violations. These are:

1. Project- level – actions that project staff can do in collaboration with other USAID projects.
 - a. Activities that individual staff will conduct for internal use or benefit (such as annually accomplishing the US Government’s online e-learning course on family planning legislative compliance)
 - b. Activities that projects will conduct to help others (the next level) preempt, prevent or avoid vulnerabilities or outright violations of the policies (such as develop ICV materials to be used in orienting staff)
2. Project-partners level – these are activities that projects should expect partners to conduct or comply with as part of the terms of partnership.
 - a. Internal or intra-organizational activities – among its staff or as assistance to its own partners (such as heads or leaders of the partner organization are expected to orient their own staff on ICV policies)
 - b. Activities to be conducted by the partner-organizations’ partner implementers or actual service providers (such as post the all-family planning methods posters in every clinic under the partner organization)
3. In areas not directly covered by the project, some minimum activities will have to be conducted to ensure compliance and prevention of vulnerabilities or violations (such as conducting ICV orientations for health officers through the DOH Regional Offices (DOH-ROs)).

Proposed types of actions and specific activities for each level are collated and summarized in the matrix in Annex A. This matrix guides staff in the conduct of activities relating to the project, its partners, and the context in which the project operates. Implementing activities at these three levels has three overall objectives for ensuring ICV policy compliance: 1) expand or increase the awareness on ICV policies from project central and field personnel to project partners, grantees, and allied service providers; 2) strengthen project implementation of internal controls and partner organization’s capabilities; and 3) improve monitoring, evaluation and feedback systems to provide better information, decision-making, and further improvement of operational policies.

NECESSARY ACTIONS TO ENSURE ICV COMPLIANCE

To ensure full compliance with local and US policies on informed choice and voluntarism, and the unacceptability of abortion as a method of family planning, projects should exhaust all efforts, including but not necessarily limited to the following:

1. The inclusion of US government family planning policies and statutory requirements as standard provisions in grants and sub-contracts (see Annex B),
2. Inclusion of Philippine government family planning policies related to ICV as standard provisions in grants and subcontracts
3. ICV-related activities for grants and subcontracts awardees, such as:
 - a. explanation to the grantees/subcontractors the conditions for funds utilization provided for in the various family planning and abortion-related policy requirements as early as cost negotiations stage
 - b. orientation on ICV for grants and subcontracts recipients

- c. in the course of the partners implementation of its activities, the partner (grantee or subcontractor) should be required to accomplish a Partner Level Checklist for Implementation of ICV Policy Requirements (sample in Annex C)
 - d. partners submit signed forms of Commitment to Compliance with ICV Policy Requirements (see Annex D).
 - e. grantees/subcontractors to obtain from its partners/implementers signed compliance commitment forms (Annex D).
 - f. grantees/subcontractors integrate in their information provision, monitoring activities regarding ICV compliance, utilizing the recommended forms in this plan.
 - g. grantees/subcontractors integrate ICV orientation into its general human resource orientation for newly hired staff.
 - h. grantees/subcontractors monitor and submit reports on ICV compliance on a quarterly basis
4. Inclusion of orientation on ICV as an issue of quality of care and as basic information and principles imparted to recipients of project-funded training for family planning service providers.
 - a. inclusion of signed commitment to comply with ICV policies in registration forms for supported training courses (Annex D)
 - b. requiring all trainers to submit at the end of each training course ICV Policy Compliance Information Dissemination Certificate (Annex E) certifying that the trainees had received information on these policies during the training and had understood the implications of non-compliance with the same.
 5. Distribution of the latest family planning reference book, the Family Planning: A Global Handbook for Providers, to grantees, subcontractors and project partner family planning service providers.
 6. Distribution of the all-methods family planning wall poster and desk flipcharts to all partner family planning service providers.
 7. Require grantees/subcontractors to ensure that the all-methods family planning wall posters and desk flipcharts are available in their network of clinics and providers.
 8. Mandatory annual accomplishment of the web-based e-learning course on United States government family planning policies and statutory requirements for all project staff
 9. Technical staff participation in inter-agency ICV compliance monitoring orientation-training workshops.
 10. Formation of a committee, or ICV compliance core team, with the following core members:
 - a. a point or focal person who will be responsible for all activities related to the implementation and monitoring of ICV compliance in all project-assisted areas as part of their scope of work;
 - b. a focal person as secretariat at the national office who shall be responsible for documentation, submission and filing of all ICV compliance-related documents
 - c. a quality specialist, or equivalent, designated as over-all focal person for ICV at the national level, mandated to collate/consolidate all reports from project sites, document vulnerabilities, organize trainings or orientation, and materials
 11. Whenever and wherever applicable and practicable, inclusion of ICV policies and compliance discussions in all meetings, presentations and conferences whether as formal orientations or informal reminders to audiences – such as grants pre-award orientations, private practicing midwives consultative working group meetings, grants final technical and cost negotiations with proponents, regular visits to partners, and others.
 12. Regular reporting of ICV compliance activities from the field and regional office based staff.
 13. Development and implementation of a functional monitoring and reporting system within the project.

14. Train public and private partners to enact local policies and ensure programs are consistent with Philippine laws respecting, upholding, enabling Filipinos to exercise their right to be informed, choose, act on their choices, access quality family planning and maternal and child health services (FP-MCH) information, products and services.

ORIENTATION OF PARTNERS AND SERVICE PROVIDERS ON ICV

This section of the document presents details of how to conduct an orientation on ICV for project partners and service providers. The one-day orientation is designed for public and private service providers in different settings, including rural health units, community health stations, public and private hospitals, birthing homes and private midwife clinics. A similar general orientation design and tools can be used for project grantee and subcontract partners.

While the focus of this orientation is on ICV, the conduct of this orientation with partners is also a good opportunity to consider including additional modules on environmental impact mitigation and/or gender.

Objectives

General Objective: To enable public and private hospitals to strengthen its family planning provision and use in compliance with government policies on ICV [and promotion of gender equality and environmental mitigation, if desired].

Specific Objectives: At the end of the one-day orientation the participants will be able to: (1) understand the principles of ICV-compliant [gender responsive and environment-friendly] family planning information, product and service provision to clients based on relevant Philippine Government family planning statutory and policy requirements; (2) determine what is ICV-compliant family planning provision and discuss what constitutes vulnerability or violation; (3) adapt the provisions/guidelines of the DOH AO on ICV [and environmental mitigation] measures to local realities of the hospital; and (4) plan for next steps to strengthen family planning program implementation.

Preparation

The orientation is supported by a PowerPoint presentation (Annex F), thus requiring the availability of some technology where this orientation will take place. Otherwise, the presentation may be printed and converted into transparencies, or participants may be given printed hand-outs to take home or make notes on during the presentation.

The PowerPoint presentation includes suggested talking points or script to help the facilitator present the material. Answers and explanations to case studies are included. The presenter must study the notes well ahead of the presentation itself in order to be familiar with the content and script. It would be best to get additional background information on quality of care in family planning in order to provide clear examples or illustration for each of the client's rights and provider's needs. (Annex G is a summary of these clients' rights and providers' needs. This was taken from EngenderHealth's COPE: Client-Oriented Provider-Efficient Services Manual which is a good resource material on the subject).

The presenter must likewise be familiar with the National Family Planning Program Policy (DOH AO 50-A s. 2001), a copy of which is attached here as Annex H. The slide deck also includes additional slides on the Magna Carta of Women and the DOH Administrative Order 2011-0005, Guidelines on Ensuring Quality Standards in the Delivery of Family Planning Program and Services through Compliance to Informed Choice and Voluntarism.

Suggested Activity Flow

Time	Activity	Person Responsible
8:30 – 9:00	Registration Pre-test (see Annex I) Invocation National Anthem Introduction of Participants Welcome Message Objectives	Host
9:00 – 11:00	<u>Session 1 - Presentation:</u> DOH family planning program <u>Session 2 - Presentation:</u> Broad range of family planning methods	DOH-RO Local government unit (LGU) Family Planning Coordinator
11:00 – 12:00	<u>Session 3 - Presentation:</u> Overview and review of national laws and policies related to ICV presented as quality of care in the Philippine setting; DOH Administrative Order 2011-005: Guidelines on Ensuring Quality Standards in the Delivery of Family Planning Program and Services through Compliance to Informed Choice and Voluntarism	Project
1:30 – 2:30	<u>Session 4 - Workshop:</u> Identification of gaps related to DOH AO on ICV, and responsiveness of family planning services in your health care facility <u>Session 5 - Workshop:</u> Planning workshop in response to identified gaps	Host and Project
2:30 – 3:30	<u>Session 6 – Plenary Discussion:</u> Issues and concerns regarding the identified activities/strategies to improve FP-MCH provision	Project
3:30 – 4:00	Synthesis	Host
	Post-test (see Annex I)	Project
	Closing Remarks	Host

MONITORING OF COMPLIANCE TO ICV POLICY REQUIREMENTS

Annexes J, K and L provide the tools necessary to monitor ICV compliance at the facility level.

The tool in Annex J is for use with facility managers, supervisors and providers. It is intended to serve as a rapid assessment of national family planning policy compliance. It is not necessary to follow this tool verbatim, but rather during the course of conversation to obtain the information requested it may be necessary to ask additional questions and probe deeper to obtain details about a given issue. It is the responsibility of the user to continue the in-depth discussion to the point necessary to gather all the necessary information and provide a comprehensive report to the ICV compliance core team. This tool is intended to serve as a guide to the interviewer. It is not necessary to fill in the guide during the interview. However, for record keeping purposes, please fill in the tool immediately following the interview and submit the form to the appropriate entity within your respective office.

When all pertinent questions in the interview have been asked and answered, all feedback and comments have been taken, be sure to address the service provider's questions, issues or concerns. Do not leave the interview without addressing issues that you had noted during the interview.

Annex K provides a tool for interviewing family planning clients at the facility. The results of this tool must be reported jointly with the results of the assessment tool for facility managers and providers. If the results obtained by the two tools do not match, further investigation will be required. When conducting site visits for interviews, ICV monitors should also briefly take the time to make some observations at the facility. A checklist for this purpose is in Annex L.

Based on the answers to the questions in this tool and the facility tool, the interviewer will draw a conclusion as whether there is a potential vulnerability in a service delivery site or whether there is a potential violation of legislative and policy requirements to ensure quality of care initiatives in family planning. If during the use of the tool there is a 'red flag' that indicates a potential violation, it is necessary to report the potential violation immediately to the ICV compliance core team and appropriate USAID representative to initiate an in-depth investigation.

Should vulnerabilities or violations occur at anytime, anywhere, the project partner or staff who identifies such a situation must immediately report it to the project focal person or team for ICV. The latter shall then help facilitate the documentation of the alleged possible vulnerability or violation by filling up a reporting or incident report form (sample in Annex M). This signed report will then be faxed or scanned/emailed immediately to the project focal person who will then notify the Chief of Party. The project Chief of Party is required to notify the USAID Office of Health through its Agreement/Contract Officer Representative within 72 hours of being aware of the possible vulnerability or violation, if it is related to targeting or coercive issues.

USAID will conduct the investigations together with the DOH to determine whether a violation has been committed or not. USAID Philippines will then communicate with USAID Washington for the next steps. In the event that a violation has indeed been committed, USAID Washington is required by law to report such violation to the United States Congress. The project will await instructions from USAID for the next steps. Relationships should continue. Feedback must be given to the partner and the DOH-RO explaining the situation and the steps being taken.

TRAINING OF STAFF AND PARTNERS ON ICV MONITORING

To build the capacity and stewardship role of local partners, particularly DOH-ROs and LGUs, to monitor ICV related issues in their locality, it is advisable to also work with these partners to establish ICV monitoring teams at the local level. Training of these teams is described in this section of the document. The same training outline can be used for training project staff. Environmental mitigation monitoring may also be included in the training, if this component is included in the remit of the ICV compliance monitoring team.

Objectives

General Objective: To enable project personnel/local stewards to facilitate attainment of family planning outcomes by strengthening information, service, product provision and use.

Specific Objectives: At the end of training participants will be able to: (1) understand the principles of ICV in family planning service provision; (2) determine what ICV-compliant family planning provision is; (3) demonstrate the use of monitoring tools for family planning clients and service providers for the ICV compliance; (4) identify needs for improvement of the local service delivery network in relation to provision of ICV-compliant family planning information, product and services to clients; adopt a monitoring and reporting system for family planning policy compliance in relation to local realities; and (5) plan for next steps to strengthen family planning provision and use, and the local health referral system, as mandated by the DOH AO on ICV;

Preparation

All preparatory activities outlined in the section above are also relevant to this training for ICV monitoring teams. In addition, it is important that all participants in this training have a basic, scientific, evidence-based knowledge of all family planning methods, and have read and understood the DOH Administrative Order on ICV.

Program of Activities

Date/Time	Activity/Topics	Facilitator/Speaker
DAY 1		
9:00- 10:00	Pre-test (see Annex I)	Project
	Opening Message	DOH-RO
	Objectives and Expectations	DOH-RO
10:00 – 11:00	<u>Session 1 - Presentation:</u> DOH family planning program <u>Session 2 - Presentation:</u> Broad range of family planning methods	DOH-RO
11:00 – 12:00	<u>Session 3 - Presentation:</u> Overview and review of national laws and policies related to ICV presented as quality of care in the Philippine setting; DOH Administrative Order 2011- 005: Guidelines on Ensuring Quality Standards in the Delivery of Family Planning Program and Services through Compliance to Informed Choice and Voluntarism	Project
1:00 – 3:00	<u>Session 4 – Workshop:</u> Identification of gaps related to ICV compliance in respective geographical areas Followed by plenary session	Project and DOH-RO
3:00 – 4:00	<u>Session 5 – Presentation:</u> Familiarization with the monitoring tools, reporting forms, reporting systems and lines of reporting Followed by open forum	Project
4:00 – 5:00	<u>Session 6 – Workshop:</u> Familiarization with the monitoring tools through role playing, and discussions Followed by plenary session	Project and DOH-RO
DAY 2		
8:30 – 9:00	Recap of Day 1	Project
9:00 – 11:00	<u>Session 6 – Practicum:</u> Hands-on ICV compliance monitoring in family planning (Annex N)	Participants travel to identified facilities
11:00 – 12:00	<u>Session 7 – Plenary:</u> Discussions on issues and concerns regarding compliance to ICV and environmental mitigation as experienced during the practicum	Project
1:00 – 4:15	<u>Session 8 - Workshop:</u> Planning for next steps in implementing ICV compliance (Annex O) Followed by plenary session	Project and DOH-RO
4:15 – 5:00	Synthesis	DOH-RO
	Post-test (see Annex I)	PRISM2
	Closing Remarks	DOH-RO

ENSURING COMPLIANCE WITH ENVIRONMENTAL MITIGATION POLICIES

Healthcare waste contains potentially harmful microorganisms which can infect patients, healthcare workers and the general public. Healthcare service provision generates waste, 80% of which is considered to be general waste in nature, while, 20% is considered hazardous—infectious, toxic or radioactive. About 1% of the total waste is composed of sharps. Annually, an estimated 16,000 million injections are administered worldwide, but not all needles and syringes are properly disposed of afterwards. About 3% of healthcare waste are chemicals and pharmaceuticals. Around 1% of the total healthcare waste contains genotoxic waste, radioactive matter and heavy metal content.

There are policies that govern healthcare waste management. The DOH has published the Health Care Waste Management Manual¹. Likewise, the DOH and Department of Environment and Natural Resources (DENR) issued the Joint Administrative Order 02, series of 2005 which presents policies and guidelines for the effective and proper handling, collection, transport, treatment, storage, disposal of healthcare waste (Annex P). The Philippine Health Insurance Corporation (PhilHealth) likewise has its accreditation standards related to environmental mitigation (Annex Q).

It is therefore incumbent upon health projects to comply with these policies, including projects that conduct activities that do not directly produce waste. Projects can develop a work plan on environmental compliance monitoring. Some of the activities to be considered are described below.

1. Internally within the project, develop reporting mechanisms, reporting tools
 - Collaborate with field staff in the conduct of compliance monitoring
 - Utilize compliance monitoring reports to tighten technical assistance to partners
 - Integrate environment mitigation and monitoring with relevant project technical initiatives
2. In collaboration with other USAID partners, develop reporting mechanisms and tools
 - Collaborate with other USAID partners at the national level to improve tools, monitoring and reporting systems
3. Assist DOH, LGUs and project partners to develop local policies/program on environmental mitigation monitoring related to management/disposal of potentially hazardous waste in FP-MCH provision and use:
 - Orient grantees on environmental compliance and monitoring. A sample PowerPoint presentation, designed for use with private practicing midwives, which could be adapted for this purpose is included in Annex R.
 - Collaborate with grantees and other partners regarding activities related to environment mitigation monitoring and reporting
 - Collaborate with grantees and other project partners on support activities related to environmental mitigation specifically on health care waste management such as simple product inventory mechanisms, expired pharmaceutical products, sharps, etc
 - Together with grantees, conduct monitoring among health care facilities of partners
 - Feedback the information that will be generated to local stewards to be used in their program implementation reviews, annual operational planning, regular technical meetings for immediate operational resolution and to fast track compliance to LGU, DOH and PhilHealth standards on environmental mitigation and protection

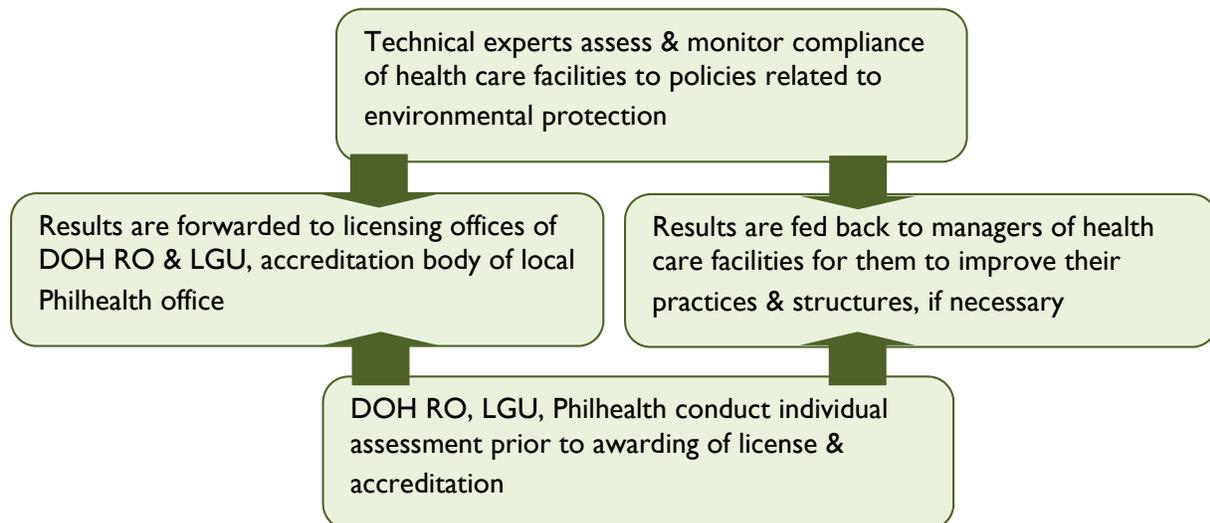
¹ http://www.doh.gov.ph/sites/default/files/Health_Care_Waste_Management_Manual.pdf

- Together with local stewards, gather local policies passed and programs implemented by LGUs and other partners in relation to environmental mitigation. Evaluate these policies as their relevance to FP-MCH provision and use
 - Develop technical initiatives to assist partners in improving implementation of environmental mitigation and protection measures in relation to FP-MCH services, product provision and use
4. Support DOH-ROs and local stewards in institutionalizing LGU-wide continuous quality improvement in localities that include environmental mitigation and monitoring as part of improving safety in FP-MCH provision and use:
- Package the process documentation, results of quality assessment and monitoring, environmental [and ICV] compliance monitoring as basis of strategic and annual operational planning
 - Develop materials, activity designs, planning tools for local planning to improve quality FP-MCH services, products, information provision and use

Project staff, together with LGUs and partners can conduct a baseline assessment of environmental mitigation and decide on the frequency of monitoring visits. A simplified environmental compliance tool is found in Annex S.

Stewards and public health managers of DOH-ROs and LGUs can utilize the results of the environment compliance monitoring to further assist health care providers to set up structures and mechanisms to ensure that their practices protect the environment and do not further contribute to its degradation. Further, the results can then be forwarded to the regulatory bodies of the DOH-RO and LGUs, as well as to the local PhilHealth office, to ensure compliance of individual health care providers. Figure 1 below shows a simplified workflow on monitoring and feedback.

Figure 1. Operationalizing the Environmental Compliance Monitoring



ANNEXES

- Annex A: Matrix of Possible Actions to Ensure Compliance with ICV Mandates
- Annex B: Contractual Provisions Relevant to ICV in Family Planning
- Annex C: Partner Level Checklist for Implementation of ICV Policy Requirements
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- Annex P: Joint DENR and DOH AO 02, series of 2005
- Annex Q: PhilHealth Benchbook Quality Standards for Health Provider Organizations
- Annex R: Orientation and Compliance to Health Care Waste Management (PowerPoint)
- Annex S: Environmental Compliance Assessment Tool

Annex A: Matrix of Possible Actions to Ensure Compliance with ICV Mandates

Types of Actions	Actions Within Scope of Project Operations		
	Project Activities	Activities of Project Partners	Activities in Project Context
Informing those concerned about standards of ICV compliance	<ul style="list-style-type: none"> • Reproduce and distribute to staff the summary sheet of US government family planning policies and legislative mandates • Develop ICV policy summary sheet similar to above for project partners • Require staff to attend at least one training-orientation workshop on ICV policies and compliance monitoring • All staff complete the on-line course on the subject as required by USAID on an annual basis • Update, reproduce, distribute and utilize ICV compliance monitoring orientation tools 	<ul style="list-style-type: none"> • Project partners participation in training-orientation session on ICV policy compliance monitoring • Project partners’ partner-implementers’ participation in training-orientation session on ICV policy compliance monitoring • Dissemination of ICV policy summary informational sheets to partners and implementers 	<ul style="list-style-type: none"> • Inclusion of ICV policies as part of advocacy messages when paying courtesy calls on local chief executives • Sharing/distribution of ICV policy summary sheets to local chief executives, etc. • Suggest inclusion of ICV policies into health education sessions for mothers, volunteer community health workers, etc.
Training on effort to meet standards	<ul style="list-style-type: none"> • Use updated ICV compliance monitoring orientation toolkit as trainers’ guide • Conduct training of facilitators for ICV compliance orientation sessions among project staff (and partners) • Maintain pool of trained trainers or facilitators who know how to orient trainees and/or project partners on ICV policies • Continue inter-agency collaboration for ICV 	<ul style="list-style-type: none"> • Trained facilitators among partners to ensure roll out of the orientation among their implementers • Incorporate ICV module or session into orientation activities for partners • Conduct of post-training follow up of trained/oriented partner-implementers 	<ul style="list-style-type: none"> • Open invitation to representatives from non-USAID direct recipient areas to participate in ICV policy compliance monitoring training-orientation workshops

Types of Actions	Actions Within Scope of Project Operations		
	Project Activities	Activities of Project Partners	Activities in Project Context
Applying standards in providers and service managers training	<ul style="list-style-type: none"> • Develop ICV compliance module within providers and service managers training • Ensure ICV policy compliance in all service delivery training materials • Whenever applicable, participate in USAID updates or discussions on ICV especially with the DOH central 	<ul style="list-style-type: none"> • Proper conduct of ICV training sessions • Regular follow-up of trained partners' implementers determining ICV compliance of trained service providers • 	<ul style="list-style-type: none"> • Sharing of ICV compliance monitoring tools with health officers or supervisors from non-USAID areas
Applying standards in providing information to clients and potential users	<ul style="list-style-type: none"> • Check materials to ensure that they are ICV compliant such as: incentives or financial rewards for FP acceptance are not included • Procure, request and ensure availability of all-methods posters in relevant languages 	<ul style="list-style-type: none"> • Wide distribution of all-methods posters among partner Implementers • Incorporate ICV in partners' activities or advocacies such as in their regular publications or websites • Develop potential ICV compliance champions among partners 	<ul style="list-style-type: none"> • Share with non-USAID areas the all-family planning methods posters in the vernacular • Distribute as number of copies would allow • Challenge local health officers to reproduce and distribute
Applying standards in grants, sub-contracts and donations in kind	<ul style="list-style-type: none"> • Include ICV policies and monitoring in solicitation request, pre-award/ implementation orientation. • Include proponent ICV compliance plan in RFP/A; • Prepare ICV compliance monitoring checklist; • Require ICV compliance report prior to tranche releases 	<ul style="list-style-type: none"> • Ensure that proponent's ICV compliance plan is implemented; • Accomplish monitoring forms/checklists; • Submit compliance reports; • Sign certification of ICV orientation participation and understanding as well as commitment to monitoring 	

Types of Actions	Actions Within Scope of Project Operations		
	Project Activities	Activities of Project Partners	Activities in Project Context
Applying standards in monitoring and evaluation	<ul style="list-style-type: none"> • Develop ICV monitoring system • Develop ICV reporting system • Standard ICV monitoring tools available 	<ul style="list-style-type: none"> • Regular conduct of ICV monitoring integrated into partners' regular project monitoring activities • Correct use of appropriate monitoring tools • Propose recognition of partners/implementers with regular monitoring activities and best ICV compliance practices 	<ul style="list-style-type: none"> • Local health officers from non-USAID recipient areas may join in the monitoring activities
Applying standards in providing other technical assistance	<ul style="list-style-type: none"> • Regular reminders and monitoring of partners • Update ICV status and collate monitoring reporting results 	<ul style="list-style-type: none"> • Regular monitoring of ICV compliance orientation and monitoring; • Ensure functional referral systems broad range of family planning methods availability 	<ul style="list-style-type: none"> • Provision of ICV compliance monitoring materials such as tools, posters, reporting forms, etc in non-assisted areas
Documenting and reporting actions to comply with standards	<ul style="list-style-type: none"> • Secretariat regular monthly reminders to senior managers regarding monitoring reports submission • Inclusion of ICV-related activities and monitoring results in quarterly accomplishment reports 	<ul style="list-style-type: none"> • Inclusion of ICV-related activities and monitoring results in partners' accomplishment reports 	<ul style="list-style-type: none"> • Inclusion of ICV compliance in regular reports from LGUs (as should be embodied in the coming AO on ICV)
Reporting incidents of possible violations of standards	<ul style="list-style-type: none"> • Standard ICV Vulnerability or Violation Incident Report Form available 	<ul style="list-style-type: none"> • Ensure access to ICV related standard forms • Close coordination with project field teams for monitoring and reporting possible vulnerabilities or violations 	<ul style="list-style-type: none"> • DOH-RO partners shall orient non-assisted sites on ICV vulnerability or violation reporting forms and system

Types of Actions	Actions Within Scope of Project Operations		
	Project Activities	Activities of Project Partners	Activities in Project Context
Reviewing status of implementing planned actions	<ul style="list-style-type: none"> • Regular project staff meetings to include reports, discussions and feedback on ICV compliance monitoring status, issues, concerns and recommendations for improvement • ICV focal persons to regularly review ICV compliance monitoring status, make necessary recommendations and implement such needed actions to ensure active vigilant awareness raising and compliance among staff and partners 	<ul style="list-style-type: none"> • Project partners provide feedback to project field staff on status, issues, concerns and recommendations for ICV compliance monitoring • Inclusion of ICV reports, results, best practices, updates, etc. in project reviews by partners 	<ul style="list-style-type: none"> • DOH-ROs and LGUs in non-assisted areas provide venues for review of ICV status incorporated in regular activities such as during maternal death reviews,

Annex B: Contractual Provisions Relevant to ICV in Family Planning

H. 38: VOLUNTARY POPULATION PLANNING (June 2008)

- a. Requirements for Voluntary Sterilization Program. None of the funds made available under this contract shall be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any individual to practice sterilization.
- b. Prohibition on Abortion-Related Activities:
 - (1) No funds made available under this award will be used to finance, support, or be attributed to the following activities: (i) procurement or distribution of equipment intended to be used for the purpose of inducing abortions as a method of family planning; (ii) special fees or incentives to any person to coerce or motivate them to have abortions; (iii) payments to persons to perform abortions or to solicit persons to undergo abortions; (iv) information, education, training, or communication programs that seek to promote abortion as a method of family planning; and (v) lobbying for or against abortion. The term "motivate", as it relates to family planning assistance, shall not be construed to prohibit the provision, consistent with local law, of information or counseling about all pregnancy options.
 - (2) No funds made available under this award will be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilizations as a means of family planning. Epidemiologic or descriptive research to assess the incidence, extent or consequences of abortions is not precluded.
- c. The contractor will insert this provision in all subcontracts.

H.39: VOLUNTARY POPULATION PLANNING ACTIVITIES - SUPPLEMENTAL REQUIREMENTS (JANUARY 2009)

- a. Voluntary Participation and Family Planning Methods:
 - (1) The recipient agrees to take any steps necessary to ensure that funds made available under this award will not be used to coerce any individual to practice methods of family planning inconsistent with such individual's moral, philosophical, or religious beliefs. Further, the recipient agrees to conduct its activities in a manner that safeguards the rights, health and welfare of all individuals who take part in the program.
 - (2) Activities which provide family planning services or information to individuals, financed in whole or in part under this agreement, shall provide a broad range of family planning methods and services available in the country in which the activity is conducted or shall provide information to such individuals regarding where such methods and services may be obtained.
- b. Requirements for Voluntary Family Planning Projects:
 - (1) A Family planning project must comply with the requirements of this paragraph.
 - (2) A project is a discrete activity through which a governmental or nongovernmental organization or public international organization provides family planning services to people and for which funds obligated under this award, or goods or services financed with such funds, are provided under this

award, except fund solely for the participation of personnel in short-term, widely attended training conferences or programs.

(3) Service providers and referral agents in the project shall not implement or be subject to quotas or other numerical targets of total number of births, number of family planning acceptors, or acceptors of a particular method of family planning. Quantitative estimates or indicators of the number of births, acceptors, and acceptors of a particular method that are used for the purpose of budgeting, planning, or reporting with respect to the project are not quotas or targets under this paragraph, unless service providers or referral agents in the project are required to achieve the estimates or indicators.

(4) The project shall not include the payment of incentives, bribes, gratuities or financial rewards to (i) any individual in exchange for becoming a family planning acceptor or (ii) any personnel performing functions under the project for achieving a numerical quota or target of total number of births, number of family planning acceptors, or acceptors of a particular method of contraception. This restriction applies to salaries or payments paid or made to personnel performing functions under the project if the amount of the salary or payment increases or decreases based on a predetermined number of births, number of family planning acceptors, or number of acceptors of a particular method of contraception that the personnel affect or achieve.

(5) No person shall be denied any right or benefit, including the right of access to participate in any program of general welfare or health care, based on the person's decision not to accept family planning services offered by the project.

(6) The project shall provide family planning acceptors comprehensible information about the health benefits and risks of the method chosen, including those conditions that might render the use of the method inadvisable and those adverse side effects known to be consequent to the use of the method. This requirement may be satisfied by providing information in accordance with the medical practices and standards and health conditions in the country where the project is conducted through counseling, brochures, posters, or package inserts.

(7) The project shall ensure that experimental contraceptive drugs and devices and medical procedures are provided only in the context of a scientific study in which participants are advised of potential risks and benefits.

(8) With respect to projects for which USAID provides, or finances the contribution of, contraceptive commodities or technical services and for which there is no subaward or contract under this award, organization implementing a project for which such assistance is provided shall agree that the project will comply with the requirements of this paragraph while using such commodities or receiving such services.

(9) (i) The recipient shall notify USAID when it learns about an alleged violation in a project of the requirements of subparagraphs (3), (4), (5) or (7) of this paragraph; (ii) The recipient shall investigate and take appropriate corrective action, if necessary, when it learns about an alleged violation in a project of subparagraph (6) of this paragraph and shall notify USAID about violations in a project affecting a number of people over a period of time that indicate there is a systemic problem in the project; (iii) The recipient shall provide USAID such additional information about violations as USAID may request.

c. Additional Requirements for Voluntary Sterilization Programs

(1) None of the funds made available under this award shall be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any individual to practice sterilization.

(2) The recipient shall ensure that any surgical sterilization procedures supported in whole or in part by funds from this award are performed only after the individual has voluntarily appeared at the treatment facility and has given informed consent to the sterilization procedure. Informed consent means the voluntary, knowing assent from the individual after being advised of the surgical procedures to be followed, the attendant discomforts and risks, the benefits to be expected, the availability of alternative methods of family planning, the purpose of the operation and its irreversibility, and the option to withdraw consent at any time prior to the operation. An individual's consent is considered voluntary if it is based upon the exercise of free choice and is not obtained by any special inducement or any element of force, fraud, deceit, duress, or other forms of coercion or misrepresentation.

(3) Further, the recipient shall document the patient's informed consent by (i) a written consent document in a language the patient understands and speaks, which explains the basic elements of informed consent, as set out above, and which is signed by the individual and by the attending physician or by the authorized assistant of the attending physician; or (ii) when a patient is unable to read adequately a written certification by the attending physician or by the authorized assistant of the attending physician that the basic elements of informed consent above were orally presented to the patient, and that the patient thereafter consented to the performance of the operation. The receipt of this oral explanation shall be acknowledged by the patient's mark on the certification and by the signature or mark of a witness who shall speak the same language as the patient.

(4) The recipient must retain copies of informed consent forms and certification documents for each voluntary sterilization procedure for a period of three years after performance of the sterilization procedure.

d. Prohibition on Abortion-Related Activities:

(1) No funds made available under this award will be used to finance, support, or be attributed to the following activities: (i) procurement or distribution of equipment intended to be used for the purpose of inducing abortions as a method of family planning; (ii) special fees or incentives to any person to coerce or motivate them to have abortions; (iii) payments to persons to perform abortions or to solicit persons to undergo abortions; (iv) information, education, training, or communication programs that seek to promote abortion as a method of family planning; and (v) lobbying for or against abortion. The term "motivate", as it relates to family planning assistance, shall not be construed to prohibit the provision, consistent with local law, of information or counseling about all pregnancy options.

(2) No funds made available under this award will be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilizations as a means of family planning. Epidemiologic or descriptive research to assess the incidence, extent or consequences of abortions is not precluded.

e. The recipient shall insert this provision in all subsequent subagreements and contracts involving family planning or population activities that will be supported in whole or in part from funds under this award. The term subagreement means subgrants and subcooperative agreements.

Annex C: Partner Level Checklist for Implementation of ICV Policy Requirements

Name of Organization:: _____

Name of Respondent:: _____

Position in the Organization: _____

Date: _____

A. Project Partner Awareness of Family Planning Policy Requirements

1. Project partner personnel have attended an orientation on the ICV Policy Requirements from any USAID supported project?

Yes No

2. Is the project partner aware of any member/ /beneficiary/partner within the project that:

a. Requires or subjects family planning service providers and/or referral agents to meet predetermined quota or target on numbers of births, family planning acceptors, or acceptors of a particular family planning method?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Provides incentives to individuals in exchange for becoming acceptors or to program personnel for achieving targets or quotas for numbers of births, family planning acceptors, or acceptors of a particular family planning method?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Withholds rights or benefits of employees or patients or clients who decide not to become family planning acceptors?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Provides experimental family planning methods in the context of a scientific study in which participants are advised of potential risks and benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If response is “**YES**” to any of the above, kindly provide details (please include name of provider, brief description, and action taken by project partner):

B. Activities for Implementing ICV Policy Requirements

1. What activities have the project partner undertaken to ensure compliance of its staff, member firms, family planning service providers, or other partners?

Sub-agreements/memorandum of understanding with participating firms or grantee-partners include provisions for meeting ICV Policy Requirements. Letter of commitment.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Orientation of participating firms/partners on ICV policy requirements conducted	<input type="checkbox"/> Yes <input type="checkbox"/> No
Monitoring visits to assess grantee-partners/providers' compliance to policy requirements conducted	<input type="checkbox"/> Yes <input type="checkbox"/> No
Personnel designated to monitor and evaluate firm level provider's compliance to the family planning ICV policy requirements	<input type="checkbox"/> Yes <input type="checkbox"/> No
Poster containing information on all methods as well as information on health benefits, risks of method chosen, inadvisability, and adverse side effects disseminated and posted in clinics	<input type="checkbox"/> Yes <input type="checkbox"/> No
Facilitated the orientation or training of its partners or members' firms' service providers (doctors/nurses/midwives), etc. in family planning counseling	<input type="checkbox"/> Yes <input type="checkbox"/> No

2. The project partner is aware that their partners' project management teams at the mid-level managers, as well as service providers are required to report any alleged possible violation of the restrictions on quotas, incentives, withholding benefits or experimental activities.

Yes No

3. Has the grantee developed or have access to tools for monitoring and evaluating its member firms or grantee-partners' compliance to the family planning ICV Policy Requirements?

Yes No

4. Are there procedures in place to report possible violations to the project?

Yes No

Date Accomplished: _____

Signature: _____

Annex D: Commitment to Compliance with ICV Policy Requirements

I, _____, _____, as a legally authorized representative
(Printed Name) (Title)
of _____ do hereby certify that, to the best of my knowledge and
(Organization Name)

belief, this organization's management and the employees responsible for project implementation are aware of the policy requirements placed on the organization by [...name of project...] in relation to the following informed choice and voluntarism (ICV) policy requirements:

1. No targets or quotas shall be imposed on individual family planning service providers or referral agents
2. No incentives shall be provided to family planning providers and family planning clients in exchange for accepting family planning methods.
3. No denial of rights or benefits shall be imposed on those who do not accept family planning methods
4. Comprehensible information shall be provided to family planning clients on the family planning method they have chosen
5. Experimental family planning methods shall be used only in the context of a scientific study and with full disclosure of information to the family planning clients
6. Informed consent shall be documented prior to procedures for those choosing sterilization services
7. Ready access to other (temporary) methods shall be ensured for those who choose sterilization services
8. No incentive payments shall be provided to clients for undergoing sterilization services and for family planning personnel for doing the procedure
9. To ensure informed choice, a broad range of methods shall be offered to family planning clients directly or indirectly by family planning service providers
10. The project partner shall have no relationship with organizations managing programs of coercive abortion or involuntary sterilization or practices that may be illegal
11. No USAID funds will be used to perform or motivate/coerce people to practice abortions
12. No USAID funds will be used for lobbying for or against abortion
13. No USAID funds will be used for any biomedical research related to abortion
14. The grantee further certifies that they will not perform or actively promote abortion as a method of family planning.

I understand that to ensure compliance to the above mentioned informed choice and voluntarism policy requirements, project partner will accomplish and submit to [...name of project...] the Partner Level Checklist for Implementation ICV Policy Requirements and allow [...name of project...] staff and partners to conduct formal ICV policy compliance monitoring as integrated in the regular project monitoring visits.

I further agree that if, in spite of the efforts to comply with the ICV Policy Requirements, a possible violation occurs at any time anywhere in the project, our organization will extend full cooperation with [...name of project...] in immediately reporting the situation to [...name of project...] and cooperating with any subsequent investigation that may be conducted thereafter.

I declare under penalty of perjury that the foregoing is true and correct.

Signature over printed name

Date of Execution

Annex E: ICV Policy Compliance Information Dissemination Certificate

I, _____, _____, as a legally authorized trainer/facilitator
(Printed Name) (Title)
of _____ do hereby certify that, to the best of my knowledge and
(Organization Name)
ability I have exerted all possible efforts to disseminate accurate and comprehensive information related to the following informed choice and voluntarism policy requirements (ICV) to all my trainees and relevant partners responsible for project implementation:

1. No targets or quotas shall be imposed on individual family planning service providers or referral agents
2. No incentives shall be provided to family planning providers and family planning clients in exchange for accepting family planning methods.
3. No denial of rights or benefits shall be imposed on those who do not accept family planning methods
4. Comprehensive information shall be provided to family planning clients on the family planning method they have chosen
5. Experimental family planning methods shall be used only in the context of a scientific study and with full disclosure of information to the family planning clients
6. Informed consent shall be documented prior to procedures for those choosing sterilization services
7. Ready access to other (temporary) methods shall be ensured for those who choose sterilization services
8. No incentive payments shall be provided to clients for undergoing sterilization services and for family planning personnel for doing the procedure
9. To ensure informed choice, a broad range of methods shall be offered to family planning clients directly or indirectly by family planning service providers
10. The project partner shall have no relationship with organizations managing programs of coercive abortion or involuntary sterilization or practices that may be illegal
11. No USAID funds will be used to perform or motivate/coerce people to practice abortions
12. No USAID funds will be used for lobbying for or against abortion
13. No USAID funds will be used for any biomedical research related to abortion
14. The grantee further certifies that they will not perform or actively promote abortion as a method of family planning.

Furthermore, I understand that the trainees or participants are not just expected to be aware of these policy requirements but, more importantly, to comply with all of them as well. In order to ensure compliance, I have coordinated with the responsible organization regarding their responsibility to proactively and deliberately inform and monitor their trainees, staff and all project partners whenever and wherever the need arises.

I further agree that if, in spite of the efforts to inform and comply with the ICV policy requirements, a possible violation occurs at any time anywhere in the project, I will extend full cooperation to [...name of project...] by immediately reporting the situation to [...name of project...] and cooperating with any subsequent investigation that may be conducted thereafter.

I declare under penalty of perjury that the foregoing is true and correct.

Signature over printed name

Date of Execution

Annex F: Informed Choice and Voluntarism as a Quality Issue in FP-MCH (PowerPoint)



NOTE: This orientation slides were prepared by the ICV Inter CA TWG headed by PRISM II, HealthGov, and SHIELD

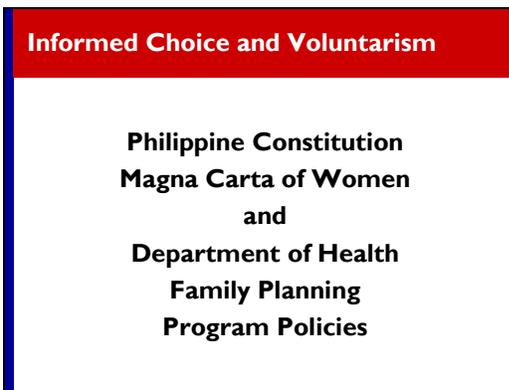


Greetings

The Family Planning Program is special in a sense because, unlike the other health programs that refer to their so-called customers as "patients", FP customers are called "clients" NOT "patients".

Because they are NOT sick to begin with, it is very important in FP program implementation and in the provision of its services that due diligence is given to ensuring that Quality of Care is provided or observed.

In the Philippines, the constitution and DOH have placed provisions and policies in order to ensure quality of care in FP programs.



What are the provisions in the Philippine constitution that are relevant to the Philippine Family Planning Program?

Also, what policies have been put in place by the DOH to ensure quality of care in the provision of FP?

1987 Constitution

Art. II, Sec. 12:
The state recognizes the sanctity of family life and shall protect and strengthen the family as a basic autonomous social institution. It shall equally protect the life of the mother and the life of the unborn from conception.

Family Planning supports this provision of the constitution in that by protecting the health and welfare of the mother and child, FP in fact saves their lives and strengthens the family as a basic unit of society.

The last statement of this article refers to ABORTION as being illegal in the country. FP has always been consistent with this article – abortion was never a method of FP in the country.

1987 Constitution

Art. XV, Sec. 1:
The state recognizes the family as a foundation of the nations. Accordingly, it shall strengthen its solidarity and actively promote its total development.

By practicing Family Planning, families are given more opportunities to improve not only their health but also their economic status.

Furthermore, the constitution ensures that in strengthening the family, each individual family's religious conviction is respected. This is embodied in the next article.

1987 Constitution

Art. XV, Sec. 3.1:
The state shall defend the right of spouses to found a family in accordance with their religious convictions and the demands of responsible parenthood.

In fact, in order to execute the above provisions of the constitution, Executive Order 119 was issued.

Magna Carta of Women

- Comprehensive women's human rights law
- Seeks to eliminate discrimination against women by recognizing, protecting, fulfilling and promoting the rights of Filipino women



Magna Carta of Women

- Comprehensive health services and health information and education
 - Covering all stages of a woman's life cycle
 - Addresses major causes of women's mortality and morbidity including access to
 - maternal care
 - responsible, ethical, legal, safe, and effective methods of family planning
- Encouraging health lifestyle activities to prevent diseases

Executive Order 119

- Identifies Family Planning as a priority health issue and points out that the DOH shall “formulate plans, programs, standards and techniques, relative to FP in the context of family welfare, provide consultative, training and advisory services to implementing agencies”.

In compliance with this executive order, the DOH has developed their FP Program Policies and Guidelines through its Administrative Order 50-A series of 2001 as follows:

DOH FP Program Policies (DOH AO 50-A s. 2001)

FP services shall be promoted based on the ff. program policies: FP as a:

[..\\..\\DOH\\Administrative Orders\\ao50A-01.pdf](#)

(it is strongly suggested that the presenter read, study and internalize the A.O. 50-A s. 2001 to be totally familiar with the provisions and to come up with illustrations or examples to drive home each point.)

Briefly discuss each of the 7 policy statements as they are described in ao 50-a s.2001 that embodies the DOH FP program policy. Remember to put a positive spin to these presentations emphasizing overall improvement in the general health of mothers, children, eventually communities leading to improved quality of life for individuals and societies/communities.

Low Levels of Contraceptive Use Threaten Filipino Women's Health and Undermine their Childbearing Desires.

1. more than half of the 3.4 million annual pregnancies are unintended,

- with 92 percent occurring to women who do not use any contraceptive method or use a traditional one

2. "expanding access to contraception could result in

- a.** 800,000 fewer unplanned births,
- b.** 500,000 fewer induced abortions
- c.** 200,000 fewer miscarriages.
- d.** prevention of as many as 2,100 maternal deaths each year—nearly half of all deaths from pregnancy-related causes.

- findings as reported in the Guttmacher Institute News Release. - April 29, 2009. NY, USA.

Briefly discuss each of the 7 policy statements as they are described in ao 50-a s.2001 that embodies the DOH FP program policy.

You may want to share the FF. Findings as reported in the Guttmacher Institute News Release. *Low Levels of Contraceptive Use Threaten Filipino Women's Health and Undermine their Childbearing Desires.* April 29, 2009. NY, USA.

- more than half of the 3.4 million annual pregnancies are unintended,
 - with 92 percent occurring to women who do not use any contraceptive method or use a traditional one
- "expanding access to contraception could result in
 - 800,000 fewer unplanned births,
 - 500,000 fewer induced abortions and
 - 200,000 fewer miscarriages.
 - Prevention of as many as 2,100 maternal deaths each year—nearly half of all deaths from pregnancy-related causes.

DOH FP Program Service Delivery

Program Principles (Four Pillars in FP Program Implementation)

- 1. Respect for the sanctity of life.**
- 2. Respect for human rights.**
- 3. Freedom of choice and voluntary decisions.**
- 4. Respect for the rights of the clients to determine their desired family size.**

How do these program policies translate to service delivery? As a guide to service providers, the DOH came up with the following program principles...

Again, discuss each one briefly as they are described in the A.O.

DOH Memo
June 29, 2006

Re:
Reiterating Compliance with Various Issuances Regarding the Guiding Principles or "Four Pillars" of the Family Planning Program

In memorandum to all regional directors of all the regional health offices or Centers for Health Development nationwide issued June 29, 2006, the DOH reiterated the importance of complying with these four pillars or guiding principles in the implementation of the FP program in the country and providing further explanations by restating the four pillars as follows: .

in the context of these principles,
all FPMCH service providers -
private or public -
MUST provide quality services
by ensuring informed and
voluntary decision-making

Ensuring Informed & Voluntary Decision-Making:

Program Principles (Four Pillars in FP Program Implementation)

- 1. Respect for life**
 - No to abortion; illegal in the Revised Penal Code
- 2. Informed choice**
 - Full information and voluntary decision-making
- 3. Birth spacing**
 - Birth spacing of 3 to 5 years
- 4. Responsible parenthood.**
 - The right to determine family size according to couple's capacity , beliefs, etc.

For example, as far as Respect for Life is concerned...

Respect for life

Not allowed:

- to perform or motivate/ coerce people to practice abortions
- any biomedical research related to abortion

Aside from the fact that the actual performance of abortion is illegal, motivating or coercing women to practice abortions is NOT allowed.

Neither is it allowed to conduct biomedical research related to abortions

In addition, if your NGO or the LGU or other stakeholders are receiving funds from the U.S. government, aside from the above prohibitions, you are also not allowed to use US Government monies to lobby either for or against abortion.

This last provision is not stated in this slide because funds from any other source (other than US Government) may be used for whatever purposes those funds recipients may want to use them – including for lobbying for or against abortion.

Respect for life

Care of post-abortion women is allowed:

Organizations or service providers may and should treat injuries or illnesses caused by abortions – whether spontaneous or induced.

However, the management or treatment of women with injuries or illnesses resulting from abortion – whether induced or spontaneous – is allowed. There should be no discrimination or preferential treatment of women with spontaneous abortion as against those who had their abortions intentionally carried out.

Ensuring Informed & Voluntary Decision-Making:

Program Principles (Four Pillars in FP Program Implementation)

- 1. Respect for life**
 - No to abortion; illegal in the Revised Penal Code
- 2. Informed choice**
 - Full information and voluntary decision-making
- 3. Birth spacing**
 - Birth spacing of 3 to 5 years
- 4. Responsible parenthood.**
 - The right to determine family size according to couple's capacity , beliefs, etc.

Let's now discuss the second pillar – Informed choice

We ensure this by doing good family planning counseling: the objective of which is – client makes the decision and that decision is made based on adequate information...

Informed Choice and Voluntarism

- **effective access to information on a wide variety of family planning choices and services;**
- **accurate information is provided, including the benefits of using family planning and the health benefits and risks of particular methods;**
- **allow people to choose voluntarily and freely whether to use family planning or a specific family planning method;**

Private Sector Mobilization for Family Health - Phase 2 (PRISM 2)

Informed Choice and Voluntarism

- **Counseling is important in ensuring that clients make informed choice**
- **The face-to-face meeting between a client and provider may be the only chance the client has to;**
 - **ask questions,**
 - **express concerns, or**
 - **learn about different methods from someone who is knowledgeable and concerned.**

Private Sector Mobilization for Family Health - Phase 2 (PRISM 2)

Informed Choice and Voluntarism

Freedom to use FP or not to use:

- **Without coercion or constraint**
- **No pressure to use one method over the other**

Private Sector Mobilization for Family Health -
Phase 2 (PRISM 2)

Informed Choice and Voluntarism

Broad range of FP methods and services:

- **are available WHERE and WHEN they are needed**
- **Referrals and linkages are ACTIVE**

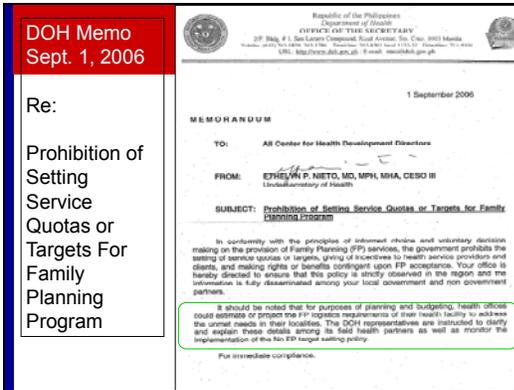
Private Sector Mobilization for Family Health -
Phase 2 (PRISM 2)

Informed choice and voluntary decisions

1. Service providers or referral agents shall not implement or be subject to quotas, or other numerical targets, of total number of births, number of family planning acceptors, or acceptors of a particular FP method

To ensure that there is no coercion in the decision making of FP clients, FP service providers are prohibited from having numerical targets, quotas on number of births, number of FP acceptors or methods.

The DOH through a memorandum issued last September 2006 reiterated this prohibition of setting targets and quotas



It should be noted that targets and quotas for FP programs per se is actually allowed for as long as these targets are not passed on as targets or quotas assigned to or required of individual FP service providers. Targets for programming and budgeting purposes are actually allowed but these numbers should not be passed on to individual health workers or referral agents as assigned or required target numbers or quotas.

Let us further define these terms...

No targets or quotas

- Service providers or referral agents shall not implement or be subject to quotas, or other numerical targets, of total number of births, number of family planning acceptors, or acceptors of a particular FP method
- Permits numerical estimates for planning and budgeting
- Manufacturer, distributor, retailer overall sales targets permitted

This guideline states that: “service providers or referral agents in the project shall not implement or be subject to quotas, or other numerical targets, of total number of births, number of family planning acceptors, or acceptors of a particular method of family planning (this provision shall not be construed to include the use of quantitative estimates or indicators for budgeting and planning purposes)...”

“Target” is a word that is often loosely used in family planning and other public health programs.

Targets that are not allowed under this provision are those that are:

- (1) predetermined;
- (2) assigned to a specific health worker and
- (3) enforced, or of consequence.

For example, if a fieldworker develops monthly targets for herself based on door to door surveys in which she asks about women’s desire to have more children and she is not required to meet those targets, these are not “targets” that are prohibited.

On the other hand, “production” targets -- defined in terms of predetermined numbers of birth or family planning acceptors, which are assigned to a fieldworker and which the fieldworker is required to achieve -- are prohibited.

Assigning of targets to a mid-level health program manager or supervisor would also be considered problematic or a possible source of vulnerability because these supervisors

are quite likely to pass on their targets to the individual field workers.

Sales targets are considered standard practice and are, thus, not prohibited.

Developing targets for planning purposes, e.g. to influence resource allocation, is not a problem. However, provider-level targets, which are assigned and required, are prohibited.

Clarification

Quota or target = a predetermined number of births, FP acceptors or acceptors of a certain FP method that a service provider or referral agent is required to achieve

The following case studies will serve to illustrate and provide us with a better understanding of these guidelines.

Case Studies: Targets and Quotas

- 1) Case # 1: A private midwife's business plan states that for her to break even, she needs to have at least 10 deliveries and 10 IUD insertions in her clinic a month.
- 2) Case # 2: When the midwife-owner of the clinic discovers that her employed midwife failed to insert the required 5 IUD insertions per month, she deducts 10% from her salary.

EXAMPLES FOR THE PRIVATE SECTOR:

- 1) A private midwife's business plan states that for her to break even, she needs to have at least 10 deliveries and 10 IUD insertions in her clinic a month.

While there seems to be target setting here, this does not constitute a violation since these targets are part of the clinic's business plan. The monitor however must make sure that these are NOT pre-determined numbers of births, or FP acceptors, or of FP acceptors of a particular method, that are passed on as quotas or target accomplishments to individual midwives or volunteer health workers as basis for their salaries or performance ratings, or rewards, benefits, this is not a violation.

- 2) When the midwife-owner of the clinic discovers that her employed midwife failed to insert the required 5 IUD insertions per month, she deducts 10% from her salary.

This is quite clearly a violation of the FP policy against setting pre-determined targets that individual service providers will be required to achieve.

Case Studies: Targets and Quotas

- 3) Case # 3: Community health workers have annual workload projections for family planning clients, based on community needs assessments.
- 4) Case # 4: Outreach workers are scolded, salary is withheld, or they may be transferred to other sites when they do not achieve their workload projections.

EXAMPLES FOR THE PUBLIC SECTOR:

1) *Community health workers have annual workload projections for family planning clients, based on community needs assessments.*

In some countries, community needs assessments are used to help field workers learn the needs for reproductive, maternal, and child health services as defined by the clients themselves. The field worker then estimates what proportion of the demand can be met during the year, in order to plan for supplies and other requirements. This is not a violation, **unless there are consequences for individual health workers for achieving (or not) the workload projected** (see Case study #2).

In order to confirm whether “annual workload projections” are violations or not, one needs to review the process by which these numbers are derived (e.g. whether they are “predetermined” by managers), whether they are assigned to individual workers as performance goals, and what happens if the numbers are not achieved.

2) *Outreach workers are scolded, salary is withheld, or they may be transferred to other sites when they do not achieve their workload projections.*

If a health worker could prove that he or she was punished in some way for not achieving workload projections, then these projections would be functioning as “quotas” and this could be a violation. However, finding and addressing the cause for poor performance (of a site or an individual) is a routine part of supervision. An effective supervisory system would document whatever steps were taken to determine why workload projections were not met. An investigation of this situation would include tracking the communication of job expectations between the supervisor and the workers, to confirm whether “predetermined” numbers were being used to measure job performance, and whether the action taken in regards to the worker reflected qualitative as well as quantitative measures of performance.

Informed choice and voluntary decisions

1. Service providers or referral agents shall not implement or be subject to quotas, or other numerical targets, of total number of births, number of family planning acceptors, or acceptors of a particular FP method
2. No payment of incentives, bribes, gratuities or financial reward to:
 - a. An individual in exchange for becoming a FP acceptor; or,
 - b. program personnel for achieving a numerical target or quota of total number of births, number of FP acceptors, or acceptors of a particular FP method

READ THE CONTENTS OF THE SLIDE

The second provision under the freedom of choice and voluntary decision-making is the prohibition of providing incentives to FP clients or to service providers.

“Incentives, bribes, gratuities, or financial reward” are defined to require the transfer of an item of value in order to influence a specific behavior (e.g. acceptance of a family planning method, or recruiting clients to achieve targets).

The policy requirements prohibit the payment of “incentives” to individuals for becoming acceptors. In order to qualify as an “incentive”, such payments must be a material or significant factor in the client’s decision to become an FP acceptor. *Reasonable reimbursement for medicine, food, medical supplies, or transportation expenses paid by the client are not considered incentives.*

Clarification

Provider payments violate the provision only when payment is based on a quota or target set as a predetermined number of **total births**, or number of **FP acceptors**, or, number of **acceptors of a particular FP method**.

With respect to program personnel, a violation occurs only if the clinic makes a payment or reward to an individual worker for achieving a numerical quota or target, expressed as a “predetermined number” of FP acceptors, acceptors of a particular method of FP, or total number of births.

Clarification

Provider payments violate the provision only when payment is based on a quota or target set as a predetermined number of total births, or number of FP acceptors, or, number of acceptors of a particular FP method.

Permitted:

- Small-value items given to all providers not connected to a target; or as reward for general overall good work;
- Per case payment to all providers
- Standard commercial discounts in social marketing programs

The following would be permitted:

- Fee for service payments to family planning providers
- Non-financial, small-value items that are provided across the board to project personnel or to individuals to acknowledge general good performance
- Distribution of promotional items, e.g. social marketing materials

Case Studies: Incentives for Clients and/or Providers

- 5) Case #5: The best “performing” health centers in a program receive supplies and/or equipment as rewards, based on health indicators including family planning acceptance.

5) *The best “performing” health centers in a program receive supplies and/or equipment as rewards, based on health indicators including family planning acceptance.*

The FP Policy Requirement applies to incentives or rewards being given to “program personnel for achieving a numerical target or quota” only the following three items: on total number of births, number of FP acceptors or number of acceptors of a particular method. Such “personnel” are not limited to providers or outreach workers, but can also include program managers. When a health center as an institution is **rewarded for the performance of its staff overall**, the rewards are presumably **not given to individual staff**, and it would not be a violation.

However, it would still be **wise to determine if the group performance goals are in any way translated into targets or quotas for individual staff members**, and if clients perceive any pressure in their decision-making that can be linked to providers wanting to meet **performance targets** in order to receive the rewards for the institution.

Informed choice and voluntary decisions

1. Service providers or referral agents shall not implement or be subject to quotas, or other numerical targets, of total number of births, number of family planning acceptors, or acceptors of a particular FP method
2. No payment of incentives, bribes, gratuities or financial reward to:
 - a. An individual in exchange for becoming a FP acceptor; or,
 - b. program personnel for achieving a numerical target or quota of total number of births, number of FP acceptors, or acceptors of a particular FP method
3. No denial of rights and benefits for those who do not accept FP

Third item under freedom of choice and voluntary decisions involves the denial of rights and benefits to those NOT accepting FP

No Denial of Rights or Benefits Based on Decision not to Accept FP

Examples:

- Food assistance or health benefits not dependent upon accepting FP services
- Employment positions or privileges not limited to FP users

FP projects shall not deny any right or benefit, including the right of access to participate in any program of general welfare or the right of access to health care, as a consequence of any individual's decision **not to accept** family planning services..."

FP Policy requirements prohibits the tying of rights or benefits, including legal privileges and powers, to the decision to accept a method of family planning, or not. Examples of violations would include denying access to health care, access of food programs, or employment to those people who do not accept family planning.

The service delivery site project is usually considered as the "actor" in this denial of benefits. An example of a violation is a threat of the denial of free health services to a client unless she agreed to be sterilized.

Also, service delivery programs may express strong preferences for fieldworkers who are currently using contraception or have small families. Such conditions can be *encouraged* in job applicants, but they cannot be *required*.

Case Studies: Denial of Rights or Benefits

- 6) Case # 6: Government jobs are limited to those who have no more than two children.
- 7) Case # 7: Community-based distribution (CBD) workers must be family planning acceptors themselves.

6) *Government jobs are limited to those who have no more than two children.*

The “denial of benefits” relates to consequences of not accepting family planning. But having a small family is not the same as being a family planning acceptor, so there’s no direct connection between this situation and the policy of informed choice. However, the impact of this policy on decision-making by couples should be considered, to see what effect it may have on informed choice and whether it reflects positively or negatively on family planning services in general (e.g., that they are seen as being driven by the government’s needs and priorities and not reflecting the needs and concerns of individuals).

7) *Community-based distribution (CBD) workers must be family planning acceptors themselves.*

By definition, the CBD workers would be part of a “service delivery project”. Selection criteria that strictly require that CBD workers **must use family planning themselves would constitute a violation** of the policies that “the project shall not deny any right or benefit...as a consequence of any individual’s decision not to accept family planning services”. However, it is generally true that the majority of CBD workers use family planning and that they feel that their credibility is strengthened as a result. Therefore, the wording of selection criteria for CBD workers should refer to “family planning acceptors *preferred*” or “family planning users *encouraged to apply*”.

Informed choice and voluntary decisions

- 4. Comprehensible information on chosen FP method

The policy guideline provides that FP projects **MUST** provide family planning acceptors comprehensible information on the health benefits and risks of the method **chosen**, including those conditions that might render the use of the method inadvisable and those adverse side effects known to be consequent to the use of the method...

Comprehensible Information

Clients must receive comprehensible information about risks, benefits, side effects, and contraindications of their chosen method

Clients choosing a particular FP method must be provided all pertinent information regarding the method they have chosen in a language that they can understand – this information includes what the method is, how it works, advantages, disadvantage, possible side-effects, how to use the method, where to get it, what warning signs to watch out for and what to do if these occur and other information.

Clarification

- “Comprehensible” does not guarantee information is comprehended
- Information should be provided in accordance with local standards
- Requirements can be met through counseling, posters, and/or package inserts

One of the ways that service providers can at least demonstrate efforts to ensure informed choice in FP is by making available conspicuously displayed wall charts containing the different FP methods.



The poster on the left is the currently available poster – **this should be prominently displayed in all clinics that provide FP services.** The poster at the right side of this slide is the latest version that is currently still being ordered.

The latest version is now available in Tagalog and Cebuano dialects

Informed choice and voluntary decisions

4. Comprehensible information on chosen FP methods
5. Full disclosure for experimental contraceptive methods and procedures

Although it probably is not applicable, it would be good to be reminded that full disclosure of information is needed for experimental contraceptive methods – currently there is no such experimental study going on in the country.

(5) Full Disclosure for Experimental Contraceptive Methods

- Experimental FP methods and procedures to be provided only in the context of a scientific study
- Client's rights to informed consent to participate in the study, including the knowledge of the risks and benefits, as well as other options for services, must be ensured

This provision is not relevant since there are no experimental studies going on with FP methods in the country.

Suffice it to say that experimental contraceptive drugs and devices and medical procedures are allowed only in the context of a scientific study in which participants are advised of potential risks and benefits.

Informed choice and voluntary decisions

4. Comprehensible information on chosen FP methods
5. Full disclosure for experimental contraceptive methods and procedures
6. Informed consent documented prior to permanent methods: BTL or vasectomy

For clients choosing permanent methods, in order to ensure informed choice, the informed consent forms are explained and signed by the clients prior to performance of the procedure.

The next slide will show the contents of the informed consent form

Informed Consent for VS

Key requirements

- Informed consent documented prior to procedure
- Ready access to other FP methods
- No incentive payments

The ultimate responsibility of securing documentation of the informed consent – meaning, getting the Voluntary Sterilization (VS) clients to sign the informed consent forms – falls on the shoulders of the FP counselor or operating room nurse assisting in the procedure at the VS site or venue. However, all trained FP counselors and service providers are expected to explain the contents of the informed consent forms to all potential VS clients before the actual day of the VS procedures. This is part of a normal FP counseling session for client who chooses VS.

Included in the informed consent form is the assurance that the VS clients were made aware of and were provided easy access to temporary methods that they can choose from either through direct provision or by referrals.

Again, VS clients must not be subjected to incentive payments that will influence their decision to accept VS as their FP method.

Guidance on payments

- Payments cannot be used as an incentive to accept, provide, or refer for VS services.
- Certain types of payments are not considered incentives provided they are “reasonable” and related to the procedure.
- Determination of “reasonable” payment must be based on country and program-specific basis using knowledge of social and economic circumstances.

Guidance on payments

Acceptors:

Recompense for legitimate, extra VS-related expenses (transport, food, medicine, lost wages during recovery period) are not generally considered incentives if “reasonable” and related to the procedure.

Guidance on payments

VS Providers:

per-case payments, and compensation for related items, are acceptable provided they are “reasonable” so that no financial incentive to do VS is created

Guidance on payments

Referral agents:

Payments for extra expenses incurred in informing or referring VS clients are acceptable provided that they are “reasonable” and related to the procedure.

Case Studies: Incentives for Clients and/or Providers

- 8) Case # 8: Sterilization clients receive money, food, and/or clothing after completing the sterilization procedure.
- 9) Case # 9: Government employees get a pay increase if they provide documentation of sterilization after the birth of the second child.

8) *Sterilization clients receive money, food, and/or clothing after completing the sterilization procedure.*

The definition of an incentive, bribe, gratuity or financial reward requires the transfer of an item of value, in order to influence or induce specific behavior by clients or program personnel -- that is, an **action** occurred *because of* the payment. In the case of clients, such payments must be a significant factor in the client's decision to become a family planning acceptor, in order for it to be a violation. Money, food, or clothing given to sterilization clients is usually done to reimburse clients for lost wages and/or out-of-pocket expenses, and to remove cost barriers in their voluntary choice of methods, and are not normally considered (by providers) to be significant factors in the client's decision. However, client interviews are needed to confirm whether such reimbursements are *perceived* as incentives and may actually be a factor in their decision-making.

9) *Government employees get a pay increase if they provide documentation of sterilization after the birth of the second child.*

Violation would be possible if this policy of getting a pay increase was in fact being implemented. AS IS, this is a HUGE vulnerability that can easily turn into a violation.

However, if the benefit is not actually provided, then this would not constitute an "incentive" as described by the policies. Still, the impact of this policy on decision-making by couples should be considered, as a factor limiting informed choice, and potentially generating negative public opinion about family planning services in general (i.e., that they are seen as being driven by the government's needs and priorities and not those of individuals).

Case Studies: Incentives for Clients and/or Providers

10) Case # 10: Providers receive per-case payment for sterilization clients.

10) *Providers receive per-case payment for sterilization clients.*

There can be legitimate reasons for being paid more for a greater number of acceptors of a specific FP method (e.g. sterilization) because it requires more work or skill. Thus, providers can make more money by providing more services, **as long as there is no “predetermined number”** that they are required to achieve in order to receive payment.

However, paying providers per “session” (that is, they are paid for showing up and providing services over a given time period) would probably have less risk of putting pressure on individual clients to become acceptors, than paying providers per client.

Informed choice and voluntary decisions

7. FP programs/projects must provide information about and access to a broad range of FP methods and services, either directly or through referral.

Informed Choice (& voluntary decision-making) as a good program strategy

Ensuring informed choice leads to:

- **better method use and client compliance**
- **continued method use**
- **satisfied clients are good ads**

Better method use and client compliance leads to reduction in unplanned pregnancies and improved health

Continued method use results from clients getting the method they want and being prepared for side effects –

This results in more clients that are satisfied with their methods because they get to choose the method that is appropriate for them and are well prepared to handle possible side effects that may or may not come with the use of the method. These satisfied clients will be the best promoters of the use of family planning.

Client-centered communications make a difference!

Research tells us...

- **The interpersonal and informational dimensions of services are key to clients' perception of service quality**
- **Client-oriented communication that tailors information to the individual has positive impact on method adoption, continuation and client satisfaction**

(Abdel-Tawab and Roter, 1996; Koenig, 1997)

Giving people a choice makes a difference

Research tells us...

- **Use of contraception is highest when people have access to a range of contraceptive methods (Ross et al, 2002)**
- **Clients who receive the method they want are more likely to continue use (Pariani, 1991)**

Research also tells us...

- **A major reason clients discontinue pills and injectables is that they are not adequately informed about side effects (EngenderHealth studies in Cambodia 2000 and Nepal 2001)**
- **Conversely, counseling about side effects significantly increases continuation (Lei et al, 1996, FHI Network, 1991)**

Informing clients about what to expect, and what is normal, reduces fear and dissatisfaction, and eases adjustment to proper method use and client satisfaction.

BOTTOMLINE:

Quality Care for Every Client

*Clients' Informed
and
voluntary decision-making*

These are the policies to ensure quality of care for our FP and MCH clients and patients – the bottomline really is quality care for every one...

A significant step towards attaining this quality of care is by complying with these policies and thereby ensure that all clients make voluntary and informed decisions regarding their reproductive plans.

Quality of Care in FP

**Meeting Clients' Rights
and
Providers' Needs**

When we talk about quality of care in Family Planning, what exactly do we mean? What comes to mind when this topic comes up?

get responses and ideas from the participants before providing the answer (by clicking)

These issues can be summarized into two: meeting clients' rights and providers' needs. When we say that we are approaching meeting clients' rights and making sure that providers have what they need to provide good care, then we are approaching delivery of quality services.

To explain further...

Quality of Care in FP

Clients' Rights	Providers' Needs
<ul style="list-style-type: none"> •Information •Access •Choice •Privacy and confidentiality •Safety •Comfort, dignity and free expression •Continuity of care 	<ul style="list-style-type: none"> •Training •Adequate supplies and good working environment •Good management support and supervision

In the provision of FP services, quality of care is defined as meeting clients' rights and providers needs...

More specifically, this means

(You may ask again what participants think are clients' rights and summarize by mentioning them one by one as you click on the items. do the same to elicit providers' needs. be sure to cite at least one example for each item. for your reference, please read in advance **appendix a: "the rights of clients and the needs of health care staff"**)

TRANSITION: Let us focus our attention this morning on at least three items on the clients' rights' list in order to provide the context for discussing compliance with FP policies in service delivery.



Annex G: The Rights of Clients

The Rights of Clients

Information: Clients have a right to accurate, appropriate, understandable, and unambiguous information related to reproductive health and sexuality, and to health overall. Educational materials for clients need to be available in all parts of the health care facility.

Access to services: Services must be affordable, available at times and places convenient to clients, without physical barriers to the health care facility, without inappropriate eligibility requirements for services, and without social barriers, including discrimination based on gender, age, marital status, fertility, nationality or ethnicity, social class, caste or sexual orientation.

Informed choice: A voluntary, well-considered decision that an individual makes on the basis of options, information and understanding. The process is a continuum that begins in the community, where people get information even before coming to a facility for services. It is the provider's responsibility to either confirm, or help the client reach an informed choice.

Safe services: Safe services require skilled providers, attention to infection prevention, and appropriate and effective medical practices. This right also refers to proper use of service delivery guidelines, quality assurance mechanisms within the facility, counseling and instructions for clients, and recognition and management of complications related to medical and surgical procedures.

Privacy and confidentiality: Clients have a right to privacy and confidentiality during delivery of services, for example, during counseling and physical examinations, and in staff's handling of their medical records and other personal information.

Dignity, comfort, and expression of opinion: All clients have the right to be treated with respect and consideration. Providers need to ensure that clients are as comfortable as possible during procedures. Clients should be encouraged to express their views freely, also when their views differ from those of service providers.

Continuity of care: All clients have a right to continuity of services and supplies, follow-up and referral.

The Needs of Health Care Staff

Facilitative supervision and management: Health workers function best in a supportive work environment with facilitative management and supervision that motivate staff and enable them to perform their tasks well and better meet the needs of external clients.

Information, training and development: For a facility to provide quality health services, staff must possess and continuously acquire the knowledge, skills and attitudes needed to provide the best reproductive and overall health services possible.

Supplies, equipment and infrastructure: In order for health workers to provide good services, staff need reliable and sufficient supplies, equipment in working order, and adequate infrastructure.

Annex H: National Family Planning Program Policy (DOH AO 50-A s. 2001)



Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY
San Lazaro Compound, Rizal Avenue
Sta. Cruz, Manila, Philippines
Tel. No. 711-9502/711-9503



September 17, 2001

ADMINISTRATIVE ORDER
No. 50-A s. 2001

SUBJECT: National Family Planning Policy

I. Background/Rationale

The government recognizes the population issue as a priority. As such the government needs to adopt policies that will take into consideration population and reproductive health approaches that respect Filipino culture and values as well as equality between men and women. Moreover, these policies should support the ultimate goal of putting people at the center of development as espoused during the International Conference on Population and Development.

Towards this end, the Department of Health established the Reproductive Health (RH) Program in 1998 with the goal of providing universal access to quality RH services. Family Planning (FP) is one of the critical elements under this program. Furthermore, the DOH has set population development and family planning as priority interventions in its vision of "Health For All" with the end-view of attaining better quality of life for all Filipinos with special focus on the poor.

Under the context of the Reproductive Health Approach, the Philippine Family Planning (FP) Program has been refocused from a demographically driven program to one that promotes FP as a health intervention to promote the health all Filipinos but with special attention to women and children. It aims to yield improvements in health status, attainment of desired fertility and eventually population growth that matches economic growth thereby contributing to sustainable development.

This Order is issued to prescribe the key policies for family planning services as an element of Reproductive Health.

Signed AO
Received in the Records
Section on 10/18/01

Annex I: Pre/post-Test for ICV Orientations and Trainings

This pre/post-test contains a number of case studies. As part of the post-test each case should be discussed in a plenary session.

1. Translating the national target for contraceptive prevalence into numerical targets for individual health service providers is a violation of the DOH Administrative Order on Ensuring Standards in the Delivery of Family Planning Program and Services through Compliance to Informed Choice and Voluntarism.

True False

CORRECT ANSWER: TRUE. The specific guidelines of the DOH AO on ICV, DOH AO 2011-0005 reiterate that “Service providers shall not be subjected to target/quota, or other numerical targets of total number of births, number of family planning acceptors or acceptors of a particular method of family planning that may run contrary to clients’ decision”.

2. The performing LGU in Mainit province wanted to increase its contraceptive prevalence, among other indicators, to facilitate the release of a performance-based grants by DOH. To ensure the increase in contraceptive prevalence, the LGU provided educational assistance to two children of mothers who agreed to under-to bi-tubal ligation. Is this an ICV-violation?

Yes No

CORRECT ANSWER: YES. The specific guidelines of the DOH AO on ICV, DOH AO 2011-0005 reiterate that incentives and financial rewards, gratuities and bribes shall not be provided in exchange of or to influence clients’ decision for becoming an family planning acceptor or for service provider to achieve a target or quota.

3. Our midwife saw that the public health nurse in the city of Ilang-ilang provided each vasectomy client with Ph1,000, 10 kilos of rice, 21 capsules of antibiotics, 10 tablets of pain reliever. She thought that this is a probable ICV vulnerability, but since this happened three months ago, she did not report it to the local ICV monitoring committee. Do you agree with the midwife’s decision?

Yes No

CORRECT ANSWER: NO. The DOH AO mandates to do monitoring and reporting every three months.

4. Since committing an abortion is a criminal offense, the health service provider with whom the client consulted to manage her high fever and vaginal bleeding due to abortion should turn the client away because treating the client will incriminate her and her license is in danger of being revoked. Do you agree?

Yes No

CORRECT ANSWER: NO. It is the client’s right to be provided with the necessary health services.

5. A 28-year old woman, pregnant of her first child, is in labor and suffers from eclampsia (with hypertension, seizure, maybe unconscious). The service provider asks her to sign a consent for bi-tubal ligation, saying that having another pregnancy will endanger her life. Do you agree with the health service provider's action?

Yes No

CORRECT ANSWER: NO. The client is suffering from eclampsia. Therefore, she is not in her proper state of mind to decide whether to undergo ligation or not. The health provider should wait until the client has fully recovered or until such time that she can understand the procedure and its consequences.

6. LGUs must ensure that their maternal health service, product and information provision follow the four pillars (respect for the sanctity of life, respect for human rights, freedom of choice and voluntary decisions or ICV, respects of the rights of clients to determine their desired family size) of the DOH policies on family planning as a quality measurement of their family planning program implementation.

True False

CORRECT ANSWER: TRUE. DOH has been consistent in these principles as explicitly expressed in DOH AO 50-A series of 2001, Memorandum issued on Sept. 1, 2006 to all DOH-ROs and in DOH AO 2011-0005.

7. A 32 year-old mother, who did not finish Grade 1 and has four children consulted the government city hospital of Malinis LGU, together with her husband. The mother does not want to get pregnant anymore and her husband supports her. The nurse-on-duty, thinking that there was no trained doctor on surgical sterilization, told the couple that the hospital could not provide any services of that nature and just sent them home without telling them on where they could get information and services. Do you agree with the nurse's action? Why?

Agree, why? _____

Disagree; what should the nurse have done? _____

CORRECT ANSWER: DISAGREE. The nurse-on-duty is duty bound to refer the couple to other health facilities offering family planning information, product and services. The DOH AO on ICV mandates that private and public health facilities shall provide universal access to quality family planning information and services to men and women whenever and wherever needed and enable them to make informed choice and voluntarism. Further, the DOH AO states that family planning services shall be part of the basic core packages of both public and private health care facilities.

8. The provincial Family Planning Coordinator of Masigla LGU found out that a private hospital conducted a bi-tubal ligation without counselling and without securing an informed consent from the client. The Family Planning Coordinator reported this to the Provincial Health Officer and the Regional ICV compliance committee. She also discussed the AO on ICV with the Medical Director and management of the private hospital. Are private health care facilities also mandated to follow the DOH AO on ICV?

Yes No

CORRECT ANSWER: YES. The DOH AO on ICV “applies to all DOH units and attached agencies such as the Commission on Population and Philippine Health Insurance Corporation, non-government organizations and the private sector.” “Compliance to ICV policy requirements shall cover the operations of both public and private health facilities providing FP services under the local government units and other government agencies in so far as their health service operations are governed by technical guidelines, standards and policies mandate by DOH.”

Annex J: ICV Monitoring Questions for Facility Managers, Supervisors and Providers

My name is _____ and I work for _____ as a _____.
I am here to collect some information about family planning services in this region/province/
municipality. I will ask you some questions about family planning services at this facility. The results of
our discussion and data collection will be used to better understand the current situation in this area
and to identify areas that might be strengthened. We are also interviewing family planning clients to
learn more about their perception of the family planning services they receive. Thank you for your
assistance in helping us better understand the family planning services in this facility.

Do you have any questions?

Name of health facility and address: _____

Date of site visit: _____

USAID project agreement or sub-agreement supporting the site: _____

Type of USAID-supported family planning activity/services conducted:

__ clinical __ education __ other (specify): _____

Person contacted and title: _____

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

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

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

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

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

3. Benefits and Incentives:

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

4. Comprehensive Information:
 - What information do you provide to clients interested in family planning? Do you provide specific information for family planning methods chosen? If so, what?
 - Do you have materials (wall chart, brochure, flipchart etc.) that explain the various family planning methods and their risks and benefits?
5. Have clients ever asked you advice about abortion? If so, what do you do?
6. Have clients ever asked you about regulation of menstruation? If so, what do you do?
7. Sterilization Services:
 - What kind of information do you provide to clients interested in bitubal ligation or vasectomy?
 - Do you ask the client to sign an informed consent form before any surgical sterilization procedure? If so, do you keep client record of informed consent?
 - Are any benefits (food, money etc.) provided to clients who choose to undergo surgical sterilization?

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

[Provide interviewee contact information]

Annex K: ICV Monitoring Questions for Clients

My name is _____ and I work for _____ as a _____.
I am here to collect some information about family planning services in this region/province/municipality. I will ask you some questions about family planning services at this facility. The results of our discussion and data collection will be used to better understand the current situation in this area and to identify areas that might be strengthened. We are also interviewing family planning clients to learn more about their perception of the family planning services they receive. Thank you for your assistance in helping us better understand the family planning services in this facility.

Do you have any questions?

Name of health facility and address: _____

Date of site visit: _____

USAID project agreement or sub-agreement supporting the site: _____

Type of USAID-supported family planning activity/services conducted:

clinical education other (specify): _____

Name of person interviewed: _____

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

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

[Provide interviewee contact information]

Annex M: Narrative Report of Vulnerability or Possible Violation of Family Planning Policies

Date of monitoring: _____

Name of facility: _____

Address of facility: _____

Reported by: _____

Witnessed by: _____

Complete name(s) of service providers or source of information: _____

Nature of the incident/possible violation:

Specific ICV policy possibly violated:

Evidence/result or outcome of the possible violation committed, if any:

Action taken by reporter/eyewitness:

Printed name and signature of eyewitness or reporter:

Noted by (signature of) the reporter's immediate superior:

Annex N: Conducting an ICV Monitoring Practicum

At least 2 to 4 weeks prior to the actual training, the organizers should choose and prepare the practicum sites. The practicum sites shall be varied as follows:

- a. Public or private hospital
- b. Public or private birthing home
- c. Population program office
- d. Rural or city health unit

The organizers will need to write to the heads of these health care facilities, mentioning the objectives of the practicum visit, points for discussion, and the data that the participants may look at.

The following matrix will help the organizer in prepping for the practicum. It contains the sample matrix of practicum sites.

Practicum Site	Classification	Address	Contact Person	Facilitator

Practicum guide

Participants should be briefed on the practicum on the day prior to the actual site visit. Herewith is a sample practicum guide.

1. Each group shall identify a group leader.
2. Before leaving for the site:
 - a. call or text the point person of the practicum site to inform them that you are coming
 - b. check the information materials to bring for the practicum site, if there are to be brought
3. Upon arrival at the facility, the facilitator, together with the group, shall pay a courtesy call to the contact person whose name is indicated in the practicum site list.
4. The facilitator shall:
 - a. introduce the group to the contact person and other health center staff present
 - b. inform them regarding the purpose of the field visit and
 - c. inform them that the group shall interview a service provider and an family planning client, if possible;
 - d. inform them that the group shall take a look at the facility's record on family planning.
5. After the introduction and courtesy call, the group shall start to interview the service providers and clients:
 - a. If there are enough service providers and clients for each of the group members then they shall work individually.
 - b. But if the facility does not have enough service providers, they may work in pairs.

- c. If at the time of the visit there is only one service provider and one family planning client, the group members shall divide themselves into two. One group shall interview the health provider and the other group shall interview the family planning client.
 - d. Assign somebody from the group to look at the data of the facility on family planning.
6. The interviewer should:
 - a. introduce her/himself and state the purpose of the interview
 - b. always be respectful and courteous
 - c. always deliver the questions in a manner that the interviewee will understand.
7. After the interview, thank the respondent for their participation and cooperation.
8. If the interviewees have questions, and none of the group members are sure of the answer, kindly discuss the question and the answer with the facilitator.
9. Once all members of the team have completed their respective service provider and client interviews, the group leader shall return to the contact person and thank her/him for welcoming the group into the facility and for the cooperation given.
10. If possible, the group leader will:
 - a. feedback very briefly the highlights of the interview results (both client and service provider interview results) to the contact person.
 - b. commend the contact person on the good practices observed by the group.
 - c. gently point out if there are things that need to be improved (e.g. the family planning wall chart is not properly posted in its appropriate location, or it cannot be seen by clients because it is hidden behind a door, etc.)
 - d. gently recommend steps to stop a particular practice that is considered to be not ICV compliant (e.g., on comprehensive information: if a client said that the counseling on injectables did not include information on side effects.)

Annex O: Guidance for Conducting an ICV Monitoring Planning Workshop

The following are sample guide questions

- a. Kindly look at each of the guidelines of the DOH AO on ICV [and environmental mitigation];
- b. Identify the gaps related to each guideline/parameter in your area of assignment;
- c. Write each gap in one metacard;
- d. Identify interventions in response to the gaps you have written,
- e. Identify your indicative time frame, responsible unit, and corresponding budget

The following is the planning matrix that can participants can fill up during the workshop:

DOH Guidelines	Gaps	Strategy	Activity	Time Frame	Person or unit responsible	Budget requirement
ICV						
ICV						
ICV						
Health care waste management						

Annex P: Joint DENR and DOH AO 02, series of 2005

REPUBLIC OF THE PHILIPPINES
DEPARTMENT OF ENVIRONMENT AND NATURAL RESOURCES
DEPARTMENT OF HEALTH

JOINT DENR-DOH
ADMINISTRATIVE ORDER NO. 02
Series of 2005

AUG 24 2005

SUBJECT : Policies and Guidelines on effective and proper handling, collection, transport, treatment, storage and disposal of health care wastes.

I. RATIONALE

The Department of Environment and Natural Resources (DENR) and the Department of Health (DOH) hereby jointly provide the following guidelines on the management of health care wastes pursuant to, among others, the following laws, rules and regulations:

- Clean Air Act of 1999 (Republic Act 8749);
- Toxic Substances, Hazardous Waste, and Nuclear Waste Control Act of 1990 (Republic Act 6969);
- Ecological Solid Waste Management Act of 2000 [Republic Act 9003]
- Refuse Disposal of the Sanitation Code of the Philippines [Chapter XVIII, Implementing Rules and Regulations, Presidential Decree 856];
- Clean Water Act of 2004 [Republic Act 9275];
- Environmental Impact Statement (EIS) System (Presidential Decree 1586);
- Hospital Licensure Act [Republic Act 4226]

II. OBJECTIVES

- A. To provide guidelines to generators, transporters and owners or operators of treatment, storage, disposal (TSD) facilities of health care waste on the proper handling, collection, transport, treatment, storage and disposal thereof;
- B. To clarify the jurisdiction, authority and responsibilities of the DENR and DOH with regard to health care waste management; and
- C. To harmonize efforts of the DENR and DOH on proper health care waste management.

III. SCOPE AND COVERAGE

These policies and guidelines shall apply to health care waste generators, transporters and owners or operators of TSD and final disposal facilities.

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IV. DEFINITION OF TERMS

A. **Health Care Wastes** - include all wastes generated as a result of the following:

1. Diagnosis, treatment, management and immunization of humans or animals;
2. Research pertaining to the above activities;
3. Producing or testing of biological products; and
4. Waste originating from minor or scattered sources (i.e. dental clinics, alternative medicine clinics, etc.)

The categories of health care wastes are enumerated in Annex "A".

B. **Health Care Waste Generators** - include health care facilities, institutions, business establishments and other similar health care services with activities or work processes that generate health care waste.

1. Hospitals (Primary Care, Secondary Care and Tertiary Care)
2. Infirmaries
3. Birthing homes
4. Clinics

- | | |
|--|--------------------------|
| [a] Medical | [e] Surgical |
| [b] Ambulatory | [f] Alternative medicine |
| [c] Dialysis | [g] Dental |
| [d] Health care centers and dispensaries | [h] Veterinary |

5. Laboratories and Research Centers

- | | |
|---|-----------------------------------|
| [a] Medical and biomedical laboratories | [e] Nuclear medicine laboratories |
| [b] Medical research centers | [f] Biotechnology laboratories |
| [c] Blood banks and blood collection services | [g] Animal research and testing |
| [d] Dental prosthetic laboratories | [h] Drug testing laboratories |
| | [i] HIV testing laboratories |

6. Drug Manufacturers

7. Institutions

- | | |
|--------------------------------------|--------------------------------------|
| [a] Drug rehabilitation center | [d] Schools of Radiologic Technology |
| [b] Training centers for embalmers | [e] Medical Schools |
| [c] Med-tech intern training centers | [f] Nursing Homes |
| | [g] Dental Schools |

8. Mortuary and Autopsy Centers

C. Health Care Waste Transporter - a person licensed by the DENR Environmental Management Bureau to convey health care waste through air, water or land.

D. Treatment, Storage and Disposal (TSD) Facilities - facilities where hazardous wastes are stored, treated, recycled, reprocessed and/or disposed of, as prescribed under DENR AO No. 2004-36, Chapter 6-2 (Categories of TSD Facilities).

V. RESPONSIBILITIES OF IMPLEMENTING & COOPERATING AGENCIES

This Joint Administrative Order shall be implemented by the DENR through the Environmental Management Bureau (EMB) and its Regional Offices, the National Solid Waste Management Commission (NSWMC), and by the DOH through its Centers for Health Development (CHD), Bureau of Health Facilities and Services (BHFS), Bureau of Health Devices and Technology (BHDT), Environmental and Occupational Health Office (EOHO) of the National Center for Disease Prevention and Control (NCDPC), the National Center for Health Facility Development (NCHFD), and the National Reference Laboratory (NRL)-East Avenue Medical Center, Quezon City.

A. The DENR-EMB shall:

1. Be the primary government agency responsible for implementing pertinent rules and regulations on the management of health care waste in the Philippines, particularly concerning the issuance of necessary permits and clearances for the Transport, Treatment, Storage, and Disposal of such wastes, as governed by RA 6969, RA 8749, RA 9275, RA 9003 and PD 1586;
2. Formulate policies, standards, and guidelines on the transport, treatment, storage, and disposal of health care wastes.
3. Oversee compliance by generators, transporters, TSD facility operators, and/or final disposal facility operators with the proper transport, treatment, storage, and disposal of health care wastes;
4. Conduct regular sampling and monitoring of wastewater in health care and TSD facilities to determine compliance with the provisions of RA 9275;
5. Require TSD facility operators and on-site treaters to present to the DENR copies of the results of microbiological tests on the health care waste treated using autoclave, microwave, hydroclave and other disinfection facilities prior to the renewal of their Permits under RA 6969;
6. Provide technical assistance and support to the advocacy programs on health care waste management; and
7. Notify DOH on cases of non-compliance or notice of violation issued to health care facilities, institutions and establishments licensed by the DOH.

B. The DOH shall:

1. Regulate all hospitals and other health facilities through licensure and accreditation under the Hospital Licensure Act (Republic Act No. 4226);
2. Formulate policies, standards, guidelines, systems and procedures on the management of health care waste;
3. Develop training programs and corresponding modules on health care waste management;
4. Provide technical assistance in the preparation of health care waste management plan as a requirement for licensing or the renewal thereof;
5. Provide technical assistance to ensure an effective and efficient implementation of health care waste management program;
6. Require all health care waste TSD facility operators and health care waste generators with on-site waste treatment facilities to use DOH-BHDT registered equipment or devices used for the treatment of health care wastes;
7. Conduct regular performance evaluation of equipment/devices used for the treatment of health care wastes by the DOH-BHDT;
8. Monitor the microbiological test of treated wastes to ensure compliance with DOH standards;
9. Evaluate DOH hospitals' compliance with proper health care waste management program;
10. Issue Department Circulars to ensure that all environmental requirements are complied with; and
11. Notify DENR on actions taken on cases of non-compliance or notice of violation issued to health care facilities, institutions, and business establishments.

C. The DOH-Centers for Health Development shall:

1. Advocate health care waste management [HCWM] practices to the Local Chief Executives, key leaders and other stakeholders;
2. Monitor health care waste management practices in all hospitals and other health care facilities;
3. Provide technical assistance on health care waste management [HCWM] through:
 - a. Training
 - b. Advisory on the preparation of HCWM plans as a requirement for licensing or the renewal thereof
 - c. Dissemination of policies, guidelines and information

- d. Monitoring and validation of the implementation of HCWM
- e. Develop, reproduce, and disseminate HCWM IEC materials
- f. Ensure compliance by health care waste generators with all pertinent laws, rules and regulations on HCWM.

VI. GUIDELINES AND PROCEDURES

A. ENVIRONMENTAL COMPLIANCE REQUIREMENTS

A.1 Documentary Requirements

A.1.1 Health Care Waste Generators

Health care waste generators are required, based on existing laws, rules and regulations, to register and secure the following permits:

A.1.1.1 From the DENR-Environmental Management Bureau

1. **Environmental Compliance Certificate (ECC)** - for the establishment of hospitals, health care facilities covered by the provisions of PD 1586 from the EMB Central Office or its Regional Offices.
2. **Permit to Operate (P/O)** - for Air Pollution Source and Control Installation from the EMB Regional Office.
3. **Discharge Permit** will be issued by the EMB Regional Office and the Laguna Lake Development Authority (LLDA) based on RA 9275 or the Clean Water Act of 2004 (See Annex "B" LLDA Jurisdiction)
4. **Hazardous Waste Generator's Registration** in compliance with the implementing rules and regulations of RA 6969 (DAO 29 series of 1992 and DAO 36 series of 2004) from the EMB Regional Office.

A.1.1.2 From the DOH-Bureau of Health Facilities and Services:

1. **Licenses** for hospitals, laboratories, dialysis clinics, birthing homes, infirmaries, psychiatric hospitals, dental prosthetic laboratories, blood banks, ambulatory clinics, and drug treatment and rehabilitation centers.
2. **Certificate of Accreditation** for Overseas Filipino Workers (OFW) medical clinics, surgical clinics, drug testing laboratories, HIV testing laboratories, water testing laboratories, medical technologist intern training centers and training centers for embalmers.

A.1.2 Health Care Waste Transporters

Health care waste transporters are required, based on existing laws, rules, and regulations, to undertake the following:

1. Register with EMB Central Office as healthcare waste transporter;
2. Secure Transport Permit from the DENR-EMB Regional Office;
3. Comply with the DENR Manifest System; and
4. Comply with other requirements specified in the Implementing Rules and Regulations of RA 6969.

A.1.3 TSD Facilities

Owners or Operators of TSD facilities are required based on existing rules and regulations to secure the following permits and clearances from DENR-EMB and DOH:

1. **Environmental Compliance Certificate (ECC)** for the Sanitary Landfill (SLF) and TSD Facility from the EMB Central Office or Regional Office
2. **Notice to Proceed** for controlled dump facility to be used as repository of health care waste from the EMB Regional Office
3. **Registration as TSD facility** based on the Implementing Rules and Regulations of RA 6969 from EMB Central Office
4. **Technology Approval** for non-burn technologies from the EMB Central Office prior to the issuance of Permit to Operate.
5. **Permit to Operate (P/O)** Air Pollution Source and Control Installation from EMB Regional Office
6. **Discharge Permit** from the EMB Regional Office or LLDA
7. **Certificate of Product Registration** for equipment or devices used for treating health care wastes from the DOH- BHDT
8. **Certificate of Technical Evaluation** for equipment or devices used for treating health care wastes from the NRL-EAMC.

B. PROCEDURES FOR SECURING PERMITS AND LICENSES

Permits and licenses shall be secured following the established procedures of the DENR and DOH.

C. SPECIFIC CRITERIA, STANDARDS, AND GUIDELINES

C.1 Handling, Collection, Storage and Transport

Handling, collection, storage and transport of health care wastes shall be in accordance with the provisions of RA 8749, RA 6969, and RA 9003, and the DOH Health Care Waste Management Manual (Chapter 5).

C.2 Treatment

1. Facilities shall consider technologies and processes used in health care waste treatment such as (1) thermal, (2) chemical, (3) irradiation, (4) biological processes, (5) encapsulation, and (6) inertization, as outlined in the DOH Health Care Waste Management Manual and subject to compliance with the provisions of RA 8749, RA 6969, and RA 9003.
2. Autoclave, microwave and hydroclave facilities shall use microbiological test to determine the treatment efficiency of the units. The results of the microbiological test shall be recorded and reported to DENR under RA 6969 and RA 9003.
3. Health care waste generators and TSD facilities shall observe a level of microbial inactivation of $6\log_{10}$ reduction or greater than the most resistant microorganism of concern in a given process.
4. Treated wastes and inert residues from TSD facilities must be disposed in controlled disposal or sanitary landfill facilities duly licensed by the DENR to handle the same.
5. Inertization is a suitable treatment for pharmaceutical wastes while encapsulation and other immobilization techniques are treatment methods considered for sharps, chemicals and pharmaceutical wastes and should therefore be placed in final disposal facilities indicated under the subsequent Section.

C.3 Final Waste Disposal Systems and Facilities

The use of the proceeding disposal facilities should only be limited to health care wastes which have undergone the necessary treatment provided under the prescribed standards stipulated in the DOH Health Care Waste Management Manual.

C.3.1 Controlled Dump Facility

1. A Controlled Dump Facility (CDF) is an interim¹ disposal facility for municipal solid waste or those that are considered as non-hazardous and non-toxic substances. In the absence of a sanitary landfill, a controlled dumpsite could accept health care waste after the indicative treatment thereof.

¹As stipulated in Section 37 of RA 9003, no open dumps shall be established and operated, nor any practice or disposal of solid waste by any person, including LGUs, which constitutes the use of open dumps for solid waste, be allowed after the effectivity of this Act (February 16, 2001); Provided, that within three (3) years after the effectivity of this Act (February 16, 2004), every LGU shall convert its open dumps into controlled dumps, in accordance with the guidelines set in

2. In addition to the operational guidelines stipulated under Section 2 of Rule XIII of the Implementing Rules and Regulations of RA 9003 or as indicated in the conditions stipulated in the issuance of the NTP, a CDF that is commissioned to accept treated health care waste should also be operated in accordance with the following specific requirements:
 - a. Identify a particular cell within the facility to serve as a site for the disposal of treated health care waste. The capacity of the allotted cell/cell(s) should be measured in order to determine the actual volume of wastes that can be accommodated in the facility.
 - b. Adequate signage should be placed in the health care waste deposition area.
 - c. The cell should be lined with a material of low permeability, such as clay or a geo-membrane such as a high-density polyethylene (HDPE) plastic liner to contain the leachate and prevent contamination of groundwater sources within the area.
 - d. Ensure that adequate soil cover is placed on the cells right after each waste spreading.
 - e. Basic record keeping of the incoming wastes indicating the time of receipt, volume or weight, source identification (i.e. name of generator or source), certification of treatment (or any similar form indicating that the waste have undergone the necessary treatment) and the general condition of the waste to be disposed.

C.3.2 Sanitary Landfill Facility

1. A Sanitary Landfill Facility [SLF] is a disposal site designed, constructed, operated and maintained in a manner that exerts engineering control over significant potential environmental impacts arising from the development and operation thereof.
2. The required dedicated cells for treated health care wastes should be built or developed prior to its operation to prevent the mixing thereof with municipal solid wastes and other wastes.
3. Aside from the ECC, which is required for such facility, the construction and development of an SLF must conform to RA 9003 and its Implementing Rules and Regulations, particularly Sections 1 and 2, Rule XIV.

Section 41 of the Act: Provided, further, that no controlled dumps shall be allowed five (5) years following effectivity of the Act (February 16, 2006).

WTD

4. Existing sanitary landfill with approved ECC for the disposal of municipal solid waste must secure an amendment of their ECC before accepting health care waste for disposal thereat.

C.3.3 Safe Burial on Healthcare Facility Premises

1. Safe burial within the premises of healthcare facilities shall be allowed in remote locations and rural areas where no TSD facilities are available. In such activity of safe burial, the health care facility must ensure that the load or capacity of the on-site burial pit is not exceeded.
2. Chemical treatment or disinfection is required prior to safe burial on hospital premises.
3. The standards for safe burial within the healthcare facility premises shall follow the guidelines specified in the DOH Health Care Waste Management Manual (See Annex "C").
4. Relative to the guidelines provided by DOH, the operation of safe burial should be in accordance with the minimum requirements for landfill.

C.3.4 Sharps and Syringes Disposal Through Concrete Vault

1. Disposal using concrete vault shall be allowed only as an alternative means of disposal of used sharps and syringes.
2. Concrete vault shall be marked with proper signage: CAUTION: HAZARDOUS WASTE OR SHARPS DISPOSAL AREA-UNAUTHORIZED PERSONS KEEP OUT.
3. Concrete vault should be watertight and must be constructed at least 1.5 meters above the groundwater level.
4. The procedures for the safe burial of sharps and syringes through concrete vault shall follow the guidelines in the DOH Health Care Waste Management Manual (See Annex "D").

C.4 Wastewater Treatment Facility

Healthcare facilities shall have their own Wastewater Treatment Facilities (WTF) or maybe connected into a sewage treatment plant. However, facilities with laboratories shall be required to pre-treat their wastewater prior to discharge into a sewage treatment plant.

VII. REPEALING CLAUSE

All other issuances whose provisions of DENR and DOH Administrative Order, Memorandum Circulars or other issuances inconsistent herewith are hereby repealed or modified accordingly.

MAB

VIII. PENALTY CLAUSE

Failure to comply with the policies/guidelines shall be subject to the penalty provision(s) of the applicable laws stated herein.

IX. EFFECTIVITY

This Order shall take effect immediately.


MICHAEL T. DEFENSOR
Secretary *in of*
Department of Environment and
Natural Resources


FRANCISCO T. DUQUE III, MD, MSc
Secretary
Department of Health

*Publication : Manila Standard Today
September 1, 2005*

ANNEX "A" - Categories of Health Care Waste

1. **General Waste** - Comparable to domestic waste, this type of waste does not pose special handling problem or hazard to human health or to the environment. It comes mostly from the administrative and housekeeping functions of health care establishments and may also include waste generated during maintenance of health care premises. General waste should be dealt with by the municipal waste disposal system.
2. **Infectious Waste** - This type of waste is suspected to contain pathogens (bacteria, viruses, parasites, or fungi) in sufficient concentration or quantity to cause disease in susceptible hosts. This includes:
 - 2.1 Cultures and stocks of infectious agents from laboratory work;
 - 2.2 Waste from surgery and autopsies on patients with infectious diseases (e.g. tissues, materials or equipment that have been in contact with blood or other body fluids);
 - 2.3 Waste from infected patients in isolation wards (e.g. excreta, dressings from infected or surgical wounds, clothes heavily soiled with human blood or other body fluids);
 - 2.4 Waste that has been in contact with infected patients undergoing hemodialysis (e.g. dialysis equipment such as tubing and filters, disposable towels, gowns, aprons, gloves, and laboratory coats);
 - 2.5 Infected animals from laboratories; and
 - 2.6 Any other instruments or materials that have been in contact with infected persons or animals.
3. **Pathological Waste** - Pathological waste consists of tissues, organs, body parts, human fetus and animal carcasses, blood and body fluids. Within this category, recognizable human or animal body parts are also called anatomical waste. This category should be considered as a subcategory of infectious waste, even though it may also include healthy body parts.
4. **Sharps** - Include needles, syringes, scalpels, saws, blades, broken glass, infusion sets, knives, nails and any other items that can cause a cut or puncture wounds. Whether or not they are infected, such items are usually considered as highly hazardous health care waste.
5. **Pharmaceutical waste** - Includes expired, unused, spilt, and contaminated pharmaceutical products, drugs, vaccines, and sera that are no longer required and need to be disposed of appropriately. This category also includes discarded items used in handling of pharmaceuticals such as bottles or boxes with residues, gloves, masks, connecting tubing and drug vials.
6. **Genotoxic Waste** - Genotoxic waste may include certain cytostatic drugs, vomit, urine, or feces from patients treated with cytostatic drugs, chemicals, and radioactive materials. This type of waste is highly hazardous and may have mutagenic, teratogenic, or carcinogenic properties.
 - 6.1 Harmful cytostatic drugs can be categorized as follows:
 - 6.1.1 Alkylating agents: cause alkylation of DNA nucleotides, which leads to cross-linking and miscoding of the genetic stock;

- 6.1.2 Anti-metabolites: inhibit the biosynthesis of nucleic acids in the cell; mitotic inhibitors: prevent cell replication
- 6.2 Cytotoxic wastes are generated from several sources and include the following:
 - 6.2.1 Contaminated materials from drug preparation and administration, such as syringes, needles, gauges, vials, packaging; outdated drugs, excess (left over) solutions, and drugs returned from the wards;
 - 6.2.2 Urine, feces, and vomit from patients which may contain potentially hazardous amounts of the administered cytotoxic drugs or of their metabolites and which should be considered genotoxic for at least 48 hours and sometimes up to 1 week after drug administration.
7. **Chemical Waste** - Chemical waste consists of discarded solid, liquid, and gaseous chemicals, for example from diagnostic and experimental work and from cleaning, housekeeping, and disinfecting procedures. Chemical waste from health care may be hazardous or non-hazardous.
 - 7.1 Chemical waste is considered hazardous if it has at least one of the following properties:
 - 7.1.1 Toxic
 - 7.1.2 Corrosive (e.g. acids of pH <2 and bases of pH >12)
 - 7.1.3 Flammable
 - 7.1.4 Reactive (explosive, water-reactive, shock-sensitive)
 - 7.1.5 Genotoxic (e.g. cytostatic drugs)
 - 7.2 Non-hazardous chemical waste consists of chemicals with none of the above properties, such as sugars, amino acids, and certain organic and inorganic salts.
8. **Waste with high content of heavy metals** - Wastes with a high heavy-metal content represent a subcategory of hazardous chemical waste, and are usually highly toxic. Mercury wastes are typically generated by spillage from broken clinical equipment (thermometers, blood pressure gauges, etc.). Whenever possible, spilled drops of mercury should be recovered. Residues from dentistry have high mercury content. Cadmium waste comes mainly from discarded batteries. Certain "reinforced wood panels" containing lead is still being used in radiation proofing of X-ray and diagnostic departments. A number of drugs contain arsenic but these are treated here as pharmaceutical waste.
9. **Pressurized Containers** - Many types of gas are used in health care and are often stored in pressurized cylinders, cartridges, and aerosol cans. Many of these, once empty or of no further use (although they may still contain residues), are reusable, but certain types notably aerosol cans, must be disposed of. Whether inert or potentially harmful; gases in pressurized containers should always be handled with care; containers may explode if incinerated or accidentally punctured.

10. **Radioactive Waste** – Includes disused sealed radiation sources, liquid and gaseous materials contaminated with radioactivity, excreta of patients who underwent radio-nuclide diagnostic and therapeutic applications, paper cups, straws, needles and syringes, test tubes, and tap water washings of such paraphernalia. It is produced as a result of procedures such as in vitro analysis of body tissues and fluids, in vivo organ imaging, tumor localization and treatment, and various clinical studies involving the use of radioisotopes. Radioactive health care wastes generally contain radionuclides with short half-lives, which lose their activity in a shorter time. However, certain radionuclides e.g. C-14 contaminated wastes have much longer half-life, more than a thousand years, which need to be specially managed in a centralized treatment facility for radioactive wastes. The same is required for the management of disused sealed radiation sources used for cancer treatment.

ANNEX "B" - Laguna Lake Development Authority Jurisdiction

The Laguna Lake jurisdiction is limited to the water shed of the Laguna Lake which is consist of the following: Rizal Provinces (13 towns); Laguna Provinces (27 towns); chartered cities of San Pablo, Antipolo, Tagaytay, Tanauan, Calamba, Sta. Rosa; Sto. Tomas and Malvar, Batangas; Silang, Carmona and GMA, Cavite; Lucban, Quezon; Taguig and Pateros, Metro Manila; chartered cities of Pasay, Caloocan, Quezon, Manila, Muntinlupa, Marikina and Pasig.

ANNEX "C" - Guidelines for Safe Burial within Hospital Premises

Safe burial within the hospital premises shall be in accordance with the guidelines specified in the DOH Health Care Waste Management Manual as follows:

1. Access to the disposal site should be restricted to authorized personnel only.
2. The burial site should be lined with a material of low permeability, such as clay or a geo-membrane such as a high-density polyethylene (HDPE) plastic liner at the bottom of the pit to prevent contaminating groundwater and avoid pollution.
3. Only hazardous health care waste should be buried. If general health care waste were also buried on the premises, available space would be quickly filled-up.
4. Large quantities (>1kg) of chemical/pharmaceutical wastes should not be buried.
5. The burial site should be managed as a landfill, with each layer of waste covered with a layer of earth to prevent odor, as well as to prevent proliferation of rodents and insects.
6. Burial site should not be located in flood prone areas.
7. Hospital ground should be secured. (e.g. fenced with warning signs).
8. The location of waste burial pit should be downhill or down-gradient from any nearby wells and about 50 meters away from any water body such as rivers or lakes to prevent contaminating sources of water.
9. Health care facilities should keep a permanent record of the size and location of all their on-site burial pits to prevent construction workers, builders, and others from digging in those areas in the future.
10. The safe burial of waste depends critically on rational operational practices. The bottom of the pit should be at least 1.50 meters higher than the ground water level.
11. It should be noted that safe on-site burial is practicable only for relatively limited period, say 1 to 2 years, and for relatively small quantities of waste, say up to 5 to 10 tons in total. Where these conditions are exceeded, a longer-term solution will be needed.

ANNEX "D" - Procedures for the Safe Burial of Sharps and Syringes through Concrete Vault

The procedures for the safe burial of sharps and syringes through concrete vault shall be in accordance with the guidelines in the DOH Health Care Waste Management Manual as follows:

1. Dig a pit (minimum size of 1 m x 1 m x 1.8 m depth), enough to accommodate sharps and syringes for an estimated period of time without reaching the groundwater level. The site must be isolated and at least 152 meters away from the groundwater supply sources and dwelling units.
2. Construct concrete walls and slabs of the pit. Provide slab with opening or manhole for easy deposition of collected sharps and syringes. The manhole should be extended a few centimeters above the soil surface to overcome infiltration of surface water.
3. Deposit the collected safety boxes filled with used sharps and needles inside the concrete vault.
4. Install a security fence around the site.

Annex Q: PhilHealth Benchbook Quality Standards for Health Provider Organizations

From section VI – Safe Practice and Environment

I. Patient and staff safety

Goal: Patients, staff & other individuals within the organization are provided a safe, functional and effective environment of care

Standards:

- The organization plans a safe & effective environment of care consistent with its mission, services & with laws and regulations

Criteria:

- The organizational environment complies with structural standards and safety codes as prescribed by law
- There are management plans which address safety, security, disposal and control of hazardous materials and biological wastes, emergency and disaster preparedness, fire safety, radiation safety and utility systems
- There are management plans for the safe and efficient use of medical equipment according to specifications

- The organization provides a safe & effective environment of care consistent with its mission, services & with laws and regulations

Criteria:

- Policies and procedures that address safety, security, control of hazardous materials and biological wastes, emergency and disaster preparedness, fire safety, radiation safety and utility systems are documented and implemented
- Policies and procedures for the safe and efficient use of medical equipment according to specifications are documented and implemented
- The design of patient areas provides sufficient space for safety, comfort and privacy of the patient and for emergency care
- All personnel understand and fulfill their role in safe practice
- Risks are identified, assessed and appropriately controlled. Where elimination or substitution is not possible, adequate warning and protection devices are used.
- A coordinated security arrangement in the organization assures protection of patients, staff and visitors.

- The organization routinely collects & evaluates information to improve the safety and adequacy of the environment of care

Criteria:

- The effectiveness of safety procedures and devices are routinely tested, monitored and improves
- An incident reporting system identifies potential harms, evaluates causal and contributing factors for the necessary corrective and preventive action.

2. Maintenance of environment of care

Goal: Comprehensive maintenance program ensures a clean and safe environment:

Standards:

- Emergency light and/or power supply, water and ventilation systems are provided for, in keeping with relevant statutory requirements and codes of practice
- Regular maintenance of grounds, facilities & equipment in keeping with relevant statutory requirements, codes of practice or manufacturers' specifications are done to ensure a clean and safe environment
- Only people trained in the maintenance of that equipment shall be allowed to provide service to said equipment. Registers and records of equipment and related maintenance are kept
- Current information and scientific data from manufacturers concerning their products are available for reference and guidance in the operation and maintenance of plant and equipment

3. Infection control

Goal: Risks of acquisition and transmission of infections among patients, employees, physicians and other personnel, visitors and trainees are identified and reduced

Standards:

- An interdisciplinary infection control program ensures the prevention and control of infection in all services
- The organization uses a coordinated system-wide approach to reduce the risks of nosocomial infections

Criteria:

- The organization undertakes case finding and identification of nosocomial infections
 - The organization takes steps to prevent and control outbreaks of nosocomial infections
 - The organization uses a coordinated system-wide approach to reduce the risks of infections acquired by the staff in the performance of their duties
- Criteria:
- There are programs for prevention and treatment of needlestick injuries and policies and procedures for the safe disposal of used needles are documented and monitored
 - There are programs for the prevention of transmission of airborne infections and risks from patients with signs and symptoms suggestive of tuberculosis or other communicable diseases are managed according to established protocols.
 - Cleaning, disinfecting, drying, packaging and sterilizing of equipment and maintenance of associated environment, conforms to relevant statutory requirements and codes of practice
 - When needed, the organization reports information about infections to personnel and public health agencies

4. Equipment and supplies

Goal: The provision of equipment and supplies supports the organization's role.

Standards:

- Planning of facilities and selection and acquisition of equipment and supplies involve input from relevant staff and is undertaken by appropriately qualified personnel.

Criteria:

- Appropriate equipment and supplies that support the organization's role and level of service are provided with due considerations to at least, the intended use, cost benefits, infection control, safety, waste creation and disposal, storage.
- Specialized equipment is operated according to specifications and only by appropriately trained staff
- Items designated by the manufacturer for single use are not reused unless the organization has specific policies and guidelines for safe reuse which take into consideration relevant statutory requirements and codes of practice

5. Energy and waste

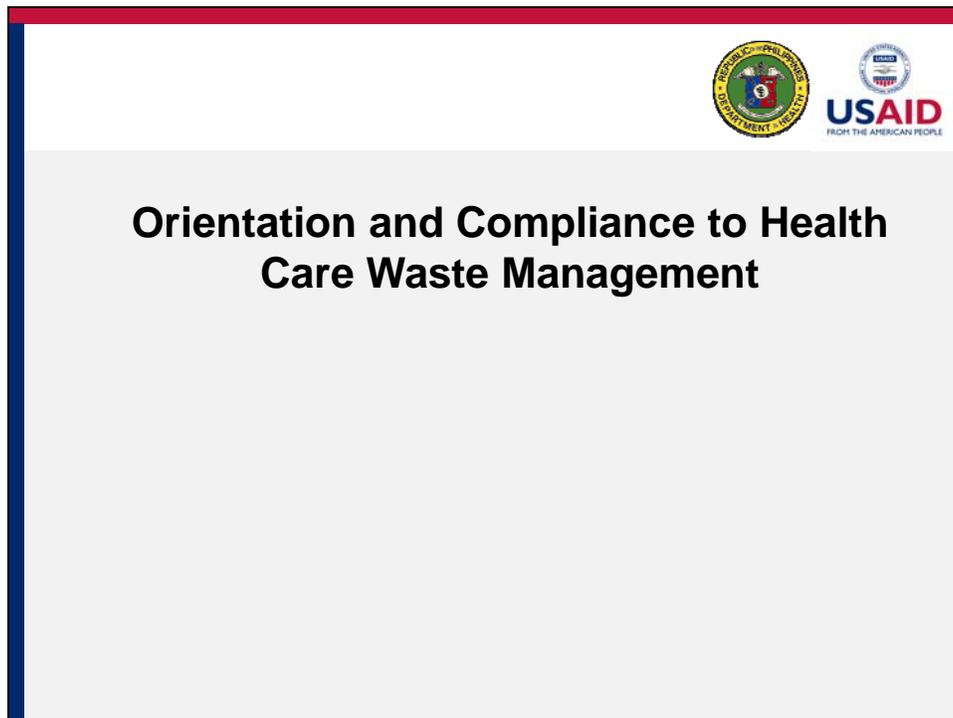
Goal: The organization demonstrates its commitment to environmental issues by considering and implementing strategies to achieve environmental sustainability

Standards:

- The handling, collection and disposal of waste conform to relevant statutory requirements and codes of practice
- The organization implements a waste disposal program which involves reuse, reduction and recycling

Annex R: Orientation and Compliance to Health Care Waste Management (PowerPoint)

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The elements of infection in the context of Healthcare Waste (HCW) are:

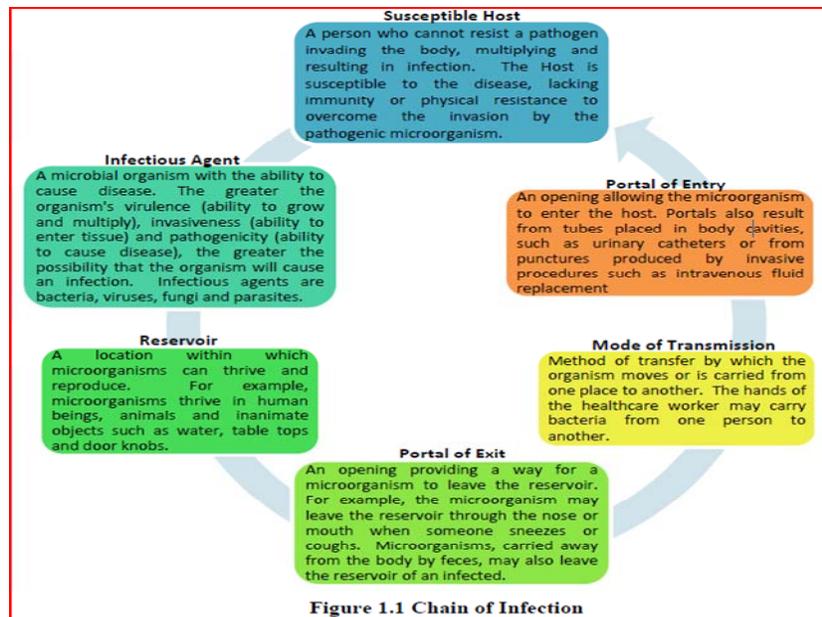
- Some components of HCW are potential reservoir of disease-causing microorganisms such as culture dishes, liquid blood, pathological waste, etc.
- The infective dose depends on the virulence of the microorganisms, the portal of entry, and the susceptibility of the host.
- Modes of transmission may involve contact (e.g. contaminated needles or blood splatter), vehicle-borne (e.g. contaminated wastewater), air-borne (e.g. aerosolized pathogens from broken culture dishes or the rupture of yellow bags), and vector-borne (e.g. rodents in an HCW storage area) transmission.
- Portals of entry include breaks in the skin and mucous membranes (e.g. needle-stick injuries or blood splashes into the mucous membranes), the respiratory tract (inhalation of pathogenic aerosols), etc.
- Potential susceptible host include HCF workers, waste handlers, patients and visitors in the HCF, landfill operators, scavengers and the general public.

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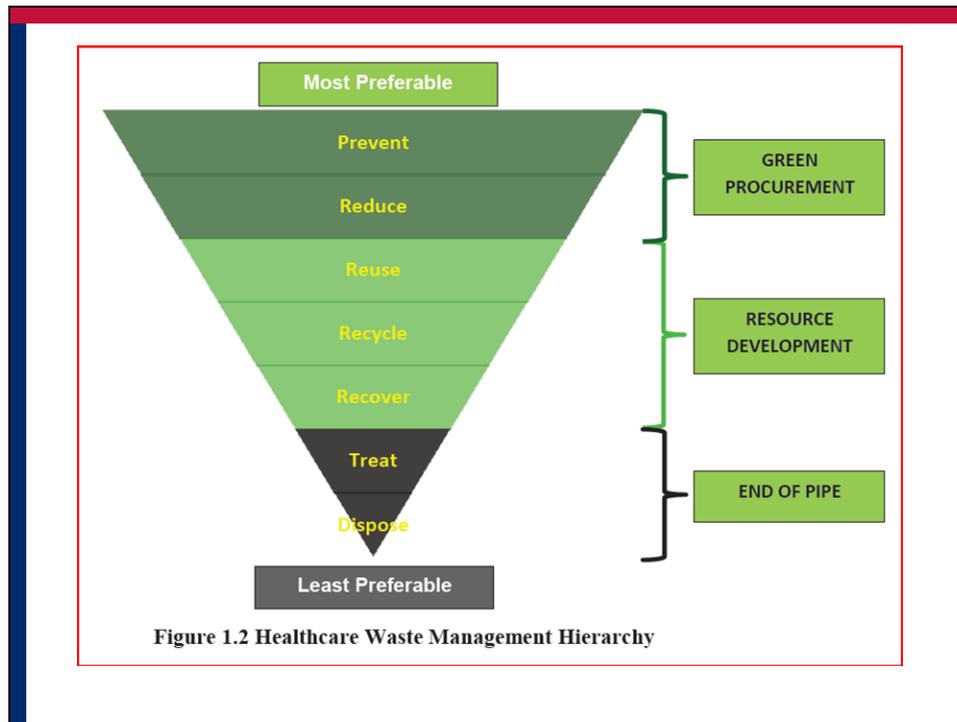
The consequences of improper handling and disposal of HCW are serious.

For example, the reuse of improperly discarded needles by intravenous (IV) drug users or accidental needle stick injuries suffered by recyclers sifting through waste dumps could lead to the spread of hepatitis B, HIV-AIDS and other blood-borne diseases.

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DENR ADMINISTRATIVE ORDER No. 29 Series 1992

Subject: IMPLEMENTING RULES AND REGULATIONS OF REPUBLIC ACT 6969

Pursuant to provisions of Section 16, Republic Act 6969, otherwise known as "Toxic Substances and Hazardous and Nuclear Wastes Control Act of 1990", the Department of Environment and Natural Resources hereby adopts and promulgates the following Rules and Regulations:

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DENR ADMINISTRATIVE ORDER No. 29 Series 1992

**Subject: IMPLEMENTING RULES AND REGULATIONS OF
REPUBLIC ACT 6969**

Section 1. Title. *These Rules and Regulations shall be known as the Implementing Rules and Regulations of Republic Act 6969.*

Section 2. Declaration of Policy. *It is the policy of the State to regulate, restrict or prohibit the importation, manufacture, processing, sale, distribution, use and disposal of chemical substances and mixtures that present unreasonable risk and/or injury to health or the environment; to prohibit the entry, even in transit, of hazardous and nuclear wastes and their disposal into Philippine territorial limits for whatever purpose; and to provide advancement and facilitate research and studies on toxic chemicals and hazardous and nuclear wastes.*

Section 3. Scope. *These Rules and Regulations shall cover the importation, manufacture, processing, handling, storage, transportation, sale, distribution, use and disposal of all unregulated chemical substances and mixtures in the Philippines including the entry, even in transit, as well as the keeping or storage and disposal of hazardous and nuclear wastes into the country for whatever purpose.*

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**JOINT DENR-DOH ADMINISTRATIVE ORDER No. 02, series of
2005**

**SUBJECT : Policies and Guidelines on effective and proper
handling, collection, transport, treatment, storage and disposal
of health care wastes.**

I. RATIONALE

The Department of Environment and Natural Resources (DENR) and the Department of Health (DOH) hereby jointly provide the following guidelines on the management of health care wastes pursuant to, among others, the following laws, rules and regulations:

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- Clean Air Act of 1999 (Republic Act 8749);
- Toxic Substances, Hazardous Waste, and Nuclear Waste Control Act of 1990 (Republic Act 6969);
- Ecological Solid Waste Management Act of 2000 [Republic Act 9003)
- Refuse Disposal of the Sanitation Code of the Philippines [Chapter XVIII, Implementing Rules and Regulations, Presidential Decree 856);
- Clean Water Act of 2004 [Republic Act 9275];
- Environmental Impact Statement (EIS) System (Presidential Decree 1586);
- Hospital Licensure Act [Republic Act 4226]

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II. OBJECTIVES

- A. To provide guidelines to generators, transporters and owners or operators of treatment, storage, disposal (TSD) facilities of health care waste on the proper handling, collection, transport, treatment, storage and disposal thereof;
- B. To clarify the jurisdiction, authority and responsibilities of the DENR and DOH with regard to health care waste management; and
- C. To harmonize efforts of the DENR and DOH on proper health care waste management.

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III. SCOPE AND COVERAGE

These policies and guidelines shall apply to health care waste generators, transporters and owners or operators of TSD and final disposal facilities.

IV. DEFINITION OF TERMS

A. Health Care Wastes - include all wastes generated as a result of the following:

1. Diagnosis, treatment, management and immunization of humans or animals;
2. Research pertaining to the above activities;
3. Producing or testing of biological products; and
4. Waste originating from minor or scattered sources (i.e. dental clinics, alternative medicine clinics, etc.)

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Health Care Waste Generators - include health care facilities, institutions, business establishments and other similar health care services with activities or work processes that generate health care waste.

1. Hospitals (Primary Care, Secondary Care and Tertiary Care)
2. Infirmaries
3. Birthing homes
4. Clinics

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“Healthcare Facilities” (HCF), for this purpose, are public, private and non-governmental institutions/facilities that contribute to the improvement of the health status of an individual, which includes:

- Clinics and healthcare units related to patient care including but not limited to dispensaries, alternative medicine clinics; obstetrics and maternity lying-in clinics; out-patient clinics; dialysis centers; drug testing centers; transfusion centers; military medical services; prison hospital and clinics; emergency medical care services; physician’s offices/clinics; dental clinics; specialized healthcare establishments such as convalescing homes and Differently Abled Person (DAP) centers; derma, vein and skin clinics
- Rehabilitation centers, hospices, psychiatric centers, and centers providing long-term healthcare services
- Related laboratories and research centers such as medical and bio-medical laboratories, biotechnology laboratories and institutions, medical research centers, blood banks and blood collection services, nuclear medicine laboratories, animal research laboratories
- Ambulance and emergency care mobiles (including medical mission and health services provided in evacuation centers)
- Teaching and training hospitals and medical schools

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Table 2.1 Categories of Healthcare Waste

CATEGORY	DESCRIPTION	EXAMPLES
Infectious	All waste suspected to contain pathogens (or their toxins) in sufficient concentration to cause diseases to a potential host.	Solid wastes from patients with infectious disease (e.g., dressings, swabs, blood bags, urine bag , sputum cups)
	Discarded materials or equipment used for diagnosis, treatment and prevention of disease of patients with infectious disease	Liquid wastes from patients with infectious disease (e.g., feces, urine, blood or other body secretions).
	Highly infectious waste include microbial cultures and stocks of highly infectious agents from Medical Analysis Laboratories and biofluids from patients with highly infectious diseases. (These require disinfection at source)	Food wastes (liquid or solid) of patients with highly infectious disease

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Sharps	Items that can cause cuts or puncture wounds.	Used or expired sharps e.g., hypodermic, intravenous or other needles; auto-disable syringes; syringes with attached needles; infusion sets; scalpels; pipettes; knives; blades; broken glass; wet ampules Except syringes and needles used for antineoplastic purposes
Pathological and Anatomical	Refers to tissue sections and body material derived from biopsies or surgical procedures that are then examined in the laboratory. Anatomical waste is a subgroup of pathological waste. This type of waste refers to recognizable human body parts such as amputated limbs, etc.	Placenta, internal organs, tissues used for diagnostic procedures such as biopsy, blood, fetus Amputated body parts like legs.

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CATEGORY	DESCRIPTION	EXAMPLES
Pharmaceutical Waste	Refers to expired, spilt and contaminated pharmaceutical products, drugs and vaccines. Also refers to discarded items used in handling pharmaceuticals. Pharmaceutical wastes include antineoplastic, cytotoxic, and genotoxic waste. Drugs usually used in oncology (antineoplastic drugs) or radiotherapy units have a high hazardous mutagenic or cytotoxic effect.	Empty vials, bottles, connective tubing Medical supplies and containers of cytotoxic drugs or chemicals;
Chemical Waste	Discarded chemicals (solid, liquid, or gaseous) generated during disinfecting and sterilizing procedures Chemical wastes can be further classified into corrosive, reactive, toxic and flammable Chemical wastes also include wastes with high content of heavy metals and their derivatives	Laboratory reagents, film developer, disinfectants and soaking solutions, solvents Concentrated ammonia solutions, concentrated hydrogen peroxide, chlorine, silver nitrate Cadmium, mercury from broken thermometers, sphygmomanometers

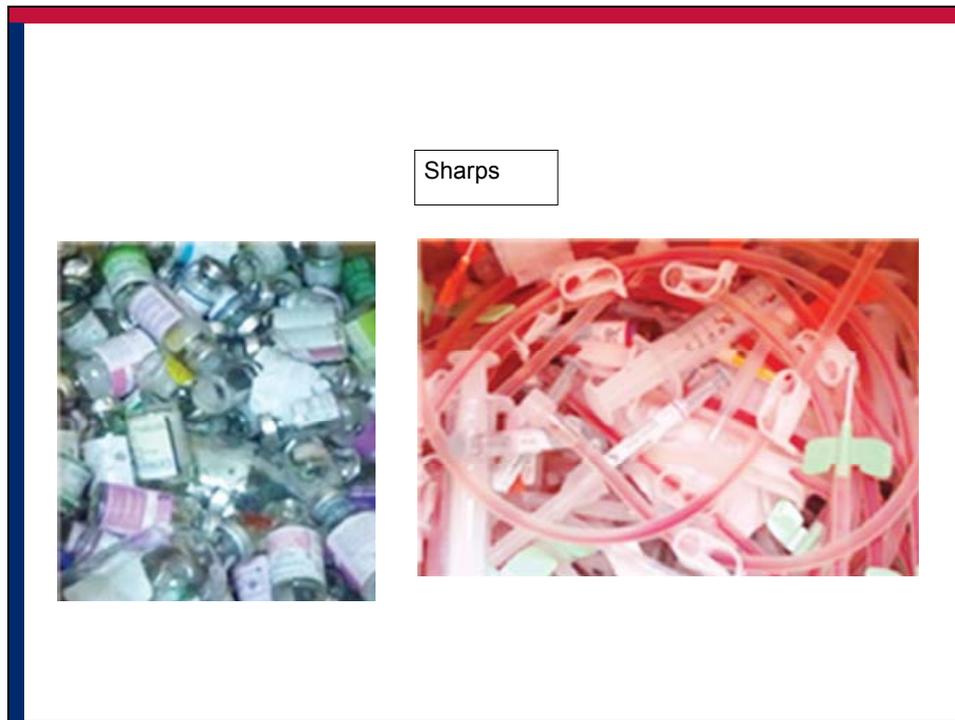
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<p>Radioactive Waste</p>	<p>Wastes exposed to radionuclide. Residues from shipment of radioactive materials and unwanted solution of radionuclides intended for diagnostic or therapeutic use.</p> <p>Liquids, gas and solids contaminated with radionuclides whose ionizing radiations have genotoxic effects.</p>	<p>Cobalt (⁶⁰Co), Technetium (⁹⁹Tc), Iodine (¹³¹I) and Iridium (¹⁹²Ir)</p> <p>Contaminated waste, patient's excretion and all materials used by patients exposed with radionuclides within 48 hours</p>
<p>Non-Hazardous or General Waste</p>	<p>Waste that has not been in contact with communicable or infectious agents, hazardous chemicals or radioactive substances, and does not pose a hazard</p>	<p>Papers, cardboards, empty bottles, tetra packs, scrap materials, pressurized containers, office wastes, food waste and other materials of patients with non-communicable disease, x-ray plates</p>

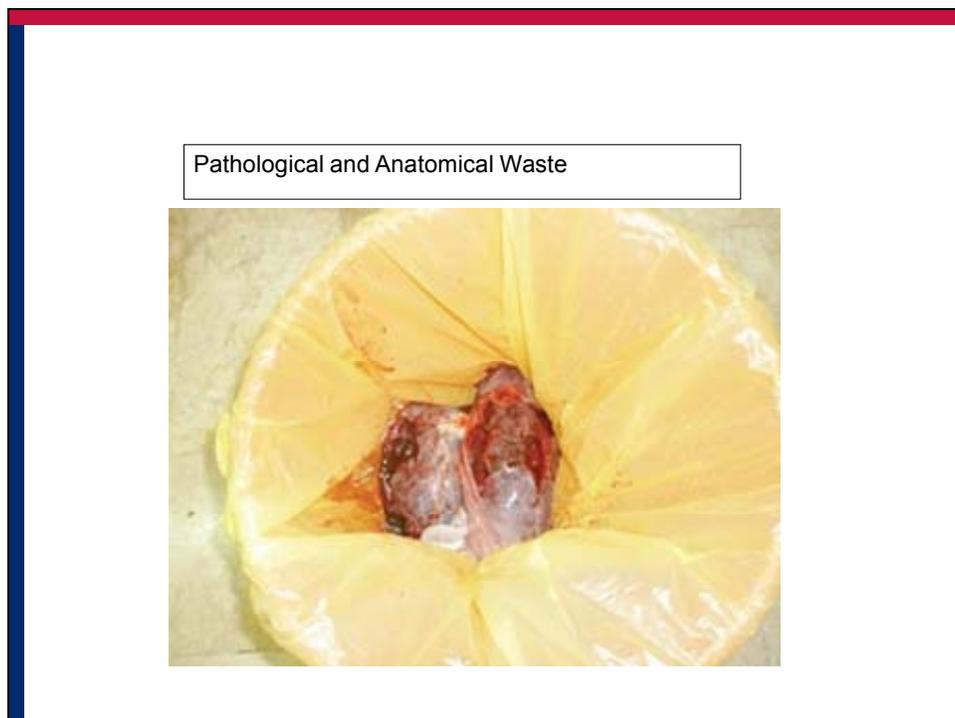
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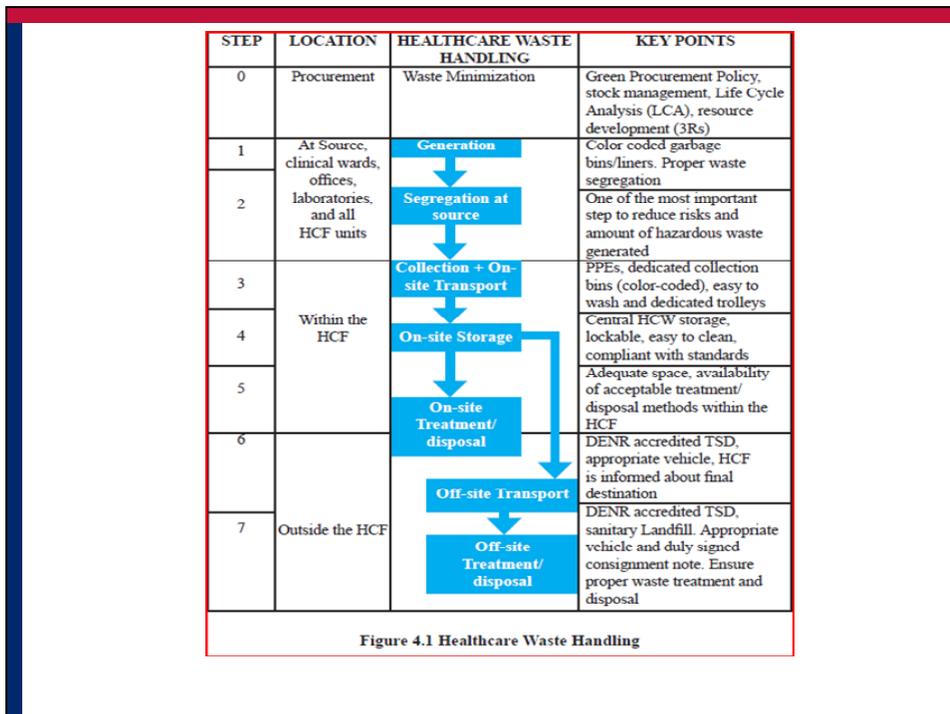


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Table 2.5 Potential Infections Caused by Exposure to Healthcare Wastes, Causative Organisms and Transmission Vehicle

Type of Infection	Examples of Causative Organisms	Transmission Vehicles (Waste items contaminated with the following:)
Gastroenteric infection	Enterobacteria, e.g. <i>Salmonella</i> , <i>Shigella</i> spp.; <i>Vibrio cholera</i> ; <i>Giardia lamblia</i> ; <i>Clostridium difficile</i> ; helminths	Feces and/or vomit
Respiratory infection	<i>Mycobacterium tuberculosis</i> ; measles virus; <i>Streptococcus pneumonia</i> , Severe Acute Respiratory Syndrome	Inhaled secretions; saliva
Ocular infection	Herpes virus	Eye secretions
Genital infection	<i>Neisseria gonorrhoeae</i> ; herpes virus	Genital secretions
Skin infection	<i>Streptococcus</i> spp.	Pus
Anthrax	<i>Bacillus anthracis</i>	Skin secretions
Meningitis	<i>Neisseria meningitidis</i>	Cerebrospinal fluid
Acquired Immunodeficiency syndrome (AIDS)	Human immunodeficiency virus	Blood, sexual secretions, body fluids
Haemorrhagic fever	Junin, Lassa, Ebola, and Marburg viruses	Feces and all body secretions
Septicaemia	<i>Staphylococcus</i> spp.	Blood
Bacteraemia	Coagulase-negative <i>Staphylococcus</i> spp.; (including Methicillin-resistant <i>S. aureus</i>); <i>Enterobacter</i> , <i>Enterococcus</i> , <i>Klebsiella</i> , and <i>Streptococcus</i> spp.	Nasal secretion, skin contact
Candidaemia	<i>Candida albicans</i>	Blood
Viral Hepatitis A	Hepatitis A virus	Feces
Viral Hepatitis B and C	Hepatitis B and C viruses	Blood and body fluids
Avian influenza	H5N1 virus	Blood, feces

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Annex S: Environmental Compliance Assessment Tool

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

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

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

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

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

3. At the DOH-RO level:
 - a. Results and recommendations of the licensing division regarding environmental protection in general and waste management in particular

All these documents are pertinent and have to be available if the facilities are licensed by the DOH and the LGU or accredited by PhilHealth.

Further, to verify what is written in their documents, the team can inspect on-site and look at the following in the facilities:

1. If the facility is generally clean
2. Waste segregation scheme
 - a. How does the facility do its waste segregation scheme
 - b. What kind of waste does it segregate
 - c. Presence of sharps' container

3. Disinfection of waste prior to disposal
4. Manner of disposal for
 - a. Sharps (presence of separate vault for sharps)
 - b. Placenta (presence of separate septic tank for placenta or does the facility allow family to bring it home)
 - c. Used supplies, commodities, etc. (ex. IUD, used supplies generated from the conduct of BTL/NSV)
 - d. Waste products from the laboratory, regular human waste from kitchen, wards, etc.
5. If the segregated waste is collected by the LGU's garbage collector
 - a. What are the waste products that the LGU's garbage collector collects (sharps, placenta, commodities, etc.)
 - b. How are they collected (dumped together with the other regular household waste)
 - c. Where are they disposed of
 - d. Distance of septic tank/vault from source of water in meters

Checklist of Environment Compliance Practices and Measures		
Facility has policies on environmental mitigation	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Facility is generally clean	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Waste segregation scheme	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Describe the waste segregation scheme of the facility		
Sharps' container	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Disinfection of sharps	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If disinfection is done, how is this done?		
Separate septic tank for general waste	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Separate vault for sharps	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Separate vault for placenta	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Allow family to bring placenta home	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Separate washing place for instruments, equipment, etc.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Distance of septic tank/vault from source of water in meters		