GUIDE IN ESTABLISHING A FUNCTIONAL SERVICE DELIVERY NETWORK (SDN) FOR MNCHN-FP SERVICES
GUIDE IN ESTABLISHING A FUNCTIONAL SERVICE DELIVERY NETWORK (SDN) FOR MNCHN-FP SERVICES
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ACKNOWLEDGEMENT

The Department of Health (Regional Health Office of Zamboanga Peninsula (IX), Regional Health Office of Northern Mindanao (X), Regional Health Office of Davao (XI), Regional Health Office of SOCCSKSARGEN (South Cotabato, Cotabato City, Cotabato Province, Sultan Kudarat, Sarangani & General. Santos City) (XII), Regional Health Office of Caraga (XIII), and the Department of Health in the Autonomous Region in Muslim Mindanao (ARMM) in partnership with the USAID’s MindanaoHealth Project, implemented by Jhpiego, recognize the valuable contributions of the following persons, agencies and institutions represented for the wealth of information shared in making a reality this “Guide in Establishing a Functional Service Delivery Network (SDN) for Maternal Newborn and Child Health and Nutrition & Family Planning (MNCHN-FP) Services”.

The generosity in time, dedicated participation and committed involvement in sharing their technical knowledge and expertise, valuable experiences and insights, and collective visions and aspirations provided during the various phases of the development of the “SDN Guide” are greatly appreciated.

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The Philippines Health Sector is now evolving with the conscious fact that public health is not the sole responsibility of government-managed and operated health facilities or providers. The private health sector is gradually integrated into a more holistic health system recognizing the need for both public and private points of care are available at all levels of the community and should be able to accommodate the population with varying health needs. What is crucial, then, is a referral system that is in place to make the health service delivery mechanisms effective and operational. This is where the Service Delivery Network (SDN) comes into play; the development of which is also prescribed in the Department of Health (DOH) Administrative Order 0029 of 2008: Implementing Health Reforms for the Rapid Reduction of Maternal and Neonatal Mortality, “to deliver the integrated Maternal, Neonatal, Child Health and Nutrition (MNCHN) services as a continuum spanning the period of pre-pregnancy, pregnancy, delivery, and post-partum/post natal ensuring that services are made available at the localities, supported by policies and resources”. The 2011 DOH MNCHN Manual of Operations also considers SDN as a “strategic response to the MNCHN/FP situation, given that no single facility or unit can provide the entire MNCHN package of services”.

To move forward in realizing the mandate to form SDNs, DOH, particularly the Regional Health Offices in Mindanao, with staunch support from the US Agency for International Development (USAID) and Jhpiego, through the MindanaoHealth Project, presents this Guide, specifically Eight Steps in Establishing a Functional Service Delivery Network (SDN), that local government units could adopt depending on the context or local health scenario. Recognizing that there are LGUs with existing health systems initiative, this document could still be helpful in guiding the improvement of existing mechanisms, in broadening the scope of services and making it more inclusive wherein public and private health service providers exist and share responsibilities to ensure that services are available at all levels of care.

This Guide is also a document that is grounded at the grassroots level in that contents were developed from series of activities such as writeshops and workshops involving all possible players of identified existing Interlocal Health Zones and/or SDNs. This makes this SDN Guide adoptable to and applicable in any given local context either taking all the Eight Steps in its entirety or at specific entry point that match the locale’s needs.

It is hoped that with this guide, more local government units will evolve into having local service delivery networks with private and public health service providers working together, communicating, connecting and are always ready to provide needed health services.

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<th>Description</th>
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<td>AHA</td>
<td>Aquino Health Agenda</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal care</td>
</tr>
<tr>
<td>AOP</td>
<td>Annual Operations Plan</td>
</tr>
<tr>
<td>ARMM</td>
<td>Autonomous Region for Muslim Mindanao</td>
</tr>
<tr>
<td>BCC</td>
<td>Behavioral Change Communications</td>
</tr>
<tr>
<td>BEmONC</td>
<td>Basic Emergency Obstetric and Newborn Care</td>
</tr>
<tr>
<td>BHS</td>
<td>Barangay Health Station</td>
</tr>
<tr>
<td>BTL</td>
<td>Bilateral tubal ligation</td>
</tr>
<tr>
<td>CEmONC</td>
<td>Comprehensive Emergency Obstetric and Newborn Care</td>
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<tr>
<td>CHD</td>
<td>Centers for Health Development</td>
</tr>
<tr>
<td>CHO</td>
<td>City Health Officer</td>
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<tr>
<td>CHT</td>
<td>Community Health Team</td>
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<tr>
<td>CPR</td>
<td>Contraceptive prevalence rate</td>
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<tr>
<td>CIPH</td>
<td>City-wide Investment Plan for Health</td>
</tr>
<tr>
<td>CSR</td>
<td>Contraceptive Self-Reliance (Plan)</td>
</tr>
<tr>
<td>DOH-RO</td>
<td>Department of Health Regional Office</td>
</tr>
<tr>
<td>EBF</td>
<td>Exclusive Breastfeeding</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded program on Immunization</td>
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<tr>
<td>ENC</td>
<td>Essential Newborn Care</td>
</tr>
<tr>
<td>FBD</td>
<td>Facility-Based Delivery</td>
</tr>
<tr>
<td>FIC</td>
<td>Fully-Immunized Children</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>GIDA</td>
<td>Geographically Isolated and Disadvantaged Areas</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education, Communication</td>
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<tr>
<td>ILHZ</td>
<td>Inter-Local Health Zones</td>
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<tr>
<td>IMCI</td>
<td>Integrated Management of Childhood Illnesses</td>
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<tr>
<td>IMR</td>
<td>Infant Mortality Rate</td>
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<tr>
<td>ISC</td>
<td>Inter-sectoral Collaboration</td>
</tr>
<tr>
<td>IUD</td>
<td>Intrauterine device</td>
</tr>
<tr>
<td>KP</td>
<td>Kalusugan Pangkalahan</td>
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<tr>
<td>LAM</td>
<td>Lactation Amenorrhea Method</td>
</tr>
<tr>
<td>LGU</td>
<td>Local Government Unit</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
</tr>
<tr>
<td>MMR</td>
<td>Maternal Mortality Ratio</td>
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<tr>
<td>MNCHN</td>
<td>Maternal, Newborn and Child Health and Nutrition</td>
</tr>
<tr>
<td>MOA/MOU</td>
<td>Memorandum of Agreement/Memorandum of Understanding</td>
</tr>
<tr>
<td>MWRA</td>
<td>Married Women of Reproductive Age</td>
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<tr>
<td>NBS</td>
<td>Newborn Screening</td>
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<tr>
<td>NMR</td>
<td>Neonatal Mortality Rate</td>
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<tr>
<td>NSV</td>
<td>No-Scalpel Vasectomy</td>
</tr>
<tr>
<td>PPP</td>
<td>Public Private Partnership</td>
</tr>
<tr>
<td>PHIC</td>
<td>Philippine Health Insurance Corporation</td>
</tr>
<tr>
<td>PHO</td>
<td>Provincial Health Officer</td>
</tr>
<tr>
<td>PIPH/CIPH</td>
<td>Province-Wide/City-Wide Investment Plan For Health</td>
</tr>
<tr>
<td>RHU</td>
<td>Rural Health Unit</td>
</tr>
<tr>
<td>SBA</td>
<td>Skilled Birth Attendants</td>
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<tr>
<td>SDN</td>
<td>Service Delivery Network</td>
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<tr>
<td>UFMR</td>
<td>Under-Five Mortality Rate</td>
</tr>
<tr>
<td>UHC</td>
<td>Universal Health Care</td>
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</table>
DEFINITION OF TERMS

- **Antenatal care coverage** is an indicator of access and use of health care during pregnancy. It constitutes screening for health and socioeconomic conditions likely to increase the possibility of specific adverse pregnancy outcomes, providing therapeutic interventions known to be effective; and educating pregnant women about planning for safe birth, emergencies during pregnancy and how to deal with them (WHO; Indicator definitions and metadata 2008).

- **Basic Emergency Obstetric and Newborn Care (BEmONC)** Refers to a capable network of facilities and providers that can perform the six (6) signal obstetric functions: (1) parenteral administration of oxytocin in the third stage of labor; (2) parenteral administration of loading dose of anti-convulsants; (3) parenteral administration of initial dose of antibiotics; (4) performance of assisted deliveries (Imminent Breech Delivery); (5) removal of retained products of conception; and (6) manual removal of retained placenta. In addition, they are able to provide minimum emergency newborn interventions such as: (1) newborn resuscitation; (2) treatment of neonatal sepsis/infection; and (3) oxygen support, including blood transfusion services.

- **Community Needs** are the gaps between what is and what should be, which can be felt by an individual, a group, or an entire community. Community/SDN Needs for MNCHN-FP services can be as concrete as: need for medicines commodities, health center building, facility accreditation for MNCHN-FP services, trained service providers; or as abstract as: improved care-seeking behavior, community support, effectiveness of service providers, and specific competence of health managers and training.

- **Community Resources/Assets** refer to those essentials to service delivery available in the community/SDN, which can include individuals, groups, organizations, buildings, and equipment that can be used to improve the quality of life for families. These may also consist of: health service providers, health facilities and community settings, physical structure or place, good road and communication network connecting public and private health facilities with clients, financial support to MNCHN-FP services, service providers, facility improvements and health service commodities for mothers and children.

- **Community Health Team (CHT)** is composed of community health volunteers led by a midwife that can provide community level care and services during the pre-pregnancy, pregnancy, delivery and post-partum period. The CHT function to help women and their families improve utilization, organize outreach services especially for remote areas and organize transportation and communication systems within the community, refer high risk pregnancies to appropriate providers, report maternal and neonatal deaths, follow-up of clients for family planning, nutrition and maternal and child care, and facilitate discussions of relevant community health issues affecting women and children.
- **Community level providers** refer primarily to Rural Health Units (RHUs), Barangay Health Stations (BHS), private outpatient clinics and its health staff (e.g. midwife) and volunteer health workers (e.g. barangay health workers, traditional birth attendants) that typically comprise the Community Health Team (CHT). This team implements the MNCHN Core Package of Services identified for the community level.

- **Comprehensive Emergency Obstetric and Newborn Care (CEmONC)** Refers to a capable facility or network of facilities that can perform the six signal obstetric functions for BEmONC and provide services for caesarean delivery, blood banking and transfusion, other highly specialized obstetric interventions; and neonatal emergency interventions including: newborn resuscitation; treatment of neonatal sepsis/infection; oxygen support for neonates; management of low birth weight or preterm newborn, and other specialized newborn services. These facilities can also serve as high volume providers for IUD and VSC services, especially tubal ligations and provide an itinerant team composed of a physician, nurse and midwife that conduct out-reach services to remote communities.

- **Early initiation of breastfeeding** refers to initiating breastfeeding of the newborn after birth within 90 minutes of life in accordance to the essential newborn care protocol.

- **Facility-Based Deliveries (FBD)** is the proportion of deliveries in a health facility to the total number of deliveries.

- **Fully Immunized Children (FIC)** is the ratio of children under 1 year of age who have been given BCG, 3 doses of DPT, 3 doses of Hepa B, 3 doses of OPV and measles vaccine to the total number of 0-11 months old children.

- **Geographically Isolated and Disadvantaged Area (GIDA)** - communities with marginalized population physically and socio-economically separated from the mainstream society such as island municipalities, upland communities, hard-to-reach areas, and conflict-affected areas.

- **Health Outcome Indicators** are parameters which reflect impact or outcomes. For MNCHN Strategy, the health outcome indicators monitored are: maternal mortality ratio, neonatal mortality rate, infant mortality rate, and under-five mortality rate.

- **Health system** refers to “all organizations, people and actions whose primary intent is to promote, restore or maintain health” by enabling delivery of health services which are “effective, safe, quality personal and non-personal interventions to those who need them, when and where needed, with minimum waste of resources” (WHO).

- **Health systems gaps** refer to the absence or lack of instruments needed to support and sustain the provision and utilization of core MNCHN services. These instruments may include accreditation of health facilities and enrolment of population groups to PhilHealth, local budget for health, private and public partnership for health, procurement and logistics.
management system, inter-LGU arrangements, functional referral and feedback system.

- **High volume providers for IUD and VSC** are RHUs (for IUDs) and hospitals (for IUDs and VSCs) and private clinics with sufficient caseload to maintain a certain level of proficiency.

- **Infant Mortality Rate** refers to the number of infants dying before reaching the age of one year per 1,000 live births in a given year. It represents an important component of under-five mortality rate.

- **Inter-local Health Zone (ILHZ)** is usually composed of but not limited to one core referral hospital, catchment rural health units, and barangay health stations.

- **Maternal Mortality Ratio** refers to the number of women who die from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of duration and site of the pregnancy, per 100,000 live births.

- **MNCHN Core Package of Services** refer to a package of services for women, mothers and children covering the spectrum of (1) known appropriate clinical case management services including emergency obstetric and newborn care in preventing direct causes of maternal and neonatal deaths which are within the capacity of the health system to routinely provide; and (2) known cost-effective public health measures capable of reducing exposure to and the severity of risks for maternal and newborn deaths that are routinely being provided by LGUs.

- **MNCHN Service Delivery Network** refers to the network of facilities and providers within the province-wide or city-wide health system offering the MNCHN core package of services in an integrated and coordinated manner. The health providers that are part of the MNCHN Service Delivery Network are: community level providers, BEmONC-capable network of facilities and providers and CEmONC-capable facilities or network of facilities. It includes communication and transportation system supporting the network.

- **Neonatal Mortality Rate** refers to the number of deaths within the first 28 days of life per 1000 live births in a given period.

- **Public Private Partnership (PPP)** is a cooperative venture between the public and private sectors built on the expertise of each partner that best meet clearly defined public needs through appropriate allocation of resources, risks and rewards. The partnership may range from health care provision, logistics management, information and communication technology to capacity building of health providers.

- **Province-wide or city-wide health system** refers to the default catchment area for delivering integrated MNCHN services composed of public and private providers organized into systems such as inter-local health zones (ILHZ) or health districts for provinces and integrated urban health systems for highly-urbanized cities. Service arrangements with other LGUs may be considered if provision and use of MNCHN core package of services across provinces, municipalities and cities become necessary. Unless otherwise specified, LGUs refer to provinces or independent cities.
Referral is a process in which a health worker at one level of the health system, having insufficient resources (drugs, equipment, skills) to manage a clinical condition, seeks the assistance of a better or differently resourced facility at the same or higher level to assist in, or take over the management of, the client’s case.

Referral System is a mechanism that ensures a close relationship among all levels of the health system that helps to ensure clients receive the best possible care closest to home; assists in making cost-effective use of hospitals and primary health care services; and helps build the capacity of health centers and enhance access to better quality care.

Service Coverage Indicators are parameters which reflect coverage or utilization of services. For MNCHN Strategy, the indicators monitored are: contraceptive prevalence rate, antenatal care, facility-based deliveries, early initiation of breastfeeding, fully immunized children, and skilled-birth attendant/skilled health professional deliveries.

Service utilization gaps refer to factors that prevent population groups from accessing and utilizing the MNCHN core package of services such as capacity to pay, availability of information, cultural preferences and distance from health facilities.

Skilled health professionals are providers such as midwives, doctors or nurses who were educated, licensed, and trained to proficiency in the skills needed to manage pregnancies, childbirth and the immediate newborn period, and in the identification, management and referral of complications in mothers and newborns.

Skilled-Birth Attendant (SBA)/Skilled Health Professional Attended Deliveries is the proportion of deliveries attended by skilled health professionals to the total number of deliveries.

Traditional Birth Attendants are regular, non-formally trained and community-based providers of care during pregnancy, childbirth, and neonatal period. Under the MNCHN Strategy, they are made part of the formal health system as members of the Community Health Teams and serve as advocates of skilled health professional care.

Under-five Mortality Rate is the probability (expressed as a rate per 1,000 live births) of a child born in a specified year dying before reaching the age of five if subject to current age-specific mortality rate.
■ **Universal Health Care (Aquino Health Agenda)** is a focused approach to health reform implementation, ensuring that all Filipinos especially the poor receive the benefits of health reform. This is a deliberate focus on the poor to ensure that they are given financial risk protection through enrolment to PhilHealth and that they are able to access affordable and quality health care and services in times of needs.

■ **Unmet need for modern family planning** is the number or rate of all women of reproductive age who want to stop having children or to postpone the next pregnancy for at least three years but are not using modern contraceptive methods.
PART I: ABOUT THE SDN GUIDE TO A FUNCTIONAL SERVICE DELIVERY NETWORK (SDN) FOR MNCHN-FP SERVICES
INTRODUCTION

To respond to the challenges of providing better health outcomes for mothers and children in Mindanao - in areas where these services are most needed, the Department of Health – Regional Health Offices in Zamboanga Peninsula (IX), Northern Mindanao (X), Davao (XI), SOCCSKSARGEN (XII), Caraga (XIII) and the Autonomous Region in Muslim Mindanao (ARMM) initiated the development of a Guide that can be used as reference by local government units in establishing functional Service Delivery Networks (SDNs).

Establishing an SDN for MNCHN-FP supports the scale-up of high-impact services to improve maternal, newborn, child health and nutrition (MNCHN) outcomes, and reduce unmet need for FP services. It aims to improve the quality and use of services at the household level, particularly in geographically-isolated, depressed and conflict-affected areas.

A. DOH MNCHN-FP Service Delivery Network

The DOH-MNCHN SDN is a province or city-wide network of public and private health care facilities and providers capable of giving MNCHN services consisting of basic, comprehensive emergency obstetric and essential newborn care. Since there is no single facility or unit that can provide the MNCHN Core Package of Services, different health care providers within the locality need to be organized into a well-coordinated MNCHN SDN to meet the needs of populations covering the continuum of care in a timely and most efficient manner.

The SDN Guide for MNCHN-FP recognizes the uniqueness of each locality, its socio-cultural, faith and belief orientation, and elements that set variations in health context as provided for in the DOH MOP for MNCHN: each uniqueness is valued and respected, including initiatives undertaken, which they find useful and beneficial in addressing local challenges and which has gained higher client acceptance.  

B. Purpose of the SDN Guide

The purpose of the SDN Guide is to support the functions of local government units (LGUs) to deliver essential services by ensuring that elements of a well-functioning SDN are in place. This involves:

1. adopting a broader view of service delivery for MNCHN-FP clients;
2. extending the scope of health care management;
3. enhancing partnerships and collaboration of stakeholders; and
4. “crossing borders and sectors” to access the needed care and services.

C. Aims and Desired Outcomes

The SDN Guide aims to put mothers, women and children at the center of the health and development agenda in local settings so that safe, acceptable and equitable health services are provided in all its health care facilities. This highlights the significant role that LGUs play in the health development and future success of their constituents: individuals, families and communities.

The use of the Guide intends to help:

1. enhance client access to needed services;
2. improve quality of services and standards of care;
3. increase client use of the MNCHN-FP services;
4. widen the scope of service coverage;
5. improve links between: (a) clients and service providers; (b) service providers and facilities; and, (c) levels of care and support services; and
6. encourage local communities/LGUs to create locally responsive initiatives.

These desired results can come with improvements in the informed decision-making process of mothers, families and communities in timely seeking and using health care, as well as in their confidence and trust in local health systems.

D. Core Processes and Activities involved in the Development of the SDN Guide

1. Consultative Workshops

Two batches of consultative workshops were conducted with participants representing multi-level and inter-sectoral groups from the six regions of Mindanao, five regions under a devolved system and one a non-devolved set-up. Participants came from the community, municipal and provincial levels, private sector, representatives from the DOH regional offices, who provided inputs/ideas drawn from experiences and official guidelines and technical resources from local, national and international agencies.
2. Writeshop

A Writeshop on the development of a Guide for Functional SDN for MNCHN-FP Services was conducted, participated in by a smaller group selected from participants of the two consultative workshops. The workshop and writeshop outputs were used in designing and drafting the First Draft of the SDN Guide.

3. Pre-test

The Draft of the SDN Guide was subjected to a pre-test with a small but well-selected group of participants who assessed its technical content, presentation and design, and provided comments and suggestions. The group represented a range of health professional categories and academic preparations, work experiences in various levels of care in public and private agencies, public policy and legislative functions.

The pre-test results showed high acceptability and agreement among participants of the content, presentation and the steps in establishing a functional SDN based on their quantitative and qualitative assessments. Suggestions to enhance and add some technical content, presentations, and application examples were given.

The second draft of the SDN Guide was used in the conduct of the two batches of the Training of Trainers (ToT) for DOH regional SDN teams. This was further used during the “field-test” experience in the first three “roll-outs” in DOH Regional Offices of Caraga (XIII), SOCCSKSARGEN (XII) and Northern Mindanao (X).

4. Training of Trainers (ToT)

Two batches of the ToT course were conducted for participants from the DOH regional offices who were selected on the basis of the functions of each division/unit and professional/technical designation involved in the MNCHN-FP program, standards and regulation, and support to health systems development.

The course was also attended by participants from non-government organizations who could provide technical assistance to the LGUs in implementing SDN activities at the provincial and city levels.

The second draft of the SDN Guide was used in the conduct of the training of trainers (ToT) and “roll-out training” for the provincial and city “SDN teams”, and in conducting orientations for other relevant groups (public and private) within the health sector and the local government agencies/units.

5. “Field Test” of the Guide

The third draft of the SDN Guide is a product of refinements generated from initial experiences of the first three regional “roll-out” training for DOH regions 13, 12 and 10, which produced concrete experiences in its application of capacitating the provincial and city SDN teams.
This third draft of the Guide is considered a “work in progress” that will further serve as a tool for enriching experiences in establishing functional SDNs in various settings in Mindanao.

Participants in the consultative-workshops, writeshop and pre-test were service providers from public and private health facilities, policy makers from provincial, city and barangay levels, barangay health workers, MNCHN-FP program managers and local health systems support staff from provincial and regional offices.

Regional and provincial MNCHN-FP managers and trainers, DOH development officers, service providers from provincial/city hospitals and health facilities from municipal/barangay levels participated in the field test/roll-out activities.

E. Intended Users of the Guide

The SDN Guide is useful for individuals and groups involved with MNHCN-FP services in the three levels of care: a) community; b) BEmONC; and c) CEmONC:

1. planning/organizing teams at different phases of organizing their cluster of communities into a service delivery network composed of:
   a. health care providers and volunteers
   b. health facility managers and supervisors
   c. health service delivery administrators
   d. community and development partners
2. provincial/city and municipal administrators and teams that manage, supervise and support health facility and community services.
3. DOH national and regional offices and development partners in providing technical assistance and other needed support to MNCHN-FP services.

The SDN Guide may be used both as a job aid and a learning aid. As a job aid, some parts may be used as charts and tools for providing and planning for delivering services. As a learning guide, this may be used in formulating local policies and in setting standard operating procedures for services or for specific client needs.
A. Primary Health Care (PHC) and People-centered Health Care:

Guiding Principles and Values

The Primary Health Care (PHC)\(^1\) values to achieve health for all require health systems that “Put people at the centre of health care,” which is rooted in universally-held values of human rights and dignity, non-discrimination, participation and empowerment, access and equity, and partnership of equals. PHC remains the benchmark to provide rational, evidence-based and anticipatory responses to health needs reflected in the following reform areas:

1. universal coverage reforms to improve health equity;
2. service delivery reforms to make health systems people-centered;
3. public policy reforms to promote and protect the health of communities; and
4. leadership reforms to make health authorities more reliable.

People-centered health care\(^2\) is the centerfold of PHC’s service delivery reforms’ vision where “individuals, families and communities are served by and are able to participate in trusted health systems that respond to their needs in humane and holistic ways.” The health system designed around people’s needs and enables them to collaborate with various stakeholders.

It aims to achieve better outcomes for individuals, families, communities, health practitioners, health care organizations and health systems by promoting:

a. Culture of care and communication;
b. Responsible, responsive and accountable services and institutions; and
c. Supportive health care environments

To achieve the vision of the People-centered health care, positive changes spanning four policy and action domains listed below are needed to drive and sustain the paradigm shift:

1. Informed and empowered - Individuals, families and communities
2. Competent and responsive - Health practitioners
3. Efficient and just - Health care organizations
4. Supportive and humanitarian - Health systems

\(^2\) World Health Organization. People at the Centre of Health Care – Harmonizing Mind and Body, People and Systems. WHO-South-East Asia Region and Western Pacific Region. 2007
The ultimate goal of PHC is better health for all. WHO has identified the following five key elements to achieving this goal, which is also referred to as the “4 + 1” policy directions to refocus health systems:

1. reducing exclusion and social disparities in health (universal coverage reforms);
2. organizing health services around people's needs and expectations (service delivery reforms);
3. integrating health into all sectors (public policy reforms);
4. pursuing collaborative models of policy dialogue (leadership reforms); and
5. increasing stakeholder participation.

The PHC service delivery reforms and the people-centered health care domains provide a strong foundation in establishing the SDN for MNCHN-FP Services consistent with the PHC core values and principles.

Participation of stakeholders is recognized as the key ingredient that puts together the PHC’s the reform areas and people-centered health care. The broader context of Participation in SDN for MNCHN-FP will be presented in STEP 4 of the Guide.

B. Health Systems Development Framework

Effective and efficient health systems contribute to every person's fundamental right to enjoy the highest standard of health. Health systems achieve better results when grounded on PHC's core values and the health systems' six building blocks (Figure 1). Even with wide variations in political, social and health systems globally and within the Western Pacific Region, there are evidences proving that adherence to the core principles or values leads to better health systems and better health outcomes.3

The aims and desirable attributes of the “Six Building Blocks” are described as follows:

1. **Leadership and governance** - ensuring strategic policy frameworks exist and combined with effective oversight, coalition-building, provision of appropriate regulations and incentives, system design and accountability.

2. **A good health financing system** - raises adequate funds for health in ways that ensure people can use needed services and are protected from financial catastrophe or impoverishment associated with having to pay for them.

3. **A well-performing health workforce** - works in responsive, fair and efficient ways to achieve the best health outcomes possible, given available resources and circumstances, i.e. there are sufficient numbers and mix of staff, fairly distributed; they are competent, responsive and productive.

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4. **A well-functioning health system** - ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and scientifically sound and cost-effective.

5. **A well-functioning health information system** - ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status.

6. **Good health services** - those which deliver effective, safe, quality personal and non-personal health interventions to those who need them, when and where needed, with minimum waste of resources.

These building blocks play significant roles in improving the: a) access, b) coverage, c) quality and d) safety of MNCHN-FP services. Consequently, positive changes initiated thru these building blocks will determine success of achieving the desired goals and outcomes of: a) improved health (level and capacity), b) responsiveness, c) financial risk protection, and, d) improved efficiency of an SDN.

A well-functioning health system is able to support a continuum of care throughout the life cycle. Interventions are focused on how they contribute to improved health outcomes using the best and most feasible scientific methods available. Services must be designed, implemented and assessed from the perspective of the users of services.
The ideal elements in a health care system that are useful in designing improvements within the service delivery network are characterized as follows:

1. focuses on meeting the population’s health needs;
2. matches services and capacity to meet the population’s needs;
3. coordinates and integrates care across the continuum;
4. information systems links patients, providers, and payers across the continuum of care;
5. provides information on cost, quality outcomes, and patient satisfaction to multiple stakeholders;
6. uses financial incentives and organizational structure to align governance, management, physicians and other health care providers in support of achieving shared objectives;
7. able to improve continuously the care that it provides;
8. willing and able to work with others to ensure that the community’s health objectives are met;

The health systems framework is meant to ensure that dynamic interactions are considered across the entire system and to minimize the risk of neglecting important parts of the system during any analysis or intervention.

C. The Aquino Health Agenda (AHA): Achieving Universal Health Care (UHC)

According to WHO western pacific declaration, the people in the region deserve to live their lives in the highest state of health possible. While there can be no guarantee of individual health, all people have a right to quality health services that are available, accessible, affordable and acceptable.

The Philippines shares the vision of placing a high premium to the vulnerable population groups and those groups who are internally displaced. Mothers, newborn and children, being most vulnerable population groups, are accorded high priority in all health actions.

The goal of the DOH Administrative Order (AO) No. 2010-0036 - Aquino Health Agenda (AHA): Achieving Universal Health Care (UHC) is towards achieving health system goals for better health outcomes, sustained health financing and responsive health system by ensuring that all Filipinos, especially the disadvantaged group to have equitable access to affordable health care. It seeks to improve, streamline, and scale up the reform strategies to address inequities in health outcomes by ensuring that all Filipinos, especially those belonging to the lowest two income quintiles, have equitable access to quality health care.

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AHA is a focused approach to health reform aimed at ensuring that all Filipinos especially the poor receive the benefits of health reform thru three strategic thrusts:

I. **Financial risk protection through expansion in National Health Insurance Program (NHIP) enrollment and benefit delivery** – the poor are to be protected from financial impacts of health care use by improving the benefit delivery ratio of the NHIP;

II. **Improved access to quality hospitals and health care facilities** – government-owned and operated hospitals and health facilities will be upgraded to expand capacity and provide quality services to help attain MDGs, attend to traumatic injuries and other types of emergencies, and manage non-communicable diseases and their complications; and,

III. **Attainment of the health-related Millenium Development Goals** - public health programs shall be focused on reducing maternal and child mortality, morbidity and mortality from TB and malaria, prevalence of HIV/AIDS, being prepared for emerging disease trends, and prevention and control of non-communicable diseases.

The approach shall strengthen the NHIP as the prime mover in improving financial risk protection, generating resources to modernize and sustain health facilities, and improve the provision of public health services to achieve the MDGs.

The Administrative Order highlights the strengthening of the aggregations of the local health systems for the purpose of inter-LGU cooperation. This mandates the different DOH regional offices and clusters to facilitate all initiatives including promotion of public-private partnership in the provision of health care and promotion of corporate practices to sustain quality and affordable health care.

**D. The DOH Kalusugan Pangkalahatan (KP)**

To accelerate the implementation of the Universal Health Care, the DOH issued the Department Order No. 2011-0188: Kalusugan Pangkalahatan (KP) Execution Plan and Implementation Arrangements, which provided guidelines to accomplish the target outputs set from 2011 to 2016 for health-related MDGs, especially those for MDG 4 and 5. This order streamlined the tasks and functions of the central DOH units to provide critical support and assistance to field units that are supervised by the Operations Cluster Assistant Secretaries and/or Undersecretaries with direct accountability to the Secretary of Health, and involves aligning financial and other resources to support the three strategic thrusts of the Aquino Health Agenda.

Included in the guidelines for the implementation of Kalusugan Pangkalahatan (KP) is the set of Performance Targets to be achieved as detailed below:

A. KP execution shall be guided by well-defined performance targets set at the regional, province, and city levels.

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B. Performance targets for KP implementation are set using the following approach:

1. Use the presence of National Household Targeting System-Poverty Reduction (NHTS-PR) families to determine where to focus KP implementation.
2. Determine service utilization gaps at provincial, city, and municipal levels using the best available current data on total population needs versus previous utilization patterns.
3. Set performance targets representing the three KP thrusts, including:
   - The number of NHTS-PR families to enroll into the NHIP, inform, and guide on benefits and entitlements;
   - The number, type, and names/locations of facilities to be upgraded to provide quality outpatient and inpatient services to NHTS-PR families;
   - The supply and distribution points of public health commodities and life-saving drugs for use by NHTS-PR families;
   - The number of Community Health Teams (CHT) to be deployed to the NHTS-PR families; and
   - The number of RNHEALS nurses to be trained as trainers of CHTs.

C. Separate targets shall be issued for areas with high concentrations of families not receiving healthcare related to MDGs. The KP breakthrough strategy for MDGs will significantly affect national-level indicators by concentrating efforts and resources in these areas.

D. To meet output targets, specific annual performance benchmarks shall be determined by the DOH Regional Officer and submitted to their respective Operations Cluster Assistant Secretary/Undersecretary for validation and endorsement for approval by the Secretary of Health. Guidelines for developing an operational monitoring scheme for KP implementation that includes incentives for performance shall be issued separately.

E. Health Service Delivery System

The Philippines is composed of three geographical divisions, with Mindanao as the second largest island to Luzon and Visayas as the smallest.

The present health care structure in Mindanao operates with two service delivery systems in its six regional health offices, namely:

1. Region 9 – Zamboanga Peninsula;
2. Region 10 – Northern Mindanao;
3. Region 11 – Davao Region;
4. Region 12 – SOCCSKSARGEN (South Cotabato, Cotabato, Cotabato City, Sultan Kudarat, Sarangani, and General Santos);
5. Region 13-Caraga Region; and
6. ARMM (Autonomous Region in Muslim Mindanao).

Regions 9, 10, 11, 12 and 13 function on a devolved/decentralized system of health service delivery, while DOH-ARMM as an autonomous region operates on a non-devolved system of health care delivery.
Among other factors, the two types of service delivery systems present its unique characteristics and the different challenges and opportunities on how the regions respond and pursue health development, particularly at the community level.

i. Devolved/decentralized delivery of health services

To improve the access to health care by the larger population, reforms have been instituted over the past years which included: 1) devolution of health services to the LGUs as mandated by the Local Government Code (LGC) of 1991 (RA 7160) and, 2) the enactment of the National Health Insurance Act of 1995 (RA 7875) which established PhilHealth as the national health insurance corporation to ensure universal coverage with financial access to quality and affordable medical care for all Filipinos.

The Philippine health care system functions on a decentralized set-up with the Department of Health (DOH) serving as the governing agency for local government units (LGUs) and private sector which are the service providers to communities and individuals. The enactment of the LGC in 1991 transferred the responsibility of managing health services to the local government at provincial and municipal levels.

In this set up, municipal governments manage the public health units (Rural Health Units and Barangay Health Stations) and the provincial governments manage the provincial hospitals and district hospitals, while the city and municipal administrations are charged with providing primary care, including maternal and child care, nutrition services, and direct service functions.

The LGUs are guaranteed local autonomy under the 1987 Constitution and the Local Government Code of 1991. Legislative power at local levels is vested in their respective Sanggunian or local legislative councils. Their administrative autonomy empower LGUs to raise local revenues, borrow and determine local expenditures, including health care costs, while continuing to receive guidance from the DOH through the regional health offices.

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The DOH was made the “servicer of servicers” by:

- developing health policies and programs;
- enhancing partners' capacity through technical assistance;
- leveraging performance for priority health programs among these partners;
- developing and enforcing regulatory policies and standards;
- providing specific programs that affect large segments of the population; and
- providing specialized and tertiary level care.

Local initiatives like the setting up of the inter-local health zones (ILHZ) and other similar/related health initiatives aimed at introducing positive changes in the health and development of individuals, families and communities will enable the LGUs to give life on how the devolved set-up can best respond to local health needs in a socio-culturally acceptable and timely manner.

### ii. Non-devolved/decentralized delivery of health services

A unique feature of the Philippine health care system is the existence of a non-devolved autonomous health care system in the ARMM consisting of the five provinces and two cities. A regional government authority manages the region, and constituent provincial and city governments report to this authority. Health services in ARMM are provided mainly through a public sector health system managed by a regional authority—the DOH ARMM. The ARMM has among the lowest health worker-to-population ratios and consequently, also has more unfavorable health indicators.

Local government spending for health is low since health is a non-devolved function and hence is paid for largely by the national and regional governments. PhilHealth shares are also low owing to limited enrolment and the small number of accredited providers.
F. The Inter-local Health System

Meeting the basic health needs of the people requires governments to define policies and ensure their successful implementation at local or district level. A “health district” is a clearly defined administrative area covering a population, at whose level a local government or administration takes over many responsibilities from central government departments.

The District Health Systems (DHS) is widely promoted by the WHO with a firm conviction that the district is the most important level for improving efficiency and responding to local health priorities and needs with focus on high-impact health interventions. It is in the best position to address local challenges by seizing local opportunities and responding to people’s health needs. In some countries, decentralization has been accompanied by effective transfer of authority and responsibility from the central level to the local/district level while in others, the weaknesses in institutional capabilities with instability in policy and environment undermined the performance of DHS.

The DOH launched the health sector reform agenda (HSRA) in 1999 as a major policy framework and strategy to improve the way health care is delivered, regulated and financed. It included the revival of the district health concept to address fragmentation of health services, with Inter-local government unit partnership as the basic framework. The Local Government Code provided for inter-LGU cooperation through Memorandums of Agreement for mutually beneficial purposes and sharing of resources and supports the concept of partnership and the establishment of ILHZs throughout the country.

The district health system enables the provincial and municipal governments together with non-government organizations, communities, and private sector in a well defined geographical area to come into a partnership through a memorandum of agreement to pursue a shared vision and common goals in providing accessible, equitable, and quality health services.

An ILHZ is usually composed of one core referral hospital, catchment rural health units, and barangay health stations. This post devolution concept showed successful experiences of some LGUs in forging partnership in the delivery of health services.

There is a wealth of experiences that organized and functional ILHZs will bring into the establishment of the SDN for MNCHN-FP services, particularly from the localities in Mindanao. The lessons learned from the ILHZ will provide a better foundation and facilitate putting in place the other SDN elements that were not part of the ILHZ. As in any development and change process, it is essential to welcome each activity as a learning experience and the improvement initiatives as “a work in progress”.


APPLICATION SESSION

G. Application Session: Establishing a Baseline for the Proposed SDN for the Mothers and Children in a Locality

Form a group/groups of SDN Team for MNCHN-FP services. Each team is composed of members representing/belonging to defined SDN area/s to work on the following outputs:

**Workshop 1:** Produce a directory of health facilities and providers (both government and private) for MNCHN-FP services representing the three levels of SDN care with the following basic information:

- a. Names and Address of health facilities
- b. Contact Persons and Designations
- c. Contact Details
- d. List of MNCHN-FP services provided

Note: Workshop 1 can be conducted in advance prior to the actual training on SDN for MNCHN-FP at the level of the “SDN” facilitated by provincial/city technical person/s responsible for MNCHN-FP and/or health system development.

**Workshop 2:** Mapping of Facilities (government and private) for MNCHN-FP

- a. Use enlarged Maps and “mapping supplies” prepared in advance before the SDN Training/Workshop, the size of the Map should be large enough for all members of the group to be able to “work on it” as a team.
- b. Two Maps are needed: one for MNCHN services and another for FP services.
- c. The “SDN” Map should reflect the proposed SDN cluster areas including an ILHZ.
- d. “Map out” the existing facilities on the map provided per SDN/ILHZ cluster.
- e. Use the following suggested shapes and colors to identify the facilities and their service categories. The use of the representative shapes and colors are not absolute, and thus, may be changed as may be logistically practical.

**Type of Facility:**

- ■ BHS – Triangle (with fill if separate structure; no fill if attached)
- ■ Private Hospitals - Heart
- ■ Main Health Centers - Star
- ■ Private Lying-In/ Clinics – Diamond

**Category:**

- ■ Community Providers – Black
- ■ BEMONC – Blue
- ■ CEMONC – Red
- ■ Government Hospitals – Cross
**Workshop 3: Identification of Available MNCHN-FP Services**

Using the Maps of Facilities completed in Workshop 2, identify the services available in each facility. Remember: Two separate Outputs are expected in this workshop session – a) MCNHN services and b) FP services.

For ease in spotting available services, please use the colors of the rectangle that enclose the name/title of the services.

### A. MATERNAL CARE SERVICES

**PRENATAL:**
- a. Using the Map in Workshop 2, in the first map, identify the facilities which provide pre-natal care by putting on a yellow push pin on the facility.
- b. If a facility does not provide pre-natal service, put on a red string from the facility using a scotch tape, trace and tie the string up to the push pin indicating that the service is provided.

**DELIVERY:**
- a. Identify the facilities which handle deliveries. Put a blue mark using a pen if the facility already has a yellow pushpin. If not, a blue push pin may be used.
- b. If a facility does not handle deliveries, put on a blue string from that facility, trace and tie the string up to the push pin indicating that the service is being provided.

**POST-PARTUM:**
- a. Identify the facilities which provide postpartum care by tying on a violet/pink string to the pushpin present in the facility.
- b. If a facility does not provide postpartum service, put on a violet/pink string from the facility, trace and tie the string up to the push pin indicating that the service is provided.

**NEWBORN SCREENING:**
- a. Identify the facilities which provide newborn screening (NBS) test. Tie a yellow/beige string to the available pushpin if the facility provides NBS. If there is no pushpin, a red push pin may be used.
- b. If a facility does not provide NBS test, put on a yellow/beige string from that facility, trace and tie the string up to the push pin indicating that the service is being provided.

**REFERRAL FOR COMPLICATED DELIVERIES:**
- a. Connect a green/yellow-green string from the BEmONC facility to the CEmONC facility where referrals on complicated deliveries are made/to be made.
B. FAMILY PLANNING SERVICES

COUNSELLING SERVICES:

a. In the second map, identify the facilities which provide counseling services by putting a red circle around the facility.

b. If a facility does not provide counseling services, put on a red string from the facility using a scotch tape, trace and tie the string up to the facility which provides the service.

PILLS:

a. Identify the facility which provides pills by putting on a blue push pin on the facility.

b. If a facility does not provide pills, put on a green/yellow-green string from the facility using a scotch tape, trace and tie the string up to the push pin indicating that the service is provided.

INTERVAL IUD:

a. Identify the facilities which provide interval IUD insertion. Put a black mark using a pen if the facility already has a blue pushpin. If not, a green push pin may be used.

b. If a facility does not provide interval IUD insertion, put on a blue string from that facility, trace and tie the string up to the push pin indicating that the service is being provided.

POSTPARTUM IUD:

a. Identify the facilities which provide postpartum IUD by tying on a violet/pink string to the pushpin present in the facility.

b. If a facility does not provide postpartum IUD, put on a violet/pink string from the facility, trace and tie the string up to the push pin indicating that the service is provided.

SUBDERMAL IMPLANT (SDI):

a. Identify the facilities which provide SDI. Tie a yellow/beige string to the pushpin present if the facility provides SDI. If there is no pushpin present, a white push pin may be used.

b. If a facility does not provide subdermal implant, put on a yellow/beige string from that facility, trace and tie the string up to the push pin indicating that the service is being provided.

Bilateral Tubal Ligation (BTL):

a. Identify the facilities which provide BTL by tying on an orange string to the pushpin present in the facility.
GENERAL INSTRUCTIONS/REMINDERS ON APPLICATION/PRACTICE SESSIONS:

1. Specific facilitation instructions are discussed during the training of facilitators/training of trainers for Establishing Functional SDN for MNCHN-FP.

2. The outputs of Application/Practice Sessions are connected/related to the technical content and outputs to be accomplished in succeeding “SDN Steps” and Training Sessions.

3. Producing the best, most accurate and complete outputs for each Application/Practice Session will be useful in making good quality outputs in succeeding sessions and consequently in using these in actual work in the “field” after the training/workshop sessions.
PART II: GUIDE TO A FUNCTIONAL SERVICE DELIVERY NETWORK (SDN) FOR MNCHN-FP SERVICES
A. Overview on the Eight (8) Steps to Establishing A Functional Service Delivery Network (SDN) for MNCHN-FP Services

There are eight (8) Steps suggested that can be taken by groups and units that would like to engage in establishing a Service Delivery Network (SDN) for MNCHN-FP services in their localities or in transforming their local initiatives into a health service delivery network to broaden the scope of services, service delivery points and population coverage.

These steps (Figure 2) are presented in a sequential manner as each can build on each step. However, depending on the actual health local health scenario and socio-cultural considerations, the actual process may differ based on the area context and prevailing conditions by which each health setting can be situated within the developmental stages each community, municipality, district, province are in within a defined “health system network” or within a “proposed SDN”.

Figure 2: Steps in Establishing a Functional Service Delivery Network (SDN)

Each “SDN” may take up different entry points or, decide on a main entry step, but may take on several simultaneous steps in pushing forward to an SDN level and towards their vision for the mothers and children in their constituency. STEP 5 of the Guide will address this task with additional discussion and provide more details.

The process of establishing functional SDN can have meaningful effects to the key players and stakeholders if each becomes part of the journey of development. In addition, it can increase their commitment level having invested in the process.
The general content areas and activities suggested for each step are as follows:

1. Formulate and proclaim a Vision and Mission of a Functional SDN for Mothers, Newborns and Children. It must present an ideal local health scenario that can inspire and motivate both the clients to desire to seek and use the services, and inspiring and fulfilling for service providers to go beyond “giving services” but more so, “be of service”.

The step suggests for the SDN MNCHN-FP Teams to formulate a Vision for MNCHN-FP, share with a wider circle of Champions, “selling” this and influencing others (persons and groups) to be part of the SDN and/or establish a separate SDN in cases where there is a wide range of areas to be covered/involved.

2. Define the desired MNCHN-FP Package of Services within the SDN. It must provide a list and brief description of these categories of services: a. the levels of care, b. core package of MNCHN-FP services appropriate for each level of care, c. social and other support services, and d. referral care. It should provide the mechanisms for ease and simplicity of “navigating” through the “network” for both clients and service providers.

3. Determine the SDN Needs and Resources for MNCHN-FP. This specifies the SDN needs for MNCHN-FP services, inventory of the resources that are available to help meet the service needs and demands, and list of resources that will be needed to be made available to achieve the desired goals towards the direction of the SDN Vision. The resources cover all aspects affecting service delivery in all three levels of care.

4. Build and Enhance Public-Private and Other Partnerships for MNCHN-FP. This step encourages the review of existing partnerships, participating sectors, areas/aspects of partnerships and other elements needed in achieving the SDN health goals. It should include expanding partnerships to include new partners from public and private sectors (facilities and service providers) and from outside boundaries available and willing to be part of the SDN in each level of care.
5 Determine the “Take-off” or Entry Points for the SDN establishment process. Each proposed SDN may take different action steps depending among others, on local socio-cultural and geographic conditions, health needs, experiences in engaging with past and present local initiatives for health development.

The proposed SDN may take either one or a mix of these possible entry points, where:

1. beginning SDN steps are initiated;
2. significant SDN steps are currently in place; and/or
3. new service components or systems are to be introduced.

6 Develop and implement an SDN Plan for Establishing, Monitoring and Evaluation. This step will undertake the rigors of participatory planning on how the SDN will be implemented in all three levels of care, with a clear component on monitoring, providing technical assistance and administrative support from the SDN, LGU levels and DOH regional levels.

7 Conduct Regular Monitoring, Review and Evaluation. The SDN development process needs to embrace the principles of continuous quality improvement (CQI) where experiential learning is inherent. This step moves the SDN towards discovering and engaging in new initiatives to further improve MCNHN-FP Services, expanding the SDN experience to new geographic sites, and in revisions of SDN plans, mechanisms, tools, resource guides, etc.

8 Institutionalize and Sustain a Functional SDN and Decide for Scale-up/ Expand MNCHN-FP Services and the SDN Experience. While this step comes at the end, its tasks are vital to making the SDN experience sustainable in making the SDN a part of the regular mandate and role of the health sector. The huge challenge lies in the strong collaboration of the national health system (DOH-national and regional) and the local health systems (LGUs).
It is important to emphasize that application of these steps may differ from one setting to another depending on the actual situation, the context from which health goals are envisioned, and the existence of past and present initiatives engaged by the “network”.

These are some of the possible scenarios in approaching SDN area establishment:

1. In certain cases, there are initiatives that had been implemented and some elements of an SDN had been installed, which are considered functional and responsive to local health needs for mothers, newborns and children;
2. In other areas, there are ILHZs, which had been established and functioning effectively;
3. There areas are where there are experiences in establishing ILHZs but had been functioning well or operating less for a variety of reasons;
4. In cases where the ILHZ has gained a certain level of maturity and stability, the approach can take the path of “transitioning” from the ILHZ concept to the SDN development concept.

In any of the above-cited cases, the process of SDN establishment may take a “multiple-step” and/or a chain of approaches as its entry points. The SDN team is encouraged to go through a process of “visioning”, consultations and consensus to reach the decisions on the development change/s to be pursued for the health of mothers and children. The decisions may take on to any of the following action areas:

a. new MNCHN-FP program/project (Adolescent Health, MNCHN-FP Counseling for Out-of-School Youth/Unwed Mothers; HIV-AIDS infections among mothers and their newborns);
b. new service or care components (MNCHN-FP in Occupational Health/ Corporate settings; Breastfeeding Counseling among Working Mothers; establishing a tertiary private partner hospital as LAPM services provider);
c. new geographic units/facilities (e.g. adjacent areas added to existing network);
d. new SDNs in big provinces; and “Cross-border MNCHN-FP Project”.

Approaches to such change will be based on what each “SDN” has for its vision of health development, how they decide (missions-goals-objectives) to achieve its vision of health in their locality, its determination of what change goals and approaches are best done consistent with their local context and socio-cultural orientation and behaviors in addressing change.

A detailed information for each step will be presented in the succeeding pages.
1.1. Formulate a Vision

A vision is a dream of the best things possible that can happen for the people we care about. Dream Big! Vision statements inspire and motivate. Developing an effective vision statement starts with dreaming big about the future of the organization (SDN). It is a good mental picture created from emotion and passion to achieve a dream.

The vision statement must communicate what the health SDN believes to be the ideal conditions for mothers, newborn, children and family in the communities. It should “picture” how things would work if important issues on the health of mothers and children are perfectly addressed. With a vision statement, the SDN makes clear to everyone the beliefs and governing principles of the SDN as an organization.

Some vision statements on SDN for MNCHN-FP services are presented here which may provide inspiration and ideas in framing a vision for your own SDN:

“To have a Service Delivery Network where every Mother, Newborn and Child regardless of socio-political-religious affiliation is important and accorded equal access to the ‘BEST-QUALITY’ Healthcare that respects the culture, custom and decision of every Person, Group and Community.” - SDN Writeshop, August 2014

“SDN for MNCHN where mothers and children have equal access and opportunity to seek and receive basic services at all times and when needed, avail essential services from other health facilities, provided with needed assistance to receive quality and safe care at all levels of service centers in a timely and compassionate manner.” - SDN Consultative Workshop, July 2014
A functional MHCHN-FP service delivery network providing accessible, people-centered and quality continuum of health care for mothers, newborn, child, and adolescents in a responsive local health system in partnership with supportive stakeholders from all sectors.” - SDN Consultative Workshop, July 2014

A responsive, accessible, sustainable, culture-sensitive and client-friendly facility providing service by competent care and people-centered providers within a strong public and private partnership network of facilities, providers, community volunteers and other partners.” - SDN Writeshop, August 2014

A HEALTH CENTER/HEALTH FACILITY - where ALL services for Mothers, Newborns and Children are offered and affordable, supplies are always available, the clinic is clean and comfortable, and where SAFETY and SATISFACTION of Clients and Service Providers is ALWAYS FIRST.” - SDN Writeshop, August 2014 -

Here is an example of a Vision for Service Delivery Reform that functions as a tool to guide the process of transforming service delivery:

"Vision for a Service Delivery Reform –

Service Delivery Reform will: make it easier for people to do business with government in a time and manner that suits their circumstances; give people better quality services and more intensive help and support at times in their lives when they need it; and, give people better service from government that ensures they receive the benefits and support they are entitled to in ways that are effective for them.” - Service Delivery Reform: Transforming Government Service Delivery, Australia 2011

1.2. Formulate Mission Statement/s

An organization’s mission statement describes what the group is going to do, and why it’s going to do it. Mission statements are similar to vision statements, but they are more concrete, and more “action-oriented” than vision statements.

The mission may refer to a problem, such as poor access to health facilities and health care providers, or a goal, such as universal coverage for MNCHN-FP services in a city, municipality or barangay.
Mission statements are less detailed but provide a hint where to start, and how an organization may address the problems identified.

Some general guiding principles about mission statements are:

- **Concise.** Although not as short as a vision statement, a mission statement should get its point across in one sentence.
- **Outcome-oriented.** Mission statements explain the overarching outcomes the organization is working to achieve.
- **Inclusive.** While mission statements do make statements about your group’s overarching goals, it should do so very broadly. Good mission statements do not limit the strategies or sectors that may get involved in the project.

The following mission statements are examples that meet the above criteria:

- To promote maternal and child health through a comprehensive and integrated MNCHN-FP initiative at all levels of service points.
- To create a sustainable MNCHN-FP strategy through the establishment of a dynamic and responsive SDN management system and supportive fiscal management policies.
- To develop a participatory MNCHN-FP initiative through collaborative planning, community action, and policy advocacy at all SDN levels.
- To establish a dynamic and responsive SDN for MNCHN-FP through a progressive and acceptable system and mechanism for a private-public partnership for health.

While vision and mission statements themselves should be short, it often makes sense for an organization to include its deeply held beliefs or philosophy, which may define both its work and the organization itself. One way of doing this without sacrificing the directness of the vision and mission statements, is to include guiding principles as an addition to the statements. These can lay out the beliefs of the organization while keeping its vision and mission statements short and to the point.

### 1.3. “Proclaim” the SDN Vision and Mission

A clear and powerful vision statement provides direction to all stakeholders, especially the clients and partners. It can be viewed as an inspirational goal. For a DREAM to translate into a REALITY, it must be shared with people and institutions with common goals and passion for the work of ensuring good health and development for mothers and children. It describes what the organization would like to achieve in the future.

With an agreed SDN Vision and Mission within the “SDN Visioning team,” it is necessary to communicate that vision to all stakeholders. This task requires understanding it, not only from the mind but also from the heart. It requires translation from words to images that will be meaningful to others with a vivid picture of what will be achieved. This needs to be done in a way that excites and attracts the others so that they will want to do what needs to be done - to progress from vision to reality!
Proclaiming and selling a vision requires commitment to communicate this Dream to a wider landscape to reach more people and more sectors, geographic areas and health systems approaches. People need to “buy in” to the vision and mission to make things happen – to pursue those dreams to make them real!

“Selling and proclaiming the vision requires passion, emotion and conviction or skills of persuasion.” The inspiration and motivation of stakeholders and participants in a new adventure need to be “championed” beyond the usual strategies, to more action-and-results oriented and “out-of-the-box” means of pursuing a Dream (Vision) in more powerful and inspiring ways (missions)!

The five (5) attributes necessary for successful communication of a Vision are:

1. clarity of the message (need to be clear about the vision and mission statements and values from which these derive),
2. complementary (how and to what extent the vision will benefit the people to whom it is imparted);
3. use of language (use of meaningful metaphors that unite stake holders in a way that allows the listeners to see the vision as if it was real);
4. credibility (leaders’ personal commitment to the vision must be visible); and
5. leading by example (leaders should set an example to others by behaving in ways consistent with their stated values – ‘walking the talk [vision]’)

To succeed in “selling, sharing and buying into the vision” it is important to recognize who (people) and what (groups, institutions, agencies) can be the “Champions for the Cause of Mothers and Children” and for the Health Care sector! They may now be involved in the current local health initiatives ready to expand their participation and/or there are those discovering and seeking opportunities to be part of the journey of care and development for families and communities.

The concept of the Vision as an ingredient of Vision-Mission-Objectives-Strategies-Action (VMOSA) Plans will be pursued further when we get to STEP 6 which focuses on Planning and Implementing the SDN.

1.4. Application Session: WORK on YOUR DREAMS for the Mothers and Children in your SDN

Work together with each SDN/locality’s own shared vision and mission of putting people at the centre of health care, they can –

a. State your Dreams (“visions”) for your SDN communities on the (a) Health and (b) Services for the following:

<table>
<thead>
<tr>
<th>Women and Mothers</th>
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<th>Adolescent &amp; Youth</th>
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</table>
b. Formulate your SDN’s Mission Statements and the Desired Goals to achieve the set Vision/s

**Mission Statement:**

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**Goals:**

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c. What will be your SDN’s Guiding Principles in pursuing your Vision and Mission for mothers and children a reality?
STEP 2: DEFINE THE DESIRED PACKAGE OF SERVICES FOR THE MNCHN-FP AND SUPPORT SERVICES WITHIN THE SDN

2.0. Introduction

Organization of service delivery as defined by WHO, is “choosing the appropriate level for delivering interventions and the degree of integration.” This highlights the essential concepts of integration and continuity of care. The higher the degree of integration and the greater the continuity of care, the more efficient the organization of care is in attending to patient needs.

The SDN team should define the kind of MNCHN-FP services that their SDN will make available, accessible and be integrated to be delivered in all the three levels of care. These include the core package of services, referral care and support services, including the need for partnerships in ensuring availability of services for the mothers, newborn and children ensuring continuity of their care. This demands setting up facilitative mechanisms to navigate through the network for clients and service providers.

2.1. The DOH General Principles for MNCHN-FP Services

The goal of achieving the rapid reduction of maternal and neonatal mortality shall be accomplished through effective population-wide provision of integrated MNCHN services appropriate to a locality. The DOH AO No. 2008-0029 specifies that all reforms and improvements in local health systems shall create intermediate results that will lower the risk of dying related to pregnancy and childbirth.

The following are the desired intermediate results for the maternal and child health:

1. Every pregnancy is wanted, planned and supported;
2. Every pregnancy is adequately managed throughout its course;
3. Every delivery is facility-based and managed by skilled birth attendants; and,
4. Every mother-and-newborn pair secures proper postpartum and postnatal care with smooth transitions to the women’s health package for the mother and child survival package for the newborn.

These results shall be achieved through these aspects in the health systems:

1. **Health service delivery** – addressing direct causes of mortality at childbirth by managing deliveries in basic emergency obstetric and newborn care (BEmONC) or comprehensive emergency obstetric and newborn care (CEmONC) facility. Public health services that reduce risk of dying and improve the well-being of women, mothers and their children shall be made available. A core list of high priority interventions shall be promoted and supported by DOH for implementation by province-wide or city-wide health systems;

2. **Health regulation** – enforcement of regulatory measures and guidelines related to the establishment and operations of health facilities and capacity building of adequate staff through competency-based standards that are linked with suitable performance-based incentive mechanisms;

3. **Health financing** – application of combined financing strategies using instruments available through DOH and LGU budgets, PhilHealth payments and other funding sources. These sources shall finance the acquisition of additional capacities and maximize utilization of services particularly in the population groups where maternal and neonatal mortality is most severe; and

4. **Governance for health** – establishment of governance mechanisms that secure the political commitment of local stakeholders and exact accountabilities for results. These mechanisms shall have broad-based participation, non-partisan leadership and sustained popular support to assure continued local effort regardless of different political, economic and socio-cultural conditions.

Specific guidelines and other details are found in the MNCHN AO 2008-0029 and in the Manual of Operation (MOP) for the MNCHN strategy.

### 2.2. The SDN Levels of Care for MNCHN-FP Services

The three levels of MNCHN-FP care that must be available within a designated SDN according to the MOP guidelines for MNCHN strategy should include:

1. **Community level service providers** refer to outpatient clinics like Rural Health Units (RHUs), Barangay Health Stations (BHSs), and private clinics, including their health staff and volunteer health workers.
   
   At the community level of care, transportation and communications system on a regular - 24/7- basis should be in place so that mothers, newborns and children can be transported promptly to the nearest service providers, birthing facilities or to the referral facilities as needed.

2. **Basic Emergency Obstetrics and Newborn Care (BEmONC)-capable facilities** refer to a network of public and private facilities and providers that are capable of delivering the six signal functions. These include hospitals, RHUs, BHSs, lying-in clinics or birthing homes operating on a 24-hour basis;
For BEmONC facilities, the availability of RED CROSS card (Donor’s Card) will facilitate access to blood supply in cases of referral out to Comprehensive Emergency Obstetrics and Newborn Care (CEmONC) capable facilities. The MNCHN-FP Committee of each LGU should be proactive and consistent with their blood collection mechanism, and realistic and ‘doable’ in their areas to ensure availability of blood supply for MNCHN services.

3. CEmONC-capable facilities refer to a network of end-referral facilities capable of managing complicated deliveries and newborn emergencies. Ideally, a CEmONC-capable facility should be located within less than two hours of travel from the residence of priority populations or from the referring facility. CEmONC-capable facilities can serve as high volume providers for IUD and VSC services, especially tubal ligations and no-scalpel vasectomy.

Within the SDN, functional transportation and communications system on a regular - 24/7- basis should be in place in both the BEmONC and CEmONC facilities. It supports the function of an SDN in providing access to the needed care to clients to address the barriers of physical distance and communication.

The availability of blood and properly-equipped laboratory facilities need to be in place particularly in CEmONC facilities as blood is crucial to the survival of both the mothers and newborns requiring emergency interventions.

For private facilities, it is helpful to have affordable packages for high-risk mothers and newborns. In addition, private service providers need to have affordable professional service fees to improve access to the needed services and decongest public facilities. Accreditation of private facilities and providers will support clients who are PhilHealth members. The private sector plays important role in an SDN.
2.3. Core Package of MNCHN-FP Services

The MNCHN Core Package of Services as specified in the DOH MNCHN strategy MOP consists of interventions that need to be delivered for each of the life stages:\(^1\):

1. **Pre-pregnancy**: provision of iron and folate supplementation, advice on FP, healthy lifestyle, provision of FP services, prevention and management of infection and lifestyle-related diseases.

   Modern FP reduces unmet need and unwanted pregnancies that expose mothers to unnecessary risk from pregnancy and childbirth. Unwanted pregnancies are associated with poorer health outcomes for both mother and her newborn. Effective provision of FP services can reduce maternal deaths by 20 percent. This encompasses adolescent health services, deworming of women of reproductive age, nutritional counseling, and oral health.

2. **Pregnancy**: first prenatal visit at first trimester, at least four prenatal visits throughout the course of pregnancy to detect and manage danger signs and complications of pregnancy, provision of iron and folate supplementation for three months, iodine supplementation and two tetanus toxoid immunization, counseling on healthy lifestyle and breastfeeding, prevention and management of infection, and oral health services.

3. **Delivery**: skilled birth attendance/skilled health professional-assisted and facility-based deliveries including the use of partograph, proper management of pregnancy and delivery complications and newborn complications, and access to BEmONC or CEmONC services.

   The emphasis on the importance of access to emergency obstetrics and newborn care (EmONC) services is due to the shift from the risk approach to pregnancy management to that which considers all pregnancies to be at risk. Under the risk approach pregnant women are screened for risk factors and only those diagnosed with pregnancy complications are referred to facilities capable of providing EmONC services.

   The risk approach recommends that all pregnant women should deliver with assistance from skilled health professionals and to have access to EmONC services since most maternal deaths occur during labor, delivery or the first 24 hours post-partum and most complications cannot be predicted or prevented.

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4. **Post-Partum:** visits within 72 hours and on the 7th postpartum day to check for conditions such as bleeding or infections, giving the mother Vitamin A supplements and, within 48 hours at the health facility, provide counseling on FP, available postpartum FP/PPIUD services, maternal nutrition, lactation and postnatal visit of the newborn.

Newborn care until the first week of life: Interventions within the first 90 minutes such as immediate drying, skin-to-skin contact between mother and newborn, cord clamping after 1 to 3 minutes, non-separation of baby from the mother, early initiation of breastfeeding, and essential newborn care after 90 minutes to 6 hours, kangaroo mother care, newborn care including newborn screening, prior to and after discharge, as well as additional care as provided for in the “Clinical Practice Pocket Guide, Newborn Care Until the First Week of Life.”

5. **Child Care:** immunization, micronutrient supplementation (Vitamin A, iron); exclusive breastfeeding up to six months, sustained breastfeeding up to 24 months with complementary feeding, integrated management of childhood illness, injury prevention, oral health and insecticide-treated nets for mothers and children in malaria endemic areas.

6. **Adolescent and Youth Health**: a) essential health package (basic health care and management; identify common health concerns and issues: screen for risk taking behaviors; render preventive health management and counseling on substance use, sexuality, violence and injury prevention, and improve mental health); b) adolescent pregnancy package (reduce rates: mortality and morbidity from adolescent pregnancy and puerperium); and, c) sexually-transmitted infections/HIV package (reduce morbidity and mortality from STIs and HIV; and prevent STIs/HIV and its complications).

The recommended core package of MNCHN-FP services for the life stages enumerated above from numbers 1 to 6 are discussed in more detail in the DOH Manual of Operations (MOP) for the MNCHN Strategy which is the current Official Reference endorsed by the DOH.

The guide to the provision of Adolescent and Youth Health services are detailed in the 2008 DOH Manual of Standards for Adolescent-Friendly Health Services.

Based on the actual status of MNCHN services in each “SDN area” and according to the Vision and Mission set by the stakeholders, specific services that respond to their local needs, according to their unique setting and context can be added to support the SDN implementation goals and objectives.

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2.4. Referral Care for MNCHN-FP Services

a. Referral Process

Referral is a process in which a health worker at a one level of the health system with insufficient resources (drugs, equipment, skills) to manage a clinical condition seeks the assistance of a better resourced facility at higher level to assist in, or take over the management of, the client’s case.

An effective referral system ensures a close relationship among all levels in the health system and helps ensure that clients receive the best possible care closest to home. It assists in making cost-effective use of hospitals and primary health care services and helps build the capacity of health centers and enhance access to better quality care.

In most cases, a high proportion of clients seen at the outpatient clinics of secondary facilities can be appropriately attended at primary health care centers at lower overall cost to the client and the health system5.

A good referral system helps ensure that:

a. clients receive optimal care at the appropriate level and not unnecessarily costly;

b. hospital facilities are used optimally and cost-effectively;

c. clients who most need specialist services can access these in a timely way; and

d. primary health services are well utilized and their reputation is enhanced.

Furthermore, the benefits of a good referral system include:

a. increase in the efficiency and effectiveness of the health system;

b. strengthening peripheral health facilities;

c. improvement in decision making capacity at lower levels; and

d. promotion of cooperation and complementation between the three levels of care.

b. Reasons and Purpose of Referral

The key reasons for referral either an emergency or routine case include:

1. to seek expert opinion about the client
2. to seek additional or different services for the client beyond the facility’s capability
3. to seek admission and management for the best interest of the client
4. to seek the use of diagnostic and therapeutic tools (technical examination or intervention)

The referral loop consists mainly of the –

a. referring or initiating health care provider or health facility, who prepares an outward referral to communicate the client’s/ patient’s condition, status and pre-referral interventions provided, and the reason/s for the referral; and

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Referral is a two-way process to ensure that continuum of care is covered. The process involves the public, private, community-based health care providers and health care facilities, which can take the form of a vertical, horizontal, or diagonal relationship/s as shown in Figure 3:

In addition, within the concept of the SDN for MNCHN-FP, this may include cross-border network relationships. Given this innovative approach of crossing service sectors (public-private) and crossing borders (geographic and political boundaries) in delivering health services, it is necessary that official agreements and forged between sectors and between borders.

This will be one of the key responsibility areas of the SDN management and advisory levels (STEP 8).

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<tr>
<th>Figure 3. SDN Referral System</th>
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<td><strong>Inside Border</strong></td>
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<tr>
<td>Private</td>
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<tr>
<td>Tertiary Hospital</td>
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<td>Private Hospital</td>
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<td>Private Clinic/</td>
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<td>Private Provider</td>
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![Figure 3. SDN Referral System](image-url)
**c. Referral Information System**

Proper documentation of essential referral processes reflect the quality and success of the systems according to the aims and intended results of the SDN. This provides a record of how well functional is the referral system in particular, and the service delivery in general.

It is recommended for SDNs to plan for a unified record system that links facilities and support units which will be useful in tracking patient/client care in various levels of MNCHN-FP care.

In both the referring and receiving facilities, it is important to maintain a good Referral Registry. This means, complete, accurate, timely and accessible to concerned providers and staff.

1. A referral register is a means for maintaining a list of all outward and inward referrals for one facility or service provider. Information registered will include:
   a. client referred,
   b. where referred,
   c. when and why referred,
   d. whether the referral case is closed or continuing
      -the returning referral/back-referral form has been received with any necessary rehabilitation or follow-up, and
   e. whether it was an appropriate referral or if there were any issues.

2. In some areas, they maintain a directory of MNCHN-FP services that records all facilities, organizations and individual providers providing specialty care for MNCHN-FP and contact information, i.e. landline and mobile numbers, preferably devoted for the purpose of easy and timely access.

   A complete and updated Directory of MNCHN-FP services can facilitate the search for the most appropriate service provider for a particular referral.

3. At the receiving referral facilities (BEmONC- or CEmONC-capable), where a significant volume of clients/patients are attended to, using a colored marker or colored page is suggested for the chart forms to: signal and/or alert service providers that the client is a referral case and, as such, will need special and urgent care.

   Colored markers can remind service providers at referral facilities on discharge, to accomplish a back referral form with vital information such as: discharge diagnosis, clinical summary, services provided, and follow-up care to be done by the provider at referring facility.

4. On the client’s Discharge/Home Care Slip, in addition to the information on “take home” medications, diet, exercise, rest and sleep, among others, it should reflect the scheduled date of the clinic check-up, and information on what to watch out for (risk/danger signs) that will warrant immediate visit to the service provider/clinic visit even before the scheduled follow-up visit.

   A properly filled-out back referral form and the Discharge/Home Care Slip will guide the community level providers in providing the needed follow-up care.
5. A good referral registry provides helpful information on how effective is the MNCHN-FP “referral loop” is in its implementation in full cycle of service provision reflecting the forward referral and back-referral flow. This will help track the:

- service/care flow of MNCHN-FP clients across the three levels of SDN care;
- health and support services made available and provided at different service points;
- involvement/participation of providers and partners within the SDN health care system; and
- efficiency and effectiveness of the SDN resource management;

Hence, it is important to include the MNCHN-FP referral system within the SDN in the conduct of regular monitoring and supervisory visits.

d. Key Roles and responsibilities in a Referral Network:

Generally, the roles and responsibilities of the units involved in a referral system will include the following:

1. Referring facility –
   a. ensures staff awareness of the referral guidelines;
   b. ensures continuous supply of referral forms;
   c. keeps directory of health facilities;
   d. ensures recording of referral activities;
   e. devises mechanisms to track referral;
   f. provides transport to emergency cases;
   g. assigns referral coordinator/liaison officer;
   h. ensures staff at point of entry understand referral process;
   i. ensures referred patients are seen by appropriate professional;
   j. considers attached investigations;
   k. ensures prescheduled referrals are seen without delay; and,
   l. devises follow-up plans as part of the back-referral responsibility

2. Receiving Facility –
   a. assigns referral coordinator;
   b. ensures staff at point of entry understand referral process;
   c. ensures referred patients are seen by appropriate professional;
   d. considers attached investigations;
   e. ensures prescheduled referrals are seen without delay; and,
   f. devises follow-up plans for home care.

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For a well-organized referral system, it is important to have a referral coordinator or liaison officer at the second (provincial hospitals) level and third (regional hospitals/medical centers) level health care facilities where there are larger volumes of referral transactions taking place.

The referral coordinator or liaison officer will be responsible for both the in-and out-referrals, specifically:

- a. facilitate scheduling by using applicable communication;
- b. ensure availability of service at receiving end;
- c. facilitate transportation for emergency cases; and,
- d. keep referral registry

At the municipal level, this function can be a designated function to the public health nurse or supervising midwife based at the Main Health Center. The specific roles and responsibilities of persons assigned at the referring facility and receiving facilities will be based on the facility service profile like number of services, patient caseload, scope and terrains of geographic areas included, and other facility-related and health system set-up factors which will also determine the number and kind of human resources available to deliver the expected roles that facilities need to deliver.

One important task that needs to be accomplished on Referrals by the SDN is the drafting of the Referral Agreements among member/participating facilities and service providers covering both the public and private sectors belonging to an SDN.

The referral arrangements can rationalize the referral process for both clients/ patients and service providers:

- a. helps referring facilities and providers to be selective about which patients they will refer;
- b. thorough in providing pre-referral interventions;
- c. helps receiving providers and facilities to be ready in receiving referrals for MNCHN-FP;
- d. enables receiving providers and facilities to be purposive and timely in providing needed care;
- e. reduces demand for specialty care; and
- f. reduces delays and waiting times.

A more seamless referral process can improve the relationship between referring and receiving facilities and providers.

Figure 4 shows a general referral pathway highlighting the main service component and the corresponding information needed to be accomplished at the referring/initiating facility and at the referral/receiving facilities.

To track the progress of SDN’s referral care, referral agreements and a set of measures to assess whether objectives are being achieved should be formulated. This aspect will be addressed appropriately in STEPs 6 and 7 of the SDN Establishment Process.
Figure 4. Sample Referral Flow for Maternal, Newborn Child Health and Nutrition highlighting the basic Referral Information System

REFERRING ORGANIZATION
(Health Facility or Provider)

REFER CLIENT

Directory:
-Consult
-Find Provider

Referral Form:
-Fill out part A
-Give to client

FOLLOW-UP CLIENT

Referral Form:
-Review form returned by receiving org or client

Client tracking form:
-Update

REFER BACK CLIENT

Referral Register:
-Complete
-Update

RECEIVING ORGANIZATION
(Health Facility - BeMONC/CeMONC)

RECEIVE CLIENT

Referral Form:
-Client takes to provider

Client tracking form:
-Fill out
-Place in client file

MANAGE THE CLIENT

Referral Register:
-Complete
-Update

Referral register:
-Complete
-Update
e. Referral Guidelines and Agreement within the SDN

It is important to work on Referral Guidelines/Agreements to be feasible and/or “doable” within the SDN. It can be initiated based on the existing referral network and improve on the areas of MNCHN services in the three levels of care and in the navigational” flow of the referral network identified as “choke points” in the access and use of services. These are the service points where unnecessary “delays” in services and assistance often take place.

The following approaches can be used as guide for SDN committee/teams in working on improving referral network:

1. Review what are the common reasons/causes of low or poor utilization of health services;
2. Review your SDN’s/community’s referral guidelines, taking note of why referral flow is not complied with, and the reasons for the low records of “back-referrals”;
3. Identify elements in the system that motivate clients to use MNCHN-FP services and how LGU management can improve or simplify operational requirements;
4. Invite some key stakeholders involved or affected by the referral system;
5. Include in the review issues on timeliness and regularity in the availability of health commodities and supplies.

It is likely, that formulating referral guidelines and agreements or improving the existing documents can be the early activities that the SDN partnerships (both public and private) can accomplish.

To make the task manageable, it is suggested to start applying the guidelines and agreements within a smaller cluster of the network. As a “field test”, it can be applied first on specific MNCHN-FP services that may require referrals. This will provide the means to focus on specific aspects to improve on and prevent being overwhelmed by challenges that can present itself during the “field test implementation”. The improved referral guidelines and agreements can be a good input to the final agreements for the partnerships and collaboration that can be formalized.

f. Sample Resources on Referral and SDN


A Health Referral System was developed by Northern Mindanao in 2012 through the leadership of the DOH Northern Mindanao Region (Region 10)\(^7\) to respond to the challenge of putting into organized, systematic and coordinated fashion the general flow of health service delivery from the lowest level of health care provision at the BHS and main health centers (RHUs) to the higher referral facilities, including private hospitals using the main pathways of the public health system that takes overall responsibility according to the government mandate.

The scope of the Northern Mindanao Health Referral System (NMHRS) Manual includes all conditions and specialties needing referrals for higher level care. The development process of the NMHRS Manual included a review of existing referral guidelines the DOH national referral manual (2001), those available and used within Region 10 and a consultation on Multi-regional-Mindanao Wide Health Referral System (Regions 9, 10, 11, 12, CARAGA & ARMM) in 2010 which provided ideas, information and local context perspective of responding to the identified needs.

The participatory-consultative process provided the setting for discussion of relevant issues and concerns and formalizing agreements to make the manual responsive to the situation and needs of the region. The final output was the Northern Mindanao Health Referral System (NMHRS) Manual of 2012.

“The NMHRS Manual was developed to address the gap of referring patients to the appropriate health facility, to guide healthcare workers on the proper approach and management of patients, and to remind the health workers and stakeholders of the ethical standards, respect and attitude toward patients, significant others, stakeholders in the community and their co-health workers.

To bridge the gap between the preventive and curative medical services, emphasis on the 3 C’s, Coordination, Cooperation and Communication as essential to an effective Health Referral System is highlighted in this manual. Also, to ensure the quality and efficiency of the referrals, stakeholders were guided on the principle of referring the Right Patients to the Right Facility at the Right Time all the Time.”

2. From the PRISM 2 Experience

The USAID PRISM 2 project had engaged in several initiatives directed at improving the role, performance and contribution of the private sector for MNCHN-FP goals. These initiatives include the development of mechanisms and tools to make service delivery more accessible and available to clients.

Tools related to referral care were formulated and introduced to selected areas adapted to fit the local context for use as aids in service provision, including the sample Referral Flow (Figure 5) for Postpartum and Newborn Care shown in the following page.

Other examples of Referral Flows will be made available at the annexed section to the SDN Guide as SDN Resource Section.

8 Ilagan, Rogelio. Standard Referral Framework for Special Groups. PRISM 2
Guide in Establishing a Functional Service Delivery Network (SDN) for MNCHN-FP Services

Figure 5. Referral Flow for Postpartum and Newborn

**HOME**

**Woman delivers**

**Hospital of Choice (Public and Private)**

**Public and private BeMONC(able)/CeMONC(able) / Birthing Homes/PPMs/Lying in**

**Essential Intrapartum and Newborn Care; Active Management of Third Stage of Labor**

**ASSESSMENT**

**Mother:**
- PE: Check for bleeding/discharges, uterus, lacerations, edema, skin color, abdominal pain, urinary and bowel complaints

**Baby:**
- Apgar score, weight and temp., umbilical stump, congenital anomalies, urine and bowel output, sucking reflex, caput, hematoma, pre-maturity

**Complications**

**YES**

**Can MHO / Attending Physician / Physician on-call treat the complication?**

**YES**

- Mother: Counseling on EBF, FP Nutrition; birth registration, post-partum visit
- Baby: Hepatitis B Immunization, Vit. K; Newborn screening test, Newborn Hearing Tes

**NO**

**Hospital of Choice (Public and Private CeMONC-able)**

**Client referred to AY Reproductive Health Services / SGBV / IWG Case Managers for further procedures / directions and advice for post-partum (within 7 days & between 4th-6th week postpartum) and child care**

**Client sent home and to come back to facility for the next post-partum visit (within 7 days & between 4th-6th week postpartum) and child care**
With the call from DOH for the establishment of functional SDNs for MNCHN-FP services, it will be useful to review existing technical and administrative guidelines, and the presence of working groups for MNCHN-FP services at the provincial, municipal levels and at the referral health facilities. The deeper participation and integration of health facilities and providers/specialists from the private sector, will be crucial in coordinating effectively all activities on SDN operations.

Equally important is to take special interest and attention to similar initiatives generated from various areas in Mindanao which will have outputs that are closer to our own context of quality improvements for the health of our mothers and children.

Additional details for STEP 2 will also be discussed in STEP 8.

**2.5. Support (Non-medical) Services for MNCHN-FP**

The challenges on the use of health services are often classified as Supply-side barriers and Demand-side barriers. The supply-side barriers include the limited and uneven number of accredited facilities; unaffordable health facilities; inadequate supply of medicines in RHUs; and lack or ineffective communication or social marketing strategy.

Demand-side barriers include the lack of financial resources (for medicines and provider fees); lack of information on benefits and availment process; lack of resource to visit health facilities; and perception of poor quality of healthcare services.

Physical access to service providers and facilities is considered the most difficult barrier to respond from both the Demand and Supply sides since this will require a substantial government investment on human resources for health, facilities and services. Furthermore, this requires improvements in the mode of transportation and development of roads and terrains that will connect people with services in the most efficient and affordable means.

Connecting and navigating through the health system to access the health care intervention and/or social support present can be a huge challenge. These situations most often are the activity or action flows, such as those:

1. from the clients’ homes/communities to the nearest health facility,
2. between health facilities (in case of referrals), and even
3. within and between offices and agencies responsible for the support
4. between levels of care and support services

Hence, for the SDN to be effective and relevant in improving the health condition of mothers and children, it has to address these aspects of the “network” operations to succeed in improving the clients’ use of MNCHN-FP services since these have always been identified as a barrier that is difficult and expensive service pathways to travel.
The main aspects in understanding the need for social services that are included in this guide will focus on:

- transportation and communication support,
- provision of temporary homes for expectant mothers and high-risk newborns from the geographically-isolated and depressed areas (GIDAs) requiring referral care, and
- financial assistance in the use of the needed MNCHN-FP services.

**Transportation and Communication Systems at the Community**

Some of the possible interventions and actions that the communities can explore to respond to the need for transportation and communication services for priority population groups (MNCHN-FP in GIDAs) may include the following:

a. At the community level, discuss among the CHTs and community leaders or barangay officials who have the capacity to mobilize resources in the area and those supportive to local health initiatives.

b. Plan how the community or barangay can provide or secure resources to support the transportation and communication needs of the clients.

c. Identify transportation and communication systems available in the area from both the public and private sectors. Explore possible arrangements for community’s use in transporting clients from their homes/residences to the nearest health care provider or health facility and back to the community.

d. Propose a local ordinance/legislation to support the communication and transportation plan for MNCHN-FP.

e. At the SDN and PHO levels, include in the plan how members/participants of the SDN can provide support to transportation and communication and/or facilitate sourcing for such needs.

f. Benchmark with other experienced and successful ILHZs that achieved management and financial autonomy, which enabled SDN members to be supported.

The following examples of transportation and communication support to priority clients are reported to having been implemented in some ILHZs and LGUs in Mindanao:

a. Expectant mothers from priority groups and areas are transported to health facilities and back to their homes after deliveries (two-way “door-to-door” transport);

b. Expectant mothers from the GIDAs boarded in temporary shelters are transported from the “maternity waiting homes” to health facilities and back to their homes after deliveries (two-way “door-to-door” transport);

c. Use of vehicle and/or costs of transportation of expectant mothers, high risk newborns from the GIDAs to health facilities and back to their homes will be provided by organized community groups;

d. Local initiatives like “lay-away” fund and/or package for personal supply and other needs during delivery by specific expectant mothers and newborns (for newborn screening fee);
e. Communication systems that can be utilized may include:

1. simple two-way radios,
2. cellular phones,
3. landlines, and,
4. other means of transmitting message.

f. Efficiency in communications is critical in ensuring clear and timely communications:

- between the community level (CHTs and clients) and the nearest facility and service providers; and,
- between the different levels of SDN and among CHT members and local government leaders.

Temporary Homes for Expectant Mothers/High-risk Newborns

Among the barriers in accessing health services is, crossing the physical distance between the homes of mothers and children and the nearest health provider and health facility. This is most common in GIDAs where the challenges include, travel time, costs of travel, accompanying person and family factors.

These realities can be responded to by the LGUs through the SDNs vision for “demand and supply” gaps to be narrowed down if not closed, focusing on the main barriers to health care access. Strategies that had been initiated in some areas in Mindanao include the following:

1. “Maternity Waiting Homes” – in areas where access to the nearest hospital and birthing facility is a problem, “maternity waiting homes” are set-up for expectant mothers from GIDAs. On discharge from the hospital or birthing center, mothers and their newborns are brought back to the “maternity waiting home” for a few days, providing opportunities for follow-up visits and clinic check-up.

   For newborns requiring extended care in the health facility or from a service provider, the postpartum mother could stay in this “maternity waiting homes” to allow her to care (“kangaroo care” if needed) for her sick newborn, feed her newborn with her own breast milk and initiate breastfeeding as soon as the baby is able to suck successfully.

   This initiative is best supported by the LGUs fully or in part and/or by the community groups.

2. “Adopt-a-Mother” (Relative/Friend) - in other communities where setting up “maternity waiting home” is not yet feasible, a local initiative to “adopt a relative or a friend” can be introduced. An expectant mother with a willing relative or family friend residing in areas accessible to the birthing homes or hospital, could stay in the relative's/friend’s home, which can serve as “maternity waiting homes.”

   In such arrangement, the family’s health plan should include preparation for own meals and personal necessities to lessen the burden of “adopting families.”
3. Foster Families for Expectant Mothers - families who are willing to accommodate expectant mothers as recommended by the LGU unit (social services) or a local group as part of a community initiative.” Foster families are partly supported with food commodities from social services of the LGUs or by some organized community groups.

In both the “Adopt-a-Mother” and Foster Family set up, part of the CHTs’ role is to help families of expectant mothers connect with relatives and friends residing in areas accessible to health/birthing facilities who will be willing to accept such arrangements on one hand.

In addition, the CHTs will help facilitate access to any support to foster families for food and other basic needs for the mother. Furthermore, the CHTs can be the useful link between these mothers/families and appropriate government and non-government support services that can respond to the mother’s needs.

**Assistance for PhilHealth Membership and Facility Accreditation**

The Aquino Health Agenda (AHA) provided for strategic thrusts to achieve universal health care thru the Kalusugan Pangkalahatan (KP):

a. rapid expansion in NHIP enrollment and benefit delivery using national subsidies for the poorest families;
b. improved access to quality hospitals and health care facilities through accelerated upgrading of public health facilities; and
c. improved health of mothers, newborns and children by meeting the MDG health goals (4 and 5).

To ensure better access to health and improve health outcomes, the DOH-AO 2010-0036⁹ specifies roles that support the SDN establishment to DOH, PhilHealth, LGUs and Development Partners:

a. The DOH’s leadership functions in:
   1. developing guidelines for CHT, SDN and clinical practice;
   2. delivering health service packages referral care;
   3. contracting with private providers;
   4. generating and maximizing PhilHealth benefits; and
   5. upgrading local health facilities to comply with PhilHealth accreditation standard and meeting the MDGs.

b. PhilHealth on functions to:
   1. expand NHIP coverage to poor families while leveraging for local counterparts and providing member and provider services to promote utilization of NHIP benefits;
   2. secure financial risk protection for inpatient services by implementing a no-balance-billing policy in government hospitals; and,
   3. seek financial instruments and strategies to maintain financial sustainability.

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c. LGUs are assisted to:
  1. develop policies and plans appropriate to their locality and consistent with AHA implementation, installation of instruments to sustain provision of services;
  2. mobilize and utilize resources to organize and sustain the CHT and SDN;
  3. allow local hospitals and public health facilities appropriate incentives to improve their capacity to deliver services; and,
  4. organize CHTs and SDNs in partnership with the private sector for effective delivery of health service packages, and contract private providers to supplement available services or provide other services that cannot be delivered by existing public providers (e.g. FP services such as tubal ligation or caesarean sections).

d. Development Partners: (1) provide development assistance consistent with the national thrusts and directions for health; (2) align and harmonize their systems and processes with government procedures and institutional reforms to the best extent possible; (3) cooperate in the establishment of mechanisms to track development assistance for the AHA; and, (4) ensure the sustainability and institutionalization of assistance projects to appropriate agencies/offices.

For local communities, cities and provinces in Mindanao, the DOH and the LGUs need to direct their actions on the following AHA strategic thrusts:
   a. Expansion in the enrollment and benefit delivery to the PhilHealth insurance of priority and most vulnerable populations for MNCHN-FP services and include additional segments of vulnerable populations;
   b. Accreditation of hospitals and other health facilities by DOH and PhilHealth, with priority to those that are part of the SDNs to be certified as BEmONC and CEmONC facilities, to ensure access to quality health care facilities, and
   c. Formulation of local policies and guidelines on the management of PhilHealth fund and other financial resources providing fiscal autonomy and supportive to enhancing facility capability and community support mechanisms.

These strategies are essential elements in ensuring quality health care and will also contribute to sustaining the operation of the health facilities in providing safe and quality MNCHN-FP services in all three levels of SDN care.

The leadership and governance role of both the DOH and the LGU to support the establishment and effective implementation of the SDN clusters can help create a new and dynamic way of achieving the health and development goals of the LGU, in general, and, for mothers and children in particular.

Information on leadership and governance in SDN for MNCHN-FP is provided in each of the STEPS, these will be given operational details in STEP 8 of SDN Establishment Process.
2.6. Application Session: Work to Update Desired Services in your SDN’s Facilities for MNCHN-FP Services

By this time, your SDN Team has formulated and enhanced your stated Vision of health for your mothers, newborns and children based on the current conditions and context. Furthermore, your Team has decided what your SDN communities desire to have to make the local development initiatives move towards that Vision.

In this STEP, state clearly what services must be put in place at each level of care in your SDN. Using Table 1 below, fill-up columns 2 and 3 appropriately.

<table>
<thead>
<tr>
<th>SDN Levels of Health Care</th>
<th>What MCHN-FP Services/ Components of Care are Needed? (present/projected)</th>
<th>Where are these Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1. Presently available?</td>
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<tr>
<td></td>
<td></td>
<td>2. To be made available?</td>
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<td></td>
<td></td>
<td>Public</td>
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<td></td>
<td>Private</td>
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<tr>
<td>Community Level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BEmONC Level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CEmONC Level</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The MNCHN-FP services that each SDN aims to provide should be consistent with the SDN vision for mothers and children formulated (STEP 1) and with consideration of the local context of each area. The SDN may now decide a) the kind of services to be made available, b) the way these services are to be delivered, c) the kind of social services and other support that must be provided, and d) how the client pathway across the levels of care can be made as “seamless” as possible.

The information generated from this exercise will be useful in determining the NEEDS and RESOURCES of the SDN member units, which will be accomplished in STEP 3 of the SDN Establishment Process. For example, if the SDN’s desire is for their expectant at-risk mothers from GIDAs and/or from areas where transportation may not be as reliable and efficient must be supported, then there is a need for the following:

a. “maternity waiting homes” to become part of the SDN care component for expectant mothers, and,

b. transportation and communication support services to be customized to the realities of the selected priority areas.

Moreover, for a more client-and community-friendly service delivery to happen, the SDN needs to ensure that “enabling and supportive environment” will be planned for strategically that will require the development and application of the health systems’ tools and mechanisms. These will be further discussed in STEP 8 of the SDN Guide.

The guiding principles in drafting your SDN’s Service Goals will anchor on the PHC’s and People-centered Care to making these services available, accessible, acceptable, affordable and promotive of people’s rights to health and local health systems development.

Of prime value to the success of service delivery is ensuring the continuity of care across different levels of care. In this regard, three characteristics should be emphasized as key performance indicators for a functional SDN as amplified earlier in this STEP 2: a) communication, b) transportation, and c) referral systems.
3.0. Introduction

With a clear and inspiring vision, the SDN team is ready to step forward armed with ideas on how to proceed to each step. Everyone can share ideas about what the SDN needs in addressing the MNCHN situation within the “network”. This step reminds the team to identify what are needed (needs) and what is/are available (resources).

Community Needs and Resources are two sides of the same coin. To get a view of your community and “network”, it is important to look at what you have and what you need. With these things clear in your mind, your team can make a positive impact on the problem you wish to address. Understanding the needs and assets will help your organization clarify which direction to go to and how to get there.

3.1. Assess the SDN/Community NEEDS for MNCHN-FP

Needs can be defined as the gap between what is and what should be, which can be felt by an individual, a group, or an entire community.

In addressing health issues and concerns that affect mothers and children in our communities in the provinces and/or cities, detailed information is important on the needs of specific clients and the institutions and/or organizations that serve them. These considerations should be analyzed within the specific socio-cultural-religious and geographic context from where the cluster of communities in an SDN belongs.

Relative to this, it is important to be aware of the resources available to address the needs to deliver quality MNCHN-FP services according to set standards, and within the community’s perspective on the issues related to the challenges in the health service access and its acceptability by the clients.

Community/SDN Needs for delivery of MNCHN-FP services are identified below.

It may be as concrete as the following:

1. need for medicines,
2. MNCHN and FP commodities,
3. health center building (a repair or upgrade),
4. facility accreditation to deliver MNCHN-FP services,
5. trained service providers (on MNCHN-FP),

or, it may be as abstract as the following:

6. improved care-seeking behavior,
7. community support,
8. effectiveness of service providers,
9. specific competence requirements of health managers and training, and
10. guidelines for CHTs and community volunteers.

Other examples of NEEDs for MNCHN-FP include facility and public transportation to be available at the community level on a 24/7 basis, to transport mothers and children to-and-from referral facilities, and to be used for regular “outreach” health services in GIDAs.

Examining situations closely helps uncover what is truly needed specific to conditions prevailing in a given cluster of communities that may compose an SDN, which could lead toward future improvement.

3.2. Identify the SDN/Community RESOURCES (or ASSETS)

RESOURCES or ASSETS may include individuals, groups, organizations and institutions, buildings, real estate properties, equipment or anything that can be used to improve the quality of life for families through improved services for mothers and children.

Community or SDN ASSETS/RESOURCES may consist of the following:

a. health service providers - in health facilities and community settings, types/ categories, number and clinical/technical expertise of service providers according to the level of service delivery points (community, health centers, referral hospitals) for MNCHN-FP services.

b. health facilities – level of care classification, capability for MNCHN-FP services, laboratory and diagnostic facilities, blood banks/collection units, public and private referral facilities for MNCHN-FP services.
c. physical structure or place – health facility/hospital, health center or health post, school, church, library, recreation center or a multi-purpose hall. It could include an unused building that could house a community hospice or “maternity waiting home” for expectant mothers.

d. a community service that makes life better for families or community members like a government post that provide or facilitate delivery of services like a barangay office, social services office or a liaison offices of government and/or non-government offices. It can include good public transportation, early childhood education center, and community recycling facilities.

e. good road and communication network connecting public and private health facilities with clients, financial support to MNCHN-FP services, service providers, facility improvements and health service commodities for mothers and children.

f. a person or groups of persons in the community are potential community assets. This can involve people with skills or talents, knowledge about the community, relating with people, and willing to perform any task or needed effort such as: making phone calls, giving information, volunteer companion to expectant mother or treatment partner for TB clients, drivers’ cooperatives, moving equipment or supplies and other related tasks.

Community ASSESTS/RESOURCES could also include mother/parent volunteers, drivers’ cooperatives, public or private facilities that can be used for mothers’ and parents’ classes and youth groups, among others.

The key role of the CHTs in supporting the families with mothers and children in “navigating” through the health systems needs to be highlighted to include responsibilities to motivate and support clients as they move through the stages in the life cycle and the health and wellness continuum.

3.3. Decide on the SDN Needs and Resources for MNCHN-FP Services

In determining the needs and resources for the SDN, refer to your responses from STEPS 1 and 2. Using the information from STEP 2, review the components of health care and support services that your SDN may want to give priority to.

The following questions can be useful in assessing and determining what are the most essential NEEDS and RESOURCES for MNCHN-FP of your SDN/community:

1. What MNCHN-FP services do you desire to be offered/made available by your SDN? How should these services be delivered?
   1.1. Where/at what level/s should these be available?
   1.2. For services available now, what component/s of care need to be added/improved?

2. Describe the characteristics of the service facilities for MNCHN-FP?
   2.1. Physical set-up and amenities
   2.2. Client environment
   2.3. Working environment for service providers

“Everyone in the community can be a strong force for community improvement... a Champion for SDN and MNCHN-FP, if only we know what their assets are, and could put them to use”.
3. How accessible and affordable are the services in terms of:

3.1. Distance and availability of public transport:
   a. between facilities/referral facilities?
   b. between service providers?

3.2. Are transport and communication facilities available?
   a. between facilities/referral facilities?
   b. between service providers?

3.3. Service delivery (access and quality) – public and private facilities and providers

4. How sufficient are the MNCHN-FP service facilities and providers within and around the SDN/community?
   4.1. Public facilities/providers, and
   4.2. Private facilities/providers

5. How supportive/facilitative are the network/navigation mechanisms in:
   5.1. Availing of Referral Care and Follow-up
   5.2. Accessing Social and other support services

6. What is the status of the financial investment/risk management for health within the proposed SDN?
   6.1. Are the health facilities available accredited by both the DOH and PhilHealth?
   6.2. What proportion of the low income population is enrolled with PHIC?
   6.3. For population not covered by the PHIC, are there available alternatives that can be accessed with assistance from the LGU?
   6.4. Are there social support sources for other financial obligations?

3.4. Determine the Need for Partnerships for MNCHN-FP Services

With the SDN communities clear about their desired state of health for their mothers and children, and presented in a powerful and inspiring vision and mission, comes the task of installing the basic structure of an SDN that will be an effective mechanism to ensure that the network of facilities and providers that shall deliver the MNCHN-FP core package of services within the SDN cluster members.

   a. Principles for LGUs in identifying providers within the SDN

   1. Health providers, professionals and facilities that are operating in the area and had signified consent shall be designated as part of the SDN.
      As much as possible, LGUs are advised to develop or establish new facilities to provide MNCHN services.

   2. Private and public health providers should be part of the SDN

   3. Defining the SDN shall not be restricted within political boundaries of the province. Collaboration across provinces is considered in order to better serve priority populations better.
b. Need for Public-Private Partnership (PPP) in Hospitals/Facilities

The flowchart (Figure 8) designed for PPP in Hospital Management provides a simple way to help an organization or LGU determine its plan of pursuing a PPP project for MNCHN-FP services in their SDN areas.

Figure 8: A Simplified for Determining need for a Public-Private Partnership

1. **Is there an unmet health needs?**
   - YES: **Can you meet the unmet health need by yourself? In a cost-effective manner? In a timely manner? Or with better quality than private sectors?**
     - YES: STOP
     - NO: **Can you source fund from the national gov't agency or other development agencies?**
       - YES: STOP
       - NO: **Explore possible PPP arrangements**

2. **Do you have sufficient technical management expertise to meet the unmet health needs?**
   - YES: STOP
   - NO: **Explore possible PPP arrangements**
The following questions are adopted for the MNCHN-FP strategy from those presented in Figure 8. These may be helpful as guide for the SDN teams in its decisions to engage in a public-private partnership:

1. Is there an unmet need for MNCHN-FP services within your SDN cluster? In what areas/aspects of services are unmet? In what level/s of service delivery care are unmet needs identified? Is the identified “unmet need” a new component of care to be introduced in response to the new/enhanced vision and mission of the SDN?

2. Are you able to meet these unmet MNCHN-FP health needs through your existing service delivery points of care? Are the services for the unmet health needs provided in a cost-effective manner? And conducted in a timely manner? Are the health services provided comparable or of better quality than those done by the private sector?

3. Are you able to source the needed funding from the national government agencies or other development agencies to support desired improvements of the MNCHN-FP services? Can you source funding needed to support the establishment and implementation of your proposed SDN for MNCHN-FP?

4. Do you have sufficient technical management expertise within the SDN cluster to meet the unmet MNCHN-FP needs? Are these needed expertise available at all levels? And in all SDN cluster areas?

If the answers to these questions are:

a. **All are NO** – there is a greater need for partnership with the private sectors, development partners, other public sector groups with needed expertise and/or available services to contribute but had not been involved in the past, and with greater need for community partners;

b. **Some YES and some NO** – explore the NO areas in your answers to identify possible PPP partnership arrangements needed, and to discover the existing PPP arrangements that will further improve the work of your YES areas;

c. **All YES** – the PPP arrangement will not be needed by the SDN at this time. The SDN is technically capable and administratively able to respond to the needs for MNCHN-FP within the network.

The PPP is useful if the organization (SDN and its component units) will benefit from improved technical and managerial capabilities in meeting unmet MNCHN-FP health needs, such as managing professional providers and facility accreditation process, enforcing clinical practice guidelines, credentialing the service providers, handling mortalities and morbidity conferences, monitoring disease trends, controlling healthcare-associated infections, and managing assets and finances, and others.

Although the process takes time and requires careful attention, it is essential in creating strong, viable partnerships that produce lasting change.
3.5. Benefits in Assessing the SDN Needs and Resources for MNCHN-FP

a. Assessment helps gain a deeper understanding of the community - its own needs and assets, its culture and social structure -- a unique web of relationships, history, strengths, and conflicts that defines it.

b. Community assessment helps uncover underlying culture and social structures that will help us understand how to address the community’s needs and utilize its resources.

c. An assessment encourages the community/SDN members to consider its assets and how to use them; its needs and how to address them. This should be the first step in their learning to use their own resources to solve problems and improve community life.

d. It helps make appropriate decisions about priorities for program or system improvement. It is often disadvantageous in the end, to address community issues without fully understanding what they are and what caused them.

In the same measure, failing to take advantage of available community resources and tools misses an opportunity to increase the community’s capacity for solving its own problems and creating its own change.

e. It helps eliminate “unpleasant surprises” down the road of development. Identifying needs and resources before starting a program or initiative means that we know from the beginning what we are dealing with, and are less likely to be blindsided later by something unexpected.

Assessments of resources and needs should be done regularly throughout the life of project interventions/initiatives:

a. Prior to planning - gives the group members, community leaders, and those being served an idea of how to improve their circumstances.

b. During implementation - makes sure that the group is on target not only at the start and at the end of a project, but also during its implementation. Identifying needs and assets during the life of the initiative helps us use our own resources well, and ensures that we are addressing the right issues in the right way.

c. On-going basis - either on-going or after the completion of a project, it is important to celebrate successes and learn from setbacks to further the work of community development.
APPLICATION SESSION

3.6. Application Session: Work on Your SDN/Community Needs and Resources

If your SDN has a specific goal to focus on such as reducing teen pregnancy, it will be useful to identify local needs (such as better communication between parents and teens, education and counseling programs, planning or designating a specific clinic day for teens/adolescents) and resources (such as youth outreach programs, peer counselors, other youth-oriented interest groups).

The presence of sectoral and/or interest groups in the community provides opportunities for identifying their individual strengths/assets and the potential of expanding the scope of partnerships to provide better services and more support. Setting up an Adolescent Health Community Program could be one of the entry points that an SDN may consider in enhancing the MNCHN-FP services within their SDN.

On the other hand, if your SDN team's goals are more broad-based like improving the health needs of mothers and children from the under-served population in an urban setting or those in the GIDA areas - identifying assets and needs can help your team decide which aspect of the problem to tackle first (STEP 5).

The objective of Table 3 is to come up with a list of the NEEDS of the SDN community to make available the RESOURCES needed that will enable the health facilities and service providers to deliver the kind of MNCHN-FP services desired based on the Vision of health development in the areas of coverage. The services are more than what are available and provided at present.

It is important to include the NEEDS and RESOURCES that will improve the flow of MNCHN-FP services:

- between service providers,
- between facilities,
- between public sector units (social services, financial assistance, etc) and
- between support and social services that mothers and children will need

These actions will hopefully further motivate those from the health systems to continue to do better each time. It could also enable clients to desire and decide to use the services mainly because they see the benefits of doing so and it makes them feel that they are part of the journey towards the goal of having healthy mothers, children and families.
Table 3. Sample Summary Tool for the Determining the SDN Needs for MNCHN-FP

It is helpful for the selected SDN to establish a database on the desired status of the MNCHN/FP services. It can be initiated by providing information that will answer the following questions:

<table>
<thead>
<tr>
<th>Aspects/areas of SDN level of care</th>
<th>What Must We Have in our SDN for MNCHN-FP services? (Ideal/Desirable)</th>
<th>What do We Have that help achieve our service objectives? (Present/Functional)</th>
</tr>
</thead>
<tbody>
<tr>
<td>This column provides a tentative list of aspects/areas of SDN level of care to work on to improve the delivery of MNCHN-FP services. Depending on the priorities of your SDN, fill-up the relevant items that must be addressed to achieve your SDN's health and development goals for mothers and children.</td>
<td>This column will itemize the Desired/Ideal Resources that should be available or in-place within the SDN to achieve the Vision, Mission and Goals!. This will answer the question: “What Must We Have in our SDN for MNCHN-FP services?” in all the three levels of SDN care.</td>
<td>This column will contain the list of Resources that are presently available in the SDN communities that help achieve the desired quantity and quality of MNCHN-FP services. It answers the question: “What do we have that help achieve our service objectives?”</td>
</tr>
</tbody>
</table>

I. Health Services
   A. Community Level
   B. BEmONC Level
   C. CEmONC Level

II. Health Facilities
   A. Community Level
   B. BEmONC Level
   C. CEmONC Level

III. People
   A. Clients/Patients
   B. Service Providers
   C. Volunteers
   D. Program Partners

IV. Partnership and Collaboration
   A. Private Institutions
   B. Government Agencies
   C. Development/program Partners

V. Policy and Management Support
   A. Legislations
   D. Administrative Orders
   E. Financial Assistance

VI. Others (Specify below)
   A.
   B.
### What do We Need to Have to achieve better Service Outcomes?

This column will contain the list of Needs that must be made available to make the desired SDN quality and quantity of MNCHN-FP services and Care in all its three levels of care - a reality. It answers the question: “What do We Need to Have to achieve better Service Outcomes?”

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### What Must We Have in our SDN for MNCHN-FP services? (Ideal/Desirable)

This column will contain the list of possible sources of the Need assistance identified in Column 4. It may include government and non-government organizations whose mandate and/or advocacies are inclined towards the general or specific aspects identified to be promotive of pushing for enhancing health and development goals for mothers and children. It can include specific groups of peoples’ organizations, interest groups and corporations whose advocacies share the vision for MNCHN-FP services. It answer the question: “What/where are the possible Sources for this Need?”

<table>
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<th>What Must We Have in our SDN for MNCHN-FP services? (Ideal/Desirable)</th>
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STEP 4 – BUILD AND ENHANCE PARTNERSHIPS FOR MNCHN-FP SERVICES [ENGAGEMENT OF PUBLIC-PRIVATE AND OTHER PARTNERS]

4.0. Introduction
With a clear vision for your SDN and having identified your needs and resources, the SDN team is ready to plan how to get to that vision. This is the time to determine who are the people and groups that can help prosper your SDN towards its vision. With past and present experiences in delivering health services, alliances are forged and partnerships are built with various stakeholders. These may include individuals (“champions”), interest groups, government and non-government agencies, corporate, finance and development partners.

4.1. Overview on Partnership
Building partnerships are recognized as powerful strategies when engaging in new projects and advances in systems and technology. The same experiences were undertaken in improving and strengthening the health of mothers, children and families in a holistic way locally and in other countries. By thinking, planning, and working together, the individuals and groups that make a community can accomplish goals that neither could achieve alone.

a. General Guidelines for Successful Partnerships

The process of building a collaborative partnership involves: a) recognizing opportunities for change; b) mobilizing people and resources to create changes; c) developing a vision of long-term change; d) seeking support and involvement from diverse and non-traditional partners; e) choosing an effective group structure; f) building trust among collaborators; and, g) developing learning opportunities for partners.

The general principles to create and sustain successful partnerships are:

- Mutual Understanding. Partners need to understand each other’s needs, respective resources, language, and goals to effectively communicate and to partner with each other for specific projects.

PART II: GUIDE TO A FUNCTIONAL SERVICE DELIVERY NETWORK (SDN) FOR MNCHN-FP SERVICES

- Securing Trust. No partnership can be successful without trust. Recognizing that trust takes time to build and keeping commitments and promises is one of the measures for securing trust.
- Openness and honesty about plans, resources and requirements are critical elements. A frank discussion on “what I need to get out of this relationship for my organization” is relevant in building an on-going relationship.
- Clarity of Goals. Clear discussion and agreement about the shared mission and goals is essential and can be fostered beginning with clearly defined short and longer term achievable results that are used to define the roles and responsibilities of partners.
- Finding Champions. Sponsorship to by committed leaders with the power to achieve results from the initiatives is crucial. The framework may vary in terms of organizational structure for governance.
- Sharing Data. Making good use of data in all stages helps determine goals and mobilize support. Frank discussions about sharing data, data security, access, and reporting will need to be part of the dialogue for successful partnerships.
- Recognizing contributions. Ongoing recognition of partner contributions is essential. Acknowledgement of progress and accomplishments will help ensure recognition of all contributions to success.
- Ensuring mutual benefit. An effective partnership will work to achieve benefits for each partner while also working toward the common goal.
- Insuring productivity. Efficiency of meetings ensures sound decision making process and provides opportunities for inputs assuring active engagement of all in the process.

b. A continuum of partnerships in health promotion

Partnerships in health promotion may range on a continuum from networking through to collaboration.

1. Networking - Involves the exchange of information for mutual benefit. For example, youth services within an SDN or community meet monthly to provide updates on their work and discuss issues affecting young people. Networking is one of the least formal forms of partnership and requires little time or trust between partners.
2. Coordinating - Involves exchanging information and altering activities for a common purpose. For example, an inter-agency group for children’s services meets and plans a campaign to lobby to the local council for “building a child-friendly environment” and providing child-specific services.

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3. Cooperating - Involves exchanging information, altering activities and sharing resources. It requires a significant amount of time, a high level of trust between partners, and an ability for agencies to share their turf.

For example, a group of public health centers and private clinics may pool some resources with a business corporation to launch a ‘Family Fun Run’ as a way to make the families more engaged in healthy lifestyle.

4. Collaborating - Includes enhancing the health promotion capacity of the other partners for mutual benefit and a common purpose. It requires partners to give up a part of their turf to another agency to create a better or more seamless service system.

For example, a group of schools may fund a youth agency to establish a full-time position to coordinate a Youth Program, provide professional development for teachers, and train student peer counselors.

c. Inter-sectoral Collaboration

Inter-sectoral collaboration (ISC) is a recognized relationship between a part or parts of the health sector and those of another sector formed to take action on an issue to achieve health outcomes... in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone (WHO, 1997). It includes collaboration between health and non-health sectors, as well as among the public and private stakeholders within the health sector. The focus is on involving the health system or addressing the social determinants of health broadly.

ISC may be described in different ways: collaborations, partnerships, coalitions, etc.

Collaboration takes place at different levels: coordination of services within a particular area, partnerships or joint projects/programs to address issues, building broad awareness of social problems, community mobilization, and addressing inequality through community development or policy advocacy.

The level and focus of collaborative activity can move through various levels, thus, involving both horizontal and vertical collaboration:

1. Horizontal collaboration occurs across sectors that are at the same level and includes:
   ■ between sectors within the health sector (hospitals, health centers, home care) that deliver programs and services, or
   ■ between health and non-health sectors (social services, education, housing, transportation, etc)
   ■ across divisions or departments within the government sector.

   Horizontal collaboration is effective in bringing together diverse resources, expertise, and experience to solve complex issues whose solutions lay outside the capacity of any one sector. Its benefits lie in the potential to build capacity and maximize the use of combined resources.

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2. Vertical collaboration occurs at different levels and includes:
   ■ between different levels of government: national, provincial or municipal, barangay, or
   ■ related to geography (local, regional or provincial), or
   ■ within organizations (senior administrative levels to the level of service/program provision or direct care).

   Vertical collaboration is important when an issue involves both governmental and non-governmental partners and there is a need for consistent policy and sustained resources. Both are important for success. Change can occur simultaneously on vertical and horizontal levels, thereby adding to the complexity of the process.

4.2. Public-Private Partnership (PPP)

a. Public-Private Partnership (PPP) in Health

Partnerships is an important vehicle for building and sustaining the capacity to promote health and prevent illness as it brings together diverse skills and resources that increase the efficiency of the health system to have a greater impact on health outcomes.

A good definition of PPP – “a project that proportionally apports the risks and rewards to the government and private entity partners.”

As practiced, a PPP can be a:
1. tool for government governance or management;
2. novel approach to delivering government goods and services;
3. tool for development; and,
4. less controversial phrase for privatization or contracting out.

The PPPs recognize that governments and private entities each have certain advantages relative to one another in performing specific tasks. The institutional assets that they bring into the partnership can perform complementary and synergistic effects to the overall project outcomes.

For example, the government is effective in mobilizing resources for the poor, while a private enterprise is successful in fostering innovation and efficiency. In bringing government and private enterprise together in a PPP, the advantages of each can be synergistically harnessed to provide services that neither one can do very well alone.

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PPPs for Health in the Philippines

The PPPs in health has been cited in the Guidebook on Public-Private Partnership in Hospital Management published by Asian Development Bank in 2013. Among the emerging PPPs models in health noted are the following:

1. outsourcing of clinical or technical (ancillary) services to private enterprises and organizations;
2. outsourcing of support services, like laundry, transportation, logistics, security, janitorial, and food and nutrition services;
3. contracting out the direct provision of certain health services to a private provider (e.g. TB treatment, health education); and
4. contracting or integrating private insurance schemes to cover specific populations, especially in low-income areas.

The three common PPP modalities for health are: 1) contracting out of services, 2) joint ventures, and 3) franchising. In addition, several models of contracting out to the private sector are available, such as the following:

a. Collaboration initiated by private companies or nongovernment organizations to develop or deliver health services for specific public health maladies and diseases and/or to specific groups, such as the development of vaccine manufacturing, maternal care, child health services, parasite control, malaria, and HIV/AIDS;
b. Contracting for integrating private insurance schemes to cover specific populations; and,c. Outsourcing clinical or technical (ancillary) services to private sector enterprises or organizations.

Department of Health National Policy on Public-Private Partnership

To fulfill the country’s health and development goals for its people and to achieve its share in meeting the MDGs 4, 5 and 6, the DOH has set the goal of expanding the coverage of essential health services to its people particularly to the women, mothers and children.

Recognizing the gains of private sector partnership experiences in the local setting and focused interventions and its large capacity to contribute to the expansion of service coverage, DOH issued Administrative Order (AO) No. 2006-0008: Guidelines on Public-Private Collaboration in Delivery of Health Services including Family Planning for Women of Reproductive Age in 2006.5

AO No. 2006-0008 is an official declaration of partnership as a national policy to establish and sustain a supportive environment in the health sector that promotes public-private sector collaboration in the delivery of health services to women of reproductive age at all levels sufficient to reduce risks of maternal deaths.

The general guidelines cover the following aspects:

1. Supportive environment for Public-Private Collaboration,
2. Conducive Regulatory System,
3. Fair Health Financing System, and,

The document provides for the expected roles of the DOH Central and Regional offices, the Local Government Units (LGUs) at the provincial and city levels, the Autonomous Region in Muslim Mindanao (ARMM), and the private sector. It included the creation of four teams to help lay-out the directions and aid in the implementation of the Public-Private Collaboration project:

a. Policy and Standards Development Team for Service Delivery;
b. Policy and Standards Development Team for Financing;
c. Policy and Standards Development Team for Regulation; and,
d. Sectoral Management and Coordination Team.

**Private Sector Mobilization for Family Health Project – Phase 2 (PRISM2)**

The Private Sector Mobilization for Family Health Project – Phase 2 (PRISM2) is part of USAID’s initiative to build enduring public-private partnerships that will ensure the availability of and access to quality FP-MCH products and services. PRISM2 provided support to the DOH, Department of Labor and Employment, LGUs and other national and local partners in the provision of technical assistance to the private sector to strengthen its role in the delivery of FP-MCH services.

PRISM1 initiated the private sector participation in meeting the demand of Filipino families for FP and MCH products and services with government as partner. PRISM1 developed models in engaging private sector to inform public policies and develop a sector-wide approach for FP and MCH provision.

PRISM2 worked on the gains of PRISM1 and scaled-up its reach to achieve critical mass. PRISM2 supported cross-cutting efforts such as alliance building, advocacy and institutional development. The resource materials and tools developed under PRISM2 are useful in aiding provinces and cities in the establishment of their SDNs for MNCHN-FP services.

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Guide Questions in Planning for PPP for SDN

Part of the resources developed by PRISM2 was The PPP MiniToolkit that included Guide Questions. The following questions are helpful when planning to form these PPPs as part of the SDN for MNCHN-FP.

Stage 1: Identifying Preconditions for Partnership
1.1. What is the nature of the problem that PPP might solve, and why is it necessary to bring together the actors from the different sectors to solve it?
   a. How are key actors (stakeholders) affected by the problem?
   b. To what extent are resources from different stakeholders required?
1.2. What are the organizational capacities of the various stakeholders about to be involved in the partnership?
   a. Do the key stakeholders have effective organizations?
   b. What are the key organizations and players in the sectors?
   c. Who are the key movers?
1.3. What is the history of the issue and relations among stakeholders?
   a. How much tension must be overcome to enable cooperation?
   b. What present or potential coalitions exist among key actors?
   c. To what extent is the issue widely perceived as a “crisis” so otherwise reluctant parties might be willing to try something new?
   d. Which stakeholders are “ready” for collaboration? Which are not?
   e. What are the impediments to partnering?

Stage 2: Convening the Partners
2.1. How should the sectoral representatives be brought together?
   a. Who should call the meeting?
   b. Where should the meeting be held?
   c. What rules should govern the meeting?
   d. What is the purpose of the meeting?

Stage 3: Setting Shared Directions
3.1. How can the parties establish a climate of hope and a willingness to try new alternatives, especially in a context of conflict or blame?
3.2. How can the parties reach a joint definition of the problem?
   a. What are the ingredients of a successful definition?
   b. How can a “problem” be defined as an “opportunity”?
3.3. How can the parties share information and perspectives that makes constructive use of their differences?
   How can their different perspectives be combined to develop strategies that make good use of their diverse resources?
3.4. Can the parties develop shared strategic direction for the problem that affects all their interests and utilizes their diverse resources?

Stage 4: Implementing Action Strategies

4.1. How can the stakeholders implement detailed plans in ways that respect their differences and interests?
4.2. Who will mediate inevitable tensions and conflicts among the partners of the PPP?
4.3. How will decisions be handled, and to what extent is participation by grassroots groups required for effective implementation?
4.4. What kinds of capacity-building are necessary for the different actors to carry out their parts of the process effectively?

Stage 5: Institutionalizing and/or Expanding Successful PPPs

5.1. How do successful PPPs decide to terminate, continue, or expand?
How can the actors mobilize continuing or expanded resources to support continuing or expanded activity?

Figure 6 provides a framework for appreciating the role of private sector providers and facilities in a PPP in setting up and sustaining the SDN.

Additional resources developed by the PRISM2 project relevant to initiatives in establishing SDN for MNCHN-FP Services are included in the SDN Resource Materials that will accompany the Guide in Establishing a Functional Service Delivery (SDN) for MNCHN-FP Services.

Figure 6. Strengthening the SDN through PPP: The Optimal Setting
4.3. Establish and/or Strengthen Community Partnerships for MNCHN-FP

Improving our communities where people are healthy, safe, and cared for will take a lot of work. The ability to partner effectively with other individuals and organizations -- both inside and outside the community -- is key in making this a reality.

Building healthier communities is the process of people working together to address what matters to them. Engagement is promoted among members of the community, who share a common place (rural community or urban neighborhood), or experience, including being an adolescent or member of an ethnic minority group.9

The purpose of the partnership with the community should be clear. Community stakeholders can participate in a variety of ways, at different levels of influence, in – (1) identifying needs, (2) generating solutions, (3) planning new initiatives, and (4) service delivery.

It is important to be as inclusive as necessary and feasible in calling for participation of community groups. Any group planning and introducing change, like the MNCHN-FP teams will need to remember that every community is made up of a wide range of stakeholders interests that may include:

- local residents or area-based groups;
- communities of Interest;
- faith-based (church) groups;
- racial, ethnic and cultural groups; and
- local community and voluntary groups.

The availability of human resources provides a “treasure box” of community assets waiting to be tapped.

In establishing a “network of service providers” in an SDN to address the health needs of the community, it is beneficial to be purposive in planning the extent or degree of community participation. This is an important ingredient in working for sustainability of health initiatives.

The MNCHN-FP services cover the life cycle continuum for women, mothers and children as its range of service provisions. It involves services and activities provided at all levels of care from the community to the two levels of facility-based services (BEmONC and CEmONC). This underscores the importance of ensuring the strength of community participation that needs to be established that can stand sustainability challenges.

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a. Degrees of Community Participation

The Degrees of Community Participation moves across the following development stages towards increasing depth and strength of relationship as described below and shown in Figure 10:

1. Co-option: token involvement of local people; representatives are chosen, but have no real input or power.
2. Compliance: tasks are assigned, with incentives; outsiders decide agenda and direct the process.
3. Consultation: local opinions are asked; outsiders analyze and decide on a course of action.
4. Cooperation: local people work together with outsiders to determine priorities; responsibility remains with outsiders for directing the process.
5. Co-learning: local people and outsiders share their knowledge to create new understanding and work together to form action plans with outsider facilitation.
6. Collective Action: local people set their own agenda and mobilize to carry it out, in the absence of outside initiators and facilitation.

Diverse stakeholders shape their holistic efforts through collaborative partnerships. These partnerships give communities a structure for organizing, planning, and implementing their ideas. Collaborative partnerships is the mechanism for designing comprehensive strategies that strengthen children and families.

b. MNCHN-FP Support Services at the Community Level

The CHTs are instrumental in improving client access to health care facilities and professional/skilled service providers and in mobilizing available community resources to support clients throughout the maternity experience in particular.

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10 Howard-Grabman, Liza and Snetro, Gail. How to Mobilize Communities for Health and Social Change – A Field Guide. Health Communication Partnership,
These can include arrangements for various needs, such as transportation and communication services, and the need for “maternity waiting homes” for mothers and children from the GIDAs and/or where there are no regular transport facilities available.

The partnerships that are established with local neighborhood cooperatives, faith-based/religious organizations and other barangay-initiated projects to support young families and other vulnerable population achieve better health outcomes at the community level.

The CHTs as part of the MNCHN-FP SDN are involved in organizing, improving capacity and delivering services. They take the initiative of helping formulate realistic plans to meet the community needs and acceptable to its local context and setting.

CHTs can be effective in creating the means by which MNCHN-FP clients and their families can smoothly “navigate through the paths connecting the health system” from-and to the communities.

4.4. Analysis of Partnership Contribution

A partnership approach provides a comprehensive and widespread cross-sector collaboration which can bring in development initiatives that are creative, coherent and integrated to address the most challenging problems. By working separately, different sectors develop activities in isolation, at times competing with each other and/or duplicating efforts and wasting resources, which can often lead to the ‘blame culture’ where chaos or neglect is regarded as someone else’s fault.

Partnerships provide new opportunities to recognize the qualities and competencies of each sector and in finding new ways of harnessing these for the common good.

In addition, each sector has different competencies, aspirations and styles of operation that can be brought together to achieve a common vision.

a. Identifying Partner Organizations/Groups for MNCHN-FP

At an early stage of forming partnerships, it is critical to:

1. identify what types of partner organizations would add value to your SDN for MNCHN-FP;
2. explore the range of options available either by building on existing and proven contacts or by seeking new ones; and
3. select the most appropriate partners and secure their active involvement.

Take time to analyze information to arrive at an appropriate decision to confirm the partners’ characteristics – their profile, organizational vision and mission, areas of interest and ‘track record’ in its development work, and how these can contribute to support MNCHN-FP services in specific areas.

In some instances there may be little or no choice about partners. If working with departments or units of local government is necessary, extra effort may be needed to in persuading them to be actively involved in the SDN by showing them how they, too, can
benefit from working in constructive collaboration with other sectors. In all situations, it is important to be realistic about what the partnership is likely to achieve and to be open about the challenges involved.

b. **Resource Mapping for Potential Partners**

Prior to formalizing a partnership, it is important for the partners to consider what resources will be needed for the agreed project or program of work. This work would have been well completed in STEP 3: Determine the NEEDS and RESOURCES of the “Network” for MNCHN-FP.

Typically this is worked out in terms of funding requirements. However, one of the real benefits of working across-sectors is the potential access to a wide range of non-cash resources that the partners can bring to the partnership.

A partnership meeting dedicated to identifying the resources each partner might contribute can be invaluable. A consultative meeting or through a workshop format, these can offer opportunities for partners to fully explore their own potential for resource contribution and – in the spirit of gentle competition can lead them to make tangible commitments that will enable the partnership to get underway more efficiently.

The framework presented in Figure 11 is useful in performing a Partnership Contribution Analysis aimed at achieving the common vision and mission (STEP 1) for mothers and children in an SDN.

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**Figure 11. Analysis of Partnership Contribution**

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<tr>
<td><strong>Key Strategies</strong></td>
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1. What Health Care Results/Outcomes can be Achieved Together?

2. What Partner Strengths can the Partnership Utilize?

3. What Strategies and Activities can two or more partners work on Together?
There are many ways of doing this dynamically. The simplest way is to ask all those attending the meeting to express or write each resource contribution that they can offer. This can be conducted through an open and free sharing of what each institution/individual can offer given the present conditions.

Apart from the very tangible contributions this will yield, the process is also invaluable in building respect, understanding and teamwork between partners – which are all important pre-conditions of successful collaboration.

4.5. Rewards (Benefits) and Risks of Partnership and Collaboration

Each partner needs to assess the risks and rewards that may arise from involvement in cross-sector initiatives. A partner should understand the potential risks and rewards of fellow partner organizations almost as deeply as their own if they are to commit themselves to genuine collaboration and the principle of 'mutual benefit'.

a. Benefits in Partnerships and Collaboration

The areas of benefit that may be common to all partners include:

a. Professional development of key staff/personnel  
b. Better access to information and different networks  
c. Greater 'reach' for service coverage  
d. Improved operational efficiency  
e. More appropriate and effective products and services  
f. Greater innovation  
g. Enhanced credibility  
h. Increased access to resources

In addition, there are rewards that are specific to individual partners. Ideally these, too, are acknowledged and shared at the start of the partnership to enable mutual appreciation of each other’s specific priorities and ensure that all partners understand the expectations from the partnership.

The benefits of collaborative multi-agency working within a range of service settings are as follows:

- enhance and improve health outcomes for mothers, children and young people, through joint services and support readily available and easily accessible,
- build a cohesive community approach through multi-agency practitioners taking greater ownership and responsibility in addressing local needs jointly, thus, avoiding duplication or overlap of service provision,
■ promote mutual support, encouragement and exchange of ideas among staff, help in sharing of expertise, knowledge and resources for training increased between the services offered and those required by mothers, children, young people and their families to meet their needs,
■ improved co-ordination of services resulting in better relationships, improved referrals and the addressing of joint targets,
■ increase staff morale knowing that they do not work in isolation and that issues and problems can be resolved collaboratively
■ more enthusiastic and committed staff who have high expectations of themselves and others

b. Possible Risks in Partnerships and Collaboration

Organizational risks for each of the sectors may arise in any of the following areas11:

Reputation impact - organizations and institutions value their reputation and, hence, will rightly be concerned that reputation can be damaged either by the partnership itself or by any fall-out in the future should the partnership fail.

1. Loss of autonomy - working in collaboration inevitably means less independence for each organization in the areas of joint work.
2. Conflicts of interest - whether at strategic or operational levels, partnership commitments can give rise to split loyalties and/or to feeling pushed to settle for uncomfortable compromise.
3. Drain on resources - partnerships typically require heavy investment (especially of time), in advance of any appropriate level of ‘return’
4. Implementation challenges - once a partnership is established, a fresh set of commitment and challenges are presented for each partner organization as the partnership moves into project implementation

Risk assessment is important and may easily be ignored in the enthusiasm for potential benefits from collaboration. Partners should encourage each other to undertake such assessments at an early stage of the collaboration and find opportunities to address such concerns together as partners in an open and non-judgmental atmosphere. Partnerships are popular among organizations as they seek creative ways to undertake new initiatives, stretch limited resources, and build community-wide support for missions and services.

Collaboration Risks12 result when partnerships fail to meet the expectations. The most common mistake is the failure to fully consider the risks of the project or program. It is important to proceed carefully and diligently. When two organizations, with different cultures, histories and perspectives come together to accomplish something, a wide range of unexpected events can occur.

Groups that believe at the start of the relationship that they are of “one mind,” find the unique group cultures emerge during the delivery of a collaborative effort.

For example:

1. The motivation of one partner may change over time, and the partnership may no longer be in the best interest of the nonprofit.
2. One or both organizations realize that they did not accurately project the amount of effort and resources the partnership would require. As a result, the partnership is consuming more resources than its benefits warrant.
3. One partner discovers something about the other that makes continued affiliation inappropriate or too risky.
4. One partner fails to live up to the promises made to the other, putting in jeopardy the results sought by both.
5. The organizations involved in a collaborative effort discover they are not compatible, perhaps due to a culture clash or personality conflict involving representatives from each group.
6. One or both partners feel that their “brand” has been lost or subsumed in the partnership.

4.6. Governance and Accountability in Partnership

Even at an early stage, partnerships will need to have governance structures in place to ensure that decision-making, management and development arrangements are appropriate and operate effectively.

Partners are accountable to a number of different ‘stakeholders’ including:

1. Partnership project beneficiaries
2. External (non-partner) donors (who will each have their own reporting requirements)
3. Individual partner organizations (which will each have their own accountability and governance systems)
4. Each other as partnering colleagues

Accountability is a driver of a partnership than is commonly recognized. For this reason, governance and accountability procedures need to be agreed upon and put at the heart of the Partnership Agreement. Generally, partners will have choices about what they do and how they do it. They may consider a range of options from informal arrangements (e.g. an ad hoc collection of individuals), to those that are highly formal (e.g., a new legally registered organization with independent governance and accountability procedures) before choosing the most appropriate for their needs.

It is important to remember that, however, informal a partnership is, a “Partnering Agreement” is always necessary to avoid later misunderstandings and conflict.
Related to hospital/health facility services, there is a range of service delivery components and services where partnerships can be a favorable response to these needs among others, including those for clinical and clinical support services, non-clinical services, infrastructure and equipment and management services.

At the SDN level (provincial or city), partnership and collaboration can be specific or focused on services that the public sector will recognize as their weakness not necessarily in relation to the competence of service providers or capability of the health facilities, but possibly on the aspects of ensuring availability of physical and material resources, management of health facilities and ensuring collaboration of all units included in the SDN care.

The specifics of governance on the SDN for MNCHN-FP will be deliberated more in STEP 8 of this Guide.
APPLICATION SESSION

4.7. Application Session: Work on the Partnership NEEDS in your SDN

In all situations, it is important to be realistic about what the partnership is likely to achieve and be open on the challenges involved. For STEP 4, perform the following tasks taking into account the realities and conditions in your SDN communities:

a. Assess Partnership and Collaboration Needed at each SDN Level of Care

As a group, reflect on the experiences of partners for MNCHN-FP that were engaged with your SDN/community at present and past periods. Using Table 4.1. as worksheet, perform the following activities in assessing existing partnerships and collaboration:

1. List down the names of the partners (column 1) using Table 4.1, Identify at what level of the SDN care (e.g. community, BEmONC, CEmONC) are/were these partners involved.

In cases where your SDN/ILHZ communities had worked with many partners, select those that you think were more useful to the project or those that were partners over a longer period of time.

2. Identify each with:
   a. institutional/group profile and sector (column 2),
   b. institutional interests (column 3),
   c. key benefits and outcomes from the partnership (column 4), and
   d. possible SDN Needs and Resources for MNCHN-FP that can be addressed (column 5).
<table>
<thead>
<tr>
<th>Names of Stakeholders (Present and Potential)</th>
<th>Sector/classification (Public, private, profit, non-profit)</th>
<th>Interests/Fields of Operation</th>
<th>Key benefits and outcomes gained from the partnership</th>
<th>Possible SDN Needs</th>
<th>Resources that can be addressed</th>
</tr>
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<tbody>
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b. Identification of Possible Partners/Champions for your SDN at each Level

The journey of change towards the desired state of health for your mothers and children may be influenced by the people and institutions that will work for the SDN services. Selection of potential partners is a critical task to have the right kind of partners that can truly contribute to the work to be done.

With the initial outputs from the mapping of health facilities and providers and other relevant documents and references available, accomplish Table 4.2. to identify potential/possible SDN partners for MNCHN-FP services.

1. Names of Partners – this will include health facilities, providers of health services, community support groups, development partners, other “SDN champions” (column 1);
2. Specify the Person in-charge, sectoral (public/private) and political/geographic representation (column 2);
3. Provide exact address, contact details and other relevant institutional information (column 3); and,
4. Specify the possible role/services that can be offered to the SDN goals and/or objectives (column 4).

For health facilities that can serve as referral hospitals, specify if within- and/or outside the SDN political/geographic borders. The information from this table will be helpful in drafting of partnership agreements and policy support mechanisms.
Table 4.2. Identification of SDN Partners/Champions for MNCHN-FP Services

<table>
<thead>
<tr>
<th>Names of SDN Partners</th>
<th>Person in Charge and Sectoral classification (Public/private; political/ geographic)</th>
<th>Address and Contact Details (Location, phone numbers, email address, etc.)</th>
<th>Possible roles/services that can be offered to the SDN Goals and Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Facilities, Providers, Community Groups, Development Partners, SDN 'champions')</td>
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5.0. Introduction

The high level of awareness directed at achieving the MDGs 4 and 5 as a national and local commitment highlights the urgency of implementing interventions to save the lives of mothers and children from deaths caused by preventable factors. Various strategies and interventions had been crafted to respond to local barriers and discovering potential resources as success ingredients in improving the elements involved in the local health systems.

In many areas in Mindanao, several initiatives and innovations had been introduced to address these health goals applying the need to customize them into the local socio-cultural and political context as well as geographical setting.

In pursuing higher level objectives and wider scope of implementation for the MNCHN-FP strategy, it is significant to capture the initiatives that brought in gains and benefits to the delivery of health services to the women, mothers and children and use them as their “building blocks” in establishing their SDN.

5.1. Overview on the Establishing Process

Deciding to establish a functional SDN is a challenging CHANGE decision for everyone involved and responsible for making things happen. Any change effort or initiative must start with a vision. Whether the change is prompted by external (political, economic, social or technological) or internal factors (policy, systems or structure), creating a vision will clarify the direction for the change. In addition, the vision will assist in motivating those that are impacted to take action in the right direction.

A vision statement tells you where you are going and why. It paints a compelling work of a desired future state. It can make anyone who reads it or hears it want to support, work for, give to, or in some other way be part of your organization.
It has been said that all IMPROVEMENTS are results of CHANGE, but not all CHANGE will result to improvements. A clear Vision for the mothers and children within the SDN areas and the need for CHANGE will build a strong foundation for the PLANNED CHANGE to make clear the expected improvements as a result of a functional SDN.

At this stage, it is important to review the Vision of the SDN that the group had formulated (STEP 1) to capture the essential points that need to be addressed in the decisions to take and guide in translating it into operational details. This will be an opportunity to confirm the desire for the Change of establishing the SDN.

For every new programs and strategies, every initiative and trail blazing activity, every trial run of a process to improve and develop new ways of thinking, working and solving problems, relating and reaching out, there are new learning and “windows of opportunity” presented to the SDN cluster/s.

In this STEP (5), concerned LGUs committed to establishing a functional SDN for MNCHN-FP will need to remember these realities in health care:

1. MNCHN gaps and problems vary from one area to another, which require customizing interventions in accordance with the peculiarities and needs of specific communities or areas;
2. not all the gaps and issues can be addressed at the same time, but should be resource-oriented, prioritized according to the assessment on the health situation of mothers and children, and appropriate to the situation; and,
3. reforms in service delivery, governance, regulation, and financing are needed for sustained improvement on the health of mothers and children.

Taking the small but purposive steps toward achieving the development and health goals for mothers and children through a functional SDN, guided by the national DOH and guidelines, will pave the way to the desired state of well-being.

5.2. Elements and suggested Indicators of a Functional SDN for MNCHN-FP

The DOH Manual of Operations for the MNCHN Strategy (2011) aims to guide an LGU-wide implementation of the MNCHN strategy by determining the MNCHN-FP SDN and ensuring that elements of a well functioning SDN are in place. This involves a broader view of managing service delivery, enhancing partnerships and collaboration of stakeholders, including “crossing borders and crossing sectors”, and taking into account the unique characteristics and features present in each geographic and socio-cultural setting.
The following are the elements with the suggested indicators of a Functional SDN for MNCHN-FP:

1. Community Health Teams (CHTs) are functional
   a. Organized, trained and deployed
   b. Providing health information including PhilHealth and basic MNCHN-FP services to families
   c. Assuming designated roles and responsibilities
   d. Provided with basic information/guidelines on:
      ■ access to providers and facilities providing MNCHN-FP services
      ■ access and use of transport and communication facilities

2. RHUs/BHSs, health centers, and private clinics are providing MNCHN-FP services
   a. Facility-based health services–list of services, schedules, costs of services (particularly from private facilities and providers), and use of Electronic Masterlisting and Tracking Tool (EMTT);
   b. Outreach/mobile services– regular services to GIDAs, special “response” (emergency/ disaster/outbreaks) to areas with poor access to specific MNCHN-FP services such as the long-acting and permanent method (LAPM) and long acting reversible contraceptive (LARC).
   c. Facility-based and Outreach/mobile MNCHN-FP services are planned and implemented collaboratively by public and private sectors.

3. Functional Community-based transport and communication systems
   a. Organized transport and communication system
   b. Guidelines on the use of transport and communication facilities
   c. Name/s and contact information of authorized/responsible persons for transport and communication services (approving person/s, driver, etc)

4. BEmONC-capable facility has transport and communication system
   a. Certified BEmONC capable facility by DOH-CHD
   b. Basic MNCHN-FP services are implemented regularly in accordance with the approved clinical/technical guidelines
   c. Provide appropriate in-referrals and out-referrals of MNCHN-FP clients

5. CEmONC-capable facility have transport and communication system
   a. Regular implementation of comprehensive MNCHN-FP services in accordance with approved clinical/ technical guidelines
   b. Initiate collaboration among health providers by providing feedback, conducting maternal death reviews, discussion on clinical standards and elevate results to LHBs/LCEs and health managers for proper action.
   c. provide appropriate in-referrals and out-referrals of MNCHN/FP clients

6. Public and private sectors actively participating
   a. Covered by a partnership agreement/memorandum of understanding
   b. Private facilities and practitioners/providers affiliated with the SDN;

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c. Private sector facilities regularly providing Field Health Service Information System (FHSIS) reports;
d. Private sector represented in all levels of management/technical structure

7. Referral mechanism initiated/established for each SDN;
   a. Written guidelines on the referral mechanism (adapted);
   b. Referral services documented by both the referring and referral facilities
   c. Plan for strengthening SDN-MNCHN-FP referral available

8. Blood services available and accessible
   a. Names of blood service facilities, locations and schedules
   b. Name/s and contact information of responsible persons when providing blood services outside clinic/office hours
   c. Availability of Blood Collection Units (BCUs) within the network

9. Organized MNCHN-FP SDN Management structure and guidelines;
   a. Written MOUs/MOAs among network members (‘across borders, across sectors, etc.)
   b. Private sector membership/representation
   c. MNCHN-FP-SDN implementation plan
   d. Regular meetings of key stakeholders duly documented
   e. M&E system installed
   f. Presence of community-feedback mechanism

10. Functional health systems instruments for SDN
    a. Availability of a health service delivery system ensuring all services for MNCHN-FP including services for adolescent and youth
    b. Presence of policies on the SDN and MNCHN-FP core package of services
    c. NHIP accreditation of health facilities and providers
    d. DOH national policies adopted into local policies such as promotion of Facility-based Delivery (FBD), Exclusive Breastfeeding (EBF), immunization, micronutrient supplementation, and CSR policies and guidelines.
    e. Implementation of RA 7600 (Rooming-in and Breastfeeding Act) and EO 51 (Milk Code) in all birthing facilities
    f. Institutionalized local policies supportive of MNCHN-FP implementation
    g. Institutionalized data quality check, functional logistics management and procurement system

Figure 12. Phases of SDN Development
5.3. Assess the Clusters for SDN Functions

In accomplishing STEP 5, the SDN team needs to situate their communities are in relation to the SDN concept and suggested indicators. For this task, your SDN team may need to review the outputs from STEPS 1 to 4 as those relate to the actual setting and scenarios in your cluster areas, recognizing the achievements and available opportunities for the planned CHANGE.

The following questions may be helpful in a “brainstorming” session:

a. Are there some SDN Steps initiated/in place?
   1. functional community health teams on priority population areas – GIDAs, tribal communities, etc.
   2. partnerships with support services – e.g. transport/communication services: association of motorcycle owners and drivers, owners of private vehicles, etc.
   3. improvements in package of facility-based interventions – regular outreach services, referral support, etc.

b. Are there significant SDN Steps now operational or in place?
   1. there are functional inter-local health zones (ILHZZs)
   2. there are existing partnerships with a number of private service providers (OB/Peds and Midwives) and facilities
   3. a CEmONC-accredited private tertiary hospital agreed as end-referral hospital for the clustered areas of the (name/s) SDN/s

c. Are there new service components and systems to be Introduced?
   1. new program/service components – start the Adolescent Health Program, improved Counseling and Communication package for Young/Teen-age Mothers, etc.
   2. new geographic units/health facilities - new municipality to be included in the SDN, new private maternity clinic to join the SDN, etc.
   3. new SDN Systems – new clustered areas to be organized as a new/separate SDN, etc.

d. Are there new clustered areas organizing into SDN/s?
   1. Initial partnerships forged with private OB-GYN and Pediatric practitioners, with 1 private midwife clinic
   2. Clustered municipalities/district health units organized or re-organized in an ILHZ link with private providers

The “SDN Guide for MNCHN-FP Services” aims to serve as a tool to help strengthen the functions of the LGU clusters to deliver the essential services by ensuring that elements of a well functioning SDN are in place as well as enhance the existing local initiatives set-up, including the functional ILHZZs which are deemed responsive to local needs and aspirations.
At any given time, there are conditions that offer opportunities to promote health of the families. These create “SDN windows of opportunity” that may become “take-off” points. These may include opportunity windows of:

1. new health and/or governance policy directions;
2. local crisis/disaster response;
3. new public-private partnerships;
4. development partners; and
5. economic/business investments.

Timely and appropriate response is needed to access the “opportunity windows” in order not to lose the possible benefits that can enhance MNCHN-FP service delivery in the SDN area. “Windows of opportunity” often present itself on a short term basis and may “close” and will open in another time with by then, different opportunities to offer.

5.4. Decide on the Entry Points and Approaches

a. “Take-off “ or Entry Points for SDN Establishment Process

As described earlier, each SDN can have different “take-off” or entry points in addressing their planned change of establishing a functional SDN for MNCHN-FP. This action will be based on certain considerations and realities that each SDN cluster may have - their context, priority needs and available resources.

Using the earlier-mentioned elements and suggested indicators for functional SDN for MNCHN-FP services and based on the situational analysis of your SDN clustered areas, your team can make a simple self-assessment on what phase of SDN development your SDN clustered areas can be classified.

The journey towards a functional SDN level can start with any of the four SDN phases of MNCHN-FP care development:

1. Pre-SDN Phase – service providers and facilities at this phase function independently with no or little relationship established between them. The barangay and municipal health care services maybe able to meet their own population’s needs.

On the other end, public health units from each level may be in less supported conditions and are not provided with needed resources and capability-building support for both health facilities and health workers.

Each level may be providing excellent care and services to mothers, newborns and children, but there is no, is less connecting care pathways for clients to take when there is a need to move up to seek or avail of other services.
2. **SDN Entry Phase** - in this phase, the interest for service delivery has extended to creating some “service paths” for the MNCHN-FP clients to seek their needed care and support services beyond their community and their health facilities.

There may now be established partnership agreements between the public health facilities and providers with private facilities and providers. In addition, there are initiatives of public support for social and health services that connect the barangay and municipal levels, as well as municipal and provincial/city levels that make the referral care services and financial health assistance more accessible and available to mothers and children needing the higher levels of care.

3. **SDN Transition Phase** – this phase is characterized by more advanced elements that enables the health system clusters to coordinate and manage health services from a higher level of care structure. The structure can respond and support client access to the basic, secondary and even tertiary levels of MNCHN-FP care needed. At this stage, there may be some partnerships with some private hospitals, private OB-GYN and pedia practitioners and private midwife clinics that are set-up. In many areas, the successful implementation of the ILHZ best projects this model.

With the strength of development as an ILHZ, its will be a best option to move towards a full functioning SDN for MNCHN-FP system.

4. **Functional SDN Phase** – this highest level of SDN developmental stage will capture the overall ideal visions of a responsive and efficient service delivery network in making the complete care for mothers and children available, accessible and acceptable.

The SDN now has a complete “network” of service delivery system where clients can avail more efficiently of the needed service from all three SDN levels of care: a) community, b) BEmONC and c) CEmONC.

The health services are available from both public and private facilities, with needed financial support (health insurance) and social services (DSWD and community) accessible through facilitative means.

The elements that will sustain the SDN will be the presence of: a) organized MNCHN-FP SDN management structure with guidelines (9th) and, b) functional health systems instruments for SDN (10th).

The elements with the suggested criteria will be used as basis in assessing, monitoring and evaluating the presence and effectiveness of the SDN for MNCHN-FP set-up.

**b. Approaches to Banner the SDN Establishment/Strengthening**

The SDN convergence approach offers several opportunities to link technical and financial assistance packages.

1. **“Opportunity Approach”**

This focuses on identifying program component, service and care elements, human resource complementation, “maternity waiting homes” to improve facility-based
deliveries, or strategies like transportation and communication system that can potentially provide early success for all stakeholders.

For example, SDNs with strong service delivery provision but with weak demand generation capabilities as evidenced by low patient visits for MNCHN-FP services may need packages that include CHT mobilization, including support for the organization, capacity building, expanded transport and communication systems (“door-to-door” delivery for at-risk mothers, newborn and children) and systems to track services.

It could be in terms of improving the outreach services to GIDAs of FP Itinerant Teams, or deployment of health professionals and volunteers to vulnerable populations and/or priority areas:

a. “Doctors-to-the-Barrios” Program
b. Nurse Deployment Program
c. Midwives in Every Community in ARMM (MECA) in DOH ARMM
d. Community Extension Projects of academic institutions
e. Other similar/related initiative

In addition, it can be the presence of new development partners (United States Agency for International Development, Australian Agency for International Development, Japan International Cooperation Agency, NFSD) that can provide technical and financial assistance to specific care components on MNCHN-FP in a locality.

2. “An Issue Approach”

This starts with identifying service delivery objectives, infrastructure/s, capacity-building for service providers, accrediting health facilities, and development of policies that have a major impact on specific public health priorities.

Such issues include: (1) facility-based deliveries, (2) teen pregnancy, (3) HIV-AIDS among the youth, (4) violence against women and children, (5) health and safety of women, mothers and children in disaster/risk areas, or, (6) cultural and faith-based considerations affecting health-seeking decisions on MNCHN-FP.

SDNs can link with certified hospitals that are Centers of Excellence (CoEs), LAPM trainers and those for other training courses in MNCHN-FP (Essential Intrapartum and Newborn Care (EINC), Mother-Baby Friendly Hospital Initiative (MBFHI), and other courses). In addition, partnership with service providers and facilities can be used to conduct regular outreach services to GIDAs.

Financing and policy support packages (availability and flexibility in SDN fund use) can be the incentives for sustainability mechanisms for SDNs with good service delivery and demand generation capabilities.
3. “Sector Approach”

This can focus on policy areas which can have large health impacts, such as:

1. increasing health insurance coverage (PhilHealth) of vulnerable populations,
2. engaging in PPPs and cross-border referrals of health facilities;
3. increasing participation/affiliations of private midwives, maternity clinics, business and industrial partnerships, inter-LGU/GO partnerships (PhilHealth enrolment, DSWD, etc.) and
4. partnerships with school nurses in organizing an Adolescent Health Programs in cities and highly urbanized provincial capitals

Furthermore, in areas with functional ILHZs, an option to develop a CEmONC capability within their network of facilities and providers with financing systems tied to PhilHealth can be offered with Technical Assistance from DOH CHDs, PhilHealth, and development partners like MindanaoHealth.

In such setting where local communities have promotive leadership environment from LGUs and their partners, creative and distinct initiatives on MNCHN-FP services can be designed that are more adaptable and acceptable in their own localities.

Some areas/communities situated beside or close to each other may opt to form an SDN partnership that will respect the “crossing of borders and sectors”, as a more responsive and workable option. This may, therefore, differ in the entry points for technical assistance and the approach for the SDN establishment process, given that each will have variations in the context and geographical challenges.

As a reminder for STEP 5, each group that will respond to the challenge of establishing the SDN for MNCHN-FP. Need not take each step one-at-a-time because it is acknowledged that there are initiatives taken in improving the service delivery system in various localities in Mindanao.

In such cases, the efforts are directed at identifying what needs to be improved and completed for each step.

This way, each SDN team may be engaged in one or several steps simultaneously depending on each situation.
The marks of success in planning (STEP 6) for your SDN should make sure that the changes the SDN hopes to bring into the health system are included in the Strategic Plan. These may include the following:

1. Greater flexibility in the use of funds and resources
2. New partnerships to provide additional “point-of-care” in delivery systems
3. Better targeting of those most in need of each level of services
4. Joint development of goals with agreed indicators to measure progress
5. Shared infrastructure for sustainability of workforce and systems
APPLICATION SESSION

5.5. Work on Approaches and Entry Points to Establish Functional SDN:

a. Sample exercises

For practice exercises, select any 2 of the 3 cases presented below. Use the SDN elements and indicators presented in this STEP as basis for analyzing the cases.

SDN Case 1: Region/Province:_________________________

<table>
<thead>
<tr>
<th>Compliant SDN Elements</th>
<th>SDN Elements to Improve/work on</th>
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<tbody>
<tr>
<td>Elements 1 to 4 are highly compliant</td>
<td>Element 5 – CEmONC Services</td>
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<tr>
<td>Element 4 is nearly compliant</td>
<td>Element 6 – Public-Private Partnerships with providers/facilities</td>
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<td>Element 7 – Referral Care/Services</td>
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<td>Element 8 – Blood Services</td>
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<td>Element 9 – Management Structure and Guidelines</td>
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<td></td>
<td>Element 10 – Functional Health Systems Instruments for MNCHN-FP</td>
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</tbody>
</table>

General Remarks: Service delivery at the community level is good; LGU-NGO support is strong; MNCHN-FP supportive development partners are available.

Questions:
1. What changes will your SDN team give priority in addressing? Why?
2. What approach/es and the steps will you take in establishing your SDN?
3. What indicators will you consider important in your team’s decision/s?
4. When do we expect to start seeing the change in indicators?

SDN Case 2: Region/Province:_________________________

<table>
<thead>
<tr>
<th>Compliant SDN Elements</th>
<th>SDN Elements to Improve/work on</th>
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<tbody>
<tr>
<td>Elements 1 to 4 are highly compliant</td>
<td>Element 6 – Public-Private Partnership</td>
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<tr>
<td>Elements 5 to 7 are moderately well compliant; Partnership with Private Sectors more on providers, less facilities</td>
<td>Element 7- Referral Care</td>
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<td>Element 8 – Blood Services</td>
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<td>Element 9 – Management Structure and Guidelines</td>
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<td>Element 10 – Functional Health Systems Instruments for MNCHN-FP</td>
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</tbody>
</table>

General Remarks: Service delivery network for MNHCHN-FP is well functioning; with accredited health facilities; good performing ILHZ; sufficient funding source for operations; more private partners needed, etc.
Questions:
1. What changes will your SDN team give priority in addressing? Why?
2. What approach/es and the steps will you take in establishing your SDN?
3. What indicators will you consider important in your team’s decision/s?
4. When do we expect to start seeing the change in indicators?

SDN Case 3: Region/Province: _________________________

<table>
<thead>
<tr>
<th>Compliant SDN Elements</th>
<th>SDN Elements to Improve/work on</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elements 1 to 4 are highly compliant</td>
<td>Element 8 – Blood Services</td>
</tr>
<tr>
<td>Elements 5 to 7 are moderately well compliant</td>
<td>Element 9 – Management Structure and Guidelines</td>
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<tr>
<td></td>
<td>Element 10 – Functional Health Systems Instruments for MNCHN-FP</td>
</tr>
</tbody>
</table>

General Remarks: Service delivery network for MNCHN-FP is well functioning; accredited health facilities; sufficient funding source for operations; successful ILHZ performance, etc

Questions:
1. What changes will your SDN team give priority in addressing? Why?
2. What approach/es and the steps will you take in establishing your SDN?
3. What indicators will you consider important in your team’s decision/s?
4. When do we expect to start seeing the change in indicators?

b. Presence/existence of the SDN Elements

Decide how SDN area/s will approach the process of establishing an SDN. The Team may need to make an analysis of the present scenarios on SDN for MNCHN-FP.

<table>
<thead>
<tr>
<th>What SDN Element/s are now Present?</th>
<th>What Indicators are now considered Strong?</th>
<th>What Indicator/s Need Improvement?</th>
<th>What Elements Need Development Change/s?</th>
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</table>
c. Assessing the Status of the Functional SDN Elements for MNCHN-FP

Based on your group’s outputs on Establishing a Baseline for SDN and Mapping of Facilities and Providers, rate/grade each element based on the actual status of the indicators provided for each element. Use the grading scale provided for each element in column 4.

<table>
<thead>
<tr>
<th>ELEMENTS</th>
<th>INDICATORS</th>
<th>Actual Grade/ Rating</th>
<th>Grading Scale</th>
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</thead>
<tbody>
<tr>
<td>1. Community Health Teams (CHTs)/ BHWs are Functional.</td>
<td>Organized, trained, and deployed. Providing health information including PhilHealth and basic MNCHN-FP services to families Assuming designated roles and responsibilities Provided with basic information/guidelines on: - Access to providers and facilities providing MNCHN-FP services</td>
<td></td>
<td>Red: 0 – 1 Yellow: 2-3 Green: 4</td>
</tr>
<tr>
<td>2. RHUs/ BHS, health centers, and private clinics are providing MNCHN-FP services</td>
<td>Facility-based health services – list of services, schedules, cost of services and use of electronic master-listing and tracking tool Outreach/ mobile services – regular services to GIDAs, special “response” (emergency/ disaster/ outbreaks) to areas with poor access to specific MNCHN-FP services such as the LAPM and LARC Facility-based and outreach/ mobile MNCHN-FP services are planned and implemented collaboratively by public and private sectors</td>
<td></td>
<td>Red: 0-1 Yellow: 2 Green: 3</td>
</tr>
<tr>
<td>3. Functional Community-based transport and communication systems.</td>
<td>Organized transport and communication system. Guidelines on the use of transport and communications facilities. Name/s and contact information of authorized/responsible persons for transport and communication services (approving person/s, driver, etc.)</td>
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<td>Red: 1 Yellow: 2 Green: 3</td>
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<tr>
<td>4. BEmONC-capable facilities have transport and communication system.</td>
<td>Certified/ Licensed BEmONC capable facility by DOH-CHD. Basic MNCHN-FP services are implemented regularly in accordance with the approved clinic/ technical guidelines. Provide appropriate in-referrals and out-referrals of MNCHN-FP clients</td>
<td></td>
<td>Red: 1 Yellow: 2 Green: 3</td>
</tr>
<tr>
<td>5. CEmONC-capable facilities have transport and communication system.</td>
<td>Regular implementation of comprehensive MNCHN-FP services in accordance with approved clinical/ technical guidelines. Initiate collaboration among health providers by providing feedback, conducting maternal death reviews, discussion on clinical standards and elevate results to LHBs/ LCEs and health managers for proper action. Provide appropriate in-referrals and out-referrals of MNCHN-FP clients.</td>
<td></td>
<td>Red: 1 Yellow: 2 Green: 3</td>
</tr>
<tr>
<td></td>
<td>Red: 0 – 1</td>
<td>Yellow: 2 – 3</td>
<td>Green: 4</td>
</tr>
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<tr>
<td>6. Public and private sectors actively participating.</td>
<td>Covered by a partnership agreement/ memorandum of understanding. Private facilities and practitioners/providers affiliated with the SDN. Private sector facilities regularly providing FHSIS reports. Private sector represented in all levels of management/technical structure.</td>
<td>Written guidelines on the referral mechanism (adapted) Referral services documented by both the referring and referral facilities. Names of blood service facilities, locations and schedules. Written MOU/ MOAs among network members (across borders, across sectors, etc.).</td>
<td>Written MOU/ MOAs among network members (across borders, across sectors, etc.). Regular meetings of key stakeholders duly documented. M and E system installed. Presence of community-feedback mechanism.</td>
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<tr>
<td>7. Referral mechanism initiated/ established for each SDN.</td>
<td>Names and contact information of responsible persons when providing blood services outside clinic/office. Availability of Blood Collection Units (BCUs) within the network.</td>
<td>Regular referral services documented by both the referring and referral facilities. Plan for strengthening SDN-MNCHN-FP referral available. MNCHN-FP SDN implementation plan.</td>
<td></td>
</tr>
<tr>
<td>8. Blood services available and accessible.</td>
<td>Local guidelines for the referral mechanism (adapted) Referral services documented by both the referring and referral facilities. Names of blood service facilities, locations and schedules. Written MOU/ MOAs among network members (across borders, across sectors, etc.).</td>
<td>Private sector membership/ representation. MNCHN-FP SDN implementation plan.</td>
<td></td>
</tr>
<tr>
<td>9. Organized MNCHN/FP SDN Management structure and guidelines</td>
<td>Names and contact information of responsible persons when providing blood services outside clinic/office. Availability of Blood Collection Units (BCUs) within the network.</td>
<td>Private sector membership/ representation. MNCHN-FP SDN implementation plan.</td>
<td></td>
</tr>
<tr>
<td>10. Functional health systems: instruments for SDN</td>
<td>Local guidelines for the referral mechanism (adapted) Referral services documented by both the referring and referral facilities. Names of blood service facilities, locations and schedules. Written MOU/ MOAs among network members (across borders, across sectors, etc.).</td>
<td>Local guidelines for the referral mechanism (adapted) Referral services documented by both the referring and referral facilities. Names of blood service facilities, locations and schedules. Written MOU/ MOAs among network members (across borders, across sectors, etc.).</td>
<td></td>
</tr>
</tbody>
</table>

**Red:** 0 – 1

**Yellow:** 2 – 3

**Green:** 4
6.0. Introduction

Planning determines in advance what should be accomplished and how these should be done. Plans need to specify priorities and the best and most practical ways of getting things done.

6.1. Overview on Health Planning

a. Health Planning

Planning is a systematic process of identifying and specifying desirable future goals, outlining appropriate courses of action, and determining the resources required to achieve them. It should aim at improving the health status of mothers and children, ensuring equity and fairness of access and responsiveness of the health system to the perceived needs of the community, taking into account available resources and the available means and methods of health care\(^1\).

Planning goes through a sequence of steps completing into a cycle that answers four basic questions (shown in Figure 13):

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The main goal of the planning process is aimed at establishing a functional SDN for MNCHN-FP services and in succeeding implementing events, to aim at:

a. scaling up interventions and/or services;
b. expanding the geographical and sectoral scope/s of the SDN; and,
c. sustaining and/or strengthening the “life of the SDN”.

The aim specifies the focus of the SDN plan. It is important to remember that the SDN plan/s should now become an essential component of planning and, thus, should be included in any planning requirements for strategic (medium term) and operational (annual) plans at the provincial, city, municipal and barangay levels.

The plans for SDN implementation for MNCHN-FP should result in the benefits, which can include among others:

a. addressing the major health problems of mothers and children;
b. responding to health service demands;
c. improving access and equity in health care; and -
d. promoting cost effectiveness.

In crafting the SDN vision statement for MNCHN-FP services in Step 1, it is important to make sure if the following themes were reflected:

1. what services are offered and how services are made available to clients;
2. how simply and effectively facilitated are the “access procedures” to service providers and facilities at all levels of care;
3. what social and financial support can be available in an efficient, effective and timely manner;
4. are the service providers and health facilities demonstrating values and principles of PHC and “people-centered” care; and
5. in what ways can the SDN be a useful instrument in sustaining health systems development responsive to the changing needs of the communities?

b. Important Issues to remember during the Planning Process

With new initiatives introduced into the SDN concept, a new perspective of planning needs to be considered. Planning for the SDN on MNCHN-FP will be important due to a number of conditions which may be present in different SDN areas requiring unique responses:

1. Translation of:
   a. new health policy into a plan of action (e.g. “public-private partnerships”)
   b. new initiative plan (such as the “SDN plan”) to be included or integrated into the current provincial and/or city plan,
2. Re-planning on the basis of results of existing plan for the purpose of reviewing existing health problems and needs, and rendering services which are more effective and efficient within the SDN context,
3. Emergence of a new health problem (like incidence of HIV-AIDS and STD among adolescents, or increased incidence of pregnancy among the youth), which may require a special strategy or program;

4. Meeting the necessary standards (core package of MNCHN-FP interventions) and achieving the set objectives (improving service access and increasing service utilization);

5. Maximizing on available resources by reaching more clients (such as organized “outreach for FP services”); and

6. Ensuring coordinated effort and action (inter-sectoral and community partnerships).

6.2. PLANNING STEPS for SDN on MNCHN-FP Implementation

Table 6.1 (page 97) shows how each step in the planning process leads to the next action step - from planning to action\(^2\). The WHO Planning Framework in a District Health level for Maternal and Newborn Health* shown below with adaptations for SDN for MNCHN-FP.

6.3. PLAN for Establishing Functional SDN for MNCHN-FP Services

SDN Planning Overview

Using the existing plans for the SDN of province- and city-wide health systems, rationalization plans and facility mapping, the LGUs will need to review and update the match between the existing public and private capacities with demand for the MNCHN Core Package of Services by their constituents, identifying the priority populations in municipalities within the province.

The LGU needs to define the network of facilities and/or providers that can deliver the MNCHN Core Package of Services at all levels and providing easy navigation between the levels of SDN care.

To ensure access of priority populations to all MNCHN services, it is important for the LGU to perform the following:

1. identify and designate facilities and providers that can deliver services in each of the health care in the continuum from pre-pregnancy, pregnancy, delivery, post-partum and newborn periods;

2. verify if the identified facilities and providers can provide the standard MNCHN-FP services, to ensure that mothers and children have access to the complete package of services from all levels of care, with CEmONC-capable facility or network of facilities as end referral;

3. LGUs with existing facility mapping or Rationalization Plan, showing access of priority populations to facilities updating the matching of facilities with demand for services should be done, especially if the mapping or Rationalization Plan was done some years ago.

### Table 6.1. Planning Process for the SDN on MNCHN-FP Services

<table>
<thead>
<tr>
<th>Steps</th>
<th>Tasks</th>
<th>Products</th>
</tr>
</thead>
</table>
| 1. MNCHN-FP situation analysis for the SDN component clusters.        | Study current maternal, newborn, children and adolescent health status and the services available within the SDN. Identify possible problems/ gaps in services (may do SWOT analysis). | -Summary of maternal, newborn, children and adolescent health status.  
-Summary of MNCHN-FP service delivery system.  
-Description of problems/ gaps in services.  
-Map of health facilities, services and location of service providers within SDN. |
| 2. Analyze causes of identified problems. Include social support services Identify status of health facilities (public and private). | Investigate/analyze the possible causes of problems identified in Step 1. Include and specify whether it is:  
a) access-related, and/or  
b) demand-related, and  
c) supply-related. | -Description of causes of problems. Organize into categories that will be easy to recall, like grouping according to the functional SDN elements.  
-Categories according to Functional SDN elements will be useful in accomplishing the succeeding steps. |
| 3. Select priority problems on MNCHN-FP, based on evidences and community feedback. | Identify problems on maternal, newborn, children and adolescents’ health care problems that should be addressed as high priorities during this planning period. | -Selection of priority problems.  
-Relate to the decisions on what functional SDN elements need to focus on at a time. |
| 4. Set goals according to set health goals and how feasible the approaches can achieve success. | Develop SDN, facility-and community-based goals for the reduction of maternal, neonatal and children’s mortality and morbidity rates. | -Statement of SDN goals for identified vulnerable population groups.  
-Specify goals whether long, medium or short term. Relate to the SDN vision, establishment and sustainability. |
| 5. Develop strategies and set objectives | Design strategies for meeting the goals that address both SDN MNCHN-FP services and SDN establishment/ sustainability.  
Set objectives for strategies – short, medium and long term, ensuring that each goal has specific strategies with higher success possibilities. | -Description of strategies, objectives to be reached, targets and approximate time needed to implement it.  
-Strategies should/can be “innovative, trailblazing, visionary” reflective of how best the uniqueness and differences of the local context and conditions. |
| 6. Plan activities for health | Decide what the SDN team should do to implement the strategies.  
Decide what key areas will the stakeholders do to implement or assist with strategy implementation. | -Selected key activities and responsible units based on the key strategies identified within the SDN context priorities. |
| 7. Estimate required resources for MNCHN-FP activities and the SDN establishment and sustainability | Estimate the cost of selected activities and assess the availability of funding. Identify possible sources of funds, technical assistance and partners (local, national, international) | -Estimated resource needs and funding gaps based on SDN MNCHN-FP conditions and priorities, which may include:  
a. Human resources for health  
b. Equipment and technology  
c. Medical supplies and commodities  
d. Communication and transport  
e. Community and social services |
| 8. Develop MNCHN-FP action plan within the context of the SDN Functionality. | Put together goal, objectives, strategies, activities and resources needs. | -Action plan showing activities, responsibilities, schedule, estimated resource needs and funding sources. |
| 9. Develop a monitoring plan that will include all the SDN levels of care. | Decide what the SDN Team should do to monitor the progress of the SDN plan in achieving the objectives and targets set for the SDN. Facility-and community-based monitoring should be included and specified in the plan. | -A monitoring plan on the MNCH-FP services within the SDN that will cover the following:  
a. SDN Functional Structure level;  
b. Facility level; and  
c. Community level |

* with adaptations for the application to the SDN context for MNCHN-FP services
a. STEPS in Developing STRATEGIC and ACTION Plans

1. Describe the vision for the SDN initiative (the dreams for how things should be).
2. State the mission (the what and why).
3. State the objectives (how much of what the group hopes to accomplish by when).
4. Identify the strategies (how things will be accomplished).
5. Develop (or refine) the action plan by stating the specific community/system changes to be sought that will result in the accomplishment of your goals and objectives.
6. Identify action steps for one or two key community/system changes in the action plan (who is going to do what by when).
7. Implement action steps as planned.

b. Setting OBJECTIVES for Establishing Functional SDN

Objectives refer to specific measurable results for the initiative's broad goals. An organization's objectives generally lay out how much of what will be accomplished by when.

The three basic types of objectives are:

1. Individual/group-level objectives – relate to changing the behaviors of people (what they are doing and saying) and the results of their behaviors. For example, an increase in antenatal consultations, facility-based deliveries, or better acceptance to FP methods.

   “By 2016 (when), to increase by 20% (how much) the proportion of mothers deciding (what) and/or delivering (what) at health facilities.”

2. Community-level outcome objectives - relate to behavioral outcome objectives, that are more focused on a community level instead of an individual level. For example, CHTs operating “maternity waiting homes” for expectant and immediate postpartum mothers from GIDAs.

   “By 2016 (when), 3 (how many) of the 5 GIDA selected areas have functional “maternity waiting homes” (what) for MNCHN-FP services.

3. Process objectives - refer to implementation of activities necessary to achieve other objectives. For example, a community implementing a community nutrition program for mothers and young children.

   “By 2017 (when), the 2 SDN clusters (how many) are functional SDNs for MNCHN-FP services (what) in ___Province/City”

c. STRATEGIES for Functional SDN Establishment

Strategies explain how initiatives will reach its objectives. Organizations often have a variety of strategies that may include people from different parts or sectors of the community. Strategies can be broad or specific.

The following types of specific strategies that can guide most interventions are:

1. Enhancing skills and providing information
   1.1. providing skills training for CHTs and volunteers to help service providers achieve service targets and improve coverage;
   1.2. developing locally-relevant MNCHN-FP support materials to improve communication with individuals (mothers) and community groups (vulnerable populations).

2. Enhancing health services and support mechanism
   2.1. establishing regular outreach services to GIDA areas;
   2.2. ensuring adequate stock of essential medicines and supplies;
   2.3. improving/simplifying the Information and Communication Mechanism of the SDN referral network.

3. Modifying access, barriers, and opportunities
   3.1. setting up community transportation support network for MNCHN-FP referrals;
   3.2. working with religious and/or tribal leaders in addressing cultural beliefs and practices;
   3.3. improving the client navigation flow within and through the SDN referral network

4. Instituting change/s in the consequences of efforts
   1.1. setting partnership incentives with traditional birth attendants;
   1.2. engaging into a progressive partnership with private practitioners and private health facilities for SDN;
   1.3. drafting policies to provide incentives for SDN facilities and/or SDN communities that had achieved their targets and/or SDN initiatives set in place on time or ahead of target date/s

5. Modifying and/or formulating promotive policies and guidelines
   5.1. adapting national policy and guidelines to match local situation;
   5.2. formulating policies to allow SDN members broader autonomy in management of services, financial and human resources;
   5.3. establishing supportive management system and/or performance-based rewarding system
d. **ACTION Planning**

An action plan describes: what change/s will happen; who will do what; what needs to be done, when will these changes happen. The action plan should be clear to everyone involved to have a greater chance of success in the implementation.

The plan refers to: a) specific (community and systems) changes to be sought, and b) the specific action steps necessary to bring about changes in all of the relevant sectors, or parts, of the community. An organization’s action plan describes in great detail exactly how strategies will be implemented to accomplish the objectives developed earlier in this process.

Action steps are developed for each component of the intervention or changes sought for SDN communities and in the health systems operations.

Action steps should include:

1. Action step(s): What will happen
2. Person(s) responsible: Who will do what
3. Date to be completed: Timing of each action step
4. Resources required: Resources and support (what is/are needed and what is/are available)
5. Barriers or resistance, and a plan to overcome them!
6. Collaborators: Who else should know about this action.

### 6.4. Planning for MONITORING and EVALUATION

The key question to be addressed at this stage of the planning cycle is “how will we know when we get there and what have we achieved?”

To generate the needed information, it is expected that the SDN Team will be able to:

- develop indicators;
- identify means of verification; and
- plan for monitoring and evaluation of the SDN plan

a. **MONITORING**

Monitoring is a systematic and continuous assessment of the progress of an activity over time. It is done through the process of collecting, coordinating, processing, measuring and communicating information to assist management in decision-making.
Monitoring ensures that:

1. work progresses according to schedule;
2. standards are maintained;
3. resources are used rationally and as planned;
4. required information is available and used, etc.;
5. problems are detected during implementation so that corrective measures are applied; and
6. plans are verified to ascertain that they are being implemented in the way and manner planned.

Planning a Monitoring System

In monitoring, select indicators that answer the question: “what is going to show that we have accomplished our objective?” To decide on an indicator, review the objectives of the plan and the targeted audience: what is the expected result of the effort and who is the intended user of the service?

Many indicators can be set for each objective. But it is important to select one or a limited number of key indicators that will best show that the objective was accomplished.

Some of the methods used in monitoring may include: a) observation, b) interviews, and c) routine reporting. Both formal and informal, quantitative and qualitative methods can be used to check periodically on any aspects of the initiative or program being implemented.

The monitoring plan should identify who will be involved in reviewing progress and providing feedback on a regular basis. Table 6.2 shows a matrix that can be used in preparing a plan specific for monitoring SDN implementation.

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<table>
<thead>
<tr>
<th>SDN Elements/Plan Components (What)</th>
<th>Indicators (What)</th>
<th>Monitoring Schedule (When/How Often)</th>
<th>Level of Responsibility (Who)</th>
<th>Method/s of Monitoring (How)</th>
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b. EVALUATION^5

Evaluation is the systematic assessment of actions to improve planning or implementation of current and future activities. It examines changes and their significance in relation to one or more of these long term and medium term issues:

1. relevance
2. effectiveness
3. efficiency
4. impact, and
5. sustainability

The evaluation plan needs to identify:

1. who will use the evaluation;
2. what they want the evaluation to accomplish;
3. how they would use its results; and
4. what difference the information would make.

The findings will – a) answer the evaluation questions; b) describe the situation and compare it to what was expected; and c) explain the reasons for the situation and its consequences for achieving program goals.

Evaluation analyses the extent to which changes in key variables or outcomes can be attributed to the interventions undertaken by the program or project. It requires careful analysis of qualitative and/or quantitative data to provide a critical understanding of the multiple factors affecting the outcome. Thus, evaluation can suggest more comprehensive ways to increase effectiveness.

The monitoring and evaluation plan should contain the following

- purposes of monitoring and evaluation (who can/will use the results)
- timing of monitoring and evaluation in the project/program cycle
- aspects of the project to be monitored
- who will be responsible for managing and carrying out the plan
- what methods of gathering data will be used
- resources, supplies and materials, infrastructure and logistics needed

It important to emphasize that in any planning process, the decision to monitor and evaluate interventions and/or initiatives must be included in the plan. This will ensure that the following management functions are established:

a. tracking progress and minimizing implementation barriers,

b. providing timely intervention/s at certain challenging points, and

c. determining the measure of successful interventions are established.

---

Given the depth and complexity of factors considered in conducting an Evaluation on the Establishment and/or Strengthening an SDN for MNCHN-FP, and the need to decide for an external group to conduct the evaluation, it will be sufficient for the SDN team to ensure that an evaluation will be conducted at a set time or phase in the life of the SDN.

Implementing the Monitoring and Evaluation Plans are discussed in detail in the next STEP (7).

6.5. IMPLEMENTING the PLAN on ESTABLISHING the SDN

One of the most challenging aspects of initiating improvements is implementing the plan – that is, getting what is on paper to come to life and achieve the goals and strategies included in the plan.

a. PLAN IMPLEMENTATION

Once the planning and budgeting process has been accomplished and approved by the appropriate authorities, the success of the plans will depend on how well they will be implemented.

There are three aspects that should be kept in mind: (1) Effectiveness; (2) Efficiency; and, (3) Timeliness.

1. EFFECTIVENESS

When implementing a planned activity or intervention, the expected result is called the output.

Example 1: if ten (10) newly-trained rural health midwives who completed the FPCBT 2 course can demonstrate correctly the new competencies taught in the course, this is an output of effectiveness of the training activity conducted.

Example 2: if an SDN plans to establish the network for MNCHN-FP services comprising all the 3 levels of care, and when an official partnership agreement among identified clusters is signed, this becomes an effective output of the initiative.

Effectiveness refers to the extent the outputs have been achieved as compared to the targets set in the objectives. To achieve the objectives set in the plan of action, it is important for all activities to be fully implemented, reaching the set targets and covering all the activity components.

“A good plan implemented today is better than a perfect plan implemented tomorrow.” — George Patton
2. **EFFICIENCY**

Implementation of any activity involves utilization of resources. This could be human resources, financial resources, time, and other material and logistical resources. As described earlier, implementation of an activity results in an output.

Efficiency relates the output to the resource inputs and refers to the measure of output per unit resource input.

Example: A scheduled outreach to a GIDA area to conduct prenatal check-up and immunization to target 10 pregnant mothers and 15 infants. Resources and logistics prepared were enough to cover 10-12 mothers and 15-17 infants.

Only 2 mothers came and 4 infants were brought for immunization. This activity produced little output compared to the resources spent, which will require another schedule to cover the vulnerable clients the soonest time possible.

3. **TIMELINESS**

In planning, activities are planned to be implemented at given times and within a given period of time. In most cases, the outcome of activities depend on the completion of earlier scheduled activities. It is clear that partial or lack of implementation of activities as scheduled would lead to delayed or no implementation of succeeding future activities. Thus, it is important to endeavor to undertake and complete activities as scheduled in the plan of action.

Example: Training of the proposed BeMONC team or of a member of the team is postponed due to unanticipated factors. These may include political activities, lack of funds, unplanned activities (e.g. health team is called to attend another workshop), transfer of personnel, or lack of logistics in time for the scheduled training.

This delay in the training of service providers affects the delivery of the new service and/or accreditation of the health facility to provide the MNCHN-FP services. Harmonization of plans, early requisition of funds and other logistics and supplies, and use of coordination meetings could help in reducing some of these problems.

Proper implementation of planned activities requires proper and sufficient preparation of the following, among others:

- a. management and administrative requirements,
- b. identification of resources needed,
- c. allocation of tasks, and
- d. setting deadlines.
The designated person in-charge supervises the preparation and implementation of all activities to ensure that various tasks are accomplished within the set deadlines. These deadlines and tasks should be made known to all those involved in the conduct of the activities. This will ensure effective, efficient and timely completion of activities.

**b. SUCCESS in Implementation of PLANS**

Ensuring higher success on outputs will depend on how well the plans were prepared in relation to the desired outputs and outcomes, giving due consideration to different resources needed and the socio-cultural and physical context of the locale where the plans are intended to be carried out.

The key factors\(^6\) for implementing a plan include understanding the objectives, and the sequence of events that must take place to ensure success. Proper implementation of a plan will have substantial impact on the success of an organization. The elements of a plan that must be analyzed include: a) objectives, b) key issues, and c) team motivation.

It is important to set measurable objectives that can show progress that can be monitored and provide a means of adjusting the plan to ensure full implementation of the project.

1. **Objectives** - identifying the objectives of the project is the first step in analyzing the success factors in a plan. An objective identifies, in measurable terms, what the team is planning to accomplish.

   For example, one objective of a CHT is to identify the families that are unable to access regular MNCHN-FP services in their locality.

   In this scenario, it is important to analyze the ability of a CHT member to help clients and their families avail of community resources and receive timely referral care services.

2. **Key Issues** - analyzing key success factors of the plan requires identifying what issues may get in the way of achieving the objectives. These issues may include: inadequate resources, lack of competent/trained service providers at a BeMONC facility or irregular service provision of some MNCHN-FP services due to stock-outs of commodities and supplies.

   Analyzing issues as possible setbacks can be assigned to a team tasked to look at the plan from all angles. With possible difficulties identified, the team members need to muster resources to meet each challenge.

3. **Team Motivation** - the key motivational issues for implementing the SDN plan include: a) making sure the objectives are clear to each team member, b) establishing and maintaining a clear focus throughout the process, and c) helping each team member take ownership of the plan. Each member must be able to see how their contribution will be valued, and what the rewards are for active participation in the plan.

4. **Monitoring Progress** - as the plan progresses, there should be checkpoints to monitor and analyze progress made toward completion of the project. As the progress at each checkpoint is analyzed, revisions can be made to ensure the project meets the objectives that were established at the beginning of the process.

A thorough follow-up at the completion of the project will allow the team to analyze which factors were the key to the plan’s success.

It is important to remember that strategic planning is not about producing a plan, but rather about the leadership engaging others to achieve the organization’s vision, mission and goals. In many instances, a “good plan” falls short when the course is charted, the strategic directions are set, and then, little or nothing significant at all happens after.

Strategic planning is a process that includes – charting a direction, determining the course, and reaching a destination.

A plan that identifies and sets clear implementing goals and strategies is needed in order to reach the destination. The decision to include in the plan the conduct of Monitoring and Evaluation in Strategic and Action Planning will ensure proper implementation of strategies and activities.

The two management functions of monitoring and evaluation will help guide the implementers of the plan if they are fully aware and clear about the indicators that will be used to determine the status and the success of implementation.

For this Guide, the actual conduct of Monitoring and Evaluation of the SDN processes will be discussed in STEP 7.

“Even if you’re on the right track, you’ll get run over if you just sit there.”
— Will Rogers
APPLICATION SESSION

6.6. Work on the Plans for your SDN including Plans for Monitoring and Evaluation:

Using the SDN training group’s outputs from Services and Facilities Mapping, Steps 1 to 5 and other pertinent information, formulate the following plans for your SDN for MNCHN-FP:

a. Strategic Plan – 3 to 5 years, using Table 6.2
b. Action Plan – 6 Months, using Table 6.3

At your SDN level, it is very important to consider that the planning process is inclusive, involving people who have significant influence in the community (for example, elected officials, community volunteers), as well as the people who are most affected by the issue/problem (such as women, mothers with young children, residents of low-income neighborhoods).

Finally, depending on the range of desired services to be accessible and the scope and characteristics of the communities (municipalities and barangays) to be covered, it is often helpful to organize working committees for each specific objective, that can focus on efforts so they will have the greatest possible impact.

A good output in this STEP (6) will define the quality and meaningful outputs in the next STEPS (7 and 8).
Table 6.2. Strategic Directions in Planning for SDN Establishment/Implementation

<table>
<thead>
<tr>
<th>Development/Implementation Elements/Components</th>
<th>Strategies and Key Activities</th>
<th>TARGET OUTCOMES/ DESIRED RESULTS (Milestones)</th>
</tr>
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<tbody>
<tr>
<td></td>
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<td>Introduction Phase (Timeline: _____)</td>
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<td>Early Implementation Phase (Timeline: ___)</td>
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<td>Scale-up Phase (Timeline: ____ )</td>
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<td>Sustainability Phase (Timeline: ______)</td>
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Table 6.3. Action Plan for SDN Introduction/Early Implementation (Timeline: ____________)

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<tr>
<th>*Objectives</th>
<th>*Action Steps</th>
<th>Resources Required</th>
<th>Date to be Completed</th>
<th>Person(s) Responsible</th>
<th>Potential Barriers or Resistance</th>
<th>Possible Partners/Collaborators</th>
<th>Desired Outputs/Outcomes</th>
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* Possible areas/aspects to cover in the Action Plan -

1. Establishing the baseline of the SDN cluster for MNCHN-FP services.
2. Steps at initiating SDN Introduction process - refer to the appropriate steps your SDN will be working on
3. Monitoring SDN Action Plan
4. Policy formulation for SDN
5. Documenting the SDN Experience
7.0. Introduction

Establishing a functional SDN to ensure delivery of services to mothers and children is a great leap undertaken by the DOH to achieve the noble purpose of “reaching the unreacheable”, supporting and enabling the weak, and vulnerable population groups and widening the network of stakeholders to participate in creating the needed change in the health system.

STEP 6 provided the foundation for ensuring standards of service quality by making sure that Monitoring and Evaluation are treated as an integral part of planning process and not as a detached element to be addressed separately. In STEP 7, these two processes will be discussed further, highlighting the differences and complementing functions that each contribute to the success of any initiative.

While evaluation is seen as an end-step in any program/project life, for long-term initiatives like the establishment of a Functional SDN for MNCHN-FP services, evaluation serves as a critical and pivotal role in moving towards strengthening the foundations of the programs and projects established early on.

A conceptual model (Figure 7.1)\(^1\) in planning to scale-up MDG 4 and 5 is useful in planning, monitoring and evaluating a functional SDN for MNCHN-FP services. It identifies the components essential in the planning and implementation flow such as: a) Inputs, b) Process, c) Outputs, d) Outcomes, and e) Impact.

This framework emphasizes the objectives of “reducing inequities” across the landscape of the given “contextual factors”. This is essential to the success of establishing the SDN in different localities. The conceptual model provides a broad view on how monitoring and assessment functions can be applied in relation to the establishment of a Functional SDN for MNCHN-FP services. It helps situate objectives and measurements/indicators in each level of health care component in relation to the structure of the “network” and how to strengthen the integration and connectedness of health services and initiatives in the health system.

\(^{1}\)Brycea, Jennifer, et.al. Evaluating the scale-up for maternal and child survival: A common framework. 3 October 2010.
Crucial to achieving the goals of establishing and sustaining a functional SDN for MNCHN-FP would be the successful generation of these outputs:

a. Improved health systems functioning for MNCHN-FP – refers to improvements reflected in the following areas:
   1. Governance – formulation and implementation of policies and plans for SDN and MNCHN-FP services;
   2. Human Resources – acceptable number, “skill-mix” and competencies for MNCHN-FP and right behaviors and attitudes;
   3. Availability of Commodities, Equipment and Supplies – availability of the recommended facility equipment, commodities and supplies, with no incidents of “stock-outs.”

b. Increased MNCHN-FP Services – improvements reflected in the following areas:
   1. Access – geographic distance to health facilities; availability of transport facilities for health facilities and at the community level of care; affordability of services including membership to PhilHealth;
   2. Quality – compliance of service providers and health facilities with recommended evidence-based clinical protocols and program standards;
   3. Efficiency – number/percentage of MNCHN-FP services available/ provided at the three levels of SDN care;
4. Utilization – proportion/percentage of MNCHN-FP clients availing of the services, and
5. Effective Coverage – proportion/percentage of MNCHN-FP clients reached by the services, including areas with ACCESS barriers.

In planning and implementing for monitoring the functionality of the SDN on MNCHN-FP services, it is necessary to select indicators that reflect progress of activities on: 1) Inputs, 2) Process, and 3) Outputs.

In relation to evaluation of the success of SDN-MNCHN-FP, the key indicators to be selected must be towards those meeting the goals and objectives for: 1) Outcomes, and 2) Impact. The types of indicators to be selected will depend on the type, level and extent of coverage of the plan that specifies the period of implementation.

7.1. Value of MONITORING and EVALUATION

Monitoring progress and evaluating results are key functions to improve the performance of those responsible for implementing programs/projects. To judge progress in achieving the objective of improving the health of mothers and children in a given population, it is necessary to assess such improvement by using indicators that can indirectly measure changes in the health of mothers and children.

Monitoring and Evaluation are two sides of a measurement coin. Together, they provide data and perspective necessary to guide strategic planning and decision making, design and implement programs/projects and rationally allocate resources.

Table 7.1 describes the basic concepts differentiating monitoring and evaluation.

<table>
<thead>
<tr>
<th>Monitoring</th>
<th>Evaluation</th>
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<tbody>
<tr>
<td>Focuses on activities that are done – when, how many, where, at what cost, how well.</td>
<td>Focuses on the impact of the activities – did the activities achieve the planned objectives &amp; targets?</td>
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<tr>
<td>Data is collected during the time when the plan is being implemented. Monitoring is continuous during the entire project implementation period.</td>
<td>Data is often collected before the start of the implementation period. This allows comparisons to be made between the situation before and after implementation. Data is also collected at the end, or soon after, the end of the implementation period.</td>
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<tr>
<td>Monitoring is very helpful in identifying problems so that corrective actions can be taken during the implementation period. It helps to improve the quality of MNCHN-FP services.</td>
<td>Evaluation is useful in finding out the impact of MNCHN-FP services at the end of a period of time. This information is useful for planning the next program of activities and for informing other stakeholders about what can be achieved.</td>
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</table>
7.2. MONITORING

a. Overview

Monitoring is a process of comparison, across populations or geographical areas, to highlight differentials or to detect changes over time (to measure progress) between reality and goals.

It functions as a “formative evaluation” tool in which interventions can be introduced without waiting for the final end results to address issues detected or discovered that may significantly affect the success of the project.

Monitoring is a management tool for effective and efficient implementation. Those responsible for monitoring should be open to modifying original plans during the implementation period, if needed. By comparing what has been accomplished in relation to targets set in advance, monitoring will be able to: a) identify problems before it is too late, b) provide analysis why progress fell short of expectations, c) identify constraints, and c) point the measures to overcome them.

When monitoring signals that something is off course, a review of the situation should be undertaken to assess if objectives need to be modified.

Monitoring encompasses follow-up of Inputs (vaccines, funds, personnel, etc.), the Process (activities/tasks being done according to accepted norms and standards), Outputs (products meet specifications, services are delivered as planned, training results in new skills, etc.) and finally, the Outcome (the short-term effect of the program or campaign).

b. Documentation

Accurate, complete and timely recording and reporting of information gathered from monitoring are essential instruments for appropriate and relevant response from key players concerned with MNCHN-FP, the SDN network, DOH and partners.

It has always been emphasized that “Information is the lifeblood of any organization and/or group, regardless of size and scope of influence.” Even more vital is when behind the numbers and figures are lives of real people, mothers and children.

Progress (monitoring) reports on the delivery of MNCHN-FP services within the SDN may include the following components:

- List of specific objectives and activities that were to be accomplished during the quarter (or six month period);
- Degree to which each was completed, with numbers;
- Identification of constraints or obstacles that explain why certain objectives/activities were not completed as planned (if applicable);
- Identification of additional resources, training, etc., needed to help overcome these constraints;
- Updated list of objectives/activities planned for the next period; and
- Financial accounting: what was budgeted and spent during the report period and any proposed changes for the next period.
7.3. Indicators for SDN Monitoring and Evaluation

Indicators are markers of health status, service provision or resource availability, designed to enable the monitoring of service performance or program goals. They are measurements that have the power to summarize, represent or reflect certain aspects of the health of persons in a defined population. In other cases, they may serve as indirect or proxy measurements for information that is lacking.

INDICATORS are summary statistics that measure progress. Managers and planners should use specific indicators for each phase of MNCHN-FP program implementation cycle (inputs, process, output and outcome):

a. Inputs: core program ingredients that enable services to be delivered (e.g. human/financial resources, physical facilities, equipment, etc.).

b. Process: multiple activities carried out to achieve program objectives (e.g. in-service training on MNCHN-FP guidelines, functional CHTs, etc).

c. Outputs: results of MNCHN activities at the program level (e.g. utilization rate of MNCHN-FP services).

d. Outcome: changes measured at population level (e.g. % increase in exclusive breastfeeding for 6 months, coverage rate of facility-based deliveries, etc).

e. Impact: anticipated end results of a program (e.g. reduction of: maternal mortality, and newborn mortality).

For monitoring and evaluation indicators in establishing a functional SDN for MNCHN-FP, review the suggested indicators of the SDN elements. Based on the plans formulated to achieve the goals for a functional SDN, select the appropriate indicators to be used which had been determined by each SDN cluster.

Good indicators limit and focus data collection. The basic principles are to keep the information requirements to a minimum and collect information that will be most helpful to those who will use it. A common problem is that too much data is being collected, and is not being analyzed or used.

To assess whether the set objectives have been achieved, evaluation will include areas of: 1) context, 2) input, 3) process, and 4) impact. In can be internal, that is carried out by the implementers, or external.

The essence of evaluation is to determine program performance, effectiveness and efficiency. In other words, an evaluation can be carried out to:

1. decide whether an activity was worth doing;
2. determine whether the objectives set were achieved;
3. determine (formative evaluation) whether activities should be continued or not; and
4. determine whether the project should be extended elsewhere, etc.

For findings to be credible and persuasive, they must flow from data gathered and backed up by evidence collected. The findings should focus on issues related to the purpose of the evaluation. Its results should be used to: 1) improve future planning; 2) assist decision-making; 3) indicate where further action will be needed; and, 4) decide if further research is needed.
7.4. SCORECARD for SDN on MNCHN-FP

**a. Overview**

The Enterprise Scorecard was developed by the Civil Service Commission (CSC)\(^2\) which was applied to their institutional Performance Governance System (PGS). The CSC Enterprise Scorecard was modeled from the Balanced Scorecard of the Harvard Business School, which is a management tool for translating vision to actionable strategies and commitments that lead to breakthrough results.

Saving lives of mothers, newborns and children surely demand that SDNs for MNCHN-FP should produce “breakthrough results!” With such expectations, the commitments of the SDNs need to be translated into powerful actions that must ensure outcomes at the earliest possible timelines to reach more mothers and children to receive quality and safe care needed.

**b. Scorecard for Monitoring SDN**

The SDN-MNCHN-FP Scorecard (Figure 7.1 as example) adopted from the CSC Enterprise Scorecard, equally adapted its premise that “you cannot manage what you cannot measure.” In this Scorecard, the goals of the SDN elements are translated into specific objectives, measures, and targets for easy “tracking” of events and progress gained at specific timelines.

<table>
<thead>
<tr>
<th>Elements</th>
<th>Objectives</th>
<th>Measurement (Indicators)</th>
<th>Baseline</th>
<th>1st Qrt</th>
<th>2nd Qrt</th>
<th>3rd Qrt</th>
<th>4th Qrt</th>
<th>Targets</th>
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<td>1. Community Health Teams</td>
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<td>6. Public-Private Partnership</td>
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<td>9. Management Structure</td>
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*adopted from the Civil Service Commissioner’s PGS framework

The SDN Scorecard is a useful tool for monitoring the progress of the “SDN development pathway” as reflected in the SDN Plans using the elements as basis for the SDN plans. The focus of “change”, objectives, measures, baselines and targets will vary among SDN clusters in accordance to their local needs, context and visions of development for mothers and children.

c. Guidelines in Using the SDN-MNCHN-FP Monitoring Scorecard

Refer to the Plan formulated in STEP 6 on establishing a Functional SDN for MNCHN-FP to accomplish the SDN Score Card for Monitoring the Strategic Plan/Action Plan.

1. Decide what elements and areas/aspects of development should the SDN Team focus on in monitoring within specified periods of plan implementation.

2. It is important to note that all data needed for monitoring the progress should be promptly gathered and processed for timely monitoring to take place.

3. For each SDN component included in the plan (column 1) –
   a. Formulate the specific objectives for establishing/strengthening the SDN for MNCHN-FP services (column 2);
      Depending on the plans formulated by the SDN clusters, an element may require more than one objective and may need several measures/indicators and targets to be set.
   b. Based on the objectives formulated, set specific measures using the suggested indicators that will clearly describe the status of implementation of the SDN elements (column 3);
   c. State the baseline (current situation/condition) in measurable terms of the specific SDN element/s (column 4);
      The baseline information can be reflected in more than one statement that should be understood by all stakeholders. Accurate and clearly worded statements will be useful in tracking the progress of the establishment of functional SDNs.
   d. Move forward to column 9 and state target/s to be reached to achieve the objectives (column 2), which can be measured by the set indicators in column 3;
   e. It is essential to set powerful and challenging targets, enough for the key players to have a strong motivation to reach their SDN goals. The targets can be drawn from the vision and mission formulated in STEP 1 by the group.
   f. For columns 5 to 8, rate/score the progress gained based on the targets set using the following suggested “color-coded” criteria:
      
      | Color   | Description               |
      |---------|---------------------------|
      | GREEN   | Accomplished 90-100% of the targets |
      | YELLOW  | Accomplished 75-89% of the targets |
      | RED     | Accomplished below 75% of the targets |

Simplifying monitoring by using a color-coded criteria for rating and recording allows for a more accurate and timely compliance to the function of monitoring.

This, however, does not limit the SDN clusters from using additional tools that they consider appropriate and useful in their own settings and/or the “maturity” of the SDN functionality.

4. The SDN management team can decide – a) what information should be gathered/monitored; b) methods to be used and means of verification; c) who should be involved in conducting monitoring and documenting (recording and reporting) the processes, d) what would be the agreed monitoring timelines; and, e) who will be using the reports/who will be furnished copies of the reports.
Accurate, timely and efficient recording and reporting of monitoring results will ensure greater success in achieving the targets set, as well as efficient use of human, material and financial resources, among others.

As earlier presented, documentation of all information gathered during the implementation period and generated from the experiences are essential in making sound judgments and deciding on the steps to be taken in timely interventions and in moving forward.

Tables 7.3 and 7.4 show the actual forms that can be used in applying the principle of the Balanced Scorecard in monitoring the events in establishing a functional SDN for MNCHN-FP.

7.5. EVALUATION

Evaluation is the systematic acquisition and assessment of information to provide useful feedback about a project/program (e.g. on health). It is a set of activities and data collected that allows accurate understanding of the way the program is or is not working, and what factors affect program activities and targets.

a. Types of Evaluation

There are many different types of evaluation, depending on the project being evaluated and the purpose of the evaluation. The most important distinction in evaluation types is that between formative and summative evaluation.

i. Formative evaluation strengthens or improves the program/activity being evaluated, by examining the delivery of the program, the quality of its implementation, and the assessment of the organizational context, personnel, procedures, and inputs.

ii. Summative evaluation examines the effects or outcomes of a program/activity. They summarize it by describing what happens subsequent to delivery of the program; assessing whether the object can be said to have caused the outcome; determining the overall impact of the causal factor beyond only the immediate target outcomes; and, estimating the relative costs associated with the program/activity.
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<tr>
<th>SDN Elements</th>
<th>Targets</th>
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Table 7.3: SCORE CARD for MONITORING of Strategic Plan on SDN for MNCHN-FP

*Adapted from the Civil Service Commission's PICS framework

Guide in Establishing a Functional Service Delivery Network (SDN) for MNCHN-FP Services
Table 7.4. SCORE CARD for MONITORING Annual Functional on SDN for MNCHN-FP*

<table>
<thead>
<tr>
<th>SDN Elements</th>
<th>Objectives</th>
<th>Measures (Indicators)</th>
<th>Baseline</th>
<th>1st Quarter</th>
<th>2nd Quarter</th>
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*Adapted from the Civil Service Commission’s PGS framework
c. Framework for Evaluation of health systems strengthening

The evaluation for the SDN should be approached from the health systems perspective. Evaluation of health systems strengthening comprises four major indicator domains: 1) system inputs and processes, 2) outputs, 3) outcomes, and 4) impact. System inputs, processes and outputs reflect health systems capacity. Outputs, outcomes and impact are the results of investments and reflect health systems performance.

The four indicator domains will influence the different levels of the health care delivery system, of which the SDN occupies a critical place. The goal and objective of evaluating the SDN will guide which domains will be the focus of evaluation. At the SDN level (provincial/city), the indicators on: 1) system inputs and processes, 2) outputs, and 3) outcomes will be very meaningful, while all the four domains will be essential to the regional and national offices of the DOH, Department of Interior and Local Government (DILG) and other national offices responsible for providing technical and social services.

Evaluation of scaling up requires a solid monitoring system with data on baseline trends for key indicators. Such data should be complemented by in-depth studies and analyses to bring together all data to draw conclusions on attribution of changes to specific interventions. If effectiveness of interventions can be established, cost-effectiveness analysis is essential to draw the ultimate conclusions.

7.6. Evaluation of the SDN for MNCHN-FP

The purpose of evaluation is to assess what has been achieved to identify strengths and weaknesses, achievements and constraints. Based on the findings, evaluation of the SDN implementation should provide answers to the following questions:

a. Does the SDN for MNCHN-FP initiative as implemented meet the health needs of the mothers and children in the province/city?

b. Were there gaps in the selection of the activities during the implementation phase that need to be filled in order to receive the full benefits of the SDN initiative? Was there an appropriate balance of activities in all the elements?

c. How much capacity has been built to sustain what has been achieved and possibly expand activities? These include qualified trainers, supervisors, commitment of health staff in three SDN levels of care and regional expertise to develop and sustain SDN service interventions.

d. What were the constraints/barriers that have to be overcome in order to arrive at satisfactory implementation, and what are feasible solutions to these constraints/barriers?

e. What resources were required in terms of organization, manpower and funds, and what resources are likely to be needed if the strategy is to be expanded? What resources can be made available at each relevant levels to implement the SDN initiative?
To answer these questions, the evaluation will need to review documents, interview different stakeholders, visit health facilities, organize review meetings and other activities that can provide quality information on the implementation experience.

These information will be needed to accomplish the following tasks/steps that will be needed for the conduct of a Review and Re-planning for SDN implementation:

- **Step 1:** Assess what has been achieved in each major activity areas: identify constraints and specify resources required
- **Step 2:** Identify feasible solutions for the constraints
- **Step 3:** Assess how the SDN initiative should be expanded and develop recommendations for what should be done.

The results and information gathered from monitoring activities conducted will provide critical inputs to form the basis in arriving at major decisions for the SDN at the management and administrative as well as DOH regional levels.

### 7.7. SDN Annual Review and Re-planning

The aim of the review is to analyze the experiences in implementing the MNCHN-FP services through the SDN and to summarize the lessons learned and to decide whether and how SDN implementation will be continued in the future. The review is a bridging step between the early implementation and expansion phases.

The review may be followed immediately by planning for expansion or this may be scheduled after an interval period. In many instances, it may be appropriate to conduct the activities back-to-back.

The objective of conducting the review on SDN is to identify ways of strengthening and sustaining SDN implementation as a main strategy to improve the quality of care for women, mothers and children in health facilities, in the communities and in the home, based on a review of previous experiences.

The expected outcomes of the review are:

- a. a detailed set of recommendations describing the scope, pace, and emphasis of expansion, and,
- b. a draft report summarizing the findings on which the recommendations are based.

Examples of major recommendations decided at the end of the review may include:

- a. Continuing the implementation of the SDN for MNCHN-FP services within the same cluster areas and with the same package of services;
- b. Organize/start a new SDN cluster areas with identified entry points and SDN elements and/or health services to focus implementation;
c. Start a new package of services to be included in the present SDN within the same SDN cluster areas; or

d. Temporarily discontinue the implementation of the SDN model and continue with the existing functional IHLZ that is equally responsive to meeting the health needs of mothers and children

The decision on what to plan for in the coming year/s will consider potential barriers and constraints that may be a strong force to overcome, especially with weak or limited technical, financial, socio-political and policy support available in the province/city.

All relevant staff (including those from the private facilities), partners and major stakeholders are encouraged to participate in the entire review process. Participants should include key representatives from the levels of SDN care.

Officials of the DOH regional offices and Local Government Executives who are in a position to endorse and promote the outcomes of the review are encouraged to attend the consensus meeting scheduled on the last day of the review. This provides the opportunity to bring together all those who were not able to participate in the review, but whose support and endorsement of the recommendations is crucial to the future success of implementation.

To conclude the desk review, a consensus meeting can be organized, where the findings and the recommendations are presented to a broader group of stakeholders, who should include senior decision makers in the DOH, the LGUs concerned at the (a) provincial/city, (b) municipal, (c) barangay levels, (d) representatives from other relevant LGUs, (e) private sectors, and (f) partner organizations.

The aim of the meeting is to reach consensus on the recommendations of the review and obtain commitment for their future implementation of SDN activities.
7.8. Work on Monitoring and Evaluation for the SDN for MNCHN-FP

Based on your outputs from STEP 6 on Planning, Implementing and Monitoring, please provide information on the following questions:

1. How will your SDN team implement the Plans on Monitoring and Evaluation for your SDN community clusters to achieve the goals for Mothers, Newborns and Children. State at least four (4) key strategies powerful enough to result to successful implementation.
   a. __________________________________________
   b. __________________________________________
   c. __________________________________________
   d. __________________________________________
   e. __________________________________________

2. Review the indicators that your SDN team had selected in STEP 6 during the preparation of the plans. Determine if there is a need to change some indicators to become more powerful measures of the goals your SDN would like to achieve.
   Table 7.4 below will help review and finalize decisions on the indicators selected.

<table>
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<tr>
<th>SDN Elements</th>
<th>Indicators (may use several indicators per element)</th>
<th>Type of Indicators (Inputs-Process-Outputs-Outcomes-Impact)</th>
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STEP 8 – INSTITUTIONALIZE AND SUSTAIN THE FUNCTIONALITY OF THE SERVICE DELIVERY NETWORK (SDN)

8.0. Introduction on Sustainability

Improving the health and well-being of families and communities requires changing health-related behaviors from the clients as well as behaviors in planning and implementing services. This means addressing factors that influence behaviors of clients, service providers, health administrators and partners. With changing health needs and increasing challenges in making resources available, there is a need to focus on public health initiatives that can have sustainable impact.

Sustainability is about creating and building momentum to maintain community-network-wide change by organizing and maximizing community assets and resources. It means institutionalizing policies and practices within communities and organizations. A Sustainability Model showed 10 important factors in sustaining CHANGE in health care, grouped into categories of: Process; Staff; and Organization. Process includes: 1) benefits beyond helping patients, 2) credibility of evidence, 3) adaptability of improved process, and 4) effectiveness of the system to monitor progress. Staff consists of: 5) involvement and training to sustain the process, 6) attitudes toward sustaining the change, 7) senior leadership engagement, and 8) clinical leadership engagement. Organization includes: 9) fit with the organization's strategic aims and culture, and, 10) infrastructure for sustainability.

Health calls for essential integration in managing national and local health systems. Putting health in all the policies in development agenda of local and national governance provides a firm foundation for sustainability.

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8.1. “Health in All Policies”

a. Concept

“Health in All Policies” is an approach to improve health by incorporating health considerations into decision-making across sectors and policy areas. Its goal is to ensure that decision-makers are informed about consequences of policy options on health, equity, and sustainability during the policy development process. It identifies ways how decisions in multiple sectors affect health, and how it can support achievement of goals from multiple sectors/diverse governmental partners to work together to advance development goals.

There are many ways to implement a health initiative that applies the “Health in All Policies” approach. These vary in the process, structure, scope, and participation in initiatives depending on various factors, such as the needs of a community, available resources, and relationships of key partners. There are many opportunities for local and national governments to promote health in decision-making and fully embed health into all aspects of decision-making.

b. Key Elements of “Health in All” Policies

The five key elements that emerged as vital to the success of this work are:

1. **Promote health, equity, and sustainability** through two avenues:
   a. incorporating health, equity, and sustainability into specific policies, programs, and processes, and
   b. embedding health, equity, and sustainability considerations into government decision-making processes so that healthy public policy becomes the normal way of doing business.

2. **Support inter-sectoral collaboration** brings together partners from many sectors to recognize links between health with other policy areas, build partnerships and increase government efficiency.

3. **Benefit multiple partners** builds on the idea of “co-benefits” and “win-wins,” to benefit partners in addressing the goals of public health to benefit more than one end (achieve co-benefits) and create efficiencies across agencies (find win-wins). This will reduce redundancies and ensure more effective use of scarce resources.

4. **Engage stakeholders** such as community members, policy experts, advocates, members of the private sector, and funders. Robust stakeholder engagement will ensure that work is responsive to community needs and will garner valuable information to create meaningful and impactful change.

5. **Create structural or procedural change** on how agencies relate to each other and how decisions are made. This requires structures that can sustain inter-sectoral collaboration. This means “embedding” or “institutionalizing” Health in All Policies within existing or new structures and processes of government.

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8.2. Supportive Political Environment and Framework

At the outset, sustainability requires an approach that emphasizes development of a network of service providers, partners, leaders and administrators who understand and can lead the SDN Movement, and who can develop long-term buy-in and support throughout the SDN cluster areas. These are crucial to ensuring lasting change and making a difference in the lives of mothers and children.

Mechanisms of how best the interventions are supported in all its needs, from the technical, financial and operational assistance should be installed to ensure the provision and utilization of the MNCHN-FP health initiatives at all levels.

Critical to an effective MNCHN-FP referral system and a functional service delivery network is a national and local level policy and political support. Experiences from various global settings recommend the development and availability of:

1. Operational guidelines including a unified records' system, description of when and where a provider should refer, healthcare worker training and monitoring, and referral-receiving facility protocols;
2. Standards of care and protocols for the management of normal and abnormal obstetric and neonatal conditions at all levels of the referral system;
3. Provider performance targets, annual or semi-annual review sessions; and,
4. Monitoring and evaluation system.

In addition, it is important to have a mechanism to routinely update standards of care, service delivery guidelines and protocols as necessary. Systemic changes across health facility levels need to be done simultaneously if possible. Depending on the change needed, one level or facility may have extra demands made on them which can create resentment if staff do not see changes being made elsewhere.

8.3. Local Health Systems Instruments for MNCHN-FP Service Delivery Network

Each SDN cluster must decide how and when they will take the initiative forward. Guiding principles and core values that place people in the center of health and development should serve as the guide in planning and implementing initiatives directed at improving services and service delivery.

The DOH provides guidelines on mechanisms to enhance or sustain delivery of MNCHN services through the use of local health systems instruments. These instruments are classified into: governance, regulations and financing.

a. Governance Measures

Health governance refer to actions and measures adopted by the government, health providers and the community to organize itself in the promotion and protection of the health of its population.

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To implement the MNCHN Strategy, governance is having the

- a. vision of what the LGU wants to achieve such as in reducing maternal, newborn and child deaths;
- b. involvement of all stakeholders in the locality and coordination mechanism to synchronize their actions;
- c. monitoring system to assess progress,
- d. health information system to gather necessary data,
- e. system that would continuously improve capacity of health human resource,
- f. functional procurement and logistics management system to ensure availability of supplies in health facilities,
- g. health promotion and behavior change to increase demand, improve feedback and sustain support for programs,
- h. support for the MNCHN strategy as shown by commitments to use local funds interventions for services such as:
  - i. contracting or hiring personnel,
  - ii. enrolling members to NHIP,
  - iii. upgrading facilities for accreditation and procurement of logistics, drugs and supplies

b. Regulatory Measures

Adopting the MNCHN Strategy in a province or city requires executive issuances and/or legislations to facilitate and sustain its implementation. The identified areas requiring policy issuance support and/or legislation are:

1. Issuance of a Policy Directive Adopting the MNCHN-FP package of interventions to be made available to clients at appropriate levels of care with adherence to standards of quality.
2. Advisory as an executive order or a local legislation issued to concerned health facilities and other institutions in the locality to promote the adoption of the Core MNCHN-FP Package of Services made available to clients and to inform communities of the services that can be availed of at each level of care.
3. The policy directive to promote and enforce regulations supportive of MNCHN-FP goals and objectives, such as:
   - a. promotion of facility-based deliveries, and prohibition of Traditional Birth Attendants (TBA)-assisted deliveries;
   - b. promotion and adoption of FP services as part of the package of interventions, which would result to adoption of the Contraceptive Self Reliance (CSR) policies and guidelines; and
   - c. reiteration of existing laws/legislation to promote MNCHN-FP interventions such as exclusive breastfeeding, and adherence to Milk Code provisions; immunization of children, use of fortified foods, micronutrient supplementation and the like.
4. Engagement of different health facilities as members of the MNCHN-FP SDN from the community up to the province/city level, and across private and public facilities
c. Financing Measures

Financing measures are key to the continuous and sustained operations of the network of MNCHN-FP health care facilities in the LGUs. After identifying MNCHN-FP interventions appropriate to the needs of the target population groups, the LGU should:

a. generate resources to fund critical investment requirements, and,
b. develop schemes that would minimize cost of implementation.

The LGUs can consider the following options to generate resources for new investments and operational costs and minimize expenses in the delivery of the core MNCHN package of services:

a. Increase in LGU budget allocation,
b. PhilHealth reimbursements and mobilization of external resources, and
c. cost recovery schemes and local financing schemes.

Through the insurance system (PhilHealth), health providers are reimbursed expenses for services rendered to a PhilHealth member or beneficiary. LGUs can receive reimbursements provided that they undergo the processes for accreditation of public health facilities and providers.

Strategies that LGUs can explore to minimize cost in service provision include: (1) cost sharing among LGUs, (2) pooled procurement for drugs, commodities and supplies, (3) rational drug use, and, (4) installation of a functional logistics management system.

The DOH MNCHN Manual provides further details on these local health systems instruments which can be made more adaptable to local SDN experiences.

8.4. SDN Leadership and Management

An important ingredient to sustain change initiatives is a structure that will provide mechanisms of ensuring that implementation of planned change will continue towards achieving the set goals. An organizational structure helps set the health systems instruments to be applied more effectively to the planned change.

The SDN Leadership and Management structure can be organized both at the DOH-Regional Office and at the Provincial/City levels. In areas where an existing structure/s for MNCHN-FP programs are in place, the concerned management may opt to expand the roles and responsibilities to include the SDN activities.

At the DOH regional level, the roles of the SDN Committee may be as technical advisor, resource facilitator and as link to various agencies on matters involving MNCHN-FP and SDN.

At the provincial/city level, the structure will serve as the management board that will ensure effectiveness and efficiency of MNCHN-FP service provision in all three levels of SDN care. This will include services by private sector partners (facilities and providers) that are part of the SDN, and support services to clients needed in “navigating” within each care level and referral services.
Depending on the local needs, socio-cultural and demographic context and stage or phase of SDN development, new roles and responsibilities may evolve to respond to the realities that will present itself and the changing health landscape.

A. SDN-FP Management Board (Provincial/City Level)

An SDN Management Board will be responsible for establishing and sustaining a functional SDN by installing the following:

1. organized MNCHN-FP SDN management structure and policies,
2. functional health systems instruments for SDN,
3. coordinated health and support services in all levels of care and among the SDN cluster members,
4. technical, administrative and financial support systems in place,
5. continuing quality improvement systems,
6. dynamic and responsive health information system,
7. competent and responsive health care providers at all levels, and
8. mechanisms for ensuring availability of commodities and resources

i. Roles and Functions

The SDN Management Board assumes administrative and management functions over SDN implementation for a longer period of time.

The SDN, being a collective of health facilities, service providers and partners from both the public and private sectors from various levels of care in a province or city, there is a need to be bound by an official agreement essential to ensuring success of the SDN.

The SDN Management Board is responsible for achieving positive outcomes including scale-up of MNCHN-FP services by establishing and sustaining a functional SDN through the following key activities:

1. Formulate SDN plans and policies for MNCHN-FP integral to the overall health and development plan of the province/city.
2. Facilitate the official issuance of guidelines, policies and operational systems supportive to the SDN’s vision and mission for MNCHN-FP.
3. Provide regular provincial/city forum for discussion of issues and coordination of SDN technical activities.
4. Ensure that the SDN MNCHN-FP initiative is guided by policies, procedures and standards of the DOH administrative issuances.
5. Build partnerships with private sectors, other government agencies and development partners on MNCHN-FP service delivery.
6. Monitor and evaluate progress through use of agreed SDN MNCHN-FP indicators, with regular reporting on targets and benchmarks;

7. Review results on initiatives and ensure that lessons learned are used for policy development in:
   a. service delivery,
   b. financing,
   c. management, and
   d. quality improvement

ii. Membership
To be effective in carrying out the expected roles and responsibilities of members, the composition and size of any working group must consider the following in ensuring greater success in accomplishing the tasks:

1. Professional and technical competencies and personal attributes;
2. Feasibility in calling for and/or attending meetings and SDN events;
3. Access to technical and administrative resources;
4. Possess positive/progressive thinking and decision-making skills;
5. Willingness to assume new and/or additional responsibilities;
6. An active member of the private sector representative should be a member of the management committee;
7. Comfortable working in teams and relating with various groups.

A group of seven to nine regular members for a management committee will be a functional size to provide sectoral and technical representations. Private sector representation is an essential SDN membership indicator. It must consider feasibility in organizing meetings and performing essential functions.

b. Provincial/City SDN Technical Team
Depending on the structural set-up or prevailing operational systems in a province/city, the Local Chief Executive (LCE) may decide to create an SDN MNCHN-FP Team at the initial phase of SDN implementation to provide technical support to the SDN Management Board. This group can be composed of technical staff from the service units and volunteer representative directly concerned with MNCHN-FP. For provinces/cities that have existing/similar operational structure, the LCE may decide to mainly expand/enhance the functions of the existing group to include SDN implementation.
c. SDN Advisory Committee (DOH-RO Level)

The SDN Advisory Committee can be operational within a short-term period to provide initial assistance to the LGUs in establishing the SDN for MNCHN-FP. It can function for a three-year term consistent with the early implementation phase of establishing the SDN for MNCHN-FP, to provide technical and administrative assistance and initiate access to development resources.

a. Roles

At the DOH regional level, its role will be advisory and will function as:

1. technical adviser on MNCHN-FP and SDN to the provincial/city SDNs within the region;
2. link to availing resources for facility enhancements, accreditation, services on standards and regulation;
3. network to accessing SDN commodities and other resources needed for MNCHN-FP services;
4. facilitate access to relevant development partners; and,
5. mentor for health service quality, standards and regulations.

On the fourth year, the SDN development project is expected to be “mainstreamed” into the regular administrative function of the LGUs.

b. Functions/Tasks

In overseeing the implementation of the establishment of the SDN for MNCHN-FP in the region, the SDN Advisory Committee will:

1. Provide a regional forum for discussion of issues and coordination of SDN technical activities at the regional level.
2. Ensure that the initiatives on SDN for MNCHN-FP has effective policies and procedures, and standards are within the DOH mandate to guide the technical aspects of implementation.
3. Facilitate the issuance of guidelines, policies and operational systems that are supportive to the SDN’s vision and mission for (mothers, newborns, children) MNCHN-FP.
4. Provide assistance to the LGUs in establishing the SDN in:
   4.1. harmonizing technical and operational work undertaken by the different SDN provincial/city participants
   4.2. Liaising with development partners and other groups on matters related to MNCHN-FP service delivery.
   4.3. Initiating health sector linkages to larger government initiatives such as poverty reduction and economic health development.
5. Build collaboration, commitment and support within the CHD levels and in relating to the broader community in Mindanao.
6. Review the progress of SDN implementation, providing timely advice and assistance as appropriate.
7. Provide assistance to the SDN clusters on proposed changes in service delivery and tools that will help accelerate and scale-up MNCHN-FP services to the new/additional communities.
8. Effect the institutionalization of monitoring and evaluation of progress of SDN-MNCHN-FP indicators (input, process and output interventions), and documentation of experiences.
9. Conduct a review of the SDN implementation phase in the aspects of improvements in service delivery, financing, management and quality improvement and ensuring that lessons learned are used in expansion and policy development.

8.4. Sustainability Indicators on SDN for MNCHN-FP

The final point in sustaining the initiatives on establishing a functional SDN for MNCHN-FP is to focus on the 9th and 10th elements and their indicators of the MNCHN-FP scale-up interventions. These reflect the application of the health systems instruments recommended by the DOH in the MNCHN Manual of Operations.

Element 9: Organized MNCHN-FP SDN Management structure and guidelines;

1. Written Memoranda of Understanding/Agreements (MOUs/MOAs) among the network members ("across borders, across sectors", etc.)
2. Private sector membership/representation
3. MNCHN-FP-SDN implementation plan
4. Regular meetings of key stakeholders duly documented
5. Monitoring & Evaluation system installed
6. Presence of community-feedback mechanism
Element 10: Functional health systems instruments for SDN

1. Availability of a health service delivery system ensuring all services for MNCHN-FP including services for adolescents and youth
2. Presence of policies on the SDN core package of MNCHN/FP services
3. NHIP accreditation of health facilities and providers
4. Locally-adapted national DOH policies such as promotion of Facility-based Delivery, Exclusive Breastfeeding, immunization, micronutrient supplementation, and CSR policies and guidelines
5. Implementation of the RA 7600 (Rooming-in and Breastfeeding Act) and EO 51 (Milk Code) in all birthing facilities
6. Institutionalized local policies supportive of the MNCHN-FP implementation
7. Institutionalized data quality check, functional logistics management and procurement system

While strengthening the implementation of the 9th and 10th elements cited above, it is important also to refer back to STEP 7, on the discussion of the indicators on 1) improving health systems functioning, and, 2) increasing MNCHN-FP services.
APPLICATION SESSION

8.6. Work on Sustainability of the Functional SDN for MNCHN-FP

Based on your proposed SDN’s vision, mission, goals, objectives and plans which were accomplished from STEPs 1 to 7, prepare the following outputs for STEP 8:

1. Organize your SDN Management Board, with the following features:
   a. proposed membership and size
   b. rationale for the specific membership
   c. expected roles/responsibilities of the SDN Board

2. Action steps for the SDN Management Board to accomplish for the first six months:
   a. initial core MNCHN-FP intervention areas to target
   b. health systems instrument to focus for the initial work
   c. priority agencies and organizations to link for the initial steps
   d. resources needed and possible source/s

3. List the Functional SDN elements and indicators that can show extent of accomplishment for the first six months.
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