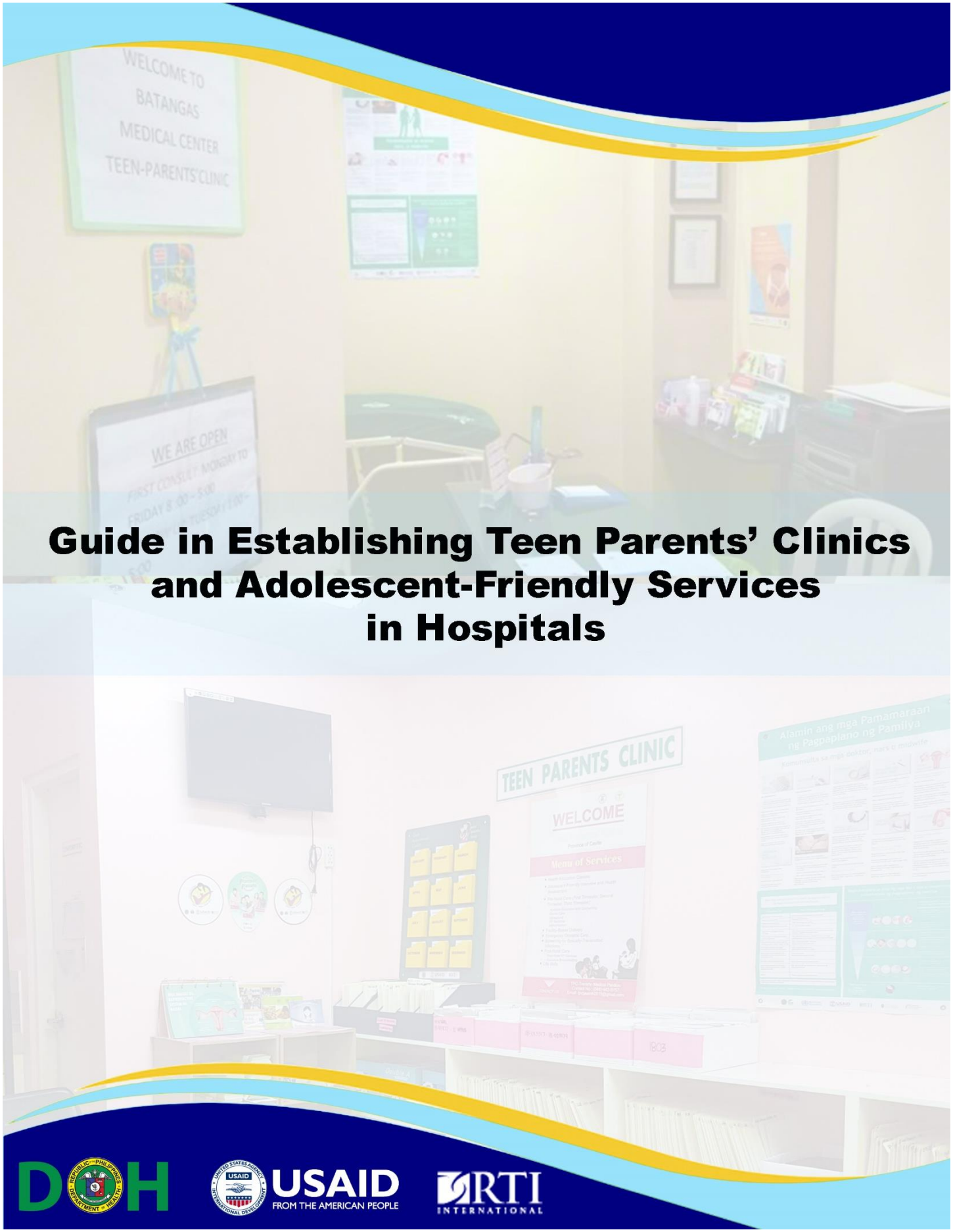

Guide in Establishing Teen Parents' Clinics and Adolescent-Friendly Services in Hospitals

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Sincere gratitude is extended to the following people who contributed to the completion of this Guide:

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TPC Management Team

Acronyms and Abbreviations

AHDP	Adolescent Health and Development Program
AJA	Adolescent Job Aid
ANC	Antenatal Care
AOG	Age of Gestation
BEmONC	Basic Emergency Obstetric and Newborn Care
BMI	Body Mass Index
BTL	Bilateral Tubal Ligation
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
DOH	Department of Health
DSWD	Department of Social Welfare and Development
EBF	Exclusive Breastfeeding
EDC	Expected Date of Confinement
EDD	Expected Date of Delivery
FP	Family Planning
FPCBT	Family Planning Competency-Based Training
GAD	Gender and Development
HACT	HIV/AIDS Core Team
HEADSS	Home, Education/Employment, Eating, Activity, Drugs, Sexuality, Safety and Suicide
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HSP	Health Service Provider
HTSP	Healthy Timing and Spacing of Pregnancy
IEC	Information, Education, Communication
ITR	Individual Treatment Record
IUD	Intrauterine Device
LMP	Last Menstrual Period
Ob-Gyn	Obstetrician-Gynecologist
OPD	Outpatient Department
PHIC	Philippine Health Insurance Corporation
PNP	Philippine National Police
PPIUD	Postpartum Intrauterine Device
PSI	Progestin Sub-dermal Implant
RHU	Rural Health Unit
SDN	Service Delivery Network
STI	Sexually Transmitted Infection
THK	Teen Health Kiosk
TPC	Teen Parents' Clinic
VAW	Violence Against Women
WCPU	Women and Children Protection Unit
WHO	World Health Organization

About This Guide

This guide is designed as a reference material in establishing a Teen Parents' Clinic (TPC) in hospitals which have the capability to provide Comprehensive Emergency Obstetric and Newborn Care. In the context of the Service Delivery Network, the TPC is considered as a referral facility for pregnant, postpartum or post-abortion adolescents aged 19 and below.

This document provides guidance for all hospital personnel in dealing with adolescent clients as a whole. It serves as a resource for hospital management in formulating enabling policies and guidelines and in setting up adolescent-friendly services in the hospital in general and the TPC in particular. It also provides guidance in the formulation of strategic directions and operational strategies to ensure an integrated and holistic continuum of care for pregnant, postpartum and post-abortion adolescents.

This guide contains procedures, protocols, and guidelines for the delivery of comprehensive services to pregnant, postpartum/post-abortion adolescents covering antenatal care, information and counseling on breastfeeding and family planning, facility-based delivery, postpartum/post-abortion care, and postnatal care, among others.

The manual mainly draws from the experiences of the General Emilio Aguinaldo Memorial Hospital in Trece Martires City, Cavite and the Batangas Medical Center in Batangas City in setting up and operationalizing the TPCs with technical assistance from the LuzonHealth Project.

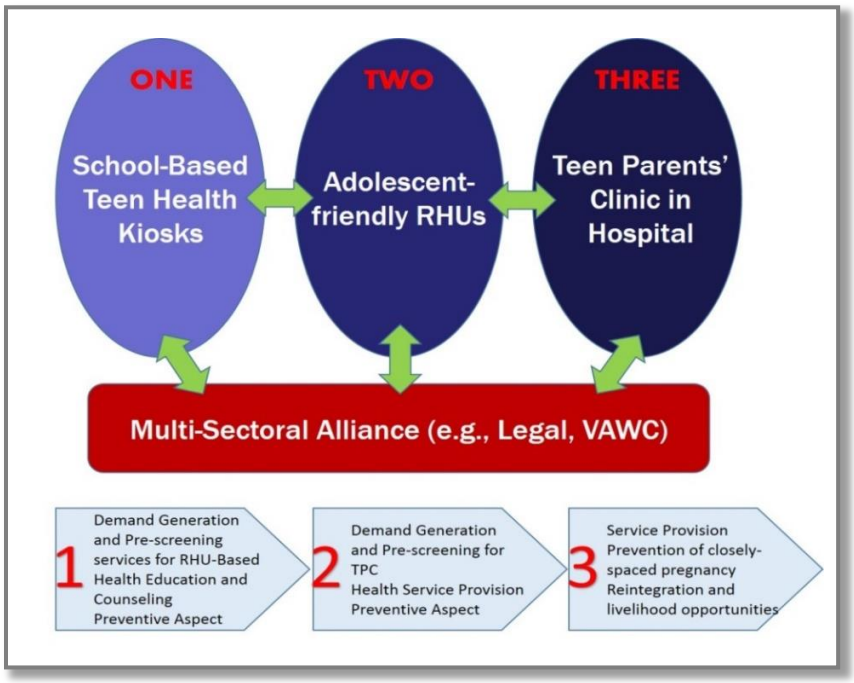
I. Introduction

Teen pregnancy is a national concern. Based on the 2013 National Demographic and Health Survey, the Philippines' age-specific fertility rate for adolescent women 15-19 years old has reached 57 live births per 1,000 women, up from the 54 reported in 2008. The rate went down to 47 in 2017, but this is still a worrying figure. Nine percent of Filipino women in this age group have begun childbearing—7% are already mothers while another 2% are pregnant with their first child. The likelihood of maternal death among them is twice that among women over 20 years (DOH, UNFPA, WHO, 2002), and they face increased risks of dropping out of school and facing limited economic opportunity.

Adolescent mothers often lack the knowledge, education, experience, income, and access to reproductive health services. In the Philippines, moreover, the teenage mother also has to bear the effects of judgment and stigma, making their already difficult situation even worse.

In 2013, the Department of Health (DOH) issued Administrative Order No. 2013-0013 or the National Policy and Strategic Framework on Adolescent Health and Development (*Annex 1*). The administrative order provides, among others, for: (i) increasing access to quality and adolescent-friendly health care services and information for adolescents, including access to quality hospitals and health care facilities, following prescribed national standards (*Annex 2*); (ii) expanding health insurance for adolescents; and (iii) enhancing skills of service providers, families, and adolescents to protect their health and development.

Cognizant of this, selected provincial and city government partners in Luzon have taken greater efforts to implement their local Adolescent Health and Development Program (AHDP), with technical assistance from the Integrated Maternal, Neonatal, Child Health and Nutrition/Family Planning Regional Project in Luzon (LuzonHealth) of the United States Agency for International Development.



Framework of the Three-Pronged Approach to the Local Adolescent Health and Development Program

The needs of adolescents, especially those who have begun early childbearing, are now addressed within the ambit of a Service Delivery Network (SDN). Provincial/City Health Offices are adopting a three-pronged approach involving schools, the Rural Health Units (RHU)/City Health Offices, and district or DOH-retained hospitals, among others, to achieve three desired states, namely:

1. Prevention of early initiation to sex among adolescents.

2. Early and timely referral of adolescents currently pregnant to a health facility for antenatal care, skilled birth attendance, Comprehensive Emergency Obstetric and Neonatal Care (CEmONC), facility-based delivery, and education and counseling on excusive breastfeeding (EBF).

3. Prevention of shorter birth interval or closely spaced repeat pregnancy among young mothers through family planning (FP) information, counseling and services.

The Teen Parents' Clinic (TPC) in hospital was conceptualized as part of the three-pronged approach. It is aimed specifically at providing tertiary level obstetric and maternal care to pregnant adolescents, since such pregnancies are considered high-risk and should be under the care of a tertiary level health facility from the beginning of pregnancy, during childbirth, and immediately after childbirth.

The TPC is not meant to function in silo; on the contrary, it is also intended to systematize the provision of adolescent-friendly services of the entire hospital system. The TPC shall serve primarily as an adolescent-friendly reception, counseling and referral hub for pregnant adolescents and adolescent mothers coming from other hospital departments, from school-based Teen Health Kiosks, RHUs, private birthing clinics, and other facilities within the SDN, where an SDN exists.

II. Setting up the TPC

This section discusses the essential steps required in setting up a TPC in the hospital. The steps are not necessarily presented in chronological order, and may therefore be accomplished simultaneously.

Determine an appropriate management structure to oversee the provision of adolescent-friendly services in the TPC and the hospital.

The Chief of Hospital shall issue a **Hospital Order** (*Annex 3*) providing guidelines for the promotion of adolescent-friendly health services in the hospital and the establishment of the TPC. The order situates the TPC within the organizational structure of the hospital, lodged within the Department of Obstetrics and Gynecology, and under the direct supervision of the Department Head/Chairperson who shall exercise oversight function over TPC operations.

The hospital order shall include the organization of the TPC Management Committee which is an expanded Hospital Management Committee or Executive Committee. Generally, the Hospital Management or Executive Committee is chaired by the Chief of Hospital, with the heads of the different units/departments (such as Medical, Nursing, Laboratory, Ancillary, Administrative, Personnel, Accounting and Budget Services) as members. The Hospital Management/Executive Committee becomes a TPC Management Committee with the participation of the Ob-Gyn and Pediatrics Department Heads and the designated TPC Coordinator.

The TPC Management Committee shall provide the overall strategic direction of the TPC and is responsible for the formulation of policies, guidelines, rules and regulations governing TPC operations. Its members shall regularly monitor and evaluate the implementation of the policies and guidelines to ensure smooth operations of the TPC, including the delivery of support services in other hospital units, as well as to immediately address issues and concerns affecting such operations.

Appoint a TPC Coordinator to lead the TPC Core Team.

In the same hospital order, the Chief of Hospital shall appoint a TPC Coordinator, and create and designate the permanent TPC Core Team members as well as its rotating and on-call members. As much as possible, the names of the frontline health service providers (i.e., TPC Coordinator and permanent TPC Core Team members) shall be specified in the hospital order.

Ideally, the TPC Coordinator shall be at least an Ob-Gyn senior resident, medical specialist, or consultant with permanent position. She/he serves in a supervisory role but need not be present in the daily operations of the TPC.

The hospital order likewise lists the roles and responsibilities of the TPC Coordinator, which may include but are not limited to the following:

1. Together with the TPC Core Team, lead the service capacity assessment using the scoping tool.

2. Develop and implement an action plan to address gaps and strengthen service capacity.

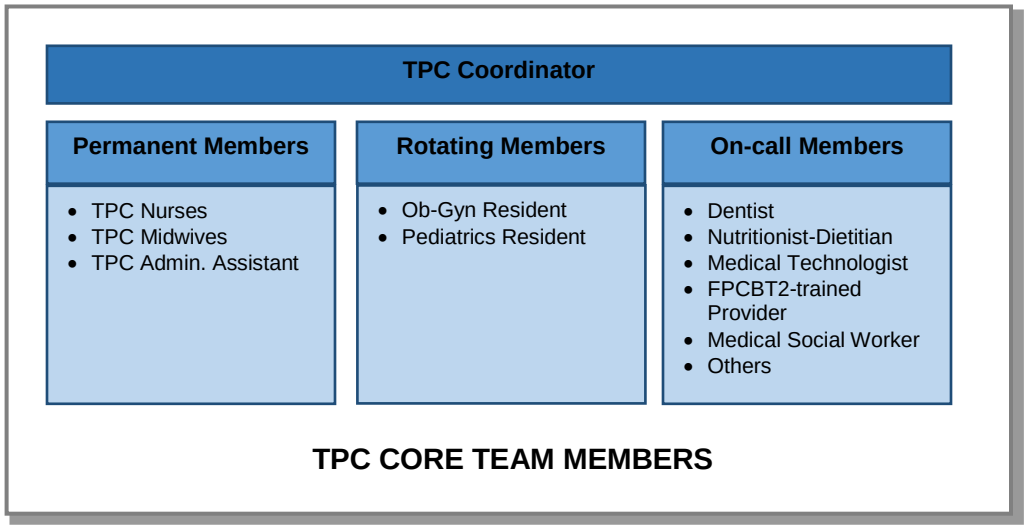
3. Monitor the status of implementation of the action plan.

4. Manage the operations of the TPC.

5. Ensure and monitor the implementation of interdepartmental referral for nutrition, dental, pediatric, surgical, labor and delivery services, and referral to other facilities/organizations providing adolescent services (including RHUs, health centers, and *barangay* health stations) for follow-up services such as infant immunization and subsequent supply of FP commodities.

6. Orient the medical and paramedical staff of the different units/departments of the hospital on respectful maternity care and the services offered at the TPC, including its location, operating hours, and operating procedures.

7. Formulate the clinic's annual Work and Financial Plan, to include program drugs, supplies and logistics, and ensure its approval and inclusion in the hospital's overall Work and Financial Plan.



The permanent TPC Core Team members with their respective minimum competency requirement are as follows:

1. At least one TPC nurse, trained in Family Planning Competency-Based Training (FPCBT1) and Adolescent Job Aid (AJA)
2. At least one TPC midwife, trained in FPCBT1 and AJA
3. At least one TPC administrative assistant who has attended an orientation on adolescent-friendly services

They are the frontline health service providers assigned to deliver services at the TPC on a day-to-day basis.

The rotating TPC Core Team members, on the other hand, are the Ob-Gyn and Pediatrics resident physicians. An Ob-Gyn and a Pediatrics resident physician shall be assigned to the TPC daily to respond to and manage cases and referrals as part of quality service provision.

The on-call TPC Core Team members are the dentist, nutritionist-dietitian, medical technologist, surgeon, FPCBT2-trained provider, and medical social worker, among others. They shall be called to render service at the TPC on a per-need basis.

Assess the hospital's capacity to deliver quality adolescent-friendly services.

Using the **TPC Scoping Tool** (*Annex 4*), the TPC Core Team shall assess the current capacity of the hospital to provide quality adolescent-friendly services. The hospital's capacity will be assessed in terms of availability of trained personnel, type of FP/Maternal, Neonatal, Child Health and Nutrition services provided, instruments and equipment, supplies and commodities, and presence of space where services can be given, among others. These areas of concern are based on standards set by the DOH and World Health Organization (WHO). The assessment encompasses the different hospital services/units involved in providing respectful maternity care for pregnant and postpartum/post-abortion adolescents.

The scoping tool is also designed to collate data, as available, on the prenatal, labor/delivery, postpartum, family planning, and other health/medical services currently being provided by the hospital to adolescents.

The baseline data collected, as well as the results of the assessment, are subsequently used for monitoring and evaluation purposes. The TPC Core Team shall ensure that periodic assessments are conducted using the scoping tool as a monitoring instrument until the required functionality indicators are met.

Enhance/establish adolescent-friendly services in the hospital in general, and in the TPC in particular.

Data generated during the assessment shall be consolidated and shall serve as the TPC's baseline data. Likewise, the results of the assessment shall be analyzed to determine gaps and challenges hindering the operations of the TPC and the delivery of adolescent-friendly support services in the hospital.

The TPC Core Team shall identify and prioritize the improvement of hospital units/departments such as, but not limited to, the Emergency Room, Labor and Delivery Rooms, the Ob-Gyn Ward, and the Laboratory. These units/departments provide support services to the TPC in the delivery of the continuum of care for pregnant and postpartum/post-abortion adolescents who are either enrolled at the TPC or accessing services in the hospital.

The TPC Core Team shall then identify gaps in staff complement (including minimum competency requirements), space that provides visual and auditory privacy, instruments and fixtures, drugs and medicine including medical/surgical supplies needed in all hospital units/departments that may be required in the delivery of quality adolescent-friendly services for pregnant and postpartum/post-abortion adolescents.

The TPC Coordinator shall designate either the TPC nurse or midwife as the clinic's Logistics Point Person who will ensure that necessary drugs, supplies and logistics are available at all times. The TPC Core Team shall then develop an action plan to address the gaps, challenges and barriers to the enhancement or installation of adolescent-friendly services in the hospital and the TPC. The said action plan shall be submitted to the Ob-Gyn Department Head, who

shall endorse the same to the Chief of Hospital for approval. The TPC Core Team subsequently implements the action plan immediately upon approval of the Chief of Hospital.

III. TPC Guiding Principles

The hospital aims to provide a positive experience through adolescent-friendly services to pregnant and postpartum/post-abortion adolescents by establishing a TPC as a place where these adolescent clients feel safe, accepted, respected, supported and comforted. As such, the hospital and the TPC Core Team shall: fully respect the right of adolescent girls who become pregnant, had given birth or had an abortion, to have access to health services that will reduce the risk of maternal morbidity and mortality caused by early pregnancy; strictly adhere to policies of privacy and confidentiality; and closely subscribe to the Patient's Rights, including the Rights of Children. The hospital and the TPC must likewise provide spaces, materials and equipment that are adolescent-friendly.

To ensure the adolescent's privacy and confidentiality, the following etiquette for health providers must be practiced at all times:

1. The hospital and the TPC shall provide a safe and nonthreatening environment for the client from the time she enters the hospital/clinic, during the interview/assessment, and when she leaves the clinic.

2. Client information will not be discussed with anyone else within and outside the consultation room, except in a case management conference by authorized staff.

3. Notes or scratch papers containing client information shall be immediately and properly disposed of.

4. All client records are considered confidential files and should be kept in a separate and locked cabinet designated for TPC clients only. The TPC recording and reporting point person shall keep a separate folder for each client that shall contain the accomplished client intake form and individual treatment record.

5. The TPC staff shall assure the TPC clients that they are bound to maintain confidentiality, except under specific circumstances, such as, but not limited to:
    a. Disclosure of intent or attempt of suicide
    b. Plans of homicide
    c. Intention for unsafe abortion
    d. Other situations that may potentially harm the client or others

6. Audiovisual privacy shall be observed at all times.

The support areas in the hospital, such as the Emergency, Labor and Delivery Rooms, and Ob-Gyn Ward shall allocate at least a separate area for pregnant and postpartum/post-abortion clients to provide visual and auditory privacy. If a separate space cannot be provided, curtains, at the least, can be used to separate the pregnant and postpartum/post-abortion clients from the rest of the clients.

Likewise, the Emergency, Labor, Delivery Rooms and the Ob-Gyn Ward shall, at all times, be staffed with at least one nurse/midwife who has undergone orientation on adolescent-friendly services. She/he shall provide and ensure the provision of adolescent-friendly services, particularly respectful maternity care.

The hospital and TPC service providers shall subscribe to and promote respectful maternity care by:

- Respecting beliefs, traditions and culture.
- Empowering the client and her family to become active participants in health care.
- Providing continuous support during labor, including open two-way communication between client and provider.
- Allowing choice of companion during labor and birth and freedom of movement during labor.
- Allowing client's choice of position during birth.

To ensure the safety of the adolescent mother and her child, service provision throughout the period of pregnancy to childbirth up until post-delivery/post-abortion shall conform with current practice standards:

1. Pregnant adolescents consulting the Emergency Room for labor pains but are assessed to be in inactive labor shall not be sent home but shall be admitted to a halfway house/facility such as a BEmONC-capable facility that is within the hospital premises or within a 5-kilometer radius, has available emergency transport, and is a member of the SDN where the referring hospital is the apex facility. As soon as active labor is observed, the pregnant adolescent shall be immediately referred to the CEmONC hospital.

2. The hospital shall practice active management of third stage of labor and essential intrapartum newborn care. All medical and paramedical hospital staff shall be trained in dealing with adolescents and respectful maternity care to ensure positive experience in all phases of service delivery needed by the pregnant adolescent. Nonmedical staff shall likewise be oriented on dealing with the adolescents and the services available for adolescents at the hospital and the TPC.

Interdepartmental referrals shall be the major demand generation strategy to increase utilization of TPC services to ensure that all pregnant adolescents are identified and provided quality services on safe motherhood. Therefore:

1. All female adolescents seeking medical/dental care shall be asked their last menstrual period (LMP). For any suspicion of pregnancy, an adolescent may be referred to the TPC for further evaluation. She shall be provided with the following key messages:
    a. Adolescents are at risk of unplanned pregnancy and sexually transmitted infections, including HIV/AIDS.
    b. This facility provides special services for adolescents at the TPC.
    c. Visit our trained HSPs at the TPC.

2. All pregnant adolescents with threatened abortion, inevitable abortion, post-abortion or premature labor shall be referred to the TPC for registration and counseling before discharge. They shall be provided with the following key messages:
    a. Adolescent mothers are at risk of closely spaced repeat pregnancies within as early as 11 days post-abortion.
    b. This facility provides special services for adolescents at the TPC.
    c. Visit our trained HSPs at the TPC for FP counseling and other services.

3. All postpartum adolescents shall be referred to the TPC and they shall be provided with the following key messages:
    a. Adolescent mothers are at risk of closely spaced repeat pregnancies within as early as three weeks postpartum.
    b. This facility provides special services for adolescents at the TPC.
    c. Visit our trained HSPs at the TPC for FP counseling and other services.

To encourage shared responsibility and male participation in family planning, TPC health service providers shall endeavor to involve the male partners of its adolescent clients in health education classes, prenatal care, family planning counseling, and other applicable services to enable the pair to realize and acknowledge their reproductive health roles and responsibilities as a couple and to make the right voluntary decision either individually or jointly.

The TPC shall also integrate healthy timing and spacing of pregnancy (HTSP) as an approach and shall use the Reproductive Life Plan as an optional tool for preventing unintended and/or closely spaced repeat pregnancies and for promoting family planning among postpartum/post-abortion adolescent clients.

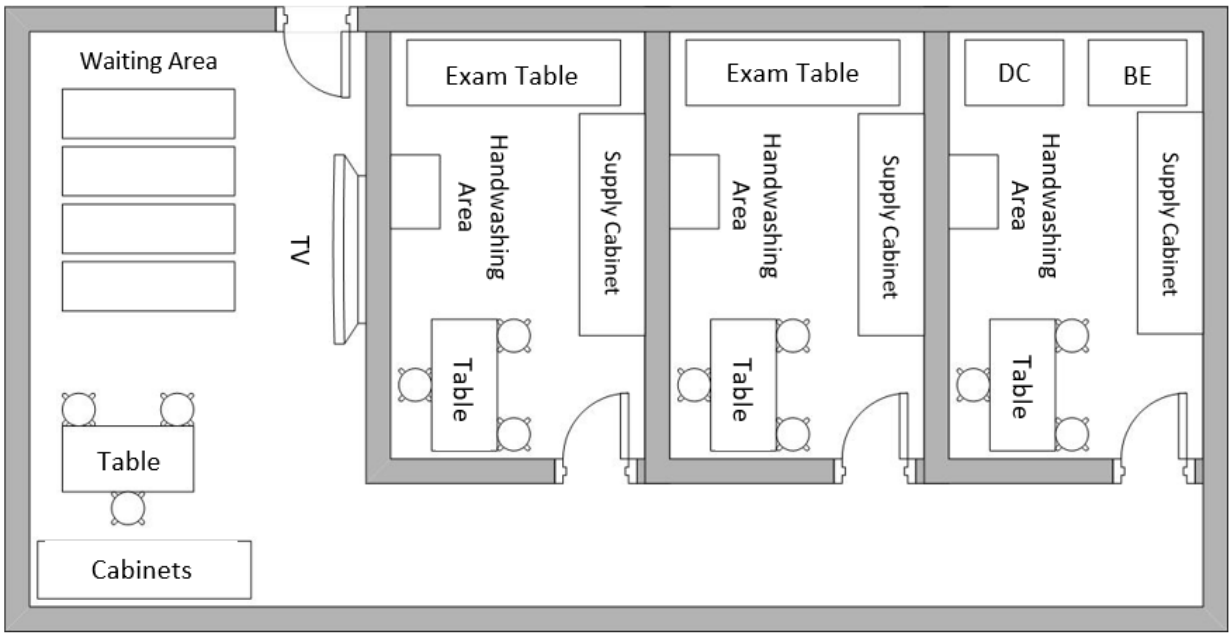
HTSP helps female adolescents and their partners delay or space their pregnancies to achieve the healthiest outcomes for them and their newborns, infants and children, reducing maternal, neonatal and child morbidity and mortality. The Reproductive Life Plan (*Annex 5*) serves as a useful prompt for HTSP and FP counseling. It is a simple graphic tool for individual planning on whether to have (more) children, when to have them and how many, considering one's own health, priorities and aspirations. These two interventions work within the context of voluntary and informed contraceptive choice and consider the clients' fertility intentions and desired family size.

IV. Operationalizing the TPC

Clinic Location and Setup

The TPC Core Team shall identify and propose to the Chief of Hospital a space where the TPC shall be installed. The TPC is best located in an accessible place within the hospital, preferably at the Outpatient Department, and ideally in a separate room big enough to accommodate a waiting area and a consultation and examination room for pre/postnatal and post-abortion care, FP counseling and services, and dental/laboratory services that provides audiovisual privacy (Option 1, below).

Option 1

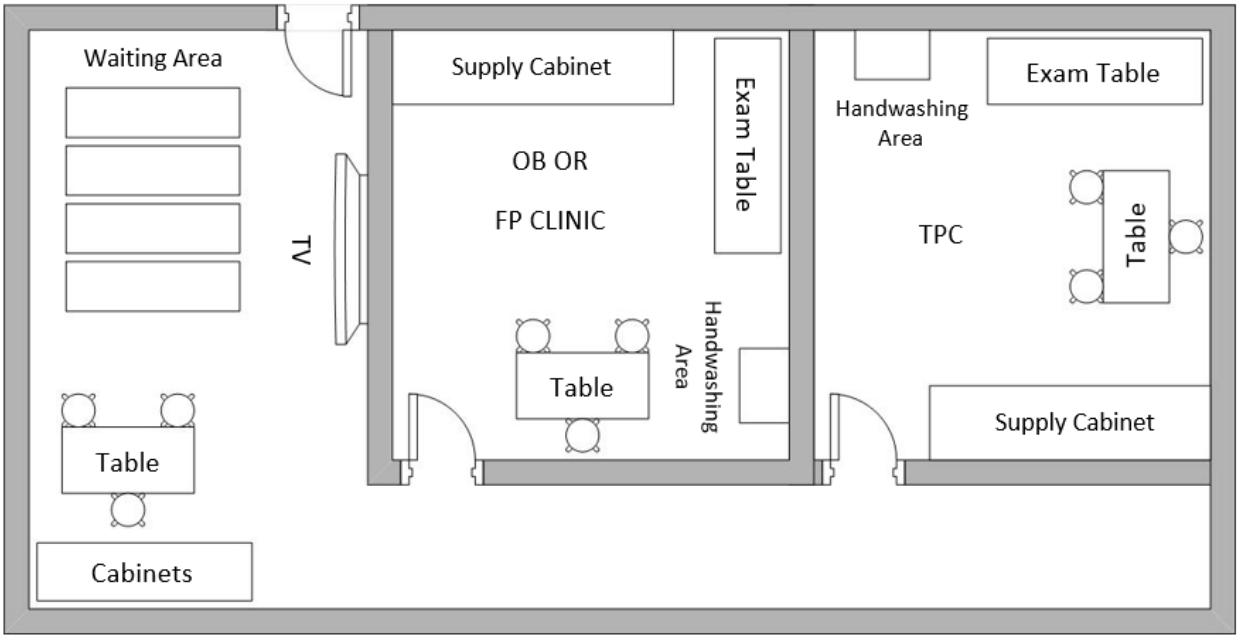


However, in the absence of a separate space, the TPC can be located within the FP Clinic or the Ob-Gyn Department's Outpatient Clinic for as long as there is audiovisual privacy (Option 2, next page).

In instances where a permanent separating wall between rooms is not feasible, visual privacy can be accomplished by putting up curtains or placing cabinets in between the spaces. Auditory privacy, meanwhile, can be accomplished by talking in low modulated voices or by requesting other staff to vacate the room temporarily while an adolescent is in consult.

Aside from the basic furniture such as office tables, chairs and examining tables, the TPC shall, at the minimum, be equipped with medical instruments, such as stethoscope, sphygmomanometer, digital thermometer, weighing scale (Detecto), and height measurement mounted on the wall.

Option 2



The TPC shall be provided with a cabinet for safekeeping of intake forms, Mother/Baby Book or *Booklet ni Nanay at ni Baby*, etc. The cabinet shall have a lock to ensure privacy and confidentiality of records. A separate medicine and medical supplies cabinet with lock shall also be made available to avoid pilferage.

The TPC shall display relevant information, education, communication (IEC) materials, brochures, flip charts and posters in the waiting area as well as in the consultation/treatment areas.

The consultation/treatment room and examining table shall be provided with a pillow and blanket. The consultation/treatment areas, moreover, shall be provided with hand sanitizers and paper hand towels if a handwashing facility is not available.

The TPC shall observe segregation and proper health care waste management. Properly labeled and covered garbage bins should therefore be placed at the waiting area and the consultation/treatment areas.

Ideally, the TPC should have its own clean comfort room. However, access to a clean comfort room within the immediate vicinity of the clinic is acceptable.

Operating Hours

The TPC operating hours shall coincide with the consultation schedules of the Outpatient Department where the TPC may be located. However, it is best for the TPC to also offer flexible hours to accommodate the after-school schedule of in-school adolescents.

To ensure that pregnant and postpartum/post-abortion adolescents are managed adequately even if the TPC is closed, a health service provider oriented on adolescent-friendly services

shall be assigned in all shifts at the Emergency Room. This provider shall handle all adolescents seeking emergency consultation and/or admission.

All pregnant and postpartum/post-abortion adolescents seen at the Emergency Room shall be advised and referred to the TPC for registration, psychosocial assessment, information, education and counseling, and antenatal/postpartum/post-abortion care.

Signage

The hospital shall, as much as possible, install promotional and directional signage (*Annex 6*) in strategic locations within and outside its premises to raise public awareness of the TPC, its operating schedule, and the services it offers to adolescents.

The signage shall display the trunk line and website of the hospital, the telephone/mobile number or extension number of the TPC, and, when possible, the names and contact information (e.g., mobile number, e-mail address) of the TPC Core Team, including the rotating and on-call members.

Adolescent Clients

TPC clients are either walk-in or referred pregnant and postpartum/post-abortion adolescents. Referred clients are further classified into outside referrals and interdepartmental referrals.

1. Outside referrals
    a. Pregnant or postpartum/post-abortion adolescents referred by schools
    b. Pregnant or postpartum/post-abortion adolescents referred from the community via the RHUs/health centers, private lying-in clinics, and other public/private hospitals that are SDN member facilities
    c. Pregnant or postpartum/post-abortion adolescents referred by other health facilities that are not members of the SDN or by non-health facilities such as the Women and Children Protection Unit (WCPU), Philippine National Police (PNP), Department of Social Welfare and Development (DSWD), etc.

2. Interdepartmental referrals from within the hospital
    a. Pregnant adolescents or postpartum/post-abortion adolescents referred by other departments of the hospital (e.g., Ob-Gyn, Pediatrics, Surgery, Internal Medicine, Emergency and other hospital units), including:
        i. Adolescent mothers with babies admitted at the hospital's nursery or Pediatric Department
        ii. Adolescent mothers with babies for immunization
    b. Adolescents suspected to be pregnant referred by other departments of the hospital

3. Walk-in clients -- Adolescents who may have learned about the existence of a TPC in the hospital and purposely visited the hospital for consultation at the TPC.

Registration

A pregnant or postpartum/post-abortion adolescent seeking consultation at or referred to the TPC shall be enrolled and registered as a TPC client and shall be issued a **TPC Identification**

Card (*Annex 7*) upon presentation of a valid identification card (school, barangay, postal ID, etc.), and providing the minimum vital identification information in the **Adolescent Client Intake Form (Initial Visit)** (*Annex 8*).

New clients may be enrolled on a daily basis but subsequent client visits may be scheduled on certain days of the week to avoid overcrowding.

Health Service Providers

The TPC Coordinator is the manager of the TPC and is responsible for the overall operations of the clinic.

The TPC shall operate as a "one-stop shop" where, as much as possible, services needed by pregnant and postpartum/post-abortion adolescents are provided within the premises of the TPC. The TPC Core Team shall request the presence and services at the TPC of any of the following: a surgeon, dentist, nutritionist, medical technologist, FPCBT2-trained health service provider, and a medical social worker, depending on the needs of the pregnant, postpartum/post-abortion adolescents.

The TPC Core Team, including the rotating and on-call members, will provide quality antenatal care, skilled birth attendance, facility-based delivery, quality postpartum care, information, education and counseling services on exclusive breastfeeding and FP, and the appropriate FP method freely chosen and accepted. They will also establish interdepartmental coordination and collaboration, and a functional referral mechanism with a service delivery network and other organizations/facilities providing adolescent health services.

TPC Services

1. Enrolment/registration using the appropriate intake form

2. Orientation on TPC services, pathway of health services, including policies and processes

3. Basic client assessment and psychosocial assessment and counseling using the HEADSS framework

4. Medical history taking, physical examination, and diagnostic procedures such as, but not limited to, laboratory and radiology/sonography

5. Ob-Gyn services
   a. Prenatal, postpartum/post-abortion care
   b. Birth and emergency planning
   c. Immunization
   d. Emergency obstetric care
   e. Labor and delivery
   f. Family planning

6. Pediatric services
   a. Non-obstetric health problems of the pregnant and postpartum/post-abortion adolescents
   b. Care of the newborn including cord care and immunization

7. Referral services
    a. To other departments/units/services of the hospital
        i. Dental
        ii. Nutrition
        iii. Gender and development (GAD) or WCPU if available
        iv. Medical social services
    b. To an SDN member facility
        i. Continuing FP use (follow-up or resupply), as applicable
        ii. Postpartum follow-up services
        iii. Child immunization services

8. Health education

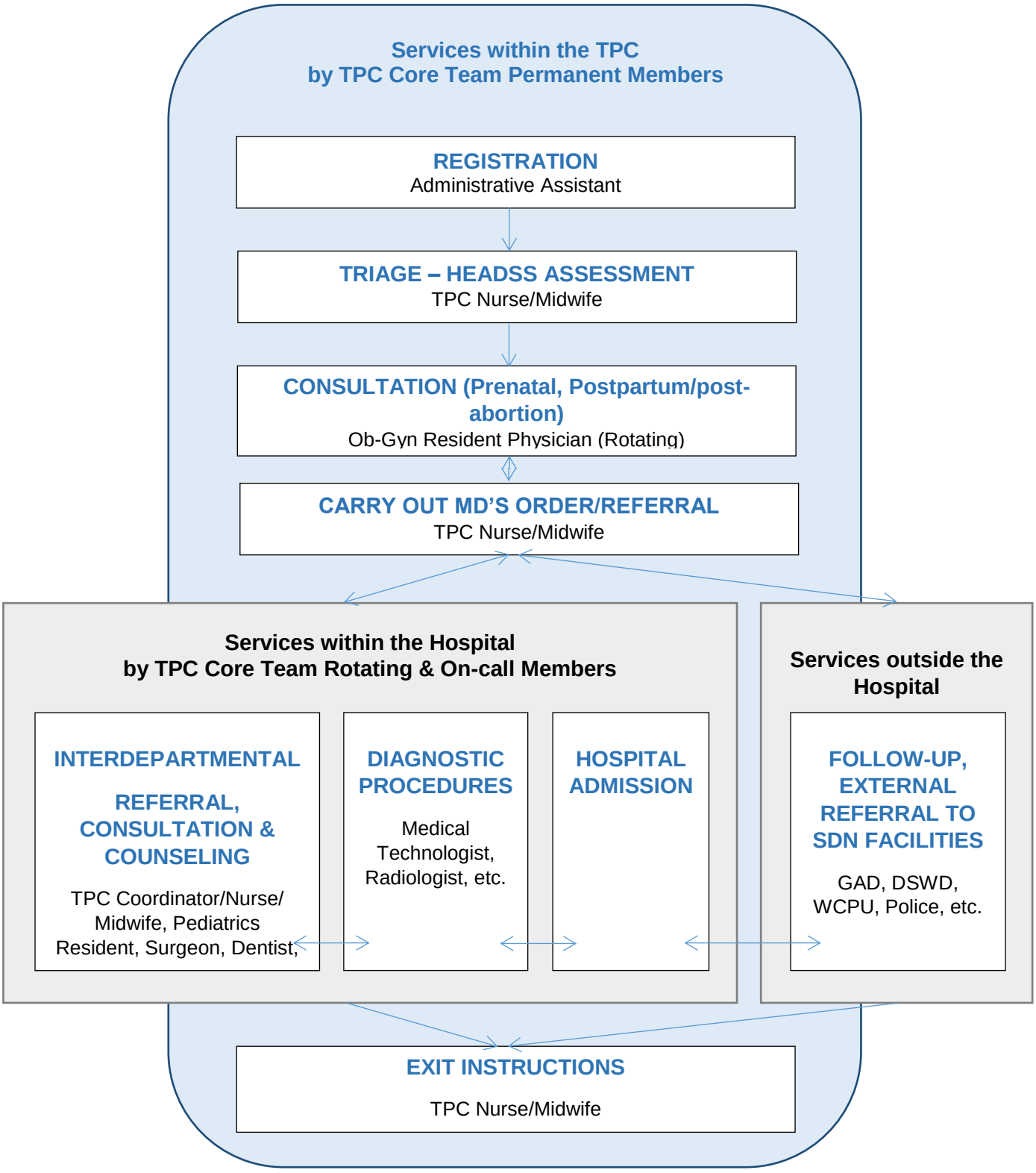
Health education at the TPC will consist of six major modules (*Annex 10*). Each module has a corresponding session plan, as follows:

a. Module 1: Female Reproductive Health: Parts and Functions
b. Module 2: Stages of Pregnancy
    i. Bodily Changes During Pregnancy
    ii. Signs and Symptoms During Pregnancy
c. Module 3: Nutrition During Pregnancy
d. Module 4: Oral Health for Teen Parents
e. Module 5: Newborn Care: Breastfeeding Practice
f. Module 6: Family Planning

The six modules can be integrated and delivered one-time or by module.

V. TPC Service Guidelines

TPC SERVICE FLOW



Pregnant or postpartum/post-abortion adolescent clients visiting the hospital's Outpatient Department (OPD) for the first time shall secure a client record/card at the registration counter using the priority lane. The OPD registration clerk shall instruct the pregnant or postpartum/post-abortion client and companion to proceed to the TPC for registration.

Registration

TPC Administrative Assistant

As soon as the client and her companion (i.e., parent, guardian, etc.) enter the clinic, they will be warmly welcomed by the TPC administrative assistant who shall enroll the client in the TPC **Adolescent Target Client List** (*Annex 12*) and issue her with a TPC Identification Card (*Annex 7*) to facilitate the identification of the client at the OPD, Emergency Room, Labor Room and Delivery Room, and other relevant units of the hospital in subsequent visits.

The TPC administrative assistant shall accomplish the Client Intake Form (*Annex 8*) and individual treatment record (ITR), using the hospital's existing ITR form, and shall endorse the client with the Intake Form and ITR to the TPC nurse/midwife.

Prenatal Services

TPC Nurse/Midwife (Receiving the Client)

The TPC nurse/midwife shall perform the following:

1. Secure consent for privacy and confidentiality.

2. Accomplish the Client Intake Form (*Annex 8*).

3. Check and record on the ITR the vital signs, blood pressure, pulse rate, respiratory rate, temperature, height, weight, and body mass index (BMI) of the client.

4. Orient the client and her companion about the services offered by the TPC, including the schedule of checkup and activities that the client must attend.

5. Provide the client with a Mother/Baby Book. The Mother/Baby Book will serve as the home-based record of the client and her baby.

6. Advise the client to stay at the waiting area and wait for her number to be called for the consultation. IEC materials or video clips may be given or shown to the client while waiting for consultation.

7. Refer/endorse the client with the duly accomplished intake form to the Ob-Gyn resident physician on duty at the TPC.

8. Alert/inform the Ob-Gyn of any negative condition/risk identified during HEADSS assessment.

Ob-Gyn Resident-on-Duty

The Ob-Gyn Resident-on-Duty at the TPC shall perform the following:

1. Secure consent for examination.

2. Conduct a medical and physical examination in an adolescent-friendly manner, and get the client's past and focused obstetrical history, taking note of any negative condition/risk identified by the nurse/midwife during HEADSS assessment.

3. Assess the following elements in the physical examination and record findings in the ITR:
   a. General appearance: gait and movements, behavior (verbal and nonverbal), general hygiene
   b. Skin
   c. Conjunctiva
   d. Chest: breathing, retractions, heaves
   e. Breasts (if applicable)
   f. Abdominal examination (gestation appropriate)
   g. Pelvic examination and/or speculum examination (if applicable)
   h. Extremities

4. Indicate in the ITR the diagnostic procedures to be performed on the client.

5. For clients on follow-up, the Ob-Gyn resident-on-duty shall:
   a. Discuss with the client and parent/guardian the findings of the laboratory test results.
   b. Provide appropriate management based on clinical and laboratory findings.
   c. Give additional requests for necessary repeat laboratory tests.
   d. Use the TPC Follow-up Visit Form (*Annex 9*) to record pertinent findings during the follow-up visit. This form will be included in the client's envelope.

6. Provide nutritional advice to the patient and remind her of her weight gain requirement based on her BMI as advised by the nutritionist-dietitian.
   a. For underweight and malnourished clients, refer to Pediatrics Outpatient Unit and Nutrition and Dietetics Department for evaluation and management. Fill up the **Outgoing Referral Form** (*Annex 15B*) and facilitate transfer of patient.
   b. Recommend weight gain for adolescents throughout pregnancy (Nancho & Llanto):
      i. Normal: 11-14 kg
      ii. Underweight: 16-18 kg
      iii. Obese: 9 kg

7. Provide prescription for vitamin supplementation.

8. Develop and discuss with the client the birth and emergency plan, which shall be properly recorded in the Mother/Baby Book.

9. Discuss the contents of the Mother/Baby Book, especially the sections on:
   a. *Mapanganib na Palatandaan sa Panahon ng Pagbubuntis*
   b. *Plano sa Paghahanda sa Oras ng Panganganak at Emergency*
   c. *Paghahanda para sa Panganganak*

10. Advise the client to seek immediate medical attention at the facility should she experience any of the mentioned danger signs.

11. Ask client and parent/guardian if they have any question or areas that need clarification.

12. Advise client of the date of her next prenatal visit or where to go in case of emergency.

13. Refer the client to the TPC Coordinator who is the Ob-Gyn consultant-in-charge or specialist for further consultation and management if necessary.

14. The Ob-Gyn resident-on-duty or the TPC Coordinator shall direct the client back to the TPC nurse/midwife to carry out his/her orders, such as tetanus toxoid immunization, micronutrient and vitamin supplementation, and referral.

TPC Nurse/Midwife (Attending to the Client)

The TPC nurse/midwife shall perform the following:

1. Administer the tetanus toxoid and record it in the Mother/Baby Book.

2. Dispense and instruct the client on dosage of vitamin and mineral supplementation, such as:
   a. Elemental iron: 27-60 mg/day
   b. Folic acid: 400 mcg/day
   c. Calcium: 1,600 mg/day

3. Request and schedule routine laboratory tests to be performed on the client, such as:
   a. Complete blood count
   b. Blood type, antibody screen, Rh
   c. Urinalysis and/or urine culture, as needed
   d. Screening tests for sexually-transmitted infection:
      i. Rapid Plasma Reagin or Venereal Disease Research Laboratory
      ii. Rubella titer
      iii. Hepatitis B surface antigen (HBsAg)
      iv. HIV (if applicable, with consent)
   e. Fasting blood sugar or Random blood sugar or 75g Oral Glucose Tolerance Test
   f. Pelvic ultrasound
   g. Radiologic/sonographic study

4. Request Laboratory Services to deliver diagnostic results to the TPC as soon as available, preferably before the client's next follow-up visit.

5. Provide counseling on exclusive breastfeeding (EBF) and family planning (FP), preferably with the partner in attendance:
   a. All pregnant adolescent mothers should be counseled on the benefits of EBF and how to promote, establish and sustain EBF in the baby's first six months. The lactational amenorrhea method may be discussed as an FP method, emphasizing the three important criteria that need to be met: (i) the mother is exclusively or nearly exclusively breastfeeding; (ii) the mother is amenorrhoeic; and (iii) the baby is six months old or younger.
   b. All pregnant adolescents shall be provided FP counseling. Once the client has voluntarily decided to accept a method, the preferred method shall be recorded in the

Mother/Baby Book for validation and provision of method immediately after delivery (if the chosen method is Progestin-only Pills, PSI, or PPIUD).

c. All postpartum/post-abortion adolescents shall be provided FP counseling and provided the chosen method once the client has voluntarily chosen and accepted a method. If the chosen method is PSI or interval IUD, and the TPC nurse/midwife is not trained to perform these procedures, the FP clinic provider shall perform the procedure preferably at the TPC.
d. The TPC may record the FP method provided to the adolescent to complete the record of the adolescent; however, the duly accomplished FP Form 1 (*Annex 13*) and reporting shall be the responsibility of the FP Clinic to avoid duplication.

6. Prepare the Referral Form for special referrals as recommended by the Ob-Gyn resident-on-duty, including referrals for negative conditions/risks such as abuse, suicidal tendencies, etc. to organizations/facilities outside the hospital, e.g., PNP, DSWD. Clients should preferably still be seen at the TPC, as much as possible.

Nutritionist/Dietitian

The nutritionist/dietitian-in-charge will proceed to the TPC, receive the TPC Referral Form, indicate the time she/he saw the client, and sign the return slip for the client as proof of receiving the referral. The nutritionist/dietitian-in-charge will then perform the following:

1. Conduct a focused history and evaluation in an adolescent-friendly manner.

2. Assess the nutritional status of the client, including anthropometric (i.e., height/weight/BMI), biochemical (i.e., lab tests such as Hg, etc.), clinical (i.e., pallor, etc.) and dietary (i.e., 24-hour food recall or food frequency questionnaire). The results of any available tests will establish what diet to prescribe to the client.

3. Record findings on the TPC Referral Form.

4. Request necessary laboratory tests that will be given to the client and advise the client and parent/guardian (or the TPC nurse/midwife, if applicable) to have the laboratory results ready on the scheduled follow-up.

5. Provide nutritional advice to the patient and remind her of her weight gain requirement based on her BMI.

6. For underweight and malnourished clients, give a concrete diet plan applicable to and affordable by the patient.

7. Weight gain for adolescents throughout pregnancy (Nancho & Llanto):
   a. Normal: 11-14 kg
   b. Underweight: 16-18 kg
   c. Obese: 9 kg

8. Clients on follow-up**:** Discuss with the client and parent/guardian the improvement in the patient's nutritional status as well as findings of the laboratory test results, if any. Provide appropriate management based on clinical and laboratory findings. Give additional requests for necessary repeat laboratory tests. Discuss the diet plan.

9. Ask client and parent/guardian for any questions or areas for clarification.

10. Advise client of her next follow-up visit, if necessary.

11. Refer the client back to the TPC nurse/midwife regarding his/her findings during this visit for further instructions.

12. Inform the TPC nurse/midwife once the consultation is over to have the patient referred to other service providers who may need to see the patient.

Dentist-in-Charge

The dentist-in-charge will proceed to the TPC, receive the TPC Referral Form, indicate the time she/he saw the patient, and sign the return slip for the client as proof of receiving the referral. The dentist-in-charge will then perform the following:

1. Conduct a focused dental history and evaluation in an adolescent-friendly manner.

2. Assess the dental condition of the patient.

3. Record findings on the TPC Referral Form.

4. If the client needs dental prophylaxis or other dental procedures, inform the TPC nurse/midwife for him/her to assist and instruct the client to proceed to the Dental Clinic of the hospital.

5. Provide dental advice to the client.

6. Clients on follow-up: Discuss with the client and parent/guardian the client's dental condition and the management appropriate for the client.

7. Ask client and parent/guardian if they have any questions or areas that need clarification.

8. Advise client of her follow-up dental visit, if necessary.

9. Refer the client back to the TPC nurse/midwife regarding his/her findings during the visit for further instructions.

10. Inform the TPC nurse/midwife once the consultation is over to have the patient referred to other service providers who may need to see the patient.

Medical Social Worker

The medical social worker shall perform the following:

1. Assess the financial capacity of the client.

2. Refer the client to the PhilHealth point person for enrolment or availment of appropriate financing schemes, such as medical assistance programs (MAP) of senators, congressmen, and local officials, PAGCOR/PCSO, GAD fund, etc.

TPC Nurse/Midwife (Before Releasing the Client)

Before the client and her companion leave, the nurse/midwife shall:

1. Provide the client with the schedule of the health education classes and enjoin her and her partner to attend along with other TPC clients.

> **INCREASING FOLLOW-UP PRENATAL VISITS**
>
> To help ensure 4ANC, the TPCs in Cavite, Batangas and Laguna have introduced the use of a Client Appointment Caddy and its accompanying Prenatal Visit Card (PNVC) (*Annex 24*).
>
> The appointment caddy is an easy reference tool for the TPC nurse/midwife to track clients' succeeding prenatal visits. In each visit, before a client is dismissed, the TPC HSP writes down the date of the next visit in the PNVC and in the Mother/Baby Book, and informs the client of the date of next visit together with the home care instructions. The PNVC is retained in the TPC while the Mother/Baby Book is brought home by the client. The TPC HSP will now put the PNVC in the corresponding month pocket in the caddy. If the client does not visit on the scheduled month, the TPC HSP will notice it since the card remains in the pocket of the previous month. A follow-up call or text to the client may then be carried out.

2. Request the client to fill up the **Client Feedback Form** (*Annex 17*).

3. Remind the client of the schedule of her next follow-up prenatal visit as advised by the Ob-Gyn resident-on-duty. The recommended frequency of prenatal visits during the first trimester is every four weeks until 28 weeks, or more frequent if the Ob-Gyn so requires.

Postpartum/Post-Abortion and Postnatal Services

The postpartum/post-abortion and postnatal period is also an important part of maternal care. Postpartum/post-abortion and postnatal care provides an opportunity for identifying and managing any complications that may develop during this phase of recovery. This is a time to reinforce and assess breastfeeding habits and practices of the postpartum/postnatal client to ensure that her baby is exclusively breastfed. It is also a period to reiterate with her and her partner the various forms of family planning methods that are safe, effective and appropriate for them and assist them in acquiring the method that is best for them.

As soon as the client and her companion (i.e., partner, parent, guardian, etc.) enter the clinic, they will be warmly welcomed by the TPC administrative assistant who shall perform the following:

1. Get the client's ITR if the client availed prenatal services at the TPC and add follow-up record forms.

2. Enroll the client in the Adolescent Target Client List (*Annex 12*) if the client did not have her prenatal care at the TPC, accomplish the client's ITR, and endorse the client with her ITR to the TPC nurse/midwife.

3. Provide the client with a Mother/Baby Book (as necessary) and TPC ID to facilitate identification of the client at the OPD, Emergency Room and other relevant units of the hospital.

The TPC nurse/midwife shall perform the following:

A. If first visit of postpartum/post-abortion or postnatal adolescent client:
   - Secure consent for privacy and confidentiality.
   - Accomplish the Client Intake Form *(Annex 8*).
   - Check and record in the ITR the vital signs of the client: blood pressure, pulse rate, respiratory rate, temperature, height, weight and BMI.
   - Orient the client and companion about the services offered by the TPC, including the schedule of checkup and activities that the client must attend.
   - Advise the client to stay at the waiting area and wait for her to be called for consultation. IEC materials or video clips will be given or shown to the client while waiting for consultation.
   - Refer/endorse the client with the duly accomplished intake form/ITR to the Ob-Gyn resident-on-duty at the TPC.
   - Refer the client's newborn with the accomplished Mother/Baby Book to the Pediatric resident-on-duty for consultation.
   - Provide breastfeeding and FP counseling for postpartum/postnatal clients and FP counseling for post-abortion clients.
   - Completely accomplish FP Form 1 (*Annex 13*) of postpartum/post-abortion adolescent clients who have decided to voluntarily accept an FP method and have secured parental/guardian consent.
   - Provide FP method of choice to adolescent clients or refer them to the FP clinic as needed.
   - Submit accomplished FP Form 1 to the FP Clinic for recording and reporting.
   - Provide newborn care/immunization as ordered by the pediatric resident-on-duty and record all services rendered in the Mother/Baby Book.

B. If postpartum/post-abortion or postnatal adolescent is already a TPC client:
   - Check and record in the ITR and/or Mother/Baby Book the vital signs of the client: blood pressure, pulse rate, respiratory rate, temperature, height, weight and BMI.
   - Advise the client to stay at the waiting area and wait for her to be called for consultation. IEC materials or video clips will be given or shown to the client while waiting for consultation.
   - Refer/endorse the client with the duly accomplished ITR/Mother/Baby Book to the Ob-Gyn resident physician on duty at the TPC.
   - Refer the client's newborn with the accomplished Mother/Baby Book to the pediatric resident-on-duty for consultation.
   - Provide breastfeeding and FP counseling for postpartum/postnatal clients and FP counseling for post-abortion clients.
   - Completely accomplish FP Form 1 of postpartum/post-abortion adolescent clients who have decided to voluntarily accept FP method and have secured parental/guardian consent.
   - Provide FP method of choice to adolescent clients or refer them to the FP clinic as needed.
   - Submit accomplished FP Form 1 to the FP Clinic for recording and reporting.

- Provide newborn care/immunization as ordered by the pediatric resident-on duty and record all services rendered in the Mother/Baby Book.

VI. Hospital Service Guidelines

Emergency Room

1. Pregnant adolescents in labor or with obstetrical complications or emergencies, such as threatened (missed, inevitable or imminent) miscarriage, suspected ectopic pregnancy or related problems, shall be accompanied by the TPC nurse/midwife and referred to the Emergency Room of the hospital for evaluation and management. The client shall ideally have her TPC ID and Birth Plan with her.

2. The client will be received by an adolescent-friendly ER nurse and placed in a room/place in the ER with visual/auditory privacy (at least separated from other clients by a curtain/screen).

3. The resident-in-charge shall immediately assess the client and refer her to the respective consultant-in-charge for further instructions.

4. The Ob-Gyn resident-on-duty shall perform the following:
   a. Determine if the pregnant adolescent is in active labor or not.
   b. Admit the client in active labor to the labor room.
   c. Refer the client in inactive labor to the nearest SDN member facility that is a BEmONC-capable facility with emergency transport system.
   d. Determine the complication or emergency of a pregnant adolescent.
   e. Admit the client to the appropriate ward.

5. The ER nursing staff shall inform the TPC nurse/midwife of the client's status and whereabouts (i.e., admitted or referred).

Labor/Delivery Room

1. The adolescent-friendly Labor Room/Delivery Room nurse/midwife shall receive the adolescent in active labor and place her in a room/place with visual/auditory privacy (at least separated from other clients by a curtain/screen).

2. The Labor Room/Delivery Room HSP shall subscribe to respectful maternity care by:
   a. Providing continuous support during labor, including open two-way communication between client and provider.
   b. Allowing choice of companion during labor and birth and freedom of movement during labor.
   c. Allowing client's choice of position during birth, with consideration of maternal and newborn safety.

3. The Labor Room/Delivery Room HSP shall review client records if the adolescent has chosen an FP method during prenatal care.

4. The Labor Room/Delivery Room HSP shall secure parent/guardian consent for FP service provision, if not previously completed.

5. The Labor Room/Delivery Room HSP shall inform the Ob-Gyn resident-on-duty that the client has initially decided to accept an FP method and that there is parent/guardian consent.

6. The Ob-Gyn resident-on-duty attending to the delivery shall verify with the client if she has decided to accept an FP method while waiting for the delivery of the placenta, especially if the chosen method is PPIUD.

7. For clients who confirm acceptance of PPIUD as FP method:
   a. The Ob–Gyn resident-on-duty or the Labor Room/Delivery Room HSP trained in PPIUD shall fill up FP Form 1 and request the client to affix her signature for consent.
   b. The Labor Room/Delivery Room HSP shall prepare the instruments and supplies needed for the PPIUD insertion.
   c. The Ob-Gyn resident-on-duty or the Labor Room/Delivery Room HSP trained in PPIUD insertion shall insert the IUD at least 10 minutes after the delivery of the placenta if appropriate for the client.

8. The Labor Room/Delivery Room HSP shall record all services, including drugs/medicines, provided/administered to the adolescent while in the Labor Room/Delivery Room.

9. The Labor Room/Delivery Room HSP shall accompany and endorse the postpartum client to the adolescent- friendly ward nurse on duty.

10. As applicable, the Labor Room/Delivery Room HSP shall submit the duly accomplished FP Form 1 to the FP clinic for recording and reporting.

Ward

1. The adolescent-friendly ward nurse/midwife shall receive the postpartum/post-abortion or pregnant adolescent with obstetric complications (threatened, imminent, incomplete, complete abortion) and place her in a room/place with visual/auditory privacy (at least separated from other clients by a curtain/screen).

2. The adolescent-friendly ward nurse/midwife shall provide all the needed services of the adolescent client until cleared for discharge.

Discharge Instructions

Once the client is cleared by the Ob-Gyn resident and/or consultant-in-charge as fit to go home after delivery (normal vaginal delivery or Caesarean section), the ward nurse shall inform the TPC nurse/midwife to perform the following before discharge:

1. Assess if the client has any relevant personal or emotional issues that need to be addressed.

2. Review with the client the checklist, *Pangangalaga sa Ina sa Loob ng 42 Araw*, found in the Birth Plan:
   a. Sa loob ng 24 oras:
      i. Pag-iksamen at paggagamot ng mga palatandaang nangangailangan ng mabilis na pagkilos (hal., mahirap na paghinga, pangingitim, pagdurugo, lagnat, labis na pananakit ng puson, kombulsyon)
      ii. Vitamin A 200,000 IU cap *(minsan sa loob ng apat na linggo pagkapanganak)*
      iii. Rapid plasma reagin*, kung hindi isinagawa sa panahon ng pagbubuntis*
      iv. Tetanus toxoid *kung hindi naibigay*
      v. Karagdagang iron *at* folic acid *(hanggang tatlong buwan)*

vi. *Pagpapayo sa nutrisyon,* FP *at pag-aagwat ng pag-aanak, pag-alaga sa sanggol at mga susunod na konsultasyon sa* TPC
vii. *Pagbigay ng wastong payo at suporta sa pagpapasuso*

b. *Sa loob ng isang linggo, kung maaari 2-3 araw:*
   i. *Pagsusuring pisikal*
   ii. *Suriin kung may pagdurugo o may masangsang na amoy mula sa puwerta*
   iii. *Presyon ng dugo*
   iv. *Karagdagang* iron *at* folic acid
   v. Vitamin A*, kung hindi pa nabigyan*
   vi. *Tingnan kung may suliranin sa pagpapasuso*
   vii. *Suriin kung may mga mapanganib na palatandaan: lagnat, impeksyon sa daluyan ng ihi o sa sugat (sa pwerta o sa tiyan kung* Caesarian*), pananakit sa paligid ng pwerta, pamumutla o anemia*

c. *At 4-5 linggo:*
   i. *Pagsusuring pisikal*
   ii. *Karagdagang* iron *at* folic acid
   iii. *Suriin kung may mga panganib na palatandaan*
   iv. *Pagpapayo sa nutrisyon at pagpaplano ng pamilya*

3. Assist the client in completing the portion on *Tala ng Aking Pagkapanganak* in the Birth Plan.

4. The TPC nurse/midwife shall perform the following if the client is an FP acceptor or potential acceptor:
   a. Ensure that all potential acceptors have secured parent/guardian consent and that FP Form 1 is completely accomplished with signatures affixed.
   b. If the client was inserted with PPIUD, the TPC nurse/midwife (if trained in PPIUD) or any PPIUD provider of the hospital shall provide the client with post-IUD insertion counseling such as schedule for next visit for checkup, cutting of string, expected signs and symptoms, and potential complications and what to do.
   c. If client signified accepting a Progestin-only Pill after being counseled by the FPCBT1-trained TPC nurse/midwife, provide the pill prior to discharge.
   d. If the client, after being properly counseled, signified accepting PSI and the parent/guardian consent has been secured, FP Form 1 shall be completely accomplished and the client shall be referred to the PSI provider of the FP clinic for PSI insertion prior to discharge.
   e. Provide the client with an accomplished FP Card and instruct the client to always bring the card during subsequent FP checkup and resupply, whether at the TPC, hospital FP clinic or other SDN member facilities, e.g., RHU.

5. The TPC nurse/midwife shall endorse all accomplished FP Forms 1 of adolescent clients to the FP Clinic for recording and reporting.

6. The TPC nurse/midwife shall inform the postpartum adolescent about the schedule of her postpartum visit at the TPC.

7. When applicable/available, the client may be referred to a breastfeeding support group for breastfeeding counseling.

8. Request the client to accomplish the Client Feedback Form (*Annex 17*)

VII. Management Functions

Financing

Ensuring the financial protection of an adolescent client and her newborn, particularly those belonging to the *Listahanan* or *Pantawid Pamilyang Pilipino Program* (4Ps) and Modified Conditional Cash Transfer (MCCT) program, is a vital component of TPC operations that should be running smoothly and implemented in accordance with existing government guidelines.

1. **Ensuring awareness and utilization of the PhilHealth benefits packages.** The TPC Coordinator/nurse/midwife shall ensure maximum utilization of the PhilHealth maternal care/ newborn care and family planning (FP) benefit packages that can be availed of by the adolescent and her newborn. (*Annex 18*)

2. **Determining classification and eligibility of the adolescent client.** The TPC Coordinator/nurse/midwife shall refer the pregnant adolescent client to the Medical Social Services Unit which, in coordination with the PhilHealth point person, shall determine the adolescent client's eligibility to PhilHealth benefits and how to enroll her if the client is not yet enrolled or enrolled but not yet eligible. (*Annex 19*)

3. **Enrolling adolescent clients to ensure PhilHealth eligibility.** The TPC Coordinator/nurse/midwife shall refer the pregnant adolescent to the Medical Social Services to ensure that she and her newborn baby are covered by social health insurance. (*Annex 20*)

Logistics

The TPC shall ensure tracking of expendable clinic commodities, especially drugs, medical supplies, and FP commodities. It is critical that the clinic is able to organize and update records for quantities received, quantities dispensed to clients, quantities issued to other hospital departments, if any, and quantities in stock. The TPC shall likewise be able to monitor drug/commodity expiration and ensure that effective standards of procedures for commodity and drugs storage are followed accordingly.

The TPC nurse/midwife designated as the TPC logistics point person shall adopt the logistics forms provided for under the DOH Guide to FP in Hospital Recording and Reporting.

The **TPC Daily Stock Record for FP** will serve as the TPC's basis for determining FP commodity availability. Critical in the implementation of TPC is ensuring commodity security; thus, tracking of commodities available at the end of each day/month is vital. The TPC nurse/midwife shall keep the TPC Daily Stock Record and shall account for the following:

- Quantities in stock (previous month's balance)
- Quantities received
- Quantities dispensed to clients
- Losses (noted during inventory) and Expiring Commodities
- Stock available at the end of the day/month

From the daily recording, the TPC nurse/midwife shall compute for the balance of commodities every day and at the end of each month.

The TPC nurse/midwife shall submit to the FP Clinic every afternoon the following:

- **Daily Stock Record Book** (*Annex 21*)
- **Daily Dispensing Record Book** (*Annex 22*)

The TPC nurse/midwife shall likewise submit to the FP Clinic the **Monthly Physical Inventory and Commodity Expiration Record** (*Annex 23*) every 5th working day of the following month.

Recording and Reporting

The TPC will adopt a set of recording and reporting tools to help track its accomplishments vis-à-vis some indicators. These indicators include, but are not limited to the following:

For tracking early and timely referral of currently pregnant adolescents to the TPC and the provision of maternal and child care and FP services:

1. Number of adolescents, 10-19 years old, seen at the TPC, disaggregated by source of referral (e.g., school/Teen Health Kiosk, RHU, private lying-in clinic, walk-in, etc.)
2. Number of adolescents, 10-19 years old, provided with antenatal services
3. Number of adolescents, 10-19 years old, who attended health education classes
4. Number of newborns provided with postnatal services

For the prevention/delay of closely spaced pregnancy through postpartum FP counseling and services:

1. Number of adolescents, 10-19 years old, who received FP counseling
2. Number of adolescents, 10-19 years old, who used an FP method

The TPC Coordinator shall designate the administrative assistant as the recording and reporting point person to ensure complete, accurate, timely and reliable recording and reporting of TPC performance to the TPC Management Committee.

TPC Recording Form

The TPC Adolescent Target Client List (*Annex 12*) will serve as the main client record of all pregnant and postpartum adolescents who avail of TPC services. It consists of three sections (Prenatal Services, Postpartum Services, and Family Planning Services) that show the continuum of care given to TPC clients, starting from psychosocial assessment and counseling, antenatal care, health education, labor/delivery, postpartum care, postnatal care, breastfeeding counseling, family planning counseling and services, as well as referral to other relevant agencies/institutions.

To facilitate the timely recording of all TPC clients served during the day, an electronic version of the Target Client List will be made available.

FP Form 1 and Parental Consent Form

Upon a client's expression of intent to accept an FP method, the FPCBT1 and AJA-trained TPC health service provider will need to conduct a thorough assessment of the client and generate critical information by filling out FP Form 1. FP Form 1 (*Annex 13*) serves as the client's Individual Treatment Record (ITR) for FP services. This is a two-page form, the front page of

which is divided into five sections, namely: medical history, obstetrical history, assessment of risk for sexually-transmitted infection, assessment of risk for violence against women (VAW), and physical examination. It also includes sociodemographic information (e.g., client's personal data, type of acceptor, and FP method used) and an acknowledgment section requiring the client's signature to signify that she/he has been provided FP counseling.

The updated FP Form 1 likewise includes a section on parental/guardian consent. This is a prerequisite for clients under 18 years of age. The health service provider also has the option to seek parental/guardian consent using the Parental Consent Form (*Annex 14*).

The back portion is divided into columns and generates the following information: date of visit; medical findings (medical observations, complaints, complications, services rendered/procedures, laboratory exams, treatment and referrals); FP method/supplies given (method/brand and number of units); name of provider; and signature and date of follow-up visit.

This record may be accomplished by the FPCBT1-trained TPC health service provider for FP counseling/services provided at the TPC, but the forms will be endorsed by the TPC to the hospital's FP Clinic for safekeeping.

TPC Reporting Form

The **TPC Reporting Form** (*Annex 16*) captures the monthly summary of the following indicators:

I. Demographics
   a. Number of adolescents who got pregnant while in school, disaggregated by grade/year level
   b. Number of pregnant out-of-school adolescents
   c. Gravidity/parity of pregnant adolescents
   d. Number of adolescents with PhilHealth coverage
   e. Number of adolescent clients disaggregated by residence
II. Referrals
   a. Total incoming referrals, disaggregated by source
   b. Total incoming referrals with referral slip
   c. Number of adolescents referred from the TPC to other departments/facilities/agencies, disaggregated by classification of referral facility
III. Antenatal Services
   a. Number of adolescents who received psychosocial counseling
   b. Number of adolescents provided antenatal services, disaggregated by age of gestation (AOG) at first visit
   c. Number of adolescents who completed 4ANC
   d. Number of adolescents who attended health education sessions
IV. Delivery, Postpartum and Postnatal Services
   a. Number of adolescents who delivered in the facility, disaggregated by type of delivery
   b. Number of adolescents who received postpartum services
   c. Number of newborns provided postnatal services
V. Family Planning Services
   a. Number of adolescents who received FP counseling
   b. Preferred FP method of adolescents
   c. Number of adolescents who utilized FP methods, disaggregated by method

The TPC Reporting Form is accomplished by the TPC administrative assistant, reviewed by the TPC coordinator, and submitted to the Medical Center Chief/Chief of Hospital within 15 days after the month being reported, copy-furnishing the Ob-Gyn Department Head.

Monitoring and Evaluation

The TPC Management Committee shall review and approve the annual TPC work and financial plan, incorporate this into the hospital's Annual Operational/Work and Financial Plan, and monitor the implementation of this plan.

The committee shall meet regularly based on an agreed upon schedule. Special meetings, however, may be called as the need arises or upon the request of any member of the committee.

The TPC Management Committee shall likewise lead the conduct of a semiannual TPC Program Implementation Review to determine the progress of implementation of the TPC work plan, review performance versus planned targets and objectives, and recommend specific actions to address the identified challenges and difficulties. The TPC Scoping Tool can likewise be used to regularly assess the status of the TPC and hospital services prior to the scheduled Program Implementation Review.

Quality Assessment

To ensure that services provided by the TPC are delivered consistently and efficiently, assessment of the quality of services for adolescents in relation to the list of adolescent-friendly characteristics outlined by the WHO for adolescent-friendly health services will be done. Assessment will be initiated by the TPC Coordinator, with representatives from the TPC Management Committee. This will be held on a regular basis with presentation of results to stakeholders. The tool for assessment will be adapted from the *Quality Assessment Guidebook: A Guide to Assessing Health Services for Adolescent Clients* published by the WHO (2009).

A Case Conference will be held to discuss both a success story and a difficult case encountered at the TPC. It will highlight several areas of concern such as client profile, interventions made at the TPC and relevant units of the hospital, and outcome of the client encounter. This will be presented by the TPC Coordinator of the case to relevant stakeholders.

According to the *WHO Quality Assessment Guidebook: A Guide to Assessing Health Services for Adolescent Clients* (2009), health services, to be considered adolescent-friendly, should have the following characteristics:

1. Equitable: All adolescents, not just certain groups, are able to obtain the health services they need.
2. Accessible: Adolescents are able to obtain the services that are provided.
3. Acceptable: Health services are provided in ways that meet the expectations of adolescent clients.
4. Appropriate: The health services that adolescents need are provided.
5. Effective: The right health services are provided in the right way and lead to a positive contribution to the health of adolescents.

The WHO guidebook further lists down specific adolescent-friendly characteristics under each major characteristic outlined above. These characteristics will be used as standards by which the TPC will be assessed by relevant stakeholders. The table below shows the detailed list of characteristics and their corresponding definitions.

CHARACTERISTIC	DEFINITION
Equitable: All adolescents, not just certain groups, are able to obtain the health services they need.	
Policies and procedures are in place that do not restrict the provision of health services on any terms.	No policies or procedures restrict the provision of health services to adolescents on the basis of age, sex, social status, cultural background, ethnic origin, disability or any other area of difference.
Health care providers treat all adolescent clients with equal care and respect, regardless of status.	Health care providers administer the same level of care and consideration to all adolescents regardless of age, sex, social status, cultural background, ethnic origin, disability or any other reason.
Support staff treat all adolescent clients with equal care and respect, regardless of status.	Support staff administers the same level of care and consideration to all adolescents regardless of age, sex, social status, cultural background, ethnic origin, disability or any other reason.
Accessible: Adolescents are able to obtain the services that are provided.	
Policies and procedures are in place to ensure that health services are either free or affordable to adolescents.	All adolescents are able to receive health services free of charge or are able to afford any charges that might be in place.
The point of health service delivery has convenient hours of operation.	Health services are available to all adolescents during convenient times of the day.
Adolescents are well-informed about the range of available reproductive health services and how to obtain them.	Adolescents are aware of what health services are being provided, where they are provided, and how to obtain them.
Community members understand the benefits that adolescents will gain by obtaining the health services they need, and support their provision.	Community members (including parents) are well-informed about how the provision of health services could help adolescents. They support the provision of these services as well as their use by adolescents.
Some health services and health-related commodities are provided to adolescents in the community by selected community members, outreach workers and adolescents themselves.	Efforts are underway to provide health services close to where adolescents are. Depending on the situation, outreach workers, selected community members (e.g., sports coaches) and adolescents themselves may be involved in this.
Acceptable: Health services are provided in ways that meet the expectations of adolescents.	
Policies and procedures are in place to guarantee client confidentiality.	Policies and procedures are in place to maintain confidentiality of adolescents' information at all times (except where staff are obliged by legal requirements to report incidents such as sexual assaults, road traffic accidents or gunshot wounds, to the relevant authorities). Policies and procedures address: 1. Registration – Information on the identity of the adolescent and the presenting issue are

CHARACTERISTIC	DEFINITION
	gathered in confidence. 2. Consultation – Confidentiality is maintained throughout the visit of the adolescent to the point of health service delivery (i.e., before, during and after a consultation). 3. Record-keeping – Case records are kept in a secure place, accessible only to authorized personnel. 4. Disclosure of information – Staff do not disclose any information given to or received from an adolescent to third parties such as family members, school teachers or employers, without the adolescent's consent.
The point of health service delivery ensures privacy.	The point of health service delivery is located in a place that ensures the privacy of adolescent users. It has a layout that is designed to ensure privacy throughout an adolescent's visit. This includes the point of entry, the reception area, the waiting area, the examination area, and the patient-record storage area.
Health care providers are nonjudgmental, considerate, and easy to relate to.	Health care providers do not criticize their adolescent patients even if they do not approve of the patients' words and actions. They are considerate to their patients and reach out to them in a friendly manner.
The point of health service delivery ensures that consultations occur in a short waiting time, with or without an appointment, and (where necessary) with swift referral.	Adolescents are able to consult with health care providers at short notice, whether or not they have a formal appointment. If their medical condition is such that they need to be referred elsewhere, the referral appointment also takes place within a short time frame.
The point of health service delivery has an appealing and clean environment.	The point of health service delivery is welcoming, attractive and clean.
The point of health service delivery provides information and education through a variety of channels.	Information that is relevant to the health of adolescents is available in different formats (e.g., posters, booklets and leaflets). Materials are presented in a familiar language, easy to understand and eye-catching.
Adolescents are actively involved in designing, assessing and providing health services.	Adolescents are given the opportunity to share their experiences in obtaining health services and to express their needs and preferences. They are involved in certain appropriate aspects of health service provision.
Appropriate: The health services that adolescents need are provided	
The required package of health care is provided to fulfil the needs of all adolescents either at the point of health service delivery or through referral linkages.	The health needs and problems of all adolescents are addressed by the health services provided at the point of health service delivery or through referral linkages. The services provided meet the special needs of marginalized groups of

CHARACTERISTIC	DEFINITION
	adolescents and those of the majority.
Effective: The right health services are provided in the right way and make a positive contribution to the health of adolescents	
Health care providers have the required competencies to work with adolescents and to provide them with the required health services.	Health care providers have the required knowledge and skills to work with adolescents and to provide them with the required health services.
Health care providers use evidence-based protocols and guidelines to provide health services.	Health service provision is based on protocols and guidelines that are technically sound and of proven usefulness. Ideally, they should be adapted to the requirements of the local situation and approved by the relevant authorities.
Health care providers are able to dedicate sufficient time to work effectively with their adolescent clients.	Health care providers are able to dedicate sufficient time to work effectively with their adolescent clients.
The point of health service delivery has the required equipment, supplies, and basic services necessary to deliver the required health services.	Each point of health service delivery has the necessary equipment, supplies, including medicines, and basic services (e.g., water and sanitation) needed to deliver the health services.

For each characteristic, the TPC Coordinator will conduct individual interviews and focus group discussions with relevant stakeholders which include the following: adolescent client, health care provider, health facility manager, and support staff. Each characteristic may be assessed using a Likert scale or any scoring tool that is easy to interpret. Comments and feedback on each characteristic will be collected as well to provide some basis for the quantitative assessment.

Finally, for each characteristic found to be weak, the TPC Coordinator along with key opinion leaders will then list down the action points for improvement, time frame for improvement, and the point person, in achieving these goals.

Annexes

Annex 1: National Policy and Strategic Framework on Adolescent Health and Development (DOH Administrative Order 2013-0013)

Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

MAR 2 1 2013

ADMINISTRATIVE ORDER
No. 2013 - 0013

SUBJECT: National Policy and Strategic Framework on Adolescent Health and Development

I. BACKGROUND AND RATIONALE

The twenty million (19,844,578) adolescents age 10-19 years comprise21.5% of the country's population (NSO, 2010). Thus, they are essential to achieve the Millennium Development Goals and should be part of the national strategy to reduce poverty.
Adolescents face many threats to their health and well-being. While mortality rate in this age group are low, they are susceptible to conditions that are related to their increased mobility, socialization (Valenzuela-Teoxon, 2007), and risk-taking behavior. One in every 10 young women ages 15-19 is already a mother, doubling the likelihood of maternal death compared to those over 20 years (DOH, UNFPA, WHO, 2002) and increasing the risk of dropping out of school and facing limited economic opportunities. Sixteen (16) percent of abortion attempts occur among teenagers (Singh, 2006).Sexually Transmitted Infections, HIV and AIDS, drugs, alcohol, and smoking are also on the rise among adolescents. Drowning and transport accidents are among the top five causes of death among the 10-14 and 15-19 age group(DOH, 2005). Three percent of young people ages 15-27 have attempted to commit suicide (UPPI/DRDF, 2002).Issues of assault and bullying are also causing increasing concern among parents, educators, and adolescents themselves.

Administrative Order 34-A, s 2000, the Adolescent and Youth Health (AYH) Policy was issued in April 2000, creating the Adolescent and Youth Health Sub-program under the Program for Children's Health Cluster of Family Health. It envisions "well-informed, empowered, responsible and health adolescents & youth" and had a mission to "ensure that all adolescents & youth have access to quality comprehensive health care and services in an adolescent & youth-friendly environment".

In 2006, the Department of Health (DOH) created the Technical Committee for Adolescent and Youth Health Program (AYHP), composed of both government and non-government organizations dedicated to uplifting the welfare of adolescents and tasked to revitalize the AYHP. The committee embarked on a Strategic Plan for Accelerated Action on Adolescent Health. In 2010, the National Center for Disease Prevention and Control (NCDPC) drafted a National Standards and Implementing Guide for Adolescent Friendly Health Facility, an Adolescent Job Aid manual and a Primer on Legal Bases for the Adolescent Health Services in the Philippines.

Due to an increasing health risky behavior among our Filipino adolescents, the DOH embark on revising the current policy and address the major adolescent health problems, marginalized groups and humanitarian emergency settings and to provide

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clear understanding among implementers and to guarantee program sustainability thus this Order is developed.

II. DECLARATION OF POLICIES

1. *The 1987 Philippine Constitution* charges the State to promote and protect the youth's physical, moral, spiritual, intellectual, and social well-being and prioritizes the health of children.
2. *The Convention on the Rights of the Child,* which the Philippines ratified with the force of law in 1990, defines a child as "every human being below the age of 18 years unless, under the law applicable, majority is attained earlier" and directs States to "strive to ensure that no child is deprived of his or her right of access to such health care services."The Committee on the Rights of the Child, in its General Comment No. 4 (2003) emphasized Adolescent Health and Development in the context of the CRC (CRC/GC/2003/4)
3. The Report of the International Conference on Population and Development(ICPD, 1994), Chapter VI, B. 6.15, states that "Youth should be actively involved in the planning, implementation and evaluation of development activities that have a direct impact on their daily lives. This is especially important with respect to information, education and communication activities and services concerning reproductive and sexual health, including the prevention of early pregnancies, sex education and the prevention of HIV and other sexually transmitted diseases."
4. In September 2000, the Philippines and other member nations ratified and signed the Millennium Declaration which embodies global and country commitments, specific targets and milestones for 2015, including the Eradication of extreme poverty and hunger (MDG 1), Promotion of gender equality and empowerment of women (MDG 3), Reduction of Child Mortality (MDG 4), Improvement of Maternal Health (MDG 5), and Combating HIV and AIDS, malaria, and other diseases (MDG 6)
5. Republic Act No. 10354, signed into law on December 21, 2012, provided for a National Policy on Responsible Parenthood and Reproductive Health.
6. Administrative Order No. 43 s. 2000 adopted the elements of Reproductive Health Framework which includes services for Adolescent and Youth Health (AYH), Violence Against Women & Children (VAWC), Family Planning (FP), Maternal and Child Health & Nutrition (MNCHN), Prevention and Management of Abortion and its Complication (PMAC), Prevention and Management of Reproductive Tract Infections (RTI), Education and Counseling on Sexuality and Sexual Health, Breast & Reproductive Tract Cancers & other Gynecological Conditions, Men's Reproductive Health, and Prevention & Management of Infertility & Sexual Dysfunction.
7. AO 2008-0029 was enacted for Implementing Health Reforms for Rapid Reduction of Maternal and Neonatal Mortality
8. AO 2006-0016 provided a National Policy and Strategic Framework on Child Injury Prevention
9. AO 2007-0010 provided a National Policy on Violence and Injury Prevention
10. AO 2011-0003 enacted the National Policy on Strengthening the Prevention and Control of Chronic Lifestyle Related Non-Communicable Diseases

11. RA 8371 promotes the Rights of Indigenous Cultural Communities/ Indigenous Peoples

III. OBJECTIVES

This Order aims to:

1. Provide a strategic framework for the Adolescent Health Program that is anchored on Universal Health Care
2. Provide policy direction and guidance for DOH offices, its attached agencies, LGUs, and development partners in prioritizing interventions for adolescent health

IV. COVERAGE AND SCOPE OF APPLICATION

This Order shall apply to the entire public and private health system, to include DOH bureaus, Centers for Health Development (CHDs), hospitals and other health facilities, attached agencies, local government facilities, external development partners and other stakeholders implementing health programs for and with adolescents.

V. DEFINITION OF TERMS

1. Adolescent: refers to young people between the ages of 10 and 19 years who are in transition from childhood to adulthood (RA10354) and are the primary targets of this Order, differentiated from "youth" and "young people".

2. Early adolescence is from 10-13 years old. Middle adolescence 14-16 years. Late adolescence 17-19 years. (Philippine Pediatric Society)

3. Children refers to person below eighteen (18) years of age or those over but are unable to fully take care of themselves or protect themselves from abuse, neglect, cruelty, exploitation or discrimination because of a physical or mental disability or condition.(RA 7610).

4. Adolescent Health is a state of complete physical, mental and social well-being of persons aged 10-19 years.

5. Reproductive Health Rights of Adolescents and Youth refer to their human right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health (CPD, 2012)

6. Early pregnancy: refers to pregnancy in women less than 20 years old.
7. Bullying or Peer Abuse: refers to willful aggressive behavior that is directed towards a particular victim who may be out-numbered, younger, weak, with disability, less confident, or otherwise vulnerable (DepEd)

8. Empowerment: refers to having a sense of self-worth; to have and to determine choices, access to opportunities and resources, the power to control their own lives; and the ability to influence the direction of social change to create a more just social and economic order, nationally and internationally.(UN, 2001)

9. Adolescent Participation: refers to public processes in which adolescents are involved in decision making, either directly or through representatives. Adolescent

participation recognizes adolescents as citizens and stakeholders in the present – not just in the future. (IAWGCP, 2007)

10. Evolving Capacities: The UNCRC recognizes that children in different environments and cultures, with different life experiences, will acquire competencies at different ages, and this process will vary according to circumstances. Children do not acquire competencies merely as a consequence of age, but rather through experience, culture, and levels of parental support and expectation. Evolving capacities is central to the balance between empowerment and protection. (Save the Children, 2007)

11. Life skills are abilities for adaptive and positive behavior that enable individuals to deal effectively with the demands and challenges of everyday life (WHO definition)

12. The Private Sector refers to health providers and facilities (individual practitioner, clinics, hospitals, facilities, drug outlets) licensed and regulated under existing laws but otherwise operating outside the ownership or management of the government.(DOH AO 2012-0004).

VI. GENERAL GUIDELINES

1. The Adolescent Health and Development Program (AHDP) shall be in accordance with the thrusts of the National Objectives for Health, the Philippine Development Plan, the AIDS Medium Term Plan, the Millennium Development Goals, and the Philippine Youth Development Plan of the National Youth Commission.

2. The AHDP shall target primarily adolescents age 10-19 years. This will complement the roles of the Council for the Welfare of Children, which serves to protect the rights of children under 18 years old, and the National Youth Commission, which is mandated to provide leadership in the formulation of policies for youth ages 15-30. Few programs address the unique health needs of very young adolescents ages 10-14. Thus resources need to be directed to this age group while also preventing pregnancies before the age of 20, when there is an increased risk of maternal (DOH, UNFPA, WHO, 2002) and infant (Phipps, 2002) mortality, low birth weight babies (NSO) , and limiting of the woman's education and livelihood opportunities.

3. The AHDP shall aim to achieve the following health outcomes: (1) Healthy Development; (2) Healthy Nutrition; (3) Sexual and Reproductive Health; (4) reduction of substance use; (5) reduction of injuries and mortality, morbidity and psychosocial consequences of injures; (6) reduction of all forms of violence and mortality, morbidity and psychosocial consequences of violence; and (7) Mental health. (National Standards and Implementation Guide for the Provision of Adolescent-Friendly Health Services, DOH, 2010)

4. The AHDP recognizes the risks inherent to early sexual initiation or having one's first sexual intercourse occurring before the adolescent is physically and psychosocially capable of dealing with the consequences of sexual intercourse and shall aim to delay sexual initiation among adolescents.5. The AHDP shall respect the rights of all adolescents. Specific strategies for marginalized and vulnerable

groups need to be put in place to promote equity and inclusion. Marginalized groups include, but are not limited to, the following: Adolescents in Indigenous Communities as defined in RA 8371, Adolescents (Persons) with Disability (RA 9442), Adolescents (Children) in Conflict with the Law (RA 9344), Drug-dependent Adolescents (RA 9165), Abandoned and Neglected Adolescents (RA 9523), Adolescents on the Streets, Adolescents in Commercial Sexual Exploitation, Adolescent Survivors of Calamity, Adolescents in Situations of Armed Conflict, Adolescent Key Affected Populations, Adolescent Survivors of Abuse and Exploitation (RA 7610).

6.6. Program strategies shall include:

a. Health Promotion and Behavior Change for adolescents to utilize health services, practice healthy behaviors, avoid risks, and participate in governance and policy decisions affecting their health and development
b. Improving access to quality and adolescent-friendly health care services and information for adolescents, including access to quality hospitals and health care facilities following the National Standards and Implementation Guide for Adolescent-friendly Health Services and utilizing various settings outside the health system, such as schools, cruising sites, and social media, to promote adolescent health.
c. Expanding Health Insurance. The DOH shall design a proposal for an Adolescent Health Package with PhilHealth while mobilizing other sources of financing such as local government and the private sector.
d. Enhancing skills of service providers, families, and adolescents to protect their health and development
e. Strengthening partnerships among adolescent groups, government agencies, civil society, the private sector, families and communities to make them accountable for the achievement of MDGs
f. Strengthening policy at all levels to ensure that all adolescents have access to information and services
g. Ensuring sufficient resources to implement a sustainable adolescent health program
h. Resource mobilization. The Department of Health and Centers for Health Development shall provide funds for technical assistance, monitoring, and advocacy. The Council for the Welfare of Children, National Youth Commission, Department of Education, and Department of Social Welfare and Development shall provide counterpart funds to implement the Adolescent Health and Development Program within the scope of their responsibility. The Philippine Health Insurance Corporation shall develop benefits coverage for adolescent members and beneficiaries. Local government units shall provide funding for the implementation of the AHDP in their area, mobilizing external resources and internal funding such as SK funds and the GAD budget.

7.7. Monitoring and Evaluation systems shall be strengthened to improve access to strategic information to effectively assess the attainment of goals and utilize data in developing programs to forward adolescent health. To this end, the DOH shall develop a Five-year Strategic Plan for the AHDP with Goals, Objectives, Indicators, and Targets, including a monitoring and evaluation plan to measure attainment of

the goals and objectives. The DOH and the National Statistics Office shall provide the necessary data, including baseline data disaggregated for the 10-19 age groups.

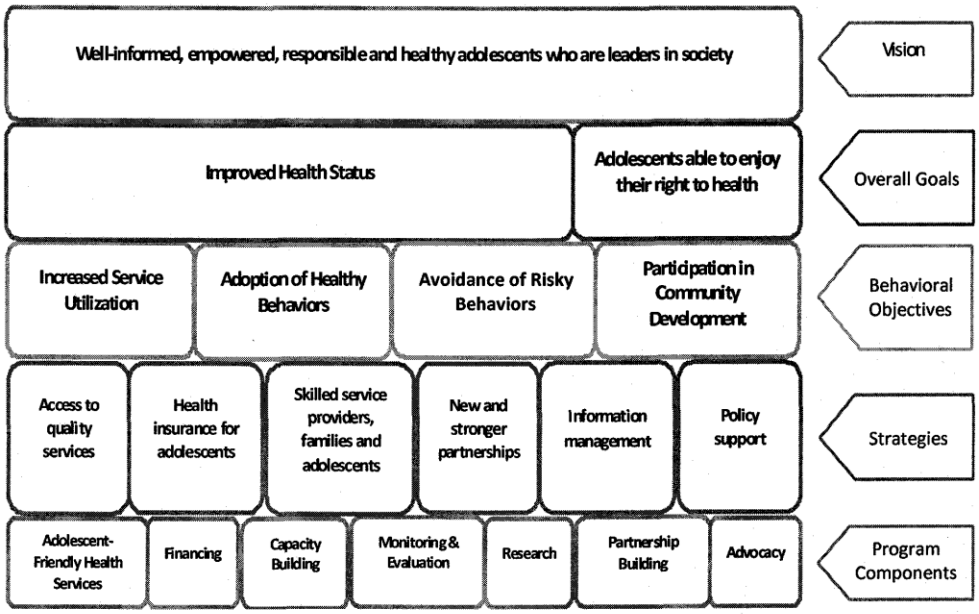
VII. STRATEGIC FRAMEWORK

Strategies of the AHDP shall be designed in accordance with the Program's Vision, Mission, and Goals. Health status outcomes and adolescents' rights shall be enjoyed through positive behavior change, which are achieved by a variety of strategies. In turn, these strategies will be built upon actionable program components. These elements are non-linear as multiple health and development goals call for a range of interventions delivered in an integrated manner.

1. **VISION AND MISSION**
   Vision: Well-informed, empowered, responsible and healthy adolescents who are leaders in society
   Mission: Ensure that all adolescents have access to quality comprehensive health care and services in an adolescent-friendly environment
2. The AHDP's **OVERALL GOALS** are to improve the health status of adolescents and to enable them to fully enjoy their right to health.
3. **GUIDING PRINCIPLES**

   a. The Adolescent Health Program is guided by the Convention on the Rights of Children which states that it should be of the ***Best interests of the child; the adolescent's rights are indivisible and interrelated; Non-discrimination, have Access to accurate information; have access to life-saving interventions*** as long as he/she is mature enough to face the consequences***; contain a meaningful adolescent participation; recognize adolescent as a whole person needing supportive environment; suitable Life skills to help him/her cope with and manage their lives in a healthy and productive manner; capacitate the family as the primary source of basic knowledge, behavior, attitudes, and skills necessary for his/her well being; a Life Cycle Approach where it continue to affect health and development of an adolescent from infancy to parenthood;*** Respect the adolescent's right to ***privacy and confidentiality***, including with respect to advice and counseling on health matters; Recognize the involvement, commitment, accountability, and ***responsibility in all areas o***f sexual and reproductive health as well as the protection and promotion of reproductive health concerns specific to men and boys(UNFPA); Recognize the positive impact of ***peer education***, and the positive influence of ***proper role models***, especially those in the worlds of arts, entertainment and sports (CRC/GC/2003/4)

STRATEGIC FRAMEWORK



VIII. IMPLEMENTING MECHANISMS

1. ORGANIZATIONAL STRUCTURE

The DOH shall act as the lead agency, along with the LGUs, for the implementation of this Order. The National Center for Disease Prevention and Control - Family Health Office shall designate a Sub-program Manager for Adolescent Health and Development. The DOH shall convene a Technical Working Group on Adolescent Health and Development whose primary role is to oversee the implementation of the Program and monitor progress based on the M&E Framework.

IX. ROLES AND RESPONSIBILITIES

1. **DOH - National Center for Disease Prevention and Control (NCDPC), National Center for Health Promotion(NCHP), National Epidemiology Center (NEC), Philippine National Aids Council (PNAC)**
   - Serve as the focal point for overall planning, management, monitoring, and evaluation of the AHDP
   - Provide technical leadership in all matters pertaining to the AHD
   - Advocate for adolescent health and development in national and local public forums
   - Ensure meaningful participation of adolescents at all stages of the program cycle

- Create, strengthen, and maintain inter-agency links and public-private partnerships
- Formulate an age- and development-appropriate Reproductive Health and Sexuality Education curriculum in coordination with the DSWD, DepEd, CHED, and TESDA,
- Provide parents with adequate and relevant scientific materials on the age-appropriate topics and manner of teaching Reproductive Health and Sexuality Education to their children
- Development, implementation, and monitoring of a Health Promotion, Communications, and Advocacy Plan for Adolescent Health and Development
- Provide age-disaggregated data necessary to for monitoring and evaluation of results of the AHDP
- Provide technical assistance and guideline in matters pertaining to STI and HIV and AIDS and services for Young Key Affected Populations

2. **Center for Health Development**
   The Centers for Health Development are responsible for:
   - Localization and dissemination of this Order
   - Providing technical assistance to local government units in implementation
   - Monitoring results and reporting these to the DOH Central Office
   - Creating inter-agency links to support local government units in implementation of the AHDP
   - Advocating for policies and resources at the local level.
   - Ensuring that hospitals and health care facilities under CHD management meet the National Standards for the Provision of Adolescent-Friendly Health Services.

3. **Department of Education (DepEd), Commission on Higher Education (CHED), and Technical Education and Skills Development Authority (TESDA)**
   - With the DOH and DSWD, formulate an age- and development-appropriate Reproductive Health and Sexuality Education curriculum
   - Provide parents with adequate and relevant scientific materials on the age-appropriate topics and manner of teaching Reproductive Health and Sexuality Education to their children
   - Integrate other adolescent health concerns in school curriculum
   - Mobilize teachers, guidance counselors, and parents to implement the AHDP

4. **Department of Social Welfare and Development (DSWD)Commission on Population (POPCOM),National Anti-Poverty Commission (NAPC),**
   - With the DOH, DepEd, CHED, and TESDA, formulate an age- and development-appropriate Reproductive Health and Sexuality Education curriculum
   - Provide parents with adequate and relevant scientific materials on the age-appropriate topics and manner of teaching Reproductive Health and Sexuality Education to their children

- Provide adolescent-friendly health services and protection to adolescents who are out of school, with disabilities, in conflict with the law, drug dependent, on the streets, in prostitution, survivors of calamity, in situations of armed conflict, and survivors of abuse and exploitation
- Train multi-disciplinary teams for Women and Child Protection Units and sustain 24/7 Crisis Interventions Units in every region
- Formulate policies, programs and measures on adolescent participation
- Assist in monitoring and evaluation of results of the AHDP
- Create inter-agency links to build the support of local government units for the implementation of the AHDP
- Advocate, mobilize and generate resources for adolescent development

5. **Council for the Welfare of Children (CWC)**
   - Integrate adolescent health and development in national and local development plans
   - Advocate for adolescent rights as enshrined in the CRC
   - Include adolescent health and development issues in the Country Report to the CRC

6. **Commission on Human Rights (CHR)**
   - Integrate the rights of adolescents in information and public advocacy, research, and training
   - Investigate violations of adolescents' rights and provide legal aid

7. **National Statistics Office (NSO)**
   - Provide age-disaggregated data necessary to for monitoring and evaluation of results of the AHDP

8. **Philippine Health Insurance Corporation (PhilHealth)**
   - Provide benefits coverage for adolescents, particularly marginalized sub-sectors

9. **Professional Medical and Allied Medical Associations, Academic Institutions, Adolescent and Youth Organizations**
   - Develop members' capacity to provide adolescent-friendly health services
   - Provide technical assistance in the formulation of policies, guidelines, and tools for adolescent health and development
   - Contribute to research on adolescent health and development
   - Participate in monitoring and evaluation of results of the AHDP
   - Advocate for adolescent rights as enshrined in the CRC
   - Participate in the design and implementation of adolescent health and development programs
   - Participate in the monitoring and evaluation of results of the AHDP

10. Non-Government, Faith-based, Civil Society Organizations, the United Nations and other development partners working with and for adolescents

- Implement adolescent-centered programs and outreach services in priority communities that are consistent with the AHDP in coordination with government agencies
- Provide technical assistance in the formulation of policies, guidelines, and tools for adolescent health and development
- Contribute to research on adolescent health and development
- Advocate, mobilize and generate resources for adolescent health and development

11. Private Sector

- Enforce policies for the protection of adolescent employees
- Implement workplace programs for parents of adolescents
- Support adolescent health and development activities in communities, schools, and other settings

12. Local Government Units

- The provision of reproductive health information, care and supplies shall be the joint responsibility of the National Government and Local Government Units (LGUs).
- LGUs must ensure provision of basic adolescent health care services including, but not limited to, the operation and maintenance of facilities and equipment necessary for the delivery of a full range of reproductive health care services and the purchase and distribution of family planning goods and supplies as part of the essential information and service delivery package defined by DOH.
- LGUs, specifically the Rural Health Units, City Health Offices, and Provincial Health Offices, are responsible for designing, funding, implementing, and monitoring local Adolescent Health and Development programs suited for adolescents in their area, in partnership with youth, government agencies, civil society, and the private sector, under the technical guidance of the CHD and this Order. LGUs should design specific strategies to reach marginalized and vulnerable adolescent sub-sectors. They should ensure meaningful participation of adolescents and communities in this process. Hospitals and health care facilities under LGU management must meet the National Standards for the Provision of Adolescent-Friendly Health Services.

X. REPEALING CLAUSE

The provisions of previous Orders and other related issuances inconsistent or contrary with the provisions of this Administrative Order, including AO 34-A s, 2000, are hereby revised, modified, repealed or rescinded accordingly. All other provisions of existing issuances which are not affected by this Order shall remain valid and in effect.

XI. SEPARABILITY CLAUSE

If any provision of this Order is declared unauthorized or rendered invalid by any court of law or competent authority, those provisions not affected thereby shall remain valid and effective.

XII. EFFECTIVITY

This Order shall take effect immediately.

[redacted] **MD**
Secretary of Health

Annex 2: National Standards for Adolescent-Friendly Health Services

Standard 1: Adolescents in the catchment area of the facility are aware of the health services it provides and find the health facility easy to reach and obtain services from.

Input criteria:

1.1 There is a well-defined plan to inform adolescents in the community as to the availability of services at the facility.
1.2 The health facility has a signboard which indicates: the type of health services that are provided and when they are provided, and that adolescents are welcome.
1.3 Flexible time schedule for adolescent clients, if possible, is in place.
1.4 Policies and procedures to provide health services to adolescents free of charge or at affordable prices are in place.
1.5 A plan to provide outreach health services to adolescents, particularly those belonging to special groups in the catchment area of the health facility, is in place.

Standard 2: The services provided by health facilities to adolescents are in line with the accepted package of health services and are effectively provided on-site or through referral linkages by well-trained staff.

Input criteria:

2.1 An agreed upon package of services to be provided to adolescents is in place.
2.2 An agreed upon list of essential commodities and supplies is in place.
2.3 A focal person has been designated for the provision of adolescent-friendly health services (AFHS).
2.4 Service providers have been trained/oriented for the provision of AFHS and are competent in managing adolescent clients and providing guidance to their parents.
2.5 Protocols/guidelines to provide services competently in a nonjudgmental, caring, considerate, gender-sensitive and culture-sensitive attitude and manner are in place.
2.6 Clinical management guidelines for the provision of the specified health services are in place.
2.7 A resource directory of organizations and referral networks providing health services that are not provided at the facility is available.
2.8 Appropriate forms for referral and feedback are available.

Standard 3: The health services are provided in ways that respect the rights of adolescents and their privacy and confidentiality. Adolescents find surroundings and procedures of the health facility appealing and acceptable.

Input criteria:

3.1 Standard operating protocols (SOP) to maintain a good ambiance for adolescents, including a clean spacious waiting area, potable drinking water, clean toilets and educational materials, are in place.
3.2 The confidentiality and privacy policy of the facility is clearly displayed in the clinic and is clearly articulated to the client and their parents or accompanying adults.

3.3 Health facility procedures to ensure confidentiality of the adolescent clients and their parents are in place.
3.4 Health facility procedures to ensure privacy for the adolescent clients and their parents are in place.
3.5 Protocols for the staff to provide services in a friendly and appropriate manner are in place.
3.6 Mechanisms to involve adolescents in the designing, provision and assessment of health services are in place.
3.7 The flow design of the utilization of services to keep the waiting time short and informative is in place.

Standard 4: An enabling environment exists in the community for adolescents to seek and utilize the health services that they need and for the health care providers to provide the needed services.

Input criteria:

4.1 A plan of activities (including community assemblies, meetings with parents, group meetings and school visits) to be carried out in the community to inform community members about the benefits and availability of services to adolescents is in place.
4.2 Procedures to communicate with all adults visiting the health facility the benefits and availability of services to adolescents are in place.
4.3 Plans to provide some health services and commodities to adolescents by selected community members, NGOs, outreach workers and adolescents themselves are in place.
4.4 A plan to carry out advocacy for support to provision of services for adolescents from the Local Development Plan exists.

Source: Adolescent Health and Development Program Manual of Operations, DOH, 2017

Annex 3: Hospital Order (Sample)

Republic of the Philippines
Department of Health, Regional Office IV-A
BATANGAS MEDICAL CENTER
Batangas City
ISO 9001:2008 CERTIFIED

HOSPITAL ORDER

January 4, 2017

HOSPITAL ORDER
NO. 041, s. 2017

Effective immediately, the following personnel hereby compose the **TEEN-PARENTS CLINIC HOSPITAL COMMITTEE** for the period of one year:

Chairperson: [redacted]

Vice-Chairperson: [redacted]

Members:

[redacted] – Family Medicine/OPD
[redacted] – Gender and Development
[redacted] – OB GYNE Department
[redacted] – Dental
[redacted] – Budget Office
[redacted] – Hospital Information Management
[redacted] – Nursing Service
[redacted] – Health Education and Promotion Officer
[redacted] – Medical Social Service
[redacted] – Nutrition and Dietetics
[redacted] – Gender and Development

All orders and issuances, or parts thereof which are inconsistent with this order are hereby repealed, amended or modified accordingly.

This order being issued for the good of public service is hereby confirmed, declared official and made of record.

[redacted], M.D., FPCS, MHA
Medical Center Chief II

BatMC-HR-F003 Effective Date: October 3, 2014

This is a computer generated form. No STAMPING needed.

Annex 4: TPC Scoping Tool

ADOLESCENT HEALTH AND DEVELOPMENT PROGRAM
Scoping of Teen Parents' Clinic (TPC) in Hospitals

I. INTRODUCTION

The scoping aims to:

- Establish baseline data on adolescent prenatal, labor/delivery, postpartum, family planning and other hospital services, as available.
- Determine the state of readiness of the hospital in providing adolescent-friendly services, and address identified gaps.

The areas of concern to be assessed are based on standards set by the DOH and WHO.

II. BASIC INFORMATION

Name of Hospital:	
Address:	
Email Address:	
Landline Number:	
Mobile Number:	

III. BASELINE DATA

Please supply the following information, where available.

A. Prenatal Consultations (2016)[1]

Age	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
10-14 y.o.													
15-19 y.o.													
Subtotal													
>19y.o.													
TOTAL All Ages													

B. Prenatal Consultations (2017)[1]

Age	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
10-14 y.o.													
15-19 y.o.													
Subtotal													
>19y.o.													
TOTAL All Ages													

[1]Number of individuals, not episodes.

C. AOG at First Visit

AOG	2016	2017
1st Trimester (≤84 days)		
2nd Trimester (85-189 days)		
3rd Trimester (≥190 days)		
TOTAL		

D. GP

Score	2016	2017
$G_1 P_0$		
$G_2 P_1$		
$G_2 P_0$		
$G_3 P_2$		
$G_3 P_1$		
$G_3 P_0$		
Others, specify:		
TOTAL		

E. Deliveries (2016)

Age	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	**Total**
10-14 y.o.													
15-19 y.o.													
Subtotal													
>19y.o.													
TOTAL All Ages													

F. Deliveries (2017)

Age	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	**Total**
10-14 y.o.													
15-19 y.o.													
Subtotal													
>19y.o.													
TOTAL All Ages													

G. Demographics of Adolescent Clients 10-19 Years Old Who <u>Delivered</u> in the Facility

1. Residence		
City/Municipality, Province	2016	2017

1. Residence		
City/Municipality, Province	2016	2017
TOTAL		

2. Educational Status at Time of Pregnancy		
Educational Status	2016	2017
In-school		
Out-of-school		
TOTAL		

3. Financing		
Coverage	2016	2017
By PHIC, as dependents		
By PHIC, enrolled at Point of Care (for NHTS clients)		
By financing mechanisms other than PhilHealth		
Not covered		
No data		
TOTAL		

H. FP Uptake <u>Among Postpartum Adolescent Clients</u>

FP Method	2016	2017
Pills		
Injectable		
Interval IUD		
Postpartum IUD		
Condom		
PSI		
BTL		
LAM		
SDM		

FP Method	2016	2017
Other NFP		
TOTAL		

I. Postpartum Consultations (2016)[2]

Age	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
10-14 y.o.													
15-19 y.o.													
Subtotal													
>19y.o.													
TOTAL All Ages													

J. Post-partum Consultations (2017)[2]

Age	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
10-14 y.o.													
15-19 y.o.													
Subtotal													
>19y.o.													
TOTAL All Ages													

IV. QUALITY STANDARDS FOR ADOLESCENT-FRIENDLY SERVICES IN THE HOSPITAL

Please check the appropriate column (Yes/No) and provide additional information, if any, under the Remarks column.

A. Teen Parents' Clinic

AREAS	YES	NO	REMARKS
Infrastructure/Workspace			
Space			
1. Does the hospital have available space which can meet the 25 sq. m. minimum area requirement for the TPC?			
2. Is the identified space accessible and appropriate for pregnant adolescents who would come for consult?			
3. Is the space clean, well-lit, well-ventilated and comfortable?			
Signage			
4. Is there an existing signage in the hospital that indicates the services offered to adolescents, including the schedule?			

[2]Number of individuals, not episodes.

AREAS	YES	NO	REMARKS
a. If yes, is the signage visible, attractive, inviting and strategically located?			
Counseling/consultation area			
5. Does the area contain only what are necessary (e.g., table, chair) and is it free from distraction (e.g., stored supplies/materials)?			
6. Does the area offer audiovisual privacy?			
Waiting/bench conference area			
7. Does the area provide comfortable and sufficient number of chairs for clients?			
Examining/treatment area			
8. Does the area offer audiovisual privacy?			
9. Does the area have the following medical equipment and materials?			
a. Examining bed with stirrups and covered with bedsheet, pillows and blanket			
b. Examining gown with hanger			
c. Foot stool			
d. Tray with medical supplies			
e. Clothes hook or rod			
f. Garbage can			
10. Does the area have handwashing facility?			
Comfort room			
11. Do clients have access to a comfort room (within or close to the TPC) that is always open and available?			
12. Does the comfort room have the following?			
a. Running water			
b. Handwashing area			
c. Exhaust fan			
d. Covered garbage can			
Infection prevention measures			
13. Does the facility provide covered, segregated garbage bins?			
14. Does the facility implement the proper disposal of sharps and infectious wastes?			
Adolescent-Friendly Procedures			
15. Does the facility observe a queuing system to minimize client waiting time?			
16. Does the facility have attentive and respectful staff and health providers?			
17. Are the facility's records storage and safekeeping practices in adherence to standards of confidentiality and data protection, e.g., use of a lock and key system?			
18. Does the facility have room to implement a one-stop-shop arrangement for clients?			

AREAS	YES	NO	REMARKS
19. Does the facility provide a feedback mechanism to solicit comments and suggestions from clients?			
Supply/Equipment			
20. Does the facility have the following necessary and functional equipment?			
a. Weighing scale			
b. Thermometer			
c. Stethoscope			
d. Sphygmomanometer			
e. Height measurement			
21. Does the facility have a refrigerator to ensure proper storage and care of vaccines, medicine, etc.?			
22. Does the facility have the following audiovisual equipment for health education purposes?			
a. TV			
b. Laptop			
c. Projector			
d. Speaker			
23. Can the facility sustainably provide and store the following instruments/supplies for TPC operations:			
a. First aid kit			
b. Medicine cabinet with basic drugs			
c. Basic medical supplies, e.g., sterile gloves, syringe, needles, gauze, cotton, surgical tape, povidone iodine, ethyl alcohol			
d. Vaccines			
e. FP commodities, e.g., pills, injectable, condom, SDM beads			
f. Interval IUD kit			
g. IEC materials, e.g., FP wall chart, poster on the danger signs of pregnancy, Mother/Baby Book, health education videos			
h. Recording/reporting forms (e.g., FP Form 1, intake forms, adolescent Target Client List)			
Staff Capacity			
24. Does the hospital have enough number of Ob-Gyn residents who can be rotated for duty at the TPC?			
25. Does the hospital have enough number of pediatric residents who can be on call for the TPC?			
26. Does the facility have <u>at least two</u> staff (RN/RM) trained in FPCBT1 and AJA who can			

AREAS	YES	NO	REMARKS
be appointed permanently to the TPC to serve as frontline service providers?			
27. Does the facility have access to FPCBT2-trained service providers who can be on call for PSI and interval IUD services among clients?			
28. Can the facility provide <u>at least one</u> support staff to be in charge of registration, triage, vital signs taking, recording and reporting, and scheduling of clients, among others?			
29. Can the facility organize and conduct an orientation on adolescent-friendly services and respectful maternity care among service providers in support areas outside of the TPC?			
Service Capacity			
30. Does the facility currently provide the following services to adolescents?			
a. Psychosocial assessment and counseling			
b. Prenatal services			
c. Dental assessment			
d. Nutrition counseling			
e. Laboratory services			
f. Postpartum services			
g. Postnatal services			
h. Family planning counseling and services			
31. Does the facility have existing clinical guidelines for the delivery of said services?			
32. Does the facility have competent staff (e.g., IPC/C-trained) to conduct health education classes not only for adolescents but also for parents and partners?			
33. Can the facility refer clients to the RHU for continuing FP use/resupply of commodities?			
Policy/Systems			
34. Can the facility issue an order/memorandum for the establishment and implementation of the TPC, now and in the long run?			
35. Does the facility have a budget allocation for the TPC?			
36. Does the facility have a system of procurement of medicine and supplies necessary for the management of maternal conditions/complications in adolescents?			
37. Does the facility have an existing recording and reporting system that captures the services provided to adolescents?			
38. Does the facility conduct regular self-			

AREAS	YES	NO	REMARKS
assessments of quality of care?			
39. Does the facility have an approved, operational intra/interdepartmental/facility referral system that has the following?			
a. Updated directory of public/private referral facilities/agencies/institutions within and outside the SDN, categorized according to issues			
b. Appropriate forms for referral, both within and outside the hospital			
c. Mechanism to find out the results of the referral			
d. Key referral messages at each point of contact with the client			

B. Support Areas

AREAS	YES	NO	REMARKS
Outpatient Department			
1. Does the area have a designated waiting area for adolescents?			
2. Are the staff in the registration/triage area oriented on managing adolescents, adolescent services available in the hospital, referral mechanism, etc.?			
Emergency Room			
3. Does the area have a designated/separate space for adolescents with at least visual privacy?			
4. Are the staff oriented on managing adolescents, adolescent services available in the hospital, referral mechanism, etc.?			
5. Is there a halfway area available for access by pregnant adolescents not yet in active labor?			
6. Is there an FPCBT1-trained service provider in the halfway area?			
Labor Room			
7. Does the area have a designated/separate space for adolescents with at least visual privacy?			
8. Are the staff oriented on managing adolescents, respectful maternity care, adolescent services available in the hospital, referral mechanism, etc.?			
9. Is there a policy allowing adolescents to have their companion of choice?			
Delivery/Operating Room			

AREAS	YES	NO	REMARKS
10. Does the area have a designated/separate space for adolescents with at least visual privacy?			
11. Are the staff oriented on managing adolescents, respectful maternity care, adolescent services available in the hospital, referral mechanism, etc.?			
12. Are there FPCBT2-trained PPIUD service providers available on call?			
13. Is there a policy allowing adolescents to have their companion of choice?			
14. Is the facility practicing essential intrapartum newborn care?			
Recovery Room			
15. Does the area have a designated/separate space for adolescents with at least visual privacy?			
Ward			
16. Does the area have a designated/separate space for adolescents with at least visual privacy?			
17. Are the staff oriented on managing adolescents, respectful maternity care, adolescent services available in the hospital, referral mechanism, etc.?			
FP Clinic			
18. Are the staff oriented on managing adolescents, adolescent services available in the hospital, referral mechanism, etc.?			
19. Are there FPCBT2-trained interval IUD service providers available on call to provide services at the TPC?			
20. Are there FPCBT2-trained PSI service providers available on call to provide services at the TPC?			
Pharmacy			
21. Are the staff oriented on managing adolescents, adolescent services available in the hospital, referral mechanism, etc.?			
Laboratory			
22. Does the area allow pregnant adolescents to be in the priority lane for service delivery (e.g., for special laboratory procedures not provided at the TPC such as ultrasonography)?			
23. Are the staff oriented on managing adolescents, adolescent services available in the hospital, referral mechanism, etc.?			
24. Are there staff available on call to provide			

AREAS	YES	NO	REMARKS
routine laboratory services (e.g., blood extraction, urinalysis, stool exam, etc.) and subsequently release results at the TPC?			
Dental Unit			
25. Does the area allow pregnant adolescents to be in the priority lane for service delivery?			
26. Are the staff oriented on managing adolescents, adolescent services available in the hospital, referral mechanism, etc.?			
Nutrition Unit			
27. Are the staff oriented on managing adolescents, adolescent services available in the hospital, referral mechanism, etc.?			
28. Are there staff available on call to provide counseling and services at the TPC?			

V. POTENTIAL MEMBERS OF THE TPC TWG

Position/ Department	Name	Years of service in the hospital	AJA-trained (Yes/No)	Contact Information (Email & Mobile Number)
COH				
Chief of Clinics				
Chief Nurse				
OB Dept. Head				
Pediatrics Dept. Head				
Administrative Officer				
FP Point Person				
Others, specify:				

VI. OTHER COMMENTS/INSIGHT

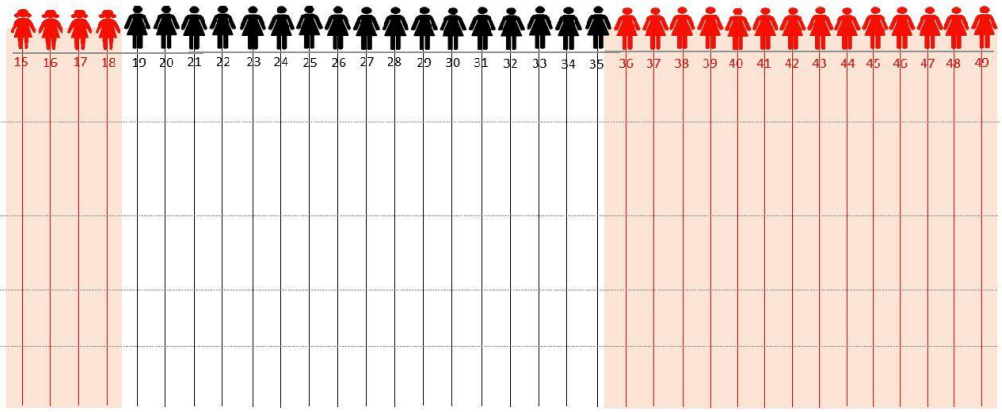
Interviewee:		Interviewer:	
Position:		Position/Office:	
Date:			

Annex 5: Reproductive Life Plan

Pangalan: _____ **Lagda**: _____

Edad (Bilugan ang numero sa ibaba) **Petsa**: _____

REPRODUCTIVE LIFE PLAN



1. Buntis ka ba? Kung oo, markahan ng "X" ang linyang katapat ng edad kung kailan ka manganganak.
2. Ilang beses ka nang nanganak? Markahan ng "X" ang bawat linya ng edad kung kailan ka nanganak. Lagyan ng 2 o higit pang "X" kung kambal o multiple birth.
3. Ilang beses ka nang nakunan o namatayan ng anak? Markahan ng "X" ang bawat linya ng edad kung kailan ka nakunan o namatayan ng anak.
4. Ilan pa ang gusto mong anak? Markahan ng "X" ang bawat linya ng edad kung kailan mo gustong manganak.
5. Anong plano/pangarap mo para sa sarili? Isulat sa linya ng edad kung kailan gagawin.

Alam mo ba na:

- Mapanganib sa kalusugan ang pagbubuntis bago mag-18 taong gulang, pagkalipas ng 35 taong gulang, at kung higit sa 5 na ang mga anak
- Mapanganib din ang pagbubuntis kung ikaw ay may mga kalagayang medikal (sakit sa puso, alta presyon, diabetes, etc.)
- Maaari kang magbuntis muli 4 na lingo pagkapanganak (kung hindi nagpapasuso) o 6 na buwan pagkapanganak (kung hindi gumagamit ng LAM)
- Maaari kang magbuntis muli 11 araw matapos makunan
- Matapos manganak, kailangan ng 'di bababa sa 24 na buwang pahinga para matiyak na malusog at ligtas ang susunod na pagbubuntis
- Matapos makunan, kailangan ng 'di bababa sa 6 na buwang pahinga para matiyak na malusog at ligtas ang susunod na pagbubuntis

Ito ang mga ligtas at epektibong paraan para 'di muna magbuntis. Ang gusto ko ay:

☐ LAM ☐ Implant ☐ IUD
☐ Pills ☐ Injectable ☐ FAB Methods _____

Ito ang mga ligtas at epektibong paraan para 'di na magbuntis. Ang gusto ko ay:

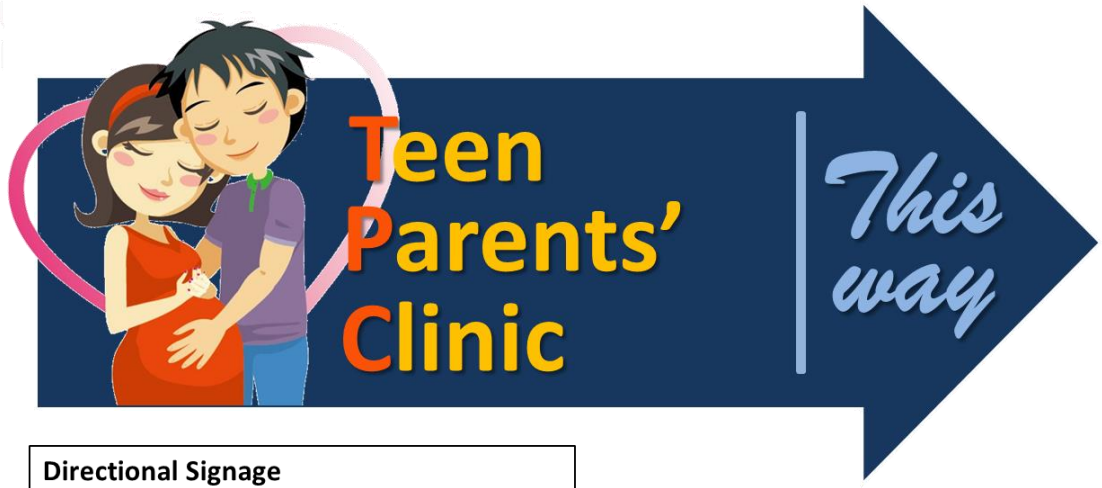
☐ BTL ☐ IUD ☐ Implant
☐ NSV ☐ Injectable

Paalala:

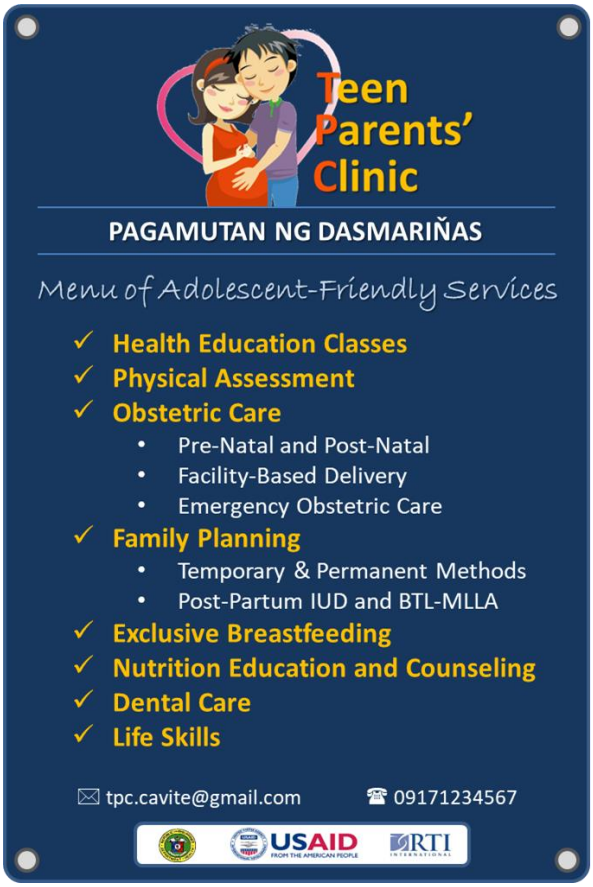
- Ibahagi at talakayin sa iyong partner ang iyong plano.
- Kung may pagbabago sa planong ito, ipaalam agad at sumangguni sa iyong Health Service Provider.
- Mag-"healthy lifestyle" para maging malusog sa panahon ng pagbubuntis at sa lahat ng pagkakataon.

USAID FROM THE AMERICAN PEOPLE RTI INTERNATIONAL

Annex 6: TPC Signage (Sample)



Directional Signage	
Material:	Acrylic plastic
Dimension:	W – 36in, L – 18in
Price:	Approx. P1,200.00



TPC Menu of Services	
Material:	Acrylic plastic
Dimension:	23in W x 30in L
Price:	P2,500
Quantity:	1 pc.

Note: Customized in each TPC in terms of location, email and phone.

Annex 7: TPC Identification Card

(Front)

Name of Hospital
Teen Parents' Clinic
City/Municipality, Province

Picture

2x2

TPC ID No.: _____Date Issued: _____

Name: _____
Birthday: _____
Address: _____

Contact Details: Mobile No.: _____
Landline No.: _____

(Back)

In case of emergency, please notify:

Parent/Guardian's Name: _____
Address: _____
Mobile and/or Landline No.: _____

*If found, please return this identification card to the Teen Parents' Clinic of the hospital located at*_____ *or contact* _____.

Issued by:

_____
TPC Coordinator

Annex 8: Adolescent Client Intake Form (Initial Visit)

TEEN PARENTS' CLINIC
(Complete Address)

Referred By

- ☐ School: _____
- ☐ Rural Health Unit: _____
- ☐ Barangay/Community: _____
- ☐ Other Department/Unit of the Hospital: _____
- ☐ Private Lying-in Clinic: _____
- ☐ Public Lying-in Clinic: _____
- ☐ Walk-in

Personal Information

Name: (Last Name, First Name, Middle Name)	Date:
Date of birth: (MM/DD/YYYY)	Age:
Address:	
Living with:	
Contact details: ☐ Mobile phone: ☐ Landline: ☐ Email: ☐ Others (Facebook, etc.):	Identifying documents: ☐ Birth certificate ☐ School ID ☐ Others:
Educational status: ☐ Currently enrolled (School and Grade Level) _____ ☐ Not enrolled/studying	
Emergency contact details: Name: Relationship: Address: Contact details: ☐ Mobile number: ☐ Landline: ☐ Others:	
Companion's Name (if other than parent/partner/guardian): (Last Name, First Name, Middle Name) Date of Birth: Relation to client: Address: Screening questions: 1. Bakit po ninyo dinala o sinamahan si (name of client) dito sa TPC? 2. Kilala ninyo po ba ang kanyang mga magulang, kapatid o kamag-anak? Maaari po bang	

malaman kung ano mga pangalan ng kanyang mga magulang, kapatid o kamag-anak?

3. Ang tinitirahan ninyo ba ay inyong pagmamay-ari, inuupahan o nakikitira lang?

4. Sino po ang mga kasama ninyo sa bahay?

5. Meron po bang mga kapitbahay o kamag-anak na madaling mahingan ng tulong sa panahon ng emergency?

Contact details:
- ☐ Mobile number:
- ☐ Landline:
- ☐ Others:

Consent for Confidentiality

Sa susunod na bahagi ng interview, nais kong makausap ka (Name of Client) na mag-isa sa Consultation Room.

Nais kong ipabatid na lahat ng ating mapag-uusapan ay "confidential". Ibig sabihin, lahat ng iyong (client) sasabihin sa akin ay walang ibang makakaalam. Ngunit, kung may mga bagay na maaaring makakasama sa iyo o sa ibang tao, maaari kong sabihin ito sa iyong mga magulang o guardian o kinauukulan.

Lahat ng mga impormasyon na makakalap natin at maitatala dito sa "Intake Form" na ito at iba pang mga mahalagang dokumento na inyong isusumite ay ituturing namin na confidential at walang maaaring makakuha nito nang walang kaukulang pahintulot ng mga kinauukulan.

Pumapayag po ba kayo sa kundisyon na ito?

Client's Name & Signature:	
Parent/Guardian/Companion's Name & Signature:	

Personal/Social History (HEADSS) (Refer to AJA Manual for Management)

Area of Concern	Notes/Plans
Home ▪ Kanino ka nakatira ngayon? Sino ang mga kasama mo sa bahay? ▪ Meron bang problema sa inyong pamilya at sa iyong tinutuluyan kung saan ikaw ay maaring maapektuhan? ▪ May malalapitan/makakausap ka ba sa pamilya, kamag-anak o kaibigan mo kung ikaw ay may problema? ▪ May pagkakataon bang naisip mong maglayas? Saan mo balak pumunta kung sakali? Bakit?	
Education ▪ Nag-aaral ka pa ba? Anong grade/year mo na? ▪ Nagkaproblema ka na ba sa paaralan, kamag-aral o mga guro mo? Bakit? ▪ Nakaranas ka ba ng pangungutya, pang-aapi at pananakit ng iba sa iyo sa paaralan? ▪ Kamusta naman ang mga grades mo? Ano ang paborito mong subject? Saan ka nahihirapan?	

Area of Concern	Notes/Plans
▪ Nagtatrabaho ka na ba? Anong uri ng trabaho? Gaano kadalas?	
Eating ▪ Gaano ka kadalas kumain sa isang araw? Ano ang madalas mong kainin? Nakakakain ka ba nang maayos? ▪ Kuntento ka ba sa itsura ng katawan mo noong hindi ka pa nagbubuntis? ▪ Nag-aalala ka ba kung maibabalik mo pa ang dating hubog ng iyong katawan matapos ka manganak? ▪ Naisip mo na ba kung ano ang iyong gagawin upang maibalik ang dating hubog ng iyong katawan matapos ka manganak?	
Activity ▪ Ano ang kadalasan mong ginagawa sa "free time" mo? ▪ Sino ang kadalasan mong kasama sa "free time" mo? Bakit? ▪ Sumasali ka ba sa mga gawain o "activities" sa paaralan mo? Sa komunidad mo? ▪ Gaano ka kadalas gumamit ng Internet? Facebook? Instagram? Atbp. ▪ Nakakatulog o nakakapagpahinga ka ba nang maayos?	
Drugs ▪ Nakasubok ka na bang gumamit ng sigarilyo, marijuana o ipinagbabawal na gamot? Gaano ka kadalas gumamit? ▪ Nakasubok ka na bang uminom ng beer, alak o katulad na inumin? Gaano ka kadalas uminom?	
Sex/Sexuality ▪ Ilang taon ka noong una kang makipagtalik? ▪ Ilan na ang iyong naging nakatalik o sexual partners? ▪ Gumagamit ka ba ng kahit anong uri ng proteksyon? (Halimbawa: condom, pills, atbp.) ▪ Nagkaroon ka na ba ng impeksyon sa iyong ari o pwerta dulot ng pakikipagtalik? Kung oo, ano ang iyong ginawa upang mabigyang lunas ito? ▪ Ano ang pakiramdam mo sa pagbubuntis mo? ▪ Sino ang ama ng iyong dinadala? Kamusta and relasyon ninyo? Ano ang pakiramdam niya sa pagbubuntis mo? Ano ang plano niya sa pagbubuntis at panganganak mo? ▪ Naging biktima ka ba ng pagsasamantala, panghihipo o panghahalay? Kung oo, sino-sino ang nakakaalam nito? ▪ Ano ang pakiramdam ng mga magulang/kapatid/kamag-anak/mga kaibigan sa pagbubuntis mo? ▪ Ano ang plano ng mga magulang/kamag-anak o nag-aalaga sa iyo sa pagbubuntis at panganganak mo?	

Area of Concern	Notes/Plans
▪ Nababahala ka ba sa iyong kalusugan at sa mga pagbabago sa iyong pangangatawan? ▪ Handa ka na ba sa pagiging isang ina?	
Safety ▪ Nakaranas ka na bang sinaktan, sinampal, sinipa, tinulak o hinipuan ng kahit sino? ▪ Nakaranas ka ba ng pananakit o pananakot ng karelasyon mo ngayon?	
Suicide/Depression ▪ Nakakaramdam ka ba ng matinding pagkabalisa o pagkalungkot? ▪ Naisip mo na bang saktan ang sarili mo o magtangkang magpakamatay? Naiisip mo bang ipalaglag ang dinadala mo? May mga ginawa ka ba o ininom na gamot para malaglag ang dinadala mo? ▪ Mayroon bang miyembro ng pamilya mo o malapit na kamag-anak na nakaranas ng matinding kalungkutan o pagkabalisa, o di kaya'y nagtangkang magpakamatay?	

Other Findings

Physical Examination

Please use existing hospital CPG and forms in place, as approved by DOH.

Recommendations & Plans

- ☐ Prenatal checkup at Ob-Gyn OPD
- ☐ Postpartum checkup at Ob-Gyn OPD
- ☐ Refer to (Fill up referral form.)
  - ☐ For STI: HACT
  - ☐ For VAW: DSWD, PNP-WCPU, NGOs, Others
  - ☐ For financial assistance: PhilHealth, Medical Social Services
  - ☐ Others, specify:

Reason for referral: _____

Follow-up Instructions

Sunod na Checkup:	Mag-attend ng Module:
Date/Time:	Topic: Date/Time:

Accomplished By

Name and Signature of TPC Service Provider:	
Date/Time:	

Annex 9: TPC Follow-up Visit Form

TEEN PARENTS' CLINIC
(Complete Address)

Date:	Time:
Client Name:	Age:
Companion's Information:	
Name:	Relation to Client:
Type of Follow-up: ☐ Prenatal: AOG _____ ☐ Postpartum	☐ Module Class: _____ ☐ Others: _____
Personal Concerns (HEADSS)	
Pregnancy/Postpartum Concerns	
☐ Nutrition	
☐ Immunization	
☐ Breastfeeding	
☐ Signs and symptoms	

Physical Examination

Please use existing hospital CPG and forms in place, as approved by DOH.

Recommendations & Plans

- ☐ Prenatal checkup at Ob-Gyn OPD
- ☐ Postpartum checkup at Ob-Gyn OPD
- ☐ Refer to (Fill up referral form.)
  - ☐ For STI: HACT
  - ☐ For VAW: DSWD, PNP-WCPU, NGOs, Others
  - ☐ For financial assistance: PhilHealth, Medical Social Services
  - ☐ Others, specify:

Reason for referral: _____

Follow-up Instructions

Sunod na Checkup:	Mag-attend ng Module:
Date/Time:	Topic: Date/Time:

Accomplished By

Name and Signature of TPC Service Provider:	
Date/Time:	

Annex 10: Suggested Health Education Modules

Module 1: Female Reproductive Health: Parts and Functions

Duration: Approximately 60-90 minutes

OBJECTIVES:

1. Knowledge (Anatomy and Physiology)
    - Understand the functions of the female reproductive organs
    - Connect the functions of the female reproductive organs to bodily changes occurring during pregnancy
2. Skills (Hygiene)
    - Perform hygiene care during pregnancy such as: hand washing, breast care, perineal care and oral care
3. Attitude (Reproductive Health)
    - Appreciate the functions of the female reproductive organs and their connection to pregnancy

STEPS:

1. Begin the session by engaging the participants (and companions) in small talk: Ask about how the day is, commuting to and from the center, etc.
2. Orient the participants about the topics, including the duration of the session.

Part 1: Anatomy and Physiology

Approximately 30 minutes

1. Before the start of this teaching-learning session, as the health class educator/facilitator, begin by relating your own story of:
    a. The first time you noticed changes in your breast size
    b. The first person you informed about your first menstruation
    c. What you did when you had your first menstruation

2. Ask the same story from the participants.

3. After the participants have shared, ask them to answer the following questions:
    a. What is the reason women experience development of breast size?
    b. Can you tell why women need to menstruate?
    c. When did you notice that your hips changed its size?

4. Use their answers in connecting issues of physical changes in pregnancy. Follow the table below, as your guide for discussion/facilitation.

Question	Participants' Response	Female Reproductive Anatomy and Physiology	Connection with Pregnancy Physical Changes
1. What is the reason women experience	Possible responses: 1. It's normal for women 2. It's part of growing	Introduce the answer by stating the following: 1. Breast development is a vital part of reproduction	Explain that: 1. Breast changes are one of the earliest signs of pregnancy.

Question	Participants' Response	Female Reproductive Anatomy and Physiology	Connection with Pregnancy Physical Changes
development of breast size?	up 3. It's a preparation for breastfeeding	among females. 2. Females develop full breasts long before these are needed to nurse their offspring. 3. Breast development happens in distinct stages throughout a woman's life, first before birth, again at puberty, and during the childbearing years. 4. Changes also happen to the breasts during the menstrual cycle and when a woman reaches menopause. http://www.hopkinsmedicine.org/healthlibrary/conditions/breast_health/normal_breast_development_and_changes_85,P00151/	2. This is a result of the hormone progesterone. 3. Most pregnant women experience tenderness down the sides of the breasts and tingling or soreness of the nipples. 4. Some women report breast itching; this is due to skin stretching. 5. This is because of the growth of the milk duct system and the formation of many more lobules. http://www.hopkinsmedicine.org/healthlibrary/conditions/breast_health/normal_breast_development_and_changes_85,P00151/ Watch the video: https://www.youtube.com/watch?v=NfJVfGccelA **How Do My Breasts Make Milk?**
1. Can you tell why women need to menstruate? *(Bakit nagkakaroon ng buwanang dalaw o pagdurugo?)*	Possible responses: 1. It's normal for women. 2. It's part of growing up. 3. It's a rite of passage. 4. It's a preparation for motherhood.	Introduce the answer by stating: *Ang buwanang pagdurugo ay dahil sa regular na pagpapalit ng lining o pang-ibabaw na sapin ng matres na nagaganap kapag walang nangyaring fertilization sa pagitan ng itlog o egg cell ng babae at isang semilya o sperm cell ng lalaki. Ang fertilization ay nagaganap lamang kapag nagtalik ang isang lalaki at babae at nagtagpo ang kanilang itlog at semilya.* (http://kalusugan.ph/mga-kaalaman-tungkol-sa-menstrual-cycle/) Simple, scientific explanation: 1. Discuss first the anatomy of the Female Reproductive System. a. Use illustrations. b. Discuss the following: **I. The external female reproductive anatomy**	1. Connect the discussion by showing this video: Resource: Fertilization and Pregnancy Development https://www.youtube.com/watch?v=VmlcRqdDqH4 2. Using an illustration, ask the following questions: *a. Ang tinatawag na lining ng uterus na numinipis at kumakapal dulot ng proseso ng pagreregla ay tinatawag na…?* *b. Oo o hindi. Ang lahat ng babae na nakakaranas ng pagreregla ay maaaring magkaanak?* *c. Oo o hindi. Maaari pa ring mabuntis kung makikipagtalik*

Question	Participants' Response	Female Reproductive Anatomy and Physiology	Connection with Pregnancy Physical Changes
		Structures of external female reproductive anatomy include: • Pubic hair: Surrounds the female reproductive organs • Clitoris: Sensitive ball of tissue creating sexual pleasure • Labia majora (outer lips): Two folds of skin, 1 on either side of the vaginal opening that protect the female organs • Labia minora (inner lips): Two folds of skin, inside the labia majora, that extend from the clitoris • Urethra: Opening where urine leaves the body • Vaginal opening: Where a man's penis is inserted during sex, and where blood flows out during menstruation • Anus: Where solid waste leaves the body. **II. The internal female reproductive anatomy** Primary structures and organs include: • Uterus (womb): Reproductive organ where a fertilized ovum, or egg, grows and develops into a fetus • Fallopian tube: Each of the two tubes that link the ovaries to the uterus. An ovum travels along one of these tubes once a month. Fertilization occurs in this tube. • Ovary: Two reproductive glands where ova (eggs) develop and one is released each month • Ovarian follicle: A hollow ball of cells that contains an immature ovum. Located in each ovary	*habang may buwanang dalaw?* *d. Ang sipit-sipitan tinatawag ding…? (Ituro sa larawan.)* e. *Ang bahagi ng kasarian kung saan mananatili ang fetus ng siyam (9) na buwan ay ang…? (Ituro sa larawan.)*

Question	Participants' Response	Female Reproductive Anatomy and Physiology	Connection with Pregnancy Physical Changes
		• Endometrium: The lining of the uterus, which gradually thickens and then is shed during menstruation • Cervix: Lower portion of the uterus that extends into the upper vagina. It produces mucus. • Vagina: Joins the outer sexual organs with the uterus. http://www.intrahealth.org/files/media/preservice-education-family-planning-reference-guide/MPsFPRG_unit3.pdf	
2. When did you notice that your hips changed its size?	Possible responses: 1. It's normal for women. 2. It's part of growing up. 3. It's a rite of passage. 4. It's a preparation for pregnancy.	Emphasize the following: 1. As your pelvis (the large bone across your hips) begins to grow, your hips get wider, your breasts develop and your waist gets smaller. 2. Girls' bodies become softer and shapelier. 3. Some girls also gain weight quickly during this time.	Watch the video: **How pregnancy changes your pelvis** https://www.youtube.com/watch?v=x0L-VWPjf7s&ebc=ANyPxKpe5L9AdyTIc4AKN1qnrFMc3MUntpZ3FhUDaLqRJZjxsNwkWoJgBXPLP7nyrycwks2Wvp43RK8a62JNq0ajbbq5b6FyTw

Summarize the discussion by showing the following video clip:
How your body changes in pregnancy (https://www.youtube.com/watch?v=gpGslYFExc8)

5. Ask for any need for clarifications, any questions, and concerns regarding the discussion. You can do this by doing the following:
   a. Handing out a piece of paper for participant to write her questions, clarifications, concerns.
   b. Asking the participant to summarize what she has learned during the discussion.

Part 2: Skills Training (Hygiene)

Approximately 45 minutes

1. For this part of the module, you will train the participant how to maintain proper personal hygiene during pregnancy. These skills involve:
   a. Hand washing
   b. Breast care
   c. Perineal care
   d. Oral care

2. You will have to use the demonstration-return demonstration teaching technique, in order to ensure retention of learned skills. Also, you will be able to detect any additional skills training needed should the participants find it difficult to perform the skills correctly.

3. Refer to the table below for your guide in discussion/facilitation of skills training.

Skills	Emphasis	Teaching resources	Skills check
1. Hand washing	Before and after: 1. Preparing food 2. Eating 3. Touching/contact with sensitive body parts	**WHO Hand Hygiene Video** https://www.youtube.com/watch?v=s08yiZBSGOw	Finishes hand washing together with "Happy Birthday" song.
2. Breast care	1. Wear a good supportive bra. 2. Avoid using harsh drying soap or body wash. 3. Hot water can be very drying to the skin. Reference: https://www.huggies.com.au/pregnancy/health-and-care/physical-changes/breast	Using a human "dummy", teach care of the following breast part: 1. Areola (nipples) 2. Breast	Does circular motion when wiping/cleaning breast parts.
3. Perineal care	1. Wash with warm, not hot, water and soap-free products during showering or bathing. 2. Then pat dry using clean, dry clothing. 3. Avoid: a. Excessive washing b. Vaginal sprays c. Perfume d. Talc e. Antiseptics	Using a human "dummy", teach perineal care using the "front-to-back" wiping technique.	Uses "front-to-back" wiping technique during perineal care.
4. Oral care	When experiencing morning sickness and vomiting: 1. Don't brush your teeth immediately after vomiting. 2. Rinse your mouth with water (preferably fluoridated tap water) after vomiting. When brushing teeth: 1. Use a toothbrush with a small head, such as a one for toddlers. 2. Take your time. Slow down your brushing action. 3. Try closing your eyes and concentrate on your breathing. https://www.huggies.com.au/pregnancy/health-and-care/physical-changes/teeth	Video clip: **Dental Care During Your Pregnancy** https://www.youtube.com/watch?v=CS_iWgkNphw	Demonstrates use of dental floss.

Part 3: Attitude Development

Approximately 30 minutes

4. Close the teaching-learning session by validating understanding and by giving the following questions to be written on a piece of paper:
   a. *Ano ang mga natutunan ko?* (body parts)
   b. *Bakit may mga nararamdaman akong pagbabago sa katawan ko?* (changes related to pregnancy)
   c. *Paano ko aalagaan ang sariling katawan?* (hygiene)

5. End the teaching-learning session by congratulating the participants for any new knowledge and skills learned.

Module 2: Stages of Pregnancy

Session 2.1: Bodily Changes During Pregnancy

Duration: Approximately 60-90 minutes

OBJECTIVES:

1. Knowledge (Bodily changes during pregnancy)
   - Discuss normal development during pregnancy.
   - List maternal life-threatening complications.
2. Skills (Partner involvement) (Parents, Partner):
   - Perform vital signs assessment (temperature check, pulse rate, respiratory rate) (Hygiene).
3. Attitude (Follow-up visits)
   - Agree to attend next schedules of follow-up visits/discussions.

STEPS:

1. Begin the session by engaging the participants (and companion) in small talk: ask about how their day is going, commute to and from the center, etc.
2. Orient them about the topics, and duration of the whole session.

Part 1: Stages of Pregnancy (Normal Development During Pregnancy)

Approximately 30 minutes

1. Before the start of this teaching-learning session, begin by asking how the participants recognized she is pregnant.

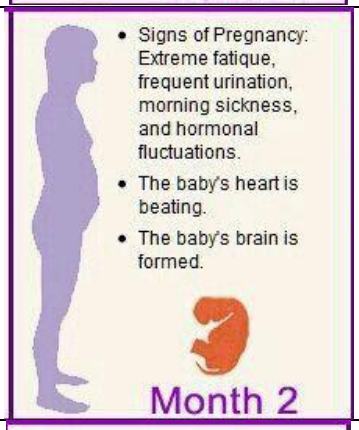
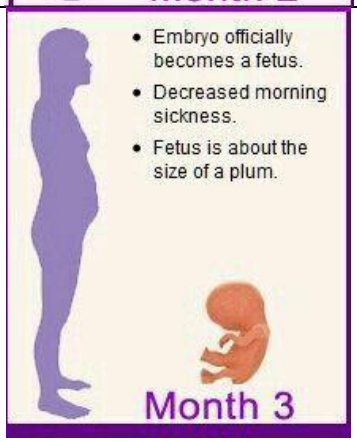
2. At the same time, ask what their concerns were upon finding out of the pregnancy.

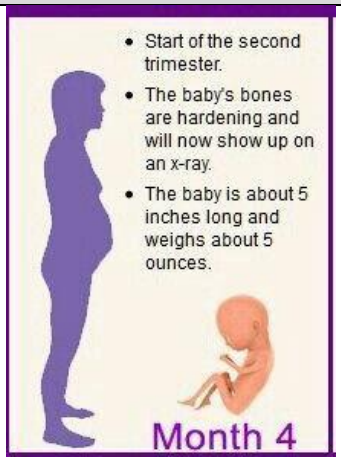
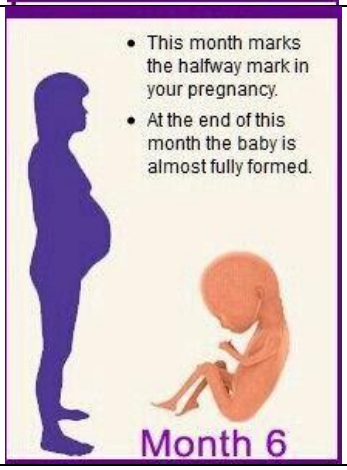
3. To allay their fears, you can introduce the participants to how to compute for the Expected Date of Delivery (EDD) by using Nagele's Rule. This is to:
   a. Educate the participants on EDD.
   b. Make them feel empowered by teaching one new knowledge.

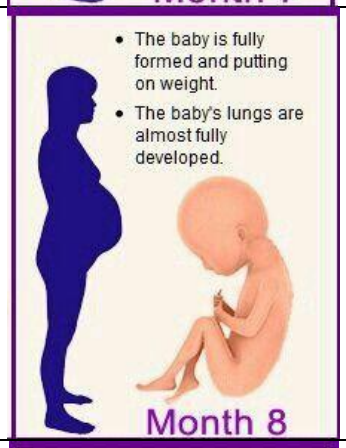
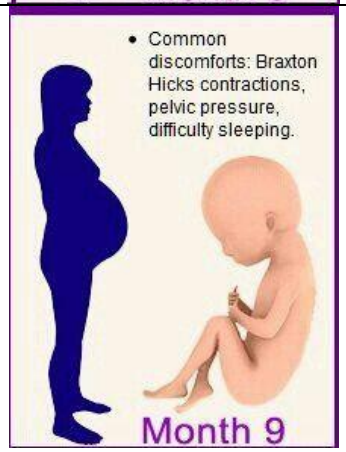
4. Give sample dates to compute for EDD. Take extra note when it is difficult and becomes an unpleasant activity for the participants due to literacy difficulty.

5. Use the activity in introducing the topic on Stages of Pregnancy.

6. Follow the table below as your guide for discussion/facilitation.

Stage	Illustration	What Will Happen to You	
1st Trimester		***Normal***	***Needs Immediate Attention***
		• Extreme tiredness • Tender, swollen breasts. Your nipples might also stick out. • Upset stomach with or without throwing up (morning sickness) • Cravings or distaste for certain foods • Mood swings • Constipation (trouble having bowel movements) • Need to pass urine more often • Headache • Heartburn • Weight gain or loss	
			

Stage	Illustration	What Will Happen to You	
2nd Trimester		• Body aches, such as back, abdomen, groin, or thigh pain • Stretch marks on your abdomen, breasts, thighs, or buttocks • Darkening of the skin around your nipples • A line on the skin running from belly button to pubic hairline • Patches of darker skin, usually over the cheeks, forehead, nose, or upper lip. Patches often match on both sides of the face. This is sometimes called the mask of pregnancy. • Numb or tingling hands, called carpal tunnel syndrome • Itching on the abdomen, palms, and soles of the feet	• *Nausea, loss of appetite, vomiting, jaundice or fatigue combined with itching.* • *These can be signs of a serious liver problem.*
			
			

Stage	Illustration	What Will Happen to You	
3rd Trimester		• Shortness of breath • Heartburn • Swelling of the ankles, fingers, and face. • Hemorrhoids • Tender breasts, which may leak a watery pre-milk called colostrum • Your belly button may stick out • Trouble sleeping • The baby "dropping", or moving lower in your abdomen • Contractions	*Any sudden or extreme swelling or if you gain a lot of weight really quickly,*
			
			

7. As you end the discussion, allow the participants to list maternal life-threatening complications and what they should do immediately when they encounter any of those.

8. Then summarize the discussion with this video clip:
   How a baby develops during pregnancy (https://www.youtube.com/watch?v=h82ltr84_Yg)

9. Ask for areas that need clarification, any questions, and concerns regarding the discussion. You can do this by doing the following:

a. Handing out a piece of paper for the participants to write their questions, clarifications, concerns.
b. Asking the participants to summarize what they had learned during the discussion

Part 2: Partner Involvement (Parents, Partner) Skills Training

Approximately 45 minutes

1. Before the start of this teaching-learning session, begin by asking the participant's companion (Parent, Partner) for any concerns she/he might have regarding the participant's pregnancy.

2. Ask if she/he recognizes any life-threatening conditions the participant may encounter.

3. Then introduce the need for involvement in the care of the participant's pregnancy.

4. Empower the partner by teaching basic caregiving skills.

5. Use the demonstration-return demonstration teaching-learning technique for the skills training.

6. Remember to be patient and helpful during the course of skills training.

7. Follow the table below as your guide for facilitation of the skills training.

Vital Signs	Emphasis	Demonstration	Return Demonstration
Temperature	Important to check during pregnancy. If there is fever, it can indicate that the pregnant woman is developing an infection.	1. When assessing the skin, you should take note of three different characteristics: color, temperature and moisture. 2. The most accessible of these places is the inside of the bottom lip. 3. Take a look and note whether the color is indeed pink or some other color. It might be pale if the person is cold, blue if he is hypoxic, red if he is hot or even yellow if he is suffering from some illness. http://www.diversalertnetwork.org/medical/articles/Assessing_Basic_Vital_Signs	A. Check by: • Taking note of the skin color. • Looking for any abnormal signs in the skin, such as color, warmth, moisture. B. Validate the assessment.
Pulse rate	Very slow or very fast heart rate may indicate heart problems.	1. To find the radial pulse, place two of your fingers where the base of the patient's thumb meets his wrist. 2. The pulse will most likely be between that spot and the most prominent tendons of the wrist. **3.** If you are having difficulty finding the heart rate, you may be pressing too hard or not pressing hard enough. 4. Once you locate the pulse, count the number of beats in 1 full minute (60 seconds). 5. Take note of the quality of the pulse, if it strong or weak.	A. Check if: 1. Able to locate the pulse. 2. The fingers used for assessment are pressing too hard or not pressing hard enough. 3. The pulse is counted in 1 full minute

Vital Signs	Emphasis	Demonstration	Return Demonstration
		http://www.diversalertnetwork.org/medical/articles/Assessing_Basic_Vital_Signs	B. Validate the assessment.
Respiratory rate	Very slow or very fast breathing may indicate difficult breathing of the pregnant woman, and should be observed immediately for any respiratory problems.	1. Once you have counted the heart rate, shift your focus to the breathing. 2. Leave your fingers on his wrist, but watch for his chest to rise. 3. If you're unable to detect respirations by watching the chest, it might be helpful to watch the abdomen or the shoulders instead. 4. Folds of the patient's clothing might also aid your observation of respirations. **5.** Since respirations are less frequent than heartbeats, count the number of beats in 1 full minute (60 seconds). 6. Words like "unlabored," "gasping," "wheezing" or "labored" are used to describe the quality of respirations. http://www.diversalertnetwork.org/medical/articles/Assessing_Basic_Vital_Signs	A. Check if: 1. Proceeded directly after counting the pulse 2. Watches rise and fall of the chest 3. Uses folds of the patient's clothing might as aid in observing for respirations. 4. The respiratory rate is counted in one (1) full minute B. Validate the assessment

8. In training the partner about vital signs assessment, emphasize that the skills are just to aid in the initial assessment of the pregnant partner, and not as a substitute for any needed immediate medical attention.

Part 3: Attitude Development

Approximately 30 minutes

1. At this point of participants' visit, encourage them to agree to the succeeding visits at the center, by having them decide (if possible) on the exact date of your monthly teaching session with them.

2. End the teaching-learning session by congratulating the participants for any new knowledge and skills learned.

Session 2.2: Signs and Symptoms During Pregnancy

Duration: Approximately 60-90 minutes

OBJECTIVES:

1. Knowledge (Discomforts)
   - Discuss bodily changes during pregnancy and associated physical discomforts.
2. Skills (Body mechanics)
   - Demonstrate proper body mechanics during pregnancy.
   - Manage common physical discomforts during pregnancy.
3. ATTITUDE (Physical exercise)

- Plan daily light walking routine (venue, distance, duration).

STEPS:

1. Begin the session by engaging the participants (and company) in small talk: ask about how their day is going, any changes in their mood, tolerance to heat or cold, mood swings, etc.
2. Orient them about the topics, and duration of the whole session.

Part 1: Physical Discomforts During Pregnancy

Approximately 45 minutes

1. Before the start of this teaching-learning session, ask the participants how they manage the physical discomforts they are experiencing.

2. If there are any, allay the fear by teaching one pregnancy skill: 10 CLOTHING HACKS FOR PREGNANCY

3. Waistband cheat
   a. For pants, shorts, or skirts that you can mostly zip up but are just a little too snug to button, try this reliable trick: Thread hair elastic partway through the buttonhole and back through its tail. Pull to tighten and wrap the loop around the button.
   b. Better yet, a waistband expander is specifically designed for the job.

4. Use the activity in introducing the topic on managing physical discomforts during pregnancy.

5. Follow the table below as your guide for discussion/facilitation.

Trimester	Physical Discomforts	Management	Duration
1st Trimester	• Extreme tiredness		
	• Tender, swollen breasts		
	• Upset stomach with or without throwing up (morning sickness)		
	• Mood swings		
	• Constipation (trouble having bowel movements)		
	• Need to pass urine more often		
	• Headache		
	• Heartburn		
2nd Trimester	• Body aches, such as back, abdomen, groin, or thigh pain		
	• Stretch marks on your abdomen, breasts, thighs, or buttocks		
	• Darkening of the skin around your nipples		
	• A line on the skin running from belly button to pubic hairline		

Trimester	Physical Discomforts	Management	Duration
	• Numb or tingling hands called carpal tunnel syndrome of the feet		
	• Itching on the abdomen, palms, and soles		
3rd Trimester	• Shortness of breath		
	• Heartburn		
	• Swelling of the ankles, fingers, and face		
	• Hemorrhoids		
	• Tender breasts, which may leak a watery pre-milk called colostrum		
	• Your belly button may stick out		
	• Trouble sleeping		
	• The baby "dropping", or moving lower in your abdomen		

6. As you end the discussion, provide the participants with a list of physical discomforts during pregnancy. Have her provide management for each physical discomfort.

7. Then summarize the discussion with this video clip:
   KB: Huntahan: Paano masisiguro ang malusog na pagbubuntis (Part 1)
   https://www.youtube.com/watch?v=Que04NQgZOU

8. Ask for areas that need clarification, any questions, and concerns regarding the discussion. You can do this by doing the following:
   a. Handing out a piece of paper for participants to write their questions, clarifications, concerns.
   b. Asking the participants to summarize what they have learned during the discussion

Part 2: Body Mechanics Skills Training

Approximately 45 minutes

1. Start the skills training session with this video clip:
   What are the right body postures during pregnancy? - Sanghamitra
   https://www.youtube.com/watch?v=9k_vjca4kN0

2. Follow the table below as your guide for skills training facilitation.

Body Part	Correct Posture	Duration	Skills Check
Back			
Hips/Waist			
Legs			
Sleeping			
Sitting			

3. Use the demonstration-return demonstration teaching-learning technique for the skills training.

4. Remember to be patient and helpful during the course of skills training.

Part 3: Attitude development

Approximately 15 minutes

1. Ask the participants for any new skills acquired during the teaching-learning session.

2. Emphasize the need to be active and exercise.

3. Encourage the participants to plan a daily light walking routine by:
   a. Providing a piece of paper sketching their walk from their house to their intended venue for exercise.
   b. Writing on the piece of paper the following:
      - Time of the day to exercise
      - Duration of the exercise
      - Frequency of the exercise

End the teaching-learning session by congratulating the participants for any new knowledge and skills learned.

Module 3: Nutrition During Pregnancy

Duration: Approximately 60-90 minutes

OBJECTIVES:

1. Knowledge (Recommended Dietary Allowance)
   - Discuss ideal food choices appropriate to financial resources.
2. Skills (Cravings)
   - Mind setting techniques during cravings.
3. Attitude (Vitamins/Supplements)
   - Ask available vitamins/supplements from the center.

STEPS:

1. Begin the session by engaging the participants (and company) in small talk: ask about food cravings, daily eating habit, weight changes, etc.
2. Orient them about the topics, and duration of the whole session.

Part 1: Recommended Dietary Allowance During Pregnancy

Approximately 30 minutes

1. Before the start of this teaching-learning session, ask the participants how they manage the food cravings they are experiencing.

2. Start the discussion by showing this video clip:
   Pinoy MD: Masustansyang pagkain para sa naglilihing buntis

https://www.youtube.com/watch?v=NEHnsnkyoYc

3. After watching the video clip, show this image to the participant:

4. Ask the participants what in the recommended foods can their family afford to prepare daily.

5. If there are foods they find unaffordable for their family budget, what are the alternatives they can prepare for themselves?

6. Check and validate the participants' meal plans.

Part 2: Mindset Skills Training (Cravings)

Approximately 45 minutes

1. Start the skills training session with this video clip:
   Totoo ba ang paniniwala ni Juan sa paglilihi?
   https://www.youtube.com/watch?v=1-gVeUHQ0FU

2. Try to explain the psychological theory of food cravings.

3. Follow the table below as your guide for skills training facilitation.

Cravings	Meaning	Alternative Food	Excessive Eating
Ice and bizarre substances	Linked to an iron deficiency – even though none of those items contain significant amounts of iron		
Chocolate	Believed to signal a shortage of magnesium	Foods that contain magnesium include whole grains, beans,	

Cravings	Meaning	Alternative Food	Excessive Eating
		nuts, seeds, and green vegetables such as spinach	
Red meat	A transparent cry for protein		
Note: "There is no scientific explanation for food cravings. There are no data saying that what a woman craves is related to something her body or her baby needs, and there are no data to support that typical pregnancy food cravings are harmful, either," explains Brown. http://www.babycenter.com/0_food-cravings-and-what-they-mean_1313971.bc			

4. The skills to be trained here are how to overcome unhealthy food cravings or aversion by justifying to self that food cravings are their body's signal to attend to some nutritional deficiencies.

5. To do this, show pictures of foods. Then have the participants justify what their nutritional deficiency is.

6. Check and validate participants' answer to each question.

Part 3: Attitude Development (Vitamins/Supplements)

Approximately 15 minutes

1. As you reach this part of the teaching-learning session, wait to see if the participants will ask for any dietary, vitamins and supplements they can avail of from the center.

2. If the participants will not exhibit this behavior, then ask them, if they have supplements/vitamins they need that you feel we can offer them.

3. End the teaching-learning session by congratulating the participants for any new knowledge and skills learned.

Module 4: Oral Health for Teen Parents

Duration: Approximately 90 minutes

OBJECTIVES:

1. Knowledge
   - To explain the importance of oral health especially during and after pregnancy.
   - To demonstrate proper tooth brushing technique, use of dental floss and oral rinse.
   - To correct myths and misconceptions about dental procedure in pregnancy.
   - To promote the dental services available at the Batangas Medical Center.
2. Skills
   - To learn proper hand movement during tooth brushing.
   - To learn proper tooth flossing.
   - To learn proper rinsing.
3. Attitude
   - To promote appreciation of oral health during and after pregnancy.

STEPS:

1. Begin the session by engaging the participants (and companions) in small talk: ask about how the day is, commute to and from the TPC etc.
2. Orient the participants about the topic and duration of the session.

Part 1: Importance of Oral Health during and After Pregnancy

Approximately 30 minutes

1. **How pregnancy can affect your mouth**
   Although many women make it nine months with no dental discomfort, pregnancy can make some conditions worse, or create new ones. Regular checkups and good dental health habits can help keep you and your baby healthy.

2. **Pregnancy gingivitis**
   Your mouth can be affected by the hormonal changes you will experience during pregnancy. For example, some women develop a condition known as "pregnancy gingivitis", an inflammation of the gums that can cause swelling and tenderness. Your gums may also bleed a little when you brush or floss. Left untreated, gingivitis can lead to more serious forms of gum disease. Your dentist may recommend more frequent cleanings to prevent this.

3. **Increased risk of tooth decay**
   Pregnant women may be more prone to cavities for a number of reasons. If you're eating more carbohydrates than usual, this can cause decay. Morning sickness can increase the amount of acid your mouth is exposed to, which can eat away at the outer covering of your tooth (enamel).

   Brushing twice a day and flossing once can also fall by the wayside during pregnancy for many reasons, including morning sickness, a more sensitive gag reflex, tender gums and exhaustion. It is especially important to keep up your routine, as poor habits during pregnancy have been associated with premature delivery, intrauterine growth restriction, gestational diabetes, and preeclampsia.

4. **Pregnancy tumors**
   In some women, overgrowths of tissue called "pregnancy tumors" appear on the gums, most often during the second trimester. It is not cancer but rather just swelling that happens most often between teeth. They may be related to express plaque. They bleed easily and have a red, raw-looking raspberry-like appearance. They usually disappear after your baby is born.

5. **The food you eat matters**
   Your baby's teeth will begin to develop between the third and sixth months. That's why you need sufficient quantity of nutrients – especially vitamins A, C and D, protein, calcium and phosphorous. While it is normal for pregnant women to have the desire to eat more, frequent snacking can be an invitation to tooth decay. When you do snack, choose foods that are low in sugar and nutritious for you and your baby, such as raw fruits and vegetables, yoghurt or cheese, and make sure to follow your physician's advice regarding diet.

6. **Morning sickness**
   If you have morning sickness and vomiting frequently, try rinsing with a teaspoon of baking soda mixed with water to stop acid from attacking your teeth.

7. **After your baby is born**
   Continue taking care of your mouth and your baby's mouth too. Although newborns usually have no visible teeth, most baby teeth begin to appear generally about six months after birth. Begin cleaning your baby's mouth during the first few days after birth by wiping the gums with a clean, moist gauze pad or washcloth. As soon as teeth appear, decay can occur.

Part 2: Skills Development

Approximately 45 minutes

Proper Tooth brushing, Flossing and Use of Mouth Rinse

The Modified Bass Technique

1. Place bristles along the gum line at a 45˚ angle; bristles should contact both the tooth surface and the gum line.

2. Gently brush the outer tooth surfaces of 2-3 teeth using a vibratory back and forth, and rolling motion. Move brush to the next group of 2-3 teeth and repeat.

3. Maintain a 45˚ angle with bristles contacting the tooth surface and gum line. Gently brush using back and forth, and rolling motion along the entire inner tooth surface.

4. Tilt the brush vertically behind the front teeth. Make several up and down strokes using the front half of the brush.

5. Place the brush against the biting surface of the teeth and use a gentle back and forth scrubbing motion. Brush the tongue from back to front to remove odor-producing bacteria.

Proper Flossing




1. **Wind and Pinch**
- Wind 18" of floss around middle fingers of each hand.
- Pinch floss between thumbs and index fingers leaving 1"-2" length in between.
- Use thumbs to direct floss between upper teeth.

2. **Grasp**
- Keep a 1"-2" length of the floss taut between fingers.
- Use index fingers to guide floss between contacts of the lower teeth.

3. **Guide**
- Gently guide floss between the teeth by using a zig-zag motion. Do not snap floss between your teeth.
- Contour floss around the side of the tooth.

4. **Slide**
- Slide the floss up and down against the tooth surface and under the gum line.
- Floss each tooth thoroughly with a clean section of floss.

Mouth Rinse

Mouth rinse is used for a variety of reasons: to freshen breath, to help prevent or control tooth decay, to reduce plaque (a thin film of bacteria that forms on teeth), to prevent or reduce gingivitis (an early stage of gum disease), to reduce the speed that tartar (hardened plaque) forms on the mouth. It can be done before or after brushing, but it is not a substitute for brushing or flossing.

Steps on rinsing

1. Pour 4 teaspoon of oral rinse in a cup.
2. Without diluting with water, empty the cup into your mouth.
3. Swish for 60 seconds in your mouth.
4. Spit the solution in the sink.

Part 3: Myths and Facts About Dental Procedure During Pregnancy

Approximately 10 minutes

1. **Dental x-rays are safe**
   Dental X-rays are sometimes necessary if you suffer a dental emergency or need a dental problem diagnosed. Your dentist will cover you with a leaded apron that minimizes exposure to the abdomen. Your dentist will also, whenever possible, cover your throat with a leaded thyroid collar to protect the thyroid from radiation.

2. **Local anesthesia for dental procedure**
   If you're pregnant and need a filing, root canal or tooth pulled, one thing you don't have to worry about is the safety of the numbing medications your dentist may use during the procedure. They are, in fact, safe for both you and your baby.

   A study in the August 2015 issue of the *Journal of the American Dental Association* followed a group of pregnant women who had procedures that used anesthetics like lidocaine shots and a group that did not. The study showed these treatments were safe during pregnancy, as they cause no difference in the rate of miscarriages, birth defects, prematurity or weight of the baby. "Our study identified no evidence to show that dental treatment with anesthetics is harmful during pregnancy." Said study author Dr. Hagai. "We aimed to determine if there was a significant risk associated with dental treatment with anesthesia and pregnancy outcomes. We did not find any such risk."

3. **Dental treatment should be avoided during pregnancy**
   A dental checkup is recommended during pregnancy. Local anesthetics and X-rays are okay although they are to be done only when necessary. The dentist should be informed of the pregnancy before any procedure since some dental treatments are to be avoided entirely during pregnancy, such as amalgam removal and taking of antibiotics.

4. **Women lose a tooth for each child they have given birth to**
   More of an 'old wives' tale' than a myth, this is untrue. Hormonal changes while pregnant can exaggerate bacteria in the mouth that can cause bleeding gums or gingivitis. Tooth loss is unlikely with a thorough and regular cleaning regimen.

Part 4: Attitude Development

Approximately 5 minutes

1. Ask the participants any new skills acquired during the teaching-learning session.

2. Emphasize the need to practice proper tooth brushing, flossing and rinsing.

3. End the teaching-learning session by congratulating the participants for any new knowledge and skills learned.

Sources:

- Healthy mouth references by American Dental Association
- http://www.dentistryiq.com/articles/2015/01/pregnancy-myths-and-the-dental-office-debunked.html
- http://usprofessional.gumbrand.com/media/wysiwyg/OralCareTopics/Success_technique.jpg
- http://www.freethefixtures.com/wp-content/uploads/2016/01/Flossing.jpg
- http://www.listerine.com/mouth-coach/rinsing-guide

Module 5: Newborn Care: Breastfeeding Practice

Duration: Approximately 60-90 minutes

OBJECTIVES:

1. Knowledge- Breastfeeding
   - List benefits of exclusive breastfeeding practice.
2. Skills - Breastfeeding Techniques
   - Demonstrate proper breastfeeding techniques.
3. Attitude- Breastfeeding Practice
   - Agree to ensure exclusive breastfeeding practice.

STEPS:

1. Begin the session by engaging the participants (and company) in small talk: ask about budget preparation during pregnancy, who in their family will take care of the newborn.
2. Orient them about the topics and duration of the whole session.

Part 1: Recommended Dietary Allowance During pregnancy

Approximately 30 minutes

1. Before the start of this teaching-learning session, allow the participants to watch this video clip:
   a. **KB: Angkop na pag-aalaga sa sanggol at pagbibigay importansya sa pagpapasuso,** GMA News and Public Affairs
   b. https://www.youtube.com/watch?v=A9xYqXh9vWk

2. After watching the video clip, ask the participants about their feelings towards the practice of breastfeeding.

3. List all their verbalized feelings, then provide appropriate education for each feeling of concern coming from the expecting mothers.

4. Follow the table below as your guide for facilitating the discussion:
   Source: ***Gabay sa Nanay sa Tamang Pagpapasuso***
   Trainer's Reference Manual
   http://www.wpro.who.int/philippines/publications/final_copy_gabay_sa_nanay_tsek.pdf

Part 2: Medical Explanation of Common Breastfeeding Concerns

Approximately 30 minutes

Breastfeeding Concerns	Medical Explanation	Practical Tips
1. Walang Gatas, Konting Gatas, Kulang ang Gatas ni Nanay	1. Provide an illustration of a woman's breast (page 62). 2. Discuss the roles of	1. Discuss this: Mga Bagay na Maaring Makatulong sa Pagdaloy ng Gatas ni

Breastfeeding Concerns	Medical Explanation	Practical Tips
	hormones, namely prolactin and oxytocin, in the production of human milk (page 63).	Nanay (page 65).
2. Pamamaga ng Suso	1. Discuss the effect of "Painful post-feeding let-down reflex." 2. During breastfeeding, baby triggers tiny nerves in the nipple. These nerves cause hormones to be released into the bloodstream. 3. Symptoms of letdown reflex.	1. Discuss this: Lunas sa Pamamaga ng Suso (page 79).
3. Mga Problema sa Utong	1. Allow the participants to realize the following: a. Mother's nipples come in many shapes and sizes. b. Most nipples protrude and are easy for baby to grasp. c. There are some variations in size and shape that make it difficult for them to nurse successfully. d. Flat or inverted nipples may make it difficult to nurse the baby.	1. Discuss this: Lunas sa Problema ng mga Utong (page 82).
4. Pagpapasuso Habang Nagtatrabaho o Nag-aaral	1. Allow the participants to realize that anytime, anywhere, the mother can express her milk using appropriate breast milk collection techniques.	1. Discuss the following: a. Paghahanda ng Lalagyan ng Kokolektahing Gatas ni Nanay (page 86). b. Pag-iimbak ng Gatas na Nakolekta ni Nanay para kay Baby (page 87). c. Paano Pagsabayin ang Pagpapasuso at Pagtatrabaho ni Nanay (page 89).

Part 3: Skills Development: Breastfeeding Techniques

Approximately 45 minutes

1. Start the skills training session by presenting a "dummy baby".

2. Ask the participants to demonstrate how to hold the baby while doing breastfeeding.

3. Demonstrate to the participants the following breastfeeding positions (refer to pages 71-73):
   a. Paduyan o Pahele (Cradle Hold)
   b. Paekis (Reversed Cradle Hold)
   c. Salumkipkip (Clutch Hold)
   d. Patayo (Standing)
   e. Pahiga
   f. Pahigang Nakatagilid
4. After demonstrating, allow the participants to return demonstrate the above-mentioned breastfeeding technique positions.

5. Ask the participants to demonstrate; provide feedback and skills enhancement coaching.

Part 4: Attitude Development: Exclusive Breastfeeding Practice

Approximately 30 minutes

1. Start the attitude development session by presenting the advantages of exclusive breastfeeding practices.

2. Follow the table below as your guide for facilitating the discussion.

Advantages to the	Benefits
Baby	1. Mas matalino, kasi ang gatas ni Nanay ay nakakatulong sa pagpapa-unlad ng utak. 2. May proteksyon sa mga impeksyon, gaya ng pagdudumi (diarrhea), pulmonya, o ibang sakit. 3. May proteksyon laban sa allergies.
Mother	1. Mababa ang peligro, o risk, na magkaroon ng pagdurugo pagkapanganak (postpartum hemorrhage). ‡ 2. Mas mahabang panahon na hindi mag-ovulate. 3. Mas madaling magpasuso ng gabi. 4. Mas maraming pahinga. 5. May espesyal na bonding kay Baby. 6. Bihirang lumiban sa trabaho/eskwela, kasi bihirang magkasakit si Baby.

3. As you reach this part of the teaching-learning session, wait to see if the participants will be most comfortable when choosing the method of feeding her newborn.

4. If the participants will choose formula milk over breastfeeding technique, provide her with an assignment in which she will show the computation of her expenses for her choice of formula milk in terms of months, up to two years.

5. Then emphasize that breastfeeding technique does not cost any amount of money.

6. End the teaching-learning session by congratulating the participants for any new knowledge and skills learned.

Module 6: Family Planning

Duration: Approximately 60-90 minutes

OBJECTIVES:

1. Knowledge - Family Planning Methods
    - Compare benefits of available family planning methods.
2. Attitude - Decision in Using Family Planning Methods
    - Agree to use one preferred method of family planning, post-delivery.

STEPS:

1. Begin the session by engaging the participants (and company) in small talk: ask about how many siblings do they have, how many go to school, how many are with employment.
2. Ask if it was hard for them to relate with all their siblings. Ask why.

Part 1: Attitude Development: Decision in Using Family Planning Methods

Approximately 60 minutes

1. Start the attitude development session by showing this documentary:
   Front Row: Bente Dos
   GMA News and Public Affairs
   https://www.youtube.com/watch?v=MtAAHPoHQu0

2. After showing the documentary, use the following questions in facilitating the attitude development to the participants:
   a. Which one do you prefer, a large family with financial difficulty? Or a small family that can sustain its needs?
   b. Why do you think the family reached its size of 22?
   c. Do you agree that if only the parents of the family practiced family planning, it would not have reached its size of 22 children?
   d. If you can control the size of your future family, how many children do you prefer to raise?

3. Further explore the participants' attitude towards family planning by asking the following questions:
   a. What will be the limitations if ever you will raise a big family?
   b. What will be the limitations of your future children if they will grow up in a big family?
   c. Which would your future children be more thankful for: having a lot of siblings, or enjoying the quality of their life even if they grow up with only a few siblings?

4. For the last part of the attitude development session, give the participants a paper balloon and decorating materials. Ask them to decorate the paper balloon as beautifully as they can.

5. Then after decorating, ask the participants to blow the paper balloon until it explodes with too much air.

6. Once the paper balloon is blown up and deformed due to too much air, ask the participants how they felt when the balloon they decorated was deformed because of infusing too much air.

7. Relate the activity to the idea of lack of family planning.

Part 2: Family Planning Methods

Approximately 30 minutes

1. Use the table below in facilitating the discussion on Family Planning Methods:

   Source:
   Pakikipag-usap Ukol sa Reproductive Health/Pagpaplano sa Pamilya sa Iyong Komunidad Kodigo para sa mga Peer Educators
   http://www.pfpi.org/pdf/crm-fp/CPEs%20and%20MPEs%20JOb%20Aid%20Tagalog%20-%20RH%20Only%20revised.pdf

   Mga Benepisyo ng Pagpaplano ng Pamilya
   http://hesperian.org/wp-content/uploads/pdf/fil_wwhnd_2010/fil_wwhnd_2010_13.pdf

Methods	Benefits	Protection
Pills	1. Pinipigilan ng mga hormonal na kontraseptibo ang obaryo ng babae na maglabas ng itlog. 2. Pinapakapal din ang mucus sa bukana ng matres na nagpapahirap sa semilya na makarating sa loob ng matris.	Di permanente, panandalian Nagbibigay proteksyon laban sa kanser ng obaryo at matris
DMPA	1. Injectable na pamamaraan, binibigay tuwing ikatlong buwan. 2. Ligtas at epektibo, panandalian. 3. Di nangangailangan ng pag-inom ng tableta, pwede sa anumang edad, at konti ang side effects. 4. Maaaring gamitin ng babaeng nagpapasuso.	3 buwan
Vasectomy at Ligation (BTL)	1. Lubhang epektibo, ligtas, isang operasyon lang ang kailangan. 2. Para sa mga ayaw nang magkaroon pa ng mas maraming anak.	Permanenteng pamamaraang kontraseptibo
Condom	1. Lubhang epektibo kapag tama at palagian ang paggamit. 2. Madaling gamitin, panandalian, maaaring maging back-up method, at nagbibigay proteksyon laban sa STD/HIV/AIDS.	Epektibo habang ginagamit

2. Provide illustrations of the mentioned family planning methods.

3. Towards the end of the discussion, allow the participants to identify the method according to the picture/illustration.

Part 3: Attitude Development: Decision in Using Family Planning Methods

4. Emphasize the need for family planning by allowing the participants to choose which among the methods they want to use after the appropriate time, post-delivery.

5. To do this, have the participants choose which among the illustrations/pictures they find most useful for their future families.

6. End the teaching-learning session by congratulating the participants for any new knowledge and attitude learned.

Annex 11: Health Class Attendance Record

TEEN PARENTS' CLINIC
(Complete Address)

Client Name:		
Date	**Module**	**Assessment**
	Module 1: Female Reproductive Health: Parts & Functions	☐ Demonstrated expected outcomes ☐ Needs follow-up Comments: TPC Coordinator/Point Person:
	Module 2: Stages of Pregnancy	
	Session 1: Bodily Changes During Pregnancy	☐ Demonstrated expected outcomes ☐ Needs follow-up Comments: TPC Coordinator/Point Person:
	Session 2: Signs and Symptoms During Pregnancy	☐ Demonstrated expected outcomes ☐ Needs follow-up Comments: ☐ TPC Coordinator/Point Person:
	Module 3: Nutrition During Pregnancy	☐ Demonstrated expected outcomes ☐ Needs follow-up Comments: ☐ TPC Coordinator/Point Person:
	Module 4: Oral Health for Teen Parents	☐ Demonstrated expected outcomes ☐ Needs follow-up Comments: ☐ TPC Coordinator/Point Person:
	Module 5: Newborn Care: Breastfeeding Practice	☐ Demonstrated expected outcomes ☐ Needs follow-up Comments: ☐ TPC Coordinator/Point Person:
	Module 6: Family Planning Decision	☐ Demonstrated expected outcomes ☐ Needs follow-up Comments: ☐ TPC Coordinator/Point Person:

Annex 12: TPC Adolescent Target Client List

TARGET CLIENT LIST FOR ADOLESCENT SERVICES IN HOSPITAL

A. PRENATAL															
1	2	3	4	5	6	7	8	9	10	11	12	13			
DATE OF REGIS-TRATION (mm/dd/yy)	SERIAL NO.	NAME OF CLIENT (Surname, First Name, MI)	COMPLETE ADDRESS / PHONE NUMBER	DATE OF BIRTH (mm/dd/yy)	AGE	REFERRED BY: 1. School 2. Brgy./BHS 3. RHU 4. Private 5. Walk-in / With referral slip? (Y/N)	NAME OF REFERRING FACILITY	Got pregnant while in school? (Y/N) / Gr./Yr. Lvl. at time of Pregnancy	LMP (mm/dd/yy) / G-P	EDC (mm/dd/yy)	Psychosocial Interview, Counseling using HEADSS & Use of Appropriate Algorithms (Y/N)	DATE of PRENATAL VISITS			
												Visit for 1st Trimester (0-84 days)	Visit for 2nd Trimester (85-189 days)	1st Visit for 3rd Trimester (190+ days)	2nd Visit for 3rd Trimester (190+ days)
1															
2															
3															
4															
5															
6															
7															
8															
9															
10															
11															
12															
13															
14															
15															
16															
17															

A. PRENATAL																					
14	15	16	17					18						19			20		21		22
PHIL-HEALTH covered? (Y/N)	Did the CLIENT and her PARTNER attend a health education class?	TETANUS STATUS	DATE TETANUS TOXOID VACCINE GIVEN					MICRONUTRIENT SUPPLEMENTATION						STI SURVEILLANCE			OUTGOING REFERRAL		PREGNANCY OUTCOME		
If Y, M for "member" or D for "dependent".	If both = 2, pregnant client only = 1, neither = 0.		TT1 (Day 0)	TT2 (After 1 month)	TT3 (After 6 months)	TT4 (After 1 year)	TT5 (After 1 year)	DATE & NO. IRON W/ FOLIC ACID WAS GIVEN						DATE TESTED FOR SY	RESULT OF SY TESTING (+/-) / DATE	GIVEN PENICILLIN (Y/N) / DATE	REFERRED to another FACILITY? (Y/N) If Y, REASON for REFERRAL	NAME OF REFERRAL FACILITY CLASSIFICATION[a] (Use code)	DATE TERMINATED	OUTCOME[b]/ SEX (M/F) (Use code)	REMARKS
																					1
																					2
																					3
																					4
																					5
																					6
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																					15
																					16
																					17

[a] *Classification of Referral Facility:*
1 = TPC
2 = Public Hospital (Lvl. 2-3)
3 = Private Hospital (Lvl. 2-3)
4 = Others, specify

[b] *Outcome:*
LB = Live Birth
FD = Fetal Death
AB = Abortion

C. FAMILY PLANNING

29	30	31	32	33												34	35	
DATE OF REGISTRATION (mm/dd/yy)	METHOD ACCEPTED[f]	TYPE OF CLIENT[e]	PREVIOUS METHOD, IF ANY[f]	FOLLOW-UP VISITS (Upper Row: Next Service Date / Lower Row: Date Accomplished)												DROPOUT	REMARKS	
AGE	(Use code)	(Use code)	(Use code)	1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th	DATE & REASON[g] (Use code)		
																		1
																		2
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[f] *FP methods:*
PILLS = Pills
INJ = DMPA or CIC
IIUD = Interval IUD
PPIUD = Postpartum IUD
CON = Condom
IMP = Subdermal Implant
BTL = Bilateral Tubal Ligation
NSV = Vasectomy
NONE = No Previous Method/New Acceptor
LAM = Lactational Amenorrhea
SDM = Standard Days Method
NFP-BBT = Basal Body Temperature
NFP-CM = Cervical Mucus Method
NFP-STM = Symptothermal Method

[g] *Reasons for dropout:*
A = Pregnant
B = Desires to be pregnant
C = Medical complications
D = Fear of side effects
E = Changed clinic
F = Partner disapproves
G = Menopause
H = Lost/moved out of area/residence
I = Failed to get supply
J = IUD expelled
K = Change method
L = No supply of FP commodity
M = Age out for BTL
N = Unknown

For LAM:
O = Mother has menstruation/amenorrheic w/in 6 mos.
P = No longer fully/exclusively breastfeeding
Q = Baby is more than 6 mos. old

	NAME OF CLIENT (Surname, First Name, MI)	B. POST-PARTUM																
		23						24		25	26				27		28	
		LIVE BIRTH						POST-PARTUM VISITS			MICRONUTRIENT SUPPLEMENTATION				FP COUNSELING			
		DATE AND TIME OF DELIVERY (mm/dd/yy)	TYPE OF DELI-VERY (NSD/ CS)	BIRTH WEIGHT (grams)	PLACE OF DELIVERY[c] (Use code)		ATTEN-DED BY[d] (Use code)	Indicate DATE & NAME of FACILITY (if other than hospital)		DATE & TIME INITIATED BREAST-FEEDING	IRON			VITAMIN A	DATE FP COUNSELING GIVEN	DESIRED FP METHOD[f] (Use code)	REMARKS
					HEALTH FACILITY (Specify)	NID		W/in 24 hours after delivery	W/in 1 week after delivery		DATE / NO. OF TABLETS			DATE			
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3																		
4																		
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15																		
16																		
17																		

[c] Health Facility or Non-Institutional Delivery (NID)

This refers to deliveries by place:
Health facility: Hospitals, RHUs, lying-ins/birthing homes
Non-institutional delivery (NID): home, in-transit, others

Code: RHU, BEmONC, CEmONC, Hospital, Lying-in clinics

[d] *Attended by:*
MD = [illegible] H = Hilot/TBA
RN = [illegible] O = Others
RM= Midwife

[e] *Type of client:*
CU = Current User
NA = New Acceptor

Other acceptors:
CU-OA-CM = Changing Method
CU-OA-CC = Changing Clinic
CU-OA-RS = Restarter

A. PRENATAL SERVICES

1-6. **Basic Information.** Upon client's presentation of the referral form (from referring school/RHU/private birthing clinic/community/other units of the hospital) and official identification documents (e.g., birth certificate, school identification card if currently enrolled, and/or any valid legal or official document to confirm identity), the assigned TPC health provider shall initiate the recording of the following basic information in Columns 1-6 of the Target Client List:

a. **Date of Registration.** This information shall be written in the format *mm/dd/yy* in Column 1.
b. **Serial Number.** The TPC shall assign the client's serial number to the adolescent client and shall indicate this number in Column 2.
c. **Name of Client.** Write the name of the adolescent client in Column 3 in the format *Surname*, *First Name*, *Middle Initial*.
d. **Complete Address and Phone Number.** Ask for the complete address and contact number of the client or her guardian. Indicate the required information in Column 4. Write the address in the upper row using the format *House Number and Street, Barangay, Municipality/City,* and the contact number (landline or mobile) in the lower row.
e. **Birth Date and Age of Client.** Ask the client's birth date and age at the time of registration. It is best to base the information from a valid ID or birth certificate, if available. Indicate the date of birth in Column 5 in the format *mm/dd/yy*. Write down the age in Column 6.

7. **Referred By.** In this column, determine the type of facility where the client was referred from. In the upper row, input any of the following:

a. "1" if the client was referred by a school or school-based Teen Health Kiosk
b. "2" if referred by a barangay health worker or any other health service provider from the barangay or, specifically, a Barangay Health Station
c. "3" if referred by an RHU
d. "4" if referred by a private facility,
e. "5" if she is a walk-in client, i.e., not referred

Use the lower row to indicate if the client arrives with a corresponding referral slip from the referring facility. Write "Y" if yes and "N" if no.

8. **Name of Referring Facility.** Specify the name of the referring facility, as applicable.

9. **Got pregnant while in school?** Determine if the client got pregnant while in school, and enter the corresponding response in the upper row of Column 9.

a. If the client is pregnant on the first visit, ask if she is still enrolled. Write "Y" if yes and "N" if no.
b. If the client's first visit is for postpartum and/or family planning services, ask if she was enrolled in school at the time she got pregnant. Write "Y" if yes and "N" if no.
c. If the client is not and has never been pregnant, write "N".

For clients with "Y" responses in the upper row, indicate in the lower row the grade or year level they were in at school (i.e., elementary, high school, or college) when they got pregnant.

10. **Last Normal Menstrual Period (LMP)/Gravida-Parity (G-P).** Write in this column two entries: LMP and G-P. For LMP, ask the client to recall the first day of her last menstrual period. Write the LMP date in *mm/dd/yy* format in the upper row. For gravida (G), ask the client how many times she has been pregnant, including her current pregnancy. For parity (P), ask how many were delivered (more than 20 weeks AOG regardless of the outcome). Write the G-P in the lower row.

11. **Expected Date of Confinement (EDC).** Compute the expected date of confinement using the LMP indicated in Column 10. Write down the computed EDC in Column 11.

    Formula for Computing EDC:

LMP:	January-March	=	+ 9 months + 7 days + 0 years
	April-December	=	- 3 months + 7 days + 1 year

Example:	LMP	=	4	14	2012	
	Formula	=	- 3	+ 7	+	1
	EDC	**=**	**1**	**21**	**2013**	

12. **Psychosocial Interview and Counseling.** If the client was provided psychosocial interview and counseling using HEADSS (Home, Education/Employment, Activities, Drugs, Sexuality, and Safety/Suicide Risk) and appropriate algorithms, input "Y" in Column 12. If this was not conducted, input "N".

13. **Prenatal Visits.** Column 13 has four sub-columns to segregate visits per trimester. If the client had a prenatal checkup on the 1st trimester (0-12 weeks or 0-84 days), write the date of visit in the first sub-column. If a prenatal checkup was done on the 2nd trimester (13-27 weeks or 85-189 days), write the corresponding date of visit in the second sub-column. Similarly, if visits were conducted on the 3rd trimester (28+ weeks or 190 days and above), write the dates of the visits in the 3rd and 4th sub-columns.

    To be reported as 4ANC, at least one visit in the 1st trimester, one visit in the 2nd trimester, and two visits in the 3rd trimester are required. It may be emphasized that prenatal visits, and subsequently deliveries, involving adolescent mothers are ideally done at the TPC of the CEmONC-capable hospital.

14. **PhilHealth Coverage.** To determine the client's eligibility for PhilHealth benefits, ask if she is covered by PhilHealth whether as a member or dependent (below 21 years old), and verify if said membership is active. An active membership requires at least three payments within six months from the time of admission.

    You may ask any of the following questions: "*Are you enrolled now in PhilHealth?*" or "*Is any of your parents a PhilHealth member?*" If the client responds Yes to either question, write "Y" in the upper row of Column 14; if she responds No to both, write "N." For clients covered by PhilHealth, indicate "M" in the lower row if she is a member (i.e., if she answered Yes to the first question) or "D" if she is a "dependent" (i.e., if she answered Yes to the second question).

15. **Health Education Class.** In Column 15, indicate if the adolescent client and/or her partner attended a health education class provided by the TPC. Write "2" if both the

client and her partner attended, "1" if only the client attended, or "0" if neither was able to attend.

16. **Tetanus Status.** Look or request for a record of the client's past or present pregnancy and write in this column the tetanus toxoid immunization she has already received. Use the following codes for input in Column 16:

Code	Description
TT1	The client has received only one dose of TT
TT2	The client has received two doses of TT (TT1 and TT2)
TT3	The client has received TT1, TT2, and TT3
TT4	The client has received TT1, TT2, TT3, and TT4
TT5	The client has already received five doses of TT (Fully Immunized Mother)
NONE	The client has not received any TT dose (still to be given TT1)
UNKNOWN	If no information has been obtained from the client's records

17. **Tetanus Toxoid Given.** Column 17 has five sub-columns (TT1 to TT5). Write in the appropriate column the date the dose of tetanus toxoid was administered during the prenatal visit in the facility. Observe the correct interval, as follows:

TT Dose	Interval
TT1	As early as possible during pregnancy or even in a nonpregnant woman of childbearing age
TT2	At least four weeks after the first dose, within the same pregnancy
TT3	At least six months after TT2
TT4	At least one year after TT3
TT5	At least one year after TT4

18. **Micronutrient Supplementation Given.** For Column 18, write the date and number of Iron with Folic Acid (IFA) tablets given to the client. Indicate the date given in the upper row and the number of IFA tablets in the lower row.

19. **STI Surveillance.** Column 19 has three sub-columns. For the "Tested for Syphilis" column, indicate the date the test was done, if applicable. Under "Result for SY Testing", write "+" in the upper row if the syphilis rapid plasma reagin or rapid diagnostic test result was positive or "-" if the rapid plasma reagin or rapid diagnostic test result was negative. Write the date the test result was issued in the lower row. For the "Given Penicillin" column, put "Y" in the upper row if the syphilis-positive pregnant woman was provided penicillin or "N" if not. In the lower row, write the date the penicillin was administered.

20. **Outgoing Referral.** Column 20 has two sub-columns. In the first sub-column, indicate in the upper row if the patient was referred to another facility. Write "Y" if Yes or "N" if No. If the client was indeed referred, write the reason for referral in the lower row.

    In the second sub-column, write the name of the outgoing referral facility in the upper row, and indicate the classification of this referral facility in the lower row, as follows:
    a. "1" if another TPC
    b. "2" if a Level 2-3 public hospital
    c. "3" if a Level 2-3 private hospital
    d. "4" if referred to other facilities. Specify further the type of facility, e.g., RHU, nonhospital private facility, other hospital departments, etc.

21. **Pregnancy Outcome.** For Column 21, write the date (*mm/dd/yy*) the current pregnancy ended in the sub-column "Date Terminated". Under the "Outcome" sub-column, write the outcome of the pregnancy—whether it is a live birth, fetal death or abortion—in the upper row, and the sex of the child in the lower row. In cases of multiparous births, two or more codes and sexes may appear in this sub-column. Use the following codes:

Code	Definition
LB	**Live Birth.** The complete expulsion or extraction from the mother's womb of a product of conception, irrespective if the fetus, after such separation, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of muscles.
FD	**Fetal Death.** Death of the fetus prior to its complete expulsion from the mother. Death is indicated by the fact that after separation, the fetus does not breathe or show any evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. (20 weeks and above)
AB	**Abortion.** Termination of pregnancy before the fetus becomes viable. (Before the 20th week or 5th month of pregnancy)

22. **Remarks.** You may use this column to make notes on why a pregnant woman failed to return for her prenatal visit. You may also indicate dates and reasons such as transfer to another city/municipality/province, presently ill, hospitalized, etc. Other data of importance concerning the patient may likewise be recorded.

B. POSTPARTUM SERVICES

1. **Live Birth**. In cases of live birth, write the date (*mm/dd/yy*) and time (*hh:mm AM/PM*) the client gave birth to serve as basis for succeeding entries. Indicate the client's type of delivery in the second sub-column: "NSD" for a normal spontaneous delivery or "CS" for Caesarian section. The weight of the infant (in grams) must then appear in the "Birth Weight" sub-column. If there is more than one birth, the birth weights of all newborns must appear.

   The sub-column "Place of Delivery" is further divided into two columns: "Health Facility" and "Non-Institutional Delivery". For health facility deliveries, use the following codes in the upper row: "RHU", "BEmONC", "CEmONC", "Hospital", or "Lying-in Clinic"; then, write the name of the health facility in the lower row. If the delivery occurred in other places (i.e., at home, in a mode of transport, etc.), specify the place in the "Non-Institutional Delivery" sub-column. Two or more entries may appear in this sub-column in cases of multiple births at different places.

   In the "Attended By" sub-column, identify the designation of the birth attendant with the highest professional rank. Use the following codes:

Code	MD	RN	RM	H	O
Designation	Doctor	Nurse	Midwife	*Hilot*	Others

2. **Postpartum Visits.** Column 24 is divided into two sub-columns corresponding to the two required postpartum visits: within 24 hours after delivery and within one week after delivery. In the upper row of the designated column, write the date of the postpartum

checkup. In the lower row, indicate the name of the health facility where the postpartum checkup was conducted.

3. **Date and Time Initiated Breastfeeding.** For Column 25, write the date (*mm/dd/yy*) and time (*hh:mm AM/PM*) the post-partum mother initiated breastfeeding.

4. **Micronutrient Supplementation.** Column 26 is divided into iron and vitamin A supplementation. For "Iron", write in the upper row the date/s the iron supplements were provided and, in the lower space, the number of tablets given. For "Vitamin A", indicate only the date the supplementation was given.

5. **FP Counseling.** For column 27, write the date family planning counseling was provided in the first sub-column in the format *mm/dd/yy*. In the second sub-column, identify the specific FP method of interest chosen by the client. Refer to No. 31 for the list of FP methods and their corresponding codes.

6. **Remarks.** For Column 28, enter any other relevant information concerning the postpartum mother, e.g., multiple births.

C. FAMILY PLANNING SERVICES

1. **Date of Registration.** In the upper row of Column 29, write the date (*mm/dd/*yy) when the client first visited the facility for family planning services. In the lower row, indicate the age of the client at the time of this visit.

2. **Method Accepted.** In Column 30, specify the actual family planning method accepted by the client. Use the codes below:

CODE	Method
Pills	Pills
INJ	Depo-medroxy Progestone Acetate (DMPA)/ Combined Injectables Contraceptives (CIC)
IIUD	Interval Intrauterine Device
PPIUD	Postpartum Intrauterine Device
CON	Condom
IMP	Implants
BTL	Female Sterilization/Bilateral Tubal Ligation
NSV	Male Sterilization/No-Scalpel Vasectomy
LAM	Natural Family Planning-Lactational Amenorrhea Method
SDM	Natural Family Planning-Standard Days Method
NFP-BBT	Natural Family Planning-Basal Body Temperature
NFP-CM	Natural Family Planning-Cervical Mucus Method
NFP-STM	Natural Family Planning-Symptothermal Method
NONE	No Previous Method (New Acceptor)

3. **Type of Client.** Indicate the type of client in Column 31. Refer to the table below for the categorization:

CODE	Type of Client
NA	**New Acceptor.** A client who has NEVER accepted *any* FP method at any clinic before.

CODE	Type of Client
CU	**Current User.** A client who is a regular and continuing user of an FP method in the clinic.
	Other Acceptors, including:
CU–OA–CM	**Changing Method (CM).** A continuing user who is shifting to another method.
CU–OA–CC	**Changing Clinic (CC).** A continuing user who has been using the same method, but is a new client to the clinic.
CU–OA–RS	**Restart (RS).** A client who has stopped FP practice for at least one month but has resumed using the same method in the same clinic.

4. **Previous Method.** For column 32, as applicable, write the last FP method used prior to accepting the new method. Use the codes in Column 31.

5. **Follow-up Visits.** Column 33 has 12 sub-columns for 12 follow-up visits on family planning. Write in each column two entries: the scheduled date of service in the upper row, and the actual date of visit in the lower row. Use the format *mm/dd/yy*.

6. **Dropout.** For Column 34, write the date when the client is dropped from the record based on the following FP method dropout criteria:

    a. *Pills* – A client is considered a dropout from the method if she:
        i. Failed to come and get her resupply from the last 21 white pills up to the last brown pill (if the pills have a set of brown tablets/iron); or within seven days from the 21st pill/last pill (if the pills contain only a set of white tablets).
        ii. Got supply from or transferred to another provider or clinic. In this case, the client is listed as Other Acceptor (Changing Clinic) in the clinic she transferred to, and a Dropout in her former clinic.
        iii. Decided to stop the use of the pills for any reason.

    b. *Injectables* – A client is considered a dropout if she:
        i. Failed to visit the clinic on the scheduled date of visit up to the last day of the two weeks after the scheduled date of visit (e.g., in the case of DMPA, every three months).
        ii. Failed to visit the clinic on the scheduled date of visit up to the last day of a week after the scheduled date of visit (e.g., in the case of NET-EN, every two months).
        iii. Got supply from or transferred to another provider or clinic. In this case, the client is listed as Other Acceptor (Changing Clinic) in the clinic she transferred to, and a Dropout in her former clinic.
        iv. Decided to stop receiving the injectable for any reason.

    c. *IUD* – A client is considered a dropout if she:
        i. Decided to have it removed.
        ii. Had an expelled IUD that was not reinserted.
        iii. Did not return on the scheduled date of follow-up visits 3-6 weeks after insertion. It is good medical practice to follow up on the client yearly, but the client is dropped out if she does not return for two years.

    d. *Condom* – A client is considered a dropout if she/he fails to return for resupply on the scheduled visit; or decides not to use condoms for any reason.

e. *Lactational Amenorrhea Method* – A client is considered a dropout if any one of the following three conditions *is not met*:
   i. The mother is amenorrhoeic or has no menstruation within six months. Spotting or bleeding during the last 56 days postpartum is not considered return of menses.
   ii. Fully/exclusive breastfeeding means no other liquid or solid except breastmilk is given to the infant. Intervals should not exceed four hours during the day and six hours at night.
   iii. The baby is less than six months old.

f. *Natural Family Planning:*

   Standard Days Method (SDM) – A client is considered a dropout if she:
   i. Fails to return on the follow-up date to identify her own fertile and infertile periods.
   ii. Has no indication of SDM use through beads or no knowledge of the first day of menstruation or cycle length.
   iii. Decides to stop the use of the method.

   BBT/Billings/Symptothermal Method – A client is considered a dropout if she:
   i. Fails to return on the follow-up date to check on the correct charting and/or proper use of the method.
   ii. Fails to identify her own fertile and infertile periods.
   iii. Decides to stop the use of the method.

   Note:
   - The client is given a period of time (i.e., two months) as a learning user to practice correct charting with assistance before she is recorded as a new acceptor. She is only considered a new acceptor if she can identify and chart her fertile and infertile periods correctly.
   - An autonomous user can be considered a Current User as these clients no longer need assistance in charting from the health workers. The service provider should undertake a follow-up visit with the client before dropping her out.

g. *Female Sterilization/BTL* – A client is considered a dropout if she reaches 50 years of age or experiences the following conditions: menopause, or underwent hysterectomy or bilateral salpingo-oophorectomy. Follow-up of clients should be undertaken prior to dropping out.

h. *Implants* – A client is considered a dropout if she did not return to the facility three years after implant insertion for removal and replacement of the implant rod.

7. **Remarks.** Indicate in this column the date and reason for every referral made to other clinics/facilities and for every referral received from other clinics/facilities which can be due to medical complications or unavailable family planning services and other pertinent findings significant to client care.

Annex 13: FP Form 1

SIDE A **FAMILY PLANNING (FP) FORM 1** ver. 3.0

FAMILY PLANNING CLIENT ASSESSMENT RECORD

Instructions for Physicians, Nurses and Midwives: ***Make sure that the client is not pregnant by using the questions listed in SIDE B.*** *Completely fill out or check the required information. Refer accordingly for any abnormal history/findings for further medical evaluation*

CLIENT ID: _____

PHILHEALTH NO.: _____

NHTS?: ☐Yes ☐No **Pantawid Pamilya Pilipino Program(4Ps):** ☐Yes ☐No

NAME OF CLIENT: _____ __ __/__ __/__ __ __ __ ____ _____ _____
Last Name Given Name MI Date of Birth Age Educ. Attain. Occupation

ADDRESS: _____ _____ _____ _____
No. Street Barangay Municipality/City Province Contact Number Civil Status Religion

NAME OF SPOUSE: _____ __ __/__ __/__ __ __ __ _____ _____
Last Name Given Name MI Date of Birth Age Occupation

NO. OF LIVING CHILDREN: _____ **PLAN TO HAVE MORE CHILDREN?** ☐ **Yes** ☐ **No** **AVERAGE MONTHLY INCOME:** _____

Type of Client

☐ New Acceptor Reason for FP: ☐ spacing ☐ limiting ☐ others_____

☐ Current User

☐ Changing Method Reason: ☐ medical condition ☐ side-effects _____

☐ Changing Clinic

☐ Dropout/ Restart

Method currently used (for Changing Method):

☐ COC ■ IUD ☐ BOM/CMM ☐ LAM

☐ POP ☐ Interval ☐ BBT ☐ others

☐ Injectable ☐ Post-Partum ☐ STM specify: _____

☐ Implant ☐ Condom ☐ SDM

I. MEDICAL HISTORY

Does the client have any of the following?

■ severe headaches / migraine	☐Yes	☐No
■ history of stroke / heart attack / hypertension	☐Yes	☐No
■ non-traumatic hematoma / frequent bruising or gum bleeding	☐Yes	☐No
■ current or history of breast cancer / breast mass	☐Yes	☐No
■ severe chest pain	☐Yes	☐No
■ cough for more than 14 days	☐Yes	☐No
■ jaundice	☐Yes	☐No
■ unexplained vaginal bleeding	☐Yes	☐No
■ abnormal vaginal discharge	☐Yes	☐No
■ intake of phenobarbital (anti-seizure) or rifampicin (anti-TB)	☐Yes	☐No
■ Is the client a SMOKER?	☐Yes	☐No
■ With Disability?	☐Yes	☐No

(if YES please specify: _____)

II. OBSTETRICAL HISTORY

Number of pregnancies: G_____ P _____

_____ Full term _____ Premature

_____ Abortion _____ Living children

Date of last delivery __ __/__ __/__ __ __ __

Type of last delivery ☐Vaginal ☐Cesarean Section

Last menstrual period __ __/__ __/__ __ __ __

Previous menstrual period __ __/__ __/__ __ __ __

Menstrual flow :

☐scanty (1-2 pads per day)

☐moderate (3-5 pads per day)

☐heavy (>5 per pads day)

☐ Dysmenorrhea

☐ Hydatidiform mole (within the last 12 months)

☐ History of ectopic pregnancy

III. RISKS FOR SEXUALLY TRANSMITTED INFECTIONS

Does the client or the client's partner have any of the following?

■ abnormal discharge from the genital area	☐Yes	☐No
if "YES" please indicate if from: ☐Vagina ☐Penis		
■ sores or ulcers in the genital area	☐Yes	☐No
■ pain or burning sensation in the genital area	☐Yes	☐No
■ history of treatment for sexually transmitted infections	☐Yes	☐No
■ HIV / AIDS / Pelvic inflammatory disease	☐Yes	☐No

Implant = Progestin subdermal implant; IUD = Intrauterine device; BTL = Bilateral tubal ligation; NSV = No-scalpel vasectomy; COC = Combined oral contraceptives; POP = Progestin only pills; LAM = Lactational amenorrhea method; SDM = Standard days method; BBT = Basal body temperature; BOM = Billings ovulation method; CMM = Cervical mucus method; STM = Symptothermal method

IV. RISKS FOR VIOLENCE AGAINST WOMEN (VAW)

■ unpleasant relationship with partner	☐Yes	☐No
■ partner does not approve of the visit to FP clinic	☐Yes	☐No
■ history of domestic violence or VAW	☐Yes	☐No

Referred to: ☐ DSWD
☐ WCPU
☐ NGOs
☐ Others (Specify: _____)

V. PHYSICAL EXAMINATION

Weight: _____ kg Blood pressure: _____ mmHg

Height: _____ m Pulse rate: _____ /min

SKIN:
☐ normal
☐ pale
☐ yellowish
☐ hematoma

CONJUNCTIVA:
☐ normal
☐ pale
☐ yellowish

NECK:
☐ normal
☐ neck mass
☐ enlarged lymph nodes

BREAST:
☐ normal
☐ mass
☐ nipple discharge

ABDOMEN
☐ normal
☐ abdominal mass
☐ varicosities

EXTREMITIES
☐ normal
☐ edema
☐ varicosities

PELVIC EXAMINATION
(For IUD Acceptors)
☐ normal
☐ mass
☐ abnormal discharge
☐ cervical abnormalities
☐ warts
☐ polyp or cyst
☐ inflammation or erosion
☐ bloody discharge
☐ cervical consistency
☐ firm ☐ soft
☐ cervical tenderness
☐ adnexal mass / tenderness
☐ uterine position:
☐ mid
☐ anteflexed
☐ retroflexed
☐ uterine depth: _____ cm

ACKNOWLEDGEMENT:

This is to certify that the Physician/Nurse/Midwife of the clinic has fully explained to me the different methods available in family planning and I freely choose the _____ method.

_____ _____
Client Signature Date

For WRA below 18 yrs. Old:
I hereby consent _____ to accept the Family Planning method.

_____ _____
Parent/Guardian Signature Date

SIDE B **FP FORM 1**

FAMILY PLANNING CLIENT ASSESSMENT RECORD

DATE OF VISIT (MM/DD/YYYY)	MEDICAL FINDINGS (Medical observation, complaints/ complication, service rendered/ procedures, laboratory examination, treatment and referrals)	METHOD ACCEPTED	NAME AND SIGNATURE OF SERVICE PROVIDER	DATE OF FOLLOW-UP VISIT (MM/DD/YYYY)

How to be Reasonably Sure a Client is Not Pregnant

1. Did you have a baby less than six (6) months ago, are you fully or nearly-fully breastfeeding, and have you had no menstrual period since then?	☐ Yes	☐ No
2. Have you abstained from sexual intercourse since your last menstrual period or delivery?	☐ Yes	☐ No
3. Have you had a baby in the last four (4) weeks?	☐ Yes	☐ No
4. Did your last menstrual period start within the past seven (7) days?	☐ Yes	☐ No
5. Have you had a miscarriage or abortion in the last seven (7) days?	☐ Yes	☐ No
6. Have you been using a reliable contraceptive method consistently and correctly?	☐ Yes	☐ No

- If the client answered **YES** to at least one of the questions and she is free of signs or symptoms of pregnancy, provide client with desired method.
- If the client answered **NO** to all of the questions, pregnancy cannot be ruled out. The client should await menses or use a pregnancy test.

Annex 14: Parental Consent Form (Sample)

Province of Cavite
Municipality/City of Trece Martires

PARENTAL CONSENT FORM
FOR CLIENTS BELOW 18 SEEKING FAMILY PLANNING SERVICES

ENGLISH VERSION:
This is to signify my full consent for my daughter/son _____ (name of daughter/son 17 years old and below), _____ years old, to receive family planning services/commodities from _____ (name of RHU/CHO), as a response to her current reproductive health and family planning need.
I likewise certify that my daughter/son was provided with full information on the full range of family planning methods, their benefits and possible complications.

NAME OF PARENT/GUARDIAN: _____
SIGNATURE: _____
Date: _____

TAGALOG VERSION:
Pinahihintulutan ko po ang aking anak na si _____ (pangalan ng kliyente na may edad 17 pababa), _____ taong gulang, na tumanggap ng family planning services/commodities mula sa _____ (pangalan ng RHU/CHO), bilang bahagi ng kaniyang kasalukuyang pangangailangang pangkalusugan at tamang pagpaplano ng pamilya (RPRH need).
Pinatutunayan ko rin na ang aking anak ay nabigyan ng sapat na impormasyon at kaalaman sa paggamit ng family planning methods, pati na rin ang mga benepisyo at posibleng komplikasyon ng paggamit nito.

NAME OF PARENT/GUARDIAN: _____
SIGNATURE: _____
Date: _____

Annex 15A: TPC Incoming Referral Form

Date: _____

Name of Referring Facility/Department: _____
Address: _____

Respectfully referring to you our client:

Name:	Age:
Reason for referral:	

Thank you,

_____
Signature over Printed Name of
Referring Health Service Provider

- **Return Slip** -

To **Referring Facility/Department**,

Thank you for referring your client to us.

Name:	Age:	Date:
		Time:
The following are our findings/diagnosis:		
Plan of management/recommendations:		

Next follow-up visit with us:	Date:	Time:

Thank you,

_____
Signature over Printed Name of
TPC Health Service Provider

Annex 15B: TPC Outgoing Referral Form

TEEN PARENTS' CLINIC
(Complete address)

Refer to: ☐ Ob/Gyn (OPD) ☐ Pediatrics (OPD) ☐ Others: o For STI: HACT o For VAW: DSWD, PNP-WCPU, NGOs, Others o For financial assistance: PhilHealth, Medical Social Services o Others, specify: _____	Date: Time:

Respectfully referring to you our client:

Name:	Age:
Reason for referral:	

*Please advise the client to return to the **Teen Parents' Clinic** for final instructions. Please sign the Return Slip below. Instruct the client to surrender the slip to the TPC.*

Thank you,

_____
Signature over Printed Name of TPC Coordinator/Nurse/Midwife

- Return **Slip** -

To **Teen Parents' Clinic**,

Thank you for referring your client to us.

Name:	Age:	Date: Time:
The following are our findings/diagnosis:		
Plan of management/recommendations:		
Next follow-up visit with us:	Date:	Time:

Thank you,

Resident-in-Charge/Consultant/Service Provider: _____
Department: _____

Annex 16: TPC Reporting Form

TPC MONTHLY REPORTING FORM

Region:			
Province:			
Month:		Year:	
Hospital:			

TOTAL NEW ADOLESCENT CLIENTS RECORDED FOR THE MONTH	10-14 y.o.	15-19 y.o.	TOTAL

	INDICATOR	TOTAL	Female			Male		
			10-14	15-19	Total	10-14	15-19	Total
A. DEMOGRAPHICS								
1	No. of adolescents who got pregnant while in school	0	0	0	0	-	-	-
	a. Gr. 6-below	0			0	-	-	-
	b. Gr. 7	0			0	-	-	-
	c. Gr. 8	0			0	-	-	-
	d. Gr. 9	0			0	-	-	-
	e. Gr. 10	0			0	-	-	-
	f. Gr. 11	0			0	-	-	-
	g. Gr. 12	0			0	-	-	-
	h. ALS	0			0	-	-	-
	i. Vocational	0			0	-	-	-
	j. College	0			0	-	-	-
2	No. of pregnant out-of-school adolescents	0			0	-	-	-
3	Gravidity/parity of pregnant adolescents	0	0	0	0	-	-	-
	a. G1 P0	0			0	-	-	-
	b. G2 P1	0			0	-	-	-
	c. G2 P0	0			0	-	-	-
	d. G3 P2	0			0	-	-	-
	e. G3 P1	0			0	-	-	-
	f. G3 P0	0			0	-	-	-
	g. Others	0			0	-	-	-
4	No. of adolescents with PhilHealth coverage	0			0	-	-	-
B. REFERRALS								
1	Total incoming referrals	0	0	0	0	0	0	0
	a. Schools/school-based THKs	0			0			0
	b. RHU	0			0			0
	c. Private facility	0			0			0
	d. Walk-in	0			0			0
	e. YAKAGIN appointment	0			0			0
2	Total incoming referrals with referral slip	0	0	0	0	0	0	0
	a. Schools/school-based THKs	0			0			0
	b. RHU	0			0			0
	c. Private facility	0			0			0
3	No. of adolescents referred from the TPC to other departments/facilities/agencies	0	0	0	0	0	0	0
	a. Public health facility	0			0			0
	b. Private health facililty	0			0			0
	c. Other hospital departments	0			0			0

	INDICATOR	TOTAL	Female			Male		
			10-14	15-19	Total	10-14	15-19	Total
C. ANTENATAL SERVICES								
1	No. of adolescents who received psychosocial counseling	0			0			0
2	No. of adolescents provided antenatal services	0	0	0	0	-	-	-
	a. Had first TPC ANC visit in 1st trimester	0			0	-	-	-
	b. Had first TPC ANC visit in 2nd trimester	0			0	-	-	-
	c. Had first TPC ANC visit in 3rd trimester	0			0	-	-	-
3	No. of adolescents who completed 4ANC	0			0	-	-	-
4	No. of adolescents who attended health education sessions	0			0			0
D. DELIVERY & POST-PARTUM SERVICES								
1	No. of adolescents who delivered in the facility	0	0	0	0	-	-	-
	a. NSD	0			0	-	-	-
	b. CS	0			0	-	-	-
2	No. of adolescents who received post-partum services	0			0	-	-	-
3	No. of newborns provided post-natal services	0			0			0
E. FP SERVICES								
1	No. of adolescents who received FP counseling	0			0			0
2	Preferred FP method of adolescents	0	0	0	0	0	0	0
	a. Pills	0			0	-	-	0
	b. Injectable	0			0	-	-	0
	c. IUD	0			0	-	-	0
	d. Condom	0			0			0
	e. Implant	0			0	-	-	0
	f. BTL/NSV	0			0			0
	g. LAM	0			0	-	-	0
	h. SDM	0			0			0
	i. Other NFP	0			0			0
3	No. of adolescents who utilized FP methods	0	0	0	0	0	0	0
	a. Pills	0			0	-	-	0
	b. Injectable	0			0	-	-	0
	c. IUD	0			0	-	-	0
	d. Condom	0			0			0
	e. Implant	0			0	-	-	0
	f. BTL/NSV	0			0			0
	g. LAM	0			0	-	-	0
	h. SDM	0			0			0
	i. Other NFP	0			0			0
F. CLIENT RESIDENCE								
1		0			0			0
2		0			0			0
3		0			0			0
4		0			0			0
5		0			0			0
6		0			0			0

	INDICATOR	TOTAL	Female			Male		
			10-14	15-19	Total	10-14	15-19	Total
7		0			0			0
8		0			0			0
9		0			0			0
10		0			0			0
11		0			0			0
12		0			0			0
13		0			0			0
14		0			0			0
15		0			0			0
16		0			0			0
17		0			0			0
18		0			0			0
19		0			0			0
20		0			0			0
21		0			0			0
22		0			0			0
23		0			0			0
24		0			0			0
25		0			0			0
26		0			0			0
27		0			0			0
28		0			0			0
29		0			0			0
30		0			0			0
31		0			0			0
32		0			0			0
33		0			0			0
34		0			0			0
35		0			0			0
36		0			0			0
37		0			0			0
38		0			0			0
39		0			0			0
40		0			0			0
41		0			0			0
42		0			0			0
43		0			0			0
44		0			0			0
45		0			0			0

Prepared by: _____ Date: _____
TPC Coordinator

Noted by: _____ Date: _____
Medical Center Chief/Chief of Hospital

Annex 17: Client Feedback Form

TEEN PARENTS' CLINIC
(Complete address)

Name (Optional):	Type of Respondent:
Age:	☐ Client/Client's Partner
Date of Enrollment:	☐ Parent/Guardian

INSTRUCTIONS:	**RATING SCALE:**	
In order for us to improve the services of the Teen Parents' Clinic, we would like to get your feedback on the services we provided. Your comments and suggestions are highly appreciated. *(Upang mapabuti pa ang serbisyo ng Teen Parents' Clinic, nais naming malaman ang iyong karanasan sa mga serbisyong aming naihandog sa inyo. Anumang komento at suhestyon na iyong maibibigay ay aming ikagagalak.)* After each statement, kindly indicate your rating on the box provided using the rating scale on the right. *(Sa bawat pangungusap, pakisulat ang iyong "rating" sa kahon gamit ang rating scale sa kanan.)*	**5**	Strongly agree *(Masidhing sumasang-ayon)*
	4	Agree *(Sumasang-ayon)*
	3	Undecided *(Walang opinyon)*
	2	Disagree *(Hindi sumasang-ayon)*
	1	Strongly disagree (*Masidhing hindi sumasang-ayon)*

STAFF	**RATING**
TPC staff treats all clients with equal care and respect, regardless of status.	
Orientation on the TPC services given by the TPC staff is adequate and clear.	
TPC staff provides timely referral to relevant service units/departments.	
Ob-Gyn resident treats all clients with equal care and respect, regardless of status.	
Orientation on the OB services given by the OB resident is adequate and clear.	
Hospital nursing and allied health staff are adolescent-friendly.	
Referral service staff are adolescent-friendly.	
SERVICES	**RATING**
Policies and procedures are clear, understandable and easy to follow.	
TPC clinic schedule is convenient.	
Health education class is very informative and helpful.	
Family planning options are discussed clearly and adequately.	
Family planning services are free and available.	
Ob-Gyn OPD services are adolescent-friendly.	
Labor & Delivery Room services are adolescent-friendly.	
In-hospital postpartum care is adolescent-friendly.	
Referral services are efficient and adolescent-friendly.	
FACILITY	**RATING**
Clinic has an appealing and clean environment.	
Clinic ensures privacy and confidentiality.	
It has the required equipment, supplies and necessary basic services.	
COMMENTS/SUGGESTIONS	

Annex 18: PhilHealth Benefits Packages

The following PhilHealth benefits packages can be availed by an accredited hospital and made available to a pregnant or postpartum adolescent and her newborn:

a. **Prenatal Care Package (ANC 01)** – This covers essential health services for women about to give birth during the antenatal period regardless of method of delivery and pregnancy outcome (e.g., Caesarian delivery, breech extraction). The women should have been given at least four prenatal checkups/visits with the last one during the last trimester. RVS Code is ANC 01 and the package may be availed of from the hospital at the rate of P1,500.

b. **Maternal Care Package (MCP 01)** – This covers essential health services during the antenatal period, entire stages of labor, normal delivery and immediate postpartum, including follow-up visits within the first 72 hours and one week after delivery. RVS Code is MCP 01 and the package may be availed of by the hospital with the rate of P6,500.

c. **Normal Spontaneous Delivery (NSD 01)** – This covers essential health services for normal, low-risk vaginal deliveries and postpartum period (intrapartum care, delivery and postpartum care) within the first 72 hours and seven days after delivery. RVS Code is NSD 01 and the package may be availed of with the rate of P5,000.

d. **Other Methods of Deliveries** covered by PhilHealth:
   I. **Caesarian Section (CS)** – Caesarian section, primary. RVS Code: 59513. Case Rate: P19,000.
   II. **Caesarian Section (CS)** – Caesarian delivery. RVS Code: 59514. Case Rate: P19,000.
   III. **Caesarian Section (CS)** – Caesarian delivery only, following attempted vaginal delivery after previous Caesarian delivery. RVS Code: 59620. Case Rate: P19,000.
   IV. **Complicated Vaginal Delivery** – Vaginal delivery only, with or without episiotomy and/or forceps. RVS Code: 59409. Case Rate: P9,700.
   V. **Breech Extraction** – Caesarian delivery. RVS Code: 59411. Case Rate: P12,120.
   VI. **Vaginal Delivery after Caesarian Section** –Vaginal delivery only, after previous Caesarian delivery, with or without episiotomy. RVS Code: 59612. Case Rate: P12,120.

e. **Newborn Care Package (99432)** – This covers essential health services for the newborn within the first hours of life, regardless of their delivery and presence of co-morbidities. The care should include immediate drying of the baby, skin-to-skin contact, non-separation of the baby for early breastfeeding initiation, eye prophylaxis, Vitamin K administration, weighing of the newborn, first dose of Hepatitis B and BCG vaccine, newborn screening test for metabolic diseases, and hearing screening test. RVS Code is 99432 and the package may be availed of with the rate of P1,750.

f. **Family Planning Services**
   i. **IUD Insertion (58300)** – This covers both postpartum and interval IUD. RVS Code is 58300 and the package may be availed of with the rate of P2,000. This can be availed of as a second case rate.
   ii. **Subdermal Implant Package (FP001)** – This covers insertion of implantable subdermal contraceptive including counseling and follow-up.

g. **Voluntary Surgical Contraception: Bilateral Tubal Ligation (BTL) (58600)** – This covers ligation or connection of fallopian tubes, abdominal or vaginal approach. RVS Code is 58600 and the package may be availed of with the rate of P4,000.

Annex 19: Classification of Adolescent Clients

a. **Can Afford to Pay** – adolescent client whose parents can afford to pay the premium or are a lifetime member
   - With a parent/s who is/are members of the formal sector
   - With a parent/s who is/are members of the informal sector (includes, among others, street hawkers, market vendors, pedicab and tricycle drivers, small construction workers, and home-based industries and services; self-earning; MW)
   - With a parent/s who is/are able to pay the required contributions regularly and has paid at least three months' premium contributions within the immediate six-month period prior to the first day of confinement
   - With parent/s who is/are a lifetime member
   - **Not Eligible**: With parents who are unregistered but financially capable; not declared by parents (who shall be required to register under the POS and shall pay the prescribed annual premium)

b. **Cannot Afford to Pay/Financially Incapable** – adolescent client whose parents cannot afford to pay the premium
   - With a parent/s who is/are classified as indigent members (DSWD-identified poor families: *Listahanan*, 4Ps, MCCT), paid by the national government
   - With a parent/s who is/are classified as sponsored members (fully subsidized by any of the following: LGUs, NGAs, private entities, NGOs, corporations, or individuals)
   - **Not Eligible:** With parents who are not registered or inactive but were assessed by the MSWO/SWDO as financially incapable and eligible and qualified to avail of PhilHealth benefits. In this case, these patients get enrolled under the POS system.

Annex 20: PhilHealth Enrolment of Adolescents to Ensure Eligibility

1. Enrollment with PhilHealth of the pregnant adolescent clients or expectant mothers shall be governed by PhilHealth Circular 025-2015 (for the Benefits of Women About to Give Birth) and PhilHealth Circular 025-2017 (for the Implementation of Point-of-Service and Parallel Implementation of Point-of-Care).

2. The health care provider shall refer the following pregnant mothers to the Medical Social Worker for assessment to the Point of Care or Point of Service:
    a. Those who are not yet registered with PhilHealth
    b. Those who are members but are not covered nor eligible due to the lack of qualifying contributions
    c. Those who are qualified dependents of their parents (covered or not covered)

3. Those who are currently classified as eligible by being a dependent of an eligible parent can avail of the ANC Package (ANC01) and MCP Package (MCP01). To ensure that the newborn baby will also qualify for the newborn care package (99432), the adolescent client shall need to change status from being a dependent to being a primary member to ensure eligibility of her newborn child and benefit from future services that the child will need.
    a. Proceed to the PhilHealth point person of the hospital and bring a copy of the parent's Member Data Record (MDR) and ID and other requirements as may be required by the hospital.
    b. Express intention to enroll the adolescent client as a primary member, then secure and accomplish the copy of the PhilHealth Membership Registration Form (PMRF).
    c. The MSWO or SWDO or hospital-designated personnel shall register the Point of Service patient through the Point of Service within 72 hours from date of admission but prior to discharge.
    d. The PIN of newly registered Point of Service patients shall be emailed and transmitted to the hospital.

4. Enrolment as primary member (Section 9-10 of IRR; Section V-7 of PhilHealth Circular 25). All emancipated or pregnant women shall be enrolled as a primary member:
    a. For Emancipated Individuals or Single Parents: Any person below 21 years of age, married or unmarried but with a child, shall be enrolled as a principal member.
    b. Pregnant women who are dependents of their parents shall be enrolled as principal members to ensure that their children are also covered.

5. Pregnant mothers who were assessed by the medical social worker, but did not qualify for Point of Care or Point of Service, shall still be covered under the provisions of Section 39b of the IRR of the National Health Insurance Act of 2013, provided that the following procedures are met prior to discharge from the health facility:
    a. The client shall submit to the PhilHealth Local Insurance Office (LHIO) or PhilHealth Regional Office (PRO) an accomplished PMRF and any one of the following documents:
        i. Medical certificate from her physician confirming pregnancy
        ii. Photocopy of the laboratory/ultrasound confirming pregnancy
        iii. Photocopy of her admission records
    b. The adolescent client shall be required to enroll or shift to the Informal Economy Program.

c. To be able to immediately avail of the benefits, the adolescent client (or her parents), shall pay the prescribed premiums for one year or the missed/unpaid premium of the applicable year.
d. The client should secure the copy of the receipt, the certificate of contributions, and the MDR.
e. In the absence of the Health Care Institution (HCI) Portal, or if ever claim will be denied due to lack of qualifying contributions, the member may present the PhilHealth Official Receipt (POR) or Certificate of Premium Payment (CPP) to the accredited health care facility as proof of payment and entitlement to PhilHealth benefits.

6. Under the Point of Service, a patient, or in cases when the patient is a minor, his/her guardian, if assessed as financially incapable by the MSWO/SWDO, shall be qualified to avail of PhilHealth benefits, based on the following conditions:
    a. With a parent/s who is/are classified as indigent members (DSWD-identified poor families: *Listahanan*, 4Ps, MCCT), paid by the national government
    b. With a parent/s who is/are classified as sponsored members (fully subsidized by any of the following: LGUs, NGAs, private entities, NGOs, corporations, or individuals)

7. Adolescent clients with parents who are not registered or not eligible due to lack of qualifying contributions, but were assessed by the MSWO/SWDO as financially incapable and eligible and qualified to avail of PhilHealth benefits, will be enrolled under the Point of Service system. Upon official enrolment, the adolescent client and her child become immediately entitled to PhilHealth benefits, not only of FP/MCH-related services but for all case rates.

Annex 21: Daily Stock Record Book

Daily Stock Record Book						
Program:						
Stock name and preparation:						
Units of Stock:						
Year:						
Month:						
Day	**Stocks Received From:**	**Quantity Received**	**Quantity Dispensed to Hospital Patients**	**Quantity Issued to Different Hospital Departments (with staff conducting FP counselling and providing services)**	**Losses**	**Balance**
				Previous Month's Balance		
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						
28						
29						
30						
31						
				End of the Month Balance		

Annex 22: Daily Dispensing Record Book

This record contains the quantities of FP/MCH commodities dispensed to specific clients. The TPC nurse/midwife shall accomplish duplicate copies of this form and shall keep a copy of this form to document and complete the information on total commodities dispensed to clients everyday (in the TPC'S Daily Stock Record for FP/MCH) and submit a copy of FP Commodity Daily Dispensing Record to the FP Clinic.

Daily Dispensing Record Book
Program:_____

				Drug Names/Preparation																	
Date	**Name of Client**	**Address**	**Age**	**Quantity Dispensed**																**Signature of Client**	**Remarks**

The TPC nurse/midwife shall:

- Fill out the General Information.
- List down the names of all FP commodities, MCH drugs, and medicines and their preparation.
- Identify the date of visit, name, address, and age of client.
- Indicate the quantity of commodities provided to the client.
- Ensure that clients acknowledge receipt of commodities/drugs with their signature.
- Indicate other notes in the remarks portion.
- Update the TPC'S Daily Stock Record for FP.

Annex 23: Monthly Physical Inventory and Commodity Expiration Record

The monthly physical count verifies the availability and number of units of each FP commodity and MCH drug or medical supply currently in stock. It provides an opportunity to verify if the data in the Daily Stock Record books are correct and allows the identification of expiring commodities.

Monthly Physical Inventory and Drug Expiration Record

Program:

Personnel in charge:

Date accomplished:

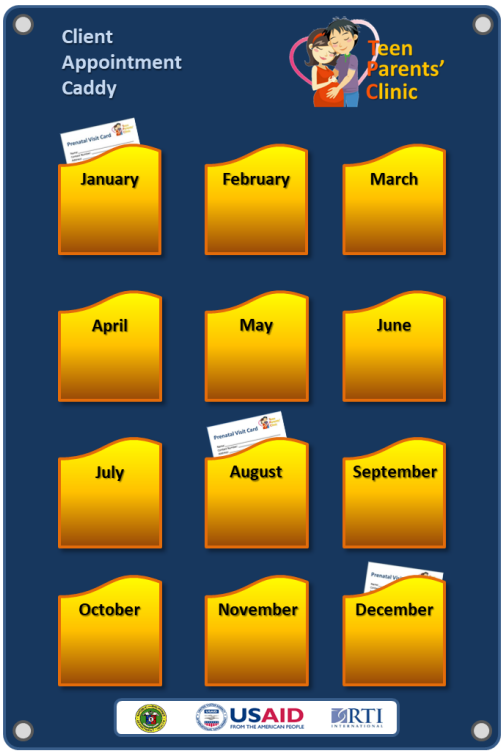
No.	Product and preparation	Manufacturer	Lot Number	Expiration Date	Mark (X) if stocks expire within the next 6 months	Balance Based on Physical count of all stocks	Number of Stocks that are: expired, tampered, damaged,	Balance of stocks based on the *Daily Stock Record*	Other Losses (Not Recorded in the DSR)	TOTAL Physical count of all USABLE stocks (STOCKS 0N HAND)	ACTION NEEDED FOR EXPIRING STOCKS *(to be returned to the CHO/PHO/ DOHRO/ Central Office; to be shared with Facility-X; for immediate dispensing to midwives)*
						(A)	(B)	(C)	(D) D = (C - A)	(E) (A) - (B) =(E)	
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											

The TPC Nurse/Midwife shall:

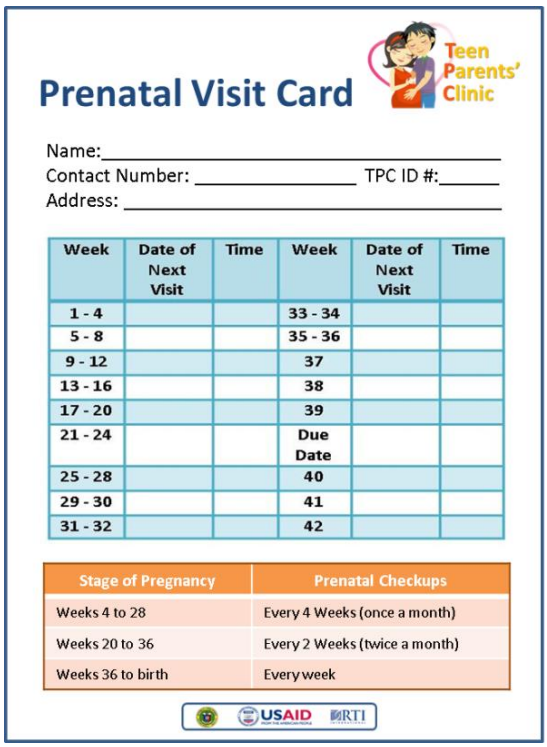
- Physically count the number of units of FP commodities/MCH drugs and record the results on the Monthly Physical Inventory and Commodity Expiration Record.
- In cases where there are differences between the physical count and the Daily Stock Record, inform the TPC Coordinator of the losses in order to address the reasons for the discrepancy.
- Check and record the expiration dates of drugs during this activity.
- For newly-received stocks, check each product's expiration date and record it on the same form.
- Whenever any lot reaches six months until the expiration date, take note of this fact and decide whether or not it will be used before it expires.

- If any lot of any product cannot be used before expiration, send them back to the Municipal/City/Provincial Health Office/DOHRO/DOH-Central Office so that these can be sent to other units that can utilize them immediately. In the case of drugs that are purchased by the LGU, notify the Provincial Health Office (in the case of district or provincial hospitals), or the DOHRO (in the case of medical centers and DOH-retained hospitals) for appropriate action.
- If commodities expire, take the following steps:
    - Remove them from the shelves and place them in a closed carton box.
    - Notify the Provincial Health Office /DOHRO.
    - Deduct them from the balance shown in the Daily Stock Record Book under the "losses" column, with the annotation, "expired." Stock quantity should also be noted in the Monthly Physical Inventory and Drug Expiration Record with "expired" written in the Remarks column.
    - Coordinate with the Provincial Health Office or the DOHRO for the proper disposal of the expired stocks.
- For any losses either due to expiration, other conditions that render the stock unusable (such as damage due to sun exposure, discoloration, infestation, etc.), or disappearance (missing due to unaccounted losses, pilferage, etc.), note and carry over to the Daily Stock Record in the column of "losses" and the row indicating the date the inventory was done in order to update the current balance.
- Submit a copy of the **FP Monthly Physical Inventory and Commodity Expiration Record** to the FP Clinic.

Annex 24: Client Appointment Caddy and Prenatal Visit Cards



Client Appointment Caddy
Material: Acrylic plastic or Nylon cloth
Dimension:
Base: 23in W x 30in L
Pockets: 4.5in W x 5in L
Price: Approx. P2,500.00



Prenatal Visit Card

Teen Parents' Clinic

Name:_____
Contact Number: _____ TPC ID #:_____
Address: _____

Week	Date of Next Visit	Time	Week	Date of Next Visit	Time
1 - 4			33 - 34		
5 - 8			35 - 36		
9 - 12			37		
13 - 16			38		
17 - 20			39		
21 - 24			Due Date		
25 - 28			40		
29 - 30			41		
31 - 32			42		

Stage of Pregnancy	Prenatal Checkups
Weeks 4 to 28	Every 4 Weeks (once a month)
Weeks 20 to 36	Every 2 Weeks (twice a month)
Weeks 36 to birth	Every week

USAID RTI

Prenatal Visit Card
Material: Soft Cardboard
Dimension: 4in W x 6in L
Price: P5.00
Quantity: 4,000 sheets