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Consolidated Annual Report on Activities Implemented under the Joint Programme "Strategy to Improve Maternal and Neonatal Health in the Philippines"

Report of the Administrative Agent
for the period 1 January - 31 December 2012

Multi-Partner Trust Fund Office
Bureau of Management
United Nations Development Programme
http://mptf.undp.org

31 May 2013

PARTICIPATING ORGANIZATIONS

United Nations Population Fund (UNFPA)

United Nations Children's Fund (UNICEF)

World Health Organization (WHO)

CONTRIBUTORS

Australian Agency for International Development (AusAID)

Table of Contents

EXECUTIVE SUMMARY

This 2012 Annual Consolidated Report under the Joint Programme, "United Nations Joint Programme Strategy to Improve Maternal and Neonatal Health in the Philippines" covers the period from 1 January to 31 December 2012. This report is in fulfillment of the reporting requirements set out in the Standard Administrative Arrangement (SAA) concluded with the Contributor. In the Memorandum of Understanding (MOU) signed by Participating Organizations, the Annual Progress Report is consolidated based on information, data and financial statements submitted by Participating Organizations. It is neither an evaluation of the Joint Programme nor an assessment of the performance of the Participating Organizations. The report is intended to provide the Steering Committee with a comprehensive overview of achievements and challenges associated with the Joint Programme, enabling it to make strategic decisions and take corrective measures, where applicable.

The year 2012 brought both challenges and achievements. Achievements remained aligned to the three-pronged strategy to reduce maternal and neonatal deaths: (i) skilled birth attendance, (ii) emergency obstetric and neonatal care, (iii) and family planning. These achievements included the following: (a) adoption and roll out of the Essential Intrapartum and Newborn Care protocol; (b) continued capacity building of Local Government Unit health service providers, and a growing base of acceptors on family planning; (c) forged public-private partnerships in Reaching the Urban Poor project sites that helped address the various social determinants to health; (d) refinements of the standardized Maternal, Newborn, Child Health and Nutrition monitoring tool; and (e) integration of Reproductive Health (RH) interventions and services within local Disaster Risk Reduction and Management plans as well as the inclusion of RH commodities for distribution during emergency/disaster situations.

One of the challenges faced included community and political sentiments "for" and "against" the Reproductive Health Bill.

The Multi-Partner Trust Fund Office (MPTF Office) of the United Nations Development Programme (UNDP) serves as the Administrative Agent of the Joint Programme. The MPTF Office receives, administers and manages contributions from the Contributor, and disburses these funds to the Participating UN Organizations in accordance with the decisions of the Steering Committee. The Administrative Agent (AA) is responsible for consolidation reports submitted by each Participating Organization. Transparency and accountability of this Joint Programme operation is made available through the Joint Programme website of the MPTF Office GATEWAY at http://mptf.undp.org/factsheet/fund/JPH00.

The report is presented in two parts. Part I is the Annual Narrative Report and Part II is the Annual Financial Report.

PART I: ANNUAL NARRATIVE REPORT

Programme Title & Project Number

- Programme Title: United Nations Joint Programme Strategy to Improve Maternal and Neonatal Health in the Philippines
- MPTF Office Project Reference Number: 00083660

Country, Locality(s), Priority Area(s) / Strategic Results

Country/Region: Philippines- Metro Manila Area, General Santos City

Priority area/ strategic results

Participating Organization(s)

- United Nations Population Fund
- United Nations Children's Fund
- World Health Organization

Implementing Partners

- Department of Health-Philippines

Joint Programme Cost (US$)

JP Contribution from AUSAID (pass-through):	$ 9,101,663
Agency Contribution	
• *by Agency (if applicable)*	
Government Contribution *(if applicable)*	
Other Contributions (donors) *(if applicable)*	
TOTAL: $ 9,101,663	

Programme Duration

Overall Duration *(months)*	10 months
Start Date[1]	27 August 2012
Original End Date	31 December 2012
Current End date	30 June 2013

Programme Assessment/Review/Mid-Term Eval.

Assessment/Review
☐ Yes ■ No Date: *dd.mm.yyyy*
Mid-Term Evaluation Report
☐ Yes ■ No Date: *dd.mm.yyyy*

Report Submitted By

- Name: Arvi P. Miguel
- Title: JPMNH Programme Coordinator
- Participating Organization (Lead): UNCO
- Email address: arvi.miguel@one.un.org

[1] The start date is the date of the first transfer of the funds from the MPTF Office as Administrative Agent. Transfer date is available on the MPTF Office GATEWAY

Acronyms

AMTSL	Active Management of the Third Stage of Labor
AWP	Annual Work Plan
ARMM	Autonomous Region of Muslim Mindanao
BEMONC	Basic Emergency Obstetric and Neonatal Care
CHT	Community Health Team
DOH	Department of Health
DRRM	Disaster Risk Reduction and Management
EINC	Essential Intrapartum and Newborn Care
FHSIS	Field Health Services Information System
FP	Family Planning
GIDA	Geographically Isolated and Disadvantaged Area
ICT	Information and Communication Technology
IUD	Intra Uterine Device
JPMNH	Joint Programme on Maternal and Neonatal Health
LGU	Local Government Unit
MCP	Maternity Care Package
MDR	Maternal Death Review
MISP-RH	Minimum Initial Service Package for Reproductive Health
MNCHN	Maternal, Newborn, Child Health and Nutrition
NICU	Neonatal Intensive Care Unit
PPP	Public-Private Partnerships
rCHITS	Real-time Community Health Information Technology System
RMNH	Reproductive, Maternal and Newborn Health
RP/RH	Responsible Parenthood/ Reproductive Health
RUP	Reaching the Urban Poor
SIM	Self-Instructional Module
SPEED	Surveillance in Post Extreme Emergencies and Disasters
UNCO	United Nations Coordination Office
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UY	Unang Yakap
WHO	World Health Organization

1. Purpose

- To improve the provision of continuum of quality care and services from pre-pregnancy, antenatal, intra-partum, post-natal and neonatal care based on agreed national standards adapted to local conditions;
- To increase equitable access to and utilization of RH/maternal and newborn information, goods and services in the JPMNH priority areas; and
- To enhance the effectiveness of national and sub-national support to local planning, implementation, and monitoring of the MNCHN strategy.

2. Results

i) Narrative Reporting on Results

A major step in improving access to quality Maternal and Neonatal information and services is the passage of the Responsible Parenthood and Reproductive Health Law (Republic Act 10354). Among others, the RP-RH Law (RA 10354) will further enable national and local government units to implement the three-pronged strategy to reduce maternal and neonatal deaths namely (a) skilled birth attendance, (b) emergency obstetric and neonatal care, (c) and family planning.

Important contributions to the reduction of maternal and neonatal deaths using the three-pronged strategy include the following:

- Skilled Birth Attendance
  - 64 midwives in geographically isolated and difficult areas were trained on Basic Emergency Obstetric and Neonatal Care (BEMONC), as part of the local service delivery networks.
- Emergency Obstetric and Neonatal Care
  - 27 health facilities were accredited under the Philippine Health Insurance Corporation's (PhilHealth) Maternity Care Package. It does not only ensure financial sustainability for facility-based deliveries but also quality of care through the meeting of minimum standards.
  - 5 teams (composed of doctor, nurse and midwife) were trained on BEMONC. This will ensure that 5 more facilities have staff who are capable of addressing maternal and neonatal complications.
  - Evidence based clinical practice guidelines for MNH care were developed and disseminated, which includes *the Essential Newborn Care Protocol and Policies on EINC – "Philippine Policies Mandating Safe and Quality Care for Mothers and their Newborns"*
- Family Planning
  - 115 local government health service providers in JPMNH provinces were trained on Family Planning. There were 8,157 new acceptors of family planning in JPMNH sites.
  - In partnership with the Family Planning Society, 38 health service providers/health staff were trained on voluntary surgical FP methods, 602 on basic family planning and 140 on IUD insertion. The partnership also generated 2,136 new acceptors for long-acting and permanent FP methods.

In addition, 3 JPMNH provinces are regularly conducting Maternal Death Reviews to identify areas for improvement and strengthening; develop and implement action plans to address gaps on maternal care that may have caused maternal deaths; and monitor progress of the interventions after MDRs. Moreover, public-private partnerships were established in 3 LGU sites covered by the Reaching the Urban Poor initiative. These experiences served as (local) models for MNCHN service delivery scale up. 5 out of 9 LGU sites support local collaborative initiatives that address various social determinants to health.

Initial pilot testing on the implementation of the DOH's MNCHN monitoring tool that was supported by UNICEF in three provinces was completed. Baseline data gathering for 4 sentinel sites concluded. Introduction of real time Community Health Information Tracking System (rCHITS), proceeded in three target GIDA municipalities, with very promising results. Initial talks among national government agencies on interoperability of data systems were also conducted.

Being one of the countries that is most prone to natural disasters, the Minimum Initial Service Package (MISP)[2] for Reproductive Health was integrated in 2 provincial and 15 municipal Disaster Risk Reduction and Management (DRRM) Plans. This will ensure that maternal health and family planning are included in the disaster preparedness and response initiatives of the said provinces and municipalities.

There is an overlap in JPMNH activities in the the selected urban setting in 2013 with a UNICEF initiative, the investment case program of AusAID Canberra through the Universities of Melbourne and Queensland. In the Philippines, said intervention will be introduced as Evidence-based Planning (EBaP) in 3 urban cities, one of which is the urban JPMNH site. EBaP aims to support the local planning and budgeting processes of target local government units through documentation of impact and attendant cost/investment implications.

Delays and challenges in implementation

Universal implementation of Family Planning programmes continue to be a challenge due to strong opposition from national and local Catholic groups. UNFPA had to discontinue its partnership with the province of North Cotabato after the local government made pronouncements to support only Natural Family Planning, apparently in deference to the local Bishop. Taking a different approach, UNFPA initiated Health Leadership Programmes for local government officials and managers highlighting the country's commitment to the International Conference on Population and Development (ICPD).

During the implementation year under review, some obstacles were encountered -- such as experienced difficulties in the political milieu of target LGUs; policy shifts in the cooperative development strategy of donors; and delays in receipt of project funding as a result of a decision by the PUNOs to change the Administrative Agent (AA) from UNFPA to the MPTF Office. Due to governance issues, UNFPA has also put on hold partnerships with the ARMM provinces of Lanao del Sur and Maguindanao. UNFPA shall consider resuming partnership with ARMM provinces after the UN has finalized and is ready to implement its ARMM Assistance strategy.

Full implementation of health system support activities such as the MNCHN Monitoring Tool, rCHITS in more GIDA municipalities, midwifery and nursing curriculum reform and capacity building of primary health facilities on EINC that were planned in 2012 needed to be rescheduled to 2013 due to the delay as a result of the change in AA.

[2] MISP includes maternal health services, prevention and management of gender-based violence, prevention and management of STI and AIDS, and adolescent reproductive health services. Herein, FP is part of the early recovery to the period of stability of an emergency.

Notwithstanding the above challenges, the Joint Programme was able to exhibit a working relationship that conveys the UN's *delivering as one* approach. A prime example was the issuance of the UN Joint Statement supporting the RP-RH Bill, signed by the Heads of Agencies of UNFPA, UNICEF and WHO.

Moreover, expanding the stakeholders' base in mobilizing more groups in reducing maternal deaths was achieved through the partnership with the 162 to 52 coalition (i.e. private sector alliance aimed at reducing maternal deaths) and the continued engagement with the Family Planning Society (i.e. private sector groups promoting Family Planning).

ii) Indicator Based Performance Assessment

	Achieved Indicator Targets	Reasons for Variance with Planned Target (if any)	Source of Verification
Outcome 1: Improve Access to Quality Continuum of Care and Services to Mothers and Neonates in Identified JPMNH Sites			
Output 1.1: Advocacy for Policy/ Standards			
Indicator: Multi-stakeholder legislative policy agenda with special focus on MNCHN is made available Baseline: 2 Target: 2 (national) 3-5 local	RP-RH Bill passed into law (RA 10354)		copy of Responsible Parenthood and Reproductive Health Law
	27 health facilities were accredited by Philhealth for Maternity Care Package services		Master list of MCP accredited facilities per province
	3/3 LGUs adopted the MNCHN Policy.		LGU Data/FHSIS
	3/3 Provinces pilot tested MNCHN monitoring tool	-Revision of tool necessary after pilot test - delayed release of funds to 4Q 2012 - for implementation in 1Q in 2013	Activity report Actual outputs
Output 1.2: Increase use of the health sector of available and appropriate ICT tools and frameworks for health policy development, improvement of service delivery			
Indicator: Availability of an ICT/ Knowledge management support to improve MNCHN service delivery performance, with special focus on vulnerable communities (e.g. adolescence, GIDAs, urban poor) Baseline: 0 Target: 1	3/3 GIDA municipalities with Real Time Community Health Information Technology System (rCHITS) system pilot-tested	- delayed release of funds to 4Q 2012 - for implementation beginning in 1Q in 2013	Activity report
	1/1 draft policy developed on internal validation of the LGU scorecard		Activity report & documentation
	4/8 baseline quantitative data in sentinel sites are available	delayed release of funds to 4Q 2012 - for implementation beginning in 1Q in 2013	Activity report & documentation
Output 1.3: Evidence-based practices on Maternal-Newborn Health Implemented and Institutionalized			
Indicator: Number of evidence-based clinical practice Standards for MNH	15 staff trained on BEMONC and 115 health service providers(HSPs)		Training master list per province

	Achieved Indicator Targets	Reasons for Variance with Planned Target (if any)	Source of Verification
are developed and disseminated Baseline: 0 Target: 2	trained on FP in 2012		
	2/2 Evidence based clinical practice guidelines for MNH care developed and disseminated (Essential Newborn Care Protocol and Policies on EINC – "Philippine Policies Mandating Safe and Quality Care for Mothers and their Newborns"		Hard and soft copies of the policies distributed to health partners; files at WHO library.
	0/2 MNCHN-EINC integrated in pre-service curricula	delayed release of funds to 4Q 2012 - for implementation beginning in 1Q in 2013	
	1/7 LGUs with primary facilities integrated EINC	delayed release of funds to 4Q 2012 - for implementation beginning in 1Q in 2013	
Indicator: Number of Public Private Partnership models for MNCHN service delivery for scale-up Baseline: 0 Target: 3	support given to Family Planning Society and 162 to 52 coalition		work plans with FPS and 162 to 52 coalition
	2 provinces and 16 municipalities		copies of local DRRM plans
	3/3 PPP models (RUP Sites) for MNCHN Service Delivery scale up.		LGU data/FHSIS
Indicator: % of facilities without stock outs of essential RMNH commodities Baseline: 53% Target: 75%	3 provinces, 1 city and 40 municipalities		forecasting estimates by LGUs
	commodities procured and handed over to DOH for distribution		earmarking forms and deeds of donation
Outcome 2: Increased Access and Utilization of Core RHMNH Services in Geographically Isolated or Economically Depressed Areas of JPMNH Sites.			
Output 2.1: Improved LGU support in the provision of responsive RMNH services in GIDA/urban poor areas			
Indicator: % of LGU with alternate Baseline:	3 provincial MDR teams trained	DOH recommends that MDRs be done at provincial level only	DOH training masterlist
	3 provinces regularly conducted	DOH recommends that MDRs be	MDR minutes of meeting

	Achieved Indicator Targets	Reasons for Variance with Planned Target (if any)	Source of Verification
Target:	Maternal Death Reviews	done at provincial level only	
	187 CHTs monitoring maternal deaths and disseminating information on teen pregnancy		CHT masterlist per province
	0/8 JPMNH LGUs' capacity enhanced on increasing access to quality RMNH services in GIDA/urban poor areas	delayed release of funds to 4Q 2012 - for implementation beginning in 1Q in 2013	
Outputs 2.2. Addressing Social Determinants of RHMNH			
Indicator: Number of partner LGU supporting GIDAs/Urban Poor vulnerable communities with interventions to address social determinants of RMNH Baseline: 4 (WHO-2009) Target: 10 (WHO-2015)	Forum on Teen Pregnancy conducted		documentation of Teen Pregnancy Forum
	5/9 LGUs-RUP sites are supporting initiatives to address social determinants of health		

iii) A Specific Story

Surveillance in Post Extreme Emergencies and Disasters (SPEED)

Gathering data and assessing the health and emergency situations during disasters and emergencies are difficult, often delayed and with questionable accuracy. This problem often causes disease outbreaks and even unnecessary deaths within evacuation camps, disaster communities and communities who adopt internally displaced persons. Most diseases during such disaster and emergency occurrences therefore become poorly contained if not totally uncontained or managed.

Following the big leptospirosis outbreak after three typhoons in 2009, the World Health Organization, with the Department of Health worked on a surveillance system that is responsive to a disaster or emergency setting. SPEED serves as an early warning surveillance tool that monitors health conditions and trends after an emergency or disaster using SMS and web-based applications. It aims to detect early potential disease outbreaks and to monitor emerging health conditions, and provides timely information on health trends and situations in the affected communities with attention to several non-communicable diseases which may have public health significance. Moreover, SPEED provides daily real-time reporting, which facilitates immediate verification and further investigation by the surveillance team.

The project has been pilot tested and a self-instructional module was developed to enable nation-wide simultaneous training on SPEED. Training and advocacy among local government health professionals in the Philippines, is currently being undertaken to ensure that the technology can be implemented on a national scale. The SPEED-SIM was launched together with EINC-SIM on 12 November 2012. SPEED-SIM is now being used during disasters; partners welcomed the innovation and it proved to be very useful in immediately assessing health situations in disaster areas. As proof of its usefulness and acceptability, it was awarded the "Gawad Kalinga Award" for technology innovations for health in 2012.

Reaching the Urban Poor (RUP) Project

Urban populations are increasingly exposed to unhealthy environments, disasters, climate change, violence and injuries, tobacco and other drugs, and epidemics. Without good governance, access to health care and shelter, adequate resources and capacities, the urban poor carry the greatest burden. In particular, there is poor access and utilization of health services among urban poor communities (especially the informal settlers), leading to poor performance of health centers and facilities in terms of health outcomes. A number of determinants contribute to poor access and utilization to health services:

- Urban poor households do not have the resources to pay for health services and other related costs (transportation, medicines, etc);
- There is also the phenomenon of social exclusion, which is defined as the systematic exclusion of the urban poor population from opportunities, decent employment, security, capacity, and empowerment that would have given them better control over their health and lives (Kawachi et al,) and
- Behavioral and cultural beliefs and practices.

The RUP approach addresses the poor access to and utilization of health services and the health inequities in urban centers by implementing health services that employ the use of social mobilization and community organizing to promote social cohesion and community participation. The communities are assisted to identify their problems (health problems and their social determinants), prioritize and plan interventions that

would address these problems. In implementing the approach, Local Government Units would be able to strengthen their health services delivery to urban poor communities by mobilizing community volunteers, conducting outreach medical services and developing community organizing skills among its health service providers. The Local Government Units are also assisted in linking the urban poor communities to both government agencies and private organizations to address social determinants of health.

All of the RUP sites (9/9) were able to demonstrate increases in core Maternal and Neonatal Health indicators, particularly facility-based deliveries, early initiation to breastfeeding and prenatal care. The increases in the performance of the health centers were attributed by the health service providers to the: 1) mobilization of volunteers who provided navigation services to the households in their community and 2) intensified health activities such as health events, outreach/ medical missions and house-to-house visits. Five of the nine sites were able to implement projects to address the identified social determinants by linking with government agencies and private institutions. For example, the Taguig City Health Office, with its partner NGO, Simbayanan ni maria Community Foundation, linked with Hortaleza Foundation to provide livelihood training (barbering and cosmetology) and start-up kit to at least 20 members of eight RUP barangays.

In summary, here are some of the other accomplishments of the implementation of the RUP approach:

- Database of health information and socio-demographic data including non-health concerns, established
- Health service delivery to the identified urban poor communities, strengthened
- Communities are addressing identified social determinants of health
- Local Government Units (barangay and city) providing support to RUP activities
- Peoples' Organizations, women's groups, sectoral groups (e.g. senior citizens, transport groups) and key community leaders are also providing support to the program.

Essential Intrapartum and Newborn Care (EINC) Protocol

Background

In the Philippines, 40,000 newborns die in the country each year, from causes that are mostly preventable such as complications of prematurity (41%), severe infection (16%) and birth asphyxia (15%).[3] Most deaths occur within the first two days of life, and conditions surrounding labour, delivery and the immediate postpartum period have been pinpointed as contributory factors. Only if measures are instituted to reduce newborn mortality more rapidly can we hope to achieve MDG 4 by 2015. Similarly, the Philippines also has a high burden of maternal deaths with an estimated 5,000 deaths annually. Results from a recent national health survey revealed MMR in the country has in fact increased from 162/100,000 live births in 2006 to 221/100,000 live births in 2010.[4] Post-partum haemorrhage continues to be a major cause of maternal mortality (41%).

A study was conducted in 2009 in 51 of the largest hospitals in 9 regions in the Philippines using an assessment tool developed by the World Health Organization (WHO) to assess birthing practices. Results of the study showed that performance and timing of evidence-based interventions for immediate newborn care were below WHO standards. In these hospitals, practices prevented Philippine newborns from benefiting

[3] Black RE, Cousens S, Johnson HL, Lawn JE, Rudan I, Bassani DG, Jha P, Campbell H, Walker CF, Cibulskis R, Eisele T, Liu L, Mathers C, for the Child Health Epidemiology Reference Group of WHO and UNICEF (CHERG). (2010) Global, regional, and national causes of child mortality in 2008: a systematic analysis. Lancet 375: 1969–87

[4] 2011 Family Health Survey, Philippines National Statistics Office

from their mothers' natural protection in the first hour of life compromising the newborn's chance for maintenance of warmth and survival beyond the newborn period.

Strategy

In 2009, the Philippines Department of Health (DoH) began a hospital-based initiative to change practices for safe and quality care of mothers and newborns. Supported by the WHO and the Joint Programme on Maternal and Neonatal Health, the project is being piloted in 11 hospitals and referred to as the "Scale-Up EINC Project" or "Unang Yakap 4&5." It is a call for all practitioners and health facilities to adopt and embrace the safe and quality care of essential intrapartum and newborn care (EINC). EINC practices are evidence- based standards recommended for adoption in Philippine hospitals with maternal and newborn care services and birthing facilities, both in the government and private sectors, by the DoH, Philippine Health Insurance Corporation and the WHO.

The recommended EINC practices during the intrapartum period as part of this protocol include continuous maternal support by having a companion of choice during labour and delivery, freedom of movement during labour, monitoring progress of labour using the partograph, non-drug pain relief before offering labour anaesthesia, position of choice during labour and delivery, spontaneous pushing in a semi-upright position, non-routine episiotomy, and active management of the third stage of labor (AMTSL). The recommended EINC practices for newborn care are a series of time-bound interventions: immediate and thorough drying of the newborn, early skin-to-skin contact between the mother and newborn, properly-timed cord clamping and cutting, non-separation of newborn and mothers for early breastfeeding initiation.

Implementation

Since 2010, selected DOH-retained hospitals have trained in and adopted the EINC Unang Yakap 4&5 set of practices as part of a program of the DoH, funded by the Joint Programme on Maternal and Neonatal Health and WHO. The innovation is a joint collaboration effort of the DoH, WHO and UNICEF. WHO took the lead in the assessment of the newborn care practices in selected health facilities in the country. UNICEF is supporting the scale up of the initiative in its Local Government Unit (LGU) health facilities.

The EINC strategy uses a health systems strengthening approach with various components:

- A clinical practice guideline (CPG) on newborn care component that used GRADE (Grades of Recommendation, Assessment, Development, and Evaluation) methodology;
- Policy support for the newborn CPG through the issuance of a DoH national policy and incorporation with existing policies for Mother-Baby Friendly Hospital Initiative criteria and the Maternal, newborn and child health and nutrition policy for the maternal practices;
- Health financing "incentivization" of the new practices through reforms in the maternal care packages and newborn care packages of the national health insurance system (PHILHEALTH);
- Incorporation in pre-service and in-service curricula starting with medical, nursing and midwifery

How is this Innovative?

EINC represents the highest standard for safe and quality care for birthing mothers and healthy newborns. It is considered innovative because the package emphasizes a chronological core sequence of actions, performed methodically (step-by-step) such that essential time-bound interventions are not interrupted, treating the mother and newborn as an inseparable socio-biological unit. The approach is different also in the sense that it was initiated as a quality improvement initiative in referral hospitals in contrast to the existing approach of the Department of Health to start capacity building in primary facilities. Initial experience showed that the referral centers took the initiative to cascade the EINC training to their network of feeder/referring primary facilities.

academic societies and incorporation in professional licensure examinations;

- Creation of social marketing handle ("The First Embrace or Unang Yakap") and campaign initially targeted to change health worker behaviour and institutionalize the change in pilot hospitals;
- Use of social media for the dissemination of and sustenance of trained centres and personnel; and
- Creation of centres of excellence through technical assistance for the hospital.

Scale-up implementation of EINC was undertaken in 11 government hospitals collectively representing about 70,000 annual live births, approximately 3 per cent of all national live births. Since October of 2010, in each of these hospitals, the scale-up process has entailed:

- A baseline situational analysis including delivery assessments, time-motion studies in the delivery areas and newborn intensive care unit (NICU), baseline neonatal morbidity and mortality data;
- Training workshops of all hospital staff; and
- Monitoring and evaluation or facilitated supervision phase consisting of weekly meetings with the hospital EINC Working Group over a typical 6 month period with repeat assessments.

Recommended EINC practices have been replicated by primary facilities (called "lying in centers") connected to hospitals that were part of scale-up activities through their referral systems. This led to the creation of training teams within the pilot hospitals themselves. There are spontaneous requests from many private facilities, local government units, and even legislators who seek to have health workers in their locality trained in Unang Yakap. The process was replicated by the USAID-funded SHIELD project in Mindanao where they used the Quality Improvement Collaborative process to create service delivery networks between the rural health units and the provincial hospitals.

Results

Results of the EINC Scale-up implementation program have been positive, with admissions to the neonatal intensive care units dropping and reduced neonatal sepsis rates, decreased newborn deaths and more satisfied mothers. More hospitals and health professionals are aware of the protocol and are providing EINC care.

Outcomes

Marked improvement in early initiation of breastfeeding

Breastfeeding within the FIRST hour of life	Percentage (%)		Median Time to Initiation (min)	
	Pre-training	Post-training	Pre-training	Post-training
PGH	27	100	21	13
Tondo Medical	90	90	50	61
Cotabato Regional	90	100	43	28
Jose Reyes	36	60	27	61
East Ave	20	40	61	46
San Lorenzo Ruiz	70	100	52	60
Gen San	0	70		26
Fabella	4	40	84	17

In the 33,421 cumulative live births across the 11 project sites, this scale-up process has been effective in changing practices at sites that have manifested "ownership" and conscientious implementation of the practices. There was as much as a 75% reduction in NICU admissions, term mortality and sepsis case fatality rates and increase in exclusive breastfeeding rates at 7- and 28-day follow-up visits. It was found that in one hospital, in an early prospective cohort of 1459 newborns, babies who benefited from skin-to-skin contact were almost two times as likely to appropriately breastfeed within one hour compared to then those who DID NOT receive IMMEDIATE skin to skin contact. Babies who breastfed appropriately were almost two times more likely to exclusively breastfeed at 28 days. Skin-to-skin contact was associated with lower number of deaths and cases of sepsis, and other newborn complications. In addition, improvements are also seen in maternal care and infection control practices, and in reduced workloads and expenses. Breastfeeding initiation rates and duration of the first breastfeed have improved.

An example of improved outcomes was administration of oxytocin. Intramuscular oxytocin administration was documented to range, with most dramatic at one hospital which had a baseline oxytocin coverage at 28% in the first month and 100% by the second month, which remained at 100% by the sixth month.

Simple cost-saving calculations by hospitals have revealed substantial savings averaging almost 500 Philippine peso per vaginal delivery (approximately 12 USD).

Lessons Learned

EINC is impressive in its ability to change health worker behaviour within a short period of time and has the ability to reduce newborn morbidity and mortality. Based on experience to date, constraints to rapid national scale-up include the need for a critical mass of trainers and innovative means of training large numbers of health workers with the capacity for refresher or review, such as the use of the internet and computer-based technology. A present constraint might be the lack of a functional health information management system in many facilities that can capture real time data.

Potential Application

The potential for nationwide scale up is large because the health systems elements such as policy and financing are in place for its adoption in all health facilities and by all skilled birth attendants. The social marketing handle is catchy and the national government has assumed ownership of the brand. Compliance at facility level is monitored through the use of facility based checklists and monitoring formats as part of the quality improvement initiative. At the national and subnational management levels, compliance is to be monitored through the incorporation of the EINC indicators in the national program monitoring tool and in the PHILHEALTH checklist for accreditation.

Additional elements such as the maternal and neonatal death reviews, and expanding evidence-based guidelines to antenatal and postpartum care are also planned. The use of computer-based self-instructional modules will be explored, with capacity for online certification of training. Costing studies, expansion of curriculum integration efforts from medical academe to nursing and midwifery academe are also in the pipeline.

Potential for Wider Application

Scale-up to reach a wider number of facilities, mostly primary, is ongoing. Health facilities in identified Joint Programme on Maternal and Neonatal Health areas of UNICEF, UNFPA and WHO are being targeted. Trainings of health workers will be done under the Joint Program on Maternal and Newborn Health. Scale-up will also be done functionally. Aside from primary facilities, the Joint Program will expand to creating service delivery networks for seamless delivery of quality care.

This evidence based practice model shows that simple but effective EINC practices during the intrapartum period can have substantial positive health outcomes. With positive results such as reduced numbers of admissions to the neonatal intensive care units and decreased neonatal sepsis rates and thus more satisfied parents, it would be worthwhile for other countries to learn from this experience and to explore opportunities to implement such interventions adapted to their local context.

Further Information: Essential Intrapartum & Newborn Care (EINC) Evidence-based Practices for Safe & Quality Care of Birthing Mothers & Their Newborns A DOH Maternal, Newborn, Child Health and Nutrition (MNCHN) Strategy to Save Mothers & Newborns
http://www2.wpro.who.int/NR/rdonlyres/A3448DDC-2256-48E5-ADC1-C901A1B3E1E6/0/EINCbrochure_sept2011.pdf

Real-time Community Health Information Tracking System (rCHITS)

In the Philippines, a large volume of maternal, newborn and child health data is collected daily in a typical government health center – for the most part written on paper or cards – poses significant challenges including high rates of errors and delays in reporting. Over the last decade, however, information and communication technology has become a vital tool in all sectors including health. Since 2011, the government has been supporting a pilot initiative which aims to use technology to improve data collection, reporting systems in rural areas and evidence-based decision-making at decentralized levels in the Philippines.

The 'Real-time Monitoring of Key Maternal and Child Health Indicators through the use of the Community Health Information Tracking System' called 'rCHITS', a computerization project for government primary health care centers, was developed collaboratively with the University of Philippines, College of Medicine Medical Informatics Unit and the health staff of Pasay City in metropolitan Manila. rCHITS was developed to address the concern above and has been tested in 3 pilot municipalities: Pairing technology-based data collection, organization and use methods with motivated users in decision-making roles is a key feature of this health systems innovation.

rCHITS allows data to be gathered and stored at the barangay (village) level even when there is no access to the internet. Using a data encoding software called Frontline SMS. Data gatherers send data via mobile phone to their barangay health unit where a point person stores the data. This data is later sent to the municipal health office and then to National Telehealth Center server in Manila. Local health planners and mayors gain access to fresh data by logging on to the network to guide decision makers and take strategic directions for adequate implementation of health programmes.

So far the project has been piloted successfully in 3 Local Government Units. Although concerns were raised that some frontline data gatherers, particularly long-serving RHU staff and elderly midwives, would have difficulties to take to on the new technology, experiences in the pilot sites indicate that they do adapt to the system easily. Initial evaluation of the pilot phase indicated that a so-called *LGU dashboard* as a visualization tool for local chief executives was very well received. Also the Department of Education, meantime, saw the long-term value of the project. With tracking of births within the municipality and tracking of immunization per village, it is now possible to arrive at necessary statistical data as to how many children to expect to enter first grade in six years' time. This will release them from the very tedious annual mapping of expected enrollees. It is also expected by 2013 that the Department of Budget Management will issue a memorandum to all local Government Units in Philippines to install rCHITS in their respective municipalities to use their own budget for the maintenance of the system.

Computerized health information system is an innovative and effective strategy that allows cohesive and timely information to inform decision-making and provide quality services to mothers and children living in rural areas. While pilot results have been encouraging and scale up is planned, more time is still needed to effect behavior change and capacity building at the community level. It was also recommended that in the next phase, increased community participation be encouraged as this will impart a sense of ownership, which is a crucial aspect in sustainability.

PART II: ANNUAL FINANCIAL REPORT

2012 ANNUAL FINANCIAL REPORT

This chapter presents financial data[5] and analysis of the Joint Programme as of 31 December 2012. Financial information is also available on the MPTF Office GATEWAY, at the following address: http://mptf.undp.org/factsheet/fund/JPH00.

1. Sources and Uses of Funds

As of 31 December 2012, the Australian Agency for International Development has deposited US$ 9,193,600 and US$ 4,612 has been earned in interest, bringing the cumulative source of funds to US$ 9,198,212. Of this amount, US$ 9,101,663 has been transferred to three Participating Organizations of which US$ 848,091 has been reported as expenditure. The Administrative Agent fee has been charged at the approved rate of 1% on deposits and amounts to US$ 91,936. Table 1.1 provides an overview of the overall sources, uses, and balance of the Joint Programme funds as of 31 December 2012.

Table 1.1. Financial Overview (in US Dollars)

	Prior Years as of 31-Dec-11	Current Year Jan-Dec 2012	TOTAL
Sources of Funds			
Gross Contributions	-	9,193,600	9,193,600
Fund Earned Interest and Investment Income	-	4,612	4,612
Interest Income received from Participating Organizations	-	-	-
Refunds by Administrative Agent to Contributors	-	-	-
Other Revenues	-	-	-
Total: Sources of Funds	**-**	**9,198,212**	**9,198,212**
Uses of Funds			
Transfer to Participating Organizations	-	9,101,663	9,101,663
Refunds received from Participating Organizations	-	-	-
Net Funded Amount to Participating Organizations	**-**	**9,101,663**	**9,101,663**
Administrative Agent Fees	-	91,936	91,936
Direct Costs (Steering Committee, Secretariat…)	-	-	-
Bank Charges	-	101	101
Other Expenditures	-	-	-
Total: Uses of Funds	**-**	**9,193,700**	**9,193,700**
Balance of Funds Available with Administrative Agent	**-**	**4,512**	**4,512**
Net Funded Amount to Participating Organizations	-	9,101,663	9,101,663
Participating Organizations' Expenditure	-	848,091	848,091
Balance of Funds with Participating Organizations	**-**	**8,253,572**	**8,253,572**

[5] Due to rounding, total in the tables may not add up.

Interest income is earned in two ways: 1) on the balance of funds held by the Administrative Agent ('Fund earned interest'), and 2) on the balance of funds held by the Participating Organizations ('Agency earned interest') where their Financial Regulations and Rules do not prohibit the return of interest. As of 31 December 2012, Fund earned interest amounts to US$ 4,612 and no interest was received from Participating Organizations. Details are shown in the table below.

Table 1.2. Sources of Interest and Investment Income (in US dollars)

	Prior Years as of 31-Dec-11	Current Year Jan-Dec 2012	TOTAL
Administrative Agent			
Fund Earned Interest and Investment Income	-	4,612	4,612
Total: Fund Earned Interest and Investment Income	**-**	**4,612**	**4,612**
Participating Organization (PO) Earned Interest Income	-		
Participating Organization (PO)	-	-	-
Total: Interest Income received from PO	**-**	**-**	**-**
Total	**-**	**4,612**	**4,612**

2. Contributions

Table 2 provides information on cumulative contributions received from AusAID as at 31 December 2012.

Table 2. Contributions (in US dollars)

Contributor	Prior Years as of 31-Dec-11	Current Year Jan-Dec 2012	TOTAL
Australian Agency for International Development	-	9,193,600	9,193,600
Total	-	**9,193,600**	**9,193,600**

3. Transfer of Funds

Allocations to the JP Participating Organizations are approved by the Steering Committee and disbursed by the Administrative Agent (AA). The AA has transferred US$ 9,101,663 to three Participating Organizations (UNFPA, UNICEF and WHO) as of 31 December 2012. Table 3 provides information on the cumulative amount transferred to each Participating UN Organization.

Table 3. Transfers by Participating Organization (in US dollars)

Participating Organization	Prior Years as of 31 Dec 2011	Current Year Jan-Dec 2012	TOTAL
	Transferred Amount	Transferred Amount	Transferred Amount
UNFPA	-	5,294,423	5,294,423
UNICEF	-	2,364,388	2,364,388
WHO	-	1,442,852	1,442,852
Total	**-**	**9,101,663**	**9,101,663**

4. Overall Expenditure and Financial Delivery Rates

All expenditures reported for the year 2012 were submitted by the Headquarters' of the Participating UN Organizations via UNEX, the MPTF Office Reporting Portal. These were consolidated by the MPTF Office.

4.1 Expenditure Reported by Participating Organization

As shown in table 4.1, cumulative transfers amount to US$ 9,101,663 and cumulative expenditures reported by the Participating Organizations amount to US$ 848,091. This equates to an expenditure delivery rate of 9%. UNFPA has the highest delivery rate with a reported expenditure amount of US$ 719,452 (13% delivery), followed by WHO with US$ 121,179 (8% delivery) and UNICEF with US$ 7,461 (0.3% delivery).

Table 4.1. Cumulative Expenditure of Participating Organizations and Financial Delivery Rate (in US dollars)

Participating Organization	Transferred Amount	Total Expenditure	Delivery Rate Percentage
UNFPA	5,294,423	719,452	13.59
UNICEF	2,364,388	7,461	0.32
WHO	1,442,852	121,179	8.40
Total	**9,101,663**	**848,091**	**9.32**

Due to change in administrative arrangements for this current fund, the first months were spent on acquiring the necessary clearances from the various agencies for the new funding modality. Arrangement and agreements were made in the early half of the year. Thereafter, funds were made available at the level of the

individual UN agencies by September 2012 (please refer to Section II of the narrative report, page 4). At the onset of Q3 until mid Q4, the project experienced staff turn-over across all the three UN agencies that required a period of learning amongst the new staff.

By the last quarter of the year, development of Terms of Reference with government counterparts, review of proposals and subsequent contract processing were conducted. Thus, the last quarter of the year was focused on these preparatory activities prior to contract signing. Hence, the low utilization rate illustrated in the above table.

4.2. Total Expenditure Reported by Category

Project expenditures are incurred and monitored by each Participating Organization and are reported as per the agreed upon categories for harmonized inter-agency reporting. In 2006 the UN Development Group (UNDG) set six categories against which UN entities must report project expenditures. Effective 1 January 2012, the UN Chief Executive Board modified these categories as a result of IPSAS adoption to comprise eight categories. The old and new categories are noted below.

2012 CEB Expense Categories	2006 UNDG Expense Categories
1. Staff and personnel costs	1. Supplies
2. Supplies, commodities and materials	2. Personnel
3. Equipment, vehicles, furniture and depreciation	3. Training
4. Contractual services	4. Contracts
5. Travel	5. Other direct costs
6. Transfers and grants	
7. General operating expenses	
8. Indirect costs	6. Indirect costs

Table 4.2 reflects expenditure as categorized in the UNDG approved 8-category expenditure format as of 31 December 2012.

In 2012, the highest percentage of expenditure was on General operating (64%). The second highest expenditure was on Supplies, commodities and materials (14%), and the third, on Contractual services (11%). Indirect support costs are within range at 7%.

Table 4.2. Total Expenditure by Category (in US dollars)

Category	Expenditure			Percentage of Total Programme Cost
	Prior Years as of 31-Dec-11	Current Year Jan-Dec 2012	TOTAL	
Staff & Personnel Cost (New)	-	9,417	9,417	1.19
Suppl, Comm, Materials (New)	-	114,908	114,908	14.50
Equip, Veh, Furn, Depn (New)	-	1,276	1,276	0.16
Contractual Services (New)	-	84,569	84,569	10.67
Travel (New)	-	76,300	76,300	9.63
Transfer and Grants (New)	-	-	-	0.00
General Operating (New)	-	506,245	506,245	63.86
Programme Costs Total	**-**	**792,714**	**792,714**	**100.00**
Indirect Support Costs Total	-	55,378	55,378	6.99
Total	**-**	**848,091**	**848,091**	

5. Transparency and accountability

The MPTF Office continued to provide information on its GATEWAY (http://mptf.undp.org) a knowledge platform providing real-time data, with a maximum two-hour refresh, on financial information from the MPTF Office accounting system on contributions, programme budgets and transfers to Participating Organizations. All narrative reports are published on the MPTF Office GATEWAY which provides easy access to nearly 9,600 relevant reports and documents, with tools and tables displaying financial and programme data. By providing easy access to the growing number of progress reports and related documents uploaded by users in the field, it facilitates knowledge sharing and management among UN Organizations. It is designed to provide transparent, accountable fund-management services to the UN system to enhance its coherence, effectiveness and efficiency. The MPTF Office GATEWAY has been recognized as a 'standard setter' by peers and partners.