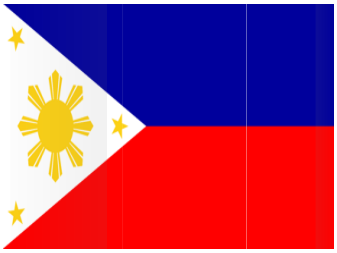

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Consolidated Annual Report on Activities Implemented under the Joint Programme on Maternal and Neonatal Health

REPORT OF THE ADMINISTRATIVE AGENT FOR THE PERIOD 1 JANUARY – 31 DECEMBER 2015

Multi-Partner Trust Fund Office
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United Nations Development Programme
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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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CONTENTS

Joint Programme on Maternal and Neonatal Health Phase 2
ANNUAL PROGRAMME NARRATIVE PROGRESS REPORT
1 JANUARY – 31 DECEMBER 2015

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) • United Nations Population Fund • United Nations Children's Fund • World Health Organization	**Implementing Partners** • Department of Health, PhilHealth • City Government of Quezon City, Municipalities of Aleosan, Arakan, Midsayap and President Roxas (of North Cotabato), Lebak and Kalamansig (of Sultan Kudarat and Malungon (Sarangani) • Provincial Governments of North Cotabato, Sultan Kudarat and Sarangani • NGOs: Philippine Society for Responsible Parenthood, Zuellig Family Foundation, Center for Health Solutions and Innovations, Save the Children, Philippine Legislator's Committee on Population and Development, UP National TeleHealth Center, Xavier Science Foundation, McCann, Center for Innovation Change and Productivity
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

AJA	:	Adolescent Job Aide
AOP	:	Annual Operational Plan
ASRH	:	Adolescent Sexual and Reproductive Health
BEmONC	:	Basic Emergency Obstetric and Newborn Care
BCC	:	Behavior Change Communication
BHS	:	Barangay Health Station
BiRTS	:	Birth Registration Tracking System
BTL	:	Bilateral Tubal Ligation
C4D	:	Communication for Development
CCT	:	Conditional Cash Transfer
CICP	:	Center for Innovations. Change and Productivity
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
DILG	:	Department of Interior and Local Government
DOH	:	Department of Health
DRRM	:	Disaster Risk Reduction Management
DSWD	:	Department of Social Welfare and Development
EINC	:	Essential Intrapartum and Newborn Care
FBD	:	Facility-Based Delivery
FDS	:	Family Development Sessions
FHSIS	:	Field Health Service Information System
FP	:	Family Planning
FPAS	:	Family Planning Action Sessions
GIDA	:	Geographically Isolated and Disadvantaged Area
GBV	:	Gender Based Violence
HH	:	Household
HHH	:	Howard Hubbard Hospital
HLGP	:	Health Leadership and Governance Program
HSP	:	Health Service Provider
IEC	:	Information, Education and Communication
IMR	:	Infant Mortality Rate
IP	:	Intrapartum
IUD	:	Intra-Uterine Device
IVRS	:	Interactive Voice Response System
IYCF	:	Infant and Young Child Feeding
JP	:	Joint Programme
JPMNH	:	Joint Programme on Maternal and Neonatal Health
KMITS	:	Knowledge Management and Information Technology Service
LARC		Long Acting Reversible Contraceptive
LAPM	:	Long Acting Permanent Method
LB	:	Live births
LHIS	:	Local Health Information System

LCR	:	Local Civil Registrar
M&E	:	Monitoring and Evaluation
MBFHI	:	Mother Baby Friendly Hospital Initiative
MCP	:	Maternal Care Package
MDG	:	Millennium Development Goal
MDR	:	Maternal Death Review
MINTS	:	Mag-Ina Telereferral System
MISP-RH	:	Minimum Initial Service Package for Reproductive Health
MLGP	:	Municipal Leadership and Governance Program
MLLA	:	Mini Laparotomy under Local Anesthesia
MMR	:	Maternal Mortality Ratio
MNCHN	:	Maternal, Neonatal, Child Health and Nutrition
MNH	:	Maternal and Neonatal Health
MNDRS	:	Maternal Neonatal Death Reporting and Surveillance
NHTS		National Household Targeting System
NHTS-PR	:	National Household Targeting System – Poverty Reduction
NMR	:	Neonatal Mortality Rate
NOSIRS	:	National Online Stock Inventory Reporting System
NSV	:	Non-Scalpel Vasectomy
OCD	:	Office of Civil Defense
PDQ	:	Partner-defined Quality
PLCPD	:	Philippine Legislators' Committee on Population and Development
PHIC/PhilHealth	:	Philippine Health Insurance Corporation
POPCOM	:	Commission on Population
PP	:	Postpartum
PPP	:	Public Private Partnership
PRSP	:	Philippines Society for Responsible Parenthood
QMMC	:	Quirino Memorial Medical Center
rCHITS	:	Real-time Community Health Information System
RH	:	Reproductive Health
RUP	:	Reaching Urban Poor
SBA	:	Skilled Birth Attendants
SDN	:	Service Delivery Network
SPHERE	:	School-Peers-Health-Engagement-Research-Employment
SRH	:	Sexual Reproductive Health
TA	:	Technical Assistance
TBD	:	To be determined
TCL	:	Target Clientele List
TWG	:	Technical Working Group
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
UP-NTHC	:	University of the Philippines – National Telehealth Center
WHO	:	World Health Organization
XSFI	:	Xavier Science Foundation Inc
ZFF	:	Zuellig Family Foundation

EXECUTIVE SUMMARY

In 2015, the two-year Phase 2 of the Joint Programme on Maternal and Neonatal Health (JPMNH) gained momentum as it geared into its 7th to 18th month of program implementation in seven (7) municipalities (Aleosan, Arakan, President Roxas, Midsayap, Lebak, Kalamansig, and Malungon) and three (3) provinces (North Cotabato, Sultan Kudarat, and Sarangani) in Region 12 and District 2 of Quezon City in the National Capital Region.

During this period, through the concerted effort 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)) with support from the Australian government, the programme supported the development of a wide range of studies and technical assistance products, which were adopted into plans, policies[1], mechanisms and systems[2] by the DOH, PhilHealth, and some LGUs in JPMNH Phase 2 areas.

In addition, JPMNH supported area health systems capacity strengthening in its Phase 2 sites through Health Leadership and Governance Program (HLGP) for JPMNH local chief executives, finalization and distribution of DOH training modules on Basic Emergency Obstetric and Newborn Care (BEMONC), communication planning for maternal-newborn health services for JPMNH LGUs.

Initial provincial level consolidation of results from 2015 Field Health Surveillance and Information System (FHSIS) of JPMNH Phase 2 provinces and municipalities indicate improvements in facility-based deliveries (FBD), skilled birth attendance (SBA), early breastfeeding initiation and contraceptive prevalence rate (CPR).

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 committed to reduce by three-quarters by 2015. MMR, which is estimated at 152/100,000 live births (LB) in 1990, decreased to 129/100,000 LB in 2010, but at 114/100,000 LB in 2015 (WHO, 2015) did not meet the MDG 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) have nearly been achieved in 2015, the sizeable proportion of deaths of infants in the first 28 days, representing 42% and 56% of U5MR and IMR, respectively 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.

[1] These include two national policies, Minimum Initial Service Package of Sexual and Reproductive Health (MISP-RH) in Health Emergencies and Disasters (DOH AO 2016-0005) and inclusion of subdermal implants as one of the modern methods recognized by the National Family Planning Program (DOH AO 2015-0006) and local ordinances in JPMNH sites supporting maternal-newborn health.

[2] In 2015, the Health Leadership and Governance Program (HLGP) was expanded to cities and linked to DOH program for regional offices and the DOH through the KMITS, adopted the Maternal Neonatal Death Reporting and Surveillance System (MNDRS). Demonstration of linkages between the electronic health information system (rCHITS) and local civil registry in JPMNH sites continued in 2015. To supplement DOH's stock and inventory reporting system, which was put on hold in 2015, JPMNH piloted the "Track and Trace" logistics management system for family planning commodities.

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:

This section presents JPMNH Phase 2 results for 2015, in terms of indicators for achieving the outcome of improving quality, access to, and utilization of IP, PP, and FP services in JPMNH areas, and outputs in five sub-outcome (SO) result areas that formed JPMNH's strategic focus areas: (SO1) quality of IP and PP care, (SO2) demand for IP, PP, and FP services, (SO3) availability of quality FP services, (SO4) area health systems in support of IP, PP, and FP services, and (SO5) institutionalization of joint working approach to program management and implementation.

Data for 2015 on initial measures for impact and outcome indicators from provincial consolidation of the Field Health Surveillance and Information System (FHSIS) in JPMNH Phase 2 areas is still undergoing data quality checks at the provincial and regional levels. In line with JPMNH project closeout in June 2016, a third-party firm will collect and validate administrative and institution data for 2015 for all JPMNH Phase 2 indicators to provide endline data for the JPMNH project completion report.

Results of outcome indicators on improving quality, access and utilization of IP, PP and FP services

Aggregation of initial provincial and regional consolidation of the 2015 FHSIS in JPMNH areas indicate that the 2015 targets for indicators on access and utilization of IP and PP services have been met and present significant improvement from 2014 results, as follows:

- Facility-based deliveries (FBD) increased, from 86% in 2014 to 89% in 2015.
- Live births attended by skilled birth attendants (SBA) increased from 83.5% in 2014 to 88.9% in 2015.
- Post-partum women who initiated breastfeeding within one hour after giving birth increased from 86.5% in 2014 to 91.5% in 2015.
- Contraceptive prevalence rate (CPR) increased from 75.8% in 2014 to 77.7% in 2015.

Results of programme output areas

To improve the quality, access to, and utilization of IP, PP, and FP services in its implementation areas, JPMNH programmed 21 output result areas which correspond to each of the five JPMNH sub-outcome areas. Among the UN agencies of the JPMNH, assistance initiatives for these result areas are led at the central and regional level by WHO, UNFPA at the provincial level and UNICEF at the municipal and city district level. This section presents JPMNH progress in 2015 on these output result areas.

On improved quality of IP and PP care (SO1). To improve the quality of intrapartum and postpartum care, JPMNH activities are programmed to support the development and strengthening of functional BEmONC and CEmONC facilities, institutionalization of EINC in public health facilities, and development and implementation of client-centered and culturally-centered intrapartum services.

Output 1.1 Functioning BEmONC Facilities. In 2015, JPMNH continued to provide support to health care facilities to be capable to deliver Basic Emergency Obstetric and Newborn Care (BEmONC) services 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, through BEmONC and EINC training of health professionals.

- The Basic Emergency Obstetric and Newborn Care (BEmONC) Modules for Midwives were turned over to the Department of Health in July 2015. These manuals are now being utilized by all of the 31 DOH-accredited BEmONC training centers in their BEmONC midwives' training. The first batch of printed modules were distributed to 1,565 participants and 100 trainers.
- 45 Rural Health Midwives were trained on Basic Emergency Obstetric and Neonatal Care (BEmONC) including post-training mentoring support in the provinces of North Cotabato, Sultan Kudarat and Sarangani.

Output 1.2 Functioning CEmONC Facilities. Activities in 2015 to support the development of functional CEmONC facilities include capacity building for Caesarian Section in proposed CEMONC facilities (3 district hospitals) and logistical support, including the operationalization of blood banks in North Cotabato, Sultan Kudarat and Sarangani.

Output 1.3 EINC institutionalized in JPMNH SDN sites. To institutionalize EINC in its SDN sites, in 2015, JPMNH commissioned *formative and assessment studies* to guide its assistance program, *assisted LGU partners* in training health service providers (HSPs) on enhanced intrapartum, postpartum and newborn care practices and capacity-building of partner DOH-ROs/LGUs for post-training supportive supervision, monitoring and mentoring and *supported the DOH* in monitoring the implementation of MNCHN-EINC, IYCF and MBFHI Initiative and Milk Code Compliance in JPMNH areas, as well as, in promoting expanded EINC through development of social marketing templates. Key findings, progress and results of these initiatives are presented below.

- The formative research to identify provider-related and health system barriers in the provision of quality maternal and newborn care was completed on July 2015. This qualitative study identified barriers to facility delivery, which included having more than four children, living in a geographically isolated and disadvantaged area (GIDA) and membership in the government's conditional cash transfer (CCT) program, Pantawid Pampamilyang Pilipino Program (4Ps). Transportation costs, out-of-pocket expenditures and limited income were also considered as barriers to facility access.
- The assessment of intrapartum-postpartum related trainings was completed in October 2015. This study focused on the public health sector in JPMNH areas in Region 12 and noted the following challenges to IP and PP training implementation: (1) less or no administrative support; (2) no equipment and facilities; (3) some doctors do not adhere to the standards secondary to preference to the status quo, and secondary gains related to the performance of alternative intervention; and (4) MNCHN programs were not integrated in the system.
- Training assessment of the implementation of midwifery and nursing pre-service curricular integration of Essential Intrapartum and Newborn Care is expected to end in 2016. This assessment aims to determine the degree of implementation of EINC practices in the various nursing and midwifery schools and recommend steps to improve the implementation of the EINC strategy. Methodologies include questionnaires and school visits to representative areas in the country for on-site observation, interviews and focus group discussions of trainers, trainees, school administrators, implementers and students.
- JPMNH assessment of status of supportive supervision completed in November 2015. Tool on supportive supervision, monitoring and mentoring to be developed and finalized by October 2016 in coordination with subnational DOH and partner LGUs. DOH will assume responsibility for the pretesting, pilot testing and finalization of these tools after JPMNH project closeout in June 2016.
- Training assistance to LGUs and DOH/ROs included:
    - Further training on Harmonized BEmONC of 50 health service providers of designated but not yet functioning BEmONC facilities in Region 12 JPMNH sites.

    - Development Management Officers (DMOs) of DOH Regional Office, and LGU and retained hospital staff were capacitated on supportive supervision and M&E on Harmonized BEmONC for midwives (37 graduates), Care for the Small Baby (6 program managers), Maternal Death Surveillance and Review (21 graduates).
- On the adherence of health facilities to the implementation of MNCHN-EINC, IYCF and MBFHI Initiative and Milk Code Compliance, a monitoring team from JPMNH TWG, Family Health Office-DOH and Regional Family Cluster staff conducted the implementation monitoring in September 2015.
    - Findings supported that several hospitals in Region 12 and QC are MBFHI accredited however not all of these hospitals are implementing the initiative nor complying to the Milk Code and IYCF policies.
    - To further support MBFHI, JPMNH through WHO provided capacity building, including the provision of training supplies and breast models on lactation management where a total of 105 HSPs from various birthing facilities and hospitals of the JPMNH sites graduated.
- To assist DOH in the social marketing of the expanded EINC, JPMNH supported the conduct of a workshop in February 2015. Based on this workshop, social marketing templates were developed and are currently under review of the DOH-Health Promotion and Communications Services Office. Production and distribution of these social marketing materials will be done in the second quarter of 2016 after nationwide pilot-testing.

In 2015, the DOH-Family Health Office requested JPMNH assistance in supporting the development of evidence-based policy and guidelines on prematurity and low birth weight, clinical practice guidelines on select causes of neonatal morbidity and mortality, and updating or revision of DOH AO-2009-0025 on Adopting Policies on Essential Newborn Care to become "Adopting Policies and Guidelines on Essential Intrapartum and Essential Newborn Care". The request for proposals (RFPs) have been advertised and review of proposals and selection completed in March 2016. Selected contractors will be engaged by April 2016 to complete these policies by June 2016.

Output 1.4 Culture-sensitive and client-centered IP care. To assist DOH and LGU partners to provide client-centered maternal health services, particularly for intrapartum care, JPMNH supports the implementation of the Partnership Defined Quality (PDQ) methodology to improve the quality and accessibility of services with community involvement in defining, implementing and monitoring the quality improvement process. PDQ links quality assessment and improvement with community mobilization. In 2015, JPMNH reviewed and finalized the PDQ module for maternal health services, held regional and provincial PDQ feedback meetings, conducted monitoring visits in PDQ Phase 1 sites of Quezon City, Sarangani and Sultan Kudarat, and PDQ technical exchange conferences.

<u>On increased demand for IP, PP and FP services (SO2)</u>. JPMNH support towards increasing demand for maternal and newborn health services includes assistance to community health teams (CHTs) and other MNCHN support groups to capacitate them to address MNH issues of adolescents and of the poorest two quintiles in the Philippines, who have been identified through the National Household Targeting System for Poverty Reduction (NHTS-PR), as well as, the application of behavior change communication (BCC) or communication for development (C4D) strategies to influence health-seeking behavior.

Output 2.1 CHT/community MNCHN support groups are functional in JPMNH areas to address MCH issues of Q1 and Q2 poor and adolescents. To address issues on adolescent health, especially on adolescent sexual behaviors, teenage pregnancy and non-access to health services JPMNH refocused its Phase 1 strategy on reaching the urban poor (RUP) to RUP interventions on adolescent health care and management in its Phase 2 implementation. Two (2) major documents to support these interventions have been developed: (1)

Adolescent Health and Development Programme, Manual of Operations and (2) Supplemental Modules to the Adolescent Job Aid. The first manual is intended for adolescent health and development program officers, focal persons, and clinic managers in government, private, and NGO facilities to guide them in the design of adolescent health and development program. In 2015, the manual was field-tested in two cities, succeeding field-testing in rural municipalities will be conducted in 2016. The second document, consisting of Supplemental Modules to the Adolescent Job Aid had been developed and pilot-tested. These modules were envisioned to help service providers and their facilities become more responsive and conducive to provide appropriate and necessary adolescent health services. As a supplementary training module, it is also envisioned to be used by the DOH in its training of adolescent health providers to facilitate and make more efficient their use of the Adolescent Job Aid Manual.

JPMNH supports CHTs, LGUs, and inter-local health zones in utilizing the Family Development Sessions (FDS) as a communication channel to provide information on maternal and neonatal health and family planning among NHTS poor families, consisting of conditional cash transfer (CCT) recipients and non-CCT recipients. In 2015, to streamline the existing modules on FDS, JPMNH supported the harmonization of the FDS guidelines of DOH, DSWD and POPCOM. The harmonized guidelines were pilot-tested and thereafter implemented in Sultan Kudarat, North Cotabato, Saragani, and in District 2 of Quezon City.

Output 2.2 C4D/BCC in IP, PP and FP services implemented. To link couples who have received FP information in the FDS and have unmet FP needs to FP counselling and service delivery, JPMNH initiated the conduct of Family Planning Action Sessions (FPAS) in three JPMNH provinces. Though the conduct of FPAS, couples with unmet need for family planning are properly counseled on the full range of modern family planning methods available, and thereafter linked to immediate service provision. These FPAS have effectively linked demand generation to service delivery and has thereafter contributed to the significant increase of CPR in JPMNH provinces. In 2015, JPMNH supported the conduct of FDS and FPAS:

- In North Cotabato, four ILHZs were supported to conduct FP demand generation activities with FPAS and have reached 240 CCT households. CPR increased from 68.4% in 2014 to 72.8% in 2015 (Provincial FHSIS).
- In Sultan Kudarat, seven IEC campaigns on FP, including LAPM and male involvement in FP were conducted; five municipalities were supported in the conduct of FP advocacy and demand generation focusing on LAPM using the FPAS. CPR increased from 60% in 2014 to 68% in 2015 (Provincial FHSIS).
- In Sarangani, 57 FDS adopting the FPAS were supported and have reached 632 CCT households. CPR increased from 52% in 2014 to 58% in 2015 (Provincial FHSIS).

To influence maternal and newborn health-seeking behavior, JPMNH provides communication for development (C4D) support to its LGU partners. In the first quarter of 2015, the results of the research study commissioned by JPMNH on Communication Research Analysis on maternal and newborn health-seeking behavior were disseminated and discussed with DOH, LGU partners in Region 12 and Quezon City. The main findings of this research include: (1) communication channels utilized, from most likely to least likely: word of mouth, CHT visits, barangay/purok meetings, general assemblies, posters, flyers, health center consultations, formal media (radio, TV, internet); (2) pregnant women are generally aware of recommended MNH practices, but not of their importance; (3) partners mainly provide monetary support, help in doing chores; (4) 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; (5) inadequate information regarding PhilHealth benefits. This dissemination was followed by a joint planning workshop to develop effective communication methods and materials. In September 2015, JPMNH engaged a team of development communication experts from the Xavier Science Foundation Inc. (XSFI) to develop strategic and context-specific communication interventions. For Region 12 municipalities assisted by JPMNH, a C4D planning workshop was held in

October 2015, in Davao City. The planning workshop identified common issues to be addressed by all municipalities: (a) strengthening of communication on importance of recommended practices for maternal and newborn health and (b) expanding the reach of interventions to include support groups (husbands, in-laws, mothers of pregnant women). As a result of this workshop, communication plans were drafted by each municipality to address unique issues such as those related to cultural practices and religious beliefs. Across municipalities, a combination of all appropriate channels will be used. The C4D strategy for Quezon City will focus on teen pregnancy and will begin in 2016.

On the availability of quality FP services (SO3). To continue its support to improve the availability of quality FP services in 2015, JPMNH supported training of health service providers through the engagement of regional training centers, pilot-tested its assistance to capacitate LGUs to program for adolescent sexual and reproductive health (ASRH) and scaled-up its assistance to deliver information on prevention of teen pregnancies and sexually-transmitted diseases through the Philippine Commission on Population's (POPCOM) Youth Hub initiative, You-for-you (U4U), with the involvement of LGUs. To address gender issues in accessing FP services, an operations research is being conducted to study avenues for male involvement in FP discussions and joint decision-making among couples for FP. Likewise, JPMNH provided assistance on FP logistics management to DOH-CO through the pilot-testing of a bar-coding system, as an alternative to the National Online Stock and Inventory Reporting System (NOSIRS). Lastly, to support and sustain sub-dermal implants as a modern FP method, JPMNH provided assistance to DOH in drafting the national policy on inclusion of subdermal implants as one of the modern methods recognized by the National Family Planning Program and the PhilHealth circular on PhilHealth Subdermal Contraceptive Implant Package.

Output 3.1 Comprehensive FP methods are available for women and men. In 2015, JPMNH supported the strengthening of Regional DOH Training institutions in Region 12 and NCR as a mechanism for sustainability and institutionalization by which trainings on Family Planning can be more efficiently decentralized. This yielded memorandum of understanding (MOU) with two regional training centers, 85 trained FP trainers and 427 trained health service providers. JPMNH also supported the capacity building and service delivery for Long Acting and Permanent Methods (LAPM) including the popularization of sub-dermal implants. These had been conducted through LGU partners, NGOs, hospitals and itinerant FP missions. As a result of FPCBT and LAPM capacity-building in 2015:

- 103 health service providers were trained on IUD insertion, of whom 99 were given post-training evaluation (PTE) certification.
- 12 FPCBT capacity-building and LAPM missions were conducted in North Cotabato yielding 25 trained health service providers all of whom were given PTE certification and 2,254 women of reproductive age (WRA) served with quality LAPM
- In Sultan Kudarat, 7 BTL and implant missions were conducted which provided quality LAPM to 2,745 WRA
- 11 LAPM missions were conducted in Sarangani, yielding 60 trained health service providers, half of whom were given PTE certification and 2,631 WRA provided quality LAPM

Output 3.2 FP policies applied in JPMNH areas. In lieu of working with local civil society organizations to apply FP policies in JPMNH areas, in 2015, JPMNH supported DOH in drafting DOH AO 2015-0006 on the National policy on inclusion of subdermal implants as one of the modern methods recognized by the National Family Planning Program, as well as, the PhilHealth Circular 038-2015 on PhilHealth Subdermal Contraceptive Implant Package.

Output 3.3 Health workers competent in using ASRH job aide. JPMNH have expanded its support for ASRH in 2015, from capacitating health workers to use the ASRH job aide to capacitating LGUs to design and

implement an integrated ASRH program, through the pilot testing and development of a monitoring and evaluation tool for the SPHERE (School, Peer, Health, Engagement, Research, Employment) framework in JPMNH sites. These components refer to various local settings where young people may be reached with ASRH information and services. Likewise, peer education sessions and web and mobile phone-based youth communication platforms under the You-for-you (U4U) were scaled up in 2015 with the involvement of LGUs. POPCOM in collaboration with the Center for Health Solutions and Innovations (CHSI) and UNFPA, developed and implements the U4U to deliver critical information to Filipino teens to prevent teen pregnancy and reduce the prevalence of sexually transmitted infections through online and mobile platforms. In the conduct of U4U, teen facilitators both in-school and out-of-school have been trained to conduct peer education sessions through interactive teen trails. JPMNH activities and outputs in 2015 for SPHERE and U4U included:

- Conduct of four SPHERE advocacy workshops in Sultan Kudarat, Sarangani and Quezon City, resulting to 1,411 young people trained on ASRH and five LGUs adopting the SPHERE framework, three of whom received the SPHERE intervention package.
- U4U Scale-up events in Sultan Kudarat and Sarangani participated by 11 LGUs with 50 teen facilitators trained to conduct U4U caravan and 2,954 youths reached by the Teen Trail. In District 2 Quezon City three Teen Trail events were conducted, reaching 501 young people. In North Cotabato, U4U activities were conducted in 15 municipalities and have reached 2,250 youths.

As part of the strategy to popularize U4U, CHSI entered the U4U Teen Trail in the Anvil Awards, a prestigious competition of communication programs in November 2015. On February 26, 2016, U4U received the top prize in the 51st Anvil Awards recognized by the Public Relations Society of the Philippines (PRSP). U4U bagged the Grand Anvil award for the best communication program implemented on a sustained basis. U4U received a Silver Anvil for the use of social media and a Gold Anvil for its implementation on a sustained basis. The Gold Anvil recognition automatically positioned U4U to compete with 27 other Gold Anvil winners for the most coveted, Grand Anvil award. U4U also won a Special Award for PR Excellence on Social Good, given to communication programs that have resulted in measurable changes in stakeholders' knowledge, attitudes and practices.

Output 3.4 Functional FP logistics management system in place. In 2015, JPMNH support to FP logistics management included training on a computer-based projection and modeling system which facilitates analysis and planning for future resource requirements for health programs using the SPECTRUM software. Through SPECTRUM, LGUs are provided with a tool to analyze and plan investments for FP, as it relates to an increase in CPR, reduction of unmet need, reduction of maternal deaths, aversion of unintended pregnancies and abortion complications. Four training events on Spectrum for Family Planning Programme were conducted in 2015 through the Philippine Legislators' Committee on Population and Development Foundation (PLCPD). These were attended by 114 participants from North Cotabato, Sultan Kudarat, Sarangani and District 2 Quezon City. Given programmatic challenges to the implementation of NOSIRS, which DOH put on hold for system improvement in 2015, as an alternative FP logistics system, JPMNH piloted "Track and Trace", a barcoding system that could be operated through mobile devices, such as smartphones and tablets. The operational research on the Track and Trace distribution system will be completed and will be presented to DOH by June 2016.

Output 3.5 Gender issues affecting access to services addressed. JPMNH engaged Philippine Society of Responsible Parenthood (PSRP) in 2015 to conduct an operational research, which includes a baseline of male involvement in FP and a study of demand generation activities that would encourage husbands to attend Family Development Sessions and how this links towards joint decisions among couples for family planning counselling and availment of service for chosen FP method. This operational research will be completed by June 2016.

On strengthening health systems in support of IP and PP (SO4). JPMNH continued to work on strengthening the components of area health systems to improve the functionality of the SDN in JPMNH areas.

Output 4.1. MDRs strengthened and instituted. At the provincial-level, initial gains in 2014 on strengthening and institutionalizing MDRs, in terms of the quarterly conduct of Maternal Death Review (MDR) and the appreciation of provincial MDR teams of its importance and the emphasis on its formulation and dissemination and compliance with recommendations continued in 2015. In 2015, two MDRs were conducted in North Cotabato, with 70 percent of recommendations addressed; in Sultan Kudarat, one MDR was conducted, with 70 percent of recommendations addressed; and two MDRs were conducted in Sarangani, with 65 percent of recommendations addressed.

Output 4.2 Increased capacity of LGUs and ROs in PPP management for IP, PP, and FP and Output 4.4 Increased capacity of ROs in providing technical assistance to LGUs on IP/PP elements of MNCHN. At the regional level, JPMNH continued to support DOH Regional Office 12 (DOH-RO12) and DOH-NCRO in increasing their capacity to provide technical assistance to LGUs on IP/PP elements of MNCHN.

- In 2015, the dissemination of WHO information products on MNCHN to government and non-government partners was completed. Three national government agencies, 10 local government units, and 15 non-government partners (CSOs, private facilities, development agencies) received brochures on MCP advocacy materials, breastfeeding social marketing materials, complete sets of ICD 10 books, ICD 10 for Maternal and Pregnancy Related Deaths, CPG on Intraprtum and Immediate Postpartum, EINC brochures, pamphlets, newsletters, advocacy and social marketing materials, and self-instructional modules.
- For DOH-RO12, JPMNH followed through on the results of the GIS-based health resource and facility mapping conducted in 2014. The study, entitled Geographic Accessibility to Emergency Obstetric and Neonatal Care (EmONC) showed 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 also confirmed 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. To follow through with this finding and to explore the engagement of the private sector for the delivery of quality intrapartum, postpartum and newborn care services, JPMNH brokered the initial meeting between Region 12 public hospitals and birthing facilities and the private-owned Howard Hubbard Hospital (HHH), located in Polomolok South Cotabato in July 2015. At this meeting, an agreement was reached that HHH will be part of the SDN for MNH services within the JPMNH areas of Region 12. Further visits to the HHH was made and referral schemes were discussed from August to December 2015.
- As a follow-through to JPMNH assistance in the provision of management updates on key MCN concerns and related health system support, in 2015 JPMNH assisted DOH-NCR to provide technical assistance to the City Government of Quezon City to strengthen its implementation of MNCHN guidelines, through the formulation /development and finalization of implementing rules and regulations (IRRs) for the following Quezon City Ordinances: (1) IRR on SP 2151s 2012 Procedure in Issuance of Live Birth Certificates; (2) IRR on SP2171 s2012 Prohibiting Home Births in Quezon City; (3) IRR on SP2327 s2014 Maternity and Infant Health Home Visiting Program; (4) IRR on SP2379 s2014 Submission of Monthly Reports; (5) 2015 Ordinance creating the Quezon City Maternal and Neonatal Council (QCMNC).

Output 4.3 Increased capacity of LGUs/LCEs on local health governance for IP/PP elements of MNCHN. At both the provincial and municipality/ city district level, JPMNH continued its assistance to LGUs/LCEs to increase their capacity on local health governance for IP/PP elements of MNCHN, in terms of the operationalization of the SDN and institutionalization of the use of the MNCHN monitoring tool and strengthening supervisory capacities of health managers, as well as, through the Health Leadership and Governance Program (HLGP), which has been enhanced to include municipalities and cities.

- The HLGP aims to address inequities in the local health system by empowering local leaders, including governors, mayors, and local health officials, through leadership and governance training, coaching and practicum. The programme intends to enable local leaders to drive reforms that would improve provincial and municipal health systems. This translates to empowered local chief executives and local health leaders who are able to improve institutional arrangements and craft responsive policies and programs particularly for the poor. The enrolled local officials graduated from the curriculum in 2015 but the partnership continues to monitor progress in the provinces and municipalities covered by the intervention.
    - The Governor of Sarangani, PHOs of Sultan Kudarat and Sarangani, and 21 provincial board members and department heads participated in and graduated from PLGP sessions.
    - The colloquium for Municipal Leadership and Governance Program (MLGP) is currently attended by 15 Mayors and 15 MHOs in Sultan Kudarat and Sarangani. It has been completed by the Municipalities of Lebak and Kalamansig of Sultan Kudarat on July 31, 2015; and Pres. Roxas, North Cotabato on December 2, 2015. The rest of the JPMNH municipalities (except for Arakan, North Cotabato and Malungon, Sarangani) are scheduled to complete the program in January 2016, while Quezon City is on track to complete the City Leadership and Governance Program (CLGP) in March 2016.
- In October 2015, a review by the Quezon City Health Department (QCHD) of the MNCHN monitoring tool resulted in revisions to the tool and its standard forms. This was followed by the drafting of guidelines on the use of the tool conducted in December 2015. A similar process for all Region 12 municipalities is planned in the first quarter of 2016.
- In broad strokes, the following were accomplished in the operationalization of the SDN, through the engagement with the Center for Innovations, Change and Productivity (CICP) in 2015: (1) mapping of existing health facilities providing MNCHN core package of services including identification of partners and public and private service providers through the use of a Rapid Quality Assessment and Mapping tool. A total of 300 health facilities in Region 12 and QC were assessed; (2) SDN strategic planning workshops with implementers and stakeholders were conducted in Quezon City, on June 1-2, 2015 and on July 27 to 29, 2015, in Region 12; (3) SDN Management Teams were formed with signed local issuances or Executive Orders, paving the way for institutionalization; and (4) engagement of barangay (village) level involvement, with the creation of barangay management teams and inter-barangay clusters and documentation of various models of agreements on referral and transport of pregnant women and mothers about to deliver.

Output 4.5 PhilHealth accreditation of facilities achieved. As part of its continuing assistance for PhilHealth-accreditation of health facilities in JPMNH areas, six (6) Philhealth-DOH-LGU dialogues were conducted in the provinces of North Cotabato, Sultan Kudarat and Sarangani in 2015. These dialogues are aimed to further support 50 municipality LGUs in the three JPMNH provinces to be oriented on the accreditation requirements for Maternity Care Package (MCP). From these 2015 dialogues, 48 health facilities have been identified and targetted for MCP accreditation. These dialogues also incorporated awareness raising seminars on PhilHealth circulars on MCP, newborn care package (NCP), expanded primary care benefit (Tamang Serbisyo sa Kalusugan ng Pamilya- Tsekap) and on health insurance coverage and benefits for women about to give birth (WATGB).

- 5 Orientation activities on maternity incentive program conducted; with target reach of 56 municipalities and 75 health facilities in Sarangani, Sultan Kudarat, and North Cotabato

- Conducted orientation/training on PhilHealth Circular No. 22 on Women about to give birth (WATGB), Newborn Care Package (NCP) and Training of Trainors (TOT) on Tsekap Package: 2 in NCR and 6 in North Cotabato, Sultan Kudarat, and Sarangani.

At the municipality and city district level, JPMNH further integrates its PHIC accreditation and utilization support to Region 12 mLGUs and Quezon City-District 2 through the operationalization of the SDN to address both accreditation and utilization issues, as well as, through community awareness raising on benefits of new MNH-related Philhealth circulars and issuances through its implementing partner for Communication for Development (C4D).

Output 4.6 MISP-RH integrated into local DRRM plans. The DOH AO 2016-0005 on the implementation of the Minimum Initial Service Package for Reproductive Health (MISP-RH) has been developed with programmatic support from UNFPA, to serve as a national policy guideline by which Sexual and Reproductive Health (SRH) concerns are properly addressed in emergency situations. JPMNH has supported capacity building for the conduct of MISP Level 1 trainings aimed to capacitate service providers on SRH and gender-based violence (GBV) Prevention, and MISP Level 2 trainings aimed to integrate MISP in local disaster risk reduction and management (DRRM) Plans.

In 2015, 90 members and service providers of the Provincial/Municipal Disaster Risk Reduction and Management Offices in North Cotabato, Sarangani, Sultan Kudarat have been trained on MISP Level 1 and now possess the basic knowledge and skills in providing SRH-related services during emergencies. In addition, 11 provincial and municipal local government units in North Cotabato (4) and Sarangani (7) have integrated MISP in their 2016 Annual Investment Plans for Health as a result of the MISP Level 2 Training provided to them.

This local capacity on MISP is complemented by a national pool comprised of 50 MISP trainers, training manuals (Localized MISP Manual for LGUs, Manual for Standard RH Services in emergencies, ASRH in Emergencies Module, enhanced DSWD youth module incorporating AJA and ASRHiE).

To further sustain and institutionalize this initiative, JPMNH is also supporting the drafting of a Joint Memorandum Circular (JMC) among DOH, DILG, OCD and DSWD on the integration of the MISP (and aspects of ASRH) in the NDRRMP and local DRRM plans.

Output 4.7 Vital registration strengthened. To strengthen the vital registration system, JPMNH, through the University of the Philippines-National Telehealth Center (UP-NTHC) continued its assistance in building capacities at DOH-CO, DOH-ROs and in JPMNH sites through the implementation and monitoring of maternal and neonatal death surveillance, reporting and review systems and in JPMNH areas by strengthening the linkage of the real-time Community Health Information Tracking System (rCHITs) to the local civil registrar (LCR).

- To ensure the timeliness and quality of data entered to the Maternal and Neonatal Death Reporting and Surveillance (MNDRS) at the DOH website, JPMNH provided technical and funding support to the formulation /development and finalization of implementing rules and regulations (IRRs) for Quezon City Ordinances on: (1) Prescribing Procedures in the Issuance of a Certificate of Live Birth by Hospitals, Lying–in Clinics, Registered Midwives and other Maternity Practitioners in Quezon City to Avoid or Lessen the Occurrences of Clerical or Typographical Errors in the Entries and/or Information in the Birth Certificate and (2) Requiring All Hospitals and Birthing Homes in Quezon City to Submit to the Quezon City Health Department a Monthly Report on the Number of Maternal Deaths, Neonatal Deaths and Live Births and other Related Information Within Five (5) Working Days of the Succeeding Month.

- In 2015, rCHITS field staff were organized and deployed to strengthen the previous gains of rCHITS 2 in JPMNH areas by addressing problems encountered in its hardware (particularly the mobile phones) and its software. In some LGUs, smartphones were replaced with tablets. Local technical support through LGU-hired staff or partnerships with local academic institutions were sourced. Development and testing on optimization of the software on birth registration tracking System (BiRTS) has nearly been completed and will be fielded to JPMNH health facilities in Quezon City by December 2015.

- In the third quarter of 2015, PHIC issued an advisory listing CHITS as one information system considered interoperable with the PHIC information system, along with the ClinicSys of DOH.

Output 4.8 Health information system operational in health facilities in (partner) LGUs. To ensure that initiatives in improving the health information system (HIS) will be sustained and operational in health facilities in LGUs, in 2015 JPMNH initiated to institutionalize sustainability mechanisms and linkage of rCHITS to the LGU Dashboard.

- In 2015, the assessment tools for LGU decision-making using rCHITS and data demand for use in decision-making were pre-tested. Software development and testing on optimization of the LGU Dashboard has nearly been completed, with the beta-testing of the dashboard in Region 12 which began in November 2015. In Quezon City, the CHITS Technical Working Group (TWG) led by the City Health Officer and composed of health and civil registry staff was organized. Work was started on the development of the Mag-Ina Telereferral System (MInTS) for sending online referral from the lying-in clinic to the hospital MInTS Dashboard that will trigger a visual, sound, and SMS notification upon receipt of the participating LGU-operated end referral hospitals (i.e., Quezon City General Hospital and DOH-retained Quirino Memorial Medical Center). The MInTS project was also presented to the City Local Health Board meeting. Guidelines on the telereferral system are being developed by the multi-stakeholder TWG.

<u>On institutionalizing a joint working approach to programme management and implementation (SO5).</u> JPMNH institutionalization of its joint working approach to programme management and implementation through the sharing of its knowledge products and through its actual implementation of joint programming.

Output 5.1 Knowledge generated and shared with DOH, Australian Government, other Donors, and UN agencies. To share the knowledge products, including reports, studies, and data generated from its initiatives, JPMNH will make use of a web portal for knowledge management with a sharepoint repository. JPMNH will have its web portal within the UN Web Portal, the first module of which is the JPMNH website. In December 2015, the contracted firm, MSIT completed the design and functionality of the JPMNH website and with UNDP IT was set to upload JPMNH content in the webserver in the first quarter of 2016. This will be followed by quality assurance and system demonstration which is scheduled in March 2016.

Output 5.2 Joint planning, management, implementation, monitoring, evaluation, and reporting systems are functioning.

JPMNH technical team leadership is rotated annually among the three UN agencies. In May 2015, UNICEF took over as technical team leader from UNFPA. In April 2016, the technical leadership will be turned over to WHO. The JPMNH team includes focal persons and project officers from the three UN agencies, programme coordinator and M&E specialist. The JPMNH team coordinates and implements the 2-year JPMNH workplan and M&E plan. In 2015, 11 joint technical working group (TWG) meetings were conducted and two Project Steering Committee meetings. Per JPMNH workplan, two joint monitoring visits were conducted in JPMNH Phase 2 areas in 2015: (1) District 2, Quezon City on March 16, 2015 and (2) municipalities of Lebak and

Kalamansig in Sultan Kudarat and Cotabato City on June 24-26, 2015. In December 2015, two PIRs were conducted for JPMNH Phase 2 areas: (1) PIR for JPMNH areas in Region 12, held on December 7-8, 2015, at Microtel Hotel, Davao City and (2) PIR for District 2, Quezon City, held on December 10, 2015, at Sulo Hotel, Quezon City.

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. Likewise, EINC promoted shared responsibility in child care and encouraged the husband/ partner to be sensitive to their wife's need during birthing process.

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, which included partners mainly provide monetary support and help in doing chores and 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. To address these issues JPMNH C4D support to develop strategic and context-specific communication interventions will look into expanding the reach of interventions to include support groups (husbands, in-laws, mothers of pregnant women).

In May 2015, a workshop on gender mainstreaming for JPMNH partners and program managers was conducted with local resource persons from NEDA. Likewise, in Sultan Kudarat, seven IEC campaigns on FP, including LAPM and male involvement in FP were conducted.

JPMNH has also supported the development and use of a Manual for Standard RH Services in emergencies (e.g. How to conduct RH medical mission, Core Messages for RH and GBV in Emergencies) in MISP trainings. In 2015, 90 members and service providers of Provincial/Municipal Disaster Risk Reduction and Management Offices in North Cotabato, Sarangani, Sultan Kudarat have been trained on MISP Level 1 and now possess the basic knowledge and skills in providing SRH-related services during emergencies.

Delays in implementation, challenges, issues. With a JPMNH project officer in each UN agency, there was greater focus and dedication on JPMNH project implementation, however, delays were still experienced. JPMNH baseline and endline data collection have not started as planned due to delays in the procurement process. The completion of the baseline data collection has also been delayed due to the unexpected number of health facilities to be surveyed to cover the SDN, sampling frame not readily available in LGUs and RHUs, and longer time needed to test tablet-based survey tool.

Changes in DOH's leadership and the implementation of the High Impact (Hi-5) Breakthrough Program also posed challenges to implementation due to the prioritization of DOH-Hi5 activities and orientation and engagement of new officials on JPMNH objectives and initiatives.

Despite the passage of the RPRH Law, pro-RH groups still need to continue vigilance and engage in advocacy and public awareness initiatives given the continued strong opposition from anti-RH groups in implementation aspects such as in the drafting of the IRR and through petition for TROs.

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. Likewise, in 2015 the DOH included the purchase of 670,000 implants in their budget amounting to Php 335,000,00. However, in a two-page resolution dated June 17, 2015, the Supreme Court issued a temporary restraining order, prohibiting the Department of Health (DOH) from "procuring, selling,

distributing, dispensing or administering, advertising and promoting the hormonal contraceptive 'Implanon' and 'Implanon NXT.'" It also prohibited the Food and Drug Administration (FDA) from "granting any and all pending application for reproductive products and supplies, including contraceptive drugs and devices." This TRO also hindered the full implementation of PhilHealth Circular 038-2015 on benefit package for LAPM, particularly the use of sub-dermal implants. Likewise, the PHP 1B billion budget cut by Congress for the DOH's procurement of contraceptives poses a major issue and challenge.

Notable lessons for JPMNH in 2015 include the following:
(1) The JPMNH modeling of the SDN surfaced the need for harmonized regulatory, monitoring, and supportive supervision mechanisms while demonstrating that when local political will is harnessed to prioritize health issues, MCH goals can be achieved. Local health system elements need to be strengthened both on the ground through local chief executives, but also on national level through leadership on key policies and standards such as on health human resource and health information systems.
(2) The joint approach facilitated the exchange of information with and among the three United Nations (UN) agencies and simplified coordination with key partners, in particular the DOH and the Australian government. This resulted in improved coordination.
(3) The joint working approach was also advantageous in the program implementation. The approach to strengthen local health systems benefits from the oversight and monitoring of lower level LGUs by higher level LGUs. Municipalities benefit from the oversight and monitoring of the provincial and regional health offices that UNFPA and WHO assist, respectively. Alignment of programs and bidirectional flow of information from municipal, provincial and regional levels were also facilitated. Efficiency in terms of decreasing the number of meetings attended by local health staff was achieved to a limited extent.

As JPMNH prepares to close the programme in the next three months, its way forward will be guided by the following views:
(1) JPMNH is strategically placed in being able to transmit experiences in local service delivery network building to the national policy-making level given the structure of having DOH as national JPMNH steering committee chair and UN agencies working at various levels of local government. Development and dissemination of key knowledge management products and process documentation are vital to bringing the lessons learned from JPMNH to both the outgoing and incoming administration.
(2) Continued advocacy for “unfinished” legal agenda remains, including the temporary restraining order on subdermal implants, and the RPRH Law provision requiring parental consent of adolescents to access contraception, among others.
(3) Sustainability of some interventions such as health leadership and governance training of LGUs will be handed to the regional level Department of Health since complementary training of the Development Management Officers on mentoring and oversight of LGUs were also commissioned by the DOH.

ii) Indicator Based Performance Assessment:

	Achieved Indicator Targets (2015)	**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)/43.20 (2015)/ 39.45 (2016)* Actual: 64.02 (2014)	86.58	Partial data on maternal deaths and livebirths for QC District 2, only covers January to November 2015. Data will be completed and validated by the endline study, which will collect 2015 annual data in April to May 2016, for submission in June 2016. Note: The TWG plans to revisit the validity of reporting an aggregate MMR measure for JPMNH areas.	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)/ 5.23 (2015)/ 5.18 (2016)* Actual: 5.32 (2014)	5.86	Partial data on neonatal deaths and livebirths for QC District 2, only covers January to November 2015. Data will be completed and validated by the endline study, which will collect 2015 annual data in April to May 2016, for submission in June 2016.	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)/ 85.91 (2015)/ 87.6 (2016)* Actual: 85.96 (2014)	88.68	Data will be validated by the endline study, which will collect 2015 annual data in April to May 2016, for submission in June 2016.	FHSIS at the municipal and city district levels

	Achieved Indicator Targets (2015)	**Reasons for Variance with Planned Target (if any)**	**Source of Verification**
Indicator: Percentage of live births attended by skilled health personnel Baseline (2013): 84.98 Planned Target: 84.6 (2014)/ 86.39 (2015)/ 87.98 (2016)* Actual: 83.53 (2014)	88.86	Data will be validated by the endline study, which will collect 2015 annual data in April to May 2016, for submission in June 2016.	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%	2.15	Partial data from 3 of 8 municipalities/city district. Data will be completed and generated by the endline study, which will collect 2015 annual data in April to May 2016, for submission in June 2016.	
Indicator: Percentage of postpartum women who initiated breastfeeding within 1 hour after giving birth Baseline (2013): 79.45 (corrected) Planned Target: 82.6 (2014)/ 86.44 (2015)/ 90.19 (2016)* Actual: 86.49 (corrected)	91.49	Data will be validated by the endline study, which will collect 2015 annual data in April to May 2016, for submission in June 2016.	FHSIS at the municipal and city district levels
Outcome 2: Increased demand for intrapartum, postpartum and family planning services			
Indicator: Percentage of women with unmet need for family planning	TBD	Data for all JPMNH areas will be generated by the baseline study. Results from demand generation activities among NHTS in 21 GIDA municipalities in JPMNH provinces and cities, indicate that 32.7% of 109,523 NHTS profiled families have unmet FP needs.	

	Achieved Indicator Targets (2015)	**Reasons for Variance with Planned Target (if any)**	**Source of Verification**
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	TBD	Data will be generated by the baseline study. Results from demand generation activities among NHTS in 21 GIDA municipalities in JPMNH provinces and cities, indicate that 32.7% of 109,523 NHTS profiled families have unmet FP needs. Of 35,905 families with unmet FP needs, 8,379 participated in 512 Family Development Sessions, of these participants, 82% were provided FP counselling and 62% (5,160) became new FP acceptors.	
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)/72 (2015) 73 (2016)* Actual: 71.70 (2014)	70.33	Data will be validated by the endline study, which will collect 2015 annual data in April to May 2016, for submission in June 2016.	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)/ 75.4 (2015) 77.3 (2016)* Actual: 75.81 (2014)	77.68	Data will be validated by the endline study, which will collect 2015 annual data in April to May 2016, for submission in June 2016.	FHSIS at the municipal and city levels

	Achieved Indicator Targets (2015)	**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)*	TBD	Data will be generated by the endline study	
Output 4.1 MDRs strengthened /instituted Indicator 4.1.1 Percentage of MDR recommendations implemented Baseline (2013): Planned Target: (2014) /100 (2016)*	68	Partial data for three provinces. Data will be completed and validated by the endline study	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)*	TBD	Data will be generated by the endline study	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.
3. 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
4. *Data for January to June 2016 cannot be collected for the 2016 Annual Report, as data will only be available 3-4 months after JPMNH project closeout on June 30, 2016.

iii) A Specific Story

The first step

Mayor Rolando P. Garcia once described himself as a workaholic Mayor of Kalamansig, Sultan Kudarat. For him working hard will attain the success of their programs. This notion started to change when the Municipal Leadership and Governance Program (MLGP) came into his life. He realized that working hard is not enough to be an effective Local Chief Executive (LCE).

"Before I just work plainly and did not mind other things," says Mayor Rolando. "When I enrolled in MLGP I realized my misgivings as a leader. I realized that I need the support of my stakeholders."

The municipality of Lebak encountered lots of health problems. As identified in their road map, they did not have Barangay Health Action Plan, they had small budget on health and lack of health human resource. These were some of the problems that they encountered. When they are not yet enrolled in the program, they did not know what to do. They did not have a clear picture of the health situation in their municipality.

"Although our Mayor was supportive in our health programs, he did not yet understand health governance," says Dr. Marife C. Aruta, the Municipal Health Officer of Kalamansig. "The health workers were complaining about the lack of (genuine) support of the officials in our municipality."

Mayor Rolando rely everything to his MHO. He entrusted all health related problems to Dr. Marife because he did not have a clear picture of their health situation. The local officials did not yet realize their roles in health governance. Although they had efforts before, it's still hard to convince their constituents because they did not have realization in their part as leaders. They did not have proper information and dissemination campaign to inform the public about the health programs.

Kalamansig is a first class municipality in the province of Sultan Kudarat wherein the main source of livelihood is farming and fishing. It is one of the three coastal municipalities of Sultan Kudarat that has plains, valleys, hills and mountainous topography. The municipality has 15 barangays in which 10 barangays are situated in the coastal areas and 5 barangays on the highlands. According to the 2010 census, Kalamansig has a population of 46,408 people.

With the number of their population, it implies a better health services. When Dr. Marife was not yet enrolled in MLGP, she admits that she blames her staff about their problems.

"After MLGP I realized that I am part of the problem. Before, I keep on blaming my staff if there's a problem in our RHU. Through MLGP I realized that I am also part of the solution. That realization motivates me to change my attitude," says Dr. Marife.

"The program makes me aware of the things that I did not know," says Mayor Rolando. "Before I rely on my MHO but now I realize that I need to ask her about our health inequities. I also need to involve other stakeholders to solve our problems."

MLGP has an important contribution in Leadership and Governance aspect of their 6 building blocks. Because of their awareness, willingness and commitment to health programs they accomplished a lot. As part of their accomplishments they have passed and implemented health related ordinances and resolutions. For example, they expanded their Local Health Board with monthly regular meetings. They created an Executive Order requiring all barangays to establish Barangay Health Boards. Moreover, they have accredited their RHU and birthing home to Philhealth for sustainability. They have purchased one ambulance and one recue vehicle. They

also address the problems on open defecation thru allocation of budget for toilet bowl fabrication and outsourcing of funds for the construction of public toilets (in barangay Pag-Asa). They also coach Barangay Captains to increase their health budget to at least 5% of barangay IRA. These are some of their accomplishments and they are trying their best to fill the other gaps in terms other issues on health.

"I should say that our leadership and governance have improved after we enrolled in MLGP," says Dr. Marife. "Our local officials are now supportive of the health programs."

"LCE should improve because he/she is the one who approve the budget. If I do not know what the problem is, I would be hesitant to give the budget," says Mayor Rolando.

One of the important things that Mayor Rolando learned in MLGP is being patient as a leader. He knows that if he is patient in dealing with people or their programs, it will have a big chance to be successful. He is also aware that there's limitation in all the things that he do.

"I learned to be (extra) patient. To achieve a goal you have to be patient. I do my best in all the things that I do. But I am also aware that there is limitation because no one can do beyond his best," says Mayor Rolando

The ownership of the problem as well as their acceptance to it aids them to make the right solutions to it. They become proactive in finding solutions to their health problems. They would not realize their deficiencies as health service provider.

"If you do not own and accept the problem, you cannot craft the right solution to it. You cannot craft a policy because you do not understand the problem," says Dr. Marife. "If I did not enroll in MLGP, I would not realize my insufficiencies as MHO. As being part of the problem, we should be part of the solutions."

RHU-Lebak is really committed to their health mission and vision. They are doing their best in implementing their health programs with the support of different NGOs and government agencies. They want to involve the health workers and most especially the community for the successful outcome of their health programs.

"After we identified our problems and strategies, we now know what to do. We now know how to deliver health services to the people," says Mayor Garcia.

Moreover, Mayor Garcia now makes dialogue with people. He now understands the importance of stakeholders' participation in the implementation of their programs.

"I make sure that I talk to my constituents. I make dialogues with them and ask their needs."

There's a change of health seeking behavior of the people in Kalamansig. Because of their newly constructed RHU, new health equipment, complete health facilities and approachable health staff, the patients are now willing to avail their services.

"There's an improvement in terms of health seeking behavior of the people in Kalamansig. Before there were 30-40 per day patients in RHU, now it increases to 90 per day," says Dr. Aruta.

"The people are encouraged to visit the RHU," says Mayor Garcia. "I hope the program will continue for those municipalities who want to improve."

Although there are still health problems in Kalamansig, they are glad that they now know what to do. They are now united to solve those problems. Dr. Marife acknowledges the support of MLGP and she is thankful for it. Because for her MLGP serves as the first step towards reaching their goal for Kalusugan Pangkahalatan.

"A journey of a thousand miles begins with a single step," says Dr. Marife. "If I relate that quote to our municipality, MLGP is one of the steps to reach our goal."

Shared Vision of Quality Health Care

What if defining, implementing, and monitoring the quality improvement process in health centers had community involvement? This was exactly was Partnership Defined Quality (PDQ) was all about. PDQ linked quality assessment and improvement with community mobilization. It was an intervention that promoted local ownership and building of support for quality initiatives through a series of consultation meetings and workshops involving health service providers and key community members. The activities explored attitudes and practices related to the provision and utilization of health services; enabled the development of a shared and common vision of what quality services are from varying perspectives; and allowed for the key players to collaboratively work on common problems and craft solutions to improve quality.


PDQ QI Team Members, Quezon City

In each health center, a PDQ Quality Improvement (QI) Team was organized. They took the lead and were involved with the initial stages of planning, to implementation, and to monitoring and evaluation of quality improvement interventions. The composition of the team varied depending on the LGU. Volunteer members from the various health offices included the provincial health nurse, municipal health officer, rural health midwife, barangay health worker, and community health team member. Volunteer members from the community included the barangay chairman, barangay councilor, parent leader, nongovernment organization representative, municipal councilor in health, TA officer, and IP leader. Because of the continued feedbacking meeting at the city/provincial levels and regional levels, monitoring and mentoring visits in Bagumbayan, Sultan Kudarat; Malapatan, Sarangani; and District 2, Quezon City, clients had indicated improvements in their previous areas of concern. PDQ had direct impact to the community as it directly affected the health services that they are provided with.

Different sites identified problems that each site's QI team worked on to address. Problems that were satisfactorily addressed through PDQ included the ones in the table:

Bagumbayan, Sultan Kudarat

Problem	Results after intervention
Poor attitudes of midwives during service delivery	All midwives reported that they treated their clients fairly and with respect. 100% of clients who gave feedback chose "happy" with comments.

Problem	Results after intervention
Unclear use of the ambulance by the community	The ordinance on the proper use of ambulance had been drafted and is now at the SB level for approval. Once the ordinance is approved at the SB level, the client evaluation form will be implemented.
Low prenatal visit	Based on the target client list, there was 100% four ANC visits. This was supported/facilitated with efforts such as when the Poblacion Barangay Captain provided an incentive of P1,000 to day care workers and barangay health workers to promote facility visits and prenatal care; and the road rehabilitation done in Purok Islam, Barangay Poblacion that made facility visits easier.
Client's failure to return for their scheduled visits	90% of clients returned during their scheduled visit. There is now a fixed schedule of midwife visit to the barangay health stations (BHS). This was also facilitated by the actions mentioned above.
Malnutrition of preschool children and mothers	Nutrition rate among preschool children and mothers reached the Department of Health (DOH) target; and this problem had been streamlined and removed as a concern for MNCH.

Malapatan, Sarangani

Problem	Results after intervention
Lack of skill of newly hired health staff	66% to 80% job order positions were trained on EPI , FP, PNC and LSS. 100% job order positions were mentored and coached on MNCH skills. 80% of job order positions that were trained and mentored demonstrated self confidence. 100% of job order positions for midwives assigned in barangays and birthing homes had been provided with basic maternal neonatal and child health and nutrition (MNCHN) services training per DOH protocol.
Poor implementation of MNCHN Ordinance	Twelve barangays had a resolution adopting the MNCHN Ordinance. There was an increase in the number of pregnant women who had prenatal check-ups. There was an increase in the number of deliveries in Lun Padidu. 44% increase in facility-based delivery (FBD) compared to the previous year of the same quarter. There was an increase in the number of post natal check-ups. There was an increase in the number of performance of FIC compared to the previous year of the same quarter. There was an increase in the number of PHIC enrolled pregnant mothers.

District 2, Quezon City

Problem	Results after intervention
Poor provider-client and client-provider attitude	54% of 26 clients who gave feedback were satisfied. Supportive supervision was integrated in health center meetings. Health staff were more open to feedback and comments. Community members were more open to health workers. The feedback tool was integrated in the health center process of those covered by the TA.
No separate waiting area for TB clients in health center, posing an infection risk for mothers and children	As a response, the barangay placed a roof over an adjacent waiting shed, which became the waiting area for TB clients. There were also times when it served as the area for sputum collection.
Lack of privacy during FP and TB consultations	Anecdotal records show an increase in number of clients availing of TB and FP services in health facility.

To ensure that efforts in the areas will be sustained and to help other areas start with their own PDQ, the Module for Maternal Health Services was developed. This will be used for the training of trainers. This module was a product as well of consultations with stakeholders.

From a Challenge to an Opportunity

The Reducing Unmet Need for FP/LAPM Project, which was focused in District 2 of Quezon City, was supposed to help 3,000 women be provided with subdermal implants. Unfortunately, the Philippine Supreme Court issued a temporary restraining order (TRO) on the purchase, distribution and dispensation of subdermal implants (SDI) in all government facilities. However, this did not stall the efforts of the providers and the volunteers in working towards reducing their district's unmet need. Instead, this was turned into an opportunity for the utilization of other FP methods and provision of other technical assistance to help strengthen enabling environments and reduce unmet need.

With support from UNFPA and technical assistance from CHSI, 3,020 women had been provided with other types of long acting and permanent methods (LAPM). Moreover, 45 health service providers (HSPs) were trained on subdermal implants while 101 volunteer health workers (VHWs)[3] were oriented on family planning and their roles in the delivery of FP services. Recognizing the importance of building the capacity of HSPs to support the youth population, 56 HSPs were oriented on the Adolescent Job Aid (AJA).

"Yung natutunan namin, nagagamit namin sa field. Kailangan pa ma-improve ng mga tao ang kaalaman sa FP at spacing sa panganganak," says Lilibet, a volunteer health worker from barangay Bagong Silangan. Even Ms. Vicky Bravo, District II PPO Coordinator observed that *"CHWs and BHWs learned how to properly counsel on FP and to have a good attitude when in the area*."

But the technical assistance that had been making the health workers smile was the development of the United Family Profile Form, which was the end-product of the Barangay Action Plans for Unmet Need developed by the community stakeholders. This form consolidated the information needed for different services in one form and greatly reduced the redundancy of field work for different information needed. It also provided for a more efficient way of tracking clients and organizing their health and family information. Fourteen health service providers, 97 volunteer health workers, and 149 parent leaders from three barangays had been oriented on the use of the form. Recognizing its value, the District 2 Health Office had already issued a memorandum adopting the United Family Profile Form and is now being used in all health centers under District 2.

City Health Workers, Lupang Pangako Health Center, Payatas

[3] Volunteer Health Workers (VHWs) refer to city health workers (CHWs), barangay health workers (BHWs), and barangay nutrition scholars (BNS).

Continued pursuit of MDGs to lower maternal and newborn deaths

UNICEF Health & Nutrition Chief Dr Willibald Zeck (third from left) hands over the BEmONC training modules for Midwives to Zenaida Recidoro, Safe Motherhood Programme Manager for the DOH. Joining them are UNICEF health specialists and DOH officials.

MANILA, 13 JULY 2015 – UNICEF Philippines has turned over to the Department of Health the harmonised modules on Basic Emergency Obstetric and Newborn Care (BEmONC) to equip all Filipino midwives to standardize the quality of care. Dr Willibald Zeck, UNICEF Philippines Chief of Health and Nutrition, presented the training modules to DOH Usec Nemesio Gako, Usec Vicente Belizario, Jr., Asec Paulynn Rosell-Ubial, Asec Gerardo Bayugo, and other DOH senior officials.

"UNICEF presents these modules to Secretary Janette Garin and the DOH, since maternal and newborn care are key elements of our Hi-5 priorities. This is a very timely initiative, particularly in the context of the Philippines where one woman dies every two hours in giving birth. The MNCHN strategy seeks to mitigate the risks on the lives of Filipino women of reproductive age and their newborn children," Dr Zeck said today, at the formal turnover ceremonies at the DOH.

Gako and the undersecretaries and assistant secretaries formally received the modules on behalf of Sec Garin, who is on official mission overseas.

In support of the DOH's Family Health Office, UNICEF assisted to develop the modules as part of the Joint Program on Maternal and Newborn Health (JPMNH) with the Australian Embassy. The modules were created in close consultation with DOH Program Managers, midwives' groups, academe, and partners like the United Nations Population Fund (UNFPA) and the World Health Organization (WHO).

According to the latest Philippine statistics, 3,800 women die at childbirth every year. There are at least more than 300,000 women under the age of 19 in need of proper care during childbirth especially in rural areas. Statistics also show that most maternal deaths occur during the intra-partum and immediate post-partum periods. Close to half of child deaths occur in the first 28 days or the neo-natal period.

UNICEF and DOH recently launched the use of the harmonised modules in the BEmONC training series to rapidly increase the pool of trained health workers in as part of the DOH's Maternal, Newborn and Child Health and Nutrition (MNCHN) strategy. The modules include essential intrapartum and newborn care (EINC) and active management of Third Stage of Labor.

Dr Willibald Zeck (seventh from left) after the turnover rites. With him are ASecs. Bayugo, Paulyn Rosell-Ubial and Elmer Punzalan; and USecs. Vicente Belizario and Nemesio Gako, acting OIC who delivered the acceptance message for Secretary Janette Garin.

Dr Zeck lauded the BEmONC approach that highlights the importance of having committed and skilled health professionals in health facilities to improve access and utilisation of quality health interventions at all stages of pregnancy and child care – from delivery, and up to the child's early years. Dr Zeck added that beyond training, a plan to systematically scale-up the training and maintain the quality of care after the training underlies most success stories.

Participants' modules, Facilitators' Manual and a CD with updated materials on all the BEmONC topics, will be disseminated across the country including the DOH accredited training centres.

"We are thankful for the generous support and cooperation of our partners – the Australian Government, DOH, the UNFPA and WHO for supporting this initiative. We also thank the health associations including the Board of Midwifery, Integrated Midwives Association (IMAP)

and Association of Philippine Schools of Midwifery (APSOM); and all the participating midwives, for their contribution. This lays a key milestone in our ability to reach all parts of the country, including remote and disadvantaged areas, with inclusive and quality maternal and neonatal care," said UNICEF Philippines Representative Lotta Sylwander.