PD-ABG-540

THE PHILIPPINE CHILD SURVIVAL PROGRAM

Project Number 492-0406

FINAL REPORT

June 1990 - July 1993

(One Volume Only)

Prepared by Management Sciences for Health
under Contract No. AID 492-0406-C-00-0079-00

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TABLE OF CONTENTS

* In an appropriately labeled envelope accompanying this Report.

Monograph No. 3- Setting Quantitative Objectives in Health Sector Programs: Lessons Learned from the Philippine Child Survival Program

Monograph No. 4- The Field Health Services Information System: Its Role in Decentralizing Health Services in the Philippines

Monograph No. 5- Social Marketing Communications: Its Contribution to the Philippine Child Survival Program

Monograph No. 6- Paying for Performance: An Approach to Donor Funding in the Philippines

INTRODUCTION

This Final Report of the Philippine Child Survival Program Technical Assistance Team (CSP/TAT) covers the period June 1990 through July 1993. For each of the main components of the Project (Epidemiology-based Planning, health information systems, IEC/social marketing, and program implementation/evaluation), the report consists of:

1. A summary of the major accomplishments, categorized into main "themes" around which the three years of the project have revolved for that particular component;

2. A brief analysis of the factors that have facilitated or inhibited these accomplishments; and

3. Recommendations for action by the DOH and by USAID, particularly concerning next steps for Child Survival.

The TAT recognizes that the CSP is a coordinated effort of the Department of Health staff and volunteers, with USAID as its invaluable partner. This report attempts to make clear what the role of the TAT has been in this undertaking, what the TAT has accomplished, what issues need to be addressed, and what specific steps can be taken to ensure that the gains achieved by the DOH through CSP can be sustained after the program has ended.

The Philippine Child Survival Program (CSP) of the Department of Health (DOH) is a five-year (1989-1994), $50 million USAID-funded program for the DOH to make available basic health services to mothers and children via 10 categories of child survival interventions. CSP began in late 1989 and will end in March 1994.

The CSP's stated purpose is "to increase the availability, utilization, and sustainability of child survival-related services, including child spacing." The primary means by which the DOH aims to achieve this purpose is by implementing policies and programs which have significant impact on maternal and child morbidity and mortality. The CSP has assisted this process by influencing a health agenda that consists of annual policy objectives and corresponding performance benchmarks. The policy objectives have revolved around two basic themes: (a) adoption and implementation of major reforms in health service delivery management, financing and organization; and (b) demonstration of progress in service coverage and quality.

The CSP is a performance-based sector assistance program where annual payments (tranches) of USAID assistance to the GOP, beginning in December 1989, have been conditioned upon GOP agreement to specific policy reforms and implementation of these reforms as measured against *performance benchmarks*. At the beginning of the CSP, the DOH and USAID agreed upon a series of annual performance benchmarks which, when achieved, indicated the achievement of critical policy reforms and policy objectives. These benchmarks, with the exception of nine service delivery targets to be achieved by the end of the program, were reviewed (and the next year's benchmarks subsequently updated whenever necessary) during the annual performance benchmark reviews. Consequently, the achievement of these benchmarks triggered the release by USAID of the corresponding

annual tranche. To support the DOH in making all this happen (including proper documentation of benchmark achievement) the Project Coordinating Unit (PCU) had been set up and the TAT has also been actively involved in all stages of the process.

The TAT, originally composed of four long-term advisors, was contracted by USAID beginning in August 1990, to assist the DOH in four program areas: epidemiology-based planning, health information systems, health care financing, and social marketing/IEC. The TAT was expanded in early 1991 to include a long-term advisor for programs and evaluation. The TAT worked closely with DOH program managers, with the PCU, and with USAID to make sure that all the annual performance benchmarks were achieved and fully documented. Over and above this, the TAT has also assisted the DOH in identifying the Department's technical assistance needs concerning child survival, and how best to address those needs.

In 1991, midway in the project, the CSP was evaluated by an independent team led by a senior staff member of USAID/Washington. By the end of 1992, the consensus concerning the CSP was that: (1) as a DOH program, progress in planning, financing and implementing the 10 Child Survival interventions was evident; (2) as a USAID project, there had been substantial progress in creating the conditions for achieving the goal of reducing infant and child mortality and morbidity rates; and (3) as a method of grant disbursement, the three annual tranches totalling $33 million (at the time of the mid-term evaluation) had been completed on the basis of successful accomplishment of performance benchmarks specified in the agreement between the DOH and USAID.

In 1992, the health care financing component was spun off to form the core of the new Health Finance Development Project, of which the former CSP resident advisor on health care financing is now a member.

As the CSP draws to a close, the technical assistance team looks back to nearly three years of painstaking but very rewarding work in support of the DOH and in pursuit of the project's overall objectives. Realizing that their experience provides important lessons for others in the "development community" who are involved with or are designing similar health sector assistance programs, the team has attempted to document the project highlights through a series of monographs and a video, for the benefit of these "development" professionals. This report represents the final brush stroke to the CSP picture. It focuses on the highlights of the individual experiences of the remaining four resident advisors over the past three years, with the intention of putting forth what they perceive to be the major project issues that the DOH still needs to address, if the gains achieved in the CSP are to be sustained and built on, towards reduced infant and child mortality and morbidity.

TECHNICAL REPORTS

PLANS AND PROGRAMS

I. ACCOMPLISHMENTS

Epidemiology-based planning was an important component of the Child Survival Program (CSP) from its inception in 1989. The Department of Health Chief-of-Staff (and CSP Director) was personally involved in developing the new Area Program-Based Planning methodology. With high-level support the new methodology was quickly field-tested and then implemented throughout the country (see **Annex 5**: Child Survival Program Monograph No. 2, "Area Program-Based Health Planning in the Philippines" for a more detailed description).

Area Program-Based Health Planning (APBHP) was being carried out in every province by mid-1990. The health planning adviser arrived in Manila in August 1990. For the next three years he worked closely with the Internal Planning Service (IPS) under three different directors [Dr. Teresa Nano (1990-1991), Dr. Wilfredo Asoy (1991-1992), and Dr. Zenaida Ludovice (1992-1993)]. During this period there were several major themes associated with APBHP which affected the way health planning has been done in the Philippines.

THEME # 1: **Health Planning (through APBHP) has followed a systematic, standardized approach throughout the country, directly involving health workers at all levels.**

Prior to APBHP the health planning process took place mainly at the provincial level, and health staff at lower levels (such as barangay nurses) were rarely involved. This changed with the advent of APBHP. From the midwife's point of view APBHP represented both good news and bad news, with the good outweighing the bad. The good news included:

- The midwife, through APBHP, could now identify which barangays in her catchment area had low coverage levels for important programs. She could now prioritize those barangays, too make sure that their coverage levels would improve. In addition, she could identify which programs were performing poorly in a number of barangays, thereby flagging them as needing more of her time and attention.

- The midwife now felt that she was more involved in determining the priority activities that she needed to address. For some this was empowering.

The bad news, again from the typical midwife's perspective, included:

- APBHP required about two-three weeks full-time work (in addition to her regular duties). This meant many late nights trying to calculate coverage rates for major programs, barangay by barangay.

- After supplying the data needed for her plan at the Barangay Health Station (BHS) catchment area level, many midwives never received a written copy of their plan, so that in many cases they were not able to identify which barangays and which programs needed special effort.

The fact that the new APBHP methodology was codified and standardized in a manual (now in its 4th edition) meant that all health workers throughout the country were doing health planning in basically the same way. This made it easier for health managers at different levels to assess the plans and programs more easily than otherwise would have been the case.

The TAT Planning Advisor worked closely with the Internal Planning Service (IPS) to strengthen the capability of planners at municipality, district, provincial, and regional levels, especially concerning APBHP. The major accomplishments included:

- Training of health staff from every province and region regarding APBHP
- Development of a system for determining the quality of submitted plans
- Development of a "core group" of central office staff committed to strengthening the capability of local health managers in health planning and management
- Achievement of all CSP health planning benchmarks
- Increased use of epidemiology in health planning, for targeting high-risk persons, areas and programs

THEME #2: **With the devolution of health services, APBHP needs to be modified to meet the needs of local government units.**

During the period 1992-1993 the most important single fact affecting health planning in the Philippines was the devolution of health services to local governments (provinces and municipalities). The TAT planning advisor, working with colleagues in the Local Government Assistance and Monitoring Service (LGAMS) and IPS, focused on the following objectives:

- Development of a health planning manual appropriate for local government officials
- Writing a monograph on APBHP to make it easier for local government officials and health staff to identify the major health planning issues
- Development of training approaches to strengthen the capability of local health planners to work independently of central and regional DOH staff
- Coordination of planning activities between LGAMS, IPS, and the major public health programs
- Development of a medium-term Child Survival Plan, in association with the Office of Special Concerns

II. MAJOR CONSTRAINTS/ PROPOSED SOLUTIONS

During this three-year period, the major constraints to more effective epidemiology-based health planning included:

A. Health Planning, in the APBHP approach, focused on which areas and programs were performing poorly rather than on which programs/interventions would have the greatest impact on preventable child mortality

B. Health planners devoted their energies to producing a plan that would be approved in Manila rather than on implementing the plan. There was too much concentration on a document and too little on carrying out appropriate health activities.

C. Planners at the local level were not told of any "ceiling" or maximum amount of funds they could request. As a result, many provinces requested 10-20 times more augmentation funds than they were actually given. This resulted in a greater deal of frustration on the part of many planners.

D. The APBHP was too complicated and time-consuming for most health staff.

The TAT Planning Advisor suggested to the DOH several possible "solutions" to solve these problems:

A. The APBHP approach needed to be modified to include more emphasis on prioritization and determining which programs were most important from the point of view of impact. The APBHP methodology did include a small section to prioritization, but it was less than adequate.

B. Emphasis should shift from plan preparation to plan implementation. This has already begun in the DOH as planners gradually understand the APBHP approach better and better.

C. When augmentation funds from the Government of the Philippines (GOP) or donors is available, local planners should be informed of the approximate amount and should plan accordingly.

D. A major effort to streamline and simplify (and shorten) the APBHP approach, without eliminating its key features which make it effective, should be undertaken in order to make the whole process more "user-friendly" to local government units. This would also facilitate the increased involvement of NGOs, the private sector, and other groups in the planning process.

III. SUGGESTED NEXT STEPS

1. Prepare a simplified APBHP manual for use by local government units.

2. Use the "benchmark approach" to help provincial planners focus on the most important health activities.

3. Inform local planners of approximate amount of augmentation funds available.

4. Link budgeting and planning more closely at the local level.

5. Make sure all midwives, nurses, and doctors have copies of their local plans.

HEALTH & MANAGEMENT INFORMATION SYSTEMS

ACCOMPLISHMENTS

In making a final report on the accomplishments of the Resident Advisor, it is essential to refer to the original expectations/ description of tasks and services to be provided. There are two basic sources: the Terms of Reference (TOR) which itemizes the requirements for technical assistance and the Program Assistance Approval Document (PAAD) which provides the rationale for the project.

In terms of primary purpose for this engagement, the TOR and the PAAD have the following to say:

TOR: ***The principal objectives of Technical Assistance (TA) in this area are: (1) to assist the DOH Health Intelligence Service and the Management Advisory Service in the development and nationwide implementation of health and management reporting systems; (2) to assist Child Survival Program (CSP) managers in assessing, analyzing and utilizing health and management information for management (or Health Management Information) in formulating policies and provisions for the improvement of institutional capacity to collect, process and utilize information.***

PAAD: ***Provision for a long-term advisor in this area will ensure that the [FHSIS] is fully developed and sustainable by enhancing DOH capabilities to manage the system and utilize [FHSIS] data for targeting of services.***

In 36 months of this professional engagement from 01 July 1990 to 30 June 1993, the Resident Advisor met these objectives. This can be established from the following listing of accomplishments. For presentation purposes, the accomplishments are broken down and categorized according to specific requirements stated in the TOR and PAAD.

A. HEALTH AND MANAGEMENT INFORMATION SYSTEMS DEVELOPMENT AND IMPLEMENTATION

1. *TOR. Assist in the on-going installation of the FHSIS, with specific emphasis on systems redesign and training for implementation in the National Capital Region (NCR).*

   - Participated in the finalization of the design and development of the Field Health Services Information System (FHSIS) for the NCR.
   - Assisted in the implementation of the system in Manila, Marikina, and Caloocan.
   - Assisted the Health Intelligence Service (HIS) and the Management Advisory Services (MAS) in the training of system implementors in the NCR.
   - Designed and implemented the system for monitoring and evaluating FHSIS implementation in NCR.

- Provided direct assistance in the computerization of the reporting forms for NCR.

2. *TOR. Assist in planning the institutionalization, maintenance and upgrading of FHSIS, with particular priority on operational management, logistics support, data quality assurance, phase-in of new information components, training in analysis and use of data at the national program, regional and provincial management levels.*

   PAAD. ... central and field staff have sufficient understanding of the [FHSIS] system to perform monitoring, evaluation and routine operational management functions.

   PAAD. ... development of a timely and non-disruptive system for periodically modifying the [FHSIS] in response to the implementation of new nationwide programs.

   - Prepared the operations procedures manual for all FHSIS coordinators in the regions. It should be noted that FHSIS covers all CSP programs and service delivery activities.

   - Designed and implemented the system for monitoring and evaluating FHSIS implementation in the regions.

   - Prepared the organizational structure for FHSIS and the flowchart of activities of various actors in the FHSIS hierarchy, from the midwives to the central office.

   - Assisted HIS in planning and preparing for consultative workshops with regional and provincial coordinators, program managers, regional directors and program coordinators. Participated and acted as facilitator in all of these workshops.

   - Provided physical help in producing quarterly regional output tables and reviewing outcomes to determine their usability by the program managers.

   - Personally visited seven regional offices in nine days to have firm grasp of the computerization problems and encourage regional operators to submit reports on time.

   - Conducted the systems development course for selected HIS staff.

   - Prepared the training design, syllabus, teaching aids and materials, program and administrative requirements for conducting the training course on "The Management of the FHSIS as a System".

   - Conducted various consultancy sessions for the regional FHSIS coordinators to improve their respective performance in FHSIS.

- o Provided technical inputs for the refinement of the FHSIS logistics system.

- o Physically participated in the monitoring activities of the management groups.

- o Conducted a series of workshops, separately for the FHSIS technical managers and for the FHSIS provincial coordinators, to:

  - prepare plans that would systematically consolidate data from the field

  - design parallel non-computer-based reporting to tap the field personnel to initiate such a system so that the outputs can be easily usable even by field people

  - finalized the designs of the simplified output tables (SOT).

- o Provided FHSIS management groups a set of recommendations on what to undertake in place of monitoring activities which, in 1992, had to be postponed due to lack of funds.

- o Assisted HIS in identifying parallel reporting being done in the field in connection with varying requirements of some central office programs and specifying solutions to the attendant problems.

- o Assisted HIS in the production of the 1991 output tables, and helped HIS design the simplified format of the output tables for easy use.

- o Prepared the draft of the "Guidelines for the Continuing Implementation of FHSIS", a set of instructions to be issued by the Secretary on how to continue FHSIS despite devolution; this was presented by the Acting HIS Director to the Regional Directors and was received favorably.

- o Provided technical assistance to the FHSIS national manager in dealing and communicating with the regional FHSIS coordinators.

- o Prepared a concept paper for updating and upgrading FHSIS through the setting up of a prototype laboratory in the province of Cebu, and included various technologies currently being tested in the DOH (particularly the geographic information system).

- o Prepared a proposal to seek funding for the development of a Local Government Information System (LGIS) laboratory in Cebu.

- o Met with various institutions -- National Computer Center (NCC), Development Academy of the Philippines (DAP), Technology and Livelihood Center (TLRC), and the National Statistics Office (NSO) to seek their participation and commitment to the LGIS Lab project. During the meetings, the RA received enthusiastic commitment and support from the institutions.

- o Caused the creation of a Management Committee (ManCom) which evaluated program requests for inclusion in FHSIS; participated in deliberations to include ARI and PIHES in the system.

3. TOR. *Assist in developing priority information systems, namely: central office health and management information data base; department-wide program budgeting system; logistics monitoring system.*

   PAAD. *Assist with the development of a central office computer capability for processing [FHSIS] data.*

   - o Provided direct assistance in the computerization of the reporting forms for NCR.

   - o Participated in ManCom meetings which decided on, among other things, the transfer of computerization responsibilities from MAS to HIS, the training of HIS staff in the processing of FHSIS, defining the period for the installation of FHSIS at the regional health offices.

   - o Assisted MAS in the preparation and finalization of the *FHSIS Computer Operator's Procedures Manual.*

   - o Assisted MAS in the selection of the appropriate RDBMS for the DOH; this RDBMS was used as the basic platform for the regional subsystem and subsequent systems to be developed for the DOH.

   - o Provided technical inputs to MAS in the installation of the regional subsystem, the development of the national subsystem, and the reformatting of the provincial subsystem.

   - o Provided technical inputs in the refinement of the FHSIS logistics system.

   - o Provided MAS prototype logistics system for use in the development of the DOH logistics system; was consulted by the DOH consultant rationalizing this system.

   - o Defined the information requirements, designed and supervised the development of the Targeted Areas Monitoring System (TAMS) for the Community Health Services (CHS) and the Projects Monitoring System (PMS) for the Project Coordinating Unit (PCU).

   - o Prepared for the MAS the Manual on Systems Development Standards which consists of a complete set of materials to serve as guidelines to MAS in developing information systems; prepared and finalized the documents of systems-related activities such as database management, terms of reference for proposals, etc.; prepared and finalized the manual for database management and initiated its development.

- o Participated in evaluating proposals for some systems development projects in the Department.

4. *TOR. Participate in information management-related activities and projects such as surveys, field investigations, and sentinel surveillance.*

   - o Assisted HIS in drawing up a Management Plan for the setting up of a population-based information system to complement FHSIS and consulted the National Statistics Office (NSO) Administrator regarding coordination and cooperation in the implementation of the Plan.

   - o Solicited NSO's assistance in assessing HIS staff capability and developing a training/retraining program based on the required skills that were identified.

   - o Provided inputs in the operations of the current hospital surveillance activity for notifiable diseases.

   - o Visited several regional offices to follow up on the production of the 1991 output tables; the RA also took the opportunity to get first hand information on the problems of the processing nodes, and while there, identified operational problems and solved many of these.

   - o Visited several provinces to help in the collection of data and eliciting opinions on implementing non-computerized processing.

B. DATA COLLECTION, ANALYSIS AND USE

1. *TOR. Assist in systematizing available data from surveys and administrative reports for baseline assessments and program reviews of the DOH service interventions comprising the Child Survival Program.*

   PAAD. ... development of an [FHSIS] monitoring and evaluation system.

   - o Designed the baseline monitoring system of FHSIS, prepared the computer programs and processed the results of the baseline monitoring which were submitted by HIS to the DOH management; it should be noted that all CSP programs are included in FHSIS.

   - o Assisted HIS staff in the design of the FHSIS regular monitoring scheme for data recording and reporting.

   - o Physically participated in the monitoring activities of HIS management groups which were in charge of specific geographic areas in the country.

   - o Assisted HIS staff in the analysis and interpretation of the results of data that resulted from the monitoring activities.

- o Reviewed the status of nationwide implementation of FHSIS with the program managers and directly assisted the management teams in troubleshooting in the provinces.

- o Assisted the HIS management groups in:

  - preparing profiles of regions, provinces and cities under each group's care;

  - defining the functions of each member;

  - outlining the group's activities in the field and training them to do these properly; and

  - finalizing the operations manual, among others.

- o Assisted HIS in identifying parallel reporting being done in the field instigated by programs who wanted more data from the field and specifying solutions to the attendant problems.

- o Visited various provinces to help in collecting 1990-92 data, introducing to provincial FHSIS users the simplified output tables, and elicit opinions on implementing non-computerized reporting among DOH field offices .

- o Assisted the Projects Coordinating Unit (PCU) in analyzing various program data that would be included in the quarterly assessment of progress towards achieving the CSP program benchmarks; helped PCU prepare the documentation of various benchmarks; such documentation included analysis, consolidation and packaging of these data.

2. TOR. *Assist in developing and testing indicators of efficiency, effectiveness and equity of Child Survival Program services.*

   - o Initiated moves with key staff of HIS toward presenting a modified reporting layout in the output tables by including only the relevant and useful indicators; this was done after lengthy discussions and negotiations with program managers.

   - o Assisted PCU in negotiating CSP indicators with program managers.

   - o Function was moved to Programs/Evaluation Advisor.

3. TOR. *Assist central and field managers in data-based decision-making and resource allocation and organize training activities designed to promote appropriate use of data for operational decision-making.*

   PAAD. *... training in the intended use of HIS data will also be needed.*

- Prepared a long term training program for FHSIS implementors enumerating the skills to be developed, the intended participants, the schedules and the resources required.

- Prepared the training design, syllabus, teaching aids and materials, program and administrative requirements for conducting the training course "The Management of FHSIS as a System".

- Conducted various consultancy sessions for the regional FHSIS coordinators to improve their respective performance in FHSIS.

- Provided technical inputs for the data utilization training.

- Provided technical advice to FHSIS management groups re their roles in teaching midwives how to use the output tables.

- Assisted HIS staff in the analysis and interpretation of the results of monitoring data.

- Provided FHSIS management groups a set of recommendations on what to undertake in place of monitoring activities which had to be postponed due to lack of funds.

- Oriented DOH provincial and regional planners on strategies for improving FHSIS to meet devolution requirements; also conducted a survey among them to determine the viability of continuing FHSIS among the DOH field personnel.

- Prepared a concept paper for updating and upgrading FHSIS through the setting up of a prototype laboratory in the province of Cebu, and included various technologies currently being tested in the DOH (particularly the geographic information system).

- Prepared a proposal to seek funding for the development of a Local Government Information System (LGIS) laboratory in Cebu.

- Met with various institutions -- National Computer Center (NCC), Development Academy of the Philippines (DAP), Technology and Livelihood Center (TLRC), and the National Statistics Office (NSO) to seek their participation and commitment to the LGIS Lab project. During the meetings, the RA received enthusiastic commitment and support from the institutions.

C. INSTITUTIONALIZATION

1. *TOR. Guide, monitor and evaluate programs in information-related policy and resource commitments of the DOH, particularly as these bear upon the performance-based evaluation of the Child Survival Program.*

- o Caused the creation of the FHSIS ManCom which is the policy-making body for FHSIS matters; the Operations Committee which oversees day-to-day FHSIS matters; the Management Team, which is composed of five management groups tasked with monitoring the implementation of FHSIS in the different regions. Participated in ManCom meetings which decided on, among other things, the transfer of computerization responsibilities from MAS to HIS, the training of HIS staff in the processing of FHSIS, defining the period for the installation of FHSIS at the regional health offices.

- o Conducted various consultancy sessions for the regional FHSIS coordinators to improve their respective performance in FHSIS.

- o Assisted the HIS Director, the Acting HIS Director and the HIS staff in preparing, finalizing, presenting, and defending the 1991, 1992, and 1993 HIS budget.

- o Assisted and provided inputs to PCU in its annual evaluation of CSP programs; such inputs included DOH policy and resource commitments to the information system.

2 TOR. *Serve as technical advisor to USAID and DOH on monitoring indicators of physical progress during annual program evaluation.*

- o At the request of USAID, prepared a scheme for the midterm evaluation of the CSP project; actively supported the midterm evaluation team in all its activities.

- o Actively assisted the DOH, through the PCU, in ensuring that all the annual CSP benchmarks would be met; in 1991 and 1992, was the CSP-TAT point person for making sure that each benchmark requirement was met by the respective DOH program to the satisfaction of USAID; oftentimes this involved personally doing the benchmark requirement himself for the program.

- o Provided technical assistance to the developer of the geographic information system (GIS) by defining the information requirements of the system.

3. TOR. *Prepare and execute an implementation plan approved by DOH whose objectives are to improve relevance and quality of information available for decision-making and to institutionalize these improvements at central and field levels.*

PAAD. *...work to develop DOH central staff capability to plan, manage and evaluate systems of data collection that are complementary to [FHSIS]*

- o Prepared and submitted to the Undersecretary/Chief of Staff an FHSIS Management Plan which served as the FHSIS benchmark submission for 1990 and which became the master plan for the succeeding activities of FHSIS; the Management Plan became the model for all succeeding FHSIS plans prepared by HIS and the regions. The Plan contained the following comprehensive

sections: Functions of the Operating FHSIS, the Operating FHSIS, Flow of Activities, Strengthening the Health Intelligence Service for FHSIS Maintenance, Maintenance Activities, Schedule of Activities, and Investment Requirements.

- o Defined the range of major and minor activities for FHSIS and their responsibility centers.

- o Assisted HIS in drawing up a Management Plan for the setting up of a population-based information system to complement FHSIS and consulted the National Statistics Office (NSO) Administrator regarding coordination and cooperation in the implementation of the Plan.

- o Solicited NSO's assistance in assessing HIS staff capability and developing a training/retraining program based on the required skills that were identified.

- o Prepared a management plan for 1993 - 1995 to assist incoming HIS Director define directions for the reorganized HIS; the plan also describes in acceptable detail the capability building program for HIS staff.

4. *TOR. Assist in developing an evaluation and monitoring model designed to measure the impact and progress of Child Survival programs and policies.*

   - o Together with PCU, designed a scheme to actively monitor performance of CSP programs toward achieving the nine CSP delivery targets in relation to meeting the annual performance benchmarks.

   - o Assisted HIS staff in the analysis and interpretation of FHSIS data particularly those that related to CSP programs. results of monitoring data.

   - o Function was moved to Program/Evaluation Advisor.

D. DEVOLUTION

The decentralization of health services to local government units, (LGU) brought about by the enactment into law of the Local Government Code (LGC), was not an anticipated development in the CSP-TAT TOR or the PAAD. It was. however, a reality which the RA had to pay attention to and exert much effort for as it had a direct bearing on his work. In this connection, and in support of the DOH, the RA accomplished the following:

- o Facilitated special consultative sessions with FHSIS implementors in the field to discuss the effects of the LGC on FHSIS down to the lowest facility level.

- o During provincial trips, held special sessions with Regional Directors, Provincial Health Officers, Municipal Health Officers and their staff to assess the effects of the devolution to FHSIS and the general reporting system.

- o Conceptualized alternatives to the reporting system in case of unlikely disruption of reporting by LGUs.

- o Oriented DOH regional and provincial planners on strategies for improving FHSIS to meet devolution requirements; also conducted a survey among them to determine the viability of continuing FHSIS among the field health personnel.

- o Prepared the "Guidelines for the Continuing Implementation of FHSIS", a set of instructions for issuance by the Secretary to all field health workers; this was presented by the Acting HIS Director in a National Staff Meeting to the Regional Directors who received it warmly.

- o Prepared a proposal to restructure HIS to equip itself for the demands of decentralization.

RECOMMENDATIONS

Since FHSIS has been the *de facto* public health information system for the Department, there is need in the very near future for DOH to accomplish the following:

A. <u>For the System Itself</u>

(1) Decide immediately what irreducible minimum and (non-expandable) set of indicators would be required of the system at the central level, at the regional level, and if it can be helped at the provincial, city, and municipal levels.

(2) Thereafter simplify further the system's various components that interface with the data generators and information users. This involves the Target Client List (TCL) and the reporting forms at the BHS and RHU levels and the output tables at the Provincial Health Office (PHO), LGU, and Regional Health Office (RHO) levels.

(3) Provide the PHO the necessary technical and content capabilities to be able to design subsystems that respond rapidly to Local Government Officials (LGO) information requirements at both the municipal and provincial levels. This means equipping the PHO system with the necessary tools and training the appropriate personnel. Personnel do not have to be required to be computer programming proficient. User-friendly software tools are already available and the Regional Computer Operator (RCO) is there to lend a hand at all times.

(4) Embark on enhancing the present software to include statistical analysis and information quality management. Right now, the system simply does data entry, processing [addition, some percentage computations, layouting], and production [printing output tables which are basically mirror images of data submitted]. It does not yet have the capability to crosstab data-of-so-many-months with data-of-so-many-programs which will be required of the system soon given the database that it has built.

(5) Develop the system's innate capability to use multi-media for presenting data to LGOs: maps, graphics, etc.

B. Structure

(1) To coordinate all the activities and requirements of the system, continue to assign the management of the FHSIS to HIS.

(2) To cope with the new demands on the system, modify the mandate of HIS to include the routine and non-routine information systems and the analysis and assessment of health data.

(3) Support HIS in its efforts to upgrade its staff technically.

(4) Retain the Regional FHSIS Coordinator (RFC) and the Regional Computer Operator (RCO) and make the nucleus of an information management group in the region. Together with other regional information management groups they must form a network with HIS.

(5) Strengthen the Provincial FHSIS Coordinator (PFC) and PHO Computer Operator (PCO) through constant capability-building activities sponsored by the RHO and HIS. The PHO must also be provided the tools to be able to respond to LGO information requirements.

(6) The MHO, Public Health Nurse (PHN), and the midwives should be given refresher courses from time to time. This will update them on FHSIS processes, keep them in touch with FHSIS development, and give them information on tools available to them in their support of LGOs.

- o The HIS, the RHO and the PHO must always make their resources available to LGOs.

C. Computerization

(1) Require HIS and MAS to continue looking for ways to improve the software being used in processing FHSIS data.

(2) Require HIS, assisted by MAS [which is the primary subcontractor for FHSIS computerization], to manage the computerization activities of the system. MAS should not do computerization without coordinating with HIS.

(3) Require HIS, not MAS, to monitor all computers in the field. It then informs MAS of maintenance problems.

D. Leadership

(1) Retain, encourage and support the present National FHSIS Coordinator as he is in a position to chart the course of FHSIS.

(2) Require the OPHS programs, IPS, MAS, LGAMS, PCU, and other offices with working relations with HIS to support HIS and the National FHSIS Coordinator in his management of the system and give him the resources to pursue the improvement of the system.

(3) Assert influence by requiring the HIS leadership to update the Department on FHSIS performance and require the HIS to test the framework for health analysis and assessment regularly.

(4) Define for HIS the framework by which it wants the nation's health analyzed and assessed.

(5) As FHSIS covers many levels and involves many functions, require FHSIS leadership to be aware of the following to be effective:

- *Be forward-looking*: Be mindful of future requirements; be anticipatory, not lagging behind in forceful recommendations to DOH management; be proactive not reactive.

- *Be quality oriented*: Information and knowledge being the wealth of an organization, the leaders must insist on accuracy, consistency and comprehensiveness. To do this effectively leaders must grasp what is really needed better than anybody else.

- *Be value driven*: Recognize to what extent information increases the credibility of the DOH, how much the information produced by the system influences the direction health care should take, and how effective indicators measured by the system input are to the assessment of the well-being of the nation.

- *Be results seeking*: Strive to meet what was promised and be obstinate about expecting outputs delivery when due.

- *Be thorough in outlook*: Understand that analysis is an expected activity in the system, and that those who lead must therefore make sure that the framework and reasons for analysis are well-established; that the tools for analysis are learned and in place; and that all requirements are anticipated well in advance.

- *Be conscientious of linkages*: Know that FHSIS cannot exist alone and that it cannot operate without dependence on other systems which are part of the health network. Therefore the leadership must examine the areas where cooperation must be sought and interconnection effected to enhance the value of the system's information.

E. Government network

(1) Share the FHSIS database, which is a rich resource, with other government agencies. HIS and MAS must therefore equip themselves technologically to allow other government agencies access to these databases.

(2) Require HIS to be aware, at the same time, that it needs to access the databases of other government agencies for its analysis and assessment work. It must therefore equip itself technologically to be able to access these databases.

(3) Subscribe to the efforts of government to establish a communication network among different agencies -- including the regional, provincial and city offices -- by offering its resources and supporting the development and maintenance of this network.

PROGRAMS & EVALUATION

A. SCOPE OF WORK

1. ACHIEVEMENT OF 1993 SERVICE DELIVERY GOALS

The Resident Advisor (RA) worked closely with Maternal and Child Health Service (MCHS) and Family Planning Service (FPS) in measuring and tracking the accomplishment of the 1993 service delivery targets set by CSP. On 3 of the service delivery targets, data is missing and will be available from the Demographic and Health Survey (DHS). Of the remaining 6 service delivery targets, 5 seem to have been met and on the 6th, tetanus toxoid immunization coverage, very considerable progress has been made. A more detailed presentation of the results of the service delivery goals is attached as **Annex 1.**

2. EPIDEMIOLOGICAL ASSISTANCE TO MATERNAL AND CHILD HEALTH SERVICE (MCHS)

The RA worked closely with MCHS in developing objective tools and using these in field evaluations. This included a post-NID coverage survey and evaluation of hospitals regarding maternal mortality, and a study of the performance of trained hilots.

3. SUPERVISION AND MONITORING

The RA worked very closely with the Office of Public Health Services (OPHS) and Health Intelligence Service (HIS) in developing an integrated supervisory checklist and supervisory system which is now in use throughout the Philippines with good results.

4. PROGRAM INTEGRATION

The RA helped to ensure that activities such as supervision and logistics support were provided in an integrated fashion. He also tried to ensure that activities of different services were brought together, such as micronutrient supplementation being integrated into EPI service delivery.

B. SPECIFIC AREAS OF INVOLVEMENT

1. INTEGRATED SUPERVISORY CHECKLIST (ISC)

BACKGROUND

In 1990, a field investigation of existing supervisory checklists was carried out by HIS staff. This investigation showed that in three regions there were a total of more than 25 separate supervisory checklists. On average, they were 4½ pages long, contained 90 different items to be checked, and were designed in such a way as to make follow-up difficult. Although the checklists existed in profusion, they were rarely used and few filled-up copies could be found in the offices of provincial program coordinators, district nurse supervisors, or public health nurses (PHNs).

Based on the absence or lack of a systematic supervisory tool, HIS staff, the RA, and the staff of the OPHS developed a supervisory checklist that examined 20 separate items related to public health programs and scored them from 1 to 5 based on very objective and clear criteria.

ACCOMPLISHMENTS

The ISC was extensively pilot tested in Cavite province prior to a formal field test in four remote provinces: Kalinga Apayao, Basilan, Zamboanga del Sur, and Northern Leyte. Six provinces from the same region were used as control area, and a baseline survey was conducted in randomly selected health facilities in all ten provinces. The ISC was carried out in the four experimental provinces and a follow-on health facility survey was carried out six months later. The follow-on survey showed that midwife performances judged by the total score on this checklist had improved 42% compared to an 18% increase in the control area.

Based on the results of the field test, the ISC was implemented nationwide. HIS staff trained more than 4,500 PHNs and Municipal Health Officers (MHOs) in the use of the ISC. All the health facilities in the country were provided with the health facility version of the ISC and the supervisor's version was provided to more than 6,000 different supervisors including provincial program coordinators and district nurse supervisors.

A long-term follow-up of the implementation of the ISC in one of the provinces that had been used in the field test, Zamboanga del Sur, indicated that the ISC was still being used 2 years after initial implementation. It is not clear whether that will be possible in the rest of the country, however, a health facility survey by HIS indicated that it was being used in more than 50% of health facilities in the rest of the country. The same survey indicated that the improvements in midwife performance was directly proportional to the amount of supervision that was carried out.

The health facility survey also showed that only 35% of health facilities were receiving regular supervision, but that those health facilities were performing remarkably well.

ISSUES AND PROBLEMS

The low level of supervision currently seen in the field seems to be due to people being busy with the NIDs and a lack of emphasis on supervision coming from the provincial level. While there is a substantial decrease in the amount of Transportation Expense Vouchers (TEVs) available for PHNs, it seems that the presence or absence of TEVs does not explain the amount of supervision carried out. Where provincial program coordinators visited RHUs and BHSs and looked into the PHN's blue copy of the supervisory checklist, there was frequent supervision carried out.

RECOMMENDATIONS TO THE DOH

1) The ISC should be discussed at the National Staff Meeting.

2) The ISC should be included on the checklist given to central office staff when visiting the provinces as part of their routine monitoring.

3) Letters will have to be written to Provincial Health Officers (PHOs) to encourage the routine use of this ISC.

4) The ISC will have to be revised to include new programs such as Control of Acute Respiratory Infections (CARI) and new definitions that more closely agree with program guidelines.

2. LOGISTICS

BACKGROUND

There have been numerous attempts in the past to deal with the issue of logistics in the DOH. In 1988 a large study called "LOGDAMS" was carried out to analyze what the problems were in terms of ensuring adequate drugs and supplies in peripheral health facilities. Inspite of the generally agreed upon recommendations few actions were actually implemented by the DOH. This happened despite the widespread acknowledgement that logistics and supplies was the achilles' heel of almost all the DOH programs.

ACCOMPLISHMENTS

A committee was established shortly before the transition to the current administration, which examined issues of logistics and supplies and made some recommendations. One of the most important of these was the hiring of a Filipino consultant to work full time with the Office of Management Services to improve procurement systems. This consultant has been particularly helpful in sorting out the difficult problems that the DOH faces.

The RA helped the Field Epidemiology Training Program (FETP) carry out a logistics survey which provided the first field level data on availability of supplies at RHU and BHS level. This showed for instance that more than 60% of facilities had no cotrimoxazole even though it is an essential part of the CARI program. On the other hand, some programs such as Control of Diarrheal Disease (CDD) have done quite well and there were only 10% of facilities that were out of stock of Oresol (ORS).

The Family Planning Service (FPS) in coordination with CARE has established a logistics system for delivering family planning supplies to RHUs throughout the country. The RA worked with FPS and others to ensure that at least a few key drugs were included in that system.

ISSUES AND PROBLEMS

While it appears that distribution may be improving there is still a need to streamline procurement and ensure that there is sufficient funding for drugs and supplies. This is particularly challenging under devolution where the responsibility for funding will be at least partly that of the LGU's.

RECOMMENDATIONS TO THE DOH

The DOH needs to agree on which drugs it will fund centrally and the mechanism by which it will do that. It also needs to develop a short, preferably less than 25 items, list of medicines essential for the working of a BHS and RHU. Hopefully, this list would prevent local governments from purchasing useless or harmful drugs.

3. FIELD HEALTH SERVICES INFORMATION SYSTEM (FHSIS)

BACKGROUND

The FHSIS represents an attempt to make systematic recording uniform throughout the country. The system began development in 1988 and, by April of 1990, was implemented on a nationwide basis. It is now to the point that there is one standard way of doing recording and reporting from one end of the country to the other.

ACCOMPLISHMENTS

The RA helped particularly with the simplification of output tables so that they more accurately reflected what the program managers needed to know. Also, an attempt was made to ensure the continuation of the FHSIS by supplying every health facility with a standard target client list over the next year. This would reduce recurrent costs, roughly ₱1 million per year.

The FHSIS seems to be working very well at field level. It provides accurate information as far as can be judged by household surveys and health facility surveys, and is widely used by PHNs and MHOs in judging the performance of the midwives.

ISSUES AND PROBLEMS

The major problem with the FHSIS has been the computerization and the generation of output tables for the use by managers at all levels.

With devolution there was some concern that the FHSIS may not be maintained, however initial analysis a few months after devolution has taken place indicates the FHSIS continues to be used throughout the country.

RECOMMENDATIONS TO THE DOH

1) The DOH should continue supporting the FHSIS to the tune of about a million pesos per year for the next 4 or 5 years at least.

2) The DOH should also contract out to a specialist computer firm the development of an integrated and simple system to analyze the data that does come out of the FHSIS at peripheral level.

4. DATA UTILIZATION

BACKGROUND

The establishment of the FHSIS and other information generating activities such as FETP is founded on the belief that managers can use data to make decisions about their programs. A study conducted in early 1990 in regions 1, 2 and CAR indicated that, in fact, many mid-level managers had considerable problems examining tables, looking at graphs, and using data to make management decisions. This same study also showed that managers generally did not know which of their areas were performing well and which were performing poorly as based on objective quantitative data.

ACCOMPLISHMENTS

The RA carried out a needs assessment and discussed the problem widely within the DOH. An article by the RA on this issue of data utilization by managers was accepted for publication in the International Journal of Epidemiology.

Based on the findings of the needs assessment, training modules were developed and training of all MHOs and PHNs in the country took place. This training focused on the use of tables and cumulative graphs such as the EPI cumulative graph recommended by WHO.

The training was very difficult to carry out because there was a shortage of skilled trainers in this particular area.

An evaluation by HIS indicated that the knowledge of nurses in regards to tables and simple graphs improved over that which had been found during the initial training needs assessment. However, there was a disappointing improvement in the knowledge about cumulative graphs.

ISSUES AND PROBLEMS

The whole area of data utilization is a difficult one and certainly an area that requires long-term commitment in order to see improvement. While there has been some small progress made it appears that there are still few program managers who can easily interpret data and have facility with quantitative measures.

RECOMMENDATIONS TO THE DOH

The DOH should develop a logbook for PHNs and MHOs which takes them through an analysis of different aspects of program performance in a systematic way so that they can get the most out of the data coming from the FHSIS.

5. NATIONAL IMMUNIZATION DAYS (NIDs)

BACKGROUND

The government of the Philippines agreed to eradicate polio by the year 2000. The National Immunization Days were seen as a supplement to routine immunization, an effort to increase coverage, and increase the seroconversion of children by giving more doses. In addition to polio vaccination, the NIDs also included tetanus toxoid for women of child bearing age, measles vaccine for children 9-24 months, DPT and BCG.

ACCOMPLISHMENTS

The RA worked closely with the people in EPI on technical issues, organizational matters, and monitoring and supervision. The NIDs were a smashing success and a post-NID coverage survey indicated that 90% of Filipino children under 5 years old had been immunized on the second NID, with coverage on the first NID at 88%. As far as the RA knows, these are the highest such coverage figures ever achieved in this kind of activity.

ISSUES AND PROBLEMS

While polio immunization was stunningly successful, there were many missed opportunities for measles immunization and tetanus vaccination. The inclusion of other antigens such as DPT and BCG also interfered with the successful implementation of the NIDs nationwide.

RECOMMENDATIONS TO THE DOH

1) The guidelines for NID need to be simplified to focus just on OPV, measles, Vitamin A, and tetanus toxoid. Much progress has already been made in this area.

2) The use of home visits prior to the NIDs by health workers and BHWs proved to be a remarkably effective tool in assuring high turnout. The DOH needs to ensure that this activity occurs during the next NIDs.

3) The DOH needs to ensure that enough funds are available for the procurement of vaccines, needles and syringes. It appears that the DOH is willing to commit ₱270 million in 1993 for NIDs. This should certainly attract donor support.

6. MICRONUTRIENTS

BACKGROUND

More than 8 randomized community trials have now shown the efficacy of Vitamin A supplementation in terms of reducing overall infant and child mortality. The evidence supporting widespread use of Vitamin A is now the strongest for any of the child health interventions. There is also strong evidence that Iodine supplementation for women and children may also be very helpful in terms of ensuring normal psychomotor development.

ACCOMPLISHMENTS

The RA working with MCHS, Nutrition Service and HKI ensured that Vitamin A was given to all children coming for measles immunization during the routine EPI sessions held every Wednesday.

The RA and the CSP Chief of Party were also responsible for the inclusion in the NIDs of Vitamin A. During the May 1993 NID, 200,000 I.U. of Vitamin A was given to all children 12-59 months of age. The post-NID coverage survey indicates that 75% of all children received the dose of Vitamin A.

The RA also helped push forward the National Micronutrient Day (NMD) activities. This activity would give the second dose of Vitamin A to all children who had gotten it the first time and also ensure that mothers received Iodine capsules.

ISSUES AND PROBLEMS

The only foreseeable issue is continued funding support for Vitamin A and Iodine.

There is also some concern that the NMDs need considerable attention in order to be as much of a success as the NIDs were.

RECOMMENDATIONS TO THE DOH

1) A full time person dedicated to looking at the long term solutions to micronutrient malnutrition such as food fortification is required. This would be an area where technical assistance may also be required seeing as there is very little experience in the Philippines with food fortification.

2) The DOH also needs to ensure continued funding support for Vitamin A and Iodine to be used as part of the NIDs and the NMDs.

7. MATERNAL CARE

BACKGROUND

The Philippines has a reasonably high maternal mortality rate (MMR) estimated to be between 100 and 200 per 100,000 live births. A maternal mortality survey conducted as part of the Demographic and Health Survey (DHS) should provide the most accurate estimates for the MMR. In the past, the Maternal Care (MC) program of the DOH has lacked focus and direction.

ACCOMPLISHMENTS

The RA worked closely with the MC division for a year and a half trying to get the division to focus on improving prenatal and postpartum care. A Home Based Maternal Record (HBMR) was developed and field tested and proved to be a useful tool for improving the quality of prenatal care. The coverage of prenatal care also seemed to increase during the three years of the CSP although clear data will only be available through the DHS.

A manual of operations for midwives regarding prenatal, obstetrical and postpartum services has been developed by the DOH at least partly with the assistance of the RA. The manual is close to being completed and will be field tested and printed by the end of 1993.

A number of studies have been carried out looking at quality of care and cause of maternal mortality. Together with the FETP national surveillance system, maternal mortality reporting from all the sentinel hospitals was begun.

ISSUES AND PROBLEMS

The single biggest issue facing MC is the lack of scientific basis for interventions to be carried out. For example, there is still no evidence that increased and improved prenatal care actually decreases maternal mortality.

From a number of studies carried out by the DOH and FETP, it appears that the quality of care provided by government hospitals is fairly low and needs to be improved, particularly in peripheral areas.

RECOMMENDATIONS TO THE DOH

1) A high level task force needs to be set up to examine ways of improving obstetrical care in government hospitals. It does not seem that the lack of supplies explains the high mortality rates observed in women who have been in the hospital for more than 48 hours.

2) Until better scientific evidence is available, the DOH should still continue on improving the quantity and quality of prenatal services. Prenatal care may serve as a vehicle for the delivery of interventions once they become widely

accepted. For example, low dose aspirin for the prevention of pre-eclampsia would have to be provided probably through prenatal services.

8. WORK WITH FETP AND OTHER OFFICES ON DATA COLLECTION

BACKGROUND

The FETP was established in order to give the DOH its own capacity to carry out epidemiological studies. There has also been efforts on the part of other services such as MCHS to carry out household surveys to assess program performance.

ACCOMPLISHMENTS

The RA worked closely with FETP on a number of different studies particularly related to program evaluation. FETP had focused primarily on outbreak investigations.

The RA also helped the FPS develop the skills to carry out cluster surveys based on the WHO EPI methodology to measure quickly and easily the Contraceptive Prevalence Rate (CPR) at province level.

RECOMMENDATIONS TO THE DOH

1) FETP and its activities are crucial to the proper management of programs, and it needs to be institutionalized.

IEC/SOCIAL MARKETING

I. INTRODUCTION

The objective of the IEC/Social Marketing(SM) of the Child Survival Program (CSP) has been to increase the demand for child survival services among the public through the increased understanding and use of modern communications, social marketing and behavior analysis and thereby and in the reduction of infant morbidity and mortality. The IEC/SM component of the CSP continued the work begun by the DOH's Public Information and Health Education Service (PIHES) in partnership with USAID under the Philippines Communications for Child Survival Project (HEALTHCOM) from 1988 to 1990. Resident Advisor Jose Rafael Hernandez provided technical assistance to the DOH under CSP from August 1990 to May 1993 continuing his work begun with the HEALTHCOM Project.

The use of social marketing had proven successful in creasing immunization rates between 1989 and 1990 during the EPI/Measles campaign conducted with assistance form HEALTHCOM. The IEC/Social marketing methodology combines a fundamental focus on the clients— their beliefs, attitudes, behaviors, and practices— with a systematic approach for managing the process. This approach consists of a five-step process of 1)assessing the problem, 2) planning the strategy, 3) developing and testing the materials and elements of the plan, 4) implementing the activities, and 5) evaluating the results using feedback to refine the program. This project continued to utilize and refine this IEC/Social Marketing methodology.

II. ACCOMPLISHMENTS

The major accomplishments of the IEC/SM component can be distinguished by two categories: institutionalization of the social marketing process within the DOH and specific, successful applications of social marketing.

A. Institutionalization

In 1987 the DOH created the Public Information and Health Education Service to develop and implement public education on health issues. The IEC/SM Resident Advisor assisted the PIHES to understand and utilize a social marketing approach to health education which draws upon the disciplines of communications, behavioral analysis, marketing, instructional design and anthropology to promote changes in health behavior.

Through on-the-job training, orientation sessions, and workshops the PIHES and child survival managers developed the capability to plan and execute systematic communication strategies. PIHES focused on training in strategic thinking, communication planning, market research and project management. The PIHES staff received practical on-the-job training on the EPI and Control of Diarrheal Disease (CDD) campaigns. A workshop on formative research, one of the foundations of social marketing, was developed and conducted with assistance from the IEC/SM RA, Dr. Robert Hornik, the research firm TRENDS, Frank Small and Associates, Kabalikat, and the PIHES and was instrumental in creating an awareness and appreciation for the

value of social marketing among the PIHES staff, health educators and information officers of various health offices early on in the project.

The project also assisted the PIHES to institutionalize the process and the capability to identify and contract private sector organizations to handle the communication needs of the Department. This includes using local research firms to conduct Knowledge, Attitudes and Practices (KAP) studies on Polio/Tetanus Toxoid (TT) and Breastfeeding and advertising forms contracted for the EPI and CDD campaigns. This shift to using the private sector required imparting management skills to PIHES staff so that they could become communication program managers rather than only implementors.

The use of social marketing expanded beyond the child survival programs within the DOH indicating a more widespread adoption of social marketing as a tool to accelerate demand for health services and an acceptance of the value of working with the private sector in improving health status. Program managers with responsibilities in MCH, Nutrition, Family Planning, Tuberculosis, Malaria, etc. were included in workshops on the planning and execution of schistosomiasis, Tuberculosis (TB), Environmental Health/Excreta Disposal and Voluntary Blood Donation programs to follow the social marketing process in the design and execution of their communication campaigns.

The Behavior Change Benchmark workshop was held in July 1992 with the DOH to identify the key behaviors of health clients and health providers in Breastfeeding, Weaning, CDD, EPI, Acute Respiratory Infections (ARI), and Family Planning and to formulate strategies for promoting these core behaviors. Program priorities were jointly set and an integrated approach to changing consumer health behavior was agreed upon. One of the milestone to come out of this workshop was the agreement to change from an approach focused on separate vertical programs to a "mother and child paradigm" approach which integrates the key behaviors necessary for a health child.

B. Application of Social Marketing

EPI

In order to maintain the momentum of the National EPI/Measles campaign started under HEALTHCOM, the CSP assisted the DOH to develop and conduct the follow-on National EPI/Measles campaign launched in November 1991. New creative materials were developed and translated into five dialects in addition to Tagalog. "Sales Conferences" and "Echo Sales Conferences," originally tested in the pilot campaign, were used again to provide orientation to the project staff involved in each region and to initiate the "kick off" activities. Video materials were developed and produced for use by the Public Health Officers/Health Educators at the echo sales conferences.

The DOH decided to continue the successful EPI campaigns focusing next on using polio as the "hook" to bring people in to be immunized. The baseline

research on polio and TT began in 1991 including focus group discussions among housewives to determine their knowledge, attitudes, and practices. In 1993, two National Immunization Days were the focus of the EPI/Polio campaign: April 21 and May 19, 1993. The RA was actively involved in the creative development of the campaign and soliciting private sector support. Procter and Gamble Philippines donated radio and TV commercial airtime to the National Immunization Day campaign for three weeks worth ₱3 million. Both Immunization Days went very well judging from the media exposure; newspapers and various reported that the DOH surpassed the immunization targets set.

CDD Campaign

PIHES, with the assistance of HEALTHCOM conducted an extensive CDD market assessment and designed a CDD communications strategy involving two modules: the first to lay the groundwork by explaining the concept of dehydration and emphasizing its dire consequences and the second to promote the product that can "rehydrate" the child. The first, Module A, was launched in November-December 1991, to create awareness and understanding of dehydration using the concept of an "accomplice" (Kasabwat) to diarrhea.

Module B to promote Am for prevention of dehydration and Oresol for treatment was designed, materials were prepared and pretested including radio and TV spots, print and point of services items, and scheduled to take place in 1992. However, the campaign has been delayed due to administrative difficulties with the private sector contracts. At the end of March 1993 it appeared that the contractual issues had been resolved to the satisfaction of the DOH Legal Services and the CDD Module B could soon be implemented.

IEC Kit for Midwives

The PIHES is nearing completion of the Midwives Integrated Communication Aid for Child Survival (MICACS) as pretesting was completed and the results submitted in June to the research from TRENDS for analysis. The MICACS, developed with the input of midwives attending four regional workshops, integrate various health messages to be imparted by the midwife to the mother. the materials were pre-tested with midwives and mothers and it was determined that three separate versions would be necessary including special ones for Muslim and CAR publics. It is projected that the MICACS will be completed and available for distribution nationwide by the end of 1993.

Health News

The RA worked with the media to popularize health education by promoting health news on radio and TV. A 12-month program Health News/Report on-the-Air negotiated with Channel 13 started September 1992. The daily health/medical news report was promoted by a primetime 30-second spot by Health Secretary Juan M. Flavier inviting TV viewers to watch the 5-7 minute health tips every day at 5:30 p.m. In addition Channel 2 has aired monthly health shows.

Project Video

The Academy for Educational Development (AED) produced a video for USAID on the Child Survival Program's successful use of program mode of assistance. The video is intended to promote the use of program mode of assistance and the performance-based disbursement mechanism to create an environment in which real partnership in development is possible. the video has been well received already by USAID/Washington.

III. FACILITATING AND INHIBITING FACTORS

A. Facilitating Factors

The DOH's own recognition of the need to institutionalize a systematic health communication methodology has been the most important facilitating factor for the IEC/Social Marketing component of the CSP. The DOH learned through the EPI and CDD campaigns that strategies for institutionalizing public health social health marketing must be initiated at the onset of a project beginning with an assessment of the health problem and incorporating the client's perspective. IEC/social marketing campaigns involving the private sector have been utilized by the DOH in areas other than child survival—tuberculosis, malaria, schistosomiasis, environmental health, and voluntary blood donation indicating the acceptance of this methodology to increase demand in health services.

B. Inhibiting Factors

In order to implement timely and effective social marketing programs, the DOH public bidding process needs to run smoothly and efficiently. the PIHES staff have developed their ability to be communication program managers. It is mostly the complicated bidding and contracting process that has hampered their ability to complete programs such as the CDD Module B campaign.

Over the life of this contract, changing personnel in the procurement office has required revisions to contracts and prolonged the bidding process. Sometimes these delays meant the activities were not completed within the funding period and funds had to be returned. A shortage of paper at one point delayed production of print materials since the bidding process had to be repeated to include the supply of paper. Slow payments by the Government caused the suspension of project activities when funds were not available to pay KBP. Changes in the government administration have contributed to project delays as well. Questions about the legality of previous contract bids even after they were cleared with the DOH Legal Service and Internal Audit during the previous administration caused the suspension of the CDD Phase II campaign.

IV. RECOMMENDATIONS

The PIHES has the talent and the capacity to develop nd manage successful IEC/Social Marketing programs. However, the problems encountered in the EPI and CDD campaigns need to be resolved. The complicated bidding and contracting process needs to be streamlined in order to effectively employ the private sector and the media in health communications. Contracts must be executed and paid on time.

In addition to improving the administrative processes, it is recommended that attention be paid to the human resources required to continue to provide effective health communications. Newly trained health personnel must be given further opportunities to practice their IEC skills in order to keep them challenged. Lastly, leaders within the DOH who will build upon the successes of the last five years of IEC/social marketing must be identified and encouraged to promote social marketing as a means to continue improving health-related practices.

ADMINISTRATIVE REPORT

Andersen Consulting was tapped to provide financial and administrative management of the Child Survival Program. The scope of assistance covered the following areas:

- *management of local resources* - to ensure that appropriate local resources are harnessed to support the requirements of the project;
- *financial management of local currency component* - to ensure the orderly management of local funds for the requirements of the project; and
- *general office supervision* - to ensure the organized conduct of office activities and smooth flow of operations

ACCOMPLISHMENTS

Management of Local Resources

1. Local Staff

By June 1991, the hiring of local office staff for the CSP was completed. With the assistance of the Office Manager, applicants for the secretaries and drivers were interviewed and evaluated prior to selection.

Job descriptions for the various positions were developed. These served as guidelines regarding the principal functions and responsibilities of the technical manager, office manager, secretaries, and drivers/messengers.

A Performance Review Report was developed to provide a basis for evaluating the performance of the local CSP staff. The evaluation which is due on an annual basis, serves as a basis for determining merit increases.

A Compensation Plan for the local CSP staff which outlines the compensation and benefits for the various positions was developed and subsequently approved by the Contract Services Office of USAID, Manila.

2. Short-term Technical Assistance

Local consultants were contracted by CSP to provide assistance in various areas, as shown below.

Consultant	Project
Marilyn N. Gorra	Development of a Manual for Area Program-Based Health Planning

Consultant	Project
Antonio P. Santiago	Identification of Appropriate Mechanisms for Private Sector Participation in Health Planning and Implementation
Beaulah P.Taguiwalo	Document Editing and Publications Development of the Child Survival Program
Rhais M. Gamboa	Assessment of the Field Epidemiology Training Program Component of the Primary Health Care Financing Project
Milagros F. Silva	Preparation of the Financial Aspect of the Logistics Action Plan for the Department of Health

3. **Participant Training, Analytical Research, and Publications**

Research organizations, management firms, and consultants was tapped to conduct studies and surveys in response to requirements of the CSP. **Attachment 1** summarizes projects and activities funded by the CSP for Participant Training, Analytical Research, and Publications.

4. **Workshops**

Over the duration of the program, the CSP has participated and/or funded workshops, a complete list of which is shown in **Attachment 2.**

Financial Management of Local Currency Component

1. **Opening of Bank Account**

A peso checking account at Far East Bank and Trust Company was opened for the exclusive use of the CSP. A balance equivalent to US$40,000.00 which was estimated to cover approximately two months of the program's requirements was maintained. Cash disbursements were replenished monthly by MSH/Boston.

2. **Setting Up of Systems and Procedures**

Systems and procedures were established in relation to the processing of requests for cash advance and liquidation reports and administration of a petty cash fund. With inputs from the Office Manager, improvements were put in place to better address the requirements of the program.

A financial information system was implemented using MSH accounting forms, records, and reports. To provide internal control over expenditures, the following steps were instituted:

a) Requisition slips, purchase orders, and other authorizations for expenditures were required for the processing of payments.

b) Commodities and services received were inspected and approved before further processing could be made.

c) Billings and invoices submitted by the vendors were reviewed thoroughly for correctness of prices and extensions.

d) The accounts payable voucher was prepared after documentation to support billings and invoices was deemed adequate. Supporting documents were stamped "PAID" to avoid possibility of their being presented later in support of another billing, claim voucher, check, etc.

e) The check was prepared only after the accounts payable voucher was approved by the Chief of Party.

3. **Preparation of Financial Reports**

At the end of the month, AC consolidated the transactions of the CSP and submitted the Accounting Package to MSH/Boston. The package consisted of the following documents:

a) Top Sheet (a summary of expenditures to date);

b) Estimate of Monthly Financial Requirements;

c) Bank Statement;

d) Account Reconciliation Form;

e) Check Book Register Form;

f) Deposit Register Form;

g) Field Expense Summary;

h) Time Sheets of the CSP Chief-of-Party (Dr. Solter), Health Information Systems Advisor (Mr. Sta. Maria), and Programs/Evaluation Adviser (Dr. Loevinsohn);

i) Report on Advance Account; and

j) Accounts Payable Vouchers.

General Office Supervision

1. **Office Systems and Procedures**

Office systems and procedures were established in relation to the purchase of equipment and office supplies, use of project vehicles, recording of office communications, monitoring of photocopying activities. Together with the Office Manager, the systems and procedures were reviewed periodically and improvements were introduced when necessary.

2. **Inventory of Equipment and Furniture**

Over the life of the program, the CSP regularly updated the inventory report which contained the following information: description of equipment or furniture, acquisition cost, property number, physical location or person in-charge of the equipment or furniture.

The final inventory report for the CSP is shown in **Attachment 3.**

CHILD SURVIVAL PROGRAM
PROJECTS AND ACTIVITIES FUNDED UNDER PARTICIPANT TRAINING, ANALYTICAL RESEARCH AND PUBLICATIONS

1. Evaluation of Module B Campaign in the Control of Diarrheal Diseases communications pilot area.

2. Health care financing Benchmark Studies

   - o An Evaluation of the Philippine Medical Care Commission/Health Maintenance Organization (PMCC/HMO) Tie-Up Project
   - o Strengthening the HMO Industry through Regulation
   - o Policy, Regulatory, and Political Framework for Health Services Privatization
   - o A Study on Cost Containment in Department of Health (DOH) Hospitals
   - o A Study on User Fees/Cost Sharing in DOH Hospitals
   - o National and Local Government Shares in Health Care Financing
   - o Uses and Sources of Funds for Child Survival Interventions
   - o The Role of the Community Health Service in Public-Private Sector Collaboration
   - o Development of an Agenda for Public-Private Sector Collaboration
   - o PMCC/HMO Tie-up: Second Evaluation

3. Data gathering and documentation for the CSP mid-term evaluation

4. Dr. Mariquita J. Mantala as consultant and liaison between the DOH-Project Coordinating Unit and CSP

5. Integrated Supervisory Checklist Project

   - o Printing of the Health Facility and Supervisory Checklist Manuals
   - o Training on the use of the checklists
   - o Evaluation of the checklists

6. Preparation of the Implementation Guidelines/Briefer/Manual

7. National Immunization Days (NID)

- o Printing and distribution of materials for NID
- o Conferences and caucuses for broadcasters and NGOs
- o Communications

8. Institutionalization of CSP through Devolution

9. Midwives Integrated Communications Aid for Child Survival

10. Invitational travel to conferences and seminars of

- o USec. Tomas Maramba
- o USec. Jaime Galvez-Tan
- o ASec. Linda Milan
- o Dr. Lourdes Casimiro
- o Dr. Wilfredo Asoy
- o Dr. Jose Miguel Vergara

11. CSP publications

- o Area Program-Based Health Planning Manual
- o Clinical Manual
- o CSP monographs

CHILD SURVIVAL PROGRAM
WORKSHOPS

WORKSHOP	DATE	VENUE
CSP Technical Assistance Team Workshop	January 16-17, 1991	Development Academy of the Philippines
CSP Policy Matrix Indicators Workshop	January 23-24, 1991	Research Institute for Tropical Medicine
Assessment of the Area Program-Based Health Planning Workshop	February 5-8, 1991	Research Institute for Tropical Medicine
FHSIS Consultative Workshop on Regional and National Expansion	March 5-7, 1991	Research Institute for Tropical Medicine
CSP Benchmark Consultative Meeting	July 9, 1991	Population Center Foundation
Formative Research Workshop	July 11, 1991	Department of Health
Presentation of the Case Study Evaluation Report for EPI	July 12, 1991	Manila Pavilion
DOH-CSP Team Building Workshop	August 1-2, 1991	Development Academy of the Philippines
Joint Meeting of the CSP-TAT and the DOH on the Technical Assistance Requirements of the DOH	August 28, 1991	Asian Institute of Tourism

WORKSHOP	DATE	VENUE
Comprehensive Maternal and Child Health (CMCH) Forum on the Overview of the CSP and Update on the Program Activities	September 26, 1991	Department of Health
Internal Planning Service - Second Phase of Core Group Training	September 30-October 6, 1991	Development Academy of the Philippines
Annual Benchmark Review	November 6, 1991	Philippine Trade Training Center
Presentation of the CSP Mid-term Evaluation Team's Findings and Recommendations	November 8, 1991	Philippine Trade Training Center
FHSIS Workshop	November 15, 1991	Manila Pavilion
CMCH Forum on the Comprehensive Nutrition Plan	November 29, 1991	National Rehydration Treatment and Training Center
FHSIS Workshop on Monitoring	January 10, 1992	Manila Pavilion
CSP 1992 Strategic Planning Workshop	January 30-31, 1992	Ternate, Cavite
PMCC-HMO Tie-up Project Evaluation Consultative Workshop	February 26, 1992	Asian Institute of Tourism
CSP Benchmark Review	March 5, 1992	Development Academy of the Philippines
Sustainability of the CSP vis-a-vis Decentralization Workshop	May 29-30, 1992	Ternate, Cavite
FHSIS Workshop (Streamlining FHSIS Operations and Design of the FHSIS System Back-up)	June 2-3, 1992	Manila Pavilion

WORKSHOP	DATE	VENUE
Behavior Change Benchmark Meeting	June 15, 1992	Department of Health
Behavior Change Strategic Planning Workshop	July 29-31, 1992	Development Academy of the Philippines
1992 CSP Performance Benchmarks Meeting	August 21, 1992	Nutrition Center of the Philippines
Annual Review of the 1992 CSP Performance Benchmarks	November 4, 1992	Manila Midtown Hotel

CHILD SURVIVAL PROGRAM
PERMANENT INVENTORY RECORD
As of July 31, 1993

VOUCHER	CHECK NO.	DESCRIPTION OF EQUIPMENT (w/ Serial No. if applicable)	AMOUNT P	AMOUNT $	PROPERTY NO.	PHYSICAL LOCATION/DISTRIB'N	REMARKS*	PERSON ACCOUNTABLE
A. Equipment								
0008	310007	IBM Electric Typewriter -Electronic Personal Wheelwriter; Model 6781, SN0220936	24,500.00	991.90	ET-092690-01	Office Manager	W	L. Maling
0031	310028	Refrigerator -GE, 5 cu. ft.,SN1051164	6,405.00	259.31	REF-112690-01	Pantry	W	L. Maling
0091	310016	Filing Cabinet -4 drawers	8,175.00	330.97	FC-101690-01	Secretarial Area	NW	L. Maling
		-3 pcs. P2,475 each + P250.00			FC-101690-02		W	
		change of color			FC-101690-03		W	
		COMPAQ LTE286-Laptop Computer SN #6039HAF40051		4,159.56	LC-010991-01	Technical Manager	W	T. Sabella
		SN #6038MAF40622		4,033.76	LC-010991-02	Resident Advisor	W	B. Loevinsohn
		SN #6038MAF40615		4,033.76	LC-010991-03	Resident Advisor	W	M. Sta. Maria
		SN #6039HAF40969		4,159.56	LC-011391-04	Resident Advisor	W (Procured in USA)	J. Hernandez
0113	044757	Alphone Master Intercom -w/ three substations	2,662.00 495.00 495.00	95.08 17.68 17.68	IC-011191-01 IC-011191-02 IC-011191-03	CSP Office HIS Office IPS Office	W W W	L. Maling -do- -do-
0191	193023		728.20	25.78	IC-031391-04	CHS Office	W	-do-

W - Working
NW - Not Working

VOUCHER	CHECK NO.	DESCRIPTION OF EQUIPMENT (w/ Serial No. if applicable)	AMOUNT P	AMOUNT $	PROPERTY NO.	PHYSICAL LOCATION/DISTRIB'N	REMARKS*	PERSON ACCOUNTABLE
0140	044783	Alenaire Split Type Aircon	40,680.00	1,446.43	AC-020591-01	CSP Office	W	L. Maling
0163	193001	-1.5 TR floor mounted (FCU SN11109047, model ASI, 5SF; ACCU SNI0578919-modelACI.5HA)						
0145	044786	U-Bix Copying Machine -Model 2502MR; SN9441182 (w/ 8 1/2 x 11, 8 1/2 x 14, 11x 17 cassettes, del. tray, working table and pedestal w/ transformer)	65,000.00	2,321.43	CM-020591-01	CSP Office	W	L. Maling
0026	193054	Sony Micro Cassette Recorder -M-440 V	1,300.00	46.02	MCR-031291-01	Resident Advisor	W	B. Loevinsohn
0921	255960	Sony Micro Cassette Recorder -TCM-81-SN #125339	1,300.00	51.22	MCR-071292-02	CSP Office	W	L. Maling
0152	044791	Club Computer (AT Model 333) -4MB RAM, 80386 Micropro. -33 MHZ, 64KB, Cache Memory -1 x 80MB Fixed Disk -- 658609/9102-634 -Colorgraphics Card 905954 -1.44MB Disk Drive (3.5") -- 5944027/9015655 -1.2 MB Disk Drive (5 1/4") -- 8868996 -FD & HD Adaptor-10160445 -AT I/0-0208411 -Enhanced Keyboard; 0122932 -- 9012787	149,489.00	5,338.89	CC-022691-01 EH-022691-02	Secretarial Area Secretarial Area	W W	L. Maling L. Maling
		Color Monitor (Philips -14") -SN009103003883	9,786.00	349.50	CM-022691-03	Secretarial Area	W	L. Maling
		-AVR 500 watts SN 90-15079	3,572.00	127.57	AVR-022691-04	Secretarial Area	W	L. Maling

VOUCHER	CHECK NO.	DESCRIPTION OF EQUIPMENT (w/ Serial No. if applicable)	AMOUNT P	AMOUNT $	PROPERTY NO.	PHYSICAL LOCATION/DISTRIB'N	REMARKS*	PERSON ACCOUNTABLE
		:Printer Cable-SN9101-599						
		:Okidata Microline 391 Plus :-SN912A0010011			:PCPC-022691-0	:Secretarial Area	W	:L. Maling
		:HP Jet Series III-Printer :-SN3048A35832		825.00	:CP-030191-01	:Secretarial Area	W	:L. Maling
0256	193089	:Standard Electric Fan :-SN9281161 :-Stand Fan :-Wall Fan		2,100.00	:LP-081991-06	:Secretarial Area	W :(Procured	:L. Maling
			1,160.00 990.00	41.43 35.36	:EF-041691-01 :EF-041691-02	:RAs Area :Secretarial Area	W :(Procured In USA) W W	:L. Maling :L. Maling :L. Maling
1208	575517	:RGX-5500,Robin Portable Generator :-5,500 watts, single phase,220V, : 60Hz, brushless,direct-coupled : to EY-40D, 10HP Robin gasoline : engine, air-cooled, enclosed in : a steel frame :-SN	43,890.00	1,784.15	:G-021293	:Back of DOH Bldg. #3	W	:L. Maling
1291	575596	:Cyclone Electric Fan : --SN92060884 : --SN92060948 :-Stand Fan : 2 units at P1,105.ea.	2,210.00	89.11	:EF-033193-01 :EF-033193-02	:Conference Area :RAs Area	W W	:L. Maling :L. Maling

VOUCHER	CHECK NO.	DESCRIPTION OF EQUIPMENT (w/ Serial No. If applicable)	AMOUNT P	AMOUNT $	PROPERTY NO.	PHYSICAL LOCATION/DISTRIB'N	REMARKS*	PERSON ACCOUNTABLE
B. Vehicle		Jeep Cherokee (211)	-	40,502.00	JC-0591-01	-	W	W. Caldino
		Jeep Cherokee (212)			JC-0591-02	-	W (Procured In USA)	A. de Taza
C. Furnitures								
0003	310002	Executive Table	11,200.00	453.44	ET-101690-01	Resident Advisor	W	S. Solter
0012	310009	-4 pcs. at P2,800.ea.			ET-101690-02	Resident Advisor	W	B. Loevinsohn
					ET-101690-03	Resident Advisor	W	M. Sta. Maria
					ET-101690-04	Resident Advisor	W	J. Hernandez
0123	044767	Executive Table (Jr.)	3,300.00	117.86	ET-101690-05	Office Manager	W	L. Maling
0154	044793							
0123	044767	Office Tables	2,500.00	89.30	JET-101690-06	Technical Manager	W	T. Sabella
0154	044793		2,500.00	89.30	JET-101690-07	Secretary	W	L. Riazo
0003	310002	Secretary's Table	5,700.00	230.77	ST-020491-08	Secretary	W	N. Magcalen
0012	310009	-3 pcs. at P1,900. ea.			ST-020491-09	Near Xerox machine	W	E. Samarro
					ST-020491-10	AC Officer	W	C. Marin
0003	310002	Typing Table	1,300.00	52.63	TT-101690-01	Office Manager	W	L. Maling
0012	310009							
0208	193037	Printer Table	980.00	34.69	PT-032391-12	Secretarial Area	W	L. Maling
0003	310002	Conference Table	2,900.00	117.41	CT-101690-13	Secretarial Area	W	L. Maling
0012	310009							

VOUCHER	CHECK NO.	DESCRIPTION OF EQUIPMENT (w/ Serial No. if applicable)	AMOUNT P	AMOUNT $	PROPERTY NO.	PHYSICAL LOCATION/DISTRIB'N	REMARKS*	PERSON ACCOUNTABLE
0003	310002	Visitor's Chair	3,000.00	121.46	VC-101690-04	Healthcom Office	NW	L. Maling
0012	310009	-4 pcs. at P750 ea.			VC-101690-05	Secretary	W	L. Riazo
					VC-101690-06	AC Officer	W	C. Marin
					VC-101690-07	Secretary	W	N. Magcalen
0003	310002	Conference Chair	7,200.00	291.50	CC-101690-08	Conference Area	W	L. Maling
0012	310009	-6 pcs. at 1,200. ea.			CC-101690-09	-do-	W	-do-
					CC-101690-10	-do-	W	-do-
					CC-101690-11	-do-	W	-do-
					CC-101690-12	-do-	W	-do-
					CC-101690-13	-do-	W	-do-
0029	310026	Executive Chairs	10,200.00	412.96	EC-110290-14	Healthcom Office	NW	L. Maling
		-4 pcs. at P2,550 ea.			EC-110290-15	Healthcom Office	NW	L. Maling
					EC-110290-16	Resident Advisor	W	S. Solter
					EC-110290-17	Resident Advisor	W	J. Hernandez
0123	004767	Executive Chair	2,800.00	100.00	EC-110290-18	Resident Advisor	W	B. Loevinsohn
0154	004793							
0123	004767	Clerical Revolving Chair	3,000.00	107.14	CC-020491-19	Technical Manager	W	T. Sabella
0154	004793	-2 units at P1,500. ea.			CC-020491-20	Office Manager	W	L. Maling
0123	004767	Hanging Shelves	7,200.00	257.14	HC-020491-06	Resident Advisor	W	B. Loevinsohn
0154	004793	-3 units at P2,400. ea.			HC-020491-07	Technical Manager	W	T. Sabella
					HC-020491-08	Office Manager	W	L. Maling
0210	193039	Visitor's Chair (Sulihiya)	350.00	12.39	VC-031391-25	Healthcom Office	W	N. Magcalen
0210	193039	Visitor's Chair (Sulihiya)	350.00	12.39	VC-031391-26	-do-	W	L. Riazo
0022	310019	Mini-blinds (39 sq. ft.)	3,200.00	129.55	MB-102290-01	CSP Office	W	L. Maling
0230	193056	Computer Table	3,000.00	106.19	CT-040391-01	CSP Office	W	L. Maling

VOUCHER	CHECK NO.	DESCRIPTION OF EQUIPMENT (w/ Serial No. if applicable)	AMOUNT P	AMOUNT $	PROPERTY NO.	PHYSICAL LOCATION/DISTRIB'N	REMARKS*	PERSON ACCOUNTABLE
0028	310025	Conference Table Tinted	3,200.00	129.55	CT-102890-14	FACS Office	W	Dr. L. Milan
		-w/4 Conference Chairs			CC-102890-21	-do-	W	-do-
		(Sulihiya)			CC-102890-22	-do-	W	-do-
					CC-102890-23	-do-	W	-do-
					CC-102890-24	-do-	W	-do-
0210	193039	Executive Table	2,100.00	74.34	ET-031391-15	Office of the Chief of Staff	W	USec.J.G.Tan
0003	310002	Back Hanging Cabinet	12,500.00	506.07	BHC-101690-01	Resident Advisor	W	S. Solter
0012	310009	-5 pcs. at P2,500. ea.			BHC-101690-02	Resident Advisor	W	M. Sta. Maria
					BHC-101690-03	Resident Advisor	W	J. Hernandez
					BHC-101690-04	Office Manager	W	L. Maling
					BHC-101690-05	Secretarial Area	W	L. Maling
0123	004767	Hanging Cabinet (Repair)	3,900.00	139.29	HC-020491-06	Resident Advisor	W	B. Loevinsohn
0154	004793	-3 units at P1,300. ea.			HC-020491-07	Technical Manager	W	T. Sabella
					HC-020491-08	Computer Area	W	L. Maling
0210	193039	Cabinet (Bookcase)	1,700.00	60.18	CBC-031391-09	PIHES Office	W	C. Manlngas
0018	310015	Pantry Cabinet	3,780.00	153.04	PC-110190-10	Secretarial Area	W	L. Maling
0030	310027	- 1 unit						
0018	310015	Modular Dividers	31,050.00	1,257.09	MD-110590-01 to 15	CSP Office	W	L. Maling
0030	310027	-15 panels at P2,070. ea.						
0123	004767	Modular Dividers	12,000.00	487.57	MD-020491-16 to 19	CSP Office	W	L. Maling
0154	004793	-4 panels at P3,000.ea.						
0003	310002	Secretary's Chair	3,600.00	145.75	SC-101690-01	Secretarial Area	W	L. Maling
0012	310009	-3 pcs. at P1,200.ea.			SC-101690-02	Secretarial Area	W	-do-

ANNEXES

SUMMARY OF CHILD SURVIVAL PROGRAM SERVICE DELIVERY TARGETS 1988-1993

July 1993

1) Percent of all children at age one who are fully immunized increases from 65% (1988) to 85% (1993).

STATUS: Target was accomplished! FHSIS indicates that FIC was 90% in 1992. Data from post NID coverage survey (fig. #1) shows that measles coverage has been consistently high (85%) over the last 4 years.

2) Percentage of pregnant women with at least 2 doses of tetanus toxoid increases from 50% (1991 household survey) to 80% (1993).

STATUS: Post NID survey indicates that TT2+ is now 72.5% (fig. #2). The target may be accomplished by the end of 1993.

3) Percent of all midwives, nurses, and doctors working at, or below, the level of the district hospital trained in new ARI case management, increases from 0% (1989) to 40% in 1993.

STATUS: Target was accomplished! Health facility survey done by HIS in July 1993 shows that 72% of midwives have already been trained as have 84% of PHNs (fig. #3).

4) Percent of DOH outreach workers trained to deliver a wide range of FP services increases from 59.5% (1990 FPS survey analyzed by UPPI) to 75% by 1993.

STATUS: Target was accomplished! Health facility survey done by HIS in July 1993 shows that 75% of midwives have already been trained (50% since 1990!). 84% of RHUs have staff trained in IUD insertion (fig. #4).

5) Percent of DOH health facilities delivering a broad range of FP services appropriate to the type of facility increases: BHS:from 1.9% (1990) to 40% in 1993. RHU from 0.5% (1990) to 50% in 1993. District Hospitals from 0% (1990) to 25% (1993)

STATUS: Target was accomplished! Health facility survey done by HIS in July 1993 indicates that 44% of BHSs are providing a broad range of services (fig. #5). 70% of RHUs are able to provide broad range of services (fig. #6).

6) Total Contraceptive Prevalence Rate for all program methods whether provided by the public or private sector, increases from 22% (1988 Contraceptive Prevalence Survey, UPPI) to 35%.

STATUS: Actual CPR won't be known until DHS results in Sept. 1993. Much progress has been made in terms of IUD and pills but VSC has not improved (fig. #7). The latter is a critical problem because VSC makes up more than 50% of contraceptive prevalence (fig. #8).

7) Percent of all pregnant women served by DOH at least three prenatal visits increases from 48% (1991 household survey) to 80% by 1993.

STATUS: Data not currently available. Available from 1993 DHS.

8) Percent of all births attended by trained personnel, including trained TBAs, increases from 76% (1991) to 85% in 1993.

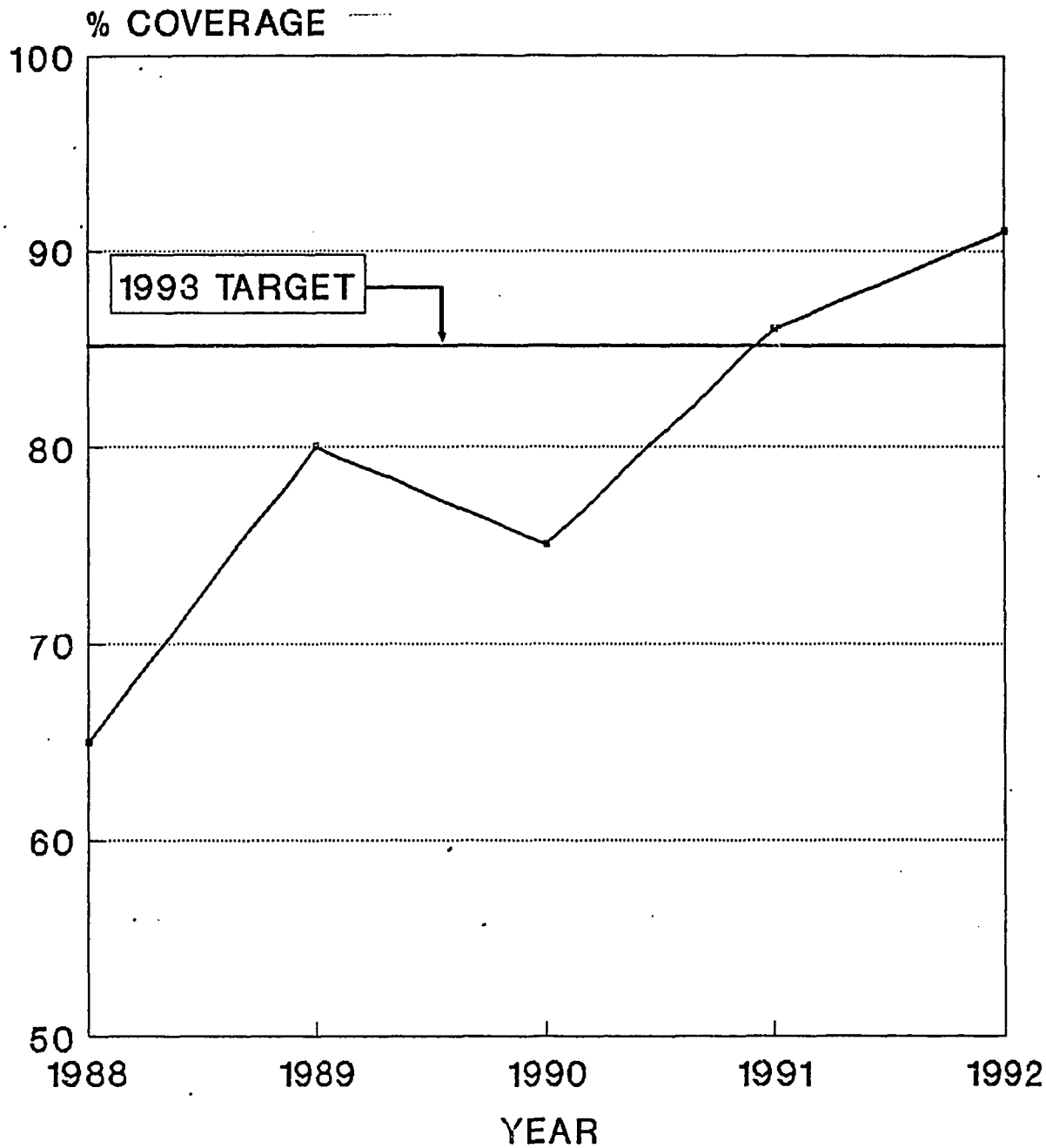
STATUS: Data not currently available. Available from 1993 DHS.

9) ORT use rate in all cases of diarrhea among children under five years of age, increases from 25% (1991 household survey) to 60% in 1993.

STATUS: Data not currently available. Available from 1993 DHS.

FIGURE 1

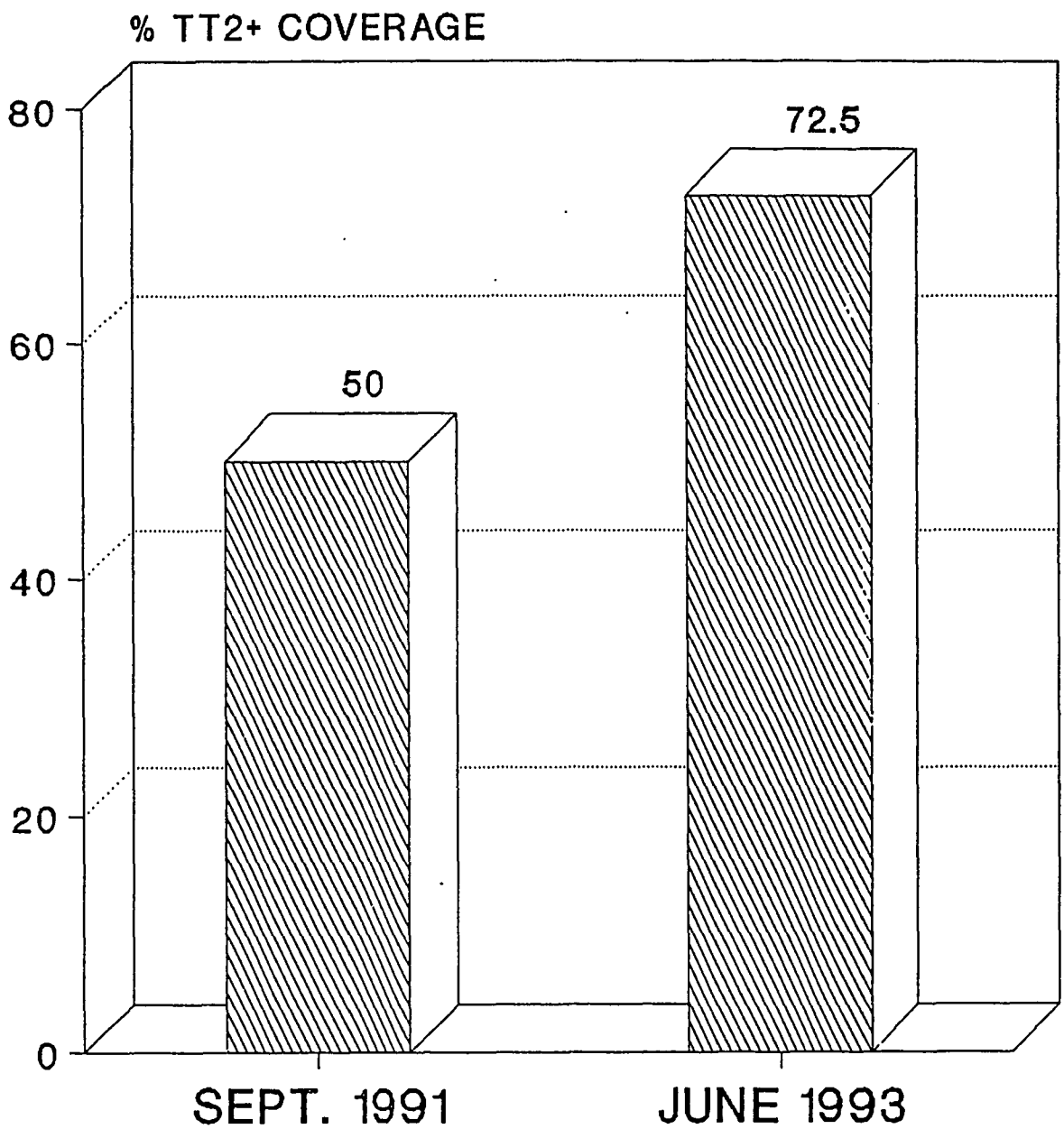
% OF CHILDREN FULLY IMMUNIZED BY AGE ONE (FIC), 1988-1992 ALL PHILIPPINES



SOURCE: FHSIS, MCHS

FIGURE 2

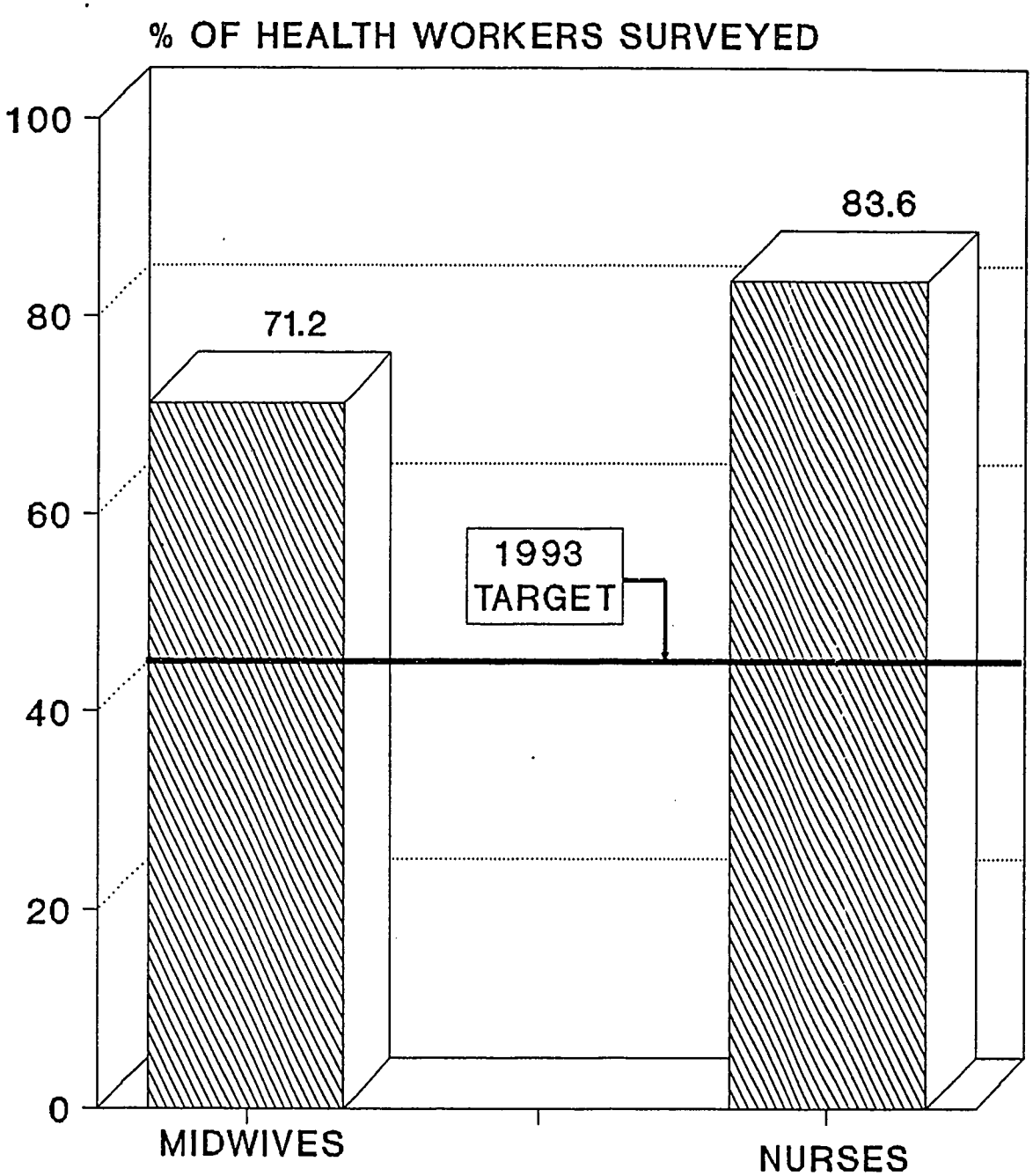
TETANUS TOXOID (TT2+)COVERAGE AMONG MOTHERS OF INFANTS ACCORDING TO HOUSEHOLD SURVEYS



SOURCES: 1993 POST-NID SURVEY
1991 "TRENDS" SURVEY

FIGURE 3

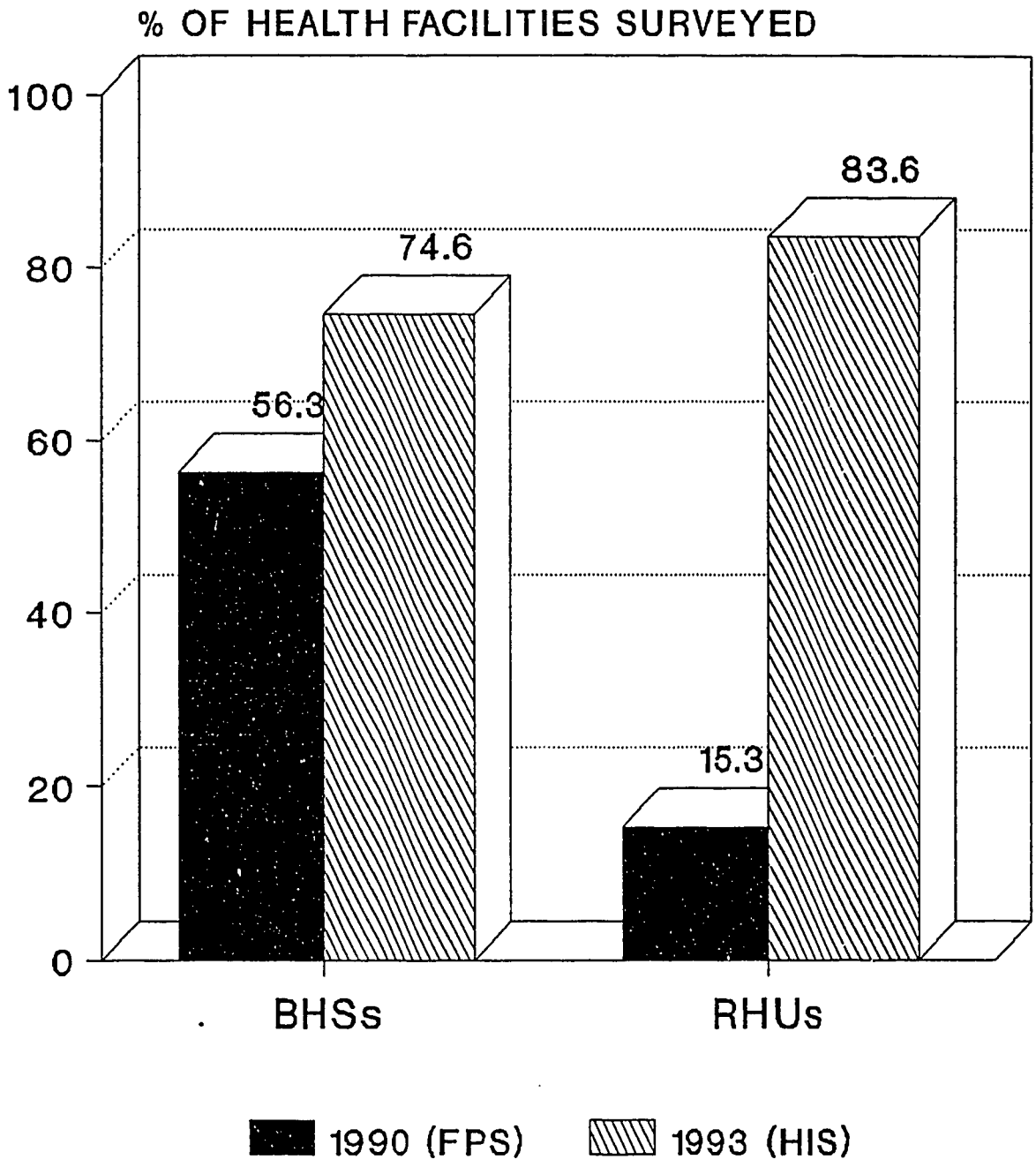
MIDWIVES AND NURSES TRAINED IN MANAGEMENT OF ARI BY JUNE 1993



SOURCE: HEALTH INTELLIGENCE SERVICE
HEALTH FACILITY SURVEY (N=179)

FIGURE 4

BHSs AND RHUs WITH APPROPRIATE LEVEL OF FP TRAINING 1990 and 1993

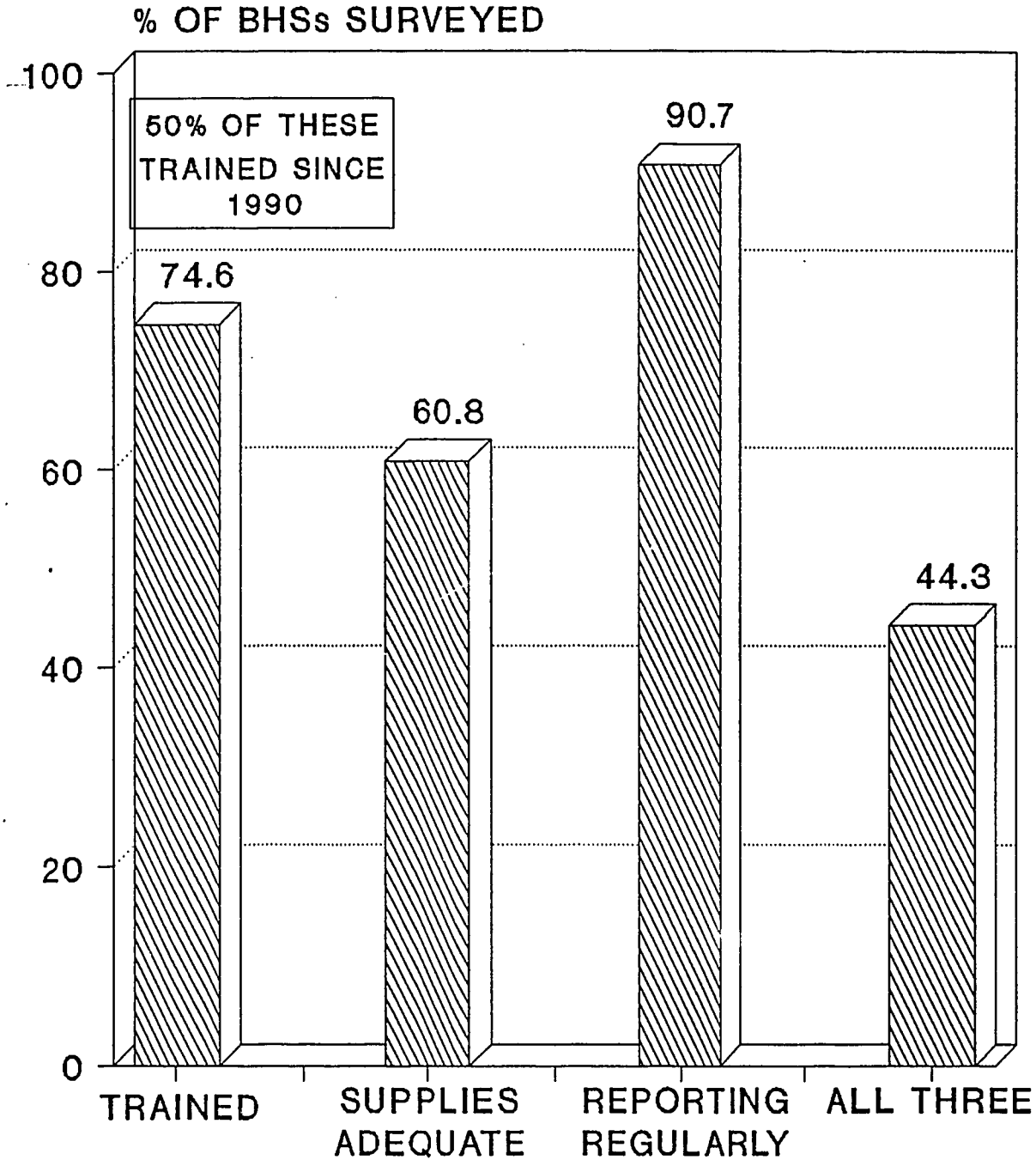


SOURCES: 1993 HIS HEALTH FACILITY SURVEY
1990 FPS SURVEY ANALYSED BY UPPI

65

FIGURE 5

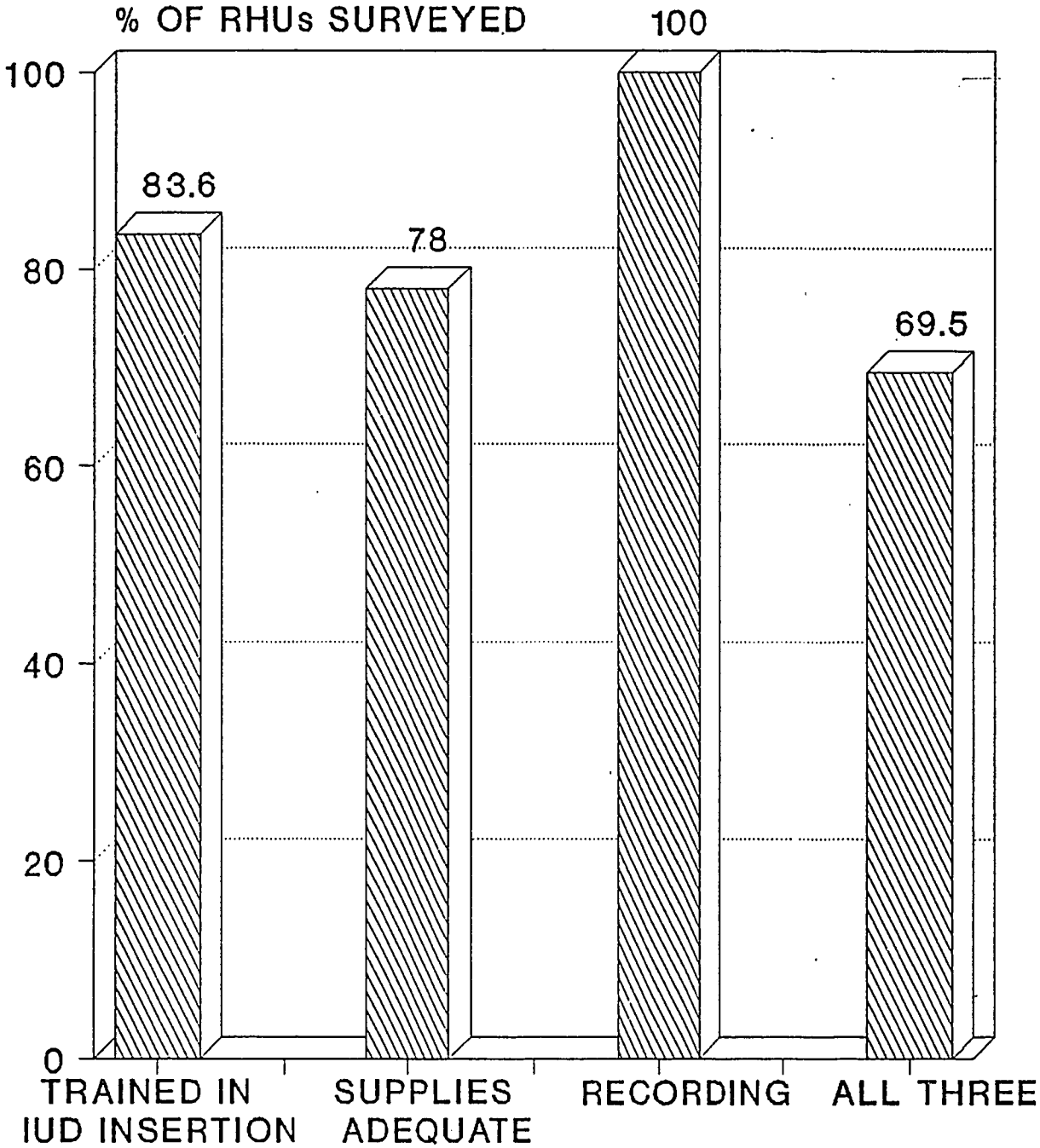
BHSs ABLE TO DELIVER BROAD RANGE OF FAMILY PLANNING SERVICES, JUNE 1993



SOURCE: HEALTH INTELLIGENCE SERVICE
HEALTH FACILITY SURVEY (N=118)

FIGURE 6

RHUs ABLE TO DELIVER BROAD RANGE OF FAMILY PLANNING SERVICES, JUNE 1993



SOURCE: HEALTH INTELLIGENCE SERVICE
HEALTH FACILITY SURVEY (N=61)

FIGURE 7

NEW ACCEPTORS OF FAMILY PLANNING BY METHOD (1989 = 100)

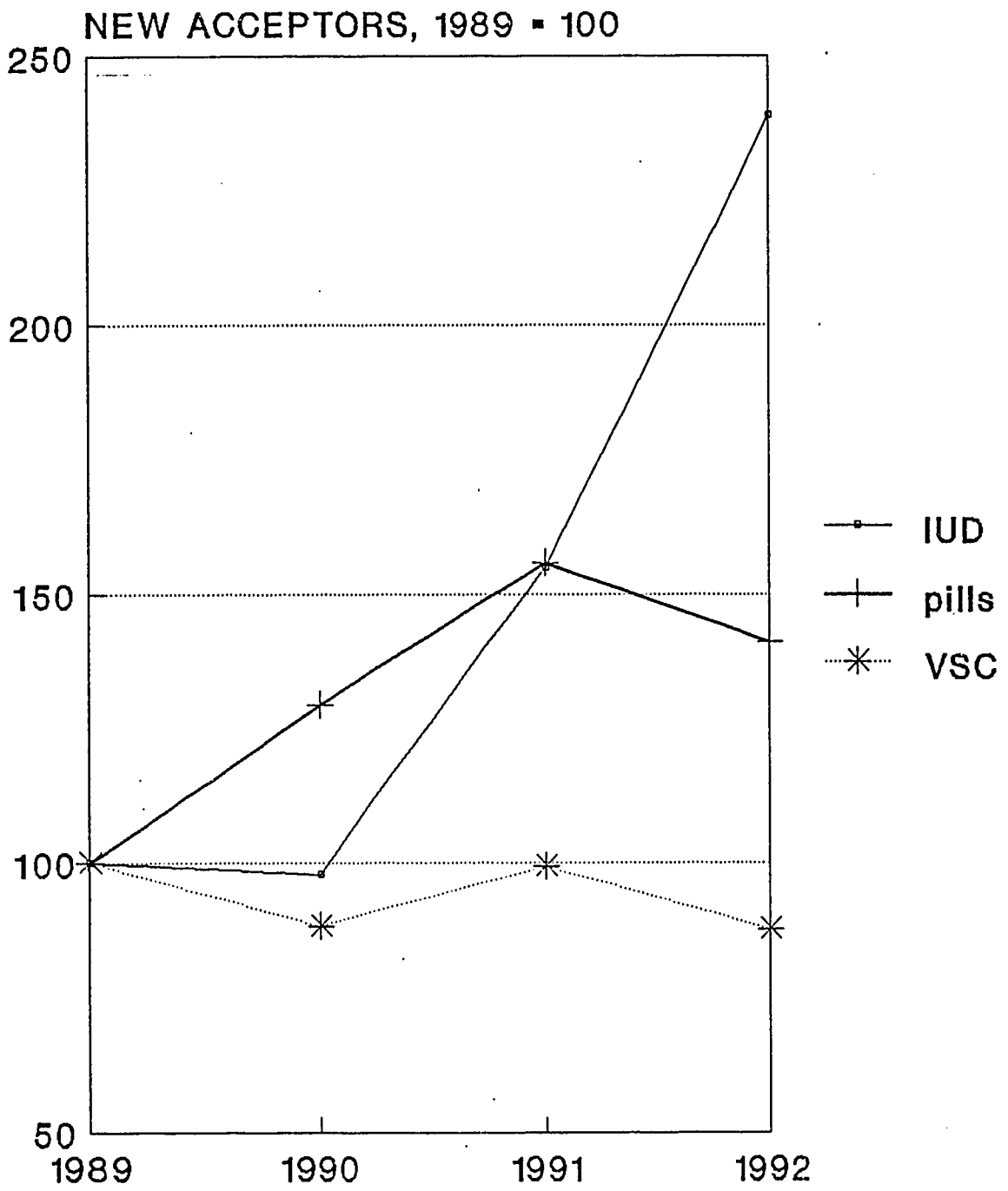
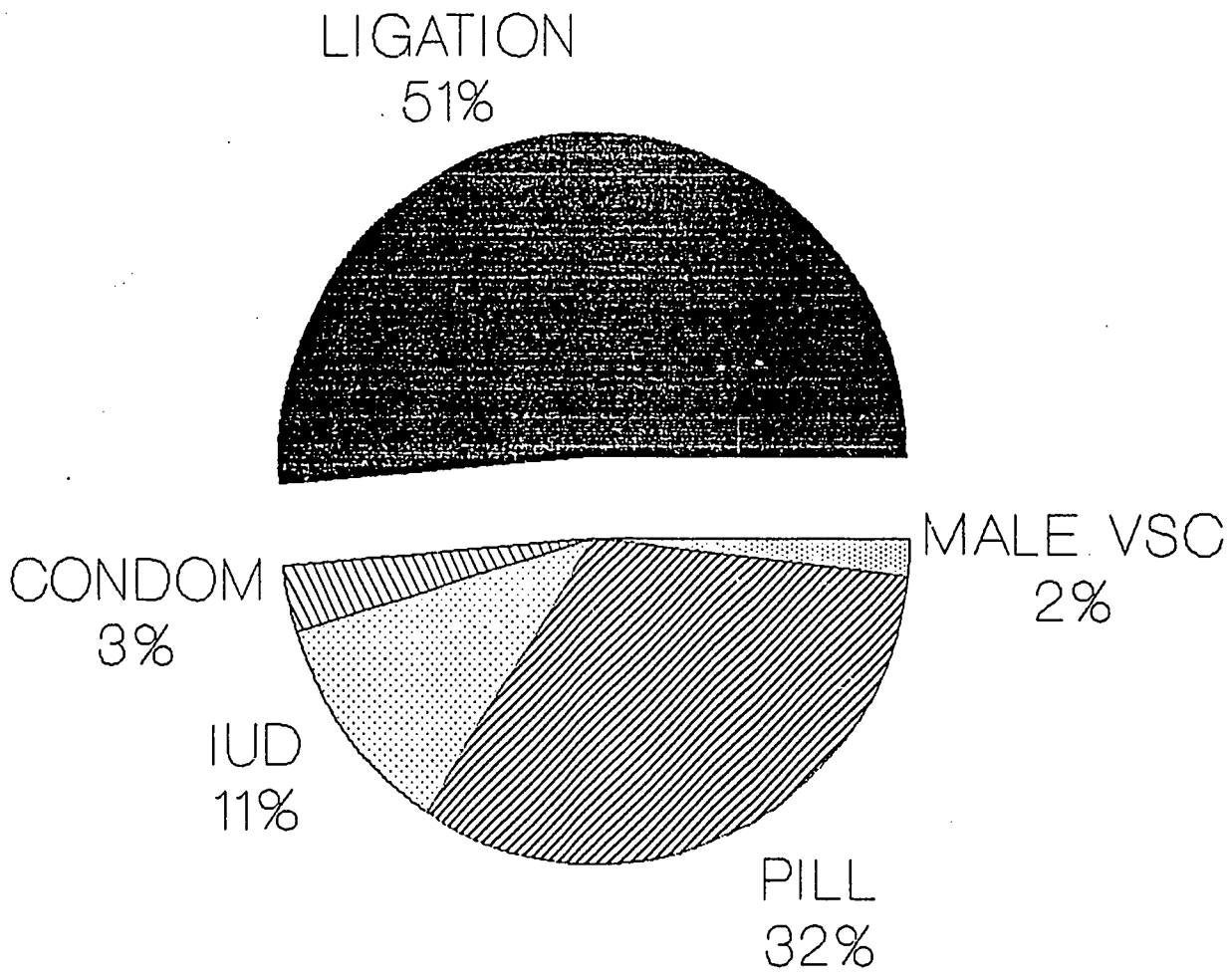


FIGURE 8

METHOD MIX AMONG MCRA's USING MODERN, PROGRAM METHODS 1988 NDS



CHILD SURVIVAL PROGRAM
POLICY IMPLEMENTATION MATRIX
(Selected Performance Benchmarks 1989–1993)

Goal : To contribute to a reduction in the variances in infant and child mortality and morbidity rates among and within provinces and regions while simultaneously lowering the corresponding national rate.

Purpose: To increase the availability, utilization and sustainability of child survival–related services, including child spacing, particularly to underserved and high risk groups.

CATEGORIES OF POLICY REFORM	POLICY OBJECTIVES	PERFORMANCE BENCHMARKS	DUE DATE	DOCUMENTATION REQUIRED/ REMARKS
STRATEGY I:	TO CREATE CONDITIONS THAT FOSTER THE EFFICIENT DELIVERY, INCREASED AVAILABILITY AND UTILIZATION OF CHILD SURVIVAL–RELATED SERVICES, PARTICULARLY TO UNDERSERVED AREAS AND HIGH–RISK GROUPS.			
A. Targeting of Child Survival Services	Determination of priority underserved geographic areas	1. Priority ranked list of provinces and cities, based on classification of provinces and cities using DOH–established high–risk and geographical access criteria.	Prior to release of first tranche.	1. Benchmark was achieved in Nov. 1989.
	Budget allocations linked to program and geographic targeting.	2. Increased budget appropriations given to priority high–risk and underserved provinces and cities.	October 1990	2. Benchmark was achieved in Oct. 1990.
	Determination of functional (programmatic) priorities for additional services and programs.	3. DOH provincial plans address priority child survival–related programs, including family planning and nutrition a. Priority provinces b. 50 percent of total provinces c. 100 percent of provinces	 October 1990 October 1991 October 1992	3. a) Benchmark was achieved in Oct. 1990. b) Benchmark was achieved in Oct. 1991. Submitted provincial plans of acceptable quality from 37 non–priority provinces that (a) addressed priority CS–related programs, (b) specified service priorities, service levels, commodities required, annual performance targets and required resources including staff; & (c) included inputs from provincial representatives of other GOP agencies, e.g., POPCOM, NNC.

CATEGORIES OF POLICY REFORM	POLICY OBJECTIVES	PERFORMANCE BENCHMARKS	DUE DATE	DOCUMENTATION REQUIRED/ REMARKS
				The same documentation will satisfy benchmarks I-C.1 and I-D.5. Also submitted a checklist developed jointly by DOH & USAID which prescribed the attributes of a plan of acceptable quality. c) Benchmark was achieved in Oct. 1992. Submitted provincial plans for all 75 provinces. Also submitted evaluation checklist and ratings of all 75 plans re acceptable quality.
B. Increased Delivery of Child Survival Services	Supply of services from DOH, NGOs and private commercial sector increases in accordance with prioritized provincial plans	1. Annual service delivery performance targets for priority provinces, based on national end-of-program indicators, set by DOH. 2. Achievement of national end-of-program service delivery coverage indicators. a. Percent of all children at age one who are fully immunized increases from 65% (1988) to 85% (1993) b. Percentage of pregnant women with at least 2 doses of tetanus toxoid increases from 50% (1991 household survey) to 80% (1993)	Prior to releases of tranches 2, 3 and 4	1. Benchmark was achieved in Oct. 1991 and Oct. 1992. Submitted 1991 and 1992 provincial performance targets which were negotiated using a process that ensured that each province will contribute a fair share towards achieving the 1993 national service performance targets.

CATEGORIES OF POLICY REFORM	POLICY OBJECTIVES	PERFORMANCE BENCHMARKS	DUE DATE	DOCUMENTATION REQUIRED/ REMARKS
		c. Percent of all births attended by trained personnel, whether private or public including trained TBAs, increases from 76% (1988) to 85% in 1993 d. Percent of all pregnant women served by DOH with at least three prenatal visits increases from 48% (1991 household survey) to 80% by 1993 e. Percent of DOH outreach workers trained to deliver a wide range of FP services increases from 59.5% (1990 FPS survey analyzed by UPPI) to 75% by 1993 f. Percent of DOH facilities delivering a broad range of FP services appropriate to the type of facility increases for: –BHS from 1.9% (1990) to 40% in 1993 –RHU from 0.5% (1990) to 50% in 1993 –District Hospitals from 0% (1990) to 25% (1993) g. Percent of all midwives, nurses, and doctors working at, or below the level of the district hospital trained in new ARI case management, increases from 0% (1989 excluding Bohol) to 40% in 1993		

CATEGORIES OF POLICY REFORM	POLICY OBJECTIVES	PERFORMANCE BENCHMARKS	DUE DATE	DOCUMENTATION REQUIRED/ REMARKS
		h. ORT use rate in all cases of diarrhea among children under five years of age, increases from 25% (1991 household survey) to 60% in 1993		
		i. Total Contraceptive Prevalence Rate for all program methods whether provided by the public or private sector, increases from 22% (1988 Contraceptive Prevalence Survey, UPPI) to 35%.		
C. Decentraliz-ation	Decentralization of health planning to the regional and provincial levels	3. Regional and provincial health managers trained in health planning a. Priority provinces b. 50% of total provinces c. 100% of provinces	 October 1991 October 1992 October 1993	3. a) Benchmark was achieved in Oct. 1991. b) & c) Benchmarks were achieved in Oct. 1992 Submitted a report, for all 75 provinces, on the number & type of regional & provinc-ial health personnel trained. The provincial staff who were trained were: PHO and APH or Med. Specialist III. From the RHO, the following were trained: ARD, Chiefs of Technical Services and Health Manpower Div., and Supervisory Planning Officer.
	Integrated delivery of child survival-related services at the provincial level	4. Distribution of integrated MCH operations guide to all regions.	October 1991	4. Benchmark was achieved in Oct. 1991. Submitted a distribution report of the integrated MCH operations guide. The manual was distributed to the Municipal Health Officers.

CATEGORIES OF POLICY REFORM	POLICY OBJECTIVES	PERFORMANCE BENCHMARKS	DUE DATE	DOCUMENTATION REQUIRED/ REMARKS
	Integrated health information reporting at the local and national levels	7. New Field Health Service Information System (FHSIS) operational in all provinces, including an approved management policy statement identifying central, regional and provincial level staff responsible for FHSIS operations and monitoring.	October 1990	7. Benchmark was achieved in Oct. 1990.
	Coordination of child survival-related programs at the national level	9. Designation of DOH Assistant Secretary or DOH official at comparable level for coordination of all GOP and foreign-assisted child survival-related activities.	October 1990	9. Benchmark was achieved in Oct. 1990.
STRATEGY II:	<u>TO ENSURE THE SUSTAINED COMMITMENT TO, DEMAND FOR AND FINANCING OF CHILD SURVIVAL SERVICES THROUGH BOTH THE PRIVATE AND PUBLIC SECTORS</u>			
A. Government Commitment	Program Budgetting of DOH demonstrates funding for child survival activities	2. Activities planned by DOH to achieve performance targets are fully funded, as evidenced by advices of allotment	Prior to release of:	2. Advices of Allotment
		a. Priority provinces	a. 2nd tranche	a. Benchmark was achieved in Oct. 1990.
		b. 50% of total provinces	b. 3rd tranche	b. Benchmark was achieved in Oct. 1991.
		c. 100% of provinces	c. 4th tranche	c. Benchmark was achieved in Oct. 1992.
	AID-funded Field Epidemiology Training Program (FETP) institutionalized in DOH and used as a resource for targeted epidemiology-based planning	3. DOH organizational structure formally revised to incorporate FETP as as division or service with permanent positions and budget established.	October 1992	3. Benchmark was achieved in Oct. 1992. Submitted 2 Administrative Orders signed separately by Secs. Periquet and Flavier, insitutionalizing FETP as part of HIS. Also submitted an Institutionalization Plan for FETP and Revitalization Thrusts for HIS that includes the revised organizational structure of HIS which now prescribes its new mandate and staffing complement.

CATEGORIES OF POLICY REFORM	POLICY OBJECTIVES	PERFORMANCE BENCHMARKS	DUE DATE	DOCUMENTATION REQUIRED/ REMARKS
B. Internalizing the Demand for Preventive Health Services	Development of a strategy for internalizing promotive/preventive health behaviors	3. Adoption & execution of a strategy promoting smaller family size, delayed marriages, complete immunizations, breastfeeding and early illness/disease intervention, etc.	October 1992	3. Benchmark was achieved in Oct. 1992. Submitted a report that analyzed the degree to which the DOH has met its target of promoting the internalization of promotive/preventive behaviors, as planned for in their family planning, EPI, breastfeeding, CDD & ARI programs.
C. Financial Sustainability	Development of a cost containment strategy for DOH services	6. Development of a program of action for the implementation of identified cost-containment schemes in DOH facilities at the regional, provincial and district levels.	October 1991	6. Benchmark was achieved in Oct. 1991. Submitted a report that (1) documented existing cost containment activities in selected DOH facilities; (2) described a methodology for classifying and measuring costs; and (3) identified possible areas for cost containment.
	Development of an improved cost recovery scheme for DOH facilities and services	7. Completed analysis of (a) existing user-fee and cost-sharing experiences in selected facilities and services; (b) potential of user fees to cover DOH recurrent costs; and (c) recommendations for strengthening user fee retention system.	October 1991	7. Benchmark was achieved in Oct. 1991. Submitted a report that: (1) documented existing regulations and experiences on user fee and cost sharing; (2) analyzed the potential for user fees to cover recurrent costs of the DOH; and (3) identified areas for policy reform to strengthen the user fee system. As evidence that senior DOH staff responsible for policy formulation have discussed report findings and future policy actions, an annex of the report contained the documentation of the discussion held with senior staff and officials of the DOH last September 26, 1991.

CATEGORIES OF POLICY REFORM	POLICY OBJECTIVES	PERFORMANCE BENCHMARKS	DUE DATE	DOCUMENTATION REQUIRED/ REMARKS
D. Increased Private Sector Involvement	Development of plans for the privatization of the Philippine Heart Center, Philippine Children's Medical Center, the National Kidney Institute and the Lung Center of the Philippines	1. Completed studies on: (a) the policy, regulatory, and legislative framework for health services privatization and (b) the privatization of the four specialty hospitals.	October 1991	1. Benchmark was achieved in Oct. 1991. Submitted reports on: (1) the policy, regulatory/legislative, and political framework for health services privatization; and (2) the feasibility of privatizing the four specialty hospitals.
	Stimulation and facilitation of HMO development	5. Proposed regulations and quality control guidelines for HMO operations	October 1991	5. Benchmark was achieved in Oct. 1991. Submitted: (1) the draft regulation, which included a Memorandum of Agreement (MOA) between the DOH and the Securities and Exchange Commission (SEC), and a DOH Administrative Order (AO); and (2) a report that documented the consultative process undertaken to formulat the regulation.
	Privatization of DOH services	7. Private sector entity contracted for field distribution of Hepatitis B vaccine.	October 1991	7. Benchmark was achieved in Oct. 1991. Submitted: (1) the Notice of Award to the winning bidder for the field distribution of Hepatitis B vaccines; and (2) the Purchase Order for the services of Medtest, the winning bidder.

Annex 3

FIELD HEALTH SERVICES INFORMATION SYSTEM

INTEGRATED SUPERVISORY CHECKLIST

FIELD HEALTH SERVICES INFORMATION SYSTEM

INTEGRATED SUPERVISORY CHECKLIST

HEALTH FACILITY COPY

"Above all serve the people"

NAME OF HEALTH FACILITY: _____

HEALTH INTELLIGENCE SERVICE

OFFICE OF PUBLIC HEALTH SERVICES

Republic of the Philippines
Department of Health

OFFICE OF THE SECRETARY

SAN LAZARO COMPOUND, RIZAL AVENUE, STA. CRUZ, MANILA, PHILIPPINES
TEL. NOS. 711-6105 • 711-6061

MESSAGE

My Dear Fellow Health Workers,

The highest goal any of us can hope to achieve is to serve others, to share with them all our knowledge, skills, and commitment. I am reminded of the parable of a village which had no church but which had collected all the money and materials needed to build one. The biggest problem they faced was deciding where the church should be situated. When a site on the western part of the village was suggested the people on the eastern part would complain. When a site north of the village was recommended, everybody complained that it was too far away.

Around this time a terrible drought hit the village and the harvest was very poor. Everyone worried about hunger because the average yield was only 5 cavans of rice per hectare. There were two farmers who were very close friends, and who lived in adjacent barrios. Due to their small plots they each harvested only one cavan of rice and were extremely worried about their families well-being.

One of the farmers, out of concern for the welfare of his friend's family, decided that he would divide his meager harvest in two and take it to his friend's house. He put the half cavan of rice on his shoulders and set off in the middle of the night. At the border between the two barrios, in the pitch dark, the two friends bumped into each other.

"Where are you going at this time of night?" asked the first farmer.

"To your home to give you this half sack of rice," answered the second farmer. "And you?"

The first farmer started to laugh. "I was on my way to give you this half sack of rice as your share of my poor harvest."

The two friends embraced each other and tears welled from their eyes. The people of the village decided that they should build their church on the spot where the two friends met because it was the point nearest heaven.

Through the sharing of your knowledge and skills with your communities, your health facilities too will be points close to heaven. This supervisory checklist is a tool that will help you improve the health services that you provide to your communities, but it is only a tool. You are the ones that must provide the care, concern, and sharing that will really improve the health of your communities.

I wish you all the best of luck,

Juan M. Flavier, M.D., M.P.H.
Secretary of Health

27 July 1992

Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY
SAN LAZARO COMPOUND, RIZAL AVENUE, STA. CRUZ, MANILA, PHILIPPINES
TEL. NOS. 711-6106 • 711-6061

FOREWORD

We have been preoccupied with our task of providing quality health care. Indeed, most of our time and resources have been used to search for and operationalize the most acceptable, effective and efficient methods of health service delivery and, in determining performance standards for our service providers.

In order to enforce these methods and standards, we need to ensure that appropriate systems link the program manager with the program implementor. The **Integrated Supervisory Checklist**, pilot tested by the Health Intelligence Service in collaboration with the Office for Public Health Services, has proven to be a most promising strategy for improving the performance of our much valued frontliner, the midwife, through a system which enhances the role of her supervisors.

On behalf of the directors and managers of public health programs, I am endorsing the implementation of the Integrated Supervisory Checklist by all public health nurses and health officers. With your continued commitment and cooperation, I am confident that we shall move a few more steps closer to our common goal: quality health care.

Manuel G. Roxas, MD, MPH
Undersecretary for
Public Health Services

INTRODUCTION FOR MIDWIVES ON THE USE OF THE INTEGRATED SUPERVISORY LOGBOOK

This logbook has been designed to help you keep track of your performance so that you can better serve the people in your catchment area. The main point of this logbook is NOT to judge your performance *but to help* improve it!

THE POINT OF THIS LOGBOOK IS NOT TO JUDGE YOUR PERFORMANCE, BUT TO IMPROVE IT!!

A) 20 ITEMS WILL BE EXAMINED SYSTEMATICALLY: Twenty items selected by program managers as essential to good performance will be examined objectively. This does not mean that other aspects of your work are unimportant! The 20 items will be used to see which of your programs need the most attention.

B) SCORES WILL BE ASSIGNED FOR EACH ITEM: Each item is assigned a score from 1 (the lowest) to 5 (the best) based on objective criteria explained in the attached pages. THERE ARE NO TRICKS! You and your supervisor should agree on the score for each item. Your supervisor should answer any questions that you have. The total score should then be placed on the enclosed performance graph which should be displayed on a wall of your health facility.

C) THIS LOGBOOK MUST BE KEPT IN YOUR HEALTH FACILITY: This so that all supervisors can see your progress.

D) THE IMPORTANCE OF KEEPING GOOD RECORDS: For all health workers, recording what we have done is an essential aspect of caring for our patients. Keeping good records is not just a bureaucratic obligation; it is a necessary part of providing high quality patient care.

KEEPING GOOD RECORDS IS AN ESSENTIAL PART OF PROVIDING HIGH QUALITY SERVICES.

E) IF AN ITEM CANNOT BE CALCULATED BECAUSE OF INCOMPLETE RECORDING A SCORE OF 1 WILL BE GIVEN: To emphasize the importance of proper recording a score of 1 will be given for any item that cannot be calculated because of inadequate record keeping.

F) THIS CHECKLIST SHOULD BE USED EVERY MONTH: In order to ensure that services are improving this checklist should be used once a month. Experience in pilot provinces showed monthly supervisory visits were the most effective in raising scores.

G) SUPPLIES AND LOGISTICS: Three items on the checklist involve assessing your stock levels of contraceptive pills, ORS, and INH. You may feel that it is unfair for your performance to be judged on the basis of something you may not be able to influence. However;

1) as stated above the point of this logbook is not to judge performance but to IMPROVE IT. A health facility with inadequate supplies cannot provide good service.

2) All health workers have a responsibility to do whatever is necessary to ensure that their health facility has adequate supplies. This includes filling out requisitions, communicating the lack of supplies to your superiors quickly, and traveling to pick up supplies when necessary.

3) With the introduction of the Local Government Code, you will have greater responsibility for ensuring that your health facility has enough logistics and supplies. Under the LGC logistics and procurement will be primarily the duty of local government units.

H) DEFINITIONS: There are a few terms used in this logbook that are important to define clearly.

1) CATCHMENT POPULATION (or total population) refers to the population that your facility is responsible for and which is covered by your TCLs (ledger book). The catchment population must be based on the census data from 1990, NOT on your own surveys. (PHDP midwives should have their own TCLs and their own health facility code.)

2) LAST MONTH refers to the last calendar month. For example if a supervisory visit takes place on July 12th, the last month would refer to June 1 to June 30.

3) X MONTHS AGO refers to the number of months prior to the supervisory visit. For example, if a visit occurs in July, and we're interested in cases seen "4 months ago" this would refer to patients seen in March (7-4=3).

4) VISIT NUMBER refers to the number of the visit and not the month in which it takes place. For example if the 1st supervisory visit takes place in July it would be recorded as visit #1 NOT visit #7.

5) RANDOM SELECTION means that a number from the table of random numbers provided, is used to select the case on the TCL. For example, there were 6 newly registered women for prenatal care last month. In order to randomly select one record for review the supervisor should begin at the upper left-hand corner and move down the column. So during the first supervisory visit the supervisor would examine the record of the woman who was first on the AP TCL during the last month. She then crosses out the number 1 and during the next visit uses the second record and crosses out the number 2, etc. The supervisor would skip any random number that was larger than 6 (i.e.7, 8,9).

60 RANDOM NUMBERS (between 1 and 9)

1	7	9	2	8	4	2	5	2	5	7	2	6	4	6	2	1	9	1	4	2	7	6	9	5	6	2	5	9	6
2	1	4	2	9	8	4	7	3	7	8	1	3	1	4	5	9	4	7	8	2	3	1	5	3	7	6	3	1	6

I) ENDEMIC DISEASES: Indicators have been included on the checklist for leprosy and malaria. Because these diseases are not endemic everywhere, they have been placed below the total score. The scores on these indicators should NOT be included in the total score. (This would be unfair to areas which are non-endemic.)

J) FOR REMOTE HEALTH FACILITIES NOT EASILY REACHED BY SUPERVISORS

If your health facility is very remote and difficult for supervisors to reach you can supervise your own performance by following the instructions in this logbook. (For the indicators on CDD knowledge and Nutrition knowledge give yourself a score of 3.) You should also supervise yourself monthly! Your supervisor can verify your score when she comes on her next supervisory visit.

MATERNAL CARE

1) COVERAGE OF EARLY PRENATAL CARE:

Objective: To ensure that as many women as possible are receiving prenatal care and that at least 50% of them have their first visit during their 1st trimester.

CALCULATION:

$$\frac{\text{\# OF NEWLY REGISTERED MOTHERS SEEN IN THEIR 1ST TRIMESTER}}{\text{MONTHLY TARGET (TOTAL POPULATION X 0.003*)}} \text{ X 100\%}$$

* 3.5% of the population are pregnant during the year and there are 12 months in the year. 0.035 / 12 = 0.003

VISIT #1 --- = %	VISIT #2 --- = %	VISIT #3 --- = %	VISIT #4 --- = %	VISIT #5 --- = %	VISIT #6 --- = %
VISIT #7 --- = %	VISIT #8 --- = %	VISIT #9 --- = %	VISIT #10 --- = %	VISIT #11 --- = %	VISIT 12 --- = %
VISIT 13 --- = %	VISIT #14 --- = %	VISIT #15 --- = %	VISIT #16 --- = %	VISIT #17 --- = %	VISIT 18 --- = %
VISIT 19 --- = %	VISIT #20 --- = %	VISIT #21 --- = %	VISIT #22 --- = %	VISIT #23 --- = %	VISIT 24 --- = %

SCORING:
>50% = 5 POINTS
40% - 49% = 4 POINTS
30% - 39% = 3 POINTS
20% - 29% = 2 POINTS
<20% = 1 POINT

EXAMPLE: If the health facility has a catchment population of 3,500 and 7 women were newly registered for prenatal care last month out of which 3 were seen during their 1st trimester the calculation would be like this;

$$\frac{\text{\# seen in 1st trimester}}{\text{population X 0.003}} = \frac{3}{3{,}500 \text{ X } 0.003} = \frac{3}{10.5} = 28.6\%$$

The score would thus be 2 points!

2) QUALITY OF PRENATAL CARE:

Objective: To ensure that you carry out all the essential activities associated with good quality prenatal care.

RANDOMLY SELECT ONE WOMAN LISTED ON THE PRENATAL TCL AS NEWLY REGISTERED LAST MONTH AND OBTAIN THAT WOMAN'S INDIVIDUAL TREATMENT RECORD (ITR).

60 RANDOM NUMBERS (between 1 and 9)

1	7	9	2	8	4	2	5	2	5	7	2	6	4	6	2	1	9	1	4	2	7	6	9	5	6	2	5
9	6	2	1	4	2	9	8	4	7	3	7	8	1	3	1	4	5	9	4	7	8	2	3	1	5	3	7

SCORING:

1 POINT +
1 POINT IF THE AGE OF GESTATION (AOG) IS RECORDED
1 POINT IF THE BLOOD PRESSURE (BP) IS RECORDED
1 POINT IF THE WEIGHT (WT.) IS RECORDED
1 POINT IF THE RISK STATUS IS RECORDED
(EVEN IF THE WOMAN IS NOT AT RISK, HER NORMAL STATUS SHOULD BE INDICATED.)

visit	1	2	3	4	5	6	7	8	9	10	11	12
AOG												
BP												
WT.												
RISK												
visit	13	14	15	16	17	18	19	20	21	22	23	24
AOG												
BP												
WT.												
RISK												

EXAMPLE: If the ITR has the BP and weight recorded but not the risk or the age of gestation then a score of 3 would be given (i.e 1 point + 1 point for the BP + 1 point for the weight).

3) FREQUENCY OF PRENATAL CARE:

Objective: To ensure that pregnant women are receiving at least 3 prenatal visits.

CALCULATION:

$$\frac{\text{\# OF WOMEN WITH EDCs LAST MONTH WHO HAD "ADEQUATE"* PRENATAL CARE}}{\text{\# OF WOMEN HAVING EDCs LAST MONTH}} \times 100\%$$

* "ADEQUATE" PRENATAL CARE is defined as having at least 3 prenatal visits to your health facility recorded in the TCL with at least one visit in the 2nd trimester and one visit in the 3rd trimester.

VISIT #1 --- = %	VISIT #2 --- = %	VISIT #3 --- = %	VISIT #4 --- = %	VISIT #5 --- = %	VISIT #6 --- = %
VISIT #7 --- = %	VISIT #8 --- = %	VISIT #9 --- = %	VISIT #10 --- = %	VISIT #11 --- = %	VISIT 12 --- = %
VISIT 13 --- = %	VISIT #14 --- = %	VISIT #15 --- = %	VISIT #16 --- = %	VISIT #17 --- = %	VISIT 18 --- = %
VISIT 19 --- = %	VISIT #20 --- = %	VISIT #21 --- = %	VISIT #22 --- = %	VISIT #23 --- = %	VISIT 24 --- = %

SCORING:
>90% = 5 POINTS
65% - 89% = 4 POINTS
55% - 64% = 3 POINTS
25% - 54% = 2 POINTS
<25% = 1 POINT

Note: If the EDCs are not calculated or recorded give a score of 1 point.

EXAMPLE: Imagine that there are 4 women on the TCL who had EDCs last month. The first one had 2 prenatal visits, the second had 3 prenatal visits all in the last trimester, the third had 4 prenatal visits all in the 2nd trimester, and the fourth had 4 prenatal visits including 2 in the last trimester. Only the fourth woman would have obtained "adequate" prenatal care. The calculation would be;

1/4 = 25% (the score would be 2 points, see scoring above)

4) TETANUS TOXOID COVERAGE:

Objective: To ensure that all mothers and their babies are protected from getting tetanus.

CALCULATION:

$$\frac{\text{\# OF WOMEN ON AP TCL WITH EDCs LAST MONTH WHO HAD TT2+*}}{\text{TOTAL POPULATION X 0.003**}} \times 100\%$$

* TT2+ means that the woman had two or more doses of TT by the time she was supposed to deliver.

** 3.5% of the population are pregnant during the year and there are 12 months in the year. 0.035 / 12 = 0.003

VISIT #1 --- = %	VISIT #2 --- = %	VISIT #3 --- = %	VISIT #4 --- = %	VISIT #5 --- = %	VISIT #6 --- = %
VISIT #7 --- = %	VISIT #8 --- = %	VISIT #9 --- = %	VISIT #10 --- = %	VISIT #11 --- = %	VISIT 12 --- = %
VISIT 13 --- = %	VISIT #14 --- = %	VISIT #15 --- = %	VISIT #16 --- = %	VISIT #17 --- = %	VISIT 18 --- = %
VISIT 19 --- = %	VISIT #20 --- = %	VISIT #21 --- = %	VISIT #22 --- = %	VISIT #23 --- = %	VISIT 24 --- = %

SCORING:

>80% = 5 POINTS
70% - 79% = 4 POINTS
60% - 69% = 3 POINTS
50% - 59% = 2 POINTS
<50% = 1 POINT

5) QUALITY OF POST-PARTUM CARE:

Objective: To ensure that all post partum mothers receive appropriate care including commencement of breast feeding.

RANDOMLY SELECT ONE WOMAN ON THE PRENATAL CLIENT LIST WHO HAD AN EDC THREE MONTHS PRIOR TO THE SUPERVISORY VISIT. LOOK FOR THE WOMAN'S NAME ON THE POST-PARTUM CLIENT LIST.

60 RANDOM NUMBERS (between 1 and 9)

1	7	9	2	8	4	2	5	2	5	7	2	6	4	6	2	1	9	1	4	2	7	6	9	5	6	2	5
9	6	2	1	4	2	9	8	4	7	3	7	8	1	3	1	4	5	9	4	7	8	2	3	1	5	3	7

SCORING:

1 POINT +
1 POINT IF THE WOMAN HAD A RECORDED CLINIC VISIT BETWEEN HER 4TH AND 6TH WEEK (4-6)
1 POINT IF THE WOMAN STARTED BREASTFEEDING (BF.) HER CHILD AND THE DATE IS RECORDED
1 POINT IF THE MOTHER HAS HAD AT LEAST 3 HOME VISITS (3HV)
1 POINT IF THE MOTHER HAS RECEIVED A HIGH DOSE (200,000 IU) VITAMIN A CAPSULE

visit	1	2	3	4	5	6	7	8	9	10	11	12
4-6												
BF.												
3 HV												
VIT A												

visit	13	14	15	16	17	18	19	20	21	22	23	24
4-6												
BF.												
3 HV												
VIT A												

FAMILY PLANNING

6) NEW TO THE PROGRAM:

Objective: To ensure that couples desiring contraception join the program.

CALCULATION:

OF MCRAs WHO WERE NEW TO THE PROGRAM (NP*) LAST MONTH

EXPECTED # OF NP (TOTAL POPULATION x .0049**) x 100%

* New to the program (NP) refers only to Program methods. Withdrawal and rhythm are NOT included.

** 14% of the population are Married Couples of Reproductive Age (MCRAs), 85% of MCRAs are eligible for family planning (i.e they're not pregnant or infertile), 49% of continuing users are new acceptors (1988 NDS), and there are 12 months in the year.

0.0049 = 14% X 85% X 49% / 12

VISIT #1 --- = %	VISIT #2 --- = %	VISIT #3 --- = %	VISIT #4 --- = %	VISIT #5 --- = %	VISIT #6 --- = %
VISIT #7 --- = %	VISIT #8 --- = %	VISIT #9 --- = %	VISIT #10 --- = %	VISIT #11 --- = %	VISIT 12 --- = %
VISIT 13 --- = %	VISIT #14 --- = %	VISIT #15 --- = %	VISIT #16 --- = %	VISIT #17 --- = %	VISIT 18 --- = %
VISIT 19 --- = %	VISIT #20 --- = %	VISIT #21 --- = %	VISIT #22 --- = %	VISIT #23 --- = %	VISIT 24 --- = %

SCORING:
>35% = 5 POINTS
28% - 34% = 4 POINTS
20% - 27% = 3 POINTS
13% - 19% = 2 POINTS
<13% = 1 POINT

7) FOLLOW-UP RATE AMONG MCRAs NEW TO THE PROGRAM

Objective: To ensure that MCRAs that are new to the program do not drop out quickly and that they are well followed up.

CALCULATION:

$$\frac{\text{\# OF NPs 6* MONTHS AGO FOR PILLS, WHO HAD ADEQUATE** FOLLOW-UP}}{\text{\# OF MCRAs WHO WERE NPs (FOR PILLS) 6 MONTHS AGO}} \times 100\%$$

* Month of the supervisory visit minus 6. E.g. if supervision occurs in August look at NPs in February (8 - 6 = 2)

** ADEQUATE follow-up means that the couple came back 4 times or more in the last 6 months to obtain their supply of pills.

NOTE: If there were no NPs 6 months ago give a score of 1.

VISIT #1 --- = %	VISIT #2 --- = %	VISIT #3 --- = %	VISIT #4 --- = %	VISIT #5 --- = %	VISIT #6 --- = %
VISIT #7 --- = %	VISIT #8 --- = %	VISIT #9 --- = %	VISIT #10 --- = %	VISIT #11 --- = %	VISIT 12 --- = %
VISIT 13 --- = %	VISIT #14 --- = %	VISIT #15 --- = %	VISIT #16 --- = %	VISIT #17 --- = %	VISIT 18 --- = %
VISIT 19 --- = %	VISIT #20 --- = %	VISIT #21 --- = %	VISIT #22 --- = %	VISIT #23 --- = %	VISIT 24 --- = %

SCORING:
100% = 5 POINTS
90% - 99% = 4 POINTS
80% - 89% = 3 POINTS
75% - 79% = 2 POINTS
<75% = 1 POINT

8) ADEQUACY OF FAMILY PLANNING SUPPLIES:

Objective: To ensure that you have enough family planning supplies to provide to your clients.

CALCULATION:

$$\frac{\text{\# OF CYCLES OF PILLS IN STOCK, AT HEALTH FACILITY}}{\text{REQUIRED \# OF CYCLES (CONTINUING USERS x 2 IF BHS, x 3 IF RHU)}} \text{ X } 100\%$$

NOTE: Obtain the number of continuing users of pills from summary output tables or form M-1.

VISIT #1 --- = %	VISIT #2 --- = %	VISIT #3 --- = %	VISIT #4 --- = %	VISIT #5 --- = %	VISIT #6 --- = %
VISIT #7 --- = %	VISIT #8 --- = %	VISIT #9 --- = %	VISIT #10 --- = %	VISIT #11 --- = %	VISIT 12 --- = %
VISIT 13 --- = %	VISIT #14 --- = %	VISIT #15 --- = %	VISIT #16 --- = %	VISIT #17 --- = %	VISIT 18 --- = %
VISIT 19 --- = %	VISIT #20 --- = %	VISIT #21 --- = %	VISIT #22 --- = %	VISIT #23 --- = %	VISIT 24 --- = %

SCORING:
80%-200% = 5 POINTS
>200% = 3 POINTS
50%-80% = 2 POINTS
<50% = 1 POINT

EXAMPLE: If you work in a BHS and have 25 continuing users of pills and have 120 cycles of pills then the calculation would be;

$$\frac{\text{\# of cycles in stock}}{\text{required \# of cycles}} = \frac{120}{25 \text{ X } 2} = \frac{120}{50} \text{ x } 100\% = 240\%$$

This indicates an over-supply and would be given a score of 3 points (see above).

CONTROL OF DIARRHEAL DISEASE

9) CDD KNOWLEDGE AND SKILLS:

Objective: To ensure that you are familiar with the CDD treatment chart and can properly diagnose and treat dehydration.

Your supervisor will give you a role play or questions about diarrhea based on the treatment chart. You will have to be able to assess the degree of dehydration, decide how much oresol to give to a dehydrated child, know what to do for a child with dysentery, and how to properly prepare oresol.

==========

10) ADEQUACY OF ORS SUPPLY:

Objective: To ensure that you have enough ORS in stock to deal with all the cases you are likely to see.

CALCULATION:

$$\frac{\text{\# OF PACKETS OF ORS IN STOCK, AT HEALTH FACILITY}}{\text{AUTHORIZED STOCK LEVEL}} \times 100\%$$

VISIT #1 --- = %	VISIT #2 --- = %	VISIT #3 --- = %	VISIT #4 --- = %	VISIT #5 --- = %	VISIT #6 --- = %
VISIT #7 --- = %	VISIT #8 --- = %	VISIT #9 --- = %	VISIT #10 --- = %	VISIT #11 --- = %	VISIT 12 --- = %
VISIT 13 --- = %	VISIT #14 --- = %	VISIT #15 --- = %	VISIT #16 --- = %	VISIT #17 --- = %	VISIT 18 --- = %
VISIT 19 --- = %	VISIT #20 --- = %	VISIT #21 --- = %	VISIT #22 --- = %	VISIT #23 --- = %	VISIT 24 --- = %

SCORING:
67%-200% = 5 POINTS
34%-66% = 3 POINTS
>200% = 2 POINTS
<33% = 1 POINT

NOTE: If no authorized stock level has been calculated give a score of 1 point.

EXPANDED PROGRAM ON IMMUNIZATION

11) BCG COVERAGE

Objective: Ensuring that you are doing ACTIVE MASTERLISTING and are reaching large numbers of children.

CALCULATION:

$$\frac{\text{\# OF INFANTS RECEIVING BCG LAST MONTH}}{\text{MONTHLY TARGET (CATCHMENT POP.x 0.0025*)}} \times 100\%$$

* 3% of the population are infants and there are 12 months in the year. 3% / 12 = 0.0025

VISIT #1 --- = %	VISIT #2 --- = %	VISIT #3 --- = %	VISIT #4 --- = %	VISIT #5 --- = %	VISIT #6 --- = %
VISIT #7 --- = %	VISIT #8 --- = %	VISIT #9 --- = %	VISIT #10 --- = %	VISIT #11 --- = %	VISIT 12 --- = %
VISIT 13 --- = %	VISIT #14 --- = %	VISIT #15 --- = %	VISIT #16 --- = %	VISIT #17 --- = %	VISIT 18 --- = %
VISIT 19 --- = %	VISIT #20 --- = %	VISIT #21 --- = %	VISIT #22 --- = %	VISIT #23 --- = %	VISIT 24 --- = %

SCORING:
>90% = 5 points
75%-89% = 3 points
50%-74% = 2 points
<50% = 1 point

12) FIC FOLLOW-UP RATE

Objective: Ensuring that you are following up all the infants on your masterlist (TCL) so that they become fully immunized

CALCULATION:

 # OF INFANTS WITH 1ST BIRTHDAY LAST MONTH WHO ARE FULLY IMMUNIZED
——————————————————————————————X 100%
 # OF INFANTS WITH 1ST BIRTHDAY LAST MONTH (SEE NOTE BELOW)

NOTE: Children who have transferred out will NOT be counted in either the numerator or the denominator as long as it is plainly written in the "remarks" column that the infant has moved away.

VISIT #1 — = %	VISIT #2 — = %	VISIT #3 — = %	VISIT #4 — = %	VISIT #5 — = %	VISIT #6 — = %
VISIT #7 — = %	VISIT #8 — = %	VISIT #9 — = %	VISIT #10 — = %	VISIT #11 — = %	VISIT 12 — = %
VISIT 13 — = %	VISIT #14 — = %	VISIT #15 — = %	VISIT #16 — = %	VISIT #17 — = %	VISIT 18 — = %
VISIT 19 — = %	VISIT #20 — = %	VISIT #21 — = %	VISIT #22 — = %	VISIT #23 — = %	VISIT 24 — = %

SCORING:
100% = 4 POINTS
80%-99% = 2 POINTS
<80% = 1 POINT

+1 POINT IF ALL THE FIC RECEIVED 100,000 IU VITAMIN A

13) USE OF EPI MONITORING CHART:

Objective: To ensure that you are using an EPI monitor chart to keep track of your EPI accomplishments. If your accomplishment is low the chart will indicate the need for increased EPI activities.

SCORING:

1 POINT +

1 POINT if there is an EPI chart for this year on the wall

1 POINT if the target population is calculated correctly (i.e. TP x 3%, DO NOT USE SERVICE TARGET)

1 POINT if the chart includes data from the last month (UTD)

1 POINT if the FIC accomplishment at the end of the year will be >85%

visit	1	2	3	4	5	6	7	8	9	10	11	12
CHART												
T.P.												
UTD.												
>85%?												

visit	13	14	15	16	17	18	19	20	21	22	23	24
CHART												
T.P.												
UTD.												
>85%?												

UNDER FIVE CLINICS

14) FOLLOW UP OF HIGH RISK CHILDREN

Objective: Ensure that you are adequately following up the children who are "at risk".

SELECT RANDOMLY 4 CHILDREN, WHO WERE ENTERED ON THE UFC CLIENT LIST MORE THAN 4 MONTHS AGO

60 RANDOM NUMBERS (between 1 and 9)

1	7	9	2	8	4	2	5	2	5	7	2	6	4	6	2	1	9	1	4	2	7	6	9	5	6
2	5	9	6	2	1	4	2	9	8	4	7	3	7	8	1	3	1	4	5	9	4	7	8	2	3

SCORING:

1 POINT + 1 POINT for each child who has been weighed at least once in the last 3 months.

NUTRITION:

15) FOLLOW-UP OF MALNOURISHED CHILDREN

Objective: Ensure that you are adequately following up your moderately and severely malnourished children.

SELECT RANDOMLY 4 CHILDREN, WHO WERE ENTERED ON THE 0-83 CLIENT LIST.

60 RANDOM NUMBERS (between 1 and 9)

1	7	9	2	8	4	2	5	2	5	7	2	6	4	6	2	1	9	1	4	2	7	6	9	5	6	2	5
9	6	2	1	4	2	9	8	4	7	3	7	8	1	3	1	4	5	9	4	7	8	2	3	1	5	3	7

SCORING:

1 POINT + 1 POINT for each child who was weighed in the last 3 months AND received Vitamin A in the last 6 months.

16) NUTRITION KNOWLEDGE:

Objective: To ensure that you are aware of some of the basic information needed to offer sound nutritional advice and treat nutritional problems when necessary.

Your supervisor will give you a role play or ask you a few questions about some aspect of nutrition such as; Breastfeeding, Weaning, Vitamin A deficiency (VAD), Iodine Deficiency Disease (IDD), Iron Deficiency Anemia (IDA), and Growth Monitoring.

TUBERCULOSIS CONTROL

17) TB CASEFINDING - SPUTUM COLLECTION:

Objective: To ensure that you are doing your best to find all cases of TB by collecting sputum specimens from symptomatics.

CALCULATION:

$$\frac{\text{\# OF 1ST SPUTUM SAMPLES COLLECTED LAST MONTH*}}{\text{MONTHLY TARGET (TOTAL POPULATION X 0.0066**)}} \text{ X } 100\%$$

*** Only include sputum samples that were listed on the TCL not on any other list.**

**** The prevalence of TB is believed to be 6.6 per 1,000 population, there are 12 months in the year, and to maintain a sputum positivity rate of 8.3% you need to collect 12 sputum to find one positive.**

0.0066 = .0066 X 12 / 12

VISIT #1 — = %	VISIT #2 — = %	VISIT #3 — = %	VISIT #4 — = %	VISIT #5 — = %	VISIT #6 — = %
VISIT #7 — = %	VISIT #8 — = %	VISIT #9 — = %	VISIT #10 — = %	VISIT #11 — = %	VISIT 12 — = %
VISIT 13 — = %	VISIT #14 — = %	VISIT #15 — = %	VISIT #16 — = %	VISIT #17 — = %	VISIT 18 — = %
VISIT 19 — = %	VISIT #20 — = %	VISIT #21 — = %	VISIT #22 — = %	VISIT #23 — = %	VISIT 24 — = %

SCORING:
>50% = 5 POINTS
40% - 49% = 4 POINTS
20% - 39% = 3 POINTS
10% - 19% = 2 POINTS
<10% = 1 POINT

18) TB CASEHOLDING - FOLLOW UP OF PATIENTS

Objective: To ensure that you are properly following up all your TB patients.

CALCULATION:

$$\frac{\text{\# OF TB PATIENTS BEING PROPERLY* FOLLOWED UP}}{\text{\# OF SPUTUM +VE AND CAVITARY PATIENTS DISCOVERED IN LAST 6 MONTHS}} \times 100\%$$

* PROPER follow up means that the patient has received his/her medicine within the last month. Where the patient has NOT obtained his or her medicine in the last month a record must exist of a follow up visit to the house of the patient. In those cases where a patient transferred to another area a carbon copy of the referral note should be available in the health facility. (see pages 45 to 47 of the National Tuberculosis Control Program Manual.)

VISIT #1 --- = %	VISIT #2 --- = %	VISIT #3 --- = %	VISIT #4 --- = %	VISIT #5 --- = %	VISIT #6 --- = %
VISIT #7 --- = %	VISIT #8 --- = %	VISIT #9 --- = %	VISIT #10 --- = %	VISIT #11 --- = %	VISIT 12 --- = %
VISIT 13 --- = %	VISIT #14 --- = %	VISIT #15 --- = %	VISIT #16 --- = %	VISIT #17 --- = %	VISIT 18 --- = %
VISIT 19 --- = %	VISIT #20 --- = %	VISIT #21 --- = %	VISIT #22 --- = %	VISIT #23 --- = %	VISIT 24 --- = %

SCORING:
100% = 5 POINTS
80%-99% = 3 POINTS
50%-79% = 2 POINTS
<50% = 1 POINT

If there have been no TB patients in the last 6 months give a score of 1.

19) ADEQUACY OF TB DRUG SUPPLY

Objective: To ensure that you have an adequate supply of anti-TB medicines available to treat all your patients.

CALCULATION:

OF INH TABLETS[1] AVAILABLE IN FACILITY (INCLUDE BLISTER PACKS)
---------- =*
OF PATIENTS ON SCC & SR TREATMENT X 30 (TABLETS/MONTH)

[1]300mg tablet (the number of 100mg tablets should be divided by 3)

* NUMBER OF MONTHS WORTH OF INH SUPPLY

VISIT #1 --- = *	VISIT #2 --- = *	VISIT #3 --- = *	VISIT #4 --- = *	VISIT #5 --- = *	VISIT #6 --- = *
VISIT #7 --- = *	VISIT #8 --- = *	VISIT #9 --- = *	VISIT #10 --- = *	VISIT #11 --- = *	VISIT 12 --- = *
VISIT 13 --- = *	VISIT #14 --- = *	VISIT #15 --- = *	VISIT #16 --- = *	VISIT #17 --- = *	VISIT 18 --- = *
VISIT 19 --- = *	VISIT #20 --- = *	VISIT #21 --- = *	VISIT #22 --- = *	VISIT #23 --- = *	VISIT 24 --- = *

EXAMPLE: If there were 3 patients on SCC and 2 patients on SR and the health facility had 250 INH tablets in stock then the indicator would be calculated like this;

250 INH tablets / 5 patients x 30 tablets/mo. = 250/150 = 1.67 months supply of INH

SCORING:
>3 MONTHS SUPPLY = 5 POINTS
2-3 MONTHS SUPPLY = 4 POINTS
1-2 MONTHS SUPPLY = 2 POINTS
<1 MONTHS SUPPLY = 1 POINT

99

SCORING:

100% = 5 POINTS
101% - 115% = 3 POINTS
85% - 99% = 2 POINTS
<85% OR >115% = 1 POINT

EXAMPLE: If you selected the 3rd indicator, and found that there were 7 women on the target client list who completed their 6th week post partum while on the form M-1, 5 women were reported as completing 6 weeks post-partum then the calculation would look like this;

$$\frac{\text{\# of women in TCL}}{\text{\# on form M-1}} = \frac{7}{5} \times 100\% = 140\% \text{ (score = 1 point)}$$

150.

ENDEMIC DISEASES

1) LEPROSY CASE FINDING AND MANAGEMENT:

Objective: To ensure that you are doing your best to find new cases of leprosy and are providing good follow-up for existing cases.

RANDOMLY SELECT ONE PATIENT WITH LEPROSY FROM THE LEPROSY CLIENT LIST OR LEPROSY INDEX BOX.

34 RANDOM NUMBERS (between 1 and 9)

4 3 5 9 1 2 4 7 4 6 3 5 9 3 1 2 9
4 5 1 1 2 9 1 7 8 3 4 8 3 7 6 9 1

SCORING:

1 POINT +

1 POINT IF ALL HOUSEHOLD CONTACTS HAVE BEEN EXAMINED IN THE LAST YEAR. (CONTACTS THAT ARE DOCUMENTED TO HAVE REFUSED OR HAVE MOVED SHOULD NOT BE INCLUDED) (C.E.)

1 POINT IF THE PATIENT'S LAST VISIT WAS WITHIN THE LAST MONTH

1 POINT IF S/HE CAME WITHIN 7 DAYS OF THE LAST COLLECTION DUE DATE

1 POINT IF THERE IS ANY EVIDENCE OF ACTIVE CASE FINDING ON FORM M-1 FOR THE LAST MONTH (E.G. DROP-IN CONSULTATION OR REFERRAL)

visit	1	2	3	4	5	6	7	8	9	10	11	12
C.E.												
L.M.												
+/-7D												
ACF												

visit	13	14	15	16	17	18	19	20	21	22	23	24
C.E.												
L.M.												
+/-7D												
ACF												

2) ADEQUACY OF MALARIA DETECTION AND TREATMENT:

Objective: To ensure that cases of malaria are found, diagnosed and treated properly.

SCORING:

1 POINT +
1 POINT IF THE MIDWIFE COLLECTED ANY SMEARS LAST MONTH
(SEE FORM M-1)
1 POINT IF THE RESULTS OF THE SMEARS ARE RECORDED
(SEE SURVEY FORM, FORM 1)
1 POINT IF THERE IS AT LEAST ONE POSITIVE SMEAR RECORDED
1 POINT IF THERE ARE 50 OR MORE CHLOROQUINE TABS. IN STOCK

visit	1	2	3	4	5	6	7	8	9	10	11	12
SMEAR												
RES.												
1+VE												
>50												

visit	13	14	15	16	17	18	19	20	21	22	23	24
SMEAR												
RES.												
1+VE												
>50												

101

ACKNOWLEDGEMENTS:

The development of this checklist would have been impossible without the help and insights of;

Dr. Manuel G. Roxas and the staff of the Office of Public Health

Dr. Manuel M. Dayrit and the staff of the Health Intelligence Service

Dr. Zenaida Ludovice (Internal Planning Service).

Dr. Elvira SN Dayrit and the staff of the Maternal and Child Health Service

Dr. Jovencia Quintong and the staff of The Family Planning Service

Mrs. Adelisa Ramos and the staff of The Nutrition Service

Dr. Francisco Valeza and the staff of The Tuberculosis Control Service

Dr. Jesus Abella and the staff of the Communicable Disease Control Service

Eng. Celestino Asinas and the staff of the Malaria Control Service

Dr. Milagros Fernandez and the staff of RHO IX,

Dr. Ricardo Ochoterena and the staff of the IPHO of Zamboanga del Sur

Dr. Carmencita P. Icao and the staff of IPHO of Zamboanga del Norte and staff

Dr. Natividad Castillo and the staff of IPHO of Basilan and staff

Dr. Nelsa L. Amin and the staff of IPHO of Sulu and staff

Dr. Prudencio J. Ortiz and the staff of Region VIII

Dr. John Kam and the staff of the IPHO of Northern Samar

Dr. Vitus T. Hobayan and the staff of the IPHO of Western Samar

Dr. Jovencia F. Ordona and the staff of Cordillera Autonomous Region

Dr. Juan Q. Bartolo, Jr. and the staff of IPHO of Kalinga Apayao

Dr. Ferdinand T. Tolentino and the staff of IPHO of Ifugao

Dr. Saturnino Bayasen and the staff of IPHO of Benguet

Dr. Apolinario A. Pilit and the staff of IPHO of Mountain Province

UNICEF

Child Survival Program

United States Agency for International Development

SUPERVISOR'S COMMENTS AND SUGGESTIONS

VISIT # ___ Date: |___|___| 199__ Supervisor's Name: _____	COMMENTS AND SUGGESTIONS	Who is responsible for accomplishing?	Target date for accomplishing	Actually accomplished?
VISIT # ___ Date: |___|___| 199__ Supervisor's Name: _____	COMMENTS AND SUGGESTIONS	Who is responsible for accomplishing?	Target date for accomplishing	Actually accomplished?
VISIT # ___ Date: |___|___| 199__ Supervisor's Name: _____	COMMENTS AND SUGGESTIONS	Who is responsible for accomplishing?	Target date for accomplishing	Actually accomplished?

SUPERVISOR'S COMMENTS AND SUGGESTIONS

VISIT # ___ Date: |___|___| 199__ Supervisor's Name: _____	COMMENTS AND SUGGESTIONS	Who is responsible for accomplishing?	Target date for accomplishing	Actually accomplished?
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VISIT # ___ Date: |___|___| 199__ Supervisor's Name: _____	COMMENTS AND SUGGESTIONS	Who is responsible for accomplishing?	Target date for accomplishing	Actually accomplished?

10c

Integrated Supervisory Checklist	CATCHMENT POPULATION: 199___ = ___			199___ = ___				
Visit Number	1	2	3	4	5	6	7	8
Date of Visit								
MCH 1. Coverage of early prenatal care								
2. Quality of prenatal care								
3. Frequency of prenatal care								
4. Tetanus toxoid coverage								
5. Quality of post partum care								
F.P. 6. New to the Program (NP)								
7. Follow-up rate for NPs								
8. Adequacy of F.P. supplies								
CDD 9. Knowledge and skills								
10. Adequacy of ORS supply								
EPI 11. BCG coverage/ masterlisting								
12. FIC follow-up rate								
13. EPI monitoring chart								
UFC 14. Under five clinic follow-up								
NUTR 15. Follow-up of malnourished								
16. Nutrition knowledge								
TB 17. TB casefinding sputum collection								
18. TB caseholding follow-up of Pts.								
19. Adequacy of drug supply								
HIS 20. Accuracy of FHSIS reporting								
** TOTAL SCORE **								
1. Leprosy								
2. Malaria								
Supervisor's initials								
Health worker's initials								

Integrated Supervisory Checklist	CATCHMENT POPULATION: 199___ = ___			199___ = ___				
Visit Number	1	2	3	4	5	6	7	8
Date of Visit								
MCH 1. Coverage of early prenatal care								
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4. Tetanus toxoid coverage								
5. Quality of post partum care								
F.P. 6. New to the Program (NP)								
7. Follow-up rate for NPs								
8. Adequacy of F.P. supplies								
CDD 9. Knowledge and skills								
10. Adequacy of ORS supply								
EPI 11. BCG coverage/ masterlisting								
12. FIC follow-up rate								
13. EPI monitoring chart								
UFC 14. Under five clinic follow-up								
NUTR 15. Follow-up of malnourished								
16. Nutrition knowledge								
TB 17. TB casefinding sputum collection								
18. TB caseholding follow-up of Pts.								
19. Adequacy of drug supply								
HIS 20. Accuracy of FHSIS reporting								
** TOTAL SCORE **								
1. Leprosy								
2. Malaria								
Supervisor's initials								
Health worker's initials								

FIELD HEALTH SERVICES INFORMATION SYSTEM

INTEGRATED SUPERVISORY CHECKLIST

SUPERVISOR'S COPY

"Above all serve the people"

NAME OF SUPERVISOR: _____

HEALTH INTELLIGENCE SERVICE

OFFICE OF PUBLIC HEALTH SERVICES

Republic of the Philippines
Department of Health

OFFICE OF THE SECRETARY

SAN LAZARO COMPOUND, RIZAL AVENUE, STA. CRUZ, MANILA, PHILIPPINES
TEL. NOS. 711-9106 • 711-9061

MESSAGE

My Dear Fellow Health Workers,

The highest goal any of us can hope to achieve is to serve others, to share with them all our knowledge, skills, and commitment. I am reminded of the parable of a village which had no church but which had collected all the money and materials needed to build one. The biggest problem they faced was deciding where the church should be situated. When a site on the western part of the village was suggested the people on the eastern part would complain. When a site north of the village was recommended, everybody complained that it was too far away.

Around this time a terrible drought hit the village and the harvest was very poor. Everyone worried about hunger because the average yield was only 5 cavans of rice per hectare. There were two farmers who were very close friends, and who lived in adjacent barrios. Due to their small plots they each harvested only one cavan of rice and were extremely worried about their families well-being.

One of the farmers, out of concern for the welfare of his friend's family, decided that he would divide his meager harvest in two and take it to his friend's house. He put the half cavan of rice on his shoulders and set off in the middle of the night. At the border between the two barrios, in the pitch dark, the two friends bumped into each other.

"Where are you going at this time of night?" asked the first farmer.

"To your home to give you this half sack of rice," answered the second farmer. "And you?"

The first farmer started to laugh. "I was on my way to give you this half sack of rice as your share of my poor harvest."

The two friends embraced each other and tears welled from their eyes. The people of the village decided that they should build their church on the spot where the two friends met because it was the point nearest heaven.

Through the sharing of your knowledge and skills with your communities, your health facilities too will be points close to heaven. This supervisory checklist is a tool that will help you improve the health services that you provide to your communities, but it is only a tool. You are the ones that must provide the care, concern, and sharing that will really improve the health of your communities.

I wish you all the best of luck,

Juan M. Flavier, M.D., M.P.H.
Secretary of Health

27 July 1992

10

Republic of the Philippines
Department of Health

OFFICE OF THE SECRETARY

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FOREWORD

We have been preoccupied with our task of providing quality health care. Indeed, most of our time and resources have been used to search for and operationalize the most acceptable, effective and efficient methods of health service delivery and, in determining performance standards for our service providers.

In order to enforce these methods and standards, we need to ensure that appropriate systems link the program manager with the program implementor. The **Integrated Supervisory Checklist**, pilot tested by the Health Intelligence Service in collaboration with the Office for Public Health Services, has proven to be a most promising strategy for improving the performance of our much valued frontliner, the midwife, through a system which enhances the role of her supervisors.

On behalf of the directors and managers of public health programs, I am endorsing the implementation of the Integrated Supervisory Checklist by all public health nurses and health officers. With your continued commitment and cooperation, I am confident that we shall move a few more steps closer to our common goal: quality health care.

Manuel G. Roxas, MD, MFH
Undersecretary for
Public Health Services

INTRODUCTION TO THE INTEGRATED SUPERVISORY CHECKLIST FOR SUPERVISORS

The Integrated Supervisory Checklist (ISC) is a tool for you to use in helping your midwives provide high quality health services to all the people in their community. The ISC has been extensively field tested in 4 provinces (Zamboanga Sur, Basilan, Northern Samar, and Kalinga Apayao), and led to a major improvement in midwives' performance. Performance, as measured by the total scores on the ISC, improved by 42% in 6 months in the 4 pilot provinces. In the six control provinces (Zamboanga Norte, Sulu, Western Samar, Mountain Province, Benguet, and Ifugao), there was only a 18% increase in scores. This meant, for example, that the proportion of women with 3 prenatal visits and tetanus toxoid immunization improved 31% in the experimental areas compared to 6% in the control health facilities.

The improvement in scores seen in the provinces where the ISC was implemented was directly related to the frequency with which it was used (see figure #1). Notice that in the control areas where there was no ISC, the frequency of supervisory visits was unrelated to improvement in scores. Therefore, using the ISC on a monthly basis will have a definite impact on performance.

USING THE ISC ON A MONTHLY BASIS WILL IMPROVE PERFORMANCE MARKEDLY.

FIG. #1: EFFECT OF FREQUENCY OF USE OF I.S.C. ON CHANGE IN PERFORMANCE SCORE IN PILOT AREAS

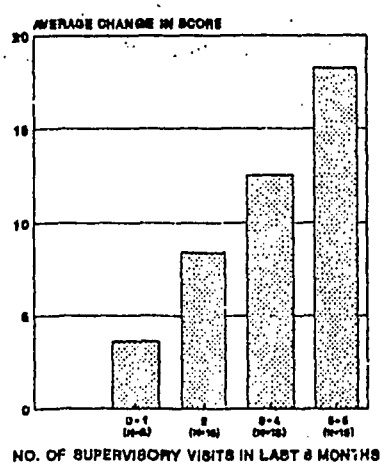
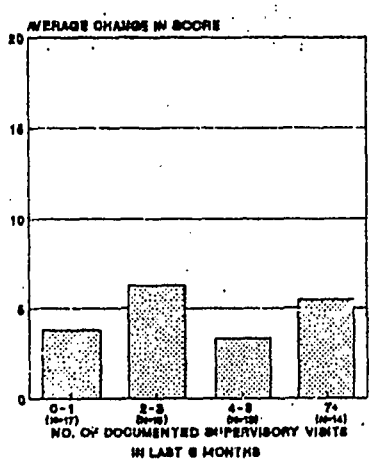


FIG. #2: EFFECT OF FREQUENCY OF DOCUMENTED SUPERVISION ON CHANGE IN PERFORMANCE SCORE, CONTROL AREAS



Focus group discussions conducted by independent social scientists indicated that both the supervisors and the midwives felt the ISC made the relationship between them more professional and productive. Supervision carried out using the ISC is enjoyable and makes for smooth interpersonal relations with the midwives you supervise.

SOME BASICS OF SUPERVISION

A. WHY DO WE DO SUPERVISION?

There are two fundamental reasons for supervising another person's work:

1) TO IMPROVE PERFORMANCE

In order for us to improve the health of the Filipino people, we must strive to improve the quality and quantity of the services we provide. We are interested in RESULTS because it means that there will be less suffering, less disease, less pain. Hence a supervisor should NOT be interested in "judging" the performance of a health worker, only in IMPROVING her (or his) performance.

> WE DON'T NEED TO CRITICIZE PERFORMANCE
> WE NEED TO IMPROVE PERFORMANCE

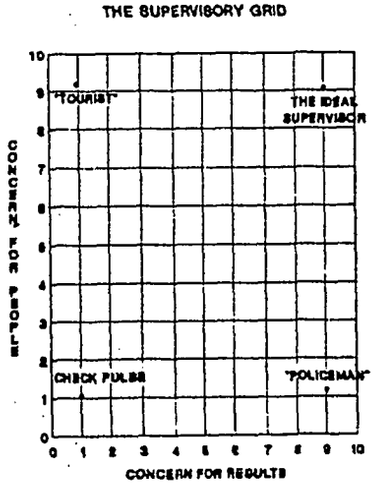
2) TO SUPPORT AND EMPATHIZE WITH HEALTH WORKERS:

We need to support and empathize with the health workers we supervise. We do this not just to achieve results, but because we love them as fellow human beings, members of our family. We have concern for them as we expect others to be concerned about us.

> WE NEED TO BE CONCERNED ABOUT THE PEOPLE WE WORK WITH, AS WE EXPECT OTHERS TO BE CONCERNED ABOUT OUR WELL-BEING

One way of being thinking about the role of the supervisor is to look at the figure below, sometimes called the supervisory grid. Some supervisors are only concerned with being liked. When visiting a health facility they ask mostly about the health worker's family or the barrio fiesta. This kind of supervisor, sometimes called a "tourist", may have concern for the health worker but has little interest in results.

THE SUPERVISORY GRID



Some supervisors on the other hand are very strict and come to the health facility as if they were the police looking for criminals. They may be very interested in results but do not show any concern for the health worker herself. Other supervisors show little regard for results and also no concern for the health worker. These supervisors should have their pulse checked in order to ensure that they are still alive.

The ideal supervisor is obviously one who is concerned both about results AND about the well-being of the health worker.

> A GOOD SUPERVISOR IS CONCERNED BOTH WITH RESULTS AND THE WELL BEING OF THE HEALTH WORKER BEING SUPERVISED.

B. WHAT THINGS CAN WE DO TO SUPERVISE EFFECTIVELY?

1) BE THERE!!It's impossible to be an effective supervisor if you don't go and visit the health facilities that you are responsible for! Sometimes there are health facilities that are very remote that you can not visit monthly. In those cases you can have the health worker supervise herself using the ISC and you can check her own ratings when you go on your next visit.

2) BE POSITIVE!!

The more positive you are about the work of the people you supervise the better they will perform. This is called the "self-fulfilling prophecy". Many studies in psychology have demonstrated its effectiveness. For example, school children at the end of grade 2 are given good or bad report cards at random, that is, the report cards are unrelated to their real performance. The report cards are shown to their Grade 3 teachers. At the end of Grade 3 the students perform much closer to their fake grade 2 report cards than their actual grade 2 performance. The students who received good report cards perform well and the ones who got the bad reports cards performed poorly regardless of their true grade 2 performance. The Grade 3 teachers have treated the students with good report cards as "smart" and the ones with bad "report" cards as "stupid" and this actually effects the students' performance.

> TREATING PEOPLE AS THOUGH THEY CAN PERFORM WELL WILL ACTUALLY IMPROVE THEIR PERFORMANCE

3) CRITICIZE CAREFULLY!! None of us likes to be criticized! Unfortunately, sometimes there are things that we are not doing well that need to improved. In order to gently correct mistakes there are a few simple things you, as a supervisor, can do.

a) Be specific! It's generally easier for people to accept criticism that is very specific because they can see for themselves what the problem is. For example, it is preferable to say, "these 3 patients with TB need to be followed up because they have not come in for their medicines in the last month" than to say "You are not following up your patients well!"

b) Express your confidence that the problem can be resolved! This is related to being positive and taking advantage of the "Self-fulfilling prophecy." For example, it would be easier for the health worker to accept the criticism about the 3 TB patients if the supervisor said something like, "I'm sure that you will follow up these 3 patients well. The next time I come back I'm confident that you will have solved this problem."

c) Limit the number of criticisms you make! Even if there are many problems that need to be resolved it is not useful to make too many criticisms at one time. Firstly, health workers will become depressed and may react badly. Secondly, they won't be able to resolve all the problems if they are confronted with too many at one time.

117

CRITICIZING CAREFULLY MEANS:

1) BEING SPECIFIC

2) EXPRESSING CONFIDENCE THAT THE PROBLEM CAN BE RESOLVED

3) LIMITING THE NUMBER OF CRITICISMS MADE AT ONE TIME

4) ACKNOWLEDGE SUCCESS!! Many studies in psychology have demonstrated that having one's success recognized by others is an important motivating factor. Whenever you see honest success or progress its critical to acknowledge it openly and warmly. You should be congratulating health workers more often than you criticize them.

5) SET OBJECTIVES THAT ARE S.M.A.R.T.!! Whenever you make recommendations to health workers or set objectives, they should be S.M.A.R.T. That is they should be; Specific, Measurable, Achievable, Responsibility clearly defined, Time-bound.

6) FOLLOW UP CONSISTENTLY!! More things go wrong because of poor follow-up than any other single cause. If you don't follow up regularly performance will not improve.

SIX SIMPLE THINGS TO IMPROVE SUPERVISION

1) BE THERE!!

2) BE POSITIVE!!

3) CRITICIZE CAREFULLY!!

4) ACKNOWLEDGE SUCCESS!

5) SET OBJECTIVES THAT ARE S.M.A.R.T.!

6) FOLLOW UP CONSISTENTLY!

C. ANALYSIS OF DATA FROM YOUR SUPERVISORY VISITS:

The ISC is almost like a health facility survey. It gives you important information about which programs are working well and which need more attention. It also tells you at a glance which health facilities need more help. It is very helpful and easy to consolidate the data from the ISC and use it for management purposes. In this logbook you will find some copies of the checklist that are specially designed to help you analyse the results of your supervisory visits (these are titled "analysis of results from supervisory visits").

In the blank space labeled "A" place the number of health facilities that you visited. You can analyze the data whenever you like, although it makes sense to have a minimum of 10 visits to analyse.

In column 1 place the total of all the scores on each indicator. For example, if you visited 5 health facilities (a small number to analyse) and they scored 2,3,1,4,1 on indicator #1, i.e. coverage of early prenatal care, you would total up the scores and place 11 (2+3+1+4+1) in column 1.

In column 2 put the result of: column 1 / "A". In the example this would be 11/5 = 2.2

In column 3 put the rank of the average score of that indicator. For example you would compare the 2.2 average score of early prenatal care with the average scores of the other indicators. Rank number 1 would be given to the indicator with the highest score and rank number 20 would be given to the lowest.

In column 4 place the number of health facilities with scores of "1" on that indicator. For the example above two facilities got a score of "1" so a 2 would be placed in column 4.

In column 5 put the result of: column 4 / "A" x 100%. In the example this would be 2/5 x 100% = 40%

Column 6 is meant to identify indicators that have low scores and what actions are needed to improve them.

D. SUMMARY OF STEPS IN USING THE INTEGRATED SUPERVISORY CHECKLIST:

1) Use health facility copy of ISC and calculate scores for each of the 20 indicators

2) Calculate the total score for all the 20 indicators.

3) Copy the results from the health facility copy into the supervisors copy of the ISC.

4) Examine previous scores and comments to see if suggested actions were taken.

5) Come up with comments (remember to be SMART) and record them on the sheet provided.

6) Have the health worker place the score on her performance graph.

7) After conducting 10 or more supervisory visits use the analysis sheets to see which programs and health facilities need extra attention.

QUESTIONS RELATED TO CDD KNOWLEDGE AND SKILLS

THE HEALTH WORKERS ANSWERING THESE QUESTION CAN USE THE CDD TREATMENT CHART. IT IS MEANT TO BE A TOOL FOR THEM!

JANUARY

A mother brought her 2 1/2 year old daughter Lorna to Bago Barangay Health Station. Lorna was assessed and found to have dry tongue and mouth. Skin pinch of her abdomen goes back slowly. The mother said Lorna's urine was dark in color and in small amount.

What should the midwife do to manage this case. Include assessment of dehydration, Treatment Plan and amount of Oresol to give.

SCORING:
3 POINTS FOR MENTIONING TREATMENT PLAN B
2 POINTS FOR 600-800 ML. OF ORESOL IN 1ST 4-6 HOURS
5 POINTS FOR BOTH
1 POINT IF NEITHER

==========

FEBRUARY

THIS IS A ROLE PLAY!!! INFORMATION TO BE GIVEN TO HEALTH WORKER:

"Mario is 3 years old and weighs 13 kg. His diarrhea started 24 hours ago and he had 3 liquid stools. You can ask me any question you like about the signs and symptoms of Mario."

INFORMATION TO BE GIVEN ONLY WHEN SPECIFICALLY ASKED FOR BY THE HEALTH WORKER.

Mario looks quite well. His mouth is wet, his skin goes back quickly when pinched, his eyes look normal, his pulse is normal, and he passes urine normally. Mario's mother says that the child is thirsty. All other signs and symptoms are unremarkable.

ASK THE HEALTH WORKER WHAT TREATMENT PLAN SHE WOULD USE FOR THIS CHILD AND HOW MUCH ORESOL SHE WOULD GIVE.

SCORING:
3 POINTS FOR PLAN A
2 POINTS FOR 1/2-1 CUP (100-200 ML.) ORESOL EVERY L.B.M.
5 POINTS FOR BOTH ANSWERS CORRECT
1 POINT FOR NEITHER ANSWER CORRECT

MARCH

THIS IS A ROLE PLAY!!! INFORMATION TO BE GIVEN TO HEALTH WORKER:

"Danny is 3 years old and weighs 13 kg. His diarrhea started yesterday. You can ask me any question you like about the signs and symptoms of Danny."

INFORMATION TO BE GIVEN ONLY WHEN SPECIFICALLY ASKED FOR BY THE HEALTH WORKER.

Danny has had 3 liquid stools. You find that he looks quite well. His mouth is wet and skin pinch goes back quickly. His pulse is normal, his eyes looks normal too. He had passed urine 30 minutes ago. All other signs and symptoms are unremarkable.

ASK THE HEALTH WORKER WHAT TREATMENT PLAN SHE WOULD USE FOR THIS CHILD.

SCORING:
5 POINTS = DEHYDRATION (IF 4 OR MORE SIGNS AND SYMPTOMS ASKED FOR)

3 POINTS = NO DEHYDRATION (IF 3 OR LESS SIGNS AND SYMPTOMS ASKED FOR)

2 POINTS = SOME DEHYDRATION

1 POINT = SEVERE DEHYDRATION

==========

APRIL

THIS IS A ROLE PLAY!!! INFORMATION TO BE GIVEN TO HEALTH WORKER:

"Julio is 8 months and weighs 6.5 kg. He has diarrhea for a week You can ask me any question you like about the signs and symptoms of Julio."

INFORMATION TO BE GIVEN ONLY WHEN SPECIFICALLY ASKED FOR BY THE HEALTH WORKER.

Julio has had 10 liquid stools the day he was brought to the health center. He is very quiet and weak; had no urine since last night. There are no tears when he cries. His eyes are very sunken. His fontanel also is sunken. His pulse is very fast (160/minute). All other signs and symptoms are unremarkable.

ASK THE HEALTH WORKER WHAT TREATMENT PLAN SHE WOULD USE FOR THIS CHILD.

SCORING:
5 POINTS = SEVERE DEHYDRATION (IF 4 OR MORE SIGNS AND SYMPTOMS ASKED FOR)

3 POINTS = SEVERE DEHYDRATION (IF 3 OR LESS SIGNS AND SYMPTOMS ASKED FOR)

2 POINTS = SOME DEHYDRATION

1 POINT = NO DEHYDRATION

MAY

A) Mario is 2 1/4 years old and comes to your health center with signs of some dehydration. How much ORS should be given him within 4-6 hours?

B) After 4 hours Mario still has some dehydration but is improving. If the mother can stay at the Health Center, what should be done next?

SCORING:

3 POINTS IF ANSWER TO PART A IS 600-800 ML.

2 POINTS IF ANSWER TO PART B IS "GIVE ADDITIONAL 600-800 ML."

5 POINTS IF BOTH PARTS ANSWERED CORRECTLY

1 POINT IF NEITHER PART ANSWERED CORRECTLY

==========

JUNE

Mila, who is 11 months old, is brought to the health center because she has had bloody diarrhea for three days. The doctor assesses the child and finds that she has no signs of dehydration and she is not febrile or malnourished.

The doctor is not surprised that the child has bloody diarrhea because in the last week many patients have had the same illness.

What should the doctor do to treat Mila?

SCORING:

1 POINT +

1 POINT FOR ANTIBIOTIC THERAPY

1 POINT FOR HOME FLUIDS OR CONTINUED FEEDING

1 POINT FOR REASSESSMENT IN 24-48 HOURS

1 POINT IF ALL THREE MENTIONED.

JULY

Ask the health worker the following question: "What feeding advice would you give to the mother of a 6 month old infant with diarrhea and mild dehydration?"

SCORING:
3 POINTS = FOR SAYING "CONTINUE BREASTFEEDING
2 POINTS = FOR A REPLY SUCH AS "INCREASE THE FREQUENCY OF MEALS (EVERY 3-4 HOURS)" OR "GIVE AN EXTRA MEAL PER DAY AFTER THE DIARRHEA."
5 POINTS FOR BOTH
1 POINT FOR NEITHER

==========

AUGUST

THIS IS A ROLE PLAY!!! INFORMATION TO BE GIVEN TO HEALTH WORKER:

"Belen brings her 16 months old son, Ruben to you. Ruben has diarrhea for 2 days. You can ask me any question you like about the signs and symptoms of Ruben as if I was Belen."

INFORMATION TO BE GIVEN ONLY WHEN SPECIFICALLY ASKED FOR BY THE HEALTH WORKER.

Ruben has vomited twice and had 6 watery stools since last night. His eyes ar somewhat sunken, mouth and tongue very dry, skin pinch goes back somewhat slowly. Breathing is rather fast and he is a bit irritable. All other signs and symptoms are unremarkable.

ASK THE HEALTH WORKER HOW SHE WOULD ASSESS RUBEN'S HYDRATION STATUS.

SCORING:
5 POINTS = SOME DEHYDRATION (IF 4 OR MORE SIGNS AND SYMPTOMS ASKED FOR)
3 POINTS = SOME DEHYDRATION (IF 3 OR LESS SIGNS AND SYMPTOMS ASKED FOR)
2 POINTS = SEVERE DEHYDRATION
1 POINT = NO DEHYDRATION

118

SEPTEMBER

A child named Elsa is brought to you for treatment of diarrhea. Elsa is 1 year old and weighs 10 kg. You assess Elsa and find that she has some dehydration. You also find that she has a fever of 40.5 C (104. 9 F) and blood and mucas in the stool.

What would you do for Elsa?

SCORING:
3 POINTS FOR MENTIONING ORS

2 POINTS FOR MENTIONING COTRIMOXAZOLE OR NALIDIXIC ACID

5 POINTS FOR MENTIONING BOTH

1 POINT FOR MENTIONING NEITHER

==========

OCTOBER

Ask the health worker to prepare a liter of ORS.

SCORING:

1 POINT FOR HAVING A PACKET OF ORS

1 POINT FOR HAVING CLEAN WATER READILY AVAILABLE

1 POINT FOR CORRECTLY MEASURING 1 LITER (USING A LITER SOFT DRINK BOTTLE, A DEXTROSE BOTTLE, OR AN OLD MEDIUM NESCAFE GLASS).

1 POINT FOR POURING THE WHOLE SACHET INTO THE PITCHER
1 POINT FOR STIRRING THE MIXTURE CORRECTLY.

If the health worker cannot prepare the oresol for lack of water, a pitcher, or something to stir the mixture with a score of 1 should be given. How will they mix oresol if a dehydrated child needs it?

NOVEMBER

THIS IS A ROLE PLAY!!! INFORMATION TO BE GIVEN TO HEALTH WORKER:

"Susan, an 8 months old infant is brought to your health facility because of diarrhea. You can ask me any question you like about the signs and symptoms of this Susan."

INFORMATION TO BE GIVEN ONLY WHEN SPECIFICALLY ASKED FOR BY THE HEALTH WORKER.

Susan had 6 liquid stool yesterday. She is also irritable and not playing much. She vomited once this morning. Her mouth appears dry. All other signs and symptoms are unremarkable.

ASK THE HEALTH WORKER HOW SHE WOULD ASSESS SUSAN'S HYDRATION STATUS.

SCORING:

5 POINTS = SOME DEHYDRATION (IF 4 OR MORE SIGNS AND SYMPTOMS ASKED FOR)

3 POINTS = SOME DEHYDRATION (IF 3 OR LESS SIGNS AND SYMPTOMS ASKED FOR)

2 POINTS = SEVERE DEHYDRATION

1 POINT = NO DEHYDRATION

==========

DECEMBEP

Ask the health worker: "Name four things that parents can do to prevent diarrhea in infants (children under 1)?"

SCORING:

1 POINT +

1 POINT FOR MENTIONING BREAST FEEDING

1 POINT FOR MENTIONING HAND WASHING AFTER DEFECATING AND BEFORE PREPARING FOOD

1 POINT FOR MENTIONING USING CLEAN WATER

1 POINT FOR: HAVING FAMILY MEMBERS USE A LATRINE

QUESTIONS ON NUTRITION

JANUARY

"A 14 month old child who had pneumonia 2 weeks ago comes to your clinic and is found to be moderately malnourished. What would you do for this child?"

SCORING:
1 POINT +
1 POINT FOR MENTIONING VITAMIN A
1 POINT FOR MENTIONING TFAP
1 POINT FOR CONTINUING TO MONITOR THE GROWTH OF THE CHILD
1 POINT FOR MENTIONING ALL THREE

==========

FEBRUARY

"When should pregnant women receive iron supplements and how much should they receive?"

SCORING:
3 POINTS if the health worker mentions 5th month of pregnancy until delivery.
2 POINTS if she says 2 60mg tablets of ferrous sulfate or 1 100mg tablet.
5 POINTS IF SHE GETS BOTH CORRECT
1 POINT IF NEITHER CORRECT

==========

MARCH

Ask the health worker the following questions about women who want to work outside the home after having a baby. The correct answers are in brackets.

i) How can a woman working outside the home still give her baby breast milk if the baby cannot be cared for at the place of work? (Expressing the milk by hand or with a breast pump)

ii) How long will expressed breast milk stay good if left outside? (8 hours)

iii) What will happen to the woman's production of breastmilk if the baby is given bottle feeding and she does not express her milk? (it will decrease)

SCORING:
1 POINT +
1 POINT FOR EACH CORRECT ANSWER
1 POINT IF ALL THREE CORRECT

APRIL

"Please plot on a growth monitoring chart a child who is 9 months old and weighs 7.0 kilos. Two months later the same child weighs 7.0 kilos. Plot both weights and interpret the growth curve of the child."

SCORING:

2 POINTS if the health worker correctly plots both weights.
3 POINTS if health worker says that the child's growth curve is flat and this means that the child is in danger.
5 POINTS FOR BOTH CORRECT
1 POINT IF NEITHER CORRECT

==========

MAY

"Name four foods that are naturally rich in iron".

SCORING:

1 POINT +
1 POINT for each food mentioned from the following list liver, meat, legumes, (e.g. munggo), green leafy vegetables, and whole grain cereals.

==========

JUNE

"Name four kinds of food that contain lots of Vitamin A"

SCORING:

1 POINT +
1 POINT for each food mentioned from the following list: green leafy vegetables such as malunggay, kangkong, alugbati, ampalaya, kamote tops. Yellow vegetables such as carrots, sweet potato, and squash. Animal sources such as liver, egg yolk and milk.

==========

JULY

Give the health worker the following scenario: "The mother of a 3 month old baby comes to you because she feels that the baby is hungry after breastfeeding. The baby cries after feeding and the mother is worried. What would you say to the mother?"

SCORING:

0 POINTS IF THE HEALTH WORKER SUGGESTS FORMULA FEEDS OR WEANING
1 POINT +
1 POINT IF SHE SUGGESTS BURPING THE CHILD OR HOLDING THE CHILD
1 POINT IF SHE WOULD REASSURE THE MOTHER
1 POINT IF SHE SAID SHE WOULD WEIGH THE BABY
1 POINT IF SHE MENTIONS ALL THREE

AUGUST

"Besides children with signs or symptoms of Vitamin A deficiency, which children should receive vitamin A supplements?"

SCORING:
1 POINT +
1 POINT IF THE HEALTH WORKER MENTIONS MALNOURISHED CHILDREN (1ST, 2ND AND 3RD DEGREE).
1 POINT FOR MENTIONING MEASLES
1 POINT FOR MENTIONING CHRONIC DIARRHEA
1 POINT FOR MENTIONING VITAMIN A DEFICIENCY (NIGHTBLINDENSS AND XEROPHTHALMIA)

==========

SEPTEMBER

Give the health worker the following scenario: "The mother of a 10 day old baby comes to you for advice because she feels that because of her small breasts she is not producing enough milk for her baby. What advice would you give to the mother?"

SCORING:
1 POINT +
1 POINT if the health worker says that small breasts are not a cause of lack of milk.
1 POINT if the health worker says more frequent sucking by the baby will lead to greater milk production.
1 POINT if the health worker suggests that the mother should try eating more and drinking more fluids.
1 POINT IF ALL THREE MENTIONED
0 POINTS if the health worker suggests the use of breast milk substitutes.

==========

OCTOBER

Give one point for each correct answer related to the dose of Vitamin A supplements. (THE CORRECT ANSWER IS IN BRACKETS)

i) How much Vitamin A should be given to a 2 year old child? (200,000 IU)
ii) How often should this dose be given? (every 6 months)
iii) What is the correct dose of Vitamin A for a pregnant woman? (none! pregnant women should not receive Vitamin A)

SCORING:
1 POINT +
1 POINT FOR EACH CORRECT ANSWER
1 POINT IF ALL THREE CORRECT

123

NOVEMBER

Give the health worker the following scenario: "A pregnant woman living in a mountainous area comes to you because she has a swelling in her neck. What do you think the problem is and what would you do about it?

SCORING:
1 POINT +
1 POINT IF HEALTH WORKER SAYS THAT THE WOMAN MIGHT HAVE GOITER
1 POINT IF SHE WOULD GIVE AN INJECTION OF IODINE OIL OR A IODINE CAPSULE
1 POINT IF SHE WOULD RECOMMEND IODIZED SALT
1 POINT IF MENTIONS ALL THREE

==========

DECEMBER

Ask the health worker the following questions. Correct answers are in brackets:

i) **What is the most important stimulus for increased breast milk production (sucking by the baby).**

ii) **What happens to breast milk production when bottle feeding is used? (it decreases).**

iii) **What is the <u>minimum</u> age up to which a baby should be breastfed? (12 months)**

SCORING:
1 POINT +
1 POINT FOR EACH CORRECT ANSWER
1 POINT IF ALL THREE CORRECT

124

ACKNOWLEDGEMENTS:

The development of this checklist would have been impossible without the help and insights of;

Dr. Manuel G. Roxas and the staff of the Office of Public Health

Dr. Manuel M. Dayrit and the staff of the Health Intelligence Service

Dr. Zenaida Ludovice (Internal Planning Service)

Dr. Elvira SN Dayrit and the staff of the Maternal and Child Health Service

Dr. Jovencia Quintong and the staff of The Family Planning Service

Mrs. Adelisa Ramos and the staff of The Nutrition Service

Dr. Francisco Valeza and the staff of The Tuberculosis Control Service

Dr. Jesus Abella and the staff of the Communicable Disease Control Service

Eng. Celestino Asinas and the staff of the Malaria Control Service

Dr. Milagros Fernandez and the staff of RHO IX,

Dr. Ricardo Ochoterena and the staff of the IPHO of Zamboanga del Sur

Dr. Carmencita P. Icao and the staff of IPHO of Zamboanga del Norte and staff

Dr. Natividad Castillo and the staff of IPHO of Basilan and staff

Dr. Nelsa L. Amin and the staff of IPHO of Sulu and staff

Dr. Prudencio J. Ortiz and the staff of Region VIII

Dr. John Kam and the staff of the IPHO of Northern Samar

Dr. Vitus T. Hobayan and the staff of the IPHO of Western Samar

Dr. Jovencia F. Ordona and the staff of Cordillera Autonomous Region

Dr. Juan Q. Bartolo, Jr. and the staff of IPHO of Kalinga Apayao

Dr. Ferdinand T. Tolentino and the staff of IPHO of Ifugao

Dr. Saturnino Bayasen and the staff of IPHO of Benguet

Dr. Apolinario A. Pilit and the staff of IPHO of Mountain Province

UNICEF

Child Survival Program

United States Agency for International Development

C.S.P. FILES

Integrated Supervisory Checklist SUPERVISOR'S COPY		HF NAME							
	Date of Visit								
MCH	1. Coverage of early prenatal care								
	2. Quality of prenatal care								
	3. Frequency of prenatal care								
	4. Tetanus toxoid coverage								
	5. Quality of post partum care								
F.P.	6. New to the Program (NP)								
	7. Follow-up rate for NPs								
	8. Adquacy of F.P. supplies								
CDD	9. Knowledge and skills								
	10. Adequacy of ORS supply								
EPI	11. BCG coverage/ masterlisting								
	12. FIC follow-up rate								
	13. EPI monitoring chart								
UFC	14. Under five clinic follow-up								
NUTR	15. Follow-up of malnourished								
	16 Nutrition knowledge								
TB	17. TB casefinding sputum collection								
	18. TB caseholding follow-up of Pts.								
	19. Adequacy of drug supply								
HIS	20. Accuracy of FHSIS reporting								
** TOTAL SCORE **									
1. Leprosy									
2. Malaria									
Supervisor's initials									
Health worker's initials									

C.S.P. FILES

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RECOMMENDATIONS RE CHILD SURVIVAL SUSTAINABILITY

1. NATIONAL IMMUNIZATION DAYS (NIDs)/ NATIONAL MICRONUTRIENT DAYS (NMDs)

   a) A flexible, quick-release fund (which does not have to be large) which can be used for critical contingencies during the last 2-3 months before NID or NMD.

   b) Foreign exchange (dollars in exchange for pesos) for procurement of vaccines and micronutrients (for NIDs and NMD). UNICEF does this now but their absorptive capacity for pesos is limited.

   c) Printing of materials for 1994 NID.

2. LOGISTICS

   Fund the DOH Logistics Consultant, Dr. Bing Alano, (under the UPECON contract) to continue as a logistics consultant.

3. MICRONUTRIENTS

   Food fortification advisor (if possible, long-term — could be a PASA from the Department of Agriculture).

4. BUDGET AND FINANCING

   a) Examine budgeting process in the DOH (make it more systematic and simpler). Could be Brad Schwartz (of REACH).

   b) Develop a mechanism so DOH can spend money the first six months of the year.

5. CDD & ARI

   a) Training in case management for CDD and ARI for midwives, nurses, and doctors (only 30% of hospital staff trained in CDD).

   b) Fund contractuals for CDD, ARI and EPI. CSP funds them now. GOP may not be able to continue them.

-CSP Technical Assistance Team
July 1993