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A GUIDE TO PLANNING LOCAL GOVERNMENT HEALTH SERVICES

The Matching Grant Program in the Philippines

Management Sciences for Health
Boston

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Acknowledgments

The Philippines devolved health care to municipalities, cities, and provinces in 1991. Three years later Management Sciences for Health, with funding from the US Agency for International Development, began assisting the Department of Health to facilitate decentralizing health care. This *Guide to Planning Local Government Health Services* is the result of seven years of technical assistance that led to the development of the Matching Grant Program (MGP) for Local Government Units (LGUs).

The roots of the MGP lie in a community-based system that identified women with unmet need for family planning and who were at risk for pregnancy-related illnesses. The community-based monitoring system has since been expanded to include childhood immunization, vitamin A supplementation, and tetanus toxoid vaccine to protect neonates. The Philippine system differs from other community-based monitoring systems in that it focuses on eliminating the unmet needs of women and children for public health services rather than on achieving higher prevalence or coverage rates for services.

At this time, the MGP uses a participatory and evidence-based approach to train local government health staff and to assist them in planning and budgeting public health care services. The learning-by-doing method used by the MGP was adapted from the World Health Organization's *District Problem-Solving Guidelines for Maternal and Child Health, Family Planning and Other Public Health Services* (Thorne, Sapirie, and Rejeb 1993). The Department of Health's regional Centers for Health Development are now funding and expanding the MGP among LGUs in their respective regions.

The project team in the Philippines included Dr. José Rodriguez, Dr. Robert Timmons, Dr. Florante Magboo, Dr. Cecile Lagrosa, and, in alphabetical order, Dr. Lynette Adorio-Arce, Dr. Jocelyn Cabarles, Dr. Nicolas Catindig, Ms. Theresa Fernandez, Ms. Rose Ann Gaffud, Dr. Roberto Rosadia, Mr. Alipio Salipot, Dr. Michael Singh, and Dr. Grace Viola. Dr. Steve Sapirie from Management Sciences for Health in Boston provided frequent and valuable technical assistance in developing the MGP and this guide.

A Management Sciences for Health team in Boston also contributed to development of this guide. Ms. Laura Lorenz, editor, drew on her background in instructional design to maximize the guide's clarity and practicality for participants and facilitators. Dr. Riitta-Liisa Kolehmainen-Aitken was the technical reviewer. Ms. Linda Suttenfield led the production and design team. Ms. Ceallaigh Reddy did the copyediting and composition, Ms. Rebecca Marshall was the proofreader, and Dr. Barbara Timmons provided editorial oversight.

Preface

This guide describes the approach used in the health sector of the Philippines for enabling Local Government Units (LGUs) to assess unmet needs in their communities for four essential health services and to plan and implement interventions that facilitate the delivery of these services. The Philippines Department of Health (DOH) launched the Matching Grant Program (MGP) in 1999 to assist municipalities and cities[1] to expand the coverage and quality of primary health care provided for women and children in a decentralized health program setting.

The MGP promotes partnership between the DOH and LGUs and supports the department's quality improvement program, or *Sentrong Sigla*. The MGP dramatically raises the coverage of four cost-effective public health technologies: child immunization, tetanus toxoid vaccine, vitamin A supplementation, and family planning. The program contributes to the attainment of national health objectives by expanding and improving health services for the poor. (For more information on the MGP, see "MGP Frequently Asked Questions," pages 8–12.)

Implemented by local teams, the MGP is an example of how local health services can generate their own data and use it to manage an intensive public health effort to enhance the coverage of important primary health care services. Local teams plan and implement every step of the MGP process, which begins with gathering and summarizing family health data. The management of health data is a challenge for countries at all levels of development. The Philippine experience with the community-based monitoring and information system (CBMIS), a basic component of the MGP, demonstrates that local teams can be successful at generating and using local data to identify their problems, address unmet needs, improve service quality, and improve the management of health programs.

[1] In the Philippines, municipalities are subdivisions of a province. Each municipality is divided into several *barangays* (villages), one of which serves as the seat of government. Cities are municipal corporations created by law and operated under special laws, called charters. They are organized out of existing political units in urban areas and are financially and administratively independent of the province in which they are located. Like municipalities, cities consist of a number of barangays. Provinces, cities, municipalities, and barangays are all called Local Government Units, or LGUs.

This guide provides planning and instructional materials for three MGP stages: Orientation, Phase I, and Phase II. For each stage, the guide provides session guidelines, supporting materials, forms, and facilitator's notes.

In addition, the guide provides step-by-step guidelines for facilitating the MGP "team learning-by-doing" process developed, refined, and applied by the Management Sciences for Health (MSH) project team over a five-year period throughout the Philippines. Using the MGP action-learning approach, health managers and staff learn to produce results while working together as an efficient planning and management team.

Using This Guide

Intended Users of This Guide

This guide is designed to be used primarily by the MGP management teams of the DOH's Centers for Health Development (CHDs). Housed in the DOH's regional health offices, these teams are responsible for implementing the MGP in their regions.

Other potential users of this guide include:

- **LGU managers,** to learn about the responsibilities involved in and the benefits of making a commitment to the MGP;
- **DOH decision-makers and program managers,** to better understand the MGP implementation process, how to integrate it into decentralization efforts, and how to apply the learning-by-doing process to other program and service enhancement efforts;
- **collaborating agencies working in the Philippines,** to increase their awareness of the MGP process, promote collaboration, and encourage application of the methods in other technical cooperation projects;
- **health administrators and institutions in other countries,** to adapt these experiences and methods to similar efforts for enhancing the delivery of local health services.

How to Use This Guide

The MSH project team developed this guide through repeated application of the MGP process throughout the Philippines. The materials provided are useful for orienting policymakers, recruiting program participants, developing a workshop schedule, and preparing the instructional handouts required to conduct each phase of the MGP process. Facilitators may photocopy the materials and handouts contained in the guide, or print them from the CD-ROM attached to the inside back cover. Files for some handouts are included in Microsoft Word formats, to facilitate their adaptation to local contexts.

The guide is divided into five sections:

- **Orientation**—briefly describes the Orientation phase and provides important information materials, including a suggested letter of intent and a draft memorandum of agreement, as well as handouts on the MGP and Sentrong Sigla.

- **Phase I: Data Collection and Needs Assessment**—provides a workshop schedule and a syllabus containing guidelines, supporting materials, and forms for 11 sessions. Phase I introduces the participants to the CBMIS, provides a field practicum exercise, and helps the participating teams plan for carrying out community surveys and facility assessments.
- **Facilitator's Notes: Phase I**—offers advice for leading sessions and enhancing team participation during the learning process.
- **Phase II: Data Analysis and Intervention Planning**—provides a suggested workshop schedule and a syllabus containing guidelines, supporting materials, and forms for nine sessions. In Phase II, the participants analyze their data, identify problems, set objectives, and plan and get approval for their interventions.
- **Facilitator's Notes: Phase II**—offers advice for leading sessions and enhancing team participation during the learning process.

The guide also provides two appendixes. Appendix A is composed of eight Best Practices and Technical Updates that share successful examples of MGP interventions. They may help to generate ideas for possible program intervention and strategies. Appendix B is composed of Quality Standards Lists and Facility Self-Assessment Checklists for two types of health facilities: Barangay Health Stations/Health Centers and Rural Health Units/Health Centers. The Department of Health developed these standards and checklists with support from MSH under the Sentrong Sigla program. The standards, guidelines, and checklists may be used as is or adapted to the quality standards and needs of other countries.

Adapting This Guide to Your Context

This guide uses names for the local government entities and local health services that are the main channel for delivering services in the Philippines under the national public health program. In the Philippines there are four types of Local Government Units (LGUs): province, city, municipality, and barangay. Each type of LGU has clear and legally recognized boundaries over which it exercises authority and within which it performs public functions, including the delivery of health services. The smallest political unit in the Philippine system of government is the barangay. Municipalities and cities consist of several barangays.

The Local Government Code of 1991 mandated the devolution of health services to LGUs and made local government executives responsible for operating local health services. Under the devolved system, the centers of authority for local health services are provincial governments, city governments, and municipal governments. Provincial Governors operate the provincial and district hospital system, while Local Chief Executives (mayors) operate Main Health Centers for cities, Rural Health Units (RHUs) for municipalities, and Barangay Health Stations for a single barangay or a cluster of barangays, depnding on their size.

Devolution of health services to LGUs also changed the role of policymakers, program managers, and technical staff at the regional levels. Regional staff no longer provide direct health services. Rather, they provide technical assistance to LGUs and monitor the implementation of health programs and services. Centers for Health Development (CHDs) are regional offices of the Department of Health responsible for providing technical assistance to LGUs and for interregional sharing of technical capabilities.

Health administrators and institutions in other countries may wish to adapt this guide to their context by using locally applicable names for local government entities and health services.

Using the CD-ROM

The CD-ROM that accompanies this guide provides the following programs and files:

- PDF (portable document format) files of the session guidelines, facilitator's notes, handouts, and forms
- Adobe Acrobat Reader, so CD-ROM users may download and use the program to open and search the PDF files provided
- A "Read Me" file containing all information needed to download and use Adobe Acrobat Reader, open the PDF files, and create participant binders

Facilitators may use the PDF files to print hard copies of session guidelines, handouts, facilitator's notes, and forms.

Abbreviations

BCG	bacillus Calmette-Guerin (tuberculosis vaccine)
BHS	barangay health station
BHW	Barangay Health Worker
CAST	Causal Analysis Summary Table
CBMIS	Community-Based Monitoring and Information System
CHD	Center for Health Development
CHO	City Health Officer
CQI	Continuous Quality Improvement
CRP	Certification and Recognition Program
DOH	Department of Health
DPT	diptheria, pertussis, tetanus (tetravalent vaccine)
FIC	fully immunized child
FSAC	Facility Self-Assessment Checklist
GMC	growth monitoring chart
HC	Health Center
IMR	infant mortality rate
LAM	lactational amenorrhea method
LCE	Local Chief Executive
LGU	Local Government Unit
LOI	letter of intent
LPP	Local Government Unit Performance Program
MHO	Municipal Health Officer
MGP	Matching Grant Program
MMR	maternal mortality rate
MOA	memorandum of agreement
MSH	Management Sciences for Health
MWRA	married women of reproductive age
OPV	oral polio vaccine
ORS	oral rehydration solution
PAB	protection at birth (from neonatal tenanus)
PhilHealth	Philippine Health Insurance Corporation
PHN	Public Health Nurse
PMTAT	Program Management Technical Assistance Team

PHO	Provincial Health Office
RHU	Rural Health Unit
TTV	tetanus toxoid vaccine
USAID	US Agency for International Development
WHO	World Health Organization

Introduction

In 1999, the DOH launched the MGP to help municipalities and cities to expand service delivery coverage and improve the quality of primary health care for women and children in a decentralized health program setting. The MGP is a highly effective grant mechanism and service delivery strategy that makes resources available locally and helps LGUs develop the capacity to improve the delivery of vital local health services. By focusing on expanding the delivery of services, the MGP addresses inequities in health service provision and facilitates the flow of funds to the point of service (service delivery level). The program allows LGUs to develop initiatives to meet local health needs based on data and ideas that they generate themselves.

As a component of the USAID-assisted Integrated Family Planning and Maternal Health Program, the MGP initially targeted municipalities and cities with large populations but is now available to smaller and poorer municipalities that can be clustered (e.g., a health district).

Under the MGP, the DOH provides grants of PhP250,000 to 500,000 (approximately US$4,900–9,800) to interested and eligible LGUs through the CHDs. To participate in the MGP, a municipality must indicate its commitment to implement and sustain the program by providing counterpart funding equivalent to at least 25 percent of the MGP grant amount. LGUs use these funds to meet Sentrong Sigla (quality) certification requirements and/or to enroll indigent families in the Indigent Program of the Philippine Health Insurance Corporation (PhilHealth).

MSH, with funding from USAID, provided technical assistance to all municipalities, cities, provinces, and regions that participated in the MGP between January 1999 and January 2002. As of January 31, 2002, 183 municipalities and cities in 40 provinces and 4 independent cities in 14 regions of the Philippines were enrolled in the program. Of the 183 cities and municipalities enrolled, 110 had at least one Sentrong Sigla–certified health facility, and 102 had an existing memorandum of agreement with PhilHealth for the enrollment of their indigent constituents in PhilHealth's Indigent Program. Of those with an memorandum of agreement, 67 had already paid their premiums, covering about 83,000 households.

MGP Facilitation and Management Transferred to the DOH

The MSH project team has trained CHD and provincial-level teams to be MGP process facilitators and to monitor MGP activities in participating LGUs. These teams have enrolled new LGUs and have assumed responsibility for monitoring MGP activities in their regions or provinces.

As of January 2002, all CHDs, and provincial teams from Catanduanes, Negros Occidental, Negros Oriental, Davao Sur, South Cotabato, Saranggani, Davao Norte, Sultan Kudarat, and North Cotabato had been trained. They have trained newly enrolled LGUs and have assumed responsibility for monitoring MGP activities in their regions or provinces.

The MGP Learning-by-Doing Approach

The premise of the MGP learning-by-doing approach is that local health teams will be most effective if they learn data collection, analysis, and planning procedures through application, with limited teaching by facilitators. The participants carry out each step of the process as a group, using the session guidelines, instructional materials, and forms provided in the guide. It is expected that the facilitators will provide only limited guidance, to maximize the participants' learning and their ownership of the process as they make and correct their own mistakes.

The MGP Planning and Implementation Process

The MGP planning and implementation process, managed by the CHDs and carried out by the LGUs, is a systematic sequence of activities in five stages:

- Orientation
- Phase I: Data Collection and Needs Assessment
- Collect Field Data
- Phase II: Data Analysis and Intervention Planning
- Implement Interventions

Note: This guide provides detailed sessions, guidelines, handouts, and facilitator's notes for three stages: Orientation, Phase I, and Phase II. The participants implement the remaining two stages—"Collect Field Data" and "Implement Interventions"—when they return to their LGUs. Instructional materials for these stages are not included in this guide. A summary of these stages is provided in the material that follows.

Orientation

To lay the groundwork for the Orientation phase, the DOH and the MSH project staff send information about the MGP to the CHD that will be planning and implementing the program in its region. The DOH Regional Director and his/her staff review this information, assess potential interest in their region, and determine whether and when to begin implementing the program.

If they decide to proceed, the Regional Director and his/her staff form a regional technical assistance team, with participation by the provincial and district levels. In addition, they hold discussions with Municipal Health Officers (MHOs), City Health Officers (CHOs), and mayors, with the goal of obtaining their support for and commitment to the program.

Next, the CHD identifies LGUs that might be eligible for and benefit from participation in the MGP. The CHD team sends them information about the MGP process, pre-enrolls the LGUs that express interest, and invites their managers to participate in a one-day Orientation workshop. Some LGUs send a team to the workshop, while others join a team for a clustered group of LGUs. For the workshop, participants join in large- and small-group discussions that explore the benefits of enrolling in the program, the MGP planning and implementation process, and the requirements for program success.

Following Orientation, the LGUs consider their interest in participating in the MGP. If they decide to enroll, they initiate a memorandum of agreement with the CHD to confirm their interest and to request that their MGP team participate in Phases I and II.

Phase I: Data Collection and Needs Assessment

Based on LGU expressions of interest, the CHD MGP team makes plans to implement Phase I with between three and five LGU teams, having six to ten members each. Examples of team members include the MHO or CHO, nurse supervisors, sanitary inspectors, and data managers.

Phase I is a three-day workshop that familiarizes the LGU teams with the CBMIS and prepares them to carry out community surveys of unmet needs for the MGP-targeted services: child immunizations, tetanus toxoid vaccine, vitamin A supplementation, and family planning. The teams learn to use the Family Profile (Form 1) and the forms for summarizing and tabulating family data gathered at the community level. The teams also learn how to conduct facility assessments for Sentrong Sigla certification. The teams leave the workshop with an activity and resource plan for carrying out the CBMIS and facility assessment surveys in selected barangays.

Collect Field Data

During this stage, which generally lasts two to four months, the participants carry out the community surveys and facility assessments in selected barangays and summarize the gathered data. The team enlists clinic staff and supervisors, midwives, and Barangay Health Workers (BHWs) to conduct the surveys and assessments and provides them with training and supervision to ensure that the data gathered are comprehensive and accurate. The team administers the facility assessment for Level One Sentrong Sigla certification in all health centers in the selected barangays.

The team members enter their survey data in the MGP forms (1, 2, and 3) and tables. They prepare a map showing community households, health facilities, and communications and other infrastructure, such as roads. They prepare baseline data on health problems and precursors, and service performance related to the four MGP-targeted services. Last, the LGU team identifies potential local sources of financial, material, and other support for the interventions they will design in Phase II.

Phase II: Data Analysis and Intervention Planning

Phase II is a three-day workshop that engages the LGU teams in a structured analysis of their data. The participants determine the extent of coverage of the four MGP-targeted services in their catchment areas, identify the level of unmet need for these services in each community surveyed, and prioritize areas for taking action. They identify health and service problems and their underlying causes. They formulate program objectives, set targets, develop ideas for improvement, and identify interventions that will enable them to achieve their objectives.

Each session in Phase II produces a product that the teams use in developing their implementation plan. The plan identifies implementation activities, the persons responsible, and the resources required. The plan also sets deadlines and provides information on matching grant funds, where the funds will be used, additional resources required, and potential funding sources.

During the last session of Phase II, the teams present their plans to the CHD MGP team, provincial-level staff, municipal representatives, and mayors, with the goal of gaining support for their interventions. The CHD team presents its monitoring plan. A panel of decision-makers provides guidance for proceeding with implementation, and all participants confirm their commitment to the plans presented.

Implement Interventions

During this final stage, which generally takes five months to one year, the LGU teams implement their planned interventions. Implementation tasks include mobilizing the required support and resources from their city or municipality, engaging staff and community organizations in the implementation process, and monitoring results by periodically updating their CBMIS forms. During this stage, the CHD team is responsible for monitoring LGU team progress, managing funding allocations, and taking care of the accounting for the grants.

Sharing and Building on MGP Success

The LGUs often develop innovative and successful interventions for improving service coverage and quality and raising the awareness of families about the importance of childhood immunizations, tetanus toxoid vaccine, vitamin A supplementation, and family planning. Successful innovations are documented and shared with other LGUs and regions.

Over time, the MGP project team has developed a wealth of successful intervention examples that participating LGUs have applied in their targeted areas. These case studies and technical notes are shared with the new LGU enrollees to foster the generation of ideas. Some of these notes are used as handouts during training and are included in this guide.

Implementation of the MGP provides opportunities for other enhancements at the LGU level, such as the design and implementation of LGU disease surveillance, linked with regional sentinel surveillance sites. These enhancements may be independent efforts or may be coordinated through district or provincial health offices.

The Learning-by-Doing Process

The learning-by-doing process of the MGP planning workshops is a proven method of group learning that results in enhanced service reach and improved service quality. The MGP learning-by-doing process is based on a decentralized program methodology developed and applied to health program planning for more than 35 years. The World Health Organization has successfully used the approach presented in this guide for health-sector planning and programming, national health and intersectoral development project planning, and district-level problem solving. It has also been used for special applications, such as design of the municipal-level disease surveillance system supported by PMTAT in the Philippines.

Principles

The underlying principles of this method include:

- The implementation of change is most successful when the people responsible for providing and managing services are also responsible for planning and implementing changes designed to improve service coverage and quality.
- Team learning-by-doing creates a sense of team spirit that sustains teams' efforts to implement their plan, meet and overcome obstacles, and make health service adjustments and improvements.
- A planning process that uses learning-by-doing engages the participants and results in deeper learning of practical methods. In this workshop, the participants learn by doing as they:
  - collect and present data
  - analyze and define problems
  - set objectives and targets
  - generate and select ideas
  - design interventions
  - plan implementation
  - prepare and present proposals
  - implement interventions
- Involving individuals from all levels of the health system in the learning-by-doing process helps to clarify roles and relationships among the various levels and enhances cooperation and support for successful implementation.
- Learning is enhanced when the data, strategies, and plans produced during the training sessions become actual planning and monitoring documents that the teams continue to use and update throughout the year. For example, the teams will more likely apply MGP methods in the future because they use their MGP problem indicators, objectives, and targets to monitor and evaluate their efforts throughout implementation.

Prerequisites for Success

There are a number of basic requirements, or prerequisites, for success with the MGP's learning-by-doing approach. Making sure these are fulfilled is the responsibility of the MGP managers at the regional, provincial, and district levels. These prerequisites include ensuring that:

- LGU team members represent all levels and perspectives of the health service delivery system;
- LGU teams recognize and accept responsibility for designing a sound set of interventions and for implementing these interventions within the planned time with the available resources. The teams must feel accountable for the successful implementation of their plan and for the resulting service performance improvements;
- the teams recognize that they play an important role in how well the national health system functions, in meeting national health objectives, and in meeting the service needs of the families in their communities;
- each session results in products that the teams use in the following sessions. These products become part of the intervention implementation plan;
- the facilitators make as few suggestions to the teams as possible. Directions or ideas provided by the facilitators could prevent the teams from generating their own ideas and thereby reduce their ownership of the resulting plan;
- the sessions stay within the planned timeframe, with products completed during the sessions themselves or in the evening. Adhering to a strict schedule ensures that the teams learn how to work together under pressure, increases the team's efficiency, allows the training to proceed according to the schedule, and simulates real-life implementation;
- all team members have an equal opportunity to contribute ideas and help develop session products. For example, the facilitators should make sure that the responsibilities for facilitating team discussions, managing team tasks, and doing presentations rotates through the team. The facilitator must ensure that the team listens to and considers the ideas of all its members equally and does not cater to long-standing hierarchical relationships among staff.

Outputs and Results

The MGP learning-by-doing process results in:

- LGU team intervention plans that will actually be implemented;
- improved capacity by team members to apply these methods to other planning tasks;
- new LGU staff competencies in data analysis, intervention design, and activity planning;
- new ideas and strategies for mobilizing resources and political and community support for service improvement;
- enhanced respect for the planning capabilities of LGU staff and managers.

CHD Team Checklist: MGP Planning and Implementation Process

Orientation

- ❑ Assess potential regional interest in the program and determine when and where to begin implementation.
- ❑ Form a regional technical assistance team.
- ❑ Solicit support from CHOs and mayors.
- ❑ Identify LGUs that might be eligible for and benefit from participation in the MGP and share information with them.
- ❑ Pre-enroll LGUs that express interest, and invite their managers to participate in Orientation.
- ❑ Facilitate Orientation.
- ❑ Ask interested LGUs to commit to sending a team to participate in the Phase I and II workshops.

Phase I: Data Collection and Needs Assessment

- ❑ Make plans for implementing Phase I with between three to five LGU teams.
- ❑ Facilitate Phase I.
- ❑ Make sure that the participants leave the workshop with plans for carrying out community surveys and facility assessments in selected barangays.

Collect Field Data

- ❑ Monitor data collection efforts of the LGU team and provide support as necessary.

Phase II: Data Analysis and Intervention Design

- ❑ Prepare the site and materials for Phase II, and invite dignitaries for the final session.
- ❑ Facilitate Phase II.

Implement Interventions

- ❑ Monitor LGU team progress, provide support to the teams as necessary, manage the grant allocations, and do the accounting.

Orientation

Orientation lays the groundwork for planning and implementing the MGP in a region. This section contains facilitator's guidelines for planning and implementing efforts to recruit LGUs, orienting LGU teams to the benefits and requirements of the MGP, and planning for the Phase I training workshop.

Materials:

CHD Orientation Checklist
The Matching Grant Program
MGP Frequently Asked Questions
A Primer on Sentrong Sigla (Philippine Quality Assurance Program)
Sample Letter of Intent
Sample Memorandum of Agreement
Sample Materials List: MGP Phase I Training Workshop
Sample Workshop Layout

Orientation encompasses a pre-enrollment process, a one-day orientation workshop for LGU representatives, and planning for the Phase I workshop. This section of the guide describes the orientation process, outlines its steps, and provides the following supporting materials:

- CHD Orientation Checklist
- The Matching Grant Program
- MGP Frequently Asked Questions
- A Primer on Sentrong Sigla (Philippine Quality Assurance Program)
- Sample Letter of Intent Sample Memorandum of Agreement
- Sample Materials List: MGP Phase I Training Workshop
- Sample Workshop Layout

Pre-Enrollment

Pre-enrollment has three steps: creating a shortlist of municipalities, communicating with the local mayors, and forming a regional support team.

Creating a shortlist of municipalities. The first step in preparing to implement the MGP in a region is to identify municipalities that might benefit from and be interested in participating in the program. To meet the criteria for MGP participation, an LGU must have:

- cooperated well with initiatives and programs of the DOH in the past;
- a proven ability to deliver health services, particularly outreach activities, in its catchment areas;
- a full or almost full complement of staff;
- demonstrated an ability to satisfactorily deliver priority health programs;
- at least one health facility that is Sentrong Sigla certified;
- sizeable and important client populations, possibly including communities with considerable health problems and unmet needs;
- a catchment area with economically depressed communities or populations;
- leadership support for family planning;
- enough Barangay Health Workers (BHWs) or other community health volunteers to gather needed data (the recommended ratio of BHWs to population is 1:30).

Create a shortlist of the municipalities that meet this criteria.

Communicating with the Local Chief Executive (mayor). The next step is to send a letter inviting Local Chief Executives to participate in the MGP. With the invitation, include a draft letter of intent that the mayor should sign and return if s/he is interested in enrolling her or his LGU in the program.

Forming an MGP team for a CHD. A regional MGP support team for a CHD leads the MGP planning and monitoring process. The team's members normally include:

- a CHD MGP point person
- CHD program coordinators
- DOH representatives responsible for the participating LGUs
- a representative from the Provincial Health Office

Orientation Workshop

Preparing for and leading the one-day Orientation workshop involves four steps: scheduling Orientation, inviting the participants, preparing and leading the program, and getting LGU commitment.

Scheduling the Orientation workshop. Upon receipt of a letter of intent from one or more LGUs, schedule and make arrangements for a formal Orientation workshop. Ideally, a group of LGUs will participate in the workshop together.

Inviting the participants. The workshop participants normally include the following LGU representatives:

- mayor (or a designated representative)
- chairperson of the Committee on Health
- Municipal Health Officer or City Health Officer
- health program coordinators
- Budget Officer
- Supply Officer
- Population Officer

Preparing for and leading the Orientation workshop. The one-day Orientation workshop focuses on the technical and financial aspects of the MGP. The CHD MGP facilitators should provide an overview of each topic, with enough information to help the participants determine whether to commit to enrolling in the MGP. The facilitators should make sure to cover the following technical and financial topics:

Technical Topics

- MGP objectives
- DOH objectives supported by the MGP
- health programs supported by the MGP
  - EPI, or full immunization for children
  - tetanus toxoid vaccine for pregnant women
  - vitamin A supplementation for children
  - family planning
- CBMIS
- Sentrong Sigla
- PhilHealth
- MGP technical roles and responsibilities of the CHD, Provincial Health Office, and the LGU

Financial Topics

- amount of the MGP grant
- MGP memorandum of agreement
- LGU counterpart or matching funds
- MGP budgetary guidelines and use of LGU counterpart funds
- setting up a bank account (MGP trust fund)
- financial roles and responsibilities of the CHD and the LGU

Get LGU commitment to the MGP. After attending the Orientation, LGU leadership and management must decide whether to commit to the MGP. In particular, LGU leaders and managers must agree to comply with the requirements and responsibilities of enrolling in the MGP and sign a memorandum of agreement. An example of an MGP requirement is an LGU commitment to providing matching funds in an amount equivalent to at least 25 percent of the MGP grant.

Plan for Phase I

Planning for the Phase I training workshop involves two steps: scheduling the workshop and preparing to lead it.

Scheduling the MGP Phase I workshop. Once an LGU has submitted its memorandum of agreement, you should confirm the LGU's commitment and set dates for the Phase I workshop. Discuss and reach agreement with the participating LGUs on the size and membership of their teams and on the timing of the workshop. (It is advisable to tentatively schedule the Phase II workshop also, to ensure that it is on the participants' calendars.) Normally, three or four LGU teams attend the Phase I and II workshops together.

Preparing to lead the Phase I workshop. Once you have enrolled several LGUs and scheduled the Phase I workshop, begin to prepare to lead the workshop. Use the session guidelines, facilitator's notes, and supporting materials provided in this guide as you prepare. Manage the logistical concerns, such as arranging for the training facility and accommodations for the participants. Prepare for each participant a binder containing the Phase I session guidelines, handouts, and forms. (You may make photocopies using the guide materials, or print copies using the CD-ROM provided with the guide.) The participants should receive their Phase I binder on the first day of the workshop. The participants will receive the Phase II binder at the start of the Phase II workshop.

CHD Orientation Checklist

Pre-Enrollment

- ❑ Develop a short list of LGUs to invite to participate in the MGP. Criteria include past cooperation with the DOH by LGU officials and health staff, a full complement of health staff, and at least one Sentrong Sigla–certified health facility.
- ❑ Send letters of invitation to the Local Chief Executives (mayors) of the short-listed LGUs. Include a draft letter of intent to facilitate the mayor's response.
- ❑ Schedule an Orientation workshop for LGUs that have submitted a letter of intent.

Orientation Workshop

- ❑ Form a CHD MGP team. Team members should include a CHD MGP point person, CHD health program coordinators, a DOH representative, and a Provincial Health Office representative.
- ❑ Send workshop invitations to the mayor (or his/her designated representative); the chairman of the Committee on Health, Municipal Health Officer or City Health Officer, health program coordinators, and the LGU Budget, Supply, and Population Officers.
- ❑ Prepare for and lead the workshop. Present on the following topics:

Technical topics

- MGP objectives
- DOH national health objectives supported by the MGP
- health programs supported by the MGP
- CBMIS and BHW needs
- Sentrong Sigla
- Indigent Program of PhilHealth
- technical roles and responsibilities of the CHD, province, and LGU

Financial topics

- amount of MGP grant
- MGP memorandum of agreement
- LGU counterpart funds
- MGP budgetary guidelines and use of the LGU counterpart funds
- setting up a bank account (MGP trust fund)
- financial roles and responsibilities of the CHD and the LGU

- ❑ Get commitment to enroll in the MGP. LGUs demonstrate their commitment by signing the MOA and agreeing to meet the requirements for enrolling in the MGP.

Plan for Phase I

- ❑ Schedule the Phase I workshop. Tentatively schedule Phase II.
- ❑ Arrange for the training facility and accommodations.
- ❑ Prepare participant binders.

The Matching Grant Program

In 1999, the DOH launched the MGP to assist municipalities and cities to expand service delivery coverage and improve the quality of primary health care for women and children in a decentralized health program setting. The MGP is a highly effective grant mechanism and service delivery strategy that makes resources available locally and helps LGUs to develop the capacity to improve the delivery of vital local health services. By focusing on expanding the delivery of services, the MGP helps to correct inequities in health service provision and to facilitate the flow of funds to the point of service (service delivery level). The program allows LGUs to develop initiatives to meet local health needs based on data and ideas that they generate themselves.

As a component of the USAID-assisted Integrated Family Planning and Maternal Health Program, the MGP initially targeted municipalities and cities with large populations but is now available to smaller and poorer municipalities that can be clustered (e.g., a health district).

Under the MGP, the DOH provides grants of PhP250,000 to PhP500,000 to interested and eligible LGUs through the Centers for Health Development (CHDs). To participate in the MGP, a municipality must indicate its commitment to implement and sustain the program by signing a memorandum of agreement and providing counterpart funding to the MGP grant. LGUs use these matching funds to meet quality certification requirements and/or to enroll indigent families in the Indigent Program of the Philippine Health Insurance Corporation (PhilHealth).

MSH, with funding from USAID, provided technical assistance to all municipalities, cities, provinces, and regions that participated in the MGP between July 1999 and January 2002. The MSH team developed an MGP technical assistance package that uses a learning-by-doing approach in LGU training and planning activities. The MGP package includes training health providers in implementing a CBMIS and conducting health facility self-assessments. The LGUs use their survey and assessment data to plan and monitor innovative and responsive MGP interventions to address the unmet needs of women and children in priority areas.

The MSH project team has trained CHD and provincial-level teams to be MGP process facilitators. These teams have enrolled new LGUs and have assumed responsibility for monitoring MGP activities in their regions and provinces.

As of January 31, 2002, 183 municipalities and cities in 40 provinces and four independent cities in 14 regions of the Philippines were enrolled in the program. Of the 183 cities and municipalities enrolled, 110 had at least one Sentrong Sigla–certified health facility, and 102 had a memorandum of agreement with PhilHealth for the enrollment of their indigent constituents in PhilHealth's Indigent Program. Of those with a memorandum of agreement, 67 had already paid their premiums, covering about 83,000 households.

MGP Frequently Asked Questions

What is the MGP?

The MGP is one of the programs of the LGU Performance Program (LPP). The MGP provides grants and technical assistance directly to municipalities and cities.

The goal of the LPP is to promote partnership between the DOH and the LGUs to expand and improve the quality of family planning, maternal and child health, and nutrition services.

Through the LPP, the DOH provides technical and financial assistance to LGUs.

Other programs of the LPP, the Base Grant Program and the Top Performers Program, provide grants and technical assistance to provinces and large cities. All three programs support the Sentrong Sigla movement of the DOH.

What are the national health objectives and targets for the year 2004 that the MGP supports?

The DOH national health objectives for 2004 are:

- to reduce the infant mortality rate (IMR) from 35 (1995) to 17;
- to reduce the maternal mortality rate (MMR) from 172 (1998) to 86.

The DOH national targets for family planning and selected maternal and child health programs for 2004 are:

- to increase the number of fully immunized children from 90 percent (1997) to 95 percent;
- to increase the number of pregnant women who have received at least two tetanus toxoid vaccinations from 38 percent (1998) to 80 percent;
- to increase the number of children provided vitamin A capsules from 90 percent (1998) to 100 percent;
- to increase the rate of contraceptive prevalence for modern methods from 32 percent (1999) to 60 percent.

What are the specific objectives of the MGP?

The MGP contributes to the attainment of the national health objectives and targets by expanding and improving health services for the poor. The MGP and LGUs expect to achieve the following targets:

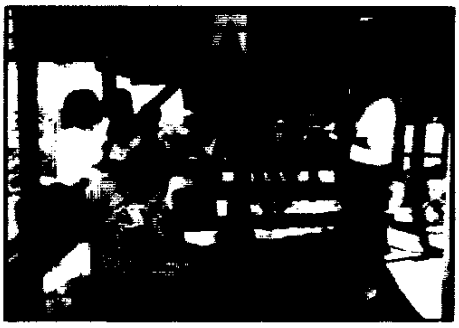
- to increase the use of modern contraceptives by currently married women;
- to ensure that at least 80 percent of children under 12 months of age are fully immunized;
- to ensure that at least 80 percent of children who are the youngest in their families are protected against neonatal tetanus;
- to ensure that vitamin A supplementation has been provided to at least 85 percent of children under five in the previous six months.

Who can participate in the MGP?

Priority is given to municipalities and cities with a population of at least 80,000 and which require technical and financial assistance to improve the quality and coverage of their public health services, in particular family planning, maternal and child health, and nutrition.

Who benefits from the MGP?

Children under the age of five years and women of reproductive age who are poor and live in depressed areas benefit from the program.



How does the MGP work?

1. Regional CHDs invite eligible LGUs to submit a letter of interest to participate based on the program description in the MGP Fact Sheet.
2. An interested LGU submits a letter of intent to a CHD.
3. The CHD orients the interested LGUs on the details of the MGP and assesses the LGU's needs.
4. The CHD and LGU sign a memorandum of agreement.
5. The CHD releases 40 percent of the MGP grant.
6. The LGU conducts a community-based assessment of households.

7. The LGU develops a work plan using the assessment data, with technical assistance from the CHD and province, and submits the plan to the regional CHD for approval.
8. The CHD releases the remaining 60 percent of the grant upon approval of the work plan.
9. The LGU implements the work plan.
10. The CHD and province monitor MGP implementation in the area and provide technical assistance.
11. A subsequent grant may be made available to any LGU that reapplies, subject to the availability of funds, the LGU's need for further improvement in health service delivery through innovative interventions, and the LGU's ability to fulfill its MGP commitments as demonstrated by its previous performance.
12. Steps 4–11 are repeated.

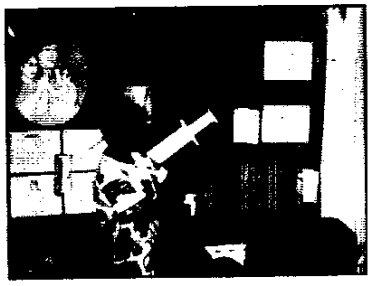
How much is the grant?

The MGP provides funding of at least PhP500,000 (approximately US$9,800) per LGU.

What health services can be expanded?

For the first phase, the MGP is targeting the following services, but other services may be added in the future.

Family Planning



Child Immunization

Vitamin A Supplementation

How does service delivery funded by the MGP differ from other programs and services provided by the municipality or city?

MGP allows participating LGUs to implement alternative, innovative, and/or expanded service delivery interventions to increase service coverage.

What is the role of the CHD?

The CHD:

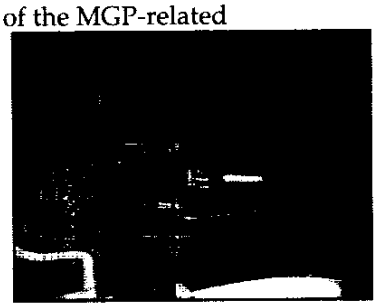
- provides financial assistance to the LGUs as specified in Article III of the memorandum of agreement, subject to availability of project funds and in accordance with government accounting and auditing procedures;
- issues and circulates pertinent technical and administrative policies, standards, and guidelines governing the implementation of the health interventions being supported by the MGP;
- in coordination with the province, provides technical assistance to the LGUs in the following areas to ensure the effective and efficient implementation of the MGP and to respond to operational issues encountered in the course of implementation:
  - meeting Sentrong Sigla certification standards;
  - training on community-based assessment of households;
  - formulating and implementing the MGP work plan;
  - enrolling poor families in the health insurance program for indigents;
  - identifying and replicating best health practices.
- in coordination with the province, monitors the progress of all LGUs participating in the MGP and gives feedback about the overall implementation of the health interventions and compliance with the provisions of the memorandum of agreement;
- coordinates the provision of assistance to the LGUs from the province, cooperating agencies, and other offices operating under the LPP;
- organizes forums, consultative meetings, and other activities that provide venues for sharing and technical exchange among LGUs.

What is the role of the Municipal or City Health Office?

The Municipal or City Health Office:

- issues a Municipal/City Council resolution that attests to the appropriation of LGU counterpart funds as specified in Article I, Section 2.4 of the memorandum of agreement;
- designates an MGP point person or coordinator to oversee the implementation of the MGP-related activities of the LGU;
- conducts a quality assurance self-assessment and undertakes activities to meet Sentrong Sigla standards;
- conducts a CBMIS survey;
- formulates a work plan based on the CBMIS survey and presents the work plan to the DOH for approval;

- integrates the approved MGP work plan into the annual LGU health plan;
- implements the approved work plan;
- enlists the support of other stakeholders in the implementation of the MGP-related activities of the LGU;
- receives, safeguards, and utilizes for the proper purpose all resources provided by the DOH under MGP;
- maintains records of MGP transactions (financial or otherwise) for auditing and spot-checking by representatives of the DOH, donor agency (USAID), other government agencies, and authorized representatives at any time;



- prepares and submits to the DOH the following official reports within the month following the period being reported:
  - midterm progress report
  - audited midterm fund utilization report
- ensures adequate LGU representation in conferences, supervisory and monitoring visits, consultative meetings, etc., to further improve the implementation of the programs supported by the MGP.

How is the work plan evaluated and approved?

The CHD MGP team will meet to assess whether the work plan meets the requirements below.

- It supports the national health objectives and targets, particularly for family planning, maternal and child health, and nutrition.

- The interventions identified support the provincial vision and strategies.
- Community support and involvement will be used to the greatest extent possible.
- It will be implemented using existing resources (staff, facilities, transport, and the recurrent budget as supplemented by the matching grant).
- It considers the improvement of staff and service performance, quality of care, and efficiency.
- Service delivery activities are clearly defined and match the budget.
- Proposed service delivery activities are likely to increase service delivery coverage.
- Interventions have a reasonable chance of obtaining a measurable impact within 12 months.

What reports are required?

Midterm and end-of-project reports on technical and financial accomplishments are required and should be based on the approved MGP work plan. The health staff are expected to present the work plan and reports to the Local Chief Executive.

What happens after the LGU successfully implements the work plan?

Apply again, of course!

A Primer on Sentrong Sigla (Philippine Quality Assurance Program)

What is the Sentrong Sigla?

Sentrong Sigla (literally Centers of Vitality) is a joint effort of the DOH and the LGUs designed to ensure the availability and accessibility of quality health services in health centers and hospitals.

What is the objective of the Sentrong Sigla?

The Sentrong Sigla program is aimed at fostering better and more effective collaboration between the DOH and the LGUs. In this collaboration, the DOH provides technical and financial assistance and the LGUs implement health programs and develop health systems.

What are the benefits of participating in Sentrong Sigla?

For Local Chief Executives

- Increased appreciation by constituents/clients
- Positive recognition of local officials
- Improved health services and facilities, as a result of the national government grants and technical assistance provided

For health workers

- Improved performance as a result of training and capacity-building activities
- Positive recognition by clients and officials
- Increased feelings of self-fulfillment and job satisfaction
- Improved health service delivery

For the public

- Increased access to quality health services
- Increased ability to demand quality health services
- Increased self-reliance

What are the major strategies of Sentrong Sigla?

Sentrong Sigla has two complementary strategies: the Certification and Recognition Program (CRP) and Continuous Quality Improvement (CQI).

The CRP focuses on improving health facility compliance with established quality standards. Under the CRP, a CHD team assesses the facility's compliance with the established standards. Facilities that meet the standards are certified by the DOH as providing quality health services.

CQI is a process that emphasizes building staff capacity to work as a team to identify service delivery challenges, apply CQI tools, and improve service quality. Facilities that achieve the first level of Certification and Recognition Program certification are eligible to receive technical assistance in CQI.

Who can participate in the Certification and Recognition Program?

The CRP is open to all provincial and district hospitals, rural health units or health centers, and barangay health stations that meet the following criteria:

For provincial and district hospitals

- licensed for the last 12 months or with a pending request for renewal of its license in the same category as the previous year. The hospital categories are:
  - provincial or city hospital (tertiary care)
  - district (secondary care)
- no gap in its license to operate for the last five years
- accredited as "mother/baby friendly"

For rural health units or health centers

- a permanent, full-time, licensed physician on staff
- a reliable source of water
- a comfort room or latrine for use by patients and staff
- a stethoscope
- a blood pressure apparatus with cuff
- a thermometer
- a weighing scale for infants and adults

For barangay health stations

- having a main rural health unit or health center that is already Sentrong Sigla-certified
- housed in a permanent structure, with a permanently assigned midwife who provides regular health services
- a reliable source of clean water
- a comfort room/latrine for patients
- a stethoscope
- a blood pressure apparatus with cuff
- a thermometer
- a weighing scale for infants and adults (but not bathroom scale)

What are the benefits of participating in the CRP?

Facilities that are Sentrong Sigla–certified will receive a seal to display in front of the health facility. The seal serves as a symbol of quality and excellent health services.

All Sentrong Sigla-certified facilities have the opportunity to receive technical assistance in CQI, which could help them to achieve the process and outcome standards required for higher levels of quality certification. For example, a facility that reaches Level III certification and maintains the required standards for two semesters will automatically receive a Sentrong Sigla Hall of Fame certificate.

What are the priority areas for quality assessment under the CRP?

- infrastructure/amenities
- services
- attitude and behavior of health workers
- human resources
- equipment
- drugs, medicines, and supplies
- health information system
- community intervention

How does a health facility become certified as Sentrong Sigla?

- The health facility uses the Quality Standards List for its category to assess its readiness for Sentrong Sigla certification. LGUs that are participating in the MGP may use the MGP's Facility Self-Assessment Checklist as their assessment tool. (This tool is included in the appendix.)
- Once the health facility decides that it is ready to be certified, the LGU submits a letter of intent to the CHD expressing its interest in being assessed for Sentrong Sigla certification.
- Upon receipt of the letter of intent, the CHD Sentrong Sigla team first determines whether the facility meets the inclusion criteria. If so, the CHD team schedules an assessment visit in coordination with the LGU. If not, the LGU is advised to hold its request until it meets the inclusion criteria.
- The CHD team conducts the assessment as scheduled, using the Health Facility Assessment Module.
- Immediately after the assessment, the CHD team gives feedback or a briefing to the health facility's personnel and the Local Chief Executive, if possible, on the team's major findings.
- The CHD team deliberates on the final results and, within two weeks, informs the Local Chief Executive, in a letter, of the results of its assessment.
- The CHD presents all certified facilities with Sentrong Sigla seals during a regional event or ceremony.

How does a certified health facility advance to the CQI phase?

A facility enters the CQI phase as soon as it receives Sentrong Sigla certification. During the CQI phase, the facility strives to meet higher-level standards by developing and implementing quality improvement initiatives.

Sample Letter of Intent

With every invitation sent to an LGU to participate in MGP Orientation, you should also send a copy of this draft letter of intent, to facilitate LGU participation. Fill in the blanks as appropriate, for example, by writing in the name of the Regional Director and the LPP or MGP Coordinator. (Leave blank the lines that the LGU is responsible for filling in.)

Letter of Intent

Municipality/City of _____

Date _____

Dr. _____
Regional Director
Department of Health
CHD for _____

Dear Dr. _____,

This letter of intent signifies our interest to apply for the Matching Grant Program (MGP). We are aware that our participation in the MGP is subject to the availability of LGU slots for this year and our willingness to agree on the program requirements, which will be discussed during the MGP Orientation.

Sincerely,

_____
Mayor

Below are names of other LGU officials you may contact regarding our application:

Name	Position	Phone
_____	_____	_____
_____	_____	_____

cc: _____, Provincial LPP Coordinator

Sample Memorandum of Agreement

This sample memorandum of agreement, once signed, becomes a legal document that commits the DOH and the LGU to fulfill various technical, financial, and administrative roles and responsibilities related to planning and implementing the MGP. An LGU that wishes to participate in the MGP must sign a memorandum of agreement in order to send a team to participate in the Phase I workshop.

Department of Health
MATCHING GRANT PROGRAM

MEMORANDUM OF AGREEMENT

KNOW ALL PEOPLE BY THESE PRESENTS:

The Department of Health Center for Health Development (hereinafter referred to as "DOH"), represented by DR._____, Director IV;

and

The Municipal/City Government of _____(hereinafter referred to as LGU) herein represented by HON._____, Mayor;

WITNESSETH

WHEREAS, the DOH, pursuant to the Local Government Code of 1991 transferred the responsibility for health services delivery and program implementation to the Local Government Units (herein referred to as LGUs or LGU);

WHEREAS, the DOH retains, among others, the functions of developing special health programs and projects and extending support services and other forms of assistance to the LGUs such as technical, administrative, logistics and financial support;

WHEREAS, the DOH is leading a nationwide movement called the "Sentrong Sigla Movement" (herein referred to as SSM) to improve the quality of health services;

WHEREAS, the DOH is implementing reforms to increase the access of indigent Filipinos to health services through the Indigent Program of the "Philippine Health Insurance Corporation" (herein referred to as PhilHealth);

WHEREAS, a special program of assistance called the "Matching Grant Program" (herein referred to as MGP) is developed by DOH, as part of the LGU Performance Program II (LPP II) in support of the Grants and Technical Assistance Pillar of SSM and the Indigent Program;

WHEREAS, the DOH wants to support the LGU in expanding the coverage of family planning, maternal and child health, and nutrition (FP/MCH/N) services;

WHEREAS, a memorandum of agreement is needed to identify the specific terms and conditions needed in the implementation of the MGP as a program of assistance;

NOW, THEREFORE, for and in consideration of the foregoing premises, the parties hereto agree as follows:

ARTICLE I: GENERAL PRINCIPLES

Section 1: Definition of the Program

The MGP is a program of assistance to municipalities and cities, which aims to increase the accessibility of FP/MCH/N services;

Through this Program, the DOH provides financial and technical assistance to selected LGUs;

The MGP is part of the DOH's Sentrong Sigla Movement and is sustained by the increase of coverage of the Indigent Program of the PhilHealth;

Section 2: Terms of LGU Participation

2.1 LGU participation is voluntary subject to its acceptance and adherence to the conditions set forth in this agreement;

2.2 LGU will provide counterpart funding, not less than 25% of the total grant amount, which will be used whichever is applicable,

2.2.1 To have at least one of its health facilities certified as Sentrong Sigla;

2.2.2 To enroll identified indigent families to the Indigent Program of PhilHealth;

2.3 LGU is committed to enroll identified indigent families in the Indigent Program of PhilHealth;

2.4 An LGU's continued participation is contingent upon its performance of the package of activities reflected in its approved MGP work plan, appropriate use of the grant and other conditions identified in Article III of this agreement.

ARTICLE II: ROLES AND RESPONSIBILITIES OF BOTH PARTIES UNDER THE MGP

Section 3: Responsibilities of DOH

3.1 Provides financial assistance to the LGU as specified in Article III, subject to availability of project funds and in consonance with the existing government accounting and auditing procedures;

3.2 Issues and circulates pertinent technical and administrative policies, standards and guidelines governing the implementation of the health interventions being supported by the MGP;

3.3 In coordination with the province, provides technical assistance to the LGU in the following areas to ensure the effective and efficient implementation of MGP and to respond to operational issues encountered in the course of implementation:

3.3.1 meeting Sentrong Sigla certification standards;

3.3.2 training in the use of the Community-Based Monitoring and Information System (CBMIS);

3.3.3 formulation and implementation of MGP work plan;

3.3.4 enrollment of identified indigent families in the Indigent Program; and

3.3.5 identification and replication of best health practices.

3.4 In coordination with the province, monitors the progress of all LGUs participating in the MGP and gives feedback regarding the overall implementation of the health interventions and compliance to the provisions of this agreement;

3.5 Coordinates the provision of various types of assistance to the LGU from the province, cooperating agencies and other offices operating under the LPP II; and

3.6 Organizes forums, consultative meetings and other activities aimed at providing a venue for LGU-LGU sharing and technical exchange.

Section 4: Responsibilities of the LGU

4.1 Issues a Sangguniang Resolution that will attest to the appropriation of LGU counterpart funds as specified in Article I, Section 2.4. The counterpart funds will be used to _____
_____;

4.2 Designates an MGP Point Person or Coordinator who will oversee the implementation of MGP-related activities of the LGU;

4.3 Conducts Quality Assurance (QA) self-assessment and undertakes activities to meet Sentrong Sigla standards;

4.4 Implement CBMIS;

4.5 Formulates a work plan based on the CBMIS survey data and presents this to the DOH for approval;

4.6 Integrates the approved MGP work plan in the annual LGU health plan;

4.7 Implements approved work plan;

4.8 Enlists support of other stakeholders in the implementation of MGP-related activities of the LGU;

4.9 Receives, safeguards, utilizes for the proper purpose all resources provided by DOH under MGP;

4.10 Maintains records of MGP transactions (financial or otherwise) that will be available for auditing and spot checking by representatives of DOH, donor agency (USAID), other concerned government agencies and authorized representatives at any specified time;

4.11 Prepares and submits to the DOH the following official reports within the month following the period being reported:

a) quarterly updated CBMIS Form 3 report
b) duly audited mid-term fund utilization report; and

4.12 Ensures adequate LGU representation in conferences, supervisory and monitoring visits, consultative meetings, etc. organized to further improve the implementation of the programs supported by MGP.

ARTICLE III: SPECIFIC AGREEMENTS

Section 5: Effectivity and Duration

This agreement shall take effect upon signing of the parties involved and shall remain in force for the entire period indicated in the approved MGP work plan

subject to the compliance of both parties to the terms and conditions set forth in this agreement.

Section 6: Financial Assistance

6.1 The Grant

DOH will release to the LGU an amount of _____(PhP_____.00) for the period covering _____ to be given in two stages:

6.1.1 The first release of funds, representing 40% of the total MGP grant, will be upon signing of the MOA and used for the conduct of the CBMIS training and survey;

6.1.2 The second release of funds, representing the balance, will be upon the approval of the work plan;

6.2 Financial Guidelines

6.2.1 The LGU shall open a separate trust fund account for the MGP Fund which shall be called "MGP Trust Fund Account."

To facilitate the efficient payment of all the MGP funded transactions, the LGU shall not be allowed to deposit the grant into a time deposit account.

6.2.2 The MGP grant shall be disbursed for the conduct of the CBMIS training and survey, and for the implementation of the approved MGP work plan.

Changes in the amount per item or budgeting for unplanned activities are allowed as long as these will not exceed the total amount of the grant provided to the LGU and these will support the attainment of the program objectives. To reflect these changes, the approved MGP work plan should be updated, a copy of which should be provided to the LGU Accountant and DOH.

6.2.3 The LGU is allowed to use savings realized from completed activities and any interest earned provided that these will support activities that will contribute to the attainment of the program objectives.

Any amount that remains uncommitted/unobligated at the end of the contract period may be reprogrammed by the LGU for activities that will further expand service delivery.

6.2.4 The LGU must submit a duly audited financial report every six (6) months to the DOH.

ARTICLE IV: GROUNDS FOR TERMINATION OF LGU PARTICIPATION IN THE MGP

Section 7: Termination of Agreement

The Agreement may be terminated by DOH upon proof of non-compliance of the LGU to any of the terms and conditions set forth in this Agreement in accordance with the following:

7.1 The DOH will serve a notice of non-compliance to the LGU. If the LGU fails to comply within 30 days upon receipt of the notice and the DOH remains dissatisfied with the LGU performance, the DOH shall serve the notice of termination. Upon receipt of the notice of termination, the LGU shall suspend the processing of any MGP-funded transactions except those otherwise allowed in the notice of termination.

7.2 Within 30 days upon receipt of the notice of termination, the LGU shall revert to DOH all the unobligated/ uncommitted amount in favor of the LPP Fund.

Signed this _____day of _____in the year _____ by:

MUNICIPALITY/CITY OF_____:

_____ Municipal/City Mayor

_____ Regional Director

WITNESSED BY:

_____
MHO

_____
Regional LPP Point Person

ACKNOWLEDGMENT

(Republic of the Philippines)
Province of _____) S.S.

At _____, Philippines on this _____, 2000 personally appeared before me the following persons with the respective community tax certificates to wit:

Name	CTC No.	Date/Place of Issue

Known to me to be the same persons who executed the forgoing, and they acknowledged to me that the same is their free and voluntary act and deed, in the capacity in which they appeared.

WITNESS MY NOTARIAL SEAL on the date and place of herein above written.

NOTARY PUBLIC

Doc. No. _____
Page No. _____
Book No. _____
Series of 2000

Sample Materials List: MGP Phase I Training Workshop

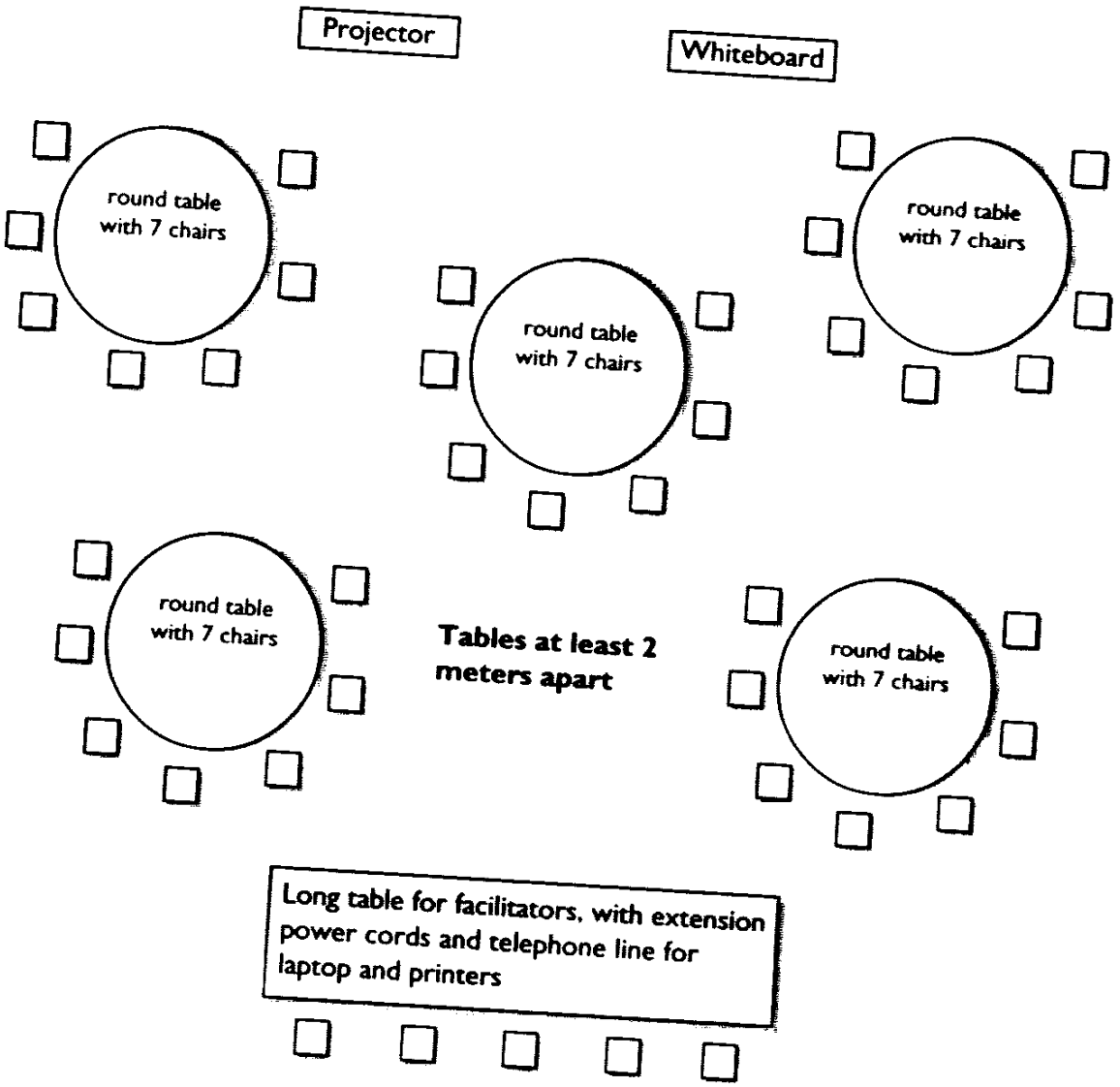
What: MGP Phase I Workshop for Sultan Kudarat
Where: Davao
When: November 20–22, 2001
No. of LGUs: 4
No. of Participants: 35 (including IPHO and CHD 12 staff)
No. of CHD Trainers:

Materials Needed:	Quantity	Description
MGP-TAP Phase I modules	40	in three-ring binder
Phase I session guides in acetate (session 1–11)	2 sets	from Phase I module
Mongol brand pencil # 1	40	sharpened
Family Profiling Exercise	40 sets	file name is "Family Profiling exercise.doc"
blank Family Profile Form 1 8 1/2 " x 14" back to back	500	file name is "family profile (template).doc"
blank Family Profile Form 1 in acetate	10 sets	file name is "family profile (template).doc"
Family Profile Form 1 exercise (data of 5 families)	40	all files in directory "Family Profile (Form 1)"
template Form 2 letter size	100	file name is "Barangay CBMIS Tally Sheet-Form 2 (template).xls"
Form 2 sample, letter size	40	file name is "Barangay CBMIS Tally Sheet-Form 2 (samples).xls" sheet "F2 Mar Ex"
Form 2 sample in acetate	4 sets	file name is "Barangay CBMIS Tally Sheet-Form 2 (samples).xls" sheet "F2 Mar Ex"
Form 2 exercise answer key	2 sets	file name is "Barangay CBMIS Tally Sheet-Form 2 (samples).xls" sheet "F2 Mar Ans"
blank Form 3 letter size	100	file name is "Catchment Area CBMIS Tally Sheet-Form 3 (template).xls"
Form 3 exercise forms, letter size	40	file name is "Catchment Area CBMIS Tally Sheet-Form 3 (samples).xls" sheet "F3 Mar Ex"
Form 3 exercise in acetate	4 sets	file name is "Catchment Area CBMIS Tally Sheet-Form 3 (samples).xls" sheet "F3 Mar Ex"
Form 3 exercise answer key	2 sets	file name is "Catchment Area CBMIS Tally Sheet-Form 3 (samples).xls" sheet "F3 Mar Ans"
Call Cards	300	pages 72–73 of guide (print back-to-back)
Call Cards, Midwife Copy	300	pages 74–75 of guide (print back-to-back)
Call Cards in acetate	2	pages 74–75 of guide (print back-to-back)
Work and financial plan matrix forms 8 1/2 " x 14"	30	page 132 of guide
LGU plan matrix forms in acetate	30	page 132 of guide
Priority Barangay Matrix in letter size	30	page 130 of guide
transparency pens:		
black fine	7	
blue fine	7	
red fine	7	
Pentel brand pens:		
black fine	7	
blue fine	7	
red fine	7	
cotton buds pack of 30s	1 pack	
acetone 60 ml in plastic container	2 bottles	
white board marker: black or blue	4	
stapler	2 units	
staple wire	1 box	
pencil sharpener	2 units	
packing tape	1 roll	
masking tape	1 roll	
ordinary transparency	50 sheets	
colored transparency	20 sheets	
extra sharpened pencils	1 box	
letter size bond paper	200 sheets	
8 1/2" x 13" bond paper	200 sheets	
floppy disks	1 box	
BJC 85 printer	1 unit	
black toner cartridge	5	
colored toner cartridge	3	
digital camera with accessories and battery	1 unit	

Sample Workshop Layout

MGP-TAP Phase I Workshop for Sultan Kudarat (4 LGUs)

Set-up for the function room:



Amenities for the function room:

- 2 microphones, preferably wireless
- overhead projector
- white board with eraser
- extension power cords
- phone line for Internet connection
- coffee and tea

Phase I: Data Collection and Needs Assessment

Session Guidelines

Phase I introduces the participants to the Community-Based Monitoring and Information System (CBMIS), provides a field practicum exercise, and helps the participating teams plan for conducting a community survey and facility assessment in their catchment area.

This section contains guidelines and supporting materials for 11 sessions:

1. Opening Program
2. Community-Based Monitoring and Information System—Family Profile (Form 1)
3. Family Profile Field Practicum
4. Review and Correct Family Profiles (Form 1)
5. Barangay CBMIS Tally Sheet (Form 2)
6. Call Cards and Midwife's Copy
7. Catchment Area CBMIS Tally Sheet (Form 3)
8. "From the Top (Well Almost!)"
9. Updating the Community-Based Monitoring and Information System
10. Health Facility Assessment
11. Planning for the Community Survey and Facility Assessment

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Session 1: Opening Program

Overview

During this session, the participants learn about the workshop's objectives. They receive a workshop syllabus and information about the program's working methods and the learning-by-doing approach. They discuss the workshop schedule, the house rules, and any administrative concerns.

Objectives

By the end of this session, the participants will:

- understand the workshop's objectives and the method of work
- be familiar with the workshop syllabus, session guides, and background materials
- understand the rationale behind the team approach to implementing the MGP
- have increased knowledge of the CBMIS

Materials

The materials needed for this session include:

- Workshop Objectives
- Gantt Chart: MGP Training Workshops and Field Work
- Schedule: MGP Phase I Training Workshop
- Phase I: Sessions, Tasks, and Products
- The Learning-by-Doing Process
- Method of Work
- House Rules
- The Matching Grant Program
- "The Matching Grant Program: A Strategy to Expand Local Health Service Delivery"

Program

The program for today's session includes:

1. Opening
   - Invocation
   - National Anthem
   - Welcome Address
2. Introduction
   - Participants and facilitators introduce themselves and share their expectations regarding the workshop
3. Workshop Objectives
4. Workshop Schedule
5. General Instructions
6. Overview of the MGP and the CBMIS

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Workshop Objectives

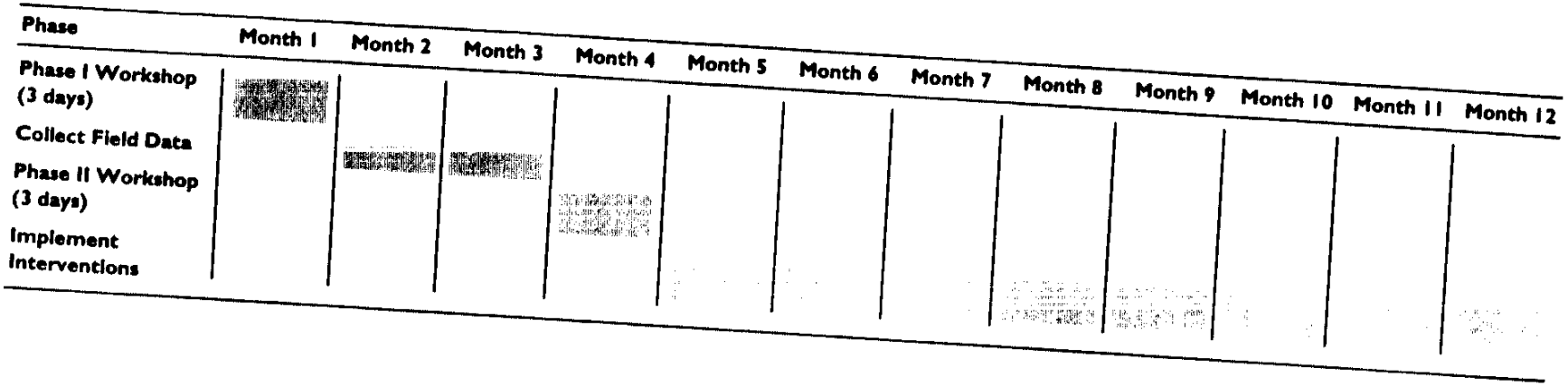
By the end of the MGP Phase I training workshop, all LGU teams will have:

1. prepared their plan to set up their CBMIS and conduct a health facility assessment. In particular, they will:
   - understand the purpose and design of the MGP
   - understand the CBMIS and the use of its tools
   - be familiar with the Facility Self-Assessment Checklist and its use
   - be prepared to prioritize barangays in their city/municipality for MGP implementation
2. finalized a proposal for conducting family profiles and carrying out a facility assessment
3. presented their proposals for rolling out the CBMIS to the local CHD and received comments on and approval of their plans. The teams will also be assured of CHD MGP team support for successful implementation.

At the end of the Phase I training workshop, the CHD MGP team and facilitators will be:

1. in a position to assess the LGU proposals for their technical soundness, practicability, and applicability;
2. able to pledge and deliver support as needed to assist the LGUs in successfully implementing their plan for rolling out the CBMIS, conducting family profiles, and carrying out a facility assessment.

Gantt Chart: MGP Training Workshops and Field Work



Schedule: MGP Phase I Training Workshop

	Day 1	Day 2	Day 3
8:00am–12:00 noon	Session 1: Opening Program Session 2: Family Profile—CBMIS (Form 1)	Session 4: Review and Correct Family Profiles Session 5: Barangay CBMIS Tally Sheet (Form 2) Session 6: Call Cards and Midwife's Copy	Session 10: Health Facility Assessment
12:00 – 1:00	Break	Break	Break
1:00-5:00 pm	Session 3: Family Profile Field Practicum	Session 7: Catchment Area CBMIS Tally Sheet (Form 3) Session 8: "From the Top (Well, Almost!)" Session 9: Updating the CBMIS	Session 11: Planning for the Community Survey and Facility Assessment

Phase I Session Titles, Objectives, and Products

Session	Session Title and Objectives	Main Products of Each Session
1	**Opening Program** Understand the workshop objectives, design, and method of work Understand the MGP and CBMIS	Participants' understanding of the workshop objectives, design, and methods of work, and the benefits and goals of the MGP and CBMIS
2	**Family Profile — CBMIS (Form 1)** Have a clear understanding of the CBMIS Fill out several Family Profiles correctly	Five practice Family Profiles (Form 1) completely and correctly filled out
3	**Family Profile Field Practicum** Conduct Family Profile field interviews Correctly complete a Family Profile (Form 1) for each family interviewed	Minimum of five completed Family Profiles (Form 1) per participant Checklist of requirements for planning and carrying out surveys in their barangays
4	**Review and Correct Family Profiles (Form 1)** Review completed Family Profiles and identify any problems Identify common problems encountered in filling out Form 1 Revise Family Profiles based on feedback	Five correctly filled out Family Profiles (Form 1) from the field practicum
5	**Barangay CBMIS Tally Sheet (Form 2)** Correctly fill out the Barangay CBMIS Tally Sheet (Form 2) using the sample data provided	A correctly filled out Barangay CBMIS Tally Sheet (Form 2)
6	**Call Cards and Midwife's Copy** Identify unmet client needs using completed Family Profiles Correctly fill out a Call Card Correctly create a Midwife's Copy for each completed Call Card	Several correctly completed Call Cards and a Midwife's Copy for each completed Call Card
7	**Catchment Area CBMIS Tally Sheet (Form 3)** Correctly fill out a Catchment Area CBMIS Tally Sheet	A correctly completed Catchment Area CBMIS Tally Sheet (Form 3)
8	**"From the Top (Well, Almost!)"** Summarize data for a barangay and a catchment area using data from the field practicum and filling out tally sheets Identify unmet client needs per family using actual data Issue call cards as needed Create a Midwife's Copy for every call card issued	A correctly completed Barangay CBMIS Tally Sheet (using data from the field practicum) Several correctly filled out Call Cards and a Midwife's Copy for each completed Call Card A correctly completed Catchment Area CBMIS Tally Sheet (Form 3)
9	**Updating the CBMIS** Update CBMIS forms (Forms 1, 2, and 3)	New and updated Family Profiles, a Barangay CBMIS Tally Sheet, and a Catchment Area Tally Sheet
10	**Health Facility Assessment** Understand the objectives, strategies, and benefits of Sentrong Sigla certification Use the Facility Self-Assessment Checklist (FSAC) to assess a facility's readiness for Level I Sentrong Sigla certification Use a Causal Analysis Summary Table (CAST) to summarize a facility's deficiencies, problems, and areas for improvement	A completed FSAC for one facility A partially completed CAST that identifies the facility's deficiencies, problems, and areas for improvement
11	**Planning for the Community Survey and Facility Assessment** Prioritize the barangays and select those to be surveyed Prepare a work and financial plan for preparing for and carrying out the survey and assessment Set target dates for Phase II workshop	A list of prioritized barangays for the community survey and facility assessment A work and financial plan for an initial community survey and facility assessment in prioritized barangays Agreed-upon dates for Phase II training

The Learning-by-Doing Process

The learning-by-doing process of the MGP planning workshops is a proven method of group learning that results in enhanced service reach and improved service quality. The MGP learning-by-doing process is based on a decentralized program methodology developed and applied to health program planning for over three-and-a-half decades. The World Health Organization has successfully used the approach presented in this guide for health-sector planning and programming, national health and intersectoral development project planning, and district-level problem solving. It has also been used for special applications, such as the design of a municipal-level disease surveillance system supported by PMTAT in the Philippines.

Principles

There are five underlying principles of this effective team-learning method.

- The implementation of change is most successful when the people responsible for providing and managing services are also responsible for planning and implementing changes designed to improve service coverage and quality.
- Team learning-by-doing creates a sense of team spirit that sustains team efforts to implement their plan, meet and overcome obstacles, and make health service adjustments and improvements.
- A planning process that uses learning-by-doing engages the participants and results in deeper learning of practical methods. In this workshop, the participants learn by doing as they:
  - collect and present data
  - analyze and define problems
  - set objectives and targets
  - generate and select ideas
  - design interventions
  - plan implementation
  - prepare and present proposals
  - implement interventions
- Involving individuals from all levels of the health system in the learning-by-doing process helps to clarify roles and relationships among the various levels and enhances cooperation and support for successful implementation.
- Learning is enhanced when the data, strategies, and plans produced during the training sessions become actual planning and monitoring documents that the teams continue to use and update throughout the year. For example, the teams will be more likely to apply MGP methods in the future because they use their MGP problem indicators, objectives, and targets to monitor and evaluate their efforts throughout implementation.

Prerequisites for Success

There are a number of basic requirements, or prerequisites, for success with the MGP's learning-by-doing approach. Making sure these are fulfilled is the responsibility of the MGP managers at the regional, provincial, and district levels. These prerequisites include ensuring that:

- LGU team members represent all levels and perspectives of the health service delivery system;
- LGU teams recognize and accept responsibility for designing a sound set of interventions and for implementing these interventions within the planned time period and with the available resources. The teams must feel accountable for the successful implementation of their plan and for the resulting service performance improvements;
- the teams recognize that they play an important role in the functioning of the national health system, in meeting national health objectives, and in meeting the service needs of the families in their communities;
- each session results in products that the teams use in the following sessions. These products become part of the intervention implementation plan;
- the facilitators make as few suggestions to the teams as possible. Directions or ideas provided by the facilitators could prevent the teams from generating their own ideas and thereby reduce their ownership of the resulting plan;
- the sessions stay within the planned timeframe, with products completed during the sessions themselves or in the evening. Adhering to a strict schedule ensures that the teams learn how to work together under pressure, increases the team's efficiency, allows the training to move ahead, on schedule, and simulates real-life implementation;
- all team members have an equal opportunity to contribute ideas and help develop session products. For example, the facilitators should make sure that the responsibility for facilitating team discussions, managing team tasks, and leading presentations rotates through the team. The facilitator must ensure that the team listens to and considers the ideas of all its members equally and does not cater to long-standing hierarchical relationships among staff.

Outputs and Results

The MGP learning-by-doing process results in:

- LGU team intervention plans that will actually be implemented;
- improved capacity by team members to apply these methods to other planning tasks;
- new LGU staff competencies in data analysis, intervention design, and activity planning;
- new ideas and strategies for mobilizing resources and political and community support for service improvement;
- enhanced respect for the planning capabilities of LGU staff and managers.

Method of Work

Session Guidelines

Each session guideline has the same format, with the following sections:

- Title
- Overview
- Objectives
- Materials
- Tasks
- Products

Method of Work

Most sessions follow a standard method of work, which includes a plenary briefing, group work, and—sometimes—plenary presentations:

A Plenary Briefing

To open each session, the facilitator leads a plenary briefing, lasting no longer than 10 to 15 minutes, to explain the session *objectives*, the *materials* to be used, the *tasks* to be accomplished, and the expected *products*. S/he shares examples of the forms to be used during the session and the expected products. Copies of all forms and products are included with the materials provided for each session. The facilitator will not lecture on the tasks and processes for the session but will define and illustrate important terms.

Group Work

Following the briefing, the teams accomplish their assigned tasks and products. Between two and three hours of the session are devoted to active team learning-by-doing. The facilitator provides little outside support as the teams review data, organize their work, discuss, reach consensus, and prepare their products. Facilitators are available to provide definitions and answer procedural questions, if required, but they will not suggest ideas or solutions to the tasks. The session's products are to be completed by the end of the time allowed for group work. If the team does not complete its products during the session, the team members will be expected to work in the evening in order to complete the products before the next day.

Plenary Presentations

The teams will close some sessions by presenting their products in plenary. These presentations allow the teams to share ideas and provide an opportunity for the facilitators to give feedback and guidance. The time allowed for these presentations is short—usually only 15 or 20 minutes per presentation.

House Rules

- The schedule of sessions and time allowed for tasks and presentations will be strictly adhered to. Manage your time well.
- The use of local dialects is encouraged.
- The participation of all team members is required and must be assured by the Municipal Health Officer or City Health Officer. The team should rotate among its members such tasks as recording discussions and leading presentations, so that all members have an opportunity to do all tasks.
- Please turn all cell phones off during the sessions.
- All participants are to arrive on time and stay in the sessions until their completion.

The Matching Grant Program

In 1999, the DOH launched the MGP to assist municipalities and cities to expand service delivery coverage and improve the quality of primary health care for women and children in a decentralized health program setting. The MGP is a highly effective grant mechanism and service delivery strategy that makes resources available locally and helps LGUs to develop the capacity to improve the delivery of vital local health services. By focusing on expanding the delivery of services, the MGP helps to correct inequities in health service provision and to facilitate the flow of funds to the point of service (service delivery level). The program allows LGUs to develop initiatives to meet local health needs based on data and ideas that they generate themselves.

As a component of the USAID-assisted Integrated Family Planning and Maternal Health Program, the MGP initially targeted municipalities and cities with large populations but is now available to smaller and poorer municipalities that can be clustered (e.g., a health district).

Under the MGP, the DOH provides grants of PhP250,000 to PhP500,000 to interested and eligible LGUs through the Centers for Health Development (CHDs). To participate in the MGP, a municipality must indicate its commitment to implement and sustain the program by signing a memorandum of agreement and providing counterpart funding to the MGP grant. LGUs use these matching funds to meet quality certification requirements and/or to enroll indigent families in the Indigent Program of the Philippine Health Insurance Corporation (PhilHealth).

MSH, with funding from USAID, provided technical assistance to all municipalities, cities, provinces, and regions that participated in the MGP between July 1999 and January 2002. The MSH team developed an MGP technical assistance package that uses a learning-by-doing approach in LGU training and planning activities. The MGP package includes training health providers in implementing a CBMIS and conducting health facility self-assessments. The LGUs use their survey and assessment data to plan and monitor innovative and responsive MGP interventions to address the unmet needs of women and children in priority areas.

The MSH project team has trained CHD and provincial-level teams to be MGP process facilitators. These teams have enrolled new LGUs and have assumed responsibility for monitoring MGP activities in their regions and provinces.

As of January 31, 2002, 183 municipalities and cities in 40 provinces and four independent cities in 14 regions of the Philippines were enrolled in the program. Of the 183 cities and municipalities enrolled, 110 had at least one Sentrong–Sigla-certified health facility, and 102 had a memorandum of agreement with PhilHealth for the enrollment of their indigent constituents in PhilHealth's Indigent Program. Of those with a memorandum of agreement, 67 had already paid their premiums, covering about 83,000 households.

Session 2: Community-Based Monitoring and Information System—Family Profile (Form 1)

Overview

Using the sample data provided, the participants fill out five Family Profiles (Form 1) each. The team shares data for one family in plenary, answers questions from the group, and corrects its forms.

Objectives

At the end of the session, the participants will have:

- formed a clear understanding of the CBMIS
- filled out five Family Profiles (Form 1) correctly

Materials

The materials needed for this session include:

- How to Fill Out and Use the Family Profile (Form 1)
- Family Profiling Exercise
- Family Profile, Form 1 (template) (five forms per participant)
- "Expanding the Delivery of Health Services through a Community-Based Monitoring and Information System" (see tab "Best Practices and Tehcnical Notes")

Tasks

The tasks involved in preparing for and implementing this session are listed below.

1. Read "How to Fill Out the Family Profile (Form 1)."
2. Fill out Form 1 for five families using the data provided in the Family Profiling Exercise.
3. Present the output for one family in a plenary session, lead a discussion, and answer any questions.
4. Correct Form 1 as needed, since the forms will be used extensively in subsequent sessions.

Products

By the end of this session, each participant will have:

- five completely and correctly filled out Form 1s, for five families.

How to Fill Out and Use the Family Profile (Form 1)

This instruction sheet provides all the information needed to fill out the Family Profile (Form 1) correctly. Read these instructions before beginning to fill out a form for the first time, and refer to them when questions or issues arise. Use a pencil to fill out this and all other CBMIS forms, to facilitate revisions and updates.

What Is a Family?

For the Family Profile, a family is defined as any one of the following:

- husband and wife without children
- husband and wife with child/children
- father and child/children only
- mother and child/children only

When filling out the form, please note that:

- a man and a woman are considered married even if they are not legally married as long as they are staying under one roof and consider each other as permanent partners;
- a child/children may be legitimate, illegitimate, legitimated, or adopted;
- a married child staying in the same household will require a separate Family Profile.

General Information

The General Information section provides the Barangay Health Worker (BHW) with the basic information s/he will need in order to visit the family again when updating the form in future.

Address

Write down the exact address of the family being interviewed. Write the house number, street, purok,[1] and barangay. If none, ask for (and make a note of) any landmark that will make it easy to locate the residence of the family again.

Respondent

Write the name of the respondent or the person who provided the information regarding the family. It is highly recommended that the mother or wife be the respondent. If the mother or wife is not available, any other person in the family may qualify as a respondent, provided s/he is knowledgeable about the family's health status (vaccinations, use of family planning, etc). Otherwise, return at another time to interview a qualified respondent.

Father

Write the complete name of the father.

Birthday

Write the birthday of the father in the format mm/dd/yy.

[1] A purok is a zone within a barangay.

Age

Write the age of the father.

Mother

Write the complete name of the mother.

Birthday

Write the birthday of the mother in the format mm/dd/yy.

Age

Write the age of the mother.

Barangay health station/Barangay health center

Write the name of the barangay health station or barangay health center (for cities) that covers the area where the family resides.

Rural health unit

Write the name of the rural health unit that covers the area where the family resides.

Municipality/City

Write the name of the municipality or city where the family resides.

Province

Write the name of the province.

BHW

Write the name of the BHW whose scope of responsibility or catchment area includes the area where the family resides.

Rural Health Midwife

If the facility is a BHS, write the name of the Rural Health Midwife in charge of the BHS and whose scope of responsibility includes the area where the family resides.

Public Health Nurse

Write the name of the Public Health Nurse supervising the RHM whose scope of responsibility includes the area where the family resides.

Interviewer

Write the complete name of the interviewer.

Date surveyed

Write the month, day, and year when the interview was conducted.

Date of last update

Write the month, day, and year when the form was last updated.

Part I. Data on children 0–4 years old (0–59 months old, start from the eldest)

To complete Part I, the interviewer records the name, age, and vaccination status for all children under the age of 5 in the family.

Name

Write the names of all children aged 0–59 months old in the family. Start with the eldest qualified child and list the rest in descending order by age.

Birthday

Write each qualified child's date of birth (mm/dd/yy) in the corresponding box.

Age

For each child 12 months of age or older, write her/his age in years and write the letter "Y" to indicate years. For children aged 0-11 months, write her/his age in months and write the letter "M" to indicate months.

Where does the child receive vaccinations?

For each child, ask the respondent where the child received her/his vaccinations. If the child has not received any vaccination at all, leave this box blank. If the child received her/his vaccinations from a barangay health station or barangay health center, write the letter "B." If the child received her/his vaccinations from an rural health unit or main health center, write "R." If the child received her/his vaccinations from a private clinic, write "P," and if from a government hospital, write "G."

If the response is either "P" or "G," and the child is not yet fully immunized, write "A" in the last column (Remarks), and see Action A at the bottom of the form. Action A instructs the BHW in charge of this family to do a monthly follow up with the family regarding the child's vaccinations until they are completed and s/he can update the corresponding Family Profile.

Does the child have any vaccination record?

For each child, determine whether s/he has a vaccination record or not. If the child has a vaccination record, put "Y" for Yes and ask to look at the record. If the child was vaccinated in a government facility, such as an rural health unit or a barangay health station, the vaccinations should be recorded in a growth monitoring chart (also called a Yellow Card). If a child was vaccinated in a private health facility, s/he should have a record of the vaccinations in a "baby's book." If the child has no vaccination record or it has been lost, write "N" for No or None.

If the child does not have a vaccination record, write "B" in the last column (Remarks), and see Action B at the bottom of the form. Action B is to advise the mother to go to the nearest health facility to ask for a vaccination card.

Childhood Vaccinations

All children should receive 1 dose of bacillus Calmette-Guerin (BCG), 3 doses of diphtheria, pertussis, and tetanus (DPT), 3 doses of oral polio vaccine (OPV) and 1 dose of measles vaccines before her/his first birthday to be considered a fully immunized child.

BCG: bacillus Calmette-Guerin, a live attenuated vaccine given to infants after birth to protect them against tuberculosis; usually injected into the right deltoid region of the arm (sometimes given in the buttock by private practitioners) that may cause a scarring or dimpling of the skin.

DPT: a vaccination against diphtheria, pertussis, and tetanus, usually injected into the upper outer portion of the thigh. Normally, 3 doses are given to infants at monthly intervals starting 6 weeks after birth. It is important that all 3 doses be given before the first birthday of a child.

OPV: oral polio vaccine, given orally to infants starting at 6 weeks after birth at monthly intervals to prevent poliomyelitis. It is important that all 3 doses be given before the first birthday of a child.

Measles vaccine: a vaccination against measles, usually given to infants at the age of 9 months or before 12 months. If a child was given measles vaccination earlier than 9 months (for example, during an outbreak of measles, in evacuation areas in times of disasters, etc.), it should be repeated at 9 months or before the child reaches 12 months.

Vaccinations Received

Check the vaccination record, if available, for each child. In the appropriate columns, copy the dates when the vaccinations were received. For children 12-59 months old who have not received 1 or more vaccinations, write "N" in the appropriate columns for any vaccinations not received. For children 0-11 months old with no vaccination record, ask the respondent if s/he recalls whether the child received doses of antigens (BCG, DPT, OPV, and measles vaccine). If the respondent says yes and knows the date, write it down. If the respondent says yes but cannot recall the dates, put a "Y" in the corresponding column for each antigen received. Leave the column blank if the vaccination has not yet been received.

For any child 0–11 months old who has received no vaccinations or who has not followed the vaccination schedule, write "C" in the last column (Remarks), and see Action C at the bottom of the form. Action C is to refer or accompany the mother and child to the midwife for an immediate vaccination.

For any child 12–59 months old for whom there is a vaccination column marked "N" or for whom the respondent says that complete doses of a vaccination were not received, write "D" in the last column (Remarks), and see Action D at the bottom of the form. Action D is to advise mother to consult the Rural Health Midwife about the child's vaccinations.

Fully Immunized Child (for children 9 months to 4 years old)

A fully immunized child is a child who has received 1 dose of BCG, 3 doses of DPT, 3 doses of OPV, and 1 dose of measles vaccine before her/his first birthday. If the child is fully immunized based on her/his vaccination record and the respondent's recall, put "Y" in the appropriate column. If the child is not fully immunized, put "N." If the respondent claims that the child is fully immunized but there is no written record, the interviewer should write "B" in the last column (Remarks) and see Action B at the bottom of the form. Action B is to advise the mother to go to the nearest health facility to ask for a vaccination card. The BHW should also check the records of the health facility and revise Form 1 as necessary.

Vitamin A (for children 1–4 years old only)

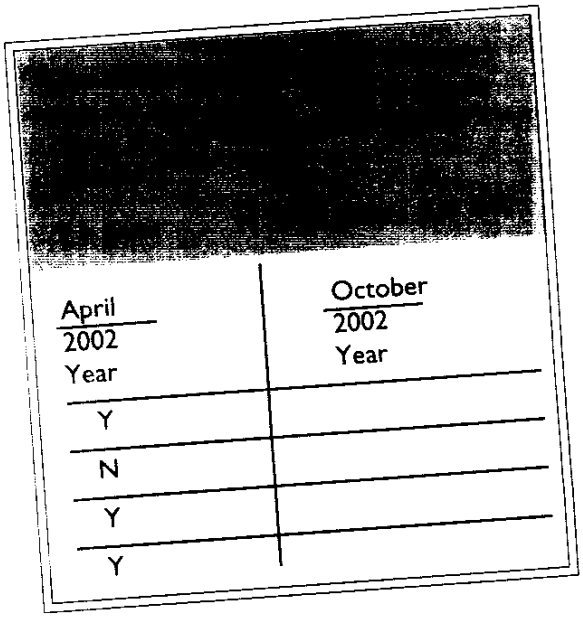
All children 12–59 months old are given 200,000 IU of vitamin A every 6 months as part of the DOH's effort to eliminate micronutrient malnutrition.

Vitamin A supplementation campaigns are conducted every 6 months, usually during April and October (for example, when *Garantisadong Pambata* [Preschoolers Health Week] takes place). Write down the appropriate year under April and October, depending on the date of the survey. See the two examples that follow.

Example 1

If the survey date is July 12, 2002, write down the year 2002 in the column headings for April and October. This date will serve as the point of reference for when the child should have received vitamin A supplementation. For a survey date of July 12, 2002, you interviewer's question then pertains to vitamin A supplementation given in April 2002. Write "Y" in the column for April 2002. The column of October 2002 will be left blank since October has still to come.

After writing down the year, ask the respondent if the child received vitamin A supplementation at any time during the last six months. If the answer is yes, write the letter "Y."



April 2002 Year	October 2002 Year
Y	
N	
Y	
Y	

Example 2

If the survey was conducted on November 9, 2002, write the year 2002 in the October column and the year 2003 in the April column, to serve as the point of reference when vitamin A supplementation should have been given to the child. Since the survey date was November 9, 2002, the question would then pertain to vitamin A supplementation given last October 2002. The column of April 2003 should then be left blank since April 2003 has still to come.

After writing down the year, ask the respondent if the child received vitamin A supplementation at any time during the last six months. If the answer is yes, write the letter "Y."

April 2003 Year	October 2002 Year
	Y
	Y
	Y
	Y

For both examples, if the child was not given vitamin A in the last 6 months, write "N" in the appropriate column, write "E" in the last column (Remarks), and see Action E at the bottom of the form. Action E advises giving vitamin A capsule at once if available, or advising the mother to bring the child to the nearest health facility for the next scheduled vitamin A supplementation. In addition, the interviewer or community health worker should give the mother information about the importance and benefits of vitamin A supplementation. If child is not high risk (not sickly or malnourished), inform the mother of the next vitamin A supplementation activity. If child is sickly or malnourished, tell the mother to bring the child to the health center for proper assessment and vitamin A supplementation, if necessary.

Administering Vitamin A

Vitamin A capsules (200,000 IU) are colored deep red or yellow with a tip. Administer vitamin A by cutting off the tip of the capsule and squeezing the content (liquid) into the mouth of the child. For capsules without tips, puncture the capsule with a pin. Show the respondent a sample capsule to help her remember and not to confuse it with OPV, which is also administered orally.

Remarks

This column is for any action or health services rendered (actions to be taken) at the time of interview and other important health information about the child. Make sure to record the appropriate code letter every time there is a condition for which an action was or should be taken. There could be more than one action to be taken depending on the identified needs of the client. The interviewer may also use this column to record other relevant health information needed for service delivery regarding the client.

Part II A. Tetanus Toxoid Vaccination (TTV) for Pregnant Women

Is the mother/wife pregnant?

Put a check in the Yes box if she is pregnant, and put a check in the No box if she is not pregnant. The interviewer should advise all pregnant women to go to the midwife or health center for a prenatal checkup and TTV, if necessary.

Total number of TTV doses received

In the box provided, record the number of TTV doses the woman has received during her lifetime, even if she is not currently pregnant. Write 0 (zero) if she has not received any TTV during her lifetime.

Tetanus Toxoid Vaccination (TTV)

TTV is an antitetanus injection shot given to women, especially pregnant women, to prevent the child from getting neonatal tetanus. TTV is injected into the upper arm or buttocks. Neonatal tetanus in newborns is a disease characterized by a history of all 3 of the following:

- normal suck and cry for the first 2 days of life
- onset of illness between the 3rd and 28th day of life
- inability to suck followed by stiffness of the body and/or convulsions

TTV schedule:

TTV1 – at any time during pregnancy
TTV2 – at least 4 weeks after TTV1
TTV3 – at least 6 months after TTV2
TTV4 – at least 1 year after TTV3
TTV5 – at least 1 year after TTV4

If a pregnant woman receives all 5 doses of TTV, then her child is considered to be protected at birth (PAB) from neonatal tetanus.

Part II B. Protection at Birth (PAB against Neonatal Tetanus)

To be filled out only if the age of the youngest child is 0–2 years old (0–35 months old)

When was each TTV dose received in reference to the youngest child?

Put a check in the appropriate boxes for all TTV vaccines the woman received while pregnant with her youngest child. Ask first about TTV1, then TTV2, and so on. For example, ask "When did you receive TTV1, during or prior to pregnancy with your youngest child?" Repeat the question for each TTV dose.

Was the child protected at birth (PAB)?

Put a check in the Yes box if the youngest child is PAB (because the mother received all 5 doses of TTV). Put a check mark in the No box if the youngest child is not PAB (because the mother has not received all five doses of TTV).

Part III. Family Planning Practice of Married Woman of Reproductive Age (MWRA)

The interviewer asks five questions of a currently married woman of reproductive age to determine whether she has an unmet need for family planning. Please note that the interviewer does ***not*** *need to ask these questions of women who:*

- *are widowed or separated (with no permanent partners);*
- *have had their ovaries, and/or uterus, and/or fallopian tubes surgically removed;*
- *are menopausal.*

Who Are Women with Unmet Needs for Family Planning?

Women with "unmet needs" include:

1. women who would like to space their children or do not want to have any more children but are not using any family planning method;
2. women who are using a family planning method but are not satisfied with their method.

Are you currently pregnant?

If the answer is "Yes," put a check in the box next to Yes and remind her of the need for prenatal care and tetanus toxoid vaccination, if needed. **End of Survey**

If the woman answers "No/Unsure," put a check in the corresponding box and proceed to the next question by following the arrow.

Do you want to have an additional child/children?

If the answer is "Yes, within 1 year," put a check in the corresponding box and inform her of the need for prenatal care when she gets pregnant and of the family planning services available in the health center in case she changes her mind. **End of Survey**

If the answer is "No" or "Yes, after 1 year," check the corresponding box and proceed to the next question by following the arrow.

Are you using any family planning method?

If the answer is "No," put a check in the corresponding box. A check indicates that the woman has an unmet need for family planning because she either does not want to have another child or she wants to delay the birth of her next child. Give the woman information about family planning services and refer her to a midwife or the health center. **End of Survey**

If the answer is "Yes," check the corresponding box and proceed to the next question by following the arrow.

Are you satisfied with the family planning method you are using?

If the answer is "No," put a check in the corresponding box and advise the woman to go to the health center for counseling and information about changing methods. This woman has an unmet need, because she is not satisfied with the family planning method she is currently using and is likely to discontinue or drop out if not given the proper advice or guidance. Proceed to the next question by following the arrow.

If the answer is "Yes," check the corresponding box and proceed to the next question by following the arrow.

What method are you using?

Check the appropriate box of the family planning method she is using. If the woman is using a traditional method, do the action suggested. **End of Survey**

If the woman/mother is classified as using the lactational amenorrhea method (LAM) make sure that all 3 of the following are found:

- she has a baby less than 6 months old;
- she is amenorrheic;
- she is breastfeeding the baby day and night without supplementation.

If the woman is using pills or condoms, provide her with a new supply of her chosen method (if the interviewer or BHW has the necessary supply) if needed, or remind her about her next scheduled visit to the health center for resupply and/or check up. **End of Survey**

Important Note: After the interview, please review the Family Profile (Form 1) for completeness and accuracy. Make sure that you have gathered all needed information before thanking the respondent for her cooperation. Also, please review and repeat to the respondent all the necessary health advice and information you provided her and her family before leaving.

In the boxes that follow, please find information on modern and traditional methods of family planning.

Modern Methods of Contraception

oral contraceptive pills (OCP): tablets taken orally each day for at least 20 days of the menstrual cycle. They suppress ovulation. They are not to be confused with foam tablets, which are inserted into the vaginal canal shortly before sexual intercourse to prevent conception by killing the sperm cells. Examples of pills are Logentrol, Nordette, Trinordiol, Ovral, Norlestrin, Marvelon 28, Femenal, Logynon, Diane 35, Micropil, and Rigevidon.

intra-uterine device (IUD): a small plastic or metal device that is inserted into the uterus by a doctor/nurse and remains there until removed by a doctor/nurse or expelled. The IUD is not to be confused with chemical preparations or devices (such as a diaphragm), which are inserted into the vaginal canal shortly before sexual intercourse. Most IUDs are known as loops or coils. The IUD in the public sector program is called copper-T 380A.

injectables: an injection that is normally given every two or three months and is known as Depo-Provera, Noristerat, or DMPA (depo medroxyprogesterone acetate). Injectables prevent ovulation by stopping the pituitary hormone from releasing the egg from the ovary.

diaphragm/foam/jelly/cream: female methods that are used in the vagina. A diaphragm is a rubber device placed at the entrance to the uterus before intercourse to prevent sperm from entering the uterus. Aerosol foam is spermicidal foam (from an aerosol can) that is inserted into the vaginal canal just before sexual intercourse. The most common brand names are Emko and Delfen. The diaphragm should be used in combination with jelly or cream.

condom: a rubber or latex sheath, which is used by the male during sexual intercourse and prevents sperms from entering the uterus. Condoms are most commonly known as rubbers. Some brand names are Trust, Gold Coin, Silver Tex, Fuji, Samoa, and Conform.

tubal ligation (BTL) or **female voluntary sterilization (FVS):** a permanent method to avoid pregnancy by means of tying or cutting the fallopian tubes, which prevents the egg from flowing to the uterus. Note that hysterectomy (surgical removal of the uterus) or salphingo-oophorectomy (surgical removal of fallopian tubes and ovaries) are not considered to be female sterilization.

vasectomy (VAS) or male voluntary sterilization (MVS): a relatively minor surgical operation (as compared to tubal ligation) done on men for contraceptive purposes. It is a permanent method performed on men by means of tying or cutting the *vas deferens* to prevent sperm cells from mixing with semen during ejaculation.

lactational amenorrhea method (LAM): a temporary family planning method that may be used by a woman to avoid pregnancy if she has a baby less than six months old, her menstrual period has not returned, and she is breastfeeding the baby day and night without supplementation. All three conditions must be met for a mother to be classified as using LAM. If at least one condition mentioned above is not met, the mother cannot be classified as using LAM.

LAM, a child spacing method promoted by the Department of Health (DOH), requires full and regular breastfeeding, which results in the delay of the mother's ovulation. LAM is a temporary method that can be used only until the infant is six months old. If at the time of interview the youngest living child is more than six months old, the woman cannot be considered to be using LAM anymore even though she is breastfeeding.

Natural Family Planning

mucus, Billings, or ovulation: a method by which a woman checks the consistency of her vaginal mucus to determine the time of her ovulation.

thermometer, temperature, or basal body temperature (BBT): a method by which a woman gauges her ovulation by observing the fluctuations in her BBT during her menstrual cycle.

symptothermal: a method that involves monitoring both the consistency of vaginal mucus and fluctuations in BBT during the menstrual cycle.

Traditional Methods of Family Planning

withdrawal: refers to voluntary withdrawal of the penis just before climax (ejaculation) is reached during sexual intercourse.

calendar/rhythm/periodic abstinence: a method in which a couple avoids sexual intercourse on certain days of the woman's menstrual cycle (around the time of ovulation) to avoid pregnancy. The woman calculates and marks on the calendar the days she is likely to be fertile in order to remind the couple not to have sexual intercourse on those fertile days. Likewise, a couple is using the rhythm method if they use a rule to determine which days not to have sexual intercourse, for example, no sexual intercourse from day 8 to day 21 of the woman's menstrual cycle.

Family Profile Exercise

Use the data provided in this handout to fill out five Family Profiles (Form 1). Refer to the instruction sheet for Form 1 when questions or issues arise. Use a pencil to fill out all CBMIS forms, to facilitate revisions and updates.

Background Information

The Municipality of San Nicolas is a fifth-class municipality located in the province of Sulu. It is composed of 35 barangays with a total population of 82,000. It has 18 barangay health stations and 1 rural health unit, named the Kalinga Rurual Health Unit. The Rural Health Physician is Dr. Hugo del Prado and the only Public Health Nurse is Mrs. Tina dela Cruz. All of the municipal health staff including the BHWs completed their MGP training in February 2001.

On returning to work after the MGP training, the diligent Rural Health Midwife, Mrs. Nilda San Juan, in charge of the Pinyahan Barangay Health Station, immediately deployed all her BHWs to conduct a survey among their assigned families. Mrs. San Juan has two barangays in her catchment area: Pinyahan and Ibayo. The BHWs of Barangay Ibayo finished the survey in two weeks, and Mrs. San Juan has already summarized the data. For Barangay Pinyahan, however, Mrs. Milagrosa Tatlonghari (one of five BHWs) has not yet conducted the survey or completed Family Profiles for the five families she is in charge of. These families are residing in a very hard-to-reach area of Barangay Pinyahan.

Data for Five Families

Data for the five families to be interviewed follows. Complete a Family Profile (Form 1) for each family assuming that today is March 9, 2001 and that all respondents were the mothers.

1. Alvarez Family

- They reside at 109 Kalayaan St., Barangay Pinyahan.
- The father is Mr. Cesar Alvarez, born on April 3, 1960.
- The mother is Mrs. Regina Alvarez, born on January 9, 1962.
- Mr. And Mrs. Alvarez are legally married.
- They have 5 children all under 5 years of age:
  - Cathrina, born on September 13, 1996
  - Nico, born on August 12, 1997
  - Jacob, born on July 15, 1998
  - Jeremy, born on June 1, 1999
  - Abby, born on July 5, 2000
- Cathrina received her vaccinations from a private physician but her vaccination record is lost. Her mother recalls that she received BCG, 3 doses of DPT, and 3 doses of OPV, but

did not receive measles vaccine. She has also not received vitamin A supplementation during the past 6 months.

- Nico received his vaccinations from a private physician, and his baby record is intact. The record shows that he was vaccinated with BCG, 3 doses of DPT, and 3 doses of OPV but did not receive measles vaccine. He has not been given a vitamin A capsule during the past 6 months.
- Jacob received his vaccinations at the barangay health station. The growth monitoring chart (GMC) record shows that he received all required vaccinations before his first birthday. He has also been given vitamin A supplementation during the past 6 months.
- Jeremy received his vaccinations at the barangay health station. His GMC record shows that he received BCG, 3 doses of DPT, and 3 doses of OPV, but no measles vaccine. He has not received any vitamin A supplementation during the past 6 months.
- Abby is receiving her vaccinations at the barangay health station. Her GMC record has the following information:
  - BCG: 07/05/2000
  - DPT1: 09/01/2000
  - DPT2: 10/05/2000
  - OPV1: 09/01/2000
  - OPV2: 10/05/2000
- Mrs. Regina Alvarez is not currently pregnant. She has received two tetanus toxoid vaccinations (TTV) during her lifetime. She received her first dose of TTV (TTV1) prior to her pregnancy with her youngest, child Abby. She received the second dose (TTV2) while she was pregnant with Abby.
- Mrs. Regina Alvarez expressed that she and her husband do not want to have any more children. They are not currently using any family planning method.

2. Carbonel Family

- They reside at 121 Kalayaan St., Barangay Pinyahan.
- The father is Mr. Arturo Carbonel, born on December 23, 1970.
- The mother is Mrs. Helen Carbonel, born on May 12, 1972.
- They are legally married.
- They have 5 children:
  - Cha-Cha, born on August 22, 1992
  - Noelle, born on April 2, 1994
  - Julie Anne, born on November 15, 1996
  - Jasmine, born on October 29, 1997
  - MJ, born on April 25, 2000
- Julie Anne received her vaccinations at the local government hospital. Her vaccination record shows that she received BCG, 2 doses of DPT, 2 doses of OPV, and no measles vaccine. She has received vitamin A supplementation during the past 6 months.
- Jasmine received her vaccinations at a private clinic. Her baby record shows that she was

given BCG, 3 doses of DPT, and 3 doses of OPV but no measles vaccine. She received vitamin A supplementation during the last *Garantisadong Pambata*.

- MJ is receiving her vaccinations at the barangay health station. Her GMC card shows the following information:
  - BCG: 04/25/2000
  - DPT1: 06/10/2000
  - DPT2: 07/15/2000
  - OPV1: 06/10/2000
  - OPV2: 07/15/2000
- Mrs. Carbonel is currently pregnant. She has never received any tetanus toxoid vaccinations.

3. Natividad Family

- They reside at 321 Matapang St., Barangay Pinyahan.
- The father is Mr. Carlito Natividad, born on October 12, 1973.
- The mother is Mrs. Lita Natividad, born on June 17, 1974.
- They are not married but have been living together for 8 years.
- They have 3 children:
  - Cecille, born on December 11, 1993
  - Macy, born on October 21, 1996
  - Aaron, born on March 28, 2000
- Macy received her vaccinations from a private clinic. Her baby immunization record shows that she received BCG, 3 doses of DPT, 3 doses of OPV, and measles vaccine before she turned 1 year old. She was not given vitamin A supplementation
- Aaron was also vaccinated at the same private clinic. His baby record shows the following:
  - BCG: 03/28/2000
  - DPT1: 05/01/2000
  - DPT2: 06/10/2000
  - DPT3: 07/15/2000
  - OPV1: 05/01/2000
  - OPV2: 06/10/2000
  - OPV3: 07/15/2000
  - Measles vaccine: 12/28/2000
- Mrs. Natividad is currently pregnant. She has already received 5 doses of TTV. She received her first 3 doses of TTV before her pregnancy with her youngest child, Aaron. She received the fourth dose (TTV4) while she was pregnant with Aaron and the fifth dose (TTV5) during her current pregnancy.

4. Esteban Family

- They reside at 234 Kalayaan St., Barangay Pinyahan.
- The father is Mr. Romeo Esteban, born on January 13, 1965.

- The mother is Mrs. Alicia Esteba, born on June 12, 1965.
- They are married.
- They have 2 children:
  - Oliver, born on August 30, 1999
  - Czarina, born on September 5, 2000
- Oliver received his vaccinations at the barangay health station. His vaccination record shows that he received BCG, 3 doses of DPT, 3 doses of OPV, and measles vaccine before he turned 1 year old. He was not given vitamin A supplementation.
- Czarina was also vaccinated at the barangay health station. Her vaccination record shows the following:
  - BCG: 09/20/2000
  - DPT1: 11/10/2000
  - DPT2: 12/12/2000
  - DPT3: 01/20/2001
  - OPV1: 11/10/2000
  - OPV2: 12/12/2000
  - OPV3: 01/20/2001
- Mrs. Esteban is not currently pregnant. She had 1 tetanus toxoid vaccination (TTV1) prior to her pregnancy with her youngest child, Czarina.
- Mr. and Mrs. Esteban plan to have another child after a year. They are currently using withdrawal as a family planning method and are not satisfied with it.

5. Cinco Family

- They reside at 222 Matapang St., Barangay Pinyahan.
- The father is Mr. Martin Cinco, born on March 25, 1975.
- The mother is Mrs. Rosario Cinco, born on August 22, 1977.
- They are legally married.
- They have a child named Redentor, born on October 2, 2000.
- A private physician is providing vaccination services to Redentor. His vaccination record shows the following:
  - BCG: 10/15/2000
  - DPT1: 12/10/2000
  - DPT2: 01/12/2001
  - DPT3: 02/16/2001
  - OPV1: 12/10/2000
  - OPV2: 01/12/2001
  - OPV3: 02/16/2001
- Mrs. Cinco is not currently pregnant. She has had 3 TTVs during her lifetime. She received the first 2 TTV doses before she got pregnant with Redentor and the third dose when she was pregnant with Redentor.
- They are planning to have another child after a year. Mrs. Cinco is satisfied using contraceptive pills.

FAMILY PROFILE

CBMIS Revised Form as of 02/2001

FORM 1, page 1

General Information

Address: _____

Respondent: _____

Father: _____

Birthday: _____ (mm/dd/yy) Age: _____

Mother: _____

Birthday: _____ (mm/dd/yy) Age: _____

Civil Status: ( ) Single ( ) Married ( ) Widow ( ) Separated

BHS/BHC: _____

RHU: _____

Mun/City: _____

Province: _____

NOTE: Please use pencil in completing the forms to facilitate updating!

BHW: _____

RHM: _____

PHN: _____

Interviewer: _____

Date Surveyed:

Date of last update: _____

Part I. Data of children 0–4 years old (0–59 months old, start from the eldest)

Name	Birthday (MM / DD / YY)	Age	Where does the child receive vaccinations? B = BHS/BHC, R = RHU/MHC, P = Private, G = Gov't Hosp (See "A" below)	Does the child have any vaccination record? Y = Yes, N = No (See "B" below)	Vaccinations Received (For children 0–11 months old, write the date when vaccination was given) (For children 12–59 months old, put a Y if child was given vaccination or an N if not given) If the child 0–11 months old has NO vaccination or the vaccination schedule is NOT followed, (See "C" below) If the child 1–4 years old has INCOMPLETE or NO vaccination, (See "D" below)								FIC (For children 9 months to 4 years old) Did the child receive all the preceding vaccinations before his first birthday? Y = Yes, N = No	Vitamin A (For children 1–4 years old only) Was the child given vitamin A capsule (200,000 IU) during the past 6 months? (e.g. Garantisadong Pambata Activities) Y = Yes, N = No (See "E" below)		Remarks
					BCG	DPT 1st dose	DPT 2nd dose	DPT 3rd dose	OPV 1st dose	OPV 2nd dose	OPV 3rd dose	Measles		April Year	October Year	

Actions to be taken

A. If the child receives vaccination services from private clinics/hospitals and government hospitals, followup the child's vaccinations until completed.

B. Advise the mother to get a copy of the vaccination record from the health facility where the child received the vaccinations or ask the midwife of the nearest BHS to make another record.

C. Refer or accompany the mother and child to the midwife for ***immediate vaccination***.

D. Advise the mother to consult the midwife for completion of the child's vaccinations.

E. Give vitamin A capsule at once if available or advise the mother to bring the child to the nearest health facility for the next scheduled vitamin A supplementation.

Part II A. Tetanus Toxoid Vaccination (TTV) for Pregnant Women

Is the mother/wife pregnant? ☐ Yes ☐ No

Total number of TTV doses received ☐ Doses

If the woman is pregnant, inform her of the importance of prenatal care and tetanus toxoid vaccinations that are available at the nearest health facility.

Part II B. Protection at Birth (PAB) against neonatal tetanus: For women with children 0–2 years old only

Name of youngest child (***0–2 years old only***): _____ Age of youngest child: _____

Complete this table only if the age of the youngest living child is 0 to 2 years old (0–35 months old)

TTV Dose	When was each TTV dose received in reference to the youngest child? **Check the appropriate boxes**		Was the child protected at birth (PAB)? **Check the appropriate box** ***PAB is defined as any of the following:*** • 2 TTV doses during the pregnancy with the youngest child, or • 1 TTV dose during the pregnancy with the youngest child plus 2 doses prior to the pregnancy, or • 3 TTV doses prior to the pregnancy with the youngest child
	During the pregnancy with the youngest child	Prior to the pregnancy with the youngest child	
TTV 1	☐	☐	☐ **Yes** (Protected at Birth)
TTV 2	☐	☐	☐ **No** (NOT protected at birth)
TTV 3	☐	☐	
TTV 4	☐	☐	
TTV 5	☐	☐	

Part III. Family Planning Practice of Married Woman of Reproductive Age (MWRA) (Mother/Wife)

The following should not be interviewed for Part III:

☐ Widowed or separated women ☐ Menopausal women

☐ Women with ovaries and/or uterus and/or fallopian tubes surgically removed due to a medical condition (e.g. tumors, ectopic pregnancy)

Actions to be Taken

1. Are you currently pregnant? *(See response to Part II A)*

- ☐ Yes → Remind her again of the need for prenatal care and tetanus toxoid vaccination. **–END OF INTERVIEW–**
- ☐ No/Unsure ↓

2. Do you want to have additional child/children?

- ☐ Yes, within 1 year → Inform her of the need of prenatal care when she gets pregnant and the available family planning services in the health center in case she changes her mind. **–END OF INTERVIEW–**
- ☐ Yes, after 1 year ↓
- ☐ No ↓

3. Are you currently using any family planning method?

- ☐ No → ***MWRA not wanting another child or wants to space but not practicing family planning*** She has an **UNMET NEED for family planning**. Inform her about family planning services and refer/accompany her to the midwife or to the health center.
- ☐ Yes ↓

4. Are you satisfied with the FP method you are using?

- ☐ No → ***MWRA practicing family planning but not satisfied with the method she is using*** She has an **UNMET NEED for family planning**. Refer or accompany her to the midwife or to the health center for counseling. **–Proceed to Question #5–**
- ☐ Yes ↓

5. What method are you using? **(✓) Check the appropriate box**

Modern Methods		Traditional Methods	
☐ P	= Pills	☐ W	= Withdrawal
☐ IUD	= Intrauterine Device	☐ CAL	=Calendar / Rhythm
☐ Inj	= DMPA / Injectable		
☐ C	= Condom		
☐ BTL	= Bilateral Tubal Ligation		
☐ VAS	= Vasectomy		
☐ NFP	= Natural Family Planning		
☐ LAM	= Lactational Amenorrhea		

→ ***MWRA practicing family planning but using traditional methods*** Inform her of the benefits of using modern family planning methods. Refer or accompany her to the midwife or to the health center for counseling.

A mother may be classified as using LAM if all 3 of the following are true:
1. She has a baby less than six months old,
2. She is amenorrheic (not menstruating), and
3. She is breastfeeding the baby day and night without supplementation.

If any of the above no longer applies, refer her to the midwife for counseling.

Session 3: Family Profile Field Practicum

Overview

Working in assigned teams, the participants interview families with target clients in a nearby community and complete Form 1 for at least five families each. The participants share their field interview experiences in a plenary session and draft a checklist of requirements for conducting surveys in the future.

Objectives

At the end of the session, the participants will be able to:

- conduct Family Profile field interviews
- correctly complete Form 1 for each family interviewed

Materials

The materials needed for each team for this session include:

- a list of teams, their assigned vehicles, and sections of the community to visit
- a map of the areas to be visited
- Form 1 (template) (five or more per participant)

Tasks

The tasks involved in preparing for and implementing this session are listed below.

1. Conduct the survey in the assigned area by completing Form 1 for each family interviewed. It is anticipated that each participant will interview at least five families with qualified target clients: children 0–59 months old, and/or pregnant women, and/or married women of reproductive age.
2. Share field interview experiences at a plenary session.
3. Draft a checklist of requirements to facilitate survey planning and implementation in future.

Products

By the end of this session, the participants will have completed:

- at least five Family Profiles per participant
- a checklist of requirements for planning and carrying out surveys when they return to their LGUs

Session 4: Review and Correct Family Profiles (Form 1)

Overview

During this session, the participants review the copies of Form 1 completed by another team and identify any problems with the completed forms. They revise their own forms based on feedback from others and identify common problems in filling out Form 1.

Objectives

By the end of the session, the participants will be able to:

- review completed copies of Form 1 and identify any problems
- revise Form 1 based on feedback
- identify common problems encountered in filling out Form 1

Materials

The materials needed for this session include:

- copies of Form 1 completed during Session 3 (field practicum)
- How to Fill Out and Use the Family Profile (Form 1)

Tasks

The tasks involved in preparing for and implementing this session are listed below.

1. Exchange completed copies of Form 1 with another group as assigned by the facilitator.
2. Review all copies of Form 1 completed by another group. Check them for completeness and errors. For clarification, refer to the "How to Fill Out and Use the Family Profile (Form 1)."
3. Using a pencil (not a pen), identify and circle any errors. Do not make the corrections.
4. Return the reviewed copies of Form 1 to the group that generated them so they may make any needed corrections.
5. Make any corrections identified on your forms.
6. Identify common problems in filling out the forms and share them with the larger group.

Products

By the end of this session, each participant will have:

- at least five correctly filled out copies of Form 1, developed during the field practicum and reviewed and corrected during this session

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Session 5: Barangay CBMIS Tally Sheet (Form 2)

Overview

During this session, the participants learn how to fill out the Barangay CBMIS Tally Sheet (Form 2). They fill out a Tally Sheet using data from the sample Form 1 (filled out during Session 2). In plenary, one group presents its completed Form 2, and the other participants raise questions and discuss issues. In closing this session, the teams correct their forms as needed.

Objectives

By the end of the session, the participants will be able to:

- correctly fill out a Barangay CBMIS Tally Sheet (Form 2)

Materials

The materials needed for this session include:

- Form 1 (completed during Session 2)
- How to Fill Out and Use the Barangay CBMIS Tally Sheet (Form 2)
- the sample Form 2, partially completed

Tasks

The tasks involved in preparing for and implementing this session are listed below.

1. Read "How to Fill Out and Use the Barangay CBMIS Tally Sheet (Form 2)" and review the sample Form 2, partially completed.
2. Using the sample Form 2, summarize the copies of Form 1 completed during Session 2.
3. Participate in a plenary session in which one team presents its completed Form 2.
4. Compare your team's completed Form 2 with that of the presenter, raise questions, and discuss issues.
5. Make corrections to your Form 2 as needed.

Products

By the end of this session, each team will have:

- a correctly filled out Form 2

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How to Fill Out and Use the Barangay CBMIS Tally Sheet (Form 2)

The Rural Health Midwife summarizes all of the Family Profiles (Form 1s) from each BHW under her into a Form 2 in order to keep track of the total number of target clients in a particular barangay. She categorizes her clients into different target groups, as listed.

This instruction sheet provides all the information needed to fill out Form 2 correctly. Read these instructions before beginning to fill out a Form 2 for the first time, and refer to them when questions or issues arise. Use a pencil to fill out this and all other CBMIS forms, to facilitate revisions and updates.

Part IA. Children 0–11 Months Old (vaccination status)

This section consists of four categories, numbered 1, 2, 3, and 4. Using data from all Form 1s, the midwife tallies the number of children into the category where they belong. The total number of children 0–11 months old is the sum of categories 1, 2, 3, and 4.

Part IB. Children 12–23 Months Old (vaccination status)

This section consists of two categories, numbered 5 and 6. Using data from all Form 1s, the midwife tallies the number of children into the category where they should belong. The total number of children 12-23 months old is the sum of categories 5 and 6.

Part IC. Children 12–59 Months Old (vitamin A supplementation status)

This section consists of two categories, numbered 7 and 8. Using data from all Form 1s, the midwife tallies the number of children into the category where they belong. The total number of children 12–59 months old is the sum of categories 7 and 8.

Part IIA. Tetanus Toxoid Vaccination (TTV) Status for Pregnant Women

This section consists of two categories, numbered 9 and 10. Using data from all Form 1s, the midwife tallies the number of pregnant women according to their TTV status into the category where they belong. The total number of pregnant women is the sum of numbers 9 and 10. This sum could serve as the actual denominator for computing the percentage of pregnant women who have received TTV2 plus.

Part IIB. Children 0–35 months old (tetanus toxoid protection at birth)

This section consists of two categories, numbered 11 and 12. Using data from all Form 1s, the midwife tallies the number of children into the category where they belong. The total number of children 0-2 years old is the sum of categories 11 and 12.

Part III. Family Planning and Nonpregnant Married Women of Reproductive Age

This section consists of four categories numbered 13, 14, 15, and 16. Using data from all Form 1s, the midwife tallies the number of married women of reproductive age into the category where they belong, according to their family planning practice. The total number of nonpregnant married women of reproductive age is the sum of categories 13, 14, 15, and 16. This sum plus the sum of pregnant women can serve as the actual denominator for computing the contraceptive prevalence rate.

Total Number of Current Users

This section categorizes clients practicing family planning by the method they use. The sum of all the methods should be equal to the sum of categories 14 and 16.

Barangay CBMIS Tally Sheet

CBMIS Revised Form as of 02/2001

Barangay: **Pinyahan**
BHS/BHC: **Pinyahan**
Mun/City: **San Nicolas**

RHM: **Mrs. Nilda San Juan**
Date: **March 11, 2001**

Form 2, page 1

TARGET GROUPS Purok:	BHW 1	BHW 2	BHW 3	BHW 4	BHW 5	BHW 6	BHW 7	BHW 8	BHW 9	BHW 10	BHW 11	BHW 12	BHW 13	BHW 14	BHW 15	BHW 16	BHW 17	Total
IA. Vaccination status of children 0–11 months old																		
1. Children 9–11 months old with INCOMPLETE or NO vaccination at all		3	2	5	6													
2. Children 0–8 months old with NO vaccination or with recommended vaccination schedule NOT followed		1	2	1	4													
3. Children 0–8 months old with recommended vaccination schedule followed		1	1	1	3													
4. Children 9–11 months old who are Fully Immunized Children (FIC)		2	3	2	2													
TOTAL number of children 0–11 months old (sum of # 1, 2, 3 & 4)		7	8	9	15													
IB. Vaccination status of 1 year old children (12–23 months)																		
5. Children 1 year old (12–23 months) with INCOMPLETE or NO vaccination at all		3	2	2	3													
6. Children 1 year old (12–23 months) who are Fully Immunized Children (FIC)		2	2	3	3													
TOTAL number of 1 year old children (12–23 months (sum of # 5 & 6)		5	4	5	6													
IC. Vitamin A supplementation status of children 1–4 years old (12–59 months)																		
7. Children 1–4 years old (12–59 months) NOT given Vitamin A capsule during the past six months		3	2	1	3													
8. Children 1–4 years old (12–59 months) GIVEN Vitamin A capsule during the past six months		4	7	1	2													
TOTAL number of children 1–4 years old (12–59 months old) (sum of # 7 & 8)		7	9	2	5													
II A. Tetanus Toxoid Vaccination Status of pregnant mother/wife																		
9. Pregnant with NO TT or with TT1 only		1	2	3	4													
10. Pregnant with TT2 +		0	1	2	2													
TOTAL number of pregnant mother/wife (sum of # (9 & 10)		1	3	5	6													

TARGET GROUPS Purok:	BHW 1	BHW 2	BHW 3	BHW 4	BHW 5	BHW 6	BHW 7	BHW 8	BHW 9	BHW 10	BHW 11	BHW 12	BHW 13	BHW 14	BHW 15	BHW 16	BHW 17	Total
II B. Protection at Birth																		
11. Children Protected at Birth		3	4	4	8													
12. Children Not Protected at Birth		5	4	5	9													
Sum of # 11 & 12		8	8	9	17													
III. Family Planning and Nonpregnant Married Women of Reproductive Age (MWRA)																		
13. MWRA not wanting to have a child or wants to space but NOT practicing family planning		1	2	1	5													
14. MWRA practicing family planning but NOT satisfied with the method she is using		2	1	1	2													
15. MWRA wanting a child within 1 year		1	4	3	2													
16. MWRA practicing family planning and satisfied with the method she is using		5	3	3	4													
TOTAL number of nonpregnant MWRA (sum of # 13, 14, 15 & 16)		9	10	8	13													
FP Methods Used by Current Users																		
P Pills		2	1	2	1													
IUD Intrauterine Device		1	1	0	0													
INJ DMPA / Injectable		0	1	1	0													
C Condom		2	0	1	1													
BTL Bilateral Tubal Ligation		1	0	0	2													
VAS Vasectomy		0	0	0	0													
NFP Natural Family Planning		0	0	0	0													
LAM Lactational Amenorrhea Method		0	0	0	1													
W Withdrawal		0	1	0	1													
C Calendar		1	0	0	0													
TOTAL FP Methods Used by Current Users *(should equal the sum of # 14 & 16)		7	4	4	6													

Session 6: Call Cards and Midwife's Copy

Overview

During this session, the teams use Family Profiles to identify unmet client needs. They fill out Call Cards and create a Midwife's Copy for every Call Card created. They share their experience in plenary and raise and answer questions. In closing the session, they revise their Call Cards as needed.

Objectives

By the end of the session, the participants will be able to:

- identify unmet client needs using completed copies of Form 1
- correctly fill out a Call Card
- correctly create a Midwife's Copy for each completed Call Card

Materials

The materials needed for this session include:

- Form 1 (completed during Session 2)
- How to Fill Out Call Cards
- CBMIS Call Card (template)
- CBMIS Call Card—Midwife's Copy (template) for each Call Card
- "Personalized Client Follow-Up through Call Slips" (see tab "Best Practices and Technical Notes")

Tasks

The tasks involved in preparing for and implementing this session are listed below.

1. Read "How to Fill Out Call Cards."
2. Using the completed copies of Form 1 from Session 2, identify the families' unmet needs and create Call Cards.
3. Make a Midwife's Copy for each Call Card created.
4. Participate in a plenary session in which each team presents a completed Call Card.
5. Compare your team's completed Call Cards with those of the presenters, raise questions, and discuss issues.
6. Make corrections to your Call Cards and each Midwife's Copy as needed.

Products

By the end of this session, each team will have:

- several correctly filled out Call Cards
- a Midwife's Copy for each completed Call Card

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How to Fill Out Call Cards

This instruction sheet provides all the information needed to fill out Call Cards correctly. Read these instructions before beginning to fill out a Call Card for the first time, and refer to them when questions or issues arise. Use a pencil to fill out this and all other CBMIS forms, to facilitate revisions and updates. Please note that the Call Card is a two-sided document. It should be folded twice. The name of the card, with Sentrong Sigla symbol, is on the front cover. The midwife's invitation is on the inside front cover.

General Information

In the ruled spaces on the front of the Call Card, write down the name and address of the person (usually the mother) being invited. The midwife who is extending the invitation should sign the invitation letter printed on the inside cover.

Vaccinations for Children 0–11 Months Old

The card provides two vaccination schedule tables for children 0-11 months old. For each table:

- write down the name and age of the child needing vaccinations;
- check the vaccination that the child needs;
  Important Note: Do not check the vaccinations that s/he has already received.
- write down the date when you plan to give the vaccinations;
- write down the place where you plan to give the vaccinations;
- once the child has received the scheduled vaccinations, write down the date when the service was actually given;
- once the child has received the scheduled vaccinations, the midwife should sign her name on the column provided for in the table.

Vitamin A Supplementation for Children 1–4 Years Old

In the vitamin A supplementation table:

- write down the name and age of the child needing vitamin A supplementation;
- write down the date when you plan to give the vitamin A supplementation;
- write down the place where you plan to give the vitamin A supplementation;
- once the child has received the vitamin A supplementation, write down the date when the service was actually given;
- once the child has received the vitamin A supplementation, the midwife should sign her name on the column provided for in the table.

Tetanus Toxoid Vaccination (TTV) for Pregnant Women

In the TTV table:

- write down the name and age of the pregnant woman needing TTV;
- check the TTV that she needs;
  Important Note: Do not check the TTVs she has already received.
- write down the date when you plan to give the TTV;
- write down the place where you plan to give the TTV;
- once the pregnant woman received the scheduled TTV, write down the date when the service was actually given;
- the midwife should sign her name on the column provided for in the table once the service was actually given.

Family Planning Service

In the family planning service table:

- write down the name and age of the woman needing family planning service;
- write down the kind of service that she needs (for example, family planning counseling);
- write down the date when you plan to give the service;
- write down the place where you plan to give the service;
- once the woman has received the service, write down the date when the service was actually given;
- once the woman has received the service, the midwife should sign her name on the column provided in the table.

Tetanus Toxoid (TT) Vaccination for Pregnant Women

Name: _____ Age: _____

Services Needed		Date When TT Vaccination Will Be Given	Place Where TT Vaccination Will Be Given	Date Given	Signature of Midwife
	TT 1				
	TT 2				
	TT 3				
	TT 4				
	TT 5				

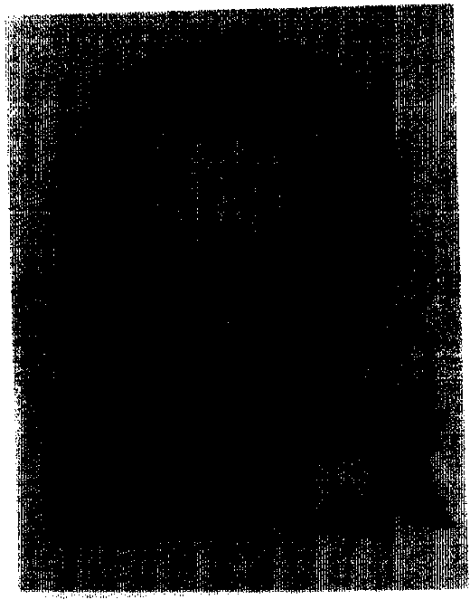
Family Planning Service

Name: _____ Age: _____

FP Services Needed	Date When Service Will Be Provided	Place Where Service Will Be Provided	Date Provided	Signature of Midwife

Matching Grant Program

CBMIS Call Card



_____

_____

_____

Sa Sentrong Sigla, Health Ang Una !

Dear _____,

Greetings from the staff of your local health center.

Recently, our local health department through our Barangay Health Workers (BHW) conducted a survey in your area to identify the health services needed by your family. This is our effort to reach out to each and everyone in your community. From the information you provided our BHWs, we found that the health service/services listed on the following tables is/are needed by one or more members of your family.

Please do not hesitate to use the free services that our friendly health personnel will provide on the scheduled date and place.

Sincerely

Vaccinations for Children 0–11 Months Old

Name of Child: _____ Age: _____

Vaccinations Needed	Date When Vaccination Will Be Given	Place Where Vaccination Will Be Given	Date Given	Signature of Midwife
BCG				
DPT 1				
DPT 2				
DPT 3				
OPV 1				
OPV 2				
OPV 3				
Measles				

Name of Child: _____ Age: _____

Vaccinations Needed	Date When Vaccination Will Be Given	Place Where Vaccination Will Be Given	Date Given	Signature of Midwife
BCG				
DPT 1				
DPT 2				
DPT 3				
OPV 1				
OPV 2				
OPV 3				
Measles				

Vitamin A Supplementation for Children 1–4 Years Old

Name of Child	Age	Date When Vitamin A Will Be Given	Place Where Vitamin A Will Be Given	Date Given	Signature of Midwife

CBMIS Call Card—Midwife's Copy

Mother: _____ BHS: _____
Address: _____
Midwife: _____

Vaccinations for Children 0–11 Months Old

Name of Child: _____ Age: _____

Vaccinations Needed Date	When Vaccination Will Be Given	Place Where Vaccination Will Be Given	Date Given	Signature of Midwife
BCG				
DPT 1				
DPT 2				
DPT 3				
OPV 1				
OPV 2				
OPV 3				
Measles				

Name of Child: _____ Age: _____

Vaccinations Needed Date	When Vaccination Will Be Given	Place Where Vaccination Will Be Given	Date Given	Signature of Midwife
BCG				
DPT 1				
DPT 2				
DPT 3				
OPV 1				
OPV 2				
OPV 3				
Measles				

Vitamin A Supplementation for Children 1–4 Years Old

Name	Age	When Vaccination Will Be Given	Place Where Vaccination Will Be Given	Date Given	Signature of Midwife

CBMIS Call Card—Midwife's Copy (cont.)

Tetanus Toxoid (TT) Vaccination for Pregnant Women

Name: _____ Age: _____

Services Needed		Date When TT Vaccination Will Be Given	Place Where TT Vaccination Will Be Given	Date Given	Signature of Midwife
	TT 1				
	TT 2				
	TT 3				
	TT 4				

Family Planning Service

Name: _____ Age: _____

FP Services Needed	Date When Service Will Be Provided	Place Where Service Will Be Provided	Date Provided	Signature of Midwife

Session 7: Catchment Area CBMIS Tally Sheet (Form 3)

Overview

During this session, the participants learn how to fill out the Catchment Area CBMIS Tally Sheet (Form 3). They fill out a Form 3 using sample data from the Form 1s completed during Session 2. In plenary, one group presents its completed Form 3, and the other participants raise questions and discuss issues. In closing this session, the teams correct their forms as needed.

Objectives

By the end of the session, the participants will be able to:

- correctly fill out a Catchment Area CBMIS Tally Sheet (Form 3)

Materials

The materials for this session are:

- How to Fill Out and Use the Catchment Area CBMIS Tally Sheet (Form 3)
- copies of completed Form 1 (from Session 2)
- completed Form 2 (from Session 5)
- Form 3 (sample, partially filled out)

Tasks

The tasks for this session are listed below.

1. Read "How to Fill Out and Use the Catchment-Area CBMIS Tally Sheet (Form 3)."
2. Using the completed Form 2 from Session 5, complete the partially completed Form 3 provided for this session.
3. Participate in a plenary session in which one team presents its completed Form 3.
4. Compare your team's completed Form 3 with that of the presenter, raise questions, and discuss issues.
5. Make corrections to your team's Form 3 as needed.

Products

By the end of this session, each team will have:

- a correctly completed Catchment Area CBMIS Tally Sheet (Form 3)

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How to Fill Out and Use the Catchment Area CBMIS Tally Sheet (Form 3)

This instruction sheet provides information about filling out the Catchment Area CBMIS Tally Sheet (Form 3) and using the data to identify barangays with the greatest unmet needs. Read these instructions before beginning to fill out Form 3 for the first time, and refer to them when questions arise. Use a pencil to fill out this and all other CBMIS forms, to facilitate revisions and updates.

General Information

The midwife uses this form to summarize all Form 2 data from the barangays in her catchment area. The form provides columns for summarizing data for up to five barangays.

Form 3 data provide the midwife with an overall picture of her catchment area and help her to identify the barangay(s) with the greatest number and percentage of clients with unmet needs. Form 3 allows the midwife to compare data among barangays and prioritize which to attend to first.

Example

The following exmple provides vaccination data for children 0–11 months old from two barangays in the catchment area of a Rural Health Midwife.

Numbers and Percentages of Unmet Need for Vaccination of Children 0–11 Months Old in Malambing and Matipuno

Target Groups	Barangay Malambing		Barangay Matipuno	
IA. Vaccination of children 0–11 months old	Number (N)	Percent (N ÷ Total x 100)	Number (N)	Percent (N ÷ Total x 100)
1. Children 9–11 months old with INCOMPLETE or NO vaccination at all	15	52%	15	34%
2. Children 0–8 months with NO vaccination or with recommended vaccination scheduled NOT followed	6	21%	6	14%
3. Children 0–8 months old with recommended vaccination scheduled followed	5	17%	11	25%
4. Children 9–11 months old who are fully immunized	3	10%	12	27%
TOTAL number of children 0–11 months old (sum of numbers 1–4)	**29**	**100%**	**44**	**100%**

In the example, look at the "Number" column for each barangay. This column shows the actual number of children aged 9–11 months with incomplete vaccinations or no vaccination at all. In this example, Barangay Malambing and Barangay Matipuno each have 15 children in this category. Ideally, all of these children should be immediately attended to. However, logistical challenges and lack of staff may prevent quick action in both barangays at once. The midwife must prioritize which barangay to attend to first.

Look at the "Percent" column for each barangay. This column shows the rate or percentage of children aged 0–11 with incomplete vaccinations or no vaccination. In this example, 52% of the children aged 0–11 months in Barangay Malambing and 34% of children aged 0–11 months in Barangay Matipuno need vaccinations. The midwife should prioritize Barangay Malambing, because it has a higher percentage of children 0-11 months old with an unmet need for vaccinations.

Catchment Area CBMIS Tally Sheet—Form 3

BHS/BHC: **Pinyahan**
Mun/City: **San Nicolas**

RHM: **Mrs. Nilda San Juan**
Date: **March 11, 2001**

Form 3, page 1

TARGET GROUPS	Barangay Pinyahan		Barangay Ibayo		Barangay		Barangay		Barangay		Total	
IA. Vaccination status of children 0–11 months old	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)
1. Children 9–11 months old with INCOMPLETE or NO vaccination at all			9	27%								
2. Children 0–8 months old with NO vaccination or with recommended vaccination schedule NOT followed			10	30%								
3. Children 0–8 months old with recommended vaccination schedule followed			12	36%								
4. Children 9–11 months old who are Fully Immunized Children (FIC)			2	6%								
TOTAL number of children 0–11 months old (sum of # 1, 2, 3 & 4)			33	100%								
IB. Vaccination status of 1 year old children (12–23 months)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)
5. Children 1 year old (12–23 months) with INCOMPLETE or NO vaccination at all			15	43%								
6. Children 1 year old (12–23 months) who are Fully Immunized Children (FIC)			20	57%								
TOTAL number of 1 year old children (12–23 months) (sum of # 5 & 6)			35	100%								
IC. Vitamin A supplementation status of children 1–4 years old (12–59 months)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)
7. Children 1–4 years old (12–59 months) NOT given vitamin A capsule during the past six months			10	37%								
8. Children 1–4 years old (12–59 months) GIVEN vitamin A capsule during the past six months			17	63%								
TOTAL number of children 1–4 years old (12–59 months old) (sum of # 7 & 8)			27	100%								
II A. Tetanus Toxoid Vaccination Status of pregnant mother/wife	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)
9. Pregnant with NO TT or with TT1 only			3	20%								
10. Pregnant with TT2 +			12	80%								
TOTAL number of pregnant mother/wife (sum of # (9 & 10)			15	100%								

TARGET GROUPS	Barangay PINYAHAN		Barangay IBAYO		Barangay		Barangay		Barangay		Total	
II B. Protection at Birth	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)
11. Children Protected at Birth			28	78%								
12. Children Not Protected at Birth			8	22%								
Sum of # 11 & 12			36	100%								
III. Family Planning and Nonpregnant Married Women of Reproductive Age (MWRA)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)
13. MWRA not wanting to have a child or wants to space but NOT practicing family planning			9	36%								
14. MWRA practicing family planning but NOT satisfied with the method she is using			4	16%								
15. MWRA wanting a child within 1 year			0	0%								
16. MWRA practicing family planning and satisfied with the method she is using			12	48%								
TOTAL number of nonpregnant MWRA (sum of # 13, 14, 15 & 16)			25	100%								
FP Methods Used by Current Users												
P Pills			3	19%								
IUD Intrauterine Device			2	13%								
INJ DMPA / Injectable			5	31%								
C Condom			3	19%								
BTL Bilateral Tubal Ligation			1	6%								
VAS Vasectomy			0	0%								
NFP Natural Family Planning			0	0%								
LAM Lactational Amenorrhea Method			1	6%								
W Withdrawal			1	6%								
C Calendar			0	0%								
TOTAL FP Methods Used by Current Users *(should equal the sum of # 14 & 16)			16	100%								

Session 8: "From the Top (Well, Almost!)"

Overview

During this session, the teams use the copies of Form 1 from their field practicum (Session 3) to summarize barangay and catchment area data and identify unmet client needs. They fill out Form 2 and Form 3, and create Call Cards and Midwife's Copies. They share their experiences in plenary and raise and answer questions. In closing the session, they revise their forms as needed.

Objectives

By the end of the session, the participants will be able to:

- summarize data for a barangay and a catchment area using actual data (from the field practicum copies of Form 1, developed in Session 3)
- identify unmet client needs per family using actual data
- correctly fill out Call Cards for families that need them
- correctly create a Midwife's Copy for each Call Card created

Materials

The materials for this session are:

- Family Profiles completed during the field practicum (Session 3)
- Form 2 (template)
- Form 3 (template)
- CBMIS Call Card (template) (several Call Cards per team)
- CBMIS Call Card—Midwife's Copy (template) (one for each Call Card)

Tasks

The tasks for this session are listed below.

1. Summarize the family data collected during the field practicum (Session 3) by filling out a Form 2 and a Form 3.
2. Separate any incomplete copies of Form 1 from the field practicum and give them to the facilitators, who will pass them on to the health staff responsible for completing them.
3. Using the completed copies of Form 1 from the field practicum (Session 3), identify the families' unmet needs, and create Call Cards as needed.
4. Make a Midwife's Copy for each Call Card created.
5. Enter relevant data in the table prepared by the facilitation team. These data will include the area surveyed, the number of families surveyed, the number of Call Cards issued, and the percentage of families requiring Call Cards.
6. Collect and collate all completed forms and give them to the facilitator, who will deliver them to the health staff responsible for the area surveyed.

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Products

By the end of this session, each team will have:

- a correctly completed Form 2
- several correctly filled out Call Cards, and a Midwife's Copy for each completed Call Card
- a correctly completed Form 3

Barangay CBMIS Tally Sheet—Form 2 (template)

Barangay: _____
BHS/BHC: _____
Mun/City: _____

RHM: _____
Date: _____

Form 2, page 1

TARGET GROUPS Purok:	BHW 1	BHW 2	BHW 3	BHW 4	BHW 5	BHW 6	BHW 7	BHW 8	BHW 9	BHW 10	BHW 11	BHW 12	BHW 13	BHW 14	BHW 15	BHW 16	BHW 17	Total
IA. Vaccination status of children 0–11 months old																		
1. Children 9–11 months old with INCOMPLETE or NO vaccination at all																		
2. Children 0–8 months old with NO vaccination or with recommended vaccination schedule NOT followed																		
3. Children 0–8 months old with recommended vaccination schedule followed																		
4. Children 9–11 months old who are Fully Immunized Children (FIC)																		
TOTAL number of children 0–11 months old (sum of # 1, 2, 3 & 4)																		
IB. Vaccination status of 1 year old children (12–23 months)																		
5. Children 1 year old (12–23 months) with INCOMPLETE or NO vaccination at all																		
6. Children 1 year old (12–23 months) who are Fully Immunized Children (FIC)																		
TOTAL number of 1 year old children (12–23 months) (sum of # 5 & 6)																		
IC. Vitamin A supplementation status of children 1–4 years old (12–59 months)																		
7. Children 1–4 years old (12–59 months) NOT given Vitamin A capsule during the past six months																		
8. Children 1–4 years old (12–59 months) GIVEN Vitamin A capsule during the past six months																		
TOTAL number of children 1–4 years old (12–59 months old) (sum of # 7 & 8)																		
II A. Tetanus Toxoid Vaccination Status of pregnant mother/wife																		
9. Pregnant with NO TT or with TT1 only																		
10. Pregnant with TT2 +																		
TOTAL number of pregnant mother/wife (sum of # (9 & 10)																		

TARGET GROUPS Purok:	BHW 1	BHW 2	BHW 3	BHW 4	BHW 5	BHW 6	BHW 7	BHW 8	BHW 9	BHW 10	BHW 11	BHW 12	BHW 13	BHW 14	BHW 15	BHW 16	BHW 17	Total
II B. Protection at Birth																		
11. Children Protected at Birth																		
12. Children Not Protected at Birth																		
Sum of # 11 & 12																		
III. Family Planning and Nonpregnant Married Women of Reproductive Age (MWRA)																		
13. MWRA not wanting to have a child or wants to space but NOT practicing family planning																		
14. MWRA practicing family planning but NOT satisfied with the method she is using																		
15. MWRA wanting a child within 1 year																		
16. MWRA practicing family planning and satisfied with the method she is using																		
TOTAL number of nonpregnant MWRA (sum of # 13, 14, 15 & 16)																		
FP Methods Used by Current Users																		
P Pills																		
IUD Intrauterine Device																		
INJ DMPA / Injectable																		
C Condom																		
BTL Bilateral Tubal Ligation																		
VAS Vasectomy																		
NFP Natural Family Planning																		
LAM Lactational Amenorrhea Method																		
W Withdrawal																		
C Calendar																		
TOTAL FP Methods Used by Current Users *(should equal the sum of # 14 & 16)																		

Catchment Area CBMIS Tally Sheet—Form 3

BHS/BHC: _____ RHM: _____

Mun/City: _____ Date: _____

Form 3, page 1

TARGET GROUPS	Barangay		Barangay		Barangay		Barangay		Barangay		Total	
IA. Vaccination status of children 0–11 months old	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)
1. Children 9–11 months old with INCOMPLETE or NO vaccination at all												
2. Children 0–8 months old with NO vaccination or with recommended vaccination schedule NOT followed												
3. Children 0–8 months old with recommended vaccination schedule followed												
4. Children 9–11 months old who are Fully Immunized Children (FIC)												
TOTAL number of children 0–11 months old (sum of # 1, 2, 3 & 4)												
IB. Vaccination status of 1 year old children (12–23 months)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	
5. Children 1 year old (12–23 months) with INCOMPLETE or NO vaccination at all												
6. Children 1 year old (12–23 months) who are Fully Immunized Children (FIC)												
TOTAL number of 1 year old children (12–23 months) (sum of # 5 & 6)												
IC. Vitamin A supplementation status of children 1–4 years old (12–59 months)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	
7. Children 1–4 years old (12–59 months) NOT given Vitamin A capsule during the past six months												
8. Children 1–4 years old (12–59 months) GIVEN Vitamin A capsule during the past six months												
TOTAL number of children 1–4 years old (12–59 months old) (sum of # 7 & 8)												
II A. Tetanus Toxoid Vaccination Status of pregnant mother/wife	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	
9. Pregnant with NO TT or with TT1 only												
10. Pregnant with TT2 +												
TOTAL number of pregnant mother/wife (sum of # (9 & 10)												

Form 3, page 2

TARGET GROUPS	Barangay		Barangay		Barangay		Barangay		Barangay		Total	
II B. Protection at Birth	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)
11. Children Protected at Birth												
12. Children Not Protected at Birth												
Sum of # 11 & 12												
III. Family Planning and Nonpregnant Married Women of Reproductive Age (MWRA)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)
13. MWRA not wanting to have a child or wants to space but NOT practicing family planning												
14. MWRA practicing family planning but NOT satisfied with the method she is using												
15. MWRA wanting a child within 1 year												
16. MWRA practicing family planning and satisfied with the method she is using												
TOTAL number of nonpregnant MWRA (sum of # 13, 14, 15 & 16)												
FP Methods Used by Current Users												
P Pills												
IUD Intrauterine Device												
INJ DMPA / Injectable												
C Condom												
BTL Bilateral Tubal Ligation												
VAS Vasectomy												
NFP Natural Family Planning												
LAM Lactational Amenorrhea Method												
W Withdrawal												
C Calendar												
TOTAL FP Methods Used by Current Users *(should equal the sum of # 14 & 16)												

Tetanus Toxoid (TT) Vaccination for Pregnant Women

Name: _____ Age: _____

Services Needed	Date When TT Vaccination Will Be Given	Place Where TT Vaccination Will Be Given	Date Given	Signature of Midwife
☐ TT 1				
☐ TT 2				
☐ TT 3				
☐ TT 4				
☐ TT 5				

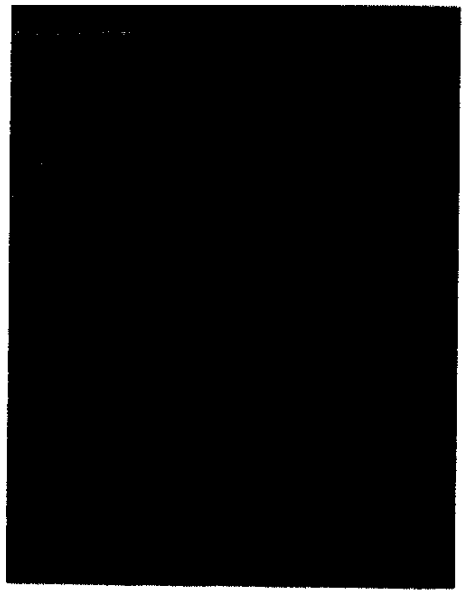
Family Planning Service

Name: _____ Age: _____

FP Services Needed	Date When Service Will Be Provided	Place Where Service Will Be Provided	Date Provided	Signature of Midwife

Matching Grant Program

CBMIS Call Card



_____

_____

_____

Sa Sentrong Sigla, Health Ang Una !

Dear _____,

Greetings from the staff of your local health center.

Recently, our local health department through our Barangay Health Workers (BHW) conducted a survey in your area to identify the health services needed by your family. This is our effort to reach out to each and everyone in your community. From the information you provided our BHWs, we found that the health service/services listed on the following tables is/are needed by one or more members of your family.

Please do not hesitate to use the free services that our friendly health personnel will provide on the scheduled date and place.

Sincerely

Vaccinations for Children 0–11 Months Old

Name of Child: _____ Age: _____

Vaccinations Needed	Date When Vaccination Will Be Given	Place Where Vaccination Will Be Given	Date Given	Signature of Midwife
☐ BCG				
☐ DPT 1				
☐ DPT 2				
☐ DPT 3				
☐ OPV 1				
☐ OPV 2				
☐ OPV 3				
☐ Measles				

Name of Child: _____ Age: _____

Vaccinations Needed	Date When Vaccination Will Be Given	Place Where Vaccination Will Be Given	Date Given	Signature of Midwife
☐ BCG				
☐ DPT 1				
☐ DPT 2				
☐ DPT 3				
☐ OPV 1				
☐ OPV 2				
☐ OPV 3				
☐ Measles				

Vitamin A Supplementation for Children 1–4 Years Old

Name of Child	Age	Date When Vitamin A Will Be Given	Place Where Vitamin A Will Be Given	Date Given	Signature of Midwife

CBMIS Call Card—Midwife's Copy

Mother: _____ BHS: _____
Address: _____
Midwife: _____

Vaccinations for Children 0–11 Months Old

Name of Child: _____ Age: _____

Vaccinations Needed Date	When Vaccination Will Be Given	Place Where Vaccination Will Be Given	Date Given	Signature of Midwife
BCG				
DPT 1				
DPT 2				
DPT 3				
OPV 1				
OPV 2				
OPV 3				
Measles				

Name of Child: _____ Age: _____

Vaccinations Needed Date	When Vaccination Will Be Given	Place Where Vaccination Will Be Given	Date Given	Signature of Midwife
BCG				
DPT 1				
DPT 2				
DPT 3				
OPV 1				
OPV 2				
OPV 3				
Measles				

Vitamin A Supplementation for Children 1–4 Years Old

Name	Age	When Vaccination Will Be Given	Place Where Vaccination Will Be Given	Date Given	Signature of Midwife

CBMIS Call Card—Midwife's Copy (cont.)

Tetanus Toxoid (TT) Vaccination for Pregnant Women

Name: _____ Age: _____

Services Needed		Date When TT Vaccination Will Be Given	Place Where TT Vaccination Will Be Given	Date Given	Signature of Midwife
	TT 1				
	TT 2				
	TT 3				
	TT 4				

Family Planning Service

Name: _____ Age: _____

FP Services Needed	Date When Service Will Be Provided	Place Where Service Will Be Provided	Date Provided	Signature of Midwife

Session 9: Updating the Community-Based Monitoring and Information System

Overview

During this session, the teams use sample data to update the copies of Form 1 originally completed during Session 2. Using the updated copies of Form 1, the teams complete Form 2 and Form 3, share their completed forms in plenary, and raise and answer questions. In closing the session, they revise their forms as needed.

Objectives

By the end of this session, the participants will understand:

- the process of updating the CBMIS forms: the Family Profile, Barangay CBMIS Tally Sheet, and Catchment Area CBMIS Tally Sheet
- the importance and benefits of correctly updating the CBMIS forms

Materials

The materials for this session are:

- How to Update the Family Profiles (Form 1)
- Family Profile Updating Exercise
- Form 1 (completed during Session 2, using sample data)
- Form 2 (partially complete)
- Form 3 (partially complete)
- "Using the Community-Based Monitoring and Information System to Help Reduce Unmet Needs" (see Appendix A)

Tasks

The tasks for this session are listed below.

1. Read "How to Update the Family Profile (Form 1)."
2. Working in teams and using the data provided in "Family Profile Updating Exercise," update the copies of Form 1 completed during Session 2.
3. Use the updated Family Profiles to complete the sample Form 2 and Form 3 provided for this session.
4. Participate in a plenary session in which one team presents its updated forms.
5. Compare your team's completed forms with that of the presenter, raise questions, and discuss issues.
6. Make corrections to your team's Form 3 as needed.

Products

By the end of this session, each team will have:

- new and updated copies of Form 1, Form 2, and Form 3

How to Update the Family Profile (Form 1)

This instruction sheet provides information about updating Family Profiles (Form 1). It provides information only on those sections that may need to be updated. It does not include instructions for sections that will stay the same (for example, the mother's birth date). Read these instructions before beginning to update Form 1 for the first time, and refer to them when questions arise. Use a pencil to fill out this and all other CBMIS forms, to facilitate revisions and updates.

Ideally, BHWs will update the Family Profiles for their respective families at least once a month, or more often when necessary. In cases where the BHW visits her families less frequently, she should update the forms during each visit. In addition, the BHW should fill out new Family Profiles for any new families (for example, newlyweds and families) that have moved to the area. The BHW must inform the midwife if any families have left the area, so she can exclude the Family Profile data for that family. In revising Form 1, the BHW should erase the outdated entry and write down the current data.

Important Note! The BHW updates only those entries that need to be changed.

The midwife then uses the updated Family Profile data to update Forms 2 and 3.

Important Note! When updating Forms 2 and 3, exclude Family Profile data for any families that have left the area.

General Information

Father's Age

Erase the father's age at the time of the survey or previous update, and write his age for the current date.

Mother's Age

Erase the mother's age at the time of the survey or previous update, and write her age for the current date.

Date of Last Update

In the space provided, write the date of this update. For succeeding updates, erase the previous date (of last update) and replace it with the current date.

Important Note: Do not change the date of survey, as this is a permanent entry and indicates the first contact with the family!

Part I. Data on children 0–59 months old (start from the eldest)

Name

Any child who has turned five years old should be erased from the list. Add any newborns to the children listed in the table. Remove from the list any child who has died. In cases where the cause of death is due to a communicable disease (for example, measles), the BHW should immediately notify the midwife so the proper control and prevention measures may be taken in the family and in the community.

Age of Children

For each child, erase his or her age at the time of the survey or the previous update, and write the child's current age.

Vaccinations Received

For children who were 0–11 months old at the time of the survey or previous update but are now 1 year old, **do not** erase the dates of vaccination entered under each antigen to change them to "Y". Just leave the entries as they were initially entered during the initial survey. Changing the dates of vaccination to "Y" will not have any bearing at all and is just a waste of time and effort.

For children who were 1–4 years old at the time of the survey or previous update and had incomplete vaccinations or no vaccination at that time but have received the needed vaccinations since, erase the "N" entry under each antigen and put the date when the vaccination was given. This will serve as a useful reference in counterchecking the entries in the FIC column.

Part II B. Protection at Birth against Neonatal Tetanus

Replace any child who has turned 3 years old since the survey or previous update with a child 0–2 years old. If the family has no child 0–2 years old, leave the table blank.

Family Profile Updating Exercise

Background Information

The Municipality of San Nicolas is a fifth-class municipality located in the province of Sulu. It is composed of 35 barangays with a total population of 82,000. It has 18 barangay health stations and 1 rural health unit, named Kalinga Rural Health Unit. The Rural Health Physician is Dr. Hugo del Prado and the only Public Health Nurse is Mrs. Tina dela Cruz. All of the municipal health staff, including the BHWs, completed their MGP training in February 2001.

The rural health midwife, Mrs. Nilda San Juan, is in charge of the Pinyahan barangay health station, which covers two barangays, Pinyahan and Ibayo. The initial survey of these two barangays was completed last March 2001, and Mrs. San Juan was able to identify the target clients with unmet needs. Call cards were issued and services were provided to these clients. The BHWs update the Family Profiles of their assigned areas on a monthly basis, and Mrs. San Juan summarizes the data in Forms 2 and 3.

The BHWs of Barangay Ibayo have just finished updating their Family Profiles and Mrs. San Juan has already summarized the data for the barangay. For Barangay Pinyahan, however, Mrs. Milagrosa Tatlonghari (one of five BHWs) still has to update the profiles of the families in her area, which is hard to reach. With the addition of two new families that have just moved to her area of responsibility, she now has a total of seven families under her care.

Data for Seven Families

Data for two new families as well as updated information on the original five families follow. Complete and update the Family Profile (Form 1) for each family assuming that today is June 22, 2001. For all families, the respondents were the mothers.

1. Alvarez Family

- Cathrina now has a vaccination record (Mrs. Alvarez requested a copy of the vaccination record from the private physician following the advice of the BHW). She was given vitamin A supplementation last April 2001, together with her siblings Nico, Jacob, and Jeremy.
- Jeremy received measles vaccine on April 25, 2001 (the barangay health station had an extra dose at that time).
- Abby received the remaining vaccinations she needed. DPT3 and OPV3 were given last March 21, 2001. She received measles vaccine on April 25, 2001.
- Mrs. Regina Alvarez submitted herself for a bilateral tubal ligation last month during one of the ligation activities of the municipality. She expressed satisfaction with the method.

2. Carbonel Family

- Julie Anne and Jasmine both received vitamin A supplementation in April 2001.
- MJ contracted measles and had severe complications. He died of measles bronchopneumonia.
- Mrs. Carbonel delivered a baby boy named Noel last May 20, 2001. Noel's GMC from the BHS shows that he received BCG on May 23, 2001.
- Mrs. Carbonel received two doses of TTV (March and April 2001) while she was pregnant with Noel.
- The couple has decided not to have any more children, and Mrs. Carbonel is taking contraceptive pills. She is satisfied with the method.

3. Cinco Family

- Mrs. Cinco is still on contraceptive pills.

4. Esteban Family

- Oliver was given vitamin A supplementation in April 2001.
- Czarina was given measles vaccine on June 14, 2001.
- Mrs. Esteban shifted her family planning method from withdrawal to oral contraceptive pills. She is pleased with the new method.

5. Natividad Family

- Both Macy and Aaron received vitamin A supplementation in April 2001.
- Mrs. Natividad gave birth to Tiffany on June 12, 2001. Tiffany was given BCG at the barangay health station on June 20, 2001, as shown on her GMC.
- Mrs. Natividad is a fully immunized mother. She received her fifth TTV during her pregnancy with Tiffany.
- Mrs. Natividad is breastfeeding Tiffany day and night without supplementation. She is still not menstruating. She admitted dissatisfaction with the method and fears getting pregnant again.

6. Santos Family

- This married couple just recently moved to #3 Kalayaan Street.
- The father is Alipio Santos, born on October 14, 1968.
- The mother is Marichu Santos, born on June 24, 1970.
- They have two children:
  - Clarissa, born on January 16, 1999
  - Cecille, born on July 10, 2000

- Clarissa was vaccinated at the BHS serving their previous residence but her vaccination record was lost. Based on mother's recall, Clarissa received BCG, 3 doses of DPT, and 3 doses of OPV, but no measles vaccine. She has not been given any vitamin A supplementation within the past 6 months.
- Cecille's GMC from the barangay health station showed the following:
  - BCG: 07/20/2000
  - DPT1: 09/06/2000
  - OPV1: 09/06/2000
- Mrs. Santos is currently pregnant.
- Mrs. Santos has had two doses of TTV during her lifetime. She received the first dose before she got pregnant with Cecille, and the second dose during her pregnancy with Cecille.

7. Carlos Family

- This married couple just recently moved to #3 Kalayaan Street, together with the Santos family.
- The father is Pedro Carlos, born on February 17, 1975.
- The mother is Lany Carlos, born on March 13, 1977.
- They have four children:
  - Don, born on March 8, 1994
  - Eve, born on May 16, 1995
  - Beatrice, born on February 21, 1997
  - Diego, born on December 15, 1998
- Don was vaccinated at a private clinic and his record shows that he completed the primary series of childhood vaccinations before his first birthday. He was also given vitamin A supplementation last April 2001.
- A private physician also vaccinated Eve, but her record is lost. Based on mother's recall she was given BCG, 3 doses of DPT, 3 doses of OPV, but no measles vaccine. She received vitamin A supplementation in October 2000.
- Beatrice was vaccinated at the BHS from their previous residence but her vaccination record is lost. Based on her mother's recall, she was given BCG, 3 doses of DPT, 3 doses of OPV but no measles vaccine. She has not received vitamin A supplementation within the past 6 months.
- Diego was also vaccinated at the BHS from their previous abode, and his vaccination record is also lost. Based on her mother's recall, he was given BCG, 3 doses of DPT, 3 doses of OPV, but no measles vaccine. He has not received vitamin A supplementation within the past 6 months.
- Lany is currently pregnant.
- She received 1 dose of TTV during her pregnancy with Diego.

FORM 1, page 1

FAMILY PROFILE

CBMIS Revised Form as of 02/2001

General Information

Address: 109 Kalayaan St. Barangay Pinyahan
Respondent: Regina Alvarez
Father: Cesar Alvarez
Birthday: 04 / 03 / 1960 (mm/dd/yy) Age: 40
Mother: Regina Alvarez
Birthday: 01 / 09/ 1962 (mm/dd/yy) Age: 39
Civil Status: ( ) Single (✓) Married ( ) Widow ( ) Separated

BHS/BHC: Pinyahan HC
RHU: Kalinga
Mun/City: San Nicolas
Province: Sulu

NOTE: Please use pencil in completing the forms to facilitate updating!

BHW: Mrs. Milagrosa Tatlonghari
RHM: Mrs. Nilda San Juan
PHN: Mrs. Tina Dela Cruz
Interviewer: Mrs. Milagrosa Tatlonghari
Date Surveyed: March 09, 2001
Date of last update:

Part I. Data of children 0–4 years old (0–59 months old, start from the eldest)

Name	Birthday MM	Birthday DD	Birthday YY	Age	Where does the child receive vaccinations? B =BHS/BHC R =RHU/MHC P =Private G =Gov't Hosp (See "A" below)	Does the child have any vaccination record? Y = Yes N = No (See "B" below)	Vaccinations Received (For children 0-11 months old, write the date when vaccination was given) (For children 12–59 months old, put a Y if child was given vaccination or an N if not given) If the child 0–11months old has NO vaccination or the vaccination schedule is NOT followed, (See "C" below) If the child 1–4 years old has INCOMPLETE or NO vaccination, (See "D" below)								FIC (For children 9 months to 4 years old) Did the child receive all the preceding vaccinations before his first birthday? Y = Yes N = No	Vitamin A (For children 1–4 years old only) Was the child given vitamin A capsule (200,000 IU) during the past 6 months? (e.g. Garantisadong Pambata Activities) Y = Yes N = No (See "E" below)		Remarks
							BCG	DPT 1st dose	DPT 2nd dose	DPT 3rd dose	OPV 1st dose	OPV 2nd dose	OPV 3rd dose	Measles		April 2001 Year	October 2000 Year	
Cathrina	09	13	96	4 y	P	N	Y	Y	Y	Y	Y	Y	Y	N	N		N	
Nico	08	12	97	3 y	P	Y	Y	Y	Y	Y	Y	Y	Y	N	N		N	
Jacob	07	15	98	2 y	B	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	
Jeremy	06	01	99	1 y	B	Y	Y	Y	Y	Y	Y	Y	Y	N	N		N	
Abby	07	05	00	8 m	B	Y	07/05/00	09/01/00	10/05/00		09/01/00	10/05/00						

Actions to be taken

A. If the child receives vaccination services from private clinics/hospitals and government hospitals, followup the child's vaccinations until completed.
B. Advise the mother to get a copy of the vaccination record from the health facility where the child received the vaccinations or ask the midwife of the nearest BHS to make another record.
C. Refer or accompany the mother and child to the midwife for ***immediate vaccination***.
D. Advise the mother to consult the midwife for completion of the child's vaccinations.
E. Give vitamin A capsule at once if available or advise the mother to bring the child to the nearest health facility for the next scheduled vitamin A supplementation.

Part II A. Tetanus Toxoid Vaccination (TTV) for Pregnant Women

FORM 1, page 2

Is the mother/wife pregnant?	☐ Yes	✓ No
Total number of TTV doses received	2 Doses	

If the woman is pregnant, inform her of the importance of prenatal care and tetanus toxoid vaccinations that are available at the nearest health facility

Part II B. Protection at Birth (PAB) against neonatal tetanus: For women with children 0–2 years old only

Name of youngest child (***0–2 years old only***): ***Abby***

Age of youngest child: **8 months**

Complete this table only if the age of the youngest living child is 0 to 2 years old (0–35 months old)

TTV Dose	When was each TTV dose received in reference to the youngest child? **Check the appropriate boxes**		Was the child protected at birth (PAB)? **Check the appropriate box**
	During the pregnancy with the youngest child	Prior to the pregnancy with the youngest child	*PAB is defined as any of the following* • 2 TTV doses during the pregnancy with the youngest child or • 1 TTV dose during the pregnancy with the youngest child plus 2 doses prior to the pregnancy, or • 3 TTV doses prior to the pregnancy with the youngest child
TTV 1			☐ **Yes** *(Protected at Birth)*
TTV 2	✓	✓	✓ **No** *(NOT protected at birth)*
TTV 3			
TTV 4			
TTV 5			

Part III. Family Planning Practice of Married Woman of Reproductive Age (MWRA) (Mother/Wife)

The following should not be interviewed for Part III:

☐ Widowed or separated women ☐ Menopausal women

☐ Women with ovaries and/or uterus and/or fallopian tubes surgically removed due to a medical condition (e.g. tumors, ectopic pregnancy)

1. Are you currently pregnant? *(See response to Part II A)*

- ✓ No/Unsure → **2. Do you want to have additional child/children?**
- ☐ Yes → **Actions to be Taken**: Remind her again of the need of prenatal care and tetanus toxoid vaccination **–END OF INTERVIEW–**

2. Do you want to have additional child/children?

- ✓ No → **3. Are you currently using any family planning method?**
- ☐ Yes, after 1 year → **3. Are you currently using any family planning method?**
- ☐ Yes, within 1 year → Inform her of the need of prenatal care when she gets pregnant and the available family planning services in the health center in case she changes her mind **–END OF INTERVIEW–**

3. Are you currently using any family planning method?

- ☐ Yes → **4. Are you satisfied with the FP method you are using?**
- ✓ No → ***MWRA not wanting another child or wants to space but not practicing family planning***: She has an **UNMET NEED for family planning**. Inform her about family planning services and refer/accompany her to the midwife or to the health center **–END OF INTERVIEW–**

4. Are you satisfied with the FP method you are using?

- ☐ Yes → **5. What method are you using?**
- ☐ No → ***MWRA practicing family planning but not satisfied with the method she is using***: She has an **UNMET NEED for family planning**. Refer or accompany her to the midwife or to the health center for counseling **–Proceed to Question #5–**

5. What method are you using?
(✓) **Check the appropriate box**

Modern Methods	Traditional Methods
☐ **P** = Pills	☐ **W** = Withdrawal
☐ **IUD** = Intrauterine Device	☐ **CAL**=Calendar / Rhythm
☐ **Inj** = DMPA / Injectable	
☐ **C** = Condom	
☐ **BTL** = Bilateral Tubal Ligation	
☐ **VAS** = Vasectomy	
☐ **NFP** = Natural Family Planning	
☐ **LAM** = Lactational Amenorrhea Method	

→ ***MWRA practicing family planning but using traditional methods***: Inform her of the benefits of using modern family planning methods. Refer or accompany her to the midwife or to the health center for counseling

A mother may be classified as using LAM if all 3 of the following are true

1. She has a baby less than six months old.
2. She is amenorrheic (not menstruating), and
3. She is breastfeeding the baby day and night without supplementation.

If any of the above no longer applies, refer her to the midwife for counseling.

FORM 1, page 1

FAMILY PROFILE

CBMIS Revised Form as of 02/2001

General Information

Address: 121 Kalayaan St. Barangay Pinyahan
Respondent: Helen Carbonel
Father: Arturo Carbonel
Birthday: 12 / 23 / 1970 (mm/dd/yy) Age: 30
Mother: Helen Carbonel
Birthday: 05 / 12/ 1972 (mm/dd/yy) Age: 28
Civil Status: ( ) Single (✓) Married ( ) Widow ( ) Separated

BHS/BHC: Pinyahan HC
RHU: Kalinga
Mun/City: San Nicolas
Province: Sulu

NOTE: Please use pencil in completing the forms to facilitate updating!

BHW: Mrs. Milagrosa Tatlonghari
RHM: Mrs. Nilda San Juan
PHN: Mrs. Tina Dela Cruz
Interviewer: Mrs. Milagrosa Tatlonghari
Date Surveyed: March 09, 2001
Date of last update:

Part I. Data of children 0–4 years old (0–59 months old, start from the eldest)

Name	Birthday MM	Birthday DD	Birthday YY	Age	Where does the child receive vaccinations? B =BHS/BHC R =RHU/MHC P =Private G =Gov't Hosp *(See "A" below)*	Does the child have any vaccination record? Y = Yes N = No *(See "B" below)*	Vaccinations Received (*For children 0–11 months old*, write the date when vaccination was given) (*For children 12–59 months old*, put a **Y** if child was given vaccination or an **N** if not given) If the child 0–11months old has NO vaccination or the vaccination schedule is NOT followed, (***See "C" below***) If the child 1–4 years old has INCOMPLETE or NO vaccination, (***See "D" below***)								FIC (***For children 9 months to 4 years old***) Did the child receive all the preceding vaccinations before his first birthday? Y = Yes N = No	Vitamin A (***For children 1–4 years old only***) Was the child given vitamin A capsule (200,000 IU) during the past 6 months? (e.g. Garantisadong Pambata Activities) Y = Yes N = No *(See "E" below)*		Remarks
							BCG	DPT 1st dose	DPT 2nd dose	DPT 3rd dose	OPV 1st dose	OPV 2nd dose	OPV 3rd dose	Measles		April 2001 Year	October 2000 Year	
Julie Anne	11	15	96	4 y	G	Y	Y	Y	Y	N	Y	Y	N	N	N		Y	
Jasmine	10	29	97	3 y	P	Y	Y	Y	Y	Y	Y	Y	Y	N	N		Y	
MJ	04	25	00	10 m	B	Y	04/25/00	06/10/00	07/15/00		06/10/00	07/15/00						

Actions to be taken

A. If the child receives vaccination services from private clinics/hospitals and government hospitals, followup the child's vaccinations until completed.
B. Advise the mother to get a copy of the vaccination record from the health facility where the child received the vaccinations or ask the midwife of the nearest BHS to make another record.
C. Refer or accompany the mother and child to the midwife for ***immediate vaccination***.
D. Advise the mother to consult the midwife for completion of the child's vaccinations.
E. Give vitamin A capsule at once if available or advise the mother to bring the child to the nearest health facility for the next scheduled vitamin A supplementation.

Part II A. Tetanus Toxoid Vaccination (TTV) for Pregnant Women

FORM 1, page 2

Is the mother/wife pregnant?	✓ Yes	☐ No	If the woman is pregnant, inform her of the importance of prenatal care and tetanus toxoid vaccinations that are available at the nearest health facility
Total number of TTV doses received	0 Doses		

Part II B. Protection at Birth (PAB) against neonatal tetanus: For women with children 0–2 years old only

Name of youngest child (***0–2 years old only***): **MJ**

Age of youngest child: **10 months**

Complete this table only if the age of the youngest living child is 0 to 2 years old (0–35 months old)

TTV Dose	When was each TTV dose received in reference to the youngest child? **Check the appropriate boxes**		Was the child protected at birth (PAB)? **Check the appropriate box**
	During the pregnancy with the youngest child	Prior to the pregnancy with the youngest child	*PAB is defined as any of the following:* • 2 TTV doses during the pregnancy with the youngest child or • 1 TTV dose during the pregnancy with the youngest child plus 2 doses prior to the pregnancy or • 3 TTV doses prior to the pregnancy with the youngest child
TTV 1	☐	☐	☐ **Yes** (*Protected at Birth*)
TTV 2	☐	☐	
TTV 3	☐	☐	
TTV 4	☐	☐	
TTV 5	☐	☐	✓ **No** (*NOT protected at birth*)

Part III. Family Planning Practice of Married Woman of Reproductive Age (MWRA) (Mother/Wife)

The following should not be interviewed for Part III:

☐ Widowed or separated women ☐ Menopausal women

☐ Women with ovaries and/or uterus and/or fallopian tubes surgically removed due to a medical condition (e.g. tumors, ectopic pregnancy)

1. Are you currently pregnant? *(See response to Part II A)*

- ☐ No/Unsure → **2. Do you want to have additional child/children?**
- ✓ Yes → **Actions to be Taken**: Remind her again of the need of prenatal care and tetanus toxoid vaccination. **–END OF INTERVIEW–**

2. Do you want to have additional child/children?

- ☐ No → **3. Are you currently using any family planning method?**
- ☐ Yes, after 1 year → **3. Are you currently using any family planning method?**
- ☐ Yes, within 1 year → Inform her of the need of prenatal care when she gets pregnant and the available family planning services in the health center in case she changes her mind. **–END OF INTERVIEW–**

3. Are you currently using any family planning method?

- ☐ Yes → **4. Are you satisfied with the FP method you are using?**
- ☐ No → ***MWRA not wanting another child or wants to space but not practicing family planning***: She has an **UNMET NEED for family planning**. Inform her about family planning services and refer/accompany her to the midwife or to the health center. **–END OF INTERVIEW–**

4. Are you satisfied with the FP method you are using?

- ☐ Yes → **5. What method are you using?**
- ☐ No → ***MWRA practicing family planning but not satisfied with the method she is using***: She has an **UNMET NEED for family planning**. Refer or accompany her to the midwife or to the health center for counseling. **–Proceed to Question #5–**

5. What method are you using? (✓) **Check the appropriate box**

Modern Methods	Traditional Methods
☐ **P** = Pills	☐ **W** = Withdrawal
☐ **IUD** = Intrauterine Device	☐ **CAL**=Calendar / Rhythm
☐ **Inj** = DMPA / Injectable	
☐ **C** = Condom	
☐ **BTL** = Bilateral Tubal Ligation	
☐ **VAS** = Vasectomy	
☐ **NFP** = Natural Family Planning	
☐ **LAM** = Lactational Amenorrhea Method	

→ ***MWRA practicing family planning but using traditional methods***: Inform her of the benefits of using modern family planning methods. Refer or accompany her to the midwife or to the health center for counseling.

A mother may be classified as using LAM if all 3 of the following are true:

1. She has a baby less than six months old
2. She is amenorrheic (not menstruating) and
3. She is breastfeeding the baby day and night without supplementation

If any of the above no longer applies, refer her to the midwife for counseling.

FORM 1, page 1

FAMILY PROFILE

CBMIS Revised Form as of 02/2001

General Information

Address: 222 Matapang St. Barangay Pinyahan
Respondent: Rosario Cinco
Father: Martin Cinco
Birthday: 03 / 25 / 1975 (mm/dd/yy) Age: 25
Mother: Rosario Cinco
Birthday: 08 / 22/ 1977 (mm/dd/yy) Age: 23
Civil Status: ( ) Single (✓) Married ( ) Widow ( ) Separated

BHS/BHC: Pinyahan BHS
RHU: Kalinga
Mun/City: San Nicolas
Province: Sulu

NOTE: Please use pencil in completing the forms to facilitate updating!

BHW: Mrs. Milagrosa Tatlonghari
RHM: Mrs. Nilda San Juan
PHN: Mrs. Tina Dela Cruz
Interviewer: Mrs. Milagrosa Tatlonghari
Date Surveyed: March 09, 2001
Date of last update:

Part I. Data of children 0–4 years old (0–59 months old, start from the eldest)

Name	Birthday (MM DD YY)	Age	Where does the child receive vaccinations? B =BHS/BHC R =RHU/MHC P =Private G =Gov't Hosp *(See "A" below)*	Does the child have any vaccination record? Y = Yes N = No *(See "B" below)*	Vaccinations Received (*For children 0–11 months old*, write the date when vaccination was given) (*For children 12–59 months old*, put a **Y** if child was given vaccination or an **N** if not given) If the child 0–11months old has NO vaccination or the vaccination schedule is NOT followed, (*See "C" below*) If the child 1–4 years old has INCOMPLETE or NO vaccination, (*See "D" below*)								FIC (*For children 9 months to 4 years old*) Did the child receive all the preceding vaccinations before his first birthday? Y = Yes N = No	Vitamin A (*For children 1–4 years old only*) Was the child given vitamin A capsule (200,000 IU) during the past 6 months? (e.g. Garantisadong Pambata Activities) Y = Yes N = No *(See "E" below)*		Remarks
					BCG	DPT 1st dose	DPT 2nd dose	DPT 3rd dose	OPV 1st dose	OPV 2nd dose	OPV 3rd dose	Measles		April Year	October Year	
Redentor	10 02 00	5 m	P	Y	10/15/00	12/10/00	01/12/01	02/16/01	12/10/00	01/12/01	02/16/01					

Actions to be taken

A. If the child receives vaccination services from private clinics/hospitals and government hospitals, followup the child's vaccinations until completed.
B. Advise the mother to get a copy of the vaccination record from the health facility where the child received the vaccinations or ask the midwife of the nearest BHS to make another record.
C. Refer or accompany the mother and child to the midwife for ***immediate vaccination***.
D. Advise the mother to consult the midwife for completion of the child's vaccinations.
E. Give vitamin A capsule at once if available or advise the mother to bring the child to the nearest health facility for the next scheduled vitamin A supplementation.

Part II A. Tetanus Toxoid Vaccination (TTV) for Pregnant Women

FORM 1, page 2

Is the mother/wife pregnant?	☐ Yes	✓ No
Total number of TTV doses received	3 Doses	

If the woman is pregnant, inform her of the importance of prenatal care and tetanus toxoid vaccinations that are available at the nearest health facility

Part II B. Protection at Birth (PAB) against neonatal tetanus: For women with children 0–2 years old only

Name of youngest child (***0–2 years old only***): **Redentor** Age of youngest child **5 months**

Complete this table only if the age of the youngest living child is 0 to 2 years old (0–35 months old)

TTV Dose	When was each TTV dose received in reference to the youngest child? **Check the appropriate boxes** — During the pregnancy with the youngest child	Prior to the pregnancy with the youngest child
TTV 1	☐	☐
TTV 2	☐	✓
TTV 3	✓	✓
TTV 4	☐	☐
TTV 5	☐	☐

Was the child protected at birth (PAB)? **Check the appropriate box**

PAB is defined as any of the following

- 2 TTV doses during the pregnancy with the youngest child or
- 1 TTV dose during the pregnancy with the youngest child plus 2 doses prior to the pregnancy, or
- 3 TTV doses prior to the pregnancy with the youngest child

✓ **Yes** (*Protected at Birth*)

☐ **No** (*NOT protected at birth*)

Part III. Family Planning Practice of Married Woman of Reproductive Age (MWRA) (Mother/Wife)

The following should not be interviewed for Part III

☐ Widowed or separated women ☐ Menopausal women

☐ Women with ovaries and/or uterus and/or fallopian tubes surgically removed due to a medical condition (e.g. tumors, ectopic pregnancy)

1. Are you currently pregnant? (*See response to Part II A*)

- ✓ No/Unsure → **2. Do you want to have additional child/children?**
- ☐ Yes → **Actions to be Taken**: Remind her again of the need of prenatal care and tetanus toxoid vaccination. **–END OF INTERVIEW–**

2. Do you want to have additional child/children?

- ☐ No → **3. Are you currently using any family planning method?**
- ✓ Yes, after 1 year → **3. Are you currently using any family planning method?**
- ☐ Yes, within 1 year → Inform her of the need of prenatal care when she gets pregnant and the available family planning services in the health center in case she changes her mind. **–END OF INTERVIEW–**

3. Are you currently using any family planning method?

- ✓ Yes → **4. Are you satisfied with the FP method you are using?**
- ☐ No → ***MWRA not wanting another child or wants to space but not practicing family planning***: She has an **UNMET NEED for family planning**. Inform her about family planning services and refer/accompany her to the midwife or to the health center. **–END OF INTERVIEW–**

4. Are you satisfied with the FP method you are using?

- ✓ Yes → **5. What method are you using?**
- ☐ No → ***MWRA practicing family planning but not satisfied with the method she is using***: She has an **UNMET NEED for family planning**. Refer or accompany her to the midwife or to the health center for counseling. **–Proceed to Question #5–**

5. What method are you using?

(✓) **Check the appropriate box**

Modern Methods	Traditional Methods
✓ **P** = Pills	☐ **W** = Withdrawal
☐ **IUD** = Intrauterine Device	☐ **CAL** = Calendar Rhythm
☐ **Inj** = DMPA Injectable	
☐ **C** = Condom	
☐ **BTL** = Bilateral Tubal Ligation	
☐ **VAS** = Vasectomy	
☐ **NFP** = Natural Family Planning	
☐ **LAM** = Lactational Amenorrhea Method	

→ ***MWRA practicing family planning but using traditional methods***: Inform her of the benefits of using modern family planning methods. Refer or accompany her to the midwife or to the health center for counseling.

A mother may be classified as using LAM if all 3 of the following are true:

1. She has a baby less than six months old
2. She is amenorrheic (not menstruating), and
3. She is breastfeeding the baby day and night without supplementation

If any of the above no longer applies, refer her to the midwife for counseling.

FORM 1, page 1

FAMILY PROFILE

CBMIS Revised Form as of 02/2001

General Information

Address: 234 Kalayaan St. Barangay Pinyahan
Respondent: Alicia Esteban
Father: Romeo Esteban
Birthday: 01 / 13 / 1965 (mm/dd/yy) Age: 36
Mother: Alicia Esteban
Birthday: 06 / 12/ 1965 (mm/dd/yy) Age: 35
Civil Status: ( ) Single (✓) Married ( ) Widow ( ) Separated

BHS/BHC: Pinyahan HC
RHU: Kalinga
Mun/City: San Nicolas
Province: Sulu

NOTE: Please use pencil in completing the forms to facilitate updating!

BHW: Mrs. Milagrosa Tatlonghari
RHM: Mrs. Nilda San Juan
PHN: Mrs. Tina Dela Cruz
Interviewer: Mrs. Milagrosa Tatlonghari
Date Surveyed: March 09, 2001
Date of last update:

Part I. Data of children 0–4 years old (0–59 months old, start from the eldest)

Name	Birthday (MM)	Birthday (DD)	Birthday (YY)	Age	Where does the child receive vaccinations? B =BHS/BHC R =RHU/MHC P =Private G =Gov't Hosp (See "A" below)	Does the child have any vaccination record? Y = Yes N = No (See "B" below)	Vaccinations Received (For children 0–11 months old, write the date when vaccination was given) (For children 12–59 months old, put a Y if child was given vaccination or an N if not given) If the child 0–11months old has NO vaccination or the vaccination schedule is NOT followed, (See "C" below) If the child 1–4 years old has INCOMPLETE or NO vaccination, (See "D" below): BCG	DPT 1st dose	DPT 2nd dose	DPT 3rd dose	OPV 1st dose	OPV 2nd dose	OPV 3rd dose	Measles	FIC (For children 9 months to 4 years old) Did the child receive all the preceding vaccinations before his first birthday? Y = Yes N = No	Vitamin A (For children 1–4 years old only) Was the child given vitamin A capsule (200,000 IU) during the past 6 months? (e.g. Garantisadong Pambata Activities) Y = Yes N = No (See "E" below): April 2001 Year	October 2000 Year	Remarks
Oliver	08	30	99	1 y	B	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		N	
Czarina	09	05	00	6 m	B	Y	09/20/00	11/10/00	12/12/00	01/20/01	11/10/00	12/12/00	01/20/01					

Actions to be taken

A. If the child receives vaccination services from private clinics/hospitals and government hospitals, followup the child's vaccinations until completed.
B. Advise the mother to get a copy of the vaccination record from the health facility where the child received the vaccinations or ask the midwife of the nearest BHS to make another record.
C. Refer or accompany the mother and child to the midwife for ***immediate vaccination***.
D. Advise the mother to consult the midwife for completion of the child's vaccinations.
E. Give vitamin A capsule at once if available or advise the mother to bring the child to the nearest health facility for the next scheduled vitamin A supplementation.

Part II A. Tetanus Toxoid Vaccination (TTV) for Pregnant Women

FORM 1, page 2

Is the mother/wife pregnant?	☐ Yes	✓ No
Total number of TTV doses received	1 Doses	

If the woman is pregnant, inform her of the importance of prenatal care and tetanus toxoid vaccinations that are available at the nearest health facility

Part II B. Protection at Birth (PAB) against neonatal tetanus: For women with children 0–2 years old only

Name of youngest child (***0–2 years old only***): *Czarina* Age of youngest child: **6 months**

Complete this table only if the age of the youngest living child is 0 to 2 years old (0–35 months old)

TTV Dose	When was each TTV dose received in reference to the youngest child? **Check the appropriate boxes**		Was the child protected at birth (PAB)? **Check the appropriate box**
	During the pregnancy with the youngest child	Prior to the pregnancy with the youngest child	*PAB is defined as any of the following* • 2 TTV doses during the pregnancy with the youngest child or • 1 TTV dose during the pregnancy with the youngest child plus 2 doses prior to the pregnancy or • 3 TTV doses prior to the pregnancy with the youngest child
TTV 1	☐	☐	☐ **Yes** *(Protected at Birth)*
TTV 2	☐	✓	✓ **No** *(NOT protected at birth)*
TTV 3	☐	☐	
TTV 4	☐	☐	
TTV 5	☐	☐	

Part III. Family Planning Practice of Married Woman of Reproductive Age (MWRA) (Mother/Wife)

The following should not be interviewed for Part III:

☐ Widowed or separated women ☐ Menopausal women

☐ Women with ovaries and/or uterus and/or fallopian tubes surgically removed due to a medical condition (e.g. tumors, ectopic pregnancy)

1. Are you currently pregnant? *(See response to Part II A)*

- ✓ No/Unsure → **2. Do you want to have additional child/children?**
- ☐ Yes → Remind her again of the need of prenatal care and tetanus toxoid vaccination **–END OF INTERVIEW–**

2. Do you want to have additional child/children?

- ☐ No → **3. Are you currently using any family planning method?**
- ✓ Yes, after 1 year → **3. Are you currently using any family planning method?**
- ☐ Yes, within 1 year → Inform her of the need of prenatal care when she gets pregnant and the available family planning services in the health center in case she changes her mind **–END OF INTERVIEW–**

3. Are you currently using any family planning method?

- ✓ Yes → **4. Are you satisfied with the FP method you are using?**
- ☐ No → ***MWRA not wanting another child or wants to space but not practicing family planning*** She has an **UNMET NEED for family planning** Inform her about family planning services and refer/accompany her to the midwife or to the health center **–END OF INTERVIEW–**

4. Are you satisfied with the FP method you are using?

- ☐ Yes → **5. What method are you using?**
- ✓ No → ***MWRA practicing family planning but not satisfied with the method she is using*** She has an **UNMET NEED for family planning** Refer or accompany her to the midwife or to the health center for counseling **–Proceed to Question #5–**

5. What method are you using?
(✓) Check the appropriate box

Modern Methods	Traditional Methods
☐ P = Pills	✓ W = Withdrawal
☐ IUD = Intrauterine Device	☐ CAL=Calendar Rhythm
☐ Inj = DMPA / Injectable	
☐ C = Condom	
☐ BTL = Bilateral Tubal Ligation	
☐ VAS = Vasectomy	
☐ NFP = Natural Family Planning	
☐ LAM = Lactational Amenorrhea Method	

→ ***MWRA practicing family planning but using traditional methods*** Inform her of the benefits of using modern family planning methods. Refer or accompany her to the midwife or to the health center for counseling

A mother may be classified as using LAM if all 3 of the following are true:
1. She has a baby less than six months old
2. She is amenorrheic (not menstruating) and
3. She is breastfeeding the baby day and night without supplementation

If any of the above no longer applies, refer her to the midwife for counseling.

Actions to be Taken

FORM 1, page 1

FAMILY PROFILE

CBMIS Revised Form as of 02/2001

General Information

Address: 321 Matapang St. Barangay Pinyahan
Respondent: Lita Natividad
Father: Carlito Natividad
Birthday: 10 / 12 / 1973 (mm/dd/yy) Age: 27
Mother: Lita Natividad
Birthday: 06 / 17/ 1974 (mm/dd/yy) Age: 26
Civil Status: ( ) Single (✓) Married ( ) Widow ( ) Separated

BHS/BHC: Pinyahan BHS
RHU: Kalinga
Mun/City: San Nicolas
Province: Sulu

NOTE: Please use pencil in completing the forms to facilitate updating!

BHW: Mrs. Milagrosa Tatlonghari
RHM: Mrs. Nilda San Juan
PHN: Mrs. Tina Dela Cruz
Interviewer: Mrs. Milagrosa Tatlonghari
Date Surveyed: March 09, 2001
Date of last update:

Part I. Data of children 0–4 years old (0–59 months old, start from the eldest)

Name	Birthday MM	Birthday DD	Birthday YY	Age	Where does the child receive vaccinations? B =BHS/BHC R =RHU/MHC P =Private G =Gov't Hosp (See "A" below)	Does the child have any vaccination record? Y = Yes N = No (See "B" below)	Vaccinations Received (For children 0–11 months old, write the date when vaccination was given) (For children 12–59 months old, put a Y if child was given vaccination or an N if not given) If the child 0–11months old has NO vaccination or the vaccination schedule is NOT followed, (See "C" below) If the child 1–4 years old has INCOMPLETE or NO vaccination, (See "D" below)								FIC (For children 9 months to 4 years old) Did the child receive all the preceding vaccinations before his first birthday? Y = Yes N = No	Vitamin A (For children 1–4 years old only) Was the child given vitamin A capsule (200,000 IU) during the past 6 months? (e.g. Garantisadong Pambata Activities) Y = Yes N = No (See "E" below)		Remarks
							BCG	DPT 1st dose	DPT 2nd dose	DPT 3rd dose	OPV 1st dose	OPV 2nd dose	OPV 3rd dose	Measles		April 2001 Year	October 2000 Year	
Macy	10	21	96	4 y	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		N	
Aaron	03	28	00	11 m	P	Y	03/28/00	05/01/00	06/10/00	07/15/00	05/01/00	06/10/00	07/15/00	12/28/00	Y			

Actions to be taken

A. If the child receives vaccination services from private clinics/hospitals and government hospitals, followup the child's vaccinations until completed.
B. Advise the mother to get a copy of the vaccination record from the health facility where the child received the vaccinations or ask the midwife of the nearest BHS to make another record.
C. Refer or accompany the mother and child to the midwife for ***immediate vaccination***.
D. Advise the mother to consult the midwife for completion of the child's vaccinations.
E. Give vitamin A capsule at once if available or advise the mother to bring the child to the nearest health facility for the next scheduled vitamin A supplementation.

Part II A. Tetanus Toxoid Vaccination (TTV) for Pregnant Women

FORM 1, page 2

Is the mother/wife pregnant?	✓ Yes	☐ No
Total number of TTV doses received	5 Doses	

If the woman is pregnant, inform her of the importance of prenatal care and tetanus toxoid vaccinations that are available at the nearest health facility

Part II B. Protection at Birth (PAB) against neonatal tetanus: For women with children 0–2 years old only

Name of youngest child (***0–2 years old only***): ***Aaron*** Age of youngest child: **11 months**

Complete this table only if the age of the youngest living child is 0 to 2 years old (0–35 months old)

TTV Dose	When was each TTV dose received in reference to the youngest child? **Check the appropriate boxes**		Was the child protected at birth (PAB)? **Check the appropriate box**
	During the pregnancy with the youngest child	Prior to the pregnancy with the youngest child	*PAB is defined as any of the following* • 2 TTV doses during the pregnancy with the youngest child, or • 1 TTV dose during the pregnancy with the youngest child plus 2 doses prior to the pregnancy, or • 3 TTV doses prior to the pregnancy with the youngest child
TTV 1			
TTV 2		✓	✓ **Yes** *(Protected at Birth)*
TTV 3		✓	☐ **No** *(NOT protected at birth)*
TTV 4	✓	✓	
TTV 5			

Part III. Family Planning Practice of Married Woman of Reproductive Age (MWRA) (Mother/Wife)

The following should not be interviewed for Part III:

☐ Widowed or separated women ☐ Menopausal women

☐ Women with ovaries and/or uterus and/or fallopian tubes surgically removed due to a medical condition (e.g. tumors, ectopic pregnancy)

1. Are you currently pregnant? *(See response to Part II A)*

☐ No/Unsure

✓ Yes → Remind her again of the need of prenatal care and tetanus toxoid vaccination. **–END OF INTERVIEW–**

Actions to be Taken

2. Do you want to have additional child/children?

☐ No ☐ Yes, after 1 year ☐ Yes, within 1 year → Inform her of the need of prenatal care when she gets pregnant and the available family planning services in the health center in case she changes her mind. **–END OF INTERVIEW–**

3. Are you currently using any family planning method?

☐ Yes

☐ No → ***MWRA not wanting another child or wants to space but not practicing family planning***

She has an **UNMET NEED for family planning**. Inform her about family planning services and refer/accompany her to the midwife or to the health center. **–END OF INTERVIEW–**

4. Are you satisfied with the FP method you are using?

☐ Yes

☐ No → ***MWRA practicing family planning but not satisfied with the method she is using***

She has an **UNMET NEED for family planning**. Refer or accompany her to the midwife or to the health center for counseling. **–Proceed to Question #5–**

5. What method are you using?

(✓) **Check the appropriate box**

Modern Methods	Traditional Methods
☐ **P** = Pills	☐ **W** = Withdrawal
☐ **IUD** = Intrauterine Device	☐ **CAL**=Calendar / Rhythm
☐ **Inj** = DMPA / Injectable	
☐ **C** = Condom	
☐ **BTL** = Bilateral Tubal Ligation	
☐ **VAS** = Vasectomy	
☐ **NFP** = Natural Family Planning	
☐ **LAM** = Lactational Amenorrhea Method	

→ ***MWRA practicing family planning but using traditional methods***

Inform her of the benefits of using modern family planning methods. Refer or accompany her to the midwife or to the health center for counseling

A mother may be classified as using LAM if all 3 of the following are true

1. She has a baby less than six months old
2. She is amenorrheic (not menstruating), and
3. She is breastfeeding the baby day and night without supplementation

If any of the above no longer applies, refer her to the midwife for counseling.

FORM 1, page 1

FAMILY PROFILE

CBMIS Revised Form as of 02/2001

General Information

Address: _____

Respondent: _____

Father: _____

Birthday: _____ (mm/dd/yy) Age: _____

Mother: _____

Birthday: _____ (mm/dd/yy) Age: _____

Civil Status: ( ) Single ( ) Married ( ) Widow ( ) Separated

BHS/BHC: _____

RHU: _____

Mun/City: _____

Province: _____

NOTE: Please use pencil in completing the forms to facilitate updating!

BHW: _____

RHM: _____

PHN: _____

Interviewer: _____

Date Surveyed:

Date of last update: _____

Part I. Data of children 0–4 years old (0–59 months old, start from the eldest)

Name	Birthday (MM / DD / YY)	Age	Where does the child receive vaccinations? B =BHS/BHC R =RHU/MHC P =Private G =Gov't Hosp *(See "A" below)*	Does the child have any vaccination record? Y = Yes N = No *(See "B" below)*	Vaccinations Received (*For children 0–11 months old*, write the date when vaccination was given) (*For children 12–59 months old*, put a Y if child was given vaccination or an N if not given) *If the child 0–11months old has NO vaccination or the vaccination schedule is NOT followed,* **(See "C" below)** *If the child 1–4 years old has INCOMPLETE or NO vaccination,* **(See "D" below)**								FIC *(For children 9 months to 4 years old)* Did the child receive all the preceding vaccinations before his first birthday? Y = Yes N = No	Vitamin A *(For children 1–4 years old only)* Was the child given vitamin A capsule (200,000 IU) during the past 6 months? (e.g. Garantisadong Pambata Activities) Y = Yes N = No *(See "E" below)*		Remarks
					B C G	DPT 1st dose	DPT 2nd dose	DPT 3rd dose	OPV 1st dose	OPV 2nd dose	OPV 3rd dose	Measles		April Year	October Year	

Actions to be taken

A. If the child receives vaccination services from private clinics/hospitals and government hospitals, followup the child's vaccinations until completed.

B. Advise the mother to get a copy of the vaccination record from the health facility where the child received the vaccinations or ask the midwife of the nearest BHS to make another record.

C. Refer or accompany the mother and child to the midwife for ***immediate vaccination***.

D. Advise the mother to consult the midwife for completion of the child's vaccinations.

E. Give vitamin A capsule at once if available or advise the mother to bring the child to the nearest health facility for the next scheduled vitamin A supplementation.

Part II A. Tetanus Toxoid Vaccination (TTV) for Pregnant Women

FORM 1, page 2

Is the mother/wife pregnant? ☐ Yes ☐ No

Total number of TTV doses received ☐ Doses

If the woman is pregnant, inform her of the importance of prenatal care and tetanus toxoid vaccinations that are available at the nearest health facility

Part II B. Protection at Birth (PAB) against neonatal tetanus: For women with children 0–2 years old only

Name of youngest child (***0–2 years old only***): _____ Age of youngest child: _____

Complete this table only if the age of the youngest living child is 0 to 2 years old (0–35 months old)

TTV Dose	When was each TTV dose received in reference to the youngest child? **Check the appropriate boxes**		Was the child protected at birth (PAB)? **Check the appropriate box**
	During the pregnancy with the youngest child	Prior to the pregnancy with the youngest child	***PAB is defined as any of the following:*** • 2 TTV doses during the pregnancy with the youngest child or • 1 TTV dose during the pregnancy with the youngest child plus 2 doses prior to the pregnancy or • 3 TTV doses prior to the pregnancy with the youngest child
TTV 1	☐	☐	☐ **Yes** (Protected at Birth)
TTV 2	☐	☐	
TTV 3	☐	☐	
TTV 4	☐	☐	☐ **No** (NOT protected at birth)
TTV 5	☐	☐	

Part III. Family Planning Practice of Married Woman of Reproductive Age (MWRA) (Mother/Wife)

The following should not be interviewed for Part III:

☐ Widowed or separated women ☐ Menopausal women

☐ Women with ovaries and/or uterus and/or fallopian tubes surgically removed due to a medical condition (e.g. tumors, ectopic pregnancy)

1. Are you currently pregnant? *(See response to Part II A)*

- ☐ No/Unsure → **2. Do you want to have additional child/children?**
- ☐ Yes → **Actions to be Taken**: Remind her again of the need for prenatal care and tetanus toxoid vaccination **–END OF INTERVIEW–**

2. Do you want to have additional child/children?

- ☐ No → **3. Are you currently using any family planning method?**
- ☐ Yes, after 1 year → **3. Are you currently using any family planning method?**
- ☐ Yes, within 1 year → Inform her of the need of prenatal care when she gets pregnant and the available family planning services in the health center in case she changes her mind **–END OF INTERVIEW–**

3. Are you currently using any family planning method?

- ☐ Yes → **4. Are you satisfied with the FP method you are using?**
- ☐ No → ***MWRA not wanting another child or wants to space but not practicing family planning*** She has an **UNMET NEED for family planning** Inform her about family planning services and refer/accompany her to the midwife or to the health center

4. Are you satisfied with the FP method you are using?

- ☐ Yes → **5. What method are you using?**
- ☐ No → ***MWRA practicing family planning but not satisfied with the method she is using*** She has an **UNMET NEED for family planning** Refer or accompany her to the midwife or to the health center for counseling **–Proceed to Question #5–**

5. What method are you using?
(✓) **Check the appropriate box**

Modern Methods		Traditional Methods	
☐ P	= Pills	☐ W	= Withdrawal
☐ IUD	= Intrauterine Device	☐ CAL	= Calendar / Rhythm
☐ Inj	= DMPA / Injectable		
☐ C	= Condom		
☐ BTL	= Bilateral Tubal Ligation		
☐ VAS	= Vasectomy		
☐ NFP	= Natural Family Planning		
☐ LAM	= Lactational Amenorrhea		

→ ***MWRA practicing family planning but using traditional methods*** Inform her of the benefits of using modern family planning methods. Refer or accompany her to the midwife or to the health center for counseling

A mother may be classified as using LAM if all 3 of the following are true:
1. She has a baby less than six months old
2. She is amenorrheic (not menstruating) and
3. She is breastfeeding the baby day and night without supplementation.

If any of the above no longer applies, refer her to the midwife for counseling.

Barangay CBMIS Tally Sheet—Form 2

Barangay: Pinyahan
BHS/BHC: Pinyahan
Mun/City: San Nicolas

RHM: Mrs. Nilda San Juan
Date: March 11, 2001

Form 2, page 1

TARGET GROUPS Purok:	BHW 1	BHW 2	BHW 3	BHW 4	BHW 5	BHW 6	BHW 7	BHW 8	BHW 9	BHW 10	BHW 11	BHW 12	BHW 13	BHW 14	BHW 15	BHW 16	BHW 17	Total
IA. Vaccination status of children 0–11 months old																		
1. Children 9–11 months old with INCOMPLETE or NO vaccination at all		3	2	5	6													
2. Children 0–8 months old with NO vaccination or with recommended vaccination schedule NOT followed		1	2	1	4													
3. Children 0–8 months old with recommended vaccination schedule followed		1	1	1	3													
4. Children 9–11 months old who are Fully Immunized Children (FIC)		2	3	2	2													
TOTAL number of children 0–11 months old (sum of # 1, 2, 3 & 4)		7	8	9	15													
IB. Vaccination status of 1 year old children (12–23 months)																		
5. Children 1 year old (12–23 months) with INCOMPLETE or NO vaccination at all		3	2	2	3													
6. Children 1 year old (12–23 months) who are Fully Immunized Children (FIC)		2	2	3	3													
TOTAL number of 1 year old children (12–23 months) (sum of # 5 & 6)		5	4	5	6													
IC. Vitamin A supplementation status of children 1–4 years old (12–59 months)																		
7. Children 1–4 years old (12–59 months) NOT given Vitamin A capsule during the past six months		3	2	1	3													
8. Children 1–4 years old (12–59 months) GIVEN Vitamin A capsule during the past six months		4	7	1	2													
TOTAL number of children 1–4 years old (12–59 months old) (sum of # 7 & 8)		7	9	2	5													
II A. Tetanus Toxoid Vaccination Status of pregnant mother/wife																		
9. Pregnant with NO TT or with TT1 only		1	2	3	4													
10. Pregnant with TT2 +		0	1	2	2													
TOTAL number of pregnant mother/wife (sum of # (9 & 10)		1	3	5	6													

TARGET GROUPS Purok:	BHW 1	BHW 2	BHW 3	BHW 4	BHW 5	BHW 6	BHW 7	BHW 8	BHW 9	BHW 10	BHW 11	BHW 12	BHW 13	BHW 14	BHW 15	BHW 16	BHW 17	Total
II B. Protection at Birth																		
11. Children Protected at Birth		3	4	4	8													
12. Children Not Protected at Birth		5	4	5	9													
Sum of # 11 & 12		8	8	9	17													
III. Family Planning and Nonpregnant Married Women of Reproductive Age (MWRA)																		
13. MWRA not wanting to have a child or wants to space but NOT practicing family planning		1	2	1	5													
14. MWRA practicing family planning but NOT satisfied with the method she is using		2	1	1	2													
15. MWRA wanting a child within 1 year		1	4	3	2													
16. MWRA practicing family planning and satisfied with the method she is using		5	3	3	4													
TOTAL number of nonpregnant MWRA (sum of # 13, 14, 15 & 16)		9	10	8	13													
FP Methods Used by Current Users																		
P Pills		2	1	2	1													
IUD Intrauterine Device		1	1	0	0													
INJ DMPA / Injectable		0	1	1	0													
C Condom		2	0	1	1													
BTL Bilateral Tubal Ligation		1	0	0	2													
VAS Vasectomy		0	0	0	0													
NFP Natural Family Planning		0	0	0	0													
LAM Lactational Amenorrhea Method		0	0	0	1													
W Withdrawal		0	1	0	1													
C Calendar		1	0	0	0													
TOTAL FP Methods Used by Current Users *(should equal the sum of # 14 & 16)		7	4	4	6													

Catchment Area CBMIS Tally Sheet—Form 3

BHS/BHC: **Pinyahan**
Mun/City: **San Nicolas**

RHM: **Mrs. Nilda San Juan**
Date: **March 11, 2001**

Form 3, page 1

TARGET GROUPS	Barangay Pinyahan		Barangay Ibayo		Barangay		Barangay		Barangay		Total	
	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)
IA. Vaccination status of children 0–11 months old												
1. Children 9–11 months old with INCOMPLETE or NO vaccination at all			9	27%								
2. Children 0–8 months old with NO vaccination or with recommended vaccination schedule NOT followed			10	30%								
3. Children 0–8 months old with recommended vaccination schedule followed			12	36%								
4. Children 9–11 months old who are Fully Immunized Children (FIC)			2	6%								
TOTAL number of children 0–11 months old (sum of # 1, 2, 3 & 4)			33	100%								
IB. Vaccination status of 1 year old children (12–23 months)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)
5. Children 1 year old (12–23 months) with INCOMPLETE or NO vaccination at all			15	43%								
6. Children 1 year old (12–23 months) who are Fully Immunized Children (FIC)			20	57%								
TOTAL number of 1 year old children (12–23 months) (sum of # 5 & 6)			35	100%								
IC. Vitamin A supplementation status of children 1–4 years old (12–59 months)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)
7. Children 1–4 years old (12–59 months) NOT given vitamin A capsule during the past six months			10	37%								
8. Children 1–4 years old (12–59 months) GIVEN vitamin A capsule during the past six months			17	63%								
TOTAL number of children 1–4 years old (12–59 months old) (sum of # 7 & 8)			27	100%								
II A. Tetanus Toxoid Vaccination Status of pregnant mother/wife	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)
9. Pregnant with NO TT or with TT1 only			3	20%								
10. Pregnant with TT2 +			12	80%								
TOTAL number of pregnant mother/wife (sum of # (9 & 10)			15	100%								

TARGET GROUPS	Barangay PINYAHAN		Barangay IBAYO		Barangay		Barangay		Barangay		Total	
II B. Protection at Birth	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)
11. Children Protected at Birth			28	78%								
12. Children Not Protected at Birth			8	22%								
Sum of # 11 & 12			36	100%								
III. Family Planning and Nonpregnant Married Women of Reproductive Age (MWRA)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)
13. MWRA not wanting to have a child or wants to space but NOT practicing family planning			9	36%								
14. MWRA practicing family planning but NOT satisfied with the method she is using			4	16%								
15. MWRA wanting a child within 1 year			0	0%								
16. MWRA practicing family planning and satisfied with the method she is using			12	48%								
TOTAL number of nonpregnant MWRA (sum of # 13, 14, 15 & 16)			25	100%								
FP Methods Used by Current Users												
P Pills			3	19%								
IUD Intrauterine Device			2	13%								
INJ DMPA / Injectable			5	31%								
C Condom			3	19%								
BTL Bilateral Tubal Ligation			1	6%								
VAS Vasectomy			0	0%								
NFP Natural Family Planning			0	0%								
LAM Lactational Amenorrhea Method			1	6%								
W Withdrawal			1	6%								
C Calendar			0	0%								
TOTAL FP Methods Used by Current Users *(should equal the sum of # 14 & 16)			16	100%								

Session 10: Health Facility Assessment

Overview

During this session, the participants learn about the DOH Sentrong Sigla certification program. They visit a facility and carry out an assessment using the Facility Self-Assessment Checklist (FSAC). They summarize the facility's deficiencies, problems, and areas for improvement in a Causal Analysis Summary Table (CAST), and two teams present their findings in plenary.

Objectives

By the end of the session, participants will:

- understand the objectives, strategies, and benefits of participating in the DOH's Sentrong Sigla program
- be able to use the Facility Self-Assessment Checklist (FSAC) to assess a facility's readiness for Level I Sentrong Sigla certification
- have experience using a CAST to summarize a facility's deficiencies, problems, and areas for improvement

Materials

The materials for this session are:

- a list of teams and their assigned vehicles and facilities (for carrying out the facility assessment)
- A Primer on Sentrong Sigla
- Quality Standards List for Rural Health Units and Health Centers Level 1 (see Appendix B)
- Facility Self Assessment Checklist (FSAC) for Rural Health Units and Health Centers Guide for Improving Quality of Health Services Level 1 (see Appendix B)
- Quality Standards List for Barangay Health Stations Level 1 (see Appendix B)
- Facility Self Assessment Checklist (FSAC) for Barangay Health Stations Guide for Improving Quality of Health Services Level 1 (see Appendix B)
- partially completed CAST (Columns A–D) (sample)
- CAST (template)

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Tasks

The tasks for this session are listed below.

1. Read "A Primer on Sentrong Sigla."
2. Read the Level 1 Quality Standards List and FSAC applicable to the facility assigned to your team for the practicum (either a barangay health station or a rural health unit/health center).
3. Carry out a facility assessment using the FSAC. Team members should discuss among themselves how to organize the team to conduct the assessment. Each team will:
   - assess one type of facility, either a barangay health station or a rural health unit/health center
   - complete one FSAC for its assigned facility
   - summarize the results of its FSAC using CAST (Columns A–D)
4. Upon returning to the workshop, the teams will participate in a plenary presentation. One team will present a partially completed CAST from the assessment of a rural health unit/health center. Another team will present a partially completed CAST from its barangay health station assessment.

Products

By the end of this session, the participants will have a:

- completed FSAC for one facility (either a barangay health station or a rural health unit/health center)
- partially completed CAST that identifies the assessed facility's deficiencies, problems, and areas for improvement

A Primer on Sentrong Sigla (Philippine Quality Assurance Program)

What is the Sentrong Sigla?

Sentrong Sigla (literally Centers of Vitality) is a joint effort of the DOH and the LGUs designed to ensure the availability and accessibility of quality health services in health centers and hospitals.

What is the objective of the Sentrong Sigla?

The Sentrong Sigla program is aimed at fostering better and more effective collaboration between the DOH and the LGUs. In this collaboration, the DOH provides technical and financial assistance and the LGUs implement health programs and develop health systems.

What are the benefits of participating in Sentrong Sigla?

For Local Chief Executives

- Increased appreciation by constituents/clients
- Positive recognition of local officials
- Improved health services and facilities, as a result of the national government grants and technical assistance provided

For health workers

- Improved performance as a result of training and capacity-building activities
- Positive recognition by clients and officials
- Increased feelings of self-fulfillment and job satisfaction
- Improved health service delivery

For the public

- Increased access to quality health services
- Increased ability to demand quality health services
- Increased self-reliance

What are the major strategies of Sentrong Sigla?

Sentrong Sigla has two complementary strategies: the Certification and Recognition Program (CRP) and Continuous Quality Improvement (CQI).

The CRP focuses on improving health facility compliance with established quality standards. Under the CRP, a CHD team assesses the facility's compliance with the established standards. Facilities that meet the standards are certified by the DOH as providing quality health services.

CQI is a process that emphasizes building staff capacity to work as a team to identify service delivery challenges, apply CQI tools, and improve service quality. Facilities that achieve the first level of Certification and Recognition Program certification are eligible to receive technical assistance in CQI.

Who can participate in the Certification and Recognition Program?

The CRP is open to all provincial and district hospitals, rural health units or health centers, and barangay health stations that meet the following criteria:

For provincial and district hospitals

- licensed for the last 12 months or with a pending request for renewal of its license in the same category as the previous year. The hospital categories are:
  - provincial or city hospital (tertiary care)
  - district (secondary care)
- no gap in its license to operate for the last five years
- accredited as "mother/baby friendly"

For rural health units or health centers

- a permanent, full-time, licensed physician on staff
- a reliable source of water
- a comfort room or latrine for use by patients and staff
- a stethoscope
- a blood pressure apparatus with cuff
- a thermometer
- a weighing scale for infants and adults

For barangay health stations

- having a main rural health unit or health center that is already Sentrong Sigla-certified
- housed in a permanent structure, with a permanently assigned midwife who provides regular health services
- a reliable source of clean water
- a comfort room/latrine for patients
- a stethoscope
- a blood pressure apparatus with cuff
- a thermometer
- a weighing scale for infants and adults (but not bathroom scale)

What are the benefits of participating in the CRP?

Facilities that are Sentrong Sigla–certified will receive a seal to display in front of the health facility. The seal serves as a symbol of quality and excellent health services.

All Sentrong Sigla-certified facilities have the opportunity to receive technical assistance in CQI, which could help them to achieve the process and outcome standards required for higher levels of quality certification. For example, a facility that reaches Level III certification and maintains the required standards for two semesters will automatically receive a Sentrong Sigla Hall of Fame certificate.

What are the priority areas for quality assessment under the CRP?

- infrastructure/amenities
- services
- attitude and behavior of health workers
- human resources
- equipment
- drugs, medicines, and supplies
- health information system
- community intervention

How does a health facility become certified as Sentrong Sigla?

- The health facility uses the Quality Standards List for its category to assess its readiness for Sentrong Sigla certification. LGUs that are participating in the MGP may use the MGP's Facility Self-Assessment Checklist as their assessment tool. (This tool is included in the appendix.)
- Once the health facility decides that it is ready to be certified, the LGU submits a letter of intent to the CHD expressing its interest in being assessed for Sentrong Sigla certification.
- Upon receipt of the letter of intent, the CHD Sentrong Sigla team first determines whether the facility meets the inclusion criteria. If so, the CHD team schedules an assessment visit in coordination with the LGU. If not, the LGU is advised to hold its request until it meets the inclusion criteria.
- The CHD team conducts the assessment as scheduled, using the Health Facility Assessment Module.
- Immediately after the assessment, the CHD team gives feedback or a briefing to the health facility's personnel and the Local Chief Executive, if possible, on the team's major findings.
- The CHD team deliberates on the final results and, within two weeks, informs the Local Chief Executive, in a letter, of the results of its assessment.
- The CHD presents all certified facilities with Sentrong Sigla seals during a regional event or ceremony.

How does a certified health facility advance to the CQI phase?

A facility enters the CQI phase as soon as it receives Sentrong Sigla certification. During the CQI phase, the facility strives to meet higher-level standards by developing and implementing quality improvement initiatives.

Causal Analysis Summary Table (CAST)—Sample

Name of Facility: San Juan RHU
LGU: San Juan, La Union
Date Assessed by Staff: Sept. 6, 2001

Category (A)	**Deficiency, Problem, or Area of Improvement** Corresponds to "Xs" or circled "Nos" in the FSAC (B)	**Classification** Put a ✓ under the column which classifies the item in Column B		**Causes** (E)
		Related to FIC, TT, FP and/or VAC* (C)	Related to other programs (D)	
Infrastructure	Limited number of chairs/benches for patients in all waiting and service provision areas	✓	✓	
	Treatment/examination room has no visual and auditory privacy	✓	✓	
Health Service: Immunization	Daily temperature-monitoring chart neither posted nor updated	✓		
Health Service: Acute Respiratory Infection in Children	Cotrimoxazole out of stock		✓	
Health Service: Nutrition	No copy of Guidelines for Micronutrient Supplementation	✓		
Human Resources	No sanitary inspector		✓	
	No staff trained in gender sensitivity training	✓	✓	
Equipment	No speculums	✓		

* FIC = fully immunized child, TT = tetanus toxoid, FP = family planning, VAC = vitamin A deficiency

Causal Analysis Summary Table (CAST)

Name of Facility: _____
LGU: _____
Date Assessed by Staff: _____

Category (A)	**Deficiency, Problem, or Area of Improvement** Corresponds to "Xs" or circled "Nos" in the FSAC (B)	**Classification** Put a ✓ under the column which classifies the item in Column B		**Causes** (E)
		Related to FIC, TT, FP and/or VAC* (C)	Related to other programs (D)	

* FIC = fully immunized child, TT = tetanus toxoid, FP = family planning, VAC = vitamin A deficiency

Session 11: Planning for the Community Survey and Facility Assessment

Overview

During this session, the teams select barangays for the initial community survey and facility assessment that they will carry out in their LGUs before returning for the Phase II training workshop. The teams develop an objective and draft a work and financial plan that lists activities to support their objectives. For each activity, they identify the person(s) responsible for implementation, establish a timeframe, and estimate the costs. Each team presents its plan in a plenary session. A panel reviews the plan, offers suggestions, and gives approval. In closing this session, the participants agree on dates for the Phase II training workshop.

Objectives

By the end of this session, the participants will have:

- prioritized the barangays where they will be carrying out an initial CBMIS community survey and facility assessment
- identified and developed a work and financial plan for preparing for and carrying out the survey and assessment
- agreed on the timing of the Phase II training workshop

Materials

The materials for this session are:

- Criteria for Selecting Priority Barangays
- Prioritizing Barangays for the Community Survey and Facility Assessment
- List of Prioritized Barangays (sample)
- List of Prioritized Barangays
- Preparing the MGP Work and Financial Plan for Community Survey and Facility Assessment
- MGP Work and Financial Plan for Community Survey and Facility Assessment

Tasks

The tasks for this session are listed below.

1. Make a list of all the barangays in your municipality/city. Referring to the section on "Criteria for Selecting Priority Barangays," select disadvantaged barangays where you would like to carry out an initial CBMIS community survey and facility assessment. Using the "List of Prioritized Barangays" template, list your selected barangays in order of priority, with the highest priority barangay first.

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2. Identify all the activities involved in planning for and conducting the survey and assessment for prioritized barangays. These activities include:
   - ensuring support from LGU executives as well as the cooperation of the community;
   - including all barangay households in the community survey;
   - putting in place all logistics for the community survey and facility assessment;
   - facilitating the timely completion of the survey and assessment;
   - ensuring that your data are of good quality;
   - managing the data collection and analysis process;
   - preparing and submitting reports.
3. Using the "MGP Work and Financial Plan for Community Survey and Facility Assessment" template, prepare a work and financial plan for your initial community survey and facility assessment.
4. Practice presenting your plan to a facilitator and revise as needed.
5. Present the plan in plenary (30 minutes per team).
6. Based on questions and comments received during the plenary, revise and finalize your work and financial plan.
7. Collectively agree on target dates for the Phase II training workshop.

Products

By the end of this session, the participants will have:

- a list of prioritized barangays for the community survey and facility assessment
- a work and financial plan for an initial community survey and facility assessment for prioritized barangays
- agreed-upon dates for the Phase II training

Criteria for Selecting Priority Barangays

Later you will implement the CBMIS in all of the barangays in your municipality. During this phase of the MGP, however, you will select only a few barangays, usually those that are more disadvantaged than others. Examples of disadvantages include insufficient health staff to provide quality health care and limited accessibility.

Because our goal is to provide equity in health, we must focus our resources on disadvantaged barangays—communities that have the greatest needs. Once we are able to provide for the unmet needs of these barangays, we will find other barangays with unmet needs. We will refocus our resources and reach our new priority barangays.

Criteria you may use to prioritize barangays for the initial community survey and facility assessment include:

- low program coverage of the four MGP-targeted services (childhood immunizations, tetanus toxoid for pregnant women, vitamin A supplementation, and family planning)
- low BHW to household ratio (the ideal ratio is 1:20)
- hard to reach
- economically disadvantaged

Prioritizing Barangays for the Community Survey and Facility Assessment

In prioritizing barangays where you will carry out the initial CBMIS community survey and facility assessment, follow these steps:

1. Determine the amount of grant funds that your municipality will receive from the MGP.

2. Determine the size of population that you are likely to cover, given the amount of your grant. Use the following guidelines to determine the size of population you can cover:
   - PhP500,000.00 covers a population of 80,000
   - PhP250,000.00 covers a population of 30,000
   - PhP125,000.00 covers a population of 15,000

3. Make a list of all the barangays in your catchment area. Include the total population per barangay. Review the handout "Criteria for Selecting Priority Barangays," and determine which barangays you wish to prioritize (due to their low program coverage, low BHW to household ratio, access problems, and/or economically disadvantaged populations).

4. Enter your barangays in the "List of Prioritized Barangays" in descending order of priority (with the highest priority barangay first). Review the amount of grant funds available to you. Underline (or circle) your prioritized barangays until the total population of the selected barangays equals the population you can expect to cover with your grant money.

List of Prioritized Barangays (Sample)

Name of city or municipality: Bagac
Total population: 32110
Total number of barangays: 12
Total number of prioritized barangays: 3

MGP Coordinator: _____
Position: _____
Contact Nos.: _____
Grant amount: PhP125,000

Prioritized Barangay (A)	Population (B)	No. of Families (C)	No. of BHWs (D)	Population to BHW Ratio (C/D)	Rank
Quinawan	7,989				
Paysawan	3,566				
Binuangan	3,245				
Ibis	2,989				
Bayawan	2,657				
Balong	2,432				
Kayawan	1,978				
Poblacion	2,345				
Ibaba	1,655				
Sapa	1,233				
Basay	989				
Pili	1,032				

List of Prioritized Barangays

Name of city or municipality: _____
Total population: _____
Total number of barangays: _____
Total number of prioritized barangays: _____

MGP Coordinator: _____
Position: _____
Contact Nos.: _____
Grant amount:

Prioritized Barangay (A)	Population (B)	No. of Families (C)	No. of BHWs (D)	Population to BHW Ratio (C/D)	Rank

Preparing the MGP Work and Financial Plan for Community Survey and Facility Assessment

In order to complete their MGP Work and Financial Plan, the team members must identify their objective, activities, expected products, person(s) responsible, timeframe, resources, and source of funds.

Objective — a short statement that defines the desired results of the activities to be undertaken in implementing the CBMIS in selected barangays and conducting the facility assessment. The objective could indicate the information that will be generated, the staff that will have been trained, and the date by which these results will be achieved.

Activities — a short, descriptive title of each activity. An example is "train the participating BHWs in filling out Family Profiles."

Expected Products — the result of an activity. When the product is completed, then the activity is also complete. For example, if the team identifies "train the participating BHWs in filling out Family Profiles" as one of its activities, then the expected product would be "BHWs prepared to interview families and correctly fill out Family Profiles in their barangays."

Person Responsible — the person(s) responsible for carrying out and coordinating implementation. In this column, write down their names. Several team members may carry out some activities, but one member must oversee the activity, make sure that it is completed, and ensure that the activities produce the expected product(s).

Timeframe — the activity's start date and completion date. The team must strike a balance between allowing too short a time, which could lead to failure to complete the activity, and too long a time, which could cause the team to lose interest or work inefficiently.

Resources — anything needed to carry out an activity. Examples of resources include people, logistics, supplies, facilities (such as a barangay hall), or a vehicle.

Source of Funds — the estimated cost for this activity as well as the source of funding. For example, if a team estimates it will spend PhP 10,000.00 for reproducing the forms and identifies the LGU as the source of these funds, then the team should write PhP 10,000.00 in the LGU column.

Matching Grant Program
Work and Financial Plan for Community Survey and Facility Assessment

Municipality/City of _____

Objective: _____

Activities	Expected Products	Person/s Responsible	Timeframe		Resources	Source of Funds (give value in pesos if possible)				
			Date Start	Date End		MGP	LGU	CHD	PHO	Others

Phase I: Data Collection and Needs Assessment

Facilitator's Notes

This section provides Facilitator's Notes for the 11 sessions of Phase I. The notes offer advice for planning and leading sessions, and enhancing team participation during the learning process. Facilitators should refer to the session guidelines for a list and examples of the materials needed for each session.

Facilitator's Notes

Session 1: Opening Program

Overview

This session provides the participants with an overview of the workshop's objectives and syllabus, as well as information about the expected working methods, the learning-by-doing approach, the workshop schedule, and the house rules. During this session, the participants begin to forge a team identity. The Regional Director or his/her representative participates in the session and conveys the importance of making plans based on actual data and how this affects the role of the LGUs as implementers of health programs. The participation of the Regional Director demonstrates the support of the CHD for the MGP and its objectives.

Duration

about 45 minutes

Timing

5 minutes	Opening
10 minutes	Introduction
5 minutes	Workshop Objectives
10 minutes	Workshop Schedule
5 minutes	General Instructions
10 minutes	Overview of the MGP and the CBMIS

Planning Notes

Follow up with the Regional Director to make sure that s/he or a representative attends this session as planned. Brief her/him ahead of time so s/he is prepared to clarify the common issues listed under the facilitation notes.

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Facilitation Notes

This session sets the stage for the entire workshop.

1. Have each team sit together. Introduce the participants as a group and identify them clearly as a team. Continue this emphasis on team membership throughout the workshop.

2. The Regional Director or his/her representative should be present during the opening program and express her/his personal interest in this activity. In particular, s/he must convey to the participants the importance of this type of planning process, for which a team approach is the key principle. S/he should also emphasize the importance of making plans based on actual data, and how this approach affects the role of LGUs as health program implementers. S/he should challenge the LGU teams to produce sound MGP proposals in order to receive the grant support they are expecting.

   Encourage the Regional Director to use this opportunity to make some key points:

   - The teams are engaged in this process in order to produce an actual proposal for enhancing service performance in four key intervention areas and make the best use of the matching grant funds being provided.
   - The process will expose the teams to practical tools and methods for collecting and analyzing data as well as for using data to identify current problems and to design practical interventions to overcome these problems.
   - The CHD and Provincial Health Office will support these efforts throughout the training and implementation process. They are partners in this effort and will be committing support to the plans developed during the workshop.
   - During the Phase I and Phase II workshops, staff from the Regional Health Directorate and the Provincial Health Office will participate, but they have been asked not to intervene in (or dominate) team discussions.
   - The primary task of the Phase I training workshop is for each team to prepare itself to collect fresh, valid data down to the household level on current unmet needs related to family planning, child immunization, vitamin A supplementation, and tetanus toxoid immunization. The Regional Director should convey that this research is a golden opportunity to develop new ways to strengthen the collection and use of health data, and that the teams' efforts will benefit the country's overall health information system.

3. Explain the workshop's objectives, broken down into general and specific terms, and share the workshop syllabus.

4. Explain the program's working methods and the learning-by-doing-approach in detail, and discuss the implications for participants and facilitators alike. For example, explain that the learning-by-doing approach requires the strict management of session time limits, and that the teams may need to work in the evening to complete unfinished tasks and products.

5. Present the session tasks and their resulting products. Explain that these products, combined with the experience of preparing them, will provide valuable input to the work and financial plans that the teams will prepare and present to their fellow participants and a CHD panel during the workshop's final session.

6. Discuss the workshop schedule and the house rules. Address any questions or issues raised by the participants. Encourage the use of local dialect and emphasize that all team members must participate fully throughout. Address any administrative concerns.

Facilitator's Notes

Session 2: Community-Based Monitoring and Information System—Family Profile (Form 1)

Overview

This session introduces the CBMIS and provides each team with a structured experience in filling out the Family Profile (Form 1) using sample data. This exercise prepares them for collecting data in the community in Session 3.

Duration

2 hours, 25 minutes (approximately)

Timing

10 minutes	Briefing
60 minutes	Read the instruction sheet and fill out 5 Family Profile forms
15 minutes per team	Plenary presentation

Materials

Family Profiles (answer key for five families)

Planning Notes

Print out one Family Profile (Form 1) template on acetate per team, for sharing data in plenary using an overhead projector.

Facilitation Notes

Avoid answering questions that arise. Instead, encourage the participants to resolve issues themselves by referring to the Instruction Sheet and any relevant DOH policies.

1. Ask the participants to read "How to Fill Out and Use the Family Profile (Form 1)" before proceeding to the "Family Profiling Exercise."
2. The "Family Profiling Exercise" provides sample data for five families. Working as a group, each participant should fill out five Family Profiles using these sample data. Encourage discussion among the group members. Ask the participants to write their names on the space provided for the interviewer in every Family Profile they complete.

PREVIOUS PAGE BLANK

3. Ten minutes before the end of the group work, ask each group to present a completed Form 1 in plenary. Assign them a family and ask them to fill out a form printed on acetate.

4. Allow an average of 15 minutes per group for presentations, including questions and answers. However, be somewhat flexible with time management for the plenary presentations. For example, the participants will probably raise more questions and issues during the first presentation, so let the first group continue for longer than 15 minutes. The participants usually raise fewer issues with succeeding groups, so they will need less time.

5. The person doing each presentation should remain standing to answer questions raised by the other groups.

6. Ask the groups to compare their completed forms with that of the presenter. Promote discussion by encouraging the participants to raise questions and issues. Remind them to refer to the instruction sheet and any relevant DOH policies in seeking answers. As much as possible, avoid answering their questions directly.

7. Remind the participants to write their names on the space provided for the interviewer in every Form 1.

8. Before ending this session, ask the participants to make any needed corrections in their forms. This will reinforce their learning and help them to complete the forms accurately in Session 3, when they will be deployed in the community to interview families with target clients. The teams may need to correct their forms outside of class time.

FAMILY PROFILE

CBMIS Revised Forms as of 02/2001

FORM 1, page 1

General Information

Address: 109 Kalayaan St. Barangay Pinyahan
Respondent: Regina Alvarez
Father: Cesar Alvarez
Birthday: 04 / 03 / 1960 (mm/dd/yy) Age: 40
Mother: Regina Alvarez
Birthday: 01 / 09/ 1962 (mm/dd/yy) Age: 39
Civil Status: ( ) Single (✓) Married ( ) Widow ( ) Separated

BHS/BHC: Pinyahan HC
RHU: Kalinga
Mun/City: San Nicolas
Province: Sulu

NOTE: Please use pencil in completing the forms to facilitate updating!

BHW: Mrs. Milagrosa Tatlonghari
RHM: Mrs. Nilda San Juan
PHN: Mrs. Tina Dela Cruz
Interviewer: Mrs. Milagrosa Tatlonghari
Date Surveyed: March 09, 2001
Date of last update:

Part I. Data of children 0–4 years old (0–59 months old, start from the eldest)

Name	Birthday MM	Birthday DD	Birthday YY	Age	Where does the child receive vaccinations? B =BHS/BHC R =RHU/MHC P =Private G =Gov't Hosp (See "A" below)	Does the child have any vaccination record? Y = Yes N = No (See "B" below)	Vaccinations Received (For children 0-11 months old, write the date when vaccination was given) (For children 12–59 months old, put a Y if child was given vaccination or an N if not given) If the child 0–11months old has NO vaccination or the vaccination schedule is NOT followed, (See "C" below) If the child 1–4 years old has INCOMPLETE or NO vaccination, (See "D" below)	DPT 1st dose	DPT 2nd dose	DPT 3rd dose	OPV 1st dose	OPV 2nd dose	OPV 3rd dose	Measles	FIC (For children 9 months to 4 years old) Did the child receive all the preceding vaccinations before his first birthday? Y = Yes N = No	Vitamin A (For children 1–4 years old only) Was the child given vitamin A capsule (200,000 IU) during the past 6 months? (e.g. Garantisadong Pambata Activities) Y = Yes N = No (See "E" below) April 2001	October 2000	Remarks
Cathrina	09	13	96	4 y	P	N	Y	Y	Y	Y	Y	Y	Y	N	N		N	
Nico	08	12	97	3 y	P	Y	Y	Y	Y	Y	Y	Y	Y	N	N		N	
Jacob	07	15	98	2 y	B	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	
Jeremy	06	01	99	1 y	B	Y	Y	Y	Y	Y	Y	Y	Y	N	N		N	
Abby	07	05	00	8 m	B	Y	07/05/00	09/01/00	10/05/00		09/01/00	10/05/00						

Actions to be taken

A. If the child receives vaccination services from private clinics/hospitals and government hospitals, followup the child's vaccinations until completed.
B. Advise the mother to get a copy of the vaccination record from the health facility where the child received the vaccinations or ask the midwife of the nearest BHS to make another record.
C. Refer or accompany the mother and child to the midwife for ***immediate vaccination***.
D. Advise the mother to consult the midwife for completion of the child's vaccinations
E. Give vitamin A capsule at once if available or advise the mother to bring the child to the nearest health facility for the next scheduled vitamin A supplementation.

Part II A. Tetanus Toxoid Vaccination (TTV) for Pregnant Women

Is the mother/wife pregnant? ☐ Yes ☑ No

If the woman is pregnant, inform her of the importance of prenatal care and tetanus toxoid vaccinations that are available at the nearest health facility.

Total number of TTV doses received [2] Doses

Part II B. Protection at Birth (PAB) against neonatal tetanus: For women with children 0–2 years old only

Name of youngest child (***0–2 years old only***): Abby

Age of youngest child: 8 months

Complete this table only if the age of the youngest living child is 0 to 2 years old (0–35 months old)

TTV Dose	When was each TTV dose received in reference to the youngest child? **Check the appropriate boxes**		Was the child protected at birth (PAB)? **Check the appropriate box**
	During the pregnancy with the youngest child	Prior to the pregnancy with the youngest child	*PAB is defined as any of the following:* • 2 TTV doses during the pregnancy with the youngest child, or • 1 TTV dose during the pregnancy with the youngest child plus 2 doses prior to the pregnancy, or • 3 TTV doses prior to the pregnancy with the youngest child
TTV 1	☐	☑	☐ **Yes** *(Protected at Birth)*
TTV 2	☑	☐	☑ **No** *(NOT protected at birth)*
TTV 3	☐	☐	
TTV 4	☐	☐	
TTV 5	☐	☐	

Part III. Family Planning Practice of Married Woman of Reproductive Age (MWRA) (Mother/Wife)

The following should not be interviewed for Part III:

☐ Widowed or separated women ☐ Menopausal women

☐ Women with ovaries and/or uterus and/or fallopian tubes surgically removed due to a medical condition (e.g. tumors, ectopic pregnancy)

Actions to be Taken

1. Are you currently pregnant? *(See response to Part II A)*

- ☐ Yes → Remind her again of the need of prenatal care and tetanus toxoid vaccination. **–END OF INTERVIEW–**
- ☑ No/Unsure ↓

2. Do you want to have additional child/children?

- ☐ Yes, within 1 year → Inform her of the need of prenatal care when she gets pregnant and the available family planning services in the health center in case she changes her mind. **–END OF INTERVIEW–**
- ☐ Yes, after 1 year ↓
- ☑ No ↓

3. Are you currently using any family planning method?

- ☑ No → ***MWRA not wanting another child or wants to space but not practicing family planning*** She has an **UNMET NEED for family planning**. Inform her about family planning services and refer/accompany her to the midwife or to the health center. **–END OF INTERVIEW–**
- ☐ Yes ↓

4. Are you satisfied with the FP method you are using?

- ☐ No → ***MWRA practicing family planning but not satisfied with the method she is using*** She has an **UNMET NEED for family planning**. Refer or accompany her to the midwife or to the health center for counseling. **–Proceed to Question #5–**
- ☐ Yes ↓

5. What method are you using?
(✓) Check the appropriate box

Modern Methods	Traditional Methods
☐ **P** = Pills	☐ **W** = Withdrawal
☐ **IUD** = Intrauterine Device	☐ **CAL**=Calendar / Rhythm
☐ **Inj** = DMPA / Injectable	
☐ **C** = Condom	
☐ **BTL** = Bilateral Tubal Ligation	
☐ **VAS** = Vasectomy	
☐ **NFP** = Natural Family Planning	
☐ **LAM** = Lactational Amenorrhea Method	

→ ***MWRA practicing family planning but using traditional methods*** Inform her of the benefits of using modern family planning methods. Refer or accompany her to the midwife or to the health center for counseling.

→ A mother may be classified as using LAM if all 3 of the following are true:
1. She has a baby less than six months old,
2. She is amenorrheic (not menstruating), and
3. She is breastfeeding the baby day and night without supplementation.

If any of the above no longer applies, refer her to the midwife for counseling.

FAMILY PROFILE

CHMIS Revised Form as of 02/2001

FORM 1, page 1

General Information

Address: 121 Kalayaan St. Barangay Pinyahan
Respondent: Helen Carbonel
Father: Arturo Carbonel
Birthday: 12 / 23 / 1970 (mm/dd/yy) Age: 30
Mother: Helen Carbonel
Birthday: 05 / 12/ 1972 (mm/dd/yy) Age: 28
Civil Status: ( ) Single (✓) Married ( ) Widow ( ) Separated

BHS/BHC: Pinyahan HC
RHU: Kalinga
Mun/City: San Nicolas
Province: Sulu

NOTE: Please use pencil in completing the forms to facilitate updating!

BHW: Mrs. Milagrosa Tatlonghari
RHM: Mrs. Nilda San Juan
PHN: Mrs. Tina Dela Cruz
Interviewer: Mrs. Milagrosa Tatlonghari
Date Surveyed: March 09, 2001
Date of last update:

Part I. Data of children 0–4 years old (0–59 months old, start from the eldest)

Name	Birthday MM	Birthday DD	Birthday YY	Age	Where does the child receive vaccinations? B = BHS/BHC R = RHU/MHC P = Private G = Gov't Hosp (See "A" below)	Does the child have any vaccination record? Y = Yes N = No (See "B" below)	Vaccinations Received (For children 0–11 months old, write the date when vaccination was given) (For children 12–59 months old, put a Y if child was given vaccination or an N if not given) If the child 0–11months old has NO vaccination or the vaccination schedule is NOT followed, (See "C" below) If the child 1–4 years old has INCOMPLETE or NO vaccination, (See "D" below)								FIC (For children 9 months to 4 years old) Did the child receive all the preceding vaccinations before his first birthday? Y = Yes N = No	Vitamin A (For children 1–4 years old only) Was the child given vitamin A capsule (200,000 IU) during the past 6 months? (e.g. Garantisadong Pambata Activities) Y = Yes N = No (See "E" below)		Remarks
							B C G	DPT 1st dose	DPT 2nd dose	DPT 3rd dose	OPV 1st dose	OPV 2nd dose	OPV 3rd dose	Measles		April 2001 Year	October 2000 Year	
Julie Anne	11	15	96	4 y	G	Y	Y	Y	Y	N	Y	Y	N	N	N		Y	
Jasmine	10	29	97	3 y	P	Y	Y	Y	Y	Y	Y	Y	Y	N	N		Y	
MJ	04	25	00	10 m	B	Y	04/25/00	06/10/00	07/15/00		06/10/00	07/15/00						

Actions to be taken

A. If the child receives vaccination services from private clinics/hospitals and government hospitals, followup the child's vaccinations until completed
B. Advise the mother to get a copy of the vaccination record from the health facility where the child received the vaccinations or ask the midwife of the nearest BHS to make another record.
C. Refer or accompany the mother and child to the midwife for ***immediate vaccination***.
D. Advise the mother to consult the midwife for completion of the child's vaccinations
E. Give vitamin A capsule at once if available or advise the mother to bring the child to the nearest health facility for the next scheduled vitamin A supplementation

Part II A. Tetanus Toxoid Vaccination (TTV) for Pregnant Women

Is the mother/wife pregnant? ☑ Yes ☐ No

Total number of TTV doses received [0] Doses

If the woman is pregnant, inform her of the importance of prenatal care and tetanus toxoid vaccinations that are available at the nearest health facility.

Part II B. Protection at Birth (PAB) against neonatal tetanus: For women with children 0–2 years old only

Name of youngest child (*0–2 years old only*): MJ

Age of youngest child: 10 months

Complete this table only if the age of the youngest living child is 0 to 2 years old (0–35 months old)

TTV Dose	When was each TTV dose received in reference to the youngest child? **Check the appropriate boxes**		Was the child protected at birth (PAB)? **Check the appropriate box**
	During the pregnancy with the youngest child	Prior to the pregnancy with the youngest child	*PAB is defined as any of the following:* • 2 TTV doses during the pregnancy with the youngest child, or • 1 TTV dose during the pregnancy with the youngest child plus 2 doses prior to the pregnancy, or • 3 TTV doses prior to the pregnancy with the youngest child
TTV 1	☐	☐	☐ **Yes** *(Protected at Birth)*
TTV 2	☐	☐	☑ **No** *(NOT protected at birth)*
TTV 3	☐	☐	
TTV 4	☐	☐	
TTV 5	☐	☐	

Part III. Family Planning Practice of Married Woman of Reproductive Age (MWRA) (Mother/Wife)

The following should not be interviewed for Part III:

☐ Widowed or separated women ☐ Menopausal women

☐ Women with ovaries and/or uterus and/or fallopian tubes surgically removed due to a medical condition (e.g. tumors, ectopic pregnancy)

Actions to be Taken

1. Are you currently pregnant? *(See response to Part II A)*

- ☑ Yes → Remind her again of the need of prenatal care and tetanus toxoid vaccination. **–END OF INTERVIEW–**
- ☐ No/Unsure ↓

2. Do you want to have additional child/children?

- ☐ Yes, within 1 year → Inform her of the need of prenatal care when she gets pregnant and the available family planning services in the health center in case she changes her mind. **–END OF INTERVIEW–**
- ☐ No ↓
- ☐ Yes, after 1 year ↓

3. Are you currently using any family planning method?

- ☐ No → ***MWRA not wanting another child or wants to space but not practicing family planning*** She has an **UNMET NEED for family planning**. Inform her about family planning services and refer/accompany her to the midwife or to the health center. **–END OF INTERVIEW–**
- ☐ Yes ↓

4. Are you satisfied with the FP method you are using?

- ☐ No → ***MWRA practicing family planning but not satisfied with the method she is using*** She has an **UNMET NEED for family planning**. Refer or accompany her to the midwife or to the health center for counseling. **–Proceed to Question #5–**
- ☐ Yes ↓

5. What method are you using?
(✓) Check the appropriate box

Modern Methods	Traditional Methods
☐ **P** = Pills	☐ **W** = Withdrawal
☐ **IUD** = Intrauterine Device	☐ **CAL**=Calendar / Rhythm
☐ **Inj** = DMPA / Injectable	
☐ **C** = Condom	
☐ **BTL** = Bilateral Tubal Ligation	
☐ **VAS** = Vasectomy	
☐ **NFP** = Natural Family Planning	
☐ **LAM** = Lactational Amenorrhea Method	

→ ***MWRA practicing family planning but using traditional methods*** Inform her of the benefits of using modern family planning methods. Refer or accompany her to the midwife or to the health center for counseling.

→ A mother may be classified as using LAM if all 3 of the following are true:
1. She has a baby less than six months old,
2. She is amenorrheic (not menstruating), and
3. She is breastfeeding the baby day and night without supplementation.

If any of the above no longer applies, refer her to the midwife for counseling.

FAMILY PROFILE

CBMIS Revised Form as of 02/2001

FORM 1, page 1

General Information

Address: 222 Matapang St. Barangay Pinyahan
Respondent: Rosario Cinco
Father: Martin Cinco
Birthday: 03 / 25 / 1975 (mm/dd/yy) Age: 25
Mother: Rosario Cinco
Birthday: 08 / 22/ 1977 (mm/dd/yy) Age: 23
Civil Status: ( ) Single (✓) Married ( ) Widow ( ) Separated

BHS/BHC: Pinyahan BHS
RHU: Kalinga
Mun/City: San Nicolas
Province: Sulu

NOTE: Please use pencil in completing the forms to facilitate updating!

BHW: Mrs. Milagrosa Tatlonghari
RHM: Mrs. Nilda San Juan
PHN: Mrs. Tina Dela Cruz
Interviewer: Mrs. Milagrosa Tatlonghari
Date Surveyed: March 09, 2001
Date of last update:

Part I. Data of children 0–4 years old (0–59 months old, start from the eldest)

Name	Birthday (MM / DD / YY)	Age	Where does the child receive vaccinations? B = BHS/BHC, R = RHU/MHC, P = Private, G = Gov't Hosp (See "A" below)	Does the child have any vaccination record? Y = Yes, N = No (See "B" below)	Vaccinations Received (For children 0–11 months old, write the date when vaccination was given) (For children 12–59 months old, put a Y if child was given vaccination or an N if not given) If the child 0–11months old has NO vaccination or the vaccination schedule is NOT followed, (See "C" below) If the child 1–4 years old has INCOMPLETE or NO vaccination, (See "D" below)								FIC (For children 9 months to 4 years old) Did the child receive all the preceding vaccinations before his first birthday? Y = Yes N = No	Vitamin A (For children 1–4 years old only) Was the child given vitamin A capsule (200,000 IU) during the past 6 months? (e.g. Garantisadong Pambata Activities) Y = Yes N = No (See "E" below)		Remarks
					BCG	DPT 1st dose	DPT 2nd dose	DPT 3rd dose	OPV 1st dose	OPV 2nd dose	OPV 3rd dose	Measles		April Year	October Year	
Redentor	10 02 00	5 m	P	Y	10/15/00	12/10/00	01/12/01	02/16/01	12/10/00	01/12/01	02/16/01					

Actions to be taken

A. If the child receives vaccination services from private clinics/hospitals and government hospitals, followup the child's vaccinations until completed.
B. Advise the mother to get a copy of the vaccination record from the health facility where the child received the vaccinations or ask the midwife of the nearest BHS to make another record
C. Refer or accompany the mother and child to the midwife for ***Immediate vaccination***.
D. Advise the mother to consult the midwife for completion of the child's vaccinations.
E. Give vitamin A capsule at once if available or advise the mother to bring the child to the nearest health facility for the next scheduled vitamin A supplementation.

Part II A. Tetanus Toxoid Vaccination (TTV) for Pregnant Women

Is the mother/wife pregnant?	☐ Yes	☑ No	If the woman is pregnant, inform her of the importance of prenatal care and tetanus toxoid vaccinations that are available at the nearest health facility.
Total number of TTV doses received	3 Doses		

Part II B. Protection at Birth (PAB) against neonatal tetanus: For women with children 0–2 years old only

Name of youngest child (***0–2 years old only***): Redentor Age of youngest child: 5 months

Complete this table only if the age of the youngest living child is 0 to 2 years old (0–35 months old)

TTV Dose	When was each TTV dose received in reference to the youngest child? **Check the appropriate boxes**		Was the child protected at birth (PAB)? **Check the appropriate box** *PAB is defined as any of the following:* • 2 TTV doses during the pregnancy with the youngest child, or • 1 TTV dose during the pregnancy with the youngest child plus 2 doses prior to the pregnancy, or • 3 TTV doses prior to the pregnancy with the youngest child
	During the pregnancy with the youngest child	Prior to the pregnancy with the youngest child	
TTV 1		✓	☑ **Yes** *(Protected at Birth)*
TTV 2		✓	☐ **No** *(NOT protected at birth)*
TTV 3	✓		
TTV 4			
TTV 5			

Part III. Family Planning Practice of Married Woman of Reproductive Age (MWRA) (Mother/Wife)

The following should not be interviewed for Part III:

☐ Widowed or separated women ☐ Menopausal women
☐ Women with ovaries and/or uterus and/or fallopian tubes surgically removed due to a medical condition (e.g. tumors, ectopic pregnancy)

1. Are you currently pregnant? *(See response to Part II A)*

- ☑ No/Unsure → **2. Do you want to have additional child/children?**
- ☐ Yes → **Actions to be Taken**: Remind her again of the need of prenatal care and tetanus toxoid vaccination. **–END OF INTERVIEW–**

2. Do you want to have additional child/children?

- ☐ No → **3. Are you currently using any family planning method?**
- ☑ Yes, after 1 year → **3. Are you currently using any family planning method?**
- ☐ Yes, within 1 year → **Actions to be Taken**: Inform her of the need of prenatal care when she gets pregnant and the available family planning services in the health center in case she changes her mind. **–END OF INTERVIEW–**

3. Are you currently using any family planning method?

- ☑ Yes → **4. Are you satisfied with the FP method you are using?**
- ☐ No → ***MWRA not wanting another child or wants to space but not practicing family planning***: She has an **UNMET NEED for family planning**. Inform her about family planning services and refer/accompany her to the midwife or to the health center. **–END OF INTERVIEW–**

4. Are you satisfied with the FP method you are using?

- ☑ Yes → **5. What method are you using?**
- ☐ No → ***MWRA practicing family planning but not satisfied with the method she is using***: She has an **UNMET NEED for family planning**. Refer or accompany her to the midwife or to the health center for counseling. **–Proceed to Question #5–**

5. What method are you using? (✓) **Check the appropriate box**

Modern Methods	Traditional Methods
☑ **P** = Pills	☐ **W** = Withdrawal
☐ **IUD** = Intrauterine Device	☐ **CAL**=Calendar / Rhythm
☐ **Inj** = DMPA / Injectable	
☐ **C** = Condom	
☐ **BTL** = Bilateral Tubal Ligation	
☐ **VAS** = Vasectomy	
☐ **NFP** = Natural Family Planning	
☐ **LAM** = Lactational Amenorrhea Method	

→ ***MWRA practicing family planning but using traditional methods***: Inform her of the benefits of using modern family planning methods. Refer or accompany her to the midwife or to the health center for counseling.

→ **A mother may be classified as using LAM if all 3 of the following are true:**
1. She has a baby less than six months old,
2. She is amenorrheic (not menstruating), and
3. She is breastfeeding the baby day and night without supplementation.

If any of the above no longer applies, refer her to the midwife for counseling.

FAMILY PROFILE

CBMIS Revised Form as of 02/2001

FORM 1, page 1

General Information

Address: 234 Kalayaan St, Barangay Pinyahan
Respondent: Alicia Esteban
Father: Romeo Esteban
Birthday: 01 / 13 / 1965 (mm/dd/yy) Age: 36
Mother: Alicia Esteban
Birthday: 06 / 12/ 1965 (mm/dd/yy) Age: 35
Civil Status: ( ) Single (✓) Married ( ) Widow ( ) Separated

BHS/BHC: Pinyahan HC
RHU: Kalinga
Mun/City: San Nicolas
Province: Sulu

NOTE: Please use pencil in completing the forms to facilitate updating!

BHW: Mrs. Milagrosa Tatlonghari
RHM: Mrs. Nilda San Juan
PHN: Mrs. Tina Dela Cruz
Interviewer: Mrs. Milagrosa Tatlonghari
Date Surveyed: March 09, 2001
Date of last update:

Part I. Data of children 0–4 years old (0–59 months old, start from the eldest)

Name	Birthday MM	Birthday DD	Birthday YY	Age	Where does the child receive vaccinations? B =BHS/BHC R =RHU/MHC P =Private G =Gov't Hosp (See "A" below)	Does the child have any vaccination record? Y = Yes N = No (See "B" below)	Vaccinations Received (For children 0–11 months old, write the date when vaccination was given) (For children 12–59 months old, put a Y if child was given vaccination or an N if not given) If the child 0–11months old has NO vaccination or the vaccination schedule is NOT followed, (See "C" below) If the child 1–4 years old has INCOMPLETE or NO vaccination, (See "D" below)								FIC (For children 9 months to 4 years old) Did the child receive all the preceding vaccinations before his first birthday? Y = Yes N = No	Vitamin A (For children 1–4 years old only) Was the child given vitamin A capsule (200,000 IU) during the past 6 months? (e.g. Garantisadong Pambata Activities) Y = Yes N = No (See "E" below)		Remarks
							BCG	DPT 1st dose	DPT 2nd dose	DPT 3rd dose	OPV 1st dose	OPV 2nd dose	OPV 3rd dose	Measles		April 2001 Y/N	October 2000 Y/N	
Oliver	08	30	99	1 y	B	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		N	
Czarina	09	05	00	6 m	B	Y	09/20/00	11/10/00	12/12/00	01/20/01	11/10/00	12/12/00	01/20/01					

Actions to be taken

A. If the child receives vaccination services from private clinics/hospitals and government hospitals, followup the child's vaccinations until completed.
B. Advise the mother to get a copy of the vaccination record from the health facility where the child received the vaccinations or ask the midwife of the nearest BHS to make another record.
C. Refer or accompany the mother and child to the midwife for ***immediate vaccination***.
D. Advise the mother to consult the midwife for completion of the child's vaccinations.
E. Give vitamin A capsule at once if available or advise the mother to bring the child to the nearest health facility for the next scheduled vitamin A supplementation.

Part II A. Tetanus Toxoid Vaccination (TTV) for Pregnant Women FORM 1, page 2

Is the mother/wife pregnant?	☐ Yes	✓ No	If the woman is pregnant, inform her of the importance of prenatal care and tetanus toxoid vaccinations that are available at the nearest health facility.
Total number of TTV doses received	1 Doses		

Part II B. Protection at Birth (PAB) against neonatal tetanus: For women with children 0–2 years old only

Name of youngest child (***0–2 years old only***): *Czarina* Age of youngest child: **6 months**

Complete this table only if the age of the youngest living child is 0 to 2 years old (0–35 months old)

TTV Dose	When was each TTV dose received in reference to the youngest child? **Check the appropriate boxes**		Was the child protected at birth (PAB)? **Check the appropriate box** *PAB is defined as any of the following:* • 2 TTV doses during the pregnancy with the youngest child, or • 1 TTV dose during the pregnancy with the youngest child plus 2 doses prior to the pregnancy, or • 3 TTV doses prior to the pregnancy with the youngest child
	During the pregnancy with the youngest child	Prior to the pregnancy with the youngest child	
TTV 1	☐	✓	☐ **Yes** *(Protected at Birth)*
TTV 2	☐	☐	✓ **No** *(NOT protected at birth)*
TTV 3	☐	☐	
TTV 4	☐	☐	
TTV 5	☐	☐	

Part III. Family Planning Practice of Married Woman of Reproductive Age (MWRA) (Mother/Wife)

The following should not be interviewed for Part III:

☐ Widowed or separated women ☐ Menopausal women

☐ Women with ovaries and/or uterus and/or fallopian tubes surgically removed due to a medical condition (e.g. tumors, ectopic pregnancy)

1. Are you currently pregnant? *(See response to Part II A)*

- ✓ No/Unsure → **2. Do you want to have additional child/children?**
- ☐ Yes → Remind her again of the need of prenatal care and tetanus toxoid vaccination. **–END OF INTERVIEW–**

2. Do you want to have additional child/children?

- ☐ No → **3. Are you currently using any family planning method?**
- ✓ Yes, after 1 year → **3. Are you currently using any family planning method?**
- ☐ Yes, within 1 year → Inform her of the need of prenatal care when she gets pregnant and the available family planning services in the health center in case she changes her mind. **–END OF INTERVIEW–**

3. Are you currently using any family planning method?

- ✓ Yes → **4. Are you satisfied with the FP method you are using?**
- ☐ No → ***MWRA not wanting another child or wants to space but not practicing family planning*** She has an **UNMET NEED for family planning**. Inform her about family planning services and refer/accompany her to the midwife or to the health center. **–END OF INTERVIEW–**

4. Are you satisfied with the FP method you are using?

- ☐ Yes → **5. What method are you using?**
- ✓ No → ***MWRA practicing family planning but not satisfied with the method she is using*** She has an **UNMET NEED for family planning**. Refer or accompany her to the midwife or to the health center for counseling. **–Proceed to Question #5–**

5. What method are you using? (✓) **Check the appropriate box**

Modern Methods	Traditional Methods
☐ **P** = Pills	✓ **W** = Withdrawal
☐ **IUD** = Intrauterine Device	☐ **CAL**=Calendar / Rhythm
☐ **Inj** = DMPA / Injectable	
☐ **C** = Condom	
☐ **BTL** = Bilateral Tubal Ligation	
☐ **VAS** = Vasectomy	
☐ **NFP** = Natural Family Planning	
☐ **LAM** = Lactational Amenorrhea Method	

→ ***MWRA practicing family planning but using traditional methods*** Inform her of the benefits of using modern family planning methods. Refer or accompany her to the midwife or to the health center for counseling.

A mother may be classified as using LAM if all 3 of the following are true:
1. She has a baby less than six months old,
2. She is amenorrheic (not menstruating), and
3. She is breastfeeding the baby day and night without supplementation.

If any of the above no longer applies, refer her to the midwife for counseling.

Actions to be Taken

FAMILY PROFILE

CHMIS Revised Form as of 02/2001

FORM 1, page 1

General Information

Address: 321 Matapang St. Barangay Pinyahan

Respondent: Lita Natividad

Father: Carlito Natividad

Birthday: 10 / 12 / 1973 (mm/dd/yy) Age: 27

Mother: Lita Natividad

Birthday: 06 / 17/ 1974 (mm/dd/yy) Age: 26

Civil Status: ( ) Single (✓) Married ( ) Widow ( ) Separated

BHS/BHC: Pinyahan BHS

RHU: Kalinga

Mun/City: San Nicolas

Province: Sulu

NOTE: Please use pencil in completing the forms to facilitate updating!

BHW: Mrs. Milagrosa Tatlonghari

RHM: Mrs. Nilda San Juan

PHN: Mrs. Tina Dela Cruz

Interviewer: Mrs. Milagrosa Tatlonghari

Date Surveyed: March 09, 2001

Date of last update: _____

Part I. Data of children 0–4 years old (0–59 months old, start from the eldest)

Name	Birthday MM	Birthday DD	Birthday YY	Age	Where does the child receive vaccinations? B = BHS/BHC R = RHU/MHC P = Private G = Gov't Hosp (See "A" below)	Does the child have any vaccination record? Y = Yes N = No (See "B" below)	Vaccinations Received (For children 0–11 months old, write the date when vaccination was given) (For children 12–59 months old, put a Y if child was given vaccination or an N if not given) If the child 0–11 months old has NO vaccination or the vaccination schedule is NOT followed, (See "C" below) If the child 1–4 years old has INCOMPLETE or NO vaccination, (See "D" below)								FIC (For children 9 months to 4 years old) Did the child receive all the preceding vaccinations before his first birthday? Y = Yes N = No	Vitamin A (For children 1–4 years old only) Was the child given vitamin A capsule (200,000 IU) during the past 6 months? (e.g. Garantisadong Pambata Activities) Y = Yes N = No (See "E" below)		Remarks
							BCG	DPT 1st dose	DPT 2nd dose	DPT 3rd dose	OPV 1st dose	OPV 2nd dose	OPV 3rd dose	Measles		April 2001 Year	October 2000 Year	
Macy	10	21	96	4 y	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		N	
Aaron	03	28	00	11 m	P	Y	03/28/00	05/01/00	06/10/00	07/15/00	05/01/00	06/10/00	07/15/00	12/28/00	Y			

Actions to be taken

A. If the child receives vaccination services from private clinics/hospitals and government hospitals, followup the child's vaccinations until completed

B. Advise the mother to get a copy of the vaccination record from the health facility where the child received the vaccinations or ask the midwife of the nearest BHS to make another record.

C. Refer or accompany the mother and child to the midwife for ***immediate vaccination***.

D. Advise the mother to consult the midwife for completion of the child's vaccinations

E. Give vitamin A capsule at once if available or advise the mother to bring the child to the nearest health facility for the next scheduled vitamin A supplementation

Part II A. Tetanus Toxoid Vaccination (TTV) for Pregnant Women FORM 1, page 2

Is the mother/wife pregnant?	✓ Yes	☐ No
Total number of TTV doses received	5 Doses	

If the woman is pregnant, inform her of the importance of prenatal care and tetanus toxoid vaccinations that are available at the nearest health facility.

Part II B. Protection at Birth (PAB) against neonatal tetanus: For women with children 0–2 years old only

Name of youngest child (***0–2 years old only***): **Aaron** Age of youngest child: **11 months**

Complete this table only if the age of the youngest living child is 0 to 2 years old (0–35 months old)

TTV Dose	When was each TTV dose received in reference to the youngest child? **Check the appropriate boxes**		Was the child protected at birth (PAB)? **Check the appropriate box** *PAB is defined as any of the following:* • 2 TTV doses during the pregnancy with the youngest child, or • 1 TTV dose during the pregnancy with the youngest child plus 2 doses prior to the pregnancy, or • 3 TTV doses prior to the pregnancy with the youngest child
	During the pregnancy with the youngest child	Prior to the pregnancy with the youngest child	
TTV 1	☐	✓	✓ **Yes** *(Protected at Birth)*
TTV 2	☐	✓	☐ **No** *(NOT protected at birth)*
TTV 3	☐	✓	
TTV 4	✓	☐	
TTV 5	☐	☐	

Part III. Family Planning Practice of Married Woman of Reproductive Age (MWRA) (Mother/Wife)

The following should not be interviewed for Part III:

☐ Widowed or separated women ☐ Menopausal women

☐ Women with ovaries and/or uterus and/or fallopian tubes surgically removed due to a medical condition (e.g. tumors, ectopic pregnancy)

1. Are you currently pregnant? *(See response to Part II A)*

- ☐ No/Unsure → **2. Do you want to have additional child/children?**
- ✓ Yes → **Actions to be Taken**: Remind her again of the need of prenatal care and tetanus toxoid vaccination. **–END OF INTERVIEW–**

2. Do you want to have additional child/children?

- ☐ No → **3. Are you currently using any family planning method?**
- ☐ Yes, after 1 year → **3. Are you currently using any family planning method?**
- ☐ Yes, within 1 year → Inform her of the need of prenatal care when she gets pregnant and the available family planning services in the health center in case she changes her mind. **–END OF INTERVIEW–**

3. Are you currently using any family planning method?

- ☐ Yes → **4. Are you satisfied with the FP method you are using?**
- ☐ No → ***MWRA not wanting another child or wants to space but not practicing family planning***: She has an **UNMET NEED for family planning**. Inform her about family planning services and refer/accompany her to the midwife or to the health center. **–END OF INTERVIEW–**

4. Are you satisfied with the FP method you are using?

- ☐ Yes → **5. What method are you using?**
- ☐ No → ***MWRA practicing family planning but not satisfied with the method she is using***: She has an **UNMET NEED for family planning**. Refer or accompany her to the midwife or to the health center for counseling. **–Proceed to Question #5–**

5. What method are you using? **(✓) Check the appropriate box**

Modern Methods	Traditional Methods
☐ **P** = Pills	☐ **W** = Withdrawal
☐ **IUD** = Intrauterine Device	☐ **CAL**=Calendar / Rhythm
☐ **Inj** = DMPA / Injectable	
☐ **C** = Condom	
☐ **BTL** = Bilateral Tubal Ligation	
☐ **VAS** = Vasectomy	
☐ **NFP** = Natural Family Planning	
☐ **LAM** = Lactational Amenorrhea Method	

→ ***MWRA practicing family planning but using traditional methods***: Inform her of the benefits of using modern family planning methods. Refer or accompany her to the midwife or to the health center for counseling.

A mother may be classified as using LAM if all 3 of the following are true:
1. She has a baby less than six months old,
2. She is amenorrheic (not menstruating), and
3. She is breastfeeding the baby day and night without supplementation.

If any of the above no longer applies, refer her to the midwife for counseling.

Facilitator's Notes

Session 3: Family Profile Field Practicum

Overview

This session provides each team with practical field experience in interviewing families with target clients and filling out the Family Profile (Form 1) in the field. In Session 2, the participants worked on sample data in the classroom. During this session, the participants experience what it is actually like to enter the community and interview families. They will increase their understanding of the process of collecting reliable data. This field experience will be valuable when they plan for and manage the CBMIS effort in their LGUs. It will increase their appreciation for the challenges facing the BHWs responsible for collecting data from target families in their catchment areas.

Duration

3 hours or more. Please note that this session will require the full time allotted.

Timing

Briefing	10 minutes
Team preparation	30 minutes
Field practicum	2 hours
Plenary presentation	15 minutes per team

Planning Notes

It is imperative for the facilitation team to prepare the logistics for this session well in advance.

1. The primary planning task is to coordinate with the Rural Health Midwife in charge of the area where the field practicum will take place. Consult with her regarding the:
   - selection of relatively accessible areas in her catchment area where teams can carry out family profiling interviews;
   - availability of a sufficient number of BHWs to accompany the teams;
   - timing of the field practicum (i.e., morning, afternoon, or evening), with the goal of ensuring optimum availability of both the BHWs and the target families.

   In addition, arrange for:
   - a sufficient number of vehicles to transport the teams to and from the designated areas;
   - snacks for all participants;
   - pick-up points where participants will assemble for their return trip to the workshop venue.

Facilitation Notes

All aspects of the field experience—from planning for the field practicum to carrying out the field interviews—provide important lessons for team members.

1. The session finishes with a short plenary, when the participants share their field experiences. If the participants return late or are very tired, they may ask to postpone the plenary until the following day. However, it is best to discuss the field experience immediately upon returning from the field. Keeping this session short—about 20 minutes to an hour—should help to convince the participants to stick to the session schedule and meet in plenary immediately.

2. In the plenary, prompt feedback by asking the question: "How do you feel after the survey?" Write down the participants' comments. When everyone has had a chance to contribute to the discussion, group the comments into categories. The participants may find this helpful as they develop their CMBIS planning and implementation checklist. Examples of categories might include:
   - negative factors, such as no local guide, no road map, no respondent around, and no vaccination record;
   - positive factors, such as having plenty of copies of the forms available;
   - planning points, such as carrying out the surveys when the respondents are available and having community maps available.

3. To complete this session, ask the group to develop a checklist that will help them to plan for and carry out the family profile survey in their LGUs. The participants may develop this checklist immediately or complete it as homework. The participants will use this checklist in the planning exercise in Session 11, the final session of the Phase I workshop.

Facilitator's Notes

Session 4: Review and Correct Family Profiles (Form 1)

Overview

During this session, each team reviews the copies of Form 1 filled out by another team, identifies any problems with the recorded data, and revises its own forms based on feedback from another team. This experience will prepare them to manage the quality of the data that the BHWs will be gathering in their catchment areas.

Duration

1 hour, 10 minutes

Timing

10 minutes	Briefing
15 minutes	Review Family Profile forms
30 minutes	Correct Family Profile forms
15 minutes	Discuss common mistakes in filling out the Family Profile form

Facilitation Notes

As with other sessions, do not answer the participants' substantive questions directly. Instead, encourage them to find the answers themselves. Refer them to the Instruction Sheet and any relevant DOH policies.

1. Remind the participants to write their names on the space provided for the interviewer in every Form 1 they have completed.

2. Assign which groups will swap forms.

3. While the groups are reviewing and correcting the forms, visit each group to answer any procedural questions and guide the participants in their work. As mentioned above, do not answer their substantive questions directly; rather, refer them to the Instruction Sheet.

4. Be strict with the time for this session. For example, allow only 15 minutes to review the forms and 30 minutes to make the corrections.

5. After the groups have made their corrections, ask them to share the most common mistakes they have encountered in completing Form 1. Limit each group's presentation to three minutes.

Facilitator's Notes

Session 5: Barangay CBMIS Tally Sheet (Form 2)

Overview

During this session, each team will gain experience in summarizing client data by filling out a Barangay CBMIS Tally Sheet (Form 2). They will summarize data from the copies of Form 1 that they filled out during Session 2. This experience will prepare them for using their field practicum data to develop baseline information on families with target clients.

Duration

1 hour, 30 minutes

Timing

10 minutes	Briefing
60 minutes	Read instruction sheet and fill out Form 2
20 minutes	Plenary session (1 group only)

Materials

Form 2 (answer key)

Planning Notes

Print one copy of Form 2 (template) on acetate, for one team to share data in plenary using an overhead projector.

Facilitation Notes

Encourage the participants to raise questions among themselves and in plenary regarding Form 2, and to refer to the instruction sheet for answers.

1. Ask the participants to read "How to Fill Out and Use the Barangay CBMIS Tally Sheet (Form 2)" before beginning to enter any data in the form.

2. Since all groups are summarizing the same set of family data, their completed copies of Form 2 should all be the same.

3. Ten minutes before they finish filling out Form 2, select one group to present its completed Form 2 in plenary. Ask the selected group to fill out the form printed on acetate.

PREVIOUS PAGE BLANK

4. Allow 20 minutes for the group presentation, including questions and answers. The person doing the presentation should remain standing to answer questions raised by the other groups.

5. Ask the groups to compare their completed forms with that of the presenting group. Promote discussion by encouraging the participants to raise questions and issues regarding the presentation and Form 2. Remind them to refer to the instruction sheet and any relevant DOH policies in seeking answers. As much as possible, avoid answering their questions directly.

6. Ask the groups to correct their forms, if needed, because they will be using them in subsequent sessions.

Barangay CBMIS Tally Sheet Answer Key—Form 2

Barangay: **Pinyahan**
BHS/BHC: **Pinyahan**
Mun/City: **San Nicolas**

RHM: **Mrs. Nilda San Juan**
Date: **March 11, 2001**

Form 2, page 1

TARGET GROUPS Purok:	BHW 1	BHW 2	BHW 3	BHW 4	BHW 5	BHW 6	BHW 7	BHW 8	BHW 9	BHW 10	BHW 11	BHW 12	BHW 13	BHW 14	BHW 15	BHW 16	BHW 17	Total
IA. Vaccination status of children 0–11 months old																		
1. Children 9–11 months old with INCOMPLETE or NO vaccination at all	1	3	2	5	6													17
2. Children 0–8 months old with NO vaccination or with recommended vaccination schedule NOT followed	1	1	2	1	4													9
3. Children 0–8 months old with recommended vaccination schedule followed	2	1	1	1	3													8
4. Children 9–11 months old who are Fully Immunized Children (FIC)	1	2	3	2	2													10
TOTAL number of children 0–11 months old (sum of # 1, 2, 3 & 4)	5	7	8	9	15													44
IB. Vaccination status of 1 year old children (12–23 months)																		
5. Children 1 year old (12–23 months) with INCOMPLETE or NO vaccination at all	1	3	2	2	3													11
6. Children 1 year old (12–23 months) who are Fully Immunized Children (FIC)	1	2	2	3	3													11
TOTAL number of 1 year old children (12–23 months) (sum of # 5 & 6)	2	5	4	5	6													22
IC. Vitamin A supplementation status of children 1–4 years old (12–59 months)																		
7. Children 1–4 years old (12–59 months) NOT given Vitamin A capsule during the past six months	5	3	2	1	3													14
8. Children 1–4 years old (12–59 months) GIVEN Vitamin A capsule during the past six months	3	4	7	1	2													17
TOTAL number of children 1–4 years old (12–59 months old) (sum of # 7 & 8)	8	7	9	2	5													31
II A. Tetanus Toxoid Vaccination Status of pregnant mother/wife																		
9. Pregnant with NO TT or with TT1 only	1	1	2	3	4													11
10. Pregnant with TT2 +	1	0	1	2	2													6
TOTAL number of pregnant mother/wife (sum of # (9 & 10)	2	1	3	5	6													17

Form 2, page 2

TARGET GROUPS Purok:	BHW 1	BHW 2	BHW 3	BHW 4	BHW 5	BHW 6	BHW 7	BHW 8	BHW 9	BHW 10	BHW 11	BHW 12	BHW 13	BHW 14	BHW 15	BHW 16	BHW 17	Total
II B. Protection at Birth																		
11. Children Protected at Birth	2	3	4	4	8													21
12. Children Not Protected at Birth	3	5	4	5	9													26
Sum of # 11 & 12	5	8	8	9	17													47
III. Family Planning and Nonpregnant Married Women of Reproductive Age (MWRA)																		
13. MWRA not wanting to have a child or wants to space but NOT practicing family planning	1	1	2	1	5													10
14. MWRA practicing family planning but NOT satisfied with the method she is using	1	2	1	1	2													7
15. MWRA wanting a child within 1 year	0	1	4	3	2													10
16. MWRA practicing family planning and satisfied with the method she is using	1	5	3	3	4													16
TOTAL number of nonpregnant MWRA (sum of # 13, 14, 15 & 16)	3	9	10	8	13													43
FP Methods Used by Current Users																		
P Pills	1	2	1	2	1													7
IUD Intrauterine Device	0	1	1	0	0													2
INJ DMPA / Injectable	0	0	1	1	0													2
C Condom	0	2	0	1	1													4
BTL Bilateral Tubal Ligation	0	1	0	0	2													3
VAS Vasectomy	0	0	0	0	0													0
NFP Natural Family Planning	0	0	0	0	0													0
LAM Lactational Amenorrhea Method	0	0	0	0	1													1
W Withdrawal	1	0	1	0	1													3
C Calendar	0	1	0	0	0													1
TOTAL FP Methods Used by Current Users *(should equal the sum of # 14 & 16)	2	7	4	4	6													23

Facilitator's Notes

Session 6: Call Cards and Midwife's Copy

Overview

During this session, each team will use the Family Profiles from Session 2 to identify unmet client needs and fill out a Call Card and a Midwife's Copy. This experience will increase the team's understanding of the process of creating and implementing a Call Card system to improve service utilization and reduce unmet client needs in their catchment areas.

Duration

1 hour, 20 minutes (approximately)

Timing

10 minutes	Briefing
30 minutes	Read instruction sheet and fill out Call Card(s) and Midwife's Copy
40 minutes (approximately) (about 10 minutes per group)	Plenary session

Materials

CBMIS Call Card—Midwife's Copy (3 answer keys)

Planning Notes

1. When printing the CBMIS Call Card, print it as a double-sided sheet if possible. Fold an example and share it with the participants during your briefing session. The folded, two-sided form has three panels per side.

2. Print out Call Card (templates) on acetate, for sharing data in plenary using an overhead projector.

Facilitation Notes

Encourage the participants to raise questions in their groups and in plenary regarding the Call Card and Midwife's Copy. Refer them to the instruction sheet when they have questions.

1. Ask the participants to read the "How to Fill Out Call Cards" before beginning to fill out any Call Cards.

2. Since all groups are using the same set of sample family data to create their Call Cards, their completed Call Cards should all be the same. Each team will have four completed Call Cards and four Midwife's Copies by the end of the session.

3. Ten minutes before they finish creating their Call Cards, ask each group to present one Call Card in plenary. Assign one family per group, and give each group a Call Card printed on acetate to fill out for its presentation.

4. Allow about 10 minutes on average for each Call Card presentation, including questions and answers. The person doing the presentation should remain standing to answer questions raised by the other groups.

5. Ask the groups to compare their completed form with that of the presenter. Promote discussion by encouraging the participants to raise questions and issues regarding the presentation and the Call Card. Refer to the instruction sheet and any relevant DOH policies in seeking answers. As much as possible, avoid answering their questions directly.

6. Ask the participants to correct their Call Cards, if needed, because they will be using them in subsequent sessions.

7. After the plenary, the facilitator may show pictures of LGUs using Call Cards during MGP activities. Pictures may be found in "Personalized Client Follow-Up through Call Slips," one of the handouts for this session.

CBMIS Call Card—Midwife's Copy: Esteban

Mother: Alicia Esteban BHS: Pinyahan
Address: 234 Kalayaan St., Barangay Pinyahan
Midwife: Mrs. Nilda San Juan

Vaccinations for Children 0–11 Months Old

Name of Child: _____ Age: _____

Vaccinations Needed Date	When Vaccination Will Be Given	Place Where Vaccination Will Be Given	Date Given	Signature of Midwife
BCG				
DPT 1				
DPT 2				
DPT 3				
OPV 1				
OPV 2				
OPV 3				
Measles				

Name of Child: _____ Age: _____

Vaccinations Needed Date	When Vaccination Will Be Given	Place Where Vaccination Will Be Given	Date Given	Signature of Midwife
BCG				
DPT 1				
DPT 2				
DPT 3				
OPV 1				
OPV 2				
OPV 3				
Measles				

Vitamin A Supplementation for Children 1–4 Years Old

Name	Age	When Vaccination Will Be Given	Place Where Vaccination Will Be Given	Date Given	Signature of Midwife
Oliver	1 y	03/15/01			

Tetanus Toxoid (TT) Vaccination for Pregnant Women

Name: Age:

Services Needed		Date When TT Vaccination Will Be Given	Place Where TT Vaccination Will Be Given	Date Given	Signature of Midwife
	TT 1				
	TT 2				
	TT 3				
	TT 4				

Family Planning Service

Name: Alicia Age: 35 y

FP Services Needed	Date When Service Will Be Provided	Place Where Service Will Be Provided	Date Provided	Signature of Midwife
FP Counseling	03/10/01			

CBMIS Call Card—Midwife's Copy: Natividad

Mother: Lita Natividad BHS: Pinyahan
Address: 321 Matapang St., Barangay Pinyahan
Midwife: Mrs. Nilda San Juan

Vaccinations for Children 0–11 Months Old

Name of Child: _____ Age: _____

Vaccinations Needed Date	When Vaccination Will Be Given	Place Where Vaccination Will Be Given	Date Given	Signature of Midwife
BCG				
DPT 1				
DPT 2				
DPT 3				
OPV 1				
OPV 2				
OPV 3				
Measles				

Name of Child: _____ Age: _____

Vaccinations Needed Date	When Vaccination Will Be Given	Place Where Vaccination Will Be Given	Date Given	Signature of Midwife
BCG				
DPT 1				
DPT 2				
DPT 3				
OPV 1				
OPV 2				
OPV 3				
Measles				

Vitamin A Supplementation for Children 1–4 Years Old

Name	Age	When Vaccination Will Be Given	Place Where Vaccination Will Be Given	Date Given	Signature of Midwife
Macy	4 y	03/15/01			

Tetanus Toxoid (TT) Vaccination for Pregnant Women

Name: Age:

Services Needed		Date When TT Vaccination Will Be Given	Place Where TT Vaccination Will Be Given	Date Given	Signature of Midwife
	TT 1				
	TT 2				
	TT 3				
	TT 4				

Family Planning Service

Name: Alicia Age: 35 y

FP Services Needed	Date When Service Will Be Provided	Place Where Service Will Be Provided	Date Provided	Signature of Midwife
FP Counseling	03/10/01			

CBMIS Call Card—Midwife's Copy: Carbonel

Mother: Helen Carbonel BHS: Pinyahan
Address: 121 Kalayaan St., Barangay Pinyahan
Midwife: Mrs. Nikka San Juan

Vaccinations for Children 0–11 Months Old

Name of Child: MJ Age: 10 m

Vaccinations Needed Date	When Vaccination Will Be Given	Place Where Vaccination Will Be Given	Date Given	Signature of Midwife
BCG				
DPT 1				
DPT 2				
DPT 3	03/14/01	Pinyahan HC		
OPV 1				
OPV 2				
OPV 3	03/14/01	Pinyahan HC		
Measles	03/14/01	Pinyahan HC		

Name of Child: _____ Age: _____

Vaccinations Needed Date	When Vaccination Will Be Given	Place Where Vaccination Will Be Given	Date Given	Signature of Midwife
BCG				
DPT 1				
DPT 2				
DPT 3				
OPV 1				
OPV 2				
OPV 3				
Measles				

Vitamin A Supplementation for Children 1–4 Years Old

Name	Age	When Vaccination Will Be Given	Place Where Vaccination Will Be Given	Date Given	Signature of Midwife

Tetanus Toxoid (TT) Vaccination for Pregnant Women

Name: Age:

Services Needed		Date When TT Vaccination Will Be Given	Place Where TT Vaccination Will Be Given	Date Given	Signature of Midwife
	TT 1	03/14/01	Pinyahan HC		
	TT 2				
	TT 3				
	TT 4				

Family Planning Service

Name: Age:

FP Services Needed	Date When Service Will Be Provided	Place Where Service Will Be Provided	Date Provided	Signature of Midwife

CBMIS Call Card—Midwife's Copy: Alvarez

Mother: Regina Alvarez BHS: Pinyahan HC
Address: 109 Kalayaan St., Barangay Pinyahan
Midwife: Mrs. Nilda San Juan

Vaccinations for Children 0–11 Months Old

Name of Child: Abby Age: 8 months

Vaccinations Needed Date	When Vaccination Will Be Given	Place Where Vaccination Will Be Given	Date Given	Signature of Midwife
BCG				
DPT 1				
DPT 2				
DPT 3	03/14/01	Pinyahan BHS		
OPV 1				
OPV 2				
OPV 3	03/14/01	Pinyahan BHS		
Measles				

Name of Child: _____ Age: _____

Vaccinations Needed Date	When Vaccination Will Be Given	Place Where Vaccination Will Be Given	Date Given	Signature of Midwife
BCG				
DPT 1				
DPT 2				
DPT 3				
OPV 1				
OPV 2				
OPV 3				
Measles				

Vitamin A Supplementation for Children 1–4 Years Old

Name	Age	When Vaccination Will Be Given	Place Where Vaccination Will Be Given	Date Given	Signature of Midwife
Cathrina	4 y	03/14/01	Pinyahan BHS		
Nico	3 y	03/14/01	Pinyahan BHS		
Jeremy	1 y	03/14/01	Pinyahan BHS		

Tetanus Toxoid (TT) Vaccination for Pregnant Women

Name: Age:

Services Needed		Date When TT Vaccination Will Be Given	Place Where TT Vaccination Will Be Given	Date Given	Signature of Midwife
	TT 1				
	TT 2				
	TT 3				
	TT 4				

Family Planning Service

Name: Regina Age: 39 y

FP Services Needed	Date When Service Will Be Provided	Place Where Service Will Be Provided	Date Provided	Signature of Midwife
FP Counseling	03/10/01			

Facilitator's Notes

Session 7: Catchment Area CBMIS Tally Sheet (Form 3)

Overview

This session provides the participants with practical experience in filling out the Catchment Area CBMIS Tally Sheet (Form 3) using data from the sample Family Profiles (Session 2). This experience will prepare them for managing the process of collecting and synthesizing baseline data on unmet needs in their catchment area when they return to their LGUs.

Duration

1 hour

Timing

10 minutes	Briefing
30 minutes	Read instruction sheet and fill out Form 3
20 minutes	Plenary session

Materials

Form 3 (partially complete)

Planning Notes

Print one copy of the Form 3 example on acetate, for one group to present in plenary using an overhead projector. The example is contained in the handouts for Session 7, in the Session Guidelines.

Facilitation Notes

Encourage the participants to raise questions in their groups and in plenary regarding Form 3. Remind them to refer to the instruction sheet when they have questions.

1. Ask the participants to read "How to Fill Out and Use the Catchment Area CBMIS Tally Sheet (Form 3)" before beginning to fill out Form 3.

2. Since all groups are using the same set of family data to create their Form 3, their completed copies of Form 3 should all be the same.

3. Ten minutes before the teams finish filling out Form 3, assign one group to present its Form 3 in plenary. Give the group a Form 3 printed on acetate for its presentation.

4. Allow about 20 minutes for the group's presentation, including questions and answers. The person doing the presentation should remain standing to answer questions raised by the other groups.

5. Ask the groups to compare their completed form with that of the presenter. Promote discussion by encouraging the participants to raise questions and issues regarding the presentation and Form 3. Always remind them to refer to the instruction sheet and any relevant DOH policies in seeking answers. As much as possible, avoid answering their questions directly.

6. Remind the groups to correct their respective copies of Form 3, if needed, because these will be used in subsequent sessions.

Catchment Area CBMIS Tally Sheet Answer Key—Form 3

BHS/BHC: **Pinyahan**
Mun/City: **San Nicolas**

RHM: **Mrs. Nilda San Juan**
Date: **March 11, 2001**

Form 3, page 1

TARGET GROUPS	Barangay Pinyahan		Barangay Ibayo		Barangay		Barangay		Barangay		Total	
IA. Vaccination status of children 0-11 months old	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)
1. Children 9-11 months old with INCOMPLETE or NO vaccination at all	17	39%	9	27%							26	34%
2. Children 0-8 months old with NO vaccination or with recommended vaccination schedule NOT followed	9	20%	10	30%							19	25%
3. Children 0-8 months old with recommended vaccination schedule followed	8	18%	12	36%							20	26%
4. Children 9-11 months old who are Fully Immunized Children (FIC)	10	23%	2	6%							12	16%
TOTAL number of children 0-11 months old (sum of # 1, 2, 3 & 4)	44	100%	33	100%							77	100%
IB. Vaccination status of 1 year old children (12-23 months)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)
5. Children 1 year old (12-23 months) with INCOMPLETE or NO vaccination at all	11	50%	15	43%							26	46%
6. Children 1 year old (12-23 months) who are Fully Immunized Children (FIC)	11	50%	20	57%							31	54%
TOTAL number of 1 year old children (12-23 months) (sum of # 5 & 6)	22	100%	35	100%							57	100%
IC. Vitamin A supplementation status of children 1-4 years old (12-59 months)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)
7. Children 1-4 years old (12-59 months) NOT given Vitamin A capsule during the past six months	14	45%	10	37%							24	41%
8. Children 1-4 years old (12-59 months) GIVEN Vitamin A capsule during the past six months	17	55%	17	63%							34	59%
TOTAL number of children 1-4 years old (12-59 months old) (sum of # 7 & 8)	31	100%	27	100%							58	100%
II A. Tetanus Toxoid Vaccination Status of pregnant mother/wife	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)	Number (N)	Percent (N÷Totals100)
9. Pregnant with NO TT or with TT1 only	11	65%	3	20%							14	44%
10. Pregnant with TT2 +	6	35%	12	80%							18	56%
TOTAL number of pregnant mother/wife (sum of # (9 & 10)	17	100%	15	100%							32	100%

Form 3, page 2

TARGET GROUPS	Barangay Pinyahan		Barangay Ibayo		Barangay		Barangay		Barangay		Total	
II B. Protection at Birth	Number (N)	Percent (N+Totalx100)	Number (N)	Percent (N+Totalx100)	Number (N)	Percent (N+Totalx100)	Number (N)	Percent (N+Totalx100)	Number (N)	Percent (N+Totalx100)	Number (N)	Percent (N+Totalx100)
11. Children Protected at Birth	21	45%	28	78%							49	59%
12. Children Not Protected at Birth	26	55%	8	22%							34	41%
Sum of # 11 & 12	47	100%	36	100%							83	100%
III. Family Planning and Nonpregnant Married Women of Reproductive Age (MWRA)	Number (N)	Percent (N+Totalx100)	Number (N)	Percent (N+Totalx100)	Number (N)	Percent (N+Totalx100)	Number (N)	Percent (N+Totalx100)	Number (N)	Percent (N+Totalx100)	Number (N)	Percent (N+Totalx100)
13. MWRA not wanting to have a child or wants to space but NOT practicing family planning	10	23%	9	36%							19	28%
14. MWRA practicing family planning but NOT satisfied with the method she is using	7	16%	4	16%							11	16%
15. MWRA wanting a child within 1 year	10	23%	0	0%							10	15%
16. MWRA practicing family planning and satisfied with the method she is using	16	37%	12	48%							28	41%
TOTAL number of nonpregnant MWRA (sum of # 13, 14, 15 & 16)	43	100%	25	100%							68	100%
FP Methods Used by Current Users												
P Pills	7	30%	3	19%							10	26%
IUD Intrauterine Device	2	9%	2	13%							4	10%
INJ DMPA / Injectable	2	9%	5	31%							7	18%
C Condom	4	17%	3	19%							7	18%
BTL Bilateral Tubal Ligation	3	13%	1	6%							4	10%
VAS Vasectomy	0	0%	0	0%							0	0%
NFP Natural Family Planning	0	0%	0	0%							0	0%
LAM Lactational Amenorrhea Method	1	4%	1	6%							2	5%
W Withdrawal	3	13%	1	6%							4	10%
C Calendar	1	4%	0	0%							1	3%
TOTAL FP Methods Used by Current Users *(should equal the sum of # 14 & 16)	23	100%	16	100%							39	100%

Facilitator's Notes

Session 8: "From the Top (Well, Almost!)"

Overview

This session provides the participants with additional practical experience in using Family Profiles to summarize barangay and catchment area data and identify unmet client needs. During this session, they use actual data from their field practicum to fill out Form 2 and Form 3 and create Call Cards and Midwife's Copies. This experience will help to prepare them for managing the process of identifying unmet client needs when they return to their LGUs.

Duration

1 hour, 10 minutes

Timing

Briefing	10 minutes
Summarize Family Profile data from the field practicum using Forms 2 and 3, and create needed Call Cards	60 minutes

Planning Notes

Facilitators may do this planning activity either before the session starts or while the teams are filling out Form 2, Form 3, Call Cards, and Midwife's Copies.

1. Draw a table on a white board. The table should have columns for the area surveyed, number of families surveyed, number of Call Cards issued, and percentage. The table should look like this:

Area Surveyed (A)	No. of Families Surveyed (B)	No. of Call Cards Issued (C)	Percentage (C/B)
Total			

Facilitation Notes

Encourage the participants to raise questions in their groups and in plenary regarding Form 2, Form 3, and Call Cards. Remind them to refer to the instruction sheets for these products when they have questions.

1. Ask the participants to use the Family Profiles from their field practicum to summarize data from Forms 2 and 3.

2. Ask the participants to use only correctly completed copies of Form 1 from the field practicum (Session 3) to summarize data and identify the families' unmet needs. Ask the teams to separate and hand in any incomplete copies of Form 1, so they can be passed on to the health staff who will be responsible for completing them.

3. Ask the teams to create Call Cards as needed and to make a Midwife's Copy for each Call Card created.

4. As the groups finish their work, ask them to fill in the columns in the table drawn on the white board. The goal of this activity is to determine the percentage of families with unmet needs in the area that the teams surveyed during Session 3.

5. Collect and collate all forms created by the teams and deliver them to the health staff responsible for the area surveyed.

Facilitator's Notes

Session 9: Updating the Community-Based Monitoring and Information System

Overview

This session provides the teams with practical experience in updating their CBMIS. In this session, they update the copies of Form 1 that they prepared in Session 2 and the relevant copies of Form 2 and Form 3. The handout "Family Profile Updating Exercise" provides the new data the participants will use to update the sample profiles.

Duration

2 hours, 15 minutes

Timing

10 minutes	Briefing
40 minutes	Read the instruction sheet and complete the forms using sample data on seven families
30 minutes (approximately)	Plenary presentation of updated Form 1
50 minutes (approximately)	Plenary presentation of updated Forms 2 and 3

Materials

- Form 1 (7 answer keys)
- Form 2 (complete)
- Form 3 (complete)

Planning Notes

Print templates of Forms 1, 2, and 3 on acetate, for presenting data in plenary using an overhead projector.

Facilitation Notes

Encourage the participants to raise questions in their groups and in plenary regarding the process of updating Form 1, 2, and 3. Remind them to refer to the instruction sheets for these products if they have questions.

1. Ask the participants to read "How to Update the Family Profile" before starting to update the copies of Form 1 that they developed in Session 2.

2. Ask the teams to use the sample data provided in "Family Profile Updating Exercise" when they update Form 1. Note that the handout provides sample data on seven families. Also note that the forms completed by the teams should all be the same, as they are using the same data.

3. Ten minutes before they finish updating Form 1, assign one family to each group to present in plenary. Give each group Form 1 printed on acetate for their presentation. Tell the groups to use a different color pen to highlight the changes they have made in their assigned profile.

4. Also assign one group to present their updated Form 2 and another to present their updated Form 3. Give each group the relevant forms printed on acetate for their plenary presentation. Note that the teams should not make any more Call Cards.

5. Allow an average of seven minutes for each Form 1 presentation, including questions and answers. Be flexible with time management for the plenary presentations. Allow the first team to have a little extra time, as the first presentation usually takes longer. The person doing the presenting should remain standing to answer questions raised by the other groups.

6. Ask the groups to compare their completed copies of Form 1 with those of the presenters. Promote discussion by encouraging the participants to raise questions and issues regarding the presentation and the process of updating Form 1. Refer to the Instruction Sheet and any relevant DOH policies in seeking answers. As much as possible, avoid answering their questions directly.

7. Remind the participants to correct their copies of Form 1 as needed, because they will be using them in subsequent sessions.

8. Allow about 10 minutes per group for the presentations of Forms 2 and 3 in plenary. The presenters should remain standing to answer questions, and the other teams should correct their Tally Sheets as needed.

FAMILY PROFILE

CHMIS Revised Form as of 02/2001

FORM 1, page 1

General Information

Address: 109 Kalayaan St. Barangay Pinyahan
Respondent: Regina Alvarez
Father: Cesar Alvarez
Birthday: 04 / 03 / 1960 (mm/dd/yy) Age: [redacted]
Mother: Regina Alvarez
Birthday: 01 / 09/ 1962 (mm/dd/yy) Age: 39
Civil Status: ( ) Single (✓) Married ( ) Widow ( ) Separated

BHS/BHC: Pinyahan HC
RHU: Kalinga
Mun/City: San Nicolas
Province: Sulu

NOTE: Please use pencil in completing the forms to facilitate updating!

BHW: Mrs. Milagrosa Tatlonghari
RHM: Mrs. Nilda San Juan
PHN: Mrs. Tina Dela Cruz
Interviewer: Mrs. Milagrosa Tatlonghari
Date Surveyed: March 09, 2001
Date of last update: [redacted]

Part I. Data of children 0–4 years old (0–59 months old, start from the eldest)

Name	Birthday MM	Birthday DD	Birthday YY	Age	Where does the child receive vaccinations? B =BHS/BHC R =RHU/MHC P =Private G =Gov't Hosp *(See "A" below)*	Does the child have any vaccination record? Y = Yes N = No *(See "B" below)*	Vaccinations Received (*For children 0–11 months old*, write the date when vaccination was given) (*For children 12–59 months old*, put a Y if child was given vaccination or an N if not given) If the child 0–11months old has NO vaccination or the vaccination schedule is NOT followed, *(See "C" below)* If the child 1–4 years old has INCOMPLETE or NO vaccination, *(See "D" below)*								FIC *(For children 9 months to 4 years old)* Did the child receive all the preceding vaccinations before his first birthday? Y = Yes N = No	Vitamin A *(For children 1–4 years old only)* Was the child given vitamin A capsule (200,000 IU) during the past 6 months? (e.g Garantisadong Pambata Activities) Y = Yes N = No *(See "E" below)*		Remarks
							BCG	DPT 1st dose	DPT 2nd dose	DPT 3rd dose	OPV 1st dose	OPV 2nd dose	OPV 3rd dose	Measles		April 2001 YRV	October [redacted] YRV	
Cathrina	09	13	96	4 y	P	[redacted]	Y	Y	Y	Y	Y	Y	Y	N	N	[redacted]		
Nico	08	12	97	3 y	P	Y	Y	Y	Y	Y	Y	Y	Y	N	N	[redacted]		
Jacob	07	15	98	2 y	B	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	[redacted]		
Jeremy	06	01	99	[redacted]	B	Y	Y	Y	Y	Y	Y	Y	Y	[redacted]	N	[redacted]		
Abby	07	05	00	[redacted]	B	Y	07/05/00	09/01/00	10/05/00	[redacted]	09/01/00	10/05/00	[redacted]	[redacted]	[redacted]			

Actions to be taken

A. If the child receives vaccination services from private clinics/hospitals and government hospitals, followup the child's vaccinations until completed.
B. Advise the mother to get a copy of the vaccination record from the health facility where the child received the vaccinations or ask the midwife of the nearest BHS to make another record.
C. Refer or accompany the mother and child to the midwife for ***immediate vaccination***.
D. Advise the mother to consult the midwife for completion of the child's vaccinations.
E. Give vitamin A capsule at once if available or advise the mother to bring the child to the nearest health facility for the next scheduled vitamin A supplementation.

Part II A. Tetanus Toxoid Vaccination (TTV) for Pregnant Women FORM 1, page 2

Is the mother/wife pregnant?	☐ Yes	✓ No
Total number of TTV doses received	2 Doses	

If the woman is pregnant, inform her of the importance of prenatal care and tetanus toxoid vaccinations that are available at the nearest health facility.

Part II B. Protection at Birth (PAB) against neonatal tetanus: For women with children 0–2 years old only

Name of youngest child (***0–2 years old only***): Abby Age of youngest child: [redacted]

Complete this table only if the age of the youngest living child is 0 to 2 years old (0–35 months old)

TTV Dose	When was each TTV dose received in reference to the youngest child? **Check the appropriate boxes**		Was the child protected at birth (PAB)? **Check the appropriate box**
	During the pregnancy with the youngest child	Prior to the pregnancy with the youngest child	*PAB is defined as any of the following:* • 2 TTV doses during the pregnancy with the youngest child, or • 1 TTV dose during the pregnancy with the youngest child plus 2 doses prior to the pregnancy, or • 3 TTV doses prior to the pregnancy with the youngest child
TTV 1		✓	☐ **Yes** *(Protected at Birth)*
TTV 2	✓		✓ **No** *(NOT protected at birth)*
TTV 3			
TTV 4			
TTV 5			

Part III. Family Planning Practice of Married Woman of Reproductive Age (MWRA) (Mother/Wife)

The following should not be interviewed for Part III:

☐ Widowed or separated women ☐ Menopausal women

☐ Women with ovaries and/or uterus and/or fallopian tubes surgically removed due to a medical condition (e.g. tumors, ectopic pregnancy)

1. Are you currently pregnant? *(See response to Part II A)*

- ✓ No/Unsure → **2. Do you want to have additional child/children?**
- ☐ Yes → **Actions to be Taken**: Remind her again of the need of prenatal care and tetanus toxoid vaccination. **–END OF INTERVIEW–**

2. Do you want to have additional child/children?

- ✓ No → **3. Are you currently using any family planning method?**
- ☐ Yes, after 1 year → **3. Are you currently using any family planning method?**
- ☐ Yes, within 1 year → Inform her of the need of prenatal care when she gets pregnant and the available family planning services in the health center in case she changes her mind. **–END OF INTERVIEW–**

3. Are you currently using any family planning method?

- ✓ Yes → **4. Are you satisfied with the FP method you are using?**
- ☐ No → ***MWRA not wanting another child or wants to space but not practicing family planning***: She has an **UNMET NEED for family planning**. Inform her about family planning services and refer/accompany her to the midwife or to the health center. **–END OF INTERVIEW–**

4. Are you satisfied with the FP method you are using?

- ✓ Yes → **5. What method are you using?**
- ☐ No → ***MWRA practicing family planning but not satisfied with the method she is using***: She has an **UNMET NEED for family planning**. Refer or accompany her to the midwife or to the health center for counseling. **–Proceed to Question #5–**

5. What method are you using? **(✓) Check the appropriate box**

Modern Methods	Traditional Methods
☐ **P** = Pills	☐ **W** = Withdrawal
☐ **IUD** = Intrauterine Device	☐ **CAL**=Calendar / Rhythm
☐ **Inj** = DMPA / Injectable	
☐ **C** = Condom	
✓ **BTL** = Bilateral Tubal Ligation	
☐ **VAS** = Vasectomy	
☐ **NFP** = Natural Family Planning	
☐ **LAM** = Lactational Amenorrhea Method	

→ ***MWRA practicing family planning but using traditional methods***: Inform her of the benefits of using modern family planning methods. Refer or accompany her to the midwife or to the health center for counseling.

A mother may be classified as using LAM if all 3 of the following are true:
1. She has a baby less than six months old,
2. She is amenorrheic (not menstruating), and
3. She is breastfeeding the baby day and night without supplementation.

If any of the above no longer applies, refer her to the midwife for counseling.

FAMILY PROFILE

CBMIS Revised Form as of 02/2001

FORM 1, page 1

General Information

Address: 121 Kalayaan St. Barangay Pinyahan
Respondent: Helen Carbonel
Father: Arturo Carbonel
Birthday: 12 / 23 / 1970 (mm/dd/yy) Age: 30
Mother: Helen Carbonel
Birthday: 05 / 12/ 1972 (mm/dd/yy) Age: [redacted]
Civil Status: ( ) Single (✓) Married ( ) Widow ( ) Separated

BHS/BHC: Pinyahan HC
RHU: Kalinga
Mun/City: San Nicolas
Province: Sulu

NOTE: Please use pencil in completing the forms to facilitate updating!

BHW: Mrs. Milagrosa Tatlonghari
RHM: Mrs. Nilda San Juan
PHN: Mrs. Tina Dela Cruz
Interviewer: Mrs. Milagrosa Tatlonghari
Date Surveyed: March 09, 2001

Date of last update: [redacted]

Part I. Data of children 0–4 years old (0–59 months old, start from the eldest)

Name	Birthday MM	Birthday DD	Birthday YY	Age	Where does the child receive vaccinations? B =BHS/BHC R =RHU/MHC P =Private G =Gov't Hosp (See "A" below)	Does the child have any vaccination record? Y = Yes N = No (See "B" below)	Vaccinations Received (For children 0–11 months old, write the date when vaccination was given) (For children 12–59 months old, put a Y if child was given vaccination or an N if not given) If the child 0–11months old has NO vaccination or the vaccination schedule is NOT followed, (See "C" below) If the child 1–4 years old has INCOMPLETE or NO vaccination, (See "D" below)								FIC (For children 9 months to 4 years old) Did the child receive all the preceding vaccinations before his first birthday? Y = Yes N = No	Vitamin A (For children 1–4 years old only) Was the child given vitamin A capsule (200,000 IU) during the past 6 months? (e.g. Garantisadong Pambata Activities) Y = Yes N = No (See "E" below)		Remarks
							BCG	DPT 1st dose	DPT 2nd dose	DPT 3rd dose	OPV 1st dose	OPV 2nd dose	OPV 3rd dose	Measles		April 2001 Year	October [redacted] Year	
Julie Anne	11	15	96	4 y	G	Y	Y	Y	Y	N	Y	Y	N	N	N	[redacted]		
Jasmine	10	29	97	3 y	P	Y	Y	Y	Y	Y	Y	Y	Y	N	N	[redacted]		
[redacted]																		

Actions to be taken

A. If the child receives vaccination services from private clinics/hospitals and government hospitals, followup the child's vaccinations until completed
B. Advise the mother to get a copy of the vaccination record from the health facility where the child received the vaccinations or ask the midwife of the nearest BHS to make another record.
C. Refer or accompany the mother and child to the midwife for ***immediate vaccination***.
D. Advise the mother to consult the midwife for completion of the child's vaccinations.
E. Give vitamin A capsule at once if available or advise the mother to bring the child to the nearest health facility for the next scheduled vitamin A supplementation

Part II A. Tetanus Toxoid Vaccination (TTV) for Pregnant Women FORM 1, page 2

Is the mother/wife pregnant? ☐ Yes ☐ No

Total number of TTV doses received ☐ Doses

If the woman is pregnant, inform her of the importance of prenatal care and tetanus toxoid vaccinations that are available at the nearest health facility.

Part II B. Protection at Birth (PAB) against neonatal tetanus: For women with children 0–2 years old only

Name of youngest child (***0–2 years old only***): Noel Age of youngest child: ☐

Complete this table only if the age of the youngest living child is 0 to 2 years old (0–35 months old)

TTV Dose	When was each TTV dose received in reference to the youngest child? **Check the appropriate boxes**		Was the child protected at birth (PAB)? **Check the appropriate box**
	During the pregnancy with the youngest child	Prior to the pregnancy with the youngest child	*PAB is defined as any of the following:* • 2 TTV doses during the pregnancy with the youngest child, or • 1 TTV dose during the pregnancy with the youngest child plus 2 doses prior to the pregnancy, or • 3 TTV doses prior to the pregnancy with the youngest child
TTV 1	☐	☐	☐ **Yes** *(Protected at Birth)*
TTV 2	☐	☐	☐ **No** *(NOT protected at birth)*
TTV 3	☐	☐	
TTV 4	☐	☐	
TTV 5	☐	☐	

Part III. Family Planning Practice of Married Woman of Reproductive Age (MWRA) (Mother/Wife)

The following should not be interviewed for Part III:

☐ Widowed or separated women ☐ Menopausal women

☐ Women with ovaries and/or uterus and/or fallopian tubes surgically removed due to a medical condition (e.g. tumors, ectopic pregnancy)

1. Are you currently pregnant? *(See response to Part II A)*

- ☐ No/Unsure → **2. Do you want to have additional child/children?**
- ☐ Yes → Remind her again of the need of prenatal care and tetanus toxoid vaccination. **–END OF INTERVIEW–**

2. Do you want to have additional child/children?

- ☐ No → **3. Are you currently using any family planning method?**
- ☐ Yes, after 1 year → **3. Are you currently using any family planning method?**
- ☐ Yes, within 1 year → Inform her of the need of prenatal care when she gets pregnant and the available family planning services in the health center in case she changes her mind. **–END OF INTERVIEW–**

3. Are you currently using any family planning method?

- ☐ Yes → **4. Are you satisfied with the FP method you are using?**
- ☐ No → ***MWRA not wanting another child or wants to space but not practicing family planning*** She has an **UNMET NEED for family planning**. Inform her about family planning services and refer/accompany her to the midwife or to the health center. **–END OF INTERVIEW–**

4. Are you satisfied with the FP method you are using?

- ☐ Yes → **5. What method are you using?**
- ☐ No → ***MWRA practicing family planning but not satisfied with the method she is using*** She has an **UNMET NEED for family planning**. Refer or accompany her to the midwife or to the health center for counseling. **–Proceed to Question #5–**

5. What method are you using? **(✓) Check the appropriate box**

Modern Methods	Traditional Methods
☑ **P** = Pills	☐ **W** = Withdrawal
☐ **IUD** = Intrauterine Device	☐ **CAL**=Calendar / Rhythm
☐ **Inj** = DMPA / Injectable	
☐ **C** = Condom	
☐ **BTL** = Bilateral Tubal Ligation	
☐ **VAS** = Vasectomy	
☐ **NFP** = Natural Family Planning	
☐ **LAM** = Lactational Amenorrhea Method	

→ ***MWRA practicing family planning but using traditional methods*** Inform her of the benefits of using modern family planning methods. Refer or accompany her to the midwife or to the health center for counseling.

A mother may be classified as using LAM if all 3 of the following are true:

1. She has a baby less than six months old,
2. She is amenorrheic (not menstruating), and
3. She is breastfeeding the baby day and night without supplementation.

If any of the above no longer applies, refer her to the midwife for counseling.

Actions to be Taken

FAMILY PROFILE

CBMIS Revised Form as of 02/2001

FORM 1, page 1

General Information

Address: 222 Matapang St. Barangay Pinyahan
Respondent: Rosario Cinco
Father: Martin Cinco
Birthday: 03 / 25 / 1975 (mm/dd/yy) Age: [redacted]
Mother: Rosario Cinco
Birthday: 08 / 22/ 1977 (mm/dd/yy) Age: 23
Civil Status: ( ) Single (✓) Married ( ) Widow ( ) Separated

BHS/BHC: Pinyahan BHS
RHU: Kalinga
Mun/City: San Nicolas
Province: Sulu

NOTE: Please use pencil in completing the forms to facilitate updating!

BHW: Mrs. Milagrosa Tationghari
RHM: Mrs. Nilda San Juan
PHN: Mrs. Tina Dela Cruz
Interviewer: Mrs. Milagrosa Tationghari
Date Surveyed: March 09, 2001
Date of last update: [redacted]

Part I. Data of children 0–4 years old (0–59 months old, start from the eldest)

Name	Birthday MM	Birthday DD	Birthday YY	Age	Where does the child receive vaccinations? B =BHS/BHC R =RHU/MHC P =Private G =Gov't Hosp *(See "A" below)*	Does the child have any vaccination record? Y = Yes N = No *(See "B" below)*	Vaccinations Received (*For children 0–11 months old*, write the date when vaccination was given) (*For children 12–59 months old*, put a Y if child was given vaccination or an N if not given) If the child 0–11months old has NO vaccination or the vaccination schedule is NOT followed, (*See "C" below*) If the child 1–4 years old has INCOMPLETE or NO vaccination, (*See "D" below*)								FIC (*For children 9 months to 4 years old*) Did the child receive all the preceding vaccinations before his first birthday? Y = Yes N = No	Vitamin A (*For children 1–4 years old only*) Was the child given vitamin A capsule (200,000 IU) during the past 6 months? (e.g. Gerantisadong Pambata Activities) Y = Yes N = No *(See "E" below)*		Remarks
							BCG	DPT 1st dose	DPT 2nd dose	DPT 3rd dose	OPV 1st dose	OPV 2nd dose	OPV 3rd dose	Measles		April Year	October Year	
Redentor	10	02	00	[redacted]	P	Y	10/15/00	12/10/00	01/12/01	02/16/01	12/10/00	01/12/01	02/16/01					

Actions to be taken

A. If the child receives vaccination services from private clinics/hospitals and government hospitals, followup the child's vaccinations until completed.
B. Advise the mother to get a copy of the vaccination record from the health facility where the child received the vaccinations or ask the midwife of the nearest BHS to make another record
C. Refer or accompany the mother and child to the midwife for ***immediate vaccination***.
D. Advise the mother to consult the midwife for completion of the child's vaccinations.
E. Give vitamin A capsule at once if available or advise the mother to bring the child to the nearest health facility for the next scheduled vitamin A supplementation.

Part II A. Tetanus Toxoid Vaccination (TTV) for Pregnant Women FORM 1, page 2

Is the mother/wife pregnant?	☐ Yes	☑ No	If the woman is pregnant, inform her of the importance of prenatal care and tetanus toxoid vaccinations that are available at the nearest health facility.
Total number of TTV doses received	3 Doses		

Part II B. Protection at Birth (PAB) against neonatal tetanus: For women with children 0–2 years old only

Name of youngest child (***0–2 years old only***): **Redentor** Age of youngest child: [redacted]

Complete this table only if the age of the youngest living child is 0 to 2 years old (0–35 months old)

TTV Dose	When was each TTV dose received in reference to the youngest child? **Check the appropriate boxes**		Was the child protected at birth (PAB)? **Check the appropriate box** *PAB is defined as any of the following:* • 2 TTV doses during the pregnancy with the youngest child, or • 1 TTV dose during the pregnancy with the youngest child plus 2 doses prior to the pregnancy, or • 3 TTV doses prior to the pregnancy with the youngest child
	During the pregnancy with the youngest child	Prior to the pregnancy with the youngest child	
TTV 1	☐	☑	☑ **Yes** *(Protected at Birth)*
TTV 2	☐	☑	☐ **No** *(NOT protected at birth)*
TTV 3	☑	☐	
TTV 4	☐	☐	
TTV 5	☐	☐	

Part III. Family Planning Practice of Married Woman of Reproductive Age (MWRA) (Mother/Wife)

The following should not be interviewed for Part III:

☐ Widowed or separated women ☐ Menopausal women

☐ Women with ovaries and/or uterus and/or fallopian tubes surgically removed due to a medical condition (e.g. tumors, ectopic pregnancy)

1. Are you currently pregnant? *(See response to Part II A)*

- ☑ No/Unsure → **2. Do you want to have additional child/children?**
- ☐ Yes → **Actions to be Taken**: Remind her again of the need of prenatal care and tetanus toxoid vaccination. **–END OF INTERVIEW–**

2. Do you want to have additional child/children?

- ☐ No → **3. Are you currently using any family planning method?**
- ☑ Yes, after 1 year → **3. Are you currently using any family planning method?**
- ☐ Yes, within 1 year → **Actions to be Taken**: Inform her of the need of prenatal care when she gets pregnant and the available family planning services in the health center in case she changes her mind. **–END OF INTERVIEW–**

3. Are you currently using any family planning method?

- ☑ Yes → **4. Are you satisfied with the FP method you are using?**
- ☐ No → ***MWRA not wanting another child or wants to space but not practicing family planning***: She has an **UNMET NEED for family planning**. Inform her about family planning services and refer/accompany her to the midwife or to the health center. **–END OF INTERVIEW–**

4. Are you satisfied with the FP method you are using?

- ☑ Yes → **5. What method are you using?**
- ☐ No → ***MWRA practicing family planning but not satisfied with the method she is using***: She has an **UNMET NEED for family planning**. Refer or accompany her to the midwife or to the health center for counseling. **–Proceed to Question #5–**

5. What method are you using? (✓) **Check the appropriate box**

Modern Methods	Traditional Methods
☑ **P** = Pills	☐ **W** = Withdrawal
☐ **IUD** = Intrauterine Device	☐ **CAL**=Calendar / Rhythm
☐ **Inj** = DMPA / Injectable	
☐ **C** = Condom	
☐ **BTL** = Bilateral Tubal Ligation	
☐ **VAS** = Vasectomy	
☐ **NFP** = Natural Family Planning	
☐ **LAM** = Lactational Amenorrhea Method	

→ ***MWRA practicing family planning but using traditional methods***: Inform her of the benefits of using modern family planning methods. Refer or accompany her to the midwife or to the health center for counseling.

A mother may be classified as using LAM if all 3 of the following are true:

1. She has a baby less than six months old,
2. She is amenorrheic (not menstruating), and
3. She is breastfeeding the baby day and night without supplementation.

If any of the above no longer applies, refer her to the midwife for counseling.

FAMILY PROFILE

CBMIS Revised Form as of 02/2001

FORM 1, page 1

General Information

Address: 234 Kalayaan St. Barangay Pinyahan

Respondent: Alicia Esteban

Father: Romeo Esteban

Birthday: 01 / 13 / 1965 (mm/dd/yy) Age: 36

Mother: Alicia Esteban

Birthday: 06 / 12/ 1965 (mm/dd/yy) Age: [redacted]

Civil Status: ( ) Single (✓) Married ( ) Widow ( ) Separated

BHS/BHC: Pinyahan HC

RHU: Kalinga

Mun/City: San Nicolas

Province: Sulu

NOTE: Please use pencil in completing the forms to facilitate updating!

BHW: Mrs. Milagrosa Tatlonghari

RHM: Mrs. Nilda San Juan

PHN: Mrs. Tina Dela Cruz

Interviewer: Mrs. Milagrosa Tatlonghari

Date Surveyed: March 09, 2001

Date of last update: [redacted]

Part I. Data of children 0–4 years old (0–59 months old, start from the eldest)

Name	Birthday MM	Birthday DD	Birthday YY	Age	Where does the child receive vaccinations? B = BHS/BHC R = RHU/MHC P = Private G = Gov't Hosp (See "A" below)	Does the child have any vaccination record? Y = Yes N = No (See "B" below)	Vaccinations Received (For children 0–11 months old, write the date when vaccination was given) (For children 12–59 months old, put a Y if child was given vaccination or an N if not given) If the child 0–11months old has NO vaccination or the vaccination schedule is NOT followed, (See "C" below) If the child 1–4 years old has INCOMPLETE or NO vaccination, (See "D" below)								FIC (For children 9 months to 4 years old) Did the child receive all the preceding vaccinations before his first birthday? Y = Yes N = No	Vitamin A (For children 1–4 years old only) Was the child given vitamin A capsule (200,000 IU) during the past 6 months? (e.g. Garantisadong Pambata Activities) Y = Yes N = No (See "E" below)		Remarks
							BCG	DPT 1st dose	DPT 2nd dose	DPT 3rd dose	OPV 1st dose	OPV 2nd dose	OPV 3rd dose	Measles		April 2001 YY	October YY	
Oliver	08	30	99	1 y	B	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	[redacted]		
Czarina	09	05	00	[redacted]	B	Y	09/20/00	11/10/00	12/12/00	01/20/01	11/10/00	12/12/00	01/20/01	[redacted]	[redacted]			

Actions to be taken

A. If the child receives vaccination services from private clinics/hospitals and government hospitals, followup the child's vaccinations until completed.

B. Advise the mother to get a copy of the vaccination record from the health facility where the child received the vaccinations or ask the midwife of the nearest BHS to make another record

C. Refer or accompany the mother and child to the midwife for ***immediate vaccination***.

D. Advise the mother to consult the midwife for completion of the child's vaccinations.

E. Give vitamin A capsule at once if available or advise the mother to bring the child to the nearest health facility for the next scheduled vitamin A supplementation.

Part II A. Tetanus Toxoid Vaccination (TTV) for Pregnant Women FORM 1, page 2

Is the mother/wife pregnant?	☐ Yes	☑ No
Total number of TTV doses received	1 Doses	

If the woman is pregnant, inform her of the importance of prenatal care and tetanus toxoid vaccinations that are available at the nearest health facility.

Part II B. Protection at Birth (PAB) against neonatal tetanus: For women with children 0–2 years old only

Name of youngest child (***0–2 years old only***): ***Czarina*** Age of youngest child: [redacted]

Complete this table only if the age of the youngest living child is 0 to 2 years old (0–35 months old)

TTV Dose	When was each TTV dose received in reference to the youngest child? **Check the appropriate boxes**		Was the child protected at birth (PAB)? **Check the appropriate box**
	During the pregnancy with the youngest child	Prior to the pregnancy with the youngest child	*PAB is defined as any of the following:* • 2 TTV doses during the pregnancy with the youngest child, or • 1 TTV dose during the pregnancy with the youngest child plus 2 doses prior to the pregnancy, or • 3 TTV doses prior to the pregnancy with the youngest child
TTV 1	☐	☑	☐ **Yes** *(Protected at Birth)*
TTV 2	☐	☐	
TTV 3	☐	☐	☑ **No** *(NOT protected at birth)*
TTV 4	☐	☐	
TTV 5	☐	☐	

Part III. Family Planning Practice of Married Woman of Reproductive Age (MWRA) (Mother/Wife)

The following should not be interviewed for Part III:

☐ Widowed or separated women ☐ Menopausal women

☐ Women with ovaries and/or uterus and/or fallopian tubes surgically removed due to a medical condition (e.g. tumors, ectopic pregnancy)

1. Are you currently pregnant? *(See response to Part II A)*

- ☑ No/Unsure → **2. Do you want to have additional child/children?**
- ☐ Yes → Remind her again of the need of prenatal care and tetanus toxoid vaccination. **–END OF INTERVIEW–**

2. Do you want to have additional child/children?

- ☐ No → **3. Are you currently using any family planning method?**
- ☑ Yes, after 1 year → **3. Are you currently using any family planning method?**
- ☐ Yes, within 1 year → Inform her of the need of prenatal care when she gets pregnant and the available family planning services in the health center in case she changes her mind. **–END OF INTERVIEW–**

3. Are you currently using any family planning method?

- ☑ Yes → **4. Are you satisfied with the FP method you are using?**
- ☐ No → ***MWRA not wanting another child or wants to space but not practicing family planning*** She has an **UNMET NEED for family planning**. Inform her about family planning services and refer/accompany her to the midwife or to the health center. **–END OF INTERVIEW–**

4. Are you satisfied with the FP method you are using?

- ☑ Yes → **5. What method are you using?**
- ☐ No → ***MWRA practicing family planning but not satisfied with the method she is using*** She has an **UNMET NEED for family planning**. Refer or accompany her to the midwife or to the health center for counseling. **–Proceed to Question #5–**

5. What method are you using? **(✓) Check the appropriate box**

Modern Methods	Traditional Methods
☑ **P** = Pills	☐ **W** = Withdrawal
☐ **IUD** = Intrauterine Device	☐ **CAL**=Calendar / Rhythm
☐ **Inj** = DMPA / Injectable	
☐ **C** = Condom	
☐ **BTL** = Bilateral Tubal Ligation	
☐ **VAS** = Vasectomy	
☐ **NFP** = Natural Family Planning	
☐ **LAM** = Lactational Amenorrhea Method	

→ ***MWRA practicing family planning but using traditional methods*** Inform her of the benefits of using modern family planning methods. Refer or accompany her to the midwife or to the health center for counseling.

A mother may be classified as using LAM if all 3 of the following are true:

1. She has a baby less than six months old,
2. She is amenorrheic (not menstruating), and
3. She is breastfeeding the baby day and night without supplementation.

If any of the above no longer applies, refer her to the midwife for counseling.

Actions to be Taken

FAMILY PROFILE

CHMIS Revised Form as of 02/2001

FORM 1, page 1

General Information

Address: 321 Matapang St. Barangay Pinyahan
Respondent: Lita Natividad
Father: Carlito Natividad
Birthday: 10 / 12 / 1973 (mm/dd/yy) Age: 27
Mother: Lita Natividad
Birthday: 06 / 17/ 1974 (mm/dd/yy) Age: [redacted]
Civil Status: ( ) Single (✓) Married ( ) Widow ( ) Separated

BHS/BHC: Pinyahan BHS
RHU: Kalinga
Mun/City: San Nicolas
Province: Sulu

NOTE: Please use pencil in completing the forms to facilitate updating!

BHW: Mrs. Milagrosa Tatlonghari
RHM: Mrs. Nilda San Juan
PHN: Mrs. Tina Dela Cruz
Interviewer: Mrs. Milagrosa Tatlonghari
Date Surveyed: March 09, 2001
Date of last update: [redacted]

Part I. Data of children 0–4 years old (0–59 months old, start from the eldest)

Name	Birthday MM	Birthday DD	Birthday YY	Age	Where does the child receive vaccinations? B =BHS/BHC R =RHU/MHC P =Private G =Gov't Hosp (See "A" below)	Does the child have any vaccination record? Y = Yes N = No (See "B" below)	Vaccinations Received (For children 0–11 months old, write the date when vaccination was given) (For children 12–59 months old, put a Y if child was given vaccination or an N if not given) If the child 0–11months old has NO vaccination or the vaccination schedule is NOT followed, (See "C" below) If the child 1–4 years old has INCOMPLETE or NO vaccination, (See "D" below)								FIC (For children 9 months to 4 years old) Did the child receive all the preceding vaccinations before his first birthday? Y = Yes N = No	Vitamin A (For children 1–4 years old only) Was the child given vitamin A capsule (200,000 IU) during the past 6 months? (e.g. Garantisadong Pambata Activities) Y = Yes N = No (See "E" below)		Remarks
							BCG	DPT 1st dose	DPT 2nd dose	DPT 3rd dose	OPV 1st dose	OPV 2nd dose	OPV 3rd dose	Measles		April 2001 Year	October Year	
Macy	10	21	96	4 y	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	[redacted]		
Aaron	03	28	00	[redacted]	P	Y	03/28/00	05/01/00	06/10/00	07/15/00	05/01/00	06/10/00	07/15/00	12/28/00	Y	[redacted]		
Tiffany	[redacted]			[redacted]	[redacted]	[redacted]	[redacted]											

Actions to be taken

A. If the child receives vaccination services from private clinics/hospitals and government hospitals, followup the child's vaccinations until completed
B. Advise the mother to get a copy of the vaccination record from the health facility where the child received the vaccinations or ask the midwife of the nearest BHS to make another record.
C. Refer or accompany the mother and child to the midwife for ***Immediate vaccination***.
D. Advise the mother to consult the midwife for completion of the child's vaccinations.
E. Give vitamin A capsule at once if available or advise the mother to bring the child to the nearest health facility for the next scheduled vitamin A supplementation

Part II A. Tetanus Toxoid Vaccination (TTV) for Pregnant Women FORM 1, page 2

Is the mother/wife pregnant?	☐ Yes	☑ No	If the woman is pregnant, inform her of the importance of prenatal care and tetanus toxoid vaccinations that are available at the nearest health facility.
Total number of TTV doses received	5 Doses		

Part II B. Protection at Birth (PAB) against neonatal tetanus: For women with children 0–2 years old only

Name of youngest child (***0–2 years old only***): [redacted] Age of youngest child: [redacted]

Complete this table only if the age of the youngest living child is 0 to 2 years old (0–35 months old)

TTV Dose	When was each TTV dose received in reference to the youngest child? **Check the appropriate boxes**		Was the child protected at birth (PAB)? **Check the appropriate box** *PAB is defined as any of the following:* • 2 TTV doses during the pregnancy with the youngest child, or • 1 TTV dose during the pregnancy with the youngest child plus 2 doses prior to the pregnancy, or • 3 TTV doses prior to the pregnancy with the youngest child
	During the pregnancy with the youngest child	Prior to the pregnancy with the youngest child	
TTV 1	☐	☑	☑ **Yes** *(Protected at Birth)*
TTV 2	☐	☑	☐ **No** *(NOT protected at birth)*
TTV 3	☐	☑	
TTV 4	☐	☑	
TTV 5	[redacted]		

Part III. Family Planning Practice of Married Woman of Reproductive Age (MWRA) (Mother/Wife)

The following should not be interviewed for Part III:

☐ Widowed or separated women ☐ Menopausal women

☐ Women with ovaries and/or uterus and/or fallopian tubes surgically removed due to a medical condition (e.g. tumors, ectopic pregnancy)

Actions to be Taken

1. Are you currently pregnant? *(See response to Part II A)*

- [redacted] No/Unsure → **2. Do you want to have additional child/children?**
- ☐ Yes → Remind her again of the need of prenatal care and tetanus toxoid vaccination. **–END OF INTERVIEW–**

2. Do you want to have additional child/children?

- ☑ No → **3. Are you currently using any family planning method?**
- ☐ Yes, after 1 year → **3. Are you currently using any family planning method?**
- ☐ Yes, within 1 year → Inform her of the need of prenatal care when she gets pregnant and the available family planning services in the health center in case she changes her mind. **–END OF INTERVIEW–**

3. Are you currently using any family planning method?

- ☑ Yes → **4. Are you satisfied with the FP method you are using?**
- ☐ No → ***MWRA not wanting another child or wants to space but not practicing family planning*** She has an **UNMET NEED for family planning**. Inform her about family planning services and refer/accompany her to the midwife or to the health center. **–END OF INTERVIEW–**

4. Are you satisfied with the FP method you are using?

- ☐ Yes → **5. What method are you using?**
- ☑ No → ***MWRA practicing family planning but not satisfied with the method she is using*** She has an **UNMET NEED for family planning**. Refer or accompany her to the midwife or to the health center for counseling. **–Proceed to Question #5–**

5. What method are you using? (✓) **Check the appropriate box**

Modern Methods	Traditional Methods
☐ **P** = Pills	☐ **W** = Withdrawal
☐ **IUD** = Intrauterine Device	☐ **CAL**=Calendar / Rhythm
☐ **Inj** = DMPA / Injectable	
☐ **C** = Condom	
☐ **BTL** = Bilateral Tubal Ligation	
☐ **VAS** = Vasectomy	
☐ **NFP** = Natural Family Planning	
☑ **LAM** = Lactational Amenorrhea Method	

→ ***MWRA practicing family planning but using traditional methods*** Inform her of the benefits of using modern family planning methods. Refer or accompany her to the midwife or to the health center for counseling.

A mother may be classified as using LAM if all 3 of the following are true:
1. She has a baby less than six months old,
2. She is amenorrheic (not menstruating), and
3. She is breastfeeding the baby day and night without supplementation.

If any of the above no longer applies, refer her to the midwife for counseling.

FAMILY PROFILE

CBMIS Revised Form as of 02/2001

FORM 1, page 1

General Information

Address: #3 Kalayaan St. Barangay Pinyahan
Respondent: Lany Carlos
Father: Pedro Carlos
Birthday: 02 / 17 / 1975 (mm/dd/yy) Age: 26
Mother: Lany Carlos
Birthday: 03 / 13/ 1977 (mm/dd/yy) Age: 24
Civil Status: ( ) Single (✓) Married ( ) Widow ( ) Separated

BHS/BHC: Pinyahan HC
RHU: Kalinga
Mun/City: San Nicolas
Province: Sulu

NOTE: Please use pencil in completing the forms to facilitate updating!

BHW: Mrs. Milagrosa Tatlonghari
RHM: Mrs. Nilda San Juan
PHN: Mrs. Tina Dela Cruz
Interviewer: Mrs. Milagrosa Tatlonghari
Date Surveyed: June 22, 2001

Date of last update:

Part I. Data of children 0–4 years old (0–59 months old, start from the eldest)

Name	Birthday MM	Birthday DD	Birthday YY	Age	Where does the child receive vaccinations? B = BHS/BHC R = RHU/MHC P = Private G = Gov't Hosp *(See "A" below)*	Does the child have any vaccination record? Y = Yes N = No *(See "B" below)*	Vaccinations Received (*For children 0–11 months old*, write the date when vaccination was given) (*For children 12–59 months old*, put a Y if child was given vaccination or an N if not given) If the child 0–11months old has NO vaccination or the vaccination schedule is NOT followed, (*See "C" below*) If the child 1–4 years old has INCOMPLETE or NO vaccination, (*See "D" below*)								FIC (*For children 9 months to 4 years old*) Did the child receive all the preceding vaccinations before his first birthday? Y = Yes N = No	Vitamin A (*For children 1–4 years old only*) Was the child given vitamin A capsule (200,000 IU) during the past 6 months? (e.g Garantisadong Pambata Activities) Y = Yes N = No *(See "E" below)*		Remarks
							BCG	DPT 1st dose	DPT 2nd dose	DPT 3rd dose	OPV 1st dose	OPV 2nd dose	OPV 3rd dose	Measles		April 2001 Year	October 2001 Year	
Beatrice	02	21	97	4 y	B	N	Y	Y	Y	Y	Y	Y	Y	N	N	N		
Diego	12	15	98	2 y	B	N	Y	Y	Y	Y	Y	Y	Y	N	N	N		

Actions to be taken

A. If the child receives vaccination services from private clinics/hospitals and government hospitals, followup the child's vaccinations until completed.
B. Advise the mother to get a copy of the vaccination record from the health facility where the child received the vaccinations or ask the midwife of the nearest BHS to make another record.
C. Refer or accompany the mother and child to the midwife for ***immediate vaccination***.
D. Advise the mother to consult the midwife for completion of the child's vaccinations.
E. Give vitamin A capsule at once if available or advise the mother to bring the child to the nearest health facility for the next scheduled vitamin A supplementation.

Part II A. Tetanus Toxoid Vaccination (TTV) for Pregnant Women FORM 1, page 2

Is the mother/wife pregnant?	✓ Yes	☐ No	If the woman is pregnant, inform her of the importance of prenatal care and tetanus toxoid vaccinations that are available at the nearest health facility.
Total number of TTV doses received	1 Doses		

Part II B. Protection at Birth (PAB) against neonatal tetanus: For women with children 0–2 years old only

Name of youngest child (***0–2 years old only***): Diego Age of youngest child: 2 y/o

Complete this table only if the age of the youngest living child is 0 to 2 years old (0–35 months old)

TTV Dose	When was each TTV dose received in reference to the youngest child? **Check the appropriate boxes**		Was the child protected at birth (PAB)? **Check the appropriate box** *PAB is defined as any of the following:* • 2 TTV doses during the pregnancy with the youngest child, or • 1 TTV dose during the pregnancy with the youngest child plus 2 doses prior to the pregnancy, or • 3 TTV doses prior to the pregnancy with the youngest child
	During the pregnancy with the youngest child	Prior to the pregnancy with the youngest child	
TTV 1	✓		☐ **Yes** *(Protected at Birth)*
TTV 2			✓ **No** *(NOT protected at birth)*
TTV 3			
TTV 4			
TTV 5			

Part III. Family Planning Practice of Married Woman of Reproductive Age (MWRA) (Mother/Wife)

The following should not be interviewed for Part III:

☐ Widowed or separated women ☐ Menopausal women
☐ Women with ovaries and/or uterus and/or fallopian tubes surgically removed due to a medical condition (e.g. tumors, ectopic pregnancy)

1. Are you currently pregnant? *(See response to Part II A)*

- ☐ No/Unsure → **2. Do you want to have additional child/children?**
- ✓ Yes → **Actions to be Taken**: Remind her again of the need of prenatal care and tetanus toxoid vaccination. **–END OF INTERVIEW–**

2. Do you want to have additional child/children?

- ☐ No → **3. Are you currently using any family planning method?**
- ☐ Yes, after 1 year → **3. Are you currently using any family planning method?**
- ☐ Yes, within 1 year → Inform her of the need of prenatal care when she gets pregnant and the available family planning services in the health center in case she changes her mind. **–END OF INTERVIEW–**

3. Are you currently using any family planning method?

- ☐ Yes → **4. Are you satisfied with the FP method you are using?**
- ☐ No → ***MWRA not wanting another child or wants to space but not practicing family planning*** She has an **UNMET NEED for family planning**. Inform her about family planning services and refer/accompany her to the midwife or to the health center. **–END OF INTERVIEW–**

4. Are you satisfied with the FP method you are using?

- ☐ Yes → **5. What method are you using?**
- ☐ No → ***MWRA practicing family planning but not satisfied with the method she is using*** She has an **UNMET NEED for family planning**. Refer or accompany her to the midwife or to the health center for counseling. **–Proceed to Question #5–**

5. What method are you using? **(✓) Check the appropriate box**

Modern Methods	Traditional Methods
☐ **P** = Pills	☐ **W** = Withdrawal
☐ **IUD** = Intrauterine Device	☐ **CAL**=Calendar / Rhythm
☐ **Inj** = DMPA / Injectable	
☐ **C** = Condom	
☐ **BTL** = Bilateral Tubal Ligation	
☐ **VAS** = Vasectomy	
☐ **NFP** = Natural Family Planning	
☐ **LAM** = Lactational Amenorrhea Method	

→ ***MWRA practicing family planning but using traditional methods*** Inform her of the benefits of using modern family planning methods. Refer or accompany her to the midwife or to the health center for counseling.

A mother may be classified as using LAM if all 3 of the following are true:
1. She has a baby less than six months old,
2. She is amenorrheic (not menstruating), and
3. She is breastfeeding the baby day and night without supplementation.

If any of the above no longer applies, refer her to the midwife for counseling.

FAMILY PROFILE

CBMIS Revised Form as of 02/2001

FORM 1, page 1

General Information

Address: #3 Kalayaan St. Barangay Pinyahan
Respondent: Marichu Santos
Father: Alipio Santos
Birthday: 10 / 14 / 1968 (mm/dd/yy) Age: 32
Mother: Marichu Santos
Birthday: 06 / 24/ 1970 (mm/dd/yy) Age: 30
Civil Status: ( ) Single (✓) Married ( ) Widow ( ) Separated

BHS/BHC: Pinyahan HC
RHU: Kalinga
Mun/City: San Nicolas
Province: Sulu

NOTE: Please use pencil in completing the forms to facilitate updating!

BHW: Mrs. Milagrosa Tatlonghari
RHM: Mrs. Nilda San Juan
PHN: Mrs. Tina Dela Cruz
Interviewer: Mrs. Milagrosa Tatlonghari
Date Surveyed: June 22, 2001
Date of last update:

Part I. Data of children 0–4 years old (0–59 months old, start from the eldest)

Name	Birthday MM	Birthday DD	Birthday YY	Age	Where does the child receive vaccinations? B = BHS/BHC, R = RHU/MHC, P = Private, G = Gov't Hosp (See "A" below)	Does the child have any vaccination record? Y = Yes, N = No (See "B" below)	Vaccinations Received (For children 0–11 months old, write the date when vaccination was given) (For children 12–59 months old, put a Y if child was given vaccination or an N if not given) If the child 0–11 months old has NO vaccination or the vaccination schedule is NOT followed, (See "C" below) If the child 1–4 years old has INCOMPLETE or NO vaccination, (See "D" below): BCG	DPT 1st dose	DPT 2nd dose	DPT 3rd dose	OPV 1st dose	OPV 2nd dose	OPV 3rd dose	Measles	FIC (For children 9 months to 4 years old) Did the child receive all the preceding vaccinations before his first birthday? Y = Yes, N = No	Vitamin A (For children 1–4 years old only) Was the child given vitamin A capsule (200,000 IU) during the past 6 months? (e.g. Garantisadong Pambata Activities) Y = Yes, N = No (See "E" below): April 2001 Year	October 2001 Year	Remarks
Clarissa	01	16	99	2 y	B	N	Y	Y	Y	Y	Y	Y	Y	N	N	N		
Cecille	07	10	00	11 m	B	Y	07/20/00	09/06/00			09/06/00							

Actions to be taken

A. If the child receives vaccination services from private clinics/hospitals and government hospitals, followup the child's vaccinations until completed.
B. Advise the mother to get a copy of the vaccination record from the health facility where the child received the vaccinations or ask the midwife of the nearest BHS to make another record
C. Refer or accompany the mother and child to the midwife for ***immediate vaccination***.
D. Advise the mother to consult the midwife for completion of the child's vaccinations
E. Give vitamin A capsule at once if available or advise the mother to bring the child to the nearest health facility for the next scheduled vitamin A supplementation.

Part II A. Tetanus Toxoid Vaccination (TTV) for Pregnant Women **FORM 1, page 2**

Is the mother/wife pregnant?	✓ Yes	☐ No	If the woman is pregnant, inform her of the importance of prenatal care and tetanus toxoid vaccinations that are available at the nearest health facility.
Total number of TTV doses received	2 Doses		

Part II B. Protection at Birth (PAB) against neonatal tetanus: For women with children 0–2 years old only

Name of youngest child (***0–2 years old only***): ***Cecille*** Age of youngest child: **10 m**

Complete this table only if the age of the youngest living child is 0 to 2 years old (0–35 months old)

TTV Dose	When was each TTV dose received in reference to the youngest child? **Check the appropriate boxes**		Was the child protected at birth (PAB)? **Check the appropriate box** *PAB is defined as any of the following:* • 2 TTV doses during the pregnancy with the youngest child, or • 1 TTV dose during the pregnancy with the youngest child plus 2 doses prior to the pregnancy, or • 3 TTV doses prior to the pregnancy with the youngest child
	During the pregnancy with the youngest child	Prior to the pregnancy with the youngest child	
TTV 1		✓	☐ **Yes** *(Protected at Birth)*
TTV 2	✓		✓ **No** *(NOT protected at birth)*
TTV 3			
TTV 4			
TTV 5			

Part III. Family Planning Practice of Married Woman of Reproductive Age (MWRA) (Mother/Wife)

The following should not be interviewed for Part III:

☐ Widowed or separated women ☐ Menopausal women

☐ Women with ovaries and/or uterus and/or fallopian tubes surgically removed due to a medical condition (e.g. tumors, ectopic pregnancy)

1. Are you currently pregnant? *(See response to Part II A)*

- ☐ No/Unsure → **2. Do you want to have additional child/children?**
- ✓ Yes → **Actions to be Taken**: Remind her again of the need of prenatal care and tetanus toxoid vaccination. **–END OF INTERVIEW–**

2. Do you want to have additional child/children?

- ☐ No → **3. Are you currently using any family planning method?**
- ☐ Yes, after 1 year → **3. Are you currently using any family planning method?**
- ☐ Yes, within 1 year → Inform her of the need of prenatal care when she gets pregnant and the available family planning services in the health center in case she changes her mind. **–END OF INTERVIEW–**

3. Are you currently using any family planning method?

- ☐ Yes → **4. Are you satisfied with the FP method you are using?**
- ☐ No → ***MWRA not wanting another child or wants to space but not practicing family planning*** She has an **UNMET NEED for family planning**. Inform her about family planning services and refer/accompany her to the midwife or to the health center. **–END OF INTERVIEW–**

4. Are you satisfied with the FP method you are using?

- ☐ Yes → **5. What method are you using?**
- ☐ No → ***MWRA practicing family planning but not satisfied with the method she is using*** She has an **UNMET NEED for family planning**. Refer or accompany her to the midwife or to the health center for counseling. **–Proceed to Question #5–**

5. What method are you using? (✓) **Check the appropriate box**

Modern Methods	Traditional Methods
☐ **P** = Pills	☐ **W** = Withdrawal
☐ **IUD** = Intrauterine Device	☐ **CAL**=Calendar / Rhythm
☐ **Inj** = DMPA / Injectable	
☐ **C** = Condom	
☐ **BTL** = Bilateral Tubal Ligation	
☐ **VAS** = Vasectomy	
☐ **NFP** = Natural Family Planning	
☐ **LAM** = Lactational Amenorrhea Method	

→ ***MWRA practicing family planning but using traditional methods*** Inform her of the benefits of using modern family planning methods. Refer or accompany her to the midwife or to the health center for counseling.

A mother may be classified as using LAM if all 3 of the following are true:
1. She has a baby less than six months old,
2. She is amenorrheic (not menstrualing), and
3. She is breastfeeding the baby day and night without supplementation.

If any of the above no longer applies, refer her to the midwife for counseling.

Barangay CBMIS Tally Sheet Answer Key—Form 2

Barangay: Pinyahan
BHS/BHC: Pinyahan
Mun/City: San Nicolas

RHM: Mrs. Nilda San Juan
Date: June 22, 2001

Form 2, page 1

TARGET GROUPS Purok:	BHW 1	BHW 2	BHW 3	BHW 4	BHW 5	BHW 6	BHW 7	BHW 8	BHW 9	BHW 10	BHW 11	BHW 12	BHW 13	BHW 14	BHW 15	BHW 16	BHW 17	Total
IA. Vaccination status of children 0–11 months old																		
1. Children 9–11 months old with INCOMPLETE or NO vaccination at all	1	2	3	4	2													12
2. Children 0–8 months old with NO vaccination or with recommended vaccination schedule NOT followed	0	2	1	2	4													9
3. Children 0–8 months old with recommended vaccination schedule followed	3	2	3	3	4													15
4. Children 9–11 months old who are Fully Immunized Children (FIC)	2	3	2	4	5													16
TOTAL number of children 0–11 months old (sum of # 1, 2, 3 & 4)	6	9	9	13	15													52
IB. Vaccination status of 1 year old children (12–23 months)																		
5. Children 1 year old (12–23 months) with INCOMPLETE or NO vaccination at all	0	4	4	3	2													13
6. Children 1 year old (12–23 months) who are Fully Immunized Children (FIC)	2	3	3	2	2													12
TOTAL number of 1 year old children (12–23 months) (sum of # 5 & 6)	2	7	7	5	4													25
IC. Vitamin A supplementation status of children 1–4 years old (12–59 months)																		
7. Children 1–4 years old (12–59 months) NOT given Vitamin A capsule during the past six months	3	4	3	2	2													14
8. Children 1–4 years old (12–59 months) GIVEN Vitamin A capsule during the past six months	9	7	8	7	9													40
TOTAL number of children 1–4 years old (12–59 months old) (sum of # 7 & 8)	12	11	11	9	11													54
II A. Tetanus Toxoid Vaccination Status of pregnant mother/wife																		
9. Pregnant with NO TT or with TT1 only	1	0	1	2	2													6
10. Pregnant with TT2 +	1	1	2	3	3													10
TOTAL number of pregnant mother/wife (sum of # (9 & 10)	2	1	3	5	5													16

Form 2, page 2

TARGET GROUPS Purok:	BHW 1	BHW 2	BHW 3	BHW 4	BHW 5	BHW 6	BHW 7	BHW 8	BHW 9	BHW 10	BHW 11	BHW 12	BHW 13	BHW 14	BHW 15	BHW 16	BHW 17	Total
II B. Protection at Birth																		
11. Children Protected at Birth	3	6	9	5	14													37
12. Children Not Protected at Birth	4	4	3	10	3													24
Sum of # 11 & 12	7	10	12	15	17													61
III. Family Planning and Nonpregnant Married Women of Reproductive Age (MWRA)																		
13. MWRA not wanting to have a child or wants to space but NOT practicing family planning	0	2	3	1	2													8
14. MWRA practicing family planning but NOT satisfied with the method she is using	1	2	1	1	2													7
15. MWRA wanting a child within 1 year	0	3	2	4	2													11
16. MWRA practicing family planning and satisfied with the method she is using	4	5	7	4	7													27
TOTAL number of nonpregnant MWRA (sum of # 13, 14, 15 & 16)	5	12	13	10	13													53
FP Methods Used by Current Users																		
P Pills	3	2	2	2	3													12
IUD Intrauterine Device	0	1	1	1	1													4
INJ DMPA / Injectable	0	1	1	1	2													5
C Condom	0	1	0	1	0													2
BTL Bilateral Tubal Ligation	1	1	0	0	0													2
VAS Vasectomy	0	0	0	0	0													0
NFP Natural Family Planning	0	0	1	0	1													2
LAM Lactational Amenorrhea Method	1	0	1	0	1													3
W Withdrawal	0	0	1	0	1													2
C Calendar	0	1	1	0	0													2
TOTAL FP Methods Used by Current Users *(should equal the sum of # 14 & 16)	5	7	8	5	9													34

Catchment Area CBMIS Tally Sheet Answer Key—Form 3

BHS/BHC: **Pinyahan**
Mun/City: **San Nicolas**

RHM: **Mrs. Nilda San Juan**
Date: **June 22, 2001**

Form 3, page 1

TARGET GROUPS	Barangay Pinyahan		Barangay Ibayo		Barangay		Barangay		Barangay		Total	
IA. Vaccination status of children 0–11 months old	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)
1. Children 9–11 months old with INCOMPLETE or NO vaccination at all	12	23%	7	17%							19	20%
2. Children 0–8 months old with NO vaccination or with recommended vaccination schedule NOT followed	9	17%	16	38%							25	27%
3. Children 0–8 months old with recommended vaccination schedule followed	15	29%	14	33%							29	31%
4. Children 9–11 months old who are Fully Immunized Children (FIC)	16	31%	5	12%							21	22%
TOTAL number of children 0–11 months old (sum of # 1, 2, 3 & 4)	52	100%	42	100%							94	100%
IB. Vaccination status of 1 year old children (12–23 months)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)
5. Children 1 year old (12–23 months) with INCOMPLETE or NO vaccination at all	13	52%	14	48%							27	50%
6. Children 1 year old (12–23 months) who are Fully Immunized Children (FIC)	12	48%	15	52%							27	50%
TOTAL number of 1 year old children (12–23 months) (sum of # 5 & 6)	25	100%	29	100%							54	100%
IC. Vitamin A supplementation status of children 1–4 years old (12–59 months)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)
7. Children 1–4 years old (12–59 months) NOT given Vitamin A capsule during the past six months	14	26%	15	38%							29	31%
8. Children 1–4 years old (12–59 months) GIVEN Vitamin A capsule during the past six months	40	74%	24	62%							64	69%
TOTAL number of children 1–4 years old (12–59 months old) (sum of # 7 & 8)	54	100%	39	100%							93	100%
II A. Tetanus Toxoid Vaccination Status of pregnant mother/wife	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)	Number (N)	Percent (N÷Total×100)
9. Pregnant with NO TT or with TT1 only	6	38%	9	43%							15	41%
10. Pregnant with TT2 +	10	63%	12	57%							22	59%
TOTAL number of pregnant mother/wife (sum of # (9 & 10)	16	100%	21	100%							37	100%

Form 3, page 2

TARGET GROUPS	Barangay Pinyahan		Barangay Ibayo		Barangay		Barangay		Barangay		Total	
II B. Protection at Birth	Number (N)	Percent (N+Totalx100)	Number (N)	Percent (N+Totalx100)	Number (N)	Percent (N+Totalx100)	Number (N)	Percent (N+Totalx100)	Number (N)	Percent (N+Totalx100)	Number (N)	Percent (N+Totalx100)
11. Children Protected at Birth	37	61%	32	65%							69	63%
12. Children Not Protected at Birth	24	39%	17	35%							41	37%
Sum of # 11 & 12	61	100%	49	100%							110	100%
III. Family Planning and Nonpregnant Married Women of Reproductive Age (MWRA)	Number (N)	Percent (N+Totalx100)	Number (N)	Percent (N+Totalx100)	Number (N)	Percent (N+Totalx100)	Number (N)	Percent (N+Totalx100)	Number (N)	Percent (N+Totalx100)	Number (N)	Percent (N+Totalx100)
13. MWRA not wanting to have a child or wants to space but NOT practicing family planning	8	15%	9	27%							17	20%
14. MWRA practicing family planning but NOT satisfied with the method she is using	7	13%	4	12%							11	13%
15. MWRA wanting a child within 1 year	11	21%	8	24%							19	22%
16. MWRA practicing family planning and satisfied with the method she is using	27	51%	12	36%							39	45%
TOTAL number of nonpregnant MWRA (sum of # 13, 14, 15 & 16)	53	100%	33	100%							86	100%
FP Methods Used by Current Users												
P Pills	12	35%	3	19%							15	30%
IUD Intrauterine Device	4	12%	2	13%							6	12%
INJ DMPA / Injectable	5	15%	5	31%							10	20%
C Condom	2	6%	3	19%							5	10%
BTL Bilateral Tubal Ligation	2	6%	1	6%							3	6%
VAS Vasectomy	0	0%	0	0%							0	0%
NFP Natural Family Planning	2	6%	0	0%							2	4%
LAM Lactational Amenorrhea Method	3	9%	1	6%							4	8%
W Withdrawal	2	6%	1	6%							3	6%
C Calendar	2	6%	0	0%							2	4%
TOTAL FP Methods Used by Current Users *(should equal the sum of # 14 & 16)	34	100%	16	100%							50	100%

Facilitator's Notes

Session 10: Health Facility Assessment

Overview

This session provides participants with an overview of the DOH's Sentrong Sigla certification program and practical experience in assessing a facility using the self-assessment checklist based on Sentrong Sigla quality standards. They also gain experience in using a summary table to summarize a facility's deficiencies and areas for improvement.

Duration

3 hours, 45 minutes

Timing

15 minutes	Briefing
45 minutes	Prepare for assessment
2 hours	Field practicum: Health facility assessment
45 minutes	Plenary presentation

Planning Notes

It is imperative for the facilitation team to prepare the logistics for this session well in advance.

1. The primary planning task is to coordinate with health staff in charge of the area where the field practicum will take place. Consult with them regarding the:
   - selection of relatively accessible areas where teams can carry out facility assessments;
   - availability of a sufficient number of BHWs and RHU staff to accompany the teams;
   - timing of the field practicum, with the goal of ensuring access to the selected facilities.
2. In addition, arrange for:
   - a sufficient number of vehicles to transport the teams to and from the designated areas;
   - snacks for all participants;
   - pick-up points where participants will assemble for their return trip to the workshop venue.

3. Another important planning task is to group the participants and assign each team to one of two types of facilities: a barangay health station and a rural health unit/health center. Be sure to group rural health unit/health center participants together and assign them to assess an rural health unit/health center. Also, group barangay health station participants together and assign them to assess a barangay health station. Any CHD or Provincial Health Office staff members participating in the session should join a team for the assessment, but advise them to allow the participants to take the lead role.

4. In addition, print two copies of the CAST template on acetate, for two teams to present in plenary, using an overhead projector.

Facilitation Notes

All aspects of the field experience—from planning for the field practicum to carrying out the assessments—provide important lessons for team members.

1. In opening this session, give a plenary briefing that includes the following points.
   - Remind the participants about the importance of evaluating their facilities' preparedness to respond to unmet needs identified by the CBMIS as well as their level of preparedness for Sentrong Sigla certification.
   - Present the session's objectives and underscore the importance of meeting all the minimum standards for certification as an Sentrong Sigla facility. Be very candid in explaining how to conduct a self-assessment. Make sure the participants understand that they must treat each item in the Facility Self-Assessment Checklist (FSAC) with the respect it deserves, as the assessment data will have an impact on the interventions planned.
   - Present the materials that the participants will use during the session. Ask them to make sure that they have all the materials listed in their session guide. They should have two types of Quality Standards Lists—one for an rural health unit and another for a barangay health station—and two corresponding FSACs. Make sure that the teams understand that they will only use the Quality Standards List and accompanying FSAC for the type of facility they will be assessing. Suggest that they keep the Quality Standards List and FSAC for the other type of facility for their reference.
   - Share the team assignments and the name and location of the facility assigned to each team. If vehicles are available, tell each team their vehicle assignment.
   - Let the participants know that two teams will be selected to present their field practicum experience in plenary, although all teams will be required to submit their FSAC and Causal Analysis Summary Table (CAST) forms to the facilitation team.
   - Explain how to complete columns A–D of the CAST. Explain also that these are the only columns the participants will need to complete during this session.
   - Advise the team to get back to the venue as soon as they are finished and work on filling out columns A–D of their CAST.

2. When the teams have returned to the workshop venue and completed their CAST, visit each team and briefly review its FSAC. Point out any possible errors, inconsistencies, or vague entries in the FSAC.

3. Choose two teams to present in plenary and ask them to fill out forms on acetate for use with an overhead projector. If they have made changes based on your suggestions, ask the group to use a different color pen to highlight the changes.

4. In plenary, one team will present its partially completed CAST for an rural health unit/ health center; another, its CAST for a barangay health center. Allow an average of 20-25 minutes for each presentation, including questions and answers. Promote discussion by encouraging the participants to raise questions and issues regarding the presentation and the process of carrying out facility assessments and filling out the CAST. The person doing the presenting should remain standing to answer questions raised by the other groups.

5. Remind the participants that the goal of this exercise is to prepare them for doing assessments of their own facilities, and that now they should be able to identify all deficiencies, problems, or areas for improvement accurately.

6. In closing this session, collect the FSAC and CAST for each facility assessed. Give these forms to the relevant facilities, for their use in reviewing their compliance with Sentrong Sigla quality standards.

Facilitator's Notes

Session 11: Planning for the Community Survey and Facility Assessment

Overview

During this session, the participants prepare their initial community survey and facility assessments. They create a prioritized list of the barangays where they will implement community surveys and facility assessments. They develop a work and financial plan and present it in plenary to their workshop colleagues and a panel of CHD staff, who must approve the plans. An important facilitator's task in this session is to guide each team in formulating an objective for its initial community survey and facility assessment effort. The final activity in this session involves getting agreement from all participants on target dates for the Phase II training workshop.

Duration

about 4 hours, 30 minutes

Timing

15 minutes	Briefing
1.5 hours	Prepare plans for the survey and assessment and prepare visual aids for the plenary presentation
30 minutes	Practice plenary presentations and revise
2 hours	Present LGU plans in plenary
15 minutes	Set target dates for Phase II training workshop

Planning Notes

Preparing for this session ahead of time will improve the review process, strengthen team learning, and help the session stay on schedule.

1. Before the session, ask the CHD staff to create a panel to review and approve the work and financial plans that the teams will present in plenary. The panel members must actively critique the plans before approving them. These suggestions will benefit all of the workshop's participants.

2. Prepare a schedule for the plenary session, which should include a brief introduction of team members by each LGU and a 15-minute open forum for questions and answers from the participants, facilitators, and CHD panel.

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Facilitation Notes

Encourage the participants to raise questions in their groups and in plenary regarding the process of developing a work and financial plan for their community survey and facility assessment. Remind them to refer to the Instruction Sheets if they have questions.

1. Ask the teams to start the process of prioritizing barangays for community surveys and facility assessments by reading the "Criteria for Selecting Priority Barangays." Ask them to create a complete list of all the barangays in their catchment area. Refer them to the "List of Prioritized Barangays" tool. Remind them that they must list the barangays in descending order of priority, with the most important barangay first.

2. Advise the teams to base their selection of barangays on three things: their prioritized list, the available funding, and the amount of time between workshops. They will use the MGP Work and Financial Plan template in preparing their plans. Remind the teams that they should in future carry out community surveys and facility assessments in all barangays in their catchment area, but that for this initial effort they are selecting only a few, due to the short amount of time available between workshops.

3. Each team should create a work and financial plan for carrying out community surveys and facility assessments in their prioritized barangays. Remind them that they will be presenting these plans in plenary, and that they will be subject to approval by a panel of CHD staff participating in the plenary. Carefully explain the format for the work and financial plan. Make sure all participants understand the terminology used in the form.

4. Explain each column on the form and answer any questions. Do not proceed until you are sure that the teams understand the format and the information they must write down in the form. In explaining the form, be sure to discuss the following:
   - **Expected Products.** For example, if the team identifies "train the participating BHWs in filling out Family Profiles" as one of its activities, then the expected product would be "BHWs prepared to interview families and correctly fill out Family Profiles in their barangays."
   - **Person(s) Responsible.** The team must identify the person(s) responsible for carrying out and coordinating the activity. In this column, write down their names. Several team members may carry out some activities, but one member must oversee the activity, make sure that it is completed, and ensure that the products are developed as expected.
   - **Timeframe.** The timeframe in which the activity must be carried out includes the activity's start date and completion date. The team must strike a balance between allowing too short a time, which could lead to failure to complete the activity, and too long a time, which could cause the team to lose interest or work inefficiently.
   - **Resources.** Examples of resources include people, logistics, supplies, facilities (such as a barangay hall), a vehicle, or anything else needed to carry out the activity.
   - **Source of Funds.** This column should specify the estimated cost for this activity as well as the source of funding. For example, if a team estimates it will spend PhP 10,000.00 to reproduce the forms and identifies the LGU as the source of these funds, then the team should write PhP10,000.00 in the LGU column.

5. Each team must finalize its plan and prepare supporting materials (acetate copy) for its presentation. Advise the teams to have a hard copy of their plans ready for writing down notes or suggestions from the audience and the CHD panel when the teams present their plans in plenary.

6. Set a rehearsal schedule and follow it strictly. If a team needs to revise its plan before presenting it in plenary, suggest it make the corrections right away and present the improved plan in plenary.

7. The CHD panel should identify activities that the CHD can do for all LGUs to facilitate implementation of the community survey and facility assessments. Examples of CHD support include printing forms for the LGUs, providing logistics, and providing technical assistance in training LGU health staff. Make sure that all teams hear the panel's recommendations for each plan, as its comments are often a good learning experience for all.

8. While one member of the team is presenting the plan, another team member should be assigned to write down comments and suggestions from the CHD panel. These amendments must be considered for implementation.

9. To close this session, the group must agree on a date for the Phase II training workshop. In setting the date, the group must consider the following:
   - Phase I participants must also attend the Phase II training workshop. It is not appropriate to substitute other staff.
   - The initial community survey and facility assessments must be completed before the Phase II training workshop begins. The reports that must be ready before the Phase II training workshop starts include the Form 3 and columns A–D of a CAST.
   - The time allowed between training workshops should not exceed eight weeks.

Phase II: Data Analysis and Intervention Planning

Session Guidelines

During Phase II, the LGU teams prepare their development strategy and work plan for rapidly increasing coverage rates for immunization, family planning, and vitamin A supplementation and to make the service improvements necessary for Sentrong Sigla certification.

This section contains guidelines and supporting materials for ten sessions:

1. Opening Program
2. Survey and Facility Data
3. The Health Facility Situation
4. The Health Map
5. The Problem
6. Objectives and Targets
7. Ideas for Improvement
8. The LGU Plan

8a. The Regional/Provincial Monitoring Plan

9. Presentation of the LGU Plan

Session 1: Opening Program

Overview

During this session, the participants learn about the workshop's objectives. The participants receive a workshop syllabus and information about the program's working methods and the learning-by-doing approach. They discuss the workshop schedule, the house rules, and any administrative concerns.

Objectives

By the end of the session, all LGU teams will:

- understand the workshop objectives and methods of work;
- understand the roles and responsibilities of various health offices (for example, CHD, Provincial Health Office, and Local Health Office) involved in implementing the MGP;
- be aware of various sources and uses of resources for implementing the MGP;
- be familiar with the workshop syllabus, session guides, and background materials;
- know the session schedules and house rules;
- feel challenged by the CHD to produce a sound plan of work and budget that will convince the mayor and other decision-makers to provide the support requested.

Materials

The materials for this session are:

- Workshop Objectives
- Gantt Chart: MGP Training Workshops and Fieldwork
- Schedule: MGP Phase II Training Workshop
- Phase II: Session Title, Objectives, and Products
- The Learning-by-Doing Process
- Method of Work
- House Rules

Program

The program for today's session is listed below.

Opening

- Invocation
- National Anthem
- Welcome Address
- Roles and Responsibilities of Stakeholders

Workshop Objectives

Workshop Methodology

Workshop Schedule

House Rules

Workshop Objectives

By the end of the Phase II MGP Planning Workshop, all LGU teams will have prepared:

1. a health development strategy and plan to rapidly increase coverage rates for immunization, family planning, and vitamin A supplementation, and to make the health facility and service improvements necessary to achieve Sentrong Sigla certification. In particular, the teams should have:
   - defined their health problems, service performance problems, and underlying difficulties;
   - set health improvement objectives and service performance targets;
   - identified creative solutions to addressing their identified problems and achieving Sentrong Sigla certification.

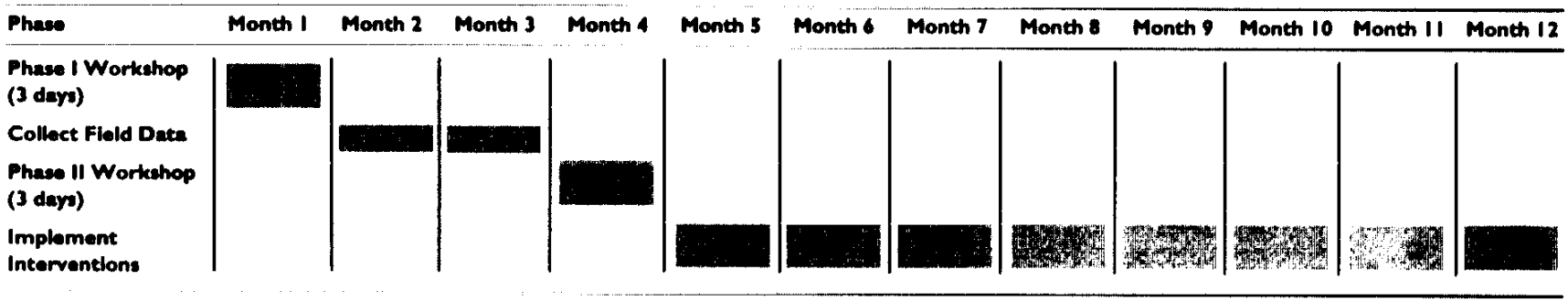
2. a work plan and budget for implementing their strategic interventions to reduce service delivery problems and health facility deficiencies. The teams will present their plans to a panel of decision-makers. They will also be prepared to to submit periodic reports showing progress towards reducing unmet needs, increasing program coverage, and addressing service difficulties.

By the end of the Phase II training workshop, regional and provincial decision-makers will have:

1. developed and defined a plan that will monitor each LGU's MGP interventions, service delivery improvement activities, CBMIS activities, Sentrong Sigla certification, and allocation and use of funding;
2. provided feedback on LGU team work plans and budgets and confirmed commitment to the plans.

Gantt Chart: MGP Training Workshops and Field Work

The Opening Program (Session 1) marks the beginning of the Phase II Training Workshop, which takes place in Month 4. Upon completing the workshop, the teams will return to their LGUs and implement their MGP interventions, which will take place over approximately eight months, beginning in Month 5.



Schedule: MGP Phase II Training Workshop

	Day 1	Day 2	Day 3
8:00am–12:00 noon	Session 1: Opening Program Session 2: Survey and Facility Data	Session 5: The Problem	Session 8: The LGU Plan
12:00 – 1:00	Break	Break	Break
1:00-5:00 pm	Session 3: The Health Facility Situation Session 4: Health Map	Session 6: Objectives and Targets Session 7: Ideas for Improvement	Session 9: Presentation of the LGU Plan

Phase II Session Titles, Objectives, and Products

Session	Session Title and Objectives	Main Products of Each Session
1	**Opening Program** Understand the workshop objectives, syllabus, process, and materials Understand responsibility for producing a sound MGP implementation plan Be aware of various sources and uses of resources for implementing the MGP Feel challenged by the CHD to produce a sound plan of work and budget	Participants' understanding of the workshop objectives, design, and method of work, as well as the responsibilities of various offices and levels to plan for, implement, and monitor interventions to increase coverage rates and make service improvements
2	**Survey and Facility Data** Discuss experiences during the CBMIS roll-out, survey, and health facility assessment Present community survey results (CBMIS Form 3) and facility assessment	A CBMIS Form 3 A partially completed Causal Analysis Summary Table (CAST)
3	**The Health Facility Situation** Complete analysis of facility deficiencies and their causes	A completely and correctly filled out Consolidation of CASTs Table
4	**The Health Map** Analyze CBMIS survey data from a geographic perspective Identify and map priority areas according to level of unmet needs, poor access, underserved populations, and facility deficiencies Create a list of priority barangays	Health map showing areas with unmet needs, poor access, underserved populations, and facilities with deficiencies Table of Unmet Needs, by MGP-Targeted Service Population Table Table of Priority Areas
5	**The Problem** Identify service performance problems, related health problems, and underlying difficulties Define indicators for measuring these problems, and quantify the indicators where data are available	A completely filled out Health Problem Table, with problem definitions and indicators
6	**Objectives and Targets** Taking into account national health objectives, produce a statement of objectives and targets that expresses the desired improvements in health and service performance, and the desired improvement in or reduction of difficulties	A completely filled out LGU Objectives and Targets Table
7	**Ideas for Improvement** Generate ideas for strategic interventions Select the interventions that the team feels are most feasible and will be most effective at improving health and service performance Write brief narratives that describe the selected strategic interventions	A List of Strategic Interventions A table of Selected Interventions and Their Narrative Descriptions
8	**The LGU Plan** Prepare an MGP Activity Plan that lists the strategies, activities, products, person(s) responsible, resources needed, and sources, as well as the timeframe for each intervention	An MGP Activity Plan
8a	**The Regional/Provincial Monitoring Plan** Develop and define a monitoring plan for each LGU's MGP interventions, CBMIS activities, Sentrong Sigla certification, and allocation and utilization of funding Develop a monitoring checklist Define the MGP monitoring and support responsibilities of the relevant CHD and Provincial Health Office	A Regional/Provincial Monitoring Plan A Monitoring Checklist
9	**Presentation of the LGU Plan** Each LGU presents its MGP Activity Plan to a panel of decision-makers The decision-maker panel provides feedback about the plans and a commitment of support The CHD-MGP team presents its Monitoring Plan	Feedback from decision-makers to be incorporated into the teams' MGP Activity Plans for service performance improvement and Sentrong Sigla certification

The Learning-by-Doing Process

The learning-by-doing process of the MGP planning workshops is a proven method of group learning that improves the reach of services and their quality. The MGP learning-by-doing process is based on a decentralized program methodology developed and applied to health program planning for more than 35 years. WHO has successfully used the approach presented in this guide for health sector planning and programming, national health and intersectoral development project planning, and district-level problem-solving. It has also been used for special applications, such as the design of the municipal-level disease surveillance system supported by PMTAT in the Philippines.

Principles

Five principles underlie this effective team-learning method:

- The implementation of change is most successful when the people responsible for providing and managing services are also responsible for planning and implementing changes designed to improve service coverage and quality.
- Team learning-by-doing creates a sense of team spirit that sustains teams' efforts to implement their plan, meet and overcome obstacles, and make health service adjustments and improvements.
- A planning process that uses learning-by-doing engages the participants and results in deeper learning of practical methods. In this workshop, the participants learn by doing as they:
  - collect and present data
  - analyze and define problems
  - set objectives and targets
  - generate and select ideas
  - design interventions
  - plan implementation
  - prepare and present proposals
  - implement interventions
- Involving individuals from all levels of the health system in the learning-by-doing process helps to clarify roles and relationships among the various levels and enhances cooperation and support for successful implementation.
- Learning is enhanced when the data, strategies, and plans produced during the training sessions become actual planning and monitoring documents that the teams continue to use and update throughout the year. For example, the teams will be more likely to apply MGP methods in the future because they use their MGP problem indicators, objectives, and targets to monitor and evaluate their efforts throughout implementation.

Prerequisites for Success

There are a number of basic requirements, or prerequisites, that must be met for the MGP's learning-by-doing approach to be successful. Making sure these are fulfilled is the responsibility of the MGP managers at the regional, provincial, and district levels. These prerequisites include ensuring that:

- LGU team members represent all levels and perspectives of the health service delivery system;
- LGU teams recognize and accept responsibility for designing a sound set of interventions and for implementing these interventions within the planned time with the available resources. The teams must feel accountable for the successful implementation of their plan and for the resulting service performance improvements;
- the teams recognize that they play an important role in the functioning of the national health system, in meeting national health objectives, and in meeting the service needs of the families in their communities;
- each session results in products that the teams use in the following sessions. These products become part of the intervention implementation plan;
- the facilitators make as few suggestions to the teams as possible. Directions or ideas provided by the facilitators could prevent the teams from generating their own ideas and thereby reduce their ownership of the resulting plan;
- the sessions stay within the planned timeframe, with products completed during the sessions or in the evening. Adhering to a strict schedule ensures that the teams learn how to work together under pressure, increases the team's efficiency, allows the training to move ahead, on schedule, and simulates real-life implementation;
- all team members have an equal opportunity to contribute ideas and help develop session products. For example, the facilitators should make sure that the responsibility for facilitating team discussions, managing team tasks, and leading presentations is shared by all team members. The facilitator must ensure that the team listens to and considers the ideas of all its members equally and does not cater to long-standing hierarchical relationships among staff.

Outputs and Results

The MGP learning-by-doing process results in:

- LGU team intervention plans that will actually be implemented;
- improved capacity by team members to apply these methods to other planning tasks;
- new LGU staff competencies in data analysis, intervention design, and activity planning;
- new ideas and strategies for mobilizing resources and political and community support for service improvement;
- enhanced respect for the planning capabilities of LGU staff and managers.

Method of Work

Session Guidelines

Each session guideline has the same format, with the following sections:

- Title
- Overview
- Objectives
- Materials
- Tasks
- Products

Method of Work

Most sessions follow a standard method of work, which includes a plenary briefing, group work, and—sometimes—plenary presentations.

A Plenary Briefing

To open each session, the facilitator leads a plenary briefing, lasting no longer than 10 to 15 minutes, to explain the session **objectives**, the **materials** to be used, the **tasks** to be accomplished, and the expected **products**. S/he shares examples of the forms to be used during the session and the expected products. Copies of all forms and products are included with the materials provided for each session. The facilitator will not lecture on the tasks and processes for the session but will define and illustrate important terms.

Group Work

Following the briefing, the teams accomplish their assigned tasks and products. Between two and three hours of the session are devoted to active team learning-by-doing. The facilitator provides little outside support as the teams review data, organize their work, discuss, reach consensus, and prepare their products. Facilitators are available to provide definitions and answer procedural questions, but they will not suggest ideas or solutions to the tasks. The session's products are to be completed by the end of the time allowed for group work. If the team does not complete its products during the session, the team members will be expected to work in the evening in order to complete the products before the next day.

Plenary Presentations

The teams will close some sessions by presenting their products in plenary. These presentations allow the teams to share ideas and provide an opportunity for the facilitators to give feedback and guidance. The time allowed for these presentations is short—usually only 15 or 20 minutes per presentation.

House Rules

- The schedule of sessions and time allowed for tasks and presentations will be strictly adhered to. Manage your time well.
- The use of local dialects is encouraged.
- The participation of all team members is required and must be assured by the Municipal Health Officer or City Health Officer. The team should rotate among its members such tasks as recording discussions and leading presentations, so that all members have an opportunity to do all tasks.
- Please turn all cell phones off during the sessions.
- All participants are to arrive on time and stay in the sessions until their completion.

Session 2: Survey and Facility Data

Overview

During this session, the teams start to discuss their experiences in implementing the community survey and facility assessment. For example, they should discuss how they managed the BHW training and what they did to ensure the quality of the data gathered. The team is expected to complete columns A and B of the Causal Analysis Summary Table (CAST) for every facility assessed, bring the table to the session, and share it in plenary.

Objective

By the end of the session, the participating LGU teams will have:

- presented the results of their initial CBMIS barangay survey and health facility assessment.

Materials

The materials for this session are:

- Questions for Session 2: Presenting CBMIS Data and Facility Assessment
- Session 2 Presentation Matrix
- completed copies of Form 3 (CBMIS Tally Sheet) for all priority barangays
- completed copies of Facility Self-Assessment Checklists (FSACs) for facilities serving the priority barangays
- CAST (sample)

Tasks

The tasks for this session are listed below.

1. Discuss your experiences during the CBMIS survey and health facility assessment. Using the questions and presentation matrix provided, prepare to present your experiences in plenary.

2. Transfer your CBMIS Form 3 data and partially filled out CASTs to transparencies.

3. Participate in a plenary session in which each team presents its experiences and data (Form 3 and CASTs).

Products

By the end of this session, each team will have presented its:

- Form 3
- partially completed CASTs (Columns A and B)

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Questions for Session 2: Presenting CBMIS Data and Facility Assessment

1. What went well?
2. What went wrong?
3. What did you do to address or solve your challenges?
4. What is the total population of the municipality or city?
5. How many barangays does the LGU have?
6. How many barangays have you prioritized?
7. How many barangays have you surveyed?
8. How many BHWs does the municipality or city have, and what is the BHW to barangay ratio?
9. How many BHWs did you train in CBMIS?
10. How many BHWs did the survey?
11. How did you train your BHWs?
12. How many households are there in the barangay and how are they distributed within the barangay?
13. How many households were surveyed?
14. What were the dates and duration of the survey?

Session 2: Presentation Matrix

LGU: _____
Total population: _____
Total number of barangays: _____
Total number of barangays prioritized: _____
Total number of barangays surveyed: _____

Name of Barangay*	No. of Households	No. of BHWs	No. of BHWs Trained in CBMIS	No. of BHWs Who Did the Survey	No. of Households Surveyed
Total					

* for priority barangays

Causal Analysis Summary Table (CAST)

Name of Facility: San Juan RHU
LGU: San Juan, La Union
Date Assessed by Staff: Sept. 6, 2001

Category (A)	**Deficiency, Problem, or Area of Improvement** Corresponds to "Xs" or circled "Nos" in the FSAC (B)	**Classification** Put a ✓ under the column which classifies the item in Column B		**Causes** (E)
		Related to FIC, TT, FP and/or VAC* (C)	Related to other programs (D)	
Infrastructure	Limited number of chairs/benches for patients in all waiting and service provision areas	✓	✓	
	Treatment/examination room has no visual and auditory privacy	✓	✓	
Health Service: Immunization	Daily temperature-monitoring chart neither posted nor updated	✓		
Health Service: Acute Respiratory Infection in Children	Cotrimoxazole out of stock		✓	
Health Service: Nutrition	No copy of Guidelines for Micronutrient Supplementation	✓		
Human Resources	No sanitary inspector		✓	
	No staff trained in gender sensitivity training	✓	✓	
Equipment	No speculums	✓		

* FIC = fully immunized child, TT = tetanus toxoid, FP = family planning, VAC = vitamin A deficiency

Session 3: The Health Facility Situation

Overview

In this session, the teams review the deficiencies, problems, and/or areas for improvement for all the facilities they assessed, determine the extent of each problem, and begin to explore its causes. In addition, they classify the deficiencies, problems, and areas for improvement related to the four services targeted by the MGP and to Sentrong Sigla certifications and begin to set priorities for future interventions.

Objectives

By the end of the session, the participating LGU teams will have:

- completed their analysis of the facility deficiencies and their causes
- confirmed which are of priority concern for early resolution

Materials

The materials for this session are:

- a completed FSAC for every facility serving priority barangays
- a partially completed CAST (Columns A and B) for every facility serving priority barangays
- a Consolidation of CASTs (sample)
- a Consolidation of CASTs (template)

Tasks

The tasks for this session are listed below.

1. Review all CASTs and cross out any deficiency, problem, or area for improvement that has already been addressed or acted upon by the team.

2. Using the Consolidation of CASTs, summarize all CAST data by category, by deficiency, by number of facilities with deficiencies, and by classification.

3. Classify each deficiency, problem, or area for improvement by putting a check in the appropriate column. If it is related to Expanded Programme on Immunization, family planning, and vitamin A supplementation, put a check in Column D. If it is related to other programs, put a check in Column E.

4. Discuss and identify the possible cause(s) for each deficiency, problem, and area for improvement listed in Column B in each facility by asking "Why is this so?" As a group, reach consensus on the cause, and write it in Column F.

5. Participate in a plenary session by presenting the "Consolidation of CASTs Table" for the facilities serving your priority barangays. (Please note that this task is optional.)

Products

By the end of this session, each team will have

- a completely and correctly filled out Consolidation of CASTs

Consolidation of CASTs—Sample

Number of Priority Barangays: 5
Number of Facilities Assessed: 5

Category	Deficiency, Problem, or Area of Improvement Corresponds to "Xs" or circled "Nos" in the FSAC	No. of Facilities with Deficiencies	Classification Put a ✓ under the column which classifies the item in Column B		Causes
			Related to FIC, TT, FP and/or VAC*	Related to other programs	
(A)	(B)	(C)	(D)	(E)	(F)
Infrastructure	Limited number of chairs/benches for patients in all waiting and service provision areas	4/5	✓	✓	Limited space in the rural health unit
	Treatment/examination room has no visual and auditory privacy	2/5	✓	✓	Treatment or examination room has no door
Health Service: Immunization	Daily temperature-monitoring chart neither posted nor updated	3/5		✓	Delayed delivery by LGU supplier
Health Service: Acute Respiratory Infection in Children	Cotrimoxazole out of stock	5/5	✓		Staff not trained on CBPM-NP
Health Service: Nutrition	No copy of Guidelines for Micronutrient Supplementation	1/1		✓	Guidelines not reproduced
Human Resources	No sanitary inspector	5/5	✓	✓	Sanitary inspector recently retired
	No staff trained in gender sensitivity training	5/5	✓	✓	No training offered by CHD/PHO
Equipment	No speculums	5/5	✓		Stolen

* FIC = fully immunized child, TT = tetanus toxoid, FP = family planning, VAC = vitamin A deficiency

Consolidation of CASTs

Number of Priority Barangays: 5
Number of Facilities Assessed: 5

Category (A)	**Deficiency, Problem, or Area of Improvement** Corresponds to "Xs" or circled "Nos" in the FSAC (B)	**No. of Facilities with Deficiencies** (C)	**Classification** Put a ✓ under the column which classifies the item in Column B		**Causes** (F)
			Related to FIC, TT, FP and/or VAC* (D)	Related to other programs (E)	

* FIC = fully immunized child, TT = tetanus toxoid, FP = family planning, VAC = vitamin A deficiency

Session 4: The Health Map

Overview

In this session, the team creates a health map of their priority barangays that illustrates the identified areas that are underserved, have poor access, and have the most unmet needs.

Objectives

By the end of the session, LGU teams will have:

- analyzed CBMIS survey data from a geographic perspective
- identified priority areas based on:
  - unmet needs
  - poor access
  - ratio of population to barangay health workers (underserved areas)
  - facility deficiencies
- created a list of prioritized barangays

Materials

The materials for this session are:

- a map of the priority barangays (to be provided by the LGU team)
- Identifying Areas with Unmet Needs
- Identifying Areas with Poor Access
- Identifying Underserved Areas
- Identifying Facilities with Deficiencies
- Prioritizing Our Catchment Area
- Population data and number of BHWs per barangays (to be provided by the LGU team)
- Completed Form 3 for all priority barangays (presented in Session 2)
- Consolidation of CASTs Table (from Session 3)
- yellow, green, red, and blue tags
- flip charts, marking pens, and masking tape

Tasks

The tasks for this session are listed below.

1. Select a team member to act as moderator for the session.

2. Review the map of your area. Make sure that your map uses symbols to show all major geographical features and health facilities.

3. Using your Form 3 data, identify the barangays with the highest unmet needs, and complete the "Table of Unmet Needs" in the handout "Identifying Areas with Unmet Needs." As you fill out this table, consider the following questions:
   - Are there barangays that stand out in terms of unmet needs across all programs, or is the coverage even across the catchment area?
   - If coverage problems are predominant in a specific area, why do you think this is happening?

On your map, tag the three highest priority barangays using the **red** tags provided.

4. Using the handout "Identifying Areas with Poor Access," identify areas with poor access in your priority barangays and identify possible reasons for poor access in these areas. On your map, tag the three areas with poorest access using the **yellow** tags provided.

5. Referring to the handout "Identifying the Underserved Areas," complete the Population Table. On your map, tag the three areas with the highest ratio of population per BHW using the **green** tags provided.

6. Referring to the handout "Identifying Facilities with Deficiencies," review the CAST of all health facilities found on your map. Are there other categories, such as infrastructure, attitude and behavior of health workers, health information system, and/or lack of community interventions where you have identified problem areas or deficiencies? On your map, tag the three facilities with the most deficiencies using the **blue** tags provided.

7. Next, refer to the handout "Prioritizing Our Catchment Area." Prioritize the barangays in your catchment area by level of need, as shown by the concentrations of colored tags. For example, areas containing all four colors of tags are areas of first priority. Areas that have red and yellow or red and blue tags are areas of second priority. List your first, second, and third priority barangays in the "Table of Priority Areas." As you do this exercise, ask yourself the following questions:
   - Are the barangays with the highest unmet needs (for any of the four programs) also the barangays with poor access?
   - Are the barangays with the highest unmet needs (for any of the four programs) also underserved areas?

8. Participate in a plenary session in which each team presents its health map and list of priority barangays.

Products

By the end of this session, each team will have completed a:

- health map showing areas of poor access, underserved clients, and unmet needs
- Table of Unmet Needs, by MGP-Targeted Service
- Population Table
- Table of Priority Areas

Identifying Areas with Unmet Needs

Using your Form 3 data, complete the "Barangay" column by writing down the relevant numbers, for example, the number of children older than 9 months who have incomplete or no vaccinations. Barangays with the highest unmet needs will have the highest numbers in this column. On your health map, tag the three barangays with the highest unmet needs using the **red** tags provided.

Table of Unmet Needs, by MGP-Targeted Service

MGP-Targeted Service	Barangay
Fully Immunized Child: Children older than 9 months who have incomplete or no vaccinations Children younger than 9 months who have no vaccinations or whose vaccinations have not followed the recommended schedule	
Tetanus Toxoid Vaccination: Pregnant women with no TTV or TTV1 only	
Vitamin A Supplementation: Children 1–4 years old who have not received vitamin A supplementation	
Family Planning: MWRA who do not want to have a child or who want to space their next child but are not practicing family planning MWRA who are practicing family planning but are not satisfied with their current family planning method	

As you fill out this table, consider the following questions:

- Are there barangays that stand out in terms of unmet needs across all programs, or is the coverage even across your catchment area?
- If coverage problems are predominant in a specific area, why do you think this is happening?

After you have added all needed **red** tags to your health map, go back to the session guide and accomplish the next task.

Identifying Areas with Poor Access

Services are accessible when clients or patients can easily reach and use them. The definition of accessibility depends on the current local situation and the clients' perspective. Accessibility can relate to geography, operating schedule, and/or service delivery.

Access Problems Related to Geography

Consider the following questions:

- What is a reasonable amount of time or distance (e.g., 30 minutes or 1 hour, 5 kms or 2 kms) for clients to travel to reach the health facility?
- Is transportation available for reaching the health facility at all times?
- Approximately what proportion of the community cannot easily travel to the facility? For example, what proportion of the community lives outside the range of reasonable travel time or distance?

Having considered all of these factors, do you think that there are areas with problems of access related to geography in some parts of your catchment area? If so, identify the areas using the **yellow** tags provided.

Access Problems Related to Operating Schedule

In considering whether your operating schedule contributes to problems of access, ask the following questions:

- Which days of the week (Monday–Friday) or hours of the day is the health facility open?
- Approximately what proportion of the community is not able to get to the facility during the weekdays (because of work, school, etc.)? How about on weekends?
- Approximately what proportion of the community is not able to get to the facility during the hours of operation (because of work, school, etc.)?
- Are key health personnel (physician, nurse, midwife, etc.) available at the health facility when it is open?
- Do clients have to wait for services because health personnel are tardy?
- Are waiting times long for any other reason?
- Does the health facility ever close without notice?
- When the health facility plans to close during its normal operating hours (e.g. on pay days, for meetings, etc.), is there a way for clients to find out?

Having considered all of these factors, do you think that there are areas with problems of access related to the operating schedule in some parts of your catchment area? If so, identify these areas on your map using the **yellow** tags provided.

Access Problems Related to Service Delivery

In considering whether your catchment area has access problems related to service delivery, ask the following questions:

- Are all MGP-targeted services (childhood and tetanus toxoid vaccinations, family planning, and vitamin A supplementation) available in the catchment area's health facilities?
- Are clients able to access these services at convenient times?
- Are there any facility or staff deficiencies constraining the delivery of the MGP-targeted services?

Having considered these factors, do you think that there are areas with problems of access related to service delivery in some health facilities? If so, identify these areas on your map using the **yellow** tags provided.

Next, continue to review your access problems related to service delivery by reviewing the "Causes" column of your Causal Analysis Summary Table (CAST). Ask the following questions:

- Does the health facility have a stock of the essential medicines and supplies it needs to provide quality services? Examples of medicines and supplies include vaccines, contraceptives, antibiotics, paracetamol, syringes, and disposable gloves.
- Does the health facility have the basic clinical equipment it needs to provide family planning services? Examples of equipment include a speculum, covered pans, and sterilization equipment.
- Does the health facility have trained staff to provide immunization, family planning, and vitamin A supplementation services?

Having considered these factors, do you think that there are areas with problems of access related to service delivery in some health facilities? If so, identify these areas on your map using the **yellow** tags provided.

After you have added **yellow** tags to the three areas on your health map with the most difficult problems related to access, go back to the session guide and accomplish the next task.

Identifying Underserved Areas

Use the Population Table to determine underserved barangays in your catchment area. In Column A, write the names of the barangays that you have surveyed. In Column B, write the actual or projected population in that barangay. In Column C, write the number of households. In Column D, write the number of BHWs in the barangay. Calculate the ratio of catchment households per BHW by dividing the total number of households (Column C) by the total number of BHWs (Column D). Enter the ratio in Column E.

Population Table

A	B	C	D	E
Barangay	**Actual* or Projected Population**	**Number of Households**	**Number of BHWs in Barangay**	**Average Number of Households per BHW (C/D)**

* if available

On your map, place **green** tags in the three areas with the highest ratio of population per BHW.

After you have added all needed **green** tags to your health map, go back to the session guide and accomplish the next task.

Identifying Facilities with Deficiencies

Looking at and addressing health facility deficiencies that are not directly related to health service delivery will move you closer to achieving Sentrong Sigla certification.

Review your CAST again. Did you identify any categories as problem areas or deficiencies not related to service delivery? Examples might include infrastructure, attitude and behavior of staff, lack of a health information system, not enough chairs for patients, no comfort room for patients, and lack of community interventions.

Have you identified facility deficiencies for these types of categories? If so, identify these areas on your map using the **blue** tags provided.

Prioritizing Our Catchment Area

At this point, your health map shows which barangays have:

- unmet needs (*red* tags)
- poor access (*yellow* tags)
- underserved populations (*green* tags)
- health facilities that have significant deficiencies (*blue* tags)

Observe whether some barangays have areas with more than one color of tag.

In an ideal situation, you would address needs and problems throughout your catchment area. For now, however, you must prioritize areas for improvement based on your existing resources and greatest identified needs, as shown by the concentration of colored tags.

Group your barangays into one of the following categories:

First Priority

Areas that contain tags of all four colors. These barangays have unmet needs, poor access, underserved populations, and health facilities with deficiencies.

Second Priority

Barangays that contain red tags and either yellow or green tags. These areas have unmet needs plus poor access or underserved populations.

Third Priority

Barangays that contain red tags but no yellow or green tags. These areas have unmet needs but also have good access and are well served.

Write the names of these barangays in the relevant box in your Table of Priority Barangays.

Table of Priority Barangays

1st Priority:
2nd Priority:
3rd Priority:

Session 5: The Problem

Overview

During this session, the team creates a three-part definition of the problems they are confronting, as identified through the mapping exercises and data analysis done during previous sessions. Their definition includes indicators and baseline values for the selected indicators.

Objectives

By the end of the session, LGU teams will have:

- identified their service performance problems, related health problems, and underlying difficulties
- developed a definition of their current problems
- defined indicators for measuring these problems and quantified baseline values for the indicators where data are available

Materials

The materials for this session are:

- Health Benefits of Vitamin A Supplementation
- Health Benefits of Family Planning
- Defining Your Problems and Their Indicators
- Using the Table of Problems and Indicators: Loyola Barangay Example
- Table of Problems and Indicators (Diarrhea Example)
- Table of Problems and Indicators (template)
- Form 3 (from Session 2)
- Completed CASTs (from Session 3)
- Table of Priority Barangays (from Session 4)
- The Health Map (from Session 4)

Tasks

The tasks for this session are listed below.

1. Review the handout "Defining Your Problems and Their Indicators." Also review the handouts "Using the Table of Problems and Indicators: Loyola Barangay Example" and the "Table of Problems and Indicators (Diarrhea Example)."

2. Using your Session 2 data, identify the service performance problems of greatest concern. Identify indicators for measuring these service performance problems. In the appropriate columns of the Table of Problems and Indicators template, list the problems, indicators, and their baseline values. Note the timeframe of the indicator and its baseline value.

3. Next, using data from your CBMIS survey, identify the health problems of greatest concern that are related to the service performance deficiencies. Identify indicators for measuring these health problems. In the appropriate columns of the template, list the problems, indicators, and their baseline values. Note the timeframe of the indicator and baseline value.

4. Using data from Session 3 and other information, identify the underlying causes or difficulties related to the service performance problems. Identify indicators for measuring these difficulties. In the appropriate columns of the template, list the problems, indicators, and their baseline values. Note the timeframe of the indicator and baseline value. Where appropriate, define problems or their indicators in terms of the specific barangays where the problems are most prevalent. When doing so, be sure to identify the barangay.

5. When you have completed the assignment, fill out a "Table of Problems and Indicators" printed on acetate and be prepared to present your table in plenary.

Products

By the end of this session, each team will have completely filled out:

- a Table of Problems and Indicators

Health Benefits of Vitamin A Supplementation[1]

Globally, three million children suffer from clinical vitamin A deficiency (exhibiting the signs and symptoms of eye damage and xerophthalmia). However, the full magnitude of vitamin A deficiency often remains hidden: an estimated 140–250 million children under five years old are at risk of sub-clinical vitamin A deficiency, mainly in Asia and Africa. Though showing none of the ocular signs or symptoms, these children suffer a dramatically increased risk of death and illness, particularly from measles and diarrhea.

Long known to be a principal cause of childhood blindness (250 000–500 000 children lose their sight each year), vitamin A deficiency is now recognized as a major contributing factor in an estimated one to three million child deaths each year.

Vitamin A is essential for the functioning of the immune system and for the healthy growth and development of children. The simple provision of high-dose vitamin A supplements every four to six months not only protects against blindness but has been repeatedly shown to have a dramatic and multiple impact on the health of young children (aged 6–59 months).

- Mortality from all causes is reduced by 23 percent.
- Measles mortality is reduced by 50 percent.
- Diarrhea mortality is reduced by 33 percent.
- Eighty-five percent coverage in vitamin A supplementation can result in a 90 percent reduction in the prevalence of severe xerophthalmia. Coverage below 25 percent is unlikely to have an impact on xerophthalmia.

The 50 percent reduction in measles mortality is the same if vitamin A supplementation is given preventively (if children's vitamin A levels are raised before they have measles) or as a treatment for measles case management. Given that many children with measles are never seen at health facilities, the preventive strategy of supplementation can have the biggest health impact. For maximum health impact, program managers should aim to reach at least 80 percent of children 6–59 months of age.

Reducing the Impact of Measles and Diarrhea

Vitamin A supplementation has been shown to have a positive impact on child mortality, particularly with measles and diarrhea.

Research studies that looked at the impact of vitamin A supplementation on the impact of measles on children have shown that vitamin A supplementation:

- enhances immune response;
- reduces the severity of measles;
- decreases the incidence and/or severity of major complications (diarrhea, pneumonia, croup, or otitis media);
- results in fewer days in hospital;
- leads to faster recovery and fewer post-measles complications.

[1]This material was adapted slightly from the WHO Web site *http://www.who.int/vaccines-diseases/en/vitamina/science/sci02.html*.

Research studies that looked at the impact of vitamin A supplementation on the impact of diarrhea on children have shown that vitamin A supplementation:

- reduces the frequency of moderate and severe diarrhea;
- results in fewer signs and symptoms of dehydration;
- lowers clinic attendance and the frequency of diarrhea-related hospital admissions.

Recent Findings

Vitamin A supplementation and malaria

A recent study in Papua New Guinea found that when young children were given vitamin A supplements three times a year they had 30 percent fewer malaria attacks and the number of malaria parasites in their blood dropped by 36 percent.

Vitamin A supplementation and HIV/AIDS

Trials are currently ongoing to determine if vitamin A supplementation can reduce the mother-to-child transmission of HIV during lactation.

References

These documents are all available on line. Visit the WHO Web site http://www.who.int/vaccines-deseases/en/vitamina/science/sci02.shtml *and click on the reference to go directly to the document.*

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Health Benefits of Family Planning[1]

Women's Health

Contraceptive use reduces maternal mortality and improves women's health by preventing unwanted and high-risk pregnancies and reducing the need for unsafe abortions. Some contraceptives also improve women's health by reducing the likelihood of disease transmission and protecting against certain cancers and health problems.

Each year over 500,000 women die from causes related to pregnancy and childbirth. The most common causes of maternal death are complications of pregnancy and delivery such as hemorrhage, sepsis, complications of unsafe abortion, hypertensive disorders of pregnancy, and obstructed labor.

Pregnancy also affects women's health: for each maternal death in a developing country, more than 100 women suffer illnesses related to pregnancy and childbirth. A significant proportion of these deaths could be avoided through the effective use of family planning; it is estimated that 100,000 maternal deaths could be avoided each year if all women who said they wanted no more children were able to stop childbearing.

Contraceptives: Safe, Effective, and Protective

Contraceptives provide a safe and effective way to regulate fertility and preserve health. A variety of methods are available.

- **Barrier methods.** Condoms, and to a lesser extent spermicides and the diaphragm, play an important role in the prevention of sexually transmitted diseases (STDs). STDs are a significant problem in many countries and can lead to pelvic inflammatory disease, infertility, and in some cases, death. Although no contraceptive is 100 percent effective at preventing disease transmission, condoms can greatly reduce transmission of human immunodeficiency virus (HIV), the virus that causes AIDS.
- **Hormonal methods.** Combined oral contraceptives offer significant protection against:
  - life-threatening diseases such as ovarian cancer, endometrial cancer, ectopic pregnancy and pelvic inflammatory disease;
  - health conditions that impair quality of life such as iron deficiency anemia, benign breast disease, menstrual problems and functional ovarian cysts.

  Progestin-only contraceptives reduce monthly blood loss and therefore help protect against anemia and also have been reported to protect against some STDs and pelvic inflammatory disease. For some conditions, the protective effect remains even after the method is no longer being used.
- **Lactational Amenorrhea Method.** Exclusive breastfeeding of infants between 0 and 6 months provides important benefits for the infants. Breastfeeding provides special nutritional benefits to the infant and protects against diarrhea, coughs and colds, and other common illnesses.

[1] This material was adapted slightly from WHO/FHE/FPP/95.11, available on the WHO Web site at *http://who.int/reproductive-health/publications/FPP_95_11/FPP_95_11_chapter1.en.html*.

Abortions

Termination of pregnancies can be risky to a woman's health. Unsafe abortions and their complications are a major cause of maternal death and illness; approximately 70,000 women die each year as a result of unsafe or incomplete abortion and many more suffer complications. Infertility due to tubal infections resulting from unsafe abortion is common in some areas. Using contraception to prevent unwanted pregnancies helps to reduce the number of abortions.

High-Risk Pregnancies

Pregnancy is particularly risky to certain groups of women—very young women, older women, women with more than four children, and women with existing health problems. If all high-risk pregnancies were prevented, maternal mortality could be reduced by up to 25 percent.

- Adolescent women who become pregnant face serious health risks because their bodies may not be physically mature enough to handle the stress of pregnancy and childbirth. Women 15–19 years old have up to three times the maternal death rate of those 20–24 years old. They are especially likely to suffer from pre-eclampsia and eclampsia, obstructed labor, and iron deficiency anemia.
- The risks of childbearing also are greater in older women, as their bodies may be less able to deal with the physical stresses of pregnancy and childbirth. Women over the age of 35 are five times more likely to die in pregnancy or childbirth than women 20–24 years old. The risk of giving birth to babies with low birthweight or disabilities also increases in older women.
- The risk of maternal death increases for each successive birth after the fourth; the risk is one and one-half to three times higher for women with five or more children than for women with two or three children. Pregnancy and childbirth is riskier for these women, as they are more likely to suffer from anemia, require blood transfusions during delivery, and die of hemorrhage than women with fewer children.
- Women who have existing health problems face an increased risk of death if they become pregnant. For example, the risk of dying from anemia, hepatitis, heart disease, renal disease, malaria, and cholera is higher in women who are pregnant.

Defining Your Problems and Their Indicators

It is essential that everyone on the team understands and reaches agreement on the critical health and service problems and underlying difficulties that the MGP intervention(s) or activities will address. The team will be setting health problem reduction objectives and performance improvement targets in the next session. Refer to this handout as you carry out your discussion, define your indicators, and set their baseline values.[2]

The overall objectives of the MGP are to:

- fully immunize children up to one year old
- provide vitamin A capsules twice a year to all children one to four years old
- provide tetanus toxoid vaccine to all pregnant women
- make modern contraception services available to all "married" women of childbearing age

Most teams should plan to make improvements in all four services—childhood immunizations, tetanus toxoid vaccinations, vitamin A supplementation, and family planning—related to the MGP objectives. Some teams may choose to focus on selected services, based on identified needs in priority barangays. Some teams may choose to work only in barangays where the needs are greatest.

The Table of Problems and Indicators provides columns for three types of problems:

- service performance problems
- health problems
- underlying causes or difficulties

Start to fill out your Table of Problems and Indicators by identifying the service performance problems you feel are of greatest concern. In the appropriate columns, list your key problems, indicators that provide evidence of and can be used to measure these problems, and indicator baseline values (including a timeframe). Next, identify the important health problems related to the facility's service performance problems. List each health problem and the indicators that provide evidence of and can be used to measure the extent of the problem in the population, and their baseline values (including the year when measured). Complete the table by identifying important underlying causes or difficulties related to your service performance problems, and listing their indicators, baseline value, and the timeframe.

A discussion of types of service performance problems, health problems, and underlying causes and difficulties and their indicators and baseline values follows.

[2] In the Philippines, the MGP funding organization defined the four services to be targeted for improvement: childhood immunization, tetanus toxoid vaccinations for pregnant women, vitamin A supplementation, and family planning. For this reason, the teams begin to fill out their Health Problem Table by listing their service performance problems and indicators first. In other contexts, where the services to be improved are not already specified, teams may begin by listing their health problems and then proceed to listing service performance problems and underlying difficulties and their indicators.

Service Performance Problems

Types of service performance problems and their indicators and baseline values include:

Inadequate coverage

A common indicator for measuring coverage is the proportion of a target population that is currently receiving the specified service. **Note:** "Unmet need" complements the coverage rate. For example, if the coverage rate for vitamin A supplementation is 45 percent, then the unmet need is 55 percent, for a total of 100 percent.

Inadequate service quality

Indicators for inadequate service quality are evidence that services of specific types are not being delivered according to established standards of performance. Typical indicators for inadequate service quality include:

- the percentage of staff who have been found to perform a clinical procedure incorrectly (e.g., have failed to inform new mothers of the benefits of family planning);
- the number of facilities that lack an important element of service (e.g., health education materials, immunization records).

Health Problems

Types of health problems and their indicators and baseline values include:

Morbidity

Typically, indicators for morbidity include the overall incidence or the rate of incidence of a given disease or condition in a population. Baseline value would be the overall incidence or rate of incidence in a given period, usually one year. For the MGP, you will identify morbidity incidence or morbidity rates related to diseases or conditions that could have been prevented by vaccinating children against childhood diseases, vaccinating pregnant women against tetanus toxoid, providing vitamin A supplementation to children, and providing married women of reproductive age with better access to family planning. For example, the baseline value for morbidity related to childhood immunizations could be the number of cases of measles reported in the past year or the rate of cases per 1,000 children in the past year.

Mortality

Indicators for mortality include the number deaths or the rate of deaths from a given disease or condition in a population. For the MGP, you will identify mortality incidence or mortality rates related to diseases or conditions that could have been prevented by the four MGP-targeted services. Baseline values for mortality indicators include the number of deaths or the rate of deaths that occurred in a recent period, usually one year.

At-risk populations

The indicator for at-risk populations would be the number or percentage of people in a target group who are not protected by a preventive intervention, such as immunization or contraception. The indicator's baseline value would define the unprotected group in absolute terms or as a percentage in a given period.

Other consequences of the disease or condition

Indicators for other consequences of a disease or condition might be numbers or rates of complications, disabilities, handicaps, or other unhealthy conditions resulting from inadequate provision of a particular service. The indicators' baseline values could include the number or rate of complications, or the prevalence of a certain condition, such as number or percentage of women who were anemic during their pregnancy in a given year.

Underlying Causes or Difficulties

Types of underlying causes or difficulties and their indicators and baseline values include:

Inadequate public awareness

An indicator of insufficient public awareness would include evidence that clients (usually mothers and families) have inadequate knowledge or understanding of the benefits related to receiving a particular service, such as childhood vaccinations or family planning. The baseline value of the indicator for public awareness is usually expressed as the percentage of mothers or families who, when surveyed, cannot cite the benefits of a particular service or intervention.

Low public appreciation of services

Indicators of low public appreciation might include the number of complaints recently received, a downward trend in attendance, or the results of a recent opinion survey. The baseline value of these indicators could be qualitative or quantitative data from focus groups or surveys, attendance rates, or the percentage of patients who do not comply with prescribed treatments.

Constraints within the community

Indicators of constraints within the community include factors that inhibit the achievement of full coverage by a given service. An example of a constraint indicator is resistance from church leaders or other local organizations to the provision of a given service. Another is poor socioeconomic conditions in a given population. Baseline values for such indicators could include instances of bad publicity and measures of poverty.

Difficulties of client access to services

Indicators of client access difficulties include the distance to reach the health center, high service costs, limited clinic hours, and frequent staff absences. Baseline values of these indicators would be measures of these factors—for example, the average distance traveled or the actual clinic hours.

Resource difficulties

Indicators of resource difficulties include a shortage of critical resources (for example, facilities, vehicles, drugs, vaccines, and other supplies). The baseline value could be the percentage of facilities lacking critical equipment, experiencing stock-outs, or lacking a vehicle.

Staff difficulties

Indicators of staff difficulties include a lack of critical staff, a lack of trained staff, or evidence of poor staff performance or motivation. Examples of baseline values for these indicators include the percentage of facilities or barangays lacking critical staff, or the percentage of staff without training in a certain service or skill.

Reviewing a Completed Table of Problems and Indicators

Normally, you will find a cause and effect relationship between the indicators for the three types of problems: service performance problems, health problems, and underlying difficulties. You may find that several indicators may be related to a given health problem, service performance problem, or underlying difficulty. Your challenge is to identify the most important problems in each of the three categories and use these to define the situation in your LGU and determine where to focus attention for improvement.

The handout "Using the Table of Problems and Indicators: Loyola Barangay Example" and its accompanying Table of Problems and Indicators (Diarrhea Example) provide an example of problems, their indicators, and indicator baseline values related to diarrhea. **Note:** This example is not intended to bias your definition of your problems. Rather, it is intended to promote creative thinking as your team works to define the priority health problems in your catchment area.

Using the Table of Problems and Indicators: Loyola Barangay Example

In Loyola Barangay, the number of children coming to the health center with diarrhea is a serious problem, as are the number of severe cases and the number of childhood deaths due to diarrhea. The LGU has received funding to improve its services related to preventing and treating diarrhea in children. The team is working toward designing an intervention that will improve services and reduce childhood mortality and morbidity due to diarrhea. The LGU team uses the Table of Problems and Indicators to explore the cause and effect relationship between its diarrhea-related service performance problems, the health problem of the prevalence of diarrhea in children, and the underlying difficulties that may be contributing to diarrhea-related service performance and health problems.

Service Performance Problems

Unfortunately, only 65 percent of the children who present with diarrhea received oral rehydration solution (ORS) last year. Some severe cases last year were not referred to the health center immediately for treatment. Only 35 percent of mothers in Loyola Barangay received health education on the prevention and management of diarrhea from a trained BHW during the past year. The percentage of the population lacking access to safe drinking water is 25 percent. The percentage of the population that is not using sanitary excreta disposal is 75 percent.

Health Problems

Based on service data for the catchment area, 18 percent of the pediatric health consultations provided last year were for episodes of diarrhea in children under five years old. Five percent of all childhood diarrhea cases presented were severe, and four children in the barangay died from diarrhea last year. Only 10 percent of all children under four months old in Loyola Barangay are exclusively breastfed.

Underlying Difficulties

The LGU team has observed that a major underlying difficulty in this LGU is the shortage of ORS in health centers. Only six of the 27 service points have an adequate supply of ORS. Access to services is another difficulty, as five of the LGU's 12 barangay health stations are open only two days per week, and half of the barangay's 10 sitios[3] are geographically inaccessible to BHWs. Overall, the BHW-to-household ratio in this LGU is one BHW for every 200 households, and only 25 percent of BHWs have received training in educating clients about the prevention and treatment of diarrhea in children. The living conditions in this barangay are also a difficulty, as about half of the population is living in unhygienic conditions.

[3] A sitio is a zone within a rural barangay.

In the sample Table of Problems and Indicators that follows, the team has listed its problems, their indicators, and the baseline values for these indicators separately. It is useful to separate an indicator and its value in order to track changes or progress in indicators over time. For example, the high percentage of pediatric consultations that involved episodes of diarrhea in children under five annually is a problem. In Loyola Barangay, 18 percent of all pediatric consultations last year involved diarrhea. A reduction in the percentage of pediatric consultations involving diarrhea over the next year would demonstrate positive change or progress.

Table of Problems and Indicators (Diarrhea Example)

Team: Loyola Barangay

Health			Service Performance			Underlying Cause or Difficulty		
Problem[1]	**Indicator**	**Baseline Value**	**Problem**	**Indicator**	**Baseline Value**	**Problem**	**Indicator**	**Baseline Value**
High prevalence of childhood diarrhea	Percentage of all pediatric consultations annually that concern diarrhea in children under five	18% last year	Lack of access to safe drinking water	Percentage of the population not using safe drinking water	25% (1999) [2]	Families living in poor hygienic conditions	Percentage of all families in catchment area who live in unhygienic conditions	50% (1999)
Prevalence of severe cases of diarrhea in children	Percentage of all cases of diarrhea annually that are severe in children under five	5% last year	Lack of access to sanitary excreta disposal	Percentage of the population not using sanitary excreta disposal	75% (1999)	Shortage of ORS in health centers	Percentage of all health centers with adequate supply of ORS	22% last year
Childhood deaths due to severe diarrhea	Number of child deaths annually due to diarrhea	4 deaths last year	Lack of maternal awareness of prevention and management of childhood diarrhea	Percentage of all childhood diarrhea cases annually who receive ORT	65% last year	BHS clinics open only two days per week	Percentage of clinics open only two days per week	42% currently
	Percentage of all infants less than 4 months old that are exclusively breastfed (EBF) in a given year	10% EBF last year		Percentage of all severe diarrhea cases annually who are immediately referred to an HC	80% last year	BHWs unable to follow up all households	Number of households per BHW	200:1 currently
				Percentage of all mothers in catchment area who have received appropriate health education on childhood diarrhea	35% last year	Sitios without access to health services	Percentage of all sitios that have access to health services	50% currently
						Lack of BHWs trained in conducting mother's class on childhood diarrhea	Percentage of all BHWs who have been trained to conduct mother's class on childhood diarrhea	Estimated 25% last year

1 Each listed problem could relate to more than one indicator.

2 According to the Demographic Health Survey (DHS). (Please note that this barangay, its data, and the DHS are fictitious.)

Table of Problems and Indicators

Team _____

Health			Service Performance			Underlying Cause or Difficulty		
Problem[1]	**Indicator**	**Baseline Value**	**Problem**	**Indicator**	**Baseline Value**	**Problem**	**Indicator**	**Baseline Value**

[1] Each listed problem could relate to more than one indicator.

Session 6: Objectives and Targets

Overview

During this session, each team produces a table of LGU objectives for reducing health problems and targets for improving service performance. These objectives and targets will be quantitative expressions of desired improvements in the health of the catchment area population, the service performance of the relevant health facilities, and the underlying difficulties identified.

Objectives

By the end of the session, each participating team will have:

- identified objectives and targets for reducing problems and making improvements in service performance and health as well as the underlying difficulties related to the four MGP-targeted services.

Materials

The materials for this session are:

- Table of Problems and Indicators (from Session 5)
- National Health Objectives
- Setting LGU Objectives and Targets
- LGU Objectives and Targets Table (example)
- LGU Objectives and Targets Table (template)

Tasks

The tasks for this session are listed below.

1. As a team, briefly discuss the session objectives and the handout "Setting Objectives and Targets" in order to gain a common understanding of the MGP definition of objectives and targets, the recommended steps for setting objectives and targets, and ideas of alternative approaches to setting targets.

2. Review the handout "National Health Objectives" and the Quality Standards List for your type of facility to determine whether there are national objectives and targets that provide guidance on setting LGU objectives and targets.

3. Review the "Table of Problems and Indicators" you developed during Session 5. For each type of problem, select the indicators that you wish to include in your LGU Objectives and Targets Table. List these indicators and their baseline values in the appropriate columns.

4. Next, set objectives and targets by quantifying the magnitude of the improvement or reduction that you hope to achieve for each indicator. Set a timeframe for achieving each objective or target. The timeframe may be shorter than the MGP implementation period, or it may be longer. List your objectives and targets in the relevant columns of your table.

Product

By the end of this session, each team will have a completely filled out:

- LGU Objectives and Targets Table

National Health Objectives

Indicator	Benchmark by 2004
Percentage of all children 12 to 23 months old who are fully immunized against preventable childhood diseases in a given year	95%
Percentage of all pregnant women whose children will be protected against tetanus toxoid in a given year because the women have received at least two tetanus toxoid vaccinations	80%
Percentage of all children 12 to 59 months old who have received vitamin A supplementation in a given year	100%
Percentage of all married women of reproductive age using contraception in a given year (Contraceptive Prevalence Rate)	60%

Setting LGU Objectives and Targets

Definition of Terms

service performance improvement target — the desired increase in coverage of one or more specific services for identified segments of the catchment population. The increase may be expressed in absolute numbers or as a percentage. It may also be expressed as a desired improvement in a specific quality of care indicator (or indicators). With reference to the diarrhea example, a service performance improvement target would be to increase the percentage of all childhood diarrhea cases annually who receive oral rehydration solution from 65 percent to 85 percent in one year.

health improvement objective — the desired reduction or improvement in one or more health problems in the catchment area's population. This reduction or improvement may be expressed in absolute numbers or as a percentage. With reference to the diarrhea example, a health improvement objective would be to reduce the annual percentage of pediatric consultations due to diarrhea in children under five per year from 18 percent to five percent in one year.

underlying difficulty reduction target — an expression of the desired extent of improvement in a previously defined underlying cause or difficulty. May be expressed in absolute numbers or as a percentage. With reference to the diarrhea example, an underlying difficulty reduction target would be to increase the percentage of facilities having an adequate supply of oral rehydration solution in a given year from 22 percent to 74 percent (from six of 27 facilities to 20 of 27 facilities) in one year.

Setting Objectives and Targets

Service Performance Improvement Targets

1. Review your Table of Problems and Indicators and select the service performance problems (and indicators) you will focus on.
2. Transfer the relevant indicators and their baseline values from your Table of Problems and Indicators to the appropriate columns in your LGU Objectives and Targets Table.
3. Set a target for reducing or increasing the baseline value for each indicator and specify the time period.

Health Problem Improvement Objectives

1. Review your Table of Problems and Indicators and select the health problems (and indicators) you will focus on.
2. Transfer the relevant indicators and their baseline values from your Table of Problems and Indicators to your LGU Objectives and Targets Table.
3. Set a target for reducing or increasing the baseline value for each indicator and specify the time period.

Underlying Difficulty Reduction Target

1. Review your Table of Problems and Indicators and select the underlying difficulties (and indicators) you will focus on.
2. Transfer the relevant indicators and their baseline values for these underlying difficulties from your Table of Problems and Indicators to your LGU Objectives and Targets Table.
3. Set a target for reducing or increasing the baseline value for each indicator and specify the time period.

Alternative Approaches to Target Setting

Your team may prefer to use an alternate approach to setting objectives and targets. For example, you may choose to:

- raise the coverage for critical services evenly throughout the city, barangay, or LGU;
- set coverage targets in selected, currently underserved areas (city, municipality, barangay, sitio, or purok);
- set targets in terms of the number of barangays where you will progressively introduce the new intervention, with the intent of reaching full coverage for critical services in each barangay over time.

LGU Objectives and Targets Table—Example (to Decrease Diarrhea-Related Morbidity and Mortality)

Health Problem			Service Performance Problem			Underlying Cause or Difficulty		
Indicator	Baseline Value	Improvement Target	Indicator	Baseline Value	Improvement Target	Indicator	Baseline Value	Improvement Target
Percentage of all pediatric consultations annually that concern diarrhea in children	18% last year	5% in one year	Percentage of all childhood diarrhea cases annually who receive ORT	65% last year	85% in 1 year	Percentage of all health centers with an adequate supply of ORS	22% last year	74% (20 of 27) in 6 months
Number of child deaths annually due to diarrhea	4 deaths last year	0 in 6 months	Percentage of all severe diarrhea cases annually who are immediately referred to an HC	80% last year	100% in 3 months	Number of households per BHW	200:1 currently	100:1 in one year
Percentage of all infants less that 4 months old that are EBF in a given year	10% EBF last year	30% EBF in one year	Percentage of all mothers in catchment area who have received appropriate health education on childhood diarrhea in any given year	35% last year	70% in 6 months	Percentage of all BHWs who have been trained to conduct mother's class on childhood diarrhea	Estimated 25% last year	70% in one year

EBF = exclusively breastfed
HC = health center
ORT = oral rehydration therapy
ORS = oral rehydration solution

LGU Objectives and Targets Table
(to Increase Coverage for Maternal and Child Health Services and Prepare the Health Facility for Sentrong Sigla Certification)

Health Problem			Service Performance Problem			Underlying Cause or Difficulty		
Indicator	Baseline Value	Improvement Target	Indicator	Baseline Value	Improvement Target	Indicator	Baseline Value	Improvement Target

Session 7: Ideas for Improvement

Overview

During this session, the teams will review their LGU Table of Objectives and Targets. Drawing from their experience and from examples of best practices elsewhere in the Philippines, they will brainstorm to develop interventions that will address their identified problems. The teams will list and describe their proposed interventions.

Objectives

By the end of this session, the participating teams will have:

- generated ideas for strategic interventions
- selected interventions that the team feels are feasible and will be effective at addressing the identified problems
- written brief narratives that describe these strategic interventions

Materials

The materials for this session are:

- LGU Objectives and Targets Table (from Session 6)
- Understanding Differences between Strategic Actions and Routine Service Activities
- Guidelines for Generating and Selecting LGU Team Strategies
- List of Strategies (sample)
- List of Strategies (template)
- Selected Strategies and Narrative Descriptions (template)
- "Bringing Sterilization Services to the Main Health Center" (see Appendix A)
- "Mother-Baby Watch" (see Appendix A)
- "EPI Plus" (see Appendix A)

Tasks

The tasks for this session are listed below.

1. Review your "LGU Objectives and Targets Table" (from Session 6).

2. Briefly discuss team guidelines for generating and selecting strategies in order to gain a common understanding of how to ensure that all team members have an opportunity to contribute ideas and opinions.

3. Brainstorm and list ideas or interventions that adhere to the guidelines and which have the greatest potential to improve or reduce the problem's baseline indicators within the next four to nine months. Use a decision-making process that ensures that all team members have an equal opportunity to contribute ideas and participate in selecting strategies.

4. In the "List of Strategic Interventions" table, list your prioritized interventions and their related indicators (with baseline values) and improvement targets or objectives.

5. In the "Selected Interventions and Their Narrative Descriptions" table, list your selected interventions and write a narrative description for each one.

Products

By the end of this session, the participants will have completed:

- a list of selected strategies
- a brief narrative describing each selected strategy

Understanding Differences between Strategic Interventions and Routine Service Activities

The MGP grant supports strategic interventions that result in improvements in routine service activities as well as health problems and underlying difficulties. Understanding the difference between strategic interventions and routine service activities will help your team to develop interventions that will result in reaching your objectives and targets and gain the support of the CHD review panel in Session 9.

Definition of Terms

strategic intervention addresses one or more identified problems and results in the development and implementation of a new approach or set of procedures or practices, that, once established, will continue in future. An example of a strategic intervention related to the diarrhea example might be to establish a participatory community learning program on the risks, prevention, and management of childhood diarrhea. Presumably the initiative would involve discrete developmental activities, such as designing the program, reproducing the training modules, and training BHWs in the new procedures, which would not need to be repeated.

routine service activity relates to delivering or supporting the delivery of a health service provided on a regular basis, albeit at an insufficient level at the current time. An example of a routine service activity related to the diarrhea example would be for BHWs to provide education at the household level using the modules for diarrhea management. Presumably BHWs would be expected to provide household-level education on an ongoing basis, as part of their regular responsibilities.

Examples

Examples of strategic interventions and routine service activities related to the MGP-targeted services follow.

Strategic Interventions

- recruiting and organizing new BHWs for priority barangays and training the midwives and all BHWs to implement a new approach to monitoring and serving clusters of underserved households there;
- establishing a mechanism for monitoring stocks and procuring vaccines, vitamin A capsules, and supplies of specified contraceptives;
- designing a new style of community health education that combines events, media, and community monitoring to raise coverage rates for immunization and family planning;
- arranging, through the support of the mayor's office, for the installation of a continuous, safe water supply for the Main Health Center.

Routine Service Activities

- monitoring and following up on the delivery of targeted services in priority barangays by BHWs and midwives;
- following procedures for monitoring the stock of vitamin A capsules and contraceptives;
- purchasing stocks of single dose vaccines for targeted facilities;
- inviting identified married women of reproductive age who do not desire any more children or who want to space their pregnancies to the health center for family planning counseling;
- conducting health education activities for the public at large;
- mobilizing resources from community and nongovernmental organizations to facilitate outreach activities to poorly served communities.

Guidelines for Generating and Selecting LGU Team Strategies

1. All strategies must support the National Health Objectives for 2004.
2. Strategies and development activities should be innovative.
3. Community and local political support and involvement should be sought and used to the greatest extent possible.
4. Grant money can be used for new initiatives for service delivery expansion, but not for salaries or honoraria for LGU officials and personnel, capital outlay, construction, or renovation.
5. Linkages with other government and nongovernmental organizations are encouraged to enhance cooperation, collaboration, and the sharing of resources.
6. Attention should be focused on households or families in greatest need, first within the priority barangays, and eventually throughout all barangays of the LGU.
7. Care must be taken in designing strategies, to avoid creating future routine budget requirements that cannot be fulfilled.

List of Strategic Interventions (Diarrhea Example)

Problem Indicator (Including Baseline Value)	Improvement Objective/Target	Strategic Intervention
BHW-to-household ratio was 1:200 in Barangay A last year	Obtain 1:100 BHW--to-household ratio in one year	Advocate to municipal and barangay officials for the immediate recruitment and hiring of BHWs
35% of all mothers in catchment area received appropriate health education on childhood diarrhea last year	70% of all mothers in catchment area receive appropriate health education on childhood diarrhea in one year	Design a community-centered initiative to increase the use of ORT by catchment-area families in their homes
65% of all childhood diarrhea cases received ORT last year	85% of all childhood diarrhea cases receive ORT in one year	Make ORS packets available in every household in the community

List of Strategic Interventions

Problem Indicator (Including Baseline Value)	Improvement Objective/Target	Strategic Intervention

Selected Interventions and Their Narrative Descriptions (Diarrhea Example)

Strategic Intervention	Narrative Description
Advocate to municipal and barangay officials for the immediate recruitment and hiring of BHWs	Develop a presentation for municipal and barangay officials that will convince them of the negative health impact of the current high BHW-to-household ratio and generate their support for a BHW recruitment and hiring campaign
Establish participatory community learning on the risks, prevention, and management of childhood diarrhea	Design and implement a training program and supporting materials that use a participatory learning approach to teach families about the risks, prevention, and treatment of diarrhea in children; train BHWs in the program so they can educate catchment area families
Make ORS packets available in every household in the community	Develop new ORS procedures so BHWs can ensure that ORS packets are available in every household in their community; design and implement a training program to teach BHWs to use these procedures

Selected Interventions and Their Narrative Descriptions

Strategic Intervention	Narrative Description

Session 8: The LGU Plan

Overview

During this session, each team makes a list of activities for implementing the strategic interventions identified in the previous session. The team will develop a workplan that identifies the products expected to result from each selected activity, the person responsible for the activity, the required resources, and the timeframe.

Objective

By the end of the session, the LGU teams will have:

- identified activities for implementing strategic interventions
- identified needed resources and their source(s)
- identified the person(s) who will responsible for each activity
- established a time frame for each activity
- developed a work plan that will serve as a planning and monitoring guide for implementing strategic interventions

Materials

The materials for this session are:

- Health Map (from Session 4)
- List of Strategic Interventions (from Session 7)
- Selected Strategies and Their Narrative Descriptions (from Session 7)
- Developmental and Routine Service Activities and Resources that Support Strategic Interventions (Diarrhea Example)
- MGP Developmental Activity Planning Terms
- Matching Grant Program Activity Plan (Diarrhea Example)
- Matching Grant Program Activity Plan (template)
- MGP Milestones
- "Strengthening Provincial Municipal Partnerships through Sub-Granting" (see Appendix A)

Tasks

The tasks for this session are listed below.

1. Review and discuss the handout "Strategic Actions and Resources vs. Routine Service Activities and Resources." Reach a common understanding of the differences between the types of activities and resources that are strategic and the types of activities and resources that are routine.

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2. Review and discuss the handout "MGP Developmental Activity Planning Terms," and reach a common understanding of these terms, which you will note are also the column headings of the MGP Activity Plan.

3. In the first column of your MGP Activity Plan, list the strategies generated during Session 7 and compiled in your "List of Strategic Interventions."

4. In the second column, list the major activities involved in implementing each strategic intervention. Refer to the "MGP Milestones" handout to remind you of the major activities of the MGP.

5. Continue to fill out your MGP Activity Plan by listing expected products of each activity, the person responsible, the resources needed, their source(s), and the timeframe. Refer to the handout "MGP Activity Planning Terms" as needed.

6. Prepare to present the plan in plenary.

Product

By the end of this session, each team will have:

- a Matching Grant Program Activity Plan

Session 8a: The Regional/Provincial Monitoring Plan

Overview

During this session, the provincial and/or regional team makes a list of its monitoring objectives and the activities required to carry out its monitoring functions. The team also discusses and selects components and indicators for its monitoring checklist.

Objective

By the end of the session, regional and provincial staff will have developed and defined:

- their MGP monitoring and support responsibilities
- a monitoring checklist
- a Regional/Provincial Monitoring Plan

Materials

The materials for this session are:

- MGP Developmental Activity Planning Terms
- MGP Milestones
- Regional/Provincial Monitoring Plan (template)

Tasks

The tasks for this session are listed below.

1. Review the handout "MGP Milestones."
2. Develop a monitoring checklist. Include activities related to:
   - LGU implementation of their MGP workplans
   - CBMIS roll-out, including updating and verifying the data
   - Sentrong Sigla certification of relevant facilities
   - service performance improvements
   - allocation and utilization of funding
   - CHD and Provincial Health Office support
3. Develop a monitoring workplan.
4. Prepare to present the plan in plenary.

Products

By the end of this session, each team will have developed a:

- Monitoring Checklist
- Regional/Provincial Monitoring Plan

MGP Developmental Activity Planning Terms

strategic intervention — an approach for improving service performance or addressing health problems or underlying difficulties. The LGU team is responsible for designing and implementing the intervention. A strategic intervention usually results in a new approach or set of procedures that, once established, will continue. In your work plan table, enter the name or a very brief description of the intervention, as listed in Session 7.

developmental activities — step-by-step actions undertaken by an LGU team to implement its MGP strategic interventions. Developmental activities usually take place within a set timeframe. They lead to new approaches or capacities that improve the performance of services or their support activities and will continue. In your work plan table, enter a brief description of the developmental activity.

expected products — observable and measurable outputs of each activity. Once a product is produced, the activity is completed. An example of a product is education modules for training BHWs in conducting maternal awareness education related to risks, prevention, and treatment of diarrhea in children. In your work plan table, enter just the title of the product.

person responsible — the name of the person who is primarily responsible for the activity and its product and who will be held accountable for managing implementation. In your work plan table, list the person by name. You may list other staff who will be supporting the completion of the activity, but it should be clear who is primarily responsible.

developmental resources — major resources required for implementing developmental activities (as opposed to routine service activities). An example of developmental resources is the funding that would be required to produce a new procedures manual. In your work plan table, enter the amount of funding needed for each activity.

source of developmental resources — the agency, government department, or private organization that is funding the activity. In your work plan table, list the funding source(s) by name.

timeframe — the period when you expect to be planning and implementing the activity. In your work plan table, list the activity's planned start date and completion date.

regional/ provincial monitoring objectives (on the Regional/ Provincial Monitoring Plan) — specific CHD and Provincial Health Office expectations related to their ability to monitor LGU implementation of the work plans and the anticipated results. The CHD team and Provincial Heath Office are is responsible for monitoring LGU resource mobilization and utilization, revisions to the strategy and plan (in the face of unexpected obstacles), CBMIS roll-out, service performance improvements, possible health problem reduction, and CHD and Provincial Health Office support provided to the LGUs.

Developmental and Routine Service Activities and Resources that Support Strategic Interventions (Diarrhea Example)

This table provides a quick example of types of developmental and routine service activities (and resources) that support strategic interventions related to reducing the incidence of diarrhea in children and increasing the use of ORS by catchment area families. You will note that developmental activities take place within a set time, require finite or one-time resources, and may be supported by MGP funds. Routine service activities are ongoing (no set timeframe) and require resources that the LGU would normally provide on an ongoing or as-needed basis as part of their regular budget. Refer to this example as you fill out your MGP Activity Plan and anticipate ongoing resources required to sustain improvements in service performance.

Strategic Intervention	Developmental		Routine Service	
	Activity	Resources Required	Activity	Resources Required
Design and implement a community-centered initiative to improve use of oral rehydration therapy by catchment area families	1. Develop procedures whereby BHWs can ensure that oral rehydration solution packets are available in every household	No resources required (except staff time)	1. Midwives continue to train, supervise, and support BHWs in the effort to distribute ORS to families and to train them in mixing the solution	No resources required
	2. Train existing BHWs in the new ORS distribution procedures and in teaching how to make oral rehydration fluids at home	Training materials, snacks	2. Procure needed supplies	Oral rehydration solution packets
			3. Monitor stocks and order new supplies as needed	Oral rehydration solution packets
Establish a participatory community learning program on the risks, prevention, and management of childhood diarrhea	1. Design the program	Materials for developing community modules	1. BHWs conduct education at the household level using the modules for diarrhea management	Reproduction costs related to providing materials for BHWs to use and leave with families
	2. Reproduce the modules on childhood diarrhea for use in BHW training	Reproduction costs		
	3. Train BHWs using the modules	Training materials, snacks		

Matching Grant Program Activity Plan (Diarrhea Example)

LGU _____

Strategic Intervention	Developmental Activities	Expected Products	Person Responsible	Developmental Resources	Amount and Source of Developmental Resources	Timeframe	
						Start Date	End Date
Design and implement a community-centered initiative to improve oral rehydration solution use by catchment area families	1. Develop procedures for BHWs to ensure that ORS packets are available in every household in their community	A set of procedures for obtaining and distributing ORS to every household	MHO: Dr. Rueda			9/24/2001	10/12/2001
	2. Train existing BHWs in the new oral rehydration solution distribution procedures and in teaching how to make oral rehydration fluids at home	Modules developed and all existing BHW trained in ORS supplies management	Midwife: Mrs. Tagle	Training materials and snacks	LGU: PhP1,500.00	10/16/2001	10/17/2001
		Community education modules	MHO: Dr. Rueda (with the support of PHN: Mrs. Morales and Midwife: Mrs. Tagle)	Reproduction Costs	MGP: PhP10,000	9/24/2001	10/17/2001
Establish a participatory community learning program on the risks, prevention, and management of childhood diarrhea	1. Design the program; develop the modules						
	2. Train BHWs in the modules for childhood diarrhea			Training materials and snacks	LGU: PhP1,500.00	10/22/2001	11/9/2001

MHO=Municipal Health Officer
PHN=Public Health Nurse

Matching Grant Program Activity Plan

LGU _____

Strategic Intervention	Developmental Activities	Expected Products	Person Responsible	Developmental Resources	Amount and Source of Developmental Resources	Timeframe	
						Start Date	End Date

MGP Milestones

CBMIS

1. Plan and implement activities to address immediate as well as medium- to long-term service performance problems in all barangays implementing the CBMIS.
2. Expand (roll out) the CBMIS to other priority barangays.
3. Maintain the CBMIS by updating and verifying CBMIS data and submitting quarterly reports to the CHD and Provincial Health Office.
4. Evaluate the program.

Sentrong Sigla Certification

1. Plan and implement activities to address prioritized deficiencies for selected facilities (based on the Causal Analysis Summary Table).
2. Conduct assessments of other health facilities.
3. Apply for Sentrong Sigla certification.
4. Monitor compliance with quality standards using the Facility Self-Assessment Checklist.

Regional/Provincial Monitoring Plan

CHD and Provincial Health Office Monitoring Objectives:

1.
2.
3.

Strategic Intervention	Developmental Activities	Expected Products	Person Responsible	Developmental Resources	Amount and Source of Developmental Resources	Timeframe	
						Start Date	End Date

Session 9: Presentation of the LGU Plan

Overview

During this session, each team will present its LGU plan in a plenary session attended by all LGU teams, provincial and regional health staff, and invited guests. The presentations will describe the main points of the teams' expected achievements and service improvements, resource requirements, and their resource mobilization strategy. A panel will provide feedback on each plan. The CHD and Provincial Health Office staff will also present their monitoring plan. The chairperson will close this session and the workshop by summarizing the workshop results and confirming commitment to the plans.

Objectives

By the end of the session, LGU teams will have:

- presented their MGP Activity Plan for service performance improvement and Sentrong Sigla certification to a panel of decision-makers
- obtained a positive response, suggestions for improvement, and a commitment of support from the panel of decision-makers

Also by the end of the session, the group of CHD and Provincial Health Office staff will have:

- presented their MGP monitoring plan and confirmed their commitment to support the LGU efforts

Materials

The materials for this session are:

- MGP Activity Plan (from Session 8)
- presentation aids

Program

The program for this session is listed below.

1. The chairperson introduces the program and provides a brief background presentation.
2. Each LGU team presents its MGP Activity Plan.
3. The CHD and Provincial Health Office team presents its Regional/Provincial Monitoring Plan.
4. A panel of decision-makers provides feedback and reiterates their commitment of support.

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Products

By the end of this session, each team will have:

- documented acknowledgment of its plan
- comments on the plan
- a commitment of support from the panel of decision-makers

Phase II: Data Analysis and Intervention Planning

Facilitator's Notes

This section provides Facilitator's Notes for the nine sessions of Phase II. The notes offer advice for planning and leading sessions, and enhancing team participation during the learning process. Facilitators should refer to the session guidelines for a list and examples of the materials needed for each session.

Facilitator's Notes

Session 1: Opening Program

Overview

This session provides the participants with an overview of the workshop's objectives and syllabus, as well as information about the expected working methods, the learning-by-doing approach, the workshop schedule, and the house rules. The Regional Director or her/his representative participates in the session to convey her/his interest in the project proposals that the teams will present in plenary at the end of the workshop. The participation of the Regional Director reinforces the support of the CHD for the MGP and its objectives.

Duration

about 30 minutes

Timing

10 minutes	Invocation, National Anthem
20 minutes	Welcome, and Challenge Facilitator Briefing

Planning Notes

In preparing for this session:

1. Follow up with the Regional Director to make sure that s/he or a representative attends this session as planned. Brief her/him ahead of time so s/he is prepared to challenge the teams by bringing up the points listed under the facilitation notes.

2. To ensure continuity of participation and teamwork, make sure that the staff who participated in the Phase 1 workshop also participate in the Phase 2 workshop. Do not allow substitution of participants except when the role of the new participant is crucial in making decisions (e.g., municipal health officer).

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Facilitation Notes

This session sets the stage for the entire workshop.

1. Have each team sit together. Introduce the participants as a group and identify them clearly as a team. Continue this emphasis on team membership throughout the workshop.

2. The Regional Director or her/his representative should be present during the opening program and express her/his personal interest in this activity. In particular, the Regional Director must challenge the teams to produce sound strategies for major service enhancement and proposals with a high probability of success. The Regional Director should point out that the activities proposed by the LGUs should not be routine activities associated with providing services and managing programs. Rather, the activities must be developmental. S/he should express confidence in the LGU teams' knowledge of success in their areas. This challenge should come from her/him, not from the workshop facilitators. The Regional Director should promise to return to hear the proposals and make decisions on funding.

3. Explain the workshop's objectives broken down into general and specific terms, and share the workshop syllabus.

4. Present the session tasks and their resulting products. Explain that these combined products will make up each team's LGU plan, to be presented in plenary at the end of the workshop.

5. Explain the program's working methods and the learning-by-doing-approach in detail, and discuss the implications for participants and facilitators alike. For example, explain that the learning-by-doing approach requires the strict management of session time limits, and that the teams may need to work in the evening to complete unfinished tasks and products.

6. Discuss the workshop schedule and the house rules. Address any questions or issues raised by the participants. Encourage the use of local dialects, and emphasize that all team members must participate fully throughout.

7. Warn the teams that they will be introduced to a number of new concepts and terms. They should pay close attention to these terms and try to understand them and ask questions when these concepts are first introduced. This understanding is necessary for them to correctly complete important session products that become portions of each team's proposal.

8. Advise the teams to read through the guideline materials as a group before starting each session's tasks.

9. Address any administrative concerns.

Facilitator's Notes

Session 2: Survey and Facility Data

Overview

This session provides each team with experience in transferring the results of its facility assessment to a CAST (Columns A and B) and assessing the extent of unmet needs in its barangays. Teams will use these data later to prioritize barangays for service delivery improvements. This session is also an opportunity for participants to explore the validity of their data.

Duration

2.5 hours, approximately

Timing

10 minutes	Briefing
1 hour	Group work
30 minutes per team (approximately)	Plenary presentation

Facilitation Notes

Observe the teams without being intrusive. Avoid answering questions that arise. Instead, encourage the participants to resolve issues themselves.

1. Introduce the session guide, highlighting the materials required, the tasks to be done, and the expected products. Present the timeframe and emphasize the need to finish within the allotted time and the need to keep team presentations to 30 minutes each, including questions and answers.

2. During group work, observe the teams and ensure that they remain focused on their tasks and begin to discuss their survey experiences immediately. The guide questions (in the Session 2 Presentation Matrix) will help them organize their thoughts, guide their discussion, and prepare their presentation.

3. Make sure that the guide questions are clear to the team members. If any team seems to need guidance:
   - ask how the LGU managed the BHW training and what types of actions it took to ensure the quality of the data gathered;
   - get the team to list the steps that it took to prepare for and administer the survey, especially in areas with few BHWs;

- make sure that the team identifies the procedures it used to ensure full survey coverage of its targeted barangays.

4. Make sure that each team transfers its presentation matrix to an overhead transparency for use in its plenary presentation.

5. As each team prepares its products for this session, check that team members are transferring:
   - their Form 3 data to an overhead transparency;
   - their FSAC data to a CAST, Columns A and B, for every health facility assessed. The team must transfer the deficiencies identified in the FSAC verbatim to the CAST, without revising the original statements;
   - one partially completed CAST to an overhead transparency. Assign a facilitator from a rural health unit or barangay health station to review each team's CAST before the team creates its transparency.

6. Allow an average of 15 minutes per group for its presentation, including questions and answers. However, be somewhat flexible with time management for the plenary presentations. For example, the participants will probably raise more questions and issues during the first presentation, so let the first group continue for longer than 15 minutes. The participants usually raise fewer issues with succeeding groups, so they will need less time.

7. Presenting their Form 3 data allows the LGU teams to determine the status of their barangays vis-à-vis the four MGP-targeted services and assess the extent of the unmet needs in its catchment areas. The teams should note extremes of performance (both extremely good and most deficient). Problem barangays should be highlighted in red or yellow on the transparency.

8. The partially completed CAST allows an LGU team to see the deficiencies in a particular health facility. Later, the team will use these data to prioritize barangays for service performance improvements.

9. During the plenary session, explore the validity of the data presented and the accuracy of the percentage of total households surveyed. For example, every time a team shows that it surveyed all households in a barangay, be sure to question this assertion. If the CPR looks unusually high, ask the team if it checked the validity of the interview methods used by the BHWs conducting the survey. Data problems such as these will be an ongoing issue as the teams update their CBMIS forms. It is important to begin to address the issue of data validity during the Phase II workshop.

10. Confirm the definition of a "surveyed household," that is, any household for which a Family Profile (Form 1) has been completed. Remind the teams that the BHWs should complete a Form 1 for every family whether or not the household has members who represent the target groups.

11. After sharing the team's Form 3 and a partially completed CAST in plenary, the person doing the presentation should remain standing to answer questions raised by the other groups.

12. Ask the groups to compare their completed forms with that of the presenter. Promote discussion by encouraging the participants to raise questions and issues. As much as possible, avoid answering their questions directly.

13. Before ending this session, ask the teams to make any needed corrections to their forms, as they will be using these in subsequent sessions on health mapping and planning. Correcting the forms also reinforces their learning.

Facilitator's Notes

Session 3: The Health Facility Situation

Overview

This session provides the teams with experience in reviewing the deficiencies, problems, and/or areas of improvement for the facilities assessed. It also provides them with experience in determining the extent of each problem and exploring its causes. The teams identify the deficiencies that must be addressed to enable the LGUs to respond to unmet needs, improve their service performance, and move closer to Sentrong Sigla certification. The product of this session will be one basis for defining service performance problems and underlying difficulties.

Duration

2.5 hours, maximum

Timing

15 minutes	Briefing
1 hour, 15 minutes	Group work
1 hour (15 minutes per team, as time allows)	Plenary presentations

Facilitation Notes

Observe the teams without being intrusive. Avoid answering questions that arise. Instead, encourage the participants to resolve issues themselves.

1. Introduce the session, the handouts, the tasks to be done, and the products to be completed. Note that the plenary presentation for this session is optional and will depend on the pace at which the groups work and the participants' preferences. In addition, you should also cover the following topics:
   - Explain how to fill out and use the other columns of the CAST.
   - Emphasize that the LGU must address most, if not all, deficiencies in order to be certified. However, since resources are limited, the team should prioritize the deficiencies that are most important to address, for example, those that most constrain the delivery of the four MGP-targeted services.
   - Explain that in the future Sentrong Sigla certification will require a facility to demonstrate actual program performance for the services it is providing. Thus, the CBMIS forms that the team has been completing will help the LGU to demonstrate actual program performance as well as achieve high service coverage.
   - Emphasize that the teams must read all handouts for this session.

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2. Observe each team to see if it understands the instructions and has been filling out the CAST correctly. Make sure that all team members, especially those working at the municipality or city level, participate in the team's discussion of causes that may underlie the identified problems.

3. Ask the teams to identify the deficiencies that most constrain the delivery of the four MGP-targeted services.

Facilitator's Notes

Session 4: The Health Map

Overview

In this session, each team creates a health map of its priority barangays. The map will help the team to identify underserved areas with poor access and the areas with the greatest unmet needs.

Duration

3 hours

Timing

15 minutes	Briefing
1 hour, 45 minutes	Team preparation
45 minutes to 1 hour (15 minutes per team, as time allows)	Plenary presentations

Planning Notes

In planning for this session:

1. Advise each team to bring a map of its overall area of responsibility. Explain that the map should provide sufficient detail for each barangay. It is not advisable for the teams to develop maps for individual barangays or to draw their map during the session.

Facilitation Notes

Observe the teams without being intrusive. Avoid answering questions that arise. Instead, encourage the participants to resolve issues themselves.

1. Introduce the session, highlighting the materials required, the tasks to be done, and the products that will be completed. In addition, you should perform the following tasks:
   - Emphasize that the product of the session is a health map showing areas that are underserved, have poor access, and have the highest levels of unmet needs.
   - Remind the team to identify a moderator for the group.
   - Remind the team that their map should only have three tags of each color (red, yellow, green, and blue), or 12 tags in all. They will place these tags on their top three priority areas for low BHW to population ratio, underserved populations, unmet needs, and facilities with deficiencies.

- Point out the important products of the health mapping exercise. These products include the Table of Unmet Needs, Population Table, and Table of Priority Areas.
- Emphasize that the team should read through all the guidance materials together.

3. Be vigilant about assisting teams that find the health mapping exercise difficult. In particular, observe them as they tag their priority areas and, most importantly, identify real problems. Provide assistance as needed.

4. The health map provides a geographic definition of the problems and the areas needing focus. The maps will be crucial in the following sessions, when the teams define problems and set improvement targets and objectives. The maps will also be useful for prioritizing the barangays and facilities that most deserve attention and resources, given the reality of limited resources and staff time.

Facilitator's Notes
Session 5: The Problem

Overview

In this session, the teams create a three-part definition of the problems they are confronting, as identified through the mapping data analysis carried out during previous sessions. They develop this three-part definition by filling out a "Table of Problems and Indicators," which provides columns for listing service performance problems, health problems, and underlying difficulties. For each type of problem, the teams must develop indicators and indicator baseline values.

This session is one of the most important and challenging of the entire MGP planning process. The facilitator(s) must provide a careful, complete briefing, paying close attention to the definition of terms in the handout "Defining Your Problems and Their Indicators."

Duration

about 4 hours

Timing

15 minutes	Briefing
2 hours, 25 minutes	Team preparation
45 minutes to 1 hour (15 minutes per team, as time allows)	Plenary presentations
20 minutes	Audience feedback

Planning Notes

In preparing for this session, keep in mind that challenges associated with this session's tasks include developing the participants' understanding of:

- the process of defining LGU health problems by first analyzing and defining service performance problems. This approach is useful because it helps the team to focus its MGP planning and intervention design on the four MGP-targeted services and the health problems that will benefit most from improvements in those services.[4]

[4] In the Philippines, the MGP funding organization defined the four services to be targeted for improvement: childhood immunization, tetanus toxoid vaccinations for pregnant women, vitamin A supplementation, and family planning. For this reason, the teams begin to fill out their Health Problem Table by listing their service performance problems and indicators first. In other contexts, where the services to be improved are not already specified, teams may begin by listing their health problems and then proceed to listing service performance problems and underlying difficulties and their indicators.

- the concept of an indicator. Most team members will have had little or no experience in defining indicators for demonstrating problems and measuring improvements. It is essential to begin this session by briefing the participants on indicators and how to formulate them. The handout "Defining Your Problems and Their Indicators" will be useful in expanding the teams' understanding of the concept of an indicator.

Facilitation Notes

Observe the teams without being intrusive. Avoid answering questions that arise. Instead, encourage the participants to resolve issues themselves.

1. Introduce the session, highlighting the materials required, the tasks to be done, and the products that will be completed. In addition, you should perform the following tasks:

   - Explain the difference between the three types of problems that the teams will focus on in this session: service performance problems, health problems, and underlying causes or difficulties.
   - For service performance problems, discuss the two main aspects—inadequate coverage and inadequate quality—and how to measure them. Encourage the teams to express coverage rates in a positive way. This concept is particularly important where coverage rates are good.

     Note: "Unmet need" is complementary to the coverage rate. For example, if the coverage rate for vitamin A supplementation is 45 percent, then the unmet need is 55 percent.

   - For health problems, present common health problems and their indicators. Examples of common health problem indicators include morbidity (the overall incidence or the rate of incidence of a given disease or condition in a population) and mortality (the number of deaths or the rate of deaths from a given disease or condition in a population). Baseline values may be expressed as absolute numbers or as the rate of occurrence in a population.
   - For underlying difficulties, discuss the types of underlying causes that contribute to service performance problems. Examples include inadequate public awareness, difficulties of client access, and lack of resources.

2. In addition, guide the participants as they begin this session by bringing up the following points:
   - Before starting to work on this session's products, read the handouts and examples and discuss these within the team.
   - Continue to refer to your health maps. Consider highlighting the link between some health problems and the locations where they are most prevalent. This linking may be helpful for identifying the causes for some problems.

- Be careful of the difference between unmet need and service coverage. They are complementary.
- Be suspicious of very high coverage rates, since the data may not be valid. For example, if measles cases are occurring in spite of high immunization coverage, then the data are invalid something is wrong, due to vaccine failure or cold chain problems.
- If high coverage is reported, then do not define as a problem the small percentage that remain uncovered.
- Try to formulate appropriate indicators for all problems cited, even if you have no data for the indicator.
- Remember that the indicator should measure the defined problem.

3. The product of this session, the health problem definition, is crucial in the following sessions and must be completed. Most teams will probably complete their definition in the evening, to address comments and suggestions made during the plenary discussion.

Facilitator's Notes

Session 6: Objectives and Targets

Overview

In this session, each team produces an LGU Objectives and Targets Table that lists indicators for each type of problem as well as baseline values and improvement objectives and targets. Some teams may wish to revise their Table of Problems and Indicators as a result of their work during this session.

Duration

about 2 hours

Timing

15 minutes	Briefing
1 hour	Team preparation
45 minutes to 1 hour (15 minutes per team, as time allows)	Plenary presentations

Facilitation Notes

Observe the teams without being intrusive. Avoid answering questions that arise. Instead, encourage the participants to resolve issues themselves.

1. During this session, the teams may find it challenging to express improvement objectives or targets as changes in the indicators defined during Session 5 (in the Table of Problems and Indicators). In setting a target for the desired level of change in indicator value, the team should take into account the timeframe for the intervention as well as improvements that may be required in the level of service coverage and the underlying difficulties.

2. Introduce the session, highlighting the materials required, the tasks to be done, and the products that will be completed. In addition, perform the following tasks:
   - Note that the template for the LGU Objectives and Targets Table is similar to the template for the Table of Problems and Indicators.
   - Ask the teams to start their work by reviewing their Health Problem Table (from Session 5), DOH objectives (in the handout National Health Objectives), and ideas of alternative ways to set targets, as described in the handout "Setting LGU Objectives and Targets."

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- Explain that "objectives" relate to addressing problems, while "targets" relate to improving service coverage. The target is the desired level of coverage by a specific service that will be achieved as a result of the planned intervention(s). Objectives are the desired reductions in the indicators of the health problem(s) being addressed. Objectives are expressed quantitatively as the number of cases or the incidence rate.
- Ask the teams to be ambitious in setting objectives for addressing health problems. If there are currently no cases of a disease for which prevention activities are being carried out, the objective might be to maintain the current level of performance (while acknowledging that there may be some undetected cases).
- Ask the teams to set realistic (but still ambitious) service performance targets. Their service performance targets need to be high enough to make the attainment of the health improvement objective feasible.
- Remind them that not all of the indicators defined in the Table of Problems and Indicators from Session 5 need to be included in the LGU Objectives and Targets Table. The teams must make strategic choices of interventions in areas of greatest need in order to produce the maximum health and service performance benefits given available resources.
- It is perfectly legitimate to set 100 percent coverage targets (for one or more MGP services) for priority barangays.
- They should convert the negative indicators formulated in the problem statement into positive indicators for targets and objectives. For example, they should list the target indicator as the percentage of improvement in coverage.

3. Teams may wish to revise some problems or indicators in their Table of Problems and Indicators as a result of this session.

4. Answer questions about definitions and procedures, but do not provide assistance in defining or calculating selected indicators and their values. Encourage the teams to be both realistic and ambitious and to take other obligations into consideration when estimating likely accomplishments over the next year. Advise them not to limit their ambition in target setting because of current resource shortages. Instead, advise them that in the next session, they will identify resource needs and devise strategies for mobilizing the required resources.

Facilitator's Notes

Session 7: Ideas for Improvement

Overview

In this session, the teams will review the LGU Objectives and Targets Table (from Session 6) and work together to generate a list of possible solutions to the problems they have identified. They should follow the guidelines listed in the handout Guidelines for Generating and Selecting LGU Team Strategies. They will list their proposed interventions in the List of Strategic Interventions and describe them in the Selected Interventions and Their Narrative Descriptions table.

Duration

about 2.5 hours

Timing

15 minutes	Briefing
1 hour, 30 minutes	Team preparation
45 minutes to 1 hour (15 minutes per team, as time allows)	Plenary presentations

Facilitation Notes

Observe the teams without being intrusive. Avoid answering questions that arise. Instead, encourage the participants to resolve issues themselves.

1. Introduce the session, highlighting the materials required, the tasks to be done, and the products to be completed.

2. Introduce the team preparation activity, which is a brainstorming and prioritization exercise that results in two products: a List of Strategic Interventions and a Selected Interventions and Their Narrative Descriptions table. Advise the teams to draw on their own experiences as well as the best practices described in the handouts. In addition, perform the following tasks:
   - Encourage the teams to use group brainstorming and prioritization techniques that ensure full participation by all members in generating ideas, selecting among them, and reaching consensus.
   - Share the sample List of Strategic Interventions (Diarrhea Example). Note that the sample interventions listed address the health problems in the Table of Problems and Indicators (Diarrhea Example).

- Suggest that each team select a moderator to facilitate the discussion and ensure that all team members have an equal opportunity to contribute ideas and make decisions. The team should also select a scribe to record the proposed solutions in the table template.
- Provide assistance as needed regarding the definition of terms, proper use of templates, brainstorming methods, or best practices from elsewhere in the Philippines.
- Encourage the teams to select at least six strategic interventions from their brainstormed list. Remind them that one intervention can address several health problems or unmet needs.
- Suggest that they choose among the suggested interventions by identifying those that:
  - best satisfy the "Guidelines for Generating and Selecting Team Strategies";
  - are likely to be highly effective in solving several problems and unmet needs;
  - are most feasible;
  - will benefit those families and communities in greatest need.
- Remind them that the selected interventions should not require major increases in the LGU's regular budget, unless the team has already made plans for generating additional funds.
- Remind them that strategic interventions should result in a new approach or set of procedures that, once established, will continue. These interventions may improve the performance of routine services or support activities.
- Remind them to pay attention to strategies for mobilizing local resources for supporting service facilities, development costs, and operating costs.

3. The teams should not be shy about admitting that they have not been able to come up with a strategic intervention for some problems. This admission is preferable to writing a general (meaningless) statement for an objective and target.

4. The team should give each strategy a short title and write a brief description in the template provided. They will find the description useful as they develop ideas of activities and fill out their MGP Activity Plan in Session 8.

Facilitator's Notes
Session 8: The LGU Plan

Overview

In this session, each team makes a list of activities for implementing the strategies identified in Session 7. The teams also identify the products that will result from the completion of each activity, the person responsible for each activity, the required resources, and the anticipated timeframe.

Duration

about 3 hours

Timing

15 minutes	Briefing
2 hours, 45 minutes	Team preparation

Facilitation Notes

Observe the teams without being intrusive. Avoid answering questions that arise. Instead, encourage the participants to resolve issues themselves.

1. Introduce the session, highlighting the materials required, the tasks to be done, and the products to be completed. Point out that at the end of the session, each team will have a draft of its MGP Activity Plan, which it will present to decision-makers during Session 9.

2. In your briefing, emphasize the following points:
   - The period that this workplan should cover is usually one year.
   - The team should refer to and use products developed during previous sessions as well as the templates and handouts from this session in developing its MGP Activity Plan.
   - The plan will contain not only activities for implementing the selected strategies from Session 7, but also activities for achieving Sentrong Sigla certification and for rolling out the CBMIS to other barangays.
   - The team should provide concrete examples to illustrate the difference between the two types of MGP developmental activities—strategic actions and routine service activities—and their respective resources.
   - Every activity needs to have a product. For example, the modules developed under the participatory community learning strategic intervention are a product. The number of BHWs trained using these modules is also a product. Products are generated by and mark the end of each activity. Some products may also be inputs required for other activities. For example, the modules are required for and must be completed before the BHWs are trained.

- A named person (not just her/his title or position) must be responsible for each activity.
- Teams should list their activities on large sheets of paper to ensure full understanding and participation of all team members in planning their development work over the next 12 months.
- A team may need to rework its list of activities several times before every team member is confident that the activities planned can actually be carried out, given team members' other, ongoing responsibilities.
- The team needs to estimate the resources required for each activity and the corresponding source. Examples of sources include the LGU (primary source), the MGP, donor agencies, the community, and the DOH.
- A Gantt chart is an optional but useful product that can assist the team in developing a realistic schedule for implementing MGP activities over the coming months. The facilitator should emphasize again that each activity generates a product and is complete when the product is generated.
- Remind the team that MGP activities are developmental and lead to improvements in services. Developmental activities are not services. Emphasize that any services to be provided by an NGO or community source should not be listed as developmental activities. Rather, it is the effort required to set up these services that constitutes the developmental activity.

3. The elements of each team's MGP Activity Plan should be consistent with the team's earlier products, which have identified problems, indicators, objectives and targets, and strategies. A team may redefine its strategies after having considered the difficulties of implementing them. However, discourage the team from revising its problems and targets.

4. Throughout the session, provide the teams with assistance, as needed, in differentiating developmental and service activities and resources.

5. At the end of the session, provide the teams with assistance, as needed, in reproducing a sufficient quantity of draft plans to meet the needs of the review panel during the plenary presentation in Session 9.

Facilitator's Notes

Session 8a: The Regional/Provincial Monitoring Plan

Overview

In this session, the regional and provincial team makes a list of its monitoring objectives and the activities it will need to do in order to carry out its monitoring functions. The team should discuss, list, and select components and indicators for its monitoring checklist.

Duration

about 3 hours

Timing

15 minutes	Briefing
2 hours, 45 minutes	Team preparation

Facilitation Notes

1. Introduce the session, highlighting the materials required, the tasks to be done, and the products to be completed. During your briefing, emphasize that the CHD and Provincial Health Office group:
   - will have, at the end of the session, a draft of its Monitoring Plan and a monitoring checklist;
   - will present its plan to decision-makers and the LGU teams during the final session. Audience members will be looking to the CHD and Provincial Health Office group to provide support for the implementation of their strategies. The Monitoring Plan should include support activities and monitoring and evaluation activities. The group must be clear and specific about the extent of support it is committing to provide to the LGU's as they implement their MGP strategies;
   - should plan to undertake many levels and types of monitoring. For example, the team may wish to monitor activity completion, resource use, service performance, health improvements, and data validity;
   - should include in its Monitoring Plan activities related to rolling out the CBMIS, updating and verifying CBMIS data, and achieving Sentrong Sigla certification (as listed in the handout "MGP Milestones");
   - should delegate monitoring and support responsibilities, as discussed during orientation. The Monitoring Plan and the monitoring checklist must specify CHD and Provincal Health Office monitoring and support responsibilities, and the team must make sure that each group understands its responsibilities;

2. At the end of the session, provide the team with assistance, as needed, in reproducing a sufficient quantity of draft plans to meet the needs of the review panel during the plenary presentation in Session 9.

Facilitator's Notes

Session 9: Presentation of the LGU Plan

Overview

This session is a formal plenary with invited guests. In this session, the LGU teams and the CHD and Provincial Health Office team present their plans, get feedback from the review panel, and receive a commitment of support for plan implementation.

Duration

2.5 hours

Timing

10 minutes	Briefing (by the facilitator) and Opening (by the Chairperson)
80 minutes (about 20 minutes per team)	Presentation of plans
60 minutes	Panel of decision-makers summarizes their feedback and support

Planning Notes

1. Follow up with the invited guests to make sure that they attend this session as planned.

2. Ask the chairperson to brief the invited guests ahead of time on their roles during this session and what is expected of them. The briefing may be done when the guests are invited, the night before the session, or both.

3. Provide the teams with an opportunity to rehearse their presentations and receive feedback from the facilitators on how to improve them. Advise the teams to avoid excessive detail in their presentations. Rather, they should describe the main points of their expected achievements, service improvements, and resource requirements.

Facilitation Notes

1. The chairperson introduces the invited guests and the members of the panel. The Chairperson provides the invited guests with a brief background of the program, the activities accomplished to date, and the past week's planning efforts.

2. The chairperson must keep the program on schedule. She should allow each team 20 minutes to deliver an oral presentation that presents its health map, enumerates its identified problems, describes the selected intervention, and presents its MGP Activity Plan. The team should support its presentation with graphics (such as its health map, charts, and

graphs). The time allotment should include time for questions and comments from other participants, the facilitators, and the invited guests. The chairperson should take care to avoid debate at this point. If necessary, the chairperson may remind the participants that the panel will be providing feedback on all of the presentations and plans later in the session, once all the presentations are completed.

3. During their presentations, the teams should clarify their strategies for resource mobilization.

4. The CHD and Provincial Health Office group may present its monitoring plan immediately following the teams' presentations or after the decision-makers' response.

5. Once the presentations are completed, the panel of decision-makers will give their reactions to each proposal. The panel may ask for a break at the end of the presentations to discuss among its members the comments they wish to make. The panel's feedback should include guidance on proceeding with implementation. Panel members should express any serious reservations they may have about any of the proposals. Any reservations should include suggestions for revisions. These suggestions may be useful in guiding all teams on how to adjust their plans.

6. After the panel members have given their feedback, the chairperson summarizes the results of the workshop, confirms commitment to the plans, and closes the session and the workshop.

Glossary

barangay — a geographic division within a town or municipality (which consists of several barangays). A barangay is the smallest political unit in the Philippine system of government. A barangay is headed by a *Punong Barangay* or Barangay Captain.

Barangay CBMIS Tally Sheet (Form 2) — a form for summarizing the data from all Family Profiles (Form 1) in a given barangay. The summarized data provides an overall picture of the magnitude of the unmet needs for immunizations, tetanus toxoid vaccinations, vitamin A supplementation, and family planning in a barangay.

barangay health station/barangay health center (BHS/BHC) — a health facility that provides services for a barangay or a cluster of barangays, depending on their size.

Call Card — a personalized invitation sent by a midwife to a family with unmet needs. The Call Card lists the basic health services needed by targeted members of the family, and the date and place where these services will be given.

Catchment Area CBMIS Tally Sheet (Form 3) — a form for summarizing the Form 1 data from several barangays. The summarized data gives the midwife an overall picture of her catchment area and helps her to identify barangay(s) with unmet needs and plan for future efforts.

Causal Analysis Summary Table (CAST) — a table for listing the deficiencies, problems, and areas for improvement for one health facility.

center for health development (CHD) — regional offices of the Department of Health. CHDs are responsible for providing technical assistance to Local Government Units (LGUs) and for sharing staff capabilities with other regions.

Certification and Recognition Program (CRP) — one of two complementary strategies of the Sentrong Sigla. The CRP focuses on improving health facility compliance with established quality standards. Facilities that meet these standards are certified by the DOH as providing quality health services.

Community-Based Monitoring and Information System (CBMIS) — an information system that enables health service providers to systematically identify, categorize, and prioritize women and children with unmet needs for immunizations, tetanus toxoid vaccinations, vitamin A supplementation, and family planning.

Consolidation of CASTs Table	a table for summarizing data on facility deficiencies throughout a barangay or cluster of barangays.
Continuous Quality Improvement (CQI)	a process-oriented approach to improving service quality. The CQI approach emphasizes building staff capacity to work as a team to identify service delivery challenges, apply tools, and improve service quality.
current users	the total number of married women of reproductive age using any family planning method in a barangay, catchment area, or other specific geographic area at a specific point in time.
developmental activities	step-by-step actions undertaken by the LGU team to implement its MGP strategic interventions. These one-time activities are intended to result in a new approach or set of procedures that, once established, will continue.
developmental resources	major resources critical for the completion of developmental activities—both strategic actions and routine service activities.
developmental strategy	a strategic intervention designed by an LGU team to address and reduce service performance problems, health problems, and underlying difficulties.
difficulties	underlying causes of service performance problems.
expected products	the observable and measurable outputs of each activity. Once a product is produced, the activity is completed.
Facility Self-Assessment Checklist (FSAC)	a self-evaluation guide for health staff to use in assessing the quality of the services provided at their facility and evaluating their level of preparedness for Sentrong Sigla certification.
Family Profile (Form I)	a two-page form in which BHWs or other community volunteers record general information about the family as well as data on immunizations, tetanus toxoid vaccinations, vitamin A supplementation received, and family planning practices.
field practicum	the community survey and facility assessment carried out by LGU teams in their catchment areas between the MGP Phase I and Phase II planning workshops. The teams use the field practicum data to develop their MGP Activity Plan.
fully immunized child	a child who has received all required doses of the vaccinations against the six immunizable diseases.
Gantt chart	a visual planning tool that presents a team's timeframe for implementing its MGP interventions.
***Garantisadong Pambata* (Preschoolers Health Week)**	a nationwide campaign against micronutrient malnutrition conducted every six months at designated centers or during home visits by health workers and volunteers. The campaign workers give a vitamin A capsule (200,000 IU) to children 12 to 59 months old.

growth monitoring chart (also known as "yellow card") — a card for recording a child's weight at regular intervals during its first year of life and when all vaccinations are received.

health improvement objective — the desired reduction or improvement in one or more health problems in the catchment area's population.

health map — a map showing the catchment area of an LGU team. The LGU team uses the map to prioritize barangays for MGP interventions.

health problem — a population's health-related problem (e.g., morbidity, mortality, or consequences of a disease or condition) that could be addressed by an MGP intervention.

Indigents Program — a social insurance program implemented by PhilHealth that aims to provide high-quality and affordable health care services to the marginalized sector, particularly the bottom 25 percent of the population who cannot afford to pay health insurance premiums.

LGU Objectives and Targets Table — a table where an LGU lists indicators, baseline values, and improvement objectives and targets for its health problems, service performance problems, and underlying difficulties.

Local Government Unit (LGU) — a political subdivision, structure, or unit. In the Philippines, there are four types of LGUs: province, city, municipality, or barangay. LGUs have clear and legally recognized boundaries over which they exercise authority and within which they perform public functions.

married women of reproductive age — married women 15 to 49 years old. "Married" does not necessarily mean legally married; if a woman stays with a man under one roof and considers the man her permanent partner, the couple is considered married for the purpose of the CBMIS Family Profile.

Matching Grant Program (MGP) — a grant mechanism to help municipalities and cities expand service delivery coverage and improve the quality of primary health care provided to women and children in a decentralized health program setting. Under the MGP, the DOH provides grants of between PhP250,000 and 500,000 to interested and eligible LGUs through the CHDs.

MGP Activity Plan — a table for listing an LGU's MGP strategy, developmental activities, expected products, person responsible, developmental resources, the amount and source of developmental resources, and timeframe.

memorandum of agreement — a legal document signed by the local government (mayor and/or governor) and the Regional Director prior to initiating implementation of the MGP in a locality. The memorandum of agreement defines the implementation and financial roles and responsibilities of the LGU and the CHD under the MGP.

National Objectives for Health — a national government strategy for significantly improving the nation's health. The document provides a list of national goals and objectives for health by 2004.

operating schedule the specific hours that a health facility is open.

person responsible the name of the person who is primarily responsible for the activity and its product and who will be held accountable for managing implementation.

PhilHealth the Philippine Health Insurance Corporation, mandated by law to administer the National Health Insurance Program (NHIP).

prioritized barangays barangays that an LGU team has prioritized for initiating MGP interventions. The team prioritizes barangays based on their levels of unmet needs, poor access, underserved populations, and underlying difficulties.

purok a zone within a barangay.

Quality Standards List a list of recommended standards and requirements for providing quality services under the Sentrong Sigla. There are two lists—one for Rural Health Units (RHUs)/Health Centers (HCs) and the other for Barangay Health Stations (BHSs). These standards are national program guidelines of the Department of Health (DOH).

regional/provincial monitoring objectives specific CHD and Provincial Health Office expectations related to their ability to monitor LGU implementation of the work plans and the anticipated results.

routine service activity a routine service activity is related to delivering or supporting the delivery of a health service provided on a regular basis, albeit at an insufficient level at the current time. A routine service activity is initiated as an MGP developmental activity and then continues over time as part of ongoing services and/or support activities.

rural health unit a health facility providing primary health care services (primarily preventive rather than curative services) for an entire town or municipality. An RHU is usually located in the town proper.

Sentrong Sigla (Centers of Vitality) a joint effort of the DOH and LGUs to ensure the availability and accessibility of high-quality health services in health centers and hospitals.

service performance improvement target the desired increase in coverage of one or more specific services for identified segments of the catchment population.

service performance problem a problem related to the reach and accessibility of a facility's services. In the context of the MGP, it is a problem that relates to coverage by the four MGP-targeted services and that can be addressed by an MGP intervention.

session products the specific outputs produced by a team at the end of each MGP planning workshop session (both Phase I and Phase II).

sitio a sitio is a zone within a barangay.

source of developmental resources the agency, government department, or private organization that is funding the activity.

strategic action — a strategic action addresses one or more identified problems and results in the development and implementation of a new approach or set of procedures or practices, that, once established, will continue in future. Strategic actions are discrete activities that do not need to be repeated.

strategic intervention — an LGU strategy or approach for raising service performance or addressing health problems or underlying difficulties. A strategic intervention usually results in the development of a new approach or set of procedures that, once established, will continue.

Table of Problems and Indicators — a table for listing the health problems, service performance problems, and underlying difficulties faced by an LGU team. The table also provides columns for listing the indicator(s) and baseline value(s) for each problem.

targets — a desired improvement, usually in a specific quality of care indicator, service, or difficulty. Targets may be expressed quantitatively, either as a percent or as absolute numbers.

timeframe — the period when the LGU will be planning and implementing the activity.

underlying difficulty reduction target — an expression of the desired extent of improvement in a previously defined underlying cause or difficulty.

underserved areas — barangays with a BHW to household ratio lower than one BHW per 25 households (e.g., 1:50 or 1:100).

unmet needs — the unmet needs of a family, barangay, and/or catchment area for an MGP-targeted service (childhood immunizations, tetanus toxoid vaccination, vitamin A supplementation, and/or family planning).

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About Management Sciences for Health

Management Sciences for Health (MSH) is a private, nonprofit organization, dedicated to closing the gap between what is known about public health problems and what is done to solve them. Since 1971, MSH has worked with policy-makers, health professionals, and health care consumers around the world to improve the quality, availability, and affordability of health and population services.

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We provide long- and short-term technical assistance through four Centers of Excellence: Leadership and Management, Health Services, Health Reform and Financing, and Pharmaceutical Management. Our award-winning publications and electronic products augment our assistance through the Centers of Excellence.

Current major efforts by MSH to address problems in public health include the following:

- MSH manages two global programs funded by the US Agency for International Development: the Management and Leadership Program and the Rational Pharmaceutical Management Plus Program. The worldwide Strategies for Enhancing Access to Medicines (SEAM) Program is funded by the Bill & Melinda Gates Foundation.

- MSH is the managing partner of the Partnership for Child Health Care, Inc., which implements USAID's principal child survival project, Basic Support for Institutionalizing Child Survival (BASICS II). MSH also manages the consortium that carries out Advance Africa, a major program for integrating and scaling up family planning and reproductive health services in Africa.

- MSH is carrying out several national projects, including three in Africa (Guinea, Senegal, and South Africa), two in Latin America and the Caribbean (Haiti and Nicaragua), five in Asia (Afghanistan, Bangladesh, India, two in the Philippines), and one in the Newly Independent States (Georgia).

Appendix A

Over time, the MGP project team has developed a wealth of successful intervention examples that participating LGUs have applied in their target areas. Facilitators share these intervention examples, entitled Best Practices and Technical Notes, with new LGU enrollees to foster the generation of ideas. The Best Practices and Technical Notes provided in Appendix A are:

"The Matching Grant Program: A Strategy to Expand Local Health Service Delivery"

"Expanding the Delivery of Health Services through a Community-Based Monitoring and Information System"

"Personalized Client Follow-Up through Call Slips"

"Using the Community Based Monitoring and Information System to Help Reduce Unmet Needs"

"Bringing Sterilization Services to the Main Health Center"

"Mother-Baby Watch"

"EPI Plus"

"Strengthening Provincial-Municipal Partnerships through Subgranting"

TECHNICAL NOTES

THE MATCHING GRANT PROGRAM
A Strategy to Expand Local Health Service Delivery

Background

In 1999, the Philippine Department of Health launched the Matching Grant Program (MGP) to help municipalities and cities expand service delivery coverage and improve the quality of primary health care for women and children in a decentralized system. The program aims to fully immunize children under 12 months of age, protect newborns from tetanus, supplement the diets of children from one to five years of age with vitamin A, and increase the use of modern contraceptives among married women of reproductive age.

As a component of the Integrated Family Planning and Maternal Health Program, the MGP initially targeted municipalities and cities with large populations but is now available to smaller and poorer municipalities (health districts, for example) that can be clustered. The shift was made to strike a balance between the goal of achieving impact and the need to focus resources on disadvantaged populations.

The MGP focuses on expanding service delivery in these areas through financial and technical assistance while promoting improved quality of services. By focusing on service delivery expansion, the program intends to correct inequities in the delivery of health services and facilitate the flow of funds to the point of service.

How the Matching Grant Program Works

The MGP uses a "grantee-friendly" application process, with the local government units (LGUs) defining their own goals and strategies based on actual needs (see Box 1). Through the Department of Health Centers for Health Development, the MGP provides grants of about PhP250,000-500,000 (US$5,000-10,000) to interested LGUs. A grantee municipality or city provides additional funds to indicate commitment to the program and enhance program sustainability. In the past, LGUs determined how much they would contribute, but this amount was later standardized at no less than 25% of the total grant amount. LGUs use their contributions to meet the Sentrong Sigla certification requirements and/or to enroll indigent families in the Indigent Program of the Philippine Health Insurance Corporation (PhilHealth).

Management Sciences for Health, through funding from USAID, provides technical assistance to all participating municipalities, cities, provinces, and regions. The MGP technical assistance package, which uses a learning-by-doing approach, was developed and used in training and planning activities for the LGUs (see Box 2). The technical assistance package includes training health providers to implement the community-based monitoring and information system, and conducting health facility self-assessments to

Box 1. The MGP Process

1. A Department of Health Center for Health Development (CHD), formerly known as the Regional Health Office, invites eligible LGUs to submit a letter of interest to participate based on the program description in the MGP Fact Sheet.
2. An interested LGU submits a letter of interest to the CHD.
3. The CHD orients the interested LGU to the MGP and assesses the LGU's needs.
4. The CHD and LGU sign a memorandum of agreement.
5. The CHD releases 40 percent of the MGP grant.
6. The LGU conducts a community-based assessment of households and a health facility assessment.
7. The LGU develops a work plan using the assessment data, with technical assistance from the CHD and concerned province, and submits the plan to the CHD for approval.
8. The CHD releases the remaining 60 percent of the grant upon approval of the work plan.
9. The LGU implements the work plan.
10. The CHD and concerned province monitor MGP implementation in the area and provide technical assistance.
11. A subsequent grant may be made available to any LGU that reapplies, subject to the availability of funds, the LGU's need for further improvement in health service delivery, and its ability to fulfill its MGP commitments as demonstrated by its previous performance.
12. Steps 4-11 are repeated.

establish innovative and responsive interventions that address the unmet needs of women and children. The community-based monitoring and information system enables health service providers to identify, categorize, and prioritize women and children who need health services. The health facility self-assessment helps LGUs identify the deficiencies of their existing health facilities. Together, the data generated from the community-based monitoring and information system and health facility self-assessment provide a basis for planning and monitoring MGP activities.

During the early stages of MGP implementation, the community-based monitoring and information system survey was conducted after the LGU work plan had been formulated and approved. This prevented the LGUs from preparing a needs-based plan from the outset and made it necessary to spend time adjusting the plan based on the survey results. The process was changed, making the baseline survey a prerequisite for work planning.

Box 2. MGP Technical Assistance Package for LGUs

Phase 1

Day 1

Session 1: Workshop Objectives, Design, and Program of Work

To enable participants to understand the workshop objectives, method of work, and the rationale of the team approach to implementing the MGP technical assistance package.

Session 2: Community-Based Monitoring and Information System (CBMIS):
Family Profile (Form 1)

To enable participants to understand the CBMIS and correctly fill out the Family Profile.

Session 3: Family Profile Field Practicum

To enable participants to plan and conduct a field interview, including actually filling out a Family Profile.

Day 2

Session 4: Review of Family Profiles

To give participants the skills to review and correct the Family Profiles.

Session 5: Barangay CBMIS Tally Sheet (Form 2)

To enable participants to summarize the Family Profiles using the Barangay CBMIS Tally Sheet.

Session 6: Call Cards and Midwife's Copy

To enable participants to identify the unmet needs of each family using data from Family Profiles, properly fill out a call card, and prepare a duplicate copy (midwife's copy) for each call card issued.

Session 7: Municipal CBMIS Tally Sheet (Form 3)

To enable participants to properly fill out a Municipal CBMIS Tally Sheet.

Session 8: "From the Top"

Using data from the field practicum, to enable participants to summarize information using Forms 2 and 3, identify the unmet needs of each family, fill out call cards and midwife's copies as needed, and summarize completed Barangay CBMIS Tally Sheets for eventual transfer to the Municipal CBMIS Tally Sheet.

Session 9: Updating the CBMIS

To enable participants to appreciate the importance of properly updating the CBMIS forms and understand the process of CBMIS updating.

Day 3

Session 10: Health Facility Assessment

To enable participants to use the facility self-assessment checklist in conjunction with the Sentrong Sigla Quality Standards Lists and identify corresponding areas for improvement.

Session 11: Planning for CBMIS Initial Profiling and Facility Assessment

To enable participants to plan for CBMIS roll-out (training of health workers), survey of priority barangays, and assessment of health facilities.

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Box 2, continued: MGP Technical Assistance Package

Phase 2 (2 months after Phase 1)

Day 1

Session 1: Workshop Objectives

To enable participants to understand the workshop objectives and become familiar with the workshop syllabus, session guides, and background materials.

Session 2: Developing the Definition of the Problem

To enable participants to identify health problems, define the indicators for measuring and monitoring the chosen problems, and quantify the current problems.

Session 3: Presentation of CBMIS Data and Health Facility Assessment

To enable participants to present the results of their initial CBMIS survey.

Day 2

Session 4: Health Facility Assessment Discussion and Causal Analysis

To enable participants to analyze and prioritize health facility deficiencies, problems, and areas for improvement.

Session 5: Defining the Problem-Health Mapping

To enable participants to construct a health map, analyze CBMIS survey data, and identify priorities.

Session 6: Formulation of Objectives and Targets

To enable participants to set objectives for reducing health problems and targets for increasing service delivery coverage.

Session 7: Idea Generation and Selection

To enable participants to identify the most appropriate intervention(s) to reduce the problem(s).

Day 3

Session 8: LGU Planning

To enable participants to develop an LGU plan that addresses the service delivery problems and health facility deficiencies and areas for improvement to qualify for certification.

Session 9: Regional/Provincial Planning

To enable regional/provincial participants to develop a monitoring checklist for health service delivery, certification, and MGP fund utilization

Session 10: Presentation of LGU Plan for Health Service Delivery and Sentrong Sigla Certification

To enable participants to present their LGU plan for service delivery expansion and achievement of quality standards for certification.

The way in which funds were released was also modified so that funds would be available to conduct the baseline survey. Instead of releasing the grant as a lump sum upon approval of the LGU work plan, funds are now released in two tranches: 40 percent upon signing of the memorandum of agreement and 60 percent upon approval of the work plan.

The Benefits of Implementing the MGP

The MGP, as a granting mechanism and service delivery strategy, is effective in assisting LGUs to improve health services by making more resources available locally. According to an evaluation conducted by the Population Council, the MGP has also enabled the local governments to mobilize additional resources, either financial or in kind, from other sources, such as the Department of Health regional offices, provincial health offices, nongovernmental organizations, and private drug companies, to implement their work plans.

In addition, the MGP planning process allows LGUs to identify gaps in demand generation and service delivery and to adopt multipronged approaches to address these gaps. The community-based monitoring and information system is particularly useful in identifying people who have little or no access to essential public health services, either by choice or by circumstance.

Finally, the MGP adopts a highly participatory process that involves the Department of Health regional offices, provincial health offices, municipal/city health offices, local officials, and volunteer health workers. The Department of Health regional offices manage the program at the subnational level, from identification of grantees to monitoring of plan implementation. The provincial health offices, with their regional counterparts, provide technical assistance to the municipalities and cities during training in use of the community-based monitoring and information system and in the course of program implementation. Municipal/city health workers are primarily responsible for planning and implementation. Local officials provide counterpart resources, in cash, in kind, or both, to facilitate the implementation of planned interventions. The volunteer health workers play a crucial role in implementing the community-based monitoring and information system, particularly in the conduct of the house-to-house survey. The involvement of different levels of government in MGP implementation has reestablished the collaborative relationships that existed before devolution.

Status of MGP Implementation

To date, 145 municipalities and cities across 41 provinces in 14 regions of the country are enrolled in the program (see Table 1). Of these, 81 (56%) have at least one Sentrong Sigla-certified health facility, while 67 (46%) have enrolled their indigent constituents, numbering about 87,764 families, in PhilHealth's Indigent Program. More municipalities and cities are expected to enroll by the end of 2001, as regions and provinces become more interested in the MGP.

Table 1. Matching Grant Program Enrollees, by Region, as of August 31, 2001

Region	No. of Provinces w/ MGP Enrollees	No. of Enrolled Municipalities/Cities (as of 8/31/2001)	% of Enrollees w/ Sentrong Sigla-Certified Health Facility (as of 12/31/2000)	% of Enrollees w/ Indigent Families Enrolled in PhilHealth's Indigent Program (as of 8/31/2001)
Philippines	**41**	**145**	**55.9**	**46.2**
National Capital Region	n.a.	3	100.0	66.7
Cordillera Administrative Region	0	0	0.0	0.0
Ilocos	3	9	44.4	44.4
Cagayan Valley	2	4	75.0	25.0
Central Luzon	3	4	100.0	100.0
Southern Tagalog	6	7	100.0	85.7
Bicol	3	15	33.3	20.0
Western Visayas	2	17	35.3	35.3
Central Visayas	2	7	71.4	14.3
Eastern Visayas	5	13	23.1	76.9
Western Mindanao	2	2	50.0	50.0
Northern Mindanao	2	3	66.7	33.3
Southern Mindanao	6	53	62.3	47.2
Central Mindanao	3	6	50.0	50.0
Autonomous Region of Muslim Mindanao	0	0	0.0	0.0
CARAGA	2	2	100.0	50.0

Notes:

1. MGP areas account for 10.2% of total number of Sentrong Sigla-certified health facilities nationwide.
2. MGP areas account for 16.6% of total number of indigent families enrolled in PhilHealth's Indigent Program.

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a nonprofit organization strengthening health programs worldwide

United States Agency for International Development (USAID)

Updates from the Field
TECHNICAL NOTES

EXPANDING THE DELIVERY OF HEALTH SERVICES THROUGH A COMMUNITY-BASED MONITORING AND INFORMATION SYSTEM

Background

The 1998 Philippines National Demographic and Health Survey indicates that coverage rates for childhood immunization, vitamin A supplementation, use of family planning, and protection from neonatal tetanus are still well below the desired levels. About 65 percent of children 12-23 months are fully immunized, and only half of the youngest children in families are protected from neonatal tetanus. Vitamin A is distributed twice a year during national campaigns, so coverage is generally high unless there is a supply or distribution problem. Although contraceptive prevalence has increased steadily over the past 30 years, use of modern contraceptive methods is relatively low, at 32 percent. A significant portion of women and children remain either unserved or underserved by essential public health services.

At present, a national health information system is used to determine targets for specific health services as a fixed proportion of a projected population. This system may be useful for allocating supplies, but it is not a good basis for calculating rates of achievement. Moreover, the existing reporting system captures only those who actually go to government health facilities and, therefore, fails to give an accurate picture of coverage rates. Since Local Government Units (LGUs) very seldom, if ever, organize community outreach activities, many families, particularly those in economically depressed, hard-to-reach areas, lack information about or access to basic health services. These people remain faceless and are neglected because there are no deliberate and sustained efforts to assess their needs and why they are not using services. The challenge, therefore, is twofold: (1) to routinely identify the women and children in *barangays* (villages) who are not using public health services, who have discontinued using the services, who are dissatisfied with the services, or who are no longer on schedule for services; and (2) to revise routine service delivery activities to give better access to all families in barangays.

What Is the Community-Based Monitoring and Information System?

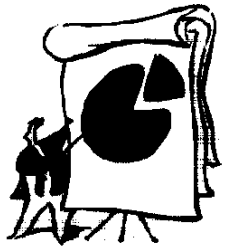
In 1999, the Department of Health, with technical assistance from Management Sciences for Health (MSH) and the Population Council, introduced a community-based monitoring and information system (CBMIS) to all Local Government Units participating in its Matching Grant Program (MGP). The new CBMIS evolved from a system introduced in 1996 in the province of Pangasinan in the north and Iloilo City in the south. The earlier version focused on family planning, while the new one also covers child survival services: tetanus toxoid vaccinations for pregnant women to protect newborns from tetanus, immunization, and vitamin A

MATCHING GRANT PROGRAM
Department of Health

Community-Based Monitoring and Information System

CBMIS

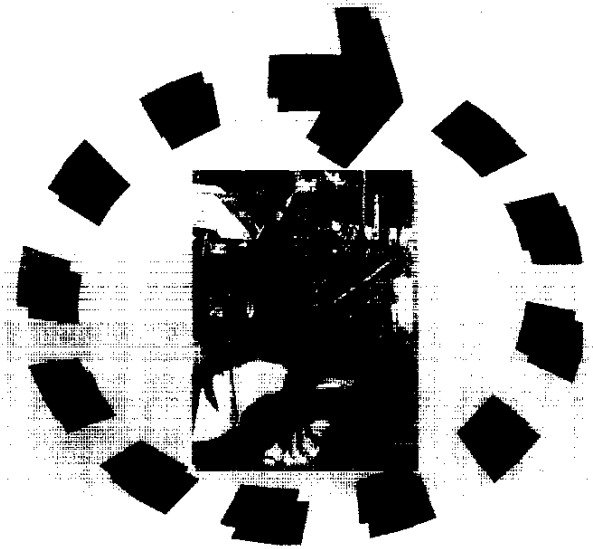
Proportion of the population served by routine or existing health interventions



Proportion of the population missed by routine or existing health interventions

4. Maintain CBMIS
- Update CBMIS Form 1
- Update Midwives' copies of call cards
- Update FHSIS Target Client List

1. Identify All Target Clients
- Family enumeration by the BHWs using CBMIS Form 1
- Systematizing work of BHWs



3. Plan & Implement Interventions
- Give call cards to all families with unmet needs (priority levels)
- Other interventions aside from the existing or routine services
- For example, TTV during pre-marriage counseling or Voluntary Surgical Sterilization in cooperation with other GOs/NGOs

2. Summarize and Analyze Form 1
- Summarize Family Profiles using CBMIS Forms 2 & 3
  - ✓ Determine the number of clients with unmet needs
  - ✓ Data for planning interventions

supplementation. These are the program activities the MGP currently supports.

The CBMIS enables health service providers to systematically identify, categorize, and prioritize women and children for these services. It provides the basis for planning and implementing interventions that use available resources more effectively. Volunteers canvass households barangay by barangay to complete family profiles. Midwives complete tallies to create a picture of the health problems in barangays: children who have not received essential public health services, and married women of reproductive age (MWRA) who want to space births and are not using a contraceptive method or who are using a method but are dissatisfied with it. After completing a "spot map," doctors, nurses, and midwives meet to develop plans to modify their service delivery activities to tackle the problems in a cost-effective way.

A health worker completes a Family Profile during a home visit

How Does the CBMIS Work?

The CBMIS consists of four steps: identifying women and children who need services, summarizing and analyzing family profiles, planning and implementing service delivery interventions, and maintaining the CBMIS.

☞ Identifying women and children who need services

Community health volunteers, known as Barangay Health Workers (BHWs), conduct a family enumeration to identify women and children. In some areas, other community volunteers, such as the Barangay Nutrition Scholars or Barangay Supply Point Officers, help with the household visits. Data on vaccinations against the six immunizable diseases are collected on children under 3 years of age, on vitamin A capsules given to children between 1 and 5 years of age during the past 6 months, on tetanus toxoid vaccinations given to MWRA, and on the desire of MWRA to space births or stop having children. Before making household visits, field coordinators providing technical assistance to the Department of Health conduct a four-day training and planning workshop for LGU health personnel, including doctors, nurses, and midwives. This training focuses on conducting household visits, completing CBMIS forms, processing data, and interpreting and using these data to develop more effective service delivery activities. The midwives, in turn, orient and train their BHWs, particularly in collecting the data during household visits. During the workshop, participants visit nearby communities, accompanied by local health workers familiar to families in the communities, to practice interviewing women and collecting data.

Each BHW is assigned a number of households to survey. The number is limited, to allow the worker to finish the survey in a reasonable time, given population density and terrain. To ensure the quality of the data gathered, midwives usually accompany selected BHWs during their first few interviews until they are confident that the community health workers can do a good job.

BHWs use a two-page **Family Profile (Form 1)** during household visits—one form for each family. The form includes space to record (1) general information about the family; (2) a list of all children under 5 years old and the vaccinations and vitamin A capsules they have received; (3) a history of the tetanus toxoid vaccinations MWRA have received, including information on protection of the youngest child against neonatal tetanus; and (4) information on family planning practices. The BHWs keep this Family Profile and update it monthly as health services are provided.

☞ Summarizing and analyzing family profiles

As each interviewer completes her survey of assigned households and submits the completed Family Profiles, the midwife starts totaling the data on the **Barangay Tally Sheet (Form 2)**. The tally sheet summarizes the data gathered from the Family Profile by barangay. A tally sheet is completed for every barangay. It provides an overall picture of the magnitude of the unserved and underserved: children who have not been fully immunized or received vitamin A capsules; MWRA

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FAMILY PROFILE

CBMIS Revised Form as of 02 2001

FORM 1, page 1

General Information

Address: _____
Respondent: _____
Father: _____
Birthday: ___/___/_____ (mm/dd/yy) Age: _____
Mother: _____
Birthday: ___/___/_____ (mm/dd/yy) Age: _____
Civil Status: ( ) Single ( ) Married ( ) Widow ( ) Separated

BHS/BHC: _____
RHU: _____
Mun/City: _____
Province: _____

NOTE: Please use pencil in completing the form to facilitate updating!

BHW: _____
RHM: _____
PHN: _____
Interviewer: _____
Date Surveyed: _____
Date of last update: _____

Part I. Data of children 0 - 4 years old (0 - 59 months old, start from the eldest)

Name	Birthday			Age	Where does the child receive vaccinations? B = BHS/BHC R = RHU/MHC P = Private G = Gov't Hosp *(See "A" below)*	Does the child have any vaccination record? Y = Yes N = No *(See "B" below)*	Vaccinations Received (*For children 0-11 months old,* write the date when vaccination was given) (*For children 12-59 months old,* put a Y if child was given vaccination or an N if not given) If the child 0-11 months old has NO vaccination or the vaccination schedule is NOT followed, *(See "C" below)* If the child 1-4 years old has INCOMPLETE or NO vaccination, *(See "D" below)*								FIC *(For children 9 months to 4 years old)* Did the child receive all the preceding vaccinations before his/her first birthday? Y = Yes N = No	Vitamin A *(For children 1-4 years old only)* Was the child given Vitamin A capsule (200,000 iu) during the past 6 months? (e.g. Garantisadong Pambata Activities) Y = Yes N = No *(See "E" below)*		Remarks
							BCG	DPT			OPV			Measles				
	MM	DD	YY					1st dose	2nd dose	3rd dose	1st dose	2nd dose	3rd dose			April ___ Year	October ___ Year	

Actions to be taken

A. Follow-up the child's vaccination until completed.

B. Advise the mother to get a copy of the vaccination record from the health facility where the child received the vaccinations or ask the midwife of the nearest BHS to make another record.

C. Refer or accompany the mother and child to the midwife for ***immediate vaccination.***

D. Advise the mother to consult the midwife for completion of the child's vaccinations.

E. Give vitamin A capsule at once, if available, or advise the mother to bring the child to the nearest health facility for the next scheduled Vitamin A supplementation.

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Part II.A. Tetanus Toxoid Vaccination (TTV) for Pregnant Women

Is the mother/wife pregnant?	☐ Yes	☐ No
Total number of TTV doses received	☐ Doses	

If the woman is pregnant, inform her of the importance of prenatal care and tetanus toxoid vaccination that are available at the nearest health facility.

Part II B. Protection at Birth (PAB) against neonatal tetanus: For women with children 0-2 years old only

Name of youngest child (0-2 years old only) _____ Age of youngest child: _____

Complete this table only if the age of the youngest living child is 0 to 2 years old (0-35 months old)

TTV Dose	When was each TTV dose received in reference to the youngest child? Check the appropriate boxes: During the pregnancy with the youngest child	Prior to the pregnancy with the youngest child	Was the child protected at birth (PAB)? Check the appropriate box. *PAB is defined as any of the following:* ◆ 2 TTV doses during the pregnancy with the youngest child, or ◆ 1 TTV dose during the pregnancy with the youngest child plus 2 doses prior to the pregnancy, or ◆ 3 TTV doses prior to the pregnancy with the youngest child
TTV 1			☐ Yes (Protected at Birth)
TTV 2			
TTV 3			
TTV 4			☐ No (NOT Protected at Birth)
TTV 5			

Part III. Family Planning Practice of Married Women of Reproductive Age (MWRA) (Mothers/Wife)

The following should not be interviewed for Part III:

☐ Widowed or separated women ☐ Married but not living with husband

☐ Women with ovaries and/or uterus and/or fallopian tubes surgically removed due to a medical condition (e.g. tumors, ectopic pregnancy)

1. Are you currently pregnant? (See response to Part II A) ☐ No/Unsure ☐ Yes → Actions to be Taken: Remind her again of the need for prenatal care and tetanus toxoid vaccination. END OF INTERVIEW.

2. Do you want to have additional children? ☐ Now or in 2 years ☐ Not sure/Undecided → Inform her of the need for prenatal care when she gets pregnant and the importance of having a healthy pregnancy and healthy baby. END OF INTERVIEW.

3. Are you currently using any family planning method? ☐ Yes ☐ No

☐ No

☐ LAM = Lactational Amenorrhea Method

1. [illegible]
2. [illegible]
3. [illegible]

Barangay CBMIS Tally Sheet

CBMIS Revised Form as of 02/2001

Barangay : _____ RHM : _____

BHS/BHC: _____

Mun/City : _____ Date : _____

FORM 2, page 1

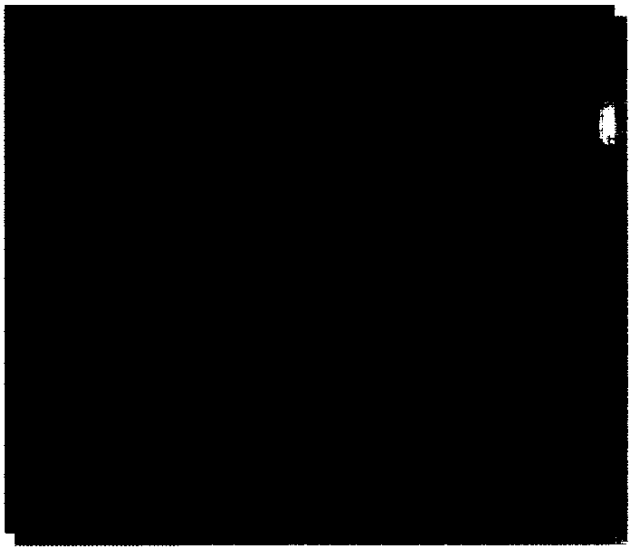
TARGET GROUPS	BHW 1	BHW 2	BHW 3	BHW 4	BHW 5	BHW 6	BHW 7	BHW 8	BHW 9	BHW 10	BHW 11	BHW 12	BHW 13	BHW 14	BHW 15	BHW 16	BHW 17	Total
Purok:																		
I.A. Vaccination status of children 0-11 months old																		
1. Children >9 months old with INCOMPLETE or NO vaccination at all																		
2. Children <9 months old with NO vaccination or with recommended vaccination schedule NOT followed																		
3. Children <9 months old with recommended vaccination schedule followed																		
4. Children 9-11 months old who are Fully Immunized Children (FIC)																		
TOTAL number of children 0-11 months old (sum of #1, 2, 3, & 4)																		
I.B. Vaccination status of 1 year old children (12-23 months old)																		
5. One year old children (12-23 months) with INCOMPLETE or NO vaccination at all																		
6. One year old children (12-23 months) who are Fully Immunized Children (FIC)																		
TOTAL number of 1 year old children (12-23 months) (Sum of # 5 & 6)																		
I.C. Vitamin A supplementation status of children 1-4 years old (12-59 months old)																		
7. Children 1-4 years old (12-59 months) NOT given Vitamin A capsule during the past six months																		
8. Children 1-4 years old (12-59 months) GIVEN Vitamin A capsule during the past six months																		
TOTAL number of children 1-4 years old (12-59 months) (Sum of # 7 & 8 only)																		
II.A. Tetanus Toxoid Vaccination for Pregnant Women																		
9. Pregnant with NO TT or with TT1 only																		
10. Pregnant with TT2+																		
TOTAL number of pregnant women (Sum of # 9 & 10)																		

FORM 2, page 2

	[illegible]	[illegible]	[illegible]	BHW 4	BHW 5	BHW 6	BHW 7	BHW 8	BHW 9	BHW 10	BHW 11	BHW 12	BHW 13	BHW 14	BHW 15	BHW 16	BHW 17	Total

who either want to space births or stop having children but are not practicing family planning; or who use contraceptives but are dissatisfied with the method they are using.

After totaling data from the Family Profiles on tally sheets from each barangay, midwives compare tallies from each barangay on **Form 3 (Municipal Tally Sheet)**. The municipal tally sheet is a two-page form that records barangay totals and percentages so health personnel can compare the problems and accomplishments of different villages. For a midwife covering several barangays, as is mostly the case in the Philippines, the form is important in establishing which barangay(s) should be given priority.

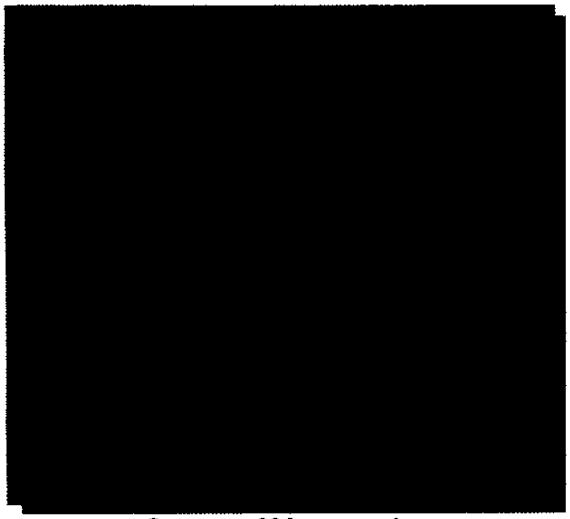


Health worker highlights most significant health problems on tally sheet

☛ Planning and implementing service delivery interventions

With the evidence about which families need health services, the midwife is ready to formulate an annual work plan with the help of her nurse supervisor and technical assistance from regional offices of the Department of Health. Planning involves making a spot map of communities with poor access to health services, underserved populations, or relatively high numbers of families in need of public health services. Barangays or *puroks* (communities within a barangay) are then prioritized, and service delivery practices are reviewed and revised to eliminate gaps in service utilization. The work plan specifies the person responsible for each activity, the due date, and the resources required to implement each activity. It is devised to be carried out with municipal funds, and financial support and technical assistance from the regional health office.

Midwives and their supervisors can repeat the problem-solving process described above at any time during the year as data are routinely tallied from updated Family Profiles. Midwives usually issue "call cards" to families that need services. The call card specifies what services are needed and when and where to get them. When appointments are not kept, midwives have BHWs return to the home to investigate, provide the service, or make other arrangements.



Spot map of 3 barangays in Lapu-Lapu City, Cebu

☛ Maintaining the CBMIS

It is essential to assess the effectiveness of the work plan. Specifically, it is necessary to determine the extent to which the needs of the priority clients have been met and the appropriateness of the service delivery interventions implemented. This assessment can be done only if the LGU maintains the CBMIS. CBMIS maintenance entails updating the Family Profiles either every month or every time health services are provided. It also requires quarterly updating of Forms 2 and 3 and analyzing the data they contain to identify and carry out more effective interventions.

The midwife's duplicate copies of call cards also need to be updated as services are delivered. The call cards are removed from the files only after the target client list has been updated.

Municipal CBMS Tally Sheet

CBMS Revised Form as of 02/2001

Barangay: _____

BHS: _____

Municipality: _____

RHM : _____

Date : _____

FORM 3, page 1

	Barangay		Barangay		Barangay		Barangay		Barangay		Total	
I.A. Vulnerability	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)
1. Children												
2. Children												
3. Children												
4. Children												
TOTAL		100%		100%		100%		100%		100%		100%
I.B. Vulnerability	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)
5. Only												
6. Only												
TOTAL		100%		100%		100%		100%		100%		100%
II.C.	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)
7. Children												
8. Children												
TOTAL		100%		100%		100%		100%		100%		100%
II.A. Vulnerability	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)
9. Preg												
10. Preg												
		100%		100%		100%		100%		100%		100%

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TARGET GROUPS	Barangay		Barangay		Barangay		Barangay		Barangay		Total	
	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)
II.B. Protection at Birth (PAB)												
11. Children Protected at Birth												
12. Children NOT Protected at Birth												
Total number of youngest child 0-2 years old surveyed (Sum of # 11 & 12)		100%		100%		100%		100%		100%		100%
III. Family Planning and Non-pregnant Married Women of Reproductive Age (MWRA)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)	Number (N)	Percent (N÷Total x 100)
13. MWRA not wanting to have a child or wants to space but not practicing family planning												
14. MWRA practicing family planning but not satisfied with the method she is using												
15. MWRA wanting a child within 1 year												
16. MWRA practicing family planning and satisfied with the method she is using												
Total number of non-pregnant MWRA (Sum of # 13, 14, 15 & 16)		100%		100%		100%		100%		100%		100%
FP Methods Used by Current Users												
P = Pills												
IUD = Intrauterine Device												
Inj = DMPA/Injectable												
C = Condom												
BTL = Bilateral Tubal Ligation												
VAS = Vasectomy												
NFP = Natural Family Planning												
LAM = Lactational Amenorrhea Method												
W = Withdrawal												
CAL = Calendar/Rhythm												
TOTAL Number of Current Users (Should equal the sum of # 14 & 16)		100%		100%		100%		100%		100%		100%

Tetanus Toxoid (TT) Vaccination for Pregnant Women

Name : _____ Age : _____

Services Needed	Date when TT vaccination will be given	Place where TT vaccination will be given	Date Given	Signature of Midwife
TT1				
TT2				
TT3				
TT4				
TT5				

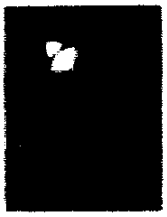
Family Planning Service

Name : _____ Age : _____

FP Services Needed	Date when service will be provided	Place where service will be provided	Date Provided	Signature of Midwife

Matching Grant Program

CBMIS Call Card



_____
_____
_____

Dear _____,

Greetings from the staff of your local health center.

Recently, our local health department through our barangay health workers (BHWs) conducted a survey in your area to identify the health services needed by your family. This is our effort to reach out to each and everyone in your community. From the information you provided our BHWs, we found that the health service/services listed on the following tables is/are needed by one or more members of your family.

Please do not hesitate to avail of the free services to be given by our friendly health personnel on the scheduled date and place.

Sincerely,

Vaccinations for children 0-11 months old

Name of child _____ Age _____

Vaccinations Needed	Date when vaccination will be given	Place where vaccination will be given	Date Given	Signature of Midwife
BCG				
DPT 1				
DPT 2				
DPT 3				
OPV 1				
OPV 2				
OPV 3				
Measles				

Name of child _____ Age _____

Vaccinations Needed	Date when vaccination will be given	Place where vaccination will be given	Date Given	Signature of Midwife
BCG				
DPT 1				
DPT 2				
DPT 3				
OPV 1				
OPV 2				
OPV 3				
Measles				

Vitamin A Supplementation for children 6-9 years old

Name of Child	Age	Date when vitamin A will be given	Place where vitamin A will be given	Date Given	Signature of Midwife

This is one way of tracking whether priority clients have already been served, as reflected in the decreasing number of women and children with unmet needs. The CBMIS data may be used to complement the DOH's Field Health Service Information System target client list.

Status of CBMIS Implementation

The CBMIS has been introduced in more than 50 selected municipalities and component cities participating in the Matching Grant Program. Several regional and provincial health offices have expressed interest in providing financial support to their municipalities and component cities to implement the CBMIS and conduct the training and planning workshop in their areas. It is expected that the CBMIS will be used in more than 200 municipalities and component cities by 2002.

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BEST PRACTICES

PERSONALIZED CLIENT FOLLOW-UP THROUGH CALL SLIPS

Background

Talisay is one of the municipalities of Cebu Province, which is located in the Visayas region of the Philippines. It is about 13 kilometers from Cebu City. As of February 2000, it had a population of 150,278. The municipality comprises 22 *barangays* (villages), including 4 far-flung barangays that have limited access to regular transportation. It has three main health centers and one newly opened district hospital.

Although Talisay is a progressive town with numerous factories, industries, and businesses, the health status of its women and children remains wanting. In 1998, only 83% of its children between the ages of 0 and 11 months were fully immunized. Meanwhile, only 50% of mothers were fully immunized, and 40% were found to be family planning (FP) defaulters, triggering an increase in the birth rate. This was demonstrated by an increase in births at the maternity clinic, with simultaneous deliveries occurring at times.

These conditions may be partially attributable to the inability of health personnel to visit their catchment barangays. Their mobility has been curtailed because of the Commission on Audit regulation that incentives cannot be provided for travel within a 50-kilometer radius. This regulation posed a problem because health workers had to use their own funds to pay for visits to their catchment areas. So health workers tended to stay in the health centers and wait for the clients to come to them. The programs' coverage rates, therefore, dropped and the unmet needs of the people increased.

In 1999, the Matching Grant Program (MGP) of the Department of Health began providing financial and technical assistance to Talisay. Its initial activities under the MGP included establishing a community-based monitoring and information system (CBMIS) which identifies priority clients for FP and maternal and child health (MCH) services, primarily through a household survey. The initial survey showed that many children were not immunized, a number of pregnant mothers had either incomplete or no tetanus toxoid (TT2+) immunization, and current FP users were not obtaining their supplies from the health centers. This is consistent with the findings of the 1998 National Demographic and Health Survey, which showed national program coverage rates far below desired levels. The same survey revealed a wide gap between FP knowledge and practice. For instance, 97.6% of all women surveyed knew about specific contraceptive methods, but the contraceptive prevalence rate remained low at 47%.

The Intervention

The Municipality of Talisay regarded the advent of the MGP as an opportunity to address the low coverage rates, particularly for fully immunized children (FIC), TT2+ immunization, vitamin A supplementation, and FP. With MGP funds, health personnel will be able to regularly visit their catchment

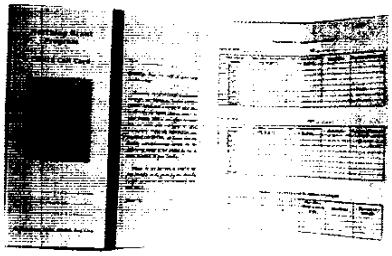
barangays to provide services to those who are unable to go to the health center. This outreach activity is known locally as *Panagtambayayong.*

The health centers carry out a Panagtambayayong at least once a month for their respective catchment barangays, specifically to follow up and reach program defaulters. It runs for three days, usually starting on a Wednesday. Each team is composed of either a doctor or nurse, two or three midwives, and the volunteer health worker of the barangay. Every member of the team receives P250 (US$5) per day as an incentive.

In preparation for the Panagtambayayong, call slips are distributed to all program defaulters, advising them to come to the health center during the scheduled dates of the Panagtambayayong. There are three types of call slips: for child immunization, TT immunization, and FP. The call slips are issued to ensure that mothers bring their children to the health center for immunization and that FP defaulters come for their supplies as scheduled.

Positive Outcomes

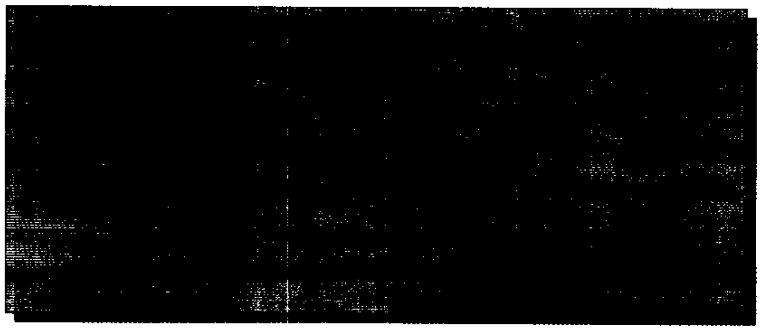
- Improved coverage rates in the municipality of Talisay (see Table 1). About 90% of those issued call slips actually come for services during the Panagtambayayong;
- Personalized follow-up of defaulters, letting target clients know that they are important;
- Increased demand for routine health services;
- Stronger partnership between health workers and barangay leaders. The Municipal Health Officer and/or the nurse attend the meetings of the Association of Barangay Captains as regular members;
- Allocation of supplies based on priorities. Those issued call slips are guaranteed that supplies will be available; and call cards that evolved from the one used in Talisay are now being used in all MGP sites (see below).



Lessons Learned

- Call slips improve utilization of services.
- Call slips add a personal touch to the provision of services because they indicate concern for the welfare of clients.
- It is important to involve community leaders and give them feedback about their constituents' health status to enlist their support.
- Outreach services and the distribution of call slips are seen as means of encouraging clients to visit health centers for scheduled routine services.

Table 1. Coverage Rates for Selected Program Indicators Talisay, Cebu, 1998 and 1999



* Based on FHSIS
** Based on CBMIS

Note: MGP implementation started in August 1999

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BEST PRACTICES

USING THE COMMUNITY-BASED MONITORING AND INFORMATION SYSTEM TO HELP REDUCE UNMET NEEDS

Background

Malaybalay City, the capital of Bukidnon Province in Northern Mindanao, is one of the 145 municipalities and component cities currently enrolled in the Matching Grant Program of the Philippine Department of Health. About 128,542 people distributed in 22,000 households in 46 *barangays* (villages) inhabit this mountain city.

As a Matching Grant Program enrollee, Malaybalay City is expected to establish and maintain a community-based monitoring and information system (CBMIS). The CBMIS is a tool for identifying and prioritizing women and children who have unmet needs for family planning and selected maternal and child health services. These services include vaccination against the six immunizable diseases, for children less than 12 months old; tetanus toxoid immunization for women; and vitamin A supplementation for children 12-59 months old.

How Communities are Monitored

Baseline Survey

For its initial survey in 2000, the City Health Office mobilized approximately 500 people to collect household data. The team was composed of Barangay Health Workers (BHWs), Barangay Nutrition Scholars, Barangay *Kagawads* (Councilmen) on Health, and other community volunteers.

The BHWs assigned a number to each family, and each Family Profile was numbered accordingly. Each BHW could decide what system to use for assigning family numbers in her barangay, but it had to be one that is easy to use. To ensure that all families were counted, the data collectors were assigned specific areas to cover and instructed to visit every household in their areas.

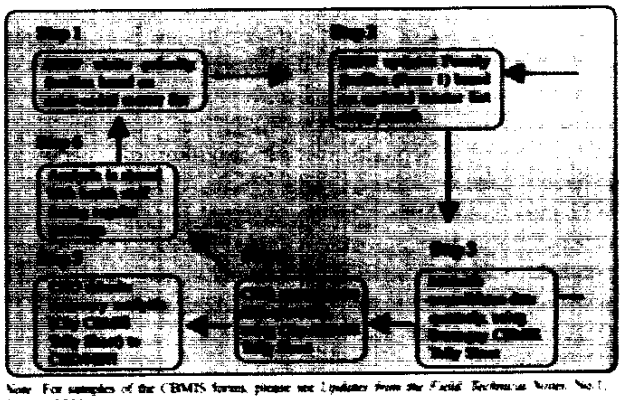
Family Profiles were completed only for permanent residents, that is, families who had lived in the barangay for at least six months. Those with less than six months' residency were considered transients and were excluded from the survey. Although they did not form part of the CBMIS baseline data, these families were able to use the services provided at the health centers.

At the end of the survey, the midwife checked the individual Family Profiles under her jurisdiction, and, with the BHWs, established a color-coded master list of individuals for each barangay. The master list, which contains the names of the individuals, was developed to facilitate tracking of unmet needs and subsequent updating of Family Profiles. Outreach services were organized, not only in areas with a high level of unmet needs but also in far-flung barangays and areas without trained health staff.

CBMIS Updating

After completing the family enumeration and collection of baseline data, families identified with unmet needs are prioritized for immediate services and Family Profiles are updated. BHWs are responsible for updating the Family Profiles monthly (see Figure 1). The master list prepared by the BHW and the midwife based on the survey serves as the tracking form for the BHW and the main source of information for updating the Family Profiles.

Figure 1. CBMIS Updating Process: Malaybalay City



Note: For samples of the CBMIS forms, please see *Updates from the Field: Technical Notes*, No. 1, Series of 2001.

BHWs are also responsible for visiting homes to check on the health needs of families in their catchment areas. Since one BHW covers one *purok* (zone), or about 100 families, in Malaybalay, each family is visited once per quarter on average. The BHW

gives priority to families with unmet needs in scheduling these visits. These families are closely monitored to ensure that they are on schedule for services, particularly immunizations.

The BHW brings the color-coded master list on home visits. A red or orange mark on or beside a name indicates a need for a particular service. If the required service(s) has been provided, a yellow mark replaces the red or orange mark. New names are entered into the master list as new births are recorded and as new Family Profiles are completed for families that have satisfied the six- month residency requirement. The master list is also updated as routine services are provided at the health center or during special outreach activities. The BHWs make a point of reviewing the records of the health center to check if any of the individuals in their catchment area have been provided with the necessary services. Relevant new information is reflected in the appropriate Family Profiles at the end of each month.

At the end of each quarter (CBMIS Day), the midwife conducts individual sessions with her BHWs to check the entries in the Family Profiles, after which the BHWs update their respective master lists. The midwife and the BHW review the master list together and again identify the priority targets using color codes.

The midwife consolidates the data for her catchment area and submits the consolidated report (Barangay CBMIS Tally Sheet) to the City Health Office. The City Health Office reviews the form and, if necessary, returns it to the midwife for corrections.

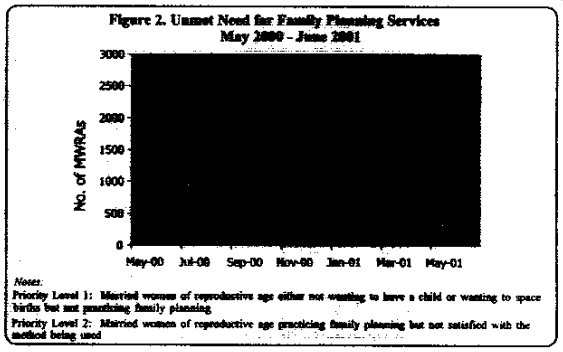
The City Health Office consolidates all Barangay CBMIS Tally Sheets submitted by the midwives and forwards copies of the consolidated report (Municipal CBMIS Tally Sheet) to the DOH's Center for Health Development in Northern Mindanao and Management Sciences for Health. The analysis is also shared with health staff during regular staff conferences.

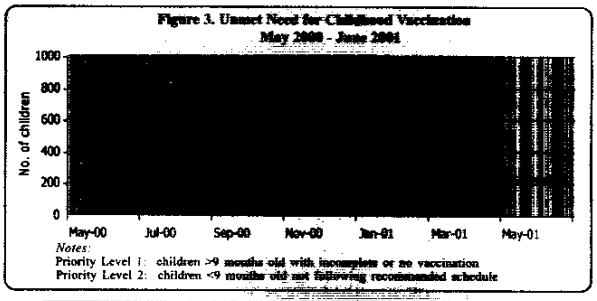
Results

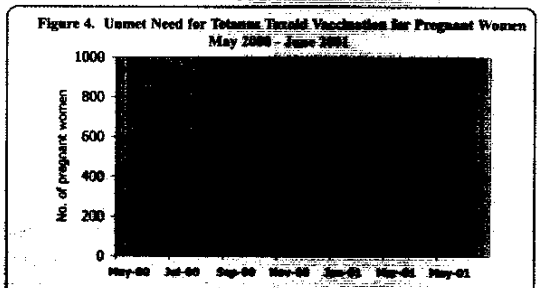
Monthly updating of Family Profiles by the BHWs allowed the City Health Office to focus its services on priority clients. As a result, family planning practice improved, as shown by the decrease in the number of non-family planning users among married women of reproductive age who either no longer wanted to have a child or wanted to space births (Figure 2). Moreover, 9-11 month old children having incomplete or no vaccination dropped from a baseline of 635 to 234 (Figure 3). The number of pregnant women either without tetanus toxoid vaccination or with only one tetanus toxoid shot also decreased from 712 to 113 (Figure 4).

Realizing the major role played by the BHWs in implementing the CBMIS, the City Health Office invested additional resources in training and retraining BHWs to use the system. Each BHW was given a bag with basic items such as pencils, a pencil sharpener, a clipboard, folders, fasteners, and an umbrella. It also contains an IEC kit, a handbook written in *Cebuano* that serves as a ready reference for BHWs when they do home visits. The handbook covers topics such as maternal and childcare, nutrition, breastfeeding, family planning, infectious diseases, and management of diarrhea.

The local government likewise keeps the BHWs highly motivated by ensuring that they receive a monthly honorarium of at least PhP200 (US$4). In cases where the barangays are unable to provide the full amount, the city government pays the difference. In addition, the BHWs receive a quarterly CBMIS honorarium of PhP100 or US$2 (this will increase to PhP200 by next year) and are enrolled in the Indigent Program of the Philippine Health Insurance Corporation.







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BEST PRACTICES

BRINGING STERILIZATION SERVICES TO THE MAIN HEALTH CENTER

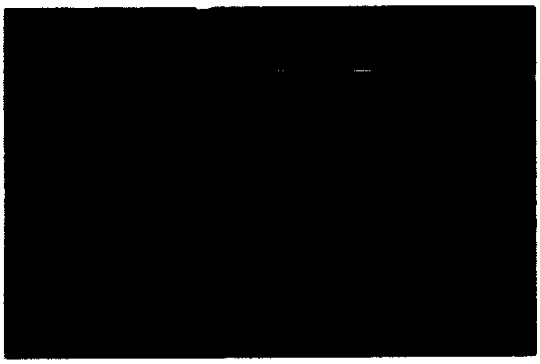
Background

In the past, the district hospital was the nearest provider of sterilization services for family planning (FP) clients in the municipality of Valencia in Bukidnon Province. Since the district hospital was located in a mountainous area in another municipality, potential clients were discouraged from using voluntary surgical sterilization (VSS) services.

Today, VSS services are available at Valencia's own health center. In July 1999, the municipal health staff, with some nongovernmental organizations (NGOs), decided to set up a mini-operating room in the main health center. This was made possible through the joint efforts of the municipality of Valencia and the Department of Health through its Matching Grant Program (MGP).

The Intervention

Setting up a mini-OR in the main health center supports the goal of the MGP, which is to reduce unmet need for FP by increasing the number of FP acceptors. In line with this effort, the municipal health staff embarked on a massive information campaign to promote voluntary sterilization as a major program method. Before the mini-OR's formal opening on 16 June 2000, the health staff participated in the meetings that *barangay* (village) captains organized to disseminate information about the benefits of voluntary sterilization and the services at the health center. During the community-based monitoring and information system survey, volunteer health workers also promoted sterilization among priority clients.



Funds for setting up the mini-OR were provided by the Local Government Unit (LGU), P40,000 (US$800) from the health budget and P60,000 (US$1,200) from the Local Government Support Equalization Fund. The municipality of Valencia provides funds for drugs. In addition, P175,000 (US$3,500) was allocated from the MGP to cover the costs of supplies and instruments and the surgeon's fee. The cost of drugs and supplies is about P780 (US$16) per client for bilateral tubal ligation (BTL) and P365 (US$7) for vasectomy. The surgeon receives an honorarium of P150 (US$3) per client. With the MGP grant also comes a package of technical assistance from the Department of Health, primarily through Management Sciences for Health (MSH).

How It Works

VSS services are available from Tuesday to Friday at Valencia's main health center. A team led by Dr. Ismael Naypa, Jr., a private practitioner and former Chief of Surgery of the Bukidnon Provincial Hospital, provides the services. The health center midwife counsels potential clients, while the public health nurse takes care of the scheduling of patients. Patients from neighboring barangays are usually scheduled on the same day to facilitate the transport of patients from the health center to their respective homes.

Providing transport to clients is a means of encouraging them to use the services. When no vehicle is available, voluntary female sterilization clients,

particularly indigent clients, are given transportation allowances. Vasectomy clients, on the other hand, usually receive five kilos of rice, noodles, and sardines or whatever foodstuffs are available from the Department of Social Welfare and Development. This is one way of offsetting the workdays that male clients lose when they choose to undergo sterilization.

Outcomes/Future Plans

Since the mini-OR's opening in June 2000, the main health center of Valencia, Bukidnon, has served 102 clients for BTL and 7 for vasectomy. This is a significant contribution to the municipality's FP program, considering that only 1 male and 42 female sterilizations were performed in 1999 at the district hospital in San Fernando. From January to June 2000, 88 women had BTL but 42 of these were clients of Marie Stopes International.

Currently, VSS services are available only to Valencia residents. However, the main health center is considering making its services available to neighboring municipalities in the near future through mutually agreed-upon cost-sharing schemes. Meanwhile, the surgeon is willing to offer his services to interested municipalities to train their doctors in standard procedures. The vision is for Valencia's main health center to become a center for training on VSS for other municipalities in the province that wish to set up similar facilities. Voluntary female sterilization in Bukidnon Province is expected to increase, thus improving the sterilization rate for the region as a whole. According to the 1998 National Demographic and Health Survey, only 5.2%of currently married women in the Northern Mindanao Region, where the province is located, opted for sterilization. This is far below the national average of 10.3%. The survey showed that voluntary female sterilization is the preferred contraceptive method in the Philippines.

Lessons Learned

For any major health undertaking requiring substantial financial resources, it is important to enlist the support of the LGU. This requires intensive and sustained advocacy efforts to enable local leaders to understand and appreciate the benefits of the intervention to the community. In the case of Valencia, the Municipal Health Officers took the initiative to discuss the idea of a mini-OR in their main health center with the Office of the Mayor and the Local Health Board.

Information, education, and communication are also vital in ensuring the success of any intervention. In the case of voluntary sterilization, it is important to create a cadre of client-advocates to correct any misconceptions that couples may have about the method.

Finally, the LGU has to establish close collaboration with the private sector and the NGOs for the provision of essential health services. The LGU should continuously be on the lookout for possible "champions" or partners who are willing to commit their time and efforts for the benefit of their community.

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Updates from the
BEST PRACTICES

"MOTHER-BABY WATCH"

(Sustansya Para sa Masa)

Background

The municipality of San Jose del Monte in Bulacan is a 1999 recipient of the LPP-Matching Grant Program. One of the activities implemented under this project is the community-based monitoring and information system (CBMIS). The barangay health workers (BHWs), under the supervision of the rural health midwife, performed family health and nutrition profiling of all the families in their areas of coverage. One problem identified was poor health-seeking behavior and health practices among mothers in the areas of prenatal and postnatal care, family planning, immunization, and growth monitoring for infants and preschoolers.

The Intervention

To improve health-seeking behavior and health practices among the target population, the LPP-Matching Grant Program of San Jose del Monte adopted the "Mother-Baby Watch" (MBW) concept under the *Sustansya Para sa Masa* (SPM) banner of the government. The project enrolls high-risk pregnant women who are screened, then monitored regularly throughout the course of their pregnancies. At birth, their babies are likewise enrolled and each pair is followed up until the baby turns 24 months.

The project issues MBW cards to all enrollees to keep track of the services they use. Three types of incentive points are awarded depending on the type of service obtained: must points, extra points, and star points. Mothers earn *must points* when they have a regular prenatal check-up or receive a tetanus toxoid shot. *Extra points* are earned if a mother uses iodized salt and attends a health/nutrition class, while *star points* are awarded to fully immunized mothers, mothers who breastfeed up to six months, and those whose babies are fully immunized at 9 months of age. For babies, *must points* are earned when monthly weights are plotted on the growth monitoring chart and for timely introduction of complementary food. *Extra points* are given when the growth chart is kept and the trend of the growth curve is upward, while *star points* are awarded when the baby sustains a 12-month period with an upward growth curve.

It is estimated that a mother-child pair can earn a total of 25 points in a month. Each point is equal to P1, and attending health personnel grant a coupon to the mother for every 25 points earned. The mothers redeem the coupons at designated redemption centers, where they can get fortified food, iodized salt, and weaning complementary food in exchange for the coupons. Certificates of completion of vaccination are likewise awarded to fully immunized mothers and fully immunized children.

SPM benefactors were organized and mobilized to help provide incentives for MBW enrollees. Each SPM benefactor may opt to support several mother-baby pairs. Among themselves, SPM benefactors organized a movement to help health center personnel manage the program. Various committees were

formed, for example, the Committee on Ways and Means for resource generation, Review and Screening for enrolling beneficiaries, and Incentives and Rewards for ensuring the availability of supplies at redemption centers.

Committee, enrolled in the project, and issued Mother- Baby Watch cards. About 50 SPM benefactors have already signed their pledges of commitment to support one to four mother-baby pairs for approximately 33 months (that is, P25 per month per mother-child pair). The prepared containing an assortment of fortified noodles, margarine, orange juice, sardines, and iodized salt. "Baby packs" containing a selection of fortified noodles, cereals, juice, eggs, and iodized salt are also available. About 100 more benefactors are expected to

How the Program Works

Guidelines for Implementing Mother-Baby Watch

Activity	Strategy/Method	Requirements
1. Identify target pregnant women	• Prepare list of all pregnant women in the barangay based on Monitoring Quasi Program Family Profile survey of BHWs/ Barangay Nutrition Scholars • Prepare list based on set criteria • Submit endorsement of candidates from barangay officials or SPM review committee at the barangay level • Review endorsed candidates at municipal level	• MGP Family Profile • Criteria for selection • SPM Review Committee at barangay level • SPM Review Committee at Rural Health Center (MHC) level
2. Screen eligible [illegible]	• Organize meeting of selected candidates • Rural Health Midwife (RHM) or Rural Health Physician (RHP) will explain the MBW objectives and mechanics • Issue MBW-SPM card duly accomplished and signed • Maintain a minimum of enrolled pregnant women per barangay	• RHM sends invitation to candidates; RHP prepares agenda for meeting • Speakers invited and materials prepared • MBW-SPM card duly accomplished • Masterlist form
3. Identify/select potential SPM benefactors	• Prepare a list of probable SPM benefactors per barangay and municipality/city • Organize and conduct benefactors' meeting	• RHM sends invitation to candidates; RHP prepares agenda for meeting • Speakers invited and materials prepared • MBW-SPM card duly accomplished • Masterlist form
4. Organize SPM Movement (Review Committee at barangay/municipal level)	• Present concept, structure, and functions during SPM benefactors' meeting • Conduct election of officers	• List of recommended SPM benefactors per barangay • Send out letters of invitation to prospective benefactors; prepare pledgers/commitment form of commitment form • Create final list of SPM benefactors • Set guidelines for redemption
5. Identify/select redemption centers	• Coordinate with stores/groceries • Set guidelines for redemption	• Guidelines for redemption
6. Implement/ Monitor MBW-SPM	• Provide services at all Barangay Health Stations/MHCs • Issue points/issue redemption coupons	
7. Disseminate experiences	• Document and disseminate experiences	

Results

To date, 86 pregnant mothers from 14 barangays of the Rural Health Unit II of San Jose del Monte have been properly screened by the SPM Review

main health center of San Jose del Monte in Tungkong Mangga has initially been designated as a redemption center where beneficiaries can exchange coupons for food items. For pregnant and postpartum mothers, "mother packs" have been

attend the succeeding SPM Benefactors Meeting and register as members of the SPM Movement.

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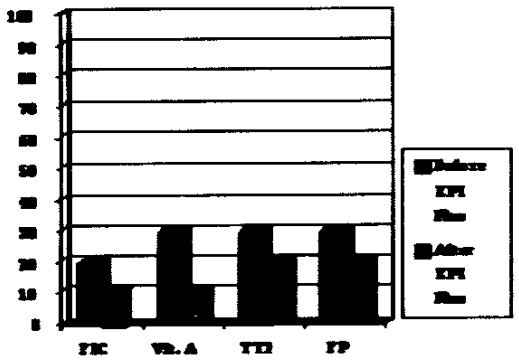
BEST PRACTICES

"EPI PLUS"

Background

In May 1999, Bago City in Negros Occidental became a recipient of the LPP-Matching Grant Program. The LGU promptly set up a community-based monitoring and information system (CBMIS). The baseline survey revealed that a significant proportion of women and children needed immunization, Vitamin A supplementation, and family planning services (see Figure 1). Essential health services had to be expanded to respond to these needs. Thus, a strategy was designed to bring these services closer to the women and children of Bago City.

Figure 1. Proportion of Target Clients with Unmet Needs by Type of Service Needed



The Intervention

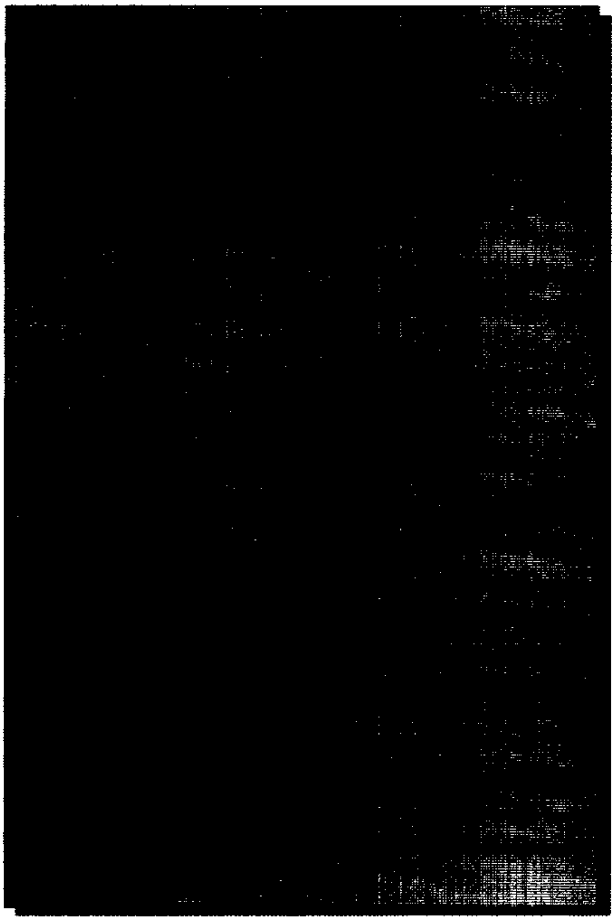
The Expanded Program on Immunization Plus (EPI Plus) is an expansion of the Department of Health's immunization program (EPI) to prevent childhood illnesses such as tuberculosis, poliomyelitis, diphtheria, pertussis, and tetanus. The word "Plus" means the integration of other health programs, such as nutrition and family planning, into the EPI delivery system. The Plus also means that other stakeholders, including local chief executives, *barangay* (village) officials, *purok* (zone) presidents, and representatives of

nongovernmental organizations, are involved in health service delivery in their communities. The City Health Office takes the lead in carrying out the EPI Plus activities. Table 1 summarizes the program.

Table 1. EPI Plus Features and Teams

Features	EPI Team	EPI Plus Team
• Team members	• Nurse, Midwife, Barangay Health Worker (BHW)	• MD, Nurse, Midwife, BHW (Health Education and Promotion Officer, Med Tech., Sanitary Inspector as irregular members)
• No. of teams	• One (whole city)	• Three (emplimist)
• Area of coverage	• 24 barangays	• 24 barangays
• Health programs involved	• EPI	• EPI, FP, TT Immunization, Vit. A supplementation
• Target population	• Infants (0-11 months old)	• Infants (0-11 months old), Children (12-59 mos. old), Mothers (15-49 years old)
• Schedule of visits	• One visit per 1-2 barangays/month	• 2-3 visits per barangay/month
• No. of visits per barangay/month	• 1 visit	• 2-3 visits
• Service vehicle	• One	• One

22



Results

Bringing health services directly to the barangays of Bago City has provided numerous benefits to women and children with unmet needs. This initiative by the LGU helped in reaching clients who are not able to go to the health centers or barangay health stations. Likewise, the performance of the City Health Office improved, as reflected in the reduction in the number of unserved and underserved clients for immunization, family planning, and nutrition services (Figure 1). Other benefits to clients included consultations for prenatal, postnatal, and family planning services. Pap smears were also provided during EPI Plus days.

In far-flung areas of Bago City, mothers expressed their appreciation to the program for bringing services to their area. It reduced their expenses for transportation and the time they spent traveling to the barangay health station or health center for services.

Lessons Learned

- EPI Plus is effective in reducing the unmet needs of target clients;
- CBMIS is a reliable and accurate tool for assessing the health needs of the community and developing realistic interventions;
- Proper identification of the root causes of the problems is a necessary component in planning efficient and appropriate health interventions;
- Community health volunteers (BHWs and Barangay Nutrition Scholars) are among the best partners in delivering health services to the community;
- Mobilizing community resources is important for improving access to services and responding to the health needs of the community;
- There should be active involvement and coordination among all stakeholders in the community. The commitment of everyone from the health staff, team members, and city and barangay officials to the residents is important in ensuring the success of the EPI Plus program.

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TECHNICAL NOTES

STRENGTHENING PROVINCIAL-MUNICIPAL PARTNERSHIPS THROUGH SUBGRANTING

Background

The Province of Negros Occidental in the Visayas was among the first group of grantees under the Local Government Unit Performance Program (LPP) of the Department of Health. As an LPP grantee, the province was expected to achieve the project's benchmarks for child immunization, tetanus toxoid immunization, vitamin A supplementation, and contraceptive prevalence rate by the year 2000. As an incentive, all grantees that achieved the benchmarks before 2000 received premiums. This group of achievers, one of which was Negros Occidental, came to be known as the LPP Top Performers.

To maximize the use of its premium grant, Negros Occidental decided to subgrant 70% of the amount to selected municipalities and component cities in the province to enable them to expand and improve the delivery of their health services. Under the LPP, the Province of Pangasinan in Luzon was the first to embark on a subgranting initiative. Pangasinan shared its experience in implementing the initiative during a national summit attended by all Local Government Units participating in the LPP. Negros Occidental's Subgranting Program was launched shortly after the summit.

The Experience with Subgranting in Negros Occidental

Building on the experience of Pangasinan and adopting the mechanism used by the Department of Health's Matching Grant Program, Negros Occidental initiated its Subgranting Program in 1999 through the leadership of the Provincial Health Office (See Box 1). To date, the province has provided subgrants to two groups of Local Government Units.

Signing of Memorandum of Agreement between the province and the municipality

During the initial phase, the province solicited proposals from municipalities and component cities. Out of the 26 that were invited, 22 came back with proposals. Twelve Local Government Units subsequently became beneficiaries under the first phase of Negros Occidental's Subgranting Program.

The selection of subgrantees was based primarily on the quality of the proposals, which means that the activities proposed for funding should generate demand, expand the delivery of sustainable, high-quality health services, and demonstrate measurable impact on service coverage within 12 months. It was also crucial that the Local Government Units (LGUs) commit counterpart funds equal to at least 25% of the total subgrant of PhP100,000 (US$2,000) per LGU. Some LGUs gave more than 25%. For example, one subgrantee, La Carlota City, released PhP65,000 (US$1,300), while another, the Municipality of Isabela, made available PhP50,000 (US$1,000) in counterpart funds.

To ensure accountability, each subgrantee was required to designate a coordinator, open a separate trust fund account, and submit a quarterly progress and financial report. All subgrantees were also required to establish a community-based monitoring and information system like the one used in all Matching Grant Program areas.

Box 1: How the Subgranting Program Works

1. The Provincial Health Office (PHO) organized a series of exploratory meetings with Municipal and City Health Officers and mayors (February 1999).

2. The PHO conducted a program planning session to set the program vision, mission, and technical and financial guidelines (February 1999).

3. The province sent a letter to municipalities and component cities, informing them about the program and its mechanics and inviting them to submit proposals for funding (March 1999).

4. The PHO reviewed all submitted proposals based on the following criteria: (a) proposed activities should be new or expansions of current activities that aim to expand service delivery and (b) activities must show measurable increase in service coverage within a year (May 1999).

5. The PHO submitted the screening and evaluation results to the governor, specifying the criteria and the corresponding ranking of the Local Government Units (LGUs) based on the criteria (June 1999).

6. The governor's office sent a letter to all LGUs informing them of the results of the evaluation (June 1999).

7. The PHO met with the Municipal Health Officers of selected LGUs for preliminary orientation on the program and to discuss the orientation schedule for the rest of the key LGU officials (June 1999).

8. The PHO conducted individual orientation meetings for all grantee LGUs. In attendance were the mayor, vice-mayor, chairperson of the Committee on Health of the *Sangguniang Bayan* (City/Municipal Council), budget officer, accountant, auditor, health personnel, and *barangay* (village) captains. During these meetings, the mayors, if present, signed their respective memoranda of agreement (MOAs). If the mayors were not present, the MOAs were left with the respective Municipal Health Officers, with instructions to have the MOAs signed as soon as possible (July-August 1999).

9. The *Sangguniang Panlalawigan* (Provincial Council) passed a resolution authorizing the governor to enter into a memorandum of agreement with the grantee LGUs (October 1999).

10. The governor signed the MOAs (November 1999).

11. The PHO briefed all provincial department heads on the program to ensure their cooperation and facilitate processing of program-related documents (November 1999).

12. The Provincial Treasurer's Office released the funds to the subgrantees (December 1999).

For the second phase, Negros Occidental used its base grant savings from the LPP to provide funds to its lower-level units. The same eligibility criteria and requirements were applied (see Box 2). However, unlike in the first phase, when all subgrantees received the same amount, available resources were allocated based on need and on the LGU's commitment to improve health services as demonstrated by its increasing health budget. Six LGUs received PhP150,000 (US$3,000) each, while another six got PhP100,000 (US$2,000) each.

The Benefits of Subgranting

Both the province and municipalities/ component cities regard subgranting as an effective mechanism for fostering stronger partnerships. It was noted that after devolution, the close alliance that used to characterize their relationship was somehow strained. The subgranting scheme enabled them to work together again in a coordinated fashion to achieve greater program impact.

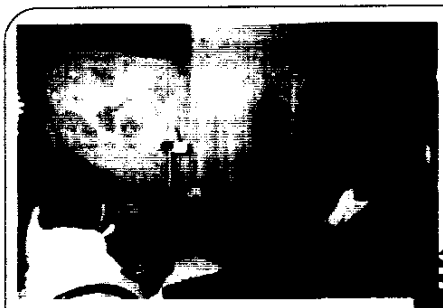
From the point of view of the province, subgranting enabled it to achieve synergy in the use of available resources by focusing on priority activities. The budget for health, especially for drugs and medical supplies, generally increased (see Table 1) as a result of the advocacy efforts of the Provincial Health Office. Subgranting also paved the way for the Provincial Health Office to more systematically provide technical assistance to these units.

Meanwhile, the municipalities and component cities regard provincial subgranting of funds as a better mechanism than in-kind assistance. They feel that they have more flexibility under this arrangement, since they can use the funds to focus on priority initiatives that could not be funded out of their regular budget, including procurement of drugs and supplies. In short, the Subgranting Program empowered the municipalities and component cities to effectively implement interventions specific to their localities.

For instance, La Carlota City was able to upgrade its family planning clinic

Box 2: Eligibility Requirements

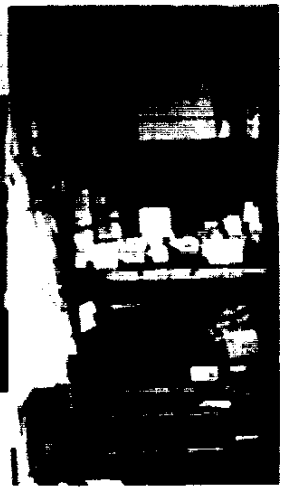
1. Not qualified under the Matching Grant Program of the Department of Health;
2. Local Chief Executive (LCE) and other local officials committed to increasing service coverage;
3. The ability to submit a proposal that clearly indicates the LGU's program objectives, a set of activities to improve demand generation and delivery of high-quality services, and corresponding budget broken down by source;
4. Willingness of the LCE to enter into a Memorandum of Agreement with the provincial government; and
5. Willingness of the LGU to commit counterpart funds equivalent to 25% of the total subgrant.



... Orienting the LGU on the Subgranting Program.

... Local Chief Executive signing the Memorandum of Agreement.

and establish two satellite barangay family planning clinics using its subgrant. Another example is the Municipality of Isabela, which used its subgrant to conduct outreach activities and follow-up operations in hard-to-reach areas and to defray the costs of transporting clients to and from the hospital for tubal ligation.



La Carlota City's family planning clinic that was upgraded using the subgrant

Table 1
Health Budgets of Subgrantees (in PhP), 2000 and 2001

LGU	2000			2001		
	Personnel	Maintenance & Other Operating Expenses	TOTAL	Personnel	Maintenance & Other Operating Expenses	TOTAL
1. Calatrava	4,058,955	845,500	4,904,455	4,167,352	1,000,500	5,167,852
2. Toboso	2,111,699	380,100	2,491,799	2,303,102	560,000	2,863,102
3. Victorias City	7,131,496	140,000	7,271,496	7,802,766	215,000	8,017,766
4. E. B. Magalona	2,063,847	154,000	2,217,847	2,263,062	163,000	2,426,062
5. La Carlota City	9,411,362	787,300	10,198,662	9,095,398	855,800	9,951,198
6. San Enrique	2,106,788	414,000	2,520,788	2,112,507	67,000	2,179,507
7. Hinigaran	6,279,903	111,000	6,390,903	6,782,083	111,000	6,893,083
8. Cauayan	9,046,799	897,300	9,944,099	9,425,339	857,000	10,282,339
9. La Castellana	1,177,438	32,000	1,209,438	n.a.	n.a.	n.a.
10. Sipalay	4,648,229	1,470,000	6,118,229	4,076,055	1,470,000	5,546,055
11. Isabela	3,370,604	500,000	3,870,604	3,700,059	800,784	4,500,843
12. Escalante	3,032,715	508,000	3,540,715	3,305,596	108,000	3,413,596

Source: Provincial Health Office, Negros Occidental
Notes: The budgets exclude the subgrant.
N.a.: not available

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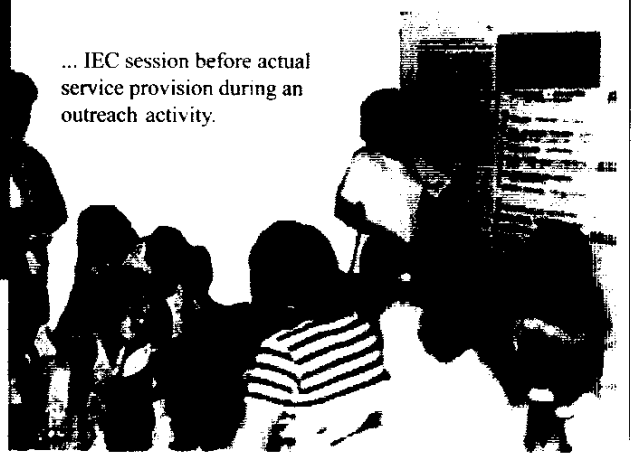
Municipal health staff of Isabela on their way to an outreach site.



... IEC session before actual service provision during an outreach activity.

Sustaining the Initiative

Funds from the LPP will not be available beyond 2001. The challenge, therefore, is to sustain the subgranting initiative using Department of Health or provincial funds. Given greater flexibility in how LGUs can use funds and the opportunity to allocate provincial resources based on local priorities, the municipalities and component cities have regarded the Subgranting Program as a good mechanism for fostering stronger partnerships between the province and the municipalities/component cities.

The share of national internal revenue taxes allocated to provinces, municipalities, cities, and barangays are 23%, 34%, 23%, and 20%, respectively. It may seem that municipalities are getting the lion's share but because there are about 1,525 municipalities nationwide and only 78 provinces and about 85 cities, each municipality's share is actually much lower than that of a single province or city. This is aggravated by the fact that the actual share of each province, city, and municipality is also allotted based on population size and land area. This disadvantages the smaller municipalities because they absorbed most of the devolved national-level functions, including direct provision of health services. Collaboration among LGUs should, therefore, be continuously explored and encouraged to leverage more resources for health, particularly at the municipal level.

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Appendix B

MGP training workshop participants evaluate their facilities' preparedness to respond to unmet needs identified by the community-based monitoring and information system, as well as their level of preparedness for Sentrong Sigla certification. Appendix B provides two types of Quality Standards lists—one for a rural health unit and another for a barangay health station—and two corresponding Facility Self-Assessment Checklists. Each team should only use the Quality Standards List and accompanying FSAC for the type of facility it will be assessing. The Quality Standards Lists and FSACs provided in Appendix B are:

Quality Standards List for Barangay Health Stations, Level 1

Facility Self-Assessment Checklist for Barangay Health Stations, Level 1

Quality Standards List for Rural Health Units and Health Centers, Level 1

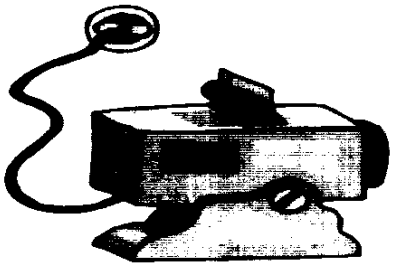
Facility Self-Assessment Checklist for Rural Health Units/Health Centers, Level 1

Quality Standards List for Barangay Health Stations

Level 1

Certification and Recognition Program
Sentrong Sigla Movement

October 2000



What is Sentrong Sigla Movement?

Sentrong Sigla Movement (SSM) aims to improve the quality of public health services. Through its ***Certification and Recognition Program or CRP***, Sentrong Sigla recognizes local government units (LGUs) and certifies health facilities that meet requirements and standards to deliver quality services.The CRP has three levels of certification with Level 1 as the entry level. The participating facility progresses through Levels 1, 2 and 3 until it gets elevated to the SSM's Hall of Fame. A Sentrong Sigla certified facility eventually gets into the continuous quality improvement (CQI) mode enabling the facility staff to set their own standards of quality.

What is the Level 1 Quality Standards List for Barangay Health Stations (BHS)?

The Level 1 Quality Standards List for Barangay Health Stations (BHS) includes the recommended standards and requirements for providing quality services. This list was developed based on existing program guidelines from the Department of Health (DOH).

There are general conditions or requirements that are critical in every facility and are therefore considered as inclusion criteria for participation in Level 1:

- The BHS's main rural health unit or health center is Sentrong Sigla certified.
- The BHS is housed in (or within) a permament structure with a permanently assigned midwife that provides regular health services.
- The BHS has the following:
  - **Regular source of clean water**
  - **Comfort room/latrine for patients**
  - **Blood pressure apparatus with cuff**
  - **Stethoscope**
  - **Thermometer**
  - **Weighing scale for infants and adults (but not bathroom scale)**

Who is the Quality Standards List's intended user?

The List is meant for service providers or staff, local health managers, local chief executives, Sentrong Sigla teams and other users interested and involved in improving quality of services being provided in the facility. Using the List, any user will be able to assess if his/her facility meets the quality standards for providing health services or if not, what improvements are needed to meet the standards.

What health facilities are being referred to?

The Sentrong Sigla Certification and Recognition Program covers health facilities like hospitals, rural health units/health centers and barangay health stations. This List is intended only for **barangay health stations**.

What is the focus of Level 1 standards?

Level 1 standards focus on "inputs" like the basic infrastructure, equipment, pharmaceuticals and supplies and other conditions that are necessary to demonstrate "preparedness" or "readiness" of the facility to provide the services. There are also some "process" standards that are already included. These standards are in the following areas:

- **Infrastructure/Amenities**
- **Health Services**
- **Attitude and Behavior of Health Workers**
- **Health Human Resources**
- **Equipment**
- **Drugs, Medicines and Supplies**
- **Health Information System**
- **Community Interventions**

Note to Users:

The List provides the basic standards and requirements that are being recommended under Sentrong Sigla for Level 1 certification. There are corresponding standards for Levels 2 and 3. Once a facility meets Level 1 standards and gets certified, under the Sentrong Sigla Certification and Recognition Program, the facility and its staff will be introduced to continuous quality improvement (CQI) tools and techniques in order to maintain Level 1 standards, and also strive for higher levels of certification.

It is expected that certain aspects of quality standards maybe defined differently and may vary from program to program, facility to facility and from one person to another. However, for Sentrong Sigla, these are the standards being recommended. These standards were developed based on existing DOH program standards and was a result of a series of consultation activities at different levels of the health system.

The BHS should have the following general infrastructures/conditions/amenities:

- Generally clean and orderly environment
- Sufficient seating space for patients
- Sign board listing facility hours and available services
- Adequate lighting and ventilation
- Light source for examinations: goose neck lamp and flashlights
- Covered water supply - sufficient for hand-washing and for comfort rooms or latrines
- Hand washing area with water, soap and towels
- Functional and clean comfort rooms or latrines (for health staff and clients) with adequate water supply
- Covered garbage containers (waste segregation and sharp objects)
- Cleaning/sterilizing supplies for clinical instruments
- Storage space/room for supplies, drugs and medicines
- A treatment area/examination area with visual and auditory privacy

The facility should practice the following:

- Clinic hours, services and whereabouts of staff posted in a strategic area readable by all clients and service providers.
- Client waiting time must be as brief as possible. Clients should be seen by health staff within 15 minutes of registration.
- During clinic hours, direct client care should take precedence over all other tasks. Clients should not be made to wait merely because the BHS midwife or CHVW is writing or transferring notes, doing reports or performing other tasks not directly related to client care.
- The BHS should maintain occasional hours during evenings and weekends to accommodate clients who are unable to consult or visit during regular clinical hours. The BHS should provide services during non-traditional hours <u>at least</u> once a week, considering clients who may not be available during regular office or work hours.

2. Health Services

The following programs and services must be in place available at the health facility at all times

2.1. Expanded Program on Immunization

- Immunization sessions should be conducted in the BHS as regularly as possible. Although Wednesday has been adopted as the national immunization day, immunization days may be held on other days.

- Schedules should be displayed to inform mothers of the time and day at which immunization services are to be provided. However, clients who request immunization on other days should not be turned away. Wastage of vaccine is a minimal program cost and should not be overemphasized or used as a barrier to vaccine administration.

- The facility should practice a "one needle and one syringe policy" because of the danger of transmitting Hepatitis B and AIDS (HIV infection) through unsterile needles and syringes. Therefore, one sterile syringe and needle should be utilized for each injection. Disposable syringes and needles should be used only once and then collected in a puncture proof container to be burned and buried.

- BCG, OPV, DPT, measles, hepatitis B and tetanus toxoid vaccines should be available at all times and should be stored under proper cold chain conditions.

- BHS midwife should conduct patient counseling on effectiveness, risks, benefits, potential side effects and treatment for such side effects of each vaccine.

The following conditions, equipment and supplies must be present in order for the facility to qualify as providing this service:

- Immunizations offered daily or at least 3X a week (depending on catchment population)
- Outreach immunization services offered in hard-to-reach areas
- EPI Manual (latest version)
- Updated Target Client List or Master List (at least within the week)
- Adequate supplies of BCG, OPV, DPT, measles, hepatitis B and tetanus toxoid vaccines for at least one week.
- Proper cold chain maintained: vaccine carriers with ice cold packs (immunization days).

Disease Surveillance

- The BHS should perform disease surveillance. Surveillance data can be used by the BHS or the RHU to improve strategies in delivering health services and thus prevent these diseases from occurring, e.g. immunizable diseases like diptheria, pertussis, tetanus, polio and measles.

- The BHS midwife and community health volunteer workers (CHVWs) should be involved in reporting, investigating and reporting to the next higher level of the health system, e.g. RHU/HC.

- Surveillance data must be complete, accurate and on time.

The following conditions must be present in order for the facility to qualify as providing this service:

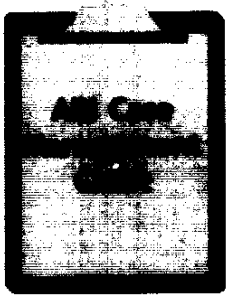
- ❍ Case definitions available
- ❍ Notifiable disease reporting forms available
- ❍ Notifiable disease reporting forms submitted weekly to RHU
- ❍ Investigation of all acute flaccid paralysis (AFP) cases, neonatal deaths and measles outbreaks
- ❍ Immediately reporting all AFP and neonatal tetanus (NT) cases to the RHU/HC in the fastest possible means
- ❍ Reported cases followed up by BHS for public health reasons especially 60 days follow-up done with MHO/PHN on all AFP cases detected

- The BHS should have the equipment and supplies necessary to recognize and treat pneumonia. Cotrimoxazole and other medicines like paracetamol (for fever) should be available at all times.

- Referral to higher level or other facilities, e.g. RHUs or hospitals should be done for clients needing further management.

- BHS midwife should continue creating awareness among mothers and childminders on home care for children with simple cough and colds and early signs of pneumonia through information and health education activities.

The following conditions, equipment and supplies must be present in order for th facility to qualify as providing this service:



- ARI Case Management Chart posted
- Thermometer
- Tongue depressors
- Flashlights or pen light
- Timer or watch with second hand
- Cotrimoxazole (adult tabs), at least 25 tabs
- Paracetamol (500 mg tabs), at least 50 tabs
- In client or patient education/counseling basic messages should include:
  - home management of simple coughs and colds w/o use of cough/cold medicines
  - detection of early pneumonia using simple signs like rapid breathing and chest indrawing
  - information on when, where and how to bring the child with pneumonia for treatment

- The BHS should have the equipment and supplies necessary to diagnose and treat diarrheal diseases. Referral to other or higher level facilities should be done for diarrheal clients needing further management.

- In the BHS, all patients with no dehydration or who have been successfully rehydrated in the facility should be given ORS to take home to prevent dehydration.

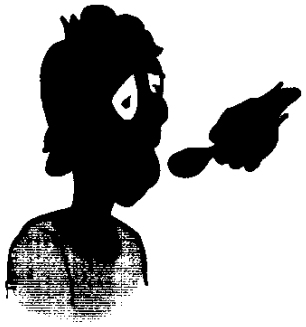
- As part of appropriate and prompt response to diarrhea outbreak/cholera/ disease surveillance, the facility should:

  - ensure potability of drinking water within the catchment area in conjunction with the Environmental Sanitation Program;

  - enforce sanitation code, especially on food sanitation in conjunction with the Environmental Sanitation Program;

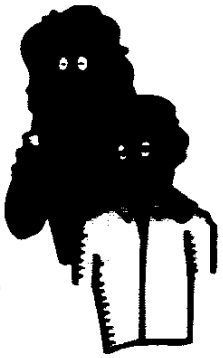
  - promote personal and domestic hygiene through health education, and

  - assure adequate supply of ORS sachets



The following conditions, equipment and supplies must be present in order for the facility to qualify as providing this service:

- ❍ CDD Case Management Chart posted
- ❍ Functional Oral Rehydration Therapy (ORT) corner with benches, table, glasses, pitcher, spoon, potable water, calibrated container for measuring and Oral Rehydration Sachets (ORS)
- ❍ ORS sachets available at all times
- ❍ Updated daily record of diarrhea cases
- ❍ In client or patient education/counseling basic messages should include:



  - Give the child more fluids than usual to prevent dehydration;
  - Continue to feed the child; and
  - Take the child to the health worker if child does not become better in three days or earlier if the child develops some signs/ symptoms like many episodes of watery stools, repeated vomiting, marked thirst, fever, blood in the stool and eating or drinking poorly.

Micronutrients Supplementation/Nutrition

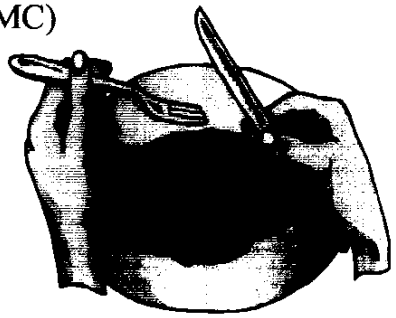
- The BHS should have the equipment and supplies necessary to prevent, detect and control nutritional deficiencies and specific micronutrient disorders.

- The BHS should have iron, iodized oil capsule or iodized salt and vitamin A capsules available at all times for supplementation of target groups e.g. iron tablets for all pregnant and lactating women; iron drops for infants and iron syrup for school children.

- BHS midwife should refer clients needing further management to other or higher level facilities.

The following conditions, equipment and supplies must be present in order for the facility to qualify as providing this service:

- Guidelines for Micronutrient Supplementation
- Operation Timbang (OPT) Records for the whole BHS catchment
- Updated Target Client List (at least within the week)
- Under 5 growth cards/Growth monitoring charts (GMC)
- CBPM-NP RHM Guidebook
- Basic Three Food Groups Brochures
- Salt Iodization Testing Kit
- Micronutrients available: iron, iodine, vitamin A
- Functional balance beam or other weighing scales
- In-client or patient nutrition education/counseling, basic messages should be emphasized like importance of proper nutrition including:
    - Balanced diet
    - Desirable food habits
    - Consumption of fortified foods
    - Use of iodized salt
    - Importance of breast-feeding/weaning foods



- The BHS should provide all medically approved, safe, effective and legally acceptable program methods. These specific services should include:
  - Pills, IUDs, NFP (in selected facilities by referral), LAM, Condoms and DMPA
  - Referral for tubal ligation/vasectomy in selected facilities where there are trained personnel
  - Referral for relevant laboratory exams, e.g., Pap smear, wet smear, gram staining, pregnancy test, and urinalysis
  - Referral for further management of complications and/or side effects that may arise as a result of family planning methods
- The BHS should ensure the availability of all program methods at all times. When necessary, the facility should refer clients to RHU or other facilities/clinics that provide FP services it cannot provide, such as IUD or sterilization.
- FP supplies should be sufficient and equipment should be in working order.
- BHS midwife should counsel clients about the effectiveness, risks, and benefits of the different contraceptive methods. BHS midwife should provide information neutrally, without allowing their own biases to affect clients' choices.

The following conditions, equipment and supplies must be present in order for the facility to qualify as providing this service:

- ❍ Updated Target Client List (at least within the week)
- ❍ Updated FP Form 1 - BHS worksheet
- ❍ Contraceptives/Supplies available (at least 1 month allowed stock level):
  - Condoms
  - Oral contraceptives-combination and progesterone only
  - DMPA } in areas with trained health worker
  - IUDs } in areas with trained health worker
- ❍ Antiseptic solution (povidone iodine; cidex) and chlorine 75%
- ❍ Sterilized Equipment available to include:
  - Forceps—alligator, pick-up, ovum, tenaculum, uterine
  - Forceps container
- ❍ Kelly pad/linen for examination table
- ❍ Examination table with linen or paper and changed between clients
- ❍ Light source (gooseneck lamp, flashlight)
- ❍ NFP charts for distribution (in selected facilities)
- ❍ Other leaflets/handouts on FP for distribution
- ❍ Referral Form for sterilization
- ❍ Patient counseling on information about all methods, effectiveness, risks, and benefits of various methods

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- BHS midwife should be knowledgeable about the types of TB patients and the three (3) treatment regimens available. The BHS should have equipment and supplies necessary for case finding and treatment of clients diagnosed with tuberculosis.

- The BHS midwife should allocate the medicines for the complete duration of therapy for TB patients started on treatment.

- All clients should be counseled on proper compliance and adherence to treatment. Health education should also include some expected drug interactions and what clients should do upon experiencing them.

- All clients should have sputum examination on scheduled time to be able to assess the individual patients' response to treatment. This is also the way to determine "cure" for TB patients.

The following conditions, equipment and supplies must be present in order for the facility to qualify as providing this service:

- Updated Target Client List/National Tuberculosis Program (NTP) TB Register (at least within the week)
- Supplies to include:
  - Sputum cups
  - Glass slides
  - Designated sputum collection and staining area
- Anti-TB Drugs:
  - Type I } good for at least 5 patients
  - Type II }
  - Ethambutol, in blister packs
  - Streptomycin Sulfate

STD/AIDS Prevention and Control Program

- STD/AIDs prevention and control program services should be available in all STD service facilities. At the BHS level, the health worker should be capable of referring patients to the RHU/HC, a hospital or other facilities.

- Whenever possible, acceptable, affordable and effective case management of STD patients will be made accessible to all individuals.

- Syndromic management will be applied when and where reliable laboratory diagnostic support is not consistently available.

The following conditions, equipment and supplies must be present in order for the facility to qualify as providing this service:

- Syndromic Management Chart posted
  - Patient counseling to include:
    - Explanation of the diagnosis to the patient
    - Instructions on the importance of completing treatment
    - Encourage client to bring partner for evaluation and treatment
    - Provision of health education to prevent further transmission of STDs
  - Provision of adequate supply of condoms
- Monthly reporting using primary level reporting form accomplished and submitted to the next higher level
- Referral mechanism in place so clients not responding to treatment at this level will be referred to a designated Social Hygiene Clinic, secondary care level or referral center where a laboratory is available to perform the basic laboratory tests required to diagnose most STDs as well as for HIV testing.

- The BHS personnel should practice strict personal and environmental hygiene to reduce disease transmission within the facility.

- Practices that should be followed within the facility include the following:

  - Hand-washing with soap and water before and after each client contact and use of comfort room/latrine
  - Examination table disinfected daily

- The BHS should provide water testing/quality monitoring services

- The BHS should have copies of updated list of water sources and food establishments within its catchment area

- Each facility should have available toilet bowls, or at least toilet bowl molds for distribution to households without toilets

The following conditions, equipment and supplies must be present in order for the facility to qualify as providing this service (some items have already been incorporated under basic infrastructure):

- Adequate supply of toilet bowls or toilet bowl molds for households without toilets and toilet bowl molds
- Adequate chlorine granules for disinfection of water supply facilities
- Copy of updated list of status of water supply and sanitation facilities within the area of coverage of the facility
- Copy of list of food establishments with sanitary permits and their updated sanitation conditions
- Information and education materials on environmental sanitation
- Record of number of bowls distributed or produced using the toilet bowl molds.

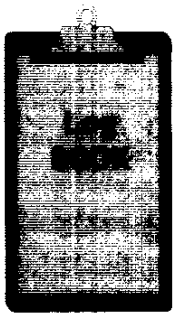
- The BHS should promote that all women of reproductive age should receive a pelvic exam and pap smear annually for three (3) years in a row (This service is provided at the appropriate facility and with proper back-up support from the physician.) If all three are negative, clients need to go to the facility only every three years for a pap smear.

- The BHW midwife should counsel patients as to the risk factors for contracting cervical malignancy, not using condoms, frequent STDs, multiple partners, etc.

- The BHW midwife should be trained on and with necessary equipment and supplies to perform a pap smear. The BHS midwife should collect and fix the specimen for reading by a higher level facility (RHU or hospital).

The following conditions, equipment and supplies must be present in order for the facility to qualify as providing this service:

- Updated Target client list/log book of clients (at least within the week)
- Pap smear: for collection of specimen
  - Glass slides
  - Wooden spatula (Ayer's spatula) or cervical brush
  - Fixative (95% ethanol or others)
  - Pencil



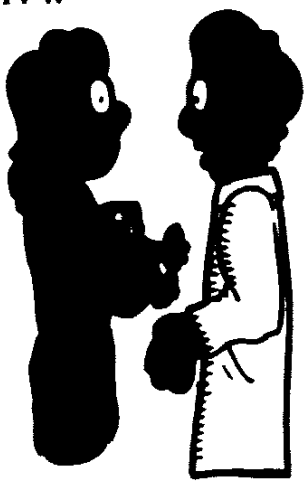
- Referral facility for pap smear reading
- Referral forms
- Individual patient record of Pap Smear results
- IEC materials on Cervical Cancer and self-breast examination (SBE) i.e. leaflets, posters

Maternal Care

- The BHS should provide a whole range of maternal care services to include providing tetanus immunization to clients/mothers, pre-natal, natal (delivery) and post partum care.

The following conditions, equipment and supplies must be present in order for the facility to qualify as providing this service:

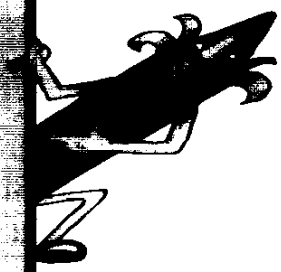
- Updated target client list/book (at least within the week)
- TT vaccines and syringes & needles
- Record of pre-natal/natal/post natal visits conducted
- Record of home visits made by BHW midwife/CHVW
- Available forms for birth certificates
- Home based maternal records (HBMR) for distribution to new clients/replacements
- IEC materials
- OB Emergency Manual & Algorithim



3. Attitude & Behavior of Health Workers

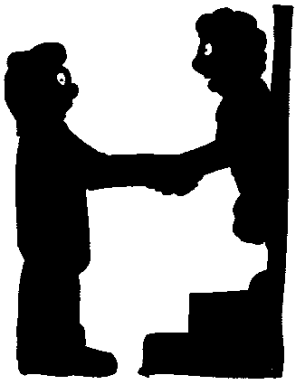
The attitude and behavior of health workers is one of the most important factors affecting the way clients/patients judge the quality of services in any health facility.

The midwife is expected to:



[illegible] verbally as [illegible] rapport.

[illegible] of competence in anticipating [illegible] patients by:



- Maintaining 2 way communication
- Being a good listener
- Being non-judgmental
- Not giving false reassurances
- Giving appropriate instructions to patients by explaining prescriptions clearly and correctly explaining laboratory results and facilitating follow-up of clients

[illegible]

- Being courteous and always explain the procedure
- Ask permission before proceeding
- Avoid gender slurs/insults and discriminating words against women
- Being careful in examining women patients. This is especially true when examining women during obstetrical and gynecological examinations and as urchin/survivor of abuse/violence
- Not blaming a victim or survivor of abuse or violence

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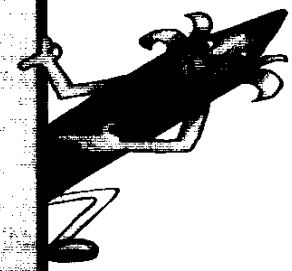
- Respecting patient's decision without compromising overall patient management
- Assuring patient's privacy and confidentiality of given information at all times
- Promptly responding to patient's request for care
- Speaking politely and with modulated tone

- Respecting patients' culture and religion
- Providing for patients needs that are influenced by culture and religion
- Offering choices/options to patients

The BHS should have at least one midwife assigned to the facility with the physician and nurse from the mother RHU conducting regular visits. The midwife should be complemented by a group of organized volunteer health workers to assist in the facility.



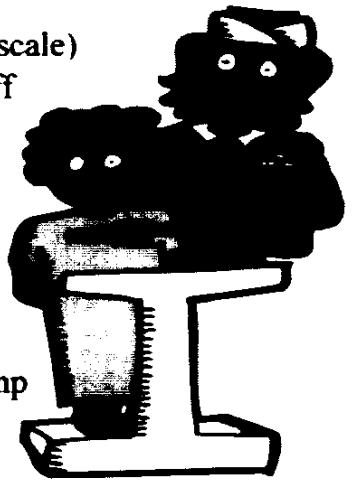
- The midwife should be trained in specific DOH-mandated courses to deliver competent care in a full range of services. These courses include:

1. **Basic EPI Skills Training**
2. **Disease Surveillance Training**
3. **Pneumonia Case Management**
4. **CDD Case Management**
5. **Community-Based Planning and Management of Nutrition Program (CBPM-NP)**
6. **Basic Family Planning Course (or Level I) or Comprehensive Family Planning (or Level II)**
7. **DMPA Training (if not included in either Level I or Level II)**
8. **Training on National Tuberculosis Control Program**
9. **Training on Basic Counseling for STD/AIDS**
10. **Skills Training on Pap Smear Collection (for those trained in FP Basic/Compre course)**
11. **Gender Sensitivity Training**
12. **NTP Training - DOTS**
13. **Family Planning Counseling Training**

- The midwife or visiting physician should spend a minimum of 10 minutes with each client in history-taking (new clients), examination, treatment and health education. Clients can be seen by the midwife, nurse or physician or a combination of staff depending on their complaint.
- The midwife should be supervised by the RHU nurse or physician on a regular basis to determine her technical proficiencies in performing her tasks.

The BHS should have the following essential equipment to provide basic services:

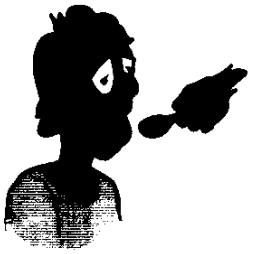
- Stethoscope
- Weighing scales-adult and infant (beam or Ming scale)
- Sphygmomanometer with adult and pediatric cuff
- Vaccine Carrier with ice packs
- Sterilizer or covered pan and stove
- Inventory of equipment and supplies
- Examination table with clean linen/paper
- Bench or stool for examination table
- Kelly pad/clean linen/plastic lining
- Light source for examination like goose neck lamp with bulb and flashlight with batteries
- Speculums-large and small



6. Drugs, Medicines & Supplies

1 The BHS should have the following eight essential drugs:

1. Cotrimoxazole
2. Amoxicillin
3. INH
4. Rifampicin
5. Pyrazinamide
6. Paracetamol
7. ORS (in sachets)
8. Nifedipine



2 The BHS should have the following basic supplies for examination, medical [illegible] and simple surgical cases:

- alcohol/disinfectant
- gauze/bandages/plaster or adhesive tape
- cotton
- disposable gloves
- sutures
- disposable needles
- disposable syringes
- lubricant (KY Jelly) or clean water
- slides and cover slips
- sharp containers
- tape measures

3 Adequate supply of disinfectants, antiseptics and/or insecticides.

4 Available storage for drugs.

Drugs/medicines are kept off the floor and away from the walls. They should be protected from rodents, insects and environmental elements (sunlight, heat, humidity, floods, moisture, etc.) and kept in a safe place to ensure that no pilferages occur.

5 Complete and updated inventory of stock cards and supply records.

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7. Health Information System

7.1 [illegible]

1. A functioning two-way referral system with procedures for on-referral/ back referral of clients/patients and the necessary referral forms.
2. Updated statistical record/board/displays
3. Completed/updated (at least within the week) Field Health Information Systems (FHSIS) reports and target client lists (TCLs)

7.2 [illegible]

8. Community Intervention

The BHS should have a [illegible] community health volunteer workers (CHVWs)

- The BHS midwife, in coordination with organized groups/community organization and NGOs, should, whenever needed, organize outreach services to communities being served especially on areas otherwise inaccessible to health workers or regular health services.

- The BHS midwife should conduct activities to encourage the participation of CHVWs in their catchment since CHVWs are essential partners in delivering basic health services at the community level.

- Organized CHVWs should refer and follow-up patients to BHS or RHUs or other levels of health care delivery system e.g., other health units and hospitals.

- The BHS midwife and CHVWs should conduct community health interventions through barangay assemblies, "Dengue Linis Brigade", patients/mothers classes, breastfeeding support groups, etc.

- The BHS should have a program or activities to encourage and support community participation and partnership for health interventions.

Sentrong Sigla Movement
is a project of the Department of Health in partnership with
Local Government Units with technical assistance from Management Sciences
for Health (MSH) and funding support from the United States Agency for International Development (USAID Contract No.: AID492-0480-c-00-5093-00).

MSH

FACILITY SELF-ASSESSMENT CHECKLIST (FSAC)
FOR BARANGAY HEALTH STATIONS (BHS)
GUIDE FOR IMPROVING QUALITY OF HEALTH SERVICES
Level I

Introduction

This Facility Self-Assessment Checklist (FSC) is a self-evaluation guide for the BHS staff towards improving quality of health services being provided at the BHS. The checklist contains a list of questions derived from the *Quality Standards List (QSL) for BHS Level I* that are recommended by the Department of Health for *Sentrong Sigla* certification. The use of this checklist together with the QSL will help the BHS staff do the following:

- Assess the BHS's compliance to Sentrong Sigla Level I quality standards,
- Identify and recognize problems or areas of improvement in service delivery,
- Identify ways or opportunities to solve problems or improve services, and eventually
- Get certification for the BHS as Sentrong Sigla

Instructions for Using the Facility Self-Assessment Checklist

For each question, encircle or mark either **YES**, **X** (for Yes, but needs improvement) or **NO** depending on the situation in your facility at the time of your assessment. A column for **REMARKS** is provided for any notes or details that you might need to pay attention to in improving the situation. Be as self-critical and honest as possible in your responses.

Example

Questions	Yes	Yes, but needs improvement	No	Remarks
1. Is there a CDD Case Management Chart posted in the BHS	YES	X	NO	
2. Does the BHS have a regular source of clean water	YES	X	NO	Explore possibility of having own deep well
3. Does the BHS have an updated Target Client List (TCL)	YES	X	NO	Get help from BHWs to update the list

For question #1, the respondent is very sure that a CDD Management Chart is posted at the ORT Corner of the BHS.

For question #2, the respondent believes that although the BHS has been assured of continues supply of clean water from a nearby household, it will be better if it could build a deep well of its own and not rely or burden other people for water.

For question #3, the respondent admits that the TCL for family planning does not contain all the names of MWRA in the BHS's catchment areas and therefore needs to improve this aspect of identifying target clients or beneficiaries.

Each **NO** or **X** answer represents an opportunity for health service improvement. Remember, the more opportunities for improvement you find, the more you will be able to enhance quality of your service. Use your creativity to think of remedies or solutions to problems in the delivery of high quality services. This is your facility's initial step to Sentrong Sigla certification.

Instructions for Using the Results of the Self-Assessment

Once you have completed the self-assessment, meet with your supervising nurse and physician to review and discuss all the responses. Consider taking the following steps:

1. Agree on the areas to be improved using the following criteria:

   a. Does everyone agree that the problem(s) needs to be solved?
   b. Can the problem be solved with available resources? Are there possible resources that could be tapped?
   c. Do team members agree to accept responsibility for specific activities required to solve the problem(s)?

2. Make a list of areas to be improved in the order of importance.

3. Plan specific activities to improve the situation or condition and then set a date for completing the activities.

4. Implement improvements and keep all team members involved

5. Make a written request to the DOH Center for Health Development for Sentrong Sigla assessment after improvements have been made.

* * * * *

FACILITY SELF-ASSESSMENT CHECKLIST FOR BARANGAY HEALTH STATIONS (BHS)

*The following are the **inclusion criteria** for Level I Sentrong Sigla Certification. All criteria should be met by the BHS before requesting the DOH Center for Health Development for an assessment for certification.*				
1. Is the RHU or Health Center of our BHS a Sentrong Sigla certified facility?	YES	X	NO	
2. Is our BHS housed in (or within) a permanent structure?	YES	X	NO	
3. Does our BHS have a permanently assigned midwife to provide regular health services?	YES	X	NO	
4. Does our BHS have the following?				
a. Regular source of clean water	YES	X	NO	
b. Functioning comfort room or latrine for client use	YES	X	NO	
c. Blood pressure apparatus with cuff	YES	X	NO	
d. Stethoscope	YES	X	NO	
e. Thermometer	YES	X	NO	
f. Weighing scale for infants and adults (not bathroom scale)	YES	X	NO	

1. INFRASTRUCTURE/AMENITIES

1.1. Is our BHS free from rubbish?	YES	X	NO	
1.2. Does our BHS have benches or chairs for patients in all waiting and service provision areas?	YES	X	NO	
1.3. Does our BHS have a signboard listing facility hours, available services and whereabouts of staff that is posted in a strategic area?	YES	X	NO	
1.4. Does our BHS have lighting that permits easy reading of forms?	YES	X	NO	
1.5. Does our BHS have ventilation windows, electric fans or air conditioners?	YES	X	NO	
1.6. Does our BHS have a gooseneck lamp or flashlight for examination?	YES	X	NO	
1.7. Does our BHS have a hand washing area with covered water supply, soap and towels?	YES	X	NO	
1.8. Does our BHS have covered water supply for comfort rooms or latrines?	YES	X	NO	
1.9. Does our BHS have covered garbage containers for waste segregation?	YES	X	NO	
1.10. Does our BHS have a separate container for sharps (*needles, blades and other sharp objects*)?	YES	X	NO	
1.11. Does our BHS have cleaning or sterilizing supplies for clinical instruments?	YES	X	NO	

1.12. Does our BHS have a storage space or room for supplies, drugs and medicines?	YES	X	NO	
1.13. Does our treatment or examination area have visual privacy?	YES	X	NO	
1.14. Does our treatment or examination area have auditory privacy?	YES	X	NO	
1.15. Does our BHS have a special schedule at least once per week for clients who may not be available during regular office or work hours?	YES	X	NO	

2. HEALTH SERVICES

2.1. IMMUNIZATION				
2.1.1. Does our BHS conduct immunization sessions daily or at least 3X per week (depending on catchment population)?	YES	X	NO	
2.1.2. Does our BHS serve clients who request immunization on other days?	YES	X	NO	
2.1.3. Are disposable syringes and needles used only once ?	YES	X	NO	
2.1.4. Are used disposable syringes and needles collected in a puncture-proof container, then burned and buried?	YES	X	NO	
2.1.5. Does our BHS have the latest version of the EPI Manual?	YES	X	NO	
2.1.6. Is our Target Client List or Master List updated weekly?	YES	X	NO	
2.1.7. Does our BHS have the following vaccines for at least one week?				
a. BCG	YES	X	NO	
b. OPV	YES	X	NO	
c. DPT	YES	X	NO	
d. Measles	YES	X	NO	
e. Hepatitis B	YES	X	NO	
f. Tetanus Toxoid	YES	X	NO	
2.1.8. Does our BHS have vaccine carriers with ice cold packs during immunization days?	YES	X	NO	
2.2. DISEASE SURVEILLANCE				
2.2.1. Are DOH case definitions available in our BHS?	YES	X	NO	
2.2.2. Does our BHS submit a Notifiable Disease Report weekly to MHO/CHO/PHO?	YES	X	NO	
2.2.3. Does our BHS conduct an investigation of every single case of acute flaccid paralysis (AFP) cases, neonatal deaths and measles outbreaks?	YES	X	NO	
2.2.4. Does our BHS report all AFP and neonatal tetanus cases to the RHU/HC within a week of identification of cases?	YES	X	NO	
2.2.5. Does our BHS (together with the RHU/HC) follow up each reported AFP Case after 60 days?	YES	X	NO	

2.3. CONTROL OF ACUTE RESPIRATORY INFECTIONS				
2.3.1. Is there an ARI Case Management Chart posted in our BHS?	YES	X	NO	
2.3.2. Does our BHS have tongue depressors?	YES	X	NO	
2.3.3. Does our BHS staff have a timer or watch with second hand?	YES	X	NO	
2.3.4. Does our BHS have at least:				
a. 25 cotrimoxazole adult tablets?	YES	X	NO	
b. 50 paracetamol (500 mg.) tablets?	YES	X	NO	
2.4. CONTROL OF DIARRHEAL DISEASES				
2.4.1. Is there a CDD Case Management Chart posted in our BHS?	YES	X	NO	
2.4.2. Does our BHS have an ORT Corner with benches, tables glasses, pitcher, spoon, calibrated container for measuring potable water and ORS?	YES	X	NO	
2.4.3. Does our BHS have ORS sachets?	YES	X	NO	
2.4.4. Does our BHS have a record of water quality test that was done in the past month?	YES	X	NO	
2.4.5. Does our BHS have an updated record of diarrhea cases?	YES	X	NO	
2.5. MICRONUTRIENTS SUPPLEMENTATION				
2.5.1. Does our BHS have the following micronutrients?				
a. Iron tablets for all pregnant and lactating women	YES	X	NO	
b. Iron drops for infants	YES	X	NO	
c. Iron syrup for school children	YES	X	NO	
d. Iodized oil capsules	YES	X	NO	
e. Iodized salt	YES	X	NO	
f. Vitamin A capsules	YES	X	NO	
2.5.2. Does our BHS have the Guidelines for Micronutrient Supplementation?	YES	X	NO	
2.5.3. Is our Operation Timbang (OPT) Record updated monthly or quarterly depending on the nutritional status of the child?	YES	X	NO	
2.5.4. Is our Target Client List updated weekly?	YES	X	NO	
2.5.5. Does our BHS have Under 5 growth cards/Growth Monitoring Charts (GMC)?	YES	X	NO	
2.5.6. Does our BHS have the CBPM-NP RHM Guidebook?	YES	X	NO	
2.5.7. Does our BHS have available copies of the Basic Three Food Groups brochure for distribution?	YES	X	NO	
2.5.8. Does our BHS have Salt Iodization Testing Kit?	YES	X	NO	
2.6. FAMILY PLANNING				
2.6.1. Does our BHS offer referral services for the following laboratory exams?				
a. Pap smear	YES	X	NO	
b. Wet smear	YES	X	NO	

c. Gram Staining	YES	X	NO	
d. Pregnancy test	YES	X	NO	
e. Urinalysis	YES	X	NO	
f. Natural Family Planning (if not trained)	YES	X	NO	
g. Tubal ligation	YES	X	NO	
h. Vasectomy	YES	X	NO	
i. Management of Complication and/or side effects arising as a result of FP method	YES	X	NO	
2.6.2. Is our Target Client List updated weekly?	YES	X	NO	
2.6.3. Does our BHS have copies of FP Form1?	YES	X	NO	
2.6.4. Does our BHS have at least one month supply of the following contraceptives?				
a. Condoms	YES	X	NO	
b. Pills	YES	X	NO	
c. DMPA (*if staff is trained*)	YES	X	NO	
d. IUDs (*if staff is trained*)	YES	X	NO	
2.6.5. Does our BHS have antiseptic solution (povidone iodine; cidex) or chlorine 75%?	YES	X	NO	
2.6.6. Does our BHS have the following sterilized forceps?				
a. Alligator forceps	YES	X	NO	
b. Pick-up forceps	YES	X	NO	
c. Ovum forceps	YES	X	NO	
d. Tenaculum	YES	X	NO	
e. Uterine forceps	YES	X	NO	
2.6.7. Does our BHS have a forceps container?	YES	X	NO	
2.6.8. Does our BHS have an examination table?	YES	X	NO	
2.6.9. Does our BHS have a kelly pad/linens for the examination table?	YES	X	NO	
2.6.10. Does our BHS have NFP charts for distribution?	YES	X	NO	
2.6.11. Does our BHS have other FP leaflets/handouts for distribution?	YES	X	NO	
2.7. TUBERCULOSIS CONTROL				
2.7.1. Is our Target Client List/TB Register updated weekly?	YES	X	NO	
2.7.2. Does our BHS have sputum cups?	YES	X	NO	
2.7.3. Does our BHS have glass slides?	YES	X	NO	
2.7.4. Does our BHS have a designated sputum collection and staining area?	YES	X	NO	
2.7.5. Does our BHS have the following anti-TB drugs:				
a. Type I (*good for at least 5 patients*)	YES	X	NO	
b. Type II (*good for at least 5 patients*)	YES	X	NO	
c. Ethambutol	YES	X	NO	
d. Streptomycin sulfate	YES	X	NO	
2.8. STD/AIDS PREVENTION and CONTROL				
2.8.1. Is there a Syndromic Management Chart posted in our BHS?	YES	X	NO	
2.8.2. Does our BHS have condoms for distribution to patients?	YES	X	NO	

2.8.3. Does our BHS accomplish and submit a monthly report using primary level reporting form to the next higher level?	YES	X	NO	
2.9. ENVIRONMENTAL SANITATION				
2.9.1. Does our BHS have a copy of the updated list of status of water supply and sanitation facilities within our area of coverage?	YES	X	NO	
2.9.2. Does our BHS have a copy of the list of food establishments with sanitary permits and their updated sanitation conditions?	YES	X	NO	
2.9.3. Does our BHS have chlorine granules for disinfecting water supply facilities?	YES	X	NO	
2.9.4. Does our BHS have toilet bowls for distribution to households without toilets?	YES	X	NO	
2.9.5. (*For a facility that does not have toilet bowls for distribution*) Does our BHS have toilet bowl molds?	YES	X	NO	
2.9.6. Does our BHS have a record of number of bowls distributed or produced using the toilet bowl mold?	YES	X	NO	
2.9.7 Does our BHS have information and education materials on environmental sanitation (e.g. dengue fever, proper waste disposal, etc.)	YES	X	NO	
2.10. CANCER CONTROL – CERVICAL CANCER SCREENING				
2.10.1. Is the Target Client List/log book of clients updated weekly?	YES	X	NO	
2.10.2. Does our BHS have the following supplies for pap smear specimen collection?				
a. Glass slides	YES	X	NO	
b. Wooden spatula (A217 spatula) or cervical brush	YES	X	NO	
c. Fixative (95% ethanol or others)	YES	X	NO	
d. Pencil	YES	X	NO	
2.10.3. Does our BHS have a referral facility where pap smear specimen collected are sent for reading and interpretation?	YES	X	NO	
2.10.4. Does our BHS keep individual patient records of pap smear Results?	YES	X	NO	
2.10.5. Does our BHS have IEC materials on cervical cancer (leaflets, posters) and self-breast examination (SBE)?	YES	X	NO	
2.11. MATERNAL CARE				
2.11.1. Is Target Client List/book updated weekly?	YES	X	NO	
2.11.2. Does our BHS have a record of pre-natal/natal/post-natal visits conducted by staff?	YES	X	NO	
2.11.3. Does our BHS have birth certificate forms?	YES	X	NO	

2.11.4. Does our BHS have Home Based Maternal Records (HBMR) for distribution to new clients?	YES	X	NO	
2.11.5. Does our BHS have IEC materials for maternal care?	YES	X	NO	
2.11.6. Does our BHS have an OB Emergency Manual & Algorithm chart?	YES	X	NO	

3. ATTITUDES AND BEHAVIOR OF HEALTH SERVICES

3.1. Does our BHS midwife greet patient verbally to establish rapport?	YES	X	NO	
3.2. Does our BHS midwife exhibit technical competence in articulating information to patients by:				
a. Maintaining 2-way communication?	YES	X	NO	
b. Being a good listener?	YES	X	NO	
c. Being a non-judgmental?	YES	X	NO	
d. Giving appropriate instructions?	YES	X	NO	
e. Not giving false assurances?	YES	X	NO	
3.3. Is our BHS midwife woman-friendly by:				
a. Being courteous and always explaining any procedure?	YES	X	NO	
b. Asking permission before proceeding?	YES	X	NO	
c. Avoiding gender slurs/insults and discriminating words?	YES	X	NO	
d. Being careful in examining women and not blaming victims/survivor of abuse/violence?	YES	X	NO	
3.4. Is our BHS midwife caring and gender-sensitive by:				
a. Respecting patient's decision without without compromising overall patient management?	YES	X	NO	
b. Assuring patient's privacy and confidentiality of given information at all times?	YES	X	NO	
c. Promptly responding to patient's request for care?	YES	X	NO	
d. Speaking politely and with modulated tone?	YES	X	NO	
3.5. Is our BHS midwife culture-sensitive by:	YES	X	NO	
a. Respecting patient's culture and religion?	YES	X	NO	
b. Providing for patient's needs accordingly?	YES	X	NO	
c. Offering choices and options?	YES	X	NO	
3.6. Does our BHS midwife provide information to clients without allowing personal biases to affect client choices?	YES	X	NO	

4. HEALTH HUMAN RESOURCES

4.1. Is the BHS complemented by BHWs to assist the midwife?	YES	X	NO	
4.2. Is our BHS midwife trained on the following DOH mandated courses?				
a. Basic EPI Skills Training	YES	X	NO	
b. Disease Surveillance Training	YES	X	NO	
c. Pneumonia Case Management	YES	X	NO	
d. CDD Case Management	YES	X	NO	
e. Community-Based Planning and Management of Nutrition Program (CBPM-NP)	YES	X	NO	
f. Basic Family Planning Course (or Level I)	YES	X	NO	
g. Comprehensive Family Planning (or Level II)	YES	X	NO	
h. DMPA Training (if untrained in either Level I or Level II)	YES	X	NO	
i. Training on National Tuberculosis Control Program – DOTS	YES	X	NO	
j. Training on Basic Counseling for STD/AIDS	YES	X	NO	
k. Skills Training on Pap Smear Collection (for those untrained in FP Basic/Compre Course)	YES	X	NO	
l. Gender Sensitivity Training	YES	X	NO	
m. Family Planning Counseling Training	YES	X	NO	
4.3. Did the RHU/HC nurse or physician visit our BHS midwife in the past month?	YES	X	NO	

5. EQUIPMENT (non-program specific)

5.1. Does our BHS have a sterilizer or covered pan and stove?	YES	X	NO	
5.4. Does our BHS have large speculums?	YES	X	NO	
5.5. Does our BHS have small speculums?	YES	X	NO	
5.4. Did our BHS conduct a complete inventory of equipment within the last 6 months?	YES	X	NO	

6. DRUGS, MEDICINES and SUPPLIES

6.1. Does our BHS have at least a one month supply of the following essential drugs? (*Three have already been incorporated under CARI and CDD*)				
a. Amoxicillin	YES	X	NO	
b. INH	YES	X	NO	
c. Rifampicin	YES	X	NO	
d. Pyrazinamide	YES	X	NO	
e. Nifedipine	YES	X	NO	

6.2. Does our BHS have the following basic supplies for examination, emergency medical and simple surgical cases?				
a. Alcohol/disinfectant	YES	X	NO	
b. Gauze/bandages/plaster or adhesive tape	YES	X	NO	
c. Cotton	YES	X	NO	
d. Disposable gloves	YES	X	NO	
e. Sutures	YES	X	NO	
f. Disposable needles	YES	X	NO	
g. Disposable syringes	YES	X	NO	
h. Lubricant (KY Jelly) or clean water	YES	X	NO	
i. Slides and coverslips	YES	X	NO	
j. Tape measures	YES	X	NO	
6.3. Does our BHS have an disinfectants, antiseptics and/or insecticides?	YES	X	NO	
6.4. Did our BHS conduct a complete inventory of supplies within the last 6 months?	YES	X	NO	

7. HEALTH INFORMATION SYSTEM

7.1. Does our BHS have referral slips or forms?	YES	X	NO	
7.2. Are our 10 Leading Causes of Mortality and Morbidity and other vital health statistics updated annually?	YES	X	NO	
7.3. Are our Field Health Information Systems (FHSIS) forms complete and updated within the week?	YES	X	NO	

8. COMMUNITY INTERVENTION

8.1. Is the BHW: household ratio equal to 1:20?	YES	X	NO	
8.2. Did our BHS midwife conduct the monthly meeting of BHWs in the past month?	YES	X	NO	
8.3. Did our BHS midwife and BHWs organize or attend barangay assemblies, patients' classes, mothers' classes, breastfeeding support groups, or the like in the last 3 months?	YES	X	NO	
8.4. Did our BHWs follow-up patients referred to the Main RHU in the last three (3) months?	YES	X	NO	

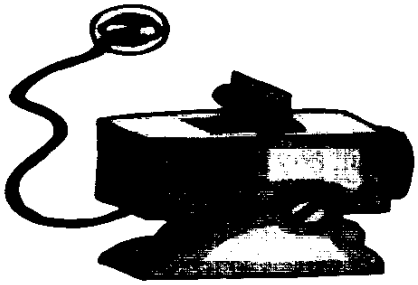
* * * * *

Quality Standards List for Rural Health Units and Health Centers

Level 1

Certification and Recognition Program
Sentrong Sigla Movement

October 2000



What is Sentrong Sigla Movement?

Sentrong Sigla Movement (SSM) aims to improve the quality of public health services. Through its ***Certification and Recognition Program or CRP***, Sentrong Sigla recognizes local government units (LGUs) and certifies health facilities that meet requirements and standards to deliver quality services.The CRP has three levels of certification with Level 1 as the entry level. The participating facility progresses through Levels 1, 2 and 3 until it gets elevated to the SSM's Hall of Fame. A Sentrong Sigla certified facility eventually gets into the continuous quality improvement (CQI) mode enabling the facility staff to set their own standards of quality.

What is the Level 1 Quality Standards List for Rural Health Units (RHU) and Health Centers (HC)?

The Level 1 Quality Standards List for Rural Health Units and Health Centers includes the recommended standards and requirements for providing quality services. This list was developed based on existing program guidelines from the Department of Health (DOH).

There are general conditions or requirements that are critical in every facility and are therefore considered as inclusion criteria for participation in Level 1:

- **Regular source of clean water**
- **Comfort room/latrine for patients**
- **Blood pressure apparatus with cuff**
- **Stethoscope**
- **Thermometer**
- **Weighing scale for infants and adults (but not bathroom scale)**

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Who is the Quality Standards List's intended user?

The List is meant for service providers or staff, local health managers, local chief executives, Sentrong Sigla teams and other users interested and involved in improving quality of services being provided in the facility. Using the List, any user will be able to assess if his/her facility meets the quality standards for providing health services or if not, what improvements are needed to meet the standards.

What health facilities are being referred to?

The Sentrong Sigla Certification and Recognition Program covers health facilities like hospitals, rural health units/health centers and barangay health stations. This List is intended only for **rural health units and health centers**.

What is the focus of Level 1 standards?

Level 1 standards focus on "inputs" like the basic infrastructure, equipment, pharmaceuticals and supplies and other conditions that are necessary to demonstrate "preparedness" or "readiness" of the facility to provide the services. There are also some "process" standards that are already included. These standards are in the following areas:

- **Infrastructure/Amenities**
- **Health Services**
- **Attitude and Behavior of Health Workers**
- **Health Human Resources**
- **Equipment**
- **Drugs, Medicines and Supplies**
- **Health Information System**
- **Community Interventions**

Note to Users:

The List provides the basic standards and requirements that are being recommended under Sentrong Sigla for Level 1 certification. There are corresponding standards for Levels 2 and 3. Once a facility meets Level 1 standards and gets certified, under the Sentrong Sigla Certification and Recognition Program, the facility and its staff will be introduced to continuous quality improvement (CQI) tools and techniques in order to maintain Level 1 standards, and also strive for higher levels of certification.

It is expected that certain aspects of quality standards maybe defined differently and may vary from program to program, facility to facility and from one person to another. However, for Sentrong Sigla, these are the standards being recommended. These standards were developed based on existing DOH program standards and was a result of a series of consultation activities at different levels of the health system.

The RHU HC should have the following general infrastructure conditions amenities:

- Generally clean and orderly environment
- Sufficient seating space for patients
- With regular electricity/power source
- Adequate lighting and ventilation
- Light source for examinations: goose neck lamp and flashlights
- Covered water supply-sufficient for hand-washing and for comfort rooms or toilets
- Hand washing area with water, soap and towels
- Functional clean comfort rooms or latrines for health staff and clients with handrails for the disabled
- Covered garbage containers (waste segregation)
- Separate container for sharps (needles, blades and other sharp objects)
- Examination table with clean linen/paper
- Bench or stool for examination table
- A treatment area/examination area with visual and auditory privacy
- Storage space/room for supplies, drugs and medicines
- Cleaning/sterilizing supplies for clinical instruments

The facility should practice the following:

- Clinic hours, services and whereabouts of staff posted in a strategic area readable by all clients and service providers.

- Client waiting time must be as brief as possible. Clients should be seen by health staff within 30 minutes of registration.

- During clinic hours, direct client care should take precedence over all other tasks. Clients should not be made to wait merely because staff are writing or transferring notes, doing reports or performing other tasks not directly related to client care.

- The RHU/HC should maintain occassional hours during evenings and weekends to accommodate clients who are unable to consult or visit during regular clinical hours. The RHU/HC should provide services during non-traditional hours <u>at least</u> once per month, considering clients who may not be available during regular office or work hours.

Expanded Program on Immunization

- Immunization sessions should be conducted in the RHU/HC as regularly as possible. Although Wednesday has been adopted as the national immunization day, immunization days may be held on other days.

- Schedules should be displayed to inform mothers of the time and day at which immunization services are to be provided. However, clients who request immunization on other days should not be turned away. Wastage of vaccine is a minimal program cost and should not be overemphasized or used as a barrier to vaccine administration.

- The facility should practice a "one needle and one syringe policy" because of the danger of transmitting Hepatitis B and AIDS (HIV infection) through unsterile needles and syringes. Therefore, one sterile syringe and needle should be utilized for each injection. Disposable syringes and needles should be used only once and then collected in a puncture proof container to be burned and buried.

- BCG, OPV, DPT, measles, hepatitis B and tetanus toxoid vaccines should be available at all times in the facility and should be stored under proper cold chain conditions.

- The RHU/HC should conduct patient counseling on effectiveness, risks, benefits, potential side effects and treatment for side effects of each vaccine.

The following conditions, equipment and supplies must be present in order for the facility to qualify as providing this service:

- ❍ Immunizations offered at least once per week (depends on catchment population)
- ❍ Outreach immunization services offered in hard-to-reach areas
- ❍ EPI Manual (latest version)
- ❍ Target Client List or Master List (updated weekly)
- ❍ Adequate supplies of BCG, OPV, DPT, measles, hepatitis B and tetanus toxoid vaccines based on average monthly consumption (with at least one month's supply at anytime)
- ❍ Proper cold chain maintained:
  - Refrigerator exclusively for vaccine use and with voltage regulator
  - Vaccine thermometer (placed inside the refrigerator) with temperature maintained between 2-8°C
  - Daily am and pm temperature monitoring charts posted and updated
  - Written contingency plan for a "power failure"
  - Vaccine carriers with ice cold packs

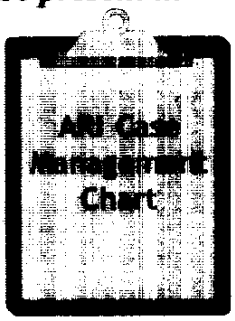
- The RHU/HC should perform disease surveillance to measure the magnitude of the local health problems and the effects of the control programs delivered. Surveillance data can be used by the facility to improve strategies in delivering health services and thus prevent these from occurring, e.g. immunizable diseases like diptheria, pertussis, tetanus, polio, measles, etc.
- The RHU/HC staff and community health volunteer workers (CHVWs) should be involved in reporting, investigating and reporting to the next higher level of the health system.
- Surveillance data must be complete, accurate and on time.

The following conditions must be present in order for the facility to qualify as providing this service:

- Case definitions available
- Notifiable disease reporting forms available
- Notifiable disease reporting forms submitted weekly to provincial/city or municipal health office
- Investigation of all acute flaccid paralysis (AFP) cases, neonatal deaths and measles outbreaks
- Immediately reporting all AFP and neonatal tetanus (NT) cases to the regional offices (surveillance personnel) through the fastest possible means
- Reported cases followed up by RHU/HC for public health reasons especially 60 days follow-up done on all AFP cases detected

- The RHU/HC should have the equipment and supplies necessary to diagnose and treat common acute respiratory illnesses.
- Cotrimoxazole and other antibiotics should be available at all times in the facility.
- Referral to other or higher level facilities, e.g., hospitals should be done for clients needing further management.
- RHU staff should continue creating awareness among mothers and childminders on home care for children with simple cough and colds and the detection of early signs of pneumonia through information and health education activities.

The following conditions, equipment and supplies must be present in order for the facility to qualify as providing this service:



- ❍ ARI Case Management Chart posted
- ❍ Thermometer
- ❍ Tongue depressors
- ❍ Flashlights or pen light
- ❍ Timer or watch with second hand
- ❍ Cotrimoxazole (adult tabs.), at least 100 tablets
- ❍ Paracetamol (500 mg tabs.), at least 100 tablets
- ❍ In client or patient education/counseling basic messages should include:
  - home management of simple coughs and colds w/o use of cough/cold medicines
  - detection of early pneumonia using simple signs like rapid breathing and chest indrawing
  - information on when, where and how to bring the child with pneumonia for treatment
  - CHVWs as part of the health service delivery network should refer patients to higher levels of the health care system e.g. barangay health stations, rural health units/health centers and hospitals and conduct follow up visits
  - outreach activities should be done in areas otherwise inaccessible to health worker or to regular health services

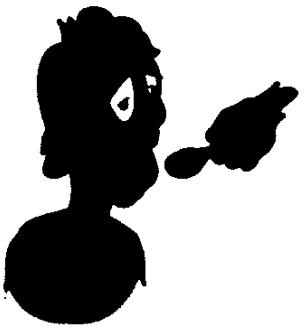
- The RHU/HC should have the equipment and supplies necessary to diagnose and treat diarrheal diseases. Referral to other or higher level facilities should be done for diarrheal clients needing further management.

- In the RHU/HC, all patients with no dehydration or who have been successfully rehydrated in the facility should be given ORS to take home to prevent dehydration.

- Antibiotics should ONLY be used for dysentery or for suspected cholera cases with severe dehydration; otherwise, these are ineffective and should NOT be given. Other DOH policies on anti-parasitic drugs and antidiarrheal drugs should be followed based on previously issued policies and guidelines.

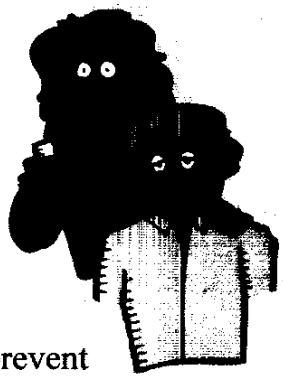
- As part of appropriate and prompt response to diarrhea outbreak/cholera/ disease surveillance, the facility should:

  - ensure potability of drinking water within the catchment area in conjunction with the Environmental Sanitation Program;
  - enforce sanitation code, especially on food sanitation in conjunction with the Environmental Sanitation Program;
  - promote personal and domestic hygiene through health education, and
  - assure adequate supply of ORS sachets



The following conditions, equipment and supplies must be present in order for the facility to qualify as providing this service:

- ❍ CDD Case Management Chart posted
- ❍ Functional Oral Rehydration Therapy (ORT) corner with benches, table, glasses, pitcher, spoon, calibrated container for measuring potable water and Oral Rehydration Sachets (ORS)
- ❍ ORS sachets available at all times
- ❍ Updated daily record of diarrhea cases
- ❍ In client or patient education/counseling basic messages should include:



  - Give the child more fluids than usual to prevent dehydration;
  - Continue to feed the child; and
  - Take the child to the health worker if child does not become better in three days or earlier if the child develops some signs/symptoms like many episodes of watery stools, repeated vomiting, marked thirst, fever, blood in the stool and eating or drinking poorly.

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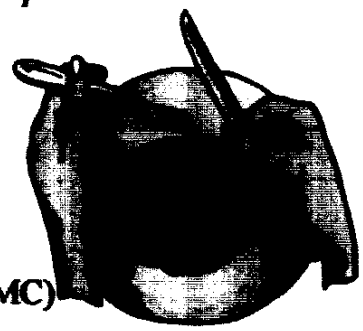
- The RHU/HC should have the equipment and supplies necessary to prevent, detect and control nutritional deficiencies and specific micronutrient disorders.

- The RHU/HC should have iron, iodized oil capsules/iodized salt and vitamin A capsules available at all times for supplementation of target groups e.g. iron tablets for all pregnant and lactating women; iron drops for infants and iron syrup for school children.

- RHU personnel should refer clients needing further treatment to other or higher level facilities like hospitals.

The following conditions, equipment and supplies must be present in order for the facility to qualify as providing this service:



- ❍ **Guidelines for Micronutrient Supplementation**
- ❍ **Operation Timbang (OPT) Records for the whole RHU catchment**
- ❍ **Updated Target Client List (at least within the week)**
- ❍ **Under 5 growth cards/Growth Monitoring Charts (GMC)**
- ❍ **CBPM-NP RHM Guidebook**
- ❍ **Basic Three Food Groups Brochures**
- ❍ **Salt Iodization Testing Kit**
- ❍ **Micronutrients available: iron, iodine, vitamin A**
- ❍ **Functional balance beam or other weighing scales**
- ❍ **In-client or patient nutrition education/counseling, basic messages should be emphasized like importance of proper nutrition including:**
  - **Balanced diet**
  - **Desirable food habits**
  - **Consumption of fortified foods**
  - Use of iodized salt
  - Importance of breast-feeding/weaning foods

- The RHU/HC should provide all medically approved, safe, effective and legally acceptable program methods. These specific services should include:

  - Pills, IUDs, NFP (in selected facilities by referral), LAM, Condoms and DMPA
  - Tubal Ligation and Vasectomy in selected facilities where there are trained personnel and in cases where there are no trained staff, referral must be in place
  - Relevant Laboratory Exams, e.g., Pap smear, wet smear, gram staining, pregnancy test and urinalysis
  - Management of complications and/or side effects that may arise as a result of family planning methods

- The RHU/HC should ensure availability of all program methods at all times. When necessary, the RHU/HC should refer clients to other facilities or clinics that provide FP services it cannot provide, such as IUD or sterilization.

- FP supplies should be sufficient (one month allowed stock level) and equipment should be in working order.

- RHU/HC staff should counsel clients about the effectiveness, risks, and benefits of the different contraceptive methods. Staff should provide information neutrally, without allowing their own biases to affect clients' choices.

The following conditions, equipment and supplies must be present in order for the facility to qualify as providing this service:

- ❍ Updated Target Client List (one month)
- ❍ FP Form 1
- ❍ Contraceptives/Supplies available:
  - Condoms
  - Oral contraceptives-combination and progesterone only
  - DMPA
  - IUDs
- ❍ Antiseptic solution (povidone iodine; cidex) and chlorine 75%
- ❍ Sterilized Equipment available
  - Forceps—alligator, pick-up, ovum, tenaculum, uterine
  - Forceps container
- ❍ Kelly pad/linen for examination table
- ❍ Examination table with linen or paper and changed between clients
- ❍ Examination table
- ❍ Light source (gooseneck lamp, flashlight)
- ❍ NFP charts for distribution (in selected facilities)
- ❍ Other leaflets/handouts on FP for distribution
- ❍ Referral Form for sterilization
- ❍ Patient counseling on information about all methods, effectiveness, risks, and benefits of various methods

- RHU/HC should be knowledgeable about the types of TB patients and the three (3) treatment regimens available. The RHU/HC should have equipment and supplies necessary for case finding and treatment of clients diagnosed with tuberculosis.
- The RHU/HC staff should allocate the medicines for the complete duration of therapy for TB patients started on treatment.
- All clients should be counseled on proper compliance and adherence to treatment. Health education should also include some expected drug interactions and what clients should do upon experiencing them.
- All clients should have sputum examinations on the scheduled time to be able to assess the individual patient's response to treatment. This is also the way to determine "cure" for TB patients.

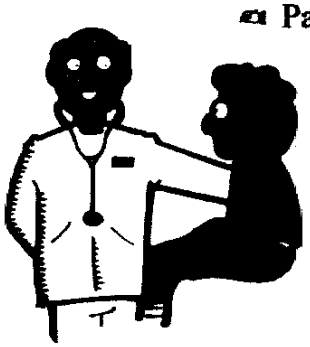
The following conditions, equipment and supplies must be present in order for the facility to qualify as providing this service:

- Updated Target Client List/National Tuberculosis Program (NTP) TB Register (at least within the week)
- Updated microscopy logbook/NTP Laboratory Register (within the week)
- In designated microscopy centers, the facility should have:
  - Microscope
  - Medical technologist or designated microscopist
  - Laboratory supplies: 1) AFB reagent, 2) sputum cups, and 3) glass slides
- For other health facilities (non-microscopy centers):
  - Sputum cups
  - Glass slides
  - Designated sputum collection and staining area
- Anti-TB Drugs:
  - Type I } good for at least 5 patients
  - Type II }
  - Ethambutol, in blister packs
  - Streptomycin Sulfate

- STD/AIDs prevention and control program services should be available in all STD service facilities.
- Whenever possible, acceptable, affordable and effective case management of STD patients will be made accessible to all individuals.
- Syndromic management will be applied when and where reliable laboratory diagnostic support is not consistently available.

The following conditions, equipment and supplies must be present in order for the facility to qualify as providing this service:

- Syndromic Management Chart posted
- STD patients managed according to the National STD Case Management Guidelines which include:
  - Correct and appropriate STD drugs prescribed or given to patients
  - Patient counseling to include:
    - Explanation of the diagnosis to the patient
    - Instructions on the importance of completing treatment
    - Encouraging the client to bring partner for evaluation and treatment
    - Provision of health education to prevent further transmission of STDs
  - Provision of adequate supply of condoms



- Monthly reporting using primary level reporting form accomplished and submitted to the next higher level
- Referral mechanism in place so that clients not responding to treatment at this level will be referred to a designated Social Hygiene Clinic, secondary care level or referral center where a laboratory is available to perform the basic laboratory tests required to diagnose most STDs as well as for HIV testing.

- The RHU/HC should practice strict personal and environmental hygiene to reduce disease transmission within the facility.
- Practices that should be followed within the facility include the following:
  - Hand-washing with soap and water before and after each client contact and use of comfort room
  - Examination table disinfected daily
- The RHU/HC should provide water testing/quality monitoring services
- The RHU/HC should have an updated list of water sources and food establishments within its catchment area.
- The RHU/HC should have available toilet bowls for distribution to households without toilets or at least toilet bowl molds.

The following conditions, equipment and supplies must be present in order for the facility to qualify as providing this service (some items have already been incorporated under basic infrastructure:

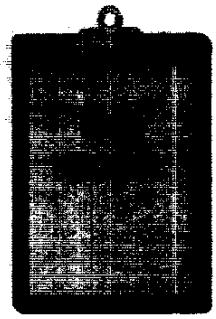
- Copy of Sanitation Code of the Philippines and Implementing Rules and Regulations
- Adequate chlorine granules for disinfection of water supply facilities
- Environmental Sanitation Kit containing tools for water and food facilities testing/monitoring
- Updated list of status of water supply and sanitation facilities within the area of coverage of the facility (one month)
- List of food establishments with sanitary permits and their updated sanitation conditions (one month)
- Information and education materials on environmental sanitation.
- Updated list of households with or without sanitary toilet facilities.
- Adequate supply of toilet bowls for distribution to households without toilets or at least toilet bowl molds.

- The RHU/HC should promote that all women of reproductive age should receive a pelvic exam and pap smear annually for three (3) years in a row. If all three are negative, clients need to go to the facility only every three years for a pap smear. For abnormal smears (Class II – IV) the client should be referred to higher levels for further management.

- The RHU/HC staff should counsel patients as to the risk factors for contracting cervical malignancy, not using condoms, frequent STDs, multiple partners, etc.

- The RHU/HC staff should be trained on and have the necessary equipment and supplies to perform a pap smear and collect the specimen for reading by a higher level facility (hospital).

The following conditions, equipment and supplies must be present in order for the facility to qualify as providing this service:



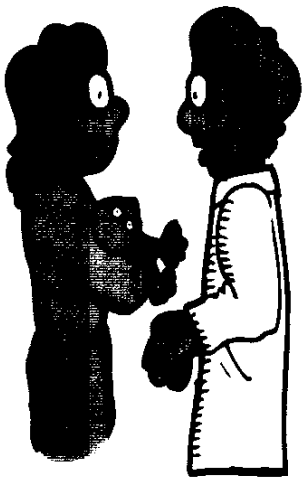
- ❍ **Updated Target Client List/log book of clients (at least within the week)**
- ❍ **Pap smear: for collection of specimen**
  - **Glass slides**
  - **Wooden spatula (Ayer's spatula) or cervical brush**
  - **Fixative (95% ethanol or others)**
  - **Pencil**
- ❍ **Referral facility for pap smear reading**
- ❍ **Referral forms**
- ❍ **Individual patient record of Pap Smear Results**
- ❍ IEC materials on Cervical Cancer (leaflets, posters) and self-breast examination (SBE)

Maternal Care

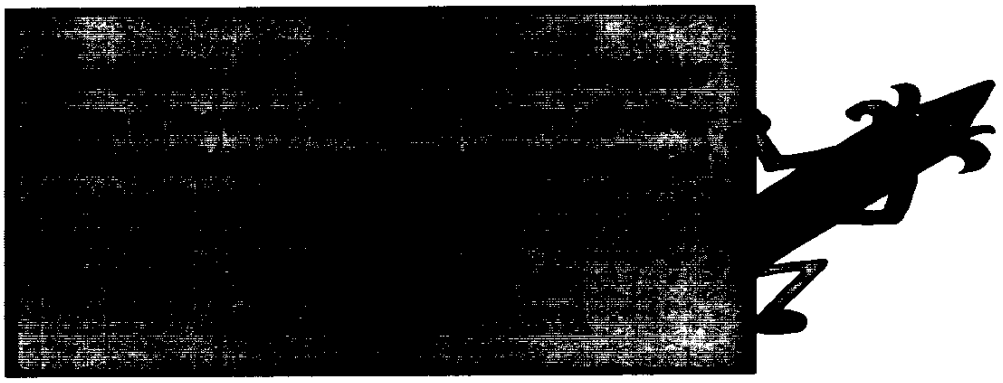
The RHU/HC should provide a whole range of maternal care services to include providing tetanus immunization to clients/mothers, pre-natal, natal (delivery) and post-partum care.

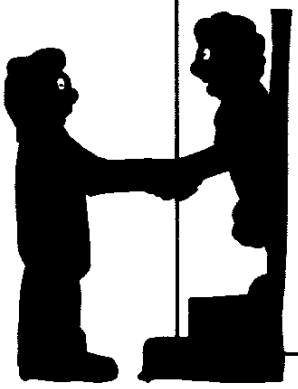
The following conditions, equipment and supplies must be present in order for the facility to qualify as providing this service:

- ❍ Updated Target Client List/book (at least within the week)
- ❍ TT vaccines and syringes & needles
- ❍ Records of pre-natal/natal/post-natal visits conducted
- ❍ Records of home visits made by RHU/HC staff/CHVW
- ❍ Available forms for
  - birth certificates
  - death/fetal birth certificates
  - other pertinent records
- ❍ Home Based Maternal Records (HBMR) for distribution to new clients
- ❍ IEC materials
- ❍ OB Emergency Manual & Algorithim



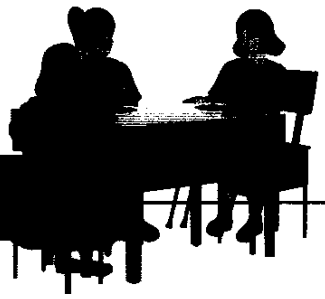
3. Attitude & Behavior of Health Workers





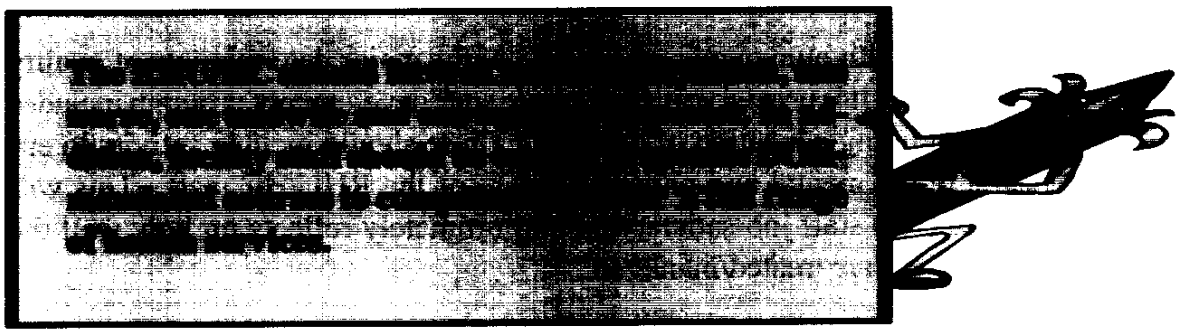
- Maintaining 2 way communication
- Being a good listener
- Being non-judgmental
- Not giving false reassurances
- Giving appropriate instructions to patients by explaining prescriptions clearly, explaining laboratory results correctly and facilitating follow-up of clients

- Being courteous and always explain any procedure
- Ask permission before proceeding
- Avoid gender slurs/insults and discriminating words against women
- Being careful in examining women patients. This is especially true when examining women during obstetrical and gynecological examinations and as survivors of abuse/violence
- Not blaming victim/survivor of abuse/violence



- Respecting patient's decision without compromising overall patient management
- Assuring patient's privacy and confidentiality of given information at all times
- Promptly responding to patient's request for care
- Speaking politely and with modulated tone

- Respecting patients' culture and religion
- Providing for patients needs that are influenced by culture and religion
- Offering choices/options to patients



The RHU/HC staff should be trained in specific DOH mandated courses to include:

1. Basic EPI Skills Training
2. Disease Surveillance Training
3. Pneumonia Case Management
4. ARI Case Management
5. CDD Case Management
6. Community-Based Planning and Management of Nutrition Program (CBPM-NP)
7. Basic Family Planning Course (or Level I)
8. Comprehensive Family Planning (or Level II)
9. DMPA Training (if untrained in either Level I or Level II)
10. Training on National Tuberculosis Control Program - DOTS
11. Training on Microscopy
12. Training on Basic Counseling for STD/AIDS
13. Syndromic Management of STD/AIDS
14. Training on Environmental Health Programs and Regulations
15. Skills Training on Pap Smear Collection (for those untrained in FP Basic/Compre Course)
16. Gender Sensitivity Training
17. Training on Counseling Skills on Violence Against Women

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- The health human resource is one of the major determinants of quality service. It is crucial that appropriate staff development program includes continuing education of the staff. These should include activity to ensure the mental and physical fitness of the RHU/HC staff. This will result to staff job satisfaction and ultimately reflects on how well the patients are treated/managed.

- Continuing education and updates for RHU staff should be implemented for appropriate/rational use of technology on diagnostic and treatment modalities.

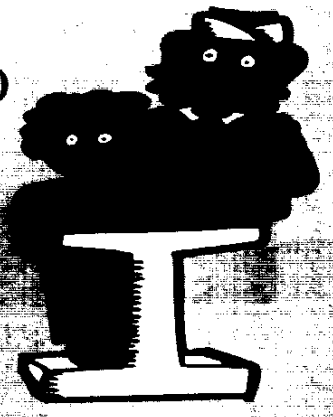
- There should be regular "competency-based" assessments of staff to determine their technical proficiencies in performing their duties and responsibilities.

- Facility staff should spend a minimum of 10 minutes with each client in history-taking (new clients), examination, treatment and health education. Clients can be seen by midwives, nurses, doctors, or any combination of staff depending on their complaint. Every client does not have to be seen by a doctor.

- Supervisors should also ensure that they regularly assess job satisfaction either through surveys,interviews, or focused group discussions.

[redacted]

- Stethoscope
- Weighing scales-adult and infant (beam or Ming scale)
- Sphygmomanometer with adult and pediatric cuff
- Vaccine Carrier with ice packs
- Sterilizer or covered pan and plate
- Inventory of equipment and supplies
- Examination table with [illegible] paper
- Bench or stool for examination table
- Kelly pad/clean towel/plastic lining
- Light source for examination like goose neck lamp with bulb and flashlight with batteries
- Speculums-large and small



6. Drugs, Medicines & Supplies

The RHU/HC should have the essential drugs, medicines and supplies in order to provide good services.

The RHU/HC should have the following eight essential drugs:

1. Cotrimoxazole
2. Amoxicillin
3. INH
4. Rifampicin
5. Pyrazinamide
5. Paracetamol
7. ORS
8. Nifedipine

Available basic supplies for examination, emergency medical and simple surgical cases:

- alcohol/disinfectant
- cotton
- disposable gloves
- lubricant (KY Jelly) or clean water
- disposable needles
- disposable syringes
- sutures
- slides and coverslips
- gauze/bandages/plaster or adhesive tape
- sharps containers

The RHU/HC should have the following:

- weighing scales - adult and infant (beam or Ming scale)
- disposable gloves in examination room
- speculums - large and small
- lubricant (KY Jelly) or clean water
- microscope (if microscopy center)
- sterilizer or covered pan and stove
- inventory of equipment & supply
- refrigerator
- disposable needles and syringes

Adequate supply of disinfectants, antiseptics and or insecticides to include cleaning supplies for the facility and for clinical instruments.

Available storage for drugs.

Drugs/medicines are kept off the floor and away from the walls. They should be protected from rodents, insects and environmental elements (sunlight, heat, humidity, floods, moisture, etc.) and kept in a safe place to ensure no pilferages.

Complete and updated inventory of stock cards and supply records.

Updated (within 6 months) and complete inventory of equipment.

7. Health Information System

1. A functioning two-way referral system with procedures for on-referral/back referral of clients/patients and the necessary referral forms.

2. Updated RHU/HC statistical record/board/displays.

3. Completed/updated (within one week) Field Health Information Systems (FHSIS) forms and target client lists (TCLs).

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8. Community Intervention

The RHU/HC should have active community health volunteer workers (CHVWs).

CHVWs are essential partners in delivering basic health services at the community level. There should be programs and activities to encourage their participation.

The CHVWs should refer patients and then follow-up to higher levels of health care delivery system e.g., barangay health stations, other health units and hospitals.

The RHU/HC, in coordination with organized patient groups/community organization and NGO's should, whenever needed, organize outreach services to communities being served especially on areas otherwise inaccessible to health workers or regular health services.

RHU/HC staff and CHVWs should encourage and support community participation and partnership for health interventions like Barangay Assemblies, Dengue Linis Brigade, Patients Classes, Breastfeeding Support Groups, etc.

MSH

Sentrong Sigla Movement
is a project of the Department of Health in partnership with
Local Government Units with technical assistance from Management Sciences
for Health (MSH) and funding support from the United States Agency for International Development (USAID Contract No.: AID492-0480-c-00-5093-00).

FACILITY SELF-ASSESSMENT CHECKLIST (FSAC)
FOR RURAL HEALTH UNITS (RHUs)/HEALTH CENTERS (HCs)
GUIDE FOR IMPROVING QUALITY OF HEALTH SERVICES
Level 1

Introduction

This Facility Self-Assessment Checklist (FSAC) is a self-evaluation guide for the RHU/HC staff towards improving quality of health services being provided at the RHU/HC. The checklist contains a list of questions derived from the *Quality Standards List (QSL) for RHUs/HCs Level I* that are recommended by the Department of Health for *Sentrong Sigla* certification. The use of this checklist together with the QSL will help the RHU/HC staff do the following:

- Assess the RHU/HC's compliance to Sentrong Sigla Level I quality standards,
- Identify and recognize problems or areas of improvement in service delivery,
- Identify ways or opportunities to solve problems or improve services, and eventually
- Get certification for the RHU/HC as Sentrong Sigla

Instructions in Using the FSAC

For each question, encircle or mark either **YES**, **X** (for Yes, but needs improvement) or **NO** depending on the situation in your facility at the time of your assessment. A column for **REMARKS** is provided for any notes or details that you might need to pay attention to in improving the situation. Be as self-critical and honest as possible in your responses.

Example:

Questions	Yes	Yes, but needs improvement	No	Remarks
1. Is there a CDD Case Management Chart posted in the RHU/HC?	(YES)	X	NO	
2. Does our RHU/HC have a storage space or room for supplies, drugs and medicines?	YES	(X)	NO	Storage needs proper ventilation and new padlock
3. Does the RHU/HC have an updated Target Client List?	YES	X	(NO)	Get help from BHWs to update the list

For question #1, the respondent is very sure that a CDD Management Chart is posted properly and conspicuously at the ORT Corner of the RHU/HC.

For question #2, the respondent believes that although the RHU/HC has a storeroom for supplies, drugs and medicines, there is a need to organize, improve ventilation and secure the storeroom.

For question #3, the respondent admits that the TCL for family planning does not contain all the names of MWRA in the RHU/HC's catchments areas and therefore needs to improve this aspect of identifying target clients or beneficiaries.

Each **NO** or **X** answer represents an opportunity for health service improvement. Remember, the more opportunities for improvement you find, the more you will be able to enhance quality of your services. Use your creativity to think of remedies or solutions to problems in the delivery of high quality services. This is your facility's initial step to Sentrong Sigla certification.

Instructions in Using the Results of the Self-Assessment

Once you have completed the self-assessment, meet as a health team to review and discuss all the responses. Consider taking the following steps:

1. Agree on the areas to be improved using the following criteria:

   a. Does everyone agree that the problem(s) needs to be solved?
   b. Can the problem be solved with available resources? Are there possible resources that could be tapped?
   c. How long does it take to address the problem?
   d. Do team members agree to accept responsibility for specific activities required to solve the problem(s)?

2. Plan specific activities to improve the situation or condition and then set a date for completing the activities.

3. Implement improvements and keep all team members involved.

4. Make a written request to the DOH Center for Health Development for Sentrong Sigla assessment after improvements have been made

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FACILITY SELF-ASSESSMENT CHECKLIST FOR RHUs/HEALTH CENTERS

*The following are the **inclusion criteria** in Level I Sentrong Sigla Certification. <u>All criteria should be met</u> by your facility before requesting the DOH Center for Health Development for an assessment for certification.*				
Does our RHU/HC have the following?				
1. Regular source of clean water	YES	X	NO	
2. Functioning comfort room or latrine for client use	YES	X	NO	
3. Blood pressure apparatus with cuff	YES	X	NO	
4. Stethoscope	YES	X	NO	
5. Thermometer	YES	X	NO	
6. Weighing scale for infants and adults (not bathroom scale)	YES	X	NO	

1. INFRASTRUCTURE/AMENITIES

1.1 Is our RHU/HC free from rubbish?	YES	X	NO	
1.2 Does our RHU/HC have benches or chairs for patients in all waiting and service provision areas?	YES	X	NO	
1.3.Does our RHU/HC have electric power available at all times through whatever source (*power lines or generator*)?	YES	X	NO	
1.4 Does our RHU/HC have lighting that permits easy reading of forms?	YES	X	NO	
1.5. Does our RHU /HC have good ventilation windows, electric fans or air conditioners?	YES	X	NO	
1.6. Does our RHU/HC have a gooseneck lamp and flashlight for examination?	YES	X	NO	
1.7. Does our RHU/HC have a hand washing area with covered water supply, soap and towels?	YES	X	NO	
1.8. Does our RHU/HC have covered water supply for comfort rooms or latrines?	YES	X	NO	
1.9. Do our comfort rooms have handrails for the disabled?	YES	X	NO	
1.10. Does our RHU/HC have covered garbage containers for waste segregation?	YES	X	NO	
1.11. Does our RHU/HC have a separate puncture-proof container for sharps (*needles, blades and other sharp objects*)?	YES	X	NO	
1.12. Does our RHU/HC have an examination table with clean linen/paper?	YES	X	NO	
1.13. Is there a bench or stool for our examination table?	YES	X	NO	
1.14. Does our treatment or examination area have auditory privacy?	YES	X	NO	
1.15. Does our treatment or examination area have visual privacy?	YES	X	NO	
1.16. Does our RHU/HC have a storage space or room for supplies, drugs and medicines?	YES	X	NO	
1.17. Does our RHU/HC have cleaning or sterilizing supplies for clinical instruments?	YES	X	NO	

1.18. Are our clinic hours, services and whereabouts of staff posted in a strategic area visible to all clients and service providers?	YES	X	NO	
1.19. Are clients seen by our staff within 30 minutes of registration?	YES	X	NO	
1.20. Does our RHU/HC have a special schedule at least once per month for clients who may not be available during regular office or work hours?	YES	X	NO	
1.21. Does our RHU/HC conduct regular outreach services in hard-to-reach areas?	YES	X	NO	

2. HEALTH SERVICES

2.1. IMMUNIZATION				
2.1.1. Does our RHU/HC conduct immunization sessions at least once per week?	YES	X	NO	
2.1.2. Does our RHU/HC serve clients who request immunization on other days?	YES	X	NO	
2.1.3. Are disposable syringes and needles used only once?	YES	X	NO	
2.1.4. Are used disposable syringes and needles collected in a puncture-proof container, then burned and buried?	YES	X	NO	
2.1.5. Does our RHU/HC have the latest version of the EPI Manual?	YES	X	NO	
2.1.6. Is our Target Client List or Master List updated weekly?	YES	X	NO	
2.1.7. Does our RHU/HC have at least one month supply (based on average monthly consumption) of the following vaccines at anytime?				
a. BCG	YES	X	NO	
b. OPV	YES	X	NO	
c. DPT	YES	X	NO	
d. Measles	YES	X	NO	
e. Hepatitis B	YES	X	NO	
f. Tetanus Toxoid	YES	X	NO	
2.1.8. Does our RHU/HC have a refrigerator exclusively for vaccines?	YES	X	NO	
2.1.9. Does our vaccine refrigerator have a voltage regulator?	YES	X	NO	
2.1.10. Does our vaccine refrigerator have a vaccine thermometer?	YES	X	NO	
2.1.11. Does the thermometer indicate a temperature between 2-8°C?	YES	X	NO	
2.1.12. Is there a daily temperature-monitoring chart that is posted and updated (am/pm)?	YES	X	NO	
2.1.13. Does the chart indicate that the temperature has been maintained between 2-8 degrees?	YES	X	NO	
2.1.14. Does our RHU/HC have a written contingency plan for "power failure"?	YES	X	NO	
2.1.15. Did our RHU/HC have a power failure for at least 3 hours or temperature in the vaccine refrigerator that rose above 8 degrees?	YES	X	NO	

2.1.16. If YES, was our cold chain maintained during the power failure or when the temperature in the vaccine refrigerator rose above 8 degrees? **(SKIP this question if not applicable)**	YES	X	NO	
2.1.17. Does our RHU/HC have vaccine carriers with ice cold packs?	YES	X	NO	
2.2. DISEASE SURVEILLANCE				
2.2.1. Are DOH case definitions available in our RHU/HC?	YES	X	NO	
2.2.2. Does our RHU/HC submit a Notifiable Disease Report weekly to MHO/CHO/PHO?	YES	X	NO	
2.2.3. Does our RHU/HC conduct an investigation of every single case of acute flaccid paralysis (AFP) cases, neonatal deaths and measles outbreaks?	YES	X	NO	
2.2.4. Does our RHU/HC report all AFP and neonatal tetanus cases to the regional office (surveillance unit) within a week of identification of cases?	YES	X	NO	
2.2.5. Does our RHU/HC follow-up each reported AFP case after 60 days?	YES	X	NO	
2.3. CONTROL OF ACUTE RESPIRATORY INFECTIONS				
2.3.1. Is there an ARI Case Management Chart posted in our RHU/HC?	YES	X	NO	
2.3.2. Does our RHU/HC have tongue depressors?	YES	X	NO	
2.3.3. Does our RHU/HC have a timer or watch with second hand?	YES	X	NO	
2.3.4. Does our RHU/HC have at least:				
a. 100 cotrimoxazole adult tablets?	YES	X	NO	
b. 100 paracetamol (500 mg.) tablets?	YES	X	NO	
2.4. CONTROL OF DIARRHEAL DISEASES				
2.4.1. Is there a CDD Case Management Chart posted in our RHU/HC?	YES	X	NO	
2.4.2. Does our RHU/HC have an ORT Corner equipped with benches, tables, glasses, pitcher, spoon, calibrated container for measuring potable water and ORS?	YES	X	NO	
2.4.3. Does our RHU/HC have ORS sachets?	YES	X	NO	
2.4.4. Does our RHU/HC have a record of water quality test that was done in the past month?	YES	X	NO	
2.5. MICRONUTRIENTS SUPPLEMENTATION				
2.5.1. Does our RHU/HC have the following micronutrients?				
a. Iron tablets for all pregnant and lactating women	YES	X	NO	
b. Iron drops for infants	YES	X	NO	
c. Iron syrup for school children	YES	X	NO	
d. Iodized oil capsules	YES	X	NO	
e. Iodized salt	YES	X	NO	
f. Vitamin A capsules	YES	X	NO	
2.5.2. Does our RHU/HC have a copy of the Guidelines for Micronutrient Supplementation?	YES	X	NO	
2.5.3. Is our Operation Timbang (OPT) Record updated monthly or quarterly depending on the nutritional status of the child?	YES	X	NO	

2.5.4. Is our Target Client List updated at least within the week?	YES	X	NO	
2.5.5. Does our RHU/HC have Under 5 growth cards/Growth Monitoring Charts (GMC)?	YES	X	NO	
2.5.6. Does our RHU/HC have the CBPM-NP RHM Guidebook?	YES	X	NO	
2.5.7. Does our RHU/HC have available copies of the Basic Three Food Groups brochure for distribution?	YES	X	NO	
2.5.8. Does our RHU/HC have a Salt Iodization Testing Kit?	YES	X	NO	
2.6. FAMILY PLANNING				
2.6.1. Does our RHU/HC offer the following laboratory exams?				
a. Pap smear	YES	X	NO	
b. Wet smear	YES	X	NO	
c. Gram Staining	YES	X	NO	
d. Pregnancy test	YES	X	NO	
e. Urinalysis	YES	X	NO	
2.6.2. Does our RHU/HC provide the service for management of complications and/or side effects that may arise as a result of the use of a family planning method?	YES	X	NO	
2.6.3. Is our Target Client List updated monthly?	YES	X	NO	
2.6.4. Does our RHU/HC have copies of FP Form1?	YES	X	NO	
2.6.5. Does our RHU/HC have at least one month supply of the following contraceptives?	YES	X	NO	
a. Condoms	YES	X	NO	
b. Pills	YES	X	NO	
c. DMPA	YES	X	NO	
d. IUDs	YES	X	NO	
2.6.6. Does our RHU/HC have antiseptic solution (povidone iodine; cidex) or chlorine 75%?	YES	X	NO	
2.6.7. Does our RHU/HC have the following sterilized forceps?				
a. alligator forceps	YES	X	NO	
b. pick-up forceps	YES	X	NO	
c. ovum forceps	YES	X	NO	
d. tenaculum	YES	X	NO	
e. uterine forceps	YES	X	NO	
2.6.8. Does our RHU/HC have a forceps container?	YES	X	NO	
2.6.9. Does our RHU/HC have NFP charts for distribution?	YES	X	NO	
2.6.10. Does our RHU/HC have other FP leaflets/handouts for distribution?	YES	X	NO	
2.7. TUBERCULOSIS CONTROL				
2.7.1. Is our Target Client List/TB Register updated weekly?	YES	X	NO	
2.7.2. Is our Microscopy logbook/NTP Laboratory Register updated weekly?	YES	X	NO	
2.7.3. (*For designated microscopy centers*) Does our RHU/HC have a medical technologist or a designated microscopist?	YES	X	NO	

2.7.4. (*For designated microscopy centers*) Does our RHU/HC have a microscope?	YES	X	NO	
2.7.5. (*For designated microscopy centers*) Does our facility have AFB reagent?	YES	X	NO	
2.7.6. Does our RHU/HC have available sputum cups?	YES	X	NO	
2.7.7. Does our RHU/HC have glass slides?	YES	X	NO	
2.7.8. Does our RHU/HC have a designated sputum collection and staining area?	YES	X	NO	
2.7.9. Does our RHU/HC have the following anti-TB drugs:				
a. Type I (good for at least 5 patients)	YES	X	NO	
b. Type II (good for at least 5 patients)	YES	X	NO	
c. Ethambutol	YES	X	NO	
d. Streptomycin sulfate	YES	X	NO	
2.8. STD/AIDS PREVENTION and CONTROL				
2.8.1. Is there a Syndromic Management Chart posted in our RHU/HC?	YES	X	NO	
2.8.2. Does our RHU/HC have the National STD Case Management Guidelines?	YES	X	NO	
2.8.3. Does our RHU have condoms for distribution to clients?	YES	X	NO	
2.8.4. Does our RHU/HC accomplish and submit a monthly report using primary level reporting form to the next higher level?	YES	X	NO	
2.9. ENVIRONMENTAL SANITATION				
2.9.1. Is our list of status of water supply and sanitation facilities within our area of coverage updated monthly?	YES	X	NO	
2.9.2. Is our list of food establishments with sanitary permits and their sanitation conditions updated monthly?	YES	X	NO	
2.9.3. Does our RHU/HC have a copy of the Sanitation Code of the Philippines and Implementing Rules and Regulations?	YES	X	NO	
2.9.4. Does our RHU/HC have chlorine granules for disinfecting water supply facilities?	YES	X	NO	
2.9.5. Does our RHU/HC have an Environmental Sanitation Kit containing tools for water and food testing/monitoring?	YES	X	NO	
2.9.6. Does our RHU/HC have toilet bowls for distribution to households without toilets?	YES	X	NO	
2.9.7. (*For a facility that does not have toilet bowls for distribution*) Does our RHU/HC have toilet bowl molds?	YES	X	NO	
2.9.8. Does our RHU/HC have a list of households with/without sanitary toilets that has been completed within the last six months?	YES	X	NO	
2.9.9. Does our RHU/HC have information and education materials on environmental sanitation (i.e., dengue fever, proper waste disposal, etc.)?	YES	X	NO	
2.10. CANCER CONTROL – CERVICAL CANCER SCREENING				
2.10.1. Does our RHU/HC have the following supplies for pap smear specimen collection?				
a. Glass slides	YES	X	NO	

b. Wooden spatula (A217 spatula) or cervical brush	YES	X	NO	
c. Fixative (95% ethanol or others)	YES	X	NO	
d. Pencil	YES	X	NO	
2.10.2. Is our Target Client List/logbook of clients updated weekly?	YES	X	NO	
2.10.3. Does our RHU/HC have a referral facility where pap smear specimen collected are sent for reading and interpretation?	YES	X	NO	
2.10.4. Does our RHU/HC keep individual patient records of Pap Smear Results?	YES	X	NO	
2.10.5. Does our RHU/HC have IEC materials on cervical cancer (leaflets, posters) and self-breast examination (SBE)?	YES	X	NO	
2.11. MATERNAL CARE				
2.11.1. Is our Target Client List/book updated at least within the week?	YES	X	NO	
2.11.2. Does our RHU/HC have a record of pre-natal/natal/post-natal visits conducted by staff?	YES	X	NO	
2.11.3. Does our facility have the following forms?				
a. birth certificate	YES	X	NO	
b. death/fetal birth certificates	YES	X	NO	
c. other pertinent records	YES	X	NO	
2.11.4. Does our RHU/HC have Home Based Maternal Records (HBMR) for distribution to new clients?	YES	X	NO	
2.11.5. Does our RHU/HC have IEC materials for maternal care?	YES	X	NO	
2.11.6. Does our RHU/HC have an OB Emergency Manual & Algorithm chart?	YES	X	NO	

3. ATTITUDE AND BEHAVIOR OF HEALTH WORKERS

3.1. Do our RHU/HC staff greet patient verbally to establish rapport?	YES	X	NO	
3.2. Do our RHU/HC staff exhibit technical competence in articulating information to patients by				
a. Maintaining 2-way communication?	YES	X	NO	
b. Being a good listener?	YES	X	NO	
c. Being non-judgmental?	YES	X	NO	
d. Giving appropriate instruction?	YES	X	NO	
e. Not giving false assurances?	YES	X	NO	
3.3. Are our RHU/HC staff women-friendly by:				
a. Being courteous and always explaining any procedure?	YES	X	NO	
b. Asking permission before proceeding?	YES	X	NO	
c. Avoiding gender slurs/insults and discriminating words?	YES	X	NO	
d. being careful in examining women and not blaming victims/survivor of abuse/violence?	YES	X	NO	

3.4. Are our RHU/HC staff caring and gender-sensitive by:				
a. Respecting patient's decision without compromising overall patient management?	YES	X	NO	
b. Assuring patient's privacy and confidentiality of given information at all times?	YES	X	NO	
c. Promptly responding to patient's request for care?	YES	X	NO	
d. Speaking politely and with modulated tone?	YES	X	NO	
3.5. Are our RHU/HC staff culture-sensitive by:				
a. Respecting patient's culture and religion?	YES	X	NO	
b. Providing for patient's needs accordingly?	YES	X	NO	
c. Offering choices and options?	YES	X	NO	
3.6. Do our RHU/HC staff provide information to clients without allowing personal biases to affect client choices?	YES	X	NO	

4. HEALTH HUMAN RESOURCES

4.1. Does our RHU/HC have at least one physician, one nurse, one midwife and one sanitary inspector?	YES	X	NO	
4.2. Does our RHU/HC have at least one staff trained on the following DOH mandated courses?				
a. Basic EPI Skills Training	YES	X	NO	
b. Disease Surveillance Training	YES	X	NO	
c. Pneumonia Case Management	YES	X	NO	
d. ARI Case Management	YES	X	NO	
e. CDD Case Management	YES	X	NO	
f. Community-Based Planning and Management of Nutrition Program (CBPM-NP)	YES	X	NO	
g. Basic Family Planning Course (or Level I)	YES	X	NO	
h. Comprehensive Family Planning (or Level II)	YES	X	NO	
i. DMPA Training (if untrained in either Level I or Level II)	YES	X	NO	
j. Training on National Tuberculosis Control Program – DOTS	YES	X	NO	
k. Training on Microscopy	YES	X	NO	
l. Training on Basic Counseling for STD/AIDS	YES	X	NO	
m. Syndromic Management of STD/AIDS	YES	X	NO	
n. Training on Environmental Health Programs and Regulations	YES	X	NO	
o. Skills Training on Pap Smear Collection (for those untrained in FP Basic/Compre Course)	YES	X	NO	
p. Gender Sensitivity Training	YES	X	NO	
q. Training on Counseling Skills on Violence Against Women	YES	X	NO	
4.3. Did our RHU/HC conduct an individual performance evaluation of our staff last January (for July-December performance) or last July (for January-June performance)?	YES	X	NO	

5. EQUIPMENT (non-program specific)

5.1. Does our RHU/HC have a sterilizer or covered pan and stove?	YES	X	NO	
5.2. Does our RHU/HC have large speculums?	YES	X	NO	
5.3. Does our RHU/HC have small speculums?	YES	X	NO	
5.4. Did our RHU/HC conduct a complete inventory of equipment within the last 6 months?	YES	X	NO	

6. DRUGS, MEDICINES and SUPPLIES

6.1. Does our RHU/HC have at least a one-month supply of the following essential drugs? (*Three have already been incorporated under CARI and CDD*)				
a. Amoxicillin	YES	X	NO	
b. INH	YES	X	NO	
c. Rifampicin	YES	X	NO	
d. Pyrazinamide	YES	X	NO	
e. Nifedipine	YES	X	NO	
62. Does our RHU/HC have the following basic supplies for examination, emergency medical and simple surgical cases?				
a. Alcohol/disinfectant	YES	X	NO	
b. Cotton	YES	X	NO	
c. Disposable gloves	YES	X	NO	
d. Lubricant (KY Jelly) or clean water	YES	X	NO	
e. Disposable needles	YES	X	NO	
f. Disposable syringes	YES	X	NO	
g. Sutures	YES	X	NO	
h. Slides and coverslips	YES	X	NO	
I. Gauze/bandages/plaster or adhesive tape	YES	X	NO	
6.3. Does our RHU/HC have disinfectants, antiseptics and/or insecticides?	YES	X	NO	
6.4. Did our RHU/HC conduct a complete inventory of supplies within the last 6 months?	YES	X	NO	

7. HEALTH INFORMATION SYSTEM

7.1. Does our RHU/HC have referral slips or forms?	YES	X	NO	
7.2. Are our 10 Leading Causes of Mortality and Morbidity and other vital health statistics updated annually?	YES	X	NO	
7.3. Are our Field Health Information System (FHSIS) forms complete and updated within one week?	YES	X	NO	
7.4. Did our BHWs follow-up patients referred to the Main RHU in the last three (3) months?	YES	X	NO	

8. COMMUNITY INTERVENTION

8.1. Is the BHW: households ratio equal to 1:20?	YES	X	NO
8.2. Did our RHU/HC conduct the monthly meeting of BHWs in the past month?	YES	X	NO
8.3. Did our RHU/HC staff and BHWs organize or attend barangay assemblies, patients classes, mothers classes, breastfeeding support groups, breastfeeding support groups or the like in the last 3 months?	YES	X	NO

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