MindanaoHealth Project

February 18, 2013, to December 31, 2018

FINAL REPORT

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The US Agency for International Development (USAID)'s MindanaoHealth (MH) project provided support to the Government of Philippines to reduce maternal and newborn mortality. MH worked with Philippines government agencies (national, provincial, and local), civil society organizations, public and private health facilities, hospital associations, professional organizations, and the private sector. The project's focus was: i) institutionalizing an integrated, improved maternal, newborn, and child health and nutrition/family planning (FP) services; ii) strengthened demand for primary care services; and iii) improved maternal and FP services by addressing all policy and systems barriers, especially among populations belonging to the lowest wealth quintiles and conflict-affected areas in Mindanao.

Cover photo : Woman and baby, South Cotabato Provincial Hospital, November 24, 2016

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Abbreviations

4ANC	four antenatal care
AHZ	area health zone
AJA	adolescent job aid
ANC	antenatal care
AO	administrative order
ARMM	Autonomous Region of Muslim Mindanao
ASRH	adolescent sexual and reproductive health
AY	adolescent and youth
AYRH	adolescent and youth reproductive health
BCS	Balanced Counseling Strategy
BEmONC	basic emergency and obstetric newborn care
BHS	barangay health station
BHW	barangay health worker
BTL	bilateral tubal ligation
BueNasCar	Buenavista, Nasipit, Carmen
CAA	conflict-affected area
CCT	conditional cash transfer
CHO	city health office
CHW	community health worker
COE	center of excellence
CPMS	clinical practice mentoring site
CPR	contraceptive prevalence rate
CPS	clinical practice site
CSO	civil society organization
CYP	couple-years of protection
DepEd	Department of Education
DMPA	depot medroxyprogesterone acetate
DOH	Department of Health
DOH-CO	Department of Health Central Office
DOH-RO	Department of Health Regional Office
DQC	data quality check
DSWD	Department of Social Welfare and Development
EBF	exclusive breastfeeding
EMR	electronic medical record

EO	executive order
EOP	end of project
FBD	facility-based delivery
FHSIS	Field Health Services Information System
FP	family planning
FPCBT	family planning competency-based training
GIDA	geographically isolated and disadvantaged area
HEEADSS	home, education, employment, activities, drugs, sexuality, and safety
HIS	health information system
HSP	health service provider
IEC	information, education, and communication
ILHZ	interlocal health zone
IP	indigenous peoples
IPHO	integrated provincial health office
IUD	intrauterine device
LAPM	long-acting permanent method
LARC	long-acting reversible contraceptive
LCE	local chief executive
LGU	local government unit
LIPH	Local Investment Plan for Health
MCH	maternal and child health
MCP	Maternity Care Package
MECA	Midwives in Every Community
MH	MindanaoHealth
MHO	municipal health office
MLLA	minilaparotomy using local anesthesia
MNCH	maternal, newborn, and child health
MNCHN	maternal, newborn, and child health and nutrition
MNH	maternal and newborn health
MPH	Maguindanao Provincial Hospital
MRL	Muslim religious leader
NCP	Newborn Care Package
NDP	Nurse Deployment Program
NGO	nongovernmental organization
OPD	outpatient department
PhilHealth	Philippine Health Insurance Corporation
PHN	public health nurse
PHO	provincial health office

PIR	program implementation review
PM	permanent method
POPCOM	Commission on Population
PPFP	postpartum family planning
PPIUD	postpartum intrauterine device
PPP	public-private partnership
PRISM2	Private Sector Mobilization for Family Health Phase II
PSI	progestin subdermal implant
PTE	post-training evaluation
PY	project year
RH	reproductive health
RHM	rural health midwife
RHU	rural health unit
RIT	regional implementation team
RPRH	Responsible Parenthood and Reproductive Health
SBA	skilled birth attendant
SDN	service delivery network
SDP	service delivery point
SOCCSKSARGEN	South Cotabato, Cotabato, Sultan Kudarat, Sarangani, and General Santos City
SPMC	Southern Philippines Medical Center
SRH	sexual and reproductive health
STI	sexually transmitted infection
TA	technical assistance
TCL	target client list
TOT	training of trainers
TTP	*Toktok Planado Pamilya*
TWG	technical working group
USAID	US Agency for International Development
USG	United States Government
WHO	World Health Organization
WRA	women of reproductive age
YOLO	Youth Optimizing Life Choices

Executive Summary

REACH-Marawi, February 14, 2018

Background

Despite economic growth in the Philippines over the last few years, health outcomes and coverage of basic health services have lagged behind. In 2012–13, the country faced challenges in meeting its commitment to health-related Millennium Development Goals. Its maternal mortality ratio and infant mortality rate were still higher than the Millennium Development Goal targets of 52 and 19, respectively. While the modern contraceptive prevalence rate increased marginally from 2006 to 2011, almost one-quarter of Filipino women of reproductive age (WRA) still had unmet need for family planning (FP).

The government acknowledged the need for health system strengthening to improve these statistics. Even though the government undertook several initiatives, the country has still struggled to improve maternal, newborn, and child health and nutrition (MNCHN)/FP outcomes.

Goals and Objectives

In response, the US Agency for International Development helped support the government by investing in integrating services at the regional level in Zamboanga Peninsula, Northern Mindanao, Davao,

SOCCSKSARGEN, Caraga, and Autonomous Region in Muslim Mindanao, and scaling up proven best practices that result in better maternal and child health outcomes.

It developed MindanaoHealth (MH), its integrated MNCHN/FP regional project, to increase the number of service providers who can deliver high-quality MNCHN/FP services, generate demand and utilization of MNCHN/FP services and address the barriers that prevent populations with the highest unmet need from using these services, and harness the support of stakeholders at all levels to make sure all national policies and guidelines on MNCHN/FP are adopted and supported.

Results

Performance indicators, specifically contraceptive prevalence rate (CPR) for all methods, four antenatal care (4ANC) visits, and facility-based deliveries (FBDs), increased in all Mindanao regions. The proportion of WRA with unmet need for FP decreased in Northern Mindanao, Davao Region, and Autonomous Region in Muslim Mindanao (ARMM). ARMM showed highest gains in terms of 4ANC and FBDs, at 431% and 131% rate of increase, respectively, and in the reduction of FP unmet need, at 36%. The increase in FBDs in Mindanao regions, except for Davao Region, is higher than the average rate of increase in the country. Furthermore, the reduction in FP unmet need in Northern Mindanao, Davao Region, and ARMM, ranging from 12–36%, is higher than the national average reduction of 4.6%.

In close collaboration with the government, MH almost doubled the number of accredited facilities in the region. A total of 258 facilities completed Maternal Care Package reaccreditation, 326 local government units (LGUs) issued policies on PhilHealth reimbursement, and 30% of Department of Health (DOH)-certified providers were accredited in long-acting permanent methods. The number of service delivery points that provide FP counseling and services increased by more than ninefold. MH helped establish 21 service delivery networks (SDNs) that can provide seamless MNCHN, FP, and adolescent and youth (AY) services.

MH saw over a 50% increase in current FP users and couple-years of protection (CYP). Sixty health facilities—10 Centers for Teens and 50 AY-friendly facilities—now offer AY reproductive health services. It also developed a cohort of certified trainers in various FP services.

All facilities in 15 provinces, 28 municipalities, and ARMM institutionalized annual data quality checks. It established FP commodity tracking systems across facilities at the LGU level to help track and resolve stock-outs.

MH reached 19,719 women, children, and youth in conflict-affected areas through outreach activities. Additionally, MH reached 2,014 community health workers, who in turn engaged 8,413 WRA, providing information on FP and referring 6,955 to service facilities with MH's SDN.

MH's accomplishments include addressing some challenges: Mindanao region's security situation affected MH's ability to follow through with all activities according to project timelines, with timely revisions being made to revive the momentum. The new Philippine Health Insurance Corporation (PhilHealth) accreditation renewal or initial application requirement implemented in January 2018 in the region saw an immediate reduction in the number of facilities that were able to renew their accreditation, which was identified by MH for relevant authorities. FP commodity security remained an area that required concerted efforts of coordination amongst SDNs that included timely data recording and reporting issues. MH was able to address these by establishing inter-LGU and facilities' commodity mechanism within SDN to efficiently address stock-outs by operationalizing DOH memoranda on FP commodity share of provincial hospitals and linking Department of Health Regional Offices (DOH-ROs) and PHOs to the national FP logistics hotline to address communication gaps on logistics within the health system, ensuring availability of buffer stocks.

Recommendations

This report includes recommendations on sustaining the gains made under MH, including integrating FP in maternal health services to improve CYP, establishing a robust SDN model to improve referrals and service provision, and initiating adolescent- and youth-friendly services.

At-a-Glance Recommendations

Ensure complementarities in supply- and demand-side investments for service uptake.

Invest in provider regulation and certification for sustained improvement.

Establishing referral systems is essential for clients' experience of continuum of care.

No commodity, no program—the government must invest in commodity security.

Training alone is insufficient to sustain provider performance—investment in implementing a robust provider monitoring, coaching, and mentoring program is key.

Include provision of timely supportive supervision to colleagues in master trainers mandate.

To sustain MH efforts, the government must develop a robust human resources plan and strengthen MH-forged partnerships with private clinics and hospitals to efficiently gather, analyze, and share data.

Sustainability and scale-up of SDNs can significantly address unmet need and quality of care.

Investing in enhancing providers' skills that lead to improved performance across all cadres is an urgent need.

Public Sector

To avert **stock-out**, the DOH's central FP logistics management must assess performance of third-party logistics contractors in the delivery and distribution of commodities to health facilities, and of the national supply chain and logistics management system to identify prevailing bottlenecks to cut down on the more than 3 months of commodity restocking at the facility level. A **coordination mechanism** needs to be put in place to allow DOH pharmacists and family health associates to reallocate and redistribute commodities based on inventory and need.

Standardized, robust information systems to record progress made in meeting policies, informing plans and strategies, and budgeting allocations to address needs and gaps with LGUs, SDN partners, and government officials are essential for a strong health system.

Vigilant and thorough technical oversight of LGUs by DHO-ROs on timely and accurate **data recording and reporting is essential** to improve and monitor recording of CYP through integration of FP in maternal health services, improvement of referrals and seamless service provision, and initiation of AY-friendly services.

Demand generation efforts, when made alongside strengthened service delivery, warrant meeting a client's needs holistically. The public and private sector must coordinate and collaborate on complementing **supply- and demand-side initiatives**.

The government can address the lack of **master trainers** with updated skills by engaging trained providers from health centers to provide supportive supervision for their own colleagues. The advantage is peers can benefit from their colleagues' skills and develop norms around quality assurance and accountability.

Monitoring, coaching, and mentoring are inherent components of enhancing providers' and health facilities' skills and performance in meeting client needs. Sustained improvement in service provision is required to assure uptake.

Robust **security protocols and strategies are essential** for successful interventions in fragile areas, such as ARMM.

Public-Private Partnerships

Comprehensive plans for investments in provider skills and health care facilities through formal **regulation and certification** are essential for enhancing provider performance and instigating healthy competition in achieving government commitments.

Sustained engagement and collaborative agreements with LGUs, municipal health offices, and the private sector are key for a strengthened health system.

Sustaining a **robust human resources plan and partnerships** forged by MH with selected private clinics and hospitals will allow for an efficient mechanism to gather, analyze, and share data, preventing double counting and missing client/service numbers.

Successful public-private partnership is based on the **principle of shared governance**, acknowledging that both the government and private sector have advantages relative to one another. Establishing and sustaining **SDNs** is vital, especially when LGU officials request it, and the DOH-RO strongly supports the networks. Government support ensures involvement/participation of private-sector, community-based organizations, professional organizations, and indigenous peoples in the SDN structure.

Partners

Learning and leveraging best practices and gains made when designing strategies helps prevent duplication of efforts. MH benefited from the learning, resources, and gains of HealthGov, SHIELD, and the Private Sector Mobilization for Family Health Phase II, and consensus of all key stakeholders.

MH recorded minimal increase in CPR of any method in regions Zamboanga Peninsula, SOCCSKSARGEN, and CARAGA. Per the 2017 National Demographic and Health Survey results, there is also an increase in these regions' FP unmet need, so emphasis and **stronger advocacy on the scaling up of emerging proven good practices**, such as SDN in geographically isolated and disadvantaged areas, FP/AY integration in the hospital, and *Toktok Planado Pamilya*, among others, is essential, especially during regional dissemination forums.

Background

Launching the Brokenshire Hospital Program for Teens, 2015

Context and Project Rationale

The World Bank's latest edition of *Global Economic Prospects* (2017) ranked the Philippines as the world's 10th fastest-growing economy, but health outcomes and coverage of basic health services lagged behind what would be expected of a country of the Philippines' level of economic development. In 2012–13, the country faced challenges in meeting its commitment to health-related Millennium Development Goals. The maternal mortality ratio and infant mortality rate were still at 221 per 100,000 live births and 22 per 1,000 live births in 2011[1] against the Millennium Development Goal targets of 52 and 19, respectively. The Philippines' projected population in 2010 stood at 92 million, growing at an annual rate of 1.9% (NSCB www.nscb.gov.oh), with poverty incidence at approximately 26.5% of the total population (NSCB, 2009). While the modern contraceptive prevalence rate (CPR) increased marginally from 36% in 2006 to 38% in 2013, some 23% of Filipino women of reproductive age (WRA) had unmet need for family planning (FP).[2]

The Philippines government acknowledged the need for health system strengthening as the backbone of achieving universal health care. It took several initiatives in this regard:

- Devolution of health services through the Local Government Code of 1991
- Introduction of maternal, newborn, and child health and nutrition (MNCHN) and FP policy frameworks and strategies (manual of operations, the micronutrient supplementation manual of operations, multisector child health strategy)

[1] Philippine Statistics Authority (PSA). 2013. *Breastfeeding, Immunization, and Child Mortality*. Quezon City, Philippines: PSA.
[2] National Statistics Office [NSO; Philippines], ICF Macro. 2009. *Philippines National Demographic and Health Survey 2008: Key Findings*. Calverton, Maryland, USA: NSO and ICF Macro.

- Reformation of social health insurance
- Passing the Responsible Parenthood and Reproductive Health (RPRH) Act of 2012,3 providing umbrella legislation for a series of new and revised policies

Effective translation of policy into action was inconsistent. There was evidence of sporadic and inadequate adaptation of policies to local context, inconsistent interpretation and implementation of critical guidelines, insufficient human resources for health with skills and capacity, and weak coordination mechanisms among service provision facilities. High-unmet need for FP remained unresolved; women, men, youth, and children in geographically isolated areas in the lowest economic quintile and with low education showed wide disparities in access to MNCHN/FP information and services.

The US Agency for International Development (USAID) in the Philippines responded to these challenges by supporting the government through investments in the integration of MNCHN and FP at regional level in Luzon, Visayas, and Mindanao. Service integration had the potential to improve the health of Filipino families by helping expand their access to these services in communities, homes, and facilities in both the public and private sectors while addressing the distinct health needs within the local context of selected sites in each of the three regions. Each region considered the needs of priority sectors, including men and WRA and youth, both boys and girls. USAID's investment was also a contribution toward achieving the country's Millennium Development Goals 4 and 5 by focusing on scaling up proven best practices that result in better maternal and child health (MCH) outcomes.

USAID Philippines' health strategy goal, Family Health Improved, had three distinct yet interrelated objectives:

- Objective 1: Improve supply of services, including the availability and quality of public-sector services, and selective expansion of the private sector as primary care supplier.
- Objective 2: Strengthen demand for primary care services through encouraging adoption of appropriate health behaviors within families.
- Objective 3: Remove policy and systems barriers to improve supply and demand for services.

The integrated MNCHN/FP regional project, MindanaoHealth (MH), was developed to contribute to the achievement of each of the three objectives by:

- **Objective 1:** Increasing the number of competent service providers available in both the public and private sectors to deliver high-quality MNCHN and FP services, scaling up the adoption of innovative practices
- **Objective 2:** Generating demand and utilization of MNCHN/FP services and addressing the barriers that prevent WRA, men, and youth from using appropriate MNCHN/FP services
- **Objective 3:** Harnessing the support of national, regional, and local stakeholders in the adoption of and compliance with national policies and guidelines on MNCHN/FP, and instituting support management systems, such as data quality checks (DQCs), referral protocols, and supportive supervision

[3] With amendments made in March 2013

MH Goal and Objectives

Priority LGU

- Liloy Interlocal Health Zone (ILHZ), Zamboanga del Norte
- District 2, Zamboanga del Sure
- South ILHZ, Bukidnon
- ClaJaViTa, Misamis Oriental
- 3rd District, Davao City
- DMaBaMaS, Davao del Sur
- CoMMMoNN, Compostela Valley
- BITES, Sultan Kudarat
- South Cotabato Provincewide
- Arakan Valley Complex
- D.O. Plaza Service Delivery Network (SDN), Agusan del Sur
- Iranun SDN, Maguindanao

CAAs

- Northern Basilan/Isabela
- Southern Basilan
- Sulu
- Zamboanga
- Marawi
- Cotabato

Jhpiego implemented the MH project with its consortium partner, Research Triangle Institute, from February 2013 to December 2018. This period included a 10-month extension period. MH supported the Government of the Philippines to:

- Identify and address gaps in the quality, availability, and accessibility of public-sector FP and MNCHN services.
- Selectively expand the private sector to become part of the primary health care providers network.
- Strengthen appropriate health behaviors within families and communities, increasing the demand and use of primary care services.
- Identify and address policy and systems barriers that impede demand and supply of services.

It was essential for a project of MH's scope and objectives to remain vigilant and responsive to distinct, emerging needs in certain intervention areas. MH demonstrated the agility to course correct during its 6 years of programming. It aligned its objectives and activities with government resolutions and policies, and provided the public sector with technical assistance (TA) in keeping with its needs. MH received unequivocal USAID support in its course correction and remaining responsive needs over the life of the project that required technical resources, financial resources, and a longer timeline.

In project year 5 (PY5; October 1, 2016–February 18, 2018), MH adjusted its technical interventions, leveraging its 4-year gains. With USAID's approval, adjustments responded to the immediate/intermediary outcomes of its 4-year efforts, the changing external environment, the Philippine Health Agenda, and USAID's *Pointers for the Development of the FY2017 Work Plan*. To do this, MH:

- Accelerated efforts to contribute to meeting the new Sustainable Development Goal targets for 2030 and Family Planning 2020.
- Focused interventions in priority conflict-affected areas (CAAs) (USAID Development Objective #2 on peace and stability in CAAs), including three cities under the City Development Initiative in Mindanao.

- Planned initiatives that complemented the Department of Health Regional Office (DOH-RO) support plan and the Local Government Unit (LGU) Annual Operational Plan on FP, MNCHN, and adolescent and youth reproductive health (AYRH).
- Collaborated with other USAID implementing partners, select USAID-related Mindanao programs, and private-sector entities geared toward expanding the reach of FP/MNCHN/AYRH services to WRA and men of reproductive age, including adolescents and youth (AYs).
- Invested in enhancing the capacity of Department of Health (DOH) and provincial health office (PHO) stewards in program management to improve quality and ensure sustainability of their interventions at the end of the project.

In the aftermath of the unfortunate Marawi Siege, MH received a 10-month extension from March–December 2018 to continue program interventions in areas with low income/poor populations, high FP unmet need, and high teenage pregnancies with high newborn deaths. As this 10-month period also marked project closeout, MH concentrated on consolidating gains and best practices. The MH team undertook a 3-day comprehensive program implementation review (PIR) with USAID.

Capacity Index: An Assessment Tool

MH developed a tool to identify LGUs/CAAs for urgent and sustained interventions and TA. The tool used demographic and geographic profiles, and progress of LGUs after receiving MH TA to assess MH LGUs' gains on FP/reproductive health (RH) services and helped establish an enabling environment for sustainability.

The assessment employed a capacity index to measure 13 key indicators that denote availability of, access to, and increase in demand for FP and AY services, and evaluate the enabling environment for sustainability. The tool also took into account the unique demographic and geographic context of each intervention site and weighted four prioritized indicators to a sum of 100: service delivery – 40, demand generation – 20, policy and financing – 20, AYRH – 20. Assessments of the remaining nine indicators and their respective subcomponents/elements used a 1 to 3 scoring scale (with 3 being the highest) and multiplied these by the corresponding weight to arrive at a maximum composite FP Capacity Index of 100. Based on review findings, with USAID support, MH prioritized 12 LGUs and six CAAs where teenage pregnancy rates and unmet need for FP were high, and where conflict adversely affected health system/service provision. MH made concerted efforts in these locations to consolidate and support regional health offices, with a focus on:

- Accelerating implementation of Executive Order (EO) No. 12 to reduce unmet need for modern FP services
- Enhancing local health system capacity to respond to health emergencies by assisting with restoration of basic FP and MCH services
- Consolidating gains made by the project during its 5-year implementation in Mindanao

Key Assumptions

MH committed to meeting its objectives with the following assumptions:

- Commitment to improving quality will be sustained at the national, provincial, district, and facility level.
- The DOH-RO and LGUs will be accountable and accept responsibility for regulation of private-sector hospitals and providers.
- Local governments and facilities will collect accurate and timely data related to performance.
- Increased social participation of civil society will be harnessed to stimulate accountability and more equitable maternal and newborn health (MNH) outcomes.
- Champions within and outside of the health sector will be active advocates and role models for system improvement.
- The poor and most vulnerable will be able to understand and access social insurance schemes.

Geographic Reach

MH worked closely with the DOH to meet project objectives. With a focus on select intervention regions, MH forged partnerships with the five DOH-ROs and the DOH Autonomous Region of Muslim Mindanao (ARMM), LGUs in 19 provinces, two highly urbanized cities, and 368 municipalities to help the government achieve its commitments to reduce maternal and under-5 deaths and to reduce unmet need for modern FP.

Figure 1.

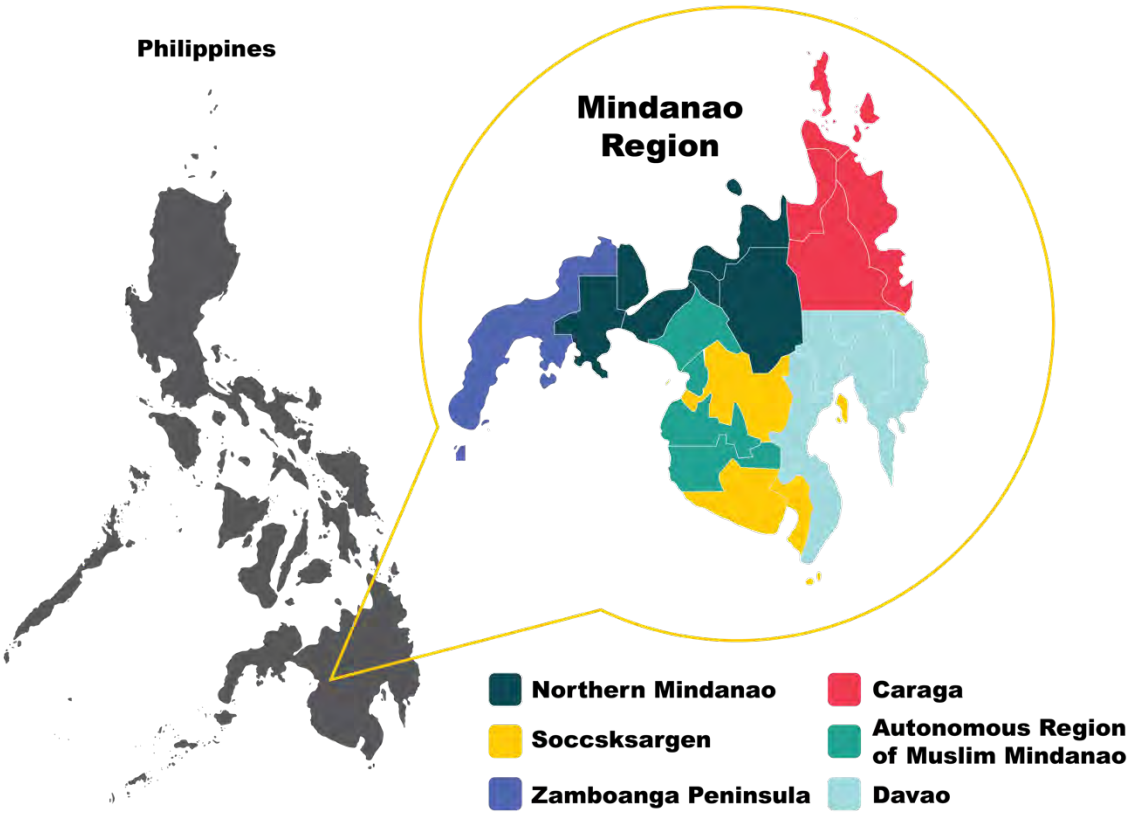
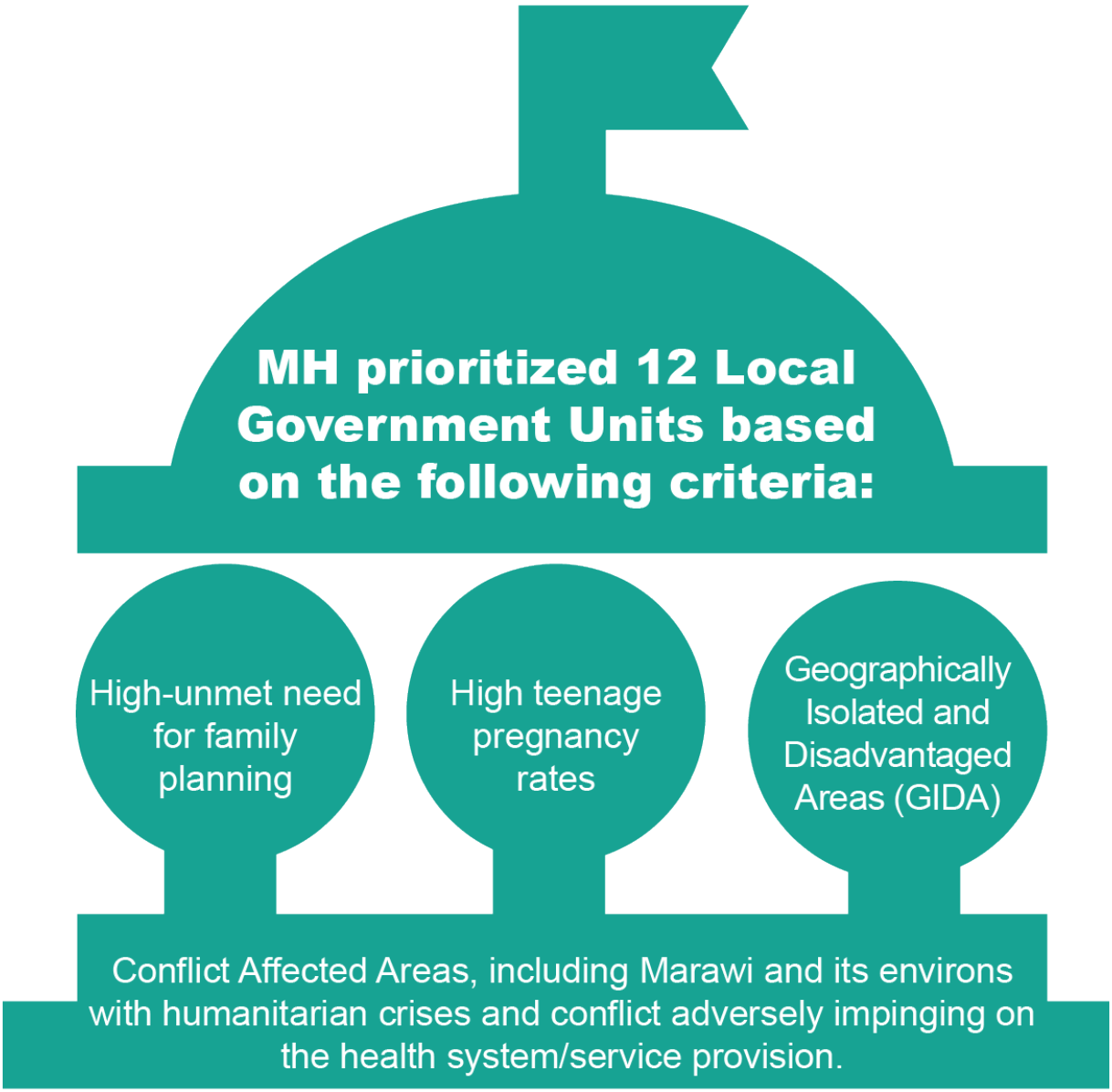


Figure 2.



MH Approach

MH was cognizant of the fact that close collaboration with DOH Mindanao was vital for identifying TA requirements, its acceptance, and sustainability. MH therefore invested time in directly engaging with and orienting the six DOH regional health offices, PHOs in 19 provinces, and governments of the two cities and LGUs on the project goals and objectives. MH identified them as key stakeholders and engaged with them at each stage of planning to ensure project investments addressed prioritized needs and had government acquiescence and support. During implementation, MH kept stakeholders updated on progress and lessons learned. Collaborative implementation helped translate MH's TA into improved availability, accessibility, and uptake of high-quality, integrated FP/MNCHN/AY services.

Supporting DOH strategies and aligning visions, MH refined its technical approach to remain consistent with USAID integrated maternal, newborn, and child health (MNCH)/FP goals, the World Health Organization (WHO)'s health systems framework, and the Philippines' Health Sector Agenda.

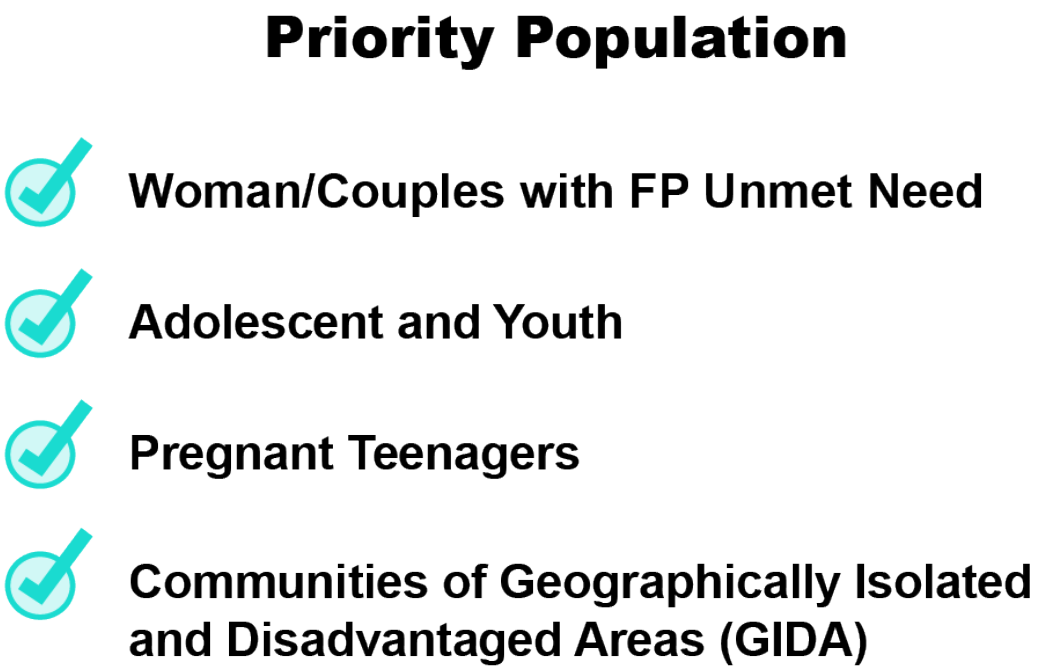
Stakeholders

MH categorized its stakeholders into five distinct categories and engaged with each according to their level of involvement in implementation:

- DOH regional officers
- Provincial health officers
- Public and private service providers and health care facility managers
- Civil society organizations (CSOs)/nongovernmental organizations (NGOs)
- Clients/beneficiaries

MH's technical approach focused on addressing three distinct yet interlinked health system gaps in three major components: supply, demand, and policy/financing. While the approach is visually compartmentalized, interventions in each complemented and/or leveraged others, accelerating results, particularly among priority populations. These approaches made it easier to introduce and institutionalize necessary sustainability mechanisms into every level of the health system.

Figure 3.

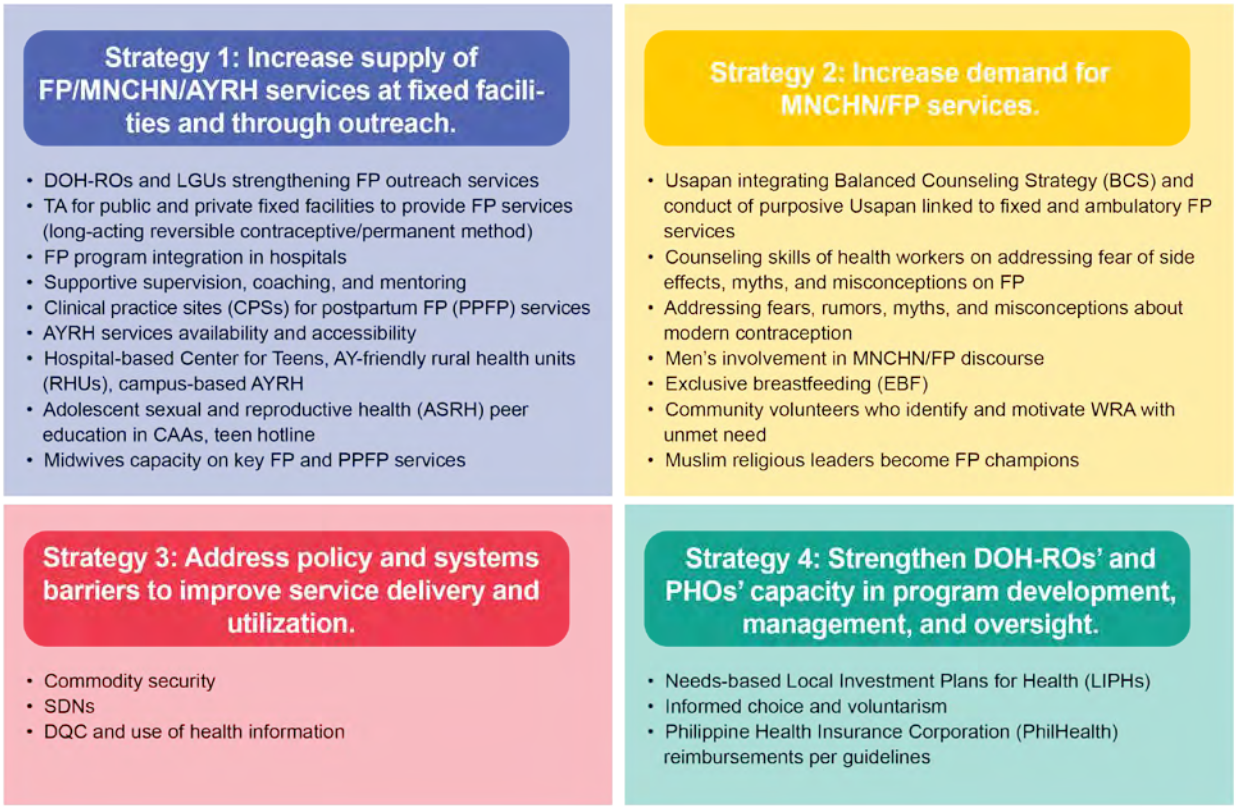


Key Implementation Strategies

MH prioritized its interventions within the three key focus areas of the project—supply, demand, and improved policy implementation—and delineated four specific strategies to meet each one.

FP Services Supply	Demand	Policy and Financing
• Quality FP/AY services • Strengthened referral • Enhanced client profiling	• Usapan • Client follow-up • CSO engagement	• Provider certification • Facility accreditation • Commodity security • DQC • Institutionalize SDN

Figure 4.



Working in Partnership

MH implemented its strategic approach and provided needs-based TA in close collaboration with the government as key stakeholder. During the project, the government upheld its commitment by undertaking the following initiatives:

- DOH investments in health facility improvements through its Health Facility Enhancement Program
- Deployment of nurses under the Nurse Deployment Program and midwives under the Midwives in Every Community (MECA) program in ARMM
- Centralized distribution of FP commodities at the DOH (starting 2015)
- DOH policies facilitating nationwide implementation of the government's MNCHN/FP program and the RPRH Act
- LGUs' efforts to meet PhilHealth's accreditation criteria for providers and facilities ; implementation of PhilHealth reimbursement policies
- Increased outreach services in partnership with CSOs and private providers, taking services closer to the underserved
- Receiving/accepting collective technical support from development partners on MNCHN/FP service delivery and health systems strengthening.

Key Results

Health worker Virginia Cadano doing prenatal care

Over the course of MH project implementation, MH collected National Demographic and Health Survey results from the six MH intervention regions on CPR, unmet FP need, antenatal care (ANC), and facility-based delivery (FBD). In close partnership with the government, MH:

- Increased Maternity Care Package (MCP)/Newborn Care Package (NCP)-accredited facilities from within MH-supported sites from 168 in 2013 to 301 in 2018.
- Increased the number of service delivery points (SDPs) providing FP counseling and services from 81 in 2012 to 744 in September 2018.
- Established 21 SDNs that could provide seamless MNCHN, FP, and AY services.
- Institutionalized an annual DQC mechanism in all facilities by trained health service providers (HSPs), aligned with resolutions and policies issued by the local chief executives (LCEs)/health leadership in ARMM, 15 provinces, and 28 municipalities.
- Developed a cohort of certified trainers—25 on bilateral tubal ligation (BTL), 72 on postpartum intrauterine device (PPIUD), and six on long-acting reversible contraceptive (LARC)/progestin subdermal implant (PSI)–gaining independence from Manila-based trainers.
- Traced the increase in current FP users from approximately 1.1 million at the start of the MH intervention site at baseline in 2012 to almost 1.7 million at endline, with a corresponding trend in couple-years of protection (CYP).

Table 1. National Demographic and Health Survey maternal, newborn, and child health and nutrition/family planning indicators by region, 2013 and 2017

Region	Modern Methods Contraceptive Prevalence Rate		Unmet Family Planning Need		Antenatal Care		Facility-Based Delivery	
	2013	2017	2013	2017	2013	2017	2013	2017
Philippines National	38.0%	40.3%	12.5%	16.7%	42.5%	86.5%	61.1%	77.7%
Zambo Pen	36.2%	42.0%	21.9%	24.0%	35.8%	88.9%	43.4%	72.3%
Northern Mindanao	37.6%	44.9%	20.2%	17.8%	42.9%	92.0%	52.6%	76.0%
Davao	39.3%	48.9%	17.5%	13.5%	33.1%	91.9%	62.9%	74.1%
SOCCSKSARGEN	44.2%	50.8%	15.6%	17.5%	33.2%	74.1%	48.5%	63.5%
Caraga	39.0%	46.8%	13.7%	17.8%	45.9%	90.4%	55.5%	77.2%
ARMM	15.3%	18.7%	27.6%	17.8%	9.0%	47.8%	12.3%	28.4%

The negligible increase in CPR in Zamboanga Peninsula; South Cotabato, Cotabato, Sultan Kudarat, Sarangani, and General Santos City (SOCCSKSARGEN); and Caraga points toward a need to share evidence on the effectiveness of SDNs in geographically isolated and disadvantaged areas (GIDAs), integration of FP and AY in hospitals, and engagement with clients at their doorstep through the *Toktok Planado Pamilya* (TPP) initiative.

MH achieved end-of-project CYP projections.

What worked?

- Underserved communities' access to quality long-acting permanent method (LAPM) services at fixed facility and outreach
- Service data recorded and shared by public- and private-sector service providers and facilities
- Effective supportive supervision for providers trained on PPIUD services

MH recorded a 128% increase in CYP generated by LAPM/LARC methods when comparing the baseline-estimated figure of 228,438 to 334,079 in PY5. This increase was recorded in spite of the temporary restraining order issued by the Supreme Court that disallowed the DOH to provide implants. That said, the private sector, including nonprofits/NGOs, did not remove the implant from the method mix they offered to their clients.

In ARMM in particular, all provinces except Lanao del Sur recorded an increase in CYP performance during the life of the project. Because recurring conflict constrained service delivery, MH strengthened partnerships with local CSOs, such as United Youth of the Philippines in Maguindanao, Tarbilang Foundation in Tawi-Tawi, Pink Pinay in Basilan, Likhaan Foundation in Sulu, and Al Mujadilah in Lanao del Sur. MH also forged partnerships with Marie Stopes International and collaborated with private hospitals in Basilan, such as Juan S. Alano Memorial Hospital and Amor Mclintock Isma. Mindanalano Hospital, a private facility based in Lanao del Sur, served clients from Marawi and Lanao del Sur, with help from MH on LAPM provision, in addition to at a non-ARMM public facility.

MH focused on institutionalizing **availability and accessibility of AYRH services** by aligning its agenda with government mandates, building on existing health system structures and networks,[4] and collaborating with agencies across the social sector. MH adopted a multipronged approach that included introducing risk assessment, information and counseling, and service provision in different settings; introducing initiatives to help AYs build their life skills and manage their sexual health and fertility; and linking AYs to educational and livelihood skills development opportunities.

In collaboration with the public and private sector and CSOs, MH helped build the **competencies and readiness of 744 SDPs** to provide AYs with information, counseling, referrals, and services pertaining to their distinct RH needs. These investments, together with the government's commitment for sustainability, are poised to instill healthy behaviors in this demographic, paying dividends in years to come. By end of the project, 19 hospitals had integrated FP/AY programs into their cache of services. In addition to MH's assistance, this integration was also in part a response to the 2014 DOH Memorandum on the Establishment of FP Programs in Hospitals, DOH Administrative Order (AO) No. 2013-0013 National Policy and Strategic Framework on Adolescent Health and Development. More than 110 RHUs/city health offices (CHOs) and schools were declared AYRH-friendly by project end—an increase from 47 in PY5.

MH collaborated with the government and supported more than 700 SDPs in maintaining low incidences of **FP commodity stock-outs** in project-assisted sites. This effort ensured none of these facilities had to turn away a client because of commodity shortages. Effective coordination between SDPs and the government included executing key activities:

- Regular supplies from the DOH Central Office (DOH-CO)
- Buffer stocks maintained at regional level
- The regional implementation team's effective and efficient coordination and reporting mechanism at the local level
- The Commission on Population (POPCOM)'s FP commodity tracking and monitoring mechanism
- The DOH-ROs' inventory management through pharmacists deployed in the provinces
- Use of simplified FP commodity inventory, order form, and commodity tracking tools (supply management and reporting system, infrastructure management service, and the contraceptive distribution logistics management information system) in more than 85% of RHUs and CHOs
- Recording and reporting of actual consumption reports to the FP logistics hotline and FP commodity online monitoring using Facebook

MH made a concerted investment in **enhancing the knowledge, skills, and performance** of more than 1,000 service providers in FP service provision throughout the life of the project, focusing on capacity of service providers to counsel on and administer FP/PPFP services. Training alone does not translate into improved quality of services, so the project led performance improvement sessions with doctors, nurses, and midwives on service provision of short-acting methods (e.g., progestin-only pills), subdermal implants, and intrauterine devices (IUDs) within 48 hours to 6 months postpartum. Accessible PPFP method mix allowed women to voluntarily choose FP based on their health needs and cultural sensitivities.

[4] Where possible, the AYRH component of MH collaborated with stakeholders within the SDN and aimed to expand the scope of the SDN by including unconventional stakeholders.

MH Strengthens FP Service Availability

- Fully trained providers deployed in program focus health service facilities (trained on: BTL-minilaparotomy using local anesthesia [MLLA], PPFP/PPIUD, PSI, FP competency-based training level 2 [FPCBT2])
- Nineteen hospitals providing FP and AY services after integration of these services in the overall cache of services
- Increase in PhilHealth MCP-accredited RHUs/CHOs/private birthing facilities receiving and reinvesting their IUD and PSI procedure reimbursements for sustenance and growth in LARC/permanent method (PM) (especially PSI) FP clients

The project subsequently conducted **supportive supervision visits** that helped service providers retain and improve the quality of their skills. To augment MH's focus on sustainability, the project trained high-performing service providers as FP trainers, especially for provinces that lacked this capability and/or were spending unsustainable funds on capacity-building visits to other provinces.

Early on in the project, MH focused exclusively on scaling up **centers of excellence** (COEs) in Northern Mindanao, City of Cagayan de Oro of Misamis Oriental, Bukidnon, Lanao del Norte, Agusan del Norte, and Agusan del Sur. During implementation, MH recognized two critical barriers to effective supportive supervision and mentorship for remote facilities: low volume of FP/PPFP clientele and time commitment for trainers that they were unable to meet. MH identified **clinical practice mentorship sites** (CPMSs) and built their capacity to mentor and train service providers on PPIUD. Each CPMS was a high-volume public or private facility in a suburban area. Providers, rather than trainers, were required to visit the nearby CPMS and arrange provider practice, supervision, and evaluation. Since September 2017, the DOH certified 37 facilities as CPMSs by sharing and using the MH-designed performance checklist for CPSs.

MH's investments increased the number of **SDPs integrating FP** in their MNCH services. The project exceeded its projections. Of the total SDPs integrating FP services, 17% were private-sector facilities. The government demonstrated its commitment and momentum in addressing unmet FP need by exceeding its SDP targets in Northern Mindanao, Davao, SOCCSKSARGEN, and Caraga. Zamboanga Peninsula remained within range of its planned SDP targets. By the end of the project, 744 SDPs had integrated FP into the range of their services. This is significant compared to the 81 SDPs providing FP services in 2012, at the start of the project. Of the 744:

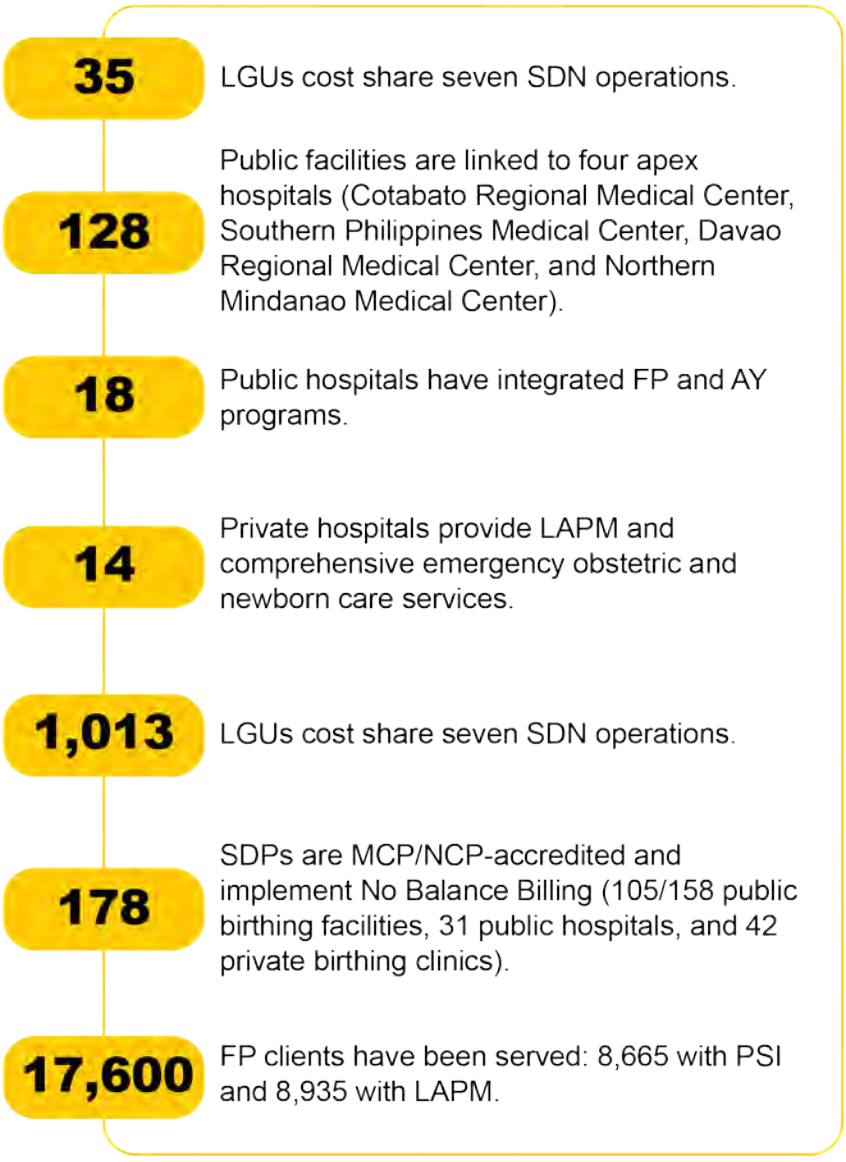
- 513 are located in rural areas
- 618 are public-sector facilities
- 126 are private service providers

Factors influencing SDPs to integrate FP/RH services include:

- MH shared the cost of the initial investments required for upgrading the facility for FP services with SDPs.
- An accessible training design for medical doctors (4-day staggered FBCBT1 with counseling skills course) allowed providers to combine learning with their duties.
- An EO from the highest office called for a serious review of approaches to limit family size, address teenage pregnancies, and increase private providers' involvement.

ARMM achieved targeted public SDPs but fell short on including projected figures of private providers. MH was able to enhance skills of 150 health workers in the region during the course of the project.

Figure 5.



MH established 21 SDNs across the project intervention areas. These networks enhanced potential FP clients' accessibility to services through integrated/seamless services via referrals or within the same facility's different departments. In collaboration with the regional DOH and stakeholders across the health system, MH developed the **SDN Operational Guide** to assist provinces and cities with systematically establishing an SDN. The eight-step process in this guide served as the foundation upon which MH provided TA.

MH expanded the scope and improved the efficiency of DOH certification and PhilHealth accreditation systems through participation in the National Implementation Team and its technical working group (TWG). MH successfully advocated to make PPIUDs and subdermal implants reimbursable, and to include nurses and midwives in the accreditation system. Not only has reimbursement proven to be a strong motivator and accountability mechanism for FP service providers, but it also allows the government to monitor and ensure high-quality FP services at all health system levels. To further increase the availability of FP services, MH supported the DOH to identify and prioritize noncertified facilities at the national and regional levels.

DOH accreditation of providers and facilities was one of the project's key focus areas. MH helped facilities and collaborating LGUs secure reaccreditation having completed and meeting MCP requirements. Accredited facilities were able to benefit from PhilHealth reimbursement policies, which translated into reinvestment of reimbursement into their facilities, providing sustainability and the opportunity to further strengthen service provision. By the end of the project, more than 300 MH-supported health facilities were accredited; 95 received their first accreditation, and 206 facilities upheld MCP/NCP **PhilHealth accreditation**, exceeding end-of-project projections**.**

More than 300 (333 of 368) LGUs received and utilized **PhilHealth reimbursements**. They benefited from reinvesting these funds in their health care facilities and strengthening their health care facilities and services. Likewise, an MH-supported cohort of almost 400 individual LAPM providers secured PhilHealth accreditation after attending MH-facilitated trainings and received needs-based supportive supervision and coaching to meet accreditation criteria.

Toward the end of the project, 12 priority sites and five provinces/highly urbanized cities were performing with minimal TA from the project and accomplished end-of-project targets at 104% and 123%, respectively—an indication of **sustainability of best practices**. These included:

- Public sector's improved capacity/competencies to provide FP services
- Hospital's mobile teams taking services to the underserved
- Effective partnerships among private, public, and civil society for MNCHN/FP
- Increase in LGU-initiated outreach services

One of MH's core objectives was to highlight the importance of data and their use in analysis of progress, development of strategic plans, and allocation of resources. MH invested in enhancing government and private-sector competencies in capturing, verifying, and using high-quality data by providing TA and persistent advocacy for institutionalization of **DQCs** within the multitiered government system. SOCCSKSARGEN LCEs and provincial city health officers in 13 provinces and 28 municipal local units issued policies mandating investments in DQC teams, equipment, logistics, and budget support for onsite data cleaning and validation activities through EO or office orders.

ARMM adopted a "no report, no commodity" policy, so compliance with reporting and DQC is high.

The 1993 devolution of government resulted in inconsistent health reporting tools across the health system. In collaboration with the USAID-funded LuzonHealth program and provincial LGUs, MH led a data workshop with FP coordinators and hospital management information system managers from 15 public hospitals to improve and **standardize data reporting and accuracy across provincial and DOH-retained regional hospitals**. During the May 2018 session, participants were oriented on the Field Health Service Information System (FHSIS), established a common understanding of key definitions (e.g., current users), and learned to disaggregate or consolidate data.

LGU Capacity Analysis Results

MH developed a capacity assessment index to identify needs and monitor improvement across intervention LGUs. This assessment tool, called the Capacity Index, measured the status of 13 key indicators with the potential to enhance availability and access to FP/AY services, increase demand, and establish an enabling environment for sustainability. After a year of interventions, MH undertook another LGU capacity analysis to deliver FP/AY services to well-informed and counseled clients within an enabling policy environment.

Except for Davao City, the increase in the FP Capacity Index ranged from 4% to 69%, with Lanao del Sur posting the highest percentage increase. MH attributes overall increase in the FP Capacity Index to:

- 136% increase in AY-friendly facilities (from 55 in PY5 to 130 in PY6)
- 25% increase in LGUs that conducted DQCs (from 280 in PY5 to 349 in PY6)
- Increase in certified HSPs after undergoing training and supportive supervision

Sustained support to 21 SDNs across USG sites, resulting in four functional, 10 operational, and seven organized SDNs

Q: What is the FP Capacity Index?

A: It is an assessment tool measuring 13 key areas for provision of high-quality FP/AY and MNCH services. The tool applies weighted scoring to four key components:

- Service delivery 40%
- Demand generation 20%
- Policy and financing 20%
- AYRH 20%

Each of the four key components has subcomponents. Each subcomponent is assessed on a 1 to 3 scale, then multiplied with the corresponding weight to measure on an index of 100.

The indices serve as proxies:

- High/Level 3 (green zone) : 76 to 100
- Medium/Level 2 (yellow zone) : 51 to 75
- Low/Level 1 (red zone): 50 and below

While there was an overall increase in the total FP Capacity Index scores, there was a reduction in MCP/NCP-accredited and validated SDPs providing FP counseling and services (from 757 in PY5 to 744 in PY6). An increase in incidence of commodity stock-outs affected improvement scores of LGUs, such as Zamboanga del Sur, Misamis Oriental, and Cagayan de Oro.

Zamboanga City, Davao Oriental, Lanao del Sur, Tawi-Tawi, Sulu, and Zamboanga del Norte, located in the red zone in 2017, moved to the yellow zone. Ten of the 18 MH intervention sites in the yellow zone moved to the green zone in the fourth quarter of PY6, while the eight remaining fell short of reaching the green zone. High scores on policy and financing mechanisms reflect government support to institutionalize reforms for provision of high-quality FP/AY services along the continuum of care across all levels of health care.

One concern remains: Davao City's lack of initiative and progress during the year.

Figure 6. **FP Composite Index by USG-sites, September, 2017 (Q4PY5)**

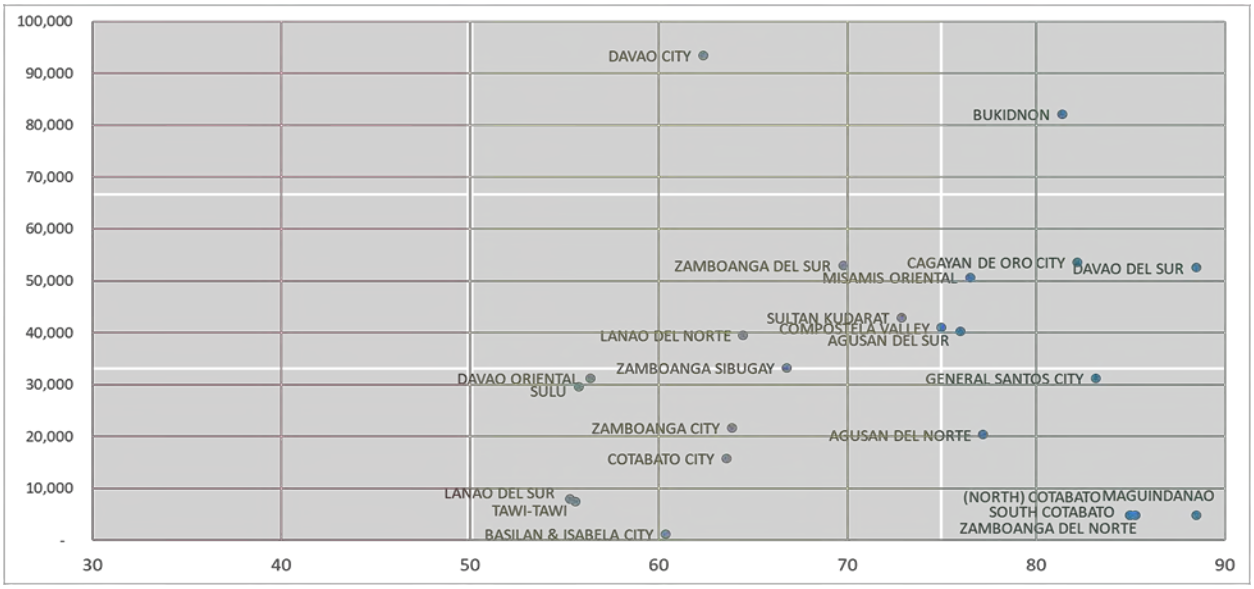
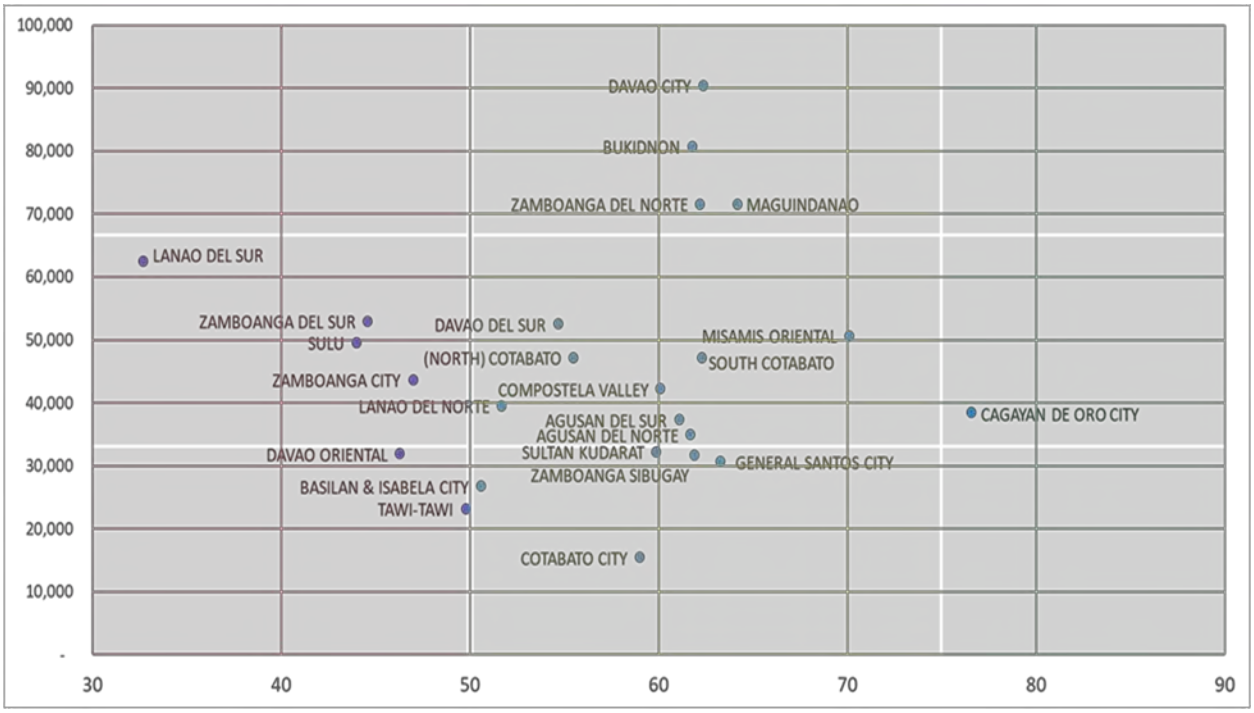


Figure 7. FP Composite Index by USG sites, September 2018 (Q4PY6)



At the end of the project

- There were **six Level 1 (red) sites** closer to Level 3 (Green zone). Zamboanga City, Davao Oriental, Lanao del Sur, Tawi-Tawi, Sulu, and Zamboanga del Norte moved to Level 2 (yellow zone), with Zamboanga del Norte
- **Ten of the 18 sites in Level 2** progressed to Level 3.
- **Seven sites** fell short of meeting Level 3 (green zone) scores, with no change for Davao City. Lanao del Sur posted the highest increase, attributed to the accelerated support to the region in the aftermath of the Marawi Siege.

In the wake of the unfortunate Marawi Siege, MH was one of the first respondents to the humanitarian crises and donated:

- 4,000 jerry cans and 8,000 Aquatabs to DOH-ARMM
- 2,000 jerry cans and 4,000 Aquatabs to the integrated provincial health office (IPHO)-led Lanao del Sur Marawi Crisis Team

MH supported:
FP service provision: At least two outreach service camps were organized each month, while 46 of the region's 53 facilities were able to provide FP services.
Humanitarian relief: Installed 10 water tanks in health facilities with technical support from the Strengthening Urban Resilience for Growth with Equity team (technical provider to Salintubig Initiative) in health facilities/barangay health stations (BHSs) in Ambolong and Tuca in Marawi and the Nunungan RHU in Lanao del Norte.
Maternal and newborn services: Provided services, including provision of dignity and maternity kits, to 7,722 pregnant and 5,881 postpartum women, respectively.
Psychosocial services: In partnership with Duyog Marawi, provided psychosocial support and counseling to almost 250 women and men during outreach services.
Infrastructural support: Installed solar power and solar refrigerators in four health facilities.

To meet the needs of CAA populations, outreach activities and number of clients exceeded MH-projected figures. When security was not a barrier, the project held activities to meet the needs of these underserved populations. MH supported the IPHO Lanao del Sur, which led the Marawi Crisis Team. MH, with its partners, such as United Nations Populations Fund and Zuellig Family Foundation provided hygiene kits), pregnancy kits and jerry cans and Aquatabs to internally displaced populations hosted by four municipalities: Calanugas, Binidayan, Buadiposo, and Taraka.

Additionally, to support outreach efforts, MH provided IPHO Lanao del Sur and CHO Marawi with:

- 14,400 hand fans and 30 flip charts with FP messages
- Nearly 50 Usapan flip charts, 50 informed choice and voluntarism wall charts, 20 essential intrapartum and newborn care (preparing for birth charts), 342 FP placemats, 37 FP stamps, and two boxes of easel sheets

Lessons and experiences: MH documented lessons, best practices and its experiences in compendia, other publications, and advocacy materials; and presented key findings during regional dissemination forums. MH gleaned lessons and recommendations included in this report from these comprehensive documentation efforts.

MH's TA forged partnerships with key stakeholders for collective efforts over the 6-year collaboration . These provided a wealth of potential best practices and learning as the project introduced and institutionalized integrated FP, MNH, and AY services. Some initiatives evolved into formal guidelines/campaigns for scale-up and replication, such as campus-based AYRH services. MH started this initiative, Youth Optimizing Life Opportunities (YOLO), in 12 schools in Agusan del Norte in partnership with the provincial Department of Education (DepEd) division and expanded to an additional 22 schools within the province under the leadership of the provincial DepEd superintendent, with minimal MH support. Mere sharing of this initiative among provincial DepEd leadership led to further expansion to an additional six schools within the District 2 SDN in Zamboanga del Sur, including an orientation for Zamboanga Sibugay's DepEd division's core team.

Products and tools developed and handed over to stakeholders included:

- SDN Operational Guide
- Operational guides for hospital-based programs or Centers for Teens
- PPIUD Manual: Facilitators' Guide
- PPIUD Manual: Handbook for Health Service Providers
- Frequently Asked Questions on Modern FP Methods
- Social Media Guide for AYRH (#SoMe4AYRH)
- Teen Hotline: Operational Considerations, Protocols, and Procedures
- Khutba or sermon guide for Muslim religious leaders on FP, RH and MCH topics
- Community Health Workers (CHWs) Toolkit
- Rapid Home, Education, Employment, Activities, Drugs, Sexuality, and Safety (HEEADSS) Guide

By MH closeout, the project had more than 15 promising best practices documented and used as evidence in advocacy by the project and by the DOH-RO during regionwide activities.

MH developed specific needs-based technical guides: i) client referral guides for SDNs for Agusan del Norte's BueNasCar (Buenavista, Nasipit, Carmen) and Agusan del Sur's D.O. Plaza, and ii) an operations manual for DepEd and Agusan del Norte's YOLO program.

Collaborating with WHO's subnational initiative, Accelerating Convergence Efforts through Systems Strengthening for MNH, MH informed the development of a user-friendly toolbox on MNH and FP that consolidated relevant technical guidelines and technologies. Launched in September 2017, MH shared the resource with partners in Davao Region as reference guidelines when adapting to local settings.

MH presented its SDN implementation learnings and insights at the learning clinic organized during USAID's national dissemination forum. Participants particularly appreciated the nonprescriptive approach adopted by the project in setting up SDNs. LuzonHealth drew an interesting comparison between MH's SDN approaches and its own, where the operation of SDN revolves around the influence of Batangas Medical Center as its apex facility in the referral mechanism, addressing challenges posed by the propensity of higher-level hospitals to operate autonomously out of SDN's larger goals and objectives. MH shared its holistic approach, which emphasizes strong governance and leadership. MH considered its emphases the main drivers to crystallizing a financing mechanism, public-private and community partnership, cross-border and cross-sector referrals, capacity-building, and translating policy into action.

In the true spirit of collaboration, learning, and adaptation, MH witnessed the birth of FP and AY champions. Health partners from hospitals, RHUs, and PHOs shared their own journey and learning curve, from passive implementers with biases and personal barriers to becoming FP/AY champions. These champions acknowledged the impact of sustained professional relationships/partnerships, where all stakeholders collectively measured, shared, and appreciated gains made, and resolved operational challenges through consultations and learning from others' successes. Recognizing their critical role within the health care system, hospitals vowed to work in collaboration with other SDPs, the government, and other stakeholders.

Chronic Challenges and Recommendations

Mindanao as a region presented challenges emanating from the security situation that affected mobility and the team's ability to follow through with all activities according to stipulated timeframes. MH noted additional challenges that influenced actual service delivery in Table 2.

Table 2. MindanaoHealth (MH)-identified challenges influencing service delivery

Challenge	Impact
The January 1, 2018, PhilHealth accreditation renewal or initial application requirement included submission of the Department of Health (DOH) license to operate for all Maternity Care Package (MCP) providers/birthing homes.	An immediate impact was a reduction in the number of public and private health facilities that were able to renew their MCP/Newborn Care Package PhilHealth accreditation. This is due to non-compliance to the DOH's new licensing requirement.
MH Efforts	
• MH and other stakeholders brought the service facilities'/providers' inability to comply with DOH licensing requirements to the attention of the Responsible Parenthood and Reproductive Health National Implementation Team. • MH also highlighted the challenges arising from a lack of clarity in the requirement that led to multiple interpretations of these new guidelines, adding to the confusion. • MH did not observe any response/action taken by the concerned authorities until project closeout.	

Commodity security: FP programs cannot avoid commodity stock-out if the delivery of FP commodities from the DOH-CO are not timely and if LGUs do not procure FP commodities to augment dwindling supplies. Despite MH and its stakeholders' efforts, MH observed during last year of the project that the DOH-CO continued to disburse FP commodities to various SDPs using a "push" strategy with inadequate inventory or need analysis.

The DOH-CO did not undertake the required review of the consumption reports the DOH-ROs and LGUs submitted through the FP logistics hotline. SDP inventory reports reflected critically low stock levels of IUDs and PSIs, and increasing demand for PSIs. Aggravating the situation was that the DOH did not procure FP commodities in 2018. As a result, MH observed that FP commodity stock-outs for short- and long-term methods would increase, compounded by generated demand for FP services. To avert stock-out, the DOH's central FP logistics management needs to assess performance of third-party logistics contractors in the delivery and distribution of commodities to health facilities, and of the national supply chain and logistics management system to identify prevailing bottlenecks to cut down on the more than 3 months of commodity restocking at the facility level.

MH provided technical support to shift commodity supply from a push-/target-oriented strategy to one based on demand and use. As the first step, MH focused on evolving existing mechanisms toward institutionalization of FP commodity recording and reporting through the FP commodity tracking network (logistics hotline and social media). MH helped enhance the efficacy of regular monitoring of overall health commodity stocks, including FP, with coordination mechanisms at the regional and local levels. These mechanisms using inter-LGU and facility coordination facilitated DOH pharmacists and family health associates to immediately reallocate and redistribute commodities based on inventory and need.

Data recording and reporting: The DOH led national-level orientation sessions for core hospital teams on the importance of FP recording, reporting, and follow-up using MH's TA. While the DOH led the initiative in collaboration with the DOH-ROs, DOH-ROs' and facilities' data recording and reporting have been slow due to human resource management. The facility appoints one person to record data and relies completely on this designated focal person. Often, management adds this task onto the existing tasks of a staff member, resulting in data recording slipping in the staff member's priorities. The focal person does not record data if s/he is busy with other tasks or is unavailable. Another challenge is frequent staff turnover due to transfers. The facility is unable to replace trained personnel immediately, leading to gaps in data recording. Vigilant and thorough technical oversight of LGUs by DHO-ROs can address this gap.

Sustainability Recommendations

The project recorded many gains under MH, including improved CYP through integration of FP in maternal health services; establishment of a robust SDN model, improving referrals and seamless service provision; and initiation of AY-friendly services, which meet the unique needs of the AYs within intervention communities. Overall, MH data demonstrate that the project's inputs were necessary but not sufficient to establish consistently optimal continuum of care through linkages among the three facility levels, private service providers, and underserved communities. MH observed some areas that required sustained systemic emphasis to optimize the investments made.

Complementary supply-side and demand-side investments will achieve uptake of available, accessible, high-quality services. Demand generation efforts, when made alongside strengthened service delivery, can warrant meeting a client's needs holistically. Some examples include:

In Davao Region, mobile LAPM services reached underserved communities, but only after raising awareness of the Centers for Health Development, PHOs, municipal health offices (MHOs), and LGUs to address the needs of the conditional cash transfer (CCT) holders with unmet FP needs. Similarly, when MH collaborated with Marie Stopes International and other local HSPs for LAPM at Cateel District Hospital and Baganga Lying-in Center, they scheduled services on designated days and spread this information among communities' weeks in advance.

Directed messaging toward segmented groups through Usapan events showed increase in FP uptake. Clients benefit from counseling and detailed information provided by HSPs on their voluntary method of choice from within the community and at the health facility. Likewise, Usapan facilitators' skills in addressing both individual and group concerns are effective, provided facilitators have the opportunity to provide feedback to one another and collectively improve their skills.

Regulation and certification, a cornerstone of high-quality services, is resource intensive. Comprehensive plans for investments in provider skills and health care facilities are essential for enhancing provider performance, instigating healthy competition in achieving government commitments.

Referral mechanisms: Lack of efficient referral mechanisms affects clients' experience of the continuum of care. This is one of the leading reasons for sluggish FP service uptake. Sustained engagement and collaborative agreements with LGUs, MHOs, and the private sector are key for a strengthened health system, which MH learned through the establishment of SDNs.

Learning and leveraging best practices and gains made when designing strategies helps prevent duplication of efforts. MH benefited from the learning, resources, and gains of HealthGov, SHIELD, and the Private Sector Mobilization for Family Health Phase II project when developing pathways to navigate and meet project objectives and goals. Bypassing or short-circuiting a consultative process to secure consensus of all key stakeholders before launching any initiative can impede implementation, as even one dissenting voice can influence political will and commitment.

Commodity security: Commodity is essential to empower trained providers to translate their skills into practice, meet client expectation, and achieve the government's zero tolerance on unmet need for FP.

Monitoring, coaching, mentoring: These are inherent components of enhancing providers' and health facilities' skills and performance in meeting client needs. Sustained improvement in service provision and uptake can be assured by: fund allocation for supportive supervision, especially following comprehensive training programs; mandatory orientation by the DOH-ROs of newly deployed development management officers on MNCHN/FP; and developing monitoring, coaching, and mentoring plans together with DOH representatives and joint/synchronized mentoring/coaching activities with PHO team. To optimize benefits of resources, DOH-ROs can use anatomic teaching models to assess provider skills in case there are no clients at the time of supervisory visit.

Security: Robust security protocols and strategies are essential for successful interventions in fragile areas, such as ARMM. Initiatives, such as group visits, internal alert systems, and securing prior clearance by DOH- ROs, PHOs, and local authorities, need to be put in place, regardless of these being resource-intensive measures.

Master trainers: The government can address the lack of master trainers with updated skills by engaging trained providers from health centers to provide supportive supervision for their own colleagues. The advantage is peers can benefit from their colleagues' skills and develop norms around quality assurance and accountability.

Evidence-based decision-making: The government has various health information systems (HISs) used across its health facilities, and there is no uniform mechanism to capture private-sector data. MH supported and advocated for standardized, robust information systems to record progress made in meeting policies, informing plans and strategies, and budgeting allocations to address needs and gaps with LGUs, SDN partners, and government officials during project life. MH made DQCs one of its key investments, building the capacities of LGUs and DOH-ROs on the use of the dashboards for advocacy, project review, and planning. For example, MH noted that hospitals did not disaggregate data, which posed challenges when following up with/tracking clients, especially AY clients. MH trained IT personnel and FP coordinators on data recording/reporting using the DOH's FP recording/reporting templates. Similarly, electronic data generation, which includes date of birth, helps facilities respond or adjust to the needs of their AY clients, process claims, and identify providers who assisted clients. Sustaining MH investments by developing a robust human resources plan and strengthening partnerships forged by MH with selected private clinics and hospitals will allow for an efficient mechanism to gather, analyze, and share data, preventing double counting and missing client/service numbers.

SDN: Establishing and sustaining SDNs is vital, especially when LGU officials request it, and the DOH-RO strongly supports the networks. The government's commitment is reflected in:

- Five DOH regional directors and the DOH-ARMM secretary's endorsed and adopted the SDN Operational Guide.
- Public and private facilities in the SDN implemented the No Balance Billing Policy for 4Ps/CCT households. This demand generation strategy encourages clients to utilize health services at the facility.
- The DOH and LGUs developed health facility plans considering strategic locations that were responsive to SDN strategy and better access to MNCHN/FP and other health services.
- Government support ensured involvement/participation of private-sector, community-based organization, professional organization, and indigenous peoples (IP) in the SDN structure
- Successful public-private partnership (PPP) is based on the principle of shared governance, acknowledging that both the government and private sector have advantages relative to one another.

Adding SDN to the regular agenda of local health boards, RICT, regional implementation team (RITs), and other official/formal coordinating mechanisms has the potential to generate collective support for and sustainability of SDN initiatives at all levels.

Enhancing skills and performance: MH invested extensively in training and providing supportive supervision to a wide range of service provider cadres. Some overall lessons:

- PPFP/PPIUD trainings should have no more than 15 participants and include practice on actual IUD insertions to instill confidence in providers as they return to their facilities.
- Supportive supervision must be incorporated as an inherent part of any skill. MH has evidence on its efficacy in providers' improved performance compared to a training without post-training supportive supervision.
- CPSs should be established for providers to learn, practice, and improve their skills.

Quality, integrated FP/MNCHN/AY service delivery is possible when LGUs and private clinics:

- Can maintain the physical structure/infrastructure of their MCP/NCP PhilHealth-accredited facilities.
- Ensure commodities and zero stock-outs through efficient planning and procurement.
- Remain compliant with Level 3 DOH hospital criteria that classifies them as reporting units, submit timely reports to the DOH-ROs, implement policy/technical guidelines, and operationalize these policies at implementing levels.

Performance, Impact, and Data

Data Included in This Report

Many of the tables and figures included in this report present data by year, defined as:

- Year 1 (February 2013–September 2013)
- Year 2 (October 2013–September 2014)
- Year 3 (October 2014–September 2015)
- Year 4 (October 2015–September 2016)
- Year 5 (October 2016–September 2017)
- Year 6 (October 2017–September 2018)

CYP: As of June 2017, 88%, or 1,081,842 CYP, were recorded of the end-of-project target of 1,232,995. MH contributed 34% to the overall health systems accomplishment, as reported in the FHSIS.

lncrease in FP current users: MH saw an increase of 366,971 users from the 2013 baseline of 1,070,486 users. This reflects a 103% cumulative accomplishment (1,437,457 users against the end-of-project target of 1,399,564 users).

SDPs providing FP services: MH capacitated 718 SDPs (or 108% of the end-of-project target of 663) to provide FP counseling and services; 493 provide LARC/PM services, 42 are certified clinical practice and mentoring sites for PPFP/PPIUD, 13 hospitals have an integrated FP program, and five are a certified COE on PPIUD.

AYRH services: MH's efforts resulted in 60 health facilities (public and private) now providing AYRH services, with the establishment of Centers for Teens in 10 hospitals and 50 AY-friendly facilities (see details in Annex E).

SDPs with stock-outs of FP commodities: Stock-out rates for pills, depot medroxyprogesterone acetate (DMPA), and IUDs remained at 3% as of PY4, a reduction of 40% from PY3 stock-out rates of 5%. The strong collaboration with POPCOM field teams and established tracking mechanisms of FP commodities across facilities at LGU levels helped track and resolve incidences of stock-out in every facility.

PhilHealth accreditation: A total 258 facilities (78%) completed MCP reaccreditation, while 326 LGUs (89%) issued policies on PhilHealth reimbursement. On FP accreditation, there are 148 LAPM PhilHealth-accredited providers out of 489 DOH-certified providers (six BTL-MLLA-accredited providers out of 65 certified and 142 PPIUD-accredited providers out of 424 certified). Other health facilities are waiting for the DOH's Health Facility Enhancement Program support in order to comply with required structure.

MH completed compendia on SDNs, FP programs in hospital settings, AYRH, and Usapan sessions as a demand generation approach. MH subsequently integrated and published them in four separate compendia of lessons and experiences on interventions of USAID implementing partners in the Philippines: *SDN: Policies, Resource- Matching and Monitoring*; *FP in Hospitals: A Case for Localization, Integration and Cohesion*; *AY Health and Development: The Path for Innovations and Meaningful Participation*; and *The Usapan: A Behavioral Change and Communication Strategy to Help Achieve Zero Unmet Need for FP*. In addition, MH documented 19 emerging best practices. It disseminated these practices in two regions.

MH has so far established 21 SDNs across project sites. Best practices emerged on PPP, such as the unified reporting system in Iligan, six private hospitals' enlistment of the SDN in Sultan Kudarat, community-based transportation and communication support for referral in Agusan del Sur, and the PPP on health in Davao City, to better serve the health needs of the IP community. Eight SDN sites documented referral mechanisms and protocols, while nine SDNs initiated the integration of modern FP program in hospitals serving as end referral facilities for LAPM services. The two Caraga regions incorporated SDNs and AY protocols in their respective referral manuals.

Supportive supervision: This key project activity saw more than half of the 1,050 PPIUD-trained HSPs (617) supportively supervised, with 35% (371) certified across 173 SDPs.

Outreach in CAAs: MH's efforts helped reach 19,719 women, children, and youth in CAAs through outreach efforts, providing information, support, and referrals for FP/MCH services.

CHWs: A key source of FP information, counseling, and referral support, the project surpassed its overall target by reaching 2,014 CHWs, who in turn engaged with 8,413 WRA, providing information on FP and referring 6,955 to service facilities within MH's SDN.

Overall, MH's performance met its estimated projections, specifically:

- Reduced unmet need and increased use of modern FP methods in USG-assisted sites by:
  - Scaling up, institutionalizing, and sustaining proven best practices and promising high-impact interventions on strengthening FP and MCH
  - Improving quality of FP and MCH service delivery
- Scaled up evidence-based best practices and promising high-impact interventions on adolescent RH to help reduce teenage pregnancies
- Bolstered capacity of local health systems in consolidating results and institutionalizing effective strategies to help reduce unmet need for modern FP and MCH.
- Developed and studied/investigated innovative approaches in the provision of high-quality adolescent RH and gender-friendly health services.
- Assisted in immediate response to health emergencies in Marawi City and its corridors, and restoration/strengthening of essential FP and MCH services in Marawi City and other CAAs.

Current Modern FP Users in USG-Assisted Areas

Table 3. Distribution of number of current users in US Government/MindanaoHealth-assisted sites by priority clusters, PY5-PY6

Project Areas Clustered by Level of Priority	2012	PY5	PY6		
			Projections PY6	Actual	%
Priority areas: 12 priority sites	704,076	1,065,334	1,100,761	1,148,358	104
Conflict-affected area sites: Basilan, Sulu, Tawi-Tawi, Zambo City, Cotabato City	267,936	147,063	180,564	174,758	97
Marawi and its environs		103,029	118,590	107,044	90
5 nonpriority sites	98,474	152,795	215,487	267,977	124
Projectwide	1,070,486	1,468,221	1,615,402	1,698,137	105

Figure 8. Summary of accomplishments and trends in current users (Q4PY2–Q3PY6)

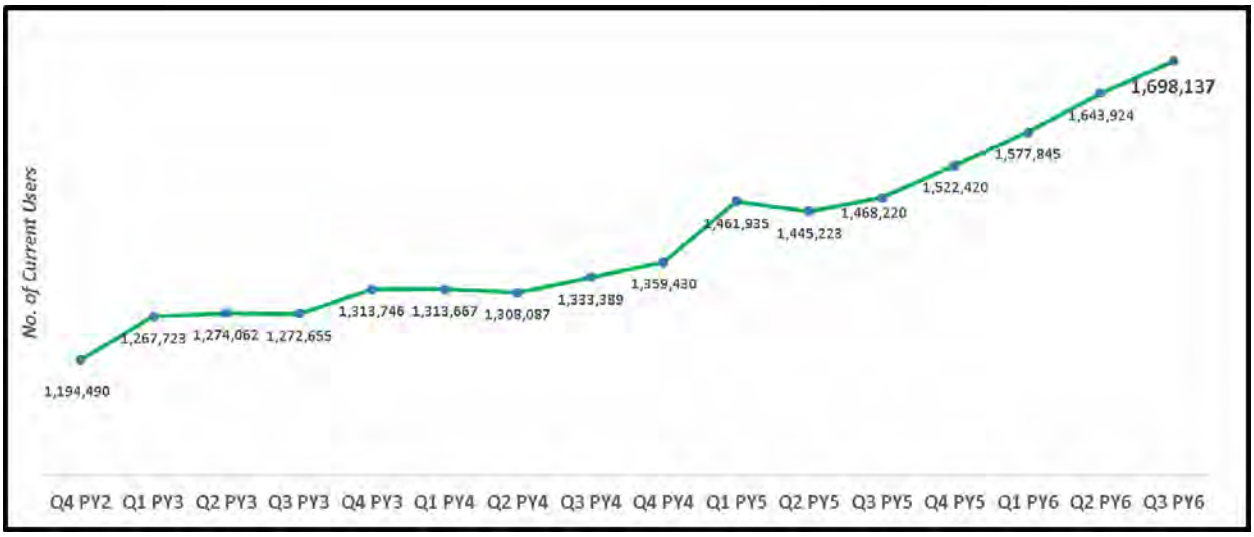


Figure 8 illustrates the upward trajectory of current users during the last four quarters of the project. With an average increase rate of 3.1% per quarter, the project observed the highest in the second quarter of PY6. The highest increase, 14.3% in Bukidnon—from 113,043 to 129,194—was due to five key initiatives:

- Creation of the provincial FP itinerant team that uses the SDN approach in providing LARC services, especially in GIDAs and in areas where there are no or very few trained HSPs on LARC services
- Clear delineation of provincial/municipal/city RPRH implementation team roles, avoiding duplication
- Institutionalization of recording and reporting system with periodic DQCs
- Functional logistics reporting, recording, management, and data utilization
- Incremental increase of MH-assisted CHWs, pointing to the efficacy of community-based demand generation initiatives

During last year of the project, the 12 priority LGUs and the nonpriority areas cluster consisting of 5 LGUs exceeded their PY6 target and contributed 67% and 16%, respectively, to the overall total current users (Table 4).

Table 4. Distribution of current users by type of modern family planning methods, in US Government/MindanaoHealth-assisted areas, Q3PY6

Project Areas	LAPM (NSV/BTL)		LARC (PPIUD, IUD, PSI)		SARC (Pills, DMPA, Condom)		Natural Family Planning		Total	
	#	%	#	%	#	%	#	%	#	%
Priority areas: 12 priority sites	102,240	9%	193,642	17%	735,878	64%	116,598	10%	1,148,358	67
Conflict-affected area: Basilan, Sulu, Tawi-Tawi, Zambo City, Cotabato City	9,593	9%	17,467	17%	122,982	64%	24,716	10%	174,758	10.5
Lanao del Sur and Norte	3,979	9%	11,216	17%	72,486	64%	19,363	10%	107,044	6.5
5 non-priority sites	26,879	9%	53,584	17%	151,638	64%	35,876	10%	267,977	16
Project-wide	142,691	8%	275,909	17%	1,082,984	64%	196,553	12%	1,698,137	100

BTL = bilateral tubal ligation, DMPA = depot medroxyprogesterone acetate, IUD = intrauterine device, LAPM = long-acting permanent method, LARC = long-acting reversible contraceptive, NSL = no-scalpel vasectomy, PPIUD = postpartum IUD, PSI = progestin subdermal implant, SARC = short-acting reversible contraceptive

Despite the efforts to raise awareness on the safety and efficacy of long-term contraceptive methods, short-term methods remain popular with highest uptake, most significantly in CAAs. This could be due to the perception that short-term methods have fewer side effects or due to the ease of availability of these contraceptives. Use of condoms points toward the involvement of men in pregnancy spacing.

The initiative to disaggregate potential clients' needs into those who want to limit and those who want to space helped providers and community-based workers conduct client-centered counseling and efficient client follow-up, supporting women's voluntary choice through side effect management, if any. PSI uptake shows an upward trend. MH attributes this to four reasons:

- Acceptability among clients due to the "less invasive procedure compared to IUD"
- Availability in outreach settings due to ease in method provision
- Increase in HSPs who received training and supportive supervision, which led to DOH certification (PhilHealth accreditation requirement)
- Higher PhilHealth reimbursement for PSIs compared to IUDs (PHP 3,000, PSI; PHP 2,500, IUD), which can motivate the provider, provided woman is informed voluntary choice compliant

WRA Profiled and Identified with Unmet Need for FP

Table 5. Women of reproductive age (WRA) profiled and identified with unmet need in family planning (FP) as of Q4PY6

Project Areas	WRA with Unmet Need for FP*	Accomplishment for Q4PY6	Cumulative Accomplishment		
			Target, End of Project	Actual	%
Priority areas: 12 USG sites	464,639	450,317	464,639	720,262	155
Conflict-affected area sites: Basilan, Sulu, Tawi-Tawi, Zambo City, Cotabato City	112,663	12,094	112,663	18,761	17
Marawi and environs (Lanao del Sur and Lanao del Norte)	75,109	10,944	75,109	39,281	52
5 nonpriority sites	116,074	30,278	116,074	40,605	35
Projectwide Total	**768,485**	**503,633**	**768,485**	**818,909**	**107**

* - Target based on the costed implementation plan as per Department of Health memo issued on November 16, 2017. In program implementation reviews, end-of-project target is only 470,840.

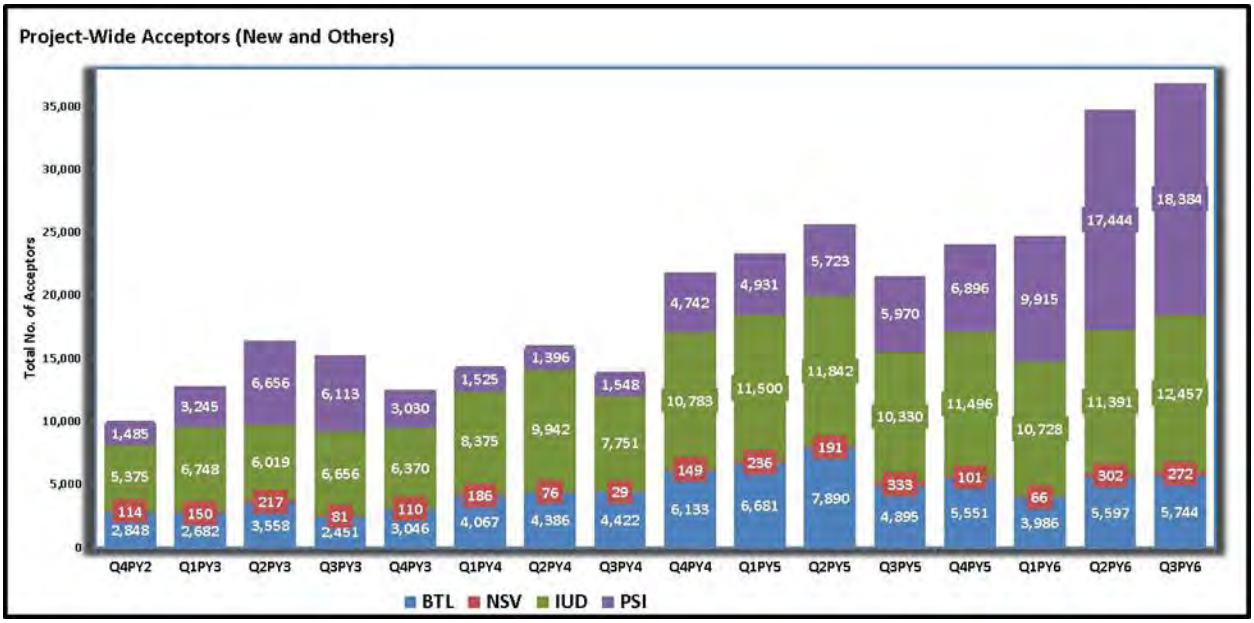
The project noted multiple reasons for the reduction of WRA with unmet need. An overarching reason is a stronger health system with all stakeholders collaborating in provision of quality continuum of care. Key factors include:

- Creation of the provincial FP itinerant team that used the SDN approach in providing LARC services, especially in GIDAs and in areas where there are no or very few trained HSPs on LARC services
- Creation of provincial/municipal implementation teams, which clarified the roles of each agency involved in the implementation of RPRH at the local level, thereby increasing support to FP outreach services, both technical and financial
- Institutionalization of recording and reporting system with periodic DQC that recorded WRA provided with FP services
- Functional logistics reporting, recording, management, and data utilization that prevented stock-out of FP commodities, coupled with the strong intermunicipal and interregional coordination, especially on FP commodity sharing

- Quarterly incremental increase in the number of MH-assisted CHWs who reached WRA with unmet need, providing FP information and referral for FP services
- Including the profiling of WRA and identifying those with unmet need for FP as part of demand generation initiatives
- Proactively reaching WRA by LGU health teams and/or DOH-deployed family health associates conducting house-to-house campaigns with community health worker support
- Improving the health information system

Client profiling for unmet FP need remained low in CAAs because profiling in Marawi and its environs started in the later part of project year 6, in the second quarter, after training newly hired 40 family health associates for Lanao del Sur and Marawi. Other reasons included restriction on mobility and capacity to reach island and mountainous barangays in ARMM and other CAAs, low number of mobilized CHWs, and sporadic and incomplete reports from Zamboanga City and Isabela City.

Figure 9. Long-acting reversible contraceptive-permanent method acceptors by method/quarter, Q4PY2–Q3PY6

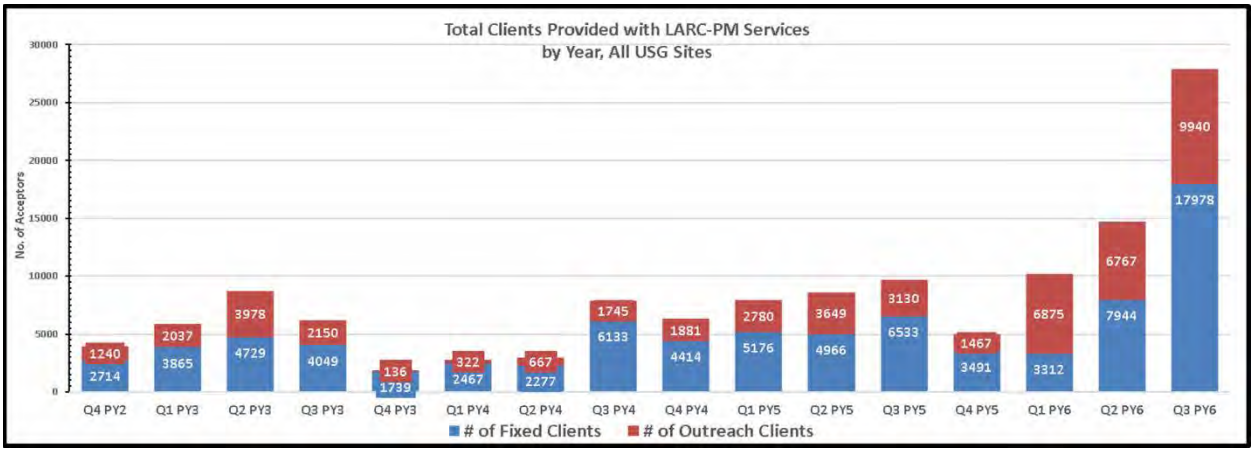


Source: DOH FHSIS

Fixed service provision sites show a steady increase in providing LARC/PM services due to improved capacity of providers and facilities. The closedown of an NGO that provided most outreach services may be one contributing factor, combined with the fact that the LGU FP outreach services only offer short-acting reversible contraceptives/natural FP and LARC/PSI.

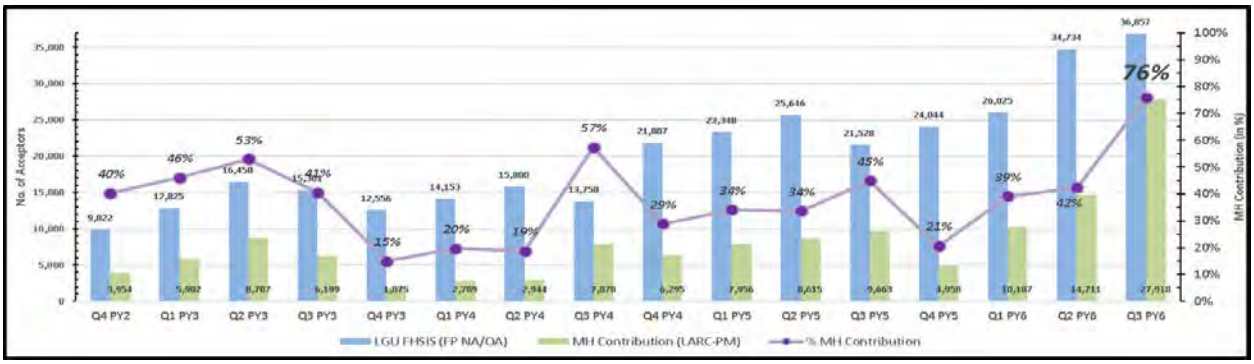
Until the end of the MH project (the third quarter of PY6), contribution of private-sector partners remained small, as 12 private birthing facilities that could not meet all DOH license-to-operate requirements had to suspend their services. Another 41 public health facilities in Misamis Oriental and Cagayan de Oro City were unable to renew their MCP/NCP PhilHealth accreditation due to the same reason.

Figure 10. Long-acting reversible contraceptive-permanent method clients served in fixed sites and outreach activities supported by MindanaoHealth (Q1PY3–Q3PY6)



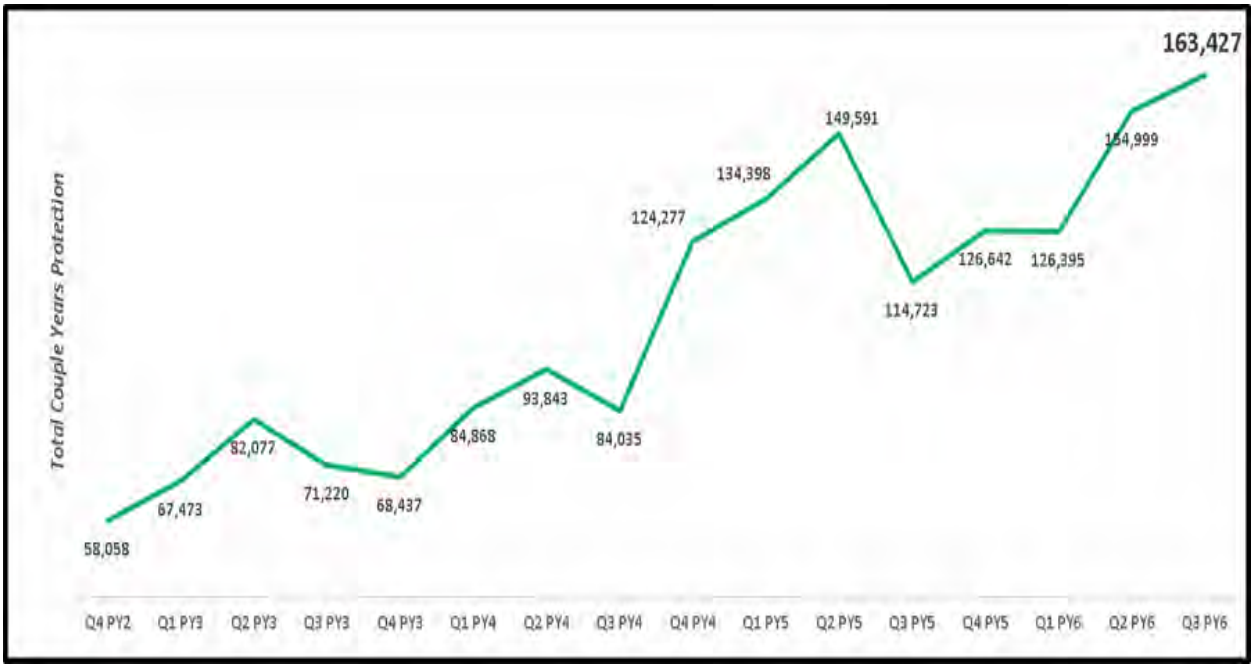
LGU-initiated outreach services increased with improved capacity of public-sector hospitals' mobile/outreach service teams combined with the accelerated, sustained support from MH.

Figure 11. MindanaoHealth (MH) contribution to reported long-acting reversible contraceptive-permanent method acceptors (Q1PY3–Q3PY6)



CYP in USG-Assisted Areas

Figure 12. Couple-years of protection by project quarter, Q1PY3–Q3PY6



Sustained increase in the uptake of LARCs/PM is a consequence of:

- HSPs receiving supportive supervision after trainings
- Hospitals integrating FP and AY services within hospital services
- SDPs providing FP counseling and services (81 in 2012 to 744 in Q4PY6, of which 90 are also providing AYRH-friendly health services)
- Outreach services provided by public hospitals through mobile FP teams from IPHOs, RHUs, and NGOs, especially in GIDAs and CAAs
- RHUs/CHOs with PhilHealth MCP/NCP accreditation that reimburses providers/facilities for IUD and PSI services
- Client referral mechanism for WRAs opting for LARCs/PMs
- Collaboration between and among SDPs within SDNs

While MH accomplished—in fact, exceeded—its overall CYP projections, the figures from urbanized cities did not achieve anticipated numbers. Davao City achieved 66% of the end-of-project projection, Zamboanga City achieved 71%, Cagayan de Oro City achieved 88%, and General Santos City achieved 65%. The reason for this shortfall is twofold: the concentration of private service providers in urban contexts serving women who can afford the services and do not want to wait in long lines for services, and FHSIS data that capture mostly public-sector performance. In urbanized cities, the challenge has always been how to sustain the integration of private SDPs' accomplishment into the LGUs' FHSIS. Scale-up of the project gains on integrating private accomplishments into the FHSIS report through SDN initiative is very slow due to varied operational challenges and the lack of clear national guidelines to strengthen the health information management system through PPP, given the increasing number of privately owned/managed facilities providing FP/MNCHN/AY services.

Stock-Out Rate of Contraceptive Commodities at FP SDPs

For the first 2 years of the project, MH focused on strengthening capacities of logistics management systems at the facility and PHO/DOH-RO levels. MH promoted the use of the supply management and reporting system. It also helped set up inter-LGU coordination mechanisms that would enable PHOs and DOH-ROs to monitor stock-outs and inventory analysis to prevent overstocking and reallocation.

By the beginning of PY3 and PY4, almost 900 surveyed facilities had stock-out rates under 1% because the DOH outsourced FP commodity warehousing and distribution. The DOH also developed a social media network for FP commodity tracking, set up an FP logistics hotline for real-time reporting and response on reported stock-out, and developed a simple, easy-to-use commodity inventory tool to aid LGUs with tracking expendable supplies in health facilities. The coordination among PHOs, POPCOM, and DOH-ROs ensured availability of buffer stocks at the regional offices. The government used an alert mechanism at the provincial and regional DOH level, identifying SDPs with inventories breaching the buffer stock and efficiently responding by linking them with a regional and DOH-CO FP logistics hotline. RITs/provincial implementation teams included commodity security in their meeting agendas, which was also effective in resolving bottlenecks.

MH recorded a breach in the acceptable 3% stock-out rate in PY6 due to a break in the supply chain from the central down to facility level. Causes included:

- An absence of a truly demand-driven logistics management system
- The DOH's restructuring, causing shortages in staff and capacity to manage and implement a nationwide FP logistics system
- The DOH not using SDPs' submitted consumption reports to calculate project allocation
- LGUs not procuring FP commodities, even the 23% of LGUs in Mindanao with a contraceptive self-reliance policy ; only 30 LGUs reported procuring commodities

Table 6. Stock-out rate of family planning commodities in US Government/MindanaoHealth-assisted service delivery points in Q4PY6

Project Areas	Baseline 2016	Status for the Quarter, Q4PY6				
		Acceptable Level, 2018	Actual			
			Type	Num	Den*	%
Priority areas: 12 priority sites	Pills 1%	Pills 2%	Pills	17	457	3.7
		Depot medroxypro gesterone acetate –	Depot medroxypr ogesterone acetate	9	457	2.0
			Condom	5	457	1.1
Conflict-affected areas: Basilan, Sulu, Tawi-Tawi, Zambo City, Cotabato City	Depot-medroxy-progest-erone acetate (DMPA) 0% Intra-uterine device (IUD) 1% Condom 1% Beads 11%	DMPA 1% IUD 0% Condom 1% Beads 3%	Beads	68	457	14.9
			IUD	4	457	0.9
			Pills DMPA Beads	9 3 1	96 96 96	9.4 3.1 1.0
Marawi and environs (Lanao del Sur and Lanao del Norte)			Beads	39	90	43.3
5 nonpriority sites			Pills	8	94	8.5
			Beads	15	94	16.0
Projectwide			Pills	34	737	4.6
			DMPA	12	737	1.6
			Condom	5	737	0.7
			IUD	4	737	0.5
			Beads	125	737	17.0

* No. of service delivery points in the priority clusters

MH provided TA to 737 SDPs to avert stock-out of FP commodities from 2014 to 2018. Data show the commonly reported stock-outs were the Standard Days Method beads (14%), pills (6%), and condoms (5%). Stock-out of pills and condoms occurred in SDPs in Davao City and Tawi-Tawi, while stock-out of Standard Days Method beads was most pronounced in Zamboanga del Sur, Zamboanga del Norte, and Lanao del Sur, including Marawi City. MH tracked stock-out of Standard Days Method beads only in the last 2 years of the project, after the project learned that unavailability of a client's preferred voluntary choice discouraged them from seeking timely consultation for information and counseling on other methods (see Table 6/7).

Pills comprise more than 40% of total modern FP users' voluntary choice. Therefore, a stock-out of pills has the most impact on current modern FP users. Commodity procurement plans failed to take into account user behavior (i.e., women continued to use progestogen-only contraceptive pills even when they were not lactating, instead of switching to a combined oral contraceptive). This led to overstock of combined oral contraceptives.

None of the SDPs in Caraga, Northern Mindanao, and SOCCSKSARGEN reported stock-outs:

- Caraga's DOH-RO hired pharmacists with assigned municipalities to monitor FP and other medical supplies in RHUs.
- POPCOM Northern Mindanao assigned staff to monitor FP commodities for the entire region through a combination of phone interviews, field visits, and inventory reports received by family health associates.

- SOCCSKSARGEN's DOH-RO purchased progestogen-only contraceptive pills and augmented the supplies of the provinces.

Table 7. Status of family planning commodity stock-out by year

Annual Stockout Report																			
Commodities	Baseline			2014			2015			2016			2017			2018			Average Stockout Rate
	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	
Pills	220	974	23%	169	764	22%	8	764	1%	0	764	0%	10	737	1%	34	737	5%	6%
DMPA	245	964	25%	89	764	12%	0	764	0%	1	764	0%	10	737	1%	12	737	2%	3%
IUD	115	981	12%	21	764	3%	0	764	0%	1	764	0%	5	737	1%	4	737	1%	1%
SDM Beads	88	764	12%										74	737	10%	125	737	17%	14%
Condom	317	1023	31%	171	764	22%	3	764	0%	0	764	0%	5	737	1%	5	737	1%	5%
Annual Stockout Rate			24%			15%			0.4%			0.1%			3%			5%	

SDPs' FP Counseling and Services

Table 8. Service delivery points providing family planning counseling and services as of Q4PY6

Project Areas	Baseline 2013	Accomplishment for the Quarter, Q4PY6		
		Target, PY6	Actual	%
Priority areas: 12 priority sites	49/457	444	449	1014
Conflict-affected area sites: Basilan, Sulu, Tawi-Tawi, Zambo City, Cotabato City	26/186	93	98	105
Marawi and Environs (Lanao del Sur and Lanao del Norte)		87	82	94
5 nonpriority sites	6/94	91	115	126
Projectwide	81/737	715	744	104

Target in PY6 is 97% of 737 = 715

FP counseling and services was one of the key supply-side indicators, and MH exceeded its projections for functional SDPs by 33%. The project heavily invested in enhancing the knowledge, skills, and performance of service providers, leading to DOH certification, which is a PhilHealth accreditation requirement. SDPs providing FP counseling and services rose from 81 in 2012 to 744 by the last year of the project.

Toward the end of the project, the third quarter of PY6, 12 SDPs suspended their services on two counts: failure to comply with the DOH's license-to-operate requirements and transfers to hospitals (nine in Davao City, two in Misamis Oriental, and one in Cagayan de Oro City). However, at the same time, MH added 12 private birthing facilities managed by members of Unified Private Midwives Association of General Santos City to its database as SDPs offering FP counseling and services.

Table 9. Distribution of service delivery points by ownership/control, location (rural/urban), and type of facility, as of Q4PY6

Project Areas	Ownership		Location		Type of Facility		
	Public	Private	Rural	Urban	Hospital	Rural Health Unit/ City Health Office	Clinic
Priority areas: 12 priority US Government sites	304	145	306	143	124	234	91
Conflict-affected area sites: Basilan, Sulu, Tawi-Tawi, Zambo City, Cotabato City	85	15	62	36	30	62	6
Marawi and Environs (Lanao del Sur and Lanao del Norte)	74	8	73	9	16	62	4
5 nonpriority areas	70	45	72	43	28	55	32
Projectwide	533	213	513	231	198	413	133

To note:

- 69% of the functional SDPs are located in rural areas.
- 71% of the functional SDPs are public/government run.
- Of the total 744 functional SDPs, 56% are RHUs/CHOs, 27% are hospitals, and the remaining 17% are private clinics.
- By the end of PY5, MH had trained and provided supportive supervision to 884 HSPs on PPFP/PPIUD, 794 on LARC/PSI, 722 on FPCBT2, and 234 on BTL-MLLA. The DOH-ROs also conduct training on FPCBT1 and FPCBT2 in collaboration with MH.

CHWs Providing FP Information, Referrals, and/or Services during the Year

Table 10. US Government-assisted community health workers providing family planning information, referrals, and/or services by priority cluster, Q4PY6

Project Areas	Baseline 2013	Actual, Q4PY6			Target, PY6	%
		F	M	Total		
Priority areas: 12 priority US Government sites	420	3,165	17	3,182	2,027	157
Conflict-affected area sites: Basilan, Sulu, Tawi-Tawi, Zambo City, Cotabato City	28	576	11	587	824	71
Marawi and environs (Lanao del Sur and Lanao del Norte)		356	3	359	252	142
5 nonpriority sites	1,032	594	3	597	584	102
Projectwide	1,480	4,691	34	4,725	3,687*	128

*In program implementation review, target is 3,358. In the allocation of target to local government units, rounding up of numbers resulted in a total of 3,687.

MH empowered CHWs by increasing their knowledge, skills, and performance, which addressed the most common barrier to modern contraceptive uptake—fear of side effects. By the end of the project, 4,725 service providers identified women with unmet need, providing counseling, referrals, and follow-up for side effect management and/or method switch support to their clients. The project added 543 new CHWs from Bukidnon (105), South Cotabato (55), Davao Oriental (50), Lanao del Norte (44), Misamis Oriental (41), Zamboanga del Sur (20), Zamboanga Sibugay (13), Zamboanga del Norte (99), Davao City (105), and Tawi-Tawi (11) during the last quarter of the project. Of these, 32 are male CHWs.

MH identified 11 project intervention sites with fully engaged, proactive CHWs profiling and referring clients comparatively much higher than other sites. Those of note included Bukidnon (692%), Davao Oriental (236%), Basilan (202%), Lanao del Norte (167%), Agusan del Sur (162%), Agusan del Norte (113%), and Zamboanga del Sur (106%).

SDPs Providing FP/RH Services for AYs

Table 11. Distribution of US Government/MindanaoHealth-assisted adolescent and youth reproductive health friendly facility by priority cluster, as of Q4PY6

Priority Cluster		Base	PY5			Target vs. Accomplishment PY6						Cumulative Accomplishment			
	End-of-Project Target	line 2012				Hospital		Rural Health Unit		School		Hospital	Rural Health Unit	School	End-of-ProjectTotal (c)
			Hosp	RHUs	Sch.	Target	Accomp	Target	Accomp	Target	Accomp				
Priority areas: Nonconflict-affected area sites	78 SDPs		5	26		7	7	3	4	6	6	12	30	6	48
Conflict-affected area sites: Basilan, Sulu, Tawi-Tawi, Zambo City, Cotabato City			1	2				27	28			1	30		31
Marawi and environs (Lanao del Sur and Lanao del Norte)				3		1	1	1	1			1	4		4
Nonpriority areas			2	4	12	3	3	1	3		22	5	7	34	46
Projectwide	78	0	8	35	12	11	11	32	36	6	28	19	71	40	130

Service delivery points (SDPs) include either hospitals, nongovernmental organization (NGO) clinics, rural health units (RHUs), educational institutions, at least one in US Government-assisted local government units

These SDPs includes Davao Regional Medical Center located in Davao Province, a non-MH project area, but serves as the end referral hospital of Compostela Valley and San Pedro Hospital, a private hospital with TeenHub launched in PY6Q4 that offers information, counseling and referral, and services for natural family planning methods only.

(c) Schools are included in the denominator because program implementation review definition includes a wide array of adolescent and youth SDPs, such as hospitals, NGO clinics, RHUs, and educational institutions providing either information, counseling, services, and/or referral.

MH exceeded its overall end-of-project projections for SDPs with integrated services for AYs. Synergies among MH, DOH-ROs, LGUs, and other agencies expanded AYRH services in 19 hospitals, 71 RHUs, and 40 educational institutions. These facilities provided almost 65,000 FP/RH services, including sexual and RH (SRH) information, risks screening, counseling, and referrals, including for modern FP methods.

AYRH-Friendly Facilities

Hospitals

MH assisted hospitals in drafting respective operational guidelines in addition to training of core teams of AYRH providers. Partial reports from 17 of 19 hospitals revealed that an estimated 30,654 AY clients accessed wide-ranging FP/RH services covering perinatal care (prenatal, delivery, and postnatal care), FP services, management of sexually transmitted infections (STIs) and violence against women and children, and psychosocial risk assessments using HEEADSS in PY6.

Table 12. Family planning/reproductive health (FP/RH) services provided to adolescents and youth (AYs) in AY-friendly hospitals, PY6

Name of Hospital	Service Delivery Network	FP to AY 2017	FP to AY 2018			FP/RH Services July–September 2018		
			January–March (Q2)	April–June (Q3)	July–September (Q4)	FP Methods	HEEADSS Risks Guidance	Perinatal Care
ZDS-Margosatubig Regional Hospital	ZDS District 1	622	641	725	115	28	87	
Dr. Justiniano R. Borja Hospital	ClaJaViTa	1,058	1,761	2,109	1,175	**279**		**896**
Maguindanao Provincial Hospital	IranunClu str	195	141	281				
Bukidnon Provl Hospital-Maramag	South LHZ	30	727	1,642				
Davao Oriental Prov'l Medical Center		38	563	722				
Compostela Valley Provl Hospital –Montevista	CoMMMo NN		481	543	533	**93**	56	**384**
Sultan Kudarat Provincial Hospital	BITES	4,498	2,077	2,065				
Butuan Medical Center				1,020				
San Pedro Hospital		New in Q4						
Bunawan District Hospital		7	97	61				
Gregorio T. Llutch Hospital	Iligan	173	32					
Agusan Del Norte Provl Hospital	BueNas-Car SDN	217	360	1,000				
Southern Philippines Medical Center	DC District3 SDN	302	411	826				
Brokenshire Memorial Hospital	Davao City-Wide	106		310				
Davao Regional Medical Center	CoMM-MoNN	Not updated						

Name of Hospital	Service Delivery Network	FP to AY 2017	FP to AY 2018			FP/RH Services July–September 2018		
			January–March (Q2)	April–June (Q3)	July–September (Q4)	FP Methods	HEEADSS Risks Guidance	Perinatal Care
Dr J. P. Royeca Hospital		102	471	1,112	627	112	515	
South Cotabato Provincial Hospital	South Cotabato	1,363	1,124	2,016	1,570	332	1,238	
Cotabato Regional Medical Center		Not updated		2,350				
Democrito O. Plaza Provincial Hospital	D.O. Plaza HZ	306	266	227				

The increasing trend in the number of AYs seeking SRH services in hospitals indicates that on the supply side, hospitals are prepared and equipped to handle the unique FP/SRH needs of young people, and on the demand side, AYs are opening up to seek and access needed services in facilities. Howeverm there is still a need to effectively link demand generation to FP service provision to narrow the gap between AYs provided with FP services compared with the number of AYs seeking perinatal care in hospitals. First noted in PY6Q3, this trend persisted in Q4PY6, as observed in two hospitals, namely J.R. Borja Hospital and CVPH-Montevista, with 279 and 93 AYs, respectively, provided with FP services, out of 896 and 384 teen mothers, respectively, who gave birth in the said hospitals.

RHUs/CHOs

MH analysis from the partial reports received from 55 of 71 MH-assisted RHUs showed more than 20,000 FP/RH services accessed by AY clients during the last year of the project.

Table 13. Family planning (FP)/reproductive health services provided to adolescents and youth (AYs) in AY-friendly rural health units (RHUs)/city health offices (CHOs), PY6

Project Areas*	Counseled		Referred		FP Service	
	M	F	M	F	M	F
Priority areas: Non-conflict-affected area sites	1,361	5,290	57	1,826	62	1,948
Conflict-affected area sites: Basilan, Sulu, Tawi-Tawi, Zambo City, Cotabato City	1,791	3,785	1	1,108	297	1,102
Marawi and environs (Lanao del Sur and Lanao del Norte)	52	287	20	390	0	13
Nonpriority areas	13	331	8	264	13	97
Projectwide	3,217	9,693	86	3,588	372	3,160

*In the total 71 RHUs assisted, 10 are not included in the list but are noteworthy to be mentioned. In non-conflict-affected area sites, seven RHUs in Zamboanga Del Norte, a nontarget local government unit, were provided with technical assistance, which resulted in the endorsement of the PHO for the Department of Health (DOH) Regional Office assessment for certification as AY-friendly facilities: Salug RHU, Katipunan RHU, Dapitan CHO, Dipolog CHO, Godod RHU, Manukan RHU, and Polanco RHU and Lying-in. In nonpriority sites, three RHUs in Olutangga, Talusan, and Mabuhay belonging to fourth-/fifth-class municipalities in Zamboanga Sibugay received training of health providers on the DOH's adolescent job aid protocol and are now working toward meeting minimum criteria for youth-friendly facilities.

MH's TA to Lamitan CHO transformed its two RHUs into youth-friendly facilities and established a "*Kasangyangan sin Kamakanakan*" (youth development focusing on adolescent RH) banner. This initiative, presented at the "Delivering Result, Creating Public Value and Governance" fair, was one of the finalists for the Galing Pook Award, a respected award-giving body in the Philippines that searches for and recognizes innovative practices of LGUs.

Schools

Agusan del Norte's DepEd Division expanded YOLO to 34 schools during last year of the project, from the initial 12 schools in PY5. Supported by trained school providers—guidance counselor designates and health and nutrition nurses—guidelines, and SRH messaging, YOLO reached more than 6,000 learners with SRH information.

Table 14. Distribution of learners assessed using home, education, employment, activities, drugs, sexuality, and safety by psychosocial risks detected, Department of Education Division of Agusan del Norte, PY6

Reporting Period	Number of AY Assessed with Rapid HEEADSS	Referred	Risks Identified*							
			Home Thought of running away	Home violence	Suicidal thoughts	Environment - bullying	Alcohol drinking	Drug exposure	Smoking	Sexuality
June 2017–March 2018**	5,670	21	1,604	1,216	1,000	2,547	702	616	324	1,960
April–June 2018	99	20	11	12		12	4	4	4	11
July–August 2018	1,087	1	386	249	296	589	135	114	53	512
Total	**6,856**	**42 (0.3%)**	**2,001 (16%)**	**1,477 (12%)**	**1,296 (10.4%)**	**3,148 (25%)**	**841 (6.7%)**	**734 (5.9%)**	**381 (3%)**	**2,483 (20%)**

*** -** Some learners have more than one psychosocial risks (12,403)
**- Data source from annual implementation report of Department of Education Division of Agusan del Norte YOLO program, June 2017–March 2018

#SoMe4AYRH (Social Media for AYRH)

According to the 2013 Young Adult Fertility and Sexuality survey, Facebook remains the most used social media outlet, with more than three-quarters (80.3%) of youth using the Internet for social networking. The project's TA to six partner agencies'/institutions' implementing programs on AY health showed significant results:

- MH trained and equipped 14 individuals from six partner agencies/institutions on crafting SRH messages and administering social media accounts, particularly the Facebook platform.
- MH enabled six partner agencies/institutions, including the DepEd Division of Agusan del Norte (YOLO), Agusan del Norte Provincial Hospital Center for Teens, DOH Caraga Region, POPCOM

Caraga, Population Division of Davao CHO, and Brokenshire Hospital Program for Teens were, to create respective Facebook accounts with SRH messages.

- MH helped launch four of six assisted agencies'/institutions' social media platforms : YOLO Facebook account for Agusan del Norte DepEd Division, AGAKAY for Agusan del Norte Provincial Hospital Center for Teens, Teen Talk Davao for Davao CHO's Population Office, and Brokenshire Hospital's Program 4 Teens.

- MH put together and presented *#SOME4AYRH - A Guide in Using Social Media & Social Networking Sites for AYRH Advocacy* at the WHO, Korea International Cooperation Agency, and MH Region 11 dissemination forum.

Women Giving Birth Receiving Uterotonics in the Third Stage of Labor

Table 15. Distribution of women giving birth who received uterotonic postpartum by priority cluster, Q1-Q4, PY6

Project Areas	Target, PY6	Accomplishment		
		Actual, Q4PY6	Actual, Q1–Q4PY6	%
Priority areas: 12 US Government priority sites	4,837	4,002	14,059	291
Conflict-affected area sites: Basilan, Sulu, Tawi-Tawi, Zambo City, Cotabato City	2,489	1,196	4,636	186
Marawi and environs (Lanao del Sur and Lanao del Norte)	1,739	2,417	11,021	634
5 nonpriority sites	934	308	2,750	294
Projectwide	9,999	7,923	32,466	325

To track this indicator, MH selected sentinel birthing facilities (both public and private) in every project intervention province/highly urbanized city based on criteria that included: presence of an MH-trained basic emergency and obstetric newborn care (BeMONC)/essential intrapartum and newborn care provider, PhilHealth accreditation for MCP/NCP, documented guidelines on use of oxytocin, and available oxytocin. By the end of the project, data showed 32,466 women received uterotonic—an increase than the MH-etimated projection of approximately 10,000.

PPFP/PPIUD-Trained Providers Certified by the DOH

SOCCSKSARGEN recorded the highest number of PPIUD-trained HSPs who received supportive supervision, at 92.7%, followed by Caraga (90.7%), Zamboanga Peninsula (76.8%), Davao Region (67.1%), Northern Mindanao (65.3%), and ARMM (61.8%). The common factor in the sites with more than 85% of PPIUD-trained HSPs completing post-training evaluation (PTE)/supportive supervision is the support of the provincial/city chapter of the Integrated Midwives Association of the Philippines. This body has been instrumental in contacting and mentoring HSPs for PTE and active engagement of the Provincial DOH Office.

MH observed a variance across the regions on PPIUD-trained HSPs certified by the DOH. Two key factors for success are commitment of regional FP program coordinators, as seen in SOCCSKSARGEN, and strong leadership at the PHO, as evidenced in Zamboanga del Sur. MH learned that trainees' willingness to complete the required PPIUD cases and undergo supportive supervision, and the DOH-RO's commitment to work with available master trainers and with MH are essential for PTE leading to DOH certification for providers.

Table 16. Postpartum intrauterinie device (PPIUD)-trained health service providers by status (completed supportive supervision or certified by Department of Health) as of Q4PY6

Project Areas	Baseline 2012	Trained[a]	Supportive Supervision Recommended for Certification	%	Service Delivery Point (SDP) Coverage[b]
Priority areas: 12 US Government sites	55	534	447	83.7	349
Conflict-affected area sites: Basilan, Sulu, Tawi-Tawi, Zambo City, Cotabato City	24	102	60	58.8	46
Marawi and environs (Lanao del Sur and Lanao del Norte)	2	47	19	40.4	33
5 nonpriority sites	7	201	135	67.2	86
Projectwide	88	884	661	74.8	514

a In Q4PY6, those who are no longer with the health service were removed from the total number of health service providers who attended MindanaoHealth-assisted/supported training. This number is lower than that reported earlier.
b No. of SDPs where PPIUD-trained health service providers are assigned

Davao Region, despite the availability of capable facilities and master trainers, did not fare well, as only 33 of a cohort of 96 trained and supervised providers received DOH certification. The reason for ARMM's performance lies in the inability of trained service providers to complete 10 PPIUD cases, meaning they did not meet the stipulated requirement. Clients prefer other less invasive methods in the region. The noteworthy variances in the certification process in terms of time and documents vary among DOH-ROs. For example, an FP regional program manager requires the submission of pre- and post-test results, notwithstanding the PTE timeframe. While DOH-SOCCSKSARGEN is facilitative, others require frequent follow-up. Other reasons for not meeting anticipated projections for trained providers to be certified are insufficient trainers/mentors to conduct PTE and provide onsite mentoring/coaching of trained service providers.

The data used for this analysis have not been updated. MH does not know if new trainees have been added, and those who left or were transferred were removed from the database. For example, of the 59 PPIUD-trained providers in Agusan del Sur and Agusan del Norte, 11 left the service, and seven were unable to comply with the requirement and opted not to practice PPIUD anymore.

Table 17. Number of service delivery points in Marawi City with functional health service provision

Indicator	Baseline 2017	Accomplishment for the Quarter, Q4PY6			Cumulative Accomplishment, 2018		
		Target	Actual	%	Target	Actual	%
Marawi and its corridors	0	21	21	100	21	21	100

MH was able to record that the nine projected health facilities in Marawi provided essential MNCHN/FP services at the time of gathering data during project closeout. Likewise, MNCHN/FP services were further strengthened in other nearby 12 facilities in Lanao del Sur (seven) and Lanao del Norte (five).

RHUs/CHOs Conducting DQCs

Table 18. Distribution of US Government (USG)/MindanaoHealth-assisted provinces/highly urbanized city that conducted data quality checks (DQCs) in PY6 by priority cluster

Project Areas	Baseline 2015	Accomplishment, PY5			Accomplishment, PY6		
		Target[a]	Q1–Q4	%	Target[b]	Q1–Q4	%
Priority areas: 12 USG sites		184/219	153/184	83	186/219	200/186	108
Conflict-affected area sites: Basilan, Sulu, Tawi-Tawi, Zambo City, Cotabato City		38/45	26/38	68	38/45	45/38	118
Marawi and environs (Lanao del Sur and Lanao del Norte)		53/63	61/53	115	54/63	63/54	117
5 nonpriority sites		34/41	40/34	118	35/41	41/35	117
Projectwide	268/368	309/368	280/309	91	313/368	349/313	112

a – Target is 84% of rural health units (RHUs)/city health offices (CHOs).
b – Target is 85% of RHUs/CHOs.
Standard: RHU/CHO conducts a DQC at least once a year.

A total of 3,669 LGUs' DQC-trained health staff across 19 provinces and two cities rolled out the DQC initiative, which is now an LGU-led activity. RHU/CHO personnel committed to regular DQCs, and MH has evidence that the transition to the electronic medical record (EMR) system, a PhilHealth requirement for facility accreditation has helped.

Davao City was the only highly urbanized city/province that did not conduct DQC for 2 years. The DQC exercise in 2016 cut the city's CPR by almost half without any FP current users in the target client list (TCL), as there was no completed FP Form 1.

Audience Recall of MH-Supported FP/RH Key Messages

Table 19. Percentage of audience recall on MindanaoHealth family planning/reproductive health (FP/RH) key messages

Project Areas	Target	Q1–Q3PY6 Accomplishment	Audience Reach for Recall of FP/RH Key Messages, Q4PY6						As of Q4PY6	%
			Health Events	Facility-Based Deliveries	Women of Reproductive Age Profiled	Community Health Workers' Clients	Others	Total		
Priority areas: 12 US Government sites	1,229,779	**976,319**	7,199	46,832	450,317	3,083	55,004	562,435	**1,538,754**	**125**
Conflict-affected area sites: Basilan, Sulu, Tawi-Tawi, Zambo City, Cotabato City	284,355	**153,607**	1,054	8,796	12,094	587	483,925	506,456	**660,063**	**232**
Marawi and environs (Lanao del Sur and Lanao del Norte)	206,169	**77,258**	1,022	3,457	10,533	359	2,648	18,019	**95,277**	**46**
5 nonpriority sites	279,697	**91,250**	1,234	5,443	30,278	597	279,081	316,633	**407,883**	**146**
Projectwide contribution (allocated as information, education, and communication materials, etc.)							156,876	156,876	**156,876**	
Projectwide	2,000,000	1,298,434	10,509	64,528	503,222	4,626	977,534	1,560,419	2,858,853	143

CAA Indicators

Health Outreach

Outreach services in CAAs exceeded its end-of-project projection (567 endline versus 315 project target), as outreach was the only means to reach the internally displaced in Marawi (Sarimanok Tent City, Guimba settlement, Balo-I and Pantar evacuation sites, and island sitios) and GIDAs with no other accessible health facility or providers. Outreach services were able to meet women's and couples' pregnancy limiting and spacing needs. Lanao del Sur exceeded its projections that it held in partnership with civil society organizations ARCHES, Duyog Marawi, and the Al-Mujadilah Development Foundation.

MH experienced challenges in further enhancing its reach to GIDA barangays in island barangays/sitios because of operational challenges in areas controlled by armed groups and the nonavailability of facilities/space for FP outreach services. The project or barangay officials transported potential clients to the población for FP services or scheduled these during local initiatives, such as People's Day in ARMM, Rose Caravan in Basilan, and Catch and Change of Sulu. The public sector integrated demand generation activities, such as Usapan, in their regular health activities and in clustered outreach activities held in partnership with the military.

Clients Reached through Outreach Activities

MH exceeded its end-of-project target of 69,737 people served in CAAs—it served 71,196 people, up from the 33,774 people served at baseline.

MH measured clients receiving information/services during outreach activities in CAAs that exhibit high levels of unmet need and poor MCH outcomes. The cumulative number of clients served surpassed projections as outreach activities increased with the support of Duyog Marawi and Balay Mindanao, which accelerated outreach and psychosocial services in Lanao del Sur and Marawi City.

The Selected 23 CSO Regions

- Zamboanga Peninsula – 9
- SOCCSKSARGEN - 5
- ARMM – 9
- Marawi – 1 (Duyog Marawi)
- Lanao del Sur – 1 (Balay Mindanaw)

Effectively Engaging CSOs with Local Governments

MH trained 23 CSOs/people's organizations operating within CAAs on how to engage with local governments for health service provision. All 23 were selected based on a criterion that included having trained members on the team; experience with advocacy that resulted in MNCHN/FP-related initiatives taken up by LGUs (such as conducting outreach, health promotion activities, and issuance of a policy or ordinance); provided financial or nonfinancial support; and engaged with public- or private-sector partners. CSOs supported demand generation, service provision, and advocacy efforts.

Youth as Peer Educators

MH projected training 373 young people as peer educators in CAAs on various MNCHN/FP topics, including health management and leadership (LGU scorecard), SDNs, localizing Millennium Development Goals 4 and 5, and AYRH. The project exceeded its projections by training an additional 191, as some dropped out of the project, while others moved to other communities. This cohort supported Usapan Barkadahan in three schools, reaching almost 260 high school students with information on sexuality and RH, and assisted in risk assessment using the rapid HEEEADSS tool with 96 student with guidance from the DepEd, Population Office, the Isabela City CHO, and the City Youth Development Council.

Key Activites Per Strategy

Launching the Brokenshire Hospital Program for Teens, 2015

The Government of the Philippines' vision and leadership in FP predates its Family Planning 2020 commitment. RH has been part of each president's Philippines Development Program to leverage the demographic dividend. In 1994, key stakeholders advocated for a national vision and strategy on FP, which culminated in the RPRH Act of 2012. RPRH, along with Family Planning 2020, has since guided the nation toward zero unmet need for modern FP. Before USAID's flagship Maternal and Child Health Integrated Program, the Philippines did not have a systematic approach to capacitating service providers in FP. The Maternal and Child Health Integrated Program/Jhpiego enhanced four public facilities into COEs that trained and mentored service providers on FP counseling and PPIUD provision. This performance strengthening approach became the new norm in the Philippines.

USAID's investments via MH helped the country progress toward meeting its targets by aggressively and innovatively building on its 31-year FP legacy. MH aligned its strategies with the RPRH Act and worked to expand and sustain the availability of high-quality reproductive, maternal, newborn, child, and adolescent health (RMNCAH) services. MH adopted four strategies feeding into the three objectives meeting USAID the Philippines' new health strategy goal "Family Health Improved" and undertook three key initiatives: strengthening SDNs, integrating FP and postpartum IUD/FP service provision, and introducing AY SRH care services.

Strategy 1: Increasing the Supply of FP/MNCHN/AYRH Services at Fixed Facilities and through Outreach

MH implemented a range of initiatives to strengthen supply of integrated services. This report details key activities.

TA for public and private facilities to provide FP/MNCHN/AYRH services (LARC/PM): To enhance the accessibility of the client to continuum of care and avoid missing an opportunity to meet the spacing/limiting needs of a woman or couple, MH engaged with providers in hospitals and private birthing facilities to add LARC/FP/PM to their cache of services. Support included enhancing their knowledge and skill on FP services. As training is insufficient if the facility is not equipped to provide the services, MH helped provide select essential infrastructure and commodity supplies.

MH invested in increasing service providers' understanding and skills on providing quality FP services. This support included building the confidence of nonperforming trained providers. MH strengthened DOH-led supportive supervision/PTE activities by providing updated information and tools, facilitating forums for sharing, and assessing providers providing services based on criteria, such as number of clients served, using a performance standard checklist.

MH recommended eligible providers for DOH certification that further qualified them for PhilHealth accreditation and claims for reimbursements necessary to sustain operations.

The percentage of certified PPIUD trainees remained low in ARMM, at 11%, compared to other regions. One reason is ARMM took time to mobilize teams for supportive supervision and strengthen its certification procedures.

MH developed CPSs for training of FP providers on PPFP/PPIUD services, in addition to the COEs, at hospitals and birthing facilities. MH evenly spread the CPSs in five MH intervention regions—Zamboanga Peninsula, Northern Mindanao, Davao, SOCCSKARGEN, and Caraga, including Basilan and Maguindanao—excluding ARMM. The government, providers, and stakeholders welcomed practice sites as coaching, mentoring, and supportive supervision centers for quality PPFP/PPIUD services. MH equipped these sites with anatomic models and training materials, and together with its partners intensified validation visits to certify facilities as both PPFP training and CPSs.

Postpartum FP/PPIUD Services in Hospitals

MH made investments to reduce unmet need of FP by expanding the PPFP method mix and increasing availability of FP/PPFP services to women and adolescents who have given birth, miscarried, or had an unsafe abortion. MH addressed missed opportunities through a health systems lens, including health financing and data/information. MH increased the number of certified, facility-level PPFP service providers to 1,253, of which 60.8% were certified by the DOH to provide PPIUDs and subdermal implants in addition to other FPCBT1 and FPCBT2 services.

Strengthened the capacity of service providers to counsel on and administer FP/PPFP: This is discussed in more detail on p. 10.

CPMS: This is discussed in more detail on p. 10.

Expanded the scope and improved the efficiency of DOH certification and PhilHealth accreditation systems: This is discussed in more detail on p. 11.

The availability of an expanded PPFP method mix significantly improved FP uptake in all MH-supported areas except for ARMM, which showed a slow and steady increase. ARMM progress is uniquely impacted by geographic barriers and cultural sensitivities that vary across its provinces. MH found that women in ARMM showed low acceptance of LARCs/PMs, especially PPIUDs, but had a high affinity for subdermal implants and other short-acting reversible methods. To accelerate national reduction of unmet need, Jhpiego and key stakeholders must provide targeted attention to the needs of this region by:

- Orienting midwives, including MECA,* on culturally appropriate counseling, FBCBT1 methods, and postpartum subdermal implants: Midwives are the first point of contact in ARMM and, through their trust with the community, can help increase FP/PPFP uptake.
- Strengthening capacity within ARMM SDNs to ensure FP services are not disrupted with expected clinical turnover in ARMM
- Partnering with civil society organizations and RHUs to continue delivering FP outreach services in ARMM's island provinces, where PPFP is less effective
- Leveraging established connections that can continue to operate in this unstable and fast-changing environment

*MECA: Midwives in Every Community in ARMM who were hired contractually but trained initially by USAID's SHIELD on essential maternal and newborn care.

MH worked closely with DOH-ROs and LGU-assisted sites for integration of FP services in hospitals. The effort drew on the 2014 DOH Memorandum on the Establishment of FP Programs in Hospitals, the gains made in the Maternal and Child Health Integrated Program and other USAID-supported projects, and development partners' support in establishing COEs on PPFP/PPIUD. MH identified DOH- and LGU-managed hospitals based on a needs assessment and selection criteria, which included having an ob-gyn department, high volume of deliveries to capture PPFP needs, and willingness of the facility management to integrate FP in the range of services provided. The FP integration mechanism included addressing key identified gaps, such as effective triaging of clients for FP, including those consulting other medical services, and skill enhancement of core staff on FPBCT1/BCS Plus, FPCBT2, BTL/MLLA, and PPIUD.

Importantly, MH assisted and supported select hospitals in developing their operational guides and implementation plans for integration of these services. Various departments and disciplines within the hospital identified potential FP clients, generated demand through group information/education on FP, and provided individualized counseling sessions. Direct interdepartmental referral or outreach services with itinerant teams on modern FP further enhanced seamless provision of services. Institutionalization of integrating the FP program mechanism required developing a technical committee with a full-time FP/RH coordinator and dedicated FP department/unit with regular hours. MH sees the government funding support for building skills and improving performance of service providers on LARC/PM as a clear indication of government commitment to sustaining integration of FP services.

Enthused by MH's efforts, the private sector trained its providers (private practicing midwives, nurses, doctors, and ob-gyn specialists) and introduced the full range of FP services for their clients. Improved availability, accessibility, and high-quality services in hospitals and nonhospital birthing facilities, especially during the postpartum, increased uptake of FP. This is discussed in more detail on p. 9.

FP Outreach Services in DOH-ROs and LGUs

The project addressed high unmet need of WRA in peripheral areas by supporting the government and its partners in introducing FP outreach services as extensions of fixed facility service provision. MH forged partnerships with several NGOs/CSOs (PSPI, Marie Stopes International, United Youth of the Philippines, ARCHESS, and the FP Organization of the Philippines), especially those serving as co-service providers of the host LGUs and DOH-ROs. The project forged partnerships with Davao-based Marie Stopes International and Jerome Foundation, Friendly Care of Davao City, and the FP Organization of the Philippines with their chapter in General Santos City for provision of outreach services (i.e., taking services to

the doorstep of the underserved). Of note were the postoutreach meetings effectively addressing key identified gaps, such as community volunteers tracking and navigating identified WRA with unmet needs.

Integrated AYRH Services

AYRH Laws and Policies
The RPRH Act of 2012 states that all public health facilities must provide age- and development-appropriate information on RPRH care to all clients, regardless of age and marital status; details access to FP by minors; and mandates that Department of Education provide age- and development-appropriate RH education.
DOH AO No. 2008-0029, the Implementing Health Reforms for the Rapid Reductions of Maternal and Neonatal Mortality's MNCHN Strategy, identifies adolescents, particularly young women up age 17, as one of the priority population groups at greatest risk for maternal deaths and complications.
DOH AO No 2013-0013, or the National Policy and Strategic Framework on Adolescent Health and Development Program, recognizes the risks inherent to early sexual initiation and aims to delay the age of sexual initiation among adolescents.

Rooted in its vision to leverage the demographic dividend, the Government of the Philippines aimed to curb the rising teen pregnancy trends nationwide. In the past decade, the Government of the Philippines instituted three critical adolescent health laws that formally, for the first time in history, identified adolescents and young parents as their own cohort in need of targeted attention and health solutions. These policies have since served as the foundation for AYRH programming in the Philippines.

MH focused on increasing the availability and accessibility of AYRH services by institutionalizing AYRH by aligning its agenda with government mandates, building on existing health system structures and networks,[5] and collaborating with agencies across the social sector.

By introducing risks assessment, information and counseling, and services in different settings, MH helped AYs build their life skills and manage their sexual health and fertility, and linked AYs to educational and livelihood skills development opportunities.

Created Centers for Teens: Centers for Teens are set up in hospitals to give adolescents and young mothers a niche within the health system by prioritizing this cohort upon arrival and providing AYRH-specific health services.

MH held 10 facility-based AYRH orientations with doctors and nurses, during which service providers learned to understand the unique adolescent experience and recognize potential FP clients using the DOH AJA and the HEEADSS risk assessment.

To operationalize these centers, MH identified AYRH stewards (e.g., pediatrics department) in each Center for Teens and led a multistakeholder design workshop to develop operational guidelines. The establishment of a protocol and oversight structure provided nurses, midwives, and doctors with a clear plan on how to implement their learnings from the AYRH orientations.

[5] Where possible, the AYRH component of MH collaborated with stakeholders within the SDN and aimed to expand the scope of the SDN by including unconventional stakeholders

Risk Assessment on HEEADSS
Demand generation for FP and accessibility of FP services are the biggest challenges to AYRH. In the Philippines, it is frowned upon by youth gatekeepers (e.g., parents or church) to openly discuss and promote contraceptive use for adolescents. Alternately, service providers at public facilities are apprehensive about providing FP to unmarried, sexually active, and nonparous adolescents.

The HEEADSS risk assessment is a DOH-designed tool to evaluate clients' physical health, psychosocial well-being, and environment. Through indirect questions, service providers learn about potential risk factors, risky behaviors, or experiences (e.g., abuse) that might contribute to a decline in health or present a need for FP.

Integrated FP and youth-friendly hospitals within the Agusan del Norte SDN. Because of the resistance toward FP demand generation, the triage level within a hospital can be a valuable touchpoint for FP or PPFP among young parents who deliver in a hospital. However, many facilities did not have the appropriate means to identify FP/PPFP clients in a discreet, safe, and unintrusive manner. MH devised an integrated FP-AYRH profiling tool (five to 10 questions) based on HEEADSS to help service providers determine potential clients with an unmet need for FP. The project introduced this tool to service providers in 11 apex or end-of-referral hospitals in addition to training them on FP counseling, service provision, financing, and data collection. To ensure long-term sustainability of youth-friendly FP services, MH also engaged health facilities in developing an operational guide and protocols.

Campus-Based AYRH

Schools provide a cohort of AYs. Youth formation learner-driven programs reinforce student performance in school through cocurricular and noncurricular interventions and initiatives. MH developed a strategy to empower school management with the knowledge, skills, and tools to engage with their students on SRH matters. Select national high schools and colleges collaborated and strengthened their counseling offices and clinics to include risk assessments and facilitate information, peer learning, counseling, and prompt referrals to youth requiring MCH RH/FP services and products. Initiatives looking into the health and well-being of a learner included counseling, health, and nutrition.

MH trained frontline staff—points of contact for students—to provide SRH information, guidance, and referral, integrating HEEADSS risk assessment tools for student profiling during enrollment and regular consults. This initiative had the approval of DOH-ROs in participating regions. Schools appointed trained staff as guidance counselors in the schools. To bolster the continuum of care within the referral mechanism, MH built the capacities of division health nurses tasked to implement the DepEd's health and nutrition program, which opens the space for nurses to ask about risk-taking behaviors, like unprotected sex and substance use, and about issues such as violence victimization and provide guidance. Schools discussed findings with counselor leads for follow-through intervention.

MH introduced the HEEADSS risk assessment to public secondary schools in Agusan del Norte and Zamboanga del Sur. It collaborated with the DepEd to educate school nurses and guidance counselors on the use of HEEADSS as a part of their regular functions, such as physical examinations. The project consciously chose to build its programming and integrate AYRH tools in the existing DepEd structure—the health and nutrition program under learning support services—to ensure AYRH support was not seen as an additional burden. MH held a design workshop with stakeholders across the education system (e.g., DepEd, nurses, principles) to develop internal policies and operations guideline that detail a protocol for risk assessment, additional counseling, and referral to health facilities.

AY-Friendly RHUs

Being the first-contact SDPs for young mothers seeking ANC, MCH, and FP, the project developed select RHUs as referral points for the Center for Teens. MH worked closely with RHUs meet the minimum criteria: available private counseling room, available AJA-trained providers, use of HEEADSS and consent form, and use of service records logbook. TA through training of RHU nurses, midwives, and doctors on AJA protocol and risks assessment, development of RHU guidelines, and provision of job aid tools, and issuance of local policy supportive of youth-friendly programs implementation helped LGUs and health providers in institutionalizing ASRH service programs for young people.

Teen Hotline

MH leveraged use of information communications technology on AY health care through Brokenshire Hospital's Teen Hotline, which began operating in October 2015 as part of the hospital's Program for Teens. The program reaches out to teens who are uncomfortable visiting facilities for consultation. To address implementation issues identified along the way, such as missed and undocumented calls, MH provided assistance in updating the Teen Hotline system to capture and record calls, alert hotline agents to missed calls, and send the caller a notice to expect a return call. MH helped develop a Teen Hotline guide to support call agents on answering hotline calls and on documentation protocol. The Teen Hotline was scaled up to selected medical centers in Mindanao: SPMC, Zamboanga City Medical Center, Cotabato Regional Medical Center, and Northern Mindanao Medical Center. The Teen Hotline received inquiries on menstruation, available services, STIs, and FP options from young people. MH also supported development of a frequently asked questions document for call agents and doctors to reference when responding to callers. MH oriented resident doctors in the ob-gyn department and members of the Brokenshire Women Center team on using the tool.

#SoMe4AYRH

In PY5, MH trained 13 representatives from the Zamboanga CHO, POPCOM, Zamboanga City Public Information Office, and IGNITE youth organization in using social media and social networking sites to provide information on sexuality and RH. The initiative took on the existing Speak Out! Zamboanga accounts and pages.

After an initial increase, engagement dropped due to the range of AY issues/problems to which Speak Out! Zamboanga and to undesired involvement of the public information office local government's activities. Political issues emerged during implementation, as the pages and accounts used were linked to the LGU of Zamboanga City. MH recommended creation of new pages and accounts solely for the campaign's use and the transfer of management to the city health department.

ASRH Peer Education in CAAs

MH successfully coordinated an initiative with peer educators from schools located in LGUs with AY-friendly RHUs and hospital-based Centers for Teens set up as referral points. The project provided TA to help schools mainstream AYRH in their campuses and link them as referring agents. The project developed youth peer educators engaged from SRH-focused CSOs to reach teen moms and facilitate referrals to outreach services. Peer educators also worked closely with the mayor and RHU-basic health units for collaborative activities, while CSO youth peer educators were trained as facilitators of Usapan TeenMoms.

Strategy 2: Increasing the Demand for MNCHN/FP Services

MH enhanced Usapan by integrating the use of BCS and linking Usapan to fixed and ambulatory FP services.

What is Usapan?
Usapan is a carefully structured and facilitated group discussion on FP and maternal health care. Usapan's objective is to promote FP and maternal health care by providing essential information that is easily understood and emotionally appealing so that at the end of the session, participants can make an informed, voluntary choice of a particular FP method or service as per their need. At the end of a Usapan group session, participants can have a one-on-one counseling session with a trained service provider for a more thorough discussion of the method or services he/she is interested in.

MH enhanced community-based group sessions on FP/RH, as these are effective mediums for information provision, counseling, and referrals for services. MH strengthened the Usapan model to support LGUs in strengthening their client profiling and referral mechanism to enhance efficient, timely referrals and service provision. MH addressed identified needs, such as gaps in client profiling, data entry data use, Usapan client referrals, service provision, and client follow-up. MH:

- Strengthened CHWs'/facilitators' communication and presentation skills, bolstered by available job aids, including algorithms allowing them to address individual queries/concerns on modern contraceptives with confidence and updated/accurate information.
- Improved client profiles/segmentation for effective Usapan and timely referral and follow-up so no client is left underserved.
- Reinforced focus on FP/AY needs through an integrated profiling mechanism reinforced through supervision.
- Ensured availability of onsite service provision and/or Usapan sessions coordinated with scheduled LARC/PM outreach camps.
- Ensured efficient use of client profiles for referral and follow-up at primary level of care.
- Enhanced monitoring and evaluation of Usapan clients, ensuring clients have been referred and followed up with to support them in making voluntary choices of preferred method of FP.
- Received testimonies of satisfied users at Usapan sessions and other community-based demand generation initiatives.
- Shared/disseminated USG-approved materials promoting and sustaining health-seeking behaviors.

Usapan for Addressing Myths and Misconceptions

MH provided TA to service providers building their competency to address clients' reservations on modern contraceptives by:

- Enhancing CHWs'/counselors' skills to understand and address clients' needs and queries
- Acknowledging the psychosocial factors influencing her/his perceptions and decision
- Holistically managing side effects of current users that may be clinical and/or psychological/emotional in nature, and allowing for method continuation or method switch based on clients' choice

BCS Plus is a client-centered counseling approach that involves a series of steps to determine the contraceptive method best suited to a client based on his/her reproductive preferences and needs.

The "plus" refers to the need for counseling, screening, and services for STIs, including HIV, and other diseases, such as cervical cancer, within the routine FP consultations.

As an activity, BCS Plus is a support initiative that helps institutionalize FP programs in private and public hospitals.

MH integrated BCS Plus in the FPCBT1 training of hospital-based doctors, nurses, and FP providers, and made it a DOH-required FP training activity. The 4-day module was adapted for hospital-based doctors and nurses, with the first batch of 16 trainers in General Santos City from SOCCSKSARGEN.

MH supported male engagement through Usapan sessions. Community-based health workers brought male partners to Usapan Bagong Maginoo or couples counseling for LARC/PM and ANC and postpartum care. Session facilitators referred potential male clients' skilled providers to address their FP informational and/or one-on-one counseling and services needs as clients and/or partners. These efforts increased men's awareness on RH and understanding of the benefits of healthy timing and spacing of pregnancies for the entire family.

Usapan in Fixed and Outreach Services

MH included sessions on LARC/PM during Usapan discussions, which generated clients opting for these services during outreach or in fixed facility settings, with Usapan participants opting for LARCs (PSIs) more than LAPMs. After MH generated evidence on the effectiveness of Usapan sessions in FP uptake, POPCOM adopted Usapan as a group education strategy during family development sessions targeting CCT beneficiaries. Some LGUs (in Compostela Valley, North Cotabato, Davao City, and Cagayan de Oro) allocated project budgets for Usapan activities in their LIPH—an indication of Usapan's effectiveness in addressing clients' FP needs and the government's commitment to achieve zero unmet need.

An Usapan's success in generating demand for FP hinges on the health workers' skill in sensitively facilitating sessions, personal interaction with participants, and correct referral.

Table 20. Number of facilitators and trainers undergoing Usapan training of trainers over life of the project

Region	Facilitators	Trainers
Autonomous Region of Muslim Mindanao	141	26
Zamboanga Peninsula	255	14
Northern Mindanao	251	19
Davao	256	9
SOCCSKSARGEN	304	8
Caraga	37	37

Health Workers' Counseling Skills on Addressing Fear of Side Effects and FP Myths and Misconceptions

MH invested in improving select rural health midwives' (RHMs') knowledge, skills, and behavior to effectively address and manage their clients' concerns regarding modern contraception—most commonly, fear of side effects and other myths and misconceptions. MH developed specific tools and materials for these trainings:

- Discussion guide for RHMs on how to talk to women about contraceptive side effects and other rumors, myths, and misconceptions of FP
- Frequently asked questions on FP methods to manage side effects and handling misconceptions
- Studies of clients' posters (in Tagalog and Visayan ; Muslim and Christian groups)

Health Facility-Based Counseling on MNCHN/FP

Counseling is a cornerstone for effective SRH-related services. MH collaborated with the Association of Deans of Philippine Colleges of Nursing- and Association of Philippine Schools of Midwifery-affiliated colleges and universities in Davao Region to enable and mobilize student affiliates in client-centered information giving and counseling on FP and safe motherhood.

MH imparted knowledge and skills on client-centered counseling through trainings and enhanced course syllabuses for nursing and midwifery students in 16 nursing schools and 11 midwifery schools. The project developed a cohort of TOTs on interpersonal communication. Nurses and midwives put into practice acquired skills by conducting health information and counseling activities as part of their community participation affiliation duties at hospitals and rural health facilities.

Clinical instructors immediately saw improved interaction between student affiliates and potential clients at the facility level, as students counseled their clients on pregnancy, FP, breastfeeding, and complications of pregnancy, such as pregnancy-induced hypertension and gestational diabetes. Students demonstrated confidence and ease in using FP job aids and techniques learned during community participation, including using flip charts on FP, the GATHER (Greet, Ask, Tell, Help, Explain, and Return) technique, and Usapan for group education.

MH also facilitated a series of meetings between partner nursing and midwifery schools affiliated with SPMC to collaboratively improve the role of student affiliates in generating demand for FP and MCH services. As a result, SPMC required student affiliates to perform tasks related to FP promotion, education, and counseling. MH took this further by integrating student affiliates' interpersonal communication tasks in the COE operating guides and documenting student affiliates' interpersonal communication activity conduct in communities and facilities. MH also undertook monitoring visits to observe implementation of interpersonal communication in four schools—three in Tagum, and one in Davao City.

St. Mary's College of Nursing enhanced its resource unit in Nsg 101 course for second-year students in their first semester. Students spent 48 hours in communities completing house-to-house visits, mother's classes, and one-on-one counseling under the supervision of a trained clinical instructor on interpersonal communication, then 96 hours in the hospital in Davao Regional Medical Center and Bishop Regan Memorial Hospital. Arriesgado School of Midwifery also enhanced its curriculum in the Mid 101 course for second-year students in their first semester.

Survey of RHM Knowledge on Modern FP

Popular Products

- FP hand fan: Clients took it home, and other family members found them attractive and useful.
- Reader-friendly "Nanay" booklet: This effective reference document reminded mothers about key behaviors for a safe and healthy pregnancy.
- CHW toolkit: Helped volunteers provide correct information on FP to clients.

MH conducted the Descriptive Survey of RHMs' Knowledge and Experience on Modern FP Counseling and Addressing Fears, Rumors, Myths, and Misconceptions to assess RHMs':

- Knowledge of modern FP methods
- Level of confidence in providing the range of available FP methods and associated services
- Competencies in addressing clients' fear of side effects and other myths and misconceptions associated with modern FP use
- Personal barriers preventing RHMs from effectively responding to their clients' needs and concerns

The survey also examined four commonly quoted reasons for not opting for modern contraceptives:

- Clients had a fear of side effects.
- Pills enhance appetite, leading to weight gain.
- Contraceptives can cause miscarriage.
- Fertility is evidence of man's manhood, so spacing and limiting are not advisable.

Survey findings highlighted significant variation in knowledge, confidence, and practice among midwives trained on FPCBT1 and those who were not, plus demography, seniority, years of service, and education. The survey found particular variations in:

- Midwives' knowledge of modern FP methods and confidence to counsel clients was generally high (75.5% average score) but varied per specific method.
- In response to the most effective contraceptive method, 61% said BTL, 13% said IUDs, 13% said DMPA/Depo-Provera, 6% said oral contraceptive pills, and 2% said the lactational amenorrhea method. Only 2% said PSIs and 0.41% said no-scalpel vasectomies.
- The midwives surveyed were generally confident in counseling clients on FP (92%) and claimed to have facilitated clients' decisions to voluntarily choose a method (94.7%).
- Pills (94.3%) were the most commonly offered method, followed by injectables (88.6%), condoms (88.2%), the lactational amenorrhea method (82.1%), IUDs (78.9%), BTL (72.4%), the Standard Days Method (56.1%), PSIs (52.8%), and no-scalpel vasectomies (38.2%).

Over the project life, MH reprinted and distributed a range of IEC materials and job aids for providers to use for their own reference and when engaging with their clients. These materials supported HSPs' efforts to increase awareness and understanding on FP and MNCHN in Mindanao. These materials also helped them improve their own understanding and skills in providing FP/MNCHN/AY services. MH developed these IEC materials in consultation with its partners and stakeholders. Stakeholder inputs strengthened each product as part of a pilot-test process:

- Immunization poster for the FP expanded program, distributed in Northern Mindanao (43 health centers in Cayagan de Oro and 21 in Misamis Oriental)
- BTL infographic product for Cagayan de Oro City
- BCS Plus training materials and updated versions: BCS Plus algorithm, BCS cards, method brochures, trainers' guides, FP desk charts, 2015 medical eligibility criteria wheel, and the 2014 clinical standards manual
- MNCHN posters and brochures from the CHANGE program distributed at SDPs
- Digital versions of FP videos, with audio-visual equipment procured for SPMC and Brokenshire Hospital and for use in health events in Davao Region and Lanao del Norte, among others
- Frequently asked questions tools and job aids for the Cohort 300 initiative
- Posters and streamers for World Vasectomy Day
- IEC collateral for Center for Teens launch and information (poster, flyer, operational guide covers)

MH undertook spot checks to observe and seek feedback on the relevance and use of these materials. Most local partners found the IEC materials helpful during discussion with clients and when dispersing key messages on FP and MNCHN.

Community Volunteers

MH developed and strengthened strategies, capacity, and skills for community-based health volunteers to identify and address unmet FP needs of women, men, couples, and AYs. MH called this cohort of volunteers the barangay population volunteers.

Barangay population volunteers made home visits to households with WRA (ages 15–49). After initial identification and client profiling, barangay population volunteers followed up with couples identified as having an unmet need for modern FP during a family development session, Usapan series, and/or premarriage counseling. Barangay population volunteers referred these individuals to the nearest health facility, while midwives provide FP counseling to help them decide which FP method to use. Another important role of barangay population volunteers is to ensure all health providers are compliant with each client's right to informed choice and voluntarism.

EBF Promotion

MH extensively promoted the benefits of EBF using varying available forums and mediums. The project:

- Reached pregnant and postpartum women and their families through community-level health events and Usapang Buntis sessions conducted in partnership with DOH-ROs and local health offices at the provincial or municipal level. RHUs with birthing facilities conducted weekly Usapan Buntis sessions for mothers on MCH integrated messages on EBF and FP.

- Developed, reprinted, and distributed reader-friendly, IEC materials, including posters and 40,000 copies of the Mother and Baby Book, an essential material for pregnant and postpartum women that records mothers and baby's health, as well as helpful information on EBF, child health and nutrition, and immunization records in 4,822 public and private health facilities in Mindanao project sites.

REACH++
This health outreach initiative for GIDAs in ARMM offered group education on EBF, FP, and safe motherhood, including prenatal care, vitamin supplementation, immunization, and malaria prevention services for children and mothers. MH supported 41 REACH++ activities with almost 8,000 participants.

- Trained providers and health facility management on use of the comprehensive tracking tool for pregnant women in Davao Region DOH-RO and reproduction of the comprehensive tracking tool.
- Assisted enhanced use of the pregnancy tracking tool for MCP-accredited facilities in Cagayan de Oro (55 facilities) to track EBF education for pregnant and postpartum women.
- Monitored 31 lactation management training-trained HSPs toward successful implementation of the Ten Steps to Successful Breastfeeding. MH also provided logbooks to record EBF clients of the 14 RHUs in the province.

Male Involvement in MNCHN/FP

MH developed specific strategies in consultation with all key stakeholders to inform and mobilize men's involvement in FP and safe motherhood that included Usapang Bagong Maginoo sessions. Men's participation at these sessions has been encouraging.

MRLs

Religious interpretations on family and pregnancy spacing have an influence on individuals when making RH choices. Cognizant of the impact religious leaders have on their communities, MH engaged with faith-based leaders to mobilize communities through leading sessions during local dialogs (health events and Usapan sessions). MH specifically requested that the leaders help clarify their congregations' understanding on the position of Islam regarding FP to manage fertility.

These MRLs engaged women and men in the community through Usapan sessions. In Basilan, 60 males were reached during group sessions, along with 30 women and 30 men in local *mushawara* (dialog). In Marawi City, an MRL spoke in front of 295 men and women during a local health event. In Maguindanao, 30 men participated in a *mushawara*/discourse on FP, RH, benefits of EBF, and ideal marrying age in Islam, and in Tawi-Tawi, 200 males attended Usapang Maginoo conducted during outreach activities. Finally, in Sulu, 10 MRLs addressed 25 couples and 25 adolescents on FP/RH in Islam.
MH provided TA to the Regional Darul-Ifta to develop a sermon/*khutba* guide for imams to reference when preparing to lead Islamic worship services at the mosque. The guide was pre-tested and secured USAID approval, and the Bureau of Madaris Education committed to sponsor the guidelines as coauthor with the Regional Darul-Ifta.

MH served as the technical partner for the CHANGE program that used the guidelines as resource and outline for its sponsored radio program, Khutba on Air, that invited MH-recommended MRLs together with DOH representatives as guests.

To meet the distinct needs of ARMM, MH engaged a technical consultant to develop a collection of guidelines and talking points for *khutbas* (sermon) broaching the benefits of healthy timing and spacing of pregnancies and EBF. These subjects were included within the larger discourse on the concept of family in Islam, male involvement in safe motherhood, parenting, and the age of marriage in Islam for men and women.

Strategy 3: Addressing Policy and Systems Barriers to Service Delivery and Its Utilization

SDNs

In attempt to harmonize a devolved and fragmented health system, the RPRH Act of 2012 mandated the establishment of SDNs across the Philippines. This mandate was rooted in ensuring equitable service provision and financial risk protection for all Filipinos. The current administration is reinforcing this mandate as a priority by focusing on the institutionalization of a people-centered SDN that links every Filipino to a primary care provider within the network. Jhpiego's efforts in health systems strengthening, via USAID investments, predated this law and continue to honor this government-led initiative for universal health care. Through the Strengthening Local Governance for Health project, Jhpiego designed the *Guiding Framework to Improve Health Sector Performance and Health Outcomes* and implemented components of the universal health care framework in individual facilities through the Maternal and Child Health Integrated Program.

MH aligned its mission with RPRH, aiming to expand and sustain the availability of high-quality RMNCAH services via the SDN. Building on the Strengthening Local Governance for Health successes, MH shifted from a singular focus to convergent implementation of the universal health care framework in the SDN context.

What is an SDN?
SDN serves as a functional network of public health facilities, private-sector facilities, and service providers that arrange and administer uninterrupted health services across the health system and all socioeconomic quintiles.

Table 21. Similarities and differences between service delivery networks and interlocal health zones

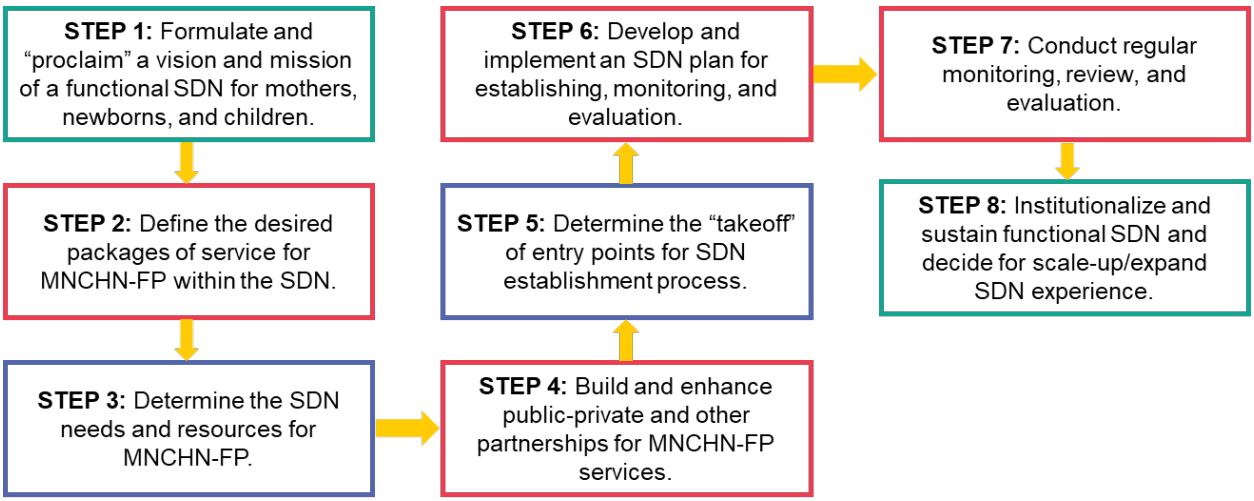
Category	Interlocal Health Zone (ILHZ)	Service Delivery Network (SDN)
Context	• Created to reintegrate hospital and public health services in a well-defined geographical area. • DHO/district hospital is the backbone.	• Organized into a well-coordinated maternal, newborn, and child health and nutrition (MNCHN) network of services that cuts across political and geographical boundaries. • Province/city is the basic unit of analysis (planning and implementation).
Legal Basis	• Article X, Sec. 13, of the Constitution • Local government code of 1991, Sec. 33 • Health Covenant of the League of Provinces of the Philippines, signed March 1999 • Executive Order 205 of January 2000, establishment of ILHZ	Same as ILHZ, plus: • Administrative Order 2008-0029 MNCHN Strategy • Administrative Order 2010-0036 AHA • Responsible Parenthood and Reproductive Health Act: Rules 4 and 5 • Philippine Health Agenda

Category	Interlocal Health Zone (ILHZ)	Service Delivery Network (SDN)
Structure	• ILHZ Health Board • Technical Management Committee	• Regional SDN Advisory Committee • SDN Management Committee (province-/citywide) • SDN Technical Working Group
Referral Services	• Level 3 hospital/comprehensive emergency obstetric and newborn care is not expressly defined as part of network.	• No apex, no SDN • Level 3/apex hospital as end referral facility (public or private)/cross-border/cross-sector

Per the Executive Order 205 of January 2000 many localities focused on and established ILHZs to reintegrate hospital and public health services into the health system. ILHZs, however, rarely engaged the private sector and were limited to the geographic boundaries of their LGU. SDNs leverage private-sector contributions (e.g., financing) and link facilities across borders so that Filipinos can access services that are not within their LGU. MH worked with provinces to either create new SDNs or transition existing ILHZs to SDNs. While the starting point for each province varied, all prioritized strengthening management and cross-border collaboration.

In collaboration with DOH-ROs and stakeholders across the health system, MH developed the SDN Operational Guide to assist provinces and cities with systematically establishing an SDN. The eight-step process in this guide serves as the foundation upon which MH provided TA. The project specifically prioritized steps two, three, four, and eight, which strengthen service delivery and management of an SDN.

Figure 13. Eight-step process for service delivery networks



Step #2 and #3

The activities under these steps (e.g., SDN mapping exercise) uncovered health system gaps—provider capacity, financing, and data reporting—that affected the availability and accessibility of FP and AYRH services.

Step #4

Each stakeholder plays an essential role in SDN sustainability and scalability. To create buy-in and ownership, MH engaged the public and private sectors at each step of the SDN creation process. MH invited representatives to join the SDN TWGs at the provincial and SDN levels so that they could advise on policy and management. At the community level, MH designed and organized partnership groups to tackle key challenges or strengthen specific aspects of the SDN. For example, in the D.O. Plaza SDN, MH facilitated the creation of a community transport group to facilitate referrals.

Step #8

Policy Issuances

Through high-level advocacy meetings with the Office of Mindanao Health Cluster, MH obtained the executive issuance necessary to create SDNs. This critical issuance kicked off the development process and unlocked technical and financial support from the DOH-RO.

Commodity Security

To shift toward demand-driven commodity distribution, MH introduced the Commodity Tracking Inventory Tool in 340 facilities. Using this tool, facilities were required to submit an FP consumption report each quarter to the FP logistics hotline or Facebook group. The report enhanced DOH capacity to project and meet commodity needs.

DQCs

MH institutionalized DQCs in 15 provinces and two cities by advising them on DQC policy development, establishing DQC teams at provincial and municipal levels, and advocating for DQC funding in municipal and provincial budgets. As a result, LGUs can use high-quality data to strengthen their monitoring and analysis, and subsequently design targeted LIPHs and advocate for additional DOH funding.

PhilHealth Accreditation

SDN membership requires that all facilities be PhilHealth accredited so that clients are protected from financial catastrophe brought by staggering hospital expenses. MH helped 290 out of 368 facilities comply with the PhilHealth accreditation requirements by assessing and addressing deficiencies. For example, if facilities lacked the ob-gyn specialists/ward necessary for accreditation, then MH arranged a memorandum of understanding between facilities.

LGU Trust Fund

MH assisted 328 SDN LGUs with modifying or creating a local PhilHealth reimbursement policy inclusive of the maternal/newborn care package. This specification was necessary for LGUs to create a separate pool of reimbursement funds that were specifically budgeted for FP services.

The government devolution in ARMM stops at the regional level rather than extending to the local level, as it has in all other Philippine regions. This structure creates a difficult political environment for ARMM provinces to execute the SDN Operational Guide. MH, however, supported Maguindanao province, which showed a strong interest and political alignment toward SDN creation. Additionally, MH linked remote island health facilities with private-sector health providers to increase services utilization where SDN creation was not possible.

DOH-ARMM pushed for inclusion of informal traditional child providers to be part of the SDN referral mechanism, as a significant proportion of childbirths occurred at home, given women and families with poor access to health providers and facilities seek out traditional birth attendants for health care.

The *Paanakan* initiative formalized and strengthened links between formal and informal childbirth providers, improving referrals by traditional birth attendants to skilled birth attendants and FBDs. This partnership evolved into an incentivized mechanism either by way of sharing PhilHealth reimbursements of an accredited facility and/or LGU funds from the Internal Revenue Allotment. The initiative requires further assessment on the ground and data on participating health care facilities* to determine any results and potential of improving maternal health indicators and outcomes.

*Basilan's Akbar and Lamitan; Lanao del Sur's Lumbabayabao; Sulu's Talipao and Maimbung; Maguindanao's South Upi, Upi, and Buluan; and hospitals (e.g., South Upi Municipal Hospital, Parang District Hospital in Sulu, among others).

Accessibility

Increased accessibility to LARCs/PMs. Across 128 public facilities and private providers, linked to four apex hospitals, 10 provincial hospitals, and 14 private hospitals that provide LAPM and comprehensive emergency obstetric and newborn care.

SDNs

SDN management structures led to LGU health policy issuances related to the RPRH law, PhilHealth reimbursement, LGU cluster pooling of resources to fund hospital operation, legitimization of SDN area designation, and availability of safe blood.

Eight SDN sites documented cross-border referral and 'accommodation of clients' mechanism and protocol. Ten SDNs initiated the integration of a modern FP program in hospitals serving as end referral facilities for LAPM services in 14 hospitals.

Two Caraga SDNs (D.O. Plaza and BueNasCar) incorporated AYRH protocols in their respective referral manuals. Referral mechanisms included:

- FP/MNCHN/AY protocols at each level of care within the network
- Guiding principles and disciplines
- Roles and responsibilities of all stakeholders down to the community level
- Blood service referral system
- Monitoring and evaluation system tracking SDN contribution to achieving health outcomes and service coverage indicators
- Functionality based on the 10 elements
- Indicators of referral efficiency

PhilHealth Accreditation

MH's technical support enabled LGUs and HSPs to meet PhilHealth accreditation requirements, as accreditation translates into revenue for the SDPs by:

- Implementing a PhilHealth reimbursements policy that reinvests MCP and FP revenue in health services via a trust fund in the form of incentives to HSPs, staff, community health team members, and traditional birth attendants
- Procuring FP commodities and supplies

PPPs

Cost-effectively addressed health system gaps via PPPs. Through SDN membership and TWG involvement, the private sector negotiated DOH-funded capacity-building activities and FP commodities. In return, the DOH benefited from having private facilities submit data to the unified reporting system, which allows for better tracking and measurement of RMNCAH services.

MH facilitated the forging of nine PPP agreements with private hospitals as core referral facilities for maternal, LARC/PM, and AYRH services; an agreement with the community transport group to provide the much-needed transportation in GIDAs; and an agreement for inclusion of 911 and subspecialty services as integral component of SDN services.

In Davao City, Marilog District 3, the city government and the Davao Medical School Foundation inked a PPP to revitalize Marilog District Hospital as a functional birthing facility, catering to at least 45,000 IP. The partnership included a role for all key stakeholders:

- Davao City Central 911 for interfacility transfer
- Davao Light and Power Company for power installation
- City council and Red Cross for blood sufficiency program
- Association of Barangay Captains for community-based transportation, security, and food
- The DOH-RO to augment the manpower of the facility, with PHP 3 million allotted to improve its electrical plan
- San Pedro College of Nursing to bring in student affiliates for their community extension activities

MNCHN Legislation

MH's technical support to the Davao City LGU helped craft the MNCHN ordinance, approved and passed into law after more than a year of deliberation by the city council and local stakeholders. The ordinance outlines five strategies:

- Provision of MNCHN core package of services
- Organization of SDN involving private and public facilities
- Regulation of FBDs to ensure that no unskilled or unlicensed health professionals will manage delivery
- Empowering community health volunteers to provide primary health care in their communities
- Distribution and utilization of MNCHN/FP commodities

Institutionalization of DQCs and Use of Health Information

Data are information, and information is vital to make informed decisions for FP programming, resource allocation, preventing duplication of efforts, and strategic course correction to achieve zero unmet FP need. MH made concerted efforts throughout project life to instill an understanding, interest, and commitment within the health system to capture, analyze, and use data for evidence-based decisions. MH identified timely use of client data as one of the means to improve use of FP services, facilitated health officials to analyze data for unmet need at regional and provincial levels, provided tools for reporting and client profiling, and mentored partners on use of data for generating demand and service delivery. Throughout the life of the project, MH advocated for preventing duplicate entries and effort, and the need for reconciling data used by government and partners to enhance complementarities in serving the underserved.

MH highlighted the use of data and data analysis in achieving zero unmet need for FP by enhancing the knowledge and skills of DOH-ROs to review and use data for decision-making and planning. Regions' investments in data capturing, quality, analysis, and use varied across regions, but some notable actions taken included:

- Davao: 48,786 (19%) of the estimated 250,278 women with unmet need were profiled and reported, while only 17% were served.
- SOCCSKSARGEN: Consistently used the tracking and reporting format and tools recommended by MH, which showed Cotabato and Sultan Kudarat provinces performed below 35% of their targets and could not meet their service projections; General Santos City also fell short, by 15%. Cotabato City (82.5%) and South Cotabato (81%) were the regional top notchers in meeting their projections/targets.
- Zamboanga peninsula: Met 47% of its baseline estimate of CCT/National Household Targeting System for Poverty Reduction clients with unmet FP need. Zamboanga City served 62% with FP services out of the 7,192 CCT WRA profiled with unmet need.
- Trained 340 DQC trainers, who in turn further empowered a cadre for DQC rollout—a cumulative total of 4,132 DQC LGU staff across 19 provinces and two cities

Additionally, Compostela Valley and Agusan del Sur demonstrated commitment to data quality and its use through:

- **Accuracy:** The provinces' data completeness and accuracy were enhanced after they detected errors and then reduced/corrected/managed them within the RHUs before reaching the PHO.
- **Time:** The provinces shortened data reporting and retrieval time from 7–10 days to 1–2 days at the RHU level and from 3–4 months to 1 month or less to consolidate and complete annual reports at the PHO level.
- **Indices:** Percentile rates increased through improved health indices from 2012 to 2016 using DQC data as a reference to monitor and update TCLs, coupled with intensified demand generation activities linked with direct service provision.
- **Programming:** LIPH, annual operational plan, and PIR processes improved with the use of clean and validated data.

- **Responsiveness:** DQC informed evidence-based programming responsive to community needs. Specific examples included the *TPP* (a household-level FP campaign to swiftly address unmet modern FP needs), Bay Mo Ampingan Ta in Talacugon RHU (accurate and updated monthly health profiling of households reflecting the 13 primary health indicators), and family development sessions held for Pantawid Pamilyang Pilipino Program beneficiaries integrating MNCHN/FP.
- **Budget:** Resource allocation for health became deliberate and efficient, leveraging existing resources and investing in focused interventions.
- **Official directives:** EOs and office orders institutionalized DQCs, facilitated the creation and mobilization of DQC teams at the provincial and municipal levels, and allocated budget to fund onsite DQC activities.

In Northern Mindanao, local health managers claimed DQCs allowed them to deliver context-specific health services, taking into account the sociocultural and economic determinants of health. Iligan City put in place a unified recording and reporting system across public and private health care facilities to track and capture the true health situation of the city.

The regional government required ARMM IPHOs to conduct DQCs on FHSIS and hospital statistics reports and to submit these to the DOH. ARMM uses the Governor's Initiative Systems Assessment to assess, review, and analyze performance and major final outputs based on data and reports, including reports submitted by IPHOs and hospitals. The region continued provincial-level client profiling and tracking unmet need.

Challenges impeding institutionalization of DQC included varying commitment and action for DQCs within LGUs and SDPs down to the barangay. Furthermore, the sheer scale of DQCs without sufficient human, technological, and time resources led to issues in the quality and timeliness of data gathered. The exclusion of private-sector facilities led to gaps in data on current users, referrals, and client follow-up. Computational errors resulted in discrepancies, especially in indicators recorded and reported as disaggregated figures. MH recommended the following solutions:

- Reinforce the benefits of using DQCs in LGUs with LCEs and local health managers when planning, implementing, monitoring, and evaluating processes.
- Empower RHMs, family health associates, and public health nurses (PHNs) to mainstream DQCs as part of quarterly monitoring covering the majority of facilities under each municipality/city.
- Enhance the understanding of LGU and facility staff and teams on the methodology of gathering and analyzing DQCs via onsite coaching through MH LGU advisors.
- Directly engage with nonreporting hospitals and private-sector facilities to motivate them to participate in DQCs.
- Enhance diligence among staff and their supervisors in populating forms and employing additional data validation mechanisms.

MH developed a rapid assessment tool that used DQCs as a source of information for LGUs to use when developing their strategic plans (2017–2019) and supported them to integrate these strategies in their LIPH. Each plan comprised critical health goals, partnerships, strategies, activities, and resources required to achieve better health outcomes.

Commodity Security at SDPs

Used as a truism, WHO's "no product, no program" slogan is relevant for effective implementation of any FP program. MH strengthened existing systems/mechanisms with the public health sector to ensure timely commodity supplies, avoiding any possibility of stock-outs. While MH monitored progress on the Supreme Court's temporary restraining order, the project advocated with LCEs/local health boards, particularly Health Leadership and Governance Program graduates, for FP commodity/other supplies budget, procurement, and disbursement. MH, in partnership with regional and LGU partners:

- Conducted rapid assessments of Learning Management System in SDN sites and prioritize addressing identified gaps.
- Linked RHUs with the commodity tracking network (FP commodity online monitoring and FP logistics hotline) for timely reporting and replenishment.
- Established inter-LGU and facilities' commodity mechanism within SDN to efficiently address stock-outs by operationalizing DOH memoranda on FP commodity share of provincial hospitals.
- Linked DOH-ROs and PHOs to the national FP logistics hotline to address communication gaps on logistics within the health system, ensuring availability of buffer stocks.
- Coached HSPs on the simplified supply management and reporting system, with focuses on inventory management, forecasting, replenishment/procurement, and recording and reporting for effective utilization.
- Built SDP personnel competency on recording and reporting of commodity consumption to POPCOM and the DOH-CO via the FP commodity monitoring network.

MH's strategic focus remained on identifying and addressing challenges and bottlenecks in policies that result in commodity stock-outs at SDPs. MH developed linkages between SDPs and commodity distribution and tracking mechanisms. The project supported the Provincial Department of Health Office, PHO, and DOH-RO to introduce a stop-gap mechanism to immediately address stock-outs by redistributing stocks from SDPs with sufficient inventory level to those reporting stock-out and replenishing facilities from the DOH-RO's buffer stock. Efforts resulted in:

- LGUs and PHO FP coordinators provided commodities to district hospitals, while RHUs dispensed commodities to private birthing homes/clinics on the condition that commodity consumption reports are submitted in return.
- DOH-RO and provincial offices installed inventory alert mechanisms that efficiently flagged SDPs with commodity inventories breaching buffer stock levels and responded by linking them with the regional and central DOH FP logistics hotline and the online FP commodity monitoring system.
- PHOs undertook quarterly stock-out monitoring and facilitated redistribution of FP commodities from facilities with little commodity usage, overstock, or commodities approaching their expiry dates to facilities with reported stock-outs.
- POPCOM in Caraga, with the approval of the RIT, established a regional FP logistics hotline with dedicated personnel to track and monitor FP commodity inventory status in all health facilities. They shared stock monitoring reports with the DOH-RO and the DOH-CO family health office for timely supplies. DOH-RO Caraga, for its part, undertook an inventory of drugs, including FP commodities, through its pharmacist and furnished inventory reports to provincial program coordinators and RHUs.
- The DOH and POPCOM introduced the supply management and reporting system or the simplified FP commodity inventory. These tools track and monitor inventory levels through issuance, dispensing, recording, and reporting/submission of actual consumption reports.

- The DOH issued a memorandum mandating that all DOH-ROs' PHNs in RHUs/CHOs and PHO FP coordinator submit quarterly, one-page FP commodity inventory and order report forms every third week of the succeeding month of each quarter. This was part of the government strategy to shift from a "push" to a "pull" system of inventory management. MH collaborated with DOH-RO and POPCOM Northern Mindanao in developing this system, together with a TA package for RHUs and CHOs.

- MH integrated the simplified logistics management system in all SDN activities to ensure availability of FP commodities, especially in primary health care facilities.

PhilHealth Accreditation and Reimbursement Process

For providers to attract more clients by integrating FP/MCH services in their facility, they require DOH certification and PhilHealth accreditation in order to be eligible for reimbursement for services provided. To support providers in meeting these two criteria, MH focused its technical support on PhilHealth accreditation of DOH-accredited FP service providers and facilities, combining guidelines on developing successful business models for providers and facility managers. MH also developed a comprehensive assessment guideline aligned with DOH criteria and conducted facility assessments to support service providers in meeting and complying with accreditation criteria. Advocacy with local health boards, LCEs, and the Sangguniang Bayan/Panglalawigan chair for efficient reimbursement policy remained a constant effort for MH.

By end of project, MH exceeded its projection for PhilHealth-accredited facilities despite the increasingly demanding DOH requirements and criteria. With 301 certified/accredited health facilities within project-supported sites, 95 facilities were accredited for the first time, while 206 facilities maintained their MCP/NCP PhilHealth accreditation.

LGUs utilized PhilHealth reimbursements per guidelines. MH responded to LGUs' distinct needs for securing accreditation and formulation of PhilHealth reimbursement. The number of public facilities that attained MCP/NCP reaccreditation by end of project reached 300, representing a 16% increase over 5 years, while the number of LGUs utilizing PhilHealth reimbursements per PhilHealth guidelines by end of project, with SOCCSKARGEN and Northern Mindanao with the most accredited PPFP/PPIUD providers, representing 74% (209) of the total PPIUD-accredited providers.

Some LGUs still do not have PhilHealth reimbursement due to incomplete Health Facility Enhancement Program-funded facilities, absence of BEmONC-trained personnel, and noncompliance of health facility design to PhilHealth's building specifications. Furthermore, the January 1, 2018, PhilHealth requirement of MCP providers/birthing homes needing a DOH license to operate when applying for initial or reaccreditation led to a reduction of the number of public and private health facilities securing or renewing MCP/NCP PhilHealth accreditation.

Strategy 4: Strengthening DOH-ROs and PHOs in Project Development, Management, and Oversight

MH undertook a range of needs-based initiatives during project life to strengthen DOH-ROs and PHOs in improving their project development and management. Notable interventions include:

LIPHs

MH introduced a new approach for developing LIPH that included using tools for rapid assessment and validation of FP/MNCHN/AY strategies together with operational pillars of the local health system. The approach required all stakeholders to revisit and, if required, revise their objectives, core strategies/activities, and targets. The effort was to make revisions based on evidence and required alignment with the Philippine Health Agenda and policies. MH imparted these tools through a series of workshops that also provided a sharing and learning forum, where participants learned about project methodologies and best practices when undertaking project review and planning. The sharing deepened understanding of the benefits of using validated health information when rationalizing plans/activities and targets premised in local needs and priorities while remaining consistent with national and regional health objectives.

Informed Choice and Voluntarism

Providers require consistent reinforcement to ensure their clients fully enjoy their right to informed choice and voluntarism when opting for FP and other SRH services. MH facilitated formal training sessions in different regions to reinforce the principles of informed choise and volunteerism, within a client centered service provision ethos and approach.

DOH-ROs

The training information management system equips program managers with Mindanao-wide, regional information on cadres of trainers and training institutions.

The system has an SMS alert system for PTE evaluation that prompts supportive supervisory visits and a redesigned matrix that includes a supportive supervision checklist and PTE score results, among others.

The RIT is a coordinating body responsible for disseminating national polices and guides on RPRH and actions of regional bodies, monitoring implementation of law at field level, and providing TA across all intervention regions. MH shared project lessons and gains in partnership with DOH-ROs and LGUs with the RIT. Throughout the life of the project, MH created opportunities to highlight operational impediments in improving service provision and invited discussion for collectively addressing these challenges, such as improving client profiling and tracking, and coordinating integration of MNCHN/FP services, developing robust mechanisms, and allocating resources for DQCs. In response to varying efficacy levels of RITs, MH proposed, with the acquiescence of DOH-RO leadership, the initiative of developing and issuing "resolutions" as a means to flag critical issues for the Regional Development Council to take to the Social Development Committee. MH supported DOH-ROs to implement DOH guidelines, specifically:

- DOH AO 2014-0041, Guidelines on Recognition of FP Training Providers
    - The AO mandates establishing a Regional FP Training Recognition Committee as a critical step toward building the capability of DOH-ROs' expansion of FP programs. As the DOH's focus on RPRH implementation increased, so did its receptiveness to MH's efforts to strengthen DOH-ROs' health human resources capability through MNHCN/FP PTE support. MH highlighted the data, reflecting low proportions of HSPs practicing the FP skills they acquired through training (22% [160/742] for FPCBT2, 7% [55/796] for LARC-PSI, 34% [355/1,035] for PPIUD, and 49% [61/125] for BTL-MLLA), owing to providers' lack of confidence to practice because of insufficient supportive supervision and provider monitoring.
    - MH held a series of consultations to inform and generate interest in the training information management system, a Web-based training database tool that systematically tracks the status of training, post-training, and certification of HSPs at the DOH-CO, DOH-RO, project, and Mindanao cluster levels. Among other outputs, MH's efforts resulted in:

- Policy supporting the implementation of the training information management system
- Development of a formal structure to support training management
- Decision to migrate FP training data from 2013 to 2017 to the training information management system
- Building competencies of the ARMM, Northern Mindanao, Davao, SOCCKSARGEN, and Caraga regional offices

- DOH AO 2017-0005, Guidelines in Achieving Desired Family Size through Accelerated and Sustained Reduction in Unmet Need for Modern FP Methods
  - MH facilitated DOH-ROs in interagency collaboration through robust information recording and reporting tools. Working through RITs. MH institutionalized improvements in the system, such as in Davao Region, where the project reconvened the RIT to expand membership, including active CSOs:
    - Presented monitoring and evaluation framework and identified TWG members.
    - Suggested TWG's mandate to DOH-RO Davao leadership for finalization.
    - Reiterated the importance of tracking unmet need at the cluster levels and quarterly reporting to the OFIM to inform Mindanao-wide intervention plans.

- DOH-ROs collaborating with interagency coordination bodies for RPRH implementation
  - MH identified fractured interagency collaboration as one of the key areas requiring improvement of FP service provision and meeting unmet need of unserved communities. MH facilitated collaboration with and among DOH-ROs, POPCOM, and other regional partners by enhancing participation at RICT/RIT and AYRH TWG meetings and in DOH- and POPCOM-initiated activities, such as trainings on MNCHN/FP, PTE, Usapan, AYRH, and unmet need identification. MH leveraged these meetings to assist the DOH in identifying strategies to improve demand generation using data on unmet need and linking it to service delivery and timely supportive supervision for trained PPFP providers. At these same meetings, the DOH updated provincial/city LGU health officers, chiefs of DOH-managed and LGU hospitals, and heads of DOH-attached agencies on the DOH's new directions and its current policies and projects.
  - Other activities include MH interventions in Northern Mindanao for RPRH implementation:
    - Assisted regional POPCOM in organizing trainings and workshops to enhance understanding and strategy development for zero unmet need for provincial and city teams. Trainings were held on FP unmet need for a core team, comprising PHO/CHO FP coordinators, provincial/city population officers, provincial/city social welfare officers, and development management operators.
    - Supported public health facilities (RHUs) in adopting measures that are AY-friendly and compliant with regional development council Resolution No. 36 s.2016.
    - Mobilized BHWs through their federation presidents to generate unmet need data, with POPCOM providing some form of mobilization funds for the BHWs.
    - Drafted a memorandum for provinces and cities to compete for Purple Ribbon Award, given by the Purple Ribbon Provincial Committee, comprising the DOH (Provincial Department of Health Office), POPCOM (provincial POPCOM officer), the Department of the Interior and Local Government, PhilHealth, and the Department of Social Welfare and Development representatives as sitting members.

CAAs

In the seven CAA sites in Mindanao (Lanao del Sur, Basilan, Maguindanao, Sulu, Tawi-Tawi, Zamboanga City, and Cotabato City), MH achieved the following accomplishments:

- Increased network of trained providers.
- Supported LAPM outreach and REACH activities, reaching over 7,800 clients.
- Through REACH, provided 2,454 infants (ages 0–59 months) with various antigens, almost 4,600 women with information on EBF, and almost 2,000 youth and nearly 1,000 men with comprehensive information on MNCHN/FP.
- Established eight partnerships with CSOs for advocacy and AYRH program implementation.

REACH
GIDAs face challenges in accessing basic services due to conflict and strife affecting mobility of communities and service providers. REACH helps organize outreach activities to deliver health services to the conflict-affected population in far-flung, underserved communities in ARMM.

Influencing Systems and Sustainability

REACH-Marawi, February (14) 2018

MH was extensive in scope and geographic intervention. Over the 6-year project, MH acquired insights on which gains can be sustainable with some effort and the unfinished agenda that requires further investments. This section lists suggestions for sustainability categorized according to MH's key core interventions (i.e., SDN, FP in hospitals, provision of PPFP/IUD, Usapan).

MH refers to institutionalization for sustainability. Institutionalization includes the following indicators:

- Revised and/or developed policy/ies and guidelines for the specific project
- Budget allocations for project implementation
- Empowered/trained human resources
- Mechanisms in place facilitating task sharing between different cadres of service providers and/or frontline health workers across facility tiers and sectors (public, private, nonprofit, NGO)
- Administratively integrated service programs through processes and protocols
- Defined and measured key performance indicators through robust monitoring efforts

SDN

Functional SDNs require strong TWG leadership. Of the 21 established SDNs, the highest-functioning SDNs had a previously established ILHZ structure and, more importantly, a strong LGU advisor and provincial health officer. The provincial health officer remained engaged and active in leading stakeholder coordination, while the LGU advisor set a clear agenda (e.g., systems gap analysis) for each meeting and served as an external facilitator during political misalignment. DOH-ROs and LCEs also play a pivotal role in the success or failure of SDN functionality and must be actively engaged.

Functional SDNs require highly skilled management teams at the local level and in the SDN TWG. During the initial rollout of SDNs, stakeholders appointed SDN coordinators who did not have the necessary technical expertise (e.g., systems analysis and design) to manage an SDN. As a result, SDN establishment progressed very slowly. MH, in consultation with stakeholders, developed criteria for SDN technical team member qualifications.

LGUs have different interpretations of an SDN (e.g., principles of organization) that impact its design and implementation. Establishing an SDN is a long and tedious process that varies across LGUs and requires sustained, evidence-based advocacy efforts beyond the health sector. To address the issue, at the national level, MH facilitated the creation of a regular intercooperation agency meeting with participation from the DOH-CO. During this meeting, implementers could level off and agree on SDN approaches, strategies, and expected results.

To sustain existing SDNs, stakeholders must continue to focus on strengthening SDN implementation management structures and overall coordination. Continued mobilization and engagement of the private sector (health and nonhealth) through PPPs are also critical to creating effective networks in urbanized areas. Private-sector involvement in the SDN management structure augments the expertise and resource requirements of the network.

Even with political buy-in, the island provinces of ARMM face the most challenges with SDN establishment because they are underdeveloped, unstable, and geographically too far for referrals. Local governments, therefore, are generally biased toward tangible infrastructure projects rather than investments in RMNCAH services and providers. Since SDNs are mandated, MH can leverage its presence, knowledge, and experience with ARMM to develop an SDN that:

- Strengthens the capacity of primary care facilities and midwives to administer RMNCAH services that are generally provided in higher-level facilities.
- Establishes innovative funding mechanisms or PPPs for transportation.
- Improves outdated communications systems (e.g., satellite phones).
- Effectively engages multiple sectors (e.g., counterterrorism).

Partnership agreements among all stakeholders must detail responsibilities, roles, and functions of each, and be transparent. EOs on the SDN and its management have the potential to sustain the SDN. A combination of an SDN management structure and TWG, if proactive, can guarantee an effective, coordinated network. SDPs within an SDN must maintain an established pool of certified trainers on a wide range of FP methods, access to COEs on FP/PPIUD, and the ability to access PhilHealth and its benefits for financial viability and sustain provision of quality care/services.

DQC

To institutionalize the gains on DQC implementation, issuance of a DQC policy with dedicated resources (staff, equipment, logistics, and budget) is imperative. The policy will serve as an imprimatur to direct health managers and staff on administrative and operational matters.

Inclusion of a DQC budget in the LIPH and annual operational plan ensures the success of the initiative, as demonstrated by the LGUs regularly conducting DQC activities. The budget should include funds for transportation, reproduction of DQC tools, training, and refreshers.

Health workers' and government leaders' commitment to the DQC initiative core vision will help it be sustainable, as will the support of the provincial LCE through issuance of EOs that mandate creation of a DQC team. Local health leaders must strengthen and apply leadership and management skills and competencies to be visionary and effective. Leaders can influence their employees by providing clear roles and expectations, and emphasizing teamwork.

The creation of a technical team at the provincial level, such as the PHO core team, that is tasked to monitor, follow up with, validate, analyze, and provide technical support and updates to RHUs and CHOs is crucial to sustaining DQC implementation. RHUs should continue their strategy of conducting regular updates and one-on-one staff mentoring. As DQC is a team effort, incentives in any form motivate teams to work as committed teams.

Installing the EMR in facilities can encourage health personnel to maintain clean, valid, and reliable data in the EMR system. Despite scarce resources and minimal support after initial DQC implementation, PHNs from RHUs can take on validation leadership, as observed by MH during implementation. PHNs empowered and inspired their RHMs and BHWs to continue their DQC activities. They crafted innovative strategies, developed a spirit of teamwork, and instilled the idea that DQC is more than a task—it is a professional obligation.

The creation of PHO TWGs and RHU-level TWGs through a formal office order can sustain implementation of monthly DQCs sent to all RHUs and their respective PHN, RHM, and DOH representatives to assure the accuracy and validity of reports/data using DQC tools and indicators. Part of their responsibility can be to conduct coaching and mentoring, if possible, for health staff.

Integration of FP in Hospitals

Saving the lives of women who have little or no access to lifesaving FP/RH information and services is a core mission. MH made the following observations for a sustainable project:

- Identify the right project implementers who are committed to and advocate for modern FP but also understand that access to modern FP methods is a social problem. Investing in orienting and educating project teams on the vision, mission, and objectives goes a long way.
- After identifying FP champions, the DOH, CHO, and other institutional stakeholders should make sure that champions are provided with necessary management and policy support to ensure that their deliverables conform to their institutions' mandates and are appreciated. Document and use champions' motivations in an advocacy tool to encourage others in departments or units in other LGU health facilities to do the same.
- Establishing an FP program technical management and committee with a committed FP coordinator helps improves FP/RH service provision and instills accountability.
- Invest in human resources for health by creating learning opportunities. Appreciate and recognize high-performing staff and providers.
- Develop a cohort of trained and skilled providers for continued provision of services, so there are no gaps when doctors or trained providers rotate to other assignments.
- Provide TA through trainings to strengthen ob-gyns' skills and confidence to perform PPIUD insertion and removal and other LARC/PM services.

- Implement a robust supportive supervision initiative, as training alone does not translate into high-quality performance and services.
- Formalize health facility affiliation with nursing and midwifery schools, and institutionalize continuing capacity-building for permanent medical staff.
- Hospital management should develop a motivating health care financing scheme to generate incentives (not necessarily cash) for staff to work on addressing the unmet need for FP. Consider incentive packages based on shared PhilHealth reimbursements, especially in recognizing extraordinary efforts and/or promoting staff based on effort.
- Develop operational guidelines and a hospital memo for the FP program. Memos should identify key players, their duties and responsibilities in ensuring efficient referrals, and implementation of 24/7 MNCHN services integrated with FP/RH and AYRH.
- Knowledge sharing among key stakeholders will help make strategies more comprehensive, effective, and user-centered.
- Use of data from standardized tools is critical to FP service provision and must be prioritized. Facilities with clearly defined data can proactively budget for FP services, ensure timely and high-quality services (e.g., client follow-up), and identify targeted approaches (e.g., outreach).
- Quality data are the bedrock of health planning and service delivery. The FP program lead must establish a strong data recording system that is analyzed and used when reviewing project performance and planning.
- Develop a two-way referral system to track and follow up with potential FP clients within and between SDNs and service providers/facilities.
- Ensure regular supply of FP products, commodities, and IEC materials. These are vital to the success of FP integration in a hospital.
- Ensure all SDN-related SDP are regulated by the DOH.
- Lobby for LGU and policy support. Invest in CHO awareness and understanding of pregnancy spacing, CYP, and the need to serve underserved communities..
- Enhance the LGUs' role through formalizing their support for timely client referrals, blood supply, and transportation assistance to ensure patients receive the medical attention they need as fast as possible.
- Establish Centers for Teens in facilities to attract AY clients, who can receive accurate information about RH and FP, and collectively address fertility management options.
- To ensure uninterrupted financial resources, hospitals need to formulate strategic implementation plans complemented by evidence-based results for annual work and financial plans. Hospital management could consider using PhilHealth reimbursements to augment funding or collecting training fees to generate revenue after receiving DOH approvals as an FP training hospital.

Clinical Practice Site Utilization

Training institutions need to effectively harness CPSs that the DOH-RO Northern Mindanao recently recognized. The partnership between Northern Mindanao Medical Center and J.R. Borja General Hospital may serve as a model for making CPSs operational as intended—as practicum sites and venues for supportive supervision, even coaching and mentoring to meet the DOH's certification requirements.

Refocusing PTE on Nonpracticing Providers

The region should explore refocusing current supportive supervision/PTE efforts to concentrate more on providers who are not practicing rather than on those ready for certification. With 11 CPSs already certified by the DOH-RO Northern Mindanao and Northern Mindanao Medical Center, there may be a need to make arrangements where trainees from facilities with high-volume deliveries could access these sites. An administrator responsible for tracking the status of PTE visits and certification needs to be hired to make the process more systematic and ensure that no trainee is left out.

Harnessing Provincial Trainers

Difficulties harnessing provincial-based PPIUD trainers to conduct cross-border supportive supervision activities can be resolved through discussions and agreements at the SDN level, if already fully functional. As a first step, city-based and provincial trainers may need to be affiliated with Northern Mindanao Medical Center as "faculty members" of the training institution and later on with provincial training institutions that the DOH-RO Northern Mindanao will recognize, per AO 2014-00041. Additional orientation and mentoring on the use of PTE tools need to be provided so provincial trainers can function effectively as supervisors, coaches, or mentors.

AYRH

In designing an AYRH program, it should be ensured that the strategies and initiatives adhere to guiding principles that promote a sense of inclusion, empowerment, and a supportive and nurturing environment. Active adolescent participation and comprehensive programming, such as providing them with access to education and livelihood skill development opportunities is essentail. For initiatves in ARMM, materials and TA needs to be linked to Islam because religion is a subject that interests youth and is important within their community. Specifically:

- Utilize available resources and manpower. Budgetary constraints did not hinder AYRH services implementation.
- Establish a harmonious working relationship with all offices and agencies.
- Regularly monitor the project.
- Equip more HSPs to work with AY clients and provide them with health services. Include other frontline staff, such as guidance counselors and school nurses.
- Acquire a computer to facilitate data recording and reporting.
- Constantly update the LCE.
- Implement programs to target male AYs.
- Support programs for parents and guardians that encourage their involvement in the lives of AYs.
- Strengthen STI, HIV/AIDS, drug abuse, and smoking implementation programs.

AYRH needs to be implemented on a large scale, where all public and private facilities are conscious of the unique health and RH needs of adolescents. Comprehensive, sustainable programs for young people guided by principles that promote inclusion, participation, empowerment, and a supportive, nurturing environment are required to address AY needs. Programs can be enriched through multisectoral, multiagency involvement to help LGUs organize out-of-school youths, build their capacities on SRH peer education, and provide

follow-up with support. Linking out-of-school youths to informal learning opportunities and livelihood skills development is also effective with collaborative efforts from all stakeholders.

Evidence-based baseline data and a needs assessment tool can help gain LGU, LCE, and stakeholder support, and guide local SRH programming. Demographic data and periodic surveys help gain LGU support, just as evidence-based advocacy can help LGUs understand and appreciate the situation on the ground and the urgency of the intervention to ensure LGU/LCE support for any AYRH program.

Harnessing capacities of existing youth-focused initiatives helps expand AY access to SRH/FP/MNCHN information, counseling, and services. Culture-sensitive, nonjudgmental, and properly trained youth peer educators encourage AY clients to participate in group conversations. Peer educator teams should have male and female members and members of different cultural backgrounds. Continually develop youth peer educators to replace those who graduate. Ensure there is funding for youth peer education activities in the relevant annual investment plan's budget.

Strengthen the feedback system for referrals made by youth peer educators. They said they did not know the outcomes of cases they referred to the schools' guidance counselors and RHUs. Youth leaders want to know if their referrals need to be improved.

Forging partnerships between schools and health facilities helps reach more of the AY population with information, risk assessments, and access to services through referral. RHU/health facility management commitment and support help sustain hospital-based service programs focused on AYs.

Policies and operational guidelines legitimize the project within the hospital system. They also help with dissemination of standard procedures in handling AY clients among hospital HSPs and support staff. They outline a more detailed pathway for AY navigation in the hospital's health care delivery system. Local policy issuances and EOs supporting youth-friendly RHUs make these programs sustainable in the long term. They encourage the health sector and other stakeholders to work together to provide AYs with access to a continuum of guidance, counseling, and services.

A specific unit or department needs to manage, oversee, and monitor the clinic, and liaise with internal and external stakeholders. Core teams of trained HSPs need to ensure smooth implementation of service programs for AYs.

HSPs trained on AY-friendly services need to document learnings from their interactions with AYs. This helps Center for Teens managers and staff gain insight into AYs' needs and other sources of information that may be inaccurate, and help hone skills in providing sensitive, effective counseling.

Schools that do not offer AYRH-related services must inform students of facilities that provide AY relevant support or counseling. Schools could also connect student with POPCOM initiatives, such as the You for You Teen Trail Initiative.

Centers for Teens can collaborate with community-based teen centers to provide risk assessment, information, guidance, counseling, and links to the health facility to expand the access of AY to RH/MNCHN services.

An EO designating the New Bataan RHU as AY-friendly was critical. It included the following policies: A memorandum order designating a focal person for the AYRH clinic; An EO creating an AY municipal council; The RPRH Care Ordinance for New Bataan, Compostela

The AY municipal council monitors the clinic's operations and provides recommendations. The municipal health officer submits a report to the local health board regarding how the policies pertaining to responsible parenthood and RH are implemented, and includes recommendations for executive and legislative action.

Annex 1

Integration of family planning in hospitals, Maguindanao Provincial Hospital, Autonomous Region in Muslim Mindanao

1974: Maguindanao Provincial Hospital (MPH) opened with 50 beds and a staff of 12. The hospital helped Maguindanaons rebuild their lives after years of strife due to the armed conflict in central Mindanao.

1986: MPH operated under an integrated setup with the integrated provincial health office (IPHO).

2010: The hospital underwent major renovations, including construction of the ob-gyn department; education room, which was also used as a delivery room; and women's and children's protection room. At the time of compiling this document, the 150-bed hospital had over 334 staff, of whom 42 were medical specialists.

FP advocacy, facility improvements, and training and augmentation of skills for medical specialists and hospital staff helped the hospital meet the demands fueled by the gradual change in Maguindanaons' health-seeking behavior.

Responding to the high incidence of maternal deaths, MPH started its family planning (FP) program within an integrated hospital setup. Implementing an FP program was a challenge in the context of the province's predominantly Muslim community, with strong traditional customs and practices. Broaching FP was taboo. However, the prevalence of maternal deaths in various municipalities prompted MPH and the IPHO to collaborate with local leaders in communities to position modern FP as an acceptable option for pregnancy spacing within the context of Islam. Grassroots health workers, who provided comprehensive medical, dental, and surgical services, were involved to advocate for FP when they engaged with their clients.

MPH undertook initiatives and strategies to comply with the Responsible Parenthood and Reproductive Health Act of 2012 to achieve zero unmet FP need and the country's commitment to the Family Planning 2020 agenda to expand access to and utilization of FP services.

Responding to the Duterte administration's Philippine Health Agenda, MPH made FP its top priority, enhancing its FP program guided by the Department of Health (DOH)'s mandate that included:

- Memorandum No. 2014-0312, Guidelines in Setting Up FP Services in Hospitals
- AO No. 2013-0013, National Health Policy and Strategic Framework on Adolescent Health and Development
- AO No. 2014-0042, Guidelines on the Implementation of Mobile Healthcare Services for FP

MindanaoHealth (MH), with some budgetary support from MPH, strengthened the capacity-building initiatives of the hospital's FP program. Trainings were conducted with the objective to integrate FP services into the hospital system to ensure all men and women of reproductive age (WRA) with unmet FP need, especially young mothers and the underserved, received FP information, counseling, and age-appropriate services while within hospital premises.

Providing integrated, readily available FP services 24/7 helped reduce, if not completely avoid, missed opportunities to provide FP services to clients. MPH's efforts aimed to:

- Identify all WRA (ages 15–49) with unmet FP need already within the various departments/units in the hospital.
- Provide FP services to these clients, including those referred to the hospital for specific FP methods and concerns.
- Develop capacity to deliver a wide range of FP methods and contribute to zero unmet FP need in the Philippines.
- Establish and/or strengthen the hospital's FP program.

Training Hospital Staff on FP Methods and Services
MPH is a training hospital for bilateral tubal ligation-minilaparotomy using local anesthesia (BTL-MLLA) and is the only comprehensive emergency obstetric and newborn care hospital in the province. It has 14 staff trained in MLLA, BTL, postpartum intrauterine device (PPIUD), interval intrauterine device, and FP competency-based training.

Post-training, the FP program boasted of having a pool of 14 trained counselors in the outpatient department (OPD), delivery room, emergency room, operating room, obstetric ward, and male and female medical ward. Distribution of trained staff ensured men and WRA visiting any hospital department had access to FP information and counseling.

Trained nurses shared their learnings with their peers during nursing service meetings, but only trained nurses counseled clients on FP.

According to the provincial FP coordinator, each PPIUD trainee could provide FP services to 10 patients within 6 months after training, and all trained service providers met the requirement.

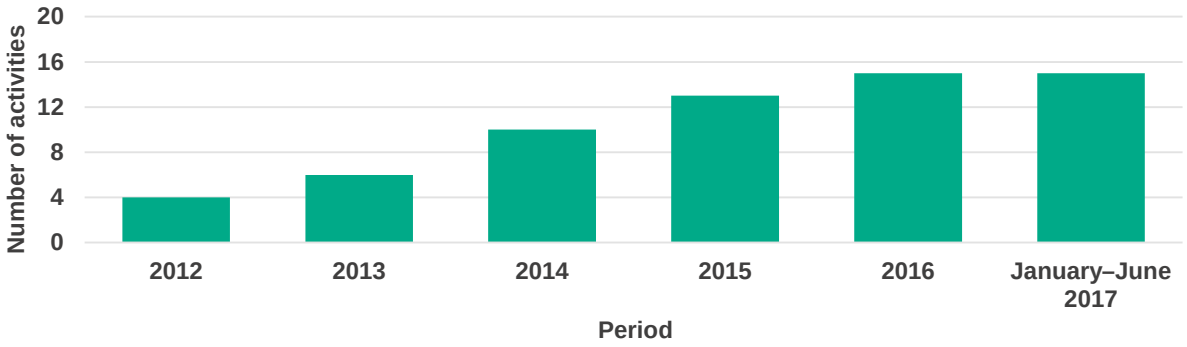
Trained counselors held daily bench conferences and health teachings on FP in the hospital's various waiting areas, such as the OPD, provided there was enough of an audience. The chief nurse identified a trained staff member to make a presentation. The assigned speaker determined the specific FP topic based on what he/she gauged would be relevant to the audience.

24/7 FP services: FP services for inpatient clients are provided in the OPD, delivery room, operating room, and obstetric ward 24/7. All FP clients received their voluntary choice of FP method before the facility discharged them, meeting the hospital's commitment to provide FP methods to 100% of FP clients.
FP advocacy: MPH, in partnership with the IPHO, conducted a series of structured Usapan group discussions with different sectors in the province to promote FP and maternal health care engaging men and WRA to take action on their FP needs. MPH conducted the Usapan series with youth, farmers, indigenous peoples, tricycle drivers, and military personnel/soldiers, who can share FP information in outreach activities in their communities.

FP forum and Buntis Congress: MPH held an FP forum and Buntis Congress with free FP services during International Women's Day in March and FP Month in August each year. Activities were held simultaneously at all health centers in the province.

Itinerant team and outreach activities: The MPH itinerant team had four members. It held outreach activities over the project years, providing the full range of FP services, including ligation at lower-tiered hospitals and rural health units (RHUs).

Figure 14. Maguindanao Provincial Hospital outreach activities, 2012–2017



Muslim Religious Leaders

MPH and the IPHO engaged with local Muslim religious leaders (MRLs) for their support and assistance to address the issue of maternal deaths, particularly the lack of accurate information on FP and the misconceptions and fears about FP methods' side effects, within Muslim communities in the province.

Despite the ongoing war between the Moro Islamic Liberation Front and the Government of the Philippines at that time, MPH and the IPHO asked to meet with the Moro Islamic Liberation Front head and MRLs to present them with provincial statistics on maternal deaths, highlighting the many cases of Muslim mothers dying of pregnancy-related complications. The data elicited concern among the MRLs, as their own children would be parents in the future. They agreed that without good reproductive health (RH) and proper FP, their daughters could end up losing their lives due to pregnancy-related complications.

The United Nations Population Fund supported awareness on the benefits of FP in Muslim communities across the province. On the recommendation of the IPHO and MPH, the United Nations Population Fund sent five MRLs—the most influential and with the largest constituencies—on study tours to Muslim countries that practice FP, such as Indonesia, Iran, and Egypt. In Cairo, the MRLs learned from the Muslim religious scholar Grand Mufti that FP is acceptable in Islam. This greatly influenced their FP acceptance.

The decision to accept FP information and methods traditionally rested solely with Muslim husbands. Because of the FP advocacy undertaken by MPH, the IPHO, and MRLs, Muslim women exercised their right to voluntarily choose FP counseling and services, and selected their voluntary method of choice without seeking their husbands' consent. This was especially true in cases when the woman's life was at risk from too many, too frequent pregnancies.

Using Information, Education, and Communication Materials and Job Aids

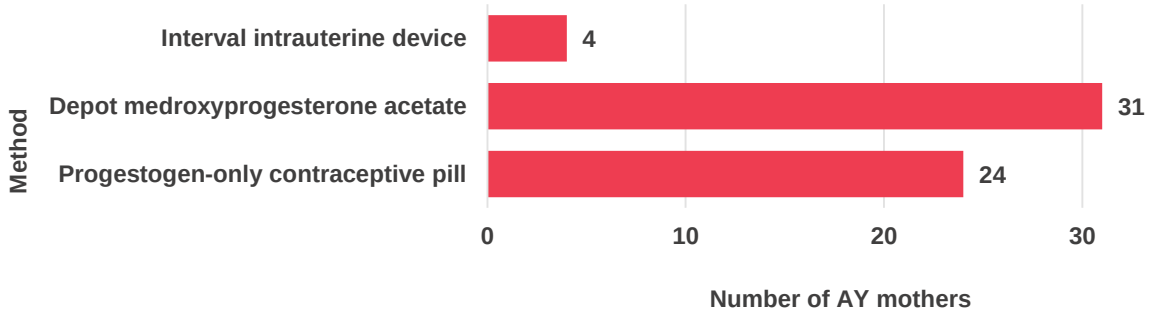
MPH used information, education, and communication (IEC) materials and job aids received from MH, the Commission on Population, and the United Nations Population Fund. These materials are used during activities on FP, such as the bench conferences, barangay mothers' classes, and the Usapan series with adolescents and youth (AYs). Visual aids helped engage the audience and made learning easier and more interesting, especially having access to FP commodity samples to understand what they looked like and how they worked.

Addressing AY Pregnancies

MPH conducted advocacy with the youth sector even before 2012, targeting students and out-of-school youth for the Usapan series because of the increasing number of teenage pregnancies in the province. The hospital's FP coordinator, trained on the adolescent job aid by MH, coordinated with school principals and school nurses to send third- and fourth-year students to MPH for the Usapan series on AY RH and FP. The hospital provided students with transportation. Barangay health workers and midwives identified out-of-school youth at risk of adolescent pregnancy in their respective communities and provided information on FP, referred them to the RHU, or brought them to the hospital for the Usapan series.

Data show MPH provided 878 teenage mothers with safe motherhood services.

Figure 15. Family planning services for adolescent and young (AY) mothers at Maguindanao Provincial Hospital, 2016



Results

Over the years, MPH noted a gradual change in the behavior for RH and FP, evidenced by the increasing number of men and WRA who accept FP information, counseling, and methods from MPH.

Figure 16. Maguindanao Provincial Hospital family planning (FP) clients, 2014–2017

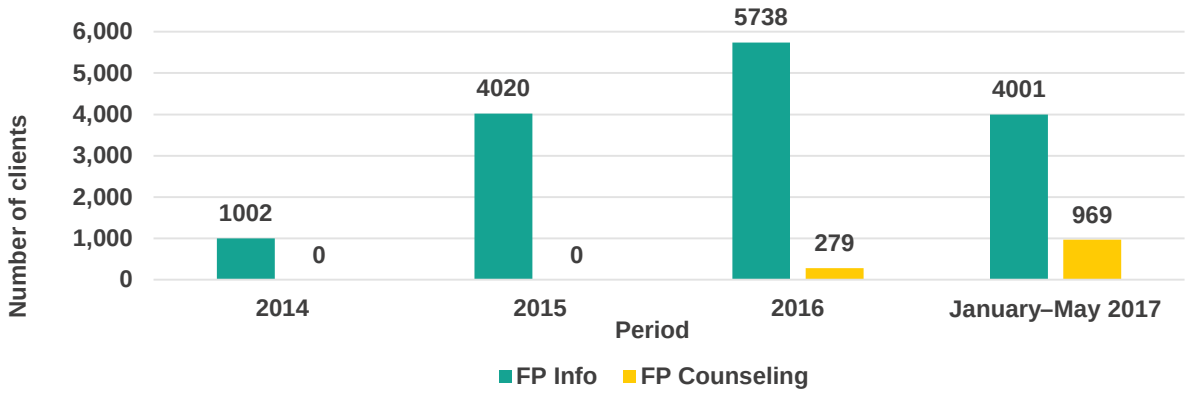
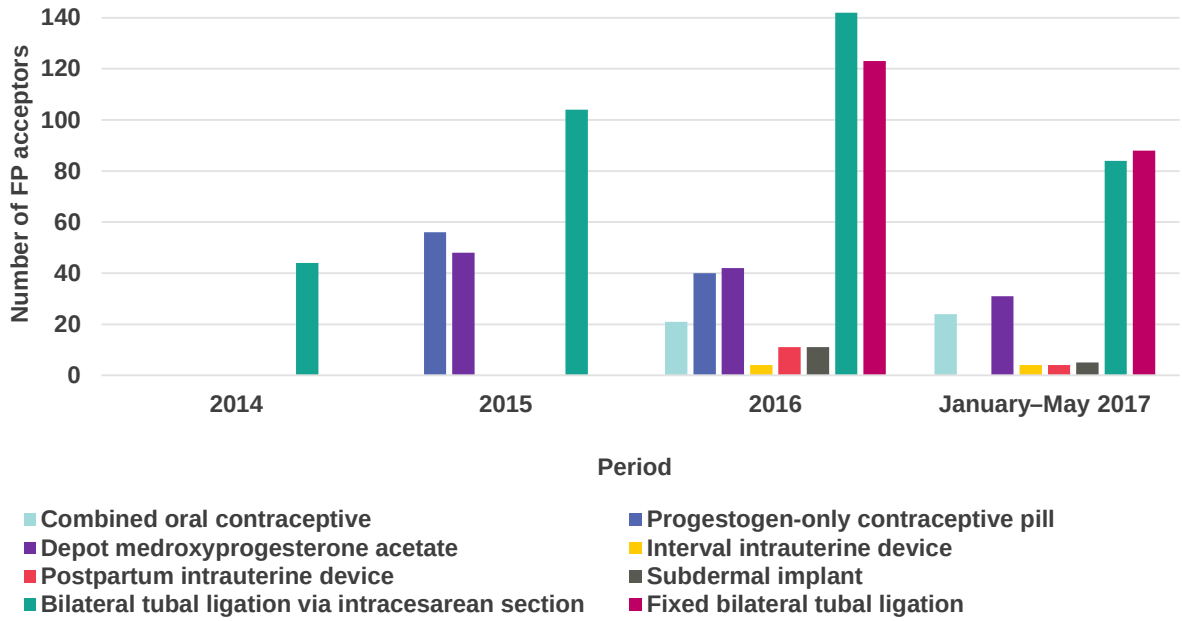


Figure 17. Maguindanao Provincial Hospital family planning (FP) services by method, 2014–2017



The upward trajectory in FP acceptance indicates behavior change among WRA. This improving health-seeking behavior is also evident in outreach activities undertaken by MPH over the past 5 years. Figure 17 indicates the increasing number of acceptors of FP services and methods provided during the outreach activities.

Figure 18. Acceptors for family planning (FP) services and methods during outreach activities by Maguindanao Provincial Hospital, 2012–2017

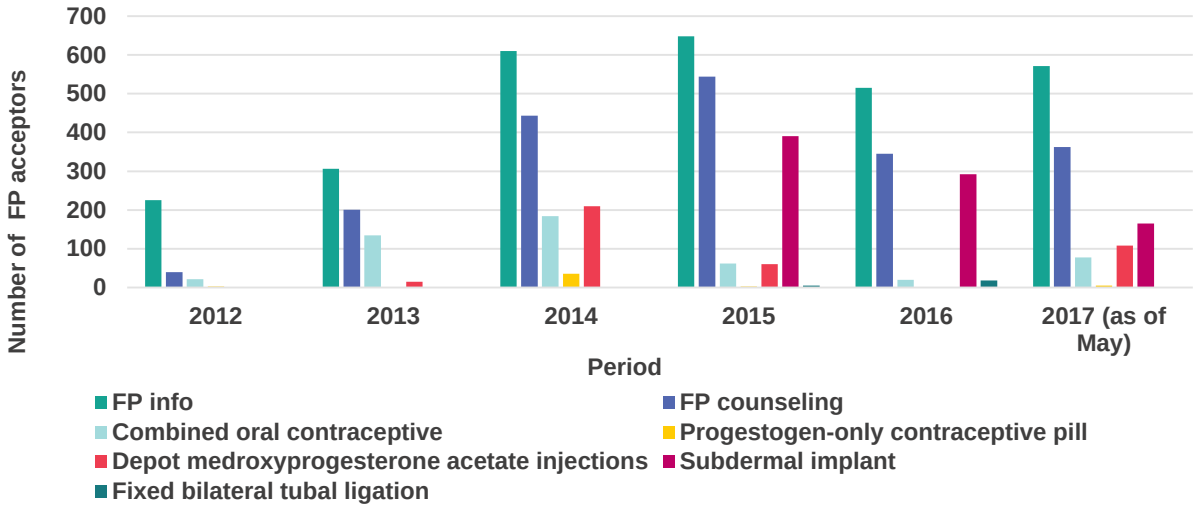


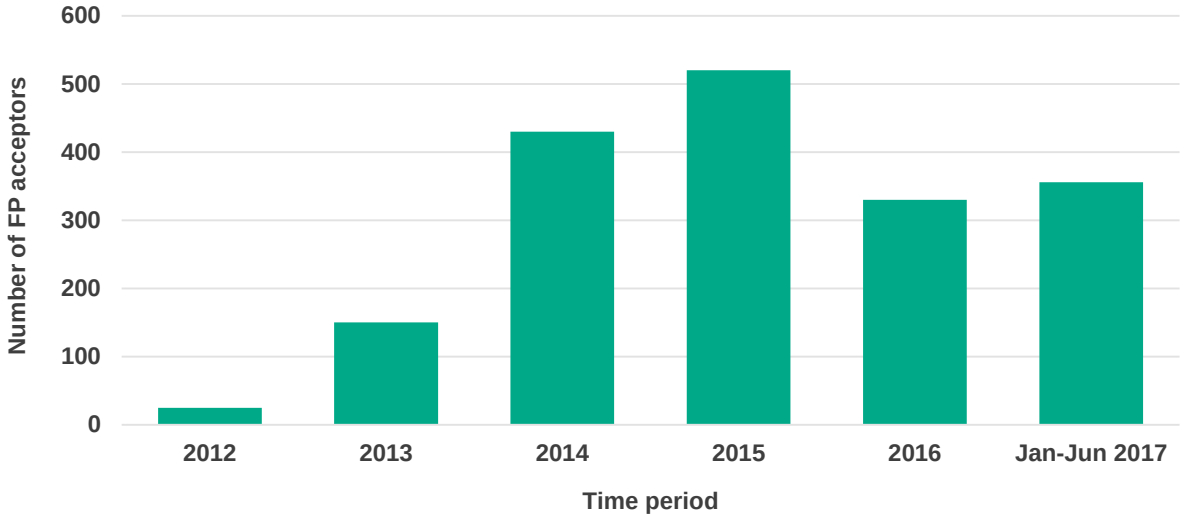
Figure 18 illustrates that FP information is now acceptable to men and WRA in the province. More clients flocked to outreach activities and accepted FP information. FP counseling clients during outreach activities also increased over time. The number of FP methods with acceptors during outreach also grew from 2012 to 2015, from only two methods with acceptors to five methods.

While the number of acceptors for each of the FP methods during outreach activities did not increase consistently from 2012 to 2017, it is worth noting that the total number of FP acceptors for all methods showed consistent growth within the same timeframe, as shown in Figure 19. The numbers of FP acceptors grew dramatically from 2012–2017.

Philippine Health Insurance Corporation

MPH's resources were augmented by Philippine Health Insurance Corporation (PhilHealth) reimbursements for FP methods (analysis pending until requested data are submitted).

Figure 19. Total number of family planning (FP) acceptors during outreach by Maguindanao Provincial Hospital, 2012–2017



MPH follows PhilHealth's guidelines for splitting facility (70%) and professional fee (30%) payments. The professional fee share goes toward a "potting" system, where all hospital service providers and staff receive a proportion based on the number of procedures or actual work performed.

Gaps and Challenges

MPH successfully advocated for FP within the context of Islam, resulting in a growing number of FP acceptors, but it still faces some challenges as it works to achieve zero unmet FP need:

- **Hospital budget:** MPH is now a 150-bed hospital, but it is still budgeted for 50 beds. It has more than 300 hospital staff, but only 53 people hold staff positions, and the rest are contract employees. To keep up with the personnel needs of the hospital, management uses hospital income to cover the cost of the manpower needed to adequately provide its clients with health services across all departments.

- **FP commodities:** In 2013–2014, MPH had an acute shortage of FP commodities, while some RHUs were oversupplied. The DOH sent inventory directly to the RHUs, not to the IPHO, and did not consider the municipality's targets. This resulted in an oversupply of FP commodities in RHUs with low FP acceptors and a shortage of commodities in municipalities and MPH with high FP acceptors. Commodity shortages were also a problem in previous years. This did not dissuade MPH from continuing to provide FP services, shifting to other FP methods with available commodities.

While MPH and the IPHO are mandated to maintain enough FP commodities and allocate provisions to RHUs with depleting supplies, they could not do so because of increasing demand generated from RH/FP advocacy. A communication sent to the DOH's Central Office requesting that FP commodities be sent directly to MPH improved supply management over the past 2 years. MPH and the IPHO allocate FP commodities to RHUs in the province based on their actual need or usage.

Timely referrals: As a referral hospital, MPH accepts patients from other parts of the province, mostly from remote areas where pregnant women are usually attended to by a traditional birth attendant, or *walyan*. Most mothers referred to MPH are already in the dire stages of pregnancy-related complications, and some are even at the brink of death. Small hospitals, lying-ins, and other birthing facilities need to make early referrals to MPH to improve patients' chances of survival.

Supportive supervision: While MPH conducted supportive supervision successfully in recent years, it used to be plagued by a lack of clients willing to accept FP methods. Trained FP service providers in lying-ins and other birthing facilities did not have enough clients to perform the required number of FP methods under supportive supervision. To stay up to date on training, service providers used a model to practice their injection, physical exam, and insertion skills.

Support for Implementation

Capacity-building: MPH supports capacity-building for its FP staff by sending them to MH-sponsored trainings. The hospital's counterpart support includes providing venues and meals for training, and per diem and travel expenses of their staff who attend training outside the hospital.

FP champions/advocates: The provincial FP coordinator stressed the importance of having an advocate or champion for FP, such as Dr. Tahir Sulaik. As chief of MPH and the IPHO, he is strategically positioned to strengthen MPH's FP program in conjunction with the IPHO FP program, bolstering each other's roles and working together to enhance FP strategies and initiatives.

Dr. Sulaik advocates for FP when providing medical services to impoverished families with eight to 12 children. He prioritizes strengthening MPH's FP program and improving the obstetric and FP facilities. He is supportive of training hospital staff to improve service provision and contribute to their professional development.

As per Dr. Sulaik, it would take less than 3 months for any hospital similar to MPH to successfully replicate MPH's FP program, as it would be an add-on to the hospital's overall setup. He also believes hospital management's sincerity and motivation, and the commitment of its staff are crucial to the success of establishing FP programs and determine the pace of setup.

Prerequisites for replication and sustaining the FP program require:

- **The right people:** Identifying the right people is crucial to sustaining the FP program. They need to be committed to providing FP services.
- **Hospital management support:** The hospital management's support helps implement FP initiatives and practices. MPH management did not issue any official memo or policy supporting FP program establishment, but it is now creating a policy document to comply with International Organization for Standardization standards.
- **Training:** Training ensures that there are enough staff to provide FP methods and services at every opportunity in the hospital. Continued training can mitigate cases of staff transfer, resignation, or retirement.

Lessons Learned and Recommendations

Mobilizing Community Leaders as FP Advocates

One of the biggest factors in the success of MPH's FP program was mobilizing MRLs in FP advocacy. This partnership yielded several positive results:

- FP is no longer considered taboo to an increasing number of Muslims in the province, especially those reached by MPH's and the IPHO's advocacy efforts with the support of MRLs.
- More Muslim men and WRA are open to accepting FP methods.
- AYs who participated in the Usapan series can now openly discuss RH and FP.
- Sectors such as farmers, tricycle drivers, and soldiers/military personnel are mobilized to advocate for FP and pass on the knowledge to others within their respective sectors.
- While some are still unwilling to accept FP due to personal or cultural considerations, the increasing number of acceptors ensures that MPH is gradually on track to meet its goal of achieving zero unmet FP need.

MPH works hard to make FP methods and services available but notes that without MRLs' FP acceptance and support, it would be hard-pressed to find FP acceptors in Maguindanao. It is vital to nurture the relationship with MRLs so they continue advocating for FP in Muslim communities by having them constantly communicate and coordinate various hospital FP activities, speak at the Usapan series, and lead opening prayers at special hospital events. This mutual respect is beneficial to both sides—it allows MPH to reach and serve more FP clients from Muslim communities, and clients receive the FP services and methods they need.

Building Credibility to Gain Public Trust and Support for Health Programs

MPH needs to build credibility as a health institution that truly serves the people. Only then will it gain the public's trust and support for its health programs and services, including FP.

From 2009–2013, MPH improved its facilities using PHP 30 million in funding secured by Dr. Sulaik during his term as secretary of health for the DOH's Regional Office in Autonomous Region in Muslim Mindanao and member of the department's National Executive Committee. Upgrading MPH to a 150-bed hospital allowed it to better serve the province.

The hospital underwent further improvements, such as the construction of the emergency complex, new surgical ward, and intensive care unit. It advocated for the community to use its much-improved health services and its new facilities.

The hospital paid for most of the new infrastructure and equipment. This prudent use of hospital income is expected to gain the public's trust in MPH's commitment to serve its constituents.

Continual learning initiatives: Training more staff to become trainers is important to fill the gap left by trained providers retiring or moving. Only full-time staff should be trained, as opposed to contractual employees, who have a high turnover rate. While there are enough doctors at MPH, additional medical staff would help address the hospital's increasing number of clients.

DOH regulations and licensure: Dr. Sulaik said some midwives still perform manual extraction of retained placenta, even when they are only licensed to perform normal vaginal delivery. The DOH needs to strengthen maternity homes' licensing procedures and closely monitor midwives to confine their practice to what their license dictates to avoid raising the risk of complication at delivery, further aggravated by late referral.

Local government unit (LGU) role in timely referral and blood supply: MPH, the IPHO, and the DOH should share the responsibility of safe motherhood with the LGU, especially since it involves LGU constituents. The LGU should provide transportation assistance to ensure patients receive the medical attention they need as fast as possible. MPH also believes LGUs should take the lead in helping its constituents in sourcing blood supply for their needs. The LGU can come up with an ordinance that requires blood banking for the barangay to ensure its constituents can immediately get blood when needed, as in cases of postpartum hemorrhage. The blood supply can be stored in MPH's blood bank.

Establishment of Teen Center: MPH already has plans to make the Teen Center a focal point for AYs to converge, get accurate information about RH and FP, and come up with plans to avoid teenage pregnancies.

Annex 2

Institutionalizing integrated services in tertiary public hospital operations: family planning and adolescent and youth services, Southern Philippines Medical Center,[6] Davao City/Davao Region

Background
The Government of the Philippines passed Republic Act No. 103541, or the Responsible Parenthood and Reproductive Health (RPRH) Act of 2012, to help address unmet FP need. Section 7 and Section 4.05, on implementing rules and regulations, stipulate that all accredited health facilities shall provide a full range of modern family planning (FP) services.

See Annex 1 for orders and a memorandum the DOH issues to help achieve and sustain zero unmet FP need.

Missed Opportunity
At the time when the RPRH Act became law in 2012, tertiary care hospitals, such as Southern Philippines Medical Center (SPMC), typically had in place:

- An FP nurse assigned to the outpatient department (OPD) provided FP services.
- Another nurse from the DOH-RO provided counseling and reporting.
- There was no FP head in the OPD.

FP services provided condoms, pills, and postpartum and interval bilateral tubal ligation (BTL), with counseling. Very few clients came for intrauterine device (IUD) insertion/removal services. Clients did not use injectables due to either cost of the contraceptive or fear of side effects.

All tertiary care facilities' ob-gyn department provided FP services. Doctors would not provide information to, counsel, or refer clients to FP methods and services in the delivery room, primarily due to caseload and too many tasks assigned to them.

Asking clients to return for FP services on a later day contributed to missed opportunities, as they are unlikely to return and are lost to follow-up. Offering integrated, same-day, 24/7 FP services would help reduce, if not eliminate, missed opportunities for service provision. By providing integrated FP services during a single health visit, clients would save time and reduce their travel costs.

Various subunits could serve as FP client identification and service entry points: the delivery room, labor room, operating room, and ward. Additionally, pediatrics, family medicine, and internal medicine were also potential FP client identification and service provision points, especially for young mothers with unmet needs and underprivileged or lower socioeconomic status clients.

[6] Southern Philippines Medical Center is a government-owned hospital administered by the DOH and is located on J.P. Laurel Avenue, Bajada, Davao City. It was renamed the Davao Regional Medical and Training Center by the Republic Act 1859.

In September 2013, the US Agency for International Development's Maternal and Child Health Integrated Program and MindanaoHealth (MH) trained 15 staff in the hospital's ob-gyn department to integrate FP in its various units and departments, and formulate operational guidelines for integrated FP services with a focus on:

- Identifying women of reproductive age with unmet FP need, regardless of their departments/units in the hospital
- Providing FP services to clients, including those referred to the hospital for specific FP methods and concerns, and clients accessing mobile outreach services organized with the PHO/CHO and/or local government units (LGUs)
- Developing capacity to deliver a wide range of FP methods

During 2013–2015, MH built capacity through 24 trainings. Multitiered cadres were trained—doctors, midwives, and nurses—including annual refreshers on comprehensive range of FP methods, including postpartum FP (PPFP), adolescent and youth reproductive health (AYRH), employing the MH FP competency-based training level 1 (FPCBT1), long-acting reversible contraceptive-progestin subdermal implant (LARC-PSI), PPFP/postpartum IUDs (PPIUDs), and essential intrapartum and newborn care.

Competency-Based Training with Balanced Counseling Strategy Plus (FPCBT1 and FPCBT2)
MH conducted training on competency-based Balanced Counseling Strategy (BCS) Plus (FPCBT1) in two batches in February 2017.[7] Table 23 shows which hospital departments participated. On March 27–28, 2017, MH conducted FPCBT2 on interval IUD insertion. Most doctors were ob-gyns and consultants, and most midwives were from the delivery room.

Training of Trainers
MH developed 11 SPMC staff as master trainers—nine medical doctors, one nurse, midwife, and technical staff. In addition, MH held a PPFP/PPIUD training of trainers (TOT), an essential intrapartum and newborn care TOT in 2014, a BTL-minilaparotomy using local anesthesia TOT in 2015, an LARC-PSI TOT in 2016 and 2017, and a BCS Plus TOT. To note: Three SPMC staff (medical doctors) are DOH-certified trainers.

Integrated FP Services Operational Guidelines
Pursuant to DOH Memorandum No. 2014-0312, MH assisted SPMC in developing an operational guide for integrated FP service provision. This guide translated identified integration strategies into specific guidance for FP service delivery units in the hospital, providing increased access to its clients and a wider range of FP services or methods from all hospital entry points.[8] The guidelines were based on self-assessment findings conducted in February 2016, using the checklists provided in the DOH memorandum circular.

Engaged short-term technical assistant: In August 2016, MH brought on a short-term technical assistant to assist SPMC to support the technical working group in finalizing the operational guide and define an organizational structure to oversee integration FP services. The short-term technical assistant developed protocols for patient flow, tagging, recording and reporting, referral, and monitoring, and a prepared hospital order. In September and November 2016, SPMC performed validations based on the short-term technical assistant's FNA to further enhance the operational guide and its implementation plan, and set target dates for operational guide and hospital order approval.

[7] February 13–17 and 20–24
[8] From Operational Guide foreword (draft)

Set up Teen Center: Alarmed by the increasing number of pregnancies and gynecological referrals among adolescents in Davao City, the SPMC medical center chief called an emergency meeting in March 2015 with the women and child protection unit, public health unit, medical social services, ob-gyn department, pediatrics, family medicine, and psychiatry to spearhead the development of the Teen Center. MH provided technical support for the SPMC Teen Center to become a reality by overseeing the task up to its completion. MH's AYRH specialist and lead consultant for the Teen Center spearheaded writing the operational guide and facilitated the adolescent job aid (AJA) training.

Eighty-three people, including hospital management, doctors, nurses, midwives, Philippine National Police representatives, civil society organization and private-sector representatives, and others, participated in the hospitalwide AJA training and the writing workshop for operational guide development. The operational guide details the:

- Rationale of the Teen Center and the framework of operations as a program spearheaded by the women and child protection unit
- Program components and the center's key services
- Management structure and respective roles and functions
- Center's overall approach
- Step-by-step guidance on serving an adolescent client
- Support systems, including recording, reporting, and monitoring

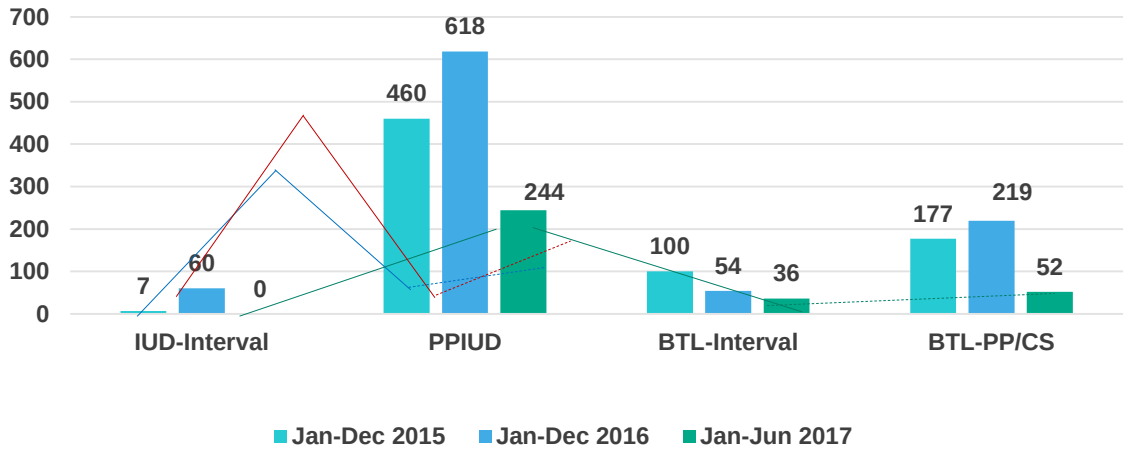
The Teen Center is a "modern and safe haven, a welcome respite for all young people with a comprehensive and holistic program for teen support and development."

Results

In 2014, SPMC became a center for excellence for PPFP/PPIUD. It conducted three batches of PPIUD TOTs for 27 participants and 19 batches for 242 participants coming from regions in Mindanao, except Autonomous Region in Muslim Mindanao.

The facility increased its FP acceptors.

Figure 20. Southern Philippines Medical Center family planning accomplishments, January 2015–December 2016 and January–June 2017



Same-Day, 24/7 FP Services

Ten hospital departments and units provided FP services. SPMC's FP clinic provided all available contraceptives, such as IUDs, pills, injectables, and condoms, and facilitated free or subsidized BTL services through the district executive office's FP fund.

Table 22. Southern Philippines Medical Center departments and units providing family planning (FP) services

Department/Unit	FP Services						
	Education/ Information	Counseling	Condoms, Pills, Injectables, Natural Family Planning	Interval Intrauterine Device (IUD)	Postpartum IUD	LARC-PSI	BTL-MLLA/ BTL ICS/IUD
Ob-gyn outpatient department	X	X	X	X		X	
Pediatric outpatient department	X	X	X			X	
Family medicine outpatient department	X	X	X			X	
Internal medicine outpatient department	X	X	X			X	
FP outpatient department	X	X	X	X		X	
Labor and delivery room	X	X			X	X	X
Operating room						X	X
Ob-gyn ward	X	X	X			X	
Pediatric ward	X	X					
Total	**8**	**8**	**6**	**2**	**1**	**8**	**2**

FP Counseling

FP counseling supports women and their partners in making informed and voluntary FP choices, with support for side effect management.

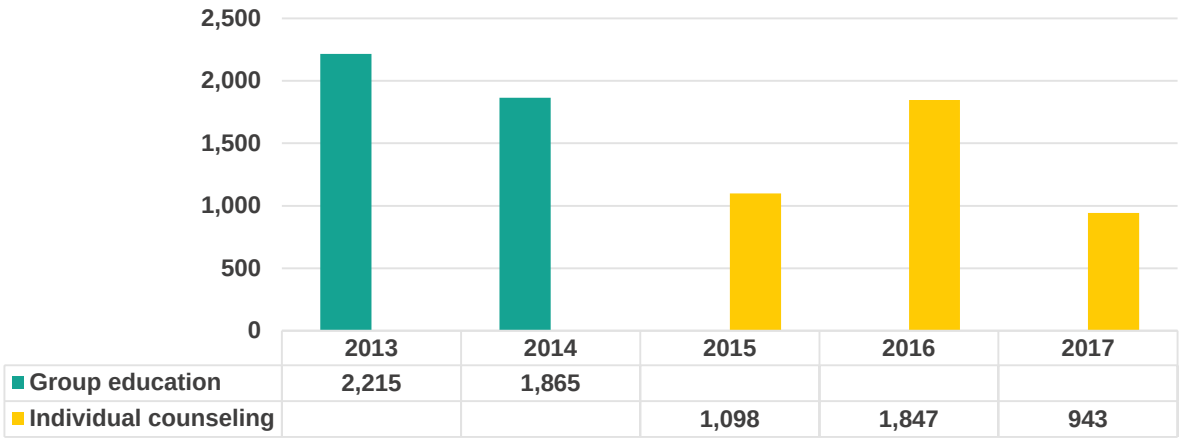
Hospital policy requires service providers to offer FP information and/or counseling services at all FP service entry points by hospital staff trained on FP counseling, they must be available 24/7, and patients should not be discharged from the ward without a session on the benefits of FP and breastfeeding.

The hospital deploys midwives trained on FP in the delivery room to counsel women in the emergency room. Patients are informed, counseled, referred (if needed), and provided with the FP service of their choice. SPMC employs two kinds of counseling: group education/counseling and individual/one-on-one counseling. Staff generate demand for FP through group counseling in the ob-gyn ward and at the Teen Center.

The ob-gyn ward requires one-on-one prenatal and postpartum counseling before discharge. Almost 8,000 women/couples were counseling on FP from 2013 to June 2017.

MH strengthened FP in the hospital by developing a cohort of service providers to deliver a wide range of FP methods at the hospital. In the words of FP consultants, those trained by the project had the confidence to perform PPIUD insertions, as before the training, they only performed interval IUD insertions. MH also strengthened providers' skills in BTL-MLLA. Doctors admitted that before the training, they did not provide in-depth FP counseling, but after the training, counseling was part of their services. Frontline nurses and midwives also treated counseling as an important component in the continuum of care. The FP information provided to clients before meeting with doctors helped clients have a better understanding their options, resulting in more FP method acceptors.

Figure 21. Southern Philippines Medical Center accomplished family planning counseling 2013–June 2017



	2013	2014	2015	2016	2017
Group education	2,215	1,865			
Individual counseling			1,098	1,847	943

Commodities

SPMC experienced several months of FP stock-outs in 2016. The facility did not have a logistic management system for FP commodities and procured all of its commodities from the DOH-RO Davao.

When SPMC reported an IUD stock-out during the first quarter of 2016, MH assisted in retrieval and transfer of IUDs to SPMC from facilities that had overstock or did not provide the FP method.

Outreach FP Services

To further increase the number of clients in underserved areas to long-acting reversible and permanent FP methods—in agreement with the provisions of DOH Administrative Order (AO) No. 2014-0042—SPMC established an FP outreach team, also known as an FP itinerant health team, in coordination with the DOH-RO Davao, LGU, and Commission on Population. During the team's initial activities, MH provided logistical support, such as transportation and meals.

Upon the LGU's request, the department head deployed two to three ob-gyns, two nurses, two midwives, and one anesthesiologist to provide facility-based BTLs for an entire day four times a year. SPMC was in charge of logistic management. The hospital does not pay participating staff any additional money to avoid violation of the hospital's policy on double compensation. LGUs informed clients of service schedules well in advance, and at times, a government-owned truck transported the FP clients to the facility. The clients were all Philippine Health Insurance Corporation (PhilHealth) members.

While SPMC did not provide side effect management services, specifically reactions to oral contraceptives, its operational guide included protocols for interval or postpartum IUDs and BTLs. PhilHealth or DOH funds paid for side effect management.

FP Services: Recording and Reporting
Hospital unit staff filled out FP forms to:

- Ensure proper recording of FP client data or information.
- Document the hospital's FP accomplishments.
- Gather data for monitoring and evaluating integrated FP services.

The ob-gyn and ward collected and reported on FP data using standard hospital forms. The OPD and ob-gyn ward maintained client logbooks. They collected and reported IUD type and timing of PPIUD insertions in the hospital management information system. OPD FP staff attending the client completed FP Form 1. The challenge was when night shift staff did not complete or filled out an incomplete FP form.

The adolescent and youth clinic also provided FP information but did not report its accomplishments. The hospital does not record or report referrals received for FP services or complications. The hospital does not yet have a two-way referral system.

Gaps and Challenges
Staffing
The FP clinic in the OPD only had one staff member and a seconded social worker from the city government. Both counseled clients, but the nurse recorded FP services, FP services cascade data, and commodity provision. The FP clinic was understaffed.

Referral System
The SPMC operational guide provides protocols on client referral, including intrareferrals, or the transfer of care for a patient from one clinician or unit to another within SPMC. As acknowledged by its medical center chief, the referral system needs strengthening to record data on the number and profile of referral cases.

SPMC can keep track of contraceptive use patterns among its clients via recordkeeping and reporting, which can help determine clients' needs and use patterns. Unfortunately, FP reports—be these monthly, quarterly, or yearly—are not timely. The delay is compounded by the fact that recording and generating statistical information is done manually.

The hospital does not record and report referrals received for FP services or FP complications because there is no referral form. Undeniably, most FP referrals are lost to follow-up. The hospital does not receive return slips for referral forms, so FP staff are unable to determine referral outcomes. The hospital receives FP referrals from lower-level facilities but had difficulty sending return slips to the referring facility. SPMC needs a functional two-way referral system, but this is difficult to accomplish if there are no additional staff to collect referral slips and report results to the FP management/technical committee and the FP core implementation team, which are in charge of FP decision-making.

A cursory look at the OPD where FP counseling takes place found:

- No auditory or visual privacy, as the FP counseling area is also the waiting area for clients
- A clean space
- Adequate light

Implementation Support
To officially institutionalize integrated FP services in tertiary public hospital operations, SPMC needed legal mandates: RA 1859, DOH AO 157, and DOH Memorandum Order 2014-0312. The political will demonstrated by the Duterte administration to decrease unmet FP need in the country to zero, as stipulated in the Philippine Health Agenda, also helped.

SPMC benefited from the technical assistance and support provided by MH on various FP trainings for hospital staff, drafting the SPMC operational guide for integrated FP services, drafting the SPMC Teen Center operational guide, and providing logistical support for outreach FP services.

Sustainability Mechanisms

PhilHealth reimbursements are part of the hospital's trust fund. All staff share reimbursements according to their "status" in the hospital, irrespective if they actually provided FP service. Half of the reimbursement goes to doctors, and the hospital distributes the remaining 50% among the rest of the staff. The facility does not use PhilHealth reimbursements to incentivize the actual FP service providers. The medical center chief plans to bring this issue up with management to work on incentive systems.

The hospital's budget is usually prepared in November of each year for implementation in the following calendar year. Its budget is integrated with the DOH-RO's, so the hospital has no control over it once approved, and it is entirely dependent on the funds downloaded by the DOH-RO. Hospital income does finance some maintenance and other operating expenses. Special hospital programs, such as FP outreach, are funded when a work plan is approved. Other sustainability initiatives already undertaken by SPMC include:

- Regularizing OPD ob-gyn clinic hours
- Establishing an FP clinic with dedicated space for information and counseling
- Organizing an FP core implementation team
- Launching the Teen Center
- Training consultants, doctors, nurses, and midwives in FP method TOTs

Sustainability parameters awaiting to be establish include:

- Establishing an FP Program Technical Management and Committee
- Hiring a full-time FP coordinator or counselor
- Developing and implementing a two-way referral system
- Formalizing SPMC's affiliation with nursing and midwifery schools
- Institutionalizing continuing capacity-building for permanent medical staff

Lessons Learned and Recommendations

- SPMC needs a computerized recording and reporting system and more human resources to meet the gaps in reporting and understaffing.
- The Executive Committee authorized more human resources.[9]
- The hospital has to set up a two-way referral system. SPMC needs to add the International Organization for Standardization logo to the referral form to track and follow up with FP clients.
- SPMC requires a mechanism for continual training and supportive supervision to replace its skilled human resources. A formal mechanism is required for timely replacement of doctors as they complete their 4-year residency and for nurses and midwives who are transferred or promoted to other cadres and facilities. Consultants can provide uninterrupted services. SPMC, being a learning hub, must put in place a strong mechanism for continuing learning and education for successor batches of providers.

[9] Interview with Dr. Vega, medical center chief

Annex 3

Teen Center, Maramag

Adolescents and youth (AYs) comprised about 25% of the population of Maramag, Bukidnon, in 2016.[10] A study conducted by a former rural health unit (RHU) doctor, Zichri K. Perocho-Pepito, called "Multistakeholders Collaborative Governance to Address Teenage Pregnancy in the Municipality of Maramag," reported a high incidence of teenage pregnancy in the municipality, at 380 cases in 2013 and 513 in 2014. Records showed incidence was highest among out-of-school youth. According to health service providers (HSPs) at the RHU and barangay health stations (BHSs), most of the pregnant teenagers stopped going to school when they got pregnant and did not return after delivery. RHUs treated AYs as regular clients, providing the same services and interventions as for adult clients. At schools, there were no sexual and reproductive health (SRH)-specific programs to orient youth.

Establishing the Teen Center (*Tambayan ng Kabataan sa Maramag*)
In September 2015, the Maramag RHU, headed by the municipal health officer, created the Maramag Teen Center, or the *Tambayan ng Kabataan sa Maramag*. The center was a youth-friendly space for youth to read, watch movies, play board games, and have friendly conversations with peers. The space was set up in collaboration and support from the Commission on Population (POPCOM), the Department of Health Regional Office of Northern Mindanao, and the private sector.

The Maramag Teen Center was located a few meters from the Maramag RHU Birthing Facility. That same year, Maramag's Sangguniang Bayan issued Resolution No. 2015-384, authorizing the local chief executive (LCE) to enter into a memorandum of agreement with POPCOM Northern Mindanao for a PHP 100,000 grant supporting the center's initial operation. POPCOM also provided a TV for showing films and an air conditioning unit to make the center more comfortable for AY clients. The Maramag local government unit (LGU) included the center in its annual implementation plan to ensure that the center had a dedicated budget, instead of using the LGU's gender and development budget.

Barangay Teen Centers Setup
Toward the end of 2016, the Maramag RHU expanded its teen program by setting up community-based teen centers in four out of 20 barangays: Base Camp, Kuya, San Miguel, and Panadtalan. The centers scheduled prenatal care and counseling services for pregnant teens as priority clients on Thursdays, along with the usual AY services that teens in these villages can access on a daily basis, supported by a local ordinance. Adolescent job aid (AJA)-trained HSPs managed the barangay teen centers and performed psychosocial risk assessments and counseling for teen clients, including home visits. The RHU and main *Tambayan ng Kabataan sa Maramag* provided barangay teen centers with logbooks and psychosocial risk assessment forms. MindanaoHealth (MH) provided technical guidance on recording and reporting to capture AY profiles, cases, and services.

The Maramag AY population knows that the *Tambayan ng Kabataan sa Maramag* is always open for them, whether they want to spend leisure time there or seek counseling from its manager. The manager counsels clients using the home, education, employment, activities, drugs, sexuality, and safety (HEEADSS) form. If the HSP discovers SRH-related risks, he/she refers the client to the municipal health officer. They use the RHU referral process. MH worked with the Maramag LGU and municipal health officer to promote and implement AY-friendly programs and initiatives. The project specifically focused on providing technical assistance for capacity-building.

[10] 25,185 of 101,827 total population, per 2016 municipal data

The RHU adopted a system of mainstreaming AY-friendly health services into its routine services. In accordance with an office memorandum, an internal policy issued by the municipal health office (MHO) on July 6, 2015, encouraged all patients ages 15–29 coming from its outpatient department, birthing home/facility, and family planning (FP) room to undergo private counseling with an AJA-trained HSP, who would conduct a psychosocial risk assessment using the tool developed by the Department of Health (DOH) and MH. AY clients went to the municipal health officer's clinic for counseling. The RHU could now identify AYs engaging in risky behaviors for appropriate management and/or referral, even if these clients did not go to the facility for that service. The center could refer some clients for higher-level health interventions.

Local Policy Supporting AY Programs in Maramag

The Municipal Ordinance 2015-108, an ordinance establishing the AY desk in the MHO and in all secondary and tertiary educational institutions within the municipality of Maramag, Bukidnon, strengthened AY programs in Maramag, requiring RHU and Teen Center HSPs to visit schools in Maramag to conduct sessions on reproductive health (RH), psychosocial risk assessment, and counseling.

AJA-trained health staff, including counselors in the RHU, coordinate with MH AJA-trained guidance counselors in secondary schools in the municipality to raise awareness on substance abuse, suicide, and RH through organized symposia, film showings, and interactive lectures.

Referrals for Services

An RHU HSP profiles AY clients and refers them to the municipal health officer or any available AJA-trained HSP for psychosocial risk assessment using the HEEADSS form. If there are no identified risks, HSPs provide appropriate health services immediately or refer clients to where they intend to go for other medical purposes.

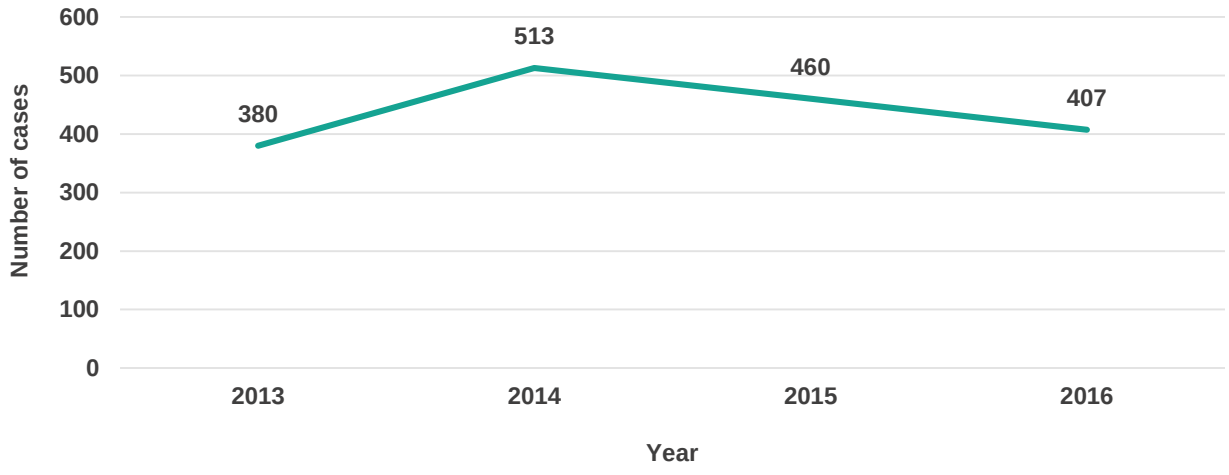
AJA-trained HSPs assigned to barangay teen centers accommodate AY clients going to the barangay health facility and conduct psychosocial risk assessments using the HEEADSS form. They use the RHU referral process. BHS HSPs refer or accompany clients, who primarily are pregnant women visiting the facility for prenatal consultations.

Results

Decrease in Teenage Pregnancy Cases

As of December 2016, the RHU recorded a 1% decrease in teenage pregnancy cases (i.e., from 19% in September 2015 to 18%). Since 2013, Maramag has shown a decreasing trend in teenage pregnancy cases, as shown in Figure 22 below.

Figure 22. Teenage pregnancy cases as reported by Maramag rural health unit, 2013–2016



The RHU attributed this positive result to its intensified efforts to promote AYRH awareness among the AY population and make AY-friendly services available.

Better Tracking and Recording of AY Clients

RHU HSPs ensured that AY clients using AYRH/FP services are recorded for tracking. From September 2015 to March 2017, HSPs provided 315 AY clients with FP information and counseling; 275 accessed FP services and methods, mostly pills, injectables, and intrauterine devices, with proper consent from their parents/guardians. Table 24 shows the AYRH services provided by Maramag RHU and satellite teen centers from 2015 to April 2017.

Table 23. Adolescent and youth reproductive health (AYRH) services provided by the Maramag rural health unit and satellite teen centers, 2015–April 2017

AYRH Services	Number of Clients
As of December 2016	
HEEADSS* risk assessment interviews	1,782
Antenatal care	973
Facility-based delivery	867
Postnatal care	867
As of 2017 (partial)	
Counseling services in school	719
Family planning services and products	590
Family planning information and counseling	315
Oral contraceptive pill	98
Postpartum intrauterine device	48
Interval intrauterine device	42
Subdermal implant	2
Depot medroxyprogesterone acetate injections	12
Lactational amenorrhea method	73

*HEADSS = home, education, employment, activities, drugs, sexuality, and safety

Maramag Experience

Center Access

Access to the center, particularly for those residing at the outskirts of the municipality, is a challenge. As a remedial measure, and with the support from the municipal health officer and municipal mayor, the center manager held outreach classes for in-school and out-of-school youth in unreached areas. Teen Center satellite hubs were established in four barangays with AJA-trained HSPs providing youth services for clients from nearby communities as a more permanent solution.

Simplified Tracking System
The Teen Center manager and staff said that the length of the HEEADSS form made it too taxing for a client to accomplish or an AJA-trained provider to administer. They revised the form and eliminated repetitive questions.

Cost
The initial PHP 100,000 grant from the regional POPCOM office used for the purchase of furniture and fixtures, and its donation of a TV and an air conditioning unit, helped the RHU make the Teen Center operational. The Maramag local government donated board games, musical instruments, and books. Some municipality residents also donated books. The staff own the computer and printer currently being used in the center.

LGU Support
The municipal LGU's support, especially the LCE, was a good start for the intervention. The LGU council understood the need for an AYRH program. It formulated and implemented local policies, and created a program budget.

Competent and Committed HSPs
Committed and competent HSPs who managed the Teen Center, along with a pool of equally trained staff capable of providing FP and other medical services, were key to successful program implementation.

The Teen Center manager, who provided AY-friendly counseling and other services to clients in a private room to ensure confidentiality, said she finds fulfillment in the work she does. She said: "I also have young kids who will be adolescents soon. I am learning a lot on the proper way of dealing with them and with possible challenges and risks they will encounter growing up."

Collaboration and Partnership
Networking and collaborating with other relevant government agencies, such as the Department of Social Welfare and Development (DSWD), Department of Education, and the women and children protection unit, and other support groups, including the private sector, strengthens AYRH program foundation. Available resources could be shared, and required (higher-level) services could be delivered through referrals.

Information, Education, and Communication Materials
Relevant promotional and information, education, and communication materials are important for encouraging potential AY clients to use AYRH services at the RHU and Teen Center.

Commitment and Policy Support
The Maramag RHU had the drive and determination from the start to promote its AY program. The LGU's commitment and policy support reinforced the RHU management's and center staff's determination to implement its AY-focused program and run the center's day-to-day operations. The capable and responsible staff ensured that the project would continue, especially now that the services are offered at the barangay level. The Maramag RHU and Teen Center were successful in establishing partnerships that provided support and resources for project start-up. The municipality assured funding by including Teen Center activities and other AY-related initiatives in its annual implementation plan.

The Maramag experience provides for some lessons and best practices:

- LGUs or facilities intending to replicate the project should first assess teenage pregnancy trends and other AY-related challenges. A facility should complete an evaluation of existing interventions to help establish a better or improved AY program, or strengthen and reinforce a version of existing strategies. Dr. Perocho-Pepito's baseline study worked well for the Maramag RHU.

- Demographic data and periodic surveys that guide AYRH program help gain LGU support and more relevant interventions for AYs are essential. Evidence-based advocacy can help the LGU understand and appreciate the situation on the ground and the urgency of the intervention to ensure LGU/LCE support for any AYRH program. Dr. Perocho-Pepito's study provided the necessary impetus for the LGU/LCE in Maramag.

- HSPs trained on AY-friendly services encourage AY clients to seek needed services. Through daily encounters with AY clients, HSPs and the Teen Center manager recognized that while mature, AYs are exposed to sources of information that could be inaccurate or easily misinterpreted, so it is important to find ways to talk to them one on one, encouraging them to seek counsel or consult with the RHU or center to get the right information from trained providers and correct sources.

- Partnering with schools and CSOs helps expand networks and effectively and efficiently reach a wider range of key populations, using coordinated and coherent messaging on SRH. The Maramag RHU's partnership with 13 schools and the Municipal Antidrug Abuse Council helped the RHU reach out-of-school youth with information on the responsible practice of sexuality, teenage pregnancy, sexually transmitted infection and HIV/AIDS prevention, delaying repeat pregnancies, and maternal, newborn, and child health and nutrition (MNCHN)/FP.

- Schools contribute to AYs' well-being. If schools do not offer AYRH-related services, they should tell students that there are other facilities where they can access needed support or counseling, like the Teen Center. Schools could also connect with POPCOM's You for You Teen Trail Initiative,[11] which could be organized alongside the Maramag RHU and Teen Center trained staff's regular school visits.

- Harnessing the capacities of the community-based teen centers to provide risk assessment, information, guidance, counseling, and links to a health facility (Maramag RHU) to expand the access of AYRH and MNCHN/FP services is essential. Physically, the Maramag RHU and Teen Center are in separate locations, and AY clients can be counseled at either location. Staff from both facilities work together to be sure all clients receive the care they need. For instance, when there are not enough HSPs at the RHU to cater to teen clients, some clients are referred to the Teen Center. Teens at the center needing higher-level health services/care are immediately referred to the RHU through the municipal health officer.

- Dedicated, trained staff assigned to the RHU and satellite *Tambayan ng Kabataan sa Maramag*, and effective management structures (municipal health officer, LCEs, and stakeholder groups) ensure the sustainability of AY program implementation. In visits to schools and barangays, Teen Center nonmedical staff can work closely with a nurse or midwife when any medical information or interventions are required.

- Local policies supportive of AY programs encourage the health sector and other stakeholder institutions to work together to provide AYs with access to a continuum of guidance, counseling, and services.

- The Maramag RHU needs to expand its AYRH program to include initiatives that promote adequate antenatal care and immunization among teenage parents. The RHU should continue to engage and collaborate with the municipal health officer-led Municipal Antidrug Abuse Council and with in-school and out-of-school groups to disseminate information on MNCHN/FP and AYRH.

- More significantly, the Maramag RHU should look into organizing other psychosocial activities that would help AYs become more productive members of society, including teaching AYs life skills through vocational and short-term courses that may benefit them, with the help of the DSWD, Department of Labor and Employment, and other agencies.

[11]Per POPCOM, "U4U is a communication campaign to prevent early sex among teens … aged 10–19. It aims to increase the knowledge of Filipino youth on delaying sexual debut, preventing teen pregnancy and avoiding sexually transmitted infections. Members of identified youth and student groups are the ones managing the event. They are oriented and trained on how to manage different parts of the youth caravan."

Annex 4

Case study: door-to-door service delivery for women and men with unmet family planning needs, Agusan del Sur Caraga

Agusan del Sur is among the provinces with the highest number of teenage pregnancies and a high unmet need for family planning (FP), underscoring the need for healthy timing and spacing of pregnancies. The provincial health office of Agusan del Sur led the launch of *Toktok Planado Pamilya* (*TPP*) to warrant those with unmet FP need were provided with the FP method of their choice.

What is *TPP*?
This initiative requires a team of health workers—nurses, midwives, community health volunteers—to visit each household within their area and identify women, men, and couples with unmet FP need. The team takes services and support to the woman's doorstep and helps her make informed, voluntary FP choices.

Communicating FP messages using simple and straightforward job aids clarifies misconceptions, debunks myths about FP methods, and facilitates the behavioral shift of women and couples using FP services. Skilled and competent health workers' face-to-face counseling addresses women's and men's concerns and fears.

TPP workers maintain a database and information system that profiles and tracks women in the community and identifies those with unmet need.

Capacity-building for health service providers (HSPs): MindanaoHealth (MH) trained 214 HSPs in FP competency-based training level 1 (FPCBT1), which involves FP counseling and dispensing of pills, condoms, injectables, and natural FP methods. The project also trained 102 HSPs in FPCBT2, which involves interval intrauterine device (IUD) insertion, and 32 HSPs on postpartum IUD (PPIUD).

Rural health units (RHUs) hold weekly Usapans for mothers with 10–15 participants. Usapan topics generally fall into the following categories:

- Usapang Buntis: This includes topics for pregnant women, such as how to prepare for childbirth, what to expect, danger signs during pregnancy, importance of delivering at a facility under skilled care, and postpartum FP.
- Usapang Puwede Pa: This is for women who already have children and opt to exercise spacing of the future children they plan to have.
- Usapang Kuntento Na: This is for women of reproductive age (WRA) who want to limit the number of children they have.

House visits: Community health workers (CHWs) conducted household visits as part of a survey, which profiled households and the people in them. They conducted this survey on a regular basis to generate a master list of the residents and households in the municipalities, which is constantly updated and maintained through the Caraga health information system (HIS). Specifically, it identified men and WRA and tracked unmet FP need in the province.

Use of job aids: *TPP* team members testified that the job aids provided by MH helped significantly. Flip charts gave them more confidence and a sense of authority when explaining FP and the different methods during household visits. Job aids facilitated women's and couples' understanding and helped correct their misconceptions about each method.

The job aids distributed in Agusan del Sur included 312 FP wall charts, 85 community health team toolkits, 7,000 FP fans for 315 barangays, 170 medical eligibility criteria wheels, 300 FP placemats, and five FP flip charts. The 2,695 barangay health workers (BHWs) in Agusan del Sur received at least one of these job aids, especially the community health team toolkit; 87 CHWs effectively communicated FP messages to women, men, and couples using the toolkit.

Information, Education, and Communication Campaign and Counseling

The *TPP* team engaged households in a discussion on FP and educated them on the benefits of healthy timing and spacing of pregnancies, aided by tools produced with US Agency for International Development support and equipped with communication strategies developed from training. Women or couples undecided about FP were encouraged to visit a health center for more in-depth, one-on-one counseling. Once they voluntarily decided to receive a particular FP method, the health center provided them with the FP method of their choice. Those who opted for long-acting reversible contraceptives/permanent methods, which are not available at health centers, were referred to health facilities and hospitals that provide them.

Updating the Caraga HIS

The focal person at the Department of Health Regional Office (DOH-RO) regularly updates the Caraga HIS to keep track of those who have yet to be served with modern FP methods or who have stopped using contraceptives. Information comes from data generated from household visits. These data are used to meet and service unmet FP need.

Results

Increase in Contraceptive Prevalence Rate

The contraceptive prevalence rate (CPR) in Agusan del Sur increased due to TPP. In the first quarter of 2017, the provincial CPR rose to 68%, up from 64.4% in the same period in 2016, an increase of 3.64%. During the same period in 2018, Agusan del Sur's CPR was already at 78%. This is significantly higher than the national CPR target of 65% (Department of Health FP Annual Report for 2016, 2017, and 2018).

Increase in New FP Acceptors

The TPP initiative contributed to increase in the number of new acceptors in the province. In the first quarter of 2016, there were 2,683 new acceptors in Agusan del Sur. In the same period in 2017, new acceptors increased to 3,182, or 499 more than the previous year, and in the first quarter of 2018, the number of new acceptors was already 4,079 (Department of Health FP Annual Report for 2016, 2017, and 2018).

In the first quarter of 2017, there were 65,785 current FP users in Agusan del Sur (Department of Health FP 2017 Annual Report). CHWs, nurses, and midwives served these users through initiatives that included TPP.

Health Workers

Health workers mentioned that they saw a vast improvement in their confidence to inform, motivate, and counsel families and individuals on FP. They attributed this to the increased knowledge and skills they acquired from trainings, seminars, discussions, and their experiences implementing health programs and interacting with their communities.

In particular, health workers improved their communication skills through regular discussions and conversations about FP. They were also better able to understand the issues and concerns of people in their communities, especially the women, through Usapan sessions, mothers' classes, and other similar focus group discussions.

Interagency Collaboration and Barangay-Level Cooperation
Collaboration among different agencies, such as the Department of Health (DOH), Department of Social Welfare and Development (DSWD), Commission on Population (POPCOM), and local government units (LGUs), is key for an effective TPP. Identifying those with unmet need utilized the DSWD's Pantawid Pamilyang Pilipino Program beneficiaries, the DOH's National Household Targeting System members, and Caraga's data system lists.

TPP conducted outreach in far-flung areas populated by indigenous groups. Due to the distance and difficulty in reaching these areas, FP interventions were incorporated into the "government on wheels" strategy adopted by various agencies and local governments. Personnel from various government agencies visit these areas to provide information and services. Health workers join these visits to provide FP outreach services.

Gaps and Challenges
Misconceptions of Modern FP
CHWs encountered ill-informed claims about side effects and other health risks caused by modern FP methods. Some people rejected modern contraception in favor of unscientific methods, which they claimed work for them. Others preferred using herbal concoctions instead of modern methods. Health workers' information dissemination and FP counseling sessions during house visits successfully debunked misconceptions and myths. Their effective communication skills and use of job aids clarified the safety of various FP methods for many households. These families were able to voluntarily choose a method appropriate for their health, lifestyle, and personal circumstances.

CHWs were able to address men's unfounded belief that tubal ligation triggers spouses' promiscuous behavior. This belief stems from some men's misconception that when women no longer have to worry about getting pregnant, they will become more sexually active and engage in extramarital sexual relations. To allay this concern, health workers educated men on FP methods, focusing on their efficiency and effectiveness, and the health and well-being of women and families.

Sociocultural Barriers
CHW saw patriarchal influence, a major sociocultural barrier, when men inhibited women from choosing any FP method because they believed having more children prevented them from poverty. In such cases, it is usually the man's decision that prevails, as the law requires spousal consent for a woman to undergo a tubal ligation operation.

Although not a primary determinant, religion is a strong deterrent to modern FP methods. There were several instances when health workers had to address religious and even biblical questions about modern FP methods. Health workers emphasized the health and general well-being of all family members as the main rationale for FP.

Tracking Clients' FP Use and Updating Database
During household visits, the *TPP* team identified or validated information on women with unmet need and served the unmet need should clients voluntarily opt for FP methods the team had on hand, particularly pills, condoms, and IUDs.

Tracking method continuation or method switch was challenging. The *TPP* team recorded house visits, client appointments at health centers, and the information gathered from clients systematically, with regular updates in the Caraga HIS. However, slow Internet connection or inability of even one CHW to update the data made for incomplete data

Unavailability of Women during TPP Visits
Persistence and patience on the part of the CHWs proved to be crucial for TPP to achieve its aim of zero unmet FP need, including unavailability of the woman or profiled women with unmet need moving to another area. Following up with clients and referring them to available and accessible services was part of CHWs' initiatives.

Teenage Pregnancy and Sexually Active Youth
Agusan del Sur is one of the provinces with the most teenage pregnancies. TPP can help reach these teenage mothers and serve their unmet need. CHWs observed that young mothers were among those who wanted information about FP, were open and willing to engage in counseling sessions, and wanted to use FP methods.

However, TPP and other strategies need to address society's stigma and disapproval. It is a challenge to reach sexually active adolescents and youth (AYs) who seek counsel from CHWs on information about safer sex and access to FP methods. Health workers need to maintain a caring atmosphere when engaging with youth to gain their confidence. They must also exercise confidentiality to protect and shield youth from peer and community disapproval.

Sex education for youth is crucial to a long-term and responsive solution to teenage pregnancies. Youth need scientific understanding of biological reproduction, healthy sexuality, and FP methods.

Reaching Indigenous Peoples and Marginalized Communities
Reaching far-flung areas, usually inhabited by indigenous groups and marginalized poor, poses a challenge in meeting unmet FP need. Due to the distance and rough terrain, outreach programs often become one-stop shops, such as the "government on wheels" strategy. FP is one of many issues discussed and services made available when the LGU undertakes outreach activities.

Just like with other potential clients, CHWs also have to deal with misconceptions about FP methods among the indigenous population, or lumads. However, lumads use FP methods that serve their unmet need once CHWs allay their concerns.

Systematic Documentation of Referrals
Despite the noted increase in FP acceptors, systematic documentation is lacking for FP service referrals. RHU and barangay health station logbooks only noted the names of those who ask about FP methods and which they voluntarily choose; they did not include written remarks about where they were referred, even when a referral was made. They also did not issue referral slips to clients referred to other facilities for FP services. Further, they did not consolidate, summarize, or store referrals in a database that could be easily accessed for research or information purposes. Referral data are mostly in raw form, such as referral forms or logbook entries. Midwives, nurses, and FP coordinators attested that they saw an uptick in women inquiring about and accessing FP methods. Nonetheless, a reliable documentation system is needed due to the importance of evidence-based reporting.

Support for Implementation
Executive Order No. 12 and the Responsible Parenthood and Reproductive Health Act, which mandate and direct concerned government agencies and LGUs to undertake measures and activities that promote and provide FP services and methods to attain zero unmet FP need, primarily support *TPP*.

LGUs and agencies, particularly the DOH, DSWD, and POPCOM, collaborate to reach targets and implement, monitor, and evaluate programs that aim to achieve these targets.

Civil society organizations and local groups that support the project provide resources and mobilize personnel to carry out *TPP* activities.

Human resource development that equips frontline personnel, including CHWs, nurses, and midwives, with competent knowledge and effective skills on FP methods is also needed. Training, seminars, and discussions are vital to increase the confidence of CHWs and enable them to effectively inform, motivate, and counsel current and potential clients. During *TPP* implementation in May 2017, MH conducted an orientation for selected midwives in 27 municipalities on how to address FP questions and misconceptions.

CHWs also need job aids and informative tools to assist them in their duties.

CHWs advocate and disseminate information, which helps build on the momentum and gains achieved by previous efforts and to facilitate changes in community culture and individual behavior to attain unmet FP need.

MH contributed to the implementation and overall success of *TPP* by supporting capacity-building activities in partnership with the DOH-RO Caraga, which prepared the nurses and midwives to dispense FP methods and equipped them with counseling skills to shift clients' behavior.

In the last quarter of 2016, MH trained CHWs specifically for providing FP information. MH also supported trainings for nurses on FPCBT1 in 2015 and intensified them in 2016. Midwives, on the other hand, were trained on FPCBT2 in June 2016. In addition, health workers received training and supportive supervision on PPIUD in the second quarter of 2016 with supportive supervision.

Sharing its resources to improve the capacity of its health workers, the Municipality of Bayugan funded and conducted a training for municipal staff on FPCBT1 in October 2016 and a training on FPCBT2 in November 2016. MH developed and distributed job aids and information, education, and communication (IEC) materials, which helped CHWs counsel and motivate clients, and increase women's, men's, and couples' understanding of issues pertaining to FP. Distribution, which intensified in the latter half of 2016, was timely and in accordance with activities of the *TPP* initiative.

MH, in partnership with Marie Stopes International, also organized nine outreach services in nine municipalities' RHUs in the first three quarters of 2016. It provided subdermal implants to RHUs for women who expressed interest in them after CHWs conducted household visits and encouraged them to visit RHUs to receive the implants.

Prerequisites for Replication
For *TPP* to be successful in other municipalities, the following steps need to be taken:

- **Databank and information management system:** A database and information management system must be set up and made operational. This system must store updated information on unmet FP need and profile and keep track of people in communities. It must have standard procedures for data encoders and designated personnel to manage it.

- ***TPP* team:** A core group, comprising a BHW, Nurse Deployment Program nurse, and midwife, assigned to specific areas must be assembled to conduct house visits that profile and identify women with unmet need and to readily serve these women with immediately available FP methods of their choice. This group must have effective communication and counseling skills and basic FP competency and knowledge.

- **Competent and trained personnel at RHUs:** RHUs must have staff who are trained and competent in counseling on and dispensing FP methods. Staff must also be able to refer clients to health facilities and hospitals providing permanent FP methods not available at the RHUs.

- **Institutional support from LGUs:** Concerned LGUs must allocate funds and resources to implement, monitor, and evaluate *TPP*. Concerned officials must make an institutional commitment to adopt the strategy.

Sustainability Mechanisms
The following mechanisms ensuring *TPP*'s sustainability need to be set up and maintained:

- **Caraga HIS:** The Caraga HIS must be maintained, updated, and utilized to attain the target of zero unmet FP need.
- **Trainings for *TPP* team and RHU personnel:** CHWs, nurses, midwives, and RHU personnel must be equipped with appropriate knowledge, competencies, and skills via training on FPCBT1, FPCBT2, PPIUD, etc.
- **Budgetary allocation:** LGUs must allocate funds to carry out *TPP* activities and continue providing free FP methods.
- **Usapan sessions, mothers' classes, and similar focus group discussions:** Existing processes/practices of gathering women for discussions, sharing, and information dissemination must be continued to ensure that clients' concerns and needs are addressed.

Lessons Learned and Recommendations
Household Visits
Continue with *TPP* or house visits to achieve the target of zero unmet FP need, but clients should not rely on these visits for their FP needs. Strategies, such as appointments with health workers at RHUs and participation in Usapan sessions or mothers' classes, must be continued so that clients change their behaviors and are able to be proactive in managing their health. In the long term, the goal should be for clients and those with unmet need to willfully visit health centers for their FP needs.

Caraga HIS
Strengthen and maintain the Caraga HIS and reduce errors (e.g., double entries) to make it a reliable source of data to help achieve zero unmet FP need. Make sure nurses and encoders regularly update data during their monthly visits to the provincial DOH when data could not be uploaded due to a slow Internet connection or lack of one.

Health Worker/Volunteer Training
Continue trainings to equip all health workers with knowledge, competencies, and skills in FP services and advocacy. Trainings should include FPCBT1, FPCBT2, PPIUD, communicating FP messages, and counseling. Training must also be conducted to increase the number of health workers who are skilled in and knowledgeable on FP.

Job Aids and IEC Materials
Continue producing and distributing effective job aids and IEC materials. IEC materials that could serve practical purposes (e.g., FP fans) are highly recommended.

Visiting Far-Flung Communities
Ensure *TPP* team makes house visits to far-flung areas with indigenous populations despite difficult access, as indigenous groups are among the most marginalized sectors of society living in dire conditions. Achieving indigenous women's unmet FP need would greatly contribute to improvement in their families' health condition.

Monitoring and Evaluation
Improve the Caraga HIS to include summarized and consolidated data on referrals, including FP services.

Counseling Youth and Young Mothers
Develop a program specifically focused on teenage mothers to avoid repeat pregnancies. This may include focus group discussions, awareness-raising activities, and one-on-one counseling. Conduct trainings on AY counseling and AY-friendly services, and implement sex education programs for youth.

Beliefs and Misconceptions about FP
Continue advocacy for women's reproductive rights and for FP and its methods and practices.

Annex 5

Service delivery network case study: integrating local health initiatives and programs through multistakeholder partnerships, Agusan del Sur, Caraga

After the Government of the Philippines enacted the Local Government Code of 1991, various health initiatives and systems emerged at the local level to address health needs. This led to the fragmentation of some health programs and services. Before 2014, the Department of Health (DOH) engaged with local health systems development initiatives to create interlocal health zones (ILHZs), which gave local government units (LGUs) the opportunity to coordinate their health operations and reintegrate health care delivery under a devolved system.

Using ILHZs as an entry point, the US Agency for International Development (USAID) introduced a service delivery network (SDN) in 2012 through its Private Sector Mobilization for Family Health Phase II (PRISM2) project through a public-private partnership (PPP) agreement. This agreement outlined how private-sector health providers would engage and be included in the SDN, meaning their services would be available to communities within the network. PRISM2 implemented its SDN as a cross-border and cross-sector two-way referral system.

The DOH Regional Office (DOH-RO) Caraga and Agusan del Sur's provincial health office (PHO), in partnership with MindanaoHealth (MH), developed a concept to strengthen the province's existing SDN. The existing referral system, supported by the Integrated Community Health Services Project, was further enhanced in 2014 by MH, which strengthened the establishment of the SDN based on the ILHZ concept and context.

The SDN was introduced in Agusan del Sur to restore integration among administrative levels between LGUs. The SDN helped forge closer links among health facilities, such as hospitals, which are either DOH retained or LGU owned, and rural health units (RHUs) and barangay health stations (BHSs), which are under municipal or city governments. The private sector was involved to strengthen availability and accessibility of health care services.

The SDN helped municipalities where no single facility could provide a complete package of services for women. These municipalities needed a network to facilitate service delivery and let women know which health facilities to visit for various health needs over their lifetime.

MH held meetings to make sure there was consensus among all partners on the SDN. Through the *Guide in Establishing a Functional SDN for Maternal, Neonatal, Child Health, and Nutrition/Family Planning (FP) Services*, the project laid out the steps and 10 essential elements needed to help partners establish a functional SDN at D.O. Plaza Memorial Hospital.

In partnership with the DOH-RO Caraga, the project conducted meetings with partners and sectors to generate support for and agreement on SDN operationalization. After meeting with the PHO, the technical team intensified its effort to formalize the SDN over the next few months by developing the D.O. Plaza ILHZ cluster and conducting LGU-based consultations and discussions at all levels to engage stakeholders.

The project also built the capacity of health providers in the three RHUs, plus various hospitals and private health facilities, to provide quality maternal, newborn, and child health and nutrition (MNCHN)/FP services, including the minimum core package of services, at all levels of care.

Baseline Assessment
In 2012, USAID's PRISM2 project supported a provincewide referral system backed by a PPP agreement. SDN partners, including public- and private-sector health providers, agreed that the SDN should:

- Not be restricted by the province's political boundaries.
- Involve the private sector to provide health services in public and private settings in accordance with DOH standards.
- Develop a unified reporting system for public and private facilities so providers regularly record and report health service delivery contributions.

In 2013, the agreement was signed and launched with a provincewide reach, but it was applicable only to the four LGUs that had private-sector providers. MH reviewed the existing SDN once it took over from PRISM2. The PHO technical team and provincial DOH agreed to prioritize the SDN based on the population served and geographical location of the facilities to enable access to services, identify core referral points and pathways, and address certain challenges. A minimum core package of services was required for all SDN member facilities that involved sectoral organizations, such as transportation groups and media establishments.

In 2014, MH strengthened the SDN using the previously approved PPP agreement and existing provincewide referral system.

Project Site Selection
Almost half of all 70 barangays in Rosario, San Francisco, and Prosperidad are hard to reach, isolated, and depressed. Some do not have health stations or permanent midwives assigned. Most suffer from limited transportation support and difficult road conditions. Often, unsafe conditions keep permanent health personnel from conducting regular visits to these areas to provide basic preventive health services.

D.O. Plaza is the core referral hospital for the D.O. Plaza area health zone and is the most accessible facility for residents in the three municipalities within the SDN. It has a 100-bed capacity and is a Level 2 public hospital. It serves as the end referral hospital for the province and neighboring municipalities along the borders of Surigao del Sur. The hospital refers clients who need higher-level management to Davao Regional Medical Center in Tagum City and Southern Philippines Medical Center in Davao City.

D.O. Plaza can be reached via the Davao-Butuan National Highway. Three minor roads also provide access for clients coming from Surigao del Sur. Although the Agusan River is a potential way for clients to reach the hospital, no ferry facilities regularly serve the route to and from Butuan City or Davao Norte.

Resource Inventory Completed
In 2013, the D.O. Plaza AHZ had six public birthing homes, three of which operated as RHUs at the same time. All had basic emergency and obstetric newborn care (BEmONC)-capable facilities. These facilities were in turn supported by 33 BHSs, which provide immediate primary health care services to the community. Overall, fewer than 50% of all barangays had BHSs; San Francisco had the lowest percentage of barangays with a BHS (30%). The DOH standard requires that every barangay has a BHS and a rural health midwife.

The AHZ has one Level 2 private hospital, one Level 2 public hospital, and two private clinics. RHUs and birthing homes in Prosperidad and Rosario are Philippine Health Insurance Corporation (PhilHealth) Maternity Care Package (MCP) accredited. The RHU in San Francisco was not MCP accredited in 2013 because its birthing facilities did not pass the required standard, but two private clinics and one BHS in San Francisco were MCP accredited.

Policy Mandate
Health facilities had already formed a loose network of providers with the potential to deliver the complete MNCHN/FP core package of services in a coordinated way. It only needed to be formally organized, and health service providers (HSPs) in the private sector needed to join, per a PPP agreement to conduct joint planning and implementation for MNCHN services delivery.

MH, with the DOH-RO Caraga and in partnership with the Agusan del Sur PHO, conducted meetings and workshops with the private and public sectors and other local stakeholders to kick off the SDN launch.

In January 2016, an SDN planning workshop facilitated the identification and mapping of health facilities, services, health providers' capabilities, service gaps, issues, and existing referral pathways. After reviewing the mapping, the network agreed to revitalize D.O. Plaza AHZ health services and identified that specifically, core package, referral care, and support services should be provided to clients and integrated into all three levels of care.

In February 2016, the project held a meeting with stakeholders to follow up on and update the status of the D.O. Plaza AHZ SDN, particularly its establishment and functionality. Participants determined the pilot location for SDN establishment in each area.

In June 2016, the project held another meeting to enhance the D.O. Plaza AHZ SDN referral system. Participants reviewed the SDN agreements and plan of action, assessed the existing referral system, and identified standard operating procedures for MNCHN/FP referral services. They also developed adolescent and youth (AY) referral protocols along the continuum of care and generated suggestions for enhancing the existing referral system.

In October 2016, the project held meetings to review SDN agreements per municipality. It also provided a brief reorientation on SDN, particularly for local chief executives (LCEs) and nonhealth participants. Participants completed SDN mapping, discussed the status of SDN services at the barangay level, and assessed the existing referral system, including its successes and challenges. They discussed the status of integrated MNCHN/FP services delivery as a continuum and agreed on and crafted plans of actions to address the challenges, gaps, and issues.

In May 2017, LGUs led orientations with targeted partners, such as public and private hospitals, private birthing clinics, private transportation groups, media establishments, municipal tribal councils, women's groups, the Federation of Barangay Health Workers (BHWs), and youth. Afterward, stakeholders in the municipalities drafted and signed partnership agreements. The municipalities' LCEs issued executive orders (EOs) to create a functional SDN and management team.

In July 2017, the project held a planning workshop with SDN partners to review the existing referral system and formulate improvements, including having sectoral organizations and other community stakeholders participate. Partners also updated the referral flow based on the referral guide and identified the minimum package of services per health facility in the four ILHZs.

Key Steps in Setting Up the SDN
Local health board: The local health boards in the three LGUs under the D.O. Plaza ILHZ were functional and met regularly. Mayors chaired the meetings, and municipal health officers served as co-chairs. The municipal health officers brought up issues and concerns on SDN in the meetings.

TWG: TWG meetings resulted in the proposal of the ILHZ-SDN Board, a separate body that would oversee SDN functionality and be the unifying and coordinating authority. Board members were representatives from provincial and municipal LGUs, the DOH, PhilHealth, the PHO, nongovernmental organizations, D.O. Plaza, the Sangguniang Panlalawigan and Sangguniang Bayan chairs on health, the Association of Barangay Captains' President, chiefs of hospitals, and municipal health officers.

Service population identification: The D.O. Plaza AHZ's population was 203,856 in 2015. On average, 31% of the population in each of the three municipalities was classified as poor—the National Household Targeting System for Poverty Reduction classified 20,466 households as poor, and the Department of Social Welfare and Development's conditional cash transfer program included 12,745 households. The D.O. Plaza AHZ had 684 trained and deployed BHWs.

Mapping available providers: The project identified public and private health facilities and providers within the D.O. Plaza AHZ SDN through an SDN mapping activity.

Identifying issues and challenges: Workshops and meetings enabled stakeholders and SDN partners to identify the issues and challenges concerning health services. In determining these gaps and challenges, stakeholders also identified the causes and agreed on specific MNCHN/FP-related priority interventions in governance, access to FP supplies and commodities, policy support and development, and service delivery.

Monitoring utilization and provision of health services: In the absence of a legitimate SDN TWG at this point, the PHO technical team monitored the services conducted, DQCs, and validation of the reports submitted to the PHO per LGU at the RHU level. Public health nurses conducted monthly data checks of the service coverage, and PHO coordinators and the DOH performed quarterly validation. The provincial level institutionalized and supported this initiative.

10-element orientation: The project oriented and trained health workers and staff from each LGU on the 10 elements of a functional SDN. They then periodically evaluated their municipalities and the SDN in general to monitor their compliance with these elements.

Results
Over the last 5 years of SDN operation in Agusan del Sur (2014–2018), the province now has:

- An end referral tertiary facility, D.O. Plaza Memorial Hospital, located within the SDN with personnel trained to provide modern FP services
- One hundred twenty-seven HSPs trained on capabilities such as postpartum intrauterine devices (PPIUDs), FP competency-based training level 1 and level 2 (FPCBT1 and FPCBT2); 47 HSPs trained using supportive supervision
- Teen centers with adolescent job aid-trained personnel at two out of three RHUs, which are fully compliant with AY-friendly facility requirements
- A DOH online system for access to safe blood, called the Blood Referral System

Select Indicators
Maternal mortality incidence remained constant, except in 2015, when there was one less death. There were four maternal deaths in 2013 and 2016. All four deaths reported in 2016 occurred in Prosperidad.

The number of infant deaths was worrying in 2014, as it significantly increased to 69 in 2014 from 36 in 2013. Of the 69 infant deaths reported, 24 were in Prosperidad, 33 were in San Francisco, and 12 were in Rosario. However, in 2015 and 2016, the number of infant deaths drastically decreased. In 2015 and 2016, there were 18 and 17 infant deaths reported, respectively. See Table 27 for more information.

Table 24. Maternal and infant deaths in the D.O. Plaza Area Health Zone, ADS (2013–2016)

Indicators	2013	2014	2015	2016
Maternal Deaths	4	4	3	4
Infant Deaths	36	69	18	17

Table 25. Maternal deaths per municipality in the D.O. Plaza Area Health Zone, ADS (2013–2016)

	2013	2014	2015	2016
Rosario	0	0	1	0
San Francisco	2	3	0	0
Prosperidad	2	1	2	4
Total Service Delivery Network	**4**	**4**	**3**	**4**

Table 26. Infant deaths per municipality in the D.O. Plaza Area Health Zone, ADS (2013–2016)

	2013	2014	2015	2016
Rosario	10	12	2	2
San Francisco	12	33	0	7
Prosperidad	14	24	16	8
Total Service Delivery Network	**36**	**69**	**18**	**17**

The D.O. Plaza AHZ improved in 2016 compared to 2013 in contraceptive prevalence rate (78%, from 61%), skilled birth attendance (91%, from 80%), and facility-based deliveries (FBDs; 90%, from 82%). All of these are on or above target.

However, for the same period, the percentages decreased for antenatal care visits (78%, from 84%), postpartum care visits (77%, from 90%), exclusive breastfeeding (78%, from 90%), and fully immunized children (84%, from 100%). Data quality checks, which generated reliable and validated data for more informed programming and decision-making by local health managers, were conducted in 2014 and 2016.

Table 27. Key indicators in the D.O. Plaza Area Health Zone, ADS (2013–2016)

Indicators	Project Target	2013	2014	2015	2016	Comparison between 2013 and 2016
Contraceptive prevalence rate	65%	61%	60%	73%	78%	
Antenatal care visits (4)	90	84%	69%	73%	78%	
Skilled birth attendance	90	80%	93%	91%	91%	
Facility-based delivery	90	82%	87%	91%	90%	
Postpartum care visits (2)	90	90%	83%	82%	77%	
Exclusive breastfeeding	90	90%	83%	81%	78%	
Fully immunized children	95	100%	103%	94%	84%	

Table 28. Contraceptive prevalence rate per municipality in the D.O. Plaza Area Health Zone (2013–2016)

Municipality	2013	2014	2015	2016
Rosario	61%	70%	76%	66%
San Francisco	43%	51%	80%	89%
Prosperidad	78%	63%	63%	75%

Project target was 65%.

Table 29. Antenatal care visits (four) per municipality in the D.O. Plaza Area Health Zone (2013–2016)

Municipality	2013	2014	2015	2016
Rosario	112%	67%	83%	75%
San Francisco	84%	86%	66%	69%
Prosperidad	70%	63%	72%	77%

Project target was 90%.

Table 30. Skilled birth attendance per municipality in the D.O. Plaza Area Health Zone (2013–2016)

Municipality	2013	2014	2015	2016
Rosario	76%	91%	82%	86%
San Francisco	87%	97%	96%	96%
Prosperidad	74%	94%	92%	93%

Project target was 90%.

Table 31. Facility-based delivery per municipality in the D.O. Plaza Area Health Zone (2013–2016)

Municipality	2013	2014	2015	2016
Rosario	71%	79%	82%	85%
San Francisco	87%	91%	96%	91%
Prosperidad	75%	88%	92%	95%

Project target was 90%.

Table 32. Postpartum care visits (two) per municipality in the D.O. Plaza Area Health Zone (2013–2016)

Municipality	2013	2014	2015	2016
Rosario	89%	87%	82%	74%
San Francisco	84%	74%	76%	72%
Prosperidad	96%	91%	87%	83%

Project target was 90%.

Table 33. Exclusive breastfeeding per municipality in the D.O. Plaza Area Health Zone (2013–2016)

Municipality	2013	2014	2015	2016
Rosario	88%	86%	82%	70%
San Francisco	113%	74%	75%	73%
Prosperidad	96%	91%	86%	85%

Project target was 90%.

Table 34. Fully immunized children per municipality in the D.O. Plaza Area Health Zone (2013–2016)

Municipality	2013	2014	2015	2016
Rosario	109%	103%	101%	93%
San Francisco	111%	97%	87%	64%
Prosperidad	83%	108%	98%	100%

Project target was 95%.

Functional SDN

As of July 2017, the D.O. Plaza AHZ was already functional, having achieved green marks in seven of the 10 elements of a functional SDN (a green mark indicates that the targets according to the identified indicators are met). Largely, the D.O. Plaza AHZ SDN needs to improve in functional, community-based transport and communication systems, referral system initiated/established for each SDN, and organized MNCHN/FP SDN management structure and guidelines.

Rosario achieved green marks in six of 10 elements. It needs to improve in functional, community-based transport and communication systems, comprehensive emergency obstetric and newborn care-capable facilities have transport and communication system, referral system initiated/established for each SDN, and organized MNCHN/FP SDN management structure and guidelines.

Prosperidad achieved green marks in seven of 10 elements. It needs to improve in functional, community-based transport and communication systems, referral system initiated/established for each SDN, and organized MNCHN/FP SDN management structure and guidelines.

San Francisco achieved green marks in eight of 10 elements. It needs to improve in referral system initiated/established for each SDN and in organized MNCHN/FP SDN management structure and guidelines.

Policy Support

As of July 2017, the LGUs of Rosario, Prosperidad, and San Francisco had each issued EOs for the Creation of an SDN Management Team for the Establishment of a Functional SDN for Modern MNCHN/FP, AY, and Other Health Programs. The EOs created the SDN management team and named the members. The EOs also identified SDN management team responsibilities, roles, and functions.

Stakeholder representatives in each of the municipalities signed partnership agreements. The agreements outlined the rationale for the partnership, defined the terms used, articulated the partnership purpose, and detailed the specific roles of each party and the mechanisms for its further institutionalization.

Gaps and Challenges

Stakeholder Commitments in the Partnership Agreement

In institutionalizing the SDN, each stakeholder and partner in the agreement must be committed and deliver on assigned responsibilities, roles, and functions. One challenge, particularly in Rosario, involved the pledge of a private-sector player to a private health facility via signed agreement. Although the representative of the private-sector organization agreed to be part of the partnership agreement during training workshops and meetings, the head of the organization hesitated to sign the agreement—he wanted further clarification on the SDN initiative before committing. The Rosario municipal health officer met with the organization head to discuss the SDN concept, processes, functions, rationale, and role expected from the partners. The municipal health officer addressed the concerns of the partner and ensured that it would fully engage in the initiative and perform its commitments.

SDN Management Structure
At the start of the SDN initiative, the project came up with an agreed-upon management structure involving the LGUs, the private sector, and other stakeholders. The partners agreed that a technical working group (TWG) must be created, but the board and TWG have not yet met since it was formed. It was only in mid-2017 that the management structure and TWG were reorganized and its members were reoriented. Per the PHO, they first decided to focus on making the SDN for the municipalities functional and forming SDN management teams. At present, since all 13 municipalities and one city in the province already initiated and/or established the SDN, a provincewide management structure and TWG could already be instituted.

Referral System
The heavy concentration of referrals to D.O. Plaza was a problem. For instance, RHUs that should have been able to provide birthing facilities were not functional, so deliveries were referred to the hospital instead. At present, this situation has improved, since the RHUs now have functional birthing facilities. In Rosario specifically, two more BHS birthing facilities are being constructed and are expected to be operational soon. Due to these factors, FBDs in the D.O. Plaza AHZ increased to 90% in 2016, from 82% in 2013.

In addition, since the SDN at the municipal level was formally re-established in mid-2017, a referral system involving all public- and private-sector partners has yet to be strengthened. SDN partners in the ILHZs in Agusan del Sur attended a planning workshop to review the existing referral guidelines. Participants were able to develop a new referral flow and identify the minimum core package of services among the various health providers in the area. However, there is a need to improve and expand the current manual on referrals, and improve the system to include all the stakeholders, such as transport groups, the media, etc. New referral forms, monitoring and evaluation, and recording and standard operating procedures must be developed and implemented.

Competency and Skills Development of HSPs
Service gaps at different levels of health care were a problem. Health workers were not trained on essential intrapartum and newborn care, BEmONC, FPCBT1, FPCBT2, and PPIUD. To address these, trainings were conducted to increase the health workers' competencies and skills. This is still a concern, as a number are still not trained. There is a need for continuous capacity-building for personnel at all levels of SDN involving various methods of and technology updates on health care services.

Skilled Birth Attendance and FBDs
Even before the D.O. Plaza AHZ existed, municipalities universally showed low or slow improvement in FBDs and skilled birth attendance. Many still preferred traditional birth attendant-assisted delivery, especially in geographically isolated and disadvantaged areas. The SDN initiative hoped to address this and proved to be successful. Beginning in 2013, skilled birth attendance improved, reaching 91% in 2016, compared to 80% 4 years before, slightly exceeding the national target of 90%. The same is true for FBD—it rose to 90% in 2016, up from 82% in 2013. The FBD result was also on target.

Support for Implementation
Provincial and Municipal Local Governments, PHO, and Municipal Health Offices
These institutions were key in leading and implementing the initiative. They took active roles in developing the SDN concept and its processes and functions, determining baseline data, setting targets, monitoring and evaluating performance, and making resources and other forms of support available.

Public- and Private-Sector Health Providers and Facilities
Public hospitals, RHUs, BHSs, private clinics and hospitals, and health providers helped achieve the project's objectives of serving the various health needs of clients and their children.

Stakeholders and Sectoral Organizations
Associations of transportation providers, media, women, senior citizens, youth, farmers, and fishers helped expand the SDN and achieve its aims, including service provision.

DOH-RO
The DOH-RO provided much-needed funds and valuable technical assistance (TA).

Donor Assistance
MH facilitated training workshops, SDN manual and referral guide development, and SDN implementation. Capability-building trainings for HSPs helped ensure that the services clients receive are high-quality, responsive, appropriate to their needs, and executed with competence.

Prerequisites for Replication

- Ensure that LGUs have the political will to pursue health programs and strategies that serve the health needs of women over the course of their lifetime to ensure health care for children and youth, and help women exercise their reproductive rights.
- Ensure that LGUs cooperate and commit to working together, regardless of their political affiliations, to make scaling up and replicating the SDN easier.
- Ensure budgetary and resource allocations to improve public health facilities and make them functional, and to continue building the skills and competency of public and private health providers at all levels of care.
- Establish initiatives that prepare, mobilize, and further involve the private sector and stakeholders in meeting the health needs of the communities.
- Facilitate a culture of collaborative and participative undertakings between the public and private sector to make sure the SDN is a success.
- Enable policies, such as an SDN provincial ordinance, EOs, and partnership agreements, to establish and sustain the SDN.

Sustainability Mechanisms
The establishment of the SDN includes systems in place to ensure its sustainability, including:

- **EOs:** The municipal mayors of Rosario, Prosperidad, and San Francisco issued EOs on the SDN and its management structure.
- **SDN management structure and TWG:** An SDN management structure is in place. A TWG exists but needs to be put into use.
- **Partnership agreements:** Public- and private-sector stakeholders signed an SDN partnership agreement specifying their responsibilities, roles, and functions to help achieve the partnership's aims.
- **Adherence to the 10 elements of a functional SDN:** LGUs were trained on and then implemented, monitored, and evaluated their performance using a functional SDN. The process for establishing and sustaining a functional SDN is documented in *Guide in Establishing a Functional SDN for Maternal, Neonatal, Child Health, and Nutrition/FP Services*.
- **Trained HSPs:** HSPs were trained on various health skills and competencies, especially MNCHN/FP.
- **SDN referral system:** The existing referral system must be expanded and improved upon to include procedures ensuring the participation of all stakeholders.

Lessons Learned and Recommendations

Enabling Policies

The EOs for creating the SDN and its management team issued by municipal mayors ensured the implementation and sustainability of the initiative. They also provided the framework and rationale for the strategy, and outlined the responsibilities, roles, and functions of the management team.

Recommendation: Ensure EOs are also issued in other municipalities committed to implementing the SDN and backed by budgetary support. A provincial ordinance on SDN establishment is essential to institutionalize the SDN at all levels, regular budget allocation, and local policy support.

Formal Partnership Agreements

Stakeholders such as transport groups and the media have already been involved in health care services, though not formally. They may view partnership agreements as a formal recognition of their participation and see the value they bring to health initiatives. These agreements outline the responsibilities, roles, and functions that each partner agrees to undertake, binding them to the SDN's aims.

Recommendation: Stakeholders must sign and implement partnership agreements in the areas that will replicate the SDN. Agreements must specify responsibilities, roles, and functions of each partner.

TA

TA equipping LGUs, the private sector, and stakeholders with the knowledge, skills, and tools that will ensure the SDN's establishment is valuable. The written manual and training workshops, based on the 10 elements of a functional SDN, are particularly helpful in achieving a functional SDN.

Recommendation: Roll out the *Guide in Establishing a Functional SDN for Maternal, Neonatal, Child Health, and Nutrition/FP Services* to other areas. Use the guide to establish an SDN for other health services other than MNCHN/FP.

HSP Capacity-Building

Training of HSPs on various MNCHN/FP competencies using supportive supervision bridged the gaps in the health services provided at various levels of health care and ensured that women's and targeted populations' health needs were met. Health personnel from the public and private sector must be equipped with skills to widen their reach and make health services more accessible.

Recommendation: Ensure continuous capacity-building for MNCHN/FP and other health services. Public- and private-sector resources and donor support need to be pooled to increase the number of HSPs trained.

Referral System

The existing manual and referral system used by the HSPs needs to be expanded to incorporate stakeholders and private-sector health care providers in the SDN.

Recommendation: Develop an inclusive referral system that involves other service lines and systems in the SDN, such as HIV/AIDS and TB services. Further develop and institutionalize coordination and communication systems among public and private health care providers, clients, and transport services.

Information Dissemination on Available Services

Communities and clients need to be informed about available health services to develop or improve care-seeking behaviors. Because the project mainly focused on establishing the SDN and ensuring stakeholder engagement, the next phase must include more information dissemination activities and materials to ensure that clients are able to access services at the appropriate health facilities.

Recommendation: Conduct IEC activities and develop materials to inform clients about the SDN's services, including PhilHealth benefits, all the way to the community level. Publicly launching the SDN initiative may also help popularize it.

MH established SDNs—four are functional, eight are operational, and nine are organized SDNs. SDNs provide services to underserved communities, ensuring a continuum of care that is provided through forged partnership between and among public and private three-tiered health care providers. An inherent component of these partnerships is an acknowledgment neither one can meet the needs of its communities alone, nor is only one sector in the best interest of the overall health system. A comprehensive, robust model, the SDN has the potential to record remarkable results in meeting unmet need.

MH developed the SDN Operational Guide through open consultations with all stakeholders exploring all possibilities of forging partnerships to achieve health and development goals. Stakeholders from three levels of service delivery participated (i.e., the private sector, public health institutions, policy and management levels, local government officials, and clients of the six regions).

The guide helps strengthen select LGU clusters to deliver essential services by establishing elements of a well-functioning network. The key component of the guide is adopting a broader view of management and delivery of health services for MNCHN/FP/AY clients, taking into account individual and unique features present in each geographic and sociocultural setting.

Endorsed by the six regional DOH directors in Mindanao, the SDN was rolled out in 15 provinces and two cities. DOH-ROs in Northern Mindanao, Davao, SOCCSKSARGEN, and Caraga allocated and spent funds for SDN establishment.

Good Practices: PPP
The Iligan City SDN embarked on a challenging task of unifying the recording and reporting of MNCHN/FP/AY service coverage across health care facilities in the city, involving all 50 health centers, the hospitals (both public and private), and other private facilities (lying-in clinics) to regularly submit Field Health Service Information System reports to the Iligan city health office. This enabled the LGU to better appreciate and see the larger picture of FP/MNCHN/AY services so that health managers and policymakers could render appropriate and informed decisions.

MH documented and shared these practices during regional dissemination forums in Northern Mindanao and Caraga regions.

Annex 6

Data quality check: sustainability guidelines for rural health facilities, Compostela Valley, Davao Region

Reliable and accurate health data are essential for improving the delivery of maternal, newborn, and child health and nutrition (MNCHN)/family planning (FP) services. Incomplete records, over- or underestimation, and untimely reporting may affect health plans and the real-time provision of FP and MNCHN services, especially to the poorest of the poor. In response to the Department of Health (DOH)'s Administrative Order No. 2008-0029, Implementing Health Reforms for Rapid Reduction of Maternal and Neonatal Mortality, the DOH Regional Office (DOH-RO) Davao program coordinators conduct yearly data validation as an integral component of the MNCHN implementation strategy.

In 2011, the US Agency for International Development (USAID)'s HealthGov project conducted a training of trainers for provincial health office (PHO) program coordinators and provincial statisticians in Davao Region on data quality checks (DQCs), which was rolled out at the rural health unit (RHU level). The next year, the trained program coordinators moved to other areas.

Compostela Valley had five PHO staff participate in the DQC training and successfully conducted onsite trainings for public health nurses (PHNs) and rural health midwives (RHMs). In succeeding years, the PHO's municipalitywide implementation hit some snags, which slowed DQC implementation. After the initial round in 2011, PHOs completed DQCs, but they did not complete follow-ups or monitoring.

Two years later, the PHO appointed a focal person for the province's health information system (HIS) to strengthen data reporting and analysis at the local level, keeping in mind that the data would later be integrated into the regional HIS (RHIS).

In mid-2013, the PHO, with assistance from MindanaoHealth (MH), held another training to revitalize DQC activities. The training focused on helping health staff understand the existing DQC forms for MNCHN and FP. It highlighted technical definitions, computations based on a new formula, and forms based on the 2012 Field Health Service Information System (FHSIS). Participants learned how to complete systematic checking, validation, and data analysis.

The PHO observed a significant difference in provincial health data collection after it implemented DQCs. Local health staff now understand the importance of DQCs.

Objectives
The Compostela Valley PHO aimed to:

- Train a new set of DQC teams and health staff who can competently implement DQCs in the province.
- Develop a data management system for planning, validation, recording, reporting, and analysis from the barangay to provincial level.
- Provide accurate documentation of the province's health indicators, especially on MNCHN and FP.
- Improve local health planning and decision-making by using DQC-validated data.

Methodology

The provincial health officer issued Office Order No. 02-2014, DQC Team of the PHO, on January 5, 2014, to ensure extensive implementation. The order mandated the creation of a DQC team, headed by the provincial health officer II, which will serve as a governing body that conducts monthly DQC activities at all RHUs. Extensive retraining sessions for PHO program coordinators were conducted in the first quarter of 2015, followed by a series of DQC refresher courses, offered in partnership with the DOH developmental management officer IV. The training included the DOH-RO Davao RHIS forms in line with the region's own HIS. Executing this initiative required:

Establishing Partnerships

MH, in partnership with the DOH-RO Davao, provided technical assistance (TA) for DQC implementation to sustain the support initially provided by USAID's HealthGov project. The DOH-RO Davao used a unique setup and technical terms compared to other regions; for instance, it used the term RHIS in lieu of FHSIS.

To ensure an effective partnership, the DOH-RO Davao and PHOs educated MH on their organizational dynamics, decision-making processes, operational functions, and management setup. Partners shared the goal of improving MNCHN and FP outcomes through high-quality data. Constant coordination and open dialog with involved agencies and partners were crucial at this phase to prevent responsibilities from overlapping.

Capacity-Building Initiatives

As of 2016, 53 health personnel, including all nurse-supervisors from 11 RHUs, were trained. Capacity-building initiatives included:

- **Refresher course on DQC:** The refresher course conducted in 2013 improved the province's DQC implementation and taught key DQC players to unify their techniques, understand the formula, and learn how to respond creatively to the constraints confronted by a low-resource setting, such as a barangay, to sustain DQC activities.

- **Onsite rollout activities:** These activities were conducted for all 384 health personnel in the province. Activities included extensive, hands-on data cleaning and actual computation of data within the RHMs. PHNs facilitated a series of monthly updates and reorientations.

- **Individual RHU sustainability strategies:** Every RHU had its own strategy to sustain DQC implementation. In Maco, the PHN conducted monthly, one-on-one sessions on data auditing and coaching. The PHN schedules sessions based on rural health workers' timely data submissions. If someone failed to submit a report on time or was the last to submit, the PHN scheduled them first on the list, as a creative way to reinforce the importance of DQCs.

Creating a DQC Technical Working Group

Per Office Order No. 02-2015, the project created a DQC Technical Working Group (TWG) in 2015 to conduct monthly validation for all RHUs. The provincial health officer II heads the TWG. Members include MNCHN, FP, and RHIS program coordinators. The TWG conducted visits and coaching sessions for RHUs, especially for sites with the lowest scores in four antenatal care visits: fully immunized children, facility-based deliveries (FBDs), skilled birth attendance, and contraceptive prevalence rate (CPR).

Some RHUs created their own TWGs to ensure DQCs are in place. In Maco, the RHM acted as the data auditor for barangay health stations (BHSs). The RHM validated data with assigned barangay health workers (BHWs) and nurses under the Nurse Deployment Program (NDP), then consolidated and plotted the data in the summary table. Once the RHM entered all data manually, the programer evaluated the data. The RHIS consolidated final data. The PHN completed the final audit, followed by a one-on-one data review session, which was normally scheduled in the first week of the month following submission. Once approved, the PHN sent the validated monthly report to the public health associates to encode and electronically send all data to the PHO.

Montevista had a similar setup to Maco, but it had a different data validation schedule. The RHM and NDP nurse examined the BHS's report. The PHN, as chair of the DQC review, conducted an on-the-spot validation with the RHM as soon as the report became available. BHWs were responsible for field revalidation in case of discrepancies.

Mawab had a different strategy, since the PHN had multiple duties. BHWs and NDP nurses worked as data validation partners. Once audited, the RHU submitted health data to the public health associate for cross-examination and clarification in case of errors before forwarding to the PHN. The PHN randomly selected the target client list (TCL) and summary tables for review.

Inter-BHS Assessment and Evaluation
Because the PHO could not visit all BHSs in the province, select municipal health personnel conducted their own inter-BHS assessments and evaluations. The Maco PHN introduced this initiative to ensure that all 37 barangays validated their data. RHMs sent their validated reports to their co-RHMs from other barangays/villages for cross-examination. To prevent bias, the project paired midwives who did not know each other to audit data. The RHMs discussed findings and shared solutions about how to improve health indicators. So far, the initiative helps the RHMs improve declining rates.

Annual DQC Review
The province held an annual data reconciliation in October or November to specifically discuss DQC-generated data. The PHO TWG presented consolidated data to stakeholders, health personnel representatives, and the provincial DOH office. Participants could discuss discrepancies and data reconciliation with the PHO and the provincial DOH office. PHNs cross-matched inconsistencies and retrieved pertinent documents for verification. Once mutually agreed upon, the province used finalized data during its program implementation review (PIR). The annual DQC review also sometimes included DQC and mentoring reorientation, PHO TWG meetings, and RHU discussions on how to improve health indicators.

Results
Data Completeness
The conscious effort to examine health data improved the completeness of TCLs, monthly reports, and summary tables. These are now regularly updated and accurate. Now, the majority of Compostela Valley health staff understand the importance of clean, reliable, and on-time data. They now pay attention to unfilled columns found in recording/reporting tools. They understand that every single number contributes to the potential health agenda of their respective municipalities. PHNs said that they noticed numerous blank spaces in TCLs before DQC training, but TCLs and other reporting forms are now completely filled out.

Data Availability
No missing values were observed in each health center's TCLs, monthly reports, and summary tables in monthly reports. In fact, salient data on maternal, newborn, and child health, including FP data, are summarized and can be clearly located in case of retrieval. DOH RHIS electronic system is installed in their respective RHUs, which houses the DQC-validated data and facilitates easy access and retrieval. Before DQCs, RHUs needed a week or two before they could provide data, which were sometimes unreliable or missing.

Data Consistency
Before DQCs, miscalculations and wrong entries were commonly made. According to the nurse-supervisors interviewed, RHMs usually made errors, including when calculating gestational age, FBD and skilled birth attendant (SBA) mismatch, FP dropouts, and even the correct name of clients. After training, an average seven to 10 data inconsistencies became one to two. Health staff now understand more technical terms and formulas. RHU data sets are now consistent and identical to the PHO's actual data found in summary tables and the RHIS.

Data Timeliness

The process now often takes 1 day instead of 2–3 days. Familiarity with the forms to use, terminologies, definitions, formula, and updating of data helps. Before training, it was a struggle to submit monthly reports to the PHN and annual reports to the PHO, since most of the data were missing, mismatched, or late. Now, DQC data are clean, complete, accurate, and submitted on time. RHMs used to submit health data reports 4–5 days late, but they now send these reports to their PHNs on time. PHNs can now submit reports to the PHO on time. According to the RHIS focal person, because of DQC training, the PHO can now consolidate all RHU reports on time and submit them to the DOH-RO Davao before its cutoff date. Sometimes submissions can still be delayed up to 5 days if there are unexpected circumstances, like overlapping meetings or out-of-town seminars.

Empowered and Confident Personnel

Health staff, particularly the RHIS focal person, are now empowered to conduct data validation and analysis, and can confidently provide coaching and mentoring support to PHNs and RHMs. Health care providers said they now feel more comfortable asking for additional equipment, such as computers and office supplies for TCL reproduction, from their local officials during municipal PIRs.

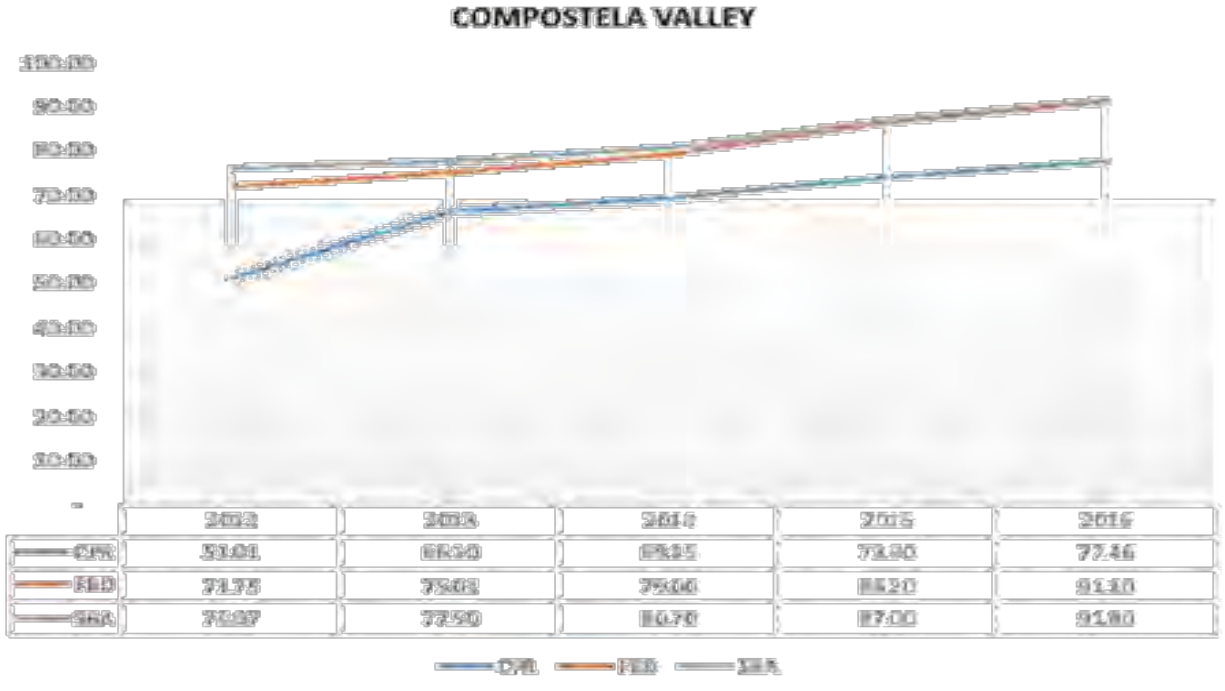
Advocacy Capacity-Building

Health staff can now discuss and recommend health program priorities to their municipal leaders with confidence now that local data quality improved. For example, the Mawab RHU identified a poor CPR percentage after the extensive DQC implementation in 2013. As a result, the municipal mayor started to increase investments in the FP program, such as providing additional funds for community-based seminars and transportation to intensify RHMs'/BHWs' house visits. RHMs and BHWs can now bring a range of FP methods and services with them during these visits.

Improved Health Indicator Percentiles

Overall, the CPR, FBD, and SBA health indicators continued to rise. Based on validated RHIS data, there is a noticeable close rate between FBD and SBA, from less than 5% interval to 0.70% in 2016 (see Figure 23). This implies that local health personnel gained ground in promoting deliveries at facilities managed by SBAs. This also explains why maternal mortality is low in the province compared to the others in Davao Region. CPR consistently increased in the province, meaning the FP campaign's focus was effective.

Figure 23. Compostela Valley contraceptive prevalence rate, facility-based deliveries, and skilled birth attendance, 2012–2016



Better Health Program Initiatives

FP networking: To ensure all women of reproductive age receive FP commodities, especially during stock-outs, RHUs worked with other RHUs that had overstock to temporarily borrow supplies until the shipment arrived.

***Bayanihan* initiative:** Health personnel can now gauge if they can reach their goal before the year ends. If RHMs fail to reach their quarterly target, the concept of *Bayanihan* comes in, where midwives work together to help each other achieve their goal based on the PHO's projected service utilization for the population. Midwives brainstorm, share experiences and strategies, mentor each other, and even attend onsite lectures/counseling (MNCHN and FP programs). RHMs and PHNs closely monitor follow-up to ensure all staff meet their annual goals.

Better Budget Allocation for Health

DQC-validated data are presented annually during PIR sessions in the province, where data are used to lobby for health agenda priorities. The local government has increased the budget every year since 2015, meaning it saw the importance of investing in health programs. The province's budget allocation for health increased by 10% from 2015 (PHP 52,630,943) to 2016 (PHP 58,077,986). 2017 saw a 4% increase (PHP 60,321,766). In Maco, the barangay's health budget increased from 5% in the previous years to 10–15% in 2017. In Montevista, the municipal budget allocation for health roughly doubled over the period of time.

Gaps and Challenges

Insufficient Manpower, Heavy Workload, and Overlapping Schedules

Health staff in government facilities handle many responsibilities, so prioritizing work is a challenge. The massive amount of clients and paperwork, coupled with understaffing, leads to health service provider exhaustion and burnout, which may affect their commitment to DQC activities.

For instance, in Mawab, before DQC training, the PHN served as nurse-supervisor and office in-charge, since there was no municipal health officer in early 2013. The PHN said that DQC was never a priority during those years, resulting in the Mawab RHU being marked as one of the poorest-performing DQC facilities in the province. Once Mawab appointed a municipal health officer, the PHN could manage DQC demands. Temporary NDP nurses, public health associates, and RHMs also helped them sustain DQC activities.

Aside from their regular duties, RHU personnel need to attend seminars and workshops every month run by the province or the DOH-RO Davao, leaving work unfinished. DQCs take time and require attention to detail, but because of unfinished work and other overlapping tasks, staff struggle to deliver, much less execute, data validation. As a solution, some RHUs delegate partial data validation and encoding to public health associates. Some schedule one-on-one data review and auditing.

DQC Budget Allocation

The municipal health officer includes DQCs in the general MNCHN and FP program budget. S/he earmarks the DQC budget for reproducing TCLs and other forms, supporting transportation for coaching/mentoring and onsite validation visits, and conducting refresher and orientation courses for new and existing health staff. To save money, some RHUs use a columnar logbook instead of printed TCLs and DQC tools. The Maco RHU photocopies logbooks instead of buying them. To cut the cost of training, RHUs include DQC lectures in their monthly meetings.

Transportation

Due to topographical challenges and the unstable situation in Compostela Valley, delayed report submissions are inevitable. The lack of logistics and transportation support force the PHO TWG to borrow government vehicles from other departments. Sometimes they take public transportation using personal money to reach RHUs for data validation activities or rely on PHN availability at other RHUs to transport their data and/or send electronic copies.

Transportation is more challenging for rural health staff in geographically isolated and disadvantaged areas, where barangay-to-barangay mobilization and onsite mentoring would be impractical. Usually, RHMs request a vehicle from their barangay captains or commute on their own to submit their monthly reports to the municipal PHN. Otherwise, the nurse-supervisor has to arrange special appointments/meetings at the RHU for DQC follow-through with BHS personnel at their preferred time.

Computer Availability and Internet Accessibility
Manual entry errors are common. They often occur when data are first entered or are typographical errors. Health data coming from the field are voluminous and can be overwhelming. Technology would help, but most RHUs cannot afford to purchase computers to automate health information processes.

PHNs' age and computer literacy also factor into why some still prefer to use the traditional method. Some RHUs hire IT staff. Public health associates can help, even if RHUs cannot afford to hire IT staff. As a result, most RHUs regularly submitted e-copies of their validated data to the RHIS focal person.

The Internet can send real-time data at the lowest cost, but Internet and network signals in the province remain unstable, especially in remote places.

Local Government Unit Commitment
DQC implementation success differs based on the commitment of local government officials and health leaders. RHU staff interviewed said they hope that the provincial TWG sustains monthly or quarterly visits to their health stations so that they can voice their needs, and health managers and program coordinators can mentor and see the real scenario on the ground. However, the PHO TWG and the RHIS focal person said they do not need to make monthly and quarterly visits, since they are confident that RHUs validate data regularly. They also said that visiting all RHUs may not be possible because they lack funds to cover transportation costs.

As a solution, the PHO proposed three strategies: conduct a semiannual data reconciliation instead of a monthly/quarterly visit, provide coaching and mentoring support to RHUs with the lowest performance ratings based on their scorecards, and visit one to two RHUs per month to ensure that it visits all 11 RHUs within the year.

Support for Implementation
MH, in partnership with the DOH-RO Davao, led DQC capacity-building for Compostela Valley PHO staff. TA included coaching, mentoring, and onsite, hands-on training to strengthen the DQC concept from the PHO level to the barangay from 2013–2017.

In 2013, MH conducted a 1-day refresher course training for the PHO TWG. Two years later, it held retraining in Davao City for four PHNs from the TWG and 11 from RHUs. The project also supported the rollout of DQC activities at the municipal and barangay levels through coaching and hands-on validation of 2014 data. As part of the training, health staff learned how to analyze and formulate health plans based on their DQC-validated data, and how to present their quality-checked data during the local government unit (LGU)'s municipal and provincial Local Investment Plans for Health (LIPHs) formulation and PIR. MH also conducts periodic onsite visits to RHUs for follow-up and mentoring.

Estimated Cost to Implement
Based on the 2013 budget, implementing DQC in all 11 RHUs costs around PHP 100,000. Consider the following budgetary needs if replicating the initiative:

- DQC tools for all HSPs for monthly data validation
- Office supplies for DQC tool reproduction and other relevant materials
- Computers for RHUs to consolidate DQC outputs

- Transport vehicle for the PHO TWG to make onsite visits, schedule regular validation, and hold onsite coaching as needed

- Meals and snacks for staff during the 1-day validation activity

Time Needed to Implement
It took 3 years for the Compostela Valley PHO to fully implement the DQC activity. The first 2 years were the transition phase. During this phase, it is recommended that DQC implementation should be packaged with close monitoring, supervision, and mentoring sessions for each RHU. Follow-up refresher courses should be conducted in the succeeding years. Practicing DQC in the work system can help facilities smoothly implement the initiative.

Prerequisites for Replication
Issuance of Office Order
The PHO TWG lobbied for a provincial resolution on DQC implementation. At the moment, however, the RHIS focal person's priority is to renew the office order issued in 2014, since the province appointed a new provincial health officer II on July 12, 2017. With a new office order will come a new set of TWG components, clearer roles and functions, and revisions that will strengthen DQC activities in the province.

Local chief executives (LCEs) need to issue an executive order (EO) to institutionalize DQC before it is scaled up. The EO is also an imprimatur for RHUs and local health leaders to strictly implement DQC in their respective areas.

Community Leader Commitment
The commitment of community leaders, particularly the LCE, the Sangguniang Bayan and Sangguniang Panlalawigan on health, and local health managers, plays a big role in motivating and inspiring frontline staff to continue DQC implementation and responsibly execute their specific responsibilities as mutually agreed upon during their sessions. The PHO TWG, as the provincial health leader, should intensify its commitment to supervise, mentor, and coach RHUs.

Pragmatic Capacity-Building Initiatives
Capacity-building needs may vary by municipality. Trained nurse-supervisors must be knowledgeable enough to generate pragmatic, creative trainings tailored to their needs, target audience, and resources. PHNs should provide DQC orientation sessions to new staff. Senior staff should support coaching activities. The PHO TWG should be urged to conduct DQC concept to the predeployment orientation in all newly hired health personnel in case trained staff leave the facility.

Sustainability Mechanisms
Leadership
Local health leaders must strengthen and apply leadership and management skills and competencies to be visionary and effective. Leaders can influence their employees by providing clear roles and expectations, and emphasizing teamwork.

Despite scarce resources and minimal support after initial DQC implementation, PHNs from RHUs showed data validation leadership. PHNs focused on the opportunities, including empowering and inspiring their RHMs and BHWs to continue their DQC activities. They crafted innovative strategies, developed a spirit of teamwork, and instilled the idea that DQC is more than a task—it is a professional obligation.

Commitment to the Vision
A clear vision means a clear direction for DQC implementation. It is crucial that stakeholders share the same values. Implementation must be aligned with their respective culture to foster cooperation and commitment. The degree of their commitment will determine the sustainability of the initiative.

It is equally important that the local government and health leaders fully support the initiative to motivate health personnel from the municipal to the barangay level. For example, in the Maco RHU, RHMs religiously implement DQCs as part of their daily routine/system, since they witnessed how their PHN strongly believes that high-quality data are the key to improving their municipality's MCH outcomes.

Creation of DQC TWG
The creation of the PHO TWG through Office Order No. 02-2015 is important to the sustainability of the implementation. The PHO TWG gave the full authority to conduct monthly DQCs to all RHUs and their respective PHN, RHM, and DOH representatives to assure the accuracy and validity of reports/data using DQC tools and indicators. Part of their responsibility is to conduct coaching and mentoring, if possible, for all health staff in the province. An RHU-level TWG should also be created.

Budget Allocation Specifically for DQC
Although there is no DQC budget at the PHO level, one should be included in its LIPH annual operational plan. Provincial/municipal health officers can advocate to the local health board for a resolution to standardize DQC funds. The budget should clearly stipulate funds for transportation, DQC/TCL tool reproduction, meals, training, and updating.

As of 2017, the PHO allotted a budget for provincial DQC implementation worth PHP 100,000 under the health planning and promotion initiative. Each LGU should include budget for DQC in its annual investment plan to sustain implementation in the succeeding years. The budget should include funds for transportation, reproducing DQC tools, meals, training, updating, and incidentals.

Adopting the Electronic Medical Record System
The electronic medical record (EMR) system can improve the quality of locally generated data. The pen-and-paper style of recording is prone to errors. An EMR system, like iClinicSys and community health information tracking systems, in facilities will encourage health personnel to continue generating clean, valid, and reliable data.

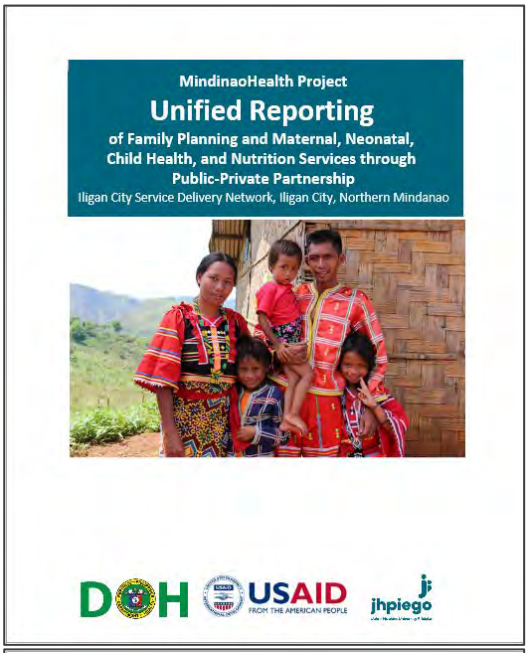
Lessons Learned and Recommendations

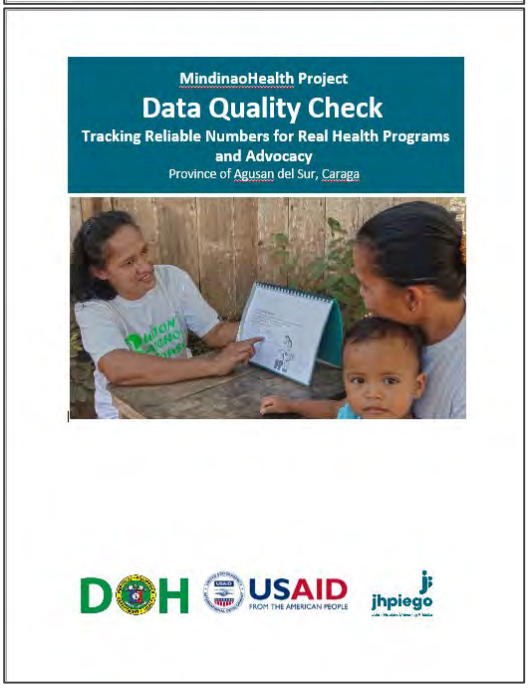
- DQC is a professional responsibility and obligation that every health staff member must religiously implement. High-quality data are the key to formulating health programs anchored in local context and responsive to community needs.
- By integrating DQC as part of daily responsibilities, more health staff would learn and stay updated on the initiative.
- Issuing an EO is a step toward DQC institutionalization. DQC implementation success, however, highly depends on leadership and individual commitments to improve health services.
- Office Order No. 02-2015 should be updated according to the current demand and in light of the newly appointed provincial health officer.
- More health staff should be hired to achieve the standard staff/client ratio and assign data encoders to the RHUs who can focus on the FHSIS and other data processes.
- Public and private health facilities should revisit DQC forms to include data cleaning and reporting of other health indicators aside from MNCHN/FP.
- Leadership, commitment, and teamwork are necessary to sustain DQC implementation.

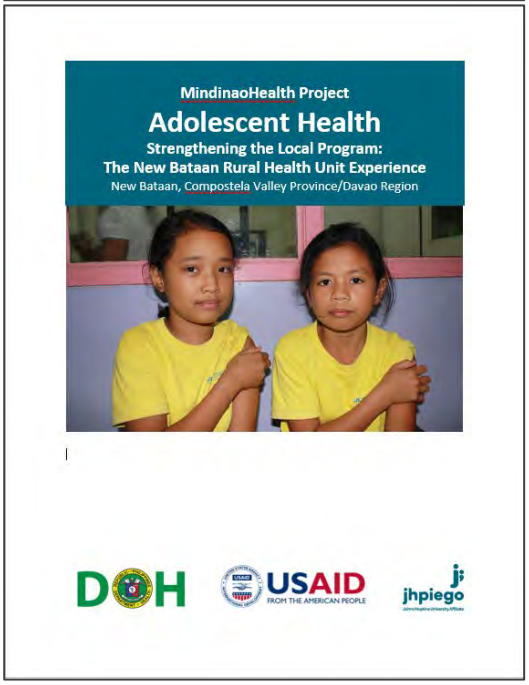
Annex 7

Hard Copies and USBs submitted to AOR's Office

GPPIS







MindinaoHealth Project

Strengthening the Family Planning Program in Maguindanao Provincial Hospital

Maguindanao Provincial Hospital, Maguindanao
Autonomous Region in Muslim Mindanao

DOH USAID FROM THE AMERICAN PEOPLE jhpiego

MindinaoHealth Project

Strengthening Local AYRH Programs through Peer Education and Youth Friendly Rural Health Unit

Rural Health Unit, Upi, Maguindanao,
Autonomous Region in Muslim Mindanao

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MindinaoHealth Project

Service Delivery Network: Integrating Local Health Initiatives and Programs through Multi-Stakeholder Partnerships

Agusan del Sur, Caraga

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MindinaoHealth Project

Empowering and Caring: A Rural Health Unit Reaching Out and Serving Adolescent and Youth Reproductive Health Needs

Rural Health Unit of Maramag
Maramag, Bukidnon, Northern Mindanao

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MindinaoHealth Project

Toktok Planado Pamilya

Door-to-Door Service Delivery for Women and Men with Unmet Family Planning Needs

Province of Agusan del Sur, Caraga

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MindinaoHealth Project

Family Planning

Institutionalizing Integrated Services in Tertiary Public Hospital Operations

Southern Philippines Medical Center[1], Davao City/Davao Region

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[1] Southern Philippines Medical Center is a government-owned hospital administered by the Department of Health and is located on J.P. Laurel Avenue, Bajada, Davao City. It was renamed the Davao Regional Medical and Training Center by the Republic Act 1859.

MindinaoHealth Project

Agusan del Norte Provincial Hospital Family Planning Program: Improving Service Delivery in the Province

Agusan del Norte Provincial Hospital

Butuan City, Agusan del Norte/Caraga

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MindinaoHealth Project

Scaling Up Postpartum Intrauterine Device Supervision and Services beyond Borders in Northern Mindanao

Northern Mindanao Medical Center

Northern Mindanao

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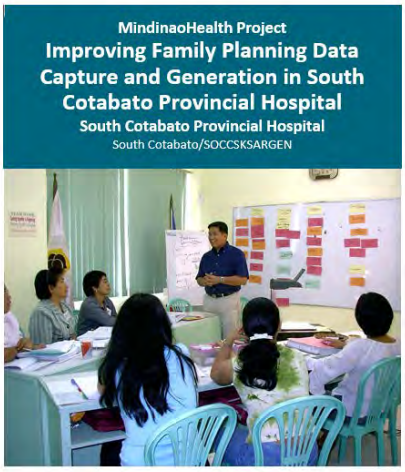
MindinaoHealth Project
Improving Family Planning Data Capture and Generation in South Cotabato Provincial Hospital
South Cotabato Provincial Hospital
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MindinaoHealth Project
Surmounting Challenges to Improve Access of Geographically Isolated and Disadvantaged Area Communities to Family Planning/Maternal, Neonatal, and Child Health and Nutrition Services
Kalamansig Rural Health Unit
Kalamansig, Sultan Kudarat/SOCCSKSARGEN
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MindinaoHealth Project
Sustainability Guidelines for Data Quality Check in Rural Health Facilities
Compostela Valley, Davao Region
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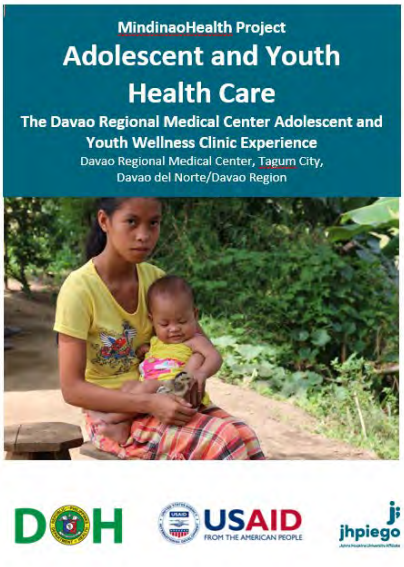
MindinaoHealth Project
Adolescent and Youth Health Care
The Davao Regional Medical Center Adolescent and Youth Wellness Clinic Experience
Davao Regional Medical Center, Tagum City,
Davao del Norte/Davao Region
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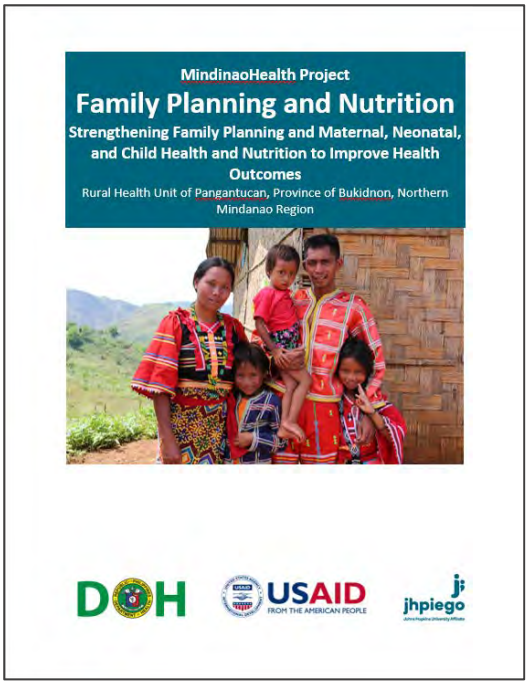
MindinaoHealth Project
Family Planning and Nutrition
Strengthening Family Planning and Maternal, Neonatal, and Child Health and Nutrition to Improve Health Outcomes
Rural Health Unit of Pangantucan, Province of Bukidnon, Northern Mindanao Region
DOH
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FROM THE AMERICAN PEOPLE
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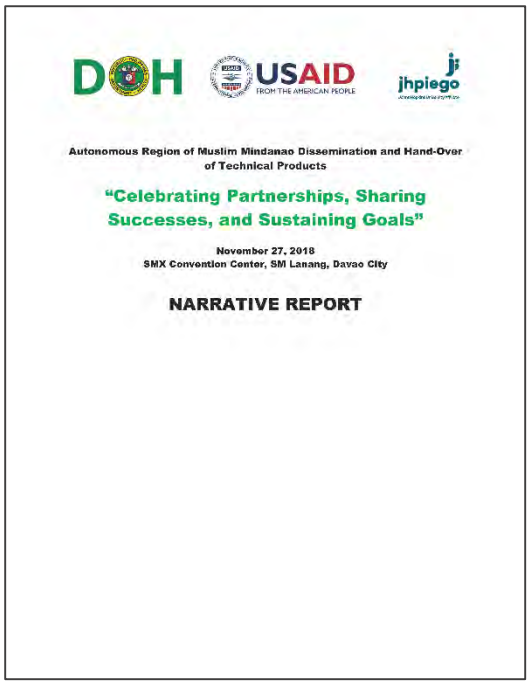
Dissemination Reports

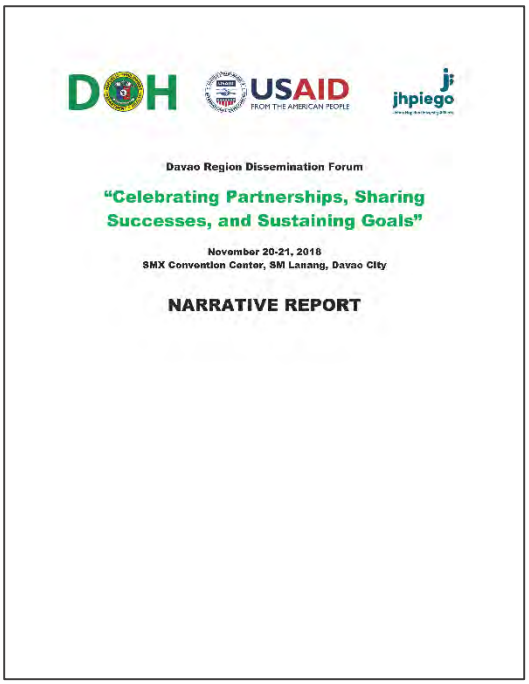


Autonomous Region of Muslim Mindanao Dissemination and Hand-Over of Technical Products

"Celebrating Partnerships, Sharing Successes, and Sustaining Goals"

November 27, 2018
SMX Convention Center, SM Lanang, Davao City

NARRATIVE REPORT

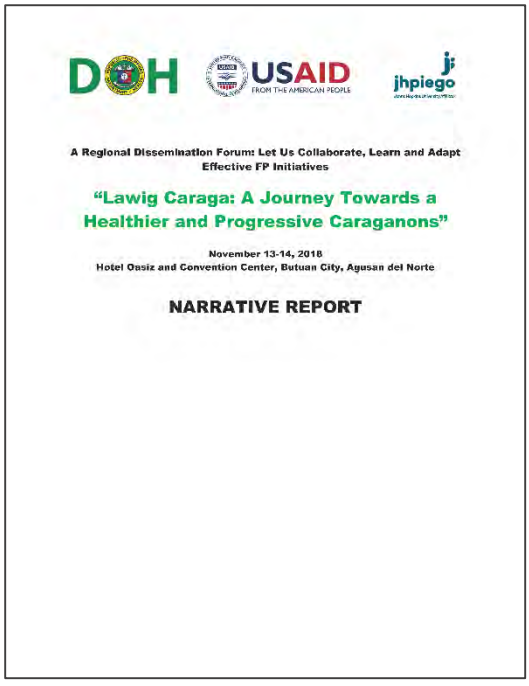


Davao Region Dissemination Forum

"Celebrating Partnerships, Sharing Successes, and Sustaining Goals"

November 20-21, 2018
SMX Convention Center, SM Lanang, Davao City

NARRATIVE REPORT

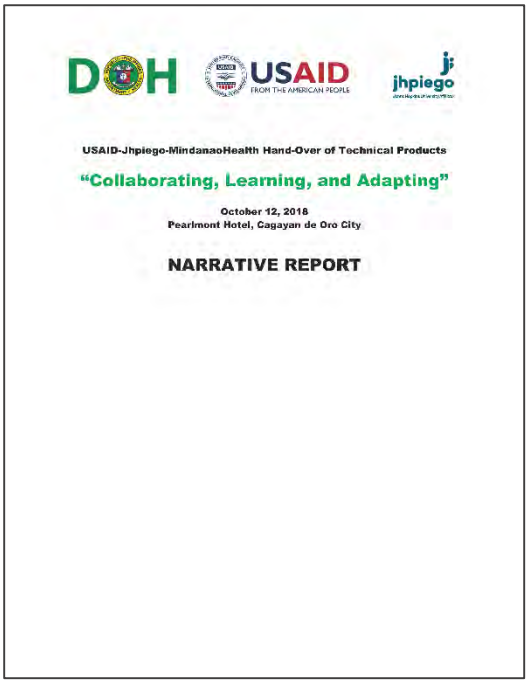


A Regional Dissemination Forum: Let Us Collaborate, Learn and Adapt Effective FP Initiatives

"Lawig Caraga: A Journey Towards a Healthier and Progressive Caraganons"

November 13-14, 2018
Hotel Oasiz and Convention Center, Butuan City, Agusan del Norte

NARRATIVE REPORT

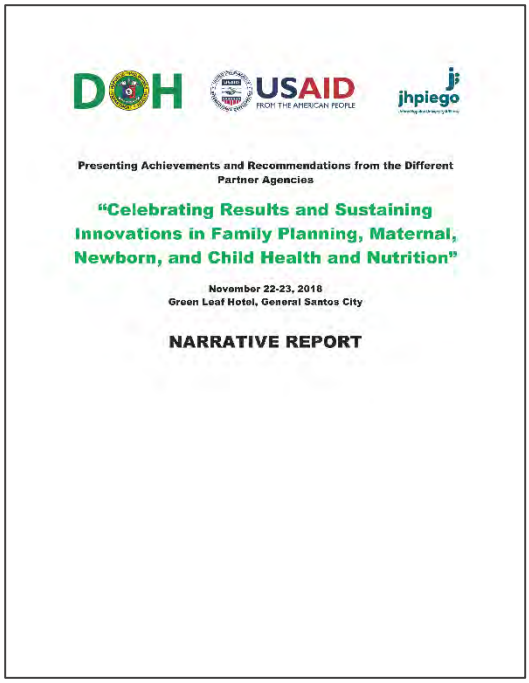


USAID-Jhpiego-MindanaoHealth Hand-Over of Technical Products

"Collaborating, Learning, and Adapting"

October 12, 2018
Pearlmont Hotel, Cagayan de Oro City

NARRATIVE REPORT

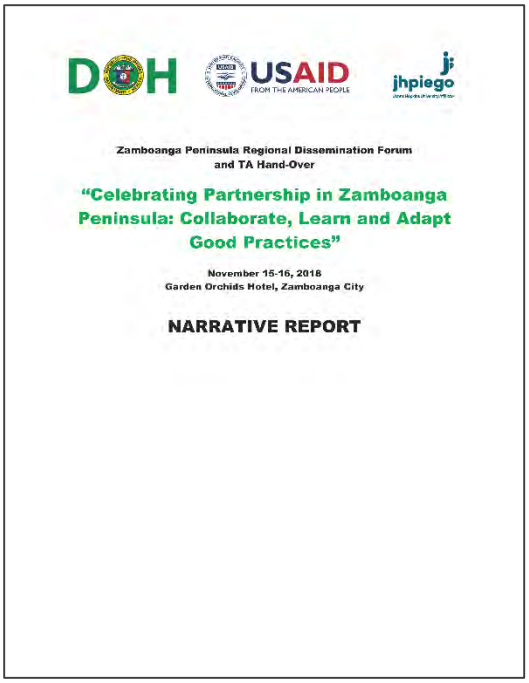


Presenting Achievements and Recommendations from the Different Partner Agencies

"Celebrating Results and Sustaining Innovations in Family Planning, Maternal, Newborn, and Child Health and Nutrition"

November 22-23, 2018
Green Leaf Hotel, General Santos City

NARRATIVE REPORT



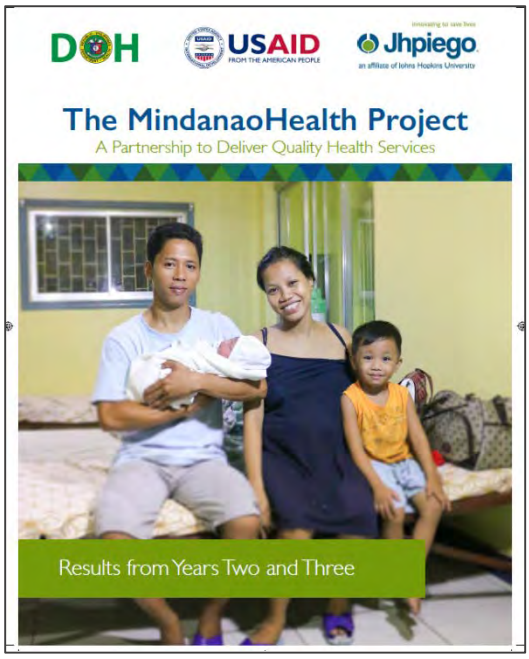
Zamboanga Peninsula Regional Dissemination Forum and TA Hand-Over

"Celebrating Partnership in Zamboanga Peninsula: Collaborate, Learn and Adapt Good Practices"

November 15-16, 2018
Garden Orchids Hotel, Zamboanga City

NARRATIVE REPORT

Magazines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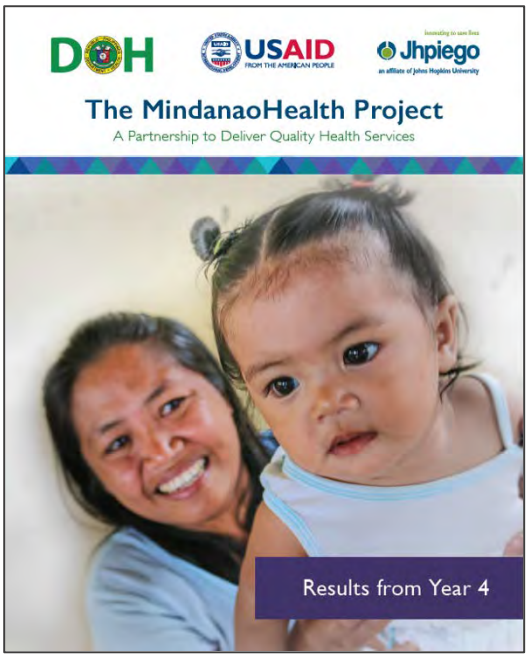
The MindanaoHealth Project
A Partnership to Deliver Quality Health Services
Results from Years Two and Three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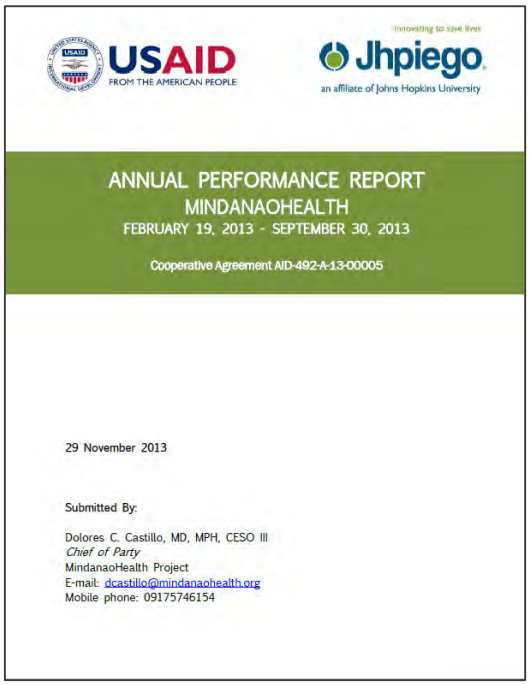
USAID
Jhpiego
The MindanaoHealth Project
A Partnership to Deliver Quality Health Services
Results from Year 4

Project reports



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ANNUAL PERFORMANCE REPORT
MINDANAOHEALTH
FEBRUARY 19, 2013 - SEPTEMBER 30, 2013

Cooperative Agreement AID-492-A-13-00005

29 November 2013

Submitted By:

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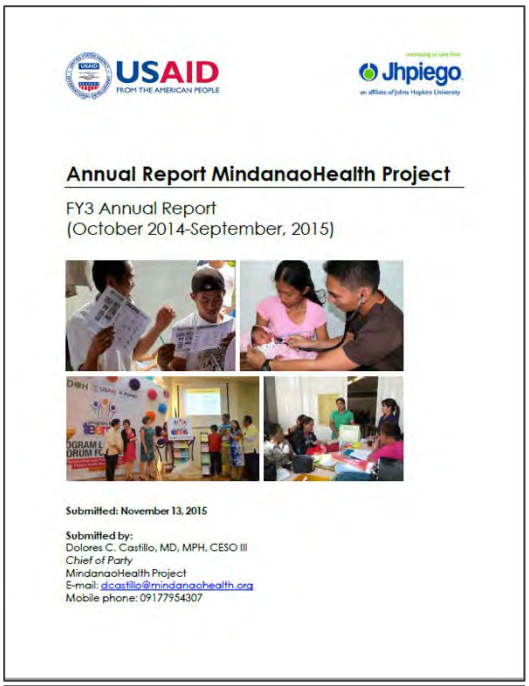

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Annual Report MindanaoHealth Project

FY3 Annual Report
(October 2014-September, 2015)

Submitted: November 13, 2015

Submitted by:
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MindanaoHealth Annual Report

Project Year Two. October 2013 – September 2014

Submitted to:
United States Agency for International Development,
Cooperative Agreement No. AID-492-A-13-00005

Submitted By:
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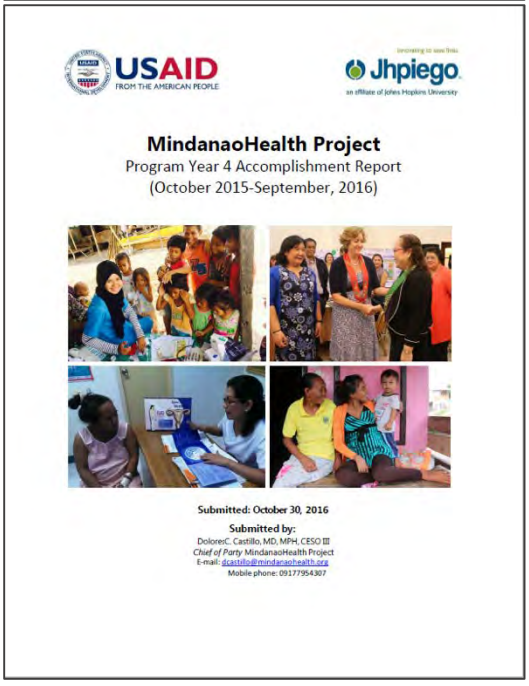

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MindanaoHealth Project
Program Year 4 Accomplishment Report
(October 2015-September, 2016)

Submitted: October 30, 2016

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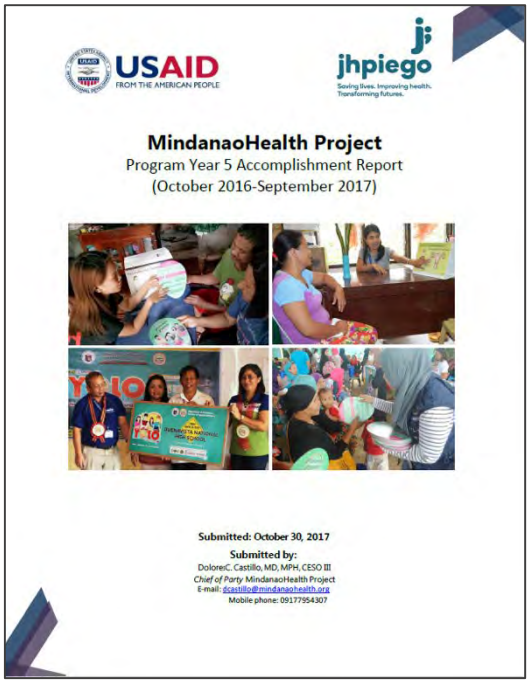

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MindanaoHealth Project
Program Year 5 Accomplishment Report
(October 2016-September 2017)

Submitted: October 30, 2017

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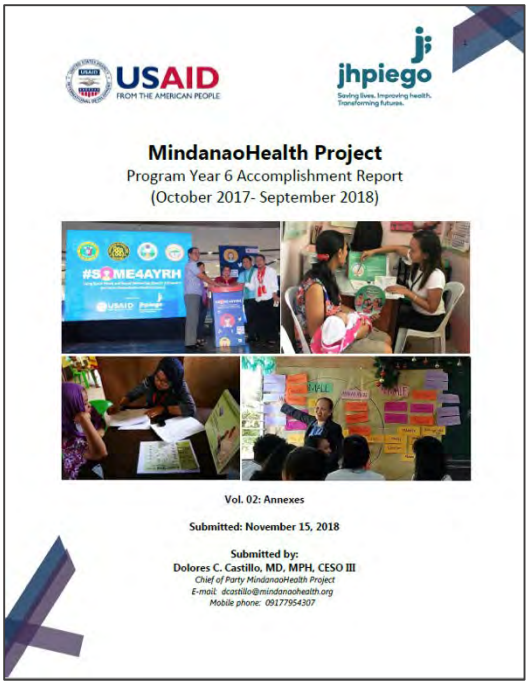

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MindanaoHealth Project
Program Year 6 Accomplishment Report
(October 2017- September 2018)

Vol. 02: Annexes

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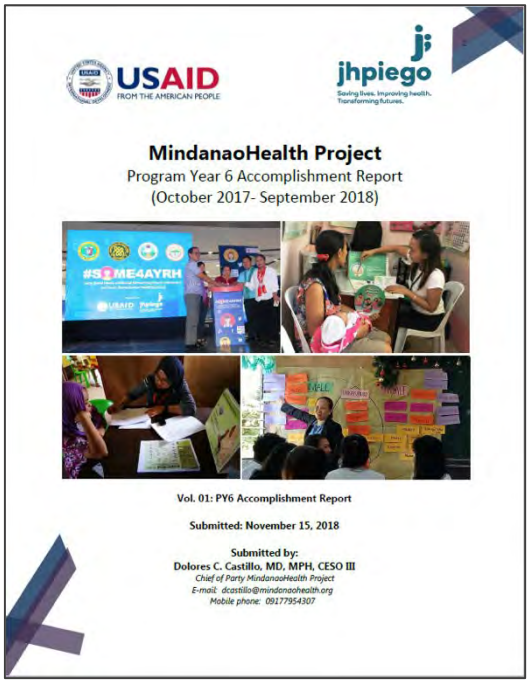

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MindanaoHealth Project
Program Year 6 Accomplishment Report
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Vol. 01: PY6 Accomplishment Report

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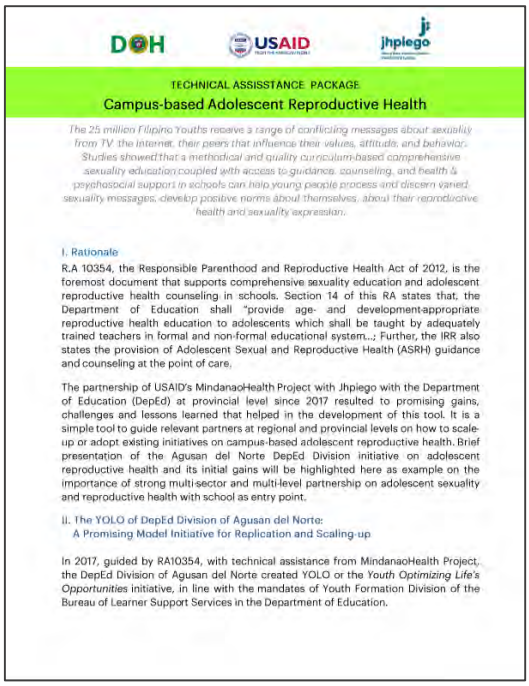
Technical Products

How-Tos



TECHNICAL ASSISTANCE PACKAGE

Campus-based Adolescent Reproductive Health

The 25 million Filipino Youths receive a range of conflicting messages about sexuality from TV, the internet, their peers that influence their values, attitude, and behavior. Studies showed that a methodical and quality curriculum-based comprehensive sexuality education coupled with access to guidance, counseling, and health & psychosocial support in schools can help young people process and discern varied sexuality messages, develop positive norms about themselves, about their reproductive health and sexuality expression.

I. Rationale

R.A 10354, the Responsible Parenthood and Reproductive Health Act of 2012, is the foremost document that supports comprehensive sexuality education and adolescent reproductive health counseling in schools. Section 14 of this RA states that, the Department of Education shall "provide age- and development-appropriate reproductive health education to adolescents which shall be taught by adequately trained teachers in formal and non-formal educational system...; Further, the IRR also states the provision of Adolescent Sexual and Reproductive Health (ASRH) guidance and counseling at the point of care.

The partnership of USAID's MindanaoHealth Project with Jhpiego with the Department of Education (DepEd) at provincial level since 2017 resulted to promising gains, challenges and lessons learned that helped in the development of this tool. It is a simple tool to guide relevant partners at regional and provincial levels on how to scale-up or adopt existing initiatives on campus-based adolescent reproductive health. Brief presentation of the Agusan del Norte DepEd Division initiative on adolescent reproductive health and its initial gains will be highlighted here as example on the importance of strong multi-sector and multi-level partnership on adolescent sexuality and reproductive health with school as entry point.

II. The YOLO of DepEd Division of Agusan del Norte:
A Promising Model Initiative for Replication and Scaling-up

In 2017, guided by RA10354, with technical assistance from MindanaoHealth Project, the DepEd Division of Agusan del Norte created YOLO or the *Youth Optimizing Life's Opportunities* initiative, in line with the mandates of Youth Formation Division of the Bureau of Learner Support Services in the Department of Education.

TECHNICAL ASSISTANCE PACKAGE

Mobile Outreach Services for Family Planning

I. INTRODUCTION

The delivery of mobile outreach services is a way to provide a full range of family planning (FP) methods to underserved communities. For the purpose of this document, mobile outreach services is defined as FP services provided by a mobile team of trained providers, from a higher-level facility to a lower-level facility. These are done in an area with limited or no FP or health services; for instance, health providers/outreach team from the Northern Mindanao Medical Center (NMMC) or Zamboanga City Medical Center (ZCMC) or civil society organizations/non-government agencies (CSO/NGO) go to the provincial or district hospitals to provide long acting permanent method (LAPM) outreach; or trained health providers from the rural health units (RHU) go to the barangay health stations (BHS) to provide long acting reversible contraceptives (LARC) as outreach activities/services.

This document can be a guide for local government units (LGUs) that plan to conduct mobile outreach services in their areas with high unmet need, in urban areas or geographically isolated and disadvantaged areas (GIDA) and communities of indigenous peoples (IP).

PRE-IMPLEMENTATION PHASE

Conduct a coordination meeting with partners – LGUs, Department of Health (DOH), mobile outreach team, and staff of the host facility at least one month prior to the schedule of outreach LAPM or LARC to clarify and level off on roles and responsibilities.

Previous experiences showed that the provinces submit their Local Investment Plan for Health (LIPH) to the DOH Regional Office (DOHRO) detailing their planned mobile outreach activities for the year. The Regional FP Coordinator will then summarize the planned outreach activities and will coordinate with the DOH-retained hospitals or medical center, the provincial/city health offices (P/CHO), LGUs and host facility for the implementation of the mobile outreach activities.

TECHNICAL ASSISTANCE PACKAGE

Postpartum Family Planning/Postpartum IUD Supportive Supervision

The purpose of this tool is to have a standardized format for the supportive supervision of postpartum family planning/postpartum IUD (PPFP/PPIUD) service providers who have undergone training in the past six months to 1 year. This tool will be succinct and will follow an outline format as the trainer who is conducting the supportive supervision is expected to have read and mastered the "Guidelines for Conducting Post-Training and On-going Supportive Supervision Visits to PPFP/PPIUD Facilities."

This guide will be divided into the following sections:

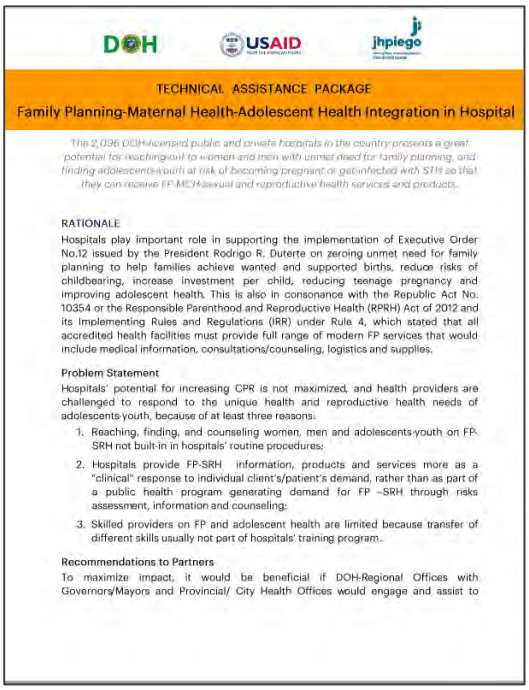
I. Preparation for supportive supervision visit
II. Things to prepare/logistics for the supportive supervision visit
III. Actual conduct of the supportive supervision visit
IV. Evaluation
V. Writing the supportive supervision report and recommendations
VI. Final certification process

I. **Preparation for the supportive supervision visit**

A point person from the Department of Health – Center for Health Development (DOH CHD) and/or Provincial/City Health Office (P/CHO) will communicate with LGUs and identified clinical practice sites. Those service providers who were recently trained must undergo supportive supervision at least three months after the training.

Venue and logistics will be the responsibility of DOH CHD or P/CHO.

Moreover, a month before the supportive supervision, the DOH CHD or P/CHO point person confirms the attendees and sends the **Participant's Accomplishment Report** form (**Annex A**) and gets them back two weeks prior to the supportive supervision. The DOH CHD/P/CHO point person then summarizes the accomplishments of the confirmed participants using the Summary of the Supportive Supervision Participants' Total PPIUD Insertions form (**Annex B**).



TECHNICAL ASSISTANCE PACKAGE

Family Planning-Maternal Health-Adolescent Health Integration in Hospital

The 2,096 DOH-licensed public and private hospitals in the country presents a great potential for reaching-out to women and men with unmet need for family planning, and finding adolescents-youth at risk of becoming pregnant or getting infected with STI so that they can receive FP-MCH-sexual and reproductive health services and products.

RATIONALE

Hospitals play important role in supporting the implementation of Executive Order No.12 issued by the President Rodrigo R. Duterte on zeroing unmet need for family planning to help families achieve wanted and supported births, reduce risks of childbearing, increase investment per child, reducing teenage pregnancy and improving adolescent health. This is also in consonance with the Republic Act No. 10354 or the Responsible Parenthood and Reproductive Health (RPRH) Act of 2012 and its Implementing Rules and Regulations (IRR) under Rule 4, which stated that all accredited health facilities must provide full range of modern FP services that would include medical information, consultations/counseling, logistics and supplies.

Problem Statement

Hospitals' potential for increasing CPR is not maximized, and health providers are challenged to respond to the unique health and reproductive health needs of adolescents-youth, because of at least three reasons:

1. Reaching, finding, and counseling women, men and adolescents-youth on FP-SRH not built-in in hospitals' routine procedures;
2. Hospitals provide FP-SRH information, products and services more as a "clinical" response to individual client's/patient's demand, rather than as part of a public health program generating demand for FP –SRH through risks assessment, information and counseling;
3. Skilled providers on FP and adolescent health are limited because transfer of different skills usually not part of hospitals' training program.

Recommendations to Partners

To maximize impact, it would be beneficial if DOH-Regional Offices with Governors/Mayors and Provincial/ City Health Offices would engage and assist to

TECHNICAL ASSISTANCE PACKAGE

Setting up a Functional Service Delivery Network

I. Background and Rationale

The Local Government Code of 1991 divided the responsibility for health services among all levels of government, with national, provincial/city governments responsible for tertiary and secondary care and smaller city, municipal and *barangay* governments providing primary care. The involvement of three different levels of government in three levels of health care created fragmentation in the overall management of the system. Local and provincial authorities retain considerable autonomy in their interpretation of central policy, and provision of the health services is often subject to local political influence. As a result, the quality of health care varies considerably across the areas in the country.

The existing system continues to challenge the LGUs that have financial, technical, and adaptive limitations. The difficulties are reflected in the health status of the people, for example:

- Estimates of maternal mortality ratio, neonatal mortality rate, and unmet need for modern family planning (FP) of women of reproductive age (WRA) remain high;
- Annual population growth rate remains one of the highest in the region; there is still a big gap in responding to the unmet need of WRA for modern FP information, and services;
- Immunization coverage rate is still low, increasing risks for disease outbreaks;
- Magnitude of TB problem in the Philippines has kept the country among those with high disease burden; and
- Rate of HIV infection among key affected population (KAP) such as men having sex with men (MSM) has lately seen a remarkable increase (UPecon-Health Policy Development Program, 2016).

Meanwhile, performance of select LGUs are still low in terms of availability, access, affordability of basic health care in hard to reach areas and urban poor communities, shortage of professional health providers, and inefficiencies in procurement of health goods and services, among others

TECHNICAL ASSISTANCE PACKAGE

The *Usapan* (Interactive Conversation) Series

I. RATIONALE

Demand-generation activities are conducted by the health providers, but sometimes, services are not immediately available thus clients are not immediately provided with a method they preferred that often resulted to missed opportunities.

One of the demand generation activities that was strengthened during the project life and that link demand generation activities to provision of services of their choice is the client-centered *Usapan* (interactive conversations) session. Through *Usapan*, issues on misinformation and misconception about wide-range family planning (FP) methods and fear of side effects will be further clarified/corrected, while informing on the availability of safe and modern options for family planning. As such, participants' understanding on FP services will be deepened to guide them in choosing freely and perform specific health behaviors that help improve quality of their lives.

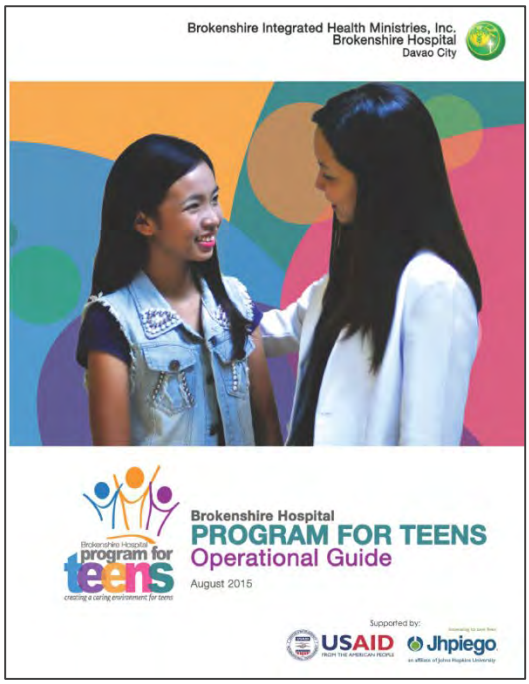
II. THE *USAPAN* (INTERACTIVE CONVERSATION)

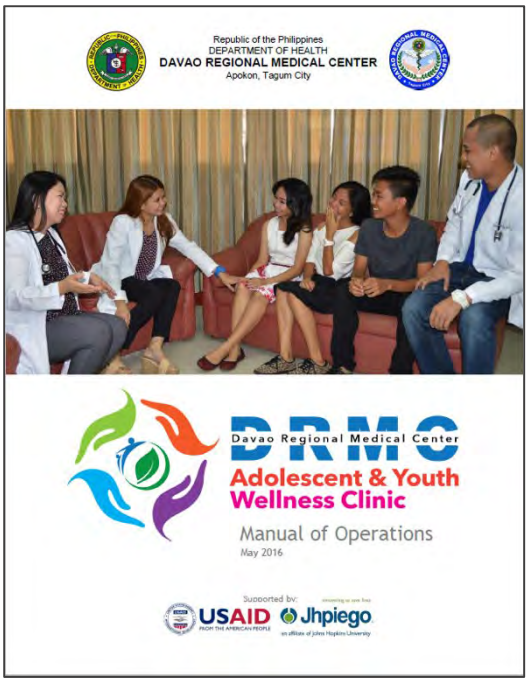
Usapan is a structured process of facilitated interactive group discussion on FP using adult learning approaches, within a supportive environment for a meaningful dialogue. This process combines provision of right amount of information that are practical and emotionally appealing to help clients choose a particular method according to his/her reproductive intention through group interactive discussions followed by one-on-one counseling and then provision of FP services of their choice in one setting.

There are four variants of *Usapan*, namely (i) *Usapang Pwede Pa*, (ii) *Usapang Kuntento Na*, (iii) *Usapang Bagong Maginoo*, and (iv) *Usapang Buntis*. Every *Usapan* session targets 10 up to maximum of 15 participants that were already pre-identified from list of WRA with unmet need, and targeted men according to their reproductive intention (limiting or spacing), and among pregnant women.

It should be noted that *Usapan* session is not a stand-alone activity but rather an integral component of other demand generation activities and service provision such as outreach, mobile clinic, CARAVANs, medical missions, etc.

Products


Brokenshire Integrated Health Ministries, Inc.
Brokenshire Hospital
Davao City
Brokenshire Hospital
PROGRAM FOR TEENS
Operational Guide
August 2015
Supported by:
USAID
Jhpiego


Republic of the Philippines
DEPARTMENT OF HEALTH
DAVAO REGIONAL MEDICAL CENTER
Apokon, Tagum City
DRMC
Davao Regional Medical Center
Adolescent & Youth
Wellness Clinic
Manual of Operations
May 2016
Supported by:
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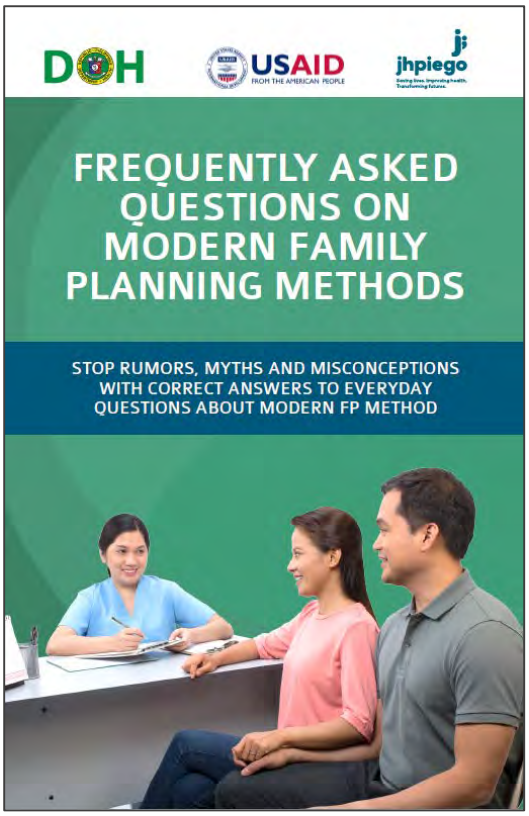
GABAY
SA KAALAMANG
PANGKALUSUGAN
Community Health Workers (CHW) HOME VISIT TOOL KIT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FREQUENTLY ASKED QUESTIONS ON MODERN FAMILY PLANNING METHODS
STOP RUMORS, MYTHS AND MISCONCEPTIONS WITH CORRECT ANSWERS TO EVERYDAY QUESTIONS ABOUT MODERN FP METHOD

Family Planning Competency-Based Training (FBCBT) 2 Postpartum Intrauterine contraceptive Device

Facilitator's Guide

DOH USAID jhpiego

خطبة

SERMON GUIDE ON FAMILY PLANNING

Family Planning Competency-Based Training (FBCBT) 2 Postpartum Intrauterine Contraceptive Device

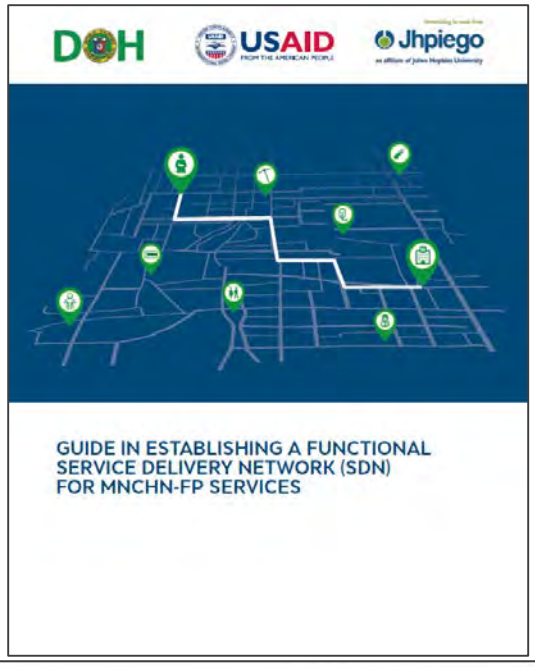
Handbook for Health Service Providers

DOH USAID jhpiego

Rapid HEEADSS

A Guide in Performing HEEADSS (Home; Education and Employment; Eating; Activities; Drugs; Sexuality; Safety; Suicide) Risks Assessment to an Adolescent-Youth Patient in a Rural Health Unit and Barangay Health Station Settings

DOH USAID jhpiego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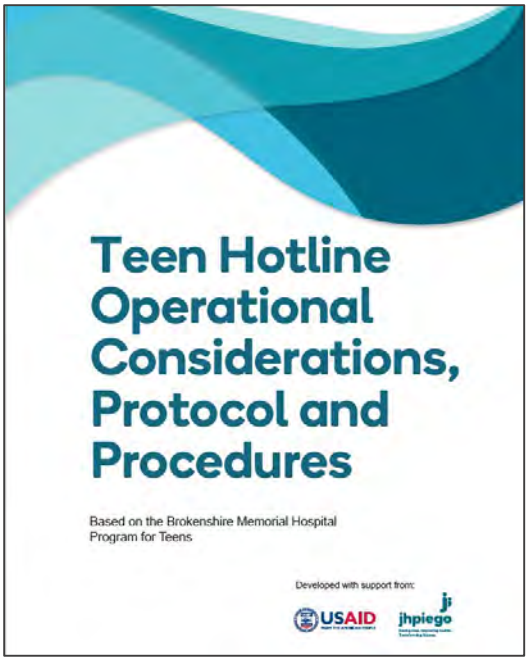
GUIDE IN ESTABLISHING A FUNCTIONAL SERVICE DELIVERY NETWORK (SDN) FOR MNCHN-FP SERVICES


Teen Hotline Operational Considerations, Protocol and Procedures
Based on the Brokenshire Memorial Hospital Program for Teens
Developed with support from:
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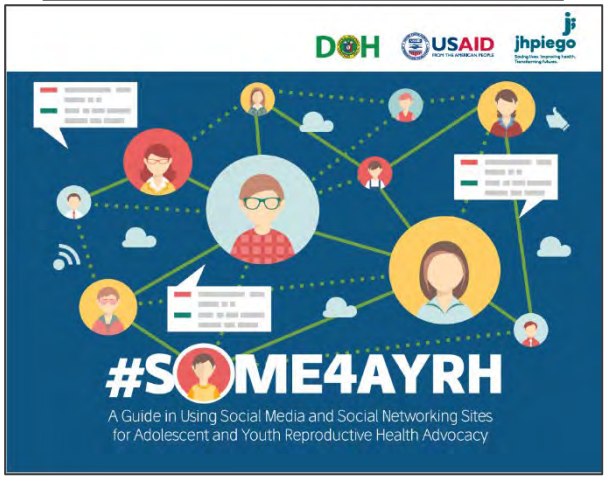
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#SOME4AYRH
A Guide in Using Social Media and Social Networking Sites for Adolescent and Youth Reproductive Health Advocacy

Training Materials