Consolidated Annual Report on Activities Implemented under the Joint Programme on Maternal and Neonatal Health

REPORT OF THE ADMINISTRATIVE AGENT FOR THE PERIOD 1 JANUARY – 31 DECEMBER 2014

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PARTICIPATING ORGANIZATIONS	
	**United Nations Population Fund (UNFPA)**
	**United Nations Children's Fund (UNICEF)**
	**World Health Organization (WHO)**

CONTRIBUTORS	
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Joint Programme on Maternal and Neonatal Health Phase 2
ANNUAL PROGRAMME NARRATIVE PROGRESS REPORT
1 JANUARY – 31 DECEMBER 2014

Programme Title & Project Number	**Country, Locality(s), Priority Area(s) / Strategic Results**
• Programme Title: Joint Programme on Maternal and Neonatal Health: Phase 2 • Programme Number *(if applicable)* • MPTF Office Project Reference Number: 00083660	Country/Region: Philippines/ National Capital Region and Central Mindanao (Region XII) *Priority area/ strategic results: Reduction in maternal and neonatal mortality rates*
Participating Organization(s)	**Implementing Partners**
• United Nations Population Fund • United Nations Children's Fund • World Health Organization	• Department of Health • City Government of Quezon City, Municipalities of Aleosan, Arakan, Midsayap and President Roxas (of North Cotabato), Lebak and Kalamansig (of Sultan Kudarat and Malungon (Saranggani) • Provincial Governments of North Cotabato, Sultan Kudarat and Saranggani
Programme/Project Cost (US$) Total approved budget: MPTF /JP Contribution: S7,580,800 • *by Agency (if applicable)* Agency Contribution • *by Agency (if applicable)* Government Contribution *(if applicable)* Other Contributions (donors) *(if applicable)* **TOTAL:** $ 7,580,800	**Programme Duration** Overall Duration: 24 months Start Date: 01.07.2014 Original End Date: 30.06.2016 Current End date: 30.06.2016
Programme Assessment/Review/Mid-Term Eval. Assessment/Review - if applicable *please attach* ☐ Yes ■ No Date: *dd.mm.yyyy* Mid-Term Evaluation Report – *if applicable please attach* ☐ Yes ■ No Date: *dd.mm.yyyy*	**Report Submitted By** o Name: o Title: o Participating Organization (Lead): o Email address:

ACRONYMS

AO	:	Administrative Order
AOP	:	Annual Operational Plan
ASRH	:	Adolescent Sexual and Reproductive Health
BEmONC	:	Basic Emergency Obstetric and Newborn Care
BHS	:	Barangay Health Station
BTL	:	Bilateral Tubal Ligation
C4D	:	Communication for Development
CHSI	:	Center for Health Solution and Innovation
CEMONC	:	Comprehensive Emergency Obstetrical and Newborn Care
CHT	:	Community Health Team
CLGP	:	City Leadership and Governance Program
CPR	:	Contraceptive Prevalence Rate
CS	:	Caesarean Section
DOH	:	Department of Health
EINC	:	Essential Intrapartum and Newborn Care
FBD	:	Facility-Based Delivery
FHSIS	:	Field Health Service Information System
FP	:	Family Planning
GIDA	:	Geographically Isolated and Disadvantaged Area
HH	:	Household
IEC	:	Information, Education and Communication
IMR	:	Infant Mortality Rate
IP	:	Intrapartum
IUD	:	Intra-Uterine Device
IVRS	:	Interactive Voice Response System
JP	:	Joint Programme
JPMNH	:	Joint Programme on Maternal and Neonatal Health
KMITS	:	Knowledge Management and Information Technology Service
LARC		Long Acting Reversible Contraceptive
LB	:	Live births
LHIS	:	Local Health Information System
LCR	:	Local Civil Registrar
M&E	:	Monitoring and Evaluation
MCP	:	Maternal Care Package
MDG	:	Millennium Development Goal
MDR	:	Maternal Death Review
MISP	:	Minimum Initial Service Package
MLGP	:	Municipal Leadership and Governance Program
MLLA	:	Mini Laparotomy under Local Anesthesia
MMR	:	Maternal Mortality Ratio
MNCHN	:	Maternal, Neonatal, Child Health and Nutrition
MNDRS	:	Maternal Neonatal Death Reporting and Surveillance
NHTS		National Household Targeting System

NMR	:	Neonatal Mortality Rate
NOSIRS	:	National Online Stock Inventory Reporting System
NSV	:	Non-Scalpel Vasectomy
PHIC/PhilHealth	:	Philippine Health Insurance Corporation
POPCOM	:	Commission on Population
PP	:	Postpartum
PPP	:	Public Private Partnership
QMMC	:	Quirino Memorial Medical Center
rCHITS	:	Real-time Community Health Information System
RH	:	Reproductive Health
SBA	:	Skilled Birth Attendants
SDN	:	Service Delivery Network
SPHERE	:	School-Peers-Health-Engagement-Research-Employment
TA	:	Technical Assistance
TBD	:	To be determined
TCL	:	Target Clientele List
U4U	:	You for You
U5MR	:	Under Five Mortality Rate
UN	:	United Nations
UNDAF	:	United Nations Development Assistance Framework
UNFPA	:	United Nations Population Fund
UNICEF	:	United Nations Children's Fund
WHO	:	World Health Organization

EXECUTIVE SUMMARY

The year 2014 was the transition from Phase 1 in the first half to Phase 2 in the second half of the year. In 2014, JPMNH Phase 2 sites met the target it has set on selected maternal and neonatal health outcomes such as facility-based deliveries, contraceptive prevalence rate and early initiation of breastfeeding. Based on global evidence, these achievements are expected to contribute to the reduction in maternal and neonatal mortality in the JPMNH Phase 2 areas. Interventions at the national and local level during Phase 1 and to some extent interventions that started during the first 6 months of Phase 2 have contributed to these results. These JPMNH Phase 1 interventions include, among others, the essential intrapartum newborn care (EINC), support to facilities to become BEmONC capable and to secure MCP accreditation, and the provision of family planning commodities and training. However, the quality of the administrative data of some LGUs necessitates further triangulation and validation.

I. Purpose

The Joint Programme on Maternal and Neonatal Health (JPMNH or JP) of the Department of Health (DOH), the United Nations (i.e., United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), World Health Organization (WHO)) and the Australian government seeks to assist the Philippine Government in rapidly reducing maternal and neonatal deaths. Maternal Mortality Ratio (MMR) is one of the Millennium Development Goals (MDG) that the country will most likely not meet. MMR, which is estimated at 120/100,000 live birth (LB)[1] is off-track in meeting the target of 52/100,000 LB by 2015. While the targets for MDG Goal 4, Under-Five Mortality Rate (U5MR) and Infant Mortality Rate (IMR) are expected to be achieved, the sizeable proportion of deaths of infants in the first 28 days, representing 42% and 56% of U5MR and IMR, respectively[2] need to be addressed to accelerate reduction in infant deaths. To this end, the Programme focuses on improving the quality, access to, and utilization of intrapartum (IP), postpartum (PP), and family planning (FP) services in JPMNH areas by improving the functionality of service delivery networks (SDN), in line with the Philippine Department of Health's Maternal Neonatal and Child Health and Nutrition (MNCHN) strategy.

JPMNH will contribute to the United Nations Development Assistance Framework (UNDAF) Outcome Area 1, "Universal access to quality social services with focus on the MDGs, specifically reproductive, maternal and neonatal health".

II. Results

i) Narrative reporting on results:

On maternal and neonatal mortality: Both MMR and NMR decreased from 67.6 to 64 per 100,000 LB and from 5.86 to 5.32 per 1000 LB, respectively for the period 2013-2014. There are indications that a large number of live births are unregistered particularly in Quezon City (QC), that contribute more than half of the population, livebirths, maternal and neonatal deaths in JPMNH sites. An increase in registered live births will therefore result in lowering the MMR and NMR. Improving vital registration systems through linkages with the Local Civil Registrar

(LCR) and the real-time Community Health Information System (rCHITS) will be continued in 2015.

The decrease in maternal and neonatal rates is the result of improvements in the access and utilization of reproductive, maternal and neonatal health services. The initiatives of JPMNH Phase 1 and 2 at the national and local levels contributed in the increase in facility-based deliveries (FBD), early initiation of breastfeeding and contraceptive prevalence rate (CPR) in Phase 2 sites. In the first 6 months of Phase 2, 85% of the planned interventions have either begun implementation or were assessing and designing the intervention.

On improving the quality, access and utilization of IP, PP and FP services: The 2014 targets for 2 out of 3 indicators on access and utilization of IP and PP services were met, as follows:

- FBD for the entire Phase 2 sites increased from 84% to 86% in 2013-2014. All the JPMNH municipalities and city district reported the same or higher FBD in 2014, except for Aleosan, North Cotabato where FBD is less than 10%.

- There was an overall increase in PP women who initiated breastfeeding within one hour after giving birth, from 90% in 2013 to 98% in 2014. However, in some LGUs (i.e., Arakan, Midsayap and President Roxas, North Cotabato) breastfeeding initiation within one hour after giving birth decreased in 2014. The increase in the overall performance of JPMNH sites despite the decline in the performance of the 3 abovementioned municipalities is due to the performance of QC District 2, which was 122% in 2014. From this statistic, the quality of the administrative data necessitates further validation.

- Live births attended by skilled birth attendants (SBA) slightly decreased from 85% to 83.5%. Like FBD, all JPMNH municipalities and city district reported higher SBA in 2014, except for Aleosan, North Cotabato where SBA decreased to less than 10%.

JPMNH provided support to health care facilities to become capable to deliver Basic Emergency Obstetric and Newborn Care (BEmONC) through the provision of essential supplies, drugs, equipment, manuals and information, education and communication (IEC) materials to BEmONC facilities and barangay health stations (BHSs)/birthing clinics as well as BEmONC and EINC training to health professionals.[3] FBD in Aleosan remains a challenge because of the absence of any public lying-in that is MCP (Maternity Care Package) accredited by the Philippine Health Insurance Corporation (Philhealth or PHIC)[4] and the low demand for the service, particularly among the indigenous community, which comprise approximately 50% of the population.

Sustainability of supply of the BEMONC trained midwives is aimed to be achieved through support for the finalization and production of DOH Harmonized BEmONC Modules for Midwives. The module shall be used in the training of midwives who were not trained at the same time as the other members of the BEMONC team.

Two studies commissioned by JPMNH identified issues and suggestions to further improve the accessibility of EmONC services. The study, entitled *Geographic Accessibility to Emergency*

Obstetric and Neonatal Care (EmONC) shows that existing BEmONC and CEmONC facilities in Region XII are accessible to about 90% of the population except for the province of Sarangani (70.8%) and 3 municipalities (Alamada, North Cotabato, Lake Sebu, South Cotabato and Malungon, Sarangani) that have an accessibility coverage below 50%. The findings confirm the importance of financial support for the transportation of pregnant women at the moment of delivery and the possibility of upgrading the Polomolok Municipality Hospital from BEmONC to CEmONC to allow 8 of the 11 BEmONC facilities in the area to be within 2 hours of reach of a CEmONC facility. On the other hand, the study on the *Baseline Assessment of BEmONC Functionality* determined whether or not the basic signal functions are performed in BEmONC facilitites in six LGUs, elucidating issues related to performance, such as training, supply, management and policies. Four (4) BEmONC facilities in Sultan Kudarat and Sarangani performed all signal functions.

Quality of SDN is expected to be enhanced with the implementation of the Partner Defined Quality (PDQ) while the LGUs are also being provided technical support to increase demand for services through participatory design of Communication for Development (C4D) interventions.

In 2014, EINC was scaled up to include private hospitals and private birthing clinics especially in NCR (Quezon City and Taguig), and in General Santos City. As a result there are already horizontal referrals between and among the public and private health facilities. The JPMNH study on the "Economic Evaluation of EINC in a Facility Setting in the Philippines" revealed that the cost of delivery at the Fabella Hospital and Quirino Memorial Medical Center (QMMC) were observed to have reduced while in General Santos the cost of delivery increased but the increase was still markedly lower than the overall average cost of hospitalization.

EINC is expected to be further scaled up with the integration of EINC in the pre-service curricula of 419 nursing and midwifery schools nationwide, building on the work of integration in the curriculum of medical schools in the earlier years of Phase 1.

A formative research in 2014 on the integration of EINC in the Medical Curricula revealed that 38 medical schools are currently integrating EINC in either the first year or second lessons both in Obstetrics and Pediatrics, with either a clinics (OSCE) or live or actual evaluation of the lessons and skills learned in the classroom.

Part of the learning agenda of JPMNH Phase 2 is a compliance report on the implementation of IP, PP and newborn care practices among trained public providers in Region XII for purposes of enhancing existing systems and guidelines and for scaling-up. The report is expected to also clarify data quality issues in the JPMNH areas.

<u>On the availability of quality FP services:</u> Contraceptive Prevalence Rate (CPR) increased from 70% to 76%[5] for the period 2013-2014. The contribution of JPMNH to this progress stems from the following Phase 2 interventions and Phase 1 activities such as the provision of FP commodities, training on basic and comprehensive FP skills and introduction of the National Online Stock Inventory Reporting System (NOSIRS):

- Scaling up of the sub-dermal implant contraception through provision of commodities, training of health care providers, provision of technical advice to DOH and conduct of a research that provided evidence in support of the formulation of a national policy on sub-dermal implant. In JPMNH sites, 6,578 women have availed of sub-dermal implant services[6] while 171 health care providers have been trained; majority of whom are in Quezon City. About 46 more health care providers in Sultan Kudarat and North Cotabato need training on implant insertion and removal.[7]

  As a result of JPMNH investments in promoting Sub Dermal Implants including training of health service providers and provision of commodities for the initial phase, the DOH leveraged its resources in the procurement of said commodities. In 2014, the department purchased 700,000 units amounting to Php 350,000,000.

- In addition, JPMNH provided services to 298 women with intra-uterine device (IUD) and 307 women with bilateral tubal ligation (BTL) and 38 men with non-scalpel vasectomy (NSV). A total 129 health service providers were trained on IUD, BTL and NSV. A big number of LGUs were not able to send doctors qualified to take the Mini Laparotomy under Local Anesthesia (MLLA) training since they do not have surgeons or obstetricians in their local health facilities. More obstetricians are needed to address the unmet needs for family planning.

- Communication and education campaign for the youth using social media: Eight (8) You for You (U4U) teen trail events, which reached 1,083 teens in Sarangani and Sultan Kudarat were conducted by JPMNH. Because of JPMNH intervention, the Commission on Population (POPCOM) scaled up U4U using their own budget, conducting 148 U4U events that reaching 20,569 young people nationwide.

U4U was developed by the Center for Health Solutions and Innovations (CHSI) Philippines, Inc. together with POPCOM and with the support of JPMNH (Phase 1) in 2013. U4U was officially launched by POPCOM in January 2014. About 148 U4U events were staged in several areas of the country that reached 20,569 Filipino youth with critical messages on ASRH. Eight (8) of these U4U events, which reached 1,083 teens were held in Sarangani and Sultan Kudarat and was supported by JPMNH. In addition, POPCOM has scaled up the conduct of U4U event and has conducted about 11 events in North Cotabato, South Cotabato, Cotabato City and Maguindanao that reached 1,457 young people. It is reported that POPCOM receives 2-5 calls per week from partners requesting for the conduct of U4U events. The social media account of U4U has approximately 25,000 followers on Facebook and about 5,000 visitors of the webpage while the U4U IVRS has reached 33,000 young people.

Beginning 2015 and as per the agreement of the National Program Steering Committee chaired by DOH Assistant Secretary Paulyn Jean Ubial, teenage pregnancy will be added as an indicator in view of the high rates of teen pregnancy at the national level and in JPMNH sites. Teen pregnancy will be reflected in the 2015 report.

On strengthening health systems in support of IP and PP. JPMNH continued to work on strengthening the components of the health systems in order to improve the functionality of the SDN.

To better understand how EmONC facilities will add up to form an SDN, A GIS Study on Access to EmONC Facility was conducted. Thru this study, appropriate referral system between BEmONC to BEmONC, BEmONC toCEmONC,, from private to public facilities and between geographic territories or areas of responsibility can be designed in order to provide a greater number of clients with better and easier access to MNCHN services, particularly IP and PP services.

Progress was achieved in providing financial protection to mothers about to give birth and their newborns with the following developments:

- Issuance of Philhealth Circular No. 022-2014 entitled, "Social health insurance coverage and benefits for women about to give birth", which defines policies and procedures that will give financial risk protection to women who are about to give birth";

- Doubling of the number of public lying-in facilities that are accredited under the Philhealth MCP in JPMNH Phase 2 sites.

Both of these developments will partly address the issue of financial accessibility to maternal and neonatal health services, which were raised in the preliminary results of the JPMNH study on Communication for Development (C4D).

JPMNH, through the WHO, provided technical advice and support in the drafting of the abovementioned Philhealth circular and is continuously working with local governments for the implementation of the circular. Increasing the awareness of the community on the benefits of the new Philhealth circular and other relevant Philhealth issuances is expected to be incorporated in the C4D plan that is being formulated. The National Program Steering Committee also agreed to include utilization of MCP benefits as an indicator beginning 2015.

Health leadership and governance is being enhanced with the City Leadership and Governance Program (CLGP) and the Municipal Leadership and Governance Program (MLGP). All JPMNH municipalities (except for Arakan) and Quezon City have been engaged and have completed the first module of the program.

2014 saw an enhancement in the frequency and quality of Maternal Death Review (MDR) conducted at the provincial level. The increased appreciation of the provincial MDR teams of the importance of MDR resulted in the quarterly conduct of MDRs and the emphasis on the formulation and dissemination of, and compliance with recommendations.

The Maternal and Neonatal Death Reporting and Surveillance (MNDRS) has been institutionalized by the DOH Knowledge Management and Information Technology Service (KMITS). MNDRS was incorporated in the 2014 workplan of DOH-KMITS and rolled-out

using their own budget in non-JPMNH areas such as Regions CAR, 4A and 4B,6,7 11, aside from Regions NCR and 12(JPMNH site). On-line MNDR reports are available at the DOH website. The real-time Community Health Information Tracking System (rCHITs) has been installed in all JPMNH sites in Region 12. A program for maternal tele-referral was developed and piloted for QC between Murphy Lying-In Clinic and QMMC.

As part of JPMNH advocacy, the UN agencies as part of the DOH RH-MCH Technical Working Group, assisted in the drafting of the National Policy on the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) in Health Emergencies, Natural and Man-made Disasters. Said policy incorporated learnings from the humanitarian response from JPMNH sites, and aims to establish coordinative linkages between government agencies from national, regional to local governments on the effective implementation of the MISP; and to identify roles and responsibilities between key stakeholders relative to the implementation of programmatic interventions of MISP on the prevention and management of sexual violence, reduction of STI/HIV transmission, prevention of maternal and neonatal morbidities and mortalities, and planning for comprehensive RH services.

On institutionalizing a joint working approach to programme management and implementation. A joint working approach characterized the management and implementation of JPMNH Phase 2, as evidenced by the jointly formulated JPMNH work plan for 2014-2016, a single programme results framework, one monitoring and evaluation (M&E) plan, one National Programme Steering Committee that reviews, oversees and provides direction to the programme and one Technical Working Group that ensures coordination and alignment of intervention (such as the adolescent health program) and the joint monitoring visits conducted in July and September 2014.

In 2014, the joint approach facilitated the exchange of information with and among the 3 United Nations (UN) agencies, simplified coordination with key partners namely the DOH and the Australian government since these agencies communicate with only one focal person instead of three and resulted in a unified direction, common message and complementation and augmentation of each of the UN agencies' specialization and interventions towards an integrated implementation.

On gender mainstreaming: The JPMNH, while already integrally focused on maternal and neonatal care, added the dimension of male involvement in FP in program implementation and assessment. The communication research on community behaviors related to maternal and newborn health identified key issues faced by men and women in accessing reproductive, maternal and neonatal services. EINC promoted shared responsibility in child care and encouraged the husband/ partner to be sensitive to their wife's need during birthing process. The demand generation activity in Sultan Kudarat used the Family Development Session (FDS) as vehicle for conducting FP sessions to reach CCT beneficiaries. In 2014, 2507 women of reproductive age and their husband were served by LAPM (BTL and implant) in Sultan Kudarat.

ii) Indicator Based Performance Assessment:

	Achieved Indicator Targets (2014)	Reasons for Variance with Planned Target (if any)	Source of Verification
Impact: Improved quality of facility based intrapartum and postpartum care			
Indicator**:** Maternal mortality ratio = maternal deaths/livebirths X 100,000 Baseline (2013): 67.63/100,000 (LB) Target: 63.87 (2014)/39.45 (2016)	64.02		Field Health Service Information System (FHSIS)/ LCR at the municipal, city and city district levels
Indicator: Neonatal mortality rate (NMR) = neonatal deaths/livebirths X 1,000 Baseline: (2013) 5.86 Planned Target: 5.42 (2014)/ 5.18 (2016)	5.32		FHSIS and LCR at the municipal, city and city district levels
Outcome 1: Improved quality of facility based intrapartum and postpartum care			
Indicator: Percentage of facility-based deliveries Baseline (2013): 84.39 Planned Target: 83.2(2014)/ 87.6(2016)	85.96		FHSIS at the municipal and city district levels
Indicator: Percentage of live births attended by skilled health personnel Baseline (2013): 84.98 Planned Target: 84.6 (2014)/ 87.98(2016)	83.53	.	FHSIS and LCR at the municipal and city district levels
Indicator: Percentage of pregnant women who had a caesarean section (CS) in catchment areas Baseline (2013): Planned Target: 5-15%[8]	To Be Determined (TBD)	Data will be generated by the baseline study	
Indicator: Percentage of postpartum women who initiated breastfeeding within 1 hour after giving birth Baseline (2013): 90.09 Planned Target: 82.6 (2014)/ 90.19(2016)	97.77	Quezon City district 2 performance is higher than 100% in 2013-2014. The data will be validated by the baseline study. The targets, accordingly will be revised.	FHSIS at the municipal and city district levels

	Achieved Indicator Targets (2014)	Reasons for Variance with Planned Target (if any)	Source of Verification
Outcome 2: Increased demand for intrapartum, postpartum and family planning services			
Indicator: Percentage of women with unmet need for family planning Baseline: (2013) Planned Target:	TBD	Data will be generated by the baseline study	
Output 2.1 Community Health Team (CHT)/community MNCHN support groups are functional in JPMNH areas to address MNCHN issues of Q1 and Q2 poor and adolescents Indicator 1.1.1 Percentage of women 15-49 years old in the National Household Targeting System (NHTS) households (HHs) who are new acceptors (shifters/new acceptors) of modern FP methods Baseline (2013): Planned Target:	TBD	Data will be generated by the baseline study	
Output 2.2 C4D/BCC in IP, PP and FP interventions implemented Indicator 1.2.1 Percentage of children aged 6 months exclusively breastfed Baseline (2013): 71 Planned Target: 71 (2014)/73(2016)	71.70		FHSIS at the municipal and city levels
Outcome 3: Improved availability of good quality FP services			
Indicator: Contraceptive Prevalence Rate for modern methods Baseline (2013): 69.34 Planned Target: 73.5 (2014)/ 77.3 (2016)	75.81	There are 2 municipalities	FHSIS at the municipal and city levels

	Achieved Indicator Targets (2014)	**Reasons for Variance with Planned Target (if any)**	**Source of Verification**
Outcome 4: JP area health systems strengthened in support of IP and PP			
Indicator: Percentage of functional SDN in JPMNH sites Baseline (2013): 25% Planned Target: 25% (2014)/ 100% (2016)	25%	Sultan Kudarat rated its SDN as functional using MNCHN monitoring tool (self-assessment). The baseline study will validate the assessment	
Output 4.1 MDRs strengthened /instituted Indicator 4.1.1 Percentage of MDR recommendations implemented Baseline (2013): Planned Target: (2014) /100 (2016)	TBD		Municipal and city health department
Output 4.2 PhilHealth accreditation of facilities achieved Indicator 4.2.1 Percentage of public lying-in facilities that are MCP accredited Baseline (2013): 32.5 Planned Target: 53.4 (2014)/ 79 (2016)	65.1		Philhealth, central and regional levels

Note:

1. The baseline study will triangulate/validate the reported data and generate the data for indicators that are not routinely/administratively generated by the local governments.
2. The 2014 targets are lower than the baseline figure for some of the indicators because in some LGUs, the performance in 2013 exceeded 100% and/or the targets were set even before the baseline data were established.

ii) A Specific Story

SCALING-UP OF SUB-DERMAL IMPLANT CONTRACEPTION

High Unmet Need for Family Planning: The MDG goal on maternal mortality and universal access to reproductive health services will most likely not be achieved by the country. The high level of maternal mortality could be driven by the high unmet need for modern family planning that puts about 5.7 million Filipinos at risk of unplanned and mistimed pregnancies. (DOH AO 2015-006)

While there exists a demand for permanent and long acting reversible contraceptive (LARC) methods, some local governments were hesitant to provide subdermal implants as one option for family planning pending the certification of the Food and Drug Administration (FDA) that sub-dermal implants are not abortifacients and the issuance of DOH AO recognizing sub-dermal implants as one of the modern family planning methods. Sub-dermal implant is a long acting reversible hormonal contraceptive that gives a 3-year protection against pregnancy and is endorsed by the United Nations Commission on Life-Saving Commodities as one of the thirteen life-saving commodities. The Progestin-only sub-dermal implant available in the Philippines is Implanon®, an etonogestrel –containing rod inserted sub-dermally in the inner side of the upper arm.

Scaling-up of Sub-dermal implants: The program on scaling up of sub-dermal implant aims to increase demand for and utilization of Progestin-only sub-dermal implant in the community through the following interventions:

- The Expanded Program on Implant Contraception (EPIC) which was implemented by the Family Planning Consortium/Philippines Society for Responsible Parenthood (PSRP) generated demand for, and distributed, sub-dermal implants to LGUs, hospitals and NGOs nationwide through its 97 partners. Provision of free commodities was deemed necessary in order to generate public demand (esp. in 2014 when the FDA has not re-issued the certificate stating that sub-dermal implants are not abortifacient) for a method that is relatively new in the country, demonstrate the advantages of sub-dermal implants as an FP method and persuade local governments to continue providing free implant services and commodities.

  Preliminary reports indicate that about 61,821 women availed of sub-dermal implants during the second half of 2014 (there are no reports yet for 58% of the sub-dermal implant units delivered). Majority of the recipients are in the 20-29 (55.9%) and 30-39 (28.4%) age groups. Around 9% are 19 years old and below. In JPMNH areas, 6,578 women have availed of sub-dermal implants.

- Nationwide training of health care providers on sub-dermal implant insertion was conducted by Ortoll Reproductive Health Unit and Dr. Jose Fabella Memorial Hospital. Partial reports indicate that there are now a substantial number of health care providers

nationwide (1,322 health care providers have been trained during period 2012-2014) that have the capabilities to perform sub-dermal implant insertion and removal services. However, there are still several areas without a trained service provider. In JPMNH provinces and city, 195 health care providers have been trained; 88% of which are in Quezon City. Additional trained health care providers on sub-dermal implant insertion are needed in Sultan Kudarat and North Cotabato. As of 2014, seven have been trained while 46 more health care providers need training.

- Technical support in the formulation of the DOH AO recognizing sub-dermal implants as one of the modern family planning method. DOH AO 2015-0006 entitled "Inclusion of Progestin Subdermal Implants as one of the Modern Methods Recognized by the National Family Planning Program" was issued last February 2015 after the FDA re-certified sub-dermal implants as non-arbortifacient. The AO defined the roles and responsibilities of the concerned agencies and specified the guidelines on, among others, the procurement, distribution, service provision, training, communication, recording and reporting on sub-dermal implants.

JPMNH provided support in scaling up sub-dermal implants through UNFPA. Specifically JPMNH supported the provision of commodities and conduct of training of health care providers in JPMNH areas. JPMNH also provided technical advice in the drafting of the DOH AO through the participation of Friendly Care/PSRP as a member of the Technical Working Group created by DOH to draft the AO on sub-dermal implants.

Since the agreements with some partners including local governments on the provision of sub-dermal implants implant services were approved after the local budgets have been appropriated, some partners were unable to provide funds for the purchase of the needed medical supplies such as the bandage and Lidocaine (anesthesia).

YOU FOR YOU (U4U) YOUTH CARAVAN

High Rates of Teen Pregnancy: The high teenage fertility rate in the Philippines of 47/1000 live births contributes to the country's high population growth rate and poses a high risk for maternal deaths among young girls. Lack of access to age-appropriate, correct and accurate information as well as adolescent-friendly sexual and reproductive health services put young people at risk of unintended pregnancies and sexually transmitted infections due to early and unprotected sexual activity.

Entertainment-Education Strategy in Reaching the Youth: U4U is an entertainment-education (enter-educate) learning package that provides young Filipinos with critical information to help them prevent teen pregnancies and sexually transmitted infections through three platforms:

1. **Teen Trail information caravan or event.** The Teen Trail is an event managed by young people providing information on ASRH.
2. **Ask U4U interactive voice response system (IVRS).** The Ask U4U IVRS is a mobile platform where mobile users can send a text alert to the system and a virtual doctor or counselor calls up the user and provides recorded messages, divided into three tracks of body, health and sex.
3. **U4U web and social media accounts.** The www.u4u.ph web is an interactive portal that allows online users to create meme cards, family decals and design statement shirts while learning about life skills and other critical information on ASRH. The website has a Teen Trail module that is designed as an online learning tool for web users. Facebook and YouTube accounts have also been set up as information sources for young people.

U4U was developed by the Center for Health Solutions and Innovations (CHSI) Philippines, Inc. together with POPCOM and with the support of JPMNH (Phase 1) in 2013. U4U was officially launched by POPCOM in January 2014. About 148 U4U events were staged in several areas of the country that reached 20,569 Filipino youth with critical messages on ASRH. Eight (8) of these U4U events, which reached 1,083 teens were held in Sarangani and Sultan Kudarat and was supported by JPMNH. In addition, POPCOM has scaled up the conduct of U4U event and has conducted about 11 events in North Cotabato, South Cotabato, Cotabato City and Maguindanao that reached 1,457 young people. It is reported that POPCOM receives 2-5 calls per week from partners requesting for the conduct of U4U events. The social media account of U4U has approximately 25,000 followers on Facebook and about 5,000 visitors of the webpage while the U4U IVRS has reached 33,000 young people.

U4U provided POPCOM and the local governments with an alternative and replicable health communication package that is entertaining, interactive and which allows young people to speak about adolescent sexuality and reproductive health (ASRH) in a safe, non-threatening setting. U4U is being implemented as an integral part of the local governments' annual investment plan (i.e., Sultan Kudarat provincial government) and campaign for young people such as the "True Love Waits" campaign of the provincial government of Sarangani led by Vice Governor Jinkee

Pacquaio. Technical assistance to the local governments of Malungon, Sarangani and Tacurong, Sultan Kudarat has resulted to a more rational and systematic approach in planning and conducting U4U activities.

Linking Provision of Information with Services. In 2015, U4U will be linked with a menu of ASRH interventions that can be rolled out in various settings in order to provide an integrated approach to ASRH programming. These interventions include a) an integrated school-based program with focus on guidance counseling, life skills and values education; b) peer education outreach program; c) facility-based services with healthy lifestyle and fitness promotion; d) parent effectiveness seminars; e) a Teen Track system; and f) career guidance and job placement. Called U4U SPHERE (School-Peers-Health-Engagement-Research-Employment), this strategy will be implemented in local governments that commit to a holistic approach in ASRH programming,

Giving birth the ‘Unang Yakap’ way

Nico Alconaba*@inquirerdotnet*
Inquirer Mindanao
5:54 AM | Sunday, November 16th, 2014

GINA Avenido with her newborn John Fritch
NICO ALCONABA

Twenty-Year-Old Gina Avenido was brought to the delivery room after her water broke at 8:45 p.m.

Inside the delivery room of the rural health unit (RHU) in the town of Lebak, three midwives and two midwifery students led Gina to a delivery bed. She was ready to give birth.

Gina was brought to the same room five hours earlier when the RHU staff thought she was about to give birth. While Gina was having contractions, Dr. Maria Asuncion Silvestre, a neonatologist and consultant of Kalusugan ng Mag-Ina Inc. (KMI), advised Gina that she didn’t have to be lying down to give birth.

Silvestre and Dr. Donna Capili, another neonatologist and KMI consultant, were in Lebak on a field visit, checking on the implementation of “Unang Yakap” (The First Embrace), a step-by-step process to ensure the health of both mother and baby.

The sequence includes the thorough drying of the baby; immediate skin-to-skin contact between mother and baby; properly timed clamping and cutting of the cord; and initiation of breast-feeding.

Unang Yakap is the popular name of the Essential Intrapartum and Newborn Care (EINC) project that is being implemented with the help of the United Nations Children’s Fund (Unicef) and other United Nations agencies.

At first, Gina thought Silvestre, Capili and Dr. Mariella Castillo, a specialist of the health and nutrition section of the Unicef, were there to attend to her. Instead, the mother-to-be had an on-the-spot educational session.

Hours before going into labor, the doctors discovered that Gina had a white cloth tied around her belly, an old practice done by a hilot (traditional birth attendant) aimed at “helping” mothers “push” their babies out.

“That’s not needed,” Castillo told Gina.

“It’s of no use. It’s like wearing a belt. When it’s too tight, you’ll have difficulty breathing,” Capili added.

Silvestre also offered water for Gina to drink, a no-no to a skilled hilot. The doctor also asked for a wet cloth to wipe Gina’s face. For Silvestre, the commonly prohibited practice of routinely not allowing food or drink is passe, and mothers should be given light snacks and water if they so desire.

“Just imagine the pain she’s going through, and yet she’s not allowed to drink, eat or even freshen up,” Silvestre said.

All these happened while Gina’s mother-in-law, Alita, silently watched as she rubbed the back of her daughter-in-law. There were no protestations from Alita, a hilot.

“I’m a hilot, but I won’t do it myself,” Alita said when asked why she and her son, Frederick, opted to have a facility-based childbirth for Gina.

“We (hilot) are no longer allowed to do that so we brought her here,” she said.

The Avenidos live in Sitio Airland in the remote village of Ragandang, more than an hour by motorcycle to the town center, where the RHU is located. As early as August, Gina was staying with her mother Teresa Gregoria’s home in the town center.

“It would be difficult for her to take an hourlong motorcycle ride, so we decided to bring her to the town center long before her due date,” Frederick said.

And Gina had her date with the delivery room on Oct. 24.

As early as 7 a.m., Gina had been experiencing contractions, but it was only after more than 12 hours that her water broke. Now lying on the delivery bed, the contractions came every 10 minutes. She continued “pushing,” amid the constant “you can do it” cheering from the midwives and the physicians.

Capili demonstrated to Gina the proper way of pushing.

“Two short and one long exhales,” Capili repeatedly told Gina, who was then pushing with her mouth closed.

At 9:50 p.m., Gina said: “I can’t do it anymore.”

As if on cue, everybody in the room cheered: “You can do it.”

Two minutes later, Gina again said: “I can’t take it anymore.”

Again, she got a “you can do it” reply.

Eleven minutes and several “pushes” later, Gina, like a lull before a storm, silently composed herself—her hands on her thighs, feet firmly pressed on the foot rest and her body in an upright position. She pushed until her baby came out.

Immediately, the baby was put on Gina’s chest for thorough drying. At the same, Castillo made the call: “Baby boy out at 10:06.”

Midwife Sharlyn Fura checked Gina’s womb for a possible second baby. There was none.

Then, Fura checked the umbilical cord. It had stopped pulsating, which meant it had completed transfusing blood (with oxygen and iron) from the placenta to the baby. It was time to cut it.

All these well-timed procedures happened while Gina and her baby were in uninterrupted skin-to-skin contact as what Unang Yakap espouses.

“Happy,” Gina said when asked how she felt. She could not stop staring at her baby.
Her baby, later named John Fritch, wore a pink beanie with the words “Happy Baby.”

Read more: http://newsinfo.inquirer.net/650939/giving-birth-the-unang-yakap-way#ixzz3VXudrkkn

Bid for better health gives birth to app

Karlos Manlupig*@inquirerdotnet*
INQUIRER MINDANAO
9:25 PM | Saturday, November 9th 2013

HEALTH workers at Malungon Rural Health Unit during a training session on rCHITS in Sarangani province last month PHOTO FROM RCHITS FACEBOOK PAGE

Midwives in the country have been on the front line of providing basic maternity and child health services.

They lack access to health information and resources, and patients visited by these health workers are unreported.

Now, a mobile phone application supported by an online system, offers access to information at the tap of a screen or click of a phone button.

The application, developed by a Filipino, Rene James Balandra Jr., offers an integrated mobile technology to health workers that can deliver real-time data reporting across the country.

Created through the efforts of the United Nations Children's Fund (Unicef) and the University of the Philippines (UP) Manila National Telehealth Center, rCHITS, or real-time monitoring of maternal and child health indicators through the Community Health Information Tracking

System, aims to reinforce health information systems by providing quick reporting of key indicators.

Health workers can now send actual reports of every case they handle through the application, which utilizes the short messaging service (SMS).

Pilot areas

The pilot rCHITS was tested from November 2011 to May 2012 in Gamay, Northern Samar; Sto. Domingo, Albay; and Glan, Sarangani.

The second rCHITS, or rCHITS2, which was launched this month, has expanded to 10 sites including the towns of Lebak and Kalamansig in Sultan Kudarat; Malungon town in Sarangani; the towns of Aleosan, Arakan, Midsayap and President Roxas in the province of North Cotabato; Puerto Princesa City; Davao City and Quezon City.

Communications firm Globe Telecom, one of the project partners, donated hundreds of Android phones and one-year worth of prepaid load for the implementation of the program.

Tomoo Hozumi, Unicef country representative, said providing real-time information addressed the need for results and accountability in the country and across the world.

“Globally and in the Philippines more than ever, there is a demand for results and accountability. Efforts to make the health system more efficient, more transparent and more responsive to information needs directly address that demand,” said Hozumi in a speech read by Dr. Mariella Castillo, UNICEF Philippines health specialist.

Let persons exist

“To deliver services meaningfully and inclusively, we need to make every person exist in our client lists. To be held accountable and be properly credited for services rendered, a record needs to be made of all contacts between families and health workers,” Hozumi added.

After the local health workers text or send their report, it will automatically be collated and included in previous reports and will immediately appear on the LGU Dashboard which is a “graphical user interface that can be accessed through the web which allows local chief executives to see the health status of his/her respective community or barangay.”

“All these in a way that facilitates, and not encumbers your daily workload. And for these data to reach health decision-makers such as your mayors and the local health boards, so that their plans and budgets become more timely and responsive to your needs,” Hozumi said.

Sheila Pregonta, a midwife from the farming town of President Roxas in North Cotabato, agreed that reporting would be faster and it would help ease their work load aside from facilitating requests for additional funds.

“It can help us with our reporting. This time, it is faster because it is in real-time. We do not have to wait for a month just for the reporting,” Pregonta said.

"Our mayor can now see data which are faster and more reliable," she added.

LGU roles

Dr. Portia Fernandez-Marcelo, director of UP Manila National Telehealth Center, said they were very interested to see how the mayors of the selected towns would utilize the real-time data.

"The idea is how will the mayor use the information in decision making?" Marcelo said.

Marcelo said they were also curious about how the project would be sustained even after the grant.

"If the mayor sees its need, maybe the LGU can continue [the program]," Marcelo said.

She added that majority of the selected areas were impoverished and were very difficult to reach. The midwives in the selected areas said they, too, were excited about having access to technology and information.

Pregonta said using the technology might be quite tricky for those who were not familiar with Android phones.

"For those who use Android phones, it is pretty easy. But for those who are new in using this device, it can be easily learned," Pregonta said.

Read more: http://newsinfo.inquirer.net/524137/bid-for-better-health-gives-birth-to-app#ixzz3VXvMqfNE

III. Other Assessments or Evaluations

Geographic Accessibility to Emergency Obstetric and Neonatal Care (EmONC): The study analysed accessibility of EmONC facilities to the people of Region XII and identified potential gaps to achieve Universal Health Care in the region. The study made use of a freely available GIS extension software developed by WHO to measure physical accessibility to health care called AccessMod and statistical data from existing sources to measure accessibility coverage according to the following indicators: a) percentage of births where the household is located within 2 hours travel time from a BEmONC and Comprehensive Emergency Obstetrical and Newborn Care (CEmONC) facility; and b) the travel time between each BEmONC facility and the nearest CEmONC facility.

The study showed that existing BEmONC and CEmONC facilities in Region XII are accessible to 89.8% of the population (universal coverage is 90%) except for the province of Sarangani (70.8%) and 3 municipalities (Alamada, North Cotabato, Lake Sebu, South Cotabato and Malungon, Sarangani) that have an accessibility coverage below 50%. Also, 11 BEmONC facilities are beyond 2 hours of reach of the nearest CEmONC facility in case of referral of complicate cases, the maximum travel time is 4.6 hours for Palimbang RHU. The findings confirm the importance of financial support for the transportation of pregnant women at the

moment of delivery and the possibility of upgrading the Polomok Municipality Hospital from BEmONC to CEmONC to allow 8 of the 11 BEmONC to be within 2 hours of reach of a CEmONC facility.

BEmONC Functionality: A Baseline Assessment of Facilities in Selected UNFPA Sites: The study assessed the functionality of 95 BEmONC facilities in UNFPA-assisted areas, using the 'signal functions" used to measure capacity to treat obstetric and newborn emergencies provided in the WHO/UNICEF/UNFPA guidelines. Of the 95 facilities assessed, only the following four facilities in Region XII performed all seven of the signal functions in the three months prior to the assessment: 2 primary hospitals and 1 RHU in Sarangani and 1 District hospital in Sultan Kudarat. Almost a third (27.4) of the facilities did not perform any of the 7 signal functions within the reference period while the rest performed varying combinations of the 7 signal functions. The signal functions reported by most facilities as not performed were "Perform assisted 2 vaginal delivery" (90.5%), "Remove retained products" (75.8%) and "Administer parenteral anticonvulsants" (69.5%). The study also identified the issues cited by health facilities for not performing all seven signal functions.

Communications Research on Maternal & Neonatal Behavior in JPMNH Areas: The study which made use of qualitative research methods found that pregnant women are generally aware of recommended MNH practices, but not of their importance. Female relatives (mothers, mothers-in-law, aunts, and older sisters) give advice on child care, but mostly about what not to do while pregnant and what to eat. They also have inadequate information regarding PhilHealth benefits. Meanwhile, their partners mainly provide monetary support and help in doing chores. The local government experienced difficulty in implementing the local ordinance because of mothers' financial situation. CHTs rely on interpersonal skills for appropriate communication

The study also identified the following supply side deterrents to maternal and newborn health practices: a) Inaccessibility of birthing facilities; b) Shortage of health staff; c) Dismissive or condescending attitude of health staff; d) Inadequate finances; e) Inadequate CHT training; and f) Shortage of medicines and equipment. Clients did not avail of maternal and newborn health services because of the following reasons: a) Perception of extra care by TBA; b) Positive previous experience with TBA; c) Lack of education of pregnant women; d) Cultural attributions; e) Attitudes of pregnant women; and f) Relationship of TBA with pregnant women. The absence of ordinance prohibiting home births or TBAs, unclear referral systems and inadequate support for health from LGU leadership had an effect on access to services.

Drivers for recommended MNH practices include; a) Nearness of residence to a birthing facility; b) Attention of health staff; c) Positive experiences with health staff; d) PhilHealth enrolment; e) Adequate reminders from CHTs; f) Incentives and rewards for facility-based deliveries; g) Prioritizing health in terms of municipal budget; h) Safety and health of the child; i) Knowing the importance of recommended practices; j) Positive previous experience of facilities and health staff, from own experience or through others'.

[1] 2013 estimates of WHO, UNICEF, UNFPA, The World Bank, and United Nations Population Division Maternal Mortality Estimation Inter-Agency Group

[2] National Demographic and Health Survey 2013

[3] Learning was enhanced during the training since the trainors joined field visits and supervised implementation.

[4] DOH AO 2015-0003 rescinded AO 2011 -0014 which mandates the Regional offices Technical Division to conduct certification of birthing facilities since the DOH licensing of birthing centers (AO 2012-0012) and the Philhealth MCP accreditation protocols require the presentation of documents and evidence of the health facility's BEmONC capability.

[5] Preliminary estimate. No data available for the municipalities of Aleosan and President Roxas, North Cotabato. The trend is not expected to be reversed when data from these municipalities are added since these municipalities constitute only a small percentage of the population in the JPMNH sites.

[6] Based on the following reports: a) status of 42% of sub-dermal implant commodities that have been distributed; and b) partial report on the training of health care providers.

[7] The national policy on implants, DOH AO 2015-0006 entitled "Inclusion of Progestin Subdermal Implants as one of the Modern Methods Recognized by the National Family Planning Program" was issued last February 2015.

[8] The target on caesarean section is based on the 2010 World Health Report, entitled "The Global Numbers and Costs of Additionally Needed and Unnecessary Caesarean Sections Performed per Year: Overuse as a Barrier to Universal Coverage", Luz Gibbons, José M. Belizán, Jeremy A Lauer, Ana P Betrán, Mario Merialdi and Fernando Althabe