



Family Planning in the Hospital

Operational Guide for Recording and Reporting



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Foreword

Strengthening the provision of family planning (FP) services in all public and private hospitals is recognized by the Department of Health (DOH) as a key enabling mechanism to ensure the successful implementation of the Responsible Parenthood/Reproductive Health Law.


It is also an effective operationalization of Executive Order No. 12, entitled “Attaining And Sustaining “Zero Unmet Need For Modern Family Planning” Through The Strict Implementation Of The Responsible Parenthood And Reproductive Health Act, Providing Funds Therefor, And For Other Purposes.”

The increasing number of clients seeking FP services from hospitals requires putting in place a workable and effective system for recording and reporting the number of clients provided with services and for tracking FP commodities dispensed to clients. Such critical information can effectively guide the hospitals, as well as the local government units and DOH Regional Offices, in preparing evidence-based plans, budgets and key interventions aimed at further improving the FP Program.

The DOH is cognizant of the need for an operational manual that can serve as guide to hospitals in systematically capturing and tracking their FP performance consistent with the provisions of DOH Department Memo 2014-0312 and the guidelines of the Field Health Service Information System.

Facilitating the systematic recording and reporting of FP performance of hospitals through the use of the Guide will help the health sector in properly accounting for the overall contribution of hospitals in achieving zero unmet need for modern family planning. To date, forty public hospitals have been using the Guide as reference and have found it useful in recording FP performance and in producing the required reports.

The DOH, therefore, enjoins all public hospitals nationwide, both DOH and local government owned, to use this Guide.


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Secretary of Health

Acknowledgments

The Department of Health (DOH) expresses its sincere appreciation and gratitude to the United States Agency for International Development (USAID) for spearheading the development of this Guide, through its LuzonHealth Project, to assist public hospitals in systematically recording and reporting Family Planning performance on a monthly, quarterly, and annual basis.

The DOH also wishes to acknowledge the valuable inputs provided by key technical staff from the following Offices in the process of developing this Guide, particularly in ensuring that the Guide is consistent with the current DOH guidelines, current working processes, and set-up at the regional and LGU levels, to wit:

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About the Manual

This is an operational manual for recording and reporting family planning (FP) services in hospitals and for tracking the range of FP services (including counseling, actual provision of services, and ensuring regular follow-up and sustained use of FP methods) to all clients seeking FP services in LGU hospitals (provincial/city hospital, district hospitals, community hospitals) and Department of Health (DOH) regional hospitals and medical centers.

The manual provides a description of each of the forms used for documenting and monitoring FP services in said facilities to help the FP Point Person or FP Team to systematically organize, plan and document FP service performance monthly, quarterly, and annually. It also describes the processes involved in completing the forms, detailing what data to record and how to report these, and indicating when and to whom these will be submitted. The annex section contains copies of these forms in PDF format.

The manual is intended primarily for the hospital's FP Team or staff directly providing FP services and tasked to record and report hospital FP Performance. Specifically, these are the hospital staff in charge of FP service provision at the Out Patient Department, OB Ward, Main OR/ Mini OR, hospital sections where in-reach activities are being conducted, FP Clinics and other hospital areas where FP counseling and services are being provided.

This can also serve as a training/orientation material for new hospital staff who will be involved in the provision of FP services as well as in recording and reporting the hospital's FP performance data.

The manual was developed in consultation with key staff from selected regional/provincial hospitals, DOH Regional Offices, and Provincial Health Offices involved in the implementation of the Family Planning Program. Technical consultative sessions were likewise conducted with the Family Health Office, Epidemiology Bureau and the Knowledge Management and Information Technology Service of the DOH Central Office to further enhance the manual and to ensure consistency with existing DOH policies.

As of August 2017, 43 hospitals in Luzon have already used this manual as reference in recording client information in the List of Potential FP Clients and FP Client Record and in reporting FP performance using the Monthly Form or M1.

List of Acronyms

A1	Annual Form 1 for Family Planning
AO	Administrative Order
BTL	Bilateral Tubal Ligation
CHO	City Health Office/r
CS	Caesarean section
DOH	Department of Health
DOHRO	Department of Health Regional Office
DR	Delivery Room
FHSIS	Field Health Service Information System
FP	Family Planning
FPCU	Family Planning Current Users
HC	Health Center
HFPCR	Hospital Family Planning Client Record
ITR	Individual Treatment Record
LGU	Local Government Unit
M1	Monthly Form 1 for Family Planning
NSD	Normal Spontaneous Delivery
NSV	Non-Scalpel Vasectomy
OR	Operating Room
PHO	Provincial Health Office/r
PSI	<i>Progestin-only Subdermal Implants</i>
RHU	Rural Health Unit
SDN	Service Delivery Network
TCL	Target Client List

I. Background

In October 2014, the Department of Health (DOH), through Department Memorandum No. 2014-0312, issued the guidelines for setting up family planning (FP) services in hospitals. The guidelines define the full range of FP services that public hospitals can provide, along with instructions on how FP service provision can effectively be set up and how the processes of recording and reporting, logistics management, financing, and management of complications will be handled given current clinical standards. The Department Memo likewise laid out the roles and responsibilities of the public hospitals and the DOH offices to ensure effective implementation of the guideline. The Department Memo applies to all local government unit (LGU) hospitals and DOH Regional Hospitals and Medical Centers.

Corollary to this, a related guideline, contained in the DOH Administrative Order 2014-0042, was issued in October 2014 for implementing mobile outreach services for FP. The goal is to ensure access of geographically isolated or highly populated and depressed areas to hospital services through other means such as the mobile health care FP services. The AO defines the standards, protocols and management arrangements for FP outreach, whether using the mobile health care services (MHCS) or not, for providing FP services such as bilateral tubal ligation by mini-laparotomy under local anesthesia (BTL-MLLA), no-scalpel vasectomy (NSV), intrauterine device (IUD) and subdermal implant. The AO applies to all DOH Central Office Units, Regional Offices, DOH-retained hospitals, LGUs, private health care providers and development partners. It likewise recommends procedures for recording, reporting and monitoring these services.

Both DOH policies recommend specific recording and reporting forms that can be utilized for documenting and tracking the FP services provided both at the hospitals and during mobile outreach services. It is, however, vital to ensure that clear operational procedures and guidelines for recording, reporting and maintaining the records of services are developed along with the updated versions of the forms that are in synch with the existing Field Health Service Information System (FHSIS) recording and reporting system so that FP performance by the hospital is clearly captured in the overall FHSIS Reports of all public health facilities.

This Guide will serve as an operational manual for recording and reporting FP services in hospitals and for tracking the range of FP services (including FP counseling, actual provision of services, and ensuring regular follow-up and sustained use of FP methods) provided to all clients seeking FP services from all LGU hospitals (such as the provincial/city hospitals, district hospitals, community hospitals) and DOH Regional Hospitals and Medical Centers.

II. Forms to Use

RECORDING FORMS

LIST OF POTENTIAL FP CLIENTS. Different hospital departments may encounter potential FP clients in their daily provision of services. Each Department (including, among others, the OPD, OB Ward, and Pedia) will identify and maintain a daily list of potential FP clients which will be forwarded to the FP point person every afternoon for consolidation. The list will include clients who may have expressed intention to use an FP method but have not yet been provided with either information or services, and clients who may have been provided with initial information through group information-giving but have not yet been provided with actual FP services. This Potential FP Client List contains the following information: Name of the Client, Age, Sex, Gravida/Para or G/P (for female clients), address and contact number. This list is vital in capturing all potential FP clients who should be scheduled for one-on-one counseling by the FP point person either immediately or before the patients' discharge. Please see **Annex 1** for sample List of Potential FP Clients.

LIST OF POTENTIAL FP CLIENTS								
Year:		Month						
Date		Name of Potential FP Client	Age	Sex (M or F)	Gravida/ Para (G/P)	Address	Contact Number	Remarks <small>[Can include information on where the patient was initially seen/identified (e.g. Ward, OPD, Pedia)]</small>
	1							
	2							
	3							
	4							
	5							
	6							
	7							
	8							
	9							
	10							
	11							
	12							
	13							
	14							
	15							
	16							
	17							
	18							
	19							
	20							
		TOTAL						

1. **FP FORM 1 (Version 3.0 2016).** Once the client has undergone one-on-one counseling and has accepted a method, the provider will generate critical information and fill out FP Form 1. For FP, the Individual Treatment Record (ITR) serves as FP Record or FP Form 1. This is a two-page form with the front page divided into five sections, namely, medical history, obstetrical history, assessment of risk for STI, assessment of risk for violence against women (VAW), and physical examination. It likewise includes socio-demographic information (client's personal data, type of acceptor and FP method used) and an acknowledgment section with the client's signature signifying that the client has been counseled).

The updated FP Form 1 likewise includes a section on parental/guardian consent. This is a pre-requisite for clients below 18 years old.

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

This record will be maintained by the hospital for all FP acceptors seen. A copy of FP Form 1 in PDF format is included as **Annex 2**.

SIDE A

FAMILY PLANNING (FP) FORM 1


ver. 3.0

FAMILY PLANNING CLIENT ASSESSMENT RECORD				CLIENT ID: _____			
<i>Instructions for Physicians, Nurses and Midwives: Make sure that the client is not pregnant by using the questions listed in SIDE B. Completely fill out or check the required information. Refer accordingly for any abnormal history/findings for further medical evaluation</i>				PHILHEALTH NO.: _____ NHTS?: <input type="checkbox"/> Yes <input type="checkbox"/> No Pantawid Pamilya Pilipino Program(4Ps): <input type="checkbox"/> Yes <input type="checkbox"/> No			
NAME OF CLIENT: _____ <div style="display: flex; justify-content: space-between;"> Last Name Given Name MI Date of Birth Age Educ. Attain. Occupation </div>							
ADDRESS: _____ <div style="display: flex; justify-content: space-between;"> No. Street Barangay Municipality/City Province Contact Number Civil Status Religion </div>							
NAME OF SPOUSE: _____ <div style="display: flex; justify-content: space-between;"> Last Name Given Name MI Date of Birth Age Occupation </div>							
NO. OF LIVING CHILDREN: _____				PLAN TO HAVE MORE CHILDREN? <input type="checkbox"/> Yes <input type="checkbox"/> No			
AVERAGE MONTHLY INCOME: _____							
Type of Client <input type="checkbox"/> New Acceptor Reason for FP: <input type="checkbox"/> spacing <input type="checkbox"/> limiting <input type="checkbox"/> others _____ <input type="checkbox"/> Current User <input type="checkbox"/> Changing Method Reason: <input type="checkbox"/> medical condition <input type="checkbox"/> side-effects _____ <input type="checkbox"/> Changing Clinic <input type="checkbox"/> Dropout/ Restart							
Method currently used (for Changing Method): <input type="checkbox"/> COC <input type="checkbox"/> IUD <input type="checkbox"/> BOM/CMM <input type="checkbox"/> LAM <input type="checkbox"/> POP <input type="checkbox"/> Interval <input type="checkbox"/> BBT <input type="checkbox"/> others _____ <input type="checkbox"/> Injectable <input type="checkbox"/> Post-Partum <input type="checkbox"/> STM <input type="checkbox"/> Implant <input type="checkbox"/> Condom <input type="checkbox"/> SDM							
I. MEDICAL HISTORY Does the client have any of the following? <input type="checkbox"/> severe headaches / migraine <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> history of stroke / heart attack / hypertension <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> non-traumatic hematoma / frequent bruising or gum bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> current or history of breast cancer / breast mass <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> severe chest pain <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> cough for more than 14 days <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> unexplained vaginal bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> abnormal vaginal discharge <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> intake of phenobarbital (anti-seizure) or rifampicin (anti-TB) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Is the client a SMOKER? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> With Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No (if YES please specify: _____)				IV. RISKS FOR VIOLENCE AGAINST WOMEN (VAW) <input type="checkbox"/> unpleasant relationship with partner <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> partner does not approve of the visit to FP clinic <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> history of domestic violence or VAW <input type="checkbox"/> Yes <input type="checkbox"/> No Referred to: <input type="checkbox"/> DSWD <input type="checkbox"/> WCPU <input type="checkbox"/> NGOs <input type="checkbox"/> Others (Specify: _____)			
II. OBSTETRICAL HISTORY Number of pregnancies: G _____ P _____ _____ Full term _____ Premature _____ Abortion _____ Living children Date of last delivery _____ / _____ / _____ Type of last delivery <input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean Section Last menstrual period _____ / _____ / _____ Previous menstrual period _____ / _____ / _____ Menstrual flow: <input type="checkbox"/> scanty (1-2 pads per day) <input type="checkbox"/> moderate (3-5 pads per day) <input type="checkbox"/> heavy (>5 per pads day) <input type="checkbox"/> Dysmenorrhea <input type="checkbox"/> Hydatidiform mole (within the last 12 months) <input type="checkbox"/> History of ectopic pregnancy				V. PHYSICAL EXAMINATION Weight: _____ kg Blood pressure: _____ mmHg Height: _____ m Pulse rate: _____ /min SKIN: <input type="checkbox"/> normal <input type="checkbox"/> pale <input type="checkbox"/> yellowish <input type="checkbox"/> hematoma CONJUNCTIVA: <input type="checkbox"/> normal <input type="checkbox"/> pale <input type="checkbox"/> yellowish NECK: <input type="checkbox"/> normal <input type="checkbox"/> neck mass <input type="checkbox"/> enlarged lymph nodes BREAST: <input type="checkbox"/> normal <input type="checkbox"/> mass <input type="checkbox"/> nipple discharge ABDOMEN <input type="checkbox"/> normal <input type="checkbox"/> abdominal mass <input type="checkbox"/> varicosities			
III. RISKS FOR SEXUALLY TRANSMITTED INFECTIONS Does the client or the client's partner have any of the following? <input type="checkbox"/> abnormal discharge from the genital area <input type="checkbox"/> Yes <input type="checkbox"/> No if "YES" please indicate if from: <input type="checkbox"/> Vagina <input type="checkbox"/> Penis <input type="checkbox"/> sores or ulcers in the genital area <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> pain or burning sensation in the genital area <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> history of treatment for sexually transmitted infections <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> HIV / AIDS / Pelvic inflammatory disease <input type="checkbox"/> Yes <input type="checkbox"/> No				EXTREMITIES <input type="checkbox"/> normal <input type="checkbox"/> edema <input type="checkbox"/> varicosities PELVIC EXAMINATION (For IUD Acceptors) <input type="checkbox"/> normal <input type="checkbox"/> mass <input type="checkbox"/> abnormal discharge <input type="checkbox"/> cervical abnormalities <input type="checkbox"/> warts <input type="checkbox"/> polyp or cyst <input type="checkbox"/> inflammation or erosion <input type="checkbox"/> bloody discharge <input type="checkbox"/> cervical consistency <input type="checkbox"/> firm <input type="checkbox"/> soft <input type="checkbox"/> cervical tenderness <input type="checkbox"/> adnexal mass / tenderness <input type="checkbox"/> uterine position: <input type="checkbox"/> mid <input type="checkbox"/> anteфлекed <input type="checkbox"/> retroфлекed <input type="checkbox"/> uterine depth: _____ cm			
ACKNOWLEDGEMENT: This is to certify that the Physician/Nurse/Midwife of the clinic has fully explained to me the different methods available in family planning and I freely choose the _____ method. <div style="display: flex; justify-content: space-between;"> Client Signature _____ Date _____ </div> For WRA below 18 yrs. Old: I hereby consent _____ to accept the Family Planning method. <div style="display: flex; justify-content: space-between;"> Parent/Guardian Signature _____ Date _____ </div>							

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

SIDE B

FP FORM 1

FAMILY PLANNING CLIENT ASSESSMENT RECORD																						
DATE OF VISIT (MM/DD/YYYY)	MEDICAL FINDINGS (Medical observation, complaints/ complication, service rendered/ procedures, laboratory examination, treatment and referrals)	METHOD ACCEPTED	NAME AND SIGNATURE OF SERVICE PROVIDER	DATE OF FOLLOW-UP VISIT (MM/DD/YYYY)																		
																						
<p>How to be Reasonably Sure a Client is Not Pregnant</p> <table border="0"> <tbody> <tr> <td>1. Did you have a baby less than six (6) months ago, are you fully or nearly-fully breastfeeding, and have you had no menstrual period since then?</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>2. Have you abstained from sexual intercourse since your last menstrual period or delivery?</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>3. Have you had a baby in the last four (4) weeks?</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>4. Did your last menstrual period start within the past seven (7) days?</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>5. Have you had a miscarriage or abortion in the last seven (7) days?</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>6. Have you been using a reliable contraceptive method consistently and correctly?</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> </tbody> </table> <p> <input type="checkbox"/> If the client answered YES to at least one of the questions and she is free of signs or symptoms of pregnancy, provide client with desired method. <input type="checkbox"/> If the client answered NO to all of the questions, pregnancy cannot be ruled out. The client should await menses or use a pregnancy test. </p>					1. Did you have a baby less than six (6) months ago, are you fully or nearly-fully breastfeeding, and have you had no menstrual period since then?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	2. Have you abstained from sexual intercourse since your last menstrual period or delivery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	3. Have you had a baby in the last four (4) weeks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	4. Did your last menstrual period start within the past seven (7) days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	5. Have you had a miscarriage or abortion in the last seven (7) days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	6. Have you been using a reliable contraceptive method consistently and correctly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
1. Did you have a baby less than six (6) months ago, are you fully or nearly-fully breastfeeding, and have you had no menstrual period since then?	<input type="checkbox"/> Yes	<input type="checkbox"/> No																				
2. Have you abstained from sexual intercourse since your last menstrual period or delivery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No																				
3. Have you had a baby in the last four (4) weeks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No																				
4. Did your last menstrual period start within the past seven (7) days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No																				
5. Have you had a miscarriage or abortion in the last seven (7) days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No																				
6. Have you been using a reliable contraceptive method consistently and correctly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No																				

3. CONSENT FORMS

- a. **PARENTAL CONSENT** – To ensure compliance with Sections 4.06 and 4.07 of the Implementing Rules and Regulations of the Responsible Parenthood/Reproductive Health (RP/RH) Law, clients below 18 years old must secure a written consent from their parents/guardian prior to availing of any FP method from the hospital. Please refer to **Annex 3** for a copy of the sample Parental Consent Form.
- b. **INFORMED CONSENT FORM for Methods Requiring Procedures.** In the case of FP clients requiring procedures, the following DOH FP Clinical guideline requirements will apply with respect to documenting client consent:
 1. The FP counselor will ensure informed consent by:
 - Reinforcing counseling to avoid regret and emphasizing that BTL and NSV are permanent methods.
 - Explaining to the client the six elements of informed consent written on the Informed Consent Form.
 - Checking that the Informed Consent Form is signed correctly by the client.
 2. Counseling must include the six elements of informed consent. When the client desires to undergo BTL/vasectomy, she/he signs an informed consent form to prove that the following six elements have been discussed:
 - Temporary contraceptives are available to the client.
 - Voluntary sterilization is a surgical procedure.
 - The surgical procedure involves risks, in addition to benefits. Among the risks is the possibility that the procedure may fail.
 - The effect of the procedure should be considered permanent.
 - The procedure does not protect against sexually transmitted diseases, including HIV/AIDS.
 - The client can decide against the procedure at any time before the operation is performed without losing the right to medical health or other services or benefits.

Sample Informed Consent Forms for Sterilization Clients and Subdermal Implant Acceptors are included as **Annexes 4** and **5**, respectively.

4. **HOME-BASED FP CLIENT CARD (Reference: DOH Department Memo 2014-0312 on FP in Hospital).** After filling out the FP Form 1, the client will be issued an FP Client Card. This card serves as the FP service card of the client, which s/he will need to bring every time s/he seeks any FP service from any facility. It contains the following information: client's name, client's number, age, client contact number, date of client visit, FP service provided, date of expected follow-up or next service date, name of the facility which rendered the service and name/signature of the service provider. It likewise includes the client's G/P and indicates whether or not the client belongs to a priority household as identified using the National Household Targeting System (NHTS). It also contains the name and address of the hospital or the RHU/HC unit that issued the card. A copy of the FP Client Card is shown on the next page with a PDF copy included as **Annex 6**.

FP CLIENT CARD					
Name of Client: _____ Client Number: _____ Age: _____ Contact Number: _____ Address: _____					NHTS? Yes __ No __ G/P ____
Date of Visit	FP SERVICES PROVIDED (Please Check)		Date of Follow-up/ Next Service Date	Name of the Facility which Rendered the Service	Name/ Signature of Service Provider
	FP Counselling	Methods Used/ FP Commodity Provided			
Client Card Issued by: _____ (Facility)					
Reminders:					
1. Please bring this FP Client card in every facility visit					
2. Immediately return to the facility in case of dizziness or any discomfort					
3. Take note of the dates of follow-up visit indicated by the service provider					

Both the FP Form 1 and the FP Client Card are not enough for the systematic and organized consolidation of client records and FP services provided by the hospitals. It is also important to have a Hospital FP Client Record (HFPCR), similar to the target clients list (TCLs) being used by the RHUs and health centers to fully document, track, and ensure sustained provision of FP services by the hospital.

After filling out the FP Form 1 and issuing the client with an FP Client Card and providing the appropriate service, client information will then be recorded in the HFPCR.

5. **HOSPITAL FP CLIENT RECORD (Patterned after the FHSIS FP-TCL).** The HFPCR serves many uses. First, it helps the FP Point Person or the FP service provider to record, plan, and provide patient care and FP services (including FP counseling provided to patients). This makes the job of the FP Point Person/Team or the supporting midwives/nurses in the hospital's FP clinic easier in monitoring service delivery to clients in general. The primary advantage of maintaining the HFPCR is that the FP Point Person/Team need not have to keep referring to the ITRs/or FP Form 1 to review **individual** patient information to monitor and track overall data on patient treatment or services to beneficiaries. It already provides the consolidated information per FP method.

The HFPCR will allow the FP Point Person/Team to systematically organize, plan and document FP service performance monthly, quarterly and annually. It serves as the source document for the official FHSIS reports that need to be submitted by the hospital to either the DOHRO (in the case of regional hospitals) or the PHO/CHO (in the case of provincial/city hospitals, district hospitals or community hospitals).

Given the new role of the hospitals in FP service provision, the HFPCR is expected to facilitate the monitoring and supervision of FP service delivery activities in the hospitals and to accurately report services delivered in the hospitals or during mobile outreach service provision. The HFPCR will contain the following information:

- Date of Registration
- Name of the Client
- Address
- Classification of the Client as NHTS or non-NHTS
- Age/ Birthdate
- Sex
- Gravida/Para (G/P)
- Date of FP Counseling Prior to Final Acceptance
- Classification for the Type of Client
- Previous Method used
- Follow-up Visits
- Drop-outs
- Remarks/ Action Taken

Important Note:

Recording Clients Who Accepted an FP Method Requiring a Procedure, e.g. Voluntary Sterilization (was not necessarily provided to the client on the day that the client accepted the method). For clients who accepted an FP method requiring a procedure, the corresponding FP Form 1 will be filled out, and the FP client will be issued a Client Card, but the actual recording of the client into the HFPCR will be done only after the actual procedure has been completed.

The DOH FHSIS guideline for recording and reporting FP current users, including criteria for drop-outs, will be followed. Please see **Annex 7** for a copy of the HFPCR.

[illegible]

Important Considerations in Recording and Reporting Clients in the HFPCR:

In the use of the patient FP Client Card and the HFPCR, it is important to clarify how the recording and reporting will proceed for clients who permanently or temporarily seek services and acquire commodities from a different facility or hospital. Three types of clients would normally be provided services by the hospital (and must be clearly determined by the FP Point Person/Team)

Type 1 Clients: These are new FP clients who decided to secure and regularly seek FP services from the hospital and will be continuously recorded and reported by the hospital under the HFPCR:

- These clients will be continuously recorded by the hospital as current users in the HFPCR unless they drop out, decide to transfer, or reach the age of 50 and above.
- These clients will initially be recorded in the HFPCR as either OTHER ACCEPTORS (if they already used a previous method) or NEW ACCEPTORS (NA) if they received FP services for the first time and will be accounted for as FP CURRENT USER (continuing user) during the next reporting month.
- Clients aged 49 and below that were provided with BTL services by the hospital shall be continuously recorded as a BTL current user unless they've reached the age of 50.
- Other commodity-based clients (Pills, IUD, PSI, injectable, condom, SDM) who have decided to regularly seek services/resupply from the hospital (oftentimes, those living near the hospitals) shall likewise be recorded as continuing FP current users of the hospital.

Type 2 Clients: These are clients who initially decided to seek services from the hospital but later went back to their respective municipalities/cities to avail of needed services from their rural health units/health centers (RHUs/HCs); they will be recorded initially as NA or Other Acceptors (Changed Method, Changed Clinic, Restart) by the hospital but will be marked as drop-outs by the hospital upon seeking services from the other facility (RHU or HC).

- These are clients who were provided with FP services/commodities only once (or for a limited period of time) at the hospitals but were referred back to RHUs/HCs for follow-up FP services/supply of commodities and future recording and reporting.
- In this case, upon referral to the other facility and transfer of responsibility, the hospital will need to record these clients as DROP-OUTS and subsequently deleted from the HFPCR, while the receiving facility, e.g., RHU/HC (which ideally should be part of a referral network/SDN) will record these clients as OTHER ACCEPTORS (part of current users or CU) in the TCL. They will be continuously recorded by the RHU/HC as CU in the TCL unless they drop out, decide to transfer, or reach the age of 50 and above.

Type 3 Clients: These are clients who initially seek FP services from the RHUs/HCs but opt to seek services or change their source of service from RHUs/HC to the hospital.

- These are clients who initially seek regular FP services/commodities from RHUs/HCs but later on decide to regularly obtain services from the hospital for different reasons (e.g., change of residence);
- They will be recorded initially as NA or Other Acceptors (Changed Method, Changed Clinic, Restart) by the RHUs/HCs but upon referral and transfer of responsibility to

the hospital, the RHU/HC will need to record these clients as DROP-OUTS and subsequently delete them from the TCL, while the receiving facility, i.e., the hospital (which ideally should be part of a referral network/SDN) will record the clients as OTHER ACCEPTORS in the HFPCR. They will continuously be recorded as current users by the hospital in the HFPCR unless they drop out, decide to transfer, or reach the age of 50 and above.

In dropping out FP clients by method, hospitals shall follow the existing DOH FHSIS guidelines to ensure synchronized FP recording and reporting by all public health facilities



REPORTING FORMS

1. **MONTHLY FORM 1 OR M1 FOR FP.** The Monthly Form 1 for FP contains indicators related to accounting and tracking FP current users and new acceptors by FP method. It will help the hospital's FP Point Person/Team to capture the monthly data and make it easier to consolidate and prepare the quarterly report for submission to the PHO/CHO or the DOHRO. A copy of the M1 form is shown on the next page and in PDF format as **Annex 8**.

Submission of M1 Reports.

- Submission of M1 Reports:
 - M1s of community/municipal/city hospitals managed by the component municipalities/cities will be submitted to the MHO/CHO.
 - M1s of city hospitals managed by the chartered city will be submitted to the CHO.
 - M1s of district and provincial hospitals owned and managed by the provincial government will be submitted to the PHO.
 - M1s of DOH-retained hospitals and medical centers will be submitted to the concerned DOHRO.
- Schedule of Submission:
 - Consistent with the FHSIS reporting schedule, all hospitals need to submit their M1 reports 15 days after the month being reported.

Important: M1s must be submitted in duplicate copies. Original copies must be submitted to the PHO/CHO/DOHRO while the duplicate must be retained at the hospital for reference.

		FHSIS REPORT for the MONTH _____ YEAR: _____ Name of Hospital _____ Address _____ FP Point Person _____ Province: _____ Region _____						Age Disaggregation of Current Users (end of the Month)		
FAMILY PLANNING METHOD		Current User (End of Previous Month/ Beginning of the Month)	Acceptors		Dropout (Present Month)	Current User (End of Current Month)	New Acceptors of the present Month	14 and Below	15-19	20-49
			New Acceptors (Previous Month)	Other Acceptors (Present Month)						
a. Female Sterilization/BTL										
b. Male Sterilization/Vasectomy										
c1. Pills -POP										
c2. Pills-COC										
d1. IUD (Interval IUD)										
d2. PP- IUD (Post-partum IUD)										
e1. Injectables- POI										
e2. Injectables -CIC										
f. NFP-CM (Cervical Mucus)										
g. NFP-BBT (Basal Body Temperature)										
h. NFP-STM (Symptothermal Method)										
i. NFP-SDM (Standard Days Method)										
j. NFP-LAM (Lactational Amenorrhea Method)										
k. Condom										
l. Progestin-only Subdermal Implant										
Total										
Prepared by: _____ (Name and Signature)										
Position _____										
Date _____										
Approved by: _____ (Name and Signature)										
Position _____										
Date _____										

The step-by-step process in preparing the M1 is indicated under Part III of this Guide.

Monthly Reports (M1s) will be submitted by LGU hospitals to the CHO/MHO/PHO/DOHRO (depending on their specific categories) through the FP coordinator and will be forwarded to the FHSIS Coordinator for final consolidation and integration into the overall report, based on the following schedule:



- *M1 Report for January 2017: deadline is Feb 15, 2017*
- *M1 Report for February 2017: deadline is March 15, 2017*
- *M1 Report for March 2017: deadline is April 15, 2017 (in the case of FP Current Users and Contraceptive Prevalence Rate (CPR) data, the M1 report for the end of March, end of June, end of September and end of December are equivalent to end of quarter report; the PHO/CHO can generate the quarterly report)*

M1s should likewise reflect the age disaggregation of the FP current users to identify adolescent clients provided with FP services.

2. ANNUAL FORM OR A1 FOR FP - (reference FHSIS Annual Report)

Submission of A1 Reports. The A1 of LGU hospitals will be submitted to the CHO/MHO/PHO (depending on category) while A1 reports of DOH Regional Hospitals and Medical Centers will be submitted to their respective DOHRO. Consistent with the FHSIS reporting schedule, all hospitals will need to submit A1 reports three weeks after the year being reported.

Important: The A1 must be submitted in duplicate copies. Original copies must be submitted to the PHO/CHO/DOHRO while the duplicate must be retained at the hospital for reference. A copy of the A1 report is shown on the next page and in PDF format as **Annex 9**.

		FHSIS REPORT for end of YEAR _____							Age Disaggregation of Current Users (end of Year)		
		Name of Hospital _____ Address _____ FP Point Person _____ Province: _____ Region _____									
FAMILY PLANNING METHOD		Current User (Beginning January Current Year)	Acceptors		Drop-Out (January - December of Current Year)	Current User (End of December Current Year)	New Acceptors of December Current Year)	14 and Below	15-19	20-49	
			New Acceptors (NA for the month of December of Previous Year + NA of January - November of Current Year)	Other Acceptors (January - December of Current Year)							
			(Add)	(Add)	(Deduct)						
a. Female Sterilization/BTL											
b. Male Sterilization/Vasectomy											
c1. Pills -POP											
c2. Pills-COC											
d1. IUD (Interval IUD)											
d2. PP- IUD (Post-partum IUD)											
e1. Injectables- POI											
e2. Injectables -CIC											
f. NFP-CM (Cervical Mucus)											
g. NFP-BBT (Basal Body Temperature)											
h. NFP-STM (Symptothermal Method)											
i. NFP-SDM (Standard Days Method)											
j. NFP-LAM (Lactational Amenorrhea Method)											
k. Condom											
l. Progestin-only Subdermal Implant											
Total											
Prepared by: _____ (Name and Signature)											
Position _____											
Date _____											
Approved by: _____ (Name and Signature)											
Position _____											
Date _____											

3. **HOSPITAL'S DAILY STOCK RECORD FOR FP.** This form will serve as the hospital's basis for determining FP commodity availability, which will be tracked vis-a-vis the existing FP current users listed in the HFPCR and potential new acceptors. Critical in the implementation of FP in the hospital is ensuring commodity security, thus tracking of commodities available at the end of each day/month is vital. A copy of the form is shown on the next page and in **Annex 10** in PDF format.

The FP Point Person/Team will keep the Hospital Daily Stock Record and should account for the following:

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

From this daily recording, the hospital can compute for balance of that commodity every day and at the end of each month.

The FP Point Person/Team will:

- Fill out the General Information.
 - Indicate the previous month's balance (baseline inventory balance).
 - Identify source and quantity of stock received at the facility at a particular day.
 - Indicate quantity dispensed to patients at the hospital.
 - Indicate the quantity issued to the different hospital departments, if any.
 - Indicate losses (if any) and record on the day losses were noted.
 - Indicate daily check and balance.
 - Compute for end of month balance.
-

HOSPITAL'S DAILY STOCK RECORD FOR FP

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

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

The FP Point Person/Team will:

- Physically count the number of units of FP commodities and record the results on the Monthly Physical Inventory and Commodity Expiration Record.
- In cases where there are differences between the physical count and the Daily Stock Record, inform the acting supervisor/hospital chief of the losses in order to address the reasons for the discrepancy.
- Check and record the expiration dates of drugs during this activity.
- For newly-received stocks, check each product's expiration date and record it on the same form.
- Whenever any lot reaches six months until the expiration date, take note of this fact and make a decision about whether or not it will be used before it expires.
- If any lot of any product cannot be used before expiration, send them back to the MHO/CHO/PHO/DOHRO/DOH-Central Office so that these can be sent to other units that can utilize them immediately. In the case of drugs that are purchased by the LGU, notify the Municipal Health Officer (MHO) or the City Health Officer (CHO) (in the case of municipal/city/community hospitals managed by the municipality or city), or the PHO (in the case of district or provincial hospitals), or the DOHRO (in the case of medical centers and DOH-retained hospitals) for appropriate action.
- If commodities do get to reach expiration, take the following steps:
 - Remove them from the shelves and place them in a closed carton box.
 - Notify the MHO/CHO/PHO/DOHRO.

- Deduct them from the balance shown in the Daily Stock Record Book under the “losses” column, with the annotation, “expired.” Stock quantity should also be noted in the Monthly Physical Inventory and Drug Expiration Record with “expired” written in the Remarks column.
 - Coordinate with the PHO or the DOHRO for the proper disposal of the expired stocks
 - For any losses either due to expiration, other conditions that render the stock unusable (such as damage due to sun exposure, discoloration, infestation, etc.), or disappearance (missing due to unaccounted losses, pilferage, etc.), note and carry over to the Daily Stock Record in the column of “losses” and the row indicating the date the inventory was done in order to update the current balance.
-

III. Illustration of Patient Flow and Data Capture Process

Initially, the FP Point Person/Team is expected to orient all hospital staff (including incoming new staff) on all FP services being provided by the hospital

A Hospital Memo has to be issued by the Hospital Chief to all Departments, specifying among others, the processes for recording and reporting, and the inter-departmental referral mechanism for FP services. Following are some examples:

1. Patients admitted in the Medical Ward with medical conditions requiring limitation of or spacing of pregnancy will be referred to the FP Clinic before discharge.
2. Post-partum/post-abortion cases will be referred to the FP Clinic for counseling before discharge.
3. Clients seeking pre-natal and other outpatient services will be:
 - a. informed of the existence of an FP Clinic in the hospitals;
 - b. encouraged to join the bench conferences or film showing or other related information-giving activities at the hospital; and
 - c. referred to the FP clinic for counseling.

Illustrative Daily Tasks of the FP Point Person/Team:

1. Conducts daily group information-giving at the hospital in the morning at the Obstetrics and Gynecology (OB/GYN) ward.
2. Records in the hospital's **List of Potential FP Clients** the clients identified to have potential need for FP services
3. Provides one-on-one counseling to potential clients visiting the FP Clinic.
4. Should potential clients accept a method, undertakes the following depending on the chosen method:
 - a. Commodity-based method:
 - Accomplish **FP Form 1** (which will be kept at the FP Clinic).
 - Issue the **FP Client Card** (with instructions on its use).
 - Accomplish the **Hospital FP Client Record** (which can be accomplished at the end of the day using the completed FP Form 1 as the source of info).
 - Accomplish the **Hospital Daily Stock Record for FP**, the **Hospital Daily Dispensing Record Book**, and **Hospital Monthly Physical Inventory Report** (monthly).
 - b. BTL/NSV or PSI:
 - Accomplish **FP Form 1** (which will be kept at the FP Clinic).
 - Issue the **FP Client Card** (with instructions on its use).
 - Obtain and document the client's informed consent (using the **Informed Consent Form**).
 - Accomplish a referral form which will be given to the surgeon for scheduling of procedure (using the hospital's **FP Referral Form**).
 - After the procedure, accomplish the Hospital FP Client Record (which can be accomplished at the end of the day using the completed FP Form 1 as the source of information).

c. BTL or PSI (for in-patient post-partum/post-abortion cases referred by the Ward Nurse):

- Identify clients with potential need for FP and record in the hospital's **List of Potential Clients**. Endorse this list to the FP point person
- Accomplish **FP Form 1** (which will be kept at the FP Clinic) upon client's acceptance of the method.
- Issue the **FP Client Card** (with instructions on its use).
- Obtain and document the client's informed consent (using the **Informed Consent Form**) and ensure that the duly-signed informed consent form is attached to the Client's chart.

5. Prepares the following hospital reports:

- M1 or the Monthly Report Form
- Q1 or the Quarterly Report Form (if required by the PHO/DOHRO)
- A1 or the Annual Report Form
- Annual Service Statistics Report Form for Family Planning

6. Reviews all OR/ DR/ OBGYN Ward records of the hospital to identify clients provided with any of the following services:

- Normal spontaneous delivery (NSD) with BTL
- Caesarian section (CS) with BTL
- Interval BTL
- Post-partum IUD
- Intra-CS PPIUD Insertion
- PSI




These clients will be recorded in the HFPCR for accounting, reporting and tracking (and future service provision, if needed) purposes.

7. Consistent with the HFPCR, documents the FP commodities dispensed to FP Clients using the:

- Daily Stock Record Form/ Balance by end of day/month
- Daily Dispensing Form.

8. Prepares the Monthly Physical Inventory.

M1 PREPARATION: AN ILLUSTRATION

 		FHSIS REPORT for the MONTH <u>March</u> YEAR:2016 Name of Hospital: HOSPITAL-A Address: _____ FP Point Person _____ Province: _____					
FAMILY PLANNING METHOD	Current User (Beginning March,2016)	Acceptors		Dropout (March, 2016)	Current User (End of March)	New Acceptors of March 2016	
		New Acceptors (February 2016)	Other Acceptors (March, 2016)				
a. Female Sterilization/BTL	20	5	2	0	27	1	
b. Male Sterilization/Vasectomy	1	0	0	0	1	0	
c. Pills	30	10	6	9	37	12	
d1. IUD (Interval IUD)	25	6	3	0	34	2	
d2. PP- IUD (Post-partum IUD)	25	8	3	0	36	5	
e. Injectables (DMPA/CIC)	20	4	3	1	26	3	
f. NFP-CM (Cervical Mucus)	0	0	0	0	0	0	
g. NFP-BBT (Basal Body Temperature)	0	0	0	0	0	0	
h. NFP-STM (Symptothermal Method)	0	0	0	0	0	0	
i. NFP-SDM (Standard Days Method)	0	0	0	0	0	0	
j. NFP-LAM (Lactational Amenorrhea Method)	20	10	0	14	16	0	
k. Condom	10	2	0	0	12	10	
l. Implant	0	0	0	0	0	0	
Total	151	45	17	24	189	33	

STEPS IN PREPARING THE MONTHLY FORM (M1):

1. Determine the Current Users for Beginning of April (2016) [This is equivalent to Current Users as of previous month: March 2016]

2. Add the Total New Acceptors of the previous Month (March 2016)

3. Add the Total Other Acceptors (April 2016)

4. Deduct the Drop-outs for the Current Month (April 2016)

Example:

FPCU (as of end of April 2016)

=




Current Users for Beginning of April (Equal to End of Month of March) = 189

+ Total New Acceptors of the Previous Month = 33

+ Total Other Acceptors for the Current Month = 13

- Drop-outs = 5

Thus FPCU end of April 2016 = 230

 		FHSIS REPORT for the MONTH <u>April</u> YEAR:2016 Name of Hospital: HOSPITAL-A Address: _____ FP Point Person _____ Province: _____					
FAMILY PLANNING METHOD	Current User (Beginning April,2016)	Acceptors		Dropout (April, 2016)	Current User (End of April)	New Acceptors of April 2016	
		New Acceptors (March 2016)	Other Acceptors (April, 2016)				
a. Female Sterilization/BTL	27	1	3	0	31	0	
b. Male Sterilization/Vasectomy	1	0	0	0	1	1	
c. Pills	37	12	3	5	47	1	
d1. IUD (Interval IUD)	34	2	2	0	38	0	
d2. PP- IUD (Post-partum IUD)	36	5	3	0	44	0	
e. Injectables (DMPA/CIC)	26	3	2	0	31	0	
f. NFP-CM (Cervical Mucus)	0	0	0	0	0	0	
g. NFP-BBT (Basal Body Temperature)	0	0	0	0	0	0	
h. NFP-STM (Symptothermal Method)	0	0	0	0	0	0	
i. NFP-SDM (Standard Days Method)	0	0	0	0	0	0	
j. NFP-LAM (Lactational Amenorrhea Method)	16	0	0	0	16	0	
k. Condom	12	10	0	0	22	0	
l. Implant	0	0	0	0	0	0	
Total	189	33	13	5	230	2	

PREPARATION OF A1 REPORT

Data reported in M1s will be entered in the Annual Consolidation Table to support the preparation of the hospital's A1 Report. Below is an illustrative example of the Annual Consolidation Report to be used for the final computation of A1 Report on FPCU.



ILLUSTRATIVE EXAMPLE OF AN ANNUAL CONSOLIDATION TABLE FOR FPCU						
(This table will support the preparation of A1 of the Hospital)						
REPORTING PERIOD	CURRENT USERS END OF PREVIOUS MONTH (BEGINNING OF CURRENT MONTH)	NEW ACCEPTORS OF PREVIOUS MONTH	OTHER ACCEPTORS OF CURRENT MONTH	DROP-OUT OF CURRENT MONTH	CURRENT USERS END OF CURRENT MONTH	NEW ACCEPTORS OF CURRENT MONTH
Dec-15	100	10	15	5	120	12
Jan-16	120	12	20	7	145	15
Feb-16	145	15	15	10	165	20
Mar-16	165	20	17	8	194	17
Apr-16	194	17	21	8	224	16
May-16	224	16	22	7	255	18
Jun-16	255	18	14	12	275	10
Jul-16	275	10	17	5	297	14
Aug-16	297	14	19	16	314	27
Sep-16	314	27	21	12	350	13
Oct-16	350	13	23	8	378	21
Nov-16	378	21	17	12	404	32
Dec-16	404	32	19	10	445	29
TOTAL		215	225	115	445	
					Should match with	
					M1 Report for Dec 2016	

STEPS IN COMPUTING FOR END OF YEAR REPORT (2016) FOR FPCU:

- Determine the **Current Users for Beginning of January (2016)** [This is equivalent to Current Users as of End of December 2015]
- Add the Total New Acceptors for the Year 2016**, computed as:
 = New Acceptors for the Month of Dec 2015 + New Acceptors for Jan.-Nov 2016)
- Add Total Other Acceptors**
 = Other Acceptors for the months of Jan-Dec 2016
- FPCU (as of end of Current Year) =**
 = Current Users for Beginning of Year (Beginning of January of Current Year) = **120**
 + Total New Acceptors (NA for the Month of Dec 2015 + NA for Jan.-Nov 2016) = **215**
 + Total Other Acceptors for the Current Year = **225**
 - Drop-outs = 115
Thus FPCU end of Year 2016 = 445

NOTE: FPCU reported in M1 for end of December **MUST MATCH** with FPCU in A1 end of Year

A1 Report to be submitted:

		FHSIS REPORT for end of YEAR _____ Name of Hospital _____ Address _____ FP Point Person _____ Province: _____ Region: _____							Age Disaggregation of Current Users (end of Year)		
FAMILY PLANNING METHOD		Current User (Beginning January Current Year)	Acceptors		Drop-Out (January - December of Current Year)	Current User (End of December Current Year)	New Acceptors of December Current Year)	14 and Below	15-19	20-49	
			New Acceptors	Other Acceptors							
			(NA for the month of December of Previous Year + NA of January - November of Current Year)	(January - December of Current Year)							
			(Add)	(Add)	(Deduct)						
a. Female Sterilization/BTL											
b. Male Sterilization/Vasectomy											
c1. Pills -POP											
c2. Pills-COC											
d1. IUD (Interval IUD)											
d2. PP- IUD (Post-partum IUD)											
e1. Injectables- POI											
e2. Injectables -CIC											
f. NFP-CM (Cervical Mucus)											
g. NFP-BBT (Basal Body Temperature)											
h. NFP-STM (Symptothermal Method)											
i. NFP-SDM (Standard Days Method)											
j. NFP-LAM (Lactational Amenorrhea Method)											
k. Condom											
l. Progestin-only Subdermal Implant											
Total											
Prepared by:		(Name and Signature)									
Position		_____									
Date		_____									
Approved by:		(Name and Signature)									
Position		_____									
Date		_____									

The Annual Statistical Report Form for Family Planning is an annual report to be submitted to the PHO by the provincial/ district/community hospitals and to the DOHRO by the DOH regional hospitals. It contains the total number of clients served by the hospitals for each FP method for the whole year. A PDF copy of this form is included as **Annex 13**.

[illegible]

ANNEXES

Annex 1: List of Potential FP Clients

LIST OF POTENTIAL FP CLIENTS

Year: _____ Month _____

Date		Name of Potential FP Client	Age	Sex (M or F)	Gravida/ Para (G/P)	Address	Contact Number	Remarks [Can include information on where the patient was initially seen/identified (e.g. Ward, OPD, Pedia)]
	1							
	2							
	3							
	4							
	5							
	6							
	7							
	8							
	9							
	10							
	11							
	12							



Annex 2: FP Form 1

SIDE A

FAMILY PLANNING (FP) FORM 1

ver. 3.0

FAMILY PLANNING CLIENT ASSESSMENT RECORD

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

CLIENT ID: _____

PHILHEALTH NO.: _____

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

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

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

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

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

Type of Client

☐ New Acceptor Reason for FP: ☐ spacing ☐ limiting ☐ others _____
☐ Current User
☐ Changing Method Reason: ☐ medical condition ☐ side-effects _____
☐ Changing Clinic
☐ Dropout/ Restart
 Method currently used (for Changing Method):
☐ COC ☐ IUD ☐ BOM/CMM ☐ LAM
☐ POP ☐ Interval ☐ BBT ☐ others _____
☐ Injectable ☐ Post-Partum ☐ STM specify: _____
☐ Implant ☐ Condom ☐ SDM

I. MEDICAL HISTORY

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

II. OBSTETRICAL HISTORY

Number of pregnancies: G _____ P _____
 Full term _____ Premature _____
 Abortion _____ Living children _____
 Date of last delivery _____
 Type of last delivery ☐ Vaginal ☐ Cesarean Section
 Last menstrual period _____
 Previous menstrual period _____
 Menstrual flow:
☐ scanty (1-2 pads per day)
☐ moderate (3-5 pads per day)
☐ heavy (>5 pads per day)
☐ Dysmenorrhea
☐ Hydatidiform mole (within the last 12 months)
☐ History of ectopic pregnancy

III. RISKS FOR SEXUALLY TRANSMITTED INFECTIONS

Does the client or the client's partner have any of the following?
☐ abnormal discharge from the genital area ☐ Yes ☐ No
 if "YES" please indicate if from: ☐ Vagina ☐ Penis
☐ sores or ulcers in the genital area ☐ Yes ☐ No
☐ pain or burning sensation in the genital area ☐ Yes ☐ No
☐ history of treatment for sexually transmitted infections ☐ Yes ☐ No
☐ HIV / AIDS / Pelvic inflammatory disease ☐ Yes ☐ No

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

IV. RISKS FOR VIOLENCE AGAINST WOMEN (VAW)

☐ unpleasant relationship with partner ☐ Yes ☐ No
☐ partner does not approve of the visit to FP clinic ☐ Yes ☐ No
☐ history of domestic violence or VAW ☐ Yes ☐ No
 Referred to: ☐ DSWD
☐ WCPU
☐ NGOs
☐ Others (Specify: _____)

V. PHYSICAL EXAMINATION

Weight: _____ kg Blood pressure: _____ mmHg
 Height: _____ m Pulse rate: _____ /min
SKIN:
☐ normal
☐ pale
☐ yellowish
☐ hematoma
CONJUNCTIVA:
☐ normal
☐ pale
☐ yellowish
NECK:
☐ normal
☐ neck mass
☐ enlarged lymph nodes
BREAST:
☐ normal
☐ mass
☐ nipple discharge
ABDOMEN
☐ normal
☐ abdominal mass
☐ varicosities
EXTREMITIES
☐ normal
☐ edema
☐ varicosities
PELVIC EXAMINATION
 (For IUD Acceptors)
☐ normal
☐ mass
☐ abnormal discharge
☐ cervical abnormalities
☐ warts
☐ polyp or cyst
☐ inflammation or erosion
☐ bloody discharge
☐ cervical consistency
☐ firm ☐ soft
☐ cervical tenderness
☐ adnexal mass / tenderness
☐ uterine position:
☐ mid
☐ anteфлекed
☐ retroфлекed
☐ uterine depth: _____ cm

ACKNOWLEDGEMENT:

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


Client Signature _____ Date _____
 For WRA below 18 yrs. Old:

I hereby consent _____ to accept the Family Planning method.

Parent/Guardian Signature _____ Date _____

SIDE B

FP FORM 1

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

How to be Reasonably Sure a Client is Not Pregnant

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

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

Annex 3: Parental Consent Form

PARENTAL CONSENT FORM FOR CLIENTS BELOW 18 SEEKING FAMILY PLANNING SERVICES

ENGLISH VERSION:

This is to signify my full consent for my daughter/son _____ (name of daughter/son 17 years old and below), _____ years old, to receive family planning services/commodities from _____ (name of the hospital), as a response to her current reproductive health and family planning need.

I likewise certify that my daughter/son was provided with full information on the full-range of family planning methods, their benefits and possible complications.

NAME OF PARENT/GUARDIAN: _____

SIGNATURE: _____

Date: _____

PARENTAL CONSENT FORM FOR CLIENTS BELOW 18 SEEKING FAMILY PLANNING SERVICES

TAGALOG VERSION:

Pinahihintulutan ko po ang aking anak na si _____ (pangalan ng pasyente na nagkakaedad na 17 pababa), _____ taong gulang, na tumanggap ng family planning (FP) services/commodities mula sa _____ (pangalan ng hospital), bilang bahagi ng kaniyang kasalukuyang pangangailangang pangkalusugan at tamang pagpaplano ng pamilya (RPRH need).

Pinatutunayan ko rin na ang aking anak ay nabigyan ng sapat na impormasyon at kaalaman sa paggamit ng *family planning methods*, pati na rin ang benepisyo at posibleng komplikasyon ng paggamit nito.

NAME OF PARENT/GUARDIAN: _____

SIGNATURE: _____

Date: _____

Annex 4: Informed Consent Form for Sterilization and Vasectomy Clients

INFORMED CONSENT FORM For Sterilization Clients

I, _____, the undersigned, request that a Surgical Sterilization (☐ bilateral tubal ligation ☐ vasectomy) be performed on my person. I make this request on my own free will, without having been forced, pressured, or given any special inducement.

I understand the following:

1. There are temporary methods of contraception available to my partner and me.
2. The procedure to be performed on me is a surgical procedure, the details of which have been explained to me.
3. This surgical procedure involves risks, in addition to benefits, both of which have been explained to me.
4. The procedure should be considered permanent. However, no surgical procedure can be guaranteed to work 100% on all people. There is a small failure rate. If the procedure is successful, I will be unable to have any more children.
5. This surgical procedure will not protect me and my partner from sexually transmitted infections (STIs), including HIV (the virus that causes AIDS).
6. I can decide against the procedure at any time before the operation is performed (and no medical, health, or other benefits or services will be withheld from me as a result).

Signature

Date

Name and Signature of Physician

Name and Signature of Witness/Spouse

Date: _____

Date: _____

If the client cannot read, a witness of the client's choosing, of the same sex and speaking the same language must sign the following declaration:

I, the undersigned, attest to the fact that the client has affixed his/her thumbprint or mark in my presence.

Signature or mark of witness/spouse

Date

Annex 5: Informed Consent Form for Subdermal Implant Acceptors

SAMPLE INFORMED CONSENT FORM For Subdermal Implant Acceptors

(Source: DOH FP Clinical Guideline)

Benefits and Risks

- My physician and/or provider have discussed with me the benefits, risks, and side effects of using the subdermal implant.
- I understand that I may experience certain side effects, including but not limited to: menstrual bleeding irregularities, acne, headache, breast symptoms, weight gain, and abdominal pain.
- I am aware that there may be bruising and discomfort at the insertion site, and that there is a possibility that I may have an allergic reaction.
- Although the subdermal implant has been proven to be a very effective contraceptive method, I am aware that there is still a small chance of pregnancy (less than one pregnancy for every 100 women using subdermal implants for one year).

Procedure

- I understand that a local anesthetic will be used to reduce the pain and discomfort during the insertion procedure.
- I have informed my physician of any known allergies, particularly against local anesthetic agents, as well as ingredients contained in the subdermal implant.
- I am aware that the insertion and removal of the subdermal implant may leave a small scar, and that some individuals are predisposed to forming thickened and/or enlarged scars.
- I understand that the subdermal implant has to be removed after three years and that I am responsible for returning to the clinic to have it removed.

Voluntariness and Confidentiality

- My decision to have the subdermal implant inserted is completely voluntary. I have been made aware that this will not affect the services and/or treatment I receive in this facility.
- I understand that I may choose to discontinue using the subdermal implant at any time and for any reason. I may opt to have it removed at this facility, or in any other facility of my choosing.
- I have been assured that confidentiality for my personal information will be maintained.

Based on the information above, I _____ (printed name),
freely give my consent for the physician to insert a subdermal implant in my arm. My
signature indicates that I have read and fully understand the statements printed above.

Signature

Date


Name and Signature of Physician
Date: _____

Name and Signature of Witness/Spouse
Date: _____



Annex 6: FP Client Card

[illegible]

Annex 8: M1 Report

		FHSIS REPORT for the MONTH _____ YEAR: _____ Name of Hospital _____ Address _____ FP Point Person _____ Province: _____ Region _____				<div style="font-size: 48pt; text-align: center;">M1</div> <div style="font-size: 24pt; text-align: center;">HSPTL</div>		Age Disaggregation of Current Users (end of the Month)		
FAMILY PLANNING METHOD		Current User (End of Previous Month/ Beginning of the Month)	Acceptors		Dropout (Present Month)	Current User (End of Current Month)	New Acceptors of the present Month	14 and Below	15-19	20-49
			New Acceptors (Previous Month)	Other Acceptors (Present Month)						
a. Female Sterilization/BTL										
b. Male Sterilization/Vasectomy										
c1. Pills -POP										
c2. Pills-COC										
d1. IUD (Interval IUD)										
d2. PP- IUD (Post-partum IUD)										
e1. Injectables- POI										
e2. Injectables -CIC										
f. NFP-CM (Cervical Mucus)										
g. NFP-BBT (Basal Body Temperature)										
h. NFP-STM (Symptothermal Method)										
i. NFP-SDM (Standard Days Method)										
j. NFP-LAM (Lactational Amenorrhea Method)										
k. Condom										
l. Progestin-only Subdermal Implant										
Total										
Prepared by: _____ (Name and Signature)										
Position _____										
Date _____										
Approved by: _____ (Name and Signature)										
Position _____										
Date _____										

Annex 9: A1 Report

		FHSIS REPORT for end of YEAR _____ Name of Hospital _____ Address _____ FP Point Person _____ Province: _____ Region _____							Age Disaggregation of Current Users (end of Year)		
FAMILY PLANNING METHOD		Current User (Beginning January Current Year)	Acceptors		Drop-Out (January - December of Current Year)	Current User (End of December Current Year)	New Acceptors of December Current Year)	14 and Below	15-19	20-49	
			New Acceptors (NA for the month of December of Previous Year + NA of January-November of Current Year)	Other Acceptors (January - December of Current Year)							
			(Add)	(Add)	(Deduct)						
a. Female Sterilization/BTL											
b. Male Sterilization/Vasectomy											
c1. Pills -POP											
c2. Pills-COC											
d1. IUD (Interval IUD)											
d2. PP- IUD (Post-partum IUD)											
e1. Injectables- POI											
e2. Injectables -CIC											
f. NFP-CM (Cervical Mucus)											
g. NFP-BBT (Basal Body Temperature)											
h. NFP-STM (Symptothermal Method)											
i. NFP-SDM (Standard Days Method)											
j. NFP-LAM (Lactational Amenorrhea Method)											
k. Condom											
l. Progestin-only Subdermal Implant											
Total											
Prepared by: _____											
Position _____											
Date _____											
Approved by: _____											
Position _____											
Date _____											

Annex 10: Hospital's Daily Stock Record

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

