I. Introduction

In 2010, the Department of Health (DOH) launched the *Kalusugan Pangkalahatan (KP)* to attain the goal of the Aquino Health Agenda (AHA) towards universal access to quality health care and services. The mobilization of Community Health Teams (CHTs) is essential in achieving this desired goal as it supports the three main thrusts of the *KP*, namely: (i) the provision of financial risk protection through the expansion of the National Health Insurance Program (NHIP) enrolment and benefit delivery; (ii) improving the access to quality hospitals and health care facilities; and (iii) attainment of the health-related Millennium Development Goals (MDGs). The *KP's* primary targets are the households listed under the National Household Targeting System (NHTS) for Rapid Poverty Reduction representing the poorest segment in our country.

The CHT Strategy is designed specifically to address the concerns of the poor in accessing health care particularly maternal-newborn-child health and nutrition (MNCHN) services by:

(i) ensuring early identification of health problems of family members through health risk assessment and development of health plans,
(ii) informing families of the benefits of PhilHealth membership and helping them seek health care and services from PhilHealth-accredited facilities,
(iii) referring them for timely utilization of needed health services to improve and promote better health status of the families.

The CHT Strategy has been implemented for more than a year now and there are feedbacks of varied experiences and learning on the CHT operations on the ground. Reports also reveal certain difficulties or inadequacies encountered by the CHTs in the performance of their expected tasks particularly in risk assessment, assistance to health use plan development and in record and report management. While results of CHT mobilization have been encouraging in certain areas, some have not come to par in generating demand for MDG-related services in their respective areas of deployment.

II. Assessment Objectives

The DOH, through the assistance of the CHT Technical Working Group (TWG) comprising of representatives from concerned DOH offices at the national and regional levels, MNCHN Program Coordinators and development partners decided to undertake an assessment of the CHT Strategy after a year of operations. This assessment aimed to:

1. validate the functionality of the CHTs;
2. establish the type and level of support received by the CHTs from the LGUs, CHDs/DOH and other concerned groups of stakeholders;
3. ascertain any improvement in the access and utilization of key MNCHN services in areas where CHTs have been deployed;
4. identify areas for enhancement in the CHT processes, tools and guides.

Results of this assessment is hoped to further strengthen the mobilization of the CHTs through improved performance of their expected tasks in generating demand for and in facilitating access to and utilization of the needed health care and services among the identified poorest families in the country.

III. Assessment Framework and Methodology

Assessment Framework. The following framework guided the assessment of the CHT operations. The assessment focused on the expected outputs and immediate results of the CHT Strategy including the various inputs necessary for the CHTs to be able to generate the demand for quality health care and services. Although it may still be premature to assess the outcome of the CHT operations in terms of improved access to and utilization of quality health care and services given only a year of operations, the assessment is designed to consider any possible dent relative to improved/increased access to selected MNCHN services.

Increased access to selected MNCHN services is influenced by both the functionality of the CHTs as they generate demand for services and also by the availability and readiness of the health care providers (facilities and staff) to deliver the needed services. The assessment though will be mainly focused on the functionality of the CHTs and will not be able to cover comprehensively the latter.

The functionality of the CHTs is considered to be largely dependent on the type and level of assistance provided which include among others their training, the guides/tools, incentives and support provided by their supervisors. In addition to this direct support, other forms of assistance were also provided as a result of innovative efforts of the local government units (LGUs) and the CHDs, examples of which include the modified recording and reporting systems, provision of other IEC materials, listing of health care facilities, designation of RN Heals for data consolidation and validation, etc.

The assessment also hopes to document contributions of the various players at the local level, particularly the participation of other government agencies (DSWD, DILG) and PhilHealth, and other development partners.

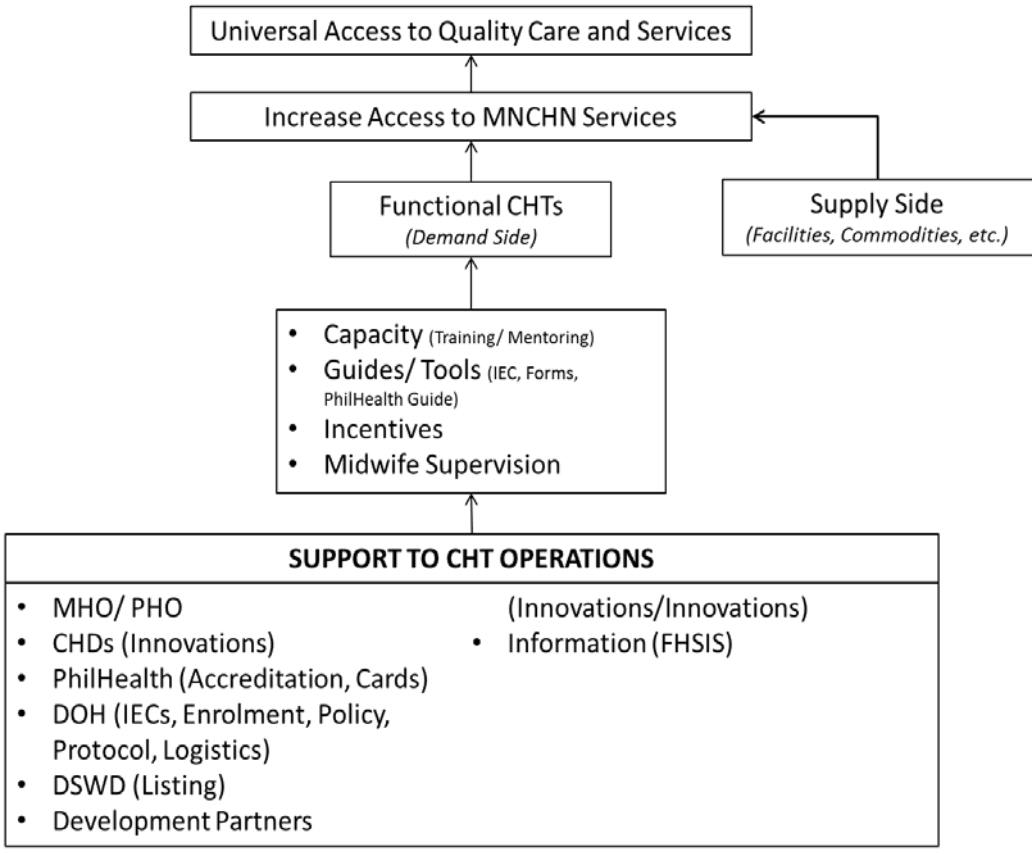


Figure 1. CHT Operations Assessment Framework

Assessment Methodology. The CHT Assessment required the following mix of data collection methodologies involving various sources of information.

- Secondary data collection (e.g. review of relevant documents like policies, guidelines, reports, etc.) formed a major part of the data collection methodology. Data routinely submitted by the CHTs to their supervisors and those received by the CHDs from the different LGUs on a monthly basis were reviewed and analyzed;

- Another bulk of the secondary data that were analyzed included the assessment reports prepared by different regions and development partners who conducted their own assessment of the CHT operations in their particular region or project sites. Some of these assessments made use of primary data collection, FGDs and interviews of selected CHT members;

  (a) DOH – NCDPC visited 31 Provinces and interviewed 125 CHT members on the status of CHT mobilization in their areas from October to November 2012. Results were tabulated through four determinants: Man, Money, Materials, and others (DOH NCDPC, 2012).

  (b) Health Policy Development Project (HPDP) under UPECON assisted five sites in the implementation of the Scale-up Phase of *Kalusugan Pangkalahatan* and assessed experiences from the activities conducted, particularly that of CHT mobilization. In addition, Health Policy Associates from UPEcon-HPDP gathered information on demand generation for KP. Interviews were conducted in eleven regions, with Center for Health Development staff as respondents.

  (c) HealthGov (Strengthening Local Governance in Health Project) conducted assessment of CHTs in November 2012 in four municipalities in Region 11: Kapalong and Sto. Tomas, Davao del Norte; Montevista, Compostela Valley; and Bansalan, Davao del Sur covering 3 barangays per municipality. The assessment tool had two parts: (i) scoring on the status of CHT deployment based on seven major steps in the CHT process and (ii) Focus Group Discussion on issues, challenges next steps and good (HealthGov, 2012).

  (d) Japan International Cooperating Agency (JICA) supported Leyte in their conduct of the Community Health Teams and assessed 252 CHT members through interviews with their supervising midwife as well as evaluating records and reports that they submit (JICA, 2012).

  (e) VisayasHealth conducted rapid assessments of CHT operations in Bohol (covering Tagbilaran City, Baclayon, Duero and Valencia) and Negros Oriental (covering Dumaguete City, Zamboangita, Bacong and Sibulan) using key informant and group interviews and FGD.

- Results of the abovementioned assessments were presented and discussed during TWG meetings. In addition, the CHT TWG conducted field validation visits on the CHT operations in 2 selected sites: Caloocan in NCR and Valenzuela, Bulacan of Region 3;

- The 3-day National Consultative Meeting on CHT held in Palawan last September 18-20, 2013 served as the culmination process of the CHT

assessment process. The assessment and validation during this consultation meeting were beefed up with the following methodologies

(1) CHDs were requested to conduct primary data collection in one selected province, one selected municipality and 3 selected barangays with the highest number of NHTS within their jurisdiction. The data collection required an interview of 10 selected CHT members per selected barangay regarding their operations and functionality. A total of 250 CHT members were interviewed in the 17 regions of the country.

(2) In the same selected province/municipality/barangays, a comparison of service coverage of selected MNCHN indicators before and after CHT deployment was undertaken to validate if there has been any improvement in service coverage, using the FHSIS as data source. This is recognized to have some limitations considering that the deployment period may have differed from one area to another, and that the proportion of NHTS may not be that significant in contrast to the other non-NHTS being catered in the selected barangays.

(3) The consultative meeting also served as venue to validate the routine CHT Reports that were submitted to the national level. The validation was centered on the deployment, mobilization and functionality of the CHTs.

(4) An overall consolidation of CHT operations and coverage was undertaken by cluster of regions once the validation was completed. Some regions though were still to submit certain data requiring further validation at the local level

The assessment of the CHT operations remains to be qualitative as this is focused on the CHT approaches and processes. Quantitative analysis of certain output/outcome was undertaken with certain limitations as indicated.

IV. Milestones in CHT Mobilization

The central role of community participation in health development is beyond question. In the early 70s, community volunteers were mobilized to serve as Barangay Health Workers to help the midwives reach their catchment households. This was followed by the organization of the Barangay Service Point Officers (BSPOs) for the Family Planning (FP) Program. During the latter part of the decade, the Barangay Nutrition Scholars (BNS) were also organized to help out in the implementation of the Philippine Nutrition Program at the community level. In 1995, the Barangay Health Workers (BHW) Act was passed stipulating the benefit packages and incentives for these community volunteer workers as the extended arm of the government in health service delivery. In addition to these volunteer workers was the need to organize community-based groups involving the community members for specific purposes such as the Breastfeeding Support Groups, the FP Satisfied Users Club and other interest groups.

2005: Women's Health and Safe Motherhood Project (WHSMP) introduced the Women's Health Team as part of its national maternal health strategy. The community-based women health team is composed of a midwife, a pregnant woman, and a traditional birth attendant (TBA) with each member given a cash incentive through a performance-based financing mechanism.

2007: Concept of health navigators was introduced in the Philippines through the Family Health Book Operations Research in Compostela Valley under HPDP to broaden the reach of maternal, newborn and child health care and nutrition (MNCHN) services (UPEcon-HPDP, 2011). The Family Health Book (FHB) contains key health messages, health use plans, list of providers, information regarding PhilHealth, and list of emergency contact numbers. The operations research showed that there was a significant improvement in terms of FP, safe deliveries and fully immunized children (FIC) and the timing of the first ANC visit by 5 percentage points. The results of the operations research showed that FHB can be a viable strategy for improving delivery of MNCHN services. This study also stressed the importance of a health use plan to further strengthen the FHB + navigator model (UPEcon-HPDP, 2011).

2008: DOH- Maternal, Newborn, and Child Health and Nutrition (MNCHN) Strategy (AO No. 2008-0029) provided for the establishment of a three-tier service delivery network (SDN) with the community level service providers as the first tier with women's health team or barangay health teams "vigorously campaign for proper birth spacing, complete required antenatal care visits, facilitate the shift from home deliveries to facility-based births attended by skilled professionals, provide postpartum and postnatal care, and ensure smooth transitions to other health care packages for women and children."

2009: USAID-SHIELD Project in the Autonomous Region for Muslim Mindanao (ARMM) organized the CHATs (Community Health and Advocacy Teams) in the project sites to educate/inform community members on FP services and other MNCHN needs. Similar of these community-based groups were organized in other USAID Project e.g. Private Sector Mobilization for Family Health (PRISM) sites and labelled as "*tumpukan"* sessions.

2011: DOH - MNCHN Manual of Operations which details the implementing guide of the MNCHN Strategy first introduced the *Community Health Team* as part of the community level service providers to inform families of health risks and assist in the development of their health use plans, facilitate their access to critical health services, advocate birth spacing and counselling for FP services; track and master list pregnant women, women of reproductive age, children below 1 year of age and perform early detection and referral of high-risk pregnancies, and reporting maternal and neonatal deaths.

2011: DOH launched the *Kalusugan Pangkalahatan* (DO No. 2011-0188), part of which is to mobilize CHTs in support to the three strategic thrusts of the Aquino Health Agenda. The *KP* Execution Plan and Implementation Arrangements indicated a total of 10.8 million NHTS-PR households to be covered through the deployment of CHTs with a ratio of 1 CHT member to 100 families. *KP* is to be implemented in three phases: (i) Launch Phase (August to December 2011), (ii) Scale-up Phase (2012 to 2013), and (iii) Sustainability Phase (2014 to 2016).

2011-1Q: DOH issued Department Memorandum 2011-0286 Guidelines on the Mobilization of CHTs which described the composition of CHTs, their roles and responsibilities of the CHTs, and the roles and responsibilities of various DOH offices in the implementation of the CHT strategy.

2011- 4Q: Training of Trainors on CHT Mobilization and Operations in 17 regions and later cascaded the training to their respective provinces, cities and municipalities by each region

2012-1Q: Orientation of Local Officials and Health Staff on CHT Strategy including recruitment and mobilization of community volunteer workers (BHWs, BNSs, parent/mother leaders) to form part of the CHTs in their respective barangays/sitios.

2012-1Q to 2Q: Training of CHT members as well as reproduction of CHT Forms and Guides to be used

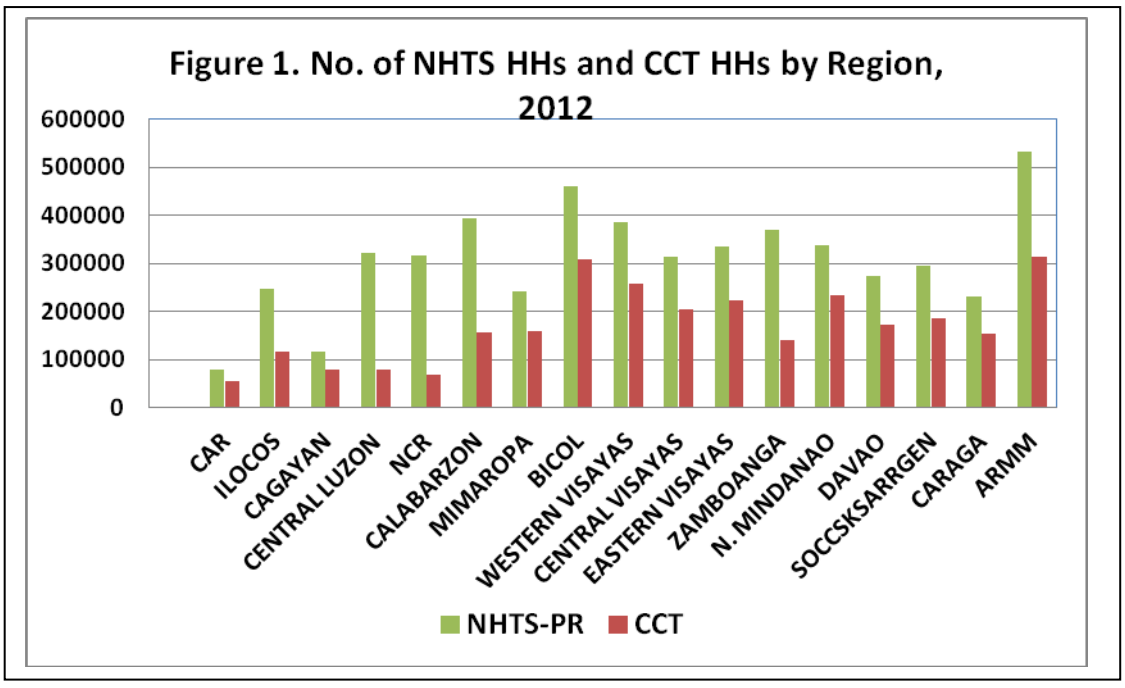
2012-3Q: Deployment of CHT members to their designated NHTS HHs

V. Results and Findings

The results of the CHT assessment are presented and discussed according to the 4 objectives set in the design. Details of these findings are found in the annexes.

A. <u>Background Profile</u>. Prior to assessing the functionality of CHTs and their possible influence on the access and utilization of services, a brief profile of the NHTS households as the primary targets of the KP is presented including that of the CHT members who were mobilized and trained to reach and serve them .

<u>(1) NHTS Households.</u> A total of 5.2 million households were enlisted by the NHTS representing the poorest households in the country. These were targeted as beneficiaries of the DOH-*Kalusugan Pangkalahatan*. A little more than half (55.4%) of these NHTS households are beneficiaries of the Cash Conditionality Transfer (CCT) or referred to as 4 Ps (*Pantawid Pamilyang Pilipino Program*) managed by the Department of Social Welfare and Development (DSWD). The 4Ps families were targeted and covered much earlier than the rest of the non-CCT NHTS households. Part of the conditions that the 4Ps families need to comply with in exchange of the cash assistance is to bring their children for complete immunization services, for the pregnant women to visit the health care providers at least 4 times for prenatal check-up and to deliver in health facilities. The ARMM has the highest number of identified NHTS households of over half a million (531,526) followed by the BICOL Region (461,222) and CALABARZON (392,811).



(2) CHT Members. The DOH-DO 2011-0188 KP Execution Plan and Implementation Arrangements provided that community volunteer workers be mobilized nationwide to form part of the Community Health Teams (CHTs) tasked to assist and serve the NHTS households. Each CHT is supposed to comprise 5 members each with the midwife as supervisor. An average ratio of 1 CHT per 100 NHTS HHs or an average of 1 CHT member per 20 HHs was estimated to be targeted for training and deployment.

As of June 2013, a total of 210,203 CHT members have been trained, a fourth (80%) short of the total targeted number estimated based on an ideal ratio of 1 CHT member to 20 NHTS HHs. Majority of the CHT members are BHWs and BNSs. In areas where there is limited number of these existing volunteer workers, parent or mother leaders currently leading a group of 4Ps families were tapped to serve as CHT members. Based on feedback during the national CHT Consultation Meeting, the BHWs are least likely to drop from being CHT members compared to the newly-recruited parent/mother leaders.

Table 1 shows that on the average, 9 of the trained CHT members (93.1%) remained deployed as of June 2013. NCR registered the highest number of drop-outs while Region 7 reported the same number of deployed CHT members as those trained. The ratio of remaining deployed CHT members to the NHTS household varies largely across regions. While a number of regions met the desired ratio of 1 CHT member to 20 NHTS HHs (Regions 3, 4A, CARAGA) or even less like CAR, CHDs 1, 4B, 5, 7 and 8, there are regions (e.g. NCR, ARMM) whose number of deployed CHT members could barely cover the listed NHTS households with a ratio of 1 CHT member to 72 to more than 100 NHTS HHs. The ARMM has only mobilized 2% of its targeted requirement due to financial and administrative constraints.

Table 1. Average Number of NHTS Households Per CHT Member

Region	Total NHTS	Target CHT Members (1CHT member to 20HHs)	No. Trained CHT Members Reported	% Trained CHTs Versus Target	CHT Members Deployed as of June 2013		Ratio of 1 CHT Member Per NHTS HHs
					No.	%	
CAR	79,816	3,991	8,019	201	6,646	82.9	1:12
Region 1	247,882	12,394	14,536	107.4	13,317	91.6	1:19
Region 2	117,940	nd	nd	nd	nd	nd	nd
Region 3	322,622	16,131	16,168	100.2	16,047	99.2	1:20
NCR	316,823	15,841	7,905	49.9	4,433	56.0	1:72
Region 4A	392,811	19,641	21,857	111.2	19,858	90.8	1:20
Region 4B	242,633	12,132	13,965	115.1	13,518	96.7	1:18
Region 5	461,242	23,062	22,656	98.2	21,725	95.8	1:18
Region 6	385,516	19,276	13,042	67.7	11,445	87.8	1:34
Region 7	314,654	15,733	17,168	109.1	17,168	100.0	1:18
Region 8	313,474	16,760	18,950	113.0	17,687	93.3	1:17
Region 9	369,236	18,462	16,394	88.7	15,458	94.2	1:24
Region 10	338,749	16,937	15,557	91.8	14,689	94.4	1:23
Region 11	272,932	13,647	11,242	82.3	11,212	99.7	1:24
Region 12	296,043	14,802	12,621	85.2	12,007	95.8	1:25
CARAGA	232,285	11,614	11,615	100.0	11,440	98.4	1:20
ARMM	538,245	26,576	3,793	14.2	3,287	86.6	1:16
Philippines	**5,257,916**	**262,896**	**225,488**	**85.7**	**209,937**	**93.1**	**1:25**

The following were the reasons for CHT drop-outs:

- It took time after the training before the CHT forms, guides and materials were provided to the newly-trained CHT members. Some of those trained already lost interest to continue as CHT members
- Some of those trained upon seeing the voluminous forms to be accomplished and the multiple tasks to be done backed out
- Most parent/mother leaders mobilized to become CHT members were not prepared to perform their expected functions as they are not familiar with the health messages and health care and services to be provided.
- Incentives intended for the CHT members were not immediately released. In fact, some regions are still in the process of releasing the incentives
- CHT members found some of the expected tasks daunting, particularly in the area of recording and reporting

B. Assessment by Objective

The purpose of this CHT assessment is four-pronged. The mobilization of the CHT members is central in the achievement of the KP's goal towards universal access to health care and services. The first major concern of the assessment is to validate the functionality of the CHT members as they reach out and serve the identified poorest households in the country. Secondly, the assistance provided to the CHTs has to be documented and double-checked if there is a need to amplify support for their operations. Thirdly, though they have functioned only for more than a year upon their training and deployment in 2011, the assessment also hopes to ascertain if there has been any improvement in the access and utilization of health care and services. Lastly, the assessment aims to identify areas for enhancement so that the access and utilization to health care and services will be further strengthened especially among the poorest households.

Objective 1. *To validate the functionality of the CHTs*

Definition. As defined in the DOH-LGU Score Card, a functional CHT is one whose members are currently performing their expected functions. Their tasks include: (i) household profiling, (ii) risk-assessment; (iii) information, education and communication of key health messages and disseminating PhilHealth information, (iv) development of health use plan; (v) directing/guiding community members to appropriate health care providers; ((vi) conduct follow-up visits, and (vii) recording and reporting. The LGU Score Card also included "attendance to regular CHT meetings" as one of the functionality criteria.

Methodology. Previous assessments by the DOH (national and regions) including various development partners on the CHT operations provided inputs relative to the functionality of the CHTs. The 17 CHDs were tasked to conduct their own interviews of 10 selected CHTs in 3 identified barangays with the highest number of NHTS households. The focus of the interview was to establish which of the abovementioned functions they actually perform, and whether these are easy or difficult to perform using a rating scale of 1 to 5 with 1 as least difficult and 5 as most difficult.

Findings on the Performance of CHT Functions. Two sets of findings are presented under this section. The first set is the assessment whether the CHTs are able to perform their expected functions, and establish which ones they found easy to undertake or difficult to perform. The second set is to look at the immediate results of their performed functions as demonstrated by the extent of NHTS HHs located and

profiled, those risk-assessed and given HUPs, and those who comply or adhere to their HUPs.

1. *CHT Functions Performed*. As defined, there are 8 key functions that a CHT member must perform to be able to help improve the poorest households' access to quality health care and services. The performance of these functions is critical in helping the NHTS HHs identify their health needs, know how and where to seek the needed health care and then followed-up if they indeed availed of said services.

1.1 In general, all the 8 expected functions of the CHT members are being performed in varying degrees and forms. Of the total 250 CHT members interviewed by the CHDs in selected provinces and municipalities, majority of them confirmed that they are able to perform their expected tasks. Of these functions, they find household profiling, risk assessment and health use plan development to be easiest to perform. On the other hand, majority felt they have difficulty in conducting follow-up visits and in managing the recording and reporting system. The following table summarizes the respondents of the CHT members:

Table 2. Functions Performed by CHT Members

Functions most commonly cited by the CHTs	**Proportion of CHT members finding the function easy to perform**		**Proportion of CHT members finding the function difficult to perform**	**Reason for Difficulty**
Household Profiling	Visayas: 95/113 SL/NCR: 36/40	85.6%	Visayas: 11/113 SL/NCR: 2/40	Too many to write, not used to the forms
Health Risk Assessment	Visayas: 80/113 SL/NCR: 37/40	76.5%	Visayas: 25/113 Sl/NCR: 3/40	Some are not familiar with the health risks and needs per vulnerable group
Providing key health messages	Visayas: 73/113 SL/NCR: 30/40	67.3%	Visayas: 36/113 SL/NCR: 7/40	CHTs can only suggest and cannot dictate. Some lack knowledge on the basic key health messages especially for the non-BHWs/ BNS CHT members
Providing Information on PhilHealth Benefits and Requirements	Visayas: 72/113 SL/NCR: 20/40	60.1%	Visayas: 35/113 SL/NCR: 9/40	No time due to busy schedule
Assist NHTS develop HUPs	VISAYAS: 79/113 SL/NCR: 27/40	69.3%	Visayas: 54/113 SL/NCR: 5/40	Confusing
Refer Client to Health Care Facilities	Visayas: 103/113 SL/NCR: 35/40	90.2%	Visayas: 5/113 SL/NCR: 0/40	Lack of follow-up and supervision or no follow-up session on HUP (region 8);
Follow-up visits	Visayas: 83/113 SL/NCR: 23/40	69.3%	Visayas 6/113 SL/NCR: 1/40	no time due to busy schedule
Recording and Reporting	Visayas: 76/113 SL/NCR: 25/40	66.1%	Visayas:12/113 SL/NCR: 10/40	Lack of reporting and recording forms (CHD) Inadequate supervision (8); No standard form being used; too many data being required to report
Attend Meeting with the supervisors	Visayas:79/113 SL/NCR: 40/40	77.8%	Visayas: 1/113 SL/NCR: 0/40	

1.2 There are however deviations observed in the performance of these tasks. Previous assessments conducted by HPDP-UPECON on the performance of the CHTs of their functions revealed a number of leakages in the overall process.

a. In the conduct of household profiling, CHTs encountered difficulties in the ever-changing list of NHTS HHs, with some delisted CCT families and the other remaining non-validated HHs. Considering that the approach of household profiling is through the Family Development Sessions (FDS), not all NHTS HHs were profiled as some did not attend the said session and the Parent Leaders assigned failed to follow them up at home;

b. Key health messages were not thoroughly explained since most of the time, the Family Health Guides were merely distributed without any explanation of its content. Some CHT partners also lack copies of the PhilHealth Guide;

c. The development of Health Use Plans was hindered by several factors:

I. Reluctance of women with FP unmet need to be interviewed for various reasons (e.g. religious beliefs, male preference for traditional method, etc.). CHT partners also failed to follow them up.

II. Discussion of adolescent reproductive health not conducive in the FDS environment. Moreover, the CHT Form 1 failed to include those below 15 years of age.

III. Some pregnant women were not issued Health Use Plans as they prefer to give birth at home, some were missed out as women were not screened for pregnancy, some pregnant adolescent refuses to divulge their prenatal state.

d. Households did not understand HUPs as its importance was not adequately explained. The HUP development was also time-consuming and that mothers were unable to wait stay due to other responsibilities. Women from CCT households decided not to proceed with developing HUP when they learned that it did not have any bearing on the receipt of their cash grant and that using the HUP doesn't mean the services they will get will be for free.

e. Conduct of follow-up visits seldom done due to limited time and high transportation costs (their allowance not enough) Flood-prone areas and geographically isolated and depressed areas (GIDAs) were also difficult to access

f. Use of multiple recording media (use of notebooks/logbooks before transferring to CHT forms), lack of standard reporting forms led to loss of important data and individual interpretations, additional indicators further burdened data collection

1.3 The HealthGov's assessment of CHT functionality in 12 barangays in the four (4) selected municipalities in CHD 11 with 24 CHT members, 48 households and 12 midwives as respondents showed that only a few of the organized CHTs that performed adequately all their functions. Specific findings include:

a. Of the 12 barangays covered in the assessment, only 1 barangay implemented fully the CHT functions (with 81-100 scores), 10 barangays

implemented adequately (with 61-80 scores) and 1 barangay implemented partially (with < 60 scores)

b. Of the 24 CHT members interviewed:
    - 24/24 were doing profiling
    - 8/24 able to deliver key health messages
    - 18/24 conducted health risk assessment
    - 10/24 assisted development of HUP (the rest verbal referral)
    - 18/24 able to follow-up on family adherence to referral
    - 20/24 able to record accomplishments in the CHT logbooks
    - 24/24 able to submit accomplishment to midwife (w/ help of RN Heals]
    - 17/24 able to report NHTS/CCT families not yet enrolled in PhilHealth

1.4 VisayasHealth's Rapid Assessment in four (4) selected LGUs in Bohol and Negros Oriental covering a total of 44 CHT partners, 42 NHTS HHs, 10 LGU health staff including 8 RN Heals and 4 barangay officials also confirmed the abovementioned results.

a. CHT partners perform the following functions: (i) home visits, (ii) accomplishment of forms, (iii) profiling of clients, (iv) PhilHealth enrollment, (v) provision of assistance during health crises, (vi) referral/s for services and (vii) attendance in meetings;

b. Some CHT partners expressed the need to have more training on the use of the Family Health Guide, updates on health concerns, skills on taking vital signs, first aid and more knowledge on 4Ps, how to convince their clients to go to the health center and more information on PhilHealth benefits and how to avail of these;

c. CHT partners in Bohol claimed unable to cover all the assigned NHTS HHs per month but they give priority to pregnant women and senior citizens. In Negros Oriental, CHT partners claimed to have visited all their assigned NHTS HHs even more than once in a month;

d. Local health staff like the PHNs, RHMs and RN Heals are aware of the functions of the CHT partners and described these to be their partners in monitoring clients for EPI, prenatal and births, help gather clients to bring to health center, provide health services, help indigent families on what to do, motivate them to visit the health center and refer health conditions;

e. Not all barangay officials are aware of the CHTs in their area. Some however know them personally but refer to them mainly as BHWs. Among the CHT functions they know of include masterlisting, check nutritional status of children, take BP, bring clients to RHUs, guide patients what to do and give information

2. Immediate Results of CHT Mobilization. If CHTs performed adequately their functions, it is assumed that these will translate into the NHTS households being located, profiled, risk-assessed, with developed health use plans and are actually availing services from the health facility/health provider. On this regard, the following were noted and observed:

2.1 *Proportion of Located NHTS HHs*. Of the total 5.2 million listed NHTS households nationwide, only three fourths (76.6%) were located. This means that not all the listed NHTS households were found and initially visited by the CHT members.

Based on the reports submitted by the CHDs, there are about 810,000 households (33.4%) that have not been reached by the CHTs, the primary reason of which was the absence of concrete addresses of the NHTS as recorded by DSWD. In NCR, there were many households without complete addresses, with only the district/zone indicated. Other regions (e.g. CHD 3) were able to account each of the NHTS HHs. Some were reported to have already transferred residence, others already died, some were double listed, and the declared households were not the ones staying in the indicated addresses.

2.2 *Proportion of NHTS HHs with HUP*: In the CHT guidelines, it was indicated that once the NHTS household has been located, each HH member should be individually listed and profiled in terms of demographic-socio-economic status and categorized into vulnerability groups. Each of those identified as vulnerable is assessed of their health risks or health needs. Based on the results of the assessment, they are to be provided with appropriate key health messages including information about access to PhilHealth accredited facilities, and then assisted to come up with their respective health use plans (HUPs). The issuance therefore of HUPs indicate that the household member has already been risks-assessed, properly informed of health messages and about PhilHealth and guided what services they need to receive and where and when to avail of them. Based on report submitted by the CHDs, only more than half (57.1%) of those NHTS HHs located have at least 1 member issued with a health use plan. If there are only half of the listed NHTS HHs located, and only half of them have been issued with a health use plan, then only about one fourth of the total listed HHs have been risk-assessed, given appropriate key health messages and guided what and how to avail services.

2.3 *Proportion of NHTS HHs with at least 1 member who availed of services*. The ultimate indicator to measure the functionality of the CHT members is the proportion of NHTS households issued with HUPs who actually accessed health care and services from the heath facility or health care provider. Most of the provinces were unable to record and report on this indicator. Those provinces with reports showed varied proportions with the ARMM reporting the lowest at 1.8% of NHTS households who availed of services to as high as 92.5% in CARAGA.

Table 3. Proportion of NHTS HHs Receiving Visits/Assistance from the CHT Members

Region	No. of NHTS HHs	NHTS HHs Located/Profiled/ Initially Visited		NHTS HHs with at least 1 member with HUP developed		NHTS HHs with at least 1 member who availed services (complied with HUP)	
		No.	%	No.	%	No.	%
CAR	79,816	72,447	90.8	cannot be determined		cannot be determined	
Region 1	247,882	220,559	89	175,684	79.6	cannot be determined	
Region 2	118,118	85,353	72.3		-	No data	-
Region 3	322,622	294,574	91.3	294,574	100	No data	-
NCR	316,823	122,492	37	83,004	68	No data	-
Region 4A	432,056	337,221	78	No data	-	No data	-
Region 4B	242,633	198,505	82	165,510	83	45,936	28
Region 5	461,242	Data to be validated		Data to be validated		No data	
Region 6	385,516	291,019	75	9,245 (Capiz Only)	72	No data	-
Region 7	314,654	314,654	100	No data	-	No data	-
Region 8	313,474	139,966	45	98,227	70	98,227	70
Zamboanga	369,236	239,211	64.8	162,149	67.8	No data	0

Region	No. of NHTS HHs	NHTS HHs Located/Profiled/ Initially Visited		NHTS HHs with at least 1 member with HUP developed		NHTS HHs with at least 1 member who availed services (complied with HUP)	
		No.	%	No.	%	No.	%
Northern Mindanao	338,749	246,536	72.8	198,379	80.5	153,533	77.4
Davao	272,932	262,685	96.2	183,207	69.7	45,289	24.7
SOCCSARR GEN	296,043	180,450	61	119,328	66.1	90,888	76.2
CARAGA	232,285	210,653	90.7	210,653	100	194,793	92.5
ARMM located	538,245	349,280	64.9		6.3	No data	0
ARMM profiled	538,245	79,170	14.7	22,011	27.8	396	1.8
Philippines	**7,868,061**	**5,212,760**	**66.3**	**2,608,453**	**50.0**	**1,113,961**	**53.7**

In addition to these reports received from the CHDs, the assessment conducted by UPECON in selected 5 provinces showed that not all NHTS HHs issued with the HUPs were able to access health care and services. For example, of those women identified with unmet FP need for modern FP method given HUPs did not adhere or comply with the HUPs. Leyte Province showing only 13% of NHTS HHs issued with HUPs have availed of services adhering to HUPs in FP while Quezon City had 87% of women given HUP have actually accessed the needed services.

Objective 2. To establish the type and level of support received by the CHTs from the DOH/CHDs, LGUs and other concerned groups of stakeholders

The mobilization of CHTs required a concerted effort at various levels of operations. Collaboration with other national agencies, particularly with the DSWD, DILG and DepEd was pursued at the national level, and was followed suit in the different regions in the country down to the provincial/city and municipal levels. Several forms of assistance to the LGUs (policy, technical and financial) were flowed in from the DOH-central office through the CHDs. The LGUs themselves put up their own counterparts while development partners were also mobilized to pitch in their contributions and assistance. This section aims to document the different resources that were mobilized to operationalize the CHT Strategy nationwide.

2.1 *Assistance Provided In Mobilizing the CHTs*. Several policies and guidelines were issued by the DOH and the DILG with concurrence of other relevant national government agencies (e.g. DSWD, DEpEd) supporting the operationalization of the CHT Strategy. Several technical guides, manuals, tools and forms were also developed to guide their mobilization, training and operations. Training were conducted at various levels, beginning from the Training of Trainers (TOT) at the national and regional levels, cascading these to the provincial/municipal/city levels down to the actual training of the CHT members themselves. Prior to the training, series of orientations were also undertaken by the CHDs with the local government officials to mobilize their support for the CHT operations. Grant assistance were provided by the DOH – national and CHDs including development partners particularly in their project sites. To top it all, the DOH paid for the health insurance premiums of all the listed 5.2 million NHTS households.

Table 4. Assistance/Support to have Received by the CHT Members

Form of Assistance	Assistance and Support to CHT Mobilization
Policy Issuances	D.O. No. 2011-0188 which provided the road map for the implementation of the *Kalusugan Pangkalahatan.*
	DOH Memo 2011-0286 which provided the Guidelines on the Mobilization of CHTs, describing each composition, their roles and responsibilities and the contributions of various DOH offices in the implementation of the CHT strategy.
	DILG issued DO. No. mandating concerned government offices to provide support in the mobilization of CHT at the local level
Technical Guides and Tools	The following technical references and guides were developed with assistance from HPDP and other development partners: • Orientation Manual for PHOs/CHOs/MHOs in Mobilizing CHTs • Operations Manual on CHT Mobilization • PhilHealth Guide • Family Health Guide • CHT collection and reporting forms (Forms 1, 2A to 2G)
Training	Funds were allocated for training and mobilization of CHTs in the 17 regions nationwide amounting to Php 2.5 billion. These also include those provided by development partners. Training Manual on CHT Mobilization was developed for NCR and later used byCHD 4A
Grant Assistance	DOH released a total amount of Php 244M in 2011 and 864M in 2012 to fast track the training of the CHT partners and at the same time to facilitate their deployment which include the reproduction of tools and guides, supplies, materials, and incentives for the CHT members, etc.
PhilHealth	PhilHealth Insurance premiums paid for all listed NHTS HHs
CHDs	Orientation and advocacy among LGUs to participate in the KP particularly in mobilizing CHTs
	Provided their own funds for CHT training and mobilization
	Innovations on data recording and reporting (e.g. CARAGA)
	Recruitment of community volunteers/parent and mother leaders
	Training of Trainers for local CHT training
Development Partners	TA in the development of policies, guides and manuals
	Training of CHTs in their respective project sites
	Innovations on data recording and reporting (e.g. CARAGA
LGUs	Mobilization of BHWs/BNS, parent leaders/mother leaders
	Counterparts for training
	Incentives for CHT members
	Additional forms/supplies/materials
	Transportation for CHT members

2.2 *Support Received As Affirmed by the CHTs.* Interviews done by the CHDs of more than 250 CHT members affirmed their receipt of various support and assistance. It can be seen that various forms of incentives were provided both in cash and in-kind. Some LGUs provided cash incentives to the new CHT members that were recruited. CHT members in some areas were also provided other paraphernalia for their use. These include umbrellas, plastic bags or CHT kits, vests, boots and hats. Only a few areas were able to develop and pass resolutions to support the operations in their respective localities.

Table 5. Assistance/Support Affirmed to have Received by the CHTs

Support	Regions										Total	
	Reg 1	Reg 2	Reg 3	Reg 4A	Reg 4B	Reg 5	NCR	Reg 6	Reg 7	Reg 8	No. (300)	%
Training	30	30	30	10	30	10	10	61	22	30	263	87.7
Mentoring/ Supervision	20	30	30	10	30	10	10	16	22	30	208	69.3
Technical Updates	0	30	24	10	30	10	10	40	9	30	193	64.3
Reference Guides/ Tools												
a. Family Health Guide	30	30	29	10		10	10	61	22	30	232	77.3
b. PhilHealth Guide	30	30	13	10		10	10	61	22	30	214	71.3
c. List of Accredited Facilities	20	30	10	-	-	-	-	61	22	30	173	57.7
d. IEC materials	0	30	9	10		10	10	61	22	30	182	60.7
Forms 1, 2A to 2G	30	30	19	10	30	10	10	61	22	30	252	84.0
Paraphernalia and supplies (pencil, kit, umbrella, etc.)	30	30	27	10	30	10	10	61	22	30	260	86.7
Resolution/AO	0	30	11	0	0	0	0	6	5	30	82	27.3
Incentives												
a. In cash (honoraria)	30	30	16	10	30	10		61	22	30	249	83.0
b. in kind (transport, meals/snacks, etc.)	30	30	24	Boots/slippers, raincoat, bag					4	30	118	39.3
c. PhilHealth enrolment	0	30	15					61	10	30	177	59.0

2.3 *Grant Assistance for CHT Operations.* Based on the records of the DOH-NCDPC, total grants cascaded to the different regions in support to CHT mobilization, training and operations amounted to Php 2.5 billion from 2011 to 2013. As shown below, these were mainly provided by the DOH with some assistance from development partners like UNICEF and the European Union (EU).

Table 8. Sub-allotments to CHDs and Funds for Transfer to DOH ARMM for Community Health Team Mobilization

CHD	2011 (DO 2011-0254)	2012			2013 (DO 2013-0052)	Total
		GOP DO 2011-0253)	EU (DO 2012-0013	UNICEF (DO 2012-0012)		
CAR	6,876,623	8,853,460	10,000,000	2,800,000	20,747,255	49,277,338
Region 1	18,736,898	38,811,387			61,723,048	119,271,333
Region 2	13,507,860	13,914,415	10,000,000		29,411,164	66,833,439
Region 3	18,129,278	56,770,646			79,332,557	154,232,481
NCR	8,792,963	60,860,665		3,900,000	78,388,980	151,942,608
Region 4A	23,638,755	68,442,634			97,760,435	189,841,824
Region 4B	8,518,365	47,811,312			60,416,084	116,745,761
Region 5	20,279,318	86,802,625			112,849,246	219,931,189
Region 6	23,673,810	65,827,585			94,993,616	184,495,011

CHD	2011 (DO 2011-0254)	2012			2013 (DO 2013-0052)	Total
		GOP DO 2011-0253)	EU (DO 2012-0013	UNICEF (DO 2012-0012)		
Region 7	17,550,870	55,498,738		1,000,000	77,848,489	151,898,097
Region 8	25,654,418	51,167,471			82,467,105	159,288,994
Region 9	11,129,963	74,591,867			90,939,833	176,661,663
Region 10	11,831,063	66,812,905			83,348,495	161,992,463
Region 11	6,794,828	56,569,065			67,960,131	131,324,024
Region 12	6,981,788	58,947,555		2,800,000	73,714,396	142,443,739
CARAGA	7,671,203	46,256,083			57,839,268	111,766,554
ARMM	14,553,668	10,405,291	80,000,000		57,931,025	162,889,984
TOTAL	**244,321,671**	**868,343,704**	**100,000,000**	**10,500,000**	**1,227,671,127**	**2,450,836,502**

Based on the total number of listed NHTS HHs, it can be seen that the DOH has invested about Php 50,000 for each NHTS household (Php 47,787) with the CAR having the highest per capita allocation at Php 61,739. Per capita allocation of DOH grant assistance almost doubled up if applied only to those NHTS HHs who were located with NCR and Region 8 with highest per capita allocations. The amount of investment for the first year of CHT operations seems quite high given the cost of training and reproduction of forms and guides for the start-up operations. The assistance can be further maximized if the CHTs continue to serve and reach out to their assigned households in the coming years. However, as previously shown in Table 1, there are a number of CHT members who have dropped out, indicating that the investment is not being fully maximized. Note that ARMM has not completely received its allocation due to administrative constraint or bottleneck.

Table 9. Per Capita Grant Assistance

Region	Total Grant Assistance Allocated	Total No. of NHTS HHs Listed	Per Capita Allocation	No. of NHTS HH Located	Per Capita Allocation Per NHTS Located
CAR	49,277,338	79,816	61,739	72,447	68,018
Region 1	119,271,333	247,882	48,116	220,559	54,077
Region 2	66,833,439	118,118	56,582	85,353	78,302
Region 3	154,232,481	322,622	47,806	294,574	52,358
NCR	151,942,608	316,823	47,958	122,492	124,043
Region 4A	189,841,824	432,056	43,939	337,221	56,296
Region 4B	116,745,761	242,633	48,116	198,505	58,813
Region 5	219,931,189	461,242	47,682	no data	-
Region 6	184,495,011	385,516	47,857	291,019	63,396
Region 7	151,898,097	314,654	48,275	314,654	48,275
Region 8	159,288,994	313,474	50,814	139,966	113,805
Region 9	176,661,663	369,236	47,845	239,211	73,852
Region 10	161,992,463	338,749	47,821	246,536	65,707
Region 11	131,324,024	272,932	48,116	262,685	49,993
Region 12	142,443,739	296,043	48,116	180,450	78,938
CARAGA	111,766,554	232,285	48,116	210,653	53,057
ARMM	162,889,984	538,245	43,904	349,280	67,657
Philippines	**2,450,836,502**	**5,282,326**	47,787	**3,565,605**	**70,795**

Objective 3. To ascertain any improvement in the access and utilization of key MNCHN services in areas where CHTs have been deployed

The goal of KP is to ensure universal access to health care and services among the poorest households in the country. The assessment attempted to measure any improvement on the access and utilization of health care and services by comparing the results of selected health indicators before and after the CHT deployment in two 6-month period: (a) between July to December, 2011 and July to December 2012; and (b) between January-June 2012 and January to June 2013. The 5 indicators include the proportion of pregnant women with at least 4 antenatal consultations (ANC), prenatal, proportion of women who delivered in health facilities, proportion of PP women with at least 2 PP visits, proportion of Fully Immunized Children (FIC) and the proportion of new FP acceptors.

Results show that there were more BHSs reporting increase in service coverage based on the selected 5 indicators after CHT deployment at 2 reference periods. The number of BHS reporting increase in the proportion of pregnant women with at least 4 ANC visits is two thirds more than the number with decreased coverage between Jul-Dec 2011 and Jul-Dec, 2012. Over the same period, the number of BHS with reported increase in facility-based deliveries and post-partum care coverage is almost twice than those reporting decreased coverage. There are also more BHS units reporting increases in the proportion of fully immunized children and new FP acceptors.

Between the Jan-Jun 2012 and Jan-June 2013, there are still more BHS units with reported increases in service coverage than those with decreased or the same coverage, except for the proportion of post-partum women with at least 2 post-partum visits. The differences though are not as marked as in the first reference period.

Though the results are encouraging, it still premature to attribute the increase in service coverage to the deployment of CHTs in these BHSs or barangays considering that there is also considerable number with reported decreased and unchanged coverage. These results must be cautiously interpreted considering that no control areas were observed over the same reference periods. It must be noted however at this point that this tracking and analysis of service coverage by barangay must be institutionalized at the RHU and BHS levels to determine if the mobilization of the CHTs is really helping to bring in the community members especially the poorest of the poor into the health care delivery system and avail of the services they direly need..

Table 10. Number of BHS Reporting Increase/Decrease in Service Coverage Pre and Post CHT Deployment (July-December 2011 – 2012) and (Jan-June 2012-2013)

Indicator	No. of BHS Reporting Change in Service Coverage Jul-Dec 2011and Jul-Dec,2012				No, of BHS Reporting Change in Service Coverage Jan-Jun 2012 and Jan-Jun 2013			
	No. BHS with Data	With Reported Increased Coverage	With Reported Decreased Coverage	No Change Reported	No. BHS with Data	With Reported Increased Coverage	With Reported Decreased Coverage	No Change Reported
Indicator 1. Proportion of pregnant women who had at least 4 ANC visits	36	26	10	0	40	21	18	1
Indicator 2. Proportion of	42	18	9	5	39	20	14	5

women who delivered in health facilities								
Indicator 3. Proportion of Post-partum women with at least 2 visits	37	21	11	5	44	19	19	6
Indicator 4. Proportion of Fully Immunized Children	47	23	16	8	44	26	17	1
Indicator 5. Proportion of New FP Acceptors	29	16	9	4	40	27	11	2

Objective 4. To identify areas for enhancement in the CHT processes, tools and guides

The last focus of the CHT assessment is to identify the bottlenecks in the operationalization of the CHT Strategy so that necessary improvements will be instituted as the CHTs continue to perform their role in improving universal access to health care and services, especially among the poor. Although most of the challenges and gaps were encountered during the initial phase of implementation, several issues continue to confront the CHT operations. The following summarizes these problems and gaps.

4.1 Continuing Challenges and Gaps in the CHT Process

- There is continuous dropping out of CHT members, especially among the non-BHW/BNS CHT members for various reasons
- Reports also showed that some CHT members require additional training and technical updates to adequately perform their expected tasks
- Substantial number of enlisted NHTS households remained unlocated/ unfound and unserved. The benefits of their automatic enrolment to PhilHeath have not been availed or utilized
- There are indications that though the CHT members perform the 8 expected functions, these are done variably in quality and frequency given the reported leakages and the partial implementation of the CHT process
- It has been reported that the supply side has not been readied at the same pace as generating the demand for services through the CHTs. Anecdotal reports have been forwarded that the health care providers (supply side) were not around or ready to provide the needed services even though the NHTS members have been guided to seek care and are properly referred,
- Several NHTS members were also non-compliant in seeking health care and services despite the advice/guide and health use plans developed by them with the assistance of the CHT member
- More quality supervision of the CHT process has not been evident except for the conduct of monthly meetings which was more often spent for data validation and consolidation between the supervisor and the CHT members
- CHT recording and reporting remained a major concern as the indicators being measured and required by DOH management have been varied and no standard forms/tools were provided as template or guide

- ❖ Operational bottlenecks continue to confront the functionality of the CHT members e.g. slow liquidation of funds, etc.
- ❖ Tracking of the progress of CHT operations at the national level has not been adequately coordinated and managed. Several information required by the DOH Regional Clusters have not been coordinated with the MNCHN Program Managers
- ❖ CHT Forms, Tools and Guides have metamorphosed into several versions, some of which are meeting the localities' peculiar needs but remain inadequate and unfriendly to use
- ❖ Midwives time for service delivery has been compromised due to demand for data consolidation and validation
- ❖ Some requirements introduced by CHT members (e.g. bringing the developed health use plans) prevents the NHTS household members avail the necessary services
- ❖ The biased focus of CHT members to the NHTS HHs only have deprived the other community members equally needing care and services from due attention and services

4.2 Recommended Areas for Enhancement

4.2.1 Enhancement on the CHT Guide, Tools and Forms

Function 1. Profiling and Updating Profiles

- Need to update Family Profile (Form 1) for new health risks/conditions e.g. transitioning from one risk group to another e.g. infant to newborn, pregnant to post-partum, post-partum to pre-pregnant (FP). Additional column for remarks may respond to these needed transitions.
- Consider including and expanding information on adolescent health care and services
- Delete non-MDG indicators being collected: PWD, malaria, non-com diseases, environmental health – safe water source and toilet
- Emphasize instruction to leave Form 1. Family Profile with the CHT

Function 2. Risk Assessment

- Retain Form 2A as is
- Update Form 2B on new antigens
- Update Form 2C on new antigens, micronutrient powder (MNP)
- Provide additional form for adolescents based on A.O. for adolescents- 2013-0013
- Update Form 2D with additional questions on TT, Ferrous Sulfate during prenatal visits and corresponding messages for each new condition should be included in the brochure. Additional question on breastfeeding during pre natal visit/check-up should be reviewed and added
- Include question on immediate post partum FP intervention in Form 2E
- Add questions on the intent to use a FP method to establish if there is any unmet need for FP. Review Form 2G used in NCR and Regions 4A and 4B
- Retain Form 2G as is
- Attach additional Forms 2a-2g for new health risks/conditions if space on previous sheet is filled up

Function 3. Provisions of IEC Messages and PhilHealth Information

3.1 Key Health Messages

- Enhance messages on FP
- Separate the risk assessment questions from the key messages.
- All key messages can be integrated into just one brochure

3.2 PHIC Benefits and availment

- PhilHealth Guide Benefit Package including rates has to be updated
- Each CHT member should be given a Philhealth guide in Tagalog or local dialect

Function 4. Health Use Plan Development

- Risk assessment and HUPs will remain in the sheet/forms. Key messages will be separated.

Function 5. Referral to Health Facilities

- Updated list of PhilHealth-accredited facilities must be provided to each CHT member
- The updated list must include the name of providers, their contact numbers and addresses as well as schedules and cost of services
- Correspondingly, the MHO/CHO should be able to identify other health facilities in their respective localities for referrals.

Function 6. Follow-up. Up Visits

- Ensure that Part 5, title on the list of services is related to the Forms. e.g. 2-f (FP) is the same with the form.
- Monthly revisits

Function 7. Recording and Reporting

- CHT members' task is only to report maternal and neonatal deaths to the midwives who in turn will validate if the information is correct
- CHT members need to submit Forms 1, 2A-2G and 3 to the RNHeals for consolidation, and to the PHN for validation
- Reports are to be submitted by the MHO/CHO to the PHO or CHD extension office for consolidation and then to the Regional Health Office.
- Review postpartum period (within 42 days not 49 days after delivery), Newborn period (0-28 days not 0-29 days)
- Add column on unmet needs who accepted any modern FP method.
- Delete PWD and Senior Citizens (Form 2)
- Add column for HH with WRA with unmet needs.
- Add column for WRA with FP unmet need and who accepted a method.
- Add column for adolescent health if the program is ready.
- Report to be done on a monthly basis

Function 8. Attendance to Meetings

- Monthly meetings with monthly submission of reports every 1st week of the succeeding month.
- Check CHT logbooks as to completeness of entries.
- Means of verification will be the signed attendance sheet and minutes of the meeting.

4.2.2 Enhance Supportive Supervision of CHT Members

One major gap identified in the CHT operations is the absence of a supervisory system that would support the CHT members perform their expected functions effectively and efficiently. Although most CHT members claimed to have attended the regular meetings with their immediate supervisors, these have been more often than not spent for data consolidation and validation. There has also been confusion who should actually supervise them – the RN Heals or the midwives themselves, with each of these options with respective advantages and disadvantages. The National CHT Consultative Meeting held last September 18-20, 2013 surfaced the need to develop a guide on supportive supervision for the CHT supervisors to use in coordinating and managing the CHT operations in their respective localities. The following are proposed recommendations to be considered in developing the supervision guide.

a. The supportive supervision manual must be anchored on the following functions of the CHT supervisor:

- ❖ Oversee the CHT implementation
- ❖ Monitor progress and status of CHT mobilization
- ❖ Train, mentor and coach CHT members
- ❖ Validate data and service coverage
- ❖ Evaluate CHT performance based on the 8 functions
- ❖ Coordinator/Facilitator/Convenor meeting
- ❖ Consolidate Reports
- ❖ Analyze data and recommend actions
- ❖ Facilitate data utilization
- ❖ Makes decisions on technical/health care delivery Issues

b. The supervision guide must be aligned with the roles and functions of the CHT supervisor as described above and focus on the particular needs and concerns.

Table 11. Specific Focus of the Supervisory Guide

Role	Particular Focus
Oversee the CHT implementation	Based on the 8 Functions
Monitor	Based on the 8 Functions
Mentoring and Coaching	Identify CHT partner who needs capacity enhancement, especially on the technicalities of HUPs, key messages, PhilHealth benefits and other identified areas of weakness
Validator	Submitted reports including the accomplished forms shall be validated by the supervisor
Performance Evaluation	Based on the 8 Functions
Coordinator/Facilitator /Convenor of meeting	Coordinate with local officials (re: local policies) and other stakeholders through CHT management group, to gather support and assistance Facilitate submission/completion of reports, including logistics and other needed resources by the CHT partners Convene meetings on a monthly basis
Consolidation of Reports	Monthly consolidation and submission of reports

Data Analysis and Utilization	Analyze data for purposes of assessing health services needed by the HH
Trainer	Orientation of non-BHWs CHTs on health programs (MNCHN, TB, etc.). Given that the CHT supervisor/RHMs are provided with updates, they shall also provide feedback/updates to CHT partners Interpersonal communication and decision making skills
Giving feedback(both to RHU management and CHT members)	

c. CHT Supervisors must be trained on the following to make them more responsive to the needs of the CHT members
   - ❖ Trained on the CHT process, especially on the tools/forms used
   - ❖ Trained on supervisory skills
   - ❖ Convene/conduct regular meetings
   - ❖ Be regularly updated
   - ❖ Tools to be used on their functions
   - ❖ Needs based supervisory and technical assistance

d. The following support from the CHT members must be made clear and owned by them:
   - ❖ Perform their expected functions (especially complete, timely and accurate submission of reports)
   - ❖ Active participation/complete attendance during meetings
   - ❖ Provide feedback to CHT supervisors

e. The following support from the various levels of administration must also be harnessed to enable the CHT supervisor perform their expected tasks

e.1 Support Needed From the Barangay
   - ❖ Formulate and pass barangay resolutions/policies supporting CHT operations (commitment re: counterpart funds, sustenance of CHT operations, security of tenure of CHT members/BHWs, development of guidelines on alignment of SK and GAD as funding sources)
   - ❖ Ensure the functionality of the CHT management group
   - ❖ Ensure that the Service Delivery Network is established and functional
   - ❖ Help identify CHT members

e.2 Support Needed from the PHO/MHO

<u>DOH National</u>
   - ❖ Provide national guidelines to all mentioned

CHD
   - ❖ Convene CHT management group based on the Joint Memorandum Circular dated Oct 2011
   - ❖ Distribution of RN Heals to provinces
   - ❖ Data management
   - ❖ Monitoring and supervision (with tool)

PHO

- Technical assistance (monthly meetings, updates and trainings)
- Logistic support (forms and tools)
- Data management
- Monitoring and supervision (with tool)
-

MHO/ CHO

- Technical assistance (monthly meetings, updates and trainings)
- Logistic support (forms and tools)
- Facilitate resolutions/ordinances
- CHT management group involving multi-sectoral groups
- Compliance to existing laws and DOH policies i.e. ICV compliance, Milk Code, etc.
- Functionality/strengthening of Service Delivery Network
- Data management
- Conduct regular inter-agency meetings (Municipal Links, DSWD, PhilHealth, etc.)
- Monitoring and supervision (with tool)

f. Recommended Content/Outline of the Supervisory Guide

I. Governing Laws and Policies
   A. RA/EOs
   B. AO AHA-UHC
   C. DO Kalusugan Pangkalahatan
   D. Joint Memorandum Circular dated Oct 2011
   E. DO CHT Mobilization/ Guidelines
   F. Service Delivery/ Program Guidelines (MNCHN, TB, ICV Compliance etc.)
   G. Local Ordinances/ Resolutions

II. Organizational Structure and Roles

III. Resource Management
   A. Logistics
   B. Human Resource

IV. Data Management
   C. Collection
   D. Analysis
   E. Utilization

V. Monitoring and Evaluation of CHT implementation

4.2.3 Standardization and Definition of Key Indicators to Track Progress in CHT Operations

The weakest link in the CHT operations is the lack of monitoring and evaluation framework to track and assess the progress and status of CHT operations at various levels of administration. For one, there is no standard set of indicators identified to track the progress/status as there have been varied requests and demands from the different DOH clusters. Secondly, there has been no standard recording and reporting system that will ensure the proper and timely collection, consolidation and submission of key information to appropriate levels for more effective management of the CHT operations. Thirdly, there is lack of appreciation and utilization of data at the national/regional and local levels. Data have been submitted routinely but no analysis have been done to generate the needed evidences to impact on better coverage and access to services. Part of the assessment was to identify key indicators that would guide the monitoring and evaluation of the CHT operations nationwiide. The following

has been recommended for consideration in the development of the CHT Monitoring and Evaluation Framework:

Table 12. Recommended Key Indicators on Monitoring CHT Operations

Indicator	Levels Data Are Needed	Definition	Frequency	Data Source
1. CHT Organization/ Mobilization				
1.1 No. CHT members functional	At all levels	CHT members trained, given materials, and with assigned NHTS households. To be reported on a cumulative basis (as of)	Monthly: BHS/ RHU Monthly: PHO/ CHD/CO	CHT Report
1.2 % of CHT members attending monthly meetings	BHS/ RHU/ Health Centers	(No. of CHT members attending monthly meetings/ No. of Functional CHT members) x 100R	Monthly	CHT Report
1.3 % of CHT members submitting monthly reports	BHS/ RHU/ Health Centers	(No. of CHT members submitting monthly reports / No. of Functional CHT members) x 100	Monthly	CHT Report
2. NHTS HHs Covered and Reached				
2.1 % NHTS HHs located and profiled	All levels	(No. of NHTS HHs located and profiled) /Total NHTS list from DSWD)x 100	Monthly: BHS/ RHU Monthly: PHO/ CHD/CO	
a. % CCT HHs located and profiled	All levels	(No. of CCT HHs located and profiled /Total CCT list from DSWD)x 100	Monthly: BHS/ RHU Monthly: PHO/ CHD/CO	CHT Report
b. % Non-CCT HHs located (profiled)	All levels	(No. of Non CCT HHs located (profiled)/Total Non CCT list from DSWD)x 100	Monthly: BHS/ RHU Monthly: PHO/ CHD/CO	CHT Report
2.2 % NHTS HHs with at least 1 member given HUP	All levels	(No. NHTS HHs with at least 1 member given HUP/ No. NHTS HHs located and profiled) x 100 **Given HUP means health risk assessed, given key messages, and assisted developing HUPs*	Monthly: BHS/ RHU Monthly: PHO/ CHD/CO	CHT Report
2.3 % CCT HHs with at least 1 member given HUP	All levels	(No. CCT HHs with at least 1 member given HUP/ No.CCT HHs located and profiled) x 100 **Given HUP means health risk assessed, given key messages, and assisted developing HUPs*	Monthly: BHS/ RHU Monthly: PHO/ CHD/CO	CHT Report sourced from existing facility forms (e.g. MCB, ECCD, CBMIS, TB Treatment Card, etc.)
2.4 % NHTS HHs	All levels	No. of NHTS HHs with at	Monthly: BHS/	CHT Report

with at least 1 member who availed of service/s		least 1 member availing of services / No. of NHTS HHs given HUPs	RHU Monthly: PHO/ CHD/CO	
2.5 % CCT HHs with at least 1 member who availed of services	All levels	(No. CCT HHs with at least 1 member given HUP/ No.CCT HHs located and profiled) x 100 **Given HUP means health risk assessed, given key messages, and assisted developing HUPs*	Monthly: BHS/ RHU Monthly: PHO/ CHD/CO	CHT Report
2.5 % of NHTS WRA with FP unmet need	All levels	[No. WRA with FP unmet need *(from Form 2F)* /No. of WRA among NHTS HHs profiled *(from Form 1)*] x 100	Monthly: BHS/ RHU Monthly: PHO/ CHD/CO	CHT Report
2.6 % of NHTS WRA with FP unmet need who received any FP services (counseling and/or any FP modern method)	All levels	(No. of WRA who received FP counseling and/or any modern FP method among NHTS HHs/ Total WRA with unmet need among NHTS HHs) x 100	Monthly: BHS/ RHU Monthly: PHO/ CHD/CO	TCL/ FHSIS
2.7 No. of maternal death	MW/RHU	Pregnant women who died due to pregnancy-related caused up to 42 days post-partum	Real time	E-alert
2.8 No. of newborn death	MW/RHU	Babies who died within 28 days after birth	Real Time	E-alert
2.9 No. of infant deaths	MW/RHU	Children who died under 1 year old	Real time	E-alert

3. Indicators on the Services Availed by NHTS Household Members

Services availed by the members of the NHTS Households need to be recorded and reported at all levels of operations using the FHSIS. For this purpose, the following are recommended for enhancement:

a. There is a need to mark in the FHSIS – Target Client Lists at the BHS/ barangay level those NHTS household members availing said services to be able to differentiate them from the rest of clients.

b. The DOH-Women, Child and Family Cluster will coordinate with the National Epidemiology Center (NEC) for the segregation of NHTS-clients from the non-NHTS clients in the generation of monthly, quarterly and annual reports.

c. Upon agreement, DOH has to issue an addendum of instructions to guide each BHS/RHU facility on how to record and report the following service coverage between NHTS and non-NHTS clients.

- % newborns initiated to breastfeeding
- % newborns given BCG birth dose

- % newborn given Hepa B birth dose
- % newborns underwent screening
- % infants/ children given immunization: DPT/PENTA, OPV, measles, MMR, ROTA, PCV
- % 0-5 year children given MNP
- % 6-59 months old given 2 doses Vitamin A
- % exclusively breastfed infants up to 6 months
- % pregnant women w/at least 4 ANC visits
- % pregnant women given ferrous sulfate
- % women delivered in facility
- % delivery attended by SBA
- % PP women w/ at least 2 PP visits
- No. of current FP users
- No. of new FP acceptors
- % of NHTS members w/ 2-week cough (TB symptomatic) received treatment

d. CHT Risk Assessment Forms need to be refined especially in obtaining the following information:
   - review existing Form for Underfive Children to be able to obtain exclusively breastfed children
   - improve Form on Family Planning to be able to obtain FP unmet need

4. Indicators to be Discontinued

It s strongly recommended that the following data being requested by the DOH – Central Office be no longer collected and submitted through the CHT system for the following reasons:

- *Source of Drinking Water and Type of Toilet Facility.* information are being collected by the Rural Sanitary Inspector (RSI) deployed at the municipal/city levels. CHT members are not in the position nor capable of determining accurately these information. Hence, these information must be obtained by DOH through the existing FHSIS or program report on environmental health.

- *No. of maternal and newborn deaths.* The DOH has already established a system on how to undertake maternal and newborn death review and reporting. Local health staff has been trained/oriented on the system involving the midwives, municipal/city and provincial health officers as members of the Maternal-Newborn Death Review (MNDR) Committee. It is not advisable to task CHT members to report said statistics through the CHT Reporting System considering that there is a prescribed process how maternal and newborn deaths are reviewed, validated and reported. The CHTs are not trained to undertake this process. Their role is only to report to their supervisor midwives these deaths and the midwives in turn are to undertake the needed validation before these are reviewed by the provincial committee. It would be advisable for DOH to fast track and facilitate the establishment of the MNDR nationwide instead of loading the burden to the CHT system which is not enabled of reporting accurate maternal-newborn deaths.

- *No. of People with Disabilities (PWIDs)*. The CHTs are not trained/oriented on what are to be considered as PWDs. These data are beng collected by DSWD. If this is needed by DOH, then it should coordinate with DSWD.

Besides, these information are not the focused of the MDG-related services which the KP has been trying to improve.

- *No. of Non-Communicable Disease Cases*. At present, the DOH has not established its own information system on the NCD cases except those cases reported through the PIDSR. The CHTs will have difficulty reporting said data considering that they have not been oriented what the NCDs are.

- *No. of Malaria cases:* There are two existing data collection systems on malaria cases. One is through the PIDSR managed by NEC which report malaria cases in non-Global Funds provinces/cities and municipalities. Malaria cases in GF-project sites are reported through the Philippine Malaria Information System (PhilMIS). Malaria cases would be difficult to be reported by the CHTs as these cases need laboratory confirmation before they are reported as malaria cases.

VI. Recommendations and Next Steps

Specific recommendations on the enhancement of the CHT process and tools have been forwarded in the previous sections. This following set of recommendations is centered on how the operationalization of the CHT Strategy can be further improved to help achieve universal access to health care and services.

A. CHT Program Plan

(1) Formulate a 5-year Strategic Plan to guide and ensure the sustained implementation and management of the CHT Strategy beyond the current administration
(2) Review the possibility of the CHT process and tools being adopted by the rest of the community volunteer workers (e.g. BHWs, BNS, etc.) in reaching and serving the other non-NHTS households in their areas of assignment. Coordinate with the BLHD handling the BHW Program regarding this proposal.
(3) Begin to consider expanding the scope and coverage of the CHT services to other non-MDG related programs and services as long as the CHT members are given the proper training and equipped with the necessary forms and tools

B. Parallel Improvement of Both the Demand and Supply Side for MNCHN Services

(1) Fast-track the establishment of the MNCHN service delivery network (SDN) in each LGU to be able to respond to the increasing demand for MNCHN services generated through the CHT Strategy
(2) Facilitate the accreditation of health care facilities especially in areas where the NHTS HHs concentration is high in order to maximize PhilHealth benefit packages

C. Strengthen intra and inter-level coordination relative to CHT Operations

(1) Establish a Technical Working Group (TWG) at the national level on CHT Operations composed of representatives from the different DOH management clusters, selected CHDs and concerned DOH offices to ensure harmonization of decisions, actions/measures and information being disseminated to the regions and LGUs

(2) Institute a consultative process (e.g. quarterly meeting) at the level of DOH cluster management to decide on critical issues and gaps relative to the CHT operations

D. Establish/Enhance the following support system

(1) Develop the Monitoring and Evaluation Framework on the operationalization of the CHT Strategy. Details of this recommendation already presented and discussed in the previous section.
(2) Develop and institute the supportive supervision system for the CHTs. Details of recommendation have likewise been presented in the previous section.
(3) Review and improve the incentives program for the CHT members both in financial and non-monetary forms.
(4) Establish continuing education for the CHT members including the other community volunteer workers operating at the ground level

E. Enhancement of the CHT Process and Tools

(1) Update the different CHT Forms and Guides
(2) Support regional and local innovations on CHT forms and tools
(3) Conduct PIR on the CHT operations preferably on a semi-annual basis
(4) Undertake an evaluation of the impact of the CHT operations after three years of implementation

Annexes

Annex 1. People Consulted on CHT Assessment

A. Members Attending the CHT Technical Working Group Meetings

1. Dr. Honorata Catibog, Chair
2. Dr. Rosalie Paje, Co-Chair
3. Dr. Juanita Basilio, MNCHN Coordinator
4. Ms. Carole Bandahala, CHT Coordinator
5. Dr. Florence Apale. FP Program Coordinator
6. Ms. Liberta Importa, Nutrition Coordinator
7. Dr. Minerva Vinluan, Adolescent Health
8. Ms. Margarita Sevillano, CHD 4A
9. Ms. Rosalie Espeleta, NCR
10. Ms. Perla Supnet Region 4B
11. Dr. Rosario Benabaye, Luzon Health
12. Dr. Ellen Bautista, Luzon Health
13. Leslie Escalada, LuzonHealth
14. Dr. Annie Asanza, HPDP
15. Dr. Bill Langit, HPDP
16. Dr. Consuelo Aranas, Mindanao Health
17. Ms. Odette de Guzman, Visayas Health
18. Dr. _____, Visayas Health
19. Dr. Shinichi Takenaka, JICA
20. Mr. Daniel Pedragosa, UNFPA
21. Romeo Catbagan Jr, FHO
22. Christian Belmonte, FHO
23. Fairuz D. Dinalo

B. People Who Attended the National Consultative Workshop on CHT Assessment , September 17-20, 2013, Fersal Hotel, Puerto Princesa, Palawan

No.	Name (Pls. Print Legibly)	Designation
1	Jimuel S. Cardenas	MO V
2	Armi A. Dela Cruz	Nurse III
3	Mary Jane Grace L. Muñoz	MO III
4	Zenaida B. Patal-E	Nurse V
5	Lailani P. Mangulabnan	MS II
6	Marilu F. Malamug	MS IV
7	Dolores A. Dacanay	Nurse IV/DOH Rep
8	Abigail Battung	Nurse II
9	May G. Del Rosario	RHP
10	Louie Ocampo	MS V
11	Eunice Rina P. Herrera	MO III
12	April Rose R. Pascua	EA IV
13	Reinhard M. Dalumpines	MS III
14	Nancy T. Pastrana	Nurse V
15	Ma. Lucila S. Agripa	Nurse VI
16	Margarita V. Sevillano	Nurse V
17	Lady Camille Malicsi	Nurse
18	Josephine A. Bacani	BHW
19	Wilma C. Oriente	BHW
20	Darwisa S. Balasote	BHW
21	Maritess H. Selga	Midwife III

22	Mariel Eden P. Reynoso	RN Heals
23	Anna Lissa C. Babon	Nurse II
24	Debra Junela S. Sungcad	Executive Asst. III
25	Leofoldo Villaester	Nurse II
26	Ashtriedley Cabinatan	Nurse II
27	Joni Dichoso, PhD	RTA. WV/Visayas Health
28	Joseph Carlo Carillo	Nurse II-CHT
29	Ma. Salvacion S. dela Cruz	MS IV
30	Ma. Teresa Santiago	Sr HPO
31	Edwin DV. Guinto	CHO II
32	Myra V. Rosario	PHN III
33	Leslie Escalada	Health System and Gender Adviser
34	Carole A. Bandahala	CHPO
35	Florencia G. Apale	MS IV
36	Shinichi Takenaka	Tech Adviser
37	Mildred Tagaran	Nurse II
38	Emmi Maui J. Cabahug	Nurse II
39	Grace M. Lim	MO IV
40	Francisco Y. Mateo	MS IV
41	Consuelo D. Aranas	DCOP
42	Fairuz D. Dinalo	FP Program Manager
43	Jonathan A. Placido	CHT Program Manager
44	Guinalia B. A. Dimaren	FP Coordinator
45	Dr. Analyn D. Dimapanat	FHC, Head
46	Dr. Cheryl Balae	RHP
47	Christine Elaine P. Peralta	EA III
48	Daniel Pedragosa	UNFPA
49	Annie A. Asanza	HPDP
50	Rosalie P. Paje	DOH-FHO
51	Romeo Catbagan Jr.	DOH-FHO
52	Liberty V. Importa	SHPO
53	Rosalie Espeleta	DOH-Rep TL
54	Onofria C. de Guzman	Sr Health Program Officer
55	Christian Belmonte	DOH-FHO
56	Eireen B. Villa	Consultant
57	Pauline Tanya F. Griarte	Technical Support to MNCHN/CHT

Annex 2. Leakages in the Performance of CHT Functions, HPDP

Functions	Leakages
Household Profiling	• "delisted" CCT families from DSWD roster • Unvalidated list of NHTS-PR and CCT families • List constantly changes • Difficulty reaching households in GIDAs • Families not profiled even when in active list ▪ FDS done in public spaces (devoid of any provisions for private conversations) ▪ Unable to attend FDS (working, no one to take care of children, house chores, not informed by PL of FDS schedule o Parent Leaders failed to follow-up on those unable to attend
Providing key health messages	• Family Health Guide and its messages should be explained, but most of the time is just left to the family • CHT members lack PhilHealth Guide • CHT members were ineffective in getting their messages across
Health Use Plan Development	• Pregnant and women w/ unmet need for MFP were not engaged in developing HUPs due to religious beliefs, male partner preference for traditional methods, misconceptions about harmful effects of artificial FR methods • Difficulty identifying women with unmet need using CHT Form 1; also fails to include women aged below 15 years old. Form 2F needs meticulous processing for identifying FP unmet need • Discussion of adolescent reproductive health among youth (parents) difficult to conduct during FDS; FDS not conducive in explaining and understanding value of HUPs • Lack of efforts from CHTs in pursuing development of HUPs for FP, did not do home visit, assisted only those who visit facilities • Pregnant women denied pregnancy (fear of parents, unmarried) • Declined HUP for FBD because spouse preferred home delivery • Pregnant women were missed out because they weren't screened for possible pregnancy using CHT forms • Some CHTs did not do health use planning for pregnant women because they believe that the Mother and Child Book and other existing forms in the RHU already did what the CHT forms intend to do • Households did not understand HUPs/did not adequately explain the need for HUP to their clients/failure of HUP development because of the time-consuming process • Mothers unable to stay during HUP development due to other responsibilities • Women from CCT households decided not to proceed with developing HUP when they learned that it did not have any bearing on the receipt of their cash grant and that using the HUP doesn't mean the services they will get will be for free • Incomplete HUPs prevented clients from utilizing FP/FBD services – missing entries on: Health risk assessment and date of planned visit • Referral to designated health facilities (CHT had no information on when and where clients may avail services) • PL fail to complete forms on follow-up visits due to time and financial constraints
Conduct Follow-up Visits	• Problems with time and transportation costs; allowance not enough • Flood-prone areas and geographically isolated and depressed areas (GIDAs) were still difficult to access
Recording	• Some important collected data is lost due to use of multiple recording media (use of notebooks/logbooks before transferring to CHT forms)Lack of Forms

	• Difficulty understanding family profile • Difficulty writing and reading materials • Proficient in using CHT Profile and Forms 2A-2G but translating data to reports (CHT Form 1 and 2) is very poor • No clear instructions on how to record: • Changing condition in Form 1 • Additional household members • Families with more than one member with similar condition • Inclusion of other indicators: senior citizens, persons with disability, environmental sanitation, risk factors for malaria and NCDs, maternal deaths • Conflict with profiling tools from other agencies e.g. PhilHealth forms • No clear guideline on reconciling collected data with TCL • Use of other existing forms/home-based records

Annex 3. Selected BHSs Reporting Increase/Decrease in Service Coverage Pre-Post CHT Deployment, 2011-2013

Indicator 1. ***Proportion of pregnant women who had at least 4 ANC visits***

Region	BHS	Total No. of HHs	No. NHTS HHs	% of NHTS HHs	Pre-CHT Deployment		Post CHT Deployment		July-Dec 2011-2012		Jan-Jun 2012-2013	
					Jul-Dec 2011	Jan-Jun 2012	Jul- Dec 2012	Jan-Jun 2013	Inc	Dec	Inc	Dec
CAR - Benguet	BHS 1	694	154	22%	11%	27%	26%	30%	1		1	
	BHS 2	1172	96	8%	23%	8%	13%	22%		1	1	
	BHS 3	541	93	17%	21%	24%	26%	30%	1		1	
CAR - Abra	BHS 1	163	109	67%	15%	15%	22%	14%	1			1
	BHS 2	396	150	38%	28%	62%	133%	9%	1			1
	BHS 3	218	114	52%	50%	35%	38%	29%		1		1
CAR- Kalinga	BHS 1	3233	728	22%	21%	18%	30%	nd	1		nd	
	BHS 2	428	212	49%	24%	33%	40%	nd	1		nd	
	BHS 3	245	143	58%	12%	16%	16%	nd	1		nd	
CAR	**9**								**inc-7 dec-2 same-0 nd-0**		**inc-3 dec-3 same-0 nd-3**	
Region 2-Cagayan	BHS 1	626	230	37%	86	105	67	67		1		1
	BHS 2	434	148	34%	45	25	42	21		1		1
	BHS 3	539	168	31%	24	7	20	13		1		1
Region 2	3								**inc-0 dec-3 same-0 nd-0**		**inc-0 dec-3 same-o nd-0**	
Region 4A - Batangas	BHS 1				2.93	3.14	3.98	3.04	1			1
	BHS 2				2.5	2.07	2.29	1.93		1		1
IV-A Laguna	BHS 2				33%	32%	37%	31%	1			1
Region 4A	**3**								**inc-2 dec-1 same-0 nd-0**		**inc-0 dec-3 same-0 nd-0**	
IV-B Bongabong	BHS 1	723	400	55%	21%	23%	30%	35%	1		1	
IV-B Pinamalayan	BHS 2	1088	638	58%	21%	44%	46%	61%	1		1	
IV-B Naujan	BHS 2	574	280	50%	24%	29%	31%	33%	1		1	
Region4B	3								**inc-3 dec-0 same-0 nd-0**		**inc-3 dec-0 same-0 nd-0**	
Region5 - Camarines Sur	BHS 1				96%	49%	32%	19%		1		1
	BHS 2				52%	73%	46%	23%		1		1
	BHS 3				77%	71%	48%	3%		1		1
Region 5	3								**inc-0 dec-3 same-0 nd-0**		**inc-0 dec-3 same-0 nd-0**	
Region 6 - Iloilo	BHS 1	63,113	6,230	10%	26%	nd	33%	44%	1		nd	
	BHS 2	40,461	3,749	9%	41%	nd	37%	15%		1	nd	
	BHS 3	72,381	5,474	8%	39%	nd	45%	44%	1		nd	
Region 6	**3**								**inc-2 dec-1 same-0 nd-0**		**inc-0 dec-0 same-0 nd-3**	
Region 7 - Cebu	BHS 1	1037	519	50%	23%	31%	28%	26%	1			1
Total Region 7	**1**								**inc-1 dec-0 same-0**		**inc-0 dec-1 same-0**	

									nd-0		nd-0	
VIII-Catarman	BHS 1	732	443	61%	nd	11	nd	18			1	
	BHS 2	674	265	39%	nd	6	nd	7	nd		1	
	BHS 3	2161	572	26%	nd	21	nd	13	nd			1
VIII - Laoang	BHS 1	386	288	75%	nd	8	nd	12	nd		1	
	BHS 2	768	322	42%	nd	8	nd	14	nd		1	
	BHS 3	830	405	49%	nd	29	nd	28	nd			1
VIII - Mondragon	BHS 1	693	322	46%	nd	21	nd	67	nd		1	
	BHS 2	696	367	53%	nd	78	nd	75	nd			1
	BHS 3	920	382	42%	nd	89	nd	85	nd			1
Total: Region 8	**9**								**inc-0 dec-0 same-0 nd-9**		**inc-5 dec-4 same-0 nd-0**	
11 - Davao	BHS 1	1489	1221	82%	nd	46	76	46	nd		same	
	BHS 2	1018	874	88%	1.1	2.30	2.30	3.90	1		1	
	BHS 3	1735	840	48%	7.34	7.48	9.48	11.97	1		1	
Total Region 11	**3**								**inc-2 dec-0 same-0 nd-1**		**inc-2 dec-0 same-1 nd-0**	
ARMM - Lanao del Norte	BHS 1	1,282	321	25%	96%	97%	98%	98.4%	1		1	
	BHS 2	436	324	74.5	94.3	95	96	97.3	1		1	
	BHS 3	390	211	54.1	95	96.3	98	98.3	1		1	
	BHS 1	2594	543	20	15	32	35	35	1		1	
	BHS 2	768	431	56%	11%	13%	13%	18%	1		1	
	BHS 3	899	480	54%	86	79	95	97	1		1	
	BHS 1	2567	1000	39%	40	46	59	65	1		1	
	BHS 2	539	274	51%	64	66	84	128	1		1	
	BHS 3	550	297	54%	67	102	81	71	1			1
Total – ARMM	**9**								**inc-9 dec-0 same-0 nd-0**		**inc-8 dec-1 same-0 nd-0**	
Philippines	**46**								**inc-26 dec-10 same-0 nd-10**		**inc-21 dec-18 same-1 nd-6**	

Indicator 2. *Proportion of women who delivered in health facilities*

Region	BHS	Total No. of HHs	No. of NHTS HHs	% of NHTS HHs	Pre-CHT Deployment		Post CHT Deployment		July-Dec 2011-2012		Jan-Jun 2012-2013	
					Jul-Dec 2011	Jan-Jun 2012	Jul- Dec 2012	Jan-Jun 2013	Inc	Dec	Inc	Dec
CAR - Benguet	BHS 1	694	154	22%	81%	88%	89%	95%	1		1	
	BHS 2	1172	96	8%	94%	93%	83%	92%		1		1
	BHS 3	541	93	17%	88%	93%	84%	95%		1	1	
CAR - KALINGA	BHS 1	3233	728	22%	20%	22%	37%	nd	1		nd	
	BHS 2	428	212	49%	nd	19%	66%	27	nd		1	
	BHS 3	245	143	58%	nd	nd	30%	52	nd		nd	
CAR - Mt. Province	BHS 1	431	174	40%	5	5	3	3		1		1
	BHS 2	424	166	39%	nd	1	1	4	nd		1	
Total CAR	**8**								**inc-2 dec-3 same-0 nd-3**		**inc-4 dec-2 same-0 nd-2**	
II – Cagayan	BHS 1	626	230	37%	44	67	83	95	1			1
	BHS 2	434	148	34%	31	38	48	69	1			1
	BHS 3	539	168	31%	45	100	100	100	1		same	
Total – Region 2	**3**								**inc-3 dec-0**		**inc-0 dec-2**	

									same-0 nd-0		same-1 nd-0	
Region 4A												
IV-A Batangas	BHS 1				1.04	1.67	1.88	2.09	1		1	
IV-A Laguna	BHS 2				1.43	0.78	1.14	1.21		1	1	
	BHS 1				29%	27%	29%	58%	same		1	
Total- Region 4A	**3**								**inc-1 dec-1 same-1 nd-0**		**inc-3 dec-0 same-0 nd-0**	
IV-B Bongabong	BHS 1	723	400	55%	23%	25%	33%	36%	1		1	
IV-B Pinamalayan	BHS 2	1088	638	58%	20%	43%	44%	50%	1		1	
IV-B Naujan	BHS 2	574	280	50%	20%	23%	28%	28%	1		1	
Total- Region 4B	**3**								**inc-3 dec-0 same-0 nd-0**		**inc-3 dec-0 same-0 nd-0**	
V - Camarines Sur	BHS 1				38%	89	75%	75%	1			1
	BHS 2				17%	75	40%	56%	1			1
	BHS 3				8%	90	64%	72%	1			1
Total – Region 5	**3**								**inc-3 dec-0 same-0 nd-0**		**inc-0 dec-3 same-0 nd-0**	
VI - Ilo-Ilo	BHS 1	63,113	6,230	10%	40%	nd	60%	49%	1		nd	
	BHS 2	40,461	3,749	9%	63%	nd	90%	26%	1		nd	
	BHS 3	72,381	5,474	8%	50%	nd	36%	29%		1	nd	
Total- Region 6	**3**								**inc-2 dec-1 same-0 nd-0**		**inc-0 dec-0 same-0 nd-3**	
VII - Cebu	BHS 1	1037	519	50%	100	100%	96%	100		1	same	
Total – Region 7	**1**								**inc-0 dec-1 same-0 nd-0**		**inc-0 dec-0 same-1 nd-0**	
VIII - Catarman	BHS 1	732	443	61%	nd	18	nd	21	nd		1	
	BHS 2	674	265	39%	nd	16	nd	28	nd		1	
	BHS 3	2161	572	26%	nd	13	nd	16	nd		1	
VIII - Laoang	BHS 1	386	288	75%	nd	18	nd	26	nd		1	
	BHS 2	768	322	42%	nd	36	nd	15	nd			1
	BHS 3	830	405	49%	nd	34	nd	26	nd			1
VIII - Mondragon	BHS 1	693	322	46%	nd	14	nd	7	nd			1
	BHS 2	696	367	53%	nd	nd	nd	4	nd			nd
	BHS 3	920	382	42%	nd	17	nd	14	nd			1
Total – Region 8	**9**								**inc-0 dec-0 same-0 nd-9**		**inc-4 dec-4 same-0 nd-1**	
11 - Davao	BHS 1	1489	1221	82%	nd	10%	34%	37%	nd		1	
	BHS 2	1018	874	88%	6.60	5.90	1280.	3.30	1			1
	BHS 3	1735	840	48%	24.3	20.50	46.40	47.60	1		1	
Total- Region 11	**3**								**inc-2 dec-0 same-0 nd-1**		**inc-2 dec-1 same-0 nd-0**	
ARMM - Lanao del Norte	BHS 1	1,282	321	25%	100	100	100	100	same		same	
	BHS 2	436	324	74.5	100	100	100	100	same		same	
	BHS 3	390	211	54.1	100	100	100	100	same		same	
	BHS 1	2594	543	20%	27	30%	26%	40%		1	1	
	BHS 2	768	431	56%	16	11%	14%	17%		1	1	
	BHS 3	899	480	54%	82	76	91	100	1		1	
	BHS 1	2567	1000	39%	58	58	49	49		1		1
	BHS 2	539	274	51%	40	47	40	70	same		1	

	BHS 3	550	297	54%	70	68	95	55	1			1
Total ARMM	**9**								**inc-2 dec-3 same-4 nd-0**		**inc-4 dec-2 same-3 nd-0**	
Philippines	**45**								**inc-18 dec-9 same-5 nd-13**		**inc-20 dec-14 same-5 nd-6**	

Indicator 3. ***Proportion of post partum women with at least 2 visits***

Region	BHS	Total No. of HHs	No. NHTS HHs	% of NHTS HHs	Pre-CHT Deployment		Post CHT Deployment		July-Dec 2011-2012		Jan-Jun 2012-2013	
					Jul-Dec 2011	Jan-Jun 2012	Jul- Dec 2012	Jan-Jun 2013	Inc	Dec	Inc	Dec
CAR - Benguet	BHS 1	694	154	22%	20%	20%	37%	34%	1		1	
	BHS 2	1172	96	8%	12%	22%	19%	24%	1		1	
	BHS 3	541	93	17%	14%	10%	19%	26%	1		1	
CAR - ABRA	BHS 1	163	109	67%	17%	17%	27%	15%	1			1
	BHS 2	396	150	38%	41%	30%	37%	28%		1		1
	BHS 3	218	114	52%	30%	20%	24%	25%		1		1
CAR - KALINGA	BHS 1	3233	728	22%	35%	28%	36%	35%	1		1	
	BHS 2	428	212	49%	40%	28%	26%	23.9		1		1
	BHS 3	245	143	58%	14%	18%	23%	15.5	1			1
CAR - Mt. Province	BHS 1	431	174	40%	9	10	7	9		1		1
	BHS 2	424	166	39%	5	7	6	6	1			1
	BHS 3	208	120	58%	100	100	100	100	same		same	
Total - CAR	**12**								**inc-7 dec-4 same-0 nd-0**		**inc-4 dec-7 same-1 nd-0**	
II - CAGAYAN	BHS 1	626	230	37%	91	117	93	90	1			1
	BHS 2	434	148	34%	46	44	58	31	1			1
	BHS 3	539	168	31%	33	28	32	23		1		1
Total – Region 2	**3**								**inc-2 dec-1 same-0 nd-0**		**inc-0 dec-3 same-0 nd-0**	
IV-A Batangas	BHS 1				2.51	3.04	3.56	2.62	1			1
	BHS 2				2.14	1.93	1.78	1.93		1	same	
IV-A Laguna	BHS 1				39%	38%	39%	36%	same			1
Total -Region 4A	**3**								**inc-1 dec-1 same-1 nd-0**		**inc-0 dec-2 same-1 nd-0**	
IV-B Bongabong	BHS 1	723	400	55%	24%	24%	32%	35%	1		1	
IV-B Pinamalayan	BHS 2	1088	638	58%	25%	55%	56%	57%	1		1	
IV-B Naujan	BHS 2	574	280	50%	24%	26%	33%	35%	1		1	
Total - Region 4B	**3**								**inc-3 dec-0 same-0 nd-0**		**inc-3 dec-0 same-0 nd=0**	
V - Camarines Sur	BHS 1				66%	37%	39%	47%		1	1	
	BHS 2				30%	54%	41%	82%	1		1	
	BHS 3				48%	37%	52%	67%	1		1	
Total – Region 5	**3**								**inc-2 dec-1 same-0 nd-0**		**inc-3 dec-0 same-0 nd-0**	
VI - Ilo-Ilo	BHS 1	63,113	6,230	10%	76%	nd	89%	41%	1		nd	
	BHS 2	40,461	3,749	9%	30%	nd	69%	26%	1		nd	
	BHS 3	72,381	5,474	8%	66%	nd	45%	33%		1	nd	
Total – Region 6	**3**								**inc-2**		**inc-0**	

									dec-1 same-0 nd-0		**dec-0 same-0 nd=3**	
VII - Cebu	BHS 1	1037	519	50%	5%	85%	63%	63%	1			1
Total – Region 7	**1**								**inc-1 dec-0 same-0 nd-0**		**inc-0 dec-1 same-0 nd-0**	
VIII - Catarman	BHS 1	732	443	61%	nd	33	nd	41	nd		1	
	BHS 2	674	265	39%	nd	24	nd	33	nd		1	
	BHS 3	2161	572	26%	nd	30	nd	23	nd			1
VIII - Laoang	BHS 1	386	288	75%	nd	26	nd	35	nd		1	
	BHS 2	768	322	42%	nd	nd	nd	63	nd		nd	
	BHS 3	830	405	49%	nd	39	nd	53	nd		1	
VIII - Mondragon	BHS 1	693	322	46%	nd	35	nd	30	nd			1
	BHS 2	696	367	53%	nd	58	nd	37	nd			1
	BHS 3	920	382	42%	nd	48	nd	48	nd		same	
Total – Region 8	**9**								**inc-0 dec-0 same-0 nd-9**		**inc-4 dec-3 same-1 nd-1**	
11 - Davao	BHS 1	1489	1221	82%	nd	98%	88%	95%	nd			1
	BHS 2	1018	874	88%	0.30%	0.2%	0.5%	3.3	1		1	
	BHS 3	1735	840	48%	9.44%	nd	nd	20%	nd		nd	
Total 11- Davao	**3**								**inc-1 dec-0 same-0 nd-2**		**inc-1 dec-1 same-0 nd-1**	
ARMM - Lanao del Norte	BHS 1	1,282	321	25%	100%	100%	100	100	same		same	
	BHS 2	436	324	74.5	100%	100%	100	100	same		same	
	BHS 3	390	211	54.1	100%	100%	100	100	same		same	
	BHS 1	2594	543	20%	32%	25%	29%	34		1	1	
	BHS 2	768	431	56%	16%	11%	14%	18		1	1	
	BHS 3	899	480	54%	82	71	91	100	1		1	
	BHS 1	2567	1000	39%	58	58	49	49		1		1
	BHS 2	539	274	51%	40	47	40	70	same		1	
	BHS 3	550	297	54%	70	68	95	55	1			1
Total - ARMM	**9**								**inc-2 dec-3 same-4 nd-0**		**inc-4 dec-2 same-3 nd-0**	
Philippines	**49**								**inc-21 dec-11 same-5 nd-13**		**inc-19 dec-19 same-6 nd-5**	

Indicator 4. ***Proportion of Fully Immunized Children (FIC)***

Region	**BHS**	**Total No. of HHs**	**No. NHTS HHs**	**% of NHTS HHs**	**Pre-CHT Deployment**		**Post CHT Deployment**		**July-Dec 2011-2012**		**Jan-Jun 2012-2013**	
					Jul-Dec 2011	**Jan-Jun 2012**	**Jul- Dec 2012**	**Jan-Jun 2013**	**Inc**	**Dec**	**Inc**	**Dec**
CAR - Benguet	BHS 1	694	154	22%	17%	17%	20%	31%	1		1	
	BHS 2	1172	96	8%	19%	15%	21%	26%	1		1	
	BHS 3	541	93	17%	8%	21%	26%	30%	1		1	
CAR - ABRA	BHS 1	163	109	67%	39%	38%	26%	35%		1		1
	BHS 2	396	150	38%	51%	46%	38%	39%		1		1
	BHS 3	218	114	52%	50%	20%	41%	22%		1	1	
CAR - KALINGA	BHS 1	3233	728	22%	4%	35%	35%	38%	1		1	
	BHS 2	428	212	49%	54%	37%	51%	31%		1		1
	BHS 3	245	143	58%	10%	20%	23%	19%	1			1
CAR - Mt. Province	BHS 1	431	174	40%	11	10	1	8		1		1

	BHS 2	424	166	39%	4	7	6	2	1			1
	BHS 3	208	120	58%	15	100	10	29		1		1
Total-CAR	**12**								**inc-6 dec-6 same-0 nd-0**		**inc-5 dec-7 same-0 nd-0**	
II - Cagayan	BHS 1	626	230	37%	115	78	90	84		1	1	
	BHS 2	434	148	34%	72	32	16	2		1		1
	BHS 3	539	168	31%	37	nd	20	15		1	nd	
Total – Region 2	**3**								**inc-0 dec-3 same-0 nd=0**		**inc-1 dec-1 same-0 nd-1**	
IV-A Batangas	BHS 1				3.14	3.14	2.83	3.25		1	1	
	BHS 2				2.43	2.36	2.36	3.22		1		1
IV-A Laguna	BHS 1				33%	23%	38%	20%	1			1
Total-Region4A	**3**								**inc-1 dec-2 same-0 nd-0**		**inc-1 dec-2 same-0 nd-0**	
IV-B Bongabong	BHS 1	723	400	55%	36%	21%	25%	20%	1		1	
IV-B Pinamalayan	BHS 2	1088	638	58%	33%	22%	45%	40%	1		1	
IV-BNaujan	BHS 2	574	280	50%	30%	37%	30%	37%	1		1	
Total – Region 4B	**3**								**inc-3 dec-0 same-0 nd-0**		**inc-3 dec-0 same-0 nd-0**	
V - Camarines Sur	BHS 1				58%	62%	59%	36%	1			1
	BHS 2				38%	45%	45%	50%	1		1	
	BHS 3				50%	79%	42%	58%		1		1
Total – Region 5	**3**								**inc-2 dec-1 same-0 nd-0**		**inc-1 dec-2 same-0 nd-0**	
VI - Iloilo	BHS 1	63,113	6,230	10%	21%	nd	91%	40%	1		nd	
	BHS 2	40,461	3,749	9%	29%	nd	77%	38%	1		nd	
	BHS 3	72,381	5,474	8%	44%	nd	90%	84%	1		nd	
Total-Region 6	**3**								**inc-3 dec-0 same-0 nd-0**		**inc-0 dec-0 same-0 nd-3**	
VII - Cebu	BHS 1	1037	519	50%	37%	0.70%	11%	35%		1	1	
Total – Region 7	**1**								**inc-0 dec-1 same=0 nd-0**		**inc-1 dec-0 same-0 nd-0**	
VIII - Catarman	BHS 1	732	443	61%	nd	21	nd	28	nd		1	
	BHS 2	674	265	39%	nd	21	nd	32	nd		1	
	BHS 3	2161	572	26%	nd	52	nd	27	nd			1
VIII - Laoang	BHS 1	386	288	75%	nd	12	nd	39	nd		1	
	BHS 2	768	322	42%	nd	18	nd	19	nd		1	
	BHS 3	830	405	49%	nd	23	nd	21	nd			1
VIII - Mondragon	BHS 1	693	322	46%	nd	23	nd	nd	nd		nd	
	BHS 2	696	367	53%	nd	35	nd	35	nd		same	
	BHS 3	920	382	42%	nd	29	nd	13	nd			1
Total – Region 8	**9**								**inc-0 dec-0 same-0 nd-9**		**inc-4 dec-3 same-1 nd-1**	
11 - Davao	BHS 1	1489	1221	82%	nd	98%	64%	61%	nd			1
	BHS 2	1018	874	88%	24.8	14.8%	17.8	28.0%		1	1	
	BHS 3	1735	840	48%	32.5	26.40%	33.4	32.4%	1		1	
Total-Region 11	**3**								**inc-1 dec-1 same-0**		**inc-2 dec-1 same-0**	

									nd-1		nd-0	
ARMM - Lanao del Norte	BHS 1	1,282	321	25%	97%	97.4%	98.1	99%	1		1	
	BHS 2	436	324	74.5	96%	96.4%	98%	98.2%	1		1	
	BHS 3	390	211	54.1	97%	97.3%	98.3	98.8%	1		1	
	BHS 1	2594	543	20%	30%	29%	37%	33%	1		1	
	BHS 2	768	431	56%	18%	11%	15%	17%		1	1	
	BHS 3	899	480	54%	131	85	133	108	1		1	
	BHS 1	2567	1000	39%	89	89	103	104	1		1	
	BHS 2	539	274	51%	82	67	100	105	1		1	
	BHS 3	550	297	54%	154	118	91	97		1		1
Total-ARMM	**9**								**inc-7 dec-2 same-0 nd-0**		**inc-8 dec-1 same-0 nd-0**	
Philippines	**49**								**inc-23 dec-16 same-0 nd -10**		**inc-26 dec-17 same-1 nd-5**	

Indicator 5*. Proportion of New FP Acceptors*

Region	BHS	Total No. of HHs	No. of NHTS HHs	% of NHTS HHs	Pre-CHT Deployment		Post CHT Deployment		July-Dec 2011-2012		Jan-Jun 2012-2013	
					Jul-Dec 2011	Jan-Jun 2012	Jul- Dec 2012	Jan-Jun 2013	Inc	Dec	Inc	Dec
CAR - Benguet	BHS 1	694	154	22%	29	29	51	52	1		1	
	BHS 2	1172	96	8%	22	41	37	39	1			1
	BHS 3	541	93	17%	4	11	9	9	1			1
CAR - ABRA	BHS 1	163	109	67%	50	71	52	40	1			1
	BHS 2	396	150	38%	214	543	192	142		1		1
	BHS 3	218	114	52%	216	162	188	90		1		1
CAR - KALINGA	BHS 1	3233	728	22%	210	186	221	nd	1		nd	
	BHS 2	428	212	49%	18	20	15	nd		1	nd	
	BHS 3	245	143	58%	32	29	16	nd		1	nd	
CAR - Mt. Province	BHS 1	431	174	40%	8	46	12	16	1			1
	BHS 2	424	166	39%	nd	3	nd	3	nd		same	
	BHS 3	208	120	58%	2	2	6	4	1		1	
Total - CAR	**12**								**inc- 7 dec-4 same – 1 nd - 0**		**inc-2 dec-6 same - 1 nd - 3**	
II – Cagayan	**BHS 1**	**626**	230	37%	31	51	49	47	1			1
	BHS 2	434	148	34%	7	12	9	7	1			1
	BHS 3	539	168	31%	2	2	2	2	same		same	
Total-Region2	**3**								**inc-2 dec - 0 same – 1 nd - 0**		**inc - 0 dec -2 same – 1 nd - 0**	
IV-A Batangas	BHS 1	nd	nd	nd	39	33	37	35		1	1	
	BHS 2	nd	nd	nd	49	34	27	29		1		1
IV-A Laguna	BHS 1	nd	nd	nd	13%	18%	17%	12%	1			1
Total -Region 4A	**3**								**1**	**2**	**1**	**2**
IV-B Bongabong	BHS 1	723	400	55%	3%	5%	5%	8%	1		1	
IV-B Pinamalaya	BHS 2	1088	638	58%	7%	13%	14%	15%	1		1	
IV-B Naujan	BHS 2	574	280	50%	5%	7%	8%	nd	1		nd	
Total-Region4B	**3**								**inc-3 dec-0 same - 0 nd - 0**		**inc-2 dec-0 same-0 nd -1**	
V - Camarines Sur	BHS 1	nd	nd	nd	22%	11%	13%	16%		1	1	
	BHS 2	nd	nd	nd	11%	13%	13%	21%	1		1	
	BHS 3	nd	nd	nd	14%	12%	14%	22%	same		1	
Total-Region 5	**3**								**inc-1 dec-1**		**inc - 3 dec-0**	

									same -1 nd -0		same -0 nd -0	
VI - Iloilo	BHS 1	63,113	6,230	10%	46%	nd	46%	38%	same		nd	
	BHS 2	40,461	3,749	9%	518	nd	498	204		1	nd	
	BHS 3	72,381	5,474	8%	1087	nd	736	567		1	nd	
Total – Region 6	**3**								**inc-0 dec-2 same-1 nd -0**		**inc-0 dec-0 same-0 nd-3**	
VII - Cebu	BHS 1	1037	519	50%	nd	71%	91%	100%	nd		1	
Total – Region 7	**1**								**nd - 1**		**1**	**0**
VIII - Catarman	BHS 1	732	443	61%	nd	20	nd	29	nd		1	
	BHS 2	674	265	39%	nd	7	nd	24	nd		1	
	BHS 3	2161	572	26%	nd	64	nd	77	nd		1	
VIII - Laoang	BHS 1	386	288	75%	nd	3	nd	24	nd		1	
	BHS 2	768	322	42%	nd	15	nd	52	nd		1	
	BHS 3	830	405	49%	nd	4	nd	11	nd		1	
VIII - Mondragon	BHS 1	693	322	46%	nd	42	nd	48	nd		1	
	BHS 2	696	367	53%	nd	25	nd	48	nd		1	
	BHS 3	920	382	42%	nd	31	nd	30	nd			1
Total-Region 8	**9**								**inc-0 dec-0 same-0 nd=9**		**inc-8 dec-1 same-0 nd-0**	
11 - Davao	BHS 1	1489	1221	82%	nd	78	51	104	nd		1	
	BHS 2	1018	874	88%	12	9	28	16	1		1	
	BHS 3	1735	840	48%	2.50%	2.30%	5.7	2.60%	1		1	
Total– Region 11	**3**								**inc - 2 dec-0 same-0 nd - 1**		**inc-3 dec-0 same-0 nd=0**	
ARMM - Lanao del Norte	BHS 1	1,282	321	25%	89.5	90%	91%	92.2	1		1	
	BHS 2	436	324	74.5	87%	87.2%	88.3	89%	1		1	
	BHS 3	390	211	54.1	88%	89.4%	90%	91.3	1		1	
	BHS 1	2594	543	20%	7%	6%	18%	37%	1		1	
	BHS 2	768	431	56%	7%	6%	5%	13%		1	1	
	BHS 3	899	480	54%	36	30	40	60	1		1	
	BHS 1	2567	1000	39%	11	24	29	60	1		1	
	BHS 2	539	274	51%	18	21	25	35	1		1	
	BHS 3	550	297	54%	30	57	34	63	1		1	
Total ARMM	**9**								**inc-8 dec-1 same-0 nd-0**		**inc-9 dec-0 same-0 nd-0**	
Philippines	49								**inc - 16 dec -9 same 4 nd - 10**		**inc-27 dec-11 same-2 nd-7**	