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**Working Paper**

## Improvement of the Implementation Procedures and Management Systems for the Health Facilities Enhancement Grant of the DOH

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Philippine Institute for Development Studies  
*Surian sa mga Pag-aaral Pangkaunlaran ng Pilipinas*

Improvement of the Implementation  
Procedures and Management Systems  
for the Health Facilities Enhancement

Grant of the DOH

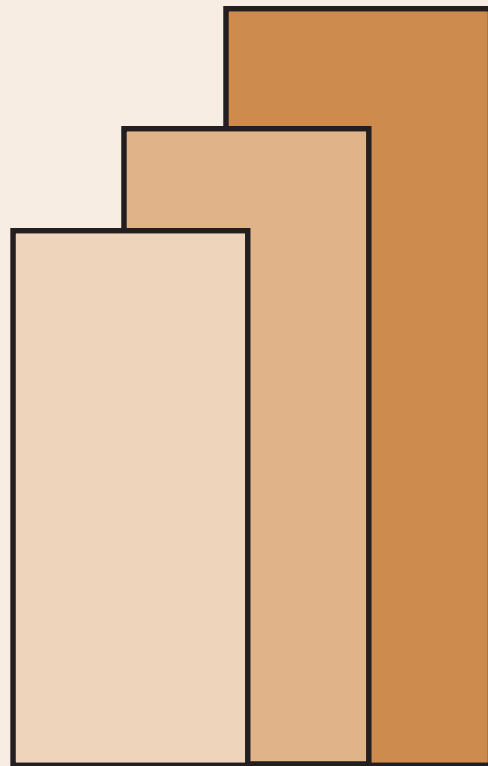
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Improvement of the  
Implementation Procedures and  
Management Systems for the Health  
Facilities Enhancement Grant of the  
Department of Health

Rouselle F. Lavado, Ida Marie T. Pantig, Kristine Tyrol Z. Rosales, and Valerie  
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July 2011

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## List of Acronyms

<b>4Ps</b>	Pantawid Pamilyang Pilipino Program
<b>AHA</b>	Aquino Health Agenda
<b>AO</b>	Administrative Order
<b>AOP</b>	Annual Operation Plans
<b>BEmONC</b>	Basic Emergency Obstetric and Newborn Care
<b>BHS</b>	Barangay Health Station
<b>CCT</b>	Conditional Cash Transfer
<b>CEmONC</b>	Comprehensive Emergency Obstetric and Newborn Care
<b>CHD</b>	Center for Health Development
<b>CO</b>	Capital Outlay
<b>CON</b>	Certificate of Need
<b>DBM-CO</b>	Department of Budget and Management-Central Office
<b>DM</b>	Department Memorandum
<b>DO</b>	Department Order
<b>DOH</b>	Department of Health
<b>FHO</b>	Family Health Office
<b>FIMO</b>	Field Implementation Management Office
<b>FUR</b>	Fund Utilization Reports
<b>GAA</b>	General Appropriations Act
<b>HFEP</b>	Health Facility Enhancement Program
<b>HPDPB</b>	Health Policy Development and Planning Bureau
<b>IMSO</b>	Internal Management Support Office
<b>IP</b>	Indigent Program
<b>LGU</b>	Local Government Unit
<b>MMR</b>	Maternal Mortality Ratio
<b>MNCHN</b>	Maternal, Neonatal and Child Health and Nutrition
<b>MOOE</b>	Maintenance and Other Operating Expenditure
<b>NCHFD</b>	National Center for Health Facility Development
<b>OSEC</b>	Office of the Secretary
<b>PBB</b>	Performance-Based Budgeting
<b>PIPH</b>	Province-wide Investment Plan for Health
<b>PNP</b>	Philippine National Police
<b>PSDT-SD</b>	Policy and Standard Development Team for Service Delivery
<b>RatPlan</b>	Rationalization Plan
<b>RHU</b>	Rural Health Unit
<b>SAA</b>	Sub-allotment Advice
<b>SARO</b>	Special Allotment Release Order
<b>TWG</b>	Technical Working Group
<b>VAT</b>	Value-Added Tax

## **Improvement of the Implementation Procedures and Management Systems for the Health Facilities Enhancement Grant of the Department of Health**

### **Abstract**

One of the major challenges in the Philippine health sector is to secure adequacy of appropriate health facilities. To address this problem, the Health Facilities Enhancement Program (HFEP) was implemented by DOH in 2007. Specifically, HFEP aims to improve facilities such as health centers and barangay health stations to sufficiently provide for emergency and primary care services. It also aims to upgrade government hospitals. This study examines the implementation of the program and probes at the rationale for the selection of facilities for upgrading. It lays out policy options to improve equity and efficiency in allocation of funds.

Keywords: health financing, health facilities, health sector, health care, hospitals

# **Improvement of the Implementation Procedures and Management Systems for the Health Facilities Enhancement Grant of the DOH**

## **I. Introduction**

One of the major challenges in the Philippine health sector is providing access to appropriate health facilities for the poor and the marginalized sector of the society. Recognizing this problem, one of the inaugural commitments of the Aquino administration is ensuring that quality and affordable care reaches each and every Filipino during his term. At the core of this commitment is the expansion of Pantawid Pamilyang Pilipino Program (4Ps), a conditional cash transfer (CCT) program targeting indigents who will be given cash conditional on utilization of maternal and child care services. Studies have shown that while cash transfer help overcome demand-side barriers to healthcare, it has to be complemented with supply-side strategies, like improvements in health facilities and training of health professional, for it to be effective (DFID, 2011).

Budgets for capital outlay have been sparse in the Department of Health (DOH) expenditure schedule from 2000 to 2006. Due to this, maintenance and upkeep of health facilities has been postponed which has resulted in deterioration of most health facilities. According to DOH, 892 Rural Health Units (RHUs) (36% of total) and 99 public hospitals (14% of total) have yet to qualify for PhilHealth accreditation. In response to this, the new administration launched the Aquino Health Agenda (AHA) where one of the three strategic thrusts is improving access to quality hospitals and health facilities through upgrading of facilities.

There have been efforts that started in 2007 to bridge the gaps in health care delivery and utilization and eventually increase access to health facilities and services. The DOH has included into the General Appropriations Act (GAA) funds for the Health Facilities Enhancement Program (HFEP) which aims to upgrade health facilities such as Health Centers and Barangay Health Stations (BHS) to sufficiently provide for emergency and primary care services. Another goal of the HFEP is to improve and upgrade facilities in government hospitals.

Since its implementation in 2007, budget for HFEP has increased from P43.5M in 2007 to P7.1B in 2011. The program has also expanded from initially targeting Local Government Units (LGUs) in Fourmula One (F1) sites only to all provinces in the country. Despite these efforts, the Department of Budget and Management (DBM) has still received feedback regarding difficulties encountered by the DOH in implementing this program.

*The Improvement of the Implementation Procedures and Management Systems for Health Facilities Enhancement Grant of the DOH* study addresses the need to identify the difficulties encountered by the DOH in implementing the program for the efficient allocation of funds for facilities across the country. It assesses the indicators used in choosing which facilities should be targeted for upgrading to ensure equity in the allocation of funds. This study specifically aims to map and examine the rationale for the choice of facilities that will be upgraded through HFEP. It also lays-out some policy options that can be considered to improve equity and efficiency in allocation of funds.

## II. Description of Program: HFEP

The DOH implemented the HFEP with the main goal of improving the delivery of basic, essential and as well as specialized health services. The project envisions revitalization of primary health care facilities and the rationalization of the various levels of hospitals to decongest end-referral hospitals.<sup>1</sup> Facilities will be upgraded to make them more responsive to the “need” of the catchment area, to provide Basic Emergency Obstetric and Newborn Care (BEmONC) and Comprehensive Emergency and Newborn Care (CEmONC) services to the population, and to strengthen the health facility referral system or network.

Specifically, the objectives of the HFEP are as follows:

1. To upgrade/establish priority BHSs and RHUs nearest to the communities in order to provide services for BEmONC to reduce maternal maternity ratio (MMR); to establish strategically located blood service facilities and upgrade end-referral/training center for B/CEmONC personnel;
2. To upgrade government hospitals/health facilities in Provinces with approved Provincial Rationalization Plans of their Health Care Delivery System based on Health Needs and its Implementation Plans linked to Provincial Investment Plan for Health (PIPH) and Annual Operation Plans (AOPs); to meet DOH Licensing and PhilHealth accreditation requirements and provide quality and appropriate health services responsive to the priority health needs of the catchment population;
3. To upgrade Philippine National Police (PNP) clinics to Level 1 (primary) general hospitals; to upgrade government hospitals (including military and PNP hospitals) from Level 1 (primary) to Level 2 (secondary) in order to accommodate nursing students as base hospital; and if necessary to upgrade from Level 2 (secondary) to Level 3 (basic tertiary) hospitals to “gatekeep” and decongest higher level tertiary hospitals; for nursing affiliation in tertiary hospitals; and to provide services for CEmONC to reduce MMR; expand services of existing tertiary hospitals to provide higher tertiary care and as teaching, training hospitals.

## III. The HFEP Budget

A separate line item was provided for the HFEP in the GAA beginning 2007. The HFEP was one of the priority programs of the DOH in 2007 in line with the health sector reforms. HFEP had a budget of P43 million at the start of the program in 2007. Of this, only P10 million was appropriated for Capital Outlay (CO) and the rest of the budget is for Maintenance and Other Operating Expenses (MOOE). In 2008, total budget increased to P1.65 billion, where P27 million was appropriated for MOOE and the rest for CO. MOOE appropriation has been steady at P27 million from 2008 to 2011, while the CO budget increased from P1.6 billion in 2008 to P7.1 billion in 2011 (see Table 1).

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<sup>1</sup> DOH Department Order no. 2008-0162 entitled, “Guidelines and Procedures for the Implementation of the Government Hospital Upgrading Project under the CY2008 Health Facilities Enhancement Program Funds of the DOH” dated 7 July 2008.

**Table 1. HFEP Budget, General Appropriations Act**

	MOOE	CO	TOTAL
2007	33,530,000	10,000,000	<b>43,530,000</b>
2008	27,522,000	1,628,000,000	<b>1,655,522,000</b>
2009	27,522,000	2,045,726,000	<b>2,073,248,000</b>
2010	27,522,000	3,224,173,000	<b>3,251,695,000</b>
2011	27,522,000	7,116,387,000	<b>7,143,909,000</b>

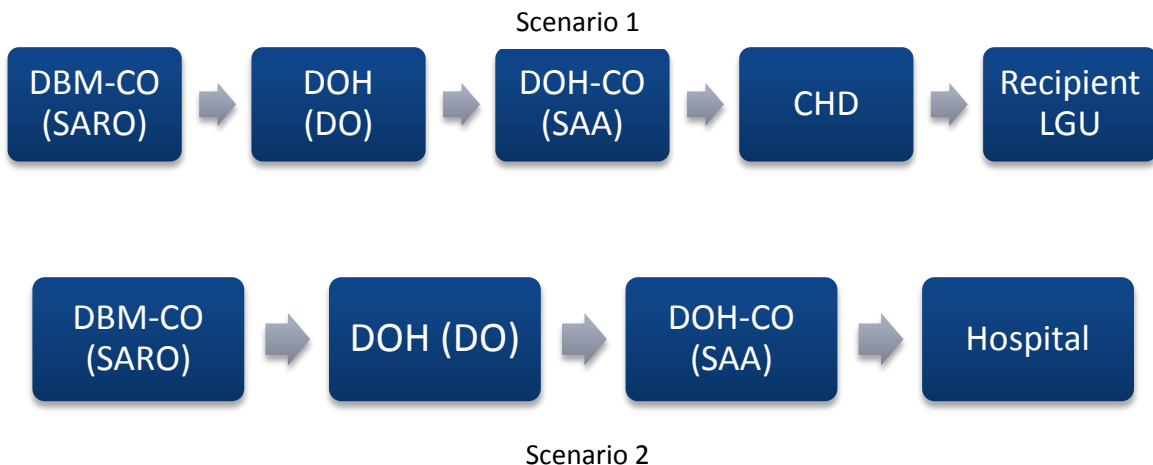
Source: General Appropriations Act, Department of Budget and Management, various years

## IV. Structure

*Regulation and Oversight.* The National Center for Health Facility Development (NCHFD) is tasked to provide coordination, technical assistance, capability building, consulting and advisory related to health facility development. NCHFD technical assistance ranges from planning, to operation and maintenance. It is composed of three divisions: the Technical Operations Division, Infrastructure and Equipment Division, and Management Systems Development Division. The Infrastructure and Equipment Division is the unit in charge of the HFEP.

*Budget Releases.* Once a request for facility is approved, a Special Allotment Release Order (SARO) is issued by the DBM. DOH then issues a Department Order (DO) indicating the guidelines for the release and utilization of funds for the recipient LGU or hospital. A Sub-Allotment Advice (SAA) is then released by NCFHD, through the Finance Service, to the Center for Health Development (CHD). The CHD then releases the fund to the Recipient LGU or hospital (Scenario 1). In some instances, however, the SAA is released directly to the hospital (Scenario 2). Figure 1 illustrates this process.

**Figure 1.** Flow of Budget Release



## V. Sources of Fund

Aside from the GAA, other sources of fund for the HFEP include realignments from the Family Health Office (FHO), Katas ng VAT, and Congressional and Senate Initiatives. Table 2 shows that in 2008, 36% of HFEP spending comes from other sources; 25% of the total HFEP spending is from the Katas ng VAT, while Congressional initiatives comprise 8% and Senatorial initiatives 3%. In 2010, FHO realigned its budget of P503 million for the upgrading of BHSs and RHUs into BEmONCs and CEmONCs.

**Table 2.** Sources of Fund for HFEP

(in '000)	2007		2008		2009		2010	
<b>GAA</b>	<b>485,412</b>	<b>100%</b>	<b>1,267,522</b>	<b>64%</b>	<b>2,045,048</b>	<b>99%</b>	<b>3,181,676</b>	<b>86%</b>
<b>Others</b>			<b>702,400</b>	<b>36%</b>	<b>30,000</b>	<b>1%</b>	<b>503,000</b>	<b>14%</b>
FHO							503,000	14%
Katas ng VAT			496,000	25%				
Congressional Initiatives			148,400	8%				
Senate Initiatives			58,000	3%	30,000	1%		
<b>Total</b>	<b>485,412</b>	<b>100%</b>	<b>1,969,922</b>	<b>100%</b>	<b>2,075,048</b>	<b>100%</b>	<b>3,684,676</b>	<b>100%</b>

### Issues

The FHO realigned funds amounting to P503 million in 2010. This amount is for the construction and upgrading of RHUs and BHSs to provide BEmONC and CEmONC services. Although this is in line with FHO's Maternal, Newborn and Child Health and Nutrition (MNCHN) Strategy, the funds were realigned due to the facilities enhancement nature of the project, which is under the responsibility of NCHFD.

On average, funds from other sources comprise only 13% of the total HFEP funds. The existence of such funds mixes up the allocation criteria of DOH (refer to section on allocation below), which is supposedly based on "needs." This need is defined in the facilities rationalization plan prepared by each province.<sup>2</sup> Since congressmen and senators allot funds to augment DOH's HFEP budget, there were cases that the criteria set by the DOH in choosing which facilities to upgrade were disregarded to accommodate their requests. It is identified that having those funds can politicize the allocation of funds, thus, the process of accepting funds from other sources needs to be carefully reviewed.

<sup>2</sup> As of June 2011, only 52 provinces prepared a rationalization plan. These provinces are: Benguet, Mt. Province, Ifugao, Ilocos Norte, Pangasinan, Isabela, Nueva Vizcaya, Cagayan, Quirino, Nueva Ecija, Batanes, Cavite, Laguna, Batangas, Rizal, Quezon, Oriental Mindoro, Occidental Mindoro, Romblon, Palawan, Marinduque, Albay, Sorsogon, Capiz, Iloilo, Guimaras, Negros Oriental, Siquijor, Bohol, Cebu, Biliran, Southern Leyte, Leyte, Eastern Samar, Samar, Northern Samar, Zamboanga Sibugay, Zamboanga del Norte, Zamboanga del Sur, Misamis Occidental, Lanao del Norte, Misamis Oriental, Compostela Valley, Davao del Norte, North Cotabato, South Cotabato, Sarangani, Sultan Kudarat, Agusan del Sur, Dinagat Islands, and Surigao del Sur. There were cases, however, that HFEP funds were given to provinces with no rationalization plan to accommodate requests by politicians.

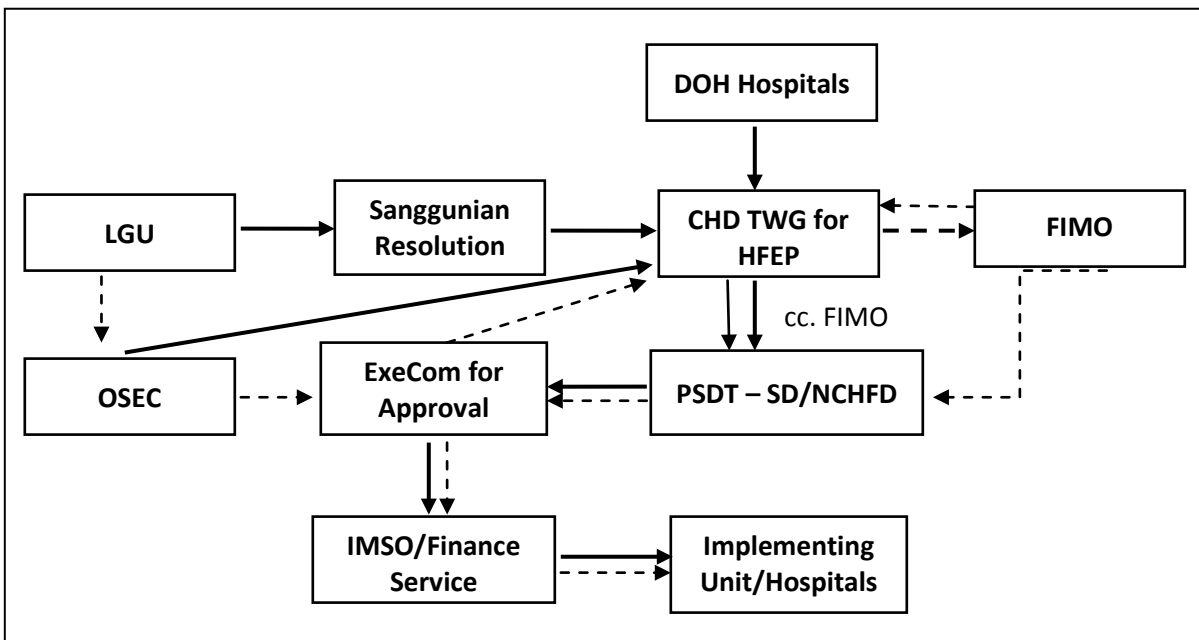
## VI. Planning and Budgeting

*Request for Funding from HFEP.* Department Memorandum (DM) 2010-0104 provides the process flow for the approval of HFEP allocation. According to the DM, all requests coming from LGUs, Office of the Secretary (OSEC) and DOH Hospitals shall be forwarded to the CHD. Hospitals under the DOH should directly forward their requests to the CHD, while LGU hospitals can submit their requests through their LGUs. The LGU will then pass a *Sanggunian Resolution* in connection to the request to the CHD. In some instances, requests are forwarded straight to the Office of the Secretary (OSEC) of the DOH or the Field Implementation Management Office (FIMO). In such case, the OSEC/FIMO will forward the request to the CHD for review and validation.

From the CHD, the requests are forwarded to NCHFD for further review before passing on to the ExeCom for approval. All requests that are forwarded to the NCHFD are also sent to the FIMO for monitoring of process. Upon approval, the requests are passed on to the Finance Service for fund processing. Lastly, approved requests/grants are sent to the requesting hospitals. Figure 2 summarizes the process flow for the approval of HFEP funding.

Before the memorandum was issued, NCHFD prepares a list of health facilities and asks CHDs to validate whether the list corresponds to the three HFEP criteria on BEmONC/CEmONC, provincial rationalization plan, and PIPH.

**Figure 2.** Process Flow of Approval for HFEP Funding in 2010



\*Figure lifted from DM 2010-0104

### Issues

This DM was released because it has been observed that requests from LGUs and DOH hospitals are addressed directly to the Office of the Health Secretary and other officials from the DOH. This is considered as a “non-preferred route” (route with - - -> in the figure above), which has been the practice despite the priority list that NCHFD has prepared.



The process flow outlined in Figure 2 makes the process more complicated. While the DM was explicit in stating that the preferred route is for LGUs to come up with a resolution and apply through their respective CHDs, allowing them to approach the OSEC directly can make the allocation of funds unfair. According to interviews, what happens in a typical “non-preferred” route is OSEC/NCHFD receive a call from the Congress asking them to allocate funds in their preferred localities. Thus, despite the presence of a criteria that serves as a basis for the allocation list, most of the time, this list gets set-aside to accommodate the requests of the Congress.

## VII. Budget Allocation

*Criteria for Selecting Facilities.* The CHDs are provided with criteria for rating the requests to ensure objectivity and fairness in assessing the requests. There are three main criteria – LGU Priority, CHD Review, and Plus Factor. Under each criterion, specific conditions with equivalent points each have to be met for approval of request. For the LGU Priority, a maximum of ten (10) points can be given if the LGU has allocated MOOE budget and Human Resources for the project; another ten points if there are LGU counterpart funds and; 15 points upon evaluating how responsive it is to the health situation status.

For CHD review, a maximum of 15 points can be given if it is within approved PIPH/AOP framework of the LGU. If it complies with the Certificate of Need (CON) and/or B/CEmONC standards/requirements, a maximum of ten points can be given and; another ten points if it is deemed “rational” by the CHD even if without Rationalization Plan (RatPlan) or not complying with RatPlan.

The Plus Factors requires that the request should have more than 85% LGU Indigent Program (IP) enrolment. The highest score for this condition is ten points. If there is a good track record in submitting reports/Fund Utilization Reports (FUR), a maximum of ten points can also be given and; another ten points if good financial management is in place.

Out of a possible 100 points, the total scores corresponding to each request shall be used by the ExeCom in deciding on the approval of requests. This criteria is summarized in the table below.

**Table 3. HFEP Criteria**

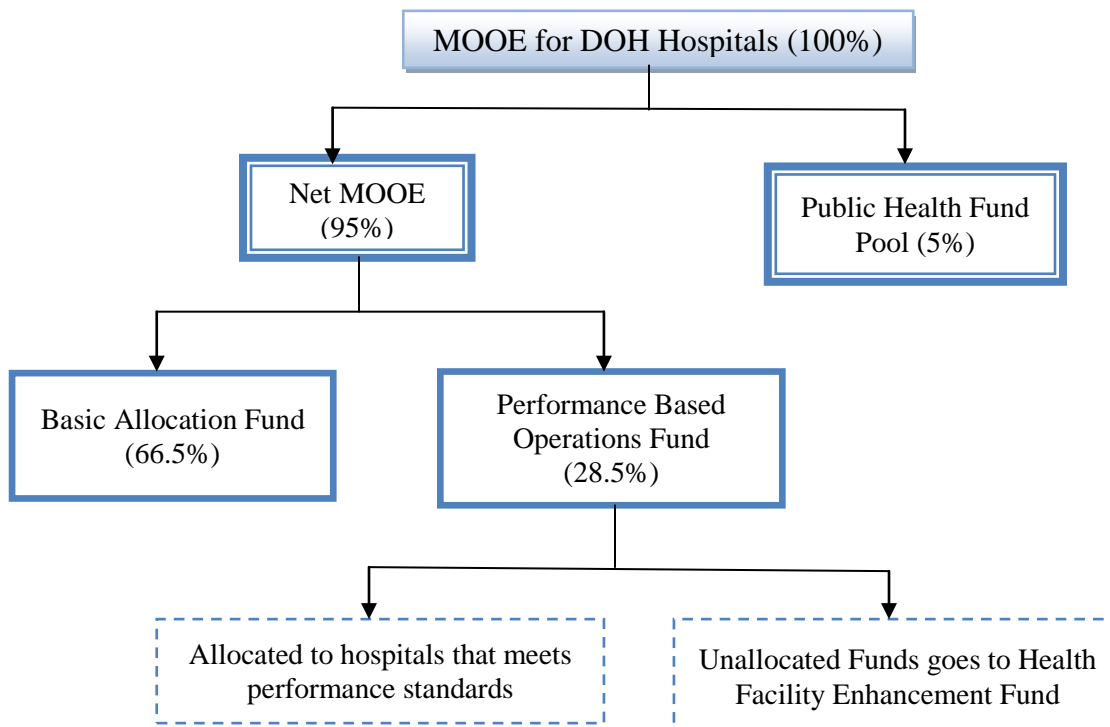
CRITERIA	DESCRIPTION	POINTS
LGU Priority	- LGU has allocated MOOE budget and Human Resources for the project	10
	- LGU counterpart funds	10
	- Responsive to health status situation	15
CHD Review	- Within approved PIPH/AOP framework of the LGU	15
	- Complying with the Certificate of Need (CON) and/or BEmONC/CEmONC standards/requirements	10
	- Deemed “rational” by the CHD if without RatPlan or not complying with the RatPlan	10
Plus Factor	- >85% LGU IP enrollment	10
	- Good track record in submitting reports/FUR	10
	- Good financial management in place	10
<b>TOTAL</b>		<b>100</b>

Source: DM 2010-0104

*Defining "Need."* Since 2006, DOH has embarked on major efforts in making sure that its funds are allocated efficiently and equitably. For the efficient allocation of funding for public health, Administrative Order (AO) no. 2006-0022 entitled "Guidelines for Establishment of Performance-Based Budget for Public Health" was passed. This AO aims to progressively allocate commodities for priority public health programs and to link budget subsidies of DOH offices to specific outputs and outcomes for targeted reforms in the public health programs. The AO lists down the guidelines for identifying the priority public health programs on the basis of burden of disease, equity, economic efficiency and cost effectiveness, and prioritizing health target diseases with the greater impact. For the progressive allocation of public health commodities, indicators such as population in need or at risk, and regional poverty indicators are used.

A separate AO was released on the guidelines for Performance-Based Budget (PBB) for DOH Hospitals (AO 2006-0027). PBB refers to the process by which DOH splits funding for the hospital MOOE into several portions, the releases of which will be based on hospital performance relative to pre-agreed performance measures (Figure 3). With this system, a hospital's budgetary allocation is linked to performance, therefore reducing the hospitals' dependence on subsidies and enhancing its internal funds generation. The AO stipulates that 70% of the MOOE for all hospitals will be provided to cover for overhead costs, but the remaining 30% will be given based on identified performance benchmarks. In case a hospital is not able to meet the target, the fund will be transferred to the Health Facilities Enhancement Fund which will be available on a competitive basis to hospitals which submitted proposals for infrastructure enhancement of upgrading.

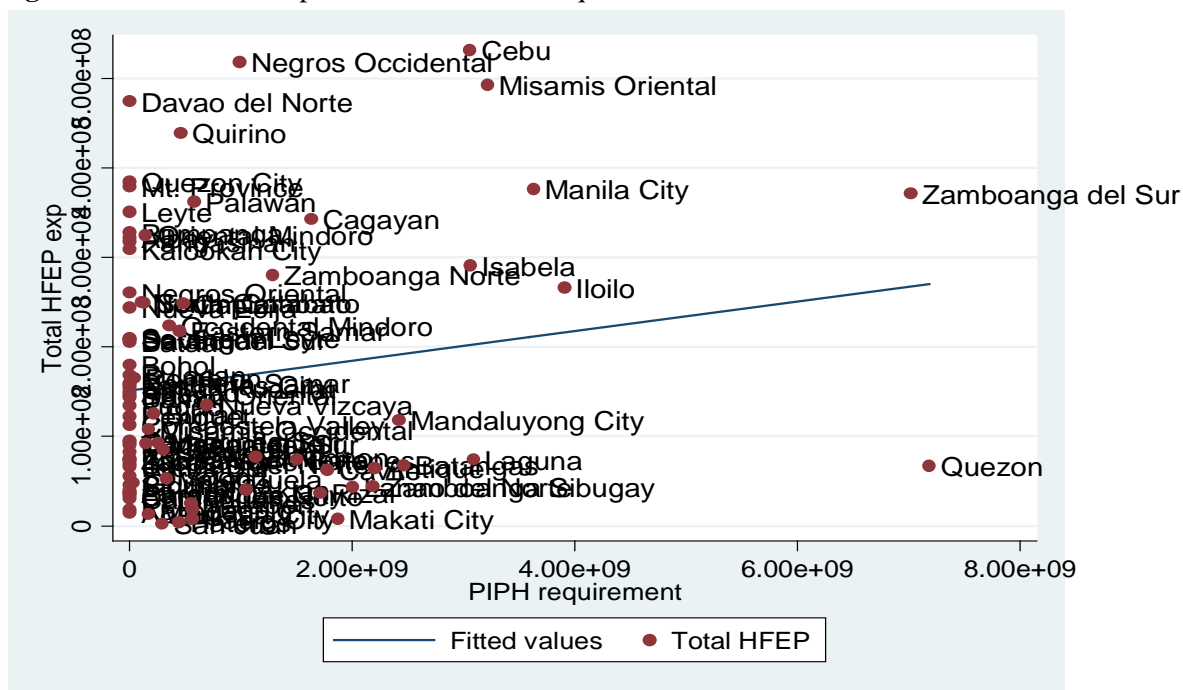
**Figure 3.** Performance Based Budgeting of Hospitals







**Figure 6.** Total HFEP Expenditure and PIPH Requirement



Correlation:  $R=0.1692$ ;  $p\text{-value}=0.1151$  (not significantly correlated)

Annex 1 and 2 presents a disaggregation of HFEP funds by fund source: GAA, FHO for BEMoNC/CEMoNC, Katas ng VAT, Congress and Senate Initiatives. The same trend remains that there are no correlations between HFEP funds allocated per province to PIPH requirement, poverty incidence, and population per capita. The highest recipient of HFEP from GAA appears to be Cebu, however, it was Quezon Province and Zamboanga del Sur with highest PIPH requirements. Batanes and Quirino received higher HFEP funds from GAA despite their relatively low poverty incidence compared to other regions. There was a significant negative correlation between population and HFEP allocation per capita. However, the relationship runs counter to expectations—the more populous the province is, the less allocation it receives from HFEP GAA funds.

The same trend of no correlation is observed for allocation of funds for BEMoNC and CEMoNC facilities. The provinces which were able to receive the highest allocations were Davao del Sur, Davao Oriental, Davao del Norte, Occidental Mindoro, Compostela Valley, Romblon, and Oriental Mindoro. On the other hand, Katas ng VAT benefitted the following provinces: Camiguin, Ifugao, Mt. Province, Guimaras, and Albay.

Senate initiatives were partial to only a handful of provinces, namely, Zamboanga del Sur, Batangas, Nueva Ecija, Negros Oriental, Camiguin, Ilocos Norte, and Oriental Mindoro. Despite non-submission of PIPH estimates which is one of the criteria in the HFEP guidelines, the provinces of Camiguin, Ilocos Norte, and Oriental Mindoro were allocated good sums of funds from Senate Initiatives.

Similarly, Congressional funds only benefitted five provinces—Manila City, Quirino, Catanduanes, Albay, and Ilocos Sur. It should again be noted that Albay and Ilocos Sur did not submit PIPH to DOH.

## *Discussion*

In this study's review of AOs, DOs, and DMs issued by DOH, it appears that there was no reference made by HFEP guidelines to the AOs issued by DOH on defining need and rationalization of health facilities. For instance, it was not evident what the link of HFEP is to the Health Facilities Enhancement Fund mentioned in the performance-based budgeting AO on hospitals. Also, while AO 2006-0029 clearly outlines what the definition of need should be, the DM issued on the criteria and process flow does not appear to be consistent with the definition of need in the AO.

Based on interviews conducted, the funding priority for 2007 and 2008 were Levels 1 and 2 hospitals to serve as base hospital for nursing students. This was following the pronouncement of the previous administration that the government will provide training hospitals for nursing students. For 2009, BHS and RHUs were included in the priority to decongest DOH tertiary hospitals. Levels 1 and 2 hospitals that were identified for BeMONC conversion were prioritized for regions with high maternal mortality rates. It should be noted that it was only in 2010 that allocations were based on clear criteria specified in administrative orders (AO 2009-0022 and AO 2010-0006).

As such, it is no surprise that when allocations from 2007 to 2010 were plotted with PIPH, poverty incidence, and equity, there seems to be no structured allocating mechanism for HFEP. While this is true for all funding sources, the gap is greater for HFEP funds that were funded by congressional and senate initiatives that appear to benefit only a handful of provinces. Since the goal of the HFEP from 2007-2010 was to reduce maternal mortality, identification of facilities for funding was geared towards reduction of travel time to health facilities, which might not equate with the poverty incidence in the provinces. According to DOH, the plan for 2011-2012 is to saturate all the upgrading needs for BEmONC and CEmONC, and 2013 onwards will focus on upgrading Levels 3 and 4 hospitals where poverty incidence and other socio-economic indicators will be considered in identifying priority facilities.

## **VIII. Budget Execution**

*Fund Releases.* In the normal course of fund release, after the GAA is ratified, DBM issues a SARO that will authorize the release of funds for HFEP. DOH then issues a Department Order that provides an outline as to how the fund will be utilized. The DO will go through different bureaus in DOH because it has to be signed by various authorities, including the Secretary of Health. After this, the finance office will issue sub-allotment orders to CHDs and hospitals. They can start entering into contracts with suppliers when they receive their SAAs.

It takes an average of 200-310 days from the date the GAA was signed to the release of SAA (Table 4). Fund release was longest in 2009 with 310 days and it has improved in 2010 with 200 days. In 2008, HFEP budget that came from the GAA line item budget was released within the year. Delays were mostly found on funds sourced from congress and senate initiative. The main source of delay is mostly from the time the GAA was passed to the time DBM issued a SARO, which, in 2008 took as long as 400 days in issuing the SARO for a Senate funded initiative.

The GAA was passed in March for 2008-2009 and in February in 2010. When cases like this happen, the common practice is to base the appropriation for the first quarter to the previous year's. Thus even if the GAA was not yet enacted, there will be funds that can be used by the department. This is the reason

why there were cases when the DO was issued before the SARO. On average, the DO was issued 5 days earlier in 2008, 133 days earlier in 2009, and 44 days earlier in 2010.

The time it took the finance office to issue SAAs ranges from 36 days in 2008 to 192 days in 2009. Details of the specific batches with their specific dates of issuances are presented in Annex 3.

**Table 4. Average Number of Days of Release of Funds**

	GAA to SAA	GAA to SARO	SARO to DO	DO to SAA
<b>2008</b>	<b>281</b>	<b>251</b>	<b>(5)</b>	<b>36</b>
GAA	170	181	(20)	10
Congressional Initiatives	283	248	(27)	62
Senate Initiatives	400	342	8	50
Katas ng VAT	270	232	18	21
<b>2009</b>	<b>310</b>	<b>246</b>	<b>(133)</b>	<b>192</b>
GAA	310	246	(133)	192
<b>2010</b>	<b>200</b>	<b>187</b>	<b>(44)</b>	<b>57</b>
GAA	200	187	(44)	57

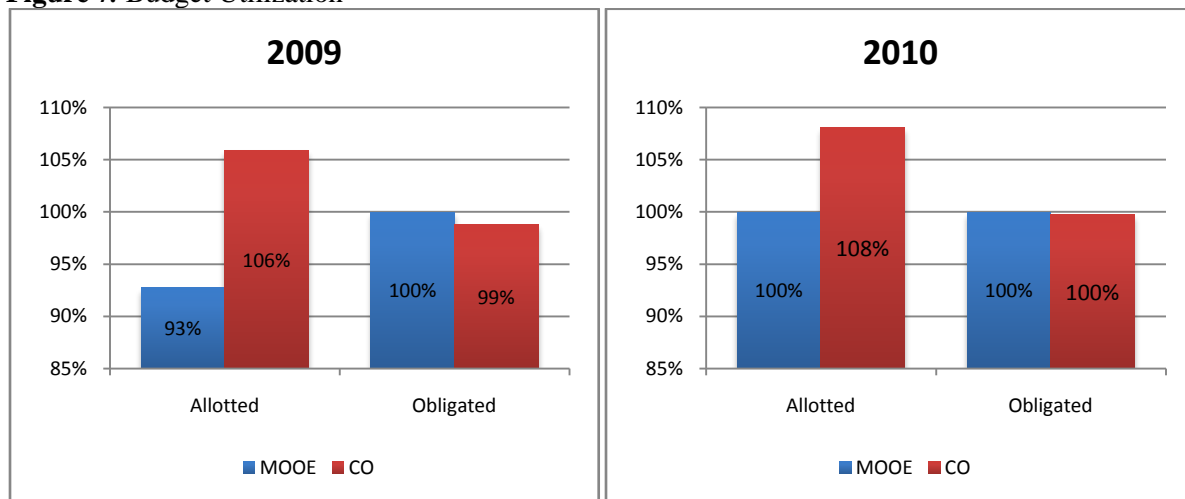
*Fund Utilization.* On the whole, the HFEP showed high utilization rates for years 2009-2010. Table 5 shows that actual allotment available is greater than the amount appropriated and a 99%-100% utilization rate for actual obligations is observed. Disaggregating by expense class, utilization rate for allotted MOOE in 2009 is only at 93%, and that utilization rate for allotted CO for 2009 and 2010 exceeded 100%. Of the total allotment released, all showed 100% utilization rates, except for CO in 2009, at 99%.

**Table 5 HFEP Appropriations, Allotments, and Obligations**

	Appropriations			Allotment Released			Actual Obligations		
	MOOE	CO	Total	MOOE	CO	Total	MOOE	CO	Total
2009	27,522,000	2,045,726,000	2,073,248,000	25,522,000	2,166,175,000	2,191,697,000	25,522,000	2,141,175,000	2,166,697,000
2010	27,522,000	3,224,173,000	3,251,695,000	27,522,000	3,485,773,000	3,513,295,000	27,522,000	3,477,733,591	3,505,255,591

Source: General Appropriations Act (GAA) and Status of Appropriations, Allotments and Obligations (SAAOB), Department of Budget and Management

**Figure 7. Budget Utilization**



\*\*% Allotted is derived by dividing Allotment Released by Appropriations; % Obligated is derived by dividing Actual Obligations by Allotment Released.

### Issues

There were many instances where the DOs were issued way before the SAROs were released. It is important that DOH-CO has a SARO on hand since it could not predict how much will be issued by DBM in one Batch. Should the guideline contains amounts higher than the SARO, this could pose a problem. A particular example cited was the case when DOH has to realign its savings from other Bureaus to HFEP because one province already entered into a contract even when the SARO was not issued. To resolve this, NCHFD resorted to realigning funds from DOH-CO.

During the period covered by the study, the bidding and awarding of contract is done by each and every LGU who received the HFEP funds. The NCHFD saw some inefficiencies in this process and is currently revising their guidelines to conduct bulk bidding and procurement at the CHD level.

Utilization rates appear to be high but it should be noted that this stops at the level of the central office giving sub-allotment to CHDs/hospitals. Monitoring of obligation of HFEP funds at the LGU level was a responsibility of the CHDs. Thus, unless the CHD submits its financial report, the Central Office will not know the fund utilization of HFEP. What the Central Office monitors, through the Infrastructure Division of NCHFD, are physical accomplishment report of each facility on reported percentage completion (for infrastructure project) and procurement/delivery status (for equipment).

## IX. Monitoring and Control

As part of HFEP Monitoring and Reporting, CHDs are in charge of conducting regular monitoring of Hospital Upgrading Projects for both DOH and LGU hospitals as well as other health facilities. CHDs are also tasked to submit Quarterly Status Reports of physical and financial accomplishment to the FIMO and providing a copy of which to the NCHFD. Once consolidated, the DOH, through the NCHFD, submits these Quarterly Status Reports to the Presidential Management Staff, the National Economic



Development Authority and other requesting agencies. Sub-allotment Utilization Reports are also submitted by the CHD to the Finance Service.

As mentioned earlier, the Infrastructure Division of NCHFD collects information on percentage completion of infrastructure projects and procurement/delivery status of equipments funded by HFEP. Using this data as proxy for fund utilization, Table 6 shows that a total of 63% of obligated funds in 2009 should have been utilized as of June 2011. Table 7 shows that for HFEP projects in 2010, 6% of the obligated funds are under pre-procurement, 36% are currently undergoing procurement, 34% are currently being delivered equipments and infrastructure projects that are being implemented, while 12% are delivered equipments and completed infrastructure projects. A problem with using this data as proxy is 27% of obligated funds in 2009 and 13% for 2010 are unaccounted for since there appears to be no status report for these projects.

**Table 6.** Physical Accomplishment Report, 2009

2009	Amount	PERCENT OF OBLIGATIONS
Completed Infra	889,802,000	41.07%
Delivered Equipment	481,895,000	22.24%
On-going Construction	195,170,000	9.01%
On-going Delivery		
TOTAL AMOUNT ACCOUNTED IN PHYSICAL ACCOMPLISHMENT REPORT	1,566,867,000	
ACTUAL OBLIGATIONS	2,166,697,000	

**Table 7.** Physical Accomplishment Report, 2010

2010	AMOUNT	PERCENT OF OBLIGATIONS
A. PRE - PROCUREMENT		6.21%
Infrastructure	177,590,000	
Equipment	40,013,000	
B. PROCUREMENT		35.68%
Infrastructure	789,538,875	
Equipment	461,168,875	
C. IMPLEMENTATION/DELIVERY		33.56%
Infrastructure	886,033,500	
Equipment	290,371,250	
D. COMPLETED		11.74%
Infrastructure	136,585,000	
Equipment	275,101,500	
TOTAL AMOUNT ACCOUNTED FOR IN PHYSICAL ACCOMPLISHMENT	3,056,402,000	
ACTUAL OBLIGATIONS	3,505,255,591	

Source: Infrastructure Division, NCHFD.

### Discussion

The monitoring and reporting system for HFEP appears to be unclear. There is a need to monitor the hospitals and health facilities upgraded in each province for effective allocation of funds. As of June 2011, DOH has given the task of conducting quarterly monitoring to the ExeCom and regional office.

Since one of the bottlenecks in monitoring has been lack of personnel, DOH has allocated some funds to hire more engineers and architects who will monitor facilities and equipment in HFEP. DOH representatives or provincial health teams will also be deployed by CHDs to assist in HFEP monitoring.

Other efforts being finalized is the use of web-based tracking system where information will be uploaded by LGU/CHD engineers so that the Central Office will receive a real time update on HFEP. This effort will be spearheaded by IMS with inputs from the CHDs.

While efforts to use the internet to have a real-time update is laudable, past experience has shown that even when online programs for monitoring and evaluation were developed, it has rarely been used due to problems in interconnectivity and difficulties encountered by CHDs/LGUs in using the program. Rather than developing a new monitoring tool, a more cost-efficient alternative that could be considered is to create a module in the Expenditure Tracking System currently being rolled-out by the Planning Division of Health Policy Development and Planning Bureau (HPDPB). This alternative will also make sure that the physical update will be tied with HFEP fund release updates.

One of the main problems that surfaced is unclear definition of roles of Infrastructure Division of NCHFD, CHDs, and FIMO in monitoring of HFEP projects in 2007-2010. DOH is currently coming up with a Department Order that will explicitly define their roles. DOH has also made HFEP implementation a priority by assigning an overall national HFEP coordinator in the Health Services Delivery Cluster.

## X. The Way Forward

### Recommendations

The results of the study suggest:

- *A clearer policy on allocation of HFEP funds needs to be drafted.* The department memorandum on HFEP allocation should be made consistent with the DOH reform agenda of rationalizing health facilities based on health needs. A good program to emulate will be allocation method of the MNCHN program (Annex 4).
- *A need for securing a sustained funding source for HFEP.* Improvements in health facilities are critical in the implementation of the Aquino Health Agenda. Allocation of some HFEP funds in the past appears to have been influenced by requests from some politicians during budget deliberations. According to interviews, these requests were mostly accommodated to ensure funding for the program in the future. Moreover, presence of other fund source, particularly congress and senate initiatives, divert the resources away from provinces who might need upgrading of facilities most. It may be more equitable if reliance on funding the project from such initiatives will be minimized and the source of fund for HFEP be guaranteed from its line item budget in the GAA. Also, one way of assuring that funds get allocated to facilities that are in pipeline for upgrading is to explicitly write the facilities as line item under HFEP in the GAA, especially for higher level facilities that will require substantial budgets.
- *A need for establishing a monitoring and evaluation plan for HFEP.* The monitoring system from 2007-2010 has unclear assignment of responsibilities as to who monitors fund utilization of HFEP. The recent initiative of DOH in issuing a Department Order that will clearly define the delineation of roles of different agents involved in HFEP is a step in the right direction. Existing budget utilization tracking systems such as the Expenditure Tracking System should also be utilized by the monitoring and evaluation group in ensuring that the policy makers in the Central Office receives real-time information on fund utilization and physical accomplishment of HFEP recipients.

## References

### List of Department Orders on Guidelines on the Utilization of Funds for Health Facilities under the Health Facility Enhancement Program (HFEP)

DEPARTMENT ORDER No.	SUBJECT
2008- 0037	Guidelines for the sub-allotment and utilization of funds to East Avenue Medical Center under CY 2008 Health Facilities Enhancement Program Funds for government hospital upgrading (Presidential Priority Project).
2008- 0038	Guidelines for the sub- allotment and utilization of funds to East Avenue Medical center under CY 2008 Health Facilities Enhancement Program Funds for government hospital upgrading (Presidential Priority Project).
2010- 0046	Guidelines for the fund transfer and utilization of funds to Lung Center of the Philippines, under CY 2010 Health Facilities Enhancement Program.
2010- 0045	Guidelines for the sub-allotment and utilization of funds to DOH hospitals under CY 2010 Health Facilities Enhancement Program.
2010- 0044	Guidelines for the sub-allotment and utilization of funds to DOH hospitals under CY 2010 Health Facilities Enhancement Program.
2010- 0041	Guidelines for the release and utilization of the sub- allotment to Davao Medical Center under the CY 2009 Health Facilities Enhancement Program Funds per SARO No. BMB-B- 09-0011461 dated September 18, 2009.
2010- 0023	Guidelines for the sub-allotment and utilization of funds to DOH hospitals under CY 2010 Health Facilities Enhancement Program Funds.
2009- 0314	Guidelines for the release and utilization of the sub- allotment/ fun transfers of CY 2009 Health Facilities Enhancement Program Funds (Senate Initiative) pursuant to the Department Order No. 2009- 0092 dated February 6, 2009 for SARO No. B- 09- 0018078 dated November 17, 2009.
2009- 0276	Guidelines for the release and utilization of the sub-allotment to Vicente Sotto Memorial Medical Center under the CY 2009 Health Facilities Enhancement Program Funds per SARO No. BMB-B- 09- 0005699 dated July 3, 2009.
2009-0260	Guidelines for the release and utilization of the sub- allotment/ fund transfers of CY 2009 Health Facilities Enhancement Program Funds pursuant to the Department Order No. 2009- 0092 dated February 6, 2009 for SARO No. B-09-0009110 dated August 12, 2009.
2009- 0249	Guidelines for the release and utilization of the sub- allotment/ fund transfers of CY 2009 Health Facilities Enhancement Program Funds pursuant to the Department Order no. 2009- 0092 dated February 6, 2009 for SARO No. B- 09- 0009482 dated August 24, 2009.
2009- 0238	Guidelines for the release and utilization of the sub- allotment/fund transfers of CY 2009 Health Facilities Enhancement Program Funds pursuant to the Department Order No. 2009- 0092 dated February 6, 2009 for SARO No. B- 09-0010953 dated September 15, 2009.
2009- 0154	Guidelines for the sub- allotment and utilization of funds to the four (4) DOH hospitals as regional heart-lung- kidney centers under CY 2008 Health Facilities Enhancement Program.
2009- 0142	Guidelines for the sub- allotment and utilization of the CY 2008 realigned funds from family health including family planning to Health Facilities Enhancement Program for the implementation of BEmONC and CEmONC activities.
2009-0092- U	Amendment to Department Order No. 2009- 0092H dated August 14, 2009 on the guidelines for the release and utilization of the sub- allotment of CY 2009 Health Facilities Enhancement Program Funds.
2009- 0092- T	Amendment to Department Order No. 2009-0092H dated August 14, 2009 on the guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2009 Health Facilities Enhancement Program Funds.
2009-0092- S	Amendment to Department Order No. 2009- 0092D dated May 22, 2009 on the guidelines for the release and utilization of the sub- allotment of CY 2009 Health Facilities Enhancement Program Funds for CHD eastern Visayas per approved SARO No. B- 10- 05760 dated July 16, 2010.
2009- 0092- Q	Amendment to Department Order No. 0092- H dated August 14, 2009 on the guidelines for the release and utilization of the sub- allotment of CY 2009 Health Facilities Enhancement Program Funds for CHD Central Luzon per approved SARO No. B- 10- 03331 dated March 1, 2010.
2009- 0092- P	Amendment to Department Order No. 0092- H dated August 14, 2009 on the guidelines for the release

	and utilization of the sub- allotment of CY 2009 Health Facilities Enhancement Program Funds for CHD Cordillera and CHD Central Luzon per approved SARO No. B- 10- 04951 dated April 26, 2010.
2009- 0092- H	Addendum to the Department Order No. 2009- 0092 dated February 6, 2009 on the guidelines for the release and utilization of the sub- allotment/ fund transfers of CY 2009 Health Facilities Enhancement Program Funds per SARO No. BMB- B- 09- 0002757 dated June 8, 2009 and BMB- B- 09- 0004309 dated June 19, 2009.
2009- 0092- G	Addendum to the Department Order no. 2009- 0092 dated February 6, 2009 on the guidelines for the release and utilization of the sub- allotment/ fund transfers of CY 2009 Health Facilities Enhancement Program Funds per SARO No. BMB- B- 09- 0006474.
2009- 0092- E	Amendment to Department Order No. 0092- D dated May 22, 2009 on the guidelines for the release and utilization of the sub- allotment/ fund transfers of CY 2009 Health Facilities Enhancement Program Funds.
2009- 0092- D	Addendum to the Department Order No. 0092 dated February 6, 2009 on the guidelines for the release and utilization of the sub- allotment/ fund transfers of CY 2009 Health Facilities Enhancement Program Funds per SARO No. B- 09- 0001192.
2009- 0092- C	Addendum to the Department Order No. 0092 dated February 6, 2009 on the guidelines for the release and utilization of the sub- allotment/ fund transfers of CY 2009 Health Facilities Enhancement Program Funds per SARO No. B- 09- 0001015.
2009- 0092- B	Amendment to Department Order No. 0092- A dated April 30, 2009 on the guidelines for the release and utilization of the sub- allotment/ fund transfers of CY 2009 Health Facilities Enhancement Program Funds.
2009- 0092- A	Addendum to the Department Order No. 0092 dated February 6, 2009 on the guidelines for the release and utilization of the sub- allotment/ fund transfers of CY 2009 Health Facilities Enhancement Program Funds.
2009- 0065	Guidelines for the sub- allotment and utilization of the CY 2008 Health Facilities Enhancement Program Funds (Senate Initiatives) for Hospital Upgrading.
2008- 0267	Guidelines for the sub- allotment and utilization of funds to Valenzuela Medical Center under CY 2008 Health Facilities Enhancement Program Funds for government hospital upgrading.
2008- 0215	Guidelines for the sub- allotment and utilization of the CY 2008 Health Facilities Enhancement Program Funds for local government hospital upgrading (CHD NCR, 2, 4-B, 5, 6, 10 and 12).
2008- 0209	Guidelines for the sub- allotment and utilization of the CY 2008 Health Facilities Enhancement Program Funds for Iloilo Provincial Hospital and Gov. William Health Facilities Enhancement Program Funds Villegas Memorial Hospital for hospital upgrading.
2008- 0207	Guidelines for the sub- allotment and utilization of the CY 2008 Health Facilities Enhancement Program Funds for local government hospital upgrading (CHD 2, 4-B, 5, 8, 9, 10, 11, 12 and CARAGA).
2008- 0206	Guidelines for the sub- allotment and utilization of the CY 2008 Health Facilities Enhancement Program Funds for local government hospital upgrading (CHD NCR, 1, 3, 4-A, 6, 7 and 10).
2008- 0205	Guidelines for the sub- allotment and utilization of funds to East Avenue Medical Center and Philippine Orthopedic Center under CY 2008 Health Facilities Enhancement Program Funds for government hospital upgrading.
2008- 0112	Guidelines for the sub- allotment and utilization of the CY 2008 Health Facilities Enhancement Program Funds for local government hospital upgrading.
2008- 0184	Guidelines for the sub- allotment and utilization of the CY 2008 Health Facilities Enhancement Program Funds for DOH/ LGU Hospital upgrading.
2008-0185	Guidelines for the sub- allotment and utilization of the CY 2008 Health Facilities Enhancement Program Funds for local government hospital upgrading.
2008- 0186	Guidelines for the sub- allotment and utilization of the CY 2008 Health Facilities Enhancement Program Funds for DOH hospital upgrading.
2010- 0205	Guidelines for the sub- allotment and utilization of funds to East Avenue Medical Center and Philippine Orthopedic Center under CY 2008 Health Facilities Enhancement Program Funds for government hospital upgrading.
2010- 0064	Guidelines for the release and utilization of the sub- allotment of CY 2009 Health Facilities Enhancement Program Funds (Continuing Appropriation) pursuant to the Department Order No. 2009- 0092 dated February 6, 2009 for SARO No. B- 10- 03794 dated March 1, 2010.
2010- 0088	Guidelines for the release and utilization of the sub- allotment/ fund transfers of CY 2010 Health Facilities Enhancement Program Funds per SARO No. BMB- B- 10- 0001481 dated March 19, 2010.
2010- 0115	Guidelines for the release and utilization of the sub- allotment of CY 2010 Health Facilities Enhancement

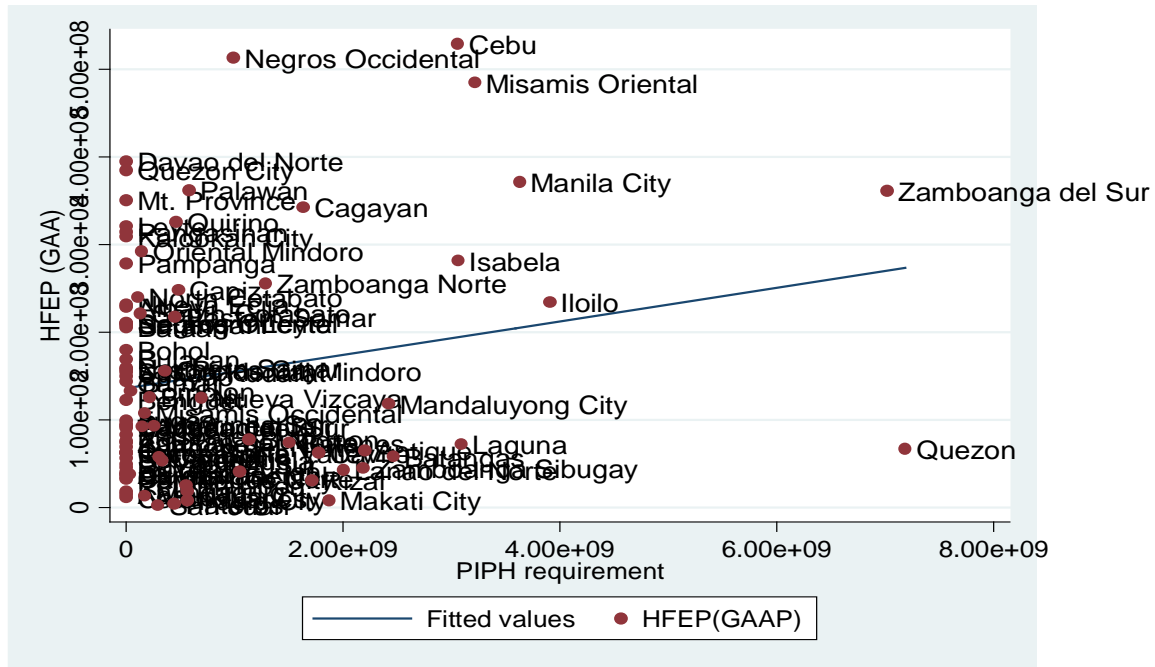
	Program Funds.
2010- 0137	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for MIMAROPA per SARO No. BMB-B- 10- 0004271 dated June 16, 2010.
2010- 0138	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for CARAGA per SARO No. BMB- B- 10- 0004271 dated June 16, 2010.
2010- 0139	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for Cordillera per SARO No. BMB- B- 10- 0004271 dated June 16, 2010.
2010- 0140	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for Cagayan Valley per SARO No. BMB- B- 10- 0004271 dated June 16, 2010.
2010- 0141	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for Ilocos per SARO No. BMB- B- 10- 0004271 dated June 16, 2010.
2010- 0142	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for Northern Mindanao per SARO No. BMB- B- 10- 0004271 dated June 16, 2010.
2010- 0143	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for SOCCSKSARGEN per SARO No. BMB- B- 10- 0004271 dated June 16, 2010.
2010- 0144	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for Eastern Visayas per SARO No. BMB- B- 10- 0004271 dated June 16, 2010.
2010- 0145	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for Central Visayas per SARO No. BMB- B- 10- 0004271 dated June 16, 2010.
2010- 0146	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for Western Visayas per SARO No. BMB- B- 10- 0004271 dated June 16, 2010.
2010- 0147	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for Metro Manila (NCR) per SARO No. BMB- B- 10- 0004271 dated June 16, 2010.
2010- 0148	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for CALABARZON per SARO No. BMB- B- 10- 0004271 dated June 16, 2010.
2010- 0149	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for DOH hospitals/ specialty centers per SARO No. BMB- B- 10- 0004271 dated June 16, 2010.
2010- 0157	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for Central Luzon per SARO No. BMB- B- 10- 0004271 dated June 16, 2010.
2010- 0168	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for DOH Blood Centers per SARO No. BMB- B- 10- 0004271 dated June 16, 2010.
2010- 0181	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for DOH hospital per SARO No. BMB- B- 10- 0004271 dated June 16, 2010.
2010- 0241	Guidelines for the release and utilization of the sub- allotment of CY 2010 Health Facilities Enhancement Program Funds.
2010- 0245	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds per SARO No. BMB- B- 10- 0024466 dated December 3, 2010.

## Annexes

### Annex 1. RELATIONSHIP BETWEEN HFEP ALLOCATION AND SOME KEY INDICATORS, BY FUNDING SOURCE

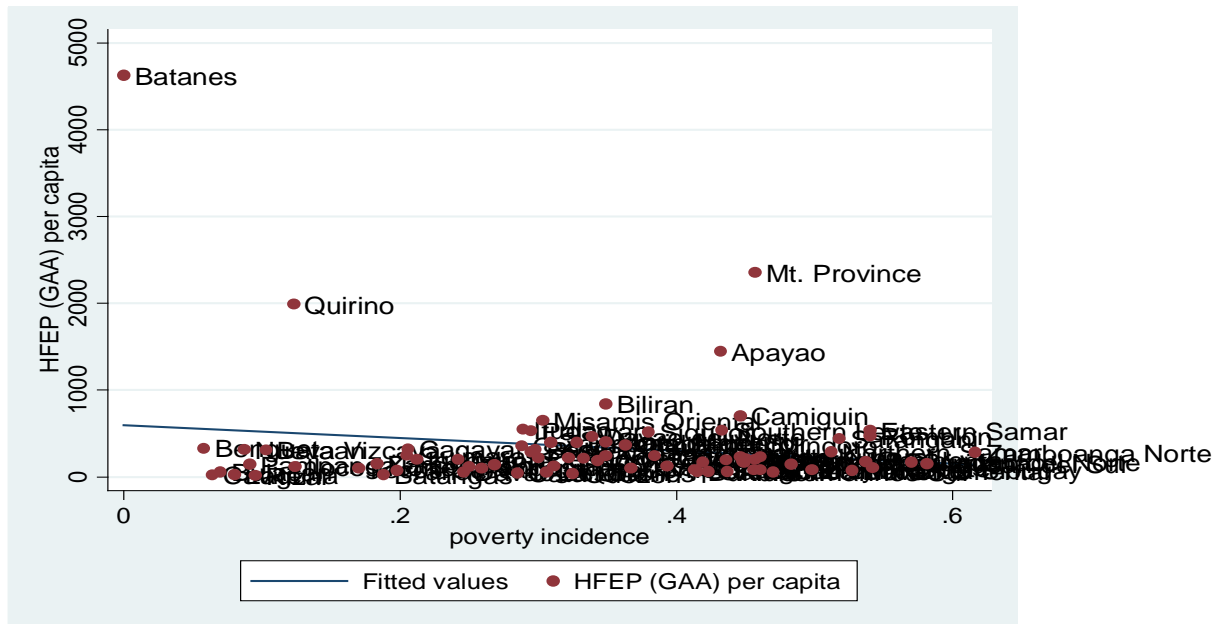
#### FUND SOURCE: HFEP GAA

#### TOTAL HFEP-GAA vs. PIPH



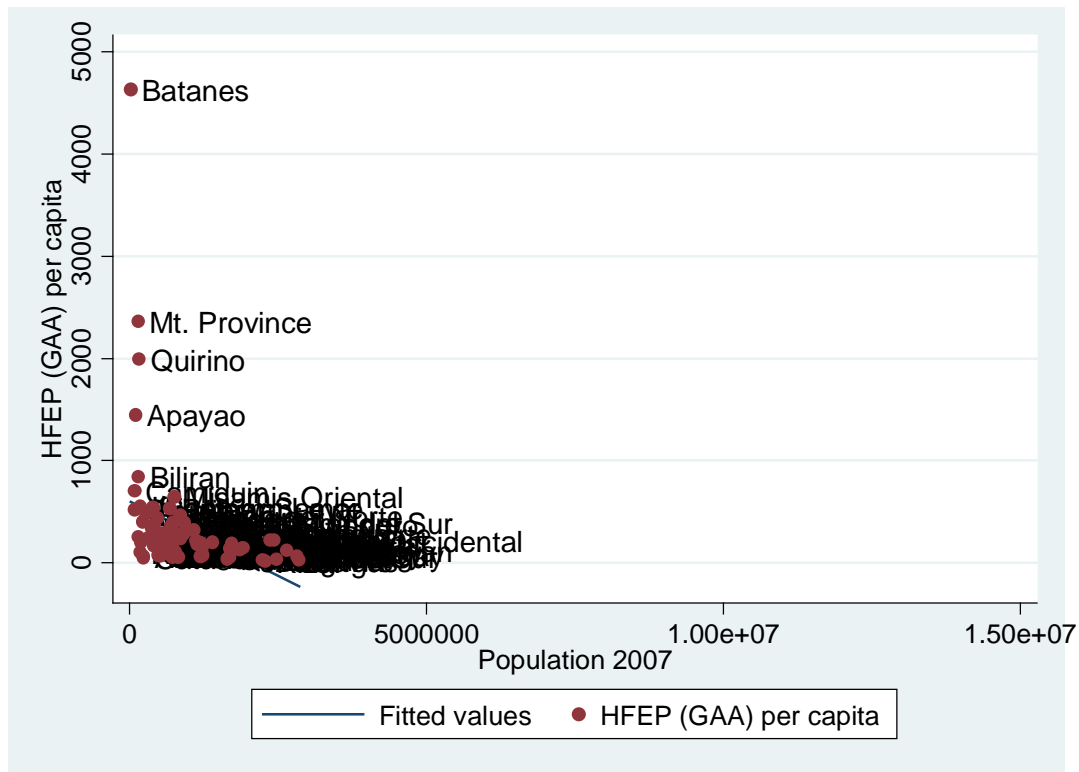
Correlation:  $R = 0.2060$ ;  $p\text{-value} = 0.0541$  (not significantly correlated)

#### HFEP GAA per capita vs. poverty incidence



Correlation:  $R = -0.1747$ ;  $p\text{-value} = 0.1236$  (not significantly correlated)

### HFEP GAA per capita vs. population

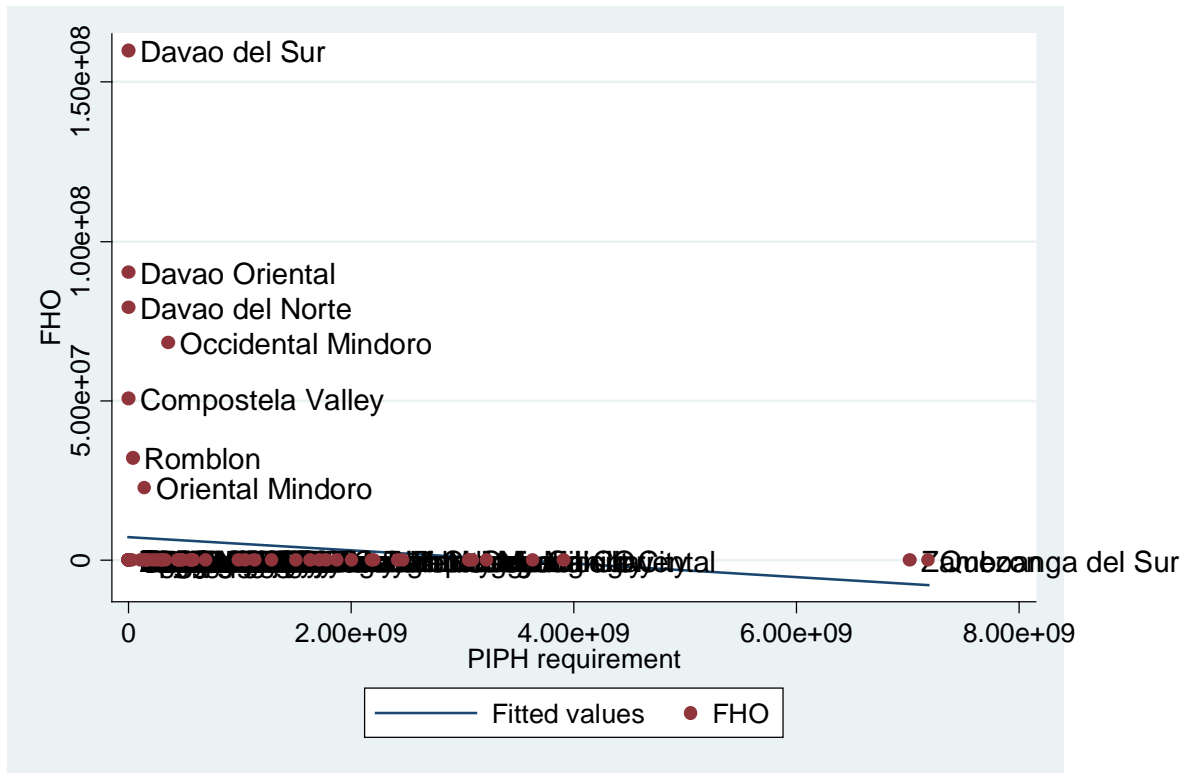


Correlation:  $R = -0.3355$ ;  $p\text{-value} = 0.0025$  (significantly correlated)



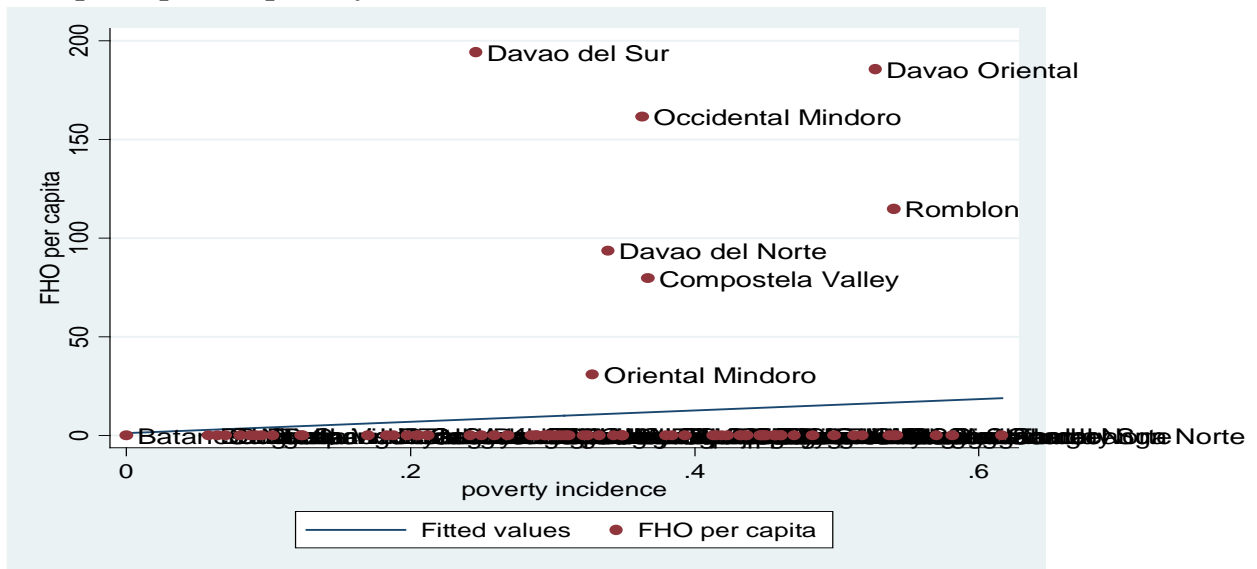
**FUND SOURCE: FAMILY HEALTH OFFICE**

**Total FHO vs. PIPH requirement**



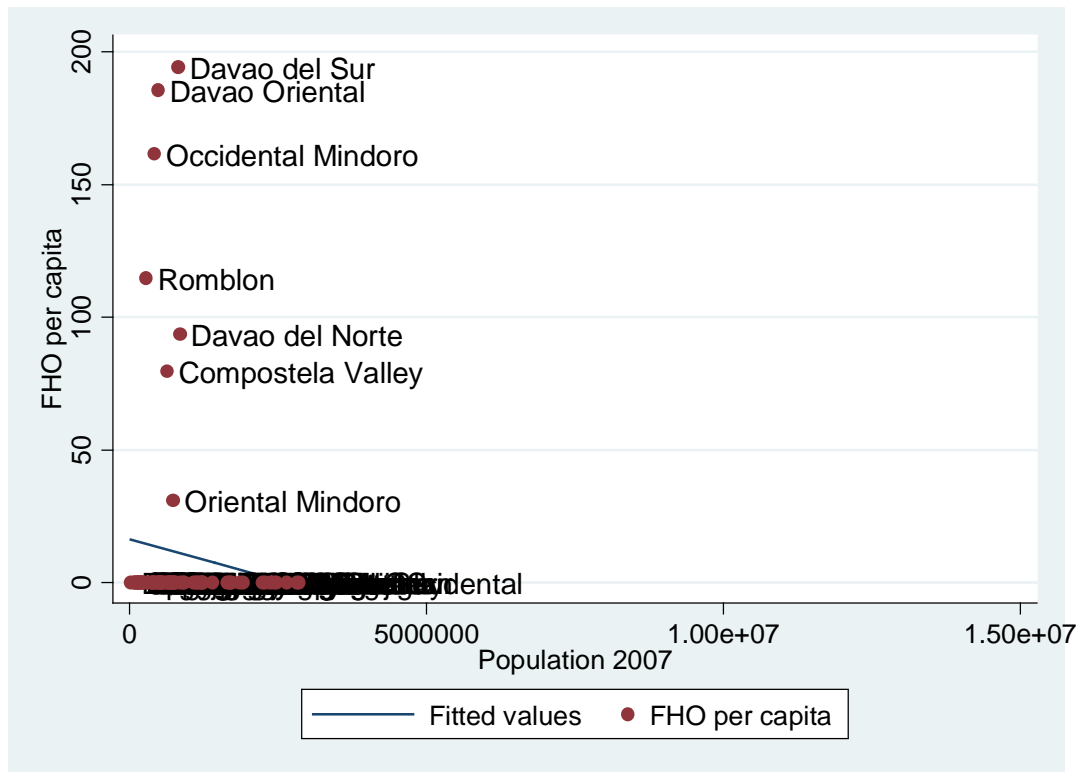
Correlation:  $R = -0.1257$ ;  $p\text{-value} = 0.2433$  (not significantly correlated)

**FHO per capita vs. poverty incidence**



Correlation:  $R = -0.1257$ ;  $p\text{-value} = 0.2433$  (not significantly correlated)

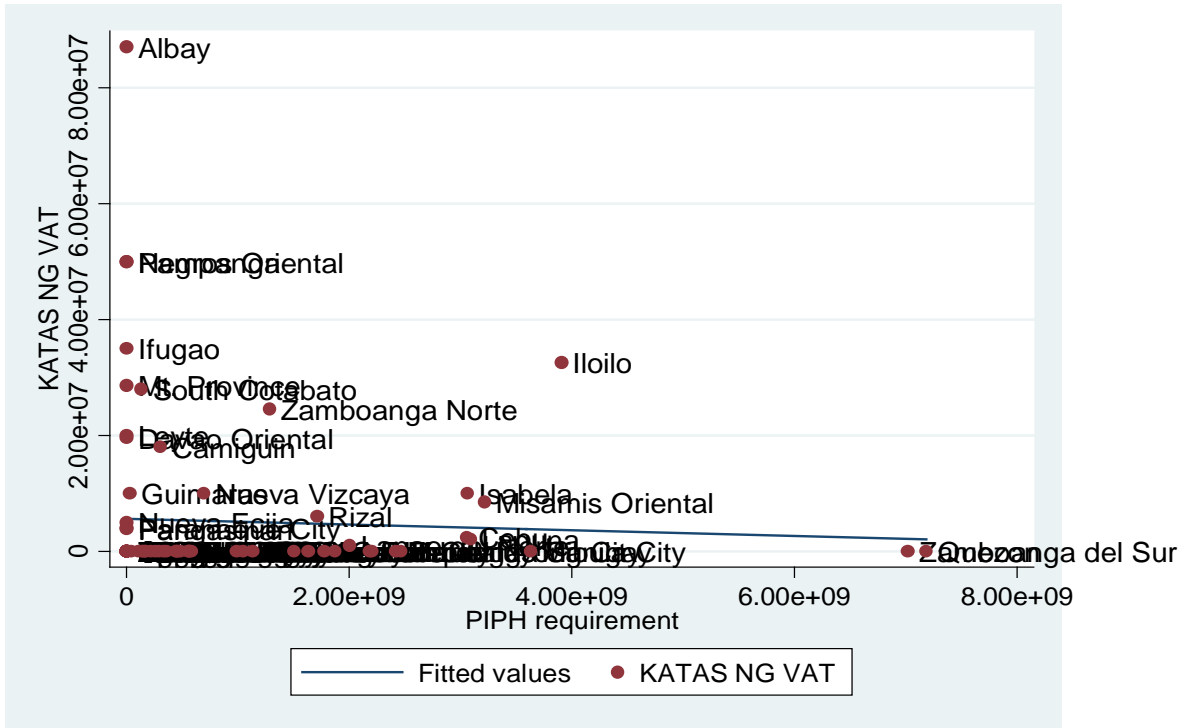
### FHO per capita vs. Population



Correlation:  $R = 0.1077$ ;  $p\text{-value} = 0.3444$  (not significantly correlated)

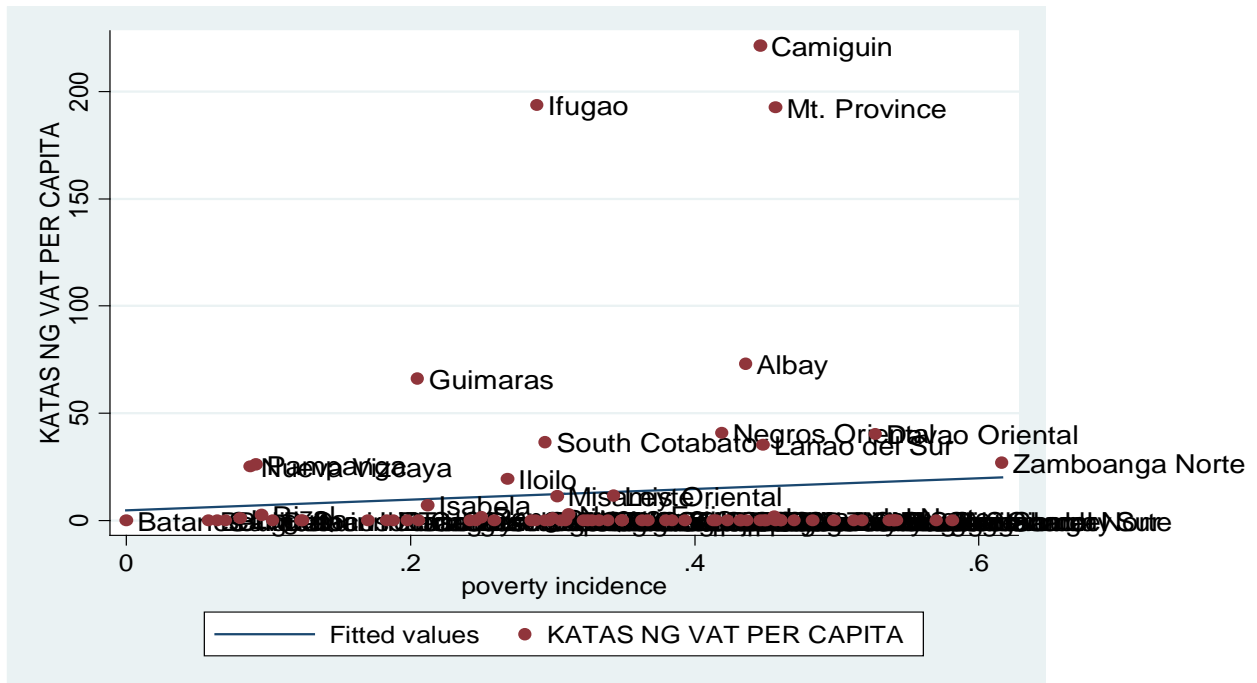
## FUND SOURCE: KATAS NG VAT

### PIPH



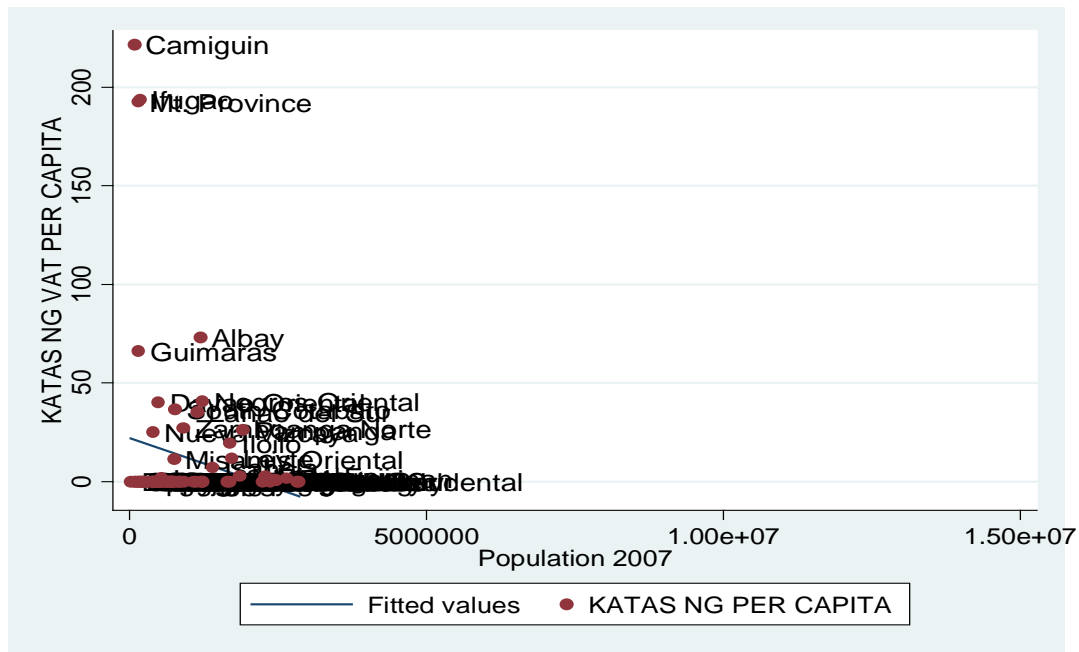
Correlation:  $R = -0.0498$ ;  $p\text{-value} = 0.6448$  (not significantly correlated)

### POVERTY INCIDENCE



Correlation:  $R = 0.0901$ ;  $p\text{-value} = 0.4999$  (not significantly correlated)

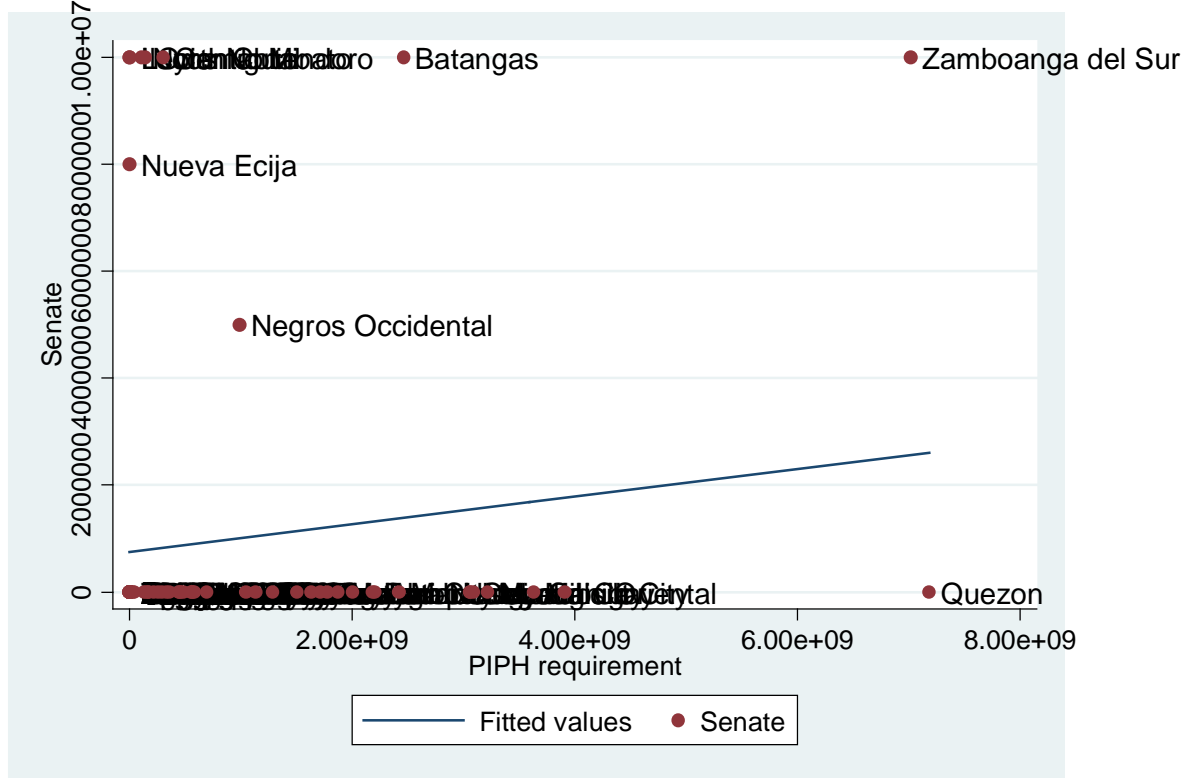
## POPULATION



Correlation:  $R = -0.1811$ ;  $p\text{-value} = 0.1103$  (not significantly correlated)

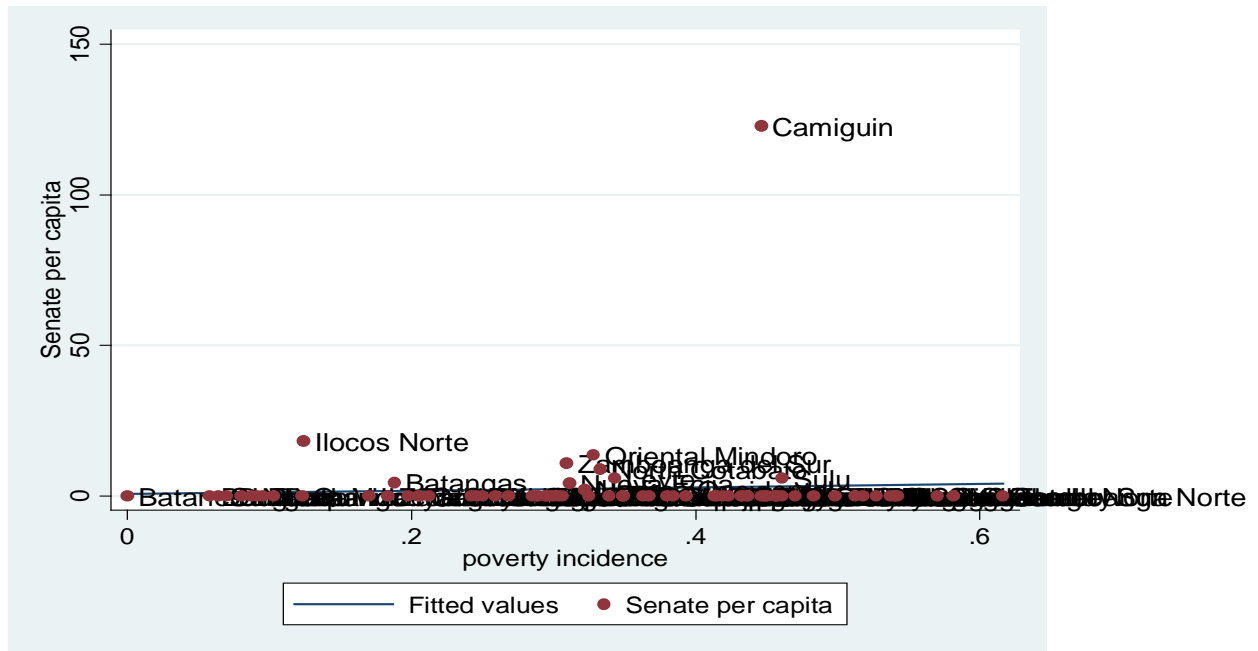
## FUND SOURCE: SENATE INITIATIVE

PIPH



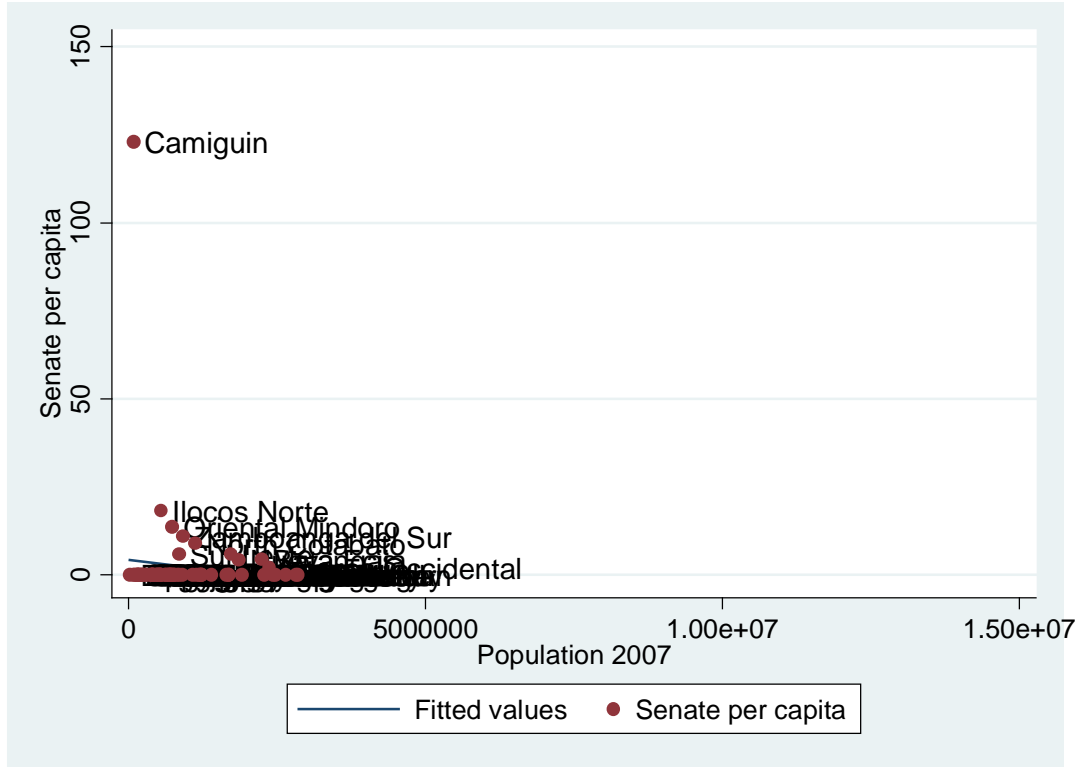
Correlation:  $R = 0.1255$ ;  $p\text{-value} = 0.2440$  (not significantly correlated)

## POVERTY INCIDENCE



Correlation:  $R = 0.0567$ ;  $p\text{-value} = 0.6198$  (not significantly correlated)

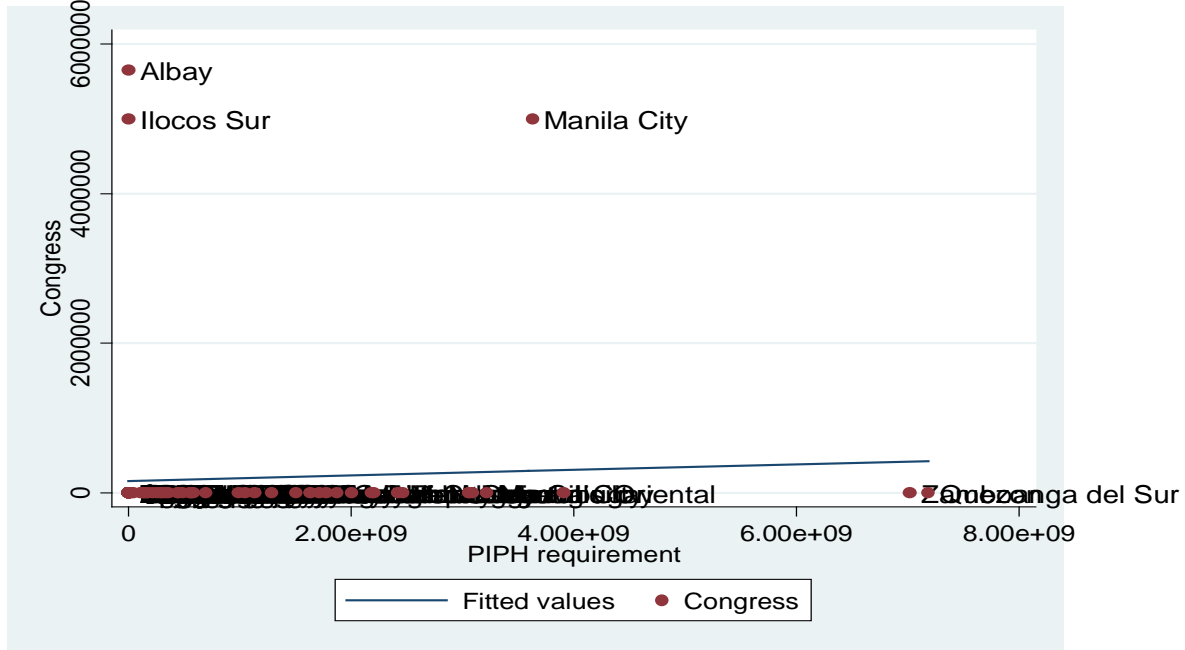
## POPULATION



Correlation:  $R = -0.1063$ ;  $p\text{-value} = 0.3511$  (not significantly correlated)

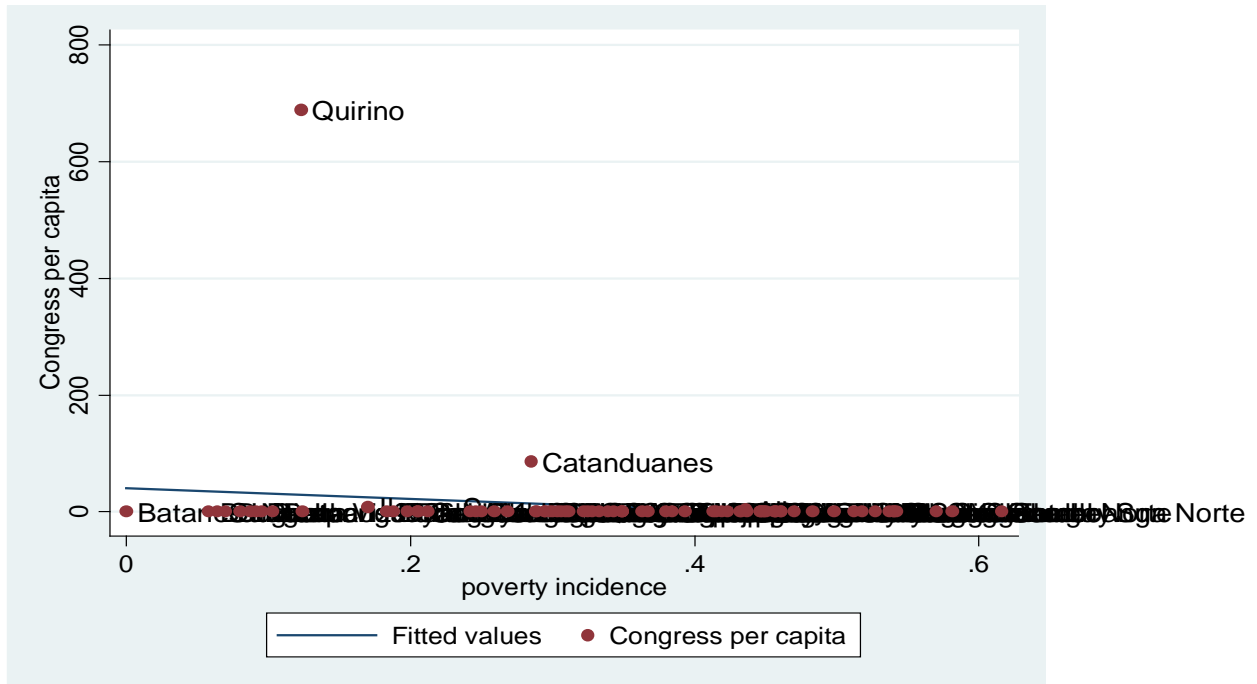
## FUND SOURCE: CONGRESS

**Total Congress vs. PIPH requirement**



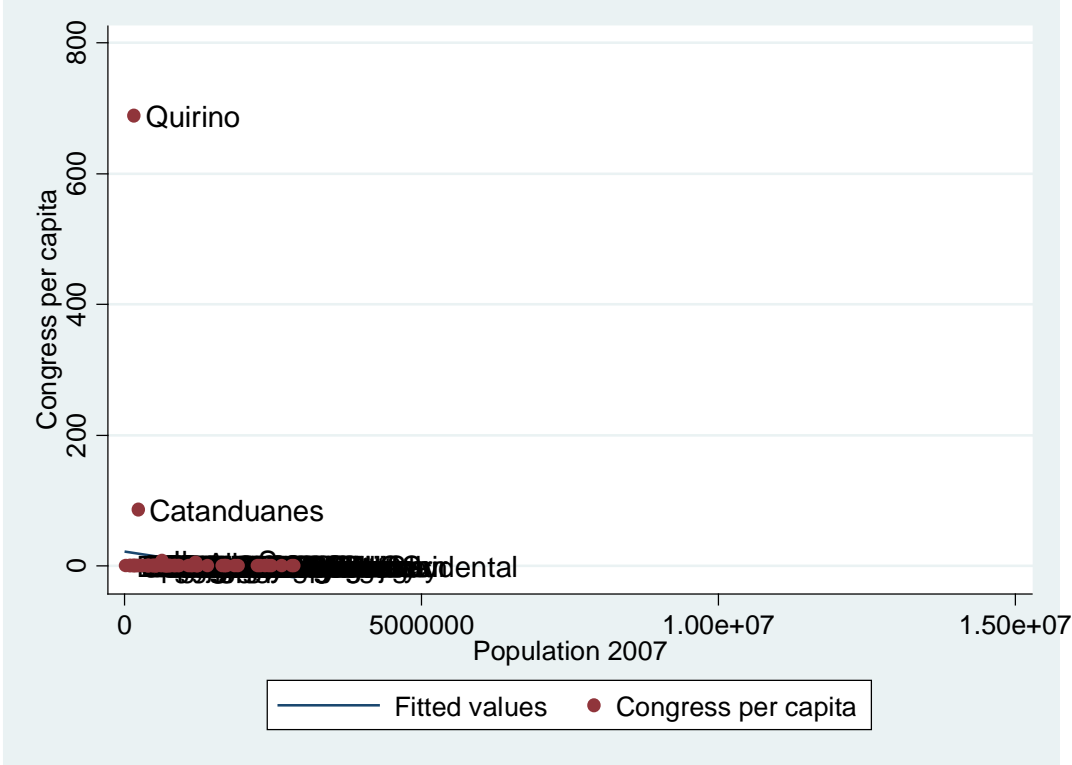
Correlation:  $R = -0.0278$ ;  $p\text{-value} = 0.7968$  (not significantly correlated)

**Congress per capita vs. poverty incidence**



Correlation:  $R = -0.1721$ ;  $p\text{-value} = 0.1295$  (not significantly correlated)

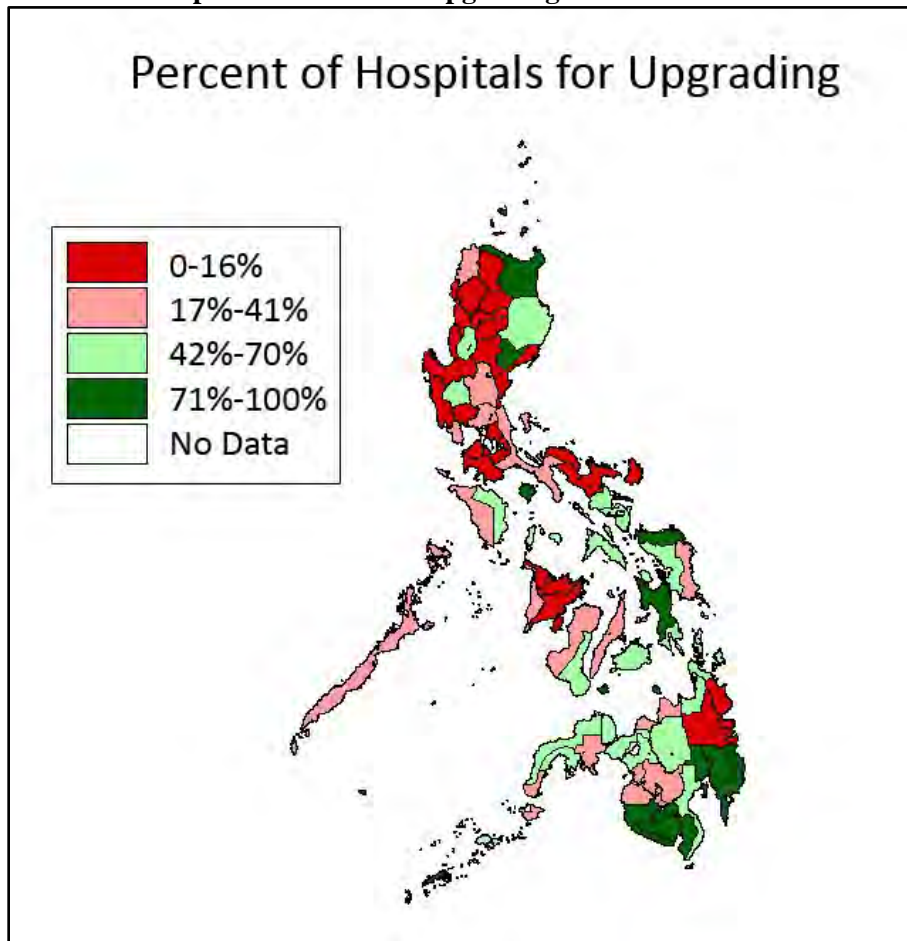
**Congress per capita vs. Population**



*Correlation: R= -0.1247; p-value=0.2736 (not significantly correlated)*

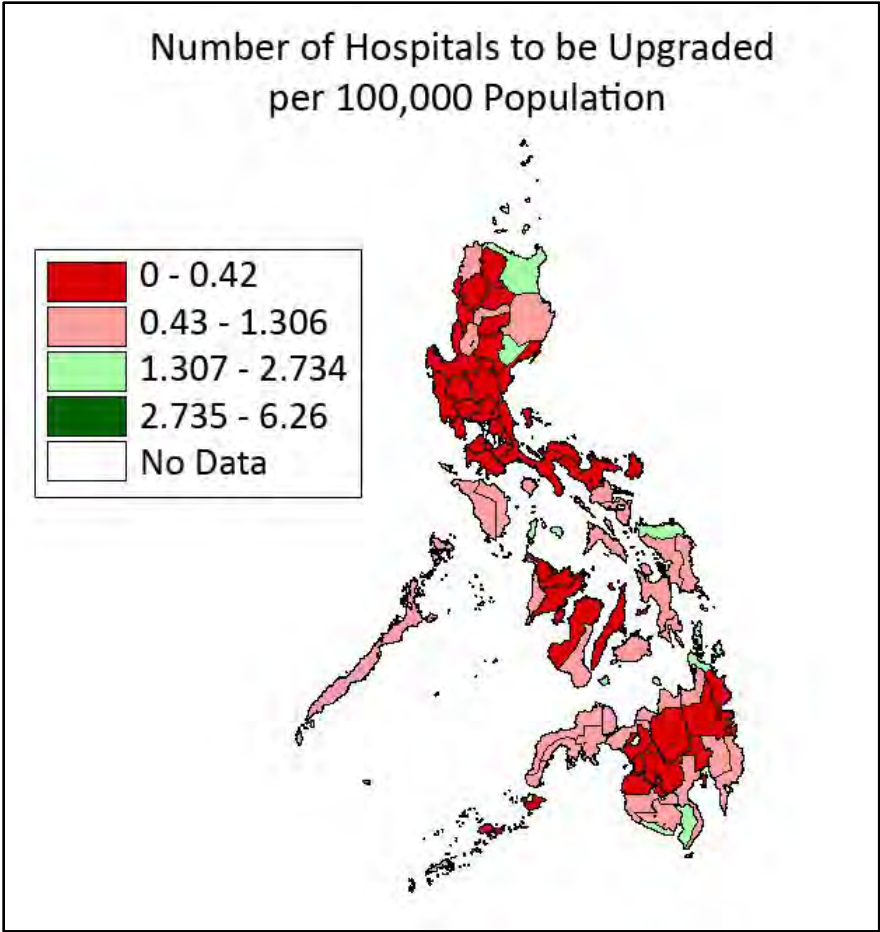


## ANNEX 2. Maps of Facilities for Upgrading in 2011



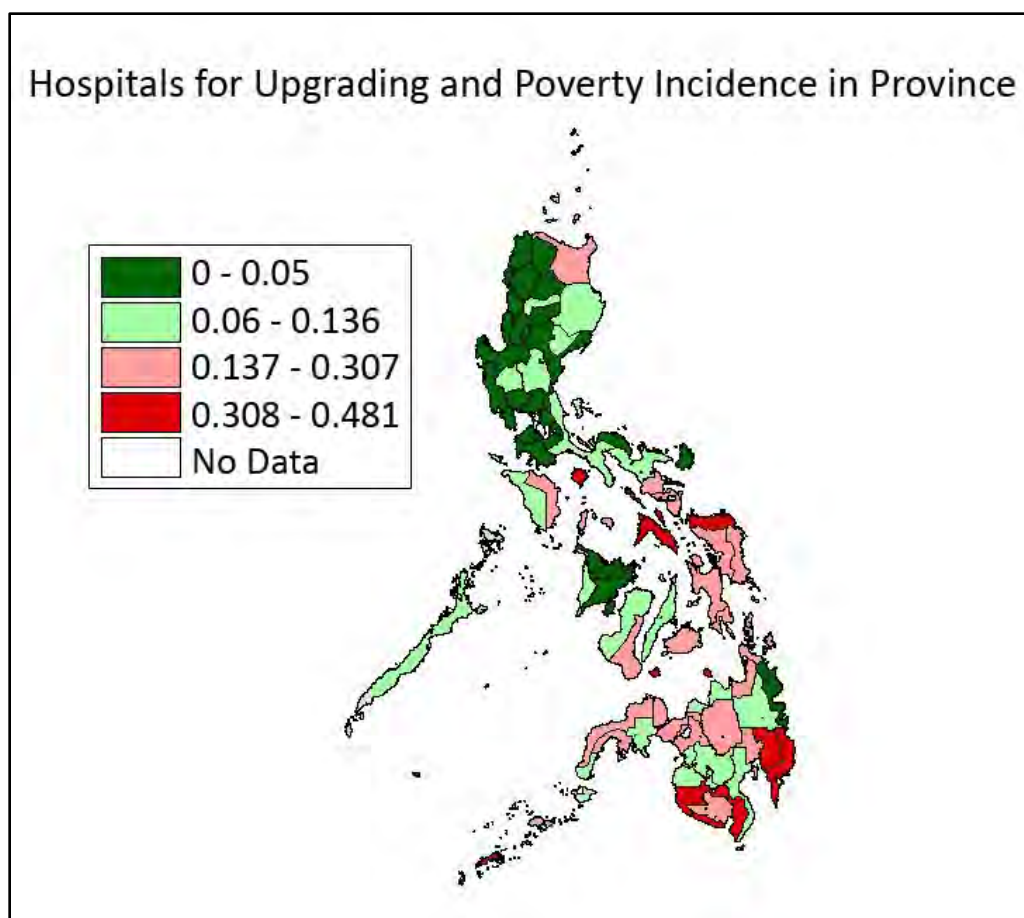
The provinces of Camiguin, Compostela Valley, Marinduque, Siquijor and Tawi-Tawi had all of their hospital for upgrading. These are mostly Level 1 and Level 2 hospitals which requested funding for the repair/expansion/renovation of their infrastructure and equipping for BEmONC/CEmONC services. Siquijor and Tawi-Tawi are both CCT sites. Sarangani, South Cotabato, Cagayan, Davao Oriental and Northern Samar are also provinces with the most number of hospitals for upgrading.

On the other hand, the following provinces had none of their hospitals for upgrading: Ilocos Sur, La Union, Pangasinan, Nueva Vizcaya, Aurora, Zambales, Cavite, Laguna, Rizal, Camarines Norte, Catanduanes, Aklan, Capiz, Guimaras, Abra, Apayao, Ifugao and Kalinga. Majority of these provinces are from Region 1, Region 4A, Region 6 and CAR.



The provinces of Batanes, Saranggani, Camiguin, Quirino, Siquijor, Surigao del Norte, Cagayan, Northern Samar, Romblon, Marinduque, Agusan del Norte, Eastern Samar, Benguet, South Cotabato and Southern Leyte had more than one hospital to be upgraded per 100,000 population.

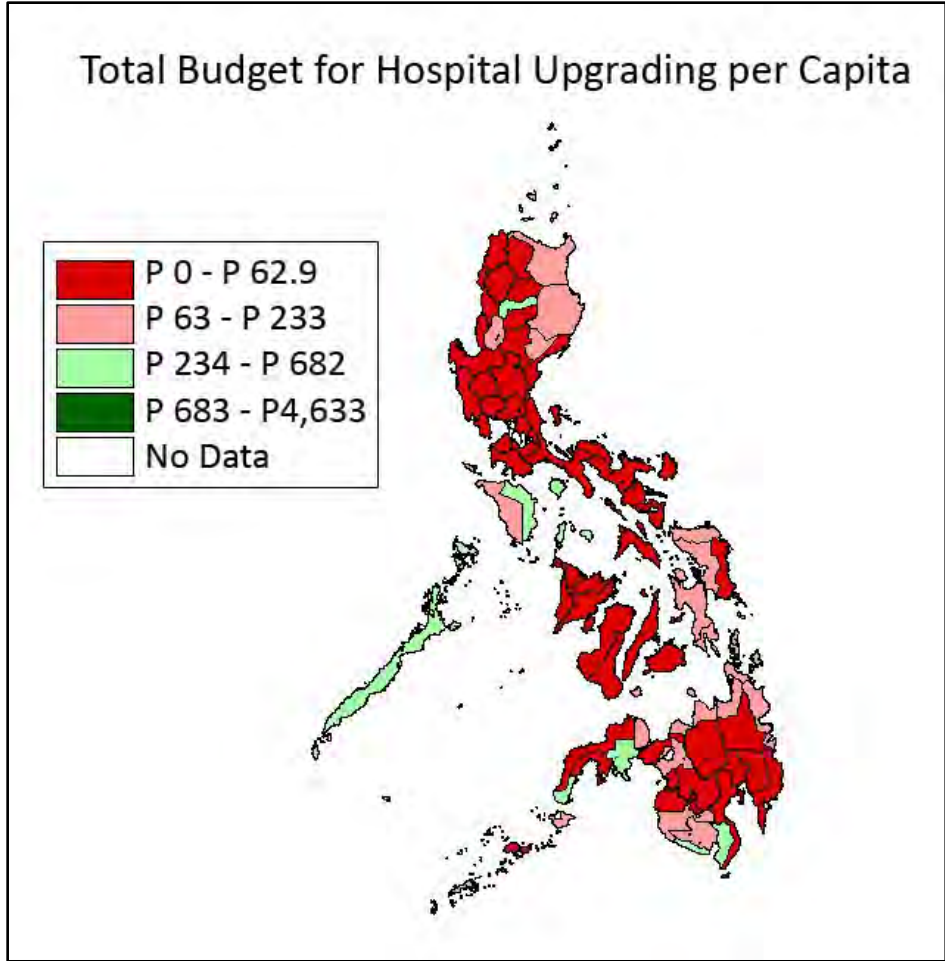
## Hospitals for Upgrading and Poverty Incidence in Province



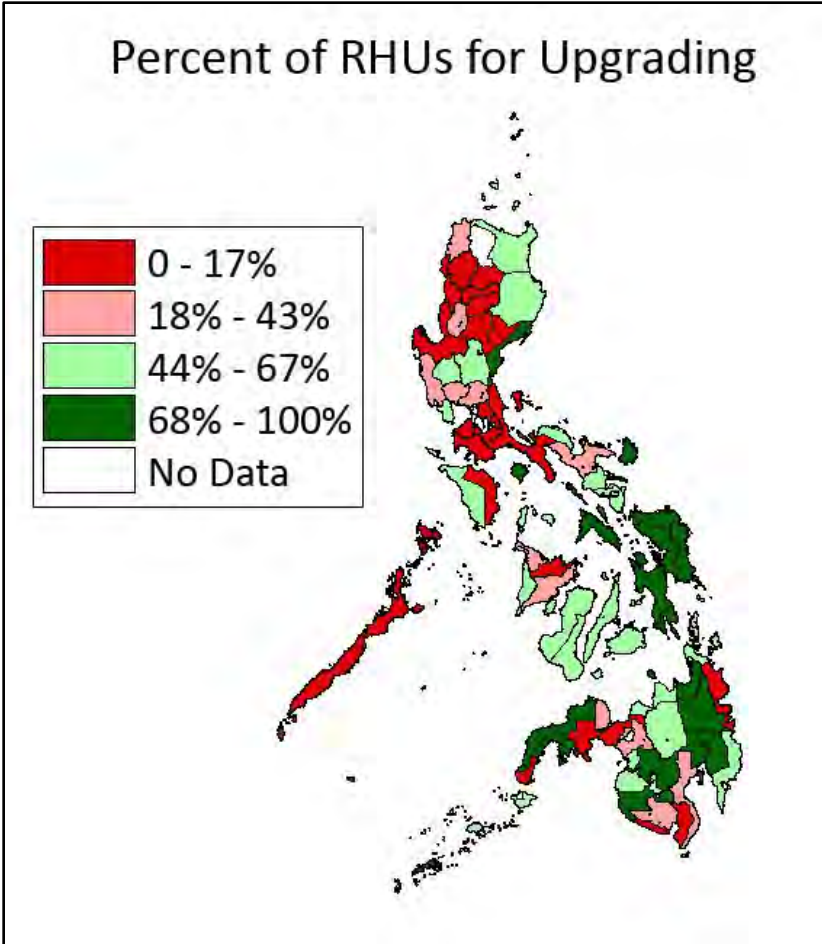
To be able to assess equity, the poverty incidence of the province should be considered. Adjusting for poverty incidence, the areas in red are the provinces with high poverty incidence and high percentage of hospitals to be upgraded. These provinces are: Sarangani, Camiguin, Davao Oriental, Northern Samar, Tawi-tawi, Siquijor, Compostella Valley, Sultan Kudarat, Marinduque, Masbate, Surigao del Norte, Sorsogon, ZamboangaSibugay, Sulu, Romblon, South Cotabato, Albay, Davao Del Norte and Bohol. These are the provinces have poverty rates of more than 40% and more than 50% of their hospitals are for upgrading.

The following provinces have low poverty rates (less than 20%) and have less of their hospitals for upgrading: Pampanga, Bulacan, Benguet, Bataan, Batangas and Ilocos Norte.

The following provinces, however, have high poverty rates, but the percentage of hospitals for upgrading are less: Surigao del Sur, Iloilo, Camarines Sur and Mountain Province. Their poverty rates range from 26.8- 45.7% and the percent of hospitals for upgrading are at 10% on average.



The top 10 provinces with highest HFEP Budget per population are: Batanes, Mt. Province, Romblon, Palawan, Zamboanga del Sur, Marinduque, Oriental Mindoro, Sarangani, Biliran and Cagayan. Most of these provinces are from Region IV-A, Region IV-B and Region 2 with a budget of more than P683 per population.

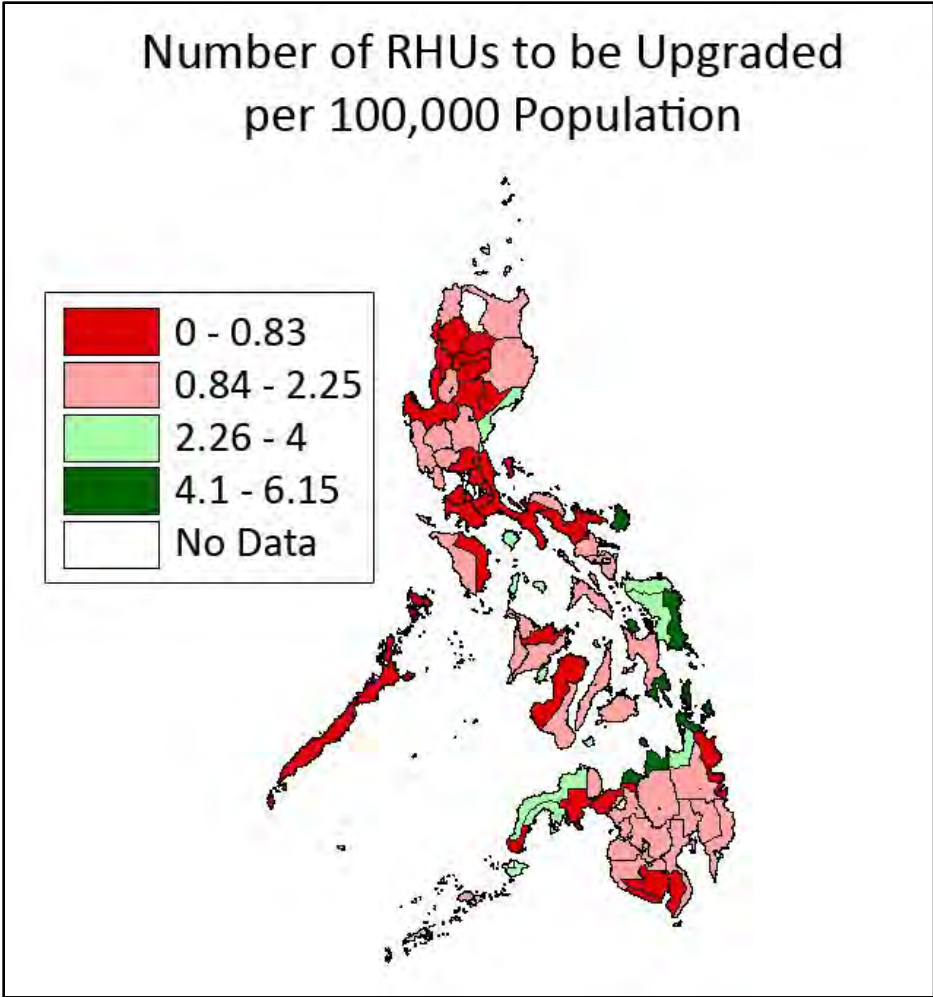


RHU facilities of the provinces of Catanduanes, Sultan Kudarat and ZamboangaSibugay had all of their facilities to be upgraded. Provinces with most of their RHUs are for upgrading are Northern Samar, Marinduque, Western Samar, Southern Leyte, North Cotabato, Eastern Samar and Camiguin.

Conversely, provinces of Abra, Ifugao, Kalinga, Mt. Province, Batanes, Quirino, Batangas, Cavite, Rizal, Capiz, Ilocos Sur, La Union, Pangasinan and Surigao del Sur had none of their facilities for upgrading. Majority of these provinces are from CAR, Region IV A and Region 1.

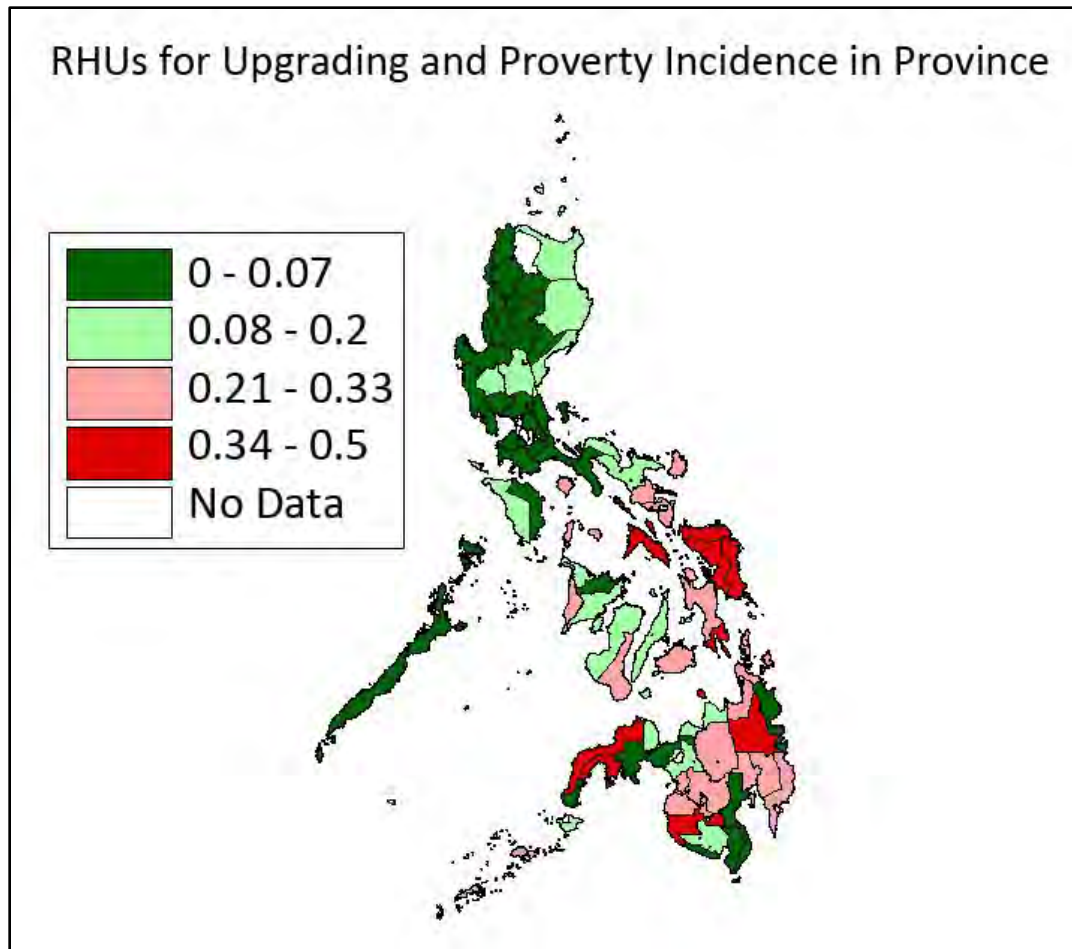
RHU upgrading are mostly for the renovation, repair and expansion of infrastructure, as well as equipping for BEmONC/CEmONC services.

NOTE: RHU universe is not updated.



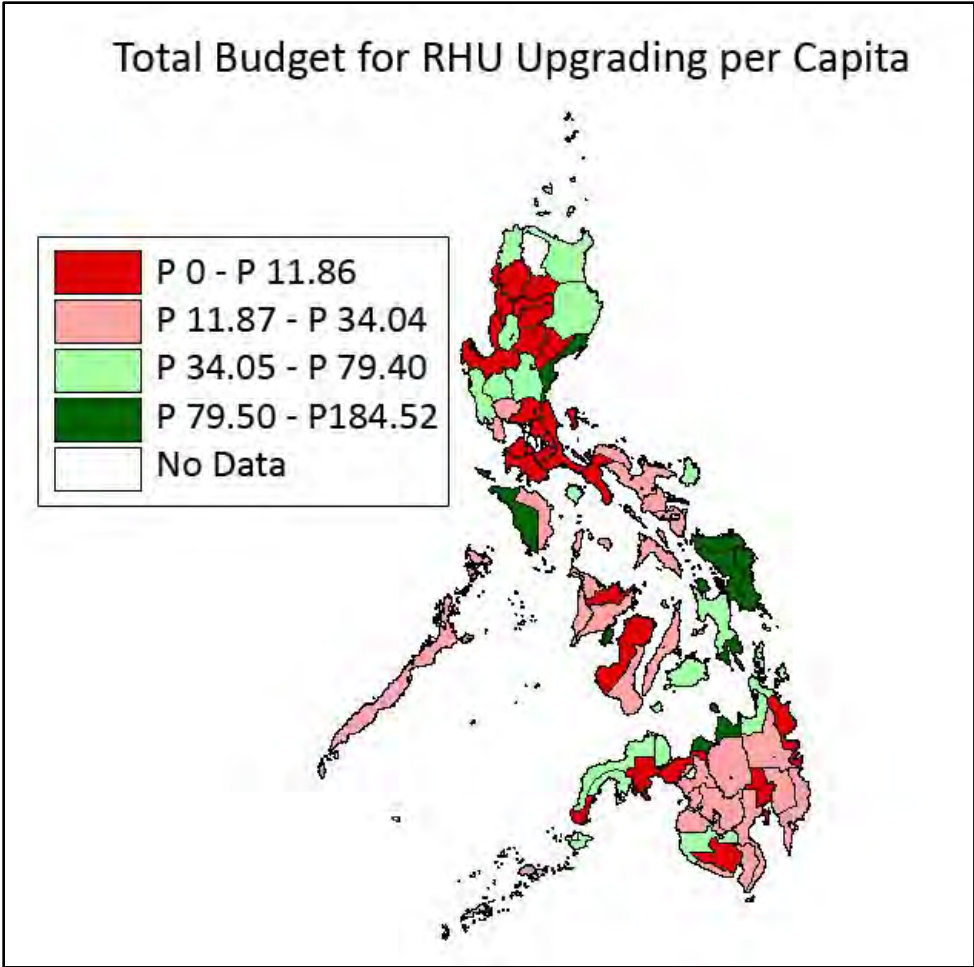
The top 10 provinces that had more than one RHU for upgrading per 100,000 population are in Camiguin, Misamis Oriental Eastern Samar, Biliran, Catanduanes, Southern Leyte, Surigao del Norte, Northern Samar, Western Samar and Aurora ranging from 3- 6 facilities.





To be able to assess equity, the poverty incidence of the province should be considered. Adjusting for poverty incidence, the areas in red are the provinces with high poverty incidence and high percentage of RHUs to be upgraded. These provinces are: Zamboanga Sibugay, Zamboanga del Norte, Northern Samar, Agusan del Sur, Eastern Samar, Sultan Kudarat, Masbate, Western Samar, Camiguin, Southern Leyte, Surigao del Norte, Davao Oriental, Tawi-tawi, Maguindanao, Marinduque, Compostella Valley, Romblon, Catanduanes, North Cotabato and Sulu. These are the provinces with poverty rates of more than 40% and more than 57% of facilities are for upgrading.

The provinces of Laguna, Nueva Vizcaya, Bulacan, Benguet, Pampanga, Palawan, Zamboanga del Sur, Ilocos Norte, Zambales and Bataan are provinces with low poverty rates as well as low percentage of RHUs for upgrading.



The top 10 provinces with highest HFEP Budget per population are Camiguin, Occidental Mindoro, Southern Leyte, Eastern Samar, Biliran, Northern Samar, Guimaras, Western Samar, Aurora and Misamis Oriental. Most of these provinces are from Region 8 with a budget of more than P79 per population.



**ANNEX 3. Issuance of SAA from the date GAA was passed**

<b>2008</b>	<b>Date GAA was passed</b>	<b>SARO Release Date</b>	<b>Date DO was approved</b>	<b>SAA Release Date</b>	<b>Number of Days GAA to SAA</b>
Batch 1	11-Mar-08	18-Jun-08	2-Feb-08	11-Mar-08	0
Batch 2	11-Mar-08	26-Aug-08	2-Sep-08	4-Sep-08	177
Batch 3	11-Mar-08	28-Aug-08	2-Sep-08	5-Sep-08	178
Batch 4	11-Mar-08	28-Aug-08	2-Sep-08	5-Sep-08	178
Batch 5	11-Mar-08	4-Sep-08	11-Jun-08	9-Jul-08	120
Batch 6	11-Mar-08	4-Sep-08	5-Sep-08	11-Sep-08	184
Batch 7	11-Mar-08	4-Sep-08	10-Sep-08	26-Sep-08	199
Batch 8	11-Mar-08	4-Sep-08	10-Sep-08	18-Sep-08	191
Batch 9	11-Mar-08	12-Sep-08	16-Sep-08	26-Sep-08	199
Batch 10	11-Mar-08	17-Sep-08	24-Sep-08	26-Sep-08	199
Batch 11	11-Mar-08	17-Sep-08	24-Sep-08	26-Sep-08	199
Batch 12	11-Mar-08	18-Sep-08	24-Sep-08	26-Sep-08	199
Batch 13	11-Mar-08	14-Oct-08	4-Jun-08	10-Jun-08	91
Batch 14	11-Mar-08	5-Nov-08	19-Nov-08	26-Nov-08	260
<b>SOURCE OF FUNDS: CONGRESS INITIATIVES</b>					
Batch 1	11-Mar-08	7-Jul-08	4-Sep-08	5-Sep-08	178
Batch 2	11-Mar-08	8-Sep-08	15-Sep-08	16-Sep-08	189
Batch 3	11-Mar-08	10-Oct-08	17-Oct-08	22-Oct-08	225
Batch 4	11-Mar-08	10-Dec-08	20-Jan-08	20-Jan-09	315
Batch 5	11-Mar-08	11-Dec-08	23-Dec-08	20-Jan-09	315
Batch 6	11-Mar-08	12-Dec-08	17-Dec-08	20-Jan-09	315
Batch 7	11-Mar-08	14-Apr-09	27-May-09	28-May-09	443
<b>SOURCE OF FUNDS: SENATE INITIATIVES</b>					
Batch 1	11-Mar-08	16-Feb-09	24-Feb-09	15-Apr-09	
<b>SOURCE OF FUNDS: KATAS NG VAT</b>					
Batch 1	11-Mar-08	15-Sep-08	8-Sep-08	16-Sep-08	189
Batch 2	11-Mar-08	29-Sep-08	8-Sep-08	18-Nov-08	252
Batch 3	11-Mar-08	2-Oct-08	13-Oct-08	17-Oct-08	220
Batch 4	11-Mar-08	23-Oct-08	3-Nov-08	11-Nov-08	245
Batch 5	11-Mar-08	24-Nov-08	19-Jan-09	17-Feb-09	343
Batch 6	11-Mar-08	5-Dec-08	19-Jan-09	3-Feb-09	329
Batch 7	11-Mar-08	11-Dec-08	9-Jan-09	20-Jan-09	315

<b>2009</b>	<b>Date GAA was passed</b>	<b>SARO Release Date</b>	<b>Date DO was approved</b>	<b>SAA Release Date</b>	<b>Number of Days GAA to SAA</b>
Batch 1	13-Mar-09	5-Feb-09	6-Feb-09	13-Mar-09	0
Batch 2	13-Mar-09	20-Mar-09	30-Apr-09	31-Mar-09	18
Batch 3	13-Mar-09	14-Apr-09	30-Apr-09	22-Jun-09	101
Batch 4	13-Mar-09	27-Apr-09	22-May-09	2-Jun-09	81
Batch 5	13-Mar-09	8-Jun-09	14-Aug-09	4-Sep-09	175
Batch 6	13-Mar-09	19-Jun-09	14-Aug-09	4-Sep-09	175
Batch 7	13-Mar-09	3-Jul-09	9-Nov-09	18-Nov-09	250
Batch 8	13-Mar-09	8-Jul-09	23-Jul-09	10-Aug-09	150
Batch 9	13-Mar-09	27-Jul-09		(transferred to ARMM)	
Batch 10	13-Mar-09	12-Aug-09	7-Oct-09	22-Oct-09	223
Batch 11	13-Mar-09	24-Aug-09	23-Sep-09	16-Oct-09	217
Batch 12	13-Mar-09	15-Sep-09	18-Sep-09	9-Oct-09	210
Batch 13	13-Mar-09	18-Sep-09	12-Feb-09	26-Feb-10	350
Batch 14	13-Mar-09	10-Nov-09	15-Mar-09	3-Mar-10	355
Batch 15	13-Mar-09	16-Nov-09		(fund transfer)	
Batch 16	13-Mar-09	17-Nov-09	21-Dec-09	(transferred to ARMM)	
Batch 17	13-Mar-09	1-Mar-10	13-Apr-09	28-May-10	441
Batch 18	13-Mar-09	1-Mar-10	12-Mar-09	13-Apr-10	396
Batch 19	13-Mar-09	26-Apr-10	28-Apr-09	28-May-10	441

Batch 20	13-Mar-09	16-Jul-10	20-Sep-09	6-Aug-10	511
Batch 21	13-Mar-09	18-Aug-10	31-Aug-09	1-Oct-10	567
Batch 22	13-Mar-09	11-Oct-10	15-Oct-09	10-Nov-10	607
Batch 23	13-Mar-09	12-Oct-10	15-Oct-09	10-Nov-10	607
Batch 24	13-Mar-09	21-Oct-10	3-Nov-09	2-Dec-10	629

<b>2010</b>	<b>Date GAA was passed</b>	<b>SARO Release Date</b>	<b>Date DO was approved</b>	<b>SAA Release Date</b>	<b>Number of Days GAA to SAA</b>
Batch 1	9-Feb-10	19-Mar-10	22-Apr-10	12-May-10	92
Batch 2	9-Feb-10	2-Jun-10	23-Feb-10	26-Feb-10	17
Batch 3	9-Feb-10	16-Jun-10	22-Jun-10	28-Jul-10	169
Batch 4	9-Feb-10	15-Jul-10	29-Jul-10	6-Aug-10	178
Batch 5	9-Feb-10	10-Nov-10	13-Dec-10	22-Dec-10	316
Batch 6	9-Feb-10	25-Nov-10	30-Nov-10	10-Dec-10	304
Batch 7	9-Feb-10	17-Dec-10	16-Feb-10	29-Dec-10	323

#### **ANNEX 4. Review of Funding Allocation under the MNCHN Grants Facility**

The Philippines has one of the highest maternal mortality in the ASEAN region. With the aim to dramatically improve the high incidence of maternal deaths in the country, the Department of Health has decided to increase budgetary support on the LGU-led Maternal, Neonatal and Child Health and Nutrition (MNCHN). This initiative identified synchronized interventions that will help improve the following reproductive health outcomes that are contributory to the reduction of maternal deaths. These outcomes include: (1) Contraceptive use (2) antenatal care (3) facility-based delivery (4) and Fully-immunized children. Last 2008, the initial year of the program, the DOH allotted a budget for LGUs as support of their contraceptive self-reliance program. In the succeeding year, DOH continuously granted LGU's based on their commitment and performance to achieve health outcomes aforementioned.

The execution of MNCHN grants is relatively systematic. The Department of Health head office is the overall technical coordinator for the MNCHN grants. On the other hand, the Regional CHD will be in-charged in assessing the eligibility of LGU (city and provinces). The maximum amount that LGUs can get is based on the predetermined ceiling estimated relative to the number of poor women of reproductive age in each locality. Prior to the release of the grant, the LGU should have the ability to achieve MNCHN intermediate outcomes. The amount of grant to be released is based on the degree of improvement of the set health indicators. Moreover, LGUS should also demonstrate the readiness to make counterpart investments (e.g. commitment to improvement of structures, enrollment of indigents to PhilHealth, accreditation of health facilities, etc). With regards to utilization and monitoring, the DOH has identified specific and systematic guidelines. CHDs and DOH-ARMM requires LGUs financial reports for them to track the movement of funds utilized. Well-defined monitoring tool was also devised to systematically check the improvement of the overall effectiveness of the program.

The General Appropriations Act in 2007 included a separate amount of P180,000,000 as Maintenance and Other Operating Expenses (MOOE) for "artificial family planning" under the National Center for Disease Prevention and Control-Family Health Office (NCDPC-FHO). This amount appropriated will be sub-allotted to CHDs and LGUs for the purchase of reproductive health commodities and the conduct of family planning seminars. An appropriation was made in 2008 for the same purpose, amounting to P167,000,000. Table below presents the key components of HFEP vis-à-vis the MNCHN Grants Facility.

	<b>Health Facility Enhancement Program (HFEP)</b>	<b>MNCHN Grants Facility</b>
Budget Source	HFEP Program Funds, line item in GAA	NCDPC-Family Health Office funds for facility upgrading
Modes of Implementation	To be undertaken by NCHFD	Funds to come from NCDPC-FHO but execution will be under NCHFD
Basis for Allocation	Hospital must have 50-bed ABC and be licensed as Primary Level or Level II Category, must have passed the Rationalization of Health Care Delivery System based on Health Needs and must be aligned with the Province-Wide Investment Plan for Health	DOH Department Order No. 2009-0311: Guidelines on the Utilization of 2009 MNCHN Grant Facility for LGUs and Management/Program Support Fund for the CHDs
Criteria for Allocation	<p><b>LGU Priority</b> (LGU has allocated MOOE and human resource for the project; LGU has counterpart funds; and should be responsive to health status situation)</p> <p><b>CHD Review</b> (within approved PIPH framework of LGU; complying with Certificate of Need and/or BEmONC/CEmONC requirements; deemed “rational” by the CHD if without RatPlan)</p> <p><b>Plus Factor</b> (&gt;85% LGU IP enrollment; good track record in submitting reports; has good financial management in place)</p>	<p><b>Performance Domains</b></p> <p><b>Domain 1:</b> Ability to demonstrate achievement of MNCHN intermediate outcomes (CPR, ANC, FBD, FIC)</p> <p><b>Domain 2:</b> Current capacity to delivery FP and MNCHN services (presence of trained staff, adequate commodities and supplies, IEC and health promotion activities, health information and surveillance, and targeting for the poor)</p> <p><b>Domain 3:</b> Commitment to pursue improvement in the delivery of health services, particularly health budget increases.</p>

**ANNEX 5**  
**HFEP-RELATED**  
**AOs/DOs/DMs**  
**Issued by DOH**

## References

### List of Department Orders on Guidelines on the Utilization of Funds for Health Facilities under the Health Facility Enhancement Program (HFEP)

DEPARTMENT ORDER No.	SUBJECT
2008- 0037	Guidelines for the sub-allotment and utilization of funds to East Avenue Medical Center under CY 2008 Health Facilities Enhancement Program Funds for government hospital upgrading (Presidential Priority Project).
2008- 0038	Guidelines for the sub- allotment and utilization of funds to East Avenue Medical center under CY 2008 Health Facilities Enhancement Program Funds for government hospital upgrading (Presidential Priority Project).
2010- 0046	Guidelines for the fund transfer and utilization of funds to Lung Center of the Philippines, under CY 2010 Health Facilities Enhancement Program.
2010- 0045	Guidelines for the sub-allotment and utilization of funds to DOH hospitals under CY 2010 Health Facilities Enhancement Program.
2010- 0044	Guidelines for the sub-allotment and utilization of funds to DOH hospitals under CY 2010 Health Facilities Enhancement Program.
2010- 0041	Guidelines for the release and utilization of the sub- allotment to Davao Medical Center under the CY 2009 Health Facilities Enhancement Program Funds per SARO No. BMB-B- 09-0011461 dated September 18, 2009.
2010- 0023	Guidelines for the sub-allotment and utilization of funds to DOH hospitals under CY 2010 Health Facilities Enhancement Program Funds.
2009- 0314	Guidelines for the release and utilization of the sub- allotment/ fun transfers of CY 2009 Health Facilities Enhancement Program Funds (Senate Initiative) pursuant to the Department Order No. 2009- 0092 dated February 6, 2009 for SARO No. B- 09- 0018078 dated November 17, 2009.
2009- 0276	Guidelines for the release and utilization of the sub-allotment to Vicente Sotto Memorial Medical Center under the CY 2009 Health Facilities Enhancement Program Funds per SARO No. BMB-B- 09- 0005699 dated July 3, 2009.
2009-0260	Guidelines for the release and utilization of the sub- allotment/ fund transfers of CY 2009 Health Facilities Enhancement Program Funds pursuant to the Department Order No. 2009- 0092 dated February 6, 2009 for SARO No. B-09-0009110 dated August 12, 2009.
2009- 0249	Guidelines for the release and utilization of the sub- allotment/ fund transfers of CY 2009 Health Facilities Enhancement Program Funds pursuant to the Department Order no. 2009- 0092 dated February 6, 2009 for SARO No. B- 09- 0009482 dated August 24, 2009.
2009- 0238	Guidelines for the release and utilization of the sub- allotment/fund transfers of CY 2009 Health Facilities Enhancement Program Funds pursuant to the Department Order No. 2009- 0092 dated February 6, 2009 for SARO No. B- 09-0010953 dated September 15, 2009.
2009- 0154	Guidelines for the sub- allotment and utilization of funds to the four (4) DOH hospitals as regional heart-lung- kidney centers under CY 2008 Health Facilities Enhancement Program.
2009- 0142	Guidelines for the sub- allotment and utilization of the CY 2008 realigned funds from family health including family planning to Health Facilities Enhancement Program for the implementation of BEmONC and CEmONC activities.
2009-0092- U	Amendment to Department Order No. 2009- 0092H dated August 14, 2009 on the guidelines for the release and utilization of the sub- allotment of CY 2009 Health Facilities Enhancement Program Funds.
2009- 0092- T	Amendment to Department Order No. 2009-0092H dated August 14, 2009 on the guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2009 Health Facilities Enhancement Program Funds.
2009-0092- S	Amendment to Department Order No. 2009- 0092D dated May 22, 2009 on the guidelines for the release and utilization of the sub- allotment of CY 2009 Health Facilities Enhancement Program Funds for CHD eastern Visayas per approved SARO No. B- 10- 05760 dated July 16, 2010.
2009- 0092- Q	Amendment to Department Order No. 0092- H dated August 14, 2009 on the guidelines for the release and utilization of the sub- allotment of CY 2009 Health Facilities Enhancement Program Funds for CHD Central Luzon per approved SARO No. B- 10- 03331 dated March 1, 2010.
2009- 0092- P	Amendment to Department Order No. 0092- H dated August 14, 2009 on the guidelines for the release

	and utilization of the sub- allotment of CY 2009 Health Facilities Enhancement Program Funds for CHD Cordillera and CHD Central Luzon per approved SARO No. B- 10- 04951 dated April 26, 2010.
2009- 0092- H	Addendum to the Department Order No. 2009- 0092 dated February 6, 2009 on the guidelines for the release and utilization of the sub- allotment/ fund transfers of CY 2009 Health Facilities Enhancement Program Funds per SARO No. BMB- B- 09- 0002757 dated June 8, 2009 and BMB- B- 09- 0004309 dated June 19, 2009.
2009- 0092- G	Addendum to the Department Order no. 2009- 0092 dated February 6, 2009 on the guidelines for the release and utilization of the sub- allotment/ fund transfers of CY 2009 Health Facilities Enhancement Program Funds per SARO No. BMB- B- 09- 0006474.
2009- 0092- E	Amendment to Department Order No. 0092- D dated May 22, 2009 on the guidelines for the release and utilization of the sub- allotment/ fund transfers of CY 2009 Health Facilities Enhancement Program Funds.
2009- 0092- D	Addendum to the Department Order No. 0092 dated February 6, 2009 on the guidelines for the release and utilization of the sub- allotment/ fund transfers of CY 2009 Health Facilities Enhancement Program Funds per SARO No. B- 09- 0001192.
2009- 0092- C	Addendum to the Department Order No. 0092 dated February 6, 2009 on the guidelines for the release and utilization of the sub- allotment/ fund transfers of CY 2009 Health Facilities Enhancement Program Funds per SARO No. B- 09- 0001015.
2009- 0092- B	Amendment to Department Order No. 0092- A dated April 30, 2009 on the guidelines for the release and utilization of the sub- allotment/ fund transfers of CY 2009 Health Facilities Enhancement Program Funds.
2009- 0092- A	Addendum to the Department Order No. 0092 dated February 6, 2009 on the guidelines for the release and utilization of the sub- allotment/ fund transfers of CY 2009 Health Facilities Enhancement Program Funds.
2009- 0065	Guidelines for the sub- allotment and utilization of the CY 2008 Health Facilities Enhancement Program Funds (Senate Initiatives) for Hospital Upgrading.
2008- 0267	Guidelines for the sub- allotment and utilization of funds to Valenzuela Medical Center under CY 2008 Health Facilities Enhancement Program Funds for government hospital upgrading.
2008- 0215	Guidelines for the sub- allotment and utilization of the CY 2008 Health Facilities Enhancement Program Funds for local government hospital upgrading (CHD NCR, 2, 4-B, 5, 6, 10 and 12).
2008- 0209	Guidelines for the sub- allotment and utilization of the CY 2008 Health Facilities Enhancement Program Funds for Iloilo Provincial Hospital and Gov. William Health Facilities Enhancement Program Funds Villegas Memorial Hospital for hospital upgrading.
2008- 0207	Guidelines for the sub- allotment and utilization of the CY 2008 Health Facilities Enhancement Program Funds for local government hospital upgrading (CHD 2, 4-B, 5, 8, 9, 10, 11, 12 and CARAGA).
2008- 0206	Guidelines for the sub- allotment and utilization of the CY 2008 Health Facilities Enhancement Program Funds for local government hospital upgrading (CHD NCR, 1, 3, 4-A, 6, 7 and 10).
2008- 0205	Guidelines for the sub- allotment and utilization of funds to East Avenue Medical Center and Philippine Orthopedic Center under CY 2008 Health Facilities Enhancement Program Funds for government hospital upgrading.
2008- 0112	Guidelines for the sub- allotment and utilization of the CY 2008 Health Facilities Enhancement Program Funds for local government hospital upgrading.
2008- 0184	Guidelines for the sub- allotment and utilization of the CY 2008 Health Facilities Enhancement Program Funds for DOH/ LGU Hospital upgrading.
2008-0185	Guidelines for the sub- allotment and utilization of the CY 2008 Health Facilities Enhancement Program Funds for local government hospital upgrading.
2008- 0186	Guidelines for the sub- allotment and utilization of the CY 2008 Health Facilities Enhancement Program Funds for DOH hospital upgrading.
2010- 0205	Guidelines for the sub- allotment and utilization of funds to East Avenue Medical Center and Philippine Orthopedic Center under CY 2008 Health Facilities Enhancement Program Funds for government hospital upgrading.
2010- 0064	Guidelines for the release and utilization of the sub- allotment of CY 2009 Health Facilities Enhancement Program Funds (Continuing Appropriation) pursuant to the Department Order No. 2009- 0092 dated February 6, 2009 for SARO No. B- 10- 03794 dated March 1, 2010.
2010- 0088	Guidelines for the release and utilization of the sub- allotment/ fund transfers of CY 2010 Health Facilities Enhancement Program Funds per SARO No. BMB- B- 10- 0001481 dated March 19, 2010.
2010- 0115	Guidelines for the release and utilization of the sub- allotment of CY 2010 Health Facilities Enhancement

	Program Funds.
2010- 0137	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for MIMAROPA per SARO No. BMB-B-10- 0004271 dated June 16, 2010.
2010- 0138	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for CARAGA per SARO No. BMB- B- 10- 0004271 dated June 16, 2010.
2010- 0139	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for Cordillera per SARO No. BMB- B- 10- 0004271 dated June 16, 2010.
2010- 0140	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for Cagayan Valley per SARO No. BMB- B- 10- 0004271 dated June 16, 2010.
2010- 0141	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for Ilocos per SARO No. BMB- B- 10- 0004271 dated June 16, 2010.
2010- 0142	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for Northern Mindanao per SARO No. BMB- B- 10- 0004271 dated June 16, 2010.
2010- 0143	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for SOCCSKSARGEN per SARO No. BMB- B- 10- 0004271 dated June 16, 2010.
2010- 0144	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for Eastern Visayas per SARO No. BMB- B- 10- 0004271 dated June 16, 2010.
2010- 0145	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for Central Visayas per SARO No. BMB- B- 10- 0004271 dated June 16, 2010.
2010- 0146	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for Western Visayas per SARO No. BMB- B- 10- 0004271 dated June 16, 2010.
2010- 0147	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for Metro Manila (NCR) per SARO No. BMB- B- 10- 0004271 dated June 16, 2010.
2010- 0148	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for CALABARZON per SARO No. BMB- B- 10- 0004271 dated June 16, 2010.
2010- 0149	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for DOH hospitals/ specialty centers per SARO No. BMB- B- 10- 0004271 dated June 16, 2010.
2010- 0157	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for Central Luzon per SARO No. BMB- B- 10- 0004271 dated June 16, 2010.
2010- 0168	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for DOH Blood Centers per SARO No. BMB- B- 10- 0004271 dated June 16, 2010.
2010- 0181	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds for Center for Health Development for DOH hospital per SARO No. BMB- B- 10- 0004271 dated June 16, 2010.
2010- 0241	Guidelines for the release and utilization of the sub- allotment of CY 2010 Health Facilities Enhancement Program Funds.
2010- 0245	Guidelines for the release and utilization of the sub- allotment/ fund transfer of CY 2010 Health Facilities Enhancement Program Funds per SARO No. BMB- B- 10- 0024466 dated December 3, 2010.





July 7, 2008

DEPARTMENT ORDER  
NO. 2008 - 0162

SUBJECT: Guidelines and Procedures for the Implementation of the Government Hospital Upgrading Project under the CY 2008 Health Facilities Enhancement Program Funds of the DOH

I. RATIONALE:

Guided by the principles of Fourmula One for Health, the Government Hospital Upgrading Project under the CY 2008 Health Facilities Enhancement Program of the DOH is being pursued in support of one of the DOH's strategic approaches to improve the delivery of basic, essential, as well as specialized health services through the rationalization and critical upgrading of health facilities nationwide.

It includes the parallel revitalization of primary health care facilities and the rationalization of the various levels of hospitals with the end in view of decongesting end-referral hospitals specially of primary health care delivery and strengthening its capabilities and potentials and consequently improving the accessibility and availability of basic and essential health care.

II. OBJECTIVES

1. To upgrade government hospitals from primary to secondary level (licensing and accreditation standards) –
  - to be more responsive to the health needs of the catchment population
  - to decongest tertiary hospitals
  - to become base hospitals for nursing students
  - if needed, to become a BEmONC or CEmONC provider
2. To upgrade government hospitals to tertiary level or to expand existing tertiary level hospitals –
  - to be more responsive to the health needs of the catchment population
  - to be referral hospitals of its catchment area or health facility network (i.e. ILHZ) or a specialty center
  - to become CEmONC
  - to become base hospitals for nursing students and for nursing affiliation



### III. SCOPE AND COVERAGE

This policy applies to all projects ( Infrastructure and Equipment ) of DOH and LGU hospitals that are included in the Government Hospital Upgrading Project under the CY 2008 Health Facilities Enhancement Program Funds of the DOH .

### IV. DEFINITION OF TERMS

1. Master Site Development Plan – translates the Hospital Development Plan into physical terms. It refers to the overall layout of the hospital compound indicating location of existing and proposed structures, landscaping and other external site works such as roadways, fencing, entrances/exits, and takes into consideration the hospital's future expansion
2. Hospital Development Plan – usually a five-year plan based on health needs of the catchment population through the rationalization of the health care delivery System based on health needs ( AO 2006-2009 dated June 15, 2006 entitled Guidelines for Rationalizing the Health Care Delivery System based on Health Needs)
3. Project Profile – taking off from the rationalization and the hospital development plans , narrates the project objectives and significance, the project scope through the enumeration of activities and services to be rendered by the proposed upgrading project, its spatial requirements based on dictates of equipment, manpower, environment, safety, regulations, and utilities. It is used as input to schematic planning.
4. Schematic Plans – pertains to initial floor plans and other architectural design drawings translating the project profile into recommended design solutions for the proposed hospital upgrading project
5. Pre-Project Implementation – is the stage of project implementation where work is done by the hospital that sets the pace for the upcoming project design and development
6. Project Design and Development – is the stage of project implementation where, at the first part, the hospital prepares, evaluates and approves the conceptual design documents of the project, reflecting the project profile and mindful of the funding limits. At the second part, the hospital prepares, from the conceptual design documents, the detailed plans and other documents for bidding purposes
7. Design and Build Project Delivery System – is an option for efficiency in project implementation where the hospital or procuring entity bids for the preparation of detailed plans and for the construction of the project and awards both as a single contract to one firm.

### V. GENERAL GUIDELINES

1. To have qualified for inclusion under the Government Hospital Upgrading Project under the DOH CY 2008 Health Facilities Enhancement Program, the hospital must at least have a 50-bed authorized capacity and be licensed as Primary Level or Level II category



2. The Hospital Upgrading Project of each recipient hospital must have passed the Rationalization of the Health Care Delivery System based on Health Needs ( AO 2006-0029 dated June 15, 2006 entitled Guidelines for Rationalizing the Health Care Delivery System based on Health Needs ) and aligned with the Province-Wide Investment Plan for Health
3. The recipient hospital must have prepared a Project Proposal document for the Hospital Upgrading Project containing Hospital Development Plan , Master Site Development Plan ; Human Resource Complement; Hospital Policies, Programs, Systems and Procedures for Operations and Maintenance ;Appropriate Infrastructure and Equipment Needs and corresponding Cost Estimates; Financing Sources including LGU support ( in the case of LGU Hospitals), Philhealth Reimbursements, Grants, Loans, etc.
4. If the recipient hospital has been identified as a provider of BEmONC (Basic Emergency Obstetrics and Newborn Care) or CEmONC (Comprehensive Emergency Obstetrics and Newborn Care), the corresponding requirements for infrastructure and equipment must be prioritized and integrated in the Hospital Upgrading Project

## VI. IMPLEMENTING GUIDELINES FOR DOH HOSPITALS

### A. PROCEDURAL GUIDELINES AND DOCUMENTARY REQUIREMENTS FOR INFRASTRUCTURE PROJECTS

#### 1. Pre-Project Implementation – The Hospital shall :

- 1.1 Check and ensure that funds have been sub-allotted to their hospital
- 1.2 Activate its Infrastructure Committee for project profile preparation, plan review, work prioritization, etc.
- 1.3 Prepare or ready the following documents :
  - Hospital Development Plan
  - Approved Master Site Development Plan
  - Project Profile
  - Soil Investigation Report of Project Site by a qualified surveyor
  - Environmental Compliance Certificate
  - Transfer Certificate of Title or Deed of Donation of Site

#### 2. Project Design and Development – The Hospital shall :

- 2.1 At the first part, prepare the following Conceptual Design Documents based on the Project Profile and funding limits, in Fifteen (15) days :
  - Schematic Plans
  - Building Sections
  - Building Elevations
  - Perspectives
- 2.2 Evaluate and approve the Conceptual Design Documents
- 2.3 Using the approved Schematic Plans, apply for Permit to Construct of the Project with the Bureau of Health Facilities and Services
- 2.4 At the second part, based on the Conceptual Design Documents, prepare the following Detailed Plans and other Documents for Bidding purposes in Forty Five (45) Working Days :
  - Detailed Architecture and Engineering plans
  - Technical Specifications



- Detailed Cost Estimates
  - Scope of Work
  - Approved Budget Cost and
  - Other documents for bidding per RA 9184 or The Government Procurement Reform Act
3. Bidding and Award - The Hospital Bids and Awards Committee (HBAC) shall:
    - 3.1 Be responsible for the Bidding and Award of the Project according to RA 9184 and its Implementing Rules and Regulation
    - 3.2 Complete the bidding and award at a reduced time frame (50%) as allowed under RA 9184
  4. Construction – The Hospital shall :
    - 4.1 Supervise project construction through its in-house or Contractual civil engineers
    - 4.2 As required for hospital safety, hire a Quality Assurance/Material Control Engineer to ensure the structural soundness and integrity of the project
    - 4.3 Ensure the proper, timely and transparent execution of the Contract including payments to the Contractor
    - 4.4 Be responsible for Final Acceptance of the Project
    - 4.5 Submit monthly reports to the CHD of physical and financial Accomplishment of the construction
  5. Design Build Project Delivery System – Should it choose this system the Hospital shall :
    - 5.1 Be governed by the rules of RA 9184 and its IRR and by the corresponding guidelines for design build scheme set forth under Government Procurement Policy Board Resolution 22-2007 entitled Approving and Adopting the Guidelines for the Procurement and Implementation of Contracts for Design and Build Infrastructure Projects
    - 5.2 Prepare the following documents in Thirty (30) days :
      - Conceptual Design Documents ( Refer to A. 2.1 for list)
      - Terms of Reference for Design Build Procurement
      - All other documents prescribed in RA 9184, its IRR and GPPB Resolution 22-2007 Annex A Item No. 7
    - 5.3 Ensure that its HBAC conduct the bidding and award for Design Build System according to RA 9184 and its IRR with a reduced time frame (50%) as may be allowed under RA 9184
    - 5.4 Assign a time frame of Forty Five (45) days for the Design Build Contractor to complete the Detailed Plans and other Bid Documents (Refer to A. 2.4 for list)
    - 5.5 Review , inspect and evaluate the Detailed Plans and recommend its approval
    - 5.6 Supervise construction through its in-house engineers or Contractual engineers
    - 5.7 As required for hospital safety, hire a Quality Assurance/Materials Control engineer to ensure the structural soundness and integrity of the project
    - 5.8 Ensure the proper, timely and transparent execution of the Contract including payments to the design build contractor
    - 5.9 Be responsible for the Final Acceptance of the project
    - 5.10 Submit monthly reports to the CHD of physical and financial accomplishment of the construction
  6. Technical Assistance – The CHD shall assist the hospital in all stages of implementation. Likewise for the National Center for Health Facility Development (NCHFD) in the Master Site Development Planning and Conceptual Design



## B. PROCEDURAL GUIDELINES AND DOCUMENTARY REQUIREMENTS FOR EQUIPMENT COMPONENT

1. Pre-Project Implementation – The Hospital shall :
  - 1.1 Follow Items A. 1.1 and 1.2 above under Pre-Project Implementation of Infrastructure projects
  - 1.2 In anticipation of Bidding and Award, prepare and ready the following documents :
    - Detailed Technical Specifications of each equipment
    - Other Documents as may be required under RA 9184 or the Government Procurement Reform Act
2. Bidding and Award – The HBAC shall be responsible for the Bidding and Award according to RA 9184 and its Implementing Rules and Regulations
3. Supply and Installation – The Hospital shall :
  - 3.1 Supervise equipment delivery, supply and installation through its in-house engineers
  - 3.2 Ensure proper, timely and transparent execution of the contract
  - 3.3 Submit monthly reports to the CHD of physical and financial Accomplishment
4. Technical Assistance – The CHD shall assist the Hospital in all stages of implementation. Likewise for the NCHFD and the Bureau of Health Devices and Technology in Technical Specifications

## VII. IMPLEMENTING GUIDELINES FOR LGU HOSPITALS

- A. The CHD shall check and ensure that the funds have been sub-alloted to them by the Finance Service
- B. The CHD shall then meet with the LGU concerned to discuss the proposed Upgrading Project and reach an agreement concerning the terms and conditions for project implementation
- C. A Memorandum of Agreement for this purpose will be executed between the CHD Director and the Provincial Governor. A copy of the MOA template is annexed to this Department Order for the guidance of the CHD
- D. In summary, the MOA contains the objectives, purpose and components of the Hospital Upgrading Project, the schedule of payments, responsibilities of the LGU and CHD from pre-project implementation to construction or equipment Installation, monitoring and reporting, and project acceptance.
- E. However, should a MOA exist between the DOH and the Province as an F1 Province or Roll-out Province site, the proposed Hospital Upgrading MOA will become a supplement to this existing MOA.

## VIII. MONITORING AND REPORTING

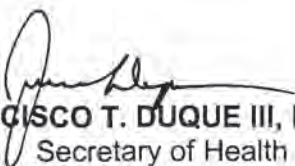
- A. The CHD shall conduct regular monitoring of the Hospital Upgrading Projects of both DOH and LGU hospitals
- B. It shall submit Quarterly Status Reports of physical and financial accomplishment to the Field Implementation and Management Office (FIMO) copy furnished the NCHFD
- C. The DOH, through the NCHFD shall submit consolidated Quarterly Status Reports to the Presidential Management Staff, the National Economic Development Authority, and other requesting agencies
- D. The CHD shall submit a Sub-allotment Utilization report to the Finance Service Copy furnished the NCHFD on or before December 31, 2008.

## IX. REPEALING CLAUSE

All other policies/issuances which are contrary to this Department Order shall be deemed superseded.

## X. EFFECTIVITY

This Department Order shall take effect immediately.

  
**FRANCISCO T. DUQUE III, MD, MSc**  
Secretary of Health



MEMORANDUM OF AGREEMENT

KNOW ALL MEN BY THESE PRESENTS:

This Agreement is entered into this \_\_\_\_\_ day of \_\_\_\_\_, 2008, in \_\_\_\_\_  
by and between

The **DEPARTMENT OF HEALTH Center for Health Development** \_\_\_\_\_  
with office address at \_\_\_\_\_  
represented by \_\_\_\_\_  
in his/her capacity as DIRECTOR IV, hereinafter referred to as CHD \_\_\_\_\_

and

The **PROVINCE OF** \_\_\_\_\_ with office address at \_\_\_\_\_  
\_\_\_\_\_ herein represented by **Hon.** \_\_\_\_\_  
\_\_\_\_\_ in his/her capacity as **GOVERNOR** hereinafter referred to as  
the PROVINCE

Witnesseth

**WHEREAS**, the DOH issued the “GUIDELINES AND PROCEDURES ON THE IMPLEMENTATION OF THE GOVERNMENT HOSPITAL UPGRADING PROJECT UNDER THE CY 2008 HEALTH FACILITIES ENHANCEMENT PROGRAM”

**WHEREAS**, the objectives of the Government Hospital Upgrading Project under the CY 2008 Health Facilities Enhancement Program are :

1. To upgrade government hospitals from primary to secondary level (licensing and accreditation standards)
  - 1.1 to be more responsive to the health needs of the catch-ment population
  - 1.2 to decongest tertiary hospitals
  - 1.3 to become base hospital for nursing students
  - 1.4 if needed, to become a BEmONC or CEmONC provider
2. In areas requiring hospital upgrading to tertiary level or expansion of existing Tertiary health services
  - 2.1 to be more responsive to the health needs of its catch-ment population
  - 2.2 to be Referral Hospitals of its catch-ment area or health facility network (i.e. in ILHZ) or as a Specialty Center
  - 2.3 to become CEmONC
  - 2.4 to become base hospital for nursing students and for nursing affiliation

**WHEREAS**, Sub Allotment Advice Order (SARO) No. \_\_\_\_\_ dated \_\_\_\_\_

\_\_\_\_\_ in the amount of \_\_\_\_\_  
has been sub allotted to the PROVINCE for the following project/s

**WHEREAS**, the purpose of the project/s is \_\_\_\_\_

**NOW , THEREFORE**, in consideration of the foregoing premises and stipulations herein set forth, the Parties hereto agree and do hereby agree as follows :

**A. FUND SCHEDULE**

1. The funds are available until December 31, 2009
2. The CHD - \_\_\_\_\_ shall pay the PROVINCE in accordance with the following schedule :

Allotment Class and Amount	Payments	Second Payment/ Succeeding Payments
_____		
_____		
_____		

**B. RESPONSIBILITIES OF THE PROVINCE**

The responsibilities of the PROVINCE are :

1. Ensure that the Hospital has the following requirements for CHD reference :
  - 1.1 Plans such as the Hospital 5-Year Development Plan based on Rationalization Process, Hospital Master Site Development Plan which translates, in physical terms the site, buildings and structures of the Hospital Development Plan, and the Hospital Investment Plan
  - 1.2 Human Resource Complement
  - 1.3 Official Policies, Systems and Procedures on Hospital Operations and Management
  - 1.4 Identified Infrastructure Needs and Cost Estimates
  - 1.5 Identified Equipment Needs and Cost Estimates
  - 1.6 Financing Sources including LGU support, Philhealth reimbursements, grants, loans



2. Ensure that Schematic Plans of infrastructure projects and the technical specifications of equipment are made according to existing DOH standards for licensing and development
3. Ensure that procurement of Infrastructure and Equipment contractors is conducted In accordance with the provisions of RA 9184, and its IRR and that CHD personnel are members of Bids and Awards Committee and Technical Working Groups for pre qualification and bid evaluation
4. Ensure that funds will be provided for the continuing maintenance and operations Of the infrastructure project and equipment
5. For the Infrastructure Component -
  - 5.1 Prepare the Schematic Floor Plans for Permit to Construct application
  - 5.2 Upon issuance of permit to construct, conduct soil boring tests of proposed project site, prepare plans showing location of utilities, as built plans of existing hospital buildings, and all other activities needed to start detailed architecture and engineering plans
  - 5.3 Complete Design Development Plans and Prepare Corresponding Detailed Architecture and Engineering Plans, Technical Specifications, Scope of Work, Bill of Quantities, Detailed Cost Estimates, Approved Budget of the Contract and all other Documents for Bidding Purposes following provisions of the National Building Code, Structural, Electrical, Sanitary and Mechanical Codes, Fire Code, Accessibility Law, and all other pertinent laws and regulations
  - 5.4 Bid and Award the infrastructure project in accordance with the provisions of RA 9184, and its IRR
  - 5.5 Supervise construction of the project following the highest standards for materials control, safety, and quality assurance and hire or assign a quality control engineer for the purpose
  - 5.6 Ensure that requests for payment are acted upon immediately and recommend to CHD any approval for payments
  - 5.7 Submit to CHD monthly progress reports of construction using CHD format
  - 5.8 Attend monitoring meetings called by the CHD and act immediately on observations made by CHD requiring corrections and revisions in construction
  - 5.9 Raise to the CHD for arbitration, any conflicts in construction and seek the clearance and approval first of the CHD for any proposed Variation Orders in construction
  - 5.10 Recommend to CHD acceptance of the Project
6. For the Equipment Component
  - 6.1 Prepare Technical Specifications of Equipment for purchase
  - 6.2 Bid and Award the Equipment in accordance with the provisions of RA 9184, and its IRR
  - 6.3 Supervise the supply and installation of the equipment



- 6.4 Ensure that requests for payment are acted upon immediately and recommend to CHD any approval for payments
- 6.5 Submit to CHD monthly progress reports of equipment supply and installation using CHD format
- 6.6 Attend monitoring meetings called upon by the CHD and act immediately on observations made by the CHD requiring corrections or revisions in supply or installation
- 6.7 Raise to CHD for arbitration any conflicts in supply and installation and seek first the clearance and approval of the CHD for any changes in Equipment Specifications, supply and installation
- 6.8 Recommend to CHD acceptance of the Equipment

### **C. RESPONSIBILITIES OF THE CHD**

The responsibilities of the CHD are

1. Ensure that the infrastructure and/or equipment components have been validated Based upon the submitted documents of the hospital as enumerated in Article B.1 above
2. Check that funds have been suballoted to the CHD for the LGU Hospital Project/s
3. Advise the hospital in the preparation of schematic plans for infrastructure and in the preparation of technical specifications for equipment
4. Approve schematic plans and issue the necessary permit to construct
5. Approve equipment specifications
6. Evaluate and approve Detailed Architecture and Engineering Plans, Technical Specifications, Detailed Cost Estimates, Scope of Work, Bill of Quantities, Approved Budget for the Contract, and all other Documents for bidding and award of infrastructure project
7. Attend all meetings called by the BAC in the conduct of procurement of contractor for infrastructure and equipment as member of the BAC and TWGs
8. Monitor progress of infrastructure construction and equipment supply and installation and act promptly on any requests for arbitration or for Variation Orders in construction and equipment works
9. Ensure that necessary certificates and licenses are issued promptly to facilitate upgraded level of the hospital
10. Upon recommendation of the PROVINCE, ensure that payments to contractors are made within the allowed period or based upon RA 9184 and auditing and accounting rules and regulations
11. Upon recommendation of the PROVINCE, act promptly on request for acceptance of the project/s
12. Provide training for Building and Equipment Maintenance
13. Submit quarterly status reports of physical and financial accomplishments to the Field Implementation and Management Office copy furnished the DOH National Center for Health Facility Development (NCHFD) and the Finance Service
14. Upon completion of project/s, submit a Fund Utilization Report to the DOH Finance Service copy furnished the NCHFD

**D. AMENDMENTS**

This MOA may be amended or revoked only upon mutual consent of both Parties; Provided that all amendments shall be covered by Supplemental Provisions signed by both Parties which shall be incorporated by way of reference as integral parts of this MOA.

**IN WITNESS WHEREOF,** the Parties have affixed their hands this \_\_\_\_\_ day of \_\_\_\_\_ 2008 at \_\_\_\_\_.

For the CHD \_\_\_\_\_

For the PROVINCE of \_\_\_\_\_

Director IV

Governor

Signed in the Presence of

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Witness

ACKNOWLEDGEMENT

REPUBLIC OF THE PHILIPPINES  
CITY OF \_\_\_\_\_

SUBSCRIBED AND SWORN TO BEFORE ME, the following personally  
appeared this \_\_\_\_\_ day of \_\_\_\_\_, 2008 at \_\_\_\_\_

Name	Residence Certificate	Date of Issue	Place of Issue
------	--------------------------	------------------	-------------------

Known to me to be the same persons who executed the foregoing document, consisting of  
6 pages including the page on which this acknowledgement is written and they  
acknowledged to me that the same is their free act and deed.

**WITNESS MY HAND AND SEAL** the day, year and place above written.

Doc No.  
Page No.  
Book No.  
Series of 2008





Republic of the Philippines  
Department of Health  
OFFICE OF THE SECRETARY

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06 February 2009

DEPARTMENT ORDER

No. 2009 - 0092

**SUBJECT:** Guidelines On The Release And Utilization Of Sub-Allotment/Fund Transfers From The Department Of Health Central Office To The Centers For Health Development and Local Government Units

**I. Rationale**

The Department of Health (DOH) is committed to achieve health sector goals, as stated in the National Objectives for Health (NOH) and the Medium Term Philippine Development Plan (MTPDP) including the attainment of the Millennium Development Goals (MDGs), through the implementation of health reforms under the *Formula one for Health (F1)*. Local Government Units (LGUs) are the main partners of DOH in achieving these goals. However, the attainment of health system goals within a devolved system is faced with the following challenges which may slow down the implementation of health reforms:

- i) Difference in health priorities between DOH and LGUs and among LGUs;
- ii) LGUs may lack the necessary skills and resources;
- iii) The catchment area of health services does not necessarily correspond to administrative boundaries which may not give enough incentives for LGUs to fully support health programs;
- iv) Certain technical resources may not be readily accessible to LGUs; and
- v) Weaknesses in governance mechanisms may lead to inefficient and inequitable health service delivery.

The DOH is mandated to assist local government units (LGUs) in effectively implementing programs, projects and activities that promote the health and well being of every Filipino. In performing this mandate, the DOH must address operational issues by systematizing the sub-allotment/transfer of resources from the DOH Central Office to the Centers for Health Development (CHDs) and to Local Government Units (LGUs). Sub-allotments/transfers shall be rationalized by (1) matching needs of CHDs and LGUs with available resources in the DOH Central Office, (2) improving coordination between the Central Office and CHDs for better implementation of programs in the field (3) harmonizing sub-allotments/transfers from various health programs and projects, and (4) establishing a reporting system that links activities with desired results and outcomes. Therefore, DOH resources shall be primarily used to leverage LGU performance based on the Province-wide Investment Plan for Health (PIPH) and as measured by the LGU Scorecard.

**2. Objective**

To provide administrative procedures in the release and utilization of funds sub-allotted/transferred to CHDs and LGUs for the implementation of programs and projects under the line items in the General Appropriations Act (GAA) for the Year 2009 specified in this order.

### 3. Scope and Coverage

- a. This Department Order shall cover all Maintenance and Other Operating Expenses (MOOE) and Capital Outlay (CO) sub-allotments and transfers for MOOE and CO from programs and projects as specified herein.
- b. This Order shall apply to all units in Central Office sub-allotting/transferring such resources and recipient CHDs and LGUs.

### 4. General Guidelines

- a. The Province-wide Investment Plan for Health (PIPH) and its Annual Operational Plan (AOP) shall be the basis for sub-allotment/transfer to CHDs and LGUs.
- b. The MOA covering the PIPH and its AOP signed by the Secretary of Health and the Governor shall be the legal basis for all transfers of funds from the DOH to the LGU.
- c. No other MOA shall be effected to implement specific transfers except for LGUs that have yet to develop their PIPH. In transition, transfers to LGUs without PIPH shall be covered by a separate MOA entered between the Secretary of Health and the Governor.
- d. CHDs shall be the focal units in managing cash transfers and steering the LGUs to attain desired health system goals.
- e. Funds sub-allotted to CHDs shall cover expenses for region-wide activities and transfers to LGUs within the region.
- f. The use of funds intended for LGUs shall be guided by:
  - Specific utilization guidelines for each program as specified in *Section 6* in this order; and
  - Allocation per LGU provided by each program.
- g. The CHDs should ensure that activities supported by fund transfers from the Central Office are reflected in the DOH counterpart in the AOP. Moreover, that this fund shall not replace the provincial and municipal investments committed in the AOP needed to improve performance.
- h. In general, transfers shall be made to support: (1) current performance levels and (2) target performance increases as stated in the AOP. Specific combinations of these two types of support will be stated in the guidelines of programs in this order.

### 5. Operational Mechanism

- a. The DOH through the CHD shall transfer cash to the trust account maintained by the LGU specifically for the transferred funds, unless otherwise specified, such as the following:
  - Health System Development Program Including Policy Support resources where it is transferred to the general fund account [Internal Revenue Allotment (IRA)] of the Provinces of Pangasinan, Mountain Province, Oriental Mindoro, Capiz, Negros Oriental, Biliran, Eastern Samar, North Cotabato, South Cotabato and Agusan del Sur
- b. CHDs may re-program funds allocated to LGUs with low disbursements to LGUs with high disbursements.
- c. For funds transferred to ARMM, DOH-Autonomous Region in Muslim Mindanao (DOH-ARMM) shall retain a maximum of 30 percent covering expenses incurred for the implementation of programs in the region.
- d. Unless otherwise specified in the specific guidelines, CHDs shall be responsible for timeliness of releases of funds to LGUs upon assessment of readiness of LGUs for the funds transfer.
- e. All disbursement of funds shall be subject to existing accounting rules and regulations.



## 6. Specific Guidelines

### a. Bureau of Local Health Development (BLHD)

Budget Line Item: A.II.e.2	<u>Health System Development Program Including Policy Support</u>
Total Amount:	PhP 276,066,667 [Maintenance & other Operating Expenses (MOOE)]
LGUs	PhP 253,066,667 (MOOE)
DOH-ARMM	PhP 23,000,000 (MOOE)

The budget line item shall be used for the *purpose* of implementing Local Health Systems Development strategies as proposed in their AOPs, including LGU Scorecard data development, generation and analysis, ILHZ development activities. The *expected outputs* are AOP activities/strategies implemented as reflected in LGU Scorecard outcomes. *Requirements for funds release* include the submission of an approved AOP 2009, or Service Level Agreement (SLA).

*Special Instructions:* The release of LGU allocation for the provinces is subject to the provisions of their respective 2009 SLAs as to allocations for fixed and variable tranches. The amount of variable tranche to be released for each of the said provinces shall be covered by the issuance of separate guidelines from the Central Office upon assessment of LGU performance by the CHD.

Budget Line Item: A.III.b.2.d	<u>Family Health including Family Planning</u>
Total Amount:	PhP 90,000,000 (MOOE)
CHD	PhP 46,000,000.00 (MOOE)
LGUs	PhP 44,000,000 (MOOE)

The budget line item shall be used by CHDs as support to LGUs on the development and implementation of PIPH/AOPs. The 2009 roll-out provinces shall use the budget line item as start-up funds for PIPH implementation including the development of the 2009 AOP. The *expected outputs* are AOP activities/strategies implemented as reflected in LGU Scorecard outcomes and with emphasis on prioritizing plan and implementation activities related to family health program, specifically in relation to maternal, neonatal, and child health and nutrition. *Requirements for funds release* include the submission of an approved PIPH.

### b. National Epidemiology Center (NEC)

Budget Line Item: A.III.b.1	<u>Epidemiology and Disease Surveillance</u>
Total Amount:	PhP 77,321,000 (MOOE)
CHD	PhP 36,196,000 (MOOE)
LGUs	PhP 25,000,000 (MOOE)
Hospitals	PhP 12,875,000.00 (MOOE)
DOH-ARMM	PhP 3,250,000.00 (MOOE)

The budget line item shall be used for the following *purposes*:

*CHDs:*

1. Conduct FHSIS training, reproduction of necessary forms and other activities
2. Conduct of Philippine Integrated Disease Surveillance Response (PIDSR) activities
3. Support to Regional Field Management Training Program (FMTP)
4. Conduct of ICD-10 Training for Coders
5. Support to the establishment of local epidemiology and surveillance system

*LGUs and DOH-ARMM:*

1. To be used exclusively for the establishment and operationalization of local epidemiology and surveillance units
2. In DOH-ARMM epidemiology and surveillance units shall particularly be for Lanao del Sur, Maguindanao and Tawi-tawi

*Hospitals*

1. To be used by Research Institute for Tropical Medicine (RITM) for the sentinel laboratories, laboratory support confirmation for anti-microbial, and laboratory support confirmation for outbreak
2. To be used by the National Kidney & Transplant Institute (NKTII) for support to Renal Registry
3. To be used by San Lazaro Hospital/SACCL for laboratory re-agents/support

The following are the *expected outputs* from the CHDs, DOH-ARMM and LGUs utilization of said line item:

1. Timely FSHSIS reports
2. FHSIS trained personnel
3. ICD-10 trained coders
4. PESU/MESU established

*Special Instructions:* NEC shall reserve the prerogative to re-program funds from one CHD to another based on performance.

**e. National Center for Disease Prevention and Control (NCDPC)**

Budget Line Item:	Public Health Development Program including Formulation of Public Health Policies and Quality Assurance
Total Amount:	PhP 70,850,000 (MOOE)
CHDs	PhP 29,700,000 (MOOE)
LGUs	PhP 34,900,000 (MOOE)
Hospitals	PhP 3,000,000 (MOOE)
DOH-ARMM	PhP 3,250,000 (MOOE)

The budget line item shall be used for the *purpose* of increasing local support for rapid elimination of endemic diseases and intensifying control of prevalent diseases in the area, to support the quality assurance (QA) efforts at the local level and mobilization of EPI activities.

The following are the *expected outputs* from the utilization of said line item:

1. Mobilization activities for Mass Drug administration for endemic diseases conducted
2. Increasing case finding for leprosy in endemic areas



3. Mobilization activities for EPI to support the routine outreach to follow-up the defaulters in areas with high unimmunized children, and Rapid Coverage Assessment (RCA) conducted
4. Essential drugs procured
5. Monitoring and rapid coverage assessment conducted
6. Capability building activities for QA conducted in ILHZ/provinces

*Special Instructions:* For performance-based grants

Budget Line Item:	Elimination of diseases as public health threat such as malaria, schistosomiasis, leprosy and filariasis
Total Amount:	PhP 43,230,000 (MOOE)
CHDs	PhP 37,030,000 (MOOE)
Sanitaria	PhP 3,900,000 (MOOE)
DOH-ARMM	PhP 2,300,000 (MOOE)

The budget line item shall be used to support activities and strategies that will eliminate filariasis, leprosy, and malaria as public health threats in endemic provinces, and for the following particular *purposes*:

*CHDs & DOH-ARMM*

1. Advocacy campaigns on the following:
  - 2.1 Kilatis Kutis launching for CHDs 3, NCR, 4A, 4B, 8, 12, Caraga and DOH-ARMM
  - 2.2 Filariasis, Malaria Awareness Months
3. social mobilization activities for mass drug administration including reproduction of needed IEC materials and MOP
4. Production of NLCP Operational Manual
5. Capacity building/Proficiency on the following:
  - 5.1 Training on Integrated Vector Control for CHDs 4B, 6 and 11
  - 5.2 Disease Surveillance (malaria) and border operations and treatment
  - 5.3 New Treatment Guidelines for Malaria
  - 5.4 Basic Leprosy and Integrated Microscopy
6. Support to QA/QC survey for drug reactions
7. Conduct zonal program review and multisectoral planning with other stakeholders
8. Conduct supervision, monitoring, rapid assessment and mid-term evaluation in provinces implementing mass drug administration;
9. Monitoring and validation of leprosy cases
10. Purchase of disability kit and supportive drugs for leprosy hyperendemic areas
11. Conduct disability surveys in filariasis-endemic areas
12. Validate existence of filariasis in other areas in the Provinces of Capiz and Lanao del Sur
13. Endemic mapping for filariasis

*Sanitaria*

1. Training, including hospitals identified as referral centers, in self-care and prevention of disabilities
2. Production and distribution of ointments for leprosy in CHDs 7 and 9
3. Validation of leprosy cases
4. Purchase of disability kit for leprosy

The following are the *expected outputs* from the utilization of said line item:

*CHDs & DOH-ARMM:*

1. Conducted advocacy campaigns (Kilatis Kutis, Filariasis, Malaria, Awareness Months) and social mobilization activities for mass drug administration
2. IEC materials and MOP reproduced, and NLPC Operational Manual in particular
3. Conducted capacity building/Proficiency on Integrated Vector Control, Malaria Disease Surveillance and Border Operations and Treatment, New Treatment Guidelines for Malaria, Basic Leprosy and Integrated Microscopy
4. QA/QC survey for drug reactions generated
5. Zonal program review and multisectoral planning conducted
6. Conducted supervision, monitoring, rapid assessment and mid-term evaluation in provinces implementing mass drug administration
7. Leprosy cases monitored and validated
8. Disability kit and supportive drugs for leprosy hyperendemic areas purchased
9. Disability surveys in filariasis-endemic areas conducted
10. Validated existence of filariasis in other areas in the Provinces of Capiz and Lanao del Sur
11. Endemic mapping for filariasis

*Sanitaria*

1. Hospital staff trained on self-care and prevention of disabilities
2. Ointments for leprosy produced and distributed
3. Leprosy cases validated
4. Disability kit for leprosy purchased

*Special Instructions:* CHDs and DOH-ARMM shall submit the following at the end of 2009:

1. Final report on activities conducted
2. Accomplishment reports per program

Budget Line Item: A.III.b.2.b.2	<u>Rabies Control Program</u>
Total Amount:	PhP 2,674,000 (MOOE)
CHD	PhP 2,674,000 (MOOE)

The budget line item shall be used to support activities and strategies that will eliminate rabies as public health threat in endemic provinces, and for the following particular *purposes*:

1. Advocacy campaigns such as Rabies Awareness Month
2. Conduct of Zonal Program Review and particularly for CHDs 4B and 9

The following are the *expected outputs* from the utilization of said line item:

1. Conducted advocacy campaigns such as Rabies Awareness Month
2. Zonal Program Review conducted and particularly for CHDs 4B and 9

Budget Line Item: A.III.b.2.b.3.b	<u>TB Control Program</u>
Total Amount:	PhP 98,316,000 [MOOE & Capital Outlay (CO)]
CHD	PhP 32,136,000 (MOOE) PhP 63,400,000 (CO)
LGUs	n/a
DOH-ARMM	PhP 1,480,000 (MOOE) PhP 1,300,000 (CO)



The budget line item shall be used for the following *purposes*:

*MOOE:*

1. To provide technical assistance in building capacities of regional and provincial health staff in the management of MDR-TB, TB in children, DOTS modular training for newly-hired nurses, TB Diagnostic Committee (TBDC) and Provider-Initiated Counseling and Testing
2. To support advocacy activities to celebrate World TB Day as well as the National TB Month

*Capital Outlay:*

1. Upgrading of Diagnostic/Treatment centers/warehouses

The following are the *expected outputs* from the utilization of said line item:

1. Advocacy campaigns conducted to celebrate World TB Day and National TB Month
2. Capacity building activities conducted on MDR-TB, TB in children, DOTS modular training for newly-hired nurses, TB Diagnostic Committee (TBDC) and Provider-Initiated Counseling and Testing
3. CHD warehouses, TB Reference Laboratories and Treatment centers/warehouses upgraded

Budget Line Item: A.III.b.2.b.3.c	<u>Other infectious diseases and emerging and re-emerging diseases including HIV/AIDS/STI, dengue, soli-transmitted helminthiasis, food and water-borne diseases</u>
Total Amount	PhP 30,600,000 (MOOE)
CHD	PhP 17,850,000 (MOOE)
Hospital/Sanitaria	PhP 12,450,000 (MOOE)
DOH-ARMM	PhP 300,000 (MOOE)

The budget line item shall be used to support activities and strategies to intensify reduction of, and enhance the capacity of the health facilities to respond to the following emerging and re-emerging infectious diseases: HIV/AIDS, dengue, soli-transmitted helminthiasis, food and water borne diseases, and for the following particular *purposes*:

1. Technical assistance, capability building and monitoring activities for LGUs
2. Implementation of national policies

The following are the *expected outputs* from the utilization of said line item:

1. Technical assistance, capacity building, and monitoring activities for LGUs, and implementation of national policies conducted.

*Special Instructions:*

1. All procurement for support to the refurbishment of Pediatric HIV Ward including medical products and commodities pertaining to pediatric patient care in San Lazaro Hospital needs clearance from NCDPC. Use of funds does not cover honoraria.
2. CHD 11 shall closely work with SACCL, Health Human resource Development Bureau (HHRDB) and NCDPC on the designation of CHD as training center for Mindanao on STI Laboratory diagnosis

Budget Line Item:	
A.III.b.2.c	<u>Non-Communicable Disease Prevention and Control</u>
Total Amount	PhP 3,900,000 (MOOE)
CHD	PhP 3,100,000 (MOOE)
LGUs	PhP 500,000 (MOOE)
DOH-ARMM	PhP 300,000 (MOOE)

The budget line item shall be used for the following *purposes*:

1. To support organization and functionality of regional coalitions for non-communicable disease prevention and control, and setting up of local coalitions at the provincial level as appropriate or applicable and support the training activities of the NCD program.
2. Funds sub-allotted to *CHD 6* will include fund transfer to the Province of Antique in the amount of PhP 500,000.00 for activities relative to the Tobacco Free Province Initiative

The following are the *expected outputs* from the utilization of said line item:

1. Functional regional/provincial coalitions for non-communicable disease prevention and control
2. Training conducted for Promotion of Healthy Lifestyle and/or Prevention of Blindness Program/Psychosocial Training for Mental Health
3. Support to Tobacco Free Initiative for the Province of Antique

Budget Line Item:	
A.III.b.2.d	<u>Family Health including Family Planning</u>
Total Amount:	PhP 250,682,237 (MOOE)
CHDs	PhP 75,700,341 (MOOE)
LGUs	PhP 141,305,990 (MOOE)
Hospitals	PhP 18,231,600 (MOOE)
DOH-ARMM	PhP 15,444,306 (MOOE)

The budget line item shall be used for the following *purposes*:

*CHDs and DOH-ARMM*

1. For expenses incurred in extending technical assistance to LGUs in accessing performance-based grants of the Family Health including Family Planning program.
2. Capability building on the Management of Oral Health Program in regions CAR, VII and X, and on Infant and Young Child Feeding (IYCF) Counseling.
3. Child Injury Safe Settings Assessment for the Provinces of Antique, Davao and Abra
4. Augmentation fund for Newborn Screening (NBS) LGU Assemblies in regions V, VIII, XII and ARMM
5. Printing/reproduction of 36 copies per region of the Child Growth Standard Manual
6. Support to *hospitals* for voluntary surgical (VSC) drugs and medical supplies

*LGUs*

1. For mobilization activities in implementation of family health programs;
2. As grants based on the capacity of LGUs to provide MNCHN including FP/RH services



3. For procurement of supplies and essential drugs and medicines for BEmONC/CEmONC facilities in regions with highest MMR and F1 priority sites
4. For Integrated Management of Childhood Illnesses (IMCI) activities in CHD-CAR and the Provinces of Ilocos Norte, Pangasinan, Mountain Province, Nueva Vizcaya, Oriental Mindoro, Negros Oriental, Biliran, Southern Leyte, Misamis Occidental, North Cotabato, South Cotabato and Agusan del Sur

The following are the *expected outputs* from the utilization of said line item:

*CHDs and DOH-ARMM*

1. Technical assistance to LGUs rendered.
2. Conducted Basic Course on Management of Oral Health Program in regions CAR, VII and X, and IYCF Counseling Integrated Course.
3. Conducted Child Injury Safe Settings Assessment in the Provinces of Antique, Davao and Abra
4. Augmentation fund provided for NBS LGU assemblies
5. 36 copies per region of the Child Growth Standard Manual printed/reproduced
6. VSC drugs and medical supplies provided to *hospitals*

*LGUs*

1. Mobilization activities conducted.
2. Essential supplies and drugs for BEmONC/CEmONC procured.
3. Enhanced knowledge, skills and practices of health workers in the wholistic assessment and management of the well and sick child
4. Conducted IMCI activities by CHD-CAR and in the Provinces of Ilocos Norte, Pangasinan, Mountain Province, Nueva Vizcaya, Oriental Mindoro, Negros Oriental, Biliran, Southern Leyte, Misamis Occidental, North Cotabato, South Cotabato and Agusan del Sur

*Special Instructions:* For performance-based grants in Reproductive Health, LGUs shall receive grants based on the results of Contraceptive Self-Reliance Assessment to be conducted by the Central Office. Actual allocation of each LGU shall be provided by the NCDPC. For ARMM, DOH-ARMM can retain a maximum of 30% out of the total amount allocated to the region for Family Health including Family Planning Program.

Budget Line Item:	
A.III.b.2.e	<u>Environmental and Occupational Health</u>
Total Amount	PhP 29,750,000 (MOOE)
CHDs	PhP 29,300,000 (MOOE)
LGUs	n/a
DOH-ARMM	PhP 450,000 (MOOE)

The budget line item shall be used for the following *purposes*:

1. Support to implementation of sanitation projects and activities to attain MDGs
  2. Support to Regional Inter-agency Committee on Environmental health (RIACEH) operation and other EOH priority activities in 16 CHDs and ARMM
  3. Awarding/performance based grants to LGUs through the CHD
- The following are the *expected outputs* from the utilization of said line item:
1. Higher level of households covered with sanitary facilities
  2. Operation of RIACEH in the 16 CHDs and DOH-ARMM
  3. Conduct of Search for Barangay with Best Sanitation Practices in the 17 regions

4. Conduct of Climate Change Conference in Regions 7, 10, and CAR
5. Conduct of Health Care Waste Management Training in Region 6 and 7

**d. National Center for Health Promotion (NCHP)**

Budget Line Item: A.III.b.4	<u>National Center for Health Promotion</u>
Total Amount:	PhP 11,500,000 (MOOE)
CHD	PhP 10,780,000 (MOOE)
DOH-ARMM	PhP 720,000 (MOOE)

The budget line item shall be used for the following *purposes*:

1. For leveraging/support to health promotion activities
2. For the operationalization of the health promotion activity of the priority health activities of the DOH
3. The following amounts from the funds transferred to *DOH-ARMM* and sub-allotted to *CHDs 3, 6, 7, 9, 10, 11, 12 and NCR* shall be used for the conduct of the 3-day Frontline Health Workers Training on Interpersonal Communication, particularly for board and lodging expenses of participants:
  - PhP 350,000.00 each for CHDs 3 and 9
  - PhP 370,000.00 for CHD 6
  - PhP 260,000.00 for CHD 7
  - PhP 340,000.00 for CHD 10
  - PhP 360,000.00 each for CHDs 11 and 12
  - PhP 390,000.00 for CHD NCR
  - PhP 220,000.00 for DOH-ARMM

The following are the *expected outputs* from the utilization of said line item:

1. Health promotion plan, which includes advocacy plan, communication plan, social mobilization plan or social marketing plan
2. Media plan and media placements (TV, radio and print)
3. Reproduction of IEC materials in local dialects and dissemination to target population
4. Conduct of advocacy meetings, social mobilization and launching events
5. Selected frontline health workers nationwide will be trained on interpersonal communications to improve the sharing of information with their client in order to direct the latter's actions to practice and sustain healthy behaviors

**e. Health Emergency Management Services (HEMS)**

Budget Line Item: A.III.b.5	<u>Health Emergency Management Staff</u>
Total Amount:	Php 131,215,000 (MOOE)
CHD	Php 33,975,000 (MOOE)
LGUs	Php 42,000,000 (MOOE)
Hospitals	Php 49,240,000 (MOOE)
DOH-ARMM	PhP 6,000,000 (MOOE)

The budget line item shall be used for the following purposes:

*CHDs and DOH-ARMM*

1. To ensure a comprehensive and integrated health sector emergency management
2. To improve capability of Health Emergency Managers



### *Hospital*

1. To strengthen the DOH – Hospital Health Sector response
2. To improve capability of Health Emergency Managers
3. To maintain functionality of OPCEN

### *LGU*

1. To empower selected LGUs on emergency management
2. To institutionalize HEM at the LGU level

The following are the *specific guidelines* on the use of the said funds:

1. Funds allocated as 60% for preparedness activities and 40% for response activities
2. Additional funds given to CHDs, Hospitals and LGUs which have at least 2 of the following criteria:
  - 2.1 With HEPPRP/Project Proposal
  - 2.2 Hazard prone areas
  - 2.3 Island provinces
  - 2.4 FI provinces
3. To be used in the conduct of preparedness activities such as:
  - 3.1.1 To be used in the conduct of meetings for the dissemination of the HEPPRP among the other health staff
  - 3.1.2 To be used in the testing of the developed HEPPRP
  - 3.1.3 To conduct intra – intersectoral and Cluster meetings in order to develop support/assistance from partner agencies.
  - 3.1.4 To conduct networking activities in order to develop/strengthen Regional HEMS networks
  - 3.1.5 To conduct advocacy meetings/activities in order to institutionalize HEMS at the LGU level.
  - 3.1.6 To conduct capability building on HEMS such as Basic Life Support (BLS), Sub – national PHEMAP, Nutrition in Emergency and Chemical Incident Management Training, etc.
  - 3.1.7 To conduct promotional and advocacy activities like the development of IEC materials and observance of the National Disaster Consciousness Month, etc.
  - 3.1.8 To be used as resource assistance in the attendance to HEMS activities called upon by the HEMS – CO.
4. To be used in the conduct of Response activities such as:
  - 4.1.1 To sustain the operationalization of the OPCEN through the provision of supplies and materials and if necessary, equipment
  - 4.1.2 To ensure the openness of communication line with HEMS Coordinators/Asst. HEMS Coordinators specially during health emergencies and disasters.
  - 4.1.3 To support the mobilization of Emergency Medical Responders during health emergency and disasters.
  - 4.1.4 To be used for the provision of antidotes, drugs and medicine, medical supplies, reagents and sample laboratory examinations/service fees as Hospital Poison Center
  - 4.1.5 To be used for the provision of logistics to the emergencies and disasters sites
5. To strengthen the Health Emergency Capacity of Davao Region
6. For the provision of sanitary toilet at selected permanent evacuation sites at the province of Albay
7. To provide for contingency funds for drugs required in emergencies/disasters in Luzon, Visayas and Mindanao at East Avenue Medical Center (EAMC), Vicente Sotto Memorial Medical Center (VSMCC) and Davao Medical Center (DMC), respectively.

Following are the *expected outputs* from the utilization of said line item:

1. Institutionalization of HEMS policies at all levels
2. Functional OPCEN specially during times of health emergency and disasters
3. Emergency Medical Responders mobilized at health emergency and disaster sites on time
4. Health emergency network organized
5. Available drugs and medicines at all disaster sites
6. Training courses on HEM conducted
7. Functional Poison Control Center

**f. National Center for Health Facilities Development (NCHFD)**

Budget Line Item: A.III.b.6.a	Formulation Of Policies, Standards, And Plans For Hospital And Other Health Facilities (NCHFD Proper)
Total Amount:	PhP 45,520,000.00 (MOOE)
CHD	PhP 5,420,000 (MOOE)
DOH Hospitals	PhP 38,600,000 (MOOE)
DOH-ARMM	PhP 1,500,000.00 (MOOE)

The budget line item shall be used for the following *purposes*:

*CHD*

1. To conduct Workshops for Rationalization Plans of Provincial Health Care Delivery System based on Health Needs for 15 FI Roll-out Provinces
2. To conduct CHD Training Workshops on Implementation Manual for Rationalization Plan

*LGUs*

1. To conduct Workshops for Rationalization Plans for FI Roll-out Provinces in ARMM

*DOH Hospitals*

1. To fully operationalize the National Reference Laboratories (NRLs) at LCP, NKTl, RITM, SLH & EAMC to perform confirmatory tests, resolution of conflicting results, external quality assessment, surveillance, training of laboratory personnel and hiring of consultants
2. To support the implementation of National External Quality Assurance (NEQAS) in Hematology and Clinical Chemistry to be conducted by the NRLs at NKTl and LCP to ensure the quality test results of clinical laboratories.
3. To upgrade laboratory services of selected regional and provincial public health laboratories through provision of reagents, supplies and equipment.

The following are the *expected outputs* from the utilization of said line item:

*CHD*

1. Provincial rationalization plans of 15 FI Roll-out provinces (in Luzon & Mindanao) which will be used as basis for investment in the health sector.
2. Rationalization plans of provinces at ARMM at the provincial level which will be used as basis for investment in the health sector specifically for provinces under ARMM.

*DOH Hospitals*

1. NEQAS in Hematology and Clinical Chemistry by NRLs at NKTl and LCP to ensure quality laboratory results and as basis for renewal of licenses of clinical laboratories by BHFS/CHDs.



2. Upgraded laboratory services of selected regional and provincial public health laboratories.

Budget Line Item: A.III.b.6.b	National Voluntary Blood Services Program (NVBSP) and Operation of Blood Centers
Total Amount:	PhP 23,318,048 (MOOE)
CHD	PhP 16,338,700 (MOOE)
DOH Hospitals	PhP 5,679,348 (MOOE)
DOH-ARMM	PhP 1,300,000 (MOOE)

The budget line item shall be used for the following purposes:

*CHD*

1. Training of Donor Recruitment Officers (DROs) in all provinces to augment training of DROs in GFR6 funded Blood Safety Sites
2. Support for the continuous operation of Blood Centers
3. Salary of Contractual Personnel

*LGU*

1. Capability building: Training of DROs for all provinces under ARMM
2. Monitoring & Evaluation of DROs.
3. Inter-Agency Meeting & Blood Letting activity.

*DOH Hospitals*

1. Total elimination of paid & replacement donation & for the blood units (1,000 units) provided to Metro Manila during lean months.
2. For confirmatory testing of blood donor samples & blood units.
3. To cover cost of (CD4) & viral load for HIV confirmed blood donors.

*Others*

1. Blood assistance to indigent patients provided by PNRC.

The following are the *expected outputs* from the utilization of said line item:

*CHD*

1. Centralized blood collection, testing & processing of blood through voluntary blood donation
2. Increased voluntary blood donation
3. Ensure safe, adequate blood supply for BEmONC, CEmONC and health facilities administering transfusion to patients in need of blood
4. Total elimination of paid & replacement donation.

*LGU and DOH Hospitals*

1. Increased voluntary blood donation.
2. Total elimination of paid & replacement donation.
3. Ensure safe, adequate blood supply for BEmONC, CEmONC and health facilities administering transfusion to patients in need of blood

*Others*

1. Provision of adequate supply of safe blood for indigent patients in government hospitals.

Budget Line Item: A.III.b.6.c	<u>Health Facilities Enhancement Program</u>
Total Amount:	PhP 2,002,526,000 (CO)
· CHD	PhP 1,922,826,000 (CO) )* * For LGU Hospital/Health Facilities upgrading. However, further fund transfer to LGUs will be subject to CHD discretion and final list from Central Office.
DOH Hospitals	PhP 79,700,000 (CO)

The budget line item shall be used for the following *purposes*:

*CHD*

1. To upgrade selected local government hospitals/facilities from primary to secondary hospital, and from secondary to tertiary level, and to become BEmONC or CEmONC facilities
2. To upgrade selected Barangay Health Stations(BHSs) and Rural Health Units (RHUs) to provide BEmONC services.
3. To establish a Geriatric Center in Metro Manila.

*LGU*

1. To upgrade selected local government hospital/health facilities from primary to secondary and from secondary to tertiary level, and to become BEmONC or CEmONC facilities.

*DOH Hospital*

1. To upgrade selected DOH Hospitals for tertiary hospital and sub-specialty services as Regional Heart-Lung-Kidney Centers (Western Visayas Regional Hospital, Bacolod City and Davao Medical Center, Davao City)

The following are the *expected outputs* from the utilization of said line item:

*CHD*

1. Upgraded selected government primary and secondary Hospitals to be more responsive to the health needs of its catchment population; to decongest DOH Tertiary Hospitals ; to become base hospital for nursing students; to become BEmONC and CEmONC facilities;
2. Upgraded RHUs and BHSs to provide BEmONC services
3. Construction of a Geriatric Center in Metro Manila

*LGU*

1. Upgraded selected government primary and secondary Hospitals to be more responsive to the health needs of its catchment population; to decongest DOH Tertiary Hospitals; to become base hospital for nursing students; to become BEmONC and CEmONC facilities;
2. Upgraded RHUs and BHSs to provide BEmONC services

*DOH Hospitals*

1. Upgraded selected DOH Hospitals for tertiary and sub-specialty services as Regional Heart-Lung-Kidney Centers to be more responsive to the health needs of its catchment population; to become referral hospital; to become base hospital for nursing school and for nursing affiliation.

*Special Instructions:* NCHFD shall provide specific guidelines and amounts upon receipt of the Special Allotment Release Order (SARO) from the Department of Budget and Management.



## 7. Functions and Responsibilities of Offices/Units in this Order:

- a. Office of the Sectoral Management & Coordination/Service Delivery (SMCO/SD) and SMCO Cluster Head
  - Collate funds for sub-allotment/transfer to the CHDs and LGUs from Central Office Units;
  - Issue the Department Order that would enable fund sub-allotment/transfer;
- b. Field Implementation Management Office (FIMO)
  - Collate from the CHDs the following documents in accordance with the routine submission stipulated under Department Memorandum no. 2008-0245:
    1. LGU Scorecard;
    2. Liquidation of Sub-allotments;
    3. PIPH & AOP (as needed);
    4. HEMS Summary Report;
    5. Supplemental WFP for the sub-allotted funds;
    6. Monthly Cash Program for sub-allotted funds
  - Represent the DOH relative to the fund transfers to ARMM;
  - Receive report on the disbursement of transfer funds and Supplemental WFP for the transferred funds from ARMM.
- c. Health Policy Development & Planning Bureau (HPDPB)
  - Assist in collating the funds for sub-allotment/transfer to CHDs and LGUs;
  - Conduct M&E relative to the sub-allotted/transferred resources;
- d. BLHD
  - Collate the funds for sub-allotment/transfer to CHDs and LGUs;
  - Analyze reports on resource transfers that are submitted by the CHDs to FIMO;
  - Conduct supervision missions
- e. Central Office Units Managing Line Items for Sub-allotment/Transfer
  - Cause the sub-allotment/transfer of funds to the CHDs and ARMM;
  - Identify and submit funds for sub-allotment/transfer to the Office of the PSDT/SD and SMCO Cluster Head
- f. Finance Service
  - Manage fund releases to the CHDs;
  - Track fund releases to the CHDs; and,
  - Develop a monthly cash program based on WFP submitted for sub-allotted funds.
- g. CHDs
  - Transfer funds to the LGUs with reference to the PIPH MOA between the DOH and the LGU when LGU meets the necessary requirements for funds release
  - Manage and track the flow of funds to LGUs;
  - Submit required documents to FIMO;
  - Track fund releases to LGUs relative to the appropriate performance benchmarks;
  - Receive report on the disbursement of transferred funds from LGUs; and,
  - Provide TA to LGUs relative to use of funds transferred in PIPH/AOP development and implementation.

h. LGUs

- Manage and administer the transferred funds in accordance with Book II Title Five of the Local Government Code of 1991 and the allocated commodities in accordance with the technical guidelines issued for the purpose;
- Submit report on the disbursement of transferred funds to the appropriate CHD
  - the Provinces of Ilocos Norte, Pangasinan, Ifugao, Mountain Province, Nueva Vizcaya, Oriental Mindoro, Romblon, Capiz, Negros Oriental, Biliran, Eastern Samar, Southern Leyte, Misamis Occidental, North Cotabato, South Cotabato and Agusan del Sur shall submit quarterly Fund Utilization Report (FUR); and,
- Develop a PIPH/AOP and abide by its provisions.

i. ARMM

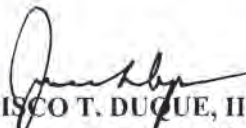
- Receive funds according to the MOA;
- Provide FIMO with a report on the disbursement of transfer funds and Supplemental WFP for the transferred funds;
- Utilize received funds according to the pertinent provisions of this Order; and,
- Develop an AOP and abide by its provisions.

**8. Monitoring and Evaluation**

- a. CHDs and ARMM shall prepare a Supplemental Work and Financial Plan and monthly cash program for sub-allotment/transfer and submit to FIMO and Finance Service.
- b. CHDs shall prepare and submit a Liquidation of Sub-allotments semi-annually to FIMO
- c. To assess implementation of PPAs, bi-annual performance assessment shall be conducted by the CHDs and the FIMO.
- d. To assess sectoral performance at the local level, annual supervision missions will be undertaken by the DOH Central Office;
- e. A general annual assessment of results using the LGU Scorecard will be conducted.

**Annexes:**

- Annex A LGU Scorecard
- Annex B *Summary Table 1: By Line Item, By CHD/LGU, By Percentage of Total MOOE*
- Annex C Semi-annual Fund Utilization Report for CHDs and LGUs
- Annex D Reporting Template

  
FRANCISCO T. DUQUE, III, MD, MSc  
Secretary of Health



I. STANDARDS FOR SET PERFORMANCE INDICATORS FOR LGU SCORECARD

F1 PPA's	Table 4. LGU SCORECARD SET I/ OUTCOMES ANNUAL PERFORMANCE ASSESSMENT		
	PERFORMANCE INDICATORS (Data Source)	DEFINITIONS & STANDARDS	KEY /SPECIAL INSTRUCTIONS INSTRUCTIONS
A. Disease Free Zone Initiatives	1- Percent coverage of target population in endemic provinces with mass treatment for Filariasis (ELF NCDPC)	<b>Numerator:</b> Number of persons given MDA <b>Denominator:</b> Total population in Implicated Units(endemic area) <b>Multiplier:</b> 100 <b>Reference:</b> FHSIS <b>Target 2010:</b> 85% Annually (NOH 2010) <b>Equity Dimension:</b> Income Class or Education (ELF NCDPC)	Endemic area may be a baranggay or municipality, or a province. Thus, the population of the implicated baranggay, municipality or province, respectively, should be used as denominator.
	2- Percent coverage of target population in endemic provinces with mass treatment for Schistosomiasis (FHSIS)	<b>Numerator:</b> Number of persons given mass treatment <b>Denominator:</b> Total population in endemic units(endemic area) <b>Multiplier:</b> 100 <b>Reference:</b> STANDARD (not in FHSIS) <b>Target 2010 :</b> 85% STANDARD (none in NOH 2010) <b>Equity Dimension:</b> Income Class or Education Level (Special Survey)	Endemic area may be a baranggay or municipality, or a province. Thus, the population of the implicated baranggay, municipality or province, respectively, should be used as denominator.
	3- Annual Parasite Incidence for Malaria	<b>Numerator:</b> Number of malaria cases in the population <b>Denominator:</b> At risk Population/general population <b>Multiplier:</b> 1000 <b>Reference:</b> FHSIS <b>Target 2010:</b> <0.1/1000 (FHSIS, NOH 2010) <b>Equity Dimension:</b> Income Class or Education Level (Malaria Information System, NCDPC)	
B. Intensified Disease Prevention and Control	4- TB Case Detection Rate (NTP Register)	<b>Numerator:</b> Number of new smear-positive TB cases identified <b>Denominator:</b> Estimated number of cases for the year <b>Multiplier:</b> 100 <b>Reference:</b> TB CUP; WHO, Monitoring Progress in TB Control, METHODS. <b>Target 2010:</b> 70% <b>Equity Dimension:</b> Income Class or Education Level (NTP Register)	<ul style="list-style-type: none"> <li>• Number of new smear + and relapse cases from the Case Finding Report</li> <li>• Estimated number of cases for the year is taken from the NTP</li> </ul>

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	5- TB Cure Rate (NTP Register)	<p><b>Numerator:</b> Number of new smear-positive pulmonary TB cases registered in a specified period that were cured</p> <p><b>Denominator:</b> Total number new smear positive pulmonary TB cases registered in the same period</p> <p><b>Multiplier:</b> 100</p> <p><b>Reference:</b> TB CUP, FHSIS</p> <p><b>Target 2010:</b> 85%</p> <p><b>Equity Dimension:</b> Income Class or Education Level(NTP Register)</p>	
C. Child Health	6- Percentage Fully Immunized Child (FHSIS)	<p><b>Numerator:</b> No. of infants given BCG, OPV3, DPT3, Hep B3 and Measles vaccine before 12 months of age</p> <p><b>Denominator:</b> Total Population x 2.7%</p> <p><b>Multiplier:</b> 100</p> <p><b>Reference:</b> FHSIS</p> <p><b>Target 2010:</b> 95% (NOH 2010)</p> <p><b>Equity Dimension:</b> Income Class or Education Level(Special Survey)</p>	
	7- Percentage of newborns initiated breastfeeding within one hour after birth (FHSIS or other data source)	<p><b>Numerator:</b> No. of postpartum women initiated breastfeeding within 1 hour after giving birth</p> <p><b>Denominator:</b> Total Population x 3%</p> <p><b>Multiplier:</b> 100</p> <p><b>Reference:</b> FHSIS</p> <p><b>Target 2010:</b> 85% STANDARD (No target in FHSIS NOH 2010)</p> <p><b>Equity Dimension:</b> Income Class or Education Level</p>	<ul style="list-style-type: none"> <li>FHSIS Post-Partum TCL is source of numerator</li> </ul>
	8- Percentage of Protein Energy Malnutrition among 0-5years old based on weight for age anthropometric measurement (OPT data from LGU records)	<p><b>Numerator:</b> Number of 0-5 years old with Below normal low &amp; Below normal very</p> <p><b>Denominator:</b> Total number of 0-5 yrs. old</p> <p><b>Multiplier:</b> 100</p> <p><b>Reference:</b> NOH 2010</p> <p><b>Target 2010:</b> 24 % (NOH 2010)</p> <p><b>Equity Dimension:</b> Income Class or Education Level(Special Survey)</p>	
D. Maternal Health	9- Percentage of Facility Based Deliveries (FHSIS)	<p><b>Numerator:</b> Number of mothers delivering in hospital, other places *</p> <p><b>Denominator:</b> Total number of deliveries in home, hospital, others</p> <p><b>Multiplier:</b> 100</p> <p><b>Reference:</b> NOH 2010</p> <p><b>Target 2010:</b> 70 % (NOH 2010)</p> <p><b>Equity Dimension:</b> Income Class or Education Level(Special Survey)</p>	*Other places must be a health facility birthing capacity
	10- Contraceptive Prevalence Rate (FHSIS)	<p><b>Numerator:</b> Number of women of reproductive age who are using (or whose partner is using) a contraceptive method at a given point in time</p> <p><b>Denominator:</b> Number of women of reproductive age at risk of pregnancy at the same point in time (14.5% of total population)</p> <p><b>Disaggregated by type of contraceptive used.</b></p> <p><b>Multiplier:</b> 100</p> <p><b>Reference:</b> FHSIS</p> <p><b>Target 2010:</b> 85 % (NOH 2010)</p> <p><b>Equity Dimension:</b> Income Class or Education Level(Special Survey)</p>	

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E. Healthy Lifestyle , Health Risk Management, and Advocacy	11- Percentage of HH's with access to safe water (FHSIS)	<b>Numerator :</b> Total no. of HH with access to safe water (Level I,II, III) <b>Denominator :</b> Total No.of HHs <b>Multiplier:</b> 100 <b>Reference:</b> FHSIS <b>Target 2010:</b> 94 % (NOH 2010) <b>Equity Dimension:</b> Income Class or Education Level(Special Survey)	
	12- Percentage of HH's with access to sanitary toilet facilities (FHSIS)	<b>Numerator :</b> Total no. of HH with Sanitary Toilet <b>Denominator :</b> Total No. of HHs <b>Multiplier:</b> 100 <b>Reference:</b> FHSIS <b>Target 2010:</b> 91 % (NOH 2010) <b>Equity Dimension:</b> Income Class or Education Level(Special Survey)	
F. Surveillance/ Epidemic Management System			
G. Disaster Preparedness and Response System			
H. Health Facilities Development Program (National/Local; Public/Private) a. Rationalization of local health facilities to include BEMOC/CEMOC b. Health human resource provision/capability building c. Integration of wellness services in hospitals	13- Average Length of Stay in Hospitals in days (Hospital Records or Reports)	<b>Numerator:</b> Total Inpatient Days of Care <b>Denominator:</b> Total Number of Admissions <b>Multiplier:</b> 100 <b>Reference:</b> Health Statistics-Tools of the Trade <b>Target 2010:</b> 5 Days STANDARD% (no NOH target) <b>Equity Dimension:</b> Charity Ward and Pay Ward Disparity (Hospital Records)	
	14- Average Occupancy Rate for 1 <sup>st</sup> to 3 <sup>rd</sup> level public and private hospitals (Hospital Reports)	<b>Numerator:</b> Total Inpatient days of care in all public and private hospitals <b>Denominator:</b> Total bed days available in all public and private hospitals <b>Multiplier:</b> 100 <b>Reference:</b> Health Statistics-Tools of the Trade <b>Target 2010:</b> 85% STANDARD% (no NOH target) <b>Equity Dimension:</b> Charity Ward to Pay Ward Disparity (Hospital Records)	Add all inpatient days of care in public and private hospitals in the province-wide health system to get numerator Add all bed days available for the year in all public and private hospitals in the PWHS
	15- Average Hospital Gross Death Rate from maternal causes (Health Facility Records or Reports)	<b>Numerator:</b> Death from maternal causes in all public and private health facilities <b>Denominator:</b> Total Maternal cases Admitted <b>Multiplier:</b> 100 <b>Target 2010:</b> <1% STANDARD% (no NOH target) <b>Equity Dimension:</b> Charity Ward to Pay Ward Disparity (Hospital Records)	Maternal causes of death are all direct causes deaths related to pregnancy

	16- BEMOC to Population ratio (LGU Records)  Expressed as ratio of 1 BEMOC: Population	<b>Numerator:</b> Number of Public and Private implementing BEMOC <b>Denominator:</b> Total Population <b>Multiplier:</b> NONE <b>Reference:</b> IPACT, Calculation of EMOC Indicators <b>Target 2010:</b> 1 BEMOC to 125,000 population <b>STANDARD</b> (no NOH target) <b>Equity Dimension:</b> Income Class or Education Level(Hospital Records)	
<b>A. Compliance to National Health Legislation and Standards for</b>			
a. Compliance to PhilHealth Accreditation standards for health facilities	17- Percentage of RHU's accredited by PhilHealth for OPB, MCP and TB-DOTS package (PHIC Records)	<b>Numerator:</b> Number of RHUs accredited by PhilHealth for specific benefit package <b>Denominator:</b> Total Number RHUs in PWHS <b>Multiplier:</b> 100 <b>Reference:</b> PHIC <b>Target 2010:</b> Out Patient Benefit (OPB) = 80% Maternity Care Package (MCP) = 90 % TB-DOTS = 50% <b>Equity Dimension:</b> Disparities of Urban To Rural Municipalities ? (Records Review)	Disaggregated for OPB, MCP, and TB-DOTS Package
b. Compliance to DOH licensing standards for health facilities			
<b>B. Enactment of Health/ Health Related local</b>			
<b>C. Improvement of Access to Low Cost Quality Drugs</b>	18- Botika ng Barangay to barangay ratio (LGU Records or PMU Records)	<b>Numerator:</b> Total Number of Botika Ng Baranggay (BnB) <b>Denominator:</b> Total Number of Baranggay <b>Multiplier:</b> None <b>Reference:</b> NOH 2010 <b>Target 2010:</b> 1 BnB for every 2 Baranggays <b>Equity Dimension:</b> Disparities of Urban To Rural Municipalities? Or of Highest and Lowest Performing Muncipality(Records Review)	
<b>A. Expansion of National Health Insurance Program (NHIP)</b> a. universal coverage	19- Percentage of families enrolled in NHIIP (PHIC Records)	<b>Numerator:</b> Total Number of Families Enrolled <b>Denominator :</b> Total number of families <b>Multiplier:</b> 100 <b>Reference:</b> NOH 2010 <b>Target 2010:</b> 85% <b>Equity Dimension:</b> Disparities of Sponsored Families and Formal Sector Families (PhilHealth Records)	

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<p>b. PhilHealth accreditation of facilities c. rational use of PHIC reimbursements d. local government</p>	<p>20- Percentage of poor families enrolled in NHIP (PHIC Records)</p>	<p><b>Numerator:</b> Total Number of poor families Enrolled <b>Denominator :</b> Total number of poor families identified by means test acceptable to PhilHealth <b>Multiplier:</b> 100 <b>Reference:</b> NOH 2010 <b>Target 2010:</b> 100 % <b>Equity Dimension:</b> Disparities of Sponsored Families and Formal Sector Families</p>	
<p>B. Increase in LGU investment for Health</p>	<p>21- Percentage of Provincial Budget allocated to health (LGU Budget Documents)</p>	<p><b>Numerator:</b> Total health budget in PWHS (all municipal health budgets + provincial health budget) <b>Denominator:</b> Total budget in PWHS (all municipal budgets + provincial budget) <b>Multiplier:</b> 100 <b>Reference:</b> NOH 2010 <b>Target 2010:</b> 22 % <b>Equity Dimension:</b> Disparities of Urban to Rural Municipalities of of Highest and Lowest Performing Municipalities(Records Review)</p>	
	<p>22- Percentage of Municipal Budget (Public Health) allocated to health (LGU Budget Documents)</p>	<p><b>Numerator:</b> Total of all Muncipal health budget in PWHS <b>Denominator:</b> Total of all Municipal budget in PWHS <b>Multiplier:</b> 100 <b>Reference:</b> NOH 2010 <b>Target 2010:</b> 15 % <b>Equity Dimension:</b> Disparities of Urban to Rural Municipalities of of Highest and Lowest Performing Municipalities(Records Review)</p>	
	<p>23- Percentage of MOOE to total local health budget (LGU Budget Documents)</p>	<p><b>Numerator:</b> Total MOOE in health budget in PWHS (all municipal health budgets + provincial health budget) <b>Denominator:</b> Total Health Budget in PWHS <b>Multiplier:</b> 100 <b>Target 2010:</b> 45% STANDARD (Not in NOH 2010) <b>Equity Dimension:</b> Disparities of Urban to Rural Municipalities of of Highest and Lowest Performing Municipalities(Records Review)</p>	
<p>A. LGU Sectoral Management</p>	<p>24- RHU/Health Center Physician to population ratio (LGU Records)</p>	<p><b>Numerator:</b> Number of RHU/Health Center Physicians in the PWHS <b>Denominator:</b> Total population in the PWHS <b>Multiplier:</b> <b>Target 2010:</b> 1:20,000 <b>Equity Dimension:</b> Disparities of Urban to Rural Municipalities of of Highest and Lowest Performing Municipalities(Records Review)</p>	
	<p>25- RHU/Health Center Midwife to population ratio (LGU Records)</p>	<p><b>Numerator:</b> Number of RHU/Health Center Midwife in the PWHS <b>Denominator:</b> Total population in the PWHS <b>Multiplier:</b><b>Target 2010:</b> 1:5,000 <b>Equity Dimension:</b> Disparities of Urban to Rural Municipalities of of Highest and Lowest Performing Municipalities(Records Review)</p>	

B. Internal Management	26- Percentage of procurement packages completed through competitive bidding in PWHS(LGU Records)	<p><b>Numerator:</b> Total PhP amount of procurement packages identified for competitive bidding that were completed through competitive bidding</p> <p><b>Denominator:</b> Total PhP amount of procurement packages identified for competitive bidding</p> <p><b>Multiplier:</b> 100</p> <p><b>Target 2010:</b> 100 % STANDARD (Not in NOH 2010)</p> <p><b>Equity Dimension:</b> NONE</p>	<ul style="list-style-type: none"> <li>A random sample of 3 procurement packages may be analyzed, as an alternative to analyzing all procurement packages</li> </ul>
	27- Percentage of annual Financing utilized <sup>2</sup> (LGU Budget Records)	<p><b>Numerator:</b> Amount of Health Budget &amp; Grants Utilized in the PWHS</p> <p><b>Denominator:</b> Total Health Budget &amp; Grants in the PWHS</p> <p><b>Multiplier:</b> 100</p> <p><b>Target 2010:</b> 100 % STANDARD (Not in NOH 2010)</p> <p><b>Equity Dimension:</b> Disparities of Urban to Rural Municipalities of of Highest and Lowest Performing Municipalities(Records Review)</p>	
	28- Percentage of audit objections raised within the year that have been cleared (LGU Records)	<p><b>Numerator:</b> Number of Audit objections raised within the year that have been cleared</p> <p><b>Denominator:</b> Total audit objections raised</p> <p><b>Multiplier:</b> 100</p> <p><b>Target 2010:</b> 100 % STANDARD (Not in NOH 2010)</p>	

II. STANDARDS FOR SET II/OUTPUT PERFORMANCE INDICATORS FOR LGU SCORECARD

Table 5. LGU SCORECARD, SET II/ OUTPUT INDICATORS Assessment Every 3 Years		
	PERFORMANCE INDICATORS (Data Source)	KEY /SPECIAL INSTRUCTIONS
<b>SERVICE DELIVERY</b>		
A. Disease Free Zone Initiatives	29) Functional public-private partnerships in TB in each Inter Local Health Zone-ILHZ within the past semester( <i>ILHZs of Province have individual scores</i> )	<ul style="list-style-type: none"> <li>Functionality established at any point in the past semester</li> </ul>
B.Intensified Disease Prevention and Control	<p>Checklist for ILHZ:</p> <p>[ ] 1. All Private provider partners in ILHZ are oriented on the guidelines of the PPMD strategy (Certificate Available)</p> <p>[ ] 2. MOU of partnership between local government and engaged private providers in the established PPMD Units within the ILHZ</p> <p>[ ] 3. For the private initiated PPMD Unit, NTP Microscopy services are available</p> <p>[ ] 4. TB Cases detected/managed by engaged Private Providers (Facility Survey)</p>	



<p><b>C. Child Health</b></p>	<p>30) Percentage of <u>public</u> health facilities in ILHZ complying with the following IMCI protocol within the past 2 semesters <b>(ILHZs of Province have individual scores)</b></p> <p><u>Checklist for ILHZ</u> <u>Checklist for ILHZ</u></p> <p>[ ]a) Physician or nurse trained on IMCI          [ ]b) Amoxicillin or Cotrimoxazole, and other essential drugs for IMCI provided by LGUs          [ ]c) Referral system to next level of govt health facility established for IMCI</p> <p>(Facility Survey)</p>	<p>• Functionality must be established for the past 2 semesters</p>
<p><b>D. Maternal Health</b></p>	<p>31) Functional public-private partnerships in CSR in each Inter Local Health Zone within past semesters - <b>(ILHZs of Province have individual scores)</b></p> <p><u>Checklist for ILHZ:</u></p> <p>[ ]1. Resolution from component LGUs endorsing :</p> <p>a) Implementation of comprehensive family planning services, as an integrated component of maternal and newborn care program packages among public and private sector providers.          b) Promote the provision of FP commodities and services in private sector workplaces</p> <p>[ ]2. Contraceptive Self Reliance plan that specifies strategies and activities for:</p> <p>a) Quantified total volume of required FP commodities and services          b) Client segmentation and corresponding financing and service delivery mechanisms for each segment</p> <p>[ ]3. Full annual budget subsidy for all Family Planning (FP)commodities and services for the poor (Income quintile 1 &amp;2)</p> <p>[ ]4. Commercial sources of FP commodities</p> <p>[ ]5. Referral system to private sector , among public providers</p> <p>(Facility Survey)</p>	<p>• Functionality must be established at any point in the past semester</p>

<p><b>E. Healthy Lifestyle , Health Risk Management, and Advocacy</b></p>	<p>32) Functional health systems established to improve chronic disease prevention &amp; control in the PWHS within past semester.</p> <p>Checklist:</p> <ul style="list-style-type: none"> <li>[ ] 1. Integrated NCD Prevention and Control Plan implemented in the PWHS</li> <li>[ ] 2. Communication Plan on Diet, Physical Activity, and Smoking Control implemented for clients in schools, workplaces, govt and non govt agencies, food establishments, etc</li> <li>[ ] 3. Risk assessment services established in appropriate public and private providers</li> <li>[ ] 4. Basic and essential drugs for the management of NCD's are included in the budget of the PWHS and available in public &amp; private providers</li> </ul> <p>(Facility Survey)</p>	<ul style="list-style-type: none"> <li>• Functionality must be established for the past semester</li> </ul>
<p><b>F. Surveillance and Epidemic Management System</b></p>	<p>33) Functional Disease Surveillance System in Province within past 2 semesters</p> <p>Checklist:</p> <ul style="list-style-type: none"> <li>[ ] 1. Presence of manpower trained in Epidemiology</li> <li>[ ] 2. Presence of room/space with dedicated Basic Information-communication Package (Computer unit, Printer, Telephone, Fax Machine, Cell Phone)</li> <li>[ ] 3. Budget Allocation for Surveillance</li> <li>[ ] 4. MOA on linkage with the private sector</li> <li>[ ] 5. Monthly Report for past 6 months                             <ul style="list-style-type: none"> <li>a. Received from all MESUs</li> <li>b. Received from Private Sector Partners</li> </ul> </li> </ul> <p>(Facility Survey)</p>	<ul style="list-style-type: none"> <li>• Functionality must be established for the past 2 semesters</li> </ul>
<p><b>G. Disaster Preparedness and Response System</b></p>	<p>34. Functional Health Emergency Disaster Preparedness and Response Program in Province within past 2 semesters</p> <p>Checklist:</p> <ul style="list-style-type: none"> <li>[ ] 1. Presence of health emergency preparedness, response and rehabilitation plan</li> <li>[ ] 2. Identified health emergency manager and team (assessment and first aid)</li> <li>[ ] 3. Presence of hospital preparedness, response and rehabilitation plan</li> <li>[ ] 4. Presence of emergency room facilities with surge capacities for disasters</li> </ul> <p>(Facility Survey)</p>	<ul style="list-style-type: none"> <li>• Functionality must be established for the past 2 semesters</li> </ul>
<p><b>H. Health Facilities Development</b></p>	<p>35. Average percentage of quantified free service out of total health expenditure per public hospital</p> <p>(Facility Survey)</p>	



<p><b>Program (National/Local; Public/Private)</b></p> <p>a. Rationalization of local health facilities to include BEMOC/CEMOC</p> <p>b. Health human resource provision/capability building</p> <p>c. Integration of wellness services in hospitals</p>	<p>36. Hospital Bed to Population Ratio for PWHS (Hospital Records)</p> <hr/> <p>37. Functional public-private partnerships in Health Facility Development for the Province-wide Health System within past 2 semesters</p> <p>[ ] 1. Facility Mapping of Public/Private Facilities</p> <p>[ ] 2. Investment Plan for Priority Facilities in PWHS</p> <p>[ ] 3. Rationalized Hospital Development Plan for all public hospitals (NOH p 97)</p> <p>[ ] 4. Documented public-private partnerships (including MOA's on Referral Systems, service contracts, Plans on Joint Activities, etc.) (Facility Survey)</p>	<ul style="list-style-type: none"> <li>• Numerator: Total implementing beds among public and private hospitals within the PWHS jurisdiction</li> <li>• Denominator: Population</li> </ul> <hr/> <ul style="list-style-type: none"> <li>• Functionality must be established for the past 2 semesters</li> </ul>
<b>REGULATION</b>		
<p><b>B. Compliance to National Health Legislation and Standards for</b></p>		
<p>a. Compliance to PhilHealth Accreditation standards for health facilities</p>	<p>38. Percentage of BEMOC/CEMOC facilities accredited by PhilHealth for MCP (PHIC Records)</p>	<p>Numerator: Number of BEMOC/CEMOC Facilities accredited by PhilHealth</p> <p>Denominator: Number of BEMOC/CEMOC</p>
<p>b. Compliance to DOH licensing standards for health facilities</p>	<p>39. Percentage of Public/Private hospitals, x-ray facilities/ clinics and laboratories (LGU Records)</p>	<p>Numerator: Total number of licensed public/private hospitals, x-ray facilities/ clinics and laboratories</p> <p>Denominator: Total number of public/private hospitals, x-ray facilities/ clinics and laboratories</p> <p>Multiplier: 100</p> <p>Target 2010: 100%</p>

<p>B. Enactment of Health/ Health Related local ordinances</p>	<p>40. All Municipalities in the ILHZ are covered with Local ordinances within the past 3 semesters on: <b><i>(ILHZs of Province have individual scores)</i></b></p> <p><u>Checklist for ILHZ :</u></p> <p>[ ] 1. No breastmilk substitutes in hospitals &amp; other health facilities based on R.A. 7600 (The Rooming In and Breastfeeding Act of 1992) Act</p> <p>[ ] 2. Responsible Pet Ownership and Dog Immunization based on RA 9482 (Anti Rabies Act)</p> <p>[ ] 3. Iodization of all salt sold in wholesale and retail outlets based on RA 8172 ( Asin Law)</p> <p>[ ] 4. Requirement of Sanitary Permit for food establishments and Health Certificates for foodhandlers based on Implementing Rules and Regulations of Sanitation Code</p> <p>[ ] 5. Enforcement of licensing of water refilling stations (Facility Survey)</p>	<p>• Functionality established for the past 3 semesters</p>
<p>C. Improvement of Access to Low Cost Quality Drugs</p>	<p>41. Price-Difference Index of 3 drugs, from (a) a commercial outlet, (b) a BnB, (c) Provincial procurement list taken within the past 3 months (Special Studies) (Facility Survey)</p> <p>*3 drugs: Amoxicillin, Paracetamol and Metoprolol</p>	<p>Price Difference Index of 3 drugs = Average Difference of lowest available price of one branded and one generic form of Paracetamol, Amoxicillin and Metoprolol, taken from three different sources: a) commercial outlet; b) BnB; and c) provincial procurement; in comparison to latest published national drug price reference index for the quarter or the nearest quarter.</p>
<p><b>FINANCING</b></p>		
<p>A. Expansion of National Health Insurance Program (NHIP)</p>		
<p>B. Increase in LGU investment for Health</p>		



GOVERNANCE		
A. LGU Sectoral Management	42. Functionality of ILHZ (ILHZs of Province have individual scores)  Levels of functionality achieved: <i>(Based on BLHD,DOH checklist of ILHZ functionality)</i>  <input type="checkbox"/> 1. Population-wide health improvement <input type="checkbox"/> 2. Continuity of care provided to individual patients <input type="checkbox"/> 3. Efficient use of scarce resources for health (Facility Survey)	
	43. Functional Community/Consumer Participation in all municipalities of ILHZ based on AO No. 2006-0020 within the past semester  Checklist for ILHZ :  <input type="checkbox"/> 1. LGU has consumer/community-centered/feedback mechanism <input type="checkbox"/> 2. LGU has mechanisms for consumers to pay for health services and increase their purchasing power <input type="checkbox"/> 3. LGU has mechanism of providing information on health and on health providers <input type="checkbox"/> 4. LGU has consumers co producing or co financing health services <input type="checkbox"/> 5. LGU involves the consumer in policy, decision-making, planning, implementation and monitoring and evaluation (Facility Survey)	• Functionality established at any point in the past semester
B. INTERNAL MANAGEMENT	44. Functional Procurement & Logistics System in all public health facilities in municipalities and province, based on R.A. 9184 within the past 2 semesters  Checklist:  <input type="checkbox"/> 1. Established and functioning Bids and Awards Committee (BAC) <input type="checkbox"/> 2. Compliance to Government Electronic Procurement System <input type="checkbox"/> 3. Policies on Streamlined procurement process that uniformly applies to all government procurement is implemented <input type="checkbox"/> 4. Materials Management tracking and inventory system in place. (Facility Survey)	Functionality established for the past 2 semesters
	45. Functional Finance System in all public health facilities in municipalities and province within the past 2 semesters  Checklist:  <input type="checkbox"/> 1. eLGAS and eBudget implemented <input type="checkbox"/> 2. 100 % personnel trained on procedures and policies (operational, managerial and executive levels) <input type="checkbox"/> 3. Integrated Management Support Monitoring and Evaluation System implemented <input type="checkbox"/> 4. Establishment of Internal Audit Service, with internal audit plans prepared (Facility Survey)	

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	<p>46. Functional Management Information System in all public facilities in Province and all Municipalities within the past 2 semesters</p> <p>Checklist:</p> <ul style="list-style-type: none"><li>[ ] 1. One staff per health facility is computer literate and equipped with computer and printer for health information management</li><li>[ ] 2. 80% of public and private providers with accurate and complete FHSIS reports in the previous 2 semesters.</li><li>[ ] 3. All public hospitals implementing Unified Management Information System</li><li>[ ] 4. Routine health and related reports encoded in electronic format in all municipalities</li><li>[ ] 5. MOA on health information system integrations with private providers implemented</li><li>[ ] 6. General M &amp; E unit established for the PWHS with a Physical and Financial Performance monitoring report in the past 2 semesters (Facility Survey)</li></ul>	
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SUMMARY TABLE 1: By Line item, By CHD/LGU, By Percentage of Total MOOE

	GAA 2009 (MOOE + CO)	Sub-allotted					Total	% Sub-allotted
		Retained	To CHDs	To LGUs*	To DOH-retained Hospitals/ Other Cities**			
					A	B		
1	<b>BLHD:</b> Health System Development Program including Policy Support	297,500,000	21,433,333	0	276,066,667	0	276,066,667	93%
	<b>BLHD:</b> Family Health including Family Planning	100,000,000	10,000,000	46,000,000	44,000,000	0	90,000,000	90%
2	<b>HEMS:</b> Health Emergency Management including provision of emergency drugs and supplies	173,892,000	42,677,000	33,975,000	48,000,000	49,240,000	131,215,000	75%
3	<b>NCDPC:</b> Elimination of diseases as public health threat such as malaria, schistosomiasis, leprosy and filariasis	622,373,000	579,143,000	37,030,000	2,300,000	3,900,000	43,230,000	7%
3a	National Filariasis Elimination Control Program			5,100,000	300,000		5,400,000	
3b	National Leprosy Control Program			12,730,000	800,000	3,900,000	17,430,000	
3c	National Malaria Control Program			19,200,000	1,200,000		20,400,000	
3d	Schistosomiasis Program							
4	<b>NCDPC:</b> Environmental and Occupational Health	51,398,000	21,648,000	29,300,000	450,000	0	29,750,000	58%
5	<b>NCDPC:</b> Family Health including Family Planning	1,229,281,000	978,598,763	75,700,341	156,750,296	18,231,600	250,682,237	20%
6	<b>NCDPC:</b> Other infectious diseases and emerging and re-emerging diseases including HIV/AIDS, dengue, food and water-borne diseases	198,797,000	168,197,000	17,850,000	300,000	12,450,000	30,600,000	15%
6a	Dengue			5,250,000	300,000	3,750,000	9,300,000	
6b	Emerging Infectious Disease			6,000,000	0	0	6,000,000	
6c	National AIDS and STI Prevention and Control Program			4,400,000	0	8,700,000	13,100,000	
6d	Intensified Disease Control - STH			2,200,000	0	0	2,200,000	
7	<b>NCDPC:</b> Public Health Development Program including formulation of Public Health Policies and Quality Assurance	94,078,000	23,228,000	29,700,000	38,150,000	3,000,000	70,850,000	75%
8	<b>NCDPC:</b> Rabies Control Program	80,000,000	77,166,000	2,834,000	0	0	2,834,000	4%
9	<b>NCDPC:</b> TB Control	1,300,007,000	1,201,691,000	95,536,000	2,780,000	0	98,316,000	8%
10	<b>NCDPC:</b> Non-Communicable Disease Prevention and Control	26,377,000	22,477,000	3,200,000	700,000	0	3,900,000	15%
11	<b>NCHFD:</b> Formulation of policies, standards, and plans for hospital and other health facilities	222,615,000	177,095,000	5,420,000	1,500,000	38,600,000	45,520,000	20%
12	<b>NCHFD:</b> Health Facilities Enhancement Program^	2,030,048,000		1,922,826,000	0	79,700,000	2,002,526,000	99%
13	<b>NCHFD:</b> National Voluntary Blood Services Program and Operation of Blood Centers	131,626,000	108,307,952	16,338,700	1,300,000	5,679,348	23,318,048	18%
	Training of Donor Recruitment Officers (DROs)			3,800,000	1,300,000		5,100,000	
	Support for operation of Blood Centers			8,900,000	0		8,900,000	
	Salary of Contractual Personnel			3,638,700	0		3,638,700	
14	<b>NCHP:</b> Health Promotion	139,960,000	128,460,000	10,780,000	720,000	0	11,500,000	8%
15	<b>NEC:</b> Epidemiology and Disease Surveillance	150,226,000	72,905,000	36,196,000	28,250,000	12,875,000	77,321,000	51%
		6,848,178,000	3,633,027,048	2,362,686,041	601,266,963	223,675,948	3,187,628,952	47%

Footnotes

\* Includes sub-allotment for DOH-ARMM

^ **NCHFD: Health Facilities** --- to CHDs amount still reflects P1,922,826,000 to be sub-alloted/transferred for LGU Hospital/Health Facilities upgrading. However, further fund transfer to LGUs will be subject to final list from Central Office

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Province of /Center for Health Development  
 (state source of fund)  
**FUND UTILIZATION REPORT**  
 For the Quarter Ended \_\_\_\_\_

**FUNDS AVAILABLE**

Beginning Balance	500,000.00	
Add: Receipts for the Quarter	<u>0.00</u>	500,000.00

**DISBURSEMENTS**

CHECK			PARTICULARS	AMOUNT	
DATE	NUMBER	PAYEE			
12/4/2007	12345	Loslah's Catering	Workshop on BEMOC	30,000.00	
12/5/2007	12346	Mae Hotel & Resto	Advocacy Meeting	50,000.00	
12/8/2007	12347	Marimar del Cuerpo	TEV on Training B	5,000.00	
12/15/2007	12348	National Bookstore	Supplies for training B	<u>1,000.00</u>	<u>86,000.00</u>

**ENDING BALANCE**

414,000.00

Certified Correct:

Approved by:

\_\_\_\_\_  
 Provincial Accountant

\_\_\_\_\_  
 Provincial Health Officer

Verified by:

\_\_\_\_\_  
 Provincial COA Auditor



## Reporting Template

Budget Line Item	Performance Indicator/ Outputs	Accomplishment
Health System Development Program Including Policy Support		
Epidemiology and Disease Surveillance		
Public Health Development Program including Formulation of Public Health Policies and Quality Assurance		
Elimination of diseases as public health threat such as malaria, schistosomiasis, leprosy and filariasis		
Rabies Control Program		
TB Control Program		
Other infectious diseases and emerging and re-emerging diseases including HIV/AIDS/STI, dengue, soli-transmitted helminthiasis, food and water-borne diseases		
Non-Communicable Disease Prevention and Control		
Family Health including Family Planning		
Environmental and Occupational Health		
National Center for Health Promotion		
Health Emergency Management Staff		
Formulation Of Policies, Standards, And Plans For Hospital And Other Health Facilities (NCHFD Proper)		
National Voluntary Blood Services Program (NVBSP) and Operation of Blood Centers		
Health Facilities Enhancement Program		





Republic of the Philippines  
Department of Health  
OFFICE OF THE SECRETARY

23 November 2009

**ADMINISTRATIVE ORDER**

No. 2009 - 0022

**SUBJECT: Guidelines on the Determination of Funds for Transfer to Local Government Units Year 2010**

**I. RATIONALE**

The Department of Health is committed to achieve the Health Sector goals through the implementation of Health Sector Reforms. These goals are reflected in the National Objectives for Health (NOH) and the Medium Term Philippine Development Plan and they include the Millennium Development Goals which are international commitments of the country. Local Government Units (LGUs) are the main partners of DOH in achieving these goals and local health systems must be in place to bring this about. However, the attainment of health system goals within a devolved system is faced with the following challenges which may slow down the implementation of health reforms:

1. Differences in health priorities between DOH and LGUs and among LGUs;
2. LGUs may lack the necessary skills and resources;
3. The catchment area of health services does not necessarily correspond to administrative boundaries which may not give enough incentives for LGUs to fully support health programs;
4. Certain technical resources may not be readily accessible to LGUs; and
5. Weaknesses in governance mechanisms may lead to inefficient and inequitable health service delivery.

The DOH is mandated to assist local government units (LGUs) in effectively implementing programs, projects and activities that promote the health and well being of every Filipino. In performing this mandate, the DOH must address operational issues by systematizing the sub-allotment/transfer of resources from the DOH Central Office to the Centers for Health Development (CHDs) and to Local Government Units (LGUs). These sub-allotments/transfers need to be rationalized by (1) matching needs of CHDs and LGUs with available resources in the DOH Central Office, (2) improving coordination between the Central Office and CHDs for better implementation of programs in the field, and (3) establishing a reporting system that links activities with desired results and outcomes.

Likewise it has become imperative that DOH resources shall be primarily used to leverage LGU performance based on the Province-wide Investment Plan for Health (PIPH) and as measured by the LGU Scorecard.

**II. OBJECTIVE**

1. Provide technical and administrative basis for the determination of the amounts from the DOH Budget as reflected in the CY2010 General Appropriations Act (GAA) for sub-allotment to CHDs and for transfer to LGUs for the implementation of programs and projects
2. Describe the principles governing how such funds shall be released and utilized



### III. SCOPE AND COVERAGE

1. This Department Order shall cover all Maintenance and Other Operating Expenses (MOOE) and Capital Outlay (CO) that shall be sub-allotted and transferred from programs and projects as specified herein.
2. This Order shall apply to all units in Central Office sub-allotting/transferring such resources and to all recipient CHDs and LGUs.

### IV. GENERAL GUIDELINES

1. The Province-wide Investment Plan for Health (PIPH) and its Annual Operational Plan (AOP) shall be the basis for sub-allotment/transfer to CHDs and LGUs. The MOA covering the PIPH and its AOP signed by the Secretary of Health and the Governor for the past and current year shall be the legal basis for all transfers of funds from the DOH to the LGU. No other MOA shall be effected to implement specific transfers except for LGUs that have yet to develop their PIPH. In transition, transfers to LGUs without PIPH shall be covered by a separate MOA entered into between the Secretary of Health and the Governor or City Mayor.
2. The CHDs shall be the focal units in facilitating and monitoring cash transfers and steering the LGUs to attain desired health system goals. They shall ensure that activities supported by fund transfers from the Central Office are reflected in the DOH counterpart column of the AOP and shall have corresponding local counterpart.

Funds sub-allotted to CHDs shall cover expenses for region-wide activities.

3. Provinces with MOAs with the DOH shall indicate in the Annual Budget for health a specific budget line item – Health Systems Development Program (HSDP). The DOH shall effect cash transfers to the account where funds for the HSDP are maintained.

In the case of the following 10 provinces where a grant from the European Commission is provided as budget support, the HSDP funds are accounted for in a subsidiary ledger in the general fund: Pangasinan, Mountain Province, Oriental Mindoro, Capiz, Negros Oriental, Biliran, Eastern Samar, North Cotabato, South Cotabato, and Agusan del Sur. For these provinces, therefore, the DOH shall effect cash transfers to the general fund, recorded in the subsidiary ledger for the HSDP, wherein the EC grant is also accounted for.

For the other Provinces, a special trust account shall be maintained for the HSDP, unless otherwise specified in the MOA or in the Service Level Agreement.

Cash transfers to LGUs shall be made to support: (1) current performance levels and (2) target performance increases as stated in the AOP. This fund shall not replace the provincial and municipal investment investments committed in the AOP.

4. For the funds transferred to ARMM, the DOH-Autonomous Region in Muslim Mindanao (DOH-ARMM) may retain a maximum of 30 percent thereof to cover expenses incurred for the region-wide implementation of programs in the region.

### V. SPECIFIC GUIDELINES

1. **The budget line items from which funds to leverage local performance are identified. This includes, but are not limited to, the following:**
  - a. Health System Development Program including Policy Support





- b. Elimination of diseases as public health threat such as malaria, schistosomiasis, leprosy and filariasis
- c. TB Control
- d. Family Health including Family Planning
- e. Health Facilities Enhancement Program
- f. Provision for Potable Water Supply

Funds obtained from the above-mentioned budget line items shall be utilized to leverage LGU performance in improving access to essential health care services and initiatives such as maternal, newborn, child health care and nutrition, tuberculosis control, quality and affordable medicines especially for the poor.

2. **The budget that shall be sub-allotted to CHDs and transferred to LGUs** will be determined by the different units in charge of priority budget line items according to the following procedures:

- a. Compute for the total MOOE needed to maintain current operational level of the unit managing the budget line item by adding 10% to previous year's (CY2009) obligations for utilities and monitoring and evaluation activities;
- b. Based on the CY2010 Operational Plan of the budget line items, compute for the total MOOE needed for the development of health policies and for the MOOE needed for commodities;
- c. Based on the CY2010 Operational Plan for budget line items, compute for MOOE needed to augment funds of CHDs in order to implement priority activities in the region;
- d. The MOOE for leveraging LGU performance is equal to the total MOOE minus the sum of MOOE for operational expenses, policy development, commodities and augmentation of CHDs operational funds;
- e. All Capital Outlay (CO) funds shall be allocated to LGU-owned health facilities.

3. **Provincial Ceilings shall be determined by the different units in charge of priority budget line items from the funds to leverage LGU performance.**

Provincial budget ceilings shall be set for the above-mentioned budget line items using indicators such as target population, poverty, and bed to population ratio as weights. Budget ceilings referred under this section shall pertain to MOOE for leveraging LGU performance.

Determination of provincial budget ceilings for MOOE to leverage LGU performance will be as follows:

- a. **Health System Development Program including Policy Support.** Funds to leverage LGU performance for health system development shall determine ceilings by:
  - i. Funds for first 16 provinces are determined based on the allocation as agreed under the Health Sector Policy Support Project;
  - ii. Provincial ceilings for the rest of the LGUs in the country are determined by:
    - 1. Deducting the total amount allocated for first 16 provinces from the total amount to leverage LGU performance
    - 2. Estimating the population of the poor in the LGU by multiplying population with the poverty rate
    - 3. Multiplying the proportion of the poor in the LGU with the amount for leveraging LGU performance
  - iii. Provincial ceiling shall consist of a fixed tranche and a variable tranche. The fixed tranche shall be 75% of the total provincial ceiling to be allocated for operations. The



- variable tranche shall be 25% of the provincial ceiling to be allocated based on the performance pursuant to the LGU Scorecard result for the previous year.
- b. ***Elimination of diseases as public health threat such as malaria, schistosomiasis, leprosy and filariasis.*** Provincial ceilings will be used to eliminate malaria, schistosomiasis, leprosy and filariasis and are determined according to the following procedures:
- i. Using Malaria Prevalence as proxy indicator to determine budget ceilings, identify the number of people affected by malaria in each province and region using the latest Field Health Service Information System (FHSIS) as reference.
  - ii. Determine the proportion of the population affected by malaria in the region by dividing the affected population in the region with the affected population nationwide.
  - iii. Assign a baseline amount to all the regions, including non-endemic areas, necessary to conduct basic advocacy and training activities.
  - iv. Deduct the total amount for baseline support to the regions from the total funds to leverage performance to get the remaining amount to be transferred
  - v. Multiply the remaining amount to be transferred with the proportion of population affected with malaria in the region to get the regional ceiling
  - vi. Allocate the regional ceiling to provinces and independent cities within the region by multiplying the proportion of the population affected by malaria in the province with the regional ceiling.
- c. ***TBControl.*** Considering the available resources to leverage LGU performance, only provinces that have low TB cure rate (CR) and low TB case detection rate (CDR) based from the 2007 NTP Profile, will receive funds to leverage LGU performance. Provincial allocations are determined as follows:
- i. Identify provinces with low CR, below 85%, and low CDR, below 70%.
  - ii. Estimate the number of population affected by TB in the province by multiplying the projected population for 2010 with the TB prevalence rate.
  - iii. Multiply the proportion of TB affected population in the province with the available funds for leveraging LGU performance to determine the provincial ceiling.
  - iv. Aggregate provincial ceilings per region to determine amounts for sub-allotment to CHDs.
- d. ***Family Health including Family Planning.*** The estimated number of married women of reproductive age (MWRA) who are poor are the basis in determining the regional and provincial ceilings for MOOE funds from Family Health and Primary Health Care. The regional and provincial ceilings are determined according to this procedure:
- i. The estimated number of women of reproductive age of each region is multiplied by each region's corresponding poverty rate based from the latest FIES.
  - ii. Allocate at least PhP 20,000,000 to all regions as the total indicative aggregate budget which their LGUs will receive as grants that will allow them to implement the policy on maternal, neonatal, child health and nutrition specifically to perform the minimum and basic activities for the program which may include, among others, training for BEmONC and Women's Health Team, procurement of emergency drugs for BEmONC, monitoring and reporting maternal deaths, advocacy and the like.
  - iii. Distribute the remaining amount by regions by multiplying the proportion of poor MWRA in the region with the remaining amount after deducting the total baseline support to LGUs.
  - iv. Allocate the regional amount to provinces within the region by multiplying the proportion of poor MWRA with the regional ceiling.



Allocation for capital outlay (CO) funds for facilities providing Basic Emergency Maternal Obstetric and Newborn Care (BEMONC) will follow these procedures:

- i. Determine regional ceilings by:
    1. Estimate the number of poor MWRA in the region;
    2. Get the proportion of MWRA in the region by dividing MWRA of the region with the national MWRA;
    3. Multiply the proportion of MWRA in the region with the total amount for CO.
  - ii. Compute for the provincial ceilings based on the following:
    1. Estimating the number of poor MWRA in the province and getting the proportion of MWRA in the province;
    2. Multiply the proportion of MWRA in the province with the regional ceiling.
  - iii. Allocate the provincial ceilings to health facilities in the province by following these rules:
    1. Facilities receiving assistance from any foreign-assisted project such as Spanish Grant, Mindanao Health Sector Development Program and the like shall not receive any additional assistance from the DOH;
    2. Only facilities identified in the facility map shall receive allocation from the program.
- e. **Health Facilities Enhancement Program.** Funds for health facilities upgrading are distributed to regions and provinces inversely proportional to the hospital bed to population ratio.
- i. Determine regional ceilings by:
    1. Get the inverse of hospital beds to population ratio of the region by dividing 1 with the hospital beds to population ratio using list of PhilHealth Accredited Facilities which should include public as well as private health facilities in the region
    2. Add the amounts in #1 above to get the total inverse hospital beds to population ratio of all regions
    3. Compute for the proportion of inverse hospital beds to population ratio by dividing inverse regional hospital beds to population ratio with the inverse national hospital beds to population ratio
    4. Multiply the proportion of hospital beds to population ratio with the total amount to be transferred to LGUs to get the regional ceilings.
  - ii. Allocate regional ceilings to provinces by:
    1. Computing for the hospital beds to population ratio of the province using the list of PhilHealth Accredited Facilities which should include public as well as private facilities in the province
    2. Get the inverse ratio of hospital beds to population and compute for the proportion by dividing inverse hospital beds to population ratio of the province with the inverse hospital beds to population ratio of the region
    3. Multiply the proportion of hospital beds to population ratio with the regional ceilings to get the provincial ceilings
  - iii. Allocate the provincial ceilings to health facilities in the province by following these rules:
    1. Only facilities identified in the rationalization plan shall receive allocation from the program
    2. Prioritize facilities in the province that have not received any assistance from the program in the last two years



3. Health facilities that will receive allocation from the program shall be prioritized as follows:
  - a. Rural Health Units (RHUs) especially those accredited by PhilHealth to provide Out-Patient Benefit Package (OPB)
  - b. District hospitals serving as co-referral hospitals of Inter-Local Health Zones (ILHZ)
- f. **Provision for Potable Water Supply.** Using the proportion of households with no access to water as basis, the regional and provincial ceilings are determined by:
  - i. Add the number of household in waterless municipalities, identified in the NAPC list. Aggregate households with no access to water into provinces and into regions.
  - ii. Get the proportion of households with no access to water in the region.
  - iii. Allocate at least PhP 25,000,000 to all regions to ensure minimum improvements in water supply of LGUs within a region.
  - iv. Allocate the remaining amount to all the regions by multiplying the proportion of households with no access to water of the region with the remaining amount after deducting the total baseline amount allocated to the region above
  - v. Allocate the regional ceiling to provinces within the region by multiplying the proportion of households with no access to water with the regional ceiling.

Annex shows indicative regional and provincial ceilings for the different budget line items. These are indicative figures pending approval of the General Appropriations Acc (GAA) of 2010 and finalization of the Work and Financial Plans (WFP) of concerned units.

#### 4. Transferring Funds to LGUs

- a. **The Central Office shall provide the necessary issuance to inform the CHDs of the available budget from each priority program for leveraging LGU performance.**The following information shall be included in the issuance:
  - i. Budget for leveraging performance disaggregated by LGUs
  - ii. MOOE to augment operational expenses of CHDs
- b. **The CHDs shall ensure that the LGUs adhere to the condition set to access the grants.** The actual amount accessible to LGUs will be determined based on:
  - i. Inclusion of priority activity in the Annual Operational Plan (AOP). The investment requirements for facility enhancements shall only be those reflected in the approved Rationalization Plan for Health Care Delivery System.
    1. Amounts for transfer to the LGU shall be based on the AOP but limited by the provincial ceiling
    2. No transfer from a particular budget line item will occur if the priority program activity is not in the AOP
    3. If the activity is in the AOP but does not require any DOH counterpart, a maximum of 20% of the provincial ceiling may be transferred.
  - ii. Obligation of LGU counterpart for the priority program.
  - iii. Estimate local counterpart using the ratio implied in the AOP.
  - iv. Determination of performance targets consistent with local and national objectives
- c. **The CHDs shall finalize the Service Level Agreement (SLA) with the LGU.** The CHDs shall formalize agreements with the LGU through a SLA which should:
  - i. state funds from the DOH to be transferred to the LGU
  - ii. state counterpart funds of the LGU coming from the province and component municipalities and cities



- iii. identify expectations from both the DOH and the LGU including target health outcomes as stated in the LGU Scorecard
  - iv. identify conditions and indicative dates of transfers
- Consistent with the PIPH/AOP process, the SLA will be approved by the Joint Appraisal Committee (JAC).
- d. **The DOH shall release MOOE funds to LGUs.** The following schedule shall be observed in transferring MOOE funds to LGUs:
    - i. Transfer 40 percent of the provincial allocation upon reaching an agreement with the LGU. This initial release shall cover activities for information, education and communication campaigns, surveillance and basic training activities.
    - ii. Transfer 40 percent of the provincial allocation upon disbursement by LGUs of the local counterpart.
    - iii. Transfer 20 percent of the provincial allocation upon meeting target health outcomes.
  - e. **Release of CO funds to LGUs.** Releases of funds for capital outlay shall be in accordance with the guidelines and procedures for the implementation of the government hospital upgrading project.

**5. Functions and Responsibilities of Offices/Units in this Order:**

- a. Policy and Standards Development Team/Service Delivery (PSDT/SD) and Sectoral Management and Coordinating Office (SMCO) Cluster Head
  - i. Issue or cause the issuance of a Department Order by the Secretary that would enable fund sub-allotment/transfer;
  - ii. Provide technical guidance to CO units related with the transfer and use of funds to leverage LGU performance
  - iii. Issue Department Memoranda that provides for the schedule of activities and deadlines of submissions related with the implementation of the DO.
- b. Field Implementation Management Office (FIMO)
  - i. Collate from the CHDs the following documents in accordance with the routine submission stipulated under Department Memorandum no. 2008-0245:
    - 1. LGU Scorecard;
    - 2. Liquidation of Sub-allotments;
    - 3. PIPH & AOP (as needed);
    - 4. HEMS Summary Report;
  - ii. Represent the DOH in relation to the fund transfers to ARMM;
  - iii. Receive Financial Utilization Report (FUR) from ARMM;
  - iv. Provide technical support to CHDs, with assistance from HPDPB and BLHD, in relation to the implementation of the DO.
- c. Health Policy Development & Planning Bureau (HPDPB)
  - i. Develop guidelines in identifying priority budget line items, budget for leveraging LGU performance
  - ii. Monitor progress of implementation of this Order
  - iii. Coordinate the allocation of funds for leveraging LGU performance with the central office units that are managing the identified budget line item.
  - iv. Provide technical assistance to central office units in allocation of funds for transfer to LGUs



- v. Evaluate the outcome of implementation.
- vi. Report the progress of the implementation of this Order to the EXECOM
- d. Bureau of Local Health Development (BLHD)
  - i. Assist FIMO in providing technical support to the CHDs to assist LGUs in implementing their AOPs
  - ii. Coordinate the transfer of funds with the concerned CO units that manage the budget line items
  - iii. Monitor the releases of funds based on the schedule stated in the SLAs
- e. Central Office Units Managing Line Items for Sub-allotment/Transfer
  - i. Identify and submit funds for sub-allotment/transfer to the Office of the Secretary through the HPDPB
  - ii. Cause the sub-allotment/transfer of funds to the CHDs and ARMM;
- f. Finance Service
  - i. Manage and track fund releases to the CHDs;
  - ii. Develop a consolidated monthly cash program based on WFP of CHDs and CO units for sub-allotted funds.
- g. CHDs
  - i. Conduct PIPH/AOP Implementation Reviews
  - ii. Conduct appraisal of LGUs' AOP and endorse to JAC for approval
  - iii. Manage and track fund releases to LGUs relative to the appropriate performance benchmarks;
  - iv. Receive reports on the disbursement of transferred funds from LGUs; and,
  - v. Provide TA to LGUs relative to use of transferred funds by urging the LGUs to:
    - 1. Develop a PIPH/AOP and abide by its provisions.
    - 2. Ratify an SLA with the appropriate CHD, which shall include, but shall not be limited to, the following:
      - a. Amount of funds to be received from DOH
      - b. Amount of LGU counterpart investments and the schedule of their releases.
      - c. Performance outcome targets to be achieved by the LGU
    - 3. Utilize received funds according to the guidelines of the fund transfer
    - 4. Manage and administer the transferred funds in accordance with Book II Title Five of the Local Government Code of 1991 and the allocated commodities in accordance with the technical guidelines issued for the purpose;
    - 5. Submit report on the disbursement of transferred funds to the appropriate CHD. The Provinces of Ilocos Norte, Pangasinan, Ifugao, Mountain Province, Nueva Vizcaya, Oriental Mindoro, Romblon, Capiz, Negros Oriental, Biliran, Eastern Samar, Southern Leyte, Misamis Occidental, North Cotabato, South Cotabato and Agusan del Sur shall submit quarterly Fund Utilization Report (FUR);

## 6. Monitoring and Evaluation

- a. Pursuant to DO 2009-0277 for the Institutionalizing Expenditure Tracking System (ETS) in the DOH Planning and Finance Management and DO 2009-0246 for Adopting the Public Finance Management Reform Strategy for the DOH, all units of the DOH shall use the Expenditure Tracking System (ETS) to:



- i. Determine funds to leverage LGU performance
  - ii. Prepare monthly cash program
  - iii. Identify recipients of these funds
  - iv. Prepare Work And Financial Plans (WFP)
  - v. Monitor progress of activities and achievement of target outputs
  - vi. Monitor obligations and disbursements of funds
- b. In accordance with the issuance on the Establishment of CHD Capacity to Support LGU-led Health Reform Implementation, the CHDs shall lead the conduct of Region-wide Program Implementation Reviews (PIR) to analyze and monitor the progress of LGUs in meeting province-wide health goals and PIPH benchmarks. With the goal of reducing performance variation across LGUs and improving overall performance of the health sector, the PIR shall facilitate LGUs' assessment of efforts for and results from the implementation of PIPH/CIPH/AOP. The use of these findings will identify priority improvements that should drive (a) LGU effort (b) delivery of CHD support and guidance to LGUs; and (c) provision by health partners' assistance to LGUs.
- c. LGUs' performance shall be monitored according to AO 2008-0017 otherwise known as the Implementing Guidelines for LGU Scorecard.

#### **VI. REPEALING CLAUSE**

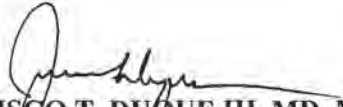

Provisions from previous issuances that are inconsistent or contrary to the provisions of this Order are hereby rescinded and modified accordingly.

#### **VII. SEPARABILITY CLAUSE**

In the event that any provision or part hereof is declared unauthorized or rendered invalid by any court or competent authority, those provisions that are not affected by such declaration shall remain valid and effective.

#### **VIII. EFFECTIVITY**

This Order shall take effect on January 2010.

  
**FRANCISCO T. DUQUE III, MD, MSc**  
Secretary of Health 

**Annex: Indicative Provincial Ceilings**

	Health Sector Development Program	Elimination of Diseases as Public Health Threat	Family Health including Family Planning (MOOE)	Health Facilities Enhancement Program	TB Program	Provision of Safe Water Supply
Region NCR	88,000,000	269,077	32,242,450	72,088,766	35,643,625	
City of Manila	5,200,000	-	4,246,225	618,649	0	
City of Mandaluyong	5,200,000	-	1,014,912	2,310,470	1,902,693	
City of Marikina	5,200,000	67,269	1,253,180	2,635,384	2,720,066	
City of Pasig	5,200,000	-	1,660,717	1,722,626	3,663,245	
Quezon City	5,200,000	-	5,878,642	1,030,132	12,500,182	
City of San Juan	5,200,000	-	651,173	707,400	524,734	
Kalookan City	5,200,000	-	4,172,104	5,546,545	0	
City of Malabon	5,200,000	201,807	1,383,037	28,210,805	2,216,471	
City of Navotas	5,200,000	-	1,062,447	-	0	
City of Valenzuela	5,200,000	-	1,956,555	3,941,585	3,406,816	
City of Las Piñas	5,200,000	-	1,441,070	2,893,373	2,970,054	
City of Makati	5,200,000	-	1,400,702	3,282,280	2,579,532	
City of Muntinlupa	5,200,000	-	1,293,047	2,212,052	0	
City of Parañaque	5,000,000	-	1,493,908	4,002,286	3,159,830	
Pasay City	5,200,000	-	1,189,197	1,971,974	0	
Taguig City	5,000,000	-	1,625,113	11,003,204	0	
Pateros	5,200,000	-	520,420	-	0	
Region CAR	14,407,730	2,928,523	25,614,228	80,724,456	3,105,678	33,305,325
Abra	4,354,913	-	6,522,898	31,123,762	0	1,562,075
Apayao	2,022,377	389,234	3,029,167	13,767,736	861,034	26,395,213
Benguet	1,288,744	-	1,930,313	16,567,906	0	5,348,037
Baguio City	3,822,723	-	5,725,771	5,941,138	0	
Ifugao*	6,622,880	148,280	567,001	13,121,097	0	
Kalinga	2,918,973	2,150,055	4,372,111	9,222,332	1,504,202	



**Annex: Indicative Provincial Ceilings**

	Health Sector Development Program	Elimination of Diseases as Public Health Threat	Family Health including Family Planning (MOOE)	Health Facilities Enhancement Program	TB Program	Provision of Safe Water Supply
Mountain Province *	5,844,486	240,954	3,466,966	10,980,486	740,442	
Region I	18,769,495	251,807	35,633,239	144,343,943	0	50,892,317
Ilocos Norte *	6,135,324	167,872	2,684,029	28,686,891	0	25,952,923
Ilocos Sur	7,820,816	-	4,768,134	23,975,386	0	
La Union	8,954,473	83,936	5,459,294	45,389,425	0	77,914
Pangasinan*	10,574,678	-	21,505,970	60,946,272	0	24,861,480
Dagupan City	1,994,206	-	1,215,812	5,345,969	0	
Region II	7,898,528	28,918,569	28,367,476	155,877,159	40,354	92,506,377
Batanes	23,489	-	77,546	28,524,587	40,354	
Cagayan	2,587,434	10,172,798	8,541,947	29,818,001	0	52,421,288
Isabela	4,498,592	18,693,603	14,851,289	46,591,860	0	31,113,776
Santiago City	405,225	-	1,337,776	15,626,141	0	
Nueva Vizcaya*	4,743,340	52,168	2,291,914	27,566,480	0	8,971,313
Quirino	383,787	-	1,267,005	27,750,090	0	
Region III	8,357,945	14,481,574	40,374,258	163,865,942	15,476,244	42,322,211
Aurora	288,338	1,803,630	1,392,856	47,221,517	0	11,009,557
Bataan	293,886	245,154	1,419,658	20,279,398	0	4,598,064
Bulacan	1,615,290	262,665	7,802,893	21,656,159	0	1,743,389
Nueva Ecija	2,929,442	262,665	14,151,089	22,219,579	15,476,244	16,685,271
Pampanga	872,152	105,066	4,213,055	16,675,470	0	
Angeles City	203,072	35,022	980,970	5,594,694	0	
Tarlac	1,446,560	560,351	6,987,815	16,515,825	0	-
Zambales	598,764	11,207,022	2,892,416	23,278,556	0	8,285,930
Olongapo City	110,442	-	533,506	10,424,743	0	
Region IV-A	10,088,100	5,087,165	44,591,876	175,606,287	0	62,564,011



**Annex: Indicative Provincial Ceilings**

	Health Sector Development Program	Elimination of Diseases as Public Health Threat	Family Health including Family Planning (MOOE)	Health Facilities Enhancement Program	TB Program	Provision of Safe Water Supply
Batangas	2,911,300	-	12,868,661	18,714,814	0	2,147,216
Cavite	1,381,382	-	6,106,046	35,312,025	0	
Laguna	1,391,189	161,783	6,149,395	24,823,726	0	5,178,115
Quezon	3,357,967	970,696	14,843,037	35,209,511	0	55,238,681
Lucena City	172,819	-	763,901	8,942,260	0	
Rizal	873,444	3,954,686	3,860,835	52,603,951	0	
Region IV-B	21,854,061	112,293,947	33,280,856	212,889,269	0	84,772,199
Marinduque	3,347,543	-	2,952,299	30,777,100	0	
Occidental Mindoro	6,975,809	9,843,669	6,152,178	36,922,678	0	13,304,582
Oriental Mindoro *	9,830,165	674,698	10,331,279	34,133,427	0	5,083,727
Palawan	9,802,123	101,775,580	8,644,790	54,628,694	0	60,096,942
Puerto Princesa City	1,728,585	-	1,524,492	27,258,302	0	
Romblon *	8,868,777	-	3,675,818	29,169,068	0	6,286,947
Region V	11,238,670	200,000	47,396,633	174,377,594	0	85,505,800
Albay	2,298,723	-	9,694,360	18,733,985	0	
Camarines Norte	1,062,001	-	4,478,756	40,393,441	0	9,830,970
Camarines Sur	3,531,551	-	14,893,542	56,950,070	0	11,097,384
Naga City	341,966	-	1,442,168	3,551,604	0	
Catanduanes	454,511	-	1,916,803	13,021,757	0	
Masbate	1,910,318	-	8,056,350	31,928,328	0	64,577,446
Sorsogon	1,639,600	-	6,914,654	29,798,410	0	
Region VI	20,620,495	286,346	45,140,389	181,367,260	0	199,245,345
Aklan	2,452,801	-	4,711,821	21,426,868	0	9,848,987
Antique	2,530,452	114,538	4,860,988	20,940,731	0	
Capiz*	10,570,465	-	3,865,762	16,518,401	0	32,873,257



**Annex: Indicative Provincial Ceilings**

	Health Sector Development Program	Elimination of Diseases as Public Health Threat	Family Health including Family Planning (MOOE)	Health Facilities Enhancement Program	TB Program	Provision of Safe Water Supply
Guimaras	568,534	-	1,092,152	30,268,863	0	6,968,700
Iloilo	4,892,184	114,538	9,397,866	40,618,714	0	56,916,068
Iloilo City	500,000	-	822,220	4,479,883	0	
Negros Occidental	10,176,525	-	19,549,066	39,296,834	0	92,638,333
Bacolod City	500,000	57,269	840,514	7,816,965	0	
Region VII	16,315,002	217,269	41,281,858	147,139,478	0	142,258,257
Bohol	6,277,574	-	11,380,441	14,879,706	0	55,933,399
Cebu	7,529,967	217,269	13,650,870	54,433,011	0	36,688,027
Cebu City	1,175,442	-	2,130,926	4,516,361	0	
Lapu-Lapu City	615,040	-	1,114,989	19,001,039	0	
Mandaue City	511,943	-	928,087	13,404,828	0	
Negros Oriental *	10,060,072	-	11,704,839	28,046,072	0	49,636,831
Siquijor	205,036	-	371,704	32,858,461	0	
Region VIII	30,853,650	200,000	39,580,807	187,473,734	0	69,300,817
Biliran*	5,680,645	-	1,392,217	90,421,479	0	
Eastern Samar *	9,966,981	-	4,321,209	12,724,957	0	
Leyte (inc. Tacloban City)	16,202,825	-	15,339,598	15,224,449	0	35,205,224
Ormoc City	2,000,000	-	1,763,111	10,125,658	0	
Northern Samar	7,310,837	-	6,921,343	20,893,281	0	24,966,701
Samar (Western Samar)	7,339,988	-	6,948,941	22,391,139	0	9,128,892
Southern Leyte *	7,278,225	-	2,894,387	15,692,771	0	
Region IX	8,778,444	1,806,029	34,041,018	175,991,058	0	104,809,331
Zamboanga del Norte	4,706,639	563,170	15,141,399	28,556,560	0	56,586,762
Zamboanga del Sur	2,372,516	582,590	7,632,457	27,182,815	0	17,732,409
Zamboanga City	2,000,000	504,911	4,657,513	18,458,737	0	



**Annex: Indicative Provincial Ceilings**

	Health Sector Development Program	Elimination of Diseases as Public Health Threat	Family Health including Family Planning (MOOE)	Health Facilities Enhancement Program	TB Program	Provision of Safe Water Supply
ZamboangaSibugay	1,699,289	58,259	5,466,663	89,601,975	0	30,490,159
City of Isabela	2,000,000	97,098	1,142,985	12,190,970	0	
Region X	14,941,086	3,153,022	35,389,943	113,403,137	0	75,890,569
Bukidnon	5,866,603	2,765,809	10,410,849	14,095,077	0	35,051,617
Camiguin	484,088	-	859,061	9,418,516	0	
Lanao del Norte	3,729,801	-	6,618,889	22,271,575	0	21,931,614
Iligan City	1,137,936	-	2,019,376	11,413,111	0	
Misamis Occidental *	8,211,137	-	7,011,713	8,213,838	0	13,066,356
Misamis Oriental	3,722,659	387,213	6,606,215	39,607,789	0	5,840,982
Cagayan De Oro City	2,000,000	-	1,863,841	8,383,232	0	
Region XI	5,645,468	19,437,815	33,762,021	154,710,146	0	71,509,360
Compostela Valley	1,220,660	3,315,247	7,300,008	87,024,808	0	25,966,729
Davao del Norte (Davao)	975,845	12,877,116	5,835,922	9,675,139	0	14,775,401
Davao del Sur	1,675,229	1,273,753	10,018,500	13,672,680	0	21,292,078
Davao City	797,074	1,867,007	4,766,804	11,999,752	0	
Davao Oriental	976,659	104,692	5,840,787	32,337,768	0	9,475,152
Region XII	25,500,105	14,067,114	35,179,687	142,502,695	0	102,780,566
Cotabato (North Cotabato)	11,206,213	1,383,938	9,251,449	11,771,927	0	39,533,494
Sarangani	10,983,870	4,764,950	5,884,094	107,606,110	0	27,015,257
South Cotabato*	7,875,901	613,137	6,771,507	11,632,883	0	7,365,666
General Santos City (Dadiangas)	2,000,000	2,785,394	2,592,848	9,517,274	0	
Sultan Kudarat	14,516,235	4,484,659	7,776,393	32,876,955	0	28,866,149
Cotabato City	2,000,000	35,036	2,903,397	9,097,546	0	
Region CARAGA	14,656,848	4,845,397	31,879,408	175,717,954	0	62,165,368

**Annex: Indicative Provincial Ceilings**

	Health Sector Development Program	Elimination of Diseases as Public Health Threat	Family Health including Family Planning (MOOE)	Health Facilities Enhancement Program	TB Program	Provision of Safe Water Supply
Agusan del Norte	2,516,793	-	3,436,774	28,851,140	0	1,396,354
Butuan City	2,000,000	-	2,505,745	9,028,948	0	
Agusan del Sur	9,597,378	2,791,957	9,359,198	39,294,012	0	47,059,964
Dinagat Islands	1,244,391	-	1,699,262	87,905,704	0	
Surigao del Norte	4,935,077	-	6,739,029	32,599,215	0	2,401,593
Surigao del Sur *	9,597,378	2,053,440	8,139,400	38,038,935	0	11,307,456
ARMM	10,982,373	200,000	46,771,855	648,983,392	13,834,099	220,172,147
Basilan	784,388	-		73,560,995	0	14,544,545
Lanao del Sur	2,436,610	-		100,563,220	7,159,688	44,093,205
Marawi City	428,369	-		32,615,756	0	
Maguindanao	3,898,340	-		185,966,550	0	72,838,683
Sulu	1,912,319	-		90,619,480	3,566,215	49,250,615
Tawi-Tawi	1,522,347	-		225,657,391	3,108,196	39,445,099
PHILIPPINES	328,908,000	208,643,654	630,528,000	3,107,062,269	68,100,000	1,500,000,000

\* F16 provinces





July 12, 2006

## **ADMINISTRATIVE ORDER**

**No. 2006- 0022**

**Subject: Guidelines for Establishment of Performance-Based Budget for Public Health**

### **I. BACKGROUND AND RATIONALE**

Pursuant to AO 2005-0023, the DOH adopted FOURmula ONE for Health as the implementation framework for health sector reforms. The specific objectives of FOURmula One for Health are to: (1) secure more, better and sustained financing for health; (2) assure the quality and affordability of health goods and services; (3) ensure access to and availability of essential and basic health packages; and (4) improve performance of the health system.

FOURmula One for Health organizes the critical reform initiatives into four sets of instruments that must be effectively applied in order to influence the performance of a high decentralized public health care system and local health care markets. These instruments are financing, regulation, service delivery, and governance.

On financing, AO 2005-0023 has established strategies that include coordinating national and local spending, focusing direct subsidies to priority programs, and adopting a performance based financing system. Specifically, these strategies call for (a) a sectorwide approach to overall management of total health investments; (b) focusing direct subsidies from national and local governments from personal and curative care to basic and essential public health goods and services commonly used by the poor; and (c) a shift from historical and incremental budgeting system into one that is performance based.

On service delivery, AO 2005-0023 has adopted the following strategies to reduce public health threats: (1) undertaking disease-free zones initiative –areas where diseases such as malaria, filariasis, schistosomiasis, rabies, leprosy and vaccine-preventable diseases are major health problems shall be identified and targeted for intensive campaigns to eliminate these diseases as public health threats; (2) implementing intensified disease prevention and control strategies –Intensified disease prevention and control strategies for other priority diseases such as tuberculosis, HIV/AIDS and other communicable diseases shall be



undertaken in intensified disease control zones where the greatest impact from health investments could be derived; and (3) enhancing health promotion and disease surveillance to reinforce the disease-free zones initiative and the intensified disease prevention and control strategies, enhanced health promotion and disease surveillance activities shall be undertaken, and to ensure that the targets for disease elimination, prevention and control are attained. Moreover, health promotion interventions shall be directed at the prevention and control of health hazards and health risk-taking behaviors, particularly those associated with lifestyle related diseases such as cardiovascular diseases, cancer, diabetes mellitus and chronic obstructive pulmonary disease among others.

Because of the public good nature of public health services and programs, these should be financed by the government. Public health programs are more cost effective and can benefit a larger segment of the population. Because it is financed by the government which has limited resources, spending for public health requires appropriate mechanism to ensure that public health programs are prioritized and managed efficiently. Thus performance-based budgeting system needs to be adopted.

This Administrative Order provides guidelines for prioritizing public health programs, and for adoption of a performance-based budget allocation and execution for priority public health programs including the implementation of performance-based awards to LGUs.

## **II. GOALS**

The ultimate goal in the implementation of performance-based budgeting of priority public health programs is to improve health outcomes as follows:

1. To eliminate *leprosy, schistosomiasis, filariasis, malaria, rabies as public health problem in specific areas*
2. To improve health outcomes related to *Vaccine Preventable Diseases, TB, HIV/AIDS, emerging infections*
3. To improve reproductive health outcomes through maternal and child health programs (*MMR, IMR, U5MR, TFR, CPR*)
4. To improve lifestyle and risk management (*anti-smoking, safe water, sanitation, among others*)

## **III. OBJECTIVES**

The specific objective is to provide guidelines for:

1. Prioritizing public health programs over time
2. Progressively allocating commodities for priority public health programs
3. Linking budget subsidies of DOH offices to specific outputs and outcomes for targeted reforms in public health programs.



4. Linking DOH assistance and transfers to LGUs to specific outputs and outcomes in public health programs that promote functional inter-local coordination on health.

#### IV. SCOPE AND COVERAGE

This AO shall apply to all DOH offices, and its attached agencies involved in critical activities related to public health thrusts and reforms.

#### V. GENERAL GUIDELINES

- A. All priority public health programs that contribute directly or indirectly to the attainment of desired health outcomes shall be subjected to PBB. These shall be periodically reviewed and changed as outcomes are achieved and as need arises.
- B. All programs, projects and activities under these priority public health programs shall be subjected to PBB. These shall include the existing functions from policy, standards and systems development, monitoring and evaluation at the central and regional levels as well as provision of technical assistance to and leveraging the performance of the LGUs.
- C. Critical commodities shall be progressively allocated under the PBB on the basis of pre-defined criteria. A strategy for more efficient targeting and allocating of these commodities shall be developed for specific population groups by economic quintile.
- D. PBB shall consist of three categories of fund schemes to be applied at all DOH levels:
  1. **Baseline Public Health Commodity Fund (BPHCF):** This shall be comprised of funds for the procurement of PH commodities that will be allocated and distributed to the LGUs to achieve national public health targets and desired outcomes. The BPHCF shall be protected from any cuts, but shall be subject to performance benchmarks.
  2. **Public Health Programs Fund (PHPF):** This shall include funds for policy and systems development and for provision of technical assistance by DOH offices to LGUs and health sector partners. The PHPF shall also include funds for fixed administrative/ utility costs for sustaining operations. The PHPF can be subject to cuts, based on agreed increments and agreed performance benchmarks.
  3. **Public Health Development Program Fund (PHDPF):** This fund will comprise of savings generated or unallocated from the PHPF, grant and loan inputs from the ODA and funds shifted from hospitals to preventive and promotive health services. This fund will be used to provide incentives for early and timely accomplishment of annual benchmarks set over the medium term period.
- E. PBB shall ensure development of a policy environment conducive for institutionalizing functional interlocal health zones.
- F. The Performance-Based Budget for Public Health shall only apply to MOOE and Capital Outlay expense items from government budgets, donor grants or loans.



## **VI. SPECIFIC GUIDELINES**

### **A. Prioritization of Public Health Programs**

1. Priority public health programs shall be identified on the basis of burden of disease, equity, economic efficiency, and cost effectiveness (See Annex A).
2. In order to focus limited health resources for greater impact, the following Millenium Development Goal (MDG) and F1 target disease shall be prioritized as follows:
  - a. Priority Level 1-Diseases of high impact and prevalence such as TB, vaccine preventable diseases and MCH concerns
  - b. Priority Level 2- All other MDG / F1 priority diseases such as malaria, HIV/AIDS leprosy, shistosomiasis, filariasis, rabies, environmental health risks among others
3. Prioritization of national health programs shall be reviewed every two years depending on evaluated need and capacity in the health sector, and after consultation with stakeholders.
3. In a ddition to n ational health program priorities, DOH shall also take into account specific diseases which are endemic in certain LGUs.

### **B. Progressive allocation of Public Health Commodities**

1. The provision of commodities for priority programs shall be based on populations in need or at risk and other factors. Other considerations for guidance in a llocation, when applicable, include population growth, epidemiology or burden of disease, ideal versus minimum target allocation to prevent outbreak, across the board versus phased allocations in target areas, poverty rate, public sector performance and ensuring the availability of buffer stocks. (See Annex B).
2. The key criteria for allocation by the DOH, through NCDPC, of public health commodities per region shall be based on regional poverty indices. Further, the key criteria for allocation of public health commodities by the CHDs to the intended beneficiaries in the LGUs shall be based on local poverty indices.
3. The DOH shall build capacity for more e fficient targeting and p rovision of public health commodities for more effective coverage of the population with public health commodities. Strategies for providing full subsidy of public health commodities for the poor shall be sustained, to the fullest extent of current capacity and supply. Strategies, which may be on partial or no subsidy basis, for specific population groups that demand commodities and have the capacity to pay for these shall also be developed.

### **C. Fund Allocation Scheme**

#### **1. BPHCF**



- a. This fund shall cover for the purchase of commodities to meet current need and capacity to ensure PH protection of the population.
  - b. This shall be determined each year and clearly identified and delineated in the work and financial plans of 2006-2010.
  - c. Performance Benchmarks on efficient targeting, progressive allocation and timely procurement and delivery of public health commodities shall be set for DOH offices.
2. **PHPF**
- a. The PHPF shall comprise the amount equivalent to the estimated requirements for accomplishing performance benchmarks set for the specific office annually.
  - b. It shall be determined each year and clearly identified and delineated in the work and financial plans of 2006-2010.
  - c. Annual Performance benchmarks shall be set in operational plans proposed and refined in work and financial plans submitted.
3. **PHDPF**
- a. This fund may be used as incentives for achieving capacity to fulfill higher levels of performance benchmarks as designed by DOH offices.
  - b. This fund shall be available to all eligible DOH offices and programs, including LGUs and other health sector partners on the basis of proposals submitted by December preceeding the fiscal year. Call for proposals shall be issued by June of each year. Allocations to offices or LGUs/partners with selected proposals shall be awarded within a month of the approval of the GAA for the year
  - c. The PHDPF shall only be used for MOOE and Capital outlay activities.

## **VII. Key Performance Benchmarks**

- A. The performance benchmarks at various levels for BPHCF for 2007-2010 shall be consistent with the following:
1. **NCDPC**
    - Public Health Commodities progressively allocated per region
    - Outcomes/Coverage Rates expected from allocated Public Health Commodities defined
    - Accurate specifications submitted to procurement office on time
  2. **Procurement Office**
    - Public Health Commodities procured and delivered within 6 months of submission of specifications or within agreed schedule
  3. **Finance Office**
    - Action on Financial vouchers relevant to Public Health Commodities completed within 2 weeks of receipt
  4. **CHDs**
    - Public Health Commodities progressively allocated per province/municipality/city
    - Monitoring report on outcomes/Coverage Rates expected from allocated Public Health Commodities, including commodity inventory report submitted on time

## 5. LGUs

- Achievement of outcomes/Coverage Rates expected from allocated Public Health Commodities

B. The performance benchmarks attached to PHPF for 2006-2010 shall be consistent with the following:

### 1. NCDPC & Other Relevant Offices in the DOH Central Office

- 2006 = Baseline studies of sources and uses of funds for priority public health programs
- 2007 = Service packages defined for each level of service (home, BHS, RHU, Private Clinics/Providers, Hospitals) for priority public health programs
- 2008 = Clinical Practice Guidelines and Public Health Practice Guidelines developed and utilized for all service packages for priority public health programs
- 2009 = Systematic and self sustaining Training scheme for Basic Training Module of priority public health programs institutionalized and accessible to all LGUs, NGOs and other health sector partners.
- 2010 = Computerized information system linking all levels of service for priority public health programs

### 2. CHDs

- 2006 = Advocacy & Information Dissemination on need for Baseline data on health profile of all barangay/municipal/provincial health systems and ILHZ in their area
- 2007 = Baseline data on health profile of all barangay/municipal/provincial health systems and ILHZ in their area
- 2007-2010 = Annual Updated data base on health profiles of local health systems  
= Advocate, implement, monitor and evaluate all mandated F1 activities in their area (eg. Advocacy for rationalization of health care delivery system)  
= Ensure that CHD personnel are oriented and trained on all F1 activities and F1 training courses, respectively

C. Other relevant performance benchmarks may be included, based on health sector requirements and capacity, and as DOH management deems appropriate. Annual Performance benchmarks will be finalized in Work and Financial Planning Guidelines issued by the Secretary of Health.

## VIII. Monitoring and Evaluation Mechanism

A. Accomplishment of DOH Offices and program managers based on key performance benchmarks and milestones shall be evaluated by Team/Cluster Heads in the first quarter of each year. Evaluations shall include provision and awarding of incentives and rewards as agreed upon by the team.



- B. Evaluation of DOH offices and program managers will be based on a convenient 3 point scale to be agreed with DOH offices and program managers by Team/Cluster Heads (Undersecretaries and Assistant Secretaries):

<b>Rating</b>	<b>Description of Performance</b>
A	100% accomplishment of Performance Benchmark or milestone based on quantitative and qualitative parameters agreed upon
B	75-99% accomplishment of Performance Benchmark or milestone based on quantitative and qualitative parameters agreed upon
C	Less than 75% of Performance Benchmark or milestone based on quantitative and qualitative parameters agreed upon

- C. Incentives attached to set performance benchmark may include the following :
1. Augmented increment of ratings in the DOH performance evaluation system
  2. Priority listing for long term and short term training opportunities
  3. Additional points added to evaluation points on proposals for access to PHDPF allocation, for upgrading of operational capacity in terms of MOOE, equipment or infrastructure
  4. Other incentives and rewards deemed appropriate

## **IX. Roles and Responsibilities**

- A. The Undersecretaries for PSDT-SD and FICT shall be responsible for the overall management of PBB system for public health to attain desired outcomes. Specifically, they shall be responsible for:
1. Setting annual performance benchmarks and evaluating performance.
  2. Instituting mechanisms to maintain integrity, validity and relevance PBB system through schemes like regular random sampling, etc
- B. The Assistant Secretary in charge of the SMCT shall be responsible for issuing annual performance measures and targets linked to PBB for public health in coordination with the PSDT-SD and FICT. He shall ensure through the HPDPB that the PBB scheme is in consonance with the over-all F1 financing strategy and goals for achieving technical and allocative efficiency. He shall also perform oversight functions and make necessary recommendations to ExeCom.
- C. The CHDs shall be responsible for technical assistance, monitoring and evaluation of the performance of local health systems in their area.

**X. REPEALING CLAUSE**

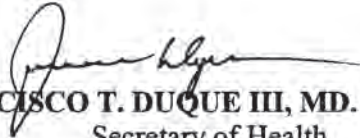
All administrative orders, rules or regulations inconsistent herewith are hereby repealed, amended and modified accordingly.

**XI. SEPARABILITY CLAUSE**

In the event that any provision of this 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.

**XII. EFFECTIVITY**

This order shall take effect immediately.

  
**FRANCISCO T. DUQUE III, MD. MSc**  
Secretary of Health

## ANNEX A.

### Considerations in Prioritization of Public Health Programs

In a dynamic setting associated with (and resulting from) health sector reform, there is a need to periodically review priority public health programs. Overall priorities may change as a result of success (or failure) in addressing a specific priority program. New information may become available that would allow a more rational ranking of priorities. Reestablishing priorities in the light of changes in the health system and in the general environment together with new information shall take into account a set of interrelated criteria for determining priorities that include the following:

1. *Burden of disease considerations.* Prioritize public health interventions based on current and changing disease patterns as measured by prevalence and incidence data in view of the lack of information to estimate DALY or similar measures.
2. *Equity considerations.* Focus public health interventions on the poor.
3. *Economic efficiency considerations:*
  - a. *Public goods.* Pure public goods, such as the provision of public health information, should receive more public attention (and probably more public resources) than private goods.
  - b. *Externalities.* If externalities are large, public attention may be required, and in some cases public financing or even public provision is justified.
  - c. *Risk pooling.* Some health conditions are rare and too costly for most uninsured individuals to pay out-of-pocket. There are some characteristics of health insurance markets (moral hazard and adverse selection) that will most likely make these markets fail without some element of public intervention. Public intervention, therefore, to create insurance markets is justified on efficiency terms.
4. *Cost-effectiveness.* Prioritize public health interventions that are effective given their cost in achieving a given target improvement in health outcomes. Priority shall be given to those needed interventions that are doable and backed by sufficient groundwork and buy-in from implementation partners. Success in achieving targets in one program could promote the achievement of targets in other programs, e.g., family planning and child health. Greater priority should be given to those critical interventions that strengthen linkages across public health interventions.



**ANNEX B**  
**Considerations in Allocation of Public Health Commodities**

**In order to improve commodity allocation to target those most in need, the following may be taken into consideration:**

**1. Current approaches to estimating commodity requirements/target population**

Current approaches to estimating commodity requirements include using the “*population at risk*” concept for programs of EPI and programs involving mass treatment (i.e., malaria, filariasis and STH) and “*population in need*” for programs involving selective treatment (i.e. malaria, filariasis, rabies, schistosomiasis, TB and leprosy).

For population at risk, estimates of commodity requirements also involved setting ideal coverage rates. For population in need, estimates of commodity requirements involved estimating expected cases.

**2. Refinements to the current estimates of commodity requirements**

The following factors need to be taken into account in refining multi-year national estimates of commodity requirements for priority public health programs:

- a. *Population growth.* Data on population projection by age and sex are provided by the National Statistics Office. For planning purposes, National Statistical Coordination Board (NSCB) recommends the use of the medium series. However, the assumptions in the medium series may not be achieved, and the more likely population projection would be the high series assumption, implying a larger population for each year in the projection period. The difference may not be large within the five year planning period.
- b. *Epidemiology or disease burden, including time frame for elimination or control of particular diseases.* Reduction in commodity requirements is expected if target coverage is achieved and sustained for a number of years, which for some diseases would take from three to five years (e.g., three years for soil transmitted helminthiasis and malaria, and five years for filariasis, and schistosomiasis). An effective surveillance system is needed to provide timely data.
- c. *Ideal target versus minimum target to prevent an outbreak.* Should commodity requirements be estimated to achieve the ideal target coverage (e.g., for EPI 95%) or in the case of budget constraints, to shoot for a minimum target coverage to prevent an outbreak (e.g., for EPI 80%)?
- d. *Across the board versus phased geographic interventions in endemic areas.* Should commodity requirements be estimated to reach all endemic areas at ideal coverage or in the case of budget constraints adopt a phase geographic targeting over a certain period of time such that some endemic areas are scheduled for



- e. *Poverty rate.* Estimates of the poverty rate are provided by the NSCB every three years based on data from the Family Income and Expenditure Survey (FIES). Useful data are also provided by national health and demographic surveys (National Demographic and Health Survey (NDHS) every five years and Family Planning Survey annually except in the year when NDHS is conducted) that provide maternal and child care and family planning data by wealth status of households. For certain commodities (child vaccines), estimates could exclude households in the high income quintiles on the assumption that these households would typically obtain services from private providers. (For EPI, only 70% of the eligible children for immunization belong to the three lowest quintiles. This rise to 85% of eligible children if only the highest income quintile households is excluded). For other commodities where it is known that the commodity is not available from the private sector (e.g., praziquantel for schistosomiasis treatment), estimation of commodity requirements may be made based on target population at risk or in need irrespective of wealth status. However, it can be argued that households in the higher income quintiles are less likely to be exposed to infection than poorer household on account of occupation and sanitation practices.
- f. *Public sector coverage and private market share.* Commodity estimates based on the assumption that all services will be provided solely by the public sector will overestimate commodity requirements if a segment of the client population obtain services from the private sector. Data on the share of the private sector in the health service market are generally not available. However, data on wealth status of households (by quintiles) can be used to estimate public sector coverage by assuming that households in either the highest or the second highest quintile would typically obtain services/information from private sector providers/dispensers. Estimates of commodity requirements of the public sector could thus be refined with this assumption regarding market share in mind.
- g. *Public sector performance (coverage rate and utilization rate) and projected improvements.* Commodity estimates based on the assumption that target coverage/utilization rates are fully met will overestimate commodity requirements since typically such targets are typically not consistently met. Achieving additional performance towards the target coverage/utilization rates not only imply commodity estimates to achieve the targets but also other resource requirements to facilitate achievement of the targets. Since the delivery of services is undertaken by LGUs, these additional resource requirements to generate additional performance can be provided through a performance-based grants or awards system (to be discussed below).
- h. *Buffer stock.* The commodity requirements over five years should avoid including a yearly requirement of additional standard percentage to cover for the buffer stock. Such an approach will lead to a compounding effect and would imply having a one year buffer stock by the end of a four year cycle.





July 12, 2006

**ADMINISTRATIVE ORDER**  
No. 2006- 0027

**Subject: Implementing Guidelines for Performance-Based Budgeting  
for DOH Retained Hospitals**

**I. RATIONALE**

The intrinsic goals of the Philippine health care system are improved health outcomes, responsiveness to client needs, and fairness in the distribution of health outcomes as well as the operational and financial means to achieving them. The achievement of these goals, as enunciated by Fourmula One for Health (F1), will be through its four main thrusts of health financing, health service delivery, regulation and health system governance.

Government hospitals are central to the execution of these strategies. Aside from its mandate of direct service delivery, particularly for the poor, government hospitals are also mandated to undertake research for the advancement of medical knowledge, provide training to ensure adequate and appropriate health human resource, as well as influence to other health facilities in the area to improve quality of care and ensure competitive pricing of services.

Funding for the operation, maintenance and improvement of government hospitals constitute more than 90% of the DOH budget for personal health care, which in turn accounts for about 60-70% of the total DOH expenditures. About 60% of the DOH hospital budget goes to personal services (PS) while 40% goes to maintenance and other operating expenses (MOOE). In 2003, hospitals have been allowed to retain revenues which in 2005 totaled more than a billion pesos or greater than 25% of the total MOOE in the sector.

However, the absence of systems to clearly link hospital performance with budgetary allocations means that the return value for the sizable investments on hospitals cannot be assured. For example, the lack of financial incentives to install good budgetary planning and control systems have not encouraged hospitals to fully realize their revenue generating potentials and shift from DOH-dependent budgets to internally generated sources of income such as social insurance reimbursements, user fee charges and other extra budgetary sources.



Performance-based budgeting refers to the process by which DOH shall split funding for the hospital MOOE into several portions, the releases of which will be based on hospital performance relative to pre-agreed performance measures. This reallocation scheme has great potential for providing incentives for solid institutional performance, motivating hospital staff members to perform better, rewarding effective business and financial management practices, securing hospital autonomy and improving the competitiveness of government hospital services. This will enhance capacity of government hospitals to influence the quality and pricing of other hospitals in their area and to improve services for the population, particularly the marginalized sectors of the society.

## **II. OBJECTIVES**

- A. Improve the quality of hospital services consistent with the core components of the Continuous Quality Improvement program of the DOH
- B. Ensure continued access to hospital services by clients, especially the marginalized sectors of the society, by securing self-sustainable hospital operations
- C. Promote optimum and efficient use of hospital resources consistent with the principles of sound business and financial management
- D. Improve allocative efficiency of the health care system by shifting national government subsidies away from personal health care and curative services towards public health care
- E. Link financial burden of DOH Hospitals' financing with incentives for the attainment of clearly defined performance outputs and outcomes

## **III. COVERAGE**

This Order shall provide the guidelines to implement the performance based budgeting system in the allocation of subsidies to all DOH hospitals.

## **IV. GENERAL GUIDELINES**

- A. In order to enhance allocative efficiency of the DOH budget and to augment public health funds, funds used for hospital services shall be shared with preventive and promotive services. DOH Budget for CY 2006-2010 shall be allocated to achieve no more than 70% financing for hospitals and no less than 17% for public health.
- B. There shall be Performance Based Allocation scheme for all DOH hospitals to improve technical efficiency of DOH Budget. It shall only apply to subsidies for the Maintenance, Operating, and Other Expenses (MOOE) of the hospital. Personnel Services (PS) of DOH hospitals shall not be linked to performance benchmarks.
- C. For purposes of improving allocative efficiency, a Public Health Development Fund Pool (PHDFP) shall be established comprising of funds from national subsidies to DOH hospitals. This shall be used to support priority public health F1 programs.



D. To improve technical efficiency, the following Fund Pools shall be established:

1. **Basic Allocation Fund (BAF):** This fund shall cover for funding of a substantial part of the MOOE of a hospital that will ensure its continuous operations. This fund shall not be linked to performance benchmarks.

2. **Performance Based Operation Fund (PBOF):** This fund shall serve as an incentive program anchored on the ability of the hospital to demonstrate achievements on the following performance benchmarks:

- Administrative
- Utilization Rate
- Quality
- Social Support
- Efficiency

3. **Health Facilities Enhancement Fund (HFEF):** This fund shall provide necessary investment support to DOH hospitals which will be made available for strategic hospital infrastructure development and equipment upgrade. Funding support shall come from any unallocated funds obtained from the Performance Based Operations Fund. An amount no more than 10% of HFEF shall be given to FICO, and NCHFD as funds to enhance operationalization of PBB subject to the satisfactory execution of provision of this Order and or upon discretion of management.

E. The ExeCom shall prescribe key performance benchmarks and measures relevant to attain F1 Medium Term Goals through Annual Planning Guidelines of the Department.

F. No new funds shall be made available to DOH hospitals in order to maintain allocative efficiency in DOH. However, should there be any new fund above the current baseline budget made available to DOH hospitals, it shall be used as a one time lump sum augmentation fund for the capital outlay of specific DOH hospitals. Any DOH hospital that receives this augmentation fund shall recompense the amount through automatic deductions from their Basic Allocation Fund over a period of five (5) years. This annual automatic deductions shall be added to the Health Facilities Enhancement Fund or the Public Health Fund Pool subject to management approval and as long as it is within the macro-allocative target of DOH.

G. The Performance Based Allocation scheme shall be anchored on full retention and use of income generated by DOH hospitals as an important element in achieving incentives and outcomes desired for DOH hospitals.

H. The National Expenditure Program (NEP) 2006 shall be the basis of the computation for fund allocation for DOH hospitals.

I. Performance Based Budgeting shall be implemented from CY 2006-2010 subject to an annual review and evaluation.



## **V. IMPLEMENTATION MECHANISM**

### **A. Fund Allocation Schemes**

1. A fixed amount equivalent to 5% of the MOOE budget per NEP 2006 shall be automatically deducted annually. It shall constitute the PHDFP for F1 programs from 2007 to 2010. Annual allocation of the fund to F1 programs shall be based on performance benchmarks for the public health programs set by the DOH.
2. Seventy percent (70%) of the net MOOE budget of hospitals per NEP 2006 shall represent the BAF for each hospital for fiscal year 2007-2010.
3. The remaining 30% of the net MOOE per NEP 2006 will be allocated to the hospitals for 2007 based on self assessment report presented in Annex A of this document, and based on the following major benchmark performance measures for 2008-2010:
  - a. Efficiency/Utilization Rate (base index of 60%)
  - b. Quality (base index of 20%)
  - c. Social Support (base index of 20%)
4. The unallocated amount from the PBOF shall comprise the HFEF. It shall be accessed on a competitive basis upon submission of proposals.

### **B. Key Performance Benchmark Measures**

- 1) The key performance benchmarks and indicators for 2006 are as follows:
  - a. Quality – Set up CQI program and committee pursuant to A.O. No. 2006-02
  - b. Social Support – Strengthen implementation of Patient Classification pursuant to AO. 51-A s. 2001
- 2) The key performance benchmarks and indicators for 2007 are illustrated in Annex A
- 3) The key performance benchmarks and indicators for 2008 to 2010 are as follows:
  - a. Efficiency Parameters which may include the following:
    - i. Case Mix and Occupancy Rates based on most recent DOH BHFS License
    - ii. Networking arrangements established with public and private facilities
    - iii. Cost per bed day vis a vis Licensing Category
    - iv. Service Capability
      - Teaching and Training Hospital, Capability to handle complex cases, Ancillary services including medical imaging, specialized laboratory procedures
  - b. Quality Parameters which may include the following:
    - i. Decreasing Nosocomial Infection Rate
    - ii. Net death rates within Internationally Accepted Standards
    - iii. Effective Hospital CQI Activities
    - iv. Minimal Adverse drug reactions / medication error rates



- v. Increasing percentage of filled and decreasing or zero % of unfilled prescriptions by hospital pharmacy
- vi. At least 50 % of MOOE used for drugs & supplies
- viii. Client Satisfaction and Responsiveness
  - Waiting time (ER, OPD and elective surgeries) , Patient Satisfaction preferably based on survey two weeks after discharge, personnel satisfaction
- c. Social Support Parameters which may include:
  - i. Increasing percentage ( % ) of PhilHealth enrolled indigent patients against total admissions
  - ii. Increasing % of internally generated funds used for indigent patients against total budget
  - iii. Increasing ratios on quantified free service over total gross revenue
- d. Other relevant parameters which may be deemed necessary to achieve FOURmula ONE for health goals

## **C. General Procedures**

### **C.1 Procedures for PBOF**

1. **Document Submission:** All of the DOH hospitals, except the specialty hospitals shall submit the self-assessment report (SAR) following on or before the end of November of each year to the CHDs. Attached as Annex A is the SAR used for CY 2007 Budget Allocation
2. **Assessment and Validation:** The CHD shall assess and validate the submitted documents as to completeness, accuracy, and other criteria as deemed necessary by NCHFD. The CHD shall submit to FICO the validated SAR.
3. **Final Performance Rating:** FICO will evaluate the SAR through a document review and/or oral presentation. Results will be endorsed to ExeCom for approval.
4. **Allocation of Performance Based Fund:** The corresponding allocation of the hospital for the PBOF shall be computed by the Finance Service for inclusion in the next year's budget proposal upon the approval of ExeCom.
5. **Regular Monitoring of Performance:** The FICO shall monitor hospitals semi-annually and submit reports to the Office of the Secretary through NCHFD.

### **C.2 Procedure for HFEF**

1. The Regional hospitals shall submit proposals for infrastructure enhancement/upgrading to CHD every fourth quarter of the year for review and evaluation. Recommendations shall be endorsed to FICO. For every approved proposal, the CHD shall receive 1 % of the approved amount for administration, monitoring, and evaluation.



2. FICO will finalize recommendations and proposals in accordance with the Hospital Strategic Development Plan for their area and submit to PSDT-SD.
3. The PSDT-SD shall prioritize proposals based on available funds and relevant guidelines. A priority list of proposals shall then be submitted to ExeCom for approval.
4. Sub-allotment to the identified proponent shall be facilitated by the Finance Service within the 2<sup>nd</sup> quarter of each year.

#### **D. Responsibilities**

1. The Hospitals shall be responsible for :
  - a. Developing a culture for linking the efficient use of government budgets to the attainment of specific outputs for improving hospital performance responsive to the needs of the community.
  - b. Ensuring availability and timely submission of required documentation and reports to achieve the goals of PBB scheme.
  - c. Closely coordinating and working with CHD, FICO, and other partners for improving performance of their hospitals.
2. The Field Implementation and Coordinating Offices (FICO) and Centers for Health Development (CHD) shall be responsible for the following:
  - a. Ensuring that implementation of the PBB will lead to the attainment of Strategic Hospital Development Goals in their areas.
  - b. Identifying and acting on all issues arising from its implementation.
  - c. Coordinating with the concerned DOH offices to support the review and revision of this Administrative Order when necessary.
3. The Policy and Standards Development Team for Service Delivery (PSDT-SD) through NCHFD shall be responsible for :
  - a. Developing standards and systems for a sound and coordinated PBB scheme for DOH Hospitals. This shall include the institutionalization of coordinative structures and development of standards, performance benchmarks, appropriate tools and training modules.
  - b. Establishing training for FICO, CHD and Hospital personnel in the implementation of a system for performance measurement, evaluation and improvement before the end of CY 2006. FICO, CHD and Chief of Hospitals shall in turn ensure that their appropriate personnel will undergo training
  - c. Managing the PBB scheme to ensure integrity, efficiency, and effectiveness in support of F1 Goals. They shall review the scheme regularly and recommend appropriate measures to improve it when necessary.

4. The HPDPB shall ensure that the PBB scheme is in consonance with the over-all F1 financing strategy and goals for achieving technical and allocative efficiency. It shall also perform oversight functions and make necessary recommendations to ExeCom.

**VI. REPEALING CLAUSE**

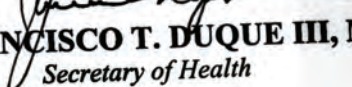
All administrative orders, rules or regulations inconsistent herewith are hereby repealed, amended or modified accordingly.

**VII. SEPARABILITY CLAUSE**

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

**VIII. EFFECTIVITY**

This order shall take effect immediately.

  
**FRANCISCO T. DUQUE III, MD, MSc**  
*Secretary of Health*



**Hospital Budget Allocation Criteria for PBOF  
Self-Assessment Report for CY 2007 Budget Proposal**

<b>I. ADMINISTRATIVE/SERVICE CLASSIFICATION (10%)</b>		<b>Rating</b>
(a) Authorized bed capacity		(5%) _____
High > 400	(5%)	
Medium 200-399	(4%)	
Low < 200	(3%)	
(b) Training and Teaching Hospitals		(5%) _____
Yes	(5%)	
No	(3%)	
Not Applicable (primary/secondary)	(0%)	
 <b>II. UTILIZATION RATES (60%)</b>		
(a) Occupancy Rates		(30%) _____
High > 85%	(30%)	
Medium High 75 – 84%	(28%)	
Medium 64 – 75%	(25%)	
Medium low 55 – 65%	(20%)	
Low < 55%	(15%)	
(b) Capability to handle Complex Cases		(20%) _____
High (Catastrophic – not less than 5 sub sub-specialty)	(20%)	
Medium (Intensive- below 5 sub sub-specialty)	(15%)	
Low (Ordinary)	(10%)	
(c) Ancillary		
1. Medical Imaging		(5%) _____
High - radiotherapy, CT Scan, MRI, Brachy Tx, Bone Scan, Mammo, EEG)	(5%)	
Medium – BA Enema, UGIS, Colonoscopy	(3%)	
Low – X-ray	(1%)	
2. Laboratory		(5%) _____
High – anatomic, , microbiology lab	(5%)	
Medium – blood chem., anatomic, clinical	(3%)	
Low – basic routine lab	(1%)	
 <b>III. QUALITY (10%)</b>		
1. Nosocomial Infection rate		(5%) _____
<2% infection rate	(5%)	
>2% infection rate	(2%)	
2. Net death rate		(5%) _____
2.5% and below	(5%)	
>2.5%	(2%)	
 <b>IV. SOCIAL SUPPORT (20%)</b>		
1. % of indigent patients supported		(20%) _____
>80% indigent	(20%)	
60-79%	(15%)	
below 60%	(10%)	
 <b>TOTAL</b>		<b>100%</b> _____
Rated by: _____ Date _____		
Reviewed by: _____ Date _____		



Republic of the Philippines  
Department of Health *FP&O 11-25-7*  
**OFFICE OF THE SECRETARY**

October 1, 2009

**DEPARTMENT ORDER**

No. 2009- 0311

**SUBJECT: Guidelines on the Utilization of 2009 Maternal, Newborn, Child Health and Nutrition (MNCHN) Grant Facility for Local Government Units (LGUs) and Management/Program Support Fund for the CHDs**

**A. BACKGROUND**

Through a congressional initiative in the 2007 General Appropriations Act (GAA) for reproductive health commodities and family planning training for LGUs, the Department of Health (DOH) developed the FP/RH/MNCHN Grant Facility in 2008 to award LGUs that performed well in delivering FP and MNCHN services to their constituents. To continuously reward LGUs for good performance, the Department of Health issued Department Order (D.O.) No. 2009-0092 on February 6, 2009. In this D.O., a portion of the Family Health including Family Planning budget line item A.III.b.2.d shall be used for the implementation of the 2009 MNCHN Grant Facility as follows a) for expenses incurred in extending technical assistance to LGUs in accessing the performance based grants/2009 MNCHN grant facility (for CHDs and DOH ARMM) and b) as grants based on the capacity of the LGUs to provide MNCHN including FP/RH services (for LGUs). A total of *One Hundred Sixty-Seven Million Pesos (PhP 167,000,000)* from the fund of Family Health including Family Planning under item III.b.2.d is allocated for the 2009 MNCHN Grant Facility.

This Department Order is issued to provide the National Center for Disease Prevention and Control (NCDPC) and the Centers for Health Development (CHDs) the specific guidelines for the disbursement of the 2009 MNCHN Grant Facility and reporting mechanisms to monitor progress of the grants' implementation. Though following the same process in the grants' implementation, a separate Department Order is issued for DOI-ARMM to specify management arrangements applicable to ARMM.

**B. ALLOCATION OF THE PhP 167,000,000**

The total amount of One Hundred Sixty-Seven Million Pesos is allocated as follows:

1. **Sixteen Million Pesos (PhP 16,000,000)** is sub-allotted at One Million Pesos (PhP 1,000,000) each to the 16 CHDs to augment the MOOE for "Local Health Assistance

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MAYLEEN V. AGUIRREN  
Chief, Records Section - IMS

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Including Health Systems Development and Public Health Program Support” specifically in performing the technical support in implementing the MNCHN Grant Facility.

2. **One Hundred Forty One Million Pesos (PhP 141,000,000)** is constituted to a MNCHN Grant Facility to award LGUs from 16 CHDs that performed well in delivering FP and MNCHN services.
3. **Ten Million Pesos (PhP 10,000,000)** is transferred to ARMM through DOH-ARMM to be constituted as MNCHN Grants for its provinces and independent/highly urbanized cities and to augment MOOE for Management/Program Support fund of the DOH ARMM.

### C. GRANT CEILINGS TO REGIONS AND PROVINCES


From the preceding section, a total of *One Hundred Fifty-One Million Pesos (PhP 151,000,000)* is constituted into the MNCHN Grants for LGUs. The amount is initially allocated to regions based on the estimated number of poor women of reproductive age (WRA). A region is composed of provinces and independent component or highly urbanized cities within the geographical area. Out of these regional allocations, *LGU ceilings* are computed based on the share of estimated poor WRA in the province. For purposes of this Department Order, an LGU refers to a province or independent/highly urbanized city.

Regional allocations from the 2009 MNCHN Grant Facility are shown below while the Annex A shows distribution of grant ceilings per province and independent /highly urbanized cities.

Table 1: MNCHN Grants Regional Allocations for LGUs

Region	Allocations
NCR	7,000,000
CAR	8,000,000
I	8,000,000
II	6,000,000
III	9,000,000
IV-A	11,000,000
IV-B	8,000,000
V	11,000,000
VI	12,000,000
VII	10,000,000
VIII	9,000,000
IX	9,000,000
X	9,000,000
XI	9,000,000
XII	9,000,000
CARAGA	6,000,000
ARMM	10,000,000
<b>TOTAL</b>	<b>Php 151,000,000</b>

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 Chief, Records Section - IMS  
 Department of Health





#### D. PERFORMANCE DOMAINS

Grants shall be awarded to LGUs that have established effective FP and MNCHN service delivery network within a province/city wide health system based on 3 performance domains. Awards shall be given to LGUs that exhibited the following:

1. Domain 1: Ability to demonstrate achievement of MNCHN intermediate outcomes, particularly contraceptive prevalence rate (CPR), antenatal care (ANC), facility-based deliveries (FBD), and fully immunized children (FIC).
2. Domain 2: Current capacity to deliver FP and MNCHN services such as the presence of trained staff; adequate commodities and supplies; IEC, health promotion and campaign activities, health information and surveillance; funding for FP and MNCHN services; and targeting of the poor.
3. Domain 3: Commitment to pursue improvement in the delivery of health services particularly increase in health budgets. This domain aims to ensure that funds transferred by DOH do not substitute funds of LGUs for health.

These performance domains have corresponding weights that shall be used in determining individual province/city-wide score. The DOH, through the CHDs, shall process and validate claims of performance submitted by LGUs. The amount of grant award per LGU shall be based on validated scores and taken from provincial or city grant ceilings.

Annex B provides a guide for CHDs in computing grants per Performance Domain.

Table 2: Performance Domains with Corresponding Weights

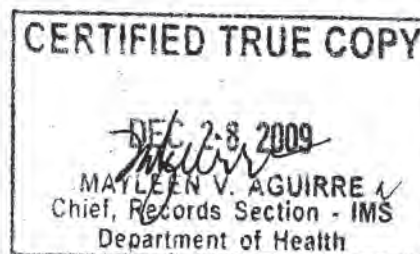
Performance Domains	Weights (%)
1. Improvement in MNCHN intermediate outcomes	40
2. Capacity to deliver MNCHN services	40
3. Commitment to pursue improvement in the delivery of MNCHN services	20

The MNCHN Grant Facility aims to award LGUs for good performance in the delivery of FP and MNCHN services. The grant facility should complement the regular LGU budget for health and not to be treated as substitute to the budget of LGUs.

Following the rules applied in the 2008 MNCHN Grant Facility, grants are awarded to LGUs upon presenting satisfactory proof of performance in the delivery of FP and MNCHN services.

#### E. PRECONDITIONS FOR FUNDS TRANSFER

The CHDs should ensure the following conditions are met prior to transfer of funds to LGUs:



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1. A **Memorandum of Agreement (MOA)** is signed by the Provincial Governor and the Secretary of Health for the Province-wide Investment Plan for Health (PIPH). For LGUs with a signed PIPH MOA, the CHDs should ensure the inclusion of the MNCHN grants in the **Service Level Agreement (SLA)** specifying conditions for funds transfer.

Transfer to LGUs without PIPH shall be covered by a separate MOA entered between the Secretary of Health, represented by the CHD Director, and the Provincial Governor/City Mayor.

Please see Annex C for templates of the MOA and SLA.

2. For LGUs with signed PIPH MOA, the Provincial Governor shall represent the municipalities and component cities within the province. The Provincial Government shall facilitate the preparation and submission of documents that would show performance of the province or city in providing FP and MNCHN services; allow the CHD to validate local performance; receive the grants in behalf of their component LGUs; manage the grant proceeds in coordination with their respective component LGUs and submit plans for the received grants for monitoring purposes.

For LGUs that do not have a signed PIPH MOA, a **Sponsor LGU** should represent the component LGUs within a province or an independent/highly urbanized city. The provincial government represented by the Governor or highly urbanized or independent city government represented by the Mayor usually acts as the Sponsor LGU but the following may be designated as Sponsor LGU with concurrence from the CHD Director if the provincial or city government cannot perform its expected roles:

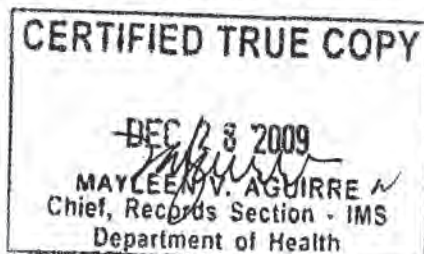
- a. Municipal or City Mayor
- b. Chapter President of the League of Municipalities
- c. Other officials that may be designated by the Provincial Governor such as the Vice Governor or Sangguniang Panlalawigan (SP) Member of the Province

From here on, LGU refers to the Province or Sponsor LGU that shall represent component municipalities/cities in the province or independent/highly urbanized cities.

#### **F. MECHANISM FOR FUNDS TRANSFER TO LGUs**

1. Domain 1 shall assess the ability of LGUs to achieve intermediate MNCHN outcomes such as CPR, ANC, FBD and FIC. The 2008 FHSIS in the CHDs will be used as basis in assessing performance in this domain.
2. Domain 2 shall assess the current capacity of LGUs to deliver FP and MNCHN services. The LGU shall submit the following documents to the CHDs:
  - a. MNHCN Grants Application Form 1: CSR Assessment signed by the Provincial Health Officer (PHO) and noted by the Governor.
  - b. MNHCN Grants Application Form 2: Certification of Expenses on MNCHN Services signed by the accountant and certified by the auditor.

Please see Annex C for templates of the above documents.





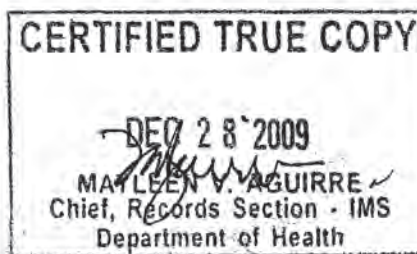
3. Domain 3 is a show of commitment from the LGU to improve health services through an increase in local budgets for health from 2008 to 2010. The LGU will submit MNHCN Grants Application Form 3: LGUs' Budget for Health signed by the PHO and noted by the Governor.

Please see Annex C for a template of the above document.

4. CHDs shall assess and validate, if needed, performance in the three domains. Scores of LGUs in each domain shall determine the equivalent grant awards. Procedures in assessing and scoring LGUs performance, documentary requirements and computation of grant awards for each domain are discussed in Annex B: assessment of LGUs' performance.
5. CHDs have the option to transfer funds to LGUs as soon as the evaluation of each Domain is done. Following principles of performance-based grants which awards LGUs for what has been achieved, further releases of grants to LGUs do not necessitate liquidation of previously received grants.
6. LGUs have until the last day of the 1<sup>st</sup> quarter of 2010 (31 March 2010) to submit necessary documents to the CHDs in order to access the grants. The CHDs have the following options for any undisbursed funds thereafter:
  - a. Allocate to other LGUs that have shown exemplary performance in delivering FP and MNCHN services,
  - b. Sub-allot funds to retained hospitals in the region for provision of FP and MNCHN services such as procurement of FP and MNCHN commodities, conduct of information campaigns and behavior change communication (BCC), or
  - c. Transfer funds to NGO providers to provide FP and MNCHN services in the province/city. Transfer of funds to an NGO provider shall be covered by a MOA entered between the Secretary of Health, represented by the CHD Director and Executive Director/ Head of the NGO.
7. As stated, the MNCHN Grant Facility is given to LGUs for their past performance in delivering FP and MNCHN services to their constituents. The DOH does not stipulate how LGUs will utilize grants received but it encourages LGUs to use the grants to augment budget in order to improve FP and MNCHN services. This will allow LGUs to access other MNCHN Grants in the future.

LGUs may have the following options in utilizing the grants:

- a. Pooled procurement of FP and MNCHN commodities, drugs and supplies which the province will distribute to component municipalities and cities including provincial and district hospitals.
- b. Augment funds for outreach activities by the province and component municipalities and cities.
- c. Distribute grants received to component municipalities and cities based on their performance in the provision of FP and MNCHN services.



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## **G. RESPONSIBILITIES OF THE DOH AND LGUs IN THE IMPLEMENTATION OF THE GRANT FACILITY**

### **1. PSDT-SD**

- a. Oversee the management and implementation of the 2009 MNCHN Grant Facility
- b. Directly supervise and manage the MNCHN Task Force
- c. Provide progress reports and advice to the Secretary of Health, whenever necessary

### **2. NCDPC**

- a. Ensure the institutionalization of outputs and recommendations of the MNCHN Task Force into the Family Health Office Programs
- b. Provide technical assistance to MNCHN Task Force on grants implementation.

### **3. MNCHN Task Force**

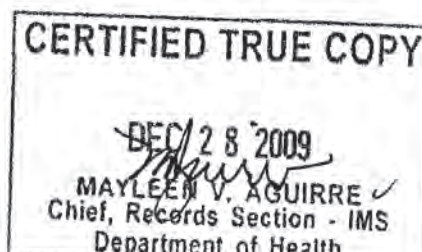
- a. In-charge of overall management of the MNCHN Grants for 2009
- b. Determine grant ceilings per region and LGU based on the estimated share of poor women of reproductive age
- c. Orient CHDs on the rules and procedures for the 2009 MNCHN Grants Facility ;
- d. Render technical assistance to CHDs, as needed
- e. Monitor disbursement and utilization of 2009 MNCHN Grants
- f. Provide progress reports to the Undersecretaries of PSDT-SD and Field Implementation and Management Office (FIMO)
- g. Lead evaluation missions, composed of multi-disciplinary team, to assess implementation of the grants
- h. Contract services of personnel in the implementation of this grant, as necessary

### **4. FIMO**

- a. Oversee the management and implementation of the 2009 MNCHN Grants by CHDs
- b. Render technical assistance to CHDs, if necessary
- c. Inform LGUs, provinces, municipalities and cities, of available MNCHN Grants

### **5. CHDs**

- a. Under the supervision of the Regional Director, create the management team for the 2009 MNCHN Grant Facility composed of the Assistant Regional Director, Head of Family Health Cluster, Family Planning Coordinator, MCH Coordinator and Finance Officer.



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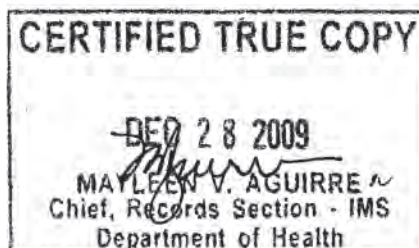
- b. The Management Team shall be responsible for the following:
  - i. Orientation of LGUs on the 2009 MNCHN Grant Facility and any subsequent grants
  - ii. Prepare the SLA or MOA with LGUs to facilitate transfer of funds
  - iii. Provision of technical assistance to LGUs to comply with requirements of the grants
  - iv. Assess and validate performance of LGUs based on criteria stated in Section D
  - v. Determination of grant awards of LGUs based on their performance in delivering FP and MNCHN services
  - vi. Disbursement of funds to the LGUs
  - vii. Monitoring and reporting the utilization of 2009 MNCHN Grant Facility
- c. Designate the Provincial Health Team Leader (PHTL) as the coordinator for the 2009 MNCHN Grants in provinces within the region
- d. Contract services of personnel in the implementation of this grant, if necessary

**6. LGUs**

- a. Concur on the SLA or MOA with the CHDs that will specify conditions in accessing the grants
- b. Submit necessary documentary requirements
- c. Allow CHDs to validate any information, if necessary
- d. Coordinate with CHDs to improve delivery of FP and MNCHN services and improvement of MNCHN intermediate outcomes

**H. REPORTING AND MONITORING MECHANISMS**

- 1. CHDs shall record all financial transactions into the web-based Expenditure Tracking System (ETS) to allow timely monitoring of grants released to the LGUs. Accomplishment of target output indicators shall also be recorded in the ETS.
- 2. A performance assessment shall be conducted by the CHDs, FIMO, National Center for Disease Prevention and Control (NCDPC) and MNCHN Task Force to assess progress in the transfer of funds to LGUs and achievement of programs, projects and activities and lessons learned from the implementation of the 2008 MNCHN Grant Facility.
- 3. Supervision missions will be undertaken by the NCDPC, FIMO, MNCHN Task Force to assess performance and render technical assistance to CHDs, if needed.
- 4. The CHDs shall conduct a post-performance audit of LGUs to verify performance in delivering FP and MNCHN services. Falsification of any information will disqualify LGUs from accessing future grants from DOH.



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**I. Disbursement of funds shall follow the usual government accounting and auditing rules and regulations.**

Annex A: LGU Grant Ceilings

Annex B: Procedures in Assessment of LGUs' Performance

Annex C: Templates

Memorandum of Agreement

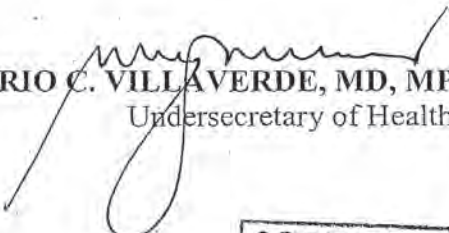
Service Level Agreement

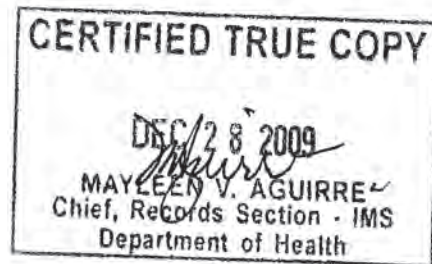
MNCHN Grants Application Form 1: CSR Assessment

MNCHN Grants Application Form 2: Certification of Expenses on MNCHN Services

MCNHN Grants Application Form 3: Budget for Health

BY AUTHORITY OF THE SECRETARY OF HEALTH

  
**MARIO C. VILLAVERDE, MD, MPH, MPM, CESO I**  
Undersecretary of Health





Annex A: LGU Ceilings for 2009 MNCHN Grants

LGUs (Provinces and Independent/Highly Urbanized Cities)	LGU Ceilings
Region NCR	7,000,000
City of Malabon	300,000
City of Navotas	200,000
City of Valenzuela	600,000
Kalookan City	850,000
City of Marikina	300,000
City of Pasig	400,000
Pateros	200,000
Taguig City	400,000
Quezon City	900,000
City of Makati	300,000
City of Mandaluyong	200,000
City of San Juan	200,000
City of Manila	850,000
City of Las Piñas	300,000
City of Muntinlupa	300,000
City of Parañaque	400,000
Pasay City	300,000
Region CAR	8,000,000
Abra	✓ 2,037,272
Apayao	946,089
Benguet	602,888
Baguio City	1,788,310
Ifugao	177,090
Kalinga	1,365,526
Mountain Province	1,082,825
Region I	8,000,000
Ilocos Norte	602,590
Ilocos Sur	1,070,491
La Union	1,225,663
Pangasinan	4,828,294
Dagupan City	✓ 272,962
Region II	6,000,000
Batanes	29,206
Cagayan	1,802,840
Isabela	✓ 3,134,471
Santiago City	282,347
Nueva Vizcaya	483,725
Quirino	267,411

LGUs (Provinces and Independent/Highly Urbanized Cities)	LGU Ceilings
Region III	9,000,000
Aurora	310,488
Bataan	316,462
Bulacan	1,739,376
Nueva Ecija	3,154,480
Pampanga	939,150
Angeles City	218,672
Tarlac	1,557,684
Zambales	644,761
Olongapo City	✓ 118,927
Region IV-A	11,000,000
Batangas	3,174,463
Cavite	1,506,250
Laguna	1,516,943
Quezon	3,661,506
Lucena City	✓ 188,441
Rizal	952,397
Region IV-B	8,000,000
Marinduque	709,669
Occidental Mindoro	1,478,851
Oriental Mindoro	2,483,417
Palawan	2,078,021
Puerto Princesa City	366,457
Romblon	883,387
Region V	11,000,000
Albay	2,249,906
Camarines Norte	1,039,448
Camarines Sur	3,456,553
Naga City	334,704
Catanduanes	444,859
Masbate	1,869,750
Sorsogon	1,604,780
Region VI	12,000,000
Aklan	1,252,578
Antique	1,292,732
Capiz	1,027,664
Guimaras	290,335
Iloilo	2,498,304
Iloilo City	218,577
Negros Occidental	✓ 5,196,870
Bacolod City	223,440

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Annex A: LGU Ceilings for 2009 MNCHN Grants

LGUs (Provinces and Independent/Highly Urbanized Cities)	LGU Ceilings
Region NCR	7,000,000
City of Malabon	300,000
City of Navotas	200,000
City of Valenzuela	600,000
Kalookan City	850,000
City of Marikina	300,000
City of Pasig	400,000
Pateros	200,000
Taguig City	400,000
Quezon City	900,000
City of Makati	300,000
City of Mandaluyong	200,000
City of San Juan	200,000
City of Manila	850,000
City of Las Piñas	300,000
City of Muntinlupa	300,000
City of Parañaque	400,000
Pasay City	300,000
Region CAR	8,000,000
Abra	2,037,272
Apayao	946,089
Benguet	602,888
Baguio City	1,788,310
Ifugao	177,090
Kalinga	1,365,526
Mountain Province	1,082,825
Region I	8,000,000
Ilocos Norte	602,590
Ilocos Sur	1,070,491
La Union	1,225,663
Pangasinan	4,828,294
Dagupan City	272,962
Region II	6,000,000
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Cagayan	1,802,840
Isabela	3,134,471
Santiago City	282,347
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Quirino	267,411

LGUs (Provinces and Independent/Highly Urbanized Cities)	LGU Ceilings
Region III	9,000,000
Aurora	310,488
Bataan	316,462
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Tarlac	1,557,684
Zambales	644,761
Olongapo City	118,927
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Batangas	3,174,463
Cavite	1,506,250
Laguna	1,516,943
Quezon	3,661,506
Lucena City	188,441
Rizal	952,397
Region IV-B	8,000,000
Marinduque	709,669
Occidental Mindoro	1,478,851
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Palawan	2,078,021
Puerto Princesa City	366,455
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Albay	2,249,906
Camarines Norte	1,039,448
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Catanduanes	444,859
Masbate	1,869,750
Sorsogon	1,604,780
Region VI	12,000,000
Aklan	1,252,578
Antique	1,292,232
Capiz	1,027,664
Guimaras	290,335
Iloilo	2,498,304
Iloilo City	218,577
Negros Occidental	5,196,870
Bacolod City	223,440

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LGUs (Provinces and Independent/Highly Urbanized Cities)	LGU Ceilings
Region VII	10,000,000 - 1
Bohol	2,756,766
Cebu ✓	3,306,747
Cebu City	516,190
Lapu-Lapu City	270,092
Mandaue City	224,817
Negros Oriental	2,835,347
Siquijor	90,041
Region VIII	9,000,000 x 3
Biliran	316,568
Eastern Samar	982,569
Leyte	3,487,963
Ormoc City	400,901
Northern Samar	1,573,795
Samar (Western Samar)	1,580,070
Southern Leyte	658,134
Region IX	9,000,000
Zamboanga del Norte	4,003,188
Zamboanga del Sur	2,017,922
Zamboanga City	1,231,386
Zamboanga Sibugay	1,445,314
City of Isabela	302,190
Region X	+1 9,000,000
Bukidnon	2,647,578
Camiguin ✓	218,468
Lanao del Norte	1,683,247
Iligan City	513,546
Misamis Occidental	1,783,145
Misamis Oriental	1,680,023
Cagayan De Oro City	473,993
Region XI	9,000,000
Compostela Valley	1,945,976
Davao del Norte (Davao)	2,500,000
Davao del Sur	1,500,000
Davao City	1,504,024
Davao Oriental	1,550,000
Region XII	9,000,000
Cotabato (North Cotabato)	2,366,793
Sarangani	1,505,324
South Cotabato	1,732,351
General Santos City ✓	663,328
Sultan Kudarat	1,989,430
Cotabato City	742,774

LGUs (Provinces and Independent/Highly Urbanized Cities)	LGU Ceilings
Region CARAGA	6,000,000
Agusan del Norte	643,498
Butuan City	469,173
Agusan del Sur	1,752,406
Dinagat Islands	349,103
Surigao del Norte	1,261,808
Surigao del Sur	1,524,012
ARMM	10,000,000
Basilan	
Lanao del Sur	
Marawi City	
Maguindanao	
Sulu	
Tawi-Tawi	

yes



LGUs (Provinces and Independent/Highly Urbanized Cities)	LGU Ceilings
Region VII	10,000,000
Bohol	2,756,766
Cebu	3,306,747
Cebu City	516,190
Lapu-Lapu City	270,092
Mandaue City	224,817
Negros Oriental	2,835,347
Siquijor	90,041
Region VIII	9,000,000
Biliran	316,568
Eastern Samar	982,569
Leyte	3,487,963
Ormoc City	400,901
Northern Samar	1,573,795
Samar (Western Samar)	1,580,070
Southern Leyte	658,134
Region IX	9,000,000
Zamboanga del Norte	4,003,188
Zamboanga del Sur	2,017,922
Zamboanga City	1,231,386
Zamboanga Sibugay	1,445,314
City of Isabela	302,190
Region X	9,000,000
Bukidnon	2,647,578
Camiguin	218,468
Lanao del Norte	1,683,247
Iligan City	513,546
Misamis Occidental	1,783,145
Misamis Oriental	1,680,023
Cagayan De Oro City	473,993
Region XI	9,000,000
Compostela Valley	1,945,976
Davao del Norte (Davao)	2,500,000
Davao del Sur	1,500,000
Davao City	1,504,024
Davao Oriental	1,550,000
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Cotabato (North Cotabato)	2,366,793
Sarangani	1,505,324
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LGUs (Provinces and Independent/Highly Urbanized Cities)	LGU Ceilings
Region CARAGA	6,000,000
Agusan del Norte	643,498
Butuan City	469,173
Agusan del Sur	1,752,406
Dinagat Islands	349,103
Surigao del Norte	1,261,808
Surigao del Sur	1,524,012
ARMM	10,000,000
Basilan	
Lanao del Sur	
Marawi City	
Maguindanao	
Sulu	
Tawi-Tawi	

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## ANNEX B: ASSESSMENT OF LGUs' PERFORMANCE

This section shall guide the CHDs in determining awards to LGUs for each Performance Domain.

### 1. DOMAIN 1

A maximum of 40% of the provincial or independent city grant ceiling will be awarded to LGUs that can show capacity to reach target MNCHN indicators particularly Contraceptive Prevalence Rate (CPR), Antenatal Care (ANC), Facility-Based Deliveries (FBD) and Fully Immunized Children (FIC) in Year 2008.

Grant awards per cluster of LGUs are determined as follows:

- Get current level of performance of each provincial or independent city LGU in the region from the 2008 FHSIS. CHDs shall use regional data collected from LGUs.
- Determine the percentage difference of each indicator from national targets by subtracting the current level of the LGU from the national target, dividing the difference with the national target and multiplying by 100. Following are national targets as set in the National Objectives for Health (NOH) for 2005-2010:

MNCHN Indicator	National Target
Contraceptive Prevalence Rate (Modern FP methods)	60%
Antenatal Care	80%
Facility-Based Deliveries	80%
Fully Immunized Children	95%

  
$$\% \text{ Difference for CPR of LGU} = \frac{(CPR_{\text{national target}} - CPR_{2008})}{CPR_{\text{national target}}} \times 100$$
  
$$\% \text{ Difference for ANC of LGU} = \frac{(ANC_{\text{national target}} - ANC_{2008})}{ANC_{\text{national target}}} \times 100$$
  
$$\% \text{ Difference for FBD of LGU} = \frac{(FBD_{\text{national target}} - FBD_{2008})}{FBD_{\text{national target}}} \times 100$$
  
$$\% \text{ Difference for FIC of LGU} = \frac{(FIC_{\text{national target}} - FIC_{2008})}{FIC_{\text{national target}}} \times 100$$

c. Give each indicator an intermediate score based on the following scale:

Percentage Difference	Score
≤0%-10%	100
11%-20%	90
21%-30%	80
31%-40%	70
41%-50%	60
51%-60%	50
61%-70%	40
71%-80%	30
81%-90%	20
91%-100%	10
101%-up	0

d. To get the overall score, multiply the score of the LGU for each indicator with its assigned weight and add the scores of the four MNCHN indicators.

MNCHN Indicator	Weight
Contraceptive Prevalence Rate	30%
Antenatal Care	10%
Facility-Based Deliveries	30%
Fully Immunized Children	30%

For example:

MNCHN Indicator	% Difference	Intermediate Score	Weight	Overall Score
CPR	35%	70	30%	21
ANC	12%	90	10%	9
FBD	24%	80	30%	24
FIC	9%	100	30%	30
<b>OVERALL SCORE</b>				<b>84</b>

e. Transfer 40% of the *LGU ceiling* to the LGU if the total score is between 80-100%.  
 Transfer 30% of the *LGU ceiling* to the LGU if the total score is equal to or below 79%.  
 In the example above, the LGU will receive 40% of the LGU ceiling for Domain 1.

*yes*



- f. Residual amounts, if any, are distributed based on the estimated number of poor WRA of provinces or independent cities within the region that received scores of 90% to 100%.
- g. FHSIS data of the region for 2008 will be used to determine performance of LGUs for Domain 1.

A spreadsheet (MS Excel) is forwarded to CHDs to facilitate computation of the grants. Department Circular 2009-0129 shall be the basis for the projected population used in computing accomplishments.

**DOMAIN 2**

A maximum of 40% of the provincial or independent city grant ceiling will be awarded to LGUs that can show their current capacity to deliver FP and MNCHN services and provide critical commodities, drugs and medical supplies, other supplies particularly for Year 2009.

- h. The following areas shall be assessed in determining current capacity of LGUs:
  - i. Support to FP and MNCHN health personnel – provision of TEVs, access to training for FP and MNCHN services.
  - ii. Procurement of total requirement of FP and MNCHN commodities, drugs and medical supplies, other supplies in LGUs' health centers and hospitals.
  - iii. Conduct of information and behavior change communication campaigns
  - iv. PhilHealth enrollment of indigents
- i. LGUs shall submit the following documents in printed and electronic format:
  - i. MNCHN Grants Application Form 1: CSR Assessment
  - ii. MNCHN Grants Application Form 2: Certification of Expenses on MNCHN Services

CHDs have the option to contract services of personnel who will assist LGUs in completing information of above forms.

- c. Follow these procedures in scoring CSR performance of LGUs:
  - i. Get the modal score of the LGU for each question in MNCHN Grants Application Form 1
  - ii. Each question is assigned points for a total score of 100. Give a full point if the modal score is 1 and no point if the modal score is 0. Scores for each question are as follows:

QUESTIONS	
<b>1. Public health professional responsible for managing FP and MNCHN services</b>	10
a. Is there a person in the LGU dedicated to managing FP and MNCHN services?	5
b. Is this staff trained on FP and MNCHN programs?	5

<b>2. Local requirements on total FP and other MNCHN commodities</b>	10
a. Is there a projection of total FP commodities like OCPs, DMPA?	5
b. Is there a projection of other MNCHN commodity requirements?	5
<b>3. Activities to educate and counsel clients about FP and MNCHN services</b>	10
a. Is there a local health plan with specific IEC activities on FP and MNCHN?	4
b. Does the LGU conduct regular IEC/ health promotion activities on FP and MNCHN?	3
c. Is counseling a regular part of the LGU's FP service delivery?	3
<b>4. Local funding for FP and MNCHN commodities and education / counseling activities</b>	25
a. Is there a budget for procurement of modern FP commodities such as OCPs, DMPA and drugs and medical supplies for VSC, other supplies, if applicable?	4
b. Is there a budget for maternal and child care commodities/ medical supplies?	4
c. Is there a budget for community outreach activities on FP and MNCHN service provision, including counseling?	4
d. Does the LGU hold major events / celebrations to promote FP and MNCHN?	3
e. Is there budget for TEVs of personnel during IEC and outreach campaigns/services?	5
f. Is there a local financing scheme or cost recovery mechanism to sustain FP and MNCHN program implementation?	5
<b>5. Utilization of local funding for FP and other MNCHN commodities and education / counseling</b>	15
a. Is the budget for procurement of modern FP commodities such as OCPs and DMPA , drugs and medical supplies for VSC and other supplies utilized?	5
b. Is the budget for maternal and child care commodities / medical supplies utilized?	5
c. Is the budget for community outreach activities on FP and MNCHN service provision, including education/ counseling utilized?	5
<b>6. Clients deemed eligible for free FP and MNCHN services are able to access services of their choice</b>	30
a. Is there a formal criteria used to determine (i.e. market segmentation) who gets free health services?	5
b. Does the LGU have a list of identified indigents?	10
c. Did the LGU earmark or allocate oral contraceptives, DMPA, VSC drugs and medical supplies , other MNCHN supplies specifically for the poor?	5
d. Does the LGU have strategies/ interventions to facilitate access to FP and MNCHN services by the poor?	5
e. Are there mechanisms to ensure that non-poor clients are referred to appropriate facilities?	5
	<b>100</b>



- d. To get the amount that the LGU will receive for Domain 2, multiply the percentage equivalent of the total score of the LGU with the equivalent grant amount for Domain 2.
- e. Residual amounts from Domain 2, if any, can be distributed to other LGUs that got scores of 80% and above. Distribution will be based on the estimated number of poor WRA.

A spreadsheet (MS Excel) is also provided to the CHDs to facilitate computation of the grants per LGU in Domain 2.

gpd



### DOMAIN 3

A maximum of 20% of the provincial or independent city grant ceiling amount will be awarded to LGUs that can show their commitment to continuously provide FP & MNCHN services by showing an increase in their regular budget for health in Year 2008, 2009 and 2010. The DOH wants to ensure that grants received by LGUs are not crowding out budget of LGUs for health. The grants should augment local budget and not be a substitute for an existing budget.

- a. LGUs shall submit MNHCN Grants Application Form 2 prepared by Budget Officer and certified correct by the Provincial Health Officer (PHO) and noted by the Governor. MNCHN Grants Application Form 2 is a consolidation of information from the province and its component LGUs. Though LGUs do not have to submit actual financial records, they should be instructed to prepare such documents for validation by CHDs if needed.
- b. CHDs shall compute the average increase in the health budget by:
  - i. Get the total of budgets for health for all LGUs in the province
  - ii. Get the difference between the health budget of 2008 and 2009 ; 2009 and 2010
  - iii. Divide the difference by the health budget for 2008 and 2009 respectively
  - iv. Compute the average increase or decrease in health budget for the whole province
  - v. Give a score of 1 if LGUs increased their budgets and 0 if otherwise
- c. Award 20% of the provincial or independent city grant ceiling to LGUs if there is an increase in average health budget in 2009 and 2010.
- d. Residual amounts, if any, shall be distributed to LGUs that increased their budget in 2009 and 2010 based on the estimated number of poor WRA.

A spreadsheet (MS Excel) is also provided to the CHDs to facilitate computation of the grants per LGU in Domain 3.

#### 4. SCHEDULE OF FUND TRANSFERS

There is a possibility that LGUs in a region would not complete their requirements at the same time which may cause delay in fund transfers mainly due to the mechanism of computing cash awards. Therefore, the CHDs have the following options in transferring funds to LGUs:

- a. Transfer funds as soon as requirements are completed and validation and computations by CHDs are done for each Performance Domain.
- b. Residual amounts from all Performance Domains, if any, may be released together with the last tranche of fund transfer.

## MEMORANDUM OF AGREEMENT

KNOW ALL MEN BY THESE PRESENTS:

This Memorandum of Agreement (MOA) entered into this \_\_\_\_ day of \_\_\_\_\_ 2009 in \_\_\_\_\_ by and between:

The **DEPARTMENT OF HEALTH (DOH)**, a National Government Agency created and existing under the laws of the Republic of the Philippines, with principal office address at San Lazaro Compound, Sta. Cruz, Manila, herein represented by \_\_\_\_\_, in his capacity as Director IV of the Center for Health Development (CHD) - \_\_\_\_\_, and hereinafter referred to as the **DOH**;

- and -

The **PROVINCE / CITY OF** \_\_\_\_\_, a Local Government Unit (LGU) established and existing under the laws of the Republic of the Philippines, with principal office address at \_\_\_\_\_, herein represented by \_\_\_\_\_, in his capacity as Provincial Governor / City Mayor, and hereinafter referred to as the **SPONSOR**;

### WITNESSETH

**WHEREAS**, the Philippines has committed to achieve the Millennium Development Goals specifically on reducing maternal and child mortality as reiterated in the National Objectives for Health 2005-2010;

**WHEREAS**, Republic Act no. 9524, otherwise known as the General Appropriations Act (GAA) of 2009, appropriated funds for "family health including family planning" through item III section b.2.d;

**WHEREAS**, One Hundred Sixty Seven Million Pesos (Php 167,000,000) from the appropriation shall constitute the 2009 MNCHN Grant Facility;

**WHEREAS**, the DOH had issued D.O. no. 2009-0092, as amended by D.O. no. 2009-\_\_\_\_, which provides the guidelines for the release and utilization of the Family Health including Family Planning line item budget for purposes of the 2009 MNCHN Grant Facility, among others;

**WHEREAS**, through the 2009 MNCHN Grant Facility, performance-based grants shall be awarded to provinces/independent/highly urbanized cities that have effectively provided or made available FP and MNCHN goods and services to its constituents;

**WHEREAS**, maximum amount that each respective province can access from the grant facility shall be commensurate to their performance, as determined by the CHDs using the following criteria: ability to demonstrate achievement and improved variance among component LGUs of key national MNCHN outcomes; current capacity to deliver core FP and MNCHN services and provide critical commodities and supplies; and, commitment to pursue improvement in the delivery of FP and MNCHN services, especially for the poor;



**WHEREAS**, for purposes of the 2009 MNCHN Grant Facility, the recipient of grant proceeds shall be referred to as the SPONSOR, which pertains to the provincial government or a city government that has, through formal instrument, committed to represent the component LGUs of a province/highly urbanized city;

**WHEREAS**, as a result of hereinabove-cited performance assessment, the SPONSOR is entitled to receive a maximum amount of \_\_\_\_\_ (P \_\_\_\_\_), subject to the conditions set forth under this MOA and the corresponding appropriate guidelines;

**WHEREFORE**, for and in consideration of the foregoing premises, the PARTIES to this MOA have agreed to undertake the following:

- 1) That the SPONSOR shall:
  - a) Announce the 2009 MNCHN Grant Facility to the LGUs that it represent and the amount that they had cumulatively been awarded by virtue of this MOA;
  - b) Consult and forge an allocation agreement with the LGUs that it represents with regard the province-wide or inter-LGU distribution of the amounts awarded by virtue of this MOA;
  - c) Inform the DOH about the finalized allocation agreement;
  - d) Open and maintain a Trust Account in a government depository bank or a Subsidiary Ledger of an existing Trust Account for the exclusive purpose of the awarded amount by virtue of this MOA and, at the same time, require the same practice from the LGUs that it represents with respect to the portions of the amounts that they receive as shares from the awarded amounts, subject to the provisions of Sections 309 to 312 of the Local Government Code;
  - e) Implement the distribution of the shares from the awarded amounts, in accordance with the allocation agreement;
  - f) Monitor the performance of the LGUs that it represent based on the criteria set forth in this MOA and the corresponding appropriate guidelines, which can be a useful source of information for the next rounds of performance-based grants;
  - g) Allow DOH to assess and re-assess its performance and validate if necessary; and,
  - h) Abide by the usual accounting and auditing rules and regulations;
- 2) That the DOH, through CHD - \_\_\_\_\_ shall:
  - a) Inform the SPONSOR about the result of the performance assessment and the amount that it can access through the 2009 MNCHN Grant Facility;
  - b) Release to the SPONSOR the hereinabove-stated amount, subject to the provisions of this MOA, pertinent guidelines and standards;
  - c) Effect the transfer of amount awarded to the SPONSOR through a Trust Account, as contemplated under Section 1(d) of this MOA, subject to usual accounting and auditing rules and regulations;



- d) Monitor and assess improvements in the performance of the SPONSOR and the LGUs it represents;
- 3) That the provisions of this MOA shall govern the relationship between the DOH and the SPONSOR; and,
- 4) That this MOA shall take effect upon signature of both PARTIES.

IN WITNESS WHEREOF, the PARTIES hereto have hereunto set their hands on the date and place above-written.

**DEPARTMENT OF HEALTH**  
 By: \_\_\_\_\_  
 Director IV, CHD - \_\_\_\_\_

**PROVINCE/CITY GOVERNMENT**  
 By: \_\_\_\_\_  
 Provincial Governor/City Mayor

*Signed in the presence of:*

\_\_\_\_\_ PHTL for \_\_\_\_\_ Province

\_\_\_\_\_ Provincial Health Officer

Republic of the Philippines )  
 \_\_\_\_\_ ) SS.

**ACKNOWLEDGEMENT**

BEFORE ME, this \_\_\_ day of \_\_\_\_\_ 2009 personally appeared:  
 \_\_\_\_\_ with CTC no. \_\_\_\_\_ issued on \_\_\_\_\_ at \_\_\_\_\_, and  
 \_\_\_\_\_ with CTC no. \_\_\_\_\_ issued on \_\_\_\_\_ at \_\_\_\_\_.

Both known to be to be the same persons who executed the foregoing MOA and they acknowledged to me that the same is their free act and deed, as well as that of the entities that they represent. This instrument consists of three (3) pages including this page, signed by the parties and their witnesses on each and every page thereof and sealed with my notarial seal.

**NOTARY PUBLIC**

Doc. no. \_\_\_\_\_;  
 Page no. \_\_\_\_\_;  
 Book no. \_\_\_\_\_;  
 Series of 2009.



# SERVICE LEVEL AGREEMENT

Regional Accountant I

This Service Level Agreement is made and entered into on this \_\_\_\_ day of \_\_\_\_\_ 20\_\_ by and between the following parties:

The **Department of Health-Center for Health Development** - \_\_\_\_\_, a regional government agency created under the laws of the Republic of the Philippines with principal office address at \_\_\_\_\_, represented by the **Director IV**, \_\_\_\_\_, and hereinafter referred to as the **DOH-CHD**;

- and -

Provincial Health Officer II

The **Provincial Government** of \_\_\_\_\_, a Local Government Unit (LGU) established and existing under the laws and regulations of the Republic of the Philippines with principal office address at **Provincial Capitol**, \_\_\_\_\_, represented by **Honorable Governor** \_\_\_\_\_, hereinafter referred to as the **Province**;

**NOW, THEREFORE** the parties hereto agree as follows:

Director III, CHD

**WHEREAS**, Republic Act 7160 otherwise known as the 1991 Local Government Code mandated for the devolution of the delivery of health services and facilities as one of the basic functions and responsibilities of all Local Government Units (LGUs) at all levels;

**WHEREAS**, the "**FOURmula One for Health**" (F1) has been adopted as the implementation framework for health reforms of the DOH and is designed to undertake critical reforms with speed, precision and effective coordination with the goal of improving the efficiency, effectiveness and equity of the Philippine Health System for all Filipinos, especially the poor;

Governor

**WHEREAS**, the reforms are implemented under a Sector-wide Development Approach for Health (SDAH), which encompasses a management perspective and coordination requirements that cover the entire health sector and an investment portfolio that encompasses all sources;

**WHEREAS**, the DOH, being the technical resource, catalyzer for health policy, and advocate for health issues on behalf of the health sector commits to the principles and conditions in Health Services Delivery, in Health Care Financing, in Good Governance for Health and in Health Regulation;

Director IV, CHD

**WHEREAS**, DOH Administrative Order 2005-0023 otherwise known as the Implementing Guidelines for **FOURmula ONE** for Health as Framework for Health Reforms has been adopted at the national and local levels;

**WHEREAS**, the Government of the Philippines has mobilized resources for the implementation of **FOURmula One for Health** in Provinces, which includes, grants from health development partners and National Government contributions for the local implementation of health programs, projects and activities.

**WHEREAS**, the DOH shall provide MOOE in the form of cash transfers to LGUs thru CHDs to support the implementation of Local Health Systems Development strategies, Family Health including Family Planning, Epidemiology and Disease Surveillance, other Infectious diseases



Regional Accountant I

and emerging and re-emerging diseases including HIV/AIDS/STI, dengue, soil transmitted helminthiasis, food and water-borne disease, Non-Communicable Disease Prevention and Control, Public Health Development Program including Formulation of Public Health Policies and Quality Assurance, Elimination of Diseases as public health threat such as malaria, schistosomiasis, leprosy and filariasis, Rabies Control Program, TB Control Program, Health Emergency Management Staff, Health Facilities Enhancement Program, Health reforms and other programs as proposed in their Annual Operational Plans (AOPs), *Provided that*, cash transfers pursuant to DOH Grant facilities shall be subject to the guidelines issued therefor;

Provincial Health Officer II

**WHEREAS**, the Province of \_\_\_\_\_ has agreed to implement *FOURmula ONE* for Health and has proved its capacity to absorb investments and sustain the reform process, among others;

**WHEREAS**, the Province of \_\_\_\_\_ has prepared a Province-Wide Investment Plan for Health (PIPH) which has been duly reviewed by the Department of Health (DOH) with the Joint Appraisal Committee (JAC), and modified accordingly and implemented based on a DOH concurred annual operational plans (AOPs) that include supplemental plans, which should be developed prior to the start of every year covered by the PIPH;

**WHEREAS**, the DOH and the Province of \_\_\_\_\_ have signed a Memorandum of Agreement (MOA) dated \_\_\_\_\_, in order to help achieve the objectives of *FOURmula one* for Health;

Director III, CHD

**NOW, THEREFORE**, and in consideration of the foregoing premises, the parties hereto agree in this SLA, referred to in the MOA as program contract, as follows:

## **ARTICLE I**

### **The Program**

#### **1.1 Coverage**

This Service Level Agreement covers the management and implementation of the Annual Operational Plan for 2009, which forms an integral part of this Service Level Agreement and includes the following: i) Procurement plan ii) Training plan, iii) Plans required for accessing funds from DOH Grant facilities, iv) Annual program indicators and milestones, v) Agreed funding support and, vi) Agreed LGU counterpart investments

Governor

#### **1.2 Expected Outputs**

The Service Level Agreement (SLA) will focus on the implementation of the attached 2009 Annual Operational Plan (AOP) of the province to achieve a Local health system performance consistent with internal & external benchmarks set in Section 3, Table 2 of this SLA.

#### **1.3 Program Funding**

The implementation of the AOP shall be funded by various sources, as indicated in the PIPH, in the Operations Plan, and in the F1 Operations Manual for Convergence Provinces. These sources include a grant from the European Commission for the F1 16 pilot provinces in the form of a direct BUDGET SUPPORT, and assistance from the DOH central office consisting of 1) direct cash DOH counterpart to the EC grant, 2) Other cash transfers from the DOH through the CHDs, subject to the appropriate guidelines issued for their purposes, 3) Performance grants pursuant to the implementation of DOH Grant facilities, and 4) Support in-kind (commodities) through the regular DOH budget, to be provided by the Central Office through the CHD.

Director IV, CHD



The EC grant and the DOH counterpart for the 16 provinces considered as "F1 Convergence Sites" shall consist of a fixed tranche and a variable tranche. The fixed tranche for 2009 will be released as indicated in Article III of this Service Level Agreement. The variable tranche will be released during the first semester of 2010 and the amount will be dependent on the performance during year 2009, as also indicated in Article III of this Service Level Agreement.

## ARTICLE II Program Implementation Arrangements

### 2.1 The DOH-CHD shall:

- a) Authorize the Province to manage the GRANT FUNDS and DOH counterpart funds, DOH cash transfers and in kind support (commodities) as it implements the PIPH to produce the deliverables and outputs indicated in this 2009 Service Level Agreement and with the F1 Operations Manual for Convergence Provinces.
- b) Provide logistical and technical support to the Province for the overall planning, management, and coordination of PIPH 2009 Annual Operational Plan priority activities and programs to ensure smooth and efficient implementation of the PIPH 2009 Annual Operational Plan.
- c) Ensure, verification and validation of submitted LGU Scorecard, documentary requirements that prove performance, and other accomplishment reports, which shall be the basis for assessing 2009 performance and for awarding of 2009 variable tranche to be released during first semester of 2010, and performance grants from DOH Grant facilities that are to be released according to the provisions of the guidelines issued for the purpose.
- d) Ensure the release of funds to the Province based on the verified physical, financial, and technical accomplishment reports as described in the F1 Operations Manual for Convergence Provinces or on performance assessment, as provided by specific guidelines for the implementation of Grant facilities.
- d) Provide other forms of assistance essential for the effective implementation of the PIPH Annual Operational Plan.

### 2.2 The Province shall:

- a) Implement all activities under the 2009 Service Level Agreement following the DOH FOURmula ONE for Health implementation guidelines (DOH Administrative Order 2005-0023) and the F1 Operations Manual for Convergence Provinces.
- b) Carry out with due diligence all activities as contained in the attached approved 2009 Annual Operations Plan (AOP) including the sub-plans during the pendency of this \_\_\_\_ Service Level Agreement between the Parties.
- c) Prepare and submit to the DOH, Program Monitoring Reports as described in the F1 Operations Manual for Convergence Provinces, the LGU Scorecard results for 2009, and documentary requirements for accessing performance grants, as prescribed by appropriate guidelines issued for the implementation of specific Grant facilities.

Regional Accountant I

Provincial Health Officer II

Director III, CHD

Governor

Director IV, CHD

**ARTICLE III**  
**Resources and Financial Obligations**

**3.1 Resources from Development Partners and National Government**

3.1.1 The Province shall receive an assured fixed allocation of about **Php \_\_\_\_\_** of support from Development Partners and the National Government for the implementation of AOP 2009, broken down as follows in Table 1, in addition to non-specified amounts in this SLA, including variable allocation for assessed performance in 2009, other cash transfers and commodities.

**Table 1.** Resources from Development Partners and National Government Support to Province for 2009

Fund Allocations	Amount (Php)	Notes
<b>A. EC Grant and DOH Counterpart, 2009</b>		
<b>1. Fixed Allocation</b>		
a. EC Grant	<b>20,609,460</b>	
b. DOH Counterpart	<b>8,048,058</b>	
<b>2. Variable Allocation</b>		
a. EC Grant	<b>5,152,365</b>	Specified only as maximum amounts available – but the amount to be released 1 <sup>st</sup> semester of 2010 will be dependent on the achievement of performance during year 2009 as described in Article 3.1.3 of this Service Level Agreement.
b. DOH Counterpart	<b>2,012,014</b>	
<b>B. Cash transfers and commodities from DOH</b>		
1. Cash transfers (from programs)	<b>Non-specified</b>	Cash transfers will be dependent on the readiness of the LGUs to produce outputs, as assessed by CHDs
2. Commodities	<b>Non-specified</b>	These are yearly commodity allocations from the DOH to the provinces thru the CHDs (i.e vaccines, TB drugs, etc.)
<b>TOTAL FIXED ALLOCATION FOR RELEASE IN 2009</b>	<b>28,657,518</b>	

3.1.2 Table 1 above will show the total amount of funds and the various sources that includes Development Partners and National Government. This is exclusive of additional cash transfers contingent on the readiness of LGUs to produce outputs as assessed by CHDs.

3.1.3 The Province can receive performance grants from Grant facilities that are implemented by DOH programs, subject to the guidelines issued for its implementation.

3.1.4 The variable EC grant and variable DOH counterpart allocations for 2009 will be released during the first semester of 2010, according to assessed

Regional Accountant I

Provincial Health Officer II

Director III, CHD

Governor

Director IV, CHD7



performance in 2009 as reflected in the 2009 LGU Scorecard of the province for the following indicators shown in Table 2.

Table 2. Indicators for Performance Assessment in 2009

PERFORMANCE INDICATORS (1)	% share of Total variable allocation for 2009 (EC Grant and DOH counterpart) (2) <sup>1</sup>	% Share of Column 2 (3)		Mode of Verification (4)
		Internal Benchmark (40%) (3a)	External Benchmark (60%) (3b)	
<b>VARIABLE ALLOCATION: SLA 2009</b>				
<b>SERVICE DELIVERY</b>				
<b>A. Disease Free Zone (Only in Endemic Provinces)</b>		(5%)	(5%)	
1. ___ Annual parasite incidence for Malaria		5%	5%	MIS, NCDPC
<b>B. Intensified Disease Prevention and Control</b>		(10%)	(10%)	
2. ___ TB Case Detection Rate		5%	5%	NTP Register
3. ___ TB Cure Rate		5%	5%	NTP Register
<b>C. Child Health</b>		(15%)	(15%)	
4. ___ % Fully Immunized Child		5%	5%	FHSIS
5. ___ % of Newborns initiated breastfeeding within 1 hour after birth		5%	5%	FHSIS and other data source
6. ___ % of Protein Energy Malnutrition among 0-5 years old based on weight for age anthropometric measurement		5%	5%	OPT data from LGU records
<b>D. Maternal Health</b>		(10%)	(10%)	
7. ___ % of Facility Based Deliveries		5%	5%	FHSIS
8. ___ Contraceptive Prevalence Rate		5%	5%	FHSIS
<b>E. Healthy Lifestyle, Health Risk Management and Advocacy</b>		(10%)	(10%)	
9. ___ % of HHs with access to Safe Water		5%	5%	FHSIS
10. ___ % of HHs with access to Sanitary Toilet facilities		5%	5%	FHSIS
<b>F. Health Facilities Development Program</b>		(10%)	(10%)	
11. ___ Upgrading capacity of health facilities identified for Basic Emergency Obstetric and New Born Care as to BEmONC standard capacity		10%	10%	Hospital Records
<b>REGULATION</b>				
<b>G. Compliance to National Health Legislation and Standards for:</b>		(20%)	(20%)	
12. ___ % of RHUs accredited by PhilHealth for: - Out Patient Benefit Package - Maternal Care Package - TB DOTS		5% 5% 5%	5% 5% 5%	PHIC Records
13. ___ No. of BnB set-up (Ratio: 1 BnB per 2 barangays)		5%	5%	LGU Records & PMU Records
<b>FINANCING</b>				
<b>H. Expansion of National Health Insurance Program</b>		(10%)	(10%)	
14. ___ % of poor families enrolled in PhilHealth		5%	5%	PHIC Records
15. ___ Identification of Indigent families through any Philhealth approved means testing mechanism		5%	5%	PHIC Records

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Provincial Health Officer II

Director III, CHD 7

Governor

Director IV, CHD 7  
Division



GOVERNANCE				
I. Internal Management		(10%)	(10)	
16.	% of provincial budget allocated for Health (2.5%)	2.5%	2.5%	LGU Budget Documents
17.	% of municipal budget allocated for health (2.5%)	2.5%	2.5%	LGU Budget Documents
18.	% of Procurement Packages above Php 250,000.00 completed through competitive public bidding I PWHS (2.5%)	2.5%	2.5%	LGU Budget Documents/ Procurement plans
19.	% of annual financing utilized (2.5%)	2.5%	2.5%	LGU Budget Documents
TOTAL		100%	100%	

- a. The 2009 VT will be will be released during the 1<sup>st</sup> semester of 2010 upon accomplishment of the aforementioned performance indicators/milestones agreed upon by both the DOH and the province.

**Legend:**

Internal Benchmark:

- Performance of PWHS is lower than the previous year = 50%
- Performance of PWHS is same or increased from previous Year = 100%

External Benchmark:

- Performance of PWHS is below the national average and below the 2010 target = 50%
- Performance in PWHS is equal or higher than the national average but lower than the 2010 target = 90%
- Performance of PWHS is higher than the national average and equal to or higher than the 2010 target = 100%

- 3.1.5 Release of funds shall conform with the procedures in the F1 Operations Manual for 16 F1 Pilot Provinces or pertinent guidelines, whichever is applicable.
- 3.1.6 The DOH shall secure the release of the 16 F1 Convergence Sites EC grant proceeds through regular government funds flow procedures and the DOH counterpart to the EC grant as funded by the Health Sector Development Program budget line item of the GAA.
- 3.1.7 The DOH shall also secure the release of other financial assistance from all Development Partners and DOH cash transfers to the intended LGUs.

**3.2 The Province shall:**

- a) Manage the program resources and ensure the delivery of inputs (e.g. rehabilitation works, equipment, capacity building, etc.) to the lower levels of local government.
- b) Maintain adequate Financial Management records and systems for the 2009 Service Level Agreement. The Financial Management System will comply with that of the DOH and the Program Donors as described in the F1 Operations Manual for Convergence Provinces.
- c) Contribute to and facilitate monitoring, evaluation, and audit activities that will be conducted in the course of the program, as described in the F1 Operations Manual for Convergence Provinces.
- d) Submit LGU Scorecard Annual Results on time and participate in Annual Monitoring conference.
- e) Submit documents required for accessing DOH Grant facilities, as stipulated under pertinent guidelines issued for the purpose.

*yes*

- f) Submit a COA audited financial report to the DOH before end of Q2 of succeeding year. Refund expenditures disallowed by audit.

**ARTICLE IV  
Miscellaneous**

**4.1 Mutual Obligations**

The DOH and the Province agree to perform, fulfill, abide by, and submit to any and all of the provisions and requirements and all matters related, contained or expressed or reasonably inferred from this Service Level Agreement Document. All unobligated amounts in DOH counterpart and EC grant funds shall be applied according to modalities determined by the DOH in consultation with the funding donors and the province. The Province shall abide by the decisions of the JAC in this regard.

**4.2 Service Level Agreement Period**

The DOH and the Province agree that the Service Level Agreement herein described shall cover activities from January to December \_\_\_\_\_

**4.3 Notices**

All notices called for by the terms of this Service Level Agreement shall become effective only at the time of receipt thereof and only when received by the parties to whom they are addressed:

For the DOH-CHD:                      The Director IV

For the Province:                      The Governor

**4.4 Integration**

The DOH and the Province agree that this Service Level Agreement expresses and integrates all agreements, promises, and covenants of the parties and supersedes all prior negotiations understanding and agreements, whether written or oral and that no modification or alteration of this Service Level Agreement shall be valid or binding on either party unless expressed in writing and executed with the same formality as this Service Level Agreement.

**ARTICLE V  
Effectivity**

This Agreement shall take effect on the date of the signing hereof by the parties concerned and shall be terminated upon satisfactory fulfillment of all the terms and conditions embodied herein. Any modification or amendments to this Agreement as proposed by either party shall mutually be agreed upon in writing by all the parties hereto.

IN WITNESS WHEREOF, the parties have hereunto set their signatures this \_\_\_\_ day of \_\_\_\_\_ 2009, \_\_\_\_\_ City.

Regional Accountant I

Provincial Health Officer II

Director III, CHD

Governor

Director IV, CHD

DOH-CENTER FOR HEALTH DEVELOPMENT

PROVINCIAL GOVERNMENT

By:

By:

\_\_\_\_\_  
Director IV, CHD- \_\_\_\_\_

\_\_\_\_\_  
Provincial Governor

*Signed in the presence of:*

\_\_\_\_\_  
Director III, CHD- \_\_\_\_\_

\_\_\_\_\_  
Provincial Health Officer \_\_\_\_\_

\_\_\_\_\_  
Regional Accountant, CHD- \_\_\_\_\_

*yw*



Regional Accountant I

**ACKNOWLEDGEMENT**

Republic of the Philippines  
City of \_\_\_\_\_

Provincial Health Officer II

**BEFORE ME**, this \_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_, in the City of \_\_\_\_\_, Philippines,  
personally appeared;

Known to me to be the same persons who executed the foregoing instrument, and they  
acknowledge that the same is their free and voluntary act and deed.

This instrument consisting of 9 pages signed on which the acknowledgement is written has  
been signed on each and every page by the parties and their instrument witness.

Director III, CHD

**WITNESS MY HAND AND SEAL**, at the place on the date first written above.

\_\_\_\_\_  
Director IV

CTC #: \_\_\_\_\_  
Issued at : \_\_\_\_\_  
Issued on: \_\_\_\_\_

Governor

\_\_\_\_\_  
Governor

CTC #: \_\_\_\_\_  
Issued at : \_\_\_\_\_  
Issued on: \_\_\_\_\_

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Director IV, CHD

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Series of 20 \_\_\_\_\_









QUESTIONS	PROVINCE	MUNICIPALITIES / COMPONENT CITIES																															
		Municipality 1	Municipality 2	Municipality 3	Municipality 4	Municipality 5	Municipality 6	Municipality 7	Municipality 8	Municipality 9	Municipality 10	Municipality 11	Municipality 12	Municipality 13	Municipality 14	Municipality 15	Municipality 16	Municipality 17	Municipality 18	Municipality 19	Municipality 20	Municipality 21	Municipality 22	Municipality 23	Municipality 24	Municipality 25	Municipality 26	Municipality 27	Municipality 28	Municipality 29	Municipality 30		
c. Did the LGU earmark or allocate oral contraceptives, DMPA, VSC drugs and medical supplies , other MNCHN supplies specifically for the poor?																																	
d. Does the LGU have strategies/ interventions to facilitate access to FP and MNCHN services by the poor?																																	
e. Are there mechanisms to ensure that non-poor clients are referred to appropriate facilities?																																	

Consolidated by:

Noted by:

Name  
Designation

Name  
Provincial Health Officer

Date:

Date:

Approved:

Name  
Governor

Date:

MNHCN Grants Application Form 2: Certification of Expenses on FP and MNCHN Services

To: CHD Director

This is to certify that the following amounts were utilized for the provision of FP and MNCHN Services in the LGU for the Year 2009.

	Local Budget	Other Sources	Please specify source	Total	Remarks
Training of personnel on FP and MNCHN Services					
Procurement of FP Commodities					
Procurement of other MNCHN Commodities					
Conduct of IEC and outreach activities					
TEVs for health personnel during IEC and outreach activities					
PhilHealth Payments for Sponsored Program					
TOTAL					

Prepared by:

Certified Correct by:

Name  
Accountant

Name  
Auditor

Date

Date

*ys*



MNHCN Grants Application Form 3: LGUs' Budget for Health

TO: CHD REGIONAL DIRECTOR

This is to certify that the following entries are true and correct.

	Local Budget for Health			Percentage Difference	
	2008	2009	2010	$\frac{Y'09 - Y'08}{Y'08} \times 100$	$\frac{Y'10 - Y'09}{Y'09} \times 100$
Province					
Municipality 1					
Municipality 2					
Municipality 3					
Municipality 4					
Municipality 5					
Municipality 6					
Municipality 7					
Municipality 8					
Municipality 9					
Municipality 10					
TOTAL					

Consolidated by:

Certified Correct:

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Name  
Designation

Name  
Provincial Health Officer

Date

Date

Noted by:

Name  
Governor

Date



28 May 2010

**DEPARTMENT ORDER**

No. 2010- 0165

**SUBJECT: Guidelines on Executing the 2010 Family Health including Family Planning Budget for Maternal, Neonatal, Child Health and Nutrition (MNCHN) Grants to Local Government Units (LGUs) including ARMM and Operations Support to Centers for Health Development (CHDs) and DOH-ARMM**

**I. BACKGROUND:**

The 2010 DOH budget for Family Health, including Family Planning, includes provision for support to Maternal, Neonatal and Child Health and Nutrition. The DOH has decided to execute this budget provision in support of the implementation of AO 2008-0029 or the Strategy to Rapidly Reduce Maternal and Neonatal Mortality. The strategy identifies coordinated interventions at each life stage towards improvements of intermediate health outcomes such as contraceptive prevalence rate (CPR), antenatal care (ANC), facility based delivery (FBD) and fully immunized children (FIC). These interventions are best delivered through an area-wide, LGU-led, network of public and private providers capable of delivering the core package of maternal, newborn, child health and nutrition (MNCHN) services. To support the local implementation of this strategy, DOH shall provide grants to LGUs funded by the 2010 budget provision for MNCHN.

From the 2008 budget, DOH awarded grants to LGUs in support of Contraceptive Self-Reliance (CSR) in their localities. From the 2009 budget, DOH awarded grants to LGUs based on their (1) performance in achieving MNCHN health outcomes, (2) capacity to provide MNCHN services, and (3) commitment to pursue improvements in services for better outcomes in the future.

For 2010, a total allocation of *Four Hundred and Sixty-Seven Million Pesos (PhP 467,000,000)* from funds of Family Health, including Family Planning, under item III.b.2.d of the 2010 GAA shall be executed as MNCHN Grants to LGUs and as operations support funds for CHDs and DOH at the Autonomous Region in Muslim Mindanao or DOH-ARMM.

This Department Order is issued to provide the National Center for Disease Prevention and Control (NCDPC), CHDs and DOH-ARMM the detailed guidelines on the execution of this budget provision.



## II. GUIDELINES

The budget funds covered by these guidelines shall be allocated, released, utilized and accounted for, to support the implementation of DOH AO 2008-0029. The funds shall be allocated based on the number of poor women of reproductive age in each locality as they are the primary intended beneficiaries in the use of these funds. The funds shall be released to provinces and independent component and highly urbanized cities to assist the province-wide and city-wide networks of providers as the basic units for planning and implementing the MNCHN Strategy. The funds shall be utilized in accordance with the approved plan of each province or city to implement the MNCHN strategy. And, the funds shall be accounted for based on the implementation of the approved plan. ARMM shall be included as a grant recipient as its governing law defines it as a special type of region-wide LGU. The grant for ARMM provinces and city shall be made to DOH-ARMM Regional Office.

### A. Allocation of 2010 MNCHN Grants

The total fund of *Four Hundred and Sixty-Seven Million Pesos (PhP 467,000,000)* is hereby allocated as follows:

#### 1. PhP 16,000,000 for Operations Support to 16 CHDs

A total of Sixteen Million Pesos (PhP 16,000,000) is allocated to 16 CHDs for the purpose of providing each CHD the amount of One Million Pesos (PhP 1,000,000) to augment operational expenses particularly in connection with planning, releasing, technical assistance and supervision of the MNCHN Grants to LGUs.

Each CHD may use these funds to support implementation of the MNCHN grants to LGUs for any activities that include, but are not limited, to the following: procurement of office supplies, expenses for communications, transportation and TEVs of CHD and DOH-ARMM personnel, expenses for orientation of LGUs' staff and officials on the MNCHN Grants, and procurement of services to assist CHDs in the implementation of the grants such as personnel to assist grant implementation. These funds remain classified as MOOE and may not be used for procurement of equipment or other purchases that may fall under the category of Capital Outlay expenses.

#### 2. PhP 423,000,000 for MNCHN Grants to LGUs

The amount of Four Hundred and Twenty-Three Million Pesos (PhP 423,000,000) shall constitute 16 regional funds for MNCHN grants to LGUs. The grants shall support LGUs in implementing the MNCHN Strategy. The total amount available for LGUs in each region is composed of (1) One Million Pesos (PhP 1,000,000) for each province/highly urbanized city plus (2) an amount proportionate to the estimated number of poor women of reproductive age in each province/highly urbanized city. If necessary, the CHDs may use One Million Pesos (PhP 1,000,000) for planning of implementation of the MNCHN Strategy in the LGU.



### 3. PhP 28,000,000 for ARMM

The amount of Twenty Million Pesos (PhP 28,000,000) is allocated to ARMM. Based on the Memorandum of Agreement (MOA) signed by the DOH and ARMM Regional Government, the regional allocation shall be distributed as follows: 30% for DOH-ARMM to augment its operational expenses particularly in rendering technical assistance to its IPHOs and CHOs in the implementation of the MNCHN Strategy and 70% as grants for the LGUs in ARMM.

The DOH-ARMM shall manage the MNCHN Grants for and in behalf of LGUs in the region. It shall also determine allocation of the grants to LGUs in the region using criteria determined by the DOH.

(See Annex A for Allocation of Grants to LGUs)

Region	CHD/DOH-ARMM Support Fund	Regional Allocation (PhP)
NCR	1,000,000	21,000,000
CAR	1,000,000	24,000,000
I	1,000,000	24,000,000
II	1,000,000	18,000,000
III	1,000,000	27,000,000
IV-A	1,000,000	33,000,000
IV-B	1,000,000	24,000,000
V	1,000,000	33,000,000
VI	1,000,000	36,000,000
VII	1,000,000	30,000,000
VIII	1,000,000	27,000,000
IX	1,000,000	27,000,000
X	1,000,000	27,000,000
XI	1,000,000	27,000,000
XII	1,000,000	27,000,000
CARAGA	1,000,000	18,000,000
ARMM	8,400,000	19,600,000
	PhP 24,400,000	PhP 442,600,000

NCDPC shall sub-allot to each CHD the region's total amount for MNCHN Grants for LGUs as well as the region's operations support fund. It shall likewise transfer to DOH-ARMM the fund to support operations for the implementation of the 2010 MNCHN Grants and equivalent amount based on ARMM's performance, as described below.

#### B. Criteria for Provinces and Cities to Access Grant Amounts Allocated to Them

The CHDs shall assess eligibility of each province/city in the region to access the grants allocated to each. NCDPC in coordination with FIMO and BLHD shall assess eligibility of DOH-ARMM to access the grant allocated to the whole ARMM.



Eligibility for the release of allocated grant shall be determined by NCDPC for DOH ARMM and CHDs for non-ARMM areas based on the application of the following two criteria:

1. Recipient ability to achieve MNCHN intermediate outcomes. Since prior years' grants have been previously received by recipient, it is expected that these grants have been used to improve MNCHN services. Thus, recipient shall receive a portion of its grant allocation based on achievement of MNCHN intermediate outcomes for 2009 particularly CPR, ANC, FBD and FIC. Recipients shall be scored depending on how far or near they are in attaining national MNCHN outcome indicators. This score will be multiplied by 50% of their respective grant allocations to determine amount that can be accessed. The 2009 Regional FHSIS data will be used as basis for assessment.

Annex B Assessment of LGUs' Performance describes the procedures in determining grant awards for this criterion.

2. Recipient readiness to make counterpart investments. The 2010 MNCHN Grants is provided as additional support to LGUs implementing the MNCHN Strategy. LGUs should demonstrate the following counterpart investments in order to access the other 50% of the LGU allocation:
  - a. Official adoption of an administrative arrangement such as setting up of the management structures to oversee the province-wide/city-wide implementation of the MNCHN Strategy. The establishment of MNCHN management structures may happen in 2009 or 2010. It should also include description of a functioning/setting up of coordinating mechanism between the province and its component municipalities and cities in providing MNCHN services in 2009 or 2010 respectively
  - b. Enrollment of eligible population, at least 20% of total indigents in the LGU (consolidated provincial and municipal enrolment), to the National Health Insurance Program (NHIP) in 2010.
  - c. Accreditation of health facilities within the MNCHN service delivery network with the Philippine Health Insurance Corporation (PhilHealth). Accreditation of facilities will consider either Out-Patient Benefit (OPB), Maternal Care Package (MCP) or both. [The number of accredited facilities over the total number of health facilities multiplied by 10% will be the amount to be released to LGUs.]
  - d. Official decisions that identify specific areas or segments of the population with the highest risks of maternal and neonatal mortality and that mandate priority actions to improve MNCHN services for these areas or segments

Meeting each of the above four counterpart investments is equivalent to the release of the grant allocation. The LGU shall submit the following documents to support the above counterpart investments:

- a. Executive Order by the Governor/ City Mayor or any equivalent stating full support and describing administrative arrangements for the province-wide or city-wide implementation of MNCHN Strategy including the coordinating mechanism of the component cities and municipalities with the province in the provision of MNCHN



services. City Mayors of independent or highly urbanized areas shall likewise issue an Executive Order providing for the city-wide coordinating mechanism in the provision of MNCHN services (15%)

Template 1 - Creating MNCHN Committee may be used by the LGU.

- b. Certification from or Memorandum of Agreement (MOA) with PhilHealth on enrollment of indigents in the LGU showing at least enrollment of 20% of indigent families in 2010 (10%)
- c. Certificate of accreditation from PhilHealth particularly for those accredited facilities within the MNCHN Service Delivery Network (10%)
- d. Comprehensive MNCHN Plan showing multi-year activities, expected outputs [specifically focusing on the 7 components of the MNCHN strategy: a) establishment of service delivery network which provides package of services for each life cycle, b) ensuring availability of safe blood supply, c) ensuring availability of family health commodities, d) setting up communication and transportation facility, e) developing and implementation of a communication plan, f) capacity building, g) ensuring quality and reliable health information system for key health indicators including proper data collection, data cleaning and validation activities], sources of funding to address needs and gaps in services especially for priority populations; unless already clearly stated, the MNCHN Plan shall elaborate the following Projects, Programs and Activities (PPA) in the PIPH/AOP: Reproductive health and Family Planning, Maternal and Child Health including activities to make health providers BEmONC and CEmONC-capable facilities, EPI and Nutrition. (15%)

### C. Execution of Grants

**The CHDs should ensure that the following requirements are met prior to transfer of funds to LGUs**

1. Transfer of funds or resources to LGUs should be covered by a Memorandum of Agreement (MOA) to specify conditions for transfer. For LGUs with an existing Province-wide/City-wide Investment Plan for Health (PIPH/CIPH), CHDs should amend the Service Level Agreement (SLA) covering the AOP for Year 2010 [Please refer to Article III on Resources and Financial Obligations under Table 1 Item B. Cash transfers and Commodities from DOH, indicate in item B.1 the amount provided to specific LGU for 2009 and 2010 MNCHN Grants; If grants are in the form of commodity or in kind, indicate allocations under B.2.] See Template 2.

For LGUs without PIPH/CIPH MOA, transfer of funds should be covered by a MOA between the CHD Director and the LGU Governor/ Mayor.

The transfer of funds from DOH to ARMM is covered by the MOA signed in May 2009 between DOH and the ARMM Regional Government (ARG). Since health services in ARMM is provided by the ARG, DOH-ARMM does not need to enter into an agreement with its IPHOs and CHO for the transfer of funds and resources. Instead, the region-wide MNCHN plan shall be the basis for transfer of resources to IPHOs.



For LGUs that do not have a signed PIPH or CIPH MOA, a sponsor LGU should represent the component LGUs within a province as represented by the Governor or an independent/ highly urbanized city as represented by the Mayor. The following may be designated as sponsor LGU with concurrence from the CHD director if the provincial or city government cannot perform its expected roles:

- a. Municipal or City Mayor of an Inter Local Health Zone (ILHZ)
  - b. Chapter President of the League of Municipalities
  - c. Other officials that may be designated by the provincial Governor such as the Vice Governor or Sangguniang Panlalawigan (SP) member of the province.
2. CHDs and DOH-ARMM shall evaluate all plans of LGUs and IPHOs/CHO, respectively for the following: (a) Common interventions proposed by LGUs, (b) local counterpart in the implementation of the MNCHN Strategy and (c) sustainability of proposed interventions. CHDs should agree with LGUs on the mode of transfer of resources, whether in cash or in-kind, schedule of assistance, target dates of completion, and counterpart investments of LGUs.
  3. For interventions that are common in all or several LGUs in the region, CHDs and DOH-ARMM have the option to offer regional procurement for LGUs. CHDs can consolidate procurement of family planning commodities, drugs and supplies, MNCHN drugs and the like at the regional level and transfer these commodities to LGUs based on their requirements and available funds. Procurement of services for technical support can also be done by CHDs, such as experts in development of key messages for MNCHN, preparation of multi-year plans, validation of health information, contracting training institutions, developing local technical assistance providers and the like. The CHDs can also contract institutions in the region that will provide training services to LGUs on MNCHN.
  4. Residual grants are amounts that are not accessed by LGUs due to their performance based on criteria discussed above. 2009 Grants that have not been obligated by July 31, 2010 shall be considered as residual grants that can be used by the CHDs to support any of the common interventions (e.g. procurement of commodities to be distributed to LGUs, training activities, contracting TA services) or as mentioned above. Any residual grants from the 2010 MNCHN Grants that are not obligated by October 31, 2010 may be used by CHDs to procure goods and services or transfer funds to assist LGUs that are already implementing their MNCHN plans as verified by CHDs. DOH-ARMM can program residual grants based on the needs of LGUs that have high maternal and infant mortality risk.
  5. Allotments for the 2009 and 2010 MNCHN Grants shall be obligated by CHDs on or before 31 December 2010. Cash requirements coming for the 2009 MNCHN Grants have to be requested from Regional Department of Budget and Management (DBM) Offices while 2010 MNCHN Grants cash requirements shall come from the Finance Management Service (FMS) of the DOH.



6. DOH-ARMM shall submit a liquidation of expenses to DOH within the first quarter of the following year.

#### **D. Utilization of Grants by LGUs**

The MNCHN Grants aims to ensure access of women, mothers and children to (1) a network of facilities with trained health care professionals delivering a core package of services with required commodities, drugs and medical supplies for pre-pregnancy, pregnancy, delivery and post-natal at different levels of care; (2) blood supply especially during maternal and neonatal emergencies; (3) transportation and communication facilities; (4) dissemination of key messages on MNCHN; and (5) a system that allows complete follow-up care. The LGUs may use the grants to support the following activities:

1. Provision of community-based services especially for priority populations by community health teams. These teams shall among others (a) identify and maintain a master list of the eligible population in a community such as couples with unmet family planning needs, pregnant women and children below one year of age, (b) refer MNCHN clients to health care professionals providing core MNCHN service package, (c) collect information on the delivery of services as needed, and (d) conduct IEC campaigns including behavior change communication (BCC) activities;
2. Establishment of a service delivery network that can provide a core package of MNCHN services for different levels of care from the community to basic health care services to emergency maternal and neonatal care up to an end referral facility providing definitive obstetrics and neonatal care. LGUs may designate public and private health facilities to be part of the MNCHN service delivery network in the locality. [Annex C. Maternal and Neonatal Care Package by Service Outlet]
3. Establish a voluntary and safe blood supply system that would ensure provision of blood services for obstetrics and neonatal emergencies.
4. Develop and implement a communication plan to increase utilization of services by eligible population as well as adherence of health providers to standards and treatment protocol.
5. Set-up a communication and transportation system to facilitate access of clients to health facilities especially during emergencies.
6. Develop a reliable health information system that would provide quality and reliable data for key health indicators.

### **III. MONITORING, EVALUATION, AND REPORTING SYSTEM**

- A. CHDs and DOH-ARMM shall provide NCDPC, FIMO, and DOH Finance a utilization report such as amount disbursed from LGU allocations either in cash or in-kind.
- B. NCDPC, in coordination with FIMO and BLHD shall put a monitoring system in place at the DOH Central Office to facilitate feedback on the grants implementation and provide technical support to CHDs and DOH-ARMM as needed. It shall particularly monitor





progress of LGUs in establishing the necessary services to deliver MNCHN such as (1) a functional community health teams in priority LGUs, (2) well organized and efficient MNCHN network of facilities, (3) transportation and communication system, (4) facilities that can provide blood supply and services during maternal and neonatal emergencies, (5) BCC and demand generation and information campaign activities. It shall also conduct a year-end assessment of the grants implementation.

- C. Work plans and expenditures for the 2009 and 2010 MNCHN Grants should be recorded in the Expenditure Tracking System (ETS) by CHDs to facilitate monitoring.

#### **IV. ROLES OF DOH IN THE IMPLEMENTATION OF THE MNCHN GRANTS**

- A. National Center for Disease Prevention and Control (NCDPC) shall be the overall technical coordinator for the MNCHN grants, which includes grants for enhancement for BEMONC/ CEMONC-capable facilities. It shall install a monitoring system for the implementation of grants, render technical assistance to CHDs as needed, report progress of grants implementation to the Secretary of Health through the Undersecretary and Assistant Secretaries for Health of PSDT-SD.

NCDPC shall create a team from the Family Health Office, FIMO, and BLHD that would provide technical support to DOH-ARMM and LGUs in ARMM for the implementation of the MNCHN Strategy. It shall coordinate with DOH-ARMM through the Field Implementation and Management Office (FIMO) for grants implementation.

- B. FIMO shall oversee implementation of grants by the CHDs and render technical support in coordination with NCDPC. It shall coordinate with DOH-ARMM for grants implementation in ARMM.
- C. Centers for Health Development (CHD) shall implement grants in the region, provide technical assistance to LGUs for the implementation of the MNCHN Strategy and utilization of the MNCHN Grants, and report progress of grants implementation to NCDPC through FIMO.
- D. The CHDs should maintain the Management Team for MNCHN Grants Facility created for the implementation of the 2009 MNCHN Grants. The Management Team shall be responsible for orienting the LGUs on the 2010 MNCHN Grants, providing technical assistance to LGUs to comply with requirements of the grants as well as in implementing the MNCHN Strategy, transfer grants to LGUs based on their performance, and monitor and report progress of grants implementation. The Provincial Health Team Leader (PHTL) is likewise designated as the coordinator of the MNCHN Grants in provinces and cities.
- E. DOH-ARMM shall coordinate with NCDPC in the implementation of MNCHN plans for the 2010 MNCHN Grants. It shall participate in a council with NCDPC and other relevant offices in DOH to support ARMM in the implementation of the MNCHN Strategy. DOH ARMM shall facilitate the assessment of performance of IPHO/ CHOs, identifying gaps in service delivery and planning for proposed interventions to improve MNCHN services



in the region. As stated, it shall provide the DOH through NCDPC, the proposal / plan to address gaps in MNCHN services with the grants facility as one possible source of funding.

- V. REPEALING CLAUSE:** This Order update/ amend the terms and conditions stated under budget line item A.III.b.2.d, Family Health including Family Planning Program specified in Department Order # 2010-0068 dated 25 January 2010 and Memorandum dated 25 February 2010, "2010 Harmonized Sub-allotments/ Fund transfer to CHDs and LGUs. All other provisions stated in the said DO and Memorandum still remains in effect"

BY AUTHORITY OF THE SECRETARY OF HEALTH:



**GERARDO V. BAYUGO, MD, MPH, CESO III**

Assistant Secretary of Health  
Internal Management Support Office

Annex A: LGU Ceilings for 2010 MNCHN Grants

LGUs (Provinces and Independent/Highly Urbanized Cities)	LGU Ceilings
<b>Region NCR</b>	<b>21,000,000</b>
City of Malabon	1,576,203
City of Navotas	1,105,377
City of Valenzuela	1,244,358
Kalookan City	1,592,226
City of Marikina	1,135,354
City of Pasig	1,196,779
Pateros	1,019,121
Taguig City	1,189,343
Quezon City	1,854,137
City of Makati	1,157,559
City of Mandaluyong	1,097,410
City of San Juan	1,039,954
City of Manila	1,612,980
City of Las Piñas	1,164,334
City of Muntinlupa	1,139,827
City of Parañaque	1,170,610
Pasay City	1,124,429
<b>Region CAR</b>	<b>24,000,000</b>
Abra	5,787,811
Apayao	3,233,326
Benguet	2,412,253
Baguio City	1,288,724
Ifugao	3,487,221
Kalinga	4,231,772
Mountain Province	3,558,894
<b>Region I</b>	<b>24,000,000</b>
Ilocos Norte	2,470,379
Ilocos Sur	3,612,104
La Union	3,978,631
Pangasinan	12,733,814
Dagupan City	1,205,072
<b>Region II</b>	<b>18,000,000</b>
Batanes	1,033,626
Cagayan	4,752,403
Isabela	7,469,417
Santiago City	1,221,522

LGUs (Provinces and Independent/Highly Urbanized Cities)	LGU Ceilings
<b>Region III</b>	<b>27,000,000</b>
Aurora	1,642,076
Bataan	1,645,931
Bulacan	4,519,309
Nueva Ecija	7,493,141
Pampanga	2,918,398
Angeles City	1,188,163
Tarlac	4,188,418
Zambales	2,323,908
Olongapo City	1,080,657
<b>Region IV-A</b>	<b>33,000,000</b>
Batangas	8,937,278
Cavite	4,683,336
Laguna	4,758,719
Quezon	10,041,314
Lucena City	1,239,203
Rizal	3,340,150
<b>Region IV-B</b>	<b>24,000,000</b>
Marinduque	2,618,136
Occidental Mindoro	4,349,365
Oriental Mindoro	6,645,698
Palawan	5,683,307
Puerto Princesa City	1,689,201
Romblon	3,014,292
<b>Region V</b>	<b>33,000,000</b>
Albay	6,407,437
Camarines Norte	3,489,606
Camarines Sur	9,307,500
Naga City	1,370,599
Catanduanes	2,070,658
Masbate	5,496,879
Sorsogon	4,857,321
<b>Region VI</b>	<b>36,000,000</b>
Aklan	4,037,387
Antique	4,136,642
Capiz	3,499,889
Guimaras	1,706,546

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LGUs (Provinces and Independent/Highly Urbanized Cities)	LGU Ceilings
Nueva Vizcaya	1,998,980
Quirino	1,551,053

<b>Region VII</b>	<b>30,000,000</b>
Bohol	7,838,648
Cebu	9,152,960
Cebu City	1,362,656
Lapu-Lapu City	1,195,224
Mandaue City	1,203,164
Negros Oriental	8,023,853
Siquijor	1,223,494
<b>Region VIII</b>	<b>27,000,000</b>
Biliran	1,668,156
Eastern Samar	3,218,856
Leyte	7,625,505
Tacloban City	1,379,579
Ormoc City	1,586,202
Northern Samar	4,544,852
Samar (Western Samar)	4,491,961
Southern Leyte	2,484,888
<b>Region IX</b>	<b>27,000,000</b>
Zamboanga del Norte	10,984,367
Zamboanga del Sur	6,038,375
Zamboanga City	3,626,202
Zamboanga Sibugay	4,606,543
City of Isabela	1,744,512
<b>Region X</b>	<b>27,000,000</b>
Bukidnon	6,854,313
Camiguin	1,452,499
Lanao del Norte	4,715,041
Iligan City	2,172,165
Misamis Occidental	4,957,684
Misamis Oriental	4,713,033
Cagayan De Oro City	2,135,265
<b>Region XI</b>	<b>27,000,000</b>
Compostela Valley	5,906,337
Davao del Norte (Davao)	7,204,897
Davao del Sur	4,682,853
Davao City	4,328,905
Davao Oriental	4,877,007

LGUs (Provinces and Independent/Highly Urbanized Cities)	LGU Ceilings
Iloilo	7,067,743
Iloilo City	1,479,148
Negros Occidental	12,744,418
Bacolod City	1,328,226
<b>Region CARAGA</b>	<b>18,000,000</b>
Agusan del Norte	2,297,314
Butuan City	1,899,845
Agusan del Sur	4,537,452
Dinagat Islands	1,638,854
Surigao del Norte	3,545,861
Surigao del Sur	4,080,673
<b>ARMM</b>	<b>27,000,000</b>
Basilan	2,517,524
Lanao del Sur	5,779,573
Marawi City	1,435,934
Maguindanao	8,503,195
Sulu	4,770,175
Tawi-Tawi	3,993,600
<b>PHILIPPINES</b>	<b>450,000,000</b>

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LGUs (Provinces and Independent/Highly Urbanized Cities)	LGU Ceilings
Region XII	27,000,000
Cotabato (North Cotabato)	6,699,976
Sarangani	4,630,620
South Cotabato	5,202,059
General Santos City	2,086,980
Sultan Kudarat	5,702,300
Cotabato City	2,678,066

LGUs (Provinces and Independent/Highly Urbanized Cities)	LGU Ceilings
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## ANNEX B: ASSESSMENT OF LGUs' PERFORMANCE

This section shall guide the CHDs in determining awards to LGUs for the criteria – Ability to Achieve MNCHN Intermediate Outcomes

A maximum of 50% of the LGU Allocation will be awarded to LGUs that can show capacity to reach target MNCHN indicators particularly Contraceptive Prevalence Rate (CPR), Antenatal Care (ANC), Facility-Based Deliveries (FBD) and Fully Immunized Children (FIC) in Year 2009.

Grant awards per cluster of LGUs are determined as follows:

- Get current level of performance of each provincial or independent city LGU in the region from the 2009 FHSIS. CHDs shall use regional data collected from LGUs.
- Determine the percentage difference of each indicator from national targets by subtracting the current level of the LGU from the national target, dividing the difference with the national target and multiplying by 100. Following are national targets as set in the National Objectives for Health (NOH) for 2005-2010:

MNCHN Indicator	National Target
Contraceptive Prevalence Rate	60%
Antenatal Care	80%
Facility-Based Deliveries	80%
Fully Immunized Children	95%

- Give each indicator a score based on the following scale:

Percentage Difference	Score
≤0%-10%	100
11%-20%	90
21%-30%	80
31%-40%	70
41%-50%	60
51%-60%	50
61%-70%	40
71%-80%	30
81%-90%	20
91%-100%	10
101%-up	0

- To get the overall score, multiply the score of the LGU for each indicator with its assigned weight and add the scores of the four MNCHN indicators.

MNCHN Indicator	Weight
Contraceptive Prevalence Rate	30%
Antenatal Care	10%
Facility-Based Deliveries	30%
Fully Immunized Children	30%

- Multiply the total percentage score of the LGU with 50% of the LGU allocation to get the amount that LGUs can access.

A spreadsheet (MS Excel) is forwarded to CHDs to facilitate computation of the grants.



## Annex C: Core Package of MNCHN Services

The maternal-neonatal service package includes interventions known to reduce the risk of maternal and neonatal deaths and promote health of the mothers and their neonates.

1. By Recipient of Service: All women of reproductive age (15-49 years old) including their neonatal should be provided with following services at various stages of their life cycle.

Life Cycle Stages	Maternal Care	Neonatal Care
<b>Pre-Pregnancy</b>	<ul style="list-style-type: none"> <li>A. Maternal Nutrition: Iron and folate: once a week for 3-6 months for women of reproductive age who are most likely to get pregnant</li> <li>B. FP Services               <ul style="list-style-type: none"> <li>1. IEC/Counseling on: (i) Responsible Parenting; (ii) Informed Choice and Voluntarism; (iii) Four Pillars on FP; (iv) Fertility Awareness; and (v) All FP methods</li> <li>2. Provision of FP services: Pills, DMPA, IUD, Condom, NFP, NSV, BTL</li> </ul> </li> <li>C. IEC/Counseling on Healthy Lifestyle: (i) smoking cessation; (ii) healthy diet and nutrition; (iii) physical activity; and (iv) moderate alcohol intake</li> <li>D. IEC/Counseling on health care and health seeking behavior</li> <li>E. Updated master listing of women of reproductive age</li> </ul>	
<b>Prenatal</b>	<ul style="list-style-type: none"> <li>A. Maternal Nutrition               <ul style="list-style-type: none"> <li>1. Iron and Folate</li> <li>2. Iodine</li> <li>3. Deworming tablet: Mebendazole or Albendazole: once every 6 months</li> <li>4. Promotion of iodized salt</li> </ul> </li> <li>B. Early detection and management of danger signs and complications of pregnancy               <ul style="list-style-type: none"> <li>1. APH</li> <li>2. Hypertensive disorders</li> <li>3. Urinary tract infections</li> <li>4. Anemia</li> <li>5. Diabetes</li> <li>6. Malaria</li> </ul> </li> </ul>	

Life Cycle Stages	Maternal Care	Neonatal Care
Prenatal	<p>C. Tetanus Toxoid Immunization: At least 2 doses before the first delivery to achieve 80% protection from maternal and neonatal tetanus. A total of 5 doses over a 3 year period following the recommended interval schedule to attain lifetime protection from <u>NT</u></p> <p>First Dose :any month at 2<sup>nd</sup> trimester  Second dose :one month after the 1st dose  Third Dose :6 months after the 2<sup>nd</sup> dose  Fourth Dose :one year after the 3<sup>rd</sup> dose  Fifth Dose :one year after the 4<sup>th</sup> dose</p> <p>D. Antenatal administration of steroids in preterm labor</p> <p>E. IEC/Counseling on FP methods including LAM</p> <p>F. IEC/Counseling on Healthy Lifestyle: 1) safe sex and HIV/STI prevention (i) smoking cessation; (ii) healthy diet and nutrition;(iii) physical activity; and (iv) moderate alcohol intake</p> <p>G. IEC/Counseling on health caring and seeking behavior</p> <p>H. Support Services:</p> <ol style="list-style-type: none"> <li>1. Antenatal registration with Mother-Child Book</li> <li>2. Birth Plan</li> <li>3. Home visit and follow-up</li> <li>4. Safe blood supply</li> <li>5. Support from family members and</li> <li>6. Organized Groups (e.g. pregnant women)</li> </ol> <p>I. Diagnostic and Screening Tests</p> <ol style="list-style-type: none"> <li>1. CBC</li> <li>2. Blood Typing</li> <li>3. Urinalysis</li> <li>4. VDRL or RPR</li> <li>5. HbSAg</li> <li>6. Oral Glucose Challenge (OGC) test</li> </ol>	

*H*



Life Cycle Stages	Maternal Care	Neonatal Care
Delivery	<ul style="list-style-type: none"> <li>A. Clean and Safe Delivery               <ul style="list-style-type: none"> <li>1. Monitoring progress of labor using partograph</li> <li>2. Identification of early signs/symptoms and management of abnormalities: (i) prolonged labor; (ii) hypertension ;(iii) mal-presentation; (iv) bleeding; (v) preterm labor; and (vi) infection</li> <li>3. Controlled delivery of head and active management of third stage of labor</li> <li>4. Delayed cord clamping</li> </ul> </li> <li>B. Basic Emergency Obstetric and Neonatal Care               <ul style="list-style-type: none"> <li>1. Parenteral administration of oxytocin</li> <li>2. Parenteral administration of loading dose of anticonvulsants</li> <li>3. Parenteral administration of initial dose of antibiotics</li> <li>4. Assisted delivery</li> <li>5. Removal of retained products of conception</li> <li>6. Manual removal of retained placenta</li> <li>7. Neonatal resuscitation</li> </ul> </li> <li>C. Comprehensive Emergency Obstetric               <ul style="list-style-type: none"> <li>1. Care Cesarean section</li> <li>2. Blood transfusion</li> <li>3. Counseling and Provision of BTL services</li> </ul> </li> </ul>	

H

Life Cycle Stages	Maternal Care	Neonatal Care
<b>Post Delivery</b>	<ul style="list-style-type: none"> <li>A. Identification of early signs and symptoms of postpartum complications: (i) hemorrhage, (ii) infection; and (iii) hypertension</li> <li>B. Maternal Nutrition               <ul style="list-style-type: none"> <li>1. Iron and folate</li> <li>2. Vitamin A</li> <li>3. Iodine</li> <li>4. Deworming tablet: Mebendazole or Abendazole</li> <li>5. Promotion of iodized salt</li> </ul> </li> <li>C. Family Planning: IEC/counseling on: (i) birth spacing; (ii) return to fertility; (iii) all FP methods including LAM, B<sub>12</sub> and vasectomy</li> <li>D. IEC/Counseling on Healthy Lifestyle: 1) safer sex and HIV/STI prevention (i) smoking cessation; (ii) healthy diet and nutrition; (iii) physical activity; and (iv) moderate alcohol intake</li> <li>E. Prevention and Management of Other Diseases as indicated: STI/HIV/AIDS</li> <li>F. Prevention and Management of Abortion Complications               <ul style="list-style-type: none"> <li>1. Removal of retained products of conception</li> <li>2. Treatment of infection</li> <li>3. Correction of anemia</li> <li>4. Anti-tetanus serum (ATS) injection</li> </ul> </li> <li>G. Diagnostic Test: cervical cancer screening, (acetic acid wash) for <math>\geq 40</math> years old women at x weeks post delivery</li> <li>H. Follow-up visit and care: all post-partum women</li> </ul>	<ul style="list-style-type: none"> <li>A. Identification of early signs and symptoms of neonatal problems (e.g. respiratory distress, change in color, etc.)</li> <li>B. Immediate Neonatal Care               <ul style="list-style-type: none"> <li>1. Cord care/dressing</li> <li>2. Warming/skin to skin contact</li> <li>3. Initiation of BF</li> <li>4. Vitamin K injection</li> <li>5. Eye prophylaxis</li> <li>6. Delayed bathing</li> <li>7. Hepa-B Immunization</li> </ul> </li> <li>C. Emergency Neonatal Care               <ul style="list-style-type: none"> <li>1. Resuscitation with Ambu bag</li> <li>2. Treatment of neonatal sepsis/ infection</li> <li>3. Oxygen supply</li> <li>4. Resuscitation and stabilization</li> <li>5. Kangaroo Care</li> </ul> </li> <li>D. Newborn Screening</li> <li>E. Intensive neonatal care for low birth weight (LBW), preterm, IUGR, babies born with congenital anomalies, and sick neonates</li> <li>F. Breastfeeding               <ul style="list-style-type: none"> <li>1. Early breastfeeding with colostrums;</li> <li>2. Exclusive BF up to 6 months;</li> <li>3. Rooming-in or bedding-in</li> </ul> </li> <li>G. BCG Immunization</li> <li>H. Support Services               <ul style="list-style-type: none"> <li>1. Birth Registration</li> <li>2. Follow-up visit and care</li> </ul> </li> </ul>



2. By Beneficiary: The maternal-neonatal service package of interventions includes services administered to individual pregnant women and neonates (clinical case management services) and a set of public health measures offered to the general population of women of reproductive age and the neonates.

Life Cycle Stages	Clinical Case Management Services	Public Health Measures
Pre-Pregnancy	A. Maternal Nutrition: Iron and folate B. FP Services 1. pills 2. DMPA 3. IUD 4. Condom 5. NFP 6. NSV 7. BTL	A. A. Maternal Nutrition: Iron and folate B. FP Services 1. IEC/Counseling on: (i) Responsible Parenting; (ii) Informed Choice and Voluntarism; (iii) Four Pillars on FP; (iv) All FP methods v) Fertility Awareness 2. Provision of FP services: pills, DMPA, IUD, condom, NFP, NSV, BTL C. IEC/Counseling on Healthy Lifestyle: 1) safer sex and STI/HIV prevention (i) smoking cessation; (ii) healthy diet and nutrition; (iii) physical activity; and (iv) moderate alcohol intake D. IEC/Counseling on health caring and seeking behavior E. Updated master listing of women of reproductive age

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Life Cycle Stages	Clinical Case Management Services	Public Health Measures
	<p>dose of antibiotics</p> <ol style="list-style-type: none"> <li>4. Performance of assisted delivery</li> <li>5. Removal of retained products of conception</li> <li>6. Manual removal of retained placenta</li> <li>7. Neonatal resuscitation</li> </ol> <p>C. Comprehensive Emergency Obstetric Care:</p> <ol style="list-style-type: none"> <li>1. Care Cesarean section</li> <li>2. Blood transfusion</li> <li>3. Counseling and provision of BTL Services</li> </ol>	
<p><b>Post Delivery</b></p>	<p>A. Identification of early signs and symptoms of postpartum complications: (i) hemorrhage; (ii) infection; and (iii) hypertension</p> <p>B. Maternal Nutrition</p> <ol style="list-style-type: none"> <li>1. Iron and folate</li> <li>2. Vitamin A</li> <li>3. Deworming tablet: Mebendazole or Albendazole</li> </ol> <p>C. Counseling and Provision of LAM</p> <p>D. Prevention and Management of Abortion Complications</p> <ol style="list-style-type: none"> <li>1. Removal of retained products of conception</li> <li>2. Treatment of infection</li> <li>3. Correction of anemia</li> <li>4. Anti-tetanus serum (ATS) injection</li> </ol> <p>E. Immediate Neonatal Care</p> <ol style="list-style-type: none"> <li>1. Cord care/dressing</li> <li>2. Warming/skin to skin contact</li> <li>3. Latching on/Initiation of BF</li> <li>4. Vitamin K injection</li> <li>5. Eye prophylaxis</li> <li>6. Delayed bathing</li> <li>7. Hepa-B Immunization</li> <li>8. BCG Immunization</li> </ol> <p>F. Identification of early signs and symptoms of neonatal problems (e.g. respiratory distress, change in color, etc.)</p> <p>G. Emergency Neonatal Care</p> <ol style="list-style-type: none"> <li>1. Treatment of neonatal sepsis/infection</li> <li>2. Resuscitation and stabilization</li> <li>3. Oxygen Support</li> <li>4. Kangaroo care</li> </ol> <p>H. Intensive neonatal care for low birth</p>	<p>A. Maternal Nutrition</p> <ol style="list-style-type: none"> <li>1. Iron and folate</li> <li>2. Vitamin A</li> <li>3. Deworming tablet: Mebendazole or Albendazole</li> <li>4. Promotion of iodized salt</li> </ol> <p>B. IEC/counseling on: (i) birth spacing; (ii) exclusive BF up to 6 months; (iii) return to fertility; and (iv) all other FP methods</p> <p>C. IEC/Counseling on Healthy Lifestyle: (i) safer sex, HIV/STI prevention (ii) smoking cessation; (iii) healthy diet and nutrition; (iv) physical activity; (v) moderate alcohol intake (v) and lifestyle-related diseases like diabetes, CVD, etc.</p> <p>D. Prevention and management of other diseases as indicated: (i) TB; (ii) malaria; (iii) schistosomiasis; (iv) STI/HIV/AIDS; (v) anemia; and (v) lifestyle-related diseases like diabetes, CVD, etc.</p> <p>E. Rooming-in or bedding-in/exclusive; Early breastfeeding and BF up to 6 months</p> <p>F. BCG Immunization</p> <p>G. Support Services</p> <ol style="list-style-type: none"> <li>1. Birth Registration</li> <li>2. Follow-up visit and care</li> <li>3. Support of community groups: BF, FP, etc.</li> </ol>

Life Cycle Stages	Clinical Case Management Services	Public Health Measures
	weight (LBW), preterm, IUGR, babies born with congenital anomalies, and sick neonate I. Diagnostic Tests 1. Cervical cancer screening (acetic acid wash) 2. Newborn Screening ore referral J. Support Service: Birth Registration	





ANNEX C:

3. By Service Outlet: The Maternal-Neonatal Care Package of services are expected to be delivered by a four-tiered network of facilities:

Life Cycle Stages	Maternal-Neonatal Care	Community-Based	First Contact Facility	BEmONC-capable Facility	CEmONC-Capable Facility
Pre-pregnancy	A. Maternal Nutrition				
	1. Iron and folate	✓	✓	✓	✓
	B. FP Services				
	1. IEC/Counseling on: (i) Responsible Parenting; (ii) Informed Choice and Voluntarism; (iii) Four Pillars on FP; (iv) Fertility Awareness (v) All FP methods	✓	✓	✓	✓
	2. Provision of FP services				
	a. Pills	✓	✓	✓	✓
	b. DMPA	✓	✓	✓	✓
	c. IUD			✓	✓
	d. Condom	✓	✓	✓	✓
	e. NFP	✓	✓	✓	✓
	f. NSV		✓	✓	✓
	g. BTL			✓	✓
	C. IEC/Counseling on Healthy Lifestyle: 1) safer sex and prevention of HIV/STIs (i) smoking cessation, (ii) healthy diet and nutrition; (iii) physical activity; and (iv) moderate alcohol intake	✓	✓	✓	✓
	D. IEC/Counseling on health caring and seeking behavior	✓	✓	✓	✓
	E. Prevention and Management of Other Diseases as indicated				
	1. STI/HIV/AIDS	prevention	✓	✓	✓
	2. Anemia	✓	✓	✓	✓
F. Updated master listing of women of reproductive age	✓				
Prenatal	A. Maternal Nutrition				
	1. Iron and Folate	✓	✓	✓	✓
	2. Vitamin A	✓	✓	✓	✓

Life Cycle Stages	Maternal-Neonatal Care	Community-Based	First Contact Facility	BEmONC-capable Facility	CEmONC-Capable Facility
	3. Deworming tablet: mebendazole or albendazole	✓	✓	✓	✓
	4. Promotion of iodized salt	✓	✓	✓	✓
	B. Early detection and management of danger signs and complications of pregnancy	✓	✓	✓	✓
	C. TT Immunization	✓	✓	✓	✓
	D. Antenatal administration of steroids in preterm labor		✓	✓	✓
	E. IEC/Counseling on FP methods especially LAM	✓	✓	✓	✓
	F. IEC/Counseling on Healthy Lifestyle) safer sex and HIV/STI prevention(i) smoking cessation; (ii) healthy diet and nutrition; (iii) physical activity; and (iv) moderate alcohol intake	✓	✓	✓	✓
	G. IEC/Counseling on health caring and seeking behavior	✓	✓	✓	✓
	H. Support Services:	✓	✓	✓	✓
	1. Antenatal registration with Mother-Child Book	✓	✓	✓	✓
	2. Birth Plan	✓	✓	✓	✓
	3. Home visit and follow-up	✓	✓	✓	✓
	4. Safe blood supply	✓	✓	✓	✓
	5. Support from community (e.g. pregnant women)	✓			
	I. Diagnostic/Screening Tests		Blood taken and referred to lab		
	1. CBC		✓	✓	✓
	2. Blood typing		✓	✓	✓
	3. Urinalysis		✓	✓	✓
	4. VDRL or RPR		✓	✓	✓
	5. HbSAg		✓	✓	✓
	6. Oral Glucose Challenge (OGC) test		✓	✓	✓
	J. Prevention and Management of Other Diseases as indicated:				
	1. STI/HIV/AIDS	prevention	✓	✓	✓

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Life Cycle Stages	Maternal-Neonatal Care	Community-Based	First Contact Facility	BEmONC-capable Facility	CEmONC-Capable Facility
	2. Anemia	✓	✓	✓	✓
Delivery	A. Clean and Safe Delivery				
	1. Monitoring progress of labor using partograph		✓	✓	✓
	2. Identification of early signs and symptoms and management of abnormalities; prolonged labor; hypertension, mal-presentation; bleeding; preterm labor; and infection	Identification of early signs and symptoms	Identification of early signs and symptoms	management	management
	3. Controlled delivery of head and active management of third stage of labor		✓	✓	✓
	4. Delayed cord clamping		✓	✓	✓
	B. Basic Emergency Obstetric and neonatal care				
	1. Parenteral administration of oxytocin		✓	✓	✓
	2. Parenteral administration of loading dose of anticonvulsants		✓	✓	✓
	3. Parenteral administration of initial dose of antibiotics		✓	✓	✓
	4. Performance of assisted delivery			✓	✓
	5. Removal of retained products of conception			✓	✓
	6. Manual removal of retained placenta			✓	✓
	7. Neonatal resuscitation		✓	✓	✓
	C. Comprehensive Emergency Obstetric Care				
	1. Care Cesarean section				✓
2. Blood transfusion				✓	
3. Counseling and Provision of BTL services				✓	
Post Delivery	A. Identification of early signs and symptoms of postpartum complications:				
	1. Maternal problems: hemorrhage, infection and hypertension		✓	✓	✓
	2. Neonatal problems like respiratory distress, change color, etc.		✓	✓	✓
	B. Immediate Neonatal Care				



Life Cycle Stages	Maternal-Neonatal Care	Community-Based	First Contact Facility	BEmONC-capable Facility	CEmONC-Capable Facility
	1. Cord care/dressing		✓	✓	✓
	2. Warming/skin to skin contact		✓	✓	✓
	3. Vitamin K injection		✓	✓	✓
Post Delivery	4. Initiation of BF/ rooming-in or bedding-in		✓	✓	✓
	5. Eye prophylaxis		✓	✓	✓
	6. Delayed bathing		✓	✓	✓
	7. Hepa-B immunization		✓	✓	✓
	C. Emergency Neonatal Care				
	1. Treatment of neonatal sepsis/ infection		✓	✓	✓
	2. Oxygen supply		✓	✓	✓
	3. Resuscitation and stabilization		✓	✓	✓
	4. Kangaroo Care		✓	✓	✓
	D. Intensive neonatal care for low birth weight (LBW); preterm, IUGR, babies born with congenital anomalies, and sick neonates		✓	✓	✓
	E. BCG Immunization	✓	✓	✓	✓
	F. Early and Exclusive BF to 6 months	✓	✓	✓	✓
	G. Maternal Nutrition	✓	✓	✓	✓
	1. Iron and folate				
	2. Vitamin A				
	3. Deworming tablet: mebendazole or abendazole				
	4. Promotion of iodized salt				
	H. Family Planning				
	1. IEC/counseling on: (i) birth spacing; (ii) return to fertility; (iii) all FP methods including LAM	✓	✓	✓	✓
	I. IEC/Counseling on Healthy Lifestyle: 1) Safer sex and HIV/STI prevention(i) smoking cessation; (ii) healthy diet and nutrition; (iii) physical activity; and (iv) moderate alcohol intake	✓	✓	✓	✓

Life Cycle Stages	Maternal-Neonatal Care	Community-Based	First Contact Facility	BEmONC-capable Facility	CEmONC-Capable Facility
	J. Prevention and Management of Other Diseases as indicated:				
	1. STI/HIV/AIDS	prevention	prevention	✓	✓
	2. anemia	✓	✓	✓	✓
	K. Prevention and Management of Abortion Complications				✓
	1. Removal of retained products of conception				
	2. Treatment of infection				
Post-Delivery	3. Correction of anemia				✓
	4. Anti-tetanus serum (ATS) Injection				✓
	L. Diagnostic and Screening Test				
	1. acetic acid wash	✓	✓	✓	✓
	2. Neonatal Screening or referral			✓	✓
	M. Support Services				
	1. Birth Registration	✓	✓	✓	✓
	2. Follow-up visit and care	✓	✓	✓	✓



4. Facility and Service Standards

Level of Care	Staffing	Training Required	Drugs/Medicines/Supplies	Equipment	Facility Set-Up
<b>CEmONC-Capable Facility</b>	<p>3 CEmOC Teams</p> <ul style="list-style-type: none"> <li>1 Team per 8-hour shift</li> </ul> <p>Each CEmONCTeam Include:</p> <ul style="list-style-type: none"> <li>3 doctors (1 per shift)</li> <li>1 anesthesiologist (on call)</li> <li>3 OR nurses (1 per shift)</li> <li>Maternity ward nurses</li> <li>Midwives (2 per shift)</li> </ul>	<p><b>Maternal Care</b></p> <ol style="list-style-type: none"> <li>Partograph and AMTSL</li> <li>Basic Emergency Obstetric Care post-partum protocol and general counseling</li> <li>Comprehensive Emergency Obstetric Care (managing complications of pregnancy and childbirth including anesthesiology)</li> </ol> <p><b>Family Planning</b></p> <ol style="list-style-type: none"> <li>Counselling on all methods</li> <li>Comprehensive FP including IUD, vasectomy and BTL insertion</li> <li>Training on VSS</li> </ol> <p><b>Cervical Cancer Screening</b> (Pap Smear)</p> <p><b>STI-HIV</b></p> <ol style="list-style-type: none"> <li>Risk Assessment, Laboratory Screening and Diagnosis Case Management: Syndromic and</li> </ol>	<ol style="list-style-type: none"> <li>Ampicillin 1 Gm</li> <li>Azithromycin 500 mg</li> <li>Calcium gluconate 10% ml</li> <li>Cefalexine 500 mg</li> <li>Cefixime 200 mg</li> <li>Chromic 2-0</li> <li>atraumatic double arm</li> <li>Cord clamp</li> <li>Dexamethasone 5 mg (1 ml)</li> <li>Diazepam 5 mg/ml</li> <li>D5Water, 500 ml</li> <li>D5Water, 1L</li> <li>Ferrous Sulfate with folic acid (60 mg FeSo4 and 400 mg folic acid)</li> <li>Gentamicin 40 mg/ml (2 ml)</li> <li>Hydralazine 20 mg/ml (1 ml)</li> <li>Hydralazine 50 mg</li> <li>IV tubings ,macro and micro</li> <li>IV canula 16,18, 20, 24</li> <li>Lidocaine 1% 5 ml</li> </ol>	<p><b>Vital Equipment</b></p> <ol style="list-style-type: none"> <li>Vaginal Speculum set</li> <li>Caesarean Section Kit</li> <li>Anesthesia machine – portable</li> <li>Incubator</li> <li>Curettage Set</li> <li>Normal Spontaneous Vaginal Delivery Kit</li> <li>Ambubag</li> <li>Pediatric Ambubag + Mask</li> <li>Simpsons</li> <li>Forceps</li> <li>Suction Machine (mobile 6 liter capacity)</li> <li>Suction Machine (portable 2 l liter capacity)</li> <li>Oxygen tank with regulator/gauge</li> <li>Spare oxygen gauge</li> <li>Nitrous oxide</li> </ol>	<p><b>EMERGENCY/ADMISSION ROOM</b></p> <ul style="list-style-type: none"> <li>Waiting area (with seats)</li> <li>Examination area with privacy</li> <li>Toilet</li> </ul> <p><b>UTILITIES</b></p> <ul style="list-style-type: none"> <li>Electric power supply (line)</li> <li>Alternate power supply</li> <li>24-hour supply of power in labor/delivery room</li> <li>Telephone/radio transceiver</li> <li>Transport service facility</li> <li>Water supply system (24 hours)</li> <li>Sewage system</li> <li>Waste disposal system</li> <li>Placenta pit</li> </ul> <p><b>LABOR/</b></p>



Level of Care	Staffing	Training Required	Drugs/Medicines/Supplies	Equipment	Facility Set-Up
		Etiologic (including management of complications) (2) Laboratory Screening  <b>Neonatal Care</b> (1) Management of Neonatal Emergencies and Complications (2) Newborn Screening (3) IYCF	(20) Lidocaine 2% 50 ml (21) Magnesium Sulfate 500 mg/ml (10 ml) (22) Mefenamic acid 500 mg (23) (24) Methylergometrine, injectable, 200 mcg/ml (25) Metronidazole 500 mg (26) Nitrofurantoin 50 mg (27) Normal Saline 0.9% 1 L IV Fluid (28) Oxytetracycline ophthalmic ointment (29) Oxytocin 10 IU (30) Phytomenadione (31) vitamin K1 injection (32) Povidone iodine solution (33) Ringer Lactate (D5LR) 1 L IV Fluid Contraceptives Condoms Oral contraceptive pills DMPA IUD	tank with regulator/gauge (15) Cervical Inspection set (16) Non-Scalpel Vasectomy Set (17) Tubal Ligation Set (18) Microscope (19) IUD Kit  <b>Standard Equipment</b> (1) Ultrasound machine (2) Anesthesia machine – upright model (3) Vacuum extraction kit (4) Stethoscope (pediatric) (5) Vacuum Forceps (6) Adult Laryngoscope (7) Pediatric Laryngoscope (8) EKG Machine	<b>DELIVERY ROOM</b> - Change room - Scrub room - Barrier door - Toilet - Bathroom  <b>MATERNITY WARD</b> - Ward space - Bed capacity - Nurses' Station - Purified water dispenser - Food facility (for patients) - Counseling Area
<b>BEmONC-capable Facility</b>	3 BEmOC Teams Per facility * 1 Team per 8-hour shift  * Each BEmONC Team Include: - 3 doctors (1 per shift) - 3 nurses (1 per shift) - 3 midwives (1 per shift) - 1 medical tech per facility network	<b>Maternal Care</b> (1) Pregnancy Tracking and Birth Planning (including new protocol on maternal death and perinatal death reporting) (2) Basic Emergency Obstetric Care (including prenatal and postnatal protocol)  <b>Neonatal Care</b> (1) Management of Neonatal Emergencies and Complications			
		(2) Newborn Screening (3) IYCF	(34) Sterile Gloves size 6, 6 1/2, 7, 7 1/2	(9) Sphygmomanometer (10) Stethoscope	<b>HEALTH STAFF ACCOMODATION</b> - Doctors

Level of Care	Staffing	Training Required	Drugs/Medicines/Supplies	Equipment	Facility Set-Up
		<p><b>Family Planning</b></p> <p>(1) Basic Knowledge (including modern methods and managing side effects) - Level 1</p> <p>(2) Comprehensive FP and IUD insertion – Level 2</p> <p>(3) BTL and NSV</p> <p><b>Breast and Cervical Cancer Screening- Level 3</b></p> <p><b>STI-HIV</b></p> <p>(1) Risk Assessment, Clinical Screening and Diagnosis</p> <p>(2) Laboratory STI Testing Syndromic Case Management</p> <p><b>Other Courses</b></p> <p>(1) Gender and Health</p> <p>(2) Leadership and Group Dynamics</p> <p>(3) Counseling</p> <p>(4) Monitoring, Evaluation, Research and Dissemination (including CBMIS and CDLMIS)</p> <p>(5) Behaviour Change Communication</p>	<p>(35) Sterile gauze 4 X 4</p> <p>(36) Suction catheter</p> <p>(37) Syringes G 2.5, 5 and 10 ml</p> <p>(38) Terbutaline 2 mg</p> <p>(39) Terbutaline 500 mcg/ml (1 ml)</p> <p>(40) Tetanus toxoid vaccine 0.5 ml (20 ml)</p> <p>(41) Triple distilled water for injection</p> <p>(42) Vitamin A 10,000 IU</p> <p>(43) Vitamin A 200,00 IU</p>	<p>(adult)</p> <p>(11) Delivery Room Table</p> <p>(12) Examination Table</p> <p>(13) Autoclave</p> <p>(14) Cut Down or Minor Set</p> <p>(15) Gooseneck lamp</p> <p>(16) Kelly pad Instrument (17) Cabinet</p> <p>Instrument Tray with rubber wheels</p> <p>(18) Infant Weighing Scale</p> <p>(19) Fetoscope/ Doppler</p> <p>(20) Adult weighing scale</p> <p>(21) Bassinet</p> <p>Emergency Light</p> <p><b>Special Equipment</b></p> <p>(1) Cardiac monitor</p> <p>(2) cardiac defibrillator</p> <p>(3) Pulse Oximeter</p> <p>(4) Glucometer</p> <p>(5) Blood chemistry analyzer</p>	<p>quarters</p> <p>- Nurses and midwives quarters</p>



Level of Care	Staffing	Training Required	Drugs/Medicines/Supplies	Equipment	Facility Set-Up
				(6) Water bath (7) Coulter counter for blood count (8) Spectrophotometer (9) Nebulizer (10) Stretcher (11) Wheel Chair (12) Ward beds with side railing (13) Revolving Stool (14) Refrigerator (15) Fire extinguisher (16) IV stands  <b>For Neonatal</b> • vaccine carriers (BHS and RHUs) • cold dogs	
<b>First Contact Facility</b>	Doctor or Nurse or Midwife	<b>Maternal Care</b> 1. Partograph and AMTSL 2. Life saving skills for obstetric complications (initial dose of oxytocin, magnesium sulphate and antibiotics) 3. Pregnancy Tracking and Birth Planning	<b>Maternal Care</b> 1. Oxytocin 2. Magnesium sulphate 3. Antibiotics (ampicillin and gentamycin) 4. IV fluids - Normal saline 5. TT vaccine 6. syringes/needles 7. Vitamin A : 100,000 IUs for pregnant women	1. vaccine ref with thermo meter (RHUs, health centers, hospitals) 2. stethoscope and sphygmomanometer 3. weighing scale 4. sterilizer 5. delivery kit 6. delivery table 7. ambu bag	1. birthing room 2. recovery room 3. consultation room/ counseling room with audio-visual privacy

Level of Care	Staffing	Training Required	Drugs/Medicines/Supplies	Equipment	Facility Set-Up
		(including new protocol on maternal death and perinatal death reporting) <b>Neonatal Care</b> 1. Management of Neonatal Emergencies and Complications 2. IYCF <b>Family Planning</b> 1. Basic Knowledge (including modern methods and managing side effects) - Level 1 <b>STI-HIV</b> 1. Risk Assessment, Clinical Screening and Diagnosis <b>Other Courses</b> 1. Gender and Health 2. Leadership and Group Dynamics 3. Counseling 4. Monitoring, Evaluation, Research and Dissemination (including CBMIS and CDLMIS) 5. Behaviour Change Communication	8. Vitamin A: 200,000 IU for PP mothers 9. Iron supplements with folate 10. Iodized salt 11. Low-dose pill 12. Condoms 13. gloves 14. tape measure 15. KY jelly 16. gauze mask 17. Mother and Child Book 18. Counseling chart 19. IEC materials 20. client forms 21. referral slips  <b>Neonatal Care</b> 1. Vitamin K 2. Gentian violet 3. Vaccine: BCG and Hepa B 4. Gloves 5. Syringes and 6. Needles 7. Mother and Child Book 8. Referral slip	8. vaccine carriers 9. cold dogs	
Community-Based	Maternal-Neonatal Health Team per barangay	<b>Maternal Care</b> 1. Pregnancy Tracking and Birth Planning	<b>Neonatal Care</b> 1. Vitamin K 2. Gentian violet	1. stethoscope and sphygmomanometer 2. weighing scale	consultation room/ counseling room with audio-visual privacy



Level of Care	Staffing	Training Required	Drugs/Medicines/Supplies	Equipment	Facility Set-Up
	- 1 Midwife per barangay	<p>(including new protocol on maternal death and perinatal death reporting)</p> <p>2. Training on CMMNC</p> <p><b>Family Planning</b> Basic Knowledge (including modern methods and managing side effects) - Level 1</p> <p><b>STI/HIV</b> Risk Assessment, Clinical Screening and Diagnosis</p> <p><b>Neonatal Care</b> Management of Neonatal Emergencies and Complications</p>	<p>3. Vaccine: BCG and Hepa B</p> <p>4. Gloves</p> <p>5. Syringes and</p> <p>6. Needles</p> <p>7. Mother and Child Book</p> <p>8. Referral slip</p> <p>9. IV fluids- Nsaline</p> <p>10. Oxytocin</p> <p>11. Magnesium sulphate</p> <p>12. Antibiotics(ampicillin and gentamycin)</p>	<p>3. sterilizer</p> <p>4. delivery kit</p> <p>5. delivery table</p> <p>6. sterilizer</p> <p>7. ambu bag</p> <p>8. vaccine carriers</p> <p>9. cold dogs</p> <p>10. vaccine ref with thermo meter</p>	
	<p>1 BHW/ volunteer workers for 20 Households</p> <p>TBA/hilot part of the team</p>	<p>1. Orientation on CMMNC</p> <p>2. Orientation on FP</p> <p>3. Training on HL</p> <p>4. Orientation on STI/HIV</p>			
Province-wide MNCHN network	<p>1 FP Itinerant Team per MNCHN network of facilities composed of:</p> <p>- 1 doctor (surgeon)</p> <p>- 2 nurses (1 nurse or 1 Midwife)</p>				

Executive Order by the Governor/ City Mayor stating full support and describing administrative arrangements for the province-wide or city-wide implementation of MNCHN Strategy

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**EXECUTIVE ORDER NO. \_\_\_\_**

Series of 20 \_\_\_\_

**CREATING THE MATERNAL NEWBORN CHILD HEALTH AND NUTRITION (MNCHN) COMMITTEE AND PROVIDING FOR ITS POWERS, DUTIES AND FUNCTIONS, AND FOR OTHER PURPOSES**

*Whereas*, Section 16 of the Local Government Code (LGC) provides that every Local Government Unit (LGU), within their respective territorial jurisdictions, shall ensure and promote health and safety, and preserve the comfort and convenience of their inhabitants;

*Whereas*, for efficient, effective and economical governance pursuant to a general welfare purpose, Section 456 of the LGC vests upon the Governor the duty to ensure the delivery of basic services and the provision of adequate facilities, and, in addition, coordinate the implementation of technical services by national offices for the province and its component cities and municipalities;

*Whereas*, the Maternal Newborn Child Health and Nutrition (MNCHN) Strategy is a National initiative to rapidly reduce maternal and newborn deaths coordinated by DOH with LGUs for the effective discharge of necessary functions and a form of National assistance to LGUs, which falls within the purview of Section 25(b & c) of the LGC;

*Whereas*, cognizant of the limited resources of LGUs to provide the MNCHN needs within their respective jurisdictions, the DOH is implementing the MNCHN Strategy, which includes supported by the MNCHN Grants Facility, among others;

*Whereas*, the Strategy would eventually result to a sustainable local MNCHN intervention;

*Whereas*, there is a need to define the provincial administrative arrangements through the activation of the Local Health Board (LHB) or creation of a committee that will assist the Governor or Mayor in ensuring the efficient and effective implementation of the MNCHN Strategy.

*Whereas*, this Order is being issued pursuant to the provision of Section 29 of the LGC, which provides that the Province/ City, through the Governor/ or Mayor, shall ensure that every component city and municipality or independent highly urbanized cities within its territorial jurisdiction acts within the scope of its prescribed powers and functions;



Now, therefore, I, \_\_\_\_\_, Governor/ Mayor of \_\_\_\_\_  
Province/City, by virtue of the powers vested in me by law, do hereby order:

**Section 1.** The activation of the LHB/ or the (creation of the MNCHN Committee) to ensure the efficient and effective implementation of the provincial/ city MNCHN Strategy. (note: in case of committee creation, its composition should also be stipulated).

**Section. 2.** The LHB pursuant to the MNCHN Strategy (or the committee) shall undertake the following functions:

- a. Review proposed technical standards, guidelines for provincial province-wide/ city-wide implementation of the MNCHN Strategy and recommend modifications as needed, for the consideration or approval of the Sanggunian Panlalawigan (SP)/ Sangguniang Bayan (SB);
- b. Develop administrative standards and procedures for the provincial province-wide/ city-wide implementation of the MNCHN Strategy, for approval of the SP/ SB;
- c. Provide specific key MNCHN technical inputs and MNCHN baseline information to the SP/SB;
- d. Formulate Design strategies, specific interventions/ activities and strategies related to the implementation of MNCHN strategy defined in the technical and administrative standards, as prescribed for approval by the SP/ SB;
- e. Recommend to the SP/ SB the implementation of the MNCHN activities in component cities and municipalities/ independent urbanized cities based on generated baseline information and monitoring and evaluation (M&E) findings;
- f. Review and discuss the proposed MNCHN plan that would address the peculiarities of the province and its municipalities/ cities, for approval of the SP/ SB;
- g. Recommend to the SP/SB the appropriation for capacitating local health facilities and converting upgrading them into BEmONC/CEmONC capable centers/facilities based on a review and analysis of M&E findings;
- h. Propose the coordinative mechanisms among the members of the MNCHN service delivery networks from within the LGU (e.g. intra-LGU) or even outside the political jurisdiction of the LGU (e.g. inter-LGU) arrangements
- i. Exercise other recommendatory functions for the SP/ SB pursuant to the implementation of the MNCHN Strategy; and,
- j. Formulate and adapt adopt its internal rules and procedures.

**Section. 3.** Effectivity. This Executive Order shall take effect immediately upon approval.

Done this \_\_\_ day of \_\_\_\_\_, 2010 at \_\_\_\_\_ Province/  
City.

\_\_\_\_\_  
Governor/ Mayor



# SERVICE LEVEL AGREEMENT

Regional Accountant I

This Service Level Agreement is made and entered into on this \_\_\_\_ day of \_\_\_\_\_ 20\_\_ by and between the following parties:

The **Department of Health-Center for Health Development** - \_\_\_\_\_, a regional government agency created under the laws of the Republic of the Philippines with principal office address at \_\_\_\_\_, represented by the **Director IV**, \_\_\_\_\_, and hereinafter referred to as the **DOH-CHD**;

- and -

Provincial Health Officer II

The **Provincial Government of** \_\_\_\_\_, a Local Government Unit (LGU) established and existing under the laws and regulations of the Republic of the Philippines with principal office address at **Provincial Capitol**, \_\_\_\_\_, represented by **Honorable Governor** \_\_\_\_\_, hereinafter referred to as the **Province**;

**NOW, THEREFORE** the parties hereto agree as follows:

Director III, CHD

**WHEREAS**, Republic Act 7160 otherwise known as the 1991 Local Government Code mandated for the devolution of the delivery of health services and facilities as one of the basic functions and responsibilities of all Local Government Units (LGUs) at all levels;

**WHEREAS**, the "**FOURmula One for Health**" (F1) has been adopted as the implementation framework for health reforms of the DOH and is designed to undertake critical reforms with speed, precision and effective coordination with the goal of improving the efficiency, effectiveness and equity of the Philippine Health System for all Filipinos, especially the poor;

Governor

**WHEREAS**, the reforms are implemented under a Sector-wide Development Approach for Health (SDAH), which encompasses a management perspective and coordination requirements that cover the entire health sector and an investment portfolio that encompasses all sources;

**WHEREAS**, the DOH, being the technical resource, catalyzer for health policy, and advocate for health issues on behalf of the health sector commits to the principles and conditions in Health Services Delivery, in Health Care Financing, in Good Governance for Health and in Health Regulation;

Director IV, CHD

**WHEREAS**, DOH Administrative Order 2005-0023 otherwise known as the Implementing Guidelines for **FOURmula ONE** for Health as Framework for Health Reforms has been adopted at the national and local levels;

**WHEREAS**, the Government of the Philippines has mobilized resources for the implementation of **FOURmula One for Health** in Provinces, which includes, grants from health development partners and National Government contributions for the local implementation of health programs, projects and activities.

**WHEREAS**, the DOH shall provide MOOE in the form of cash transfers to LGUs thru CHDs to support the implementation of Local Health Systems Development strategies, Family Health including Family Planning, Epidemiology and Disease Surveillance, other Infectious diseases



and emerging and re-emerging diseases; including HIV/AIDS/STI, dengue, soil transmitted helminthiasis, food and water-borne disease, Non-Communicable Disease Prevention and Control, Public Health Development Program including Formulation of Public Health Policies and Quality Assurance, Elimination of Diseases as public health threat such as malaria, schistosomiasis, leprosy and filariasis, Rabies Control Program, TB Control Program, Health Emergency Management Staff, Health Facilities Enhancement Program, Health reforms and other programs as proposed in their Annual Operational Plans (AOPs). *Provided that*, cash transfers pursuant to DOH Grant facilities shall be subject to the guidelines issued therefore;

Regional Accountant I

**WHEREAS**, the Province of \_\_\_\_\_ has agreed to implement *FOURmula ONE* for Health and has proved its capacity to absorb investments and sustain the reform process, among others;

Provincial Health Officer II

**WHEREAS**, the Province of \_\_\_\_\_ has prepared a Province-Wide Investment Plan for Health (PIPH) which has been duly reviewed by the Department of Health (DOH) with the Joint Appraisal Committee (JAC), and modified accordingly and implemented based on a DOH concurred annual operational plans (AOPs) that include supplemental plans, which should be developed prior to the start of every year covered by the PIPH;

**WHEREAS**, the DOH and the Province of \_\_\_\_\_ have signed a Memorandum of Agreement (MOA) dated \_\_\_\_\_, in order to help achieve the objectives of *FOURmula one* for Health;

**NOW, THEREFORE**, and in consideration of the foregoing premises, the parties hereto agree in this SLA, referred to in the MOA as program contract, as follows:

Director III, CHD

**ARTICLE I**  
**The Program**

**1.1 Coverage**

This Service Level Agreement covers the management and implementation of the Annual Operational Plan for 2009, which forms an integral part of this Service Level Agreement and includes the following: i) Procurement plan ii) Training plan, iii) Plans required for accessing funds from DOH Grant facilities, iv) Annual program indicators and milestones, v) Agreed funding support and, vi) Agreed LGU counterpart investments

Governor

**1.2 Expected Outputs**

The Service Level Agreement (SLA) will focus on the implementation of the attached 2009 Annual Operational Plan (AOP) of the province to achieve a Local health system performance consistent with internal & external benchmarks set in Section 3, Table 2 of this SLA.

Director IV, CHD

**1.3 Program Funding**

The implementation of the AOP shall be funded by various sources, as indicated in the PIPH, in the Operations Plan, and in the F1 Operations Manual for Convergence Provinces. These sources include a grant from the European Commission for the F1 16 pilot provinces in the form of a direct BUDGET SUPPORT, and assistance from the DOH central office consisting of 1) direct cash DOH counterpart to the EC grant, 2) Other cash transfers from the DOH through the CHDs, subject to the appropriate guidelines issued for their purposes, 3) Performance grants pursuant to the implementation of DOH Grant facilities, and 4) Support in-kind (commodities) through the regular DOH budget, to be provided by the Central Office through the CHD.



The EC grant and the DOH counterpart for the 16 provinces considered as "F1 Convergence Sites" shall consist of a fixed tranche and a variable tranche. The fixed tranche for 2009 will be released as indicated in Article III of this Service Level Agreement. The variable tranche will be released during the first semester of 2010 and the amount will be dependent on the performance during year 2009, as also indicated in Article III of this Service Level Agreement.

## ARTICLE II Program Implementation Arrangements

### 2.1 The DOH-CHD shall:

- a) Authorize the Province to manage the GRANT FUNDS and DOH counterpart funds, DOH cash transfers and in kind support (commodities) as it implements the PIPH to produce the deliverables and outputs indicated in this 2009 Service Level Agreement and with the F1 Operations Manual for Convergence Provinces.
- b) Provide logistical and technical support to the Province for the overall planning, management, and coordination of PIPH 2009 Annual Operational Plan priority activities and programs to ensure smooth and efficient implementation of the PIPH 2009 Annual Operational Plan.
- c) Ensure, verification and validation of submitted LGU Scorecard, documentary requirements that prove performance, and other accomplishment reports, which shall be the basis for assessing 2009 performance and for awarding of 2009 variable tranche to be released during first semester of 2010, and performance grants from DOH Grant facilities that are to be released according to the provisions of the guidelines issued for the purpose.
- d) Ensure the release of funds to the Province based on the verified physical, financial, and technical accomplishment reports as described in the F1 Operations Manual for Convergence Provinces or on performance assessment, as provided by specific guidelines for the implementation of Grant facilities.
- d) Provide other forms of assistance essential for the effective implementation of the PIPH Annual Operational Plan.

### 2.2 The Province shall:

- a) Implement all activities under the 2009 Service Level Agreement following the DOH FOURmula ONE for Health implementation guidelines (DOH Administrative Order 2005-0023) and the F1 Operations Manual for Convergence Provinces.
- b) Carry out with due diligence all activities as contained in the attached approved 2009 Annual Operations Plan (AOP) including the sub-plans during the pendency of this \_\_\_\_\_ Service Level Agreement between the Parties.
- c) Prepare and submit to the DOH, Program Monitoring Reports as described in the F1 Operations Manual for Convergence Provinces, the LGU Scorecard results for 2009, and documentary requirements for accessing performance grants, as prescribed by appropriate guidelines issued for the implementation of specific Grant facilities.

Regional Accountant I

Provincial Health Officer II

Director III, CHD

Governor

Director IV, CHD



**ARTICLE III**  
**Resources and Financial Obligations**

**3.1 Resources from Development Partners and National Government**

3.1.1 The Province shall receive an assured fixed allocation of about Php \_\_\_\_\_ of support from Development Partners and the National Government for the implementation of AOP 2009, broken down as follows in Table 1, in addition to non-specified amounts in this SLA, including variable allocation for assessed performance in 2009, other cash transfers and commodities.

**Table 1.** Resources from Development Partners and National Government Support to Province for 2009

Fund Allocations	Amount (Php)	Notes
<b>A. EC Grant and DOH Counterpart, 2009</b>		
<b>1. Fixed Allocation</b>		
a. EC Grant		
b. DOH Counterpart		
<b>2. Variable Allocation</b>		Specified only as maximum amounts available – but the amount to be released 1 <sup>st</sup> semester of 2010 will be dependent on the achievement of performance during year 2009 as described in Article 3.1.3 of this Service Level Agreement.
a. EC Grant		
b. DOH Counterpart		
<b>B. Cash transfers and commodities from DOH</b>		
1. Cash transfers (from programs)	<b>Non-specified</b>	Cash transfers will be dependent on the readiness of the LGUs to produce outputs, as assessed by CHDs
2. Commodities	<b>Non-specified</b>	These are yearly commodity allocations from the DOH to the provinces thru the CHDs (i.e vaccines, TB drugs, etc.)
<b>TOTAL FIXED ALLOCATION FOR RELEASE IN 2009</b>	<b>28,657,518</b>	

3.1.2 Table 1 above will show the total amount of funds and the various sources that includes Development Partners and National Government. This is exclusive of additional cash transfers contingent on the readiness of LGUs to produce outputs as assessed by CHDs.

3.1.3 The Province can receive performance grants from Grant facilities that are implemented by DOH programs, subject to the guidelines issued for its implementation.

3.1.4 The variable EC grant and variable DOH counterpart allocations for 2009 will be released during the first semester of 2010, according to assessed

Regional Accountant I

Provincial Health Officer II

Director III, CHD

Governor

Director IV, CHD7

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performance in 2009 as reflected in the 2009 LGU Scorecard of the province for the following indicators shown in Table 2.

**Table 2.** Indicators for Performance Assessment in 2009

PERFORMANCE INDICATORS (1)	% share of Total variable allocation for 2009 (EC Grant and DOH counterpart) (2)	% Share of Column 2 (3)		Mode of Verification (4)
		Internal Benchmark (40%) (3a)	External Benchmark (60%) (3b)	
<b>VARIABLE ALLOCATION: SLA 2009</b>				
<b>SERVICE DELIVERY</b>				
<b>A. Disease Free Zone (Only in Endemic Provinces)</b>				
1. ___ Annual parasite incidence for Malaria		5%	5%	MIS, NCDPC
<b>B. Intensified Disease Prevention and Control</b>				
2. ___ TB Case Detection Rate		5%	5%	NTP Register
3. ___ TB Cure Rate		5%	5%	NTP Register
<b>C. Child Health</b>				
4. ___ % Fully Immunized Child		5%	5%	FHSIS
5. ___ % of Newborns initiated breastfeeding within 1 hour after birth		5%	5%	FHSIS and other data source
6. ___ % of Protein Energy Malnutrition among 0-5 years old based on weight for age anthropometric measurement		5%	5%	OPT data from LGU records
<b>D. Maternal Health</b>				
7. ___ % of Facility Based Deliveries		5%	5%	FHSIS
8. ___ Contraceptive Prevalence Rate		5%	5%	FHSIS
<b>E. Healthy Lifestyle, Health Risk Management and Advocacy</b>				
9. ___ % of HHs with access to Safe Water		5%	5%	FHSIS
10. ___ % of HHs with access to Sanitary Toilet facilities		5%	5%	FHSIS
<b>F. Health Facilities Development Program</b>				
11. ___ Upgrading capacity of health facilities identified for Basic Emergency Obstetric and New Born Care as to BEmONC standard capacity		10%	10%	Hospital Records
<b>REGULATION</b>				
<b>G. Compliance to National Health Legislation and Standards for:</b>				
12. ___ % of RHUs accredited by PhilHealth for: - Out Patient Benefit Package - Maternal Care Package - TB DOTS		5% 5% 5%	5% 5% 5%	PHIC Records
13. ___ No. of BnB set-up (Ratio: 1 BnB per 2 barangays)		5%	5%	LGU Records & PMU Records
<b>FINANCING</b>				
<b>H. Expansion of National Health Insurance Program</b>				
14. ___ % of poor families enrolled in PhilHealth		5%	5%	PHIC Records
15. ___ Identification of Indigent families through any Philhealth approved means testing mechanism		5%	5%	PHIC Records



GOVERNANCE				
<b>I. Internal Management</b>		<b>(10%)</b>	<b>(10)</b>	
16. _____%	% of provincial budget allocated for Health (2.5%)	2.5%	2.5%	LGU Budget Documents
17. _____%	% of municipal budget allocated for health (2.5%)	2.5%	2.5%	LGU Budget Documents
18. _____%	% of Procurement Packages above Php 250,000.00 completed through competitive public bidding I PWS (2.5%)	2.5%	2.5%	LGU Budget Documents/ Procurement plans
19. _____%	% of annual financing utilized (2.5%)	2.5%	2.5%	LGU Budget Documents
<b>TOTAL</b>		<b>100%</b>	<b>100%</b>	

- a. The 2009 VT will be will be released during the 1<sup>st</sup> semester of 2010 upon accomplishment of the aforementioned performance indicators/milestones agreed upon by both the DOH and the province.

**Legend:**

**Internal Benchmark:**

- ⓐ Performance of PWS is lower than the previous year = 50%
- ⓑ Performance of PWS is same or Increased from previous Year = 100%

**External Benchmark:**

- ⓐ Performance of PWS is below the national average and below the 2010 target = 50%
- ⓑ Performance in PWS is equal or higher than the national average but lower than the 2010 target = 90%
- ⓒ Performance of PWS is higher than the national average and equal to or higher than the 2010 target = 100%

- 3.1.5 Release of funds shall conform with the procedures in the F1 Operations Manual for 16 F1 Pilot Provinces or pertinent guidelines, whichever is applicable.
- 3.1.6 The DOH shall secure the release of the 16 F1 Convergence Sites EC grant proceeds through regular government funds flow procedures and the DOH counterpart to the EC grant as funded by the Health Sector Development Program budget line item of the GAA.
- 3.1.7 The DOH shall also secure the release of other financial assistance from all Development Partners and DOH cash transfers to the intended LGUs.

**3.2 The Province shall:**

- a) Manage the program resources and ensure the delivery of inputs (e.g. rehabilitation works, equipment, capacity building, etc.) to the lower levels of local government.
- b) Maintain adequate Financial Management records and systems for the 2009 Service Level Agreement. The Financial Management System will comply with that of the DOH and the Program Donors as described in the F1 Operations Manual for Convergence Provinces.
- c) Contribute to and facilitate monitoring, evaluation, and audit activities that will be conducted in the course of the program, as described in the F1 Operations Manual for Convergence Provinces.
- d) Submit LGU Scorecard Annual Results on time and participate in Annual Monitoring conference.
- e) Submit documents required for accessing DOH Grant facilities, as stipulated under pertinent guidelines issued for the purpose.

- f) Submit a COA audited financial report to the DOH before end of Q2 of succeeding year. Refund expenditures disallowed by audit.

Regional Accountant I

Provincial Health Officer II

Director III, CHD

Governor

Director IV, CHD

**ARTICLE IV  
Miscellaneous**

**4.1 Mutual Obligations**

The DOH and the Province agree to perform, fulfill, abide by, and submit to any and all of the provisions and requirements and all matters related, contained or expressed or reasonably inferred from this Service Level Agreement Document. All unobligated amounts in DOH counterpart and EC grant funds shall be applied according to modalities determined by the DOH in consultation with the funding donors and the province. The Province shall abide by the decisions of the JAC in this regard.

**4.2 Service Level Agreement Period**

The DOH and the Province agree that the Service Level Agreement herein described shall cover activities from January to December \_\_\_\_\_

**4.3 Notices**

All notices called for by the terms of this Service Level Agreement shall become effective only at the time of receipt thereof and only when received by the parties to whom they are addressed:

**For the DOH-CHD:** The Director IV

**For the Province:** The Governor

**4.4 Integration**

The DOH and the Province agree that this Service Level Agreement expresses and integrates all agreements, promises, and covenants of the parties and supersedes all prior negotiations understanding and agreements, whether written or oral and that no modification or alteration of this Service Level Agreement shall be valid or binding on either party unless expressed in writing and executed with the same formality as this Service Level Agreement.

**ARTICLE V  
Effectivity**

This Agreement shall take effect on the date of the signing hereof by the parties concerned and shall be terminated upon satisfactory fulfillment of all the terms and conditions embodied herein. Any modification or amendments to this Agreement as proposed by either party shall mutually be agreed upon in writing by all the parties hereto.

**IN WITNESS WHEREOF**, the parties have hereunto set their signatures this \_\_\_\_ day of \_\_\_\_\_ 2009, \_\_\_\_\_ City.



DOH-CENTER FOR HEALTH DEVELOPMENT

PROVINCIAL GOVERNMENT

By:

By:

\_\_\_\_\_  
Director IV, CHD-

\_\_\_\_\_  
Provincial Governor

*Signed in the presence of:*

\_\_\_\_\_  
Director III, CHD-

\_\_\_\_\_  
Provincial Health Officer

\_\_\_\_\_  
Regional Accountant, CHD-



**ACKNOWLEDGEMENT**

Regional Accountant I

Republic of the Philippines  
City of \_\_\_\_\_

Provincial Health Officer II

**BEFORE ME**, this \_\_\_ day of \_\_\_\_\_ 20\_\_\_, in the City of \_\_\_\_\_, Philippines,  
personally appeared:

Known to me to be the same persons who executed the foregoing instrument, and they  
acknowledge that the same is their free and voluntary act and deed.

This instrument consisting of 9 pages signed on which the acknowledgement is written has  
been signed on each and every page by the parties and their instrument witness.

**WITNESS MY HAND AND SEAL**, at the place on the date first written above.

Director III, CHD

\_\_\_\_\_  
Director IV

CTC #:  
Issued at :  
Issued on:

Governor

\_\_\_\_\_  
Governor

CTC #:  
Issued at :  
Issued on:

Director IV, CHD

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Book No. \_\_\_\_\_  
Series of 20 \_\_\_\_\_

NOTARY PUBLIC





**A POSTSCRIPT on the:  
"Improvement of the Implementation and Procedures and Management Systems for the  
Health Facilities Enhancement Grant of the Department of Health"**

The DBM-PIDS Study on the "Improvement of the Implementation and Procedures and Management Systems for the Health Facilities Enhancement Grant of the Department of Health" provided the Department of Health significant findings which we can use to improve our delivery of services.

The study noted the following:

- a. "...none of the HFEP guidelines explicitly mentioned any of these AOs in the guidelines for allocation and release of funds for HFEP";
- b. Actual allocation of HFEP funds..."does not clearly show the link of HFEP allocation to needs specified by DOH policies on allocating based on needs";
- c. "...simple correlation suggests that the allocation per capita and poverty incidence are not related"; and,
- d. "...Correlation suggests that HFEP expenditure per capita and population are (sic) not statistically significant."

The DOH Centers for Health Development evaluates proposed Health Facilities Enhancement projects, and uses this list of criteria to screen and select facilities for inclusion:

1. Existing list of BEmONC facilities
2. Province's Rationalization Plan
3. Province Wide Investment Plans for Health (PIPH)
4. Annual Operation's Plan (AOP's)
5. DSWD-CCT areas

With the increase of Health Facilities Enhancement Program (HFEP) budget was the proportionate increase in the number of projects that were to be managed by DOH. The DOH Regional Cluster Heads were included in the screening and selection of HFEP 2011 projects, which has further aided the rational screening of HFEP projects.

The observed disconnect in the HFEP allocation by DOH and the actual needs of the provinces is admittedly an issue that the department needs to address. But one of the major reasons for this disconnect is based on the premise that capital infusion for the upgrading, repair, renovation, expansion or new construction of health facility buildings and procurement of hospital or diagnostic equipment is best allocated where their optimal use, adequate maintenance and sustainability are assured. And the potential for optimal utilization of the hospital, RHU or BHS is assured when LGUs or the existing health facility can assure the availability of adequate and appropriate human resources to operate the facility and provide the services funded by HFEP. Also, potential for optimal utilization is high when the facility or services are located strategically such that this can be accessed by various population groups instead of confined or authorized for a singular or small LGU.

With this, the potential for adequate maintenance of buildings and equipment and their sustainability is higher among LGUs or existing facilities that have track record for appropriating adequate funds for health care or hospital operations (MOOE) and among health facilities located in or near commercial areas where services, materials or networks for specialized services are more easily

accessed. A hospital administration's experience in improving schemes in healthcare financing and use of income, such as linkage with PhilHealth and other health insurance corporations, use of revolving funds and fees-for-services likewise indicate high potential for sustainability of HFEP investments.

Thus, even if the target population to be served or whose health status needs to be improved is located in a low income municipality, it is likely that the hospital to be built or upgraded would be the hospital in the urban zone nearest it and would be reflected as HFEP funds allocated to the provincial government or HFEP funds allotted to an existing DOH hospital. In a similar manner, the location of households or poor families qualifying for the CCT or conditional cash transfer from the DSWD may not be rendered feasible for construction of a BHS or hospital, and thus, the HFEP budget may be deemed better invested in one or several nearby *barangays* that are considered to be more topographically stable or in the mother RHU serving the community or households.

DM 2010-0104 which is about the HFEP guidelines being questioned, recommends that project proposals to be considered for HFEP funding are channeled through DOH-CHDs or Centers for Health Development. This is because the CHD is continually involved in the province-wide or city-wide planning for the rationalization of health care delivery. The Rationalization Plan (RatPlan) is a health sector development cum business plan proposed collegially by the province and its component municipalities and cities and the DOH. These RatPlan's prepared by the LCE's and endorsed by the CHD's are frequently used as reference to verify the accessibility and LGU commitments to maintain certain health facilities prior to firming up the HFEP project list to be funded.

The DOH uses the Rationalization Plans as the basis for allocating HFEP funds, and ideally all provinces in the country should now have their Rationalization Plans. Unfortunately, when provinces do not have RatPlan's, decisions on investments for the health facility is endorsed to the DOH EXECOM for further evaluation and approval.

In general, it is fair to say that the DOH has managed HFEP budget guided by procedures and policies that aim for allocative and technical efficiency with consideration to improve access to healthcare facilities nationwide, especially where these can impact on the achievement of Millennium Development Goals—which cover the very basic health needs of the poor. The DOH likewise admits to the fact that the degree of consistent execution of these written policies may sometimes vary in some offices or LGU's, and can be influenced by various interest groups.