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*Good Practices and Promising Interventions, Technical Series No. 1*

## Models of Family Planning Programs in Selected Philippine Hospitals

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# ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| ARMM | Autonomous Region in Muslim Mindanao |
| AYRH | Adolescent and Youth Reproductive Health |
| BRTTH | Bicol Regional Training and Teaching Hospital |
| BTL-MLLA | Bilateral tubal ligation by mini-laparotomy under local anesthesia |
| CQI | Continuous quality improvement |
| DMPA | Depomedroxyprogesterone acetate |
| DOH | Department of Health |
| DOH RO5 | Regional Office 5, DOH |
| FGD | Focus group discussion |
| FHSIS | Field Health Services Information System |
| FP | Family planning |
| FPCBT1 | Family Planning Competency-based Training, Level 1 |
| FPCBT2 | Family Planning Competency-based Training, Level 2 |
| FP/MNCHN | Family planning/maternal, neonatal, child health and nutrition |
| GIDA | Geographically isolated and disadvantaged area |
| GPPI | Good practices and promising interventions |
| HO | Hospital Order |
| HOMIS | Hospital Operations and Management System |
| IP | Implementing partner |
| IUD | Intrauterine device |
| KII | Key informant interview |
| LAPM | Long-acting permanent methods |
| LARC | Long-acting reversible contraception |
| LCDH | Lipa City District Hospital |
| LGU | Local Government Unit |
| LuzonHealth | Integrated Maternal, Neonatal, Child Health and Nutrition/Family Planning Regional Project in Luzon |
| MIMAROPA | Provinces of: Occidental Mindoro, Oriental Mindoro, Marinduque, Romblon, and Palawan, comprising Region IV-B |
| NBB | No Balance Billing policy |
| OB | Obstetrics |
| OMPH | Oriental Mindoro Provincial Hospital |
| OPD | Outpatient Department |
| P-CARES | PhilHealth Customer Assistance, Relations, and Empowerment Staff |
| PhilHealth | Philippine Health Insurance Corporation |
| PHO | Provincial Health Office |
| PHU | Public Health Unit |

| | |
|---|---|
| PPIUD | Post-partum intrauterine device |
| PSI | Progestin subdermal implant |
| RHU | Rural Health Unit |
| RP/RH | Responsible Parenthood/Reproductive Health |
| RTH | Return-to-hospital claims (claims returned by PhilHealth to the hospital for various deficiencies in documents submitted) |
| TA | Technical assistance |
| TRO | Temporary Restraining Order |
| USAID | U.S. Agency for International Development |
| USG | United States government |

# EXECUTIVE SUMMARY

Family Planning (FP) in Hospitals, a program in the Philippines with the goal to address unmet need for modern family planning methods, uses a systems approach in which hospitals play a key role in increasing demand for FP, providing quality FP services, and creating an enabling environment for family planning and reproductive health (FP/RH). Our documentation of the FP in Hospitals program across three different hospitals and levels of care consistently found that institutionalizing the FP in Hospitals program in these settings reduces unmet need for modern FP methods, particularly long-acting reversible contraception (LARC) and long-acting permanent methods (LAPM).

Our documentation at all three hospitals found that FP in Hospitals as a promising intervention covers a package of interventions with the following main features:

- ***Sustained demand generation at strategic points in the hospital*** – In addition to FP information and counseling sessions, the hospital management and the core team of FP providers supported and instituted the "no missed opportunity" principle by way of orienting and allowing non-FP staff to proactively engage potential FP clients. The core team for FP in Hospitals also established interdepartmental referral protocols.

- ***Quality FP services*** – Collaboration and funding support (e.g., from Department of Health [DOH] Regional Offices, Local Government Unit [LGUs], and the USAID/Philippines project, LuzonHealth) enabled the designation of an FP clinic/bilateral tubal ligation (BTL) room in these hospitals, managed by trained and certified service providers (doctor, nurse/midwives). In addition to the broad range of FP services that other public facilities offer, FP in Hospitals also provides some niche services such as LAPM (specifically bilateral tubal ligation by mini-laparotomy under local anesthesia [BTL-MLLA] and no-scalpel vasectomy) and LARC (progestin subdermal implant [PSI]).

- ***Systems strengthening and institutional capacity building*** – LuzonHealth provided technical assistance (TA) that focused on strengthening the building blocks to sustain FP demand generation and quality services. In particular, they focused on:

    - Training, certification, and Philippine Health Insurance Corporation (PhilHealth) accreditation of doctors, nurses, and midwives to provide quality FP services
    - Training of trainers to expand and scale up training of FP health providers in their respective geographic areas
    - Logistics management support, including stewardship in reporting commodities that are dispensed
    - Helping ensure systematic and timely recording and reporting of FP clients, which allowed FP performance in these hospitals to be accounted for in the DOH Field Health Services Information System (FHSIS) reports
    - Helping advocate for an enabling policy environment, coupled with leadership and governance strengthening
    - Promoting financial sustainability, in the form of TA in facilitating PhilHealth reimbursements, and advocacy and partnerships with the DOH Regional Offices, Provincial Health Offices (PHOs), and LGUs for FP funding and commodities

We documented the implementation of FP in Hospitals in three selected hospitals: 1) Bicol Regional Training and Teaching Hospital (BRTTH), a tertiary, DOH-retained hospital; 2) Oriental Mindoro Provincial Hospital (OMPH), a level 1, provincial government unit-owned hospital model; and 3) Lipa City District Hospital, a level 1

city-owned district hospital. In consultation with LuzonHealth, we selected these hospitals based on performance indicators and improved outcomes after LuzonHealth's interventions. Through qualitative methods (key informant interviews and focus group discussions) and a desk review of available records and reports, we aimed to answer four main learning questions to determine whether FP in Hospitals was a good practice.

### Learning Question 1: To what extent have the following factors contributed to the increased performance in FP? (a) Increased uptake of postpartum FP, (b) Increased completeness of FP performance monitoring

***1.a. Increased uptake of postpartum family planning.*** LuzonHealth reports indicated an increasing trend in the uptake of postpartum family planning, particularly postpartum IUD (PPIUD) at OMPH from October 2016 to September 2017 after LuzonHealth introduced training interventions. BRTTH saw a significant increase in the uptake of bilateral tubal ligation and progestin subdermal implant, the latter specifically after the Supreme Court lifted the temporary restraining order on that method of contraception.

***1.b. Increased completeness of FP performance reporting.*** The *Hospital Operational Guide in Recording and Reporting FP Performance in Hospitals* together with LuzonHealth's intensive training helped hospital staff to synchronize their FP forms and performance reports with the reports from the Field Health Services Information System of their respective provinces. Consequently, the LGUs and the DOH Regional Offices can now regularly obtain FP performance reports from these hospitals.

LuzonHealth also extended TA to the hospitals to use online reporting of their facilities' FP performance. From the online reports, an increasing trend could be seen toward acceptance of LARC and LAPM for 2016–2017. Available data from BRTTH showed an increase in cases of PPIUD from 115 in 2016 to 227 in 2017. OMPH also showed an increasing trend in PPIUD acceptors, from 153 in 2015 to 1,182 in 2017.

### Learning Question 2: Is the intervention effective to reduce unmet need for FP among women who delivered in the hospital?

The reduction of unmet need for FP in the three hospitals cannot be attributed to just one single intervention introduced by LuzonHealth. As articulated by the Theory of Change of the USAID Health Portfolio, three main strategies contributed to the effectiveness of FP in Hospitals as a promising intervention: demand generation, and provision of quality services, both of which are anchored on the third strategy of systems strengthening initiatives.

### Learning Question 3: Were the FP services of the hospital translated into actual FP reimbursements?

According to the three hospitals, FP services for LARC, specifically interval and postpartum IUD and BTL, were reimbursed by PhilHealth, the social insurance arm of the Philippine government. The three hospitals received a total reimbursement of PhP 10,104,000. OMPH received the highest amount (PhP 7,414,000), with BTL being the highest source of PhilHealth reimbursements.

All three hospitals had relatively large amounts of foregone reimbursements for FP services. With respect to methods, BTL had the highest at almost PhP 1,768,000 while PSI had the lowest at PhP 227,000. Foregone reimbursements can be a result of unfiled reimbursements, non-compliance to PhilHealth processing requirements (denied claims), or incomplete documentation to support the claims (return-to-hospital claims). Furthermore, PhilHealth's recent shift to an online system for processing claims has led to delays in the release of reimbursements. This may be resolved as soon as PhilHealth is able to refine its electronic system and as hospitals get accustomed to the new arrangement.

### Learning Question 4: Are PhilHealth reimbursements adequate to finance family planning program operations?

According to the key informants from the three hospitals, PhilHealth reimbursements supported FP activities. In addition, a certain proportion of revenues from PhilHealth reimbursements is usually allocated to service providers and other hospital staff. In the case of PhilHealth reimbursements for FP services, the sharing scheme among the FP service providers and other hospital staff follows the PhilHealth reimbursement policy as well as the standard practice in their respective institutions or LGUs.

However, PhilHealth reimbursements are not sufficient to fully support and sustain the entire FP in Hospitals program, particularly because of the significant amount of foregone reimbursements and delays in the release of approved claims. There are also issues specific to each hospital that affect the sustainability of the FP in Hospitals program. Nonetheless, beyond PhilHealth reimbursements, two out of the three hospital models are able to obtain direct support for their operations from their respective LGUs, generally in the form of staff support and logistics-related needs for the operations of the FP clinics and BTL clinics in the hospital.

### Recommendations

This GPPI documentation focuses on only three hospital models, and technical assistance from the three regional family planning/maternal, neonatal, child health and nutrition (FP/MNCHN) implementing partners (IPs) was limited to 10 percent of the 900 hospitals in the Philippines. As a promising intervention that has the potential to significantly address unmet need, FP in Hospitals could be replicated at a national scale, while addressing operational and funding bottlenecks and reducing variations in program implementation. Specific recommendations are as follows:

- *For DOH Central and Regional Offices:*
    - Provide funding support for scale-up of FP in Hospitals nationwide. This can be achieved by including a budget for FP in Hospitals in the Costed Implementation Plan of the FP program.
    - Increase DOH/Regional Office sub-allotments to DOH-retained hospitals to support FP in Hospitals.
    - Regional Offices should advocate with the DOH Central Office to retain augmentation funds for FP initiatives in hospitals.
    - Ensure adequate and timely provision of FP commodities and supplies at the implementing levels, particularly LGU-operated hospital facilities.
    - Review and amend guidelines on PHUs in tertiary-level hospitals so that PHUs become a prime vehicle for integrating the FP program in these settings.
- *For LGUs:*
    - Include budgets in the Provincial Work and Financial plans to support FP in Hospitals at the provincial and district levels.
    - Continued support for counterpart funding of activities related to FP itinerant/outreach activities, especially in geographically isolated and disadvantaged areas (GIDAs).
    - Ensure regular staffing of FP referral hospitals with trained doctors to perform LAPM services.
    - Conduct a performance assessment in the delivery of FP services/programs in their provincial and district hospitals to determine their contribution in reducing unmet need for modern family planning in the province and to identify the gaps and operational challenges that needs to be resolved.
- *For hospital management teams:*
    - Continue to improve and scale up promising interventions of the FP in Hospitals program, such as: demand generation activities, provision of quality FP services, training and certification for FP competencies, systematic and timely recording and reporting of FP clients, and logistics management.

    - Address bottlenecks and institute continuous quality improvement (CQI) measures to facilitate PhilHealth reimbursements and mitigate foregone reimbursements.
    - Prepare annual work and financial plans for FP activities in hospitals in close coordination with the DOH Regional Offices (for DOH-retained hospitals) and LGUs and PHOs (for provincial and district-level hospitals).
- *For PhilHealth:*
    - Further study and review the factors contributing to foregone reimbursements on FP claims in hospitals (i.e. BTL, IUD) and determine how to help hospital facilities to mitigate this problem.
    - Review existing guidelines on PhilHealth claims requirements for reimbursements.
    - Expedite and facilitate the release of approved reimbursements in government hospital facilities using the new online system. Where feasible, we further recommend that PhilHealth deploy additional staff in transitioning from manual to online e-claims processing.
    - Local PhilHealth staff (based at the province/district level) should provide feedback to the hospitals on the status of their PhilHealth claims to expedite the processing of reimbursements.
    - Review guidelines on PSI as second case rate for postpartum women of reproductive age.
- *For USAID's implementing partners:*
    - Continue to advocate for DOH and other key players to replicate and nationally scale up of FP in Hospitals.
    - Advocate to prioritize funding for FP in Hospitals at national and local levels.
    - Provide appropriate TA to improve, sustain, and scale up FP in Hospitals, especially in priority areas with high unmet need for FP.
    - Provide TA to review the implementation of the DOH Guideline on FP in Hospitals and to provide recommendations through the FP/AYRH IPs: ReachHealth and FP in the Autonomous Region in Muslim Mindanao (ARMM).
    - Relevant IPs (ReachHealth, FP in ARMM, and HealthProtect) should collaborate with DOH/Regional Offices, DOH-retained hospitals, LGUs, and PhilHealth in addressing operational bottlenecks on PhilHealth claims.
    - Through the IP for FP in ARMM, provide TA to the DOH ARMM on conducting a baseline assessment of FP in Hospitals in the region.
- *For further research:*
    - Expand the documentation to more hospitals with FP programs to determine their relevance, processes, and outcomes in reducing unmet need for FP
    - Determine the extent and magnitude of problems encountered regarding PhilHealth reimbursements for claims filed by FP Programs in hospitals
    - Determine factors contributing to the decreasing uptake of short-acting FP methods and increasing acceptance of long-acting FP methods in hospitals, including the availability of FP commodities and methods in hospitals
    - Determine the number and proportion of hospital deliveries where mothers were advised to return to the hospital after discharge to avail of PSI, and the reasons for this practice
    - Inventory and analysis of LGU ordinances and resolutions supporting FP Programs in hospitals

# 1. BACKGROUND

## 1.1 GOOD PRACTICES AND PROMISING INTERVENTIONS

The Collaborating, Learning and Adapting for Improved Health (CLAimHealth) activity provides monitoring, evaluation, and learning support to the U.S. Agency for International Development (USAID)/Philippines' Health Portfolio (2017–2023), which seeks to improve health outcomes for underserved Filipinos. CLAimHealth, one of twelve activities in USAID's Health Portfolio, generates and uses high quality monitoring and evaluation data, documents good practices and promising interventions (GPPIs), and conducts implementation research.

With respect to GPPI, a **good practice** is defined as an intervention that, through a rigorous process of peer review and evaluation, has been shown to clearly link positive effects to the practice in a specific setting and can be replicated. A **promising intervention**, on the other hand, has strong quantitative and qualitative data showing positive outcome(s) but does not yet have enough research or replication to support generalizable positive health outcomes. The context, process, and outcomes of these interventions should be assessed according to a standard set of criteria, namely: relevance, community participation, stakeholder collaboration, ethical soundness, replicability, effectiveness, efficiency, and sustainability.[1] Their effectiveness should be linked to the achievement of goals of the USAID Office of Health (OH) and the Health Portfolio's high-level indicators.

For the duration of its contract (2018–2022), CLAimHealth will identify and document 20 potential GPPIs of current and future USAID OH implementing partners (IPs). These documentations are designed to validate whether the recommended interventions are indeed GPPIs that should be replicated and scaled up at the national level. This report is the first of a technical series of selected GPPIs documented over the life of the Health Portfolio.

## 1.2 GOOD PRACTICES AND PROMISING INTERVENTIONS FOR FAMILY PLANNING AND ADOLESCENT AND YOUTH REPRODUCTIVE HEALTH

For Years 1-2 of its USAID contract, CLAimHealth selected five potential GPPIs from: (1) the three Family Planning/Maternal, Neonatal, Child Health & Nutrition (FP/MNCHN) regional IPs, i.e., LuzonHealth, VisayasHealth, and MindanaoHealth, whose cooperative agreements with USAID ended in December 2018; and (2) the Integrated Midwives Association of the Philippines, whose activity on Community Maternal, Neonatal, Child Health & Nutrition Scaleup (CMSU2) will end in 2019.

From 2013 until their closure, the three FP/MNCH IPs extended technical assistance (TA) to enhance the capacity of the Department of Health (DOH), local government units (LGUs), and other partners to develop innovative strategies and tools in providing quality FP/MNCH information and services, including adolescent youth and reproductive health (AYRH) in communities, health centers, and hospitals in U.S. government (USG)-assisted areas. The IPs also provided TA to establish or enhance service delivery networks and generate demand, and for monitoring and evaluation, policy development, logistics and supply management, and financing,

[1] Ng E, de Colombani P. Framework for Selecting Best Practices in Public Health: A Systematic Literature Review. J Public Health Res 2015; 4:577. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4693338/

especially on procedures for accreditation and reimbursements from the Philippine Health Insurance Corporation (PhilHealth), the social insurance arm of the Philippine government.

These efforts have increased the number of accredited health providers and facilities with Family Planning Competency-Based Training Level 1 (FPCBT1) and Level 2 (FPCBT2) and led to improved uptake of modern FP methods, particularly long-acting reversible and permanent methods among the underserved populations in USG-assisted sites. Partners from the DOH regional offices, provincial and city health offices, and LGUs have expressed their intentions to sustain these gains. However, these good practices have yet to be scaled up at the national level. Two new USAID IPs, ReachHealth and FP in the Autonomous Region in Muslim Mindanao (ARMM), will provide TA on FP/AYRH, helping to fill this gap and continue the unfinished work.

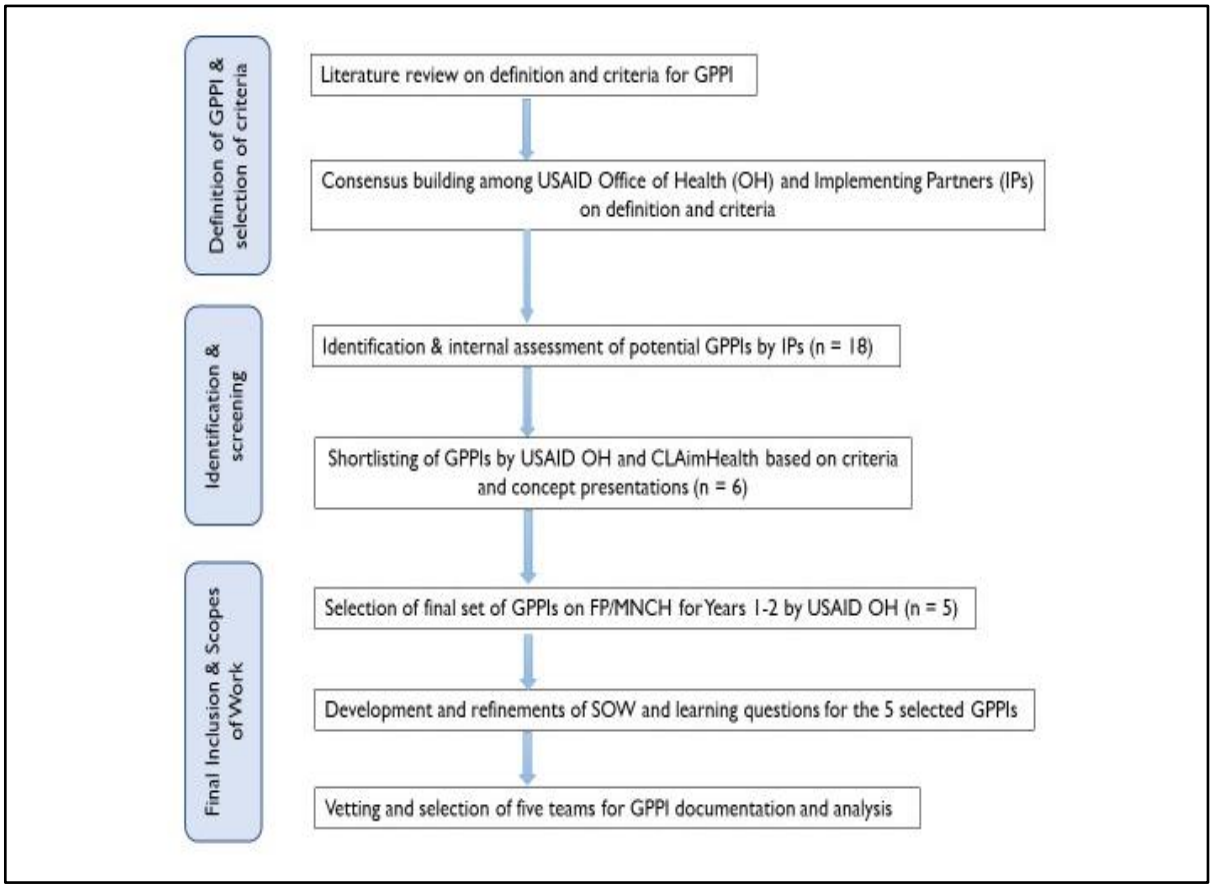
The three outgoing FP/MNCHN IPs helped identify 18 potential GPPIs on FP/AYRH by filling out a self-assessment form containing the criteria for best practices. Further consultations with the IPs and USAID OH pruned this number to six, and learning questions were developed for documentation. The scopes of work to document each GPPI were subsequently developed and approved by USAID OH. In late September 2018 through November 2018, three teams of consultants conducted field work and analyzed data for the following GPPIs: (1) FP in Hospitals, (2) FP Program for Young Parents, and (3) FP Days.

In December 2018, two other teams began work, expected to be completed in Quarter 2 of Year 2, to document the fourth and fifth GPPIs. These GPPIs are:

- Improving FP/MNCHN access for underserved populations in geographically isolated and disadvantaged areas (GIDAs) through service delivery networks (SDNs) in the provinces of Zamboanga del Sur and Sultan Kudarat, and
- Critical contributions of USAID to the journey towards self-reliance of the Integrated Midwives Association of the Philippines

Figure 1 shows the selection process for the five GPPIs for documentation in Years 1-2 that will be published as GPPI Technical Series Nos. 1–5.

### FIGURE 1. SELECTION PROCESS FOR THE FIRST FIVE GOOD PRACTICES AND PROMISING INTERVENTIONS




This first report of the technical series documents the GPPI, Family Planning in Hospitals. This report describes how TA from three local USAID IPs has helped reduce unmet need among women who gave birth in three public hospitals in the Philippines representing three levels of care: a DOH-retained/regional hospital, a provincial hospital, and a district hospital. This report also examines the effects of the FP in Hospitals program as well as the PhilHealth reimbursements and other sources of FP revenue on the hospitals' self-reliance and sustainability.

Specifically, the objective of this report is to document the sustainability mechanisms for the identified GPPI, FP in Hospitals, in the three hospital models. The documentation was guided by the following learning questions:

1) To what extent have the following factors contributed to the increased performance of FP services in terms of:
    a) Increased uptake of postpartum FP services?
    b) Completeness in FP performance reporting?
2) Are the strategies and interventions for the FP in Hospitals program effective in reducing unmet need for FP?
3) Did hospitals reimbursed by PhilHealth provide long-acting and reversible contraceptives (LARC) and long-acting permanent methods (LAPM) for FP?

a) How much was reimbursed by PhilHealth? How much was foregone by the hospitals? Why were some FP services reimbursed while others were foregone?

4) Are the PhilHealth reimbursements adequate to finance the FP program operations?

a) How were the PhilHealth reimbursements utilized by the hospitals?
b) Were these used to support other family health programs and/or other hospital needs?

# 2. OVERVIEW OF THE FAMILY PLANNING IN HOSPITALS PROGRAM

In line with the FOURmula One Plus strategy and Universal Health Care framework of the Department of Health (DOH), the National Family Planning Program of the Philippines aims to increase the modern contraceptive prevalence rate among all women to 30 percent by 2022, and to reduce the unmet need for modern FP from 17 percent in 2017[2] to 8 percent by 2022. Other key policy drivers are the Responsible Parenthood and Reproductive Health Act of 2012 (Republic Act No. 10354), which enjoins all accredited public health facilities to provide a full range of modern family planning methods, and Executive Order (EO) No. 12, s. 2017, which mandates a goal of zero unmet need for FP and funds for the implementation of Republic Act 10354.

To achieve its objectives, one of the four key components of the National Family Planning Program of the DOH is the provision of family planning in hospitals and other health facilities. Thus, the IPs prioritized providing the following TA to the hospitals: (1) baseline and situation analysis, (2) development of hospital action plans, (3) training of FP personnel, (4) demand generation, (5) service delivery, (6) logistics management, (7) recording and reporting, (8) monitoring and evaluation, (9) financing by obtaining PhilHealth accreditation for FP Package of Support, and (10) cultivating partnerships through service delivery networks.[3]

Local IPs LuzonHealth, VisayasHealth, and MindanaoHealth provided TA to over 90 public hospitals (out of 900 throughout the country) to establish or enhance FP programs. The public hospitals were selected based on consultations with key stakeholders, such as DOH Regional Offices and Provincial/City Health Offices.

The IPs used the following strategies in their work to assist hospitals: (1) secure buy-in and support from key stakeholders in the project areas (i.e., Regional Office management and FP coordinators; provincial/city health officials including their technical staff; LGU officials); (2) provide the selected hospitals with a pre-assessment checklist to enable them to conduct a self-assessment; (3) develop action plans to address the identified gaps in establishing a functional FP service/program in the hospital setting.

The IPs then planned to provide TA for the following interventions: develop hospital policy instruments; identify the core management team for FP in the hospital; strengthen capacity on FPCBT1 (counseling and introduction of various FP methods, mostly short-acting contraceptives), and FPCBT2, which covers skills building on LARC such as interval and post-partum IUD interval, progestin subdermal implant (PSI), and LAPM such as bilateral tubal ligation by mini-laparotomy under local anesthesia (BTL-MLLA) and no-scalpel vasectomy. TA also included

[2] Philippine Statistics Authority (PSA) and ICF. 2018. Philippines National Demographic and Health Survey 2017. Quezon City, Philippines, and Rockville, Maryland, USA: PSA and ICF.

[3] A service delivery network, as defined by the Responsible Parenthood and Reproductive Health (RPRH) law, is a "network of health facilities and providers within the province or city-wide health system, offering core packages of health care services in an integrated and coordinated manner."

post-training monitoring and evaluation to ensure that trained service providers can obtain appropriate certification of competencies for PhilHealth provider accreditation.

The IPs also introduced enabling systems through the development of hospital protocols for interdepartmental linkages and referrals between lower-level facilities and the hospital. Workshops on demand generation for FP in Hospitals as well as *Usapan*[4] series were instituted to ensure continuous promotion and health education of clients about family planning. IPs also helped develop guidelines such as the *FP in the Hospital: Operational Guide for Recording and Reporting*[5] to establish procedures for recording, reporting, and maintaining records of FP services in the hospital facilities. Logistics management was streamlined through the development of a logistics management recording and reporting tool.

Funding of FP in Hospitals is being sustained through PhilHealth reimbursements, DOH sub-allotments, and other sources of funds from the LGUs. The DOH-retained hospitals and the LGU-operated hospitals obtain reimbursements for FP services directly from PhilHealth and can utilize the revenue for FP programs and other related hospital needs and activities.

A DOH and USAID/Philippines report on FP in Hospitals,[6] as well as several reports from the three IPs, described the implementation of FP in Hospitals in different provinces and documented that the uptake of modern FP in these facilities, especially LARC and LAPM, has contributed to the reduction of unmet need for FP.

Despite these gains, the mechanisms for increasing the sustainability of FP in Hospitals have not been well documented. One key to sustainability is to keep the funding stream for FP services viable. Hospitals with an ample share of revenues from PhilHealth reimbursements appear to have better performing and committed FP service providers as well as sufficient resources for operations and other family health activities. Thus, the FP in Hospitals program in these settings is more likely to become self-reliant and sustainable.

# 3. METHODS

In consultation with LuzonHealth, the IP that recommended FP in Hospitals as a potential GPPI, three hospitals were selected for documentation: Bicol Regional Training and Teaching Hospital (BRTTH), the Oriental Mindoro Provincial Hospital (OMPH), and Lipa City District Hospital (LCDH), representing the regional, provincial, and district levels of service. The three hospitals were chosen because they were among the priority public hospitals that were able to accomplish a set of criteria based on LuzonHealth's performance indicators and showed improved outcomes after the introduction of the project interventions.

Qualitative methods used for data collection included key informant interviews (KIIs), focus group discussions (FGDs), and observations. Key informants within each hospital included the chief of hospitals, FP focal person, FP service providers, and PhilHealth Customer Assistance, Relations and Empowerment Staff (CARES). The non-

[4] *"Usapan"* is a Pilipino term that refers to a "discussion." The Usapan sessions facilitated by the regional IPs are either facility-based or outreach group discussions on FP and safe motherhood that end with counseling and service provision. Source: LuzonHealth technical brief. Promoting Family Planning Uptake through Enhanced Usapan. Available at: https://www.doh.gov.ph/sites/default/files/basic-page/Promoting%20Family%20Planning%20Uptake%20through%20Enhanced%20Usapan.pdf

[5] Available at: https://www.doh.gov.ph/sites/default/files/basic-page/Family%20Planning%20in%20the%20Hospital%20Operational%20Guide%20for%20Recording%20%26%20Reporting.pdf.

[6] DOH and USAID/Philippines. *Family Planning in Hospitals: A Case for Localization, Integration, and Cohesion. A compilation of USAID Lessons and Experiences in the Philippines*. 2017.

hospital key informants included the DOH FP Coordinator, Provincial Health Officer, and Provincial Health Office technical lead or FP Coordinator.

FGDs were conducted among FP clients either from the outpatient department or postpartum patients admitted in the hospital. In addition, data collectors observed how health services were provided, such as sharing of FP information and counseling. At the regional hospital, an ethical clearance from the institutional ethical review board was sought prior to documentation. In addition, prior to the KIIs and FGDs, written informed consent was obtained from the informants and respondents. Interview and observation guides were used for the KIIs, FGDs, and observations (refer to Annex A). In addition, desk reviews and content analysis of relevant documents and technical reports from the IPs and model hospitals were conducted.

There were limitations in the data collection, especially about financing and PhilHealth reimbursements, due to the Data Privacy Act of 2012. We could not access hospital records regarding FP financing and PhilHealth reimbursement and instead relied mainly on information gathered from the KIIs and from data LuzonHealth shared on foregone reimbursements.

# 4. FINDINGS AND ANALYSIS

This section has two parts. The first part presents the systems approach that LuzonHealth used to transform FP into a program rather than just a unit in the hospitals that provides FP services. The second part describes hospitals' profiles and key intervention areas that were incorporated into their facilities.

## 4.1 LUZONHEALTH'S SYSTEMS APPROACH

LuzonHealth applied a systems approach in providing TA to the three hospitals selected for analysis in this report to transform their FP services into FP programs. In a systems approach, each building block or instrument of the health system, i.e., leadership and governance, human resources, information system, financing, service delivery, and access to medicine and technology, must have adequate support to operate and sustain the FP program in the hospitals. Table 1 summarizes the TA that LuzonHealth provided to the three hospitals.

**TABLE 1. LUZONHEALTH'S TA TO HOSPITALS**

| INSTRUMENT | TECHNICAL ASSISTANCE PROVIDED |
|---|---|
| Leadership and governance | Support to create an FP management team and institutionalize an FP program in the hospital |
| Health and human resources | Support to conduct a baseline assessment of health and human resources capacity, which found inadequate staffing for FP service provision. LuzonHealth advocated for a dedicated FP point person through an official hospital order. |
| Health information system | Assistance to establish an efficient recording and reporting system. Through a dialogue among the hospital, the Provincial Health Office, and the DOH Regional Office, LuzonHealth facilitated the reporting of the hospital FP performance in the field health services information system (FHSIS). |

| | |
|---|---|
| Health financing | Support to improve FP reimbursements from PhilHealth. LuzonHealth also advocated for budget allocation for complications associated with FP methods. |
| Service delivery | Support to provide a complete range of FP services. LuzonHealth advocated for the establishment of a dedicated FP clinic. For hospitals with the capacity to perform BTL and with a large number of clients, LuzonHealth lobbied for a specially designated room for BTL. |
| Access to medicines and technology | Support to establish a logistics management system. |

## 4.2 THE THREE HOSPITAL MODELS

This section describes the FP performance of the three model hospitals that were selected for documentation:

- BRTTH, a tertiary, DOH-retained hospital;
- OMPH, a level 1, government-owned provincial hospital; and
- LCDH, a level 1, city-owned district hospital.

After a brief profile of each hospital, the documentation results for the key intervention areas will be presented, namely: (1) capacity building, (2) continuous demand generation activities in strategic points, (3) FP performance reporting, (4) FP services, and (5) sustainability mechanisms.

### 4.2.1 Bicol Regional Training and Teaching Hospital: A Tertiary-level, DOH-retained Hospital Model


*The Bicol Regional Training and Teaching Hospital in Legazpi City, Albay*

The Bicol Region (Region V) is composed of six provinces: Albay, Camarines Norte, Camarines Sur, Sorsogon, Catanduanes, and Masbate. The regional center is Legazpi City in Albay province, where the Bicol Regional

Training and Teaching Hospital (BRTTH) is located. Another DOH-retained hospital, the Bicol Medical Center, is in Naga City.


*Map of Bicol region*

BRTTH is a DOH-licensed and PhilHealth-accredited tertiary-level hospital that serves as an apex referral facility for the entire region.

The hospital has 250 beds but its daily operations exceed capacity at 480–500 beds. The hospital has six departments: Obstetrics and Gynecology, Pediatrics, Internal Medicine, Family Medicine, Surgery, and Anesthesia. The Philippine Health Research Ethics Board has accredited the BRTTH's Research Ethics Review Committee as a Level III Ethics Review Committee.

The Bicol region has a total population of 6,266,653.[7] Relevant regional health indicators are included in Table 2 below.

**TABLE 2. HEALTH INDICATORS IN THE BICOL REGION, 2017**

| | |
|---|---|
| Live births | 117,373 |
| Infant mortality rate | 6.86 per 1,000 live births |
| Maternal mortality rate | 78.38 per 100,000 live births |
| Facility-based delivery | 88.4% |
| Contraceptive prevalence rate | 63.0% |
| Unmet need* | 21.3% |

*Sources: DOH FHSIS, 2017, *NDHS 2017*

In 1990, BRTTH offered FP services in the form of commodity-based methods under the Department of Obstetrics (OB). In 2003, the OB Department also mobilized itinerant teams to conduct BTL but under spinal anesthesia. However, from 2007–2012, the hospital's FP services for the commodity-based methods and BTL were interrupted for the following reasons: (1) inadequate number of health providers for LAPM; (2) absence of certified trainers for FPCBT1 and FPCBT2 Levels 1 and 2; (3) absence of a dedicated BTL room and irregular schedule for FP advocacy activities; (4) no budget allocation for FP services and program; (5) absence of regular and permanent staff specifically designated for FP services; and (6) absence of a standard reporting and recording system.

[7] Field Health Service Information System: Annual Report 2017. Epidemiology Bureau, Department of Health. Available at: https://www.doh.gov.ph/sites/default/files/publications/2017_FHSIS_Final_0.pdf

In 2012, BRTTH continued work initiated by a USAID-supported initiative, Private Sector Mobilization for Family Health (PRISM), which introduced BTL-MLLA in the OB Department and eventually started itinerant services using the BTL-MLLA method. In 2013, the BRTTH Public Health Unit (PHU) included FP activities in its operational budget through sub-allotments from the DOH Regional Office V (RO5). To ensure that FP services would be sustained, in 2014 RO5 supported the establishment of a dedicated BTL room, managed by one doctor and a nurse. RO5 eventually recognized BRTTH as an FP service provider and training institution, enabling BRTTH to then strengthen the capacity of most FP service providers in the entire region.

Following the DOH's issuance of the Guideline in Setting up FP in Hospitals in 2014, LuzonHealth formally engaged DOH RO5 and the BRTTH Chief of Hospital in the same year to establish FP in Hospitals at the BRTTH. LuzonHealth helped conduct a pre-workshop assessment to determine the hospital's capacities to provide a broad range of FP services and identify gaps in service provision. LuzonHealth then introduced three major activities as part of its initial package of TA to the hospital: (1) a two-day consultative and planning workshop to establish FP in Hospitals, where participating hospital staff developed action plans to address the gaps; (2) a consultative and planning workshop on FP in the Hospital Recording and Reporting System; and (3) a learning workshop on demand generation for FP in Hospitals.

The next section describes the results of LuzonHealth's interventions.

## Key Intervention Areas

### *A. Capacity building*

In 2014, LuzonHealth, in partnership with DOH RO5 and the Bicol University College of Medicine, assisted BRTTH to build the FP capacity of health service providers from the provinces of Albay, Sorsogon, Catanduanes, and Masbate. In 2017, BRTTH expanded the network of FP providers in Region V by implementing more training activities. As a certified FP training institution in the region, BRTTH conducted eight batches of trainings for the FPCBT1 course, reaching 199 nurses and midwives. BRTTH also conducted eight batches of training for 30 physicians on FPCBT2. In addition, 18 health service providers (doctors, nurses, and midwives) received FPCBT2 PPIUD training. Table 3 shows the pool of certified trainers in BRTTH in 2018.

**TABLE 3. NUMBER OF CERTIFIED TRAINERS IN BRTTH, 2018**

| NUMBER OF CERTIFIED TRAINERS | FP TRAINING COURSE |
|---|---|
| 7 OB-Gynecology specialists/residents | FPCBT2 BTL-MLLA, Basic FP e-Course for Physicians |
| 4 OB-Gynecology residents and 1 nurse | FPCBT2 PPIUD |
| 2 Nurses | FPCBT1 |

*Source: BRTTH FP unit*

To date, BRTTH has the following number of certified FP service and information providers:

- Thirty FPCBT1-trained and certified midwives and nurses
- Eighteen OB consultants and residents trained and certified in BTL-MLLA
- Ten PPIUD-trained and certified OB residents
- Four trained *Usapan* facilitators (nurses and midwives).

Despite the number of FPCBT1 and FPCBT2-trained BRTTH health providers, the staff found it challenging to provide FP services to all women clients of the hospital because clients may be at any of several different hospital service points for care.

To capture all potential clients at the different hospital service points, the PHU staff recommended to the Chief of the Medical Professional Staff that orientation on the FP program should involve the other hospital personnel in these units. Hence, an orientation was conducted for the non-medical, non-allied health professional support staff (e.g., administrative staff, engineering and maintenance, housekeeping/utility, security, groundsmen) and other ancillary departments about the availability of FP services in the PHU of the hospital. The orientation of hospital personnel contributed to a more systematic and strategic approach to the provision of FP information and some assistance to potential clients needing family planning services. Now, clients at different service points are told where to go for FP services.

### *B. Continuous demand-generation activities at strategic points*

*Interview of clients who received postpartum FP methods.*

Demand generation activities were intensified in August 2017 as part of the BRTTH's commitment to attain zero unmet need. To enhance the skills of hospital workers in raising the demand for FP among clients in the different service units of the hospital, LuzonHealth conducted a *Learning Workshop on Demand Generation for FP in the Hospital's In-Reach Activities* in September 2017. The hospital subsequently developed a comprehensive plan for the hospital's In-Reach demand generation (within the hospital), building on existing efforts to promote FP services, especially among postpartum women. The plan included strengthening of internal referral and information, education, and communications (IEC) activities for FP within the hospital. The process enabled the designation of staff trained on FPCBT1 in different departments (e.g. OB-Gynecology Department, Outpatient Department [OPD]) to expand contact points among women and couples of reproductive age. From Monday to Saturday, demand-generation activities are conducted at various hospital points. For the clients in the OPD, demand generation is conducted at the BRTTH PHU where the FP clinic is situated. For admitted patients (e.g., postpartum clients), FP information is provided in the OB wards.

The number of clients receiving FP information, counseling, and services increased considerably from October 2016–June 2017. As of June 2017, 7,849 clients received FP information: 76 percent of these clients were reached at the OPD; 15 percent at the OB ward; and 9 percent at the labor and BTL rooms. Of the clients who received FP information, 2,402 (31 percent) also received related counseling and 1,932 (25 percent) accepted an FP modern method. The remaining clients, most of whom were postpartum patients, were referred back to the RHUs, either to continue with lactational amenorrhea method or to consider other modern FP methods.

### *C. FP performance reporting*

In 2017, LuzonHealth held a two-day training workshop for BRTTH on FP in Hospitals to build staff capacity on the FP recording and reporting system. Participants received a copy of *The FP in Hospital Operational Guide in*

*Recording and Reporting FP Performance in Hospitals,* developed by LuzonHealth, which provides details and instructions on proper recording and reporting of FP clients receiving services from hospitals. The workshop also provided an opportunity for participants to synchronize BRTTH forms with the existing FHSIS of the province of Albay. The guide likewise allowed the FP service providers to capture FP performance, from generating the list of potential FP clients to actual service utilization, tracking of continuing services, and preparation of FHSIS reports (i.e., Monthly Form 1 for Family Planning [M1], Annual Form 1 for Family Planning [A1], and Annual FP Statistics Report). BRTTH submits reports to the different PHOs for integration into the FHSIS. The Development Management Officers and staff members of the PHO and City Health Office conduct monitoring visits to validate the reports and evaluate the performance of the hospital's FP programs. The monitoring team used the monitoring tool that LuzonHealth developed to track hospital performance.

The recording and reporting system also includes logistics recording, which covers daily stock recording, daily dispensing, and daily issuance recording. This enabled the hospital staff to monitor the inventory, determine the monthly stock balance, and develop appropriate plans. Hospital staff members were also trained on the use of the Logistics Management Recording and Tool.

### *D. Provision of FP services*

After LuzonHealth provided TA on the FP training courses (FPCBT Levels 1&2), BRTTH began offering a broad range of modern FP services, particularly postpartum and interval BTL-MLLA, postpartum and interval PPIUD, PSI, and short-acting methods. The FP staff also teach clients about natural FP methods for those who prefer this.

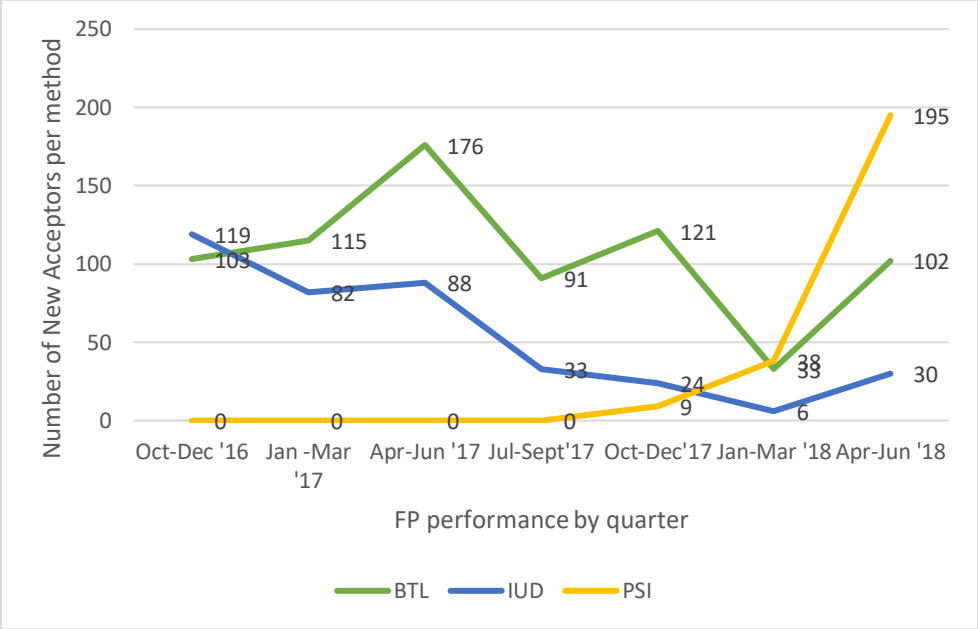
> *"Everything is being delivered at the Public Health Unit. FP is scheduled every day including Saturdays. We also serve in the delivery room, OB ward, PhilHealth wards, and pay ward. Our strategy is to train almost all the nurses here inside the hospital who are assigned in the different areas. They refer to us if they would identify clients with unmet need. All points of contact are being encouraged to identify clients including "bantays" [patient's watcher]."*
>
> - Nurse in the FP unit, BRTTH

BRTTH has a fully operational outpatient BTL room. Attending OB specialists are on call for BTL services while residents regularly rotate and are also on call. This dedicated facility was established due to difficulties in booking the operating room that was also being used for many other daily surgeries.

Figure 2 shows the number of new acceptors for permanent and long-acting FP methods. BTLs had the most in 2017, followed by IUDs and PSIs. From January to June 2018, new acceptors continued for the three methods. PSI, however, had the highest number of new acceptors — 223 — because the Supreme Court lifted its temporary restraining order on that method in November 2017.[8] On the other hand, as the PSI and BTL became more widely available, more clients opted for these rather than the IUD.

[8] In June 17, 2015, the Philippine Supreme Court issued a temporary restraining order from *(1) granting any and all pending application for reproductive products and supplies, including contraceptive drugs and devices; and (2) procuring, selling, distributing, dispensing, or administering, advertising and promoting the hormonal contraceptive Implanon and Implanon NXT.* The TRO was in response to a series of opposition to all 77 contraceptives (with FDA certifications and contraceptives for recertification) filed by the Alliance for Family Foundation (ALFI) in 2014. The TRO lasted for two years after a series of motions from ALFI. the DOH, and the Food and Drug Administration (FDA). The Supreme Court lifted the TRO in November 2017 following FDA compliance on the certification and recertification of contraceptive products.

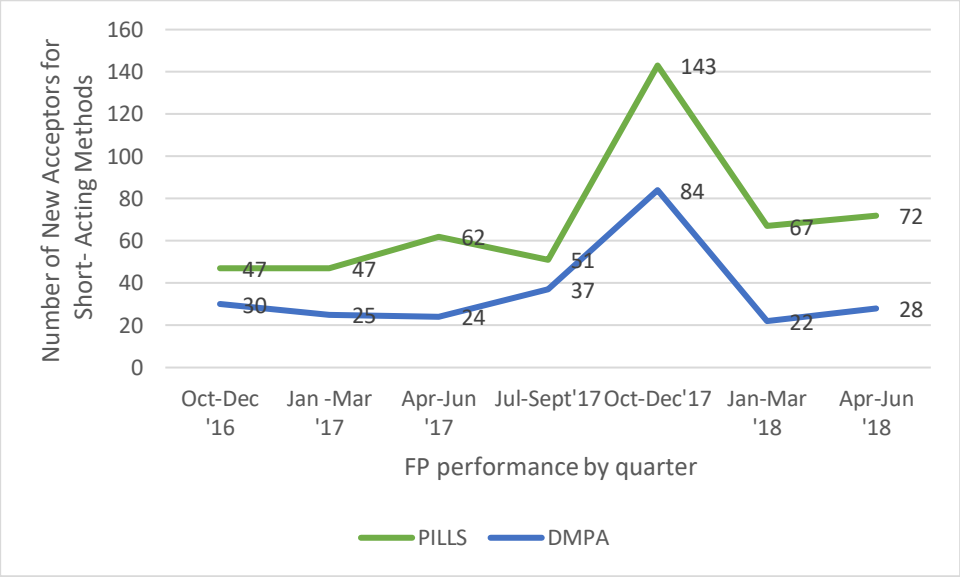
**FIGURE 2. NUMBER OF NEW ACCEPTORS, LONG-ACTING REVERSIBLE CONTRACEPTIVES AND PERMANENT METHODS IN BRTTH, OCTOBER 2016 AND JUNE 2018**




*Source: LuzonHealth FP in Hospital records, 2018*

Figure 3 shows the number of new acceptors for short-acting FP methods, depomedroxyprogesterone acetate (DMPA) injections and pills, for the same periods. The use of DMPA and pills decreased in 2018 because of the availability of PSI in late 2017. In addition, BRTTH focused its demand-generation efforts on LARC and LAPM.

**FIGURE 3. NUMBER OF NEW ACCEPTORS FOR PILLS AND DMPA IN BRTTH, OCTOBER 2016 – JUNE 2018**




*Source: LuzonHealth FP in Hospital records, 2018.*

In addition to the hospital's FP activities, BRTTH's PHU conducts quarterly FP outreach missions to the different provinces in Bicol. This activity is funded through a budget allocation from the PHU. The requesting LGU subsidizes the food and accommodation of the outreach team. This activity, which is conducted quarterly to reach potential clients in GIDAs in the other provinces of the region, can also be considered as a good practice. The arrangement of sharing resources between the BRTTH hospital and the LGU is an example of a good partnership model in the region.

### *E. Sustainability mechanisms*

Sustaining the FP program and services at the BRTTH requires multiple funding sources and/or TA from key players such as DOH RO5, BRTTH, and LuzonHealth. To increase the likelihood of sustainability, BRTTH, in collaboration with the DOH and LuzonHealth, undertook the following interventions:

1) Issuing appropriate hospital policies supporting the FP program;
2) Integrating FP activities as part of the PHU;
3) Lobbying for support from the DOH RO5;
4) Advocating for budgetary support of the FP program from the hospital funds;
5) Maximizing support from PhilHealth claims and reimbursements for FP; and
6) Conducting continuous quality improvement (CQI) sessions.

A crucial step in establishing the FP in Hospitals program is the issuance of hospital policies to strengthen the program. With TA from LuzonHealth, the Medical Center Chief at the BRTTH issued the following hospital policies, particularly for outpatient and admitted clients:

1) A hospital order (HO) regulating the creation and organization of the FP Technical Working Group;
2) HO No. 2017-000 strengthening FP in the hospital and creating the FP Hospital Management Team;
3) HO mandating strict compliance to the FP recording and reporting tools in compliance with DOH Memorandum 2014-0312; and
4) HO mandating compliance to the ISO and PHIC e-recording and reporting system.

In addition, the FP Clinic, under PHU management with support from the DOH RO5, was created and is being maintained as another key sustainability strategy. BRTTH is one of the few hospitals in the country with an active and operational PHU. The DOH RO5 began to support the BRTTH's PHU in 2013, with the rationale that FP is integral to the hospital's public health program. DOH RO5's funding support came in the form of sub-allotments to BRTTH for hiring nurses and a doctor to establish and manage the FP clinics. With the PHU's creation, the management of the FP program was moved from the OB department to the PHU, which gave the OB-Gynecology residents and specialists more time to focus on clinical management of clients.

> *"It [the Public Health Unit] was a win-win situation for all of us. Kasi yung problem talaga before, hindi kaya ng OB Department to manage an FP program kasi madami din silang patient [The OB Department's problem in the past was they were unable to manage an FP program because they had too many patients]. They can be service providers but not really part of the core management team and they have to be supported. It was likewise important for me to hire the right people for the job."*
>
> - Chief of Medical and Professional Services, BRTTH

In 2014, DOH RO5 continued its support and sub-allotted around PhP 5 million for the establishment of a BTL room, including the purchase of new medical equipment and logistics. The PHU currently provides a full range of FP services. The resource allocation from DOH RO5 has continued since 2013 but the amount has been decreasing over the years due to budget cuts from the DOH Central Office. To ensure that human resources for FP services would be secure, BRTTH included a medical specialist position and an FP staff nurse position in the hospital plantilla[9] to manage the PHU and provide FP services. At present, the sub-allotment from DOH RO5 is being used to hire additional contractual staff to assist the FP clinic staff. The hiring of a doctor and nurses to manage and operate the FP clinic and BTL room at the PHU is an integral part of the GPPI.

> *"We saw the [FP] program as something we needed to implement. The Department of Health is doing something about the FP program but it has only that much [funds] to support [us]. Not all hospitals have PHUs. BRTTH agreed to accept the PHU and to implement public health programs including FP. However, we still need the augmentation support given the financial status of BRTTH vis-à-vis the demand for services."*
>
> *- Medical Center Chief, BRTTH*

The BRTTH also has additional funding for the PHU from the *Gender and Development* fund, which comprises 5 percent of the hospital's budget allocation. This fund is used for logistics, medicines, and ancillary supplies for the

[9] "Plantilla" of positions refers to the official list of personnel that a government agency is authorized to hire under its approved budget.

FP clinic and PHU. However, the Medical Center Chief and the Head of Medical and Professional Services disclosed that there had been a big budget cut for hospital operations, from PhP 105 million in 2017 to only PhP 52 million in 2018. Nevertheless, the Hospital Chief continues to find external sources of funds to support the operations in the hospital, including the continuous provision of FP services.

PhilHealth reimbursement is an important resource for BRTTH. For example, according to LuzonHealth's tracking tool, for the period of October 2016-June 2018, around 741 clients had BTL, for which the total estimated PhilHealth claims amounted to PhP 2,964,000. Of this total, the PhilHealth reimbursements amounted to PhP 1,812,000 while claims amounting to PhP 1,152,000 were not reimbursed. For the same period, 382 clients received both postpartum and interval IUD; for this method, PhP 272,000 was reimbursed by PhilHealth while the foregone reimbursements amounted to PhP 492,000. Finally, 189 clients were reported to have accepted PSI, for which PhilHealth reimbursed the hospital PhP 492,000, while claims amounting to PhP 75,000 were not reimbursed. Foregone reimbursements can result from unfiled reimbursements with PhilHealth, return-to-hospital (RTH) claims (i.e., claims returned to hospital for various deficiencies in submitted documents), or denied claims.

For the 21-month period, the total amount claimed for FP services that BRTTH provided was PhP 2,576,000, which was shared among FP service providers and hospital staff. The FP focal person disclosed that prior to 2018, the hospital received reimbursements from PhilHealth on a quarterly basis through a manual system of processing. However, when PhilHealth shifted to an electronic system, the hospital experienced delays in reimbursements, ranging from 6–12 months.

The hospital management observed that although they can still provide required health services, the no-balance-billing (NBB) policy of PhilHealth[10] has become a challenge because of the delays in the processing of PhilHealth claims. BRTTH is hopeful that once the PhilHealth electronic system has stabilized, the reimbursements will be able to support the hospital's funding requirements for the provision of adequate and quality health services, including family planning.

To identify strategies to reduce the impact of budget cuts and funding gaps, the BRTTH management team conducted CQI sessions, where problems affecting hospital operations, including processing of PhilHealth claims, were discussed and resolved. In one of these sessions, an administrative staff person explained the "PhilHealth Ageing Process," an informal time-and-motion study to identify gaps in the processing of PhilHealth claims, particularly for the following processes: filling out forms, completing supporting documents, encoding data, and attending physicians' completing of claim forms. Based on the data gathered, the group developed strategies to improve PhilHealth processing, such as contracting additional encoders, collaborating with PhilHealth Customer Assistance, Relations and Empowerment Staff (P-CARES) to provide the necessary information for clients to complete documentary requirements, and orienting all in-house doctors and consultants on proper completion of claim forms. The PhilHealth Ageing Process also tracks the timeliness of submission of claims to the Regional PhilHealth Office, which is kept below the allowable period of filing of 60 days. Though BRTTH's CQI sessions do not necessarily focus on the FP program and services, the process nevertheless enables the management team to discuss and identify innovative ideas and strategies to resolve operational and sustainability issues proactively. The process can also help mitigate foregone reimbursements for FP claims.

[10] The NBB policy is in line with the National Health Insurance Act of 2013 (Republic Act of 2013), which states that "no other fee or expense shall be charged to the indigent patient… All necessary services and complete quality of care to attain the best possible health outcomes shall be provided to them." In 2017, PhilHealth issued PhilHealth Circular No. 2017-0006 to strengthen and improve the enforcement of the NBB policy, expanding its coverage to indigent patients, sponsored PhilHealth members, domestic workers, senior citizens, and lifetime members at the age of retirement.

In summary, BRTTH has a package of key intervention areas that contributes to the sustainability of the FP in Hospitals Program in its facility as well as the overall CPR performance of Region V. The package of interventions considered to be GPPI include the following:

- Designation of a BTL room and FP clinic in the PHU, with FP staff offering continuous services, including itinerant or outreach services, for a broad range of FP methods six days a week
- Budget allocation in the hospital's work and financial plan to support the FP program, as well as diversified funding sources such as Gender and Development funds, DOH RO5, and LGU counterpart support
- Mitigation of foregone PhilHealth reimbursements through the PhilHealth Ageing Process, an offshoot of one of the regular CQI sessions being conducted by top management
- Capacity building of BRTTH as an accredited regional training institution and a tertiary-level referral hospital for FP services in the region
- PhilHealth accreditation of certified FP providers

### 4.2.2 Oriental Mindoro Provincial Hospital: A Provincial Hospital Model


*The Oriental Mindoro Provincial Hospital in Calapan City.*

Oriental Mindoro is an island province in Region IV-B (otherwise known as MIMAROPA, an acronym for the provinces of Occidental Mindoro, Oriental Mindoro, Marinduque, Romblon, and Palawan) and comprises 14 municipalities and one city, with a total population of 917,824.[11] The province is also home to Mangyans who live in GIDAs. Mangyans comprise eight groups of indigenous people: Alangan, Bangon, Buhid, Hanunoo, Iraya, Ratagnon Tadyawan, and Tau-buid. There are approximately 100,000[12] Mangyan in both Occidental and Oriental Mindoro.

[11] Field Health Service Information System: Annual Report 2017. Epidemiology Bureau, Department of Health. Available at: https://www.doh.gov.ph/sites/default/files/publications/2017_FHSIS_Final_0.pdf
[12] Mangyan Heritage Center. Available at: www.mangyan.org/content/mangyan-groups

The province's FHSIS has recorded improving health indicators in the past five years. In 2017, the maternal mortality rate was 26.81 per 100,000 live births, or four maternal deaths for the entire year. The infant death rate was at 5.70 per 1,000 live births. The contraceptive prevalence rate reached almost 60 percent, the second highest in the region. See Table 4.

**TABLE 4. HEALTH INDICATORS OF THE PROVINCE OF ORIENTAL MINDORO, 2017**

| HEALTH INDICATORS | |
|---|---|
| Live births | 14,920 |
| Infant death rate | 5.70 per 1,000 live births |
| Maternal mortality rate | 26.81 per 100,000 live births |
| Facility-based delivery | 87.67 percent |
| Contraceptive prevalence rate | 59.64 percent |
| Unmet need for FP for low-income sexually active women of reproductive age* | 20,914 |

*Sources: DOH FHSIS, 2017; *HPDP NHTS Data Kit, 2016.*

The province has 21 public and private hospitals, including infirmaries.[13] The provincial government manages three hospitals: Oriental Mindoro Central District Hospital, Oriental Mindoro Southern District Hospital, and the Oriental Mindoro Provincial Hospital (OMPH). The two district hospitals are licensed infirmary facilities catering to municipalities in southern and central Oriental Mindoro.

The OMPH is a licensed level 1 hospital in the city of Calapan. It is a referral hospital in MIMAROPA and also received referrals from neighboring municipalities in other regions. The OMPH has a 200-bed capacity and provides a full range of health services including preventive, curative, and rehabilitative care. The hospital admits around 400–420 clients a day, which is 50 percent over its licensed capacity, making it an apex hospital in the region. To address this demand, the Provincial Health Officer, with the support of the Provincial Governor, is refurbishing two satellite hospitals and improving peripheral RHUs to decongest the provincial hospital and establish gatekeeping mechanisms in the municipalities. The province is applying to license the two district hospitals as level 1 facilities. In May 2018, House Bill No. 7751 was submitted to the Philippine Congress proposing to upgrade OMPH to a regional hospital, but this has not yet been approved.[14]

Based on interviews and records review, FP services were offered in OMPH even prior to LuzonHealth's TA in 2014. BTL was provided regularly and outreach FP missions were conducted in other facilities. However, prior to LuzonHealth's TA, the OMPH was not regularly providing the full range of modern FP methods. Additionally, logistics for FP were inadequate. Only two health personnel were trained in FP, a nurse and a doctor who was performing BTL and conducting itinerant missions in other areas of the province. FP advocacy and IEC to

[13] DOH. Health Facility List, Region IV-B (Mimaropa). National Health Facility List Registry v2.0. Available at: https://nhfr.doh.gov.ph/rfacilities2list.php?x_regcode=17&z_regcode=LIKE&x_statflag=A&z_statflag=LIKE

[14] House of Representatives, Congress of the Philippines. House Bill No. 7751: An Act converting the Oriental Mindoro Provincial Hospital in Calapan City Oriental Mindoro to Regional Hospital to be Known as Oriental Mindoro Regional Hospital and to Increase the Bed Capacity to 300 Beds, and Appropriating Funds Therefor. Available at: http://www.congress.gov.ph/legisdocs/basic_17/HB07751.pdf

generate demand was rare. Record keeping was not systematic or organized, with new acceptors not being documented in the FHSIS. The FP budget was solely for BTL instruments. The staff were unaware that they could claim reimbursements from PhilHealth for FP services.

## Key Intervention Areas

### A. *Continuous demand-generation activities at strategic points*


*The Family Planning clinic in OMPH, with services offered Monday to Friday, 8 am to 5 pm.*

Part of LuzonHealth's TA in 2014 was a two-day learning workshop to establish interdepartmental demand generation for FP in the entire hospital. The workshop was an avenue to identify gaps and provide recommendations on how the hospitals could raise the demand for FP and to reduce missed opportunities at various service points in the hospital.

With support from the PHO and the hospital management, the FP team acquired a newly renovated FP clinic. This facilitated the sharing of FP information and provision of modern FP services with clients, as well as private FP counseling.

The FP clinic is open Monday to Friday from 8 am to 5 pm. It is managed by two FP clinic staff, a nurse and a midwife. Demand generation is conducted daily in the morning, when several outpatients come to the facility for consultation.

The FP staff provide information to all women of reproductive age and couples who are seeking services regardless of the reason for their visit. The FP staff promote family planning with clients during prenatal care because FP is included in their birth plans. They also provide FP information to mothers who bring their children for immunization.

> *"My work schedule is actually from 7 am to 3 pm only. But almost every day, my working hours extend to 5 pm because there are so many clients coming to FP clinic."*
> - FP midwife, OMPH

In addition to generating demand for modern FP, the FP clinic staff organize a *Buntis Congress* (assembly of pregnant women) at the hospital grounds twice a year.

For postpartum clients admitted to the hospital, FP information is provided at the OB wards daily. In the labor room, clients who are not yet in active labor receive FP counseling. Because OMPH is a referral hospital in the island, there are clients from other municipalities who opt to deliver at the hospital. The FP clinic and delivery room staff ensure that these walk-in clients have referral letters from their midwives or RHUs. The referral

letter should include information on the number of antenatal care visits, a complete history and physical examination, and the client's choice of modern FP methods.

### *B. Capacity building*

One of the challenges for Oriental Mindoro province is the lack of budget to build the capacity of the FP staff. Therefore, LuzonHealth extended support for FPCBT training and logistics for OMPH FP staff, which started in the last quarter of 2014. At present, OMPH has six FP-trained service providers, two of whom are now trainers on PPIUD. Table 5 shows the number of staff trained in FP before and after LuzonHealth's provision of TA.

**TABLE 5. CUMULATIVE NUMBER OF HOSPITAL STAFF TRAINED IN THE PROVISION OF FP SERVICES, 2014–2018**

| Training | Prior to 2014 | With LuzonHealth'sTechnical Assistance |
|---|---|---|
| FPCBT1 | 1 service provider | 6 FP service providers (2 at the delivery/labor room, 2 at OB ward, and 2 at the FP clinic) |
| FPCBT2 | 1 service provider | 4 service providers (2 at the delivery/labor room, 2 at FP clinic) |
| PPIUD | 0 | 2 service providers |
| Interval IUD | 0 | 2 service providers |
| PSI | 0 | 2 service providers (only doctors) |
| BTL | 2 service providers | 1 service provider (doctor, part-time, also serving other satellite hospital) |
| Vasectomy | 0 | 0 |

*Sources: Interviews and FP clinic records*

### *C. FP performance reporting*

LuzonHealth also provided TA at OMPH to improve the FP program's recording and reporting system. LuzonHealth's trainers initiated this with a two-day consultative workshop, which drew on the draft of the *Operational Guide in Recording and Reporting Family Planning Performance in the Hospitals*. LuzonHealth's trainers also introduced modified FHSIS reporting forms and trained the participants on how to properly and accurately use these tools. The consultative workshop also introduced FP logistics management in hospitals to avoid stockouts and oversupply of FP commodities.

Prior to LuzonHealth's TA, OMPH's FP performance data were not included in the province's CPR as reported by the FHSIS. Although the FP coordinator submitted hospital reports to the PHO, these were not reflected in the province's performance. The FHSIS system at that time only allowed inclusion of reports from RHUs and CHOs and not from hospitals because the latter used a different information system, the Hospital Operations and Management System (HOMIS), which the DOH developed for hospital facilities. However, because of incomplete training of staff on the different HOMIS modules (not just in OMPH but in other hospitals as well), the OMPH could not report CPR performance directly to the HOMIS. With guidance from the DOH Regional Office and LuzonHealth, the OMPH, PHO, and the municipalities implemented ways to ensure that FP acceptors using FP services in the hospital were accounted for. As a result, the hospital FP team now submits monthly reports to the PHO so that the FP acceptors can be tagged in specific municipalities. According to the PHO

technical lead, the OMPH contributes significantly to the FP provincial performance (see next section for specific FP performance data for OMPH).

Despite improvements in the recording and reporting system, there are still challenges in reporting. For example, clients using the lactational amenorrhea method are not recorded properly due to difficulties in monitoring clients, and they therefore are not counted as using FP.

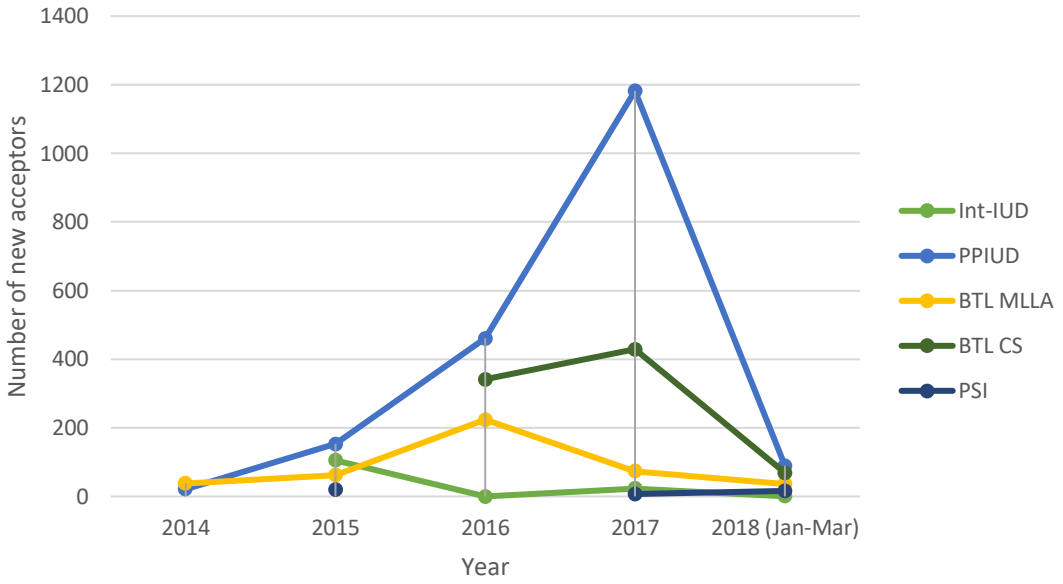
### *D. Quality family planning services*

*An 18-year-old postpartum client, provided with follow-up FP counseling before IUD insertion. [Permission obtained to publish photo.]*

While OMPH provides a full range of modern FP methods, FP postpartum services, particularly PPIUD and postpartum BTL, have seen an increased uptake. Figure 4 shows the trend of new acceptors for BTL and LARC over the past four years. Starting in 2015, one year after LuzonHealth's TA, acceptance of postpartum IUD increased dramatically. New IUD acceptors peaked in 2017 at 1,182 — almost triple the 461 new acceptors in the previous year.

The provision of PSI was halted in 2015 due to a TRO from the Supreme Court and resumed in November 2017 with the lifting of the TRO. However, because only obstetricians in OMPH were trained on PSI insertion and they render only part-time service, PSI is not being provided regularly.

**FIGURE 4. NUMBER OF NEW ACCEPTORS, LONG-ACTING REVERSIBLE CONTRACEPTIVES AND PERMANENT METHOD, OMPH, 2014–2018**



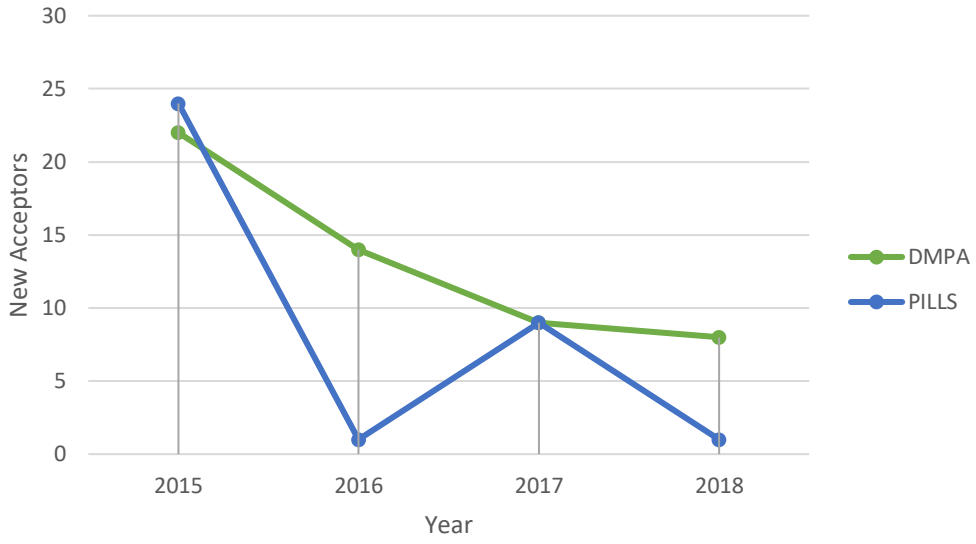

*Source: FP in Hospital records, OMPH*

BTL-MLLA acceptance increased from 2014 to 2016 but then declined significantly in 2017. This is likely because of the two doctors in OMPH who were trained to do BTL-MLLA, one resigned and the other was sent to a satellite hospital and could only render part-time services at OMPH. Subsequently, itinerant services, which were regularly offered before 2014, were abolished. To compensate, obstetricians are now providing BTL for patients undergoing a Caesarian section. The initiative started in 2016 with 341 new acceptors, and new acceptors increased by 21 percent in 2017.

The increased uptake of IUD and other postpartum FP methods can be attributed to LuzonHealth's systems approach and, more importantly, allocation of staff for dedicated FP services as well as the commitment of the hospital management. FP staff and an FP clinic were essential to support regular demand generation and service provision in various hospital points. The FP team ensured that logistics were always available and that clients received quality care, and they lobbied for FP training of staff from the DOH and development partners. The increased uptake in OMPH can also be attributed to several clients, specifically adolescents and multiparous women, opting for long-acting contraceptives to support longer birth intervals.

Only a few clients obtained short-acting modern FP methods. Figure 5 shows a decline in the use of DMPA injections and contraceptive pills from 2016 to 2018. Clients who usually use these methods are hospital and provincial government employees. Hospital clients who opt to use DMPA or pills are provided with the first dose of DMPA and a month's supply of pills and are then referred to their respective RHUs for continuation or shifting to other modern methods.

**FIGURE 5. NUMBER OF NEW ACCEPTORS, SHORT-ACTING METHODS, OMPH, 2015–2018**




*Source: FP in Hospital records, OMPH*

### *E. Sustainability mechanisms*

OMPH, with assistance from LuzonHealth, undertook the following interventions to promote sustainability of the FP in Hospital program:

1) Developed appropriate hospital policies supporting the FP program
2) Supported promotion of FP in all hospital departments
3) Ensured continued funding support from the provincial government
4) Ensured availability of procedure medications and ancillary supplies for BTL and LARC
5) Devised mechanisms to improve PhilHealth reimbursement
6) Supported indigenous people in filing PhilHealth claims and to enroll

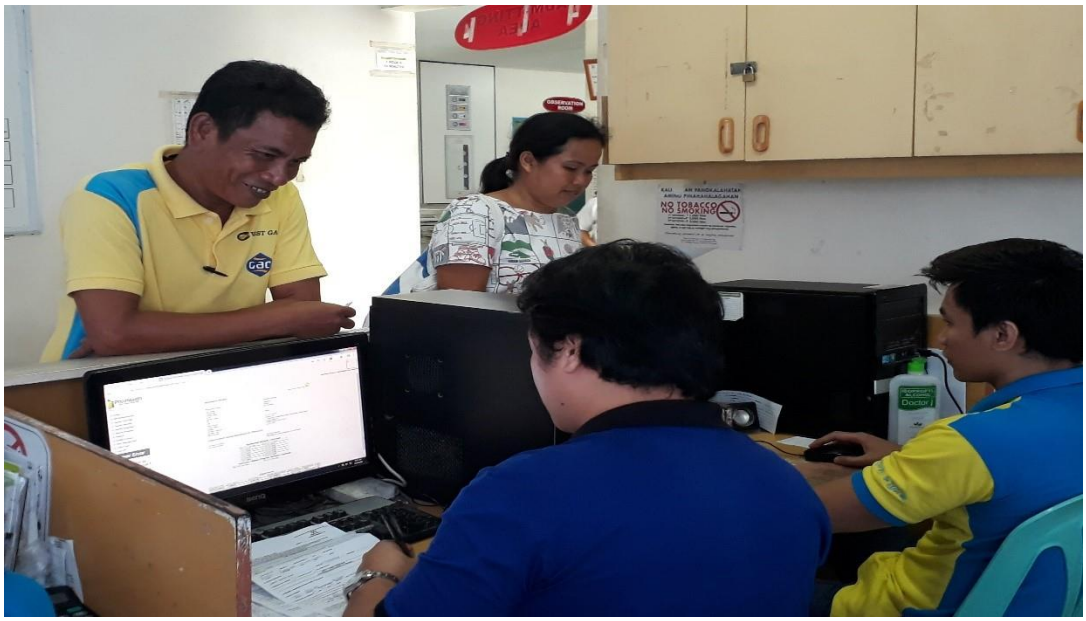
One critical intervention in establishing the FP in Hospital program is the issuance of hospital policies to strengthen the program. With TA from LuzonHealth, the FP team, together with the hospital management committee, developed a policy to institutionalize the FP program. Dr. Marpheo Marasigan, the Chief of Hospital, who had already released a hospital policy in 2016 identifying the responsibilities of each hospital area in the provision of FP services, went on to also approve the new policy put forth by the FP team and hospital management committee. These policies have enabled the promotion of FP activities in all hospital departments.

Continued funding support from the provincial government is essential to the FP program's sustainability. The provincial government's family planning budget is specifically allocated for BTL logistics, i.e., instruments, local anesthesia, and analgesics, and for ancillary supplies for LARC. This aligns with demand, as a number of clients in the hospital choose LARC and permanent methods. However, the DOH does not provide support for logistics and ancillary supplies for these methods. Other FP funding is sourced from the MNCHN grant from the DOH, primarily utilized for demand-generation activities, *Buntis* congress, and the procurement of FP commodities if supplies from DOH are insufficient; and a portion of the PhilHealth funds from the hospital. From the DOH, the PHO provides other commodities like pills, DMPA, IUD, and PSI.

In the province, the hospital obtains medications for procedures and medical supplies needed in BTL and long-acting methods on a consignment basis. The consignment system is one of the hospital's good practices to ensure availability of medicines and supplies at all times. This system reduces out-of-pocket expenditures of clients because the commodities are available to the retailer for free when needed, and it eliminates bureaucracy. The consignor (distributor of the medicines and medical supplies) places its goods for sale at the provincial hospital pharmacy or other participating divisions and offices of the consignee (the provincial government); the consignor is paid only for the actual quantity consumed.

*"We do not have to procure a bulk of medications that, at a certain point in time, are not used. The consignment process is also good as we eliminate some government procurement process that takes time..."*

- Dr. Marpheo Marasigan, Chief of Hospital, OMPH



*The PhilHealth CARES assisting clients.*

PhilHealth reimbursement is an important resource not just for the FP program but for all hospital operations. According to the Provincial Health Officer, the OMPH abides by the "No Balance Billing" policy with a 97 percent compliance rate, the highest in the region. From 2016 to the first quarter of 2018, PhilHealth reimbursement for IUD and BTL procedures amounted to PhP 3,112,000 and PhP 4,292,000, respectively. However, estimated foregone reimbursements for IUD amounted to PhP 500,000, or around 250 unreimbursed cases. The foregone reimbursements consist of: (1) FP services that are not filed with PhilHealth, (2) RTH claims due to deficiencies in submitted claims, or (3) denied claims — generally those filed beyond the 60-day filing period from the date of the patient's discharge from the hospital.

Given that PhilHealth claims are the biggest revenue source for OMPH, the hospital augmented its capacity to manage PhilHealth processes by hiring additional staff to expedite admissions, discharges, and claims reimbursement. This is expected to reduce claims denied by PhilHealth and RTH claims. PhilHealth deployed a P-CARES (PhilHealth Customer Assistance, Relations and Empowerment Staff) staff who assists clients in checking their eligibility and use of benefits. The P-CARES also promotes PhilHealth products and policies such as NBB, All Case Rates, and Point-of-Service enrollments, among others. The assigned P-CARES in OMPH regularly conducts an exit conference with the Chief of Hospital and the hospital management for feedback and communication of PhilHealth reports to the Hospital Chief. The P-CARES liaises between the hospital and PhilHealth to identify gaps and challenges and provide appropriate recommendations.

*PhilHealth CARES together with the assigned social workers implementing no balance billing and point of service policies.*

Another good practice in OPMH is the *"extra mile"* service offered by P-CARES. *Extra Mile* refers to an additional service the P-CARES provides to Mangyans and non-literate individuals. Upon checking the client's eligibility, sometimes requirements of the members are lacking, or they must fill out additional forms for membership and submit documents to the local health insurance office personally. As part of the *Extra Miles* service, the P-CARES collects and submits the requirements to the local health insurance office. This reduces cost of travel to the client and facilitates enrollment and coverage by PhilHealth.

In summary, the key interventions and innovations in OMPH that help to sustain its FP activities are:

1) Development and issuance of appropriate hospital policies supporting the implementation of FP program
2) Promotion of FP interventions in various service points and regular availability of FP services through dedicated FP staff and FP clinic
3) Strong support from the provincial government and minimizing bureaucracies in logistics procurement
4) Availability of FP commodities, procedure medications, and ancillary supplies through the consignment system
5) Development of an efficient reporting system
6) Implementing mechanisms to improve PhilHealth reimbursement

These efforts were a result of the complementary efforts and partnerships from the hospital management and staff, the provincial government and the PHO, the DOH, the LGUs of Oriental Mindoro, and TA from LuzonHealth.

### 4.2.3 Lipa City District Hospital: A District Level 1 Hospital Model


*Lipa City District Hospital.*

Lipa City is in the province of Batangas and has a population of 332,386.[15] Lipa City has one public hospital — the Lipa City District Hospital (LCDH) — and seven private hospitals. LCDH is a level 1 district hospital with a 120-bed capacity and caters to the entire city and neighboring municipalities.

From 2012–2015, it was noted that deliveries — both spontaneous deliveries and Caesarean sections —was the leading cause of discharge at the hospital. The hospital also reported that postpartum cases were increasing during the same period. The only FP service that was being provided at that time was interval IUD for clients being referred from RHUs. The Provincial Health Officer saw the need and opportunity to provide responsible parenthood/reproductive health (RP/RH) services. However, FP services were not provided regularly due to the provincial governor's position against FP.


*Map of the Batangas province and Lipa City.*

LuzonHealth engaged LCDH in 2015, which jumpstarted the of FP programs and services in the hospital. The TA package covered three strategies: addressing demand-side interventions, supply-side interventions, and policies and systems improvement.

[15] Philippine Statistics Authority, National Census, 2015.

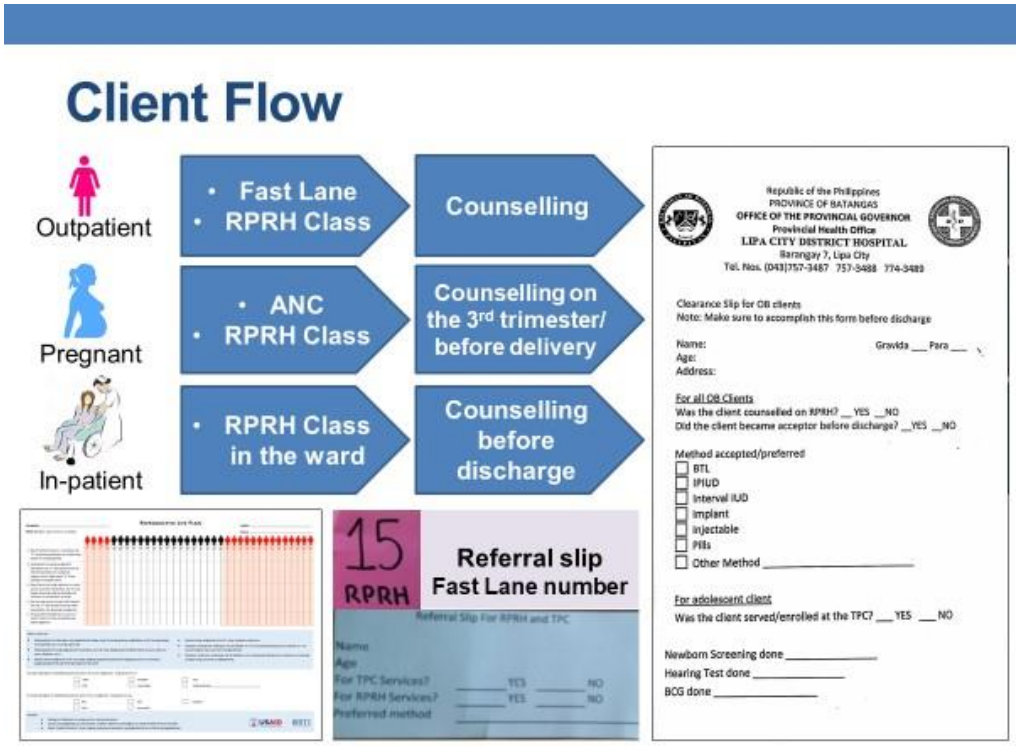
## Key Intervention Areas

### *A. Continuous demand generation at strategic points*

LCDH has two functional FP clinics, one of which is considered as the main FP facility. It is close to the hospital wards and caters to admitted and outpatient clients for LARC and LAPM. The other FP clinic is in the outpatient department and provides short-acting methods. The two FP clinics have been renamed as RP/RH clinics.

The two RP/RH clinics create demand by providing FP information. The FP health providers in the main FP clinic conduct FP classes in the OB ward and the OPD. Prior to discharge, OB clients drop by the clinics for FP services. Both clinics are open from 8 am to 5 pm Monday–Saturday. All nurses refer clients with unmet need for modern FP to the FP clinics. LuzonHealth also introduced antenatal care in 2017 for pregnant adolescents, including counseling prior to discharge.

FP clinic staff developed a client flow chart (below) to help LCDH clients navigate the hospital and access reproductive health services.




*LCDH FP client flow chart*



*Demand generation in the OPD and OB ward*

### *B. Capacity building*

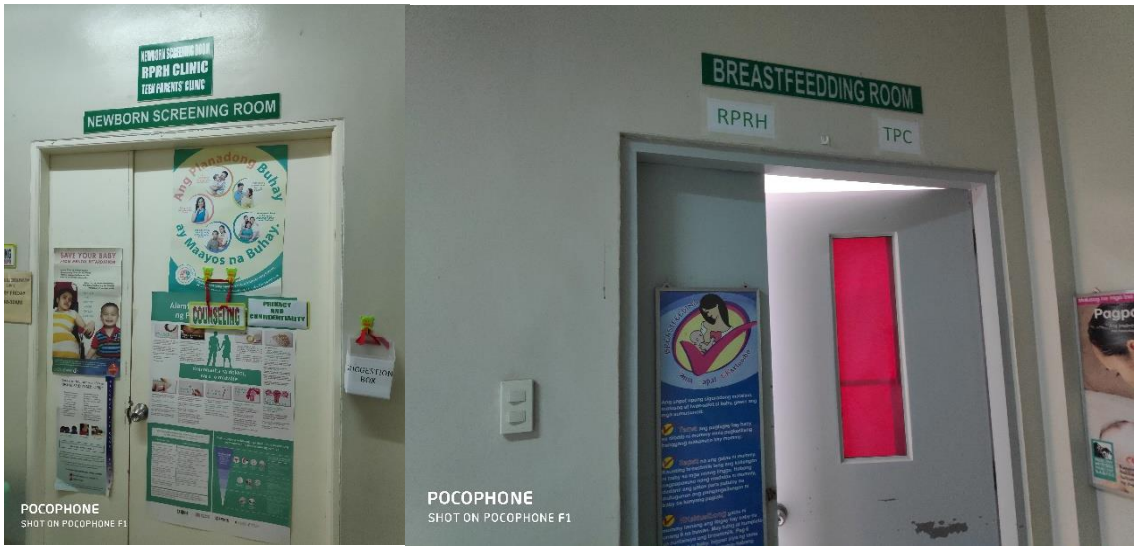
LuzonHealth provided TA to build the capacity of the hospital's FP health providers. Four health providers (one nurse and three midwives) were trained on FPCBT1 while two were trained on FPCBT2. One medical doctor was trained to perform BTL-MLLA. All trained FP staff in the hospital have a rotating schedule to operate the two FP clinics.

### *C. FP performance reporting*

LuzonHealth provided TA to enable the hospital to efficiently manage recording and reporting of its monthly and quarterly FP accomplishments to the PHO. The PHO includes the LCDH reports in the FHSIS. Improvements in the hospital's recording and reporting system have significantly contributed to the program accomplishment of the province.

### *D. Quality family planning services*

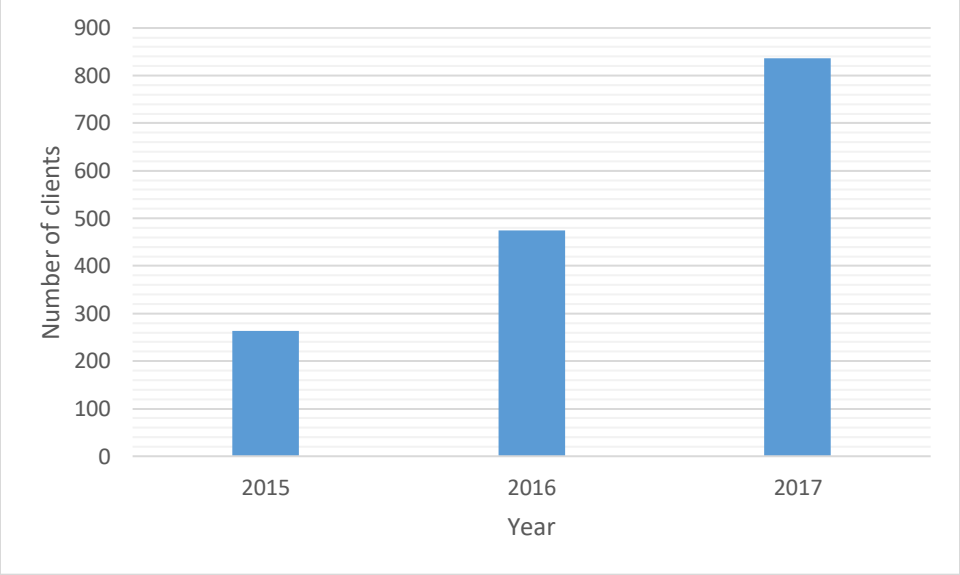
LCDH provides a wide range of FP services. The two RP/RH clinics are strategically located to optimize the chances of engagement among potential FP clients.




*The two RPRH clinics in LCDH: the FP clinic for admitted and OPD patients for LARC and LAPM (left) and for outpatient clients and provision of short-acting FP methods, located at the OPD department (right).*

Figure 6 shows the number of LCDH clients who received counseling for the period of 2015–2017. In 2017, 837 clients received counseling, a 50 percent increase from 2016.

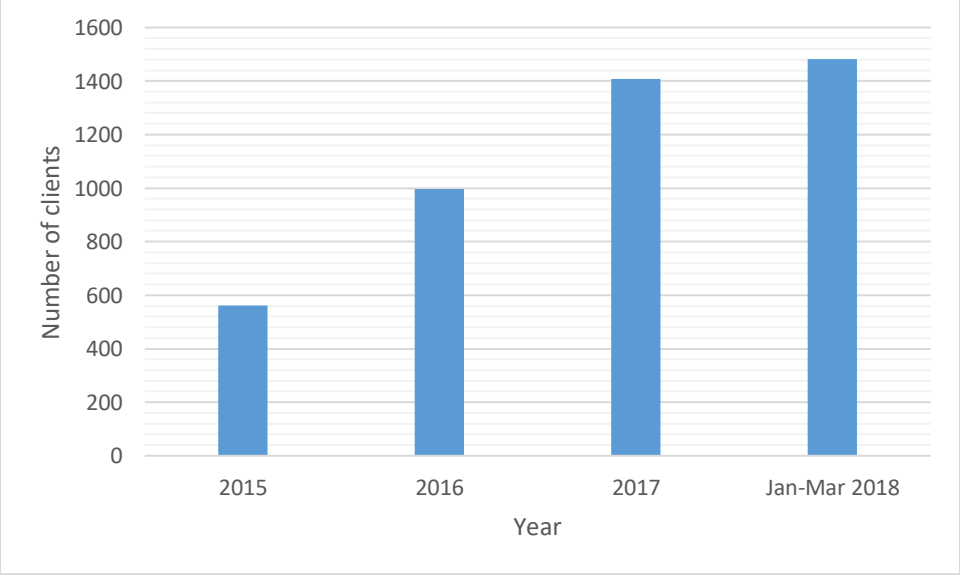
**FIGURE 6. NUMBER OF CLIENTS RECEIVING FP COUNSELING IN LCDH, 2015–2017**




*Source: LCDH hospital data*

Current users of modern FP methods also increased (Figure 7). By March 2018, 1,483 hospital clients were current users, 83 percent of whom were LARC and LAPM acceptors while the rest opted for short-acting FP methods.

**FIGURE 7. MODERN FAMILY PLANNING CURRENT USERS IN LCDH, 2015 – MARCH 2018**




*Source: LCDH Family Planning Report 2015-Mar 2018*

To support FP recording and reporting, LCDH developed an FP discharge form for postpartum clients. It is attached to the chart to ensure that a client has been informed and counseled about FP and provided with her chosen modern FP method.

### *E. Sustaining FP activities and services at LCDH*


*Client receiving family planning counseling at the LCDH FP clinic*

According to the FP coordinator, there is no specific budget line item for FP in the hospital. However, to sustain FP service provision and other FP activities at the LCDH, the following sources of support were identified: (1) Funding for training activities, which could be obtained from a development partner or from the DOH Regional Office upon a request from the PHO; (2) FP commodities from PHO, which the latter obtains from the DOH Regional Office and from the DOH Central Office; and (3) reimbursements from PhilHealth's package of support for FP.

In the past few years, the hospital has been obtaining monthly reimbursements from PhilHealth for BTL and PPIUD. From 2015–2017, 85 out of 234 BTL cases, including Caesarian section BTL, postpartum BTL, and interval BTL, were filed for PhilHealth reimbursement. The total amount that was reimbursed was PhP 340,000.

However, for 2018, these reimbursements were delayed up to four months due to PhilHealth's shift from manual to online financial transactions.

## Key elements to sustain LCDH's FP program

According to the team of FP health providers interviewed, the following elements were key to sustaining the FP program:

1) Support from the PHO
2) FPCBT training (Levels 1 and 2)
3) Health providers' commitment and dedication to their jobs
4) Presence of an accessible FP clinic and competent health providers
5) Availability of FP supplies and commodities
6) Good records management

While clearly important, these elements were primarily related to *institutional* capacities to build sustainability. However, sustaining FP programs also requires continuous demand generation, sustained funding, and an enabling environment (e.g., FP policies) to ensure continuity of program implementation.[16]

## 4.3 ANALYSIS

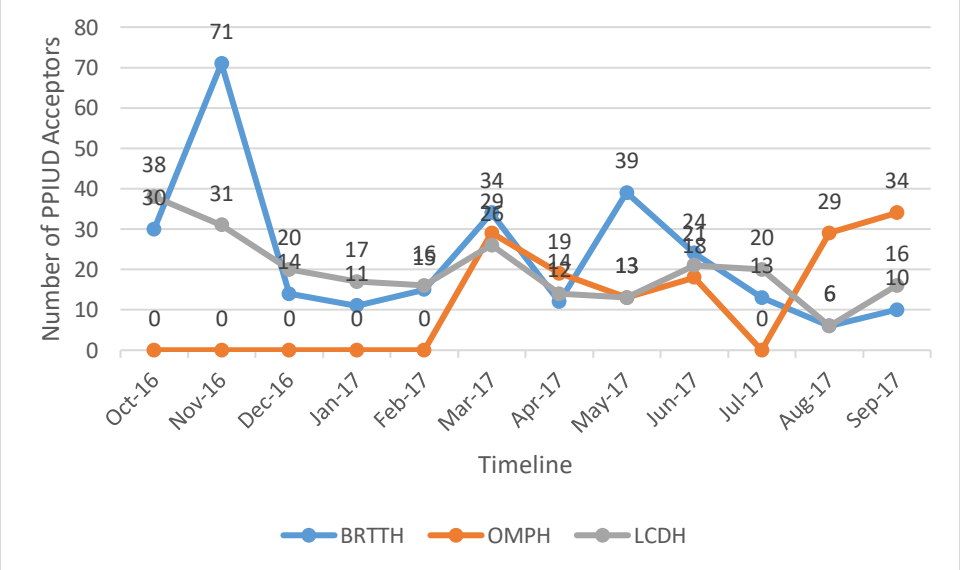
Drawing on the experiences of the three hospital models with respect to the FP in Hospitals program, we can now reflect on the learning questions in relation to GPPIs.

### Learning Question 1: To what extent have the following factors contributed to the increased performance in family planning:

#### *1a. Increased uptake of postpartum FP for IUD*

Based on LuzonHealth reports,[17] there was an increasing trend in the uptake of postpartum family planning from Oct. 2016–Sept 2017, particularly PPIUD at OMPH. Figure 8 shows that the number of PPIUD acceptors started to increase when LuzonHealth started its training intervention during the last quarter of 2016 and early part of 2017. Note, however, that OMPH started training on FPCBT2 for PPIUD at a much later period (March 2017), although it had been offering interval IUD prior to the LuzonHealth training intervention. On the other hand, for BRTTH, although the number of PPIUDs decreased in the latter part of 2017, Figure 2 (see Section 3.2.1) shows a significant increase in the uptake of BTL and PSI, the latter specifically after the Supreme Court lifted the TRO.

**FIGURE 8. TRENDS IN PPIUD UPTAKE IN BRTTH, OMPH, AND LCDH, OCTOBER 2016 – SEPTEMBER 2017**




*Source: LuzonHealth Monitoring Tool, 2016 – 2018*

Provision of FPCBT1 and FPCBT2 training activities for the FP health providers in the three hospitals provided an opportunity for hospitals to offer a wide range of modern FP methods, including LARC and LAPM. Demand-

[16] Khalifa M, Sharifa S, Moreland S. Issues and Strategies for Sustainability of Family Planning Services in Egypt. Policy Project. 2001. Available at: http://www.policyproject.com/pubs/countryreports/EGY_SFP.pdf.
[17] LuzonHealth Monitoring Tool covering the period October 2016–September 2017.

generation activities within the hospital and from the lower-level health facilities through the orientation meetings and distribution of updated IEC materials contributed to increased awareness about FP and subsequently, the uptake of postpartum modern FP methods. The much-improved referral system between the hospital and RHUs also helped in tracking and providing FP services to clients with unmet family planning needs.

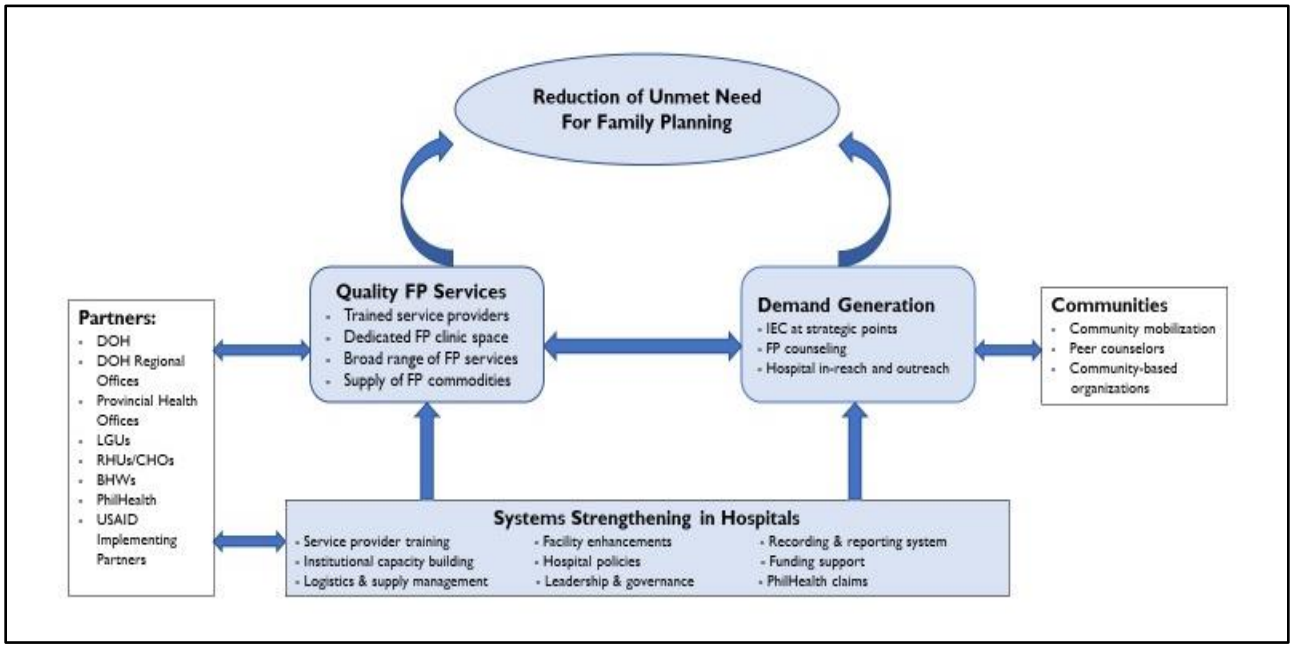
*1b. Completeness in FP performance reporting*

Prior to LuzonHealth's intervention in monitoring FP performance, the DOH had no system to track and integrate the performance of a hospital-based FP service. To address this gap, LuzonHealth developed the *Hospital Operational Guide in Recording and Reporting FP Performance in Hospitals* and trained FP providers to synchronize a hospital's forms and reports into the FHSIS. As a result, the LGU and the DOH Regional Offices now have FP performance reports that also reflect the accomplishments of hospitals in FP. This has contributed to more accurate monitoring of unmet need for modern FP and corresponding actions to increase access to FP services in the hospitals. LuzonHealth also provided TA to the hospitals to do online reporting of the FP performance of their facilities.

## Learning Question 2: Are the strategies and interventions for the FP in Hospitals program effective in reducing unmet need for FP?

The reduction of unmet need for FP, as shown in the previous section in Figures 2-3 (for BRTTH), Figures 4-5 (for OMPH), Figure 7 (for LCHD), and Figure 8 (all three hospitals for PPIUD), cannot be attributed to just one single intervention introduced by LuzonHealth. As articulated by the Theory of Change of the USAID Health Portfolio, three main strategies contributed to the effectiveness of FP in Hospitals as a GPPI: demand generation, and provision of quality services, both of which are anchored on the third strategy of systems strengthening initiatives (Figure 9).

**FIGURE 9. THREE-PRONGED STRATEGY FOR FP IN HOSPITALS**



### Learning Question 3: Were the FP services (LARC and LAPM) provided by the hospitals reimbursed by PhilHealth?

According to the three hospitals, PhilHealth reimbursed FP services for LARC, specifically interval and postpartum IUD and BTL-MLLA. Table 6 shows the reimbursements, with OMPH receiving the largest sum, mostly for BTL and IUD. As a tertiary-level hospital, BRTTH generally caters to clients requiring specialized services and encourages uncomplicated deliveries at lower-level facilities such as OMPH and LCDH.

**TABLE 6. PHILHEALTH REIMBURSEMENTS BY FP METHOD (BTL, IUD, PSI) IN THREE HOSPITALS, OCTOBER 2016–JUNE 2018**

| Hospitals | PhilHealth Reimbursements, in PhP | | | |
|---|---|---|---|---|
| | **BTL** | **IUD** | **PSI** | **Total** |
| BRTTH | 1,812,000 | 272,000 | 492,000 | 2,576,000 |
| OMPH | 4,292,000 | 3,112,000 | 10,000 | 7,414,000 |
| LCDH | 32,000 | 350,000 | 0 | 382,000 |
| **Total** | **6,136,000** | **3,734,000** | **502,000** | **10,372,000** |

*Source: LuzonHealth Monitoring Report, 2018 and author's estimates.*

However, all hospitals were found to have foregone reimbursements for FP services to varying degrees (see Table 7). BTL had the highest amount at PhP 1,768,000 while PSI had the lowest foregone reimbursement at PhP 227,000. Foregone reimbursements can be a result of unfiled claims, non-compliance to PhilHealth processing requirements (denied claims), or incomplete documentation to support the claims (RTH claims). These factors should be studied to mitigate further losses of revenue from PhilHealth reimbursements. These foregone amounts, had they been reimbursed, could have supported various hospital FP activities, procurement of FP commodities and logistics, and/or training of additional FP staff.

**TABLE 7. ESTIMATED FOREGONE REIMBURSEMENTS, BY FP METHOD, IN THREE HOSPITALS, 2016 – 1ST QUARTER 2018**

| Hospitals | Estimated Foregone Reimbursements, in PhP | | | |
|---|---|---|---|---|
| | **BTL** | **IUD** | **PSI** | **Total** |
| BRTTH | 1,152,000 | 492,000 | 75,000 | 1,719,000 |
| OMPH | | 400,000 | 152,000 | 552,000 |
| LCDH | 616,000 | 626,000 | | 1,242,000 |
| **Total**** | **1,768,000** | **1,518,000** | **227,000** | **3,513,000** |

*Source: LuzonHealth Monitoring Report, 2018*

Another complicating factor for hospitals in obtaining reimbursements was PhilHealth's recent shift to an online system for processing claims, which has led to delays (as long as four months delay in LCDH and one year in

BRTTH). However, this may be resolved as PhilHealth is able to refine its electronic system and as hospitals get accustomed to the new system.

### Learning Question 4: Are PhilHealth reimbursements adequate to finance family planning program operations?

According to the key informants from the three hospitals, PhilHealth reimbursements did help to support the FP program activities. Table 6 shows the amounts that were reimbursed from PhilHealth according to FP method for the period October 2016 – first quarter of 2018. For the three hospitals, BTL procedures had the highest amount of PhilHealth reimbursements, followed by IUD and PSI for both BRTTH and OMPH. LCDH did not collect any reimbursed amount for PSI because there were no reported acceptors during that period. On the other hand, according to the OMPH FP coordinator, OMPH was unable to obtain reimbursements for postpartum PSI insertions, a shortfall reflected in the relatively high amount in foregone reimbursements of PhP 152,000.

A certain proportion of PhilHealth reimbursements is usually allocated to service providers and other hospital staff. In the case of PhilHealth reimbursements for FP services, the sharing scheme among the FP service providers and other hospital staff follows the PhilHealth reimbursement policy as well as the standard practice in their respective institutions or LGUs.

However, overall, the amount of PhilHealth reimbursements are not yet sufficient to support and sustain the entire FP in Hospitals program, particularly because of the significant amount of foregone and delayed reimbursements. Individually, each hospital is also dealing with its own particular challenges to sustaining the FP in Hospitals program. For example, key informants for BRTTH said that there will be drastic budget cuts in 2019 (by almost half compared to 2018) as well as cuts in the augmentation fund from the DOH RO5. This portends their need to explore other sources of program support, including FP. However, the hospital management expressed hope that PhilHealth will eventually be able to fast-track the processing of claims and reimbursements with its new online system, which would help ensure sustainability of each hospital's FP program.

Beyond PhilHealth reimbursements, the OMPH and LCDH obtain direct support for their operations from their respective LGUs. This also covers support for the implementation of the FP programs in their hospitals. The OMPH is unique in that the Provincial Health Officer has a close working relationship with the Chief of Hospital and can give immediate attention to the needs of the hospital, including the provision of FP services. The LGU provides staff and logistics support for the operation of the FP and BTL clinics in the hospital. Because support for commodities and training usually come from the DOH and Regional Offices, OMPH and LCDH can get sufficient supplies of FP commodities from either the nationally distributed FP commodities or from the LGUs through the PHOs.

# 5. CONCLUSION

FP in Hospitals is a programmatic and systems approach in which hospitals play a key role in increasing demand for FP, providing quality FP services, and creating an enabling environment for FP/RH. Our documentation of the FP in Hospitals program across three different hospitals and levels of care consistently demonstrated that institutionalizing the program in these settings reduces unmet need for modern FP methods, particularly LARC and LAPM.

Our documentation found that FP in Hospitals as a promising intervention covers a package of interventions with the following main features:

- ***Sustained demand generation at strategic points in the hospital*** – In addition to offering FP information and counseling sessions, the hospital management and the core team of FP providers supported and instituted the "no missed opportunity" principle by orienting and allowing non-FP staff to proactively engage potential FP clients. Interdepartmental referral protocols were also established.

- ***Quality FP services*** – Collaboration and funding support (e.g., from DOH Regional Offices, LGUs, LuzonHealth) enabled the designation of an FP clinic/BTL room in these hospitals, managed by trained and certified service providers (doctor, nurse/midwives). A broad range of FP services are offered as with other public facilities, but FP in Hospitals can also offer services for LAPM (BTL-MLLA and no-scalpel vastectomy) and LARC (PSI).

- ***Systems strengthening and institutional capacity building*** – LuzonHealth's technical assistance focused on strengthening the building blocks to sustain FP demand generation and quality services in hospitals. Their support included:

    - Training, certification, and PhilHealth accreditation of doctors, nurses, and midwives to provide quality FP services
    - Training of trainers to expand and scale up training of FP health providers in their respective geographic areas
    - Logistics management, including stewardship in reporting commodities that are dispensed
    - Systematic and timely recording and reporting of FP clients, which allowed FP performance in these hospitals to be accounted for in the DOH FHSIS reports
    - Promoting an enabling policy environment, coupled with leadership and governance strengthening
    - Promoting financial sustainability through TA in facilitating PhilHealth reimbursements, and through advocacy and partnerships with the DOH Regional Offices, PHOs, and LGUs for FP funding and commodities.

The interviews, group discussions, visits, and records reviews conducted in the three hospitals affirm that the above main features of FP in Hospitals generally fulfill most of the preset criteria for a promising intervention (relevance, community participation, stakeholder collaboration, ethical soundness, replicability, and effectiveness.) There are, however, operational and funding challenges affecting efficiency and sustainability due to hospital budget cuts (BRTTH), delayed or foregone PhilHealth reimbursements (BRTTH, OMPH, LCDH), and reassignment of FP-trained hospital-based doctors providing LAPM services (OMPH, LCDH).

# 6. RECOMMENDATIONS

This GPPI documentation focuses on only three hospital models, and TA from the three regional FP/MNCHN IPs was limited to 10 percent of the 900 hospitals in the Philippines. As a promising intervention that can help address unmet need, FP in Hospitals could be replicated at a national scale, while resolving operational and funding bottlenecks and reducing variations in program implementation.

Specific recommendations are as follows:

- *For DOH Central and Regional Offices:*
    - Provide funding support for scale-up of FP in Hospitals nationwide. This can be achieved through the inclusion of budgets for FP in Hospitals in the Costed Implementation Plan of the FP program.
    - Increase DOH/Regional Office sub-allotments to DOH-retained hospitals to support FP in Hospitals.
    - Regional Offices should advocate with the DOH Central Office to retain augmentation funds for FP initiatives in hospitals.
    - Ensure adequate and timely provision of FP commodities and supplies at the implementing levels, particularly LGU-operated hospital facilities.
    - Review and amend guidelines on PHUs in tertiary-level hospitals so that PHUs become a prime vehicle for integrating the FP program in these settings.

- *For LGUs:*
    - Include budgets in the Provincial Work and Financial plans to support FP in Hospitals at the provincial and district levels.
    - Continue support for counterpart funding of activities related to FP itinerant/outreach activities, especially in GIDAs.
    - Ensure regular staffing of FP referral hospitals with trained doctors to perform LAPM services.
    - Conduct a performance assessment in the delivery of FP services/programs in their provincial and district hospitals to determine their contribution in reducing unmet need for modern family planning in the province and to identify the gaps and operational challenges.

- *For hospital management teams:*
    - Continue to improve and scale up good practices of the FP in Hospitals program, such as demand generation activities, provision of quality FP services, training and certification for FP competencies, systematic and timely recording and reporting of FP clients, and logistics management.
    - Address bottlenecks and institute CQI measures to facilitate PhilHealth reimbursements and mitigate foregone reimbursements.
    - Prepare annual work and financial plans for FP activities in hospitals in close coordination with the DOH Regional Offices (for DOH-retained hospitals) and LGUs and PHOs (for provincial and district-level hospitals).

- *For PhilHealth:*
    - Further review of the factors contributing to foregone reimbursements on FP claims in hospitals (i.e. BTL, IUD) and determine how to help hospital facilities to mitigate this problem.
    - Review existing guidelines on PhilHealth claims requirements for reimbursements.

- Expedite and facilitate the release of approved reimbursements in government hospital facilities using the new online system. Where feasible, deploy additional staff in transitioning from manual to online e-claims processing.
- Local PhilHealth staff (based at the province/ district level) should provide feedback to the hospitals on the status of their PhilHealth claims to expedite the processing of reimbursements.
- Review guidelines on PSI as second case rate for postpartum women of reproductive age.

- *For USAID's implementing partners:*

  - Continue to advocate for DOH and other key players to replicate and nationally scale up of FP in Hospitals.
  - Advocate to prioritize funding for FP in Hospitals at national and local levels.
  - Provide appropriate TA to improve, sustain, and scale up FP in Hospitals, especially in priority areas with high unmet need for FP.
  - Provide TA to review the implementation of the DOH Guideline on FP in Hospitals and to provide recommendations through the FP/AYRH IPs: ReachHealth and FP in ARMM.
  - Relevant IPs (ReachHealth, FP in ARMM, and HealthProtect) should collaborate with DOH/Regional Offices, DOH-retained hospitals, LGUs, and PhilHealth to address operational bottlenecks on PhilHealth claims.
  - Through the IP for FP in ARMM, provide TA to the DOH ARMM on conducting a baseline assessment of FP in Hospitals in the region.

- *For further research:*
  - Expand the documentation to more hospitals with FP programs to determine their relevance, processes, and outcomes in reducing unmet need for FP
  - Determine the extent and magnitude of problems encountered regarding PhilHealth reimbursements for claims filed by FP Programs in hospitals
  - Determine factors contributing to the decreasing uptake of short-acting FP methods and increasing acceptance of long-acting FP methods in hospitals, including the availability of FP commodities and methods in hospitals
  - Determine the number and proportion of hospital deliveries where mothers were advised to return to the hospital after discharge to avail of PSI, and the reasons for this practice
  - Inventory and analysis of LGU ordinances and resolutions supporting FP Programs in hospitals

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# ANNEX A: KII GUIDE QUESTIONS

Introduction: Your Province particularly the _____was selected to be highlighted in a documentation of good practice and promising intervention or GPPI by CLAimHealth of Panagora Group that was commissioned by the USAID to document GPPI.

We are documenting your institution and would build a story where we can gather critical information for learning, possible replication and adapting by other stakeholders. We are happy that you have accommodated us for this interview to get to know more about how you are able to support and sustain Family Planning Services/ Program at the_____.

1. Local Chief Executive/ Provincial Health Officer

1. Can you please describe to us how the province of Oriental Mindoro is able to provide support to Family Planning in the Primary level and to OMPH particular?
2. Is the FP program included in the Annual Work and Financial Plan of the province? If yes, how much is being allocated? Was there an increasing trend in the past 5 years? What were the major activities that were supported? What about support for FP in your provincial and district hospitals? What is the percentage of your total LGU budget is being provided to the OMPH? What major activities are being supported by the LGU funds?
3. What other enabling mechanisms were established to sustain FP services and programs in the hospital?
4. Other source of funding?
5. Is OMPH accredited with PhilHealth? How do you think PhilHealth is able to support the operations of the FP program and services at the OMPH?
6. What improvements in FP service performance did you observe that was contributed by OMPH?
7. Can you say that you can replicate the experience of OMPH in the district hospitals within service delivery networks/ clusters?

2. Family Planning Manager/ Focal Person

1. Please state your name, your position, and how long you have been working in this position?
2. Can you briefly describe how family planning services were provided in this hospital before the introduction of FP in Hospitals?
3. What were the major concerns in operating family planning in the hospital during that time? Please explain.
4. When did you establish FP in Hospital? Can you describe how FP in Hospital at OMPH was initiated until it became fully operational?
5. Did you receive any assistance to set it up and what were the ***key interventions*** that were implemented? Please describe.
6. What measures were carried out to ensure that FP services and related activities inside the hospitals will be operational and continuously provided?

7. What enabling mechanisms were provided by the LGU/LCE? Do you think that these are crucial in sustaining FP service provision at OMPH? Why?
8. Where do you get your resources to fund your FP services and activities at OMPH? Do you submit an annual work and financial plan for FP services in the hospital? To whom do you submit and what action is being taken? Are you able to get adequate resources from the LGU to support FP services? How much budget are you receiving annually to carry out your FP services and other activities inside the hospital?
9. Are there adequate funds? What are the gaps? How are the gaps being filled to ensure that planned activities are actually conducted inside the OMPH?
10. Are you PhilHealth Accredited facilities, what about your staff are they PhilHealth accredited providers? How much was actually reimbursed and foregone by the hospitals? Why were some FP services reimbursed while others were foregone?
11. How much reimbursements on FP are you able to receive from PhilHealth? How is this being distributed to the staff? Is this being equally shared? Please describe.
12. Please describe how the PhilHealth reimbursements utilized by the hospitals? Are these used to support other Family Health Programs/and or other hospital needs? Are the PhilHealth reimbursements adequate to finance the FP program operations?
13. Do you feel that the FP providers are motivated and satisfied with the PhilHealth share (incentive?). What were the observed changes in the behavior of the FP providers who are able to receive a portion of the Philhealth reimbursement? How was this translated to patient care? Did you observe any change with the quality of work in providing FP services? Please describe your observations.
14. What happened to the FP service performance? Are you aware of the unmet MFP needs for the province? How many of these are being addressed by the OMPH? Did you improve on PPFP and conduct of outreach services? Please describe briefly.
15. What are your observations in terms of the implications of PhilHealth reimbursements in so far as increasing the number of FP acceptors and maintaining a non-coercive engagement with the clients? how are FP providers able to balance between ICV compliance and possible coercive practice as a result of incentives received from PhilHealth reimbursements

<u>3. FP Service Provider</u>

1. Please state your name, your position, and how long you have been working in this position?
2. Please describe how demand generation for FP is being conducted inside the hospital? Where and how?
3. Can you describe what FP services are being offered at the OMPH? Are there FP services for men?
4. How many staff in the hospital are involved in FP both clinical and non-clinical? Who provides the FP services? Have they received adequate training? by Whom?
5. Do you give full range of information and services that client needs regardless of age, marital status, gender identity or socioeconomic status? Have you heard of any complaints against a provider who physically, sexually, or verbally abused a client in this facility?
6. Do you integrate FP with other maternal/ RH services in the hospital? Which are these?

7. Do you maintain client confidentiality with respect to records keeping?
8. Can you describe your logistics system in the hospital? How do you get FP supplies? Who takes charge of ensuring that they are always available? How often do you do the inventories of supplies? How do you request for additional supplies? Are you able to buy FP commodities from PhilHealth reimbursement funds? Please describe.
9. Are you an accredited Philhealth provider? Do you receive reimbursements from PhilHealth? On a monthly average can you provide me with a figure of your reimbursement from family planning services provided? How is the PhilHealth reimbursement being shared in this facility? Please describe. Are you satisfied from what you are currently receiving as PhilHealth reimbursement?
10. How do you think PhilHealth has improved FP services at the OMPH? Did you observe an increase in the number of clients with unmet MFP needs accessing your facility? Are clients still paying OOP expense for FP services? In what instance?
11. Can you describe your post-partum FP services? Which are these?
12. Are you implementing outreach/itinerant FP services in the community? Please describe.
13. How are clients being recorded and reported from your facility to the reporting office (PHO, RO)? What was the trend of FP acceptor in the last 5 years? Is there a decreasing trend in unmet need?
14. What are the continuing challenges and gaps in the provision of FP services in this facility?
15. What are your lessons learned and recommendations?

<u>4. PCares/ LHIO</u>

1. Please state your name and position and how long in the current position
2. On a regular day can you please describe how a family planning client would be assisted by your office? Please describe the process. What is your main task and responsibility?
3. Was this the same procedure that was being followed 5 years ago? Please differentiate tell us the situation before. What were the identified gaps back then?
4. When was PCare or Point of Service installed in this facility?
5. What triggered the changes in the procedure that you are experiencing now? What interventions were put in place? Was there technical assistance offered? By Whom?
6. What were the results of these interventions in so far as PhilHealth procedure in this facility is concerned? Please describe how your office contributes to these results.
7. How do you inform clients about PhilHealth benefits and how they can avail of FP services?
8. What are your observations in so far as claims and reimbursements are processed? Average length of processing? What factors facilitate or hinders the system? What are the gaps?
9. Can you say that point of care/ service is able to sustain the provision of family planning service in this facility? Why do you say so?

10. What remains to be a continuing challenge and what are your lessons learned from these experiences?
11. How else do you think can PCares support the sustainability of FP in Hospitals?