Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY
2/F, Bldg. # 1, San Lazaro Compound, Rizal Avenue, Sta. Cruz, 1003 Manila
Telefax: (632) 743-1829; 743-1786 Trunkline: 743-8301 local 1125-32 Directline: 711-9501
URL: http://www.doh.gov.ph ; E-mail: osec@doh.gov.ph

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ADMINISTRATIVE ORDER
No. 2008 - 0029

SUBJECT : Implementing Health Reforms for Rapid Reduction of Maternal and Neonatal Mortality

I. BACKGROUND AND RATIONALE

Despite previous efforts and improvement in general health status indicators, the rates of decline in maternal and neonatal mortality have decelerated in the past decade to a point where Philippine commitments to the Millennium Development Goals (MDGs) of lowering maternal mortality ratio (MMR) and infant mortality rate (IMR) may not be achieved.

However, with pregnancy and childbirth continuing to pose risks to Filipino mothers and their newborn, rapid reduction in these risks must be realized as quickly as possible while considering that variations in health outcomes and program performance across localities and population groups warrant targeted and locally-customized interventions in order to meet the rapid reduction goal.

The risk of maternal and neonatal deaths for a given population group is magnified with critical accumulation of the following four risks. First, is the risk of having mistimed, unplanned, unwanted and unsupported pregnancy. Secondly, having become pregnant exposes the mother and the fetus to the risk of not securing adequate care during the course of the pregnancy. Third, is the risk of delivering without being attended to by skilled birth attendants, namely: skilled midwives, nurses and physicians, and of not having access to emergency obstetric and neonatal care services. Lastly, there is the risk of not securing proper postpartum and postnatal care for the mother and neonate, respectively.

Long term control of mortality and morbidity and improvement in the equality of life require provision and use of a continuum of health services spanning each of the life cycle stages. Provision and use of these services would require informed decisions by mothers and their families (demand side), as well as a health system (supply side) that is responsive to their needs.

This Order applies the *Four*mula One for Health (F1) approach for the local implementation of an integrated Maternal, Neonatal and Child Health and Nutrition (MNCHN) Strategy. It outlines specific policies and actions for local health systems to systematically address health risks that lead to maternal and, especially neonatal deaths, which comprise half of reported infant mortalities.

II. STATEMENT OF POLICY

An integrated MNCHN Strategy is hereby formulated and implemented pursuant to the priorities of F1 or Administrative Order No. 0023 series of 2005; the National Objectives for Health (NOH) 2005-2010; the Philippine commitments to the Millennium Development Goals (MDG) for 2015; the lessons obtained from various maternal and child health projects; National Health Sector Meeting Resolution No. 2008-01-02; DOH Executive Committee (Execom) resolution dated February 4, 2008 with a subsequent reiteration in DOH Execom resolution dated June 10, 2008 which was supplemented by DOH Execom resolutions dated July 21 and 30, 2008; as well as in compliance with the 1992 Philippine Midwifery Act or Republic Act (RA) 7392; the Early Childhood Development Act (RA 8980) of year 2000; the Newborn Screening Law (RA 9288) of 2004; Executive Order 286 on the Bright Child Program, 2004; Executive Order 51 on the Milk Code, 1986; the Rooming-In and Breastfeeding Act (RA 7600) of 1992; and, other related laws.

This strategy shall guide the development, implementation and evaluation of various programs aimed at women, mothers and children, with the ultimate goal of rapidly reducing maternal and neonatal mortality in the country. It shall also serve as guide in the engagement, assistance and empowerment of local government units (LGUs) and other partners in rapidly achieving the maternal and neonatal mortality reduction goal.

III. GENERAL PRINCIPLES

The goal of rapidly reducing maternal and neonatal mortality shall be achieved through effective population-wide provision and use of integrated MNCHN services as appropriate to any locality in the country.

Reforms, improvements and changes in local health systems shall, among other results, create the following *intermediate results* that can significantly lower the risk of dying secondary to pregnancy and childbirth:

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 care package for the mother and child survival package for the newborn.

The above four intermediate results shall be achieved by:

1. *Health Service Delivery*—Addressing the direct causes of mortality during childbirth by managing deliveries in either a basic emergency obstetric and newborn care (BEmONC) or comprehensive emergency obstetric and newborn care (CEmONC) facility. Moreover, public health services that reduce the 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, as well as the capacity building of an

adequate health 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 areas or 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 accountability 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.

IV. GOAL AND OBJECTIVES

Goal

Rapidly reduce maternal and neonatal mortality through local implementation of an integrated MNCHN strategy.

Objectives

1. Develop, adopt, promote, implement and evaluate an integrated MNCHN strategy for the rapid reduction of maternal and neonatal mortality;
2. Engage all province-wide or city-wide health systems to adopt and implement the integrated MNCHN strategy;
3. Provide targeted support to province-wide or city-wide health systems and specific population groups where the maternal and neonatal mortality problem is most severe; and
4. Achieve national MNCHN program targets for the following key indicators by 2010:
    a. Increase modern contraceptive prevalence rate from 35.9% (Family Planning Survey, 2006) to 60%;
    b. Increase percentage of pregnant women having at least four antenatal care visits from 70% (National Demographic and Health Survey [NDHS], 2003) to 80%;
    c. Increase percentage of skilled birth attendance and facility-based births from 40% (NDHS, 2003) to 80%; and
    d. Increase percentage of fully immunized children from 70% (NDHS, 2003) to 95 percent.

V. DEFINITION OF TERMS

1. Basic Emergency Obstetric and Newborn Care (BEmONC) facilities are capable of performing six signal obstetric functions, which include: (i) parenteral administration of oxytocin in the third stage of labor; (ii) parenteral administration of loading dose of anti-convulsants; (iii) parenteral administration of initial dose of antibiotics; (iv) performance of assisted deliveries; (v) removal of retained products of conception, and (vi) manual removal of retained placenta. BEmONC facilities are also capable of providing neonatal emergency interventions which include at the minimum: (i) newborn resuscitation, (ii) treatment of

neonatal sepsis/infection; and (iii) oxygen support. It shall also be capable of providing blood transfusion services on top of its standard functions.

2. **Community level providers** refer primarily to Barangay Health Stations (BHS) and its health staff (e.g. midwife) and volunteer health workers (e.g. barangay health workers, traditional birth attendants) that typically comprise the Women's Health Team (or Barangay Health Team). These teams implement integrated MNCHN services identified for the community level. Their functions include advocating for birth spacing and counseling on family planning services; the tracking and master listing of pregnant women; assisting pregnant women and their families in formulating a birthing plan; early detection and referral of high-risk pregnancies; and reporting maternal and infant deaths. The teams shall also facilitate discussions of relevant community health issues, particularly those affecting women and children.

3. **Comprehensive Emergency Obstetric and Newborn Care (CEmONC) facilities** can perform the six signal obstetric functions of a BEmONC and in addition, perform cesarean section and provide blood banking and transfusion services along with other highly specialized obstetric services. It is also capable of providing the following neonatal emergency interventions, which include at the minimum: (i) newborn resuscitation, (ii) treatment of neonatal sepsis/infection, (iii) oxygen support for neonates, and (iv) management of low birth weight or premature newborn, along with other specialized neonatal services.

4. **MNCHN service delivery network** refers to the network of facilities and providers within the province-wide or city-wide health system offering integrated MNCHN services in a coordinated manner. It also includes the communication and transportation system supporting this network. The facility, provider type and service standards for the network shall be described in the MNCHN Operations Manual.

5. **Integrated MNCHN services** refer to a package of services for women, mothers and children that cover the continuum of the following:

   1. Known appropriate clinical case management services in preventing direct causes of maternal and neonatal deaths, and 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 neonatal deaths, that are within the capacity of the health system to routinely provide.

6. **Province-wide or city-wide health system** refers to the default catchment area for delivering integrated MNCHN services. It consists of public and private providers organized into configurations such as interlocal 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 integrated MNCHN services across provinces, municipalities and cities become necessary.

VI. SCOPE AND COVERAGE

This Order shall apply to the whole hierarchy of the DOH and its attached agencies, as well as LGUs, other public and private providers of health care and development partners implementing the MNCHN strategy.

VII. GENERAL GUIDELINES

1. Recognize the province-wide or city-wide health system as the unit for planning, organizing and implementing the MNCHN strategy. The province-wide or city-wide health system shall be the basic unit for planning, organizing and implementing MNCHN activities. The DOH shall advocate and promote the standards of a stable and mature service delivery network to local stakeholders. It shall also ensure that the standards are flexible enough to adapt to local conditions, and are appropriate to the local area and population.

2. Engage local stakeholders and strengthen public-private partnerships to support the goal of rapidly reducing maternal and neonatal mortality. Local stakeholders shall be engaged to review the current functionality of their respective local service delivery network. Functionality includes, among other things, the level and quality of coordination across the various activities and functions of public and private providers. Based on this assessment, all local stakeholders shall be enjoined to take part in activities that address maternal and newborn health.

3. Mobilize the service delivery network to deliver the integrated MNCHN services as a continuum. Universal access to and utilization of integrated MNCHN services in its full continuum spanning the pre-pregnancy, pregnancy, delivery and postpartum/postnatal care phases shall be ensured in all localities, and shall be backed-up by pertinent laws and accessible operational resources. A core list of MNCHN services include those from the women's health and child survival packages developed by the DOH.

4. Pursue improvements in the delivery of various component services in the maternal and neonatal service package. In order to mount rapid response capacity in local health systems, the MNCHN strategy shall build on existing service capacities and utilization patterns. Targeted quality improvements in facilities and human resources, together with measures to facilitate utilization by clients, shall be carried out to achieve rapid mortality reduction with minimal effort and investment in the immediate and medium term. Over time, improvements in the current delivery system configuration and services shall be introduced as standards improve, as demand increases, as local health systems acquire additional capacity, as legal and resource constraints are addressed and as the nature of the maternal and neonatal mortality problem evolves.

5. Develop and support implementation of appropriate demand-side interventions.

The DOH shall develop schemes to support local health systems in designing, implementing and evaluating appropriate demand-side interventions to improve health seeking behavior and service utilization patterns in localities. Demand-side measures shall be given due emphasis in local applications of the MNCHN strategy as life saving and cost saving interventions. These measures shall also be crafted and directed at specific target areas and populations (e.g. mothers, poor households) whichever is most appropriate and effective in a given locality.

6. Develop monitoring and evaluation systems for the MNCHN strategy. The DOH shall develop and support the establishment, operation and maintenance of monitoring and evaluation mechanisms for local implementation of the MNCHN strategy. Appropriate methodologies (e.g. maternal and perinatal death reviews) shall be employed to establish baseline, track progress and assess the impact of various interventions to improve the delivery of services in a local health system. The monitoring and evaluation system shall be developed incrementally and may begin with a limited set of readily available and verifiable indicators. It is also desired that these monitoring and evaluation mechanisms are transparent, have established dissemination channels that feed into formal feedback mechanisms to policy and management that is sustainable given local constraints and conditions.

7. Provide national support to local planning and development in support of the MNCHN strategy. The DOH shall develop and apply various instruments to help localities develop customized MNCHN strategies, strengthen their service delivery networks, secure critical goods and commodities and improve monitoring and evaluation. These instruments shall include a mix of grant assistance schemes, policy issuances, technical assistance, institutionalized training, research and development, development of new standards, provision of specialized services, financing mechanisms through PhilHealth, and regulatory measures.

VIII. SPECIFIC GUIDELINES

The following are specific guidelines for implementing the general guidelines mentioned above:

1. The province-wide or city-wide health system shall be delineated by the politico-geographic jurisdictions of its component LGUs. Other providers and LGUs outside the catchment area may also be engaged within this health system should it be necessary for the effective provision and use of integrated MNCHN services. This may be recommended if the required service capacities are not accessible within the catchment area and/or if utilization patterns by constituents and neighboring populations overlap in these jurisdictions. To sustain operations, DOH shall also facilitate compliance of these facilities with DOH licensing and PhilHealth accreditation requirements.

2. The operations of the MNCHN service delivery network shall be organized as follows:

    a. **Third Tier**—CEmONCs are public or private facilities designated as the end-referral facility for integrated MNCHN services. The default CEmONC in a given locality shall be the provincial hospital or similarly capable DOH/LGU hospital or private hospital. ***Designation of the CEmONC facility shall be based primarily on its service capacity.*** However, other criteria such as pricing, service load, quality of care, location, topography, transport system, utilization patterns and other similar parameters may be used to determine the designation of a CEmONC facility. In case of multiple CEmONC facilities (as in large or highly-populated provinces or cities), the catchment area may be divided further into specific areas of responsibility for each facility, based on criteria mentioned above.

    Ideally, the CEmONC facility shall be accessible within two hours travel from any residence/referring facility within the province/city. However, in anticipation of possible delays during referral, CEmONC facilities are recommended to be accessible within one-hour travel time. A CEmONC facility shall operate on a 24-hour basis with emergency standby capacity. At least one obstetrician/surgeon, a pediatrician, an anesthesiologist, six nurses, a medical technologist and six midwives staff the typical CEmONC.

    b. **Second Tier**—The default BEmONC facility shall consist of the core district hospital or similarly capable public or private facility assigned to serve an ILHZ or health district. In certain cases, such as in geographically isolated and disadvantaged areas or in densely-populated areas, rural health units (RHUs), health centers, BHS, lying-in clinics or birthing homes capable of performing the six signal obstetric functions and neonatal emergency care may also be designated as BEmONC facilties.

Designation of the BEmONC facility shall be based primarily on service capacity. However, other criteria such as pricing, service load, quality of care, location, topography, transport system, utilization patterns and other similar parameters may be used to determine to upgrade and designate a facility as a BEmONC facility. In case of multiple BEmONC facilities serving a particular ILHZ or health district the catchment area may be divided further into specific areas of responsibility for each facility, based on criteria mentioned earlier.

Ideally, the BEmONC facility shall be accessible within one-hour travel from any residence/referring facility within the ILHZ, health district or city. However, in anticipation of possible delays during referral, BEmONC facilities are recommended to be accessible within 30 minutes of travel time. A BEmONC facility may have a minimum staff complement of at least one physician, a nurse and a midwife. The BEmONC facility shall operate on a 24-hour basis and shall have access to communication and transportation facilities to facilitate referrals.

Public and private clinics, lying-in clinics, birthing homes and other similar facilities currently managing deliveries but have no capacity to provide the six signal obstetric functions and neonatal emergency services may acquire new capacities to qualify and be designated as BEmONCs. Acquisition of these additional capacities shall be supported by DOH in terms of addressing legal and resource constraints, with resources focused mainly in areas where the maternal and neonatal mortality problems are most severe.

c. **First Tier**—Community level service providers such as RHUs, health centers, BHS or similar private facilities shall have Women's Health Teams or Barangay Health Teams led by a nurse or a midwife organized to provide the identified MNCHN services along with other functions deemed necessary in their communities. These teams shall vigorously campaign for proper birth spacing, complete required antenatal care visits, facilitate the shift from home deliveries to facility-based births attended by skilled professionals, provide postpartum and postnatal care, and ensure smooth transitions to other health care packages for women and children.

   The RHUs, health centers and private outpatient clinics in the network shall provide MNCHN services other than managing deliveries. These services shall include family planning, prenatal services and postpartum and postnatal care aside from other public health and clinical services deemed necessary in their localities, including organizing of outreach activities;

3. The province-wide or city-wide health system shall be supported by an adequate emergency communication and transportation system. This communication system shall facilitate consultation, referral and coordination from and by peripheral facilities all the way up to the end referral facility level. LGUs are encouraged to invest in modern communication systems available in and suitable to their localities. The transportation system is intended to bring patients to and from facilities during referrals and transfers. This may be done through an organized ambulance network that services the whole breadth of the province-wide or city-wide health system or a mix of facility-based ambulances and locally available transportation with explicit arrangements for use and financing during referrals and transfers.

Appropriate measures shall be taken to facilitate the shift from home-based deliveries to facility-based births attended by skilled birth attendants. In order to facilitate the shift, schemes can be developed to provide traditional, non-skilled attendants with incentives to refer deliveries to appropriate facilities. Aside from enjoining them to join barangay health teams, qualified TBAs may be provided educational assistance to become midwives.

4. The integrated MNCHN services shall consist of clinical and public health interventions for women and children that shall be delivered through a seamless continuum of care that shall include pre-pregnancy care, antenatal care, care during delivery and postpartum and postnatal care. The minimum standard services are:
    a. Pre-Pregnancy Services
        i. Provision of correct information and responsive counseling for fertility awareness, maternal nutrition, birth spacing and adolescent reproductive health;
        ii. Active identification and servicing of population segments with unmet needs for family planning and referral to alternative sources of services and supplies when these are not available in one's service outlet or facility;
        iii. Assurance of a safety net of free family planning services and supplies for indigent potential users; and
        iv. Provision of other basic and essential services for young females and women in the reproductive age.
    b. Antenatal Care
        i. Consistent coverage of all eight essential antenatal care functions (monitoring height and weight, taking blood pressure, blood testing, urine testing, iron and folate supplementation, tetanus toxoid immunization, malaria prophylaxis where appropriate and birth planning);
        ii. Focused attention to individualized birth preparedness counseling about the place of delivery and transport arrangements to increase the mother's readiness to deliver in health facilities; and
        iii. Discussion with household member/s and preparation for childbirth with partner support and involvement in care-seeking decisions.
    c. Care during Delivery
        i. Proper channeling of patient workloads with aggressive promotion of shifting from home-based deliveries to delivery in either a BEmONC or a CEmONC, especially for women with medical conditions and other special needs by classifying them as priority for transport and servicing by the appropriate delivery/birthing facility;
        ii. Deliberate planning and special provisions for hard-to-reach segments of the population within the province-wide or city-wide system to promote facility-based deliveries;
        iii. Active conversion and mobilization of traditional birth attendants into advocates and agents of facility-based deliveries; and
        iv. Correct and updated monitoring and reporting of the number and proportion of facility-based births.
    d. Postpartum and Postnatal Care
        i. Provision of proper postpartum/postnatal care for mothers and neonates; and
        ii. Provision of the whole range of women's health care services for mothers and of the child survival package for children.

5. The DOH shall support universal local implementation of the MNCHN strategy. However, local conditions and capacities shall be considered in the adoption of MNCHN services in the different LGUs. The DOH shall periodically determine the appropriateness and responsiveness of the comprehensive and core components of the integrated MNCHN package in order to adapt to the evolving nature of the maternal and neonatal mortality problem.

6. The assessment of coordination across the various MNCHN-related activities and functions within and outside the health service system shall be in accordance with specific criteria, and made part of a local monitoring and evaluation system. The assessment shall cover coordination within the province-wide or city-wide system, between public and private service providers, and between each tier of the 3-tier service delivery network.

IX. ROLES AND RESPONSIBILITIES

For purposes of this Order, the various DOH instrumentalities, partners and other stakeholders shall have the following roles and functions:

1. **Office of the Undersecretary for Policy Standards and Development Team-Service Delivery**
   a. Provide overall leadership in the implementation of the MNCHN strategy;
   b. Mobilize and coordinate resources for implementation of the MNCHN strategy;
   c. Monitor overall progress of implementing the MNCHN strategy; and
   d. Regularly report progress of implementing the MNCHN strategy to the Secretary of Health, Execom and similar oversight bodies.

2. **National Centers for Disease Prevention and Control (NCDPC)**
   a. Reorganize its systems and processes to ably support the delivery of the integrated MNCHN services;
   b. Re-align relevant programs and services into the MNCHN framework and strategy;
   c. Provide technical leadership and assistance in the delivery of integrated MNCHN services to CHDs, LGUs and other stakeholders;
   d. Identify resources necessary to efficiently assist partners in their implementation of MNCHN;
   e. Develop service standards for MNCHN interventions; and,
   f. Coordinate monitoring and evaluation of the implementation of the MNCHN strategy.

3. **National Center for Health Facilities Development (NCHFD)**
   a. Assist designated facilities to comply with technical standards and requirements for providers in the service delivery network;
   b. Develop facility standards for MNCHN providers and other facilities within the service delivery network;
   c. Strengthen the MNCHN functions of hospitals and other facilities, including public health services; and,
   d. Assist in monitoring the progress of implementation of the MNCHN strategy.

4. **National Center for Health Promotion (NCHP)**
   a. Develop effective mechanisms to promote the MNCHN goals and strategies;
   b. Design and assess communication and health promotion schemes addressing various groups of stakeholders involved in MNCHN; and
   c. Provide technical assistance to CHDs, LGUs and other stakeholders in developing locally-specific communication and heath promotion packages.

5. **Health Human Resources Development Bureau (HHRDB)**
   a. Identify mechanisms to meet human resource requirements to operate province-wide or city- wide health systems;
   b. Develop strategy and program to retool national and local personnel in order to facilitate delivery of integrated MNCHN services;
   c. Facilitate integration and updating of existing training modules on maternal-neonatal health and other related programs;
   d. Develop training standards as part of civil service deployment and promotion criteria for local health officials.

6. **Bureau of Local Health Development (BLHD)**
   a. Develop guide/criteria for designing the province/-wide or city -wide health system providing integrated MNCHN services;
   b. Assist CHDs in the engagement of LGUs;
   c. Facilitate mainstreaming of the MNCHN strategy into the PIPH and AOPs of the F1 sites; and,
   d. Assist in monitoring local implementation of the MNCHN strategy.

7. **Health Policy Development and Planning Bureau (HPDPB)**
   a. Link MNCHN strategy implementation with DOH budget
   b. Facilitate the review and updating of policies and plans for consistency with the MNCHN strategy;
   c. Provide support in the enhancement of laws/IRRs in support of the MNCHN strategy; and
   e. Institutionalize mechanisms for the use of accurate, timely and reliable evidence for policy decisions, strategic actions and prioritization of resources and efforts.

8. **Bureau of International Health Cooperation (BIHC)**
   a. Manage external resources to support implementation of the MNCHN strategy;
   b. Influence the formulation by development partners of their country assistance package or assistance framework so that these are harmonized with the Philippine Health Sector Reform Program, in general, and the MNCHN strategy in particular; and
   c. Facilitate access to information on international experience and best practices to enhance MNCHN as necessary.

9. **National Epidemiology Center (NEC)**
   a. Provide accurate, timely and complete data as basis for policy decisions, strategic actions and prioritization of resources and efforts;
   b. Enhance FHSIS as source for tracking maternal mortality and the other childhood health outcomes;

c. Design tools to improve data collection and skills of regional/local health managers/staff, including development of compliance monitoring mechanisms; and,
d. Coordinate overall measurement of MDG-related goals on maternal-neonatal health including the conduct of national surveys and special studies.

10. Finance, Procurement and Materials Management Services

a. Assist in the development of guidelines for granting assistance to groups of stakeholders involved in the implementation of the strategy;
b. Facilitate process in transferring financial resources to the regions and LGUs as part of the overall grants approach to local health system development; and
c. Enhancing procurement and supply chain management system of essential MNCHN logistics.

11. Office of Special Concerns, Field Implementation and Management Office and Centers for Health and Development

a. Reorganize/staff to support the delivery of the integrated MNCHN services, in the context of the health sector reform elements and goals;
b. Promote the adoption of the MNCHN Policy Framework and Strategy to their catchment LGUs;
c. Advocate for the participation of multi-sectoral partners and work for the establishment of a coalition of advocates to reduce maternal and neonatal deaths in the region;
d. Promote the establishment of province-wide or city- wide health systems in the region;
e. Assist DOH-retained hospitals to qualify to serve as CEmONC facilities in their respective networks;
f. Assist LGUs in applying and qualifying for MNCHN and related grants;
g. Manage regional implementation of MNCHN and related grants facilities; and
h. Provide technical assistance to LGUs and providers implementing the MNCHN strategy.

12. Local Government Units

a. Adopt and implement the MNCHN strategy;
b. Reorganize staff to deliver the integrated MNCHN services, in the context of the health sector reform elements and goals;
c. Invest in the development of facilities and staff to improve implementation of MNCHN services;
d. Ensure adequate financing of MNCHN service inputs by allocating budgets and actively sourcing alternative financing sources such as grants;
e. Monitor and supervise local implementation of the MNCHN; and
f. Ensure sustainability of quality MCNHN services in the locality.

13. Philippine Health Insurance Corporation (PhilHealth)

a. Intensify enrollment campaigns in localities implementing the MNCHN strategy;
b. Facilitate the accreditation of facilities involved in the MNCHN service delivery network;
c. Assist facilities in improving the management of claims, payments and reimbursements; and
d. Strengthen existing benefit packages in support of the MNCHN strategy.

14. **Commission on Population (PopCom)**
    a. Reorganize staff to support the delivery of the integrated MNCHN services, in the context of the health sector reform elements and goals;
    b. Coordinate and intensify efforts at promoting family planning, especially natural family planning methods in localities implementing the MNCHN strategy; and
    c. Mobilize local population workers including barangay population workers/volunteers (Barnagay Service Point Officers) and other community-based volunteers to support the MNCHN strategy in the localities.

15. **National Nutrition Council (NNC)**
    a. Reorganize staff to support the delivery of the integrated MNCHN services, in the context of the health sector reform elements and goals;
    b. Coordinate multisectoral efforts on nutrition in support of the MNCHN strategy (i.e. consolidating efforts targeted to mothers and children below two years old); and
    c. Mobilize Barangay Nutrition Scholars to support MNCHN strategy in their localities

16. **Philippine National AIDS Council (PNAC)**
    a. Coordinate multisectoral efforts on HIV/AIDS and STI prevention in support of the MNCHN strategy; and
    b. Mobilize Local HIV/AIDS Councils (LACs) to support MNCHN strategy in their localities.

17. **Development Partners**
    a. Align country programs and support to facilitate the adoption and implementation of the MNCHN strategy, in the context of the health sector reform elements and goals; and
    b. Provide technical assistance and other forms of support to LGUs in implementing the MNCHN strategy.

18. **Professional Societies/Groups**
    a. Support the implementation and continuing development of the MNCHN strategy;
    b. Assist in the review and updating of MNCHN facility and practice standards;
    c. Assist in the development and implementation of compliance monitoring strategies for the MNCHN strategy; and
    d. Promote the adoption of the MNCHN strategy among members and component societies.

X. MANUAL OF OPERATIONS

The Undersecretary for Policy Standards and Development Team-Service Delivery shall organize and oversee the technical working group that shall draw up the Manual of Operations for the MNCHN Strategy, in consultation with maternal and child health experts and other sectoral and development partners. The Manual shall contain, among other necessary details, the following components of the MNCHN strategy:

a. Key indicators to measure progress in intermediate results
b. Integrated list of MNCHN services

c. Core list of MNCHN interventions
d. Budget execution guidelines for the MNCHN grants facility
e. Facility and service standards for the MNCHN network
f. Capacity building requirements for the MNCHN strategy
g. Coordination mechanisms within and with other province-wide or city-wide health systems
h. Monitoring and evaluation systems and implementation guide
i. Reporting and documentation

XI. REPEALING CLAUSE

Provisions from previous issuances that are inconsistent or contrary to the provisions of this Order are hereby rescinded and modified accordingly.

XII. SEPARABILITY CLAUSE

In the event that any provision or part of this Administrative Order be declared unauthorized or rendered invalid by any court of law or competent authority, those provisions not affected by such declaration shall remain valid and effective.

XIII. EFFECTIVITY

This Order shall take effect immediately.

FRANCISCO T. DUQUE III, M.D., MSc.
Secretary of Health