FORM 2D: Health Plan Implementation for MATERNAL HEALTH: PREGNANCY/PRENATAL CARE

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

D1. How many months are you pregnant?
_____ months
(Go to Question D2)

D2 . How many prenatal visits did you have?
_____ prenatal visits

(Deliver Message for D1 and D2 the go to Question D3)

D3. Are you experiencing any of the following danger signs? *(please check)*
- ☐ Severe headache
- ☐ Vaginal bleeding
- ☐ Convulsions
- ☐ Fever
- ☐ Severe abdominal pain
- ☐ Paleness

(Deliver Message for D3 then go to D4)

D4. Are you going to deliver in a health facility? _____
(*Deliver Message for D4 then go to Question D5)*

D5. Are you going to have check-up visits after your delivery? _____
(*Deliver Message for D5 then go to Question D6)*

D6. Are you aware of essential care for your baby within the first 24 hours of his/her life? ____
(*Deliver Message for D6 the go to Question D7)*

D7. Do you intend to practice family planning after giving birth (postpartum)? _____
(*Deliver Message for D7 then go to Part 2*
*Do not forget to assist respondent in also accomplishing **Form 2F**)*

Message for D1 and D2
- Healthy pregnancy means a healthy baby
- Have at least 4 prenatal check-ups (at least 1 visit during the first 3 months; at least 1 visit during the 4th to 6th months; and at least 2 visits during the 7th to 9th months). Receive Tetanus Toxoid.
- Ask your health provider to help you accomplish "*Plano sa Paghahanda sa Oras ng Panganganak at Emergency*" in your *Booklet ni Nanay at ni Baby, p.14*

Message for D3
- Immediately go to the nearest health provider
- Bring Form 2D, your PhilHealth card and Member Data Record (MDR)

Message for D4
- Give birth in a health facility to promptly manage possible complications during childbirth
- Use your PhilHealth benefits. See the Family Guide on PhilHealth if you are a member or dependent, p.7

Message for D5
- Visit your health provider on the 3rd and 7th day after delivery for check-up, early detection and management of complications.

Message for D6
- The first 30 minutes of your newborn baby's life is critical. Breastfeed your newborn and keep him/her dry and warm through skin-to-skin contact
- Within 24 hours from chilbirth, your baby must undergo Newborn Screening and should be immunized for BCG and Hepatitis B

Message for D7
- Space your children 3-5 years apart to allow your body to fully recover
- Go to your health provider to know the right Family Planning (FP) method for you and your partner

*For more information, see **Family Health Guide Health, A. Health Messages. Caring for Pregnant Woman,** p. 11

2D

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 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/day/year)
☐ To have 4 or more prenatal check ups (*preferably in PhilHealth-accredited facility*)		
☐ To develop a **Birth and Emergency Plan** with the health provider		
☐ To deliver in a health facility (*preferably PhilHealth-accredited*)		
☐ To receive care within 12 hours, 3 days and 7 days after delivery for myself and my baby		
☐ To receive family planning counseling		
☐ Others		

3.2 Plan for **EMERGENCY** Cases

Reasons for Emergency Referral	Emergency transport providers (name and contact no.)	Health Service Providers (name and address) Refer to List of Health Providers
☐ 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)

Name and address of health provider:

Services provided: (*Please include procedures, medications, advice given*)	Date of consultation(mm/dd/yy): Expected date of confinement(mm/dd/yy): Schedule of next check-up(mm/dd/yy):

Instruction of the provider:

Part 5: Service Utilization and Monitoring Form for MATERNAL HEALTH (PREGNANCY)				
Date of consultation (mm/dd/yy)	Name and address of service provider	Service(s) provided	Instruction of the provider (including referral to higher level and schedule)	Schedule of next visit to provider for check up (mm/dd/yy)

Part 5: Service Utilization and Monitoring Form for MATERNAL HEALTH (PREGNANCY)				
Date of consultation (mm/dd/yy)	Name and address of service provider	Service(s) provided	Instruction of the provider (including referral to higher level and schedule)	Schedule of next visit to provider for check up (mm/dd/yy)