

Part 1: HEALTH RISK ASSESSMENT & KEY HEALTH MESSAGES (Indicate Y, if 'yes'; N if 'no')

B1. Did your baby receive his/her first OPV, DPT and 2nd Hepa B scheduled on the 6th week after birth?

(If No, deliver Message for B1, then go to B4. If Yes and the baby is 10 weeks or above, go to B2. Go directly to B4 if below 10 weeks)

B2. Did you baby receive his/her 2nd OPV and DPT scheduled on the 10th week after birth?

(If No, deliver Message for B2 to 3, then go to B4; If Yes and the baby is 14 weeks or above, go to B3. Go directly to B4 if the baby is below 14 weeks)

B3. Did your baby receive OPV, DPT and Hepa B scheduled on the 14th week after birth?

(If No, deliver Message for B2 to B3 then go to B4. If Yes, go to B4 - if the baby is 6 mos or below, or to B5 if the baby is above 6 months)

B4. (for babies 0-6 months) Is your baby exclusively breastfeeding?

(Deliver Message for B4 then go to B5)

B5. (for babies 6-11 months) Was your baby given Vitamin A?

(Deliver Message for B5, then go to B6)

B6. Is your baby eating solid food?

(Deliver Message for B6 the go to B7)

B7. Does your baby experience any of the these?
(please check if Yes)

- Cough
- Diarrhea (soft stools at least 3 times a day)
- Fever
- Swelling of hands and feet
- Convulsion
- Poorly or unable to breastfeed, eat or drink
- Vomiting
- Chest indrawing
- Fast breathing/difficulty in breathing
- sleepy/unconscious

(Deliver Message for B7 then go to Part 2)

Message for B1

- You can get free OPV and DPT from the health center. This helps prevent your baby from having infectious diseases that may lead to permanent disability and even death.

Message for B2 to B3

- Follow the schedule of immunization to ensure that your baby is fully immunized by age 12 months.
- Bring your baby to the health center before he/she is 1 year old to complete his/her immunization: BCG, DPT 1,2,3, OPV 1,2,3; Hepa 1,2,3 and measles
- Bring your baby's immunization card or *Booklet ni Nanay at ni Baby* every time you bring him/her to your health provider

Message for B4

- Breastfeeding for the first 6 months (without milk formula, water or other foods) will protect your baby from ear infections, diarrhea and respiratory illnesses
- Breast milk is adequate for your baby's needs for the first 6 months

Message for B5

- Your baby must receive Vitamin A at 6-months. Do this every 6 months until 5 years old
- Vitamin A increases you baby's resistance to infectious diseases and helps prevent blindness

Message for B6

- Refer to "*Booklet ni Nanay at ni Baby*", p. 26 "*Tagubilin sa pagpapakin mula anim na buwan hanggang 12 buwan*" for info on complementary feeding) and p. 29 "*Pagsubaybay sa aking paglaki at pagbabao*" for growth monitoring

Message for B7

- Immediately bring your child to a health provider if you notice any of these danger signs
- Bring with you Form 2B, your PhilHealth card, MDR and the baby's birth certificate

***For more information, see Family Health Guide Health, A. Health Messages. Caring for Infant and Child, p. 8**

Part 2: GENERAL INFORMATION (to be filled out with the help of the CHT partner)

Name of Respondent (Last name, first name, mother's maiden name)	NHTS HH ID: □□□□□□□□—□□□□—□□□□
Name of Infant (Last name, first name, mother's maiden name)	Date of Birth of Infant (mm/dd/yy):
Name of CHT partner (Last name, first name, mother's maiden name)	Date of Visit when Health Plan was developed (mm/dd/yy):

Part 3: HEALTH PLAN (to be filled out with the help of the CHT partner)

3.1 Plan for REGULAR Cases

Health Goal	Referral Provider/s (name and address) (use the list of health providers in the Family Health Guide)	Date of planned visit (mm/dd/yy)
<input type="checkbox"/> To bring my baby to the health provider on the scheduled immunization date/s		
<input type="checkbox"/> To exclusively breastfeed my baby for 6 months		
<input type="checkbox"/> To ensure that my baby receives Vitamin A supplementation every 6 months		
<input type="checkbox"/> To ensure that after 6 months old, my baby receives proper solid food (Complementary Feeding)		
<input type="checkbox"/> To bring my baby to a health facility for consultation, growth monitoring and treatment		
<input type="checkbox"/> Others		

3.2 Plan for EMERGENCY Cases

Reasons for Emergency Referral	Emergency transport providers (name and contact no.)	Health Service Providers (name and address)
<input type="checkbox"/> Consultation for immediate assessment and management of danger signs		

I/we understand the health risks and needs of our family and I/we have decided to develop this health plan.

(Name and signature of respondent)

Part 4: ACTIONS TAKEN (to be filled out by the midwife, nurse or doctor)
(Please accomplish/update the Immunization Schedule in the *Booklet ni Nanay at ni Baby*)

Name and address of health provider:

Services provided: (specify vaccines and schedule, example: OPV1, DPT1, HepaB2)	Date of consultation (mm/dd/yy):
	Schedule of next check up (mm/dd/yy):

Instruction of the provider:

